

Healthcare Transformation Collaboratives Cover Sheet



1. Collaboration Name: Connected Care Collaborative

2. Name of Lead Entity: Southern Illinois Hospital Services

3. List All Collaboration Members:

| | |
|---|---|
| Anad Salem, MD | Prairie Cardiovascular Consultants, Ltd. |
| Christopher Rural Health | Quality Health Partners |
| Community Health and Emergency Services, Inc | Rides Mass Transit District |
| (CHESI) Franklin Williamson Bi-County Health | Shawnee Alliance for Seniors |
| Department Gastroenterology Care of Southern | Shawnee Health Service and Development |
| Illinois, LLC Healthy Southern Illinois Delta Network | Corporation SI Neurology and Sleep Medicine, |
| Jackson County Health Department | LLC |
| Javier Muniz, DO, LLC | SIU Center for Family Medicine – Carbondale |
| Kidney Disease and Medicine Specialty Consultants, | Southern Illinois Healthcare Medical Group |
| LLC NAACP, Carbondale Chapter | Southern Illinois Hospital Services |
| NowPow | Southern Illinois University School of Medicine |
| Pediatric Group, LLC | Swafford Pediatrics |
| | University of Illinois Extension |

4. Proposed Coverage Area: The Illinois Delta Region

5. Area of Focus:
Equity Pillar for Improvement

6. Total Budget Requested: \$43,470,497.00

0. Eligibility Screening:

Does your collaboration include multiple, external, entities? Y/N

Yes

Can any of the entities in your collaboration bill Medicaid? Y/N

Yes

1. Participating Entities:

What is the name of the lead entity of your collaborative?

Southern Illinois Hospital Services

List of Partner Entities in the Collaboration

Anad Salem, MD

Christopher Rural Health Community Health and Emergency Services, Inc (CHESI)

Franklin Williamson Bi-County Health Department

Gastroenterology Care of Southern Illinois, LLC

Healthy Southern Illinois Delta Network

Jackson County Health Department

Javier Muniz, DO, LLC

Kidney Disease and Medicine Specialty Consultants, LLC

NAACP, Carbondale Chapter

NowPow

Pediatric Group, LLC

Prairie Cardiovascular Consultants, Ltd.

Quality Health Partners

Rides Mass Transit District

Shawnee Alliance for Seniors

Shawnee Health Service and Development Corporation

SI Neurology and Sleep Medicine, LLC

SIU Center for Family Medicine – Carbondale

Southern Illinois Healthcare Medical Group

Southern Illinois Hospital Services

Southern Illinois University School of Medicine

Swafford Pediatrics

University of Illinois Extension

Are there any primary or preventative care providers in your collaborative? Y/N

Yes

Please enter the names of entities that provide primary or preventative care in your collaborative

SIH Medical Group
CHESI
Christopher Rural Health
Anad Salem, MD
Prairie Cardiovascular Consultants, Ltd.
SIU Center for Family Medicine - Carbondale
Swafford Pediatrics
Pediatric Group, LLC
Franklin Williamson Bi-County HD
Jackson County HD

Are there any specialty care providers in your collaborative? Y/N

Yes

Please enter the names of entities that provide specialty care in your collaborative

Southern Illinois Hospital Services
SI Neurology and Sleep Medicine, LLC
Javier Muniz, DO, LLC
Gastroenterology Care of Southern Illinois, LLC
Kidney Disease and Medicine Specialty Consultants, LLC
Prairie Cardiovascular Consultants, Ltd.
SIH Med. Group

Are there any hospital services providers in your collaborative? Y/N

Yes

Please enter the name of the first entity that provides hospital services in your collaborative

Southern Illinois Healthcare, an integrated healthcare system, provides hospital services through four hospitals: Memorial Hospital of Carbondale, St. Joseph Memorial Hospital (a critical access hospital), Herrin Hospital, and Harrisburg Medical Center.

Which MCO networks does this hospital participate in?

YouthCare
Blue Cross Blue Shield Community Health Plan
IlliniCare Health
Meridian Health Plan
Molina Healthcare

Are there any other hospital providers in your collaborative? Y/N

(Repeat as many times as needed)

No

Are there any mental health providers in your collaborative? Y/N

Yes

Please enter the names of entities that provide mental health services in your collaborative:

CHESI

Christopher Rural Health
Pediatric Group, LLC
Shawnee Health Service and Development Corporation
SIH Med. Group
Southern Illinois Hospital Services
SIU Center for Family Medicine – Carbondale

Are there any substance use disorder services providers in your collaborative? Y/N

Yes

Please enter the names of entities that provide substance abuse disorder services in your collaborative:

CHESI
Christopher Rural Health
Shawnee Health Service and Development Corporation
SIH Med. Group
Franklin Williamson Bi-County HD
Jackson County HD

Are there any social determinants of health services providers in your collaborative? Y/N

Yes

Please enter the names of entities that provide social determinants of health services in your collaborative:

CHESI
Christopher Rural Health
Shawnee Health Service and Development Corporation
SIU Center for Family Medicine – Carbondale
Franklin Williamson Bi-County HD
Jackson County HD
Rides Mass Transit District
Shawnee Alliance for Seniors
U of I Extension

Are there any safety net or critical access hospitals in your collaborative? Y/N

Yes

Please list the names of the safety net and/or critical access hospitals in your collaborative:

St. Joseph Memorial Hospital

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?

Y/N

Yes

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

NowPow
NAACP, Carbondale Chapter

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

Southern Illinois Hospital Services
CHESI
Christopher Rural Health
SI Neurology and Sleep Medicine
Javier Muniz, DO, LLC
Anad Salem, MD
Gastroenterology Care of Southern Illinois, LLC
Kidney Disease and Medicine Specialty Consultants, LLC
Pediatric Group, LLC
Prairie Cardiovascular Consultants, Ltd.
Shawnee Health Service and Development Corporation
SIH Med. Group
SIU Center for Family Medicine – Carbondale
Swafford Pediatrics

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

Hospital plus Other Provider Partnerships in Distressed Areas to Address Health Disparities (led By Critical Area Hospitals, Safety Net Hospitals or other hospitals in distressed communities)

2. Project Description

Brief Project Description:

Provide an official name for your collaboration. NOTE: Please ensure that this name matches the name given in the "Application Name" field in the Project Information form at the beginning of the application.

Connected Care Collaborative

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

The Connected Care Collaborative's goals are to sustainability redesign the delivery of our health care to equitably meet all of a patient's unique medical and social needs.

Detailed Project Description:

To Include a narrative description of your overall project, explaining what makes it transformational. Specify your service area, identify the healthcare challenges it faces, and articulate your goals in addressing these challenges; explain your strategy and how it addresses the causes of these challenges, and lay out the expected timeframe for the project. Describe any capital improvements, new interventions, delivery redesign, etc. Your narrative should explain the need for each significant item in your budget, clarifying how each connects to the overall goals and operations of the collaboration.

Healthcare Transformation. Access to health care impacts one's overall physical, social, and mental health status and quality of life. Healthy People 2020 emphasizes that access to health services means the timely use of personal health services to achieve the best health outcomes. They identify three distinct steps in access to care including gaining entry into the health care system, accessing a location where needed health care services are provided, and finding a health care provider whom the patient trusts and can communicate with. Healthcare is radically shifting from being episodic, reactive, and impersonal to being *continuous, predictive, and personalized*. In turn, healthcare will be more effective, efficient, and available to underserved populations. This transformation will continue to empower quality of and access to care; spur innovation and new alternative payment models; and drive greater equity.

Service Area Health and Economic Challenges. This rural region of Illinois, spanning the lower 16 and known as the Illinois Delta, has endured isolated households, low income and low educational levels, high rates of poverty, illness and mortality, as well as large numbers of medically underserved residents. In general, southern Illinois residents are more prone to have higher BMI, higher blood pressure, increased risk for diabetes and are more apt to smoke and be sedentary than all other Illinoisans. Improvements are needed in areas such as preventive screenings, healthy eating and physical activity. Residents face considerable barriers to access, demonstrated by unmet or missed primary care appointments and high emergency department utilization. Unemployment, poverty, food insecurity, access to care and lack of transportation serve as barriers to health and healthcare.

The 2010 Census and the Illinois Department of Public Health indicate there are 268,397 residents in the rural 16-county area. Unemployment rates are higher in the southern Illinois delta region than in the rest of the state, and higher than the national average. According to the Delta Regional Authority, 15 of the 16 Illinois Delta counties are deemed distressed in 2020. Additionally, according to the Delta Regional Authority, average annual job growth in the Delta region has been only one-third that of the nation since the end of the Great Depression. This is particularly distressing for the Illinois delta counties, which have experienced decline in job growth (Annual Growth Rate).

Collaboration as a catalyst. Enabled by the HFS Healthcare Transformation grant, the goal of our Collaborative is to use the HFS investment to: 1) Spur healthcare delivery

redesign so that each patient's individual needs are the focus of care; 2) Drive greater collaboration to more effectively utilize resources, propagate learnings and best practices; 3) Reduce silos between healthcare settings and community-based organizations by maximizing the effectiveness and reach of established community-based programming and their resources to create a seamless, closed-loop referral process for provider-based referrals; 4) Significantly enhance equity in healthcare outcomes; 5) Provide healthcare more effectively, particularly to underserved communities. These funds will provide the catalyst to propel healthcare transformation, especially within rural communities where lack of resources and access to proper care are so acutely felt. The projects selected are intended to provide a case study and ultimately a replicable model that can be leveraged outside the project area as a subsequent phase to this proposal.

Projects. Population health has been defined as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group." It is an approach to health that aims to improve the health of an entire human population. There are three main components of population health work: health outcomes, patterns of health determinants, and policies and interventions. The projects were specifically chosen to provide a focus on population health that purposefully emphasizes communities that have been marginalized and individuals who have been underrepresented in the work force. They intentionally support near-term needs of access and long-term sustainability. All together, these projects will help our rural region generate systemic change by creating a bridge between provider-based and community-based settings of care to ensure that patients are effectively connected to the services and resources they need for optimal health and well-being.

Project (1) – a regionalized Community Health Worker program. The idea of Community Health Workers (CHWs) as partners within clinical care teams has been gaining attention because of their effectiveness at reaching diverse populations in underserved communities to promote health initiatives. According to the Center for Disease Control, CHWs are "trained public health workers who serve as a bridge between communities, healthcare systems, and state health departments." By design, they are perfectly situated to perform health activities in hard-to-reach areas because they commonly share ethnicity, language, socioeconomic status, and life experiences with the community members they serve. They have proven to produce results to improve health by utilizing their close relationships with community members to connect them to health and social resources. It has also been shown that CHW programs are cost-effective by addressing social factors that can reduce need for expensive treatment and emergency care. CHWs tackle issues like access to care, food security, housing, transportation and social connectedness with cultural awareness and the trust of the individuals they work with. It is this trusting relationship that allows them to perform activities that help to improve clinical outcomes such as chronic disease control, mental health, quality of care, frequency of hospital use, and service delivery.

Community health workers will visit participants in the community, help reconcile their medications, facilitate completion of evidence-based prevention screenings, accompany

them to doctor's visits to be advocates of holistic care, and link them to social and legal services among other activities. Over the years other models have demonstrated that without addressing social support during healthcare interventions, no real change is accomplished. Accordingly, our intervention will spend as much time linking patients to social support as to healthcare.

Project (2) – an integrated, personalized community referral platform. NowPow enables whole-person care across whole communities. NowPow's Personalized Community Referrals make it easy to connect people to just the right community resources so everyone can stay well, meet basic needs, manage with illness and care for others. NowPow's multi-sided referral platform powers caring for people across all of life's ages and stages and across networks of all sizes and sectors. NowPow's unique population health solution also provides deep community resource and referral insights to support process improvement, network health and quality, and care access and experience. A key application within NowPow is the PowRx application, which drives resource awareness, patient engagement, and activation.

PowRx supports three types of referrals: shared, tracked and coordinated. With a shared referral, a care professional user provides resource information directly to an individual via text, email, or print. With a tracked referral, the care professional sends the patient's information to a community-based organization through a secure interface. With coordinated referrals, everyone within a network gains access to a certain level of patient information so they may collaboratively coordinate to support the patient throughout their longitudinal care. Coordinated referrals support the following functionality: ability to share and view longitudinal referral history with organizations in the coordinated network; upload and exchange documents in NowPow; CBOs can convert a referral into a client record in NowPow, allowing them to make secondary tracked and shared referrals. Referral senders and receivers are connected through a secure, bi-directional messaging platform to monitor the progress of the referral and close the loop on care.

Transformative Nature of Project Design. Southern Illinois has already begun the important and arduous work of forming clinical and community-based initiatives to drive quality and connectedness of healthcare for our rural region. The Quality Health Partners (QHP) is a clinically-integrated Physician-Hospital Organization (PHO) that uses systems and processes to improve quality and reduce cost through evidence-based medicine, performance measurement, information sharing and alignment of incentives. The QHP is comprised of 475 providers (94 primary care, 120 specialists, 211 mid-levels) representative of more than 70 clinics, as well as four hospitals. This is inclusive of five Federally Qualified Health Centers, Prairie Heart Institute, SIH Medical Group, SIU Healthcare, Pediatric Group, New Horizons (OBGYN), Heartland Women's, SI-OBGYN, and multiple independent practices, both primary care and specialty groups. The QHP Patient Registry houses 195,000 patients from a service area of just under 345,000 – just over 56% of the region's population.

The Healthy Southern Illinois Delta Network (HSIDN) is a grassroots effort established to build consensus around meeting the health needs of residents in southernmost Illinois. The network brings together local health departments, area health centers, hospitals and other community-based organizations interested in improving the health of their communities. Members work together to support healthy communities in the lower fifteen counties in Illinois. HSIDN steering committee members include Southern Illinois Healthcare, the Southern Illinois University Center for Rural Health and Social Service Development and the area's six health departments covering a fifteen-county region. Regional efforts are coordinated by the steering committee and implemented at the local level through healthy community coalitions. Coalition members and action teams engage their own communities to conduct activities and advance the overall mission of the HSIDN. The Network has grown into a strong collaborative effort of community organizations successfully leveraging resources to improve health in the Illinois Delta region. The success of the network is a direct result of the regional planning approach supported by active engagement of those representatives interested in improving the health of their communities.

Until now, these two initiatives have been supportive of one another, but largely siloed in their efforts. The Connected Care Collaborative proposes to build a bridge within these frameworks to prioritize a patient-centered approach to healthcare. By bringing these two disparate groups together via a Collaborative to support a region-wide deployment of Community Health Workers we can drive greater quality and equity within the region.

In addition to a network of clinical partners and a network of community resource partners, the Connected Care Collaborative embraces outside university academic partners to provide both training (SIU School of Medicine Office of External Relations) and evaluation (Southern Illinois University School of Medicine Department of Population Science and Policy) of the project to ensure greatest impact, assess replicability and contribute solutions toward sustainability.

A Trained, Diverse Workforce. A trained diverse workforce is critical. With the transformation of the healthcare system well underway, care coordination utilizing CHWs is now being highlighted by hospitals, health systems, and insurers as a key tool in improving patient health and satisfaction and controlling healthcare costs. In our region, the Southern Illinois University (IHA-aligned) Community Health Worker ECHO provides training for CHWs and will serve as an integral partner for this proposal. Project ECHO (Extension for Community Healthcare Outcomes) transforms the way rural, underserved communities learn and share knowledge. Originally launched in 2003 at the University of New Mexico Health Science Center, Project ECHO has grown into a national model of providing front-line clinicians with knowledge and support. Using this model, the SIU-IHA ECHO provides a virtual network for experts to mentor and share their medical expertise. The Southern Illinois University School of Medicine Community Health Worker ECHO program encompasses the following:

- 1) The CHW Generalist ECHO program provides a foundational structure on serving as a community health worker. This format includes formal instruction, field shadowing experience, and supervision training.
- 2) The CHW Specialty ECHO then deepens the basic instruction on specific health concerns, including dealing with chronic issues: diabetes, asthma, hypertension, oral care, and opioids. The School of Medicine also plans to develop different programs focused on memory and aging issues and mental health care. Each specialty series consists of formal instruction, including didactic and case presentations participants.
- 3) The CHW Evergreen Echo allows the CHW's to guide the discussion by identifying topics that would best serve them and what is happening within the work. Evergreen references a strategy, service relevant and need over an extended period. CHW Evergreen program serves as a monthly touchpoint support system for supervisors and CHWs. Each month SIU SOM will conduct a one-hour session with a brief didactic and case-based discussion on current topics.

Metrics for the SIU CHW program assess clients' self-sufficiency as the overarching umbrella for measuring clients' success. Key success metrics include clients having access to transportation, housing, the ability to sustain a job, being employable, or if not employable then eligible for entitlement benefits. CHWs offer both health care assistance as well as social support assistance. For example, ensuring clients have a PCP and utilizing their PCP; helping clients avoid unnecessary emergency department visits and helping them obtain their medications. Once these measures are sustainable, clients graduate from the program and are always allowed to check-in.

Identified Population. The QHP Patient Registry has 195,000 total patients loaded for a recent 12-month period. Medicaid patients represent 45,000 of that total. Coordination of care from the Collaborative's CHWs will focus on the common actuarial subset of the Medicaid patient population – that is, 20% of the patients (9,000) represent 80% of the total patients' costs. This subset of the Medicaid population commonly has multiple chronic conditions, significant Social Determinants of Health (SDoH) needs, difficulties with provider access and improper use of healthcare sites of care.

From these 9,000 patients, it is unlikely that all will accept assistance. In the first two years, we predict that 25% of those 9,000 high needs Medicaid patients (2,250) will accept assistance from our CHWs. We will initially budget for 90 CHWs (case load of 25 patients per CHW) and then increase the number of CHWs over the five years as word of our acceptance within the community spreads. We will also budget for 30 more CHWs to address the high SDoH needs of 5% of the remaining 150,000 patients or

7,500 in our QHP Patient Registry. Once again, assuming initial acceptance of the CHWs by this subset of patients will be limited at 10% or 750.

Expected Timeframe. All projects have developed timelines with milestones designed to ensure steady progress and that all activities will be completed. Our expected time frame for the project from implementation to sustainability is five years. Our sustainability plan is based on the critical assumption that community health workers will become, at least in part, a billable service for Illinois Medicaid patients. A detailed plan is included in the “Milestones” section of this application; at a high level, we anticipate three phases to roll out and complete all proposed initiatives:

- Year 1: Planning, Pre-Implementation, Training
- Years 2 & 3: Project Implementation, Evaluation and APM Considerations
- Years 4 & 5: Ongoing Project Implementation, Ongoing Evaluation, and Sustainability

Requested Resources. A substantial request within our proposed budget is for personnel. Hiring 120 community health workers is a task that no partnering entity could undertake without grant funding and the most crucial resource for deploying a community health worker program throughout the Delta region. In addition to the community health worker cohort, the following staff requests are critical for the implementation and evaluation of the project: critical managerial staff to oversee the community health workers and coordinate with both internal and external stakeholders on implementation activities, reporting requirements and evaluation efforts (CHW Director); critical information technology staff to assist and support the buildout of the technology infrastructure and application platforms and to work with providers regarding adoption and utilization of the NowPow tool as part of their workflows; a percentage of time from a team of researchers with SIU School of Medicine, Department of Population Science and Policy to perform all evaluation activities for the components of this project; a percentage of time from the SIU School of Medicine Director of Program Development, who oversees the ECHO programs for the School and will devote a considerable amount of time assisting and monitoring the training of the community health workers hired.

Mileage is also a substantial request. A key characteristic of community health workers is that they “meet people where they are” and assist patients in breaking down a variety of barriers they face to healthcare access. This can include activities like transportation to appointments and assisting with medications and food procurement. Therefore, travel is an extensive part of this role.

We request funds to cover basic office supplies through all five years. Additionally, in Year One, we request funds to purchase necessary hardware (computers, mobile printers, etc.) for each community health worker hired.

NowPow makes it easy to connect people to just the right community resources so everyone can stay well, meet basic needs, manage with illness and care for others. NowPow's pricing is a combination of one-time fees and annual subscription & maintenance fees. One-time fees consist of implementation, and any integration, raw data build and screener functionality services selected. Annual subscription fees consist of a user band model and ongoing maintenance fees for integrations, resource directory and network as applicable. The pricing proposal from the company includes the one-time implementation and ongoing subscriptions costs for getting the Collaborative up and running, easily expanding our network as we go. Shared costs across the collaborative are for Raw Data, the screening bundle, and resource directory maintenance. Each participating organization will have access to their own user band so they may distribute licenses as they like while providing them with an economy of scale as they grow their usage. As NowPow is well situated in Illinois and in support of this effort, they have waived the resource directory maintenance cost and given the Collaborative the option of selecting up to 5 screeners built in the platform for the price of three.

Finally, proper training for the community health workers is essential to their effectiveness and success. SIU School of Medicine adopted the Extension for Community Healthcare Outcomes (ECHO) program in 2017. This evidence-based training model focuses on an all-teach-all-learn concept and incorporates best practice protocols through tele-mentoring. SIU-IHA Forward for Community Health Workers ECHO provides guided training and a structure that supports guidelines and insight on helping clients navigate their life systems while showing them how to advocate their healthcare and ways in the world.

Equity. A myriad of factors produce and perpetuate longstanding racial inequities and poorer health outcomes in rural populations of color. Deep-rooted societal and structural racism and discrimination, coupled with the common tendency for minority populations to lack trust in the healthcare system, have given rise to profound healthcare access challenges, SDOH needs, and inequities across the system of care. This proposal seeks to narrow these inequities by addressing the deep-seated SDOH needs at the heart of the system for vulnerable populations and employ culturally diverse healthcare access teams to strengthen access across the system. Equity is an integral component of each of the projects described above. Collectively, the projects will demonstrably and disproportionately increase employment for underrepresented communities and improve the access to and the effectiveness of healthcare to underserved populations. In addition, both the Community Health Needs Assessment community input effort and those undertaken by individual projects will ensure that all aspects of successful inclusion are imbued from the start.

Measurable Health Outcomes.

| Measure | Target |
|--|--------|
| Patients age 40-69 receive an annual breast cancer screening | 55% |
| Patients ages 21-65 receive a cervical cancer screening once every three years | TBD |
| Patients have their blood pressure performed annually | 97% |
| Patients have a controlled blood pressure (<140/90) | 70% |
| Patients have an HbA1c test annually | 80% |
| Patients have an uncontrolled HbA1c (>9) or do not have an HbA1c test | <30% |
| Patients have a controlled HbA1c (8) | 60% |
| Patients have LDL tested annually | 75% |
| Patients have LDL results <100 | 50% |
| Patients have a smoking assessment done annually | 97% |
| Known smoking patients receive Smoking Cessation Counseling Annually | 60% |

The Connected Care Collaborative will create systemic change by creating a bridge between provider-based and community-based settings of care to ensure that patients are effectively connected to the services and resources they need for optimal health and well-being. This investment is necessary to truly transform our system to be patient-centered, to fully address the social determinants of health needs and reduce healthcare disparities in our most vulnerable populations in rural Illinois

Works Cited:

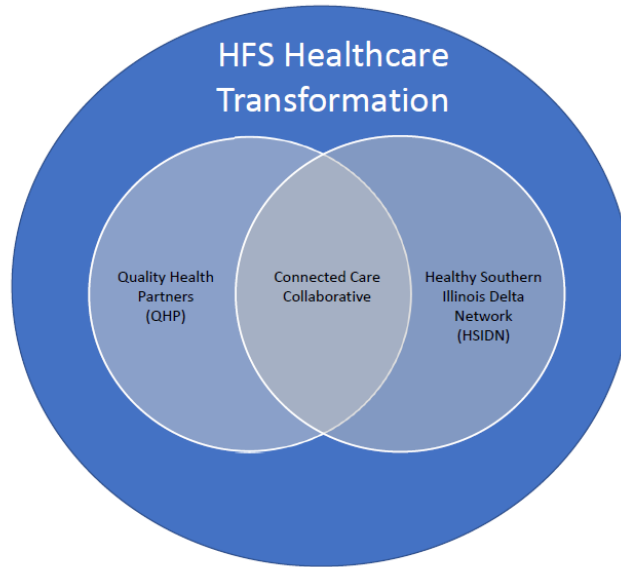
Annual Growth Rate for Covered Jobs in Delta Region, Delta Counties and Parishes, & Delta States, 2010-2015. U.S. Bureau of Labor Statistics, Quarterly Census of Employment & Wages

3. Governance Structure:

Structure and Process:

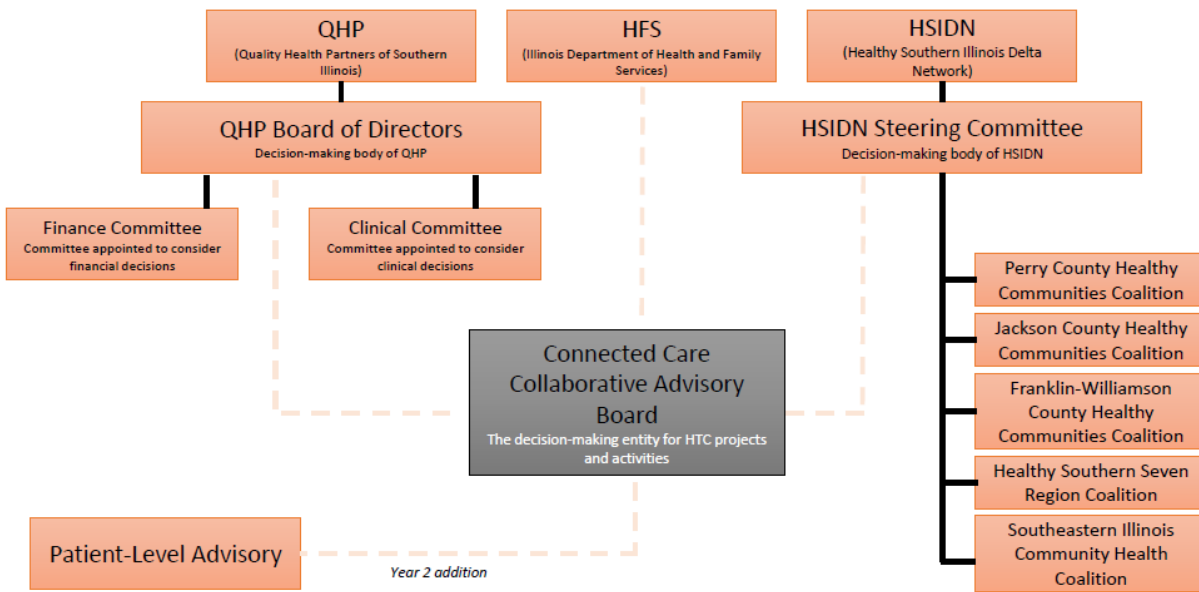
Please describe in detail the governance structure of your collaboration and explain how authority and responsibility will be distributed and shared. How will policies be formulated, and priorities set?

