

Health Equity in the U.S.

Industry Snapshot Report

July 2022



In Collaboration With



A part of the



A NOTE FROM THE BROADREACH GROUP
AND VANTAGE HEALTH TECHNOLOGIES CO-FOUNDER,

Dr. John Sargent



The World Health Organization defines health equity as a fundamental human right that “...is achieved when everyone can attain their full potential for health and well-being.”

The need for health equity is ideologically undisputed – everyone should have an equal opportunity to receive quality healthcare, regardless of their geography, race, gender or personal circumstances. In practice, this ideal is far from a reality. Health plans, providers, members, the media and the general population are putting a renewed focus on health equity in the United States.

My co-founding partner, Dr. Ernest Darkoh, and I started BroadReach Group with the vision of a world where access to good health enables people to flourish. When we met in medical school, we realized we were both passionate about improving access to healthcare for underserved populations. This shared passion is why, years later, we started BroadReach Group in 2003.

Dr. John Sargent
CO-FOUNDER, BROADREACH GROUP

Implicit in this focus are the many inequities that minority and underserved populations experience in access to care and, ultimately, health outcomes. Vantage Health Technologies — a BroadReach Group company — entered the U.S. payer and provider network in 2021. We’ve spent the last 18 months listening, learning and collaborating to better understand both the importance and challenges of health equity, and we’ve partnered with experts to suggest tangible solutions to address some of the underlying drivers of unequal access to quality healthcare in America. This paper not only synthesizes where payers and providers are on their health equity journeys, but it offers a roadmap to address these inequities and improve patient outcomes for everyone.



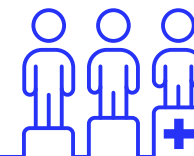
What is Health Equity?

“ The attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and other factors that affect access to care and health outcomes. ”

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

Health equity can only exist when everyone has an equal opportunity to live a healthy life. This ability is often determined by factors such as race and ethnicity, social standing, gender identity, religion, sexual orientation, disability and preferred language. Health inequities are caused by the uneven distribution of social determinants of health (SDOH), such as education, housing and the “built environment” (e.g. access to safe sidewalks, presence of public green spaces), access to transportation, employment opportunities, the law and the justice systems, health care and public health systems. [\[source\]](#)

These inequities cost the U.S. healthcare system at least \$320 billion annually. If left unchecked, these costs are estimated to rise to over \$1 trillion by 2040. [\[source\]](#) Beyond the financial cost to the entire industry, health inequities also leave a substantial impact on the country’s economy as a whole. Health disparities account for \$42 billion in lost productivity annually — not including the economic loss caused by premature death due to these inequities. [\[source\]](#)



Survey Methodology

The BroadReach Group surveyed 192 executives and leaders within payers, providers and others in the health equity landscape to understand how important health equity is within their organizations and what steps they are taking to address health inequities today and in the future. The survey ran for five weeks in June and July, 2022.



Respondents were asked to answer a 12-question multiple choice online survey.

All responses are self reported and anonymous. Respondents were targeted via a targeted LinkedIn campaign, personal email outreach to health plan executives and gathered at the SNP Conference on May 2 and AHIP Conference on June 23 2022.

The following report is a summary of the findings, expert analysis on the results and a recommended roadmap for payers and providers to take the next step to address health equity within their patient populations.

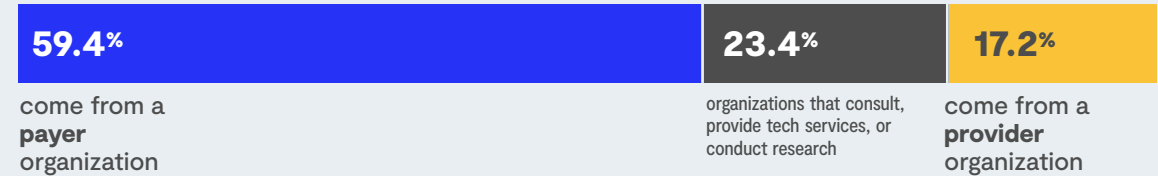


Survey Findings

The first 4 questions frame who responded to the survey

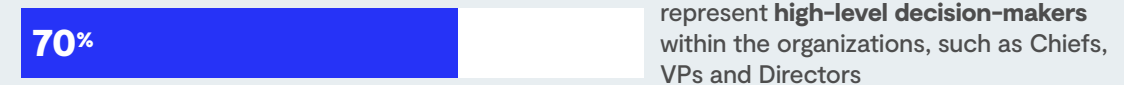
QUESTION 1.

