



Improving  
equitable  
access to care  
for every one





# What determines health?

Genes, certainly.

Medical science and technology, as well. In the last 25 years, advances in antivirals alone have resulted in less serious illness, dramatically reduced mortality, and longer lives.

Beyond these, however, what determines health is largely a set of factors that we, as a society, control.

The first of these so-called “social determinants” of health—though not the most important—is our healthcare system itself: how it defines its mission, who it gives access to, what it treats, what it charges, who pays and for what, and how well it functions.

Others social determinants are less obvious, perhaps, but no less critical: food security and nutrition, housing, income and economic stability, the physical environment, safety, a sense of belonging or community, even education, to name just a few.

As a foundation, our mandate is to improve health by improving one small area of our healthcare system: access to care. So we work to ensure the number of providers is adequate to meet the demand, and to expand provider capacity, and to increase the number of insured. But we know that’s not enough.

Access is not only a thing providers or insurers give. It is also an action people take, or don’t, for a variety of reasons. For those who lost sight of that fact, the pandemic was a powerful reminder. Making healthcare widely available and at no cost does not mean people will access it, even when the consequences of not doing so might be mortal.

Improving access to healthcare, then, requires us to understand—and account for—the lives, needs, and decisions of the people we hope will access care, whether it’s a young mother who decides that a prenatal visit is not worth packing up her toddler and spending four hours in a waiting room or a Medicare beneficiary who regularly cancels his doctor’s appointments because he doesn’t feel well enough to go.

Accounting for individual circumstance is the cornerstone of ensuring equitable access to healthcare, and from the beginning, we, as a foundation, have funded programs and organizations that try to do that. Many of them go a step further and deliver what we think of as “access plus”—access to healthcare plus housing, plus job training or employment, plus nutrition, plus community empowerment and integration.

In this report, you’ll read about a few of them. We are proud to say there are many, many more in our community, each striving to do more and better to address the conditions that affect the health of people they serve.

In 2021, as part of a strategic planning process, we began asking whether—and how—we ourselves might do more and better for the people we exist to serve.

Those questions led to two resolutions. The first was to formally acknowledge what we have been doing all along: ensuring not just access to care but equitable access to care. By making what had been implicit explicit, we hope to raise the bar for ourselves and increase the impact of our work.

The second was to commit to a learning process that will challenge us all to think more deeply about health equity in our community and the practices and policies that might improve it. By doing so, we’ll be in a better position to spot and pursue new opportunities to increase equitable access and improve health.

We are proud of what we have accomplished in the Foundation’s first 15 years. We leveraged our strengths and the strengths of our partners and our community to make real progress in improving access to care in northern Lake County. As we look ahead, we are confident that those same strengths will take us further on the path that leads to all of us having the opportunity to be as healthy as possible.

As most of you already know, at the Foundation that work will continue under the direction of a new executive director. On a personal note, then, I would like to take this opportunity—one of my last as executive director—to thank you all for your fellowship these past 15 years. Your commitment to this place and to the people who live here is a source of inspiration for me. Your work made my own more meaningful and rewarding.



A handwritten signature in black ink that reads "Ernest Vasseur".

