Trustee Insights

HEALTH EQUITY, DIVERSITY AND INCLUSION

Health Equity as an Imperative

How the board can promote sustainable improvements

BY KRISTA D. STEPNEY AND DUANE E. REYNOLDS

Like many hospitals nationwide, Lawrence General Hospital (LGH), a 200-bed independent facility located north of Boston, found itself facing significant financial hardship in the wake of the pandemic. Health care disparities in its predominantly Medicaid patient population had resulted in high morbidity and mortality rates. Leaders wanted to close the gaps to improve patient outcomes, but they also had to think about financial sustainability.

The hospital's board of trustees knew it needed to make some tough decisions that would ultimately affect LGH's future identity within the community it served. In particular, the board needed to answer this critical question: How would the organization sustainably provide care while improving health equity for its community?

As a mission-driven hospital, the answer was clear. LGH would focus on its existing role of providing high-quality care to some of the state's most vulnerable patients by making health equity a strategic priority. The timing of this decision couldn't have been better, considering the pressing community need and the recent emergence of new health equity regulations and financial models.

Even hospitals and health systems that aren't anchor institutions have much at stake. Failure to meaningfully improve health equity might not only affect patient outcomes but also risk noncompliance with numerous federal, state and payer requirements. As a result, organizations could experience financial penalties, loss of accreditation, damage to the organization's reputation and a loss of stakeholder trust.

What ensued at LGH was a multi-year improvement plan based on a comprehensive strategy assessment and a corresponding series of health equity and belonging board retreats. The sessions included board assessments, education and involvement in strategic decisions that would significantly impact their community. Today, LGH is a model organization for health equity and diversity, equity and inclusion (DEI) and is currently pursuing health equity certification with The Joint Commission.

"For me, health equity has become part of quality care," says

Christina Wolf, executive director of Population Health and Care Continuum at LGH. She works closely with the hospital's 14-member board, which includes a community college president, a public school principal and a nonprofit CEO. "It has become a necessary piece for the board. Once you normalize conversations, you can start to improve health equity and incorporate it into everything you do as an organization."

When boards understand how health equity regulations affect present-day operations —and how they may shape the future of their organizations — they can advocate for a paradigm shift that prioritizes justice and inclusivity in care, quality and experience. More specifically, boards can substantively shift the organizational culture and align organizational values with societal expectations for equity and justice.

Board involvement in health equity isn't optional. It's foundational to promote transformation and ensure operational, financial and clinical sustainability.

In this article, we discuss what boards need to know about new and emerging health equity regulations and describe what they can do to guide and support their organizations toward success.

1. Understand health equity regulations and accreditation standards

When it comes to health equity regulations, there's a lot going on at state levels, and boards must understand unique implications for their organizations.

For example, New York's Certificate of Need (CON) Law was recently amended to require hospitals, nursing homes and certain other providers to include a health equity impact assessment in CON applications, including for changes of ownership. Similar requirements may be coming to other states.

Collectively, states have adopted more than 300 regulations since 2020, according to a recent report by the Chartis Center for Health Equity and Belonging. These regulations are designed to ensure equitable access, experience and quality. For instance, at least 35 states and the District of Columbia have enacted over 100 bills since 2020 to support birthing individuals. Twenty-five states have integrated data collection and financial incentives in their Medicaid programs. States are also implementing behavioral health statutes related to increased investment, coverage and integration of services.

In addition, new and emerging accreditation standards from The Joint Commission and the Centers for Medicare & Medicaid Services (CMS) incorporate health equity through expanded data collection requirements for race and ethnicity, language and social needs of patients. These requirements are likely just the tip of the iceberg in terms of what accrediting bodies, payers and other entities may require of hospitals in the future. They also serve as the foundation for health care disparities mitigation.

2. Leverage health equity payment models

Health equity plays an important role in the National Committee for Quality Assurance (NCQA) and Healthcare Effectiveness Data and Information Set quality measures, which impact financial reimbursement. It also plays an increasingly important role in value-based health care payment models such as the ACO REACH model and others. Similarly, the Medicaid 1115 Demonstration Waiver Program allows states to waive certain provisions of the Medicaid law and receive additional flexibility

Assess board readiness to promote health equity

As boards seek to move the needle on health equity, there's no better place to start than through their own actions and processes. Here are five top-line questions to consider when assessing board readiness to lead the charge on health equity:

1. Does the board itself participate in educational sessions on systemic racism in health care, unconscious bias and micro-aggressions?
2. Does the board model a tone of respect and collaboration in its interactions with members, clinicians, executive staff, patients and other key stakeholders?
3. Is the board actively engaged in identifying diverse candidates who reflect the communities served?
4. Do individual board members accept personal responsibility for advocating for health equity?
5. Do board members participate in local community events or regional town halls to learn about diverse patient perspectives?

to design and improve their health equity programs.

