

# Trustee Insights

## HEALTH EQUITY



## Overseeing Health Equity in the Age of Emerging Risk

### Intentional, strategic actions for hospital boards

BY KARMA H. BASS, DORA BARILLA AND KEVIN BARNETT

**E**xecutive leaders and governing boards are now charged with aligning strategic priorities that address community health with a specific focus on health inequities. Incorporating health equity into strategy represents a new undertaking for some health care leaders — one that requires a shift in thinking and taking

action in such core areas as culture, structure, functions and incentives.

What has been underscored during the past couple of years of the COVID-19 pandemic is that quality improvement is not possible without addressing the health inequities of underserved and diverse populations. You simply cannot have high-quality care without equity, and the shift toward risk-based reimbursement models is recentering care from the hospital to the community and incenting health care organizations to integrate population health improvement into the strategic plan.

### The Culture Shift

Peter Drucker, the father of management theory, has been credited with saying that “culture eats strategy for breakfast.” That statement clearly applies to the imperative for paradigm shifts and transformational change in hospitals, health systems and the health care field. However well-conceived an organization’s strategies may be, the organization’s culture will determine its relative success or failure.

Change is inherently disruptive. Maintaining the status quo for any organization may seem easier in the short run, yet is unlikely to deliver long-term success. Changing culture requires leadership support, care and ongoing nurturing. Those charged with executing health equity and social determinant strategies require both understanding and explicit support from the board and executive team in order to disrupt longstanding patterns of organizational behavior. Addressing health equity and socially complex issues within our health organizations is desperately needed to improve the health of our nation. This need must be coupled with a culture that supports a change in systems of care.

Shifting cultures to prepare for this work is foundational for the success. Systems of care currently rely upon structures that were built years ago and will require the key elements of systems change. This will not only require shifts in policy,

resources, practices, relationships and power dynamics but also in [mental models](#).

Changes in mental models start with culture. Mental models address deeply held beliefs and assumptions that are taken for granted. Those beliefs influence what we think, what we do and how we talk — and are deeply engrained in culture. Executive and board sponsorship is needed for any efforts to address

health equity. A personal journey and honest dialogue must take place to understand deeply held beliefs. If the leaders and staff in a hospital or health system aren't passionate about the organization's health equity vision, they won't be enthusiastic about executing the plan, and then the strategy stands no chance.

If your organization's culture isn't ready for this type of change, start

by listening. In many organizations, there may be an understandable emphasis on immediate action and results. The reality is that people are suffering, and health care leaders need to act. Remember that listening is acting and can be an effective strategy in creating a healthy culture.

Effective health equity strategies for any hospital or health system will require an understanding of where everyone — from trustees and

## Scoring Efforts to Achieve Health Equity

**A**s the focus of health care transforms from disease management to community health improvement, the framework for meeting community health needs also is shifting from the traditional community benefits obligation to one that must now integrate with a hospital's or health system's core strategy. To be successful, these new "strategic" community efforts must focus on health inequities within communities.

The Inclusion Scorecard for Population Health is an online interactive tool for analyzing the degree to which a health system has integrated practices that support health equity. This free ISPH scorecard includes 70 best practices organized into four focus areas: key metrics, an inclusive culture, leadership accountability, and community engagement and investments.

Maria Hernandez, president and chief operating officer of Impact4Health who created the scorecard, shared the experiences of several health systems that are using it.

### *How has the ISPH scorecard been used at different health systems?*

**Maria Hernandez:** At first, it was really difficult to get in front of the right decision-makers and even harder to persuade them to form a multidisciplinary team to oversee implementation. Health equity is not the responsibility of just one department. Using the ISPH scorecard requires collaboration among leaders in very different roles — human resources, diversity and inclusion, patient experience, population health, community investments. The silos in health care are very difficult to break down.

The pandemic and the murder of George Floyd changed everything. We now have several health systems that have used it to review their health equity strategy. Many are starting with just one focus area or quadrant; the most common one is to look at how the organization is engaging the communities it serves. For example, does the organization use its community health needs assessment to support effective outreach and investments to address the determinants of health?

