Institute for Healthcare Improvement

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Leading Your Institution in Achieving Health Equity

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No conflicts to declare

Workshop Agenda 2:15 – 5:30 pm

- Welcome & Introductions (All) 2:15 – 2:45 pm
- Building Will 2:45 – 3:45 pm
  - The Problem
  - Health Equity Framework
- Ideas 4:00 – 5:15 pm
  - Special Issues
  - Case Studies
- Execution/Implementation 5:15 – 5:30 pm
  - Next Steps

  - "Stories of Self, Us, Now" – Marshall Ganz

Plan for the Day – Stories of Self

- Welcome & Introductions 2:15 – 2:25 pm
- Stories of Self 2:25 – 2:45 pm

Plan for the Day – Building Will

- Building Will 2:45 – 3:45 pm
  - The Problem
  - Health Equity Framework
- Break 3:45 – 4:00 pm

Health Equity

When all people have "the opportunity to 'attain their full health potential' and no one is 'disadvantaged from achieving this potential because of their social position or other socially determined circumstance‘”

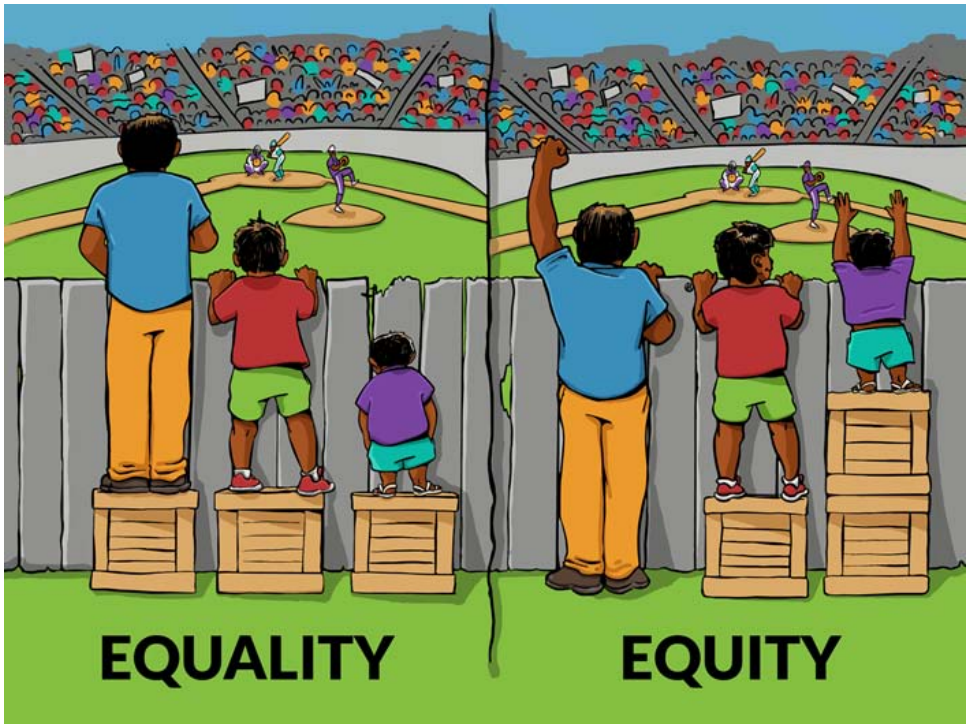
Requires a focus on poor and marginalized populations

Health Inequity

A difference or disparity in health outcomes that is systematic, avoidable, and unjust.

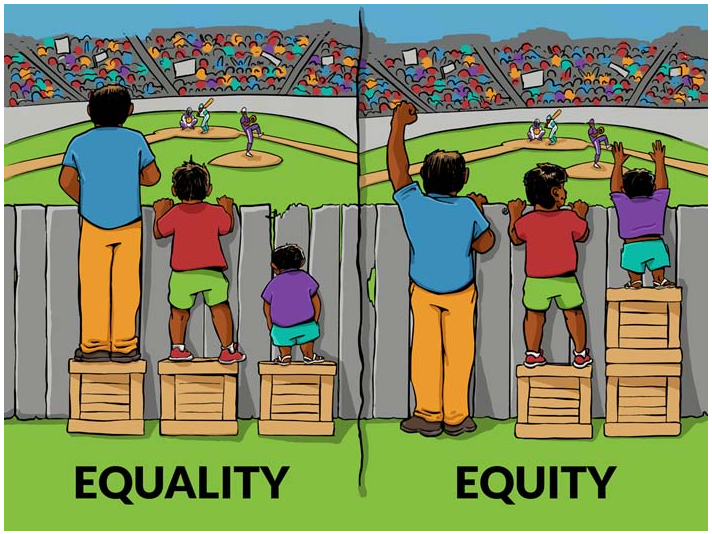
- Braveman, P.A., Monitoring equity in health and healthcare: a conceptual framework. Journal of health, population, and nutrition, 2003. 21(3): p. 181.
- Kawachi, I., A glossary for health inequalities. Journal of Epidemiology and Community Health, 2002. 56(9): p. 647
- Whitehead, M. and Whitehead, The concepts and principles of equity and health. Health Promotion International, 1991. 6(3): p. 217.

Equality *versus* Equity



Source: Interaction Institute for Social Change | Artist: Angus Maguire.

What are the different assumptions in these images?



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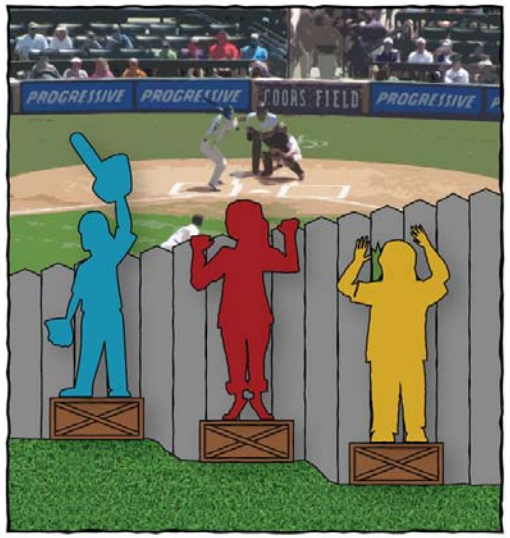
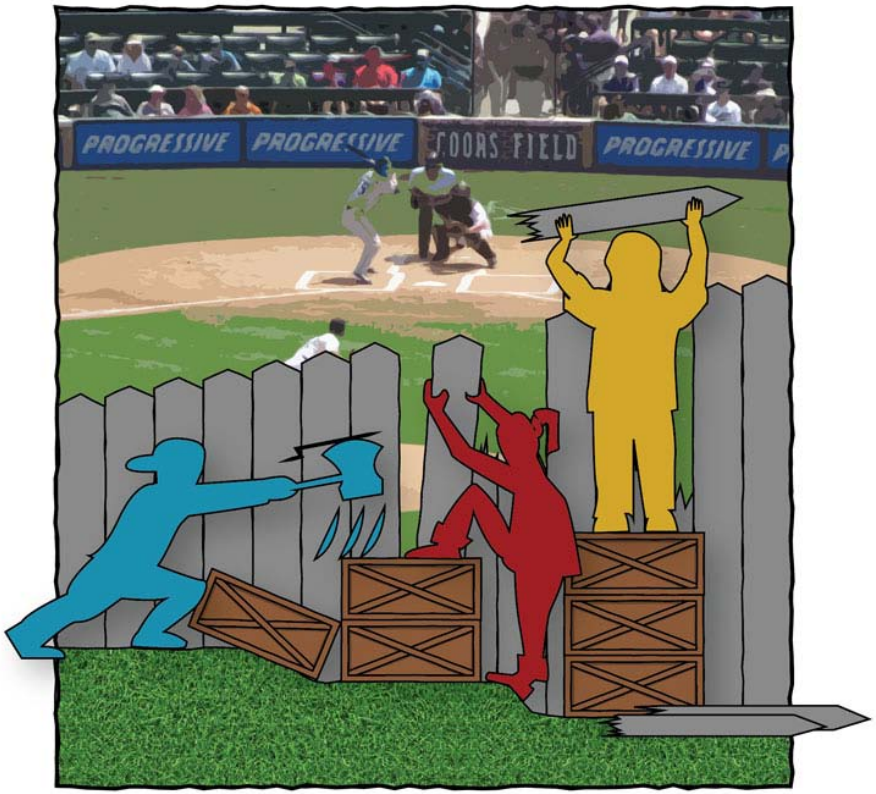


EQUALITY

EQUITY

Source: http://culturalorganizing.org/the-problem-with-that-equity-vs-equality-graphic/

What about the fence?



Source: http://culturalorganizing.org/the-problem-with-that-equity-vs-equality-graphic/

It’s not just the cost curve we have to bend. It’s also the justice curve….

The arc of the moral universe is long, but it bends toward justice

Martin Luther King, Jr.

I do not pretend to understand the moral universe, the arc is a long one, my eye reaches but little ways. I cannot calculate the curve and complete the figure by the experience of sight; I can divine it by conscience. But from what I see I am sure it bends towards justice.

Theodore Parker, Ten Sermons of Religion, 1853

We cannot understand the moral Universe. The arc is a long one, and our eyes reach but a little way; we cannot calculate the curve and complete the figure by the experience of sight; but we can divine it by conscience, and we surely know that it bends toward justice. Justice will not fail, though wickedness appears strong, and has on its side the armies and thrones of power, the riches and the glory of the world, and though poor men crouch down in despair. Justice will not fail and perish out from the world of men, nor will what is really wrong and contrary to God's real law of justice continually endure.

