Building a Systems Approach to Community Health and Health Equity for Academic Medical Centers

Year 2 Summary Presentations

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Senior Director, Health Equity Research and Policy

July 12th & 13th, 2018
Specific Aims

**AIM 1:** Create a **protected work space** for interprofessional academic medical center teams and their public health and/or community partners to **identify cross-over priorities** and opportunities for enhanced clinical, programmatic, scientific, and community **collaboration**.

**AIM 2:** Deploy site-specific **implementation plans** that bring together **community-engaged** clinical, research, educational, and administrative community health efforts into a **system of mutually reinforcing, sustainable activities**.

**AIM 3:** Develop a **research and evaluation strategy** to enrich and assess the implementation of these site-specific plans and their **outputs/outcomes for communities, the health system, and learners alike**.

[www.aamc.org/healthequitysystems](http://www.aamc.org/healthequitysystems)
Webinar Schedule

**July 12th**

- University of Florida, Gainesville
- University of Mississippi Medical Center
- MedStar Health
- University of Rochester Medical Center
- Virginia Commonwealth University

**July 13th**

- Western Michigan University Homer Stryker MD School of Medicine
- Eastern Virginia Medical School
- Florida International University
- Baylor College of Medicine/Harris Health
- Vanderbilt University Medical Center
Webinar Structure and Goals

• 10 slides, 10 minutes
• Where they started, where they are now
• Long term and project period goals
• Successes
• Challenges
• Specific requests for input
  • Other teams: 5 minutes to provide feedback/guidance
  • All: Submit input via Chat function any time
Community Issue:

Infant Mortality Disparity: Improving Access to early entry into Pre-Natal Care for women of color and/or low SES residing in Kalamazoo County
State of Affairs in 2016

Three Year Moving Average Infant Mortality Rate, By Race Kalamazoo County - 1997 to 2016*

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*2014-2016 is estimated, not the official rate

Met Healthy People 2020 Goal of 6.0
4.0 RR
Aligning Strategy with Cause: Cradle Kalamazoo - AAMC partnership

Problem

<table>
<thead>
<tr>
<th>Number</th>
<th>Infants of Color</th>
<th>White Infants</th>
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<tbody>
<tr>
<td>54</td>
<td>16.8</td>
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<tr>
<td>31</td>
<td>5.9</td>
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<td>(12) 11.9</td>
<td>(24) 2.6</td>
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Cause

1. Fragmented Systems of care
2. Stress from poverty and discrimination
3. Lack of opportunity and access
4. Health Literacy

Strategic Objectives

1. HEI-Mapping existing external and internal partners
2. Integration into the Cradle collective impact team in a meaningful way
3. Developing a process to address area of need
4. Integration of UME, GME
# Year 1 - Building the System

