ELIMINATING DISPARITIES TO ADVANCE HEALTH EQUITY AND IMPROVE QUALITY

Advancing
Health Equity

MHA
Keystone Center
A Certified Patient Safety Organization

"HOW DO I KNOW IF WE HAVE DISPARITIES, AND HOW CAN I PREVENT DISPARITIES THAT EXIST IN OUR PATIENT OUTCOMES?"

"HOW CAN I CREATE A CULTURE AND SYSTEM THAT REDUCES DISPARITIES TO IMPROVE QUALITY, SAVE LIVES AND REDUCE COST?"

Purpose of the Guide

The Michigan Health & Hospital Association (MHA) is committed to supporting its member hospitals to ensure that every person in every community receives high-quality, equitable and safe care. This guide was developed by the MHA Keystone Center to provide practical guidance for organizations seeking to eliminate disparities in care to advance health equity, including:

› The importance of incorporating an equity lens into all improvement strategies, including quality, patient safety and population health, to improve health outcomes and the patient experience.

› Establishing a common understanding of health organizations' role in addressing health disparities to achieve equity in care.

› Assessing each organization's level of implementation within key categories that have been identified as critical components of any organization's strategic plan to reduce disparities.

› Providing targeted resources and critical steps to support organizations in their journey to advance current practices toward achieving equity in care.

As health systems become increasingly focused on managing the health of populations and new payment structures hold health systems accountable for patient outcomes, these systems will need to consider the financial risk associated with allowing disparities in health outcomes to continue. The total cost of racial/ethnic disparities in 2009 was approximately $82 billion, including $60 billion in excess healthcare costs and $22 billion in lost productivity. The economic burden of these health disparities in the U.S. is projected to increase to $126 billion in 2020 and $353 billion in 2050 if the disparities remain unchanged. Racial/ethnic minorities and individuals with limited English proficiency in the U.S. are more likely to suffer an adverse event, have inappropriate and often costly tests ordered, have a longer length of stay in the hospital, be readmitted to the hospital, and incur ambulatory-sensitive hospitalizations.[1]

How to Use this Guide

The MHA Keystone Center's mission focuses on supporting healthcare providers to achieve excellence in the outcomes desired by the people they serve. The vision statement, achieving the highest quality healthcare outcomes that meet individual values, helps to guide this work. As such, the MHA Keystone Center encourages organizations to use this guide to assess the current level of hospital implementation around key strategies aimed at reducing disparities to achieve equity and improving quality. This resource will guide organizations to prioritize and act on identified gaps so that deliberate and purposeful action is taken to ensure that the outcomes across all patient populations are equitable. This document and supplemental resources are located on the MHA Keystone Center's Health Disparities webpage.[2] Sections of the guide include:

Section 1: Understanding Key Terms

Section 2: Why Equity in Care Matters

Section 3: Strategic Pillars on the Journey Toward Equity

Section 4: Recommendations for Action

Section 5: Levels of Implementation

Section 6: The MHA Keystone Center's Dedication to Achieving Health Equity

Section 7: Resource Compendium

SECTION 1: UNDERSTANDING KEY TERMS

It is important to establish a common understanding of the terms used throughout this guide. Some terms can seem interchangeable, but have distinct meanings, and their use impacts the message being delivered. Below is a list of commonly used terms along with clarification of their meaning.

Anchor Institutions: Enterprises such as universities and hospitals that are rooted in their local communities by a mission, invested capital, or relationships to customers, employees and vendors.[3]

Community Benefit: Hospital community benefits are initiatives or activities financed by nonprofit hospital organizations, as required by federal tax law, to improve health in the communities they serve. The acceptable purposes of community benefits have included improving access to care, enhancing community health, advancing medical knowledge and reducing government burden.[4]

Community Health Needs Assessment (CHNA): The Affordable Care Act (ACA) enhanced the IRS requirements for community benefits programs by mandating that a CHNA be completed every three years. The CHNA process requires that hospitals engage with residents in the community in transparent decision-making actions to assess and plan programs that address the health needs of the community and to implement and evaluate the success of those programs over time.[5]

Culture: Definition and conceptualization of culture vary across disciplines:

> Integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups.[6]

> Unique shared values, beliefs and practices that are directly associated with a health-related behavior, indirectly associated with a behavior, or influence acceptance and adoption of the health education message.[7]

> The learned and shared beliefs, values and lifeways of a designated or particular group are generally transmitted intergenerationally and influence one's thinking and action modes.[8]

Cultural Competence (Culturally and Linguistically Appropriate): Health services that are respectful of and responsive to the health beliefs, practices and needs of diverse patients can help close the gap in health outcomes.[9]

Culturally Competent Care: Ability of providers and organizations to effectively provide care to patients with diverse values, beliefs and behaviors, including tailoring healthcare delivery to meet patients' social, cultural and linguistic needs. A culturally competent healthcare system can help improve health outcomes and quality of care and can contribute to the elimination of racial and ethnic health disparities.[10]

Cultural Humility: A process of reflection and lifelong inquiry involves self-awareness of personal and cultural biases as well as awareness and sensitivity to significant cultural issues of others. Core to the process of cultural humility is the researcher's deliberate reflection of her/his values and biases. Cultural humility encourages developing an attitude of *not knowing* and learning from the patient. It is an ongoing active process for the healthcare provider.[11]

Diversity (Cultural): Cultural variety and cultural differences that exist in the world, a society or an institution. Diversity encompasses many characteristics, including but not limited to race, ethnicity, gender, age, sexual orientation, education, culture, heritage, religion, geography, physical abilities and socioeconomic status.[12]

Downstream: Interventions and strategies focused on providing equitable access to care and services to mitigate the negative impacts of disadvantage on health.[13]

Equity: The just and fair inclusion into a society in which all can participate, prosper and reach their full potential.[14]

Health Disparities: Differences in health outcomes among groups of people. Disparities can occur across many dimensions, including race/ethnicity, socioeconomic status, age, location, gender, disability status and sexual orientation. Health disparities are one way we can measure our progress toward achieving health equity.[15]

Health Equity: Definitions of health equity vary across sectors and organizations. Listed are three definitions.

