

# Building an Organizational Response to Health Disparities: Five Pioneers from the Field

*Report*



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## Acknowledgements

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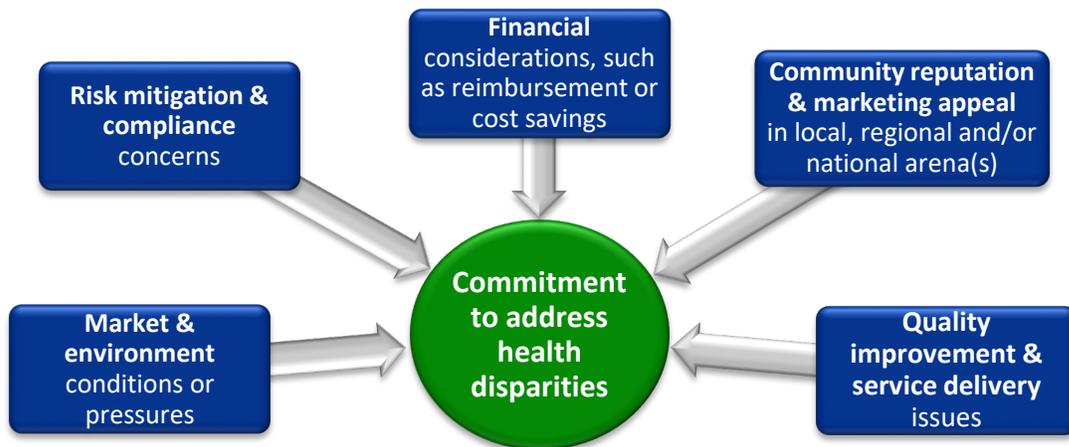
The process for identifying case study participants comprised multiple steps. First, the team conducted web searches for U.S.-based organizations that had won awards or were profiled for their commitment to addressing health disparities; this yielded 73 organizations. The team then ranked organizations based on the degree of alignment between their program(s) and the objectives of this study, which narrowed the list to 36. To further refine the set, the team conducted short screening calls to confirm an understanding of their efforts to build a business case to address health disparities and gauge interest in participation. From the refined list of 18, the team invited organizations – those that described a comprehensive longstanding program and/or multiple initiatives – to participate in a voluntary and uncompensated site visit. It is important to note that the team’s initial search was limited by the availability of public data; therefore, it is plausible that qualified organizations were not considered due to an absence of information.

The report highlights leaders in quality improvement undertaking a business case for addressing health and health care disparities. The case studies contained within focus on a limited set of activities and do not represent an attempt to evaluate, nor opine on, an organization's overall compliance with longstanding anti-discrimination law. Moreover, the content of this report reflects the terms and provisions of the contract under which the work was performed and technical direction provided by the U.S. government. Mention of trade names or organizations does not imply endorsement by the U.S. government.

## Introduction

The CMS Office of Minority Health (OMH) conducted case studies with five private-sector health care organizations to understand how they identify and address health disparities in the communities they serve. The subsequent case study reports illustrate how each organization planned for and implemented initiatives to change the way they deliver services. Each case study was developed following site visits and interviews with organization leaders and staff.

This report contains key findings from these case studies.<sup>1</sup> Each organization's business case differs; however, the underlying motivators can be grouped into five broad categories:



The case studies cover:



### Interpreter-Focused Strategy

Find out how a community hospital (Frederick Memorial Hospital) established an interpreter services program to serve the local Deaf community and later the Spanish-speaking community.



### Diversity and Inclusion Strategy

Explore how a health plan (Harvard Pilgrim Health Care) created a diversity and inclusion strategy and established a transgender-inclusive health benefits package.



### Quality-Focused Strategy

Learn about a health plan's (Health Net) efforts to increase vaccination compliance rates, reduce readmissions and close gaps in care.



### Demographic Data Collection Strategy

Understand how a health plan (Highmark Inc.) used data to identify gaps in care and designed interventions to improve access, and increase immunization rates and use of preventive services.



### Health System/Community Collaboration Strategy

Learn how a health system (Methodist Le Bonheur Healthcare) partnered with local churches to improve health care utilization and outcomes in its community.

<sup>1</sup> An executive summary is also available for each case study. The summaries describe the factors that influence organizational investment in reducing health disparities. The summaries can be found at [go.cms.gov/omh](http://go.cms.gov/omh).

## Case Study One: Frederick Memorial Hospital

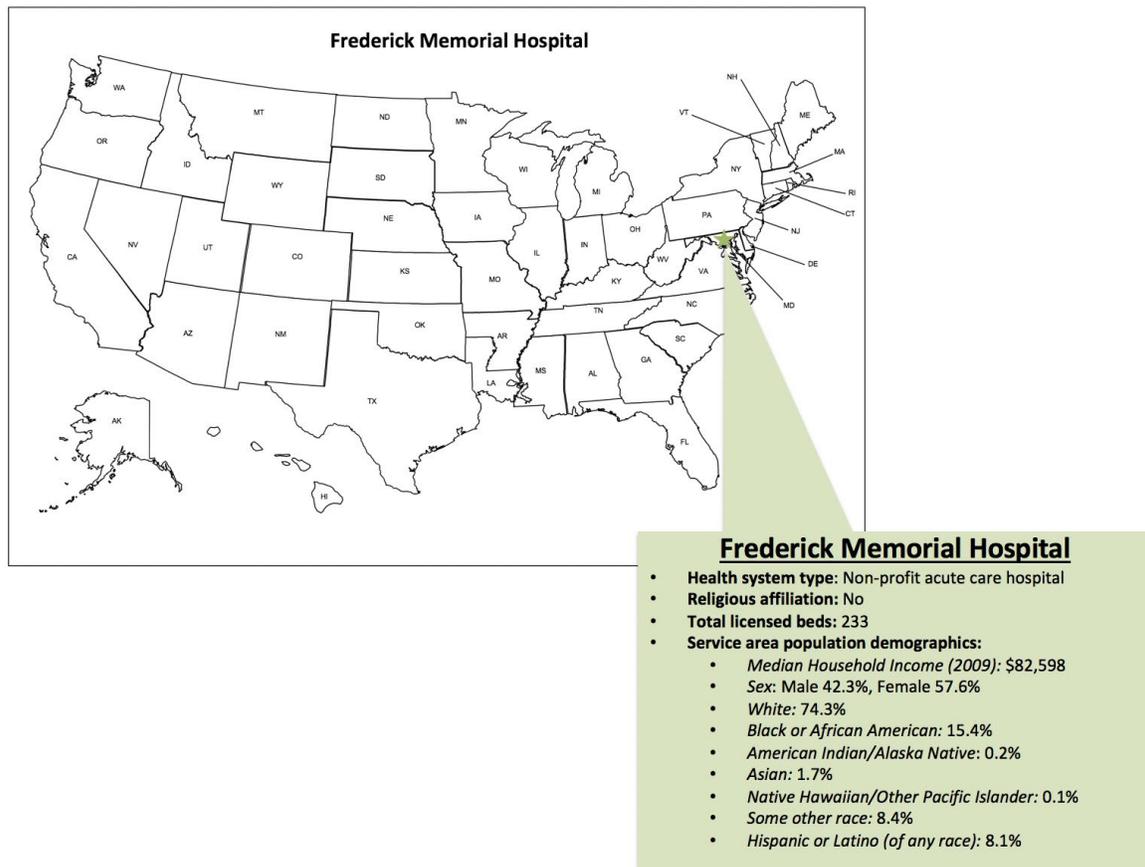
May 24, 2016

### Introduction and description

Frederick Memorial Hospital (FMH) is a non-profit 233-licensed-bed acute care hospital located in Frederick, Maryland that opened in 1902. FMH is part of the Frederick Regional Health System (FRHS). As part of FRHS, FMH provides a full range of acute care and outpatient services. At the time of the case study, FMH's hospital-based and offsite outpatient services accounted for approximately 285,000 visits annually, and FRHS provided approximately 44,600 home health and 17,600 hospice visits per year.

Figure 1 below provides a snapshot of FMH as well as the basic demographic profile of the surrounding area.

**Figure 1. Case study organization key characteristics<sup>2, 3, 4</sup>**



<sup>2</sup> Frederick Memorial Hospital and Frederick County Health Department (2016). Frederick County 2016 Community Health Assessment: Draft. Retrieved from <http://health.frederickcountymd.gov/DocumentCenter/View/1470>

<sup>3</sup> Frederick Memorial Hospital (2013). Frederick Memorial Hospital's 2013 Community Health Needs Assessment for Frederick, Maryland. Retrieved from <https://www.fmh.org/documents/FMH-Community-Health-Assessment-2013.pdf>

<sup>4</sup> Figures current as of May 2016.

At the time of the case study, FMH was the only hospital in Frederick County and the only acute care hospital within a 25-mile radius of the city of Frederick. It is located at the crossroads of both urban and rural areas: In 2016, Frederick had a population of nearly 67,000. Frederick county stretches to remote rural areas bordering on Virginia and Pennsylvania and FMH is located less than 50 miles from both Washington, D.C., and Baltimore, Maryland, and just over 25 miles from West Virginia.

While Frederick is not as diverse as the nearby Washington, D.C., or Baltimore metropolitan areas, FMH staff reported that migration from these two larger regions in recent years significantly influenced demographic shifts in the county. In fact, at the time of the case study, Frederick County was home to one of the fastest growing Hispanic populations in the state: according to FMH's 2013 Community Health Needs Assessment, the county's Hispanic population grew by nearly 170 percent between 2000 and 2009.

### **Conceptualization of health disparities reduction strategies**

FMH has long worked to improve services and access to care for its most vulnerable patients, beginning with the launch of its nationally recognized interpreter services program in the early 1990s and continuing through community-focused programs and activities. During this time, the hospital's many programs and activities were piecemeal and initiatives were introduced on an ad hoc basis in response to community needs identified at different times and within different parts of the organization. In 2012, FMH hired a director of cultural awareness and inclusion to improve cultural competence within the organization and to address issues of diversity among its staff and the population served. This hire coincided with a shift in organizational focus toward cultural awareness, and the corresponding devotion of resources to more accurate self-reported race, ethnicity, and language (REAL) data-gathering techniques (discussed later in this report).

As stated, the hospital's many programs and activities to address health disparities were initially fragmented, with initiatives introduced in an ad hoc manner to respond to community needs identified at different times and initiated in different parts of the organization. At the time of this case study, FMH was in the early stages of developing an organized, comprehensive approach to addressing health disparities, population health, and access to care. FMH had recently appointed a senior vice president (SVP) for population health to streamline its disparities-, community-, and population health-focused activities. The new executive's responsibilities included: determining and managing Community Health Needs Assessment goals; directing the community benefits committee and its outreach activities; overseeing transitions in care; and implementing an organization-wide population health strategy. To meet the three-part aim of better care for individuals, better health for populations, and lower costs, FMH needed a cohesive, coordinated approach to disparities reduction and community health activities.

Multiple external pressures also influenced FMH's internal infrastructure changes. First, the expansion of community-based activities was prompted by FMH's 2013 Community Health

Needs Assessment. Stakeholder focus groups conducted as part of the assessment highlighted a need for FMH to reach beyond the hospital's walls to better address the social determinants of health that were affecting the community.<sup>5</sup> Second, FMH received an increasing number of requests for Spanish-language services. These requests, along with the needs of the local Deaf population, spurred the expansion of their interpreter services program. Finally, pressures stemming from Maryland's reimbursement structure— as the state moved toward global budgeting – made the hospital responsible for managing population health across the community.

## Overview of initiatives

This report explores the two primary and evolving components of FMH's disparity-related work: (1) Interpreter Services, a standalone program integral to helping FMH expand access to care for minority groups; and, (2) the hospital's efforts – which were nascent at the time of the case study – to formulate a cohesive approach to addressing health disparities and managing population health.

- **Interpreter Services.** FMH's interpreting services program emerged in response to the launch of an inpatient psychiatric unit meant to serve Frederick's significant Deaf population (the Maryland School for the Deaf is located in Frederick). To design the service offering, FMH staff engaged Deaf advocates and other hospitals offering similar services to determine the best approach to serve the community. The program that initially began with two part-time American Sign Language (ASL) interpreters has grown significantly over the past 25 years. At the time of the case study, FMH Interpreter Services included in-person Spanish and ASL interpretation available seven days a week, supplemented by telephonic and video remote interpreting services.
- **Strategic Approach to Addressing Community Needs and Health Disparities.** Before hiring an SVP for population health, FMH's approach to target specific gaps in care delivery consisted of ad hoc activities. Under the new executive, FMH's population health efforts focused on ambulatory services, and involved collaborations with FMH leaders from care transitions, medical affairs, performance improvement, and cultural awareness and inclusion. The new executive also oversaw FMH's portfolio of community-based efforts. Establishing a new position responsible for establishing a strategy to manage all of its programs in a coordinated manner signaled FMH's intent to be more methodical and intentional about addressing community needs and health disparities.

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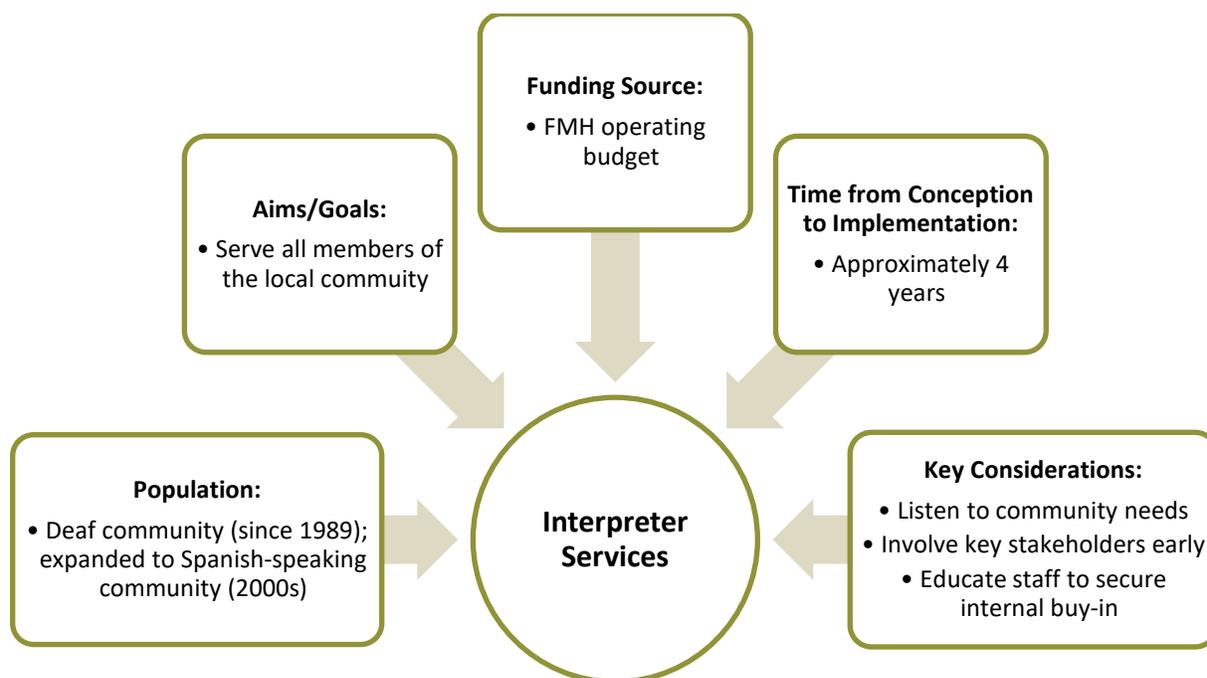
<sup>5</sup> FMH conducted nine focus groups with over 170 people representing: community care managers, FMH (Select) health plan members (aged 55+); affiliated physicians; nursing home and assisted living residents; pastors; Asian, African American, Latino, and Deaf community members.

We describe both of these initiatives in detail below. Following the initiative discussions, we summarize key considerations for developing population health and disparities-focused initiatives.

## Interpreter Services

According to interviewees, FMH’s Interpreter Services program was one of the hospital’s longest-standing and most robust initiatives. As it evolved, Interpreter Services became a standalone program and moved out from under the Patient Relations Department. FMH leaders viewed Interpreter Services as critical to ensuring that vulnerable populations could access necessary services and was one way that FMH ensured equitable service to patients while mitigating the risks of inadequate patient-provider communications. Figure 2 provides a summary of the program, including its priority populations, aims/goals, and funding sources.

**Figure 2. At a glance: Interpreter Services**



### ***Business case development (planning and assessment)***

FMH’s Interpreter Services evolved organically since its inception in 1989 in response to changing community needs and regulatory requirements. Before FMH had its adult inpatient psychiatric unit, Deaf patients often sought care at Springfield Hospital Center in Sykesville, Maryland. Although Sykesville is roughly 30 miles away, Springfield Hospital Center had the capacity to communicate with patients using sign language interpreting services. FMH recognized the gap in its own services and sought to find ways to better serve the Deaf community closer to home.

The FMH program took shape in the 1990s, informed by stakeholders and advocates whom the hospital engaged to learn more about the needs of Deaf patients. For example, FMH worked with Communication Services for the Deaf, an international non-profit organization devoted to elevating the quality of life for people who are Deaf, Deaf-blind, or hard of hearing. This external collaboration and outreach approach set a precedent that continued throughout the program. At the time of the case study, Deaf individuals continued to provide regular and valuable feedback on FMH's Interpreter Services through focus groups and direct interaction with FMH staff.

Additionally, FMH consulted with other hospitals about best practices for hiring and staffing sign language interpreters. For example, before hiring its first interpreters, FMH had to determine the scope of the interpreter role. The organization consulted other hospitals to learn how they made the best use of their interpreters' "down time" between patients. The first part-time Deaf interpreters at FMH were part of the Patient Relations Department, where they would work as patient representatives when not interpreting for patients and families.

Also, changing demographics in Frederick around the year 2000 led to an influx of Spanish-speaking patients requiring interpretation services. Initially, FMH relied on a few bilingual nurses and other Spanish-speaking employees to help interpret on an ad hoc basis. However, FMH leaders were concerned that this practice could result in inaccurate communication unless staff were trained as medical interpreters. As a result, FMH engaged with Spanish speaking stakeholders to plan how to expand the Interpreter Services program.

### ***Implementation and evaluation***

FMH became the first hospital in Maryland to launch video remote interpreting (VRI) services for Deaf patients. Later, the hospital hired the director of the Centro Hispano de Frederick as its first Spanish-language interpreter. The interpreter was the only authorized FMH translator, and a "conduit to the Hispanic community," according to FMH leadership.<sup>6</sup> Having a member from the community serve in this role helped FMH stay abreast of the Hispanic community's needs beyond language services. For language services other than ASL and Spanish, the hospital used an interpreter service endorsed by the American Hospital Association.