Governance. The governance structure of our Collaborative is built off the shoulders of two existing bodies: The Quality Health Partners (QHP) – a clinically integrated Physician Hospital Organization (PHO) and the Healthy Southern Illinois Delta Network (HSIDN). This design was chosen to help simplify data sharing, streamline data collection and goal setting and facilitate collaboration and communication within and throughout the community. This directly contributes to a higher probability of the Collaborative achieving our goals and improving the health outcomes of our rural region.



Existing QHP Governance. The governance structure of the QHP is a physician-led design. A single-member limited liability company structure allows SIH to fund the development of the PHO while sharing decision making with physicians. All major decisions are cast by the QHP Board of Directors. The Board consists of two groups: physician/Federally Qualified Health Center (FQHC) group and SIH/SIMS Group. All decisions by the board require a majority of both groups. If either group does not support a decision, the motion will not pass, and the PHO will not proceed. Approval of payer contracts, clinical measures and incentive system require two-thirds approval of each group. The QHP also operates two standing committees: a finance committee and a clinical committee. The role of the finance committee is primarily to provide financial oversight for the organization, including monitoring internal controls and accountability policies. The roles of the clinical committee are to (1 identify and select clinical programs and measures; 2 oversee the development of clinical guidelines; 3) develop multifaceted intervention approaches; (4 establish performance targets; (5 ensure adherence to credentialing requirements.

Existing HSIDN Governance. The governance structure of the HSIDN is a community-led design. All major decisions are cast by the HSIDN Steering Committee. Members include Southern Illinois Healthcare; six health departments of the region (Jackson County, Franklin-Williamson Bi-county, Southern Seven, Perry County, Hamilton county and Egyptian); the SIU School of Medicine Center for Rural Health and Social Service Development; and the University of Illinois Extension. Regional efforts are coordinated by the steering committee and implemented at the local level through healthy community coalitions. There are six regional coalitions, guided by their own taskforce priorities. Coalition members and action teams engage their own communities to conduct activities and advance the overall mission of the HSIDN. Their identified areas for focus include smoke-free housing and smoke-free places, improving nutrition and physical activity, coordinated school health/Whole School, Whole Child, Whole Community, and high impact clinical preventative services.



Connected Care Collaborative Advisory Board. The Connected Care Collaborative Advisory Board will be comprised equally of clinical and community representatives, which will ensure a local focus of control and leadership. Additionally, the Collaborative envisions HFS to be a participating body on the Advisory Board as necessary to support the development of the project in alignment with state goals. The Advisory Board will have ultimate oversight of the project – providing accountability to project goals and will be responsible for continuous quality improvement strategies and activities. In addition, various working groups will be formed to address specific issues and topics as necessary to achieve project goals.

Patient Level Advisory Board. In Grant Year 2, a patient level advisory board will be a fourth-contributing body to the Collaborative's Advisory Board. The patient-level community advisory board (CAB) will be comprised of individuals representing various disparity/priority population groups chosen based on possible lack of trust, difficulties with healthcare navigation, and healthcare-related stigma (e.g. racial/ethnic minorities; sexual and gender minorities; people who use drugs and/or are homeless; cancer survivors). This CAB will be established in Grant Year 2 to allow time for programmatic set-up. By consultation and input with this CAB, the program will seek to improve care and engagement for similar individuals who are current patients, and devise strategies to engage their constituent populations (who may not otherwise be engaged in healthcare) going forward.

Authority and Responsibility. The Connected Care Collaborative Advisory Board will have equal representation from clinical and community partners. To provide institutional support to the chain of command, Southern Illinois Healthcare (SIH) will assign two full-time employees to this effort.

The System Director of Population Health will report to the SIH Vice President of Health Transformation and is responsible for leading the development of strategies to manage the health of the populations that Southern Illinois Healthcare serves. This person will provide integration between activities of key units related to clinical transformation that creates alignment, reduces duplication of efforts and improves coordination of approaches and deployment of resources. They will develop a cross-continuum perspective by building relationships, understanding influences, and facilitating shared agendas across the acute, post-acute and ambulatory clinical network, physicians and other providers, health and social service agencies, and community partners. They will ultimately oversee the Community Health Worker program and attend every Collaborative Advisory Board meeting.

The CHW Project Director will be responsible for the implementation of the CHW program. They will be the main point of contact for each set of CHWs and connect them with proper resources. This person will engage regional and local coalitions, local health departments, healthcare systems, community-based organizations, and other partners to facilitate the work of community health workers in the southern most counties of Illinois. They will also be tasked with producing a comprehensive Delta Region Community Resource Guide and maintain it.

Each Clinical Partner in the Collaborative will have their own set of CHWs, with a lead to supervise, inform and act as a resource for their team. They will report up to the CHW Project Director.

Accountability:

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?

For accountability of the Collaborative and the projects, the members of the Collaborative will enter into a written binding agreement or contract with and among the members. The binding agreement will include the management, accountability, and inter-reliance of the participating members of the Collaborative. The binding agreement will detail the structure and governance of the Collaborative and how the members of the Collaborative will cooperate with each other to accomplish the projects, including the members' authority and responsibility, commitment to adherence to the Collaborative's policies, commitment to and accountability for achieving project outcomes, and good faith and fair dealing among the members.

New Legal Entity:

Will a new umbrella legal entity be created as a result of your collaboration? Y/N

No

Payments and Administration of Funds:

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.

Fiscal Agency. Southern Illinois Healthcare (SIH) will serve as lead agency and fiscal agent for the project. SIH is a not-for-profit health system serving the southernmost counties of Illinois with four hospitals, a comprehensive cancer center, Level II Trauma Center and more than 30 outpatient and specialty practices. SIH is the region's second largest employer with over 4,000 employees and the largest provider of charity care, unreimbursed care, and community benefits. Harrisburg Medical Center officially joined the SIH family in August of 2021 after nearly ten years of collaborating with SIH on various clinical and operational services.

Southern Illinois Healthcare is as committed to quality health services today as it was when its first hospital opened in 1875. The system is guided by its mission statement, which reflects the purpose of the organization as envisioned by its founders: "We are dedicated to improving the health and well-being of all of the people in the communities we serve." SIH works diligently to help bring health services, educational programs, free rural health clinics, parish nursing, preventative screenings and immunizations to the region's most vulnerable populations.

SIH is governed by a Board of Trustees which maintains strategic oversight to maintain organizational sustainability and overall fiduciary responsibility for SIH's operating budget. SIH operates in a highly regulated industry that meets or exceeds federal, state and local requirements that cover patient care, safety, employees, environmental and financial regulations. All grants are managed by the program director in coordination with support staff including the Grant Management Supervisor and Grant Management Specialist. Fiscal tracking is maintained by Southern Illinois Hospital Services' accounting department which includes 16 staff. One staff member is dedicated solely to grants accounting. The Compliance and Legal departments oversee compliance with federal rules and regulations. Grants are tracked according to the specific grant guidelines to ensure that the collection and timely reporting of process and outcomes is achieved. SIH has a long and successful record of administering federal, state and private foundation grants, and partnering through grants with various community entities. Throughout the SIH system, grants from various funders in aggregate approximately \$5 million are administered annually. All payment of transformation funds will be tracked centrally and participating entities will be required to produce reports to ensure funds are spent appropriately and as outlined within our proposed budget.

4. Racial Equity:

High Level Narrative:

A fundamental focus of healthcare transformation is racial equity. Please provide a high-level description of how the design of your proposal incorporates racial equity.

A range of personal, social, economic and environmental factors that impact health often occur outside the hospital or clinic walls, yet their inter-relationship affects individual and community health. These factors disproportionately affect vulnerable and underrepresented populations and adversely affect quality of life and health for all of us. Because of this, interventions that are community-based and target multiple determinants of health are most likely to be effective. Engaging allies from outside the traditional boundaries of health care and the public health sector such as education, social work, legal aid, housing, transportation and agriculture is essential to improving population health and maximizing existing assets. The QHP Board has recently voted to add detailed race, language and ethnicity (RLE) to the patient registries. Once complete, the Collaborative will be in a position to more easily identify racial and ethnic minorities. From there, we will use cultural competency to ensure their needs are met in appropriate ways.

Cultural competence is widely seen as a foundational pillar for reducing disparities through culturally sensitive and unbiased quality care. Culturally competent care is defined as care that respects diversity in the patient population and cultural factors that can affect health and health care, such as language, communication styles, beliefs, attitudes, and behaviors. Our proposal is intentionally designed to not only improve health outcomes for individuals but to remove healthcare disparities. Specific key activities that are incorporated at all levels of the community health worker program are:

- Increasing provider knowledge, attitudes, and competencies (skills) in providing culturally competent health care through required training programs and increased interaction with community health workers
- Addressing provider beliefs/cognitions about the priority population to reduce stereotyping and stigmatization by education, advocacy, and exposure
- Addressing patient beliefs and cognitions such as improved trust and decreased perceived racism by implementing trusted and culturally guided community health workers
- Provision of improved access to acceptable health services

CHWs are by design, perfectly situated to perform health activities in hard-to-reach areas because they speak the language and come from the communities they serve. The required training within our proposal will combine on-the-job training with classroom instruction, allowing a worker to earn a living wage while achieving continued growth in their occupation. The SIU School of Medicine Community Health Worker ECHO program is a recognized method of training to upskill workers who desire training in direct patient care positions. This program method was chosen because it addresses many of the barriers keeping the target populations of this project from sustainable

employment. With wages earned, these community health workers can spend their earnings in their communities, stimulating the economy and providing relief to the State's unemployment insurance pool and social services.

Racial Equity Impact Assessment Questions:

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

Rural communities of color, in particular the African American and Hispanic populations whose payer source is Medicaid, have poorer health outcomes than their Caucasian counterparts, according to the Center for Disease Control. This can be seen in rates of cardiovascular disease, cancer, and other health conditions, coupled with significantly greater challenges in accessing healthcare. Diabetes and cancer screenings (two metrics within this proposal) adversely affect the African American and Hispanic population compared to their non-Hispanic white counterparts. This proposal seeks to address the social determinants of health (SDOH) needs affecting these populations to create a more seamless system of care that improves health outcomes for these populations.

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 for this healthcare transformation project has been designed with direct, meaningful involvement and implementation by our community partners. The diverse composition of the Quality Health Partners of Southern Illinois (QHP), Healthy Southern Illinois Delta Network (HSIDN), and Advisory Board, as well as the inclusion of the local chapter for the National Association for the Advancement of Colored People (NAACP) as a project partner, ensure that the individual needs of vulnerable populations from different racial/ethnic groups in local communities are all voiced, addressed and met. Additionally, community input on community needs has been garnered by a diverse group of community stakeholders, including but not limited to healthy community coalitions, faith community nurses, health ministry volunteers and congregational health connectors. All these groups will guide the design and implementation of this project over the course of its lifecycle.

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?

The QHP is actively enhancing the patient registry to include race, language and ethnicity information. This currently missing piece of quantitative data is crucial to addressing the racial and ethnic groups most disadvantaged by the issues this proposal seeks to address; this registry enhancement is expected to be complete and operational within the first year. According to the 2020 Census, over 52,000 residents, or approximately 11% of the proposed service area of this project, identified themselves as

either non-white, or multiracial. There is much evidence in healthcare literature that Caucasian rural residents fare much better on a whole series of health outcomes than their non-white peers. A recent CDC report, *Racial/Ethnic Health Disparities Among Rural Adults*, details the higher rates of cardiovascular disease and cancer for non-white rural populations, details that non-white rural populations are less likely to see a physician due to cost and other access issues, and details that non-white rural populations rate their health as poorer than their white peers. Through this intervention strategy, disparate and underserved minority populations will directly benefit from the availability of community health workers, by significantly increasing their access to, and availability of, health services.

Furthermore, 11.7% of the region's population live with a disability compared to 8.5% of the US Population, and 18.6% live below the poverty line, compared to 14.8% of the rest of the nation (2015, US Census Bureau). Disability and poverty present huge access barriers to healthcare. Additionally, according to the 2020 census, over 75,000, or almost 20% of the region's population is age 65 or older. The elderly may face a unique combination of access barriers due to disability, illness and likely a greater need for frequent visits to their clinician (Syed, 2013).

The availability of community health workers to these disparate, underserved, and historically disenfranchised minority populations that we serve, presents an opportunity to remove major access barriers, and lead to more equitable health outcomes in the region.

Syed, S. T. (2013). *Travelin Towards Disease: Transportation Barriers to Health Care Access. Journal of Community Health. Vol. 38(5), 976-993.*

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?

A myriad of factors produces and perpetuates these longstanding racial inequities and poorer health outcomes in rural populations of color. Deep-rooted societal and structural racism and discrimination, coupled with minority populations' lack of trust in the healthcare system, have given rise to profound healthcare access challenges, SDOH needs, and inequities across the system of care. Specific equity issues directly affecting the health in the region include an insufficient volume of care management/coordination services in order to overcome a lack of health literacy, health education and an abundance of distrust of the health system; and an insufficient connection to health-related resources available in the communities. This proposal seeks to narrow these inequities by addressing the deep-seated SDOH needs at the heart of the system for vulnerable populations and employ culturally diverse community health workers to strengthen access across the region.

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

At the heart of this proposal is a goal to reduce healthcare disparities for rural Illinois residents and improve the system of care. Specifically, this project will engage our vulnerable populations in working to expand and enrich the system of care so that each patient's individual needs are the focus of care. Culturally diverse community health workers will work to integrate care that not only works to address the patients' medical needs, but also their SDOH needs. Social Determinants of Health are at the root of a wide range of health risks; we cannot begin to address patient medical needs without examining and finding solutions to root issues.

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?

All partners of the Connected Care Collaborative, as well as all Organization members of the Advisory Board, are fully committed to ensuring that this project *improves* health impacts on rural Illinois populations of color. SDOH for rural African Americans and Hispanics in Illinois have not yet been widely addressed by the healthcare system and this proposal seeks to greatly improve health outcomes for these populations. It would be naïve to assume that any proposal of this magnitude is immune to unexpected or unintended adverse impacts. Proactively, this collaboration has prioritized continual evaluation of project milestones and overall progress through a lens of health equity and inclusion. Our Community partners such as the Healthy Southern Illinois Delta Network and its coalitions, will closely monitor project implementation and will mitigate any components of the process that may result in unintended consequences or outcomes.

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?

As the partners developed this transformative project, they ensured that an Advisory Board comprised of populations most impacted by this initiative would guide the project's focus on equity and inclusion. The project has since brought on the Healthy Southern Illinois Delta Network (HSIDN), a grassroots effort established to build consensus around the health needs of residents in southernmost Illinois. The HSIDN is comprised of a diverse group of both centralized and regional entities, that implement efforts on a local level through community coalitions and action teams. Having the HSIDN involved in the coalition ensures community-based feedback for the collaborative. Finally, the project will be adding diverse and inclusive Community Health Worker staff throughout the region to better meet the health and social needs of the affected populations in rural Illinois.

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?

This proposal seeks adequate funding to realistically, and holistically, redesign the system of healthcare for rural Illinois residents impacted by SDOH needs. The project has numerous built-in mechanisms to ensure successful implementation and enforcement, including oversight by the pre-established Quality Health Partners of Southern Illinois (QHP) and Healthy Southern Illinois Delta Network (HSIDN), and the creation of a Collaborative Advisory Board. Ongoing data collection and reporting are core aspects of the Evaluation for this project and stakeholder participation/public accountability are ensured through the Advisory Board, QHP, HSIDN, and our governmental partners on the project.

The project design through the QHP, a clinically-integrated Physician-Hospital Organization, ensures ongoing data collection and public reporting via its data registries. The QHP design and implement a set of clinical protocols and outcome measures which physicians utilize to improve quality and outcomes. Implementation of an information system allows QHP and its providers to measure clinical quality, outcomes at the PHO, group, physician and patient level. The HSIDN has grown into a strong collaborative effort of community organizations successfully leveraging resources to improve health in the Illinois delta region. The success of the network is a direct result of the regional strategic planning approach supported by active engagement of those representatives interested in improving the health of their communities. By leveraging existing stakeholder participation and public accountability via two currently disparate efforts, the Collaborative has a safety net of already-established mechanisms to engage in a new initiative that connects community and clinical toward the same goal.

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?

The SIU School of Medicine will lead the project's comprehensive Evaluation Plan, which includes nearly two dozen benchmarks and indicators for project success. Both the process of enriching the system of care for rural Illinois residents, and the impacts of this new implementation on health outcomes, health equity, and quality of life, will be examined by the thorough Evaluation component of the project. The Advisory Board, QHP, and HSIDN will ensure a comprehensive assessment of the level, diversity, and quality of stakeholder engagement in the project.

5. Community Input:

Service Area of the Proposed Intervention:

Identify your service area in general terms (e.g., "West Chicago", "East St. Louis Metro Area", "Southeastern Illinois").

Illinois Delta Region

Please select all Illinois counties that are in your service area.

Randolph, Perry, Franklin, Hamilton, White, Gallatin, Saline, Williamson, Jackson, Union, Johnson, Pope, Hardin, Massac, Pulaski, Alexander, Jefferson, Wayne, Edwards, Clay

Please list all zip codes in your service area, separated by commas.

62907, 62217, 62916, 62233, 62237, 62241, 62242, 62257, 62261, 62272, 62277, 62278, 62280, 63673, 62286, 62288, 62292, 62297, 62916, 62237, 62238, 62831, 62832, 62263, 62268, 62272, 62274, 62883, 62888, 62997, 62812, 62819, 62822, 62825, 62836, 62856, 62860, 62865, 62874, 62983, 62883, 62884, 62890, 62891, 62896, 62897, 62999, 62810, 62817, 62828, 62829, 62835, 62935, 62860, 62859, 62869, 62887, 62890, 62895, 62820, 62821, 62827, 62835, 62844, 62861, 62862, 62867, 62869, 62887, 62930, 62931, 62934, 62954, 62867, 62869, 62871, 62979, 62984, 62917, 62930, 62934, 62935, 62946, 62947, 62965, 62869, 62977, 62987, 62890, 62915, 62901, 62902, 62917, 62918, 62921, 62922, 62924, 62933, 62841, 62939, 62948, 62949, 62951, 62958, 62959, 62974, 62987, 62890, 62896, 62905, 62907, 62916, 62901, 62902, 62903, 62924, 62927, 62832, 62932, 62940, 62942, 62950, 62958, 62966, 62975, 62280, 62994, 62905, 62906, 62912, 62902, 62920, 62923, 62926, 62939, 62952, 62958, 62957, 62961, 62998, 62908, 62912, 62922, 62923, 62939, 62943, 62967, 62972, 62985, 62995, 62910, 62928, 62938, 62943, 62946, 62947, 62960, 62972, 62985, 62987, 62919, 62931, 62938, 62947, 62982, 62908, 62910, 62941, 62943, 62953, 62956, 62960, 62923, 62926, 62941, 62956, 62963, 62964, 62970, 62976, 62992, 62996, 62914, 62952, 62957, 62962, 62969, 62988, 62990, 62992, 62808, 62810, 62814, 62816, 62830, 62846, 62851, 62864, 62866, 62872, 62883, 62889, 62893, 62894, 92898, 62837, 62895, 62814, 62868, 62824, 62823, 62899, 62810, 62842, 62446, 62886, 62850, 62833, 62851, 62878, 62809, 62820, 62843, 62476, 62806, 62815, 62818, 62833, 62434, 62824, 62839, 62858, 62879, 62899

Community Input:

A Comprehensive Approach to Community Health Needs. The broad interests of the communities served by three SIH hospitals – Memorial Hospital of Carbondale, Herrin Hospital, and St. Joseph Memorial Hospital (a critical access hospital) – were incorporated through input from residents, health care practitioners, local health departments, social service providers and other community organizations and partners. In July of 2021, Harrisburg Medical Center was incorporated into the SIH system of care, adding a fourth hospital to the system and serving an additional four counties in Southeastern Illinois. Because of their proximity and due to the variety of services offered at each of the different hospitals, all three hospitals define their communities as

an SIH seven-county service area. This collaborative approach aligns work efforts, avoids duplication and increases efficiencies (NACCHO, 2011).

Participants contributed to this assessment by:

- Reviewing data, identifying and prioritizing needs
- Highlighting current successful and ongoing activities
- Identifying gaps where attention is needed
- Fostering collaboration and pursuing opportunities for innovation, sustainability, and policy, system and environmental changes
- Developing plans to address significant community health issues

The selection of priority health issues and the development of the implementation plans were facilitated through a Community Health Needs Assessment Advisory Team which included the hospital administrators and five implementation teams composed of SIH representatives and community stakeholders knowledgeable about health, needs assessments and the local community. The work of these groups was facilitated by the SIH Community Benefits Department.

Community Input Activities. In addition to reviewing existing data sources, SIH used multiple primary data sources to collect community perceptions of health and health service needs. Community input activities included: 1) a community input survey, 2) survey of healthcare providers and SIH key leaders, 3) facilitated group discussions between SIH staff, local public health department staff, health and social service providers and others through the CHNA Advisory Team meetings. In the summer of 2018, community members were provided the opportunity to voice their opinions about the public health needs and priorities in their own community through a brief survey that was administered through SurveyMonkey. A convenience sample of participants was identified and included: Healthy Southern Illinois Delta Network steering committee members, healthy community coalitions, faith community nurses, health ministry volunteers and congregational health connectors, SIH employees and a sample of SIH's Second Act members.

Many of the individuals invited to participate in the survey are, or provide services to those who are, medically underserved, low-income or minority populations. For example, the Federally Qualified Health Centers staff, Healthy Community Coalition members, as well as those working in the faith communities serve all community members in an effort to improve health care access and provide education and outreach to our most vulnerable populations; i.e. low income families and those living in poverty, the uninsured and underinsured, the elderly, teens, those with behavioral health issues, etc. An invitation email with a SurveyMonkey link was sent to over 4,000 individuals. The survey was also promoted via Facebook. Responses were collected anonymously.

A total of 699 individuals completed the survey between April 27, 2018 and May 11, 2018. They were asked to rank the top health issues and key social, economic and environmental factors impacting health in our community. They were asked: 1) What do you think are the top three health Issues in our community? 2) What top three factors do

you think affect our community in a negative way? 3) What are the top three health issues in your community that should be addressed? 4) What are the top three health issues impacting members of your household?

The comments received were consistent with findings in the Community Health Profile and other primary data collected. The top health issues in the community were identified as:

- access to care
- overweight/obesity
- cancer
- diabetes
- cardiovascular disease and stroke
- mental health problems
- drug abuse/substance misuse
- prescription drug abuse

Factors identified as most adversely affecting our community in a negative way were poverty, addiction, underemployment & unemployment, lack of transportation, lack of social support and education.

The top health issues impacting members of their households were identified as mental health, obesity, diabetes, cancer, high blood pressure, heart disease, overweight, arthritis, exercise, nutrition and access to care.