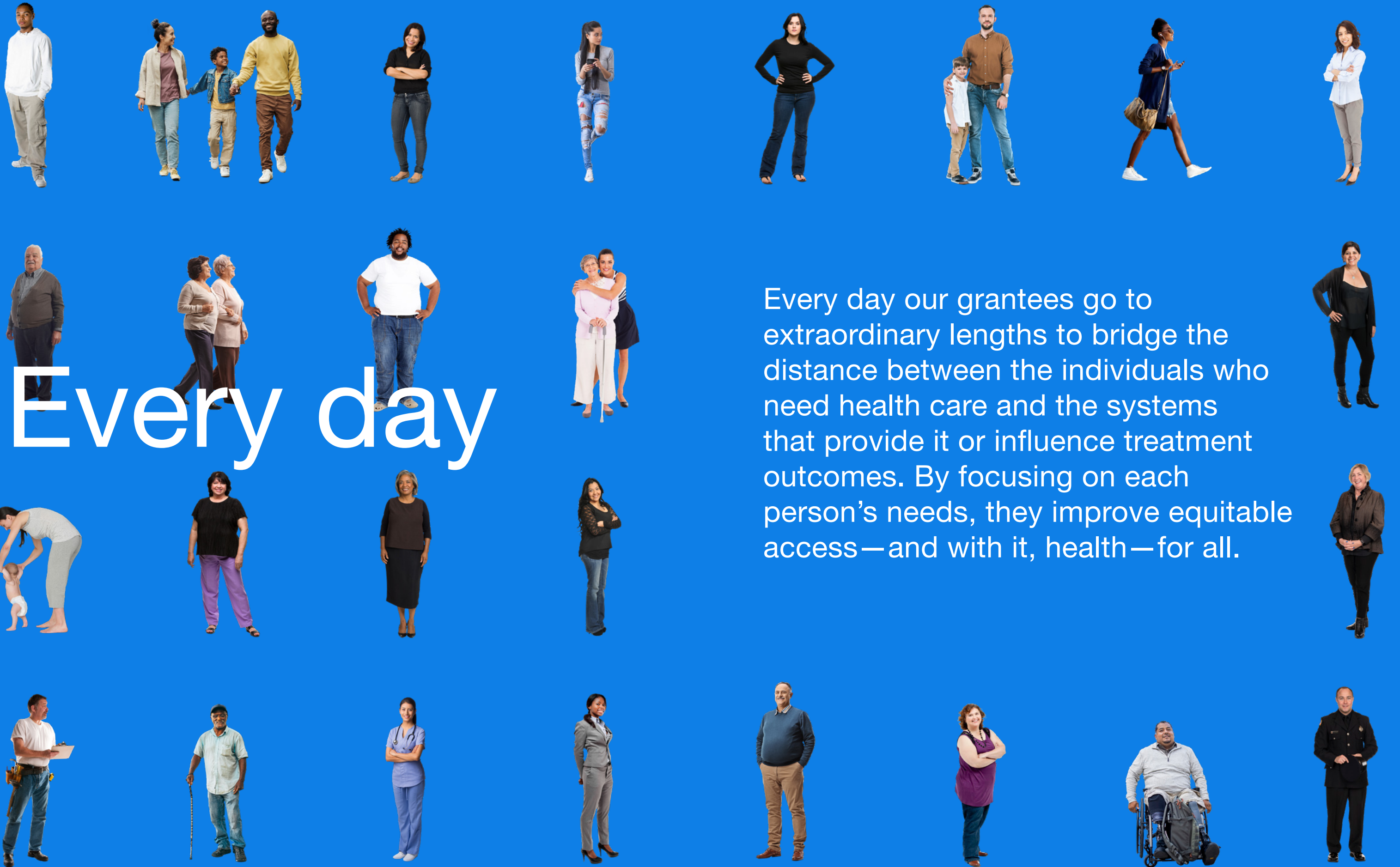
*Ernest Vasseur*  
*Executive Director*



A handwritten signature in black ink that reads "Luis A. Berrones".

*Luis A. Berrones*  
*Chair, Board of Directors*





# Every day

Every day our grantees go to extraordinary lengths to bridge the distance between the individuals who need health care and the systems that provide it or influence treatment outcomes. By focusing on each person's needs, they improve equitable access—and with it, health—for all.



“We do a good job of providing acute care, but acute care isn’t what these people need. So, I did some research and discovered mobile integrated healthcare.”

Erik Christensen, Medical Officer  
Wauconda Fire Protection District



## Increasing options for care

We see between 30 and 40 patients with chronic, under- or unaddressed healthcare problems on a regular basis—as often as every day or every week. These are people using EMS and 911 services as their primary care. We do a good job of providing acute care, but acute care isn’t what these people need.

So, I did some research and discovered mobile integrated healthcare (MIH).

With MIH, primary care physicians, hospitals, nursing facilities, or even health departments can refer patients to people like us, emergency medical service (EMS) providers, for four to eight weeks of scheduled home visits. The EMS teams provide education about the patient’s illness and medications, home assessments to eliminate slip, trip, and fall hazards, and connections to any health-related resources they might need, like food or transportation to their primary care provider.

With a grant from the Healthcare Foundation, we started developing the project—how it would work here, what we’d provide, who the strategic partners would be.

Then in February 2019, the Centers for Medicare and Medicaid Services announced something called the ET3 pilot—Emergency, Triage, Treat, and Transport—for Medicare fee-for-service patients.

