

# The Importance of Community Partnership

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**Theresa Green, PhD, MBA**

Director, Community Health Education and Policy,  
URMC Center for Community Health

*Building Bridges and Establishing Community Coalitions* is a component of HANY'S *Advancing Healthcare Excellence and Inclusion* learning collaborative, launched with generous support from the [Mother Cabrini Health Foundation](#). This series covers how hospitals can engage local leaders across sectors to build and strengthen community-based coalitions, identify shared priorities, and address health equity concerns.

# Agenda

- Introductions
  - HANY AHEI team
  - Our funder and partner
  - Our faculty
  - Objectives
- Session 1: The Importance of Community Partnership
- Resources
- Upcoming Sessions
- Questions

# Objectives

By the end of this session, participants will be able to:

- Describe the importance of the community voice in addressing health disparities;
- Articulate the relationship between social inequities and health disparities, including the impact of social determinants on health outcomes; and
- Describe the importance of high-level shared leadership in community engagement for impactful coalition building.

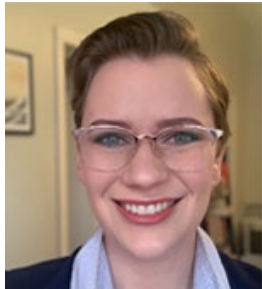
# HANYS AHEI team



**Kathleen Rauch, RN, MSHQS, BSN, CPHQ**  
Vice President, Quality Advocacy, Research and Innovation and Post-acute and Continuing Care



**Christina Miller-Foster, MPA**  
Senior Director, Quality Advocacy, Research and Innovation



**Morgan Black, MPA**  
Director, Advancing Healthcare Excellence and Inclusion



**Maria Baum, MS, RN, CPHQ**  
Project Manager, Mohawk Valley



**Rachael Brust**  
Project Manager, North Country



**Kira Cramer, MBA**  
Project Manager, Downstate

# Our funder and partner



**Mother Cabrini**  
HEALTH FOUNDATION

## OUR FUNDER

Funding from the [Mother Cabrini Health Foundation](#) allows HANY to expand its capacity to provide education, direct support, tools and data to our members in a strategic way. With this learning collaborative, we strive to effect lasting change in health equity at the local level by engaging providers and community stakeholders to address health disparities.



Insights for Healthcare

## OUR PARTNER

Through a partnership with Socially Determined, provider of Social Risk Intelligence™ solutions, [DataGen](#) will develop custom analytics for participants to help them understand how and where communities are affected by social risk so they can develop tailored intervention strategies.

# Our faculty



**Theresa Green, PhD, MBA**

Director of Community Health Policy  
and Education

*URMC Center for Community Health*

[Bio](#)



**Julia E. Iyasere, MD, MBA**

Executive Director

*Dalio Center for Health Justice  
at New York-Presbyterian*

[Bio](#)

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Center for Community Health

Hospitals/health systems  
are in the business of  
improving health



# Mission Statements...

...**improve the well-being of patients and communities** by delivering the highest quality healthcare in a safe, compassionate environment enriched by education, science and technology.

We strive to provide patients with the most **innovative and compassionate care** by our incredible doctors, every single day. We seek to make the fundamental discoveries that underlie advances in medicine.

To heal, to teach, to discover and to **advance the health** of the communities we serve.

...**improving the health of our community** and is dedicated to providing compassionate, comprehensive and innovative health care in a safe environment where the patient always comes first.

...**provide compassionate patient care** with seamless coordination and to advance medicine through unrivaled education, research, and outreach in the many diverse communities we serve.

...to provide compassionate, high-value, quality care, **improving health in Western New York and beyond**, educating future health care leaders and discovering innovative ways to advance medicine.

# “HEALTH”

The World **Health** Organization (WHO) defines **health** as 'a state of complete physical, mental and social **wellbeing**, and not merely the absence of disease or infirmity'

**So...**

**Assuring HEALTH is more than treating disease, more than health care delivery**

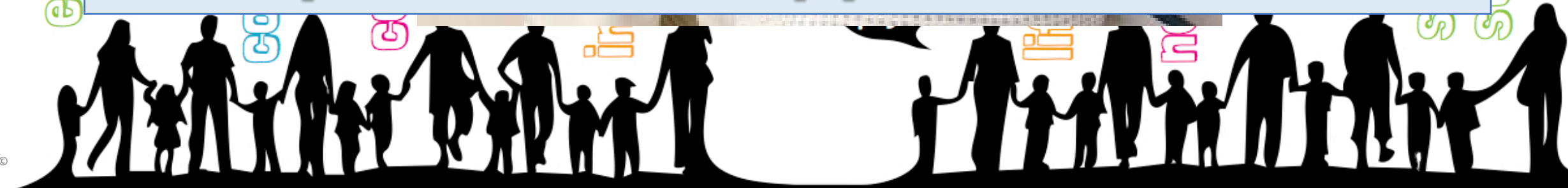
**AND...**

**Most HEALTH occurs outside of the 10-30 minute annual visit**

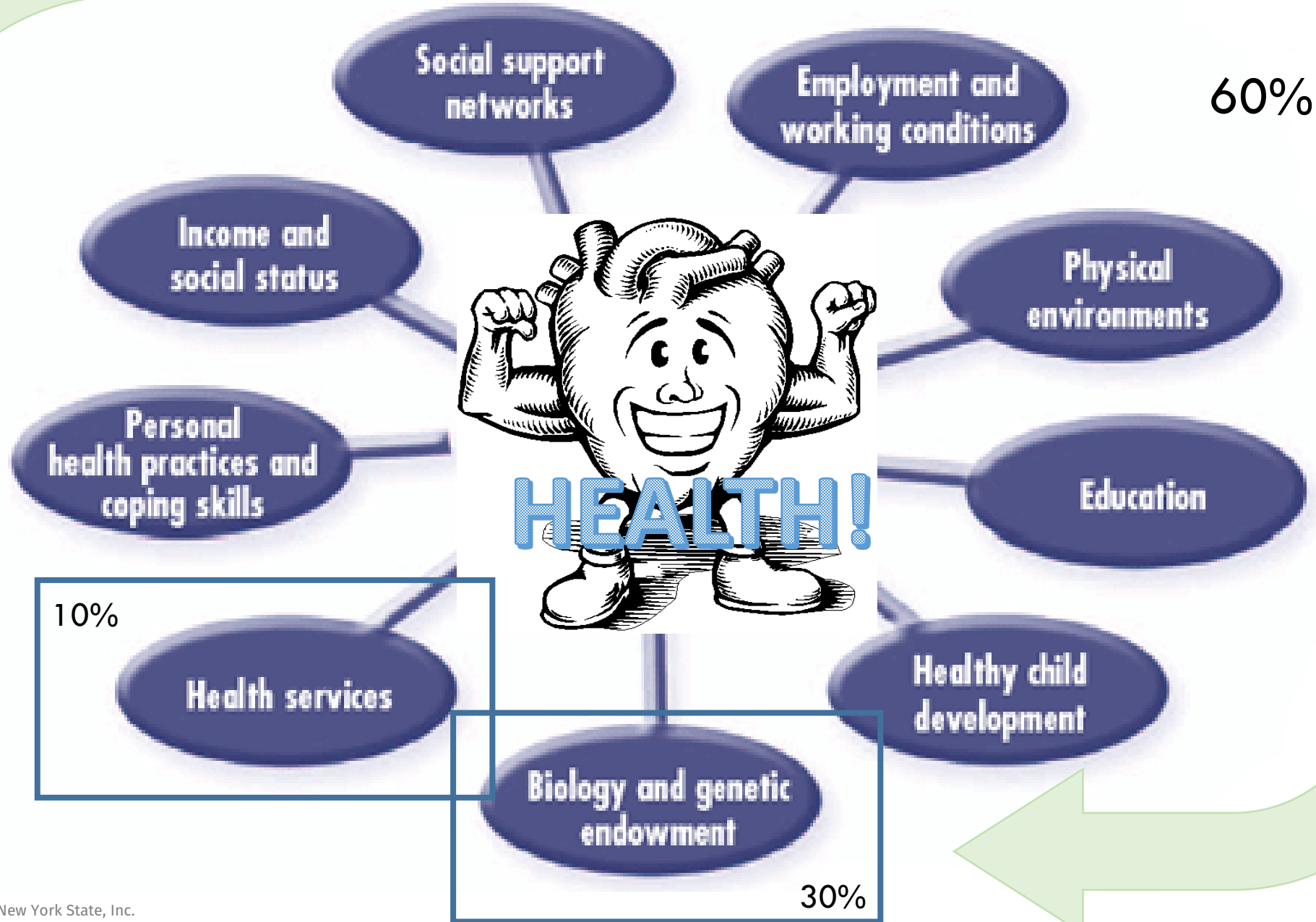
culture  
 equal opportunities  
 innovation  
 CREATIVITY  
 THRIVING & DIVERSE ECONOMY  
 respect  
 accessible education  
 SAFETY  
 WALKABLE & CYCLABLE  
 health care  
 accountable Government  
 resources  
 AFFORDABLE INTERNET ACCESS  
 BIODIVERSITY PROTECTION  
 CLIMATE CHANGE RESILIENCE  
 easy & accessible  
 flexible working conditions  
 DIVERSE AFFORDABLE WELL DESIGNED ENERGY EFFICIENT HOUSING  
 dynamic businesses  
 environment  
 sustainable growth  
 green spaces  
 community LOCAL  
 exciting conditions  
 EXCITING JOB OPPORTUNITIES  
 economic  
 involvement & inclusion



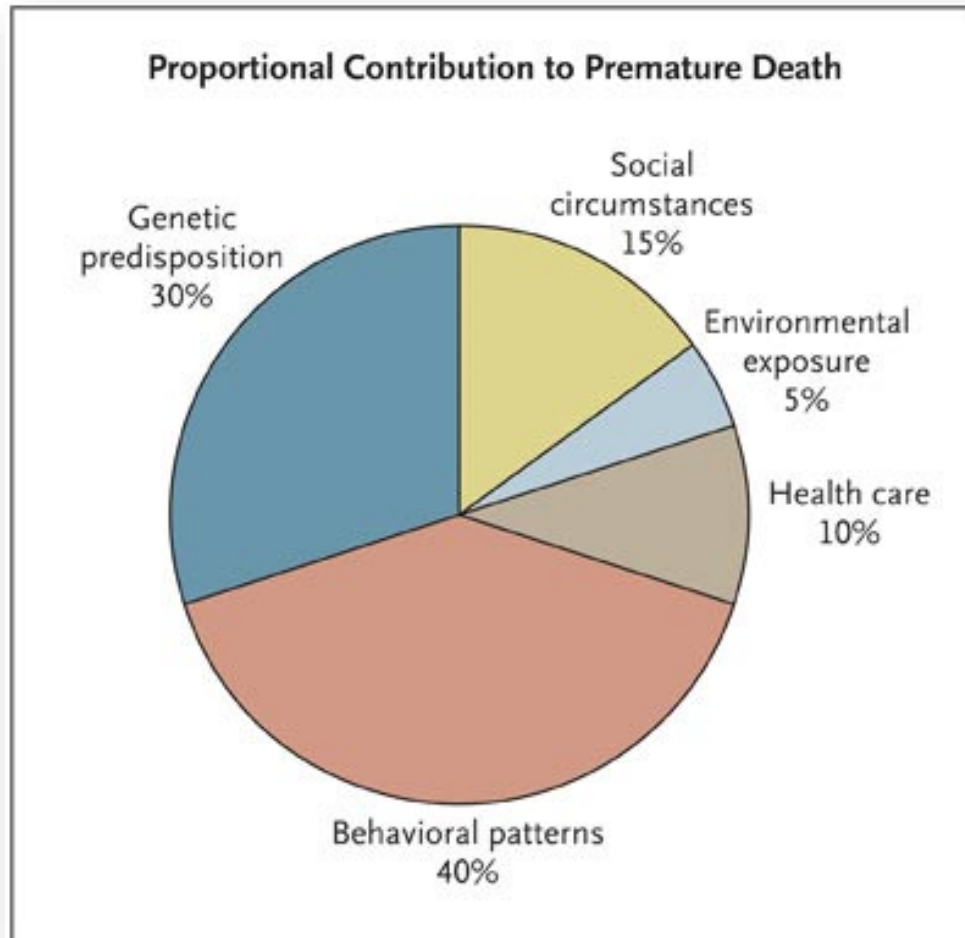
# Comprehensive approach to health



Main driver of health outcomes is *not* health care delivery.



