Reducing Racial Disparity in AMG Primary Care Offices

Maggie Smith, Anja Fries, Tracy Boecker, Lisa Starkey, Pam Xenakis, Theresa Johnson, and Rachel Green

Ascension Saint Agnes

LEAD Collaborative

Meritus Health

About Us

- Our Mission: Rooted in the loving ministry of Jesus as healer, **we commit ourselves to serving all persons with special attention to those who are poor and vulnerable**. Our Catholic health ministry is dedicated to spiritually centered, holistic care which sustains and improves the health of individuals and communities. We are advocates for a compassionate and just society through our actions and our words.
- Ascension Medical Group (AMG)
  - 8 Primary Care Offices
  - Services Baltimore City, Baltimore County, and Howard County
  - 46 primary care physicians
  - ~60,000 patients

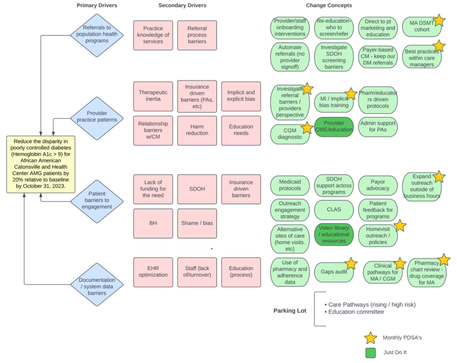
Our Why

- 26% of our Ascension Medical Group (AMG) patients have poorly controlled diabetes (HbA1c > 9)
- The rate of patients with HbA1c > 9 is 1.25x higher for Black or African American patients compared to White patients

Our goal is related to our organizational mission to serve all individuals, especially those who are poor and vulnerable. Our goal is to provide quality access and care to our patient population in Baltimore City and surrounding areas by reducing diabetes health disparities and addressing barriers to treatment.

Key Interventions and Tests of Change

1. Created driver diagram with key stakeholders and leaders across departments to identify change concepts (see below)- 3/2023
   HbA1c gaps closure audit- 4/2023 and 6/2023
   a. Identification of A1c documentation gaps in EHR
1. Population Health Programs provider feedback survey- 5/2023
   a. Created care management coverage schedule for offices
   b. Increased communication with AMG office leadership
2. Data collection regarding care management patient engagement by care pathway- 5/2023
3. Data collection regarding care plan outcome by care management care pathway- 5/2023
4. "Touch of Sugar" embedded diabetes education class at Catonsville primary care office- 6/2023, 7/2023
   a. Utilized outreach list to target African American AMG patients with HbA1c > 9
   b. Merged outreach list with other grant funded work to address SDOH barriers
   c. Implemented pre/post intervention questionnaire to assess for changes in health literacy, health confidence, and HbA1c

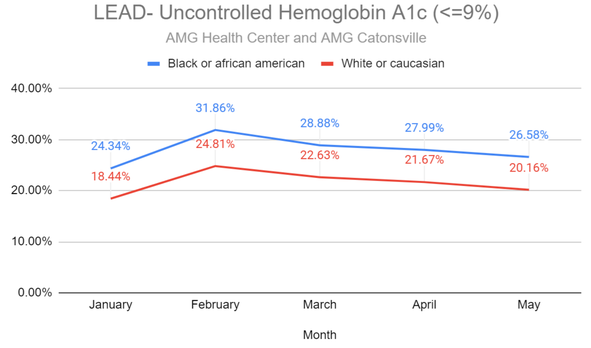


Aim Statement

Reduce the disparity in poorly controlled diabetes (Hemoglobin A1c > 9) for Black or African American Catonsville and Health Center AMG patients by 20% relative to baseline by October 31, 2023.

Data

- HbA1c Gaps Closure Audit
  - 4/2023- **12%** of gaps closed
  - 6/2023- **16%** of gaps closed
- "Touch of Sugar" Diabetes Education Class
  - No-show rate decreased from **60% to 11%**
  - % of participants who strongly agree or agree that they have a better understanding of diabetes and how to manage it increased from **75% to 100%** (n=14)
  - Of those who have gotten their HbA1c checked post-intervention, **100%** have lowered their HbA1c (n=5)



Lessons Learned and Summary

- Diabetes education embedded model is best practice
  - Increased provider engagement and referrals
  - Increased access for AMG patients
- Utilizing HbA1c as an outcome metric is difficult to track
  - Patients typically receive HbA1c testing 1-2 times per year
- Streamlining priorities across departments supported outcomes
  - Strategic direction aligned across Quality and Care Transformation, Care Management, and Diabetes Education leadership
- Success in targeted interventions due to the utilization of data to support and track initiatives

Next Steps

- Strategy related to offering equitable diabetes education in all AMG primary care practices
- Advocacy and collaboration with insurances to provide coverage for diabetes education

Advancing Access and Equity for New Jerseyans During Their Life Course: Bringing Care to the Community

Deborah Visconi, President and CEO
Katie Richardson, Senior Vice President Operations & Long Term Care Administrator
Donnalee Corrieri, Chief Communications and Marketing Officer

LEAD Collaborative

About Us

Bergen New Bridge Medical Center, a clinical affiliate of Rutgers, is a 1,070-bed hospital located at 230 East Ridgewood Avenue in Paramus, NJ. The Medical Center includes both the largest hospital and licensed nursing home in New Jersey.

BNBMC, a not-for-profit safety net facility, provides high-quality comprehensive services, including acute and ambulatory care, mental health and substance use disorder treatment, and long term care.

Our Why

- As a safety net facility, our mission is to provide increased equitable access to care for all with a specific emphasis on those underserved or marginalized.
- As a leader in elder care services and a certified NICHE (Nurses Improving Care for Healthsystem Elders) we are dedicated to increasing access to care for those 50+.

Aim Statement

Through increased partnerships and other methods, by Oct. 2023 increase access to mental health services, outpatient rehabilitation services and senior living services by 20% for people older than 50.

Key Interventions and Tests of Change

- Data capture: Capturing name and birthdate if possible, to tie back to services at the Medical Center or its satellite locations.
- Add more senior center encounters
- Work more closely with the Age Friendly initiatives

Data

- In response to our Community Health Needs Assessment and in line with our Community Health Improvement plan, we have increased our outreach, education and screening events by 20% targeting those over 50 within underserved communities/populations.
- Focused outreach for LGBTQ+, communities of color, Latine, and Asian people in towns identified by our CHNA such as Garfield, Wallington, East Rutherford, Hackensack, and Bergenfield.
- 2,510 ages 50+ first time encounters January-July 2023

Lessons Learned and Summary

- Using the Community Health Needs Assessment to determine communities most in need, our outreach activities needed to expand to include people 50+ as well as those traditionally underserved at disproportionately at risk.
- Trust is key to build engagement and potential for follow up care.
- Good giveaways attract traffic and promote engagement.

Next Steps

- Continue using and increasing strategic partnerships to build trust with marginalized groups and underserved communities.
- Ramp up Autumn outreach for flu, COVID, Pneumonia vaccines
- Marry data collected to follow up care/visits to see if outreach encounters yield use of healthcare services/better outcomes.

REDUCING DISPARITIES ON ADVANCED DIRECTION DISCUSSION

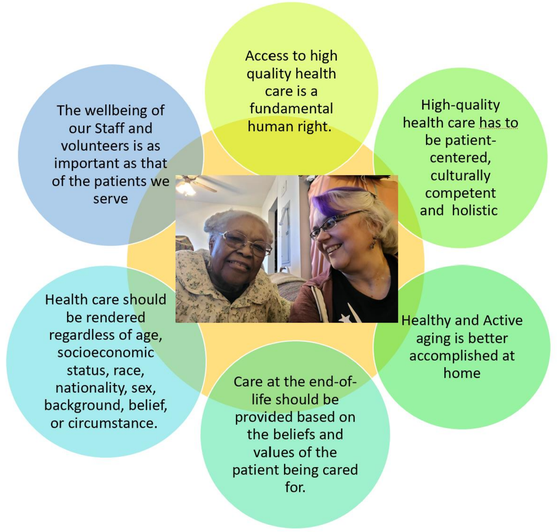
Anna Maria Izquierdo-Porrera MD PhD & Marcela Campoli PhD
Care for Your Health, Inc

LEAD Collaborative

Meritus Health

About Us

- **Our Mission**: OUR MISSION IS TO DELIVER INCLUSIVE, TRUSTED AND MULTICULTURAL HEALTHCARE WHERE CARE IS NEEDED, FOSTERING AUTONOMY AND QUALITY OF LIFE FOR ALL MEMBERS OF OUR COMMUNITY.
- **Our Values**



Our Why

Black and Hispanic older Americans are less likely than white older Americans to possess advance directives. We want to work to reduce these disparities.

Aim Statement

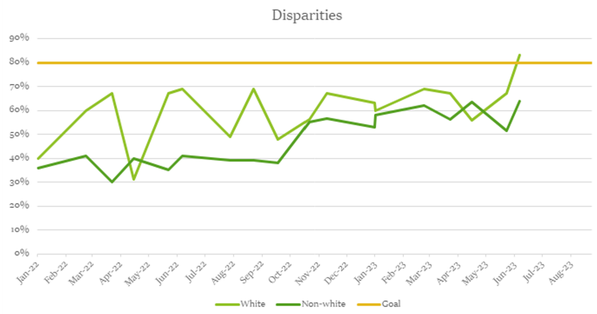
We will reduce the disparity of our advanced directives documentation (difference between advanced directives documentation for white patients and non-white patients) to less than 3% by October 2024 .

Key Interventions and Tests of Change

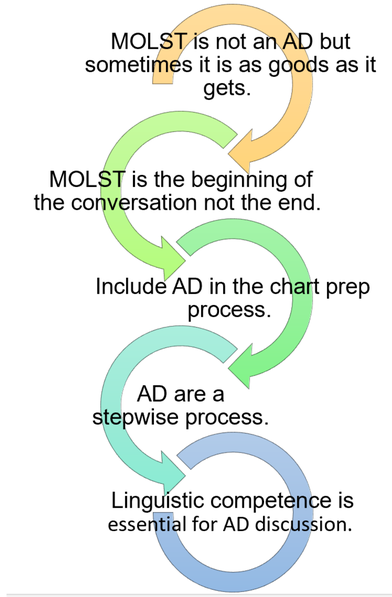
- ❑ Check for presence of MOLTS during chart preparation.
- ❑ Make a note on chief complaint of AD are missing.
- ❑ Train providers about the use of AD template
- ❑ Spread to all sites
- ❑ Train all MA to Check AD

Data

- 1. Overall improvement of Advanced Directives
- 2. The disparities have decreased overtime



Lessons Learned and Summary



Next Steps

- ❑ Create a video to educate patients on AD
- ❑ Obtain 5 wishes documentation
- ❑ Provide AD education

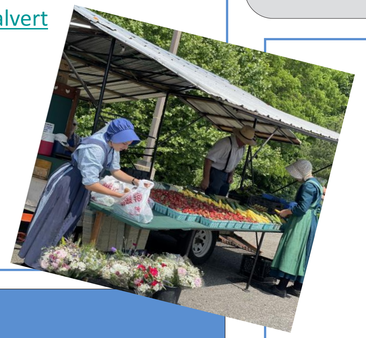
MONEY MATCHING AT THE FARMERS MARKET

Mary Golway, MSN, RN, NPD-BC & Erin Farley, MSN, RN
CalvertHealth Medical Center

LEAD Collaborative

About Us

- CalvertHealth Medical Center is an 80-bed hospital where it serves the residents of Calvert County, located in the heart of Southern Maryland.
- CalvertHealth has grown exponentially since it first opened its doors in 1919 – now it is the largest private employer in Calvert County.
- The mission of CalvertHealth Medical Center is to provide Southern Maryland residents with safe, high quality health care and promotes wellness for a healthy community.
- *HealthyCalvert* is a collaborative in Calvert County, MD that works to create an environment of health and well being for our community. Healthy Calvert



Our Why

- CalvertHealth believes in moving more and eating right, and in providing our at-risk families with access to locally sourced healthy food options.
- The Medical Center hosts a weekly farmers market, which participates in the Maryland Market Money match program – a dollar for dollar match for purchases at the market. We realized money market matching was being under-utilized, so we wanted to increase utilization to help improve access to healthy foods.

