CAPITAL AREA HealthAlliance

2020 Annual Report

Working together
to empower our community
to achieve better health

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About the Capital Area Health Alliance

The Capital Area Health Alliance believes that everyone has the right to lead a healthy lifestyle and have access to affordable, quality health care resources. As a trusted regional hub, CAHA convenes conversations, provides an inclusive platform for collaboration, and brings healthcare related resources and educational opportunities to employers, businesses and area residents.

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Capital Area Community Nursing Network

Chairs
Kelly Brittain, Associate Professor, *MSU-CON*
Joanne Goldbort, Assistant Professor, *MSU-CON*
Committee Sponsor
MSU-CON

Whole Person Care

Chair
Mary Anne Ford, Healthcare Consultant, *Capital Area Health Alliance*
Committee Sponsor
Eaton Community Health

CAPITAL AREA HealthAlliance

Identity Statement

We, the Capital Area Health Alliance,

advance our mission of:

Advocating for community and population health and for improvements in quality and access to healthcare resources

and seek to:

Empower our community to achieve better health (i.e., create improvements in the local healthcare resources, personal health, and well-being of our entire community)

by serving:

Participating organizations and area residents in the Clinton, Eaton, Ingham Tri-County area

through:

Committees and activities aimed at collectively finding solutions to current healthcare trends

and emphasizing our collaborative strengths of:

Being a trusted regional hub for collaboration with the proven ability to network and convene a broad, diverse group of stakeholders and form community partnerships to collectively address common issues.

We are sustainable by:

Funds provided through member fees and the expertise of the many dedicated professionals who volunteer their time accomplishing CAHA strategies and initiatives. Our fee-based funding may be augmented by grants or donations received to support specific initiatives and events.

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2020 Strategic Focus

1. Whole Person Care (WPC)

https://www.capitalareahealthalliance.org/whole_person_care.php

Whole person care is the coordination of health, behavioral health, and support to address social determinants of health in a person-centered and relationship-based manner, taking into account all that is important **to** the person, as well as what is important **for** the person, with goals of improved health outcomes and efficient and effective use of resources. **Strategies**:

a) Learn about the training needs of area healthcare organizations and identify resources and opportunities for organizations interested in improving the skills needed to efficiently provide person-centered, integrated care.
b) Work with state partners to develop and support sustainable models to recruit and retain the community, social service, and direct care workers needed to address changing demographic and healthcare needs and support WPC.
c) Grow momentum for WPC in the Capital Area region by engaging partners in multiple sectors, including community members, to participate in related activities.
d) Education & Networking: bring people together on specific facets of WPC.

2. Readiness for Care

https://www.capitalareahealthalliance.org/readiness_for_care_cacnn.php

Leadership preparation, clinical reasoning and critical thinking skills, and coaching new generations of healthcare professionals. **Strategies:**

a) Community education forums for nursing students
b) Millennial Nurses Speaker Bureau
c) Integrate with CAHA focus areas of Whole Person Care and Health Equity by identifying opportunities to raise awareness of these areas of focus and the skills that new professionals will need to address them.

3. Health Equity

https://capitalareahealthalliance.org/2019_health_equity_forum.php

Intentionally examine how racism creates health inequities and address these inequities throughout our work. **Strategies:**

a) Build capacity to facilitate difficult yet needed conversations.
b) Partner with Ingham County Health Department and Lansing area Truth, Racial Healing & Transformation, https://www.oneloveglobal.org/trht, to advance health and racial equity.

Any reflection of CAHA's work in 2020 must begin with how quickly plans and priorities changed. In the early weeks of the COVID-19 pandemic, CAHA's member organizations and partners undertook drastic changes in how they provided health services, responded to basic needs of our community's residents, and educated future healthcare professionals.

As CAHA strove to remain light on its feet to accommodate these rapid changes, our interdependent areas of focus—**Health Equity, Whole Person Care, and Readiness for Practice**—became increasingly relevant. What emerged were rich and challenging discussions such as the ongoing impact of racism on the health of our community; the need for creativity when addressing our healthcare workforce needs; and the compassion and humility needed to understand how to care for the whole person.

CAHA's two working groups, the Capital Area Community Nursing Network and the Whole Person Care Core Group collaborated extensively throughout 2020, weaving health equity and workforce issues throughout their work. Members brainstormed ideas and opportunities arising in response to the pandemic and talked about their fears, concerns and the impact of COVID-19 on future generations' interest in the health profession. Traumatic and preventable health and racial inequities were exposed more than ever. This was discussed at each of the groups' convenings. Conversations were had on implicit bias training and the need to help healthcare professionals understand their biases; and we acknowledged that our committees are predominantly filled with white faces and wrestled with how to bring more representative faces of our community into our work.

