FOUNDATION FOR
Health Care Quality

Improving health outcomes through collaboration, data, and finding common ground

Advancing Equity Recommendations

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Background

The Oregon Health Authority defines health equity as "when all people can reach their full health potential and well-being, and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances."[i] Unfortunately, numerous studies have shown health inequities across racial and ethnic groups,[ii] for LGBTQ communities,[iii] and socioeconomic status.[iv]

Several leading healthcare institutions have developed plans for advancing equity, including the Institute for Healthcare Improvement, and many recognize that advancing equity will require cross-sector partnerships and initiatives at the individual, organization, and structural level. Advancing equity is an ongoing, iterative process that will require input from people with lived experience, and an understanding of intersectionality and the connections across multiple dimensions of inequality.

The Advancing Equity workgroup aims to improve equitable care access, quality, and outcomes, through planning, data and policy. Advancing Equity focus areas are highlighted in **Table 1.**

Table 1: Advancing Equity Areas

Focus Area	Goals
Equity Planning	• Explore actionable steps for incorporating equity into mission, vision, values, and programming.
Using Data	• Collect sociodemographic data in an equitable and person-centered fashion. • Ensure data collection, visualization, and analysis techniques are ethical and used to reduce inequities.
Using Policy	• Advocate for equitable organization and public policies. • Pursue funding for activities related to health equity, including addressing upstream drivers of health inequities, building healthier communities, and investing in community organizations.

Recommendations

Equity Planning

Self-Assessment

- Take an organization self-assessment such as the WHO's tool or the Coalition of Communities of Color questionnaire to understand the current state and next steps to advance equity at your organization.

Equity Plan

- Make health equity a strategic priority in leadership.
- Embed equity principles into organizational mission, vision, values and programming.
- Link organization's quality goals to equity goals. Have a health equity quality improvement initiative.
- Create an actionable health equity plan with defined goals and targets.
- Commit the necessary resources to achieve health equity goals. Ensure resources are meaningfully allocated to have an impact on inequities.
- Ensure that the health equity work is equitably distributed for all impacted individuals with the necessary resources and acknowledgement for the priority of the health equity work.
- Secure sustainable and dedicated funding for health equity.

Culture of Equity

- Decrease implicit bias and create a culture of equity.
- Destigmatize discussions about bias including from race and foster staff buy-in.
- Develop learning and development strategies to educate staff about health equity. Learning and development programs could include implicit bias, cultural humility, and/or antiracism. Learning and development strategies must be continuous/ongoing and relevant to the organization's patient/client population.
- Ensuring a culture where everyone is accepted and psychologically safe.

Structural Inequities

- Address structural inequities in the physical space and institutional policies.
- Assess the physical space for inequities and make changes as needed (ex. Include accessibility, cleanliness, waiting times for services, operating hours, etc.)
- Ensure communication and information are available in accessible formats, including translating languages and audio/visual accommodations.
- Evaluate and address gaps in accessibility to clinical care including geography, technology, and mobility.
- Adopt inclusive language guidelines.
- Re-examine policies related to insurance coverage, clinical protocols for coverage, and other potential barriers to access for their impact on equity.
- Re-examine existing health-related practices and policies for their equity impacts. Avoid race-based medicine.

Partnerships

- Develop sustainable partnerships with community-based organizations.
- Be transparent about plans, goals, measures, and progress.
- Engage with communities with lived experience who are affected by inequities to partner in co-design and co-production of interventions to address inequities.
- See the Social Need Interventions recommendations for further partnership recommendations.

Using Data

Standards

- As a general principle, collect the minimum data necessary to identify and meet needs. Needs could include identifying and addressing inequities. Ensure individual sociodemographic data is collected on a voluntary, self-reported basis.
- Collect demographic data on health related social needs (at least housing, food security, and transportation); race, ethnicity, and language (REaL), sexual orientation and gender identity (SOGI), and disability.
    - Consider collecting additional demographic data on nativity, socioeconomic status (SES), veteran status, or other indicators for inequities.
    - Collect information about patient pronouns and ensure this information is available on the electronic health record to avoid mis-gendering patients.
    - Refer to the Demographic and Social Need Data Standards recommendations from the Storing and Sharing Data recommendations for potential standards to borrow from.
- Develop a multi-year plan to integrate demographic data into internal databases. Review the Storing and Sharing Data recommendations for further data system recommendations.
    - When developing new standards, turn to nationally recognized organizations for guidance. For example, the WA State LGBTQ Commission may be able to support development of SOGI data standards for Washington state.
- Work toward alignment on data fields across sectors and organizations, such as alignment between HRSA data requirements for FQHCs and DOH data requirements for inpatient hospitals.

Data Compilation

- Consider different methodologies for data collection based on the organization's capabilities and intended use. Data collection strategies could include individual self-report, imputation strategies, sampling strategies, or using aggregate indicators like zip codes.
- When possible, data should be collected on an individual level. Individual data should be collected on a voluntary self-report basis.
    - Ensure staff are trained and comfortable asking questions to collect demographic information in accessible formats.
    - Collect demographic information in a person-centered manner. Explain why data is being collected and how data will be used.
    - Allow individuals to select multiple race/ethnicity categories.

