



FY2020 Health Equity Summary

Meritus Health – June 11, 2021

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About Us

Meritus Health, western Maryland's largest health care provider, is located at the crossroads of western Maryland, southern Pennsylvania and the eastern panhandle of West Virginia.

- **Serves about 200,000 residents of the tristate region**
- **Nearly 3,000 employees**
- **500 medical staff members**
- **240 volunteers**
- **Meritus Medical Center**
 - 300 Beds
 - Magnet Recognized
 - Joint Commission Accredited
 - Teaching Hospital
 - Family Medicine Residency Program
 - 1,000+ nursing and allied health student annually
- **Meritus Medical Group**
 - 20 medical practices
 - 100+ Providers
 - Home Health
 - Equipped for Life, a medical equipment component
- **25 % owner of Maryland Physicians Care**
 - 215,000 Medicaid member health plan
- **For more information, visit [MeritusHealth.com](https://www.MeritusHealth.com)**



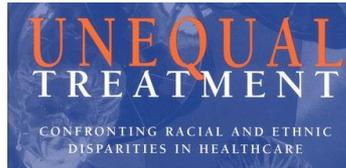
Our Mission: Meritus Health exists to improve the health status of our region by providing comprehensive health services to patients and families.

Our Vision: Meritus Health will relentlessly pursue excellence in quality, service, and performance.

Our Values: Our culture is driven by a set of values that focus on the patient and family first: respect, integrity, service, excellence and teamwork.

Executive Summary

Introduction to Health Equity at Meritus



Since the 2003 publication of the Institute of Medicine’s landmark study, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, an increasing focus has been placed on eliminating health disparities and achieving health equity in the United States.



Multiple national organizations are leading initiatives to address health disparities, including the Agency for Healthcare Research and Quality (AHRQ). Since 2003, the AHRQ has published an annual *National Health Care Quality and Disparities Report* that highlights trends in health care quality across race and ethnicity.



While it is clear from this publicly available data that some progress has been made with respect to improving certain health disparities, **significant work must still be done to address the myriad challenges that remain.** Unfortunately, new disparities have emerged during the COVID-19 pandemic, at least in part a reflection of the underlying social determinants of health that can negatively impact an individual’s health status.



To deliver on our mission, execute our vision, and embody our values outlined below, **Meritus Health will strive to achieve health equity for the patients we serve.** To effectively do this, we must understand where disparities exist in our health system.



The *FY2020 Health Equity Summary* is a first step toward designing Meritus’ roadmap to achieving health equity. It will serve as the foundation for an annual *Health Equity Report*.



Executive Summary

Understanding Our Community

The patients that Meritus Health cares for closely reflects general demographic trends in Washington County, MD.

Washington County Population Estimate by Race (left) and Ethnicity (right)

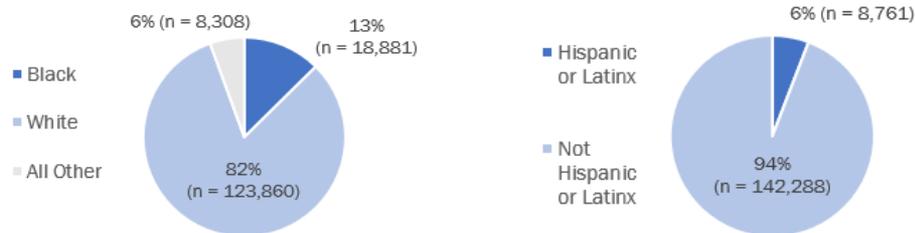


Figure 1. Washington Demographic Data. Washington County data is based on 2019 U.S. Census Bureau estimates and is stratified by race and ethnicity.

Identifying Health Disparities at Meritus

Thirteen quality and safety measures were analyzed across race, ethnicity, and language using FY2020 data and were chosen following the Institute of Medicines six domains of healthcare quality (STEEEP): safe, timely, effective, efficient, equitable, and patient centered.

Quality and Safety Measures Analyzed for Health Disparities:

- Readmission rate
- Mortality rate
- Patient harm events
- Sepsis core measure non-compliance
- Preterm births
- Early elective delivery
- C-sections
- Exclusive breast milk feeding of newborns
- Inpatient and emergency department opioid administration
- Hemoglobin A1c $\geq 9.0\%$
- Inpatient and observation average length of stay
- Emergency department throughput time
- Patient experience top box scores for care and communication

Executive Summary

Meritus Health's Health Disparities

Of the thirteen quality and safety measures analyzed across race, ethnicity, and language using FY2020 data, six measures were identified as disparities that require further investigation.

Sepsis Core Measure Non-compliance



44% higher sepsis core measure non-compliance for Black patients compared to White patients

Pre-term Birth Rates (birth prior to 37 weeks gestational age)



27% higher preterm birth rate for combined Black patients and Hispanic or Latinx patients compared to White patients

50% higher preterm birth rate for Spanish-speaking compared to English-speaking patients

Newborns Exclusively Breast Feed



36% lower rate of exclusive breast milk feeding for combined Black newborns and Hispanic or Latinx newborns compared to White newborns

Opioids Administered in the Emergency Department



21% lower ED opioid administration rate for combined Black patients and Hispanic or Latinx patients compared to White patients

Poorly Controlled Diabetes (HbA1C \geq 9)



74% higher chance of poorly controlled diabetes when comparing combined Black patients and Hispanic or Latinx patients to White patients (24.2% versus 13.9%)

Emergency Department Throughput Time (discharge time for non-admissions)



Spanish-speaking patients on average spend 11% more time in the ED than English-speaking patients

Executive Summary

Next Steps for Meritus Health

Now that health disparities have been identified, the real work must begin. It's up to all of us to ensure that Meritus Health and its leaders enact plans to eliminate the disparities highlighted in this analysis. Achieving health equity may be an even more daunting task given the pervasiveness of the societal factors at play. Still, if there is one lesson that the pandemic has taught us, it's that:

Together, we can achieve more than we imagined!

