Learning from the Pursuing Equity Initiative

Health System Team Summary Reports

Acknowledgments:

IHI is grateful to the eight health care organizations participating in the Pursuing Equity initiative for their generosity in sharing their work: Brigham and Women's Hospital Department of Medicine and Southern Jamaica Plain Health Center (Jamaica Plain, Massachusetts); HealthPartners (Bloomington, Minnesota); Henry Ford Health System (Detroit, Michigan); Kaiser Foundation Health Plan and Hospitals (Kaiser Permanente) (Oakland, California); Main Line Health (Newtown Square, Pennsylvania); Northwest Colorado Health (Steamboat Springs, Colorado); Rush University Medical Center (Chicago, Illinois); and Vidant Health (Greenville, North Carolina).

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For more than 25 years, the Institute for Healthcare Improvement (IHI) has used improvement science to advance and sustain better outcomes in health and health systems across the world. We bring awareness of safety and quality to millions, accelerate learning and the systematic improvement of care, develop solutions to previously intractable challenges, and mobilize health systems, communities, regions, and nations to reduce harm and deaths. We work in collaboration with the growing IHI community to spark bold, inventive ways to improve the health of individuals and populations. We generate optimism, harvest fresh ideas, and support anyone, anywhere who wants to profoundly change health and health care for the better. Learn more at ihi.org.

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Introduction

Eight US health care organizations — diverse in size, geographic location, and patient populations — participated in the two-year Pursuing Equity initiative, led by the Institute for Healthcare Improvement (IHI), which concluded in March 2019. These organizations used the five-component equity framework — first articulated in the 2016 IHI White Paper, *Achieving Health Equity: A Guide for Health Care Organizations* — to reduce inequities in health and health care access, treatment, and outcomes.

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.
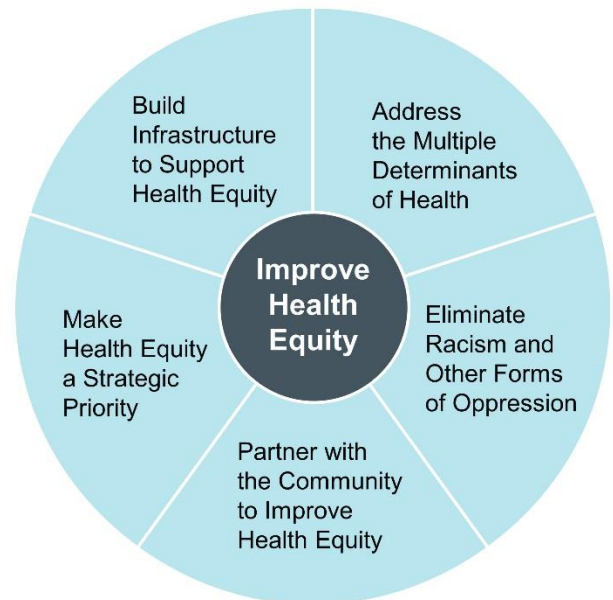
Each of the eight teams participating in Pursuing Equity wrote a summary report to share their lessons and tactics for improving equity in their health systems. Our hope is that these reports will support other health systems in their efforts to improve health equity by providing practical tips, building will for health care's role in championing equity, and presenting examples for how to use the IHI framework to organize equity improvement efforts.

While the summary reports vary in format and highlight different challenges and mitigation strategies, each report does include a brief abstract, background, achievements, challenges, and lessons. IHI's intention in publishing these team reports is to share more broadly the learning after two years of work together in the Pursuing Equity initiative.

Key Themes and Recommendations

Health care organizations play a critical role in improving health equity for their patients, employees, and communities. We hope these Pursuing Equity team summary reports provide practical guidance and recommendations for your organization, whether you are just getting started in identifying inequities or you are further along in your equity improvement journey.

Across the eight reports, some key themes and recommendations emerged:

- Create an equity-promoting environment in the health system at both the macro level by creating supportive policies and infrastructure, and at the micro level by advancing equity improvement projects where ideas can be tested on a small scale, results tracked, and then scaled.
- Senior leaders and equity champions should regularly communicate about the importance of equity and promote conversations about race and racism.
- Health care has played a role in perpetuating structural disadvantages and there is an opportunity for health systems to help dismantle racism and other forms of oppression. Courage is required to lead this work.
- Stratified and actionable data is needed to measure and make inequities visible. Do not let imperfect data be a barrier to taking action.
- Improving health equity cannot happen solely within the confines of the health system. Health care's role may need to be redefined to include addressing the social determinants of health to proactively create opportunities for wellbeing for individuals and the community.
- Focus on building personal relationships within a team. Strong relationships support learning and growth and can bring joy to work.
- Quality improvement methods guide us through a process to define a problem, set an aim, test, track, and learn what it takes to bring about equity improvements through small tests of change.
- Improving health equity is long-term work and results will not happen overnight. Celebrating small wins along the way is important.

IHI is dedicated to supporting, convening, and coaching health care organizations working to improve health equity. We will continue to update and refine our five-component framework based on the experience of the health care organizations that are testing the framework.

Team Summary Report

Brigham and Women's Hospital Department of Medicine and Southern Jamaica Plain Health Center (Jamaica Plain, Massachusetts)

Part 1: Overview

Background

In 2017, the Brigham and Women's Hospital (BWH) Department of Medicine (DOM) and Southern Jamaica Plain Health Center (SJPHC) joined the Institute for Healthcare Improvement (IHI) Pursuing Equity initiative. A multi-racial, multidisciplinary team committed to explicitly naming structural racism and using critical race theory as a primary lens to inform project design work and improve patient care. The team engaged BWH leadership to identify and address inequities in clinical outcomes; employ language to explicitly recognize factors of inequity around race, age, gender, and ethnicity; and to catalyze honest conversations about the history of racism in medicine and racial and social identities as requisite to progress in this essential work. The team considered race to be a social construct that captures the impacts of racism rather than innate biological differences, assuming that "race matters for health because racism matters" (D. Cogburn, RWJ, 2016). Given the commitment to using a structural, and therefore more radical, approach to their work, the team also pulled on the framework developed through the Racial Reconciliation and Health (RRH) project that centers on an understanding of race-based trauma and the need for more emotional containment.

Aim

Our aim is to create a racial justice and equity movement within the BWH. The team undertook initiatives based on identified opportunities to improve clinical care, recruitment, employment, and leadership engagement.

Methods/Projects

- Improving racial justice organizing and communication as well as patient-provider alliance through training and supporting a cohort of physicians.
- Applying a critical race theory (CRT) lens to address inequities in the admission process for patients with congestive heart failure (CHF) diagnosis.
- Understanding and addressing racial bias in recruitment of residents and faculty of color.
- Engaging BWH leadership for sustained commitment to racial justice and equity work.

Data/Results

- Significant change documented in practice among physicians in the "Liberation in the Exam Room" training cohort with multiple cross-department initiatives.
- Engagement of multiple clinical services to recognize, measure, and address inequities in CHF inpatient admissions and care. This project received more than $80K in hospital grant funds, led to conference presentations and publications, and engaged trainees as researchers with agency in making institutional change to address inequities.
- Bias training and new screening methodology implemented for the DOM resident recruitment with requests to expand this approach to other major training programs.
- Ongoing engagement with leadership leading to a May 2019 hospital-wide commitment event prioritizing health equity.

Conclusions/Implications/Recommendations

Addressing health inequities requires shared analysis, vocabulary, and understanding history and institutional challenges. The Pursuing Equity initiative clarified the value to BWH of investing in understanding structural racism and how it

operates on all levels. This work requires teams to see health equity work not only as an academic exercise or abstract research, but rather as a movement that requires authentic and full engagement of colleagues as partners.

Part 2: Summarize Your Work

1. Background and Context

Brigham and Women's Hospital, Surrounding Community, and Patients Served

Brigham and Women's Hospital (BWH) is a 793-bed Harvard-affiliated teaching hospital located in the Mission Hill neighborhood of Boston, Massachusetts. Mission Hill is a racially and ethnically diverse neighborhood of approximately 17,400 people. Sixteen percent of the population is black/African American, 20 percent is Latino or Hispanic, 19 percent is Asian, and 44 percent is white. The poverty rate in Mission Hill is 40 percent, and 57 percent of young people under the age of 18 live in poverty. Mission Hill is adjacent to Roxbury, a neighborhood of 53,000, 86 percent of whom identify as black, Hispanic, or Asian. BWH's location relative to the immediate community is highly relevant to our health equity efforts given that neither employee nor patient populations mirror our immediate community. For the period from October 2018 to January 2019, BWH's discharges were 73 percent white and 14 percent black or Hispanic. Black and Hispanic patient discharge rates declined 6 percent and 17 percent respectively from the prior year.

BWH's Collaborating Partners in Pursuing Equity

The BWH DOM trains more than 500 medical students, residents, and fellows each year, and accounts for nearly 40 percent of patient discharges, with 18,451 discharges in FY2018. Black and Hispanic patients accounted for 16 percent of discharges for the same period. Southern Jamaica Plain Health Center (SJPHC) is a community health center within BWH and Partners HealthCare. Every year, more than 12,000 patients from Jamaica Plain and surrounding communities make 45,000 visits to the health center. More than half of all patients identify as Latino/a and half are on public insurance.

BWH's Health Equity Context

As with most health care systems, BWH and the larger health system of Partners HealthCare, of which BWH is a founding partner, has a variety of efforts focused on diversity and inclusion (D&I) which are often separated from projects focused on health equity. There are trainings on implicit bias available to BWH staff, a Chief Diversity and Inclusion Officer and several Centers dedicated to the recruitment of faculty of color, with a separate Center for the support of women. The Center for Community Health and Health Equity (CCHHE) has spearheaded a number of projects in the Boston community and in the research arena to measure health inequities.

Despite these and other efforts to address health inequities at the hospital, there was not a clear mandate in the safety and quality improvement department of the hospital to collect and analyze data by race, ethnicity, and other potential markers for systemic inequity. There was little cross-departmental efforts to tie health data into hospital practices within the health system and in the surrounding neighborhoods. Race and ethnicity fields in the legacy electronic medical record (EMR) system were confusing and had changed at least once during a recent EMR upgrade. There was information in the system to help identify health inequities, but it was difficult to interpret and not collected consistently.

Breakthrough Theme 1: A key early clarifying moment for the DOM/SJPHC team was our recognition that there was not a shared language or measurement approach to discuss and address inequities in outcomes throughout the hospital.

SJPHC has long been a leader in racial justice in health care delivery and an advisor externally to IHI, the Massachusetts Department of Public Health, and other partners. SJPHC is an entity of BWH's CCHHE. Staff from CCHHE were partners in the IHI Pursuing Equity initiative, along with SJPHC and BWH DOM. In 2016, SJPHC's Director of Community Health was recruited by IHI to provide consultancy around next steps in their racial equity work. Through those conversations IHI became more familiar with the health center's work and RRH project with youth as well as its emerging "Liberation in the Exam Room" project with providers. SJPHC was recruited to be part of the national Pursuing Equity initiative and joined forces with the DOM Health Equity Committee leaders. This collaboration has been one of the first at BWH that connects a health center with a much larger hospital department to engage in work focused on racial justice and equity.

In 2017, BWH's DOM Health Equity Committee was established with Michelle Morse and Rose Kakoza as co-chairs and Jennifer Goldsmith providing program support. Membership included DOM Division Chiefs, leaders in quality improvement, nursing, administration, and SJPHC Racial Justice leadership. The DOM Health Equity Committee meets quarterly to plan initiatives such as a grant process to address inequities and to consider how to set a template for BWH departments to identify and address health inequities in care delivery.

The DOM/SJPHC team formed around a shared interest to lead explicitly with the legal framework of critical race theory (CRT). Given the history of the US and the level of expertise of the team members, there was agreement that a racial equity analysis could help uncover additional structural inequities, which could then be addressed intersectionally.[25] The team's work was guided by Public Health Critical Race Praxis (PHCRP), an approach utilized by researchers to study and ameliorate instances of structural racism and resultant health inequities.

Part 3: Describe Your Two-Year Journey

Framework: The Power Analysis and Group Foundation

Beginning in April 2017, DOM/SJPHC used valuable retreat time provided by Pursuing Equity to complete a power analysis of the current opportunities for growth and change at BWH. From those discussions the team established four concrete project charters that have remained consistent over the past two years and have begun to intersect and grow in exciting ways.

Breakthrough Theme 2: The team found success by sharing definitions early, reminding people not to personalize the critique of systems, ensuring that the team was multiracial so that white people were able to engage with and educate other white people about racism, and talking openly about how sexism and classism intersected with racism. These were all "a-ha" moments and helpful strategies.

Adaptive Leaders for Racial Justice

Adaptive Leaders for Racial Justice (ALRJ) emerged from earlier work SJPHC was doing with a cohort of physicians from the greater Boston area. Starting in December 2017, 14 providers and health leaders were recruited to participate in a more intensive leadership development project. The project's goals were to improve racial justice organizing and communication as well as the patient-provider alliance through training and support. Along with a larger group of hospitalists at BWH, the 14-member cohort attended three trainings: The History of Racism and Health, Racial Justice Framing, and Racial Justice Communication. They then participated in early morning labs at the health center to deepen their racial justice practice and communication skills, and monthly coaching calls focused on their local equity projects, as well as one-on-one coaching calls with SJPHC's Directors of Racial Justice and Equity. The learning culminated in a day-long retreat in July 2018 hosted by IHI. Almost all of the DOM/SJPHC team members participated in the pilot, giving the team added time to deepen relationships with each other.

Breakthrough Theme 3: The most significant breakthrough to success of the ALRJ team was the commitment to integrating a race-based trauma lens into the lab work, and the team's practice methodology where feelings are explicitly welcomed into the room and the team spends time on co-creating an emotional container in which health equity work can happen. This served the team well time and time again as our work became more challenging.

The DOM Health Equity Project on Heart Failure Admissions

The congestive heart failure (CHF) project (see Figure 1) emerged from the observations of a group of internal medicine residents who shared concerns about the perception that white patients with health failure diagnoses seemed more often to be admitted to the Cardiology Service in comparison with black and Hispanic patients who were admitted to General Medicine Service. This perception led to a rigorous analysis focused on self-referral patients who presented with CHF symptoms. The team reported findings from a 10-year single-center cohort study of 3,133 admissions of 1,967 unique patients admitted to the hospital with a principal diagnosis of CHF after self-referral to the emergency department. They found that black and Hispanic patients who were women and from Boston were less likely to be admitted to the Cardiology Service compared to white patients after adjusting for sociodemographic factors, comorbidity, and prior clinical follow-up with a primary care doctor or a cardiologist at BWH. Applying a critical race theory (CRT) lens to a clinical project aimed

at addressing inequities in admissions of patients with a CHF diagnosis was unprecedented at BWH. The team was supported by the BWH analytic team who provided data to facilitate the rigorous analysis conducted by the residents.

Breakthrough Theme 4: Both a challenge and a breakthrough related to the clinical work was engaging the multiple stakeholders in a CRT analysis. The CRT approach was unfamiliar and required all the collaborators to move from an interpersonal to a structural analysis, challenging and shifting perceptions and also creating a unified framework for collaboration and action.

The project leaders worked diligently to socialize the findings from the analysis, working with the general medicine, emergency medicine, and cardiovascular treatment teams. There was hesitancy to talk about the findings in the context of racism because of the consistent tendency to assume there had to be some level of overt interpersonal racial animus among individuals rather than interlocking patterns of policies and practices — structural racism — that resulted in the outcomes observed. The team provided multiple trainings, discussion forums, and other learning opportunities to democratize the conversation and create a sense of urgency and *momentum* around the project. The CHF admissions work was presented at IHI's annual National Forum and is now awaiting publication. There are several improvement projects underway to address the equity gaps identified with funding from the DOM and the Divisions of Cardiology and General Internal Medicine.

Figure 1. Brigham and Women's Hospital Department of Medicine Health Equity Project on Heart Failure Admissions

Who we studied:
Among 1,967 unique patients self-referred to ED with CHF symptoms:

- **Who were underlying populations:**
  Black patients are statistically younger, more likely to be female, from Boston Metro, and more likely to have Medicaid coverage.
- There are no significant differences in Elixhauser comorbidity index and Elixhauser Non-Cardiovascular Comorbidity Index between white and black patients.
- Black patients are statistically less likely to have been seen in BWH Cardiology or PCP clinic in the past year.
- Black patients were statistically less likely to have been admitted to Cardiology.

Who received care where:

- The odds of access to an inpatient cardiology bed are significant lower among **black and Latinx patients, older patients, and women**.
- The odds of access to a Cardiology bed are significantly higher among patients who have been **seen in BWH Cardiology and less likely for those seen in BWH Primary Care in the past year.**

Our conclusions:
The data suggest presence of structural inequities such as structural racism and sexism in self-referred heart failure admissions.

Inequities persist after controlling for:
- Diastolic heart failure, co-morbidity (valvular disease, arrhythmia, chronic pulmonary disease)
- And being seen in BWH cardiology clinic, PCP clinic in last year
- Being seen in BWH cardiology clinic within last year was the strongest independent predictor or cardiology admission.

**Breakthrough Theme 5*:* Time, patience, perseverance, and partnership resulted in incremental change and ultimately created a shifting and increasingly accepted narrative related to structural racism in patient care.

The DOM Health Equity Initiative Program (HEIP)

The Chair of Medicine, Dr. Joseph Loscalzo, committed more than $100K to fund health-equity-focused projects in the DOM. These funds were intended to be matched by participating divisions (see Figure 2). The committee recruited the Directors of Racial Justice Initiatives at SJPHC to train the DOM Health Equity Committee members with content from their ALRJ pilots so that they would have protected time to learn and deepen their relationships and to be better positioned to support ongoing racial justice efforts at BWH.

