PRESBYTERIAN HEALTHCARE SERVICES
COMMITMENT TO HEALTH EQUITY

2021

CONTENTS

ACKNOWLEDGEMENTS

Special thanks to everyone who contributed to the advancement of health equity at Presbyterian Healthcare Services and this report, especially the members of the Health Equity Committee. The work of advancing health equity and combating systemic racism and other forms of oppression would not be where it is today without the individual contributions of everyone involved in the work and the collective results thereof.

EXECUTIVE SUMMARY

As a healthcare organization that has served New Mexicans for 114 years, we are committed to helping every member of our community have opportunities to thrive.

Health equity is realized when every individual has fair health outcomes and the opportunity to achieve their full potential. Health equity serves as the foundation to Presbyterian's approach to improving the health of the communities we serve. Unfortunately, we continue to see health inequities in communities across the country related to access to care, quality of life, and rates of disease. The COVID-19 pandemic has only highlighted many of these inequities.

Presbyterian Healthcare Services exists to improve the health of the patients, members and communities we serve. We are a locally owned and operated not-for-profit healthcare system known nationally for our extensive experience in integrated healthcare delivery and financing.

We have grown from a small tuberculosis sanatorium founded in 1908 to a system of nine hospitals, a multi-specialty medical group with more than 1,200 providers and a statewide health plan with over 600,000 members. Collectively, Presbyterian serves nearly half of all New Mexicans with healthcare or coverage.

At Presbyterian, we have institutionalized our commitment and efforts to improve health equity. We have adopted the Institute for Healthcare Improvement (IHI) health equity framework to help us achieve higher levels of health equity for our patients, members and community. Strategies and accountability for this work cross departments and disciplines.

For example, we do extensive work in our communities to understand which assets to build on, how to strengthen what is working, and how to fill gaps in care. We have invested in and created programs to address issues that communities across our state tell us are most important to them, such as screening all our patients for social needs including food insecurity, housing, and safety; and then connecting them to resources. We provide our patients who are food insecure with access to our Food Farmacy, which provides a weekly supply of healthy food. We have community health workers and peer support specialists in our health plan, hospitals and clinics who support people with their social and behavioral health needs. We are working internally to train employees, including clinical staff, to reduce implicit bias in the areas of race, gender identity and sexual orientation, disability and more.

The work we do in all these areas also applies to our COVID-19 response. We are intentionally applying this health equity approach to all COVID education, testing, treatment and vaccinations.

Key successes for 2021

In 2021, we made significant and important progress as a health system, which expanded upon the groundwork we started in 2020, including building a critical mass of leaders engaged in laying the foundation for this work. Leaders and key stakeholders completed an assessment provided by the IHI, and we used that baseline to focus our work for 2021.

One of the first activities identified was completing a community-facing report that illustrated our assessment findings, our aspirations for the work and how it all fit into the IHI health equity framework, with clear steps in 2021 we needed to take to advance health equity. Presbyterian accomplished our goals while providing a comprehensive response to COVID-19 that included intentional work to ensure equity.

In 2021, we:

- Completed a community-facing health equity report.
- Developed and utilized a health equity data dashboard.
- Improved collection of Race, Ethnicity and Language (REaL), and Sexual Orientation and Gender Identity (SOGI) data.
- Implemented universal screening for patients' social needs and referral to resources.
- Continued community collaborations and investments.
- Implemented a COVID-19 response with equity at the core.

This report highlights work done in 2021, building on our previous efforts to make health equity a strategic priority. Through this process we have identified next steps for action in 2022, which are currently underway.

Key activities in 2022

- Address the social needs of our patients and members through universal screening, resource referral and navigation.
- Develop and implement a health equity curriculum for workforce and provider networks.
- Utilize and strengthen health equity analytics to increase understanding of patient outcomes, guide improvements in care and measure outcomes.
- Strengthen engagement with communities, patients, members and workforce regarding health equity.
- Improve healthcare services for patients and members who experience inequities in outcomes.
- Invest in our communities to improve structural and social drivers of health inequities.

OVERVIEW OF PRESBYTERIAN

Presbyterian Healthcare Services (Presbyterian) exists to improve the health of the patients, members and communities we serve. Presbyterian is an integrated statewide healthcare system including a health plan, nine acute care hospitals, 36 health clinics, three ambulance services, home healthcare and a large multi-specialty medical group. Presbyterian is the largest Medicare provider in the state and the largest private employer with more than 1,200 providers and 13,000 employees. Presbyterian provides services to nearly half of all New Mexicans.

