Health Equity Guide

Explore this guide for a definition of health equity, discover why it is important to evaluate disparities that impact health outcomes, and learn the necessary steps to start a quality improvement project that integrates reducing inequities.

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Part I
Introduction

What is Health Equity?

Understanding the difference between equality and equity is a crucial component to reducing health disparities among vulnerable populations. Equality speaks to providing the same access to treatment regardless of individual circumstances. Conversely, health equity refers to providing care without biases that factor in social determinants of health in patients' treatment. The Robert Wood Johnson Foundation defined it best, "Health equity means that everyone has a fair and just opportunity to be as healthy as possible. Equitable care requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."

To learn more on health equity and how to begin a discussion, see What is Health Equity? A Definition and Discussion Guide - RWJF

Why is it Important

The lack of health equity can have profound health implications for people. According to the 2019 National Healthcare Quality and Disparities Report, an estimated number of hospital-acquired conditions in the U.S. is approximately 2.55 million cases and 1.15 people per 100,000 population in age-standardized mortality rate due to adverse effects of medical treatment. In addition, the report showed people in poor households and people of color received worse care than their counterparts. Addressing disparities can be complex, multidimensional, individually based (socio-economical and environmental factors), and challenging. For example, rural communities face challenges such as fewer local doctors, poverty, and remote locations. While in urban communities, there may be other challenges they face that include food deserts, exposure to toxic elements, and long wait times for doctor's appointments. Each community has its unique challenges and reasons why it is essential for organizations and providers to address these inequities as part of their care to ensure quality care.

Part II
Where Do You Start?

Step 1: Collect Data

- Identify an area of interest to show improvement and determine measures. (i.e., readmissions, patient safety, care coordination, etc.)
- Determine what data sets are available to stratify. Approaching disparities requires the ability to stratify data and review factors contributing to inequitable care provided to your population and taking action.
  - **Race, Ethnicity, and Language (REAL)** data is commonly used and collected. Measures, such as readmissions rates, can be stratified by race, ethnicity, and preferred language to give you a closer look at the population most affected. Therefore, accurate data must be obtained to depict your patient population and determine what is impacting their health outcome. REAL data is collected during registration at the point of service entry.Ensure the process is in place for registrars to ask questions on race, ethnicity, and language from patients and caregivers to capture and document accurately. Having uniformity in race categories will keep the documentation consistent. Provide staff who are responsible for registration with a script and possible responses to ensure staff a comfort level in collecting REAL data.
- Additional data sets to be considered and equally important are disability status, sexual orientation/gender identity, veteran status, geography and /or other social determinants of health or social risk factors.
  - **Sexual Orientation/Gender Identity (SOGI)** data can be collected in several ways:
    - Information can be obtained through patient portals and transmitted to an EHR.
    - Questions can be included on registration form for all patients as part of the demographic section along with information about race, ethnicity, and date of birth.
    - Providers and their care team can ask questions during the patient visit/pre-admission as a part of a social or sexual history discussion, for example.
  - **Social Determinants of Health (SDOH)** data can be collected through various screening tools, such as the Health Related Social Needs assessment. Organizations can implement the protocol for responding to and assessing patients' assets, risks and experience (PRAPARE) or the Accountable Health Communities model and train existing staff (i.e., registrars/front desk staff), dedicated screeners (i.e., community health workers) or volunteers (i.e., interns) to collect and act on the SDOH impacting their population.

Step 2: Assess Opportunities for Improvement

Once your organization has decided what area to focus on and identified measures to stratify, analyze and track, you can take it a step further to determine whether disparities are driving performance.

- Identify the problem and conduct a root cause analysis by using a fishbone diagram to focus on the causes of the problem.
- After completing a root cause analysis, prioritize root causes to address using a priority matrix.
- Identify team members who will be a part of a core team that will lead efforts in the equity project. Team members should include representatives that will give multiple perspectives, including but not limited to:
  - Patient or caregiver representative
  - Quality improvement subject matter expert (SME)
  - Leadership
  - Clinician
  - Frontline staff (i.e., administrative and support staff)
  - Equity champion
    - Key characteristics to look for in an equity champion
      - Strong personality; a natural talent for team building, leadership, and advocacy
      - Pride in their work
      - Self-identified but also approved by supervisor
- Be clear in the roles of each core team member and how they will be involved. For example, how will information be shared, and who should be the person to share it. Completing a charter will help to keep the team focused on what they are trying to accomplish.

Step 3: Get Buy-in and Creating a Culture of Equity

Getting buy-in will lead to a strong culture of equity where staff across the organization recognize disparities and address inequities. A few ways you can get buy-in from staff and leadership include:

- Share data and facilitate open discussion.
  - Include staff, board of directors, patients, and family advisory committee/council in discussions.
  - Start with comfortable issues, such as language and literacy.
- Let staff know their input is vital.
  - Recognizing and acknowledging the challenges staff face when dealing with issues is essential in strategizing solutions to overcoming barriers and reducing disparities.
- Consult with everyone who will be impacted by the health equity project.
- Minimize time burdens.
  - Consider leveraging team meetings to solicit information or ideas, so it is less burdensome.
- Report back to everyone who gave input.
  - Follow up with team members who provided input and share what was adopted and why.
- Bottom line.
  - Leadership will be more responsive to interventions with a positive return on investment or if you are leveraging existing resources. Be sure to consider how this will impact the organization financially.
- Identify potential strategies that will help guide your organization as you create and advance your culture of equity. You can list your strategy, activities, and people to engage in a work plan to guide you better.

