Raising the Bar

Healthcare's Transforming Role

## Framework in Practice

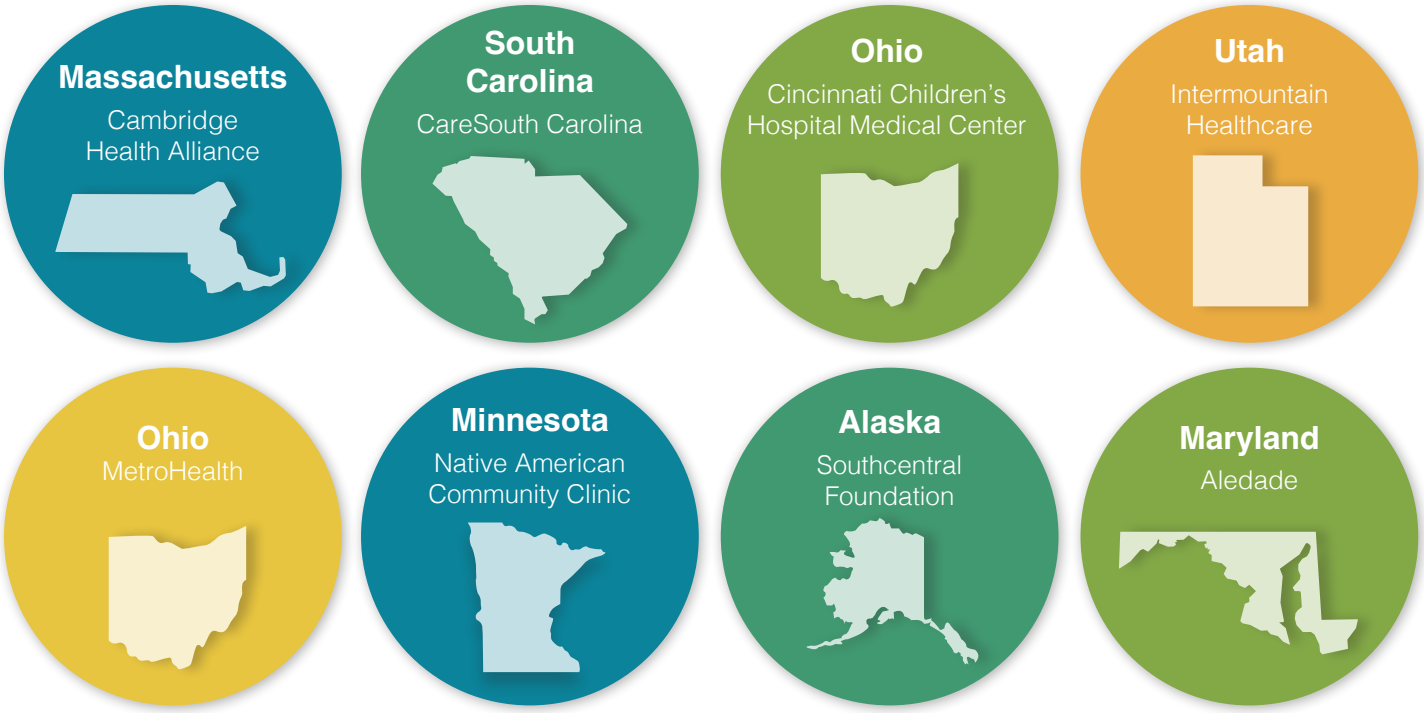
# Bright Spots

Supported by the **Robert Wood Johnson Foundation**, ***Raising the Bar*** provides an actionable framework for the entire healthcare sector to embed equity and excellence throughout its work. In this first part of the project the **National Alliance to impact the Social Determinants of Health** (NASDOH) convened extensive discussions with providers, hospitals, payers, and community leaders to develop foundational principles, essential roles, and concrete actions for the sector to help achieve optimal health for all. A second part, led by the National Partnership for Women & Families, is exploring more detailed guidance for maternal health.

# Framework in Practice:
# Bright Spots

*Raising the Bar:* Healthcare's Transforming Role aspires to a higher standard, and the five foundational principles are intended to guide transformation of healthcare organizations focused on equity and excellence. The healthcare field includes bright spots where innovative organizations are transforming the payment and delivery of care and strengthening engagement with and service to communities. This chapter highlights eight different healthcare organizations from all over the country that are already working to raise the bar, demonstrating the impact organizations who carry this work forward can have.

The bright spots highlight the work of organizations implementing the *Raising the Bar*'s five foundational principles: Mission, Equity, Community, Power, and Trust.



# Cambridge Health Alliance

**"Partnering with our communities, we will provide high quality, equitable, and affordable care for the whole person. Our patients will be able to get the care they need, how and where they want it."**

**Cambridge Health Alliance 2027 Strategic Plan**

Like much of the rest of the nation, the city of Cambridge has a complex history where cultural differences and power imbalances have played out since the days British colonists stepped onto Tribal lands. Many of those imbalances continue today.

Black neighborhoods and immigrant communities live juxtaposed to elite universities on the shared Charles River. While these universities thrive with extraordinary $50 billion investments, predominantly Black neighborhoods like Riverside and Cambridgeport, and immigrant neighborhoods, such as Eastern Cambridge, still feel the weight of historical divestment practices like redlining that exacerbated poverty in ways that are still felt today.

Cambridge Health Alliance (CHA) is a regional integrated delivery system and "anchor institution" working to counter these lingering inequities and support diverse communities in the Boston area. CHA is charting a new path towards "commonwealth" health and well-being for over 140,000 patients.

