HEALTHCARE EXECUTIVE
July/August 2023 V38 | N4

Feature

Making Progress on Health Equity, One Community at a Time

Karen Wagner

When health system CEO Douglas Ziedonis, MD, began his career in healthcare leadership, he probably never thought that one day part of his role would include planting corn with students on the land of the Navajo Nation in New Mexico. But that is just what he did this spring as part of his goal to better understand the culture of the communities he serves and issues faced by many residents of New Mexico, which has the third highest rate of poverty in the country and has been ranked at or near the bottom for child well-being, education, and family and community health, according to the Rural Health Information Hub, a national clearinghouse on rural health issues.

"We visited communities, homes and were honored to stay the night and got a great sense of what living on the land was like there—all the richness of the culture," says Ziedonis, who leads the University of New Mexico Health System and is the executive vice president of the University of New Mexico Health Sciences. "Those are the kind of things that are needed to really get a sense of these communities and their pressure points. But also the incredible human values and human experiences that healthcare systems need to really understand. And you don't get it from your hospital building."

Inequity and Misaligned Spending

Whether in urban or rural locales, communities all over the country face issues such as food and housing insecurity. These social determinants of health can lead to health inequities—disparate health outcomes that negatively impact underserved populations and most often people of color.

Focusing on these social determinants within communities is essential to addressing health inequities, which are ultimately a result of a misalignment between investments in clinical care and social care, says Anita Chandra, vice president and director, RAND Social and Economic Well-Being.

Although it is widely recognized that 20% of health is determined by clinical care, as much as 90% of healthcare spending is on clinical care, Chandra says. To truly improve health nationally, there needs to be a widespread reallocation of resources to address the upstream social structure determinants or drivers of health, she adds.

"So, when healthcare systems want to make sure they're screening for social determinants of health, that's great. But if it's not connected to other things happening in the community in a way that's sustainable, then it's data in, data out, without real sense-making," Chandra says.

Chandra and her team at RAND are studying 29 communities across the country to examine how they are evolving their approaches to building a culture of health and advancing health equity.

Although moving the national needle on health equity improvement is proving to be a considerable challenge, Chandra says communities that are

Toolkits:

Center for Community Investment

Investing in Community Health

University of New Mexico Health System

Health Extension Toolkit

making progress are addressing negative outcomes and prioritizing positive health and well-being outcomes, which are important for future planning, she says. Organizations within these communities are honest about the existence of inequities and investing in upstream drivers of inequities such as housing, transportation and economic opportunities, and tying public safety and health together.

"I have more hope at the community level because people are trying innovations," she says.

Listening to the Community

At UNM Health and Health Sciences, which includes New Mexico's only Level 1 trauma center, it was a long journey from identifying and realizing community needs to Ziedonis' and his team's visit to the Navajo homeland and numerous other communities across the state.

Several years ago, a survey of rural New Mexicans found that residents criticized the health system for "its lack of long-term commitment and attention to their needs," according to the Rural Health Information Hub. These findings led to the creation of the UNM's Health Extension Regional Offices program, or HEROs, within its Health Sciences Center, which provides programs and resources to rural and underserved communities through education, clinical service, research and health policy.

To operationalize these goals, HEROs use agents—community health workers and community health representatives—who live in the communities and who function, in part, to link local health needs with UNM resources, encourage youth to finish school and enter health careers, and strengthen community capacity to address local health problems.

"The HEROs provide support to local community organizations, and their community health workers provide a vital link for patients and their families between the healthcare system and their homes in the community," says Ziedonis. "We are fortunate to have the community health workers in our UNM health system, including the hospital to provide practical support after leaving the hospital and to also help address the social determinants of health," he says.

Ziedonis has traveled with these community representatives (also called HEROs) all over the state on listening tours to hear what community members say they need and how they would prioritize those needs.

"These heroes are our trusted partners. I rode on their coattails of trust, and we would meet with higher education and political leaders, church clergy, faith-based groups, Native American tribal leaders and Hispanic leaders and other cultural leaders," he says. "It was in the spirit of really listening to their voices."