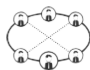
Step 4: Identify Intervention and Modality

- Identify **activities** that will address the root cause and specify **who** it will cover. For example, you may have identified a cultural disconnect between providers and the population you serve; therefore, implementing cultural competency training for your providers may be one activity to execute. Start with activities you identified in your priority matrix as the most important and feasible to address.

Example of Activities	Examples of Who it Can Impact
Cultural competency training	Providers; clinical staff
Language and literacy service enhancement	Patients
Restructuring care team or department	Microsystem (departments or care teams)
Providing financial incentives	Organization
Engaging the community; establishing community partners or participating in community coalitions	Community

- Define how the activity will be delivered. There are different modalities in which you can execute actions. For example, will the competency training for providers be held in-person or online? Take into consideration the feedback received from staff when determining the best modality for certain activities.

In-person



Telecommunications

Print

Internet

Information technology

Multimedia

Step 5: Plans for Sustainability

Communicate with your organization about the project's status to keep everyone abreast of its progress or change in objectives. Using a communications plan to identify your audience and available communication channels will help organize lines of communications and the different modalities in which you can communicate progress. As interventions are determined to be successful at a smaller scale, a decision must be made on whether adopting and scaling the intervention across the organization will be sustainable. A few ways to share information include:

- Visual display of outcomes to keep staff and patients informed (e.g., run charts)
- Dashboard reports displaying information across multiple levels of an organization (e.g.,quarterly leadership dashboards with benchmarks and targets at a summary level across services)
- Highlight progress in staff and board meetings
- Offer recognition and celebrate success for motivation

Part III
Toolbox

Below is a list of tools and templates to embark on your disparity project. Access links to toolkits within-depth resources to continue your journey to understanding inequities and advancing to providing equitable care.

Fishbone Diagram:
Fishbone diagram template to list the root causes of a problem.

How to Use the Fishbone Tool for Root Cause Analysis:
Instructions on how to use Fishbone tool for Root Cause Analysis.

Five Whys Worksheet:
Five Whys worksheet where you can state a problem and the reasons for its cause.

PDSA Worksheet:
PDSA template that will guide you through the PDSA cycle of your project.

Sustainability Decision Guide:
This decision guide helps leaders or teams determine if the interventions and changes they are making are sustainable.

Health Equity Organizational Assessment:
Assessment to determine what strategies to implement based on your organizations stage in addressing health disparities.

Communications Plan Worksheet:
Template to use to plan communications regarding improvement projects.

Creating a Culture of Equity Work Plan:
Work plan template to list strategies and activities associated to those strategies including who is responsible and how it will be sustained; it also includes a timeline.

Priority Matrix:
Tool to help prioritize which root causes to address first.

Performance Improvement Project Charter:
Template to clearly establish goals, scope, timing, milestones and team roles and responsibilities for an improvement project.

REAL Data Collection Script and Definition:
Reasons to consistently collect race, ethnicity, and language and where to collect data; recommended script for staff to use when screening for patient's ethnicity, race and language and definition for each race and ethnicity.

AHA Data-Driven Care Delivery Toolkit:
Toolkit on data collection, validation, stratification, and application of patient information to address disparate outcomes.

AHA Training and the Culture of Learning Toolkit:
Toolkit on training and education strategies and approaches to encourage cultural humility and overcome implicit bias.

AHA Diversity and Inclusion in Leadership and Governance Toolkit:
Toolkit focusing on developing diversity and inclusion leadership strategies at the board level.

AHA Community Partnerships: Strategies to Accelerate Health Equity:
Toolkit focusing on developing health care community partnership strategies that can help expand health care services, eliminate inequities, and improve health equity.

AHRQ Race and Ethnicity Data Improvement Toolkit:
Toolkit on data improvement through education and training of hospital staff

Roadmap to Reduce Disparities | Advancing Health Equity:
A six-step framework for organizations to reduce disparities and foster health equity andintegrate into all health care quality improvement efforts.

GLMA Guidelines for Care of Lesbian, Gay, Bisexual, and Transgender Patients:
Guidance on how health care providers can take positive steps to promote the health of their LGBT patients by examining their practices, policies and staff training for ways to improve access to quality care for LGBT people, including sample LGBTQ-sensitive questions for intakeforms.

The Accountable Health Communities Health-Related Social Needs Screening Tool:
A needs assessment covering five domains that community services can help with includinghousing instability, food insecurity, transportation problems and utility help needs.

A Guide to Using the Accountable Health Communities Health Related Social Needs Screening Tool:
A guide to using the HRSN screening tool including promising practices and key Insights in the ACH model and use of universal screenings.

PRAPARE Implementation and Action Toolkit:
Toolkit to assist providers collect and apply the data needed to better understand their patients' social determinants of health and transform care to meet the needs of their patients.

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