On a regular 911 call, patients have only two options: go to the ER or sign a waiver saying they don’t want to go. With ET3, patients who call 911 can get transport to alternative destinations, like an urgent care clinic, a physician’s office, or a mental or behavioral health facility. Or with telemedicine, we can also treat them in place.

When I heard about ET3, I thought, “We need to participate in this pilot *and* MIH.” Both programs expand our level of community service, increase access to care, and provide alternative choices to patients. And there are some nice synergies, too. We saw right away that the telemedicine component of ET3 would be a great addition to the MIH program.

We scheduled a meeting with the seven fire departments in our area to talk about the programs. In the end, all seven signed on to participate in MIH, which expanded our initial coverage area from about 80 to more than 200 square miles and 230,000 people. For ET3, we were able to get four of the seven departments to participate, and then we added Grayslake.

We began providing ET3 services in March 2021. We’re still working on getting mobile integrated health up and running. The challenge for MIH is sustainability. Because MIH visits are nonemergency, they’re scheduled outside firefighter-paramedics’ normal shifts. We need to make sure we can handle that additional labor cost before we launch.

Healthcare is just a very bureaucratic system. Between the state and the insurance companies, it’s been a challenge from the beginning, just being able to talk to the right person, explain why it’s beneficial for them to participate, and then get them to implement the program. We actually had a contract with Humana to start seeing their patients in the MIH, but when the pandemic hit, everything stopped.

Ultimately, our goal is to provide ET3 and MIH services to everyone, no matter what their age or coverage status, who their insurer is, or whether they have the ability to pay.





## Bringing mental health services closer to home

Whenever people are worried about meeting their basic human needs—living in unsafe conditions, not knowing if they can pay the rent, not knowing if they can provide food or get their child to the doctor—there is anxiety, depression, and trauma. Study after study has shown that people with low incomes are more susceptible to mental health challenges.

There's also a strong relationship between mental health and social justice. Living in fear of persecution, or not feeling welcome in the community, or having one's humanity denied a dozen times a day affects mental health. Josselyn exists to help these people, the ones who need services but are least likely to receive them or even to have access to them. To do it, we have to break down the barriers to access and pay attention to issues of equity.

Location is one barrier. We opened the Josselyn Center in Waukegan because we saw more and more people coming from northern Lake County to Northfield. At the new facility, we're already seeing double the number of new clients that we thought we'd see.



A second barrier is speed. When people make that choice to call, they don't want voice mail and they don't want to be told "Okay, we can see you in three months." We measure how quickly we can get from the first phone call to the first appointment, and it's under a week on average, which is really unheard of.

Another barrier is lack of trust or cultural norms that stigmatize seeking mental health support. So we work hard to hire clinicians from the community, who reflect the race, language, and culture of the people we're serving. It's easier for clients to engage if they think, "Okay, this person understands my experience, where I come from, my culture."

Therapy alone can be effective, but a lot of people need medication, as well, and access to psychiatry is really difficult for this population. We make sure that psychiatry is not only available but coordinated, with doctors talking to therapists and one electronic medical record, so there are no misunderstandings about treatment or symptoms or side effects.

Finally, we offer supported employment for those clients that aren't employed, or are looking to make a job shift, or whose mental health challenges are getting in the way of getting or keeping employment. A job does more than provide income to keep people fed and sheltered. It gives them a purpose, a reason for being, something to look forward to, a routine, and social connection. In dozens of studies, work has been shown to be clinically effective in treating mental health issues. So we work to provide it.

“It’s easier for clients to engage if they think, ‘Okay, this person understands my experience, where I come from, my culture.’”

Susan Resko, CEO  
Josselyn Center Lake County







# In extraordinary times

In early 2021, the Foundation made a series of COVID-19 vaccine community outreach, education, and navigation grants to organizations with deep roots in communities whose members faced the greatest risk of infection and greatest challenges to health. Those organizations became vital links connecting more than 10,000 individuals to the care they needed most.





“...our community members.... don't have a primary care physician, so there was no one to call and ask, 'Is what I heard true?' or 'What am I supposed to do?'”

Dulce Ortiz, CEO  
Mano a Mano



## Building knowledge and trust

For our community, the pandemic was the perfect storm—it was the lack of equity in all systems combining all at one time.