Health Equity Overview and Approach

According to the Robert Wood Johnson Foundation, health equity means that "everyone has a fair and just opportunity to be as healthy as possible." This means removing obstacles that contribute to health inequity, such as poverty and discrimination. It also means addressing the consequences including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments and healthcare.

Health equity is essential to Presbyterian's purpose to improve the health of the patients, members, and communities we serve.

In 2019, Presbyterian embarked on a formalized journey to address health equity in our communities and for our patients and members. We adopted a framework developed by the Institute for Healthcare Improvement (IHI) for healthcare organizations to achieve health equity, which identifies five practices:

- Make health equity a strategic priority.
- Develop structure and processes to support health equity work.
- Deploy specific strategies to address the multiple determinants of health on which healthcare organizations can have a direct impact.
- Eliminate racism and other forms of oppression.
- Develop partnerships with community organizations.

To achieve health equity, we seek to understand how our patients experience health inequities due to structural and social determinants of health (SDOH). We strive to remove barriers for individuals as we simultaneously seek big-picture, systemic change. To learn more about our approach and the specific domains in which we work, read our initial Health Equity Report. For a list of definitions, see Appendix A.

Community-Facing Health Equity Report

In 2021, Presbyterian completed its first community-facing health equity report. In the report, we examined the makeup of our community, illustrating the importance of implementing a system-wide health equity framework to address inequities our patients, members, and communities may face. We identified areas of need, defined the framework, and reported on findings of a leadership pulse provided by the IHI that helped us estimate what areas of the framework leaders felt we were excelling in and what areas leaders thought we could do better in. The full report can be found here.

Health Equity Data Dashboard

Presbyterian uses an integrated approach to collate social determinants of health (SDOH) information for our patients and members. Patient and member self-reported data from Presbyterian's electronic medical records and care management platform is combined with community and household data from external sources such as the Area Deprivation Index. This information is used to identify whether race, ethnicity, language, sexual orientation and gender identity factors are correlated with the quality of care or health outcomes prioritized by Presbyterian's Health Equity Committee. If so, this would indicate structural and social drivers for Presbyterian to intervene.

2021 Health Equity Insights

Table 1 below highlights insights from Presbyterian's Health Equity Dashboard, which was developed to evaluate outcomes based on different demographic factors. This information is limited to Presbyterian's patients and members who received care at Presbyterian facilities. Advanced analytics were used to assess the impact of individual factors (e.g., age, race, etc.) on quality of care and health outcomes. Significant difference in health outcomes among groups, indicated by blue below, can be positive or negative toward an outcome, meaning these groups could have significantly better or worse health outcomes to the reference group.

Table 1: Social drivers correlated with quality of care and health outcomes for Presbyterian patients and members who received care at Presbyterian facilities in 2021.

Measure	Factor							
	Age	Race	Ethnicity	Language	Gender Identity	Sexual Orientation	County	Area Deprivation Index
Perinatal Care	Yes	Yes	No	No	No	Yes	No	Yes
Breast Cancer Screenings	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Comprehensive Diabetes Care	Yes	Yes	Yes	No	Yes	No	Yes	Yes
Childhood Immunization Status	Yes	Yes	No	No	No	No	Yes	No
Colorectal Cancer Screening	Yes	Yes	No	No	No	No	Yes	No
Al Cause Readmissions	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Pneumonia Readmissions	No	No	No	No	Yes	No	No	Yes
Severe Sepsis Mortality	Yes	No	No	No	No	Yes	No	No
Septic Shock Mortality	Yes	No	No	No	Yes	No	No	No
Opioid Stewardship	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Data Source: Epic Clarity, Inovalon
Time Period: Calendar year 2021
Area Deprivation Index (ADI) definition: ADI is a measure that allows for ranking of neighborhoods by socioeconomic disadvantage in a region of interest and includes factors for the theoretical domains of income, education, employment and housing quality. More information is available on the Center for Health Disparities Research website.

For example, age, race, sexual orientation and area deprivation index are social factors that influence patients' and members' ability to access postpartum and prenatal care. At this point, further analysis is needed to understand if these factors made those groups significantly more likely to access or significantly less likely to access postpartum and prenatal care than the reference groups. And additional assessment will be required to identify causal factors and strategies to address inequities.

These initial findings allow leaders to highlight potential areas to conduct a deeper dive to support their ongoing quality improvement efforts, with a focus toward addressing groups with significantly worse outcomes and the root causes of those inequities.