Capital Area Community Nursing Network

Chairs: Kelly Brittain, Associate Professor, MSU-CON; Joanne Goldbort, Assistant Professor, Course Coordinator for Maternal and Women's Health, MSU-CON

In 2020, the Capital Area Community Nursing Network (CACNN) continued to prioritize Readiness for Practice as its focus, as well as linking its work to CAHA's other focus areas, Whole Person Care and Health Equity. CACCN developed a *Health Equity and Whole Person Care Survey* (full survey and results attached), using information from the Equity of Care Toolkit, http://www.equityofcare.org/resources/resources/2018%20EOC%20Toolkit.pdf and other sources. The survey was sent to Chief Nursing Officers of hospitals and long-term care facilities in the Tri-County area to learn about their organizations' work to address health inequities and provide person-centered care. The survey included questions on organization engagement in four action steps identified by the American Hospital Association Equity of Care campaign and the structures in place to support them. The action steps are to:

- Increase the collection and use of data on race, ethnicity, language preference and other socio-demographic data
- Increase cultural competence training
- Increase diversity in leadership and governance
- Improve and advance community partnerships

In response to the survey, CACNN identified issues to be discussed further both by CACNN and the Whole Person Care (WPC) Core Group:

- Training and policies are needed to promote understanding of the LBGTQ population. (Sparrow CNO Amy Brown shared information with CACNN on Sparrow's participation in the Healthcare Equality Index, which is the national LGBTQ benchmarking tool that evaluates healthcare facilities' policies and practices related to the equity and inclusion of their LGBTQ patients, visitors and employees).
- Handoffs across levels of care have always been challenging but are more so during this time when family caregivers are not as engaged in the process.
- Our caregivers can be the targets of racism, sexism and LGBTQ discrimination, and safe spaces are needed for them to have conversations about those experiences.
- We need to learn from each other and share policies, best practices, and resources, such as position descriptions for a diversity and inclusion officer, and policies and processes to accommodate the needs of diverse populations.

Whole Person Care Initiative

Chair: Mary Anne Ford, Healthcare Consultant, Capital Area Health Alliance

Whole Person Care is the coordination of health, behavioral health, and support to address social determinants of health in a person-centered and relationship-based manner, taking into account all that is important **to** the person, as well as what is important **for** the person, with goals of improved health outcomes and efficient and effective use of resources.

CAHA's vision for whole person care in the region is care that is, among other things: equitably accessed and delivered, person-centered, inclusive of cultural backgrounds, needs and values, provided by an educated, prepared, and diverse workforce, and committed to valuing and hearing each individual. This vision intersects with CAHA's focus on Health Equity and requires an understanding of how racism impedes implementation of person-centered, integrated care.

One of CAHA's strengths is its capacity to convene conversation. Perhaps that capacity had never been more important than in 2020, as the COVID-19 pandemic disrupted the work of healthcare workers and exposed glaring racial inequities in the healthcare system. Strategies for telephonic or virtual contact with patients were discussed, as well as telehealth resources, the potential friction of whole person care practices with social distancing requirements, and the impact of the pandemic on future generations' interest in healthcare professions. Later in the year, the Whole Person Care (WPC) Group met with Ingham County Health Department staff to discuss the Ingham County resolution declaring racism a public health crisis and explore how to engage with that work.

An educated, prepared, and diverse workforce is essential to providing Whole Person Care. CAHA's WPC Group met with Clare Luz, Director of the IMPART Alliance, a coalition of researchers, direct care workers (DCWs), clients, and agencies working together to develop a competent home care workforce, improve the lives of DCWs—many of whom are women of color—and the clients they serve. CAHA will continue to engage with the IMPART Alliance's work to establish statewide competency guidelines and credentialing requirements and to promote training to increase DCW knowledge, skills, retention, and client satisfaction. The WPC Group has discussed the findings from the Health Equity and Whole Person Care Survey and will continue to collaborate with CACCN to explore how to address the survey's findings and other workforce issues.

Planning for a 2021 virtual education session is underway, focusing on how to build sustainable models to promote behavioral health integration in our community.

Executive Director Transition

CAHA is on an exciting cusp of change and growth. Kathy Hollister completed her time as Executive Director in February 2021. Under her leadership, CAHA strengthened its operations and infrastructure, reimagined and identified its role and value in the community, and strategically established its current focus: Whole Person Care, Readiness for Care, and Health Equity. A robust executive director search was conducted in late 2020 and early 2021, with many in-depth conversations with CAHA board and transition team members on how to bring CAHA successfully into the future. CAHA is exceedingly pleased to have chosen Jason Blanks as the new Executive Director effective February 22, 2021. Jason's skills and experience are an excellent fit for CAHA. His experience working with diverse and underrepresented populations, his success in engaging partners and resources, and his executive management skills are essential assets as CAHA works to grow its presence and impact in our community.