> Equity is the absence of avoidable, unfair or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, geographically or by other means of stratification. "Health equity" or "equity in health" implies that ideally everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential.[16]

> The state in which everyone has the chance to attain their full health potential, and no one is disadvantaged from achieving this potential because of social position or any other defined circumstance.[17]

> A fair and just distribution of the resources and opportunities needed to achieve well-being.[18]

Health Inequality and Inequity: Health inequalities can be defined as differences in health status or the distribution of health determinants between different population groups. For example, differences in mobility between older adults and younger populations or differences in mortality rates among people from different social classes. It is important to distinguish between inequity and inequality in health. Some health inequalities are attributable to biological variations or free choice, and others are attributable to the external environment and conditions mainly outside the control of the individuals concerned. In the first case, it may be impossible or ethically or ideologically unacceptable to change the health determinants, so the health inequalities are unavoidable. In the second, the uneven distribution may be unnecessary and avoidable as well as unjust and unfair, so that the resulting health inequalities also lead to inequity in health.[19]

Health: A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.[20]

Implicit (Unconscious) Bias: The attitudes or stereotypes that affect our understanding, actions and decisions in an unconscious manner.[21]

Midstream: Interventions and strategies focused on decreasing barriers and improving supports that modify individual behavior.[22]

Population Health: The health outcomes of a group of individuals, including the distribution of such results within the group.[23]

REaL: Race, Ethnicity and Language

> **Race:** A category of humankind that shares certain distinctive physical traits. The U.S. Census Bureau defines race as a person's self-identification with one or more social groups. Race deals with physical characteristics.[24]

> **Ethnicity:** Linked with cultural expression and identification. More broadly defined as large groups of people classified according to common racial, national, tribal, religious, linguistic or cultural origin or background. Ethnicity deals with cultural characteristics.[25]

Social Determinants of Health (SDOH): The circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are, in turn, shaped by a broader set of forces: economics, social policies and politics.[26]

Social Inequality: Characterized by the existence of unequal opportunities and rewards for different social positions or statuses within a group or society. It contains structured and recurrent patterns of unequal distributions of goods, wealth, opportunities, rewards and punishments. A system of privilege created by institutions within an economy. These institutions include the law, business practices and government policies. They also include education, healthcare and the media.[27]

SO/GI: Sexual Orientation (SO) and Gender Identity (GI)

> **Sexual Orientation (noun):** How a person identifies their physical and emotional attraction to others.[28]

> **Gender Identity (noun):** A person's inner sense of being a boy/man/male, girl/woman/female, another gender, or no gender.[29]

Upstream: Interventions and strategies focused on improving fundamental social and economic structures to decrease barriers and improve supports that allow people to achieve their full health potential.[30]

HEALTH EQUITY
MEANS THAT EVERY PERSON HAS AN OPPORTUNITY TO ACHIEVE OPTIMAL HEALTH REGARDLESS OF:

> Race.

> Ethnicity.

> Level of education.

> Gender identity.

> Sexual orientation.

> Employment status.

> Neighborhood.

> Disability.

SECTION 2: WHY EQUITY IN CARE MATTERS

Equity in care ensures that everyone has a fair and just opportunity to attain optimal health. Inequities, or differences in people's health outcomes, are unjust and are a product of shortcomings in the healthcare structure and society. To achieve equity for all, organizations across the healthcare continuum must work to build cross-sectional partnerships and work together to remove obstacles that adversely impact health outcomes. Factors such as socioeconomic status, access to healthcare, education, neighborhood and physical environment, as well as the social and community context within which patients live, are part of a complex system of social determinants of health that play a significant role in creating long-standing disparities in health.

Since 2013, the Agency for Healthcare Research and Quality (AHRQ) has merged quality, safety and disparities by including disparities in its National Healthcare Quality and Disparities Reports[31], further showing the connection between health disparities and quality/safety.

Similar to the culture of quality and patient safety, building a culture of equity ensures that organizations use an equity lens to identify and monitor disparities in care and take responsibility for addressing those disparities. To improve health outcomes and the patient experience for all, healthcare organizations must make health equity a strategic goal as well as a focus within all improvement strategies, including quality, patient safety and population health.

Improving Quality & Safety

In the pioneering publication, Crossing the Quality Chasm, the Institute of Medicine (IOM) defined six domains of healthcare quality and describes these aims for healthcare systems.[32] These include:

Organizations across the country have been committed to addressing the first five of these domains, with an emphasis placed on improving patient safety and quality. While continuing to strive toward improving the healthcare delivery system, much work remains within the equity pillar. With studies continuing to show significant disparities in both healthcare quality and outcome metrics, one might ask — can we truly achieve quality of care without equity?
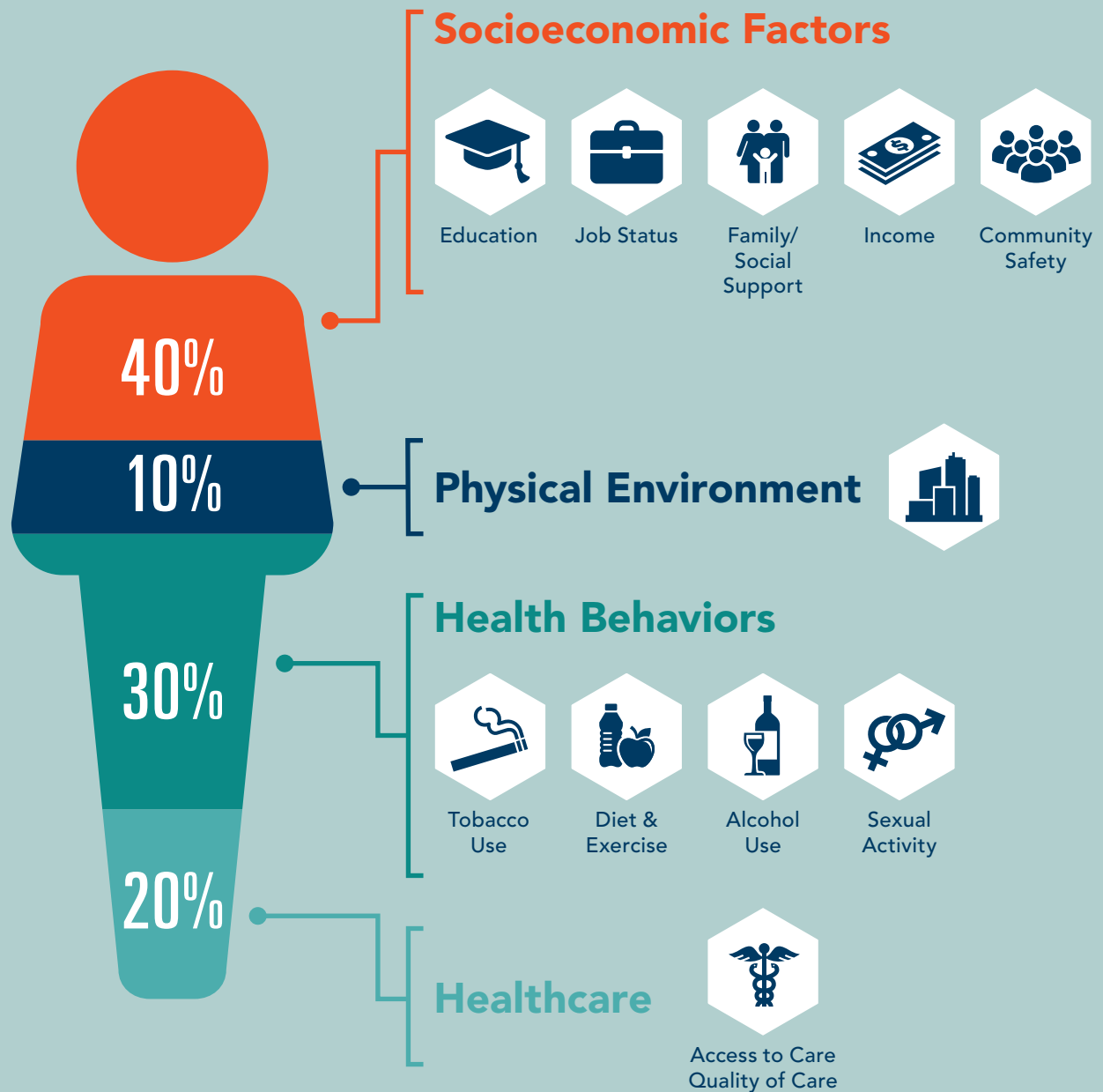
In principle, equity ensures that quality of care does not vary based on patient characteristics (race, ethnicity, gender, geographic location, disability or socioeconomic status), which are all part of the complex interaction of multiple factors that can lead to disparities in health. Although the term "disparity" is often associated with race or ethnicity alone, there are many dimensions of disparities that exist in the U.S. For example, populations of low socioeconomic status, rural and inner-city populations, and disabled populations often experience significant disparities. The social and economic conditions that exist in southeast Michigan are different from those in northern Michigan. These drive disparities in quality and access to care in different ways, depending on the population. To fully understand the impact of social, community and environmental factors on health outcomes, it is important to collect a variety of demographic data to understand the needs of your populations and evaluate all elements that play a role in health and well-being.

Achieving health equity is about taking an organizational strategic approach, which includes stratifying your data to find the lowest scores and doing something deliberate and intentional to raise them and close the gap.

Domains of Healthcare Quality

EFFICIENT	EFFECTIVE	SAFE	TIMELY	PATIENT-CENTERED	EQUITABLE
1	2	3	4	5	6

WHAT GOES INTO OUR HEALTH AND WELL-BEING

Socioeconomic Factors

Education

Job Status

Family/
Social
Support

Income

Community
Safety

40%

10% Physical Environment

Health Behaviors

Tobacco
Use

Diet &
Exercise

Alcohol
Use

Sexual
Activity

30%

20%

Healthcare

Access to Care
Quality of Care

"THE TRIPLE AIM WILL NOT BE ACHIEVED UNTIL IT IS ACHIEVED FOR ALL."

— The Institute for Healthcare Improvement[33]

If you identify any groups of patients where the quality, outcomes, safety or experience scores are lower than the rest, take an intentional look at these groups and improve them; this will improve your overall scores.

It is not just about looking at differences in race, ethnicity and preferred language. Reducing disparities involves looking at your scores in a broad, stratified manner, including socioeconomic status and factors such as housing, access to transportation, income, food insecurity, education level, occupation, geographic location, etc., in addition to other demographic data to identify disparate gaps. It provides the opportunity to take steps to pull disparate groups up to the rest of the groups, which closes the gaps and improves overall safety, quality and experience.

## What Goes into Our Health & Well-being

Healthcare represents a small percentage of the factors that influence an individual's health and well-being. Although personal responsibility plays another key role in health, the choices patients make are dependent on the choices that are available to them. Therefore, it's critical that organizations focus on measuring and identifying socioeconomic and physical environmental root causes and factors that influence disparities in care and work to incorporate a health equity lens into all quality improvement work. In practice, this means each component of quality of care mentioned above — efficient, effective, safe, timely, patient-centered — may mean different things to different patient populations, or mean different things to providers, based on the demographic characteristics of the patient. These differences must be considered when evaluating each component of quality care through the equity lens, comparing and analyzing different patient population groups.

In addition to collecting a variety of patient demographic data to understand the factors impacting the health of your patients, hospitals can use person and family engagement strategies to aid in achieving equity in quality and safety. By committing to engaging patients and families from all backgrounds as equal and active partners in healthcare improvement strategies — on patient and family advisory councils, improvement teams or hospital boards — hospitals can:

> Develop a deeper understanding of the needs, perspective, interests, values and beliefs of all patients and families from diverse backgrounds.

> Implement actions that reflect what matters most to patients at each level of hospital care.

> Evaluate if the measures and metrics set forth are consistent and relative to different patient populations.