Several regulatory requirements and guidelines influenced program development. Interviewees described pressures from accrediting agencies and federal and state government to offer culturally competent care and qualified interpreting services for patients. Under the Americans with Disabilities Act (ADA), hospitals must provide effective means of communication with patients, family members, and hospital visitors who are Deaf, blind, and/or hard of hearing. Similarly, The Joint Commission's guidelines address effective patient-provider communication. Together, these standards aim to prevent communication errors that could endanger patients or adversely impact the quality of care. To emphasize the importance of being proactive, FMH

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<sup>6</sup> Per the American Translators Association definition, the difference between translators and interpreters is that the former writes and the latter speaks. Both convert information from one language (and culture) into another. <http://www.atanet.org/pressroom/FAQ.php#FAQ5>

interviewees cited a federal lawsuit filed against a nearby hospital. Several Deaf patients were allegedly harmed following poor communication with hospital emergency department staff, and the lawsuit claimed that the hospital violated patient rights by not making sign language interpreters available during medical consultations.<sup>7</sup>

To stay ahead of legal and ethical pressures and respond to patient feedback, FMH implemented several programmatic changes:

- Launched the standalone Office of Interpreting Services, moving the service out of the Patient Relations Department.
- Collected patients' self-reported language data to measure the demand for interpreter services and track emerging needs. This began in 2007 and became more sophisticated in 2013 with the launch of FMH's new electronic medical record (EMR) system.
- Embedded equity into ongoing education activities and new employee orientation, in part through training clinical and non-clinical staff about language services.
- Established a policy that required employees to pass a language proficiency test prior to doing interpretations.
- Engaged a new VRI service in response to negative patient feedback on the original vendor.

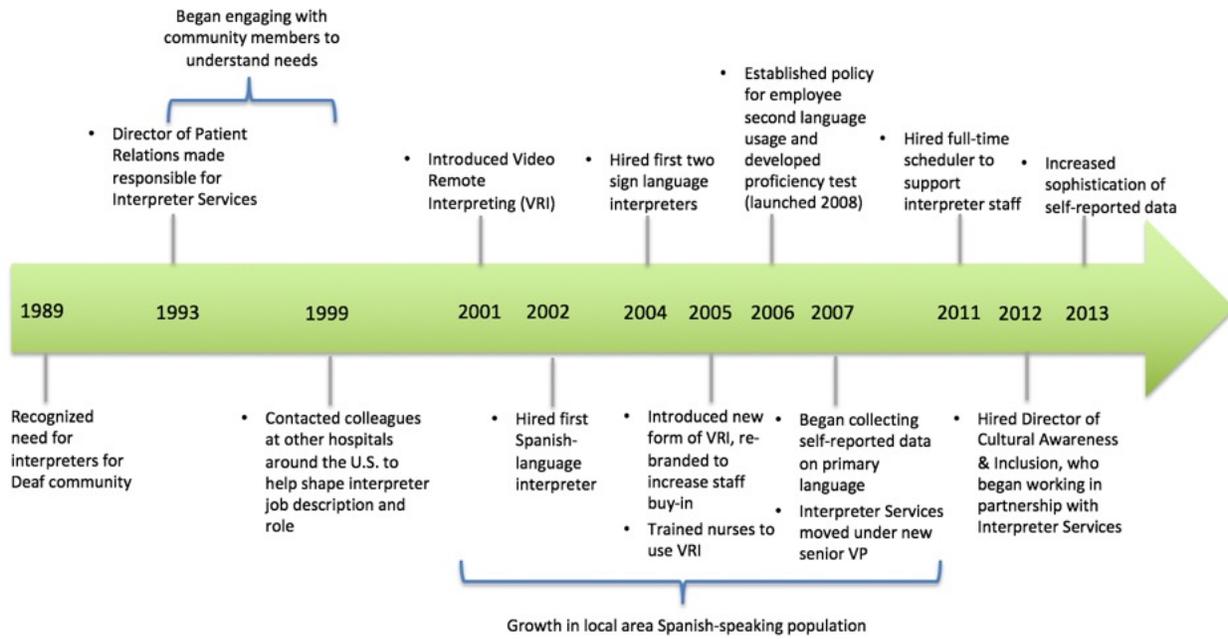
At the time of the case study, Interpreter Services had 25 staff members (13 ASL interpreters, 10 Spanish interpreters, a supervisor and a scheduler). In-person Spanish interpreting was available at least 15 hours a day and ASL bedside services were available 24/7.<sup>8</sup> By 2015, the Deaf population accounted for over 700 patients a year and received nearly 3,000 bedside hours of interpreter services. FMH staff reported that Deaf patients were traveling from other areas to receive care at FMH. Figure 3 provides a graphic overview of the program's major milestones during the last three decades.

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<sup>7</sup> Klein, A. (2005). Deaf Patients Sue Laurel Regional Hospital: Allegations Include Rights Violations and Mistreatment. *The Washington Post*. Retrieved from <http://www.washingtonpost.com/wp-dyn/articles/A38769-2005Jan26.html>

<sup>8</sup> Services supplemented by two external ASL interpreter agencies.

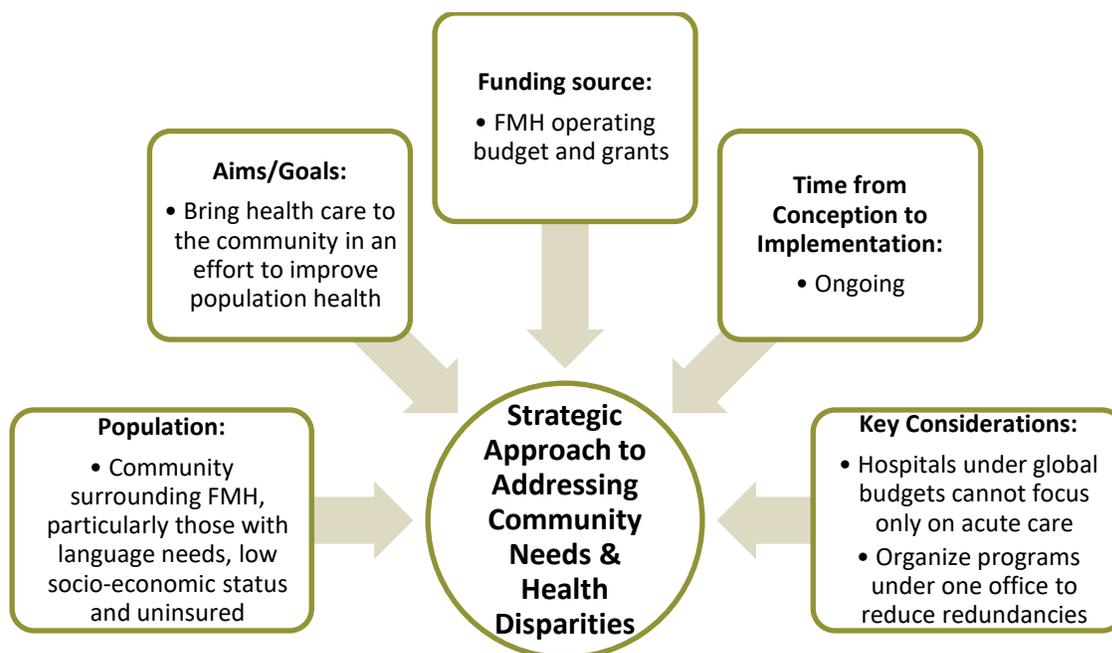
**Figure 3. Timeline of major milestones: Interpreter Services**



## Strategic Approach to Addressing Community Needs and Health Disparities

Figure 4 provides an overview of FMH’s efforts to improve population health and reduce health disparities under a cohesive strategy.

**Figure 4. At a glance: Strategic Approach to Addressing Community Needs and Health Disparities**



### ***Business case development (planning and assessment)***

Several external forces in the five years preceding this case study were credited with influencing FMH’s population health-oriented perspective. As noted, there were increasing pressures from regulatory and accrediting entities that emphasized the importance of collecting better data to identify health disparities. These included the Maryland Health Services Cost Review Commission (HSCRC), the American Hospital Association, The Joint Commission, and others. These pressures, coupled with the industry’s focus on population health, motivated FMH to better organize its community-facing activities under a single structure. Direct financial motivations to pursue this work also emerged: accountable care organizations (ACOs) became increasingly common (FMH started a Medicare ACO) and payment reduction penalties from Medicare for high 30-day hospital readmissions became a greater threat.<sup>9</sup> Also around this time, in 2014, Maryland shifted to global budgeting for all acute care hospitals in the state. That meant Maryland hospitals were accountable for the health of the population in their respective service areas, not just that of patients who received services directly at their facilities.

<sup>9</sup> For more information about the CMS Hospital Readmissions Reduction Program, refer to: <https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html>

As the topic of how providers could address health disparities gained national attention, FMH began identifying demographic shifts in its patient population. These changes were evidenced in its 2013 Community Health Needs Assessment. The report highlighted increasing diversity in the patient population, greater health disparities, and increasing presence of language barriers.

### ***Implementation and evaluation***

Over the years, FMH implemented many activities – led by different departments – to address community needs and the changing environment. The following initiatives are just a few examples of projects that were consolidated and placed under the direction of the SVP for population health.

**Bridges Program.** To increase its engagement at the grassroots level and develop trusted partnerships with underserved and diverse segments of its community, FMH established Bridges Lay Health Educator (LHE) program. According to interviewees, Bridges developed the knowledge and skills of volunteers, who, in turn, teach peers in the places they gather, socialize, or worship. The program originally focused on faith-based communities and evolved such that LHEs come from a variety of groups, speak two or more languages, and work with their peers and community members to increase health literacy and take charge of their own health. Interviewees described that the program was offered at no cost to FMH partners, such as the Asian American Center, the Faith Striders (group of African American women who support breast cancer education and screenings), and Retired Seniors Volunteer Program (RSVP). FMH sent health professionals to staff events and to plan health screenings, or work with residents on advanced directives. At the time of this case study, 42 LHEs represented more than 30 individual faith-based and non-profit organizations that completed the program.

**Care center for chronically ill.** Responding to the needs identified in the community and increasing incentives to improve population health, FMH opened a three-day-a-week clinic for the severely chronically ill in 2015. In addition to providing chronic disease management for vulnerable populations, the center was part of a larger FMH effort to deliver services that attended to social determinants of health. Interviewees discussed that community care managers from the FMH Care Transitions Office helped patients navigate the health system and connect with non-medical support services. According to FMH’s strategic transformation plan, 70 percent of patients with multiple chronic illnesses have unmet behavioral health needs, including substance use disorders. Through the navigation work, FMH aimed to identify patients who were at-risk for behavioral health issues and link them to appropriate services. Left unmet, these needs increased avoidable utilization of emergency and hospital services. At the time of this case study, FMH staff had identified a rural and isolated “community hot spot”—a location with high need/complex patients—that could benefit from the services the center provided.<sup>10</sup>

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<sup>10</sup> FMH obtained data from its Quality Improvement Organization (QIO) in May 2016 identifying the area that includes the small town of Brunswick, which had a total population of less than 6,000.

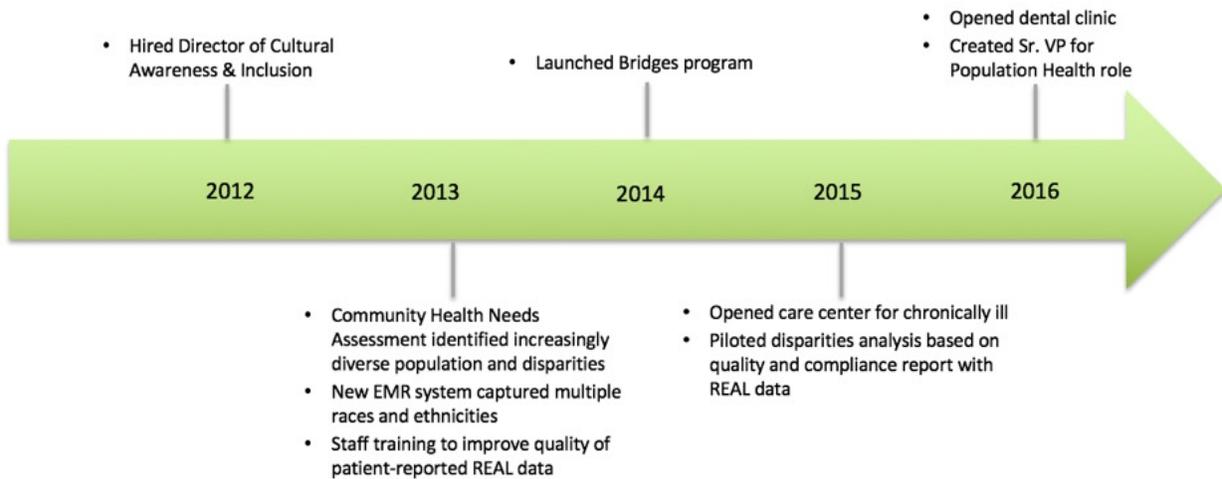
**Dental clinic.** FMH recognized a pattern of frequent emergency department (ED) visits among uninsured patients related to dental pain and poorly managed oral infections; in 2015, the FMH ED treated 1,200 patients with such dental issues. While FMH has oral surgeons on staff, until June 2016, the hospital did not offer primary dental care. FMH opened a primary dental care center fees on a sliding-scale basis to serve patients earning up to 200 percent of the federal poverty level with. The clinic is partially funded through grants and the state of Maryland and staffed by the University of Maryland Dental School. FMH anticipated the clinic would incur annual losses of between \$200,000 and \$300,000 during the early years of operation. However, FMH executives believed that over the long term, this investment would reduce costs associated with unnecessary ED use and hospital admissions. In turn, reducing unnecessary utilization helps the hospital mitigate potential losses incurred if overall hospital expenditures exceed the global budget cap.

**Community health worker program.** FMH engaged the Area Health Education Center to provide training to groups of community health workers (CHWs) who helped extend FMH's care coordination, health promotion and educational efforts into the community.<sup>11</sup> The hospital's Care Transitions Office oversaw the CHW program, in close partnership with the Asian American Center. To better meet the diverse needs of the community, more CHWs were identified through the hospital's community outreach programs (e.g. Bridges, LHEs, and RSVP). Recruiting CHWs from the community helped the organization strengthen its capacity to match resources that address the social determinants of health to identified community needs. Figure 5 provides an overview of the timing of each of these activities.

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<sup>11</sup> Area Health Education Centers around the country are funded by the federal Health Resource and Services Administration "to enhance access to high quality, culturally competent health care through academic-community partnerships to ultimately improve the distribution, diversity, and supply of the primary care health professions workforce who serve in rural and underserved health care delivery sites." Retrieved from <https://bhw.hrsa.gov/fundingopportunities/?id=ccc4f09b-e51e-4541-988b-ddc2c7593760>

**Figure 5. Timeline of major milestones: Strategic Approach to Addressing Community Needs and Health Disparities**



## Overarching considerations

Below we summarize several overarching considerations that apply to both of the initiatives, including: stakeholder engagement, financial considerations, evaluation and measurement, sustainability, and challenges/barriers.

### *Stakeholder engagement*

- **Internal engagement.** Internal buy-in for initiatives to reduce disparities and achieve health equity was evident at all levels within FMH. The creation of two key roles demonstrated this commitment: a director of cultural awareness and inclusion and an SVP for population health. Staff at all levels, including senior management, participated in frequent trainings on the organization’s language access plan, the EMR system, and processes for collecting REAL data.
- **External engagement.** FMH’s initiatives historically emerged from a desire to address specific community needs. Patient suggestions and community input continue to guide program development, with many initiatives modified in direct response to community focus groups, which are conducted as part of FMH’s community needs assessments. Collaborations with external partners have increased the hospital’s ability to address patient needs.

### ***Financial considerations***

Until shortly before this case study, FMH did not evaluate its health equity investments in aggregate. Instead, it financed its initiatives separately through various departments' operating budgets. The Interpreter Services program, for instance, grew significantly over the years without much resistance from finance leaders at the hospital, initially as part of the Patient Services budget. "We started doing this before people realized it was expensive, and it's just been part of our budget," an interviewee said. Still, program leaders tried to be cost-conscious by having interpreters provide patient services during down times until the demand for Deaf interpreter services increased.

To better coordinate resources across FMH, the hospital established a multidisciplinary community benefits committee in 2015. The committee brought together service line and executive leaders to review charitable requests and community partnership opportunities. These meetings ensured investments aligned with FMH's strategic mission and resources were allocated efficiently. Prior to the committee, FMH reviewed project and sponsorship requests in a piecemeal fashion, with each department making financial decisions independently.

### ***Evaluation and measurement***

**Data collection.** At the CEO's request and following the hire of the Director of Cultural Awareness and Inclusion, FMH began carefully reviewing its data collection processes to identify information gaps. A planned EMR system upgrade presented an opportunity for the hospital to more effectively track patients' self-report of multiple races or ethnicities, which was not previously possible. Information technology staff worked with patient access staff to ensure that additional data fields aligned with state reporting requirements and allowed managers internally within FMH to produce data reports. In anticipation of going live, FMH trained staff members who collected patient demographic information about the importance of patient-reported REAL data. To ensure the hospital effectively utilized data it collected, FMH partnered with a company that offered clinical and financial data analysis and benchmarking services.

**Data analysis and use.** FMH long relied on data analytics that were part of the Community Health Needs Assessments, Healthcare Effectiveness Data and Information Set (HEDIS<sup>®</sup>) and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS<sup>®</sup>) data, and inpatient and ED utilization reports. At the time of this case study, FMH had increased its capacity to look at data at a more granular level, which it used to pinpoint needs of vulnerable populations (e.g., access to dental services). FMH's Care Transitions Office monitors its progress on inpatient and outpatient services at the population level (e.g., by age, sex, ZIP Code and REAL data). This information was shared with both HSCRC and the Maryland QIO to benchmark against state data.

Using REAL data, supplemented with external data (from sources such as the Frederick County Public Health Department), FMH produced its first joint Community Health Needs Assessment with the Public Health Department. In 2015, FMH engaged The George Washington University

Milken Institute School of Public Health to assist with this effort, which resulted in 485 interviews with residents recruited across the county. Combined with findings from a series of focus groups conducted in 2015, these data contributed to the 2016 Frederick County Community Health Assessment.<sup>12</sup>

### ***Sustainability***

Several factors contribute to the programs' sustainability at FMH. First, because of Maryland's unique reimbursement structure, reducing disparities in the community and preventing unnecessary utilization of hospital resources yielded tangible financial benefits. Interviewees reported that as a result, the hospital was likely to continue implementing initiatives that leadership believed could demonstrate a good return on investment, even if there were large start-up costs. At the time of this case study, interviewees said that FMH planned to establish a system to better track which initiatives were the most valuable to help prioritize future commitments.

Second, the hospital's internal reorganization solidified its long-term commitment to investments in population health and addressing health disparities. FMH also created a Triple Aim committee, which provided a platform for staff across departments and divisions to share ideas and ensure adherence to the organization's key strategic goals.<sup>13</sup>

### ***Challenges and barriers***

- **Continuously improving data collection and analyses.** Executives acknowledged that the limitations of current data, particularly when it comes to assessing ROI, remained challenging despite FMH's significant improvements over the past five years. The hospital said it was challenging learning how to improve data-gathering and benchmarking techniques and to distill data from multiple sources, such as CMS and the state.
- **Challenges with REAL data collection persist.** While the upgrade to FMH's EMR system provided an opportunity to improve the data collection tool and processes, training staff and increasing patient awareness of the importance of the data collection initiative was ongoing.
- **Appropriate physician use of Interpreter Services.** Although FMH established a policy prohibiting inappropriate use of non-English language skills on the job for staff other than those trained in medical interpretation (see Interpreter Services: Implementation

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<sup>12</sup> More details on the community health assessment are available at:

<http://health.frederickcountymd.gov/DocumentCenter/View/1470>. The George Washington University Milken Institute School of Public Health Survey Report can be read in its entirety here:

<http://health.frederickcountymd.gov/DocumentCenter/View/1447>. To view the 2016 and 2017 Frederick County Community Health Assessments, visit: <https://health.frederickcountymd.gov/455/Community-Health-Assessment>

<sup>13</sup> This was a departure from the previous guiding philosophy on which FMH's earlier strategic plan was built, Studer's "Five Pillars of Excellence."

and evaluation section above), it was unable to require language proficiency testing for physicians. Unlike other staff, doctors are unlikely to be penalized for using a second language on the job, even though doing so can lead to miscommunications and medical errors. FMH increased training for physicians and other staff members about the benefits of translators and the countervailing risks. However, FMH continued to struggle to reach all corners of the organization.

