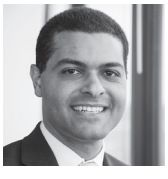
HealthLeaders Virtual Roundtable
SDoH and Health Equity: CEO

Lisa Abbott
SVP, Human Resources and Community Affairs
Lifespan
Providence, Rhode Island

David Berger, MD, MHCH, FACS
CEO
University Hospital of Brooklyn at SUNY Downstate Medical Center
New York, New York

Aric Coffman, MD, MBA
EVP, OptumCare PNW
CEO, Everett Clinic
Everett, Washington



Shereef Elnahal, MD
CEO
University Hospital
Newark, New Jersey

Jamie Reynoso
COO
Clover Health
Nashville, Tennessee

Melanie Blackman (Moderator)
Strategy Editor
HealthLeaders
Brentwood, Tennessee

THE CEO'S ROLE IN ADDRESSING HEALTH EQUITY AND SOCIAL DETERMINANTS OF HEALTH

The COVID-19 pandemic shined a brighter spotlight on health equity and social determinants of health, which motivated healthcare organizations to make greater strides in addressing those issues.

CEOs of hospitals and health systems, especially, have a pivotal role to play in ensuring everyone has fair and equitable access to healthcare. To do so, they must lead their organizations on the mission to advance healthcare equity and diversity in the communities they serve. They must implement policies, face challenges and pushbacks, and take actionable steps to solve these issues.

In this workshop-style roundtable, a panel of healthcare executives discusses these topics and explores what roles their organizations play in enabling healthcare access for all.

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HIGHLIGHTS

HealthLeaders: *What is your organization's role in addressing health equity?*

Shereef Elnahal: I view health equity not only as a major pillar of what we do, [it's] in the fabric of who we are as an organization and our history. It's important to understand what is now called the Newark Rebellion, which was a series of violent protests that happened in the late 1960s across the northern part of the country around racial reckoning. What ended up happening in Newark was a reckoning that was related to our campus.

We are a campus that displaced one of the most prosperous Black communities in the country for about a century now and continued to expand its footprint within that space that used to hold thousands of families, who were mostly Black families and were a successful community. That was done through eminent domain, one of the many [systematically racist] tools of our system that have displaced people of color disproportionately and allowed for assets to be installed for other groups to benefit from in the immediate area.

To resolve the violence, an edict came down that ended up being a negotiated agreement with the people of this city to rededicate this campus to the community, first and foremost, which placed every other mission of the organization codified in this agreement second to the one related to community.

I see the health equity mission having three pillars that have been established since that time. The first is providing equitable, high-quality healthcare, regardless of the color of people's skin, or where they come from, or what their ethnicity is. The second is what are we doing internally to support and elevate employees of color in terms of all opportunities that we can. Then, finally, it's our role as an anchor. That means we do everything we can to invest in the community.

Jamie Reynoso: At Clover Health, we have a unique perspective and role to play when it comes to addressing health equity because we are a payer. While improving health equity has always been core to our business, over the past 18 months we've focused on how the pandemic has further exacerbated health conditions and health inequities for seniors (our members) across the country. We've worked to identify and help our members overcome the indirect causes of worsened health outcomes and inequities, including transportation issues, lack of technology to access telehealth, and access to nutritious food.

We recently received feedback from the National Committee for Quality Assurance (NCQA) that Clover was identified as a high-performing Medicare Advantage plan using a prototype of the Medicare Advantage Health Equity Summary Score (HESS). HESS is a new tool developed by CMS' Office of Minority Health to recognize Medicare Advantage plans that are providing high-quality, equitable care to their beneficiaries, including groups who are disproportionately affected by social risk factors.

As a payer, we are committed to advocating for changes that benefit our members. We've all gone through the current catastrophic situation, and we know there will likely be unforeseen adverse events in the future; making sure we have policies in place to help protect our most vulnerable populations is of the utmost importance.

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Aric Coffman: In the Pacific Northwest, our business model is a mixture of care delivery through our provider organizations and a population health company, with a focus on transforming. We're kind of an in-between health insurance and care delivery in some ways, from things that we do with delegated functions and taking full capitation, as well as providing direct services to those patients. We are transforming our mindset organizationally to think about patients holistically, everything that impacts the outcomes of our patients, rather than transactionally with one visit at a time.

