

Arkansas Trustee

For Arkansas Hospital Governing Board Members

Fall 2024

BOARDROOM BASICS

Measuring Equity in Patient Care

Delivering high quality, compassionate care to all patients is a consistent goal for health care organizations across the country. For boards, the challenge is understanding whether the care provided at their organization was truly performed without regard to race, ethnicity, language or disability.

The desire to provide equitable care to all patients is an ethical baseline upon which hospital leaders and board members can generally agree. Executing equitable care is a bigger challenge. The benefits of ensuring equity of care are not just moral—studies continue to demonstrate the negative impact health inequities have on health care costs, quality of care, and ultimately patient outcomes.

What is “Equity of Care?”

The terms “equality” and “equity” are often used in health care, and the differences are significant. The Robert Wood Johnson Foundation defines the terms this way:¹

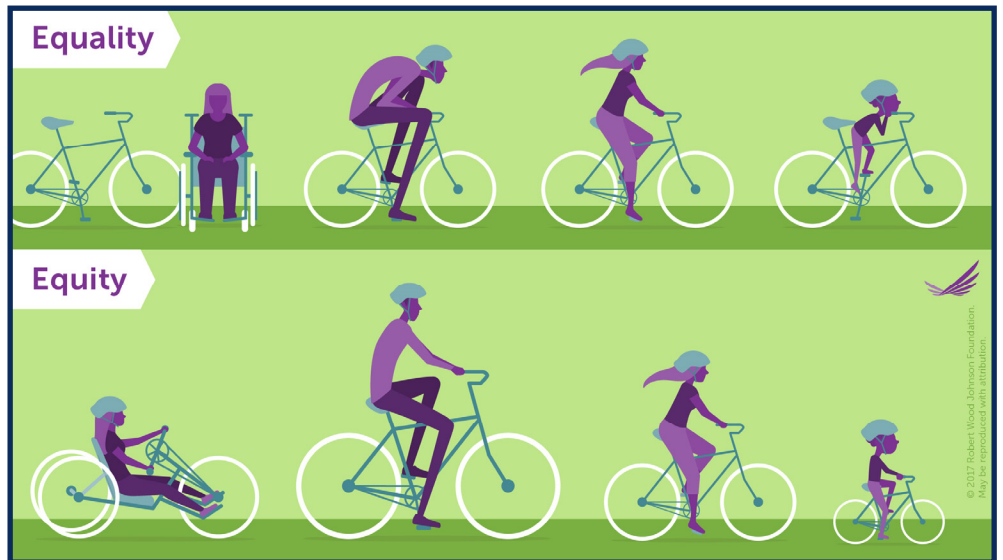
- **Equality:** Everyone gets the same—regardless if it’s needed or right for them.
- **Equity:** Everyone gets what they need—understanding the barriers, circumstances and conditions.

Equality is a “one size fits all” approach and assumes that each individual can make use of what they are given. In health care, this means everyone is offered the same treatment or care plan regardless of their background or socioeconomic status. In contrast, equity ensures that care is catered to individual needs to improve overall health and promote fairness in

health outcomes. Simple examples might include providing information in various languages and using translation services, serving food that caters to unique dietary needs, offering transportation assistance to appointments, or using a patient navigator to help a family access pharmaceutical benefits or apply for Medicaid.

Social determinants of health play a large factor in ensuring care is equitable, including income, education, language and culture. Boards can ensure equitable care is provided by first learning about the population their organization serves and the unique social factors present.

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Source: Visualizing Health Equity by Robert Wood Johnson Foundation.

President's Notebook

In Our Care

Good health – both mental and physical – is essential for every Arkansan. The Arkansas Hospital Association works every day to safeguard hospitals' operational effectiveness in advancing the health and well-being of their communities. As such, we support our hospitals in their efforts to improve the mental and behavioral health of their communities, of their patients, and of the thousands of health care employees that serve hospitals across the state.

We know that, particularly post- COVID-19, mental and behavioral health is more tenuous in America than ever before

Our hospitals are making concerted efforts to support health care workers in the areas of mental and behavioral health. We all know that it's imperative for everyone who works in the hospital to come to work clear-minded, focused, and as free as possible from mental and behavioral health challenges.

