



Real-World Lessons from COVID-19: Driving Oncology Care Forward

Spotlight on the Sutter Health Institute for Advancing Health Equity

As equilibrium is regained, one strategy for moving forward from times of terrible hardship and uncertainty is to take stock of possibilities for growth from the difficulties experienced. The 2021-2022 ACCC President's Theme selected by Krista Nelson, MSW, LCSW, OSW-C, FAOSW, encourages cancer programs and practices to lean in to three key lessons from the COVID-19 pandemic:

1. Health equity and social justice are critical drivers of quality cancer care, and practice-based solutions are needed that reduce barriers and improve health outcomes.
2. The escalating need for high-reach, high-impact psychosocial and supportive care services requires innovative care delivery models that demonstrate measurable value to the oncology ecosystem.
3. Strengthening a culture that supports professional well-being and resilience is essential to practice sustainability and provider and patient satisfaction.

The first lesson recognizes the correlative relationship between health equity and quality cancer care. Advancing health equity is not the purview of the healthcare sector alone, however. A consensus report from The Robert Wood Johnson Foundation

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explains: “Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health, such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.”¹

Recent events coupled with the realities laid bare during the COVID-19 public health emergency have brought the intersectionality of health equity and social justice to national attention. Racial and ethnic minority populations in the United States not only faced a greater burden from SARS-CoV-2 and the COVID-19 pandemic but also endured racial targeting, hate crimes, and lethal violence. With the consequences of racism and health inequities in the national spotlight, awareness elevated, and calls for action amplified, across the country and the healthcare enterprise the need for systems change to address health equity is acknowledged.²⁻⁷

The overarching question is how to effect change. The U.S. healthcare system is famously complicated, and systems change is notoriously complex.

Structural racism and inequities, explicit and implicit bias, social determinants of health, bias against ethnic and other minority groups all contribute to lack of health equity in the United States. Lessons from the COVID-19 pandemic and from healthcare organizations actively engaged in assessing care delivery through the lens of health equity can serve as guideposts for the oncology community on the path to making cancer care more equitable.

This article explores how an integrated health system in California, serving a diverse patient population, is working to embed health equity in its culture and its mission.

The Sutter Health Institute for Advancing Health Equity

Sutter Health, headquartered in Sacramento, Calif., ranks 33 on the Becker's Hospital Review 2020 list of the 100 largest hospitals and health systems in America.⁸ An integrated health system, Sutter Health serves more than 3.5 million Californians.⁹ The network includes 23 hospitals, 33 ambulatory surgery centers, 8 cardiac centers, 9 cancer centers, 4 acute rehabilitation centers, 6 mental health and addiction centers, 5 trauma centers, and 4,167 licensed general acute care beds.² According to the Sutter Health website, the network is "...committed to ensuring healthcare is accessible and inclusive to all by offering comprehensive services and quality health programs tailored to the diverse communities we serve."⁹ Sutter states that its hospitals "...serve more of the Medi-Cal patient population in Northern California than any other health system."⁹

Kristen M.J. Azar, RN, MSN/MPH, FAHA, is scientific medical director at the Sutter Health Institute for Advancing Health Equity and a research scientist at the Sutter Health Center for Health Systems Research.

Kristen arrived at Sutter Health 12 years ago to conduct research with a focus on health disparities and inequity in the primary care area; for example, diabetes, heart disease, and mental health. She credits Sutter's former chief medical officer and founding director of Sutter's Institute for Advancing Health Equity Stephen Lockhart, MD, PhD, as the physician champion with the vision to pull together the equity work underway at various

local Sutter-affiliate institutions "in a more integrated, strategic way at the health-system level and to think about how we could really leverage the power of this system to look at health equity in ways that can start to make change at a broader level, learning from the great work that was being done in the field and in our clinics."

The launch of the Sutter Health Institute for Advancing Health Equity in December 2020 was a natural evolution of this work, Azar said. "I think what's different about this institute—and what has made it very promising so far—is that we have a structure that is very innovative. We have an internal advisory committee that includes our top leaders from throughout the system—for example, population health, quality, research, digital health, community health, our ops teams—all the groups within our system that need and want to not only incorporate but integrate an equity perspective."

This is no small task for a health system serving a patient population that is 54 percent ethnically diverse and speaks more than 134 languages.

"It's been a process. It's very complicated trying to understand who needs to be involved and which stakeholders we need to include to ensure anything we do is going to be feasible, impactful, and sustainable," said Azar. Plus, Sutter Health has a strong commitment to make care better "not just for our patients but also for our local communities."

Prioritizing Data Collection

A critical first step for assessment of equitable care was assessing the health system's data. "It is a huge priority for us. Without an idea of current state in terms of existing inequities, we're flying blind," Azar said. The focus to date has been on data around racial and ethnic disparities. More than a decade ago, Sutter launched a systemwide initiative to standardize collection of self-reported race, ethnicity, ancestry, and language data. "We have very good capture of these data," Azar said. "We know that race and ethnicity can serve as markers for societal inequalities and structural racism resulting in health inequities."