Aim Statement

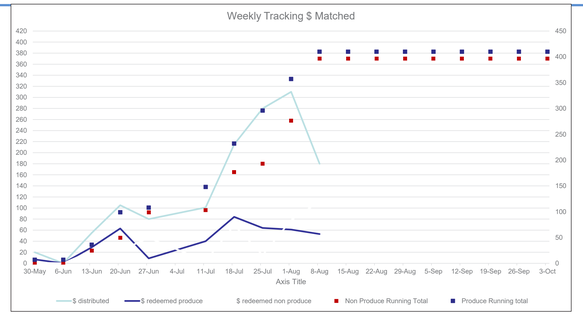
By October 31, 2023, there will be a 25 % increase over last year in matching dollars for families who participate in the Supplemental Nutrition Assistance Program (SNAP) at the Medical Center's Farmers Market.

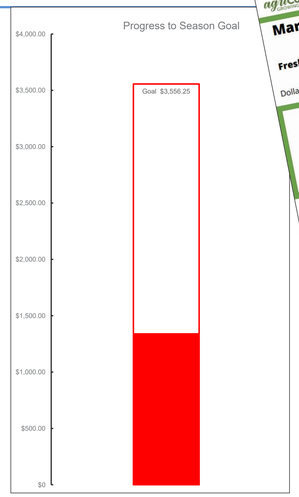
A survey done in 2021 revealed a food insecurity rate of 7.2%. within Calvert County.

Key Interventions and Tests of Change

1. Meet with stakeholders to establish intent, realistic metrics, and marketing focus for 2023.
2. Create marketing & outreach plan
3. Starting with 2023 market season (April-October) monitor weekly participation in MMM program.
4. Adjust marketing and outreach plan as needed during marketing season.

Data





Lessons Learned and Summary

- Because MMM funds are shared between 4 market locations, it was difficult to drill down to actual metrics from CHMC location only
- Original totals from end of 2022 season were not correct, so for first few weeks of tracking, we appeared to be meeting goal, but with readjusted targets, we are lagging.
- Program is grant funded, and some of the money was released later than anticipated.
- Analyze trends in WIC and Senior distribution.

Next Steps

- Adjust marketing/outreach to include expanded social media, outreach to community partners, and communication to case managers/community health workers
- Continue to monitor and track participation

LEAD Best Practice Presentation

Mwalui, A, PhD, MPH, CWP, Ferdinand, D, MPH & King, S.

Community Engagement & Consultation Group INC

COMMUNITY ENGAGEMENT & Consultation Group Inc.

LEAD Collaborative

Meritus Health

About Us

Ce-Cg is a non-profit organization that was established in 2017 with the purpose of promoting positive change one community at a time. **Our mission** is to bridge gaps and create workable solutions toward health equity with the **vision** to be a trusted leader in underrepresented communities and improve access to essential resources.

Organization Size
12-member board of directors, five executive committee members, and five competitive advantage committee members

The population we serve with collaborative work in Capital Region Washington D.C. Metropolitan (DMV)
- Montgomery County
- Prince George's County
- Frederick County
- Howard County
- LEP (Limited English Proficiency)
- Racial, Minority, Ethnic & Cultural Sub-groups
- Immigrant Communities

We offer services with referrals to access to healthcare, food, and employment assistance, professional development training, coaching and mentoring, community health education and disease prevention, and clothing

Our Why

We aim to foster positive change, address specific cultural needs, and support community efforts that bring about progress and solutions for the betterment of every individual we touch. CE-CG provides high-quality resources and opportunities to reach community-specific goals using an upstream agenda to improve health outcomes.
With forward thinking, we work collaboratively with higher ED. to address the public health workforce shortage via **Emerging Public Health Workforce (EPHW)**

Aim Statement

By July 2023, increase minority student intake into the EPHW initiative by 25% from 11% to be trained alongside professionals in the field and ensure employment placement in the specific areas of need.

Key Interventions and Tests of Change

Key Interventions: Margins of Public Health Workforce & WEE Program

Margins of Public Health Workforce
- Add 73 public health workforce entry-level positions to areas identified as limited English proficiency in the capital region as health enterprise zones by December 2025.

PDSA
P: Public health (student interns) will have opportunities to use skill sets to create effective health programs, attend program meetings, and learn how assessments are done
D: Students interns will work alongside program managers to understand data collection and data reporting
S: Using the Train-the-trainer approach of mentoring student interns for the next public health workforce pipeline
A: The biggest takeaway is diversity in the public health workforce is crucial in improving community health outcomes.

WEE Program
1.AWS
2.IT Help Support Specialist
3.English Conversation Classes

Expectations of Program
1.Individual Professional Development Plan (IPDP) using SMART goals
2.Employability Skills Training (30 hours)
3.Resume
4.Mock interview workshop & Attend 2 Career Fairs

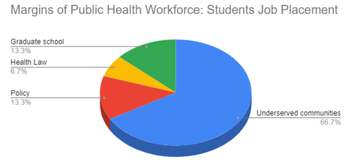
Data

Results

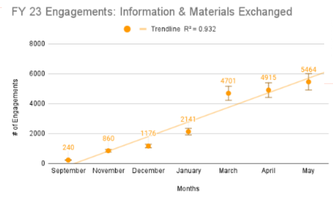
Margins of Public Health Workforce

18 students
75% of 18 students (15) did: in-person internships with us

15 students Job placement after completion of the internship
10- Underserved communities
2- Policy
1- Health law
2- Graduate school



WEE Program
1. As of May 2023, we have h
   Engagements which exceeded our community engagement goal (Encounter: 2000 and Engagement: 250)
2. As of May 2023, we have connected 207 learners to employment opportunities (Goal: 200)



Lessons Learned and Summary

- July-September Cohort (IT Training): 17 enrolled students
- English Conversation Classes will start soon
- Data interpretation, strategic planning, and cultural competency are critical in identifying barriers to accessing services
- Having a diverse workforce provides different perspectives in tackling community health concerns and increases cultural humility. Additionally, concordant relationships have increased accessibility to services and community trust

Next Steps

- Sustainability (New grant): WAR: Workforce Training Employment Assistance & Retention Program: FY 24
- Students from the Health Navigator program at Prince George's County Community College, Purdue University, Liberty University, Northeastern University, Towson University, University of Maryland (UMD) ,– a new partner- will be interning in September 2023
- New collaborative partnership with Black Physician Health Network

Food Insecurity/SDOH Interventions in Columbia, MD

Aya Shuman

Executive Director, The Institute for EDI/ Chase Brexton Health Care

The Institute for Equity, Diversity, & Inclusion
A Chase Brexton Health Care Center of Excellence

LEAD Collaborative
Meritus Health

About Us

- Founded in 1978 in Baltimore City's Mt. Vernon neighborhood, Chase Brexton began as a volunteer-based LGBT health clinic. In response to the HIV/AIDS epidemic during the early 1980's, Chase Brexton became one of the first clinics to offer medical care and support services to individuals living with HIV/AIDS.

- As the years progressed, Chase Brexton continued to expand its services to meet the healthcare needs of underserved populations in the surrounding communities.
- Chase Brexton currently operates 5 practice sites across 5 counties in Maryland, providing services to over 41,000 Maryland residents during calendar year 2022.

Our Why

Mission Statement: To provide compassionate and integrated high quality health care that honors diversity, addresses health inequities, and advances wellness in the communities we serve.

- Chase Brexton joined the LEAD Collaborative to explore innovative approaches to addressing EDI within our organization and the greater Chase Brexton community.

Aim Statement

- By December 2023, develop a system that assesses patient SDOH indicators and align 30% of our Columbia site patients (at or below the federal poverty level and beyond/that identify as food insecure), with our internal food pantry services and other applicable resources.

Key Interventions and Tests of Change

- Opened food pantries in 2 of our locations, with plans to expand to 4 locations.
- Formed an internal cross-departmental workgroup to drive the work forward, develop workflow processes, arrive at best practices, etc.
- Decided to use the Accountable Health Communities (AHC) screening tool across all Centers.
- We are in the process of building the AHC screening tool into our EMR and a patient-facing website.

Data

- **Columbia Center patients using the food pantry in 2023:**

Jan: N=28, Feb: N=33, March: N=20, Apr: N=31, May: N=43, Jun: N=45, Jul: N=40

- **Percentage of Columbia Center diabetic patients using the food pantry in 2023:**

Jan: 100% (N=28), Feb: 91% (N=30), March: 100% (N=20), Apr: 90% (N=28), May: 95% (N=41), Jun: 67% (N=30), Jul: 60% (N=24)

- **Total number of Columbia Center patients using the food pantry, over the total number of Columbia Center patients served across all service lines:**

2023	Distinct Pantry Patients Count	Distinct Patients Served Count	Percent
Jan	28	3012	0.93%
Feb	33	2643	1.25%
Mar	20	3540	0.56%
Apr	31	2985	1.04%
May	43	3390	1.27%
Jun	45	3183	1.41%

Lessons Learned and Summary

- Extensive background work was needed to arrive at a standardized SDOH data gathering process, to lay the foundation for the work to take place.
- Faced constraints due to team bandwidth/staffing challenges.
- The need for greater cross-departmental collaboration and the importance of utilizing champions across the organization to help support the work. We work closely with our Chief Operating/Quality Officer and our Chief Marketing Officer.
- Stretch goals are great but can be daunting when overly ambitious.
- Food pantry data at one site may not paint a true picture of increased utilization of pantry services across the organization.

Next Steps

- Establish ongoing data collection cadence.
- Explore ways to address recent food pantry staffing shortages.
- Explore barriers to organization-wide use of AHC screening tool.

Health Equity in Underserved Community

Erlene Washington, Lisa Walker, Ericka Easley, Wayman Scott
GBMC HealthCare, Inc.

