Community Health Needs Assessment

IMPLEMENTATION STRATEGIES

West Chester Hospital

2023 – 2025

UC Health

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Mission and Vision

Mission and Vision

Our Purpose is:
To advance healing and reduce suffering.

Our Mission is:
We are committed to advancing medicine and improving the health of all people – regardless of race, ethnicity, geography or ability to pay – by fostering groundbreaking medical research and education, delivering outstanding primary and specialty care services, and building a diverse workforce.

Our Vision is:
To use the power of academic medicine to advance the science of discovery and transform the delivery of care.

UC Health Sites

UC Health is a hospital system that is comprised of three separate facilities. Some of the projects listed on the Implementation Plans span multiple sites or are system-wide endeavors. All projects represented on this plan will be implemented at the Daniel Drake for Post-Acute Care facility. Other UC Health facilities include:

- Daniel Drake Center for Post-Acute Care
- University of Cincinnati Medical Center (UCMC)

Communities Served

Butler, Clermont, Hamilton, and Warren Counties in Ohio

2021 Community Health Needs Assessment Priorities

Priorities

The priorities for the University of Cincinnati Medical Center align with the top community health needs identified through the Regional CHNA completed in partnership with The Health Collaborative:

1. Increase access to services in order to improve equitable outcomes for the region's top health needs: behavioral health, cardiovascular disease, dental, vision, and maternal/infant health.
2. Address access to resources for health-related social needs with a focus on standardized screening and referral processes, as well as the development and strengthening of partnerships and communication between providers and community-based organizations.
3. Strengthen workforce pipeline and diversity, including cultural competence, within the healthcare ecosystem.

Significant Health Needs to be Addressed

As part of the alignment process with the Regional CHNA and resulting Regional Community Health Improvement Plan, participating partners were identified as leads for specific strategies within each priority through which the greatest impact on the community would be achieved. Implementation Strategies, listed on the following pages, will address the following prioritized health needs:

1. Increase access to services in order to improve equitable outcomes for the region's top health needs: behavioral health, cardiovascular disease, dental, and maternal/infant health.
2. Address access to resources for health-related social needs with a focus on standardized screening and referral processes, as well as the development and strengthening of partnerships and communication between providers and community-based organizations.
3. Strengthen workforce pipeline and diversity, including cultural competence, within the healthcare ecosystem.

Significant Health Needs Not Addressed

While West Chester Hsopital is able to address many of the identified community needs, there is not currently capacity or infrastructure to address the following needs, which will be taken on by community partners at the regional level:

1. Increase access to services in order to improve equitable outcomes for the region's top health needs: vision.

Process for Strategy Development

Process for Strategy Development

Strategies and Priority Projects were selected to address the needs identified in the UC Health 2021 Community Health Needs Assessment, which can be found here: https://www.uchealth.com/about/community-benefit/.

The 2023-2025 Community Health Needs Assessment and Improvement Plan (CHIP) cycle was the first time that UC Health participated in a Regional Improvement Plan. Facilitated by The Health Collaborative, the Regional CHIP convened stakeholders from across the health ecosystem, including hospital systems, public health entities, and community-based organizations that addressed the areas of greatest need within the Greater Cincinnati and Greater Dayton areas. This was a novel approach on a national scale. The Regional CHIP identified strategies across all of the participating institutions that would engage the partners to collaborate and take leadership in those tactics that were targeted within their sphere of influence. UC Health chose to align as closely as possible with the Regional CHIP in order to contribute to addressing the three greatest needs in a collaborative and impactful manner. The Regional CHIP can be found here: https://healthcollab.org/community-health-needs-assessment/.

UC Health chose to add one additional focus area to those selected at the Regional level – increasing access to service to improve equitable outcomes for maternal/infant health. This decision was based on the evident need within the population served specifically by UC Health. Additionally, UC Health is engaged in several strong partnerships that are working to address disparities within the Cincinnati pregnant population, specifically Cincinnati Cradle.