For recommended best practices and strategies on person and family engagement, view the MHA Keystone Center Patient & Family Engagement Road Map.[34]

Improving Population Health
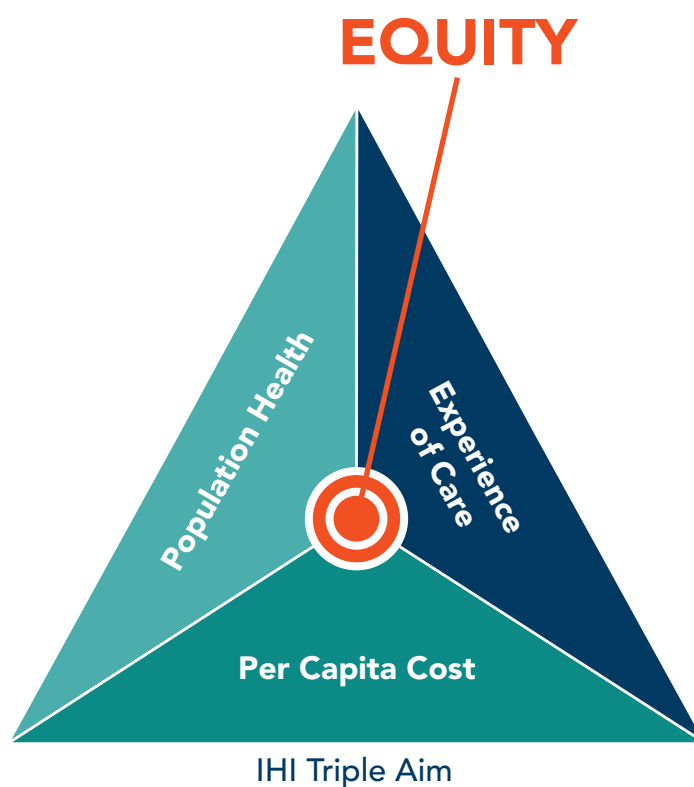
IHI Triple Aim

The guiding compass for healthcare improvement, created by the Institute for Healthcare Improvement (IHI) and commonly referred to as the Triple Aim, directs healthcare institutions looking to optimize their health system performance to pursue three dimensions: improve the health of the population, improve patient experience and reduce costs.[35] Any strategy intended to improve outcomes for the entire population must ensure and

measure that the outcomes are distributed equally across the different patient populations. Quality improvement efforts aimed at a general or nonspecific population may fail to improve or could even worsen disparities. Take, for example, infant mortality — a key indicator of population health. We have seen an overall decline in infant mortality rates (IMR) in the U.S. during the early 21st century due to many public health efforts and technology advances. Still, we have been less successful in eliminating racial, ethnic and geographical disparities in IMRs. In 2017, the overall IMR in the U.S. was 5.8 per 1,000 live births, while the IMR for the non-Hispanic black population was 11.4 per 1,000 live births.[36] Rates were also much higher for states in the South and some Midwest regions.[37]

If the goal of population health is to improve "the health outcomes of a group of individuals, including the *distribution* of such outcomes within the group,"[38, 39] organizations and communities must approach health initiatives through an equity lens — from design and implementation through data collection. Programs and interventions must target fundamental causes that lead to disparities in outcomes, moving beyond one-type-fits-all models.

Improving Financial Performance

Research shows that minorities suffer more medical errors, leading to greater clinical consequences; have longer lengths of stay for the same condition; experience higher rates of avoidable hospitalizations and 30-day readmission rates; experience more test orders for similar conditions; and are less frequent recipients of clinically beneficial, evidence-based care.[40] National analysis has estimated that health disparities cause approximately $93 billion in excess medical care costs and $42 billion in lost productivity annually.[41] The economic burden of these health disparities in the U.S. is projected to increase to $126 billion in 2020 and $353 billion in 2050 if the disparities remain unchanged.[42]

These numbers are staggering, yet even more concerning is that research often measures inequities based on race alone, not accounting for inequities related to gender, sexual orientation, disability status or physical geography. If organizations care about quality and controlling costs, they must commit to equity in care. This is especially true in the era of transformation of the reimbursement payment models — from fee-for-service to value-based care — which drives providers to focus on delivering quality care at a reasonable cost, improving the overall value of care.

MINORITIES SUFFER **MORE MEDICAL ERRORS,** HAVE **LONGER LENGTHS OF STAY** FOR THE SAME CONDITION, EXPERIENCE **HIGHER RATES OF AVOIDABLE HOSPITALIZATIONS** AND RECEIVE **MORE TEST ORDERS** FOR SIMILAR CONDITIONS

Section 2 outlines the critical role equity plays in ensuring that every person in every community receives high-quality, safe patient care. To elevate this important issue, in 2015 the American Hospital Association launched the #123forEquity Pledge Campaign[43], which urges hospitals and health system leaders to pledge to take action to improve health equity. The campaign outlines key strategies healthcare organizations must integrate and act on to accelerate progress in this field, which align with the MHA Keystone Center's focus:

> ❯ Identifying and eliminating health disparities through consistent patient demographic data collection.

> ❯ Understanding the make-up of communities to meet the healthcare needs through cultural competence.

> ❯ Working to ensure the workforce and governance structure reflects the communities served.

> ❯ Building community partnerships to share insight, tools and resources on the journey toward identifying effective strategies to improve the health of the community.

Let's take a deeper dive into some of these elements to understand their importance in improving health.

Eliminating Healthcare Disparities

A strong commitment to the collection of accurate, complete and meaningful patient demographic data is a fundamental step in identifying and eliminating disparities in care. Collecting race, ethnicity and language (REaL) data, as well as expanding the collection of disability status, sexual orientation/gender identity (SO/GI), veteran status, geography, and other social determinants of health (SDOH) or social risk factors assists health organizations in better understanding their patient populations and their needs. Once the organization has identified the data elements and categories to collect, the organization should then develop a standard process and methodology for this data collection, including who will collect the data, when it will be collected, in what format, and how to distribute it across the healthcare system.

Investing in annual workforce training focusing on the collection of various self-reported patient demographic data elements is a great way to ensure better accuracy

and completeness of patient demographic data. At a minimum, registration and administration staff should receive training during orientation on the use of a self-reporting methodology to collect patient demographic data, which removes "guesswork" and ensures the accuracy of collected data. Annually, hospitals must evaluate the effectiveness of the workforce training to ensure staff demonstrate competency in the patient self-reporting data collection methodology, using tools like observations, teach-back, post-test and others.

Once an organization has standardized the collection of these measures and begun the data collection process, the next critical element is to stratify safety, quality and outcomes measures, using patient demographic data to determine if differences in outcomes exist. If disparities do exist, organizations should deploy targeted quality improvement interventions, developed in partnership with community and patient/family advisors, to eliminate those disparities.

The community benefit programs also serve as a vital tool in addressing health disparities. Community benefit efforts center around identifying community health challenges and gaps and building community partnerships to address these gaps. Healthcare organizations should leverage the community benefit obligation's true potential in creating healthier communities by carefully examining if community benefit spending aligns with the needs of the community. Comparing internal data to regional reports, such as information from community health needs assessments (CHNA), is a great way to validate and identify what challenges and needs exist in the communities that impact health. Internal hospital patient demographic data collection and information gleaned from CHNA serve as powerful instruments in identifying root causes of disparities that can guide decisions on what programs and community investments hospitals should make to have an impact on the health of the communities.

