




# CHRONIC CARE AND SOCIAL DETERMINANTS OF HEALTH DURING THE COVID-19 PANDEMIC

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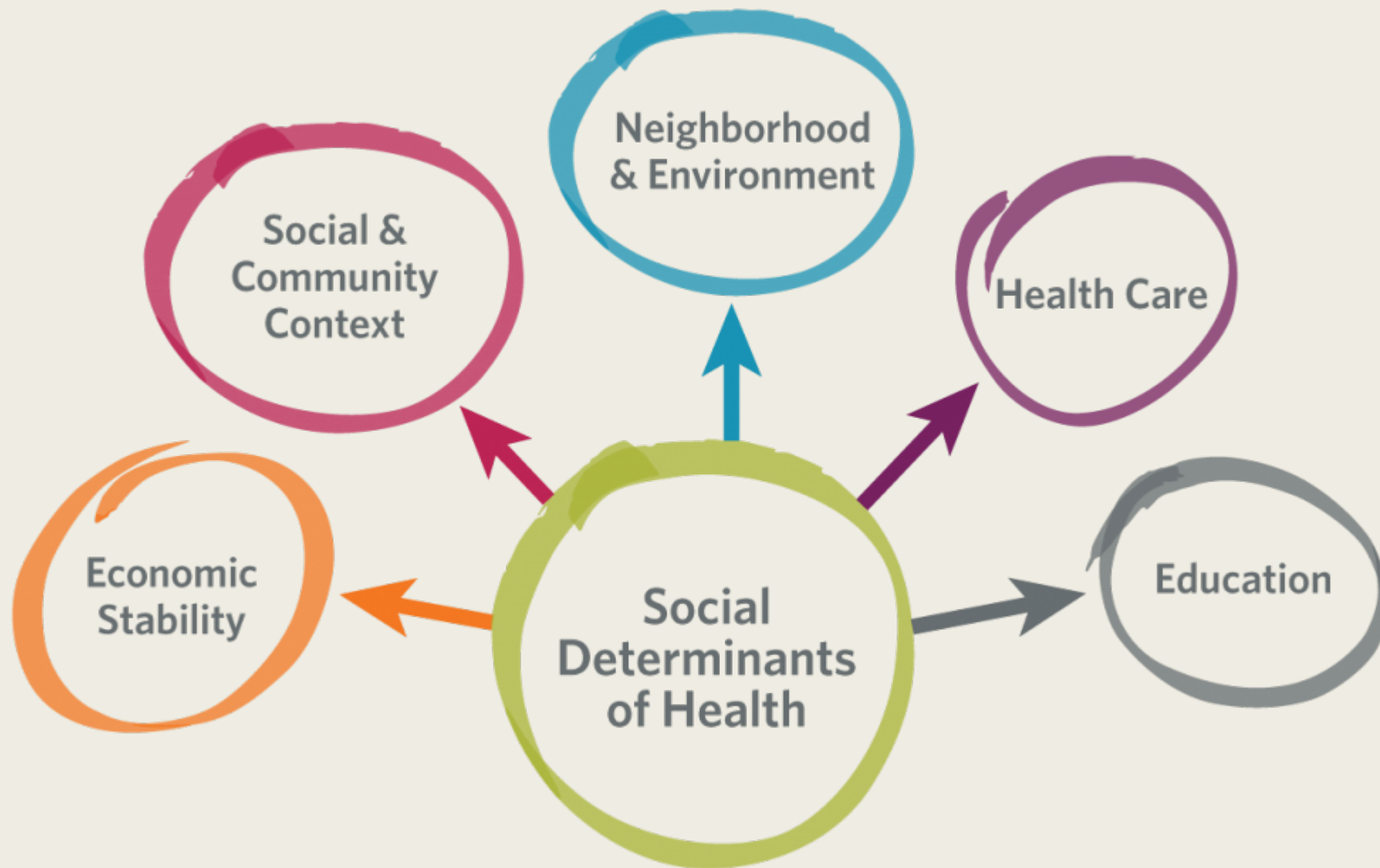


# Introductions

- Bracken Babula, MD MS
  - *Associate Quality Officer and Medical Information Officer, Jefferson Health*
- Laura Gontz, BSN MBA RN CCM
  - *Director of Care Coordination, Jefferson Health*
- Robert Fields, MD MHA
  - *Senior Vice-President and Chief Medical Officer of Population Health, Mount Sinai Health System*
- Megan Reyna, MSN RN
  - *Vice President of Government & Value Based Programs, Advocate Aurora Health*

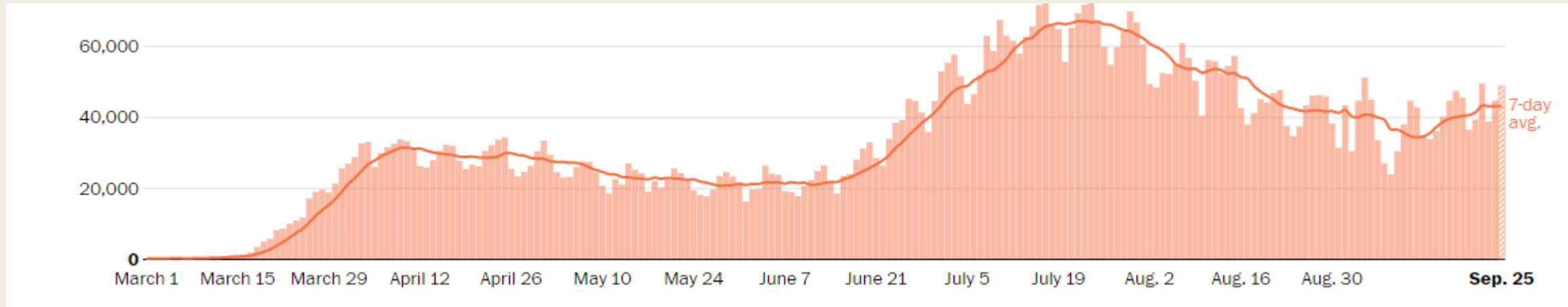
# Conflicts of interest

- Bracken Babula
  - *None*
- Laura Gontz
  - *None*
- Robert Fields
  - *None*
- Megan Reyna
  - *None*



Source: UPMC

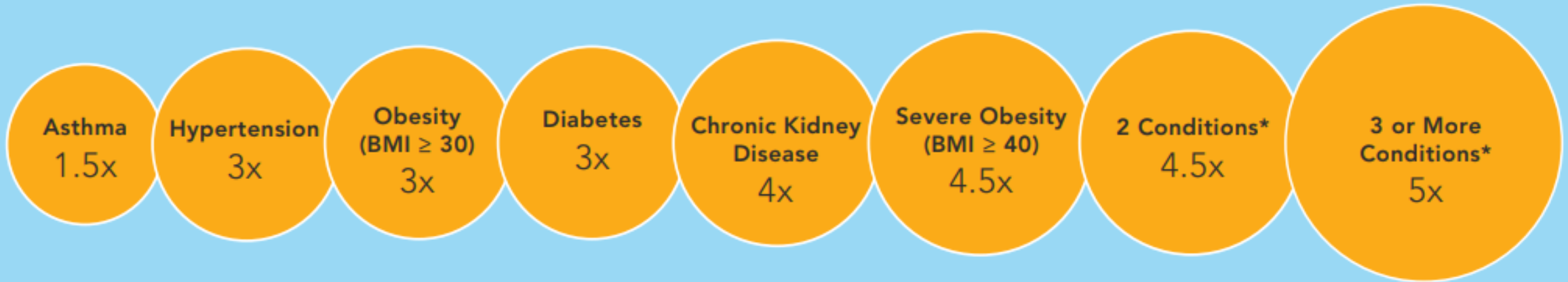
# COVID-19 Cases per Day



As of late-September:

- ~7 million cases
- 203,000 deaths

**RISK FOR HOSPITALIZATION IF YOU HAVE ANY OF THESE CONDITIONS AND GET COVID-19 COMPARED TO PEOPLE WITHOUT THE CONDITION(S).**



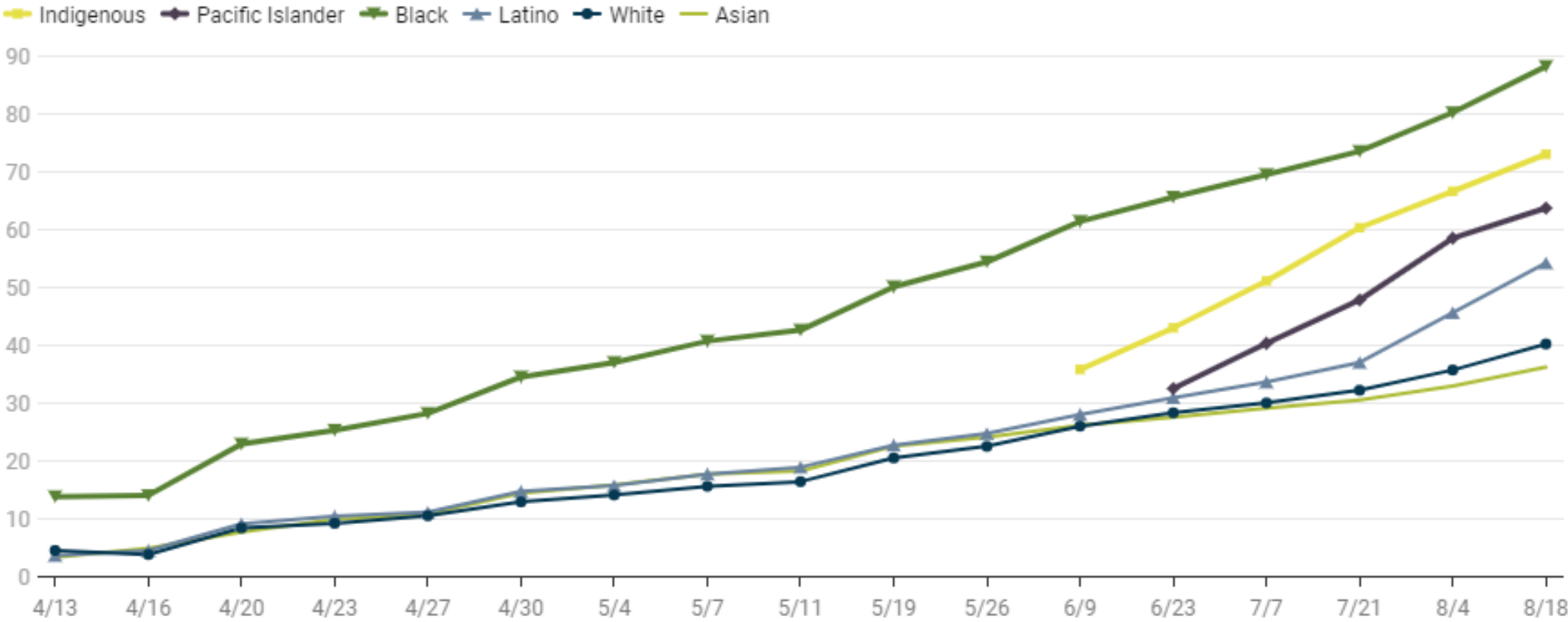
\*Conditions include asthma, obesity, diabetes, chronic kidney disease, severe obesity, coronary artery disease, history of stroke and COPD.

Rate ratios compared to White, Non-Hispanic Persons	American Indian or Alaska Native, Non-Hispanic persons	Asian, Non-Hispanic persons	Black or African American, Non-Hispanic persons	Hispanic or Latino persons
Cases <sup>1</sup>	2.8x higher	1.1x higher	2.6x higher	2.8x higher
Hospitalization <sup>2</sup>	5.3x higher	1.3x higher	4.7x higher	4.6x higher
Death <sup>3</sup>	1.4x higher	No Increase	2.1x higher	1.1x higher

Source: CDC.gov

# Black & Indigenous Americans experience highest death tolls from COVID-19

Cumulative actual COVID-19 mortality rates per 100,000, by race and ethnicity, April 13-Aug. 18, 2020

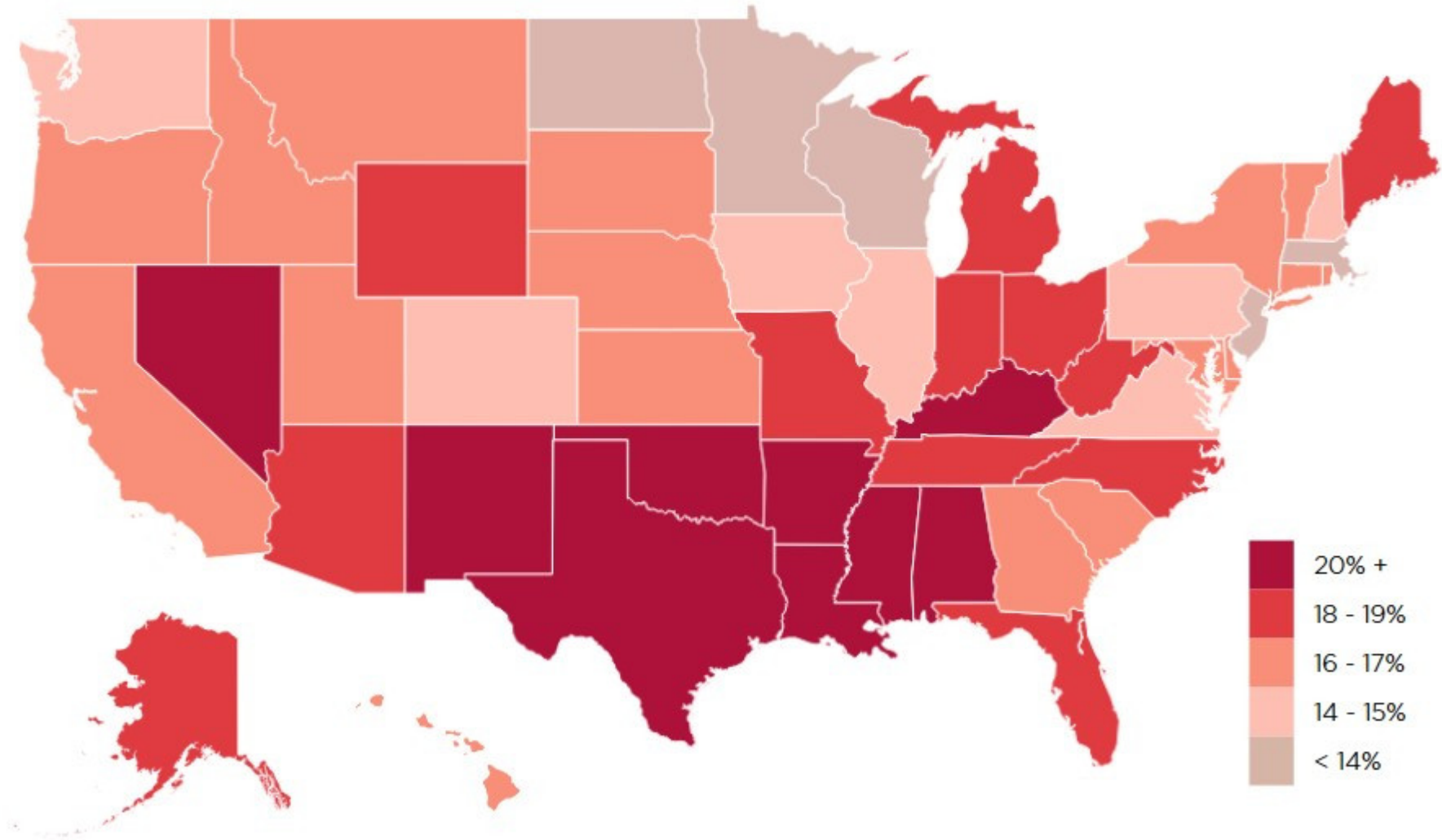


Note: Dates are not consistently scaled, but reflect data collection intervals for our Color of Coronavirus project.

