

Health Equity and Whole Person Care in Healthcare Survey Summary – July 31, 2020



As part of its commitment to intentionally support CAHA's work on health equity and whole person care, the Capital Area Community Nursing Network (CACNN) developed a survey to gather information about health equity and whole person care practices in the Capital Area region. The 10-question survey was sent to 12 organizations in the tri-county region in the summer of 2020. The organizations receiving the survey included health systems, critical access hospitals, long-term care facilities and ambulatory care facilities. The survey was sent to chief nursing officers in each facility. Five responses were returned, for a 41.7 percent return rate.

Key Findings

- All the respondent organizations are committed to health equity and have some activity underway to promote health equity in their organizations.
- Workforce diversity is viewed by most respondents as lacking at multiple levels, resulting in a workforce that does not represent the populations they serve or the community at large.
- Implicit bias training is needed for those involved in patient care and hiring.
- Although socio-demographic data is being collected, there is little evidence of use of the data to identify and address health disparities created by health inequities.

Summary of Responses

1. Commitment to Address Health Equity

All respondents indicated that their organizations have made an explicit commitment to Health Equity.

The American Hospital Association's Equity of Care campaign identifies four action steps for health systems and hospitals:

- Increase collection of socio-demographic data, including race, ethnicity, and language preference
- Increase cultural competence training
- Increase diversity in leadership and governance
- Improve and advance community partnerships

Respondents were asked to identify which, if any, of these steps are being taken in their organizations to improve each patient's experience recommendations and reduce health inequities. All of the respondents indicated that their organization is acting on one or more of these areas. Each of the five respondents is working on cultural competence training, three on increasing diversity and community partnerships and one on collection of socio-economic data.

2. Collection of Socio-Demographic Data

Respondents understood questions on this topic in two different ways, suggesting a lack of clarity in the wording of the questions about how the data was used in their work, and whether there were challenges to data collection.

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Two respondents answered the questions as being about human resources data collection. One indicated it was monitored by their HR department, but not reported anywhere. The other respondent answered that data was used for recruitment opportunities. Regarding challenges to data collection, one respondent answered that better tools are needed to collect and collate the data.

The other three respondents' answers addressed data collection about patients. They shared several ways they used the socio-demographic data:

- Reports to the state.
- To ensure the availability of resources for community members, consumers, and caregivers.
- Compare the demographic data with the service area population and employees to assure reflection of the community served, and to potentially identify disparities in service provision.

One respondent shared challenges in patient data collection related to National Outcome Measures and six-month reassessment: organization system flows and difficulty connecting with individuals within a required 30-day period.

One respondent answered the question about what they would like to do with data, indicating that they would like to do more analysis that could be shared with staff and the community to drive improvements.

3. Cultural Competence Training

Questions in this area address how training is being offered, to whom and how frequently. Respondents could also share additional information.

Four of the respondents require training for all employees; one specified that training is required for all caregivers. Four different answers were offered regarding required frequency of training: annually, upon hire and annually, twice each year, and a minimum of once each year. Two respondents indicated that training was provided online by a contracted service and suggested that their training could be improved with face to face education opportunities. All other respondents utilize contracted internet providers and in-house training, offering webinars, face to face training and interactive training modules. One respondent offers enhanced training but did not share details about it.

One respondent shared an additional comment: "What we currently offer is not adequate to fully address systemic racism, inequities and implicit bias. We are looking for expanded training to offer to all staff, with additional training for managers."

4. Workforce Diversity

Responses to two of the survey questions about diversity are best presented by sharing them verbatim.

What training and/or hiring practices would you like to see in place to have a workforce that reflects the population your organization serves and to improve EACH patient's experience?

- More diverse population in workforce, but it may be limited to the area we are in, and no persons of color live in the area.
- More LGBTQ training for employees and more training of staff on patients.

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- Resources to educate leaders on best hiring practices.
- Implicit bias training; public recognition of diversity.
- We need to increase upward mobility of color into leadership roles within the organization, recruitment and retention is also needed. Would like to examine practices and provide managers and those participating in hiring processes to be training on recognizing and avoiding implicit bias in interviewing and hiring decisions.

What are your observations about the diversity of your organization's leadership and governance?

- Mostly white women, few men and few persons of color.
- Lacks diversity in all areas.
- Opportunities identified and addressed frequently to ensure diversity is addressed – organizational surveys.
- We aren't as diverse as the population we serve and the community in which we work.
- Diversity has increased in our Board over the past two years, but still lacking. At the Director and Supervisor level there is currently little diversity. As an organization there has been a culture of promotion from within to these levels, in effort to increase upward movement, we have developed a mentorship program and encourage diverse involvement in the program.

All of the five respondents have a patient and family advisory committee, all described as diverse or broadly open to community members. Two of the five respondents have a diversity and inclusion officer, one at the corporate level and the other with multiple roles. Four of the five respondents have a process in place to resolve complaints about equity, three of them clearly designed to address patient/resident or family complaints and one which is an HR function. Again, a lack of clarity in the wording of this question led to different interpretations by respondents. One respondent did not answer the question.

5. *Community Partnerships*

Four of the five respondents shared thoughts about the value and need for community partnerships. They would like more community partnerships and have found value in those that they have, one specifically noting work with Healthy!Capital Counties and the City of Lansing. Two respondents shared what types of partnerships they would like to pursue:

- Partnerships to address a growing number of patients who are homeless and/or have substance abuse and mental health conditions.
- Partnerships to address disparities in service to Hispanic patients and connect individuals with services.
- Expand mobile crisis response in partnership with 911 dispatch, EMS and CIT trained officers from law enforcement agencies, so that the right agency takes the lead in responding, based on the individual situation.
- Expand the number of primary care settings that include a trained behavioral health consultant.

6. *Other Comments*

- From acute care to SNF to home, then out in the community after home care stops. The person is lost without enough resources to support their health and life needs. We need a stop gap. How can we all share information?