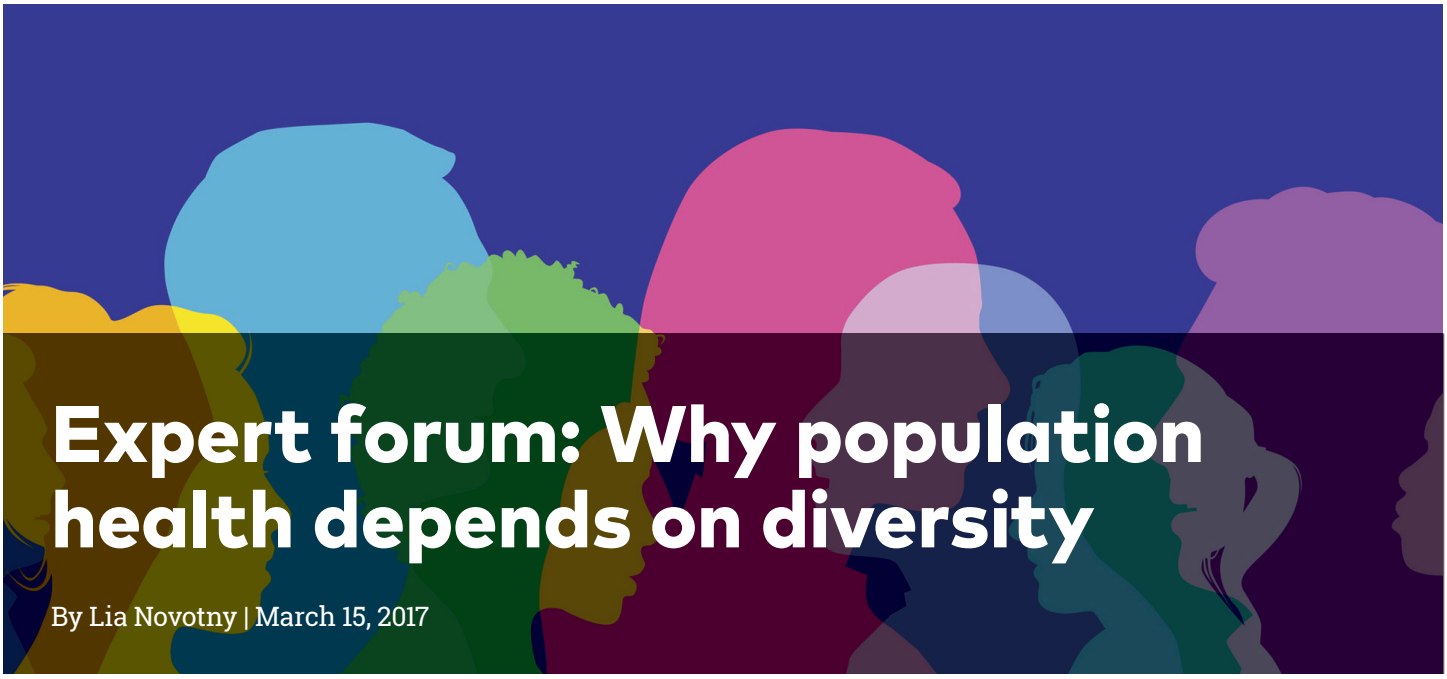

Expert forum: Why population health depends on diversity

By Lia Novotny | March 15, 2017

At the most basic level, population health management begins with understanding the population. That means bringing the right voices into the conversation, weaving a diversity of perspectives throughout the organization, and finding ways to truly operationalize health equity.

athenaInsight spoke with leaders at four healthcare systems that manage diverse populations about the steps they're taking to understand their patients' needs — and improve their clinical outcomes.

Here are edited excerpts from our conversations; please add your thoughts to the comments or tweet us @athena_Insight.

On staff, team and leadership diversity

Ryan Parker, vice president, diversity and inclusion, KentuckyOne Health: Health equity is directly tied to the idea of population health. In fact, it is the foundation. The way to really get to the root of our diverse population, their diverse social needs, and the many barriers that are facing our health consumers is to have their voices at the top of the organization.

Denise White-Perkins, M.D., PhD, director, Henry Ford Health System Institute on Multicultural Health, Michigan: As you're doing your strategic planning and trying to be proactive, having those voices at the table can often help you avoid things that might be viewed as insensitive or culturally incompetent.

Parker: Our board is now intentionally diverse. Not only racially and ethnically, but geographically. KentuckyOne covers consumers from the Appalachian Mountains to urban Louisville. The way you address healthcare in rural Kentucky is not the same as in Louisville. The way they get information is not the same. Access is not the same. It all comes back to the idea of "no decision about us, without us."