Besides doing all they can to provide a healthy working environment, many of our hospitals are providing on-site counseling services to help employees address mental health concerns and even behavioral health issues, including substance use disorder. Throughout the state, hospitals are focusing caregiving not only on patients but also on their own employees, by providing counseling services and other resources to help health care workers deal with the extreme daily stress they encounter. This helps to build healthier communities.

In the latest issue of [Arkansas Hospitals](#), we provided a number of resources hospitals can use as they meet the needs of today's workers, patients, and community members.

Speaking of resources, the AHA hosted its Annual Meeting October 30-31 in Little Rock. For those able to join us, we hope you received tools and takeaways from experts in the field to assist in tackling the everyday challenges hospitals across the state and the nation are now facing.

The leadership workshop provided leadership tenets employed by the U.S. military presented by Patrick Houlahan, a former United States Marine Corps TOPGUN pilot. Our keynote addressed recognizing the purpose in our work and was presented by Mike Massimino, former NASA astronaut and Senior Advisor for Space Programs at the Intrepid Sea, Air, and Space Museum.

We also featured a panel discussion by Arkansas hospital leaders addressing the financial sustainability of health care organizations, including actionable ideas and methods.

Other notable sessions addressed health equity, communications, unconscious bias, and leadership techniques that can be utilized across the health care management spectrum.

The Annual Meeting always provides cutting edge ideas that can be taken back to and implemented by our local hospitals.

It was an honor to visit with those that were able to attend. Make sure you mark your calendar and save the date for the 2025 Annual Meeting set for October 15-16 at the Little Rock Marriott.

Sincerely,



Bo Ryall, President and CEO
Arkansas Hospital Association

Governance Notebook

AAHT Welcomes Connie Castleberry as New President

Connie Castleberry started her term as the AAHT President on October 30th at the AHA Annual Meeting. Her term runs through 2026.

AAHT Board of Directors

- Connie Castleberry, President, Ouachita County Medical Center, Camden
- Guy Patteson, Past President, St. Bernards Healthcare, Jonesboro
- Drew Atkinson, Secretary/Treasurer, Jefferson Regional, Pine Bluff
- Jeff Showalter, Member at Large, White River Health System, Batesville
- Lila Floyd, Member at Large, Lawrence Memorial, Walnut Ridge

AAHT Regional Dinners

Be on the lookout for information regarding fall/winter regional dinners. AAHT and ACHE of Arkansas are planning to co-host regional dinners across the state featuring Jodiane Tritt, AHA Executive Vice President, who will provide a legislative update. The hope is to provide American College of Healthcare Executives (ACHE) in-person education hours to executives in attendance through a panel discussion. More information coming soon!

AAHT Website

If you have not already visited, AAHT Resources are now available online through the AHA website: [CLICK HERE](#).

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Regulatory Requirements

The regulatory foundation for equitable care in hospitals and health systems can be traced to early efforts to improve patients' rights. Decades ago, The Joint Commission was a pioneer in developing hospital accreditation standards around patients' rights, which now includes prohibiting discrimination based on factors such as age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, or gender identity or expression. Today, The Joint Commission requires hospitals to collect race and ethnicity information from patients, and the standard is a National Patient Safety Goal.²

Increasing guidelines and requirements for measuring and addressing health equity are growing, including guidelines from the Department of Health and Human Services (HHS), priorities announced by the White House, and an increased emphasis from groups including the American Hospital Association's Institute for Diversity and Health Equity.

In 2022 the Centers for Medicare and Medicaid Services (CMS) released an updated framework to advance health equity, with five priorities designed to achieve health equity and eliminate disparities. The first priority is "expand

the collection, reporting and analysis of standardized data."³

Start with Data Collection

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Data helps leaders understand how, when and where patients with varying demographics access and receive care.

What to Collect.

Identifying disparities in care and developing improvement strategies starts with collecting standardized data on "REaL": race, ethnicity

and language. Many health care systems have revised their demographic data inputs when implementing new electronic health records over the past several decades to collect this information. Data collected should include measurements required by The Joint Commission Patient Rights standards, along with Social Determinants of Health (SDOH) and Sexual Orientation and Gender Identity (SOGI) elements. Examples include questions about gender identity, housing stability, employment, food insecurity and transportation needs.