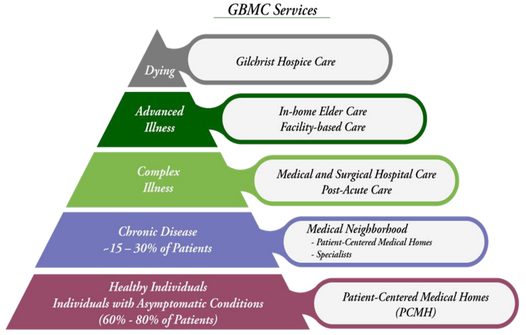
LEAD Collaborative

Meritus Health

About Us

- GBMC HealthCare is a community-based system of care including Greater Baltimore Medical Center, GBMC HealthPartners, our provider group and Gilchrist, a complete elder care company.
- The system cares for approximately 83,000 covered lives within Baltimore County and City.

Approach to Caring for a Population of Patients



Our Why

- To every patient, every time, we will provide the care would want for our own loved ones.
- GBMC is committed to accelerating the addressing of healthcare disparities, social determinants of health and leadership diversity.

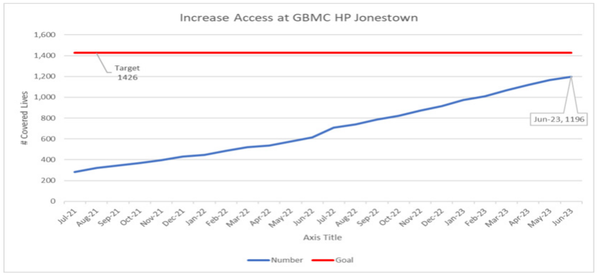
Aim Statement

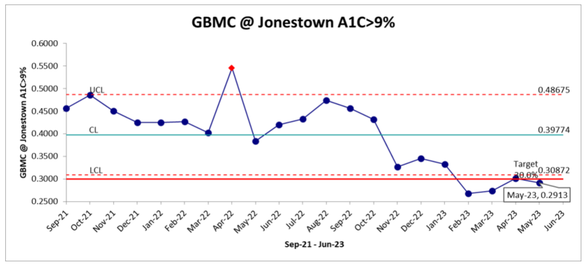
- Improve health equity in underserved communities by increasing access and addressing chronic diseases such as diabetes, hypertension and obesity

Key Interventions and Tests of Change

- Provide equitable access to healthcare
- Reduce food insecurity
- Remove transportation barriers
- Address housing instability

Data





Lessons Learned and Summary

- Identify driver changes early
  - Create materials that describe the services
  - Engage the community through focus groups to determine barriers
  - Increase relationships with city-based community, governmental and faith leaders
  - Be active in the community and show up

Next Steps

- Continue to be active within the community by working with community partners
- Continue to enlist patients using on the spot technology
- Foster relationships with community influencers

Holy Cross Health Career Pathways Program

Monika Driver, Melissa Fernandez, Kimberley McBride

HOLY CROSS HEALTH
A Member of Trinity Health

LEAD Collaborative
Meritus Health

About Us

- Holy Cross Health, founded in 1963, is a Catholic, not-for-profit health system that serves more than 160,000 individuals each year from Maryland's two largest majority minority counties — Montgomery and Prince George's counties.
- Holy Cross Health operates 2 hospitals, 3 health centers, and 3 primary care sites across the region.
- Holy Cross Health is made of more than 3,000 employees, 2,069 community-based physicians, and 167 volunteers.
- During the last five fiscal years, Holy Cross Health has provided more than $287 million in community benefit, including more than $174 million in financial assistance.
- Known as the “baby hospital” Holy Cross Health averages over 10,000 births each year.

Our Why

- As Holy Cross Health launched initiatives targeting workforce development and income inequality for our colleagues as well as the community, we welcomed the opportunity to join the LEAD collaborative – a collaborative of like-minded organizations who strive to reduce health disparities by addressing social determinants of health, such as income inequality.

Aim Statement

- By December 31, 2023, improve income inequality for 75% of participants in the HCH Career Pathways Program
  - 50% of the Pathways colleagues are over the age of 40, and 31% of those are over the age of 50.

Key Interventions and Tests of Change

- By offering departmental shadowing to prospective colleagues, they were able to gain hands on knowledge of the chosen career pathway to better understand the field.
- The use of a designated CHW for this program has offered the colleagues a point person who they can work with collaboratively. The colleagues have someone they can reach out to directly with concerns or issues, and the CHW can serve as a go between for the colleagues and the Pathways team.
- The development and release of an evaluation mid-way through the colleagues coursework provided additional feedback on how the colleagues were progressing through their program of study.
- By this program operating as a collaborative between Community Health and Human Resources, measures have been created to insure Pathways colleagues receive an increase in income to address income inequality. Upon completion, tests will be ran to determine the percentage of income increases being offered.
- Collaborating with Maryland Physicians Care (MPC), in addition to Montgomery College and Anne Arundel Community College has strengthened the program's ability to provide training and support to our colleagues.

Data

Job Title	Pay Range-Midpoint	Position Starting Pay	Position Average Pay	New Pay%
Certified Nursing Assistant	$18.33	$16.50	$19.49	Pending new placement
Certified Pharmacy Tech	$22.40	$18.00	$24.03	TBD - Certification not complete
Certified Medical Assistant	$19.44	$17.00	$20.09	(1) 3.32% increase (2) 0.0% increase*
Central Sterile Processing Tech	$19.44	$17.00	$20.91	TBD – Certification not complete

- In some cases, the initial increase may be small (or zero) but with their new skill set/certification/training/etc. they will have additional opportunity in the future that they may not have otherwise had. (wage and career growth)

Lessons Learned and Summary

- Lesson learned – insuring the program steps from application to enrollment to coursework to certification to employment are clear to colleagues and their managers.
- Lesson learned – insuring hiring managers have outlined what they are looking for in a new colleague, as well as how many they are looking to accept.
- To date: (2) CMA colleagues have received their certification and placed into new positions as of 8/1/23; (1) CNA colleague has received his certification and is determining where he would like to be placed; (5) Central Sterile Tech colleagues are completing their 400 hour externship and new position codes have been created for them; (8) Pharmacy Tech colleagues have completed their coursework, however only 2 have taken the exam. Barriers include time to study and difficulty of the exam; the Director of Pharmacy has offered tutoring to assist.
- Cohort 2 will launch in Spring 2024; planning and timelines are being established now to begin intake in Fall 2023.

Next Steps

- Working with CNA colleague on placement, providing support to Central Sterile colleagues will complete externship by mid-August, assisting Pharmacy Tech colleagues on their certification exam
- Cohort 2 – Phase I: nomination and selection will begin in September 2023; promotional materials and information sessions will take place in August/Sept 2023.
- Program planning for a joint kickoff event for new colleagues in conjunction with a graduation event for Cohort 1 colleagues.

Health Services Cost Review Commission (HSCRC)

Princess Collins, MSPH
Alyson Schuster, PhD

LEAD Collaborative
Meritus Health

About Us

- The HSCRC is an independent state agency responsible for regulating the quality and cost of hospital services in Maryland
- Since 2014, MD has had a waiver from CMS to adopt new and innovative policies under the All-Payer Model, and, later, the Total Cost of Care (TCOC) Model
- Under model, HSCRC sets hospitals global budgets and adjusts those budgets based on factors such as the quality of care provided
- MD is exempt from CMS pay-for-performance quality programs but must have equivalent all-payer hospital quality programs
- HSCRCs all-payer system serves all Marylanders

Our Why

- A goal of the Commission is to ensure that ALL Marylanders receive high-quality, low-cost care
- Health disparities are expensive and negatively impact patient experience and healthcare outcomes

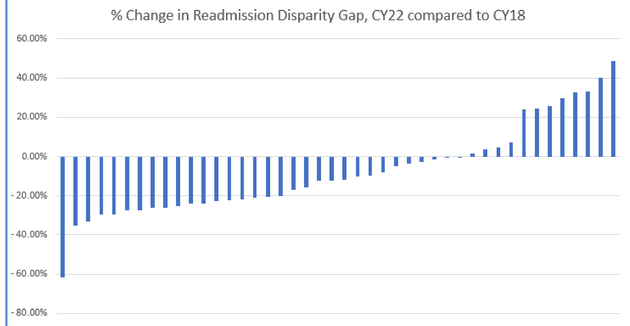
Aim Statement

- By the end of 2023, include two or more disparity measures in our pay-for-performance quality programs.
- By the end of 2026, 50% of MD hospitals will see at least a 50% reduction in disparities.

Key Interventions and Tests of Change

- Evaluation and monitoring of pay-for-performance incentive to reduce within hospital readmission disparities
- Applying different ways to visualize disparities for other quality measures
- Applying readmission gap methodology of measuring disparities to other quality measures
- Meeting with hospitals to ensure they understand the methodology of our disparity measures

Data



- 32 out of 46 hospitals have experienced reductions in the readmissions disparity gap when comparing CY 2022 to CY 2018

Lessons Learned and Summary

- Hospitals need underlying data relevant to our disparity measures to implement interventions that address disparities in care
- Stakeholders should be provided with multiple ways to visualize disparities in care
- Advancing health equity is important component of the TCOC model. Maryland has a unique opportunity to develop pay-for-performance incentives specifically for reducing disparities in healthcare outcomes. Currently the Commission has approved a payment incentive to reduce within-hospital disparities. We are working with contractors to apply our disparity gap methodology to two additional measures (Timely Follow-Up and Prevention Quality Indicators); we are planning to implement the Timely Follow-Up disparity measure into payment for CY 2024

Next Steps

- Continue to stratify measures by demographic factors to identify disparities
- Add sexual orientation and gender identity data to the data submission requirements
- Continue to create and evaluate financial incentives for hospitals to address disparities

Advancing Access and Equity for New Jerseyans During Their Life Course: Bringing Health Clinics to Underserved Older Adults

Carol Silver Elliott, Aryeh Markowitz and Ezra HaLevi
Jewish Home Family, Rockleigh & River Vale, New Jersey

The Jewish Home Family
Advancing the Art of Living.

LEAD Collaborative
Meritus Health

About Us

- Jewish Home Family is a continuum of services for older adults located in northern Bergen County, New Jersey.
- Entities include the Jewish Home at Rockleigh, Jewish Home Assisted Living, Jewish Home at Home and Jewish Home Foundation.
- Proud home of SeniorHaven, the only elder abuse shelter in New Jersey. Specialty programs include subacute rehabilitation, memory care and a nationally recognized program for the care of those with Parkinson's Disease.

Our Why

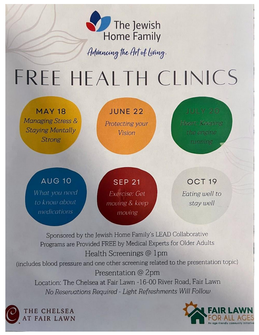
For more than a century, we have been focused on proactively meeting the health needs of older adults in our community. We know that the demographic shift of aging baby boomers will also change the way we provide care, with more being provided in the community. Our goal is to be a positive force through this change. Supporting people as they age in the community means supporting their well-being through outreach services and education. It also means reaching out to elders, rather than waiting for them to come to us.

