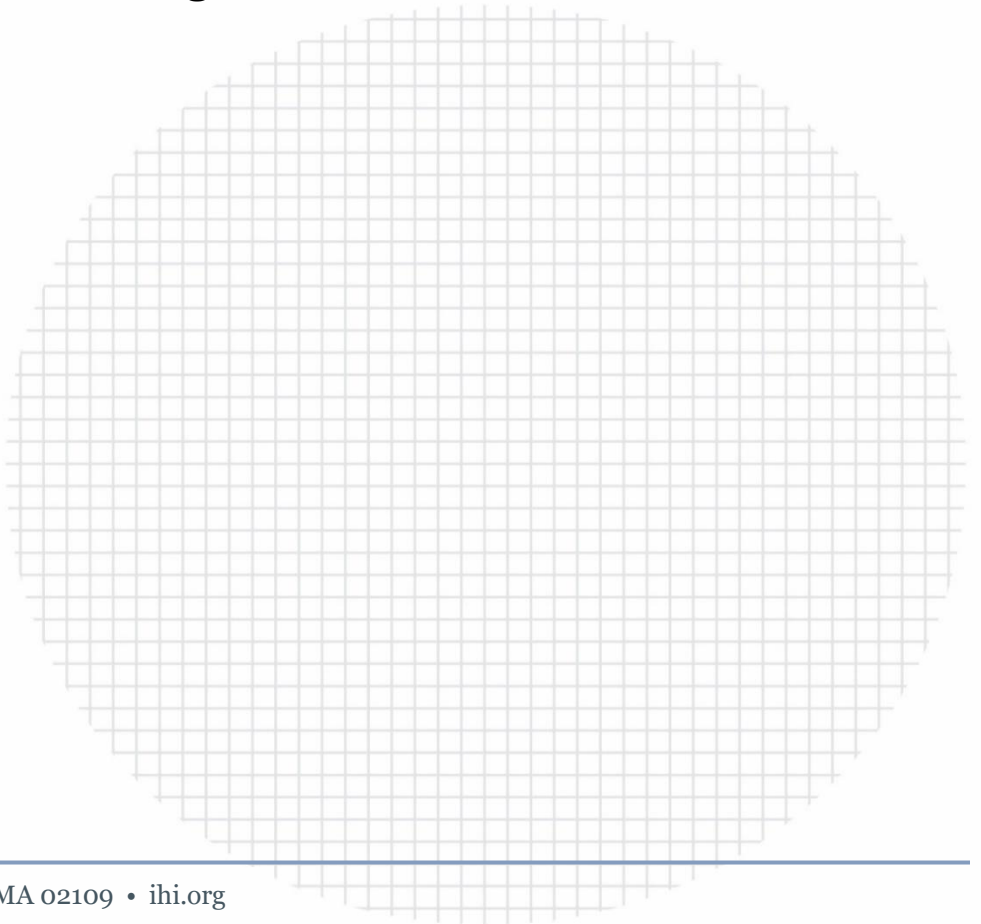




Improving Health Equity: Make Health Equity a Strategic Priority

Guidance for Health Care Organizations



AN IHI RESOURCE

53 State Street, 19th Floor, Boston, MA 02109 • ihi.org

How to Cite This Document: *Improving Health Equity: Make Health Equity a Strategic Priority. Guidance for Health Care Organizations.* Boston, Massachusetts: Institute for Healthcare Improvement; 2019. (Available at www.ihi.org)

Acknowledgments:

IHI is extremely grateful to Meghan Hassinger, lead author of the guide; Amy Reid, who provided thought leadership and direction; and John Whittington for his invaluable feedback.

IHI has deep appreciation for the eight health care organizations and individuals working with us in the Pursuing Equity initiative: 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).

Without their pioneering work and generosity in sharing what they are learning, this guide would not be possible. The authors are also grateful for the thought leadership provided by IHI leaders and faculty for the Pursuing Equity initiative, and we thank Jane Roessner and Val Weber of IHI for their guidance in developing and editing this guide.

