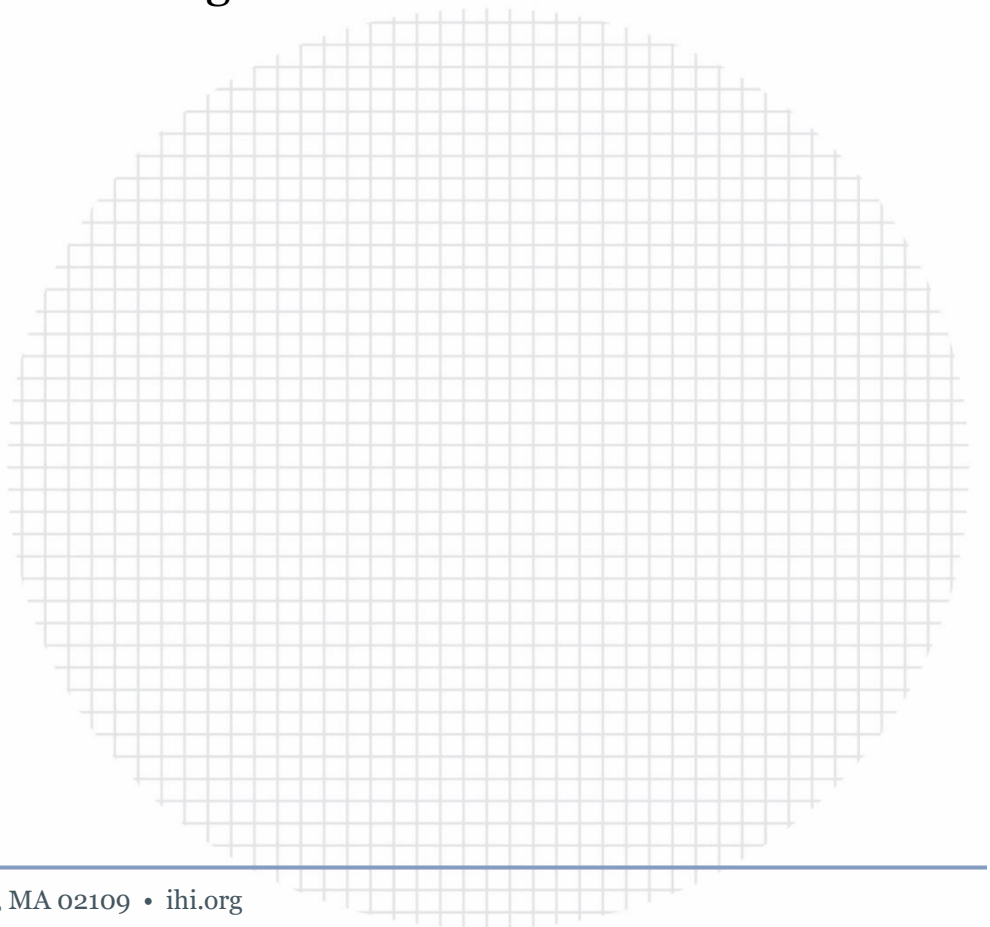
Institute for Healthcare Improvement

Improving Health Equity: Address the Multiple Determinants of Health

Guidance for Health Care Organizations



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The initiative aimed to reduce inequities in health and health care access, treatment, and outcomes by implementing comprehensive strategies to create and sustain equitable health systems. The eight health systems — diverse in size, geographic location, and patient populations served — worked with IHI to apply practical improvement methods and tools, spread ideas in peer-to-peer learning, and disseminate results and lessons to support an ongoing national dialogue and action for improving health equity.

Contents

Executive Summary

Inequities in health and health care persist despite improved medical treatments and better access to care. Health care organizations have a critical role to play in improving health equity for their patients, communities, and employees. In 2016 the Institute for Healthcare Improvement (IHI) published *Achieving Health Equity: A Guide for Health Care Organizations*, a white paper that presents a five-component framework to guide health systems in their efforts to improve health equity. Subsequently, in 2017, IHI launched the Pursuing Equity initiative to learn alongside eight US health care organizations that used the framework to identify and test specific changes to improve health equity.

This guide describes strategies and lessons learned from the eight health care organizations that have tested changes in the framework's third component: Address the Multiple Determinants of Health.

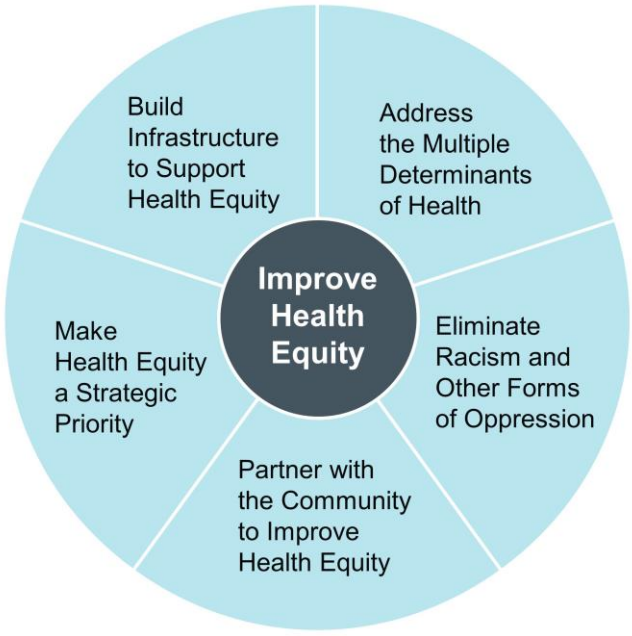
The guide includes:

- **Three strategies** for addressing the multiple determinants of health to improve health equity;
- **Examples of changes** the eight Pursuing Equity organizations have tested; and
- **Common challenges** that arise and strategies for mitigating them.

