EXECUTIVE INSIGHTS

RESILIENCY + RECOVERY

LEADERSHIP IN REBUILDING HEALTHY COMMUNITIES

Addressing health inequities and collaborating to create an effective health system for all

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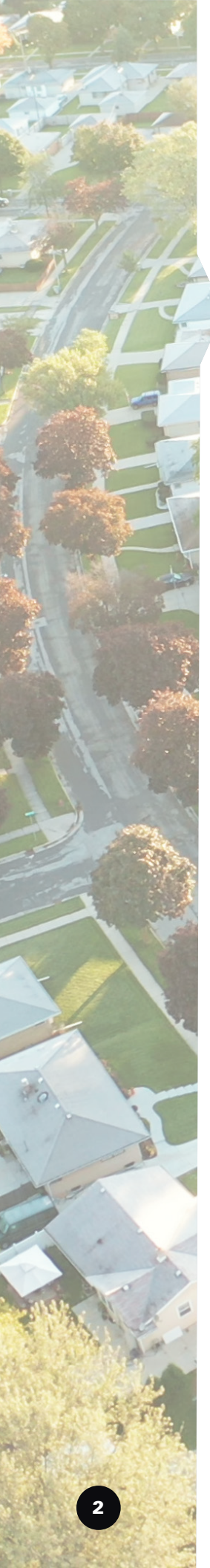

LEADERSHIP IN REBUILDING HEALTHY COMMUNITIES: ADDRESSING HEALTH INEQUITIES AND COLLABORATING TO CREATE AN EFFECTIVE HEALTH SYSTEM FOR ALL

From developing partnerships with social organizations within their communities to taking action against food insecurity during the pandemic, hospitals and health systems are taking measures to tackle disparities and inequities in a year that was challenged by the ongoing COVID-19 pandemic and racial injustice. Health leaders discussed their efforts around data-driven metrics that can measure disparities across clinical and nonclinical indicators. This executive dialogue provides an informative picture into the current challenges and next steps of American health care leaders.

KEY FINDINGS

1. Hospitals and health systems are **forming community partnerships** to address health inequities and disparities in their populations. The COVID-19 pandemic has encouraged leaders to build centers focused on health justice to identify and tackle disparities.

2. Leaders are emphasizing the importance of **data-driven work in communities**, opening windows of opportunity to improve health access, education and health behavior.

3. Many challenges still exist in health disparities data analysis, and **there is a lack of common metrics to identify disparities of care** within organizations and communities. Leaders would like to see more work in establishing common metrics for dashboards.

4. The **move toward virtual care** during the COVID-19 pandemic opened opportunities to empower patients to identify themselves, from race and ethnic background to other demographic information that would help leaders provide more equitable care.

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MODERATOR: *(Andy Shin, American Hospital Association):* **What actions are you taking as leaders in your communities to address health inequities and racial injustice?**

BETTINA TWEARDY RIVEROS *(ChristianaCare)*: In 2019, we leaned hard into building community partnerships and making community investments to expand the social care framework critical to addressing health inequities. We partnered with community organizations to meet the needs of community members, remove barriers to better health, address racial equity, support economic mobility, and advance health equity.

When COVID-19 hit, that foundation was crucial. We immediately anticipated the disproportionate impact on underserved communities and met it with an aggressive multipronged strategy. Our health equity and community health teams deployed virtual care services, community center access points for testing and care, language supports, infection prevention education and kits, and outreach through faith-based organizations and community groups with a diverse group of clinicians to educate around COVID-19 testing, safeguards and prevention, mental health impacts and flu vaccinations. Now we're working on community-centered locations for virtual care access and Covid-19 vaccination support.

MICHAEL UGWUEKE *(Methodist Le Bonheur Healthcare):* We began partnering with the community as far back as 2006 when we created the Congregational Health Network (CHN). The CHN is a partnership of different churches and denominations in the Memphis community — about 450 congregations. With CHN, we are able to develop navigators in churches to help disseminate health care messages and information and, more importantly, to track patients when they go to hospitals to help them navigate the health system. In 2009, we became one of the early adopters of REL [Race, Ethnicity and Language] as part of a Robert Wood Johnson Foundation study. We're the second-largest private employer in Memphis. We take our role seriously from both a health care perspective as well as a civic responsibility. A couple years ago, we increased the minimum wage to a $15 living wage for our associates. We also created MAAP, the Methodist Associates Advancement Program, in partnership with the University of Memphis, a career path program that allows people of all backgrounds to return to school or begin a new career path.

