EXECUTIVE INSIGHTS

RESILIENCY + RECOVERY

ADDRESSING HEALTH DISPARITIES THROUGH INNOVATIVE PARTNERSHIPS

Cooperative cross-sector collaboration

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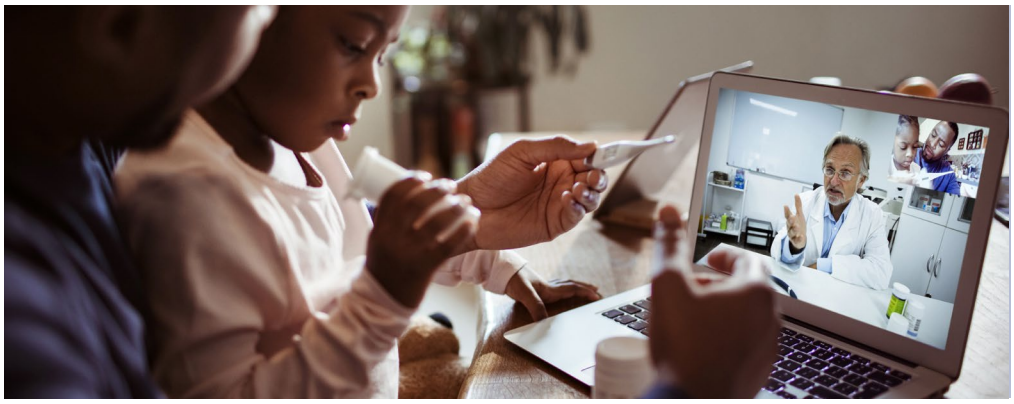

The COVID-19 pandemic brought to the forefront health inequities and further highlighted how societal factors influence health. The uneven distribution of access to care and its delivery has created health disparities across racial, ethnic, gender and socio-economic lines. The data make it clear — understanding and addressing societal factors are necessary to meet the needs of communities and/or individuals facing inequity, including communities of color. Solving this problem requires engagement and action between the health care field and community stakeholders. This virtual executive dialogue convened hospital executives across the country to discuss how health equity can progress through collaboration and partnerships.

KEY FINDINGS

1. **Analyzing HCAHPS scores and other data** can reveal opportunities for change, although some leaders struggle to navigate a large volume of disparate analytics.
2. Leaders should focus on both **local factors and the social determinants** that drive populations to hospitals.
3. Before initiating new programs to address health disparities, a health care organization should **first evaluate its community** for potential partnerships.
4. Health care organizations are aware of the need to **address systemic biases inside their own systems** to better serve their patients and communities.
5. Partnering with outside vendors can help leaders i**dentify provider bias** and understand how that bias affects patients.
5. Through analytics, **group purchasing organizations (GPOs)** can help organizations optimize diversity spend, establish benchmarks and use best practices.

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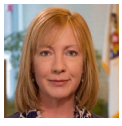

MODERATOR **Nancy Myers, R.N., PhD**
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MODERATOR (*Nancy Myers, American Hospital Association):* **What health disparities and access issues are a top priority for your organization?**

GEORGIA JACKSON (*Emory Healthcare):* Our hospital has a high case mix index. We treat a large number of complex patients who are quite advanced in their conditions. These patients are resource intensive. Our facility performs kidney, liver and pancreas transplants, as well as heart and lung transplants. In terms of health equity and disparities; one example would be the patients with renal failure in our area. The majority of these patients are African Americans, who are mainly on dialysis and have challenges meeting the criteria to receive kidney transplants.

COVID-19 highlighted the disparities even more when you look at access to care, referrals and post-discharge medications, especially for patients coming from small, rural areas. It comes down to the social determinants of health (SDOH). Many of our patients experience food insecurity, substandard housing, underemployment, etc.

Another large population of patients we provide care for have cardiac conditions. How do we ensure that they have fresh fruit and vegetables and diets that are low in sodium? That's not easy when you shop at the local convenience store because there are no supermarkets in the area. We work as an interdisciplinary team (physicians, nursing, care coordination, social services, etc.) to help patients access nutritious foods and medications and facilitate follow-up visits — even if those visits aren't at our facility. It is vital that organizations understand the influence of SDOH and seek collaborative solutions for the populations they serve.

