Aligning Diversity and Inclusion, Community Engagement, Business Operations and Population Health Efforts to Achieve Equity

November 20, 2017

Speakers:

- Rev. Kathie Bender Schwich, Senior Vice President, Mission and Spiritual Care, Advocate Health Care
- Robyn Golden, Associate Vice President, Population Health and Aging, Rush University Medical Center
- Darlene Oliver Hightower, Associate Vice President, Community Engagement, Rush University Medical Center
- Moderator: Jetaun Mallet, AHA’s Institute for Diversity
Aligning Diversity and Inclusion, Community Engagement, Business Operations and Population Health Efforts to Achieve Equity

Rev. Kathie Bender Schwich, FACHE
Senior Vice President, Mission & Spiritual Care
Advocate’s main focus in addressing health equity...

Meet the needs of diverse populations

Improve Safety, Quality and Service

Improve Health in Communities We Serve

Strategic Pillars
1. Education
2. Cultural Awareness
3. Access
4. Workforce Development
5. Community Partnership
Education: Culturally Customized Care

✓ The goal is care based on continuing, healing relationships in which needs are anticipated and customized according to a patient’s needs and values.

✓ Ethnic minorities perceive responsiveness and personalization of care as key factors that care providers need to identify, understand and prioritize for their communities and tailor care accordingly.

✓ Currently Advocate does not collect patient race/ethnicity and language data at a granular level to ensure the information is meaningful and useful in providing culturally appropriate care.

✓ Robust data collection will allow associates and physicians to provide the safest, best possible care and experience for all patients we serve.
Culturally Customized Care – Target Condition

1. Standard, consistent, meaningful diversity (race, ethnicity, language, religion, etc.) data across enterprise.
2. Data will be used to ensure all patients receive culturally customized care across the continuum.
# Culturally Customized Care – Action Plan

<table>
<thead>
<tr>
<th>Task</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data subgroup developed</td>
<td>2015</td>
</tr>
<tr>
<td>Baseline data and dashboard</td>
<td>January 2016</td>
</tr>
<tr>
<td>Granular ethnicity data collection go-live at hospital sites</td>
<td>February 2016</td>
</tr>
<tr>
<td>“We Ask Because We Care” campaign</td>
<td>February 2016</td>
</tr>
<tr>
<td>Validate and measure data process</td>
<td>Quarterly 2016</td>
</tr>
<tr>
<td>Assessment/timeline for data collection at ambulatory locations</td>
<td>April 2016</td>
</tr>
<tr>
<td>Determine how data can be used to inform how services are provided</td>
<td>October 2016</td>
</tr>
<tr>
<td>across the continuum of care</td>
<td></td>
</tr>
</tbody>
</table>
Diverse Patient Data Collection – 2016 Results

2016 Dashboard Improvements
   Decline/Unknown down to 4.7% versus 14.8% at start of project

Drivers of Improvement
   • Embedded “We Ask Because We Care” language in all training programs
   • Standardized “Unknown” to be equal to “Unable to ask”
   • Published Quarterly score cards
   • Focused attention on clear variance from baseline
     – Leadership
     – Work norms
     – Workflow
     – Comfort with questions
Cultural Awareness – Address South Asian Cardiovascular Issues

Need:
- One in 10 South Asians suffer from undiagnosed heart disease
- Cardiac related deaths under age 40

Solution:
- Advocate created the South Asian Cardiovascular Center, the first of its kind in Midwestern United States
- Program focuses on community outreach, health education and culturally sensitive advanced clinical services and research

Impact:
- Due to community outreach efforts, we see nearly 20 new patients every month, more than half of which require intensive surgical or medical intervention
- Partnering with local grocery stores
- We’ve partnered with local restaurants and faith communities to do education and reduce sodium content
Coronary Artery Disease affects South Asians four times as often as the general population.
The SACC Model

- Transformative Community Outreach
- Paradigm Shifting Innovation
- Culturally Specific Clinical Services
Transformative Community Outreach

Council of Advisors
Social Media
Retail/Business Partnerships
Faith Based Collaborations
Consumer Education
Red Sari Advocacy

TOMORROW STARTS TODAY.
A Path Forward

Evidence Based Education
Data Driven Engagement
Advocacy For Prevention & Screening
Precision of Treatment Options

Transformational Outcomes

TOMORROW STARTS TODAY.
Project H.E.A.L.T.H.

Healing Effectively After Leaving the Hospital:
A Shift to Community-Based Outreach
H.E.A.L.T.H Program Goal

Develop a supportive community health worker outreach program that bridges hospital based care to care across the continuum from hospital-to-home.

