HealthLeaders Virtual Roundtable
SDoH and Health Equity: CMO

CLINICAL PERSPECTIVES ON HEALTH EQUITY AND SOCIAL DETERMINANTS OF HEALTH

Health equity and social determinants of health have been concerns for the healthcare system for decades, but the coronavirus pandemic has exposed and heightened these concerns.

The Centers for Disease Control and Prevention have reported that several factors have contributed to health inequities during the pandemic, including discrimination, barriers to healthcare access, people in ethnic and minority groups working disproportionately in essential settings, education and wealth gaps, and crowded living conditions in ethnic and minority homes. For groups such as Black Americans, these factors have led to more COVID-19 cases, more hospitalizations, and more deaths.

Based on the elevated concerns about health equity and social determinants of health, HealthLeaders convened a panel of experts to discuss how their healthcare organizations are rising to the challenges. The panelists discussed a range of issues, including providing care to underserved communities, advocating for health equity, cultural shifts at healthcare organizations that are required to address health equity and social determinants of health, and encouraging staff members to tackle bias.

Giovannie Jean-Baptiste, MD
Executive Medical Director
Horizon Blue Cross Blue Shield of New Jersey

Adam Myers, MD
Chief of Population Health and Director of Cleveland Clinic Community Care
Cleveland Clinic

Meika Neblett, MD, MS
Chief Medical Officer
RWJBarnabas Health Community Medical Center

David Webster, MD, MBA
Vice President and Executive Medical Director for Clinical Services
Highmark, Inc.

Christopher Cheney (Moderator)
Senior Clinical Care Editor
HealthLeaders

SDI PRODUCTIONS/GETTY.COM

HIGHLIGHTS

HealthLeaders: *Many of the solutions for health equity and social determinants of health reside outside of the healthcare sector. What is the role of healthcare organizations in addressing health equity and social determinants of health?*

Adam Myers: This hasn't been traditionally a sweet spot for healthcare. We've usually focused on what happens inside of our own walls and inside of our own disciplines and areas of expertise. However, in the public health space, we've known for some time that what we do discretely in healthcare only impacts 20% or so of health outcomes. The remaining 80% of health outcomes are connected to what we commonly refer to as the social determinants of health. If we want maximal impact, then we must lean into the space outside our walls and partner in the communities we serve.

As far as the role of addressing health equity and social determinants of health, we absolutely have a role. We tend to want to own everything that we get involved in as health systems. But this is a bigger issue than we as healthcare organizations can manage on our own, so we also must develop the capability to partner and collaborate, which is often a new skill for healthcare organizations.

We also have a role simply to declare that structural racism is real and that it represents a public health crisis. Unless we counter structural racism, we will not make the progress that is necessary.

Meika Neblett: Health systems have often felt challenged in their ability to balance traditional operations while addressing the social determinants of health that exist in their communities.

When I was a student at Montessori school, I can recall the dental van and the doctor van arriving, and I asked my mom, "Why aren't their parents taking them to the dentist or to the doctor?" And my mom said, "Well, if they can't go, the van comes and helps them out." That is where we need to be—a part of the community and helping our neighbors no matter what.

David Webster: I view this from a perspective of both a payer as well as a care delivery system. It is imperative to meet people where they are and partner with community-based organizations. If we wait for people to come to a care delivery setting, we are missing the boat.

One experience that stands out for me is living in a city disproportionately affected by diabetes. The mayor in that city called together health leaders as well as several randomly picked people from the city, and six of the seven people spoke to community-based organizations like the YMCA and others being key for them in terms of managing their diabetes. As a physician leader, I was struck by that because the focus was not on a health system or even physicians. Community-based organizations were equally important.

Giovannie Jean-Baptiste: One of the most interesting things is as everyone is looking at the social determinants of health, we're all trying to figure out what our role is. At Horizon, we're coming from the payer perspective, and it's traditionally been a handoff. First you're in with your provider, then you're handed off to your insurance company to do authorizations. Now, we need a mindset that we are all one team.

"I view this from a perspective of both a payer as well as a care delivery system. It is imperative to meet people where they are and partner with community-based organizations. If we wait for people to come to a care delivery setting, we are missing the boat. "

—David Webster, MD, MBA, Vice President and Executive, Medical Director for Clinical Services, Highmark, Inc.

Myers: Ideally, this is a shared space. There is more than enough for all of us to do. Sometimes we're an investor, sometimes we're a facilitator, but we always must be a partner because we can't do this alone.

HealthLeaders: *When it comes to meeting people where they are at, particularly when it comes to underserved communities, how far should healthcare organizations go?*

Neblett: In an ideal world, we should be dealing with the whole patient and all of their needs. In the healthcare industry, we need to look at all the social determinants of health. For example, we should ask about food insecurity and develop the connections to the food banks if necessary. Within our communities, we need to position ourselves as good neighbors and as active members of the community who understand our patients' needs, whether it's social work, whether it's smoking cessation, whether it's learning how to cook, or whether it's assistance with transportation.