We improved methods of collection for Race, Ethnicity and Language (REaL) and Sexual Orientation and Gender Identity (SOGI) data

Currently many regulatory, accreditation and contractual entities require some form of demographic data capture. Non-required data capture and best practices are already in place in different parts of the organization. There is opportunity to strengthen race, ethnicity, language, sexual orientation and gender identity data capture across Presbyterian Healthcare Services. In 2021 we set a goal to improve collection of this data for all patients and members.

Established literature, best practices and our own internal analysis reveal that this information is crucial to our organization to provide equitable healthcare that does not differ in quality because of a patient or member's race, ethnicity, language, gender identity or sexual orientation. We need accurate information provided and verified by the individual in order to provide language interpretation services, appropriate patient education materials and necessary resources; and to track data to improve patient care quality.

Steps taken include reviewing current data capture and quality, aligning nomenclature and field definitions, and developing new capture and reconciliation processes. One new capture initiative was allowing patients to review and electively update their own personal information in their MyChart patient portal. The fields available for review and update include preferred first name, legal sex, gender identity, sex assigned at birth, sexual orientation, race, ethnicity, language and religion.

We implemented universal screening for patients' social needs and referral to resources

We started piloting a social needs screening tool in 2018 as part of our participation in the Accountable Health Communities cooperative agreement funded by the Centers for Medicare & Medicaid Innovation in conjunction with several organizations nationwide. The social needs screening, which was conducted only among Medicaid and Medicare beneficiaries, illustrated the breadth of needs among a subset of our patient population. In early 2021, we began to expand and test universal screening at a few clinics connected to Socorro General Hospital and a pediatric and adult primary care clinic in Rio Rancho. This pilot not only identified a large number of needs among patients, but also identified process challenges to account for upon system-wide expansion.

In 2021, social needs screening was implemented across the entire Presbyterian Delivery System, which comprises nine hospitals and more than 1,100 physicians and advanced practice clinicians in 50 specialties at more than 100 clinics throughout New Mexico. See figure below for the latest breakdown of social needs screening.

Addressing Social Determinants of Health
through Universal Screening for Social Needs

SOCIAL NEEDS IDENTIFIED

Share of social needs identified through universal screening at all Presbyterian sites, May 2021—Apr 2022 (n=84,750 needs identified; 775,893 screenings completed)
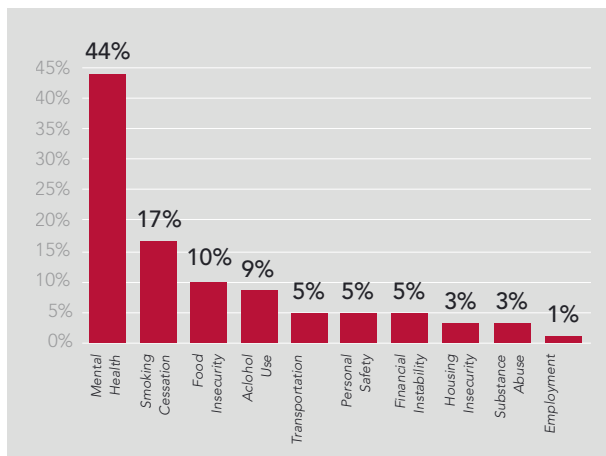
ABOUT

To truly improve the health of our patients and communities, health systems must also address the non-medical social needs of those we serve. Addressing social needs is an important way to achieve health equity.

In Q2 of 2021 Presbyterian launched universal screening for social needs. Patients are now screened at least every six months for social needs in the areas of: **Mental Health, Smoking Cessation, Alcohol Use, Food Insecurity, Personal Safety, Transportation, Financial Instability, Housing Insecurity, and Substance Use.**

Those who screen positive for social needs receive a tailored, vetted list of community resources that is automatically generated and attached to their After-Visit Summary paperwork. This list can also be accessed by patients through their MyChart portal.

RESULTS (May 2021 - April 2022)

More than **775,000** screenings initiated	Over **84,000** social needs identified	Resource lists provided to **100%** patients with social needs

Each patient who screens positive for any social need receives a tailored resource list specific to their geography and needs and is then added to their after-visit summary. Providers have reported that this can help them know their patients better and have better conversations to provide more help, when and where it is needed most.

Understanding patients' social needs enables us to effectively address determinants of health, ranging from physical environment to helping to improve the socioeconomic status of each of our patients, members and our community. This helps us battle inequities and round out our approach to improving the health of our patients, members and the community.