**Organization Type**

Integrated Delivery System

**Organization Size**

4,600 Employees

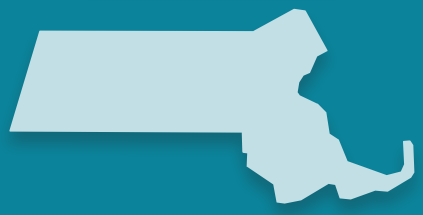
**Population Served**

150,000 Patients

43% of patients at CHA speak a primary language other than English

Urban Setting

**Massachusetts**



## MISSION

CHA's mission to improve the health and well-being of its communities is deep and sustained. The organization takes a holistic approach to meeting patient needs, offering holistic services to address health-related needs at every life stage. This ranges from connecting patients to wraparound services, providing transportation for older adults, to offering gardening as healing, and services to foster the well-being of violence survivors. At the same time, CHA provides one of the largest primary care and behavioral health service lines in the Commonwealth.

When the state enacted healthcare reform a little over a decade ago, CHA embarked on a radical journey to transform its payment model from fee-for-service to global payment to better meet the needs of its community and maintain its holistic approach to care. Within five years, CHA had gone from less than five percent to 60 percent of its payments coming from global payments and shared savings, expanding its primary care team to include mental health partners, social needs care coordinators, pharmacists, and other positions essential to provide holistic care.

A Commonwealth Fund evaluation found that CHA's changes led to improved population health and quality outcomes, increased employee satisfaction, and generated savings that the system could invest back into programs and services.

> **We have a culture of doing the right thing, focusing on the mission, and embracing honor. Even when it is hard. We acknowledge we're not perfect, but we can adapt and empathize."**
>
> **Kirsten Meisinger**, MD, Co-Director of Reproductive Health, Co-Director of Provider Engagement and Medical Director of the Union Square Family Health Center

## EQUITY

CHA makes it a priority to be welcoming and inclusive of people of all different races, cultures, and ethnic backgrounds. When patients walk into CHA's facilities, they are greeted by signs in many different languages directing them where to go. Patient facing materials are available in multiple languages and CHA cares for patients representing hundreds of ethnic groups. Staff speak more than 30 languages, and video interpretation units can bring language interpreters into CHA exam rooms with a few keystrokes. CHA facilities—including the hospital, ambulatory care centers, and school-based health centers—are conveniently and strategically located across seven cities, removing transportation barriers for many patients. This is essential to addressing systemic barriers of care in such a diverse region; one-third of the city's age 5 and older population speak languages other than English. The wide range of spoken languages includes Portuguese, Spanish, Haitian Kreyol, Nepali, Hindi, Korean, Mandarin, and Arabic. Forty three percent of patients at CHA speak a primary language other than English.

CHA's healthcare system fosters a culture of inclusion, based on a foundation of trust. Language and culturally-integrated services, such as the Brazilian Portuguese-speaking Victims of Violence team and the Haitian Mental Health team that supports Haitians experiencing trauma from climate change displacement, are embedded into the design of care. Care teams are trained in cultural humility.

CHA uses its policy and advocacy levers to make certain all patients have access to comprehensive care. For example, CHA advocated for the state to fund services for undocumented immigrants, using its research expertise to document why this type of proactive care better serves the health and finances of the Commonwealth. It has also advocated for policies inclusive of low-income seniors, LGBTQ+ individuals, reproductive rights and services, and disability rights.

CHA leadership is candid about the organization's racial equity journey: "We are not there yet." CHA is committed to increasing the percentage of providers and leaders that mirror the people it serves. The organization's approach to antiracism includes a systematic and data driven effort to examine any internal inequities, including pay differences and considering lived experience and background of employees, and developing a health integration team tasked with changing systems that are perpetuating health inequities.

## COMMUNITY

CHA takes its role as an engaged, responsive community partner seriously. Each year staff go to their partner communities to conduct listening sessions, and survey residents and community organizations about their self-identified priorities for health and well-being.

At the same time, CHA solidifies its connections to the community by training 50 community health workers each year. The volunteers are chosen from the most underserved areas in CHA's service area and for their deep connections to those communities. They undergo a robust peer support training program that prepares them

for a spectrum of positions ranging from lay volunteer health advisors to peer counselors in the Emergency Room. These positions are paid anything from a stipend for those volunteering a few hours a year to a full living wage for those who invest substantial time in supporting the community. Community peers help identify inequities and define needed changes.

CHA has worked alongside community partners in each of its communities for decades to facilitate community change, earning national recognition for such initiatives as Shape Up Somerville, the childhood obesity initiative that First Lady Michelle Obama modeled her own efforts on; and a Culture of Health Prize in Cambridge and Everett. These programs have yielded substantial improvements in rates of life-altering conditions from youth overdose to obesity to hospitalization.

In addition to the communities it serves, CHA is contracted to operate the Cambridge Public Health Department and works with public and community health functions in Somerville, Malden, Everett, and Revere. The CEO of CHA also serves as the Commissioner of Public Health for the City of Cambridge. The organization makes substantial investments in community health and well-being, including supporting regional community coalitions and supporting or fundraising to address needs identified by the community.

# CareSouth Carolina

**"Until people believe you and have trust in you, you can't accomplish much."**

**Ann Lewis**, CEO, CareSouth Carolina

For the past 40 years, CareSouth Carolina has been working to transform community-centered care, starting with the premise that a medical home built on healing, caring relationships is critical to improving health and well-being for all.

CareSouth provides that home to approximately 39,000 patients spread throughout rural South Carolina. To increase access, this Federally Qualified Health Center (FQHC), offers a range of health and social services, regardless of patients' ability to pay. It operates 14 primary clinics across five counties in the sprawling coastal plains of the state, helping patients overcome geographic barriers. And for those patients that can't get there, CareSouth goes to them via school programs and mobile clinics.

**Organization Type**

Federally Qualified Health Center (FQHC)

**Organization Size**

260 Employees

**Population Served**

Rural

40,518 Patients

56% of patients Black/African American

67% of patients at or Below 200% of Federal Poverty Guideline

30% Uninsured, 25% Medicaid, 17% Medicare, 4% Dually Eligible (Medicare & Medicaid)

South Carolina

## MISSION

In an area where more than half of the patients are Black and many experience severe poverty that has extended across generations, CareSouth is committed to improving health and well-being for all and building healthier communities. As part of the Institute for Healthcare Innovation Leadership Alliance Equity Workgroup, CareSouth works alongside 16 hospitals, health systems, FQHCs, and payers to address institutional racism within their organizations and eliminate inequities in care outcomes.