REGINALD KNIGHT *(Bassett Healthcare Network):* Chronic issues including mental health disorders, food deserts and lack of broadband internet adversely affect our populations. The pandemic has caused staffing shortages, which further inhibits patient access. We decreased our bed availability to maintain an appropriate patient-to-nurse ratio, which further squeezed our availability, thus impacting the bottom line. In rural health care, we must reorganize our financing for the health of our organizations.

STEPHEN METH *(Nuvance Health):* Every year for the past decade we analyze our HCAHPS scores. Last year was the first year in my career in which I saw statistically significant negative variances that were beyond Centers for Medicare & Medicaid Services norms. They popped up in strange places, but were uniform across our system in that patients who speak Spanish had worse care transition scores than those who speak English.

"We found that patients who speak Spanish had worse care transition scores than those who speak English, and patients who identify as Asian American reported having worse care transition scores in HCAHPS as well."

— Stephen Meth —
Nuvance Health

We found that patients who identify as Asian American reported having worse care transition scores in HCAHPS as well. In our electronic health record (EHR), it's not so easy to print out discharge instructions in any language other than English. We're purchasing a language translation module and layering it in. If you haven't done it at your organization, it's worth looking across your yearly performance through the lens of HCAHPS disparities.

ALRIC SIMMONDS JR. *(AdventHealth):* We've spent a lot of time looking at data integrity and how we incorporate existing clinical excellence work to look at disparities. Where do disparities exist? What is our control group? What is the data set? Do we include Z codes? Are we using ICD-9 or DRGs? Do you use Premier? Do you use Cerner, Epic? What data source do you use? If you have multiple platforms, does the data query give you directionally equal information about the patients you're trying to affect?

These answers become important as we start comparing groups.

As a man and physician of color, it's not lost on me how many people are surprised when they see data that show their disparities and outcomes, that having been part of my lived experience. We must allow leaders to come into this knowledge space and grapple with their lack of knowledge. We must help them operationalize real solutions using templates such as fishbone diagrams or logic models that illustrate where patients are struggling and where change needs to occur.

As I listened to Georgia talk about transplantation, I wondered how much of that transplantation need is caused by hypertensive nephropathy. If we had adequate blood pressure control in communities of color, we never would have gotten to the point of end-stage renal disease. We must focus on the local factors that we're managing, while understanding how all these ambulatory conditions end up in our hospitals.

MODERATOR: How are you moving upstream to pinpoint drivers of disparities? And with whom are you partnering to make broader change?

KATIE FEURER (*Philips):* We conducted a future health index earlier this year, and we found that more than 68% of the health care leaders surveyed indicate that their hospital or health facility is either currently developing or intends to develop plans to address health disparities within communities facing inequities. Furthermore, these health care leaders understand that they can't go it alone if they are going to make a meaningful impact on health, and are looking at strategic partnerships to help drive innovation. Part of the passion that exists within Phillips as an organization is to be there to partner, not in a necessarily technological way, but in other ways. That's very much our mission and the purpose of our organization.

SIMMONDS: To understand our own internal clinical outcomes, we are supported by and partnered with W.K. Kellogg Foundation, Health Equity Alliance, FranklinCovey, Ethicon, who is also looking at this in terms of surgical approaches, and others.

Providers make clinical choices about who is admitted, who gets consulted, who receives a scan, who is referred to surgery, who is referred to a procedure, and who is sent home. These partners have helped us identify any provider bias and also helped those providers understand how that bias leads to outcomes among patients of color or economically impoverished populations.

"We truly believe in a continuum of care that starts with prevention. It starts with enabling patients to have as many points of care in their homes as possible."

— Katie Feurer —
Philips

JOEL HENDRYX *(University Medical Center of El Paso):* We have 10 clinics in our community and more clinics in outlying towns, but we want to be more constructive and targeted about care transitions — whether patients are coming from the emergency department (ED), or where they're going to get their follow-up care. More than 30% of our patients are unfunded, which challenges our system. We are trying to find other access points for these patients, not based on their ability to pay, but to ensure that they receive needed follow-up care.

KNIGHT: On one hand, we're trying to be profitable. On the other hand, we're trying to see how we can take on risk and limit the unnecessary utilization of services. We are going to provide mission-driven health care to those with disparities, but our present systems don't support us in doing that.

FEURER: Many of the challenges that we see come from data. How do we create meaningful, val-

ue-based decisions out of disparate data points? How do we coalesce around causes?

