Achieving Clinical Equity across Texas Health

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Chief Medical Officer

‘Driving Equity and Inclusion within Texas Health and in Our Communities’

Defining Health Equity

“the state in which everyone has the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.”

National Academies of Sciences, Engineering, and Medicine. Communities in Action: Pathways to Health Equity, 2014.

https://www.nap.edu/download/24624

Texas Health Resources Snapshot

29,000+
employees of wholly owned/operated facilities and consolidated joint ventures

350+
points of access in North Texas

80+ outpatient facilities

250+ community access points

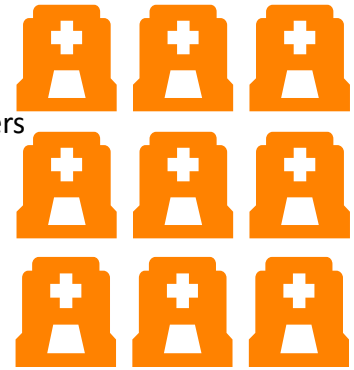
>7000 medical staff physicians

1,100+ THPG physicians/extenders

445+ primary care

315+ specialists

250+ hospitalists



29
Inpatient care locations

19 acute-care

5 short-stay

2 rehabilitation

1 transitional care

1 recovery & wellness center

$5B
in total operating revenue

$12.1B
in total assets

$757M
of charity care and community benefits

*Texas Health serves the North Texas/Dallas-Fort Worth region

Texas Health Care Delivery Model

Channels of Care

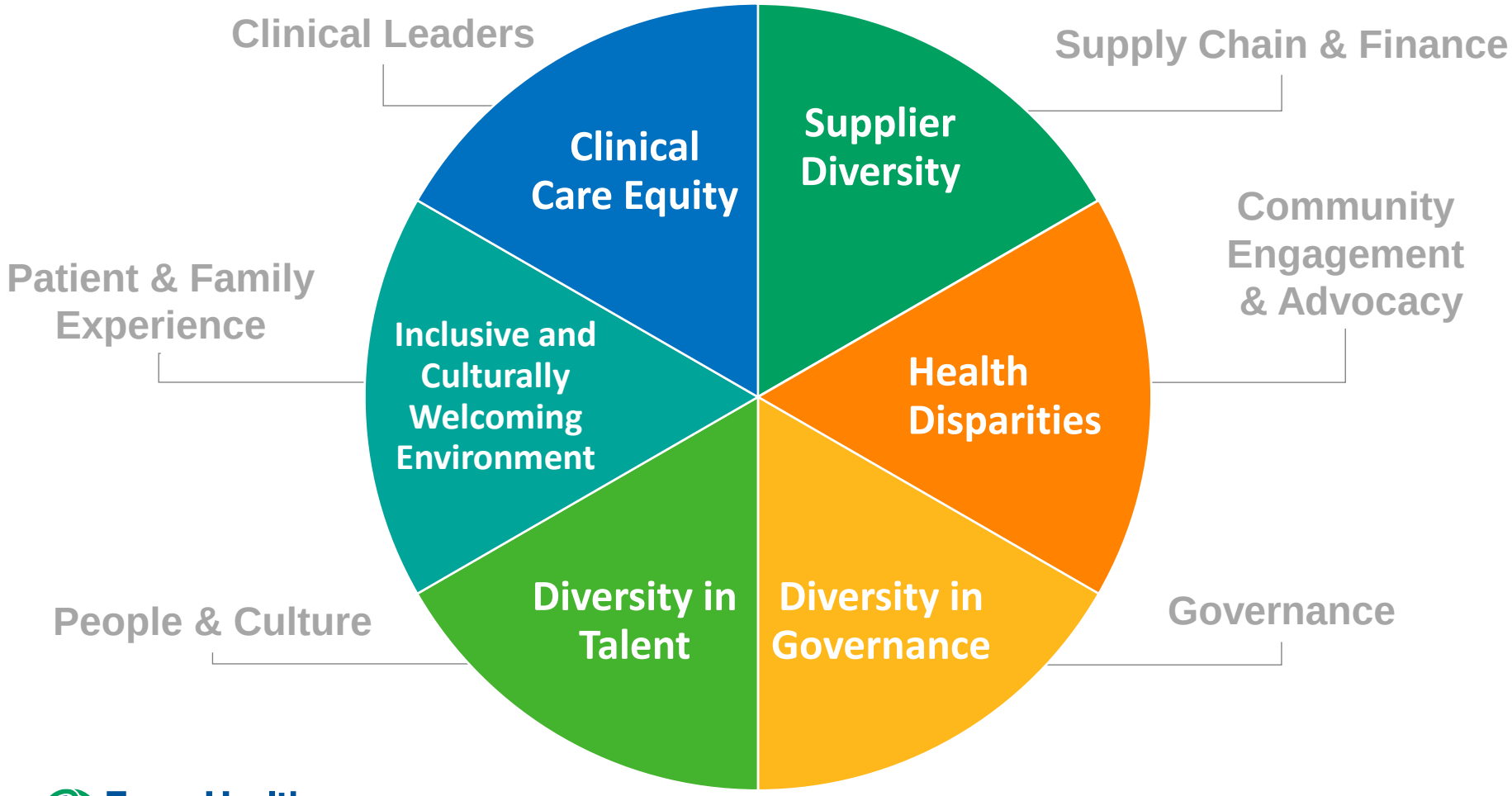
Hospitals	THPG	Ambulatory & Post-Acute	New/Virtual Channels

CMO/CNE

- **Clinical quality and safety across the care continuum**

Strategic Diversity, Equity and Inclusion Priorities

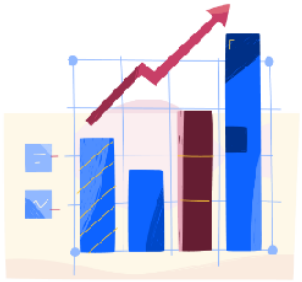
Aligning initiatives across the ecosystem



AHA Health Equity Roadmap: 6 Levers of Transformation

Culturally Appropriate Patient Care

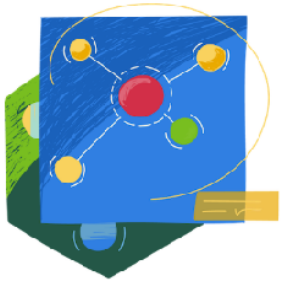
Equitable and Inclusive Organizational Policies



