Institute *for* Healthcare Improvement

The Board's Role in Governing Equity
Draft of a possible course for boards

Outcomes
1.To have a better understanding of equity issues that impact health for your specific communities.
2.To understand the role that the board can play in health equity

Pre-work
(The following are recommendations for materials that should be provided to the attendees by the executive team prior to attending this meeting.)

1. Do an analysis of the population that you serve. Understand the demographics of this population by race, sex, ethnicity, payer type and geography. (You might want to expand this with more detailed REaL and SOGI classification.) At the same time do a similar analysis of the community or communities that your organization serves and compare the two. (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?)

2. Stratify clinical outcomes that the board receives by REaL and SOGI. 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. We recommend a good faith attempt to get examples of the following data types for board members.
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.

“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.”

Examine the data and look for equity gaps. It is not the board's role to directly manage the issues seen with the data but the board should be able to have a discussion with the executive team.

3.Identify barriers that the organization presently has in place that impact our employees or patients when it comes to helping them with health. This is a difficult question to ask. Overall organizations want patients and employees to thrive but until we look at our organization with fresh eyes, we will miss the barriers. For example, many organizations have policies to encourage further education for employees. Once they have successful taken and passed a course they can get reimbursed for that course. But if you can't afford the tuition in the first place you won't take a course. One way to see this is to look at your benefits package and see which pay groups and races/ethnicity etc. uses your benefits. Your goal is to dig into practical/purposeful barriers that organizations create for certain demographics of employees and patients. We need to be honest about this one. Where are we building or buying and why are we doing that? From a business standpoint an organization might be purposefully trying to relocate from a poor area to a more affluent area. Are we ok with that from an equity standpoint or even from the mission of the organization.

(In this agenda I am identifying the main topic to be discussed. I think each session needs to be set up in such a way that the audience has a chance to participate.)
8:00-8:30 am: Welcome, Introductions, and Expectations for the day. (The way this course is set up, it is very dependent on at least some pre-work being done)

8:30-10:00 am: Value-based care and health equity. There is opportunity to capture revenue that is being lost because of health equity issues adversely impacting payment from CMS. This session will explore the following:
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 fi-

nancial health of any organization regardless of payment models. Differential access, treatment and outcomes for patients cause financial issues.

"The Hospital Value-Based Purchasing (VBP) Program of CMS is part of their on-going 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. Every one 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.

10:00- 10:15 am: Break

10:15- 11:00 am: Discussion of pre-work (As an alternative you could have used this session right after the intro in the morning and then followed with the value-based session. I chose to do it in this order because money helps people see working on equity isn't just about altruism)
During this session we will discuss observations from the pre-work. (I think we should give the participant time to share observations and questions they might have from the pre-work. They should have identified a set of issues from examining their data.)

11:00- 12:00 am: Which populations trust us, which don't and why? (it is doubtful that most board members could answer this question accurately. This session should be structured around several publicly known case examples of health systems. The University of Chicago would be one example where activists had to push the University for years to finally develop a trauma ER.) I am sure competent faculty could identify other known issues.
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?

12:00- 1:00 pm: Lunch Break

1:00- 2:15 pm: Board Makeup: what are best practices and how can we get there.
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?"

2:15- 2:30 pm: Break

2:30- 3:45 pm: How the board can support the equity team. (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?

3:45- 4:00 pm: Wrap up