# We Can Do Better — Improving the Health of the American People



Social +  
Environment +  
Behavior =  
60% contribution to  
premature death

Steven A. Schroeder, MD

Adapted from  
McGinnis JM, The case for more active policy  
attention to health promotion. Health Aff  
(Millwood) 2002;21:78-9

Schroeder SA. N Engl J Med 2007;357:1221-1228



# Contributions of Health Care to Longevity: A Review of 4 Estimation Methods

*Robert M. Kaplan, PhD*

*Arnold Milstein, MD, MPH*

Clinical Excellence Research Center,  
Stanford University School of Medicine,  
Stanford, California

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## ABSTRACT

**PURPOSE** Health care expenditures and biomedical research funding are often justified by the belief that modern health care powerfully improves life expectancy in wealthy countries. We examined 4 different methods of estimating the effect of health care on health outcomes.

**METHODS** We reviewed the contributions of medical care to health outcomes using 4 methods: (1) analyses by McGinnis and Schroeder, (2) Wennberg and colleagues' studies of small area variation, (3) Park and colleagues' analysis of County Health Rankings and Roadmaps, and (4) the RAND Health Insurance Experiment.

**RESULTS** The 4 methods, using different data sets, produced estimates ranging from 0% to 17% of premature mortality attributable to deficiencies in health care access or delivery. Estimates of the effect of behavioral factors ranged from 16% to 65%.

**CONCLUSIONS** The results converge to suggest that restricted access to medical care accounts for about 10% of premature death or other undesirable health outcomes. Health care has modest effects on the extension of US life expectancy, while behavioral and social determinants may have larger effects.

*Ann Fam Med* 2019;17:267-272. <https://doi.org/10.1370/afm.2362>.

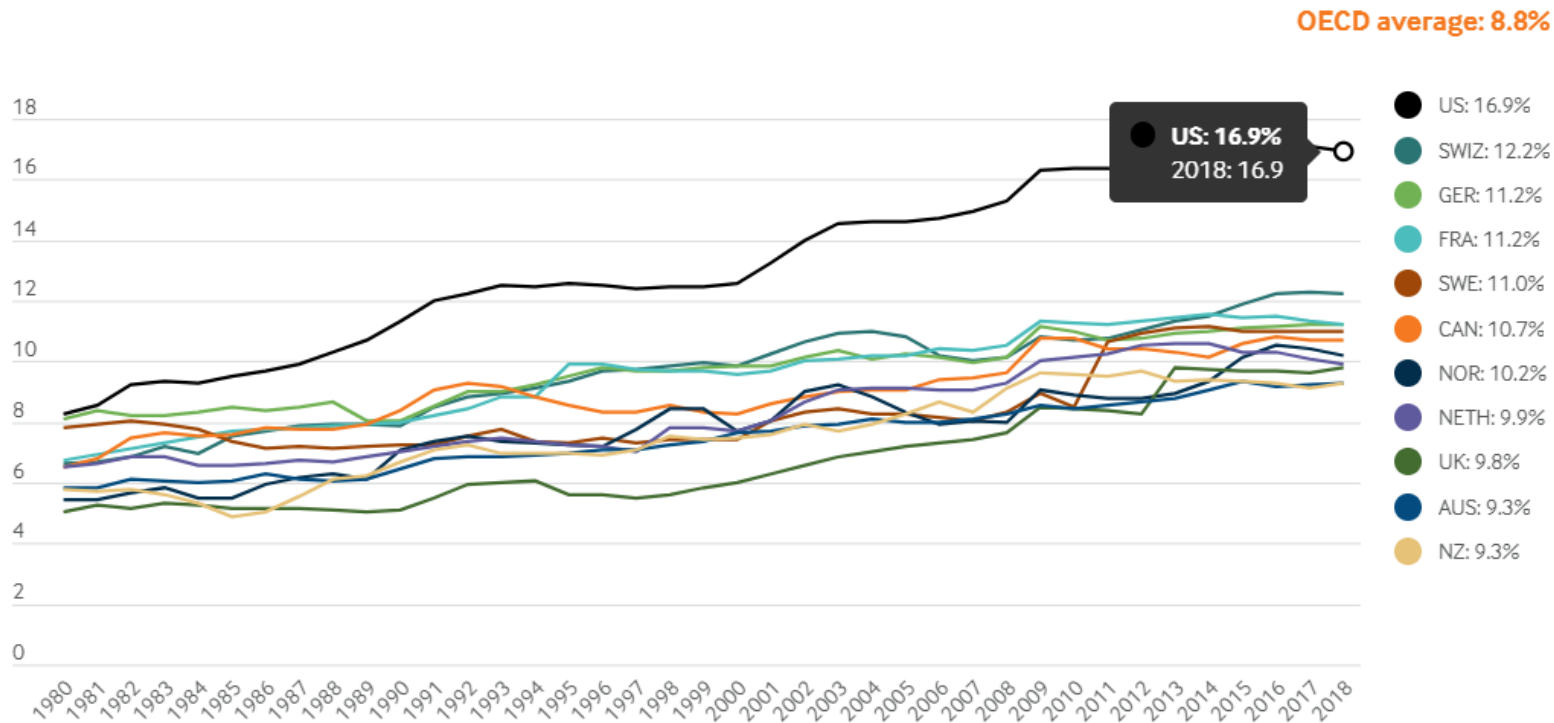
“Health care has modest effects on the extension of US life expectancy, while behavioral and social determinants may have larger effects.”

Current way of doing things  
is NOT working.



# The U.S. Spends More on Health Care Than Any Other Country

Percent (%) of GDP, adjusted for differences in cost of living  
Legend shows 2018 data\*

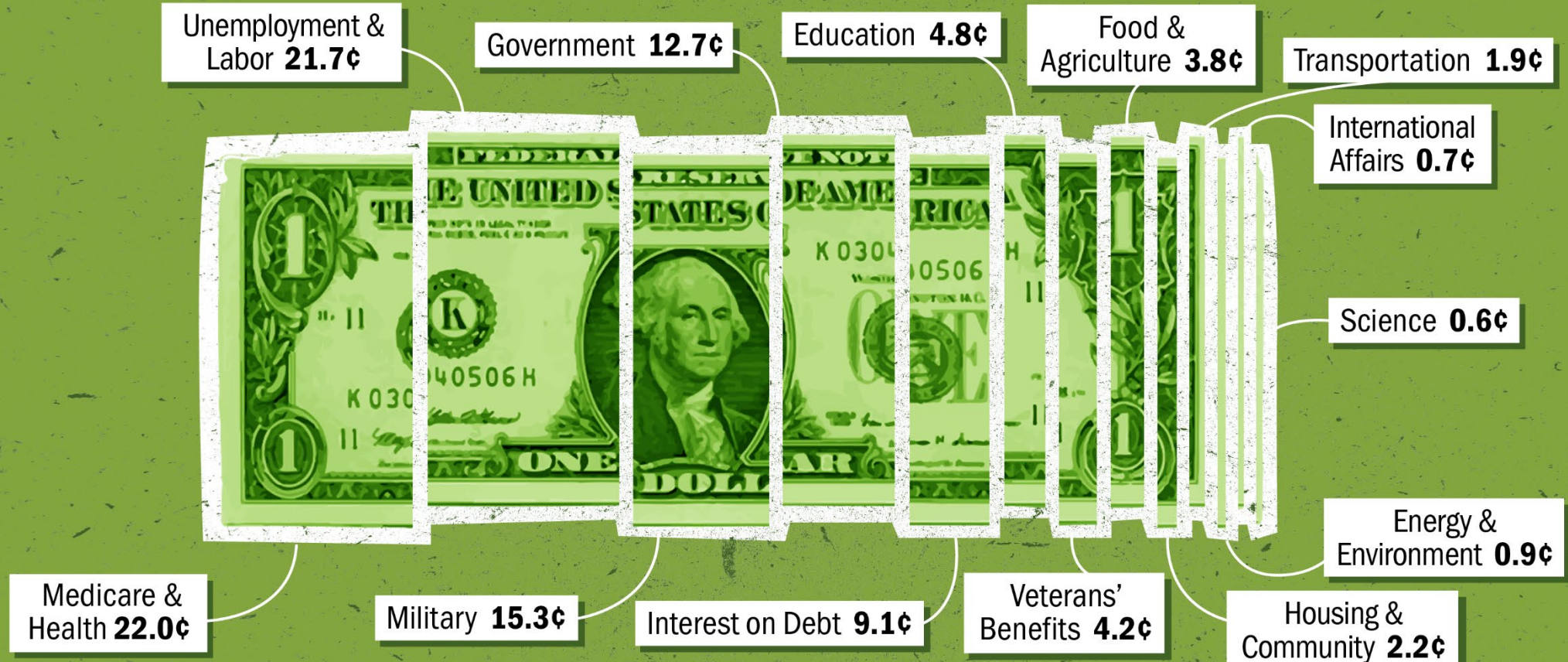


[Download data](#)

Notes: Current expenditures on health. Based on System of Health Accounts methodology, with some differences between country methodologies. GDP = gross domestic product. OECD average reflects the average of 36 OECD member countries, including ones not shown here. \* 2018 data are provisional or estimated.

Data: OECD Health Statistics 2019.