**WMed: Infant Mortality & Access to Medical Care**

<table>
<thead>
<tr>
<th>INTERNAL PARTNER</th>
<th>PROJECT:</th>
<th>EXTERNAL PARTNER:</th>
</tr>
</thead>
</table>
| **WMed: OB/GYN Clinic & Residency Program** | Develop Family Medicine Residency in FQHC:  
- Project Goal: Increase access to primary care physicians by 20% for underserved populations  
- Evidence of Impact: Increased, Battle Creek FQHC replicated the model. | Community Mental Health:  
- CHAPS/V-CHAPS  
- Whole Health Initiative |
| **WMed: Internal Medicine, Pediatrics, Family Medicine** | Cradle Kalamazoo:  
- Project Goal: Reduce infant mortality for infants of color to ≤0.1/1,000 births  
- Evidence of Impact: GOAL MET | YWCA:  
- Cradle Kalamazoo Community Infant Mortality Initiative |
| **WMed: Family Medicine**  
- Access Initiatives: Develop Family Medicine Residency in FQHC | MAGER (Professionals Accelerating Clinical & Educational Rodesign):  
- Project Goal: Develop an interprofessional training program for primary care  
- Evidence of Impact: Just beginning | Family Health Center:  
- FHC Mobile Health Unit |
| **WMed: Associate Dean of Health Equity & Community Affairs, Cheryl Dickson** | Whole Health Initiative (Integrated Behavioral Health):  
- Project Goal: Facilitate comprehensive care services for individuals with mental health problems & decrease ED utilization and acute care hospitalization  
- Evidence of Impact: Enrolment of community mental health clients | Education:  
- WMU (Kalamazoo, Health Center, Health & Human Svc College)  
- KPS  
- KRESA |
| **WMed: Division of Epidemiology & Biostatistics, Cathy Kohlhar** | Kalamazoo Collaborative Care Projects:  
- Project Goal: Facilitate diagnosis and treatment of previously undiagnosed mental illness  
- Evidence of Impact: Just beginning | Hospitals/Public Health:  
- Borgess (Women’s Clinic and Emergency Depart.)  
- Bronson (Women’s Clinic and Emergency Department)  
- KCHCS (WIC, maternal-infant home visitation, CHW)  
- Pharmacies  
- Independent maternal-infant health programs  
- Planned Parenthood |
| **WMed: Associate Dean for Clinical Affairs, Joe D’Ambrosio** | CHAP (Children’s Health Access Program):  
- Project Goal: Increase continuity to pediatric care within the underserved population  
- Evidence of Impact: 3 years into it, reducing missed appointments. | Community:  
- Gryphon Place (Cradle hotline)  
- Eastside  
- Northside  
- Edison  
- Douglass  
- ERACCE  
- Urban Alliance  
- Boys & Girls Club  
- Gospel Mission  
- Ministry with Community  
- Leave & Fishes  
- Hispanic American Council  
- Islamic Center  
- ISAAC |
| | FHC Mobile Health Unit:  
- Project Goal: To increase primary care services, especially immunization rates to KPS students and other underserved groups (YWCA)  
- Evidence of Impact: # of students served, # of students immunized |  |
Equity Focused Long-Term Impact:

• **Long Term Goal:**
  The percentage of pregnant women of color and/or low-socio-economic status residing in Kalamazoo county that received pre-natal care in their first trimester, will increase from 53.4% to 77.9% (Healthy People 2020 goal).

• **Give and Take:**
  • Unanimous recognition
  • Zero ownership
  • Competing Interest

• **Inform – Influence – Improve:**
  • Resource allocation
  • Administrative Backbone
  • Call to action
Intermediate Process Outcomes

• IPO= By February 2019, our team will have developed a recommendation for a community wide protocol triggered by a positive pregnancy test that includes health education and timely prenatal care visits within the first trimester for women of color and for women with low SES

• Mapped referral process at FHC and CHAP

• Policy developed by FHC for process at point of positive pregnancy test to see a CHW, nurse or social worker that can be used as a potential model for other providers

• We identified opportunities for involvement of learners to help map process for earlier referrals with first pregnancy test

• Reached agreement for mystery shopper at FHC and hospitals
Potential Catalysts and Landmines

- **Catalysts:**
  - New OB-GYN residency program
  - EMR linkage
  - Increased CHW’s
  - Sustained engagement and momentum

- **Landmines:**
  - Structural institutional racism
  - Power dynamics
  - Voiceless population
  - Political climate
  - Health care reform
Current State in 2018

• We have a strong collaborative relationship with CRADLE
• Involved medical trainees in the process- IHI open school chapter
• Identified primary pregnancy testing locations for interviews and mapping of referral processes
• Our FQHC developed a new policy for all women receiving positive pregnancy tests to see a CHW, nurse or social worker; use as a model process
• Major hospitals internal equity teams working to streamline prenatal intake processes
Successes

• FHC-implemented new policy: all positive pregnancy tests (at time of capture) reported to CHW, Nurse or Social Worker to connect w/ patient
• Internal equity teams at major affiliate hospitals and FHC working to streamline pre-natal intake process
• WMED neutral trusted and respected community convener
• WMED major contributor for clinical expertise, evidence-based practices, and research data backbone for all of the work
• CRADLE –operational hotline to capture needs – all levels and earlier capture of referrals for home visiting
• Care Coordination Registry – data sharing agreements, HIPAA-compliant protocols for case sharing
• Improved public awareness for resources, safe -sleep messaging and free pregnancy testing
Challenges

1. Need for consistent messaging about the importance of prenatal care in the first trimester (resources, safe-sleep messaging, care coordination)
2. Expand capacity through increased role and number of CHWs, on the ground
3. Sustainability of funding for programs linking families to resources
4. Improving education and referral process during pregnancy testing opportunities
5. Continued efforts to address community wide institutional racism that impacts Infant Mortality
6. Recruitment of diverse faculty and providers
Feedback