PRECIOUS MAYES *(Pacifica Hospital of the Valley):* Our hospitals are in the inner city and face a lot of inequity in affordable health care and housing. The homeless population here in California is devastating, and the pandemic has created another nuance. One of the challenges we've had in our hospitals is with the Immigration and Customs Enforcement (ICE). Two of our hospitals have about a 95% demographic of Latino and Hispanics, and Hawaiian Gardens is about 50% Black and 50% Latino and Hispanic.

Our communities are afraid to get health care because ICE waits to transport them to a detention center. We've set up a lot of local programs in our hospital locations with the police and fire departments to make it a safe haven so that people are not afraid to come in for the health care they deserve, regardless of their immigration status. With the pandemic, we used some of the hospitals' acreage to open up community gardens and farmers markets for free. Every week, we provide a thousand lunches in local cities where people have lost their jobs. Our local communities have been hit hard, not only by the pandemic, but also by forest fires.

JULIA IYASERE, M.D. *(NewYork-Presbyterian):* We just launched the Dalio Center for Health Justice at New York-Presbyterian. This enabled us to focus on work in health justice, health equity, and the identification and elimination of health disparities. We were part

of the first, challenging COVID-19 wave in New York City. We understood how to communicate and liaise with the community in a way that's meaningful. We gave out a fair number of small business grants to try to keep businesses open during the pandemic. We also developed a program in the hospital that supplied all our employees with breakfast, lunch and dinner for four months. Because of that, we understood the underlying food insecurity in the community as a result of lost wages, and developed a food bank. I'm really excited to have a conversation around data, because that's where we are doing a lot of our initial work; data analysis and data collection guides all our future programming.

KENNETH HOLMEN, M.D. (*CentraCare):* As the largest employer in Minnesota outside the Minneapolis-St. Paul area, we service roughly 800,000 Minnesotans in mostly a rural environment. We're improving many things related to diversity and inclusion within our organization, but the challenge is how to have a different conversation in our mostly white communities. The Black Lives Matter movement and social injustice are far removed in our mostly white communities, so how do we enable an effective conversation related to fairness, equity and inclusion for every American?

"For our communities, many a times, Black Lives Matter and social injustice is far removed, so how do we enable a conversation in our mostly white communities related to fairness, equity, and inclusion for every American?"

— Kenneth Holmen, M.D. — CentraCare

We are sponsoring and collaborating with other business and educational organizations in our geography to promote a more inclusive conversation and culture. An example includes book clubs which are popular in rural Minnesota, so we are providing free books to churches and schools to continue having conversations about race.

MODERATOR: How is your organization measuring disparities across clinical and nonclinical indicators? Does your organization have a health disparities data dashboard to guide progress on strategic initiatives?

JACK LYNCH *(Main Line Health):* For the past nine years, Main Line Health has hosted the Healthcare Disparities Colloquium; an initiative that explores health and health care disparities within underserved communities. It aims to ensure that every patient is treated with dignity and respect and receives the highest quality health care based on their individual and unique needs. We track the progress of that work through the use of dashboards in each of our major clinical groups — emergency department, intensive care units, inpatient units and obstetrics. The clinical indicators serve as guide posts for various strategic clinical and non-clinical initiatives designed to meet patient needs. For example, we've most recently established a COVID-19 vaccine administration dashboard that shows vaccine adoption rates by race and gender. We're using that dashboard data to inform education and outreach strategies among those with low COVID-19 vaccine adoption rates, primarily MLH's Black and Brown employees.

We've put a lot of effort and resources toward better understanding our patients in an effort to better serve them. A number of years ago, five students from the AHA's Institute for Diversity and Health Equity sat around my table and I asked: 'So, tell me what it was like to be an African-American female at our institution.' Two of them looked at me and said, 'I'm not African-American.' One said 'I'm bi-racial,' and the other said 'I am Hispanic.' The lightbulbs just started going off in my head, and I realized that I — and probably others in our organization — was making a decision based on an impression of that person. I knew we needed to do more to prevent these assumptions from being made.

