Adult Leadership Team-Racial Disparities

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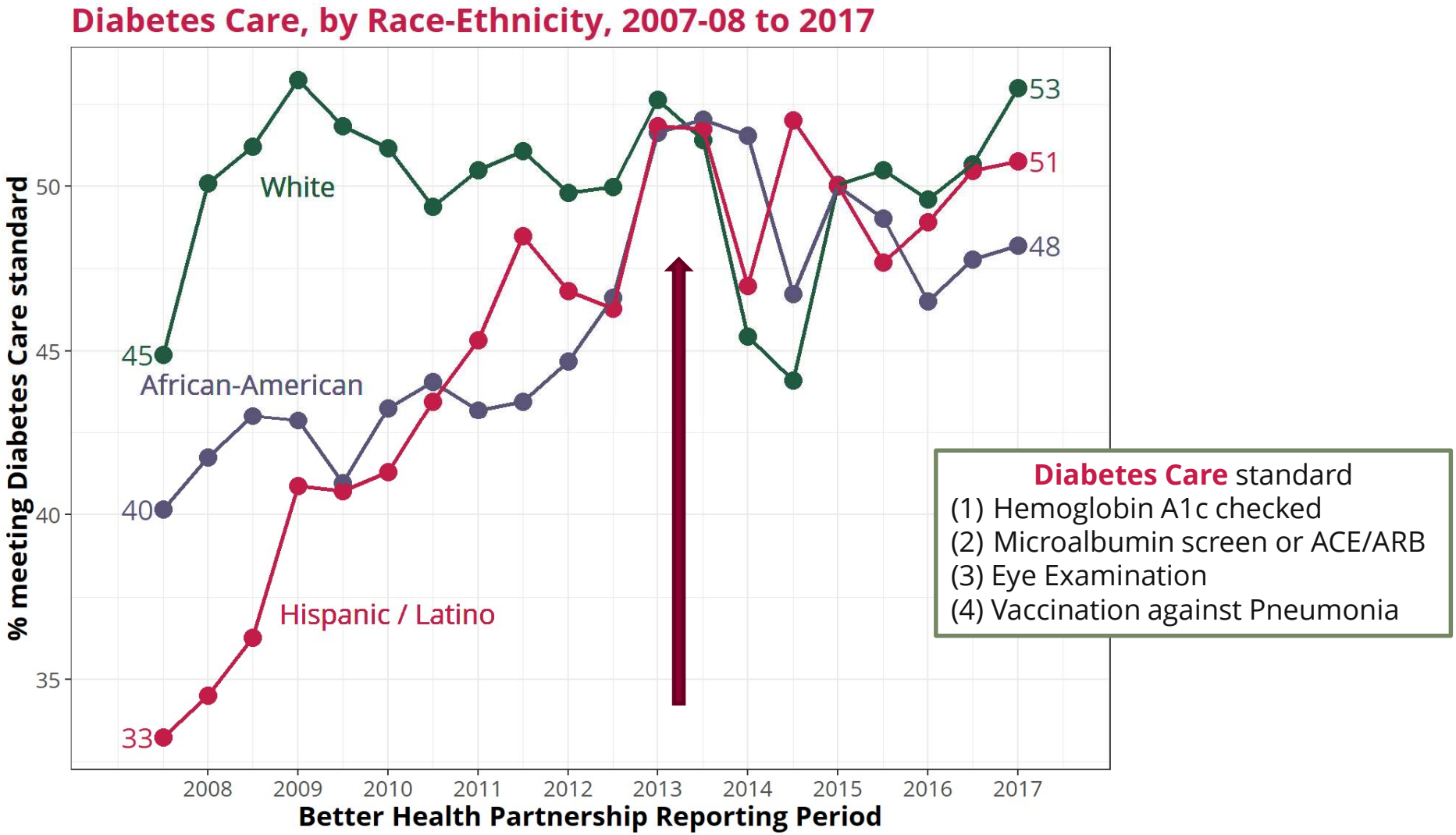
Better Care: Reduced Gaps in Adult Diabetes Care by Race/Ethnicity



Diabetes Care standard
(1) Hemoglobin A1c checked
(2) Microalbumin screen or ACE/ARB
(3) Eye Examination
(4) Vaccination against Pneumonia

Best practice sharing:
"Rising Tide Floats all Boats"

