Appendix I

Examples and Best Practices for Additional Strategies

Additional Strategies

Strategies with an evidence base and applicability to specific partners in targeted sectors.

Goal 1

1.1.5 Increase health care providers' expertise and skills, providing opportunities for patient education, ensuring that patient care is team-based, and using registry-based information systems.

PILOT DESCRIPTION	First, organizations should consider defining the roles of different care team members, ensuring that each individual feels valued and uses their skills at the highest capacity. Then they can implement processes for sharing written and verbal information about the patient, ensuring that each care team member has all the data needed to make informed care decisions. Finally, they would identify the care team to the patient and ensure they know a team is treating them.
REAL WORLD EXAMPLE	Heart Healthy: Your Guide for Life! was field tested in a randomized controlled trial with men and women working in three hospitals. The hospitals were located in Virginia, West Virginia and Ohio. The basic design of the study was a pretest-posttest experimental design in which subjects voluntarily agreed to participate in the program. The Heart Healthy program was designed to provide cardiac health promotion and disease prevention information to working adults in an easily accessible and flexible format. It was also designed to tailor that information to multiple user needs, address issues such as goal setting and monitoring, and provide comprehensive material promoting positive health behavior change across multiple topics, including diet, exercise, weight management, smoking cessation, and mood management.
POTENTIAL IMPACT	Improved access to care and services with a consistent care team, improved quality, safety, and reliability of care. Enhanced health and functioning for patients with chronic conditions to more cost-effective care.
TIMELINE FOR IMPLEMENTATION	6-9 months

Additional Strategies

1.1.6 Collaborate with payers to secure reimbursement for social workers.

SAMPLE PILOT DESCRIPTION	Modifying health plans and reimbursement to permit coverage-of-care coordination through care and/or case managers and social workers. This reimbursement would improve patients' access to and coverage of services. Providers' reimbursement for mental health services delivered in the primary care setting would also improve.
POTENTIAL IMPACT	Collaboration could improve health outcomes for patients with multiple medical conditions and complex social needs. It is important to fund and reimburse services provided by care managers and social workers in primary care settings.
TIMELINE	12-24 months

1.1.7 Advocate for improving the payment model for underinsured or uninsured people, ensuring providers are willing to participate in alternative payment models.

SAMPLE PILOT DESCRIPTION	Health care providers within the region coordinate with one another and with insurance providers and agree to implement one or more best-practice alternative payment models for patients who meet eligibility criteria.
REAL WORLD EXAMPLE	The Guide to Physician-Focused Alternative Payment Models (2015) describes several different ways of designing alternative payment methods to address the most common opportunities for improving care and some of the major barriers physicians and patients face in current payment systems (e.g. CPC+)
POTENTIAL IMPACT	Increased likelihood for uninsured and underinsured people to pursue care
TIMELINE	12-24 months

Additional Strategies

1.1.7 Advocate for improving the payment model for underinsured or uninsured people, ensuring providers are willing to participate in alternative payment models.

SAMPLE PILOT DESCRIPTION	Health care providers within the region coordinate with one another and with insurance providers and agree to implement one or more best-practice alternative payment models for patients who meet eligibility criteria.
REAL WORLD EXAMPLE	The Guide to Physician-Focused Alternative Payment Models (2015) describes several different ways of designing alternative payment methods to address the most common opportunities for improving care and some of the major barriers physicians and patients face in current payment systems (e.g. CPC+)
POTENTIAL IMPACT	Increased likelihood for uninsured and underinsured people to pursue care
TIMELINE	12-24 months

1.2.5 Identify opportunities for patients to obtain medication while at the physician's appointment.

SAMPLE PILOT DESCRIPTION	Ensure adherence to opioid prescription guidelines as outlined by the Ohio Board of Pharmacy.
REAL WORLD EXAMPLE	Society of St. Vincent De Paul Pharmacy and Wellness provides a last resort safety net for those with no other way to access their prescription medication. It is dedicated to providing completely free medication and professional pharmaceutical care to people in need from Hamilton, Butler, Warren, and Clermont counties.
POTENTIAL IMPACT	Improved prescription fill rates and medication adherence
TIMELINE	6-24 months

Additional Strategies

1.2.6 Increase school-based health and dental clinics in prioritized neighborhoods.

SAMPLE PILOT DESCRIPTION	School-based health centers often are operated as a partnership between the school and a community health organization, such as a community health center, hospital, or local health department. The specific services provided by school-based health centers vary based on community needs and resources as determined through collaborations between the community, the school district, and the health care providers.
REAL WORLD EXAMPLE	Students can be treated for acute illnesses, such as flu, and chronic conditions, including asthma and diabetes. They can also be screened for dental, vision, and hearing problems. With an emphasis on prevention, early intervention, and risk reduction, school-based health centers counsel students on healthy habits and how to prevent injury, violence, and other threats.
POTENTIAL SUPPLEMENTAL POLICIES	School-Based Health Centers Reauthorization Act of 2020, which extended authorizations for federal funding for school-based health centers through 2026. Hallways to Health Care Act expands federal funding for school-based health centers, including additional funding for behavioral health care in schools. The act also would fund demonstration projects to explore telehealth services in school-based health centers and provide resources for technical assistance.
POTENTIAL IMPACT	School-based health centers generally provide primary care services to students, although a growing number also offer mental health services while some provide limited vision and dental care. While all school-based health centers treat students enrolled at their location, some offer staff and community members services
TIMELINE	12-24 months

1.2.7 Expand telehealth services to all areas of care (primary care, specialists, behavioral health, dental, and vision care).