Focus on Social Conditions:
- Transportation
- Ability to Afford Medicine
- Food Insecurity
- Housing
- Social Support

Chronic Diseases:
- Asthma
- Diabetes
- Sickle Cell

Focus on:
- Reduce Costs
- Improve Re-admissions Rate
- Improve Health

Advocate Health Care
What is a Community Health Worker (CHW)?

- A frontline public health worker who is a trusted member of and/or has a close understanding of the community served
- Has health training that is shorter than that of a professional health care worker
- Often more impactful than clinical personnel in influencing behavior change, esp. for populations that experience disparities
What does a Community Health Worker Do?

- Establishes relationships with patients as they enter the hospital
- Continues relationship with patients beyond hospital walls
- Educate patient on warning signs of disease progression
- Provide chronic disease management services
- Make follow-up and well call checks
- Encourage completion of Follow-up PCP visit
- Identify care needs and post discharge
- Development of appointments and care coordination outside of hospital with community partners
Outcomes

- Building lifelong relationships with our patients
- Reducing readmission rates
- Establishing and/or solidifying relationships with community care providers
- Reducing Emergency Room visits
Transitional Care Model

- Establishes Trusting Relationships
- Conducts Follow Up Wellness Calls
- Schedules PCP Follow Up Appointment
- Identifies Community Support programs
- Helps Patient Set Personal Health Goals
- Refers Patients to Medical Homes
- Advocate Hospital
- Primary Care Network
- Faith Community
- Post Acute Network
- Community Orgs

Project H.E.A.L.T.H. Community Health Workers

Advocate Health Care
About the Advocate Workforce Initiative

• $3 million commitment from JP Morgan Chase
  • New Skills at Work
  • Five-year workforce development initiative 2015-2020

An employer-led, demand driven Workforce Development Program

• Align training curriculum to current and emerging trends (needs)
• Connect job seekers to employment opportunities with Advocate
• Encourages diverse candidates into our talent pipeline
• Establish ‘best practices’ creating a regional/national model

An opportunity to provide industry training to job seekers

• Focused on middle-skill positions (entry-level, skilled)
• Supportive Services (identifying and removing barriers to employment)
• Clinical Education at Advocate Sites of Care
• Incumbent Worker Strategy (NAVIGATE)
Program Goals

- ALIGN the skills of job seekers through industry training to fill available healthcare jobs in the greater Chicagoland area
- Increase DIVERSITY within the healthcare sector (Advocate), focused on middle-skill (but, not limited to)
- Provide a CAREER PATHWAY to individuals seeking advanced training/or career opportunities with the healthcare sector
- Support the ECONOMIC DEVELOPMENT through workforce and health education within the communities that we serve
Career Pathway Map
- Clinical & Non-clinical tracks
- Associate & Leader levels

Tools & Resources
At your fingertips:
- Employee Assistance Program
- Education Assistance
  - Ex: Certifications and Degrees
- Tuition Discounts
- City school partnerships
  - Ex: Grants

Soft Skills Development
- 10 sessions in 6 months
- Blended learning approach
- Build network
Outcomes/Trends

- Over **115** placements in Healthcare related roles
- Over **95%** retention rate for graduates hired with Advocate Health Care
- **15** Healthcare Employers/Consortiums have participated in the Chicagoland Healthcare Workforce Collaborative
- Engaged **7** Community Based Organizations and **2** Community Colleges as training partners
AHA Equity of Care Webinar:
Rush’s Mission to Improve the Health of Chicago’s West Side

Darlene Oliver Hightower, JD, Associate Vice President, Community Engagement

Robyn L. Golden, MA, LCSW, Associate Vice President, Population Health and Aging
I. Introduction to Rush and Chicago’s West Side
II. Collaborative Approaches to Improve Health Equity
III. Discussion/Questions
About Rush

Our mission
The mission of Rush is to **improve the health of the individuals and diverse communities we serve** through the integration of outstanding patient care, education, research and community partnership.

Our vision
Rush will be the leading academic health system in the region and nationally recognized for transforming health care.

