Organizing Thoughts for Healthcare Boards on Equity.

(You could use this for a course or article or both)

Healthcare Equity and the Board's Responsibility (We are basically looking for a set of questions and then actions which can be taken).

We have just lived through a period of incredible stress for healthcare around the world and in the US. We have seen many lives lost and we now know that many groups experienced a disproportionate share of death. The question for healthcare board members is: "What can we do about this going forward?"

We believe that board education for equity is critical. The IHI has had experience educating healthcare boards. During a period from 2007-2014, IHI ran a coarse focused on helping boards understand their role in patient safety. We created a toolkit, Governance Leadership "Boards on Board". That toolkit focused on six issues that are still relevant today: setting aims, getting data and hearing stories, establishing and monitoring system level measures, changing the environment, policies and culture, learning … starting with the board and establishing executive accountability.

In 2017-2018 IHI spent a year adding new tools that boards could use but we expanded our focus from safety to all 6 of the dimensions of the IOM quality components: safe, equitable, patient centered, timely, efficient and effective along with a focus on population health. From this work we created a board assessment tool. The assessment tool and white paper have had more than 10,000 downloads and are being used in health systems.

Healthcare boards are primarily made up of unpaid volunteers. Time is a precious commodity for them. In 2018 IHI attempted to launch a new course on quality for boards but was not able to attract the audience needed. Part of this issue may have had to do with the length of the course. For the present work we are going to have a succinct focus on health equity and boards.

Below are a set of questions that the board should be considering to understand more about equity and the health systems:

1.Which populations trust us, which don't and why?

What is the history of this organization with various groups/people in the community?

What business practices have been supportive and which have been detrimental in the community?

2.Who is on our present board and who else should be? (What about executive leadership?)

Past surveys done by the AHA have shown little progress on diversity within healthcare boards and even less among healthcare executives. Healthcare systems have been aware of this situation for years. The

question is, “What will it take for health systems to move forward?”

3.Do we know who we serve (race, ethnicity, payers etc.) and how does this compare with the community we live in? Do we analyze the specific services we provide to see if there are any particularly demographic gaps?

Boards may lack a clear understanding of the demographics of their community overall and the populations that they care for. Before you can stratify data, you have to collect the data and it is doubtful that boards have any real understanding of how the data is collected and the accuracy of the data. Has anyone even asked how many “others” are in the data base on race and ethnicity and what would that mean if there is a high percentage?

4.Do we stratify clinical outcomes that the board receives by REaL and SOGI? And what are we learning from this stratified data?

The board needs to see stratified data where it makes sense. We know from experience that very short-term hospital quality data tends to be very good and does not show significant stratification. A more meaningful approach might be to consider data in 4 tiers as described by Karthik Sivashanker and team.

Level one is access: “An excellent candidate for a level-one core equity measure is the difference between the percent of Medicaid and/or uninsured patients treated by a health care institution and the total percent of Medicaid and/or uninsured individuals in the relevant city, state, or region “

“The level two measure, defined broadly here as transitions, refers to whether patients will be offered services equitably as they transit the healthcare system.” A recent study provides a prime example of such a measure, finding that Black and Latino patients were less likely to be admitted to cardiology for heart failure care than white patients at the Brigham and Women’s hospital. Another health system in a personal communication to the author described how their cardiology services were underutilized by people of color.

“The level three measure refers to the quality of care delivered, commonly described through clinical outcomes and associated process measures.” These are the typical measures that are often not stratified for the board. As mentioned earlier, short-term measures, such as whether a particular drug was given to someone in heart failure, tend not to show much difference. But any long-term issue such as the control of hypertension or diabetes or even 30-day readmission will tend to show a difference based on stratification.

There is also a 4th level of measurement that deals with the community and we will discuss that later.

5.What impact is health equity having on CMS Value based payments?

We understand that the focus of most healthcare boards at this moment is on the finances. Many health systems have just come through a significant financial stress to their organizations and therefore the

board is looking closely at the financial health of the organization. But health equity is a factor in the financial health of any organization regardless of payment models. Differential access, treatment and outcomes for patients causes financial issues.

"The Hospital Value-Based Purchasing (VBP) Program of CMS is part of their ongoing work to structure Medicare's payment system to reward providers for the quality of care they provide. This program adjusts payments to hospitals under the Inpatient Prospective Payment System (IPPS), based on the quality of care they deliver." CMS withholds 2% of the provider's payment for 3000 hospitals across the US and rewards or penalizes hospitals based on quality outcomes that CMS measures.

CMS applied these quality domains and weights for FY 2021:

Clinical Outcomes (25 percent)

Person and Community Engagement (25 percent)

Safety (25 percent)

Efficiency and Cost Reduction (25 percent)

All of these domains are impacted by equity which can have a negative effect on the hospital payment from CMS. In clinical outcomes, hospitals are being graded on 30 day mortality for AMI, CHF, COPD, CABG surgery , Pneumonia and total hip and knee arthroplasty complications. Everyone of these conditions can be impacted by equity considerations. The best thing the board could do is to see this data stratified, recognize the different outcomes between groups and start asking leadership questions about causes and plans to rectify differences.

You can work through each of the other 3 domains, look at the stratified data and have the same discussion. This is not just an academic exercise. There is money involved in this process.

The money in the IPPS program just involves a 2% withhold. If an organization is involved with an ACO program, the rewards and penalties can be greater. Consequently, the board should see stratified data on important measures and have conversations with leadership on causes and plans.

6.What barriers do we create for our employees or patients to flourish?

This section really needs to dig into the practical/purposeful barriers that organizations create for certain demographics of patients. We need to be honest about this one. Where are we building or buying and why are we doing that?

In regard to employees, we need to look for what issues we are seeing, particularly in the lower paying jobs.

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7.What are the biggest equity issues that our CEO faces and how can we help as a board?

This is all the about the idea that no matter what the CEO and leadership team do, some will think it is too much and other will think it is not enough. The board, after understanding the leadership plan and agreeing to it regarding equity, has to commit and support the leadership team. This work will come under fire from both sides of the spectrum. Some will say too much and others will say not enough.

Is the board reviewing the community health needs and executive plan to meet those needs? Is there ongoing review to see that the plan is progressing and closing some community gaps in a measurable way?

8.Returning to a measurement strategy that should be considered when it comes to the community:

"The fourth and final level refers to the vitality of the socioeconomic and environmental conditions in the neighborhoods and communities served by the institution. Examples might include the impact of an organization on: (1) the neighborhood economy, which could be measured as the percent of supplies or services obtained from local minority-owned businesses, or the ratio of bad debt over charity care; (2) employee living conditions, which could be measured as the percent of employees receiving a living wage, or by the percent of employee accounts sent to collections for unpaid bills from their home institution; and (3) the environment, as measured by greenhouse gas emissions."

After working through these 8 areas, the following might be used as an action plan for the board .

1.Setting Aims: Set a specific aim regarding equity. Make an explicit, public commitment to measurable improvement.

2.Review Data and Hearing Stories: Select and review progress toward more equitable care . Share stories of individuals regarding equity.

3.Changing the Environment, Policies, and Culture: Commit to establish and maintain an environment that is respectful, fair, and just for all patients and staff.

4.Establishing Executive Accountability: Oversee the effective execution of a plan to achieve your aims to reduce harm from inequities, including executive team accountability for clear targets.