Figure 2. Brigham and Women's Hospital Department of Medicine Health Equity Initiative Program

2018 Health Equity Innovation Matching Program

BWH BRIGHAM AND
WOMEN'S HOSPITAL
| Department of Medicine |

Goals
* Support Health Equity innovation and operational improvement;
* engage and support population-based research or program implementation that measures & addresses inequity in patient care;
* Be action oriented, supporting meaningful, measurement and evaluation of existing inequities in patient care and to rapidly develop responses to improve quality and effectiveness of care for all patients.

Approach
* Funding will be derived from HE Committee funds matched equally with Divisional sources;
* Selected projects will understand and address obstacles to patient care by race, ethnicity, age, disability, or gender identity;
* Priority will be given to projects that have a formal role for residents/trainees from the division;
* To support interdisciplinary work, applicants may come from different DOM divisions (i.e. Cardiology and General Medicine);
* Faculty members are encouraged to engage trainees in their proposals;
* Fellows are eligible to apply for project funding.
* Proposals must address five areas:
  Aim(s) with respect to Health Equity in the DOM;
  Significance & innovation;
  Implementation plan;
  Future directions and amplification of impact;
  Synergies derived from any specified interdivisional collaboration(s).
* Proposals will be assessed based on:
  The equity impact of the proposal;
  The soundness of the proposal and implementation and operations plans;
  The probability of securing a sustainable improvement;
  Community impact;
  Cost effectiveness of proposal as detained in budget.

HEIP Funded Projects	Division
Reducing Structural Inequities in Heart Failure Management: An Approach to Improve the Quality of Heart Failure Care on the General Medicine Service	Internal Medicine
Addressing Racial, Ethnic, and Socioeconomic Disparities in Lupus Care Through an Integrated Care Management Program Pilot	Rheumatology, Immunology, and Allergy
Targeted Geriatric "No-Show" Home Visits for High-Risk, Vulnerable Older Adult Patients in the Phyllis Jen Center for Primary Care	Aging
Developing Best Practices to Collect Information on Past History of Incarceration	Women's Health
Advancing Trauma-Informed Education into Clinical Practice for Adults: A Curriculum for the Hospital Staff	Women's Health
Racial Disparities in Interhospital Transfer	Internal Medicine
Reducing Structural Inequities in Heart Failure Management: Understanding and Addressing the Drivers of Admission Service Decisions	Internal Medicine/Cardiology
The Chronic Kidney Disease Registry Race Reclassification Project	Endocrinology

Understanding and Addressing Racial Bias in Recruitment of Residents and Faculty of Color

BWH has a noticeable dearth of faculty and residents from underrepresented in medicine (UIM) backgrounds. We believe that this is in part due to implicit and explicit biases held by departmental and residency leadership. For example, there are recruitment concepts of someone who speaks with erudite diction, trained in elite institutions, and generally demonstrates "Brigham Fit." These factors are rooted in the discriminatory practices that lay at the foundation of many hospitals, including BWH. Further, the history of racism in Boston may make it difficult to attract top academic talent to practice here.

We sought to gain a deeper understanding of these biases. We worked with the DOM Residency Diversity and Inclusion Committee to learn about perceptions of race in Boston through a survey distributed to residency program applicants who participated in our applicant revisit. Several respondents commented on the lack of diversity among faculty and residents. Some stated they did not sense that diversity was emphasized at our institution. To address this, the DOM now requires all faculty who interview residency applicants to participate in implicit bias training. Two committee members were involved with reviewing all UIM residency applications to ensure that no strong applicants fell through the cracks during the recruitment process. Also, the residency program directors participated in the racial justice training sessions hosted by the DOM/SJPHC team. These activities have led to an increase in the number of incoming UIM residents compared to prior years. More work must be done to have similar success at the faculty level.

Engaging Leadership

While the three projects above allowed the DOM/SJPHC team to address different areas of racial equity, it was important to invest in engaging BWH leadership for a sustained commitment. All of the projects have elements of leadership engagement at different levels. Our team met with the president of the hospital and with key department leaders in primary care and quality improvement to build additional buy-in for equity-focused projects. As part of our team's efforts to raise awareness about structural racism, Dr. Michelle Morse, Associate Physician in the Division of Global Health Equity, invited Dr. Camara Jones, Past President of the American Public Health Association, to present at DOM Grand Rounds in January 2019, where she engaged and captivated numerous clinical leaders by providing a powerful framework that recognized and named racism in health care. Her lecture coincided with "second look" visits from UIM candidates for the DOM Internal Medicine residency program. The leadership decision to have Dr. Jones share an hour with the candidates in which they candidly discussed their own experiences reflected leadership recognition that they cannot uncouple residency recruitment from the experience of race in our institution, our community, or our city. Additionally, the HEIP grant processes were developed based on meetings with five Division Chiefs in the DOM. Under the leadership of Dr. Morse, the DOM/SJPHC team presented some of the learning over the two years of the Pursuing Equity initiative and recommended to hold an event in Spring 2019 to reaffirm BWH's commitment to health equity and to solidify a path forward. This was done in concert with the CCHHE, which will be spearheading a health equity action planning process with the participation of staff across Brigham Health.

Coda: Loss of Community Members and Recruitment of New Ones

In 2018, the DOM/SJPHC team saw two of the four black women on our team leave employment at BWH, and a third relocated and now works part-time at BWH. While the people of color (POC) team members departed for a variety of individual reasons, the significance of the loss remains painful and has impacted the group's overall understanding of racism and sexism at the hospital and at all hospitals. Rather than denying this truth, the team used a half-day retreat to name the team dynamics and mourn the loss collectively. Dr. Morse recruited Tom Kieffer, the Executive Director of SJPHC, as co-chair for the DOM Health Equity Committee. During the Fall 2018, the DOM/SJPHC team expanded to include Dr. Karthik Sivashanker, a fellow from the BWH's Quality Improvement team, Chief Medical Resident Dr. Patricia Foo, who was part of the ALRJ, as well as a new representative of CCHHE, Michelle Keenan. Yet, it is important to highlight that the white members of our team, who do not live the experience of racism daily, have stayed on the team and at BWH. This dynamic seems to mirror the privilege and comfort that is so pervasive for white people in our institution and our society. This observation of divided experience has led to reflection on the complex dynamics even within a cohesive team in a context where color and division are traditionally inextricable.

Breakthrough Theme 6: Being explicit does not make the work any easier, but it has allowed for authenticity and for deepening of the relationships on our multiracial team. The loss of people of color from hospitals happens all the time, often with no acknowledgement of the impact of structural racism.

Part 4: Describe What's Next for Equity Work

As our IHI Pursuing Equity work comes to a close, the Office of BWH's President hosted a hospital-wide reaffirmation and learning event related to health equity, *Brigham and Health Equity: Aligning Our Mission, Defining Our Future*. DOM/SJPHC team members were instrumental in planning the event and evaluation. The keynote speaker was Dr. Mary Bassett, a global and domestic health leader who wrote an important perspective piece in the *New England Journal of Medicine* regarding the adverse health effects of racial discrimination against African Americans. Her talk further clarified the need to name racism in health care. Six roundtable lunches on health equity topics were filled to capacity and most members of the Pursuing Equity team presented in these settings; 25 projects from across the institution were featured in a poster session to close the day. Michelle Morse served as co-moderator of the day and sat on a panel that discussed future paths for BWH health equity. Notably the Chair of Medicine also sat on the panel and spoke directly to the need to name racism as a factor in health care delivery. The event was remarkably well attended and simultaneously translated into Haitian Creole and Spanish to maximize accessibility. While evaluations have not yet been summarized, there seems to be an institutional commitment to offering this program annually.

The DOM HEIP grantees have begun their projects and the DOM/SJP team is crafting a community of learners model, the Health Equity University, to support the work. This new year provides the opportunity to connect more explicitly with the health equity and DEI agenda of BWH so that the many creative people working on equity are not operating in silos. SJPHC has also reinvigorated its own internal Health Equity Committee and, as always, the young people in the Racial Reconciliation and Healing program continue to serve as the nexus and inspiration for the work. We plan to gain a deeper understanding of the experience of faculty and residents of color at BWH by continuing to conduct surveys, focus groups, and "reflection rounds" hosted by our hospital's Center for Diversity and Inclusion and interfacing with residency leadership. Finally, Dr. Karthik Sivashanker is championing efforts to integrate equity and racial justice analysis into Clinical Case Reviews following adverse clinical events, evolving from a model of Quality and Safety to one of Quality, Equity, and Safety.

Breakthrough Theme 7: Achieving health equity requires teams to see the work as a movement that requires full engagement of colleagues, expansive thinking, a sense of possibility for change, and trust and partnership in this critical work. It is not beyond just an academic exercise or abstract research, but a fundamental and essential change in approach.

Team Summary Report

HealthPartners (Bloomington, Minnesota)

Part 1: Overview

HealthPartners is an integrated health care organization providing health care services and health plan financing and administration. It's the largest consumer governed nonprofit health care organization in the US, serving more than 1.8 million medical and dental health plan members nationwide. Our care system includes a multispecialty group practice of more than 1,800 physicians that serves more than 1.2 million patients. HealthPartners employs more than 26,000 people, all working together to deliver the HealthPartners mission.

HealthPartners has a longstanding strategic focus on health equity, with a strong commitment from our consumer-governed board of directors. Equity and the elimination of racial and financial class disparities have been included in our five-year stretch goals since 2005. This serves as an ambitious road map to improve the health and well-being of each member, patient, and the entire community. To help achieve this priority, we've focused on equipping people with the knowledge and resources needed to provide appropriate care and service, engaging communities to learn how to best support them, and improving care through data-driven quality improvement.

Our strategic focus on diversity and inclusion involves creating a culture where everyone is welcomed, included, and valued through an emphasis on eliminating bias and increasing cultural humility. See Figure 1 for HealthPartners' approach.

Figure 1. HealthPartners Approach to Health Equity
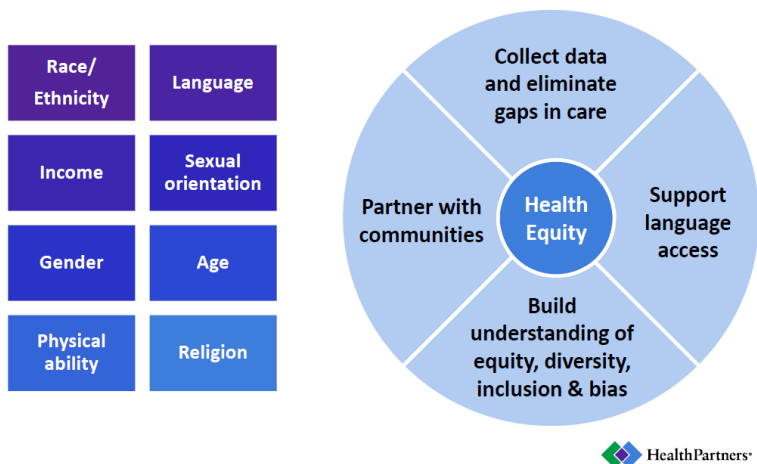
Throughout HealthPartners' participation in the Pursuing Equity initiative, our aim was to build on our strong foundation, both accelerating and aligning existing work while learning from the collective group. For example, we aim to eliminate financial and racial class disparities in our ongoing work around colorectal cancer screening by offering both FIT and colonoscopy, addressing clinician unconscious bias, and patient outreach. From 2009 to 2018, we have been able to increase screening rates for all while reducing the gap between patients who are white and patients of color from 26 percent in 2009 to 8 percent in 2018. In 2017, we mailed out over 3,000 FIT Kits to eligible patients of color and increased the screening rate by 4 percent, representing 756 more patients of color screened that year.

Other accomplishments include relaunching our internal health equity structure, launching an equity-focused workgroup on pediatric immunizations, several presentations and equity discussions with leaders and our board of directors, and receiving the 2019 CMS Health Equity Award. We feel strongly that equity needs to be embedded within the organization

and aligned closely with quality improvement, care coordination, and diversity and inclusion. Addressing inequities requires many interventions over time; there is no quick fix. Success requires the following:

- Emphasize the importance of health equity;
- Integrate health equity into overall strategic and annual plans;
- Involve the board and senior leaders in the work;
- Collect data and regularly and transparently share results;
- Focus on clinical improvements and culture;
- Engage with patients and the community; and
- Don't wait for perfection to get started.

Part 2: Summarize Your Work

Describe Your Work for Each Component of the IHI Framework to Improve Health Equity

Component 1: Make Health Equity a Strategic Priority

Accomplishments

Equity is embedded in HealthPartners' annual plans, the board of directors regularly receives updates on equity work and reviews our results (stratified by race, language, and economic status), we have a steady drumbeat of communication to all staff on issues related to equity, and key equity-related metrics are built into our executive incentive plan.

Challenges and Tips

Health care organizations have a lot of key strategic priorities requiring focus. It's important to not only make equity a strategic priority, but also demonstrate how equity supports other strategic priorities and is imperative to the success of the organization.

Component 2: Build Infrastructure to Support Health Equity

Accomplishments

- We relaunched our long-standing health equity steering and workgroup structure to be more strategic and include key decision makers (see Figure 2). Over the years, the group had gradually expanded to include almost 30 members. With the relaunch, the sponsor group is now 15 members representing ambulatory, hospital, and health plan functions under the leadership of the Chief Operating Officer and Senior Vice President for Community and Government Relations, who serve as the co-chairs.

  The group meets six times per year for 90 minutes with the purpose to: 1) provide leadership in planning and executing activities aimed at improving health equity through reducing health care disparities, improving access and supporting an inclusive culture; and 2) align health equity activities across the organization through inclusion in annual plans, and support tracking and monitoring of progress. Hospital- and ambulatory-specific steering groups and workgroups report through the Health Equity Sponsor Group in addition to interpreter services and our Equitable Care Champions Program. The Health Equity Sponsor Group is also closely connected to our organization-wide Diversity and Inclusion Sponsor Group.

Figure 2. HealthPartners Health Equity Steering and Workgroup Structure

Health Equity/Embracing Diversity & Inclusion (2019)
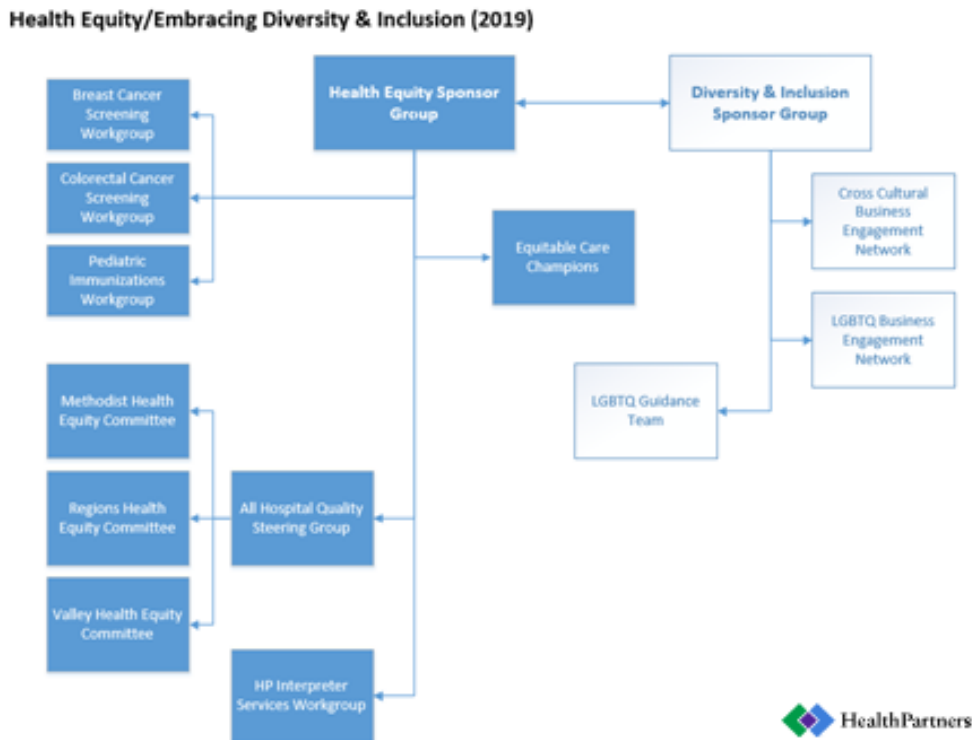
- We have robust data standards and rigor around measurement that requires all measures to be built with the ability to stratify by equity elements including race, language, country of origin, and payer type. We are able to drill down to the clinician/care team level. We reworked some of our leadership reports to more explicitly show the gap for marginalized populations.

Challenges and Tips

- It is important to come to consensus on how you will stratify your data. Once you decide that, get to work on doing something about it. The data will never be perfect, but that shouldn't stop you from getting started.
- In Minnesota, we have public reporting for health measures across medical groups within the state. An annual equity and disparities report is released by Minnesota Community Measurement. Within an organization, data transparency is imperative to drive improvement.

Component 3: Address the Multiple Determinants of Health

Accomplishments

Progress toward closing the gap in the following areas:

- Ambulatory: Breast cancer (see Figure 3) and colorectal cancer (see Figures 4 and 5) screening with new work around pediatric immunizations.
- Hospital: Readmissions and patient experience (see Figure 6), building off progress in some areas, we launched organization-wide workgroups dedicated to the topics.