Diversity, Inclusion and Cultural Competency

Increasing the diversity of the healthcare workforce and governance is an essential step in advancing cultural competency, which is the ability to provide care to

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patients with diverse values, beliefs and behaviors, including tailoring healthcare delivery to meet patients' social, cultural and linguistic needs.[44] According to the Institute of Medicine's "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," there is strong correlation between clinicians who reflect the communities they serve and their ability to build the trust necessary to achieve better health behaviors from their patients with recommended treatment.[45] Cultural gaps between patients and providers often lead to gaps in health outcomes. On the journey toward achieving equity in care delivery, hospitals should be intentional in interweaving clinical candidates who reflect the diversity of their community, interlacing inclusion and cultural competency into the culture and framework of their organization.

Diversity and inclusion are fundamental building blocks for cultural competency that celebrate the differences between individuals by bringing them together. Once organizations understand the makeup of their communities through consistent data collection, they must evaluate whether their providers and leadership reflect that community. If a gap is identified, healthcare systems should develop strategic efforts and programs to recruit and retain a diverse workforce that reflects the background and needs of their patients.

Diversity on hospital boards is also critical, as trustees who understand the culture, issues and needs of their patient population can provide deeper insight into strategic plans and make more informed decisions on how to best serve their communities.[46] Inclusion cannot be overlooked as a critical element of organizational transformation in working toward diversity. In action, inclusion creates a climate that fosters belonging, respect and value for all and encourages engagement and connection throughout the institution and community.[47] Inclusion is the glue that makes diversity work and must be part of hiring practices, employee orientations, patient care and strategic planning.

Cultural competency training is another organizational intervention that is critical in helping to address disparities. The training is designed to reshape the

attitudes, beliefs and practices of an organization and its care team. It's more than just speaking another language. It means being aware and having a strong understanding of how and why different belief systems, cultural biases, ethnic origins, family structures and a host of other culturally determined factors influence the way people experience illness, adhere to medical advice and respond to treatment — all of which impact outcomes of care.[48]

The work of building a culturally competent organization also entails addressing implicit bias, otherwise known as unconscious bias. Implicit bias examines how attitudes or stereotypes affect the understanding, actions and decisions of care providers in an unconscious way that can result in unequal care. According to a study performed in 1995 by Anthony Greenwald and M. R. Benaji, "much of our social behavior is driven by learned stereotypes that operate automatically — and therefore, unconsciously — when we interact with other people."[49] By incorporating implicit bias education into staff training, organizations can increase awareness and recognition of how individual biases, assumptions, uncertainties, beliefs and stereotypes of patients impact testing, prescription practices and communication with a certain group of patients. This education can also provide tools to prevent providers from being impacted by their implicit biases, which in turn impact patient outcomes.

To become a culturally competent organization, the Health Research & Educational Trust recommends that organizations commit to the steps outlined in "Becoming a Culturally Competent Health Care Organization Guide."[50] Those steps include: analyzing data and microtargeting surveys to improve service for the local community, communicating survey findings to determine priorities, and educating staff and aligning programming and resources to meet community needs.[51]

By making diversity, inclusion and cultural competency strategic priorities, the organization is committing to provide patient-centered, high-quality, safe care to all patients of different backgrounds and experiences, improving patient satisfaction and leading toward fewer care disparities.

Partnerships

Hospitals are often seen as anchor institutions in their communities because of their size and the economic stability they bring to their communities. As such, they have a responsibility to move beyond the four walls and partner with community organizations to improve the health and well-being of their communities — the cornerstone of population health — by addressing the root causes that lead to poor health.

As an anchor institution, a hospital should work with government and community organizations by investing in community improvement, developing strategies to bring about long-term economic improvement opportunities, and advocating for policy changes that target social and economic conditions impacting the health of the community.[52] This means to not only address the individual social needs, but also the long-standing social determinants of health conditions that affect community health. Through accurate and consistent patient and community demographic data collection, healthcare

organizations can serve as data sources that uncover what is truly happening within the community, use the data to identify gaps and advocate for interventions that can lead to meaningful, long-term changes. These interventions could range from programs and services that address immediate individual social needs like food insecurity, transportation and temporary housing to community-level policy interventions that impact deep-rooted problems such as safe housing conditions, access to sustainable healthy foods and clean air. By broadening improvement approaches to extend beyond downstream (managing health and illness) and midstream (minimization of health risk behaviors) efforts to include upstream (long-term interventions that improve community-level conditions), hospitals can drive change to improve population health.

Improving laws and policies that shape community conditions

UPSTREAM

Social and Institutional Inequalities

Racism, discrimination, classism, poverty, ableism, sexism

Addressing individuals' social needs

MIDSTREAM

Living Conditions

Housing, transportation, violence, access to good jobs and education, exposure to toxins, income

Addressing health outcomes

DOWNSTREAM

Health Outcomes, Symptoms

Poor nutrition, chronic disease, communicable disease, toxic stress, infant mortality, life expectancy

SECTION 4: RECOMMENDATIONS FOR ACTION

Below are recommended steps organizations should consider on the journey to eliminating disparities in care and promoting health equity. Consideration of each element will aid in assessing the current state within your healthcare organization to guide deliberate steps toward ensuring that the highest level of care is attained for all people, resulting in equitable outcomes across the entire patient population.

STEP 1: ASSESS

Complete the Health Equity Organizational Assessment (HEOA)[53] to assess your organization's current activity around the seven categories, identified through national research as critical components of an organization's ability to identify and address disparities.

I.   Data Collection

II.   Data Collection Training

III.   Data Validation

IV.   Data Stratification

V.   Communication of Findings

VI.   Addressing and Resolving Gaps in Care

VII.   Organizational Infrastructure and Culture

These seven categories, along with the varying levels of implementation, are discussed in more detail in Section 5. The HEOA is available for completion in the KeyMetrics system. For access, contact the MHA Keystone Center at keystone@mha.org. If your organization has already completed the HEOA, we recommend that you continue updating progress quarterly within each of the seven categories in KeyMetrics.