Our values
Rush University Medical Center's core values — innovation, collaboration, accountability, respect and excellence — are the roadmap to our mission and vision.
The West Side is Rich with Health Institutions and Clinics
Disparity Exists on the West Side of Chicago
An Intentional, Collaborative Place-Based Approach Is Needed

- Holistically address the social and structural determinants of health
- Have a unified “West Side Voice” to outside audiences
- Create opportunities to scale programs that work at the community level
- Identify and create new high-value connections between organizations
- Create common measures of success
- Increase the visibility of existing efforts
Collaborative Efforts to Improve Health

- Alliance for Health Equity and Healthy Chicago 2.0
- West Side Total Health Collaborative (WSTHC)
- West Side Anchor Committee and West Side ConnectED
- Community Health Implementation Plan (CHIP)
<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Hospital Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocate Children's Hospital</td>
<td>Norwegian American Hospital</td>
</tr>
<tr>
<td>Advocate Christ Medical Center</td>
<td>Presence Holy Family Medical Center</td>
</tr>
<tr>
<td>Advocate Illinois Masonic Medical Center</td>
<td>Presence Resurrection Medical Center</td>
</tr>
<tr>
<td>Advocate Lutheran General Hospital</td>
<td>Presence Saint Francis Hospital</td>
</tr>
<tr>
<td>Advocate South Suburban Medical Center</td>
<td>Presence Saint Joseph Hospital</td>
</tr>
<tr>
<td>Advocate Trinity Hospital</td>
<td>Presence Saints Mary and Elizabeth Medical Center</td>
</tr>
<tr>
<td>AMITA Health Adventist Medical Center La Grange</td>
<td>Provident Hospital</td>
</tr>
<tr>
<td>Ann &amp; Robert H. Lurie Children's Hospital</td>
<td>RML Specialty Hospitals</td>
</tr>
<tr>
<td>Cook County Health and Hospital System</td>
<td>Rush Oak Park</td>
</tr>
<tr>
<td>Gottlieb Memorial Hospital</td>
<td>Rush University Medical Center</td>
</tr>
<tr>
<td>Loyola University Medical Center</td>
<td>Stroger Hospital of Cook County</td>
</tr>
<tr>
<td>Mercy Hospital &amp; Medical Center</td>
<td>Swedish Covenant Hospital</td>
</tr>
<tr>
<td>Northwestern Memorial Hospital</td>
<td>University of Chicago Medicine</td>
</tr>
<tr>
<td>Chicago Department of Public Health</td>
<td></td>
</tr>
<tr>
<td>Cook County Department of Public Health</td>
<td></td>
</tr>
<tr>
<td>Evanston Health Department</td>
<td></td>
</tr>
<tr>
<td>Park Forest Health Department</td>
<td></td>
</tr>
<tr>
<td>Oak Park Health Department</td>
<td></td>
</tr>
<tr>
<td>Skokie Public Health District</td>
<td></td>
</tr>
<tr>
<td>Stickney Health Department</td>
<td></td>
</tr>
</tbody>
</table>
**Mission**

To build **community health and economic wellness** on Chicago’s West Side and build **healthy, vibrant neighborhoods**

**Vision**

To **improve neighborhood health by addressing inequities** in healthcare, education, economic vitality and the physical environment using a cross-sector, place-based strategy.

**Partners** will include other healthcare providers, education providers, the faith community, business, government and RESIDENTS that **work together to coordinate investments and share outcomes**.
Who Is At The Table?

RUSH

Presence Health

Ann & Robert H. Lurie Children's Hospital of Chicago

UI Health

Cook County Health & Hospitals System
By working together, we can magnify the impact of existing initiatives, develop new programs and provide coordinated resources to existing collaboratives.

Examples of Potential Collaborations on the West Side

**Business Units**
- Work together to hire local, buy local, invest local and engage in the community

**Patient Care**
- Collaborate on meeting community health needs

**Community Engagement**
- Support neighborhood collaboratives
- Lend expert advice and training to community based organizations
- Help advocate for systems change
Over a six-month term, the Planning Committee will determine the vision, goals, and governance of the West Side Total Health Collaborative.

In addition to the 16 Planning Committee members, sub-committees will be open to community advisors and subject matter experts.
West Side Anchor Committee
## West Side Anchor Committee

### Current initiatives

<table>
<thead>
<tr>
<th>Buy and Source Locally</th>
<th>Hire Inclusively and Develop Talent</th>
<th>Invest Locally</th>
<th>Volunteer and Support Community Building</th>
</tr>
</thead>
<tbody>
<tr>
<td>Share capital projects, contract language, and target labor hiring</td>
<td>Convene HR leads with the Healthcare Workforce Collaborative (HWC) to share build plans for:</td>
<td>Review current CDFI initiatives and work towards a joint investment</td>
<td>Map volunteer programs and share best practices</td>
</tr>
<tr>
<td>Develop joint plan for laundry services</td>
<td>- Publish job specifications for entry level jobs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Career pathway maps</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Theories of change

