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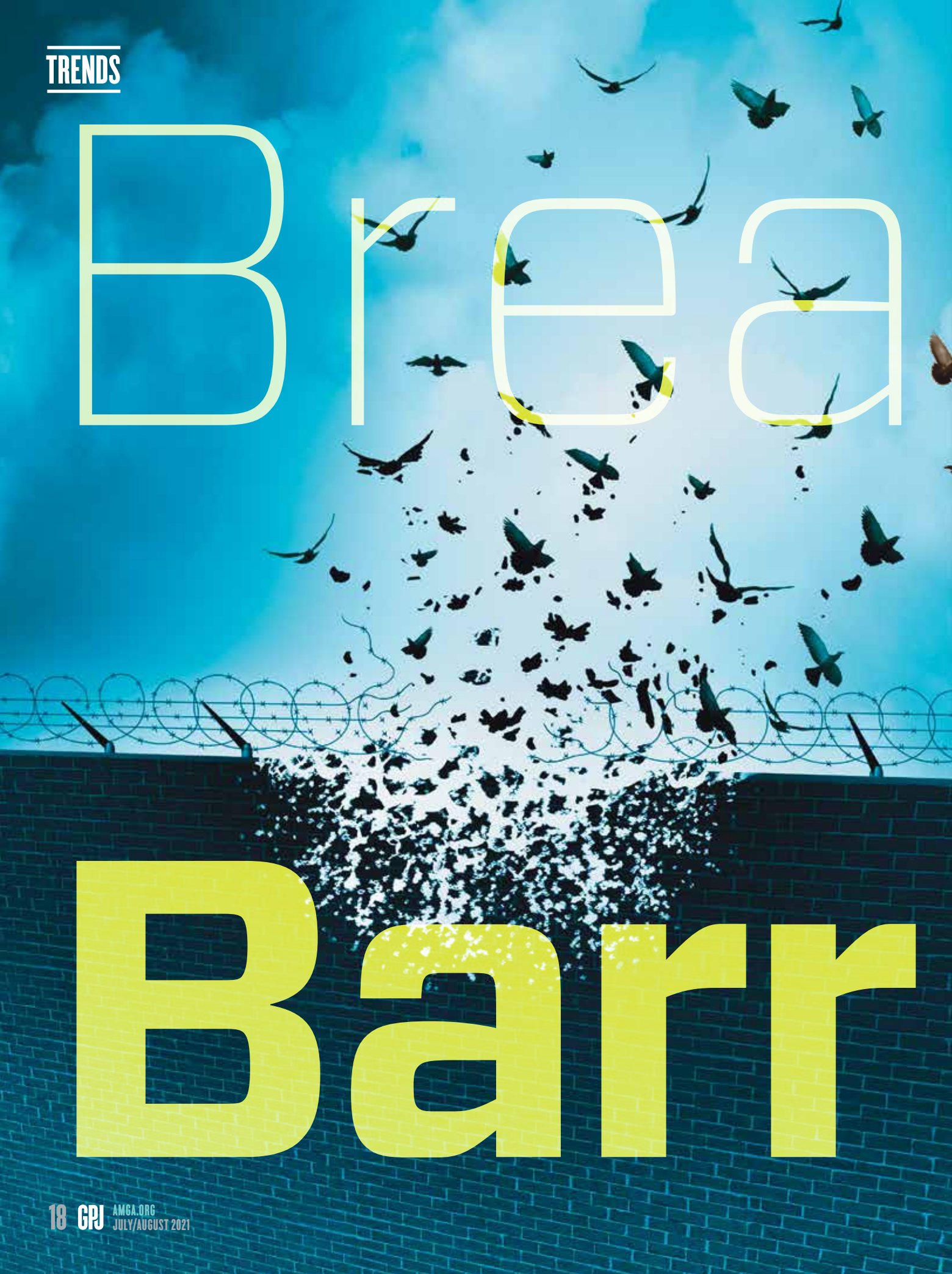

