Leadership & Management

'We alone can do our part': How US News' top 10 hospitals are addressing health disparities

Kelly Gooch - Updated Thursday, August 6th, 2020 Print | Email

The COVID-19 pandemic and deaths of Black Americans such as George Floyd have spurred many health systems to take increased focus on addressing systemic racism a

health disparities. As a result, organizations are implementing various initiatives, from outreach programs to education to recruiting a chief diversity officer.

For a closer look into their efforts, *Becker's Hospital Review* asked the top 10 hospitals named to the *U.S. News and World Reports*' 2020-21 Best Hospitals Honor Roll to reveal how they are working to limit health disparities. Read their responses below, presented alphabetically.

Editor's note: The following responses were lightly edited for length and clarity.

Joshua Adler, MD, executive vice president and chief clinical officer of UCSF Health (San Francisco): We have approached inequities from multiple angles, from addressing them in our own workforce recruitment and advancement, to systematically identifying health disparities among our patients. Any time you're trying to create a systemic change, you need to know where you currently stand, and for that, you need data. One of the most important, long-term efforts we have undertaken is to develop common definitions for demographics (e.g., racdoubene/ethnicity, sexual orientation/gender identity) and collect that information systematically from patients, which we then incorporate into our performance dashboards for quality, patient experience and access. As a result, we've been able to identify disparities across all of our performance metrics, such as hypertension control among African Americans or differing patient experiences, and set up plans to continuously improve them.

Cindy Barnard, PhD, vice president of quality at Northwestern Medicine (Chicago): Northwestern Medicine has placed optimal outcomes and mitigation of health disparities and inequities at the center of its quality priorities. There are three principal areas of focus: robust partnership with our communities; a diverse and inclusive workforce; and patient-centered quality improvement in areas of clinical vulnerability and disparities, such as COVID-19, maternal health, influenza vaccination and chronic medical conditions (diabetes, hypertension).

The approach was exemplified in a rapid response to the racial disparities identified early in the COVID-19 pandemic. Chicago region data revealed significant disparities in the rate of COVID-19 infection, hospitalization and death in Black and Latinx populations as compared to white residents. Our community partners endorsed the need for proactive engagement of patients to ensure they know what COVID-19 symptoms to monitor and how to get testing and help.

Northwestern mobilized two outreach programs to support the community. The outpatient COVID19 monitoring program provides daily calls and monitoring for patients who report symptoms or are tested for COVID-19, enabling close follow-up and referral for escalated care when needed. This was particularly important for patients who did not have an established source of ongoing primary care. The outreach program has reached over 9,000 patients, helping patients live more comfortably at home, providing them with education, reassurance and comfort.

The NM Health Outreach Promoting Equity initiative was implemented to reach out to

patients in vulnerable groups, especially Black and Latinx patients, in identified hardship communities who are also identified by a custom-developed NM predictive model as potentially at risk for serious illness if they did contract COVID-19. These are patients with comorbid medical conditions and other risk factors, including age. These screening calls enable Northwestern to provide information and education to the patient about COVID-19 symptoms and link patients back to their physicians for a test, televisit or in-person visit when needed. In the same call, we screen and make referrals for social determinants of health, such as housing or food insecurity, need for financial assistance for medications, social isolation and transportation. Over 5,000 patients have been individually called from the highest risk group, and the lower-risk patients receive text and paper mail outreach with the same resources. About 20 percent require medical support, such as a physician visit or medication refill, and 14 percent require support for social needs.

Joseph Betancourt, MD, vice president, chief equity and inclusion officer at Massachusetts General Hospital (Boston): Since 2007, MGH has been monitoring the quality of care they deliver by race, ethnicity and language in their Annual Report on Equity in Healthcare Quality. This is fundamental and foundational to being able to identify and then address health disparities, given you cannot manage what you don't measure. Over the years, MGH has developed programs to eliminate disparities once identified, including a culturally competent diabetes coaching program, a colorectal cancer screening navigator program and programs to eliminate disparities in flu shot vaccination. Currently, MGH is working on addressing disparities in patient experience related to discharge and discharge instructions.