Myers: There are a few ways that we can meet people where they are. Some of it is beginning to understand where they are, seeking to understand, rather than assuming we do.

Once we have a little bit more of that understanding, then we need to look at direct care, including mobile vans, siting clinics in different places, and bringing care to people's homes through community health workers.

Sometimes, it involves embedding our team members into existing organizations and augmenting them. For instance, we plant our physicians and specialists inside federally qualified health centers.

Sometimes, it's connecting people to the resources that they need. We're implementing a digital platform where we can place referrals

inside our electronic medical record for people to receive connections to community-based support such as housing assistance and legal aid.

HealthLeaders: *How do you advocate for health equity, and what kinds of information do your stakeholders value most?*

Webster: From both a payer and care delivery perspective, if we can't connect and engage with different subsets of our membership, we fail by not driving or improving clinical outcomes and by extension business outcomes.

Myers: We have some data, but it is not sufficient. So that's part of the next phase of the journey—calling attention to the need for additional data.

Neblett: We, too, need more data. For example, across our health system, we use multiple different EHRs. We're now moving to a single electronic health record. Soon our entire health system will utilize one EHR for outpatient and inpatient services, which will really help us generate comparative data.

Webster: We also do not have enough data. On the care delivery side, they have better data than we have on the payer side. But the data is imperfect. We often must use proxies for the data such as ZIP codes to extrapolate. We're getting better data, both from the care delivery side and from health information exchanges. But it is difficult to measure baselines and improvement when there are imperfections in the data.

HealthLeaders: *To address health equity and social determinants of health, what kinds of cultural shifts are required in your organizations?*

Jean-Baptiste: With everything that happened last year with race, it was an opening to say, "OK, let's start having conversation."

Early on, we held listening sessions, with a moderator and not necessarily an agenda. It was eye-opening. It was eye-opening to see the differences in how people perceived not just what was happening in the world, but how they saw the people they worked with. Initially, these were just open conversations, which were then brought to the leadership.

The leadership had no idea that people thought this way. We phased in having conversations including the leadership so that they could hear what people were saying. At the beginning of every call, it was made very clear that there would be no retaliation, and we asked people to be honest about how they saw the organization. What we found is that a lot of people thought there was no room for growth depending on your race or gender, and the leadership was surprised to hear that because we promote from within.

One of the things that came out of that process is cultural sensitivity training, which is mandatory. I just did mine a couple of months ago on Zoom®. We had a video to watch that was about a woman who was Caucasian and she talked about the glass ceiling at her job.

One of the things that we went through in the training was understanding how you react to hearing these things. So initially, my reaction as a Black woman was, "Really? You have a glass ceiling? You should live in my shoes." At this point in my life, it was very interesting personally that I still had that reaction. Until I went through the cultural training, I didn't realize that even I had this reaction. The mandatory trainings that we're having are forcing us to talk to each other and talk about difficult issues. It raises interesting questions—how does this translate into how I view my co-workers and how I view the membership?

Now people understand what we're talking about, and I think that the most important thing that we've done at Horizon is starting that dialogue. To make a cultural shift at a healthcare organization, you need to get people talking and to make people aware of what's going on.

Neblett: Last fall, we embarked upon an antiracism journey across the health system, and we are having very important, sometimes uncomfortable conversations at all levels of the organization. This process is creating an environment that is helping our team to learn and grow.

Myers: The past year has been one of material turmoil and struggle. Part of Cleveland Clinic's response to the year was to do listening sessions, like what you described, Giovannie. We called them Lift Every Voice. It was an opportunity for our teams to create a safe space for people to express themselves. It was very eye-opening.

HealthLeaders: *How do you encourage your staff to address racism, sexism, and other forms of bias?*

Webster: Part of the approach is to make it more comfortable to talk about racism and sexism. For many people, it is like politics—these are not topics that are discussed at work. But if racism, sexism, and other forms of bias are never discussed in a manner where people feel comfortable to talk about it, it doesn't get talked about, feelings get suppressed, and we all know that situation does not generate good results.

Having senior leaders in the organization that speak to the how and why it's important is extremely helpful. In our organization, our CEO and senior leaders speak to the importance of addressing bias.

The other thing that I've found helpful is having unconscious bias training. I was part of a group of leaders that had this training. It was good in terms of the way it was presented and the way it facilitated contemplating our feelings and perceptions as well as the conversation that resulted.

Neblett: Through our antiracism effort, Ending Racism Together, we're shifting the culture throughout our health system, and that is resulting in employees who are more comfortable having conversations about race, racism, and allyship.