A key part of empowering research through the Sutter Health Institute for Advancing Health Equity is exploring how to increase the robustness of the health network's data assets. The current emphasis is on data around social determinants of health, Azar said. Several pilot studies are underway looking at how best to collect these data. "We have the fields in our health record, so in terms of being able to enter the data, the health system is ready." But the pre-work—creating processes to ensure standardization of the data collection and entry so that the end result is quality data that can be used and interpreted with confidence—is critical. "We are actively looking at this, along with our population health department, led by our chief population health officer Chris Stanley, MD, and our chief research and health equity officer Leon Clark, MBA," said Azar. "Having our population health group leading the charge to obtain social determinants of health patient data has been really great."

At present, the process is a stepwise approach to expanding data collection that allows for careful consideration on how best to elicit information related to social determinants of health. “There are many aspects to the process,” Azar said. “How do we ask these questions in a way that’s sensitive to our patients? How do we do it in a way that physicians feel like they have what they need to address any concerns that arise? Is it different in an ambulatory setting versus an inpatient setting? Do we ask everyone or only those we have reason to believe are at higher risk? There are a lot of nuances.”

Developing the Health Equity Index

Once organizations have the data, the next step is figuring out how to create metrics to measure and improve equity in healthcare. Dr. Lockhart, now retired, was a leader and co-developer of Sutter’s Health Equity Index. The index uses analytics and dynamic applications of clinical and population data to measure outcomes of care among different patient populations. Sutter researchers designed and implemented the Health Equity Index, which is calculated as the ratio of observed to expected encounters, to identify and quantify health inequalities in healthcare systems. The index is designed to measure health equity in several ambulatory care-sensitive conditions (e.g., asthma, diabetes). Alice Pressman, PhD, MS, scientific research director of the Institute for Advancing Health Equity and co-developer of Sutter’s Health Equity Index, and colleagues, writing in an article published in *Health Equity*, explained: “To our knowledge, this is the first attempt to develop and implement a metric for measuring health equity that uses not only real-time, health system data, but also combines it with external demographic, prevalence, and utilization statistics to compute values that reflect equity of outcomes specific to each racial or ethnic group studied.”¹⁰


The authors stated that the Health Equity Index is designed to be “portable to any healthcare system.”¹⁰ To use the index, health systems need to have the following: encounter diagnoses, geographical data, age, sex, and race/ethnicity; access to local census tract data; and access to local-level prevalence data. According to the authors, with access to available prevalence data, the Health Equity Index is adaptable to any health condition. Sutter Health makes the index available to other healthcare providers to encourage collaboration and increase awareness of the need to develop processes and methods for assessing progress in advancing health equity. (The full text of the article by Pressman et al. is available at: [liebertpub.com/doi/10.1089/heq.2018.0092](https://doi.org/10.1089/heq.2018.0092).) Pressman, Lockhart, and Azar have continued their work in quantifying health equity and have recently published work describing the novel COVID-19 Vaccine Equity Index, a metric that has been used to set equity targets within Sutter to guide vaccine distribution efforts (also in *Health Equity* at: [liebertpub.com/doi/full/10.1089/heq.2021.0047](https://doi.org/10.1089/heq.2021.0047)).¹¹

Quality Team Engagement

At Sutter Health, a recent successful intervention conducted with an equity focus was “The Vital Few” initiative developed during the COVID-19 pandemic. The public health emergency’s impact

on cancer screening rates and on the potential for screening delays to lead to more late-stage cancer diagnoses has been a concern across the oncology community.¹²⁻¹⁵ Early in the pandemic, the Sutter Health Quality Team began looking at the types of preventive services most likely to be affected by pandemic-related restrictions, including screenings for breast cancer, colorectal cancer, and cervical cancer, with special attention to health equity. With health precautions in place, one component of “The Vital Few” initiative, under the leadership of William Isenberg, MD, PhD, chief quality and safety officer, and Paul Costello, MEng, director of ambulatory quality and patient safety, along with the entire Sutter Health Quality Team, quality medical directors, and many clinicians, non-clinicians, and leaders, focused on identifying and reaching out to African American and Hispanic patients. Through this work, the team was able to identify and close gaps in screening for these racial/ethnic patient subgroups.

Acknowledging Implicit Bias

Although multiple studies have shown the impact of implicit bias in healthcare and cancer care, how best to create awareness and to mitigate the effects of unconscious biases at the system, department, and individual level are topics of debate. Sutter Health has partnered with Impact4Health to design and implement training on inclusive leadership, health equity, and implicit bias. (See interview on page 39 for more.) Creating buy-in from staff across all levels of the health system is an ongoing process, Azar said. Though many physician leaders are on board with implicit bias training, logistics can be a barrier, as can the size of the health network, which includes both employed and contracted physician groups. Work is underway in partnership with Sutter Health University to find ways to provide some content on demand. The Institute for Advancing Health Equity is also interested in developing ways to augment the more traditional training formats with some experiential components, such as virtual reality or gamification, Azar said. Another consideration is how to create a learning environment in which there are opportunities to observe difficult conversations with patients through a series of case studies. “It’s the idea of not having that one-time training but how do we give people the space to really engage with what they’re being taught,” Azar said. “The second piece of that is evaluation, long-term monitoring, and understanding—does this actually change behavior? This is something that is really important for us as well. The field really has a lot of room to grow in those areas, so I’m excited that we are on this journey with so many other wonderful health systems, and researchers, and scientists who are really trying to move this forward.” 

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