Linda Burnes Bolton, DrPH, RN, senior vice president and chief health equity officer at Cedars-Sinai (Los Angeles): Cedars-Sinai is located in the heart of Los Angeles, one of the nation's most diverse cities. While racial and cultural diversity make for a vibrant city, some groups are underserved when it comes to healthcare education and outreach. That is why Cedars-Sinai's Research Center for Health Equity has provided cancer education workshops for Korean-Americans, Filipino-Americans and Black residents in churches and recreation centers. Outreach efforts in the Korean American community is particularly important because of the high rates of GI cancers among its residents. Workshops in that community have touched more than 1,700 people; 735 have attended in-depth sessions on cancer screening and prevention. Our health equity team follows up by arranging cancer screenings, often at local free clinics.

Chyke Doubeni, MBBS, family physician and inaugural director of the Mayo Clinic Center for Health Equity and Community Engagement Research (Rochester, Minn.): At Mayo Clinic, we feel called on to meet the moment, to confront racism and embrace transformation. We believe that what we do to support marginalized populatio in our workforce and communities will benefit everyone. Mayo Clinic has made an investment of $100 million over 10 years to support areas in education, research and clinical care, [to reduce health disparities]. In the area of workforce diversity, we will inv

in hiring new faculty to lead research in areas of health disparities and advance health equities across our three campuses. We are also working to strengthen community partnerships and community-engaged research to improve health equity. Mayo has campuses in Florida, Arizona and in the Midwest, and we are putting a particular focus in the Southern states because of the diverse population in these areas and the disproportionate impact of COVID-19 on populations in these areas.

Fritz Francois, MD, chief medical officer and patient safety officer at NYU Langone Health (New York City): Recognizing the importance of providing access to patients in order to address health disparities and achieve better equity, we advanced care in Brooklyn, an area with the highest percentage of Medicaid patients. Our goal was to ensure that the same quality of care delivered in our Manhattan hospital was provided in our Brooklyn hospital as well. To do so, we introduced services that did not exist at NYU Langone Hospital-Brooklyn, such as advanced endoscopy and robotic surgery. Additionally, we introduced what is fundamental to addressing disparities and achieving equity: We measured what we were doing. We looked at our metrics and asked, "Are we seeing same results as it relates to key indicators, including mortality, hospital-acquired conditions systemwide?" We were able to slowly bend that curve.

And our strategy goes beyond what we did in Brooklyn. Our ratio of number of observed deaths to number of expected deaths for the entire system is well below 1.0. That achievement is also because we've established the same standards across the entire system.

Hospital-acquired conditions were another important set of metrics. We have similarly measured that and focused on strategies that resulted in significant improvements. As it stands now, we have been able to look at all these things across various measures — surgical site infections, 30-day admissions, etc. — to ensure we were achieving the same outcomes systemwide for all our patient populations.

Julia Iyasere, MD, vice president, NewYork-Presbyterian Center for Health Justice (New York City): At NewYork-Presbyterian, we are committed to eliminating health disparities for our patients and our communities. As a part of this commitment, we conduct a comprehensive community needs assessment every three years to identify how we can help better serve our communities. The most recent assessment revealed that access to healthy food and food insecurity are core issues for our patients and their families across our system and diverse communities in New York City and Westchester County. Chronic diseases, such as obesity, diabetes and heart disease are among the leading causes of death and disability in the state, and improving nutrition and food access is a key element in preventing these conditions.

To build on these efforts, we expanded our health screening of patients to include questions around social determinants of health so that we could further understand the needs and disparities in our communities. At our Washington Heights Family Health Center, part of NewYork-Presbyterian's Ambulatory Care Network, staff found that near 30 percent of families with young children who came to the clinic said they could not always afford food.