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

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.

Contents

Executive Summary	4
Introduction	5
How to Use This Guide	6
Getting Started	6
Three Strategies for Making Health Equity a Strategic Priority	6
Conclusion	18
Appendix A: HealthPartners Glossary of Health Equity Terms	19
Appendix B: Tools for Building Will to Improve Health Equity	21
Appendix C: Leadership Communication Examples	24
References	26

Executive Summary

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

This guide describes strategies and lessons learned from the eight health care organizations that have tested changes in the framework's first component: Make Health Equity a Strategic Priority.

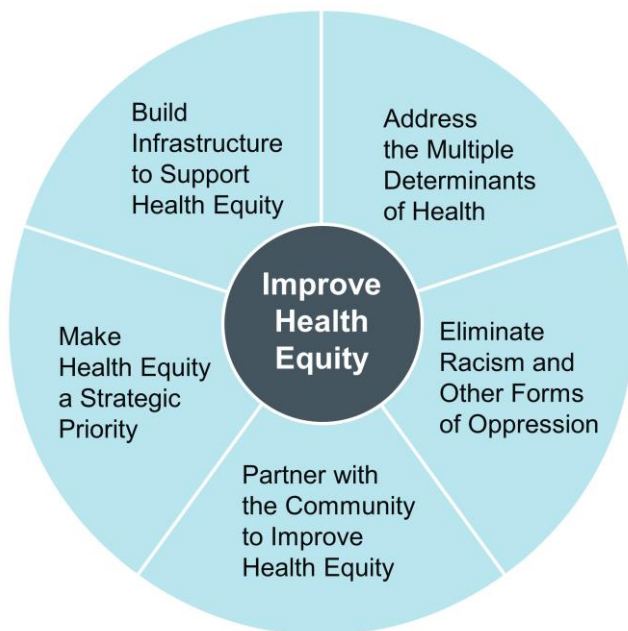
The guide includes:

- **Three strategies** for making health equity a strategic priority in your health care organization;
- **Examples of changes** the eight Pursuing Equity organizations tested in each of the three strategies; and
- **Common challenges** that arise while pursuing equity and strategies for mitigating them.

Introduction

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

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



- **Make Health Equity a Strategic Priority**

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

- **Build Infrastructure to Support Health Equity**

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

- **Address the Multiple Determinants of Health**

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

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

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

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

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

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

How to Use This Guide

This guide describes strategies and lessons learned from the eight health care organizations participating in the Pursuing Equity initiative that have tested changes in the framework's first component: Make Health Equity a Strategic Priority. Lessons learned, resources, and examples from the participating health care delivery systems are described.

Three strategies for making health equity a strategic priority in health care organizations emerged:

- Build will to address health equity;
- Include equity as a priority in the organization's strategic plan and department-level goals;
- Demonstrate senior leader ownership for and commitment to improving health equity.

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

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

- **Health equity:** IHI uses the United States Centers for Disease Control and Prevention definition for health equity: "Health equity is achieved when every person has the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances."³
- **Health inequity:** Differences in health outcomes that are systematic, avoidable, and unjust.³
- **Institutional (or institutionalized) racism:** The differential access to the goods, services, and opportunities of a society by race.⁴

Getting Started

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

Three Strategies for Making Health Equity a Strategic Priority

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

Based on the experience of organizations participating in the Pursuing Equity initiative, there is not a sequential order for implementing the three strategies for making health equity a strategic priority (i.e., they do not need to be implemented in the order in which they are presented in this guide). Many Pursuing Equity organizations found it works best to start where they have the most resources and leadership motivation to do the work.

Additionally, these organizations have a variety of reasons for committing to improve health equity. For some, there is a sound business case to improve equity. For example, because patients with complex needs disproportionately represent racial and ethnic minorities in the US, some organizations look to improve the quality of care these patients receive in an effort to control costs.⁶ For other organizations, improving equity is a moral choice to align with their organization's mission. Regardless of the reasons, improving health outcomes in your community requires organizations to make health equity a strategic priority.