Aim Statement

- Through increased partnerships and other methods, by Oct. 2023 increase access to mental health services, outpatient rehabilitation services and senior living services by 20% for people older than 50.
- To serve a greater proportion of our population and help them to stay well and strong while also connecting them to appropriate additional services as necessary.

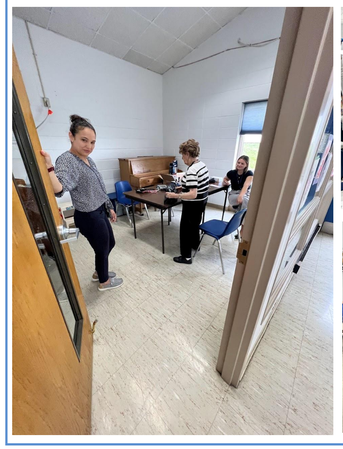
Key Interventions and Tests of Change

- We reached out to the Age Friendly Communities organization that is strong in our service area. The Fair Lawn Age Friendly coordinator was very interested in working with us.
- We developed a six session educational program that covers the body's major systems and we coupled each program with screenings. The intervention areas are:
  - Managing Stress and Staying Mentally Strong
  - Protecting your Vision
  - Heart: Keeping the Engine Running
  - What do you Need to Know about Medications?
  - Exercise: Get Moving and Keep Moving
  - Eating Well to Stay Well
- We also developed a social determinants questionnaire to be used in conversation with attendees, to get a sense of any issues that might put them at risk.



Data

- We have conducted four programs for LEAD. Our topics have included heart health, vision, managing medications and managing stress. Screenings have included blood pressure at each session, cholesterol and glaucoma. All the screenings have been well attended and well received and we have made referrals for follow up as indicated. Our participants have varied based on location of program. Unfortunately, we have not always been able to use the same facility for the program.
- We have had 75 participants and some of these attended multiple sessions.



Lessons Learned and Summary

- One thing we would consider for future sessions is to charge a minimal fee for the sessions. We think that would increase the likelihood of repeat attendance and consistency.
- We would also want a commitment to a consistent location and schedule, which has been difficult to arrange.
- We also learned that it is difficult to ask social determinants questions and a different way of approaching that topic needs to be developed.

Next Steps

- Refine program offerings
- Offer to different communities
- Develop second year program for Fair Lawn Senior Center

Kessler INSTITUTE FOR REHABILITATION
A Select Medical Hospital

Advancing Access and Equity for New Jerseyans During Their Life Course: Providing Lymphedema Devices/Garments to the Underserved

Amy Kalb, PT, MS | Sam Bayoumy, PT, MBA | Monifa Brooks, MD

LEAD Collaborative

Meritus Health

About Us

- Kessler Rehabilitation Center, the outpatient division of Kessler Institute for Rehabilitation, provides physical, occupational, hand and speech therapy at more than 100 locations throughout NJ
- We have 600+ employees
- Our target population is men, women and children of all ages, suffering from functional limitations due to disease process, post procedural issues, pain, or aging
- KRC and KIR OP centers sees 45,000 patients per year
- Kessler was founded in 1948 by Dr. Henry Kessler, in West Orange, NJ

Our Why

- Kessler and its parent company, Select Medical, share this mission statement:
- ***Select Medical will provide an exceptional patient care experience that promotes healing and recovery in a compassionate environment***
- Kessler became involved in the LEAD collaborative when we became aware of issues facing cancer patients who could not obtain custom compression garments for lymphedema either due to insurance restrictions or cost

Aim Statement

- Through increased partnerships and other methods, by Oct. 2023 increase access to mental health services, outpatient rehabilitation services and senior living services by 20% for people older than 50

Key Interventions and Tests of Change

- Canvassed Kessler's lymphedema therapists to determine the scope of the need
- Contacted multiple compression garment distributors-many conversations on why they are unable to provide garments to patients
- Contacted and discovered insurance companies have limitations/ restrictions on providing custom garments
- Found our greatest ally in the National Lymphedema Network
- Convinced stakeholders in Kessler Rehabilitation and Kessler Institute of Rehabilitation to pay for two group memberships in the National Lymphedema Network

Data

- The National Lymphedema Network provides garments to approximately 450 patients per year
- Kessler's goal is to provide garments to 30 patients per year.
- Research supports use of compression garments in reduction of lymphedema and enhancement of quality of life (Nadal Castells et.al, Johnsons et.al, Pappas et. Al)





Lessons Learned and Summary

- Research on deniable specific health care needs takes time!
- It takes a village to raise awareness
- We don't know what we don't know
- Commitment and persistence is key when attempting to institute change – PPO- Persistence Pays Off
- Engage as many allies as you can

Next Steps

- Evaluate effectiveness and sustainability of program
- Evaluate opportunities to expand within our system of care across the nation.
- Foster collaboration with Medicaid managed care plan to address access barriers for their enrollees

NTSV C-Section Disparity Rate

Charlene Harrison, MHA, Monica Jones, MD & Judy Thomas, MBA
Luminis Health

LEAD Collaborative

Meritus Health

About Us

- Luminis Health is a nonprofit regional health system formed in July 2019 to build a brighter, healthier future for our region by expanding Anne Arundel Health System with the addition of when Doctors Community Medical Center
- We have 100+ affiliated care sites, providing care for 1.8 million people in Anne Arundel and Prince George's Counties, the Eastern Shore and beyond.
- "Luminis" represents our commitment to being a beacon of hope and healing for our communities.
- Luminis Health also contributes close to $100 million annually in community benefit.

Our Why

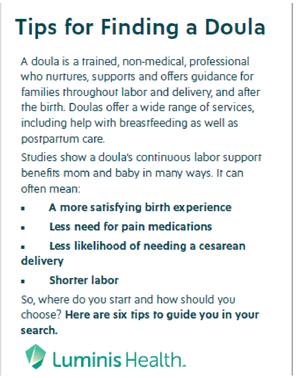
Luminis Health's mission is to enhance the health of the people and communities we serve. Our vision is living healthier together. Several years ago, we embarked on our JEDI (Justice, Equity, Diversity & Inclusion) journey; and in 2020, formed a Health Equity & Anti-Racism Task Force to advance this work. The LEAD Collaborative is directly aligned with our focus on reducing racial and ethnic disparities and addressing social determinants of health. As healthcare leaders, we want to take action on these issues and create healthier communities around us.

Aim Statement

- By November 1, 2023, reduce the disparity in NTSV C-Section rates between non-Hispanic White and Black/African American patients from 7% (current baseline) to 5%.

Key Interventions and Tests of Change

- Publication of NTSV C-Section rates by race by individual provider
- MD MOM Implicit Bias training – nursing and provider education
- Analysis of our Doula grant demonstrated that African American patients were 35% more likely to have a vaginal birth with a doula compared to without
- PDSA: At the first trimester OB visit, the clinical team will educate and introduce patients to Doula services to include utilization of Epic smart phrase and patient handout



Tips for Finding a Doula

A doula is a trained, non-medical, professional who nurtures, supports and offers guidance for families throughout labor and delivery, and after the birth. Doulas offer a wide range of services, including help with breastfeeding as well as postpartum care.

Studies show a doula's continuous labor support benefits mom and baby in many ways. It can often mean:

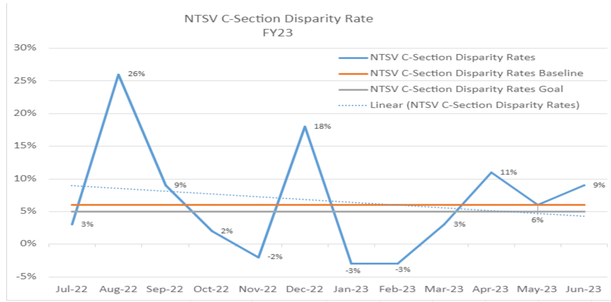
- **A more satisfying birth experience**
- **Less need for pain medications**
- **Less likelihood of needing a cesarean delivery**
- **Shorter labor**

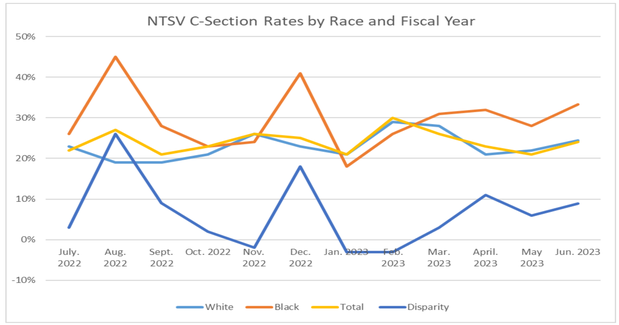
So, where do you start and how should you choose? **Here are six tips to guide you in your search.**

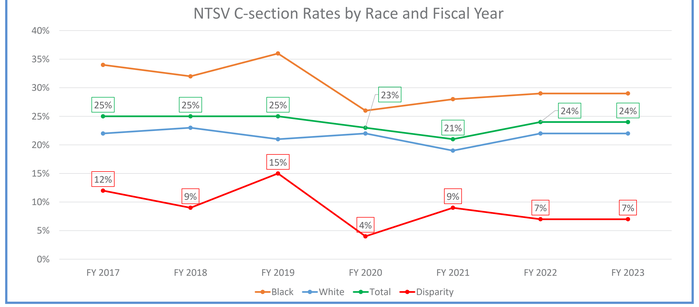
Luminis Health.

- Launched Centering Pregnancy (group prenatal care)

Data







Lessons Learned and Summary

- Publication of NTSV C-Section rates facilitated conversation among care team providers & aided in advancing the focus on this topic
- Standard work implemented to ensure all patients receive education on doula supported births
- Engagement with doula providers was critical in this process and they were invited to attend patient education classes offered at the hospital
- Patient education material was developed to provide tips on how to find the right doula for you
- Centering Pregnancy was launched to overwhelmingly positive patient feedback

Next Steps

- Continue to provide education to patients on the benefits of Doula supports births
- Champion for funding for doulas services so that patients whose insurance does not cover the service have access to this benefit
- Centering Pregnancy: continue to expand our locations where this service is offered. Review outcomes data as cohorts conclude.