A CHNA Steering Committee was formed to guide and oversee the process development of strategies. The Population Health Team and Community Relations team met with both internal and community stakeholders to identify strategies. This team included Cady Cornell, Performance Improvement Specialist, Population Health and Dan Maxwell, Manager, Community Relations. Their activities included:

- Inventory of current strategies worthy of continuation
- Inventory of current activities that may address the targeted needs
- Met with public health agencies to identify additional opportunities to collaborate
- Participated in Interact for Health's Regional Implementation Plan Group to discover opportunities for shared strategies
- Met with community-based organizations and other external stakeholders
- Met with UC Health experts and key internal stakeholders to identify and develop responses for the priority areas identified from the Community Health Needs Assessment

Internal key stakeholders, listed below, participated in discussions between January and August 2022 to generate goals, select priority projects, and ensure alignment to the Regional CHIP. The CHNA team presented an overview of the CHNA Implementation Strategies process during meetings with the Chief Administrative Officers and Chief Medical Officer for final review and approval.

Key Stakeholders engaged in the CHNA Steering Committee were:

Name	Position
Dr. Stewart Wright	Chief Medical Officer
Rob Wiehe	Chief Operating Officer
Tom Daskalakis	Chief Administrative Officer
Jimmy Duncan	Chief Human Resources Officer
Evelyn Agbomi	Manager, Clinical RN
Jenifer Brodsky	Manager, Trauma Program
Suzanne Burgei	AVP, Culture, People, & Technology
Dr. Christine Burrows	Medical Director, Internal Medicine and Pediatrics
Dr. Molly Carey	Medical Director, UC Health Obstetrics and Gynecology
Jeanetta Darno	Chief Diversity, Equity, and Inclusion Officer
Cheryl Harris	Manager, Utilization Review
Valerie Hoagland-Scarfpin	AVP, Talent Acquisition
Trish Hunter	Interim Director of Population Health
Amber Finklestein	Director, Social Work/Case Management
Yvette Kauffman	Director, Business Operations
Gina Meninger	Coordinator, Trauma Outreach and Prevention
Kacey Richards	Business Manager
Ron Rohlfing	Vice President, Hospital Administration
Dr. Hilja Ruegg	Medical Director, Integrated Mental Health Care
Dr. Rick Ryan	Vice Chair, Emergency Medicine
Dr. Sanjay Shewakramani	Medical Director, Emergency Medicine

Criteria for Strategy Selection

Our core team collected information on projects throughout the system and assessed them for inclusion based on the following criteria:

1. Alignment with the overarching regional collaborative goals and strategies
2. Opportunity for standardization in practice across the health system
3. Improvement to date if the strategy has been included in previous Community Health Improvement Implementation Strategy documents, and potential for continued growth
4. Size of impact on population within UC Health service area

Implementation Strategies

Overview of Implementation Strategies

Priority 1: Increase access to services in order to improve equitable outcomes for the region's top health needs: behavioral health, cardiovascular disease, dental, and maternal/infant health.
Behavioral Health Strategies
• Standardize mental health screening and presence of mental health providers in non-psychiatric clinics.
Expand access to MOUD and harm reduction materials in Ambulatory settings
Cardiovascular Disease Strategies
• Equip the community with tools to respond to and reduce harm during a cardiac event.
Dental Strategies
• Support ongoing efforts to provide preventative dental services and connection to an established dental home.
Maternal/Infant Health Strategies
• Provide additional support to high-risk pregnant patients through accessible, patient-centered, multimodal educational opportunities.

Priority 2: Address access to resources for health-related social needs with a focus on standardized screening and referral processes, as well as the development and strengthening of partnerships and communication between providers and community-based organizations.
Social Determinants of Health Strategies
• Improve coordination between healthcare systems and social service agencies by establishing a shared mechanism to screen, refer, and follow-up on a patients' health-related social needs. • Increase the number of CHWs to assist with connecting individuals to resources and program addressing food and housing needs.