SAMPLE PILOT DESCRIPTION	A health care system sets the goal of providing a digital option for all of its relevant services within two years. Departments within the health care system which already utilize telehealth as a means of providing care (e.g. primary care) assist and provide guidance to other internal departments (e.g. behavioral health) which have not yet implemented telehealth services.

Additional Strategies

REAL WORLD EXAMPLE	Beginning in 2019, Medicare began paying for virtual check-ins. Patients across the country can briefly connect with doctors by phone or video chat to see whether they need to come in for a visit. In response to COVID-19, the Centers for Medicare and Medicaid Services moved swiftly to significantly expand payment for telehealth services. Implementation of additional flexibilities was created so that Medicare beneficiaries living in all areas of the country can get convenient and high-quality care from the comfort of their home while avoiding unnecessary exposure to the virus.
POTENTIAL IMPACT	Telemedicine can complement and enhance in-person care by furnishing one more powerful clinical tool to increase access and choices for care.
TIMELINE	12-24 months

1.2.8 Advocate for the improvement of existing medical paratransit through Medicare and Medicaid.

SAMPLE PILOT DESCRIPTION	Track data on missed rides, canceled appointments due to lack of transportation, stranded patients, etc. to demonstrate the need for improvements.
REAL WORLD EXAMPLE	Non-emergency medical transportation (NEMT) benefit facilitates access to care for low-income beneficiaries who otherwise may not have a reliable, affordable means of getting to health care appointments. NEMT also assists people with disabilities who have frequent appointments, limited public transit options, and long travel times to health care providers, such as those in rural areas. NEMT expenses eligible for federal Medicaid matching funds include a broad range of services, such as taxicabs, public transit (e.g., buses and subways), and van programs.
POTENTIAL SUPPLEMENTAL POLICIES	Advocate for paratransit to take patients to the pharmacy where they need to pick up their medication.
POTENTIAL IMPACT	NEMT can be a cost-effective means of facilitating access to care for Medicaid beneficiaries.
TIMELINE	12-24 months

Additional Strategies

1.2.9 Advocate for insurance coverage for telehealth services not already covered.

SAMPLE PILOT DESCRIPTION	Currently, the CMS is authorized to waive requirements for Medicare telehealth services during the public health emergency relating to COVID-19, and it has done so to allow all providers that are otherwise eligible to furnish in-person services under Medicare also to furnish telehealth services.
REAL WORLD EXAMPLE	Physical therapists can use telehealth by guiding patients through prescribed exercises, analyzing the patients' performance, instructing modifications of a care program, and promoting self-efficacy. Physical therapists can use telehealth to assess a patient's home environment and recommend adjustments that improve safety and navigation, which is not as easy to replicate in the clinic. Additionally, in March 2021, the Expanded Telehealth Access Act was introduced in the U.S. House of Representatives. This bill permanently allows audiologists, physical therapists, occupational therapists, speech-language pathologists, and other providers designated by the Centers for Medicare & Medicaid Services (CMS) to provide telehealth services under Medicare.
POTENTIAL IMPACT	Hospital admissions and readmissions, emergency department visits, and urgent care visits, among other expenses, potentially will decrease if beneficiaries have access to both in-person and telehealth services.
TIMELINE	12-24 months

1.2.9 Advocate for insurance coverage for telehealth services not already covered.

SAMPLE PILOT DESCRIPTION	Currently, the CMS is authorized to waive requirements for Medicare telehealth services during the public health emergency relating to COVID-19, and it has done so to allow all providers that are otherwise eligible to furnish in-person services under Medicare also to furnish telehealth services.
REAL WORLD EXAMPLE	Physical therapists can use telehealth by guiding patients through prescribed exercises, analyzing the patients' performance, instructing modifications of a care program, and promoting self-efficacy. Physical therapists can use telehealth to assess a patient's home environment and recommend adjustments that improve safety and navigation, which is not as easy to replicate in the clinic. Additionally, in March 2021, the Expanded Telehealth Access Act was introduced in the U.S. House of Representatives. This bill permanently allows audiologists, physical therapists, occupational therapists, speech-language pathologists, and other providers designated by the Centers for Medicare & Medicaid Services (CMS) to provide telehealth services under Medicare.

