AMGA™

Advancing High Performance Health

Health Equity

Quality and Innovation Collective (QuIC)

Phase 1 Meeting Summary

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Health inequities impact how long a person lives, their quality of life, their likelihood of disease and its severity, and their access to treatment. According to the Centers for Disease Control and Prevention (CDC), our nation will achieve health equity when every person has the opportunity to attain their full health potential and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances."

Health equity is a complex challenge in America today, and research shared in the AMGA's Health Equity Quality and Innovation Collective (QuIC) illustrates why.

Despite recent recommendations for using statins to lower cholesterol, a study by Emily Bacon at the University of Colorado indicates that Black patients were 42% less likely to receive a prescription for this medication.[1] Physicians instead were two-and-a-half times more likely to give Black and Hispanic patients lifestyle changes. Yet success with lifestyle changes depends on a patient's ability to implement them, which can be particularly challenging for people who live in marginalized communities or may have challenges such as food or housing insecurity.

On August 15, 2023, AMGA members discussed such statistics, barriers to progress, and possible solutions in the first meeting of the Health Equity QuIC. It was Phase 1 in a three-part series, presented in AMGA's QuIC format, which enables participants to:

- Listen to high-level discussions in a virtual discussion forum
- Share current care practices through virtual collaborative meetings
- Create new models and care paths through interactive workshops

Danielle Casanova, MBA, vice president of Population Health Initiatives and Health Equity for AMGA, welcomed participants to the virtual

The **Health Equity QuIC** brings together healthcare organizations from across the country, serving rural and urban populations and patients from a wide range of cultures. Participants in an array of roles and specialty types— endocrinology, diabetes care, obesity, population health, quality/ outcomes, and more—include:

- Concord Hospital
- Guthrie Medical Group
- HealthPartners
- Henry Ford Health System
- Johns Hopkins University
- Sanford Health
- Scripps Health
- University of Alabama Health Services Foundation
- UC San Diego Health

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1. E. Bacon. 2017. Racial/Ethnic Differences in Treatment Recommendations: Lifestyle Changes and Medication Prescriptions for High Cholesterol. *Ethnicity & Health*, 25, 1-16.

gathering and introduced the session's moderator, Dr. Yeng Yang, who serves as medical advisor and co-chair for the Health Equity Cabinet at HealthPartners, which facilitates health equity; diversity, equity, and inclusion (DEI); and anti-racism activities across the organization.

"I'm a refugee immigrant from the Hmong American community," Yang said. "I've been doing health equity work since before there was a name for it, for most of my career. I am super thrilled to be with you today to moderate this discussion, and I'm looking forward to having lots of fantastic opportunities to learn from you all and to hear about the work in each of your organizations."

Introductions: Current Activities

Yang asked participants to introduce themselves and provide examples of current programs and activities to advance health equity.

Participants reported being at different stages of the DEI journey. Some were deep into targeted pilot programs and partnerships, and others were just figuring out how to talk about race and disparities. However, common areas of focus emerged.

Understanding patients and needs: Participants are working to understand who their patients are and the systematic nature of health disparities. This discovery involves collecting data on race, country of origin, and language; tracking chronic conditions such as hypertension and diabetes; and looking at topics such as disability, racism, ageism, and inclusion.

Where are there gaps in care? What barriers are standing in the way? Patients in rural areas might be hindered by poor access to transportation, for example. Participants talked about using needs assessments and patient satisfaction surveys and collecting social determinants of health and demographic data to find answers. Their next step: sharing this information across departments, facilities, and organizations.

Educating leaders and staff: Organizations are hosting sessions and trainings for leaders and staff alike in areas such as racism and implicit bias.

One organization saw firsthand how employees can be powerful advocates for advancing health equity. Their pilot program engaged physicians with a Nepalese background to increase colorectal cancer screening rates in that community. Other participants cited recruiting programs to bring in care providers who represent the patient community and support for research and employee-led projects.