Figure 3. HealthPartners Breast Cancer Screening by Race

Figure 4. HealthPartners Colorectal Cancer Screening by Race

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

Figure 5. HealthPartners Colorectal Cancer Screening: FIT Screening Test Mailing Results

Figure 6. HealthPartners Hospital Admissions and Patient Experience: Mental Health Unit Length of Stay by Language

Challenges and Tips

Improving rates for all and eliminating disparity gaps requires multiple interventions over time. Do not get discouraged. Equity should be an integral part of every improvement project, but you need to choose key areas to monitor progress at the highest level over time.

Component 4: Eliminate Racism and Other Forms of Oppression

Accomplishments

- Ongoing conversations at all levels about race and racism, unconscious bias trainings, tools and supports for teams addressing patient bias, specific training and information about bias and cultural humility and how it can affect the care we provide (via the Equitable Care Champions program to support education and awareness at the local level), and understanding of our region's history and inequities.
- We've developed tools and resources over the last year to better provide care and service for patients and members who identify as part of the LGBTQ communities. This includes foundational LGBTQ inclusion training for all staff as well as clinician/care team specific training.

Challenges and Tips

These conversations need to be ongoing and everyone needs to be given the opportunity to share. Over the years, we've found the YWCA It's Time to Talk "Circle Process" to be an extremely valuable tool for sometimes sensitive topics. We identify with Race Forward's statement, "We focus on race and racism explicitly but not exclusively."

Component 5: Partner with the Community to Improve Health Equity

Accomplishments

Our approach to partnering in the community has been heavily influenced by our understanding of social determinants of health and health equity. We also use our community health needs assessments as an opportunity to engage with public health and local organizations to fully understand the needs of a community. We have made strategic, long-term investments in areas such as mental health, healthy eating, and early childhood. HealthPartners has acted as a convener in our community to surface best practices and share broadly, with an eye on impact and evaluation.

Challenges and Tips

Collaboration and partnership are vital to pursuing equity. While we act as the convener on many topics related specifically to health, we are also partners on community-wide initiatives related to economic growth, workforce development, and transportation.

Part 3: Describe What's Next for Equity Work

HealthPartners will continue to accelerate and align our health equity work across our organization. We will continue acting as a convener to improve health and well-being in partnership with the communities we serve. We are focused on making care and coverage simple and affordable, and equity plays a large role in delivering upon that goal. Emerging areas of work include maternal/infant health equity, LGBTQ health, and a systematic and reliable approach for screening and referring for social determinants of health, particularly food insecurity.

Team Summary Report

Henry Ford Health System (Detroit, Michigan)

Part 1: Overview

Background

Henry Ford Health System (HFHS) has a longstanding, nationally-recognized commitment to ensuring equity in health care. We continually strive to develop innovative and culturally responsive approaches to achieving equity in the care of the diverse populations we serve.

Aim

We aimed to demonstrate how incorporating an equity lens into quality and population health improvement projects can lead to improved patient health outcomes and reduced health disparities. We used the goals outlined in IHI's five-component framework, particularly in the areas of addressing institutional racism and making equity a strategic priority.

Methods

We established a Pursuing Equity Steering Committee to provide support, guidance, and sponsorship for our equity improvement projects, the design of our equity dashboard, and our progress across the five components of the IHI framework.

Data/Results

Our transportation pilot team partnered with SPLT/Lyft to coordinate rides and transport 15 end-stage renal disease patients to their vascular access appointments. We partnered with Ford Motor Company's GoRide division to reduce missed follow-up appointments post-discharge. To date, we have six completed rides, four no-shows, and four canceled rides from patients discharged from Henry Ford Hospital.

We improved diabetes outcomes with the addition of a personalized outreach process model for patients with uncontrolled diabetes. This allowed for timelier patient follow-up and contributed to a system-level decrease in the racial quality gap between Black and White patients with uncontrolled HbA1c levels (blood sugar) from 5.3 percent to 4.4 percent from the end of 2016 to the end of 2018.

For our readmissions project, we helped revise the policy for use of our charitable fund, the Tom Groth Medical Needs Fund, to make it easier for clinical staff to use the fund to address social barriers. Soon after, we were able to improve the in-home environment for one of our patients with monies from this fund.

We continue to finalize an equity dashboard, which will highlight key system quality metrics stratified by self-reported race, ethnicity, language, and gender identity.

Conclusions/Recommendations

The Pursuing Equity initiative served as a catalyst to improve collaboration among multidisciplinary leadership and departments as we work to advance quality and process improvement projects through an equity lens. We have improved patient lives with a unique combination of IHI quality improvement tests-of-change and HFHS Lean improvement through an agile framework by strategically incorporating lessons learned into process improvement. We have tested programs that have been or are in the process of being adopted at a system level and hope to do more with continued collaboration. Finally, we have had pivotal conversations with leadership on social determinants of health and institutional racism, and on what it means to make equity a strategic priority, which has sparked future goals in diversity and unconscious bias training.

Part 2: Summarize Your Work

1. Background and Context

HFHS Equity Journey

Henry Ford Health System, a winner of the American Hospital Association Equity of Care, DiversityInc and Human Rights Campaign Healthcare Equality Index awards, has a longstanding commitment to equity in health care and conducting research to identify, understand, and reduce health care disparities and improve health care outcomes. With leadership from Dr. Kimberlydawn Wisdom, SVP Community Health and Equity and Chief Wellness and Diversity Officer, and Dr. David Nerenz, Director Emeritus of the Center for Health Policy and Health Services Research, HFHS began its equity journey in the early 1990s by acknowledging that health care disparities exist and by dedicating time and resources toward eliminating them. This led to more programs and initiatives devoted to health care equity and reducing health care disparities within the Henry Ford Health System and nationwide.

In 2008 we launched the Healthcare Equity Campaign, which heightened awareness across the organization about health disparities, training over 300 employees from over 20 disciplines across the system. We launched a Race, Ethnicity, and preferred Language (REaL) Data Collection Task Force soon after, which developed structures and processes to revise REaL data collection to align with the Institute of Medicine's recommendations from 2009. For the first time, our patients could self-report information about their race, granular ethnicity, English language proficiency and preferred language, which to this day strengthens our ability to more accurately monitor and address health and health care disparities.

Despite these advancements, there was still a need to progress the work of health and health care equity at HFHS.

HFHS Community

Henry Ford Health System is a proud and active partner in our community, continually working toward greater access to care and improved overall health. We have over 200 community partners. Although community can be defined in many ways, we focus on community as employees, patients, and the community-at-large and as a sense of connection, often accompanied by a sense of caring that unites us with each other. As demonstrated in our Community Health Needs Assessment, the health of individuals in underserved and minority communities in metropolitan Detroit are affected by multiple social factors, and Detroit itself continues to rank as one of the most stressed cities in the US. Contributing factors include poverty rate, divorce rate, housing, and health care needs. Years of housing segregation, lack of economic growth in Detroit (and moves by residents to the suburbs), and years of historical inequitable policies that have all affected the health outcomes for our patients residing in metropolitan Detroit. Each of our five hospitals selects topics to address based on the results of our Community Health Needs Assessment. Topics identified in the 2016-2019 assessment include infant mortality, chronic disease, health insurance enrollment, and domestic violence.

What were you trying to accomplish over the last two years?

We emphasized the importance of viewing quality improvement efforts through an equity lens across all system operations and in agreed upon strategic projects. To this end, we worked across the system, across silos, and across teams to advance equity at the front line, with senior leaders, in our strategy, and in our infrastructure. In addition, we aimed to improve the lives of our patients by addressing their social needs and the quality of care. For example, we aimed to decrease the racial quality gap between Black and White patients by 1 percent each year of this two-year initiative.

2. Critical Moments During the Last Two Years of the Pursuing Equity Journey

- **Launched a health equity steering committee to reduce silos and provide strategic guidance:** To bring stakeholders and influencers in equity across the system together, Dr. Wisdom and Dr. Denise White Perkins, Director for the Institute on Multicultural Health, established the Pursuing Equity Steering Committee. The committee includes senior leaders, the day-to-day Pursuing Equity team members and equity content experts, and co-chairs Drs. Wisdom and Michelle Schreiber, HFHS's Chief Quality Officer. By adding Ms. Hawkins, SVP Population Health, to represent population health to the Steering Committee, we were able to bring together equity and community health, quality and safety, and population health teams to focus specifically on how we can align our strategies around Pursuing Equity.

Hosting the fifth IHI Pursuing Equity workshop at our Henry Ford Detroit location gave us an additional opportunity to bring forward our senior and executive leaders to discuss making equity a strategic priority. At the workshop, five HFHS executive leaders, including the Chief Executive Officer and President, Wright Lassiter III, and President, Healthcare Operations & Chief Operating Officer, Robert G. Riney, shared their vision for equity as a strategic priority.

We extended our reach to other senior leaders by adding Dr. Diane George, Chief Medical Officer of Primary Care for the Henry Ford Medical Group, and Veronica Hall, President of Henry Ford Hospital (HFH), to our Steering Committee.

- **Met one-on-one with key leaders to build engagement and understanding about equity:** During the two years of the initiative, we took time to meet one-on-one with senior leaders across the organization. We utilized this time to update them on the equity improvement projects, progress around the core areas of work, and most importantly to strengthen their understanding of how their issues and concerns could be viewed through an equity lens. With the expertise of Dr. Marla Rowe Gorosh, we utilized Appreciative Inquiry to facilitate these discussions and to broach the often-difficult conversations related to institutional racism.

These meetings proved to be invaluable for building rapport and understanding with our senior leaders, giving them an opportunity to convey their needs and giving us an opportunity to discuss how equity could be integrated into their system operational goals. These conversations led to greater buy-in from senior leadership to continue to make equity a strategic priority and our goals after the IHI Pursuing Equity initiative concluded.

- **Initiated the development of a data dashboard to show equity gaps in core quality and utilization metrics:** With support from our Chief Quality Officer and Robert Brooks, Manager of Clinical & Quality Analytics, we are building an equity dashboard based on the 2019 strategic goals in quality and utilization. To gain support and interest toward the development of the dashboard, we shared updates and asked for feedback on the development at pivotal senior leadership meetings and at our monthly Steering Committee meetings. We recognize the need to have devoted staff time to develop this dashboard. We presented the equity dashboard as a central place where HFHS can identify and monitor health care disparities within our patient population. See Figure 1 below for a screenshot of the equity dashboard for our diabetes HbA1c control rates by race for patients system-wide.

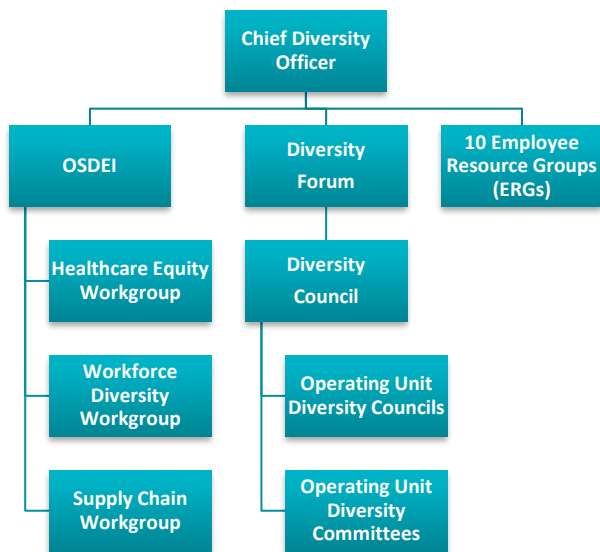**Figure 1. Henry Ford Health System Equity Dashboard for Diabetes**
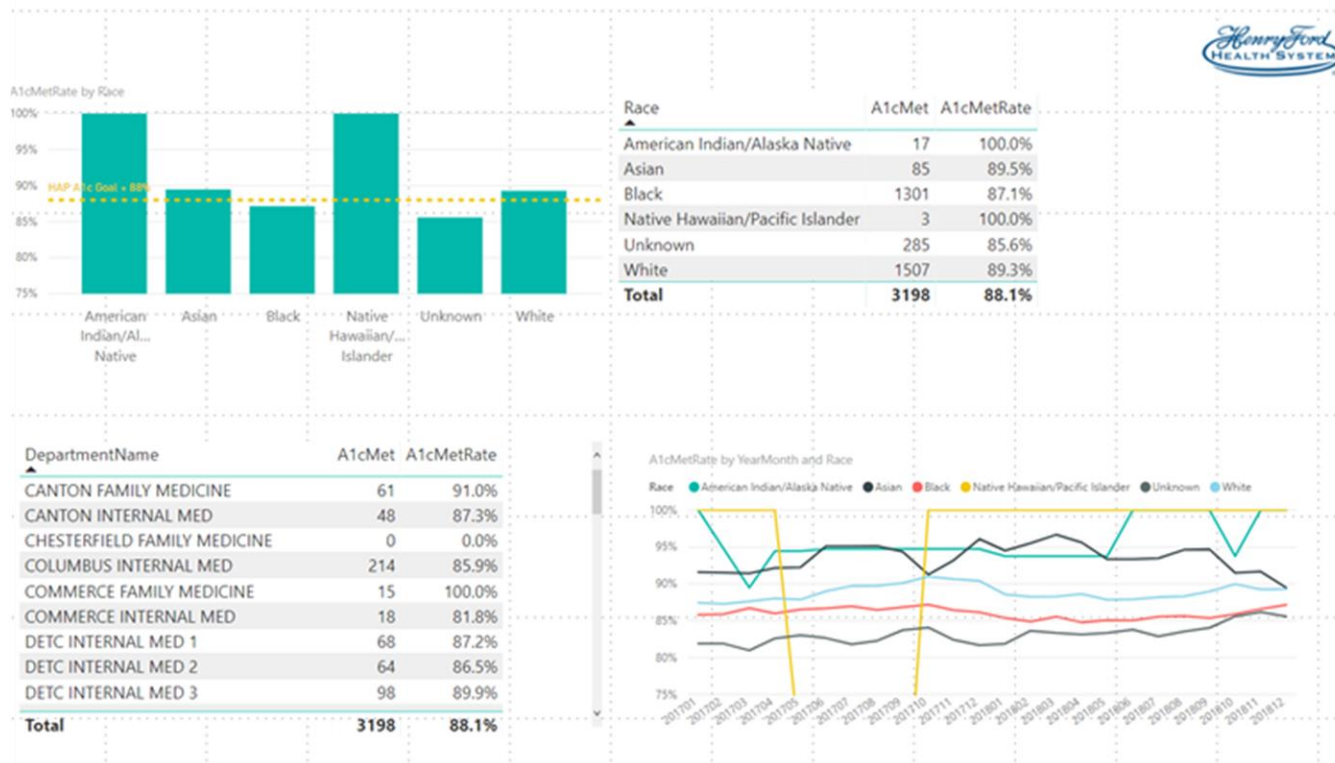
- **Integrated with existing teams on new projects to assess and deploy specific strategies to address social determinants of health (the third component of the IHI framework):** In the first project, we addressed transportation (and later food insecurity) as a barrier to care for specific HFHS patient populations. Design teams, led by those with operational accountability, were launched to reduce readmissions at Henry Ford Hospital (Detroit location) by addressing food scarcity and transportation as social determinants of health (SDOH) for patients with end-stage renal disease (ESRD). Our first pilot was to provide rides for ESRD patients through a SPLT/Lyft partnership to get those patients to vascular access appointments, but we learned that transportation was not the only SDOH patients often face, so we are planning additional pilots to incorporate other social determinants (likely food insecurity).

- **Inventory of social determinants of health tools:** Under the leadership of Susan Hawkins, SVP of Population Health, we formed a workgroup to inventory the tools being used across the system to collect social determinants of health data, as well as how these tools are used to create referrals to appropriate community/social agencies based on patient need. Initially, the workgroup identified 11 different surveys in use across HFHS that had no uniform measurement of SDOH. In addition, the workgroup hosted presentations of most of the tools to learn about them and how they are used. The team agreed to pilot WellOpp's tool and to continue to use Riverstar and Healthleads (two tools in place already), until a new Epic SDOH assessment and display tool could be implemented in Spring 2019. This refined, centralized collection of patient SDOH and consistent approaches to connecting patients with community organizations will strengthen and progress our work to close equity/quality gaps for patients and communities.

- **Discussions on institutional racism:** We invested time during this initiative to bring forward the conversation on institutional racism. We began by surveying leaders and influencers in diversity and equity within our first year to gauge where they believe HFHS is in regard to this topic. We discussed how bias and years of structurally racist policies and history in Detroit have directly or indirectly influenced health outcomes, resulting in health care disparities. We elevated the conversation from middle management to executive leadership. Because of these crucial conversations, we are bringing attention to important topics for our next steps, such as improving equity in employee hiring policies and addressing the potential need for reform in our charity care policies.

- **Regrouped after a key leader left HFHS:** In September 2018, Dr. Schreiber, Chief Quality Officer, was recruited to take a new job with the Centers for Medicare & Medicaid Services as Director of Quality Measurement and Value-Based Incentives. Though Dr. Schreiber was integral in advocating for the need to develop the equity dashboard, we are confident that this work will continue, especially with the support of our Steering Committee. Dr. Betty Chu has assumed the Chief Quality Officer role at HFHS and serves as Associate Chief Clinical Officer. It will be important to bring Dr. Chu into the Steering Committee to continue connecting equity and quality.