### ***Lessons learned***

FMH staff members highlighted lessons they learned from implementing these varied programs and activities. Overarching lessons are highlighted below.

- **Measure sustainability by assessing the value of each program and its impact on the organization's larger goals.** New undertakings related to population health and addressing disparities depend on coordinating programs as part of a strategic approach with measurable goals at the outset.
- **Define data collection and analysis needs prior to implementation.** FMH learned the importance of methodically identifying data needs in advance of implementing interventions. Waiting to design data collection and analysis plans after implementation can present challenges to effective measurement of cost and program impact.
- **Anticipate ongoing training as a component of ensuring uptake of new processes.** Customizing the capability of the new EMR system to capture REAL data with greater specificity required significant resources. The endeavor would have benefited from having a formal project manager, as implementation required cross-discipline staff coordination and effective internal communication. FMH learned that reinforcing the importance of REAL data collection internally is crucial to sustaining such efforts, and necessitates continual staff training.

### **Recommendations**

There are a number of lessons learned and recommendations that can be made for the benefit of other organizations.

- **Listen carefully.** Despite the diversity of programs FMH has implemented over the last several years, one message was consistent: The success of this type of work depends on listening to both internal and external partners. Interviewees suggested that, when working with stakeholders, asking for and listening to feedback provides the organization with valuable knowledge relevant to successfully implementing a program. Also, it shows the stakeholder groups that their opinions matter which, in turn, helps cultivate trust and increases engagement. Stakeholder buy-in is vital to making the rollout and adoption of programs smooth, and avoiding false starts. Listening can take many forms, including participating in community forums or work groups, hosting

collaborative efforts, regularly engaging with advocates and community agencies, and conducting qualitative research.

- **Demonstrate leadership commitment and accountability.** According to interviewees, once a program or initiative is approved, an organizational leader should act as a champion for the work to promote internal engagement. In addition to champions for individual initiatives, the establishment of a position(s) at a senior level dedicated to addressing issues of cultural awareness, health disparities and population health may foster greater focus and engagement across the organization.
- **Show the value of initiatives.** FMH leaders discussed the importance of prioritizing finite resources by demonstrating the value of initiatives. One FMH leader explained that the organization must ask the questions: “What is the ROI on some of these things? Are we actually getting the bang for the buck? ... [It is time] to repurpose the resources for the things that didn’t create the impact we thought they would...towards other efforts?”

## Case Study Two: Harvard Pilgrim Health Care

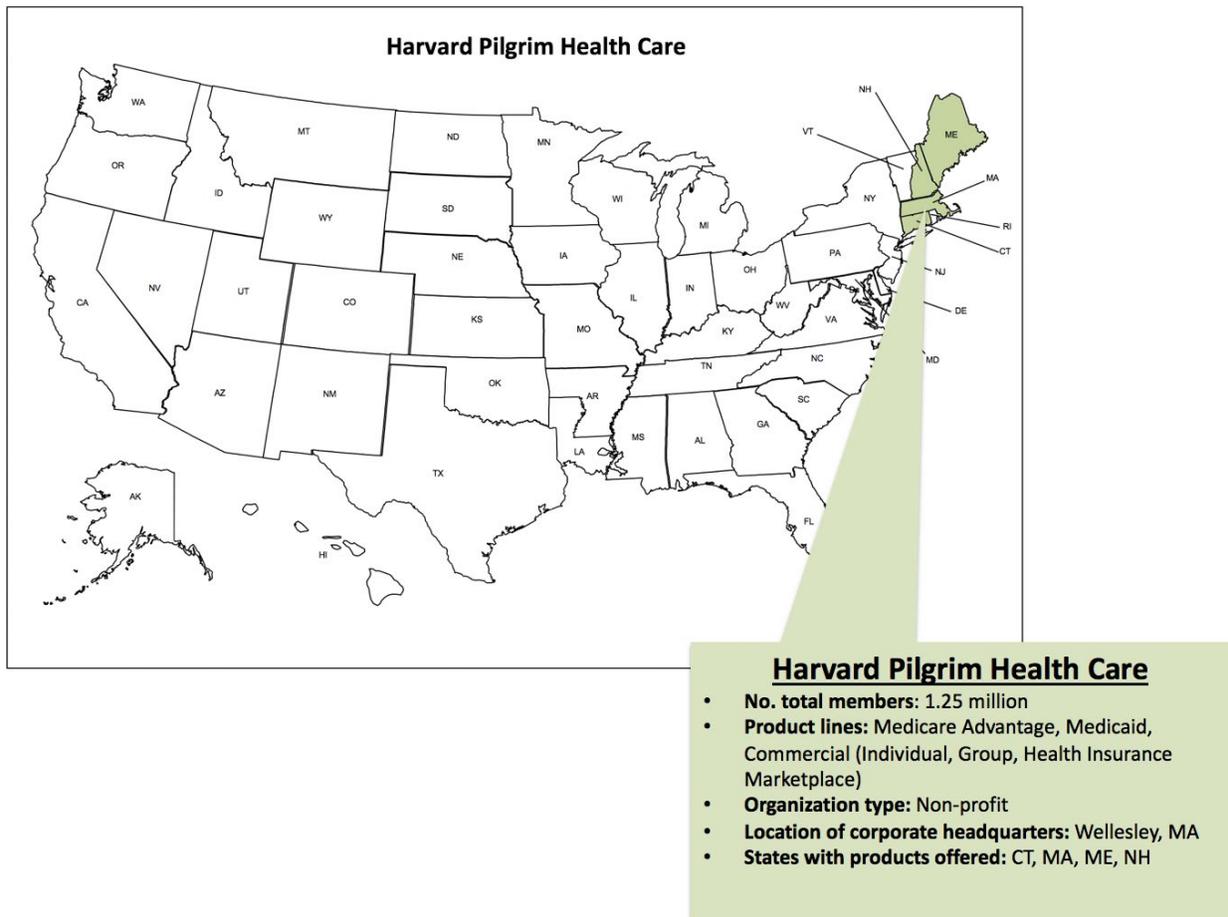
March 22, 2016

### Introduction and description

Harvard Pilgrim Health Care (HPHC) started in 1969 as Harvard Community Health Plan and merged with Pilgrim Health Care, a regional health plan, in 1994. At the time of the case study, HPHC had approximately 1.25 million members in Massachusetts, New Hampshire, Maine, and Connecticut. The organization's health insurance products include commercial options (group and individual products), Medicaid and Medicare products, as well as Medicare Advantage and Medicare Supplement plans. HPHC also offers third-party administrative services for self-insured employer plans.

Figure 6 below provides a snapshot of key characteristics of HPHC.

**Figure 6. Organization key characteristics<sup>14</sup>**



Guided by key tenets of its mission, “to improve the quality and value of health care for the people and communities we serve”, staff and leaders explained that attending to community

<sup>14</sup> Figures current as of March 2016.

needs meant providing quality care regardless of a member's race, ethnicity, or language preference. Over the past four decades, HPHC developed strong ties with key stakeholders, and was involved with several plan-led and community-based initiatives to improve cultural competency and address health disparities. More recently, HPHC refined its business strategy to formally include health care equity as a key pillar.

The effort to formalize HPHC's work to reduce health and health care disparities began in the early 2000s when HPHC joined 10 other health insurance companies to form the National Health Plan Collaborative (NHPC). The NHPC focused on identifying and testing practical approaches using race, ethnicity, and language preference data to address racial and ethnic disparities in health care. In addition, to HPHC's efforts to advance health equity for its members, the organization was recognized for its commitment to providing inclusive workplace policies and benefits coverage for sexual and gender minority employees. HPHC was recognized by the Human Rights Campaign's Corporate Equality Index and has been named a "best place to work for lesbian, gay, bisexual, and transgender equality" every year for the last decade (2006 – 2016). Taking a longer-term view, HPHC began focusing on how to ensure its future health equity initiatives were measurable, sustainable, and replicable.

### **Conceptualization of health disparities reduction strategies**

Harvard Pilgrim Health Care's origin as a community health plan significantly influenced its approach to service, which "values difference and creates value through differences in the community, in our company, in the marketplace and with our business partners, suppliers and vendors." Under new senior leadership in 2010, HPHC anticipated that it would be well-positioned to address health disparities in its member population. However, a year later, an assessment of the organization's readiness to develop a corporate diversity and inclusion strategy revealed otherwise. The assessment revealed that many of the plan's disparities reduction interventions lacked effective data collection and yielded mixed results. Historically, initiatives had been implemented in a stand-alone manner. The readiness assessment highlighted a need for an organized, cohesive approach to integrating diversity and inclusion into the organization's corporate business strategy.

At the time of the case study, HPHC had spent five years crafting a strategic plan that included ways to integrate health equity, and diversity and inclusion principles into its business practices. To support the strategy, senior leaders created the Center for Inclusion Initiatives, along with an executive level position to oversee the center. Interviewees reported that the individual would design initiatives with clear data collection points, build support from top leadership and management, and develop structured approaches to measure outcomes.

External influences also played a role in HPHC's decision to prioritize reducing disparities. First, HPHC had fielded an increasing number of requests for proposals (for health coverage) from potential customers that included questions about the plan's health equity and disparities reduction initiatives. Staff reported that these inquiries emphasized the timeliness and relevance of HPHC's efforts to integrate its health equity principles into their organizational

strategy and business practices. HPHC also saw prioritizing actions to reduce disparities as an opportunity to differentiate itself, from other insurers, to potential members purchasing individual insurance through the exchange.

## Overview of initiatives

In addition to its participation in the NHPC in the early 2000s, the plan initially undertook various limited-scope interventions to reduce members' health care disparities. For example, HPHC analyzed select Healthcare Effectiveness Data and Information Set (HEDIS®) quality measures stratified by race, ethnicity, education, and income to prioritize where to focus targeted efforts (i.e., on improving annual diabetic eye screening exam rates and reducing disparities in colorectal cancer screening rates for Hispanic members). The case study focused on HPHC's most significant initiatives to address health disparities which are summarized below:

- **Creating a Culture of Diversity and Inclusion.** Influenced by a longstanding commitment to community service and a market shifting from employer-sponsored to individual health insurance plans, executive leaders chose to make diversity and inclusion a key component of HPHC's business strategy. The organization conducted annual readiness assessments to measure HPHC's progress toward embedding this culture across six strategic priority areas.<sup>15</sup> HPHC also initiated structural changes to elevate its commitment to diversity and inclusion, including a Center for Inclusion Initiatives. An executive was appointed to oversee the center, lead the readiness assessments, and integrate diversity and inclusion into each aspect of the organization's strategic plan.
- **Transgender-Inclusive Care.** Following a request from a self-insured employer group in 2009, HPHC explored the feasibility of covering transgender care benefits. In 2010, the plan began offering this coverage to a limited number of employer customers. Simultaneously, HPHC engaged internal and external stakeholders to help shape its transgender-inclusive benefits, care, administrative and clinical policies. HPHC continued to refine the benefit offering and updated the actuarial framework supporting the coverage. By mid-2013, HPHC gradually rolled out the updated benefit offering to more employer groups, which ensured most members in Massachusetts, Maine, and New Hampshire would be covered by the start of 2015. When Massachusetts mandated coverage of transgender medical services as part of standard benefits in 2014, HPHC already had a few years of experience with a tailored benefit that met these requirements.

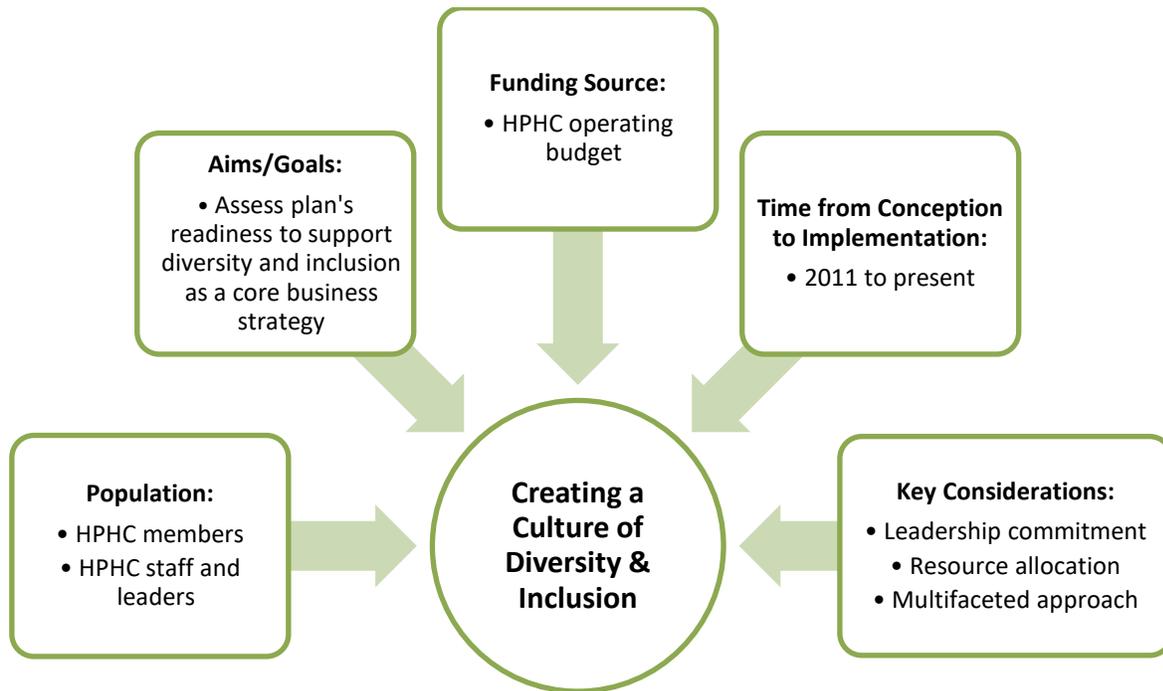
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<sup>15</sup> HPHC's enterprise-wide strategic priority areas include: executive leadership, workplace development, marketplace opportunities, supplier/vendor relationships, community engagement, and health care equity.

## Creating a Culture of Diversity and Inclusion

Below we provide a description of the planning, assessment, implementation, and evaluation processes associated with HPHC's efforts to build a culture of diversity and inclusion. Figure 7 provides a graphical summary of the work.

**Figure 7. At a glance: Creating a Culture of Diversity and Inclusion**



### ***Business case development (planning and assessment)***

In 2010, Harvard Pilgrim Health Care's senior leadership committed to integrating its longstanding and fragmented internal health equity efforts into the organization's overall business strategy. Leaders acknowledged the influence of external changes on the decision, citing shifts in the insurance market toward value-based care delivery and more individuals purchasing individual coverage rather than obtaining coverage through an employer. The changing market environment highlighted the importance of understanding consumer demographics and preferences. Simultaneously, the insurance business model that had historically focused on employer groups was giving way to private and public exchanges.

Looking ahead, HPHC anticipated that its member population would become more diverse across multiple domains including, but not limited to, race, ethnicity, disability status, gender, socioeconomic status, and geography. With this in mind, HPHC began developing a comprehensive business strategy focused on diversity, inclusion, and health equity. HPHC differentiated itself from competitors by proactively responding to a growing market of diverse individual consumers, while maintaining its longstanding commitment to improving community health.

### ***Implementation and evaluation***

The executive team committed to measuring organizational readiness to build a culture of diversity and inclusion on an annual basis. The readiness assessment tool measured organizational commitment, systems alignment, executive support, human resource and financial capacity, and included an audit of organizational capabilities. Each domain was scored on a readiness scale from low to high, with an overall numeric score. In 2011, senior management was surprised to learn that HPHC's initial readiness score was 13 out of a possible 40 points. This score indicated the plan's overall readiness to build a culture of diversity and inclusion, and, as an extension, to address disparities were not as advanced as HPHC had expected.

In 2012, HPHC created the Center for Inclusion Initiatives, along with a chief inclusion officer role – a direct report to executive leadership. The Center was tasked with promoting and overseeing the integration of inclusion-related activities into HPHC's workplace culture and business operations. According to leaders, the Center represented “another step in our efforts to be a national leader in diversity, inclusion and health care equity.” Center staff worked with and across all HPHC business units to develop diversity and inclusion programs. Underscoring their commitment to diversity and inclusion, each department was required to establish diversity and inclusion goals. Around the time of the case study, the plan had begun tying managers' bonus eligibility to the creation of goals for their business unit.

HPHC made progress toward building a culture of diversity and inclusion year after year, albeit more slowly than they expected. In 2014, to accelerate the progress and to demonstrate the organization's commitment to its goal, leaders made health equity one of the organization's six key strategic priority areas. Leaders also endorsed a number of supporting activities:

- **Creating a director of health equity, inclusion and quality improvement role.** Hired in 2015, the director was accountable for the plan's health equity activities, including the task of integrating them across all business units and identifying performance measures to evaluate their impact. The director was also asked to develop HPHC's first comprehensive health equity strategy, which would be both board-approved and enterprise-wide. The approach outlined how HPHC should prioritize member segments that experience significant variation in health care quality outcomes.
- **Using software to supplement members' self-reported REAL data.** A combination of member-provided data and software generated estimates of members' REAL data was used to support and better inform health disparity work.
- **Promoting a new approach to talent acquisition.** Recruiting efforts focused on attracting candidates who better reflected the demographics, characteristics, and experiences of the plan's member population.

- **Implementing a diversity and inclusion strategy for suppliers and vendors.** The new approach focused on building relationships with businesses owned by minorities, women, and veterans.

By 2015, the organization's readiness assessment score had risen to 36 out of 40, up from 13 (2011).

#### *Stakeholder engagement*

- **Internal engagement.** The organization worked to remove silos and align stakeholders throughout the organization in goal setting, data collection, and sharing of diversity and inclusion objectives.
- **External engagement.** In addition to recruiting diverse employees, suppliers and vendors, the organization focused on community engagement. Events included participation in workforce development with local universities, sponsorship of community engagement and cultural events, and creation of a wellness product offering that combined Eastern and Western medicine, the development of which was informed by HPHC members from Indian and Southeast Asian communities. Perhaps the most significant initiative, described in the next section, was the plan's work with gender minority communities.

#### *Financial considerations and sustainability*

Senior leadership recognized the importance of documenting the return on investment (ROI) for inclusion and health equity activities. However, leaders reported that collecting the data to quantify ROI was a significant challenge. Despite being unable to show ROI, the organization's commitment to integrating diversity and inclusion into its business practices and offering expanded insurance products strengthened its brand recognition and loyalty. At the time of the case study, measuring the impact and ROI of health equity-related and diversity and inclusion activities was an organizational priority.