Reducing Racial Disparities in Total Joint Replacement Outcomes

Kevin Crowley MS PT MBA, Steffanie Dolle RN
Justin Turcotte PhD MBA, Paul King MD,
Luminis Health

LEAD Collaborative

Meritus Health

About Us

- Luminis Health is a nonprofit regional health system formed in July 2019 to build a brighter, healthier future for our region by expanding Anne Arundel Health System with the addition of when Doctors Community Medical Center
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Aim Statement

- By 11/23/23, track and reduce the disparity in total joint patient (TJR) outcomes between non-Hispanic white and Black/African American by 50% by measuring hospital length of stay (LOS)

Key Interventions and Tests of Change

Enhanced Preoperative Education Pathways (EPrEP)

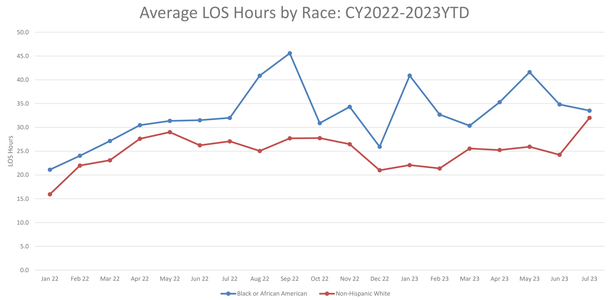
- Standardized preoperative risk assessment for all TJR patients – comorbidities, psychosocial, socioeconomic risk factors
- Minority patients and those with multiple risk factors receive one to one counseling with nurse navigator; all patients receive group preoperative education and written materials
- 1:1 counseling: comorbidity management, connection to community resources, coordination of medical clearance/PAT, 3-5 day postop check-in

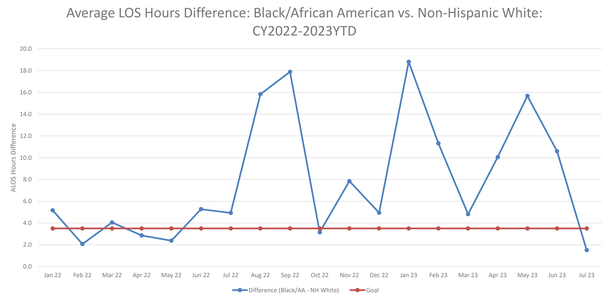
Additional LOS Interventions:

- Expansion of total joint replacement rapid recovery protocol to LH Doctors Community Medical Center
- 50% increase in ASC-based TJR to facilitate same day discharge outside of the hospital
- Prioritization of patients on discharge day through standardized rounding
- Utilization of bedside dispensing to provide patients w/ medications prior to discharge

Data

- Baseline (CY2022) ALOS hours:
  Black/African American: 32
  Non-Hispanic White: 25
  Difference: 7
  Goal Difference (50% reduction): 3.5





Lessons Learned and Summary

- Providing high risk and minority patients with additional education and access to institutional resources such as nurse navigators has been effective at reducing disparities in LOS, non-home discharge rates, 30-day ED returns and readmissions in comparison to institutional historical benchmarks
- While standardized process improvements (e.g. Discharge rounding and bedside dispense) have improved LOS overall, they do not appear to mitigate disparities given their universal application
- Additional interventions targeting Black and African American patients specifically are warranted to reduce remaining LOS disparities

Next Steps

- Grant funding secured from AARP/RWJ for expansion of the EPrEP program to LH Doctor's Community Medical Center
- Follow up study of LOS disparities to identify potential root causes and modify protocols to address contributing factors

Reducing Diabetes Disparity

Lynnae Messner, Kristie Carbaugh, Allen Twigg, Ethan Feldmiller, Maulik Joshi
Meritus Health

LEAD Collaborative

About Us

- Meritus Health serves over 200,000 residents of the tristate region, with nearly 3,000 employees, 500 medical staff members and 250 volunteers.
- Meritus Medical Center, the flagship facility of the health system, has more than 327 beds and is a Joint Commission accredited hospital. Meritus Medical Center has officially become a teaching hospital, serving as a clinical training site for the Meritus Family Medicine Residency Program, as well as for more than 1,000 nursing and allied health students annually.
- Meritus Health also includes Meritus Medical Group (MMG), a network of 20 medical practices with more than 100 providers; Meritus Home Health; and Meritus Equipped for Life, a medical equipment company.
- Meritus Health is a 25% owner of Maryland Physicians Care, a 215,000 Medicaid member health plan.

Our Why

- To work together to meaningfully reduce health disparities and advance health equity.

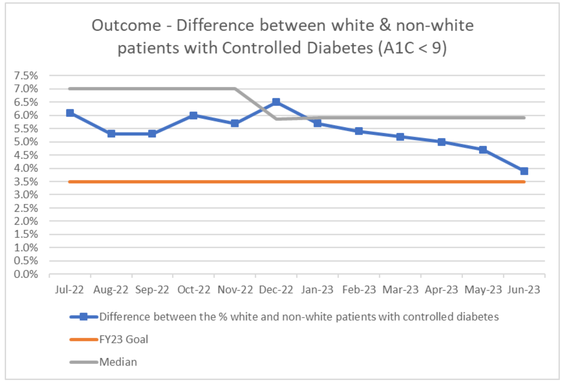
Aim Statement

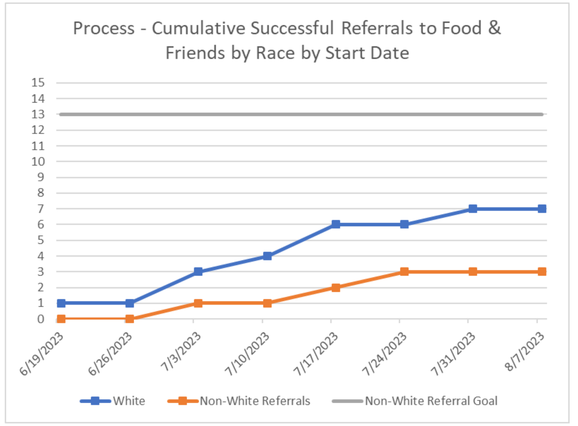
- By June 30, 2023, reduce the disparity between white and non-white patients for well controlled hA1c (<9) by 50% from 7% disparity to 3.5% disparity.

Key Interventions and Tests of Change

- Multi-disciplinary initiatives for A1C collection
  - Point of Care Testing process in the MMG practices
    - Added POC to appointment note for reminder in office
  - Lab reminder calls to patients before lab orders expire
  - Placing new orders for if there is no order for A1C and date of last A1C is greater than 1 year
- Centralized referral process for Diabetes Education to connect patients to right service at the right time
  - Wrap around services MTM, MNT, SDOH Connections
- Conduct Qualitative Interviews with non-white patients with last A1C > 9 to better understand barriers such as SDOH needs, overall health, and grocery shopping locations
- Improve Diabetes Education coverage at Walnut St from 1 day EOW to 2-3 days each week
- Refer 13 non-white patients living in 21740 and 21742 with Type 2 Diabetes, A1C > 8, & Food Insecurity to Food & Friends for home delivered meals or groceries

Data





Lessons Learned and Summary

- Multidisciplinary approach and alignment is important for reducing care gaps
- Qualitative Interviews identified SDOH needs relating to food insecurity and other financial insecurities. Also identified potential partnership with area grocery stores. Personal accountability on choosing healthy food and habits was identified as a barrier to A1C control
- Increasing Diabetes Education presence at the Walnut St. Clinic has increase A1C control within the clinic.
- Community partnership collaborative provide opportunity to reach patients where they are and bridge barriers

Next Steps

- Continue to refer to Food & Friends with primary focus on non-white patients
- Identify similar processes for patients who do not meet the zip code criteria for Food & Friends
- Increase Diabetes Education caseloads for non-white patients to match the community we serve

Meritus Health: Leadership Diversity

Scott Salzetti, VP of Team Member Services

LEAD Collaborative

About Us

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- Meritus Medical Center, the flagship facility of the health system, has more than 327 beds and is a Joint Commission accredited hospital. Meritus Medical Center has officially become a teaching hospital, serving as a clinical training site for the Meritus Family Medicine Residency Program, as well as for more than 1,000 nursing and allied health students annually.
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Our Why

- To work together to meaningfully reduce health disparities and advance health equity.

Aim Statement

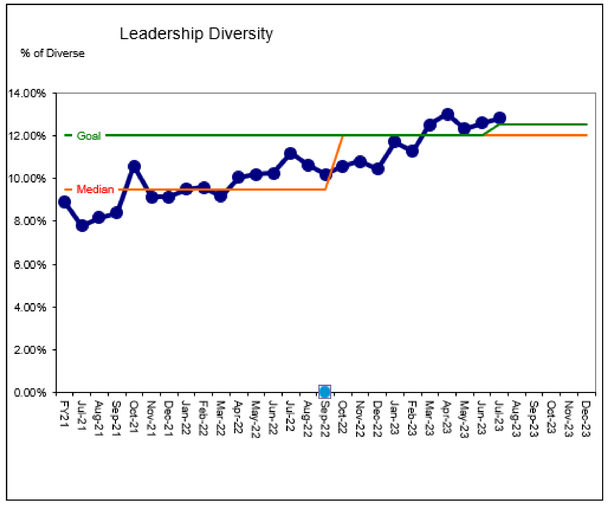
- By September 30, 2023, increase the total number of racially/ethnically diverse (self-disclosed) supervisor and above from 10.1% to 12.5%.

Key Interventions and Tests of Change

- Evaluation of local demographics and trends (ethnicity, education) verses internal composition of workforce
- Evaluate source of disparity in hiring diverse applicants thorough review of applicant tracking data, meetings with recruitment team.
- Development of staffing plan to increase outreach to underrepresented groups and to solicit feedback from key stakeholders.
- Evaluation of new candidate pipeline for diverse applicants – job boards, social media, alumni groups, HBCUs
- Evaluation of job description qualifications and revisions to job postings.
- Leveraging Employee Resource Groups to generate additional avenues for attracting diverse applicants
- Evaluation of turnover and staff level hiring of diverse candidates.
- Revisit of diversity job boards to evaluate volumes and positions.
- Partnering with organizations that support international hiring.

Data

- Between July 2021 and July 2023, the percentage of racially/ethnically diverse leaders has increased from 7.8% to 12.81% with 2.62% increase since September 2022.



Lessons Learned and Summary

- Understanding the recruitment market and local demographics was key to provide a baseline of reasonable expectations.
- Creation of a Diversity Recruitment Plan with a vast array of ideas and approaches was key as many ideas, job boards, and community contacts did not yield anticipated results.
- Partnering with HBCUs continues to be a challenge as we've been directed to several departments but they have been either non-responsive or simply provide job fair dates. A true partnership with these educational institutions is ongoing.
- Although the focus of the AIM statement was on leadership diversity, we've also keyed in on expanding sourcing channels for staff-level positions knowing that the bulk of our leadership roles will be filled from within through career pathing. Significant progress has been made and we look forward to having a more diverse base in the years to come.

Next Steps

- Identify opportunities to make inroads with HBCUs
- Leverage international hiring of RNs and Med Lab Tech's for future leaders in Nursing and the Laboratory.
- Turn our attention to the retention of underrepresented leaders and training of existing team members on unconscious bias and investigating complaints of workplace harassment and discrimination.

Expanding the Care Caller Program

Lynnae Messner, Kristie Carbaugh, Allen Twigg, Ethan Feldmiller, Maulik Joshi
Meritus Health

LEAD Collaborative

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- Meritus Health serves over 200,000 residents of the tristate region, with nearly 3,000 employees, 500 medical staff members and 250 volunteers.
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- Meritus Health is a 25% owner of Maryland Physicians Care, a 215,000 Medicaid member health plan.