It has created an opportunity for us with the pandemic to partner with the community in a different way. Through something called the Washington Healthcare Forum, we bring in key payers, key hospital leaders, health system leaders, medical group leaders, state medical associations, and hospital associations. We get together on a regular basis to start pooling our ideas, and health equity was one of the topics that we had heading into the pandemic, so it accelerated the energy in the community around that.

We've also recognized across all of our systems that we don't collect data in the same way, and that impacts the health equity conversation. If the people at the front desk aren't collecting the right information on patients, then we may be chasing the wrong populations, or may not have the information that we need to accurately capture specific outcomes.

HealthLeaders: *What specific health equity issues are you addressing and why? How did your organization establish your health equity business case and strategy?*

Lisa Abbott: Housing, or lack thereof, becomes a real impediment to well-being and better health. We're fortunate in our community to be partnering right now with the local housing authority, Blue Cross Blue Shield

of Rhode Island, Cross Roads Homeless Shelter, and a variety of others, who are keenly vested in what we're calling Medical Respite Housing.

These are [for] people who don't need to occupy an inpatient high-acuity bed in one of our hospitals but aren't prepared to be discharged because there is no place to discharge them. We're developing a pilot program where we have the right level of care, in the right facility, for the right people. This initiative demonstrates a true community partnership between the entities that I mentioned and many others.

David Berger: Diversity, equity, inclusion, and social determinants are our business. As a new CEO, certainly one of the first things was to identify and clarify what our strategy is in our strategic plan going forward. We've redone our mission and our values to highlight the issue of equity and disparities.

As an inner-city safety net hospital, there are a lot of things being worked on specific to this discussion, but I want to highlight the issue of HIV/AIDS. We have a large HIV/AIDS population, and we have two clinics that specifically address this population. One is what we call the STAR Clinic, which is the Special Treatment and Research Clinic, and that is our adult HIV clinic. Then we have the HEAT program, which was established back in 1992, and it has a comprehensive medical and mental healthcare support and access to clinical research for HIV and at-risk youth, ages specifically 13 to 24.

Within those populations, social determinants are magnified as compared to our population at large. Some of the things mentioned in terms of food security and housing certainly are important, and we're working on that. Twelve percent of the patients who come to our STAR Clinic have previously been incarcerated. We have what's called the Back to Brooklyn Grant, which is funded and provides for community health workers to escort the recently released from correctional facilities to our hospital the same day to see a medical provider and to help them set up housing as well as other case management needs.

HealthLeaders: *How does your leadership team and employees represent diversity and reflect the community you serve? How are you bringing more diverse voices to the table, and what challenges are you facing?*

Abbott: We're looking at our talent pipeline programs because we know that if we don't have people in feeder pools, we're never going to change the composition of the leadership team. We're gender balanced more than we are racially balanced, so we are looking at every single director and above position to say, if we're soliciting talent particularly from the outside, "What does that talent look like?" and "Does it look like the community that we're serving?"

We're purposeful in saying the search isn't going to close until our pool represents the available community. We keep searches open so that we are putting our money where our mouth is, and it hasn't been as hard as some people would suggest that it might be.

Now, our pools are better, our conversions are getting better. We have more racial diversity in our talent pools. We're not converting necessarily, and that's what we're going to work on. I alluded to a sizable grant that will help with talent pipelining; part of that grant will be earmarked for minority scholarships. We want to develop team members who may come into an entry-level job as an MA or a tech and help fund their college education if they want to grow their career.

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Reynoso: At Clover, we believe that great talent can, and should be, found everywhere. We also believe that a more diverse workforce creates a better company.

We've been identified as a plan performing well in providing equitable care to our plan members, about half of which are people of color. To best serve our diverse group of members, we must also have a diverse and distributed workforce—50% of our employees work remotely, and we have team members across 35 states and in Hong Kong.