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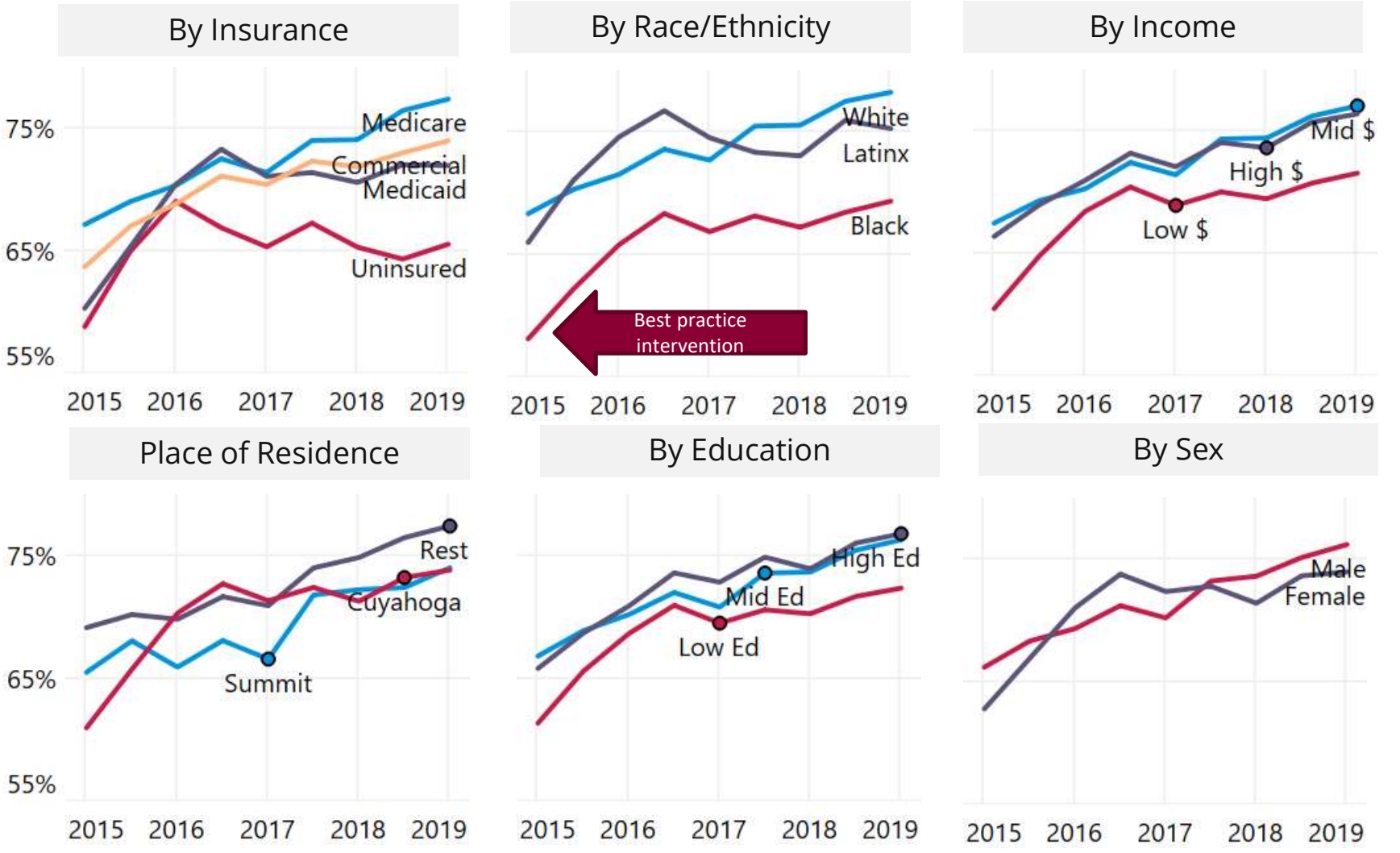