Our community is low income and suffers disproportionately from preexisting conditions. Their lives are stressful, which takes a tremendous toll on their mental health. Many work in the service industry, and when those businesses shut down, they had no source of income. Others work in factories and warehouses, which were some of the major sites for infections. We had entire families working in the same factory who all became infected with COVID-19.

At the same time, our community members are underinsured or uninsured. They don't have a primary care physician, so there was no one to call and ask, “Is what I heard true?” or “What am I supposed to do?” Many could not find accessible information in their language regarding the COVID-19 virus.

Early on, the manager of our community health workers (CHW) program, who is herself an epidemiologist, created a curriculum to train our community health workers about COVID-19: what is it, how to protect yourself, and, if you have it, how to prevent spreading infection to your loved ones.

Some infected clients who had to quarantine didn't have any type of support, friends or family who could go out and buy groceries for them, so we started making internal referrals to our CHWs to not only provide COVID-19 education but also schedule grocery deliveries to those impacted by the virus.

We were on TikTok and Instagram. We did Facebook Lives with a weekly program called Informados y Conectados, where we cleared up confusion/misinformation, gave updates, and answered common questions.

What happened in our community is a tragedy, and it was preventable. We can't keep focusing on curing disease—it's like trying to cover the sun with your finger. If we want health equity, we need to focus on prevention and the social determinants of health. We need community health workers on the ground in every community, and we need to ensure that the voice of the community is in rooms where healthcare policy decisions are being made. Those who are closest to the problem are the ones who are closest to the solution.







## Joining forces to meet more needs

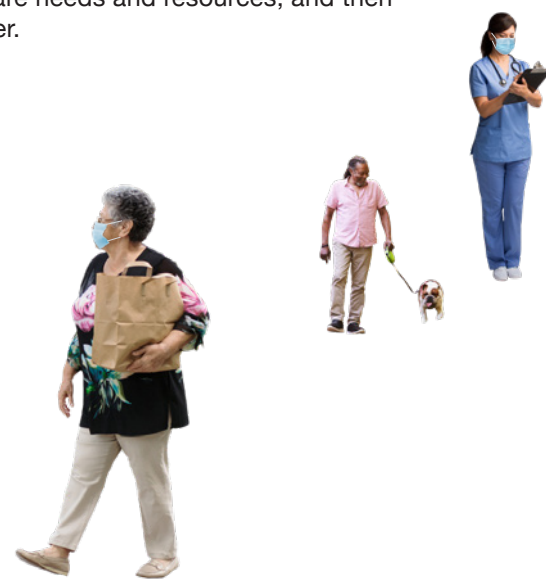
COVID really shined a light on problems that have existed for years in our healthcare system and in our society. All of us needed to stretch beyond our missions and expand our outreach and partnership efforts.

Early on in the pandemic, the Alliance for Human Services started pulling people together on a weekly Friday call—people from hospital systems, doctors, legislators, nonprofits, and funders. We talked about what the needs were in a particular community, and then we worked together to provide those services. Whoever had boots on the ground and could address it, did it. It was incredible.

For instance, food distribution is not our primary focus, but pandemic-related loss of income was really affecting some of our communities. Working together we organized and distributed food every week to more than 400 people at three different locations in northwestern Lake County. In another location we were serving nearly 800 families every other week. These events also provided us an opportunity to distribute up-to-date information about COVID-19 and a variety of resources as they became available.

When our partners in Grant Township secured vaccines and reached out for help, we all came together to answer the call. We made phone calls to eligible residents, helped them register online or over the phone, coordinated transportation to and from the vaccination sites, and staffed the events. Together, we vaccinated 2,100 of our areas most vulnerable residents.

The success of these efforts shows that we, as individual organizations, can have greater impact when we share needs and resources, and then work together.



# “Food distribution is not our primary focus, but pandemic-related loss of income was really affecting some of our communities.”

Colleen Lennon, CEO  
Antioch Area Healthcare Accessibility Alliance







# In the years ahead

The idea of equity, whether in health or in access to care, seems simple enough: that everyone has a fair and just opportunity to be healthy. What that idea will look like in practice remains to be seen. One thing we do know: the work cannot be top down. All of us—the Foundation, the healthcare system, the many organizations dedicated to improving lives and futures in our community, and the community itself—will have a role to play.



