

## Community Health Care Report

NAME OF ORGANIZATION: Equal Hope  
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MISSION OF THE ORGANIZATION:

Equal Hope's mission is to save women's lives by eliminating health disparities in Illinois. Equal Hope helps women without private insurance navigate through the complex health issues and also helps publicly insured women access high quality healthcare. We address women's health holistically with the goal of eliminating inequities in prevention, screening, diagnosis, treatment, and survivorship for women.

1. Identify the high risk/underserved and/or disadvantaged populations in the community(ies) that you serve and describe specifically the actions you have taken, based on relevant assessment data, to increase their accessibility to health services.

Equal Hope began its life as the Metropolitan Chicago Breast Cancer Task Force focused exclusively on disparities in breast cancer mortality rates for African American women in Chicago. At the time of our inception (2008), African American women were 62% more likely to die from a breast cancer diagnosis than comparable white women. As a result of this dramatic disparity, Chicago's communities on the South and West sides came together to address this inequity, and the Task Force was born. The communities with the highest breast cancer mortality rates today include: Oakland, Fuller Park, Washington Park, East and West Garfield Park, West Englewood, S. Chicago, Kenwood and Auburn Gresham (Chicago Health Atlas data for 2017).

A key driver of this disparity was found to be unequal access to quality mammography. Prior research by Equal Hope has found widespread variation in mammography quality across Metropolitan Chicago, and determined that the potential "miss rate" for detecting breast cancer by mammography is significantly higher for poor women, publicly insured women and women with less education. Additionally, resources associated with best outcomes are unevenly distributed across Chicago, with affluent women having a nearly 40 percent chance of being proximal to a Breast Imaging Center of Excellence where poor women have only a 1 percent chance of being proximal to such a center.

Ten years after we started our work, Drs. Blasé Polite, Adam Gluck and Otis Brawley published an article in the Journal of the American Medical Association (JAMA) recognizing the Metropolitan Chicago Breast Cancer Task Force's leadership role in moving Chicago from one of the worst cities in the country regarding breast cancer mortality rates for African American women to one of the most improved cities. The death gap between Black and White women in Chicago had been lowered from a 62% death gap to a 39% gap (Sighoko et al 2017).

Building upon our breast cancer racial disparities work, Equal Hope launched a new cervical cancer eradication program in 2019 at the behest of a group of physicians who were seeing far too many late stage cervical cancers even though cervical cancer is almost 100% preventable. In the case of cervical cancer both Latina and African American women have a rate 3 times higher than White women in Chicago and the areas affected include the areas mentioned above and many of the predominantly Hispanic community areas in Chicago such as Humboldt Park, East Side, Hegewisch, and New City (Chicago Health Atlas data for 2013-2017).

In light of the pandemic and the disproportionate impact it is having across the South and West side communities that we serve, Equal Hope has turned its attention to the urgent need of primary, preventative care. With over 80% of our clients claiming to have no relationship with a Primary Care Physician, what is commonly called a Medical Home, Equal Hope seeks to bring its successful healthcare navigation model developed for breast and cervical cancer care to the issue of primary, preventative care. The COVID-19 pandemic has created hardship, uncertainty and social challenges for Black and Hispanic communities. As infectious diseases like COVID-19 lay bare the racial inequities in communities throughout Metro Chicago, it has become apparent to Equal Hope that many residents lack a medical home/regular doctor or other healthcare provider and this deficit puts them at increased risk for undiagnosed and untreated illnesses. These illnesses in combination with COVID 19 can be deadly. Federal data has shown that African American and Latinx communities are three times more likely to contract the virus and two times more likely to die from Coronavirus than comparable white communities.

2. Describe specifically the strategies you have used to gather input from high risk, underserved and/or disadvantaged population and their leaders as a basis for program or service development.

Our organization was founded after a community call to action to address unjust health disparities in women's healthcare. Before we can recommend changes to the system, we believed we need to fully understand how the system operated and why it put so many people in jeopardy. This effort took nearly four years of study, spawned by the healthcare providers who were alarmed by the data, but soon became a community wide movement of healthcare providers, social workers, community activists and community members themselves. As was mentioned above, given the widespread variations in quality of care across the continuum, and the social barriers that put many poor women into untenable positions, Equal Hope developed the community based healthcare navigators model to help our clients overcome the systemic barriers causing such significant disparities.

Since we opened our doors, we have reported back to the community in October or early November. This event is now known as "Hope in Action" and it has grown to be an

event with 700+ attendees. We survey attendees on how well they enjoyed the event and what we can do to improve it. For 2020/2021, it will be a virtual event.

While the first five years of our work concentrated on health services research, quality data collection and analysis to understand the healthcare system serving women of color and where barriers to optimal healthcare might lie, we also engage in outreach and education. We thus are in constant contact with community members. Since 2012, Equal Hope has provided direct services to Chicago's most impoverished neighborhoods and those with the highest cancer mortality rates. We have formed an advocacy council with community members from our service area. Thus, the community's voice is deeply embedded in the DNA of our organization and all of our services are designed and tailored to specifically meet community needs.

Over the past four years, we have deployed a variety of consumer surveys and also held several focus groups to better understand the client's experience with Chicagoland's healthcare system. This year we are deploying a patient satisfaction survey that will ask questions regarding unmet healthcare needs.

In summary, we take a multipronged approach to involving community members and our clients in our decision-making regarding program design and interventions that will be the most helpful to the community.