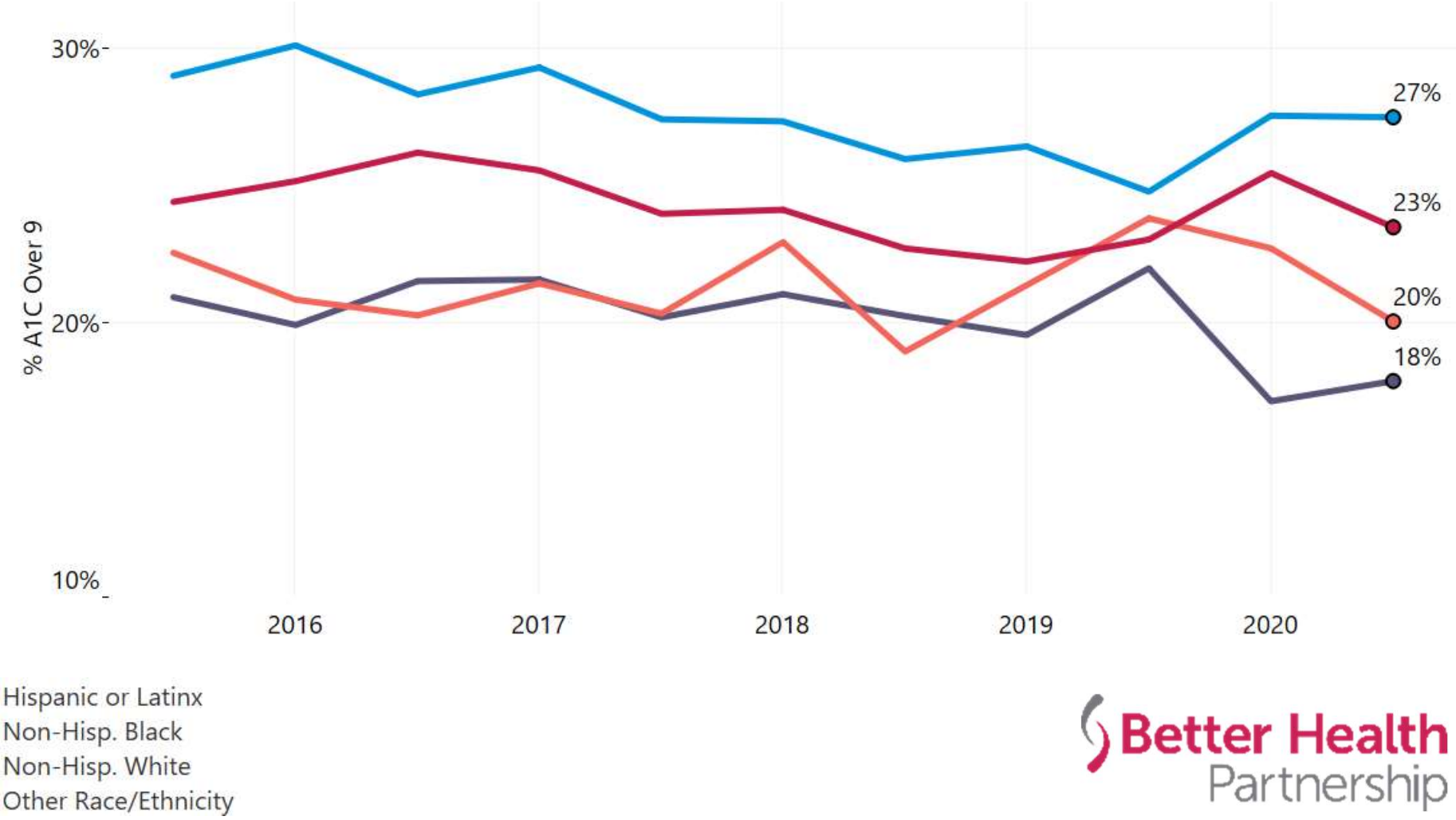
BHP: Improved Adult Blood Pressure Control; Disparities Persist

