2022-2024

Regional Community Health Improvement Plan

THE HEALTH COLLABORATIVE

GDAHA
Greater Dayton Area Hospital Association

INTERACT FOR HEALTH

Cohear

Executive Summary

Vision

We envision a southwest Ohio, northern Kentucky, and southeast Indiana region in which everyone has the opportunity to be healthy. To achieve this vision, our region is working on eliminating health disparities by embracing community voice, investing in trusted partnerships, and implementing evidence-based strategies and best practices to achieve equitable health outcomes for all.

In 2021, the Health Collaborative (THC), the Greater Dayton Area Hospital Association (GDAHA), 40 hospitals, and 22 local health departments within 26 counties created the Regional Community Health Needs Assessment (CNHA). This comprehensive health assessment of the community gives organizations information about the community's current health status as well as its most pressing health needs and disparities.

The CHNA, a data-driven review of the community's health, identified the greatest health needs in the region, resulting in the goals which are prioritized in the CHIP. The CHNA gathered over 10,000 responses from community members. Subject matter experts from hospitals, health departments, and community-based organizations across the region worked in collaboration to define the regional goals below, in the first Regional Community Health Improvement Plan.

This CHIP is critical for creating the roadmap of strategies and actions to address the top health priorities for the region, and is included in organizational level strategic plans across sectors, allowing the region to track progress, celebrate achievements, and change course as the work unfolds.

CHIP Regional Goals and Key Priorities

Goal 1

Everyone in the region has access to healthcare when they need it, specifically for the region's top needs: behavioral health, oral health, vision care, and heart disease

Priority 1.1

Establish a consistent continuum of care across health systems that centers the patient and adapts to changing needs across their lifetime

Priority 1.2

Eliminate barriers to access and increase the use of preventive services for behavioral health, oral health, vision care, and cardiovascular care

Priority 1.3

Foster health education and health literacy

Goal 2

The health care education pipeline and workforce are strong, reflect the diversity of our region, and deliver equitable care to everyone

Priority 2.1

Expand and diversify the health care workforce pipeline through education and hiring opportunities

Priority 2.2

Track and consistently publish ongoing workforce data/statistics in a regional dashboard, including class sizes, vacancy rate, and diversity percentages at a regional level, publishing these results annually

Priority 2.3

Eliminate retention disparities for racially and ethnically diverse health care workers

Goal 3

Everyone in the region has access to healthy, affordable food and quality, affordable housing

Priority 3.1

Eliminate residential evictions due to inability to pay rent

Priority 3.2

Ensure healthy food access within 10 minutes by foot or public transit in urban communities or by car in rural communities

Introduction

What is The Community Health Improvement Plan?

The Centers for Disease Control and Prevention defines a health improvement plan as "a long-term, systematic effort to address public health problems based on a community health needs assessment activity and the health improvement process." Following the Regional Community Health Needs Assessment (CHNA) for southwest Ohio, northern Kentucky, and southeast Indiana, local hospitals, health systems, public health departments, and community partners came together to align on health priorities, coordinate efforts, and reimagine the allocation of resources to create the Regional Community Health Improvement Plan (CHIP).

In 2021, the Health Collaborative (THC), the Greater Dayton Area Hospital Association (GDAHA), 40 hospitals, and 22 local health departments within 26 counties created the Regional Community Health Needs Assessment (CNHA). This comprehensive health assessment of the community gives organizations information about the community's current health status as well as its most pressing health needs and disparities.

The resulting health improvement plan is critical for creating the roadmap of strategies and actions to address the shared top priorities for the region. It defines the vision for the community's health through a collaborative process and offers coordinated, evidence-based strategies to improve the health status of that community.

Benefits of a collaborative health assessment and improvement plan include:

- Strengthening partnerships and collaboration across local health systems, public health, and community-based organizations
- Increasing transparency across sector on community improvement plans
- Going beyond medical care by driving focus to upstream/root causes of health including social determinants of health, systemic and structural determinants of health
- Identifying strengths, weaknesses, and gaps within health care delivery to address quality improvement efforts
- Aligning on a shared vision of health and priorities to maximize resource allocation and coordination
- Building infrastructure for collective impact
- Acknowledging a shared accountability towards improved health for all
- Centering equity and the lives of those with lived experience

Methods and Accountability

Methodology

The collaborative leadership team (THC and GDAHA) used Targeted Universalism to develop the Regional CHIP. Targeted universalism is "an approach that supports the needs of the particular while reminding us that we are all part of the same social fabric". This process requires full community-driven strategic participation from the outset to create universal, shared goals and targeted strategies that are group specific to achieve those goals. To learn more about the concept of Targeted Universalism and the process for utilizing this framework, view the Othering and Belonging Institute's Policy and Practice Primer. Additional information is also available in Appendix III.

Community and Stakeholder Input

The CHNA, a data-driven review of the community's health, identified the greatest health needs in the region, resulting in the goals which are prioritized in the CHIP. The CHNA gathered over 10,000 responses from community members across the 26 county region. Subject matter experts across the region and across sectors worked in collaboration to define these top goals from the data collected:

- 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 healthy, affordable food and quality, affordable housing

From December 2021 through April 2022, the collaborative leadership team developed the CHIP with input from residents, community stakeholders, hospitals, health systems, local experts, community-based organizations, and health-related advisory boards and groups that were representative of the region. The development of the 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 continued to ensure organizational alignment across hospitals, public health departments, and local key stakeholders through one-on-one meetings and ongoing communication. Additional information regarding CHNA and CHIP processes is available in Appendix III.

Accountability

The CHIP includes specific, measurable community health indicators for each priority area addressed from 2022 through 2024. This will allow the region to track progress, celebrate achievements, and change course as the work unfolds. Work plans with specific timelines will guide the implementation of strategies and document progress. The Health Collaborative will spearhead the creation of a collaborative infrastructure to track progress and provide updates to the community. Further, regional health systems' organization-specific strategic plans are actively being written in alignment with the shared priorities and strategies included in the Regional CHIP.

How to Use the CHIP

How to Use the CHIP

The strategies laid out by the CHIP are not intended to function as an all-or-nothing, step-by-step manual for every partner seeking to make change that aligns with the goals. Rather, it is a menu of options from which partners can select strategies which their organizations are well-suited to take action on or establish partnerships around. The aim is to provide a wide variety of evidence-based recommendations that are role/sector specific for driving progress toward the universal goals.

We recognize that every organization has a unique role to play in order to effect transformational change in our community.

This CHIP was designed to showcase the various strategies that can be implemented across sectors to work toward shared, regional goals. The process of drafting the CHIP involved asking diverse organizations to identify strategies which allow them to use their strengths to advance toward the universal goal. This unified approach, combined with a focus on collaborative partnerships, has the potential to transform the CHIP process from an activity of compliance to one of coordinated strategic action.

Definitions of Key Terms

Featured Strategies:

Strategies with wide evidence bases and broad applicability to partners seeking to align with the CHIP

Additional Strategies:

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

Cross-Cutting Strategies:

Strategies which span more than one priority area (e.g. relevant to both food insecurity and housing insecurity) and require deep, ongoing collaboration across different types of partner agencies throughout the region

Developing Strategies:

Strategies which are newer and as a result have less available data regarding best practices and implementation, but demonstrate a positive evidence base for efficacy thus far

Policy/Advocacy:

Opportunities for collaboration on shared advocacy initiatives to advocate for change at the public policy or system-wide level

Indicates Alignment with Healthy People 2030

Indicates Alignment with Ohio State Health Improvement Plan

Indicates a collaborative effort across multiple organizations

Goal 1

WHAT WE ENVISION FOR OUR COMMUNITY

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

Community Outcomes

How we will know if we have made a difference

SHORT-TERM

- Increase connections to behavioral health, oral health, vision care and cardiovascular care
- Reduce unnecessary emergency department use for mental health, dental, and heart disease issues

INTERMEDIATE

- Increase use of routine, preventative primary, dental, and vision care
- Expand access to health, dental, and vision insurance coverage
- Increase the number of physicians, dentists, and mental health providers
- Reduce preventable hospital readmissions

LONG-TERM

- Improve incidence rates and outcomes for:
  - Depression
  - Anxiety
  - Suicide
  - Drug overdose
  - Youth drug use
- Reduce heart disease
- Reduce lifetime tooth decay
- Reduce preventable eye diseases

Priority Populations

The people and places experiencing significant health disparities

People from racial and ethnic minority groups (Black persons, Asian persons, American Indian persons), veterans and active-duty military, people who identify as LGBTQ+, people who are uninsured or underinsured, younger community members, and males.

Goal 1

Priorities and Strategies

Evidence-informed actions to help achieve our goal

Cross-Cutting Strategies

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

Implement an evidence-based comprehensive care coordination model that connects qualified behavioral health entities with an assigned panel of eligible members with high-need behavioral health conditions.

LEAD	Hospitals, Community mental health centers, Mental health Boards
PARTNERS	Community-based organizations
SAMPLE PILOT DESCRIPTION	According to the Substance Abuse and Mental Health Services Administration, "[c]are coordination is an activity rather than a service. The Care Coordination for Certified Community Behavioral Health Clinics (CCBHC) is responsible for all care coordination, whether it involves coordination within the CCBHC, with a designated collaborating organization (DCO), or with another entity identified in the statutory language related to care coordination."
REAL WORLD EXAMPLE	WakeMed Behavioral Health Network (WMBHN), developed in 2017, is a network of behavioral health, social service, and primary care providers to improve access and care coordination for patients suffering from mental and chronic health conditions. The network itself does not provide direct service, rather it helps coordinate the space between care/providers. Collaboration through this network can bring together experts, driven by clinical data, to identify solutions and create shared goals for success.
POTENTIAL IMPACT	Improvement of patient, practitioner, and provider satisfaction, better adherence to mental and behavioral health treatment plans, long-term health care cost savings, improved patient outcomes including reduced emergency department visits, smoother hospital referrals and time to treatment, and reduced length of stay and readmissions.
TIMELINE FOR IMPLEMENTATION	12+ months

Priority 1.1

Establish a consistent continuum of care across health systems that centers the patient and adapts to changing needs across their lifetime

Featured Strategies

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

Care coordination in the primary care practice and emergency department involves deliberately organizing patient care activities and sharing information between all parties concerned with a patient's care to achieve safer and more effective care. This shift is central to incorporating a focus on social determinants of health as part of all patients' health care plans.