1. What media (methods) have you found to be most impactful in addressing the importance in pre-natal care?

2. How are your CHWs/para-professionals sustained in your programs?

3. What programs have you successfully implemented to address reproductive health (justice)/family planning?

4. How are you addressing institutional racism?

5. How do you recruit and retain ethnically diverse providers and staff?
Eastern Virginia Medical School with Sentara Healthcare, Norfolk Dept. of Public Health, Norfolk Public Schools, Norfolk Redevelopment and Housing Authority and Hampton Roads Community Health Center

Norfolk Public Housing residents need access to smoking cessation resources
State of Affairs in 2016

- February 2017 federal mandate required all public housing in the U.S. to be smoke free within 18 months
- As of July 1, 2018, Norfolk public housing became smoke-free
- Prior studies with Norfolk public housing residents indicated barriers accessing smoking cessation resources
- Study by HUD and CDC showed higher smoking rates and adverse health outcomes among adults receiving federal housing assistance (Preventive Medicine June 2017)
- With over 8,000 residents, Norfolk has the largest public housing community in Virginia
- EVMS Researcher, Andy Plunk, PhD, received HUD grant to study how the smoke-free policy will impact Norfolk public housing residents
Year 1 - Building the System

• Smoking cessation identified as a common interest among EVMS partners through the Health Equity Inventory and mapping process

• Community engagement already occurring in diverse ways
  • EVMS has been engaged in HUD-funded research with NRHA for decades
  • NDPH has engaged NRHA in Healthy Norfolk Action Plan particularly around youth physical activity and healthy eating
  • NPS has been working closely with NRHA for safety, security, enrollment matters
  • EVMS Team agreed that a program for NPS students in public housing would lead to engagement and education of the next generation of adults

• EVMS team recognized importance of connectivity and communication with the community, stakeholders and partners

• EVMS team learned that new collaborators must be identified by the community members themselves (e.g., NRHA, NPS and EVMS students)
Equity Focused Long-Term Goal

Smoking Cessation Resources will be Accessible to Everyone in Norfolk Public Housing

- EVMS faculty & student Service Learning
- Norfolk Public Housing Teen Leadership & Presentations
- Norfolk DPH Support Groups QUITLINE
- Optima Heath Educ. Info Web-based Smoking cess. resources
- HR CHC & Local MDs Prescribe Smoking cess. aids
Public Health in Public Housing: NRHA Community Health Survey

TIDEWATER GARDENS
618 Units

GRANDY VILLAGE
363 Units

YOUNG TERRACE
746 Units

DIGGS TOWN
422 Units

CALVERT SQUARE
309 Units

OAKLEAF FORREST
265 Units

2,723 TOTAL UNITS
Potential catalysts and landmines:

• Catalysts
  • Federally mandated smoke-free housing policy
  • Necessity to address immediate/long-term resident apprehensions
  • Desire to create new experiences for students - all levels
  • Demand for integrated collaborative interventions with the community and local resources

• Landmines
  • Resident anxiety over change
  • Access barriers
  • Competing efforts to help
  • Timing of other community transformation efforts (St. Paul’s Area Revitalization)
Current State in 2018

- Engaged
  - Norfolk Redevelopment and Housing Authority (NRHA)
  - Youth Program & Resource Development Leaders
  - Community Advisory Board
  - 13-17 year old students
  - Norfolk Public Schools CIO and research team
  - Sentara/Optima Health Smoking Cessation Director
  - Hampton Roads Community Health Center
- Identified telephonic, printed and web-based smoking cessation resources
Successes

• Mobilized robust community partnership around a smoke free housing policy that affect residents of public housing in Norfolk.

• Launched the summer youth program with 12 NPS students

• Developed EVMS student service learning opportunity for mentorship and community participation

• Received AAMC-CDC Cooperative Award
Challenges

• Resident disenfranchisement leading to challenges in policy implementation
• Timing of initiative and urgency for resident compliance with smoke-free housing policy
• Access to medications
• Attrition of high school students
Feedback

• What are strategies to keep (or increase) high schools students engaged (participating) each year?