Morals and Dogma of the Ancient and Accepted Scottish Rite of Freemasonry, 1871

The Disparity Landscape

- Race
- Ethnicity (including language)
- Gender
- Education
- Income
- (Class)
- Disability
- Geographic location (rural)
- Sexual orientation

Inequitable Care & Health Outcomes

- Black women have lower rates of breast cancer but are more likely to die from the disease
- Women with disabilities are less likely to receive screenings for breast and cervical cancer
- Blacks are 10 times more likely to have AIDS; Hispanics are 3 times as likely
- American Indian/Alaska Natives twice as likely as whites to have frequent mental distress
- 2.5 times more Hispanics as whites report having no doctor
- Adolescents and adults with disabilities are more likely to be excluded from sex education
- LGBT inequities related to oppression and discrimination - youth more likely to be homeless, 2-3 times as likely to attempt suicide, lack health insurance and lack knowledgeable health care providers

Inequitable Care & Health Outcomes

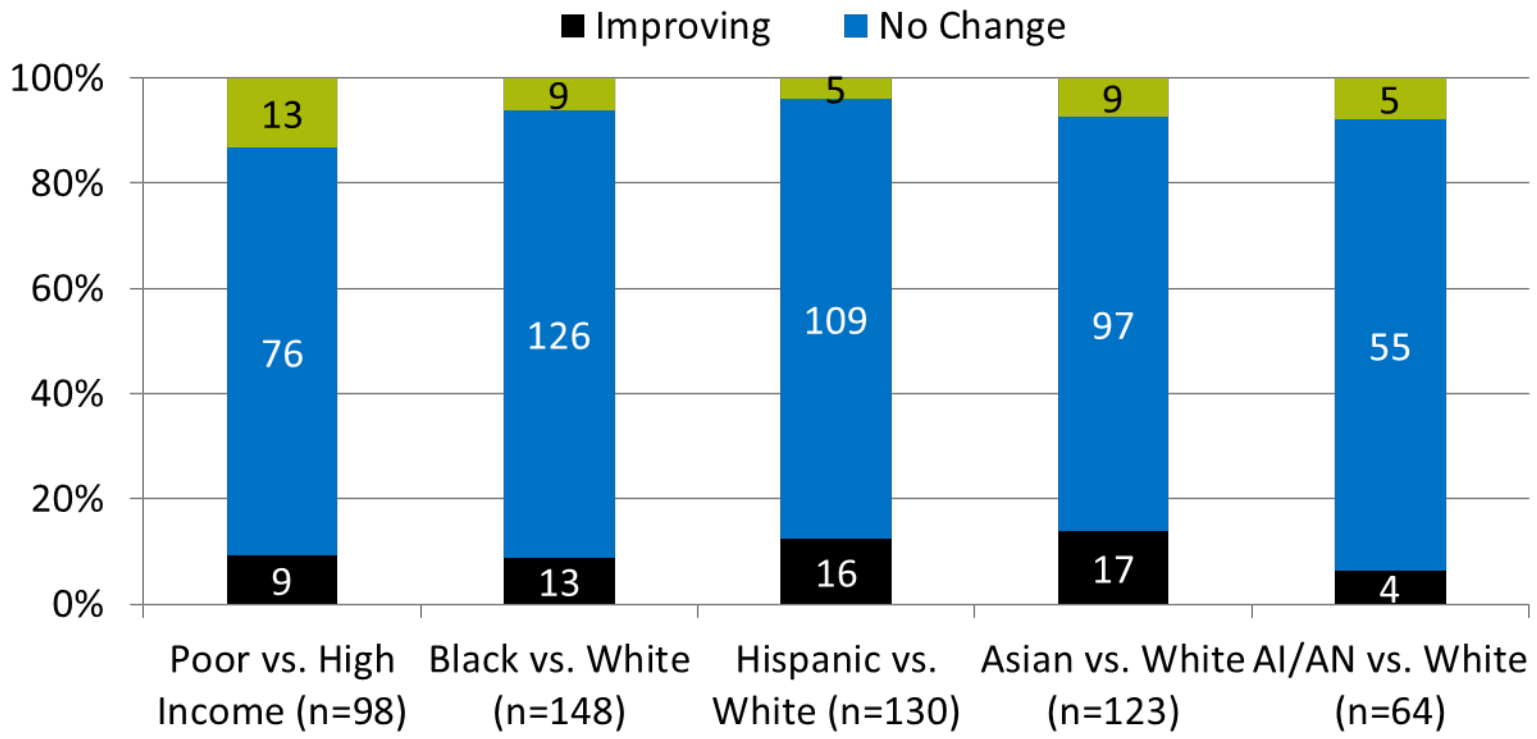
- Minority groups (except Asians) more likely to report health as fair or poor
- Infant mortality for blacks 2.5 times higher than for whites
- Low-income and uninsured adults are less likely to rate the quality of their care as excellent or very good
- Blacks are 3 times as likely to die from asthma than whites
- American Indian/Alaska Natives twice as likely to have diabetes
- Homeless populations experience unsafe discharges

2014 National Healthcare Quality & Disparities Report. June 2015. Agency for Healthcare Research and Quality, Rockville, MD.
http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/index.html
CDC Health Disparities and Inequalities Report, 2013.
HealthyPeople 2020.
WHO disability and health fact sheet. http://www.who.int/mediacentre/factsheets/fs352/en/

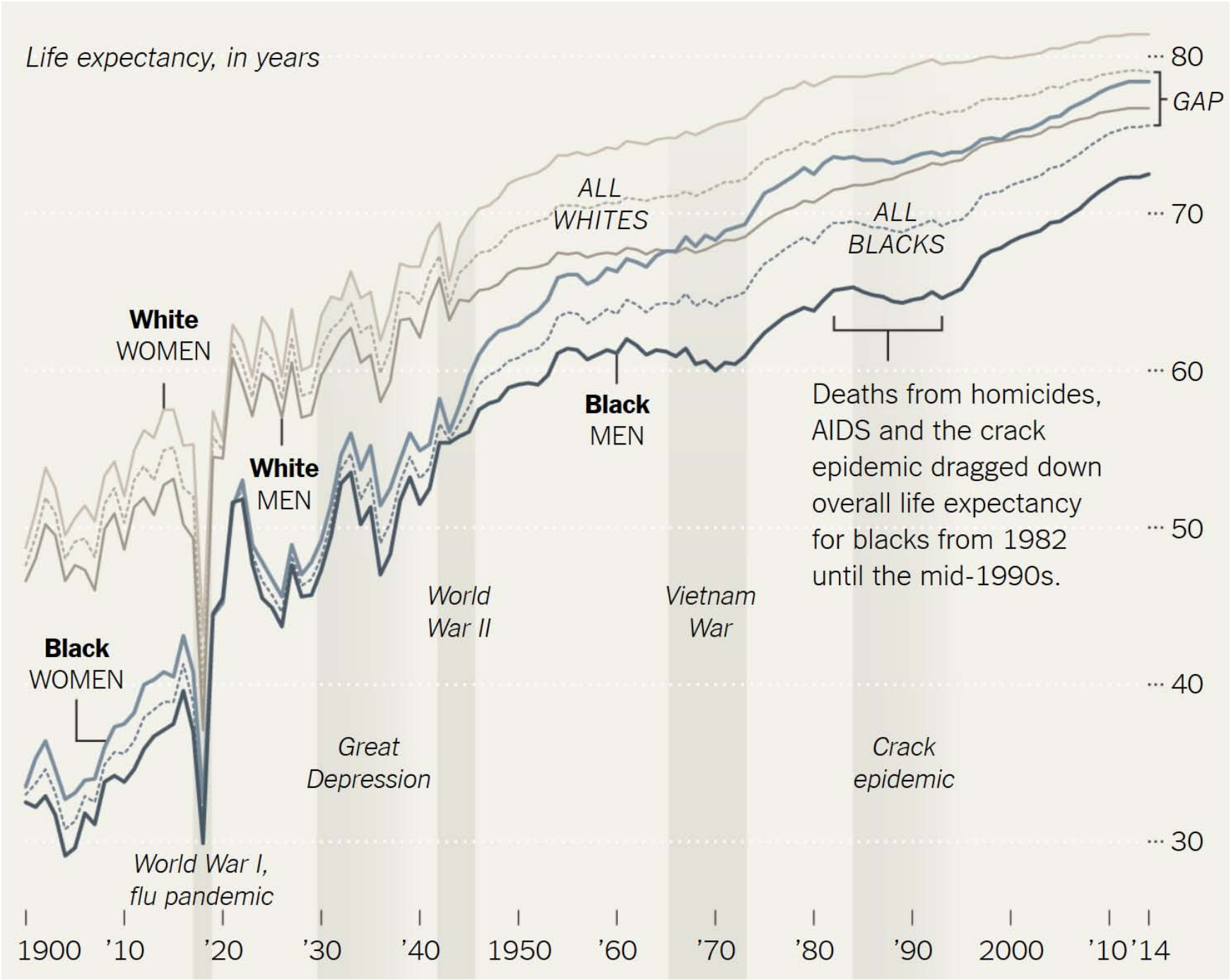
Commonwealthfund, Racial and Ethnic Disparities in US Health Care: A Chartbook, 2008.
Commonwealthfund, Achieving Better Quality of Care for Low-Income Populations: The Role of Health Insurance and the Medical Home for Reducing Health Inequities. May 2012.

QUALITY DISPARITIES: Through 2012, some disparities were getting smaller but most were not improving across a broad spectrum of quality measures

Change in Disparities: Number and percentage of quality measures for which disparities related to race, ethnicity, and income were improving, not changing, or worsening through 2012



Source: 2014 National Healthcare Quality and Disparities Reports


Life expectancy, in years
80
70
60
50
40
30
GAP
ALL WHITES
ALL BLACKS
White WOMEN
White MEN
Black MEN
Black WOMEN
Deaths from homicides, AIDS and the crack epidemic dragged down overall life expectancy for blacks from 1982 until the mid-1990s.
World War II
Vietnam War
Great Depression
Crack epidemic
World War I, flu pandemic
1900
'10
'20
'30
'40
1950
'60
'70
'80
'90
2000
'10
'14

Communication Challenges

- Communication facilitated by:
  - Trust
  - Shared language
  - Shared culture
  - Health literacy
  - Cultural expertise/competence; cultural sensitivity; cultural sensibility
  - Consistent providers
- Leading to:
  - Shared goals, shared decisions, support for self-management

Gaps in Health Workforce Capability

- Cultural competence
  - The integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of health care
- Cultural sensitivity
  - Knowing that cultural differences as well as similarities exist, without assigning values, i.e., better or worse, right or wrong, to those cultural differences
- Cultural sensibility
  - There is no notion of acquiring expertise about others but a recognition that one needs to be aware of our perspectives and how they affect our ability to have an openness about other perspectives. This leads to a generic openness to diversity of all kinds and specific knowledge is not taught.