LEAD	Emergency Medical Services (EMS), Health care organizations (Community Health Centers, Health Systems, Charitable Clinics)
PARTNERS	Social service agencies, community-based organizations, insurance providers (payers)
SAMPLE PILOT DESCRIPTION	EMS sees the need to include more primary care in their work, and decides to coordinate more closely by creating new communication channels, collaborative training programs, and joint services. Over time, the partnership leads to patients' needs and preferences being communicated at the right time to the right people, improving the delivery of safe, appropriate, and effective care.
REAL WORLD EXAMPLE	The Emergency Department Care Coordination (EDCC) Program ConnectVirginia Health Information Exchange is a statewide real-time communication and collaboration program. EDCC partners include health care providers and clinical and care management personnel for patients receiving services in Virginia to improve patient care services. 106 hospital EDs are live and participating on the network. The Virginia General Assembly established the EDCC Program to respond to the overutilization of emergency departments seen throughout the country. All health plans (3.4 million lives), multiple clinics, accountable care organizations, managed care entities, community services boards, federally qualified health centers, and skilled nurse facilities have already been onboarded or are onboarding.
POTENTIAL IMPACT	Reduce emergency department admissions, improve quality of chronic disease management, improve patient satisfaction, and better access to specialty care
TIMELINE FOR IMPLEMENTATION	6-9 months

Featured Strategies

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.

Community Health Workers (CHWs) can effectively deliver evidence-based treatments (EBTs) to meet the needs of communities with access and utilization disparities. CHWs may mobilize to step into the role of primary providers of EBTs in settings with severe workforce shortages. Still, even in higher-resourced settings, they may be involved in EBT delivery for individuals with lower levels of need, such as those who would benefit from mental health preventive services. CHW-delivered prevention and early behavioral intervention services would allow trained mental health professionals to focus their expertise on people who require more intensive services.

LEAD	Pathways Community Hub Model
PARTNERS	Hospitals, Community Health Centers, Federally Qualified Health Centers, Mental health providers, Foundations, Insurance Providers
SAMPLE PILOT DESCRIPTION	CHWs become essential members of the medical delivery system who are most likely to see underserved populations with limited or no access to dental services. CHWs can assist patients with accessing dental services. The CHWs then have the capacity to incorporate oral health information and the provision of preventive oral health services into their day-to-day practice. In addition, dental professionals can serve as key players in detecting chronic diseases such as diabetes, hypertension, and hypercholesterolemia in dental practices.
REAL WORLD EXAMPLE	The Maryland Regional Oral Health Pathways project utilizes CHWs to educate patients on dental hygiene and oral health. According to the Rural Health Information Hub, Maryland Regional Oral Health Pathways is “just one of many alternative dental workforce models that states are exploring to help reduce oral health disparities in rural America.”
POTENTIAL IMPACT	Improve clinical outcomes and decrease hospital readmission rates and costs
TIMELINE FOR IMPLEMENTATION	3-6 months

Featured Strategies

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.

Emergency Medical Services (EMS) utilize Electronic Health Record (EHR) integration to improve patient care through the health information exchange (HIE) between EMS and Emergency Department (ED) personnel.

LEAD	Health care systems (Emergency departments), Health Information Exchange
PARTNERS	First responders
SAMPLE PILOT DESCRIPTION	EMS works to establish access to patients' records via the HIE to improve care transitions and care coordination for first responders. The EMS personnel can then utilize their HIE connection to access patient EHRs for better-informed prehospital clinical decision-making that significantly impacts patient health outcomes. They can then access the data from an HIE organization to determine if the patient has been recently hospitalized and view their health history.
REAL WORLD EXAMPLE	Search, Alert, File, and Reconcile model "emphasizes that many EMS providers presently do not have access to longitudinal patient EHRs because they are not connected to an HIE organization", according to EHR Intelligence. The health data exchange within the Search, Alert, File, and Reconcile model capabilities can optimize EMS services by offering crucial information regarding hospitalizations, medications, end-of-life decisions, and medical conditions during transitions of care.
POTENTIAL IMPACT	In emergencies, patients or their families may not provide reliable information to impact initial care decisions and long-term outcomes. EHR access can reduce the threat of significant patient harm during rapid clinical decision-making in care transitions outside of the hospital setting. Health data exchange capabilities can optimize EMS services by offering crucial information regarding hospitalizations, medications, end-of-life decisions, and medical conditions during care transitions. Hospitals can ensure better care coordination by providing EMS personnel access to patient EHRs through an HIE connection. In contrast, patients are being transported from the site of an emergency to the receiving hospital. This vital pre-hospital care can mean the difference between life and death.
TIMELINE FOR IMPLEMENTATION	6-12 months

Featured Strategies

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

During crises, the more proximate and immediate the intervention, the better. On-demand and mobile crisis intervention services can help increase the speed and efficacy of treating behavioral health crises as they occur.

LEAD	Behavioral Health Providers
PARTNERS	Higher Educational Institutions, Hospitals, Federally Qualified Health Centers, Emergency Medical Services
PILOT DESCRIPTION	Mobile crisis response teams are groups of two or more crisis counselors that are centrally available to reach any person in their service areas in their home, workplace, or any other community-based location of the individual. Mobile crisis response teams serve a broad range of people in less-acute crises. Still, they can refer individuals to crisis receiving and stabilization facilities should they need a higher level of care.
REAL WORLD EXAMPLE	Families of children up to age 22 who are facing a behavioral health challenge or crisis situation can contact Mobile Response and Stabilization Services (MRSS) to get help within an hour any time of the day or night, seven days per week. Patients can also receive up to 45 days of intensive, in-home services and linkage to ongoing support. MRSS team may provide safety assessments, de-escalation, peer support, and skill-building.
POTENTIAL SUPPLEMENTAL POLICIES	Expansion of Mobile Response and Stabilization Services to support adults
POTENTIAL IMPACT	Reduce costs associated with inpatient hospitalization and improve patient safety
TIMELINE FOR IMPLEMENTATION	12-24 months

Additional Strategies

For further details on additional strategies, including real world examples, see Appendix I.

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.

Using shared decision-making and patient education, clinicians can integrate patients into treatment decisions better by using team based care. This strategy will tap the patient as the expert on their care and lifestyle preferences that must consider before ordering certain therapies.

LEAD	Primary care organizations, Federally qualified health centers
PARTNERS	Schools

Policy/Advocacy

1.1.6 Collaborate with payers to secure reimbursement for social workers.

Care management services, including social workers who may not directly see patients but provide essential services in the continuity of care, have difficulty getting reimbursed for services provided in primary care settings. It is critical to address that gap.

LEAD	Insurance providers
PARTNERS	Community-based organizations, health care providers, and government entities

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

Well-designed, patient-centered alternative payment methods can provide significant opportunities to improve the quality and outcomes of patients' care in ways that also lower health care spending.

LEAD	Insurance providers
PARTNERS	Health care providers, health care organizations

Priority 1.2

Eliminate barriers to access and increase the use of preventive services for behavioral health, oral health, vision care, and cardiovascular care

Featured Strategies

1.2.1 Support ongoing efforts to reduce hypertension and stroke in the region through preventive services.

Like so many other conditions, heart disease is often best treated as early as possible through preventive measures. These efforts at education and self-care can help avoid more deadly progressions of heart disease.

LEAD	Community-based organizations focused on cardiovascular disease and/or health disparities
PARTNERS	Public Health Departments, Community Health Centers, Health Systems, Charitable Clinics
SAMPLE PILOT DESCRIPTION	Provide self-management support and education to patients to improve knowledge about wellness and self-efficacy, lower blood pressure, increase the regularity of vision and oral screenings, and increase medication adherence.
REAL WORLD EXAMPLE	The HealthCare Connection provides self-measured blood pressure monitoring devices to enable patients to measure their blood pressure outside of a clinical setting. The HealthCare Connection's team provides one-on-one counseling, virtual or telephonic support tools, and education for patients. This strategy provides patients with high blood pressure with quality and accessibility of care and improvement of blood pressure control.
POTENTIAL SUPPLEMENTAL POLICIES	Address other manageable chronic illnesses (e.g., cholesterol, diabetes)
POTENTIAL IMPACT	Reduced incidence of hypertension and stroke and related complications, improved adherence to preventive lifestyle measures and primary care
TIMELINE FOR IMPLEMENTATION	3-6 months

Featured Strategies

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

Community Health Workers' efficacy is dependent on the quality and scope of their training. The Pathways Community Hub Model provides an excellent foundation for CHWs to be most effective in their work.

LEAD	Pathways Community Hub Model
PARTNERS	Community Health Centers, Health Systems, Charitable Clinics, Community-based organizations, Insurance Providers
SAMPLE PILOT DESCRIPTION	Collaborate with Community-based organizations to conduct universal training for CHWs in the region.
REAL WORLD EXAMPLE	Health Care Access Now conducts classroom training that addresses the core competencies in health, including knowledge of social service resources, communication skills, advocacy, CPR certification, lifespan development, and basic community health worker skills.
POTENTIAL IMPACT	More consistent services from Community Health Workers, better community access to needed care and social services resources
TIMELINE	3-6 months

1.2.3 Become a care coordination agency within the Pathways Hub Model.

Care coordination agencies (CCAs) would facilitate care coordination in the primary care practice by sharing information among the patient's care team as well as designing and coordinating all patient care-related activities using the Pathways Hub model to achieve safer and more effective care.

LEAD	Pathways Community Hub Model
PARTNERS	Partners that become care coordination agency

Featured Strategies

SAMPLE PILOT DESCRIPTION	Conducting monthly in-person/virtual visits with the client to identify needs, opening relevant Pathways, and completing health and social service Pathways to address needs. CHWs are to meet at least monthly with each client and document each meeting in the Pathways Community Hub Model data system.
REAL WORLD EXAMPLE	Deploy CHWs within various settings to provide active community-based care coordination. Providing active care coordination services to at-risk community members includes enrolling the new client in the Hub through in-person/virtual meetings to assess needs and risk factors.
POTENTIAL IMPACT	Increase access and care coordination to more patients within the community to improve health outcomes
TIMELINE	12-24 months

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

Hospitals and health systems partnering with ride-sharing businesses and other transportation services can improve health outcomes, increase patient satisfaction, and increase revenue.

LEAD	Regional transportation provider
PARTNERS	Community-based organizations
SAMPLE PILOT DESCRIPTION	A hospital establishes a partnership with its local transit authority in order to identify and solve for gaps in current fixed-route and on-demand services which serve its patients.
REAL WORLD EXAMPLE	In early 2022, CVS Health partnered with Uber Health to provide free rides to health care appointments and job training for residents of Columbus's Linden neighborhood.

Featured Strategies

POTENTIAL SUPPLEMENTAL POLICIES	Advocate for federal programs that set the stage for state and local coordination. The Coordinating Council on Access and Mobility, National Centers for Mobility Management, and Centers for Medicaid and Medicare Services set guidelines and provide grant funding to encourage coordination. States choose their schemes for transportation coordination, and some choose a mix of service types. Local coordination requires both political support and on-the-ground responsibility for sharing resources.
POTENTIAL IMPACT	Cost savings for coordination are significant for all transportation solutions. Brokerages, transit voucher or reimbursement programs, and transportation networks reduce costs and produce significant returns where coordination programs require an initial capital investment.
TIMELINE	9-12 months

Additional Strategies

For further details on additional strategies, including real world examples, see Appendix I.