Source: [APM Research Lab](#) • [Get the data](#) • Created with [Datawrapper](#)

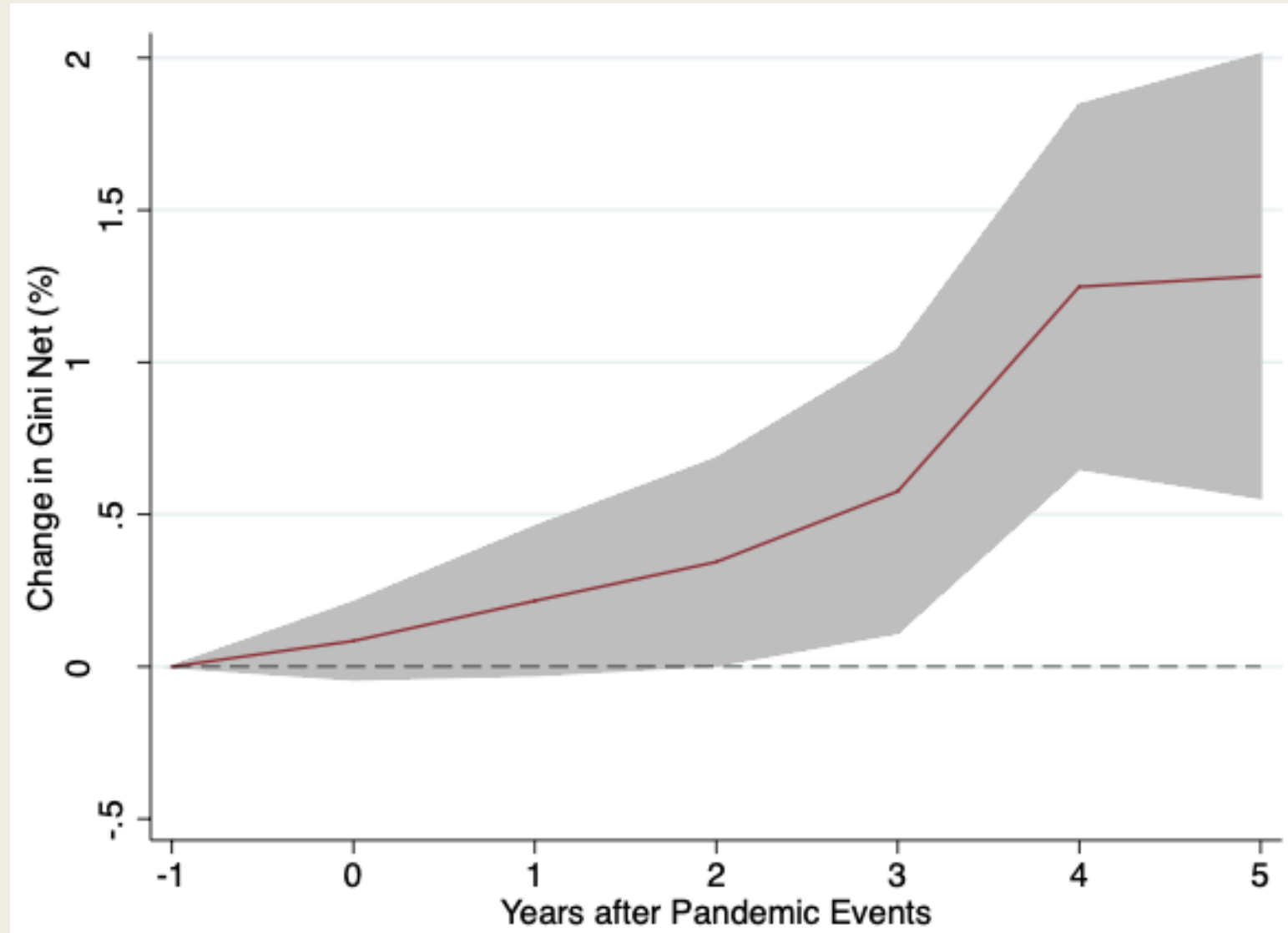
**If they had died of COVID-19 at the same actual rate as White Americans, about 19,500 Black, 8,400 Latino, 600 Indigenous, and 70 Pacific Islander Americans would still be alive.**

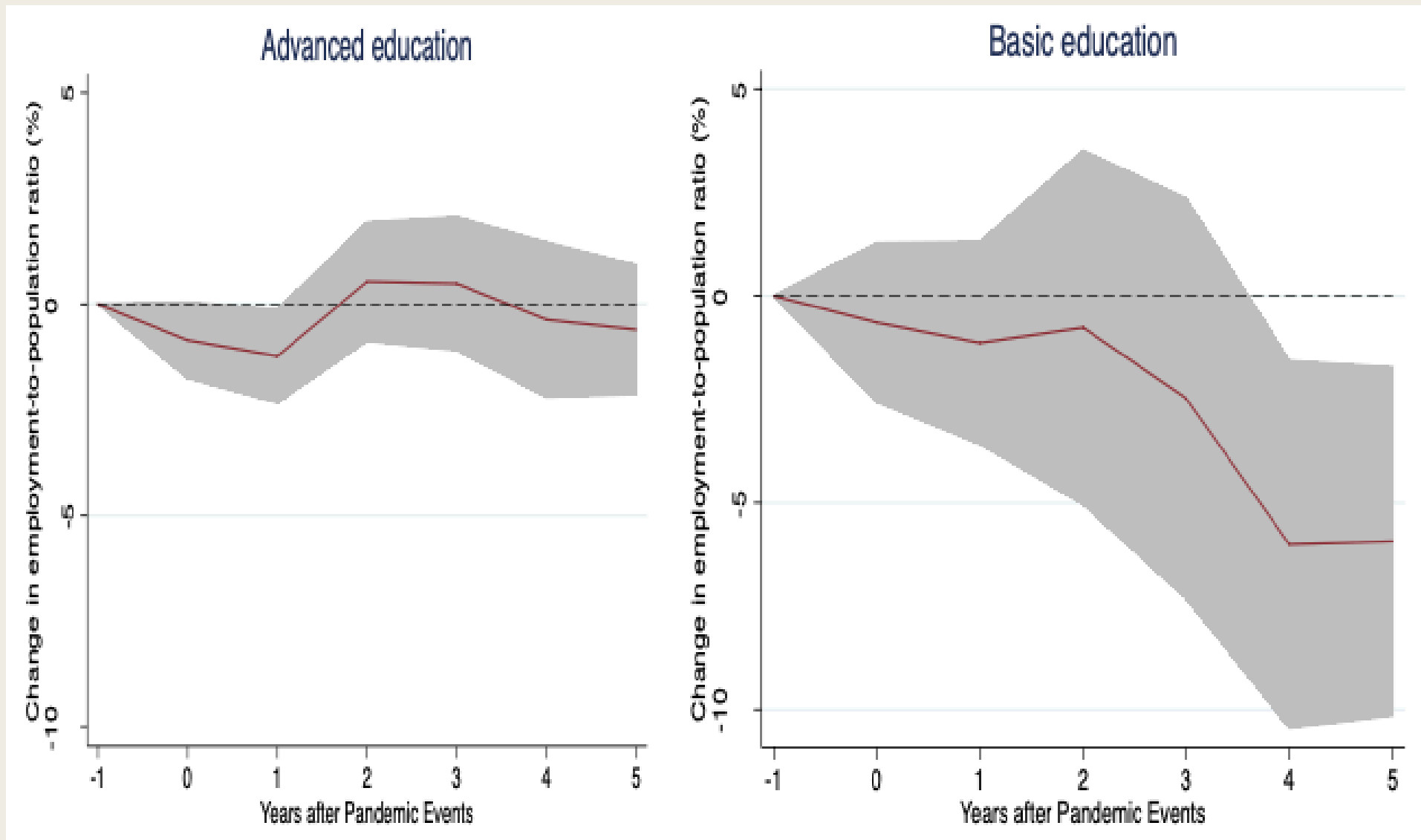
**Figure 1. Projected rates of food insecurity among the overall population in 2020 by state**



Source: Harford CAA

Gini:  
measure of statistical  
dispersion intended to  
represent the income  
inequality or wealth  
inequality within a  
nation





# Where do we go from here?

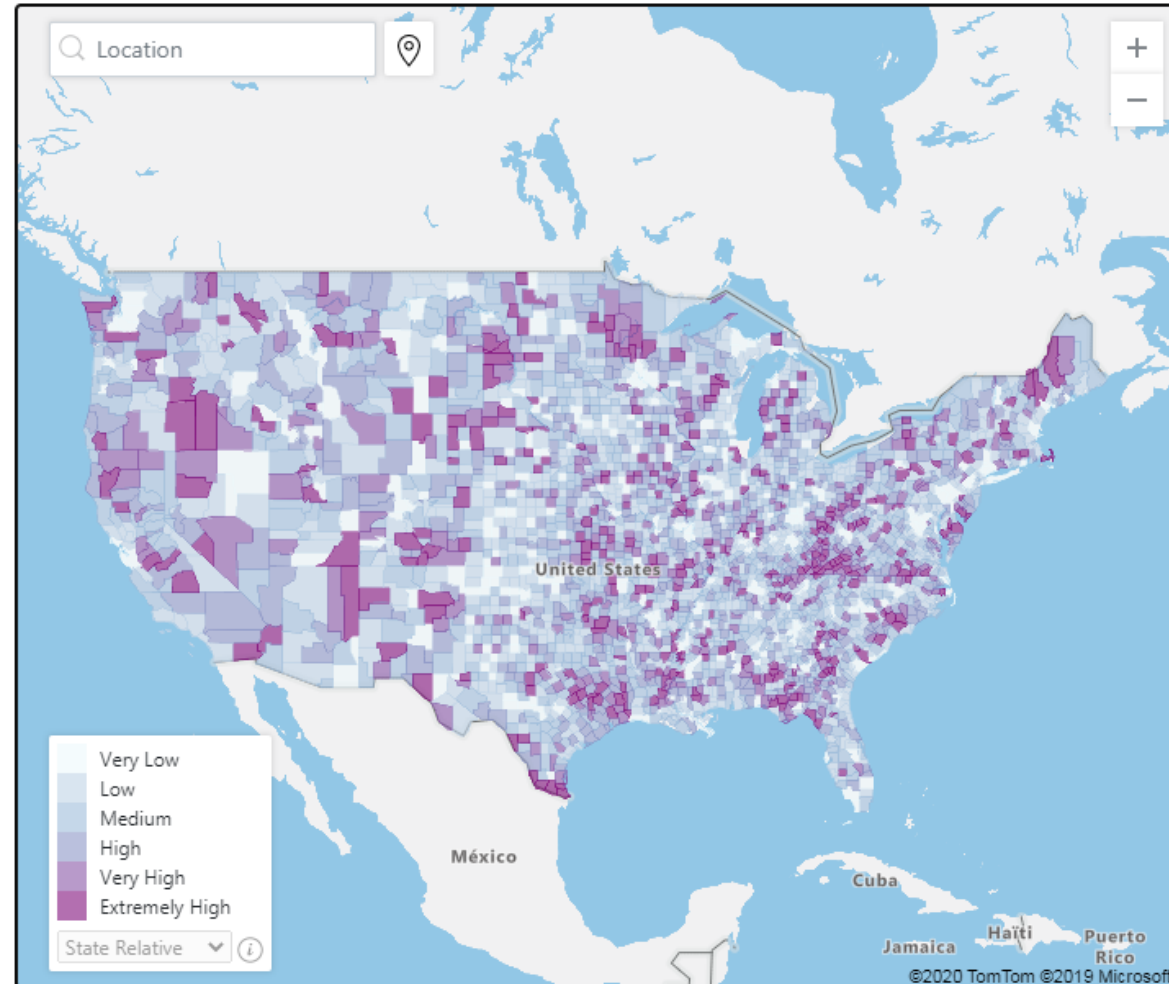
## COVID Community Vulnerability Map

Identification of the populations at risk for severe outcomes once infected to inform resource planning, interventions, outreach and other community initiatives

This map displays the communities that will experience severe outcomes if infected with COVID. It also identifies the socioeconomic factors driving the risk.

### How to use this map:

Select a geographic location or enter a reference point in the search bar to drill down to census block group level information. Double-click to zoom in.

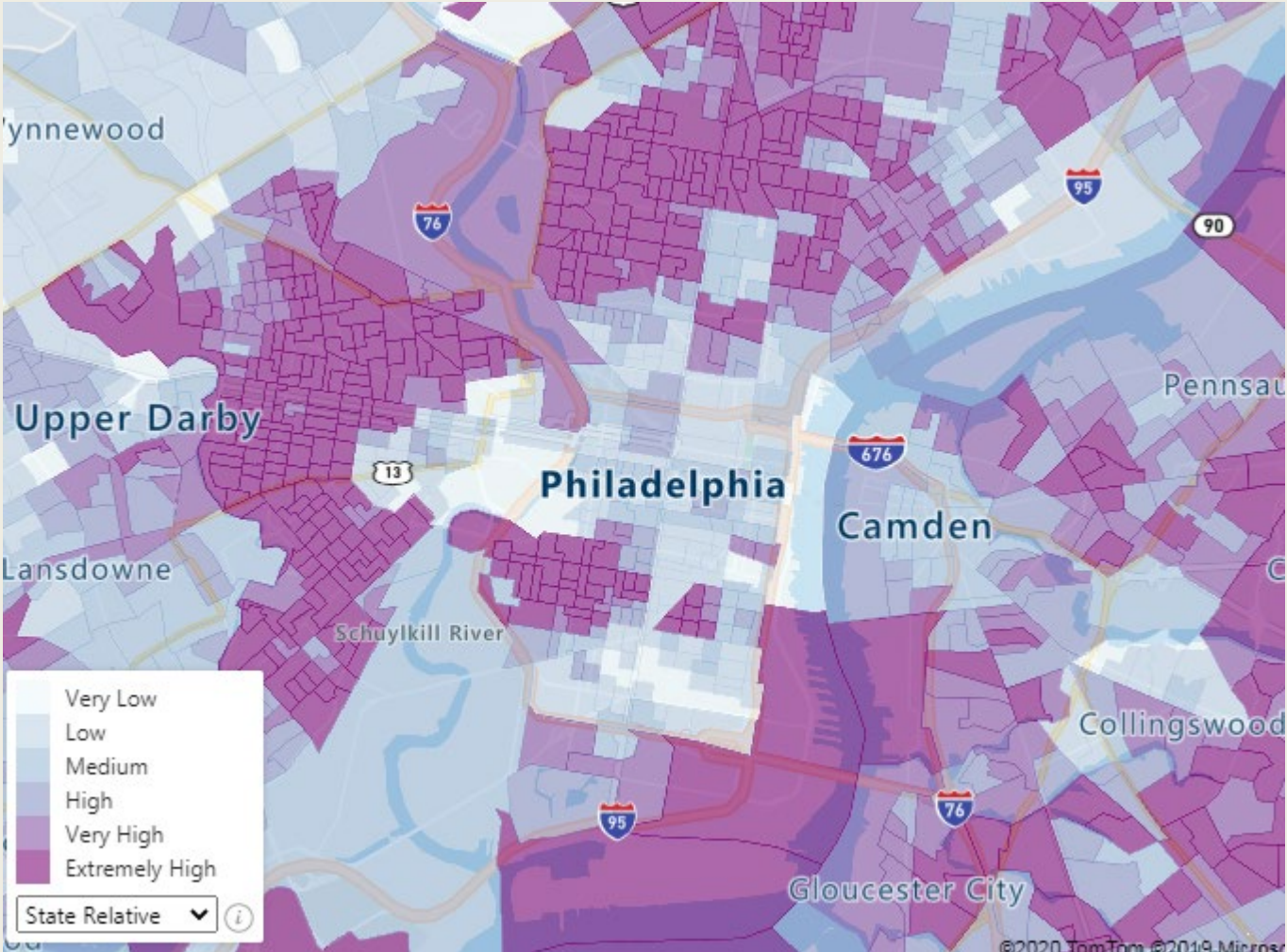


Jvion's COVID Response suite connects communities to services, surfaces vulnerable patients for proactive engagement, and informs decisions to maximize critical but limited resources.

