Advancing Health Equity

A Practical Approach to Starting Your Health Equity Journey

Dr. Debbie Zimerman
Corporate Chief Medical Officer

Eric Alexander
Director, Clinical Programs

Health Equity Defined

The scope and magnitude of health disparities exploded into mainstream American consciousness in 2020. Early on and throughout the COVID-19 pandemic, we documented reduced or delayed access to COVID-19 vaccines, increased vaccine hesitancy, and worse clinical outcomes among racial and ethnic minorities compared to white Americans. This prompted a national discussion about the extent of long-standing health disparities in chronic diseases, mortality, pregnancy outcomes, and access to care and the racial and societal inequities that created them.

The increased attention has stimulated an ongoing wave of research and thought leadership around health equity and supercharged the development of health equity efforts among health plans, care delivery systems, and government agencies. Moreover, these changes are forcing the industry to reconsider what is within our collective purview and responsibility. The extent to which socio-demographic characteristics and SDoH factors are associated with clinical outcomes is evident. The inadequacy of our social safety nets to protect the most socially and economically vulnerable helps explain why the US health care system continues to demonstrate the worst health care outcomes in the industrialized world, despite being the most expensive. If we are going to reform our failing system, we must care for those that are falling through the cracks by bridging the social and economic gap. Access to high-value, life-saving care cannot continue to depend on who you are, where you live, or how much money you make.

Key Definitions

- ***Health Equity:*** According to the Centers of Disease Control and Prevention (CDC), "Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health".
- ***Social Determinants of Health (SDoH):*** These are the non-medical factors that influence health outcomes. They include conditions in which people are born, grow, live, work, and age, such as education level, stable housing, access to reliable transportation, food security, and a sense of community.
- ***Socio-demographic Factors:*** These refer to characteristics of a population which can influence an individual's health outcomes and access to care such as race, ethnicity, gender, sexual orientation, and age.

According to the Centers of Disease Control and Prevention (CDC), "Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health". Barriers to health equity are deeply rooted in social, economic, and historical realities. At the center of the discussion about health equity are social determinants of health (SDoH)—the term given to the non-biological, non-medical factors that affect one's health status. The CDC organizes SDoH into 5 domains: 1) economic stability, 2) educational access and quality, 3) health care access and quality, 4) neighborhood and built environment, and 5) social and community context.

While SDoH factors garner a lot of attention and are important measurement tools, they notably are not inclusive of the modifiable factors that contribute to health inequities. Other drivers include socio-demographic factors (e.g., race, ethnicity, gender, age, sexual orientation), which tend to be

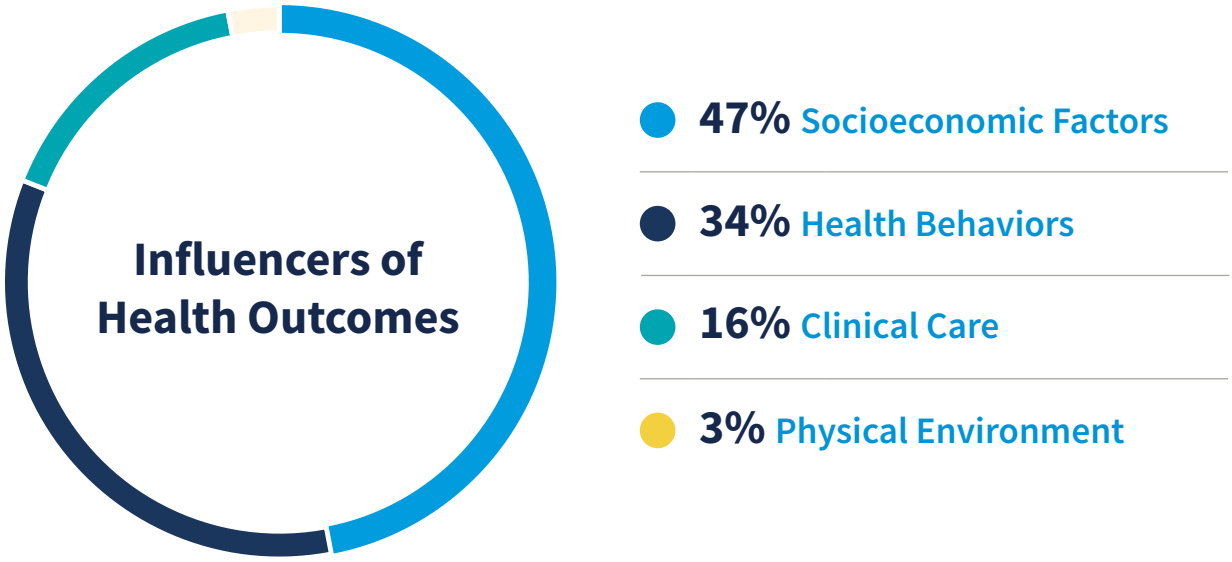
more readily available within most organizations. Still other drivers relate directly to the care delivery system and have little or nothing to do with the patient. Factors such as discriminatory policies, explicit and implicit racial bias, lack of trust, and underrepresentation in medical research cannot necessarily easily be measured, monitored, or mitigated, but are significant contributors to inequity. If we allow our vision to tunnel around SDoH exclusively, we will limit our opportunity and potential impact.