Patient Level Advisory Board. Additionally, in Grant Year 2 the program will establish a patient-level community advisory board (CAB) comprised of individuals representing various disparity/priority population groups chosen based on possible lack of trust, difficulties with healthcare navigation, and healthcare-related stigma (e.g. racial/ethnic minorities; sexual and gender minorities; people who use drugs and/or are homeless; cancer survivors). This CAB will be established in Grant Year 2 to allow time for programmatic set-up. By consultation and input with this CAB, the program will seek to improve care and engagement for similar individuals who are current patients, and devise strategies to engage their constituent populations (who are not otherwise engaged in healthcare) going forward.

[Input from Elected Officials:](#)

Did your collaborative consult elected officials as you developed your proposal? Y/N

Yes

Please select all legislators whom you consulted.

Congressman Mike Bost

Senator Tammy Duckworth

Senator Richard Durbin

Senator Terri Bryant (58th District)

Senator Dale Fowler (59th District)
State Representative Paul Jacobs (115th District)
State Representative Dave Severin (117th District)
State Representative Patrick Windhorst (118th District)

Incorporating the awareness and input of elected officials is essential to transforming the healthcare system, especially when that transformation is framed in addressing the social determinants of health impacting our communities in the Delta region. Our Collaborative members have a long, successful history of meaningful involvement of community members and leaders in transformative healthcare programming, and that successful model has been built into the framework of this initiative as well.

With a core mission to transform the healthcare delivery system for populations impacted by the social determinants of health in the Delta region, this initiative needs sustained support from Illinois' governmental leaders. To that end, included with this application are letters of sustained support for this project from U.S. Senators Dick Durbin and Tammy Duckworth, among other Federal and state elected officials. Illinois' governmental leaders have proven their support of social determinants of health programming during the COVID-19 pandemic, they steadfastly believe in an integrated healthcare delivery system that best serves the needs of vulnerable populations, and they have given their firm commitment and support to the success of this Illinois healthcare transformation effort.

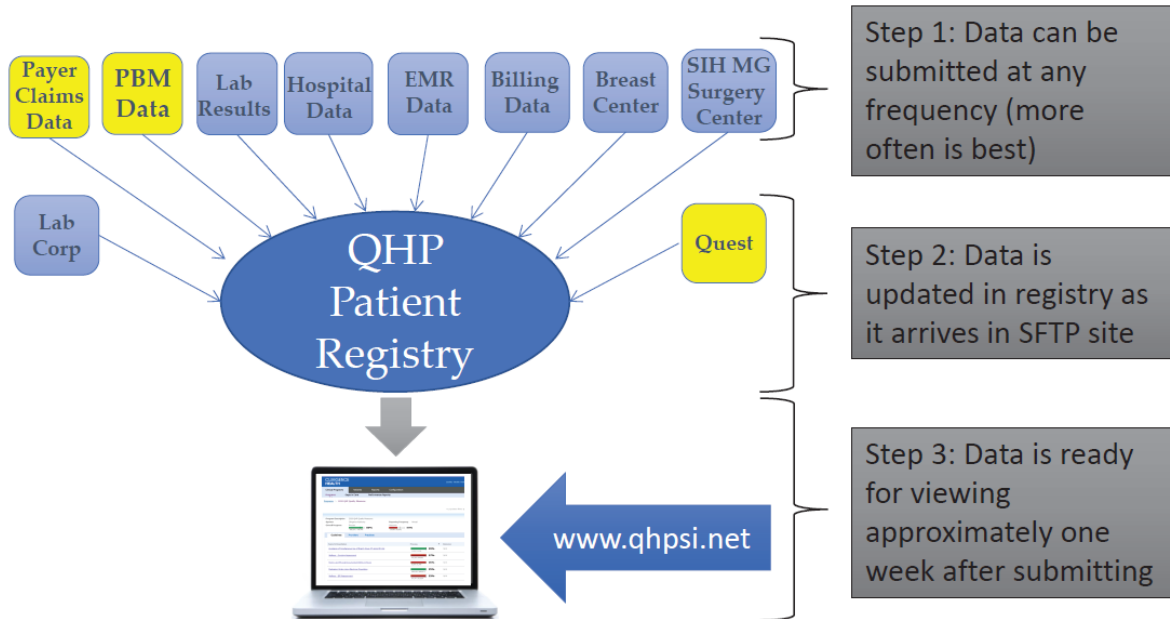
6. Data Support:

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

QHP Patient Registry. SIH has an intricate data sharing mechanism in place; the QHP Patient Registry. As SIH works with hospitals, clinicians, and FQHC's to improve the quality of healthcare, SIH also has assisted with the capacity of clinicians to be able to enter medical data or patient information in an Electronic Medical Record (EMR). Data is collected by each clinician and automatically uploaded to the PHO patient registry which is located on the QHP website (www.qhpsi.net). This process is done by an independent vendor, Clinigence. All data is entered in a standard format that has been provided to the physicians and physician practices. Using the Patient Registry, QHP is able to compile data from over 20 different electronic data sources, including hospital EMR, practice EMR, lab data, and billing data, to display and evaluate progress on the many quality measures developed by the Clinical Committee.

Currently, this data is transferred daily, however, at this time, only monthly reports are available to physicians. Future state for this process would be for physicians to have access to updated records weekly. Simultaneously, as billing information is entered into a physician's system and claims are filed with payors (insurance companies), this information is also sent to the PHO patient registry. This information is captured and

helps determine how patients are attributed to providers, and to which disease or prevention registries patients populate. When a claim is entered, it includes diagnosis and event codes that are linked to one or more prevention and/or disease registry.



This data also helps physicians monitor high acuity patients, such as those with chronic and uncontrolled diabetes or ischemic vascular disease. With data coming from many different points of collection, the primary care physician can see lab values ordered by specialists and the hospital as well as those collected by his or her office. Specially developed reports, such as the Gap Report, allow the physician office to view their scheduled patients in order of appointment time and any gaps they may have in their care. The Patient Registry filters the patient population to allow physicians to focus on those in certain disease or prevention categories, supporting the population health and clinical integration goals of QHP.

Crosswalk of Community Needs. Along with the data collected from the community, an analysis of existing community health plans and goals was also conducted, and a crosswalk was developed in order to determine similarities between the goals and objectives of various health related entities. The crosswalk was developed by reviewing 13 different sets of goals, measures, and plans. These plans/goals have been developed by various entities and organizations throughout the community and healthcare system. The plans are designed to improve the health of all southern Illinois residents. Those reviewed are as follows:

- SIH Community Health Needs Assessment – 2015 developed by SIH
- Quality Health Partners/Physician Hospital Organization (QHP/PHO) Goals 2017/2018

- Patient Centered Medical Home (PCMH) Goals from SIH Medical Group 2018
- CMS Core Measures (2018) – Joint Commission Core Measures for Hospitals
- 2017/2018 SIH Medical Group Quality Measures
- Federally Qualified Health Centers (FQHC) Cross-Reference of Clinical Programs includes clinical quality measures, MU (meaningful use) stages 1 & 2, PCMH (Patient Centered Medical Home), UDS (Uniform Data System) HRSA – Bureau of Primary Care, QHP, and IHC (Illinois Health Connect)
- Healthy Southern Illinois Delta Network (HSIDN) Goals (2015-2020) developed by the local health departments, SIU School of Medicine Center for Rural Health and Social Service Development, and SIH for the lower 15 counties of Illinois
- Illinois Project for the Local Assessment of Needs (IPLANs) developed by the local health departments: Southern Seven (2015-2019); Jackson County (2015-2019); Perry County (2017-2022); Egyptian (2017-2022); Franklin-Williamson (2017-2022)
- Illinois State Health Improvement Plan (SHIP) Priorities 2010 developed by a team of public, private and voluntary sector stakeholders appointed by the director of the Illinois Department of Public Health. The SHIP addresses reducing racial, ethnic, geographic, age, and socioeconomic health disparities.

Based on the crosswalk, the top issues in our area are:

1. Cardiovascular disease, stroke and related issues
2. Obesity/overweight
3. Diabetes
4. Cancer (lung, bronchus, breast, colorectal and cervical)
5. Chronic disease prevention, management and care coordination
6. Mental health
7. Substance abuse and prescription drug misuse

Secondary Data Sets. Information from multiple local, state and nationally recognized secondary sources was compiled using Healthy People 2020, County Health Rankings, Healthy Communities Institutes tool and Community Commons. Secondary data sources included but are not limited to health and social indicators from County Health Rankings, Illinois Department of Public Health, American Communities Survey, the U.S. Census, the Behavioral Risk Factor Surveillance System (BRFSS), Illinois State Board of Education, U.S. Department of Agriculture Food Environment Atlas, National Cancer Institute, Community Need Index, US Census Bureau State & County QuickFacts, Bureau of Labor Statistics, Centers for Disease Control and Prevention, U.S. Environmental Protection Agency, Substance Abuse and Mental Health Services Administration (SAMHSA), National Center for Health Statistics, Illinois Youth Survey, Illinois Project for the Local Assessment of Needs, SIH internal systems data and goals/plans from various entities.

The 12 categories of the Healthy People 2020 Leading Health Indicators (LHIs) served as a framework to communicate high-priority health issue while comparing our

community to state and national benchmarks. The 12 categories are: Access to Health Services, Clinical Preventive Services, Environmental Quality, Injury and Violence, Maternal, Infant and Child Health, Mental Health, Nutrition, Physical Activity, and Obesity, Oral Health, Reproductive and Sexual Health, Social Determinants, Substance Abuse and Tobacco. Using these categories provided valuable community-level information regarding underlying behavioral and social determinants of health, as well as access and barriers to health improvement.

7. Health Equity and Outcomes:

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.

Race and Poverty. The Delta service region faces significant health care disparities in patients receiving access to care, including specific preventative services necessary in achieving equitable healthcare. These disparities are especially magnified in racial/ethnic minorities and those individuals living in poverty. We are targeting Equity Pillar metrics (breast and cervical cancer screening; hypertension; adult access to preventative/ambulatory health). The populations experiencing disparities in these measures fall into two group characteristics: racial/ethnic minorities and individuals living in poverty.

We chose racial/ethnic minorities (R/EM) as they consistently experience lesser utilization of cancer screening and greater rates of undiagnosed and uncontrolled hypertension. While the majority of rural southern Illinois residents are of white race, there are some counties with large minority race populations (e.g. Alexander and Pulaski Counties each are >30% Black race). We chose individuals living in poverty (ILiP) as a population as the majority of our service counties (Illinois Delta Region) have, for example, childhood poverty rates exceeding 12.5%. Poverty is more common and concentrated in southern Illinois than the rest of Illinois (generally). Poverty directly contributes to healthcare access and utilization (i.e., ability to pay co-pays and prescriptions) and also contributes to and is associated with multiple adverse social determinants of health (SDOH; e.g., housing and food security; transportation availability). The rural nature of our service area is a compounding factor, as rural areas consistently experience disparities in cancer screenings, hypertension control, and diabetic control.

For R/EM, many of the health outcome disparities in the Equity Pillar are associated with factors such as: historical and personal distrust of healthcare, lesser clinician recommendations and follow through for some aspects of medical care; and lesser healthcare access and utilization due to SDOH barriers. All of these challenges can be mitigated through a Community Healthcare Worker (CHW) model, whereby a trained individual builds trust and encourages the patient; act as the patient advocate and

promote needed and appropriate care for the patient to the medical team; and serve as a point of referral to local services which may address SDOH. For ILiP, many of the disparities are associated with aspects of generational poverty, which result in low income and multiple adverse SDOH that serve as barriers to accessing routine care. The CHW works with ILiP much the same as R/EM, with many of the same duties to include patient education and advocacy and referral to resources to address SDOH.

References:

May FP, Almario CV, Ponce N, Spiegel BM. Racial minorities are more likely than whites to report lack of provider recommendation for colon cancer screening. *Am J Gastroenterol*. 2015 Oct;110(10):1388-94. doi: 10.1038/ajg.2015.138. Epub 2015 May 12. PMID: 25964227.

The Commonwealth Fund. In Focus: Reducing Racial Disparities in Health Care by Confronting Racism. Available at: <https://www.commonwealthfund.org/publications/2018/sep/focus-reducing-racial-disparities-health-care-confronting-racism>. Accessed 16 Nov 2021.

Institute of Medicine. 2003. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/12875>.

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 Connected Care Collaborative Community Health Worker project will address these disparities among existing patients by first examining QHP patient registry data to identify those who are not currently meeting metrics (e.g. age-appropriate screening) and those most at risk of not accessing routine and preventive care or likely experiencing adverse SDOH barriers (e.g. individuals with many missed appointments). Once identified, these individuals will be connected with a CHW and be screened with a Self-Efficiency Rating Tool (SERT; identified specific SDOH barriers). Any identified SDOH barriers will be referred by the CHW to the NowPow social services platform to be addressed with local resources. All patients accepting a CHW referral (whether positive for a SDOH barrier or not) will then work with the CHW for at least one year to see if barriers can be lowered/removed and clinical outcomes (Equity Pillar metrics specifically) improved.

The program will also establish a patient-level community advisory board (CAB) comprised of individuals representing various disparity/priority population groups chosen based on possible lack of trust, difficulties with healthcare navigation, and healthcare-related stigma (e.g. racial/ethnic minorities; sexual and gender minorities; people who use drugs and/or are homeless; cancer survivors). This CAB will be established in Grant Year 2 to allow time for programmatic set-up. By consultation and

input with this CAB, the program will seek to improve care and engagement for similar individuals who are current patients, and devise strategies to engage their constituent populations (who are not otherwise engaged in healthcare) going forward.

We anticipate that the implementation of the CHW model should have the following effects observable within 1 year (or less):

- Better patient attendance to and engagement with healthcare appointments
- Improved patient adherence to treatment plans and prescription adherence
- Improved rates of appropriate screenings (e.g., cancer; PrEP appropriateness)
- Lesser rates/degree of SDOH barrier to healthcare as assessed with the SERT and due to local resource engagement via NowPow.

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

The activities we propose will lead to the indicated impacts as we are directly acting at the individual patient level to understand and address barriers to healthcare, link each individual to local services which are equipped to address SDOH, and have a trained worker to walk with the patient for an extended time period. Further and more specifically, the activities will:

- directly address building trust in the healthcare system;
- find advocates and allies in the form of community health workers; and
- build a coordinated care system that acknowledges both social and medical issues necessary in getting the prevention necessary to address health disparities and aim for better health equity

8. Access to Care:

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.

The specific barriers we are addressing include healthcare distrust, lack of education to healthcare prioritization and proper use, and SDOH barriers (e.g., housing and food insecurity; transportation). The causes of these barriers are largely similar to those described for health equity, and include historical and personal healthcare experiences, generational poverty resulting in low educational attainment and few personal financial resources, and the compounding impact of healthcare delivery in rural areas.

For R/EM, many of the health outcome disparities in the Equity pillar are associated with factors such as: historical and personal distrust of healthcare; lesser clinician recommendations and follow through for some aspects of medical care; and lesser healthcare access and utilization due to SDOH barriers. All of these challenges can be mitigated through a Community Healthcare Worker (CHW) model, whereby a trained individual builds trust and encourages the patient; act as the patient advocate and

promote needed and appropriate care for the patient to the medical team; and serve as a point of referral to local services which may address SDOH.

For individuals living in poverty (ILiP), many of the disparities are associated with aspects of generational poverty, which result in low income and multiple adverse SDOH that serve as barriers to accessing routine care. The CHW works with ILiP much the same as R/EM, with many of the same duties to include patient education and advocacy and referral to resources to address SDOH. We have chosen to address these obstacles as they impact a large proportion of our existing patients, impact a large proportion (perhaps even more) of individuals current not at all engaged in healthcare, and are addressable by implementing several evidence-based models (CHW, NowPow) in a new fashion.

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 we will undertake to address Access barriers are largely similar to those for Equity barriers – implementing a program where a CHW with links to local resource referral via NowPow, is matched to patients experiencing poor healthcare outcomes and/or multiple SDOH potentially jeopardizing their health and healthcare, and working with them for an extended time to address barriers and improve outcomes.

We expect the implementation of the CHW model to have the following effects observable within 1 year (or less):

- Better patient attendance to and engagement with healthcare appointments
- Improved patient adherence to treatment plans and prescription adherence
- Improved rates of appropriate screenings (e.g., cancer; PrEP appropriateness)
- Lesser rates/degree of SDOH barrier to healthcare as assessed with the SERT and due to local resource engagement via NowPow.

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

The activities will lead to impacts for Access barriers for the same reasons we expect them to address Equity barriers. The activities will:

- directly address building trust in the healthcare system;
- find advocates and allies in the form of community health workers; and
- build a coordinated care system that acknowledges both social and medical issues necessary in getting the prevention necessary to address health disparities and aim for better health equity

9. Social Determinants of Health:

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 SERT screening tool has the potential to identify 21 different SDOH/barriers to successfully accessing and utilizing healthcare. Each of these measures are important and will allow our health system and CHWs to understand the range of challenges that patients face. However, our immediate goal is to address specific social determinants of health in which our entities can address with existing programs and services. Those barriers that we identified include: transportation, food insecurity, affordable care, and social isolation.

The causes of these SDOH are likely largely due to both generational poverty and the continuing diminishment of rural income and resources. As the US population increasingly congregates in urban centers, rural populations are becoming older, poorer, and of lesser educational attainment. Rural populations also frequently experience increased rates of risky behaviors (e.g. drug and alcohol use). It is increasingly difficult to find well-paying jobs, and the lack of consistent employment and higher education in the midst of inflation and rising costs of living result in more and more people living in poverty – directly impacting and increasing adverse social determinants of health.

The population of this region, the 16 southernmost counties of Illinois known as the Illinois Delta Region, is 322,189, representing 2.5% of the state's total population. The land area is 6,038 square miles or 10.9% of the state's total area. The population density of this area ranges from 12.1 to 157.9 persons per square mile, compared to a total average density in Illinois of 231.1 persons /sq.mi. According to the U.S. Census Bureau, most Illinois Delta counties have a larger percentage of residents over 65, (21.9%) compared to the state of Illinois (16.1%). All 16 Delta counties have a median household income ranging from \$34,640 to \$59,816. The median household income is \$65,866 in Illinois and \$62843 nationally. Eleven (11) of the southern 16 counties are among Illinois' poorest counties. Poverty rates range from 14.5% to 25.4% for the period 2015 to 2019 in these counties. The number of children in poverty ranges from 8.4% to 39% in the lower 16 counties, the percentage in Illinois is 14% and the national average for children in poverty is 15.1%.

References:

(<http://quickfacts.census.gov/qfd/states/17000.html>)

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 direct activities remain the same:

- directly address building trust in the healthcare system;
- find advocates and allies in the form of community health workers; and
- build a coordinated care system that acknowledges both social and medical issues necessary in getting the prevention necessary to address health disparities and aim for better health equity

A central activity within the project plan is the implementation of the NowPow platform across project partners. NowPow's personalized community referral platform fits into existing workflows, making it easy for clinicians, case workers, resource coordinators, payers and others to make high-quality referrals to trusted community services. From food banks, in-home nursing care service, and diabetes management, to cancer support, mental health counseling and respite care, NowPow helps people know where to go when needs arise—throughout all of life's ages and stages. NowPow has five primary utilizations that complement our proposed project:

- **Match.** Identify health and social needs (with or without a screening) and automatically map those needs to optimal services using NowPow's evidence-based algorithms
- **Filter.** Funnel results by critical access factors like location, preferred language, documents needed, insurance status and others
- **Engage.** Make personalized referrals to people via text, email or print in 100+ languages and send nudges to encourage follow through; give people direct access to search in support of self-care
- **Close the loop.** Track or coordinate referrals with community partners and stakeholders at all points throughout the referral process for enhanced support and measurement
- **Analyze.** Use generated data to understand outcomes at the individual, partner, population and community levels, assess resource gaps and inform reimbursement strategies and policies

We do plan additional activities that will be derived from project actions over the first two years. While we anticipate the majority of SDOH/barriers to be as listed (transportation, food insecurity, affordable care, and social isolation), we will also examine the data to see:

- what additional SDOH/barriers are most often reported;
- which of these have less-consistent and effective resources to be applied
- how can we use our data, organizational experiences, patient-level community advisory board, and community partnerships to develop/encourage new resources to address these

As addressing SDOH and similar healthcare barriers is a central function of the CHW-patient engagement, many of the same impacts listed in Equity and Access are similar here.

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

As addressing SDOH and similar healthcare barriers is a central function of the CHW-patient engagement, and we expect activities to lead to impacts for the same reasons as listed in Equity and Access are similar here.

10. Care Integration and Coordination:

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

Preventing disease before it starts is an important part of helping people live longer, healthier and better-quality lives. Improved preventative care also helps avoid unnecessary health care and helps reduce costs. Prevention, however, goes beyond providing people with information about health behaviors such as how diet, exercise, tobacco and alcohol affect health. It is also important for communities to create policies, systems and environmental supports that make healthy actions and choices easy, accessible and affordable. By identifying and highlighting health issues and gaps in care along with our plans to address them, our goals are to enhance the public's understanding about the links between risk factors, social determinants of health, policies and systems, and the long-term health status and quality of life for the community.

Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Resources that enhance quality of life can have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins. The mission of the Connected Care Collaborative is to transform the rural health delivery system for Medicaid beneficiaries in the Delta region by creating a collaborative, cross-sector, and integrated system of health resources that address social determinants of health needs and improve health outcomes, while addressing and eliminating disparities, improving community-based outcomes, and creating an equitable healthcare system. Specifically, this project will deploy community health workers across provider sites to address the social determinants of health needs of rural Illinois residents, including food insecurity, substance use/behavioral health needs, chronic condition needs, and the lack of transportation among rural Illinois residents for accessing needed healthcare.

Nearly every state is working on ways to better integrate community health workers into the health care system. Care coordination is at the heart of the Community Health Worker philosophy. As care coordinators or care managers, community health workers (CHWs) help individuals with complex health conditions to navigate the healthcare system. CHWs usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve. They advocate for and liaise between their patients and a variety of healthcare and human services organizations. CHWs strengthen patient-centered services and improve community health by meeting medically underserved individuals where they are. CHWs contribute to the overburdened health system by providing the personal attention required to connect with complex patients and engage them in appropriate health care access.

Do you plan to hire community health workers or care coordinators as part of your intervention? Y/N
Yes

Please submit care coordination caseload numbers and cost per caseload (stratified by risk, if applicable).

Community Health Workers will carry a case load of 25 patients. Caseload is intentionally set lower than what is commonly practiced in traditional care coordination models. This is a crucial component of this transformation. Effective CHWs have one foot firmly in each world: the clinical setting — where they work with physicians, nurses, and care managers to coordinate care for patients — and the community — where they live, work, and socialize. If a CHW has a high caseload, he or she may not be able to provide the necessary support for patients and may be subject to fatigue and burnout. The appropriate caseload for CHWs varies greatly depending on the type of practice and patient characteristics. Maintaining a lower caseload allows CHWs to be “high-touch” – involving very intensive care management.

Are there any managed care organizations in your collaborative? Y/N
No

If no, do you plan to integrate and work with managed care organizations? Y/N
Yes

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

Quality Health Partners (QHP) is currently contracted with several managed care organizations in the region. Managed care organizations (MCOs) are a major source of health care for the beneficiaries of both employer-funded care and of the publicly funded programs, Medicaid and Medicare. In addition, MCOs represent organized care systems that often focus their efforts on defined populations and are accountable for desired outcomes, including prevention activities. In recognition of the potential role of managed care in prevention, the Connected Care Collaborative will rely on the QHP to develop recommendations for fostering the incorporation of prevention practices.

11. Minority Participation:

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.

BEP Partners:

NowPow

Not-for-Profit Partners

National Association for the Advancement of Colored People

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.

NowPow. NowPow will have a role both in the implementation of the proposal and continue serving a presence as the projects are evaluated to assess effectiveness and utilization of the closed-loop referral system they provide. As we expand our network, NowPow's Community Engagement team will support socialization, training, onboarding, and referral partner management. They are just one part of a dedicated team that would work alongside the CCC as it scales referrals across communities.

From the start of our partnership, NowPow teams will work with the CCC to

- Understand prevalence and distribution of social needs in communities
- Drive successful resource connection, including referral outcomes and barriers to care
- Optimize referral networks that effectively support the needs of the population served
- Support data driven resource investment and policy development with deepened understanding of resource supply & demand and resource gaps in the community

National Association for the Advancement of Colored People (NAACP). To transform the healthcare delivery system for all our rural Illinois residents, including our African American communities, we must address racial equity and we must tackle the healthcare disparities that affect many of our marginalized communities. NAACP will serve on the Collaborative Advisory Board for the duration. The NAACP's mission is to secure the political, educational, social, and economic equality of rights in order to eliminate race-based discrimination and ensure the health and well-being of all persons. Through the proposed projects, the NAACP will foster strong alliances within a transformed healthcare delivery system to address health equity, social determinants of health, and overall well-being for racial and ethnic minorities in Illinois. The NAACP has a strong, well-coordinated series of chapters throughout Illinois, in nearly every county, that champions healthcare for its communities.