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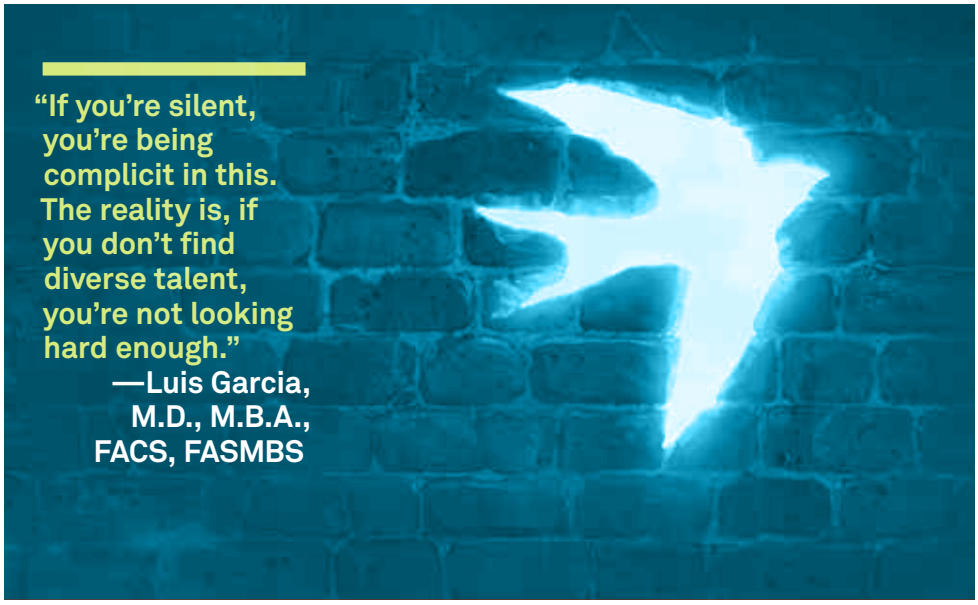
Medical group leaders share their strategies for addressing care disparities

Featuring Lydia Cook, M.D., Jerome Finkel, M.D., M.H.A., Theresa Frei, RN, B.S.N., M.B.A., and Luis Garcia, M.D., M.B.A., FACS, FASMBS

Understanding the root causes of disparities in health care and addressing them is a challenging task. It involves, among other things, focused research, community engagement, and ongoing commitment by healthcare organizations. Lydia Cook, M.D., president of Summa Health Medical Group; Jerome Finkel, M.D., M.H.A., chief primary health officer, Henry Ford Health System; and Luis Garcia, M.D., M.B.A., FACS, FASMBS, president of Sanford Health Clinic, shared their experiences addressing care disparities in a panel moderated by Theresa Frei, RN, B.S.N., M.B.A., president and chief executive officer of Sutter Valley Medical Foundation, at the AMGA 2021 Annual Conference.

Background

"This is not a new story," said Frei. "We've known for decades that in the U.S., if you are poor, have a skin color that is not white, or come from a historically marginalized group such as First Nation members or the mentally ill, there's a statistically significant chance that your life will not be as healthy as it should be." She noted that her goal for this panel was to "tell the story of healthcare inequality more fully, to tell it with a humble sense of what's working and what's not, and with the honesty of what we know and where our blind spots still lie." She focused her questions on three areas: inside healthcare institutions, outside the walls of care centers, and data.



The panelists provided diverse perspectives. Dr. Cook is president of Summa Health Medical Group, part of a three-hospital system with about 550 physicians and over 1,300 support staff in and around Akron, Ohio. Dr. Garcia is president of Sanford Clinic, the medical group for Sanford Health, which includes over 2,500 clinicians. Sanford Health is one of the largest integrated rural healthcare delivery systems, serving areas of Iowa, Minnesota, and the Dakotas. Dr. Finkel is chief primary health officer of Henry Ford Health System, a five-hospital system in southeastern and central Michigan with over 30,000 employees, a 1,900-member medical group, and a health plan.

Inside Healthcare Institutions

Frei began the discussion asking panelists about their "Aha!" moments, when their teams took a big step forward in addressing care disparities. Dr. Finkel said his "Aha!" moment related to the issue of unemployment. "We erroneously tend to see unemployment as a personal trait, as opposed to a consequence of true barriers, some of which are actually implicit and explicit within the very organizations that seek to assist in addressing social determinants of health." He noted that Detroit has the highest percentage (72%) of single-parent households in the nation. Among that group, Finkel described "Jan," a very bright, African-American, single mom in Detroit with a beautiful three-year-old daughter. Jan never finished high school, a truth for 20% of adults 25 years and older in the city. Insurance for her "semi-reliable car" cost $456 per month. Jan worked hard, but lived paycheck to paycheck. She didn't have a bank account and couldn't afford child care. Jan's mom watched her granddaughter when Jan was at work. Then, Jan's mom fell ill, and Jan had to stay home to care for both her mother and her daughter for a week. As a result, she lost her job. "So, within that one week's time," said Dr. Finkel, "this young family is now having difficulty affording food, can't afford the insurance to provide transportation, and at risk of being evicted from their apartment."