Our Why

- To work together to meaningfully reduce health disparities and advance health equity.

Aim Statement

- By June 30, 2023, increase the total number of residents in the Care Caller program from 98 to 500.

Key Interventions and Tests of Change

- Hire 2.0 FTE Care Callers to call 200 participants each week
- Create an easy application process for volunteer care callers to remove barrier of completing unnecessary paperwork
- Share volunteer opportunity internally and externally through newsletters and forums

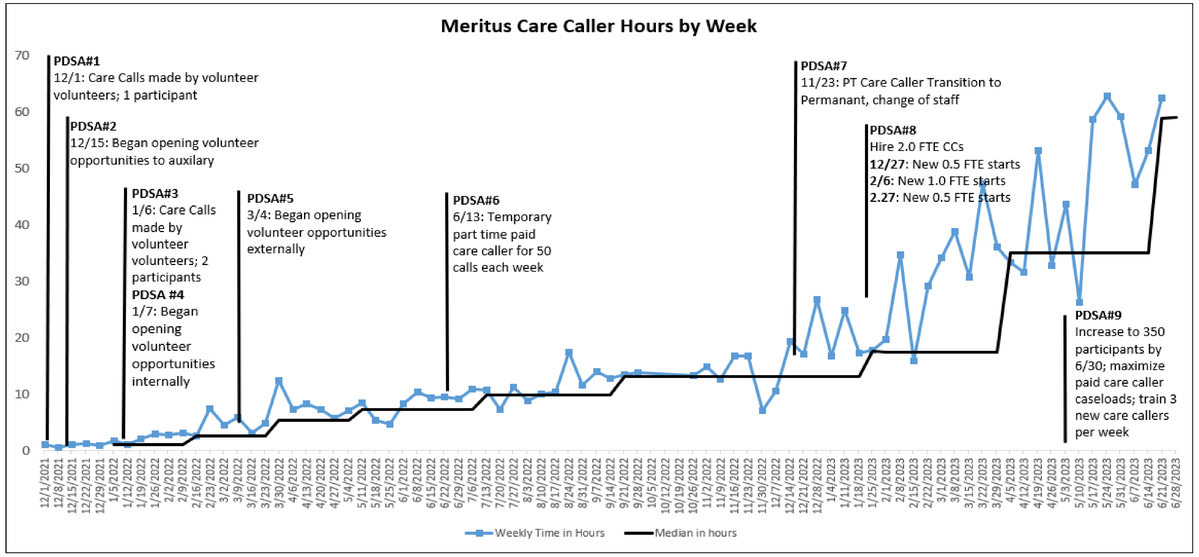
Lessons Learned and Summary

- Reducing the burden of paperwork increased external volunteers
- 2.0 FTE Care Callers are able to call 275+ participants with an average of 3 calls each month to each participant

Next Steps

- Increase volunteers by sharing opportunity in Community Partner newsletters and forums.
- Expand the program to include home visits
- Hold second annual Care Caller Luncheon to increase engagement with participants and volunteers

Data



- 37 volunteers; 2 paid callers
- 354 residents enrolled/called weekly/or their preference
- Over 500 people have been in the program
- Average 18+ minutes a call
- 5,700+ calls; 107,000+ minutes of call since 1/1/22
- **115 out of 121 (95%) say they are less lonely 4 months after start**
- *1 participant is now a volunteer*

MHA Equity Assessment

Brian Sims, Vice President, Quality and Equity; Johnny Tolbert, Director, Association Affairs
Maryland Hospital Association

LEAD Collaborative

About Us

The Maryland Hospital Association (MHA) serves Maryland's hospitals and health systems through collective action to shape policies, practices, financing and performance to advance health care and the health of all Marylanders.

MHA's membership is composed of community, teaching and specialty hospitals and health systems. Allied with the American Hospital Association, MHA is an independent organization headquartered in Elkridge, Maryland.

VISION
MHA will be Maryland's most effective advocate for improving health care across our state and the health of all Marylanders.

MISSION
MHA serves Maryland's hospitals and health systems through collective action to shape policies, practices, financing and performance to advance health care and the health of all Marylanders.

Our Why

The evidence is indisputable: racism—overt, implicit and structural—has had catastrophic consequences impacting health and life expectancy for generations. MHA leans on its mission to dismantle racism and its very real, incapacitating effects. Our AIM statement centers on an approach to improve the policy landscape for the state to prioritize health equity and illuminate blind spots in areas that may contribute to disparities in current policies or practices.

Aim Statement

By March 2024, 75% of policy issues discussed during MHA council meetings and MHA Board of Trustees meetings will include an equity assessment (EA).

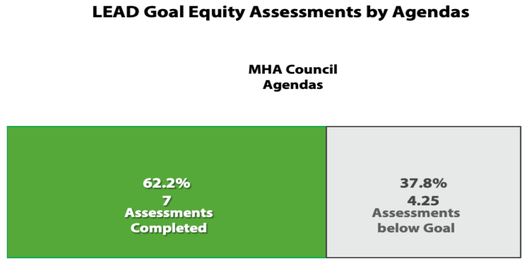
Key Interventions and Tests of Change

Participants: MHA member leaders on selected issues; MHA Staff; contracted health equity consultant: Dr. Nicole Rochester, Your GPS Doc; additional stakeholders as required.

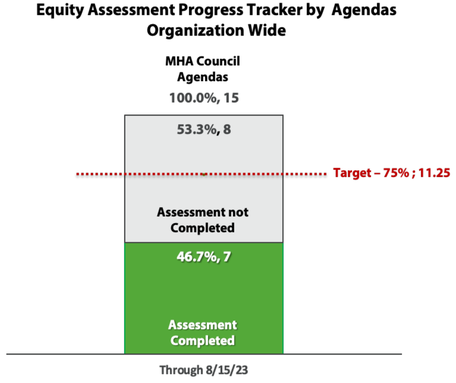
Interventions:
- Established equity policy assessment process
- Piloted approach for test design, implementation, and selection criteria
- Identified key participants for assessments
- Presented LEAD goal and provide education on the equity assessment process to MHA staff
- Created toolkit to guide assessment for facilitators, participants and end-users
- Developed tracking tool to identify agendas and topics

Tests of Change:
The initial phase of this project was heavily focused on developing equity assessment materials and identifying a process to engage internal staff. Through this work, MHA's equity team continuously enhanced and refined the equity policy assessment process, conducting seven assessments on topics engaging all governance councils.

Data



The graph above depicts MHA's current status for the LEAD goal. The graph below represents the number of equity assessments conducted organization-wide inclusive of the LEAD goal. The green bar represents the number of organization-wide assessments. Policies include: Annual Payment Update; Efficiency; ED Wait Times; Readmissions; Cannabis; Liability; MHA FY 24 Board Slate.



Lessons Learned and Summary

- The initial goal was limited to MHA's governance councils; however, issues were identified as appropriate for assessment that may not have been on a council agenda. Thus, we expanded the scope of the policies MHA assesses, engaging other groups and key stakeholders.
- MHA found sending supporting materials in advance was valuable for all participants to help facilitate efficient and productive policy discussions, while minimizing non-productive time.
- Post-survey data collection informs the equity team on whether participants' experiences met expectations and offers insight into how to improve the equity assessment process.
- The equity assessment requires participants to discuss crafting an executive summary and identifying next steps for potential action items.

Next Steps

- Educate the broader field on the recently developed MHA Equity Policy Assessment Toolkit
- Continue to identify opportunities to implement recommendations from equity assessments, improving the policy landscape for the state
- Identify opportunities to influence adoption of the equity policy assessment outside of MHA

Hydroponic Initiative

Jason Rottman, Dr. Lorena de Leon,
Brittany Young, Brooke Grossman, Adam Sewell.
Carsten Ahrens

LEAD Collaborative

About Us

- Maryland Physicians Care (MPC) provides free, quality health care services to Maryland's Health Choice enrollees by extending the full benefits of Medicaid. Our strong network of hospitals, doctors, clinics and pharmacies helps our Members live as healthy as possible through education, support, and quality programs.
- MPC is committed to reducing health disparities and has partnered with Horizon Goodwill and Washington County School to build a hydroponic garden to improve access to fresh produce
- Horizon Goodwill's mission is to remove barriers and create opportunities by helping people achieve their full potential through the dignity and power of work.

Our Why

Maryland Physicians Care and Horizon Goodwill are both committed to helping the people of Maryland live as healthy as possible by providing education, support, quality programs, and health resources.

Based on our analysis and the feedback we have received from MPC members in Western MD, food access remains the highest priority when it comes to social needs

Aim Statement

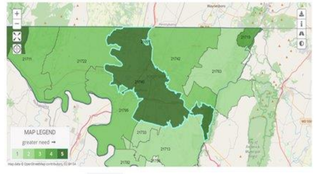
By May 30th, 2024, MPC will complete the second season of Phase I of the hydroponic project and have 50% of the hydroponic crop production ready for distribution and supply to school-based farmers market to improve access to fresh produce for Washington County residents.

Key Interventions and Tests of Change

- MPC is committed to reducing health disparities and has partnered with Horizon Goodwill and Washington County School to build a hydroponic garden to improve access to fresh produce.
- Although Horizon Goodwill is converting half of their warehouse into a "grocery for those in need", access to fresh produce remains a challenge due to hurdles such as storage, distribution, and year-round access
- MPC has provided initial funding for school-based program for 6 shelving systems (72 planting site + 85 seedling sites) & 2 towers (80 planting sites each). A total of 510 seedling + 592 planting site
- Reduce the obesity rate while improving access to nutritious food and reduce diabetes.

Data

- Hagerstown has the highest rate of food insecurity across Washington county.
- 12% of the Washington Co population is living below the poverty line with children under 6 accounting for over 21% of the poverty rate among all age groups
- There are over 3100 MPC members living in the heart of the Hagerstown's food desert with limited food source options especially healthy fresh option



- The hydroponic summer pilot yield crops in 3.5 weeks. Making it both resourceful and efficient.
- A fraction of the growth systems were used for the pilot to gain a better understanding of the growth rate. That portion yielded: 18 romaine heads, 15 softball head lettuce, 1 cilantro plant, and 3 spinach plants.

Lessons Learned and Summary

- Access to food sources is a significant challenge in Hagerstown and chain grocers have not been willing to enter the Hagerstown market.
- The advantage of these innovative types of farming is that they naturally result in a very high production output per unit area, saving on land and water resources significantly.
- Additionally, producing food in urban environments allows for direct to consumers distribution, decreasing transportation needs and reducing the carbon footprint.