"It was eye-opening to see the differences in how people perceived not just what was happening in the world, but how they saw the people they worked with. Initially, these were just open conversations, which were then brought to the leadership."

—Giovannie Jean-Baptiste, MD, executive Medical Director, Horizon Blue Cross Blue Shield of New Jersey

Myers: We're doing the listening sessions, Lift Every Voice. We're implementing implicit bias training. We're reporting out on health disparity within our organization to our executive team and to our clinical and enterprise leadership as well. We've incorporated cultural competency into our annual training.

Recently, we created a diversity inclusion and racial equity council at the Cleveland Clinic, which includes multiple stakeholders from across the organization. This group is focused on how we are approaching health equity and racism in the community and promoting inclusion of the community.

HealthLeaders: *How are your organizations addressing the elements of maternal morbidity and mortality that tie into health equity and social determinants of health?*

Neblett: To improve our performance, we started off with doing things as simple as standardizing best practices. We've also done a bit of work on connections to care and using SDOH information. So, from when the patient is at the doctor's office for their prenatal visits, as well as when they're in the hospital, we do an assessment of their SDOH and their needs, then we do very specific linkage to care.

Jean-Baptiste: What's currently happening is that we are trying to engage our pregnant patients in case management. It depends on our providers. So, our providers must send over their assessment, which lets us identify that someone is pregnant, and we reach out. There is a lot of data that is compiled as we're doing that.

The other thing that we're working on with the state Department of Health is doulas—having doulas in the community. Doulas have been in the community for years, but they have not been providers with your payer. Currently, there is a big push with the Department of Health to try to figure out how we can get doulas to be providers so that they can see health plan members. We want to build a network of doulas so that we can get to the underserved population.

Webster: It is crystal clear that this is a problem. There is national data that shows there is a difference with African American women in terms of mortality and morbidity when it comes to pregnancy. African American women have three times the maternal mortality and two times the maternal morbidity of white mothers. The prevalence of delivery complications is 46% higher. We are also being mindful about both maternal health and fetal health because fetal health is predicated on the foundation of maternal health. This must be addressed from a holistic perspective.

One thing we are focusing on is acknowledging that there is disparity and looking to work with community organizations on education and providing support services for African American women who are pregnant.

We are also working on addressing extreme prematurity. We must make it easy to get prenatal care and make sure there is an understanding of the importance of getting prenatal care. That is going to be a key driver of improving outcomes.

Another issue we are working on is thinking about not only the first, second, and third trimester, but also that fourth trimester after discharge. We are looking at this not only from a maternal perspective, but also from an infant perspective to ensuring care and support services in that area as well.

Myers: Northeast Ohio, including Cleveland, has one of the worst maternal and infant mortality rates in the nation. Several years ago, we began a collaborative community effort called First Year Cleveland that includes Cleveland Clinic along with all the other health systems and many community-based organizations. First Year Cleveland includes a variety of different tactics and approaches. It's training. It's identifying individuals' needs and connecting them to community-based organizations and others to meet those needs. It's ensuring that we have enough digital and face-to-face access and transportation.

> **"It's training. It's identifying individuals' needs and connecting them to community-based organizations and others to meet those needs. It's ensuring that we have enough digital and face-to-face access and transportation."**
>
> —Adam Myers, MD, Chief of Population Health and Director of, leveland Clinic Community Care, Cleveland Clinic

Lately, the collaborative has also added doulas to the scenario, just like what you were describing, Giovannie. The next phase will be important for us—implementing community health workers. They will be trusted voices from within the communities that will follow families longitudinally throughout a pregnancy and advocate for them, go to visits with them, then follow through that fourth and fifth trimester for the full first year and beyond to address health and social needs.

HealthLeaders: *How have your organizations uncovered evidence of health inequity within the geographies that you serve?*

Jean-Baptiste: We understand the way New Jersey looks. Everything is assigned by counties. This is just about collecting your data, which is what we do, then putting the resources in those areas. For example, our Newark and Camden areas are our most underserved populations, and there are many data points that we follow.

Quick off the top of my head is ER usage. How often are people going to the emergency room versus going to see their PCP? Our ER report is a big one, and it is presented to the state because they do look at those statistics. So, partnering with the state of New Jersey Department of Health, we look at where people are going, and you can see the clusters depending on the counties that people are living in.

Neblett: At RWJBarnabas Health, our quality teams share metrics that incorporate mortalities and morbidities, as well as healthcare-associated infections and other reports.

Just like any improvement structure, you must be open to receiving input from everywhere and looking at it through a healthcare disparity lens or a health equity lens and being open to what you see. So, openness, transparency, and accepting all information and input are the ways to gain knowledge of what's going on.