Cultural Competency v. Cultural Sensibility

- Cultural competency (expertise)
  - Emphasizes special skill or knowledge of the subject; knowing facts about other cultures
    - Belief that there are objective truths about cultural groups that can be learned
    - At worst, reduced to specific traits and do's and don'ts
- Cultural sensibility
  - Recognizes that individuals have their own sense of culture that may be lost by a categorization process that is about groups, not individuals
    - Individuals construct their own version of their culture
    - Knowledge provides only a guide or context in which to explore the individual
    - Emphasizes openness to individual viewpoints, emotions, feelings

Courtesy Nisha Dogra, Harkness Fellow

Cultural Expertise v. Cultural Sensibility

Expertise

- Culture is an externally recognized characteristic; race, ethnicity emphasized
- Generalizes differences between individuals
- Individuals are shaped by their social world and defined by their culture

Sensibility

- Culture is an internally constructed sense of self; it is dynamic, fluid, multi-dimensional; race/ethnicity is 1 aspect
- Sensitive to intra-group differences
- Individuals bring their own meanings, which change according to the context

Courtesy Nisha Dogra, Harkness Fellow

Health Literacy

- “The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions” (*Healthy People 2010*)
- 48% of Americans have inadequate or marginal literacy skills (*National Adult Literacy Survey*)

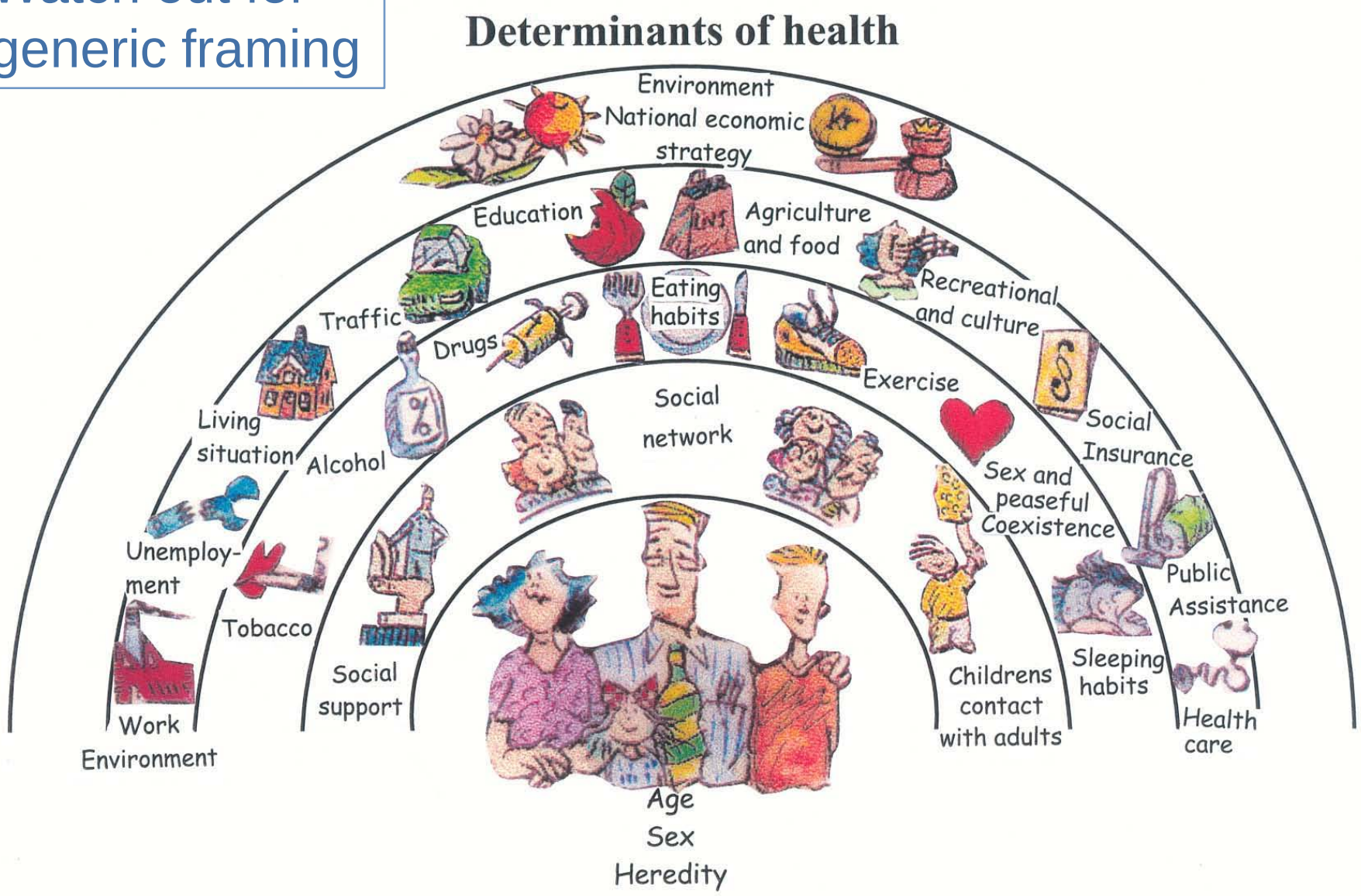
Low Health Literacy

- Problems with
  - Medications
  - Appointment instructions
  - Informed consent
  - Discharge instructions (major determinant of readmissions)
  - Health education materials
  - Insurance applications
- Solutions
  - Use plain language
  - Focus on key messages and repeat
  - Use “teach back” and “show me” to check understanding
  - Use appropriate educational materials (check reading level)

Social and Environmental (Upstream) Factors

- Historical trauma
- ACEs (adverse childhood experiences)
- Violence
- Limited access to good markets v. fast food (food security)
- Income security
- Housing security
- Built environments: playgrounds, indoor exercise facilities, sidewalks
- Transportation
- Support at home
- Social capital/isolation (Chicago heat wave)
- Stress and allostatic load
  - Life course issues
  - Resilience

Watch out for generic framing



Courtesy of the Institute for Healthcare Improvement, April 2009

A Common Problematic Assumption:

- Gaps in the quality of care in the US are so wide that substantial improvement **for all** is possible through established quality improvement and public health methods
- But QI that does not address disparities explicitly and proactively tends to **increase** gaps
- There are few examples of QI reducing disparities

Exacerbation of racial disparities following CABG Improvement Project

TABLE 2. Changes in Percentage of Patients With AMI Undergoing CABG Surgery in New York and the Comparison States Before and After New York's CABG Report Card Was Released*

	CABG for AMI, %		Change in Percentage (95% CI; *P*) (1988–1991 to 1992–1995)
	Before the Report Card (1988–1991)	After the Report Card (1992–1995)	
Disparity in CABG use between white and black patients			
New York			
White (n=267 736)	3.6	8.0	4.4 (3.4 to 5.4; <0.001)
Black (n=23 092)	0.9	3.0	2.1 (1.4 to 2.9; <0.001)
White vs black disparity (95% CI; *P*)	2.7 (1.8 to 3.6; 0.01)	5.0 (3.8 to 6.2; <0.001)	2.3 (1.4 to 3.2; <0.001)
Comparison states			
White (n=557 501)	5.9	8.8	2.9 (2.1 to 3.7; <0.001)
Black (n=23 092)	2.5	5.2	2.7 (1.6 to 3.7; <0.001)
White vs black disparity (95% CI; *P*)	3.4 (2.6 to 4.3; <0.001)	3.7 (2.8 to 4.5; <0.001)	0.2 (−0.8 to 1.3; 0.79)
Difference in disparities between New York and United States (95% CI; *P*)	−0.7 (−1.9 to 0.4; 0.21)	1.3 (−0.2 to 2.9; 0.08)	2.0 (0.7 to 3.4; 0.006)
Disparity in CABG use between white and Hispanic patients			
New York			
White (n=267 736)	3.6	8.0	4.4 (3.4 to 5.4; <0.001)
Hispanic (n=19 584)	2.9	4.8	1.9 (0.2 to 3.6; 0.03)
White vs Hispanic disparity (95% CI; *P*)	0.7 (−0.9 to 2.2; 0.38)	3.2 (1.6 to 4.7; <0.001)	2.5 (0.7 to 4.3; 0.008)
Comparison states			
White (n=557 501)	5.9	8.8	2.9 (2.1 to 3.7; <0.001)
Hispanic (n=19 584)	3.8	7.6	3.8 (2.0 to 5.6; <0.001)
White vs Hispanic disparity (95% CI; *P*)	2.1 (0.9 to 3.3; 0.001)	1.2 (−0.4 to 2.8; 0.13)	−0.9 (−2.8 to 1.0; 0.36)
Difference in disparities between New York and United States (95% CI; *P*)	−1.4 (−3.2 to 0.4; 0.13)	2.0 (−0.4 to 4.4; 0.11)	3.4 (0.8 to 5.9; 0.01)