Unfortunately, not all health care settings consistently collect this data. More importantly, while some organizations do collect the necessary data, execution of data stratification and subsequent use of the information

Health Disparities Impact Cost and Quality of Life

Health Disparities Impact Quality of Life.⁴

- The maternal mortality rate for Black women is four times higher than that for non-Hispanic White women.
- Hispanic women are 20 percent more likely to die from cervical cancer than non-Hispanic White women.
- Asian Americans are eight times more likely to die from hepatitis B than non-Hispanic Whites.
- Diabetes rates are more than 30 percent higher among Native Americans and Latinos than among Whites.

Health Inequities are Expensive⁵

- Racial health inequities are associated with substantial annual economic losses nationally, including at least \$10 billion in illness-related lost productivity and \$200 billion in premature death.
- Eliminating health inequities can lead to improved patient engagement and better health outcomes, decreased readmissions, and improved performance in value-based contracts.

American Hospital Association's Health Equity Roadmap

The AHA Institute for Diversity and Health Equity has designed the Health Equity Roadmap as a framework to guide hospitals and health care systems to advance equity. AHA goals toward advancing health equity began in 2015 with the #123forEquity Pledge Campaign, which many hospitals signed as a commitment to addressing health equity. The new roadmap is the next step, and is a toolkit to:

“support hospitals and health systems in their efforts to become more equitable organizations and dismantle structural barriers to health and overall well-being.”

It includes customized resources and action plans to guide organizations through the process, with three key steps:

1. **A Health Equity Transformation Assessment**, which is an online questionnaire designed to provide hospital or health systems with a baseline for assessing performance and opportunities for transformation in health equity.
2. **Create Action Plans and Use AHA Resources**, using the profile of your organization based on the assessment. Resources help provide structured action plans and resources.
3. **Join the Virtual Community**, to exchange ideas and connect with colleagues.

For more information, go to <https://equity.aha.org>.

in clinical performance improvement is not yet consistent.

Data Analysis. Once sufficient data is collected electronically, data analysts can then stratify (organize the information) based on patient demographics, patient concerns, and clinical studies pointing to disproportionate disease occurrence. The stratified data can help determine where opportunities to improve equitable care exist across the care continuum and clinical services.

Conducting meaningful analysis of the data requires both a workforce that is trained properly and patient records with complete data.

Board Review and Leadership

Once an organization has a process in place for data to be collected and stratified, the opportunities begin to discern differences in care and treatment. For example, access to care

(such as length of waiting time to get an appointment), diagnosis (such as mammography appointment timeliness) and treatment (such as the ability to fill prescriptions as needed or have needed surgeries) can be evaluated by race, ethnicity, gender and other factors.

Understanding the Needs of Certain Populations.

It is important to recognize the socioeconomic and cultural factors which may perhaps unconsciously influence access to care and treatment. Evaluating conditions and/or disease-specific clinical care processes and outcomes can lead to insights into why a certain patient population's needs are not being addressed equitably.

For some diseases, objective data is already available that demonstrates occurrence at a greater frequency in particular patient

populations. For example, leaders can identify “disparities-sensitive performance measures” such as controlling blood sugar levels for diabetes patients, obtaining timely colorectal cancer screenings, and preventing low-birth-weight and premature births for pregnant women.

These clinical performance measures can be organized by key filters for race, ethnicity and other factors to provide clear directions for improving patient outcomes and reducing costs through health equity.



Cultural Competency Training.

Providing equitable care across patient populations is a complex and value-driven goal. Cultural context and prior experience shape how providers interact with patients.

Because of this, cultural competency training is an essential component of an effective health equity plan. ***Diversity, equity and inclusion training is important for staff, physicians and leaders as well as the board of trustees.*** Leadership participation in these educational efforts ensures proper understanding of the issues and demonstrates a commitment to health equity.

Performance measures boards can use to evaluate the breadth, depth and success of cultural competency training include:

- Ongoing board training to better understand health equity and barriers to health and overall well-being;
- The percentage of staff, physicians and leaders who have completed health equity and cultural competency education; and
- Patient satisfaction scores and measurements of patient engagement.



Health Equity: Questions for Boards

Collecting data and beginning to understand what it means is only the first step in addressing health equity. Meaningful change requires an ongoing partnership between the board and senior leadership, starting with the board asking the right questions. Key questions for discussion may include:

- Does our organization collect the data needed to understand health disparities and social determinants of health in the communities we serve?
- Do our board and senior leadership understand the implications of the data?
- Has our board received education about not only cultural considerations, but understanding how systems and processes can impact these disparities?
- What specific goals do we have to address the disparities identified?
- How will we measure success in impacting health equity?
- What organizations should we collaborate with to improve health equity in our community?