### *What is the biggest challenge health systems face when they start out?*

**Hernandez:** Many simply have no infrastructure for this work, so they are having to hire their first ever chief diversity officer or chief health equity officer to build a foundation for an integrated strategy to reduce health inequities. Another significant challenge is access to data. Many health systems look at key metrics as one aggregate number — overall rehospitalization rates or HCAHPS scores.

### *What do you advise?*

**Hernandez:** The data needs to be sorted by REaL — race, ethnicity and language preference — and SO/GI — sexual orientation and gender identity — data. That level of analysis is necessary, but it's often not been standard practice. A genuine commitment to this work will require substantial focus and resources to address inequities. And this work will need consistent support not only from senior leaders but also from middle managers who will implement many of these new strategies.

the executive staff, to caregivers, diverse community stakeholders, business leaders and public officials — stands. Engaging in active listening and real conversations around health equity is a necessary first step. It will build trust within and across the community.

Thoroughly assessing your hospital's or health system's culture in relationship to health equity will help determine how well you're currently performing and indicate how far you need to go.

The shifts won't happen overnight. There's much more to culture change than simply creating an initiative or fulfilling any new requirements or regulations. Creating a healthy culture to address any of these complex challenges will ensure your organization has the foundation for the necessary changes to bring health and healing.

## The Structure and Function Shift

Along with cultural mindset, meaningful change requires attention to both structure and function.

As a frame of reference, 20 years ago, few hospitals had a quality improvement department. It wasn't until the Institute of Medicine's groundbreaking and heartbreaking report "To Err Is Human" was released in 1999 that hospitals began to create quality departments with dedicated staff, expertise, measurement and resources. Because of this increased focus on quality, the health care field has made progress, albeit slowly, in this area. A similar shift in mindset and in organizational structure and functions is

needed to make real progress in the area of health equity.

**Creating a new senior leadership role.** Making the decision to add a chief diversity officer or a chief health equity officer to the executive leadership team, for example, is an important first step in building organizational capacity in health equity.

For such an adjustment to be

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meaningful, it is essential to carefully consider where this position sits within the organizational chart, what the connection with other senior roles is, what competencies are required to be effective and what system of incentives across departments validates achievement of equity goals and objectives. For example:

- Does the position lie within the human resources department, signaling a primary focus on workforce development?
- If it is a new, independent role within the organization, how does it connect with senior leaders for human resources, clinical services and community health?
- In addition to setting objectives to ensure equity in the clinical care arena, is focus being given to the

strategic allocation of health system resources in communities where health inequities are concentrated?

- Does the work cross other sectors?
- Are there measurable objectives for increasing the diversity of the internal workforce?
- Does the work signal a broader commitment to diversity by building capacity and contracting with minority-owned firms?

For many organizations, having the DEI role report directly to the CEO underscores the central focus of this issue. There also are a wealth of potential metrics to track meaningful progress, and proactively considering options and developing practical strategies will ensure that creating a senior leadership position in health equity is more than symbolic.

**Identifying key competencies.** It may be unrealistic for every organization to secure a chief health equity or chief diversity officer who possesses the full spectrum of competencies reflected in the scope of issues outlined here. As such, careful consideration of the competencies present among other key senior leaders and the nature of the connection with this new position is required. A careful review of what competencies are needed, which are present and how gaps can be filled is an important exercise. It also is important to allocate adequate resources to ensure the work can be accomplished.

**A real-life example.** Swedish, a five-hospital health system in the Pacific Northwest, has created a new division called the Office

of Health Equity, Diversity and Inclusion. This division has its own budget and two new senior executives: a chief health equity officer (a physician) and a chief diversity, equity and inclusion officer.

These two new executives report directly to the CEO and have their own, distinct areas of responsibility. For example, the chief health equity officer reviews patient outcomes data stratified by race, ethnicity, sexual orientation and gender identity. Part of the work involves ensuring that these data elements are being collected from patients in the first place.