Source:  
[covid19.jvion.com/](https://covid19.jvion.com/)

# Laura Gontz

Jefferson Health



# Impact of Covid-19 on Social Determinants of Health

Laura Gontz RN, BSN, MBA, CCM





# Jefferson Health

## 13 Hospitals

- Abington Hospital
- Abington – Lansdale Hospital
- Aria – Bucks County Hospital
- Aria – Frankford Hospital
- Aria – Torresdale Hospital
- Jefferson Hospital for Neuroscience  
– *part of Vickie and Jack Farber Institute for Neuroscience at Jefferson*
- Jefferson Cherry Hill Hospital
- Jefferson Stratford Hospital
- Jefferson Washington Township Hospital
- Methodist Hospital
- Physicians Care Surgical Hospital
- Rothman Orthopaedic Specialty Hospital
- Thomas Jefferson University Hospital  
– *Sidney Kimmel Cancer Center at Jefferson (NCI-designated)*

**6,000**  
physicians/practitioners



**7,200** nurses



Abington Hospital, Jefferson Hospital for Neuroscience and Thomas Jefferson University Hospital are Magnet-designated hospitals

**50+** outpatient and urgent care locations

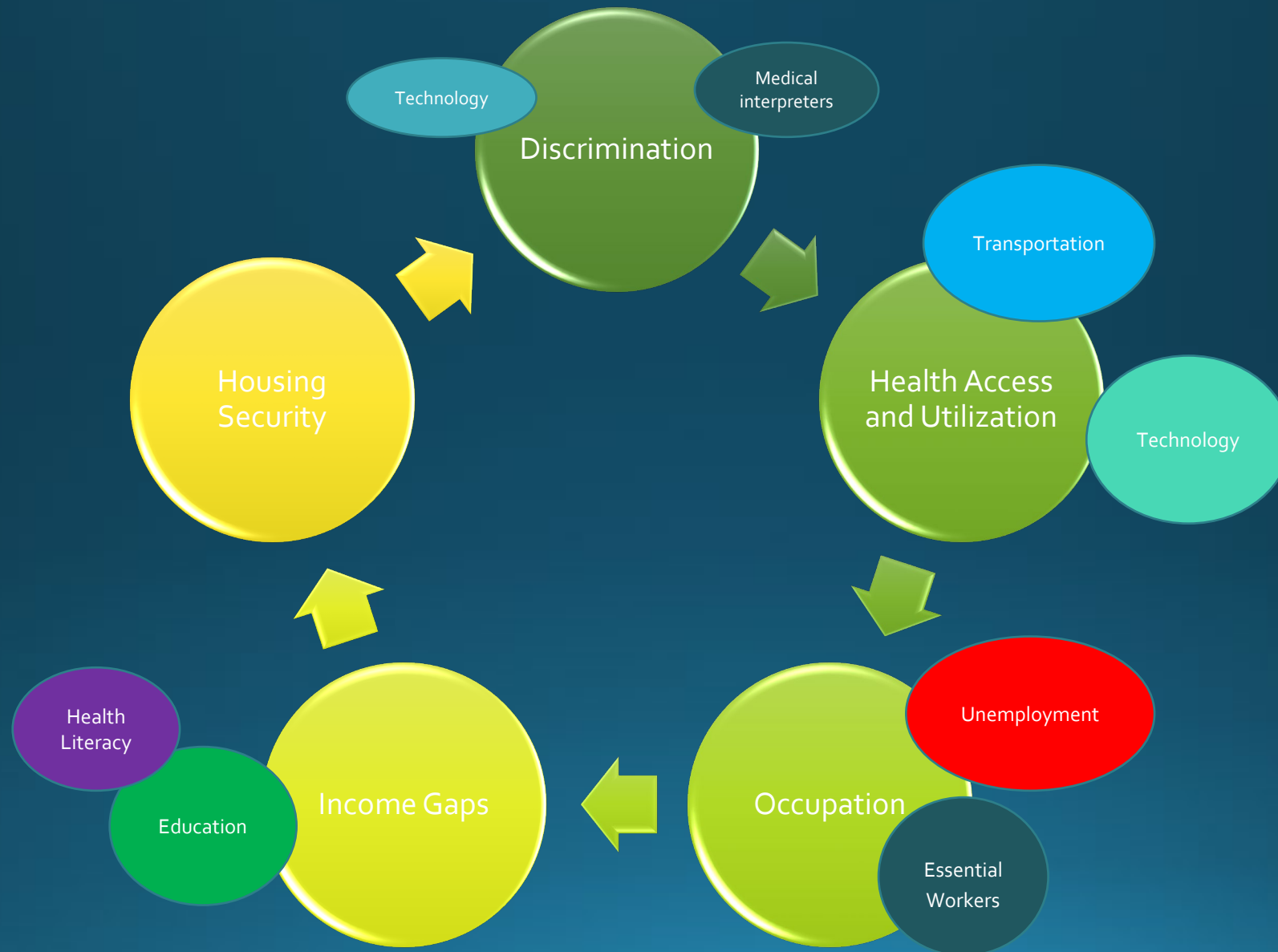
Over **3.6 million**  
patient interactions annually

**Health equity** is when everyone has the opportunity to be as healthy as possible. Long-standing systemic **health** and social inequities have put many racial and ethnic minority groups at increased risk of getting sick and dying from **COVID-19**

----- CDC



# Factors that Contribute to Increased Risk



# Support Strategy for Covid-19



# Care Coordination Escalation Plan

- Escalation plans as follows:
  - i. **Green Zone:** Symptoms are stable or resolved, patient has a good understanding of isolation precautions, and follow-up plans. Action: Continue telephonic outreach as described below (G).
  - ii. **Yellow Zone:** Persistent but stable symptoms (i.e. fever). Action: Assess for worsening. Continue to monitor or alert PCP by phone if there is a PCP available. Can order home health in the home
  - iii. **Orange Zone:** Worsening symptoms (i.e. worse cough or new mild shortness of breath) or clinical concerns requiring provider medical decision making. Action: refer to Jen Cruz Monday through Friday
  - iv. **Red Zone:** Acute Respiratory Distress. Action: Refer to ED for evaluation.

# Covid-19 Results and Education

- Standardized education utilizing CDC guidelines
- Results fast (24-36 hrs)
- Consistent follow up by centralized team
- Isolation and Depression and Perception
- Medical Interpreter Services

## Community Testing



- Care Coordinators follow patients for care coordination through quarantine
- Notification to physician for changes
- Telehealth visits used for care coordination
- **SDOH** (Social Determinants of Health) assessments completed

## Primary Care Testing



- Every Covid Positive patient was followed by care coordination who traditionally follows high risk members of the ACO
- Advanced practitioner support for patients with no PCP and weekend coverage
- SDOH assessment completed on all patients in care coordination
- Care Companion and Pulse Ox Program
- Referral to CHW for SDOH

## Transition of Care



# Transitions of Care

- Discharging with medications
- Homelessness and Inadequate Housing situations
- Lack of Food in home Food Shopping -public transportation
- Limited/Delayed home health
- In home support- fear of in home support
- In home lab draws
- Follow up appointment
- Limited access and understanding of available Technology
- Lack of social and familial support

# Care Companion

- Flagged in Ed as candidate for care coordination
- Pulse Ox and questionnaire ordered by Ed physician
- Reports built for Care Coordinator to see patient enrollment at discharge
- Alerts sent to care coordination for proactively assessment of abnormal pulse ox readings or worsening symptoms
- Series of questions answered daily along with twice daily SPO<sub>2</sub> readings

# Care Companion

**Jefferson Health.** Lizsix My Health Visits Messaging Billing Referrals More Log Out

## COVID-19 Condition Monitoring

For the questionnaire series **COVID-19 Home Monitoring**

\* Indicates a required field.

\* Do you have a fever or are feeling feverish (chills, sweating)?

Yes  No

If you have a thermometer, what is your highest temperature (in Fahrenheit) since last recording?  
A temperature greater than 100.3 indicates a fever.

\* Are you feeling short of breath today?

Yes  No

If you have a portable oxygen sensor, what is your lowest oxygen percentage since last recording?

\* Are you having a cough today?

Yes  No

\* Are you experiencing fatigue today?

Yes  No

Do you have abdominal pain?

Yes  No

# Social Determinants of Health Philadelphia Community Taskforce

The goal is to:

- building a robust community-based coordinated network
- create effective referral processes with two-way communication between partners
- share data to evaluate impact
- identify gaps in services to pursue advocacy and policy opportunities made more evident by Covid-19



# Resource Platform for Tracking

- an electronic community resource referral platform offers the potential of having a centralized community resource directory
- housing social needs screening and referrals in one place, facilitating communication between organizations
- Enabling analysis and measurement of referrals and their impact
- track and run reports on their referrals
- CLOSE THE LOOP

# Engagement with Community CBO's

- 1-hour listening sessions with Community Benefit Offices recognizing that COVID-19 has significantly increased need and the demand for the services these organizations provide
- What's working, what's not working, and what could be improved?
- The listening sessions have also provided organizations an opportunity to learn more about our Task Force and ways for continued engagement with the Task Force on a longer-term basis

# Food Insecurity

- Farmers to Families partnership
- Delivering produce to homes
- 70 patients by week 2
- Referrals from CHW, case management, ED social workers
- NEXT STEPS
  - Dc with food
  - Different Partners



# Addressing Community Needs and Preparing for the Secondary Impacts of Covid-19

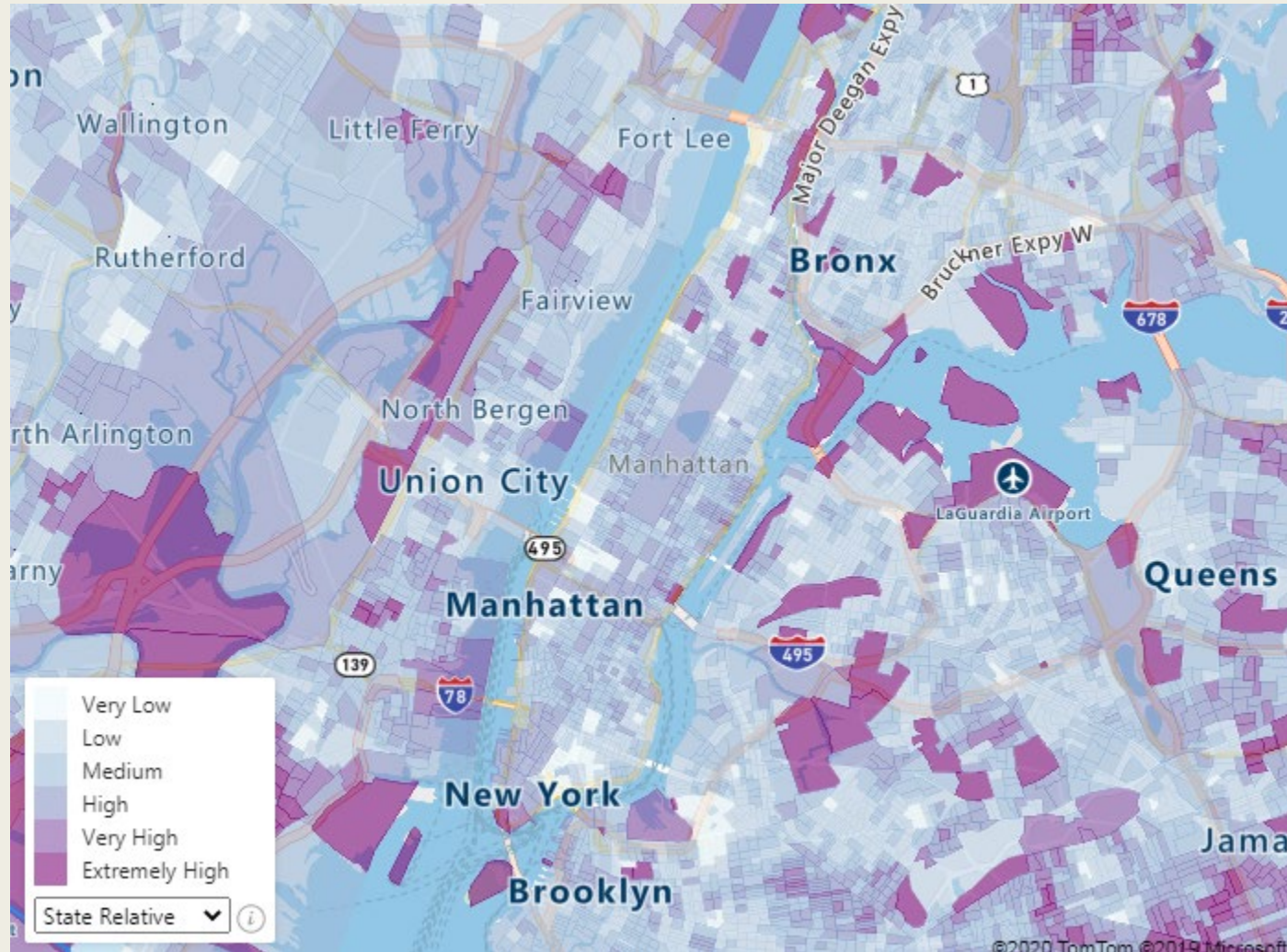
- continued conversation
- capitalize on new alliances with CBO
- enhance your teams diversity and inclusion understanding
- review organizational strategic plans for addressing SDOH and population health management
- integrate planning within your organization's COVID-19 management and response team to anticipate, identify, and address SDOH systemically for patients, employees, and families

# Thank you

- Laura Gontz - [laura.gontz@jefferson.edu](mailto:laura.gontz@jefferson.edu)