Introduction

In April 2017 the Institute for Healthcare Improvement (IHI) launched the two-year Pursuing Equity initiative to learn alongside eight US health care delivery systems that are working to improve equity at their organizations. The five-component framework presented in the IHI White Paper, *Achieving Health Equity: A Guide for Health Care Organizations*,[1] serves as the initiative's theory for how health care organizations can improve health equity. IHI continues to update and refine this theory based on learning in the initiative and the experience of the eight organizations; for example, we have updated some terminology in the original framework to reflect additional learning and clarity (see Figure 1).

Figure 1. IHI Framework for Health Care Organizations to Improve Health Equity



- **Make Health Equity a Strategic Priority**

Organizational leaders commit to improving health equity by including equity in the organization's strategy and goals. Equity is viewed as mission critical — that is, the mission, vision, and business cannot thrive without a focus on equity.

- **Build Infrastructure to Support Health Equity**

Operationalizing a health equity strategy requires dedicated resources, including human resources and data resources, as well as an organizational infrastructure.

- **Address the Multiple Determinants of Health**

Health care organizations must develop strategies to address the multiple determinants of health, including health care services, organizational policies, the organization's physical environment, the community's socioeconomic status, and encouraging healthy behaviors.

- **Eliminate Racism and Other Forms of Oppression**

  Health care organizations must look at their systems, practices, and policies to assess where inequities are produced and where equity can be proactively created.

- **Partner with the Community to Improve Health Equity**

  To support communities to reach their full health potential, health care organizations must work in partnership with community members and community-based organizations that are highly engaged with community members.

IHI developed a guide for each of the five components of the equity framework. There is not a sequential order for using the guides, but it is important to note that work in all five components is needed to improve health equity. Guides for the other four framework components are available on IHI's website.[2]

How to Use This Guide

This guide describes strategies and lessons learned from the eight US health care delivery systems participating in the Pursuing Equity initiative that have tested changes in the framework's third component: Address the Multiple Determinants of Health. Lessons learned, resources, and examples from the participating health care delivery systems are described.

Three strategies for addressing the multiple determinants of health to improve health equity emerged:

- Reduce inequities in clinical care;
- Screen for social determinants of health and ensure effective access to social services; and
- Improve health equity throughout the health system, beyond clinical care services.

The guide is organized by these three strategies and includes real examples, tips, and tools. We encourage you to read a section with your team and discuss where your organization may have opportunities to integrate these strategies.

It is also important to establish explicit definitions of terms used in this guide.

- **Health equity:** IHI uses the United States Centers for Disease Control and Prevention definition for health equity: "Health equity is achieved when every person has the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances."[3]
- **Health inequity:** Differences in health outcomes that are systematic, avoidable, and unjust.[3]
- **Health disparity:** The difference in health outcomes between groups within a population. Health disparity simply denotes differences, whether unjust or not. We often look for disparities in health outcomes or health care experience data as a sign of health inequity.
- **Institutional (or institutionalized) racism:** The differential access to the goods, services, and opportunities of a society by race.[4]
- **Multiple determinants of health:** The health care services, social factors, physical environment, and healthy behaviors that directly or indirectly determine health, as well as the policy and advocacy activities that health care organizations can conduct to achieve health equity.

Getting Started

IHI developed an assessment tool to help organizations evaluate their current health equity efforts and determine where to focus their improvement efforts.[5] Teams use this assessment to provide direction for building an equity strategy and promote equity conversations within teams. We encourage you to use the assessment findings to inform your efforts to address the multiple determinants of health.

Three Strategies for Addressing the Multiple Determinants of Health to Improve Health Equity

The purpose of this guide is to provide real-life examples from organizations striving to improve health equity and share their best practices for addressing the multiple determinants of health. Each strategy includes a brief description, key recommended actions, examples of specific changes that organizations tested for each action, challenges and mitigation strategies, lessons, and additional tools and resources.

Based on the experience of organizations participating in the Pursuing Equity initiative, there is not a sequential order for implementing the three strategies for addressing the multiple determinants of health (i.e., in the guide, the strategies are numbered for simplicity, but they do not need to be implemented in the numbered order in which they are presented). Pursuing Equity organizations have had success starting where they have the most will, leadership support, and resources to address to the multiple determinants of health.

Health care organizations can have a direct impact on multiple determinants of health, including health care services, socioeconomic status, physical environment, and healthy behaviors. Interventions that target multiple determinants of health are needed to improve health and achieve equity for all.