Forging community partnerships: Participants are also joining forces with peers outside of their own walls. Examples include working with religious organizations to create "health hubs" and integrating community health workers into maternal health.

Planning strategically for the future: From quarterly meetings to five-year plans to an "anti-racism governance structure," participants are making health equity part of business as usual at their organizations. It's a process of connecting the dots, linking long-term visioning to Centers for Medicare and Medicaid Services (CMS), Joint Commission, and federal grant requirements. The journey begins with getting people into the room to start the discussion. With a foundation to work from, the organization determines where to go from here and "bakes it into everyday processes."

Essential Aspects of a Health Equity Initiative

Before the Phase 1 meeting, participants completed a survey about the "motivating needs" of their health equity work, which Yeng described as "the most important or essential aspects to developing and implementing health equity initiatives."

Participants were asked to identify and rank their top priorities from a list that included to:

- Address implicit bias in healthcare

- Facilitate access to care

- Patient engagement and trust with healthcare system

- Identify social determinants of health across patient populations with involvement of community members

- Commit to leadership support and sponsorship

- Provider and staff education and training about disparities in care as it relates to population health, such as cancer and other screenings, and chronic disease management

- Strengthen data collection and reporting

- Patient awareness and education about chronic disease management

The top four, which shaped the day's discussion, were implicit bias, access to care, patient engagement and trust, and social determinants of health.

Address Implicit Bias

Yang kicked off the session by referencing a pre-read from the *New England Journal of Medicine*: "Tackling Implicit Bias in Health Care" by Janice A. Sabin, PhD, MSW.

"As you recall from the article, there are many, many causes to health care disparity," Yang said. "Implicit bias with clinicians and their involvement and key role in decision-making is a very important contributory factor."

"We know we can't get rid of implicit biases and that we all have them," Yang said. "The focus is to try to mitigate those harmful effects."

She talked about Emily Bacon's research into differences in statin prescriptions and high cholesterol treatment for Blacks and Hispanics and the notion of cultural competency. Ironically, she said, the cultural competency training many organizations are engaging in to tackle such disparities and inequities may be contributing to them instead.

When providers make decisions based on "stereotypes and not necessarily individualization," problems emerge, she said. "I would argue that perhaps we should be thinking about cultural humility rather than cultural competency as a core concept."

More Fodder for Conversation and Collaboration

Beyond the top four motivating needs, participants mentioned a variety of other topics they wanted to explore.

What approaches and methodologies can they use to identify and quantify health disparities? What are best practices for social determinant of health screening and responding to positive screens?

Participants also want to learn more about screening and reporting requirements, from both CMS and payers, and the financial side of health equity initiatives, from staffing them full time to finding support for programs that typically aren't billable.

Unconscious Bias Affects:

- Our **Perception** – *how we see people and perceive reality*
- Our **Attitude** – *how we react toward certain people*
- Our **Behaviors** – *how receptive/friendly we are toward certain people*
- Our **Attention/Listening Skills** – *who we pay attention to and actively listen to what certain people have to say*
- Our **Micro-affirmations** – *how much or how little we acknowledge and include people in certain situations*
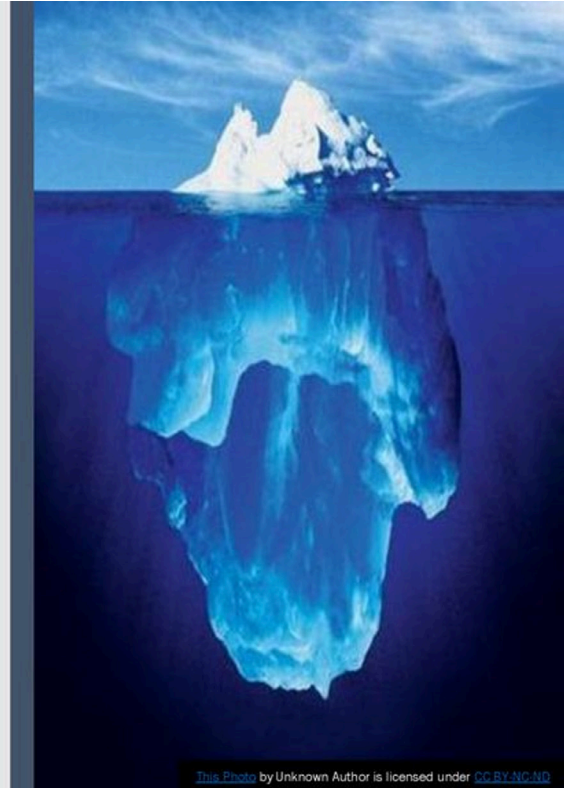
This Photo by Unknown Author is licensed under CC BY-NC-ND