“As long as we continue to think that the solutions to our problems lie within the walls of hospitals and clinics, people will continue to get sicker and the cost of healthcare will continue to rise.”

Frances Baxley, M.D., Vice Chair, Board of Directors  
Healthcare Foundation of Northern Lake County



### Questioning every assumption

It's easy to think that if we fund more clinics or improve access to them, we'll see improvements in health. But that thinking is based on some unrealistic ideas of what can be accomplished at a clinic.

The treatments that clinics can offer to patients who have advanced stages of chronic illness are limited. To fund more clinics or more access to them without investing in solutions that address the root causes of those chronic illnesses isn't a sound investment.

That's why I think what the Healthcare Foundation is doing by thinking about equity more broadly is so important. Access to services is an important social determinant of health, but we need to do what we can to address others.

When you're living in extreme poverty, relying entirely on charity from family or working for an annual income of \$10,000 or \$15,000, it's very hard to pursue a lifestyle that supports health, and there's nothing a clinic can do to change that.

When you are living with trauma—whether you're being extorted for money to keep your relatives safe, or living with abuse, or about to be homeless, or always afraid because you're undocumented or an African American male—it's hard to stay healthy.

When children go home after school and get themselves a snack and watch TV behind a locked door until their parents get home, we're setting them up to have earlier onset of chronic illnesses. The physiological changes we're seeing in children right now because of poor nutrition and obesity will have lasting effects developmentally, immunologically, cardiovascularly—effects that are very hard to undo.

A referral to a cardiologist at Lurie who tells these children to eat less butter and sugar is not going to change their ability to access healthy foods. We should be demanding—and insurance should be paying for—opportunities for children to go to a Boys and Girls Club or some similar type of after school program where they can be physically active and eat healthy snacks and hang out with trained teenage counselors.

I think about my work with people who are in recovery from substance abuse. We can prescribe suboxone, but if we want people to succeed in the long term, we also have to help them find steady work they can take pride in, which means funding programs that provide occupational training and job placement and support.

We are such a sick country. It is an absolute economic and humanitarian crisis. Masses of poor people are suffering, on a scale that would warrant some sort of national mobilization, like Roosevelt's WPA programs in the '30s.

Our healthcare system is not equipped to do the work that needs doing. At a minimum, we need to train an army of peer-based community health workers or health coaches who are culturally concordant with the people who are suffering.

As long as we continue to think that the solutions to our problems lie within the walls of hospitals and clinics, people will continue to get sicker and the cost of healthcare will continue to rise.



Improving every system

Our clients suffer from systems failures on multiple fronts.

Transportation is one—the providers who take Medicaid or Medicare are centralized in just a couple of places. Affordable or free childcare or preschool is another. Right now, to go to the doctor, people with families have to figure out an alternate care situation or take their kids out of care for the day because they won't be able to pick them up on time. Employers don't give people paid sick time or pay an actual livable wage. There is too little affordable housing, and what housing there is doesn't allow people with lower incomes to live near greenspace areas or be integrated into the community.

In terms of healthcare, a lot of the hospitals that see our clients don't think about or try to address the social determinants of health at all. They say, "Here's your stuff, here's a prescription. We don't know how you can fill it, or whether you can get it at that pharmacy. Just go to PADS."

We see them discharging someone who has a pacemaker or an open wound they have to keep clean, but they're being discharged to a homeless shelter where it's nearly impossible to do that.

Our agency works with everybody in Lake County to some degree or another. And one thing we hear from

partners over and over again is, "We see the need, but..." They'll say, "Because of our funding, we can only do this," or "We only serve this population, not that one," or "He doesn't qualify because he's just not severely mentally ill enough" and "She doesn't qualify because she's too ill." Or they'll say, "They don't fit our parameters," or "They don't have ID" or "They have ID, but they need a Social Security card and a birth certificate."

Do you know how long it takes and how hard it is to get these documents?

Even the crisis housing system fails some clients. We work with housing providers to get the longer-term homeless into housing, but there's a group of maybe 10 or so clients who are difficult to house. They have more barriers, they have paranoia or something else, and they just keep being passed over. Our providers say, "Well, they're just not ready." But the truth is, it's not that they're not ready, it's that we're not providing the right housing opportunities. They will never be "ready" for what we have. We have to give them what they need, or be more flexible.