Since the early days of the pandemic, America continues to demonstrate its commitment to addressing health inequities, even if the "how" isn't yet clear. As with most changes in health care, we can expect it to be slow. Most systems currently don't have the ability to even look at health equity in any meaningful way, let alone with the level of granularity that allows for solution design. In this whitepaper, we discuss the relationship between health equity and population health and outline the evolution, challenges, and success of Essence Healthcare's Health Equity Task Force in harnessing data-driven insights to identify and close inequities within our own population. We will discuss the composition and goals of the Task Force as well as detail some of our efforts up to the time of this writing.

Leveraging Data to Improve Outcomes

At its most fundamental level, health inequity is less a health care problem and more the health care manifestation of broader societal inequities. Housing discrimination, wealth exclusion, disinvestment in education, and other forms of discrimination result directly in many of the disparities that impact health, such as poverty, low literacy levels, lack of employment, food and utility insecurity, crime, and housing insecurity. With the realignment of financial incentives to promote population health, we have a financial as well as a moral responsibility to mitigate those impacts.

Discussions around data have traditionally revolved around clinical information—test results, diagnoses, and treatment plans. However, a revolutionary shift is underway as we acknowledge the intrinsic role that socio-demographics and SDoH factors play in shaping health outcomes. According to a report by the Office of Health Policy, clinical care accounts for only a small minority of county-level variation in health outcomes. Socioeconomic factors, however, may account for 47% of health outcomes, which is more than health behaviors (34%), clinical care (16%), and the physical environment (3%).1



[1]*"Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts." by Amelia Whitman, De Lew N., Chappel A. et al. ASPE Office of Health Policy. April 2022.*

Gleaning insights from the published literature is a good way to stimulate thought, but it's not enough to address inequities in your own population. It is essential to be able to cohort the population you serve by, at minimum, race, ethnicity, gender, socioeconomic status, and geography. Other useful data include gender identity, sexual orientation, education level, and housing/resource insecurity. As we are still early in our collective health equity journey, many payers and health systems do not routinely collect and utilize this information and, if they do, they are limited by incomplete data. Having a more complete data set is essential for identifying health disparities and tailoring effective interventions. However, members of underserved and marginalized communities are more likely than other groups to distrust the health care system and may be hesitant to provide additional personal information. Earning trust is a gradual process that takes time and must be granted by the community through actions taken. Once established, trust can lead to a more open exchange of information.

Data enables development of innovative solutions that target and eliminate barriers to care. From utilizing geospatial maps to allocate resources in underserved areas to utilizing data to inform predictive models that identify populations at high risk for health care disparities, data is revolutionizing how we tackle the inequities in health care.

A Case Study in Health Equity—Essence Healthcare

In August of 2020, Essence Healthcare convened its Health Equity Task Force under the leadership of Corporate Chief Medical Officer, Dr. Debbie Zimmerman. This group is composed of executive leadership, internal clinicians, operational staff, and analytics resources from within Essence Healthcare plus Essence members from the community and physician leadership from partner practices. Our goal was simple: advance health equity in our population using data-driven insights to drive holistic transformation.

According to Dr. Zimmerman, advancing health equity requires a shift in organizational perspectives. "Everything is our job," she explains. "Committing to advancing health equity requires an evolution of the corporate mindset of any delivery system or a payer. If there are inequities within in our population, not only is addressing them the right thing to do, but there is a business case for it."

The first hurdle, and no doubt one that many organizations currently face, is: where do we start? It is critical to avoid analysis paralysis and start collecting and analyzing data. An uncomfortable aspect of health equity work is that we're so early in the journey that the roadmap and best practices are not defined. Advancing health equity, in real terms, requires us to roll up our sleeves and embrace the trial-and-error nature of the journey. We would contend that another key element is a top-down, executive-sponsored, enterprise-wide commitment. Essence's Health Equity Task Force is supported by the top-level leadership of Essence Healthcare and is formally built directly into the organization's hierarchy, reporting up through clinical quality to Dr. Zimmerman herself.