Several years ago, we began to collect race, ethnicity and language data to monitor and measure disparities and have expanded the scope of that work to include the collection of sexual identity data. During the preregistration process, patients have the opportunity to register and provide this information using electronic tools, which may make them more comfortable than having to sit across from the registrar in a public space. This involved a significant amount of education and training for both our patients and our employees, and we launched a 'We Ask Because We Care' campaign with signage at our registration sites about how this demographic data was not an invasion of privacy but, rather, information that would allow us to better understand and better serve our communities. Recently, we've expanded this campaign beyond race, ethnicity and language data to include gender identity and sexual orientation.

DAVID LEONARD *(Spectrum Health):* We have some 15 hospitals, a health plan, a large employed physician group, and we have within our service area two medium-sized urban centers with substantial health inequities within communities of color created by decades, if not centuries, of systemic racism. In the last six months, we have recommitted to going after these inequities. Our newly formed health equity committee of our system board of directors is interested in this dashboard discussion — certainly, metrics internal to our clinical care environments, but also what should be the accepted best-practice standards and metrics of health equity within communities.

I think there are potential differences in metrics for health inequities between urban versus rural environments. We're looking within our urban cores at life expectancy as our big goal. We know we can't move the needle on that overnight. We have some census tracts where the life expectancy is 18 years less (which is comprised predominantly by African American residents) than in the next census tract, which is predominantly white. That's obviously not acceptable in this day and age, not that it ever was or should have been.

DICK FLANIGAN *(Cerner):* We have been trying to address this registrar question about achieving integrity and consistency in the data collection. Are you getting the level of data collection that is a foundation for this kind of reporting and dashboarding? Do you think you still have areas for improvement?

LYNCH: If you were to look at our 'Other' category or lack of answers pertaining to race and ethnicity, it's dropped dramatically, and the categories that people select have gone up dramatically. We're hoping that by having people register and self-identify with electronic tools, it will be much easier for them to select sexual orientation or sexual identity. They can check those instead of having to sit across from a registrar who may not be trained to ask them about their sexual orientation. I believe that the more sensitive questions should be reserved for clinicians to ask, but I think the self-identification in the preregistration process is where Cerner can play an important role.

FLANIGAN: It's a feature in the electronic health record portal, and some clients enable self-identification during preregistration. It's important as we prepare for vaccine administration at a community level, so that we can identify whether we're reaching communities. We have some big concerns under the mass vaccination scenarios in which health systems will participate. We don't want to perpetuate inequities when it comes to the vaccine.

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— Dick Flanigan — Cerner

IYASERE: All the data relating to race and ethnicity show that self-identification is the best. The more that our patients feel empowered to self-identify, the better. We are trying to leverage technological advancements to help our patients input their own data with e-blasts and notifications to their devices as well as using e-connect, a portal; by sending reminders to patients to update their own information; and by using welcome kiosks to prompt them when they come into the hospital.

There are a lot of challenges to obtaining this information. We have a new campaign, 'We ask because we care.' It focuses on the collection of race, ethnicity, sexual orientation and gender identity data. We'll ultimately phase into a roll out for social determinants of health screening across the system. We're training staff and sending information to our patients. When we increased our virtual visits, we started a virtual navigation program. Patients are called a couple of days before their first virtual visit to walk them through the virtual platform, and to make sure that they can connect. This is another opportunity to say, 'You will be asked questions about your demographics and this is why. Please input your data.' We'll already be able to prep them with the questions and why we are asking about race and ethnicity.

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> — Michael Ugwueke — Methodist Le Bonheur Healthcare

MODERATOR: What other measures are being established for the various initiatives? How are you establishing the measures to see how you're progressing and how are you establishing baselines for those measures?

UGWUEKE: When we started our CHN, we made sure that we were tracking patients from the 38109 ZIP code, one of the poorest areas in Memphis. Based on the data, we were able to discern that most of the patients coming from that ZIP code utilized our emergency services first and many are multiple users of the ED, some as many as 30-40 times a year.

Using those data and that information, we were able to educate community leaders and congregations in the ZIP code area and, in partnership with some of the pastors, began to change patient behavior and create additional access. We started tracking the number of ED visits, using it as a metric, and then looked at the effectiveness of our interventions by tracking the drop in ED visits. We've been able to use the data, to change not only behavior, but also reduce unnecessary and excessive use of a costly service.