Additional Strategies

POTENTIAL IMPACT	Hospital admissions and readmissions, emergency department visits, and urgent care visits, among other expenses, potentially will decrease if beneficiaries have access to both in-person and telehealth services.
TIMELINE	12-24 months

Goal 3

3.1.6 Partner with small landlords to subsidize property improvements for long-term commitments to affordable rentals.

SAMPLE PILOT DESCRIPTION	A health system partners with a local community-based organization to establish a fund for small landlords to repair their existing units. Funds may take the form of direct grants, forgivable loans, or low-cost loans.
REAL WORLD EXAMPLE	The Philadelphia Housing Development Corporation partnered with a local community organization, Impact Services, to administer loans to small landlords (those who own less than ten units) with renters making at or below 100% of AMI. This evidence-based intervention followed an extensive study conducted by the Urban Land Institute (ULI) and the Division of Housing and Community Development (DHCD), which determined that assisting small landlords effectively preserves naturally-occurring affordable housing.
POTENTIAL IMPACT	Reduced tenant turnover, increased stability of small landlords, higher-quality housing, reduced health impacts from unsafe housing, improved health outcomes for chronic conditions which are affected by environmental factors
TIMELINE	6-12 months

Additional Strategies

3.1.7 Offer incentives for the development and/or preservation of affordable and mixed-income housing in areas with high concentrations of poverty.	
SAMPLE PILOT DESCRIPTION	A developer wants to build 50 units in a neighborhood that has a higher than average area median income (AMI) when compared to the region, with excellent public schools. If they guarantee that at least 25 units are rented on a sliding scale to families earning target percentages below the AMI (e.g., 0–30%, 30-60%, etc.), developers can access a health system's affordable housing fund to take out a low-interest loan.
REAL WORLD EXAMPLE	UnitedHealth care provided a low-interest loan to community development corporation Chicanos Por La Causa (CLPC) to enable them to purchase and redevelop two apartment buildings in a location with little existing affordable housing convenient to a nearby center so tenants could access both health care and social services. There were up to 100 units set aside to rent to tenants earning below AMI at reduced rates, while the rest of the housing remained at market rate.
POTENTIAL IMPACT	Increased access to quality education, employment, and health care services, improved outcomes for environmentally-impacted chronic conditions (e.g., asthma), greater housing stability
TIMELINE	3-6 months

3.2.4 Promote farm-to-school programming within school districts and health systems.	
SAMPLE PILOT DESCRIPTION	Schools can implement farm-to-school programs independently; state and local policies can also support and encourage farm-to-school programming. Farm-to-school implementation varies significantly by the number of included activities, intensity, and duration of the program. Comprehensive farm to school programs have several additional components, including school gardens, nutrition, and agriculture education, recycling, composting, and food waste reduction efforts, as well as enrichment act
REAL WORLD EXAMPLE	The Cincinnati School Board adopted the resolution for the Good Food Purchasing Program in Cincinnati public schools. By adopting this resolution, the school district takes an important step toward making sure those millions support not only healthy and delicious food for students, but also a strong local economy, fair working conditions for food sector workers, and sustainable and humane farming practices. The resolution was the result of a two and a half year process led by a robust and diverse community-based coalition advocating for the Program.

Additional Strategies

POTENTIAL IMPACT	Increased willingness to try fruits and vegetable consumption, Improved dietary choices and nutrition, more robust local economy, reduced greenhouse gas emissions
TIMELINE	6-12 months

3.2.5 Increase access to healthy food during non-school hours for zip codes with high disparities within priority populations (including evenings, weekends, and summer).

SAMPLE PILOT DESCRIPTION	Targeted meal pattern flexibility and technical assistance in schools and children and adult care institutions should provide breakfasts, lunches, and after-school snacks in non-group settings at flexible meal times. Parents or guardians can also pick up meals for their children when programs are outside of operating hours. Increase student and family access to meal programs during the school year and over the summer, including specific strategies for underserved students like students experiencing homelessness and English learners, and how federal funding can support these efforts.
REAL WORLD EXAMPLE	The USDA has extended free breakfast and lunch to all Cincinnati Public Schools students for the 2021-22 school year. The federal Free and Reduced-Price Lunch program provides nutritious meals for children from low-income families. A majority of Cincinnati Public Schools qualify for community eligibility, which means all students at the schools receive free meals. The community eligiblity allows school districts in high-poverty areas to provide meals free to students in schools that qualify. Schools like Cincinnati Public Schools leverage their participation in one of USDA's summer meal programs to provide meals at no cost to students. Under normal circumstances, those meals must be served in a group setting. However, during the COVID-19 public health emergency, the law allows USDA the authority to waive the group setting meal requirement, which is vital during a social distancing situation.
POTENTIAL IMPACT	Many children rely on these programs for as many as three meals a day, underscoring how essential it is for USDA to empower schools and childcare centers to continue their dedicated efforts to serve healthy meals safely.
TIMELINE	6-12 months

Appendix II

Community Health Needs Assessment & Community Health Improvement Plan Process and Stakeholder Engagement; State and National Plan Alignment

Targeted Universalism Approach

The collaborative leadership utilized Targeted Universalism to develop the Regional CHIP. Targeted universalism is a community-driven strategic planning process with a guiding principle process of setting universal, shared goals and using targeted strategies to achieve those goals. Within this framework, a broad group of stakeholders took the priorities from the CHNA and developed a set of overarching goals for the CHIP. With those shared goals as the north stars, the 60+ CHIP stakeholders then created a set of targeted priorities and strategies that reflected the multitude of diverse sectors and partners needed to achieve the outlined goals. Each organization, hospital, health department, or community stakeholder can then identify which strategies are most in line with their capacity, geography, culture, and structure, and know that they are still working towards the universal health goals of the region.