12. Jobs:

Existing Employees:

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

The QHP Provider list offers the number of providers affiliated with the QHP – all of which live in the service region. All Southern Illinois Healthcare employees are expected, as part of their overall work performance and in order to deliver excellence, to commit to the following Commitment to Care:

1. **Commitment to Deliver Positive Patient and Colleague Experiences** We are committed to providing the highest quality of service and utmost care because everyone deserves to be treated with respect and compassion.
2. **Commitment to Support a Collaborative, Inclusive Community** We believe that leadership is within each of us and that each person may work in a different way; therefore, open and honest communication with each other is critical to our success. We value the dignity and unique strengths of each person.
3. **Commitment to Build Trust** It is our responsibility to earn the trust of our patients, guests, co-workers, and community.
4. **Commitment to Embrace my Personal Responsibility** We recognize a sense of ownership toward our job and accept responsibility for our work performance. Our culture recognizes success through collaboration and individual accountability.

This commitment to care permeates and strengthens the Quality Health Partners, as SIH holds majority presence in membership and shares exactly half of the voting board seats.

New Employment Opportunities:

Please estimate the number of new employees that will be hired over the duration of your proposal:

The focus on employment of local residents is a cornerstone of this project for all collaborative partners. Southern Illinois Healthcare is committed to hiring a permanent System Director of Population Health, and a CHW Project Director FTE. There will be **120 community health workers hired** in Year 1 of the project to deploy across the region that will help elevate the economic and social health of our residents.

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

The program will continue to facilitate the hiring of additional Community Health Workers as needed by demand. These positions directly reflect the community served by this project because a key qualifier to be a successful Community Health Worker is to be of the community they serve. Additionally, this Collaborative foresees community health worker skills as being a transferrable skillset to integrate other tools – namely Telehealth presenter training to promote patient use of and engagement with digital health. This future alignment promotes industry growth and increases access for patients – both via channels of telemedicine and via the community health worker as an intermediary.

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

CHWs are a unique workforce that requires special considerations to support effective integration into complex care programs. These considerations include identifying and hiring appropriate candidates for CHW positions; providing CHWs with training and career progression opportunities; successfully integrating CHWs into collaborative team-based models of care; and supporting and retaining existing CHWs.

Hiring. Unlike many other members of the care team – nurses, social workers, medical assistants, pharmacists – who are hired largely based on educational attainment or certification, the role of CHWs requires soft skills such as empathy, active listening, and open communication. Experts have suggested that it can be difficult for organizations to find qualified CHWs, particularly in rural areas where there may be fewer candidates. Many CHW job qualifications, moreover, are not tasks that are easily captured on a resume. The most successful CHWs demonstrate creativity and flexibility; maintain a strong connection to the community, including familiarity with available resources; and are committed to serving the population.

Training and Career Progression. CHWs, particularly those who are new to the health care industry, can benefit from customized training to help them perform their role to the greatest capacity and expand their skill sets. As noted in the Project Description, the Southern Illinois University School of Medicine Community Health Worker ECHO program allows community-based health workers with guided training that supports the CHWs to help client navigate their life systems and advocate for their health care and ways in the world. The program encompasses the CHW Generalist Program and Specialty ECHOs to deepen the instruction on the areas of health which includes: diabetes, asthma, hypertension, oral care, and opioids. With the ability to expand in areas such as memory and aging issues along with mental health care. Providing opportunities for more advanced training can help CHWs appropriately channel their natural ability for patient advocacy. This training also provides entry into the healthcare workforce, and opportunity for career development and advancement in the largest and fastest-growing industry cluster in the region.

Team Integration. After hiring and training CHWs, programs must effectively integrate the employees into care teams. With clearly defined roles and responsibilities, CHWs can support other staff and become highly valued team members. The CHW's work in connecting with patients and acting as a liaison to the community not only provides invaluable supports for patients, but it also allows nurses and physicians to operate at the top of their licenses. Thus, clinicians can dedicate more time to other critical responsibilities like providing patient care. Recognizing the clear and essential role that each care team member plays promotes higher morale and camaraderie across the team. Providers and other clinic staff will be educated with how community health workers function and how they fit within the continuum of care.

Support and Retention. A primary tool for retention is support. CHWs can pose specific retention challenges due to the nature of their work. The position involves high-touch — and often high-stress — interaction with patients that can contribute to employee turnover, making establishment of a well-functioning care team challenging. Organizations can support CHWs by helping them to address the stresses involved in their role and help them to function more effectively. If a CHW has a high caseload, they may not be able to provide the necessary support for patients and may be subject to fatigue and burnout. Alternatively, if a community health worker feels isolated without proper knowledge of available resources to help their patient, they are subject to burnout. Compassion fatigue will be assessed and mitigated through ongoing communications with CHW supervisors, and CHWs will be empowered through the Resource Hub. Additionally, the CHW Evergreen program serves as a monthly touchpoint support system for supervisors and CHWs. Each month SIU SOM will conduct a one-hour session with a brief didactic and case-based discussion on current topics. The supervisor will guide the discussion by identifying issues that would best serve them and what is happening. The Evergreen program will be accompanied by monthly technical assistance support calls that will allow CHWs and supervisors to have a safe place to share concerns and ask questions on how to move through different situations with a support team's assistance. CHWs play a unique and special role in care for the underserved. Our regional cadre of collaborating organizations is able to support and sustain individual efforts of community health workers and programs via working together and leveraging resources of individual organizations.

13. Quality Metrics:

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

The HFS Quality Strategy framework prioritizes equity across all program goals for transformation efforts. The framework includes 5 pillars of improvement: Maternal and Child Health, Adult Behavioral Health, Child Behavioral Health, Equity, and Improving Community Placement. Within this framework, the Department has identified 12 goals

that fall within 3 categories: Better Care, Healthy People/Healthy Communities, and Affordable Care as particularly relevant to the health of distressed communities. The projects within our proposal for transforming rural healthcare align with many of these goals.

Better Care – *Improve population health; improve access to care; increase effectiveness of care coordination.* Community Health Workers will improve health outcomes through individualized care coordination that goes beyond the clinical to the social determinants of health. They will provide a high level of patient engagement and support connections to needed services to access care, from transportation to affordability. NowPow’s closed-loop community services referral system will improve not only access but allow CHW and provider follow with a patient – enhancing care. The deployment of community health workers will be a collaborative effort among all partners to connect individuals to needed health services and/or guide them to better utilization of those services.

Healthy People/Healthy Communities – *Improve participation in preventative care and screenings, create consumer-centric healthcare delivery system; identify and prioritize to reduce health disparities; implement evidence-based interventions to reduce disparities.* Community Health Workers provide comprehensive and complex care to patients who are often unable to fit within the standard medical model. The CHWs take a strengths-based and personal approach to help patients make health changes and adopt preventative health behaviors. They thrive on utilizing collaboration from many different disciplines, and provide wrap-around services to the patient, providing the services that specific client needs, and not taking a one size fits all approach to medical care and treatment.

Affordable Care – *Transition to value and outcome-based payment; deploy technology initiatives and provide incentives to increase adoption of electronic health records (EHRs) and streamline and enhance performance reporting.* There are varied payment methodologies being developed by payers for health care services. Payers are moving away from fee-for-service (FFS) volume-driven health care services to value-based payment models that incentivize providers on quality, outcomes, and cost containment. This model will take advantage of the currently revised payment models and assist in the development of a new payment model for community health workers (CHWs).

Specific Measures for this project were determined via a crosswalk analysis of measures that align with the HFS Quality Strategy outlined above; clinical measures selected by Quality Health Partners (the clinically integrated PHO that will provide unity and structure for this collaborative); and measures determined by the various Community Health Needs Assessments conducted within the service region.

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

Equity Pillar

Will you be using any metrics not found in the quality strategy? Y/N

Yes

Please propose metrics you'll be accountable for improving and a method for tracking these metrics.

Metrics.

| Measure | Target |
|--|---------------|
| Patients age 40-69 receive an annual breast cancer screening | 55% |
| Patients ages 21-65 receive a cervical cancer screening once every three years | TBD |
| Patients have their blood pressure performed annually | 97% |
| Patients have a controlled blood pressure (<140/90) | 70% |
| Patients have an HbA1c test annually | 80% |
| Patients have an uncontrolled HbA1c (>9) or do not have an HbA1c test | <30% |
| Patients have a controlled HbA1c (8) | 60% |
| Patients have LDL tested annually | 75% |
| Patients have LDL results <100 | 50% |
| Patients have a smoking assessment done annually | 97% |
| Known smoking patients receive Smoking Cessation Counseling Annually | 60% |

Evaluation Overview. This evaluation plan is designed to assess the Connected Care Collaborative program in terms of outcomes and implementation. Quantitative and routine data for evaluation purposes will primarily come from the patient’s EHR (Equity Pillar and other medical outcomes) and the Self-Efficiency Rating Tool (SERT; social determinants of health [SDOH]), and NowPow (comprehensive social service and local resource referral and tracking platform). Qualitative and other, non-routine data will be obtained by interviews and surveys of selected CHWs, patients, and healthcare staff.

To summarize the entire process.

1. Each partner site will establish a pool of trained CHWs.
2. Eligible patients are identified by EHR search and outreach.
3. Patients meet with an assigned CHW and complete a SERT assessment.
 - a. Patients screening ‘positive’ for at least one SDOH/barrier are linked to the appropriate local service(s) through NowPow.
 - b. Patients screening ‘negative’ for any SDOH/barrier remain retained in the program.
- 4a. CHWs follow up with ‘positive’ patients monthly to:
 - c. re-administer the relevant section(s) of the SERT, and
 - d. query NowPow for associated service engagement
- 4b. CHWs follow up with ‘negative’ patients as needed/desired to provide suitable encouragement and navigation assistance.
5. CHWs follow up with all patients at 6-months to:
 - a. re-administer the full SERT;
 - b. check appointment attendance and prescription fulfillment; and
 - c. check clinical outcomes and measures.
6. CHWs follow up with all patients at 12-months to:

- a. re-administer the SERT;
- a. check appointment attendance and prescription fulfillment;
- b. check clinical outcomes and measures;
- c. assess the degree to which the patient engaged with the CHW;
- d. assess the degree to which the patient engaged with NowPow;
- e. assess the extent to which SDOH and clinical measures have changed over time; and
- f. assess associations between CHW/NowPow engagement, SDOH measures, and resultant clinical outcomes and measures.

CHWs are an evidence-based intervention which we presume will significantly address patient SDOH and clinical outcomes. However, how this may be devised and effectively implemented in rural areas is less clear. The evaluation plan is based upon three aspects of evaluation: process; outcomes; and implementation. Theory and general structure of the process and outcomes evaluations are drawn from elements specific to CHW evaluation^{1,2} while implementation follows the Consolidated Framework for Implementation Science (CFIR)^{3,4}.

1. *Process evaluation* - This aspect of evaluation is meant to capture elements reflecting clinical and community activities and patient experiences. Process evaluation assesses if an intervention was implemented as intended, and reasons for success or failure.
2. *Outcomes evaluation* – This aspect of evaluation is meant to capture elements reflecting the result of an implemented intervention. Outcomes evaluation assesses if an intervention accomplished its goal(s).
3. *Implementation evaluation* - The aspect of evaluation is meant to capture elements reflecting how much of an impact the intervention made on clinical operations, as well as community and patient outcomes – during the grant period and going forward. The five CFIR domains are:
 - a. *Intervention Characteristics* elements such as adaptability, complexity, cost, and evidence strength and quality
 - b. *Outer setting* elements such as: cosmopolitanism, external policies and incentives, patient needs and resources, and peer pressure
 - c. *Inner setting* elements such as: structural characteristics, networks and communications, culture, implementation climate, and readiness for implementation
 - d. *Characteristics of individuals* elements such as: individual identification with organization, individual stage of change, knowledge and beliefs about the intervention, and self-efficacy
 - e. *Process* elements such as: engaging, executing, planning, and reflecting and evaluating

For the purpose of this evaluation, we are considering the involvement of a CHW with a patient to address identified health barriers and social determinants of health will better

meet Equity Pillar metrics. Specific outcomes associated with the Equity Pillar include: breast and cervical cancer screening; hypertension; and adult access to preventative/ambulatory health.

In the next two sections, we are considering two activities:

- I) overall assessment of the CHW model as a mechanism to influence patient health and social determinants (*Process, Outcomes, and Implementation Evaluations*);
- II) individual and cumulative grantee pillar metrics (*Outcomes*).

Data to be collected for evaluation purposes will be developed specifically for each activity. We anticipate that NowPow will be a valuable platform for the consolidation of much data, especially as it related to patient-level encounters and referrals to community services. EHR data will be mined for pillar metrics and aspects of patient engagement with healthcare (e.g. visit attendance and prescription filling). Other types of data, such as interviews associated with implementation evaluation and intervention impact upon CBO operations, will be separately developed. A summary of data collected, and its uses is provided in the uploaded supplemental documentation Connected Care Collaborative_Upload 7.

Evaluation of CHW Model. It is anticipated that each partner site will establish a pool of CHWs with a supervisor. These will be linked to the NowPow platform, which will be the service identification and tracking platform used for this project. Patients eligible for CHW-based care coordination in association with pillar metrics will be identified by EHR review of existing patients, outreach to new patients, and during community engagement events. The SERT will be the standardized screening instrument implemented by each CHW upon each initial patient visit. Those patients screening 'positive' for an adverse SDOH/barrier will be linked via their CHW to NowPow for SDOH service referral and follow up. All patients will then enter a 1-year period of engagement with the CHW to address SDOH and improve clinical outcomes.

The CHW as a model for care coordination, individualized patient engagement, and enhanced care provision and receipt will be subject to evaluation via two different methods. The CHW program and individual CHWs will be subject to standardized process and outcomes evaluation, and a selection will undergo more thorough assessment by the 5 domains associated with the CFIR framework. This evaluation will examine how well the CHW model a) is implemented and potentially sustained across partners (selected sites; implementation evaluation), and b) works to increase patient utilization of indicated care/services and improve patient outcomes/screening score for the priority domains (all sites; process and outcomes evaluations).

CHW Process and Outcomes Evaluation All partners will implement means for data capture within their EHRs/NowPow such that evaluation elements can be captured across all sites.

4. *Process evaluation* elements will include such elements as: CHW hiring and training; #patients screened; # patients positive (each SDOH); # patients engaged with CHWs; #/types of patient referrals made to local services and care; aspects of time and communication between initial screen and actual resource receipt; timing and content of patient and CHW engagement over time.
5. *Outcomes evaluation* elements will include such elements as: organizational satisfaction with CHW patient engagement and referral; # referred patients who access services and care appropriate to the SDOH for which they tested positive; follow up clinical measures relevant to SDOH; and follow up Equity Pillar and other clinical outcomes; assessment of CHW sustainability; assessment regarding associations between CHW engagement, local resource referral and utilization, and clinical outcomes; improved patient clinical engagement (better visit attendance); improved patient clinical outcomes (overall);

CHW Implementation Evaluation – Development During the first year of the grant, as CHWs are hired and trained, and implementation is begun across initial partner grantees, the evaluation team will devise the implementation evaluation of CHW as a model. Specific metrics for each of the 5 implementation domains, and the data to be collected (by survey, data abstraction from NowPow/EHR, stakeholder interview) will be based in part upon the SDOH, local collaboration characteristics, and local resource availability relevant to the SDOH. The evaluation will be explicitly designed to answer the following:

- 1) Can CHWs successfully engage with patients to increase utilization of needed services and care?
- 2) Are CHWs effective in addressing patient SDOH?
- 3) Can CHWs successfully collaborate with local partners to consolidate referral to existing resources and care, and develop additional as needed?
- 4) Are CHW efforts significantly associated with improved patient clinical outcomes?
- 5) Are patients and families satisfied with CHW efforts and feel they are of value?
- 6) Are CHWs sustainable in terms of available personnel and care/service reimbursement models?
- 7) Are CHWs considered valued members of the patient treatment context by providers and administrators?

CHW Implementation Evaluation – Performance The actual CHW implementation evaluation will occur after the teams have been implemented at partner sites for at least 1 year. As implementation evaluation involves substantial time and effort, we will pick 3 partner sites for this assessment. The sites will be selected to represent a diversity of organization size, organization type(s), population size, and population demographics. We anticipate activities as follows according to the five CFIR domains.

6. *Intervention Characteristics*: data abstraction from NowPow and EHR regarding pillar metrics and process and outcomes measures; survey of providers, patients, and community organizations regarding CHW utility, acceptability and feasibility; examination of administrative records to assess costs and reimbursements; and stakeholder interviews

7. *Outer setting*: data abstraction from NowPow and EHR regarding # patients engaging with CHWs and the extent; examination of correlation between CHW patient needs and resource availability; rates and types of reimbursement for provided services; funding opportunities associated with activities of CHW (e.g. reimbursements) and local resources (e.g. state funding for food pantries)
8. *Inner setting*: data abstraction from NowPow and EHR regarding types and timeliness of communication and referrals between providers, CHWs, referral agencies, and patients; survey of CHWs, healthcare clinical and administration personnel, and referral agency staff regarding level and types of enthusiasm for the CHW structure and activities; stakeholder interviews among the same regarding barriers and opportunities for CHW success and effectiveness
9. *Characteristics of individuals*: patient satisfaction surveys to include elements of engagement with CHW and referral agency resources; CHW member survey of work acceptability and enthusiasm within the larger healthcare context; clinical, CHW, referral agency, and patient interviews regarding self-efficacy within the CHW framework and how empowerment may be retained/enhanced
10. *Process*: review of process evaluation regarding CHW implementation as planned (timing, scope, objectives, metrics); scope of CHW collaboration within healthcare and across the community; use of evaluation to refine activities to increase patient engagement and metric impact

Data analysis will utilize mixed-methods methodology. Quantitative data (surveys, abstracted data) will be subject to statistical analysis using SPSS and SAS software. Standardized methods of analysis will be utilized, such as significance (α) set at 0.05 and power (β) at 0.80. Data analysis will be descriptive (frequency, mean), exploratory (differences in data across partner sites, differences between patients based on race or gender), and predictive (regression models to assess if/how selected variables influence measured outcomes). Qualitative data (interviews) will be recorded and reviewed for key themes and information regarding processes, barriers, and facilitators. These will be collated and compared across partner sites. The outcome will be a statistical analysis of factors influencing implementation success (outcomes, cost) couched within in-depth reflection of enthusiasm, organizational fit, and possible sustainability, drafted into a report describing the utility and sustainability of CHW as a care coordination model in rural communities.

Individual and Cumulative Pillar Metrics. It is anticipated that all partner sites will address the Equity Pillar metrics. As described above, processes and outcomes for activities associated with these pillars is examined as part of the CHW overall evaluation. We plan to assess metrics across all partner sites for site-specific and cumulative outcomes. As part of the Connected Care Collaborative, each grantee will collect and provide pillar-specific metric data. Further, as all will incorporate NowPow as

their referral platform, they will specifically collect community-level resource referral and utilization metrics.

Pillar metric evaluations will occur annually. Data will be collected (NowPow, EHR query, separate survey, selected stakeholder interviews) by the evaluation team and subjected to statistical analysis (using SPSS and SAS software). While much of the analysis is expected to be descriptive (e.g. frequency, mean) and exploratory (e.g. differences across partner sites, metrics by race and income), we also plan for a fuller analysis to assess possible predictors of metric changes (e.g. linear, multivariate, and logistic regression to assess the influence of different variables on priority outcomes). Standardized methods of analysis will be utilized, such as significance (α) set at 0.05 and power (β) at 0.80.

All analyses and results interpretations will be synthesized to examine intervention facilitators, barriers, and outcomes and presented to the Connected Care Collaborative leadership committee for review and comment. Key aspects of the report will include assessments of how success in addressing priority metrics varied by race, gender, location, and partner organization. This will allow purposeful consideration of equity in terms of Bridge activities and partnerships.

References

1. Community Health Workers Toolkit. Rural health Information hub. Available at: <https://www.ruralhealthinfo.org/toolkits/community-health-workers>. Accessed 15 Nov 2021.
2. Gutierrez Kapheim M, Campbell J. Best Practice Guidelines for Implementing and Evaluating Community Health Worker Programs in Health Care Settings. Chicago, IL: Sinai Urban Health Institute, January 2014.
3. Consolidated Framework for Implementation Research. Available at: <https://cfirguide.org/>. Accessed 15 Nov 2021.
4. Damschroder LJ, Aron DC, Keith RE, Kirsh SR, Alexander JA, Lowery JC. Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implement Sci.* 2009;4:50. Published 2009 Aug 7. doi:10.1186/1748-5908-4-50

Possible Toolkits

Rohan EA, McDougall R, Townsend JS. An Exploration of Patient Navigation and Community Health Worker Activities Across National Comprehensive Cancer Control Programs. *Health Equity.* 2018 Dec 14;2(1):366-374. doi: 10.1089/hec.2018.0053. PMID: 30569028; PMCID: PMC6299797.

Center for Disease Control and Prevention. Community Health Worker (CHW) Toolkit. Available at: <https://www.cdc.gov/dhdsp/pubs/toolkits/chw-toolkit.htm>. Accessed 15 Nov 2021.

CHWCentral. Community Health Workers Evidence-Based Models Toolbox- HRSA Office of Rural Health Policy. Available at: <https://chwcentral.org/resources/community->

| Data type | Collection timing | Data source | Individual Uses | Combined Uses |
|------------------------------|--------------------------|----------------------------------|---|--|
| SERT assessment | baseline | All C ³ patients | SERT data will be used to assess: - baseline prevalence of SDOH/barriers - ability of CHWs to impact SDOH - ability of NowPow referral and services to impact SDOH/barriers | Combined, these data will be used to assess: - associations between NowPow referral and use and SDOH/barrier improvement - associations between CHW-patient engagement and clinical outcome improvement - the combined influence of CHWs and NowPow referrals to reduce SDOH/barriers and improve clinical outcomes |
| | monthly | C3 patients “+” for SDOH/barrier | | |
| | 6-months | All C ³ patients | | |
| | 12-months | | | |
| EHR | baseline | All C ³ patients | EHR data will be used to assess: - baseline patient-level healthcare engagement and adherence - changes in engagement and adherence over time - changes in clinical outcomes and Equity Pillar metrics | |
| | 6-months | | | |
| | 12-months | | | |
| NowPow | monthly | C3 patients “+” for SDOH/barrier | NowPow data will be used to assess: - which services are utilized - the degree of service utilization - the impact of service utilization on identified SDOH/barriers | |
| Surveys and Interviews (S&I) | variable | Patients | - ALL surveys/SELECTED interviews to assess satisfaction with NowPow, CHWs, and the C3 program completed during month 10-11 of the 1-year CHW partnership - SELECTED: S&I to assess aspects of program implementation and expansion during Grant Years 3-4 | Combined, these data will be used to assess: - C3 implementation - opportunities for C3 expansion - areas for C3 improvement - opportunities for C3 sustainability |
| | | CHWs | - ALL surveys/SELECTED interviews to assess satisfaction with NowPow, patient progress, and the engagement process completed during month 10-11 of the 1-year CHW partnership - SELECTED: S&I to assess aspects of program implementation and expansion during Grant Years 3-4 | |
| | | C3 staff | - SELECTED: S&I to assess aspects of program implementation and expansion during Grant Years 3-4 | |
| | | C3 clinicians | - SELECTED: S&I to assess program utility to improve patient clinical outcomes at end of Grant Years 1-4 - SELECTED: S&I to assess aspects of program implementation and expansion during Grant Years 3-4 | |
| | | NowPow-associated staff | - SELECTED: S&I to assess program utility and how to improve engagement and increase resources at end of Grant Years 1-4 - SELECTED: S&I to assess aspects of program implementation and expansion during Grant Years 3-4 | |

14. Milestones:

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

All projects within the proposal have developed milestones with timelines attached to ensure steady progress toward proposed goals and accountability to completion. Milestones with designated timelines can be viewed in the supplemental documents attached.