% with BP below 140/90 by subgroup, 2015 to 2019



% A1C Over 9; Disparities Persist

18-75 yrs. With Diabetes by Race/Ethnicity and Year



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Advancing Strategies to Address Persistent Disparities – Identify Key Drivers

The Problem: Persistent racial/ethnic and income disparities in adult chronic disease care and outcomes

SMART Aim: Racial/ethnic and income disparities in adult health care and outcomes are reduced by “x” across all PCPs in BHP collaborative by “y”

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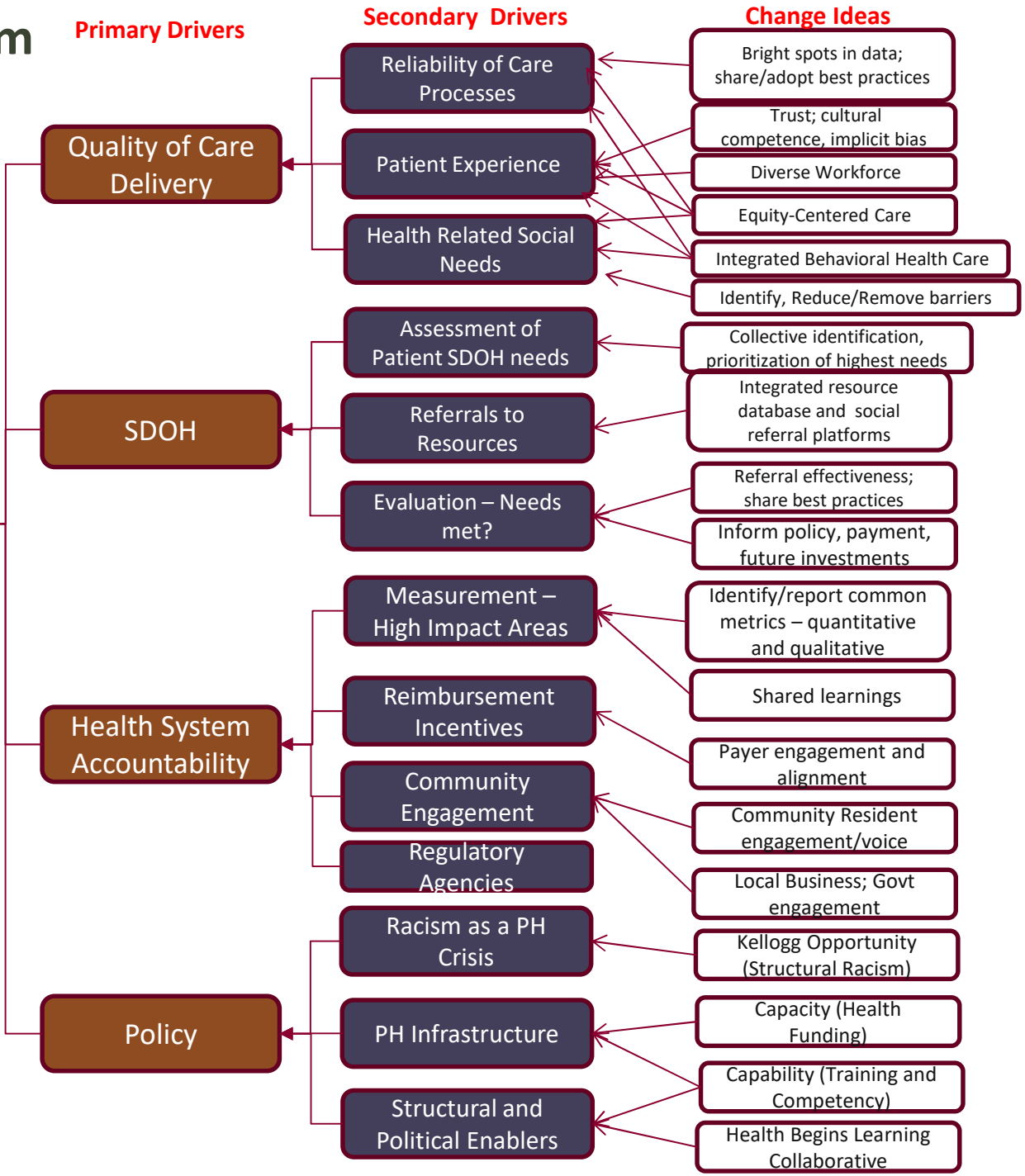
Driver Diagram