LGH's participation in the program helped the organization accelerate its health equity efforts. "The state, through CMS, is incentivizing hospitals to do a tremendous amount of work around health equity, including demographic data collection and sharing, identifying social needs and connecting people to resources," says Wolf. "We've been doing this for many years, but now we're doing it in a way that's more standardized across our state and with people who have that responsibility as their job."

In addition, CMS' new health equity index (HEI) — a consolidated score serving as a barometer of the quality of care delivered to Medicare Advantage and Part D enrollees with specific race, ethnicity, dual-eligibility and low-income status characteristics — may rely partially on hospital-reported data. Health plans may incentivize hospitals to provide this data. The HEI is scheduled for release in the 2027 star ratings.

3. Identify how to support operational leaders in driving change

Once boards understand the potential impact of regulations, they can work with the hospital or health system's senior leaders to identify the operational changes and support needed. Some of the most important areas include:

- **Empowered health equity leaders and teams.** Organizations should establish teams dedicated to proactively addressing health equity performance, including designated health equity experts who champion and execute equity initiatives across the organization. Board members can serve as advocates to ensure these teams and leaders have the resource investments required to advance strategic and cultural change.
- **Robust data collection and analytical capabilities.** Regulatory compliance and data go hand in hand. Organizations should systemically collect and use patient-reported demographic data across all locations, stratify metrics and measures to evaluate performance and develop a dashboard to summarize data on disparities in quality and access.
- **Organizational leaders must regularly review the data and address issues and opportunities.** For example, digital and analytics investments can reach at-risk patient segments (e.g., racial minorities, women, members of the LGBTQIA+ community, rural populations and groups with lower socioeconomic status) and address social needs referrals. Similarly, they should review patient and staff experience satisfaction scores by different demographic groups to identify and monitor management performance improvement opportunities.

The board should also regularly review the Community Health Needs Assessment and schedule regular updates on key services or programs designed to meet the needs of certain demographic groups. It should also review quality metrics and health outcomes data (e.g., data related to maternal morbidity, diabetes or rehospitalization) stratified by demographic groups (race, ethnicity, age and language [REAL] as well as sexual orientation and gender identity [SOGI]) to address potential health inequities.

Up-to-date training and education. Organizations must maintain a comprehensive learning and development curriculum throughout the employee life cycle. The goal of this training is to address unconscious bias that can affect clinical decision-making, incorporate cultural humility and recognize and mitigate clinical disparities. Many states require such training, and Culturally and Linguistically Appropriate (CLAS) Standards are federally mandated.

Contextualize the impact

Leaders must understand the impact of these regulations and opportunities on finances, operational processes and policies. For example, if an oversight body such as The Joint Commission were to conduct a review today, where might the organization be exposed? If the organization plans to participate in an innovative care model, how might it fare financially under a value-based contract? Where are the biggest opportunities for financial gain? Where are the potential areas of loss?

Leading for a better future

"Health equity is a journey," says Wolf. "Our board is involved in the governance piece — making sure we're following our plan, reporting up to the board on our goals and getting their input on our goals. But they're also connecting us to the resources we need, with the com-

munity organizations and resources that do this work. They're thinking about how they do this in their own organizations. And they're bringing their community perspective to help see what's true in the communities we serve."

By funding and fostering a culture of awareness and transparency, continuous learning, and inclusion, boards can lead their health care organizations to thrive within the evolving landscape of health equity regulatory requirements — and drive transformation toward a more just and equitable health care system.

Krista D. Stepney (kstepney@chartis.com) is partner and vice president of Operations, Chartis Center for Health Equity & Belonging, based in Dallas. **Duane E. Reynolds** (dreynolds@chartis.com) is chief health equity officer at Chartis and executive director, Chartis Center for Health Equity & Belonging, based in Atlanta.

Please note that the views of authors do not always reflect the views of the AHA.