# WHERE YOUR 2021 TAX DOLLAR WENT

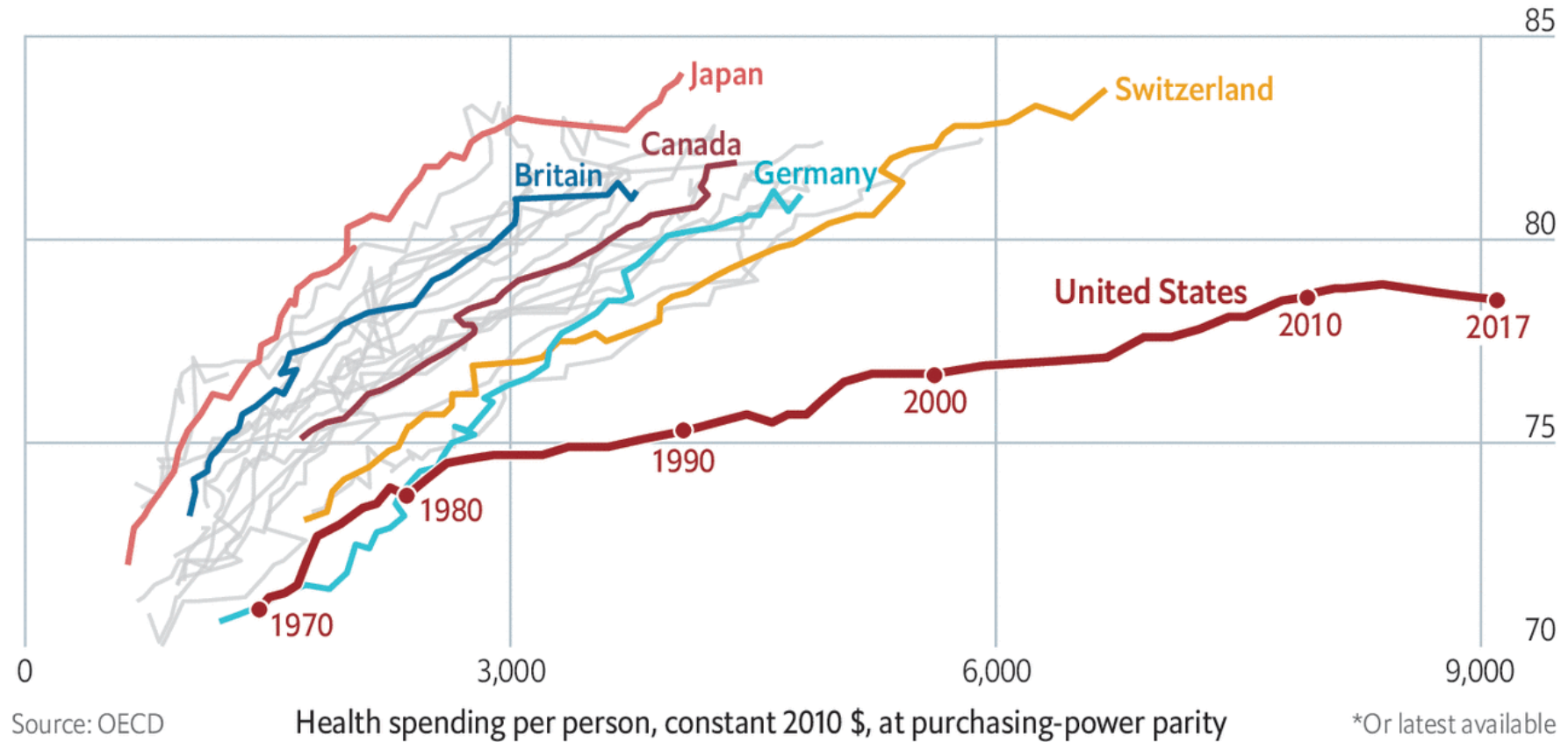


# VALUE? Outcomes per health spending?

## Odd man out

Health spending and life expectancy, 1970-2017\*, selected OECD countries

Life expectancy at birth, years



Source: OECD

The Economist

\*Or latest available

Health spending and life expectancy  
July 18, 2019 6:00pm by [Barry Ritholtz](#)



# POPULATION HEALTH

Population health is defined as **the health outcomes of a group of individuals, including the distribution of such outcomes within the group.**

Co-Chair of the Institute of Medicine Roundtable on  
Population Health Improvement  
Emeritus Vice-Chancellor for Health Sciences at the  
University of Wisconsin-Madison, School of Medicine and  
Public Health.



Kindig, DA, Stoddart G. (2003). [What is population health?](#) *American Journal of Public Health*, 93, 366-369.

# POPULATION HEALTH STUDIES THE SYSTEM = HEALTH CARE + PUBLIC HEALTH

## Medical Care

- Focused on patient care
- Episodic and reactive care
- Fragmented and duplicative
- Limited accessibility by population
- Data collection through EMR
- Limited support to community health

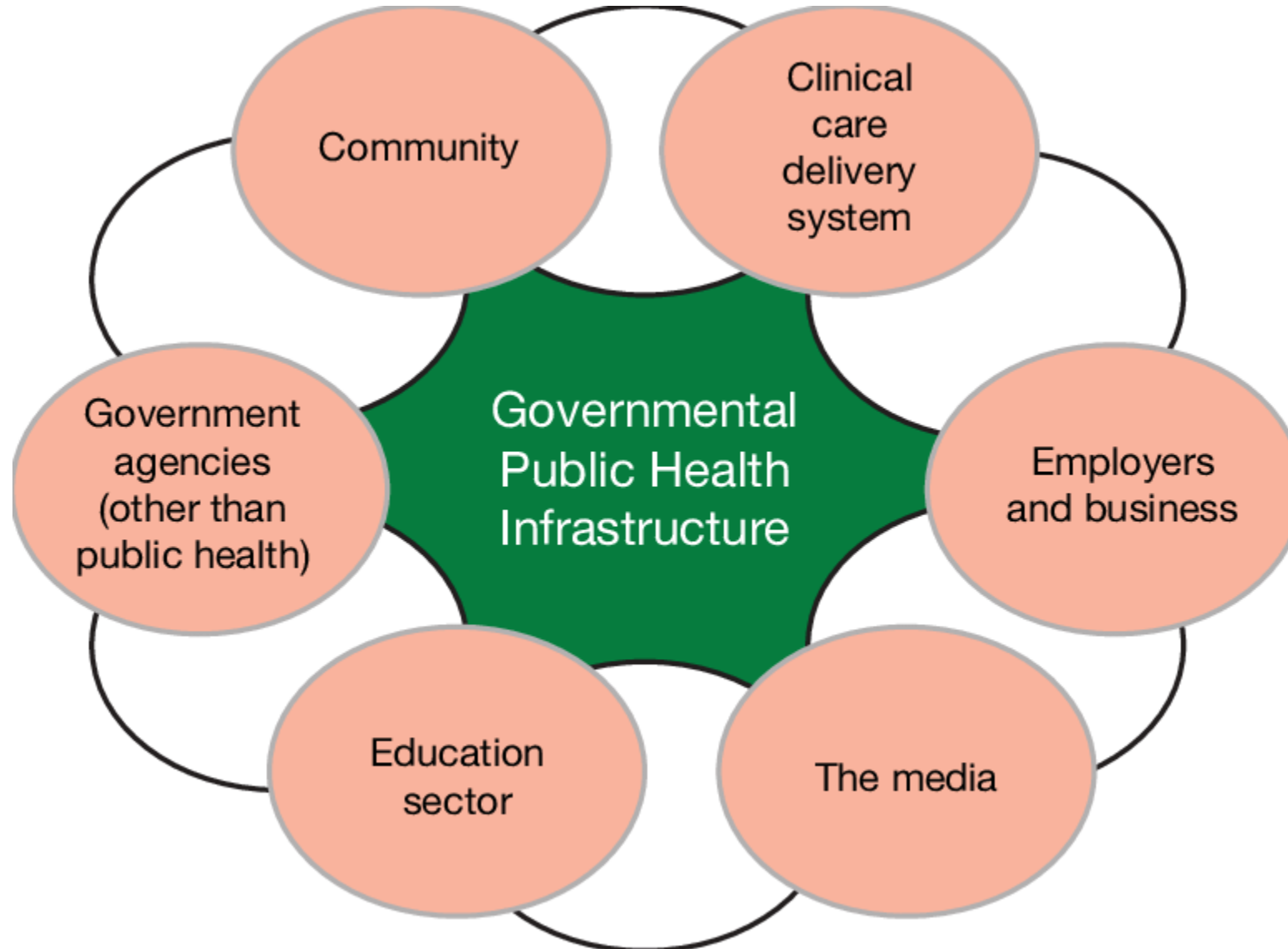
Lack of  
communication  
between the two!

## Public Health

- Focused on community
- Limited access to population individually
- Limited public visibility and understanding
- Data collection through survey
- Slow to innovate and adapt
- Lots of community interaction, limited funding

**Waste & inefficiency and Inequitable outcomes  
leads to  
Limited population health impact**

# Institute of Medicine (IOM) Population Health Model

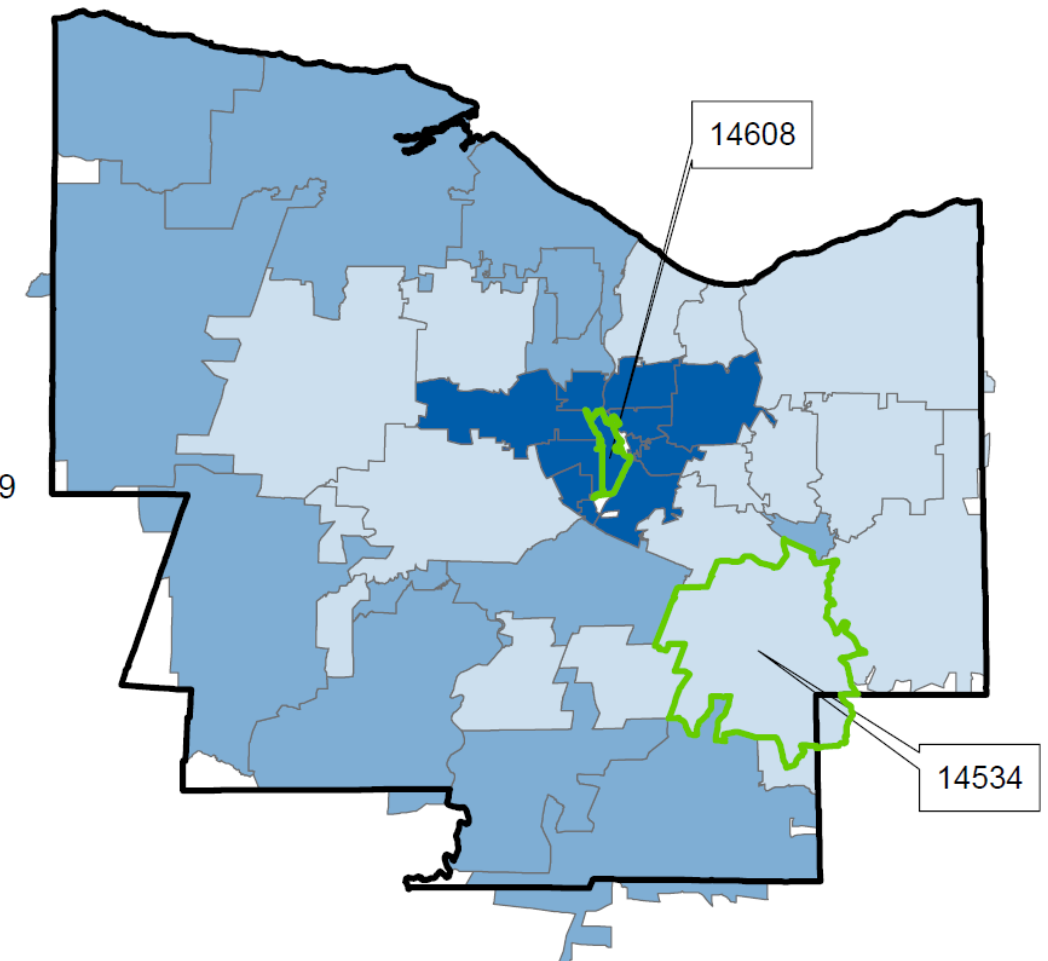
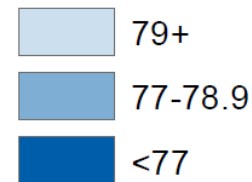


Population health is defined as the health outcomes of a group of individuals, **including the distribution of such outcomes within the group.**

## Life Expectancy by ZIP Code - Monroe County

As a resident of **Monroe County**, you can expect to live 78.2 years, but is that consistent throughout the county?