#### *Challenges and barriers*

- **Readiness for change.** As noted, HPHC leaders acknowledged their perception of the organization's readiness to embrace diversity and inclusion as a business strategy exceeded that of the initial readiness assessment results. After several years working on organizational change, HPHC believed the organization was ready to adopt a more deliberate approach to diversity and inclusion.
- **Diversifying the workforce.** As HPHC's membership grew, there was a misalignment in the diversity between HPHC's staff and members. HPHC saw an opportunity to design recruitment strategies to attract candidates with a wide range of characteristics, experiences, and backgrounds. To this end, HPHC developed a talent acquisition strategy focused on increasing workforce diversity.

- **Making culture change happen.** Changing organizational culture to integrate the diversity and inclusion principles into standard business processes takes time. Plan leadership acknowledged that assimilating structural changes, such as the Center for Inclusion Initiatives and related activities, was a long-term commitment. HPHC focused on introducing change incrementally.

*Lessons learned*

HPHC cited a number of lessons learned in its journey to create a culture of diversity and inclusion:

- **Collect baseline data.** The readiness assessment shed light on what cultural and organizational changes would be required to support organizational transformation. HPHC benefitted from the assessment's baseline measurement as it provided the plan with a clear way to measure progress.
- **Refine internal messaging.** The plan learned early on that sharing readiness assessment scores by business unit, as was done after the first assessment, alienated some divisions and undercut efforts to promote organizational support for the measurement process. Rather, framing the assessment as an opportunity for staff to give input on how HPHC could develop an inclusion strategy encouraged widespread engagement.
- **Engage with members.** Readiness assessments must not overlook the diverse needs and preferences of customers. To understand member perspectives, HPHC conducted community forums, discussions with advocacy groups, and directly engaged customers, and community leaders.

Figure 8 below presents a graphical overview of milestones associated with HPHC's work to develop a culture of diversity and inclusion.

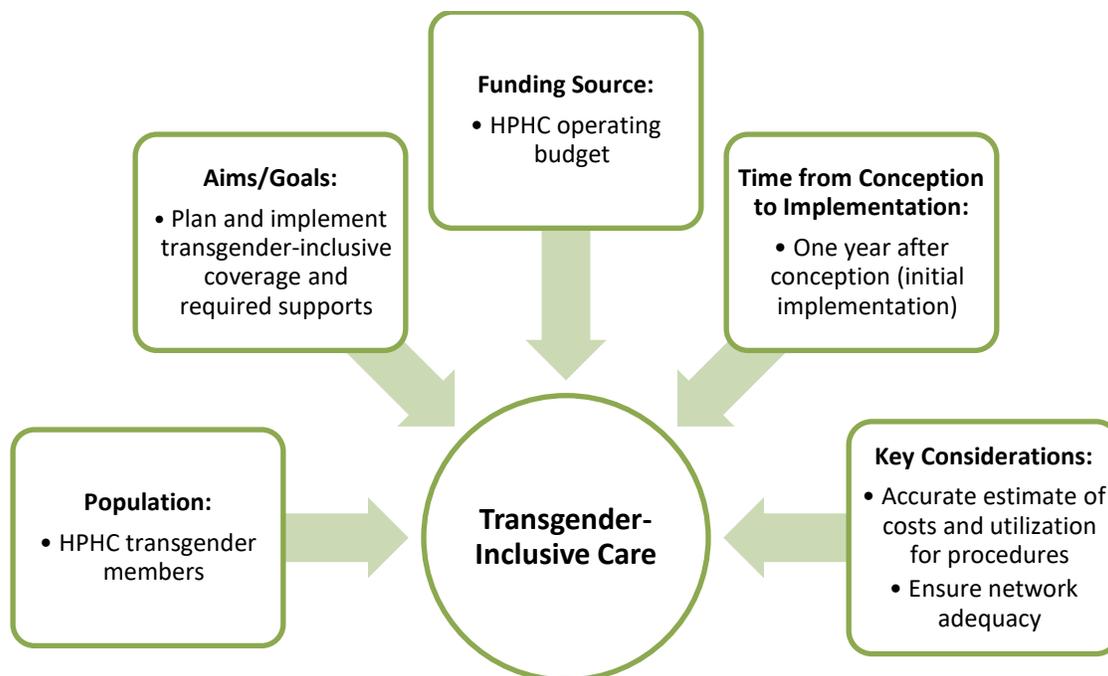
**Figure 8. Timeline of major milestones: Creating a Culture of Diversity and Inclusion**



## Transgender-Inclusive Care

Below we discuss the planning, assessment, implementation, and evaluation processes associated with HPHC’s transgender-inclusive care offering. Figure 9 provides a graphical summary of the work, including its priority population, aims and goals, funding source, time from inception, and key considerations.

**Figure 9. At a glance: Transgender-Inclusive Care**



### ***Business case development (planning and assessment)***

In response to a request made by a large self-insured employer customer in 2009, HPHC began offering coverage of some transgender benefits in 2010. Plan staff recognized the potential of extending this benefit to more of HPHC’s customers, and following this initial offering, began exploring how to do so. First, the plan held discussions with key stakeholders, including community groups, employers, advocacy groups, and local relevant health care services providers. Subsequently, the plan conducted a feasibility assessment of expanding its offering to include a comprehensive transgender-inclusive benefit package. Given the very limited supply of local providers able to offer certain specialty care services, the plan explored approaches for identifying out of network providers.

The offering represented an opportunity for HPHC to pursue a new market segment and assist existing transgender members navigate care delivery challenges unique to gender minorities. The initial offering essentially functioned as a pilot project where the plan gained experience addressing the clinical and administrative complexities of the benefit. HPHC leadership viewed

the decision to offer these comprehensive benefits as an avenue to address access disparities faced by gender minorities and enhance the range of HPHC's portfolio of products.

### ***Implementation and evaluation***

Following its initial offering to several self-insured employers in 2010, the plan slowly increased its offering to a few additional employer customers. In early 2013, HPHC began offering the benefits to all plan employees and dependents. The same year, in advance of other payers in its markets, HPHC began offering the coverage to more employer groups. Starting in early 2015, HPHC planned to offer transgender-inclusive benefits to all remaining group and individual members. However, a 2014 mandate from the state of Massachusetts that these services be offered as part of all health plans accelerated HPHC's timeline for completing benefit rollout. Given the plan's prior experience with refinements to the benefit, it was well positioned to expand the offering across its service area. At the time of the case study, Connecticut and Massachusetts mandated coverage for transgender care, and most of HPHC's fully-insured employer customers in Maine and New Hampshire had coverage of transgender-inclusive benefits.

The plan established itself as an early leader in the provision of a comprehensive transgender benefit within its market. Incorporating external feedback and reflecting on its own experience, the plan continuously made refinements to the product offering, such as enhancing the provider network and establishing specialty support services. For example, HPHC hired a dedicated nurse case manager to work with transgender members seeking to obtain medical services. The dedicated case manager helped members navigate questions about benefits and claims, while also serving as a consistent contact point. Case management staff were trained on coverage details of relevant benefits and were skilled in helping members access and navigate health care. Additionally, the case manager provided technical assistance to providers on the gender transition process and delivery of culturally competent care.

### ***Stakeholder engagement***

- **Internal engagement.** HPHC leadership continuously worked to ensure employees understood the range of benefits covered. The plan also educated staff and network providers about the disparities impacting gender minorities. Efforts included internal training sessions and discussions to build employee awareness of health disparities and social stigma affecting marginalized communities.
- **External engagement.** The Ethics Advisory Group (EAG), an HPHC internal committee that establishes medical professional and ethical standards to improve patient care, developed a framework of values that incorporated transgender benefits and care delivery into the plan's mission. The EAG held several meetings open to the public and attended by HPHC employees, community groups, advocacy groups, and representatives from other health plans. Results of the meetings informed development of the framework. HPHC used guidelines from the World Professional Association for Transgender Health Standards of Care as a starting point for developing its clinical

policies around the benefit. The plan also found stakeholder and community input to be extremely valuable. During EAG meetings, HPHC was challenged to articulate its rationale for covering certain gender affirmation services and how it would determine which treatments met criteria for coverage. The dialogue allowed HPHC to better understand the importance of ensuring that specific services were covered as a matter of policy.

#### *Financial considerations and sustainability*

Despite HPHC's initial over-estimation of the utilization of gender affirmation services when it designed the initial actuarial framework for the benefit, the plan made considerable investments to cover the operating costs and medical services provided to members. HPHC also incurred expenses associated with pre-implementation activities. The plan was not able to quantify direct investment in planning and development activities. However, leaders acknowledged that significant staff time was spent identifying in-network providers and negotiating individual contracts to improve network adequacy. Modifying administrative claims processing systems to adjudicate claims from newly contracted providers, most of whom are not otherwise part of the HPHC network, represented another area of investment.

#### *Evaluation and measurement*

At the time of the case study, HPHC was in the early stages of identifying suitable measures by which to analyze the programmatic, financial, and clinical impact of its transgender-inclusive care. HPHC leadership cited network adequacy and clinical quality as two priority areas for evaluation and measurement.

The link between the benefit offering and advancing the plan's health equity efforts was clear; however, the plan found it challenging to define measures that sufficiently reflected the quality of specific services. Also, the relatively small number of providers and transgender members restricted robust evaluation. At the time of the case study, HPHC was continuing to explore the nascent evidence base in an effort to learn about effective practices to evaluate transgender benefit offerings and care delivery.

#### *Challenges and barriers*

The most significant challenge cited by HPHC leaders and staff was developing a network of clinically qualified providers who: (1) had the expertise to perform complex specialty procedures covered by the plan and (2) practiced within a reasonable distance of the communities where members resided. HPHC realized early in the benefit planning and implementation process the necessity of engaging out-of-network physicians to provide services otherwise offered only in certain locations across the country.

Another major challenge was processing claims for services covered under the new benefit. Gender fields in the claims and other related data systems initially did not include a transgender option, which created downstream issues. For example, members who identified as male, but had not undergone gender affirmation procedures and were biologically female, were recorded

in HPHC's data systems as male. Since the claims processing system restricted certain procedures to one sex or another, some members' routine gynecological care claims were denied. After this issue surfaced, the plan eliminated the gender field from elements of its claims processing system.

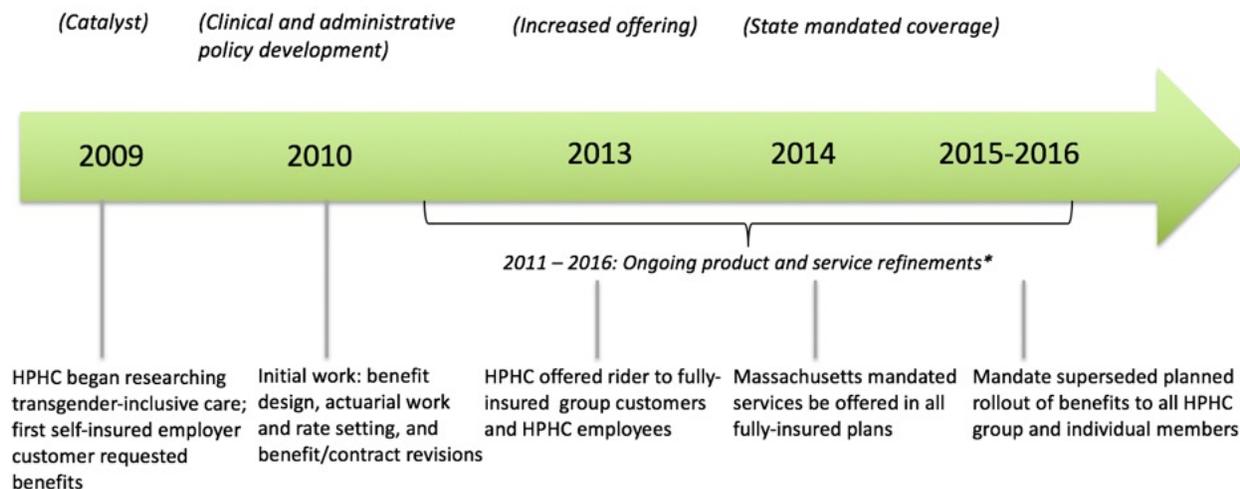
*Lessons learned*

HPHC identified the following lessons learned during the development and implementation of the benefit:

- **Multiple adjustments were required to design and price the new benefits.** Had HPHC learned about other payers' experience offering similar services, it may have been able to reduce the number and types of changes needed to its product offering. For example, during the actuarial planning process, HPHC overestimated the number of members who would use newly-covered surgical services. Once the plan gained claims experience, it had to adjust premiums to reflect the difference between projected and actual utilization patterns. Over time, HPHC found that many members took the transition process slowly and potentially never elected surgical options, even when procedures were part of covered benefits.
- **Implementation is a gradual process.** While HPHC's community partners were eager to see the benefit offered to the plan customers earlier than it was made available, design and launch of the benefit took considerable time. To properly initiate and refine the business processes and medical policies required to provide coverage, the plan phased in the benefit at a pace that was slower than community advocates preferred.
- **Network-related hurdles may persist.** Network adequacy proved to be an ongoing concern. If the plan was unable to engage enough qualified providers, leaders expected that they would have to get increasingly creative to find out-of-network solutions.

Figure 10 presents a graphical overview of milestones in HPHC's work to develop and offer coverage for transgender-inclusive care.

**Figure 10. Timeline of major milestones: Transgender-Inclusive Care**



\* Product and service refinements:

1. Developed community partnerships
2. Engaged stakeholders through Ethics Advisory Group meetings
3. Assessed and built network adequacy
4. Improved operations and implemented changes to claims workflow
5. Created role for a dedicated nurse case manager
6. Integrated member/consumer perspective

## Recommendations

HPHC shared a number of recommendations based on their experience which may benefit other organizations interested in pursuing similar work:

- **Do not underestimate the power of organizational and executive buy-in.** Ensuring widespread engagement to build a culture of diversity and inclusion and address health disparities requires staff and leadership support. Executives emphasized that leaders and management staff are best positioned to articulate the relevance of health equity work within the organization and to demonstrate changes in standard operating procedures. For HPHC, this included elevating health equity as a corporate strategic priority and linking compensation with efforts to achieve diversity and inclusion goals. Similarly, the creation of the Center for Inclusion Initiatives and associated executive positions reinforced messaging on HPHC’s overarching organizational priorities.
- **Integrate expectations for diversity and inclusion efforts throughout the organization.** Integrating changes such that they become part of the organization’s routine business practices is a long-term process. One of the organization’s tactics to ingrain efforts into existing workflows was to require that each department set inclusion and equity goals that were relevant to their work. This served to provide benchmarks by which the

organization assessed its progress and also ensured that the work did not rest on any one individual.

- **Ongoing, multi-stakeholder engagement is critical.** Ongoing engagement with the transgender community and internal and external stakeholders helped shape and improve the benefit offering over time. Feedback from members and advocates helped HPHC better understand the highly personal nature of these services. For example, conversations with stakeholders helped HPHC executives better understand the nature of gender minorities' potential safety concerns. Upon learning more about the challenges individuals often face during transition, including discrimination and potential physical harm, HPHC decided to cover services typically deemed elective for non-transgender members, such as facial feminization procedures and hormone therapy.



## Conceptualization of health disparities reduction strategies

Two entities within Health Net played key roles in the conceptualization and implementation of the organization's interventions to address disparities:

The *Cultural and Linguistics (C&L) Services department* included nine full-time employed staff members as of the time of the case study, all of whom had prior experience managing public health projects and developing solutions to address health disparities.

The *Health Equity Advisory Group (HEAG)* was comprised of staff from several different Health Net departments responsible for the organization's disparity-related projects.

C&L and HEAG collaborated to construct a three-phase framework to guide the organization's approach to managing population health and addressing health disparities. The model, called the Health Equity Framework (HEF), specified the organization's strategy for developing, implementing, and evaluating health disparities projects. In its oversight capacity, HEAG provided guidance to the C&L and other departments in executing the framework. The framework had three phases:

- **In *phase one*, Health Net prioritized health disparities reduction opportunities.** To identify and prioritize potential projects, the C&L and the Quality Improvement (QI) department analyzed Healthcare Effectiveness Data and Information Set (HEDIS®) measures by demographics, such as race, ethnicity, language, limited English proficiency, and geography. The QI department established a set of priority measures based on a combination of: the California Department of Health Care Service's mandated performance levels for Medi-Cal plans, HEDIS® performance measures, and Medicare Star Ratings.

To gain leadership buy-in for implementing initiatives to address disparities, HEAG established a business case on the assumption that addressing gaps would reduce the corporation's risk in several key areas, including: reimbursement loss, issuance of Corrective Action Plans, and poor performance on HEDIS® measures or Medicare Star Ratings.

- **In *phase two*, selected disparity projects were aligned with specific interventions.** The designated interventions were aimed at improving health outcomes for all members. The QI, C&L, Health Education (HE), and other departments collaborated to launch disparity-focused interventions. C&L led workgroups, thought oversight of specific projects depended on the type of intervention and which department was best positioned to implement it.
- **In the *final phase*, each project was evaluated.** Interventions were modified in response to evaluation results. The evaluation process sought to measure whether an intervention: (1) positively influenced member health outcomes, (2) was sustainable, and (3) could be replicated in another region of the Health Net network.

## Overview of initiatives

Although C&L's primary function was to ensure compliance with cultural competency and linguistic requirements, over the years the department expanded its efforts to include addressing health disparities. Two such C&L-led interventions included:

- **Childhood Immunization Status Combination-3.** Annual assessments of HEDIS® performance measures revealed that Health Net's childhood immunization rates were below the Medi-Cal Minimum Performance Level, especially among Russian members with limited English proficiency. The company was at risk of being issued a Corrective Action Plan. Through provider collaborations and community educational programs, Health Net worked to increase vaccination compliance rates across the state of California and within the Russian-speaking community in Sacramento County, where particularly low immunization rates existed.
- **Low-Income Health Disparities and Dual-Eligible Special Need Plans.**<sup>18</sup> An internal study found that Health Net's Medicare Advantage (MA) plans with higher numbers of both D-SNP and Low-Income Subsidy<sup>19</sup> members also had lower-than-average Medicare Star Ratings. Upon review of the findings, Health Net executives called for change. The organization prioritized work with a population of 2,300 MA members in a particular service area who were enrolled in a product that had a particularly low Medicare Star Rating. The organization developed a series of targeted interventions to reduce readmission rates and close gaps in care. Based on positive evaluation results, a series of interventions were launched that addressed access to care challenges for all D-SNP members.