The chief DEI officer is focused, in part, on increasing the diversity of the workforce — in partnership with the chief human resources officer — ensuring that all staff are aware of implicit bias and the need to implement steps to ensure an inclusion-oriented workplace. The health system's board of trustees dedicated an hour of its board meeting in March 2022 to participating in implicit bias training that the chief DEI officer has been spearheading throughout the organization's hospitals, along with its 4,000 physicians and allied health professionals and 12,000 employees.

The board of trustees also has clearly recognized that health equity work requires greater leadership focus and greater leadership diversity. The board formed a Health Equity, Justice and Social Responsibility Committee, whose executive sponsors are the senior leaders from the Office of Health Equity, Diversity and Inclusion.

Swedish also is moving beyond equity in the clinical arena to focus on social determinants of health

with its community health leader, who also works with the Office of Health Equity, Diversity and Inclusion. The goal is to identify inequities within community populations and set a course for the types of services and activities that should be developed to address them.

## The Incentive Shift

As the health care field continues on the journey to value-based care, the financial incentives for addressing health equity and social needs will increasingly be front and center.

In California, the rollout of CalAIM, a five-year, \$1.5 billion Centers for Medicare & Medicaid waiver which started January 2022, supports payment for a broad spectrum of services and social support for Medicaid enrollees. It encourages expanded partnerships with diverse community stakeholders to meet housing needs, meals, counseling and other essential services. This funding is an important step in efforts to address health inequities. At present, however, most of the incentives and potential returns will be secured by Medicaid managed care health plans.

A key consideration going forward is finding the appropriate risk-return arrangements between hospitals and health plans. In markets with multiple hospitals, those with smaller shares of the market may be in less advantageous positions to negotiate gain-sharing agreements with health plans. These incentives would target strategies to reduce preventable utilization through health equity investments.

Regardless of the relative progress toward value-based care in

different regions across the U.S., there is an imperative for hospitals to build internal capacity that will ensure financial stability in the coming years. Having senior leaders with the right competencies, accountabilities and interaction across departments is important, but additional impetus can be created by establishing incentives that send a clear signal of organizational priorities.

Some hospitals and health systems have established explicit targets tied to annual incentive pay, often referred to as "at-risk compensation." In the diversity arena, it could be the development of approved strategies to enhance outreach and recruitment efforts. In subsequent years, metrics could move from process to outcomes, rewarding success in meeting targets for recruitment in the clinical or administrative arena or both.

On the health equity side, metrics also could start with the development of internal policies that require more specific focus of community benefit spending or treasury investments in sub-geographies where health inequities are concentrated, or initiation of local policy advocacy on social determinants of health issues. These more process-oriented metrics could then evolve toward measurable reductions in preventable emergency room and inpatient care for Medicaid patients in specific low-income communities. Creating the environment for these kinds of conversations and priorities at the board and senior leadership level is an essential element of building organizational capacity in both diversity and health equity.

## Intentional and Strategic Actions

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The need for such paradigm shifts across these areas may have been hastened by the devastating, inequitable impacts of the COVID-19 pandemic. But the imperative to address health equity within community health in a more intentional, strategic way has been a long time coming. Accordingly, hospital and

health system trustees and senior leaders now face the hard work of “shifting” to align organizational strategies with efforts that ultimately will result in more equitable outcomes across the populations they serve.

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**Karma H. Bass** ([kbass@viahcc.com](mailto:kbass@viahcc.com)) is managing principal, Via Healthcare Consulting, in Carlsbad, California. **Dora Barilla** ([\[hc2strategies.com\]\(http://hc2strategies.com\)\) is president and co-founder, HC2 Strategies, Rancho Cucamonga, California. \*\*Kevin Barnett\*\* \(\[kbarnett@thecachecenter.org\]\(mailto:kbarnett@thecachecenter.org\)\) is executive director, Center to Advance Community Health and Equity, at the Public Health Institute.](mailto:dorabarilla@</a></p></div><div data-bbox=)

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