### Legend



**10 miles = 10 years of life**

*Monroe County Health Profile, 2017*

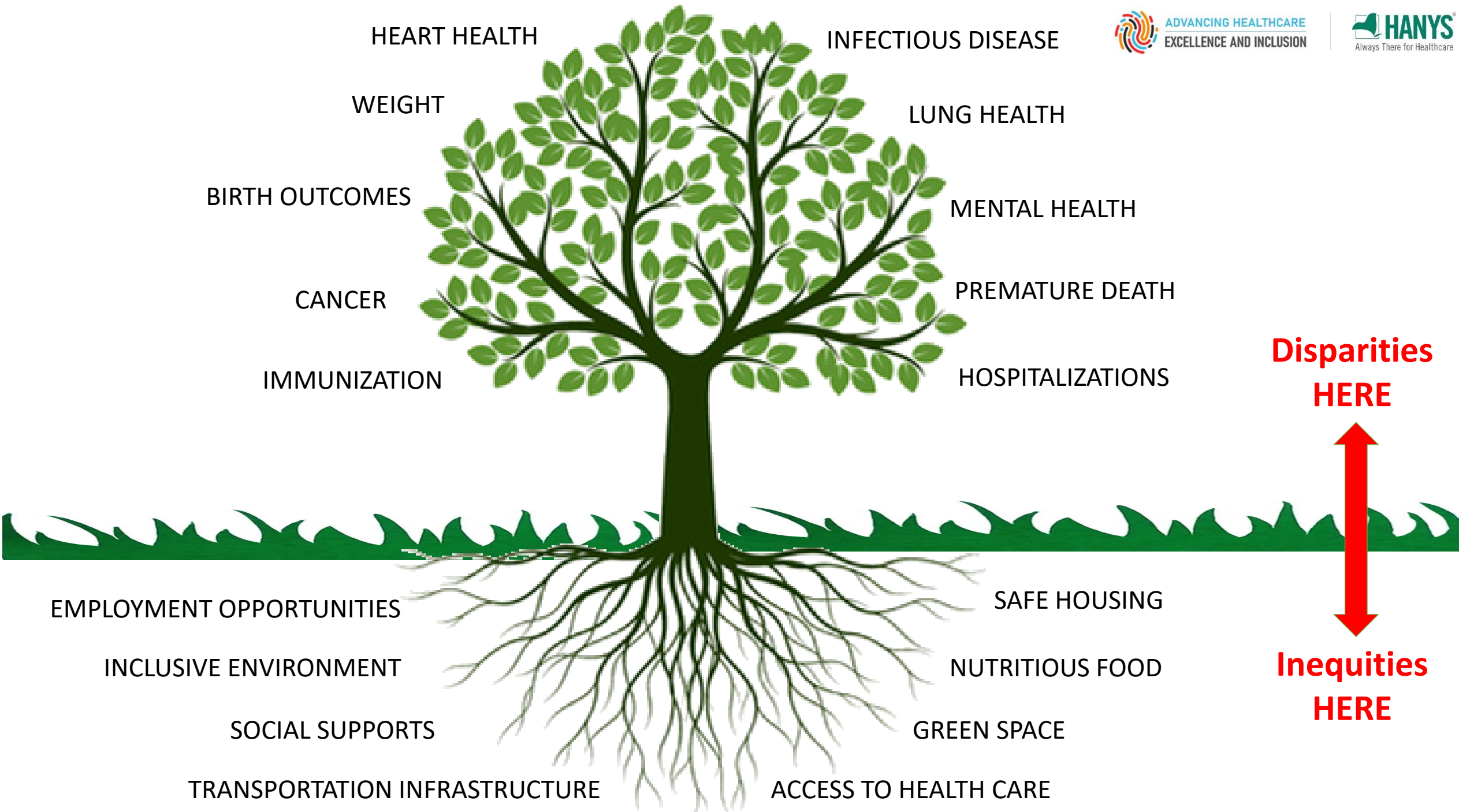
# Decrease the variation in health outcomes!

‘Health equity’ or ‘equity in health’ is the ideal that everyone has a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential.

‘Health disparity’ is avoidable, unfair, or remediable differences in health outcomes among groups of people,

- Can be due to differences in race, age, gender, social or economic status, geography or by any other means of stratification.





HEART HEALTH

INFECTIOUS DISEASE

WEIGHT

LUNG HEALTH

BIRTH OUTCOMES

MENTAL HEALTH

CANCER

PREMATURE DEATH

IMMUNIZATION

HOSPITALIZATIONS

EMPLOYMENT

SAFE HOUSING

INCLUSIVE ENVIRONMENT

NUTRITIOUS FOOD

SOCIAL SUPPORTS

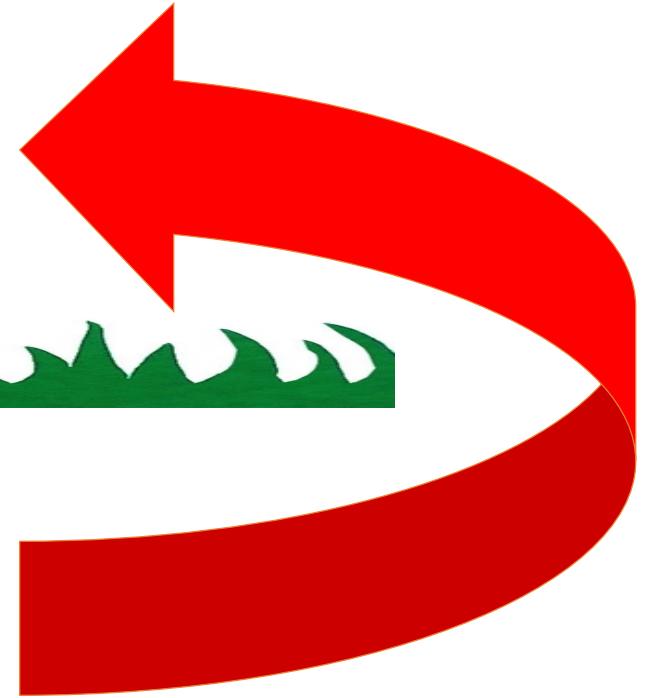
GREEN SPACE

TRANSPORTATION INFRASTRUCTURE

ACCESS TO HEALTH CARE

**STRATEGY:**

**Engage the community  
and community-based  
organizations in true  
partnership to address the  
ROOT causes of disparities**



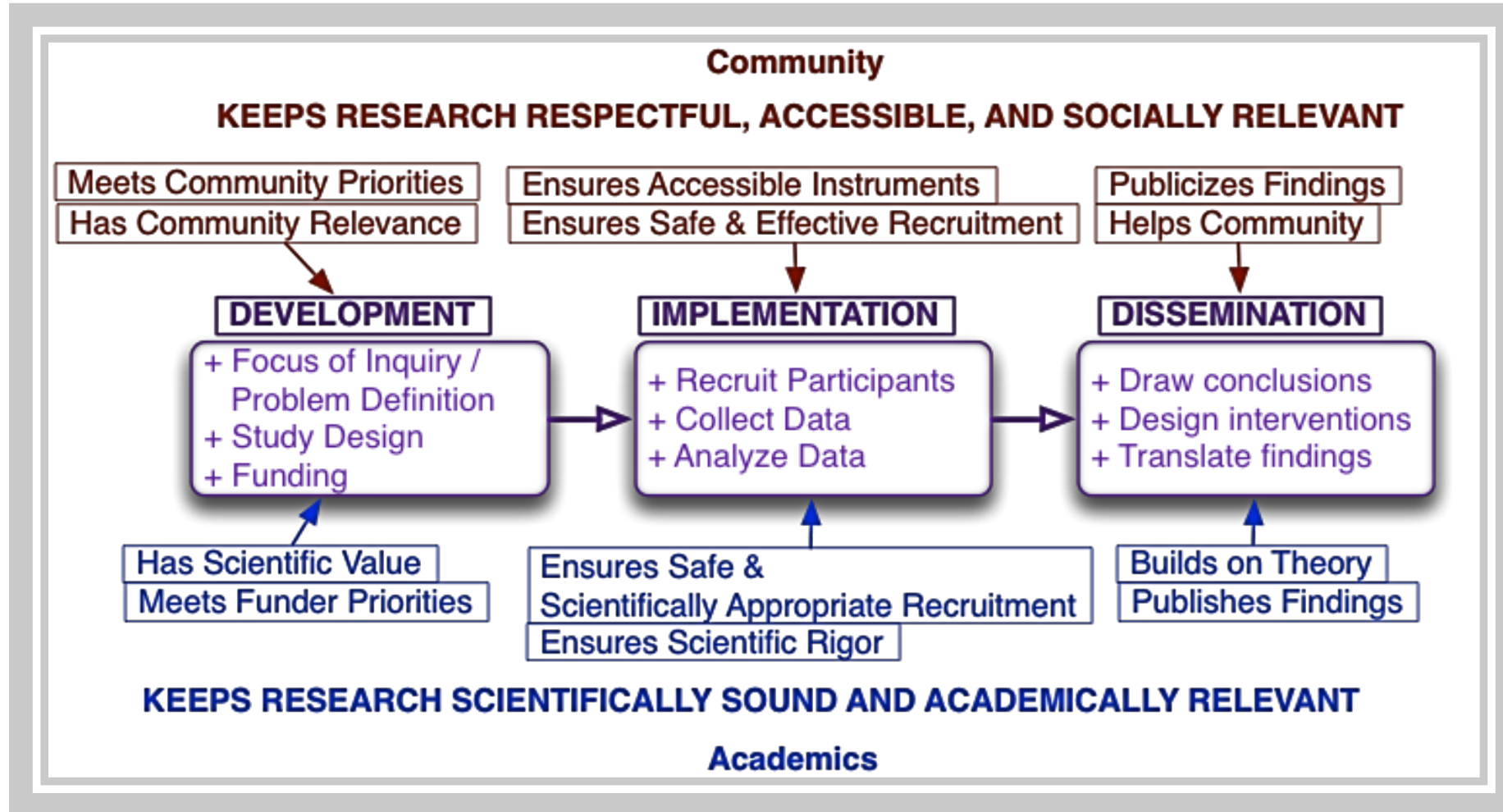
**Community engagement** is essential in addressing health equity and is defined as collaboration between institutions and the larger communities (local, regional/state, national, global) for the

GOAL!