We want to help create a health ecosystem, so that care is delivered at the point where it delivers most value for an individual and to align multiple facets of health care to focus on the best value at the right point in time for the patient.

The silver lining to the pandemic is that we've brought down so many barriers via telehealth. We partner with the Bill & Melinda Gates Foundation. We partner with MedShare and March of Dimes. We lobby government bodies around broadband access. These elements are foundational to bringing care and technology into patients' homes, which ultimately can help prevent chronic conditions.

SARAH DECARO *(Emory University Hospital):* When we look at health disparities in our community, opportunities for lobbying are huge. Medicaid in Georgia doesn't cover heart transplants. Patients 21 and older aren't insured for heart transplants if they are Medicaid recipients. We can partner state by state to combat this.

"To better understand our patient population, we are considering partnering with social determinants of health vendors who plug us in with community benefits and resources."

— Sarah DeCaro —
Emory University Hospital

To better understand our patient population, we are considering partnering with social determinants of health vendors who plug us in with community benefits and resources. We hope to better connect our patients with community benefits and resources, and then to have a dashboard showing community benefits that people seem to be lacking, and where we can connect those dots.

HAMILA KOWNACKI *(California Pacific Medical Center):* CPMC has a long-standing partnership with Northeast Medical Services (NEMS), a nonprofit community health center providing culturally and linguistically competent health care to medically underserved populations in San Francisco and the largest provider of care to the Asian community in San Francisco. CPMC serves as the hospital partner more than 30,000 NEMS Medi-Cal patients, providing them with inpatient services, hospital-based specialty and ancillary services, and emergency care. This partnership gives NEMS patients access to high-quality hospital care while NEMS manages their primary and specialty care and remains their medical home.

MODERATOR: Stephen, in the last year you've seen much stronger and statistically significant relationships between people's race, ethnicity and identity and their experience of care. How has that information led to different types of partnerships?

METH: When we look at HCAHPS, it's self-reported, not a registrar asking folks what they are or how they identify. The partnership with Cerner, our EHR vendor, also has been fruitful. We're not the only health system asking for discharge instructions, for example, in languages other than English, and we know this is an important step in preventing 30-day readmissions.

KNIGHT: We're primarily an employed physician and advanced practice clinician model. Many of the tasks for transitions of care are not work relative value-unit generating but still need to be done. That's where we sometimes run into a failure to equate cost vs. expense. We've tried to partner with some of our regional nonsystem providers because we have a large elderly population in central New York. Readmission to the hospital for the end of life is a big problem. Suppose we can work with regional nursing homes and senior centers to communicate about discharge planning and transitions of care. In that case, that will perhaps keep some of the less acute elderly in their nursing homes instead of

sending them back to our EDs.

LUCERO RODRIGUEZ *(Emory Healthcare):* We offer employees training on bias, we bring in speakers for workshops and we coach our people to be able to have difficult but crucial conversations. This helps them interact better with each other and our patients.

We recently welcomed our first chief diversity officer. We're looking forward to not only aligning within our own three hospitals, but then also aligning within our overarching system.

JACKSON: I work with Lucero and my role is relatively new. Commitment to roles such as this — and our organization's commitment to diversity, equity and inclusion, both among personnel and patients — prepares us to make a difference.

METH: Contacting or working with a GPO is helpful. They've got great data and analytics to map and improve diversity spend. Partnering with the Healthcare Anchor Network has helped us establish benchmarks and use best practices. Our Chief Procurement Officer, even in this challenging year, helped us to establish an aggressive goal for increasing our diversity spend this year.

HENDRYX: We've been working well with our county commissioners and the city. As a community, we've come together. We gave out more than 30,000 vaccine doses to citizens of Juárez, Mexico. They were able to come across the border, get their shots and go back. We have a new program in which we are working with the city of Juarez and the county to serve children who lack access.

SIMMONDS: One takeaway from this discussion is a governance model that includes executive and clinical leaders to tackle these problems. As we do that, we have to be careful of taking on the savior mentality, thinking that we are the institution and that we know the community better than they do. We have to be right there with our faith leaders and community leaders to engage the community and let them be a part of this. Part of the COVID-19 pandemic in the state of Florida was a raging disease of the unvaccinated, and that was largely predicated on a lack of trust. To reestablish that trust, we must also measure what has changed. Seeing quantifiable measures change will show us that we are making a difference.

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