CareSouth's approach to providing effective whole-person care focuses on achieving equity and excellence. It includes:

- Providing integrated, comprehensive services including community outreach, counseling, dental services, HIV/AIDS care, and more;
- Developing healing, caring relationships with patients, families, and caregivers;
- Data collection and analysis;
- Setting goals; and
- Striving to improve outcomes at both the patient and community levels.

## EQUITY

For CareSouth, developing a welcoming, inclusive, and equitable health center requires intention and structural change from within; this includes identifying racism and inequity within the organization and making concerted internal efforts to change for the better. CareSouth created an inclusion council to foster accountability in the health center's approach to tackling institutional racism and encourage the development of tangible goals for improvement. The health center implemented a minimum living wage throughout the organization, making parity adjustments for those already at or above the minimum—an over $3 million commitment that the health center rolled out in 2021. Within the next five years, CareSouth aims to have mid- and upper-level management composition match the community by race and ethnicity. To do so, CareSouth has committed to supporting internal growth, analyzing turnover data by race and ethnicity, and identifying and investing in staff to become the organization's next generation of leaders.

CareSouth has long been committed to disparities reduction. CareSouth uses data from the Robert Wood Johnson Foundation's annual County Health Rankings to drive its strategic goals. Typically, CareSouth's outcomes rankings for the five counties it serves are among the lowest in the state. CareSouth uses this data, as well as health disparities data, to prioritize partnerships that may work upstream to improve the counties' health.

The health center has measured health disparities in its patient outcomes since 2000. CareSouth is committed to achieving zero disparity in health outcomes across race and ethnicity. The center uses current data to set specific goals for each of the counties it serves and works with its partners to develop intentional programs to address patient and community needs. As part of this effort, CareSouth collects social determinants of health data using PRAPARE, a national standardized protocol that assesses patient assets, risks and experience. This enables the health center to identify and address such health-related issues as food insecurity, housing needs, transportation barriers, and access. It paints a more complete picture of the patient population, community social needs, and how to enhance holistic care efforts.

## COMMUNITY AND POWER

All of CareSouth's board members are health center patients, who are actively engaged in the community. They are uniquely positioned to foster relationships with other community stakeholders to improve such things as infrastructure, which can have a lasting impact on access to healthcare, employment, and more. For example, lack of transportation is a persistent issue in this rural area. Two board members helped CareSouth bring together the regional transportation authority and other community organizations to generate funding to expand the transportation system.

## TRUST

All of this, however, would be impossible to accomplish without trust. As Ann Lewis, CEO, noted, "Until people believe you and have trust in you, you can't accomplish much. One thing in our favor from our tenure is that they know us, and they know how we behave."

Building trust requires a large investment of time, energy, and consistency. For over 40 years, CareSouth has fostered strong, trusting relationships with patients and communities. That work never ends. For example, CareSouth purchased mobile vans to conduct COVID-19 education, testing, and vaccination outreach. Using the vans to provide pandemic-related services enabled the health center to connect with churches and smaller, rural communities and begin to develop trust and confidence needed to serve all communities effectively. CareSouth recognizes that until that trust is fully established, the health center will be limited as to what it can reasonably provide in these communities. In the meantime, CareSouth will continue to show up.

# Cincinnati Children's Hospital Medical Center

**"We asked ourselves, 'Why keep perfecting the hospital if the key issues driving health equity are outside of it?' Families and community leaders focused our attention on equity, racism, and child well-being—they served as catalysts for more explicit antiracism work. Now we were talking about upstream drivers—social determinants of health, how we do what we do, and how we show up in the community. These intentional discussions led to explicit integration of equity and antiracism into measurement, our family and community-focused approach, and improving future child outcomes."**

**Uma Kotagal**, Senior Fellow, Cincinnati Children's Hospital Medical Center

Cincinnati Children's Hospital Medical Center is one of the premier children's hospitals in the country. Yet children growing up around it experience some of the poorest health and life outcomes in the country. Recognizing this, Cincinnati Children's (CC) charted a new strategic plan in 2015, placing children and community well-being at its center. In a city where more than 40 percent of children experience poverty, CC set a goal of supporting all 66,000 of the city's children to be healthier, and make Cincinnati the healthiest place to grow up. Its efforts are working: asthma hospitalization rates for children on Medicaid, bed days in hospitals, and infant mortality decreased, and literacy, immunization, and community engagement rates all increased since CC began its efforts.

## Organization Type

**Pediatric Hospital and Medical Center**

## Organization Size

**> 16,000 employees**
(July 2020–June 2021)

**~ 1.5 million Patient Encounters**
(July 2020–June 2021)

## Population Served

540,000 children (primary catchment area - does not include national/international)

Youth and Families in the Greater Cincinnati, Ohio and tri-state Midwest Region


## MISSION AND EQUITY

CC's vision drives its mission forward: "to be the leader in improving child health." The organization's commitment to childhood well-being guides the organization's strategy and is a key measure of its performance. Recognizing that thriving societies benefit children, CC focuses on improving well-being long before any child reaches the exam room—by going into the communities it serves. Key initiatives have focused on upstream drivers of health—including improving child school readiness and parental supports, and systematically addressing social needs.

It has placed particular focus on the Avondale neighborhood. Approximately 90 percent of Avondale residents are Black and more than 40 percent are living at or below the poverty level.

More than 77 percent rent housing. The site of two Black power protests in the Civil Rights era, Avondale experienced white flight and became the epicenter of decades-long punishment upon Cincinnati's Black neighborhoods as poor Black residents were further blocked from accessing regions receiving economic subsidies. CC chose to focus on Avondale because, as a neighborhood, it had one of the greatest rates of children being hospitalized.