CHNA Community Input Process

From April-June 2021, the CHNA collected data describing the health status and key health concerns of residents throughout the 26 county region of southwest Ohio, southeast Indiana, and northern Kentucky. Below is an excerpt from the CHNA summarizing the community input process (CHNA pages 9-10):

- "8,321 community surveys available in five languages. Within this sample, representation was seen across 26 counties, males, females, ages 18-65+, Black/African American, Multiracial, Asian, American Indian, Alaskan Native, White, and Hispanic/Latino populations;
- 859 provider surveys inclusive of behavioral health, education, emergency medical services, faith-based organizations, federally qualified health centers, justice/corrections, medical care (adult, geriatric, pediatric) oral health, organizations addressing health related social needs and social determinants of health, pharmaceutical, and public health departments.
    - Providers also represented administration, direct patient care, academic, support staff, and supervisors/management.
    - Providers reported serving a variety of populations including children/youth, people with disabilities, ethnic minorities, people experiencing homelessness, people in the justice system, veterans, young adults, low-income populations, and LGBTQ+ populations;

CHNA Community Input Process

- 51 focus groups with 234 people were held, representing all three MSAs. Specifically, recruitment for these focus groups were based on advisory committee identification of populations who are traditionally underrepresented, marginalized, or experience greatest health disparities.
    - Populations represented in these focus groups include adult men, those experiencing foster care or foster parenting, youth and adults with disabilities, ethnic, cultural and language minorities, first and second-generation immigrants, people experiencing homelessness, those involved in the justice system, low-income families and individuals, parents, veterans, older adults, community members with lived experience of mental health and/or addiction, and first responders; and
- 38 stakeholder interviews were held across health and social service providers, specifically with the following being represented: mental health and substance use disorder (SUD), public health, hospital systems, Federally Qualified Health Centers (FQHCs), transportation, housing, food access, health care access and policy, school-based health and children's health care, maternal and infant care, LGBTQ+ health care, pharmacy access, and health care workforce development."

For additional information on CHNA methodology and process, see pages 9-12 of the CHNA.

CHIP Stakeholder Engagement Process

The input and information gathered during the CHNA was analyzed and presented back to advisory committees and stakeholders for prioritization. This process of aligning on shared priorities set the foundation for the implementation plan. The regional goals identified based on the needs which arose in the CHNA were:

- Everyone in the region has access to health care when they need it, specifically for the region's top needs: behavioral health, oral health, vision care, and cardiovascular care
- The health care education pipeline and workforce are strong, reflect the diversity of our region, and deliver equitable care to everyone
- Everyone in the region has access to food and stable housing

From December 2021 through April 2022, the Health Collaborative, Greater Dayton Area Hospital Association, and Interact for Health partnered with Cohear to conduct a stakeholder engagement process for identifying the detailed priorities and strategies presented in the CHIP. Those engaged during this process included community stakeholders, hospitals, health systems, local experts, community-based organizations, and health-related advisory boards and groups that were representative of the region.

CHIP Stakeholder Engagement Process

After an initial set of interviews with key regional health leaders to gather feedback on the broad structure and goals of the CHIP, the full collaborative process began. The diverse group of stakeholder self-selected into working groups which aligned with each of the three regional goals identified by the leadership team based on the CHNA. These working groups met four times: twice in person as breakout sessions of the full stakeholder group meeting at the outset and close of the project, and twice virtually as individual working groups. These meetings were used to achieve consensus regarding which priorities and strategies should be included in the CHIP, ensure that representatives of organizations throughout the region had an opportunity to weigh in on the relative applicability and feasibility of each priority and strategy for their own context, and synthesize an approach to the structure and utilization of the CHIP.

The resulting regional CHIP outlines priorities and strategies from evidence-based literature and local, state, and federal best practices and goals. After finalizing the priorities and strategies for each goal of the CHIP, collaborative leaders (THC and GDAHA) continue to ensure organizational alignment across hospitals, public health departments, and local key stakeholders through one-on-one meetings and ongoing communication.

State and National Plan Alignment

Ohio State Health Improvement Plan

The Regional CHNA and CHIP methodologies were designed from the outset to align with strategic priorities, goals, and even specific interventions described in both the Ohio State Health Improvement Plan (SHIP) and national health strategy planning efforts including Healthy People 2030.

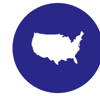
Like the CHNA which preceded it, this CHIP follows the SHIP in focusing on key health-influencing factors such as community perceptions of health care quality, access to care, health-related lifestyle behaviors, and social determinants of health (among other environmental and societal influencing factors on health).

The CHIP's goals and priorities are modeled on those of the SHIP, including the prioritization of chronic diseases (such as cardiovascular disease and hypertension) and behavioral health. Additional areas of alignment include furthering health career recruitment for minority students and creating a culturally competent medical workforce, especially in underserved communities (including rural communities).

The strategies laid out in the CHIP are designed to align with and advance the SHIP's priorities in order to create opportunities for collaboration among organizations seeking to eliminate health disparities and break down barriers to improved, more equitable community health outcomes.