Connected Care Collaborative - Creating a Regionalized CHW Program

| Milestones | 2022 Target Date | 2023 Target Date | 2024 Target Date | 2025 Target Date | 2026 Target Date |
|--|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
| Program Development | | | | | |
| Using pre-existing QHP data, determine ratio and allocation of CHW among partners | Month 7 | | | | |
| Discuss and determine infrastructure and materials needed by each partner to determine materials needed to support CHW's | Month 7 | | | | |
| Determine formal reporting method and frequency for organizations | Month 7 | | | | |
| Draft and execute contractual agreement with all partners to execute CHW program & NowPow Implementation | Month 8 | | | | |
| Review, revise, and execute annual contractual agreement with all Partners | | Month 8 | Month 8 | Month 8 | |
| Host quarterly meeting between Collaborative, QHP, HSIDN to review data and discuss progress/barriers | Months 9,12 | Months 3,6,9,12 | Months 3,6,9,12 | Months 3,6,9,12 | Months 3,6 |
| CHW Director Hired | Month 8 | | | | |
| Recruit and Hire 120 CHW's | Month 9 | | | | |
| CHW Service Launch | | Month 1 | | | |

| Milestones | 2022 Target Date | 2023 Target Date | 2024 Target Date | 2025 Target Date | 2026 Target Date |
|--|---------------------|---------------------|---------------------|---------------------|---------------------|
| CHW Training - General Course | | | | | |
| CHW Generalist Program | Months 10-11 | Months 9-10 | Months 9-10 | Months 9-10 | Months 9-10 |
| CHW Training - ECHO Specialty Series <i>*Note A-E represents the complete specialty series</i> | | | | | |
| Specialty CHW ECHO 1 - Diabetes | Months 11-12 (A) | Months 10-11 (B) | Months 10-11 (C) | Months 10-11 (D) | |
| Specialty CHW ECHO 2 - Hypertension | Months 11-12 (A) | Months 10-11 (B) | Months 10-11 (C) | Months 11-12 (D) | |
| Specialty CHW ECHO 3 - Asthma | | Months 1-2 (A) | Months 1-2 (B) | Months 1-2 (C) | Months 1-2 (D) |
| Specialty CHW ECHO 4 - Oral Care | | Months 1-2 (A) | Months 1-2 (B) | Months 2-3 (C) | Months 2-3 (D) |
| Specialty CHW ECHO 5 - Opioid | | Months 3-4 (A) | Months 3-4 (B) | Months 3-4 (C) | Months 3-4 (D) |
| Specialty CHW ECHO 6 - Develop Program Memory and Aging | Months 7-12 | | | | |
| Specialty CHW ECHO 6 - Memory and Aging | | Months 3-4 (A) | Months 3-4 (B) | Months 4-5 (C) | Months 4-5(D) |
| Specialty CHW ECHO 7 - Develop Program Mental Health | Months 7-12 | | | | |
| Specialty CHW ECHO 7 - Mental Health | | Months 4-5 (A) | Months 4-5 (B) | Months 5-6 (C) | Months 5-6 (D) |
| Specialty CHW ECHO 8 - Develop Program | | Months 7-12 | | | |
| Specialty CHW ECHO 8 - Current Issue | | | Months 5-6 (B) | Months 6-7 (C) | Months 6-7 (D) |
| CHW Training - Evergreen Series | | | | | |
| CHW Evergreen - Project Development | | Months 7-10 | | | |
| CHW Evergreen - Rollout | | Month 10 | | | |
| CHW Evergreen - Monthly Series | | Months 7-12 | Months 1-12 | Months 1-12 | Months 1-12 |

| Milestones | 2022 Target Date | 2023 Target Date | 2024 Target Date | 2025 Target Date | 2026 Target Date |
|---|---------------------|---------------------|---------------------|---------------------|---------------------|
| CHW Training - Technical Assistance | | | | | |
| Technical Assistance Calls | Months 7-12 | Months 1-12 | Months 1-12 | Months 1-12 | Months 1-12 |
| Community Resource Guide Development | | | | | |
| Compliation of community resources | Month 12 | | | | |
| First draft completion | | Month 2 | | | |
| Presentation and distrubution of draft to QHP board and HSIDN steering committee | | Month 3 | | | |
| Input from QHP and HSIDN taken and final draft created | | Month 4 | | | |
| Resource Guide distributed to Collaborative partners,QHP, HSIDN, CHW's, and placed online. | | Month 5 | | | |
| Annual Community Resource Fair <i>*Note "(X)" displays the consecutive year of the fair</i> | | | | | |
| List Compiled of attendees | Month 12 (1) | Month 12 (2) | Month 12 (3) | Month 12 (4) | |
| Venue selected | | Month 2 (1) | Month 2 (2) | Month 2 (3) | Month 2 (4) |
| Vendors selected | | Month 2 (1) | Month 2 (2) | Month 2 (3) | Month 2 (4) |
| Invitations distributed | | Month 4 (1) | Month 4 (2) | Month 4 (3) | Month 4 (4) |
| Event held | | Month 6 (1) | Month 6 (2) | Month 6 (3) | Month 6 (4) |

| Connected Care Collaborative - Integrating a Community Referral Platform (NowPow) | | | | | |
|--|---------------------|---------------------|---------------------|---------------------|---------------------|
| Milestones | 2022 Target Date | 2023 Target Date | 2024 Target Date | 2025 Target Date | 2026 Target Date |
| Stakeholder Engagement and Project Team Alignment (Organize) | | | | | |
| Hire Health Informatics Analyst | Month 6 | | | | |
| Hire Health Application Analyst | Month 6 | | | | |
| Hire CBO Coordinator | | Month 1 | | | |
| Assemble project team to ensure strategic alignment, define success metrics, and establish a concrete timeline | Month 9 | | | | |
| Determine key decision-makers and target interventions | Month 9 | | | | |
| Determine phased roll-out and user groups | Month 9 | | | | |
| Resource Directory Analysis (Launch) | | | | | |
| Define target service types based on screening tool and key focus areas | Month 10 | | | | |
| Define resource configurations for easy access to priority services | Month 10 | | | | |

| Milestones | 2022 Target Date | 2023 Target Date | 2024 Target Date | 2025 Target Date | 2026 Target Date |
|--|---------------------|---------------------|---------------------|---------------------|---------------------|
| System Set Up Design (Launch) | | | | | |
| Database and user group design based on patient visibility, access to NowPow activity, and data needs | Month 11 | | | | |
| Configurations by intervention | Month 11 | | | | |
| Define Additional Analytics Needs- Raw Data Package, Custom Reports | Month 11 | | | | |
| Define NowPow workflows (Launch) | | | | | |
| Determine data points for needs identification | | Month 1 | | | |
| Define workflow variations by user group | | Month 1 | | | |
| Align on expected NowPow functionality and data collection with workflow variation by intervention | | Month 1 | | | |
| Training (Launch) | | | | | |
| Determine training method | | Month 2 | | | |
| Finalize training plan and materials | | Month 2 | | | |
| Confirm training site and configurations are setup, and trainer(s) are provisioned with roles needed based on Customer functionality | | Month 2 | | | |
| Conduct training sessions | | Month 3 | | | |
| Referral Partners (Partner) | | | | | |
| Identify | | Month 5 | | | |
| Recruit | | Month 5 | | | |
| Onboard | | Month 5 | | | |
| Configure- service outcome details, etc | | Month 5 | | | |
| Training for referral receivers | | Month 5 | | | |

| Milestones | 2022 Target Date | 2023 Target Date | 2024 Target Date | 2025 Target Date | 2026 Target Date |
|---|---------------------|----------------------|---------------------|---------------------|---------------------|
| Transition to Support (Partner) | | | | | |
| NowPow outlines support process for issue management and Customer defines points of contact for ongoing support | | Month 6 | | | |
| Weekly meetings to review user adoption | | Month 6 (Continuous) | | | |
| Quarterly business reviews with key stakeholders | | Month 6 (Continuous) | | | |

| Connected Care Collaborative - Project Evaluation | | | | | |
|--|-----------------------|---------------------|---------------------|---------------------|---------------------|
| Milestones | 2022 Target Date | 2023 Target Date | 2024 Target Date | 2025 Target Date | 2026 Target Date |
| **Dates in this section assume a grant start date of 1 Jan 2022 and the 1st patient entered 1 July 2022 | | | | | |
| quarterly summary of SERT assessments | Month 10 (Continuous) | Continuous | Continuous | Continuous | Continuous |
| quarterly summary of patient EHR data | Month 10 (Continuous) | Continuous | Continuous | Continuous | Continuous |
| quarterly summary of NowPow usage | Month 10 (Continuous) | Continuous | Continuous | Continuous | Continuous |
| complete development of patient, CHW, C3 staff, C3 clinicians, and NowPow-associated staff survey instruments and interview guides | | Month 1 | | | |
| implement patient satisfaction survey/interview | | Continuous | Continuous | Continuous | Continuous |
| implement patient program survey/interview | | | Months 1-12 | 1-12 | |
| implement CHW satisfaction survey/interview | | Continuous | Continuous | Continuous | Continuous |
| implement CHW program survey/interview | | | Months 1-12 | Months 1-12 | |
| implement C3 staff program survey/interview | | | Months 1-12 | Months 1-12 | |
| implement C3 clinician satisfaction survey/interview | | Months 11-12 | Months 11-12 | Months 11-12 | Months 11-12 |
| implement C3 clinician program survey/interview | | | Months 1-12 | Months 1-12 | |
| implement NowPow-associated staff satisfaction survey/interview | | Months 11-12 | Months 11-12 | Months 11-12 | Months 11-12 |
| implement NowPow-associated staff program survey/interview | | | Months 1-12 | Months 1-12 | |
| develop and present semiannual evaluation to Healthcare Transformation Advisory Board | | Months 6,12 | Months 6,12 | Months 6,12 | Months 6,12 |
| Complete process and outcome evaluations | | | | | Month 11 |
| Complete implementation evaluation | | | | | Month 11 |

15. Budget:

Number of Individuals Served:

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

More than 2000 individuals with Medicaid as their payer source are estimated to be served each year (four years, as Year 1 will primarily be implementation).

Alternative Payment Methodologies:

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

Conversations among policymakers and CHW advocates in most states about financing CHWs focus heavily on Medicaid, since CHWs have historically been most effective at meeting the needs of low-income and minority populations. Medicaid is also a large and growing percentage of state budgets, and states are looking for ways to control costs and improve outcomes from the program. The data and analysis compiled from the evaluations of this model will be used to support widespread adoption of alternative payment models (APMs) and alternative mechanisms to help cover the costs of CHW work. The Collaborative believes the final APM should take into consideration the total costs of CHW services and care, be adoptable by private and public payers, and align with other payment reform efforts in Illinois.

A strong CHW workforce needs sustainable financing funding sources that it can rely on year after year. There are a number of ways that CHWs can tap into the health care financing system to access sustainable financing for their services through public and private payers. These strategies can be used with fee-for-service, pay-for-performance, bundled payment, global payments, and statewide assessments, as well as alternative payment models currently under consideration.

A recent change in federal rules makes it easier for state Medicaid programs to pay for CHW services. In July 2013, the Federal Centers for Medicare and Medicaid Services (CMS) adopted a change in the federal regulation (42 CFR 440.130(c)) governing the set of services for which state Medicaid programs can pay. Previously, Medicaid programs could pay for preventive services that were *provided by a physician* or other clinician. The rule change allows Medicaid programs to pay for preventive services *recommended by a physician* or other clinician. No single strategy works in every situation, because strategies depend on the situation and factors specific to that scenario. Furthermore, CHWs may perform diverse roles or interventions, each of which may have a different impact on costs, revenues and other outcomes.

16. Sustainability:

To 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. (i.e. how will your project continue to operate without HTC funding?) In particular, include how services that address social determinants of health will be funded on an ongoing basis (for example, through existing payment models, alternative payment methodologies for Medicaid services, or through other funding sources). In your narrative, highlight any key assumptions that are critical to making your project sustainable.

Building on our narrative in the previous section regarding Alternative Payment Methodologies, the Connected Care Collaborative commits to exploring the work required to develop a hybrid payment model for sustainability that takes into account the hospital's value based payment model, the community based third-party billing model, the FQHC bundled-rate payment model, and the new proposed accreditation and payment model for CHWs. Capturing existing payments models such as the chronic disease care management model (CDCM), the per member per month (PMPM) model, the 1815 waivers model and others provide a good foundation for exploring hybrid options. There is an opportunity here to partner with the MCOs to make the community health worker work reimbursable based on its ability to both improve health outcomes and save cost for the highest cost patients.

CHWs work in the field as “social determinants of health agents,” because they often address many issues that affect a person's health in a holistic way. It is estimated that only 20% of an individual's health outcomes are actually due to the healthcare they receive while the other 80% is due to the other factors in one's life such as socioeconomic factors, the physical environment, and one's health behaviors. By having CHWs collaborate with high utilizing patients whose payor source is Medicaid to address their social determinants of health we believe we can have a tremendous effect on an individuals' health in turn reducing unnecessary healthcare expenses.

A key assumption that is critical to making our project sustainable is the passing of new legislation outlining criteria for community health workers to become a billable service. Most recently a bill that would set up certification programs for community health workers has passed both chambers of the Illinois General Assembly, and the Senate Bill 336 will further the full implementation of the community health worker certification program that was part of House Bill 158 earlier this year.

Public comments are being considered in the development of State Plan Amendments (SPAs) and administrative rules to implement CHW, perinatal doula, and home visiting services in the Illinois Medicaid program with federal matching dollars, per the notice for public comment released by HFS most recently. Each partnering entity in the Connected Care Collaborative are bringing their strengths and resources to leverage for greater equity, quality and access to care for our Delta region residents. As a full partner with the Collaborative, HFS has the opportunity to impact and contribute to the sustainability of community health workers, and by extension this proposal. The

Connected Care Collaborative was formed knowing that we will go farther if we do not journey alone and is privileged to partner with HFS.



November 12, 2021

Woody Thorne, Vice President, Community Affairs
Southern Illinois Healthcare
1239 E Main St
Carbondale, IL 62902-3988

To Woody Thorne:

I write on behalf of Quality Health Partners of Southern Illinois, LLC (QHP) to commit our partnership in the Connected Care Collaborative. The Collaborative, led by Southern Illinois Healthcare, submits a proposal to the Illinois Department of Healthcare and Family Services (HFS) for a grant to fund the Rural Initiative for Healthcare Transformation – targeted to improve healthcare outcomes, reduce healthcare disparities, and realign resources in distressed communities for a person-centered, integrated approach to healthcare at a community level in the Delta region of southern Illinois.

We strongly support this application as it meets the needs of residents more holistically by linking healthcare services with community resources that address social determinants of health, while reducing inequities in healthcare access and delivery.

The goals of the Collaborative are to use the HFS investment to:

- 1) Spur healthcare delivery redesign so that each patient's individual needs are the focus of care;
- 2) Drive greater collaboration to more effectively utilize resources, propagate learnings and best practices;
- 3) Reduce silos between healthcare settings and community-based organizations by maximizing the effectiveness and reach of established community-based programming and their resources to create a seamless, closed-loop referral process for provider-based referrals;
- 4) Significantly enhance equity in healthcare outcomes;
- 5) Provide healthcare more effectively, particularly to underserved communities.

Through this letter, we acknowledge specific roles and responsibilities we will fulfill in this partnership. In the event this proposal is funded, we would expect our role in the Rural Initiative for Healthcare Transformation consortium to include:

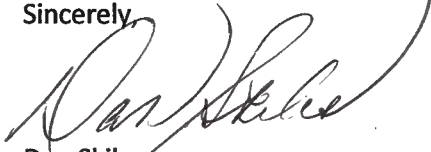
- Enhancing existing and creating new partnerships to improve health outcomes and reduce disparities by addressing maternal health, chronic disease management, and barriers to healthcare access; signing a contract with HFS and all project partners to this effect.
- Designating the time and efforts of a representative from our organization to work on this effort as a member of the Connected Care Collaborative Advisory Board.

- Contributing to any and all reporting requirements by HFS

SIH will take responsibility to lead the project's activities and oversee all agreed upon deliverables of the Collaborative.

We look forward to working with you in addressing the health and healthcare access challenges in our region, employing transformational interventions, and in turn, improving health outcomes.

Sincerely,

A handwritten signature in black ink, appearing to read "Dan Skiles". The signature is written in a cursive style and is positioned above the printed name and title.

Dan Skiles
Executive Director, QHP
VP, Health Transformation
Southern Illinois Healthcare
1239 E. Main St.
Carbondale, IL 62902



November 18, 2021

Woody Thorne, Vice President, Community Affairs
Southern Illinois Healthcare
1239 E Main St
Carbondale, IL 62902-3988

To Woody Thorne:

I write on behalf of the **Healthy Southern Illinois Delta Network (HSIDN)** to commit our partnership in the Connected Care Collaborative. The Collaborative, led by Southern Illinois Healthcare, submits a proposal to the Illinois Department of Healthcare and Family Services (HFS) for a grant to fund the Rural Initiative for Healthcare Transformation – targeted to improve healthcare outcomes, reduce healthcare disparities, and realign resources in distressed communities for a person-centered, integrated approach to healthcare at a community level in the Delta region of southern Illinois.

We strongly support this application as it meets the needs of residents more holistically by linking healthcare services with community resources that address social determinants of health, while reducing inequities in healthcare access and delivery through the implementation of an integrated Community Health Worker (CHW) program.

Formed in 2008, the HSIDN is an organization comprised of over 400 community partners from different community organizations including health departments, social service agencies, and community based organizations is committed to our vision of transforming Southern Illinois into a region that supports and enhances healthy living. Our goals are to;

- Create infrastructure leading to policy, systems & environmental changes for a healthy Southern Illinois
- Improve mental health through prevention and by ensuring access to appropriate, quality mental health services in southern Illinois.
- Reduce the number of new cancer cases, as well as illness, disability, and death caused by cancer in southern Illinois
- Promote health and reduce chronic disease risk through the consumption of healthful diets and achievement and maintenance of healthy body weights in southern Illinois.
- Improve cardiovascular health and quality of life through prevention, detection, and treatment of risk factors for heart attack and stroke; early identification and treatment of heart attacks and strokes; prevention of repeat cardiovascular events; and reduction in deaths from cardiovascular disease southern Illinois.

The currently has five active coalitions (Perry County Healthy Communities Coalition, Franklin Williamson Healthy Communities Coalition, Jackson County Healthy Communities Coalition, Southeastern Illinois Community Health Coalition, and the Healthy Southern Seven Region Coalition). Most of the coalitions have formed action teams or work groups that collaborate to the address health needs of the community. Since the inception of the HSIDN the partners have worked together on a variety of initiatives from diabetes screening and education, to tobacco prevention and control, improving the built environment, increasing knowledge of mental health and substance misuse services available, suicide prevention, increasing cancer screening, development of a web-site and community resource guides for a variety of health issues, and so much more.

The goals of the Collaborative listed below align with the goals of the HSIDN:

- 1) Spur healthcare delivery redesign so that each patient's individual needs are the focus of care;

- 2) Drive greater collaboration to more effectively utilize resources, propagate learnings and best practices;
- 3) Reduce silos between healthcare settings and community-based organizations by maximizing the effectiveness and reach of established community-based programming and their resources to create a seamless, closed-loop referral process for provider-based referrals;
- 4) Significantly enhance equity in healthcare outcomes;
- 5) Provide healthcare more effectively, particularly to underserved communities.

Through this letter, we acknowledge specific roles and responsibilities we will fulfill in this partnership. In the event this proposal is funded, we would expect our role in the Rural Initiative for Healthcare Transformation consortium to include:

- Enhancing existing and creating new partnerships to improve health outcomes and reduce disparities by addressing maternal health, chronic disease management, and barriers to healthcare access; signing a contract with HFS and all project partners to this effect.
- Designating the time and efforts of a representative from our organization to work on this effort as a member of the Connected Care Collaborative Advisory Board, to meet at least quarterly.
- Promoting, and recruiting agencies to participate in a semi-annual resource fair for Community Health Workers, healthcare entities, and community agencies to make connections and share resources.
- Providing educational materials for Community Health Workers on services offered, target groups served, and eligibility criteria, i.e. training on the Healthy Southern Illinois Delta Network, the resources available on the web-site at www.hsidn.org, how to best navigate the site, how to become involved in the community coalitions and related events and action teams, etc.
- Collaborating with the QHP/PHO and the Collaborative to offer support and provide improvement suggestions.

We understand that SIH will take responsibility to lead the project's activities and oversee all agreed upon deliverables of the Collaborative. The HSIDN looks forward to continuing our collaborative work to improving health outcomes in Southern Illinois.

Sincerely,



Sandra Schwartz, SIH Community Health Coordinator on behalf of the HSIDN Steering Committee Members

- _____ Franklin-Williamson Bi-County Health Department, Kevin Kaytor
- _____ Jackson County Health Department, Bart Hagston
- _____ Randolph County Health Department, Angela Oathout
- _____ Perry County Health Department, Barb Stevenson
- _____ Southern Illinois Healthcare (SIH), Woody Thorne
- _____ Southern Illinois University School of Medicine Center for Rural Health and Social Service Development, Jeff Franklin
- _____ University of Illinois Extension, Lynn Heins



SIH System Office

t 618.457.5200

f 618.529.0568

November 12, 2021

Woody Thorne, Vice President, Community Affairs
Southern Illinois Healthcare
1239 E Main St
Carbondale, IL 62902-3988

To Woody Thorne:

I write on behalf of Quality Health Partners of Southern Illinois, LLC (QHP) to commit our partnership in the Connected Care Collaborative. The Collaborative, led by Southern Illinois Healthcare, submits a proposal to the Illinois Department of Healthcare and Family Services (HFS) for a grant to fund the Rural Initiative for Healthcare Transformation – targeted to improve healthcare outcomes, reduce healthcare disparities, and realign resources in distressed communities for a person-centered, integrated approach to healthcare at a community level in the Delta region of southern Illinois.

We strongly support this application as it meets the needs of residents more holistically by linking healthcare services with community resources that address social determinants of health, while reducing inequities in healthcare access and delivery.

The goals of the Collaborative are to use the HFS investment to:

- 1) Spur healthcare delivery redesign so that each patient's individual needs are the focus of care;
- 2) Drive greater collaboration to more effectively utilize resources, propagate learnings and best practices;
- 3) Reduce silos between healthcare settings and community-based organizations by maximizing the effectiveness and reach of established community-based programming and their resources to create a seamless, closed-loop referral process for provider-based referrals;
- 4) Significantly enhance equity in healthcare outcomes;
- 5) Provide healthcare more effectively, particularly to underserved communities.


Through this letter, we acknowledge specific roles and responsibilities we will fulfill in this partnership. In the event this proposal is funded, we would expect our role in the Rural Initiative for Healthcare Transformation consortium to include:

- Enhancing existing and creating new partnerships to improve health outcomes and reduce disparities by addressing maternal health, chronic disease management, and barriers to healthcare access; signing a contract with HFS and all project partners to this effect.
- Designating the time and efforts of a representative from our organization to work on this effort as a member of the Connected Care Collaborative Advisory Board.
- Contributing to any and all reporting requirements by HFS

SIH will take responsibility to lead the project's activities and oversee all agreed upon deliverables of the Collaborative.

We look forward to working with you in addressing the health and healthcare access challenges in our region, employing transformational interventions, and in turn, improving health outcomes.

Sincerely,

A handwritten signature in black ink, appearing to read 'Darrell E. Bryant', written over the typed name and title.

Darrell E. Bryant
Vice President
Chief Operating Officer
SIH Medical Group
1239 E. Main St.
Carbondale, IL 62902



NowPow Letter of Support

Connected Care Collaborative

November 18, 2021

Thank you for your interest in NowPow to partner with the Connected Care Collaborative (CCC) to support connections between healthcare services and community resources for improved health and wellbeing, health equity, and access to care for Illinois' rural communities. NowPow is well equipped to work with every stakeholder – critical access hospitals, primary care sites, and FQHCs can support their patients alongside CBOs, behavioral health sites, local health departments, and academic services to meet their full spectrum of needs. NowPow's multi-sided referral platform uses a comprehensive resource directory, powerful filters, and matching algorithms, to power personalized and high-quality referrals into the community with the secure infrastructure needed to close the loop and manage patient longitudinal care collaboratively.

Individualized health information teams will be able to access an array of custom screeners, whether embedded within their EMRs/data systems or NowPow standalone, to assess for patient needs. Leveraging NowPow's filters and algorithms, identified needs can be mapped to services that are personalized for the patient, incorporating their demographic information and clinical data as well. This empowers community health workers, care coordinators, and social workers to provide shared or tracked referrals immediately upon screening completion. With a shared referral, a care professional user provides resource information directly to an individual via text, email, or print. With a tracked referral, the care professional sends the patient's information to a referral receiving organization through a secure interface.

For the care professionals using the platform, NowPow is able to offer customized integrations, platform configurations, and automations to minimize burden and support high adoption with seamless workflows. We use a flexible and standards-based integration strategy and would approach each integration uniquely, whether a deeply embedded bi-directional integration or a lighter touch Single Sign On technical project.

For the different organizations on the receiving end of referrals, NowPow offers our free CommRx tool to update the status of new referrals, schedule appointments, nudge appointment reminders to patients, and engage in direct messaging with their referral partners. Here, Community Based Organizations can tailor their workflows to be very light touch or deeply detailed with detailed workflows including reasons for declining a referral, wait-listing, appointment scheduling and details on contacting the customer and customized outcome details that can be used for evidence-based reporting and documenting service compliance for reimbursement.