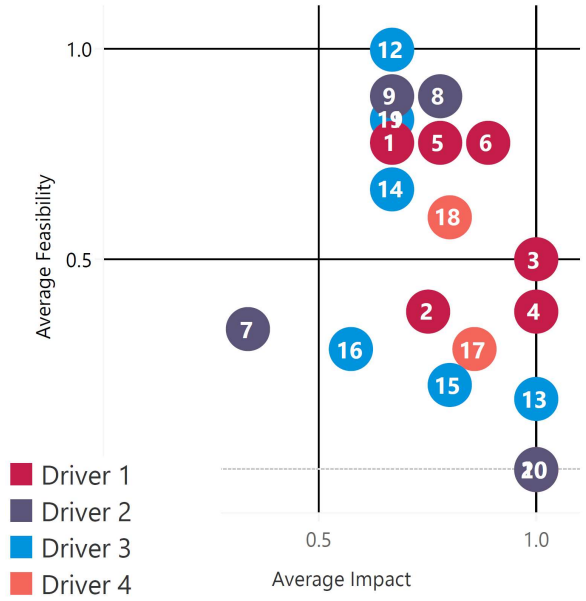
The Problem: **Persistent racial/ethnic and income disparities in adult chronic disease care and outcomes**

SMART Aim: Racial/ethnic and income disparities in adult health outcomes are reduced by "x" across all PCPs in BHP collaborative by "y"



Ranking of Change Ideas

(select any element to highlight it across the dashboard)



		Average Feasibility	Avearge Impact	Product of Scores
6	Identify, reduce/remove barriers	0.78	0.89	0.69
8	Integrated social resource database	0.89	0.78	0.69
12	Shared learnings	1.00	0.67	0.67
5	Integrated Behavioral Health Care	0.78	0.78	0.60
9	Referral effectiveness	0.89	0.67	0.59
11	Identify/report common metrics	0.83	0.67	0.56
19	Health Begins	0.83	0.67	0.56
1	Bright spots in data	0.78	0.67	0.52
3	Diverse workforce	0.50	1.00	0.50
18	Capability	0.60	0.80	0.48
14	Community engagement	0.67	0.67	0.44
4	Equity-centered care	0.38	1.00	0.38
2	Trust; cultural competence, implicit bias	0.38	0.75	0.28
17	Capacity	0.29	0.86	0.24
13	Payer engagement	0.17	1.00	0.17
16	Loca business engagement	0.29	0.57	0.16
15	Govt engagement	0.20	0.80	0.16
7	Prioritization of highest needs	0.33	0.33	0.11
10	Inform policy	0.00	1.00	0.00
20	Kellogg opportunity	0.00	1.00	0.00

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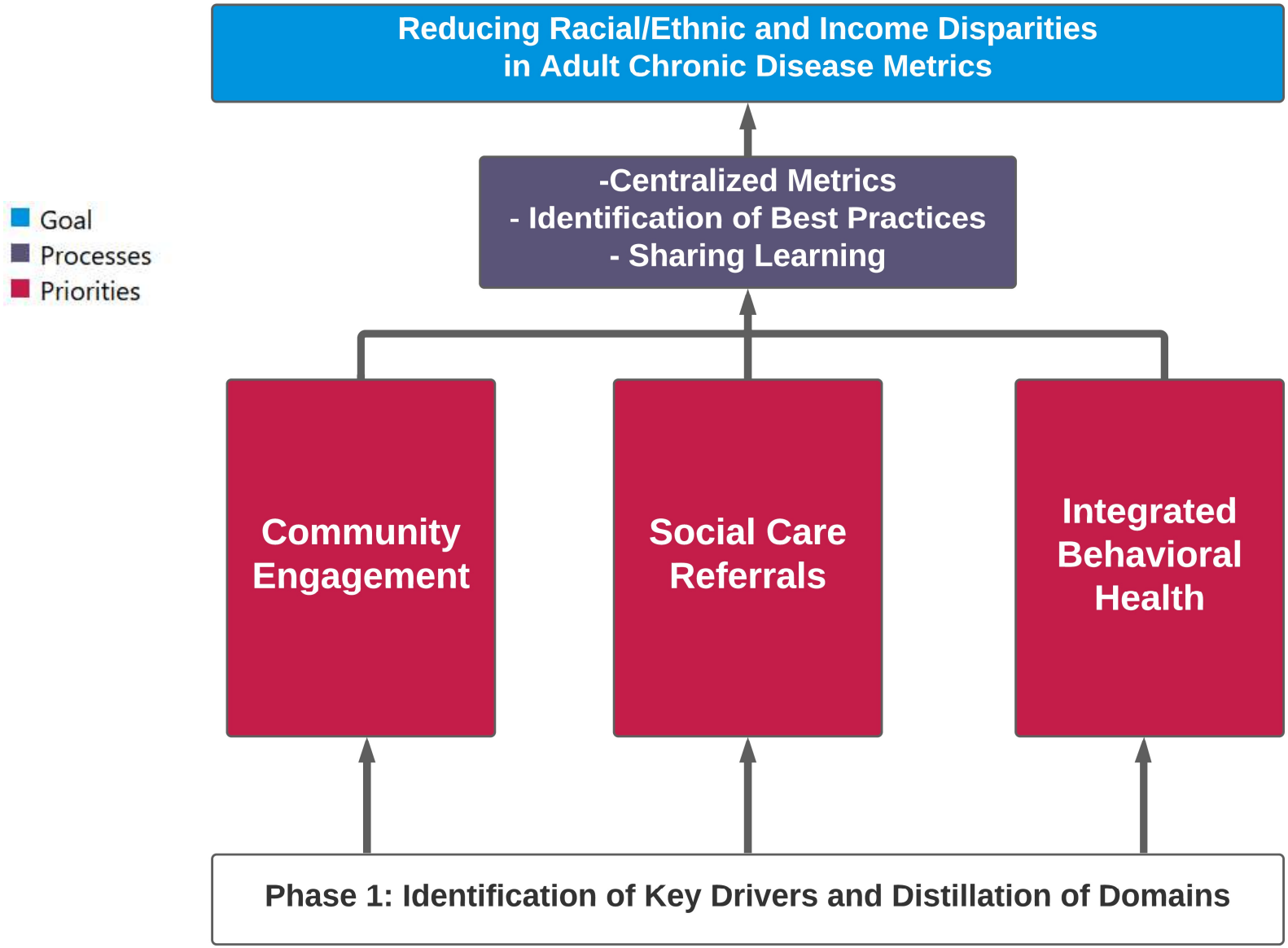
http://www.betterhealthpartnership.org/adult_driver_voting_2021.asp