    - Allow individuals to select more than one sexual orientation or gender identity.
    - Allow individuals to decline to respond.
- If individual data is not available or appropriate for your organization, consider imputation strategies to fill in missing variables or an aggregate population-level indicator such as zip codes.
    - If using imputation or aggregate indicators, make sure to audit data collection strategies for bias, including assessing each step of the imputation process. Once the process is complete, assess the data to determine if it is accurate enough to use ethically for the intended purpose.
    - Follow the Urban Institute report for ethics and empathy when using imputation data for racial equity.
- In all cases, ensure ethical data collection. Consider autonomy, transparency, privacy, intention, and outcomes, as well as data sovereignty for tribal partners.

Analytics

- Incorporate social determinant/social driver of health data. Consider starting with indicators like the Area Deprivation Index or Social Deprivation Index.
- Ensure all reportable health outcomes can be stratified by demographic fields. Start with stratification by race and ethnicity, then work toward stratification by other data categories.
    - Develop and implement a multi-year plan to incorporate other sociodemographic data fields (SOGI, disability, etc.) for analysis and intervention.
- Monitor patient/member experience metrics by demographics to ensure that providers and other staff members are proving culturally competent care.
- Design analytics intentionally to review data for inequities. (ex. of "inclusive" race/ethnicity reporting)
    - Follow the Urban Institute Do No Harm Guide for applying equity considerations to data visualization.
- Ensure individual, granular data fields are able to be re-aggregated into meaningful categories (such as "rolling up" granular ethnicity categories into broad OMB categories when necessary).
- Ensure data analytics are used for quality improvement. Avoid perpetuating harm using data.
- Ensure analytics consider intersectionality between demographic and social need categories.

Intervention

- When inequities are identified, use the data to drive interventions to improve health equity.
- Engage with communities with lived experience who are affected by inequities to partner in co-design and co-production of interventions to address inequities.

Using Policy

Organizational Policies

- Re-examine organization policies with an equity lens. Specific policies to review the employee life-cycle (hiring, support during employment, leadership development, education

opportunities, etc.), community engagement, and initiatives to advance health equity for individuals served.

- Provide ongoing DEI education and development for leadership. Ensure supplemental equity training is tailored to local needs.
- Develop a process for conflict resolution that might arise from health equity trainings or other conflict due to bias or discrimination from staff, patients, or clients.
- Monitor implementation of DEI policies in the organization and develop improvement plans when gaps are identified.
- For healthcare organizations, re-examine race-based medicine policies, especially where race is used as a proxy for biology or genetics in clinical care.
- For healthcare organizations, develop policies to adopt the patient's preferred name and pronoun in all communication. Have a process for legal name changes as well as allow patients to enter a "preferred name" or "nickname" in the electronic health record if a legal name change is not complete.
- Hospitals/healthcare organizations can take a self-assessment through the American Hospital Association and receive specific resources tailored to their current level of commitment to health equity.
- Review organization communication plans for equity and inclusion.
- Additional resources for developing equitable organization policies include the CMS health equity framework and the RWJF Raising the Bar report.

Public Policies

- Raise awareness of the broader structures and upstream factors that impact health equity. Advocate for equitable public policies to advance health equity.
- Leverage public policy to address health equity priorities, including policies that address upstream factors such as economic stability and affordable food and housing.
- Evaluate existing and upcoming policies for their impact on inequities. Use a health equity impact assessment tool to build policy that addresses health equity.
- Adopt a health equity policy framework, and encourage state and federal public health agencies to adopt a health equity policy framework.
- Leverage existing resources and partner with other organizations advocating for health equity in public policy and public health. Examples include:
    - The American Public Health Association
    - The American Academy of Family Physicians
    - The American Medical Association
    - The Root Cause Coalition
    - The World Economic Forum Health Equity Pledge
    - The Business Group on Health

Funding

- Ensure organization policies and public policies direct targeted funds to health equity work. Health equity funds can support:

- Interventions to target and reduce inequities in health outcomes.
- Health equity planning and community engagement.
- Healthy built environments and community support.
- Services that address upstream drivers of health inequities.

Stakeholder Roles and Actions

The following stakeholder roles and actions are drawn from the RWJF Raising the Bar Report. Define roles for each healthcare sector. Consider including health delivery systems, public health agencies, plans/purchasers, and more.

Leaders: C-suite executives, directors, and managers in charge of setting priorities and allocating resources.

Goal: Commit necessary resources required to achieve health equity

- 1.1: Develop actionable equity plans that involve clear targets and measures.
- 1.2: Create and sustain a culture of equity.
- 1.3 Commit the necessary resources to health equity programs and initiatives.

Health Care Providers: Physicians, other clinicians, and other providers responsible for treating and managing patients.

Goal: Provide whole-person care to achieve health equity

- 2.1: Actively promote and facilitate access to care for all in ways that accommodate diverse life circumstances and needs
- 2.2: Establish and sustain a trusting environment where everyone feels they are welcomed and treated with dignity and respect
- 2.3: Provide holistic, effective, high-quality care responsive to plans co-created with individuals, families, and caregivers

Employers: Any organizations that support and manage staff, human resource departments.