And as you expand your network, NowPow's Community Engagement team is there to support socialization, training, onboarding, and referral partner management. They are just one part of a dedicated team that would work alongside the CCC as it scales referrals across communities. From the start of our partnership, our teams will work with the CCC to

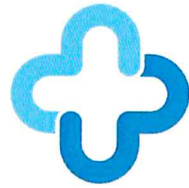
- Understand prevalence and distribution of social needs in communities
- Drive successful resource connection, including referral outcomes and barriers to care
- Optimize referral networks that effectively support the needs of the population served
- Support data driven resource investment and policy development with deepened understanding of resource supply & demand and resource gaps in the community

This is possible with NowPow's robust data and analytics options. Our dashboards are built to help manage referral processes and understand intervention outcomes as well as understand referral partner performance across the network. NowPow's Analytics team can develop any custom reporting required to support the intervention in addition to offering raw data that enables reporting at the individual patient level.

We look forward to collaboratively delivering a successful holistic rural care initiative for your patients and their communities!

Priscilla Daboni, *Senior Account Executive* | [REDACTED]

Cathryn Crookston, *VP of Sales* | [REDACTED]



CommunityHealth

& EMERGENCY SERVICES

November 18, 2021

Woody Thorne, Vice President, Community Affairs
Southern Illinois Healthcare
1239 E. Main St.
Carbondale, IL 62902-3988

To Woody Thorne:

I write on behalf of Community Health and Emergency Services Inc. to commit our partnership in the Connected Care Collaborative. The Collaborative, led by Southern Illinois Healthcare, submits a proposal to the Illinois Department of Healthcare and Family Services (HFS) for a grant to fund the Rural Initiative for Healthcare Transformation – targeted to improve healthcare outcomes, reduce healthcare disparities, and realign resources in distressed communities for a person-centered, integrated approach to healthcare at a community level in the Delta region of southern Illinois.

We strongly support this application as it meets the needs of residents more holistically by linking healthcare services with community resources that address social determinants of health, while reducing inequities in healthcare access and delivery.

As an organization which has devoted considerable resources to providing low cost healthcare services to unserved populations throughout southernmost Illinois, we are pleased to be included in this project.

The goals of the Collaborative are to use the HFS investment to:

- 1) Spur healthcare delivery redesign so that each patient's individual needs are the focus of care;
- 2) Drive greater collaboration to more effectively utilize resources, propagate learnings and best practices;
- 3) Reduce silos between healthcare settings and community-based organizations by maximizing the effectiveness and reach of established community-based programming and their resources to create a seamless, closed-loop referral process for provider-based referrals;
- 4) Significantly enhance equity in healthcare outcomes;
- 5) Provide healthcare more effectively, particularly to underserved communities.

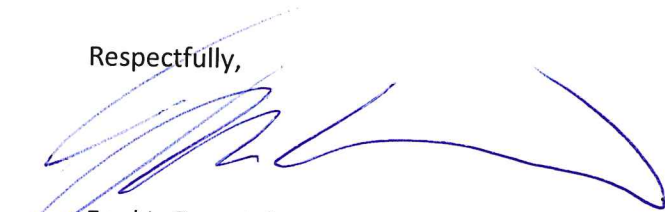
Through this letter, we acknowledge specific roles and responsibilities we will fulfill in this partnership. In the event this proposal is funded, we would expect our role in the Rural Initiative for Healthcare Transformation consortium to include:

- Enhancing existing and creating new partnerships to improve health outcomes and reduce disparities by addressing maternal health, chronic disease management, and barriers to healthcare access; signing a contract with HFS and all project partners to this effect.
- Designating the time and efforts of a representative from our organization to work on this effort as a member of the Connected Care Collaborative Advisory Board.
- With grant funding, integrating with NowPow, tailored to my organization, matching our unique audience and ability to resource the work.
- Contributing to any and all reporting requirements by HFS.

SIH will take responsibility to lead the project's activities and oversee all agreed upon deliverables of the Collaborative

We wholeheartedly endorse this SIH collaborative and will be pleased to participate. We look forward to working with you in addressing the health and healthcare access challenges in our region, employing transformational interventions, and in turn, improving health outcomes.

Respectfully,



Fred L. Bernstein
Community Health and Emergency Services Inc.



November 12, 2021

Woody Thorne, Vice President, Community Affairs
Southern Illinois Healthcare
1239 E Main St
Carbondale, IL 62902-3988

To Woody Thorne:

I write on behalf of SIU Center for Family Medicine – Carbondale to commit our partnership in the Connected Care Collaborative. The Collaborative, led by Southern Illinois Healthcare, submits a proposal to the Illinois Department of Healthcare and Family Services (HFS) for a grant to fund the Rural Initiative for Healthcare Transformation – targeted to improve healthcare outcomes, reduce healthcare disparities, and realign resources in distressed communities for a person-centered, integrated approach to healthcare at a community level in the Delta region of southern Illinois.

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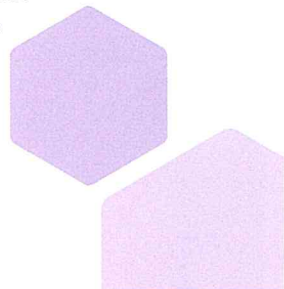
As an organization that serves the patients of Southern Illinois, we have been and continue to successfully use Community Health Workers to identify and assist the most vulnerable population's needs. We hope to grow and expand those services via this partnership.

The goals of the Collaborative are to use the HFS investment to:

- 1) Spur healthcare delivery redesign so that each patient's individual needs are the focus of care;
- 2) Drive greater collaboration to more effectively utilize resources, propagate learnings and best practices;
- 3) Reduce silos between healthcare settings and community-based organizations by maximizing the effectiveness and reach of established community-based programming and their resources to create a seamless, closed-loop referral process for provider-based referrals;
- 4) Significantly enhance equity in healthcare outcomes;
- 5) Provide healthcare more effectively, particularly to underserved communities.

Through this letter, we acknowledge specific roles and responsibilities we will fulfill in this partnership. In the event this proposal is funded, we would expect our role in the Rural Initiative for Healthcare Transformation consortium to include:

- Enhancing existing and creating new partnerships to improve health outcomes and reduce disparities by addressing maternal health, chronic disease management, and barriers to healthcare access; signing a contract with HFS and all project partners to this effect.





SIU MEDICINE
FORWARD. FOR YOU.

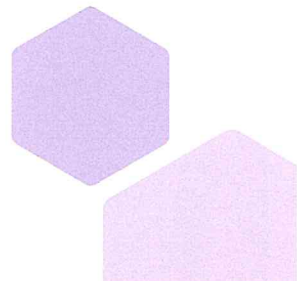
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- With grant funding, integrating with NowPow, tailored to my organization, matching our unique audience and ability to resource the work.
- Contributing to any and all reporting requirements by HFS

SIH will take responsibility to lead the project's activities and oversee all agreed upon deliverables of the Collaborative.

We look forward to working with you in addressing the health and healthcare access challenges in our region, employing transformational interventions, and in turn, improving health outcomes.

Sincerely,

Leigh Ann Keyser
Regional Clinic Administrator
SIU Center for Family Medicine – Carbondale





CHRISTOPHER GREATER AREA
RURAL HEALTH PLANNING CORPORATION

Administrative Office
P.O. Box 155
4241 Highway 14 West
Christopher, Illinois 62822

Phone: (618) 724-2401
Fax: (618) 724-9257

KIM MITROKA, PRESIDENT-CHIEF EXECUTIVE OFFICER

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DENTAL: (618) 724-9290
PHARMACY: (618) 724-2136
BILLING FAX: (618) 724-4628

FAIRFIELD COMMUNITY HEALTH CENTER
209 NW 11TH STREET
FAIRFIELD, IL 62837
(618) 842-4470 • FAX (618) 842-3437

DUQUOIN COMMUNITY HEALTH CENTER
1564 S. WASHINGTON STREET
DUQUOIN, IL 62832
(618) 542-8702 • FAX (618) 542-8792

CLAY COMMUNITY HEALTH CENTER
165 KINNAMAN DRIVE
FLORA, IL 62839
(618) 662-8386 • FAX (618) 662-4338

SESSER COMMUNITY HEALTH CENTER
6294 STATE HWY 154
SESSER, IL 62884
(618) 625-6979 • FAX (618) 625-6549

ELDORADO RURAL HEALTH
1401 U.S. HWY 45 N
ELDORADO, IL 62930
(618) 273-2951 • FAX (618) 273-2712

SHAWNEETOWN HEALTH CARE CLINIC
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SHAWNEETOWN, IL 62984
(618) 269-3815 • FAX (618) 269-3274

ALBION COMMUNITY HEALTH CENTER
33 WEST MAIN
ALBION, IL 62806
(618) 445-2287 • FAX (618) 445-2257

CRHPC - CARMi HEALTH CENTER
103 COMMERCE STREET
CARMi, IL 62821
(618) 384-5686 • FAX (618) 382-2882

MT. VERNON COMMUNITY HEALTH
CENTER
2920 VETERANS MEMORIAL DRIVE
MT. VERNON, IL 62864
(618) 244-6544 • FAX (618) 244-6577

JOHNSTON CITY COMMUNITY HEALTH
CENTER
14410 ROUTE 37
JOHNSTON CITY, IL 62951
(618) 983-6911 • FAX (618) 983-6913

REA CLINIC BENTON
206 E. CHURCH STREET
SUITE B
BENTON, IL 62812
(618) 435-9888 • FAX (618) 435-9889

November 12, 2021

Woody Thorne, Vice President, Community Affairs

Southern Illinois Healthcare

1239 E Main St

Carbondale, IL 62902-3988

To Woody Thorne:

I write on behalf of Christopher Greater Area Rural Health Planning Corporation to commit our partnership in the Connected Care Collaborative. The Collaborative, led by Southern Illinois Healthcare, submits a proposal to the Illinois Department of Healthcare and Family Services (HFS) for a grant to fund the Rural Initiative for Healthcare Transformation – targeted to improve healthcare outcomes, reduce healthcare disparities, and realign resources in distressed communities for a person-centered, integrated approach to healthcare at a community level in the Delta region of southern Illinois.

We strongly support this application as it meets the needs of residents more holistically by linking healthcare services with community resources that address social determinants of health, while reducing inequities in healthcare access and delivery.

Christopher Greater Area Rural Health Planning Corporation is a Federally Qualified Health Center serving nearly 47,000 patients across the target population. While CRHPC collaborates with various health care systems throughout its multi-county service area, the relationship with SIH in partnership with CRHPC has been a strong and coordinated effort benefiting our patients in closing referral lousps and coordinating follow-up care post discharge.

The goals of the Collaborative are to use the HFS investment to:

- 1) Spur healthcare delivery redesign so that each patient's individual needs are the focus of care;
- 2) Drive greater collaboration to more effectively utilize resources, propagate learnings and best practices;
- 3) Reduce silos between healthcare settings and community-based organizations by maximizing the effectiveness and reach of established community-based programming and their resources to create a seamless, closed-loop referral process for provider-based referrals;

“Your Community Health Center”

- 4) Significantly enhance equity in healthcare outcomes;
- 5) Provide healthcare more effectively, particularly to underserved communities.

Through this letter, we acknowledge specific roles and responsibilities we will fulfill in this partnership. In the event this proposal is funded, we would expect our role in the Rural Initiative for Healthcare Transformation consortium to include:

- Enhancing existing and creating new partnerships to improve health outcomes and reduce disparities by addressing maternal health, chronic disease management, and barriers to healthcare access; signing a contract with HFS and all project partners to this effect.
- Designating the time and efforts of a representative from our organization to work on this effort as a member of the Connected Care Collaborative Advisory Board.
- With grant funding, integrating with NowPow, tailored to my organization, matching our unique audience and ability to resource the work.
- Contributing to any and all reporting requirements by HFS

SIH will take responsibility to lead the project's activities and oversee all agreed upon deliverables of the Collaborative.

We look forward to working with you in addressing the health and healthcare access challenges in our region, employing transformational interventions, and in turn, improving health outcomes.

Sincerely,

Kimberly Mitroka, President/CEO

Kimberly Mitroka, President/CEO

Christopher Greater Area Rural Health Planning Corporation

P.O. Box 155

4241 Highway 14 West

Christopher, Illinois 62822



Shawnee Health Service

A Non-Profit Organization Serving Southern Illinois Since 1972
An Equal Opportunity Employer and Provider

109 California Street
P.O. Box 577
Carterville, IL 62918-0577
Phone (618) 519-9200
Fax (618) 985-6860

November 17, 2021

Woody Thorne, Vice President, Community Affairs
Southern Illinois Healthcare
1239 E Main St
Carbondale, IL 62902-3988

RE: Letter of Commitment

To Woody Thorne:

I write on behalf of Shawnee Health Service and Development Corporation to commit our partnership in the Connected Care Collaborative. The Collaborative, led by Southern Illinois Healthcare, submits a proposal to the Illinois Department of Healthcare and Family Services (HFS) for a grant to fund the Rural Initiative for Healthcare Transformation – targeted to improve healthcare outcomes, reduce healthcare disparities, and realign resources in distressed communities for a person-centered, integrated approach to healthcare at a community level in the Delta region of southern Illinois.

We strongly support this application as it meets the needs of residents more holistically by linking healthcare services with community resources that address social determinants of health, while reducing inequities in healthcare access and delivery.

As an organization which has provided healthcare and social services to the people of southern Illinois since 1971, we intend to fully participate in the implementation of this project. Our core healthcare service area is Jackson and Williamson counties where we operate ten (10) outpatient health centers providing family practice, internal medicine, obstetrics/gynecology, psychiatry, mental health and substance use disorder services, dentistry, pharmacy, nutrition counseling, and case management for all community residents regardless of ability to pay for services. Some of our services, such as obstetrics/gynecology and substance use disorder treatment, draw patients from throughout southern Illinois. In our social service wing, Shawnee Alliance, we provide parent education and doula support to first-time parents in Jackson, Perry, Franklin and Williamson counties and a wide array of supportive services to older adults and disabled adults in 18 counties across southern Illinois. Program goals include enabling older adults and disabled adults to maximize their independence and remain in the community, advocating for their rights and their quality of life in the community and in nursing homes, and protecting them from abuse, neglect, and exploitation.

We have a 30-year history of cooperating effectively with Southern Illinois Healthcare on a wide range of projects. We have been a member of the Quality Health Partnership since 2012, and we have staff members serving on all three (3) core committees of this Physician Hospital Organization. We have also collaborated with some of the major Managed Care Organizations in Illinois on outreach projects linking patients to care.

Finally, we have a long history of staff members serving on action teams of the Healthy Southern Illinois Delta Network (HSIDN), specifically through the Jackson County Healthy Communities Coalition and the Franklin-Williamson Healthy Communities Coalition. We participate in the steering committees of both Healthy Community Coalitions and our staff members serve as co-chairs of the Joint Access to Care team and the Behavioral Health Action Team. We also have staff members on the Southern Illinois Cancer

Action Network and the Healthy Seniors Action Team, and we contribute as needed to the activities of other teams. We can attest to the strong cooperative relationships that have developed over time among many of the organizations involved in the Connected Care Collaborative through the HSIDN.

The goals of the Collaborative are to use the HFS investment to:

- 1) Spur healthcare delivery redesign so that each patient's individual needs are the focus of care;
- 2) Drive greater collaboration to more effectively utilize resources, propagate learnings and best practices;
- 3) Reduce silos between healthcare settings and community-based organizations by maximizing the effectiveness and reach of established community-based programming and their resources to create a seamless, closed-loop referral process for provider-based referrals;
- 4) Significantly enhance equity in healthcare outcomes; and
- 5) Provide healthcare more effectively, particularly to underserved communities.

Through this letter, we acknowledge specific roles and responsibilities we will fulfill in this partnership. In the event this proposal is funded, we expect our role in the Rural Initiative for Healthcare Transformation consortium to include:

- Enhancing existing and creating new partnerships to improve health outcomes and reduce disparities by addressing maternal health, chronic disease management, and barriers to healthcare access; signing a contract with HFS and all project partners to this effect.
- Designating the time and efforts of a representative from our organization to work on this effort as a member of the Connected Care Collaborative Advisory Board.
- With grant funding, integrating with NowPow, tailored to my organization, matching our unique audience and ability to resource the work.
- Contributing to any and all reporting requirements by HFS.
- Integrating Community Health Workers into our social service operations in both our clinic-based and community-based programs, and sharing implementation best practices with other sites in the Connected Care Collaborative.
- Welcoming new patients referred to us by other Connected Care Collaborative partners.

SIH will take responsibility to lead the project's activities and oversee all agreed upon deliverables of the Collaborative.

We look forward to working with you in addressing the health and healthcare access challenges in our region, employing transformational interventions, and in turn, improving health outcomes.

Sincerely,



Patsy R. Jensen
Executive Director
Shawnee Health Service



Prairie Cardiovascular

The Doctors of Prairie

November 12, 2021

Woody Thorne
Vice President, Community Affairs
Southern Illinois Healthcare
1239 E Main St
Carbondale, IL 62902-3988

To Woody Thorne:

I write on behalf of Prairie Cardiovascular Consultants, Ltd. to commit our partnership in the Connected Care Collaborative. The Collaborative, led by Southern Illinois Healthcare, submits a proposal to the Illinois Department of Healthcare and Family Services (HFS) for a grant to fund the Rural Initiative for Healthcare Transformation – targeted to improve healthcare outcomes, reduce healthcare disparities, and realign resources in distressed communities for a person-centered, integrated approach to healthcare at a community level in the Delta region of southern Illinois.

We strongly support this application as it meets the needs of residents more holistically by linking healthcare services with community resources that address social determinants of health, while reducing inequities in healthcare access and delivery.

The goals of the Collaborative are to use the HFS investment to:

- 1) Spur healthcare delivery redesign so that each patient's individual needs are the focus of care;
- 2) Drive greater collaboration to more effectively utilize resources, propagate learnings and best practices;
- 3) Reduce silos between healthcare settings and community-based organizations by maximizing the effectiveness and reach of established community-based programming and their resources to create a seamless, closed-loop referral process for provider-based referrals;
- 4) Significantly enhance equity in healthcare outcomes;
- 5) Provide healthcare more effectively, particularly to underserved communities.

Through this letter, we acknowledge specific roles and responsibilities we will fulfill in this partnership. In the event this proposal is funded, we would expect our role in the Rural Initiative for Healthcare Transformation consortium to include:

- Enhancing existing and creating new partnerships to improve health outcomes and reduce disparities by addressing maternal health, chronic disease management, and barriers to healthcare access; signing a contract with HFS and all project partners to this effect.

Springfield

619 East Mason Street
Suite 4P57
Springfield, IL 62701
217.788.0706

O'Fallon

Three St. Elizabeth's Boulevard
Suite 2800
O'Fallon, IL 62269
618.233.6044

Decatur

1800 East Lake Shore Drive
Suite 1500
Decatur, IL 62521
217.422.6100

2965 North Main Street
Suite D
Decatur, IL 62526
217.422.6100

Effingham

503 North Maple Street
Effingham, IL 62401
217.342.3700

Carbondale

409 West Oak Street
Carbondale, IL 62901
618.529.4455

301 South Park Avenue
Herrin, IL 62948
618.529.4455

An Affiliate of Hospital Sisters Health System

Visit us at prairieheart.org

- Designating the time and efforts of a representative from our organization to work on this effort as a member of the Connected Care Collaborative Advisory Board.
- With grant funding, integrating with NowPow, tailored to my organization, matching our unique audience and ability to resource the work.
- Contributing to any and all reporting requirements by HFS

SIH will take responsibility to lead the project's activities and oversee all agreed upon deliverables of the Collaborative.

We look forward to working with you in addressing the health and healthcare access challenges in our region, employing transformational interventions, and in turn, improving health outcomes.

Sincerely,



Andrew D. Watson, CPA
Divisional Chief Financial Officer
Physician Enterprise



Pradeep Reddy, M.D., Hind Al-Sharif, M.D.
Bindu Reddy, M.D., Jeremy Gerwe, M.D.
Carline Mbeumo, M.D. Sadashivaiah Bhaskar, M.D.
Ronald Chediak, M.D. Amy Gerwe, M.D.
Annie Imboden, CPNP, Sarah Ford, CNNP,
Michelle Wharton, CFNP, Ashley May, CFNP
Kathy Herren, PA-C, Angela Henson, PA-C
Leanne DeNeal, PA-C

3412 Office Park Drive, Marion, IL 62959
310 W. St. Louis St., West Frankfort, IL 62896
28 Veteran's Drive, Harrisburg, IL 62946
900 E. Walnut St. Ste. 6, Carbondale, IL 62901
1007 S. 42nd St., Ste. 1, Mt. Vernon, IL 62864
Phone: **618-993-0404** Fax: 618-993-1717
www.pediatricgroupllc.com

November 12, 2021

To-

Woody Thorne, Vice President, Community Affairs

Southern Illinois Healthcare

1239 E Main St

Carbondale, IL 62902-3988

I write on behalf of Pediatric Group LLC to commit our partnership in the Connected Care Collaborative. The Collaborative, led by Southern Illinois Healthcare, submits a proposal to the Illinois Department of Healthcare and Family Services (HFS) for a grant to fund the Rural Initiative for Healthcare Transformation – targeted to improve healthcare outcomes, reduce healthcare disparities, and realign resources in distressed communities for a person-centered, integrated approach to healthcare at a community level in the Delta region of southern Illinois.

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- With grant funding, integrating with NowPow, tailored to my organization, matching our unique audience and ability to resource the work.
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SIH will take responsibility to lead the project's activities and oversee all agreed upon deliverables of the Collaborative.

We look forward to working with you in addressing the health and healthcare access challenges in our region, employing transformational interventions, and in turn, improving health outcomes.

Sincerely,



Pradeep Reddy M.D.

Managing Partner

November 12, 2021

Woody Thorne, Vice President, Community Affairs
Southern Illinois Healthcare
1239 E Main St
Carbondale, IL 62902-3988

To Woody Thorne:

I write on behalf of SI Neurology and Sleep Medicine, LLC to commit our partnership in the Connected Care Collaborative. The Collaborative, led by Southern Illinois Healthcare, submits a proposal to the Illinois Department of Healthcare and Family Services (HFS) for a grant to fund the Rural Initiative for Healthcare Transformation – targeted to improve healthcare outcomes, reduce healthcare disparities, and realign resources in distressed communities for a person-centered, integrated approach to healthcare at a community level in the Delta region of southern Illinois.

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- 5) Provide healthcare more effectively, particularly to underserved communities.

Through this letter, we acknowledge specific roles and responsibilities we will fulfill in this partnership. In the event this proposal is funded, we would expect our role in the Rural Initiative for Healthcare Transformation consortium to include:

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- Designating the time and efforts of a representative from our organization to work on this effort as a member of the Connected Care Collaborative Advisory Board.
- With grant funding, integrating with NowPow, tailored to my organization, matching our unique audience and ability to resource the work.
- Contributing to any and all reporting requirements by HFS

SIH will take responsibility to lead the project's activities and oversee all agreed upon deliverables of the Collaborative.

We look forward to working with you in addressing the health and healthcare access challenges in our region, employing transformational interventions, and in turn, improving health outcomes.

Sincerely,

Fakhre Alam, MD
President and CEO
SI Neurology and Sleep Medicine, LLC
2731 W Main Street, Carbondale, IL 62901

November 12, 2021

Woody Thorne, Vice President, Community Affairs
Southern Illinois Healthcare
1239 E Main St
Carbondale, IL 62902-3988

To Woody Thorne:

I write on behalf of Javier Muniz, DO, LLC to commit our partnership in the Connected Care Collaborative. The Collaborative, led by Southern Illinois Healthcare, submits a proposal to the Illinois Department of Healthcare and Family Services (HFS) for a grant to fund the Rural Initiative for Healthcare Transformation – targeted to improve healthcare outcomes, reduce healthcare disparities, and realign resources in distressed communities for a person-centered, integrated approach to healthcare at a community level in the Delta region of southern Illinois.

We strongly support this application as it meets the needs of residents more holistically by linking healthcare services with community resources that address social determinants of health, while reducing inequities in healthcare access and delivery.

The goals of the Collaborative are to use the HFS investment to:

- 1) Spur healthcare delivery redesign so that each patient's individual needs are the focus of care;
- 2) Drive greater collaboration to more effectively utilize resources, propagate learnings and best practices;
- 3) Reduce silos between healthcare settings and community-based organizations by maximizing the effectiveness and reach of established community-based programming and their resources to create a seamless, closed-loop referral process for provider-based referrals;
- 4) Significantly enhance equity in healthcare outcomes;
- 5) Provide healthcare more effectively, particularly to underserved communities.