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

Provide medication therapy experts within the health care system after being seen by a medical professional. Pharmacists are committed to patient care by ensuring the safe and effective use of medications.

LEAD	Health care organizations, Insurance providers
PARTNERS	Community-based organizations

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

According to the Health Resources and Services Administration, "[s]tudents and their families rely on school-based health centers to meet their needs for a full range of age-appropriate health care services, including primary medical care, mental/behavioral health care, dental/oral health care, health education and promotion, substance abuse counseling, case management, [and] nutrition education."

LEAD	Local experts on School Based Health Centers
PARTNERS	Health departments, Foundations

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

Telemedicine includes telehealth and other virtual services which allow patients to visit with clinicians remotely. According to healthaffairs.org, "[i]nnovative uses of this kind of technology in the provision of health care are increasing with advances in telehealth platforms and remote patient monitoring technology. New mobile health apps and wearable monitoring devices help track patients' vitals, provide alerts about needed care, and help patients access their physicians."

LEAD	Government entities
PARTNERS	Health care organizations, Health care providers

Policy/Advocacy

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

Hospitals and health care providers to track data regarding the successful use of state Medicaid and Medicare transportation services to and from health care providers and utilize this data to advocate for the improvement of these services.

LEAD	Health care organization
PARTNERS	Government entities

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

Use telehealth efforts to reduce the number of in-clinic visits and still maintain important monitoring and follow-up care. Increasing telehealth services is especially important to patients who lack transportation, yet insurance coverage can be a major barrier for many potential patients.

LEAD	Regional Health Improvement Collaborative, Community-based organizations
PARTNERS	Insurance providers

Developing Strategies

The strategies below are newer, and as a result have less available data regarding best practices and implementation, but demonstrate a positive evidence base for efficacy thus far.

- Streamline prescription access and payment systems for those without insurance or with limited insurance assistance, including those using coupons to offset prescription costs.
- Increase incentives for health care professionals to work in rural areas or with underserved populations (e.g., school loan payments).
- Advocate to streamline and improve Medicare and Medicaid prescription payment processes to ensure timely access to medication.
- Collaborate with payers to increase dental care reimbursements.

Priority 1.3

Foster health education and health literacy

Featured Strategies

1.3.1 Work to raise overall public awareness of the link between quality dental, vision, behavioral health, and cardiovascular care and positive health outcomes.

Dental, behavioral, and cardiovascular health awareness should begin at a very young age. Primary care physicians and specialists should provide continuous health education on quality care.

LEAD	Public Health Departments, Community-based organization specializing in grassroots education
PARTNERS	Dental Professionals, Behavioral health professionals, Cardiovascular specialists
SAMPLE PILOT DESCRIPTION	Dental health awareness should be assessed by adult dentists. If patients are aware of their dental health, they will know what dental practices they should maintain to have healthy teeth.
REAL WORLD EXAMPLE	The American Dental Association sponsors the National Children's Dental Health Month during February to raise awareness among children and their parents about dental health. The campaign focuses on instilling in the young the importance of regular tooth brushing and dental examinations to prevent dental problems.
POTENTIAL IMPACT	Better overall, holistic health outcomes for patients, reduced health care costs, improved adherence to treatment plans
TIMELINE	6-12 months

Featured Strategies

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

Educating patients, employers and health care providers so that they better understand their insurance coverage and benefits is crucial for creating a great patient experience.

LEAD	Public Health Department, Local experts in community engagement, Health care providers
PARTNERS	Federally Qualified Health Centers, Community health centers, Hospitals
SAMPLE PILOT DESCRIPTION	Medical professionals should clearly communicate insurance plan details with their patients. In this way, patients will fully understand a practice's payment policy. Discussing the medical bills does not have to be overly complex, but a lack of insurance literacy among some patients makes this more difficult.
REAL WORLD EXAMPLE	Medical Mutual created Health Insurance Education programming including resources designed to help take the mystery out of health insurance. They provide information regarding health insurance decisions for individuals in their families.
POTENTIAL IMPACT	Decrease the number of unpaid balances and create a better experience for patients
TIMELINE	3-6 months

Featured Strategies

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

Health literacy is the ability to find, communicate, and understand basic health services and information. Ensure health literacy materials are distributed through trusted grassroots organizations, are culturally and linguistically appropriate, and are provided in various formats (e.g., digital, live web-based, face-to-face).

LEAD	Community-based organizations
PARTNERS	Health care organizations, School systems
SAMPLE PILOT DESCRIPTION	A hospital collaborates with a local school system to create health literacy materials for high school students designed to increase their understanding of the role of primary care in overall health. These partners begin by learning about their intended audience's interests, needs, and values, in order to ensure materials are effective in both format and design. Once materials are drafted, these partners pretest them with the intended audience and make appropriate revisions to materials according to the findings of the pretest. They distribute the materials, and follow up three to six months later to assess the efficacy of this initiative by surveying relevant population members.
REAL WORLD EXAMPLE	An organization identified the ten states with the most COVID-19 cases and selected forty-two materials (i.e., webpages, infographics, and videos) related to COVID-19 prevention according to predefined eligibility criteria. We applied three validated health literacy tools including CDC Clear Communication Index to assess material understandability, actionability, clarity, and readability. The organization recommends using infographics and videos when possible, taking a human-centered approach to information design, and providing multiple modes and platforms for information delivery.
POTENTIAL IMPACT	Better health care utilization among target populations, improved prevention of some conditions, better management of chronic and other existent health conditions, improve health-related lifestyle choices
TIMELINE	6-9 months

Policy/Advocacy

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

School-based health education helps youth acquire functional health knowledge, and strengthens attitudes, beliefs, and practice skills needed to adopt and maintain healthy behaviors.

LEAD	Government Relations at Hospitals, Local Advocacy Organizations, and Schools
PARTNERS	Community-based organizations
SAMPLE PILOT DESCRIPTION	School curricula which include health-related content should contain learning outcomes directly related to students' acquisition of health-related knowledge, attitudes, and skills and are grade-level appropriate. Ensuring there is continuity between these lessons helps to ensure children adopt healthier behaviors that are likely to stick with them into adulthood.
REAL WORLD EXAMPLE	The Division of Pediatric Dentistry at The Ohio State University College of Dentistry states that "dental education has an opportunity to teach advocacy skills to future dentists, although advocacy training in predoctoral dental education has been largely ignored." They evaluated fourth-year dental student's attitudes toward advocacy, identified the type and extent of advocacy experiences during dental school, and assessed their future intentions to engage in advocacy. According to their findings, "[d]ental students with advocacy experience are more likely to report intentions to participate in advocacy as dentists. Dental education has a critical role in preparing future dentist-advocates."
POTENTIAL IMPACT	Improved health knowledge among children, better adherence to health care appointments and treatments later in life, healthier behaviors
TIMELINE	12-24 months

Policy/Advocacy

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

To help individuals compare the different features of health benefits and coverage, the Affordable Care Act requires group health plans and insurance companies to provide those covered with a summary of benefits and coverage (SBC) that accurately describes their coverage under the plan. Along with this SBC, group health plans and insurance companies must also provide a Uniform Glossary to explain standard medical and insurance-related terms.

LEAD	Government Relations at Hospitals, Local Advocacy Organizations
PARTNERS	Community-based organizations (lobbying)
SAMPLE PILOT DESCRIPTION	The SBC reflects a health plan's benefits, anticipated costs for the patient, and covered health care services. SBCs also explain other unique features, such as cost-sharing rules, and include descriptions of the limits of a person's coverage in plain, jargon-free terminology.
REAL WORLD EXAMPLE	The Dental and Optometric Care Access Act, or DOC Access Act, according to the ADA, is "...bipartisan legislation prohibits dental, and vision plans from setting the fees network doctors may charge for services not covered by the insurers. It also protects patients and brings needed equity to insurer/provider contracting. Even though 42 states have passed laws limiting interference with the dentist-patient relationship, many dental and vision plans are federally regulated, so insurers can claim they are exempt. Passage of this bill will help align the federal government with what's happening across the country. It would also balance contract negotiations between providers and large dental insurance companies."
POTENTIAL IMPACT	Individuals are more aware of their benefits and can accurately describe the benefits and coverage under the plan, better access to health services allows people to be more productive and ensures better education outcomes for children, while mitigating the risk that a person or family could be pushed into poverty by a health-related expense
TIMELINE	12-24 months

Goal 2

WHAT WE ENVISION FOR OUR COMMUNITY

The health care education pipeline and workforce are strong, reflect the diversity of our region, and deliver equitable care to everyone

Community Outcomes

How we will know if we have made a difference

SHORT-TERM

- Increase the number of students in the health care education pipeline
- Increase the number of racially and ethnically diverse students in the health care education pipeline

INTERMEDIATE

- Reduce vacancy rates for key health care positions (e.g. physicians, nurses, clinical staff, management)
- Increase health care workforce diversity for key positions
- Strengthen culturally and linguistically competent services in health care delivery

LONG-TERM

- Increase the number of patients who share the same racial or ethnic background as their health care provider
- Reduce disparities in patient outcomes and experience

Priority Populations

The people and places experiencing significant health disparities

Increase health care workforce diversity for key positions to address equity for priority populations, including members of minority racial and ethnic communities (e.g. Black persons, Hispanic or Latino persons), foreign-born persons, people who were formerly incarcerated, and people who live in rural areas.

Goal 2

Priorities and Strategies

Evidence-informed actions to help achieve our goal

Priority 2.1

Expand and diversify the health care workforce pipeline through education and hiring opportunities

Featured Strategies

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

Health care apprenticeships provide health care systems a pipeline of skilled workers, lower turnover for apprentices and mentors with skills that match organizational culture, increased loyalty, and higher productivity.

LEAD	Hospital leadership and human resources, Community-based workforce organizations
PARTNERS	Higher education institution, Hospital association
SAMPLE PILOT DESCRIPTION	Programming is created within the health care system. During the program, non-medical personnel already employed at area hospitals will gain knowledge and skills training to qualify to move into assignments as Medical Assistants or other medical personnel.