Strategy 1: Build Will to Improve Health Equity

Making health equity a strategic priority requires building will and increasing awareness about equity in your organization. Staff must understand what equity is and why it matters. Patient stories and equity data help build will, as does helping staff understand how equity relates to their organization's mission and their daily work. Increasing awareness is a necessary step for building will and must be coupled with efforts to improve health equity.

Understand Your Current and Historical Context for Inequities

Health care organizations' interventions and activities have the capacity to perpetuate, worsen, or ameliorate inequities.⁷ Health system leaders have a responsibility to understand, acknowledge, and openly communicate to their staff and community the role that the health system has played in perpetuating inequities and the broader historical context of how the inequities came to be. It can be difficult for individuals to admit that their organization has contributed to structural racism (i.e., a system of advantage based on race) through their policies, practices, procedures, and norms. However, an understanding of the root causes of racism in our organizations and communities provides the best opportunity to find solutions that can address the key drivers of inequities.

Described below are specific changes that health care organizations participating in the Pursuing Equity initiative tested to better understand and discuss their current and historical context for inequities.

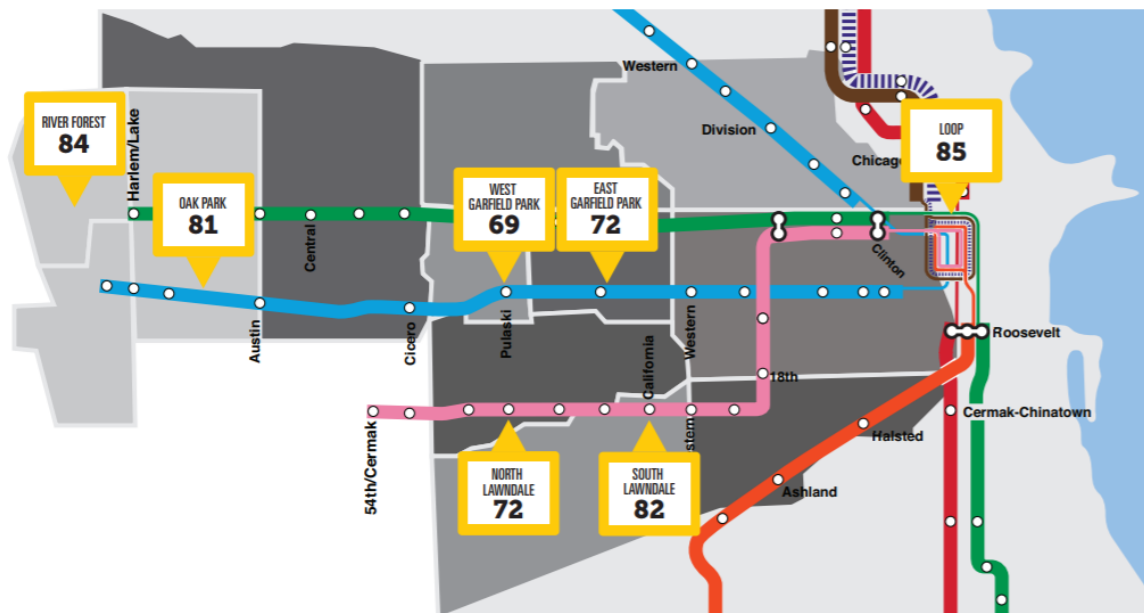
1) Visually map the community to elucidate inequities.

Pursuing Equity organizations found that visuals and maps are useful tools to build will to improve health equity.