Collection and Use of Data to Drive Action

Diverse Representation in Leadership and Governance

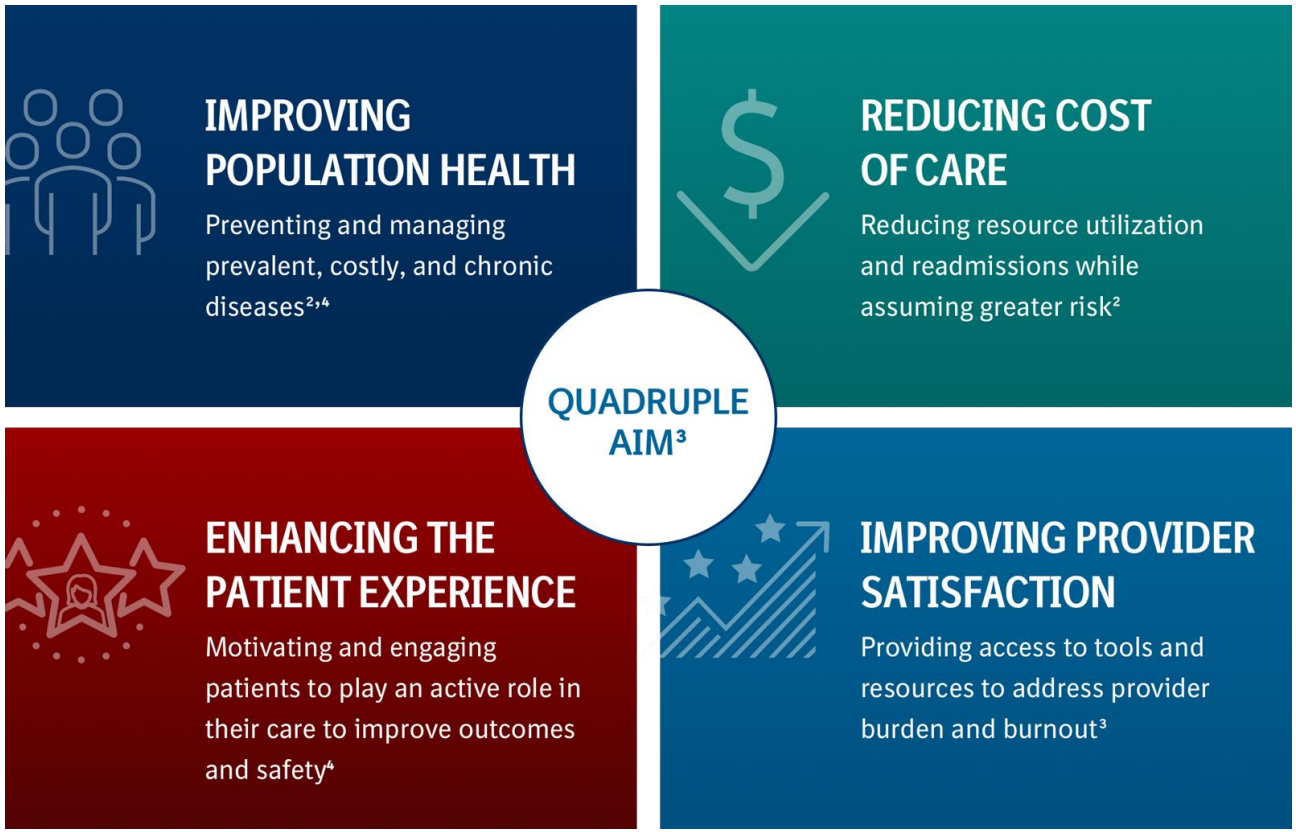
Community Collaboration for Solutions



Systemic and Shared Accountability

https://equity.aha.org/

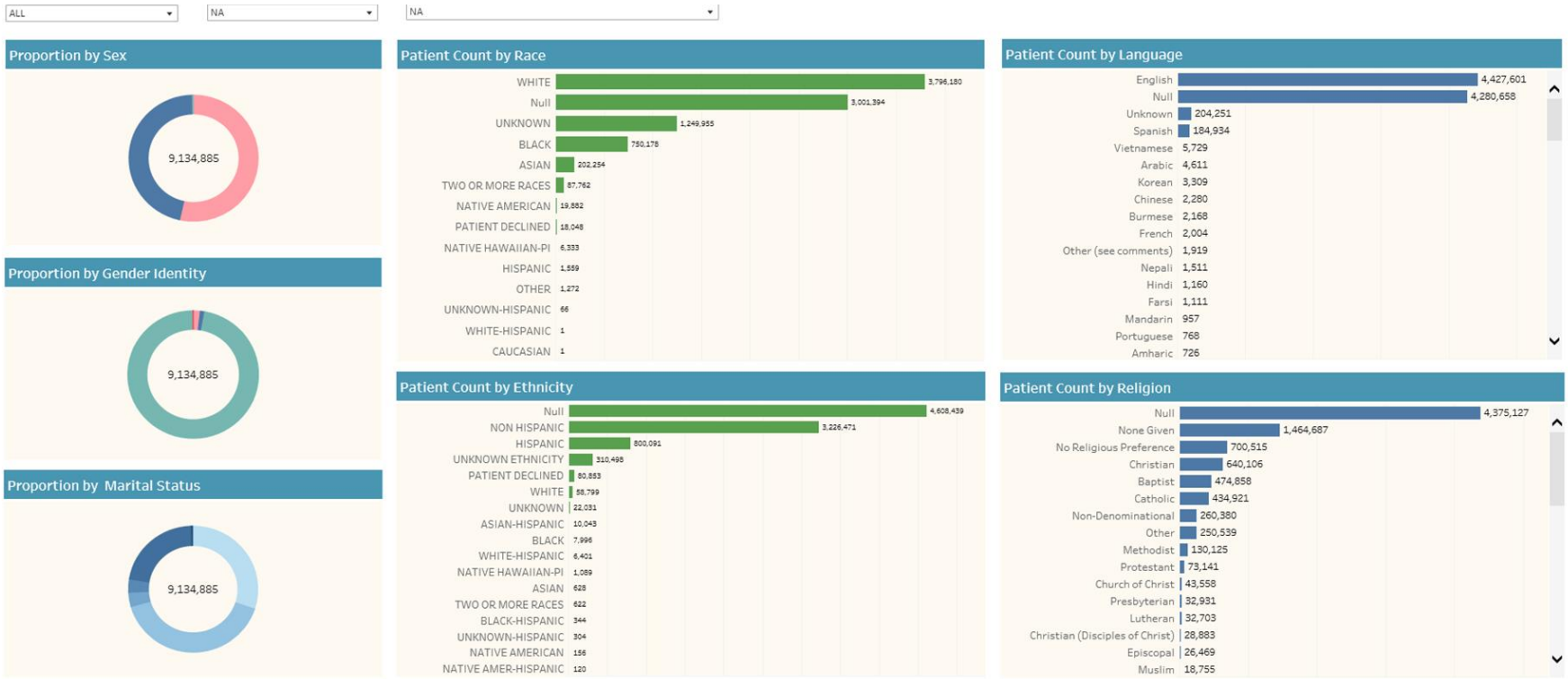
~~Quadruple~~ Quintuple Aim for Healthcare Improvement



Health Equity

Related article: https://jamanetwork.com/journals/jama/fullarticle/2788483

REaL (Race, Ethnicity & Language) Data



2022: % Missing Values

Language	Ethnicity	Race	Gender Ident.	Marital Status	Religion
0.6%	0.4%	0.8%	79.8%	1.1%	0.4%