Goal: Employ and support a diverse health workforce

- 3.1: Invest in and grow leaders who advance and embed equity, quality, and value across the organization
- 3.2: Employ and cultivate a representative workforce at all levels
- 3.3: Create and sustain workplaces and jobs where employees can be healthy, thrive, and help guide effective and equitable care while feeling psychologically safe.
- 3.4: Leverage procurement to ensure the diversity and well-being of contract workers.

Partners: Organizations that facilitate relationships across multiple sectors to achieve equity.

Goal: Engage with organizations and community residents, prioritizing those most affected by inequities

- 4.1: Engage with organizations and community residents, prioritizing those most affected by inequities
- 4.2: Build trusting relationships with individuals and organizations in the community
- 4.3: Respect and build on the expertise and power of individuals and organizations in the community.

- 4.4: Include data partnerships that transparently share information about goals, targets, and progress toward eliminating inequities.

Advocates: People and organizations who advocate for greater change.

Goal: Advocate for greater awareness and investment in health equity

- 5.1: Actively push for and adopt payment reforms, especially reforms that align investments with the mission of improving health and well-being
- 5.2: Use healthcare's voice to shape public understanding about the importance of health equity and dismantling racism and all forms of discrimination
- 5.3: Use power and influence to advocate for health equity in the development and implementation of public policies
- 5.4: Use investment and procurement power to contribute to the health and resilience of communities.

Purchaser: Organizations in charge of purchasing benefits for their employees, staff, or other clients.

Goal: Leverage purchasing strategies to advance health equity.

- 6.1: Leverage purchasing strategies to advance health equity. Pursue benefits that address physical health, behavioral health, and social need of enrollees.
- 6.2: Develop payment reforms to align with the mission of improving health and well-being for all.

Insurer: Organizations that manage health plans for enrollees.

Goal: Leverage contracts and develop initiatives to address inequities.

- 7.1: Leverage contracts to advance equity. Consider the impact of policies related to coverage, eligibility, and reimbursement rates.
- 7.2: Develop initiatives to advance equity among enrollees, such as targeted outreach campaigns or partnerships with community organizations.

Regulators and Policy: Organizations and people in charge of developing policy that governs healthcare organizations and regulating/enforcing these policies.

- 8.1: Leverage public policy to address health inequities, including upstream drivers of health outcomes.
- 8.2: Direct sustainable funding toward community organizations, especially those that address upstream drivers of health inequities.
- 8.3: Track population health inequities and aid healthcare organizations in system transformation to advance equity.

Population Health: Organizations that collect population-level data and focus on multi-sector partnerships to advance health.

- 9.1: Stratify population-level metrics by race and ethnicity for transparent reporting on health inequities.
- 9.2: Facilitate partnerships and alignment around anti-racist activities in healthcare.

Tools and Resources

- Communication Tools
  - AMA
  - CDC
- General Health Equity Resources
  - Just Lead Washington: Organizational Race Equity Toolkit
  - Coalition of Communities of Color: Protocol for Culturally Responsive Organizations
  - Coalition of Communities of Color: Tool for Organizational Self-Assessment Related to Racial Equity
  - WHO Health Equity Assessment Toolkit
- Clinics/Health Delivery Systems
  - IHI: Achieving Health Equity – A Guide for Health Care Organizations
  - Joint Commission: Health Equity
  - ANA: National Commission to Address Racism in Nursing
  - Advancing Health Equity (RWJF): Roadmap to Reduce Disparities
  - AHA Equity of Care: A Toolkit for Eliminating Health Care Disparities
  - AHA Health Equity Snapshot: A Toolkit for Action
- Health Plans
  - AHIP: Health Insurance Providers Leading Work to Advance Health Equity
- Employers
  - McKinsey: How Employers Can Help Advance Health Equity in the Workplace
- Schools
  - OSPI: Equity in Courses and Programs
- Public Health
  - DOH: Health Equity Resources for Communities and Public Health

Glossary of Terms[v]

- **Equity:** The Oregon Health Authority defines health equity as "when all people can reach their full health potential and well-being, and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances." This term is preferred over "Equality."
- **Equality:** Providing the same amounts and types of resources across populations. Seeking to treat everyone "the same" ignores historical legacies of marginalization and contemporary discrimination. Most organizations recommend achieving "Equity" instead.

- **Inequity:** Health differences that are avoidable, unnecessary, unfair, and unjust. This term is preferred over "Disparity."
- **Disparities:** A disparity typically refers to any difference, although in some uses of the term it is explicitly linked to economic, social, or environmental disadvantage. Most organizations recommend using the term "Inequity" instead.
- **Race-Based:** The practice of using race as a biological construct to inform medical protocols – such as the eGFR rate, BMI risk for diabetes, Pulmonary Function Test, and more. The AMA explicitly calls for ending the practice of using race as a proxy for biology.
- **Race-Conscious:** A framework to promote anti-racist practices, shifting the focus from race to racism in all its form.

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