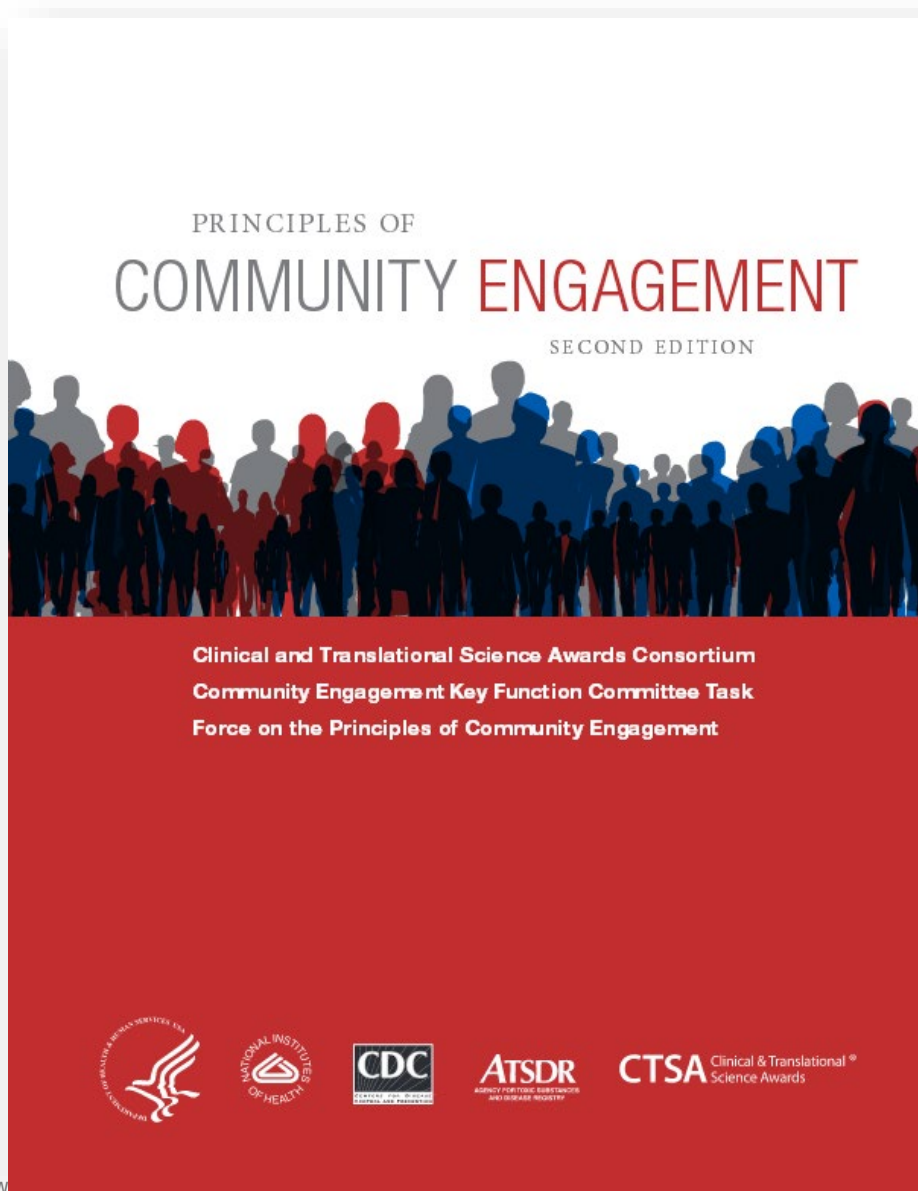
mutually beneficial exchange of knowledge and resources in a context of partnership and reciprocity.

Carnegie Foundation for the Advancement of Teaching. *The 2024 Elective Classification for Community Engagement*. <https://carnegieelectiveclassifications.org/the-2024-elective-classification-for-community-engagement/>. Published n.d. Accessed March 16, 2022.

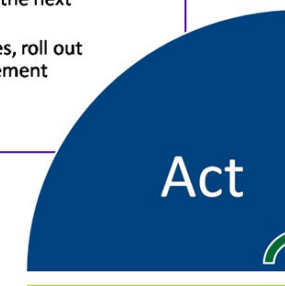
# Community Based Participatory Research



# Why Community Engagement?



- What changes need to be made to the next cycle?
- If no changes, roll out the improvement



“In general, the goals of community engagement are to **build trust, enlist new resources and allies, create better communication, and improve overall health outcomes** as successful projects evolve into lasting collaborations” (CDC, 1997; Shore, 2006; Wallerstein, 2002)

# Guiding Principles of Community-Engaged Research

**Long term engagement**

**Mutual benefit**

**Mutual respect**

**Shared findings**

**Enhanced community capacity**

**Shared responsibility**

**Evidence-based**

**Collaborative from start to finish**

**Responsive to community priorities  
and perspectives**

Developed by the University of Rochester  
Medical Center (URMC) Community Advisory  
Board, ***Approved September, 2008***

How do health systems effectively engage community to improve health and health equity?



# Opportunities for Community Engagement

1  
Shared  
Leadership

2  
Intentional  
Initiatives

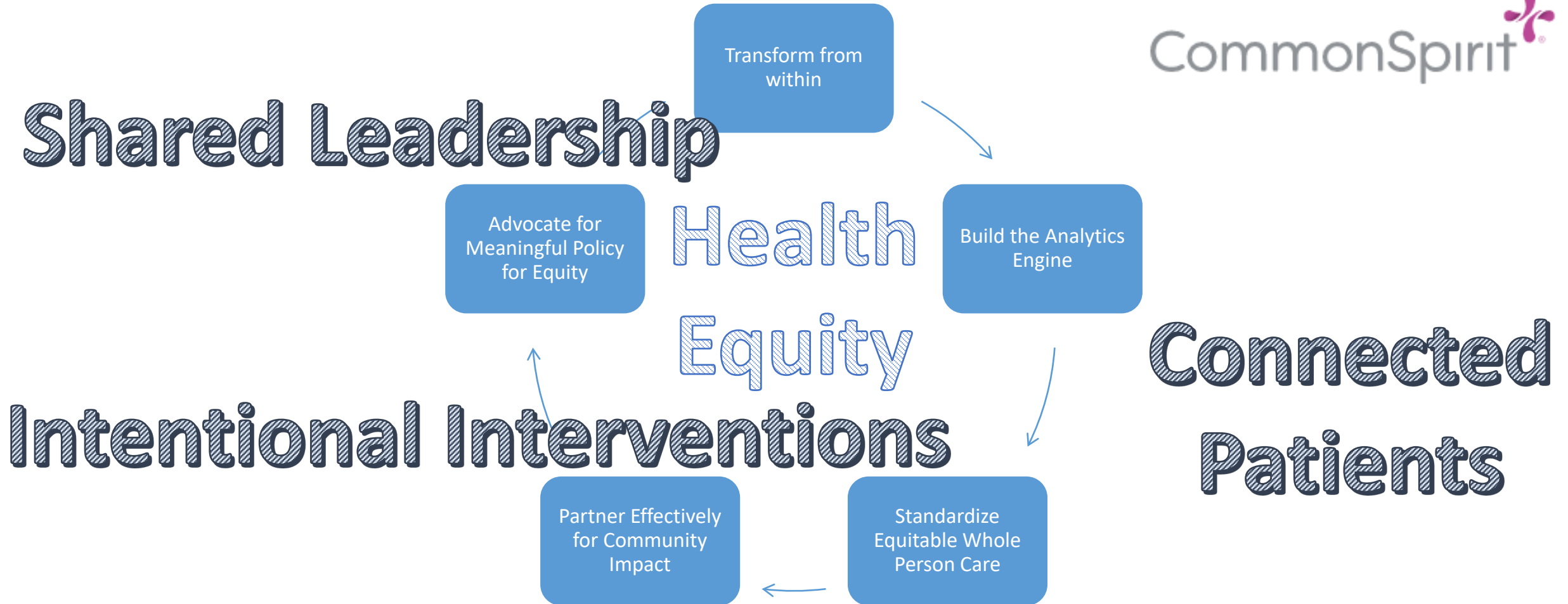
3  
Connected  
Patients

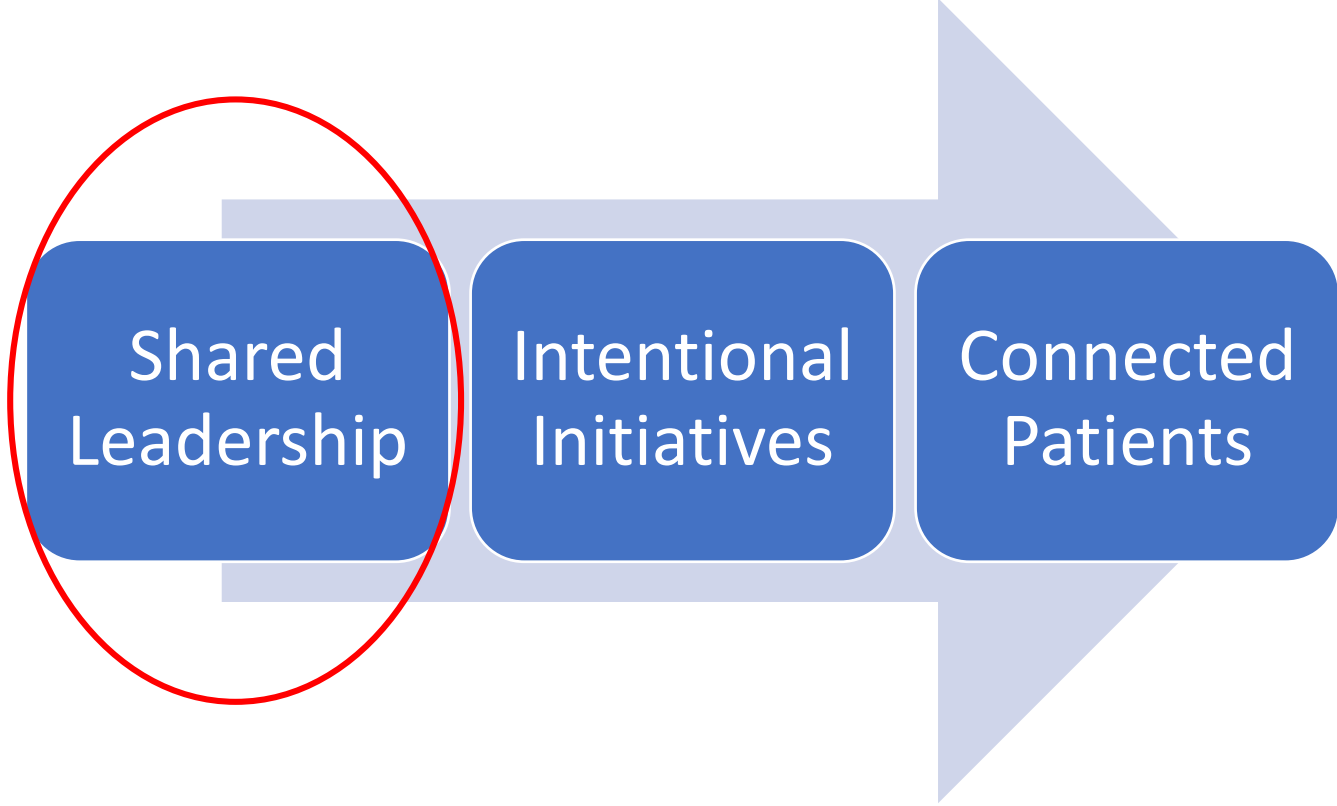


- Healthy patients
- Healthy communities
- Improved trust of the institution
- Decrease in health disparities
- Improved patient care
- More effective initiatives
- Better quality metrics
- Increased value reimbursement
- Etc., etc., etc.