<table>
<thead>
<tr>
<th>Current initiatives</th>
<th>Invest Locally</th>
<th>Volunteer and Support Community Building</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large-scale, collaborative purchasing contracts will mitigate risk, allowing local businesses to make larger capital investments in the community</td>
<td>Larger investments can generate better rates of financial and social return</td>
<td>Joint volunteering programs will build denser social networks among hospital employees and community members, building community trust, and increasing chances to build social capital</td>
</tr>
<tr>
<td>Collaborative career development and training programs will produce better qualified candidates for hospital jobs</td>
<td>A directed investment in a distressed community (to improve housing quality, e.g.) can directly improve health outcomes in the near term</td>
<td></td>
</tr>
<tr>
<td>Better employment prospects in West Side neighborhoods will spur further investment and human capital development</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Recognizing an opportunity to collaborate on the CMMI grant, the West Side Accountable Health Communities Collaborative was formed.

Partners included three health systems, multiple community based service providers, FQHC’s and an advisory board made up of representation from the areas of criminal justice, city government, Medicaid health plans and others.

While the Collaborative’s application was not awarded, all of the partners remained committed to the goal of creating a standardized screening tool and moved forward to conduct systematic health-related social needs screenings in geographically targeted area to improve the health of our patients and community.

This effort was re-branded as the Westside ConnectED.
Rush’s brief screening tool asks patients about:

- Housing
- Transportation
- Food Security
- Utilities
- Primary Care / Insurance
Utilizing various disciplines to conduct screenings:

- Patient Care Navigators,
- Certified Medical Assistants
- Students
- Social Workers (patients with complex health needs or needs that require more follow up such as housing)

Evaluating the impact:

- PDSA (Plan, Do, Study, Act) screening in Emergency Department, Primary Care Settings, Community Based Settings
- Preliminary PDSA results (to date): 24 responses (12 ED, 12 PCP)
Rush has partnered with NowPow to provide social referrals to our patients. Rush was the first hospital to integrate NowPow into Epic, our Electronic Health Record, to ensure better continuity of care.

We have officially recorded 8 closed-loop referrals via NowPow to our free-clinic partner, CommunityHealth.
Interprofessional Approach – Cross Disciplinary

Social Determinants of Health

- Food Security
- Chronic Disease
- Tobacco Control and Support

Access

Education

- Breast Cancer Screening / Prevention

Mental and Behavioral Health

SDOH Group Membership

Social Work and Community Health
- Robyn Golden (Lead); Rachel Smith (Lead); Danielle Wolf; Ethan Powe

Community Engagement
- Christopher Nolan (Lead); Robin Pratts

Care Management
- Kathleen Egan; Carli McInerney

Population Health
- Adam Claus; Elizabeth Valvo

Primary Care
- Steven Rothschild

Center for Community Health Equity
- Brittney Lange-Maia

ROPH
- Rachel Start

UI Health
- Stephen Brown

GCFD
- Emily Daniels

PIC
- Dawn Gay

West Side ConnectED Leadership
Institutionalizing and Aligning Our Efforts

Population Health Leadership Committee
• Overseeing the social determinant efforts including the SDOH screener and improving clinical and social care

Diversity Leadership Council
• New strategic goals around health equity and community partnerships

Aligning with Quality Goals
• Institutionalizing our data to align with existing metrics for buy-in
Institutionalizing and Aligning Our Efforts

Connecting to our evidence-based, interprofessional, care coordination models
  • AIMS
  • Bridge
  • Medical Home Network Interprofessional Triads

Elevating our efforts
  • Center for Health and Social Care Integration (CHaSCI)
**Elevating Our Efforts**

<table>
<thead>
<tr>
<th>Creating a “Center for Health and Social Care Integration”</th>
<th>A platform to house and elevate the non-direct services that we work on</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Various local and national partners</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Center activities</th>
<th>Continue developing and evaluating care models and innovative practices</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Spread care models to health systems, managed care, accountable care and community-based organizations across country</td>
</tr>
<tr>
<td></td>
<td>Educate and train interprofessional trainees, educators, and practitioners on best and promising practices</td>
</tr>
<tr>
<td></td>
<td>Influence policy and reimbursement mechanisms</td>
</tr>
</tbody>
</table>
In order to achieve health equity and mitigate health disparities, we must partner in a collaborative approach - including community residents/leaders, “competing” healthcare institutions, community based organizations, local government, and the business community.
Please click the link below to take our webinar evaluation. The evaluation will open in a new tab in your default browser.

https://www.surveymonkey.com/r/aha_webinar_11-20-17
Q & A
Upcoming Webinar

Part 2: Aligning Community and Employee Engagement, and Population Health Efforts to Achieve Equity

December 13, 2017

Register Here
Follow us on Twitter

@HRETTweets
@IFD_AHA