Maternal Health

Maternal Morbidity Events

National Average	Texas Health
2.0%	2.7%

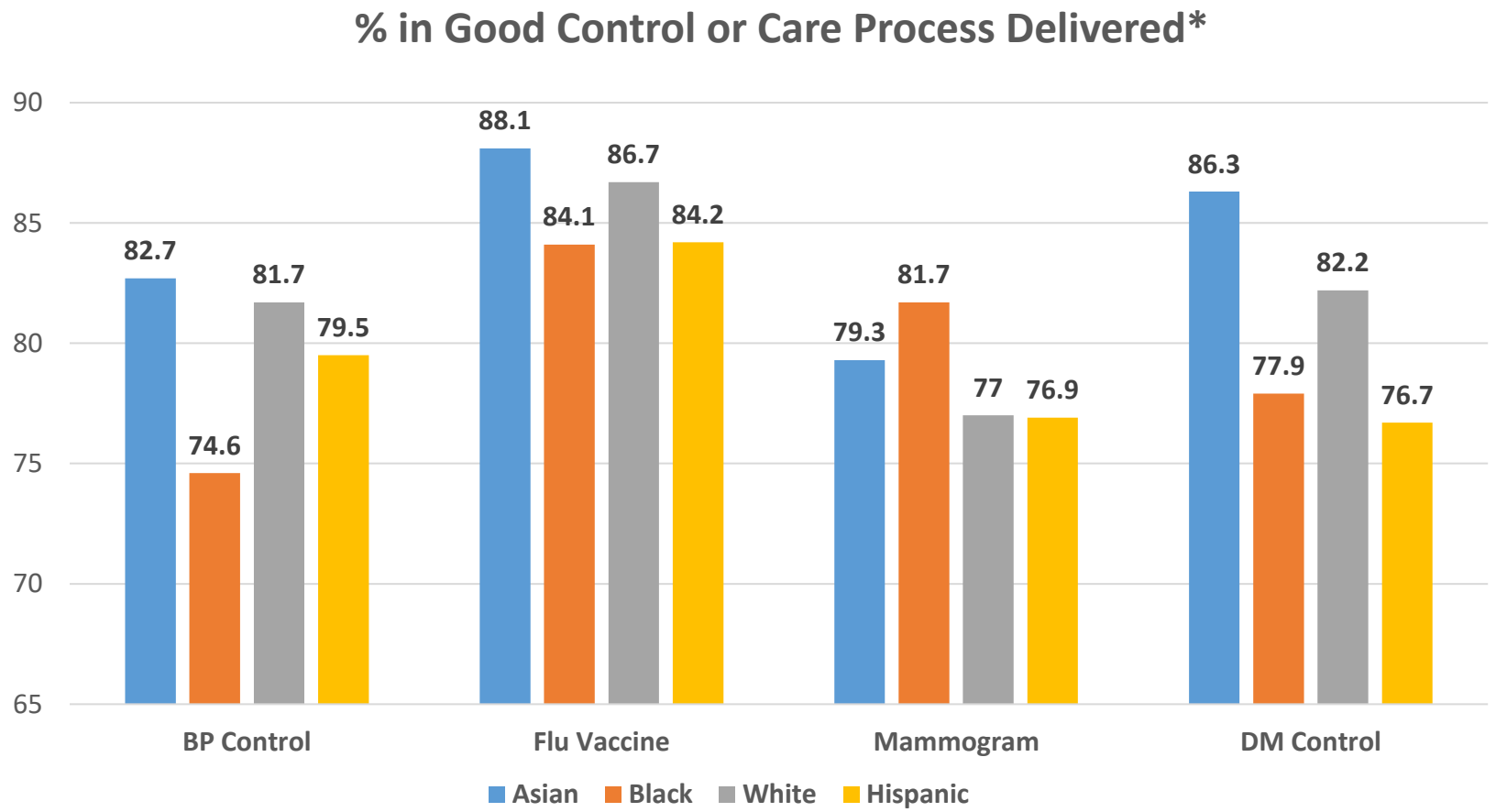
Event rate for Black mothers at THR=3.8%

C-Section Rates (PC-02 Measure)

National Average	Texas Health
25%	31%

C-section rates 5-7% higher than Texas Health baseline in mothers reporting non-white race

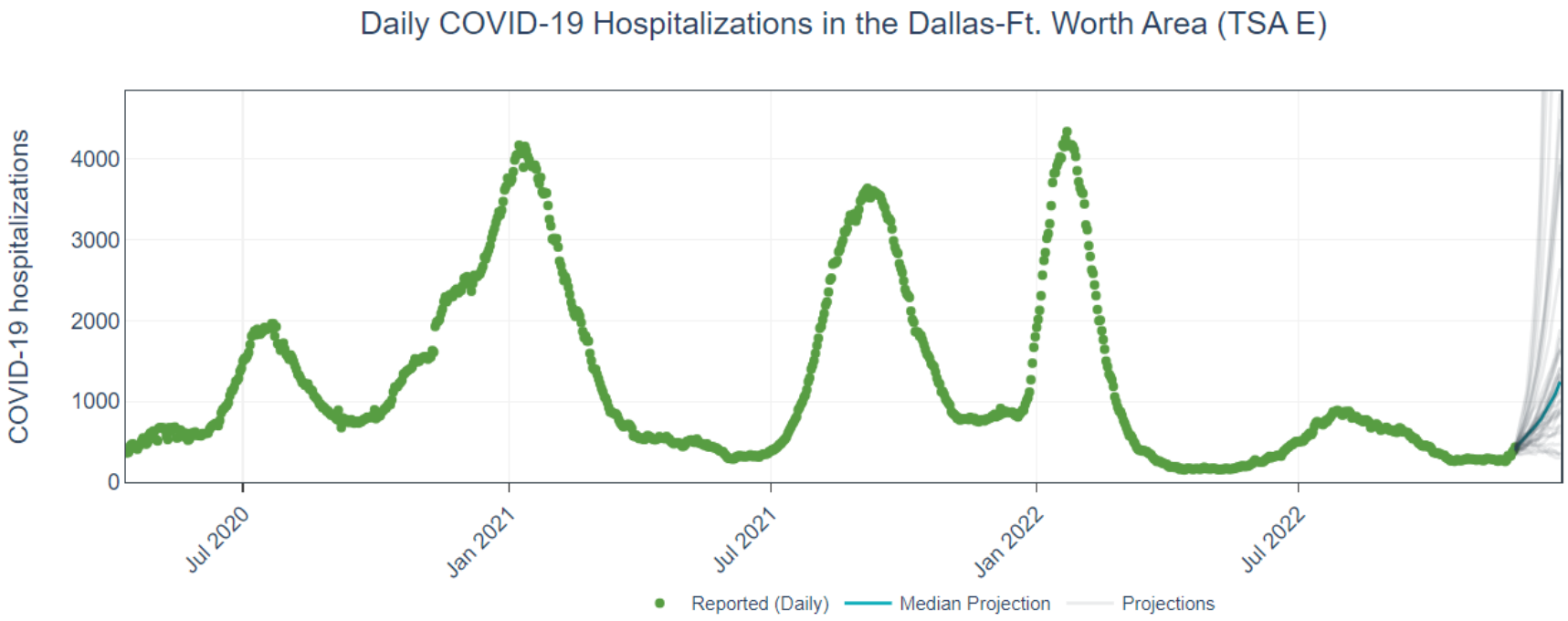
Ambulatory Care Clinical Quality Metrics