Featured Strategies

REAL WORLD EXAMPLE	The Medical Assistant Apprenticeship program is a twelve-month intensive, rigorous, and competency-based program. The program is a collaborative effort that includes Cincinnati State's Workforce Development Center, the Health & Public Safety Division, The Health Collaborative of Greater Cincinnati, Mercy Health, UC Health, and TriHealth. During their apprenticeship, apprentices undergo technical instruction provided through Cincinnati State and on-the-job learning at the employers' physician offices. They also complete self-led study time. During the internship, apprentices complete 2,000 hours of on-the-job training and 144 hours of related technical instruction. A preceptor supervises apprentices during on-the-job training.
POTENTIAL IMPACT	Provide people with an opportunity to grow professionally and improve the supply of clinical staff to fill high-need positions in the tight health care labor market, improve recruitment of a highly-skilled, diverse labor force in the health care industry
TIMELINE FOR IMPLEMENTATION	9-12 months

Featured Strategies

2.1.2 Increase career exploration and work-based learning.

Career exploration and work-based learning can include training experiences like an internship required for a credential or entry into an occupation, a clinical experience, or other paid or non-paid work experience.

LEAD	Hospital leadership and human resources, Community-based workforce organizations
PARTNERS	Higher education institutions, Employers, Hospital associations
SAMPLE PILOT DESCRIPTION	Students learn through practical experience that develops knowledge and skills necessary for success in health care careers. Career exploration and work-based learning can include job shadowing, an informational interview, or direct contact with a professional in the chosen occupation, integrated projects, service learning, internships, hospital tours, guest speakers in the classroom, career fairs, etc. to increase student awareness of various job opportunities in the health care field.
REAL WORLD EXAMPLE	TAP Health is The Health Collaborative's signature careers pipeline initiative for high school students. According to The Health Collaborative, "[t]he TAP Health Summer Academy is a group of career exploration programs consisting of TAP MD; TAP RN: Diversity; and TAP HC—programs which respectively help guide students through the ins and outs of seeking a career as a physician, registered nurse, or any career within the broad spectrum of health care." TAP Health also offers a virtual health care career exploration program, TAP Health Remote. TriHealth's School at Work partnership program with Cincinnati Public Schools (CPS) offers a 2-year, paid career exploration opportunity to high school juniors and seniors. Students work 12-15 hours/week during the school year and over the summer if desired. During the program, they explore and gain work experience in 8-10 various areas of hospital operations.
POTENTIAL IMPACT	Health care career exploration/work-based learning can help high school students explore medical specialties and offer the opportunity to learn about a broad cross-section of health care careers. Educational programming provides immediate and long-term impact in helping students feel equipped and empowered to pursue a rewarding health care career.
TIMELINE FOR IMPLEMENTATION	9-12 months

Featured Strategies

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

Collaborate with an educational institution to increase health care program capacity so that more interested and qualified applicants can gain access to programs.

PARTNERS	Higher educational institutions
SAMPLE PILOT DESCRIPTION	A hospital partners with a local university to develop and implement a sustainable, long-term collaborative process for increasing minority participation in health care-track degree programs. They recruit an advisory group composed of students who are studying medicine and belong to minority groups, and work with this group to identify gaps in the recruitment of minority health care students and resources to support their ongoing study and job placement, as well as ways to make the educational environment more welcoming and inclusive.
REAL WORLD EXAMPLE	University of Cincinnati College of Medicine, Cincinnati Children's and Minority Housestaff Association are hosting a second look event to enhance the number of an underrepresented minority in medicine (URiM) residents in each program which are defined as African-American, American Indian, Hispanic/Latinx, Native Hawaiian, and Alaska Native. Given the geographic location and the city's demographics, the primary focus has been on African-American and Hispanic/Latinx students. Diversity is a priority, and that commitment is reflected in the strategic plan of the University of Cincinnati College of Medicine. Many residency programs offer this experience as a way to enhance the diversity in programs. This program also aligns with the newly revised Accreditation Council for Graduate Medical Education common program requirements for diversity and inclusion under section I.C, which states, "The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if present), faculty members, senior administrative staff members, and other relevant members of its academic community."
POTENTIAL IMPACT	Enhance the quality of care and improve health care outcomes and address the health care needs of underserved communities and populations.
TIMELINE FOR IMPLEMENTATION	9-12 months

Featured Strategies

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

Create dedicated leadership and resources at a strategic level. Develop cross-sector collaboration critical to implementing more-effective workforce development programs. The government can serve as a convener, catalyst, and broker for these conversations.

LEAD	Cross-Sector Collaborative (Regional Health Improvement Collaborative or Foundation)
PARTNERS	Higher educational institutions, Local government entities, Community-based organizations, Hospital
SAMPLE PILOT DESCRIPTION	Establish public-private partnerships within the community to create more jobs, attract outside talent and business, increase medical research and bolster the economy.
REAL WORLD EXAMPLE	According to the office of the Governor, The Cleveland Innovation District "will be a center of excellence that acts as a catalyst for ongoing investment in Northeast Ohio, including the attraction of businesses and the talent needed to keep the state competitive in health care and IT." This district consists of several of the area's major players in education and health care, including the University Hospitals, The Cleveland Clinic, MetroHealth, Case Western Reserve University, and Cleveland State University.
POTENTIAL IMPACT	Create research, developments, and job opportunities to advance health care
TIMELINE FOR IMPLEMENTATION	24-36 months

Featured Strategies

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.

Building a diverse workforce can help health care employers achieve their overall talent recruitment and retention goals. The strategy can integrate diversity recruiting and retention techniques to increase diverse representation.

LEAD	Hospital leadership and human resources, Community-based workforce organizations
PARTNERS	Educational institutions
SAMPLE PILOT DESCRIPTION	Identify consensus on goals for increasing equity and diversity in faculty hiring, then discuss what the department hopes to accomplish by hiring and retaining more ethnically diverse faculty at all levels. Identify advocates among faculty who will support the hiring and retention of faculty from underrepresented groups. Develop metrics for assessing diversity statements and develop new faculty job postings by these metrics. Proactively recruit promising diverse candidates to various positions and invite them to apply. Create a mentorship structure for new faculty members in order to ensure their success, in conjunction with implicit bias training and other diversity, equity, and inclusion interventions for all existing staff.
REAL WORLD EXAMPLE	The National Committee of Diversity and Inclusion (AICPA) Recruitment and Retention Toolkit outlines several strategies many organizations employ to recruit and retain a diverse and inclusive workforce. This toolkit is to help leaders focus on high-priority areas for the organization. It is designed to address and offer suggestions to organizations that desire a more gender, ethnically, and generationally diverse candidate pool.
POTENTIAL IMPACT	Increasing diversity focuses on the advantages conferred by more diverse teams: they are more innovative and inventive, more capable of problem-solving, and more effective. A well-articulated, thoughtful, and explicit commitment to equity, diversity, inclusivity, and retention of faculty with ethnically diverse backgrounds. Diverse faculty leading students within academia can increase the success of diverse students.
TIMELINE FOR IMPLEMENTATION	6-9 months

Featured Strategies

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.

It is critical to recruit potential employees from neighborhoods with higher poverty rates and then support their career trajectories through intentional efforts to train them and provide access to career development and internal advancement.

LEAD	Health care leadership and human resources
PARTNERS	Community-based workforce organizations, Educational institutions
SAMPLE PILOT DESCRIPTION	• Create/offer career exploration and work-based learning opportunities to promote future pathways to students while they are in middle and high school • Designate geographic focus in high-poverty neighborhoods • Set aside positions for pipeline cohort graduates • Offer job coaching for new hires and map out potential career pathways • Partner with local educational institutions and community organizations • Provide tuition assistance for training accessible to frontline employees
REAL WORLD EXAMPLE	University Hospitals (UH) of Cleveland, Ohio, focus their workforce development initiatives on connecting community residents to job and career opportunities within the institution. The external programs focus on six high-poverty neighborhoods surrounding UH's main campus, called the Greater University Circle (GUC). The GUC has a population of about 50,000. Towards Employment, a local nonprofit organization, provides participants with skills training focused on specific open positions at UH. UH sets aside position spots outside of the normal candidate pool and hires directly from cohort graduates. UH also has an internal worker-training program for current staff, which provides encouragement and support for internal advancement. UH offers skills training initiatives and partners with education and training entities that can provide targeted skills development. In addition, employees can apply for job-specific training programs where they will receive paid training to move into a more advanced position on the career ladder.

Featured Strategies

POTENTIAL IMPACT	Inclusive, local hiring creates multiple benefits that contribute to better institutional and community outcomes in both the short and long terms. **Short-term impact:** Reduce job turnover rates. Increase recruitment process efficiency. Save internal training and orientation costs. Create a more diverse workforce. Develop partners that can uniquely adapt to the business needs. Leverage public resources by linking existing workforce development dollars to employer demand. **Long-term impact:** Improve employee morale through internal investment and strong community connections. Address issues of health equity and identify community health needs. Improve the reputation in the community. Reduce the carbon footprint by increasing the number of employees living close to work. Increase community impact by targeting underserved neighborhoods.
TIMELINE FOR IMPLEMENTATION	6-9 months

Policy/Advocacy

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

Create a culturally competent health care system to help improve health outcomes for patients and quality of care and contribute to the elimination of racial and ethnic health disparities. Cultural competence among health care professionals is acquired partly through leadership. Includes social relationships and leadership effects within health services to increase DEI efforts.

LEAD	DEI leadership at hospitals
PARTNERS	Human resource consultants, DEI consultants
SAMPLE PILOT DESCRIPTION	Recognition that diversity is necessary but insufficient to create a just and inclusive culture. Awareness that every leader and leadership team is at risk for blind spots in their organization's inclusiveness. Appreciate that narrow leadership concepts and stereotypical traits of leaders may limit an organization's ability to improve its DEI and overall performance.
REAL WORLD EXAMPLES	Avant Consulting Group, experts in creating compassionate spaces for hard conversations, partnered with UC Health's Training & Organizational Development Department to train employees via new employment orientations, newly hired and promoted leaders through quarterly leadership orientations, their council on diversity, and EPIC users regarding updates related to gender inclusion. Avant Group used an interdisciplinary approach. Academics, experiential experts, health professionals, sociologists, and historians provided education related to racial socialization, implicit bias, microaggressions, identity consciousness, multiple levels of inequities, socio-political constructions of race, structural racism, socio-structural determinants of health, fat antagonism, inclusive leadership, and gender identity/expression. These relevant workshops were designed to change attitudes, raise awareness, cultivate empathy, and enhance knowledge regarding bias and structural inequities. Avant Group was mindful of these challenging conversations and incorporated strategies to ease anxieties and promote robust dialogue.
POTENTIAL IMPACT	The more the organizational environment formally and informally supports and encourages culturally responsive assessment and service delivery, the more likely health professionals will develop cultural competence.
TIMELINE	3-6 months

Policy/Advocacy

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

The health care workforce is becoming more diverse, but there is still a need to advocate and increase the institutional and regional standards for retention, advancement, and diversity of the health care workforce in all allied health fields. Most people of color in health care jobs remain in entry-level and often lower-paying jobs with limited upward mobility.