• Aside from donated/purchased medications, how can we help assure access to smoking cessation medications for all?

• How do we maintain a cadre of physicians (academic depts., community health centers, Sentara and local physicians) available to initiate prescriptions and follow patients?

• What is the best evaluation strategy to assess the impact or influence each student has on a smoker to stop or a non-smoker not to start?
We are the FIU-Baptist Health South Miami NeighborhoodHELP Partnership: Our community health issue is management of chronic conditions such as diabetes and cardiovascular disease through addressing the social determinants of health at a household-level.
State of Affairs in 2016

• FIU Dept. of Population and Health Science Research conducts Community Health Needs Household Needs Assessment with Baptist Health

• At least one household member in 45 percent of the households reported having a diagnosis of hypertension (compared to 32.7% in all Miami-Dade).

• At least one household member in 14 percent of the households reported having a diagnosis of diabetes (compared 8% in Miami-Dade).

• Of all the households surveyed, 44 percent reported using the ER for primary care.
Year 1 - Building the System

• Built institutional collaboration between the FIU Green Family Foundation NeighborhoodHELP program and Baptist Health South Miami

• Stakeholder/gap analysis identified need for community partners in the grassroots areas of health and wellness

• Need for community gardening and healthy food delivery emerged
Equity Focused Long-Term Goal

• We serve a low-income, Miami-Dade zip code 33143, wherein 48% of residents are African-American. Our program aims to build health equity and reduce emergency room (ER) admissions for preventable chronic disease by addressing the social determinants of health (SDOH), providing access to primary care and controlling chronic disease in this community.

• By 2020, our program will result in a 30% decrease in annual SMH ER utilization among a frequent ER using cohort of uninsured patient identified by SMH in 2015, compared with 2014 baseline.
Intermediate Process Outcomes

• The new Healthy Eating and Living (HEAL) Initiative to partner with Urban Oasis Miami

• We will identify and engage patients in need into chronic disease management cohorts that are followed by the Physician Assistants (PAs) in our HH visits

• Our team will collect, analyze and disseminate evaluation data quarterly.

• FIU HWCOM Division of Research, Policy and Community Development will work with FIU MPH interns to secure outside funding to sustain HEAL program health and wellness research and activities.
Potential catalysts and landmines

• The NHELP model in the South Miami will use an approach that sends PAs into HHs and works specifically with at risk cohorts of patients on chronic disease management and wellness. The interventions include health nutrition education, food prescription and healthy food acquisition, and regular clinical monitoring of diabetes and other chronic diseases. The evaluations include quarterly inventories of eating and exercise and clinical outcomes.
Current State in 2018 : 92 enrolled Households

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<th>METRICS</th>
<th>OUTCOME July1, 2016 to June 30, 2017</th>
<th>Medicaid HEDIS Median 2015 (Last Available Year)</th>
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<tr>
<td>% Adults who had BP measured</td>
<td>100%</td>
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<tr>
<td>% Adults who had BMI screening</td>
<td>100%</td>
<td>80.8%</td>
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<tr>
<td>% Adults with DM who are controlled (A1c&lt;8)</td>
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<td>45.5%</td>
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<tr>
<td>% Adults with HTN who had their last recorded BP controlled</td>
<td>63.2%</td>
<td>54.7%</td>
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Successes

• New Community Partners

• New Learners/ MPH Interns, Med students
Challenges

• Internal vs. External Challenges
DIABETES AND CO-MORBIDITY FACTORS FOR ADULT PATIENTS

JULY 13, 2018
State of Affairs in 2016

• Some populations continue to face systemic barriers to being able to live healthy lives.

• Risk and burden of chronic diseases and other health conditions continues to persist among Houstonians (and wider U.S. population) who are socially and economically burden.

• Diabetes, cardiovascular disease and a lack of well-being impose serious health and economic consequences.
Year 1 - Building the System

➢ Used the Health Equity Inventory to list and review the projects associated with our outcomes of interest.
➢ Reviewed potential partners under domains not associated with our outcomes of interest.
➢ Identified there were a few missing departments that we realized should have been included.
➢ Found one project that was not contributing to our overarching goal.
➢ Concluded there were not any redundant projects.
➢ Learned that there are various projects taking place; all of which offer unique contributions that are working in tandem to achieve our desired outcomes.
Equity Focused Long-Term Goal

By 2022 have at least a two year trend:

1. Reducing the prevalence of elevated HbA1c (> 9) among Hispanic population by 10% through increased identification and referrals for identified co-morbidities for adult patients served by Harris Health System measured by the Harris Health System Health Leads Social Determinants of Health Screening Tool and the Patient Health Questionnaire-9 (PHQ9) depression screening; 100% of identified patients would receive a referral to a nutritionist and/or mental health providers; 80% adherence with referral appointments.