# Health Equity Blueprint for Action

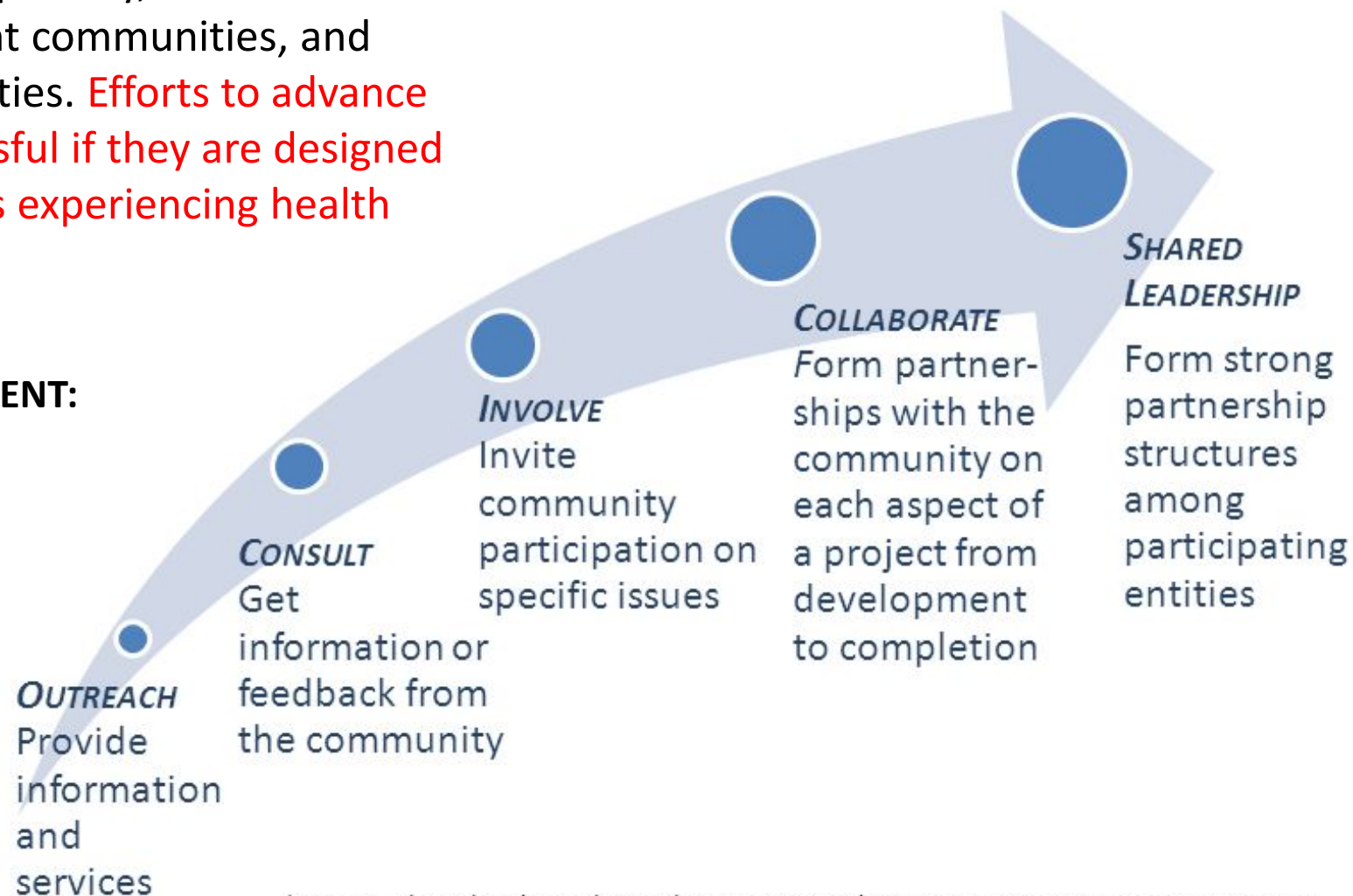




“To advance health equity, health systems must explicitly include and engage with those in poverty, communities of color, American Indians, immigrant communities, and others experiencing health inequities. **Efforts to advance health equity will be more successful if they are designed with (not simply for) communities experiencing health disparities.**”

**ADVANCE COMMUNITY ENGAGEMENT:**

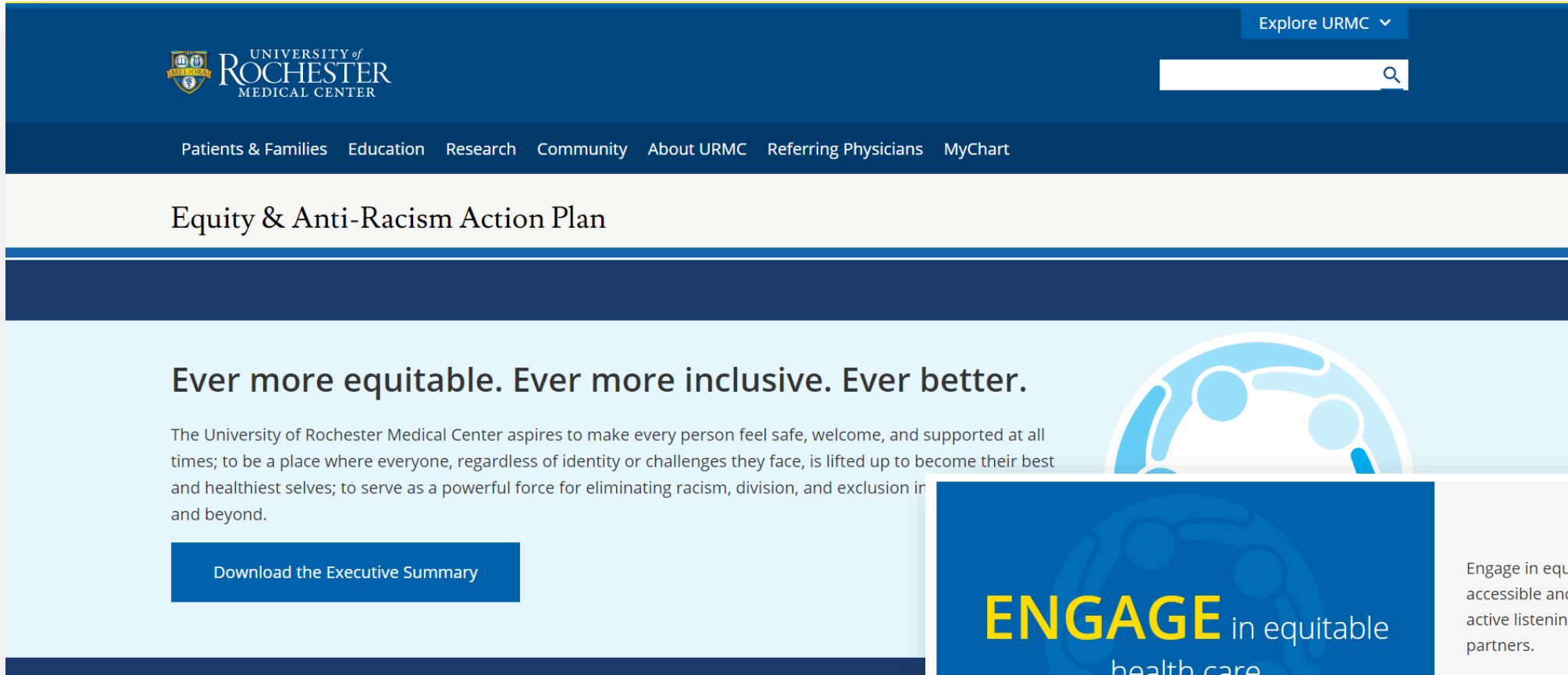
Engage community partners in leadership and decision making!



(Source: Clinical and Translational Sciences Awards Consortium Community Engagement Key Functions Committee Task Force on the Principles of Community Engagement, 2011.)

# URMC 2020-25 Equity and Anti-Racism Action Plan

- <https://www.urmc.rochester.edu/equity-antiracism-action-plan.aspx>



The screenshot shows the top portion of the URMC website. At the top left is the University of Rochester Medical Center logo. To the right is a navigation menu with 'Explore URMC' and a search bar. Below the navigation is a horizontal menu with links: 'Patients & Families', 'Education', 'Research', 'Community', 'About URMC', 'Referring Physicians', and 'MyChart'. The main heading is 'Equity & Anti-Racism Action Plan'. Below this is a large light blue banner with the text 'Ever more equitable. Ever more inclusive. Ever better.' and a paragraph describing the center's mission. A blue button labeled 'Download the Executive Summary' is positioned below the text. On the right side of the banner is a graphic of three stylized human figures holding hands in a circle.

## 5 GOALS

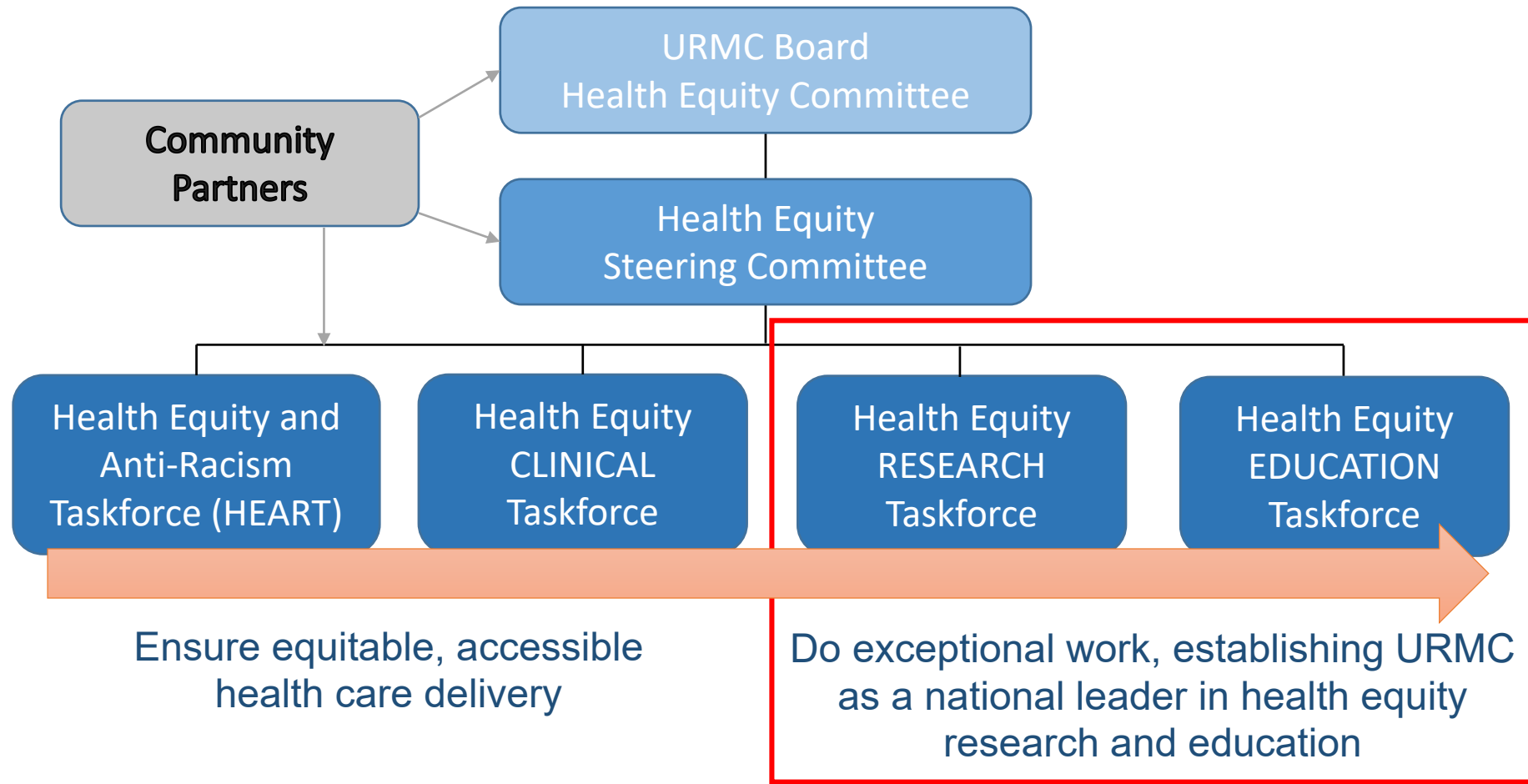
1. Build
2. Recruit
3. Nurture
4. Exemplify
5. Engage