On meeting patients where they are

Myechia Minter-Jordan, M.D., MBA, president and CEO, The Dimock Center, Boston: You have to put yourself in the patient's shoes and understand that as you build your program and services, you have to be responsive to that patient's needs.

Kemi Alli, M.D., CEO, Henry J. Austin Health Center, New Jersey: Patients came in seeking help, wanting to get better, and then it was curious to me why they would come back not having done what we discussed. My question was, "What's missing?" Understanding the patient's situation is the key to understanding what is missing. I don't hate many things, but the one thing I do hate is this word "noncompliant," because to me it takes the accountability off the healthcare institution and it places all that burden onto the patient.

Minter-Jordan: When I got here, we weren't open evenings and weekends. Everything was being done during our time. This is a working poor community, and asking them to take time off in the middle of the day to come into the clinic is not realistic. You're going to have a higher no-show rate, you're going to be more ineffective in your outcomes. Expanding to evening and weekend hours was meeting people where they were, when they had the time to dedicate to their healthcare.

Parker: We have five language services supervisors who are integrated into every safety huddle across our system. We're tracking on a weekly basis what's happening with our limited-English-proficient or deaf and hard-of-hearing patients, and we round on them every day. We're focusing on building dashboards to take a look at various quality measures — like readmission rates — for our patients who have limited English proficiency to make sure those patients have the resources they need, in the language they understand, to prevent avoidable readmissions.

Minter-Jordan: If I say, "Mr. Jones, you're diabetic and you're not following your diabetic regimen," well, maybe he can't afford the food that I'm telling him to buy, maybe he can't afford the medication. We brought on our own 340B pharmacies with that in mind — how do we make sure our patients get the medications they need?

On building trust in the community

Parker: Oftentimes the communities that you're trying to reach are intimidated by hospitals. Combine that with bad patient experience stories or perceptions, and that creates significant trust barriers. Diversity becomes a way to rebuild that trust — diversity in leadership and the workforce. I've leveraged employee affinity groups as advocates to rebuild trust with the community.

Alli: Henry J. Austin is part of the Trenton Health Team, which brings together all the individuals that have any stake in improving the lives of the people we serve. It involves police and juvenile corrections and education and social service agencies, and we meet regularly to discuss, "How does what I do affect what you do? How can we work together?"

White-Perkins: We've had instances where there was a concern in the community and we had a longstanding partnership with a group, and so they came directly to us where they could easily have gone to the press or to attorneys. But because of that trusted relationship, they were able to come to us, and we could problem-solve around the issues.

Parker: We're partnering with organizations that serve the community, ranging from refugee communities, communities with limited English proficiency, the homeless community, veterans, and deaf, hard-of-hearing or differently-abled communities. You're seeing healthcare organizations do more outreach in the places where the populations are — the local laundromats, Wal-Mart stores, beauty shops, salons, even where they worship and where they buy their food.

On operationalizing cultural competency and health equity

Parker: Providing culturally competent care should be an expectation of every healthcare provider. But it goes beyond those at the bedside. It should be an expectation for every employee who comes in contact with patients. We've worked to embed cultural competency education into every new employee orientation and annual education.

White-Perkins: Organizations also need to be accountable for being culturally competent. You can say, "We don't have any disparities," but then you

have to say, "Well, we haven't looked for them, either." We created an equity dashboard. We identified approximately 20 of the quality measures that we already look at — such as readmissions, falls, or diabetes control — and stratified by race, ethnicity, and language, to see if there were opportunities for improvement.

We found that the sites with the worst diabetes control had lower levels for utilization of existing services. So we did a pilot where we had a community health worker reach out to patients with uncontrolled diabetes, assess social barriers and other concerns around managing their disease, and link them back to services that already exist. It turned out to be a very effective intervention — for the cost of a medical assistant. Now we have a full-time permanent position of community health worker as part of our diabetes education teams.

Parker: At KentuckyOne, we are working to create culturally competent clinical pathways — similar to clinical protocols — to better serve our veteran patients. Veterans experience persistent health symptoms which remain unexplained after a complete medical evaluation. We are now exploring our ability to collect patients' military service status and track it in the EHR. Then we will be able to include more specific questions for veterans as part of our patient assessments, which we hope will help us uncover the blind spots that can lead to health disparities for veterans.

White-Perkins: When you think about quality, there are six core aspects: safe, timely, effective, efficient, patient-centered, and equitable. People understand that you can't say it's quality care if it's not safe. The same for efficient and timely and the others. But I think we still have some work to do for equity. It should be universally accepted that unless the care you're delivering is equitable, then you cannot say it's quality care.

Lia Novotny is a regular contributor to athenaInsight. Interviews were edited and condensed.