2. Providing SDOH education to staff, medical professionals, and affiliate providers measured by pre/post questionnaires, system integration of SDOH training, number of trainings offered and number of individuals trained.
Intermediate Process Outcomes

By February 2019:

1. Baylor College of Medicine faculty, trainees and students as well as Harris Health System staff will receive at least one (1) training on social determinants of health (SDOH), health equity and population health.

2. Our team will have completed the process of integrating our Baylor College of Medicine’s Center of Excellence in Health Equity, Training and Research student scholars as clinical observers for tele-health components of the Harris Health CHW Home Visit program.
## Potential Catalysts and Landmines

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<tr>
<th>Policies, Programs and Practices</th>
<th>People and Power</th>
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<tbody>
<tr>
<td>Required training for participating in clinical spaces (both)</td>
<td>Board of Trustees (both)</td>
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<tr>
<td>Psychiatry and Behavioral Sciences &amp; Family and Community Med. (Baylor)</td>
<td>President/CEO and senior leadership (both)</td>
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<tr>
<td>Hospital Accreditation – CLER, DNV GL NIAHO (both)</td>
<td>Legal Affairs, General Counsel, Corporate Compliance (both)</td>
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<tr>
<td>Center of Excellence in Health Equity, Training and Research (Baylor)</td>
<td>Harris County Commissioner’s Court</td>
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<tr>
<td>Community Outreach Svcs. &amp; Ambulatory Care Svcs. (Harris Health)</td>
<td>Harris Health Advisory Council</td>
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<tr>
<td>Academic Accreditation – LCME, ACGME, SACS COC, ARC-PA, COA, CAAHEP, ACGC (Baylor)</td>
<td>Baylor College of Medicine Deans and Department chairs / Harris Health Division heads</td>
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Current State in 2018

• Approved a clinical observer policy for Baylor College of Medicine’s Centers of Excellence in Health Equity, Training and Research student scholars

• Initiated conversations with senior leadership at Baylor College of Medicine and Harris Health System regarding the long term goal.

• Discussed project with chairs (or designees) of relevant clinical departments as well as administrative offices at Baylor College of Medicine and Harris Health System

• Met with and sought feedback from community advisory groups, including the Harris Health System Patient Council

• Completed Stakeholder Engagement Interviews with Baylor College of Medicine’s Center of Excellence in Health Equity, Training and Research junior faculty, clinical fellows and medical student scholars & Harris Health System staff
Successes

- Received favorable reviews from SDOH educational activities
- Implementation and early results from Harris Health CHW Home Visit program
- Continued support from key stakeholders at Harris Health and Baylor College of Medicine
Challenges

Based on the planned IPOs and sub-tasks, team members will need to work closely with the following units:

- Baylor College of Medicine’s School of Medicine Curriculum Renewal Taskforce, School of Health Professions Dean’s Office, and Graduate School of Biomedical Sciences Dean’s Office (student training)
- Baylor College of Medicine’s Office of Graduate Medical Education (GME training)
- Baylor College of Medicine’s Academic Council (faculty training; clinical services)
- Baylor College of Medicine’s Centers of Excellence in Health Equity, Training and Research (trainee clinical observers; SDOH content)
- Harris Health System’s Population Health Transformation (training for non-Baylor affiliated Harris Health healthcare employees)
- Harris Health System Ambulatory Care Services (clinical observer training for Baylor trainees)
Feedback

• Would any teams be willing to share their SDOH curriculum and best practices with various delivery methods with us?
  o Do others teams have best practices to share on integrating SDOH into the curriculum for students in non-MD graduate healthcare/biomedical sciences programs (e.g., PhD students)?