What type of organization do you represent?



QUESTION 2.

What is your job title?



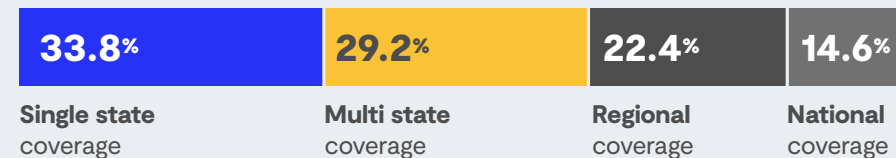
QUESTION 3.

What is the size of the population you manage?



QUESTION 4.

How would you categorize your organization?

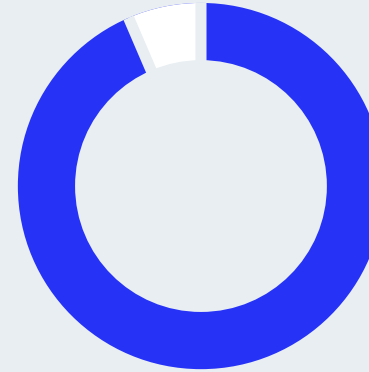


QUESTION 5.

How important is it for your organization to address disparities/inequities in health outcomes and quality measures?

Why does this matter?

This shows us that the healthcare industry overwhelmingly agrees that addressing disparities in health outcomes and quality measures is both relevant and important. It shows that payers and providers unanimously recognize the inequities and have a desire to do something about them. However as you will see later in the survey, they are extremely limited in their ability to do so today.



95%

of those surveyed believe it's important for their organization to address **disparities/inequities in health outcomes and quality measures**

49%

reporting it to be **extremely important**

24.5%

stating it is **mission critical**



QUESTIONS 6 & 7.

For approximately what percentage of your population/your staff do you have race, ethnicity and language data on?

Why does this matter?

It is essential to understand the population you are serving and how best to connect with the population within cultural and linguistic parameters. If the employee base doesn't reflect the population that they serve, they could be less likely to empathize with the patients' challenges and a lack of shared voices heard.

CARE POPULATION DATA:



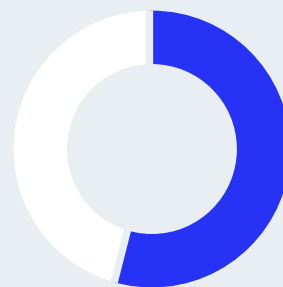
43.8%

of those surveyed don't know if they have any **race, ethnicity** or **language data** on their **care population**

only **4.2%**

have this data on 75-100% of their **population**

EMPLOYEE DATA:



Even more,

55.2%

don't know if they have this same information on their **employee population**

only **7.8%**

have this data on over 75% of their **employees**



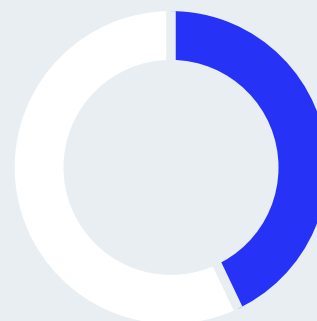
QUESTION 8.

Does your organization provide culturally and linguistically appropriate, person-centred care today?

Why does this matter?

Culturally and linguistically appropriate care can help build trust with patients. This leads to higher engagement and a better experience of care. Patient-centered reported quality outcomes, like experience of care, can have a significant impact on reimbursements and a healthcare organization's performance ratings.

When combined with results from question 7 that indicated that the majority of plans surveyed do not have race, ethnicity or language data on their patients or caregiving employees, it's clear that there is a fundamental gap in the ability of healthcare organizations to deliver person-centered care.



44.3%

of those surveyed **do not** provide culturally and linguistically appropriate, person-centered care today and only provide care in English.



While more than half,

55.7%

say they **do** offer care in other languages, but that it is **largely ad hoc**.



QUESTIONS 9 & 10

Does your organization have a roadmap to promote health equity across your people, process and technology?

If you responded “partially” to this question, do you anticipate this to be a priority within the next 12-18 months?

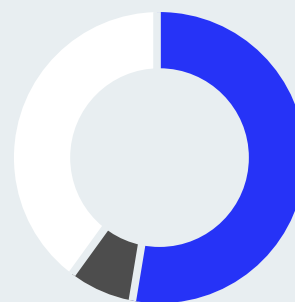
Why does this matter?