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Survey: Health Equity and Whole Person Care in Healthcare

Health Equity Definition: Health Equity is the fair, just distribution of the resources and opportunities needed for diverse members of a community to achieve well-being.

1. Is Health Equity an explicit commitment of the organization? Yes/No
2. If yes to question 1, what steps is the organization taking to improve each patient's experience and reduce health disparities resulting from health inequities? (Choose all that apply.)
    - Increasing the collection and use of race, ethnicity, language preference and other socio-demographic data
    - Increasing cultural competence training
    - Increasing diversity in leadership and governance
    - Improving and strengthening relationships with community partners
    - Other (please describe)
3. Regarding socio-demographic data:
    a. How is it used in your work?
    b. What are challenges or barriers to demographic data collection?
    c. What additional data would you like to collect that would be helpful in your work?
4. How is cultural competence training offered in your organization?
    a. Is training in house or contracted out? Offered via internet or face to face?
    b. To whom is training provided? Is training required across all settings in your organization (e.g., inpatient, ambulatory, pharmacy, home health)?
    c. How often is training provided?
    d. Is there anything else you would like to share about your organization's cultural competence training?
5. What hiring practices and training would you like to see in place to have a workforce that reflects the patient population your organization serves and to improve each patient's experience?
6. What are your observations about the diversity of your organization's leadership and governance?
7. Does your organization have:
    a. A patient and family advisory committee? If yes, what is the composition of the committee?
    b. A diversity and inclusion officer?
    c. A process to resolve complaints regarding equity? If yes, please describe.
8. How have community partnerships been helpful in your organization's efforts to improve the patient experience and reduce disparities in outcomes?
9. Are there areas in which new partnerships would support your organization in reducing health inequities and offering person-centered, integrated care?
10. Do you have any additional comments or information that you would like to share?

Health Equity and Whole Person Care in Healthcare Survey Summary – July 31, 2020

As part of its commitment to intentionally support CAHA's work on Health Equity and Whole Person Care, the Capital Area Community Nursing Network (CACNN) developed a survey to gather information about Health Equity and Whole Person Care practices in the Capital Area region. The 10-question survey was sent to 12 organizations in the tri-county region in the summer of 2020. The organizations receiving the survey included health systems, critical access hospitals, long-term care facilities and ambulatory care facilities. The survey was sent to chief nursing officers in each facility. Five responses were returned, for a 41.7 percent return rate.

Key Findings

All the respondent organizations are committed to health equity and have some activity underway to promote health equity in their organizations.

- Workforce diversity is viewed by most respondents as lacking at multiple levels, resulting in a workforce that does not represent the populations they serve or the community at large.
- Implicit bias training is needed for those involved in patient care and hiring.
- Although socio-demographic data is being collected, there is little evidence of use of the data to identify and address health disparities created by health inequities.

Summary of Responses

1. Commitment to Address Health Equity

All respondents indicated that their organizations have made an explicit commitment to Health Equity.

The American Hospital Association's Equity of Care campaign identifies four action steps for health systems and hospitals:

- Increase collection of socio-demographic data, including race, ethnicity, and language preference
- Increase cultural competence training
- Increase diversity in leadership and governance
- Improve and advance community partnerships

Respondents were asked to identify which, if any, of these steps are being taken in their organizations to improve each patient's experience and reduce health inequities. All of the respondents indicated that their organization is acting on one or more of these areas. Each of the five respondents is working on cultural competence training, three on increasing diversity and community partnerships and one on collection of socio-economic data.

2. Collection of Socio-Demographic Data

Respondents understood questions on this topic in two different ways, suggesting a lack of clarity in the wording of the questions about how the data was used in their work and whether there were challenges to data collection.

Two respondents answered the questions as being about human resources data collection. One indicated it was monitored by their HR department, but not reported anywhere. The other respondent answered that data was used for recruitment opportunities. Regarding challenges

to data collection, one respondent answered that better tools are needed to collect and collate the data.

The other three respondents' answers addressed data collection about patients. They shared several ways they used the socio-demographic data:

- Reports to the state.
- To ensure the availability of resources for community members, consumers, and caregivers.
- Compare the demographic data with the service area population and employees to assure reflection of the community served and to potentially identify disparities in service provision.

One respondent shared challenges in patient data collection related to National Outcome Measures and six-month reassessment: organization system flows and difficulty connecting with individuals within a required 30-day period.

One respondent answered the question about what they would like to do with data, indicating that they would like to do more analysis that could be shared with staff and the community to drive improvements.

3. Cultural Competence Training

Questions in this area address how training is being offered, to whom and how frequently. Respondents could also share additional information.