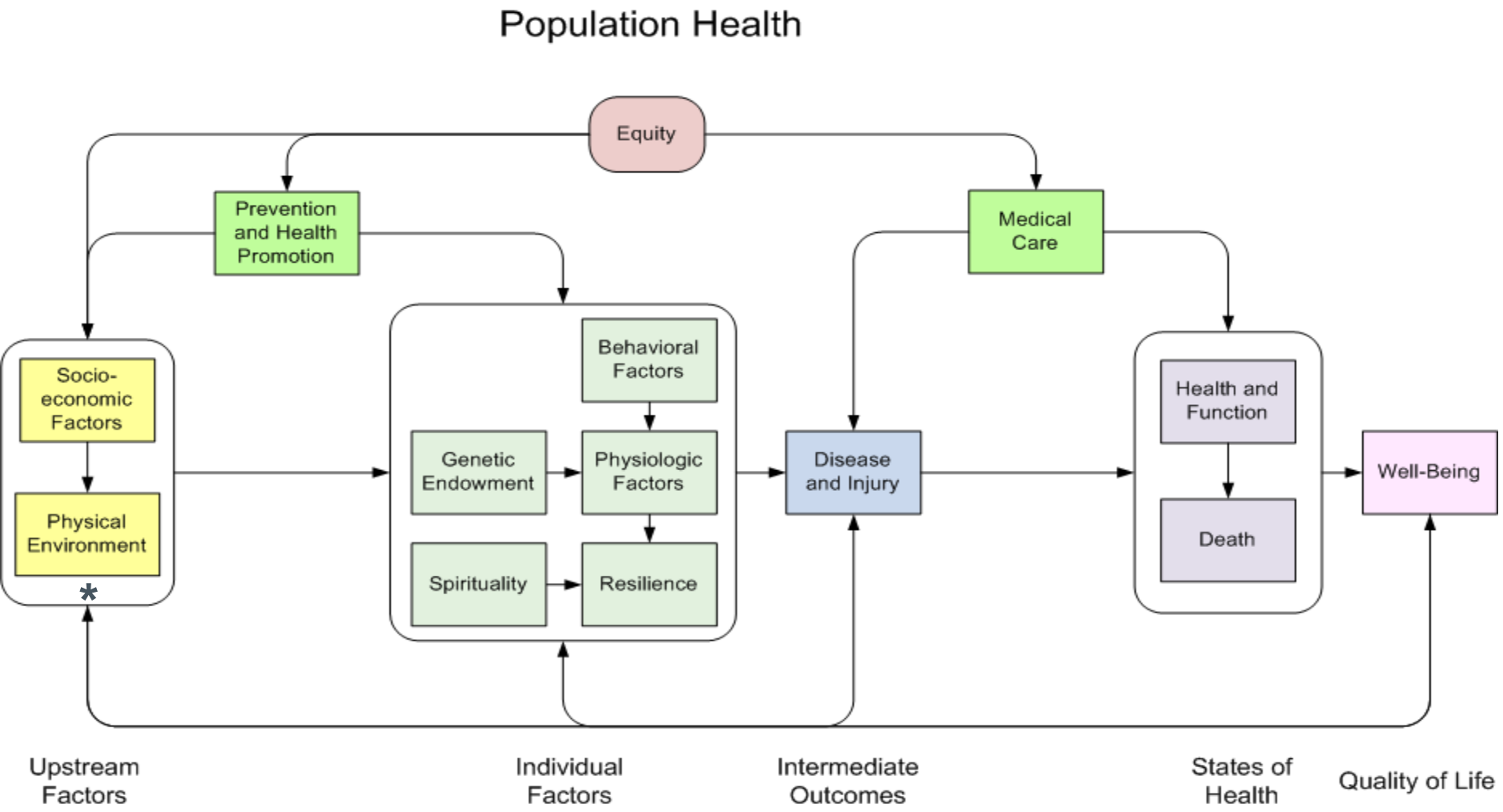
*All results adjusted for age, gender, medium income by ZIP code, insurance, percentage of black and Hispanic patients admitted annually with AMI at each hospital, and severity of illness.

Werner RM, Asch DA, Polsky D. Racial Profiling: The Unintended Consequences of Coronary Artery Bypass Graft Report Cards. *Circulation.* 2005:1257-1263.

Where We Stand

- There is lots of research on the magnitude of disparities, but relatively little work on *interventions* to reduce disparities
  - A very meager evidence based on the effectiveness of specific interventions
- Many providers, organizations, and policy makers do not know where to start to reduce disparities
- Despite language encouraging proposals on vulnerable populations, many public and private funders receive few applications

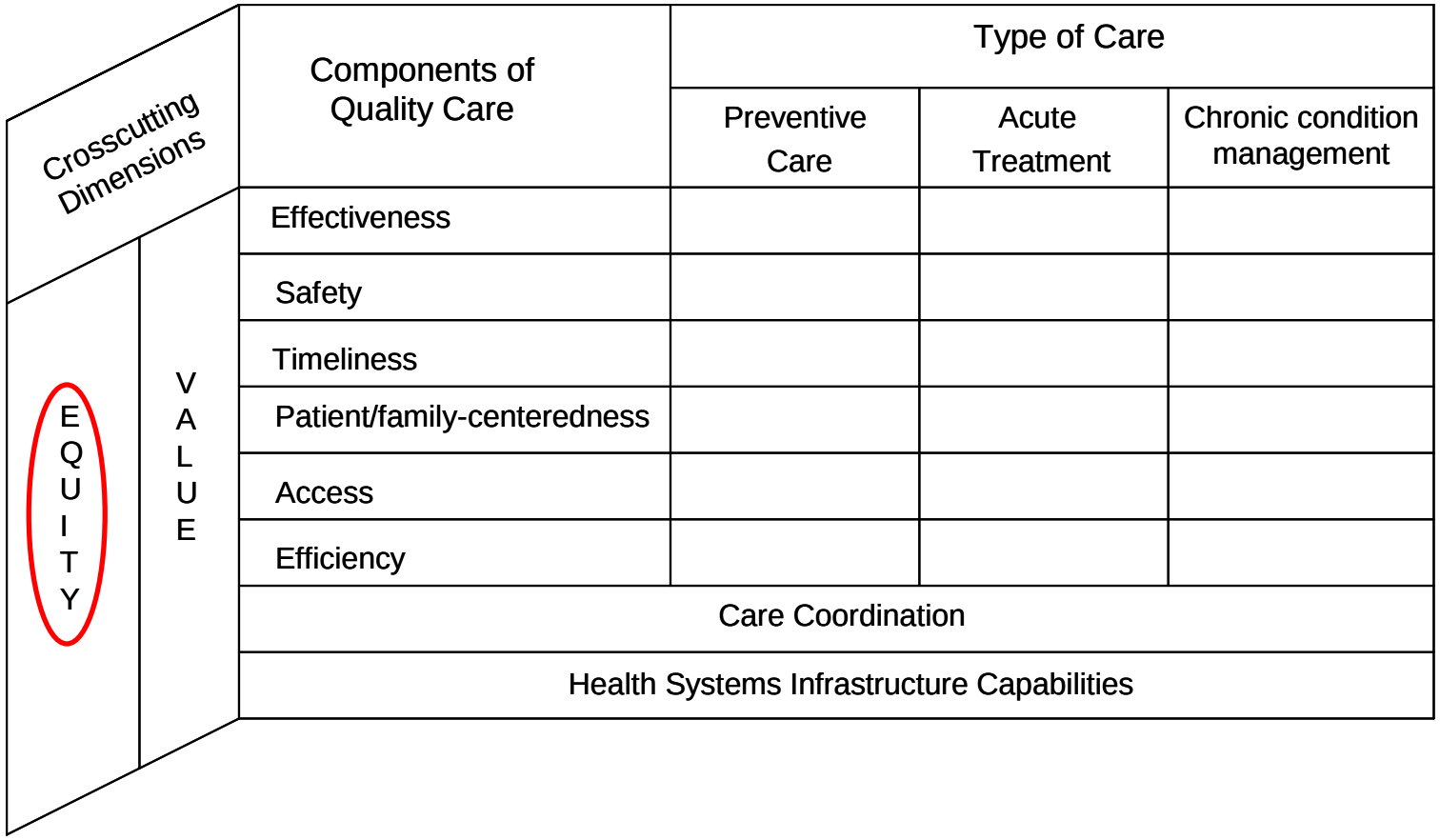
Population Health Conceptual Model



M Stiefel 11/14/2011

* And other social determinants of health

Alternative IOM Framework



Level of Engagement/Intervention Model

- Patient/Person
- Provider
- Microsystem - small unit of care delivery
- Organizations that house or support microsystems
- Communities and regions that span care delivery, prevention, and health promotion for populations
- Environment of policy, payment, regulation, accreditation

Chin and Goldmann. JAMA 2011;305:404

Implications for Funders

- Move beyond asking applicants simply to show that they have included “priority populations” in their research plan
- Ask all quality of care applicants to address specifically how they will reduce known disparities or gaps discovered in the course of the work
  - Include a measurement plan that stratifies data appropriately
- Design an overall portfolio of grants and grantees that addresses improving outcomes and reducing gaps in diverse populations and settings
- Reward applicants who address equity issues

Levels of Engagement for Disparity Interventions

- Patient/person
- Provider
- Microsystem
- Health care delivery organization
- Community and region
- Policy, payment, regulation, accreditation

Which spheres are you addressing or plan to address in your comprehensive, multifactorial approach to reducing an equity gap ?

Example - Care Coordination for Chronically Ill Patients

- Patient: engagement, empowerment, mobilization
- Provider: engagement, training in health literacy and cultural competency and sensibility
- Microsystem: teamwork, communication, QI, practice redesign, stratified data and real time feedback

Care Coordination for Chronically Ill Patients - 2

- Health care delivery organization: communication, coordination, support for patients and families across the continuum, tele-health and monitoring, focus on value and longer term fiscal horizon
- Community: activation, mobilization and integration of non-medical resources and supports, attention to social capital and social determinants
- Policy – alignment of incentives and payment to promote the above actions, diversity and disparity reporting requirements

Framework for Health Care Organizations to Achieve Health Equity

1.	**Make health equity a strategic priority**	• Demonstrate leadership commitment to improving equity at all levels of the organization • Secure sustainable funding through new payment models
2.	**Develop structure and processes to support health equity work**	• Establish a governance committee to oversee and manage equity work across the organization • Dedicate resources in the budget to support equity work
3.	**Deploy specific strategies to address the multiple determinants of health on which health care organizations can have a direct impact**	• Health care services • Socioeconomic status • Physical environment • Healthy behaviors
4.	**Decrease institutional racism within the organization**	• Physical space: Buildings and design • Health insurance plans accepted by the organization • Reduce implicit bias within organizational policies, structures, and norms, and in patient care
5.	**Develop partnerships with community organizations**	• Leverage community assets to work together on community issues related to improving health and equity

Source: http://www.ihi.org/resources/Pages/IHIWhitePapers/Achieving-Health-Equity.aspx

Pursuing Equity

- Launching *Pursuing Equity* to advance the role of health care in addressing equity
- Recruited 8 orgs: HealthPartners, Henry Ford Health System, Kaiser Permanente, Main Line Health, Methodist LeBonheur Healthcare, Northwest Colorado Health, Rush University Medical Center, Southern Jamaica Plain Health Center

Plan for the Day - Break

Break	3:45 – 4:00 pm

Plan for the Day - Ideas

- Ideas
  - Special Issues 4:00 – 4:30 pm
  - Case Studies 4:30 – 5:15 pm

Ideas: Special Issues

- Trust
- Institutional Racism
- Critical Race Theory
- Unconscious Bias
- Resiliency

Trust: Legacy of Tuskegee

- US Public Health Service (USPHS) experiment to follow natural history of untreated syphilis 1932-1972
- Black subjects left untreated and unaware of disease, and at risk for complications and premature death
- Still discussed among African-American communities wary of ‘research’ from large academic institutions
- Doriane Miller, MD told story about how UIC was called “IL Research Hospital” and Black patients didn’t want to go there because it had the word “research” in the name.