Through this letter, we acknowledge specific roles and responsibilities we will fulfill in this partnership. In the event this proposal is funded, we would expect our role in the Rural Initiative for Healthcare Transformation consortium to include:

- Enhancing existing and creating new partnerships to improve health outcomes and reduce disparities by addressing maternal health, chronic disease management, and barriers to healthcare access; signing a contract with HFS and all project partners to this effect.
- Designating the time and efforts of a representative from our organization to work on this effort as a member of the Connected Care Collaborative Advisory Board.
- With grant funding, integrating with NowPow, tailored to my organization, matching our unique audience and ability to resource the work.
- Contributing to any and all reporting requirements by HFS

SIH will take responsibility to lead the project's activities and oversee all agreed upon deliverables of the Collaborative.

We look forward to working with you in addressing the health and healthcare access challenges in our region, employing transformational interventions, and in turn, improving health outcomes.

Sincerely,

Deena Vinson, RN
Practice Manager
Javier Muniz, DO, LLC
315 S 13th Street, Suite 2
Herrin, IL 62948

November 12, 2021

Woody Thorne, Vice President, Community Affairs
Southern Illinois Healthcare
1239 E Main St
Carbondale, IL 62902-3988

To Woody Thorne:

I write on behalf of Anad Salem, MD to commit our partnership in the Connected Care Collaborative. The Collaborative, led by Southern Illinois Healthcare, submits a proposal to the Illinois Department of Healthcare and Family Services (HFS) for a grant to fund the Rural Initiative for Healthcare Transformation – targeted to improve healthcare outcomes, reduce healthcare disparities, and realign resources in distressed communities for a person-centered, integrated approach to healthcare at a community level in the Delta region of southern Illinois.

We strongly support this application as it meets the needs of residents more holistically by linking healthcare services with community resources that address social determinants of health, while reducing inequities in healthcare access and delivery.

The goals of the Collaborative are to use the HFS investment to:

- 1) Spur healthcare delivery redesign so that each patient's individual needs are the focus of care;
- 2) Drive greater collaboration to more effectively utilize resources, propagate learnings and best practices;
- 3) Reduce silos between healthcare settings and community-based organizations by maximizing the effectiveness and reach of established community-based programming and their resources to create a seamless, closed-loop referral process for provider-based referrals;
- 4) Significantly enhance equity in healthcare outcomes;
- 5) Provide healthcare more effectively, particularly to underserved communities.

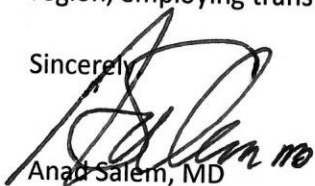
Through this letter, we acknowledge specific roles and responsibilities we will fulfill in this partnership. In the event this proposal is funded, we would expect our role in the Rural Initiative for Healthcare Transformation consortium to include:

- Enhancing existing and creating new partnerships to improve health outcomes and reduce disparities by addressing maternal health, chronic disease management, and barriers to healthcare access; signing a contract with HFS and all project partners to this effect.
- Designating the time and efforts of a representative from our organization to work on this effort as a member of the Connected Care Collaborative Advisory Board.
- With grant funding, integrating with NowPow, tailored to my organization, matching our unique audience and ability to resource the work.
- Contributing to any and all reporting requirements by HFS

SIH will take responsibility to lead the project's activities and oversee all agreed upon deliverables of the Collaborative.

We look forward to working with you in addressing the health and healthcare access challenges in our region, employing transformational interventions, and in turn, improving health outcomes.

Sincerely,

A handwritten signature in black ink, appearing to read 'Anad Salem', written over the word 'Sincerely'.

Anad Salem, MD

Owner

Anad Salem, MD

207 West Jackson St #201

Carbondale, IL 62901



SWAFFORD PEDIATRICS
KATHY SWAFFORD, M.D.

115 N. Main Street
Anna, IL 62906
Telephone: (618) 833-9355
Fax: (618) 833-9354

November 19, 2021

Woody Thorne, Vice President, Community Affairs
Southern Illinois Healthcare
1239 E Main Street
Carbondale, IL 62902-3988

To Woody Thorne:

I write on behalf of Swafford Pediatrics to commit our partnership in the Connected Care Collaborative. The Collaborative, led by Southern Illinois Healthcare, submits a proposal to the Illinois Department of Healthcare and Family Services (HFS) for a grant to fund the Rural Initiative for Healthcare Transportation – targeted to improve healthcare outcomes, reduce healthcare disparities, and realign resources in distressed communities for a person-centered, integrated approach to healthcare at a community level in the Delta region of Southern Illinois.

We strongly support this application as it meets the needs of residents more holistically by linking healthcare services with community resources that address social determinants of health, while reducing inequities in healthcare access and delivery.

The goals of the Collaborative are to use the HFS investment to:

- 1) Spur healthcare delivery redesign so that each patient's individual needs are the focus of care;
- 2) Drive greater collaboration to more effectively utilize resources, propagate learnings and best practices;
- 3) Reduce silos between healthcare settings and community-based programming and their resources to create a seamless, closed-loop referral process for provider-based referrals;
- 4) Significantly enhance equity in healthcare outcomes;
- 5) Provide healthcare more effectively, particularly to underserved communities.

Through this letter, we acknowledge specific roles and responsibilities we will fulfill in this partnership. In the event this proposal is funded, we would expect our role in the Rural Initiative for Healthcare Transformation consortium to include:

- Enhancing existing and creating new partnerships to improve health outcomes and reduce disparities by addressing maternal health, chronic disease management, and barriers to healthcare access; signing a contract with HFS and all project partners to this effect.

- Designating the time and efforts of a representative from our organization to work on this effort as a member of the Connected Care Collaborative Advisory Board.
- With grant funding, integrating with NowPow, tailored to my organization, matching our unique audience and ability to resource the work.
- Contributing to any and all reporting requirements by HFS.

SIH will take responsibility to lead the project's activities and oversee all agreed upon deliverables of the Collaborative.

We look forward to working with you in addressing the health and healthcare access challenges in our region, employing transformational interventions, and in turn, improving health outcomes.

Sincerely,



Kathy Swafford, MD
Owner/ Pediatrician
Swafford Pediatrics
115 N Main Street
Anna, IL 62906

November 12, 2021

Woody Thorne, Vice President, Community Affairs
Southern Illinois Healthcare
1239 E Main St
Carbondale, IL 62902-3988

To Woody Thorne:

I write on behalf of Gastroenterology Care of southern Illinois, LLC to commit our partnership in the Connected Care Collaborative. The Collaborative, led by Southern Illinois Healthcare, submits a proposal to the Illinois Department of Healthcare and Family Services (HFS) for a grant to fund the Rural Initiative for Healthcare Transformation – targeted to improve healthcare outcomes, reduce healthcare disparities, and realign resources in distressed communities for a person-centered, integrated approach to healthcare at a community level in the Delta region of southern Illinois.

We strongly support this application as it meets the needs of residents more holistically by linking healthcare services with community resources that address social determinants of health, while reducing inequities in healthcare access and delivery.

The goals of the Collaborative are to use the HFS investment to:

- 1) Spur healthcare delivery redesign so that each patient's individual needs are the focus of care;
- 2) Drive greater collaboration to more effectively utilize resources, propagate learnings and best practices;
- 3) Reduce silos between healthcare settings and community-based organizations by maximizing the effectiveness and reach of established community-based programming and their resources to create a seamless, closed-loop referral process for provider-based referrals;
- 4) Significantly enhance equity in healthcare outcomes;
- 5) Provide healthcare more effectively, particularly to underserved communities.

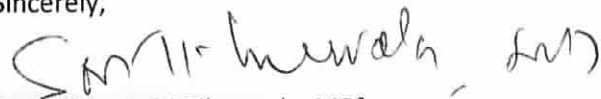
Through this letter, we acknowledge specific roles and responsibilities we will fulfill in this partnership. In the event this proposal is funded, we would expect our role in the Rural Initiative for Healthcare Transformation consortium to include:

- Enhancing existing and creating new partnerships to improve health outcomes and reduce disparities by addressing maternal health, chronic disease management, and barriers to healthcare access; signing a contract with HFS and all project partners to this effect.
- Designating the time and efforts of a representative from our organization to work on this effort as a member of the Connected Care Collaborative Advisory Board.
- With grant funding, integrating with NowPow, tailored to my organization, matching our unique audience and ability to resource the work.
- Contributing to any and all reporting requirements by HFS

SIH will take responsibility to lead the project's activities and oversee all agreed upon deliverables of the Collaborative.

We look forward to working with you in addressing the health and healthcare access challenges in our region, employing transformational interventions, and in turn, improving health outcomes.

Sincerely,

A handwritten signature in black ink that reads "Sushilkumar M Tibrewala, MD". The signature is written in a cursive, flowing style.

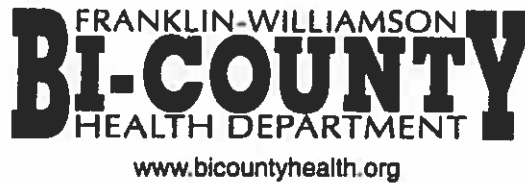
[Sushilkumar M Tibrewala, MD]

President

Gastroenterology Care of Southern Illinois

3301 Patriot Ct, Herrin, IL 62948

Williamson County Office:
8160 Express Drive
Marion, IL 62959-5817
Phone 618/993-8111
Fax 618/993-6455



Franklin County Office:
403 East Park
Benton, IL 62812-1920
Phone 618/439-0951
Fax 618/438-3005

November 17, 2021

Woody Thorne, Vice President, Community Affairs
Southern Illinois Healthcare
1239 E Main St
Carbondale, IL 62902-3988

To Woody Thorne:

I write on behalf of Franklin-Williamson Bi-County Health Department to commit our partnership in the Connected Care Collaborative. The Collaborative, led by Southern Illinois Healthcare, submits a proposal to the Illinois Department of Healthcare and Family Services (HFS) for a grant to fund the Rural Initiative for Healthcare Transformation – targeted to improve healthcare outcomes, reduce healthcare disparities, and realign resources in distressed communities for a person-centered, integrated approach to healthcare at a community level in the Delta region of southern Illinois.

We strongly support this application as it meets the needs of residents more holistically by linking healthcare services with community resources that address social determinants of health, while reducing inequities in healthcare access and delivery through the implementation of an integrated Community Health Worker (CHW) program.

- As an organization which has strong collaboration with SIH to improve the health and well-being of all the people in the communities that we serve, including the most vulnerable people in our communities for equity and access to healthcare. Improving quality of life by educational programs and projects which include, but not limited to diabetes, chronic disease, tobacco, mental health, transportation, resources that are available, COVID-19 testing, treatment and vaccination. A few of the community partners are the Franklin-Williamson Healthy Community Coalition, Healthy Southern Delta Network, Southern Illinois Public Health Consortium, and the Positive Youth Development Coalition. These community partners collaborate to enhance the health and wellbeing within our communities and to transform southern Illinois into a region that supports and enhances healthy living.

The goals of the Collaborative are to use the HFS investment to:

- 1) Spur healthcare delivery redesign so that each patient's individual needs are the focus of care;
- 2) Drive greater collaboration to more effectively utilize resources, propagate learnings and best practices;
- 3) Reduce silos between healthcare settings and community-based organizations by maximizing the effectiveness and reach of established community-based programming and their resources to create a seamless, closed-loop referral process for provider-based referrals;
- 4) Significantly enhance equity in healthcare outcomes;

5) Provide healthcare more effectively, particularly to underserved communities.

Through this letter, we acknowledge specific roles and responsibilities we will fulfill in this partnership. In the event this proposal is funded, we would expect our role in the Rural Initiative for Healthcare Transformation consortium to include:

- Enhancing existing and creating new partnerships to improve health outcomes and reduce disparities by addressing maternal health, chronic disease management, and barriers to healthcare access, signing a contract with HFS and all project partners to this effect.
- Designating the time and efforts of a representative from our organization to work on this effort as a member of the Connected Care Collaborative Advisory Board, to meet at least quarterly.
- Participating in a semi-annual resource fair for Community Health Workers, healthcare entities, and community agencies to make connections and share resources.
- Providing educational materials for Community Health Workers on services offered, target groups served, and eligibility criteria, WIC, FC, HIV services, behavioral health services, Home Health immunizations, as well as flu and pneumonia, housing, how to utilize public transportation, nutrition education services offered, local food pantries, how to utilize mass transit, health education offered, etc.
- Continuing to provide input and leadership in meetings of the Healthy Southern Illinois Delta Network Steering Committee to collaborate to “transform southern Illinois into a region that supports and enhances healthy living.”
- Continuing to participate in meetings of the Franklin-Williamson Health Community Coalition to coordinate services and resources.
- Continuing to provide updates to the coalition Resources Guides (www.hsidn.org/resources) that will be utilized to develop and update the NOW POW referral process for CHWs.

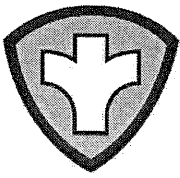
SIH will take responsibility to lead the project’s activities and oversee all agreed upon deliverables of the Collaborative.

We look forward to working with you to continue addressing the health and healthcare access challenges in our region, employing transformational interventions, and in turn, improving health outcomes.

Sincerely,



Kevin Kaytor
Administrator
Franklin-Williamson Bi-County Health Department




JACKSON COUNTY HEALTH DEPARTMENT

P.O. Box 307, 415 HEALTH DEPARTMENT RD, MURPHYSBORO, IL 62966-0307

PH: 618-684-3143 FAX: 618-684-6023

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November 17, 2021

Woody Thorne, Vice President, Community Affairs
Southern Illinois Healthcare
1239 E Main St
Carbondale, IL 62902-3988

Mr. Thorne:

I write on behalf of Jackson County Health Department to commit our partnership in the Connected Care Collaborative. The Collaborative, led by Southern Illinois Healthcare, submits a proposal to the Illinois Department of Healthcare and Family Services (HFS) for a grant to fund the Rural Initiative for Healthcare Transformation – targeted to improve healthcare outcomes, reduce healthcare disparities, and realign resources in distressed communities for a person-centered, integrated approach to healthcare at a community level in the Delta region of southern Illinois.

We strongly support this application as it meets the needs of residents more holistically by linking healthcare services with community resources that address social determinants of health, while reducing inequities in healthcare access and delivery through the implementation of an integrated Community Health Worker (CHW) program.

As a health organization which works to address public health inequities and fill gaps in services, this proposed collaborative promises to help accomplish such objectives. In addition, Southern Illinois Healthcare is the ideal partner to help lead such an effort. SIH has proven, time and again, that they are willing and able to lead projects of this size and scope.

The goals of the Collaborative are to use the HFS investment to:

- 1) Spur healthcare delivery redesign so that each patient's individual needs are the focus of care;
- 2) Drive greater collaboration to more effectively utilize resources, propagate learnings and best practices;
- 3) Reduce silos between healthcare settings and community-based organizations by maximizing the effectiveness and reach of established community-based programming and their resources to create a seamless, closed-loop referral process for provider-based referrals;

Jackson County Health Department complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-618-684-3143.

Jackson County Health Department cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-618-684-3143.

Jackson County Health Department postępuje zgodnie z obowiązującymi federalnymi prawami obywatelskimi i nie dopuszcza się dyskryminacji ze względu na rasę, kolor skóry, pochodzenie, wiek, niepełnosprawność bądź płeć.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-618-684-3143.

- 4) Significantly enhance equity in healthcare outcomes;
- 5) Provide healthcare more effectively, particularly to underserved communities.

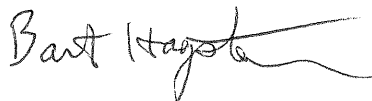
Through this letter, we acknowledge specific roles and responsibilities we will fulfill in this partnership. In the event this proposal is funded, we would expect our role in the Rural Initiative for Healthcare Transformation consortium to include:

- Enhancing existing and creating new partnerships to improve health outcomes and reduce disparities by addressing maternal health, chronic disease management, and barriers to healthcare access; signing a contract with HFS and all project partners to this effect.
- Designating the time and efforts of a representative from our organization to work on this effort as a member of the Connected Care Collaborative Advisory Board, to meet at least quarterly.
- Participating in a semi-annual resource fair for Community Health Workers, healthcare entities, and community agencies to make connections and share resources.
- Providing educational materials for Community Health Workers on services offered, target groups served, and eligibility criteria, including WIC, immunizations, HIV services, sexual health, and tobacco prevention services.
- Continuing to provide input and leadership in meetings of the Healthy Southern Illinois Delta Network Steering Committee to collaborate to “transform southern Illinois into a region that supports and enhances healthy living.”
- Continuing to participate in meetings of the Jackson County Healthy Communities Coalition, and all of its various action teams, in order to coordinate services and resources.
- Continuing to provide updates to the coalition Resources Guides (www.hsidn.org/resources) that will be utilized to develop and update the NOW POW referral process for CHWs.

SIH will take responsibility to lead the project’s activities and oversee all agreed upon deliverables of the Collaborative.

We look forward to working with you to continue addressing the health and healthcare access challenges in our region, employing transformational interventions, and in turn, improving health outcomes.

Sincerely,



Bart Hagston
Administrator

Ph#: 618/684-3143



SIU SCHOOL
of **MEDICINE**
FORWARD. FOR YOU.

November 18, 2021

Woody Thorne, Vice President, Community Affairs
Southern Illinois Healthcare
1239 E Main St
Carbondale, IL 62902-3988

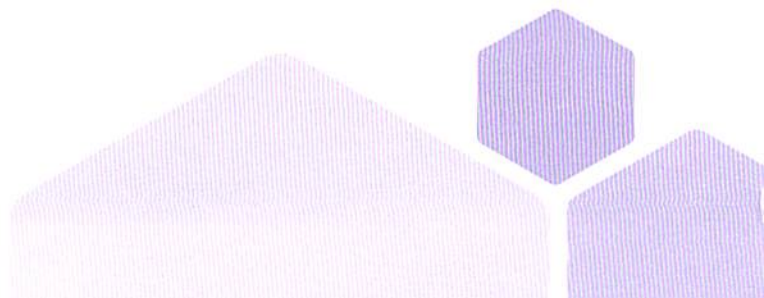
To Woody Thorne:

I write on behalf of the *SIU School of Medicine's Center for Rural Health and Social Service Development (CRHSSD)* to commit our partnership in the Connected Care Collaborative. The Collaborative, led by Southern Illinois Healthcare, submits a proposal to the Illinois Department of Healthcare and Family Services (HFS) for a grant to fund the Rural Initiative for Healthcare Transformation – targeted to improve healthcare outcomes, reduce healthcare disparities, and realign resources in distressed communities for a person-centered, integrated approach to healthcare at a community level in the Delta region of southern Illinois.

We support this application as it will help to meet the needs of residents more holistically by linking healthcare services with community resources that address social determinants of health, while reducing inequities in healthcare access and delivery through the implementation of an integrated Community Health Worker (CHW) program. These proposed efforts are complementary to those of the *CRHSSD*, our work as Rural Health Opioid Use Disorder Leadership Center, and our ongoing training efforts supporting the development of Community Health Workers. We believe this proposed work will only will strengthen partnerships and the collaborative nature of our joint initiatives.

As one of the founding members of the Healthy Southern Illinois Delta Network, the *CRHSSD* has been heavily involved in the HSIDN, an organization comprised of over 400 community partners from different community organizations including health departments, social service agencies, and community based organizations is committed to our vision of transforming Southern Illinois into a region that supports and enhances healthy living. The *CRHSSD* continues to be involved in many of the local Healthy Community Coalitions and Action Teams operating under the HSIDN. The *CRHSSD* maintains its strong commitment to the HSIDN and will work to further efforts that support addressing equity issues surrounding Social Determinants of Health, increasing community capacity, and improving health outcomes of rural Southern Illinois.

Through this letter, we acknowledge specific roles and responsibilities we will fulfill in this partnership. In the event this proposal is funded, we would expect our role in the Rural Initiative for Healthcare Transformation consortium to include:





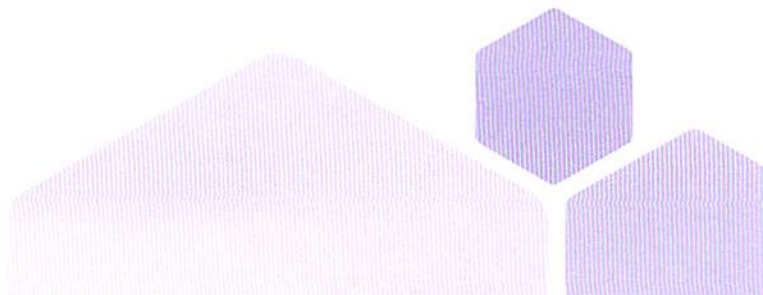
SIU SCHOOL
of **MEDICINE**
FORWARD. FOR YOU.

- Enhancing existing and creating new partnerships to improve health outcomes and reduce disparities by addressing maternal health, chronic disease management, and barriers to healthcare access.
- Designating the time and efforts of a representative from our organization to work on this effort as a member of the Connected Care Collaborative Advisory Board, to meet at least quarterly.
- Promoting, and recruiting agencies to participate in a semi-annual resource fair for Community Health Workers, healthcare entities, and community agencies to make connections and share resources.
- Providing educational materials for Community Health Workers on services offered, target groups served, and eligibility criteria, i.e. training on the Healthy Southern Illinois Delta Network, the resources available on the web-site at www.hsidn.org, how to best navigate the site, how to become involved in the community coalitions and related events and action teams, etc.
- Collaborating with the QHP/PHO and the Collaborative to offer support and provide improvement suggestions.

We understand that SIH will take responsibility to lead the project's activities and oversee all agreed upon deliverables of the Collaborative. The Center for Rural Health and Social Service Development looks forward to continuing our collaborative work to improving health outcomes in Southern Illinois.

Sincerely,

Jeffrey Franklin
Director
SIU Medicine, Center for Rural Health and Social Service Development



November 16, 2021

Woody Thorne, Vice President, Community Affairs
Southern Illinois Healthcare
1239 E Main St
Carbondale, IL 62902-3988

Dear Woody Thorne:

I write on behalf of University of Illinois Extension to commit our partnership in the Connected Care Collaborative. The Collaborative, led by Southern Illinois Healthcare, submits a proposal to the Illinois Department of Healthcare and Family Services (HFS) for a grant to fund the Rural Initiative for Healthcare Transformation – targeted to improve healthcare outcomes, reduce healthcare disparities, and realign resources in distressed communities for a person-centered, integrated approach to healthcare at a community level in the Delta region of southern Illinois.

We strongly support this application as it meets the needs of residents more holistically by linking healthcare services with community resources that address social determinants of health, while reducing inequities in healthcare access and delivery through the implementation of an integrated Community Health Worker (CHW) program.

As an organization which supports community health through policy, systems and environmental change, University of Illinois Extension partners with community organizations to improve health outcomes.

The goals of the Collaborative are to use the HFS investment to:

- 1) Spur healthcare delivery redesign so that each patient's individual needs are the focus of care;
- 2) Drive greater collaboration to more effectively utilize resources, propagate learnings and best practices;
- 3) Reduce silos between healthcare settings and community-based organizations by maximizing the effectiveness and reach of established community-based programming and their resources to create a seamless, closed-loop referral process for provider-based referrals;
- 4) Significantly enhance equity in healthcare outcomes;
- 5) Provide healthcare more effectively, particularly to underserved communities.

Through this letter, we acknowledge specific roles and responsibilities we will fulfill in this partnership. In the event this proposal is funded, we would expect our role in the Rural Initiative for Healthcare Transformation consortium to include:

- Enhancing existing and creating new partnerships to improve health outcomes and reduce disparities by addressing maternal health, chronic disease management, and barriers to healthcare access; signing a contract with HFS and all project partners to this effect.
- Designating the time and efforts of a representative from our organization to work on this effort as a member of the Connected Care Collaborative Advisory Board, to meet at least quarterly.
- Participating in a semi-annual resource fair for Community Health Workers, healthcare entities, and community agencies to make connections and share resources.
- Continuing to provide input and leadership in meetings of the Healthy Southern Illinois Delta Network Steering Committee to collaborate to “transform southern Illinois into a region that supports and enhances healthy living.”
- Continuing to participate in meetings of the Jackson County Healthy Community and Franklin/Williamson Healthy Community Coalitions and provide leadership for the Southern Illinois Food Pantry Network in order to coordinate services and resources.
- Explore collaborations and support Community Health Worker Trainings.
- Continuing to provide updates to the coalition Resources Guides (www.hsidn.org/resources) that will be utilized to develop and update the NOW POW referral process for CHWs.

SIH will take responsibility to lead the project’s activities and oversee all agreed upon deliverables of the Collaborative.

We look forward to working with you to continue addressing the health and healthcare access challenges in our region, employing transformational interventions, and in turn, improving health outcomes.