As a national leader in population health, high-value primary care management of chronic disease has always been our north star, so that is where we chose to begin. Underlying health was the strongest driver of disparities, but race was the strongest non-medical driver. Compared to white members, our African American members were more likely to not have seen a PCP in the last year. Black members as a group also had about 3% fewer total PCP visits. Other factors associated with fewer PCP visits include the presence of financial barriers, male gender, lack of affordable housing, and geography.

African American members also had higher rates of chronic diseases such as hypertension, diabetes, chronic kidney disease, and heart failure. Black members were also 51% more likely to have had an avoidable ED visit. This is the largest disparity that we identified, and it persisted even when controlling for underlying health and may correlate with medication non-adherence.

This led us to the second major hurdle: how can we maximize the use of our data? Our data were inadequate to drill down and stratify our populations across different socio-demographic and SDoH domains. Recognizing that our team, data, processes, and solutions would need time to mature, we had to find a way to bridge the data gap. First, we purchased publicly available SDoH data from Axiom. While these data are imperfect, they allow us to cohort our population by race, gender, socioeconomic status, and geography and identify trends based on those analyses.

Second, went straight to the source by convening member focus groups to attempt to identify factors leading to avoidable ED visits and medication non-adherence. This gave us the ability to identify some broad trends while we developed more sophisticated analytical capabilities.

The vignettes below detail some of our key initiatives.

COVID-19 Vaccine Hesitancy

Our first major opportunity was to address the disparity in COVID-19 outcomes and vaccine hesitancy among racial minorities in the local St. Louis market. We partnered with a local African American physician to publish a series of articles in the St. Louis American, a local weekly newspaper serving the African American population in St. Louis. This effort continues to evolve today, based on evidence that Black members are less likely to receive the flu vaccine.

Statin Gender Disparities

Women often receive less intense CVD preventive care compared to men, particularly with respect to statin prescribing. Women at risk for CVD are less likely to be offered a statin by their doctor, receive any statin treatment, and receive a statin at the recommended dose. In our own data, we identified lower statin prescribing among women and launched an educational campaign to address them. We engaged physician leadership by highlighting the variation between medical groups, launched an educational campaign targeting women in our population, and discussed barriers in medical director meetings. By the end of 2023, not only had the gap closed, but statin prescribing rates increased in both men and women compared to 2022, improving our star rating overall.

CAPABLE Program

In 2023, Essence Healthcare partnered with Johns Hopkins University to launch the Community Aging in Place—Advancing Better Living for Elders (CAPABLE) in the St. Louis market. CAPABLE is a client-directed program that brings nursing, therapy, and handyperson services to older adults to help them age in place safely and with dignity. Our preliminary data suggest a program ROI greater than 3:1 in the first 266 members. Those enrolled in CAPABLE had a 40% reduction in total costs of care from baseline and incurred costs more than $6,700 lower than controls in the first 12 months after enrollment in CAPABLE. This difference was driven largely by a 40% reduction in ED visits and a 26% reduction in hospitalization rate.

Essence Healthcare has been recognized by Johns Hopkins for our efforts related to the CAPABLE program. Essence was also one of three markets in the nation to participate in an extension study testing the integration of dedicated caregiver support resources in addition to other CAPABLE services.

LGBTQIA+ Training

Our member-facing staff voiced discomfort with their own understanding and vocabulary when speaking to members of the LGBTQIA+ community. Wishing to avoid inadvertently appearing disrespectful, they asked for resources to train them on appropriate responses. Our People and Culture team created a series of diversity and inclusion training sessions that covered race, religion, sexual preferences, gender identity, and other topics, supplemented by in-person support sessions. We documented 650 course completions and nearly 300 participants in the in-person sessions in the first 3 months.

Behavioral Health Initiative

Another effect of the COVID-19 pandemic was an intense focus on behavioral health. We stratified the Essence Healthcare population by race, gender, socioeconomic status, and marital status. The data suggested a trend toward lower outpatient behavioral health utilization and higher inpatient utilization among Black members, men, and members of lower socioeconomic strata. This variation between patient groups led us to dig deeper into our utilization trends; however, the numbers were too small to draw any meaningful conclusions.

Because under-diagnosis and under-treatment of behavioral health conditions is common in the US, particularly among minority groups, our first step was to increase awareness, screening, and management within our population as a whole. We conducted a survey of our medical groups to identify current practices and barriers to routine behavioral health screening and management. We have designed a two-pronged awareness campaign with messaging both for patients and for providers to bring attention to the prevalence and impact of depression, anxiety, substance abuse, and suicidality in the Medicare population. Finally, we will support providers with best practices for screening and treatment and recommendations for referrals to behavioral health resources.