I think that's as good a definition of health equity as I can think of: Every person being able to get what he or she needs to maintain or improve health.

“[Some clients] will never be ‘ready’ for what we have. We have to give them what they need.”

Meghan Powell-Filler, Executive Director  
PADS Lake County





“If we want to solve the problem of health equity, we have to start by including everybody, especially those who suffer the greatest inequities.”

William Coleman  
North Chicago Think Tank

## Seeing from every point of view

I think one challenge to access is to establish the value of health, healthcare, and healthcare resources. For a lot of people in black and brown communities, care and resources have been so consistently lacking or the quality of them has been so poor that their perceived value has just dropped. People are like, “Whatever you’re saying that you have for us, we don’t value it enough to even want it for ourselves. And we don’t trust you.”

We started the North Chicago Think Tank because we saw those gaps between the community and the organizations that exist to provide services to it—not only the larger healthcare entities but even community organizations. For example, a lot of community-based organizations for black health are heavily tied to the church or to nationalism. Well, lots of people can’t relate to that, so they just stay away. And nobody is really doing the kind of outreach necessary to talk to those people and find out why.

We need people to tell us, Do you go to the doctor? If so, what happens there? Do you feel like you are being heard? If not, why not? What happened to you in the past or what’s happening to you now, in those spaces, that you avoid them so vehemently?

If we want that feedback, we need to show that we value people enough to ask them in safe, nonjudgmental spaces and to give them real incentives to participate.

When you mention incentives, you get a lot of push back from organizations. They’ll say, “Why should we give people incentives?”

Well, because right now, these people feel so devalued and disengaged from the civic portion of existence that they’re refusing point blank to engage at all. They’re saying, “No, I’m not giving you any responses. I’m not taking your surveys.” In their experience, it does not benefit them at all to spend their time and their money to teach a racist system—or a system that has been an actual danger to them in the past—how to treat them better.

So we have organizations planning their next steps based only on the feedback they *did* get. And if you ask, “Who’d you get the feedback from?” they’ll say, “Well, we didn’t include everybody, but we thought of everybody.”

I can’t help but think, “Yeah, but did you? Really? That data doesn’t represent the people I’m talking to every day.”

If we want to solve the problem of health equity, we have to start by including everybody, especially those who suffer the greatest inequities.







## Learning every day

Every organization we fund has a mission to meet a specific need, whether it's health services, or housing, or food, or job training. To meet that need effectively, however, these organizations need to recognize that the clients they serve are disadvantaged, often in multiple ways, and that those disadvantages—social, economic, or environmental—are socially determined. To succeed in their mission, these organizations have to acknowledge and somehow address those disadvantages.

Two of our grantees are great examples of that kind of thinking in action: YouthBuild and Youth Conservation Corps. Both exist to provide job training and education, and both recognize that young people aren't going to be successful in the classroom or on the job if they have mental health issues. So both organizations offer mental health services that help students learn coping mechanisms and address any issues they might have like ADHD or trauma, issues that could affect their employability and job performance down the road.

What's true for organizations that provide services is true for us, as well. Our mission is to improve health by improving access to services, and that hasn't changed. But we know that access, like health

status itself, is linked to disadvantages that are socially determined, so our thinking about access has evolved.

By thinking explicitly about equitable access, we believe we can increase the effectiveness and impact of our funding. Instead of solely focusing on serving more people and creating more access points, we're asking whether those access points are fair and whether they are in places that help those who are the most disadvantaged.

Another aspect of equity that we'd like to incorporate into our grantmaking is the idea of not only asking what the community's needs are—as we do with the community needs assessments—but asking how the community wants those needs met. It's a whole new way of thinking, really, and it's the "learning with community" part of our strategic plan. Then, as we begin the "learning through grantmaking" phase of our plan, we'll try to find partners who can implement the community's ideas.