Strategy 1: Reduce Inequities in Clinical Care

The health status of individuals and populations is directly impacted by both access to and quality of health care services. Access encompasses coverage, availability of services where people live, and timeliness; lack of or limited access to health services can have major negative implications in terms of health outcomes.[6] Lack of or insufficient availability of health services, insurance coverage, and transportation are all barriers that impact access to health care services, in addition to language and affordability.[7] These barriers often lead to delays in diagnosis and treatment, delays in receiving preventive services, development of clinical complications, and an increase in hospitalizations that could have been prevented.[7] These factors affect different population groups disproportionally, leading to inequities based on race, ethnicity, socioeconomic status, age, gender, sexual orientation, and residential location.[6]

This guide proposes two tactics that health systems may use to reduce inequities in clinical care: 1) stratify clinical data by race, ethnicity, and language to identify equity gaps, and 2) customize improvement efforts to meet the needs of marginalized populations and close equity gaps.

Stratify Clinical Data by Race, Ethnicity, and Language to Identify Equity Gaps

Pursuing Equity teams have found that applying an equity lens when analyzing clinical data is a first step to reducing inequities in clinical care. Using an equity lens involves collecting data on health systems and individual patient characteristics, which allows for stratification of data by race, ethnicity, language, and other factors during analysis. Stratifying data helps health systems identify and understand where disparities exist so that quality improvement efforts can be tailored to vulnerable populations.

The guide on framework component 2, Build Infrastructure to Support Health Equity, describes strategies to support health care organizations in the process of developing the infrastructure to collect and analyze data using an equity lens.[2] Here, we include examples describing specific changes that health care organizations participating in the Pursuing Equity initiative tested to help them identify where equity gaps exist within clinical care.

Example of changes tested:

- Chicago's Rush University Medical Center (RUMC) team applied an equity lens when analyzing clinical outcomes for patients with atherosclerotic cardiovascular disease (ASCVD) and diabetes. For patients with ASCVD, they found significant disparities in health outcomes when race, gender, and health insurance were factored into data analysis. This helped Rush prioritize the most vulnerable populations and set specific aims for them. A summary of their findings from a preliminary data analysis follows.
    - Race and gender: Black patients on average had higher ASCVD risk scores, as did male patients. Black patients had a higher prevalence on each of the selected chronic conditions (ASCVD and diabetes), except for coronary artery disease (CAD), while Hispanic patients had a higher prevalence of obesity and diabetes compared to patients overall.
    - Health insurance: When examining Centers for Medicare & Medicaid Services (CMS) outcomes by Medicaid insurance coverage, those with Medicaid coverage were less likely to meet CMS165 (controlling high blood pressure measure) compared to those with non-Medicaid coverage (66.5 percent vs. 71.8 percent). When examining CMS outcomes by Medicare insurance coverage, those with Medicare coverage were less likely to meet CMS122 (diabetes A1c poor control inverse measure) compared to those with non-Medicare coverage (79.3 percent vs. 84.0 percent).

Customize Improvement Efforts to Meet the Needs of Marginalized Populations and Close Equity Gaps

Understanding where inequities exist enables health care organizations seeking to improve health equity to prioritize and tailor quality improvement efforts to meet the needs of marginalized populations, including those experiencing worse health outcomes. When creating strategies to improve care for marginalized populations, identify the specific needs and issues the population faces, as well as the community resources and assets they have. After identifying where inequities exist, Pursuing Equity teams targeted clinical and non-clinical equity improvement projects.

Example of changes tested:

- The HealthPartners team in Minnesota stratified clinical data for colorectal and breast cancer screening based on race and health insurance, identifying significant disparities for patients of color and patients with Medicaid. Using an equity lens to stratify data and surface disparities enabled the team to set specific screening goals for different racial and health insurance patient populations, with the aim of closing equity gaps in health outcomes.
    - Overall aim: Improve screening rates overall and reduce disparities in breast and colorectal cancer screening across the care group for patients of color and patients with Medicaid by December 2018.
    - Figures 2 and 3 show baseline and post-intervention breast and colorectal cancer screening rates stratified by race. The HealthPartners team identified a significant gap

between white patients and patients of color: for breast cancer screening, a 12.9 percent gap in screening rates between white patients and patients of color (82.2 percent vs. 69.3 percent); and for colorectal cancer screening, a 26.2 percent gap in screening rates between white patients and patients of color (69.2 percent vs. 43.0 percent).

- Due to the higher colorectal cancer incidence and mortality among black and Native American populations compared to other races (and based on national guidelines), HealthPartners begins screening black and Native American patients at age 45, compared to age 50 for other patients.
- The HealthPartners team used this understanding of the disparities at baseline to set specific screening goals and tailor improvement interventions to reduce disparities between white patients and patients of color.