Priority 3: Strengthen workforce pipeline and diversity, including cultural competence, within the healthcare ecosystem.
Workforce Pipeline Strategies
Regional Priority: Expand and diversify the healthcare workforce pipeline through education and hiring opportunities.
• Increase career exploration work-based learning pathways. • Implement and increase diversity, cultural competency, and empathy training of workforce professionals and leadership within health systems.

Key:

 Indicates alignment with the UC Health Strategic Plan

 Indicates alignment with the Regional CHIP

 Indicates alignment with the Ohio State Improvement Plan

Implementation Strategies to Address Access to Services

Increase access to services in order to improve equitable outcomes for the region's top health needs: behavioral health, cardiovascular disease, dental, and maternal/infant health.

Description:

The Regional CHNA identified the greater Cincinnati area's most unmet health needs by analyzing and prioritizing a combination of the region's most prevalent health conditions (identified through hospital utilization data, community member surveys, and Center for Disease Control data), most untreated health conditions (identified through community member surveys), and those health conditions most impacted by Social Determinants of Health (SDoH). Through this process, the top needs of behavioral health, cardiovascular conditions, dental, and vision were chosen as regional priorities. As noted in the Regional CHNA, approximately 30% of Cincinnati Metro residents reported nigh blood pressure or high cholesterol, which a risk factors for cardiovascular disease. Behavioral health-related concerns, such as anxiety and depression, ranked high on the list of most prevalent health conditions with more than a quarter of Cincinnati Metro residents reporting needing treatment within the past year. These conditions were also elevated as areas of unmet need and health outcomes that were significantly impacted by SDoH. Vision and dental were the two areas with the greatest unmet need, which can primarily be attributed to reduced services during the COIVD-19 pandemic. Approximately 23% of the Cincinnati Metro population reported that they had vision concerns within the last year but did not seek treatment, and around 20% of residents expressed the same sentiment for dental concerns.

UC Health chose to add one additional focus area to those selected at the regional level – increasing access to service to improve equitable outcomes for maternal/infant health. This decision was based on the evident need within the population served specifically by UC Health. Additionally, UC Health is engaged in several strong partnerships that are working to address disparities within the Cincinnati pregnant population, specifically Cincinnati Cradle.

Primary Goals:

- Increase care coordination services
- Increase new patient appointments across Ambulatory Services
- Increase mental health screening in non-psychiatric clinics

Behavioral Health

Strategy: Standardize mental health screening and presence of mental health providers in non-psychiatric clinics.

Priority Project: Collaborative Care Model

Collaborative care is a model for integrating mental health care into medical care settings to gain more insight into the individual's concerns and how to best treat them. Through this integrated mental health model, UC Health providers aim to decrease depression levels, improve quality of life, decrease stress, and lower rates of psychiatric hospitalization. The model first requires standardization in screening for mental health concerns, specifically anxiety and depression. Once patients are screened, it is important to have a mental health care manager integrated into non-psychiatric clinics to provide direct care at the time of service, with oversight from the primary medical physician and a consultant psychiatrist. The mental health care manager can assess the needs of the patient and work with them to create an appropriate treatment plan. This model increases access to mental health care by meeting patients where they are already interacting with the health care system. A pilot program is currently operating within some of the UC Health specialty clinics, specifically in clinics that traditionally have higher rates of mental health needs. UC Health also have 17 primary care practices where the model will be rolled out as resources and capacity allows.

Objectives	• Screen patients using the PHQ-9 and GAD 7 with high fidelity • Engage patients in their mental health care through education and communication with their care team • Create a reliable care escalation pathway to connect patients to the appropriate levels of care • Interface collaborative care services with other UC Health support services, such as community health workers and social workers
Goals	• Increase mental health screenings • Increase integration of mental and physical health care in familiar settings
Key Metrics	• Percent of patients who complete a mental health screening at their visit within Ambulatory Services • Percent of patients who screen positive have a visit with a mental health care manager

Priority Project: Cancer Family Care

The Cancer Support Community and Cancer Family Cares enhance the lives of people in the local community by offering free support and services to improve quality of life and cancer survivorship. Backed by evidence that the best cancer care includes psychosocial support, CSC offers community-based programs and services that are intended to provide non-medical care to men, women and children with any type or stage of cancer and to their loved ones. This project aims to increase awareness of and participation of oncology patients treated at WCH campus in Supportive services programs offered by Cancer Support Community and Cancer Family Cares.