To fully leverage the findings outlined in this summary, next steps will include the following:

- **Launch improvement projects** with specific responsibilities and timelines to address the disparities identified in this analysis.
- Continue the work of the LEAD Council, including:
 - Measuring the impact of the “**Rooney Rule**” on representation in leadership positions
 - Achieving 100% employee participation in **unconscious bias and cultural competency training**
- **Solicit feedback** from throughout the organization to determine new metrics to add for FY2021 Health Equity Report as well as metrics that may no longer need to be measured.
- For all of the above, by **involving key stakeholders, determine target dates to reach specific goals by and create accountability mechanisms** to ensure that targets are being monitored and reached.

7 The following pages provide more detail on the analysis of all measures, including those not highlighted in the Executive Summary.

Why Health Equity - Introduction

In 2003, the Institute of Medicine (IOM) published an [important study](#) entitled, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. This report demonstrated that even after accounting for socioeconomic factors like insurance status and income, racial and ethnic minorities still received lower quality health care than non-minority groups. This work suggests that racism, prejudice, and bias exist within the health care system, to the detriment of our patients.

Since 2003, multiple federal and non-profit organizations like the Centers for Disease Control and Prevention (CDC), the U.S. Department of Health and Human Services (HHS), the National Institute on Minority Health and Disparities, and the Agency for Healthcare Research and Quality (AHRQ) have launched initiatives to study and address health disparities at the national level. The AHRQ publishes an annual [National Health Care Quality and Disparities Report](#) that highlights trends in health care quality across race and ethnicity. While it's apparent based on this publicly available data that some health disparities have improved, it's also clear that many of the disparities first highlighted by the IOM still exist and that some of these have even worsened over the past decade. Unfortunately, the COVID-19 pandemic has highlighted the pervasiveness of these disparities, as evidenced by multiple studies showing that Black patients and Hispanic or Latinx patients have higher COVID-19 hospitalization and mortality rates.

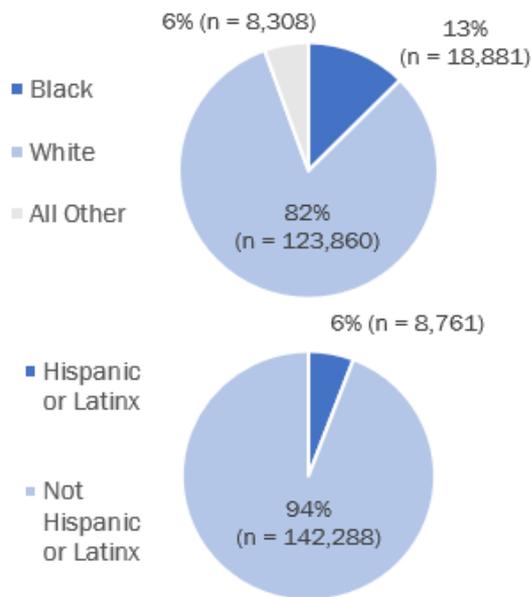
While the Institute of Medicine specifically controlled for socioeconomic access-related factors in *Unequal Treatment*, the term **health disparity** is more typically and broadly defined as **“a type of health difference that is closely linked with social, economic, and/or environmental disadvantage.”** according to Healthy People 2030, an initiative led by HHS. While health disparities are often viewed through the lens of race and ethnicity, it is important to note that sex, sexual identity, age, disability, socioeconomic status, and geographic location are all factors that contribute to an individual's health status and can be a source of health disparities.

Health equity is a term that is related to **health disparity** and represents an ideal that would be realized in a world where **“every person has the opportunity to attain his or her full health potential”** and **no one is “disadvantaged”** from achieving this potential **because of social position or other socially determined circumstances.**

To meet the needs of our community as outlined in our mission, our vision, and our values, Meritus Health will strive to achieve health equity for the patients we serve. To effectively do this, we must first understand where health disparities exist in our health system.

Why Health Equity - Introduction

Washington County Population Estimate by Race (Top) and Ethnicity (Bottom)



FY2020 Meritus Health Inpatient Admissions (Top) and Ambulatory Visits (Bottom) by Race (left), Ethnicity (middle), and Language (right)