Figure 2. HealthPartners Breast Cancer Screening Rates Stratified by Race

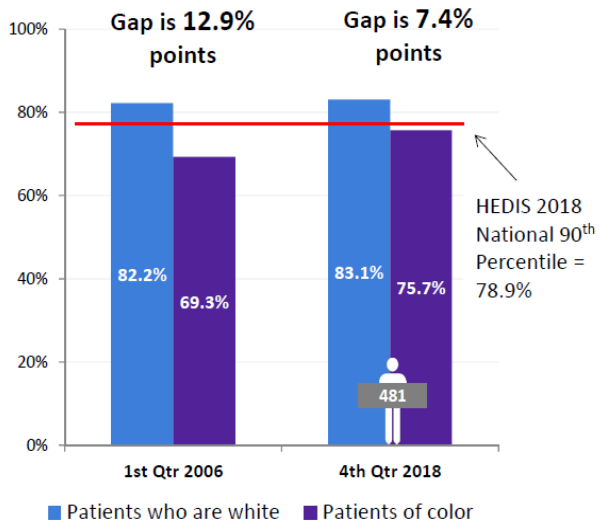
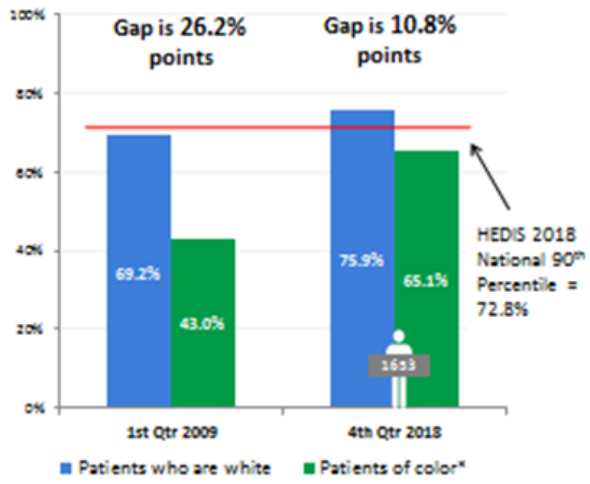


Figure 3. HealthPartners Colorectal Cancer Screening Rates Stratified by Race



**Patients of color: Black and Native American patients start screening at age 45, age 50 for all other races*

Challenges

Reflecting on the experience of the health systems participating in Pursuing Equity, a few challenges were identified.

- Health care organizations often lack the infrastructure to collect and analyze data using patient characteristics such as race, ethnicity, language, gender, and other factors.
- Most organizations that collect these data rarely use it to identify and target the most affected patients.
- Even those organizations that do analyze data and prioritize these populations for their quality improvement efforts seldom adapt improvement strategies to the specific needs of vulnerable individuals and/or populations.

Mitigation Strategies

- The guide for framework component 2, Build Infrastructure to Support Health Equity, provides guidance on frameworks, tools, and infrastructure that health systems need to better collect and stratify data using an equity lens. For organizations with the capacity to analyze data to help identify and understand equity gaps, we recommend being intentional about adapting their improvement strategies to address the specific needs of different populations.
- The Model for Improvement[8] provides a framework to guide improvement efforts and to continuously test, learn, and adapt change ideas using Plan-Do-Study-Act (PDSA) cycles. We recommend that health care organizations adopt the Model for Improvement (or another improvement method) to guide their equity improvement efforts and to make sure, after understanding the specific needs of vulnerable and marginalized populations, to continuously test and adapt change ideas using PDSA cycles.
- Similarly, we recommend the use of co-design and co-production principles when tailoring quality improvement efforts to vulnerable populations. Experience-based co-design (EBCD) is a quality improvement approach that combines narrative, participatory-action research with service design methods to improve patient and staff experiences of care.[9] Co-production focuses on the relationship or partnership between patients and providers who work together toward a shared goal of improving health and the experience of care.[10,11]

Lessons Learned

Strong data infrastructure systems and understanding where equity gaps exist is not enough to drive improvement and close gaps. Health care organizations need to ensure they are constantly using data to guide decision making, tailoring improvement strategies, and continuously co-designing, co-producing, and adapting interventions to the needs of different populations.

Tools and Resources

- Institute for Healthcare Improvement: *IHI Psychology of Change Framework*[11] (an approach to advancing and sustaining improvement together with the people directly and indirectly affected by that improvement)
- The Model for Improvement helps systematically structure an improvement project by defining a specific aim, a set of measures, and change ideas to be tested using PDSA cycles to guide continuous, iterative learning and improvement. This model could be applied by health care organizations to guide their equity efforts, especially as they relate to setting specific aims for different populations, using an equity lens to look at data, and developing and adapting change ideas to address equity gaps.

Strategy 2: Screen for Social Determinants of Health and Ensure Effective Access to Social Services

Social determinants of health (SDOH) include the social, physical, and environmental factors and conditions in which people are born, live, learn, play, work, worship, and age that impact a range of wellbeing, health, functioning, and quality-of-life outcomes.[12] SDOH can account for up to 40 percent of individual health outcomes, especially among vulnerable populations.[13] Patients with unmet social needs are more likely to visit the emergency department (ED) and have more frequent clinical appointment “no-shows” compared to those whose social needs are met.[14]

The following are examples of SDOH:[15]

- Availability and access to resources to meet daily needs (e.g., job opportunities, living wages)
- Access to medical care
- Access to healthy foods
- Access to clean water and functioning utilities (e.g., electricity, sanitation, heating, cooling)
- Access to education and health literacy programs
- Ethnicity and cultural orientation
- Familial and other social support
- Gender identity and sexual orientation
- Housing and transportation resources
- Linguistic and other communication capabilities
- Neighborhood safety and recreational facilities
- Occupation and job security
- Other social stressors, such as exposure to violence and other adverse factors in the home environment
- Social status (degree of integration vs. isolation)
- Socioeconomic status
- Spiritual/religious values, social norms and attitudes (e.g., discrimination)

Screening for SDOH in the clinical setting is a key step in addressing them and, therefore, in improving patient care and clinical outcomes. When screening for SDOH, it is important to select and adapt the SDOH assessment tool, establish a process for conducting SDOH assessment in clinical settings, and ensure effective access to social services.