> "I had a mom bring in her two-month-old for a well-child check. She answered the social needs screening questions and screened positive for food insecurity. It turns out she had lost her job in the pandemic and was having to ask friends and family for food. She was in tears when she received the after-visit summary with resources, and it allowed us to have a conversation. She has been back since then. She has a new job and things are going well. She told me that we helped her through a rough patch. This is exactly what we need to be doing. We have helped others with food insecurity, domestic violence, housing insecurity. We really can make a difference!" – *PHS pediatric provider*

Continued community collaborations and investments. PHS Communities' Health Priorities

Every three years, Presbyterian conducts community health assessments (CHA) and develops implementation plans to identify our communities' most pressing health needs. In 2021 our Community Health Priorities were: Behavioral Health, Social Determinants of Health, Access to Care, and Healthy Eating and Active Living. Read more about the programs, community partners and investments in our communities in the 2021 Community Health Impact Reports.

In 2021 we began the 2023-2025 Community Health Assessment. Presbyterian continued to take intentional steps to include health equity as a key strategic priority in both conducting our health assessments and developing implementation plans.

Epidemiological data pulled for the assessments, which established the foundation for identifying needs in the Community Health Assessments, were stratified among key demographic characteristics to allow for analysis of inequities in top health need areas. Additionally, Presbyterian made an intentional effort to engage communities directly rather than relying on community proxies, which included the implementation of a new community survey to increase opportunities for people to participate.

Conversations from our forums revealed potential populations who are affected most by health inequities, including Native Americans, Hispanic/Latinx populations (conducted in Spanish), the LGBTQ+ community, people using substances, elderly people and youth.

Collaborations with other organizations such as University of New Mexico Hospital, CHRISTUS St. Vincent Hospital, New Mexico Department of Health, and local health councils allows us to share insights and widen our reach of often overlooked populations while being mindful of assessment fatigue. This approach is ideal to lessen the burden we place on our communities to provide their valuable input.

We implemented a COVID-19 response with equity at the core
Vaccine Equity and Covid-19 Community Response

Ensuring equity is critical to Presbyterian's approach to the COVID-19 response effort in New Mexico. This focus meant making sure that diverse communities across the state had access to testing, treatment and vaccines. As we move forward with more vaccination and education strategies, we continue to ensure culturally appropriate education and materials in multiple languages and formats. All partnership efforts are designed collaboratively and aim to improve health equity, reduce disparities and underscore cultural competence and cultural humility.

As part of this effort, Presbyterian worked with community partners through a Centers for Disease Control REACH cooperative agreement focused on COVID-19 and flu vaccination in Hispanic/Latinx, Native American and African American communities in 14 New Mexico counties. Community partners like Enlace Comunitario, Central New Mexico Community College and the NAACP hosted mobile vaccination events with Presbyterian providing the vaccine; 77 community-based clinics provided 5,586 vaccines in 2021. Other partnerships include places of worship, food pantries, libraries, community centers and community-based events.

Presbyterian clinicians like Dr. Fernando Bayardo at Presbyterian Española Hospital also served as trusted voices to help answer vaccination questions. In June 2021, Presbyterian began a series of listening sessions with New Mexicans who were not yet vaccinated to understand more about reasons for hesitancy. Eleven listening sessions were held from June 2021 through early April 2022. Presbyterian shared the summaries of each session with the CDC and NMDOH. As a result, messaging and imagery were modified based on what participants shared in the listening sessions along with media chosen to reach each priority population, like increased radio advertising.

As vaccines became more readily available and the risk of flu infections increased due to the removal of mandatory COVID-19 precautions and the start of a new flu season, Presbyterian hosted joint COVID-19 and flu vaccine events, including family vaccine clinics at the Albuquerque Bio-Park, which saw unprecedented turnout due to the partnerships and incentives (free zoo entry and food).

New Mexico Department of Health data show that Native American New Mexicans have been disproportionately affected by COVID-19. Native Americans have the highest age-adjusted COVID-19 case rate (35,021 per 100,000 population) yet have the fourth lowest population count in the state. Hispanic/Latinx New Mexicans also have a high age-adjusted COVID-19 case count compared to other racial and ethnic groups.

Table 2: Cumulative age-adjusted case rate per 100,000 population by race/ethnicity.

