Ensuring Quality Care Means Prioritizing the Most Vulnerable

A Q&A WITH DR. ALISAHAH JACKSON

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Contributor to *Health Progress*

Alisahah Jackson, MD, is the first president of the new Lloyd H. Dean Institute for Humankindness & Health Justice at CommonSpirit Health. She stepped into this role in November 2022 after serving as CommonSpirit's vice president of population health innovation and policy. As part of her mission to improve health equity, she helped to establish the system's Vulnerable Populations Council. This interdisciplinary executive leadership group is improving care by creating initiatives to address social determinants of health and to support vulnerable patients across the organization. The 25-member group coordinates with the Vulnerable Populations Care Collaborative, an assemblage of clinical leaders who put these strategic plans into use across the organization, which includes more than 1,000 care sites and 140 hospitals in 21 states. *Health Progress* recently spoke with Jackson about the council and its goal of promoting quality care.

Can you tell me about the origins of the Vulnerable Populations Council and how Common-Spirit Health addressed vulnerable populations prior to its formation?

One of my responsibilities was to help our system think through how we care for our vulnerable populations. What I found when I got here was that there were so many departments and providers doing great work and taking care of what we may consider vulnerable populations. But it was very siloed. As I learned more and more, I said we really need to have some sort of infrastructure that can bring all these people together: 1) to acknowledge, recognize and celebrate the great work that they are doing; 2) to identify where there are opportunities to align work; 3) to leverage some of those best practices; and then ulti-

mately, 4) to start thinking about how to measure our work, so that we can speak to the outcomes that it is having. That's how the Vulnerable Populations Council came about.

What was the council's first initiative?

We realized pretty early on, as the conversations were happening nationally around COVID, that communities of color were disproportionately affected. We were seeing that in our facilities as well as in the national data. So, we educated our communities on that information and other risk factors. People with chronic medical conditions like diabetes and asthma were at higher risk, and we presented that information in a way that was culturally sensitive to those communities that were disproportionately affected.

We realized that we needed a process to do that. So, we worked with our marketing and communications teams to create material. They vetted it through the Vulnerable Populations Council, making sure that from a health literacy standpoint, it was at a basic reading level, using a lot of graphics and pictures to try to get the information out there.

We also had to create educational materials for our providers as well — that was an ongoing process. We were updating the information as more was coming out from the CDC and other studies. We were updating our providers on that new information.

And then, as the vaccine became available, we recognized that communities that were disproportionately affected were also hesitant to get the vaccine. So, we created a whole vaccine-awareness campaign. We went into those communities in a lot of our markets, partnering with trusted community providers and organizations, like churches, universities, and of course, public health departments. It required multiple organizations coming to the table, but getting out of this mindset of always expecting the patient to come to us, the care provider, and instead for us to really get out into the community. We had multiple vaccination events, including drive-through clinics, at community locations, like schools and churches, and at farms with migrant workers. That was extremely powerful, and we were able to serve so many more patients.

How did you track your outcomes?

For COVID, we had a COVID dashboard created by our organization's quality and data analytics teams and patient-safety leader. We were able to look at everything from hospitalizations to vaccine administration. We could leverage heat maps [graphs that show the values of data represented by a color scale] — actually even look at the zip code level — to see how we were doing. I can't stress enough the need for collaboration, and having the data to support and validate the work that we were doing.

Dr. Alisahah Jackson

Are there other council-driven changes that have made a difference in patient health?

Health literacy — clearly that was a big focus as it related to COVID. But we started to realize that we had that same issue across a lot of our different patient-education materials and information. We formed a committee to specifically focus on health literacy across our organization that also includes language services. So, making sure that we have the appropriate resources for language services in the communities we serve, and recognizing that those needs are different for each community.

There are also some things that we focused on standardizing; for example, how we collect information around someone's preferred language. With the work on COVID, we recognized that we weren't consistently capturing that information in all of our markets but that it was something we needed to do.

CommonSpirit Health uses a broad definition when defining vulnerable populations, noting that all are vulnerable at times. For the council's work, Dr. Alisahah Jackson explains they prioritize populations that are systematically excluded, face significant health disparities and are often invisible. These groups include, but are not limited to, communities of color, LGBTQ+ people and those with low health literacy.

How do you collect information about your patient populations?

Information collection is done as a part of the registration process. Our Office of Diversity, Inclusion, Equity and Belonging, which participates in the Vulnerable Populations Council, really took that on. They expanded the work around how we're collecting race, ethnicity and language data in a consistent, standardized way. One example includes working with our vendors, like those who support our electronic health records, to make sure that those fields are standardized throughout our different systems. And then training our staff on the best practice for allowing the patient to self-identify [or allowing them to choose not to disclose] those characteristics, but also recognizing that we needed to actually train our staff to feel comfortable having that conversation with the patient. We also train them to explain to the patient why we are now being much more intentional about collecting that data.

How has obtaining that type of detailed information helped your organization?

This year we are really leveraging that information to look at some of our quality measures. I think this is what hospitals and health systems should be doing, even though it's not necessarily a requirement, just yet. I think that will likely be changing as well, given some of the guidelines that you're seeing from the Centers for Medicare & Medicaid Services and other payers. It allows us to do a deeper dive into how we're doing on quality.

I think that's important because often when we aggregate data, we may get a false sense of our performance. Without the ability to start to disaggregate that data to look at specific populations, we may not realize that there's a certain population that, for example, doesn't have good diabetes control. Or maybe there's a specific clinic where patients don't have good diabetes control. Often, I would say it's more due to process or resource issues versus it being that the doctor is treating that patient with bias. Nine times out of 10, that is not the case. It usually does go back to a system that is perpetuating disparities. So, we have to get to the root cause of what's happening in that system, in that process, that's contributing to the problem. That's how we're now able to leverage the data around race, ethnicity and language.

Have you learned anything surprising from your data?

I do think that for some of my colleagues, there have been eye-opening moments. One has been assuming that processes are working as designed. If you actually go and do the deep dive or an audit, you often find that the process isn't necessarily working as designed. One example I can give is around blood pressure control. In some offices, we saw a discrepancy around blood pressure control for a certain patient population. So, we dove deeper into what was going on. There's a best practice around taking blood pressure. If a patient comes into an office and their blood pressure is elevated, you let them sit in the office for about 10 minutes in the exam room and let them kind of calm down. Then, you go back in and recheck it. And what we found is that the medical assistants saw significant turnover. Even though they had received training on this, they weren't consistently doing that blood pressure recheck. That's a process issue. We had to retrain them and make sure that providers knew to look for the documentation of a second blood pressure if it was noted as elevated, and if not, rechecking it themselves. And that actually improved some of the numbers that we were seeing. So, I think that's just an example of what you can do from a quality improvement standpoint if you're looking at the data in a different way.

Do you think that the council will help your organization to improve outcomes among vulnerable patients?

I definitely do because this council is specifically focused on caring for the vulnerable and making sure that we keep that front and center as we do our work. For us, it's a part of our mission and remaining true to it. I think having this space, where people feel comfortable and safe in bringing up some of their concerns, has been really helpful. I want to emphasize that, because I think sometimes those spaces aren't created for these types of conversations. I do think that's been a huge driver for some of the initiatives and programs, and, quite frankly, the outcomes that we've now been able to look at on the organizational level.

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