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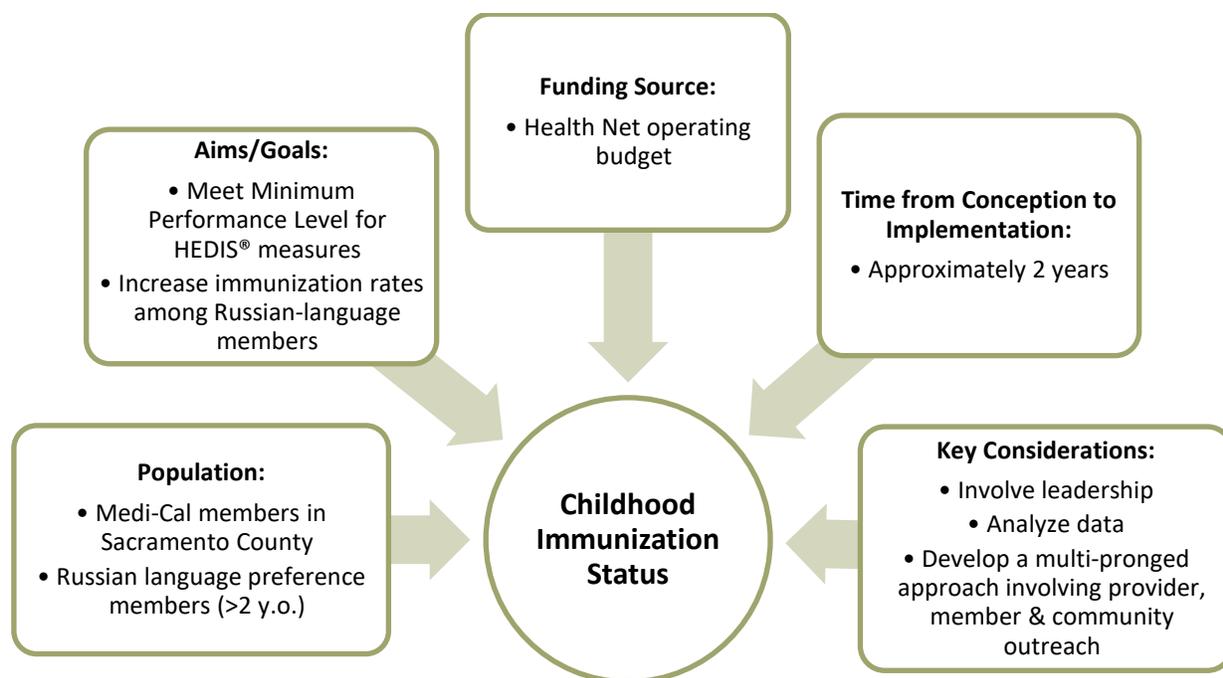
<sup>18</sup> A Dual Eligible Special Needs Plan (D-SNP) is a plan for individuals who are eligible for both Medicare and Medicaid. More information can be found at: <https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/DualEligibleSNP.html>

<sup>19</sup> A Low-Income Subsidy (LIS) beneficiary is a Medicare beneficiary with limited income and resources to pay for their Medicare prescription drug program costs. LIS beneficiaries receive assistance through Medicare's Extra Help program. More information can be found at: [https://www.cms.gov/Medicare/Eligibility-and-Enrollment/LowIncSubMedicarePresCov/index.html?redirect=/LowIncSubMedicarePresCov/%20%2003\\_MedicareLimitedIncomeNET.asp](https://www.cms.gov/Medicare/Eligibility-and-Enrollment/LowIncSubMedicarePresCov/index.html?redirect=/LowIncSubMedicarePresCov/%20%2003_MedicareLimitedIncomeNET.asp)

## Childhood Immunization Status Combination 3 (CIS-3)

Health Net’s CIS-3 initiative emerged as a proactive response to an internal review of quality measures. Executives were concerned about the prospect of a state-issued Corrective Action Plan if the organization’s performance failed to meet required standards.<sup>20</sup> Figure 12 provides a graphical summary of the CIS-3 program.

**Figure 12. At a glance: Childhood Immunization Status**



### ***Business case development (planning and assessment)***

Following leadership’s direction to identify areas of low performance across its Medi-Cal contracts, the QI department found that the CIS-3 rate was below the minimum performance level for the required HEDIS® performance measure. Although several counties showed significantly low immunization rates relative to others, Sacramento County, in particular, stood out. A language analysis found that fewer than one percent (0.88 percent) of children in Russian-speaking families in Sacramento County had been vaccinated. Analysts determined that this was not the result of incomplete data, as the associated medical records were valid. Rather, a single primary care provider serving this community proved an extreme outlier. With a vaccination compliance rate of just 0.03 percent, this provider significantly skewed the plan’s overall vaccination rate. In response, Health Net determined that a series of global

<sup>20</sup> Childhood Immunization Status Combination 3 (CIS-3) is a measure used to determine the percentage of two year old children who have received the following vaccines: four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); two H influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV) by their second birthday. More information can be found at: <https://www.ncqa.org/hedis/measures/childhood-immunization-status/>

interventions were necessary to improve childhood immunization rates. These interventions would be supplemented with additional activities tailored for the local Russian community, its members, and area providers.

### ***Implementation and evaluation***

C&L led a CIS-3 workgroup to design a number of county-level and provider-specific interventions aimed at improving immunization rates. The group analyzed disparities in Sacramento County through a series of community surveys, key informant interviews, internal data analyses, and a literature review. Topics discussed included language and transportation challenges, among others. The analyses also revealed a number of barriers to care, including: visits occurring before or after the HEDIS<sup>®</sup>-specified vaccination window, missing claims and encounter data, members' negative beliefs about childhood immunizations, the practice of granting personal belief exemptions, and provider confusion about California's new legislation (California Senate Bill 277) which required childhood immunizations prior to enrollment in elementary and secondary school.

### ***Stakeholder engagement***

To improve CIS-3 compliance rates, Health Net sent a list of members in need of vaccinations to providers on a quarterly basis. The lists included all members turning 18 months old in need of vaccinations before their second birthday. Health Net also distributed lists of care gaps and report cards to all participating physician groups on a monthly basis. Additional provider-specific interventions included: identifying physician groups with low compliance rates, collaborating with clinical account managers to work with the physician groups that had poor performance, creating an incentive for physician groups to meet benchmarks, conducting extensive chart reviews to determine if data-entry issues existed, and hosting a provider forum to provide technical assistance on California Senate Bill 277.

Health Net also recognized the importance of engaging Sacramento County parents. The organization distributed mailings on a quarterly basis that described the importance of well-child visits and vaccinations. Additional interventions also focused on educating parents and the community about the importance of vaccinations using a variety of communication channels: presentations at local schools, reminder letters to parents, phone calls in both Russian and English, print ads, member incentives for vaccination compliance, public service announcements on the radio, taped radio interviews, and a Russian language media campaign.

### ***Financial considerations and sustainability***

The provider and member focused interventions were funded through the general operating budget of each collaborating department. These interventions formed the basis of the CIS-3 health disparity project. Health Net representatives said that if the interventions achieved their pre-specified goals, the organization would consider expanding the initiatives to other member populations. The goals included:

- Increase by 10 percent the CIS-3 HEDIS® measure for plan members under the age of two with a Russian-language preference in Sacramento County.
- Increase by 50 percent the number of CIS-3-compliant two-year-old members with Russian-language preference who were associated with the specific provider whose vaccine compliance was near zero.
- Increase by 20 percent the measure of community members with a positive attitude toward childhood immunization, to be determined by community surveys conducted in Sacramento County.
- Monitor process metrics for interventions, such as the number of community members attending events, the number of immunization reminder letters mailed and phone calls placed, and the number of people reached through the media campaign in Sacramento County.

### *Evaluation and measurement*

To better understand the root cause of Health Net's performance on select HEDIS® measures, the organization's HEDIS® team conducted extensive chart reviews. As noted above, the team excluded systemic data entry error as the reason for Sacramento County's low CIS-3 compliance rate. This was the conclusion from an examination into the possibility that there were issues in the underlying data source (e.g., missing or unusual data in patient medical charts).

The C&L and HE departments also conducted surveys before and after community meetings in September 2015 and February 2016. Through these surveys, Health Net sought to understand parents' concerns about vaccines and assess the effectiveness of the vaccination education presentations conducted at local schools. Survey results showed small decreases in the number of parents who: (1) believed vaccines were bad for their children (13 percent, down from 15 percent) and, (2) would not vaccinate their child (13 percent, down from 17 percent), which indicated that community outreach efforts were having an effect.

### *Challenges and barriers*

Health Net representatives said that the widespread community-held beliefs opposing childhood vaccinations – coupled with the relative ease by which members could obtain personal belief exemptions when enrolling children in school – presented a significant barrier to successful program implementation. Additionally, the scarcity of Russian-language materials to support physician communication with patients about vaccines posed difficulties for program administrators.

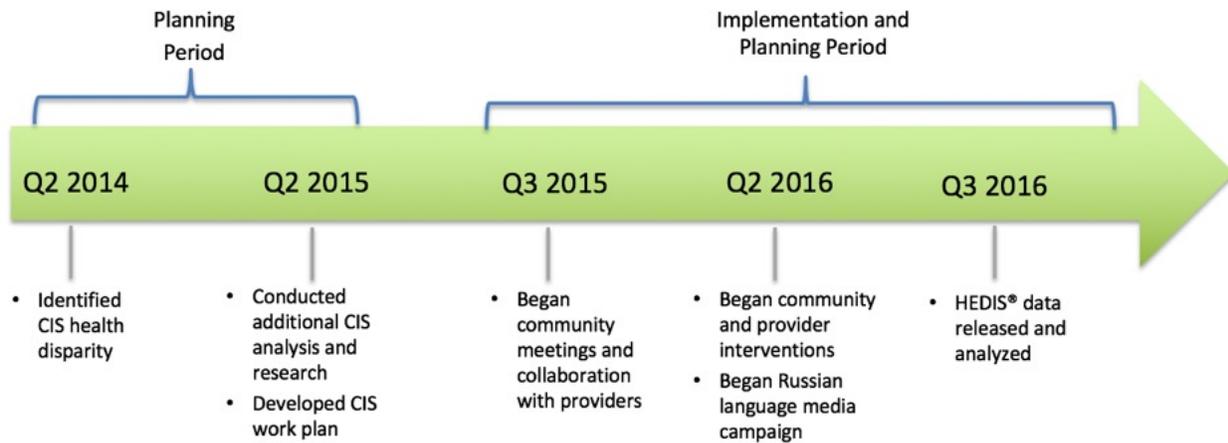
### *Lessons learned*

- **Data can be used to both identify the need for and to design tailored interventions.** Data analysis proved invaluable in both proactively identifying a compliance issue and

identifying that the low vaccination rates were present only within a specific segment of Health Net's member population.

Figure 13 presents a graphical overview of key milestones in the project to increase the rates of childhood immunization.

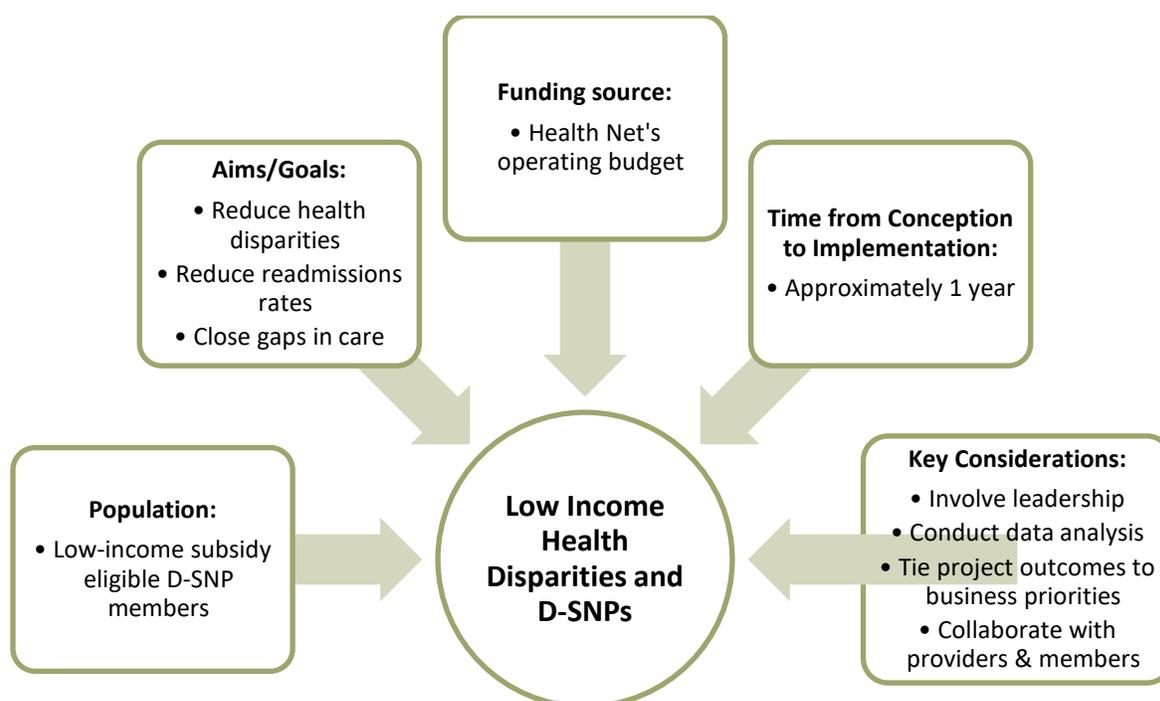
**Figure 13. Timeline of major milestones: Childhood Immunization Status**



## Low-Income Health Disparities and Dual Eligible Special Needs Plans

Similar to the work on CIS-3 that Health Net undertook, its Dual Eligible Special Needs Plans (D-SNP) initiative emerged in response to a review of quality measures. Below we provide a description of the planning, assessment, implementation, and evaluation processes associated with Health Net’s efforts to address health disparities in its dual-eligible special needs population. Figure 14 provides a graphical summary of the work, including its priority population, aims/goals, funding source, timeline, and key considerations.

**Figure 14. At a glance: Low Income Health Disparities and D-SNPs**



### ***Business case development (planning and assessment)***

An analysis of Medicare Advantage (MA) plan outcomes found that its D-SNP plans tended to have lower Medicare Star Ratings compared to other Health Net MA plans. Additional analyses found that Health Net D-SNP plans with higher percentages of members eligible for the Part D Low-Income Subsidy (LIS) tended to have lower ratings than other D-SNPs. These results raised concerns about the possibility of widespread disparities in Health Net’s D-SNP plans.

Executives acknowledged that the organization needed to increase its D-SNP contract ratings and issued a mandate to improve performance on HEDIS® measures across all of Health Net’s MA plans. Leaders also required participating physician groups to implement targeted interventions to reduce readmission rates and close gaps in care for D-SNP members.

### ***Implementation and evaluation***

The QI department was tasked with leading the initiative. The project benefitted from widespread organizational buy-in, as leaders and staff alike recognized that changes would be necessary to improve the health plan's Medicare Star Ratings and HEDIS® performance. The QI department launched the D-SNP project in mid-2014. QI department staff collaborated with a dedicated team of nurse care managers, social workers, and case management assistants who focused on finding ways to reduce readmission rates and close gaps in care. Health Net leaders redistributed the team's other responsibilities so that they could focus exclusively on the D-SNP project.

The project was divided into two tiers: *global interventions* were implemented for all D-SNP members, while *targeted interventions* were tailored to the specific needs of LIS-eligible D-SNP members.

The global interventions included:

- A wellness and prevention checklist that became part of the D-SNP welcome packages physicians distributed to new members.
- Pocket calendars to help members track appointments and on-hold messages for physician offices, in both English and Spanish, that rotated quarterly and addressed different key messages.
- Interactive voice response calls to over 130,000 members, and those identified as having medication adherence issues were offered the option to transfer the call to a pharmacist for further information.

Targeted interventions initially focused on 2,300 LIS-eligible D-SNP patients in the Central Valley area who had experienced barriers to care due to language, cultural, and socioeconomic needs. Acknowledging such issues, the LIS D-SNP targeted initiatives included:

- Assignment of bilingual case managers and scheduling interpreters to attend appointments (as needed) with non-English-speaking members.
- Increased outreach to members recently discharged from the hospital, as well as those with gaps in care or compliance issues.
- Updated member contact information with data from claims, pharmacies, and providers, and double the volume of call attempts made to members in an effort to reduce the "unable to reach" rate.
- Sent refrigerator magnets and brochures to members with key contact information for: care managers, urgent care centers, transportation services, behavioral health services, Health Net member services, and a 24-hour nurse hotline.

By late 2015, about one year after it began, the population for Health Net's targeted intervention grew to about 3,200 members.

### *Stakeholder engagement*

To facilitate engagement of providers and members impacted by the interventions, the project team conducted regular meetings with participating physician groups to assist with members' care transitions and discharge planning. To facilitate this, Health Net obtained access to the electronic medical record (EMR) systems at the three largest hospitals in the county which allowed plan staff to review members' inpatient and emergency room status. The team also increased communication with providers to offer information about gaps in care, care management concerns, and member requests. In an effort to increase members' access to provider-prescribed supplies, the team educated clinicians about the referral process required to procure durable medical equipment. In addition, the team built a direct relationship with a local Federally Qualified Health Center (FQHC), which allowed Health Net to coordinate contact between the FQHC, the plan, and Health Net members.

### *Financial considerations and sustainability*

All funding for the LIS D-SNP intervention came from Health Net's regular operating budget. Given early indications of success with the LIS D-SNP project, in 2015, Health Net expanded the interventions to all D-SNPs.

### *Evaluation and measurement*

The initiative focused on improving Health Net's performance on two measures in particular: readmission rates and gaps in care. At the time of the case study, the QI department planned to carry out a quasi-experimental analysis of HEDIS® measures pre- and post-intervention to evaluate the effectiveness of the global and targeted interventions. Preliminary analyses indicated that the readmission rate for LIS-eligible D-SNP members declined by approximately 25 percent.

Figure 15 presents a graphical overview of key milestones in the organization's efforts to reduce disparities among the dual-eligible special needs population.

**Figure 15. Timeline of major milestones: Low Income Health Disparities and D-SNPs**



### *Challenges and barriers*

The majority of challenges encountered during the project were associated with members' language, cultural, and socioeconomic needs. Due to a high percentage of Spanish-speaking plan members, communication barriers between members and providers, as well as members and plan staff, presented a significant challenge. The cost of care and medication, transportation barriers, and a lack of social supports also proved to be significant challenges for members. Launching the interventions themselves also proved challenging: member phone numbers and addresses were frequently out of date and required extensive efforts to update.

### *Lessons learned*

Although each initiative had its own distinct challenges and barriers, Health Net representatives cited a number of overarching organizational challenges associated with initiatives.

- **Infrastructure is vital.** Gathering and analyzing relevant data to assess whether health disparities decreased depends on the available infrastructure. Health Net encountered difficulties merging multiple data sources; often, providers entered EMR data in incompatible formats and with varying levels of completeness. These and other data quality issues challenged Health Net's efforts to make the business case for reducing disparities.
- **Provider bandwidth may hinder engagement.** Because many health plans were working to improve HEDIS® measures simultaneously, providers were overburdened with payer requests. Limited administrative capabilities in practices made it difficult for some providers to engage in Health Net's disparities work.

## **Recommendations**

Health Net shared a number of recommendations based on their experience which may benefit other organizations interested in pursuing similar work:

- **Gain familiarity with the population served.** Understand members' needs and what resources are available the community, including health care and infrastructure (e.g., transportation).
- **Develop a comprehensive understanding of regulations.** Ensure all relevant federal, state, and local regulations are addressed during program design.
- **Identify a champion within the organization.** This leader should be able to cultivate trust and must have confidence in the workforce charged with developing the initiative(s). Moreover, this person can give health disparities initiatives visibility and promote buy-in from top leadership.
- **Make data collection a priority.** Collect information about the health care needs of members, and understand what physician groups are doing to address these needs. This information is beneficial when developing the business case for sustainable disparities-reduction initiatives.
- **Align health disparities reduction objectives.** Coordination of the goals of both internal and external stakeholders can help build support for initiatives.