## COMMUNITY

To understand the community's challenges, CC always goes directly to the people who live there. For example, CC spent several months talking with community contributors, listening, and building trust when the organization sought to develop its new strategic plan in 2015. Parents from the communities with the poorest child health outcomes talked about what their hopes were for their children and the barriers that dimmed them. CC realized that if it were to truly seek a community where all children could thrive, it needed to broaden its vision: "We embraced the idea that to improve health we needed to move well beyond healthcare." — *Rob Kahn, Cincinnati Children's Hospital Medical Center pediatrician*

It launched the All Children Thrive (ACT) collaborative in partnership with over 100 community groups and residents in 2015. As part of its work, ACT created a community-based Capability University to assess what worked and what didn't. CC utilized its renowned expertise in improvement science and capability development to help ACT train community residents and nonprofit leaders to use quality improvement methods to improve processes and outcomes. Additionally, CC provided administrative support and accompaniment to the community teams. ACT set out to track and improve four primary outcomes—infant mortality rate, third grade reading level, a Thrive at Five measure, and inpatient bed days.

CC partnered with the Cincinnati Public Schools (CPS) to improve the third grade reading level by 10 percent every year. Over three years, the percent of third grade students reading proficiently increased from about 40 percent to more than 70 percent. Results also indicate that equity gaps closed in schools where principals used quality improvement methods to improve student outcomes.

Health measures also improved. The inpatient bed-day rate for the two target neighborhoods in Avondale and Price Hill, where 90 percent of the children were on Medicaid, decreased by 18 percent from baseline (July 2012-June 2015) to the improvement phase (July 2015-June 2018). Hospitalizations decreased by 20 percent. From early childhood education advancement to co-creating prenatal care community needs assessments with the communities they serve, CC is demonstrating what it means to partner with a broad set of contributors in a community, center the voices and leadership of community residents experiencing inequities, and build capability for meaningful change.

## TRUST

CC's efforts to improve child health and well-being have been successful because it has trusted relationships with the community. The organization's leadership—including the CEO and majority of board members—come from the communities CC's serves. These leaders had pre-established connections and trusted relationships with the community. But CC didn't stop there. The organization invested in establishing trustworthy and place-based relationships across the organization. It did this by reaching out to meet directly with the community to listen and learn. Clinicians, for example, have broken bread with mothers in underserved zip codes monthly for over five years to identify prenatal care needs and supports. This community-clinician meal-sharing has created the opportunity for continuous learning and support and helped to develop CC's clinicians' relationships with mothers served in the zip-code-based clinics. CC's investment in building this trust has made community collaboration far easier, and more effective.

Cincinnati Children's Hospital Medical Center can tell you exactly what "it takes a village to raise a child" means.

> **We shifted to focus on building trust and generosity and supporting families. We found that relationships outside of the exam room became more important than medical care itself, and that relationship-building shifted foundationally rather than conditionally. We meet our community where they are in their space as a sign of respect and less time wasted."**
>
> **Uma Kotagal**, Senior Fellow, Cincinnati Children's Hospital Medical Center

# Intermountain Healthcare

**"We strive to be obsessed with our mission of helping people live the healthiest lives possible. It's the lifeblood of our organization. Our mission is a source of motivation and meaning behind our work to care for our patients while taking steps to bring more equity to healthcare and improve community health."**

**Mikelle Moore**, Senior Vice President and Chief Community Health Officer, Intermountain Healthcare

Intermountain Healthcare's approach to health and well-being is as expansive as the three mountainous Western states it serves. This integrated delivery network places as much importance on addressing patient needs for housing, learning, and sustainability as on treating the medical conditions that brought them there in the first place. Given that social factors determine roughly 60 percent of a person's overall health, Intermountain believes that addressing them is critical to improving people's lives.

Based in Utah with locations in seven states and additional operations across the western United States, Intermountain Healthcare is a nonprofit system of 33 hospitals, 385 clinics, medical groups with some 3,800 employed physicians and advanced practice providers, a health plans division called SelectHealth with more than one million members, and other health services. Helping people live the healthiest lives possible, Intermountain is committed to improving community health and is widely recognized as a leader in transforming healthcare by using evidence-based best practices to consistently deliver high-quality outcomes at sustainable costs.

Recently, Sam, a man experiencing homelessness and mental health issues spent a month in one of Intermountain Healthcare's hospitals for treatment of cellulitis, a serious skin infection. As his discharge approached, his doctor was concerned that preventing re-infection would be difficult or unlikely given the man's circumstance.

Usually, that would be outside the physician's reach. But the doctor, a member of Intermountain's Medical Group, has a care guide on his team who deals with issues like homelessness. The guide reached out to a program that offers to house people with mental health issues and lined up a place for Sam to live.

"If he'd just been discharged and left on his own, especially during the pandemic, he'd be right back in with COVID or another infection or something else," said the physician. "Lining up housing was much better for him. It dramatically improved his quality of life."

## Organization Type

**Integrated Health System**

## Organization Size

**33 hospitals, 385 clinics, 1 million members of health plan**

**3,800 physicians and advanced practice clinicians**

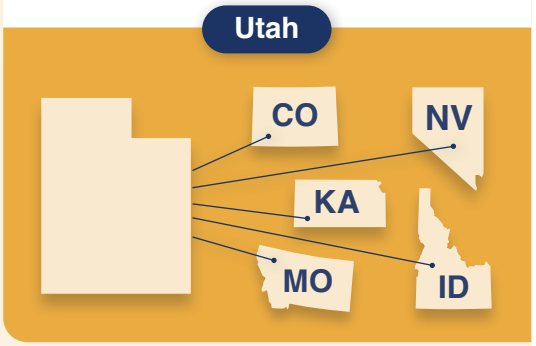
**59,000 caregivers**

**The largest private employer in Utah**

## Population Served

Headquartered in Utah, serving patients throughout Colorado, Idaho, Kansas, Montana, Nevada, and Utah's communities.

Among its 2021 patient encounters, Intermountain conducted 618,700 visits with patients in low-income clinics it owns or supports, supported more than 40,000 births, cared for patients more than 788,000 times in its emergency rooms, and provided charity care valued at $330 million.