LEAD	Health care systems, Hospital, Employees/workforce
PARTNERS	Educational institution
SAMPLE PILOT DESCRIPTION	Comprehensive standards and programs that include social support, academic support, and financial support. Standards emphasize the need and obligation to serve and advocate for a racial and ethnically diverse workforce.
REAL WORLD EXAMPLE	In 2019, U.S. lawmakers introduced the Allied Health Workforce Diversity Act (H.R. 3637), making its way through the Senate. If passed, this legislation would allow the Department of Health and Human Services to provide grants to accredited PT, OT, audiology, and SLP education programs to increase diversity in the professions. Grants could be used to provide scholarships or to support recruitment and retention efforts for students of color.
POTENTIAL SUPPLEMENTAL POLICIES	Mentorship and sponsorship programs are best practices for advancing a racially and ethnically diverse workforce.
POTENTIAL IMPACT	Health professions' education programs improve as they strive to diversify their student populations, retain students of color, and provide culturally responsive education and training
TIMELINE	6-9 months

Policy/Advocacy

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

Maintaining healthy rural communities requires a consistent and qualified rural health workforce, both living and working locally in rural communities and providing specialized support via telehealth. This strategy involves ensuring that physicians, nurses, dentists, and other health care professionals are well-educated, well-trained, and have had an experience exposing them to and preparing them for rural practice and supporting health care services in a rural context.

LEAD	Collaborative partnership of academia/university (medical colleges), Hospitals
PARTNERS	Educational Institutions, Community-based organizations

SAMPLE PILOT DESCRIPTION	Strategies, programs, and activities used to educate and train the rural health workforce may include examples such as the following from Rural Health Information Hub:
	• **"Grow-Your-Own and Career Ladder Programs**
	  • Programs like job shadowing, career fairs, and scrubs camps that introduce rural students to health careers
	  • Health care facility programs that help employees advance their education and careers, including apprenticeships
	• **Education and Training Provided in Rural Areas**
	  • Nursing and allied health education at rural community colleges
	  • Rural rotations or curricula, including rural interprofessional education experiences
	  • Residency programs and fellowships specifically designed to train physicians and nurse practitioners for rural practice
	  • Continuing and professional educational opportunities for rural health professionals
	• **Technology to Educate the Rural Health Workforce**
	  • Simulation
	  • Distance learning
	  • Telehealth applications for learning"

REAL WORLD EXAMPLE	Many medical schools offer programs that provide rural training experiences to students who are considering practicing in rural areas (Medical School Rural Track (RT) Programs). Rural tracks (also called programs, pathways, concentrations, or other terms) give students exposure to the broad scope of practice rural physicians experience. The initiative can fuel students' interest in residency and a career in a rural area. It helps other students realize that they are better suited to an urban environment, which is important before committing to rural practice.
POTENTIAL IMPACT	Investing in rural health care education can improve health outcomes in rural areas, facilitate recruitment and retention efforts, reduce workforce shortages and increase diversity.
TIMELINE	12-18 months

Priority 2.2

Track and consistently publish ongoing workforce data/statistics in a regional dashboard, including class sizes, vacancy rate, and diversity percentages at a regional level, publishing these results annually

Featured Strategies

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

Develop and routinely update core data sets that facilitate analysis of the supply, demand, and distribution of the health care workforce across health professions. Technical assistance and partnerships with licensure boards, educational organizations, and professional associations at the national, state, and local levels will be necessary.

LEAD	Health information exchange in partnership with hospitals and community health centers.
PARTNERS	Educational Institutions, Licensure/Governing Boards
SAMPLE PILOT DESCRIPTION	Develop a workforce surplus/shortage surveillance system that provides regular and frequent data (e.g., every 6–12 months) on key workforce indicators. This system would employ surveillance methods similar to those of other economic monitoring systems designed to track trends and prompt early warning of workforce changes. The development of such a system will require partnerships with public and private employers and organizations.
REAL WORLD EXAMPLE	HRSA's Bureau of Primary Care and Bureau of Health Professions conduct some monitoring primarily for nurses, primary care clinicians, mental health professionals, dentists, and pharmacists for purposes of designating health professional shortage areas/facilities and medically underserved areas/populations and informing funding decisions to support clinician training. HRSA is well-positioned to assume leadership in directing resources needed to build a data infrastructure to support health care workforce research.
POTENTIAL IMPACT	Health outcomes are associated with various health professions, whether interprofessional team-based care is more efficient, lowers costs, and leads to safer care and improved patient outcomes.
TIMELINE	6-12 months

Featured Strategies

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

Documentation of diversity, equity, and inclusion best practices to assist health care systems in maintaining employee engagement. Documentation can create a balanced organizational culture and have employees form personal relationships within the health system.

LEAD	Regional Health Improvement Collaborative with hospitals
PARTNERS	Human Resource consultants
SAMPLE PILOT DESCRIPTION	To demonstrate commitment to the organization's mission and values, make sure all leadership decisions reflect the organization's core values. The more leaders emphasize the organization's values, the more respect they can earn from employees.
REAL WORLD EXAMPLE	The National Fund of Workforce Solutions programmatic best practices engage frontline workers directly with accessible learning and career growth opportunities that expand the internal and external talent pipeline. The organizational best practices build the necessary systems and support to ensure sustainability, business impact, and the best results for workers.
POTENTIAL IMPACT	Better company culture leading to better employee engagement, retention, improved work output, more open communication, collaboration, and innovation
TIMELINE	6-12 months

Priority 2.3

Eliminate retention disparities for racially and ethnically diverse health care workers

Featured Strategies

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

Human resource metrics (such as candidate diversity, turnover rates, wage rates and changes over time, retention metrics, and awards) are important figures that can help health care organizations track their workforce and measure how effective their human resources initiatives are within the workplace.

LEAD	Health care systems including hospitals, clinics, and Federally Qualified Health Centers
PARTNERS	DEI Professionals
SAMPLE PILOT DESCRIPTION	A health care organization Implements data and analytics can help organizations spot racial differences in wages, seniority level, etc. The following data (by race) can help employers identify areas for improvement: demographics of candidates at each step of the recruiting process, employee satisfaction, wage rates, performance review data, receipt of awards, retention, and turnover.
REAL WORLD EXAMPLE	Messer construction works to provide the opportunity for employees to successfully complete projects that match their capacity, skillset, and financial strength. Messer's Inclusive Excellence Fund supports initiatives and programs offered through UC's Office of Inclusive Excellence and Community Engagement, such as CPS Strong and Summer STEM Bridge, both striving to encourage underrepresented students and eliminate barriers to a diverse pipeline of engineers. At UC Health, the Messer Diversity Discretionary Fund goes toward new initiatives and programs that build cultural competency around implicit bias and advance sustainable change that increases employee engagement and supports positive patient outcomes.
POTENTIAL IMPACT	Improve diversity, equity, and inclusion strategies for the future, increase workforce diversity over time, retain better talent, and identify positive and negative workforce trends
TIMELINE	3-6 months

Featured Strategies

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).

Patterns of racial and sex segregation exist within the health care sector. In addition, BIPOC employees are concentrated in lower-level direct care and reproductive occupations. Direct care occupations provide hands-on care for patients, such as bathing, dressing, and feeding, including nursing assistants, home health aides, and patient care technicians. Reproductive occupations perform supportive tasks such as cleaning and cooking and include housekeeping and dietary workers. These workers provide vital essential services across all types of health care organizations, including acute, outpatient, and long-term care settings, and the importance of these workers.

LEAD	Health care organizations
PARTNERS	Human resources consultants
SAMPLE PILOT DESCRIPTION	Create the most useful audits in health care; it will be essential to assure that they capture total compensation. Many physicians, particularly those practicing in academic settings, receive compensation from clinical and non-clinical activities. Comparing compensation for clinical activities alone would not capture these differences, contributing to lower overall salaries for the amount worked. • Hire auditors • Make sure auditors have appropriate employee data • Complete analysis that weeds out pay differentials based on legitimate factors • Correct pay gaps • Identify the cause of salary gaps
REAL WORLD EXAMPLE	With the support of New York Makes Work Pay (the NYS Comprehensive Employment Services Medicaid Infrastructure Grant), NYAPRS partnered with the Institute for Community Inclusion on a project to identify the most important systemic barriers that limit the employment outcomes of people with psychiatric disabilities in New York State. The program identified policy and program improvement recommendations to best address these systemic barriers. This guides future efforts to improve access of New Yorkers to more effective employment services.
POTENTIAL SUPPLEMENTAL POLICIES	Acknowledge that women are more likely to volunteer or be volunteered for non-promotable work, and, within medicine, women perceive that they are more likely to be given uncompensated work (such as unpaid committee or teaching positions and office-improvement projects) alongside clinical care.

Featured Strategies

POTENTIAL IMPACT	Identifying and addressing some of the lower wage employee pay disparities. The lack of accurate salary data creates a major barrier to leaders seeking to address inequities and to female physicians as they negotiate. Pay audits and increased transparency could help. Organizations outside of medicine have effectively used audits to reveal pay discrepancies and enhance pay equity.
TIMELINE	12-24 months

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.

Sponsors act as brand managers and publicists for those whom they are sponsoring, meaning that they both advocate for and seek out opportunities for the sponsored employee. Mentorship focuses on help that a mentor can provide directly, such as guidance, advice, feedback on skills, and coaching. Both sponsorship and mentorship can be extremely helpful tools for members of underrepresented groups who are seeking to establish themselves or grow within an organization.

LEAD	Health care organizations, Community-based organizations
PARTNERS	Educational institutions, Professional development associations
SAMPLE PILOT DESCRIPTION	Establish a formal mentorship program where new employees are matched with experienced employees to receive coaching and guidance. Train these mentors to ensure they are equipped to assist their mentees, and encourage mentors to work with mentees to set goals for improvement, touch base on a regular basis, and report out to other relevant stakeholders on the progress and efficacy of the mentorship program overall.

Featured Strategies

REAL WORLD EXAMPLE	The Stanford Nurse Mentorship Program at Stanford Health Care (SHC), relaunched in 2018, is an interactive web-based platform. According to Stanford, "[t]he program is designed to help nurses of all roles and levels of the organization succeed in reaching their own individualized goals in their nursing careers. The SHC-Nursing Mentorship Program acknowledges that aligning nurses' goals with mentors that have already achieved those goals will streamline the nurses' efforts to reaching a higher satisfaction with their professional lives. The SHC-Nursing mentorship program provides a customized mentorship pairing to each nurse's individualized career goals. Evaluation of the program by mentees has indicated a high level of satisfaction with the program and a high rate of goal achievement from their mentoring relationships. The goals of the program are to promote a culture of mentorship, professional development, teamwork, and succession planning for the future of SHC while retaining the high-quality nurses and thereby decreasing costs associated with recruitment and orientation."
POTENTIAL IMPACT	A more diverse workforce due to better retention of diverse employees, greater rates of internal promotion, improved relationships between employees at varying levels of seniority, better organizational decision making due to increased collaboration
TIMELINE	6-12 months

Featured Strategies

2.3.4 Offer flexible childcare options for health care employees.

On-site childcare provides employees with a company-sponsored childcare facility at or near their office. In-office daycare is offered during and after the traditional school day. Women and people of color are often the most in need of childcare to allow for career advancement, so that this policy could go a long way towards equity of opportunity.