State and National Plan Alignment

National Health Goals Alignment



This Regional CHIP follows in the SHIP's path by containing strategies, priorities, and goals modeled after initiatives at the national level, including:

Healthy People 2030, U.S. Department of Health and Human Services

CHIP strategies align with objectives in the following areas from Healthy People 2030:

Health Conditions
- Addiction
- Diabetes
- Heart Disease and Stroke
- Mental Health and Mental Disorders
- Oral Conditions

Health Behaviors
- Child and Adolescent Development
- Drug and Alcohol Use
- Emergency Preparedness
- Health Communication
- Nutrition and Healthy Eating
- Preventive Care

Populations*
- Adolescents
- Children
- Infants
- LGBT
- Men
- Older Adults
- Parents or Caregivers
- People with Disabilities
- Women
- Workforce

Settings and Systems
- Community
- Environmental Health
- Health Care
- Health Insurance
- Health IT
- Health Policy
- Hospital and Emergency Services
- Housing and Homes
- Schools
- Transportation
- Workplace

Social Determinants of Health
- Economic Stability
- Health Care Access and Quality
- Neighborhood and Built Environment
- Social and Community Context

*These populations were represented in the community outreach which formed the basis of the CHNA, which informed the goals, priorities, and strategies of the CHIP.

National Alignment (Continued)

The “6/18 Initiative: Accelerating Evidence into Action”, CDC

CHIP strategies align with these interventions from 6/18:

- Control High Blood Pressure
- Prevent type 2 diabetes
- Control asthma

*These populations were represented in the community outreach which formed the basis of the CHNA, which informed the goals, priorities, and strategies of the CHIP.

The “Health Impact In Five Years” (Hi-5) initiative, U.S. Centers for Disease Control and Prevention (CDC)

CHIP strategies align with these interventions from Hi-5:

- Early childhood education
- Home improvement loans and grants

Appendix III

Public Health Accreditation Board and Internal Revenue Service Requirements

Of particular importance to the regional process is helping organizations meet their governing bodies' requirements for health assessments and implementation planning. Specifically, the CHNA and CHIP were designed in compliance with PHAB (local public health department) accreditation and IRS (non-profit hospital) standards.

Public Health Accreditation (PHAB) Accreditation Standards

The CHNA and CHIP are intended to facilitate organizations' compliance with PHAB accreditation standards, including the following (from PHAB Standards Version 1.5 Overview):

"DOMAIN 1: Assess
Conduct and disseminate assessments focused on population health status and public health issues facing the community

Standard 1.1: Participate in or Lead a Collaborative Process Resulting in a Comprehensive Community Health Assessment
Standard 1.2: Collect and Maintain Reliable, Comparable, and Valid Data that Provide Information on Conditions of Public Health Importance and On the Health Status of the Population
Standard 1.3: Analyze Public Health Data to Identify Trends in Health Problems, Environmental Public Health Hazards, and Social and Economic Factors that Affect the Public's Health
Standard 1.4: Provide and Use the Results of Health Data Analysis to Develop Recommendations Regarding Public Health Policy, Processes, Programs, or Interventions

…DOMAIN 4: COMMUNITY ENGAGEMENT
Engage with the community to identify and address health problems

Standard 4.1: Engage with the Public Health System and the Community in Identifying and Addressing Health Problems through Collaborative Processes
Standard 4.2: Promote the Community's Understanding of and Support for Policies and Strategies that will Improve the Public's Health

DOMAIN 5: POLICIES & PLANS
Develop public health policies and plans

Standard 5.1: Serve as a Primary and Expert Resource for Establishing and Maintaining Public Health Policies, Practices, and Capacity
Standard 5.2: Conduct a Comprehensive Planning Process Resulting in a Tribal/State/Community Health Improvement Plan…"

Appendix IV

IRS Section 501(r)(c)

The IRS requires Charitable Hospital Associations to conduct, singly or jointly, a Community Health Needs Assessment and develop an associated Implementation Strategy in order to retain 501(c)(3) tax-exempt status. This CHIP may be adopted to fulfill this requirement, providing the Charitable Hospital Association fulfills all described requirements of the Joint Implementation Strategies listed in Section 501(r)(3):

"As with the CHNA report, a hospital facility may develop an implementation strategy in collaboration with other hospital facilities or other organizations. This includes, but is not limited to related and unrelated hospital organizations and facilities, for-profit and government hospitals, governmental departments, and nonprofit organizations.

In general, a hospital facility that collaborates with other facilities or organizations in developing its implementation strategy must still document its implementation strategy in a separate written plan that is tailored to the particular hospital facility, taking into account its specific resources.

However, a hospital facility that adopts a joint CHNA report may also adopt a joint implementation strategy. With respect to each significant health need identified through the joint CHNA, the joint implementation strategy must either [describe] how one or more of the collaborating facilities or organizations plan to address the health need, or identify the health need as one the collaborating facilities or organizations do not intend to address. It must also explain why they do not intend to address the health need.

A joint implementation strategy adopted for the hospital facility must also:

- Be clearly identified as applying to the hospital facility,
- Clearly identify the hospital facility's role and responsibilities in taking the actions described in the implementation strategy as well as the resources the hospital facility plans to commit to such actions, and
- Include a summary or other tool that helps the reader easily locate those portions of the joint implementation strategy that relate to the hospital facility."