"Words matter," one participant noted. He shared efforts to address implicit bias in patient records—noting "non-adhering patients" versus "noncompliant patients," for example—and in everyday interactions with patients and colleagues. Response has been positive so far, he reported, opening clinicians' eyes to habits they hadn't been aware of until now.

Another participant related the challenges of communication in a clinic that's "very homogenous. You think everybody reacts the same to everything."

Organizations are also looking outward in their efforts to tackle implicit bias. One example involves enlisting community health workers to ask residents what services and resources they need and what topics they want to learn about, rather than making assumptions and shaping these initiatives from the top down.

Yang inquired about whether any groups measured the impact of their efforts yet. Participants noted anecdotal feedback at the local level but said it was "really challenging" to measure progress and results on a broader scale. In the meantime, some organizations are using patient satisfaction as a proxy and using surveys to collect data.

Facilitate Access to Care

One participant's organization took a look at its ambulatory, emergency, and inpatient services. How did the need for care compare to actual usage? For Black patients, community health assessments identified mental healthcare, specifically in areas like anxiety and depression, as one of the top needs. But clinicians weren't seeing Black patients in

the clinics for these conditions. And for Black and Hispanic patients, discrepancies emerged in pregnancy and diabetes care. "We knew we had access issues," the participant said.

To learn more, the organization started pulling data from across the system, from epidemiology to primary care, and shared these dashboards with community roundtables and community partners. Data and these discussions guided efforts to fill in the gaps, like engaging with churches and other partners to expand access to care "outside of the four walls of the hospital."

"Meeting people where they're at—these are the magic words," Yang said.

Access is at the root of health inequity and why patients are falling out of the system, participants declared. They cited barriers like where a service is provided and what a patient struggles with to get there, such as buses that don't show up and private transportation alternatives that refuse to serve certain neighborhoods. Meanwhile, patients in rural areas lack the necessary network connectivity for telehealth. Adding to the challenge are other complications in a patient's life, like food or housing insecurity, and the cost of the service itself.

One participant reported working with insurers to match patients with community resources based on social determinants of health. Plans are to scale the initiative systemwide in the next year.

These examples spurred a broader discussion. Talking about barriers to access is easy. Standing up such efforts and expanding them across an entire organization is another story. How does a service, like a cancer or diabetes screening, fit in with other services? How do you pay for services that aren't reimbursable? And do you even have enough staff to carry it all out, especially if you're aiming for clinicians who are representative of the patient population?

Look at your policies, one participant suggested. Does a "three strikes" rule for appointment no-shows take into account things like housing insecurity or transportation barriers? Another participant talked about their organization's extensive outreach to different physicians, community health workers, educators, and public health researchers, calling it "a Peace Corps for medicine."

Another participant shared her team's efforts to deliver timely and topical support, like helping their community navigate the new Medicaid renewal processes. They're asking patients what they need, using the capacity they have, and "trying just everything."

In an ideal world, with systemic change, such "extraordinary heroic efforts" by individual teams and departments would not be necessary, Yang noted. "How do we do this together and put structures in place?"

Patient Engagement and Trust

Yang noted that many participants had established or were initiating programs to address health equity challenges and close the gaps. "How do you communicate these programs and resources effectively to your community partners, patients, and their families? What are some successful strategies that you have tried?"