LEAD	Health care organizations
PARTNERS	Childcare providers, Community-based organizations
SAMPLE PILOT DESCRIPTION	Organizations should first evaluate and decide which childcare benefits will improve their workplace and fit their budget. Organizations should provide childcare benefits to all employees so that both men and women feel they can advance. Lastly, organizations should offer childcare savings accounts to all employees. Organizations can offer childcare benefits of varying costs, including: • Childcare subsidies • On-site childcare • Flexible employee schedules • Predictable employee schedules • Backup childcare assistance • Flexible childcare spending accounts • Parent & caregiver employee resource groups (ERGs)
REAL WORLD EXAMPLE	Wellstar's Kennestone Hospital in Marietta, Georgia. Wellstar's learning academy is a child care center located on the hospital campus. The center remained open throughout the pandemic, serving as a lifeline for working mothers being asked to pick up extra shifts or work overtime amid surges of COVID-19 patients. Hospitals that leveraged on-site child care centers throughout the pandemic helped ease staffing shortages.
POTENTIAL IMPACT	Increase hiring pool to include parents with childcare needs, better attendance and timeliness among existing employees, increase socioeconomic diversity of hiring pool, improve employee performance by facilitating peace of mind and wellbeing and eliminating a logistical stressor
TIMELINE	6-9 months

Policy/Advocacy

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

The National CLAS Standards "are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations" according to the Centers for Medicare & Medicaid Services. CLAS are designed to be respectful of and responsive to each person's culture and communication needs. CLAS helps organizations consider cultural health beliefs, preferred languages, health literacy levels, and communication needs.

LEAD	Health care organizations
PARTNERS	Community-based organizations, health care organizations
SAMPLE PILOT DESCRIPTION	There is no single correct way to implement the National CLAS Standards. The organization may decide to implement some but not all of them, or wish to implement some sooner than others. However, to properly implement standards, organizations should collect and frequently update patient demographic data in order to assess the ongoing efficacy of CLAS interventions and any resultant changes in health outcomes or served populations.
REAL WORLD EXAMPLES	The Michigan Health & Hospital Association (MHA) developed the Eliminating Disparities To Advance Health Equity and Improve Quality guide based in part on CLAS standards in order to better support its member hospitals as they seek to provide equitable care. According to the guide, "[t]he MHA Keystone Center developed this guide to provide practical guidance for organizations seeking to eliminate disparities in care to advance health equity, including: • The importance of incorporating an equity lens into all improvement strategies, including quality, patient safety, population health, to improve health outcomes and the patient experience. • Establishing a common understanding of health organizations' role in addressing health disparities to achieve equity in care. • Assessing each organization's implementation level within key categories identified as critical components of any organization's strategic plan to reduce disparities. • Providing targeted resources and critical steps to support organizations in their journey to advance current practices toward achieving equity in care."
POTENTIAL IMPACT	Advance health equity, improve health care quality, help eliminate health care disparities by improving cultural and linguistic appropriateness
TIMELINE	3-6 months

Policy/Advocacy

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.

Creating a standardized set of best practices for making space for employees of color can help employers understand how cultural differences can impact how people work and interact at work. The best practices can assist health care systems in understanding concepts of intentional diversity, equity, and inclusion opportunities within workplaces.

LEAD	Hospital leadership, Federally Qualified Health Center
PARTNERS	Community-based organizations, Diversity, equity, and inclusion professionals
SAMPLE PILOT DESCRIPTION	A health care organization offers diversity training which focus on information relevant to their specific organization and employees, aligning with their existing diversity, equity, and inclusion initiatives and aimed at improving the weak points they have already identified. They partnering with a consultant to build customized training programs and identify remaining blind spots within the organization. Leaders communicate to the staff the importance of this training, what problems it is seeking to solve, and how the organization hopes to move forward.
REAL WORLD EXAMPLE	McLean Hospital created a core initiative of the Diversity, Equity, and Inclusion Office (DEIO) to develop sustainable practices and resources that foster growth, safety, and belonging. The DEIO Resource Page is an ever-evolving, internal resource for McLean and Mass General Brigham employees throughout the system to access educational materials, remain up to date on DEI events, and contribute to McLean's DEI initiatives.
POTENTIAL IMPACT	Strengthened team dynamics, increased diversity long-term due to healthier workplace culture, greater innovation and improved decision-making due to prevalence of a wide range of experiences and viewpoints, improved patient experience
TIMELINE	3-6 months

Goal 3

WHAT WE ENVISION FOR OUR COMMUNITY

Everyone in the region has access to healthy, affordable food and quality, affordable housing

Community Outcomes How we will know if we have made a difference

SHORT-TERM

- Increase the percent of patients screened for health-related social needs (e.g. food and housing insecurity)
- Increase referrals to community resources for patients with health-related social needs
- Increase support for existing food and housing efforts to meet the full scope of community needs
- Increase legal representation for tenants facing eviction

INTERMEDIATE

- Reduce unnecessary emergency department use stemming from patients' health-related social needs
- Decrease requests for emergency shelter
- Decrease the eviction filing rate
- Decrease mortgage and tax foreclosures
- Improve housing conditions and quality
- Increase enrollment in food assistance safety net programs (e.g. SNAP, Produce Perks)
- Increase the availability of healthy foods (e.g. fruits, vegetables)

LONG-TERM

- Decrease severe housing cost burden
- Increase available quality, affordable housing units
- Decreasing percentage of housing vacancies
- Decrease food desert areas
- Decrease household food insecurity
- Increase the consumption of healthy food (e.g. fruits, vegetables)

Priority Populations The people and places experiencing significant health disparities

Black persons, veterans and active-duty military, people with disabilities, people who are uninsured or underinsured, and foreign-born persons and those who speak English as a second language.

Goal 3

Priorities and Strategies

Evidence-informed actions to help achieve our goal

Cross-Cutting Strategies

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).

Organizing patient care activities and sharing information among all of the participants concerned with a patient's care is essential to achieve safer and more effective care.

LEAD	Coordinated care organization, Hospitals, Federally qualified health centers
PARTNERS	Social service agency, Community based organizations
SAMPLE PILOT DESCRIPTION	Health care providers screen for health-related social needs during routine health care activities. Upon identifying a patient with a health-related social need (e.g. a volatile housing situation), the provider refers this patient to a local social service agency which is equipped to follow up with this need and identify any additional areas of assistance the patient may need.
REAL WORLD EXAMPLE	Health care Access Now Adult Health Care Coordination connects community health workers (CHWs) with patients from primary care practices and Medicaid health plans. The CHWs complete a social and medical access assessment to identify the needs of the patient. Together they craft a plan to meet chronic disease self-management goals, which includes finding resources to eliminate barriers to regular and timely medical care.
POTENTIAL IMPACT	Reduced hospital admissions, improved quality of chronic disease management, improved patient satisfaction, and better access to specialty care.
TIMELINE FOR IMPLEMENTATION	3-6 months

Cross-Cutting Strategies

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

Increase the number of community health workers who play a critical role in connecting people to care, including COVID-19 care; mental health and substance use disorder prevention, treatment and recovery services; chronic disease care; and other important health services.

LEAD	Community based health care organizations
PARTNERS	Hospitals, Federally qualified health centers
SAMPLE PILOT DESCRIPTION	Community Health Workers (CHWs) are equipped with the skill sets needed to provide effective community outreach, build trust with communities, support connections to and retention in care and support services, and other strategies to increase access to care and to assist individuals in prevention services. Additionally, they can serve to assist in holistic recovery from the effects of the COVID-19 pandemic and other public health emergencies in underserved communities. These combined efforts are intended to advance public health, strengthen the public health workforce, reduce health disparities, and help underserved populations achieve health equity.
REAL WORLD EXAMPLE	Health care Access Now (HCAN) collaborates with Mercy Health as a Pathways Community Hub partner. HCAN is the Hub for the Cincinnati regional area. This partnership means an expansion of services for those members of vulnerable populations who face obstacles to good health in the Cincinnati area. The Hub provides a framework for Community Health Workers to identify and help remove barriers to health care access for underserved populations. The Hub's "pathway" model presents a structure that clarifies the different obstructions to health care that may exist for clients, including transportation, education, safety, and housing. Hub partnerships benefit health care organizations because their CHWs can access additional education. The metrics provided by all Hub members allow organizations to demonstrate the effectiveness of methods and resources.
POTENTIAL IMPACT	Extending care beyond the hospital or clinic walls to help bridge gaps in care, expand access to care and, ultimately, improve health outcomes for high-risk patients.
TIMELINE FOR IMPLEMENTATION	3-6 months

Priority 3.1

Eliminate residential evictions due to inability to pay rent

Featured Strategies

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

The expansion of care coordination agencies will ensure patients' needs and preferences are known and communicated at the right time to the right people, resulting in high-quality, high-value health care. This information sharing guides safe, appropriate, and effective care delivery.

LEAD	Care Coordination Agencies
PARTNERS	Hospitals, Federally Qualified Health Centers, Community-based organizations, Insurance providers
SAMPLE PILOT DESCRIPTION	Community health workers (CHWs) engage at-risk individuals they meet through canvassing, referrals from Managed Care Organizations, and community partners. The CHWs then complete a comprehensive needs and risk assessment. CHWs enroll clients in Hub based on evaluation, opening standardized Pathways or connections to care and services. CHWs check in with clients regularly, provide continued support, link them to care and resources and educate the client on the goal of self-sufficiency. CHWs work with clients to complete Pathways by helping to work toward goals and maintain successful care and service connections. As the Pathways are completed, they are sent to Medicaid Managed Care for reimbursement and back to community agencies.
REAL WORLD EXAMPLE	The Dayton Regional Pathways Hub coordinates and operates a network of partnering care coordination agencies. Each partner employs community health workers to ensure that the necessary resources and services are in place to support clients in overcoming barriers to accessing health care. The Greater Dayton Area Hospital Association (GDAHA) delivers the Pathways Community Hub model, an evidence-based approach to Health Care Coordination, in communities throughout the greater Dayton area.
TIMELINE	6-12 months

Featured Strategies

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.