Race/Ethnicity	COVID-19 Case rate per 100,000
American Indian or Alaska Native	35,021
Hispanic or Latino	19,650
Asian or Pacific Islander	14,426
White	14,246
Black or African American	13,051

Source: State_Report_Demographics_04.11.22.pdf (nmhealth.org) (current as of 4/11/22)

When compared to other racial groups, fewer Black and Hispanic/Latinx New Mexicans received the COVID-19 vaccine. This applies to both the percent of people with at least one dose and the percent of people who completed the primary series (two doses for Pfizer and Moderna, one dose for Johnson & Johnson). Conversely, in large part due to the Indian Health Service's effective vaccine rollout programs, nearly all Native Americans in New Mexico who were eligible for a vaccine were inoculated.

Table 3: Vaccine Administered Per Age Group.

| Race/Ethnicity	Percent With At Least One Dose	Percent With Primary Series Completed
American Indian or Alaska Native	99.00%	96.70%
Asian or Pacific Islander	99.00%	97.70%
Black or African-American	66.50%	58.00%
Hispanic or Latino	61.20%	54.50%
White	79.40%	71.70%

Source: NMDOH - Public Dashboard (current as of 4/11/22)

Utilizing predictive analytics, Presbyterian Health Plan (PHP) refined their outreach efforts to Medicare and Medicaid members who had COVID-19 infection and were also potentially at risk of going without food during their isolation period. The outreach process included screening for food insecurity, an assessment of their ability to store frozen meals safely (if members didn't have enough freezer space, more frequent, smaller shipments were sent), and enrolling the member and their caregiver to receive free meals. PHP partnered with Meals on Wheels of America to provide frozen, drop-shipped meals to a member's current place of residence or location, including those isolating in hotels during their illness. In 2021, 3,842 meals were provided to PHP members and their caregivers to help them stay well, isolated, and nourished during their COVID-19 illness. Additionally, the CHW team delivered food boxes and connected commercial members to community food resources.

Health Equity Organizational Assessment

To assess readiness and socialize the framework, Presbyterian once again administered the IHI's Health Equity Assessment to identify progress made from our 2020 baseline for perceptions of health equity among Senior Leaders and Health Equity Committee members. This survey has now been administered yearly in 2020 and 2021 to help identify shifts in perceptions. The assessment covered the five IHI domains:

- Make Health Equity a Strategic Priority
- Build Infrastructure to Support Health Equity
- Address the Multiple Determinants of Health
- Eliminate Racism and Other Forms of Oppression
- Partner with the Community to Improve Health Equity
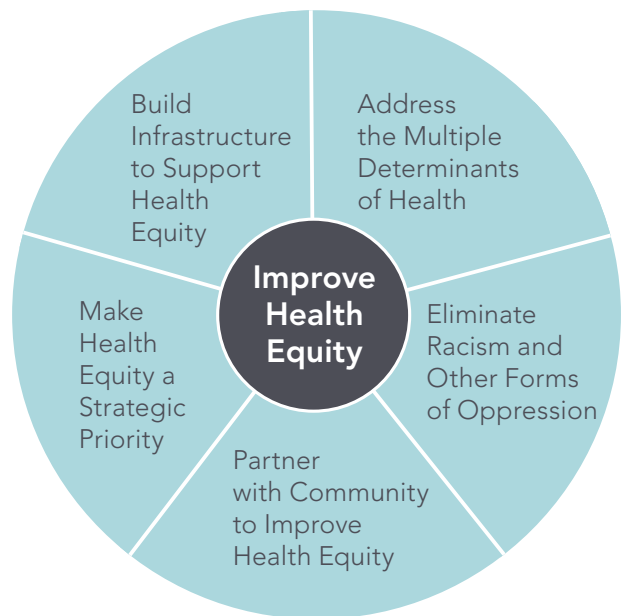
Looking Ahead: Plans for 2022

2020 was a starting point and foundation for continuing work and implementation of our Health Equity plans. In 2021, strategic milestones included creation and utilization of equity data dashboards for patients and the workforce, improvement of perinatal health equity, organizational inclusion and diversity training (including implicit bias training), and universal screening of patients for health-related social needs and other domains related to social determinants of health. We were successful in reaching our 2021 goals.

In 2022, we will focus on bringing the voice of those directly impacted by the inequities by hosting prioritized focus groups, key informant interviews, and launching dynamic surveying for the prenatal and postnatal population.

Presbyterian continues to support the adoption of universal screening by working with the clinical units to improve workflow efficiencies, providing various educational tools to support success and by deploying a process measure dashboard to help clinical units monitor adoption rates.

In 2022 Presbyterian will launch Presbyterian Inclusion Networks to allow staff to engage conversations about racism and other forms of oppression. These inclusion networks will focus on supporting organizational changes to dismantle racism.