# Robert Fields

## Mt. Sinai



# Outreach Model for SDH Gap Closure During COVID and Beyond

Rob Fields, MD MHA  
SVP CMO Population Health  
Mount Sinai Health System

NAACOS Fall Conference



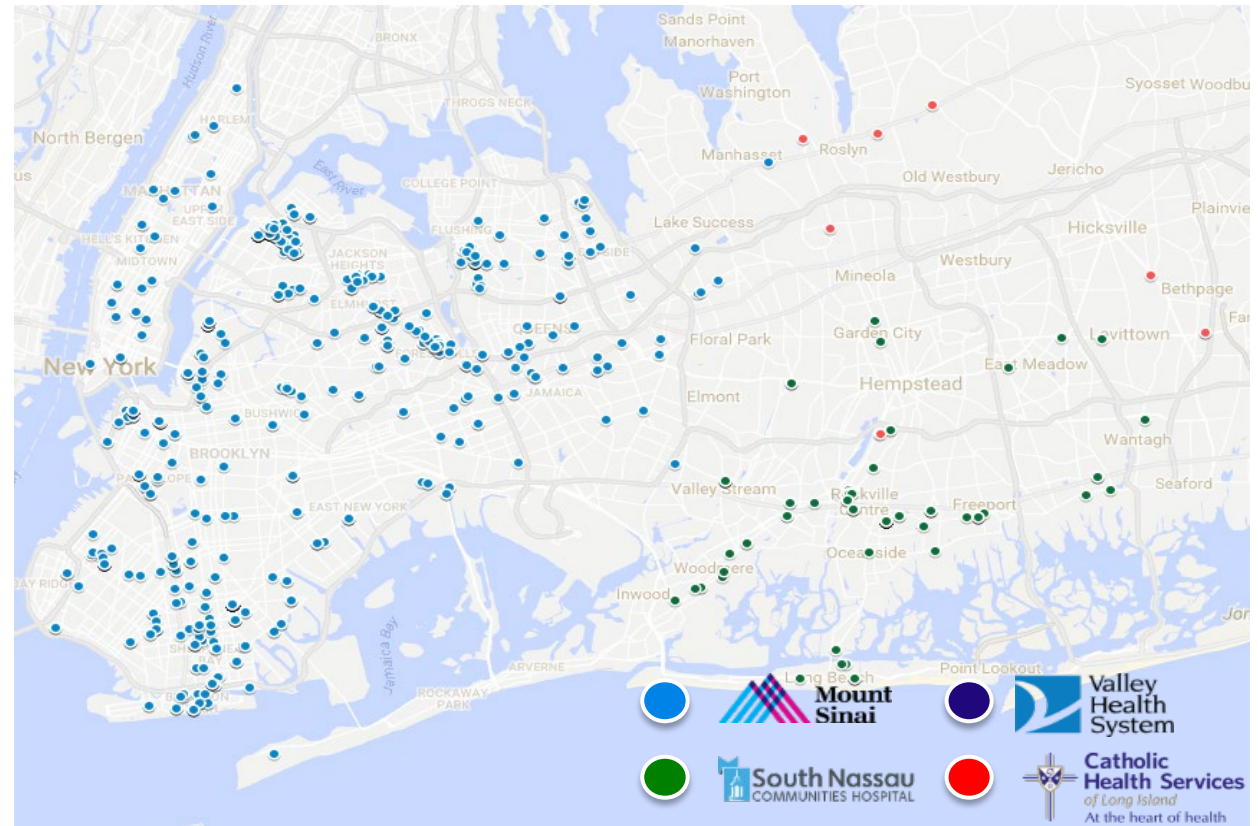
**Mount  
Sinai**

# Mount Sinai Health System: Positioned for Value

With breadth and depth of assets, Mount Sinai is well positioned as one of the highest-value providers in New York City

## Health System Assets

- ▶ Icahn School of Medicine at Mount Sinai
- ▶ Flagship academic hospital + 7 community hospitals
- ▶ >300 community care locations throughout NYC Metro
- ▶ >6,600 physicians on medical staff (~3,500 employed)
- ▶ Clinical affiliations that further our geographic reach



# Mount Sinai Health System: Investing in Value

With a focus on value, Mount Sinai has heavily invested in population health solutions, supported by a new business model engaging directly with purchasers of health care

## New Business Model

Key goals include:

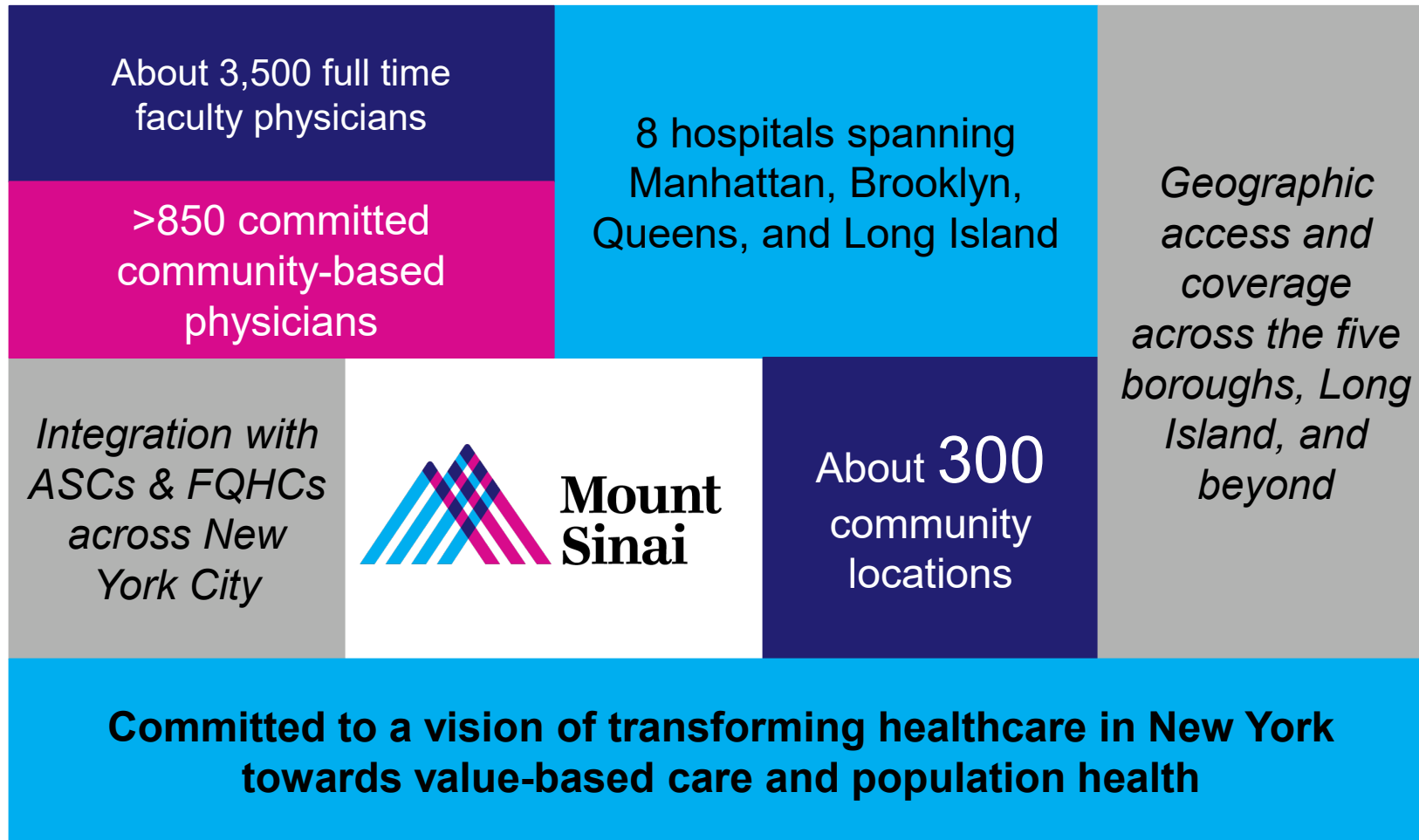
- ▶ To become the purchaser's partner of choice
- ▶ Align financial incentives around outcomes
- ▶ Earn trust with our patients so that Mount Sinai is their provider of choice
- ▶ Manage outcomes, patient experience, and costs



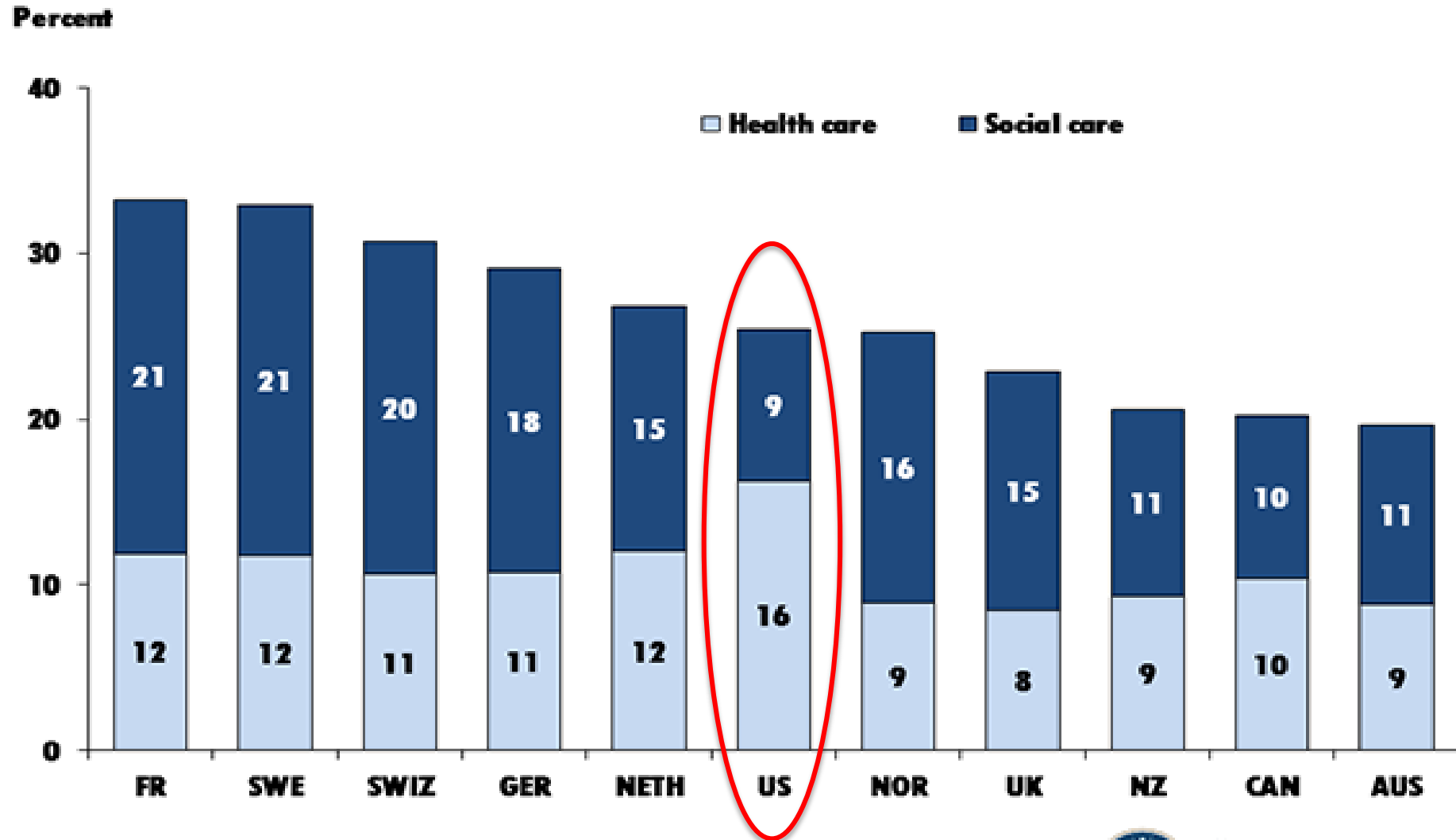
## Strategic Initiatives

- ▶ **New Leadership** – hired new leaders to launch a 400+ FTE team dedicated to population health & value
  - ▶ **Network Development** – launched clinically integrated network of hospitals & >4,000 employed and community based physicians
  - ▶ **Changing Compensation** – shifted physician compensation to an outcomes-based model
  - ▶ **Investment in Enablement** – \$100M in IT & services to enable care teams for managing populations
  - ▶ **Quality Management** – standardizing & improving care processes for chronic illness & specialty care
- ▶ Value-based contracts with all commercial health plans
- ▶ Full risk-based contracts for Medicare/Medicaid lives

# Mount Sinai Health Partners' Clinically Integrated Network

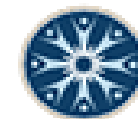


# Health and Social Care Spending as a Percentage of GDP



Notes: GDP refers to gross domestic product.

Source: E. H. Bradley and L. A. Taylor, *The American Health Care Paradox: Why Spending More Is Getting Us Less*, Public Affairs, 2013.



The  
COMMONWEALTH  
FUND

# What Are We Trying To Solve For?

*The Montefiore Health System in New York: Integrated Care and the Fight for Social Justice*

<https://www.kingsfund.org.uk/publications/montefiore-health-system-summary>



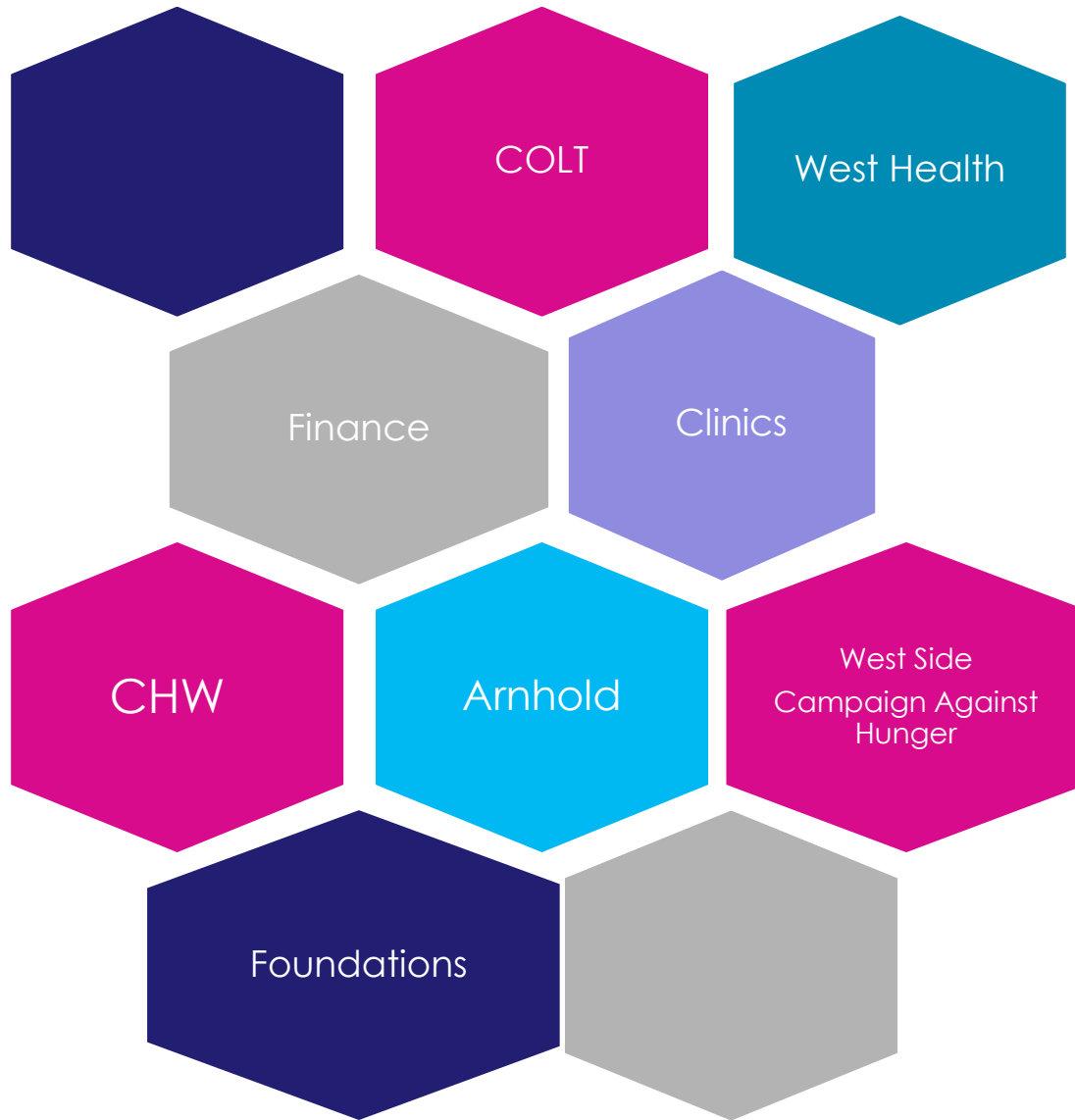
## 85<sup>th</sup> ST

- Avg. household income of 180K
- Life Expectancy 85yrs
- (better than Japan)