Legal help, emergency rental assistance funds, and landlord-tenant mediation services are key mechanisms for homelessness prevention. Health systems should partner with, refer to, and fund entities such as HOME, Legal Aid Society of Greater Cincinnati, Society of St. Vincent de Paul, and Community Action Agency that provide these services, in order to increase their capacity to provide needed help to the surrounding community.

LEAD	Hospitals, community-based organizations, legal aid societies
PARTNERS	Insurance providers
SAMPLE PILOT DESCRIPTION	A health system dedicates a funding stream to a partnership with its local Legal Aid society to create an avenue for medical providers to refer patients with legal needs related to social determinants of health.
REAL WORLD EXAMPLE	Cincinnati Children's Hospital Medical Center (CCHMC) has a medical-legal partnership called Child HeLP with the Legal Aid Society of Greater Cincinnati. This partnership has made it possible for health care providers to immediately connect a patient to legal services upon disclosing a need. In one example, CCHMC referred numerous patients to Legal Aid due to unsafe, unhealthy living conditions in their rental housing, including asthma triggers such as mold and dust. Child HeLP discovered that 16 referred families were living in housing owned by the same landlord, who had ignored previous orders to amend code violations. Child HeLP's intervention and subsequent advocacy resulted in substantial improvements to most of these units, resulting in improved housing conditions for families.
POTENTIAL IMPACT	Increased housing stability, fewer hospital admissions for patients with chronic illnesses due to improved housing quality and stability, lower health care costs over time
TIMELINE FOR IMPLEMENTATION	6-12 months

Featured Strategies

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.

Eviction prevention programs do more than prevent displacement: they have the potential to improve health outcomes, save future costs, and help stabilize a family's housing situation long term. Health systems have an opportunity to build partnerships with organizations that provide these services and provide them with increased funding to reduce evictions in the local community.

LEAD	Hospitals
PARTNERS	Local housing community-based organizations, Insurance providers
SAMPLE PILOT DESCRIPTION	A health system identifies a local provider of emergency housing assistance, including rental assistance, landlord/tenant mediation, and long-term stability coaching. The health system dedicates a funding stream to this partner for use in relevant high-need communities based on internal data. Health systems can refer patients in need of assistance to the organization and assist the organization in advertising its eviction prevention services to ensure tenants in need receive assistance.
REAL WORLD EXAMPLE	Bons Secours Mercy Health partnered with Housing Opportunities Made Equal Cincinnati (HOME) and Working in Neighborhoods (WIN) to administer funding for eviction and foreclosure prevention in the Bond Hill and Roselawn neighborhoods. Over 200 households participated in the program, and 90% remained in their homes for at least seven months after receiving this assistance, indicating increased housing stability. It is estimated that eviction rates could have been as much as 40% higher without this assistance.
POTENTIAL IMPACT	Reduced residential evictions, greater appointment and medication adherence due to reduction in additional stressors, improved mental and overall health in affected communities
TIMELINE	6-12 months

Featured Strategies

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

Health systems can impact their surrounding communities through partnerships with existing nonprofit development entities that have the expertise necessary to administer programs to create and rehabilitate quality affordable housing.

LEAD	Community-based organizations and local housing authorities
PARTNERS	Hospitals, City and county government entities
SAMPLE PILOT DESCRIPTION	A health system wants to invest in affordable housing in its surrounding community and, as a result, establishes a partnership with a local nonprofit. The health system purchases properties to rehabilitate and rent or resell at affordable prices, focusing on improving housing quality and availability. Additional services to existing neighborhood residents can also be provided through this partnership.
REAL WORLD EXAMPLE	The Healthy Homes initiative is a partnership between Nationwide Children's Hospital and Community Development for All People in Columbus. Since 2008, this partnership has impacted over 450 homes on Columbus's South Side. Healthy Homes has developed new builds and rehabilitated existing homes in disrepair to rent at affordable rates and made exterior home repair grants to neighborhood residents.
POTENTIAL IMPACT	Increase quantity of housing stock by utilizing vacant lot space and rehabilitating vacant properties, expand the availability of quality affordable housing, and help existing homeowners remain in their homes
TIMELINE	1-3 years

Featured Strategies

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.

Ensuring that affordable housing is well-maintained, secure, and healthy is a critical component of improving health outcomes related to housing.

LEAD	Hospitals
PARTNERS	Local housing organizations, City and county code enforcement entities
SAMPLE PILOT DESCRIPTION	Health systems, public servants, and local fair housing organizations convene a series of working sessions to identify ways they can collaborate to improve proactive municipal code enforcement, educate the public about their housing quality rights, identify problem landlords and neighborhoods of critical concern, and bring these action items to the attention of local governments.
REAL WORLD EXAMPLE	The Strategic Code Enforcement Management Academy (SCEMA) program brings together government entities, housing nonprofits, health nonprofits, and other interested community partners, including health systems, to learn about proactive code enforcement mechanisms and how stakeholders of different kinds can advocate for and improve code enforcement.
POTENTIAL IMPACT	Reduction in admissions for chronic illnesses impacted by environmental issues, greater housing stability due to decreased turnover
TIMELINE	3-9 months

Additional Strategies

For further details on additional strategies, including real world examples, see Appendix I.

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

Small landlords tend to have less capital, making updating and maintaining their properties more challenging, especially if they charge moderate rents. They can be incentivized to keep properties affordable while improving housing quality through low-cost loans and grants for home repairs.

LEAD	Local housing organizations, City and county government entities
PARTNERS	Community-based housing organizations

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

It is crucial to locate affordable housing in locations with high concentrations of poverty to provide low-income families with access to high-quality public schools and services and greater potential for economic mobility. Incentivizing developers to locate affordable housing in these neighborhoods through grants, low-cost loans, and other means could help increase the availability of such housing opportunities.

LEAD	Housing trust fund, Government entities, Insurance providers
PARTNERS	Health systems, developers, community development corporations, Insurance providers

Policy/Advocacy

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

As governments collaborate with developers to encourage investment in our communities, they often provide low-cost purchases of public land, government funding assistance, or tax breaks. Ensure that these public investments benefit the community, not just the developer, by requiring or incentivizing developers to make affordable housing investments that match the value of governmental support they receive.

LEAD	Government entities
PARTNERS	Developers, Health systems
SAMPLE PILOT DESCRIPTION	A municipality offers a tax credit for developing properties in a neighborhood with a large concentration of vacant buildings and empty lots. Health systems' government relations personnel collaborate to advocate for the passage of a policy that would require developers to provide affordable housing proportionate to the value of the tax credit they receive for developing in this neighborhood.
REAL WORLD EXAMPLES	The Health care Anchor Network (HAN), a collaborative of health systems across the nation, gathered on Capitol Hill to advocate for a statement regarding the necessity of universally available affordable housing and a briefing detailing key strategies for increasing the availability of affordable housing, including the reimagining of public investment in development to include affordable housing as a key priority at the local, state, and federal levels.
POTENTIAL IMPACT	Increased availability of affordable housing, reduction of displacement as distressed communities experience reinvestment, expansion of available housing stock overall
TIMELINE	3-6 months

Policy/Advocacy

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.

An expansion of the Housing Choice Voucher program would extend much-needed assistance to households that currently struggle under the burden of high rental costs. Additionally, renters' tax credits could increase the availability of affordable housing by decreasing the number of rent landlords need to collect from their tenants.

LEAD	Local housing organization (e.g. LISC, HOME)
PARTNERS	Government entities, Health systems
SAMPLE PILOT DESCRIPTION	A health system's government and accountability personnel advocate for the expansion of the HCV program and the establishment of renters' tax credits, as well as incentives for landlords to accept HCV. Health systems partner with local housing advocacy groups to expand their efforts to educate landlords regarding the benefits of accepting HCV and incentives that may be available to them locally for accepting HCV.
REAL WORLD EXAMPLES	Health clinics and health-based nonprofits are members of the National Low Income Housing Coalition, which advocated for and endorsed a bill to expand the HCV program. The bill has been introduced to Congress with bipartisan support.
POTENTIAL IMPACT	Greater mobility for users of HCV, increased housing stability, decreased homelessness
TIMELINE	3-6 months

Policy/Advocacy

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

Most code enforcement strategies are reactionary, meaning that a resident or concerned citizen must report property for a code violation to trigger municipal code enforcement actions. An alternative model is to create a rental registration system that requires proactive inspection of units and allows governments to identify problem landlords more easily.

LEAD	Government entities
PARTNERS	Health systems, housing nonprofits, health nonprofits
SAMPLE PILOT DESCRIPTION	Local health systems' housing and government relations personnel collaborate with nonprofits to present evidence-based recommendations to governments, demonstrating the need for a rental registration program.
REAL WORLD EXAMPLES	The Lead-Safe Cleveland Coalition, made up of health systems, nonprofits, public health officials, and government officials, successfully advocated strengthening Cleveland's existing rental registration program, which will require all Cleveland rental units to be inspected for lead safety by 2023.
POTENTIAL IMPACT	Better housing quality, improved outcomes for environmentally-impacted chronic conditions (e.g., asthma), reduced hospital admissions
TIMELINE	3-6 months

Policy/Advocacy

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.

Legislation that protects renters from various forms of discrimination substantially impacts marginalized groups' abilities to find quality affordable housing. Enforcing existing fair housing laws is key to ensuring they are effective. Advocating for new protections against things like the source of income discrimination in localities where they do not currently exist is also a key component of fair housing strategy.

LEAD	Local housing community-based organizations nonprofits
PARTNERS	Hospitals, Health focused nonprofits, Government entities
SAMPLE PILOT DESCRIPTION	Health systems' government relations personnel advocate for new renter protections and the strengthening and enforcement of existing protections. Health systems partner with local fair housing agencies to assist in their advocacy work through funding and platforming those efforts.
REAL WORLD EXAMPLES	Beth Israel Deaconess Medical Center (BIDMC) in Boston provided funds to the Boston Tenant Coalition to advocate for, among other things, discrimination protections in the City of Boston, which go beyond traditional discrimination protections to require that landlords proactively address the impacts of historical housing discrimination.
POTENTIAL IMPACT	Expansion of options for housing among low-income and minority renters resulting in greater social mobility, decreased likelihood of homelessness
TIMELINE	3-6 months

Policy/Advocacy

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

Affordable housing trust funds and other dedicated funding sources are cornerstones of an affordable housing strategy. Establishing a regional fund would expand the reach of existing affordable housing resources to more communities in need.