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Health System Best Practice Sharing – Key Questions

1) What are you doing at your system in this priority area that you selected as a "potential best practice" to share?
   (community engagement, social referrals, Integrated BH)

2) How are you doing it?

3) What is working well?

4) What are your challenges/ opportunities?

5) How will these strategies help to achieve the aim to reduce racial/ethnic and income disparities in adult chronic disease?

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Health System Best Practice Sharing by Prioritized Domains (Oct 2021- Jan 2022)

	Community Engagement	Integrated Behavioral Health	Social Referrals
ASIA, Inc.	X		X
Care Alliance	X		
Cleveland Clinic		X	
MetroHealth			X
NFP	X	X	
Sisters of Charity	X		
Summa			X
The Centers		X	
University Hospitals		X	
VA		X	

What are we Learning? Community Engagement

Level of integration considerations

How are community stakeholders incorporated into the health care organization?

(are they employed or external partners?)

Decision-making considerations

How is community feedback and decision-making solicitated/incorporated into the health care organization?

(High level strategic planning or ground-level?)

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What are we Learning? Community Engagement

Trust-Building

- Establish trusted relationships to advance change
- Have an influential liaison(s) from community involved
- Meet the community "where they are" to gain buy-in
- Health care organization is respected and can effectively deliver

Align on Mission and Goals

- Align health care organization's goals with needs identified from community residents and organizations
- Employees of the health care organization are passionate about their mission and working with the community – they are "authentically involved"