• Do other teams see any potential catalyst or landmines we may have missed after completing our analysis?
Vanderbilt University Medical Center

Institutional Organization for Community Health & Health Equity

July 2018

VUMC Team:
Robert Dittus, Pam Jones, Bonnie Miller, David Posch, Russell Rothman, Consuelo H. Wilkins

Presented by: Consuelo H. Wilkins
State of Affairs in 2016

By July 2019, VUMC will establish a coordinated and sustainable institutional organization (such as an “Office of Health Equity”) to advance community health and health equity.

2016

VUMC has an extensive portfolio programs across the Clinical, Education, and Research enterprise focused on community health and health equity (now in the HEI) but many of these are siloed and not well coordinated.

State of Affairs

While some programs are in place across the enterprise, learners are pushing for more of a focus on social mission.

Affairs

There is a need to build trust with the community, ensure that partnerships are mutually beneficial and to coordinate VUMC’s interface with community partners.
Year 1 - Building the System

Identified Needs:

- Internal coordination of community health/community engagement projects
- Build trust, share goals and coordinate external interface with community partners.
- More exposure to and training about community health/health equity issues for learners

Streamline process for VUMC faculty, staff and students to get involved in community health efforts

Strong community voice to guide VUMC’s community efforts

More effectively align research priorities with community needs
**Equity Focused Long-Term Goal**

Build a coordinated and sustainable institutional organization to advance community health and health equity for vulnerable populations across the research/educational/clinical VUMC enterprise.

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<tr>
<th>What They Contribute</th>
<th>Community</th>
<th>Clinical</th>
<th>Learners</th>
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<tbody>
<tr>
<td>Influences community health strategies deployed by VUMC through involvement in a Community Advisory Board</td>
<td>Improved collaboration and alignment with CHCs</td>
<td>Skills and human resources to help community partners fulfill their goals and serve their clients</td>
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<thead>
<tr>
<th>How They Benefit</th>
<th>Community</th>
<th>Clinical</th>
<th>Learners</th>
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<tbody>
<tr>
<td>Collective ability to focus on community health improvement and improve population health</td>
<td>Connections to resources in the community that address patient needs outside the health care system</td>
<td>Expanded exposure and applied learning experiences related to SDOH and community health</td>
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Intermediate Process Outcomes

Within 12 months, our team will secure approval and resources from senior leadership for an institutional organization/”office” that supports a coordinated approach to community health and health equity.

- Research existing models at other AMCs
- Define role and functionality of the “office” and its components
- Explore software that can enhance internal coordination
- Examine patient data to identify disparities
- Develop an internal and external communications strategy
- Define the role of the VUMC Community Advisory Board
Potential catalysts and landmines

**Catalysts**
- Model programs at other AMCs
- Existing people and programs
- Shift to value-based care
- Leadership connecting in new ways
- Learners interest in social mission
- Increased interest in CEnR
- CHNA requirements

**Landmines**
- Traditional AMC structures/silos
- Inertia for change
- Trust building with community
- Alignment with existing initiatives/turf issues
Current State in 2018

• Interviewed 27 stakeholders, analyzed themes, and developed desired functionality of “office”

• Researched existing models at other AMCs

• Developed proposed model
  • Defined role and functionality of the “office”
  • Considered how different offices and programs will relate to this infrastructure
# Successes

- Team collaboration: enhanced communication at the leadership level and beyond
- Development of a model for the “office” that incorporates current community health/health equity efforts, builds off the desired functionality expressed in stakeholder interviews and engages faculty/staff/students and community partners as advisors
- Analysis of AMC existing models and application of best practices to the “office” model
- Identification of current programs and partnerships that could be expanded and built upon
- Enthusiasm and buy-in from stakeholders interviewed; better understanding of stakeholder perspectives
Challenges
Determining how the “office” will intersect with faculty/staff/students who are focused on/interested in community health/health equity

Politics and need for socializing the “office” and a systems approach; demonstrating early successes

Funding and Sustainability
Feedback

• Can you share the reporting structure of similar offices at other AMCs?
• Can you share the processes for developing such an office?
• How was the “office” funded? What resources were needed to sustain the office?
• What suggestions do you have for communicating about this office and increasing buy-in across the institution and externally?
• What suggestions do you have for incorporating a joint VUMC-community advisory board?
• What suggestions do you have for measuring success?
• What software are you familiar with that might be useful to this office?