STEP 2: EVALUATE

Analyze the results of the HEOA with a cross-functional and multidisciplinary team to determine the current level of implementation (see Section 5: Levels of Implementation). Work to identify and understand gaps, barriers and areas of opportunities within each of the seven assessment categories.

Consider these additional elements while reviewing the results of the assessment and areas of opportunity:

> Identify a dedicated leader/team to support these efforts.

> Ensure health equity is a leadership-driven priority that aligns with your mission and vision.

> Build organizational capacity to address this work through developing structures and processes that support health equity.

> Set goals related to opportunities for improvement in data collection, training, use of data to drive improvement and develop an organizational infrastructure, communication and culture to address disparities in care.

> Communicate and engage all levels of staff to ensure they understand the why, what and how.

> Integrate patient demographic self-reported data collection into standard workflows, including electronic integration within the electronic medical record.

> Gather a variety of patient demographic data including race, ethnicity, and language; sexual orientation/gender identity (SO/GI); disability; veteran status; social determinants of health (SDOH); and social risk factors.

> Train different levels of staff, at various points of care, on the collection of diverse patient demographic data points, performing annual validation to assess the effectiveness of the training.

> Partner with impacted communities in the development/selection of tools and indicators used to measure and capture demographic data and backgrounds.

> Make the data useful to understand root causes:
  • Validate the accuracy and completeness of your data.
  • Compare your hospital demographic data to community demographic data.
  • Invite members of impacted communities to participate and provide further analysis of the data and help inform interventions.

❯ Develop an "Equity Dashboard" that is integrated into the existing quality/safety/experience dashboard to communicate patient outcomes within the hospital and community.

❯ Develop system-level changes that ensure sharing of key findings in a way that informs decision-makers and supports the elimination of the conditions that create health inequity.

❯ Develop culturally competent interventions that provide delivery of services that meet the cultural and linguistic diversity of the population served.

❯ Build community partnerships by bringing key learnings and insights to stakeholders, involving impacted communities to participate in the analysis of the data and working together to develop appropriate interventions to address identified gaps.

❯ Measure and track progress.

STEP 3: PRIORITIZE

Rank the necessary action items identified as gaps in the HEOA. Consider:

❯ **WHY —** Develop a clear understanding of the "why," along with a clearly defined problem statement; your organization can develop the business case for this work and get to the drivers and benefits that the project is to deliver.

❯ **WHAT —** A goal for each action item under the seven categories of the HEOA.

❯ **HOW —** A clearly defined plan of how to achieve, evaluate and monitor the goals.

❯ **WHO —** Who will be leading this work? Determine who your stakeholders, teams and customers are, both internally and externally, depending on the action item(s) you are addressing.

❯ **WHEN —** Develop a clearly defined timeline of implementation for each of your identified action items.

❯ **WHERE —** Determine where this work will take place — will it be piloted on one unit before being spread organizationwide?

STEP 4: ACT

Take action on the identified areas of opportunity and commit to reaching the **highest implementation level** within each of the seven categories and build a culture of equity (see Section 5: Levels of Implementation). Consider using the Centers for Medicare & Medicaid Services (CMS) Disparities Impact Statement[54] to develop your action plan, which provides a step-by-step quality improvement framework to identify disparities and act. Additional resources and educational opportunities are on the MHA Community site[55], available to all MHA Keystone Center members.

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

ACT   PLAN

STUDY   DO
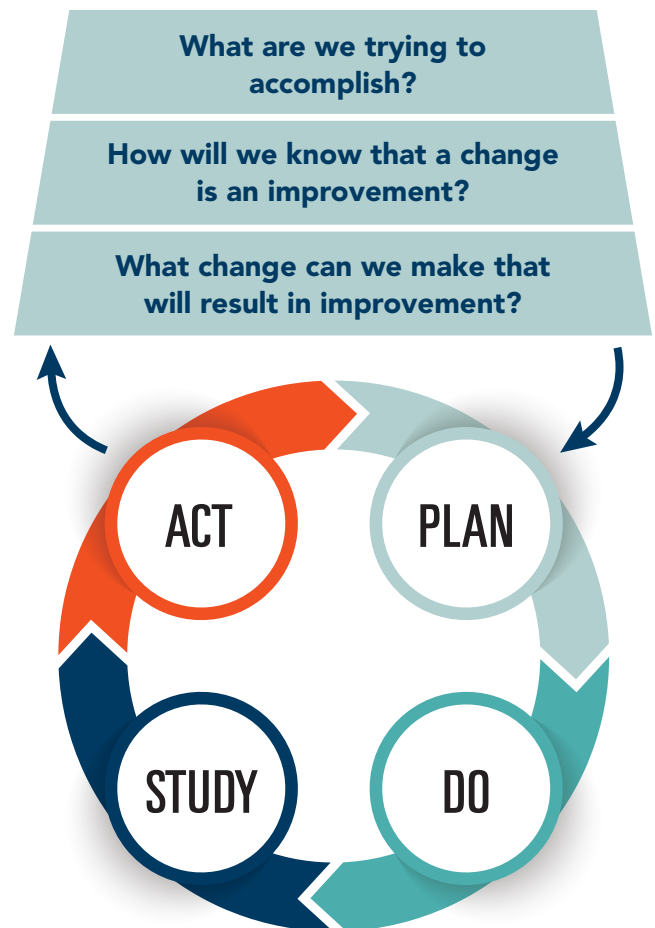
"The Plan-Do-Study-Act (PDSA) cycle is shorthand for testing a change — by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method, used for action-oriented learning." The Institute for Healthcare Improvement.

Background: The seven categories included in the [Health Equity Organizational Assessment (HEOA)](#)[56] have been identified by national research as critical components of an organization's ability to identify and address disparities. Organizations are encouraged to complete the HEOA survey in [KeyMetrics](#) using this [video series](#) as a guide. This will provide your organization with access to an organization specific HEOA dashboard outlining recommendations and next steps. Organizations are encouraged to evaluate the results and develop action plans and goals to advance each implementation level within the seven categories.