Objectives	• To increase awareness of and participation of oncology patients

	treated at WCH campus in Supportive services programs offered by Cancer Support Community and Cancer Family Cares
Goals	• Increase awareness and participation in supportive services available to oncology patients treated at WCH campus as evidenced by participation in programs offered.
Key Metrics	• Number of patients attending the Cancer Support Community Monthly Support Group • Number of Patients receiving counseling from Cancer Family Cares
Partners	• Cancer Family Cares • Cancer Support Community

Strategy: Expand access to MOUD and harm reduction materials in Ambulatory settings.

Priority Project: MOUD Initiation in the ED

The opioid epidemic continues to heavily impact the Greater Cincinnati area. Development of the ED MOUD project since the last Community Health Improvement cycle has significantly increased access to care and initiation of treatment for patients that come to the University of Cincinnati Medical Center ED. An automated screening process has been developed so that every patient who is seen in the ED is assessed for OUD risk. Between FY20-FY22, 53% of all patients with an opioid related chief complaint or discharge diagnosis was treated with MOUD, and the program is approaching the milestone of treating 1,000 patients for OUD that were identified within the ED. This project continues to grow and evolve, with plans of continued improvement, refinement, and spread throughout the UC Health system.

Objectives	• Provide screening, MOUD (buprenorphine), peer navigation, and linkage coordinators to seamlessly link patients to comprehensive longitudinal care by utilizing the EIP program • Help ensure entrance and continuous recovery at UC Health addiction sciences division or other community resources
Goals	• Increase MOUD initiation among those with a chief complaint (cc) or discharge diagnosis (ddx) related to opioids • Increase the percentage of ED MOUD patients linked to care within 14 days of ED visit
Key Metrics	• Percent of patients with a cc or ddx who receive MOUD in the ED
Partners	• Brightview • Talbert House • Center for Addiction Treatment

Cardiovascular Disease

Strategy: Equip the community with tools to respond to and reduce harm during a cardiac event.

Priority Project: Stop the Bleed & Take10 CPR

The UC Health Department of Trauma has been leading efforts to educate and train Greater Cincinnati first responders, health professionals, teachers, and community members in lifesaving "Stop the Bleed" and "Take10 CPR" techniques.

"Stop the Bleed" is a national preparedness program created after the Sandy Hook Elementary School shooting in December 2012. The goal of "Stop the Bleed" is to reduce the number of people who die from uncontrolled bleeding during mass casualty events, shootings, natural disasters, and everyday emergencies by training ordinary citizens in lifesaving bleeding control techniques. "Stop the Bleed" is provided in communities across the U.S. by the Department of Defense and Homeland Security in partnership with the American College of Surgeons, FEMA, the National Association of EMTs, the U.S. Fire Administration, Prehospital Trauma Life Support, Major Cities Chief's Association, the Hartford Insurance Company, and Johnson and Johnson.

TAKE10 Cincinnati is designed to educate and rally the community around compression-only CPR, an easy-to-learn technique that can save lives. Developed by Take Heart Austin and brought to Cincinnati by UC Health, TAKE10 is a free 10-minute training on the hands-only technique that gives people the confidence to act in an emergency. Increasing the number of people trained to start CPR, before 911 responders arrive, can improve cardiac arrest survival.

Objectives	• To increase the number of people who are trained, equipped, and empowered to help in a bleeding emergency before professional help arrives. • To cultivate and encourage grass roots efforts to provide training. • To provide program support so that trainees are able to identify life-threatening bleeding; use their hands to stop the bleeding; pack a wound; and correctly apply a tourniquet. • To increase the number of people who are trained in compression-only CPR.
Goals	• To train more people in basic bleeding control techniques in case of emergency • To train people in compression-only CPR in case of emergency
Key Metrics	• # of trainings completed • # of people trained
Partners	• Cincinnati Fire Department • Cincinnati Police Department • Cincinnati Health Department

	• The Health Collaborative • Local Fire and EMS departments

Dental

Strategy: Support ongoing efforts to provide preventative dental services and connection to an established dental home.