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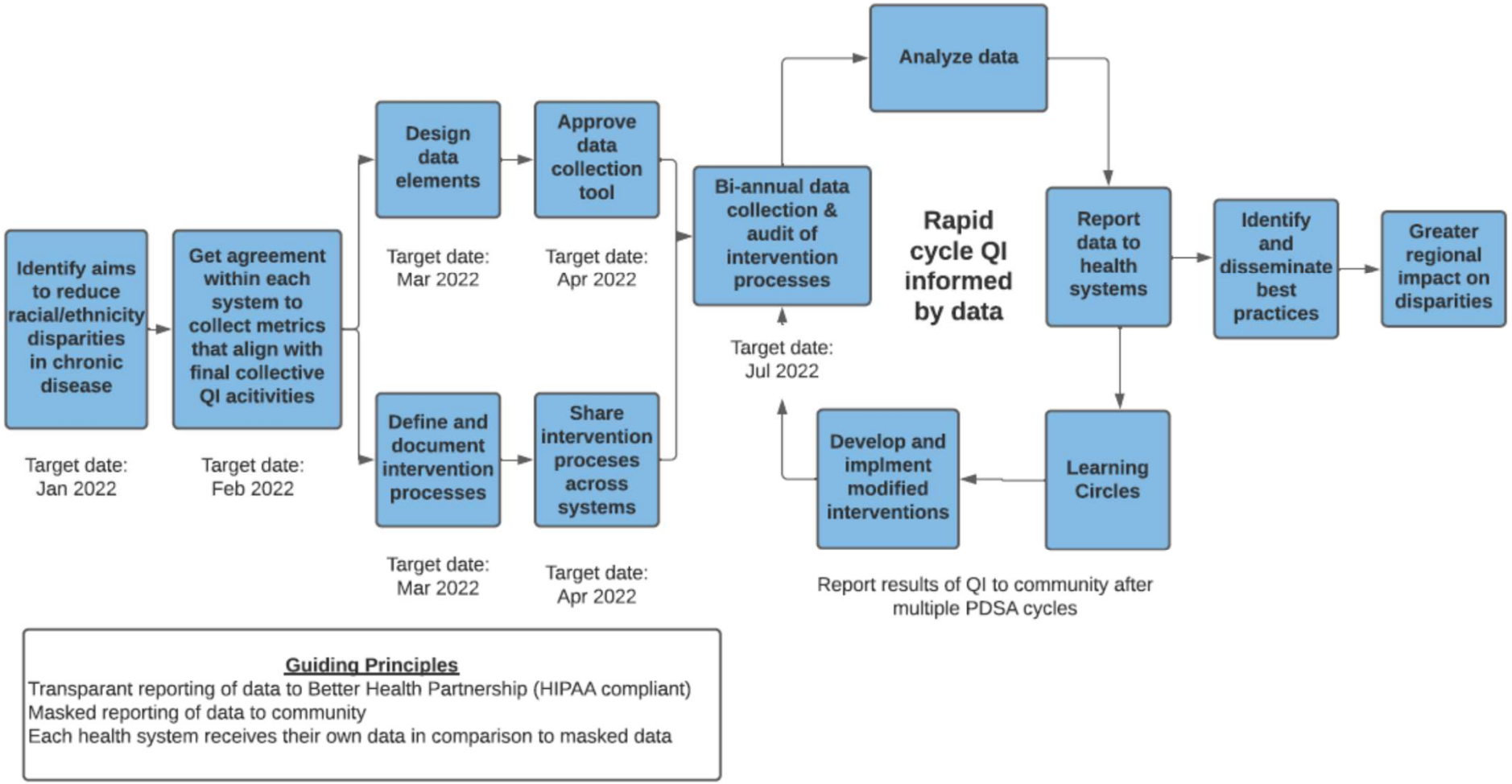
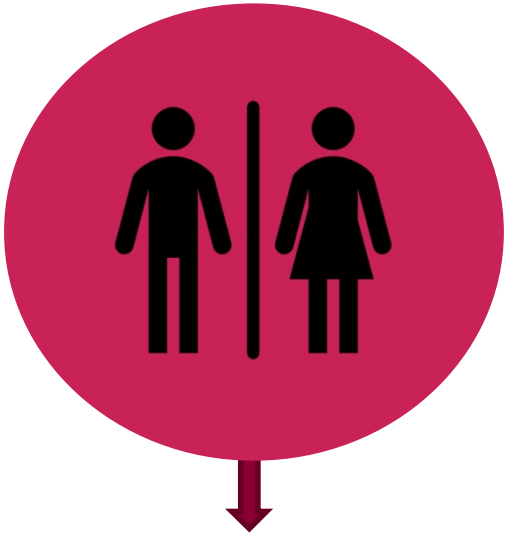
Adult Leadership Team
Phase 2 - where are we going in 2022?



What Success Looks Like



Improved Upstream Integration
+ Best Practices in Care

Reduction in Health Disparities

Community Engagement	Social Care Referral	Integrated Behavioral Health	Best Practices in Chronic Disease Care	Quality Health Outcomes
Connects to a health care provider where a trusting relationship is established	*Social needs are identified and addressed through internal & external partners*	*Behavioral health needs are identified and addressed through a care team*	*The health care provider utilizes known best practices in care to ensure they are giving appropriate treatment*	*The patient remains engaged with a health care provider – leading to an improvement in health and well-being*