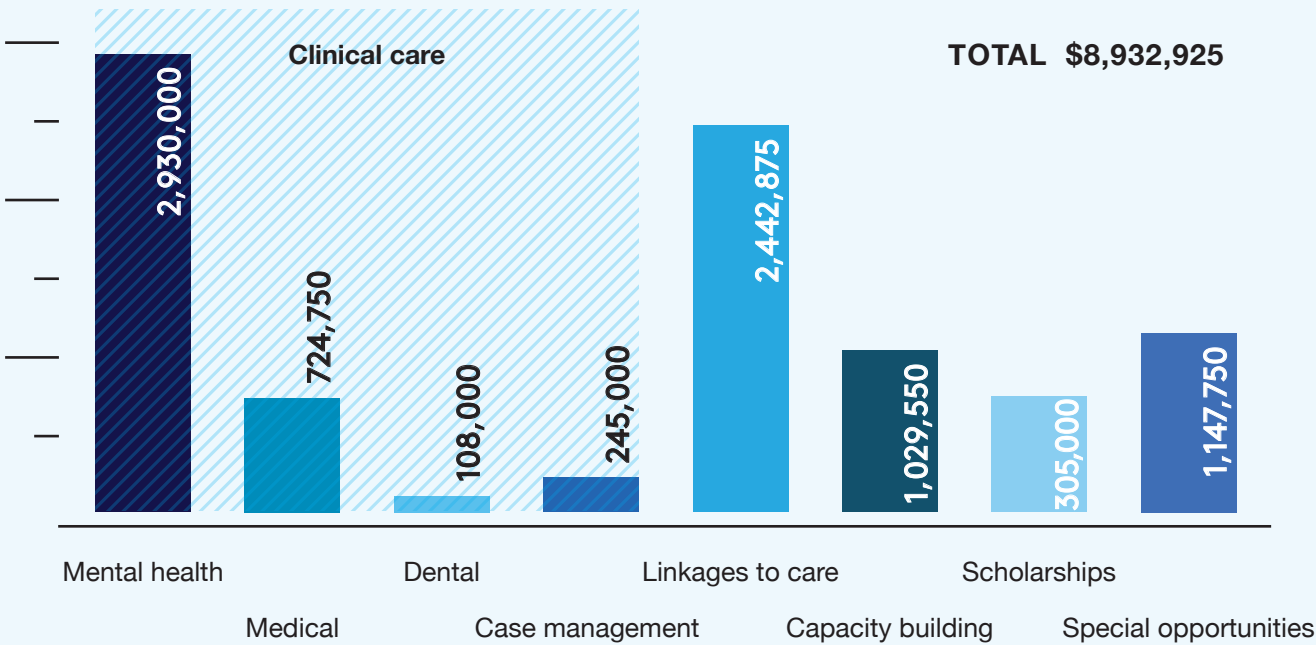
Adding the equity lens and piloting new ideas in grantmaking may be a bit challenging for us all, at the outset, but I truly believe that what we will learn and accomplish together will be well worth the effort.

“Another aspect of equity that we'd like to incorporate into our grantmaking is the idea of not only asking what the community's needs are...but asking how the community wants those needs met.”

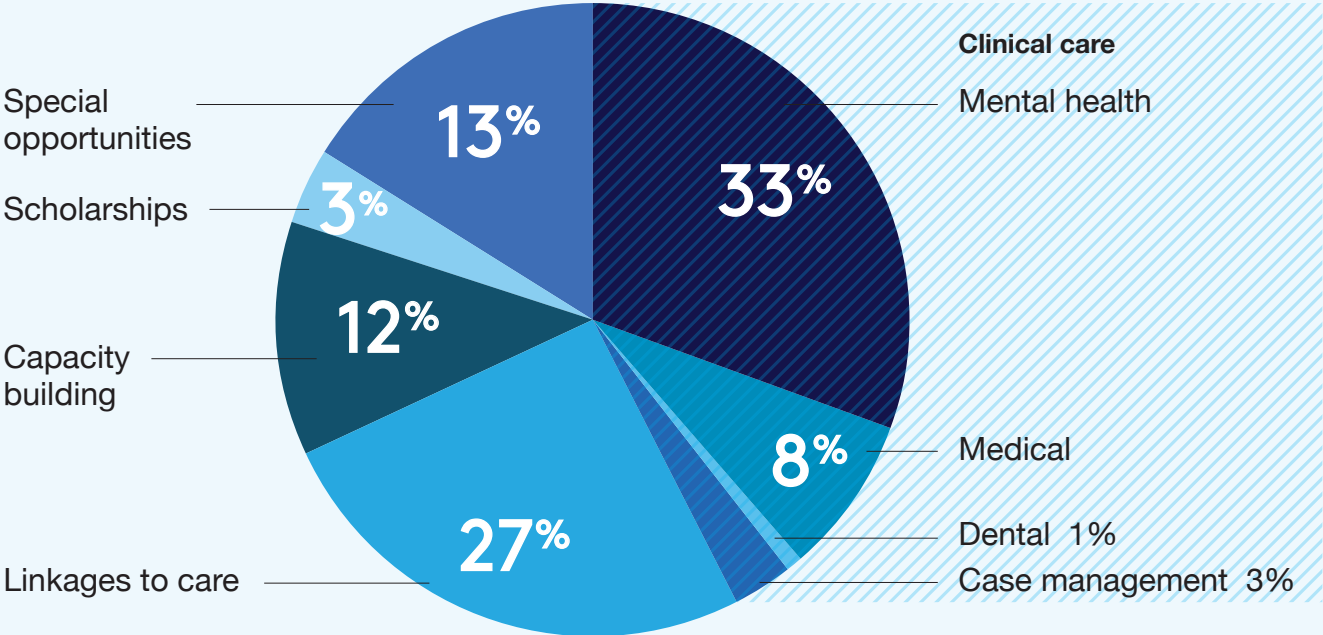
Angela Baran, Program Officer  
Healthcare Foundation of Northern Lake County