Appendix IV

References and Further Reading

Goal 1

1.0.1 Coordinate, strengthen, and expand behavioral health services in the region.

Cited:
Care Coordination for Certified Community Behavioral Health Clinics (CCBHCs) | SAMHSA
Working With a Designated Collaborating Organization (DCO) | SAMHSA
WakeMed Health and Hospitals

Further Reading:
Substance Abuse and Mental Health Services Strategic Plan FY2019-FY2023

1.1.1 Expand comprehensive primary care and emergency department care teams to include social workers and strengthen the coordination between all care areas.

Cited:
Care Coordination | Agency for Health care Research and Quality
Rural Project Summary: Regional Oral Health Pathway
Emergency Department Care Coordination (EDCC) Program
Further Reading:
Strengthening Primary Health Care: A Webinar - National ...https://www.nationalacademies.org › event › docs
Adult Health Care Coordination

1.1.2 Expand the availability of Community Health Workers in our region to help patients connect to and navigate services, particularly for mental health crises and oral trauma.

Cited:
Mobilizing Community Health Workers to Address Mental Health Disparities for Underserved Populations: A Systematic Review - PMC
Rural Project Summary: Regional Oral Health Pathway

Further Reading:
Medicaid Coverage of Community Health Worker Services | MACPAC
The Impact of Community Health Workers | AHA

1.1.3 Equip paramedics and emergency departments with access to electronic health records to expand a patient care team's access to primary care and behavioral health history.

Cited:
Emergency medicine electronic health record usability: where to from here?
Emergency Medical Services (EMS) Data Integration to Optimize Patient Care
3 Ways EHR Use, Access Boost Care Coordination Across Settings

References and Further Reading [Goal 1]

1.1.4 Provide on-demand crisis intervention services where a behavioral health crisis is occurring.

Cited:
Mobile Response Stabilization Service Tool Kit and Resource Guide V1.0

See Also
National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit
Implementing Behavioral Health Crisis Care | SAMHSA
Reimagining a Sustainable and Robust Continuum of Psychiatric Care

1.1.5 Increase health care providers' expertise and skills, providing opportunities for patient education, ensuring that patient care is team-based, and using registry-based information systems.

Cited:
Team-Based Care: Optimizing Primary Care for Patients and Providers

1.1.6 Collaborate with payers to secure reimbursement for social workers.

Cited:
Reimbursement of Mental Health Services in Primary Care Settings

1.1.7 Advocate for improvement to the payment model for people who are underinsured or uninsured, ensuring that providers are willing to participate in alternative payment models.

Cited:
Medicare alternative payment models | American Medical Association

1.2.2 Train hospital partners with Community Health Workers in clinical settings in partnership with the Pathways Community Hub Model.

Cited:
Pathways Hub - Health Care Access Now

1.2.3 Consider becoming a care coordination agency within the Pathways Hub Model.

Cited:
Partner Agency - Health Care Access Now

1.2.4 Expand partnerships between regional transportation organizations and health systems to increase patient access to transportation.

Cited:
New transportation program aims to help Linden residents access health care, job training

Further Reading:
Improving Transportation Access to Health Care Services
Transportation and the Role of Hospitals

References and Further Reading [Goal 1]

1.2.6 Increase school-based health and dental clinics in prioritized neighborhoods.

Cited:
School-Based Health Centers Reauthorization Act of 2020 | Congress.gov
S.1738 - 117th Congress (2021-2022): Hallways to Health Care Act
School-Based Health Centers | Official web site of the US Health Resources & Services Administration

1.2.7 Expand telehealth services to all areas of care (primary care, specialists, behavioral health, dental, and vision care).

Cited:
Early Impact Of CMS Expansion Of Medicare Telehealth During COVID-19 | Health Affairs

1.2.8 Advocate for the improvement of existing medical paratransit through Medicare and Medicaid.

Cited:
Non-Emergency Medical Transportation | CMS

1.3.2 Educate patients, employers, and health care providers about dental, vision, and behavioral health insurance plans.

Cited:
Understanding Health Insurance | Medical Mutual

1.3.3 Create and distribute health literacy materials in priority zip codes.

Cited:
View of A health literacy analysis of the consumer-oriented COVID-19 information produced by ten state health departments
The CDC Clear Communication Index

1.3.4 Advocate for including preventive dental and vision health into general health promotion, school curricula, and activities.

Cited:
Oral Health Advocacy Education Impacts Future Engagement: Exploration at a Midwestern US Dental School

1.3.5 Advocate for standard plan summary for Medicaid benefits for easy access for providers and patients.

Cited:
Dental and Optometric Care (DOC) Access Act - ADA Legislative Action Center
ADA prioritizes 2022 advocacy issues | American Dental Association

References and Further Reading [Goal 2]

Goal 2

2.1.1 Provide incumbent worker training program opportunities, apprenticeships, and scholarships to assist employees in advancing education and careers in health care.

Cited:
Mercy Medical Assistant Apprenticeship

2.1.2 Increase career exploration and work-based learning.

Cited:
TAP MD

Further Reading:
Roadmap for Creating a Health care Work-Based Youth Learning Program

2.1.3 Partner with educational institutions in the region to expand class size and increase minority participation by removing barriers.

Cited:
ACGME common program requirements (residency)

Further Reading:
Higher Education Collaboratives for Community Engagement and Improvement
Interim Report to the Ohio State Board of Education On Diversity Strategies for Successful Schools

2.1.4 Develop public-private partnerships to generate catalytic and transformative investments in the workforce pipeline.