The program has led to the creation of 12 health equity action laboratories aimed at addressing what community members have identified as their most pressing needs. Engaging and seeking direction from the community, rather than directives from the medical center, has been foundational to the program's success, Ziedonis says.

"There's no way we can improve the health of New Mexico only by doing clinical practice," he says. "We also need a public health orientation."

Narrowing the Gap

More than 1,000 miles away, in a setting very different from the rural communities of New Mexico, is Chicago's West Side, home to Rush University Medical Center, an acclaimed institution that includes a 671-bed hospital, the 61-bed Johnston R. Bowman Health Center and Rush University.

The largest employer on the West Side, Rush serves an area of about 500,000 largely Black and Latino residents, many of whom have less than a high school diploma and live in neighborhoods suffering from a 16-year life expectancy gap compared with residents of the city's business section, the Loop, a largely affluent area a few miles to the east.

In 2016, after completing its community health needs assessment, Rush leaders had a sort of "epiphany" that "health does not begin and end in the hospital walls and doctor's office," says Rukiya Curvey Johnson, vice president of community health equity

and engagement at Rush. The question became: "How can Rush leverage its human and economic capital to be able to advance some critical change?" Johnson says.

Leaders at Rush embarked upon an anchor strategy to tackle the life-expectancy gap. The strategy includes changing its hiring, purchasing and investing practices to benefit the surrounding communities. One initiative involves hiring hospital staff from the communities and then advancing these employees from entry-level jobs into pathways to higher-skilled roles, Johnson explains. The medical center is creating a pipeline of employees through its Rush Educational and Career Hub, a program that focuses on introducing younger students to healthcare careers so they can obtain valuable work experience and paid internships.

Under its purchasing strategy, Rush is shifting 1% of purchases to businesses on the West Side. This has involved understanding what services are available in the neighborhoods, categorizing the available vendors and then considering where shifts in spend can be made, Johnson explains. Rush has worked with an Ohio-based medical distributor to build a

Lessons Learned

As health equity requirements are being instituted by more regulators, including the Centers for Medicare & Medicaid Services, developing initiatives to reduce inequities is showing up on more and more leadership agendas. Here are a few lessons learned from leaders represented in this article.

Attain leadership buy-in. Initiatives without a push from the C-suite can only go so far. Rukiya Curvey Johnson, vice president of community health equity and engagement at Rush University Medical Center, says she is often asked how she is able to sustain this work, which represents a significant investment of time and resources. "It's the leadership," she comments. "I don't think there's any way to do this as a bottom-up [approach] … it will require strong leadership from the top … for that to cascade and for it to permeate the organization and for people to feel confident that this is where they can and should be spending their energy and effort."

Don't just check the box. The work is for the benefit of the community, but it should be considered more than just adhering to IRS rules for community benefit. "Don't treat it as a feel-good," Johnson says. "It's really thinking holistically about how this can in fact improve health outcomes."

Institute accountability. Someone has to be looking at impact and progress of efforts. Consider how to hold the organization accountable to making progress in this work, such as implementing a governance structure or metrics that are working to address both internal results, for the organization, and for the community at large, Johnson says.

Listen to your community. Douglas Ziedonis, MD, CEO, the University of New Mexico Health System, says listening tours with trusted partners within the community are an excellent way to hear the voices of the community and to understand what are the most important social determinants of health from the members' perspective. "Are you in the community really, really listening? I think that's a vital piece. That means sometimes you hear what you need to also hear and feel the anger and wide range of concerns that they have."

Be prepared to change mindsets. Studying data and identifying gaps in care is only the first part of any quality improvement initiative. Work needs to accelerate solutions for reducing or eliminating these gaps in care, says Thea James, MD, associate CMO at Boston Medical Center. "You actually have to undo somebody's mindset to be able to even do that kind of work," she says. "Most people study disparities mainly just to identify them."

facility on the West Side and set targets for hiring community members to work at the facility.