Trust: Henrietta Lacks

- Treated at Johns Hopkins University for cervical cancer in 1950
- Samples of cervical cancer cells taken without her consent for laboratory experiments
- Still used in experiments world wide, known as HeLa cells, cell line continues to live

The Immortal Life of Henrietta Lacks by Rebecca Skloot Mar 8, 2011

Slide Credit: Doriane C. Miller, MD, Associate Professor of Medicine, Director, Center for Community Health and Vitality," Reflections on Community Engagement: Listening and Learning," University of Chicago, Nov 1, 2016

What Is Institutional Racism?

Institutionalized racism is defined as differential access to the goods, services, and opportunities of society by race. Institutionalized racism is normative, sometimes legalized, and often manifests as inherited disadvantage. It is structural, having been codified in our institutions of custom, practice, and law, so there need not be an identifiable perpetrator.

- Camara Phyllis Jones, MD, MPH, PhD, Past President American Public Health Association

What Is Institutional Racism?

It is possible for racism to exist in institutional structures and policies without the presence of racial prejudice or negative racial stereotypes at the individual level.

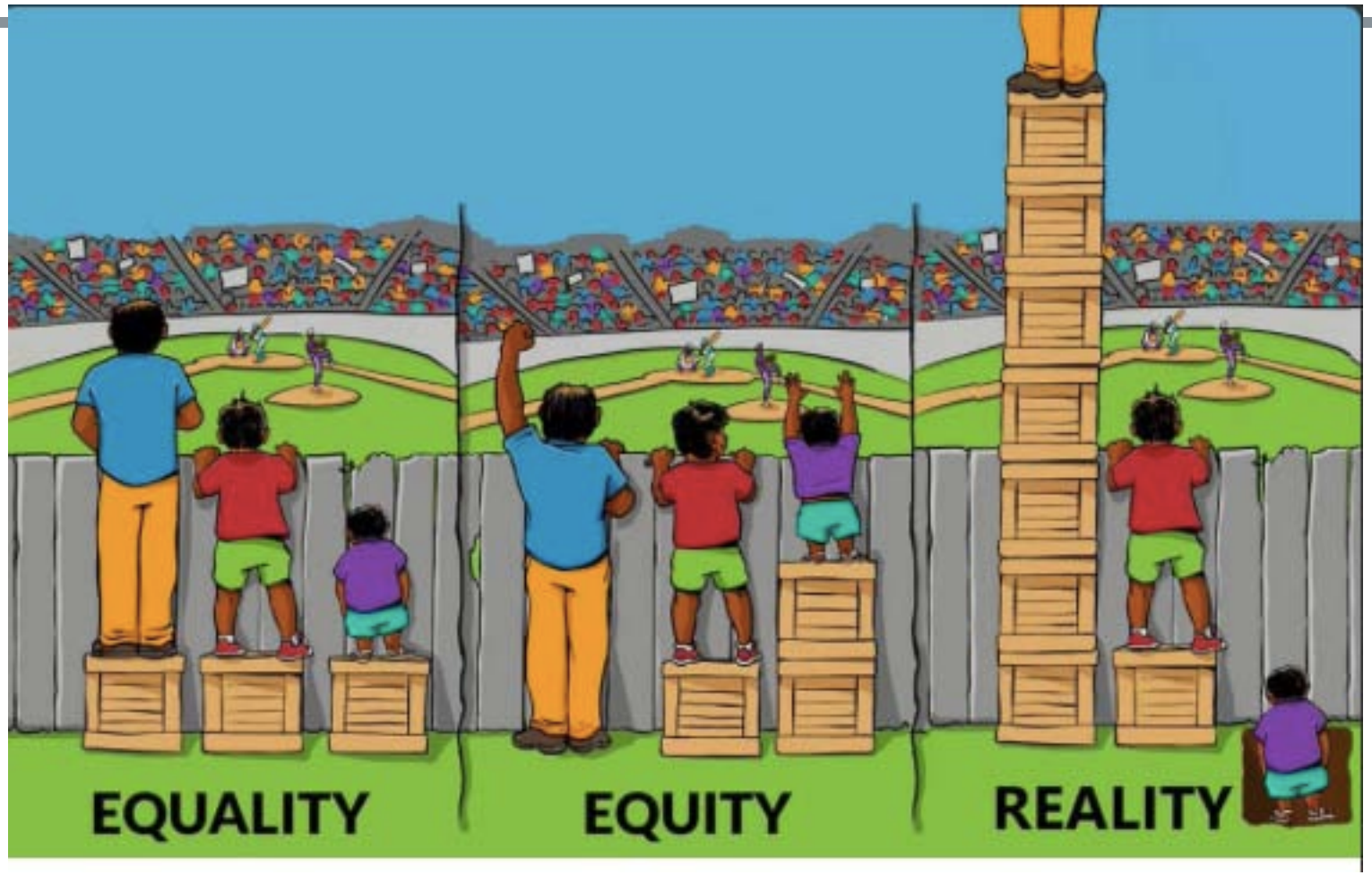
- Williams and Mohammed (2013)

What Is Health Equity, and Why Does It Matter?

David R. Williams, PhD, MPH; Professor of Public Health at the Harvard T.H. Chan School of Public Health

Have trouble viewing this video? Read the transcript.

This is the first video in an 8-part series. Click here to watch the next video and learn why we haven't made more progress on health equity.


EQUALITY
EQUITY
REALITY

What Does Institutional Racism in Health Care Look Like?

- Under-representation of people of color in leadership (executive staff and boards)
- Funding for certain priorities over others
- Unfriendly, unwelcoming atmosphere
- Location of health facilities
- Lack of transportation
- Hours of operation
- High parking fees

Critical Race Theory (CRT) and the Public Health Critical Race Praxis (PHCR)

- CRT is a decentralized movement among scholars, researchers and activists…integrates transdisciplinary methodologies…to illuminate and combat root causes of structural racism…It can be applied to a variety of disciplines…an iterative methodology for helping investigators remain attentive to equity while carrying out research, scholarship, and practice.

- Both CRT and PHCR attempt to move beyond merely documenting health inequities toward understanding and challenging the power hierarchies that undergird them.

- PHCR tailors CRT to the field of public health.

- Ford, Chandra L., and Airhihenbuwa, Collins O., "The public health critical race methodology: Praxis for antiracism research," Social Science & Medicine, 71 (August 2010) 1390-1398.

Critical Race Theory (CRT) – Key Tenets

- Race Consciousness (attention to the issue of race and racism in our areas of study; includes critical analyses of knowledge production processes; includes concept of “race as a social construct”)
- Contemporary Orientation (seeing racism in the form it exists in contemporary society, e.g., no longer Jim Crow laws, but embedded in structures and “everyday”)
- Centering at the Margins (starting point is the marginalized group rather than the point of view of the majority group)
- Praxis (theory-informed action)

- Ford, Chandra L., and Airhihenbuwa, Collins O., “Critical Race Theory, Race Equity, and Public Health: Toward Antiracism Praxis” American Journal of Public Health, April 2010, Vol. 100, No. S1, pp. S30-S35

Critical Race Theory (CRT)

- …healthcrits explore how disciplinary conventions may shape the knowledge on a topic…whether racialization already has informed existing knowledge on a topic…reflects historical biases…how conventional tools for knowledge production may influence an immediate study.

- Name one example of the application of Critical Race Theory to your field of study. Think about the body of knowledge you learned at school and how that might have been impacted by structural racism. (This exercise addresses the “knowledge production” component – taking a critical look at the foundational knowledge/evidence base upon which we build.)

- Ford, Chandra L., and Airhihenbuwa, Collins O., “The public health critical race methodology: Praxis for antiracism research,” Social Science & Medicine, 71 (August 2010) 1390-1398.

Unconscious Bias

- Stereotypes are activated automatically (without intent).
- We frequently are not aware of activation nor impact on their perceptions, emotions and behavior.
- Activated more quickly and effortlessly than conscious cognition.

Real World Studies

Slide Credit: Deborah Burnet, MD

- Resumes sent to employers advertising jobs in Chicago and Boston - randomly assigned ‘white’ or ‘AA’ sounding names. Applicants with ‘white’ sounding names were more likely to be called for interviews

  Bertrand & Mullainathan, 2004. Are Emily and Greg more employable than Lakisha and Jamal? A field experiment on labor market discrimination. *Am Econ Rev* 94:991-1013.

- Blinded symphony orchestra auditions increased hiring of women by 25%

  Goldin & Rouse, 2000. Orchestrating impartiality: The impact of ‘blind’ auditions on female musicians. *Am Econ Rev* 90:715-41.

