

BRIDGING THE DIVIDE

Community Priorities Guide Health Equity Center

By MARCUS M. MCKINNEY, DMin, LPC

Hartford, Connecticut, is one of the poorest cities in America. Thirty-two percent of its residents live below the poverty line, nearly a third of adults there do not have a high school diploma and the unemployment rate sits at 12 percent.

Saint Francis Hospital and Medical Center has served within this remarkably diverse community since 1897, when the Sisters of Saint Joseph of Chambéry founded what was then a two-room hospital. If you take a walk on Hartford's Albany Avenue, a few blocks north of the modern-day Saint Francis complex, you will hear people in this largely African-American and Caribbean neighborhood talk about their health care — and what they think needs to change. In many ways, the current great divide between what community members say they need and the ways health care tries to meet those needs begins and ends with the kinds of conversations you find occurring on the community's street corners and in its small shops.

As a therapist and minister who arrived at Saint Francis in 1984, I recall many discussions on how health care could be improved, how non-medical issues such as lack of jobs, transportation, housing and translation services had an impact on the health of communities. Above all, I recall common themes: Patients would like to have a say in

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For example, David, a 52-year-old Hartford resident, is a health care advocate committed to finding ways for the community to influence delivery of care for underserved populations. David has persistent challenges managing his diabetes. He sees several medical specialists, and, he tells me, his frustration and stress over health mostly has to do with understanding who is in charge of his care.

According to the Affordable Care Act, signed into law in 2010, consumers are back in charge.¹ But David is emblematic of the many who struggle to make sense of the health system and how to use it. The ACA mandate has meant Saint Francis, like others in the ministry, has wrestled with the difficult but important challenge of how to move beyond well-intentioned programs to a strategy that directly addresses disparities. Community health needs assessments moved us down that path, but we wanted to have ongoing community input on how care might be delivered. Our question was, could community members collaborate with providers to design a more user-friendly process with greater language and cultural sensitivity?

A WINDOW OF OPPORTUNITY

Saint Francis' board of directors, led by President



and CEO Christopher Dadlez, responded to the ministry's growing awareness of health disparities² among urban underserved populations by approving a resolution to champion greater diversity in leadership; to collect and demonstrate use of disparity data related to race, ethnicity and language (REAL) preferences; and to support progress on cultural inclusiveness. The resolution set in motion several key steps:

- Creation of a senior leadership position, vice president for community health equity
- Formation of the Diversity Collaborative, a monthly meeting of employees to identify priorities and track improvement
- Meetings with community members and Saint Francis leadership to develop a plan to address disparities

LEADING THE WAY

One Saint Francis board member, Curtis D. Robinson, had a special interest in eliminating disparities. He is a prostate cancer survivor and a successful African-American businessman with an impressive entrepreneurial track record and a passion for getting things done.

During his orientation to responsibilities as a member of the board, Robinson said he had taken to walking through the Emergency Department and talking with staff and patients.

"I heard from several men who shared their firsthand struggles with managing their health," he said. "Several had prostate cancer — but unlike me, they had no insurance and, in many cases, no regular doctor. Some shared that their cancer was discovered very late, and I thought, as a board member of Saint Francis, this was an opportunity to make an impact for these largely African-American men as well as others in our community."

Robinson said he felt called to respond to his observations, and that's how a bridge began to cross the divide between these men and the board's moves to better understand and address disparities. Robinson directed his passion to save lives, his love of the community and his experience in creating sustainable initiatives into discussions with Saint Francis leadership, community members and the vast business and philanthropic network he has established over his career.

"God called me into this, and I believe it has to be more than a program. The idea that saving a life is like saving the whole world is a powerful inspiration for this ministry," Robinson said. "We can build it on Saint Francis' Catholic health mission, create a business plan, hear from the community and establish a long-term entity to eliminate disparities and take down the barriers we are learning about."

LAUNCHING THE NEW INITIATIVE

The result was the Curtis D. Robinson Men's Health Institute, supported by a generous gift from Robinson and his wife, Sheila, as well as from the Hartford Foundation for Public Giving. A team that included Jeffrey Steinberg, MD, as medical director, an outreach coordinator, a nurse navigator and me, the vice president for community health equity, assembled to develop the Institute's work in health equity.

"More than just providing resources and navigating care," noted Steinberg, a urologist who also chaired the Saint Francis Department of Surgery, "we knew outreach to places where people meet would be needed."

The team embarked on weekly visits into the community, usually on weekends in churches, shelters and virtually anyplace where people gathered. The focus began with prostate cancer, which is the most common cancer among men

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after skin cancer. Research shows that individuals from medically underserved populations are more likely to be diagnosed with late-stage disease that might have been treated more effectively or cured if diagnosed earlier. African-American men have the highest incidence rate for prostate cancer in the United States, and they are more than twice as likely to die of the disease as Caucasian men.

Socioeconomic issues like financial challenges, where someone lives and cultural beliefs also are barriers that prevent individuals or groups from obtaining effective health care. As a result, we

were determined to let the community know we would provide care for anyone diagnosed with prostate cancer and pay for care if their insurance would not cover the cost. This was a strong message, demonstrating we were serious about eliminating barriers.

It wasn't long before our schedule filled up. The team often made three-hour visits to sites in order to offer education, help with access to primary care, testing and listening to families, who often asked for help with many more issues.