Select and Adapt the SDOH Assessment Tool

In the literature, there exist multiple tools for SDOH screening. We recommend health systems intending to start screening for SDOH explore the tools available, select the tool that best meets their needs, and adapt the tool as needed for their local context.

Developed by the American Academy of Family Physicians, The EveryONE Project is intended to serve as a toolkit to advance health equity in all communities and to provide guidance to health systems on the process of screening for and addressing SDOH.[16] The EveryONE Project identified the following categories should be included in any SDOH screening process: housing, transportation, utilities (water, electricity), employment, education, finances, and personal safety.

Pursuing Equity organizations developed and adapted their own SDOH screening tools using existing resources from the literature.

Examples of changes tested:

- The Rush University Medical Center team developed and customized a SDOH tool for use in inpatient and outpatient settings (see Figure 4) to assess access to primary care, health

insurance, food insecurity, utilities, transportation, and housing. The tool is available in English and Spanish.

Figure 4. Rush University Medical Center SDOH Screening Questionnaire

Section	Question Text
Primary Care	Do you have a doctor (primary care physician) or nurse that you see regularly? Yes No Decline to answer
Insurance	Do you have health insurance or a medical card? Yes No Decline to answer
Food Insecurity	Are you worried that your food will run out before you have money to buy more? Yes No Decline to answer
Food Insecurity	In the last twelve months, have you run out of food that you bought and didn't have money to get more? Yes No Decline to answer
Utilities	In the last two months, have you had difficulty paying your electric, gas or water bill? Yes No Decline to answer
Transportation	Do you have a hard time finding transportation to and from your medical appointments? Yes No Decline to answer
Housing Instability	Do you currently have a place to stay/live? Yes No Decline to answer
Housing Instability	In the next two months, will you have a place to stay/live? Yes No Decline to answer

Establish a Process for SDOH Assessment in Clinical Settings

Along with selecting and adapting their SDOH screening tools, it is important for health care organizations to develop processes and workflows for conducting SDOH assessments in clinical settings. The workflows identify when the SDOH screening process is conducted (e.g., when the patient first checks in, while the patient is waiting to be seen by a provider, during the clinical visit, after the visit, etc.), who administers the assessment tool (e.g., clinical staff member, non-clinical staff member, patient self-administered), the amount of time it will take, data collection method (e.g., paper vs. electronic format), and how data will be analyzed and by whom to guide decision making.

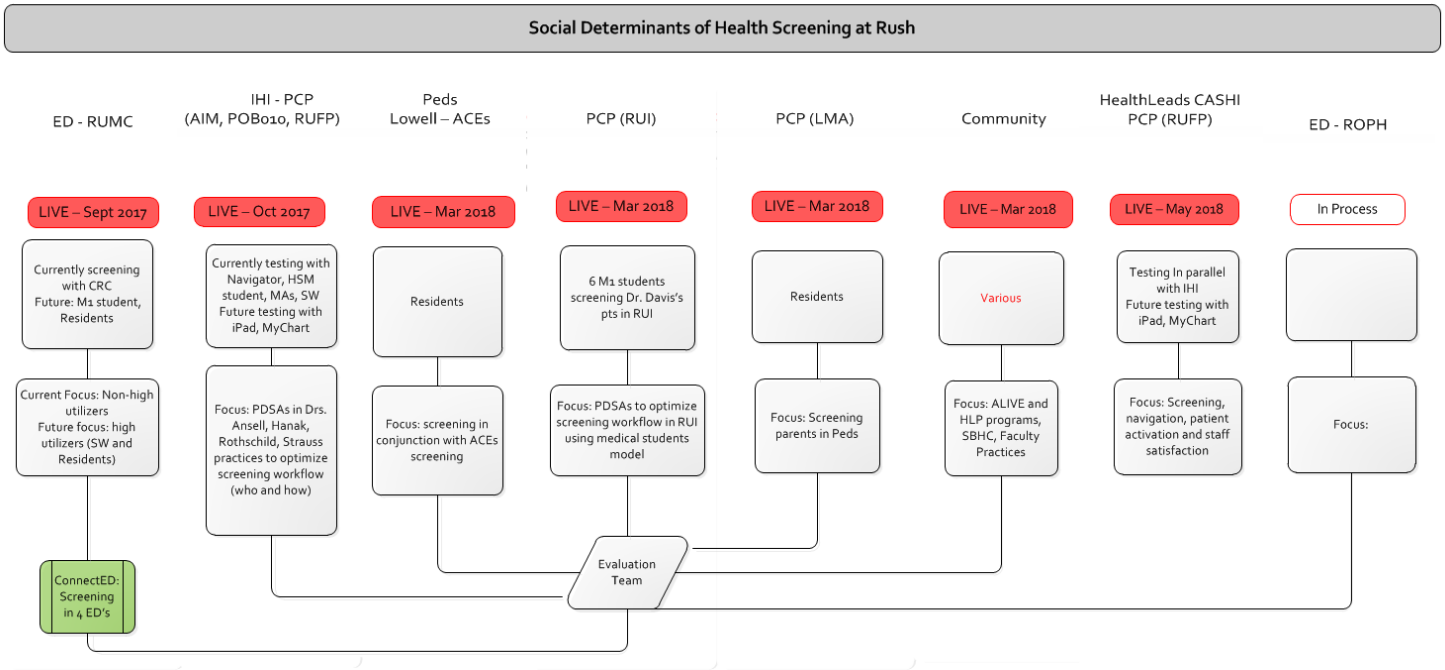
The National Association for Community Health Services developed the *PRAPARE Implementation and Action Toolkit* with resources, best practices, and lessons learned to help guide health care organizations in the process of screening for and addressing SDOH.[17] The toolkit includes sample workflow diagrams to provide guidance on who, where, when, and how to administer SDOH screening processes.