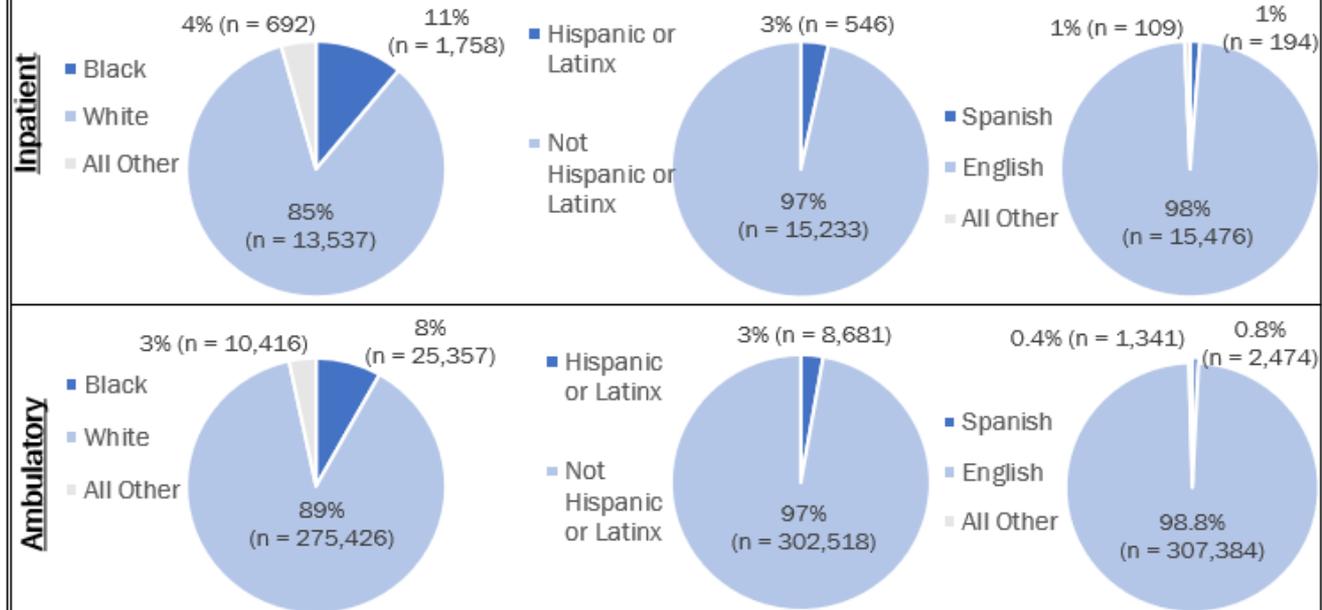


Figure 2. Washington County and Meritus Health Demographic Data. Washington County data is based on 2019 U.S. Census Bureau estimates and is stratified by race and ethnicity. Meritus Health data is based on FY2020 data and is organized by inpatient admissions (top) and ambulatory visits (bottom) by race, ethnicity, and language. Note that the total n for inpatient admissions by race does not match the total n for inpatient admissions by ethnicity and language due to Epic reporting of patients who identify as being multiracial.

Before analyzing whether disparities exist in the care that Meritus Health delivers, it is important to understand the demographics of the community it serves, summarized in the charts above.

As you can see, the patients that Meritus Health cares for closely reflect general demographic trends in Washington County.

With all of this context in mind, the overall objectives of this report are as follows:

1. **Identify possible health disparities at Meritus Health** by analyzing FY2020 data for a variety of quality and safety metrics.
2. **Highlight ongoing diversity and inclusion efforts** at the organizational level.
3. **Outline next steps** to address identified health disparities, improve care delivery, and diversify of our workforce.



Where We've Been – FY2020 and COVID-19 Data

To gain a clearer understanding of health disparities that may exist in the care that Meritus Health delivers, we chose to analyze 13 quality and safety metrics using FY2020 data. These metrics primarily focused on the inpatient setting, but specific metrics were also analyzed for the emergency department and ambulatory clinics. All data was analyzed by race for White and Black patients and by ethnicity for Hispanic or Latinx patients. A selected subset of these metrics were also analyzed by language for English and Spanish-speaking patients. To better understand care delivered during the COVID-19 pandemic, four specific metrics – length of stay, mortality rate, readmission rates, and the vaccine equity index (VEI) – were also analyzed for COVID-19 patients from April 2020 through April 2021. The entirety of these results will be presented and discussed on the following pages.

Metrics chosen for analysis were determined by relying on standard quality metrics as well as metrics deemed important to ongoing efforts at Meritus Health to deliver excellent patient care. The IOM's well-known six domains of health care quality were used as a framework to guide metric selection and data presentation. These domains are briefly described below.

Institute of Medicine – Six Domains of Health Care Quality (STEEP)

1. **Safe** – avoiding harm to patients from the care that is intended to help them.
2. **Timely** – reducing waits and sometimes harmful delays for both those who receive and those who give care.
3. **Effective** – providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
4. **Efficient** – avoiding waste, including waste of equipment, supplies, ideas, and energy.
5. **Equitable** – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.
6. **Patient-centered** – providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

Since many of the metrics analyzed fall under multiple domains of the IOM framework, data that follows will be presented across multiple domains. The 13 quality and safety measures analyzed were 1) readmission rate, 2) mortality rate, 3) patient harm events, 4) sepsis core measure non-compliance, 5) preterm births, 6) early elective delivery, 7) C-sections, 8) exclusive breast milk feeding of newborns, 9) inpatient and emergency department opioid administration, 10) hemoglobin A1c $\geq 9.0\%$, 11) inpatient and observation average length of stay, 12) emergency department throughput time and 13) patient experience top box scores for care and communication.

Where We've Been – FY2020 Data

Safe and Effective

Readmissions – FY2020

Race or Ethnicity	Patients	Readmission		O/E	Readmission Rate
		(Observed = O)	Expected (E)		
White	10,505	1,149	1,445	0.80	10.9%
Black	1,274	142	174	0.82	11.1%
Hispanic or Latinx	385	27	35	0.76	7.0%
All	12,328	1,333	1,673	0.80	10.8%

Table 1. FY2020 Risk-Adjusted Readmission Data from CRISP data. All percentages are within group comparisons. Note that the “All” row includes all patients, including races not captured elsewhere in table. For this reason, summing patients shown in other categories will not match the “All” row.