To address this disparity, NewYork-Presbyterian launched a number of healthy food access initiatives, including Food FARMacia, a pilot program that began in June 2019. This mobile food market is open on Tuesdays, Wednesdays, and Fridays, alternating between NewYork-Presbyterian and community sites and provides a wide variety of dry goods and fresh fruits and vegetables. The program is a collaboration between NewYork-Presbyterian's Ambulatory Care Network, CHALK (NewYork-Presbyterian's childhood obesity prevention program) and the West Side Campaign Against Hunger.

To date, 1,255 families have been registered. Families take home between 30 to 40 pounds of free food at each visit. The program has given away around 164,000 pounds of food so far. Through continued use of data accumulated from health screenings, this program is currently expanding in Brooklyn, Queens and Westchester.

Redonda Miller, MD, president of Johns Hopkins Hospital (Baltimore): Across the Johns Hopkins Health System, we are working to address disparities in the identification and care of patients with COVID-19 in our local Latino community.

At the Johns Hopkins Hospital and our sister hospital, Johns Hopkins Bayview Medical Center, a disproportionate share of patients admitted for COVID-19 has come from this community. These patients live in densely populated neighborhoods, tend to be essential workers and often lack access to COVID-19 testing. In addition to these risk factors, they face challenges that include language barriers and a hesitancy to seek out necessary care due to undocumented status.

In an effort to reduce this inequity, we decided to bring testing and follow-up care directly to the community through a collaboration between Johns Hopkins, the city of Baltimore, the nonprofit Baltimoreans United in Leadership Development and faith-based organizations.

Since late June, our Johns Hopkins testing "go team" has erected a tent at a church in one of the hardest-hit Baltimore City ZIP codes for appointment-based and walk-up testing. The response has been robust and has amplified the need for this work. To date, the team has conducted more than 1,000 tests. Among the Latino residents tested, about 35 percent tested positive for COVID-19, compared with less than 5 percent of non-Latinoresidents.

Plans are underway to expand this successful model to other Latino communities in central Maryland.

Adam Myers, MD, chief of population health and director, Cleveland Clinic Community Care: It is undeniable that the structure and fabric of our society has — by design — placed Black Americans and people of color at a disadvantage for hundreds years. Recent events have again highlighted the reality of structural racism and its profound effect in producing economic, political, educational, social and health inequities.

This is not new information. This reality has played out since slavery. Those disadvantages result in higher death rates of Black babies and Black mothers, a dramatically higher prevalence of chronic diseases and profoundly shorter life expectancies for Black Americans. These are just a few of the historical and enduring effects of these structural disadvantages.

As an anchor institution, Cleveland Clinic is committed to promoting better educational outcomes, job growth, safer housing and culturally inclusive healthcare that is free from implicit bias. We are actively partnering with community leaders to help strengthen community resources and mitigate the impact of social determinants of health.

In the end, health equity is the goal. Note, that I said health equity, not healthcare access. Convenient access to care is only one factor.

We cannot do this alone. But we alone can do our part.

Several years ago, we established the Langston Hughes Community Center in the Fairfax neighborhood adjacent to our main campus. Fairfax is a textbook example of a disadvantaged community and has the health disparities to show for it. The Langston Hughes Center has been a touchstone in the community where people can get health screenings, participate in health challenges, learn about healthy food, participate in exercise classes and join shared medical appointments.

Johnese Spisso, president of UCLA Health and CEO of the UCLA Hospital System (Los Angeles): The UCLA Hospital System and the David Geffen School of Medicine at UCLA support primary and specialty care, radiological and other services at Venice Family Clinic, a nonprofit community health center that provides integrated care and wellness education to underserved populations at 12 locations across our region. About 150 UCLA medical residents and faculty provide more than 4,700 volunteer hours each year, and clinic staff are UCLA Health employees. In addition, the UCLA Hospital System will recruit a chief diversity officer to strengthen our focus on strategic initiatives.

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