Minimizing Bias

Slide Credit: Deborah Burnett, MD

- Recognize that we are subject to influence of bias
- Take the implicit bias test implicit.harvard.edu/implicit/
- Diversify leaders, clinical staff, and employees
- Diversify your search committee
  - Diverse perspectives can help counteract tendency to unconscious bias
  - Broadens social network for active search

Strategies to reduce implicit bias

- **Stereotype replacement:** Recognizing that a response is based on stereotype and consciously adjusting the response
- **Counter-stereotypic imaging**: Imagining the individual as the opposite of the stereotype
- **Individuation:** Seeing the person as an individual rather than a stereotype (e.g., imaging or learning about their personal history and the context that brought them to the doctor's office or health center)
- **Perspective taking:** "Putting yourself in the other person's shoes"
- **Increasing opportunities for contact with individuals from different groups:** Expanding one's network of friends and colleagues or attending events where people of other racial and ethnic groups, gender identities, sexual orientation, and other groups may be present

Devine, et all 2012; Burgess et al, 2007

Resilience & Equity: Discrimination in the Workplace

NHS Leadership Academy

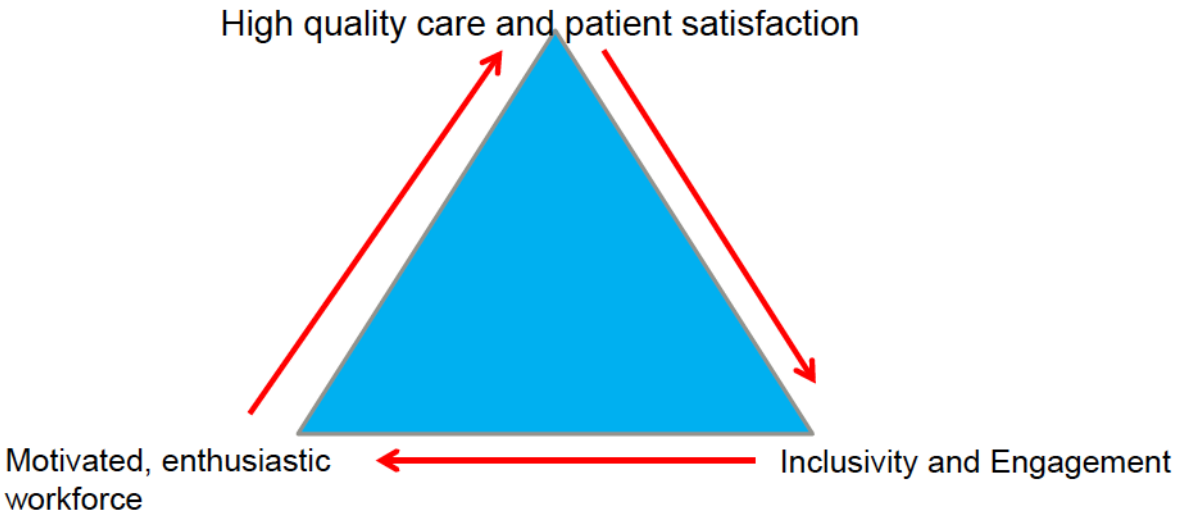
This is best evidenced by the link between ethnic discrimination against staff and patient satisfaction. **The greater the proportion of staff from a black or minority ethnic (BME) background who report experiencing discrimination at work in the previous 12 months, the lower the levels of patient satisfaction.** Where there is less discrimination, patients are more likely to say that when they had important questions to ask a nurse, they got answers they could understand and that they had confidence and trust in the nurses. Where there was discrimination against staff, patients felt that doctors and nurses talked in front of them as if they weren't there; that they were not as involved as they wanted to be in decisions about their care and treatment; and that they could not find someone on the hospital staff to talk to about their worries and fears. Most importantly, they did not feel they were treated with respect and dignity while in hospital. **The experience of BME staff is a very good barometer of the climate of respect and care for all within NHS trusts.**

Source: Yvonne Coghill, OBE, Director Workforce Race Equality Standards Implementation Team NHS England

Resilience & Equity: Discrimination in the Workplace

NHS Leadership Academy

A very simple equation!



- Source: Yvonne Coghill

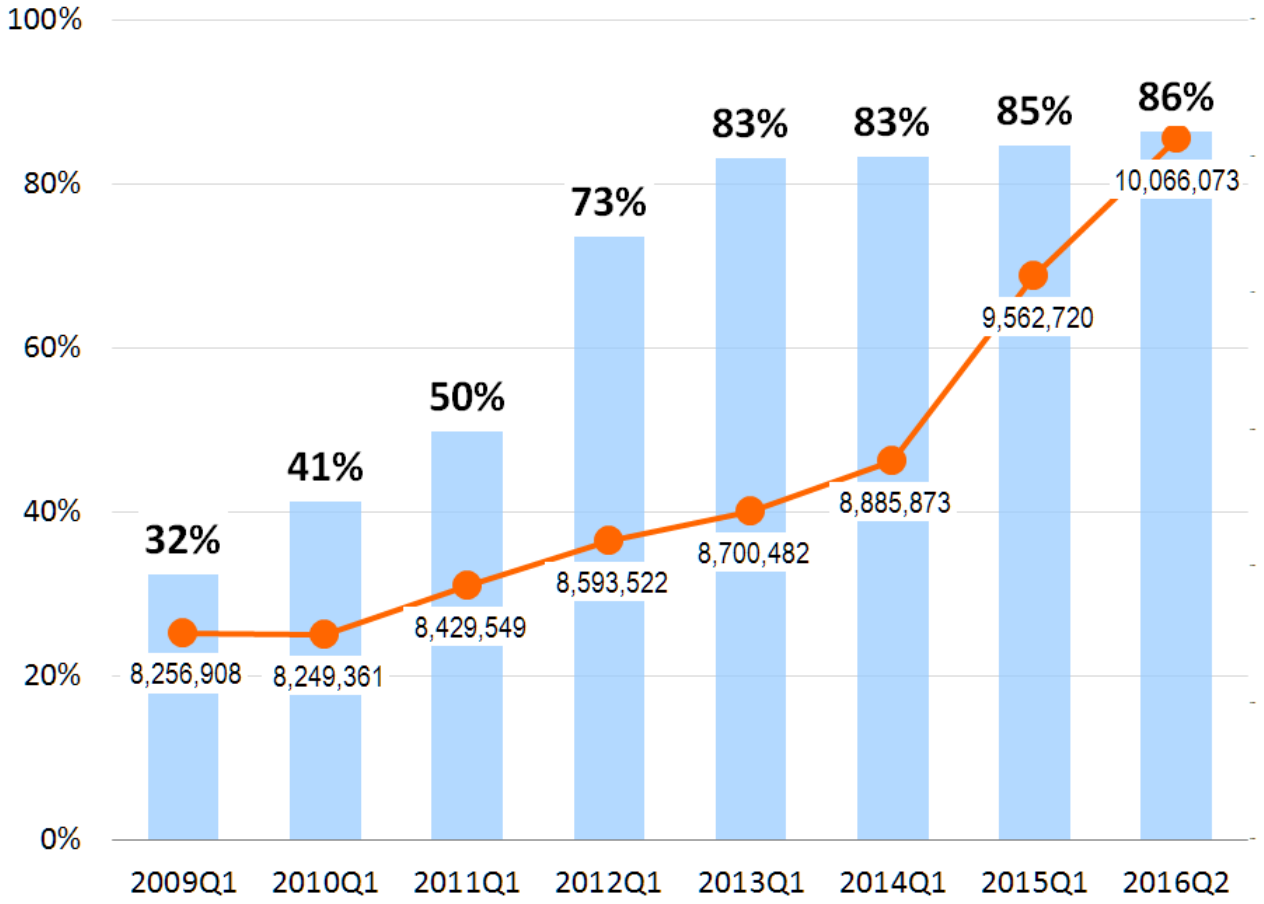
Case Studies

- Kaiser Permanente
- HealthPartners
- Henry Ford Health System
- Southern Jamaica Plain Health Center
- Contra Costa Regional Health System

Collection of Race and Ethnicity Data

KAISER PERMANENTE®

Percent of Total Programwide Membership with Race/Ethnicity Data Entered in Kaiser Permanente HealthConnect®



'Combined Race Format' Categories

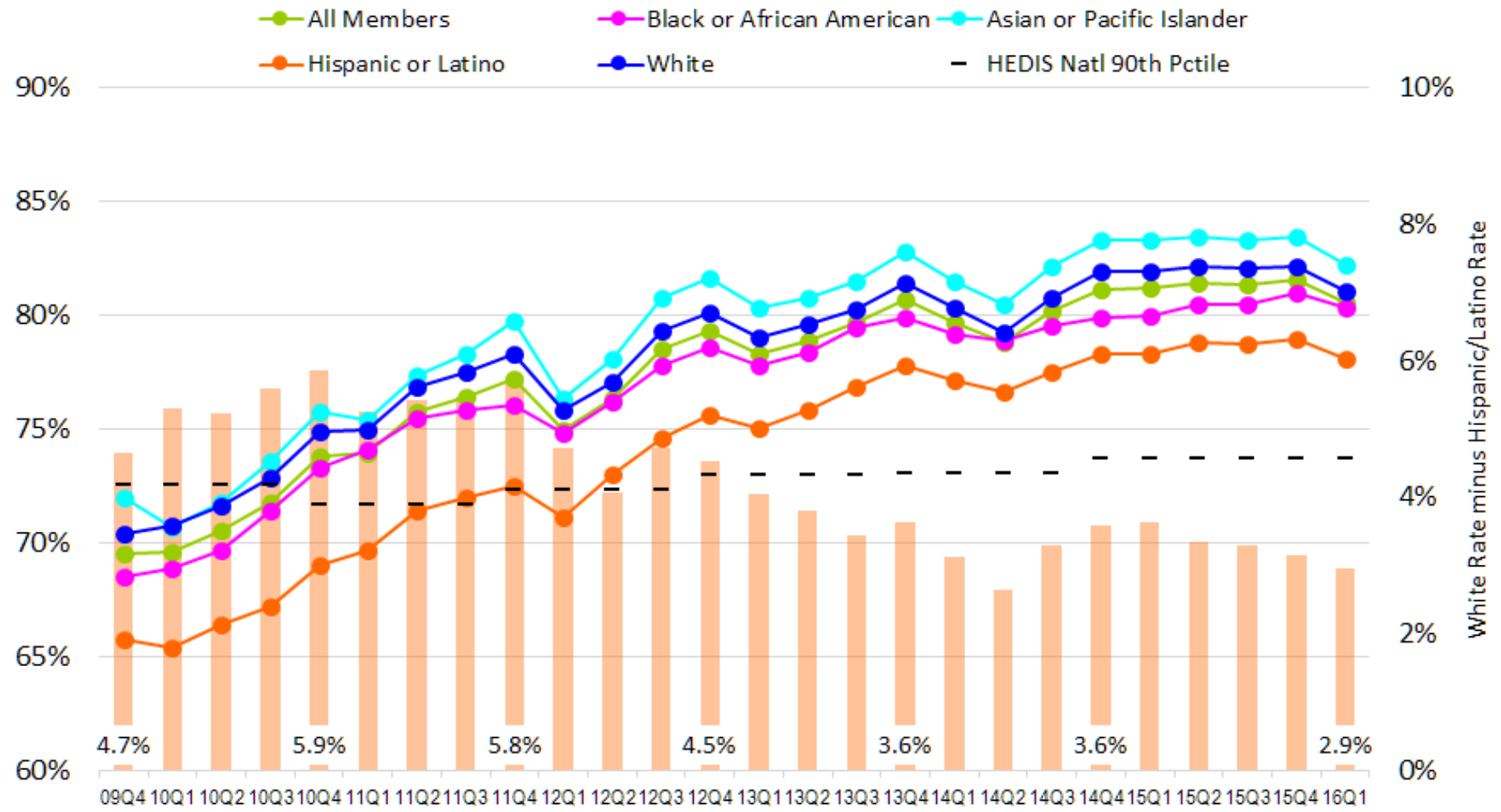
- Black or African American
- Hispanic or Latino
- Asian
- Native Hawaiian or Other Pacific Islander
- American Indian or Alaska Native
- White