## 150<sup>th</sup> ST

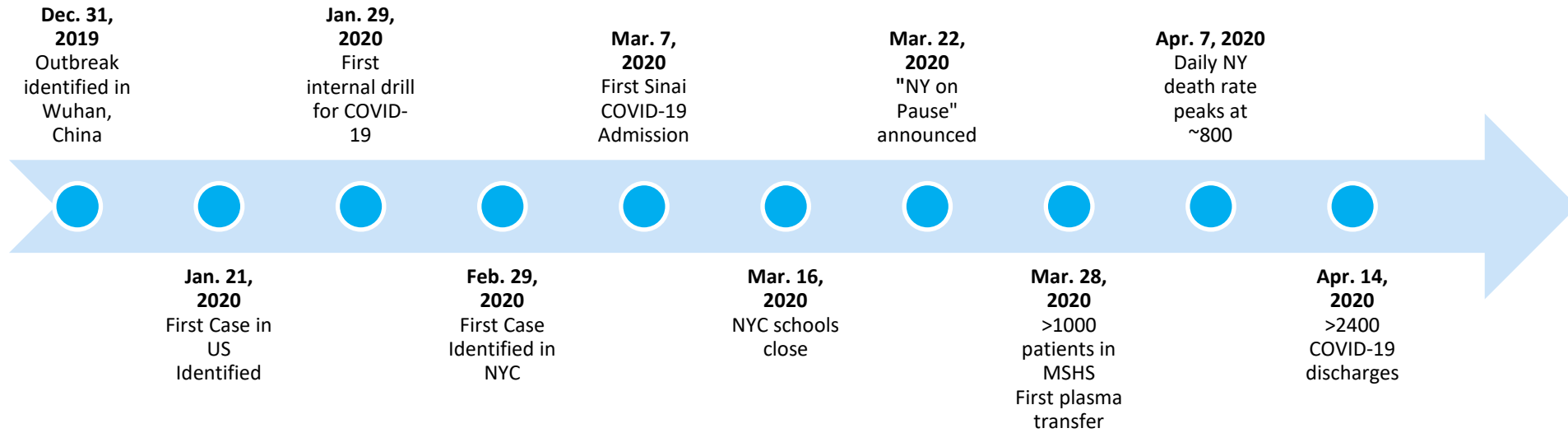
- Avg. household income of 45K
- Life Expectancy 75yrs
- Drops 3.2 years for every stop on the subway

## Collaboration- It's a Team Sport

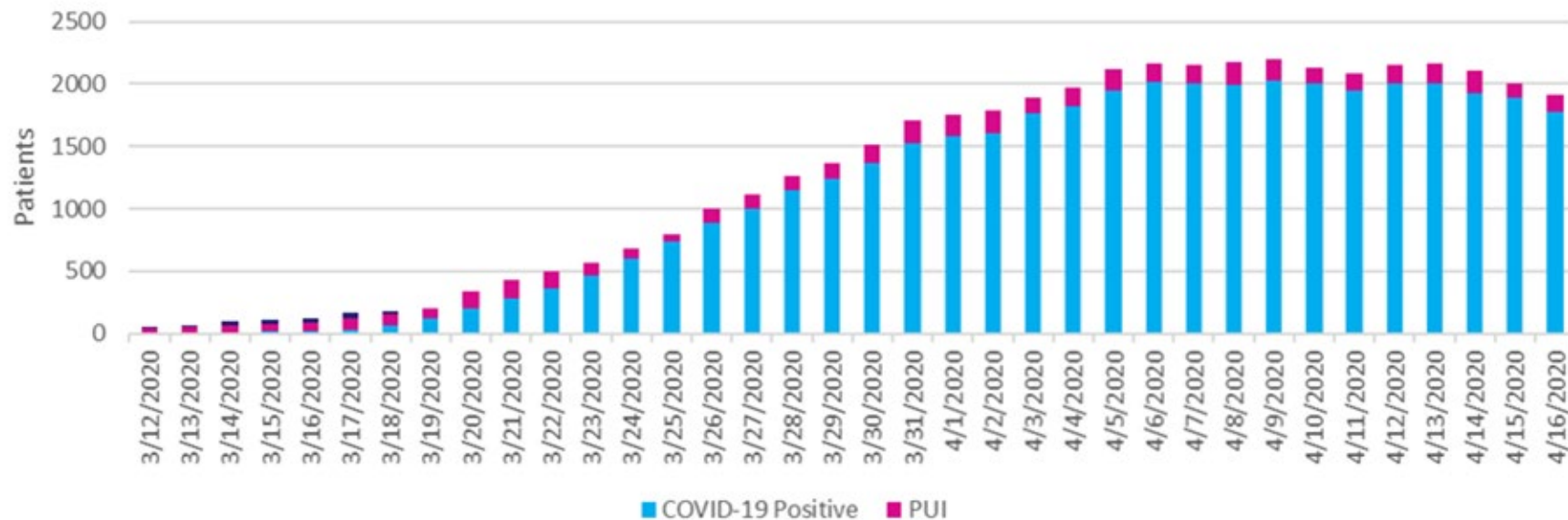


- Multi-stakeholder Partners
- Sinai as a “Hub”
- Build on Existing Relationships
- Create High Performing Network

# COVID-19 Timeline of Key Dates



### Total COVID-19 and PUI Hospitalized Patients by Day



## Goals: Avoid duplication of effort; match staffing to patient need; support a fast go-live of standard work

### ▣ One source for patient lists

- High risk Tableau dashboard for all outreach list generation

### ▣ Match skill set of available staff with probable patient need

- Use patient cohorts for patient assignment
- Leverage care management, practice-based staff (clinical/non-clinical), community based partners & community health workers

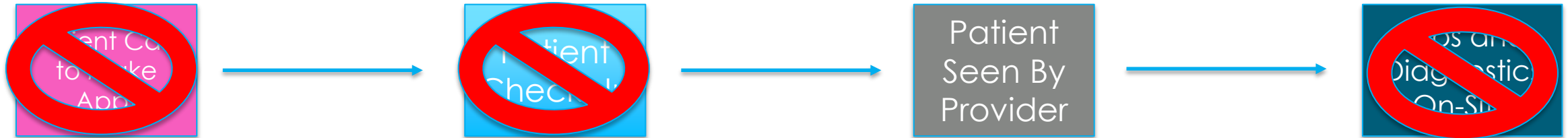
### ▣ Develop a standardized screening tool and COVID-19 specific resources

- Focus on food security, medication supply, access to a healthcare provider, mental health and safety

### ▣ Data tracking and weekly reporting

- Use standard reporting criteria
- Encourage the use of newly created Epic Smartphrases for standard documentation and easy data reporting

## Flipped Operating Model



### **Problem Statement**

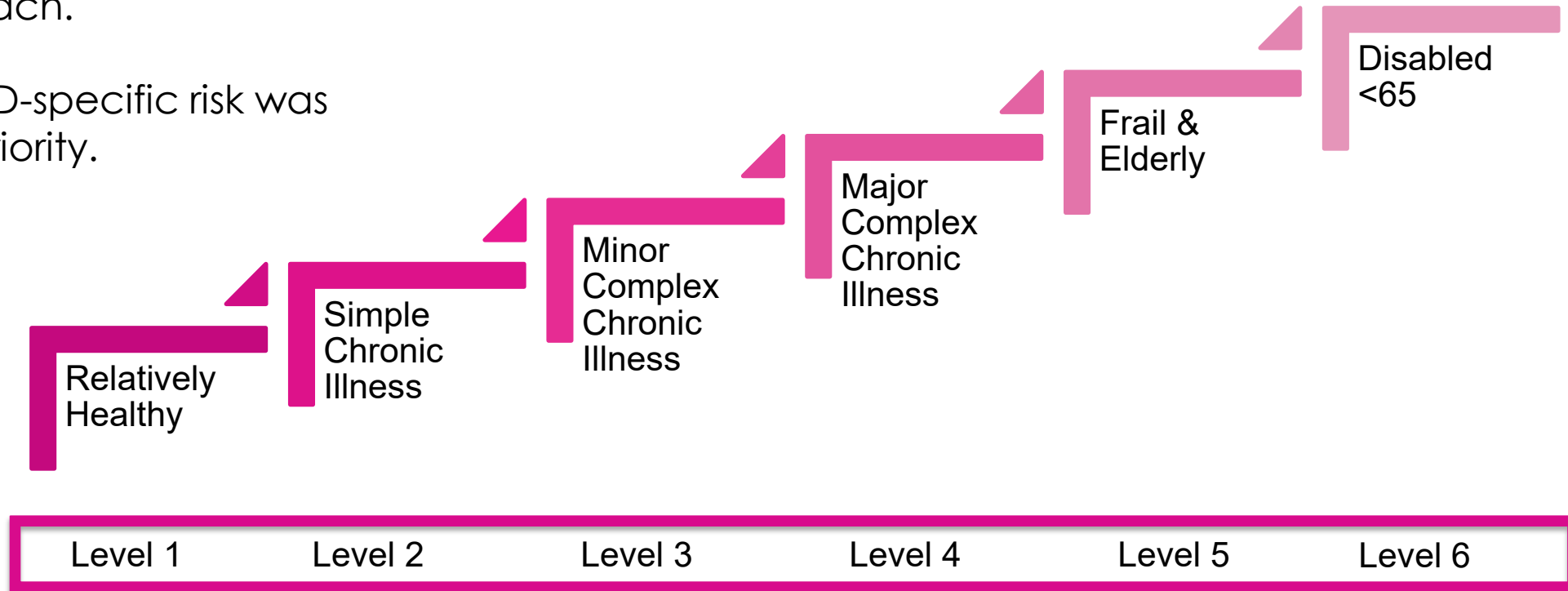
- With COVID, the standard flow disappeared overnight given passive, active and proactive cancellation of appointments.
- Telemedicine capacity increased dramatically but patients were not educated on the model.
- Increase in social and behavioral needs overwhelmed our care management staff normally geared towards “high risk” patients.

# 6 “Levels” of Risk Stratification



Step 1 was identifying the target population for outreach.

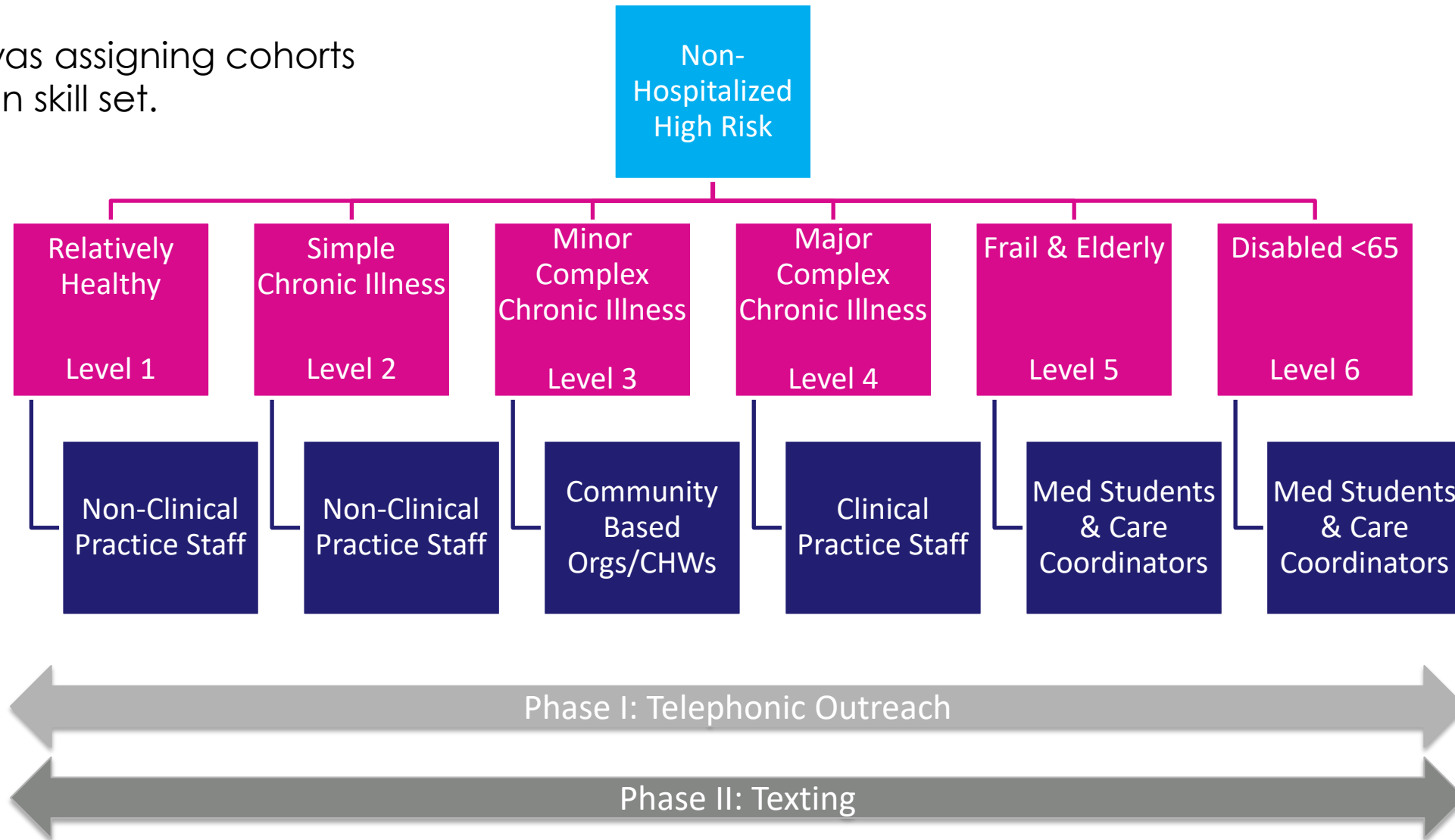
COVID-specific risk was the priority.



# Workforce Redeployment & New Partnerships



Step 2 was assigning cohorts based on skill set.



\*Risk stratification adapted from: Joynt, Karen E., et al. "Segmenting high-cost Medicare patients into potentially actionable cohorts." *Healthcare*. Vol. 5. No. 1-2. Elsevier, 2017.

# COVID-19 Community Resource Guide - **\*\*NEW\*\***

## Step 3

Creating training tools for outreach to screen for clinical and SDH gaps and empowering front desk and other staff to connect patients to resources.

**COVID-19 Community Outreach Resource Manual**  
*Mount Sinai Health Partners – Last Updated May 18, 2020*

**GOAL:** PRESERVE HOSPITAL CAPACITY FOR CRITICALLY ILL PATIENTS THROUGH THE PROVISION OF ROBUST LINKAGES AND SUPPORT TO ATTRIBUTED LIVES DWELLING AT HOME.