Sincerely,



Jennifer McCaffrey, PhD, MPH, RD
Assistant Dean, Family and Consumer Sciences

UNIVERSITY OF ILLINOIS URBANA-CHAMPAIGN

College of Agricultural, Consumer & Environmental Sciences
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University of Illinois Extension provides opportunities in programs and employment.



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109 California Street
P.O. Box 577
Carterville, IL 62918-0577
Phone (618) 519-9200
Fax (618) 985-6860

November 17, 2021

Woody Thorne, Vice President, Community Affairs
Southern Illinois Healthcare
1239 E Main St
Carbondale, IL 62902-3988

To Woody Thorne:

I write on behalf of Shawnee Alliance (SA) to commit our partnership in the Connected Care Collaborative. The Collaborative, led by Southern Illinois Healthcare (SIH), submits a proposal to the Illinois Department of Healthcare and Family Services (HFS) for a grant to fund the Rural Initiative for Healthcare Transformation – targeted to improve healthcare outcomes, reduce healthcare disparities, and realign resources in distressed communities for a person-centered, integrated approach to healthcare at a community level in the Delta region of southern Illinois.

We strongly support this application as it meets the needs of residents more holistically by linking healthcare services with community resources that address social determinants of health, while reducing inequities in healthcare access and delivery through the implementation of an integrated Community Health Worker (CHW) program.

As an organization which has provided social services throughout southern Illinois since 1983, we are committed to transforming the collaboration between healthcare and social services to better meet the needs of the people in our region. SA is a division of Shawnee Health Service and Development Corporation (SHS). As such, our entire organization is committed to the success of the project. We are submitting this separate letter of commitment to highlight the contributions we bring to the Collected Care Collaborative as a regional social service provider, but it is important to know that both the healthcare and social service divisions of SHS will work together seamlessly in implementing the goals of the Collaborative.

Here are just some of the relevant services that SA provides throughout 18 counties in southern Illinois:

- **Comprehensive Care Coordination:** SA Care Coordinators help older adults and their caregivers connect to services available in the community which enable them to maintain their independence. Care Coordinators make home visits to evaluate the older adults' ability to function independently. The evaluation is comprehensive and provides the Care Coordinators with information needed to advise the older adult and their caregiver on programs and services available to meet their needs in life domains such as physical and behavioral health, home environment, transportation, daily functioning, and legal or financial issues.
- **Choices for Care:** SA Care Coordinators provide consultation services to persons over the age of 60 and disabled persons under the age of 60. The goal is to provide information which enables participants and their caregivers to make informed decisions based on the options available in their community. Options discussed include home and community based services like in-home care and adult day services, home delivered meals, and other services available in their community. Other options include supportive living facilities, assisted living facilities, and nursing

facilities. All persons seeking admission into a nursing home in Illinois must first meet with a Choices for Care Coordinator to be informed of their options for care, and to confirm they meet the level of care needed for nursing home placement.

- **Volunteer Money Management Program:** This program provides protective services to limited income seniors who need help managing their finances. The goal of the program is to assist low income seniors, as well as to promote independent living and prevent unnecessary institutionalization, guardianship, or homelessness.
- **Adult Protective Services (APS):** APS Specialists conduct investigations and work with adults age 60 or older and adults age 18-59 with disabilities in resolving abuse, neglect, or financial exploitation situations.
- **The Bridge Program:** The Bridge Program is especially relevant to the Connected Care Collaborative, since it is an example of successful cooperation between SA and SIH. The Bridge Program begins bedside in the hospital for development of a comprehensive plan of care to meet the social determinant needs of the older adult in their home, including medical follow up. Bridge Coordinators follow the older adult home, providing an in-home assessment and monitoring. Transitional Care participants are transitioned to SA in-home care coordination following the transitional care model and may remain in services as long as there is a need.

The goals of the Collaborative are to use the HFS investment to:

- 1) Spur healthcare delivery redesign so that each patient's individual needs are the focus of care;
- 2) Drive greater collaboration to more effectively utilize resources, propagate learnings and best practices;
- 3) Reduce silos between healthcare settings and community-based organizations by maximizing the effectiveness and reach of established community-based programming and their resources to create a seamless, closed-loop referral process for provider-based referrals;
- 4) Significantly enhance equity in healthcare outcomes; and
- 5) Provide healthcare more effectively, particularly to underserved communities.

Through this letter, we acknowledge specific roles and responsibilities we will fulfill in this partnership. In the event this proposal is funded, we would expect our role in the Rural Initiative for Healthcare Transformation consortium to include:

- Enhancing existing and creating new partnerships to improve health outcomes and reduce disparities by addressing maternal health, chronic disease management, and barriers to healthcare access; signing a contract with HFS and all project partners to this effect.
- Designating the time and efforts of a representative from our organization to work on this effort as a member of the Connected Care Collaborative Advisory Board, to meet at least quarterly.
- Participating in a semi-annual resource fair for CHWs, healthcare entities, and community agencies to make connections and share resources.
- Providing educational materials for CHWs on services offered, target groups served, and eligibility criteria.
- Integrating CHWs funded by this grant throughout our social service operations, in both clinic-based and community-based programs, and sharing best practices about program

implementation. We have decades of experience in serving clients in their homes in all types of communities, and we are eager to use this expertise to assist the Collaborative in deploying CHWs.

- Continuing to provide input and leadership in meetings of the Healthy Southern Illinois Delta Network (HSIDN) Steering Committee to collaborate to “transform southern Illinois into a region that supports and enhances healthy living”.
- Continuing to participate in meetings of HSIDN action teams in order to coordinate services and resources. Specifically, we maintain active participation in the Healthy Seniors Action Team of the Franklin-Williamson Healthy Communities Coalition and the Behavioral Health Action Team of the Jackson County Healthy Communities Coalition.
- Continuing to provide updates to Coalition Resources Guides (www.hsidn.org/resources) that will be utilized to develop and update the NowPow referral process for CHWs.

SIH will take responsibility to lead the project’s activities and oversee all agreed upon deliverables of the Collaborative.

We look forward to working with you to continue addressing the health and healthcare access challenges in our region, employing transformational interventions, and in turn, improving health outcomes.

Sincerely,

A handwritten signature in cursive script, appearing to read "Patsy R. Jensen".

Patsy R. Jensen
Executive Director
Shawnee Alliance



30 VETERANS DR, HARRISBURG, ILLINOIS 62946, P: 618-253-8761 – F: 618-252-2754

November 17, 2021

Woody Thorne, Vice President, Community Affairs
Southern Illinois Healthcare
1239 E Main St
Carbondale, IL 62902-3988

To Woody Thorne:

I write on behalf of Rides Mass Transit District to commit our partnership in the Connected Care Collaborative. The Collaborative, led by Southern Illinois Healthcare, submits a proposal to the Illinois Department of Healthcare and Family Services (HFS) for a grant to fund the Rural Initiative for Healthcare Transformation – targeted to improve healthcare outcomes, reduce healthcare disparities, and realign resources in distressed communities for a person-centered, integrated approach to healthcare at a community level in the Delta region of southern Illinois.

We strongly support this application as it meets the needs of residents more holistically by linking healthcare services with community resources that address social determinants of health, while reducing inequities in healthcare access and delivery through the implementation of an integrated Community Health Worker (CHW) program.

As an organization which has worked on numerous projects with SIH to help improve transit access to non-emergency medical appointments for residents across the region, we appreciate the dedication SIH shows to improving the overall quality of life for residents in the local communities it serves.

The goals of the Collaborative are to use the HFS investment to:

- 1) Spur healthcare delivery redesign so that each patient's individual needs are the focus of care;
- 2) Drive greater collaboration to more effectively utilize resources, propagate learnings and best practices;

- 3) Reduce silos between healthcare settings and community-based organizations by maximizing the effectiveness and reach of established community-based programming and their resources to create a seamless, closed-loop referral process for provider-based referrals;
- 4) Significantly enhance equity in healthcare outcomes;
- 5) Provide healthcare more effectively, particularly to underserved communities.

Through this letter, we acknowledge specific roles and responsibilities we will fulfill in this partnership. In the event this proposal is funded, we would expect our role in the Rural Initiative for Healthcare Transformation consortium to include:

- Enhancing existing and creating new partnerships to improve health outcomes and reduce disparities by addressing maternal health, chronic disease management, and barriers to healthcare access; signing a contract with HFS and all project partners to this effect.
- Designating the time and efforts of a representative from our organization to work on this effort as a member of the Connected Care Collaborative Advisory Board, to meet at least quarterly.
- Participating in a semi-annual resource fair for Community Health Workers, healthcare entities, and community agencies to make connections and share resources.
- Providing educational materials for Community Health Workers on services offered, target groups served, and eligibility criteria, such as how to utilize public transportation.
- Continuing to provide input in meetings of the Healthy Southern Illinois Delta Network Steering Committee to collaborate to “transform southern Illinois into a region that supports and enhances healthy living.”
- Continuing to provide updates to the coalition Resources Guides (www.hsidn.org/resources) that will be utilized to develop and update the NOW POW referral process for CHWs.

SIH will take responsibility to lead the project’s activities and oversee all agreed upon deliverables of the Collaborative.

We look forward to working with you to continue addressing the health and healthcare access challenges in our region, employing transformational interventions, and in turn, improving health outcomes.

Sincerely,



Adam Lach
CEO
Rides Mass Transit District



Linda Flowers, Ph.D., President
Carbondale Branch NAACP
P.O. Box 3303
Carbondale, IL 62902-3303
carbondalebranchnaacp@gmail.com
618/203-6252

November 14, 2021

Teresa Eagleson, Director
Illinois Department of Healthcare & Family Services
(Healthcare Transformation Proposal Review)
Prescott Bloom Building
201 South Grand Ave. East
Springfield, IL 62763

Dear Director Eagleson:

I am writing on behalf of the Connected Care Collaborative, led by Southern Illinois Healthcare (SIH) and their proposal to the Illinois Dept. of Healthcare and Family Services (HFS) for a grant to fund a rural initiative for Healthcare Transformation, targeted to improve healthcare outcomes, reduce healthcare disparities and realign resources in distressed communities for a person-centered, integrated approach to healthcare at a community level in the Delta region of Southern Illinois.

The Carbondale NAACP strongly support this application as it meets the needs of rural residents more holistically by linking healthcare services with community resources that address social determinants of health and chronic disease management, while reducing inequities in healthcare access and delivery.

The Connected Care Collaborative has put together an impressive multi-disciplined, well-experienced, engaged and dedicated forward thinking leadership team. The goals of the collaborative are to use the HFS investment to: 1) Spur healthcare delivery redesign so that each patient's individual needs are the focus of care; 2) Drive greater collaboration to more effectively utilize resources, propagate learnings and best practices; 3) Reduce silos between healthcare settings and community-based organizations by maximizing the effectiveness and reach of established community-based programming and their resources to create a seamless, closed-loop referral process for provider-based referrals; 4) Significantly enhance equity in healthcare outcomes; 5) Provide healthcare more effectively, particularly to underserved communities. These funds will provide the catalyst to propel healthcare transformation, especially within rural communities where lack of resources and access to proper care are so acutely felt. This transformation will continue to empower quality of and access to care; spur innovation and new alternative payment models; and drive greater equity.

Please give full consideration to this profoundly important application as you consider the needs of the region.

Sincerely,

Linda Flowers

Linda Flowers, Ph.D.
Branch President

MIKE BOST
12TH DISTRICT, ILLINOIS

AGRICULTURE COMMITTEE
TRANSPORTATION &
INFRASTRUCTURE COMMITTEE
VETERANS' AFFAIRS COMMITTEE

Congress of the United States
House of Representatives
Washington, DC 20515-1312

1440 LONGWORTH HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-5661

23 PUBLIC SQUARE, SUITE 404
BELLEVILLE, IL 62220
(618) 233-8026

300 EAST MAIN STREET, SUITE 4
CARBONDALE, IL 62901
(618) 457-5787

November 12, 2021

Teresa Eagleson, Director
Illinois Department of Healthcare & Family Services
(Healthcare Transformation Proposal Review)
Prescott Bloom Building
201 South Grand Ave. East
Springfield, IL 62763

Dear Director Eagleson:

I am writing on behalf of the Connected Care Collaborative, led by Southern Illinois Healthcare (SIH) and their proposal to the Illinois Dept. of Healthcare and Family Services (HFS) for a grant to fund a rural initiative for Healthcare Transformation, targeted to improve healthcare outcomes, reduce healthcare disparities and realign resources in distressed communities for a person-centered, integrated approach to healthcare at a community level in the Delta region of Southern Illinois.

I strongly support this application as it meets the needs of rural residents more holistically by linking healthcare services with community resources that address social determinants of health and chronic disease management, while reducing inequities in healthcare access and delivery.

The Connected Care Collaborative has put together an impressive multi-disciplined, well-experienced, engaged and dedicated forward thinking leadership team. The goals of the collaborative are to use the HFS investment to: 1) Spur healthcare delivery redesign so that each patient's individual needs are the focus of care; 2) Drive greater collaboration to more effectively utilize resources, propagate learnings and best practices; 3) Reduce silos between healthcare settings and community-based organizations by maximizing the effectiveness and reach of established community-based programming and their resources to create a seamless, closed-loop referral process for provider-based referrals; 4) Significantly enhance equity in healthcare outcomes; 5) Provide healthcare more effectively, particularly to underserved communities. These funds will provide the catalyst to propel healthcare transformation, especially within rural communities where lack of resources and access to proper care are so acutely felt

MIKE BOST
12TH DISTRICT, ILLINOIS

AGRICULTURE COMMITTEE
TRANSPORTATION &
INFRASTRUCTURE COMMITTEE
VETERANS' AFFAIRS COMMITTEE

Congress of the United States
House of Representatives
Washington, DC 20515-1312

1440 LONGWORTH HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-5661

23 PUBLIC SQUARE, SUITE 404
BELLEVILLE, IL 62220
(618) 233-8026

300 EAST MAIN STREET, SUITE 4
CARBONDALE, IL 62901
(618) 457-5787

Pease give full and fair consideration to this application as you consider the needs of the district. If you have further questions regarding this or any other matter, please do not hesitate to contact Jerry Clarke of my staff at 618-622-0766.

Sincerely,



Mike Bost
Member of Congress

United States Senate

November 15, 2021

Teresa Eagleson
Director
Illinois Department of Healthcare & Family Services
Prescott Bloom Building
201 South Grand Avenue, East
Springfield, IL 62763

Dear Director Eagleson,

I write to express my support for the application submitted by Southern Illinois Healthcare (SIH) to the Public Act 101-650 and Public Act 101-655 (Healthcare Transformative Collaborative) program offered by the Illinois Department of Healthcare & Family Services. Funding through this grant will support the implementation of the Connected Care Collaborative in Southern Illinois.

The Connected Care Collaborative, led by SIH, is a regional partnership that has been developed to propel new healthcare interventions that mitigate and address barriers to health equity in southern Illinois. Regional partners include SIH Medical Group, Prairie Cardiovascular, SIU Healthcare, New Horizons, Heartland Women's Healthcare, Southern Illinois OB-GYN Associates, Quality Health Partners, Shawnee Health Services, Christopher Rural Health, CHESI, Anna Rural Health, multiple independent practices and SIU's Department of Population Science and Policy.

The purpose of the Connected Care Collaborative is to spur healthcare delivery redesign to meet patient needs, reduce disparity between healthcare settings, increase regional collaboration to improve service and enhance equity in services delivered. Project funds will be used to develop a regionalized community health worker program that allows for certification and to establish an integrated, personalized community referral platform. The data and analysis compiled from the evaluations of the project will be used to support widespread adoption of alternative payment models and mechanisms to help the costs of the community health worker services be adoptable by private and public payers and align with other payment reform efforts in Illinois.

During my time as a U.S. Senator, I have made it a priority to ensure Illinois healthcare facilities have access to funding that will enable them to provide the best care to residents. The proposed project has support and collaborative partnerships with several agencies in an effort to ensure a successful program.

Please accept this letter of support for Southern Illinois Healthcare's application to the Healthcare Transformative Collaborative program. In keeping with your existing rules and regulations, I urge you to give their application your full and fair consideration. If you have any questions, please contact my Downstate Director, Randy Sikowski, at (217) 528-6124.

Sincerely,



Tammy Duckworth
United States Senator

United States Senate
WASHINGTON, DC 20510-1304

November 18, 2021

Teresa Eagleson, Director
Illinois Department of Healthcare & Family Services
(Healthcare Transformation Proposal Review)
Prescott Bloom Building
201 South Grand Ave. East
Springfield, IL 62763

Dear Director Eagleson:

I am writing on behalf of the Connected Care Collaborative, led by Southern Illinois Healthcare, about their application to the Illinois Department of Healthcare and Family Services (HFS) for a Healthcare Transformation grant.

The Connected Care Collaborative (CCC) seeks to meet the healthcare needs of local residents by creating a person-centered, integrated approach at a community level in the Delta region of Southern Illinois. The goals include improving healthcare outcomes, reducing healthcare disparities, and realigning resources in distressed communities. This proposal seeks to increase collaboration between healthcare services and community resources that address social determinants of health and chronic disease management, which would reduce inequities in healthcare access and delivery.

This grant will provide the catalyst to propel healthcare transformation, especially within this region where lack of resources and access to proper care are so acutely felt. These funds will increase quality of and access to care, spur innovation, and drive greater equity. Please give full consideration to this application as you consider the needs of the region. If you have any questions, please contact my Springfield office at 217-492-4062.

Sincerely,



Richard. J. Durbin
U.S. Senator



TERRI BRYANT
STATE SENATOR
58TH SENATE DISTRICT

November 10, 2021

Teresa Eagleson, Director
Illinois Department of Healthcare & Family Services
(Healthcare Transformation Proposal Review)
Prescott Bloom Building
201 South Grand Ave. East
Springfield, IL 62763

Dear Director Eagleson:

I am writing on behalf of the Connected Care Collaborative, led by Southern Illinois Healthcare (SIH) and their proposal to the Illinois Dept. of Healthcare and Family Services (HFS) for a grant to fund a rural initiative for Healthcare Transformation, targeted to improve healthcare outcomes, reduce healthcare disparities and realign resources in distressed communities for a person-centered, integrated approach to healthcare at a community level in the Delta region of Southern Illinois.

I strongly support this application as it meets the needs of rural residents more holistically by linking healthcare services with community resources that address social determinants of health and chronic disease management, while reducing inequities in healthcare access and delivery.

The Connected Care Collaborative has put together an impressive multi-disciplined, well-experienced, engaged and dedicated forward thinking leadership team. The goals of the collaborative are to use the HFS investment to: 1) Spur healthcare delivery redesign so that each patient's individual needs are the focus of care; 2) Drive greater collaboration to more effectively utilize resources, propagate learnings and best practices; 3) Reduce silos between healthcare settings and community-based organizations by maximizing the effectiveness and reach of established community-based programming and their resources to create a seamless, closed-loop referral process for provider-based referrals; 4) Significantly enhance equity in healthcare outcomes; 5) Provide healthcare more effectively, particularly to underserved communities. These funds will provide the catalyst to propel healthcare transformation, especially within rural communities where lack of resources and access to proper care are so acutely felt. This transformation will continue to empower quality of and access to care; spur innovation and new alternative payment models; and drive greater equity.

Please give full consideration to this profoundly important application as you consider the needs of the region.

Sincerely,

A handwritten signature in black ink, appearing to read "T. Bryant", written over a horizontal line.

Terri Bryant
State Senator
58th District

DISTRICT OFFICE

2 NORTH VINE, 6TH FLOOR
HARRISBURG, ILLINOIS 62946
618-294-8951
618-294-8950 (FAX)



CAPITOL OFFICE

M103-F
STATE CAPITOL BUILDING
SPRINGFIELD, ILLINOIS 62706
217-782-5509
217-782-9586 (FAX)

DALE FOWLER

STATE SENATOR • 59TH DISTRICT

Teresa Eagleson, Director
Illinois Department of Healthcare & Family Services
(Healthcare Transformation Proposal Review)
Prescott Bloom Building
201 South Grand Ave. East
Springfield, IL 62763

Dear Director Eagleson:

I am writing on behalf of the Connected Care Collaborative, led by Southern Illinois Healthcare (SIH) and their proposal to the Illinois Dept. of Healthcare and Family Services (HFS) for a grant to fund a rural initiative for Healthcare Transformation, targeted to improve healthcare outcomes, reduce healthcare disparities and realign resources in distressed communities for a person-centered, integrated approach to healthcare at a community level in the Delta region of Southern Illinois.

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Please give full consideration to this profoundly important application as you consider the needs of the region.

Sincerely,


Dale Fowler
Illinois State Senator, 59th District

DISTRICT OFFICES:
2929 BROADWAY
SUITE 3
MT. VERNON, IL 62864
618.559.7018

206 W. COLLEGE
SUITE 22
CARBONDALE, IL 62901
618.534.9880



SPRINGFIELD OFFICE:
401 S. SPRING
ROOM 211 - A N
SPRINGFIELD, IL 62706
217.782.0387

PAUL JACOBS
STATE REPRESENTATIVE • 115TH DISTRICT

November 10, 2021

Teresa Eagleson, Director
Illinois Department of Healthcare & Family Services
(Healthcare Transformation Proposal Review)
Prescott Bloom Building
201 South Grand Ave. East
Springfield, IL 62763

Dear Director Eagleson:

I am writing on behalf of the Connected Care Collaborative, led by Southern Illinois Healthcare (SIH) and their proposal to the Illinois Dept. of Healthcare and Family Services (HFS) for a grant to fund a rural initiative for Healthcare Transformation, targeted to improve healthcare outcomes, reduce healthcare disparities and realign resources in distressed communities for a person-centered, integrated approach to healthcare at a community level in the Delta region of Southern Illinois.

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communities where lack of resources and access to proper care are so acutely felt. This transformation will continue to empower quality of and access to care; spur innovation and new alternative payment models; and drive greater equity.

Please give full consideration to this profoundly important application as you consider the needs of the region.

Sincerely,

A handwritten signature in black ink that reads "Paul C. Jacobs, OD". The signature is written in a cursive style with a long horizontal line extending to the right from the end of the name.

Paul C Jacobs, OD
State Representative 115th District

DISTRICT OFFICE:
600 HALFWAY ROAD, SUITE 103
MARION, ILLINOIS 62959
618.440.5090
618.440.5091 FAX
WWW.REPSEVERIN.COM



CAPITOL OFFICE:
223 - N STRATTON BUILDING
SPRINGFIELD, ILLINOIS 62706
217.782.1051
217.782.1275

DAVE SEVERIN

STATE REPRESENTATIVE • 117TH DISTRICT

November 10, 2021

Teresa Eagleson, Director
Illinois Department of Healthcare & Family Services
(Healthcare Transformation Proposal Review)
Prescott Bloom Building
201 South Grand Ave. East
Springfield, IL 62763

Dear Director Eagleson:

I am writing on behalf of the Connected Care Collaborative, led by Southern Illinois Healthcare (SIH) and their proposal to the Illinois Dept. of Healthcare and Family Services (HFS) for a grant to fund a rural initiative for Healthcare Transformation, targeted to improve healthcare outcomes, reduce healthcare disparities and realign resources in distressed communities for a person-centered, integrated approach to healthcare at a community level in the Delta region of Southern Illinois.

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Please give full consideration to this profoundly important application as you consider the needs of the region.

Sincerely,

A handwritten signature in cursive script that reads "Dave Severin".

State Representative, 117th District



DISTRICT OFFICE
2 N. VINE ST., SUITE 5A
HARRISBURG, ILLINOIS 62946
(618) 294-8703
E-MAIL: WINDHORST@ILHOUSEGOP.ORG

PATRICK WINDHORST
STATE REPRESENTATIVE
118TH DISTRICT

CAPITOL OFFICE
210-N STRATTON BUILDING
SPRINGFIELD, ILLINOIS 62706
(217) 782-5131
FAX (217) 782-1275

November 10, 2021

Teresa Eagleson, Director
Illinois Department of Healthcare & Family Services
(Healthcare Transformation Proposal Review)
Prescott Bloom Building
201 South Grand Ave. East
Springfield, IL 62763

Dear Director Eagleson:

I am writing on behalf of the Connected Care Collaborative, led by Southern Illinois Healthcare (SIH) and their proposal to the Illinois Dept. of Healthcare and Family Services (HFS) for a grant to fund a rural initiative for Healthcare Transformation, targeted to improve healthcare outcomes, reduce healthcare disparities and realign resources in distressed communities for a person-centered, integrated approach to healthcare at a community level in the Delta region of Southern Illinois.

I strongly support this application as it meets the needs of rural residents more holistically by linking healthcare services with community resources that address social determinants of health and chronic disease management, while reducing inequities in healthcare access and delivery.

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Please give full consideration to this profoundly important application as you consider the needs of the region.

Sincerely,

Patrick Windhorst
State Representative
118th House District