The good news was that Jan qualified for many of Henry Ford's assistance programs. The bad news was that Jan could not get a job, "even with many of the companies that seek to assist her with her social determinants." Dr. Finkel discovered that "whether due to implicit or explicit bias," if your employment application indicates that you don't have a high school diploma, you don't have a bank account, and you have a Detroit address, "in many organizations, this is an automatic rejection. We will offer food, transportation, and even housing assistance. But oftentimes, we won't offer a living wage job that can solve all those problems for this young family."

"So, for us and for me," said Dr. Finkel, "that was really an 'Aha!' moment, the way that implicit and explicit bias impacts individuals' abilities to be self-supporting and to address in the most effective way our social determinants."

Henry Ford has since instituted a $15-an-hour minimum wage within the health system. They are working with other community organizations, the city of Detroit, and United Way to provide training programs for capable individuals without diplomas and ensuring participants are paid during training. "We're also continuing to support vendors and invest in our communities ... to be able to enhance the opportunity for people to be self-sustaining."

Following up on implicit and explicit bias, Dr. Garcia noted, "This is one of those topics in which leadership matters from top to bottom and at all levels. And consistency of the message also matters." He shared his experience in a physician executive council meeting where the chair of the council asked, "Do we have the right diversity, and do we have the right leadership opportunities?" Dr. Garcia knew they did, but noted, "What I ask myself is, 'why

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is she asking that question?' And it really came down to awareness." While Dr. Garcia knew Sanford is diverse and has great opportunities for diverse people, it became evident to him that there was not enough awareness of those facts. "If you don't have the facts and if we don't speak about them, then you run into assumptions. And once you have the wrong assumptions, it's very difficult to overcome that." If you want to change the narrative, Dr. Garcia said, you must eliminate silence. "If you're silent, you're being complicit in this. The reality is, if you don't find diverse talent, you're not looking hard enough." He stressed, "This is not a technical fix. This is a cultural change. And you have to be sympathetic. You have to be empathetic. But more importantly, you have to be resilient, and you have to be intentional at speaking about it, about driving the change, and being proactive."

Outside the Walls

Moving to a focus outside the facility walls, Frei noted that for many years, health care has been known as somewhat paternalistic. "We would tell patients what they needed to do, and we would give them our care plans, and we really didn't seek feedback. And if they didn't follow them, they were noncompliant." So, asked Frei, how do we avoid that historical approach of medicine and recognize that the communities know what they need and also know what the challenges are? She asked panelists to describe how they built trust between the communities and the health system to engage the community in solving problems.

Dr. Cook described the Summa Health Equity Center, a grassroots project envisioned by the community and brought to fruition with the help of a community developer, clergy, and a real estate developer, among others. In the high-risk West Akron area, they purchased an empty lot that was a danger zone with a lot of drug selling. Now, it holds minority-owned businesses (including a barber shop and daycare center), mixed unit and

Learning from Experience

Theresa Frei, RN, B.S.N, M.B.A., shared the experiences of a young couple at Sutter Health. The 20-something first-time mother was African American. "Her whole life," said Frei, "she felt judged by her appearance. She was not expecting to be judged when she was having her baby." But after her admission to the hospital, she didn't feel like she was seen as an individual, as a new mom. She didn't feel like she was heard. After the birth, she wasn't feeling well and asked a nurse to take the baby, and the nurse's response was, 'don't you want to bond with your baby?'" So, said Frei, "there's a lot of judging going on." Soon thereafter, the young mother ended up having to have an emergency transfusion and almost lost her life. Years later, despite a prior decision to the contrary, she returned to Sutter for her second pregnancy, but had "a very difficult conversation" with her doctor, sharing her prior experience. That young mother's story has "had a ripple effect across our 50,000 employees and our 5,000 clinicians." Now, Sutter tells this and many other stories as part of their unconscious bias training. It's through these conversations, said Frei, that "we uncover and get over the errors."