Readmission rates by race or ethnicity were calculated using risk-adjusted data curated by CRISP. The observed/expected (O/E) ratio is a standard way of assessing readmission rates, where the expected value is calculated based on population-level data. To make these numbers more easily interpretable, readmission rates within each group were calculated as a percentage. The difference in risk-adjusted readmission rates for Black individuals compared to the total number is likely within the margin of error. **Based on race and ethnicity, there does not appear to be a disparity in risk-adjusted readmission rates.**

Mortality Rate – FY2020

Race or Ethnicity	Deaths	Patients	Mortality Rate
White	151	5,039	3.0%
Black	20	577	3.5%
Hispanic or Latinx	3	116	2.6%
All	177	5,759	3.1%

Table 2. FY2020 Mortality Rate from CRISP data. All percentages are within group comparisons. Note that the “All” row includes all patients, including races not captured elsewhere in table. For this reason, summing patients shown in other categories will not match the “All” row.

Risk-adjusted mortality rates were also calculated by race and ethnicity using CRISP data. The total number of patients seen in this table do not match those in the readmission table because of exclusion criteria within CRISP. With respect to mortality rates, the 0.5% difference in Black individuals compared to White individuals is likely due to the small sample size and within the margin of error. **As such, it is unlikely to represent a health disparity, but will continue to be measured moving forward.**

Where We've Been – FY2020 Data

Safe and Effective

Patient Harm Events – FY2020

Race or Ethnicity	Harm Events	% of All Harm Events	Total Patients	Harm Event Rate
White	58	90.60%	64,010	0.09%
Black	5	7.80%	11,414	0.04%
Hispanic or Latinx	3	4.70%	3,255	0.09%
All	64	-	78,679	0.08%

Table 3. FY2020 Patient Harm Events. The percentage of harm events in the rightmost column represents within group comparisons. Note that the “All” row includes all patients, including races not captured elsewhere in table. For this reason, summing patients shown in other categories will not match the “All” row.

Patient harm events, which includes over 40 different types of harm such as surgical site infections, catheter-associated urinary tract infections, hospital-acquired pressure injuries, and falls with injury, were analyzed across race and ethnicity. When looking at the percentage of harm events within a group, it **appears that rates of harm events are similar across race and ethnicity**. The total number of patients included represent those cared for in the emergency department, inpatient, and observation units, which should adequately reflect the number of patients who could have experienced a harm event.

Sepsis Core Measure Non-Compliance – FY2020

Race or Ethnicity	Patients Non-Compliant w/ Core Measure	Sepsis Patients	% Non-Compliant
White	233	707	33.0%
Black	26	55	47.3%
Hispanic or Latinx	2	12	16.7%
All	262	776	33.8%

Table 4. FY2020 Sepsis Core Measure Non-Compliance. All percentages are within group comparisons. Note that the “All” row includes all patients, including races not captured elsewhere in table. For this reason, summing patients shown in other categories will not match the “All” row.

The sepsis core measure bundle was implemented to standardize and improve care delivery to septic patients. The number of patients whose care was not compliant with this core measure bundle was calculated. As you can see, **care of Black patients is non-compliant with this core measure 13.5% more often compared to the average rate, which likely reflects a disparity**. This difference warrants further investigation and action.



Where We've Been – FY2020 Data

Safe and Effective

Preterm Births – FY2020				
Race or Ethnicity	Preterm Births	% of Total Preterm Births	Births	% Preterm Birth
White	132	72.9%	1,391	9.5%
Black	23	12.7%	206	11.2%
Hispanic or Latinx	19	10.5%	142	13.4%
Language				
English	171	94.5%	1,713	10.0%
Spanish	10	5.5%	49	20.4%
All	181	-	1,776	10.2%

Table 5. FY2020 Preterm Births. The percentages of preterm births in the rightmost column represent within group comparisons. Note that the “All” row includes all patients, including races not captured elsewhere in table. For this reason, summing patients shown in other categories will not match the “All” row.

Early Elective Delivery – FY2020			
Race or Ethnicity	Early Elective Delivery	Early Delivery	% Early Elective Delivery
White	-	108	0%
Black	-	21	0%
Hispanic or Latinx	1	15	6.7%
All	1	151	0.7%

Table 6. FY2020 Early Elective Delivery. All percentages are within group comparisons. Note that the “All” row includes all patients, including races not captured elsewhere in table. For this reason, summing patients shown in other categories will not match the “All” row.

Preterm births, defined as a birth occurring at a gestational age earlier than 37 weeks, were measured across race, ethnicity, and language. As you can see, **both Black and Hispanic or Latinx patients have preterm birth rates that are higher than the preterm birth rate for all patients. The preterm birth rate is nearly double the overall rate for Spanish-speaking patients.** These numbers may in part reflect differences in access to prenatal care, which could be driven by a variety of factors. **Altogether, these statistics likely represent a health disparity that warrants further investigation and action.**

Early elective delivery, defined as scheduled cesarean sections or medical inductions performed prior to 39 weeks of gestation without medical necessity, was measured across race and ethnicity. This standard quality measure showed that out of all early deliveries (from 37 to 39 weeks gestational age), only 1 early elective delivery occurred. **Given the sample size represented here, this is unlikely to represent a health disparity.**



Where We've Been – FY2020 Data

Safe and Effective

C-Sections – FY2020

Race or Ethnicity	Total C-Sections	% of Total C-sections	Births	C-Section Rate
White	460	79.7%	1,391	33.1%
Black	63	10.9%	206	30.6%
Hispanic or Latinx	41	7.1%	142	28.9%
Language				
English	558	96.4%	1,713	32.6%
Spanish	15	2.8%	49	30.6%
All	577	-	1,776	32.5%

Table 7. FY2020 C-Section Data. All percentages are within group comparisons. Note that the “All” row includes all patients, including races not captured elsewhere in table. For this reason, summing patients shown in other categories will not match the “All” row.