It's important to connect with the community directly and not assume you understand their voice or experience. One way we are connecting in Atlanta, Georgia, one of our key service areas, is by co-hosting events with local community- and faith-based leaders focused on identifying health equity barriers and developing creative solutions aimed at increasing access to quality services for the Medicare population in the area.

Another initiative we're proud of is our reverse mentorship program. It gives our entry-level to mid-level employees the opportunity to mentor a member of the leadership team, ask questions, and develop a close, personal relationship with leaders they might not work with on a daily basis. On the flip side, it's great for the leadership team to meet with and hear the viewpoints and ideas of frontline staff. This is how you cultivate diversity of perspectives within your organization from the ground up: instituting a true program around diversity and inclusion that lets everyone know they have a voice, and that their voices are being heard.

HealthLeaders: *What are your standards for collecting data?*

Elnahal: We're well underway in doing this, and it's harder than it looks. The first challenge is making sure that race and ethnicity data is accurate and collected reliably at either the point of care, the point of patient registration, or the point of hiring when it comes to employees. It may be a cultural and process change that you have to make across the board.

One sub-goal that we've always had within health equity is making data collection of preferred pronouns for the transgender community more reliable. The process required management change at the point of work. It wasn't something we could just impose and decree overnight and assume it's happening. Once you get that right, I think that the potential is tremendous.

It's important to have folks in the organization who are not only facilitating the data and statistical programs, but also understand health equity as a topic as well. They're few and far between, but as the American healthcare system finally reckons with this as a priority, I think you'll see more folks coming through the chain as informaticists and data professionals who have dual training, and at the very least understand the importance of the mission. That's the next step for us, and we've already started doing it with some skilled folks who we recruited specifically for that purpose.

Berger: As a health sciences university, if we want to achieve equity in our system, we need to start with our learners. Who is applying to our various schools and colleges? How do we make sure once they are admitted, they're successful? What do they know about their social determinants? Then the next level is what does the faculty look like? What is their knowledge base?

An important issue is to get this right and see what impact you're making by asking the patients. It's important to get to that granular level and understand what the patients are seeing within your institution, not just what their demographics are and what their social determinants are. One of the things that we've seen is evidence of bias in our grievances and complaints. Every hospital has a list of patient complaints and a trove of grievances. Those grievances and complaints have turned out to be a valuable source of information on how our patients are perceiving their care. We have a research project to look at the value of analyzing patient complaints and grievances and trying to tackle the issue of how providers are providing care. This is important when we analyze the issue of implicit bias.

Abbott: We're obligated to do a community health needs assessment every three years as part of our tax-advantaged status. We're about 70% government payer, so not a lot of commercial insurance here in the greater Providence area. A good source of data was what people told us about how they felt they were treated when we went out and did our last community health needs assessment. We [learned we] have some work to do.

Our patients are not always feeling like they're welcomed, necessarily. We have to change our intake strategy so that our unconscious and implicit biases aren't what we're leading with. We are mandating implicit bias training and so forth. Mandating the training is one thing. Having people behave differently in a way that is favorably experienced by the patients that walk through our doors, and their family members who are often the accompanying person who's taking the brunt of the perhaps not-so-favorable behavior—I want to see shift in that space.

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HealthLeaders: *How are you measuring the correct demographics and meaningful data of patients?*

Coffman: I'm going to ask a curiosity question. I'll give an example that came to me from the team a few weeks ago. We had identical twin girls and one is listed in the system as white and one is listed in the system as Asian, because their father was Asian [and] their mom was white. [The] mom brought in one child, [the] father brought in the other child. This is where the teams experienced some real anxiety and discomfort asking some of the questions when you have mixed-race people or you have things that they're not familiar or comfortable with, such as gender identity. How do you address that in your systems? Because it may not be just one box or category that you click, and some of our systems, we don't have the opportunity within them to catch the nuances. I'm wondering how that's getting tackled in your systems?

Elnahal: You have the principle in health equity discipline that people should be empowered to declare their identity should they be comfortable doing [so], and that philosophy informs how you collect that information. You have to ask; there's no room for assumption, there's no room for just putting it down for the person. The frontline individual needs to ask, and the person may surprise you on how they self-identify, which is the most important way to do it.