3. "A-ha" Moments That Illustrate a Key Learning, Turning Point, or Nuance

- **Equity as a strategic priority alignment:** Dr. Wisdom, SVP Community Health and Equity and Chief Wellness and Diversity Officer, asked Dr. Schreiber, Chief Quality Officer, to be her co-chair and emphasized how important it was for Ms. Hawkins, SVP Population Health, to be an integral committee member in the evolution of this initiative to move forward. During the IHI Pursuing Equity workshop in Chicago, the team had an "a-ha" moment on how equity is not currently a specific strategy within the new strategic plan. After the workshop, the two of them plus Dr. Schreiber had a robust discussion about our Pursuing Equity work with our Chief Strategic Officer. Since then, the roadmap exercises have also sparked valuable discussions on our progression in the five components of the IHI framework.

  In addition, Drs. Wisdom and White Perkins have advocated that, to continue to make equity a strategic priority, it is important to re-evaluate the Office of System Diversity and Inclusion, which Dr. Wisdom oversees, to include equity. Therefore, the division has been renamed the Office of System, Diversity, Equity and Inclusion. Figure 2 below displays this alignment and how the Pursuing Equity Steering Committee is connected.

Figure 2. Henry Ford Health System Structure for Diversity, Equity, and Inclusion

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- **Integrating equity into system operations**: A second "a-ha" moment for Janan G. Saba, the project management consultant, was when she realized we should not attempt to conduct equity improvement siloed from the rest of the organization. She learned that for equity to be integrated, we really need to work with the existing leaders and teams who are accountable for the outcomes to see the value of an equity lens through their work. And, it helps to work in tandem with other process improvement leaders to ensure the work can get done and is properly resourced and staffed.

  This awareness grew from the project work that Ms. Saba was dedicated to supporting. She saw the need for strategically supporting the priority of equitable projects system-wide. For example, Ms. Saba was instrumental in maintaining transportation as a focus for our strategic system equity work by leveraging the SPLT/Lyft relationship from Henry Ford Health System Global Health Initiative.

- **Equity data accomplishments:** Throughout the IHI Pursuing Equity initiative, "equity project design teams" were successful in demonstrating how incorporating an equity lens into quality and population health improvement projects can lead to reducing health care disparities. Our project management consultant, Ms. Saba, with the support of IHI, was able to utilize IHI quality improvement techniques as well as our internal Lean process improvement techniques in an agile framework to see results that senior leaders were willing to adopt at a system level and in alignment with other system strategies.

- **Diabetes management project:** For example, we worked with the diabetes care connection team to conduct an equity focused root-cause analysis process improvement approach to address why there is a persistent gap in diabetes HbA1c control rates between Black and White patients. We found that a personalized approach to care (letter + phone call from provider office to patient) was effective in improving patient engagement to return for completion of lab work and/or follow-up appointments. This approach also addressed what the project leads/point persons, Dr. Berrien Jones and Pam Milan, call "clinical inertia" which can give patients the impression that their blood sugar level is fine if they are not contacted about their out-of-control HbA1c results and to schedule follow-up. Conducting a small test of change with 20 patients, we saw about a 20 percent reduction in the number of patients with HbA1c levels greater than 9. This allowed for timelier patient follow-up and contributed to a system-wide racial quality gap decrease from 5.3 percent to 4.4 percent, a 0.9 percent decrease between Black and White patients from the end of 2016 to the end of 2018. As a result, the Division of Population Health Management adopted this process change as part of a larger program to have patient coordinators reach out to patients directly for scheduling follow-up appointments and lab work. This project has gone from small tests of change to adoption at a system level.

- **Transportation as a social determinant of health project:** With a long-term goal of reducing readmissions among ESRD patients by ensuring proper pre-dialysis care, our transportation project initially conducted small tests of change in partnership with SPLT/Lyft to coordinate rides for a test population of 15 ESRD patients to their vascular access appointments. To address patient social barriers in addition to transportation, we then partnered with Ford Motor Company's GoRide division to help reduce missed follow-up appointments post-discharge, beginning with patients being discharged from selected HFH units. To date, we have six completed rides, four no-shows, and four canceled rides.

  We did face some challenges related to the workload of our unit secretaries who were scheduling the patient rides. Our project lead/point person, Michele Richards, Director of Patient Care Management and Assistance, and design/project team created a script to let the patients know HFHS is offering these rides and will schedule them unless they choose to opt-out. The team continues to refine the process and will transition the work at a system level to team leads under the Department of Population Health Management.

- **Readmissions rate reduction project:** Ms. Saba helped influence the revision of the Tom Groth Medical Needs Fund policy on using the funds to address social barriers. She took advice from our network partner, Main Line Health's CEO, on considering ways to make changes to the system that are of no direct cost through policy change, and we shared that with the readmissions design team project leads/point persons, Sue Craft, former Director, Care Coordination, Family Caregiver Program and now VP Population Health Management and Rob Behrendt, Manager Care Coordination. Ms. Craft and Mr. Behrendt proposed and implemented a policy change on use of these funds. Soon after, we saw improvement in one patient life since the change allowed them to quickly receive funding for an in-home environment change.

Part 3: Describe What's Next for Equity Work

Henry Ford Health System is committed to working at the intersection of equity and quality using quality improvement interventions or Lean process improvement to address disparities in care or patient experience and within our diverse workforce. We also learned the value of continuing to address how social determinants of health data are collected throughout the system, and to continue to improve the process. We learned that as an equity team we cannot do this work in a vacuum, and we need to be well integrated with operational leaders. For example, rather than having our Pursuing Equity Steering Committee attempt to design interventions to address quality gaps demonstrated in our equity dashboard, we will identify opportunities and existing operational leads to take accountability for initiatives to close these gaps. These teams will then be accountable to the Pursuing Equity Steering Committee.

Potential steps include:

- Steering Committee monitors equity dashboard to identify gaps
- Operational leads for given metrics are asked to design an intervention to address gaps
- Steering Committee provides consultation to operational teams
- Operational teams report back to Steering Committee on their plan and progress for addressing health care disparities
- Equity dashboard and impact of projects are shared at HFHS Diversity Forum meetings
- Integrate education and training of unconscious bias into the patient experience training and professionalism coaching of clinicians and teams in all aspects of our health care delivery

The Pursuing Equity Steering Committee has served as a steward for keeping equity on the table literally and figuratively by bringing together leaders and influencers who are working hard to integrate equity into system health care improvements. Following the IHI Pursuing Equity initiative conclusion, the committee will continue to meet, and we hope to add new members that can help us better incorporate equity as a key measurable aspect of system quality.

Team Summary Report

Kaiser Foundation Health Plan and Hospitals (Kaiser Permanente) (Oakland, California)

Part 1: Overview

Background

Founded in 1945, Kaiser Permanente (KP) is an integrated nonprofit health care delivery system comprising a health plan, a hospital system, and a medical group, all working together. KP's mission is to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve. KP's health disparities vision is to be a leader in eliminating disparities in health and health care — this vision highlights the importance of KP's dedication to pursuing health equity.

Aim and Methods

The two-year Pursuing Equity initiative focused on the implementation of health equity work at KP. KP Indio, a clinic located within the Coachella Valley area of Southern California, was selected as a pilot site because of the existing health equity work and large population of Hispanic/Latino KP members. In 2017, KP data stratified by race, ethnicity, age, and gender showed a significant disparity gap in glycemic control between Hispanics/Latino and white populations (8.3 percent). Poor glycemic control (defined as HbA1c >8) over time leads to microvascular and macrovascular complications after the first and third years respectively, ultimately resulting in death after five years.[1]

The aims of the project were to improve glycemic control (i.e., HbA1c <8) among Hispanic/Latino diabetes patients by 1 percent from a baseline of 9.8 percent to 8.8percent, and to reduce the Hispanic/Latino disparity gap by 2 percent as evidenced by HEDIS data. A 1 percent decrease in HbA1c is significant in preventing microvascular and macrovascular complications in poorly controlled diabetes patients. The project focused on a cohort of 189 Hispanic/Latino members with poorly controlled diabetes (HbA1c >8).

Interventions implemented were the use of remote glucose monitoring, physician telephone appointments, nurse office visits, and the use of one-stop-shop diabetes clinic models. In addition, community interventions consisted of participating in community events and hosting a health fair at the Indio clinic.

Results and Implications

Although there was improvement in the cohort being followed, the project was unsuccessful in capturing the movement of patients from different phases of diabetes. Over the course of the project, patients moved from a state of controlled diabetes (HbA1c <8) to a poorly controlled state. Earlier identification of patients moving from in control to out of control phases would have allowed for earlier interventions to improve health outcomes and overall diabetes management.

The learning from the Pursuing Equity work at KP Indio are now being merged into KP Riverside service area diabetes initiatives. The work at KP Indio represents a small part of how the health equity strategy is being integrated within the organization. Equity work continues to remain a strategic priority for KP as we move forward in our mission to creating an equitable environment for our members and staff to thrive.

Part 2: Summarize Your Work

1. Background and Context

Kaiser Permanente serves the health care needs of 12.3 million members in eight states and the District of Columbia and operates in eight regions: Northern California, Southern California, Hawaii, Northwest (Oregon), Washington, Colorado, Georgia, and Mid-Atlantic States (Maryland, Virginia, and the District of Columbia).

- The demographics of our membership by race/ethnicity are: 46.1 percent white (non-Hispanic), 26.7 percent Hispanic or Latino (regardless of race), 14.6 percent Asian or Pacific Islander (non-Hispanic), 10.6 percent black or African American (non-Hispanic), 0.3 percent American Indian or Alaska Native (non-Hispanic), and 1.7 percent multiracial (two or more races, non-Hispanic).
- Of the 8.3 million members whose spoken language is known, 89.8 percent speak English, 7.9 percent speak Spanish, and 0.7 percent speak Chinese. Spanish is the most common language of the 450,000 members who need an interpreter.

Health equity supports the mission and vision of Kaiser Permanente and is included in the organizational quality strategy to reduce current disparities and improve clinical outcomes within the organization. KP is a multitiered large health care system that is grouped into national, regional, and service area levels (local levels). To that end, this project was supported by all levels of leadership and frontline staff who were responsible for integration and implementation of health equity at the regional and service area levels. Thus, KP joined in the Pursuing Equity two-year learning journey as a natural progression of collectively moving equity work forward. In Fall 2017, the Indio clinic was selected as a pilot site for this project given the following factors: a high population of members with low socioeconomic status, a high population of Hispanic/Latino members, and the clinic's existing work on health equity.

Indio's journey began in 2006 as KP started operations in the Coachella Valley as an expansion market. The Indio Medical Office Building (MOB) was the first KP clinic in the area. There was a limited awareness of cultural needs and a necessity for an internal quality improvement framework focusing on education of staff, employer groups, and Complete Care management. The KP Indio team identified the importance of learning from the community and created the Promotora Project to partner Spanish-speaking community lay workers with KP clinical teams and patients to improve clinical outcomes. Through the learning of the Promotora Project, the needs of the community were captured, which helped with building the Indio team. Spanish-speaking physicians and a pharmacist were hired to assist with language concordance, patient contacts, and medication adherence. The KP Indio team then embarked on a two-year journey with the Pursuing Equity initiative to focus on improving health care equity and reducing disparities, furthering work in Indio, California.

Organizational HEDIS data showed that clinical outcomes among Hispanic/Latino diabetic members were consistently lower than that of other groups (e.g., whites, Asians, and African Americans) and when compared to the white population, had the highest disparity gap (see Figure 1 below). In December 2017, member/manager inquiry focus groups were developed to assist in drafting primary drivers and interventions. Interventions were implemented using Plan-Do-Study-Act (PDSA) cycles to include increasing the frequency of patient contacts using remote glucose monitoring, physician telephone appointments, nurse office visits, and the use of one-stop-shop diabetes clinic models.

2. Describe Your Work for Each Component of the IHI Framework to Improve Health Equity

Component 1: Make Health Equity a Strategic Priority

Kaiser Permanente has a diverse workforce and serves a diverse population. Since 2007, the Kaiser Foundation Health Plan (KFHP) Board of Directors has been committed to eliminating disparities. KP's mission is to provide high-quality, affordable health care services and to improve the health of the communities we serve. The total health strategic vision expresses our mission as being trusted partners in total health, collaborating with people to help them thrive by creating communities that are among the healthiest in the nation, and inspiring greater health for America and the world.

In 2017 and 2018, KP received the AHA Health Equity Award and the CMS Health Equity Award respectively for its existing equity work in hypertension and colorectal cancer screening. In 2018, an equity framework strategy for implementation was developed by KP senior leaders and key stakeholders as the next steps for moving equity work forward across the organization. Stratified equity data is reported to KFHP Board of Directors and included in KP incentive plans, ensuring accountability for equity goals.

Opportunities and Tips

- Agreements on equity goals may vary by KP regions and populations of focus.
- Ongoing discussions occur frequently with KP regions to develop appropriate equity measures align with their quality initiatives and focused populations.

- Begin by understanding your health care system quality initiatives, populations of focus, and what matters to your board of directors.
- Develop a plan with your senior leaders and key stakeholders to demonstrate how equity aligns with the system's initiatives to make health equity a strategic priority for your health care system.

Component 2: Build Infrastructure to Support Health Equity

Equity is a dimension of KP's national clinical quality strategy derived from the six Institute of Medicine aims. The clinical quality strategy provides a focus and structure to support health equity work at KP. The KP Indio project represents an example of equity work being conducted at the local level. The clinic implemented changes to its model of care using a health equity lens (e.g., switching from a care management approach to a panel/population management approach) for diabetes care among Hispanic/Latino members. Orr and Davenport describe the model as being "proactive systems of health care delivery to meet the needs of populations instead of reacting to exacerbations of illness and acute care needs."[2] Using population health management tools and facility sites that support equity work are essential to pioneering methods that can influence large numbers of people to embrace behavioral changes of health promotion and prevention.[2]

Opportunities and Tips

- The project team members were very novice in their respective roles. Large health care systems are now experiencing more frequent staff turnover as seasoned professionals are retiring or accepting advancement opportunities. While initial IHI assessments for quality improvement (QI) readiness were performed, this may not necessarily address the team's inexperience or overall skill set. It is important to know team members' tenure in their respective roles, where they are positioned within the organizational structure, and their relationship with senior leaders. Novice teams require more coaching and guidance around QI project management and escalating issues to leaders. If the team has never worked with their senior leaders, it is important to coach the team on how to approach leaders effectively, escalate concerns appropriately, and deal with issues in a timely way. Identify allies that can assist with this task; build solid relationships not only with the project team, but also with senior leaders, middle management, and other influencers of equity work.
- Remote work is becoming a very popular modality within the health care industry as budgets and work-life balance are considerable factors in influencing the execution of work. If you are leading a team remotely, using the video camera feature and establishing a meeting frequency will assist you in better connecting with the team. The use of virtual notebooks or shared drives can enhance accessibility for team members and allows easy storage of project work. If possible, conduct on-site visits to assess how the work is being executed and to support the team.
- Large multitiered health care organizations tend to have more bureaucracy, which may delay implementation of equity initiatives. Be prepared for resistance and understand how to remove barriers within your organization to help the project team move equity work forward. Learn organizational cultural norms to gain support for this work and navigate the team through those challenges. Educate staff and leaders as much as possible as it relates to equity; creating a high-level organizational strategy is very different from executing the work at a local level.

Component 3: Address the Multiple Determinants of Health

Culturally-tailored care interventions were designed to support this work (e.g., using Spanish-speaking staff who are culturally connected to the KP members they served and involving members' families in decision making). KP Indio implemented patient-centered diabetes support groups for both English- and Spanish-speaking Hispanic/Latino members. In these groups, members shared personal stories, struggles, and advice on their own experiences with diabetes.

A manager leadership focus group was formed to provide their feedback and opportunities to help improve quality of care. A third-party research vendor was involved to assist with group moderation and next step findings such as access, affordability, and education. Based on these findings, interventions employed included physician-patient telephone appointment visits (TAVs), nurse office visits, remote glucose monitoring utilization, diabetes one-stop-shop clinic model, and community engagement by hosting a health fair and participating in community events. These interventions showed some promising progress toward improving diabetes outcomes (see Figure 1).

Figure 1. KP Indio Health Equity Work to Improve Diabetes among Hispanic/Latino Members

Project Timeline (Feb 2018 – Jan 2019)

N - **189** members who were out of control in Feb 2018

100 members (**52.9%**) saw improvement with their A1c during the course of the project

- Average A1c Change -0.523
- Average Number of A1c Tests 2.22 per MRN
- A1c Delta Range (-6.5 to +3.7)
  - 32 saw no change in A1c Value
  - 100 saw reduction in A1c Value
  - 57 saw an increase in A1c Value
- **1,667** total DM touches with an avg of 8.8 per MRN

Indio MOB Hispanic / Latino DM Type 2 Improvement Project Results						
Time Frames	Population	Results				
	N	Avg. A1c Change	# Achieved Control	# with No Change	# Improved	# Worsened
Project Feb 2018 - Jan 2019	189	-0.52	53	32	100	57
			28.0%	16.9%	52.9%	30.2%
Baseline Jan 2017 - Jan 2018	183	0.12	42	43	63	73
			23.0%	23.5%	34.4%	39.9%

Although the project has concluded, the next steps for KP Indio will include using the Your Current Life Situation (YCLS) survey to assess and identify patients' social health needs. YCLS is a survey tool that addresses the multiple determinants of health (e.g., food and housing insecurities). This survey has been adopted by two KP regions. KP Indio is working with the Care Management Institute team to customize the tool for their diabetes population. Once the tool becomes fully functional, members screened with positive survey triggers (e.g., food insecurity, depression) will be referred to Indio's social worker and/or provided with information to seek help via community resources.