Grant totals, fiscal years 2018–22\*



Distribution



\*Through May of 2022. The digital version of this report, available at [hfnlc.org/research-and-resources](https://hfnlc.org/research-and-resources), includes awards made in May 2022.

Grantees

The Healthcare Foundation of Northern Lake County supports programs and organizations that target uninsured or underinsured individuals and families, and underserved neighborhoods and communities of Antioch, Fox Lake, Grayslake—Third Lake, Great Lakes, Gurnee, Lake Villa—Lindenhurst, North Chicago, Round Lake, Wadsworth, Waukegan, and Zion.

Details regarding these and other grants can be found on our website, [hfnlc.org](https://hfnlc.org).

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|---|--|
| Advocate Charitable Foundation  | McDermott Center dba Haymarket Center                        |
| Antioch Area Healthcare Accessibility Alliance                                  | Mercy Housing Lakefront                                      |
| Arden Shore Child & Family Services   | Nicasa Behavioral Health Services                            |
| Ascend Justice  | Northeastern Illinois University Foundation                  |
| Aspire of Illinois<br>(formerly NorthPointe Resources, Inc.)                    | One Hope United  |
| Boys and Girls Club of Lake County  | PADS Lake County   |
| Cancer Wellness Center  | Pioneer Center for Human Services                            |
| Catholic Charities of the Archdiocese of Chicago                                | Rosalind Franklin University Health System                   |
| College of Lake County  | Rosalind Franklin University of Medicine & Science           |
| Community Youth Network   | SGA Youth & Family Services NFP                              |
| Cristo Rey St. Martin College Prep  | TASC, Inc.   |
| ElderCARE Lake County   | The Josselyn Center  |
| Equal Hope (formerly known as<br>Metropolitan Chicago Breast Cancer Task Force) | Thresholds   |
| Erie Family Health Centers  | Uhlich Children's Advantage Network (UCAN)                   |
| EverThrive Illinois   | United Way of Lake County                                    |
| Family Focus  | Wauconda Fire Protection District                            |
| Family Service of Lake County   | Waukegan Public Library                                      |
| Hispanic American Community Education<br>and Services (HACES)                   | Waukegan Township  |
| Kids Above All (formerly ChildServ)   | Willow House   |
| Lake County Community Development   | Youth & Family Counseling                                    |
| Lake County Crisis Center<br>(Known as A Safe Place)                            | Youth Conservation Corps                                     |
| Lake County Health Department<br>and Community Health Center                    | Youth Network Council dba<br>Illinois Collaboration on Youth |
| Lake County Sheriff's Office  | YouthBuild Lake County                                       |
| Lewis University  | YWCA Lake County   |
| Mano a Mano Family Resource Center  | YWCA Metropolitan Chicago                                    |
|   | Zacharias Sexual Abuse Center                                |
|   | Zion Benton Children's Service                               |

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