Pursuing Equity organizations developed workflows to streamline SDOH screening processes in inpatient and outpatient settings, as described below.

Examples of changes tested:

- Now in its eighth year, Main Line Health's (MLH) Medical Student Advocate (MSA) Program integrates second- and fourth-year medical students from Philadelphia College of Osteopathic Medicine to help assess MLH patients' SDOH and connect them with community resources to address their needs. In 2018, the program was rolled out in two sites, Lankenau Emergency Department and City Line Family Medicine. As of August 2019, a total of 102 Medical Student Advocates have served 1,513 patients, identified 3,688 social needs, and provided 1,535 referrals to community resources for patients.
- Rush University Medical Center developed a Future State Vision for SDOH: to be a health care system in which all patients' essential resource needs are addressed as a standard part of quality health care. "We believe that identifying the social determinants of health needs of our patients and providing resources will help us to better understand and address patients' whole health and wellbeing."
    - As part of this vision, the team established SDOH screening workflows (see Figure 5) across Rush University Medical Group primary care, ED, and inpatient units. To operationalize this effort in a sustainable way, Rush University Medical Center adopted an interprofessional team approach and established collaboration with different stakeholders and teams, including Social Work and Community Health, Population Health, Information Services, Performance Improvement, Knowledge Management, Community Engagement, Center for Community Health Equity, Rush University Medical Group Primary Care (Internal Medicine and Family Medicine), and West Side ConnectED. Additionally, the SDOH assessment tool was integrated into the system's Epic electronic health record system to allow for real-time access to identify, track, and address patients' social needs and to guide decision making.

Figure 5. Rush University Medical Group SDOH Screening Workflow



Ensure Effective Access to Social Services

A strong process for SDOH screening allows health care organizations to identify social needs and risks that may negatively impact their patient populations. However, SDOH screening is only a prerequisite; addressing SDOH demands processes and systems are in place to ensure effective patient access to social services for needs identified during screening.

Health care organizations must consider the resources they have available to address identified needs, including staff availability and time to focus on initiatives aimed at addressing SDOH; creating workflows to track patient SDOH needs, as well as access to and actual use of social services both within and outside the organization; and, importantly, establishing cross-sector and community partnerships to ensure effective and timely access to social services offered external to the health care organization.

The *PRAPARE Implementation and Action Toolkit* provides guidance to health care organizations on how to build capacity to ensure access to social services for patients identified with social needs, build partnerships with existing community-based organizations that provide access to social services and programs, and engage in advocacy work to influence policy-making in order to create lasting change.[17]

Pursuing Equity organizations implemented different strategies, tactics, and interventions to ensure effective access to social services for patients with identified social needs.

Example of changes tested:

- Rush University Medical Center built partnerships with community-based organizations to provide access to social services for patients with identified social needs (see Table 1).

Table 1. Rush University Medical Center: Community-Based Resources Mapped to Specific SDOH Needs

SDOH Need	Resources Provided
Primary Care and Insurance	Transitional Care Program and CommunityHealth
Utilities	Community and Economic Development Association of Cook County
Housing	Better Health Through Housing pilot with Center for Housing and Health Coordinated Entry System for Chicago and Suburban Cook County
Food Insecurity	Greater Chicago Food Depository and Top Box Foods referrals Food Is Medicine (inpatient) Veggie eRx referrals from Farm on Ogden (emergency department and primary care)
Transportation	Managed care organizations (First Transit) PACE (suburban public transportation service) Kaizen Health/Lyft

- To track resources and services available in the community, and to coordinate closed-loop referrals, the Rush team adopted the NowPow platform in November 2017.[18] This platform enables the team to identify social needs, find the right services for patients, provide and track referrals, actively engage patients, and analyze data in real time (see Figure 6 below). The platform has been integrated into the health system's Epic electronic health record system to help streamline the SDOH program. By June 2018, a 21 percent increase in appointment adherence had been documented.