## Case Study Four: Highmark Inc.

March 29, 2016

### Introduction and description

Highmark Health (Highmark) is a diversified health and wellness enterprise operating in Pittsburgh, Pennsylvania.<sup>21</sup> The enterprise was established in 2013 as a portfolio of several businesses and affiliates offering a wide range of healthcare-related services and products. At the time of the case study, its businesses and affiliates included Highmark Inc., the Allegheny Health Network, HM Insurance Group, Highmark Health Solutions, Visionworks of America, United Concordia, and the Highmark Foundation.<sup>1</sup> The organization's vision is that "Highmark Health's dedicated and respected employees will be leaders in the health care industry, working to improve the total health care experience of [their] customers."<sup>22</sup> Interviewees reported that this vision resonated with staff and leaders and served as a constant driver for improvement.

Highmark Inc. is a health insurance company within the Highmark Health enterprise that offers Blue Cross Blue Shield (BCBS) and Blue Shield products to commercial groups, individuals and families in West Virginia, Delaware, and Pennsylvania.<sup>1</sup> At the time of the case study, Highmark was the fourth largest health insurer in the United States, serving 5.2 million members nationally, making it the third largest BCBS insurer.<sup>23</sup>

Figure 16 below provides a snapshot of key characteristics of Highmark Inc.

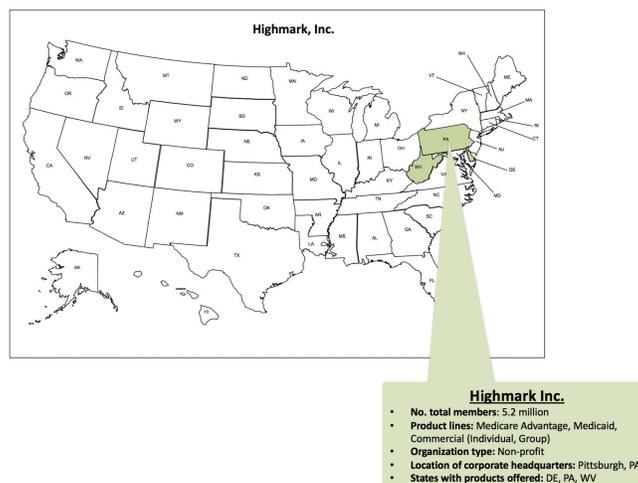
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<sup>21</sup> <https://www.highmark.com/hmk2/about/ourBusinesses.shtml>

<sup>22</sup> <https://www.highmark.com/hmk2/about/vision/index.shtml>

<sup>23</sup> <https://www.highmark.com/hmk2/newsroom/snapshot.shtml>

Figure 16. Case study organization key characteristics<sup>24</sup>



## Conceptualization of health disparities reduction strategies

In 2003, Highmark’s leadership committed to position Highmark as a leader among payers in addressing health disparities. Initially, Highmark sought to accomplish this by creating several committees with providers, stakeholders, and subject matter experts, and hosting community forums. However, the organization lacked a business case and overarching approach. In 2004, Highmark leaders identified an opportunity to participate in the National Health Plan Collaborative (NHPC), a group that convened in response to the Institute of Medicine’s 2003 *Unequal Treatment* report.<sup>25</sup> The NHPC brought together 11 health plans to evaluate “provider-, member-, and community-targeted approaches that use race, ethnicity, language and educational level (RELE) data to determine the effectiveness in these strategies in reducing gaps in care and improving the quality of care that racial and ethnic populations receive.”

After becoming a founding member of the NHPC and presenting the *Unequal Treatment* report to Highmark’s medical directors, addressing health disparities became an important aspect of the organization’s quality strategy. Highmark established the Health Equity and Quality Services (HEQS) department in 2008 to oversee the organization’s health equity initiatives. In the years following, Highmark made strides to effectively address health disparities and provide culturally competent services to its customers.

## Overview of initiatives

Two key initiatives comprise the case study with Highmark:

- **RELE Data Collection.** Interviewees stated that a key belief at Highmark is that “an organization cannot improve on what is not measured” and began collecting and

<sup>24</sup> Figures current as of March 2016.

<sup>25</sup> Smedley BD, Stith AY and Nelson AR. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington: The Institute of Medicine, 2003. <http://www.nap.edu/read/12875>

analyzing RELE data elements in 2005. These data allowed Highmark to identify whether significant gaps in care were prevalent within individual communities. Over the next several years, the organization continuously worked on ways to improve its data collection and analyses around health disparities. As a result of these analyses, interventions were initiated related to access to care issues, immunizations, preventive services, glaucoma, and diabetes.

- **Faith-Based Learning Collaborative.** The Health Equity and Quality Services department initiated the Faith-Based Learning Collaborative in 2011 after meeting with well-respected church leaders and community social service agencies in Southwestern Pennsylvania that serve primarily African American communities with a high prevalence of chronic conditions. For example, cardiovascular disease is a leading cause of death in the region. Working closely with church leaders to understand their priorities, Highmark agreed to support the community's interest in addressing heart health through a jointly-designed learning collaborative called "Take Care of My Heart." By 2013, the learning collaborative had engaged 30 churches across four counties, each of which set its own goals to encourage its members to adopt healthy lifestyles and improve heart health. Highmark supported these churches by holding health education sessions and conducting health screenings. To help monitor impact, Highmark asked churches to provide progress reports on key metrics described later in the report.

## RELE Data Collection

As Highmark became more engaged with the NHPC in 2004, a health equity champion in senior leadership impressed upon executive and management staff the importance of data collection, and the need to collect RELE data in particular. Leadership agreed that data collection should be a foundational activity for any future interventions to reduce health disparities. Subsequently, Highmark expanded its outreach to better understand the health disparities in the communities it served. Highmark senior leaders emphasized the role of data in building a business case to reduce health disparities, stating that anecdotal evidence can be countered, but data are difficult to dismiss. Data could be used to highlight or confirm what communities reported.

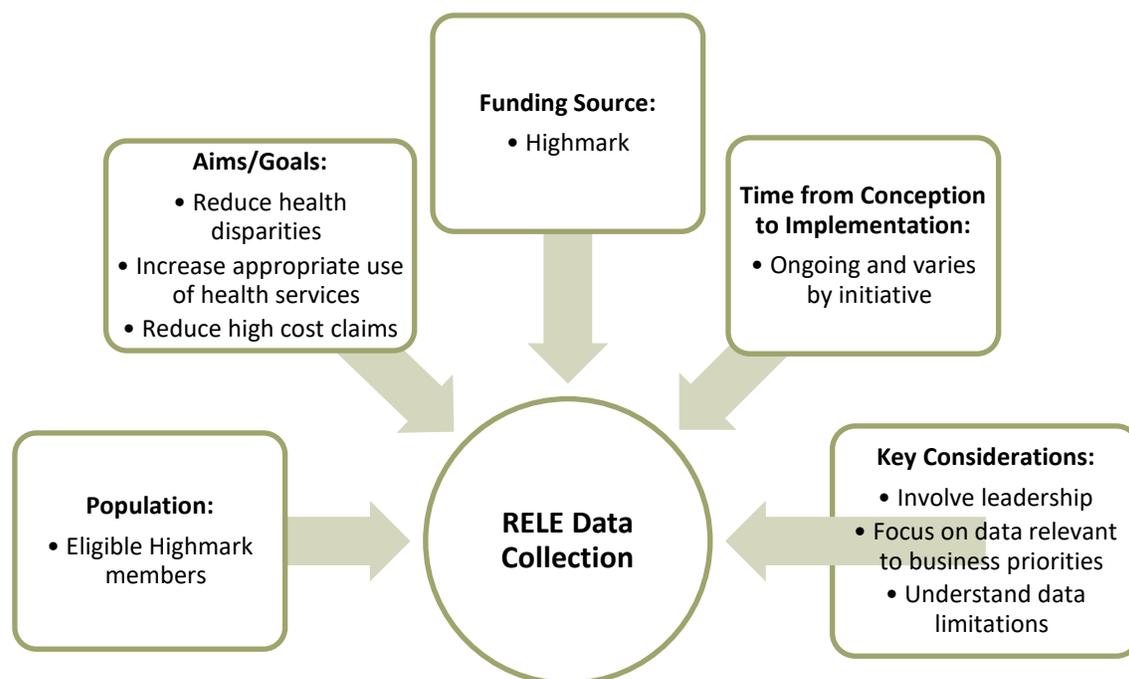
### ***Business case development (planning and assessment)***

Highmark's work to reduce health disparities originated at the senior leadership level. Leaders decided that Highmark should be "best in class" with its health equity work, which would differentiate it in the insurance market. Accordingly, Highmark achieved NCQA's Multicultural Health Care certification multiple times over the next decade.

Additionally, the HEQS department was formed and it began expanding upon the organization's earlier efforts to collect members' self-reported RELE data. HEQS used new information collected, combined with HEDIS® and claims data, to better understand health disparities. Subsequently, Highmark increased its member, provider, and community-focused interventions to reduce disparities. Also as part of the executive team, the HEQS leader increased the department's visibility and fostered inter-departmental collaboration. This allowed HEQS to garner and maintain organizational buy-in for initiatives to address health disparities.

Figure 17 provides a graphical summary of the work, including its priority population, aims/goals, funding source, timeline, and key considerations.

Figure 17. At a glance: RELE Data Collection



### ***Implementation and evaluation***

After reviewing the Institute of Medicine’s 2002 report on health disparities, Highmark senior leadership was determined to identify and address health disparities among its members. To develop a business case for the work ahead, HEQS began by analyzing data the organization already possessed in an effort to understand what disparities existed and to identify which communities were most affected.

Highmark began to identify ways to augment its own internal data after CMS started providing race and ethnicity data on Medicare Advantage members in 2003. In 2005, the organization began geocode and surname analysis of HEDIS® data. The following year, Highmark began collecting self-reported RELE data from members via paper surveys. Within five years, Highmark transitioned its collection of self-reported demographic information to the Highmark member website and online health risk assessment (HRA). The ability to collect educational achievement data was added to the member portal and the HRA in 2011 and 2015, respectively.

### ***Stakeholder engagement***

- **Internal engagement.** HEQS built internal support for its data collection work by demonstrating the relevance of the data it gathered to other departments’ business priorities. HEQS regularly shared reports on activities to reduce health disparities across the Highmark family of companies, which the department used to illustrate how its initiatives helped improve the health of members and their communities.

- **External engagement.** HEQS worked with a variety of community forums across the health plan's service areas to better understand the key issues impacting members (e.g., provider issues, difficulties accessing care).

#### *Financial considerations and sustainability*

HEQS developed sustainable data collection, reporting, and monitoring processes that were integrated throughout the organization. HEQS worked to embed its data collection processes seamlessly into other departments' workflows in order to minimize disruption and burden. The value of the investment in data collection, while difficult to measure, was recognized indirectly through improvements in Highmark's Medicare Star Ratings and HEDIS® metrics.

#### *Evaluation and measurement*

Highmark used a combination of RELE and operational data to: (1) identify areas for improvement when comparing health outcomes and metrics by patient populations, and (2) assess the effectiveness of its various health disparity initiatives. At the time of the case study, Highmark collected self-reported RELE data from approximately 17 percent of its membership. Self-reported data were used first in analyses then supplemented with indirect data, as needed.

#### *Challenges and barriers*

Highmark's low rate of member self-reported RELE data was potentially impacted by several issues, including: voluntary reporting; wariness from many members about how the data would be used; and, some commercial employer groups had stringent restrictions on plan communications with employee subscribers. As noted, to Highmark used indirect data to augment that which was self-reported by members. Indirect information proved invaluable toward painting a more complete picture of a patient population; however, the use of indirect estimation methods was less precise than members' self-reported RELE data.

#### *Lessons learned*

The HEQS department learned a number of lessons, the most important being:

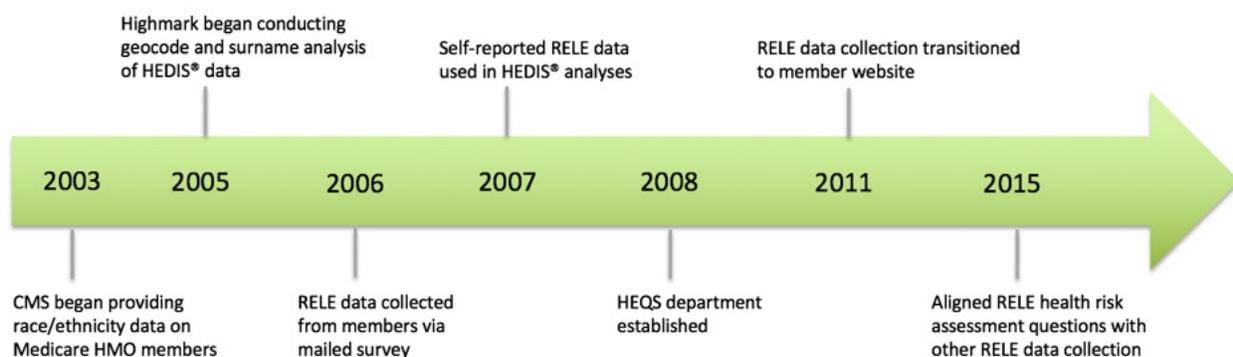
- **Data collection is foundational to supporting ongoing work to reduce health disparities.** Highmark's leadership recognized that addressing disparities without detailed quantitative and qualitative data on race, ethnicity and language preferences, as well as community needs, made developing a business case for this work difficult. Since data collection is time- and resource-intensive, organizations must be selective about what and how data are collected.
- **The data collected must be relevant to the organization's overall top line business priorities and bottom line financials.** Once collected, data can be used to support the business case to reduce health disparities, and may support other departments' needs. For example, the marketing department learned to tailor its messages for different

member communities after working with HEQS staff to understand the makeup of member communities and how they changed over time.

- **It is essential to solicit community input during the data collection process.** Listening to the community about its self-identified health needs and tying those concerns to quantitative data analyses afforded Highmark a more complete picture of disparities.
- **Involve senior leadership early** to communicate the relevance and value of RELE and associated data to the organization’s business priorities (e.g., performance on HEDIS® measures).
- **Recognize the value of qualitative data (e.g., community forum input, consumer feedback)** in giving context to initiatives designed to address disparities.

Figure 18 presents a graphical overview of key milestones in the RELE data collection project.

**Figure 18. Timeline of major milestones: RELE Data Collection**

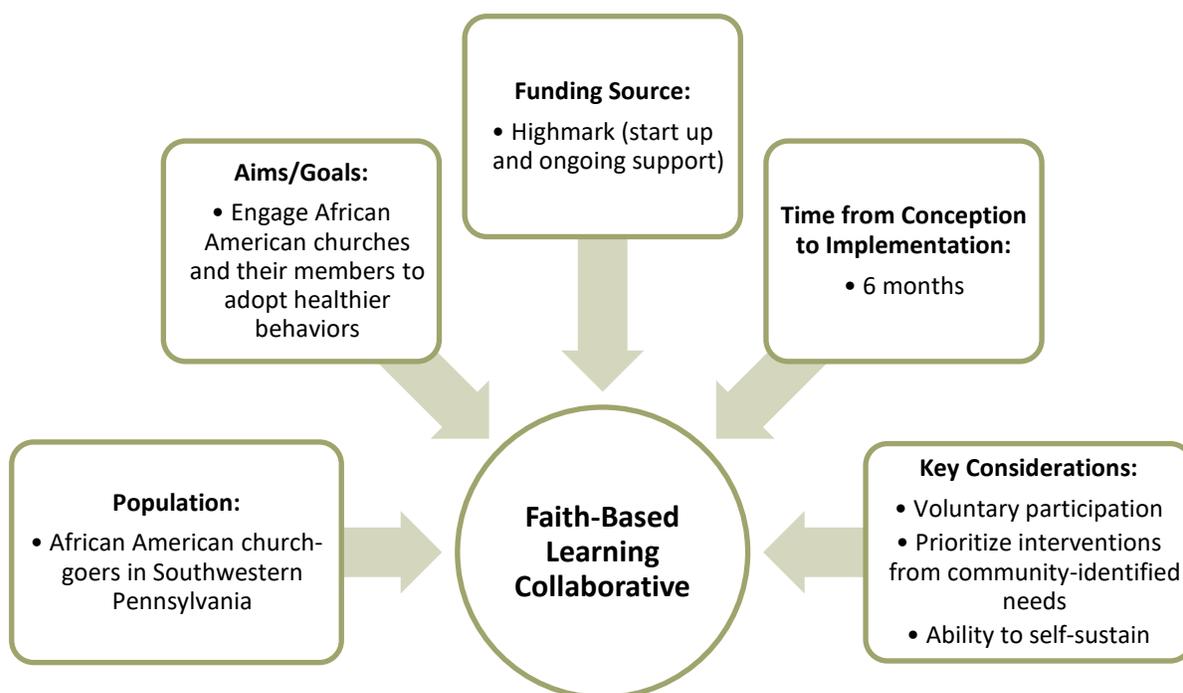


## Faith-Based Learning Collaborative

In late 2011, the idea for Highmark’s Faith-Based Learning Collaborative originated during two HEQS-organized community forums attended by community service organizations, physicians, and church leaders in Southwestern Pennsylvania. At that time, a number of the community representatives suggested that Highmark consider working with church leaders, given their status as trusted individuals in this predominately African American community. With the support of Highmark senior leadership, a member of the HEQS department with strong connections to the church community began meeting with church leaders to consider how to improve population health. As a result of these meetings, Highmark and church leaders agreed to implement “Take Care of My Heart,” a community learning collaborative focused on improving cardiovascular health.

To supplement Highmark’s resources, the plan relied on support from church leaders and health ministries at individual churches to create and maintain momentum for this initiative. A number of the participating churches already offered some basic health care services to members, such as blood pressure screening, and “Take Care of My Heart” was built upon an existing network of receptive church members. Figure 19 provides a graphical summary of the work, including its priority population, aims/goals, funding source, timeline, and key considerations.

**Figure 19. At a glance: Faith-Based Learning Collaborative**



***Business case development (planning and assessment)***

Highmark recognized the importance of engaging minority populations in efforts to improve population health and reduce disparities in health care. Highmark leadership maintained that the faith-based initiative reached almost equal numbers of non-members and members. The initiative helped to strengthen Highmark’s relationships with key community leaders and enhance its reputation.

After launching the faith-based learning collaborative, HEQS decided to limit the participants to churches, rather than any interested service organization. HEQS reasoned that because the majority of churches involved came to the initiative with an existing infrastructure (such as a health ministry or health and wellness committee) to support their participation, these entities did not require significant staffing support from Highmark.

### ***Implementation and evaluation***

Early in the collaborative, Highmark coordinated educational seminars about heart health and provided internal staff (physicians and registered dieticians) as speakers. Participants were asked to accept the “Take Care of My Heart” Highmark-branded pledge. This card included space for participants to write their individual goals for healthy eating, activities, etc. Churches organized their own exercise classes and coordinated health fairs, health screenings, and CPR classes with Highmark’s support. Activities at the churches included blood pressure readings, medication review sessions and healthy cooking demonstrations. Over time, individual churches developed a variety of activities to motivate their members to be more active and to eat healthily, such as “Biggest Loser” competitions and walking prayer groups. When possible, Highmark used a train-the-trainer model to build capacity among churches to expand wellness activities and conduct their own sessions.