Secondly, not making it a mutually exclusive fit-the-box scenario, where of course data is always strongest and most informative when it's structured. So, to do this right, you're going to have a lot of boxes, but allowing folks to declare more than one identity is yet another thing that we've tried to do here. Once you have those principles set, it's about change management, it's about training and teach-backs at the point of the work, especially for patient registration.

The extent to which you can align both employee and patient frameworks on how to collect that data is also helpful, especially when you're looking at interesting questions like, "Do we see quality disparities when it is a clinician of color treating somebody who identifies similarly to a patient or a family?" You're not going to be able to do that unless the data stacks up and is comparable.

Reynoso: One of the challenges we face is that we're usually on the other side of things—in the payment mechanism rather than the one providing care directly to patients. There are areas where there is room for improvement that we, as an overall healthcare delivery system, need to come together to figure out. For example, if you think about the CPT® and HCPCS codes that are out there, there are some that are still very specific to gender. This can be problematic because if somebody on an enrollment application identifies as female, but we (the insurer) receive claims from their provider who has identified the patient as a male, there's going to be an issue. This can negatively impact that person because they feel like there's bias against them, and it can create a lot of other downstream impacts. How do you solve for that?

We try to capture as much data as we can, but from a payer perspective, we're limited in what we do because we're not typically the ones providing the care. So we're relying on the hospital system, the provider, or whoever is submitting that data, and we're using that as the information in order to make those payments.

HealthLeaders: *What challenges have you faced in working to provide equitable access to healthcare and address social determinants of health?*

Abbott: I've mentioned the need for access to affordable housing, and that goes beyond just homelessness. There are a lot of people who can't find access to appropriate housing, but I think the question is much bigger. Access to food, and care, and school are big challenges.

We need to dedicate resources that are specific to programs that will improve the health of our most vulnerable populations. In fact, it is our responsibility to solve for social determinants and make investments that are going to serve the greater good.

Berger: A major issue for us is our ability to access capital. Even though we're a state institution, they fund a fraction of what we need on a yearly basis. We're dealing with a 1965-era building that is significantly problematic on a day-to-day basis, and that is disequity. If we are going to address health equity, that needs to be an important issue on the table: access to capital.

Elnahal: The distinction between for-profit and nonprofit is meaningless when you can accumulate in the billions in cash as a health system and use that at your discretion to ultimately drive everyone with commercial insurance out of cities and into the suburbs for complex care.

The extent to which we provide charity care at levels that are multiples over most hospitals in Jersey got us over that threshold. What I believe is that we need fundamental reform in how public institutions and healthcare are supported, if not by their jurisdiction, by the federal government—because you can do as much as you want to cover people with health insurance, but if they don't have a convenient and accessible place to get care that will accept them with open arms, it becomes very problematic.

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HealthLeaders: *How can payers and providers work together to advance health equity?*

Reynoso: The only way we're going to see success in advancing health equity is by bridging all players' different perspectives and ideas and working together to make it happen. The reality is, we payers need the providers, and providers need us payers.

We all have to align to a common vision and goal of what success looks like. And it's not just payers and providers. It's also CMS, it's Health and Human Services, all the state Medicaid programs. Everybody plays a role in this. We're all on the same trajectory; at some point we're all going to have to converge.

Berger: Part of the problem with the system is payers have a different incentive than providers and we're not completely aligned. I believe value-based payments and population health are helping us move in that direction. But from the provider standpoint, if we can work with our payers to smooth the reimbursement for the services we provide for this population, as well as figure out a way to share the cost of some of these additional services that we are required to provide, it would go a long way to making the whole system better.

Coffman: I agree wholeheartedly, and I think the beauty of it is it's all possible. When you have the information and you have the aligned incentives, then you can get the outcomes for those patients that match what they need.

There are so many areas where we still have to make progress. We have a lack of standards of how information is shared, and it makes some of those systems more costly than they need to be. There's not uniformity in the way that information comes through and how it's digested. There could be some system that sorted that out that would make it easier for people to adopt it and then would accelerate the journey.