Lydia Cook, M.D., had a somewhat similar story, involving an African-American couple in their 20s. Dad wasn't always able to come to appointments due to his work, and the patient had a doula. Although Summa has a doula program and supports mothers with that, when this working-class patient was going for her prenatal care, there was always a question about how she could afford a doula, because, said Dr. Cook, "there was an assumption that the affluent community is the only group that could afford it." The mother was taken aback somewhat, but "didn't think anything of it." Then, however, when she went to deliver, "the nursing staff was not as engaging as she felt they should be. The mother was telling her nurse that she couldn't hold anymore, and she had to push. And the nurse said, 'Well, you'll just have to hold,' and walked out of the room." The doula followed the nurse to stress that the patient "is being honest with you and you have to listen and hear her." In that short period of time, said Dr. Cook, this mother had a precipitous delivery. The baby actually hit the floor, resulting in a transfer to the neonatal nursery for observation. Dr. Cook said that incident was "a result of people's implicit bias, lack of listening, and what we describe as microaggressions." Worse, the nurse didn't want to take responsibility for what occurred and blamed the mother, who, "of course, took that guilt and was internalizing it and had some challenges with postpartum depression."

Dr. Cook and the chair of OBGYN met with Summa doulas, discussed what had happened, and conducted an analysis "to understand what we could do better." They worked with the University of Akron to have Harriet Washington, a historian who highlights medical atrocities in the Black community, give a talk with a Q&A session, which helped to "set the tone for helping people understand what the impact to the community was as a result of these kinds of biases and racist interactions among the medical community historically." Then, Dr. Cheryl Johnson, an African-American physician, put together an ongoing program on implicit bias for Summa residents and nurses, which has received a lot of positive feedback. Lastly, Summa Health community health workers are now being doula trained. The mother involved in this tale is in Summa's parents mentoring program, and, Dr. Cook noted, "she felt good that we were supporting her and that there were a lot of changes as a result of her story."

senior living, and a health practice embedded in the community. A community board makes decisions on each year's programing. "They say, 'This is what we need. This is how we want to do it, and what kind of resources are we bringing to bear alongside Summa?'" Dr. Cook noted that partnerships with Summa's minority health behavior group and others "are really the drivers of getting the voice of the community, and the community board then drives that programming. And then we lend those resources in the Summa Health Equity Center."

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—Lydia Cook, M.D.

Programs include kitchen demonstrations by local chefs, exercise programs, a program for diabetes prevention called "Sweet Life," a pregnancy program, an adolescent girls program called "Coming of Age," and a financial literacy program presented through a local bank. All this in addition to the health practice, which will write out prescriptions for patients to avail themselves of all the programming at center.

"It's exciting," said Dr. Cook, "because when we give those prescriptions to individuals, it's not just 'Do what we say. And if you don't do it, you're not compliant.' It's more of 'Here's part and parcel of what we have to offer, and these are the array of services, and we've checked off a few that you might benefit from. Go over to the Summa Health Equity Center and then see what you think you want to take part in, what you are ready for.'" Dr. Cook noted, "We really make sure that the community is the one telling us what they need and not us telling them what they need. And that builds a much stronger, trusting relationship, and the community gets what they need, and the people benefit from that."

Frei noted that the pace of building community programs can take time and is affected by budgets and other constraints. She asked what principles or actions guide the process of sustaining community partnerships for decades and how to assess success. Dr. Garcia said Sanford has a longstanding history of partnering with their communities. "We start with a basic premise that our main goal is always to be respectful of our partners and design sustainable strategies. We have to identify the right need, with the right partner, and at the right time." He identified three key points of emphasis. First, engaging in joint planning and preparation. "I think that is of utmost importance, that we have clear goals and that we have a common purpose with those partners." Second is sharing support and responsibility. Although Sanford is often the biggest supporter of any initiative or relationship, they always want the other partner to have some stake in the game "because that's what feeds sustainability and engagement." Finally, "like any other relationship, it really comes down to transparency and trust."