Examples of changes tested:

- Rush University Medical Center (RUMC) is the largest employer in West Side Chicago, Illinois. Economic deprivation (including unemployment), poverty, lack of housing, and food deserts are the byproduct of decades of structural barriers in Chicago's West Side. As a result of these factors, life expectancy in the West Side's West Garfield Park neighborhood is 69 years, while life expectancy in the Chicago Loop area (about six miles away) is 85 years. As part of their efforts to build will for improving health equity among staff and community members, RUMC developed a graphic (see Figure 2) to depict life expectancy in different Chicago neighborhoods and to illustrate the effect of decades of inequity.⁸

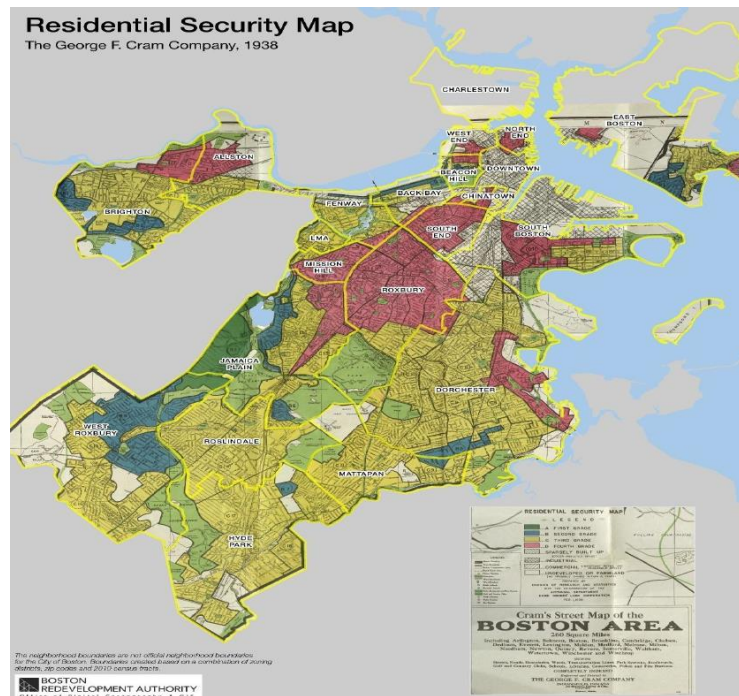
Figure 2. Life Expectancy (in Years) at Birth in Chicago by Neighborhood



- To better understand the history of Boston, Massachusetts, and surrounding neighborhoods, Brigham and Women’s Hospital Department of Medicine and Southern Jamaica Plain Health Center reviewed the Boston Residential Security Map of 1938 (see Figure 3).⁹The Home Owners Loan Corporation created a City Survey Program in the 1930s, which examined the risk levels for real estate investment in cities across the United States, including Boston. The maps used four color-coded categories to indicate each neighborhood’s risk level, with red being the most hazardous and riskiest for lenders. This became known as “redlining”: the process of financial divestment in communities that were primarily people of color, while simultaneously investing in communities that were white and wealthy. Redlining also impacted predominantly white immigrant populations, yet those groups often deserted their communities, perpetuating racial divisions in devalued areas. The effects of these racist policies are still felt in Boston and all other major US cities today.

Brigham and Women’s Hospital Department of Medicine and Southern Jamaica Plain Health Center, both located in one of these historically “redlined” Boston-area neighborhoods, know that access to transportation, health care, food, housing, and education all effect a person’s health. These organizations are thus working to deepen their partnership with key organizations and leaders in these communities as part of their anchor organizational strategy.

Figure 3. Boston Residential Security Map of 1938



2) Invite key community members and organizers who can talk with the health care workforce about the community’s history, to deepen providers’ understanding of the context in which health care is provided.

To build will for improving equity, it is important for leaders and staff to understand the history of the communities in which their health system is located and the organization’s interactions with the community from an equity perspective.