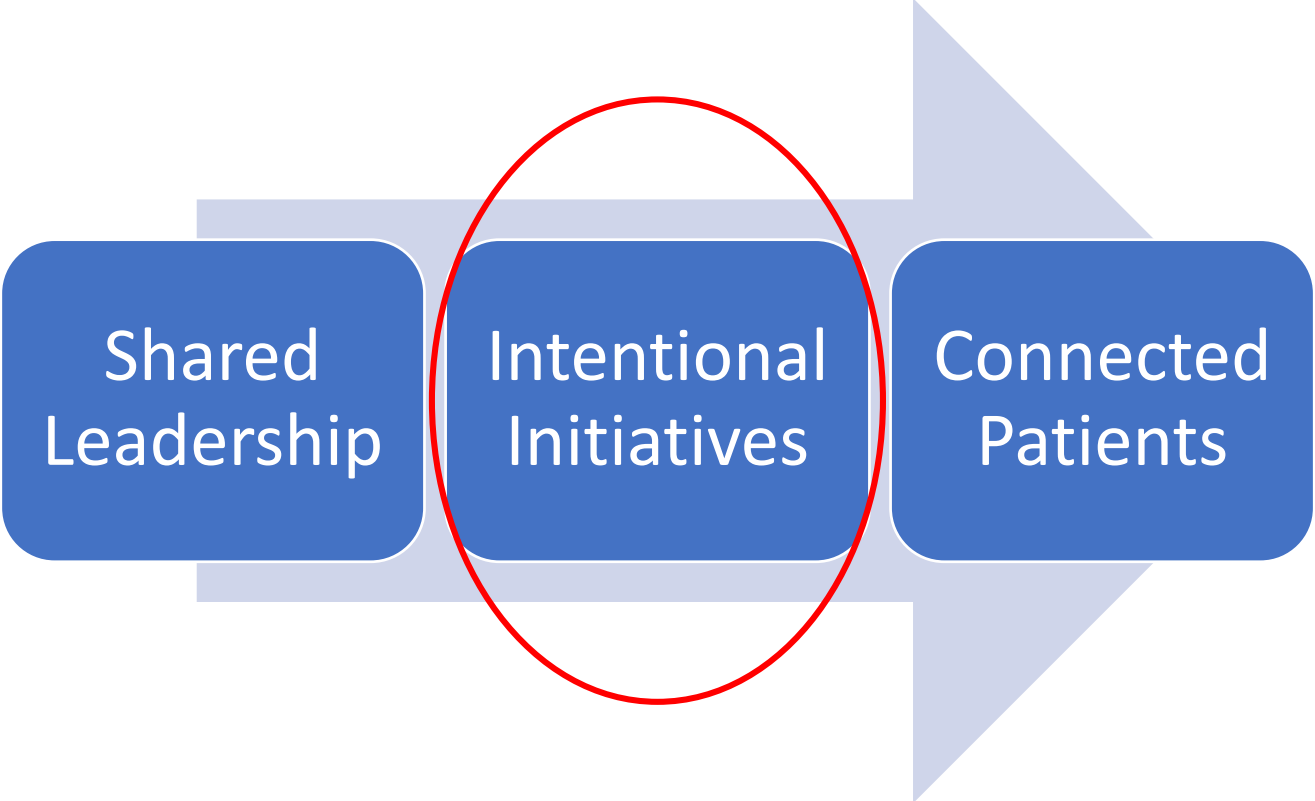
**ENGAGE** in equitable  
health care

Engage in equity as a health system by making care more accessible and reducing disparities through research, active listening, and collaboration with community partners.

[Learn More About Engaging in Equitable Health Care](#)

# EARAP Goal 5: Leadership Structure





# Health Equity Inventory – the start



AAMC.ORG | STUDENTS AND RESIDENTS SITE | CAREERS IN MEDICINE (CIM) | AAMC STORE



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

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

The AAMC is helping academic health centers achieve health and health care equity by building their capacity to create community health systems. These community health systems will strategically weave together institutional community health initiatives and partnerships with local organizations.

Medical schools and teaching hospitals are addressing health and health care inequities across their research, education, and clinical missions, but these efforts aren't always coordinated across the institution. In the absence of coordination (and formal evaluation), community health initiatives are not as efficient or effective as they could be. A lack of coordination also makes it difficult to build the

The URMC focused work on building health equity systems in 2017 through a AAMC competitive grant process.

We worked with

- *Eastern Virginia Medical School*
- *Florida International University, Herbert Wertheim College of Med*
- *MedStar Health*
- *U of Mississippi Medical Center*
- *Vanderbilt University Medical Center*
- *University of Florida*
- *Western Michigan University Homer Stryker M.D. School of Medicine*



# Health Equity Inventory – Next steps!



AAMC | Center For Health Justice

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NEWS

## Getting the House in Order

March 1, 2022

The Health Equity Inventory: A New Way to Work Together for Community Health Equity



Imagine that your neighborhood has few options for residents to purchase fresh, healthy foods. Now imagine that you run a food bank, and your clients and staff want to start a community garden to expand those options. What would you need to know to get started? The names of organizations in your community that have funding to support work on food justice would be a good place to start. You could find out about

**The URMC was selected to pilot the Health Equity Inventory Tool to begin to take community engagement to the next level.**

Working with:

- **Eastern Virginia Medical School**
- **Oregon Health & Science University**
- **University of California, San Francisco**
- **University of Rochester**
- **Vanderbilt University Medical Center**



# Health Equity Inventory Tool

a new, cloud-based coordination tool to help institutions and community organizations communicate with each other about their health equity work, initiate new partnerships and improve existing effective partnerships.

		External Partners	
School/Department/Program	Internal Contact	Organization	Contact
		FLPPS	Katherine Rogala
Community Benefits	Theresa	Systems Integration	
School of Nursing	Mitchell	Common Ground Health	
Medical Center	Ann	RCSD/East	
Hoekelman Center	Kelly	Foodlink	
Center for Community Engagement	Glenn	MCDPH	
Clinical and Translational Science Institute	Karen	Lifespan of Greater Rochester	
Office of Government and Community Relations	Clayton	Children's Institute	
Health Equity Program Support Office	Wendy	2.1.1	Jordan Marsh
Office of Equity and Inclusion	Adrie	St. Josephs Neighborhood Center	Jennifer Sahrle
URMC Faculty Group	Erik	Catholic Family Center	Lori VanAuken
Social work office	Kelly		
Center for Community Health & Prevention	Laura	Sugarwala	
Quality Institute	Irena	Boyce	



***Gathering input to jointly BUILD the tool!***



UNIVERSITY of  
**ROCHESTER**  
MEDICAL CENTER



**Health Equity Inventory**

Please complete the survey below.

Thank you!

**Initiatives**

<b>Initiative Name</b> <small>* must provide value</small>	<input type="text"/> <small>Title of Activity</small>
<b>Initiative Domain</b> <small>* must provide value</small>	<input type="text"/> <small>Primary Domain in Which Initiative is Housed</small>
<b>Initiative Type</b> <small>* must provide value</small>	<input type="text"/> <small>Type of Initiative</small>
<b>Broad Focus Area (primary)</b> <small>* must provide value</small>	<input type="text"/> <small>Main health outcome of the condition the initiative targets</small>
<b>Broad Focus Areas (secondary) [optional]:</b> <small>(Check all that apply)</small>	<input type="checkbox"/> Access to Medical Care <input type="checkbox"/> Anti-racism <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> COVID-19 <input type="checkbox"/> Crime / Criminal Justice <input type="checkbox"/> ...

- Reports of initiatives for URMC and partners
- Transparency and data sharing for all
- Opportunities to identify partnerships and synergies
- Opportunities to identify underserved populations and geographies
- Better coordination internally and with partners
- Build on existing partnerships to deepen engagement

**Health Equity Inventory = tool for deeper engagement**

# Health Equity Education Video

Purpose: To introduce viewers to the Rochester community focusing on the abundant resources, but also on the inequitable distribution of those resources based on race and socioeconomic status

Audience: Primarily graduate medical students (residents), but also undergraduate medical students, graduate students, nursing students and potentially new faculty and staff. Small bites of the video should be appropriate for use by the Office of Equity and Inclusion to demonstrated the intent of the Equity and Anti-Racism Action Plan

Length of the Video: 10-20 minutes is anticipated, with smaller sound bites for social media

# Video Interviews with...

Linda Clark (Physician, Common Ground Health, Black Physicians Network)

Wade Norwood (CEO Common Ground Health, resident, pastor)

Telva Olivares (Physician, lead of Health Equity Task Force)

Michael Mendoza (Physician, Commissioner MCDPH)

Adrienne Morgan (VP Office of Equity and Inclusion, EARAP)

Andy Carey (Social Worker with URMC Street Outreach and REACH)

Mitch Gruber (Foodlink)

Shawn Nelms (Superintendent at EAST, Warner)

Jodi Cook (Teacher in science health pathway at EAST)

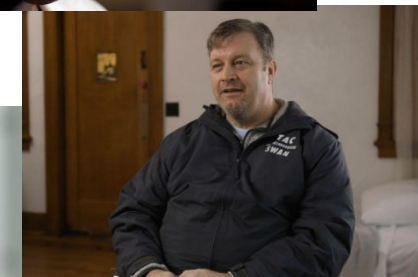
Malik Evans (Mayor Elect Rochester)