Dr. Garcia said that knowing what is and isn't working requires staying close to the relationship. This includes having Sanford physicians on the boards of their initiatives and holding annual meetings, among other things. Sanford's commitment to community engagement was reinforced by the CEO's recent announcement of a paid community service day for all employees and physicians. Participants can choose any project in the community—small or large, individual or collective—and Sanford provides a paid day off for the project. "That," said Dr. Garcia, "is something that we're very excited about. I think it speaks to the proactiveness that we want to create, engaging our communities outside of programmatic restrictions."

Data

Frei noted that while Henry's Groceries (see "Howdy, Partners") used data to help support the program and show results, many of the stories told by the panelists don't have data attached to them. She asked if any particular data sets played a role in making a big change in how care could be delivered more equitably. Dr. Finkel said the data set making the biggest difference at Henry Ford started "many, many years ago." They call it REAL data, which stands for **R**ace, **E**thnicity, **A**nd **L**anguage, and is integrated in their Epic electronic medical record (EMR). This data is used to generate the system equity dashboard and

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Henry Ford Health System partnered with Gleaners Food Bank to create Henry's Groceries, a clinic-level support program addressing food insecurity.

Howdy, Partners

Jerome Finkel, M.D., M.H.A., said there is little temptation at Henry Ford to build programs "all by ourselves" because the "magnitude of the challenges is just so significant that it would really be impossible for us to do so." Quoting Ryunosuke Satoro, Dr. Finkel said, "individually, we are one drop, but together, we are an ocean." He provided two examples of that philosophy in action.

Henry Ford's Jackson community created a health improvement organization that now has over 500 members, including community-based organizations, faith-based organizations, health systems, health departments, and businesses. "It's really a hub for the entire community to be able to identify and evaluate and respond to the community needs," said Dr. Finkel. They also have a community information exchange; all the participating organizations are connected digitally so patients have a closed-loop system where they can receive care. The community came together to purchase baby formula in bulk and provided it to mothers in need during the COVID-19 crisis. "As health providers," said Dr. Finkel, "we talk about empathy a lot. But if you can have an entire community that was an empathetic community, it would be this community."

Another example is Henry's Groceries, a partnership in the Detroit area between Henry Ford and Gleaners, one of Michigan's largest food banks (see related article on page 25). Through this program, patients at the clinic are screened for food insecurity. If they screen positive, they are connected with embedded care managers who conduct an assessment "right there on the spot." Eligible patients are then enrolled in the program and often given their first food box before they even leave the clinic. Gleaner's takes over from there, providing home delivery, "which," Dr. Finkel noted, "is a pretty significant differentiator for this food program." The food box delivery includes 14 meals and occurs every two weeks for a year. As well, the program stays in touch with patients, checking every two weeks, "Is the food enough? Is it too much?" Ultimately, said Dr. Finkel, this helps them provide some variety and to some extent honor food preferences. Statistical analyses, conducted with the assistance of Gleaners, showed that in comparison to a comparable group of non-participants, Henry's Groceries participants had a 44% decrease in ED utilization and a 15% decrease in inpatient utilization. Although A1c and BMI were not significantly different between the two groups, the cost of care for the Henry's Groceries group was $263 less per member per month. This kind of program, integrated within the community, is "the only way that we find that we can really be successful," said Dr. Finkel, "and I would say we continue to use that philosophy as we generate new and innovative ideas to try to address the needs within our communities."

to apply an equity lens on all quality improvement activities.

An example of the REAL data in action came up during COVID-19 vaccine deployment. Initially, Henry Ford vaccinated its healthcare workers. Once that was done, Dr. Finkel said, "We were kind of given the mandate to just get shots in arms, you know, let's just make sure that we're vaccinating." So, they opened the schedule, allowing anyone to directly schedule an appointment. "You might say that everyone had an equal opportunity to sign up and get vaccinated," said Dr. Finkel. "You *might* say that. But what we found was that ... our White patients were two-and-a-half times more likely to get vaccinated than our African-American patients. So equal, perhaps, but definitely not equitable." They pivoted to an "invitation only" strategy, and used the REAL data to identify specific areas, ZIP codes, and populations to target. First, invitations were sent through the MyChart patient portal. "We found that was better," said Dr. Finkel, "but still not good enough," because many of the targeted populations didn't have high levels of MyChart portal usage. To better target these populations, Henry Ford starting texting, emailing, and even calling patients who did not have or were not using MyChart accounts. Finally, to address vaccine hesitancy, they've taken their mobile vaccination clinic to faith-based organizations, "and that has been very successful." Dr. Finkel concluded, "Without this REAL data, we would not have been nearly as successful at deploying our vaccine strategy in a very equitable way."