Care Gap: **2600 pts.** **4700 pts.** **3900 pts.** **3600 pts.**

*Statistically significant differences among groups for each metric

North Texas Inpatient COVID Case Trends: April 2020-December 2022



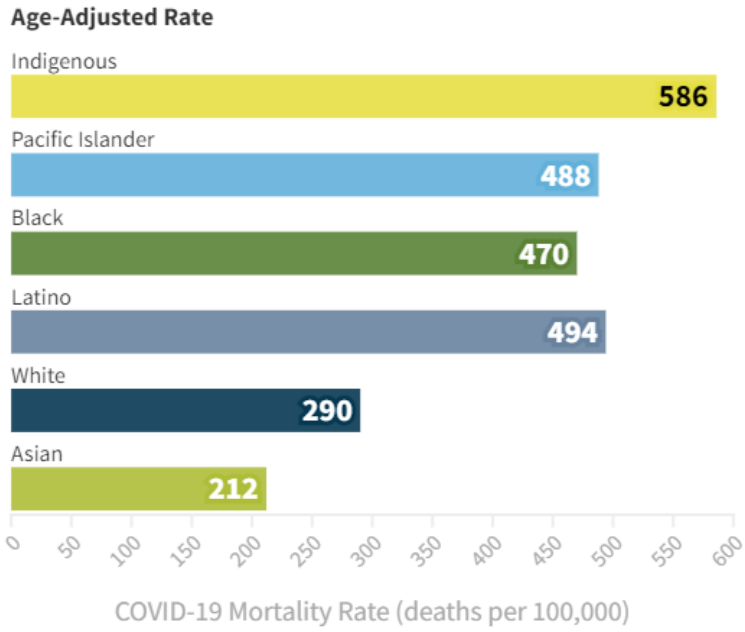
https://covid-19.tacc.utexas.edu/dashboards/texas/

Observed Disparities During COVID-19 (Race/Ethnicity, SES)

1.5-Fold Prevalence Difference (DFW Area Data)

*Data from THR-UTSW COVID Seroprevalence Study

2-Fold Mortality Difference (US Data)



https://www.apmresearchlab.org/covid/deaths-by-race

THR Study: *Journal of Hospital Medicine*

BACKGROUND: Racial and ethnic minority groups in the United States experience a disproportionate burden of COVID-19 deaths.

OBJECTIVE: To evaluate whether outcome differences between Hispanic and non-Hispanic COVID-19 hospitalized patients exist and, if so, to identify the main malleable contributing factors.

DESIGN, SETTING, PARTICIPANTS: Retrospective, cross-sectional, observational study of 6097 adult COVID-19 patients hospitalized within a single large healthcare system from March to November 2020.

EXPOSURES: Self-reported ethnicity and primary language.

MAIN OUTCOMES AND MEASURES: Clinical outcomes included intensive care unit (ICU) utilization and in-hospital death. We used age-adjusted odds ratios (OR) and multivariable analysis to evaluate the associations between ethnicity/language groups and outcomes.

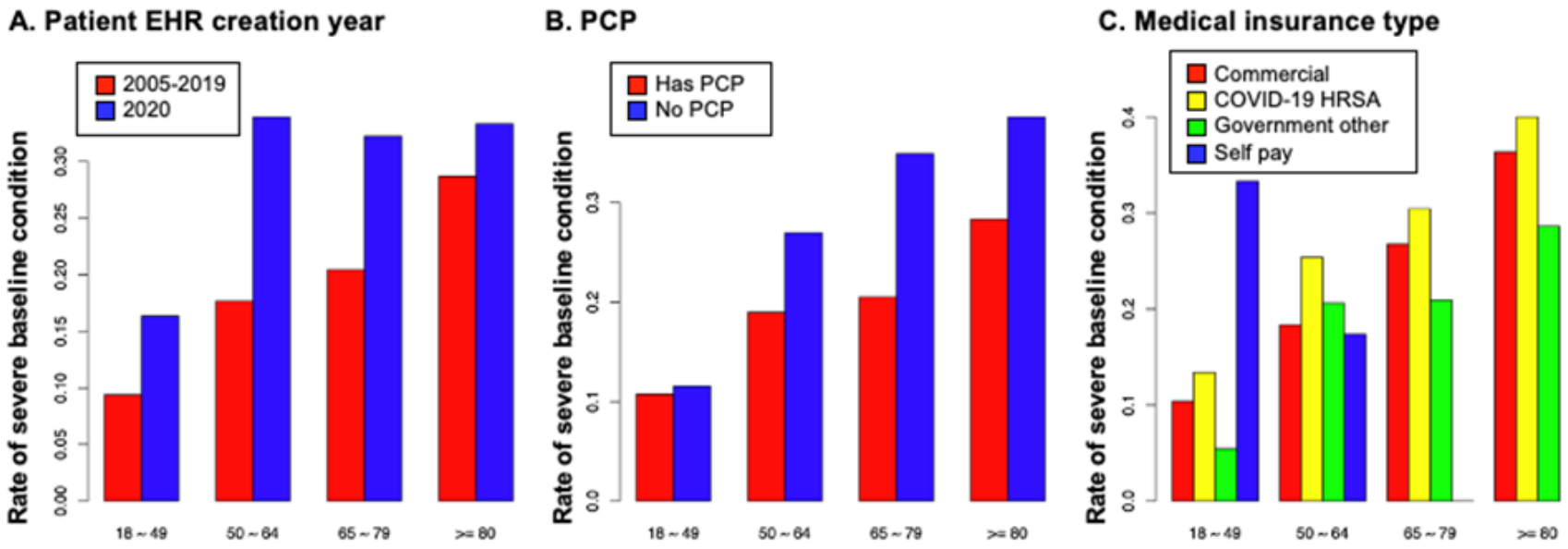
RESULTS: 32.1% of patients were Hispanic, 38.6% of whom reported a non-English primary language. Hispanic patients were less likely to be insured, have a primary care provider, and have accessed the healthcare system prior to the COVID-19 admission. After adjusting for age, Hispanic inpatients experienced higher ICU utilization (non-English-speaking: OR, 1.75; 95% CI, 1.47-2.08; English-speaking: OR, 1.13; 95% CI, 0.95-1.33) and higher mortality (non-English-speaking: OR, 1.43; 95% CI, 1.10-1.86; English-speaking: OR, 1.53; 95% CI, 1.19-1.98) compared to non-Hispanic inpatients. There were no observed treatment disparities among ethnic groups. After adjusting for age, Hispanic inpatients had elevated disease severity at admission (non-English-speaking: OR, 2.27; 95% CI, 1.89-2.72; English-speaking: OR, 1.33; 95% CI, 1.10-1.61). In multivariable analysis, the associations between ethnicity/language and clinical outcomes decreased after considering baseline disease severity ($P < .001$).