Opportunities and Tips

- The project focused on following a subgroup of patients who had HbA1c >8, enabling the team to perform multiple PDSA cycles to measure the effectiveness of interventions being used. However, diabetes is a multifactorial complex condition in which patients may go from the state of controlling their diabetes to uncontrolled states as a part of the disease process. Thus, toward the project completion the team identified that the emphasis on all three cohorts of patients (in control, out of control, and patients with no current HbA1c testing) would have improved HbA1c outcomes. For each cohort, interventions might differ and performance over time must be measured in terms of three states: patients in control, patients out of control, and patients with no current test.
- In addition, factors of work seasonality, death, and leaving the KP Health Plan altogether impacted HbA1c outcomes results. Initial data did not exclude patients in the aforementioned categories. Figure 2 shows a more accurate depiction of equity results for KP Indio to include the first three quarters of the project (2016 Q3 to 2018 Q3).
- Equity projects have multiple factors that can affect patient outcomes. Ensure that your equity projects are co-designed to anticipate all factors that may potentially impact results.

Figure 2. KP Indio HEDIS Diabetes Control Rate and Disparity Data (2016 Q3 to 2018 Q3)
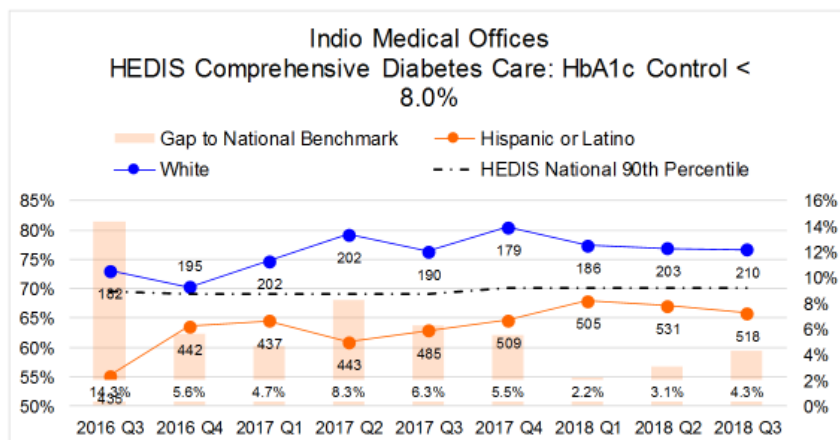
Component 4: Eliminate Racism and Other Forms of Oppression

KP has many ongoing initiatives to eliminate institutional racism for members and staff. Future building planning are co-designed with members to meet the unique needs of the communities served. Care delivery models include the *know me, guide me, and respect* me tools to provide equitable and culturally competent care. Leading Inclusively, Unconscious Bias, and Poverty simulation trainings are held for staff, leaders, and physicians to increase organizational awareness of institutional racism and other forms of discrimination (e.g. ethnicity, language, gender, gender identity, disability, age, etc.). Hiring practices are being amended to include workforce equity strategies to promote inclusion talent.

Opportunities and Tips

- The work to eliminate racism and other forms of oppression at KP has progressed tremendously, but the struggle continues. KP is continually committed to providing an equitable environment for its workforce and members to thrive.
- Know your organization's cultural norms and attitudes to be effective in addressing racism and other forms of oppression. Ensure that everyone's opinions are acknowledged and respected to collaborate cohesively in identifying organizational solutions that are most suitable for your healthcare system.

Component 5: Partner with the Community to Improve Health Equity

KP Community Health (CH) exists at all levels of the organization and partners with many community organizations across the country. Examples of Community Health initiatives can range from serving healthy foods to building gardens and walkable trails in underserved areas. The Indio team partnered with Community Health to host a health fair at the clinic that included Coachella Valley Social Services and Volunteers in Medicine. Community Health has also helped the Indio team gain more exposure and participation at community events.

Opportunities and Tips

- While Community Health exists at every level within KP, local teams may not be aware of the work that CH organizes for their local service areas and would need assistance in connecting to this group for community resources. If your healthcare system has a department devoted to partnering with community organizations, discuss the goals of your equity work and align efforts as appropriate. Community engagement strategies may not necessarily demonstrate organizational return of investment (ROI) upfront, however, these strategies may improve long-term health (e.g. patient satisfaction, engagement, and overall commitment to the health and well-being of communities).

Part 3: Describe What's Next for Equity Work

Equity work will grow and expand as organizational goals evolve. Mental health is a national health crisis, making mental health an urgent priority for KP. The progression of equity work will include focusing on reducing health disparities within mental health at KP. KP is using a multipronged approach with clinical goals to improve behavioral health outcomes. As an industry leader, KP will continue to drive forward on the mission of achieving health equity for all.

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Team Summary Report

Main Line Health (Newtown Square, Pennsylvania)

Part 1: Overview

Background

Main Line Health (MLH) is committed to pursuing equity and addressing social determinants of health. The five-hospital health system serves communities where a number of chronic diseases are more prevalent and their presentations are notably more severe due to poverty and lack of access to key social determinants of health, such as healthy food. MLH's strategic focus on equity was a key driver in joining the Institute for Healthcare Improvement's two-year initiative, Pursuing Equity.

Aim

Pursuing Equity aims to reduce inequities in health and health care access, treatment, and outcomes by implementing comprehensive strategies to create and sustain equitable health systems. Over the past two years, MLH aimed to advance a culture of diversity, respect, and inclusion where: every system effort is viewed through an equity lens and the community's voice is incorporated via sustainable partnerships; disparities are addressed as a quality of care issue; and equity is highly integrated across the system, from recruitment, retention and employee engagement, to incentives for senior leaders and measures of quality and equity performance.

Methods

To advance toward our aim, MLH instituted a variety of new programs and strategies, including: 1) establishing Together for West Philadelphia and 2) the Cornerstone Care Team; operationalizing health equity via 3) job titles and descriptions; 4) through partnerships with the MLH Clinical Environment Workgroups (CEW); and 5) mandatory diversity, respect, and inclusion training for all staff and via management incentive plans. MLH also built on some existing programs that are successfully progressing the health system toward equity such as the 6) Medical Student Advocates Program, 7) Health Career Collaborative, and 8) Healthcare Disparities Colloquium.

Data/Results

MLH, along with more than 20 other health systems, academic institutions, and community organizations, established Together for West Philadelphia (TfWP) to facilitate collaboration within West Philadelphia among community, public, and private sector stakeholders to foster 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 toward five projects that arose from its discussions.

After formally presenting the link between quality and equity, the MLH equity team completed meetings with three of the five MLH Clinical Environment Workgroups and a representative was formally invited to become a member of the MLH Quality Steering Committee. MLH has successfully integrated health equity into departments, staffing, roles and responsibilities and has built a team solely focused on addressing the complex health needs of our community. The Medical Student Advocates Program expanded its reach and is addressing social determinants of health at two additional clinic sites: Lankenau Medical Center's emergency department and City Line Family Medicine. The Health Career Collaborative is now formally linked to the American College of Surgeons, which will oversee more than 11 national programs.

Conclusions/Implications/Recommendations

To date, MLH has made and continues to make significant strides toward pursuing equity. Through our work with IHI and conversations during the Pursuing Equity initiative with Henry Ford Health System, MLH learned that equity and quality

are two sides of the same coin — you cannot have quality without equity. Therefore, in an effort to establish a much more formal relationship between quality and equity, MLH's equity and analytics teams are working together to develop an equity dashboard for each MLH Clinical Environment Workgroup. These dashboards will help the health system stratify quality metrics by race, ethnicity, and language (REaL), social determinants of health (SDOH) and sexual orientation and gender identity (SOGI) data, and to more robustly and comprehensively address health disparities.

Part 2: Summarize Your Work

1. Background and Context

Founded in 1985, Main Line Health is a not-for-profit, comprehensive health system serving portions of Philadelphia and its western suburbs. It comprises four acute care hospitals, one inpatient rehabilitative hospital, and a variety of ambulatory centers and practices, behavioral health, home care, and hospice and research facilities. For years, Main Line Health has been committed to creating an environment of diversity, respect, and inclusion. The health system proudly embraced the American Hospital Association's #123forEquity Pledge to Act to eliminate disparities in care and, in 2014, MLH CEO, Jack Lynch, was the recipient of the Institute for Diversity in Health Management's inaugural President's Award. Despite its commitment to advancing diversity, MLH identified system-wide opportunities to highly integrate equity across the system — from recruitment, retention, and employee engagement, to incentives for senior leaders — and to measure our quality and equity performance, all of which ignited our journey toward pursuing equity.

Main Line Health's commitment to pursuing equity and addressing social determinants of health is best understood in geographic and economic terms. Lankenau Medical Center, a 370-bed acute care hospital, part of the MLH, sits on the border of two Pennsylvania counties with stark disparities in health outcomes. Montgomery County is consistently ranked among the top five Pennsylvania counties in the Robert Wood Johnson Foundation's annual County Health Rankings, but Philadelphia County consistently ranks toward the bottom, and is currently last, at 67th. MLH serves communities where a number of chronic diseases are not only more prevalent, but their presentations are notably more severe because poverty and lack of access to key social determinants of health, like healthy food, exacerbate the difficulties of achieving and maintaining positive health outcomes.

MLH's strategic focus on identifying and addressing disparities in care was a key driver in joining the IHI Pursuing Equity initiative.

2. Describe Your Work for Each Component of the IHI Framework to Improve Health Equity

Over the past two years, MLH aimed to advance a culture of diversity, respect, and inclusion where: every system effort is viewed through an equity lens; disparities are addressed as a quality of care issue; and equity is highly integrated across the system. Following IHI's framework, below we describe the ways in which MLH is pursuing equity.

Component 1: Make Health Equity a Strategic Priority

- Health equity is **embedded in the health system's strategic plan**. Additionally, MLH's President & CEO and system senior leaders strongly advocate for and support health equity efforts by publicly (both internally and at external forums) speaking on the real issues that are affecting the community and how MLH is working to address these.

Component 2: Build Infrastructure to Support Health Equity

- "Health equity" has been **added to job titles**, **departments,** and embedded in several **job descriptions**:
    - Community Health and Equity (formerly Community Health Services)
    - Program Administrator for Medical Student Advocates and Health Equity
    - System Director, Health Equity and Graduate Medical Education
    - Fellowship in Health Care Disparities
    - Job descriptions of the Cornerstone Care Team: addressing the complex health needs of patients and the community via a Keystone First grant

- MLH **established a system Diversity, Respect, and Inclusion (DRI) Steering Committee** that oversees and propels all DRI initiatives, including manager and employee education and training, and monthly DRI activities.
- MLH instituted a **comprehensive training program** for all Patient Access Schedulers to learn how **to effectively collect REaL data** in an evidence-based approach.
- In 2018, MLH transitioned to the Epic electronic health record system, which (via the Social Index) 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 Advocates Program's Social Needs Assessment, 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.
- MLH **embedded equity into its Management Incentive Plan**, where leaders are accountable to 1) **reduce the gap in 30-day readmission rates of African Americans** versus all other patients; 2) **increase employee engagement** in the statement, "Leadership/management demonstrates a commitment to DRI"; 3) **increase placement of leaders** with diverse cultural, racial, gender, and ethnic backgrounds that mirror the MLH community; and 4) meet or exceed the national average for **supplier diversity** in health care.

Component 3: Address the Multiple Determinants of Health

- Annually for almost eight years, MLH hosts a system-wide **Health Care Disparities Colloquium** to examine and eliminate disparities in various health care practices and processes. MLH's overall **research into social determinants of health** has increased significantly, particularly through the work being achieved from the Health Care Disparities Colloquium. Since 2012, MLH physicians, researchers, and staff have presented over 61 research projects focusing on a variety of important topics like health literacy, transportation barriers to primary care, food access and nutritional health, unconscious bias, and stroke rehabilitation.
- Now in its eighth year, MLH's **Medical Student Advocates (MSAs) Program** integrates second and fourth year medical students from Philadelphia College of Osteopathic Medicine to help identify MLH patients' social needs and connect them with community resources to address their needs. In 2018, the program expanded to two additional clinic sites, Lankenau Emergency Department and City Line Family Medicine. There are a total of 13 MSAs who served 191 patients, identified over 336 social needs, and provided 83 referrals to community resources for patients.
- ED superutilizer project pilot: MLH used a **multidisciplinary approach to identify and address the medical and psychosocial needs of patients** that had been "treated and released" from Lankenau Medical Center emergency department more than 3+ times over a 15-month period. The pilot included six patients with a total of 89 "treat and release" ED visits in 2015 and 83 in 2016. After addressing SDOH needs, those six patients' total "treat and release" visits were reduced to six and that was maintained for six to nine months. This work has informed our **Cornerstone Care Team**, a newly-established multidisciplinary team focusing on addressing the clinical and psychosocial needs of the most complex patients in Lankenau Medical Associates.

Component 4: Eliminate Racism and Other Forms of Oppression

- MLH is just **beginning the conversation** around institutional racism.
- MLH implemented a **mandatory instructor-led Diversity, Respect, and Inclusion Learning Experience** to increase employee understanding and awareness of cultural competency and the value it brings to colleagues and patients. Part of that mandatory training is a segment on **Power & Privilege**, which via a video and question/answer session, begins to introduce the concept of institutional racism. The initial launch of the Learning Experience in 2015 was a two-day course required for all senior leaders, managers, and supervisors. To date, 1,000 leaders have undergone this specialized training. In 2017, MLH launched a one-day Learning Experience for all individual contributors, physicians, and volunteers facilitated by internal faculty, and more than 1,800 employees have attended to date.

Component 5: Partner with the Community to Improve Health Equity

- Recognizing that achieving equity cannot occur solely within the confines of its health system, MLH has been actively and successfully employing strategies to partner with community organizations, namely, through **Together for**

West Philadelphia, a collaborative (and now, a 501c3 organization) within West Philadelphia among more than 20 community, public, and private sector stakeholders to foster shared projects to maximize impact in the areas of health, education, food access, and opportunity.

- MLH **partners with Greener Partners via its Deaver Farm**, a half-acre farm featuring educational areas as well as organic production spaces, all of which is located on MLH's Lankenau Medical Center campus. During the 2017-2018 school year, the Wellness Farm educators/farmers provided educational programs to nearly 2,000 students. Additionally, the farm has produced more than 13,050 pounds of produce, with 3,550 produced between January and November 2018. This fresh produce has been distributed to 220 patients at two clinical sites in 2018 and has been used as part of health education classes.

- **Health Career Collaborative** (HCC) provides education outreach to local high school students who are at high risk for dropping out. The goal is to keep students in school by nurturing their interest in achievable health care professions. Our aim is to create a pipeline of promising new talent from the neighborhoods the health system serves. MLH partners with local medical schools, which supply medical students as teachers for the academy. The HCC is now formally linked to the American College of Surgeons, which will oversee more than 11 national programs.

Along its journey, MLH experienced the following challenge:

- Opportunity exists to raise awareness around the impact of institutional racism within our health system and to identify and implement targeted ways to address it. As is the case with other health systems, there is a challenge to create a culture that facilitates actionable conversation around institutional racism and embeds the language of institutional racism within equity.

Tips for others doing this work to improve health equity:

- Learn, understand, and respect organizational history in order to properly and effectively identify and address challenges/areas of opportunity.
- Anticipate the "nodding head syndrome" — that is, acknowledge that there will be some individuals within the organization that seemingly agree with the equity work (by nodding their heads) but will oppose it in other settings. But, do not let it stop your progress.
- Remember to always provide a space for the "community's voice" to be incorporated into the work.
- For collaboration and engaging with the community, anticipate and plan to have sense of balance for speed vs. process. While it is important to move things forward, it is also important to establish project/program structure and build replicable processes.

Part 3: Describe What's Next for Equity Work

To date, MLH has made and continues to make significant strides towards pursuing equity. In an effort to establish a much more formal relationship between quality and equity, MLH's equity and analytics' teams are working together to develop an equity dashboard for each MLH Clinical Environment Workgroup. These dashboards will help the health system stratify quality metrics by REaL, SDOH, and SOGI data and to more robustly and comprehensively address health disparities. Additionally, MLH is exploring avenues to embed language around institutional racism into its current health equity infrastructure to better facilitate open conversations about this complex issue.

Team Summary Report

Northwest Colorado Health (Steamboat Springs, Colorado)

Part 1: Overview

Background

Northwest Colorado Health is a small rural health system that supports community wellness through a range of health programs and services to help residents of all ages, income levels, and cultures live as healthy as possible. Over the decades, we expanded our services to include primary care at community health centers, a wide range of public health programs, home health and hospice services, and an assisted living facility and community center. We believe that access to health is everyone's right, regardless of their income, race, age, gender, health status, or insurance coverage.

Aim

Many individuals in northwest Colorado face economic, systemic, and geographic barriers to accessing affordable and appropriate health care and wellness services. As a rural population, typical barriers for disparate populations are amplified by long distances and limited resources. Our goal for participating in the two-year Pursuing Equity initiative was to embark on the execution of the five components of the IHI equity framework. We aim to identify key areas for improvement and be a leader at the table for community efforts that are working to reduce inequities by informing on health and wellness effects of disparate systems.

Method

Work in the five framework components was done through various means, including assessing data systems available to understand the disparities that exist within the health systems of our region, internally building capacity and knowledge of health equity, cultivating relationships with community partners, and setting the stage to allow for Northwest Colorado Health to understand the inequities in our region.

Data/Results

Our organization crafted a new strategic plan with four strategies: clarify who we are, evolve how we serve, support who does it, and expand who knows it. Within these strategies, a main objective is to "work to reduce inequity and be responsive to community needs." It is in our mission to serve any and all community members, regardless of income, race, ethnicity, background, sexual orientation, religion, or any other defining characteristic. We now have a strategic plan that identifies work to clarify our role in reducing inequities in the current health system.

