CHRISTUS HEALTH'S HEALTH EQUITY STRATEGY

KATHLEEN CURRAN AND MARCOS PESQUERA, RPH, MPH

We are excited to inaugurate a new *Health Progress* column on health equity by sharing with you CHRISTUS Health's strategy to integrate health equity, diversity and inclusion throughout its ministry.

Health equity exists when all members of society can achieve the highest level of health possible. As a Catholic health ministry, our work for health equity flows from our belief in the inherent dignity of each person, our commitment to the common good and our concern for those who are vulnerable or marginalized.

What must we do to achieve health equity? Becoming intentionally aware of the diversity of our patients and communities in order to meet their health care needs is an important first step. Do our caregivers and employees have the cultural competency tools they need to fully understand their patients' health needs and to communicate with them about their care? Do our workforces and governance structures reflect the communities we serve?

Achieving health equity also requires identifying and eliminating health disparities, which are differences in health care access or health outcomes based on factors such as race, ethnic background or socioeconomic status. Some health disparities can arise within our own hospitals, the unintentional consequence of structural systems or unconscious bias. Others can be traced to societal factors, such as poverty, housing, educational disparities and other social determinants of health.

In coming months we hope to highlight the myriad ways in which Catholic Health Association members are working to increase diversity and end health disparities. CHA's Special Committee on Diversity and Health Disparities, a board committee led by Darryl Robinson, executive vice president and chief human resources officer at Dignity Health, is developing a plan to focus on four areas: the community benefit process as a key tool in addressing health disparities; disparities in access to behavioral and mental health; diversity and disparity issues in long-term care and end-of-life care; and racism and its effect on health. We invite you to share with us your work in these areas, or other ways your facility is working on diversity and health disparities. Learning together and working together as a ministry, we can achieve health equity.

HEALTH EQUITY, DIVERSITY, INCLUSION

Many health care organizations are advancing in the journey towards health equity. From minority health and health disparities to the Affordable Care Act, multiple arrows have been pointing towards that destination, and there have been glimmers of hope in the movement towards alternative payment models that put incentives in the right place: on value, not on quantity or volume.

CHRISTUS Health, headquartered in Irving, Texas, has a long history of addressing the barriers faced by minority and underserved communities. The health system signed the American Hospital Association's equity of care pledge in 2012. That pledge grew out of the national call to action to eliminate health care disparities — a joint effort of the AHA, CHA, American College of Healthcare Executives, Association of American Medical Colleges and America's Essential Hospitals.[1]

The equity of care pledge is foundational in improving the socio-demographic data collected during patient registration. Uniform and accurate data allows analysis by race, insurance status,

ethnicity and language preference. It also makes it possible to analyze who is using health care facilities by gender, ZIP code and primary diagnosis upon admission or visit. When combined with information from community health needs assessments, such data guides decision-makers on determining programs to fund through community benefit investments and helps identify strategic partners within the community for collaborations.

At CHRISTUS Health, equity of care is one of three destination points on the organizational strategic map. Connecting the dots between community benefit, population health, care management, operations, medical groups, quality, performance and diversity allows for the integration of health equity into the care delivery process. In creating a culture of health equity, four strategic pillars guide the work — diversity and inclusion, cultural competence, community partnerships and population health.

DIVERSITY AND INCLUSION

According to the Institute of Medicine's *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, there is a strong correlation between clinicians who reflect the communities they serve and their ability to achieve better compliance from their patients with recommended treatment by building trust.[2]

CHRISTUS Health leadership regularly evaluates its socio-demographic data, and it found a gap in the gender, racial and ethnic makeup of governance boards, leaders, associates and clinicians and how it mirrors the community it serves. To bridge the gap, CHRISTUS leadership has established three programs:

In creating a culture of health equity, four strategic pillars guide the work — diversity and inclusion, cultural competence, community partnerships and population health.

- **Associate Mentorship Program:** A goal for all CHRISTUS ministries is that 20 percent of senior leaders will mentor a minority associate for 18 months. The human resources talent management team has established monthly guided interactions between a senior leader and a mentee that ensure a meaningful, mutually beneficial exchange.
- **Minority Executive Fellowship Program:** This program asks ministry senior leaders to identify minority midlevel leaders who have the greatest potential to become executives. Those individuals join the fellowship program, which exposes them to many areas of the health care system and gives them opportunities for growth and education.
- **Desarrollo de Liderazgo** (Leadership Development): CHRISTUS ministries in Latin America developed a mentorship program for women with the goal of reducing the gender gap in leadership roles. As part of the program, participants meet different health care leaders within CHRISTUS and other external organizations.

CULTURAL COMPETENCE

To help it perform while it transforms, CHRISTUS uses another strategy — improving organizational cultural competence. The ultimate goal is to develop trust with patients and communities that will improve their health and well-being, both inside and outside of the hospital.

Collecting accurate socio-demographic data from patients is essential for understanding the diverse population CHRISTUS Health serves. The ministries track patients' race and ethnicity, gender, insurance status, preferred language when receiving medical care, country of birth, age and other social determinants that affect their ability to achieve optimal health status.