CONCLUSION: The associations between ethnicity and clinical outcomes can be explained by elevated disease severity at admission and limited access to healthcare for Hispanic patients, especially non-English-speaking Hispanics. *Journal of Hospital Medicine* 2021;16:659-666.

Velasco et al, Journal of Hospital Medicine, 2021.

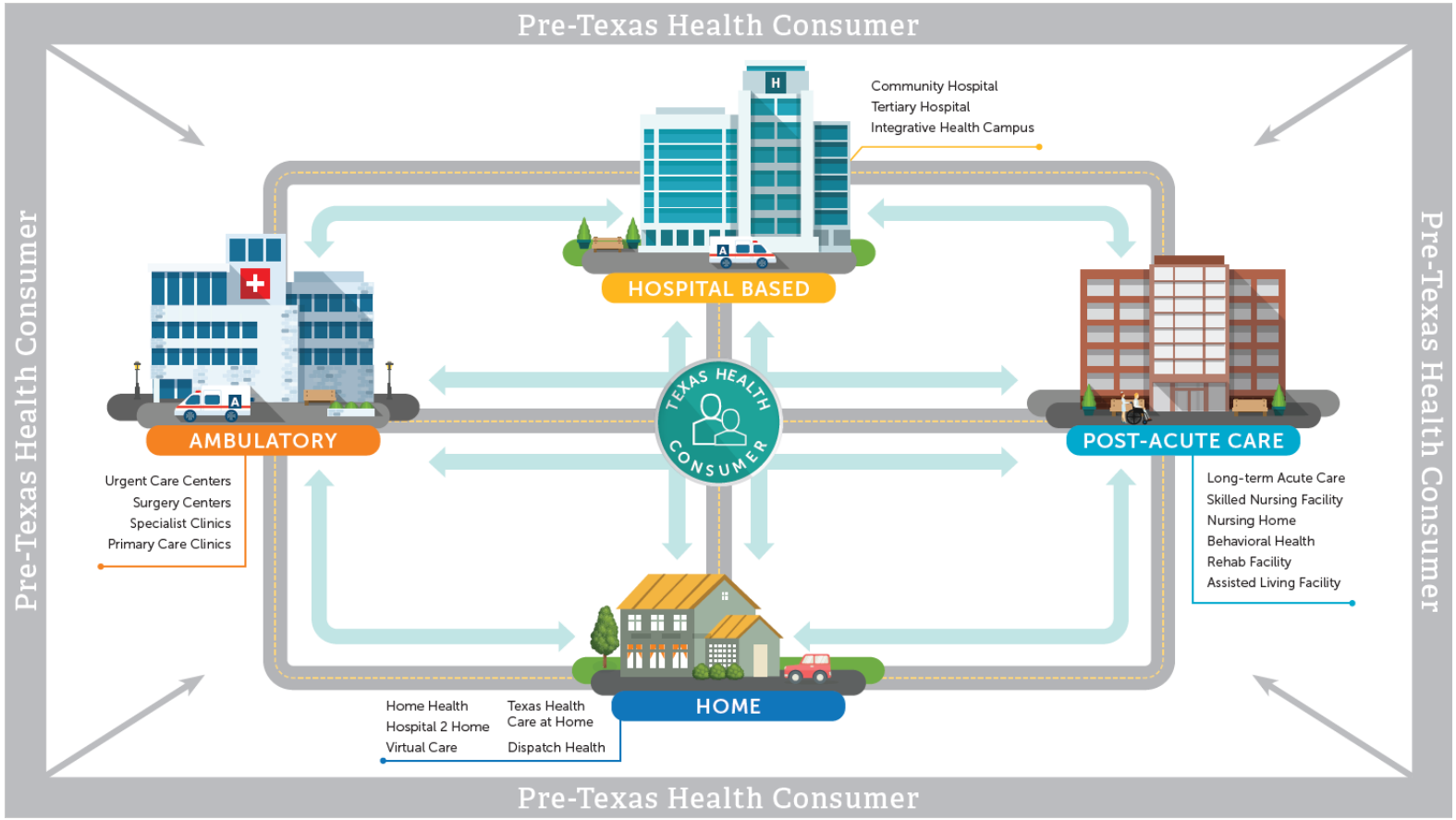
https://shmpublications.onlinelibrary.wiley.com/doi/abs/10.12788/jhm.3717

Relationship of Access to COVID Severity at Presentation



Velasco et al, Journal of Hospital Medicine, 2021.

The Consumer Care Continuum



Outreach as a Path to Equity: The Barbershop Study

ORIGINAL ARTICLE

A Cluster-Randomized Trial of Blood-Pressure Reduction in Black Barbershops

METHODS

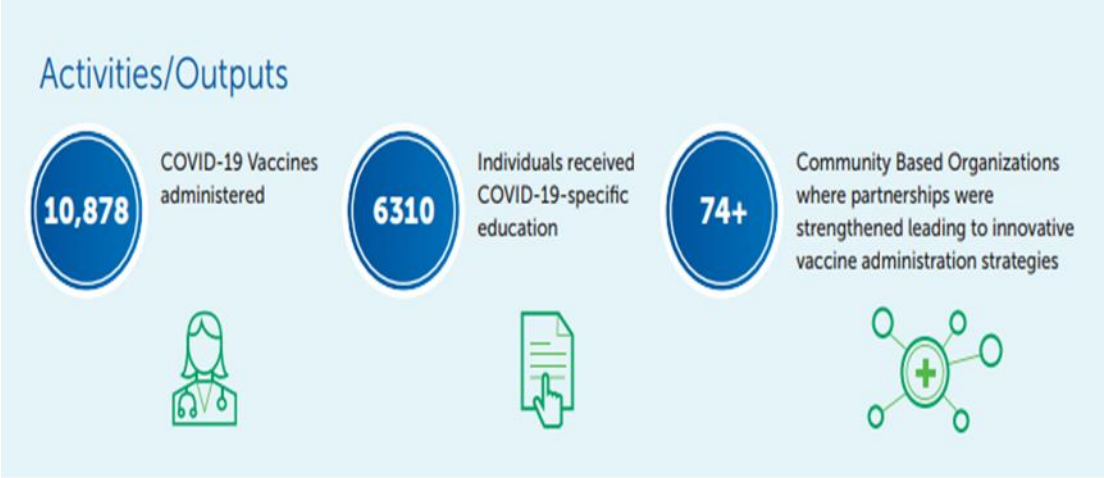
We enrolled a cohort of 319 black male patrons with systolic blood pressure of 140 mm Hg or more from 52 black-owned barbershops (nontraditional health care setting) in a cluster-randomized trial in which barbershops were assigned to a pharmacist-led intervention (in which barbers encouraged meetings in barbershops with specialty-trained pharmacists who prescribed drug therapy under a collaborative practice agreement with the participants' doctors) or to an active control approach (in which barbers encouraged lifestyle modification and doctor appointments). The primary outcome was reduction in systolic blood pressure at 6 months.