MODERATOR: In an post-COVID world, what are the priorities? What is the role of the hospital in a community or a health system in tackling the social determinants of health? What is necessary for the health care field to move forward, for hospitals and health systems in particular, to take into account as they think about their role in tackling social determinants?

LYNCH: It starts at the board level. For several years, we've been focused on doing what we can to diversify the board to fully represent the communities we serve. This is not a new concept. However, it won't happen on its own. It requires intention and commitment. When you're making strategic decisions, people around the table should bring different perspectives. However, you can't wait until you fix your governance to address disparities. That effort must be reflected in the strategic plan. In order for a health system to eliminate disparities of care and address social determinants of health, it must first acknowledge they exist.

HOLMEN: These are generational, deep-seated issues. I love the notion of metrics and creating task-

oriented work that could occur over years. To make a difference, we need a playbook for systemic reform in America involving partnerships with health plans, legacy care delivery organizations and business.

BECKY GABANY *(Memorial Health System):* There's a strong appetite right now to do something and to make a difference, and many of us are recognizing the power and privilege that we've held for so long has not been used for equity. This brings up the question: How do we do it? I have been looking for indices or best practices to figure out whether there is some kind of template. What I've found is that there are several kinds of templates that meet certain pillars of equity work or pieces of it, but not necessarily one that is comprehensive as it relates to health care.

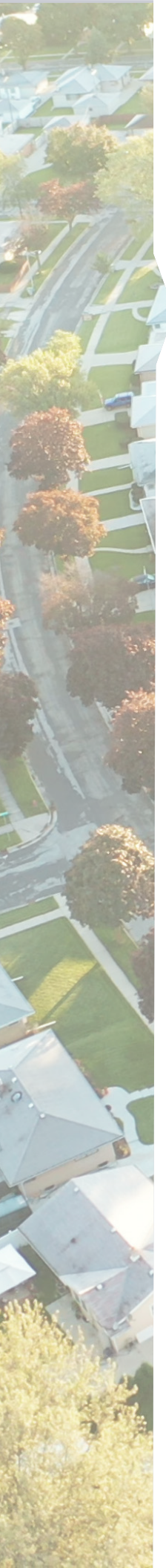
MODERATOR: As you think about the new tools, the new computing power, AI, machine learning, different technologies being used to improve operations, quality, safety, and patient experience and engagement, how do they play into your strategic planning around everything from collection of race and ethnicity data to addressing the social disparities of health within the communities you serve, recognizing that in many cases one of the big criticisms of AI is that the algorithms are inherently limited by the data they have.

FLANIGAN: As an information systems technology provider, we think a lot about how to apply tools for machine learning, and we hope they move into other levels of automation to reach more people and lower costs. What we have seen across our client base is that we have data issues, and then we have algorithms that, while not intentional, end up having a real bias in them.

IYASERE: We need to be careful when we start to think about machine learning and its use in the health care setting. We've seen some predictive modeling that has hurt instead of helped patients. As an organization, we looked at where we used race as an independent risk factor, and ended up changing the way we calculate GFR [glomerular filtration rate, a measure of kidney function]. We have to be careful about the way we employ algorithms, because over time they are embedded into the system, and people don't rethink how they're being used. We've had many conversations about the use of machine learning, AI, natural language processing, and how this can help us create predictive modeling tools, but always with that second caveat of being careful about their use.

NATHANIEL BISHOP *(Carilion Clinic):* I serve as co-chair of Carilion Clinic's inclusion council. At the medical school, following the killing of George Floyd, the dean called together a forum that resulted in the formation of the Inclusive Virginia Tech Carilion School of Medicine. It's a task force designed to complete a report in February. At our most recent steering committee, one student brought up issues around the definition of race, including the GFR, and then talked with a medical leader inside the hospital who asked the committee to look at what had happened at other academic institutions. So we have changed the GFR.

UGWUEKE: People are responsible for developing the machine learning and the algorithm that goes behind it. We are biased; there's no question. Involve those vulnerable populations that will be impacted, and then test and evaluate the technology to see if individual biases are reflected in the development of those tools before we start mass producing and mass marketing them. We can't stop the technology; obviously, it's going to take on a life of its own. But we do have an obligation and a responsibility to check for bias in algorithms before adoption in AI tools.



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