The implementation levels outlined below provide a high-level summary of key activities within each implementation category included in the HEOA dashboard and serve as a quick guide to identifying opportunities to advance efforts.

|	One to Two Star Level of Implementation	Three to Four Star Level of Implementation	Five Star Level of Implementation
Data Collection	Organization uses self-reporting methodology to collect at least **one level** of the following patient demographic data items for at least 95% of patients:	Organization uses self-reporting methodology to collect **two or more levels** of the following patient demographic data items for at least 95% of patients:	Organization uses self-reporting methodology to collect **all** levels of patient demographic data items for at least 95% of patients:
	❯ race, ethnicity and language **(REaL)** ❯ sexual orientation/gender identity **(SO/GI)** ❯ social determinants of health **(SDOH)** or social risk factors ❯ disability status, veteran status, and/or other demographic data elements		
Data Collection Training	Training is provided to staff regarding the collection of demographic data including, at a minimum, the collection of **patient self-reported REaL data.**	Training is provided to staff regarding the collection of **additional patient self-reported demographic data (beyond REaL)** such as disability status, **SO/GI**, veteran status, geography and/or other **SDOH** or social risk factors.	Organization **evaluates the effectiveness** of workforce training on an annual basis to ensure staff demonstrate competency in patient self-reporting data collection methodology for **all levels of patient demographic data (REaL, SO/GI, SDOH)** (e.g., observations, teach-back, post-test, etc.)
	Examples of training may include role playing, scripts, didactic, manuals, online modules or other tools/job aids. Patient and/or family advisors should be included in the development and delivery of workforce training to collect REaL data.		
Data Validation	Organization meets **at least one** of the following elements:	Organization meets **at least two** of the following elements:	Organization meets **all** of the following elements:
	❯ Organization has a standardized process in place to **evaluate the accuracy and completeness** (percent of fields completed) for demographic data, such as REaL, SO/GI and SDOH. ❯ Organization **addresses any system-level issues** (e.g., changes in patient registration screens/fields, data flow, workforce training, etc.) to improve the collection of self-reported demographic data such as REaL, SO/GI and SDOH. ❯ Organization has a standardized process in place to **evaluate and compare** organization-collected demographic data to community demographic data for REaL, SO/GI and SDOH.		

	One to Two Stars Level of Implementation	Three to Four Stars Level of Implementation	Five Star Level of Implementation
Data Stratification	Organization stratifies **at least one** patient safety, quality and/or outcome measure by **REaL** data.	Organization stratifies **more than one (or many)** patient safety, quality and/or outcome measure by **REaL** data.	Organization stratifies **more than one (or many)** patient safety, quality and/or outcome measure by **REaL and other demographic data (beyond REaL),** such as disability status, SO/GI, veteran status, geography and/or other SDOH or social risk factors.
Communicate Findings	Organization uses a **reporting mechanism** (e.g., equity dashboard) to routinely communicate patient population outcomes to **organization senior executive leadership (including medical staff leadership) and the board.**	Organization uses a **reporting mechanism** (e.g., equity dashboard) to routinely communicate patient population outcomes **widely within the organization** (e.g., quality staff, front-line staff, managers, directors, providers, committees and departments or service lines).	Organization uses a **reporting mechanism** (e.g., equity dashboard) to share/communicate patient population outcomes widely within the organization and **with patients and families** (e.g., Patient and Family Advisory Council [PFAC] members) **and/or other community partners or stakeholders.**
Address and Resolve Gaps in Care	Organization engages multidisciplinary team(s) to **develop and test pilot interventions** to address identified disparities in patient outcomes.	*Organization meets the previous level in addition to:* Organization **implements interventions (e.g., redesign processes, conducts system improvement projects and/or develops new services)** to resolve identified disparities and educates staff/workforce regarding findings.	*Organization meets the previous two levels in addition to:* Organization has a **process for ongoing review, monitoring and recalibrating interventions (as needed)** to ensure changes are sustainable.
Infrastructure and Leadership	Organization meets **at least one** of the following elements:	Organization meets **at least two** of the following elements:	Organization meets **all** of the following elements:

› Organization has a standardized process to train its workforce to deliver culturally competent care and linguistically appropriate services (according to the **culturally and linguistically appropriate services standards).**

› Organization has named an individual (or individuals) who has leadership responsibility and accountability for health equity efforts (e.g., manager, director or chief equity, inclusion and diversity officer/council/committee). This individual or group is responsible for engagement with clinical champions, patients and families (e.g., PFACs and/or community partners for completing strategic and action planning activities to reduce disparities in health outcomes for all patient populations).

› Organization has made a commitment to ensure equitable healthcare is prioritized and delivered to all persons, demonstrated through written policies, protocols, pledges or strategic planning documents by organizational leadership and board of directors (e.g. mission/vision/values reflect commitment to equity and is demonstrated in organizational goals and objectives).

As previously noted, the MHA Keystone Center's mission and vision directly correlate with improving the health outcomes of all individuals. As such, the MHA Keystone Center is available to support members in reducing disparities in care. Our goal is to provide resources, educational and networking opportunities, and share best practices and lessons learned within four key areas, shaped by the strategies of the #123forEquity Pledge Campaign[57].