HEQS met with several community and church leaders to obtain input on strategies for engaging the larger church community before proceeding. As the number of interested churches grew, HEQS staff worked with church leaders to identify the topics of most interest to the community, prior to planning additional meetings.

During in-person meetings organized by Highmark, church leaders reported on their activities and successes, shared ideas, and identified ways to further improve health in their community. During some of the in-person meetings, Highmark distributed free blood pressure cuffs, pedometers, automated external defibrillators, and exercise bands. These materials did not reference Highmark, as church leaders again emphasized the importance of showing their members that “Take Care of My Heart” was church-based, rather than an initiative sponsored by an outside organization that was “trying to sell them something.” Highmark also distributed health education materials from the Centers for Disease Control and Prevention and other organizations.<sup>26</sup> They chose resources that were culturally appropriate and presented in plain language.

### ***Stakeholder engagement***

- **Internal engagement.** In addition to the HEQS team, other Highmark staff helped with health education seminars when the churches did not have their own health experts to lead sessions. HEQS, along with Highmark’s marketing and communications team, wrote articles in Highmark’s provider and member newsletters about the successes of individual members who participated in “Take Care of My Heart.” HEQS considered these communication efforts an important aspect of maintaining internal Highmark buy-in for the Faith-Based Learning Collaborative.

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<sup>26</sup> The CDC publishes free public health content; samples can be found at <https://tools.cdc.gov/medialibrary/index.aspx#/results>

- **External engagement.** The engagement of community leaders and church members in this initiative was critical to its success. Key stakeholders were involved from the very beginning and through every step of the initiative. Beginning in 2012, Highmark coordinated a series of annual meetings with church leaders and volunteers to share experiences and “lessons learned” from the collaborative. Highmark used these meetings to provide more information about specific wellness topics of interest to the community. Between 50 and 70 participants who represented between 20 and 30 churches attended each meeting. At the time of the case study, the initiative focused on blood pressure monitoring. Highmark planned to distribute a form that participants could use to record readings and church members would be encouraged to track the values. Highmark also planned to have a specialist review the results.

#### *Financial considerations and sustainability*

Highmark leveraged the churches’ existing resources and volunteers to implement and sustain the initiative. This careful coordination of resources made the learning collaborative feasible. While the collaborative required a significant time investment from one HEQS staff member in the first six months, it was maintained by one HEQS staff member who dedicated about 10 percent of their time to coordinating and hosting the meetings and related activities.

Similar efforts to form collaboratives where churches had fewer leaders and less active church volunteers were not sustainable. For example, Highmark later tried, unsuccessfully, to initiate a collaborative in a Latino community. However, the churches in the area neither had the resources nor experience with health ministries. From this, Highmark concluded that without the ability to leverage existing church resources, this type of collaborative requires too many corporate resources to be sustainable given other priorities.

#### *Evaluation and measurement*

- **Data collection.** Highmark initially asked churches to provide monthly reports before and after implementation to support measurement of changes in healthy behaviors (e.g., eating habits, physical activity, medication adherence, and smoking cessation). In addition to volunteers managing multiple commitments and lacking the time to complete monthly reports, some found the data collection tools to be too complicated. Highmark later hired a consultant to follow up with churches and improve the monthly reporting response rate. Even with the consultant’s help, achieving a reasonable response rate for these monthly reports remained a challenge.

While only half of the 30 participating churches submitted the voluntary monthly reports, the partial results suggested that the “Take Care of My Heart” learning collaborative was successful in reaching its goals related to improving health lifestyles and health behaviors among participants. Of the 355 church members who responded to a survey administered at seven participating churches, the proportion of individuals who reported engaging in health behaviors “more” frequently after

taking the “Take Care of My Heart” pledge was significantly greater than the proportion that reported the “same” or “less” frequency. Interviewees also reported that the Highmark annual meetings had high participation over the years of the collaboration, suggesting that the level of engagement by the churches remained consistent over time.

- **Data analysis and use.** Survey data was presented to Highmark’s Health Equity Committee in collaboration with a researcher from the University of Pittsburgh. The survey results showed a relative increase in healthy behaviors by church members since the beginning of the intervention. Despite this, the response rate was low among the churches and the respondents did not represent a random sample from any given church. The results could not be generalized and only pertained to the seven churches that completed the surveys.

#### *Challenges and barriers*

As discussed, one of the biggest challenges was getting church members, who were all volunteers, to consistently submit data and complete reports. Some of the church representatives were overburdened by the data collection requests. For future initiatives, HEQS planned to simplify data collection tools and considered offering incentives to encourage a better response rate.

#### *Lessons learned*

- **Offer incentives for reporting.** Rewarding stakeholders for the completion of surveys might have kept more churches engaged with data collection efforts. Such incentives, combined with simpler data collection instruments and enhanced technical assistance, could yield higher response rates.
- **Engage stakeholders early.** During the “Take Care of My Heart” planning stages, Highmark staff learned the importance of listening to the community’s needs early in the development process. In early meetings, church leadership shared that they wanted to maintain control of the initiative and preferred to define Highmark’s role as that of a partner that could provide resources and education tailored to the community’s needs. Highmark developed an approach that supported these goals and emphasized that the initiative originated within the community as opposed to an insurer.

Figure 20 presents a graphical overview of key milestones in the Faith-Based Learning Collaborative.

**Figure 20. Timeline of major milestones: Faith-Based Learning Collaborative**



## Recommendations

Highmark shared a number of recommendations based on its experience which may benefit other organizations interested in pursuing similar work:

- **Involve senior leadership early.** Fostering organization-wide buy-in and identifying a senior leader to champion the work is vital to the process.
- **Consider health disparities in the context of an organization's overall business priorities.** Demonstrating how addressing disparities will help other departments achieve their goals and affect the bottom line can help create buy-in and foster cross-departmental cooperation.
- **Ground the business case for reducing disparities in data.** Doing so strengthens the overall case to reduce health disparities, while data gathering and analyses help identify disparities.
- **Partner with community leaders.** Collaboration with community leaders is key to successfully reaching and engaging members in initiatives.
- **Listen to the communities experiencing the disparities.** Hearing a community's concerns and needs helps to inform what initiatives will be most successful.

## Case Study Five: Methodist Le Bonheur Healthcare

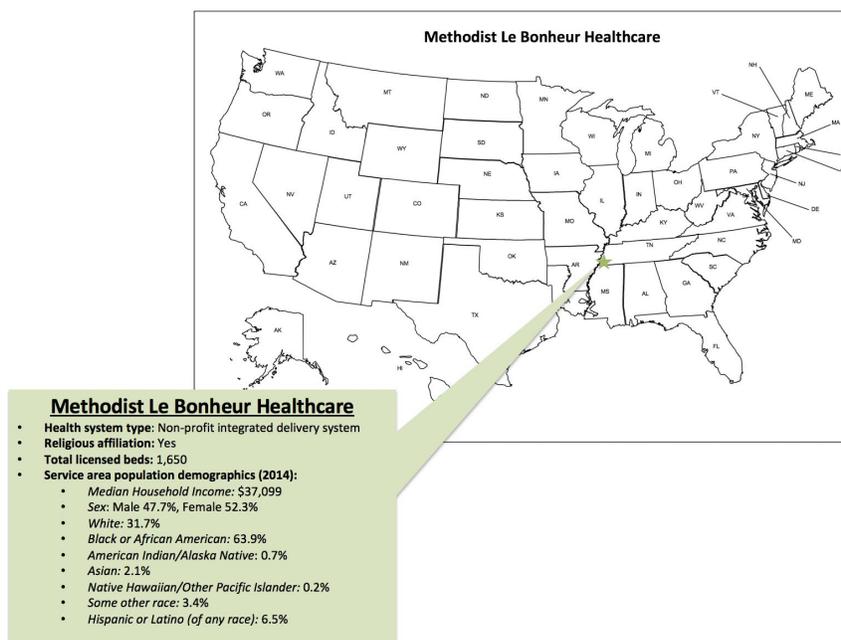
April 13 – 14, 2016

### Introduction and description

For nearly 100 years, the Methodist Le Bonheur Healthcare system (Methodist) worked to address the extreme socioeconomic and health-related inequities affecting patients in Memphis, Tennessee – an area that interviewees described as a “city of many disparities.” The faith-based non-profit organization had facilities in all four quadrants of the city. At the time of the case study, interviewees estimated that Methodist cared for between 60 and 70 percent of the uninsured Memphis residents, making it the largest charity care provider in Tennessee. In addition to serving a large uninsured population, Methodist had exclusive service contracts with private payers and employers and served around 70 percent of the commercially insured patients in Memphis. Leaders described Methodist as grounded in faith and guided by the chief executive officer’s mantra that doing the “right thing” often takes priority over more financially practical approaches to providing health care.

Figure 21 below provides a snapshot of the Methodist system and a basic demographic profile of the city.

**Figure 21. Case study organization key characteristics<sup>27, 28</sup>**



According to interviewees, the local health care delivery market was highly consolidated: at the time of the case study, Methodist had approximately 40 percent of the inpatient market share

<sup>27</sup> American Fact Finder: Community Facts (2015). *U.S. Census Bureau*. Retrieved from <https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>

<sup>28</sup> Figures current as of April 2016.

and the other major health system in the region, Baptist Memorial Health Care, accounted for about 30 percent. The city operated a county hospital in affiliation with the University of Tennessee Health Science Center. Despite a large number of single-specialty groups (particularly in neurology and orthopedics), the region had a shortage of primary care physicians (PCPs). Many of the communities in the Methodist service area were designated as PCP priority areas<sup>29</sup> and all service areas in Shelby County were medically underserved areas.<sup>30</sup> And, as highlighted in its 2016 Community Health Needs Assessment, Methodist served neighborhoods in Shelby County with many socioeconomic challenges and health disparities. They reported that “these health disparities fall along racial lines...for too many African Americans, health is an uphill battle.”<sup>31</sup>

It is in this context in which Methodist operates, providing care in Shelby County to a large population of uninsured individuals suffering from high rates of heart disease, stroke, cancer, and many other comorbidities. Table 1 compares Shelby County to state and national averages along several major health indicators.

**Table 1. Shelby County health indicators<sup>32</sup>**

	Shelby County	Tennessee	United States
Percent of adults with heart disease	5.9%	6.1%	4.4%
Heart disease: Age-adjusted death rate (per 100,000)	209	209	175
Stroke: Age-adjusted death rate (per 100,000)	52	47	38
Cancer: Age-adjusted death rate (per 100,000)	202	200	169
Breast cancer: Incidence rate (per 100,000)	128	121	123

### Conceptualization of health disparities reduction strategies

Although interviewees described Methodist’s approach to addressing health disparities as initially fragmented in nature, the health system gradually created an overarching strategy defined by collaboration between the Methodist system and community partners. Methodist formalized this strategy in 2014 by creating a health disparities council to prioritize commitments and investments aimed at addressing health disparities. “In every quadrant [of the city], there are smart people trying to address things,” an interviewee said. “One of the things we struggled with was coordinating.”

<sup>29</sup> Health Resources Services Administration Data Warehouse (2015). Retrieved from <https://data.hrsa.gov/>

<sup>30</sup> Health Resources Services Administration Data Warehouse (2015). Retrieved from <https://data.hrsa.gov/>

<sup>31</sup> Methodist Le Bonheur Healthcare Community Health Needs Assessment (2016). Retrieved from: [http://www.methodisthealth.org/files/CHNA\\_Report\\_2016.pdf](http://www.methodisthealth.org/files/CHNA_Report_2016.pdf)

<sup>32</sup> Data provided by Methodist during the case study from its Community Health Needs Assessment, using CDC data.

At the time of the case study, the council had representation from external community groups including the University of Tennessee, the University of Memphis, West Cancer Center, Methodist Healthcare Foundation, as well as Methodist health system leaders. Interviewees emphasized the important role the council played in expanding partnerships in a way that avoided overburdening community stakeholders with overlapping requests. Through their coordination, the council leveraged finite resources in the community in an efficient manner.

## Overview of initiative

**Congregational Health Network.** According to interviewees, nearly all of Methodist’s health disparities work occurred through the Congregational Health Network (CHN) initiative. Launched in 2006, CHN was described by organizational leaders as an “asset-based, faith-centered, social support intervention that improves outcomes and organizes community resources around health care.” CHN was built on the key societal and cultural thread in the region: religion. According to Methodist interviewees, 70 percent of the system’s patients reported having visited a house of worship in the previous month. As such, Methodist, in partnership with a core group of 12 churches, created the program as a means to develop trust and relationships with community members. “We are hoping to create a mindset that the churches are a part of the health system,” an interviewee said. With these connections in the community, Methodist aimed to improve population health and reduce the amount of charity care provided.

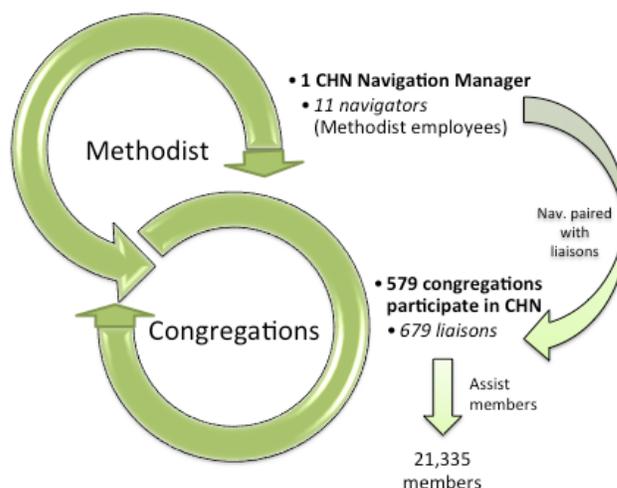
*Structure and funding:* Since the beginning of the program, CHN fostered relationships between pastors in the community and chaplains and leaders in the Methodist system, increasing the number of CHN partner congregations from the initial core group of 12 to nearly 600. Leaders in the faith community agreed to participate in CHN by signing a “covenant.” The covenant was a commitment to participate in CHN – it required the churches to identify no more than three volunteer “liaisons” to serve as community linkages to Methodist’s “navigators.” The navigators were Methodist employees who work exclusively with CHN in the hospital to cultivate trust between the health system and the congregations. Chaplains employed at each of the Methodist hospitals also played a role in the program by working closely with the pastors from the partner congregations and the navigators.<sup>33</sup> Figure 22 below provides a graphical overview of the relationships among the key stakeholders in the CHN structure; more specific information about each stakeholders’ role is also discussed below.

The health system funded CHN through its operating margins as well as through various grants received during the program’s tenure. Methodist also relied on the human resources in each of its partner congregations. “We want to leverage congregational strengths,” an interviewee said. “Congregations have always been a connecting place.”

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<sup>33</sup> The chaplains are part of the leadership team at each site and report directly to hospital administrators, rather than CHN, as their duties cover more than working with CHN.

**Figure 22. CHN structure**



*Partner congregations/churches and their pastors* worked directly with Methodist, primarily as “health care extenders” within their communities. Pastors (and liaisons, discussed more below) participated in free Methodist-sponsored education and training programs to prepare them for their CHN duties. These programs were also available to congregation members. At the time of the case study, some of these topics included: navigating the broader health system, nutrition, cancer care, HIV and STDs, Alzheimer’s disease, diabetes education, and vision health.

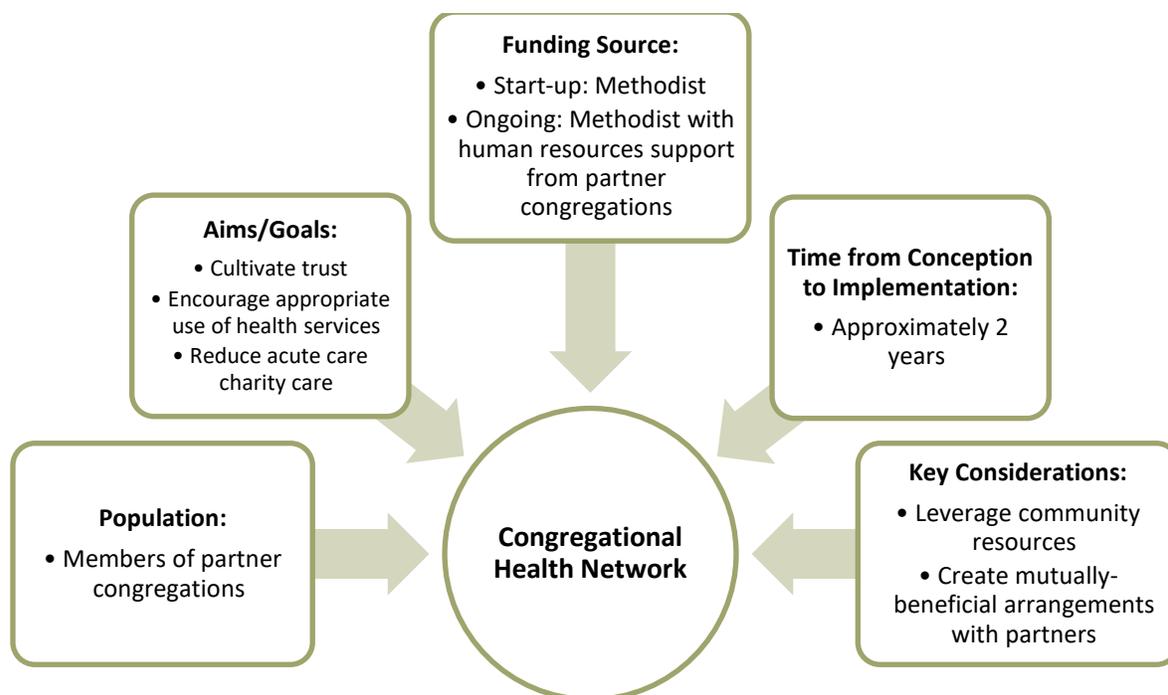
*Community liaisons* were volunteers in each of the CHN partner churches who helped the pastor enroll congregants into CHN and worked with Methodist navigators to connect with CHN members during hospital stays. These volunteers identified and obtained the necessary supports for CHN members following discharge to ease members’ transition back to their homes. Supportive activities included finding volunteers to give patients a ride home from the hospital, picking up prescriptions, preparing meals, and ensuring that equipment was delivered. Most liaisons served three-year tenures in the program which required a couple of hours of work per week.

*Navigators* were all full-time hospital employees with strong connections in the church community and a fundamental knowledge of disease processes and clinical language. At the time of the case study, Methodist had recently hired one of these 11 navigators for cancer-specific navigation and two others to improve linkages with the Latino community. In addition to collaborating closely with the community liaisons in partnership with the chaplains, the navigators worked in Methodist hospitals to identify patient needs, ensure that they were addressed, and improve patient support following discharge. This program helped to create trust between the health system and area congregations. Navigators also worked with pastors and liaisons to provide support to members of the congregation who had not entered the Methodist system.

## Congregational Health Network

Below, we provide a description of the planning, assessment, implementation, and evaluation processes associated with CHN, cataloging the program’s growth from a concept in 2006 to the centerpiece of disparities work in the region a decade later. Figure 23 provides a summary of the program, including its priority population, aims/goals, funding sources, etc.