## MISSION

Intermountain's mission—*helping people live the healthiest lives possible*—focuses not just on healthcare but also on health. Several core components help Intermountain fulfill its mission of committing above all to improving the health and well-being of all individuals, families, and communities. Intermountain:

- Seeks to keep people healthy by prioritizing wellness and preventive care, which helps people avoid problems that impair their quality of life.
- Uses evidence-based medicine to consistently deliver the best possible clinical outcomes without the variation and waste that drive up costs.
- Uses advanced health information technology, which gives the organization data that show what works, what doesn't, and how to continually improve.
- Integrates numerous care components—including hospitals, physicians, health insurance, and community engagement—to support patients throughout their lives, not just when they're ill or injured.

## EQUITY

Intermountain understands that someone's zip code has a more significant impact on their health and life expectancy than their genetic code—and it knows some zip codes have less social equity than others. It works to provide health services and outcomes that do not vary regardless of someone's race, disability, gender, sexual identity, age, income, or other personal factors. Intermountain has also:

- Expanded its hiring and governance practices to make its team better represent its community at all levels of the system.
- Provided training to help its team recognize and root out systemic racism since 2009.
- Reviewed and revised more than 200 of its internal healthcare policies with an equity lens.
- Connected with individuals in their preferred environments and communication channels. For example, Intermountain expanded community education around the "BE FAST" acronym, which helps people recognize the signs of stroke, to "RAPIDO," which improves stroke response times among the Spanish-speaking community.
- Funded educational opportunities for community members and employees who traditionally lack them, including college scholarships for minority students who are interested in healthcare careers and $5,250 in tuition each year for employees who are seeking college degrees, high school diplomas, or English language training.

## COMMUNITY

Intermountain connects with people in ways that match their needs and lifestyles—and, in the process, improving access to care for underrepresented community members. Intermountain:

- Established a network of community-based organizations that provide free mental health visits to underrepresented communities. $850,000 in funding resulted in more than 10,900 free visits to uninsured community members in 2020.

- Offers a 24/7 online service that provides urgent care treatment from anywhere at any time. Charges are nominal (and sometimes free).
- Pioneers the use of telemedicine, which helps its patients—including thousands of people in the vast western states it serves—stay close to home for the care they need.

## POWER

Intermountain is a member of the Healthcare Anchor Network, which includes over 65 U.S. health systems that are improving the economic and racial disparities that affect people's health—the *structural* determinants of health. Anchor members use their resources to fight generational trauma and poverty and higher rates of illness and death in communities of color. Intermountain has:

- Designated or contributed $74.9 million to more than 70 local community partners, not-for-profit agencies, and state and local governments to expand mental healthcare in the Intermountain West since 2020.
- Invested $53 million to address housing instability and financial wellness of low-and-moderate income communities since 2020.
- Contributed to the construction or preservation of 1,058 affordable housing units and improved the financial wellness of 274 individuals to date.
- Served as founding member of the Alliance for the Determinants of Health, which involves collaboration between public and private partners to coordinate health and social needs.
- Founded Civica Rx, a nonprofit generic drug manufacturer, to provide low-cost medications to hospital patients across the nation.
- Provided medically necessary services regardless of its patients' ability to pay. In 2020, Intermountain provided more than $169 million in financial aid to 223,327 patients. That is the equivalent of more than $460,000 worth of free care every day to 611 patients.

## TRUST

Notwithstanding all of its institutional accomplishments, the trusting relationships that make Intermountain who it is aren't organizational. They're personal.

Before Sam, the cellutitis paitent, was hospitalized, he came in to see his doctor for medication refills and mentioned his feet were hurting him. As the clinic team treated his wounds, they found he didn't have socks. "The natural solution was clear," said Sam's doctor. "I had socks. He didn't. He needed socks. I asked him if he'd feel uncomfortable if I just gave him my socks. He was very grateful."

# MetroHealth

**"Our goal was to create an infrastructure that builds equity in a sustainable way—for patients, employees, and community—for as long as the organization lives."**

**Alan Nevel**, Senior Vice President, Chief Equity Officer, MetroHealth

Not unique to Cleveland, redlining, racial covenants, and other practices that disenfranchise minorities and the poor continue to affect many aspects of the city's health and well-being including blood lead levels, safe housing, and internet access. MetroHealth is one of a number of health systems and anchor partners in Cleveland working to advance health equity and undo this history of structural racism.

The MetroHealth System is a healthcare safety net provider serving the Greater Cleveland area with over 1.4 million visits per year. Approximately 75 percent of MetroHealth's patient population is on Medicaid, Medicare or self-pay. MetroHealth has 7,800 employees and is a critical anchor institution for the health and well-being of the communities it serves and is placed in.

**Organization Type**

**Healthcare Delivery System, Safety Net**

**Organization Size**

**4 hospitals, 4 emergency departments and more than 20 health centers and 40 additional sites throughout Cuyahoga County**

**7,800 Employees**

**Population Served**

Urban and suburban

300,000 patients;
~ 75% are covered by Medicaid, Medicare, or are uninsured


## MISSION AND EQUITY

With whole health and well-being in mind, the MetroHealth System welcomes everyone. It serves individuals regardless of ability to pay and works to help those facing transportation, nutrition, education, housing, legal and other barriers. Its mission leads individuals on a pathway of health and well-being "through service, teaching, discovery, and teamwork." As part of its response to community needs, MetroHealth has outlined five key focus areas of health:

- Eliminate structural racism;
- Build cross-sector community relationships and trust;
- Address community conditions, such as poverty and housing;
- Enhance mental health services and reduce substance abuse; and,
- Reduce chronic illness and its effects.

Beyond medical care, the system commits to a mission of preventive care, and strives to cultivate the growth of the next generation's health equity leaders.

