A THOUGHT LEADERSHIP ROUNDTABLE

# Role of Digital Transformation in Health Equity

CHIME DIGITAL HEALTH LEADERS

DIVURGENT

Divurgent hosted a roundtable of tech leaders from hospitals and health systems to discuss DEI in healthcare. CHIME President and CEO Russell Branzell moderated the discussion between CHIME members.

Participating CHIME members:

**Karen Marhefka**
DHA, Deputy CMIO
RWJBarnabas

**Tim Skeen**
EVP/ECIO
Sentara

**Deb Muro**
CIO
El Camino Health

**SVP/CIO**
large pediatric hospital in the Southwest

Joining the discussion from Divurgent were:

**Sarah Brandt**
VP, Delivery

**Hannah Ellerbee**
Chief Customer Officer

**Ed Marx**
CEO

**Shane Danaher**
COO

divurgent.com

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>
> - SVP/CIO

## INTRODUCTION

Healthcare leaders increasingly talk about focusing more on patient experiences and outcomes. This movement is ripe for improving health equity, making sure everyone has a fair opportunity to get high-quality care. Regulators and policymakers have also begun to push the issue. The Centers for Medicare and Medicaid Services (CMS) released a five-point framework for health equity in 2022. The Office of the National Coordinator for Health Information Technology's (ONC) "health equity by design" approach requires that equitable access, treatment, and outcomes be baked into designing projects, policies, and technologies. The agency also has decided that equity considerations and related data capture be a part of its IT certification program.

As society becomes more dependent on devices and connectivity for many aspects of living, technology is often a top consideration for finding solutions to the equity equation. While healthcare is different in many ways from industries like retail, banking, media, and entertainment, it is still a market where people need and seek products and services that are paid for out-of-pocket, or via reimbursement, by a third party. If tech is helping address DEI in those other industries, it can certainly do similarly for healthcare.

## UNDERSTANDING HEALTH EQUITY

Health equity. Techquity. Social determinants of health (SDOH). Health disparities. The list of terms buzzes around the healthcare industry, leaving many stakeholders unsure about what the issue really is.

Buzzwords do not always indicate awareness, cautioned the SVP/CIO of a large pediatric hospital, and the overuse of the terminology without the underlying knowledge and connection to the affected populations can leave you out of touch. "You can talk about remote monitoring and social services, but these are just solutions," said the SVP/CIO. "Without an intimacy with affected communities, we aren't going to strike the right balance."

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## UNDERSTANDING HEALTH EQUITY CONTINUED

Healthcare is complex, which creates different levels of health equity, added Deb Muro, CIO at El Camino Health. "Every patient should have an advocate to help navigate this horrifically complex journey we've created that really doesn't meet anyone's needs at any level," she stated. "People on all economic levels can't get the care they need. We have a real opportunity, a real somber responsibility."

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> CIO
> El Camino Health

While physical and digital access to care, services, tools, and medications rise to the top of most discussions on health equity and the role of technology, an overlooked aspect is literacy. "Tech literacy is a part of SDOH and something we consider when trying to digitize," noted Tim Skeen, EVP and ECIO at Sentara.

In fact, he suggested terms like techquity—the strategic development and deployment of technology to advance health equity by carefully considering issues of access, ease of uptake, and sustained engagement with digital solutions—may rely on assumptions that people have tech literacy and access to leverage capabilities.

Each segment of the population has a different level of understanding tech, Muro added. "I get a lot of push back that 70-year-olds don't use technology," she said. "I find that to be inaccurate. But we need to understand each population segment and the challenges for their age, stage, and economic status."

The cacophony of terms and emerging mandates can leave health system staff, who are charged with implementing new directives, unsure how to proceed. Citing a potential loss of objectivity among the buzzwords, Karen Marhefka, Deputy CMIO at RWJBarnabas, noted the rising pressure on teams to be more inclusive in thinking and strategy can backfire. "I have a large team of people who are afraid to be objective," she reported. "They are afraid they will say the wrong thing, build the wrong thing, or not consider everything they should."

## TECH VS OPERATIONS

The educational challenge to equity does not stop at tech literacy and staff awareness. Many of the roundtable participants noted the disconnect between tech and operational leaders.