The initiative has dual benefits.

“We win as an organization because it’s closer to our facility in terms of transportation and getting to these supplies, but we’re also doing something to more broadly provide greater vitality to the community,” Johnson comments.

Rush has also been undertaking impact investing by working with community development financial institutions, such as banks and credit unions, to provide funding in areas, such as affordable housing, which have long-term impact within the community.

“Again, [we’re] always trying to think about, ‘How do we amplify collective impact by working with others to be able to contribute more resources to have more bang for our buck?” she says.

Investing in Root Causes

Rush’s choice to invest in affordable housing is one that digs deep into the root causes of inequities, says Robin Hacke, executive director of the Center for Community Investment, which helps health systems identify community priorities and develop and execute pipelines of investment projects.

“By making an investment in creating or preserving affordable housing in the community, you can actually contribute to addressing the cause of inadequate housing—a shortage of homes affordable to people at all income levels. Rather than focusing only on people currently experiencing homelessness, or people who might be facing evictions, health systems can go upstream and address the determinants of health rather than just the effects of what’s happened to people.”

CCI’s Accelerating Investments for Healthy Communities initiative has worked with hospitals to deploy millions of dollars to finance the production and preservation of affordable housing. The investments serve to “improve social, economic and environmental conditions in disadvantaged communities,” according to the CCI, while also often providing financial return for investors. For example, an investor, such as a health system, might provide a loan with a below-market interest rate to a developer to build new units of affordable housing.

Hacke says some health systems have been investing in affordable housing for decades. San Francisco-based Dignity Health (now part of Chicago-based CommonSpirit Health) has a portfolio worth between $160 and $170 million. Oakland, Calif.-based Kaiser Permanente, which began investing more recently, has committed $400 million to its Thriving Communities effort, with affordable housing investments nationwide.

Many hospital investments have been structured as debt, and the health system gets back the principal of the original investment, plus about a 2% return, depending on the specific terms. In an unstable stock market, that can represent a solid return, she says.

Hacke adds that health systems investing in and advocating for affordable housing can have powerful impact because they are not the usual messenger.

“What we say is it’s not just about making one investment, it’s about looking at the overall [health] system and trying to figure out where can you have the positive impact with your dollars, with your relationships, with your land, with everything you know how to do—data, expertise, whatever it is. So, thinking about it in a more comprehensive way is really very helpful,” she says.

Accelerating Equity

Traveling nearly 1,000 miles east from Rush’s medical center is Boston Medical Center, a 514-bed academic hospital located in Boston's historic South End, where demographics of the surrounding communities are similar to those of the communities on Chicago’s West Side.

The medical center has various services, such as a prescription food pantry, which fill in some of the gaps in need for its underserved patient populations. The impact of the COVID-19 pandemic caused leaders to take a step back and consider more substantial approaches to improving health in their communities, says Thea James, MD, vice president

of mission and associate CMO for the medical center.

"What 2020 did was give us an opportunity to look deeper" to understand the true root cause of health disparities in their communities, she says.

In 2021, BMC developed the Health Accelerator program, an approach to improving health outcomes for its underserved Black and Latino populations by quickening the timeline between identifying inequities and implementing action plans to address them.

The program focuses on five clinical areas with the most pressing racial health inequities and uses cross-functional teams of clinical experts, researchers and healthcare staff to talk with patients and determine changes that can be made to care delivery models. The five areas are pregnancy, cancer, infectious diseases, chronic conditions and behavioral health.

To begin, workgroups across the enterprise pored through clinical and research data along with data from human resources and the health plan to identify disparities and their causes, James says. "Every group had to come up with two to three things they were going to do in the next 12 to 24 months to actually close gaps that were found in a manageable and measurable way," James explains.