Examples of changes tested:

- Boston’s Southern Jamaica Plain Health Center (SJPHC) invites elders and senior organizers from their community to staff meetings to provide historical context. Many SJPHC staff also have historical knowledge of Jamaica Plain and the surrounding communities. SJPHC Directors of Racial Justice and Equity provide training on using different types of narrative to discuss the historical, cultural, and institutional patterns that have perpetuated race-based advantage. SJPHC uses the Storytelling Project Curriculum¹⁰ as a framework to discuss racism with staff, focused on four types of stories and how to go beyond the stock stories narrative:
 - Stock stories: Public, mainstream stories told by the dominant group and documented
 - Concealed stories: Not public, hidden from the dominant group, and circulated by marginalized groups
 - Resistance stories: Current and historical stories challenging stock stories and describing how racism has been resisted
 - Counter stories: New stories that build on resistance stories and are constructed to disrupt the status quo and deliberately challenge stock stories

SJPHC Directors of Racial Justice and Equity lead the group through a dialogue about the four types of stories and how they present in both the community and the health system. SJPHC discusses how certain stories can perpetuate racism in their community and how other stories have the power to promote racial justice. SJPJC Directors, elders, and senior organizers emphasize the evolution of structural racism over decades and do not personalize the critique of the health system.

Increase Awareness about Equity in Your Organization

Building will to improve health equity in your health care organization is not the responsibility of any single department. Staff in all departments have a role in improving the lives of patients, the community, and employees. Pursuing Equity teams identified that organizations need a common foundation and language that is communicated with all departments to be able to work in congruence across the organization to improve health equity.

Below are specific changes that Pursuing Equity teams tested to increase awareness about health equity throughout their organizations.

1) Share both data and patient stories about health equity.

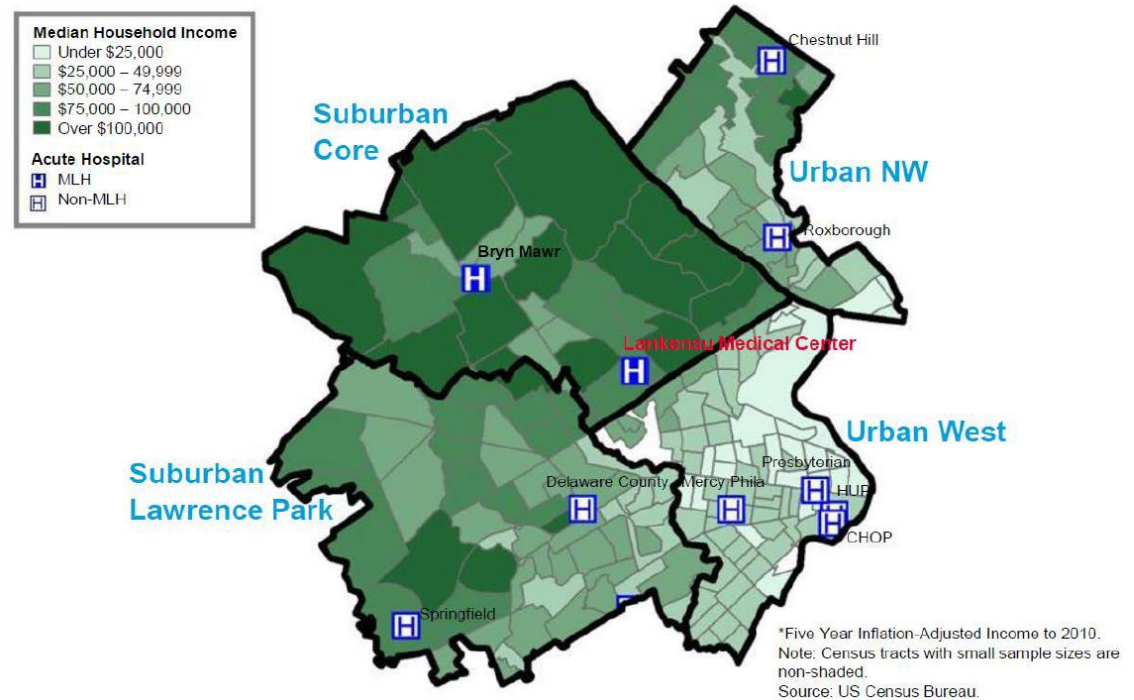
It is important to use data in partnership with narrative when working to increase awareness and make health equity a strategic priority in your organization. Using data to support your efforts to improve equity is vital to communicate and build will by showing the need to leaders, employees, and the community. A data analyst can help you better understand and display your patient demographic data, stratified by race, ethnicity, language, and other factors. (For more detail about using data to improve health equity, see the guide for framework component Build Infrastructure to Support Health Equity.²⁾)