Ethnicity

- 268 granular ethnicities

Colorectal Cancer Screening for Kaiser Permanente

All members in the HEDIS denominator, stratified by a combination of reported and imputed race/ethnicity



Hispanic/Latino denominator (2009 Q4, 2011 Q4, 2013 Q4 and 2016 Q1):

308,177 327,595 367,732 422,655

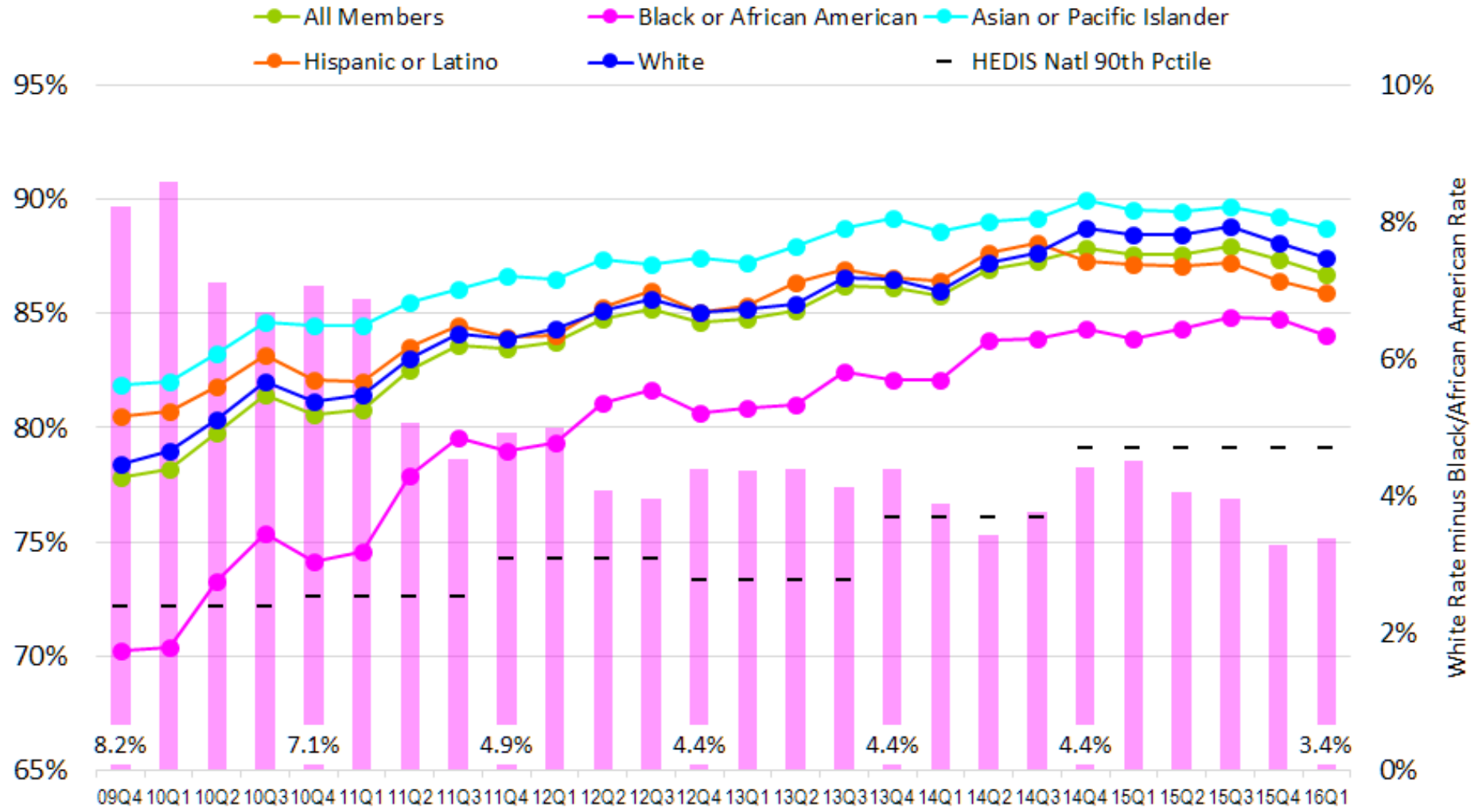
Sum of the regional numbers needed to close gaps (2009 Q4, 2011 Q4, 2013 Q4 and 2016 Q1):

19,809 19,343 16,366 18,060

KAISER PERMANENTE®

Controlling High Blood Pressure for Kaiser Permanente

All members in the HEDIS denominator, stratified by a combination of reported and imputed race/ethnicity



Black/African American denominator (2009 Q4, 2011 Q4, 2013 Q4 and 2016 Q1):

150,151 150,645 149,642 148,526

Sum of the regional numbers needed to close gaps (2009 Q4, 2011 Q4, 2013 Q4 and 2016 Q1):

9,114 7,528 6,928 6,731

KAISER PERMANENTE®

HealthPartners: Designing for Health Equity

http://www.ihi.org/education/IHIOpenSchool/resources/Pages/Activities/Averbeck-ReduceDisparities.aspx

Designing for Health Equity

VIEWPOINT

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Kaiser Permanente, Oakland, California.

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Viewpoint and **Editorial**

Achieving Health Equity by Design

Disparities in health outcomes by race and ethnicity and by income status are persistent and difficult to reduce. For more than a decade, infant mortality rates have been 2 to 3 times higher among African American populations, rates of potentially preventable hospitalization have been substantially higher among African American and Latino populations, and the complications of diabetes have disproportionately afflicted African American and Latino populations.[1] These and other disparities have persisted despite recognition that inequity costs the economy an estimated $300 billion per year.[2] In addition, health disparities threaten the ability of health care organizations to compete fiscally as insurers increasingly base payments on quality and outcomes, such as reducing preventable admissions and readmissions.

A common explanation for long-standing disparities is the challenge of addressing social determinants of health, including income inequality, poor access to transportation, inadequate educational quality, and substandard housing.[3] These factors have a profound effect on social contributors to d
likely to improve core m

It is time to broade
health care system can
vices to achieve health e
mote population health
term, which includes f
disease.[5] Incorporating
system will promote and

A case example is hy
this disorder among Afri
to 15 percentage points
population, and its effect
tially greater rate of nor
stage renal disease, a
mortality.[6] Although the
trol among Americans in
trol among African Ame
was just 40.7%.[6]

In response to this
tions have focused on in
tradition
strategie
medicati
tion, incr

It is time to broaden the expectation for what a health care system can do to

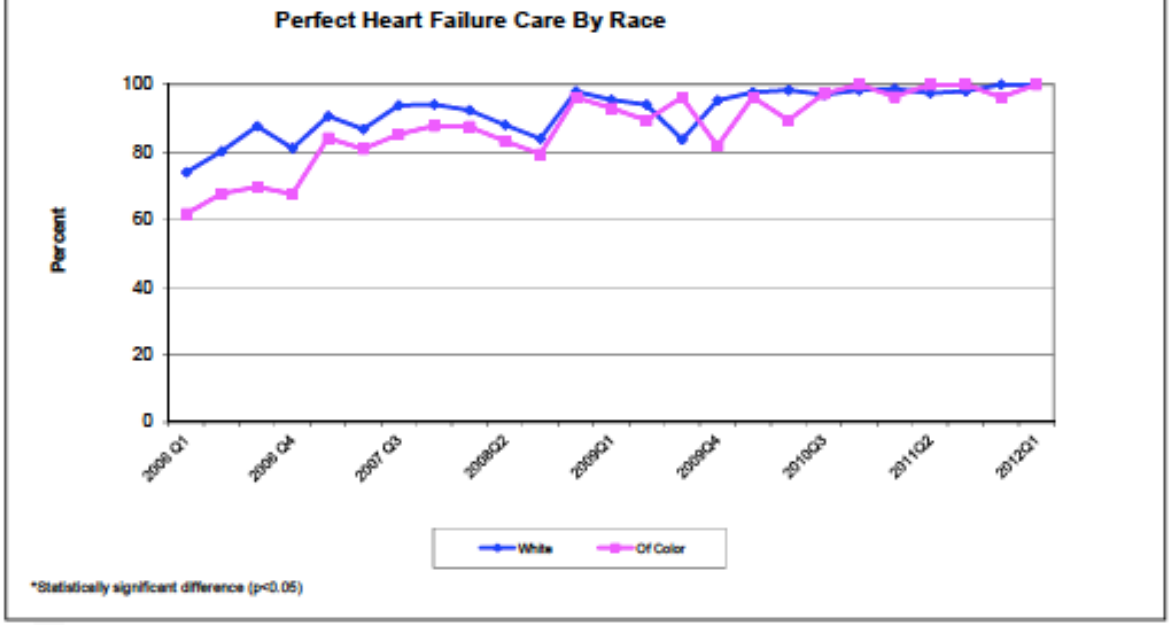
Wong WF, LaVeist TA, Sharfstein JM, JAMA, April 14, 2015