**STRATEGY:** PROACTIVELY OUTREACH TO HIGH-RISK PATIENTS TO SCREEN FOR:

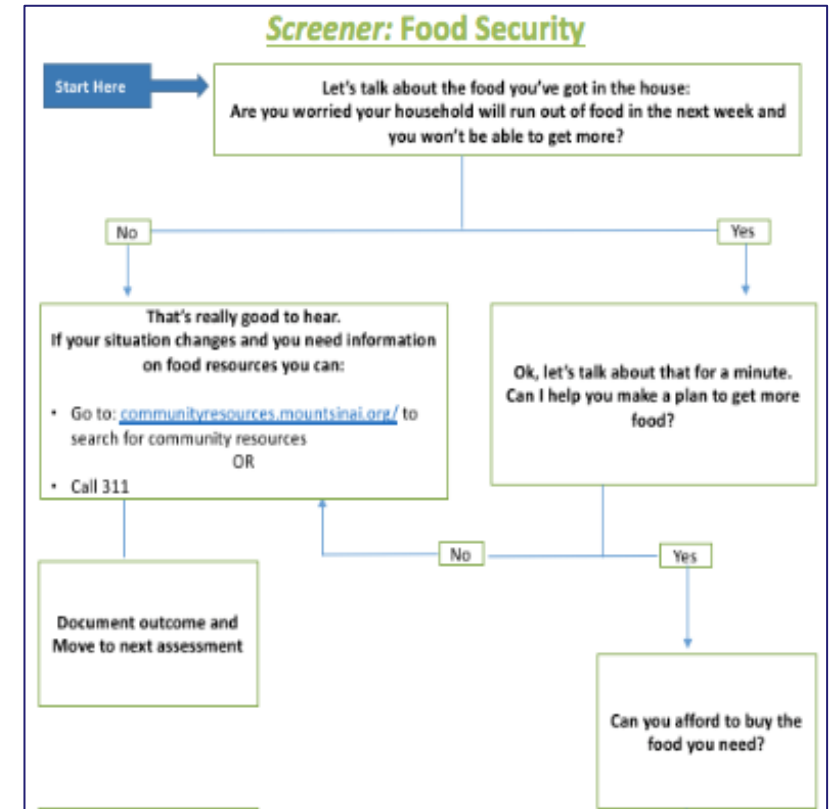
1. **FOOD INSECURITY**
2. **MEDICATION SUPPLY**
3. **HEALTH CARE ACCESS & COVID-19 SYMPTOMS**
4. **MENTAL HEALTH AND WELLBEING**
5. **CHRONIC CONDITION MANAGEMENT FOR CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD), CHRONIC HEART FAILURE (CHF) & UNCONTROLLED DIABETES —FOR MEDICAL STUDENTS AND MSHS STAFF ONLY**
6. **ADDITIONAL RESOURCES**

**GENERAL INFORMATION:**

- THIS DOCUMENT SHOULD BE USED FOR TELEPHONIC PATIENT ENGAGEMENT.
- EACH SECTION OF THIS MANUAL CONTAINS A SCREENING TOOLING TOOL WITH DECISION SUPPORT FOLLOWED BY A LIST OF RELATED RESOURCES.
- FEEDBACK, REQUESTS FOR ADDITIONAL RESOURCES, AND SUGGESTED AMENDMENTS CAN BE SENT TO: [ASHLEY.FITCH@MOUNTSINAL.ORG](mailto:ASHLEY.FITCH@MOUNTSINAL.ORG)

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**Food Resources**

**FOOD PICK-UP**

**Free Meal Pick-Up for Anyone at NYC Schools**  
Website: <https://www.schools.nyc.gov/freemeals>

**Comments:**


- Free "Grab and go" meals are available to any New Yorker
- Monday through Friday, 7:30 am through 1:30 pm
- Meals Hubs will operate for children and families from 7:30 am to 11:30 am, and for adults from 11:30 am to 1:30 pm
- To find a location, text "NYCFood" or "COMIDA" to 877-877
- No registration, ID, or documentation required.
- **No one will be turned away at any time**

# Online Access to COVID-19 Resources - **\*\*NEW\*\***




## Step 4

Evolved training documents into an online clickable format for easier deployment.




### Community Resource Center


The Community Resource Center is a tool for planning high-risk patient outreach during the COVID-19 crisis and beyond focusing on five domains. Non-clinical office staff, medical assistants, and others who are now serving in non-traditional roles can use the screening algorithms and resource directory to outreach patients who are at high risk of decompensation due to the advancement of chronic illness, lack of social supports, or COVID-19 related complications.




Food Insecurity  
Screening  
Resource Directory




Medication Supply




Healthcare Access



Mental Health & Personal Safety



Chronic Condition Management



COVID-19 Provider Resource Hub

## Food Insecurity Screening

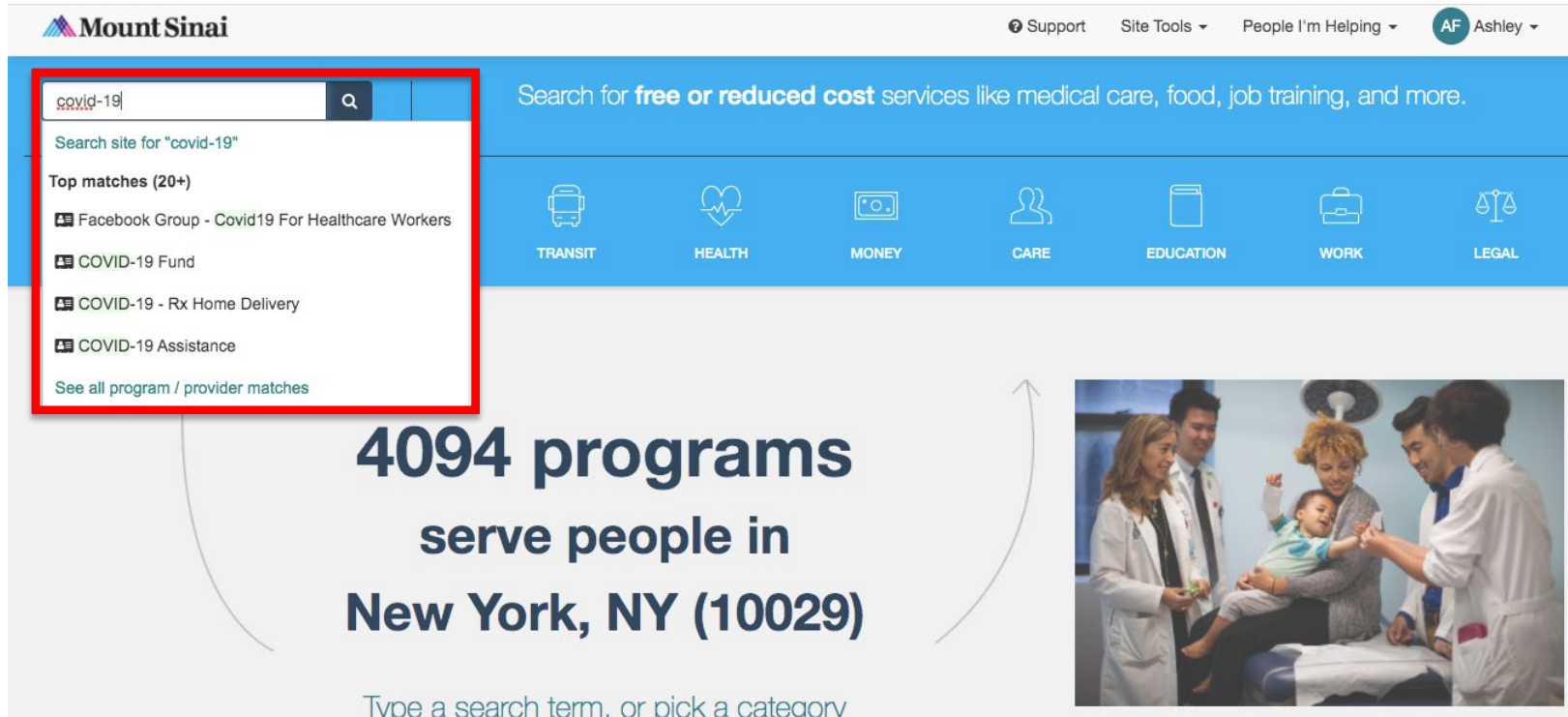
Use this screening tool to determine whether or not the patient has access to food. Click **yes** or **no** after each question to move to the next step in the workflow. [Click here](#) for a printer-friendly PDF version.

Let's talk about the food you've got in the house. Are you worried your food will run out in the next week and you will not be able to get more?

Yes

No

# Community Resource Guide - **\*\*OPTIMIZED\*\***



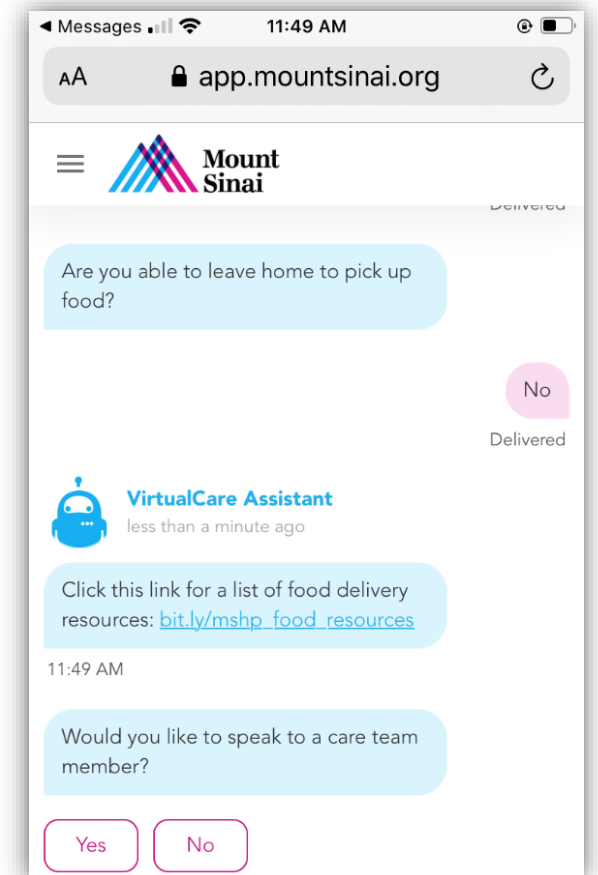
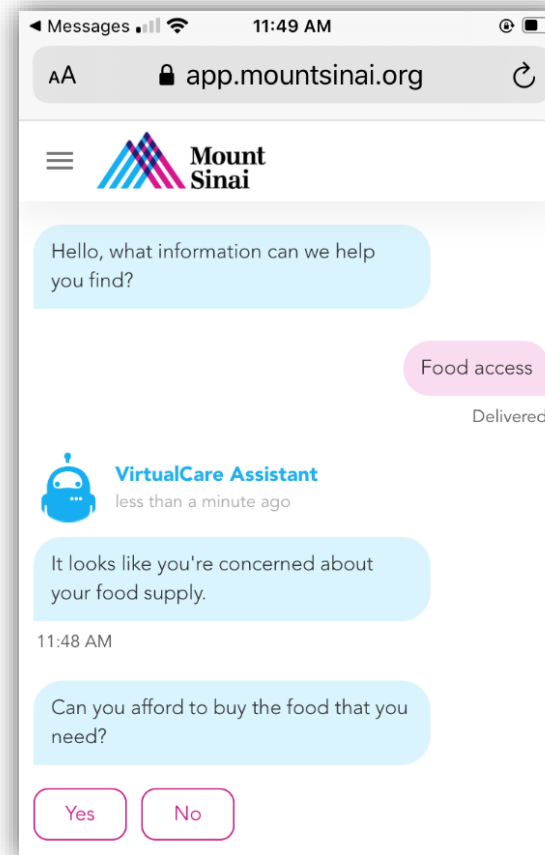
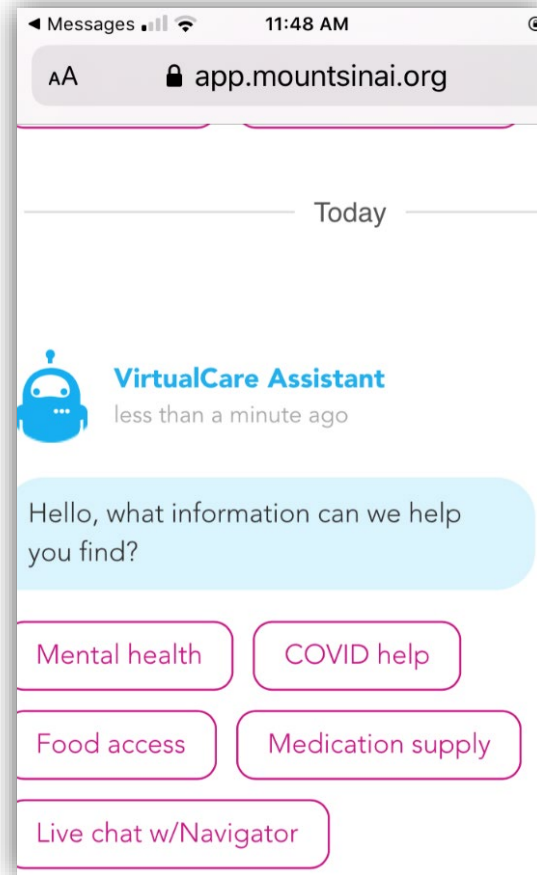
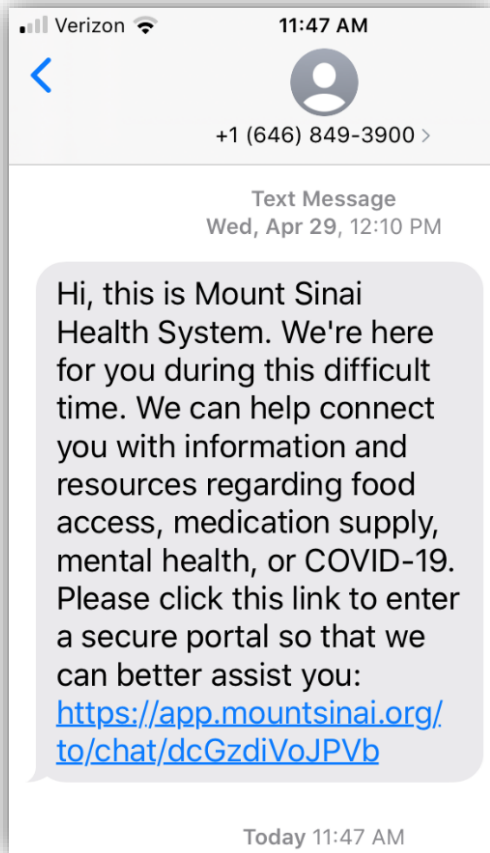
The screenshot shows the Mount Sinai website interface. At the top left is the Mount Sinai logo. To the right are links for 'Support', 'Site Tools', 'People I'm Helping', and a user profile 'AF Ashley'. A search bar contains the text 'covid-19'. Below the search bar, a dropdown menu displays 'Search site for "covid-19"' and 'Top matches (20+)'. The top matches listed are: 'Facebook Group - Covid19 For Healthcare Workers', 'COVID-19 Fund', 'COVID-19 - Rx Home Delivery', and 'COVID-19 Assistance'. Below the search bar is a navigation bar with icons and labels for TRANSIT, HEALTH, MONEY, CARE, EDUCATION, WORK, and LEGAL. The main content area features the text '4094 programs serve people in New York, NY (10029)' and a photo of medical professionals with a family. A red box highlights the search bar and dropdown menu, with a curved arrow pointing from it to the main text.