RESULTS

At baseline, the mean systolic blood pressure was 152.8 mm Hg in the intervention group and 154.6 mm Hg in the control group. At 6 months, the mean systolic blood pressure fell by 27.0 mm Hg (to 125.8 mm Hg) in the intervention group and by 9.3 mm Hg (to 145.4 mm Hg) in the control group; the mean reduction was 21.6 mm Hg greater with the intervention (95% confidence interval, 14.7 to 28.4; P<0.001). A blood-pressure level of less than 130/80 mm Hg was achieved among 63.6% of the participants in the intervention group versus 11.7% of the participants in the control group (P<0.001). In the intervention group, the rate of cohort retention was 95%, and there were few adverse events (three cases of acute kidney injury).

Victor et al, *NEJM* 2018. https://www.nejm.org/doi/full/10.1056/NEJMoa1717250

COVID-19 Vaccination: Mobile Program

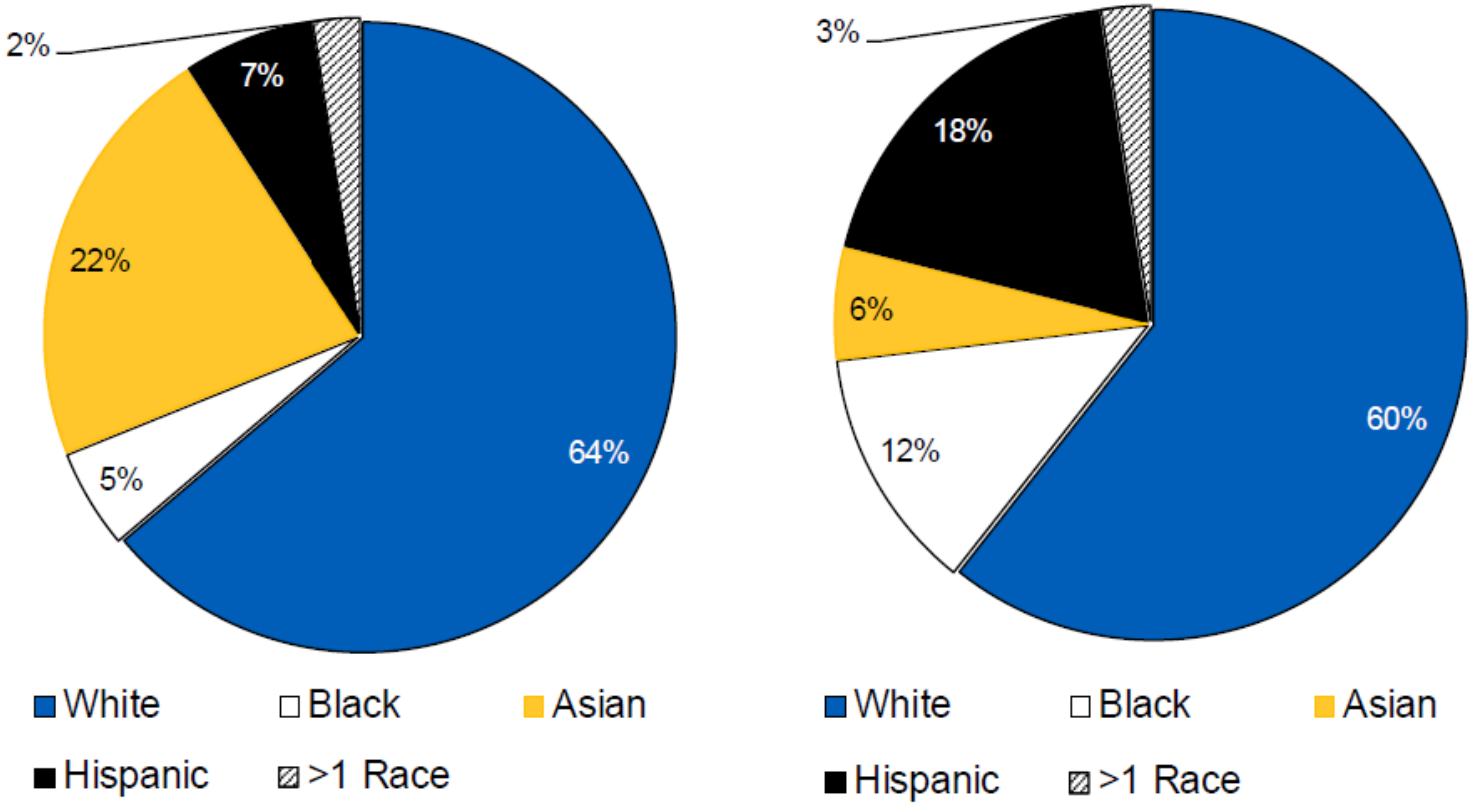


Race/Ethnicity by Vaccine Administration Site

	Tarrant County Baseline	THR Clinics Overall	THR Mobile Clinics
White	72.6%	77.5%	75.8%
Black	17.9%	12.6%	17.8%
Asian	5.8%	5.4%	4.7%
Hispanic Ethnicity	29.5%	17.4%	58.4%