Much can be done to further health equity; but it can be overwhelming on where to start. A roadmap is a staged plan of action that allows you to break down priorities into bite-sized chunks and set a S.M.A.R.T. plan towards meaningful improvement.

Additionally, health equity certifications, such as NCQA's Health Equity/Health Equity Plus Accreditation, require healthcare entities to build a roadmap and show meaningful progress to earn a health equity distinction.

<45.3%

of the respondents say their organization has a **partial, but not a formal roadmap** for promoting health equity across their people, process and technology.



Of those that responded **partial**,

53.1%

are unsure if it will be a priority in the **next 12-18 months**.

Only **8%** said that it will be a **priority**

43.5%

don't have a roadmap at all



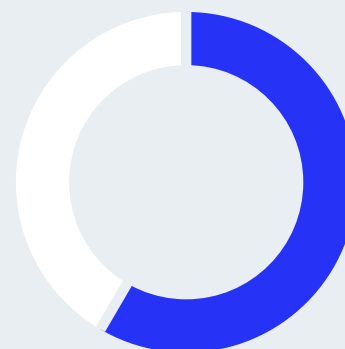
QUESTION 11.

Do you anticipate your organization pursuing the NCQA Health Equity/Health Equity Plus Accreditation in the next 24 months?

The **NCQA Health Equity/Health Equity Plus Accreditation** gives healthcare organizations an actionable framework for improving health equity.

Why does this matter?

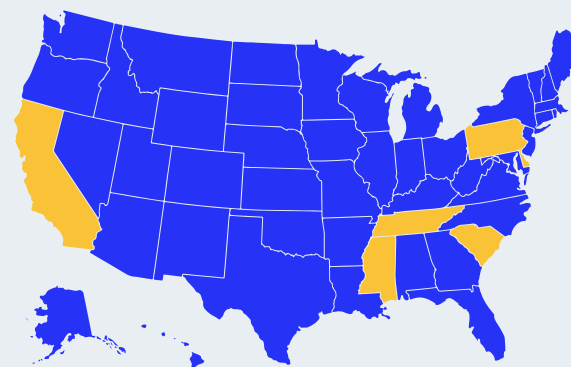
NCQA quality measures and accreditations are often seen as the gold-standard in measuring performance of a health plan. One of the objectives proposed by the CMS for the next decade includes “high quality care is synonymous with equitable care.” We will therefore likely see more fee-for-value contracts requiring healthcare entities delivering care to have accreditations like NCQA.



63.5%

of respondents were **unsure** whether their organizations anticipated pursuing the accreditation in the next 24 months

This is not surprising, as requirements are often the motivation needed to adopt change. As of April 2022, only six states (**California, Delaware, Mississippi, Pennsylvania, South Carolina, Tennessee**) require this accreditation for plans they contract with.



With the majority optional-status, it simply turns into a calculation of return on investment. We know payers are thinking about this since budget concerns are the second-most stated barrier for operationalizing health equity initiatives.



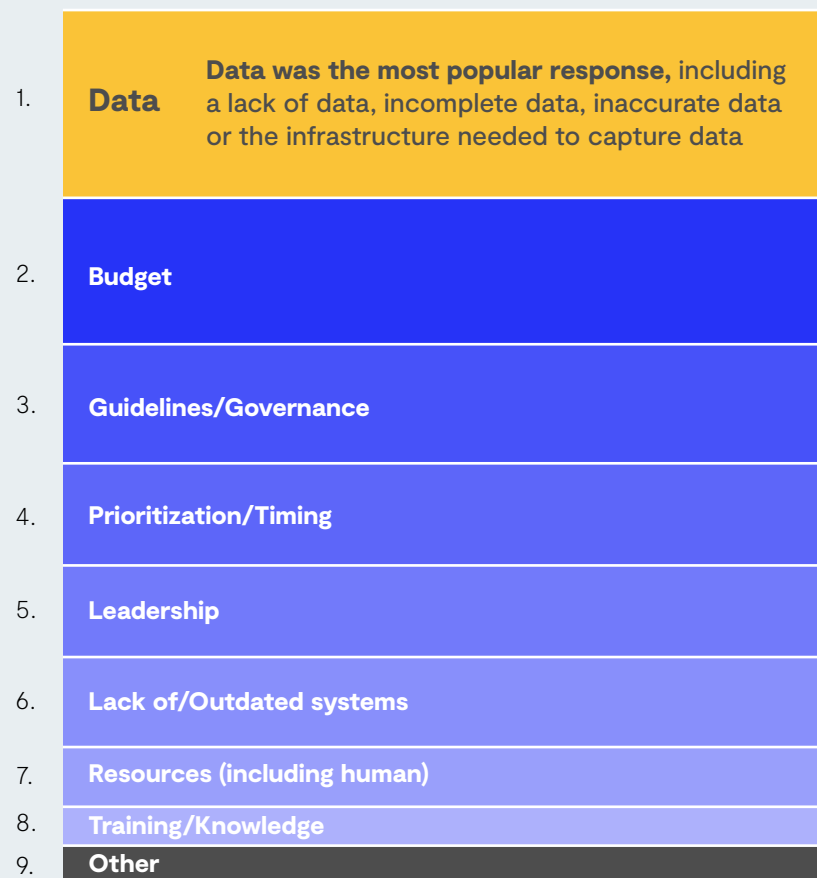
QUESTION 12.