Trust is essential, participants emphasized. If a facility has a history of biased practices or inequal care, patients will resist going there, even today. And for every successful program, it only takes one bad complaint to set progress back.

How can organizations build, or rebuild, these ties? Use tools like Press Ganey data and patient surveys. Ask the right questions and flag issues, one participant advised. Communication in healthcare can be complicated, so tailor outreach materials to patient languages and cultures. Regularly scan services in patient ZIP codes for ways to enhance care. And make "culturally competent care" a priority, both in the clinic and in community partnerships.

Sometimes, these initiatives emerge organically, as with one organization working with physicians with a Nepalese background to engage Nepalese patients in preventive health services. The next step: embedding community health workers into that patient community. The results were "more impressive than anything we could have gotten out of a consulting firm," said a participant from that organization.

A healthcare organization can be a powerful connector and convener for resources, from food banks and community gardens to assistance with insurance and health programs to helping patient groups talk about and address tough topics. But substantial obstacles stand in the way of efforts like these. Some services, such as using community health workers, can be hard to fund. For organizations with a large service area, the sheer scope of patient diversity and needs can feel overwhelming.

Participants chimed in with advice. Seek out community leaders. Look for new opportunities. Try new things. Build trust through openness and transparency about your efforts.

"Instead of doing things to communities, do things with the community," Yang said. "The community wants to know that you're going to be there for the long haul."

Identify Social Determinants of Health

A patient's neighborhood, community, and economic stability can have a big impact on health and quality of life, as do access to quality healthcare and education. Social determinants of health have been a rising priority for healthcare organizations and are a critical aspect of health equity. Yang asked participants about the barriers they're experiencing in this area and if involving members of the community helps or hinders the process.

Participants shared their efforts, from patient screening initiatives to using caregivers to capture "the voice of the customer" and therefore healthcare needs and priorities. One organization is restarting its family advisory committees to this end. Throughout, it's important to get to know patients on an individual level and raise clinicians' awareness of implicit bias.

Talk turned to data collection and the electronic health record (EHR), especially given new mandates like the Hospital Inpatient Prospective Payment System rule. Effective this year, it requires hospitals in federal payment programs to report what portion of their population is screened for various social determinants of health and how many screen positive in each category. Now that this is mandated, how do you collect this information appropriately? And who collects it, especially given that many nurses are overwhelmed?

How you communicate information is just as important, Yang said. "If you just write a patient down as non-adherent or noncompliant, then are you going to bias the next clinician who reads the note?" Instead, get to the reason why a patient isn't able to comply with a prescription or care plan and ask how you can help.

Participants are joining forces in their communities to link patients with resources. One organization talked about its commercial-size community garden and partnerships with local food pantries, churches, and food festivals. But what if a patient lacks a refrigerator for storing groceries and medicine? "Meeting patients where they are sometimes requires the entire package of problem-solving," Yang noted.

Well-intended staff are a start. But programs addressing social determinants of health also need to be implemented in a systemic way, participants noted, so that they reach everyone who needs them.

Programs addressing social determinants of health are labor-intensive and take time. Some are technologically difficult, such as creating a directory that geolocates patient transportation options by ZIP code and adding it to the EHR. In other cases, there are referrals and follow-ups to manage, not to mention the initial partnerships to forge. One participant reported taking over two years to build out just one referral initiative in its hunger-fighting efforts.

Don't get overwhelmed, one participant advised. Focus on the small things and what you can do right now. Find out the why, another suggested. Then start small and scale it out.

Next Steps

What do you hope to get out of the program? How do you see your organization collaborating and sharing with others?

Yang left participants with questions to think about before the Phase 2 virtual meeting December 4–5. Casanova also told them to watch out for information about Project Implicit, including an assessment she encouraged participants to make part of their organization's implicit bias training.

"What's apparent in the discussion today is that there's so much more work to be done," she concluded. "We're looking forward to addressing these gaps and barriers in Phases 2 and 3 of the program."

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