Newborn Exclusive Breast Milk Feeding – FY2020

Race or Ethnicity	Newborns Exclusively Fed Breast Milk	Total Newborns	% Exclusively Fed Breast Milk
White	515	1229	41.9%
Black	43	173	24.9%
Hispanic or Latinx	21	64	32.8%
All	607	1541	39.4%

Table 8. FY2020 Newborn Exclusive Breast Milk Feeding. All percentages are within group comparisons. Note that the “All” row includes all patients, including races not captured elsewhere in table. For this reason, summing patients shown in other categories will not match the “All” row.

C-section data was analyzed across race, ethnicity, and language. It appears that White patients have higher C-section rates compared to the C-section rate of all patients, by 0.6%, which likely falls within the margin of error and does not represent a disparity. **Otherwise, when looking at this data, there does not appear to be a disparity in C-section rates across race, ethnicity, or language.**

Data assessing the number of newborns that were exclusively fed breast milk before leaving the hospital was analyzed across race and ethnicity. **Both Black and Hispanic or Latinx newborns have lower rates of exclusive breast milk feeding compared to all patients, which likely represents a disparity that warrants further investigation and action.**



Where We've Been – FY2020 Data

Safe and Effective

Inpatient Opioid Administration – FY2020			
Race or Ethnicity	Unique Patients Administered Opioids	Unique Patients	% Administered an Opioid
White	5,824	8,347	69.8%
Black	706	1,000	70.6%
Hispanic or Latinx	117	189	61.9%
All	6,786	9,711	69.9%

Table 9. FY2020 Inpatient Opioid Administration. All percentages are within group comparisons. Note that the “All” row includes all patients, including races not captured elsewhere in table. For this reason, summing patients shown in other categories will not match the “All” row.

Inpatient opioid administration was measured by looking at the number of unique patients that were administered an opioid in the inpatient setting. The percentage of Hispanic or Latinx patients who were administered opioids is 8.0% lower than the percentage for all patients. **However, the small sample size suggests that this is likely not statistically significant, demonstrating that inpatient opioid administration is unlikely to be a source of a disparity.**

Emergency Department Opioid Administration – FY2020			
Race, Ethnicity	Unique Patients Administered Opioids	Unique Patients	% Administered an Opioid
White	5,518	30,020	18.4%
Black	834	5,606	14.9%
Hispanic or Latinx	131	1,007	13.0%
Language			
English	3,264	36,848	18.4%
Spanish	40	518	17.3%
All	6,588	37,607	17.5%

Table 10. FY2020 Emergency Department Opioid Administration. All percentages are within group comparisons. Note that the “All” row includes all patients, including races not captured elsewhere in table. For this reason, summing patients shown in other categories will not match the “All” row.

Emergency Department opioid administration was measured across race, ethnicity, and language for all unique patients who were administered opioids in the emergency department. **Black patients and Hispanic or Latinx patients were administered opioids at lower rates than all patients.** When combined, 14.6% of Black patients and Hispanic or Latinx patients were prescribed opioids compared to 18.4% of White patients, a 21% difference. **This difference likely represents a health disparity and opportunity for improvement.**

Where We've Been – FY2020 Data

Effective and Patient-Centered

Ambulatory Diabetes Registry - HbA1c ≥ 9.0% - FY2020				
Race or Ethnicity	Patients w/ HbA1c ≥ 9.0%	Total Patients in Registry	% of Total Patients in Registry	% of Patients w/ HbA1c ≥ 9.0%
White	1,069	7,706	89.9%	13.9%
Black	156	642	7.5%	24.3%
Hispanic or Latinx	19	81	0.9%	23.5%
Language				
English	1,246	8,458	98.7%	14.7%
Spanish	10	68	0.8%	14.7%
All	1,265	8,571	-	14.8%

Table 11. FY2020 Outpatient Diabetes Registry – HbA1c ≥ 9%. All percentages are within group comparisons. Note that the “All” row includes all patients, including races not captured elsewhere in table. For this reason, summing patients shown in other categories will not match the “All” row.

The ambulatory diabetes registry, a database of Meritus Health patients who meet diagnostic criteria for diabetes, was assessed to look at the percentage of patients who have a hemoglobin A1c (HbA1c) greater than or equal to 9.0%, a quality measure that indicates poor control of the disease. The HbA1c for these patients was measured across race, ethnicity and language. **The percentages of Black patients and Hispanic or Latinx patients with an HbA1c greater than or equally 9.0% are nearly 10% higher than the percentage for all patients.** While it is difficult to know for sure what could be driving this difference, **these results likely represent a health disparity that warrants further investigation and action.**



Where We've Been – FY2020 Data

Timely and Patient-Centered

Emergency Department Median Throughput Time – FY2020									
Race or Ethnicity	Discharged (OP-18b)			Admitted (ED-1b)			All Cases		Median Throughput (minutes)
	Total Cases	% of Cases	Median Throughput (minutes)	Total Cases	% of Cases	Median Throughput (minutes)	Total Cases	% of Cases	
White	34,748	78.3%	213	11,689	86.4%	353	49,716	79.9%	243
Black	7,486	17%	194	1,469	10.9%	353	9,697	15.6%	215
Hispanic or Latinx	1,193	3%	209	191	1.4%	360	1,487	2.4%	229
Language									
English	43,612	98.2%	209	13,304	98.3%	353	61,081	98.2%	242
Spanish	603	1.4%	232	134	1.0%	369	783	1.3%	261
All	44,403	-	210	13,523	-	353	62,210	-	238

Table 12. FY2020 Emergency Department Median Throughput Time. Median throughput times represent within group comparisons. Note that the “All” row includes all patients, including races not captured elsewhere in table. For this reason, summing patients shown in other categories will not match the “All” row.