We seek to have an inclusive culture where success looks like a well-organized, results-focused team where everyone is contributing, valued, engaged, and fulfilled in this work. In order to measure the institutional equity work within our institution and culture, we rely on our all-staff survey and staff feedback through semi-annual check-ins. These tools serve as communication mechanisms for all staff, and we seek to have high participation in each.

During our participation in the Pursuing Equity initiative, we were able to obtain the following results:

- Participation in the semi-annual check-ins increased from 36 percent to 98 percent.
- The average staff response rating increased from 3.5 to 4.0 (on a scale of 1 to 5, with 5 being the best) for the survey question: In the last month, I have received recognition or praise for doing good work.
- The average staff response rating increased from 3.6 to 4.1 (on a scale of 1 to 5, with 5 being the best) for the survey question: In the last six months, my supervisor has talked to be about my progress.

When we drilled down on the staff feedback by income, work location, and age, we saw more significant improvements in closing the gaps in the populations that had responded with a lower score.

Programmatic results on how we have pursued health equity are described in more detail below.

Conclusions

Through the work with IHI, we have come to the conclusion that Northwest Colorado Health has been rooted in equity work from the beginning. The most prevalent area of health equity up to 2014 has been ensuring access to affordable primary care both through creating community health centers and expanding access to health insurance, including Medicaid, through enrollment efforts. Nearly 25 percent of Routt and Moffat County adults ages 18 to 64 years old are uninsured, and it is estimated that 30 percent of the region's population is uninsured or underinsured. In 2013, 95 percent of community health center clients reported incomes at or below 250 percent of the federal poverty level and 55 percent of patients were uninsured. The work we have done in this area has provided access for the high population of uninsured and underinsured clients to necessary care that they might not otherwise received.

There is not another agency in our country that we know of that offers the same range of services, from birth to death, regardless of ability to pay. At the same time, there are measures we can take within our own systems, and efforts we can contribute to in the communities we serve, that can reduce disparities and improve overall outcomes in the rural health communities in which we operate.

Part 2: Summarize Your Work

Describe Your Work for Each Component of the IHI Framework to Improve Health Equity

Our focus over the last two years of the Pursuing Equity initiative was to pilot and make strides within the five components of IHI's framework. Trials, progress, and learnings in each are described below.

Component 1: Make Health Equity a Strategic Priority

Major Achievements

- Created a new two-year strategic plan with specific objectives aligned in identifying community health disparities and tailoring services to close those gaps. Objectives of the four main strategies identify specific work in the social drivers of health and advocating for health equity efforts in a rural health setting. Measurement of this plan has been developed and is reported to our board of directors on a quarterly basis.
- Widely communicate and kick off the strategic plan and align our work to Northwest Colorado Health's belief that every person deserves the right to their best health.
- Aligned departmental and programmatic work with strategies. Each of our five major service lines have a goal in their annual work plans that is aligned to the strategic objective to "Clarify our place in each community and market we serve and work to eliminate inequities." For example, our community health center has chosen to create more equitable access for our working patients by creating the goal to offer nontraditional clinic hours during nights and weekends.

Key Challenges and Lessons for Mitigation

- A major contributing factor to current and future work, be it challenge or benefit, is that 45 percent of the 11 key leaders, including the CEO, of Northwest Colorado Health have a tenure of less than 18 months in their role. To mitigate the potential for equity work to get lost in other priorities, we have built capacity within our leadership teams to cultivate leadership learnings on implicit bias and health equity, and we have also engrained equity work in to each leaders' work plan. For example, the quality team has included using a community health needs assessment, public health rankings, and conducting other market research to determine where populations may be left out of the health system so that our agency can offer more equitable services.
- Prior to the process of developing the strategic plan, the work in equity and social drivers of health were only verbalized by leaders who no longer work in the agency. From staff interviews, we learned that health equity was viewed as a project rather than a way to approach all work.
- Conducting "Lunch and Learn" sessions and other opportunities for trainings and talking about equity does not engrain it in staff thinking or culture. This is slow work, and sharing explicit examples of where daily work is directly linked to equity is crucial to inclusion and execution. Only after making this connection did we see all levels of staff

start to create ways to make paths of care more equitable to all community members, centering the idea of access around equity.

Tips for Others Doing Work in This Component

- Build capacity for this work and align it with current priorities.
- Build inclusion by utilizing input from all stakeholders of the organization. Inputs in this process included community partner interviews, with community partners of each major service line and counties served, all staff surveys, staff check-ins, board member surveys, consumer surveys and advisory groups, and leadership team narratives.
- Bring staff at all levels along in this work, and continually connect daily work to equity through stories, examples, and data.
- Include the board of directors in this work. Conduct trainings and updates on health equity work and connect their conversations to the "why" behind this work often. This will build support for health equity work at the highest level.

Component 2: Build Infrastructure to Support Health Equity

Major Achievements

- Developed a data team and data strategy with the goal of knowing all various data systems, sources, and inputs for Northwest Colorado Health, and identifying the areas in which we can stratify community, patient, and staff data by race, ethnicity, language, income/insurance, county, and zip code. Knowing where disparities exist in some service lines, and working on how to collect this data in other service lines, will establish the structure for identifying areas of focus that have the largest disparities.
- Reorganized the People Operations and Quality teams to support this work on an ongoing basis, rather than a project-based approach. This included adding support and health equity terminology to job descriptions, explicit clarity on the People Operations and Quality team role as leaders and subject matter experts in health equity, and building this team's development and capacity around equity work.
- We have dedicated considerable effort to increasing the cultural competency of our staff and partners in the community. We have a number of bilingual and foreign-born staff, and the ratio reflects that of our communities. This allows both for language access as well as cultural understanding and awareness. Consistent cultural awareness has enabled us to become a trusted health partner for Hispanic and other non-English speaking individuals. A few examples of this are:
    - o Engaging with consultants to facilitate Diversity, Equity, and Inclusion (DEI) trainings with our leadership, and integrating DEI trainings into our annual staff training requirements and orientation program for new staff.
    - o Shifting translation services from one department to an all-agency team. We now offer translation in all services of the agency, and all marketing and outreach materials are in English and Spanish.
    - o Our community outreach training recently became a certified DEI trainer and facilitator for the purpose of offering trainings to our staff and to the staff of community partners.

Key Challenges and Lessons for Mitigation

- For a small rural health system, improvements in data collection and investments in the infrastructure and staff is expensive. We were able to tie capital needs in business intelligence tools to this work, which allowed us to secure grant funding for a business intelligence tool that will enable us to access data in a more efficient manner, leading to capacity for analysis to highlight inequitable areas and show progress for closing gaps.
- With a team of six members, and multiple regulatory and internal priorities, finding the bandwidth was a challenge. We are continually looking at what this team is focused on and where we can streamline and integrate efforts. Our challenge is not adding to this team's plate while we develop capacity. Currently, we have secured operating support through grant revenue from a Colorado-based foundation, through participation with a Health Equity Advocacy Cohort. Work now is focused on how to sustain the capacity once this funding ends. In other words, even though this

work has a long-term financial and health outcome return on investment, our challenge is to find immediate return on investment in a small rural area to help support and sustain efforts.

Tips for Others Doing Work in This Component

- Include management teams and other internal influencers in this work. Conduct a baseline assessment of these key staff members' comfort and capability to use different reports, templates, and information. Ultimately, these are the team members that will need to use data reports to drive change, so it is crucial that the development of data sharing in an organization includes them. We also used this baseline data to tailor professional development for the management team.
- C-suite buy-in and board of director buy-in is key to maintaining capacity and support of the financial investment in this work. Consistently share wins and tell stories on why health equity work is so important. This is mission-minded work, and consistent reminders go a long way with buy-in and support.
- Intentionally look at current work or service lines and call out where health equity work may already exist, without historically being thought of as equity. This gives all stakeholders a concrete example of equity and an automatic win to build momentum.

Component 3: Address the Multiple Determinants of Health

Major Achievements

- In stratifying our clinical outcomes measures, we determined that disparities exist in one of the measures that we perform the best on compared to state and national averages. Being a small rural health agency, the population we serve is roughly 6,300 people in our medical clinics, with a low prevalence of diabetes at 5 percent. The CMS determined clinical quality measure (CQM) for patients with diabetes is the rate of patients with a diagnosis of diabetes (denominator) whose diabetes is not controlled (numerator). Diabetes is considered not controlled if a patient has an A1C test resulting in a score of greater than or equal to 9. In our population at the onset of this data assessment in 2017, 27 percent of our patients' diabetes was uncontrolled, where the national average was 33 percent. In stratifying our data by race, ethnicity, language, payer source, gender identity, and zip code, the data reflected that the greatest disparity in diabetes control existed in payer class. Our data reflected that patients with Medicare coverage had the lowest rate of uncontrolled diabetes, at a CQM score of 19 percent, and patients with Medicaid coverage had the highest rate of uncontrolled diabetes at 32 percent. Our case manager interviewed those patients with uncontrolled diabetes and Medicaid to understand their challenges. The theme of answers was access to healthy food and a lack of education on how to eat healthy or what the disease actually meant for their health. From this information, the clinic increased education protocols for all diabetic patients to include more information on the diagnosis of diabetes and how to maximize the benefits of food assistance programs. The clinic also increased the use of a self-management action plan for all patients with diabetes from a 55 percent use rate to 88 percent.
- Our medical clinics are in the process of integrating a screening for social determinants of health (SDOH). We are participating in an Accountable Community Health Model pilot funded by CMS, where clinics ask patients SDOH questions. From this screening, our clinic has determined that 36 percent of patients have food insecurity. This data has informed the decision to make food insecurity a focus of our work in the medical clinic. We have begun to partner with local food banks, and the Women Infant Children (WIC) and Supplemental Nutrition Assistance Program (SNAP) to streamline referral methods to those agencies. We now have information for local food banks in our clinics and are working toward a warm handoff process with these social services. We are assessing the feasibility of placing a food pharmacy in our medical clinics and will continue to track the number of patients that screen positive for food insecurity.
- A provider, the director of the community health center, a billing team member, and the CEO went to the state capital last month and met with a House of Representative member and a Senator for our district during open session in support of bills regarding insurance coverage that expands beyond the pay-for-performance model, and noted the importance of social determinants of health work.
- In northwest Colorado, roughly 11 percent of community members speak a language other than English as a first language, and in our medical and dental clinics these community members comprise 20 percent of the people we

serve. Colorado has one of the highest incidences of suicide per capita in the country, and the region we serve has only half as many behavioral health providers per community member as the state average. This leads to extreme barriers to accessing behavioral health services. Over the last five years, our clinics have worked to provide full access to behavioral health services by integrating such services into our clinics and providing telepsychiatry services as a way to access the much-needed psychiatry services. These services continue to be accessible through Northwest Colorado Health regardless of ability to pay. Despite improvements over the years in access to behavioral health services, we recently determined that only 20 percent of patients with Spanish as a first language had accessed behavioral health, as compared to 40 percent of patients with English as a first language. The clinic team has enlisted the help of our community connector team to help close this gap. This team is tasked with connecting Spanish-speaking community members to health services. Together, the community connector team and behavioral health team created a referral path into behavioral health services. Over the first few months of tracking this, we have not seen an increase in Spanish-speaking patients accessing behavioral health services. We will conduct another rapid-cycle improvement test to see how else we may improve these numbers.

Key Challenges and Lessons for Mitigation

- In the clinic setting, the addition of another screening is cumbersome and the learning takes time. We started this work over six months ago, and our success thus far is screening eight patients out of 300 in one week. This work is slow and clinic staff have not adopted it with open arms. Barriers are time and not wanting to ask the questions that they cannot immediately fix. We are mitigating by celebrating small wins and constantly painting the picture of the greater community value of this work.
- Additional clinic time spent on social determinants of health is currently working against our priorities of creating access and financial solvency of the medical clinics. With this challenge we are looking at how to best enable patients to feel comfortable answering the questions honestly while in a team-based care setting. We are testing which care team member conducts the screening to assess patient comfort while optimizing provider time and access.
- A challenge in this work in a rural area is the small sample size, which makes it challenging to track improvements quickly. Nonetheless, we consider patient qualitative feedback as valuable data and use it to act and make changes to attempt to close the gap between patients with Medicare and Medicaid coverage. Additionally, the data has not yet shown improvements in this area, or in our population of patients with diabetes as a whole as our current rate of patients with uncontrolled diabetes as grown to 32 percent. We think this is because we are starting to open access to care, and thus new patients that have a diagnosis of diabetes but have not yet received care are adding to our uncontrolled number.

Tips for Others Doing Work in This Component

- Allow time and space for multiple iterations of testing new protocols within the health care setting. Include frontline staff members in the work to build inclusion, support, and ownership. This inclusion has allowed us to fail forward, rather than producing a narrative of having a change "done to us." Evoke the power of the methodology "nothing about us without us."
- A major success was the very informative and valuable one-on-one conversations with patients about what they felt were barriers to managing a diagnosis of diabetes. Having the patient voice was critical to creating health goals that fit into their daily lives. Listening to what was important to the patient further built a trusting relationship between the clinic team and patient that sets the stage for working together going forward. Furthermore, the patient perspective allowed our team members involved in this project not to guess about barriers, but rather to understand them from a perspective other than their own. The team's original hypotheses on the barriers did not align with what the patients shared with the case managers.
- Cultural competency builds on the success of our ability to build trust and ultimately provide services to all community members. Our patients comprise a variety of different cultures and backgrounds. The diverse population we serve has varying ideas, beliefs, and knowledge with regard to health care. Cultural knowledge and awareness of self and of others will allow staff to provide the highest quality of care, while also recognizing and making necessary provisions for cultural differences.

Component 4: Eliminate Racism and Other Forms of Oppression

It is important to note that Northwest Colorado Health widened its focus for this framework component to be meaningful to the rural population in which we live. We expanded our organization's definition of the term "racism" to include other demographics such as race, ethnicity, language, income, health coverage, geographic location, sexual preference, and gender.

Major Achievements

- We formed the internal Wellness Inclusion Support and Equity (WISE) Committee within the organization, with representation of staff members from service lines and locations. The WISE Committee creates activities, tools, and programs promoting high engagement, continuous improvement, and healthy, happy employees. This team meets monthly, has had an outside facilitator conduct equity and implicit bias trainings, and has facilitated sessions that have produced the WISE Committee charter and norms. Examples of work done by this group is reworking the employee check-in process and the staff onboarding and orientation process.
- Our internal policy team has changed policies based on feedback from employees where the employee felt the policy was inequitable. An example of this is changing our employee health care benefit policy to include stepchildren and legal partners as recipients of benefits. This allows us to be more inclusive of blended families and LGBTQ families. Our prior employee health care benefit policy provided a discounted rate of medical services in our clinic to employees, spouses, and dependents. Now stepchildren and legal partners are eligible for the same discounted rate of medical services, which reduces the financial burden for those families.

Key Challenges and Lessons for Mitigation

- A positive challenge that we faced when selecting WISE Committee members from those who expressed interest was multiple applicants from the same location and team. Our goal for this committee was to have participants from each location and service line. Four staff from the same location applied to be committee members. Our mitigation for this was to let these four team members know the "why" behind our intention of representation on this committee, and then facilitate discussion about the options among the four team members and handing the decision to them. They were able to make the decision themselves, and also come up with a system of two-way communication of WISE Committee inputs and outputs that worked for their team and location.
- An unintended consequence was the reaction of team members that had developed and carried out previous policies and human resource procedures that we had flagged for updates to improve equity. In order to combat this, our leaders continually reinforced that the change did not come from a place of viewing current or previous procedures as bad, but rather as a system of an agency that experienced the growth of doubling of staff and locations in three years, thus necessitating review of what works in the present and what will be sustainable for the future.

Tips for Others Doing Work in This Component

- To involve staff in this work, be sure to provide ample tools and trainings to create a common vocabulary around health equity and inclusion. Our executive team and the WISE Committee set up the scope and guidelines for approval prior to embarking on projects. This proved to be upstream of budget requests and decision-making expectations.
- Emphasize the "why" behind the work and the importance of approaching change from a place of improvement, failing forward, and acceptance of the process. It is important to be conscious of the fact that some staff are resistant to change. Engage these people in the conversation early.

Component 5: Partner with the Community to Improve Health Equity

Major Achievements

- Through growing local efforts, we are increasingly improving our ability to address the barriers presented by poverty in northwest Colorado. There are multiple Bridges Out of Poverty startups in the region and we are on the steering committee. We intend to further utilize and enhance this program as much as possible. This is an exciting expansion

of our awareness that will allow us to better partner with community organizations and individuals to create health by overcoming deeply ingrained psychological, cultural, institutional, and social barriers.

- Our agency is leading efforts in the Communities That Care (CTC) efforts as well as the community health improvement plan. Through our work with IHI, we have been able to take our learning about systemic inequities and apply them to assessments and the data collection of these efforts. For instance, we now know the breakdown of youth that are vaping by language, school district, and grade level. This will help our community efforts be able to better target use and frame an advocacy strategy.

Key Challenges and Lessons for Mitigation

- When working across sectors with partners, the different language used in different sectors and the varying levels of knowledge about equity creates communication and collaboration challenges. We have spent a substantial amount of time on sharing learning opportunities with community partners, filtering resources to smaller social service agencies, and relationship building prior to approaching the topic of health equity.
- Leadership turnover has acted as a challenge and a benefit to furthering health equity work. The two main leads of our Pursuing Equity work left the agency at the midpoint of the project. This gave us the opportunity to rebuild and regenerate relationships with community partners, under new leadership and a new vision of lifting equity to a level of closing community gaps. In the last year and a half, the organization has a new CEO, new Director of Quality and People Ops, new Director of Public Health, and new Director of the Community Health Center, and new Director of Home Care Services. In other words, two out of five executive team members are new to their roles, and three out of six of our department directors are new to the agency. We used these changes to our advantage to reach out to existing and unlikely community partners to further relationships.