Figure 6. Rush University Medical Center Workflow for Addressing SDOH

- In 2018, Main Line Health (MLH) transitioned to the Epic electronic health record system, which (via the Social Index field) allows for data collection on sexual orientation and gender identity, as well as social determinants of health. Now, via Epic and MLH's Medical Student Advocate Program's social needs assessment (as described above), the health system can better assess its patient base and develop targeted care models that have an increased focus on vulnerable and high-risk populations.
- Similarly, since 2016, MLH has used a multidisciplinary approach to identify and address the medical and psychosocial needs of patients "treated and released" from Lankenau Medical Center Emergency Department more than three times over a 15-month period. A pilot project included six patients with a total of 89 "treat and release" ED visits in 2015 and 83 visits in 2016. After addressing SDOH needs, "treat and release" visits for those six patients decreased to a total of six visits and that level was maintained for six to nine months. The results from this pilot informed the creation of the Cornerstone Care team, a multidisciplinary team focusing on addressing the clinical and psychosocial needs of the most complex patients in Lankenau Medical Associates.
- In June 2018 Vidant Health partnered with the Food Bank of Central & Eastern North Carolina and East Carolina University Brody School of Medicine to implement a medical food pantry on the Vidant Medical Center (VMC) campus in Greenville, North Carolina. The pantry provides an emergency source of food upon discharge for VMC inpatients who are identified as "food insecure" and connects them with local community food distribution sites to meet long-term needs. The goal for the medical food pantry is to provide a two-week

supply of food to 95 percent of all VMC inpatients identified as food insecure. To accommodate special dietary needs, food bags are available in heart control, low-salt, and balanced diet options. Patients also receive educational resources about how to prepare a balanced meal. Patients receive a follow-up call to assess satisfaction with the food pantry service and access to supporting resources.

Challenges

- Consistently collecting and analyzing SDOH and demographic data across the organization requires appropriate physical and human resources infrastructure, buy-in from leadership and clinical and administrative staff, and local capacity and capability for quality improvement. See the IHI guide on framework component 2, Build Infrastructure to Support Health Equity, for more information about how to address infrastructure challenges related to efforts aimed at achieving health equity.[2]
- Health system staff raised concerns about identifying SDOH needs without having processes in place to provide resources to meet those needs.

Mitigation Strategies

- Create formal partnerships between the health system and community partners to establish closed-loop referrals and provide relevant resources to patients with SDOH and other needs. (See the IHI guide on framework component 5, Partner with the Community to Improve Health Equity, for additional information.[2])
- Build a multidisciplinary team within the health system's population health department to provide timely communication and follow-up to patients whose SDOH assessment has identified specific needs.
- Develop a system-level dashboard of quality and equity measure data that displays progress over time for SDOH screening, intervention, and trends in closing equity gaps. (For additional information, see the IHI guide on framework component 2, Build Infrastructure to Support Health Equity.[2])

Lessons Learned

Teams participating in the Pursuing Equity initiative learned many lessons during the process of deploying strategies to address SDOH.

- Ensure capacity and infrastructure (e.g., staffing resources, technological platforms, workflow processes and tools) to support assessing and addressing social determinants of health.
- The SDOH assessment tool and the process for conducting assessments needs to be customized based on the setting.
- Enable flexibility and variations in the workflows for assessing and addressing SDOH, and then streamline workflows, data collection, and data analysis.
- Multiple staff engagements/trainings on the SDOH screening tool and process are needed.
- It's important to leverage virtual technology to reach vulnerable populations.

Tools and Resources

- National Association of Community Health Centers: *PRAPARE Implementation and Action Toolkit* (includes a variety of process maps and workflow diagrams)
- American Academy of Family Physicians: Social Needs Screening Tool (part of *The EveryONE Project Toolkit* to advance health equity in all communities and provide guidance to health systems on the process of screening for and addressing SDOH)
- The Centers for Medicare & Medicaid Services Accountable Health Communities: Health-Related Social Needs Screening Tool

Strategy 3: Improve Health Equity Throughout the Health System, Beyond Clinical Care Services

Addressing areas outside of clinical care is critical for a health system to implement a holistic equity strategy. There are many areas health care can influence across its business and departments. Health care systems are large employers and have many business opportunities and decisions, all of which impact equity, whether intentionally or unintentionally. Health systems have an opportunity to be intentional in all of these decision points and policies in order to further equity, and it is critical to look at the impact across populations. Health systems can:

- Engage in policy advocacy to improve equity
- Design equitable economic and professional development processes and opportunities for all health system staff
- Consider how hiring policies disproportionately advantage or disadvantage populations (e.g., a policy not to hire tobacco users which disproportionately impacts people of color and people with lower incomes)
- Procure supplies and services from women- and minority-owned businesses in the community
- Build health care facilities in underserved and less affluent communities
- Consider the community's physical environment and the intersection of equity and access in:
    - The health system physical environment (e.g., buildings, transportation, parking fees)
    - Worksites, schools, and recreational settings
    - Investment in housing, homes, and neighborhoods
    - Reducing inequitable exposure, and exposure for all, to toxic substances and other physical hazards
    - Removing physical barriers, especially for people with disabilities
    - Review and update family policies ensuring that LGBTQ families are included in all benefits
    - Aesthetic elements such as good lighting, trees, or benches in all locations

To address health determinants beyond inequities in clinical care, below we describe and share examples of how health systems can advance in two specific areas.