CIOs may find themselves spending more time on educating leaders about equity than on finding solutions to address the problem. "It is not a technology challenge anymore; it is an operating model challenge," stated the CIO of a large pediatric hospital, adding it is important that those who drive the operations are not out of touch.

A lot of time has been spent on applying tech against an archaic operational model that hasn't been optimized, analyzed, or reengineered. "Tech isn't the problem; we've had the tools for years, and it can do all the things we want," Skeen said, noting the issue is more about changing the operational model and getting physicians to be more open to a new model. "Value-based care is the only sustainable way to solve some of this."

## TECH VS OPERATIONS CONTINUED

Other CIOs present agreed. “We have tech coming out of our ears,” Marhefka said.

Tech leaders are at a point, added the CIO of a large pediatric hospital, where there is no more tech left to buy. She explained technology and data come together to produce an output on which someone must decide. “If we don’t have the right people on the other side making those decisions, understanding it, or analyzing it, there is no more we can buy to make up for that lapse,” the CIO stated, again emphasizingthe need to educate operational leaders to spark different ways of thinking and planning.

For instance, many systems may want to implement open scheduling, but every market is not ready for that, according to the CIO of a large pediatric hospital. “Understand your populations that are willing to schedule online versus those that are not. Make it 4th or 5th grade level education, and make sure it’s not all in English — Spanish is the top language spoken in Texas, with Vietnamese second, and English third.”

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Muro pointed out the brick-and-mortar model of healthcare is outdated. “We have to get away from people coming to us for care; we need to go to the patient,” she stressed. Building more virtual care, remote monitoring, and chatbots is the better way to connect with today’s patients, she argued. “If you are going to build a hospital, it should be done smartly,” she advised, explaining rooms should be designed for multiple or flexible use. “It takes so much of my staff’s time to convert units in Epic from an ICU room to a med surge room, for example—right now, we are having capacity issues, so a baby unit one day might be a telemetry unit the next day.”

Deciding on care locations is tricky business, and facilities often are placed in the areas where the populations can afford them rather than in areas where populations have the most need for care. This economic driver is a huge influence on health equity.

“If you were driving only outcomes, not revenues, you would never put a new facility in northwest quarter of Atlanta where there are already 17 hospitals that can provide care,” said moderator Russ Branzell, president and CEO of CHIME, who said the one hospital downtown that is closing due to economics is where all the people go for care from the southeast quarter, an area of economic need. “The very basics of economics right now creates the disparity.”

## THE ECONOMIC HURDLE

Marhefka noted New Jersey is a very diverse state, with affluent sections, poor regions, and several areas of mixed socioeconomic situations. “We are a large health system that is pretty diversified throughout the state,” she reported. “But as we continue to push into more economically challenging areas of the state, we are not having a great fiscal result and may not for a couple of years.” There is some shock among the system leadership, according to Marhefka. “An organization can absolutely have that vision, that strategic goal to be everything to everyone in their community, region or state,

but they have to be aware of the reality of what happens to the fiscal base."

The mission of one large, non-profit pediatric hospital in the Southwest is to take care of all kids regardless of insurance status, according to the hospital's CIO. "We too, this year, are seeing significant losses on our financial statement. Fortunately, we have a balanced portfolio, where we have a health plan that is contributing 50% of revenues." However, when the conversations among leaders become focused on economics, they start forgetting about the mission, the CIO noted.

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"We should be able to take care of everyone, and it shouldn't matter who they are," she reasoned. "It should matter that the financial statements are balanced appropriately, that there is a balanced portfolio. But somewhere in the middle, something is out of touch. We have a significant negative margin budget this year, which we've never had before."

On the flipside, El Camino Health is not struggling financially thanks largely to servicing wealthy Silicon Valley. "If we took care of all Medicare patients, we wouldn't survive," she predicted, noting the system's reliance on commercial insurance—Google and other tech industry employer plans. "The model doesn't work if we had all Medicare insurance, due to the operational cost factor."

How tech interacts with board-level leaders is a huge factor in addressing health equity and any impact from technology.
Marhefka noted that tech conversations with the board often don't go deeper than directives to fix the website. She said change is very hard, especially in large health systems.