Priority Project: ED Dental Referrals

Patients frequently visit the Emergency Department who need dental treatment. Through this program, WCH and the dental team at Primary Health Solutions will create a process to expedite dental referrals from the ED. Patients presenting to WCH ED with urgent dental needs, which cannot be met on site, will be connected with Primary Health Solutions for oral health care. During business hours when a social worker and case manager are available, they facilitate the connection and obtain an appointment. Outside of those hours, patients will receive a pamphlet with information about Primary Health Solutions and the number to call for an appointment.

Objectives	• Expedite dental referrals from the ED and connect patients to a dental care home
Goals	• Reduce dental-related ED utilization • Increase percent of patients with an established dental home
Key Metrics	• Number of patient referrals
Partners	• Primary Health Solutions

Maternal/Infant Health

Strategy: Provide additional support to high-risk pregnant patients through accessible, patient-centered, multimodal educational opportunities.

Priority Project: Babyscripts App

Babyscripts is a phone-based app that provides pregnant patients with evidence-based information regarding pregnancy care, a connection to their care team, information about community events, and the opportunity for remote blood pressure monitoring. The

importance of attending prenatal care in order to improve health outcomes for both the mom and the baby is highlighted through the educational materials available on the app and communication with the care team. The layout of the app has been revised based on feedback from a local focus group, in an effort to make the information provided and the feel of the application as patient oriented as possible. Patients are recruited to join the app through a variety of mechanisms, including through partnership with Cincinnati Cradle's Queens Village.

Objectives	• Register patients with an account for the app • Provide patients who are at risk of hypertensive disorders of pregnancy postpartum with home monitoring blood pressure cuffs
Goal	• Increased early access to prenatal care (not sure that this fits with Babyscripts, as the patient does not get the app until they come to the appointment) • Decrease maternal morbidity and mortality • Decrease infant mortality • Increase adherence to the postpartum visit
Key Metrics	• Engagement with the app • Number of registered patients
Partners	• Cradle Cincinnati's Queens Village • Breastfeeding Outreach for Our Beautiful Sisters (BOOBS) • All Moms Empowered to Nurse (AMEN)

Priority Project: Enhance Breastfeeding Support in the Community: Baby Café

Approximately 80% of all U.S. women start breastfeeding, but, of those moms, approximately 60% do not reach their own goals. To help improve breastfeeding rates, West Chester Hospital will partner with breast feeding support groups that offer encouragement and education in all aspects of breastfeeding and its impact on daily life – from prenatal to weaning – as well as assistance with latching, pumping, and increasing or maintaining milk supply. Breastfeeding has been linked to improved health outcomes for babies and moms. In addition, breastfeeding has been linked to reduction of infant mortality. There has been an identified need in the Butler County region for further expansion of breast feeding support to the high-risk population. Butler County has one of the highest rates of infant mortality in the State of Ohio. West Chester Hospital has been asked to work with other community agencies to provide this service to the women and children of Butler County.

Objectives	• To increase the number of participants in Butler County • To educate and empower breastfeeding moms to reach their desired goal • To decrease the infant mortality rate
Goal	• To expand breastfeeding support programming at WCH (i.e. Baby Café).
Key Metrics	• Track attendance

	• Track Breastfeeding Issues/Reasons for visit (e.g. problems with latch, milk supply, etc.)
Partners	• Primary Health Solutions • Baby Café • Butler County Public Health

Implementation Strategies to Address Social Determinants of Health

Address access to and use of resources with a focus on the development and strengthening off partnerships between providers and community-based organizations.