For example, quality improvement work at the medical center found that Black women were experiencing postpartum hemorrhaging at almost three times the rate of white women, James says. Further investigation of the data by Health Accelerator researchers found that the bleeding was most often associated with preeclampsia during pregnancy. The treatment for preeclampsia is to deliver the baby, James continues, and the data showed that the faster the decision was made to deliver the baby, the less likely there was an adverse outcome. Further study of the data revealed that for Black women, physicians were taking twice as long to make that decision to deliver.

Source: "Investing In Community Health," Center for Community Investment.

Applying these findings, the medical center standardized the decision-making process for women with preeclampsia, taking variability out of the decision-making and closing the timeframe from diagnosis to delivery, James explains.

"At the same time, we continued to study and understand context for the variability in decision-making," James says.

Everyone involved in the pregnancy process—providers, nurses, patients—was interviewed. An analysis determined that part of the reason for the variability was unconscious bias on the part of healthcare workers, along with patients' lack of understanding of their conditions, according to James. The analysis also found that patients are more compliant with medical direction based on their financial situation, she says. For example, patients do not always have the time or money for transportation to go to the hospital or a medical clinical when they feel like something is wrong.

Working with patients, the medical center created a chatbot to provide information to pregnant women in a conversational way. Patients presented the questions they would like addressed by the chatbot and also worked with medical center staff to create educational videos, James says.

The crux of the Health Accelerator program is in fact its use of the patient's voice, James says. Since the start of the program, more than 15,000 people have been interviewed in the search to identify inequities and develop solutions, she says.

"What we're really doing is recognizing what the structural barriers are that perpetuate [inequity] and navigating those barriers with people, not just for them," says James.

Making an Impact

Striving to improve health equity by addressing the social determinants of health is a journey without end.

Linking community-based efforts to community impact so those efforts can be scaled for greater improvements in public health is part of what is missing to move the national needle on health equity, says RAND's Chandra.

What Chandra and her team have found is that much work needs to be done in making true sustainable progress if the country is to pivot toward narrowing the health equity gap. "There are some communities that are moving the process needles, but it is taking some time to move the outcomes needles," she comments.

At the University of New Mexico, the HEROs program has made a positive impact for patients, Ziedonis says. The community engagement of the HEROs program has helped the UNM medical center reduce its readmission rate by 83%, he says, citing the program's founder, Arthur Kaufman, MD and the program's evaluators. There have also been reduced ED visits, a stabilization of diabetes severity and reduced rates of depression.

"We're seeing that people are getting bridged to getting their medicine, getting to appointments, learning how to access the food, support for the housing, and support for transportation," Ziedonis says. "We basically see about a 4 to 1 return on investment for the community health workers [costs].

The Health Extension Regional Offices program has also served as a model for other states, he says. Through the Affordable Care Act, the Agency for Healthcare Research and Quality provided health extension grants to several states to support improvements in primary care practices and assistance for addressing social determinants of health, Ziedonis explains.

"So that was a national act that we impacted through our HERO offices and the work that we were doing," he points out.

At Boston Medical Center, early data from a small cohort of women showed an 80% decrease in postpartum readmissions from quarter to quarter over one year.

Although only about 50 women were included in the data, “It’s given us a lot of confidence that we’re on the right track,” James says.

At Rush, Johnson says the equity team is in the early phase of pulling together key metrics on the impact of all the various programs the medical center has directed toward improving health equity. The medical center has achieved its goal of hiring 17% of staff from the nearby communities, putting these employees on a more viable path to sustainable jobs.

In addition to the anchor program, Rush is also working on offering greater access points of care and partnering with other community-based organizations to provide more access to resources.

“For us, we’re driven by this life expectancy gap. And the top reasons for causes of death include chronic illnesses,” she says.

“We are actively tracking that, but we know that’s a long-term goal. And we know there’s a challenge to directly link specific economic efforts to correspond to health improvements because there are a number of variables, but we know there’s something to community well-being, the vitality of a community and how that contributes to better health in general,” Johnson says, noting that this includes whether people feel safe, have access to healthy food, and a job that provides a sustainable wage. “We know that all actually matters.”

Karen Wagner is a freelance writer based in the Chicago area.