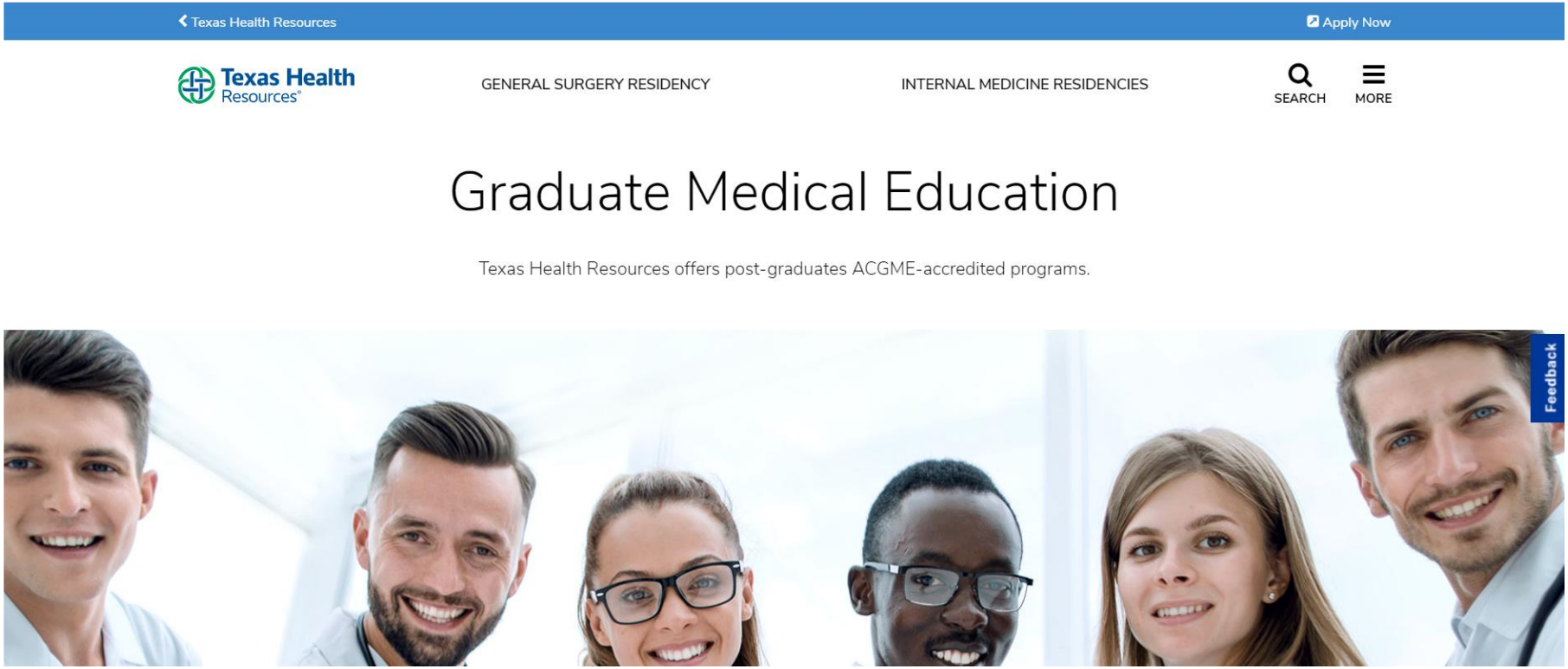
US Physician Workforce vs. Population Demographics

Figure 8. Racial and ethnic distribution of all active physicians (left) and U.S. population racial and ethnic distribution (right), 2019



https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/2021qdr.pdf

Graduate Medical Education Platform



Responding to the Clinical Equity Challenge

STRATEGY	ACTIONS
1. Improve Access to Care	• Advocate for Medicaid expansion • GME program development • Community partnerships
2. Culturally Sensitive Care Delivery	• Language services support • Workforce training and inclusion
3. Recognize and address SDOH	• Systematically analyze data to support identification of disparities • Interventions tailored to needs • Build continuum of care infrastructure

Health Systems as Partners in SDoH Solutions

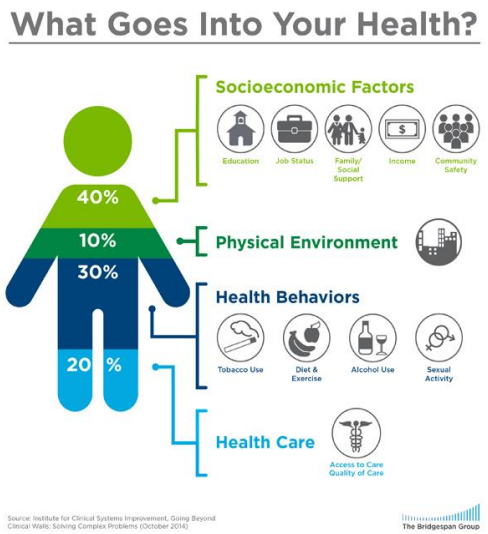
Figure 1

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community, Safety, & Social Context	Health Care System
Employment Income Expenses Debt Medical Bills Support	Housing Transportation Parks Playgrounds Walkability Zip Code/ Geography	Literacy Language Early Childhood Education Vocational Training Higher Education	Food Security Access to Healthy Options	Social Integration Support Systems Community Engagement Stress Exposure to Violence/Trauma Policing/Justice Policy	Health Coverage Provider & Pharmacy Availability Access to Linguistically And Culturally Appropriate & Respectful Care Quality of Care

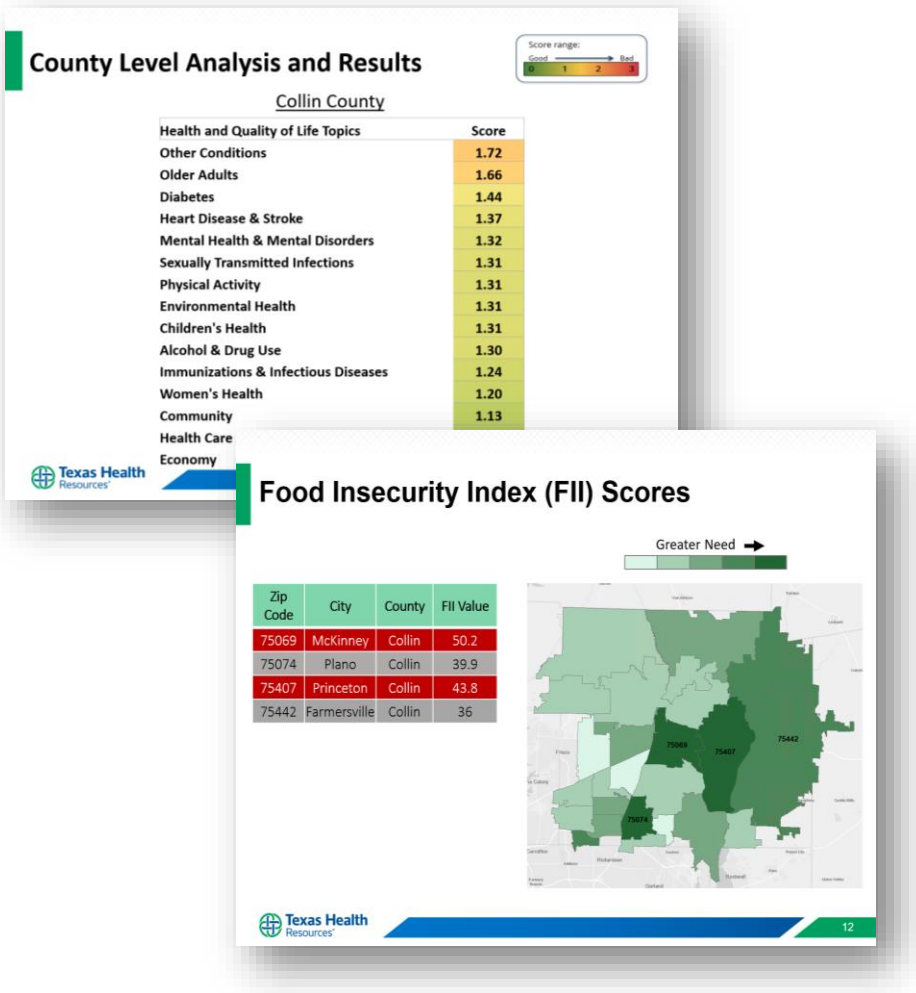
Health and Well-Being:
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