Description

Health-related social needs, or Social Determinants of Health (SDoH) are defined by the US Department for Health and Human Services as "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." The Healthy People 2030 framework identified five SDoH categories: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. The SDoH framework has been elevated in recent years as a mechanism to quantify and operationalize upstream factors that have strongly correlated, long-lasting health effects on those who are most affected. At the Population Health level, most widespread disparate outcomes are driven by SDoH.

The Regional CHIP assessed the Cincinnati Metro community at all levels of the Healthy People 2030 framework and identified food security and housing as the region's most pressing issues. While supportive of initiatives that focus on these two specific needs. UC Health chose to take a more broad approach and examine our internal processes for both screening patients for SDoH and connecting them with appropriate and accessible resources. These are truly the first two steps for ensuring that the UC Health patient population is receiving wraparound support that will improve their health outcomes across the board.

Primary Goals

- Increase screening for basic patient social determinants of health
- Standardize referral process to address patient needs with community partners

Social Determinants of Health Strategies

Strategy: Improve coordination between healthcare systems and social service agencies by establishing a shared mechanism to screen, refer, and follow-up on a patients' health-related social needs.

Priority Project: Standardization of Social Determinants of Health Screening and Referrals to Resources

UC Health Population Health staff are working with an interdisciplinary team to create a structured, standardized method of Social Determinants of Health (SDoH) data collection

across all patient care settings. The standardized screenings are being built into the UC Health electronic medical record, EPIC, and will be displayed on all patients charts for ease of access. The screenings that are being standardized across all departments will assess the following needs: food security, housing, mental health, financial resource strain, stress, depression, and social connections. By collecting this crucial information, providers will be able to execute individualized treatment and improve care coordination. Standardized screening will also allow for a better population-level understanding of social and health equity for system administrators. Testing within a select few clinics will begin in Fall of 2022, but will be spread to all patient contact points in the system.

At current state, patient referrals to support services that can address any needs identified by SDoH screening varies across each department. Creation of a referral resource directory within EPIC, UC Health's electronic medical record, will help provide consistent access to resources when patients need them, regardless of where they come in contact with the system. UC Health is working toward establishing means of communication with community-based organizations, with an end goal of establishing closed loops for confirmation of patients engaging with services and ensuring that their needs are met.

UC Health is also committed to collaboration with regional health systems, who also participated in the Regional CHNA, on standardization of referrals and collective support of community-based organizations. Through alignment and partnership across health systems, we hope to build a sustainable regional system that can respond to the changing needs of the community and capacity of the support services.

Objectives	• Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all UC health patients • Establish a resource directory and formalize partnerships with community-based organizations • Provide EPIC support to clinics who do not currently have access to SDoH screeners and chart visualizations • Train clinic staff to increase awareness of updated screening and referral operations
Goals	• Increase standardized screening across all patient care settings • Build community resources in EPIC
Key Metrics	• % of patients who are screened for SDoH on an annual basis
Partners	• The Health Collaborative

Strategy: Increase the number of CHWs to assist with connecting individuals to resources and program addressing food and housing needs.

Priority Project: HCAN Hub

Health Care Access Now (HCAN) is Cincinnati's Regional Pathways Community Hub. UC Health has a partnership with HCAN, and thus can refer patients for community-based care coordination, which "pairs individual, diverse needs with the complicated matrix of services

in our community. Care Coordination services are provided by a specialized workforce – Community Health Workers. Through advocating, educating, connecting and supporting, CHW's are partners with clients and the clinical and social services received in the community." HCAN CHWs provide support to clients for everything from healthcare care coordination, essentials such as food and housing, as well as additional supports like smoking cessation and finding childcare.

HCAN is primarily used as an additional resource for clinics who are not able to staff their own internal CHWs or whose CHWs are already at full capacity for their case load. The UC Health Women's Health Clinic has utilized this resource for patients who live outside of the primary service area of UCMC, and has specifically used this resource for those living in the WCH service area. As we continue to develop our screening processes and identify more patients with wraparound service needs, our need for additional CHW support will grow. We are in alignment with the Regional Community Health Improvement Plan in working to increase referrals to HCAN and further develop our connections with the Pathways Community Hub.