Design Equitable Economic and Professional Development Processes and Opportunities for All Health System Staff

Creating economic and development opportunities for the health care workforce requires establishing systems, structures, and policies to ensure that all staff have equal opportunity to thrive in the workforce. This requires health systems to review their current opportunities for staff; identify which staff utilize the opportunities and which staff do not, and the reasons why or why not; and assess the impact on employee retention, advancement, and joy in work. It's also advisable for health systems to review these data stratified by race, gender, and other factors (e.g., women of color, LGBTQ staff).

Examples of changes tested:

- With a focus on wage equity, Vidant Health analyzed employee wages and identified that the lowest paid employees were women of color. Believing they could improve retention with higher wages, an important investment as the largest employer in their community, Vidant Health improved equity by increasing wages for these employees.
- Rush University Medical Center assessed access to professional development opportunities by understanding the breakdown by race and gender, and the intersection of these two, of who attends professional development trainings. For employees of lower socioeconomic status, in particular, paying for professional development fees out of pocket and then getting reimbursed was creating a financial challenge and a deterrent from taking advantage of this benefit. To impact equity and access to these resources, the medical center began giving employees a monetary advance to pay for professional development opportunities.
- In a discussion on internships and fellowships for clinical providers, Pursing Equity teams raised the need for a health system to review and revise intern policies, namely, to assess the extent to which internships are paid and accessible to communities of color and low-income students. Unpaid internships are not options for many students and create an inequity in the prospective pipeline of the health care workforce. A health system can remedy this by providing paid internships.

Engage in Policy Advocacy to Improve Equity

Policy advocacy is a critical lever that health systems have at their disposal — to use their voices, resources, and support to impact the environment within which health care and communities are located. Advocacy can occur at the local, state, or federal level. To advocate for policies that improve equity, Pursuing Equity teams tested the following tactics: 1) establish relationships with policy makers to improve health and health equity in the community; 2) advocate alongside community-based organizations for improved access; and 3) work with state legislatures to revise payments and reimbursements for non-clinical health care providers.

Examples of changes tested:

- Main Line Health, along with more than 20 other health systems, academic institutions, and community organizations, established Together for West Philadelphia (TfWP) to facilitate collaboration among community, public, and private sector stakeholders on shared projects to maximize impact in the areas of health, education, food access, and opportunity. TfWP participated in the 2018 On the Table Philadelphia, an initiative to civically engage and identify opportunities to enhance the community, and received $5,000 in grant funds to support five projects that arose from its discussions.

- In 2018, Rush University Medical Center implemented a patient transportation pilot program with Lyft, with the aim of using rideshare services to address the need for timely, effective, cost-efficient, short-term transportation options so patients can get to their medical appointments. This project was launched in response to the high rates of "no-shows" to outpatient medical appointments and the high rates of patients presenting to emergency departments with conditions that could have been managed in the outpatient setting. The partnership between Rush and Lyft began through Rush's involvement with the Healthy Chicago Hospital Collaborative and is supported by various transportation efforts endorsed by the Department of Health and Aging and Department of Care Management. Areas testing this pilot program include the emergency department, inpatient units, adult primary care (three practices), pediatric primary care (three practices), the social work and community health department, and the population health program (which includes the Cancer Center, Medical Home Network [Medicaid ACO], and Transitional Care Program).

Challenges and Mitigation Strategies

- Impacting equity in the community, beyond the health system itself, can be challenging to coordinate. It also requires all health system staff have a shared understanding of equity and that leaders engaged in policy advocacy are utilizing an equity lens.
- Improving health equity throughout all areas of the health system, beyond clinical care, will challenge other priorities. For example, mandates to reduce the number of Medicaid patients being seen by the health system may negatively impact equity; increasing employee wages to improve equity for the health care workforce is an expense for the health system and requires buy-in from different stakeholders, from health system leadership to state and federal legislatures. Strong leadership commitment is needed to make equity a strategic priority, mitigate conflict when other priorities seem at odds with equity principles, and escalate challenges and make decisions that advance equity at key decision points.

Lessons Learned

Pursuing Equity teams learned that improving equity throughout and beyond the health system requires a strategy where staff and leaders in all departments can see how they contribute to the equity mission and are held accountable to do so. Leaders also need to make clear the organization's long-term commitment to improving equity and how all departments and staff play a role in this important work.

Tools and Resources

- Rush University Medical Center: *Anchor Mission Playbook*
- Center for Health Law and Policy Innovation: *Health Care in Motion* (a regular digest of updates, action alerts, policy development analysis, white papers, and advocacy tools addressing the changing health care policy landscape)

Conclusion

For health systems to improve health equity, they must develop and implement strategies to address the multiple determinants of health that directly or indirectly impact health outcomes and contribute to health inequities, from clinical care to social determinants to all areas of the health care business. These strategies include activities aimed at reducing inequities in clinical care — such as stratifying data by race, language, and other factors to identify vulnerable populations and potential equity gaps — and tailoring quality improvement efforts to meet the needs of these populations and close gaps.

Similarly, health systems have the opportunity to leverage and mobilize internal and community resources to screen for SDOH and to ensure patients have effective access to social services to meet their identified social needs. Moreover, health systems have an opportunity to address equity across the health system such as providing economic and development opportunities for all health system staff, as well as in areas outside of clinical care such as engaging in policy advocacy to improve equity.

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