Partnering with the Community

Community partnerships should be a part of the conversation as boards consider strategies to improve equity of care. Many community agencies, including religious organizations, charitable foundations, federally qualified health clinics, community nursing centers, senior centers and other

non-profit groups are familiar with serving the needs of marginalized or disadvantaged persons. Working together leverages the expertise and connections of both groups, resulting in a bigger impact with

better outcomes. Partnering with the community is one of the Institute for Healthcare Improvement's five key avenues to help achieve health equity.

Content was contributed by governWell Healthcare Consulting and Ann Scott Blouin, President & Founder, PSQ Advisory.

Sources and More Information

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2. Bhatt, Jay and Lee, Josh. Health Equity is Becoming a New Regulatory Reality. *Deloitte Health Forward Blog*. March 9, 2023. www2.deloitte.com.
3. CMS Framework for Health Equity. Last updated September 10, 2024. www.cms.gov.
4. The Joint Commission. Impact of Disparities in Health Care. Accessed October 4, 2024. www.jointcommission.org/our-priorities/health-care-equity.
5. American Hospital Association Health Equity Roadmap. Accessed October 4, 2024. <https://equity.aha.org>.

Board Leadership Hazards: 10 Events to Watch Out For

A never event is a “serious reportable event” that should never happen to a patient. Although hospital and health system boards do not provide direct patient care, there are certain board actions that would be considered hazardous or unsafe.

Even the highest performing boards can make critical governance errors if they aren’t proactive. Below are ten hazards hospital boards must be diligent to avoid.

1. Failure to Fulfill the Board’s Fiduciary Responsibility

Hospital and health system boards have a two-way responsibility: they must act in the best interests of both the hospital and the communities their hospital serves. Legally, board members must fulfill three fiduciary responsibilities:

- **Duty of Care:** Board members must be thoroughly informed before making decisions, using the same level of judgment they would use in their own personal or business activities.
- **Duty of Loyalty:** Trustees should put the needs of the organization first, preventing board members from using their position to serve themselves or their businesses.
- **Duty of Obedience:** Board members must abide by laws, regulations and standards of the organization’s operations.

Boards often fail to fulfill their fiduciary responsibility through lack of engagement, or by misinterpreting the board’s roles and responsibilities. From a legal standpoint, individual members of a board that don’t ask critical questions or engage in constructive dialogue may be considered negligent and liable for their actions or inactions.

2. Failure to Keep Quality Front and Center

Too often boards of trustees assume that quality and safety problems are not an issue unless they hear otherwise. The board sets quality and safety goals and holds the administration and medical staff accountable for achieving them. To do this, boards must:

- Understand the board’s role in ensuring quality of care and creating a culture of safety.
- Engage in ongoing education about quality and patient safety, understanding what’s happening at the organization and in the industry as a whole.
- Know how the organization is currently performing in key indicators and track progress in meeting goals.

- Understand the organization’s “culture of safety” and the changes necessary. For example, are reporting of errors and near misses encouraged and used as a learning tool?
- Consider the nature of system failures and continually ask “What can our hospital do to improve our systems to support safe, high quality care?”

3. Failure to Plan for the Future

A highly effective strategic plan is not simply a set of strategies, plans, budgets and responsibilities. Instead, it’s an ever-evolving process of examining the market and other forces for change and using that information to continually reshape or fine-tune the hospital’s strategic direction.

A typical strategic planning process includes:

1. Ensuring a strong foundation in the mission, vision and values;
2. Understanding the environment—internally, locally and nationally;
3. Understanding the challenges and opportunities based on the environmental assessment;
4. Setting direction for the organization, using the mission, vision and values as the guide; and
5. Prioritizing strategies and objectives, and handing off the plan to leadership.



Hospitals and health systems that commit to a regular, comprehensive CHNA use the process as a launching point to better fulfill the organization's community-focused mission.

5. Failure to Support the Medical Staff

Once the strategic plan is complete, the board's role is to motivate and support leadership implementation and track progress, not micromanage the implementation details.