Emergency department median throughput time was measured across race, ethnicity, and language for patients who were discharged (Centers for Medicare & Medicaid Services (CMS) metric OP-18b) and admitted (CMS metric ED-1b).

For both discharged and admitted patients, median throughput time was higher for Spanish-speaking patients compared to all patients. **While this difference may be attributable to language barriers and the use of interpreters, it represents a disparity that warrants further investigation and action.** Otherwise, median throughput time does not appear to vary across race and ethnicity.

Where We've Been – FY2020 Data

Timely and Patient-Centered

Inpatient Average Length of Stay (ALOS) – FY2020

Race or Ethnicity	Total LOS (days)	Patients	ALOS (days)
White	44,676	11,060	4.04
Black	5,459	1,306	4.18
Hispanic or Latinx	1,276	389	3.28
All	51,581	12,795	4.03

Table 13. FY2020 Inpatient Average Length of Stay (ALOS). ALOS is reported for based on within group numbers. Note that the “All” row includes all patients, including races not captured elsewhere in table. For this reason, summing patients shown in other categories will not match the “Total” row.

Average length of stay was measured for both inpatients and observation patients across race and ethnicity. **Hispanic or Latinx patients spend less time as both inpatients and observation patients compared to all patients, but it is unclear if this represents a health disparity. Otherwise, these measures do not appear to represent a health disparity.**

Observation Average Length of Stay (ALOS) – FY2020

Race or Ethnicity	Total LOS (hours)	Patients	ALOS (hours)
White	77,958	3,762	20.72
Black	10,375	587	17.67
Hispanic or Latinx	2,309	158	14.61
All	90,642	4,512	20.09

Table 14. FY2020 Observation Average Length of Stay (ALOS). ALOS is reported for based on within group numbers. Note that the “All” row includes all patients, including races not captured elsewhere in table. For this reason, summing patients shown in other categories will not match the “Total” row.

Where We've Been – FY2020 Data

Patient-Centered

Patient Experience Top Box Scores – FY2020								
Race	ED Care		Inpatient Care		Inpatient Comm. w/ Doctors		Inpatient Comm. w/ Nurse	
	Top Box Response Rate	Total Responses	Top Box Response Rate	Total Responses	Top Box Response Rate	Total Responses	Top Box Response Rate	Total Responses
White	59.32%	1362	68.42%	1197	74.95%	1206	77.33%	1210
Black	55.95%	84	67.19%	64	79.24%	64	77.98%	64
Language								
English	59.32%	1529	68.33%	1282	75%	1290	77.43%	1295
Spanish	55.56%	9	100%	9	92.60%	9	96.30%	9

Table 15. FY2020 Press Ganey Patient Experience Responses. Top Box Response Rates are the percentage of responses which received a 9 or higher on the 1 to 10 scale or “Always” selection which indicates the best possible score on the patient experience survey which is sent to all patients after an encounter at any Meritus Health location.

Patient Experience Top Box Scores were measured across race and language for the following categories: Emergency Department (ED) Care, Inpatient Care, Inpatient Communication with Doctors and Inpatient Communication with Nurses. **Based on race and language, there does not appear to be a disparity in patient experience.**

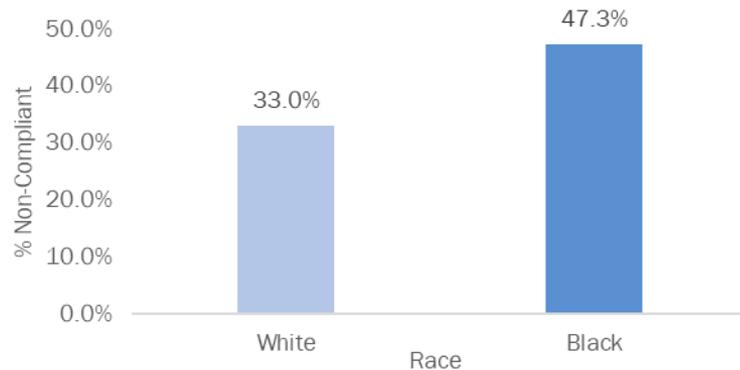


Where We've Been – Disparity Details

Main Findings

We used FY2020 data and analyzed 13 quality and safety measures to assess if health disparities exist across race, ethnicity, or language spoken. Below is a summary of this analysis highlighting 6 disparities that require further investigation and action:

1. Sepsis Core Measure Non-Compliance



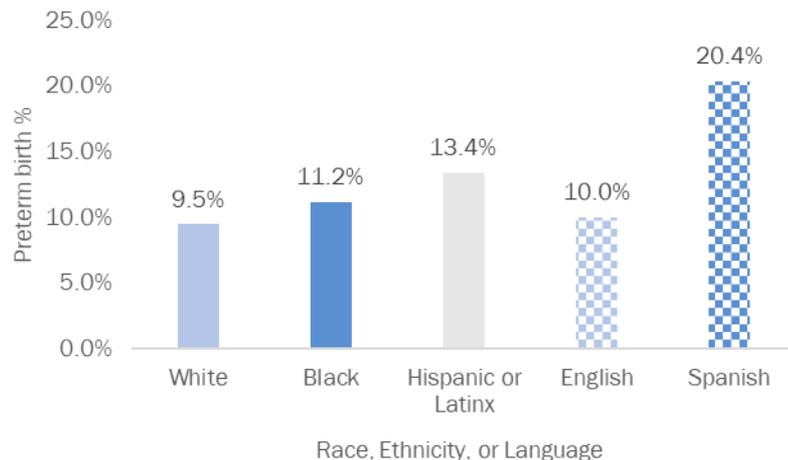
Key Data:

White patients = 33.0% non-compliance (233 out of 707)

Black patients = 47.3% non-compliance (26 out of 55)

Takeaway: 44% higher sepsis core measure non-compliance for Black compared to White patients

2. Preterm Birth % (Birth Prior to 37 Weeks Gestational Age)



Key Data:

White patients = 9.5% (132 out of 1,391 births)

Black patients = 11.2% (23 out of 206 births)

Hispanic or Latinx patients = 13.4% (19 out of 142 births)

Takeaway: 27% higher preterm birth rate for combined Black patients and Hispanic or Latinx patients compared to White patients

English-speaking patients: 10.0% (171 out of 1,713 births)

Spanish-speaking patients: 20.4% (10 out of 49 births)

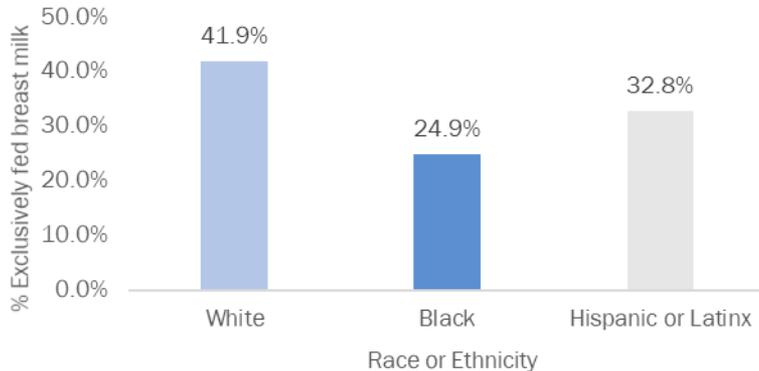
Takeaway: 50% higher preterm birth rate for Spanish-speaking compared to English-speaking patients



Where We've Been – Disparity Details

Main Findings

3. Newborns Exclusively Fed Breast Milk



Key Data:

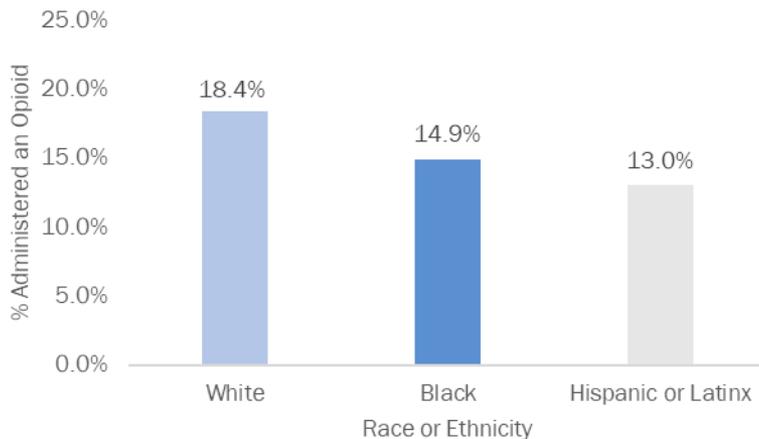
White newborns = 41.9% (515 out of 1,229)

Black newborns = 24.9% (43 out of 173)

Hispanic or Latinx newborns = 32.8% (21 out of 64)

Takeaway: 36% lower rate of exclusive breast milk feeding for combined Black newborns and Hispanic or Latinx newborns compared to White newborns

4. Opioids Administered in the Emergency Department (ED)



Key Data:

White patients = 18.4% (5,518 out of 30,020)

Black patients = 14.9% (834 out of 5,606)

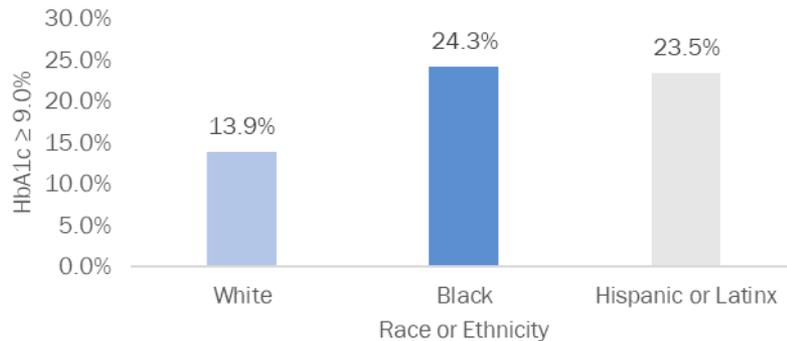
Hispanic or Latinx patients = 13.0% (131 out of 1,007)

Takeaway: 21% lower ED opioid administration rate for combined Black patients and Hispanic or Latinx patients compared to White patients

Where We've Been – Disparity Details

Main Findings

5. Poorly Controlled Diabetes (HbA1c \geq 9.0%)



Key Data:

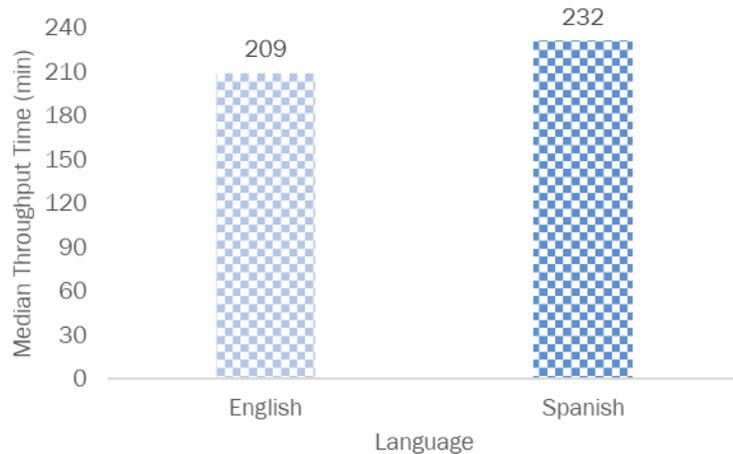
White patients = 13.9% (1,069 out of 7,706)

Black patients = 24.3% (156 out of 642)

Hispanic or Latinx patients = 23.5% (19 out of 81)

Takeaway: 74% higher chance of poorly controlled diabetes when comparing combined Black patients and Hispanic or Latinx patients to White patients (24.2% versus 13.9%)

6. ED Throughput Time – Discharged Patients



Key Data:

English-speaking patients: 209 minutes (43,612 patients)

Spanish-speaking patients: 232 minutes (603 patients)

Takeaway: Spanish-speaking patients on average spend 11% more time in the ED than English-speaking patients

Where We Are – Ongoing Work

To help eliminate disparities in care for patients at Meritus Health and in our community, the Meritus Health Leadership in Equity and Diversity (LEAD) Council was established in August 2020. The group is comprised of individuals throughout the organization from diverse backgrounds who are passionate about this topic. The LEAD Council meets monthly to discuss ongoing initiatives, review articles and scientific literature related to diversity and inclusion, and plan future work related to these issues. It is co-chaired by Meritus Health President and CEO Maulik Joshi and Allen Twigg, Executive Director of Meritus Behavioral & Community Health.

The LEAD Council plans to reach its objectives by:

- Ensuring that the diversity of Meritus Health leadership and staff is representative of the communities it serves.
- Teaching leaders and staff how to understand and speak about race and diversity.
- Raising general awareness of cultural diversity and racial biases.
- Creating ways to increase the inclusion of all people at Meritus Health, with a specific focus on understanding personal unconscious bias and eliminating racism.
- Practicing culturally competent care.
- Building trusting relationships with our community.

To date, the LEAD Council’s efforts are summarized as follows:

- Established the [Meritus Health Statement on Racism and Values of Diversity and Inclusion](#).
- Created three sub-committees to carry out the work toward meeting goals: Data, Education, and Healthcare Equality Index.
- Developed overall and quality-specific dashboards to track progress toward achieving FY2021 goals.
- Collaborated with Senior Leadership to implement the “Rooney Rule” – ensuring that at least one minority candidate is interviewed as one of the finalists for leadership positions.
- Designed a plan to achieve 100% employee participation in unconscious bias and cultural competency training during FY2022.



Where We're Going – Next Steps

Based on the results presented in this summary, disparities appear to exist across 6 of the quality and safety metrics assessed, summarized as follows:

1. Decreased sepsis core measure compliance for Black patients.
2. Increased preterm birth rates for Black patients, Hispanic or Latinx patients, and Spanish-speaking patients.
3. Decreased rates of exclusive breast milk feeding for Black newborns and Hispanic or Latinx newborns.
4. Decreased emergency department opioid administration for Black patients and Hispanic or Latinx patients.
5. Increased percentage of diabetic patients with HbA1c greater than or equal to 9.0% among Black patients and Hispanic or Latinx patients.
6. Increased emergency department median throughput time for Spanish-speaking patients who are discharged or admitted.

To fully leverage the findings outlined in this summary, next steps will include the following:

1. Launch improvement projects with specific responsibilities and timelines to address the disparities identified in this analysis.
2. Continue the work of the LEAD Council, including measuring the impact of the “Rooney Rule” on representation in leadership positions and achieving 100% employee participation in unconscious bias and cultural competency training.
3. Solicit feedback from throughout the organization to determine new metrics to add for FY2021 Health Equity Report as well as metrics that may no longer need to be measured.
4. For all of the above, by involving key stakeholders, determine target dates to reach specific goals by and create accountability mechanisms to ensure that targets are being monitored and reached.

Now that health disparities have been identified, the real work must begin. It's up to all of us to ensure that Meritus Health and its leaders enact plans to eliminate the disparities highlighted in this analysis. The COVID-19 pandemic presented a once-in-a-lifetime challenge for us all as both individuals and as an organization. Through tireless perseverance, our team rose to the occasion and delivered excellent care to the patients we serve. Achieving health equity may be an even more daunting task given the pervasiveness of the societal factors at play. Still, if there is one lesson that the pandemic has taught us, it's that

Together, we can achieve more than we imagined!



Acknowledgments

Meritus Health would like to thank the following individuals for their contributions to the *FY2020 Health Equity Summary*:

Data Analysis and Review:

- Judy Bonilla
- Patricia Wintermyer
- Meritus Health LEAD Council

Data Sources:

- Della Benford
- Drew Bergman
- April Greenlee
- Joan Hall
- Jodi Kelly
- Laura Mercer
- Alan Poole
- Kavitha Reddy
- Michael Staley

Project Management:

- Andrew Maul