## EQUITY

MetroHealth has committed to advancing equity and racial justice internally and externally. After the murder of George Floyd, the system engaged both patients and employees in a series of conversations. Patient focus groups and satisfaction surveys revealed differences in how Black and Brown people rated their care, and the system engaged in shifting toward a culture of equity and healing from the inside out.

MetroHealth's senior leaders, including the board of trustees, engaged in an immersive experience designed to eradicate systemic racism and create a stronger sense of inclusion and belonging for patients, staff, and the community. They established a range of learning experiences anchored around shared humanity—from the "Healing Begins with Listening" video series to monthly systemwide equity, inclusion, and diversity forums to creating psychologically safe environments for employees to engage in candid, respectful dialogue rather than discourse. In addition to education, MetroHealth has shifted policies and set strategic goals for racial equity and inclusion.

This commitment to equity and racial justice is deep and intersectional. MetroHealth was the first in the region to implement a pride clinic to align and support the needs of LGBTQ+ communities. Its Institute for H.O.P.E.™ works with UniteUs and addresses social needs by screening patients, linking them to services, and following up to make sure they receive those services. MetroHealth ensures language is not a barrier to healthcare by delivering, for example, bilingual speech language pathology (SLP) services in tandem with autism assessments for the Latinx community. Interviews with leaders across the system demonstrate that the commitment to equity is real and permeates every aspect of the work.

## COMMUNITY, POWER, AND TRUST

MetroHealth harnesses strategic, cross-sector community partnerships with local food banks, the local legal aid society, and other organizations to develop a shared plan for community healthimprovement. This community-driven planning process has led MetroHealth to:

- Promote digital inclusion with free or low-cost neighborhood WiFi, laptops, internet, and literacy support;
- Provide free food, especially tailored to people with food-related ailments;
- Help build new, affordable housing units; and,
- Refer underserved groups such as children and their families, older adults, immigrant communities, and returning community members to on-site legal aid.

Ensuring *all* of its community members are on track for health and well-being, MetroHealth has a correctional medicine arm at the county jail. Along with destigmatizing the return of community members from incarceration, support includes increased mental health resources and care for substance use disorder to aid in the transition and to prevent reincarceration.

In addition, MetroHealth has developed deep partnerships with public schools in zip codes experiencing inequities through the development of a School Health Program. With 1,126 clinic visits serving students across 20 schools in 2020-2021, students in the community have improved academic and healthcare outcomes. A formal evaluation showed that participation in the MetroHealth School Health Program was associated with decreased absenteeism and improved academic achievement. MetroHealth also partners with Cuyahoga Community College and other organizations to better connect patients, employees, and residents to programs such as housing; education; and workforce, digital, and community literacy training to build cradle-to-career pathways.

MetroHealth also created a partnership with the Cleveland Metropolitan School District to develop the Lincoln-West School of Science & Health, believed to be the first school within a hospital. This high school serves 87 percent students of color from nine countries, speaking seven languages. Juniors and seniors attend classes at the hospital full-time, while freshmen and sophomores attend monthly programs taught by MetroHealth staff. By senior year, students carry out internships to work at the hospital. They are paired with a mentor beginning their junior year and that partnership can continue through college. Whether in healthcare, culinary arts, or environmental science, so far, graduating seniors in the program have a 100 percent college or post-secondary education acceptance rate. Cleveland is a Say Yes to Education district, which guarantees high school graduates a full-tuition scholarship to select schools. The outcomes are impressive and show what interrupting the cycle of poverty looks like.

MetroHealth embodies what is possible when a healthcare organization uses all of its levers to raise the bar.

# Native American Community Clinic

**"What does a healthy community look like? Does a healthy community look like the absence of disease, or does it look like a vibrant community with a place for ceremony, social gathering, where we feel safe, a place to rejoice, eat good food, laugh, sing, cry together? ... [We must] ask ourselves 'what is health?' It's the presence of all these other things that give us life, meaning, help us to thrive. So, how do we create a [health system] that's focused on that?"**

**Dr. Antony Stately**, CEO, Native American Community Clinic

When the Native American Community Clinic (NACC) opened its doors in 2003, it aimed to address the health disparities that so many Native Americans face. Those running the clinic knew success depended on their ability to support cultural healing and spiritual care as well as medical care. Located in the Twin Cities of Minnesota, this FQHC serves one of the larger urban Native American populations in the country. It sits in a state that is home to 11 different sovereign Tribes.

NACC provides care to approximately 4,500 patients annually, 60 percent of them American Indian/Alaska Native. The communities it serves face significant unemployment, poverty, and unsheltered homelessness, as well as clinical risk factors, including asthma, diabetes, hypertension, cancer, smoking, and obesity. The clinic offers a full range of healthcare services that include medical, behavioral health, dental, and substance abuse programs, regardless of ability to pay.

## Organization Type

Federally Qualified Health Center (FQHC)

## Organization Size

65 employees
6 medical providers
3 behavioral health providers
3 dental providers
7 tribal health & Medication-Assisted Therapy team members
3 spiritual care providers
3 patient advocates

## Population Served

Urban

3,654 patients

62% American Indian and Alaska Native Patients (AI/AN)

19% Uninsured, 62% Medicaid, 6% Medicare, 3% Dually Eligible (Medicare & Medicaid)

90% Patients at or Below 200% of Federal Poverty Guideline


## MISSION

NACC's overarching mission is to improve the health and well-being of Native American families. NACC works to build resilience as it tackles the root causes of health disparities, such as access to food, housing, and health insurance. It works with peer-recovery coaches and community health workers to connect patients with services such as resource navigation, care coordination, outreach, and community-based activities. At the same time, NACC strives to honor health and tradition by providing spiritual care and access to traditional healing.

NACC's philosophy? Amplifying patients' joy and the things that are good in their lives makes people more resilient.

## TRUST AND COMMUNITY

NACC prioritizes cultivating trust with its patients and their families and providing responsive, culturally congruent care. NACC established an Elders in Residence program focused on supporting spiritual well-being and supporting Native American identity. NACC works with a community partner, Minnesota Indian Women's Resource Center (MIWRC), to bring cultural healing and support services into the clinic. As part of the launch of the program, the Elders did a spiritual reset of the clinic space, which proved incredibly meaningful to the community, further developing trust between the health center and those served.