Conclusions/Future Directions

Ultimately, the end goal of the health equity task force is to make its own existence unnecessary. One day, we can look forward to having the social structures in place to serve the underserved, eliminate disparities in health care, and ensure that everyone has unfettered access to quality care. Unfortunately, those days appear to be far down the road, given our current state. This reality will not come to pass on its own—we have to create it through our efforts today and in the days to come.

We've accomplished a lot in a short amount of time thanks to the innovative thinking of our team and the unwavering support of our leadership. I cannot overstate the importance of the experience gained from our successes and challenges. The reinforcing effect of applying the learnings from each effort to the next results in progressively more robust, impactful, and reproducible methods.

Going forward, our top priority is to continue to enhance the robustness of our data analytics approach. We have recently built and deployed a healthy equity dashboard, which allows us to look at our population and by age, race, gender, socioeconomic status, and other variables. We are evaluating the feasibility of building a functionality into our analytics platforms that allows us to subgroup our population by various socio-economic and SDoH variables. Making this a built-in functionality gives us more power and flexibility than making a of one-off analytics request to answer every question.

One other facet of health equity which we've left largely unexplored is the role of community partnerships. Essence Healthcare considers itself a responsible member of every community in which we operate, none more than the greater St. Louis region where we started. Our approach is to partner with other organizations only when it helps us achieve our goals, so community partnerships have not been at the forefront of our efforts as of yet. Our partnership with and outreach through the St. Louis American, a widely recognized and respected publication, is one example of partnering with another community organization to achieve our goals. We look forward to working with others to improve the health of the communities that we serve.

Continuing the Journey Towards Health Equity

Dive deeper into the crucial role of SDoH in patient-centered care and gain insights on aligning health equity with value-based programs in the AHA eBook, *"Aligning Health Equity and Value-Based Programs"* featuring discussions with Dr. Zimmerman and other experts.

5 Kaiser Permanente Survey. 2020.
6 "CareMore Health Announces New Outcomes Data from First-of-its-Kind Togetherness Program." BusinessWire. 2018.

MEET THE AUTHORS

Dr. Debbie Zimmerman

Corporate Chief Medical Officer

In her role as Corporate Chief Medical Officer for Lumeris, Dr. Debbie Zimmerman builds the clinical strategy for the organization to support the Lumeris operating model. She directs the physician leadership team in supporting health systems transform their organizations to deliver value-based care, including developing and implementing clinical programs and quality management functions. Dr. Zimmerman also leads Lumeris University, where she is responsible for all internal employee training and onboarding, physician mentoring and PCP boot camps, clinical content, and the Lumeris Innovation Conference. She is Chief Medical Officer for Essence Healthcare, a high-performing Medicare Advantage plan which has averaged 4.5 Stars forthelast 12 years. Dr. Zimmerman has a long and distinguished history of medical leadership at health plans such as Cigna, Group Health Plan, and Health Partners of the Midwest. Before joining Essence Healthcare, she served as the Chief Medical Officer of Mercy Health Plans, a provider -sponsored plan owned by Sisters of Mercy. She is also an accomplished entrepreneur, having co-founded a successful disease and complex case management firm. Dr. Zimmerman practiced internal medicine for 15 years and is licensed to practice in California and Missouri.

Eric Alexander

Director, Clinical Programs

Eric Alexander is currently Clinical Programs Director at Lumeris, a company at the center of the redesign of health care in the United States. Eric helps providers, payers, and health systems make the transition from fee-for-service to accountable care by empowering providers and using technology to enable a shift towards safe, effective, and fiscally-responsible health care. This is fulfilling work that allows him to contribute to transforming the fragmented health care delivery system into one that delivers improved outcomes at lower costs with greater levels of satisfaction.

Contact Information

info@lumeris.com

1.888.586.3747

Lumeris

ABOUT LUMERIS

Lumeris has pioneered value-based care transformation, bringing the technology driven capabilities to deliver a system of care every doctor wants for their family. As a trusted partner, we collaborate with top-tier health systems and physician practices nationwide, sharing risk and operational responsibilities to implement the most effective value-based models tailored to each population. Our innovative solutions, driven by our AI-infused technology stack, pave the way for success in value-based care, resulting in superior quality metrics, enhanced patient experience and physician satisfaction, and notable reductions in total cost of care across Medicare Advantage, Traditional Medicare, Medicaid, and Commercial populations.

With a track record of managing over $13 billion in medical spend across 12 markets, we remain dedicated to realizing the full potential of value-based care. Our Medicare Advantage prescription drug plan, Essence Healthcare, has consistently earned a 5-star rating from CMS for the past three years and consistently ranks in the top 1-2 percent of all MAPD plans for over a decade. These accolades underscore our unwavering commitment to excellence and our relentless pursuit of superior healthcare.

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