I. Hospitals' preparedness to address health disparities through the consistent collection of accurate demographic data.

II. Use of patient demographic data to identify disparities within each community.

III. Development of proper interventions to address identified disparities.

IV. Deployment of organizational and cultural structures needed to sustain the delivery of equitable care.
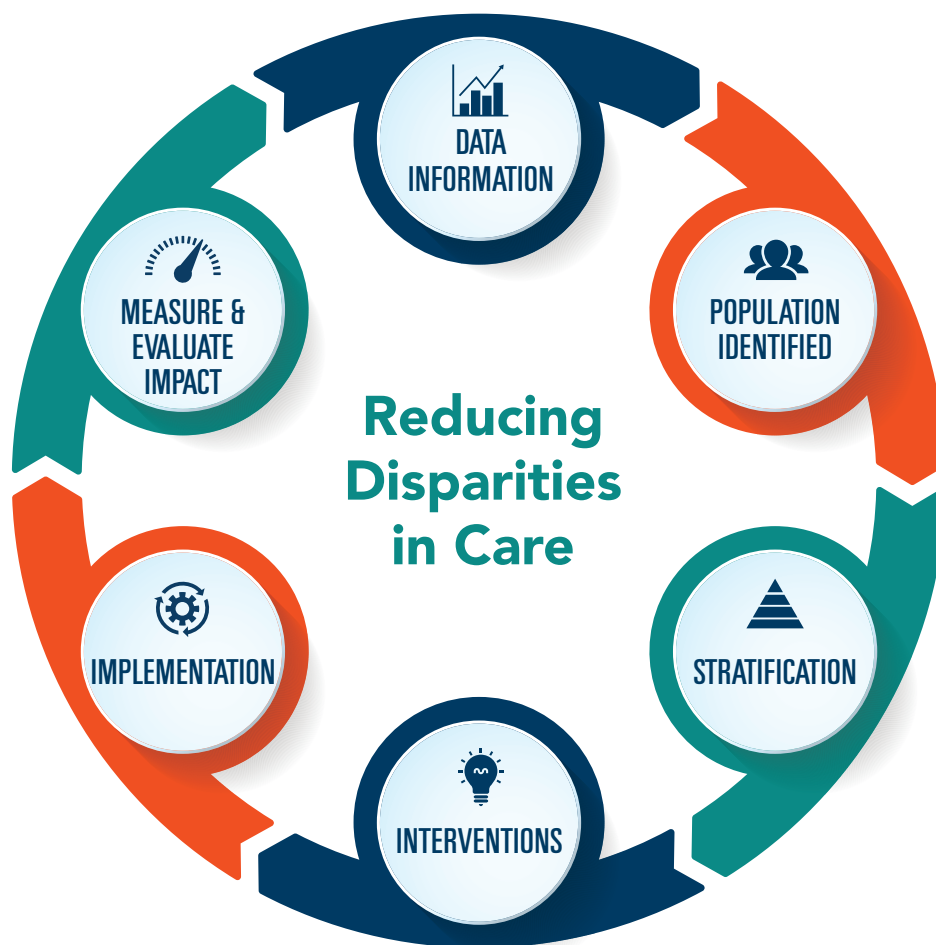
MHA Keystone Center members can access resources on the MHA Community site — an online document library that houses educational material, webinars and upcoming educational offerings.[55]

For more information, contact us at keystone@mha.org.

SECTION 7: RESOURCE COMPENDIUM

The following resource compendium, originally developed by the Partnership for Patients Hospital Improvement Innovation Network Health Equity Affinity Group, provides tools and resources within each Health Equity Organizational Assessment metric.

	Data Collection & Training	Data Validation	Data Stratification	Communicate Findings	Addressing & Resolving Gaps	Organizational Infrastructure & Culture
#123forEquity Pledge to Act to Eliminate Health Care Disparities Equity of Care AHA/HRET				✔	✔	✔
A Framework for Stratifying Race, Ethnicity and Language Data Equity of Care AHA/HRET 2014		✔	✔			
A Practical Guide to Implementing the National CLAS Standards CMS Office Minority Health	✔					✔
A Toolkit for Collecting Data on Sexual Orientation and Gender Identity in Clinical Settings Fenway Institute	✔					
Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community The Joint Commission 2014	✔					✔
AHCS: Accountable Health Communities Screening Tool (Health-Related Social Needs Screening Tool) Center for Medicare and Medicaid Innovation-Accountable Health Communities (AHC)	✔					
American Society of Healthcare Risk Management Equity of Care Assessment Tool ASHRM 2015	✔		✔			✔
Becoming a Culturally Competent Health Care Organization Equity of Care AHA/HRET 2013						✔
Building an Organizational Response to Health Equity CMS Office of Minority Health	✔		✔	✔	✔	✔
Commissioned Paper: Healthcare Disparities Measurement Disparities Solution Center 2011	✔		✔			
Compendium of Resources for Standardized Demographic and Language Data Collection CMS Office of Minority Health	✔	✔				

	Data Collection & Training	Data Validation	Data Stratification	Communicate Findings	Addressing & Resolving Gaps	Organizational Infrastructure & Culture
Disparities Impact Statement CMS Office of Minority Health	✔		✔	✔	✔	✔
Eliminating Health Care Disparities: Implementing the National Call to Action Using Lessons Learned Equity of Care AHA/HRET 2012	✔		✔	✔	✔	✔
Equity of Care: A Toolkit for Eliminating Health Care Disparities Equity of Care AHA/HRET 2015	✔		✔	✔	✔	✔
Guide to Demographic Data Collection in Healthcare Settings Ontario Central Local Health Integrated Network-Sinai Health System, 2017	✔	✔	✔			✔
Guide to Developing a Language Access Plan CMS Office of Minority Health						✔
Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries CMS Office of Minority Health				✔	✔	✔
Health Equity and Race and Ethnicity Data: The Colorado Trust The Colorado Trust Sept 2013	✔	✔	✔			
Healthcare Equality Index LGBTQ Human Rights Campaign Foundation 2018	✔	✔	✔	✔	✔	✔
HHS Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status OMB Categories for Data Collection	✔					
Improving Health Equity Through Data Collection AND Use: A Guide for Hospital Leaders Equity of Care AHA/HRET 2011	✔		✔			
Improving Patient Safety Systems for Patients with Limited English Proficiency: A Guide for Hospitals AHRQ/Disparities Solution Center 2012			✔			✔
Improving Quality and Achieving Equity: A Guide for Hospital Leaders Disparities Solution Center 2015	✔		✔	✔	✔	✔
Learning Resources — Collecting Sexual Orientation and Gender Identity Data National LGBT Health Education Center (Fenway Institute)	✔					
Mapping Medicare Disparities CMS Office of Minority Health			✔			
New York State Toolkit to Reduce Health Care Disparities: Improving Race and Ethnicity Data NY State Department of Health 2014	✔					

	Data Collection & Training	Data Validation	Data Stratification	Communicate Findings	Addressing & Resolving Gaps	Organizational Infrastructure & Culture
PRAPARE Assessment Tool: Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences National Association of Community Health Centers	✔					
Providing Language Services to Diverse Populations: Lessons from the Field CMS Office of Minority Health						✔
Race, Ethnicity, and Language Data – Standardization for Health Care Quality Improvement Institute of Medicine of the National Academies	✔	✔	✔			
Race, Ethnicity, Language Data Collection Best Practices Greater Cincinnati Health Council, 2012	✔	✔				
Reducing Health Care Disparities: Collection and Use of Race, Ethnicity and Language Data Equity of Care AHA/HRET Aug. 2013	✔		✔			
Sexual and Gender Minority Clearinghouse CMS Office of Minority Health	✔					
The Role of the Chief Diversity Officer in Academic Health Centers Institute for Diversity in Health Management, HRET 2012						✔

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