What do you see as the biggest barrier in operationalizing and furthering your health equity initiatives?

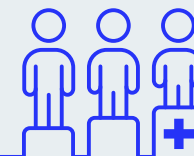
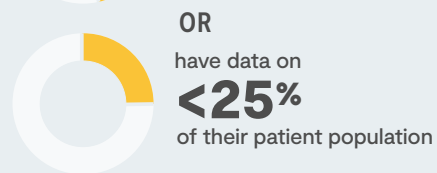
Why does this matter?

These words were chosen and written in free text by our survey respondents, and reflect the greatest challenges they see in actioning health equity plans. No surprise here that the availability of data — or a lack of it — was identified as the number-one barrier to furthering health equity.

THE RESPONSES FELL INTO THE FOLLOWING NINE CATEGORIES:



DATA being the most common response is hardly surprising since:



Where do we go from here?

The snapshot survey indicates that while leaders within payer and provider organizations recognize that health is extremely important for their populations, they lack a clear roadmap to systematically and strategically tackle it.

For most health organizations, the barrier to advancing health equity initiatives is greater than one specific issue. As we see in the data, it could be a lack of concrete patient or employee data, a lack of a formal roadmap for addressing inequities, limited budget or resources, company politics or any combination of reasons.

To better understand the real-world challenges of health inequity and how payers and providers can take steps toward achieving equitable care, we spoke with Dr. Chris Esguerra, the Chief Medical Officer for Health Plan of San Mateo, which focuses solely on those patients who are covered under Medicare and Medicaid. He's spent his career as a practicing psychiatrist and now as a health plan leader, on delivering equitable, patient-centered care. He presents a framework for addressing health inequities.

Dr. Esguerra explains, "For true improvement in health equity, unless your population is totally homogeneous, you're actually going to have to address things in a much more targeted way." To do this, data collection is a component of a larger necessary framework.

Everyone focuses on data — or lack of data — as a gap, and gets stuck there. Data is the thing that will help you understand that there is a problem, but do you know how to understand the problem? ”

The data itself will tell you that inequity exists. But it's more important to understand what's contributing to this inequity. Dr. Esguerra points out that it's easy to look to external things — such as SDOH factors — as the only cause of health inequities. It's much harder to look at the internal and structural characteristics that are contributing to these inequities. Apart from the characteristics of a particular population and their struggle, structural characteristics include the built environment in which a person lives, and their neighborhood and policies which may be contributing to inequities. Identifying the internal characteristics takes humility. The big question you should ask yourself is, are there policies or processes that you have as a payer or delivery system that contributes or reinforces inequities?



What questions do we need to ask ourselves?

Dr. Esguerra explains the key questions health systems should be asking themselves: “Do I have the right type of provider? Am I hiring staff that reflects the population I am serving, whether it’s language, ethnicity, sexual orientation or more?”

For example, if your patient population is dealing with inequalities related to sexual orientation or gender identity, do you have providers on staff who are educated on and specialize in supporting LGBTQ issues? If you don’t know, that’s why data about your staff is important.

There’s also a large amount of cultural nuance that needs to be taken into account, especially when considering how to connect with patients whose first language is not English. Translation in and of itself can be problematic. For example, when you simply translate patient communications written for an English-speaking audience into Spanish, you may end up missing the nuance and idioms that exist when you write communications for a Spanish-speaking audience in Spanish. It’s a small, simple change, but writing patient communications directly in the patient’s native language can go a long way in reaching your intended audience in a way that’s culturally more relevant.