Dr. Garcia's data in action story also arose from COVID-19. When the pandemic began, Sanford started a patient registry through its research program. Initially, the intent was to keep track of patients diagnosed with COVID-19 and follow

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—Theresa Frei, RN, B.S.N., M.B.A.

demographic and clinical characteristics to try to understand the disease. The registry includes nearly 98,000 COVID-19-positive patients, and it allowed Sanford to clearly identify risk factors such as age, obesity, chronic renal failure, vascular disease, and diabetes. From there, they started identifying which characteristics impacted admissions, length of hospital stay, mortality, etc. That became important when Sanford began using monoclonal antibodies. They were able use the registry data to identify patients who had multiple risk factors and positive COVID-19 tests, and then proactively contact those patients and bring them in for monoclonal antibody therapy. "We continue to track those positive tests," said Dr. Garcia. Sanford has given more than 2,000 doses of the monoclonal antibody therapy, "and what our numbers say is that we prevented 100 admissions, about 600 patient days, and we probably prevented anything from 12 to 15 deaths by using this approach." They used a similar approach to vaccines. With a "very limited amount of vaccines," they identified the population groups at high risk and provided the vaccine to them before others with lower risk. Dr. Garcia noted, "That is something that really worked for us."

What really keeps Dr. Garcia awake at night, though, is "how are we using the data that we already have? And if we don't start using that in a smart, intelligent way, somebody else is going to do it for us." He noted nontraditional players coming into health care, such as Amazon and Google. "You know, they have the data, and they're going to start using this data in a way that is really going to start defining how we deliver health care in the future." So more than focusing on any specific data set, Dr. Garcia says it's important to ask, "How are we using the data that we have, and should we be using it in a different way?"

Turning to the issue of sharing data with communities for maximum impact, Dr. Cook described a mayoral initiative on infant mortality focused on getting as many babies as possible to full term and through the first year of life. That initiative prompted Summa Health, Cleveland Clinic, Akron General, and Akron Children's to come together in a learning collaborative. They supported an equity officer for the mayor's office who organized all the health systems, the federally qualified health centers in the community, as well as community groups focused on infant mortality. They meet monthly to report data. Dr. Cook noted that Ohio ranks 38th out of the 50 states for infant mortality, with a little over 7% infant deaths per 1,000 births. Summa looked at several data points including preterm births, neonatal admissions, breastfeeding in the community, and infant mortality by race. They also focused on two special populations, the opioid addicted and the Nepali refugee population. Following the data through the initiative has shown several improvements. At baseline, African-American risk for infant mortality was about 38%. "As a group, with the organizations and the health systems together, we've decreased that down to 7%." Neonatal Intensive Care Unit (NICU) admissions for the opioid-addicted population was at 100% at the start of the initiative, but Summa's programs with their addicted population have decreased their NICU admissions to 31%. NICU admissions in the Nepali population also decreased, from 22% at baseline to 18% currently. Breastfeeding in the community has increased from 68% to 84%. The other most important thing, said Dr. Cook, is their Safe Sleeping program, which delivers portable cribs and shows parents how to set them up. "Our crib death is almost down to zero."

All this data is shared in the monthly group meetings, and a data dashboard is shared across the health systems and all the community organizers. Dr. Cook said it's important for the community to know about the initiatives happening in the city, "and everybody will point to infant mortality because they all know the stats, and they all are really driving and going in the same direction." She also noted that the learning collaborative approach breaks down barriers to data sharing and best practices. Participants become less afraid of not measuring up and more interested in "what are the root causes and how can we help?"

Closing the presentation, Frei said, "I'm just amazed with all the stories I heard today." From addressing implicit and explicit bias inside care facilities, to collaborative, long-term community initiatives and the data used to support them, "and not once," noted Frei, "did we talk about the data that we're collecting in Epic that's just related to inside our walls. 'Are they happy?' 'Are we talking to them?' We talked about the impact outside our walls, which is really where the care disparities hit." GPJ

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