Presbyterian will focus on a multi-faceted approach to share and communicate on all activities related to health equity. This will include utilizing multiple communication platforms, deploying a training website, and presenting at various board meetings, huddles and steering committees to get the message out.

A team devoted to the Enterprise health equity strategy will be deployed. The organization will focus on defining scope of work and role within the organization. This team will be able to partner with the key stakeholders to support the health equity regulatory requirements.

Presbyterian continues to seek to diversify funding strategies to support equity, including continuing our partnership with other local health systems, the New Mexico government (Human Services Department and Department of Health), the Centers for Disease Control and Prevention, and community groups utilizing federal funding to center health equity at the heart of COVID-19 vaccination and response campaigns.

Presbyterian continues to strengthen our institutional commitment and accountability to improving health equity. This includes improving the quality and use of data, maintaining equity-related milestones and measures at the highest level of organizational strategy each year, hard-wiring equity work across various initiatives and departments, and strengthening our transparency and reporting internally, with our community-based governance and advisory bodies, and the public.

APPENDIX A: DEFINITIONS

Term	Definition
Diversity	The practice of recognizing and respecting the unique qualities and attributes of everyone, including or involving people from a range of different social and ethnic backgrounds, different genders, sexual orientations, ways of thinking, etc.
Equity	The term "equity" refers to fairness and justice and is distinguished from equality: Whereas equality means providing the same to all, equity means recognizing that we do not all start from the same place and must acknowledge and make adjustments to imbalances. The process is ongoing, requiring us to identify and overcome intentional and unintentional barriers arising from bias or systemic structures.[1]
Health	A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.[2] *Some people have adapted this definition to also include spiritual well- being.*
Health Equity	Everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty and discrimination and their consequences, including powerlessness, and the lack of access to gainful employment with fair pay, quality education and housing, safe environments, and health care.[4]
Health disparity	The difference in health outcomes between groups within a population. Health disparity simply denotes differences, whether unjust or not.
Health inequity	Differences in health outcomes between groups within a population that are systematic, avoidable, and unjust.[4]
Health-related social needs	Individual level needs that are manifestations of the broader social influences and factors of the SDOH.
Implicit Bias	The bias in judgment and/or behavior that results from subtle cognitive processes (attitudes and stereotypes) that often operate at a level below conscious awareness and without intentional control.[4]
Inclusion	The practice or policy of providing equitable and equal access to opportunities and resources for people who might otherwise be excluded or marginalized, such as those who have physical or mental disabilities or are members of underrepresented populations. Inclusion is achieved when all individuals feel respected, accepted, and valued for their unique qualities and attributes.[4]

[1] National Association of Colleges and Employers. Retrieved from: https://www.naceweb.org/about-us/equity-definition/

[2] Saha, S., Loehrer, S., Cleary-Fisherman, M., Johnson, K., Chenard, R., Gunderson, G., Goldberg. R., Little, J., Resnick, J., Cutts, T., and Barnett K. Pathways To Population Health: An Invitation To Health Care Change Agents. Boston: 100 Million Healthier Lives, convened by the Institute for Healthcare Improvement; 2017. (Available at https://www.ihi.org/Topics/Population-Health/Pages/Pathways-to-Population-Health.aspx.)

[3] Braverman P, Arkin E, Orleans T, Proctor D, Plough A. What Is Health Equity? And What Difference Does a Definition Make? Princeton, NJ: Robert Wood Johnson Foundation, 2017.

[4] Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. Achieving Health Equity: A Guide for Health Care Organizations. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016. (Available at ihi.org)

Term	Definition
Institutional (or systemic institutionalized) racism	The differential access to the goods, services, and opportunities of a society by race.[4]
Justice	Justice is the application of fairness to individuals in population groups or communities; specifically, it is "concerned with the equitable distribution of benefits and burdens to individuals in social institutions, and how the rights of various individuals are realized."[5]
Oppression	Combination of prejudice and institutional power that creates a system that regularly and severely discriminates against some groups and benefits other groups.[6]
Social determinants of health (SDOH)	The conditions in which people are born, grow, live, work, and age. They may enhance or impede the ability of individuals to attain their desired level of health.[2]

Additional sources: The Centre for Global Inclusion.
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[6] National Museum of African American History & Culture. Social Identities and Systems of Oppression. Retrieved on 6/8/2021 from https://nmaahc.si.edu/learn/talking-about-race/topics/social-identities-and-systems-oppression