These kinds of changes can feel overwhelming. Solutions are often multi-faceted and interconnected. There are interventions and improvements you can make directly, research that can be done to identify partners who can help implement change and community outreach needed to find the local organizations who are already addressing some of these issues, so that you can support them along the way. “It’s a useful framework because it addresses power dynamics and adds a component of self-reflection and interrogation of what it is you’re doing internally,” Dr. Esguerra explains.

It’s not about doing things to a population to address inequities, it’s more about respecting what’s already going on and identifying the components that can be supported. ”

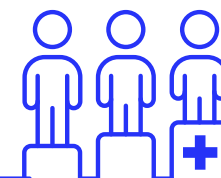


The role of technology in addressing health inequities

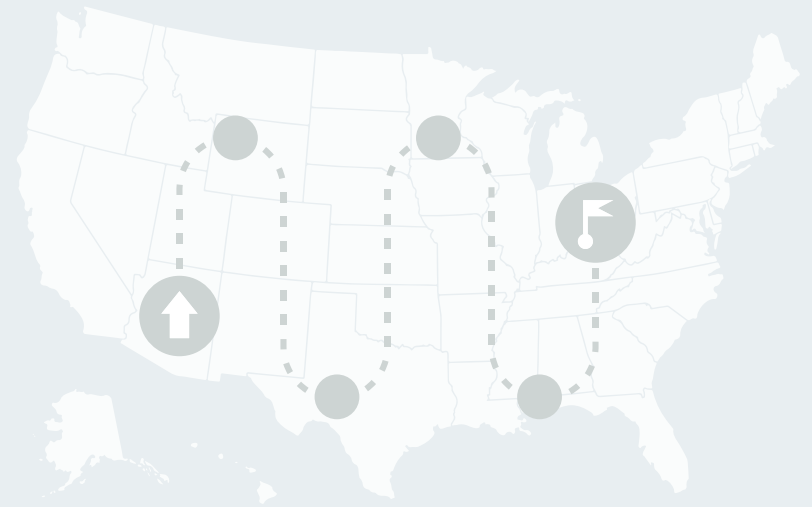
Technology can play a vital orchestration role to support oversight, management and execution of impactful health equity programs. Aside from basic data capture, protection and management, Artificial Intelligence (AI) can take disparate data sources such as SDOH and personal health data to surface key insights on populations and individuals. AI can also guide practitioners and plans to take decisive, targeted action.

All data is biased, and so it's important to understand how that bias might adversely impact the quality and level of care delivered to beneficiaries. To do this, one should go beyond technology and nurture people who understand how data is captured, collected, modified and applied across different processes. While technology plays a pivotal role, a focus on people and process is equally, if not more, important for a true systemic transformation.

Technology is a means to an end — not a silver bullet. It's a vital tool that is not a replacement for human action, but an enabler. Predictive models can help predict patient behavior and treatment adherence, and adjust risk scores, while dashboards help visualize information and next best actions. There are various organizations, including Vantage, that have developed solutions to help drive equitable health outcomes for target populations.



Addressing health equity in the US is a journey



The Department of Health and Human Services (HSS) has a driving theme across all health agencies (including CMS) to ‘protect and strengthen equitable access to high quality and affordable health care.’ [\[source\]](#) From our data collection and understanding of the larger industry, the U.S. is still in the early days of actively addressing health equity. Over the last decade, the U.S. Centers for Medicare & Medicaid Services (CMS) has been focused on increasing the collection of data on underserved populations.

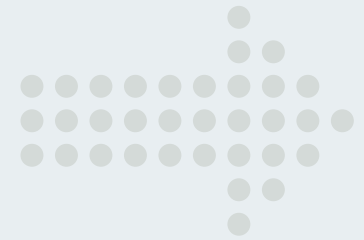
Across the realms of science and medicine, U.S. history reflects new understanding, change and advancement. These things are achieved when dedicated and multi-disciplinary people work to achieve important goals. While equitable health should be a basic human right, our current constructs are formed on unbalanced scales. Recognizing the imbalance, having the discussions to improve our footing, identifying the measurements to evaluate our processes — these are all steps in our important journey to quality, equitable care for everyone. ”

DR. AMY HELWIG: EXECUTIVE VICE PRESIDENT, RTI HEALTH ADVANCE

The first pillar in the [CMS Strategic Plan](#) for the next decade is health equity, which aims to address the health disparities that underlie the health system. Work is being done, but we are at the starting line of a marathon where the 26.2-mile course has yet to be designed. Some organizations — many of whom have a strong mission and vision that are guiding their work in this area — are much further along than others. The data in this survey shows us that there is progress being made, but much more work to be done (and many more miles to run).