**Figure 23. At a glance: Congregational Health Network**



*Note: As of 2016, 70 percent of Methodist’s population belonged to a congregation.<sup>34</sup>*

### **Business case development (planning and assessment)**

*“It is hard to quantify the benefit of mission ... Many times, you can’t make the ROI [return on investment] or business case. You need to view it as a significant strategic decision that will pay off down the road that has negative immediate financial consequences.” – Methodist leader*

CHN emerged in response to a community request on the part of Mid-South Memphis congregations. Prior to 2006, a group of 10 local congregations had assembled a community education group that worked with hospital chaplains in some of Memphis’ poorest neighborhoods called the Church Hospital Network. When the CEO of Methodist South (one of Methodist’s hospitals, which bordered a particularly poor area in Memphis) stepped down, the church elders expressed concern to Methodist system leadership that their educational efforts through the Church Hospital Network would be lost.

<sup>34</sup> [http://www.methodisthealth.org/files/CHNA\\_Report\\_2016.pdf](http://www.methodisthealth.org/files/CHNA_Report_2016.pdf)

Methodist leadership saw this period of change as an opportunity to formalize partnerships with area congregations. Moreover, the collaboration would create a connection with the community and build a program that could affect patient outcomes across the health system, not just in the southern part of the city. Encouraged by the hiring of a nationally renowned leader in leveraging community partnerships to influence health outcomes, and with the help of the original pastors from the Church Hospital Network, Methodist executives and the pastors reached out to congregations surrounding Methodist South to develop a path forward. As a result, Methodist health system leaders met with 50-60 pastors and committed to collaborating with the community to build on the Church Hospital Network model.

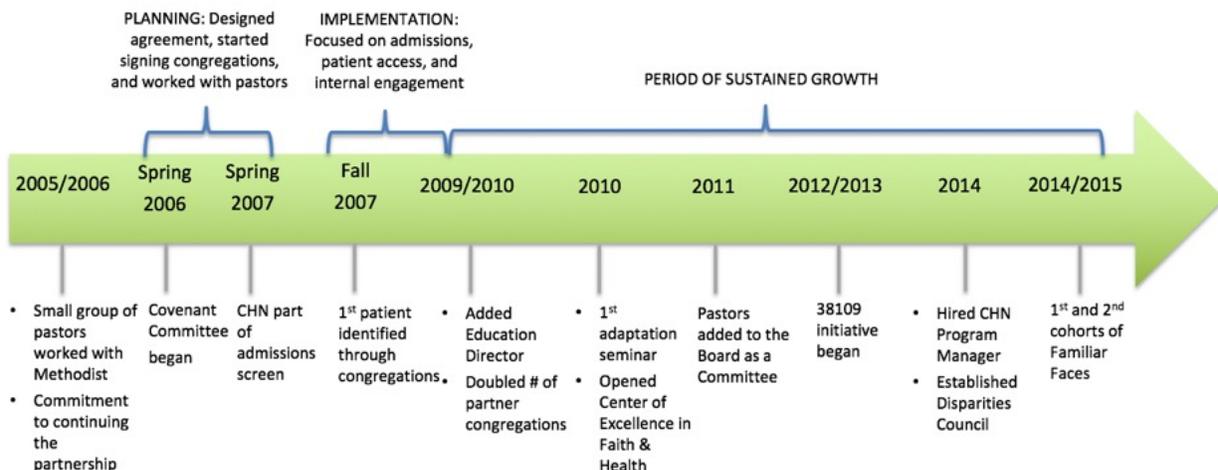
Based on Methodist's experience launching CHN, individuals involved in the roll-out of the program emphasized the importance of establishing internal as well as external buy-in at the outset of program planning.

- **Collaborate with community partners.** CHN relied on external buy-in from the earliest planning phases. Ultimately, trust has been the catchword of the program: "The trust begins with pastors trusting pastors," an interviewee said.
- **Expect to encounter barriers with internal buy-in.** Awareness and support for CHN within and across the health system did not emerge naturally during the CHN planning and assessment phases. Interviewees suggested this was due in part to Methodist being composed of eight individual hospitals, each with its own administration, registration, admissions, discharge planning, and pastoral care staff.

### ***Implementation and evaluation***

Methodists' meeting with representatives from over 50 congregations in spring 2006 commenced a decade of development, as CHN grew from a small program to the centerpiece of disparities work within the Methodist system. Figure 24 presents a graphical overview of CHN's milestones at the time of the case study.

**Figure 24. Timeline of major milestones: Congregational Health Network**



Methodist’s initial meeting in 2006 with the concerned pastors from the Church Hospital Network laid the groundwork for the establishment of a Covenant Committee and marked the first formal gathering for what became the CHN program. At the time of the case study, the Covenant Committee was composed of 12 pastors – all of whom had a prior relationship with pastors and chaplains within the Methodist system. The planning process took approximately 18 months and included identifying roles of the pastors, liaisons, and navigators within the confines of CHN, as well as developing the covenant that each pastor would sign when enrollment began in 2007. During the planning phase, the 12 pastors and key Methodist leaders also agreed on topic areas that the program’s training and education would address. The final list of topic areas focused on priority populations and conditions, which included: (1) frail elderly and advanced illness (pastoral care related to end-of-life issues); (2) mental health; (3) infants and mothers;<sup>35</sup> and (4) chronic disease (though CHN did not tackle this issue immediately, as program leaders realized its scope required a more advanced infrastructure and more resources than were initially available).

The program also included four levels of congregational participation (shown in Figure 25), based on the extent to which a congregation’s pastor, liaisons, and community were involved in various aspects of the CHN.

<sup>35</sup> CHN ultimately focused its efforts on adult health and wellness, given the community-based work of Le Bonheur Children’s Hospital in the areas of infant and maternal health.

**Figure 25. Congregational engagement levels within CHN**



At the start, CHN relied on personal relationships to encourage participation at varying programmatic levels, but as the program has progressed, recruitment has required little effort: “In the beginning, we were like salesmen trying to sell this to all of our friends,” a CHN leader said. “Once we had a functioning program that worked, we have not had to recruit congregations...word of mouth has been the biggest proponent of CHN.”

Methodist hired its first CHN navigator in spring 2007, which overlapped with efforts to integrate CHN into the hospital admissions process. Although CHN leaders built a CHN-related question (i.e., “are you a participant in CHN?”) into the intake form on Methodist’s electronic medical record (EMR) system, integrating the question into each of the Methodist hospitals’ admissions processes was challenging. Once CHN leaders realized hospital admissions staff had not fully adopted the question, CHN started trying to build internal support for the initiative using brochures, tabletop displays, trainings, etc. At the same time, CHN navigators began going from room-to-room in each hospital, asking each patient whether s/he was a member of a CHN-affiliated congregation. Although employee education on the early identification of CHN members was accelerated during the first several years of implementation, education about the importance of the CHN “checkbox” in the facility’s EMR system was an ongoing challenge. The “checkbox” system, combined with the work of navigators and chaplains to identify admitted CHN members, resulted in a spike in the number of patients connected to CHN, which meant that more patients were getting needed services.

With this growth, CHN needed to build its personnel infrastructure. Between 2009 and 2010, CHN made several significant hires. For example, Methodist hired a director of CHN education, who had previously served as the president of a bible college, a pastor in the community, and was an original member of the Covenant Committee. Based on his network, he doubled the

number of covenant congregations and CHN membership in a short time. A director of spiritual care joined the CHN executive staff in 2010. This person clarified the roles and responsibilities of the navigators and to ensure the navigators' primary reporting responsibility was to CHN rather than to the individual hospitals. CHN continued to expand between 2011 and 2014. In 2014, a program manager was hired, which further formalized the program's chain of command.

CHN also continued to expand and cement its role within Methodist and in the greater Memphis region. In 2011, CHN became part of the Methodist system's governance structure, and the health system opened its Center for Excellence in Faith & Health. The new center offered a dedicated space for continuing education and spiritual care in health, which is the primary space CHN used for its educational programs and meetings. Funding for the center came from community donations raised in partnership with the Methodist Healthcare Foundation.

#### *Stakeholder engagement*

The success of CHN has depended on internal and external stakeholder engagement.

- **Internal engagement.** Maintaining a high level of internal engagement across all departments in multiple hospitals was a challenge for CHN leaders. Leadership expressed regret about not recognizing the importance of obtaining internal buy-in across the system during the launch of CHN initiatives. Also, CHN leaders noted that the program needed to continuously "sell" itself at different levels within the hospitals, despite having the support of Methodist's top executive. Interviewees explained that CHN shows its "value" by demonstrating cost savings and through anecdotal CHN patient success stories.
- **External engagement.** The foundation of the CHN program rests on external community engagement and trust. Because the program began in response to pastors' requests, CHN has not had to put significant effort into creating external buy-in. All of its collaboration has stemmed from the partnership with a "special society of pastors," as interviewees described it.

#### *External recognition*

Due to its effective and innovative approach to addressing disparities, entities within and outside the Memphis community showed interest in replicating CHN. Program leaders worked to engage these organizations through CHN "adaptation seminars," which began in 2010 and were formalized in 2012. In April 2013, the CHN received national recognition at the CEO Summit of the Health System Learning Group, where leaders presented on the program. CHN also delivered a webinar as part of the American Hospital Association's strategic performance improvement platform, "Hospitals in Pursuit of Excellence."

### *Financial considerations*

As with any work of this kind, sustainability is built on the presence of sufficient financial resources and strong community support. Leaders at Methodist explained that the health system's board of directors sought to maintain a two percent margin each year, and any additional margin beyond that could be committed to the organization's priority work, which included CHN. In 2015, Methodist had a 5.5 percent margin; the system allocated some of this margin to CHN work.

### *Sustainability*

Due to the program's visibility and success within the community, interviewees believed the future was bright for CHN. Admitting that long-term funding was "always an ongoing concern," payers in the area had begun reaching out to program leaders to discuss reimbursement for navigator services, which could help with long-term sustainability. At the time of the case study, CHN hoped its future included have six community navigators working under the Methodist system and funded by payers.

CHN also planned to work with at-risk populations and anticipated partnering with Methodist's home health agency and Federally Qualified Health Centers (FQHCs) to expand the program beyond the hospital acute care setting. In both cases, CHN hoped to add a question about the program to the intake form used during admission to home health or for FQHC patient visits – similar to what was previously added for the inpatient setting. In 2015, the program trained three navigators to work with patients coming to Methodist from the local Christ Community FQHC to ensure patients had appropriate linkages back to the FQHC for primary care upon discharge. "The larger idea is to put people in the preventive mindset," a CHN leader said. "Long-term, if you manage [patients effectively in the community], there is a significant reduction in cost...you're not getting as many medical bills from the hospital. You're just increasing comprehension and awareness. There is no immediate return on investment or gratification, but that's the long-term big vision – the shift we're trying to make."

### *Evaluation and measurement*

**Data collection.** From CHN's beginning, data collection was a central part of the program, supporting more sophisticated data analysis as the program has progressed. Efforts focused on enrolling patients in CHN and making sure these patients had a profile in the Methodist EMR system. The profile was used to flag patients for navigation services during intake. Additionally, Methodist navigators and chaplains asked all admitted patients whether they were CHN members in order to capture individuals who were not flagged during the registration process.

**Data analysis and use.** EMR system data on program members was invaluable for creating targeted programs and demonstrating the program's financial and health-related value to the larger Methodist system. For example, analysis by Methodist's quality department showed a reduction in ED use and readmissions for the CHN population relative to all Methodist patients. Additionally, the ED data led to the establishment of the 38109 work (discussed later in the

report). At the time of the case study, CHN had partnered with researchers at the University of Tennessee to conduct a more rigorous evaluation on the impact of the navigator program.

#### *Challenges and barriers*

Despite CHN's successes over the last decade, the program experienced significant barriers to implementation and continued sustainability. As discussed earlier in the report, CHN leaders emphasized that they continued to have to "sell" the program as a cost-saving and effective initiative to a few skeptics on the Methodist leadership team. Additionally, near the beginning of program implementation, CHN had to convince Methodist's marketing department to avoid branding the initiative with Methodist's logo, which CHN leaders saw as being at odds with the community partnership mentality of the program.

At the time of the case study, data integration continued to be a challenge for the program. CHN staff were not yet able to integrate information about CHN members from the Methodist inpatient EMR system with navigator notes and other supporting documentation. As a result, navigator, social worker, and provider notes were stored in a separate database. This separate database included important information about patient support systems and needs but was not visible to most Methodist staff. Near the time of the case study, navigators had begun attending inpatient case conferences for CHN patients to facilitate information exchange and to better coordinate with Methodist discharge planning and clinical staff.

Market and population factors continued to be a hurdle for CHN and Methodist. Social determinants of health – poverty, lack of public transportation, poor access to fair housing – can limit access to health services and improvements in health outcomes, and are persistent barriers. Also, interviewees reported that access to primary care was a large issue in the region, with patients facing two- to three-hour waits at physician offices and large copays. In such an environment, the ED can seem more appealing to some patients – and education on the part of CHN may be unable to shift that perspective.

#### *Lessons learned*

Methodist shared a few key lessons learned from its time working on CHN, all of which center around the theme of engagement:

- **Coordinate efforts and resources centrally.** Assembling a Health Disparities Council was a major improvement to the way Methodist oversaw disparities work. The council facilitated the efficient allocation and prioritization of resources. Interviewees said the council also improved the organization's success rate on grant proposals.
- **Internal engagement is critical.** Although executive management supported the initiative from the beginning, one leader believed that earlier buy-in from across the organization may have improved the CHN admissions process; specifically, having engaged admissions staff consistently identify CHN members upon registration.

Additionally, leadership mentioned that the Covenant Committee would have benefited from the inclusion of members from other disciplines. Earlier and more regular input from the health system's chief medical officer and other operations staff (e.g., admissions and case management) would have also been valuable. Such changes, interviewees hypothesized, would have improved buy-in across the system and facilitated smoother programmatic implementation.

### *Program within a program: 38109*

As CHN continued to grow within the Methodist system, in 2010, a global health insurer with a large presence in Tennessee approached the health system to look into particularly high emergency department (ED) use. The insurer's inquiry prompted the system to review its internal data, which showed some troubling patterns: Residents of the ZIP code 38109 accounted for a large proportion of the health system's charity care – \$40 million worth – and had unusually high ED utilization. As a result, in 2011 and 2012, Methodist launched an initiative to better understand the data and collaborated with CHN to develop a targeted campaign in 38109 to address ED overutilization.

38109 is the largest ZIP in Memphis in terms of landmass and covered 67 square miles with a mix of inner city, industrial, and extremely rural areas. At the time of the case study, it was home to 59,000 residents, who, Methodist learned, represented the sickest population in the health system. Residents in the 38109 ZIP code were predominately African American (96 percent) and were some of the poorest in the county (25 percent of residents had annual incomes less than \$15,000). CHN program leaders used a process of "asset mapping" and learned that the ZIP code was a "desert for everything" – health care providers, food, public transportation, etc. Additionally, the largest problem befalling the region was unsafe and blighted housing.

Methodist's review of health care utilization in 38109 showed that the top 10 users in the ZIP code accounted for \$11 million in charity care the previous year. These patients shared many common characteristics: Most were in their 30s, African American, and had two or more high-risk comorbid conditions.

According to interviewees, CHN leaders believed that the key to addressing these challenges was to partner with churches in the community. By the time Methodist identified the overutilization issues, there were already 90 congregations in the ZIP code that had signed on to CHN. Senior management at Methodist met with some of the leading pastors to discuss these issues and ask them how CHN could help. The pastors, in turn, requested that Methodist establish a clinic in one of the ZIP code's more populated corners and provide assistance with wellness events. Although Methodist did not have the financial resources to build a clinic at the time, the discussion ultimately launched CHN's 38109 initiatives, which at the time of the case study, included two programs: Familiar Faces and Wellness without Walls.

*Familiar Faces* originated from Methodist's efforts to address community needs and reduce charity care write-offs for manageable and avoidable conditions. Encouraged by a group of

pastors in the area who requested the presence of a long-term and sustainable program, CHN created Familiar Faces, a program that identified the highest users of health services in Memphis to receive individualized, one-on-one work with CHN navigators. Interviewees described the work as similar to traditional social work and case management. Such work often involves traveling to the patient's home to determine the cause of particular issues that crop up in multiple, and sometimes avoidable, ED visits. For example, interviewees described a patient who continued to come to the hospital with shingles. When a navigator visited the individual's home, a flea infestation was discovered, which, when removed, eliminated the individual's need to visit the ED. Interviewees also provided other examples, such as working with a payer to obtain a shower chair for patients to prevent falls while bathing and educating family members of a patient with chronic obstructive pulmonary disease about the harm associated with smoking around that individual.

In 2013, CHN created its first cohort of 100 Familiar Faces patients. Individuals in this cohort had more than 12 ED visits per year, many of them were in their 30s and had a primary diagnosis of chronic lung disease, heart failure, diabetes, or chronic kidney disease. Program staff reviewed cost data on this cohort and found that the system's total inpatient cost per patient decreased significantly. Specifically, Methodist saw a 45 percent change in spending in the first year and 60 percent in the second, when compared to the cohort's baseline costs. Following this success, CHN created a second cohort of 82 individuals, who entered the program in 2015 and represented an even younger group than the first. At the time of the case study, the second cohort showed cost savings relative to its baseline spending.

CHN's *Wellness without Walls* initiative in 38109 began with funding from a health insurer. Wellness without Walls included semi-monthly wellness fairs in local churches and schools. During these events, residents were provided basic screenings (e.g., blood pressure, total cholesterol, blood glucose, and body mass index) in addition to community-requested health-related educational programs. CHN community navigators attended these fairs to ensure that residents were connected to various health services where needed. As a community navigator explained, the program relied on the personal connection made between the navigators and the members of the community – the navigators helped members of the community navigate around barriers, so “there are no excuses about being there and showing up” for the health services they needed.

## Recommendations

There are a number of lessons learned and recommendations that can be made for the benefit other organizations interested in addressing health disparities:

- **Work side-by-side with visible community leaders.** From their years of work with CHN, Methodist leaders reported that for a similar community-focused partnership to be successful, it is essential to engage “visible” community leaders. Organizations must find trusted leaders in the community and collaborate with them to leverage the trust they have earned and cultivated over time. Together with these community leaders,

organizations can determine how to better meet community needs. Weighing community-identified needs against joint financial and resource realities will help the organization set and manage expectations. Organizations should not overpromise and should set realistic expectations about what they can deliver: Once a commitment is made, it is essential that the organization meets the obligation(s) to maintain trust. One of Methodist's leaders described that the success of CHN rests on the relationships, which are the "secret sauce."

- **Be patient.** Methodist leadership also noted that building a community-based program does not happen quickly. Interviewees emphasized that building a sustainable program requires a significant investment of time to foster relationships. Leaders also commented that it may be beneficial for organizations to commit to starting small and building out the program as it demonstrates "success." Methodist demonstrated this commitment to proof of concept when it started the CHN with a smaller core of congregations and expanded once it had established key processes.
- **Identify community hubs.** Although CHN was clearly built on the local context in Memphis, one that heavily relies on the region's deep religious roots, Methodist leaders suggested that this model could be adapted to other geographies by identifying the activity that engages a given community. For example, in the Latino community in Memphis, Methodist was focusing on organizing around apartment complexes, senior living facilities, and soccer leagues. However, Methodist cautioned that the trust instilled in the religious and faith leaders of Memphis communities may be hard to recreate.