Next Steps

- Stand up all growth systems at Marshall Street Elementary and complete full school year harvest rotations.
- Sell portion of produce at school-based farmer's market
- Secure funding for Phase II to support the grocer and expansion of the project within Goodwill facility

Enhancing Mental Health Coordination at Community-Based Interprofessional Training Sites

Pam Parsons, Jason Hardin, Rachel Regal, Johnathan Bennett, Natalie Mansion, Martha Purvis
Richmond Health and Wellness Program, School of Nursing, Virginia Commonwealth University

LEAD Collaborative

About Us

- The Richmond Health and Wellness Program (RHWP) is a collaborative care coordination model that seeks to:
  - improve health outcomes of communities
  - enhance the lives of older adults and adults with disabilities
  - educate future practitioners through the provision of a health and wellness promotion program led by faculty and interprofessional students in urban community settings.
- Designated as an IHI Age-Friendly Health System
- Over 1400 participants enrolled, with 422 participants served in 2022:
  - 71% Medicaid, 84% Black, 31 % High School or Less, 54% Female
  - **86% of participants are 50 years+**

DOMINION PLACE	CHURCH HILL HOUSE	HIGHLAND PARK	The Rosa	VCU HEALTH HUB
2014	2018	2017	2021	2019
Section 8 senior housing	Section 8 senior housing	Section 8 senior housing	Section 8 senior housing	Community-based, non-residential
247 residents	137 residents	77 residents	77 residents	Serves East End community

Our Why

Mission

To create an environment where health providers engage with community residents to advance their health and well-being through community-based programs and services.

Aim Statement

By October 30th, 2023, we will implement an evidence-based strategy to **assess, educate and successfully connect** 80% of individuals identified with a mental health need to services, for the following:

- **Substance Use, Depression, Anxiety**

Key Interventions and Tests of Change

Overhauled Mental Health Screening

- Eliminate out of date and unused screening tools
- Add validated, tiered NIDA annual substance use screener that includes risk-stratified, evidence-based intervention options (TAPS 1/2)
- Implement tiered universal, evidence-based screening process for anxiety and depression using the PHQ4
  - Eliminated need for further assessment in 42% of cases (13 out of 31 administrations)

Enhanced Mental Health Referrals

- Implemented UniteUS, a closed-system platform for social determinant of health screens and referrals, to facilitate secure connection to available mental health services
- Established partnership with Liberation Church to provide lay mental health coaching onsite at the largest housing community partner

Strengthened Mental Health Education

- Provided staff trainings on substance use screening, as well as mental health assessment and referrals
- Implemented trauma-informed care student training module to facilitate healing interactions around mental health and other concerns

Data

Progress to Aims Statement

Figure 1. Screening rate boosted significantly following mental health screening overhaul.

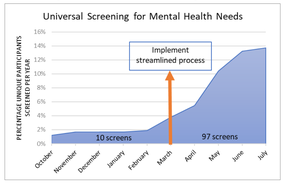
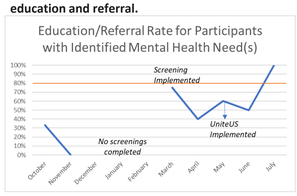


Figure 2. Identifying mental health needs through greater screening facilitated greater delivery of education and referral.



Assessment

39 TAPS substance use screens completed since March 2023.

- 17 (43%) screens were positive for mainly tobacco and/or alcohol use.
- 22 screens were negative, requiring no further follow-up.

Depression and anxiety screen to assessment process needs improvement.

- A little over half of participants are not receiving full assessment when it is indicated (i..e., positive screen, 8 of 14 screens).
- About 20% are receiving a full assessment when it is not indicated (i.e., negative screen, 5 of 25 screens).

Education and Referral

All (100%) of those with an identified substance use need received education and/or referral:

- Referrals were mostly for non-mental health resources such as a holistic provider, housing, or the YMCA.

Most (62%) of those with an identified mental health need received education and/or referral:

- Referrals were mostly for mental health resources such as counseling or psychiatry.

Lessons Learned and Summary

- Structured onsite documentation changes to guide flow of screening and suggested interventions are well-received by team and facilitate successful implementation
- Staff may have some discomfort with mental health screening and express a need for referrals post-screening, deterring implementation
- Competing demands such as a Prescription Produce Program conflict with limited resources and time for other visit concerns
- Staff value substance use screening results, particularly given evidence-based suggestions for risk-stratified interventions
- RHWP participants and community partners continue to express a need for mental health supports, related in part to widespread substance use issues within their buildings

Next Steps

- Reinforce guided universal screening with students and staff
- Identify and provide mental health training for faculty
- Continue to connect with community mental health resources
- Host the Inaugural Mental Health Conference on mental health and wellness with community partners across Southeast Virginia, along with RHWP faculty and students to address mental health needs from a policy perspective
  - Virginia State Senator Creigh Deeds will be the keynote presenter
  - Workshop to identify community mental health needs and gaps, then brainstorm actions to address those gaps through advocacy and collaboration

Advancing Access and Equity for New Jerseyans During Their Life Course

Saswati Chakraborty MSW, Ph.D/Maureen Cafferty BSN, JD
Springpoint Senior Living

LEAD Collaborative

Meritus Health

About Us

- **Springpoint Senior Living, Inc.**
  - 107 year history of serving seniors
  - 2,300 team members serving over 4,600 seniors
  - 29 Senior Living Communities:
    - 8 Life Plan Communities;
    - 19 Affordable Senior Communities;
    - 1 Assisted Living/Memory Care; and
    - 1 Skilled Nursing Community
  - Home Care Services

Our Why

- Springpoint's decision to join the LEAD initiative furthers its ongoing efforts in the area of Diversity, Equity & Inclusion. Socio-economic factors negatively impact healthcare access and outcomes. To reduce healthcare inequality, Springpoint will assess and reduce barriers to healthcare for Springpoint's low-income senior population.

Aim Statement

- Through increased partnerships and other methods, by October 2023, increase access to mental health services, outpatient rehabilitation services, and senior living services by 20% for people older than 50.

Clare MEDICAL OF NEW JERSEY

Key Interventions and Tests of Change

- Conducted surveys of seniors living in four Springpoint affordable senior housing communities with a 47% survey response rate – reflecting 186 out of 396 resident responses.
- Partnering with Clare Medical, developed a tailored program based on the results of the surveys at each community
- Conducting clinic programs that included topical education and related healthcare services based on survey results:
  - Hypertension Education/BP check
  - Healthy Eating/Nutrition/ Weight check
  - Diabetes Education/Glucose check

Data

- **Noteworthy survey findings**:
  - Almost 10% of respondents do not have regular medical check-ups
  - 80% reliant on assistance from others or public transportation to access healthcare settings
  - 69% report mild/moderate physical impairment
  - 31% report severe/total physical impairment
  - 78% report chronic health issues
  - 43% report anxiety on regular basis
  - 38% report no eye exam in the past 12 months
  - 78% report no hearing exam in the past 12 months.
  - 63% take 4-9 meds/day
  - 17% take 10 or more meds/day
  - 13% report **noncompliance** with med administration
  - Percentage with vaccinations **not** up to date:
    - Flu: 20%; Pneumonia: 42%; Shingles: 68%; COVID: 19%; Tetanus: 57%

Lessons Learned and Summary

- 15 events conducted to date with more scheduled.
- Attendance at each targeted event (BP/Glucose/BMI) to date averaged 14-18 residents (approximately 195 resident encounters)
- Expect in general sessions (Vaccination Clinic, Eye, and Hearing screenings) will see increased attendance
- Mobile healthcare delivery bringing services to the resident removes transportation barrier thereby improving access to healthcare services and screenings
- Continued and consistent presence in each community creates trust
- Need for access to mental health services
- Educational opportunities for seniors regarding insurance coverage for devices and equipment to improve quality of life at home.
- Need for increase in collaborators especially those who accept Medicaid.
- Improve communication of events

Next Steps

- Clinics to be conducted between 8/2023-10/2023:
  - Vaccine Education/Vaccinations offered
  - Homecare Services Seminar
  - Accessing Medical Supplies/Equipment
  - Hearing Education and Hearing Testing
  - Eye Health Education and Eye Exams
  - Mental Health Services/Education
- Resurvey seniors at each community to assess improvement in access to healthcare

Addressing the Equity Gap

Taryn Guy, Regional Director Diversity, Equity, and Inclusion
Catherine Cardillo, Regional Director Advocacy
Mark Lewis, Director of Population Health & Payer Analytics

LEAD Collaborative

About Us

Trinity Health Mid-Atlantic (THMA) was formed in October 2018 by the joining together of Mercy Catholic Medical Center (Mercy Fitzgerald Hospital in Darby, Pa.), Nazareth Hospital (Philadelphia, Pa.), Saint Francis Hospital (Wilmington, Del.), St. Mary Medical Center (Langhorne, Pa.), and their associated home health and PACE (LIFE) programs, physician practices, aligned joint ventures, sub-corporations, programs, and services.

Trinity Health Mid-Atlantic is the largest Catholic healthcare system serving the Greater Philadelphia area and is a part of Trinity Health of Livonia, Michigan, and sponsored by Catholic Health Ministries.

The hospitals and associated clinics, medical offices, specialized facilities, affiliated institutions, and foundations include more than 9,000 colleagues.

Our Why

THMA is committed to removing systemic barriers so that everyone has a fair and just opportunity to be as healthy as possible while working to eliminate race as a predictor of health outcomes.

Aim Statement

- By December 2023, improve health equity by more thoroughly collecting patient demographic data in the electronic health record, with a 25% increase over baseline.

Key Interventions and Tests of Change

- Increase the collection, stratification and use of race, ethnicity, and language (REaL)
- Increase the collection, stratification and use of sexual orientation and gender identity (SOGI) data
- Identify equity gaps and prioritize 1-2 health disparities for focus
- Develop an action plan to address identified health disparities

Data

- Baseline of race unknown and gender identity unknown as of June 2023.

PAT_RACE (group)	All Patients
Am Indian/Alask v2	141
Asian Indian v2	4,605
Black or African American v2	49,240
Chinese	180
Declined	2,332
Filipino	52
Guamanian or Chamorro	1
Japanese	8
Korean	37
Native Hawaiian or Other Paci..	138
Other v2	10,143
Unknown v2	23,519
Vietnamese	57
White/Caucasian v2	107,250
Grand Total	197,703

PAT_GENDER_IDENTITY	All Patients
Null	182,973
Choose not to disclose	54
Female	9,127
Male	5,493
Other	26
Transgender Female	11
Transgender Male	19
Grand Total	197,703

Lessons Learned and Summary

- Establishing a baseline revealed areas of opportunity for improvement within in specific data sets.
- Comprehensive training for staff responsible for collecting patient demographics is needed to improve the data.
- Standardizing data collection will improve efficiencies and accuracy of data collected.
- Improvement of data collection requires multi-disciplinary collaboration.

Next Steps

- Continue the work of the THMA Health Equity Committee
- Create REaL and SOGI training module
- Identify departments and colleagues for training
- Update data in September 2023

Implementing HRSN Screening

Sheryl Garland, Kim Lewis, Elizabeth Smith

LEAD Collaborative

About Us

- VCU Medical Center is the region's only comprehensive Level I trauma center verified for pediatric, adult and burn patients and central Virginia's largest safety net provider.
- The mission of VCU Health is to "Preserve and restore health for all people of Virginia and beyond through innovation in service, research, and education."
- Over 22% of the health system's patients reside in the city of Richmond, Virginia.
- Our academic health center is affiliated with Virginia Commonwealth University (VCU), an urban research university that offers access to a host of disciplines.
- VCU Health encompasses:
  - One college and five health sciences schools
  - An academic medical center and two community hospitals
  - A Level I trauma center
  - One of only two NCI-designated Comprehensive Cancer Centers in Virginia
  - The region's only full-service children's hospital
  - More than 800 physicians in 200 specialties
  - Dedicated research teams, facilities and valued partners in every field

Our Why

- Identify best practices and tools to assist with the implementation of models that support our regulatory compliance efforts around advancing health equity. The LEAD Collaborative provides us with the opportunity to learn from others who are engaging multidisciplinary teams and community partners to achieve similar goals.