Objectives	• Refer patients to HCAN for CHW services in clinics without internal staffing
Goals	• Increased connection to community resources to address social determinants of health
Key Metrics	• # of patients referred to HCAN for services
Partners	• Health Care Access Now (HCAN)

Implementation Strategies to Address Workforce Pipeline

Strengthen workforce pipeline and diversity, including cultural competence, within the healthcare ecosystem.

Description

The final piece of community analysis completed for the Regional CHNA was an examination of the healthcare ecosystem's structural barriers to improving the quality of healthcare. Community and healthcare provider surveys and focus groups pointed to a need for increased cultural competency and emphasized the importance of patients' feeling of being "heard" by their providers. Providers also indicated that there is room for greater adoption of several best practice areas specific to cultural competency across the healthcare landscape. Key stakeholders also identified workforce diversity and equitable opportunities for both entering healthcare and advancing along a career path to be barriers to success. At UC Health, many of the strategies suggested by the Regional CHIP are implemented and integrated into regular workflows. Some of these standard practices include, but are not limited to:

- Collect data on workforce gaps and training needs to inform decisions about healthcare workforce development.
- Provide incumbent worker training program opportunities, apprenticeships, and scholarships to assist employees in advancing education and careers in healthcare.

Primary Goals

- Align with regional health system workforce initiatives
- Increase student exposure to healthcare career options and opportunities

Workforce Pipeline Strategies

Strategy: Increase career exploration work-based learning pathways.

Priority Project: Healthcare Career Pathways

To create and expand partnerships with area schools designed to provide students with an opportunity to explore a diversity of career paths within healthcare. Programming will consist of three key components:

Exposure to Healthcare Careers - Professionals from a diverse range of both clinical and non-clinical roles, provide an overview of the various career opportunities in healthcare.

Hands-On Activities - Programming is designed to simulate real-world scenarios and create hands-on patient care skills including learning how to draw blood; how to suture a wound; physical therapy skills, the use of robotics in medicine, and more.

Job-Shadowing - Job shadowing allows students to experience a day-in-the-life of medical professionals from different clinical areas: pharmacy, respiratory, sterile processing, radiology and imaging, physical therapy, the emergency department, and more.

Objectives	• Increased exposure and awareness of healthcare career options and broaden healthcare experience for area students
Goals	• Give students an understanding of the diversity of careers available in healthcare. • Create opportunities to pursue an education and career in healthcare. • Expand pathways to other area schools
Key Metrics	• # of students participating in programming • # of schools involved
Partners	• Regional school districts

Strategy: Implement and increase diversity, cultural competency, and empathy training of workforce professionals and leadership within health systems.

Priority Project: Diversity, Equity and Inclusion Roadmap to Cultural Competency

The more aware we are of our own unconscious bias and increase our understanding of diversity, equity, and inclusion, the better we can ensure all patients, families and employees feel welcome.
In the Spring on 2021, the UC Health Office of Diversity, Equity, and Inclusion launched four diversity, equity and inclusion (DE&I) training modules across the system. Teams of early adopters volunteered to take the training modules and hold conversations about their learnings.

Beginning in August 2022, all UC Health employees will be part of establishing a common language around how we discuss diversity, equity and inclusion. Employees who have not yet taken the four DE&I modules will be assigned the training modules:

- Module 1 – Diversity and Inclusion Matters

- Module 2 – Basics for Managing an Unconscious Bias
- Module 3 – Hidden Barriers to Inclusion
- Module 4 – Being and Diversity and Inclusion Change Agent
-

Objectives	• Build a common language for how employees discuss DE&I • Build a roadmap for building greater cultural competency across the health system
Goals	• Increase staff cultural competency • Create common DE&I language across health system
Key Metrics	• Number of staff to complete all four modules • % Workforce trained

Accountability

September 8, 2022

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Date approved by Audit and Compliance Committee of UC Health Board of Directors