LEAD	City or county government entities
PARTNERS	Health systems, Nonprofits
SAMPLE PILOT DESCRIPTION	A health system's government relations personnel coordinate with local health and housing advocacy organizations to synthesize evidence for the benefits of a region-wide housing trust fund with a dedicated funding stream and present this evidence to governmental decision-makers.
REAL WORLD EXAMPLES	The Housing Development Consortium is an ongoing advocate for the expansion of the Washington State Housing Trust Fund. Its members include a clinic and community health services provider.
POTENTIAL IMPACT	Greater availability of affordable housing, improved conditions in existing affordable housing, long-term stabilization of the housing market, improved health outcomes for those with health conditions impacted by their living environment, reduced hospital admissions
TIMELINE	3-6 months

Priority 3.2

Ensure healthy food access within 10 minutes by foot or public transit in urban communities or by car in rural communities

Featured Strategies

3.2.1 Expand the availability of nutritious food through clinical care for high-priority populations.

Food as medicine interventions include medically tailored meals (also called therapeutic meals), medically tailored groceries (sometimes known as food "farmacies" or healthy food prescriptions), and produce prescriptions. They are typically directed by clinicians through the health care system, provided at no cost or meager cost to the patient, and funded by health care, government, or philanthropy.

LEAD	Local hospitals, Federally Qualified Health Centers, and Community-based clinics
PARTNERS	Local food policy council, Local agriculture
SAMPLE PILOT DESCRIPTION	Screen all patients for food insecurity, especially in practices that serve at-risk populations, and document findings in the electronic health record. Educate patients at risk of food insecurity about appropriate coping strategies. Physicians can help patients avoid unhealthy coping strategies like prioritizing food quantity over quality, stretching, avoiding medical care or filling prescriptions, choosing a small variety of low-cost or fast foods, fasting or skipping meals, and overeating when food is available. Patients should be screened at each visit to ensure appropriate evaluation and management of intermittent or recurrent food insecurity. Connect patients with assistance programs and encourage patients with food insecurity to utilize local food assistance programming.
REAL WORLD EXAMPLE	Kroger Health and University of Cincinnati partnered to conduct, Supermarket and Web-based Intervention targeting Nutrition or SuperWIN, a groundbreaking, randomized, controlled trial aimed at increasing diet quality and decreasing cardiovascular risk by promoting a heart-healthy diet through nutrition counseling provided by a registered dietitian. The in-aisle teaching with a Kroger Health registered dietitian significantly increased adherence to a heart healthy dietary pattern compared to traditional nutrition counseling alone. Adherence was further improved when in-aisle teaching was paired with education on how to use online shopping technologies, including grocery delivery service, the Kroger app and website, and OptUP, Kroger Health's industry-leading nutrition rating system to simplify and track healthier shopping.

Featured Strategies

POTENTIAL IMPACT	Improve patients' ability to follow dietary recommendations and access to recommended foods, alleviate food-related budget constraints that prevent patients from affording medications and paying bills, increase likelihood that patients will continue to eat healthily long-term, better disease management, fewer hospital admissions
TIMELINE	6-12 months

3.2.2 Provide Produce Prescriptions (PRx/Food As Medicine) at school-based health centers, community health centers, and health systems.

Produce prescription programs that use monetary incentives to promote fruit and vegetable consumption among under-resourced patients through physician identification and referral. Most programs target low-income patients with diet-related illnesses such as diabetes, obesity, heart disease, etc.

LEAD	Local food organizations
PARTNERS	Community-based clinics, Federally Qualified Health Centers, School-based health centers
SAMPLE PILOT DESCRIPTION	Physicians screen for and identify appropriate patients and write prescriptions for nutrient-rich foods. These prescriptions can obtain subsidized produce/food items through various community partners (local farmers' markets, grocery stores, and community-supported agriculture initiatives). PRx participants receive vouchers for use at local farmers' markets to choose fresh vegetables or fruits as economically feasible. Fresh produce mobile vans can make weekly stops at various locations, making it easier for PRx participants to use those vouchers.
REAL WORLD EXAMPLE	The Ohio Department of Health Bureau of Maternal, Child and Family Health and Produce Perks Midwest created the Infant Vitality Produce Prescription Program as a mechanism for responding to infant and maternal health needs among low-income pregnant women and mothers in counties with high infant mortality rates in the Black community relative to other Ohio counties. The Infant Vitality Produce Prescription Program improves food security for pregnant women and mothers in eligible counties all the way through an infant's first year.
POTENTIAL IMPACT	Healthier eating habits among community members in low-resource neighborhoods, better patient understanding of the role of nutrition in health management
TIMELINE	6-12 months

Featured Strategies

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.

Many rural and urban areas have limited access to healthy, affordable foods. Food deserts are found in rural and urban areas where supermarkets or grocery stores are scarce, directly contributing to food insecurity. Instead, these areas may have more convenience stores that are more likely to sell processed, shelf-stable goods rather than fresh produce. As a result, residents may have to travel to find healthy food, which can be more challenging for those without reliable access to transportation. Initiatives to increase access to healthier foods and beverages in retail venues can improve existing stores, encourage the placement of new stores, improve transportation access to healthier food retailers, and/or implement comprehensive in-store markets and promotion.

LEAD	Local Food Policy Council
PARTNERS	Hospitals, City and County governments, Foundations, Neighborhood associations, health care systems, local businesses
SAMPLE PILOT DESCRIPTION	Sell food at various retail venues in a community to increase fruit and vegetable consumption by community members. It's important to improve access to these venues and increase the availability of high-quality, affordable fruits and vegetables sold at these locations.
REAL WORLD EXAMPLE	Healthier food retail (HFR) initiatives were created by the Centers for Disease Control and Prevention to help increase people's access to places that sell healthier foods and beverages in underserved areas, including grocery stores, small stores, farmers' markets, bodegas, or mobile food retail. Initiatives can involve creating new food retail outlets that sell healthier foods, improving the quality, variety, and amount of healthier foods and beverages at existing stores, or promoting and marketing healthier foods and beverages to the individual.
POTENTIAL IMPACT	Better access to healthy food in urban areas with low public transportation service as well as rural areas
TIMELINE	9-12 months

Goal 3

Additional Strategies

For further details on additional strategies, including real world examples, see Appendix I.

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

Farm to school programs connects schools with nearby farms to incorporate locally grown foods into school breakfasts, lunches, and snacks. Local food is delivered via salad bars, fruit and vegetable bars, breakfast or lunch entrees, or taste-testing or snack programs.

LEAD	Farmers, Local food organizations
PARTNERS	Local public school systems

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).

During the pandemic, local schools and childcare centers have provided a nutrition lifeline for children, many of whom depend on USDA's child nutrition programs for the nourishment they need to grow and thrive. Ensure these resources are expanded and continue to be made available.

LEAD	Local public school systems
PARTNERS	Local food organizations

Policy/Advocacy

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

The United States Department of Agriculture's Food and Nutrition Service (FNS) operates an EBT machine that requires an FNS license. FNS allows markets to obtain a single FNS license for all eligible vendors at the market.

LEAD	Community-based food organizations, Local and federal government entities
PARTNERS	Local food organizations
SAMPLE PILOT DESCRIPTION	SNAP benefits are redeemed using one centrally located point-of-sale (POS) terminal; transactions are processed throughout the farmer's markets using script (digital coupons, certificates, tokens, or receipts).
REAL WORLD EXAMPLES	The Produce Perks program provides a $25 match on SNAP/EBT and P-EBT purchases. This means any amount spent with SNAP/EBT or P-EBT, up to $25, will be matched $1-for-$1. Produce Perks matching dollars can be spent on fruits and vegetables.
POTENTIAL IMPACT	Adopting EBT technology to accept SNAP benefits can help markets tap into a more extensive customer base by providing an easy and convenient way for individuals to redeem SNAP benefits on eligible food items. For vendors selling eligible food items, the potential for increased sales from SNAP redemptions can be substantial.
TIMELINE	12- 24 months

Policy/Advocacy

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.

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides nutritious foods, nutrition education, breastfeeding support, and referrals to health care and social services to pregnant and postpartum people with low incomes with infants and children under age 5.

LEAD	Job and Family Services
PARTNERS	Local food organization, local health advocacy organizations
SAMPLE PILOT DESCRIPTION	Determining income and/or residence eligibility in advance to reduce the duration of the certification appointment and decrease the number of documents that applicants must bring; using presumptive eligibility to begin providing food benefits as soon as pregnant applicants are determined to be income-eligible; allowing temporary 30-day certifications to give applicants more time to provide eligibility documents without delaying food benefits; and eliminating the requirement that households without any income provide a third-party statement, which can prevent or delay vulnerable families from accessing nutrition assistance during periods of prenatal, infant, and child development.
REAL WORLD EXAMPLE	The Supplemental Nutrition Assistance Program, or SNAP, is a federally funded program that provides food vouchers to low-income households. States can adjust aspects of program administration, including policies that affect the administrative burden associated with program participation. The administrative burden includes barriers that increase the costs (time, money, and psychological distress) of applying for and maintaining enrollment in SNAP. These barriers may reduce participation among households eligible for the program. SNAP receipt is associated with improved birth outcomes, reduced childhood food insecurity, and improved child health, so eligible families must have access to the program.
POTENTIAL IMPACT	Families and children unable to participate in SNAP due to procedural barriers and other difficulties in applying are more likely to be hungry and underweight. These families are also more likely to be food insecure and housing insecure.
TIMELINE	12-24 months

Thank you to all of our partners and stakeholders for participating in the CHIP collaborative process:

Hospitals and Health Systems

Bon Secours Mercy Health
The Christ Hospital Health Network
Cincinnati Children's Hospital Medical Center
Equitas Health
Kettering Health Network
Margaret Mary Health
Premier Health
St. Elizabeth Health care
TriHealth
UC Health
Wayne Health care

Additional Health care Providers

Centerville Pediatric Dentistry
The Crossroads Center
The HealthCare Connection
Montgomery County Alcohol, Drug & Mental Health Services
Westcare Foundation - East End Community Services

Community-Based Organizations and Nonprofit Partners

All-In Cincinnati
bi3
Center for Closing the Health Gap
Council on Aging of Southwestern Ohio
Cradle Cincinnati
Green Umbrella, Regional Food Policy Council
Hamilton County Oral Health Coalition
Health Care Access Now
Homefull
Housing Opportunities Made Equal
Local Initiatives Support Corporation Greater Cincinnati

Universities

The University of Cincinnati

- The University of Cincinnati and Cincinnati Children's Hospital Medical Center: Center for Clinical & Translational Science & Training

Public Health Departments

Butler County Public Health
Brown County Health Department
Champaign Health District
Cincinnati Health Department
Clermont County Public Health
Hamilton County Public Health
Northern Kentucky Health Department
Norwood City Health Department
Public Health - Dayton & Montgomery County

Local Residents

Cohear Bridgebuilder, Ashlee
Cohear Bridgebuilder, Talid

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

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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

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1.1.6 Collaborate with payers to secure reimbursement for social workers.

Cited:
Reimbursement of Mental Health Services in Primary Care Settings

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

References and Further Reading [Goal 3]

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Produce Prescriptions, Food Pharmacies, and the Potential Effect on Food Choice - 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