- ▶ Launched COVID-19 specific tags, filtering, and featuring functionality
- ▶ Added more than 2,600 COVID-specific programs
- ▶ Updated more than 60,300 programs to reflect changes in hours/availability
- ▶ Contacted 3,500+ CBO partners to provide support

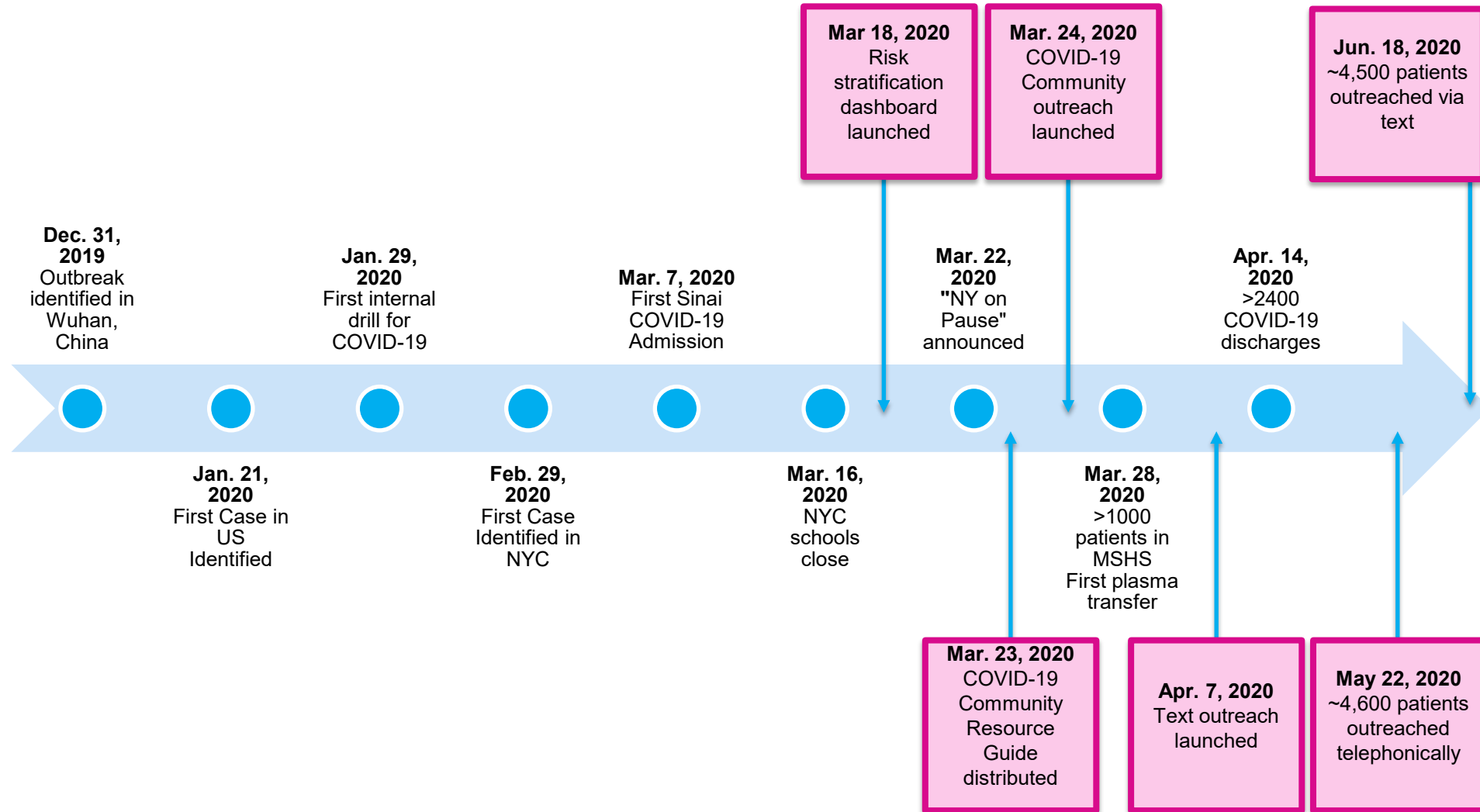
# Text-Based Outreach

- ▶ Significant increase in scale for outreach efforts.
- ▶ Turned hours of low-yield telephone time into inbound, prioritized and screened requests.
- ▶ Barriers
  - trust in the platform
  - access to technology
  - consent
  - correct cell number
- ▶ Supported triaging with community health workers, nurses, LCSW supports.

# Text-Based Outreach to Identify Support Needed



# COVID-19 Timeline of Key Dates



## Key Takeaways

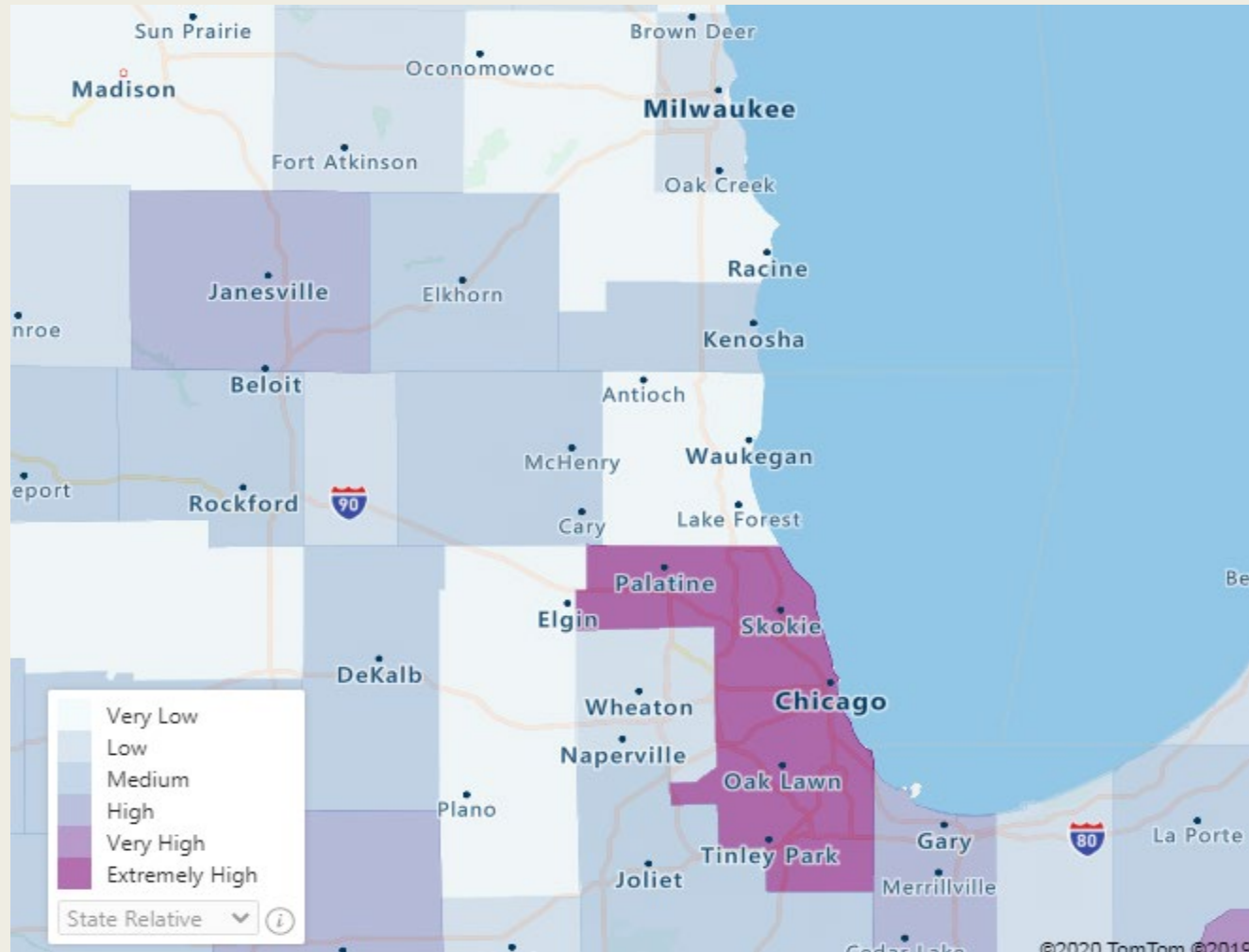
- Medical teams are resilient!
- Matching complexity and need with the appropriate resource is key.
- Much more work to do on patient engagement with technology and closing the digital divide.
- Community resources are a key part of the population health team.
- Texting can be an exceedingly helpful tool for efficient, scalable outreach.

# Thank You

*Robert.Fields@mountsinai.org*

# Megan Reyna

## Advocate Aurora Health



# Health Equity

Advocate Aurora Health's Journey

Megan Reyna, MSN, RN, Vice President of Government & Value Based Programs

[Megan.Reyna@aah.org](mailto:Megan.Reyna@aah.org)



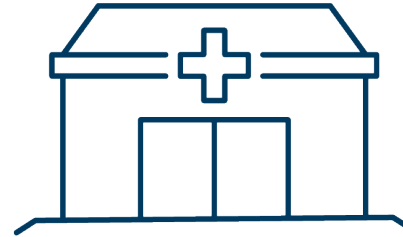
# Advocate Aurora Health



**8,300** physicians  
**75,000** team members  
**10,000 +** volunteers



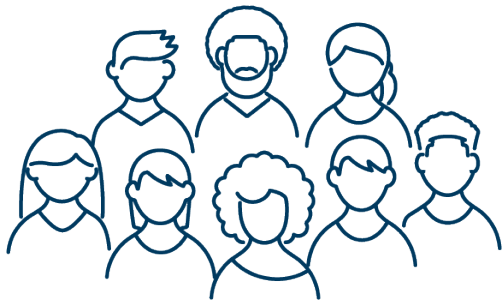
**26**  
hospitals



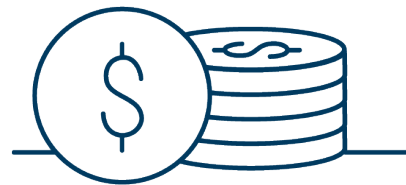
**500+**  
sites of care



**63%**  
Serious safety event  
reduction in IL



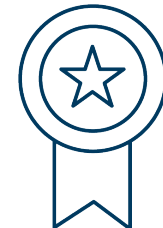
**3M** unique patients



**\$12 B**  
total  
revenue



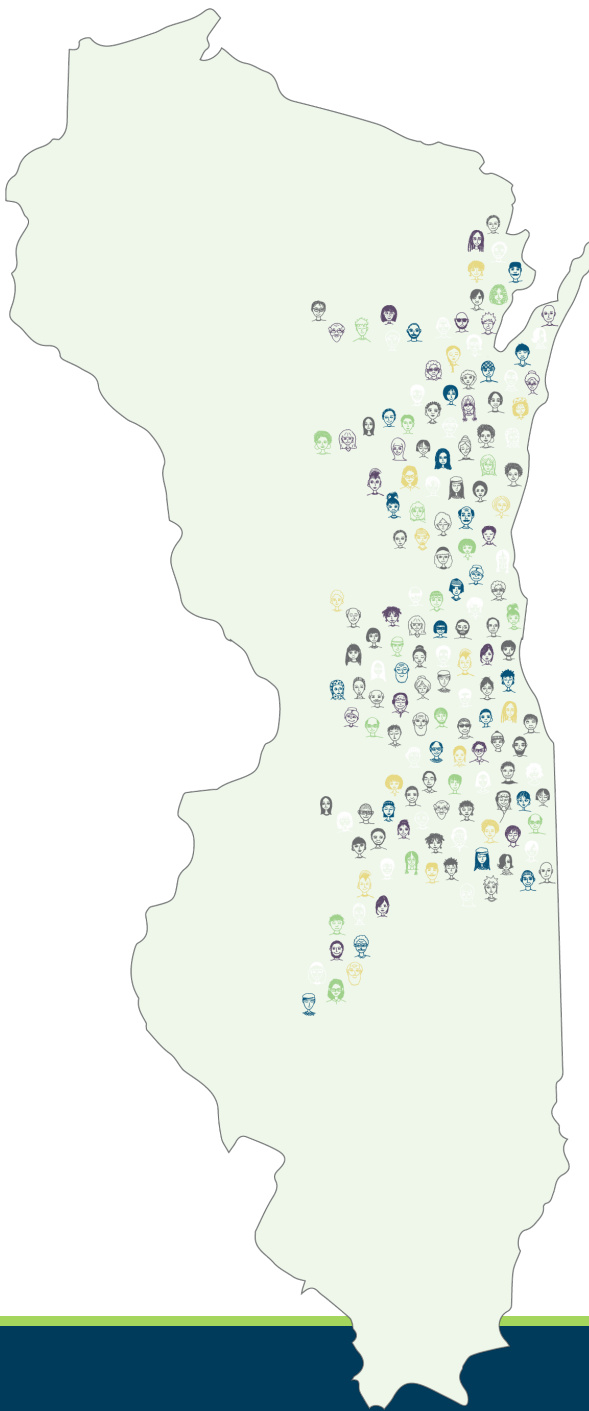
**\$1.1 B**  
capitation  
revenue



**Top 10**  
consistently for health  
outcomes in national  
peer group\*

# Enterprise Population Health

1.3 million value-based lives across 400 miles in IL & WI



## Illinois: ~1 million value-based lives representing \$4.3B

- Team Member: **35,000 lives**, \$0.1B total spend
- Commercial HMO: **221,000 lives**, \$0.7B total spend
- Managed Medicaid: **87,000 lives**, \$0.1B total spend
- Medicare Advantage: **37,000 lives**, \$0.3B total spend
- Medicare Shared Savings Program: **124,000 lives**, \$1.5B total spend
- Commercial Shared Savings: **445,000 lives**, \$1.6B total spend

## Wisconsin: ~300,000 value-based lives representing \$2.3B

- Team Member: **52,000 lives**, \$0.1B total spend
- Commercial Shared Savings: **132,000 lives**, \$0.9B total spend
- Medicare Advantage: **61,000 lives**, \$0.5B total spend
- Medicare Shared Savings Program: **81,000 lives**, \$0.8B total spend

# AAH Government Programs Current State

	<u>Illinois</u>	<u>Wisconsin</u>	
<b>Medicare Shared Savings Program (MSSP)</b>	<p><b><u>Basic Level E</u></b></p> <ul style="list-style-type: none"> <li>• ~121,385 Beneficiaries<sup>1</sup></li> <li>• 507 TINs</li> <li>• 10 Hospitals</li> <li>• 6,813 clinicians</li> <li>• Advanced Alternative Payment Model (AAPM)</li> <li>• Start date: 2012</li> </ul>	<p><b><u>Track 1</u></b></p> <ul style="list-style-type: none"> <li>• ~51,775 Beneficiaries<sup>1</sup></li> <li>• 9 TINs</li> <li>• 16 Hospitals</li> <li>• 4,678 clinicians</li> <li>• Merit-based Incentive Payment System (MIPS)</li> <li>• Start date: 2018</li> </ul> <p><b><u>Enhanced</u></b></p> <ul style="list-style-type: none"> <li>• ~25,692 Beneficiaries<sup>1</sup></li> <li>• Two TINs located in the greater Milwaukee area</li> <li>• 1,690 clinicians</li> <li>• Advanced Alternative Payment Model (AAPM)</li> <li>• Start date: 2017</li> </ul>	
<b>Medicare Bundles Program</b>	<p><b><u>BPCI-A</u></b></p> <p>Bundled Payments for Care Improvement Advanced</p> <ul style="list-style-type: none"> <li>• 135 bundles, ~8,000+ episodes<sup>3</sup>, across 8 hospitals</li> <li>• Program Size: ~\$270+ million</li> </ul>	<p><b><u>CJR</u></b></p> <p>Comprehensive Care for Joint Replacement Model</p> <ul style="list-style-type: none"> <li>• 1,079 episodes across two hospitals<sup>2</sup></li> <li>• Program Size: ~\$22.4 million</li> </ul>	<p><b><u>BPCI-A</u></b></p> <p>Bundled Payments for Care Improvement Advanced</p> <ul style="list-style-type: none"> <li>• 73 bundles, ~2,000+ episodes<sup>3</sup>, across 14 hospitals</li> <li>• Program Size: ~\$50 million</li> </ul>

1. Based on 2020 Assignment list

2. Based on Program Years 1-4

3. Annualized based on discharges through March 2020, assuming reduction in volume during COVID-19 PHE period

***"Of all the forms of inequality,  
injustice in health is the most  
shocking and the most inhuman"***  
**-Rev. Dr. Martin Luther King Jr.**

# Health Equity in Midst of COVID-19

- COVID provided a national stage for pre-existing inequities
- Care Management is pivotal
- Reinforced importance of screening for SDOH
- Being swift and agile
- Anchoring in data
- Listening to our community
- Leveraging innovation

# Health Equity Framework

(Institute of Healthcare Improvement)

<http://www.ihl.org/resources/Pages/IHIWhitePapers/Achieving-Health-Equity.aspx>

## 1. Make Health Equity a strategic priority

- Leadership commitment to improving equity
- Solid investment of resources

## 2. Develop structure and process to support Health Equity work

- Establish governance to oversee equity work
- Dedicate resources in budget to support equity work

## 3. Deploy specific strategies to address multiple Social Determinants of Health

- Healthcare services
- Healthy behaviors

## 4. Decrease institutional racism in system

- Reduce implicit bias
- Evaluation of policies, practices, and norms in patient care

## 5. Develop partnerships with community organizations


- Engage community assets
- Collaborate on community issues to address improving health

# Health Equity Framework(AAH)

## 1. Make Health Equity a strategic priority

- Leadership commitment to improving equity
- Solid investment of resources

## • External Pledges & Internal Commitments



June 01, 2020

Dear team members,


Over the weekend, following the tragic and unjust death of George Floyd, we watched fear, anger and frustration escalate into civil unrest across the country and in our own communities. As peaceful protests spiraled into riots and shocking scenes of crime, our priority was the safety of our patients and our team members.