The venues we visited were varied, and the themes discussed by community members were revealing. At one typical Saturday morning gathering in a church, a group of 40 men arrived and

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were encouraged by the pastor to share their thoughts. After the education session on prostate cancer and diabetes, one of the men said, "Thanks for the information, but my question is about how doctors talk to us. Why don't they talk simply? Why do they have to be so rushed and not listen?"

Some of the most important bridges are built during those moments. Turns out, we came to understand, health care is a culture of sorts — complete with different clothes, language, rituals and customs. It is easy to be oblivious to how these elements can come across as barriers for some in the community.

During that session, lots of men joined in to share their experiences of complicated discussions with health professionals, and they told us our outreach helped them feel more comfortable to ask questions and seek care. They offered suggestions on how medical students might benefit from hearing their thoughts and be trained to understand community concerns.

We began to imagine creating a dedicated site in the community and offering a larger scope of health equity work in addition to prostate cancer.

RESHAPING THE PARADIGM

By 2013, the Institute staff, known as the health

equity team, expanded to 10 members, adding public health experts and a language coordinator. Our goal was to broaden outreach to address other health issues and to include women and children. The lessons I learned during the early years clarified the scope and challenges of recreating a health equity strategy.

In response to the added scope of work, the Institute expanded to become the Curtis D. Robinson Center for Health Equity. Reflecting the principles we were learning, the center would be located on the first floor of the Urban League of Greater Hartford, with easy access and free parking. We designed plenty of rooms in which the community and the health equity team could

hold their discussions. The center also meant agencies and programs that address the social determinants of health could take advantage of free, collaborative, accessible space. Overall, the center's purpose was to bring together community members, health providers, local stakeholders and public policymakers in order to build a strategy informed by the ongoing assess-

ment of people providing care, receiving care and impacting care.

It made sense to include key health activities that naturally align with health equity. The center now brings together community benefit; health needs assessment; implementation planning; diversity collaborative agendas; language and cultural inclusion activities; data and quality outcome activities and ongoing focus groups to assure community voices are heard and honored.

At the same time, Saint Francis saw opportunities to change the system of care where community priorities and mission intersect. Racial and ethnic inclusion no longer is limited to brief education for employees. Inclusiveness training now occurs in collaboration with the Hispanic Health Council in a multi-session interactive training.

Now, in 2015, the center seems more than ever like a bridge. Because of it, we have encountered more than 6,800 people in outreach events. The center has become a trusted place in which to ask questions and find the kind of support needed to enter into care for families in Hartford — largely Latino and African-American. The team knows finding the right care, at the right time, in the right place is important for community members. The center is a bridge to better understanding the



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community and changing a complex health system to be more equitable. It's a bridge to discovering what the communities we serve want and need from health care. And, along the way, we have learned some lessons. We call them community health equity principles.

PRINCIPLES OF COMMUNITY HEALTH EQUITY

When I look into the eyes of people attending our events, I see a desire to be empowered. I see a community that understands health care is often complex but can be made more accessible through relationships like the ones we enjoy in our outreach events. We have learned that, while there is critical information needed to care for marginalized communities from a population health perspective, most of the communities we engage with see health care as personal.

Personalized care often is described by people in the community as the kind of assistance that can take the form of dignified and confidential financial counseling, or some help signing up for health insurance or even standing alongside someone to navigate care as they go to an appointment. We offer more than a referral to social support agencies. We are companions on the path to well-being.

Health professionals work long and hard to master their disciplines, and they pour out that knowledge to guide patients. But in turn, many communities also want to teach health providers a few things from their hard-earned experiences. We have heard over and over again that community members appreciate a “teachable” attitude from health professionals. It is often described as sharing medical information while also inviting insights during educational events or family meetings. In the inaugural meeting of the institute, one gentleman said it this way: “Don’t just bring your agenda to us. Allow us to share in ways the community’s agenda is met.”

A common sentiment from the community has been that health initiatives and programs come and go, often because of time-defined grants.

Some community members have said, “We never have a real ongoing relationship that way.”

As a result, the Curtis D. Robinson Center for Health Equity has developed a vibrant “Health Liaison” monthly meeting that gathers representatives from any site we have ever been to for follow up, planning further events and sharing health challenges that may have not come to light when the outreach was initially done.

Most of the sites we visit request repeat events. We now host an annual town hall meeting on health disparities, and it is attended by hundreds of community members and stakeholders. Among the topics addressed have been “What Does Obamacare Mean for Real People?” and “Is Food Making Us Sick?” These town hall meetings have been gatherings in line with our principles and shaped by health issues our communities have requested.

Between such events, the center bustles with focus groups, and members of the community who seek help. The team’s navigation role helps individuals find the best portal into care and follow-up. The center’s medical director also is responsible for Saint Francis clinics, enabling easy referral to primary care.

The pathway to more relevant care and greater well-being of our communities seems to welcome places like the center to bring together diversity, community benefit and outreach agendas that measurably impact the triple aim of better care, better experiences by patients and lowered costs. At Saint Francis, we feel the Curtis D. Robinson Center for Health Equity extends a bridge to focus on the mission intersection of community priorities and the resolution by the Saint Francis board for more equitable care.

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NOTES

1. <http://www.hhs.gov/healthcare/rights/>
2. See www.healthypeople.gov/2020/about/foundation-health-measures/Disparities.

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