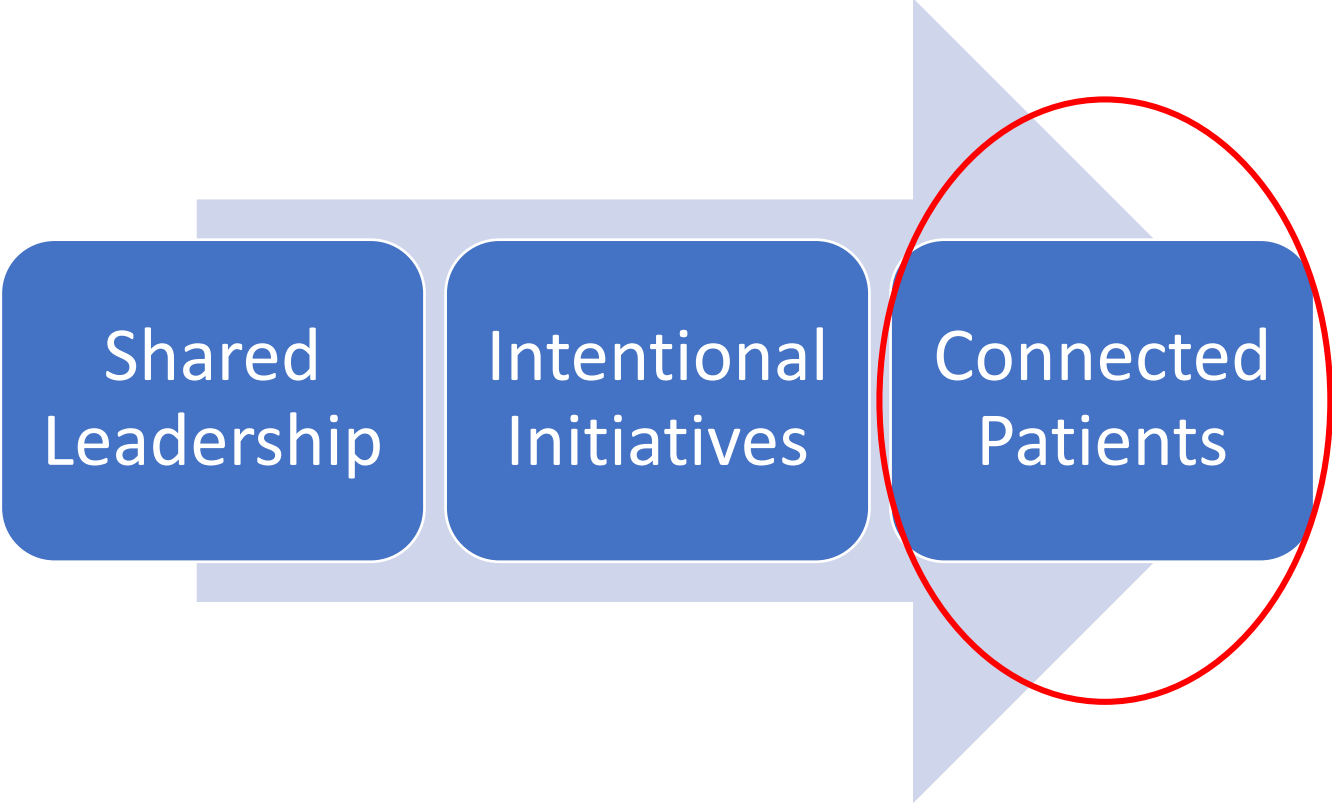
Luis Rosario-McCabe (School of Nursing, LGBTQ)

Angelica Perez (Ibero)

Seanelle Hawkins, EdD (President and CEO Urban League)

Kelly Mathews (National Center for Deaf Health Research)

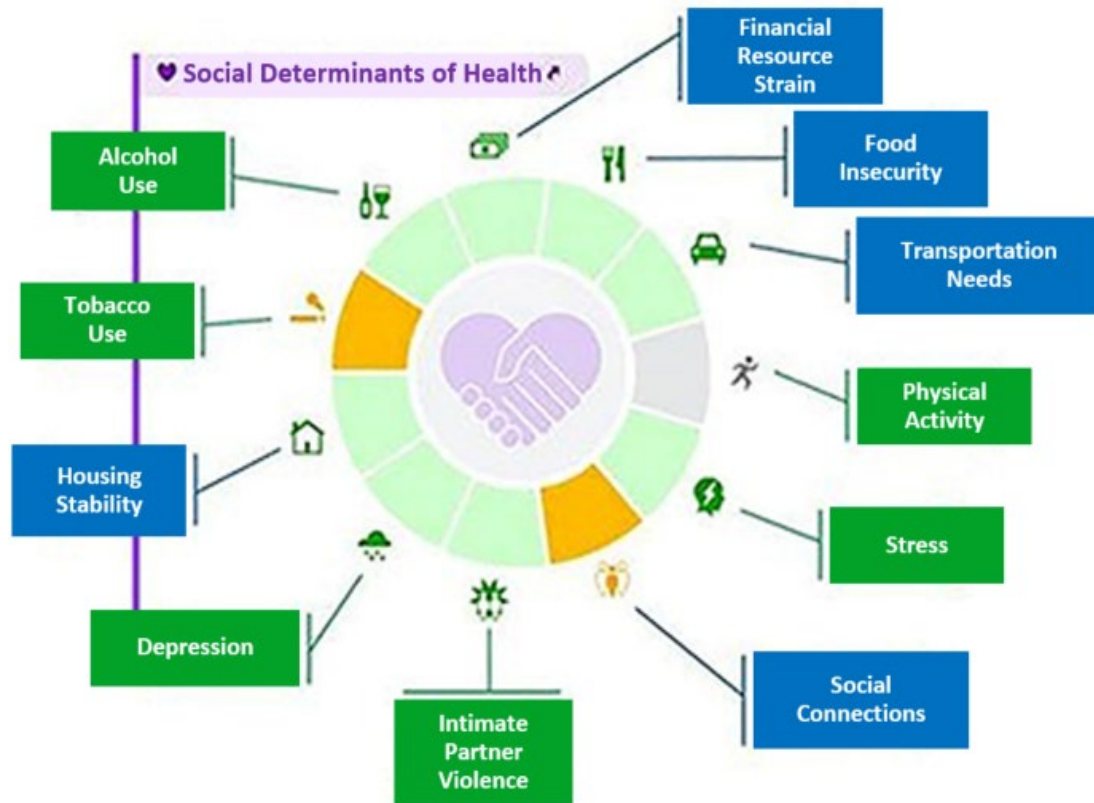






# Collecting social determinant of health information

## EPIC SDOH Wheel



Use existing tools in the EMR. For URMC that means EPIC

### EPICs Social Determinants of Health Wheel

1. Financial resource strain
2. Food insecurity
3. transportation needs
4. Physical activity
5. Stress
6. Social connections
7. Intimate partner violence
8. Depression
9. Housing Stability
10. Tobacco use
11. Alcohol use

URMC focused on three areas that we weren't collecting information for already: finance, food, transportation

# System Change: Housing



## **DePaul Hopelink at Shelter Cove**

a Short-Stay (10 bed) Residence, is a partnership between DePaul Community Services and Strong Memorial Hospital. This provides a unique residential alternative upon discharge from the hospital.



Sanctuary House



Francis Center

**Catholic Family Center (CFC)** and Strong and Highland Hospitals have partnered to provide homeless individuals with temporary transitional supportive housing (20 beds) after being discharged from the hospital.



# System Change: Food

We had the ability to screen for food insecurity, but we were missing a community partnership and workflow to help us **immediately** connect patients in **urgent need** to nutritious and affordable food options **on-site**.



The Department of Social Work and Patient & Family Services, the Health Equity Program Support Office (HEPSO), and Food and Nutrition have forged a partnership with FoodLink to operationalize food pantry pilots. The partnership includes piloting a referral-based, emergency food pantry for patients identified as food insecure at an appointment or during their hospital stay.



# System Change: Food



Patients here for a Primary Care Visit



Provider Screens for Food Insecurity during visit and creates a referral order in the Electronic Medical Record



Patient receives a printed voucher



Patient goes to patient discharge to pick up their bag(s)



Patient survey included in bags



# AHA Health Equity Roadmap: <https://equity.aha.org/>

## The Six Levers of Transformation

Research and experience show that leading health equity strategies cut across six levers of transformation within health care organizational structures. Explore and learn what's needed to build internal capacity to improve performance and advance on the equity journey.

[Download Our Literature Review](#)



**Culturally Appropriate Patient Care**



**Equitable and Inclusive Organizational Policies**

Collect



**Diverse Representation in Leadership and Governance**



**Community Collaboration for Solutions**

**Systemic and Shared Accountability**



**IFDHE**  
AHA Institute for Diversity and Health Equity

The Health Equity Roadmap

The Six Levers of Transformation

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## Community Collaboration for Solutions



Advancing health equity and fostering healthy communities by investing in strong hospital-community partnerships.

The Community Collaboration for Solutions Lever Includes:

**Understanding Your Community**

[Explore More](#)

**Strengthening Community Partnerships**

[Explore More](#)

**Investing in Your Community**

[Explore More](#)



# Community Engagement in Research and Population Health



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## Community Engagement in Research and Population Health



Theresa Green

Enroll for Free

Starts Sep 8

Financial aid available

Offered By



About Instructors **Syllabus** Enrollment Options FAQ

Creating change requires an understanding of population health data. We will begin this section by reviewing data resources, including resources for mapping data to create a visual representation of population health outcomes. We will also discuss some of the ways this data is collected by reviewing public health surveys and common data collection tools. Improving the health system often involves implementing interventions, and just like in medicine, public health interventions should be evidence-based. We will review some resources for evidence-based community health interventions and discuss ways to evaluate and disseminate results that are useful to community members.



8 videos (Total 41 min), 10 readings, 3 quizzes [See All](#)

WEEK

3



4 hours to complete

### COMMUNITY ENGAGED HEALTH SYSTEMS

Engaging the community is important in changing the paradigm and working to improve the US health system as a whole. In this section, we will explore ways in which health care delivery systems are engaging community and addressing community health. This community engagement is federally mandated for non-profit hospitals and health systems through community benefit reporting and community health needs assessments and improvement plans. In addition, the movement towards value based medicine has really motivated health systems to think beyond the walls of the hospital to explore the population's health.



4 videos (Total 22 min), 7 readings, 1 quiz [See All](#)

WEEK

4



6 hours to complete

### EFFECTIVE COMMUNITY ENGAGEMENT

In this section, we will define community-engaged research and apply the principles of effective community engagement to research as well as interventions. Community Engagement takes many forms, some much more reciprocal and collaborative than others. In this interactive discussion, our speakers will discuss the benefits of effective community engagement as well as barriers that are common, and suggestions for alleviating those challenges.



9 videos (Total 82 min), 7 readings, 4 quizzes [See All](#)

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### About this Course

Welcome to the Community Engagement in Population Health course! As you The current system is not sustainable with escalating costs, mediocre health o discuss the current system, including definitions of population health and soci countries on the triple aim -lower cost, better care, and a healthier population and evidence-based public health interventions. Now more than ever, hospita spending, community health improvement planning, and problem-based rese community engagement in practical terms with a discussion of benefits and b an effective way to engage the community in developing solutions to address

# Resources

- [Principles of Community Engagement](#) – CDC
- [Social Determinants of Health: Know What Affects Health](#) – CDC
- [Spectrum of Public Participation](#) - International Association for Public Participation
- [Community Health and Equity Resources](#) – American Hospital Association

# Thank you!

Theresa\_Green@URMC.Rochester.edu

# Upcoming sessions

**Friday, September 16, 10:00 – 11:00 a.m.**

## ***Session 2: Identifying Community Partners and Building the Team for Health Equity***

Community coalitions provide a forum to establish shared priorities, discuss inequities and propose collaborative solutions. This session will focus on strategies to identify and engage potential partners.

**Friday, September 30, 10:00 – 11:00 a.m.**

## ***Session 3: Sustaining Strong Coalitions and Measuring Success***

It is important to measure the impact of your coalition. This session will address how to sustain a coalition, use data to track progress, and how to measure the success of the coalition.





**ADVANCING HEALTHCARE**  
**EXCELLENCE AND INCLUSION**

# Questions?

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