http://jama.jamanetwork.com/article.aspx?articleid=2195960

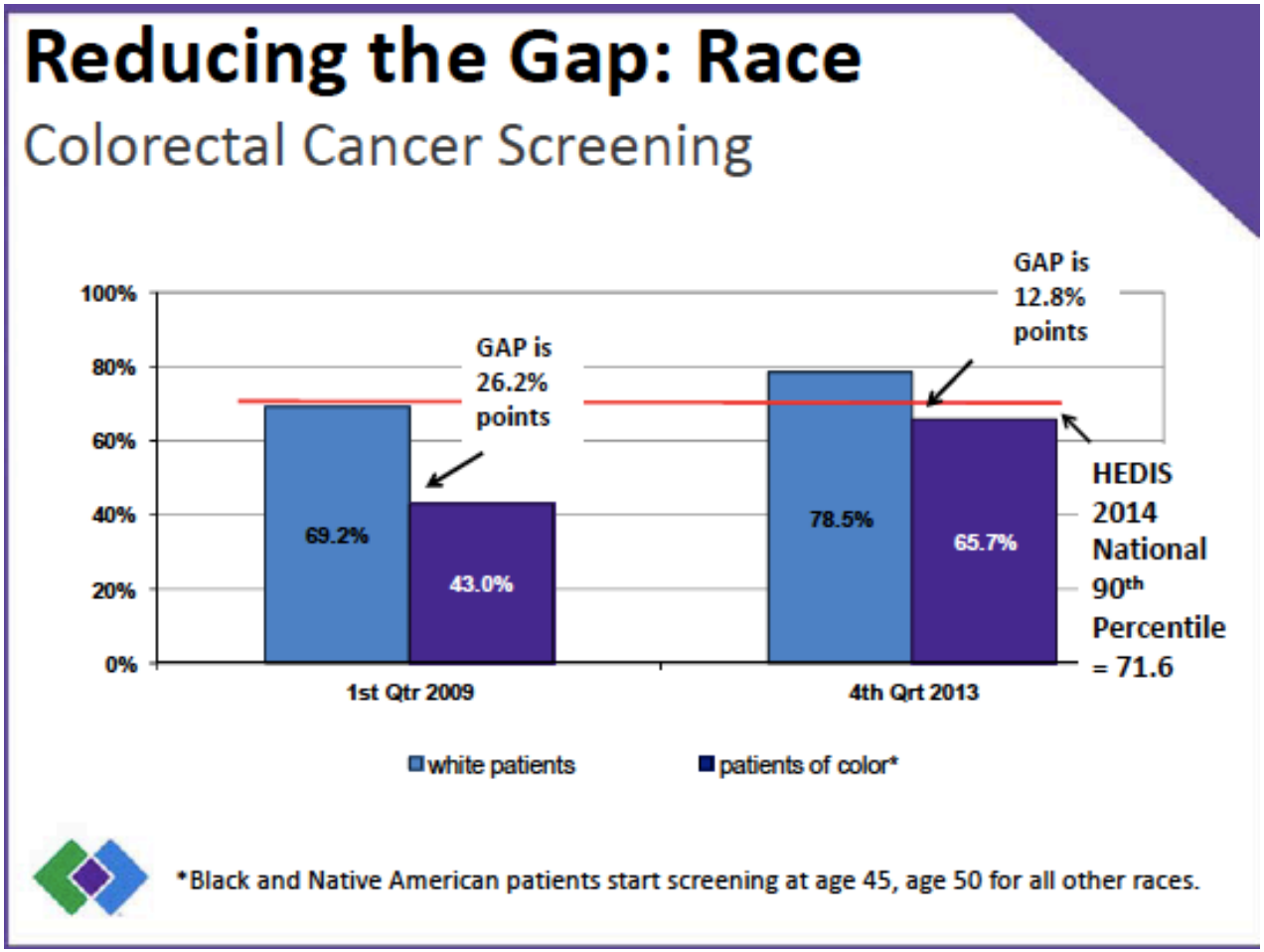
HealthPartners

Hospital Core Measure

Perfect Heart Failure Care By Race



Case Study: HealthPartners



Resources

http://www.solvingdisparities.org

Solving Disparities Roadmap

Finding Answers
Solving Disparities Through
Payment and Delivery System Reform

Make equity an integral component of quality improvement efforts - equity in all QI.

Case Study: Henry Ford Health System

- Health Equity Campaign launched in 2009, with goal: To increase knowledge, awareness, and opportunities to ensure healthcare equity is understood and practiced by HFHS providers and other staff, the research community and the community-at-large; and to link healthcare equity as a key, measurable aspect of clinical quality.

- Established a Center for Healthcare Equity under the stewardship of a senior vice president.

- Women-Inspired Neighborhood (WIN) Network, which uses a peer-support system and group prenatal care model to reduce infant mortality rates in the city of Detroit. Early results show that among 200 women enrolled in the program who have given birth so far, there have been no infant deaths (compared with an expected infant death rate in Detroit of 16 per 1,000 [3.2 per 200] live births)

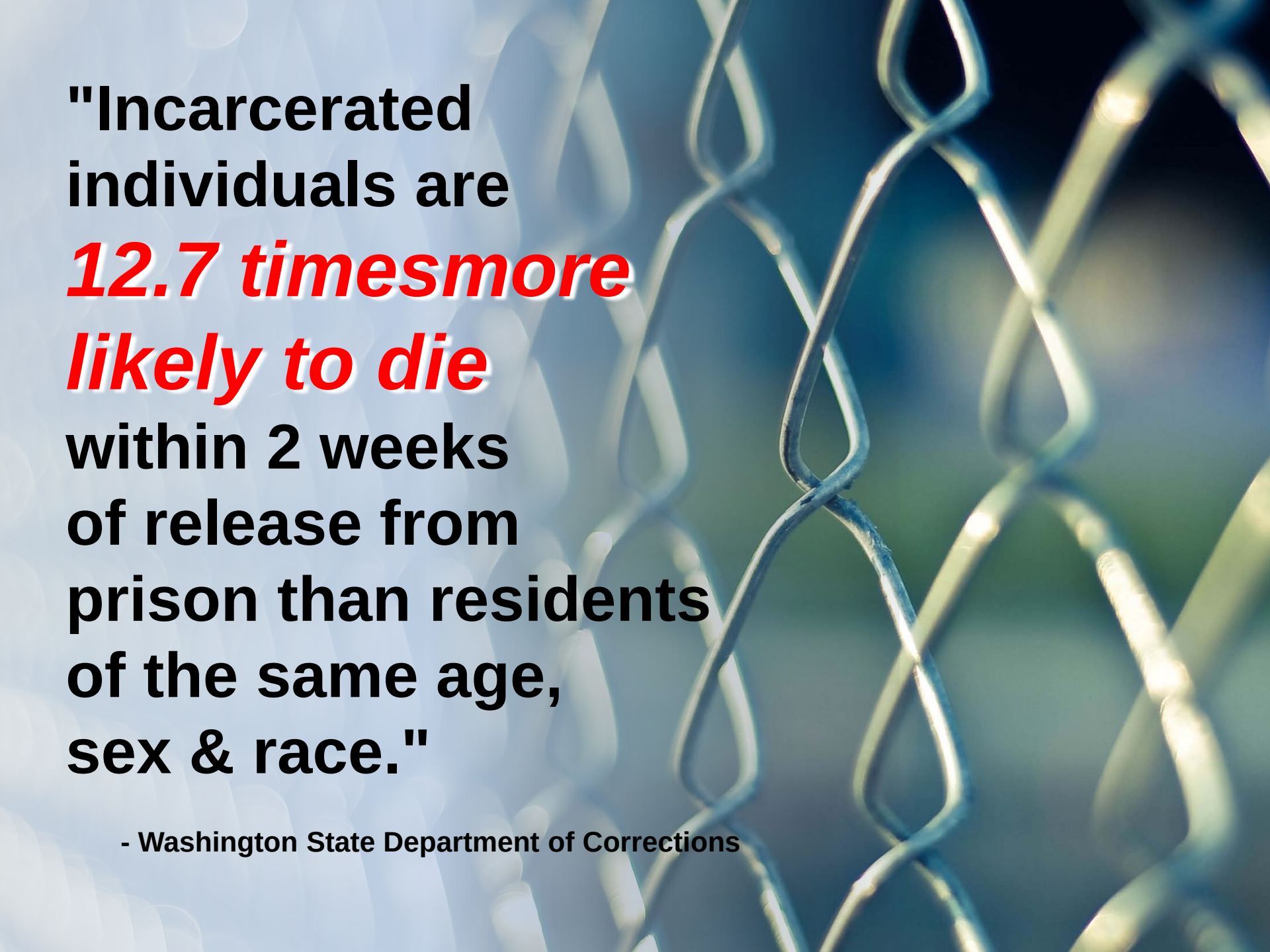
Southern Jamaica Plain Health Center: In the Exam Room

Questions for first visit goal is to make the implicit, explicit:

1. "I don't want to assume anything about your identities. How do you identify racially, ethnically, culturally and what are your pronouns?"
2. "Many of my pts experience racism in their health care. Are there any experience you would like to share with me?"
3. What have been your experiences with the healthcare system?"
4. "Have there been any experiences that caused you to lose trust in the healthcare system?"
5. "It is my job to get you. You shouldn't have to work to get me. If I miss something important or say something that doesn't feel right please know you can tell me immediately and I will thank you for it."
6. "Put up more visible cues for safe space: BLM, Flag, etc.
7. acknowledging, honoring what pts are already doing – "wow, you're already doing so much"
8. "what's happened to you" vs. "what are you doing"
9. "Being curious" can feel like colonizing language: Not, "can you explain to me why…." instead "there is something I don't know that I really need to understand…."

Contra Costa: Our Legacy. . .

Value = What Matters



"Incarcerated individuals are ***12.7 timesmore likely to die*** within 2 weeks of release from prison than residents of the same age, sex & race."

- Washington State Department of Corrections

Re-entry Health Conductors Program

Plan for the Day - Implementation

Implementation 5:15 – 5:30

What actions will you take to improve health equity when you return to your home institution?

For Discussion

- How could you make health equity a strategic priority in your organization.
- How could you begin to identify patients' non-medical health needs as part of their overall care?
- How could you connect patients to local services/resources to assist with social needs, and to promote health/prevent illness?
- How can you partner with other entities to reach patients outside the normal boundaries of the health care system?
- How could your health system contribute to the health of employees of under-represented groups and low SES?
- How could you address institutional racism in your organization?
- How can we use community health workers to provide services or link patients to needed supports?

Thank You!

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