"What I've learned in the last 2.5 years of our Epic implementation being in waves is that we have a standard product across the organization, no customization, but how we implement it based on each region is different," she noted adding the "how" is different because the appetite for technology is different in every one of those regions.

She explained there are different layers of how much patients and providers can embrace tech equity, and it is complicated and costly for organizations to understand and plan for these differences. "How vendors like Divurgent can be unique in their approach is to recognize that, especially for large health systems, having one strategic tech equity or goal is probably never going to be sustainable," she advised.

An important economic conversation to have with health system board members may be about tech debt, according to the CIO of a large, non-profit pediatric hospital. "Having too much of it but not leveraging it, and buying more and more [tech]," the CIO explained, adding when everyone in a negative financial condition is scrambling to drive revenue, they can lose sight of the strategic vision and fail to leverage the tech equity they already have. This IT leader suggested vendors could help educate hospital and health system operating leaders to overcome the deficit in their understanding

of tech equity and tech debt.

## PATHWAYS TO HEALTH EQUITY

To tackle health equity requires an understanding of the differences between communities—affordability, access, knowledge and other determinants. To consider tech as a solution, it is important that health systems know all the tech they already have and how to leverage that tech relative to the differences between patient communities. There is a stiff challenge to educating operational leaders in this way, and CIOs and vendors may have to unite to spark change in the way such leaders think and plan if there is to be quality care accessible to all.

There needs to be a solid foundation in place before equity can be truly addressed, Skeen advised, noting IT is often not even aware of all the tech solutions used across a health system.

"Technology is not the limiting factor," said Sarah Brandt, Vice President of Delivery at Divurgent, adding the key is recognizing the intersection of operational model, technology, and the workforce impact. "Too often, the workflow hasn't been fully thought through or optimized, and we haven't really shared back with staff what that looks like in their day to day—what challenges they're facing," she said. "Does the data really support the outcomes we are trying to drive?" She noted about 33% of global data is health data, and 80% of this isn't being used to inform different strategies and components.

Muro agreed, saying, "I'm hoping that measuring outcomes, what you are actually delivering, is going to help us close the health divide."

However, shifting the mindset from sick care to wellness and equity runs into a huge elephant: economics. "We are trying to force providers to think more value-based and to take risks," Skeen noted.

However, addressing underlying issues of health equity using technology is fundamentally easy to do, according to the CIO of a large pediatric hospital, who noted other industries have proven it can be done. "It's called gamification; that's what Amazon does," she said. "It comes down to income statement. It's a business decision."

Furthering the retail example, Brandt suggested patients should be considered consumers. "All these other industries have used the data to figure out what is driving the consumer," she explained, adding "consumer" doesn't have to be a dirty word in healthcare.

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A universal theme in the discussion was that the reimbursement model is broken. Single payer and universal care were common wish list items among roundtable participants, who acknowledged the current examples from other countries would need to be tweaked to be successful and improve health equity.

"Unless the government makes a big move, changing the whole risk pool would take years and years," Muro said. "Each one of us has to start moving the model forward to value-based care."

The CIO of a large pediatric hospital agreed one bite at a time is a plausible approach. "We tech leaders are now driving meaningful use 2.0, because we have fulfilled 1.0," this IT leader said, explaining 1.0 was digitalization, and 2.0 is an operational focus. "There has got to be an incentive to rebirth operational leaders in healthcare."

Muro reported incentives and penalties are working on the clinician side.

One bite of the health equity solution may be internet infrastructure. "When we took away 3G, we took away access to people who might not have the latest iPhone," said Hannah Ellerbee, Chief Customer Officer at Divurgent. "For people in rural areas who are often hours away from the nearest hospital, 3G can be life-changing."

Changing how critical access hospitals (CAHs) are defined in the United States is another bite to consider, according to Branzell. "If providers knew they could use CAHs as feeder hospitals and not lose a penny, they would all be investing in them," he said. "Today, you can't get a CAH in an urban area, but that's the access that is needed the most."

The good news is that tech leaders, as evidenced by those involved in this roundtable, are on the same page as far as leveraging existing tech and data, and working to shift the operational mindset. But with so many tech issues requiring attention, keeping the focus on health equity and how tech can deliver desired outcomes to all communities will be important to making progress, however incremental, on solutions.