Four of the respondents require training for all employees; one specified that training is required for all caregivers. Four different answers were offered regarding required frequency of training: annually, upon hire and annually, twice each year, and a minimum of once each year. Two respondents indicated that training was provided online by a contracted service and suggested that their training could be improved with face-to-face education opportunities. All other respondents utilize contracted internet providers and in-house training, offering webinars, face-to-face training and interactive training modules. One respondent offers enhanced training but did not share details about it.

One respondent shared an additional comment: "What we currently offer is not adequate to fully address systemic racism, inequities and implicit bias. We are looking for expanded training to offer to all staff, with additional training for managers."

4. Workforce Diversity

Responses to two of the survey questions about diversity are best presented by sharing them verbatim.

What training and/or hiring practices would you like to see in place to have a workforce that reflects the population your organization serves and to improve EACH patient's experience?

- More diverse population in workforce, but it may be limited to the area we are in, and no persons of color live in the area.
- More LGBTQ training for employees and more training of staff on patients.
- Resources to educate leaders on best hiring practices.
- Implicit bias training; public recognition of diversity.
- We need to increase upward mobility of color into leadership roles within the organization, recruitment and retention is also needed. Would like to examine practices and provide managers and those participating in hiring processes to be training on recognizing and avoiding implicit bias in interviewing and hiring decisions.

What are your observations about the diversity of your organization's leadership and governance?

- Mostly white women, few men and few persons of color.
- Lacks diversity in all areas.
- Opportunities identified and addressed frequently to ensure diversity is addressed—organizational surveys.
- We aren't as diverse as the population we serve and the community in which we work.
- Diversity has increased in our Board over the past two years, but still lacking. At the Director and Supervisor level there is currently little diversity. As an organization there has been a culture of promotion from within to these levels, in effort to increase upward movement, we have developed a mentorship program and encourage diverse involvement in the program.

All of the five respondents have a patient and family advisory committee, all described as diverse or broadly open to community members. Two of the five respondents have a diversity and inclusion officer, one at the corporate level and the other with multiple roles. Four of the five respondents have a process in place to resolve complaints about equity, three of them clearly designed to address patient/resident or family complaints and one which is an HR function. Again, a lack of clarity in the wording of this question led to different interpretations by respondents. One respondent did not answer the question.

5. Community Partnerships

Four of the five respondents shared thoughts about the value and need for community partnerships. They would like more community partnerships and have found value in those that they have, one specifically noting work with Healthy!Capital Counties and the City of Lansing. Two respondents shared what types of partnerships they would like to pursue:

- Partnerships to address a growing number of patients who are homeless and/or have substance abuse and mental health conditions.
- Partnerships to address disparities in service to Hispanic patients and connect individuals with services.
- Expand mobile crisis response in partnership with 911 dispatch, EMS and CIT trained officers from law enforcement agencies, so that the right agency takes the lead in responding, based on the individual situation.
- Expand the number of primary care settings that include a trained behavioral health consultant.

6. Other Comments

- From acute care to SNF to home, then out in the community after home care stops. The person is lost without enough resources to support their health and life needs. We need a stop gap. How can we all share information?

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Balance Sheet

As of December 31, 2020

ASSETS	
Current Assets	
Checking/Savings	
Checking - Huntington Bank	61,965.20
Money Market Investment - Huntington Bank	26,428.73
Total Checking/Savings	88,393.93
Other Current Assets	
Accounts Receivable - Sponsorships	0.00
Prepaid Expenses	1,058.00
Total Other Current Assets	1,058.00
Total Current Assets	89,451.93
Fixed Assets	
Office Equipment	7,675.00
Accumulated Depreciation	-7,675.00
Total Fixed Assets	0.00
TOTAL ASSETS	**$89,451.93**
LIABILITIES & EQUITY	
Liabilities	
Current Liabilities	
Accounts Payable	
Accounts Payable	5,028.75
Total Accounts Payable	5,028.75
Other Current Liabilities	
Deferred Annual Dues	18,000.00
Total Other Current Liabilities	18,000.00
Total Current Liabilities	23,028.75
Total Liabilities	23,028.75
Equity	
Unrestricted (retained earnings)	62,108.01
Net Income	4,315.17
Total Equity	66,423.18
TOTAL LIABILITIES & EQUITY	**$89,451.93**

Profit & Loss

January through December 2020

INCOME	
Contributions	0.00
Dues	110,333.00
Interest income	22.55
TOTAL INCOME	**$110,355.55**
EXPENSE	
Accounting and auditing	6,620.00
Conferences and meetings	216.28
Contract services	88,056.00
Dues and subscriptions	275.00
Information technology	596.46
Insurance	873.00
Licenses and permits	20.00
Occupancy expenses	6,068.00
Office expense	3,291.36
Travel	24.28
TOTAL EXPENSE	**$106,040.38**
NET INCOME	**$ 4,315.17**