Spiritual health integration has produced an overwhelmingly positive response from the community and has had a positive effect on clinical outcomes. The integration of spiritual health and substance use disorder (SUD) treatment has led to a significant reduction in ER visits for SUD patients. These patients report that they stay in treatment for SUD because it provides access to spiritual health services, particularly during the stress and isolation of COVID-19.

NACC has found that when there is a crisis in the community, a healthcare organization cannot wait for the timing to be "right," rather, it has an obligation to respond because the community needs them and their services.

## EQUITY AND POWER

Creating a culture that values equity internally allows NACC to provide equitable care and hold themselves accountable to the community. While NACC has historically hired care team members from within the community, NACC's current CEO, Dr. Antony Stately, is the first Native to hold the position. Under his leadership, NACC is becoming more intentional in creating representation at all levels within the organization, and NACC is deliberate in its recruitment outreach to Native communities, working against the barriers to upward mobility in place due to structural racism.

Understanding the connection between health and employment, NACC's leadership uses its hiring power and purchasing power to lift up the community and provide avenues for upward mobility for individuals and the health center's community partners. The center's position as a health home in the community helps ensure quality and accountability to their mission. Staff, providers, and leadership consider their patients "relatives," asking themselves how they would approach a loved one seeking their help and then proceeding accordingly. By taking a "partner in healing" approach, the center has been able to foster a culture of holistic, culturally sensitive care.

The center's community advocacy extends outside its own walls. NACC recognizes its power as an institution to speak up about racism and to affect change in the community. During 2018 and 2019, the "Wall of Forgotten Natives" was the largest encampment of unsheltered people in the state's history. Facing unprecedented need in the community, NACC mobilized medical response outside the clinic and called on local and state officials to take action. The CEO called the mayor of Minneapolis, governor, and county officials, urging them to respond. These efforts were effective: the mayor held a press conference calling attention to this crisis. Showing up for the community in the face of crisis both in service and advocacy solidified the health center as a trustworthy, welcoming, community-minded organization.

NACC's advocacy continues. With the success of its spiritual health integration in SUD treatment programming, the health center is working to gain Medicaid reimbursement for Native healing services. NACC leadership is also involved in Minneapolis Police Reform efforts, helping others better understand SUD and the importance of behavioral health and trauma-informed services. NACC's CEO is also an involved member of Minneapolis health and wellness committees to transform the larger structures contributing to the health and well-being of the twin cities.

# Southcentral Foundation

**"It's not about giving options and asking what you think. It's about everyone who has a stake getting to design the system. This matters to the Native leaders in our system—who are First Nations people for whom this is their life."**

**April Kyle**, President and CEO, Southcentral Foundation

**Organization Type**

Healthcare Delivery System

**Organization Size**

2,000 Employees

**Population Served**

Approximately 65,000 Alaska Native/ American Indian people

Urban/suburban Anchorage area and 55 rural villages


At Southcentral Foundation (SCF), the patients and people running the health system are one and the same. Alaska Native people are in charge of designing and delivering healthcare. Alaska Native people created SCF to provide physical, mental, emotional, and spiritual care to Alaska Native communities spread across the south central area of Alaska, stretching from the Aleutian Chain and Pribilof Islands in the west to the Canadian border in the east. The nonprofit grew out of a concerted effort to better meet the needs of those communities.

In 1982, 229 federally recognized Tribes collaborated in an unprecedented move to wrest control of their health system from the federal government. SCF is one of seven healthcare systems that emerged. Over the course of two decades, SCF has transformed its system into a care delivery model owned and managed by Alaska Native people to ensure that they have the best health and well-being possible.

SCF has over 2,000 employees serving approximately 65,000 Alaska Native and American Indian people living in Anchorage, the Matanuska-Susitna Borough, and more than 50 rural villages. SCF provides a range of services, including primary care and telehealth, through the regional Anchorage Native Primary Care Center, the Alaska Native Medical Center, and a network of village councils and community health workers, including medical, behavioral health, and dental assistants. By the late 1990s, SCF took over co-management of the Alaska Native Medical Center along with the Alaska Native Tribal Health Consortium, providing tertiary care to the entire Native population in the state—approximately 108,000 people.

SCF is the only healthcare system in the nation to win two national Malcolm Baldrige Quality Awards—the highest possible award any business can earn—with significant (75 percent) improvement in health outcomes. SCF's story demonstrates what is possible when people experiencing inequities engage in self-governance and unprecedented collaboration to change laws, policies, and systems.

## MISSION

Southcentral Foundation envisions a Native Community that enjoys physical, mental, emotional, and spiritual wellness. Working together with the community as "customer-owners" rather than "patients," SCF created a Nuka System of Care to achieve wellness. Nuka, which is Alaska Native for strong, giant structures and living things, is a whole-person system of care built on relationships and the understanding that one's health and well-being is rooted in one's past. Decisions made today can affect the health and well-being of generations to come, as well as the health and stewardship of the land, and the spiritual connectedness and well-being of ancestors and descendants.

Establishing a Nuka System of Care meant building the infrastructure around holistic models of Indigenous health and well-being. SCF replaced buildings that looked cold and formidable with ones that drew directly from indigenous conceptions that conferred dignity and connection. Recognizing that many customer-owners come into the healthcare system impacted by trauma, SCF formed integrated care teams centered around relationships. Primary care incorporated traditional healing values and practices, trauma-informed care, and mental healthcare, and SCF employed community-based health workers and employed telehealth to establish a network of trust and generate unprecedented levels of access and quality care.

The results speak for themselves. Early on, the changes led to a 44 percent decrease in ER visits, a 31 percent decrease in inpatient discharges and high customer-owner satisfaction rates. SCF also exceeded 75th percentile on several The Healthcare Effectiveness Data Information Set (HEDIS) health measures, including cervical cancer screening and diabetes poor control.