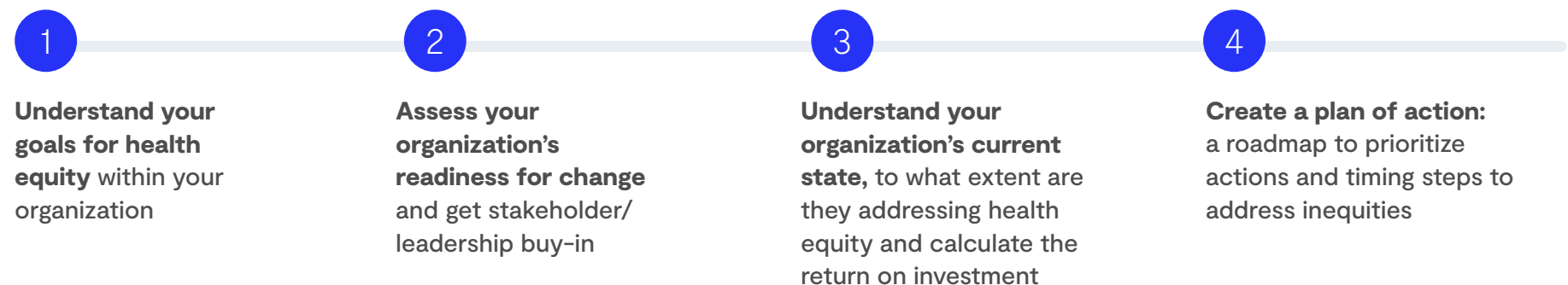
Where to from now?



The key is to take action and get started.

The key is to take action and get started. There is broad acknowledgement that health equity is important but there is inertia and confusion over where or how to start addressing health equity for underserved populations. Health equity should be seen as a lens to view and plan better and more inclusive health plans.

It's a journey, but here's what can you do today to start the journey:



It's essential that we all start this health equity journey as access to good health enables people to flourish.



Contributors

Vantage voices



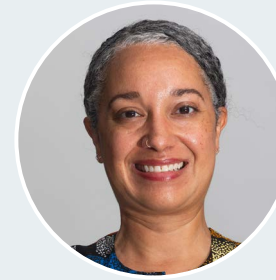
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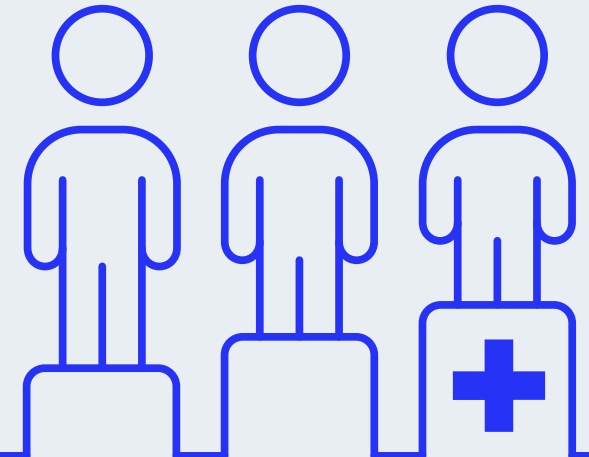
Other voices



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RTI Health Advance



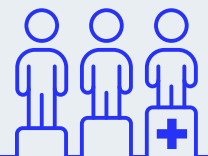


BroadReach Group is a global social enterprise that harnesses health technology and innovation to empower human action. They bring nearly two decades of deep healthcare expertise combined with world-class technology solutions to help organizations deliver better health outcomes, improved efficiency of scarce healthcare resources, cost savings, enhanced organizational performance, and more sustainable health systems. BroadReach delivers this value through two businesses. **BroadReach Health Development** delivers digitally-enabled implementation management and technical assistance services to address the world's most complex health challenges. **Vantage Health Technologies** delivers solutions for health organizations and their teams on its AI Vantage platform.

For more information, visit broadreachcorporation.com

Vantage Health Technologies sees a world where access to good health enables people to flourish. Their solutions, powered by the Vantage AI-enabled platform, go beyond dashboards, providing next best actions to payers and providers to improve outcomes, decrease costs, and optimize resources. Vantage Health Technologies believes that data alone cannot solve the world's most complex health challenges; it also requires a deep understanding of the social, cultural, and economic context in which people live. Vantage Health Technologies is part of BroadReach Group.

For more information, visit vantagehealth.tech



Contact Us

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