Cited:
Governor DeWine, Lt. Governor Husted Unveil Cleveland Innovation District

Further Reading:
Diversity and Inclusiveness in Health Care Leadership: Three Key Steps | Catalyst non-issue content
How to harness the transformative potential of public-private partnerships

2.1.5 Develop a regional recruitment and retention strategy geared towards racially and ethnically diverse populations by increasing faculty representation and support services for in-demand occupations.

Cited:
Recruitment and Retention Toolkit (from the AICPA)

Further Reading:
Improving Cultural Competence to Reduce Health Disparities for Priority Populations

References and Further Reading [Goal 2]

2.1.6 Collaborate with community-based organizations to connect diverse residents from high-poverty neighborhoods to available frontline positions, internal career development, and advancement opportunities.

Cited:
Building the Pipeline to a Healthy Community

2.1.7 Implement and increase diversity, cultural competency, and empathy training of workforce professionals (including HR) and leadership within health systems.

Further Reading:
Leadership and Cultural Competence of Health care Professionals - PMC

2.1.8 Advocate for institutional and regional standards for retention and advancement of racially/ethnically diverse workforce.

Cited:
Developing Workforce Diversity in the Health Professions: A Social Justice Perspective - ScienceDirect
HR3637 - Allied Health Workforce Diversity Act of 2019116th Congress (2019-2020)
The Importance of Mentorship and Sponsorship - PMC

2.1.9 Collaborate with and support efforts to increase rural health care education and employment opportunities.

Cited:
Pipelines to Pathways: Medical School Commitment to Producing a Rural Workforce - Longenecker - 2021
Education and Training of the Rural Health care Workforce Overview - Rural Health Information Hub

Further Reading:
University of Missouri School of Medicine's Rural Track Elective Program
Targeted Rural Underserved Track (TRUST) Program
Rural Opportunities in Medical Education (ROME)
Rural Physician Associate Program (RPAP)

2.2.1 Collect data on workforce gaps and training needs to inform decisions about health care workforce development.

Cited:
Meeting the Need for Better Data on the Health Care Workforce - The Future of Nursing - NCBI Bookshelf

Further Reading:
Discriminated by an algorithm: a systematic review of discrimination and fairness by algorithmic decision-making in the context of HR recruitment and HR development | SpringerLink

2.2.2 Develop a best practices document on engaging employees at all levels to measure and improve workplace culture in health care

Cited:
CareerSTAT | National Fund for Workforce Solutions
10 Ways to Build Culture in a Health care Organization | Ultimate Medical Academy

References and Further Reading [Goal 2]

2.3.1 Measure specific human resources data related to hiring decisions to identify hidden biases for internal assessment and improvement.

Cited:
GW Introduces Tool Providing Health Workforce Racial and Ethnic Diversity Data for 10 Professions
Messer Construction Co. makes gift to UC and UC Health

2.3.2 Address root causes of pay inequities by positions (e.g., systemic underemployment and discrimination differences in underrepresented minorities and promotion-related pay increases).

Cited:
Addressing Systemic Barriers to Employment — NYAPRS

Further Reading:
Why the Equal Pay Act and Laws Which Prohibit Salary Inquiries of Job Applicants Can Not Adequately Address Gender-Based Pay Inequity - Jeffrey A. Mello, 2019
Addressing Systemic Racial Inequity In The Health Care Workforce

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2.3.3 Provide mentorship and sponsorship efforts that strengthen networks, build resiliency and increase the representation of women, people of color, and other underrepresented minorities through development and promotion.

Cited:
Stanford Nursing Mentorship Program

2.3.4 Offer flexible childcare options for health care employees.

Cited:
WellStar Health System and Bright Horizons Team Up to Provide Child Care to Employees

Further Reading:
Employer Options When Offering Childcare Benefits | MRA

2.3.5 Establish National Cultural and Linguistically Services Standards (CLAS) standards of inclusive practices for the entire health care workforce and patients.

Cited:
National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care
ELIMINATING DISPARITIES TO ADVANCE HEALTH EQUITY AND IMPROVE QUALITY
Health-Disparities-Guide.pdf
A Practical Guide to Implementing the National CLAS Standards

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2.3.6 Create a standardized set of best practices for making space for employees of color to be heard and empowered on workplace issues of diversity and inclusion in health care.

Cited:
Diversity, Equity, and Inclusion at McLean

Further Reading:
Why Diversity and Inclusion Matter (Quick Take) | Catalyst
Confronting Racism in Health Care: Proclamations to New Practices | Commonwealth Fund

References and Further Reading [Goal 3]

Goal 3

3.0.1 Improve coordination between health care systems and social service agencies by establishing a shared mechanism to screen, refer, and follow up on patients' health-related social needs (e.g. housing, legal issues, food insecurity).

Cited:
Adult Health Care Coordination

3.0.2 Increase the number of Community Health Workers to connect individuals to resources and programs addressing food and housing needs.

Cited:
Pathways Hub - Health Care Access Now

3.1.1 Expand partnerships for resolving food needs by increasing the number of care coordination agencies within the Pathways Community Hub model.