Aim Statement

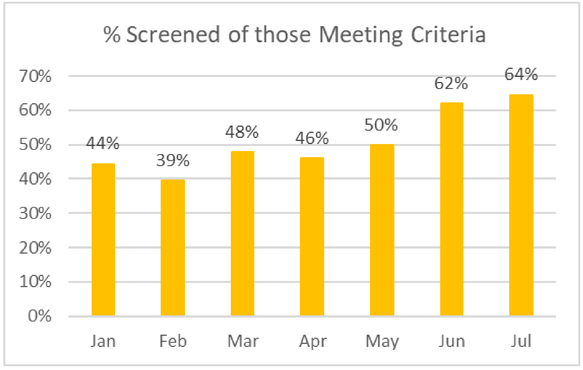
- By July 1, 2023, implement a standardized screening process to assess health related social needs (HRSN) for 80% of Medicaid, Medicare, and uninsured patients receiving care from hospital-based adult primary care and general pediatrics clinics.

Key Interventions and Tests of Change

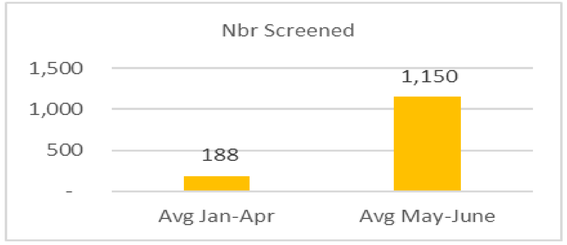
- Foundational work was done in our adult primary care clinics building on a screening process that had already been in place with outreach workers proactively connecting with patients in parallel with their primary care visit. We then expanded to our pediatric primary care clinics.
- Epic (electronic medical record) standard tools were used, with "wrap around" questions added to provide the data elements needed to meet regulatory requirements and provide management information. A standard resource sheet was developed and made available within Epic to either attach to discharge instructions or print for the patient.
- Based on learnings from this first launch we began design of a "next gen" approach to screening which embedded a high level triage screening in the rooming tab paired with referring those screening positive to the outreach workers. The intent was to allow for more patients to be screened and for the outreach workers to have more time to work with those who have a positive need. *This did require some repurposing of existing Epic functionality.

Data

- Our primary metric was getting patients meeting our designated criteria screened. While not at our originally set goal, we have seen significant progress.



- Learning #1: Outreach workers are challenged gaining access to patients.
- Learning #2: Our foundational process may not be scalable.
- Our "next gen" design was tested with significant increases in the number of patients screened.



Lessons Learned and Summary

- Develop a core process to ensure consistency across the organization ➔ ensures you'll meet regulatory requirements and have a consistent data set to support analysis
- Make it easy for staff to do what you want them to do ➔ take the time to understand their foundational workflow and where it makes the most sense to add your core process so it is seamless for them
- Engage providers and operational leaders to ensure buy-in early in the process ➔ even if you have the power of a regulatory requirement to drive compliance, having the buy-in of those who have to manage the process will result in much better solutions and outcomes.
- Leverage existing technical tools, even if they are not exactly what you need, to gain momentum and buy in ➔ get staff engaged using tools they are familiar with, requires a balance with your foundational needs

Next Steps

- Continued testing of "next gen" version of screening in the ambulatory and ED settings
- Explore addition of HRSN screening to MyChart, develop supporting processes to address needs identified through this venue.
- Determine the optimal mix of models/tools we have available to support outreach worker focus on navigation.
- Scale the model across inpatient admissions at all three facilities to support CMS regulatory compliance.

SDOH Initiative

Katherine Rodgers, MPH
Director of Community Health Initiatives, TidalHealth

TidalHealth

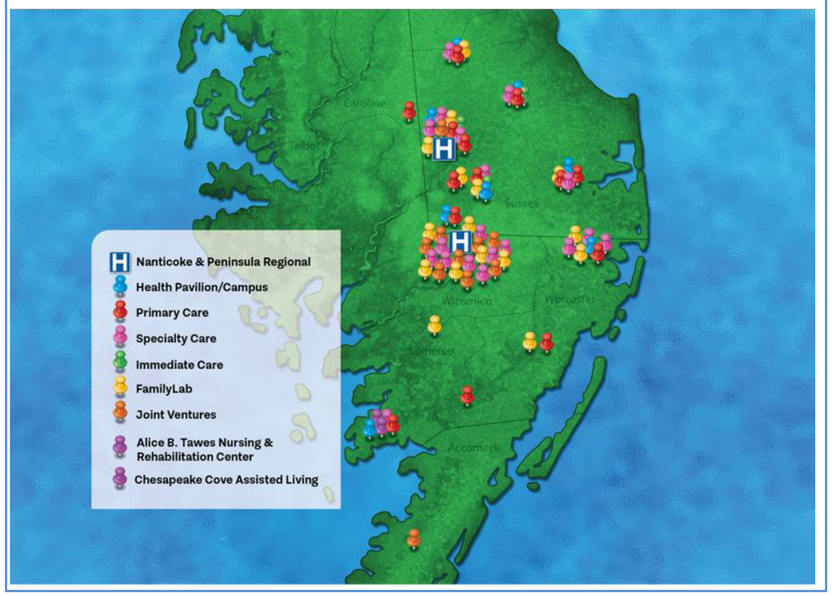
LEAD Collaborative

Meritus Health

About Us

TidalHealth Overview:

- Two acute care nonprofit hospitals + physician enterprise – 300+ providers and more than 30 locations
- Free standing medical facility, surgery center, integrated breast center, skilled nursing home, six joint ventures
- 5,000 employees
- Serving approximately 500,000 residents
- Rural Delmarva Peninsula
- Only Trauma Center for the region



Our Why

TidalHealth is committed to health equity and the elimination of racism and other forms of oppression both within our organization and throughout the greater community.

Aim Statement

Original aim statement: Increase the percentage of patients screened for social determinants of health by TidalHealth Nanticoke patient care management team from 0% to 20% by June 2023.

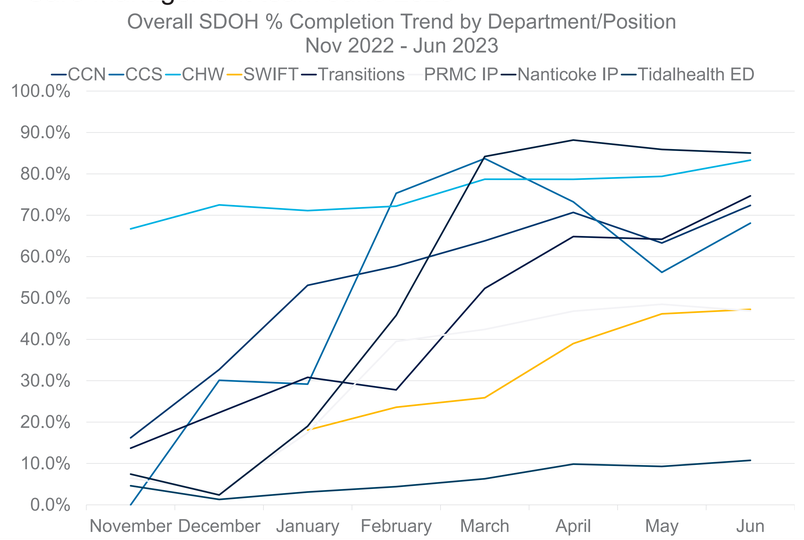
Revised aim statement June 2023:
Reduce the food insecurity disparity among African American and Hispanic patients. *Baseline:* 13.1% of African American patients screened in June 2023 had food insecurity. 9.1% of Hispanic patients had food insecurity. 4.4% of white patients screened had food insecurity.

Key Interventions and Tests of Change

- Build SDOH screening into Epic with discrete fields
- Collect data about the percentage of patients screened prior to discharge
- Collect data about the percentage screened for specific SDOH factors
- Quantify risk level of patients screened for SDOH factors
- Stratify SDOH risk fields by Race, Ethnicity, Age, Language, Gender
- Identify where greatest disparities exist and ability to impact
- Develop strategies to address food insecurity disparities
- Monitor progress

Data

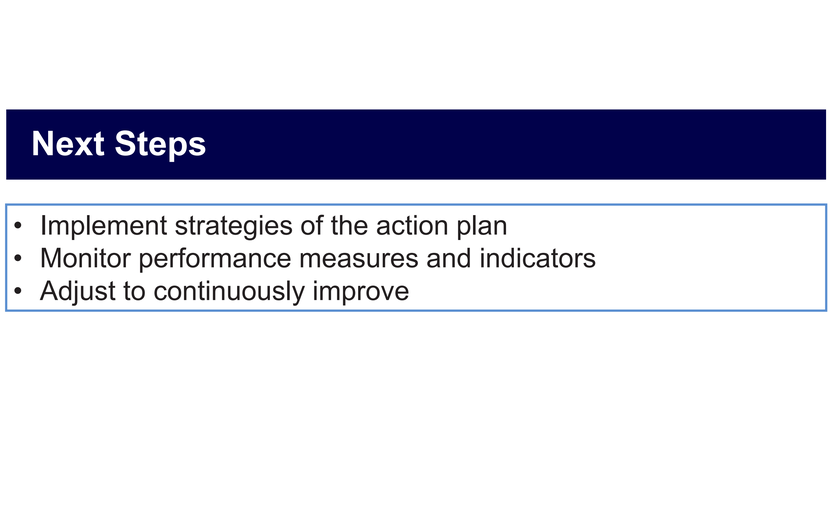
- Completion rate for SDOH – trending by department
- Stratified food insecurity data for TidalHealth Nanticoke Patient Care Management team June 2023



	Food Insecurity Present	No Food Insecurity	Unknown	Grand Total
Black/African American	13.1%	85.7%	1.2%	100.0%
Hispanic	9.1%	90.9%	0.0%	100.0%
Multiple	0.0%	100.0%	0.0%	100.0%
Other	0.0%	100.0%	0.0%	100.0%
White/Caucasian	4.4%	95.6%	0.0%	100.0%
Grand Total	**6.5%**	**93.3%**	**0.3%**	**100.0%**

Lessons Learned and Summary

By following iterative process of rapid PDSAs, stratifying data using REAL-G metrics, and analyzing data in context of community health data, we were able to develop a specific action plan with process and outcome performance measures.



Next Steps

- Implement strategies of the action plan
- Monitor performance measures and indicators
- Adjust to continuously improve