KFF



https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/

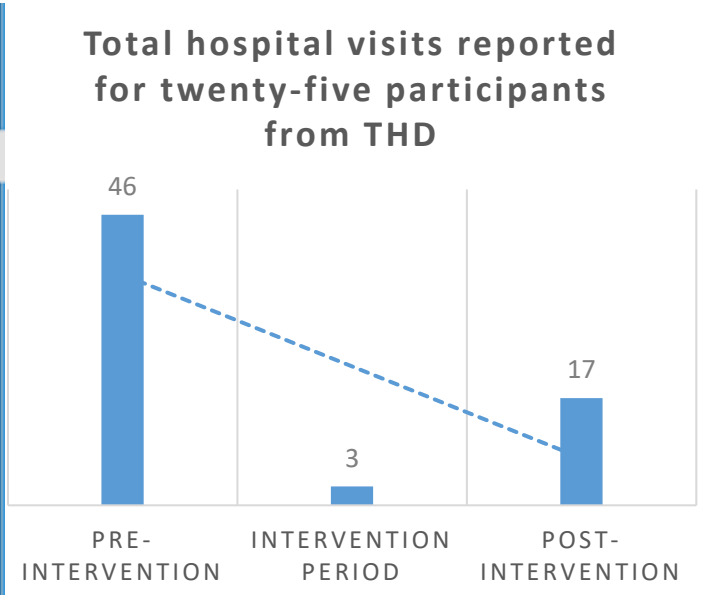
Community Health Needs Assessments (CHNA)

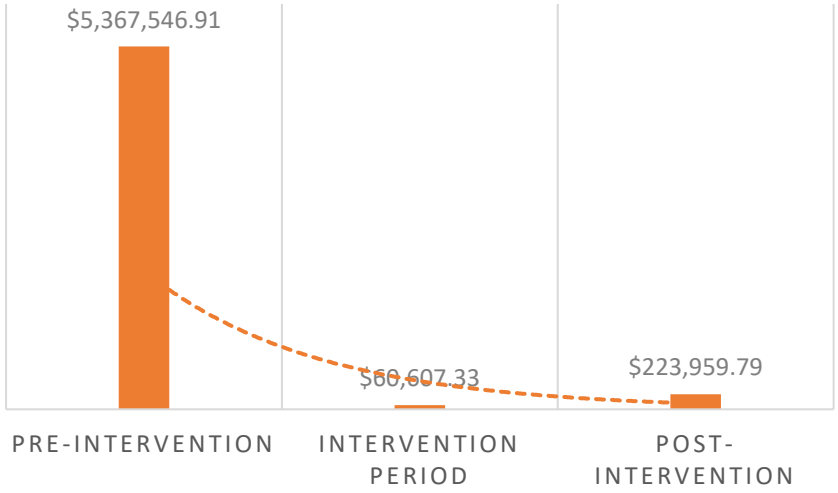


- CHNA is a systematic process that engages the community to identify and understand community health needs. The method provides a way for health systems to prioritize **community health** and **social needs**, identify barriers and inform solutions.
- Health systems conduct a CHNA every three years (ACA mandate).
- **2023-2025 priorities**: Behavioral Health, Chronic Disease, Access Health Literacy and Navigation.
- Data are used to inform award of impact grants to community organizations (January 2023 award cycle $8M)

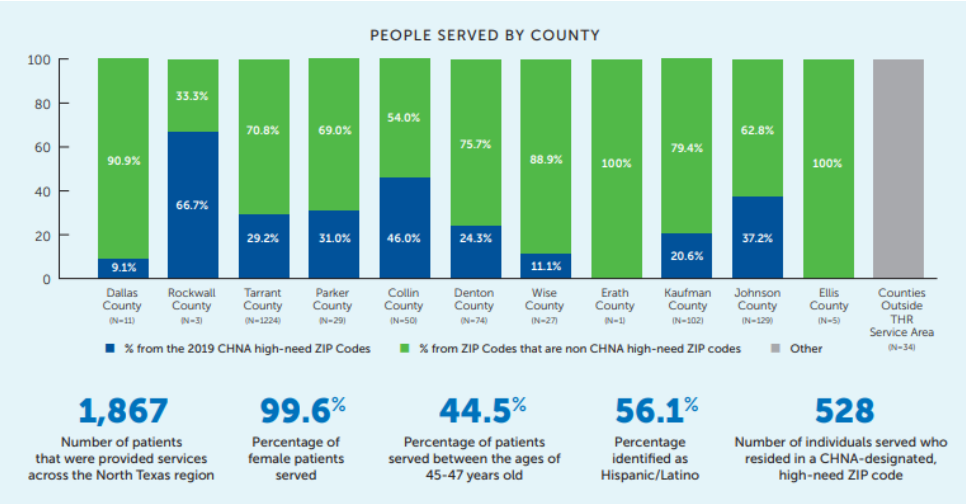
Health to Home:
A Pathway to Healing Collaborative

- Neighborhood and Physical Environment
- Housing
- Transportation
- Parks
- Playgrounds
- Walkability
- Zip Code/ Geography





Women's Health



1,867
Number of patients that were provided services across the North Texas region

99.6%
Percentage of female patients served

44.5%
Percentage of patients served between the ages of 45-47 years old

56.1%
Percentage identified as Hispanic/Latino

528
Number of individuals served who resided in a CHNA-designated, high-need ZIP code

Health Care System

Health Coverage
Provider & Pharmacy Availability
Access to Linguistically And Culturally Appropriate & Respectful Care
Quality of Care

Outcomes

Aligned Healthy People 2030 Objectives - Health Conditions

Cancer - reduce new cases of cancer and cancer-related illness, disability, and death.

98.4% Eligible females got screened for breast cancer

74.5% Females with abnormal screening returned for diagnostic procedure

45.6% Eligible patients returned their fecal immunochemical test (FIT)

74.7% Eligible adults gained access to colorectal cancer screening

86.7% Eligible female got screened for cervical cancer

88.8% Patient satisfaction

Texas Health Resources®

Continuum of Care and Wellness Outside the Walls

Community Health Workers

Faith Community Nurse Program

Through Texas Health's **Faith Community Nursing** (FCN) program, we can reach people outside of the traditional hospital or clinic setting to provide education and resources that will help improve their health and well-being.

Blue Zones Project

MOVE MORE. EAT BETTER. CONNECT.

In a nutshell, that's the Blue Zones Power 9 ® – nine lifestyle habits of those who have lived the longest. Blue Zones Project is a community-led well-being improvement initiative, implemented by North Texas Healthy Communities, a well-being outreach arm of Texas Health Resources. We partner with businesses, schools, community leaders, and residents to make healthier choices easier to make. More than 95,000 residents and nearly 500 groups and organizations have partnered to make Fort Worth the largest certified Blue Zones Community in the country and improve well-being throughout the city and beyond. Learn how you can improve your own well-being through Blue Zones Project and the Power 9.


YOU WERE JUST HERE
YOU ARE HERE
SOON YOU WILL BE HERE →
KAMAGURKA