Your work has never been more important, and Advocate Aurora Health is committed to keeping you safe as you do that work. We took steps to place numerous sites on various levels of lock down, added additional levels of security across campuses near demonstrations, postponed the introduction of mobile testing in various neighborhoods, and have remained in close contact with local authorities – and we are prepared to take other safety measures as warranted.

But we must also acknowledge that this nation is faced with not one, but two pandemics. One we have been battling since March of this year, the other, unfortunately since our nation was formed. That is why I believe our commitment to diversity and inclusion has never been more important. Individuals of diverse backgrounds and cultures are a valued part of our organization's DNA and that of the communities we serve. To be clear, Advocate Aurora Health deplores racism in any form and the work we do is intended to confront it and help bring an end to it. That good work is founded in our values of excellence, compassion and respect designed to help us achieve our purpose of helping people live well.

We understand that the events of recent days have added to the angst many of you have already felt as you work tirelessly to care for our patients and for each other. As we continue to navigate these uncertain times, please remember that we have resources available to all our team members for support you may need – whether through our Employee Assistance Program, our Mission and Spiritual Care department, or virtual team member forums – we are here for you.

Be assured this conversation will continue. Thank you for everything you do.



Jim Skogsbergh  
President and CEO  
Advocate Aurora Health

### IT IS UNDENIABLE: RACISM IS A PUBLIC HEALTH CRISIS.

As members and leaders from many of Chicago's healthcare organizations addressing the disproportionate Black and Brown mortality from the COVID-19 pandemic, we say without hesitation that **Black Lives Matter**.

No person of decency can look at the images of George Floyd's killing without feelings of rage, horror, shame and grief. The deaths of Mr. Floyd, Rayshard Brooks, Ahmad Arbery, Breonna Taylor – and too many others – are unjust and unconscionable.

We must double down on our efforts. Systemic racism is a real threat to the health of our patients, families and communities. We stand with all of those who have raised their voices to capture the attention of Chicago and the nation with a clear call for action.

The health centers and hospitals we represent are deeply woven into the fabric of the communities we serve, live and work in, and we stand united as frontline staff against racism, injustice and inaction.

Racism results in generational trauma and poverty, while also unquestionably causing higher rates of illness and death in Black and Brown communities. We have seen – in its rawest form – how the trauma of systemic racism adds to the historical injustices that have disproportionately affected communities of color. Community health centers and Chicago-area hospitals work to provide high quality, compassionate care in the face of health disparities and poor outcomes resulting from social and economic inequities.

These social determinants of health include poverty, inadequate housing, underperforming schools, police brutality, mass incarceration, food deserts, joblessness, poor access to health care and violence. All of these factors contribute to health inequities in our communities. And they serve as a recipe for pain, suffering, premature mortality – and understandable civil unrest.

In our communities, there is also resilience, innovation, a tradition of faith and a spirit of unity that manages to thrive even under the weight of this systemic burden. Imagine the potential for our communities with dramatically improved social and economic conditions and health outcomes.

It's time to fully realize this potential. It's time for action. We will work more intentionally with community-based partners in building and sustaining the sweeping change that is needed to ensure health equity across the city and particularly in our most vulnerable neighborhoods.

As healthcare organizations, we are committed to being part of the solution, both within our organizations and in partnership with local community groups. We are focused on improving access to care and eliminating racial biases that contribute to poor health outcomes.

We have come together as healthcare providers from all across the city and partnered with community-based organizations to respond to COVID-19 as part of Chicago's Racial Equity Rapid Response Team. Here are some of the steps we already are taking to help overcome the healthcare disparities in our communities:

- **COVID-19:** We are providing testing, direct care and contact tracing while also partnering with the City of Chicago to provide services and personal protective equipment to marginalized communities, educational programs and advocacy for personal practices that flatten the curve.
- **Hiring Programs:** We have implemented hiring programs that build pipelines for people of color to find careers in healthcare.
- **Community Investment:** We are keeping doctors in our community to create jobs and help rebuild strained and decimated economies.
- **Pharmacy and Grocery:** As thousands of residents are left without essential pharmacies, which have closed following vandalism and looting, healthcare providers are partnering to bring them back as rapidly as possible. We call on pharmacies and grocery stores to commit to reopening their shuttered stores on the South and West sides of Chicago to ensure access to vital medications and food.
- **Restoration and Rebuilding:** Members of our organizations are literally working side-by-side with other volunteers to rebuild ravaged demonstrations across Chicago.

• **Listening:** Many in our organizations will never know the struggle systemic racism has created for our colleagues at work and for members of our community. We vow to listen to our patients and colleagues of color and to learn from their experiences. We commit to be allies, advocates and partners in being the change we want to see in the world.

We also are committed to continue working to help Chicago and Illinois overcome systemic racism and the health care disparities it creates.

**We commit to:**

- Re-examine our institutional policies with an equity lens and make any policy changes that promote equity and opportunity.
- Improve access to primary and specialty care.
- Continue to focus on helping our communities overcome chronic conditions like diabetes, heart disease and asthma.
- Continue to advocate for investments that create innovative solutions to achieve enduring improvements in access, quality and health outcomes for our communities.
- Continue our commitment to hiring locally and promoting leaders of color.
- Renew and expand each organization's commitment to providing anti-racism and implicit bias training for physicians, nurses and staff.
- Advocate for increased funding for social needs, social services and programs that promote social justice.

Our society only truly thrives when everyone has an opportunity to succeed and live a healthy life. We are committed to moving forward together, by harnessing the collective strengths of our organizations, we will help serve our communities as agents of change.

Sincerely,

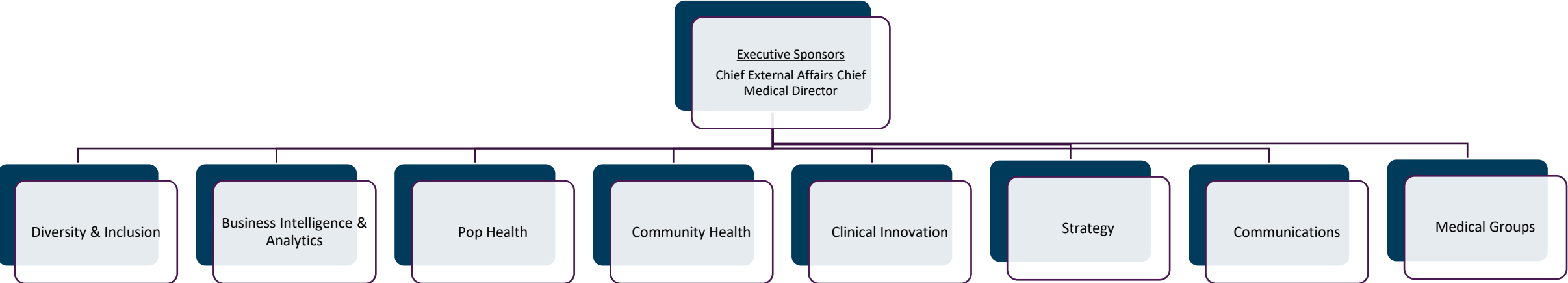


# Health Equity Framework(AAH)

2. Develop structure and process to support Health Equity work

- Establish governance to oversee equity work

## Health Equity Council



# Health Equity Framework(AAH)

3. Deploy specific strategies to address multiple Social Determinants of Health

Diversity & Inclusion

Business Intelligence & Analytics

Pop Health

Community Health

Clinical Innovation

Strategy

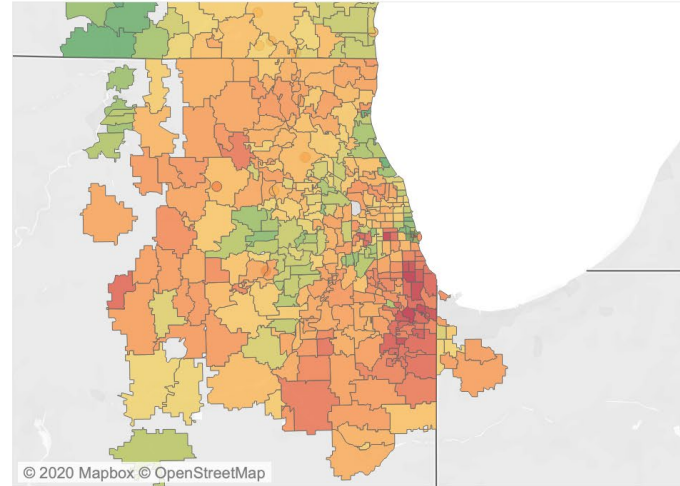
Marketing & Communications

Medical Groups

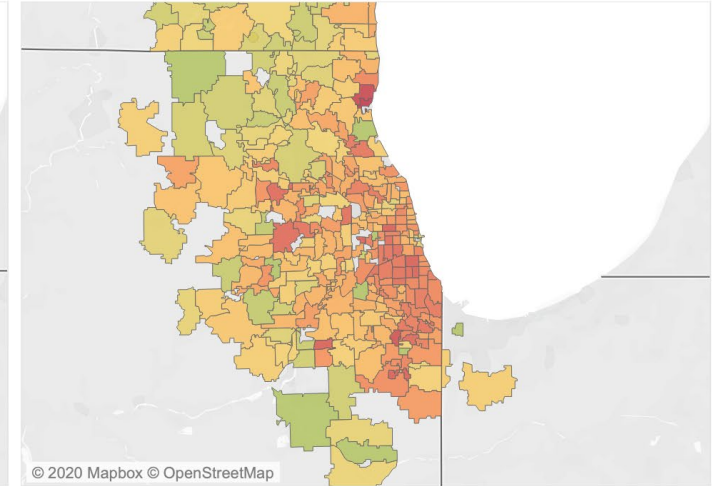
# Data Driven Focus

The power of creating 'heat maps' enables us to create laser focus for delivering interventions and leveraging community partnerships

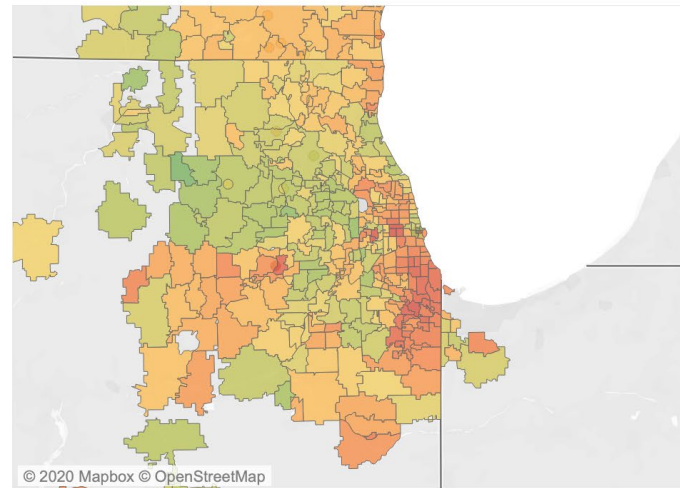
Hypertension - Relative to White



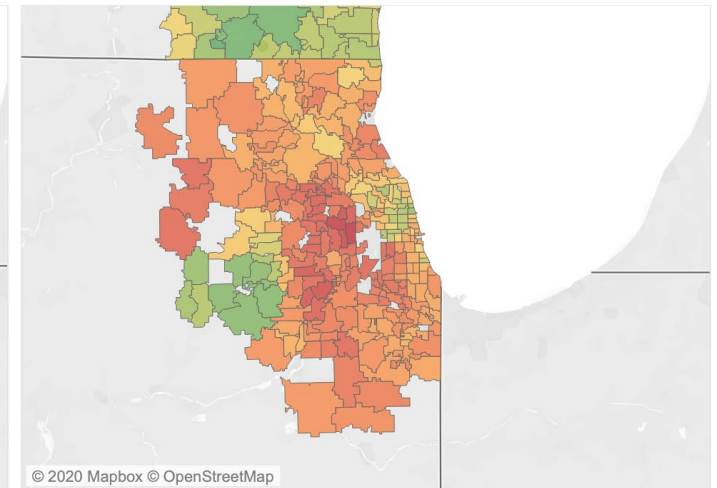
COVID-19 - Relative to White



Diabetes - Relative to White



No Flu Immunization - Relative to White



# Health Equity Framework(AAH)

## 4. Decrease institutional racism in system

- Reduce implicit bias
- Evaluation of policies, practices, and norms in patient care

- **Double Down Commitment Statements**

- Executive learning sessions focused on D&I
- Team member listening sessions
- Mandated Unconscious Bias learning for all team members
- Work team to re-examine policies and consistent administration to promote equity and opportunity

# Health Equity Framework(AAH)

## 5. Develop partnerships with community organizations

- Engage community assets
- Collaborate on community issues to address improving health



***"The most successful transformations happen when the most influential people in the system develop a shared commitment to renewal"***  
**- John Kotter on Leading Change**

# Q&A

- Bracken Babula – [bracken.babula@jefferson.edu](mailto:bracken.babula@jefferson.edu)
- Laura Gontz - [laura.gontz@jefferson.edu](mailto:laura.gontz@jefferson.edu)
- Robert Fields – [robert.fields@mountsinai.org](mailto:robert.fields@mountsinai.org)
- Megan Reyna – [megan.reyna@advocatehealth.com](mailto:megan.reyna@advocatehealth.com)