Tips for Others Doing Work in This Component

- What has worked well for us in collaboration is keeping the strength of our organizational relationships as a priority and always putting community before agency, and individual before program. The core of this expansion is focusing first on individuals, then community, and finally agency.

Part 3: Describe What's Next for Equity Work

Building sustainability through our learning with IHI is a focus identified in our new strategic plan. Northwest Colorado Health is now in a position to be a community leader in health equity work. We are continuing work with a Colorado-based Health Equity Advocacy Cohort that is focused on field-building and advocacy efforts for social determinants of health. The WISE Committee and executive team will continue to look at our agency systems to reduce internal inequities and embrace our agency value of leading by example.

When it comes to how we serve our community, we will use business intelligence and community-level data to identify areas of inequitable access, cost, or outcomes, and tailor services and advocacy efforts toward those. We have also joined the EquityLab, a two-year Colorado-based project modeled after the IHI Pursuing Equity initiative. This will allow our teams to have accountability for this work while building internal capacity and subject matter expertise.

Northwest Colorado Health answers the need for accessible, affordable, high-quality health care through a diverse menu of programs (preventative care, primary care, family planning, women's health services, hospice care, home health, wellness services, and chronic disease management) that serve ALL residents of northwest Colorado regardless of age, ethnicity, economic circumstance or insurance status, with an emphasis on serving those that the health care system has left behind. Keeping our core belief that *every person deserves the right to achieve their best health* in the forefront of efforts and services can move equity forward in the rural communities we serve.

Team Summary Report

Rush University Medical Center (Chicago, Illinois)

Part 1: Overview

Background and Aim

Rush University Medical Center (RUMC) has made achieving health equity a strategic priority for the system. At the highest level we aim to reduce the life expectancy gap between the Chicago lakefront neighborhoods and Chicago's West Side neighborhoods — a 16-year gap in life expectancy at birth between two neighborhoods that are approximately 5.5 miles apart — by 50 percent by 2030 while improving health, economic vitality, and well-being across all our neighborhoods.

At the same time, Rush acknowledges the need to examine the care we provide through a "health equity lens" to better understand and address gaps that could contribute to health disparities. This has required us to take an inside and outside approach, focusing on the communities that surround the institution as well as ensuring that all patients receive equitable care.

We have committed to explicit, measurable goals to accelerate our Community Anchor Mission strategy, working to reduce equity gaps in clinical and non-clinical areas while adopting a data-driven approach. Over the past two years, we have worked to identify gaps and needs in our patient population through screening for multiple social determinants of health (SDOH) and have linked patients with internal and external community supports and resources to address their social needs.

We are committed to improving the health of individuals, both patients and employees, and we believe this will help us to better understand and address patients' whole health and well-being while attaining their full health potential. We are committed to improving the health of "places," local neighborhoods of concentrated and segregated poverty, to help improve the living conditions for the people who live there by addressing the structural, economic, and political determinants of health.

Finally, we aim to dismantle structures that perpetuate racial, ethnic, gender, disability, and other structural inequities by addressing hiring practices, investment practices, purchasing practices, and leadership practices, among others.

Methods

Multiple strategies and programs have been established to advance toward Rush's aims.

System-Level Strategies to Promote Health Equity:

- In July 2017, Rush made health equity a strategic priority for the Rush University Health System (Rush). Being a catalyst for Community Health and Economic Vitality was identified as one of four transformative strategic priorities, and Dr. David Ansell was named Senior Vice President for Community Health Equity to lead these efforts.
- Explicit discussions about structural racism and economic investment with the senior leadership team and the system's board.
- Partnership with Information Services (IS), Knowledge Management, Quality Improvement, and Population Health Departments to form Rush's Ambulatory & Population Health Data Governance Subcommittee, giving the Equity team a platform to bring Equity and SDOH-related data requests.
- Established infrastructure and governance for health equity work (SDOH Ops and Leadership Committee), as well as integration of health equity goals into the annual Performance Improvement Plan for the medical center.
- Built a racial health equity collaborative with other health systems and the community called West Side United to address the structural, economic, and political determinants of health in 10 Chicago West Side neighborhoods.
- Published the first "State of Health Equity Report" at Rush.

Strategies to Address Social Determinants of Health Needs (Screening Process Implementation):

- Established SDOH screening workflows and began implementing screening across Rush University Medical Group (RUMG) primary care, the ED, and inpatient units. Discussions are underway with Rush Oak Park and Rush Copley to screen for SDOH in the ED.
- Used PDSA cycles to test the screening workflow with multidisciplinary team members, including first-year medical students, medical assistants, social workers, patient care navigator, and residents.
- Developed formal partnerships with NowPow and other community partners to establish closed-loop referrals and provide relevant resources to patients with needs. NowPow is a women-owned and operated company that uses a digital platform and data analytics to link people known to have chronic health and social problems to community-based providers of the health and social services that have been prescribed for them.
- Hired a team of community health workers (CHWs) and a patient care navigator within the population health umbrella to provide timely communication and follow-up to patients who screen positive for SDOH.
- Developing a system-level quality and equity dashboard with plans to implement by June 30, 2019.
- Developing a RUMG/RUMC SDOH Dashboard that displays progress on screening, intervention, and trends with plans to implement by June 30, 2019.
- Partners in Rush's Information Services and Knowledge Management are in the process of developing a Health Equity data mart.
- Developing SDOH risk/predictive model with Knowledge Management, IS, and Rush Health.

Data/Results

Rush began its journey in screening for SDOH in September 2017, starting with the Rush University Medical Center (RUMC) Emergency Department (ED), and quickly expanding to other areas across the Rush system, including Rush University Primary Care, RUMC inpatient units, Rush Oak Park Hospital ED, as well as in the community. In May 2018, Rush began participating in a second collaborative with HealthLeads called Collaborative to Advance Social Health Integration (CASHI) to expand its reach with SDOH screening in primary care and begin developing an evaluation framework.

As a major focus area for the IHI Pursuing Equity initiative, between July 2017 and March 2019 the Rush Pursuing Equity team, Social Work team, and Rush University Primary Care at RUMC undertook SDOH screening efforts through an office visit, social work visit, and patient telephone outreach. The following data reflect the results of these efforts (note that the data are not inclusive of primary care patients being screened in the ED or inpatient units):

- Number of patients screened for SDOH = 1,944
- Number of patients screening positive for 1 or more SDOH need = 547
- Top 3 SDOH needs identified = utilities, food, and transportation
- Number of patients screening positive for 1 or more SDOH need who then received After Visit Summary with NowPow resources/referrals = 139

Standard workflows for screening and referrals have been developed for primary care clinics and rolled out in three out of 13 clinics. The Rush Social Work and Community Health team are continuing to develop and spread standard workflows for screening and resources in primary care, the ED, and inpatient units so that all patients receive the resources and supports they need to thrive.

Conclusions/Implications/Recommendations

Rush recognized through this journey how pervasive structural racism is in our health care system, particularly in Chicago, and have worked to shed light on this topic across clinical settings. Making health equity a strategic priority was essential to advancing our efforts and identifying needed internal and community resources to address SDOH for patients in our system. We continue to collect and publish data on the community needs for our larger region and strive to develop a collaborative model with stakeholders to offer high-quality care to all patients who require it.

Creating partnerships that function as fully integrated, closed-loop systems remains a challenge. Changing behavior and perceptions of the large faculty body as it relates to the intersection of structural racism and health outcomes has been equally challenging in changing the health care landscape that has not fully shifted to value-based care. Finally, given that we have a three-hospital system and a health science university, bringing these practices and ideas to these other sites will be critical to advancing equity more broadly.

Part 2: Summarize Your Work

1. Background and Context

Rush is a not-for-profit academic health system serving approximately 750,000 patients per year in Chicago, Illinois, and surrounding areas. Rush's mission is to improve the health of the patients and the diverse communities it serves with nationally recognized health care, education, research, and a commitment to building community partnerships. The Rush system comprises an academic medical center just west of the downtown Chicago Loop, two community hospitals (one nine miles west and another 40 miles west), Rush University and a health sciences university (with four colleges and more than 2,500 students), as well as numerous outpatient care facilities.

Our equity journey began in 2007 when a diversity and inclusion group was formed to guide senior leadership in accelerating diversity across the medical center and university. In 2010, the first diversity and inclusion strategic plan was written and senior leaders were held accountable for achieving diversity goals as a bonus measure. In 2016, Rush changed its mission to include improving health and made community health equity one of four strategic pillars of the health system. We realized that most of our community programs were not designed to make progress on addressing health disparities and we needed to take a bolder approach to community health.

In the same year, the business units reorganized to embrace an anchor mission to hire, purchase, invest, and volunteer locally. In 2017, Rush joined the Democracy Collaborative, the Health Care Anchor Network, and the IHI Pursuing Equity initiative. In February 2018, West Side United was launched. In June 2018, a new five-year diversity and inclusion strategic plan was introduced and funded with an aim of achieving demographic parity in leadership in the next five years. A health equity strategic plan was written to encompass the whole Rush system.

Community and Other Context

The people Rush serves come from a wide variety of racial and ethnic backgrounds, with a high proportion of white, Hispanic/Latino, and black populations, and varying age groups; many are immigrants who speak languages other than English.

From the community health needs assessment (2017-2019), the needs identified for Rush's service area, the West Side of Chicago, include:

- Reducing inequities caused by the social, economic, and structural determinants of health
- Improving access to mental and behavioral health services
- Preventing and reducing chronic disease by focusing on risk factors
- Increasing access to care and community services

Despite all of our programs, outreach, investments, and good intentions, health inequities persist in the communities surrounding Rush. There is a major gap in life expectancy between Chicago's West Side and the Loop, reflecting high levels of hardship and disease in West Side communities. To effectively address this hardship and disease burden, an intentional, collaborative, place-based approach called West Side United (westsideunited.org) was developed. This initiative has informed the development of Rush's community strategy, which includes health equity as a critical component.

2. Describe Your Work for Each Component of the IHI Framework to Improve Health Equity

Major Achievements

Component 1: Make Health Equity a Strategic Priority

- Health equity is a strategic priority for the organization and has been specifically called out in Rush's Community Anchor Mission strategy.
- Senior leadership team and board engagement on equity and participation in the IHI Pursuing Equity initiative.
- Hosted IHI Pursuing Equity Workshop 4 at Rush and invited key leaders and management to participate.
- Deployed an organizational assessment survey to key departments and organizational leadership in 2017 and 2018.
- Practices are in place to recruit, retain, and develop employees at all levels.
- Encourage diverse supplier procurement.

Component 2: Build Infrastructure to Support Health Equity

- Governance structure is in place to deploy equity work strategically across the organization.
- SDOH screening has been implemented across RUMC's primary care, ED, and inpatient units and we are developing a mechanism to capture discrete data to demonstrate impact/reach.
- First IS team in the country to develop Epic interface for full EHR integration with NowPow.
- Working to onboard additional community partners to the NowPow platform to facilitate closed-loop referrals.
- Discussing sustainable partnership between Quality Improvement and Equity areas.
- Dedicated supports hired to carry out Equity/SDOH-related work (SDOH Navigator, SDOH Social Worker, SDOH Program Manager, Lead CHW, and additional SWs for primary care to more fully support the program).
- Health equity course developed for employees to engage them in the organization's equity journey and courses offered to HSM and M1 students.
- "State of Health Equity Report" (first of its kind at Rush) released in March 2019 provides opportunities for deeper discussions on areas to focus improvement effort.
- Finding long-term supportive permanent housing for four patients identified as having frequent admissions (inpatient or ED).
- Established an internal food pantry to address food insecurity on inpatient units.
- Ushered through a contractual arrangement with Lyft ride-share company to provide non-emergency medical transportation (NEMT) assistance (migrating to Kaizen Health in 2019).

Component 3: Address the Multiple Determinants of Health

- Great strides have been made to obtain buy-in across departments and implement new processes to address social needs. We cannot understate the impact of having our community partners use the NowPow platform to coordinate the provision of resources and to allow for sharing data in real time. Being able to close the loop on referrals has helped to reassure physicians (champions) that we have a process for connecting people who screen positive for social needs to the services they need.
- A formal evaluation team was engaged to help understand why community health indicators, indicator reports, and report cards are valuable tools to improve health equity as well as to identify elements of successful community health indicator efforts. This team, consisting of a statistician and an epidemiologist, was led by Elizabeth Lynch, PhD, from Rush's Department of Preventive Medicine. Dr. Lynch is a cognitive psychologist whose research focuses on developing and evaluating novel community-based interventions to reduce health disparities.
- Drafted a framework for tools/dashboards needed for various audiences (stewards, providers, leadership). We have developed an initial version of quality and equity dashboard. A next step is to validate and operationalize the dashboard with input from key clinical and operational leaders.

Component 4: Eliminate Racism and Other Forms of Oppression

- Developed Rush's four-step approach to addressing institutionalized racism.
- Rush has committed to providing unconscious bias training to at least 1,000 employees in its first year. This began in 2018 and has continued to roll out.
- Rush is the first health system to develop a comprehensive policy for immigrant safety, particularly for those without citizenship documentation, and has committed to treating all persons and not permitting US Customs and Immigration Enforcement (ICE) access into our facilities to break up families and impede patient care.
- Our policies and systems support the hiring, retention, and professional growth of people of color and other marginalized groups in the organization and the community, including people with disability, formerly incarcerated, difficult to hire youths ages 17 to 25, LGBTQ, and others.

Component 5: Partner with the Community to Improve Health Equity

- Rush is committed to relationship building and collaboration with the community. Much of the work on this component is achieved through the West Side United anchor mission efforts. Additionally, Rush's health and health system pillar contains West Side ConnectED, an effort to partner meaningfully with three other health systems, multiple community-based organizations, the Chicago Department of Public Health, and others to promote and implement screening and navigation services in EDs. ConnectED is the health care pillar of West Side United.
- Rush is partnering with NowPow to connect patients to nearby vital health and social services.
- To address food insecurity/hunger, Rush is working with Top Box Foods, a nonprofit community-based organization that focuses its work in food deserts to increase access to healthy and affordable food with the help of neighborhood partners, the involvement of volunteers, and corporate sponsors.
- Rush and CEDA (Community and Economic Development Association of Cook County, Inc.) have agreed to initiate a closed-loop referral pilot project with NowPow to address patients' utilities needs. CEDA's Energy Services Program assists eligible Cook County residents with their home heating and cooling energy costs as well as emergency furnace repair.
- As lack of transportation has surfaced as one of the most consistent barriers identified from our SDOH screening. Rush has thus entered into a contractual agreement with Lyft ride share company to provide non-emergency medical transportation (NEMT) services.
- Rush has entered into an agreement with the Center for Housing and Health to develop a housing pilot in which a limited number of patients identified as experiencing homelessness are offered long-term housing assistance with wraparound care management services. At this time, we have housed four patients in either temporary bridge or permanent housing, with space for two additional patients.

Key Challenges

We are in the beginning stages of understanding the SDOH needs of our patient population and how those needs impact health outcomes. Physicians currently have access to performance dashboards in the Epic EHR to see how they are performing on ambulatory quality measures (CMS); however, as an institution, we do not collect or report stratified data on quality measure performance using an equity lens (e.g., data stratified by race, ethnicity, language, and age).

In addition, with the rollout of SDOH screening in RUMG primary care and RUMC inpatient settings, we have an opportunity to better understand and respond to our patients' needs and how these needs may be related to health outcomes such as ambulatory quality measures, readmissions, and ED visits.

Component 4 (Eliminate Racism and Other Forms of Oppression) is an area of improvement for Rush. A current strength in this area is frequent exposure to this topic by executive leadership, but this has not translated consistently across staff at the front lines of care. Middle managers with capacity to address topics do not feel empowered to create meaningful change. The bureaucracy of certain health plans such as Medicaid and Rush's payment policies further contribute to bi-directional structural racism.

Lessons for Mitigation

- Establish uniform metrics/measures to determine baseline data and define success for projects aimed at achieving equity.
- Collect SDOH and demographic data uniformly across the organization.
- Monitor SDOH screening status at a system level using dashboards.
- Implement an evaluation plan to determine outcomes and plan for hiring additional FTEs and developing new programs accordingly.
- Organize a series of courageous conversations and take dialogue about equity to the front lines, as well as to payers.
- New hire orientation should include an equity module.
- Establish a communication plan and engage stakeholders at the front line, management, senior leaders, the board, and the community.
- Create a strong partnership between quality/performance improvement and population health.

Part 3: Describe What's Next for Equity Work

While Rush's work continues to make health equity a part of our culture, we still have some work to do in understanding care gaps caused by inequities. This is key to understanding where we need to grow, and also in taking an honest (and accurate) assessment of our understanding as leaders at Rush. To decrease inequities and improve the health of the people and communities we serve, Rush must also address the complex social, economic, and structural determinants of health. We must concentrate and align Rush's available resources so they have the greatest impact.

A long-term strategy is required to think broadly and boldly about what it will take to achieve measurable results and build healthy communities. We will need to track our progress by testing and measuring so we can learn what really works. Community health improvements will require extraordinary leadership, engagement of both the public and private sectors, and strong guidance from people in the community.