4. Failure to Understand Community Needs

Improving the health of the community is the driving mission for most, if not all, hospitals and health systems. Meeting community health needs starts with first understanding what those needs are. Conducting a comprehensive community health needs assessment (CHNA):

- Provides a "snapshot" of the community's health and needs.
- Allows the board to assess where and how the hospital should direct its attention, set priorities and allocate resources.
- Is an opportunity to strengthen community relations and build community partnerships.
- Fulfills the IRS requirement that not-for-profit hospitals regularly conduct a CHNA.

The board is responsible for credentialing and privileging, but the board's opportunity to build relationships with the medical staff is much broader. The hospital/medical staff relationship should be a trusting partnership, where both the medical staff and hospital work closely together to provide quality care for patients. The board is also responsible for setting the tone to support physicians at a time when provider burnout requires extra attention. Specific actions boards can take to support physicians include:

- Making a clear commitment to support the physical and mental health needs of physicians and other providers.
- Working with the medical staff to identify and implement concrete actions to make the hospital a more productive, efficient environment.
- Including physicians in various stages of strategic planning.
- Allowing opportunities for the medical staff to share challenges with the board directly.
- Responding to physician input about quality of care and opportunities for improvement.

10 Board Leadership Hazards: Failure to...

- Fulfill the board's fiduciary responsibility
- Keep quality front and center
- Plan for the future
- Understand community needs
- Support the medical staff
- Plan for tomorrow's workforce
- Engage in robust dialogue
- Keep conflict out of the boardroom
- Engage in continuous knowledge growth
- Hold the board accountable

6. Failure to Plan for Tomorrow's Workforce

Hospitals must be well-prepared for increasing service demands and changes in health care expectations while also experiencing burnout and shortages in key areas, including physicians, nurses and allied health professionals. Creating a strong and resilient organization requires boards to:

- Prioritize employee engagement.
- Invest in leadership development, from front-line supervisors to the highest levels of leadership.
- Invest in technology that improves the patient experience and strengthens employee retention.

- Seek opportunities for providers to practice at the top of their license.
- Embrace strong employee communication and organizational transparency.

7. Failure to Engage in Robust Dialogue

At a minimum, boards must understand and fulfill their fiduciary responsibilities. But for boards to be impactful and make change they must challenge assumptions, using continual flows of information to ask questions like “what could that mean for our hospital?” and “what could or should we do now to be prepared?”

Visionary, forward-thinking boards do not happen by chance. They build on the sound foundation of their missions, a good understanding of community health care needs and the bigger perspective of how health care is evolving. They ask penetrating questions and engage in vibrant conversations to help board members identify and evaluate new and different strategies, overcome challenges and encourage calculated risk-taking.

8. Failure to Keep Conflict Out of the Boardroom

A conflict of interest exists when a board member, senior leader, or employee has a personal or business interest that may be in conflict with the interests of the hospital or health system. The challenge is that board members are often affiliated with many business, social, charitable and religious organizations in the

community. Conflicts of interest can be complicated, and are almost always unintentional. Boards can keep conflict out of the boardroom by:

- Maintaining a written conflict of interest policy that is reviewed by the board annually.
- Requiring board members and senior leaders to annually disclose potential conflicts of interest.
- Encouraging self-monitoring, where board members are transparent and identify when they should remove themselves from a conversation or vote.
- Documenting all real or potential conflicts and how they were addressed.

Boards should also ensure the recruitment and selection of new board members align with the organization’s conflict of interest policies, and that candidates are willing to be candid about potential conflicts.

9. Failure to Engage in Continuous Knowledge Growth

Governance education is a continual process, not an end result. The end result is greater knowledge, understanding and heightened leadership intelligence that ensures trustees are fully-prepared to engage and make evidence-based vs. “gut”-based decisions.



Boards that are committed to continuous education typically define the most critical areas for board education and develop a 12-month curriculum using a combination of external resources and leveraging existing knowledge and expertise within the organization’s board and leadership team.

10. Failure to Hold the Board Accountable

A governance practices and performance assessment is an organized evaluation of board members’ satisfaction with all aspects of board performance in fulfilling the board’s governance responsibilities. Governance assessments are typically an online survey that every board member completes, providing self-ratings of board, committee and individual performance.

Successful assessments enable boards to identify “governance gaps,” or areas in which boards have the greatest potential for improvement. Boards can then address the gaps through a combination of targeted education and recruitment of future trustees.