Cited:
Pathways Hub - Health Care Access Now

3.1.2 Increase funding to support ongoing efforts to provide residents access to legal defense, emergency rent, tenant advocacy, and other housing and eviction services.

Cited:
Services & Specialties Child HeLP (Legal Aid)
Identifying and Treating Substandard Housing Cluster Using a Medical-Legal Partnership

3.1.3 Invest in eviction diversion programs that offer rental assistance, mediation, legal representation, and other social and housing services to tenants and landlords.

Cited:
Bon Secours Mercy's eviction program improved health equity

3.1.4 Establish nonprofit affordable housing development collaboratives with existing local community-based organizations.

Cited:
Affordable Housing

3.1.5 Ensure all subsidized and naturally-occurring affordable housing is safe and up to code through collaboration with local fair housing organizations and relevant municipal departments.

Cited:
Strategic Code Enforcement Management Academy

References and Further Reading [Goal 3]

3.1.5 Ensure all subsidized and naturally-occurring affordable housing is safe and up to code through collaboration with local fair housing organizations and relevant municipal departments.

Cited:
Strategic Code Enforcement Management Academy

3.1.6 Partner with small landlords to subsidize property improvements for long-term commitments to affordable rentals.

Cited:
Rental Improvement Fund - MAKING PHILADELPHIA BETTER BLOCK BY BLOCK

3.1.7 Offer incentives for the development and/or preservation of affordable and mixed-income housing in areas with high concentrations of poverty.

Cited:
UnitedHealth care Helps a Nonprofit in Phoenix Provide Medicaid Members with Housing and Services | HUD USER

3.1.8 Incentivize developers who receive public investment in publicly-owned land, public funds, or tax exemptions to provide affordable housing

Cited:
"Housing for Health" Policy Day draws attention to the need for stable, affordable housing - Health care Anchor Network

3.1.9 Advocate to expand Housing Choice Vouchers (HCV) and/or the creation of a targeted renters' tax credit to assist families, while also incentivizing landlords to accept HCV.

Cited:
Senators Introduce Bipartisan Bill to Increase Choice for Voucher Holders | National Low Income Housing Coalition

3.1.10 Support or expand rental registration programs that require or incentivize landlords to register their properties.

Cited:
Lead-Safe Rental Requirements Approved By Cleveland City Council | WKSU

3.1.11 Support existing legislation to ban housing discrimination based on the source of income, and advocate to improve the enforcement of existing fair housing laws, including federal protections related to race, disability, national origin, sexual orientation, and gender.

Cited:
Health Care Institutions Invest in Tenant Protections for Community Health — Shelterforce

3.1.12 Establish and help contribute to consistent, dedicated funding streams for affordable housing investment region-wide (e.g., a regional housing trust fund).

Cited:
Washington State Housing Trust Fund

References and Further Reading [Goal 3]

3.2.1 Maintain and/or increase enrollment in federal food assistance and education programming and policies through the removal of barriers to participation for qualifying families and individuals.

Cited:
Produce Prescriptions, Food Pharmacies, and the Potential Effect on Food Choice - PMC
Produce Perks Midwest | Ohio Department of Health
Produce Perks
Infant Vitality PRx Produce Prescription Program

Further Reading:
Produce Prescription Program (PRx)
Food is medicine: actions to integrate food and nutrition into health care | The BMJ

3.2.3 Support and fund the capacity and implementation of healthy food access points (e.g., food co-ops, nonprofits, farmers' markets, healthy food pantries, and supermarkets) and food equity plans.

Cited:
Healthier Food Retail: An Action Guide for Public Health Practitioners

Further Reading:
Approaches to Increase Access to Foods that Support Healthy Eating Patterns - RHIhub SDOH Toolkit
Nutrition: Strategies and Resources | DNPAO | CDC

3.2.4 Promote farm-to-school programming within school districts and health systems.

Cited:
Farm to school programs | County Health Rankings & Roadmaps
Good Food Purchasing Program

Further Reading:
Farm to School | Greater Cincinnati Regional Food Policy Council
Program: Farm to school | Healthy food playbook

3.2.5 Increase access to healthy food during non-school hours for zip codes with high disparities within priority populations (including evenings, weekends, and summer).

Cited:
Free & Reduced-Price Lunch Program | Cincinnati Public Schools

3.2.6 Invest in the technological and human capacity of local farmers' markets to accept federal food assistance program benefits and promote these markets to program participants.

Cited:
How it Works – Produce Perks Midwest

Further Reading:
Supplemental Nutrition Assistance Program (SNAP) at Farmers Markets: A How-To Handbook
Fruit and Vegetable Incentive Programs for Supplemental Nutrition Assistance Program (SNAP) Participants: A Scoping Review of Program Structure - PMC

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Fruit and Vegetable Incentive Programs for Supplemental Nutrition Assistance Program (SNAP) Participants: A Scoping Review of Program Structure - PMC

3.2.7 Maintain and/or increase enrollment in federal food assistance and education programming and policies by removing barriers to participation for qualifying families and individuals.

Cited:
State WIC Agencies Use Federal Flexibility to Streamline Enrollment | Center on Budget and Policy Priorities
Reduced Administrative Burden for SNAP - Prenatal-to-3 Policy Impact Center
Barriers That Prevent Low-Income People From Gaining Access to Food and Nutrition Programs