Once patients' realities are understood, insights into their strengths and challenges in adopting healthy behaviors allow for the development of educational interventions to help front-line staff and care providers build trusting relationships. For example, associates are now required to take online courses that ad-

dress diversity and inclusion concepts and help individuals identify unconscious biases that can affect the patient-provider relationship.

Language access is essential for cultural competence, so CHRISTUS Health has made it a priority throughout the ministries. This strategy involves consolidating outside contract providers, updating all language access policies, standardizing all technology, and training and qualifying bilingual staff.

Those steps will be followed by evaluating patient and clinician satisfaction with the services and monitoring the ministries' ability to pull data on language preference and health outcomes from the electronic medical records.

COMMUNITY PARTNERSHIPS

The definition of population health includes the health and well-being of communities, not just a panel of patients. Hospitals, as anchor institutions, need to serve as catalysts for convening government and the many organizations that hold a piece of the puzzle in addressing access to care and the social determinants of health. Many public health think tanks[3] have determined that 80 percent of any community's ability to experience ultimate health resides outside of hospital walls.

Community benefit work is key to identifying community health challenges, social challenges and establishing partnerships with organizations that are the subject-matter experts on addressing social gaps. This is where and why internal data is so important. When the health system's internal data is pulled and compared to what is happening in the community, it becomes clear that the health challenges are the same. Internal data makes it possible to clearly demonstrate how efforts in health equity, community benefit and population health need to work hand in hand.

Community benefit work is key to identifying community health challenges, social challenges and establishing partnerships with organizations that are the subject-matter experts on addressing social gaps.

At CHRISTUS Health, after reviewing internal and external data, leadership decided to address emergency department utilization visits primarily for hypertension, analyzing all patient populations and then focusing on minority and uninsured patients. This equity of care initiative incorporated the assignment of a primary care provider regardless of a patient's ability to pay, transportation resources, prescription assistance and chronic disease management education into the care management process. During this first stage, the focus was on process rather than on impact or quantity of patients served. This focus helped untangle barriers in reporting health outcomes, not just when patients were referred internally, but also when they went to the ministry's community partners for care.

POPULATION HEALTH

Population health is a discipline of real numbers that have a real story behind them. Using population health management tools and processes means measuring success and tracking outcomes — truly meaningful use of data. Electronic medical records were designed to acquire data, but then came the task of devising reports that presented relevant and user-friendly data to inform decision-makers about where to invest resources in order to have the greatest impact on the health of the most vulnerable communities.

For example, data can paint a picture of the chronic conditions that affect the most vulnerable patients. CHRISTUS Health looked at emergency department revisits by the top five diagnoses, then stratified the data by race/ethnicity and neighborhood ZIP code. Comparing that data to the community profile in the U.S. Census revealed an over-representation of African-American patients revisiting the emergency department.

Adding information about insurance status, primary care physician assignment, gender, age, and religion provided a collection of relevant data points to help leaders decide which community investments and culturally competent strategies would best improve the health of the ministries' populations.

CALL TO ACTION

AS CHRISTUS Health knows, the health equity journey is a long one, and many miles remain. To help achieve results in your organization, as a leader, ask yourself:

1. Is health equity embedded into the culture of my organization?

2. Does my organization reflect the gender, racial and ethnic diversity of the communities it serves, at all levels — associates, managers, senior leaders and governing boards?

3. Do I look at my electronic medical records data and community benefit data to get a meaningful picture of my community?

4. Do I strategically align with community partners that can help alleviate the challenges of the most vulnerable persons in my communities?

5. Is socio-demographic as well as electronic medical record data driving the focus for population health programs?

6. Is equity of care incorporated into my organization's leadership incentive program?

Your leadership is critical for the successful integration of equity of care into the fiber of your organization. We have made great progress as an industry, but according to the AHA, health disparities are our nation's new chronic condition. To have a meaningful impact in addressing health disparities as an industry, we need to invest in our ability to establish metrics that allow us to measure the impact that our efforts inside the hospital have once our patients are discharged.

Our mission to extend the healing ministry of Jesus Christ means improving quality of life for the poor, the underserved and minority populations who experience health disparities. Alternative payment models that incentivize value rather than volume are central to achieving this goal. In waiting for these models to stabilize, health care organizations must work on their ability to measure impact on population health interventions. In Catholic health care, there is a moral obligation to care for the poor and vulnerable, therefore it is our responsibility to embrace this journey and place our at-risk communities at the top of our strategic maps until we reach our destination.

KATHLEEN CURRAN is senior director of public policy, the Catholic Health Association, Washington, D.C.

MARCOS PESQUERA is system vice president for health equity, diversity and inclusion, CHRISTUS Health, Irving, Texas.

NOTES

1. American Hospital Association, "Pledge to Act," *123forEquity Campaign to Eliminate Health Care Disparities*, www.equityofcare.org/pledge/index.shtml.

2. Brian D. Smedley, Adrienne Y. Stith and Alan R. Nelson, eds., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Washington, D.C.: The Academies Press, 2003).

3. David A. Kindig, ed., "What Are Population Health Determinants or Factors?" *Improving Population Health: Policy. Practice. Research.* Blog, University of Wisconsin, Population Health Sciences, http://improvingpopulationhealth.typepad.com/blog/what-are-health-factors determinants.html.

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, July - August 2018