## EQUITY

Alaska Native people have borne some of the worst health outcomes in the nation. SCF works in concert with the Alaska Native Tribal Council and state and local policymakers to eliminate inequities and assure that Alaska Native people have the best health and well-being possible. This includes negotiating with the federal government to adequately fund services that community partners have prioritized.

For example, 75 percent of Alaska Native people have experience high levels of trauma, ranging from child abuse or neglect to sexual abuse. This kind of toxic stress can result in a 40-fold higher rate of health and life inequities over the course of a person's life—and cycle through subsequent generations. SCF created and supports community-driven responses, including cradle-to-childhood well-being pathways.

This well-being pathway evolved into The New Generations Project, a five-year federal grant program that ensures and promotes physical, mental, emotional, and spiritual well-being, school readiness, and generational healing for children starting from birth to age eight. As part of the program, SCF offers on-site health-related services such as housing, employment, legal aid, and Native culture-based education. A Traditional Healing Clinic bridges Alaska Native healing practices with modern ones.

In another effort aimed at interrupting the cycle of generational trauma and violence, SCF and tribal leaders invited indigenous men to reclaim their identity and act as Family Wellness Warriors. As Warriors, trusted traditional community healers collaborate with families to provide educational, socioemotional, physical, mental, and spiritual well-being tools and resources. While designed to restore relational healing to support Alaska Native people, all community members are welcome. They created community-based healing events, called Beauty for Ashes, for people to share their stories with one another.

## COMMUNITY, POWER, AND TRUST

The culture and voice of Alaska Native people reverberate throughout everything SCF does. SCF's strategy development and decision-making is driven by the voice of customer-owners and community. The organization is deliberate in building community partnerships that model healing and trusted relationships.

SCF leadership meets with individual village councils to determine the services each sovereign Tribe wants to provide to its community. This network of deep relationships was activated to quickly determine Tribal approach to COVID-19 and proved effective and durable: Alaska rapidly achieved over 80 percent vaccination rates in a number of villages.

Alaska Native people and Southcentral Foundation together demonstrate what equity and racial justice can accomplish when practiced with dedication over a generation.

# Aledade

**"If you are truly responsible for the health of the community, that may not require you to be building housing, but you could be in the legislature advocating for it."**

**Sean Cavanaugh**, Chief Commercial Officer and Chief Policy Officer at Aledade

Founded in 2014, Aledade is a physician enablement company helping independent practices, health centers, and clinics deliver better care to their patients and thrive in value-based care. Its model includes data analytics, guided workflows, regulatory expertise, payer relationships, and integrated care solutions with the goal of empowering physicians to succeed financially by keeping people healthy. Aledade serves more than 1,000 practices in 37 states, and shares in the risk and reward across more than 140 value-based contracts representing more than 1.7 million patient lives under management

**Organization Type**

Physician Enablement Company

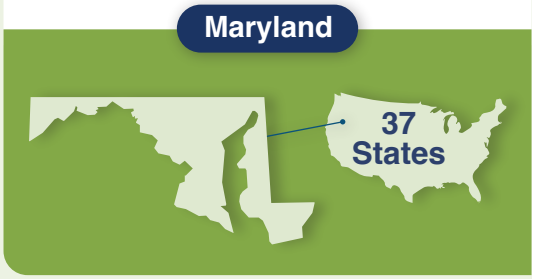
**Organization Size**

More than 1,000 primary care practices and health centers serving 1.7 million patients in value-based contracts

Staff of over 800 experts in health policy, technology, and practice transformation

**Population Served**

Urban, suburban, rural settings across 37 states




## MISSION

Aledade is in the business of advancing value-based primary care to improve the health and well-being of all patients. Aledade supports independent physician practices, health centers and clinics with the tools they need to improve care and expand access to more patients. For Aledade, the best way to improve care quality and outcomes is to shift from a fee-for-service model, where payment is tied to services provided, to a value-based one where the emphasis is on preventive care and physicians are reimbursed according to patient outcomes.

The company supports physicians by delivering the technical assistance, data analytics, educational support, funding, in-person support, and technology necessary for them to successfully adapt their practices to delivering value-based care where the focus is on efficiency and high-quality care rather than the volume of services delivered.

## EQUITY

Aledade believes that health equity is central to value-based care and critical to ensuring the health and well-being of all individuals, particularly those historically or presently underserved. The company includes equity as one of its key business metrics and has incorporated equity into its objective and key result (OKR) measures. Aledade quantifies equity impacts by tracking disparities in chronic condition management, such as rates of

uncontrolled hypertension. Using this information, it establishes goals for improvement and discrete actions to achieve results. Aledade has hired a vice president of health equity and has equipped this individual with the resources and staffing needed to make a lasting impact.

Aledade also acknowledges it has the ability and responsibility to promote equity—not merely for equity's sake, but because all patients–especially the most vulnerable—deserve to have access to physicians that are part of a high functioning accountable care organization (ACO). The organization engages and partners with physician practices that are run by and those that serve predominantly minority and/or vulnerable communities. Aledade assists these practices with payment arrangements that encourage and support preventive care and a focus on improving quality. It also assists practices in leveraging clinical data to identify disparities in care and close care gaps.

## COMMUNITY AND POWER

Aledade leverages its power as a convener. It actively reaches out to healthcare payers to identify collaboration opportunities to address key social risk factors in the communities they serve. This includes aligning funding opportunities to address needs such as transportation for patients, office equipment to minority and CHC practices, patient outreach for hard-to-reach patient populations, and empowering community health workers to advance health education around social determinants of health (SDOH) needs.

As Sean Cavanaugh, Chief Commercial Officer and Chief Policy Officer at Aledade sees it, advocating for what a community needs goes beyond medical services "If you are truly responsible for the health of the community, that may not require you to be building housing, but you could be in the legislature advocating for it."

# Raising the Bar

Healthcare's Transforming Role

2022