Specifically, Rush will commit to continuing efforts in the following areas:

- Roll out SDPH screening across all RUMG primary care practices, ED, and inpatient units.
- Make it easier and faster to implement interventions based on SDOH needs.
- Create more closed-loop partnerships with community organizations.
- Finalize SDOH dashboard to efficiently share data on the screening and follow-up in an articulate way to guide decision making.
- Finalize the quality and equity dashboard, with plans to implement it in the new fiscal year.
- Ensure health equity is a component in Rush University Medical Center's value-based care strategy that Lumina Health Partners is helping us to create.
- Ensure quality measures and value-based performance indicators are stratified by SDOH and related demographic data before they are published.
- Develop a strategy and plan around maternal equity and link to West Side United efforts.
- Publish annual data on the "State of Health Equity" throughout the Rush system.

Team Summary Report

Vidant Health (Greenville, North Carolina)

Part 1: Overview

Vidant Health is a mission-driven 1,712-bed rural academic health system serving more than 1.4 million people in 29 counties in eastern North Carolina. It is a not-for-profit system comprising 14,000 team members, nine hospitals, home health and hospice services, a dedicated children's hospital, rehabilitation facilities, pain management and wound healing centers, and specialized cancer centers. Vidant Medical Group, a multispecialty provider group with more than 500 providers in 90+ locations, is also a part of the health system. Vidant's flagship hospital, Vidant Medical Center, is a 970-bed Level I trauma center and serves as the teaching hospital for the Brody School of Medicine at East Carolina University in Greenville, North Carolina.

Vidant acknowledges that of the Institute of Medicine's six aims for improvement — care that is safe, timely, efficient, effective, equitable, and patient centered — the lack of national progress around the equity aim demands a system-wide, inclusive strategic approach.

Vidant's approach to pursuing equity and inclusion is aligned with the "quadruple aim" which states, "Health care is a relationship between those who provide care and those who seek care, a relationship that can only thrive if it is symbiotic, benefiting both parties."[1] In this vein of thinking, Vidant's strategy is anchored in the realization that equity and inclusion will not be achieved with patients and communities if it is not a priority within a health system's own culture.

Vidant developed four charters to address equity and inclusion — strategy, governance, and education; workforce equity; community partnerships; and social determinants of health (SDOH) for both team members and communities — and made equity and inclusion a strategic priority beginning in 2017.

Part 2: Summarize Your Work

Equity and Inclusion Journey

Throughout North Carolina, there is increased awareness of the impact of social determinants of health (SDOH) on the health status of our communities. In their April 2018 white paper, the North Carolina Department of Health and Human Services states:[2]

> In North Carolina, people feel the impact of unmet health-related social needs every day. More than 1.2 million North Carolinians cannot find affordable housing and one in 28 of our state's children under age 6 is homeless.[i,ii,iii] North Carolina has the 8th highest rate of food insecurity in the United States, with more than 1 in 5 children living in food insecure households. In some North Carolina counties, one in three children live in food insecure households.[iv] Additionally, nearly one quarter of North Carolina children have experienced adverse childhood experiences, including physical, sexual or emotional abuse or household dysfunction, like living with someone struggling with a substance use disorder.[v] These and other social determinants of health disproportionately impact Medicaid beneficiaries, negatively impact health, and drive higher health care costs. We also know that intervening in and addressing beneficiaries' needs in these areas can have direct impact on the Medicaid population's health and can yield a strong short-term and long-term return on health and economic outcomes.

i. The National Alliance to End Homelessness. "The State of Homelessness in America." 2016.
ii. The US Department of Housing and Urban Development defines an affordable home as one that requires families to spend no more than 30% of household annual income on housing. Families who pay more than 30% of their income for housing are considered cost burdened and may have difficulty affording necessities such as food, clothing, transportation and medical care.
iii. Administration for Children & Families. "Early Childhood Homelessness in the United States: 50-State Profile." June 2017.
iv. NC Child. "North Carolina Child Health Report Card 2018." 2018.
v. Data Resource Center for Child & Adolescent Health. "The National Survey of Children's Health." 2012.

Vidant joined the IHI Pursuing Equity initial cohort in 2017 and chose two executive sponsors who were best suited to address equity and inclusion for team members and the organization's overall culture: John Marques, SPHR, SHRM-SCP, Chief Human Resource Officer, and Julie Kennedy Oehlert, DNP, RN, Chief Experience Officer. The entire Vidant senior executive team participated in the IHI Health Equity Self-Assessment Tool (HESAT) for Health Care Organizations.[3]

Vidant launched a steering committee to oversee the equity and inclusion work, including leaders from various departments and hospitals across the system, representatives from Brody School of Medicine and East Carolina University, and community leaders from the areas Vidant serves. This steering committee also took the HESAT.

Results of the HESAT affirmed that although Vidant had a desire to improve equity and inclusion, there was no intentional strategy or governance processes to realize that desire. Vidant developed four charters to organize their equity and inclusion work: strategy, governance, and education; workforce equity; community partnerships; and social determinants of health for both team members and the eastern North Carolina communities Vidant serves. Vidant has three strategic imperatives — quality, experience, and finance — and equity and inclusion became a strategic priority in 2017 when it was added to the experience imperative.

Strategy, Governance, and Education

Vidant understands that to eliminate structural and organizational racism, the work must be sequenced to ensure that the strategy is understood; that equity and inclusion definitions are created and communicated so they are consistent and known; and that a governance structure built on policy and education is in place to support the work across the other charters.

To quote Vidant Chief Executive Officer Mike Waldrum, MD, MSc, MBA, "Vidant Health believes that we will not achieve health equity without workforce equity, and we will not achieve workforce equity without addressing the social determinants of our workforce and the structural racism and bias that exists in the very fabric of our organization."

Vidant defines equity as promoting fairness by giving everyone what they need to be successful regardless of race, gender, age, or cultural differences. Vidant defines inclusion as intentionally utilizing the unique strengths and talents within each person to drive innovation and support individual team and organizational success.

Vidant provided an equity and inclusion education session in unintended bias for their three boards in March 2017. This session covered bias and micro-aggressions, and the education was cascaded to all human resources leaders. A workplace aggression committee, separate from yet aligned with the equity and inclusion steering committee, was formed and added the term "micro-aggression" to the definition in the workplace aggression corporate policy VH-HR80. The May 2019 board education session was also devoted to equity and inclusion and focused on workforce equity metrics; community partnerships designed to improve workforce equity; Vidant programs focused on team member awareness and education on equity, inclusion, and workplace aggression; and the connection between health equity and language access services and how Vidant is responding to this need.

In 2018 Vidant launched Leadership CORE (Comprehensive and Compassionate Operational and Relational Excellence), an 11-month course of bi-weekly classes which includes a four-hour session on Leading for Equity and Inclusion that is mandated for all leaders. Objectives for this class include the ability to identify, define, and raise awareness of unintended bias; the ability to assess potential consequences and strategies to minimize the impacts of unintended bias; and the examination of health care equity and health disparities in eastern North Carolina. To date, 247 leaders have completed the class.

In 2018 Vidant launched online, interactive education around equity and inclusion for all team members both as part of the on-boarding experience and as part of yearly education requirements. To date, 1,156 new team members and 7,170 existing team members have completed this education. In 2018 Vidant also launched an equity and inclusion salon designed for small groups to gather with a facilitator and explore why equity and inclusion are important to Vidant's mission as well as to the organization's safety, quality, experience, and financial outcomes. To date, 263 team members have participated in an equity and inclusion salon, and a salon was included in the May 2019 board education session on equity and inclusion.

In 2019 Vidant created an experience committee which reports to the Vidant Health board and is the governing body for Vidant's equity and inclusion work. The committee charter states that it will provide oversight and monitor interventions involving patient experiences, including complaints and grievances, team member experiences, workplace safety, and equity and inclusion. The committee's priorities are to increase workforce education on equity, expand and improve language access services, and increase leadership diversity. Success in these areas will be measured by the number of team members who received education on bias, the number of patients who received requested interpreter services, and the number of persons of color who hold positions at a manager or higher level.

Next steps for the strategy, education, and governance charter are to standardize the metrics that will be reported to the board, review the membership of the equity and inclusion steering committee, and update the steering committee work charter.

Workforce Equity

The most important SDOH affecting eastern North Carolina communities is access to economic opportunities. The North Carolina Department of Commerce annually ranks the state's 100 counties based on economic well-being and assigns each a Tier designation. Most of the counties served by Vidant are listed in the top 40 most economically distressed areas in the state (73 percent of the counties Vidant Health serves are classified as Tier 1, severely distressed; 24 percent are classified as Tier 2; 3 percent are classified as Tier 3). These economic challenges impact patients' ability to obtain employment, which results in a large population being underinsured or uninsured. Vidant is the largest employer in its service area, and many of Vidant's patients are team members as well.

In 2017 Vidant increased the starting wage to $12 per hour for team members. The data in Table 1 shows that of the team members in entry-level positions who were impacted by the starting wage increase, 61 percent were black; of that 61 percent, 74 percent were black females.

Table 1. Vidant Health Entry-Level Team Member Impact of Starting Wage Increase to $12/Hour (July 2017)

Ethnicity	Female	Male	Total	Percent
Native American	5	1	6	0.35%
Asian	3	3	6	0.35%
Black	792	272	1,064	61.29%
Hispanic	42	15	57	3.28%
Not specified	18	8	26	1.50%
Two or more	9	0	9	0.52%
White	452	116	568	32.72%
Totals	**1,321**	**415**	**1,736**	**100%**

In 2018 Vidant reviewed population representation by ethnicity and compared it to team member and leadership positions (see Table 2). Overall, Vidant team member population closely aligns with and reflects the demographics of eastern North Carolina. Vidant management demographics, however, do not fully reflect those of eastern North Carolina and Vidant's team member population. Vidant's goal is to increase the representation of people of color in leadership positions by 15 percent by the end of fiscal year 2022 through recruitment and internal development efforts.

Table 2. Vidant Health Stratified Historical Ethnicity Data (February 2018)

Eastern North Carolina				Vidant Health Team Members				Vidant Management (Including Supervisors)		
Ethnic Group	Count	Index		Ethnic Group	Count	Index		Ethnic Group	Count	Index
Asian	17,951	1.2%		Asian	255	2.3%		Asian	9	1.0%
Black	456,747	29.9%		Black	2,871	26.2%		Black	123	12.7%
Hispanic	124,920	N/A		Hispanic	221	2.0%		Hispanic	18	1.9%
Native American	10,138	0.7%		Native American	46	0.4%		Native American	7	0.7%
Not Specified	65,879	4.3%		Not Specified	137	1.2%		Not Specified	10	1.0%
Pacific	1,419	0.1%		Pacific	5	0.0%		Pacific	0	0.0%
Two or More	36,400	2.4%		Two or More	49	0.4%		Two or More	4	0.4%
White	938,709	61.5%		White	7,382	67.3%		White	798	82.4%
Total	1,527,243			Total	10,966			Total	969	

In 2018 Vidant launched stay interviews, which are structured meetings between team members and their immediate supervisor. Verbiage was added to the stay interview toolkit to prompt managers to identify, encourage, and support advancement opportunities within Vidant and to provide information on educational development, resume writing, and interviewing skills. Vidant also has an Emerging Leadership Program (ELP) and, starting in 2017, applications were blinded to encourage a more diverse applicant/candidate pool.

In 2019 Vidant Medical Center established a pilot initiative to assist team members with an interest in advancing their careers. Team members from across Vidant Medical Center were invited to participate and met with human resources team members to learn about resume preparation, interview skills, tuition assistance, and other development resources. This pilot resulted in participation by 55 team members, of which over 80 percent identified as black, Hispanic, Native American, or other ethnicity. This pilot validated the need and thirst among team members for assistance with navigating career development options.

Next steps for the workforce equity charter:

- Develop, implement, and maintain strategies that increase and retain a diverse workforce that reflects Vidant's patient population and the communities it serves.
- Establish relationships with organizations that support black, Naitve American, and Hispanic workforce development.
- Build relationships with and identify points of contact with organizations that would support recruitment and advancement efforts, with a focus on institutions of higher education and professional organizations that serve minority populations.
- Develop a referral process and communication pathway between community resource partners and Vidant talent acquisition to provide career resource planning and connect identified community members with potential employment opportunities.
- Partner with local community colleges and technical/vocational institutions to assess the feasibility of offering educational opportunities on the Vidant campus or within the West Greenville community.

Community Partnerships

Vidant has a long, rich history of community partnerships. The purpose of the community partnerships charter is to create awareness of these partnerships and the work being done as well as create synergy across programs.

Vidant partners with local faith organizations and schools to provide free health screenings, education, and support within the communities they serve. One of the faith partnerships, HealThy Neighbors, partners with faith leaders to develop lay health advocates known as faith health ambassadors who promote health within their congregations and communities. These faith health ambassadors assist community members in connecting with and navigating the Vidant Health system.

Vidant partners with schools to provide free health education to students, families, staff, and faculty. This program also seeks to proactively promote health and well-being and connect community members to the health system. School

partnerships also incorporate programming to address adverse childhood experiences, as research shows that early life experiences can impact an individual's health status throughout their life.

Currently each Vidant Health hospital has a grants program, and collectively they provide $1.7 million annually in grant funding to non-profit and government entities across the region to implement community health programs that are located outside the walls of the hospitals. These grant programs focus primarily on access to care (physical, mental, or dental health), chronic disease prevention and management, and nutrition and physical activity.

The locally funded initiatives take place in community centers, churches, schools, Boys and Girls Clubs, senior centers, civic clubs, free clinics, and other community venues. Making these programs available in a variety of locations across the community increases access to wellness and prevention strategies, health education, and health care services in rural communities. Locating these programs and initiatives directly in the communities served by Vidant helps remove both the transportation and financial barriers to accessing important health information and health care services that are frequently experienced by uninsured, underinsured, and low-income families.

The next step for the community partnership charter is to review the funding eligibility criteria. The Vidant board has requested that community program funding include requests for team member wellness programs as well as community wellness.

Social Determinants of Health

For this charter Vidant chose to focus on two specific issues: food insecurity and language access services. Vidant assesses patient SDOH needs during ambulatory visits as well as with every inpatient admission through the use of a standard assessment which is completed by inpatient case managers. Based on identified needs, specific referrals are made to community organizations/agencies to assist individual patients in meeting their SDOH needs.

Food Insecurity

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. This Medical Food 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. Patients referred to the Medical Food Pantry receive a two-week supply of food based on their medical dietary needs. The goal for the pantry is to provide a two-week supply of food to 95 percent of all VMC inpatients identified as food insecure.

Language Access Services

Vidant believes that communication is the cornerstone of excellent care and that care team members cannot provide compassionate, empathetic, top-quality, safe care without meeting the communication needs of patients who do not speak English or prefer to get their health information in a language other than English.

In 2017 Vidant assessed its language access services and interpreter program. The number of patients identified during the registration process who have limited English proficiency (LEP) or who prefer a language other than English (LOTE) was compared to the number of interpreter contacts. There was less than a 1:1 ratio for identified patients to combined interpreter presence (on site, video, and phone). It was also acknowledged that lack of access to interpreter services created barriers to care in rural hospitals and clinics.

The goal is for LEP and LOTE inpatients to have an average of four interpreter contacts per day as well as to provide appropriate resources in outpatient settings. Vidant adopted a new interpreter platform in 2018 which improved ease of connecting to a live, remote interpreter via iPad or mobile phone application. Comparing the same one-week period from 2018 to 2019, there was a 45 percent increase in minutes of service. Vidant also hired additional full-time interpreters, which allowed coverage at rural hospitals and outpatient clinics. As of March 2019, outpatient interpreter encounters have also been trending upward since these initiatives were introduced in August 2018.

In 2019 Vidant launched a centralized phone service for patients and team members to request language access services. This line is answered 24/7 by a live language services leader. The number and a description of available services is

published on a newly created intranet page for our team members, in the patient handbook, and on the Vidant website. Team members are also educated on interpreter services during new tem member orientation.

Other program enhancements include updated and standardized position descriptions, which include educational requirements, certification expectations, and language proficiency assessments; participation in daily safety huddles to report the number of inpatients who require interpreter services; and increased education on identifying and reporting potential safety hazards related to language.

All current interpreter team members have participated in the Bridging the Gap training program, which makes them eligible to sit for national certification. Additionally, Vidant is creating a bilingual program to leverage its language resources among existing team members.

Next steps for the social determinants of health charter:

- Assess and address food insecurity in team members through the same standard assessment used with patients.
- Simplify the language access services request process to improve response to real-time needs.
- Increase the presence of on-site interpreters at identified high-need locations.

Part 3: Describe What's Next for Equity Work

Vidant Health is proud of the accomplishments and advancements that were made during the IHI Pursuing Equity partnership but knows there is still much work to be done. Vidant is actively reviewing both patient and team member data to identify gaps based on race, ethnicity, and language.

When reviewing race, ethnicity, and language demographic information on registered Vidant patients, the health system identified that this data is not collected for 100 percent of patients. As this data is essential to identify gaps in health care equity, a charter and work group are now in place to improve this data collection, with a goal set based on national best practice.

Vidant has much additional work to do in reviewing quality of care outcomes by race, ethnicity, and language. After data collection has been improved, it is Vidant's goal to have all quality data stratified by race, ethnicity, and language by 2020, starting with reports at the board level.

Vidant currently reports team engagement by race and ethnicity. More work needs to be done to respond to this data at an organizational level.

Pursuing equity and inclusion within a health system is essential to ensure that patient care is safe, timely, efficient, effective, patient centered, and *equitable*, and to achieve those aims team members must feel that their culture is safe, inclusive, and equitable as well.

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