3. Describe specific partnerships with other providers and community-based organizations to promote continuity of health care for high risk/underserved and/or disadvantaged populations.

Partnership and collaboration is a core value of Equal Hope. Equal Hope has developed partnerships with various federally qualified health centers, including Chicago Family Health Center, Esperanza Health Center, Family Christian Health Center, Howard Brown Health, Mile Square Health Center and Lawndale Christian Health Center, free clinic CommunityHealth and women's health provider Planned Parenthood. These partners have entered into memorandum of understandings whereby Equal Hope will send them new clients who currently do not have a regular place of primary care. A major barrier that uninsured populations face in establishing care comes from Medicaid's "free care rule." This rule requires Medicaid providers to avoid providing for free anything they would bill Medicaid for. Therefore, a sliding scale fee is necessary for all visits including establishment and well visits. Low-income individuals find it hard to afford such a fee for a well visit. Equal Hope pays for the establishment visit at these partner locations so that clients can establish a relationship with these facilities and get underlying chronic illnesses assessed.

Equal Hope also has an active referral network of partners made up of community and faith-based organizations serving Chicago's underserved communities in Cook County for education, outreach/awareness and medical home referrals. Through medical home partnerships, Equal Hope formed a Community Health committee with partner primary care providers. This committee is creating a reporting tool so that Equal Hope can receive a report back from the medical homes on health issues detected at the establishment visit that navigators may help the client with. For instance, nutrition

counseling or physical activity might be advised and Equal Hope navigators would look for resources for clients identified with such needs.

4. Provide two examples of how you have used the community-oriented approach to program development specified in the attached principles to develop a program of service for high risk/underserved and/or disadvantaged populations specified in the guidelines. Include in each description components of the current program and the following quantitative information for the most recent year available:

Equal Hope's medical homes project was developed using several community-oriented approaches, first through a community needs assessment and secondly through community engagement. After a decade of providing breast preventative health services to low-income communities and more recently expanded to other women's cancers, Equal Hope conducted a community needs assessment and found that navigating women to preventive screenings was only half of the battle. Equal Hope found that over 80% of clients did not have a medical home or regular access to care. These clients were entirely disconnected from the healthcare system except for the services they received through Equal Hope. 60% of Equal Hope clients are uninsured and of those who are insured, 75% are on Medicaid. Those on Medicaid are assigned a medical home but many are unaware of the assignment and are not utilizing their designated medical home.

Through these efforts, Equal Hope identified a lack of a medical home as a significant issue for many Black and Hispanic Chicagoans. Lack of a regular place for healthcare puts a person at increased risk for undiagnosed and untreated illness. Medical homes have been shown to decrease health disparities in low socioeconomic groups through increased preventative care services and reduced emergency room utilization (Reibling, 2016). Having a relationship with a primary care provider is one of the key factors in addressing an individual's underlying health conditions. Additionally, given the social determinants of health and the conditions that many Chicagoans of color live in, the incidence of many chronic diseases is higher for people of color. Thus the very people who need a medical home are the least likely to have one. The medical home program educates Chicagoans on the benefits of having a medical home and gives them the means to establish one.

Community engagement is another community-oriented approach utilized to develop and sustain the medical homes project. Equal Hope also developed a survey to ask both our clients who do not have a medical home but are regular seekers of care and others outside of the program who may not be regular seekers of preventive healthcare as to what are their barriers to establishing a medical home. This information helps modify the program as necessary to address any additional unmet needs of the community.

**Medical Homes Project:** Staff canvas neighborhoods and visit venues where community members with fewer resources are present such as the Night Ministry, food pantries, laundromats, and faith-based organizations and educate communities on the importance of having a medical home. Outreach activities include social media promotion, radio, TV and dissemination by other social service agencies. Equal Hope places flyers/pluggers in essential places of business, churches, libraries, community

centers, health facilities; direct email; as well as one-on-one interactions with current and former clients. With COVID 19, these activities have been modified and we are providing education and outreach through virtual platforms like Zoom, Facebook, Twitter, and Instagram. Equal Hope is also creating and disseminating various new Public Service Announcements (PSAs) to promote this project through radio, television, and social media.

EH has developed partnerships with a variety of federally qualified health centers, free clinics and Planned Parenthood to establish medical home placements for uninsured women and men. Equal Hope navigates Chicagoans to a medical home and pays for the establishment visit and, thus removing financial barriers for uninsured individuals. Individuals find Equal Hope through our outreach, social media, internet searches and advertising. Clients sign intake forms and navigators contact our partner health facilities to schedule clients for establishment visits and conduct appointment reminders. Navigators ensure clients have all the required documents needed to establish care at a medical home. If a client receives a referral for a cervical screen, mammogram, or another preventative health screen the navigator reaches back to the client to get them scheduled for follow up.

5. Number of clients served

Since 2012, Equal Hope has run the largest multi-institutional outreach/navigation program in Metro Chicago. Last year Equal Hope reached 23,803 individuals, educated 9,428, and navigated 1,051 to preventative health screenings within the disadvantaged communities in the Chicagoland area.

6. Total amount budgeted by your organization for the program **\$134,782**
7. Percent that program budget is of total agency budget **12%**
8. Percent of program budget that is directly reimbursed by third party payers **0%**
9. Percent of program budget that is covered by public/private grants **59%**

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