Examples of changes tested:

- Pennsylvania's Main Line Health, which serves portions of Philadelphia and its western suburbs, has reviewed US Census Data on Geography and Income for their surrounding neighborhoods (see Figure 4). One of their acute hospitals, Lankenau Medical Center, is located at the divide between one of the state's wealthiest areas and one of the poorest. Main Line Health uses this data to increase awareness of inequities that exist in their community. Understanding the demographics of the people who comprise your community is vital to serve the values, languages, and cultural beliefs of your patients.

Figure 4. US Census Data on Geography and Income: Philadelphia and Western Suburbs

Geography & Income



- Main Line Health created a multidisciplinary team, consisting of primary care providers, a clinical psychologist, nurse case managers, social workers, a nurse manager, and Medical Student Advocates, to address the complex needs of patients who are the highest utilizers of the emergency department (ED) for primary care types of conditions. The team conducted a social determinants of health screening for each identified patient. One patient had more than 30 ED visits in one year. The multidisciplinary team reviewed the screening results for this patient and identified lack of electricity in the patient’s home as the main driver for the ED visits. Hospital leaders paid the patient’s electricity bill and connected the patient to other community resources. As a result, the patient’s engagement with primary care has increased and he has not been to the ED in more than a year.

Health systems can use patient stories and data about the communities they serve to build awareness about the social factors that impact health, in order to inform their efforts to redesign health care services to improve health equity.

2) Create a shared language for health equity in your organization.

Organizations participating in the Pursuing Equity initiative found immense value in creating a shared language for discussing equity in their organizations. Without the foundational knowledge of and agreement on health equity terminology, organizations often struggle to have meaningful conversations about equity and racism. Develop a glossary of equity terms for use in your organization — a living document that is updated over time — and ensure it’s available for all staff to reference. Equity trainings, discussion groups, book clubs, and newsletters provide additional opportunities to stimulate dialogue, raise awareness, and identify additional glossary terms.

Examples of changes tested:

- Southern Jamaica Plain Health Center created a shared glossary as part of their Liberation in the Exam Room work,¹¹ an initiative in which physicians and other medical professionals from the greater Boston area come together to discuss best practices to integrate a racial justice framework into health care delivery.
- See Appendix A for another example of a glossary developed by HealthPartners (Bloomington, Minnesota).

Challenges and Mitigation Strategies

Pursuing Equity organizations faced several challenges with building will to improve health equity. Here we describe those challenges and the organizations' suggested mitigation strategies, based on their own experience.

- Staff may be resistant to improving health equity and may see this as extra work to fit into their already busy work schedules. Mitigation strategies include framing equity as core to the organization's mission, vision, and values; emphasizing that you cannot have quality and safety in patient care without equity; and instituting a recognition program to reward individuals who are contributing to equity improvements.
- Organizational culture may need to change in order to build will to improve health equity. Mitigation strategies to engage staff in equity efforts include the following:
 - If your organization embraces academia, hierarchy, and credentials, use equity data and research as a shared language to engage staff.
 - If your organization is consensus driven, averse to conflict, and relationship focused, leverage storytelling as a shared language that builds relationships and helps understand varying experiences.
 - If your organization is undergoing a large transition and is risk averse, emphasize that being risk averse can be challenging for the tough conversations required to improve equity; anchor on a strong sense of community and desire for systems to work for all.

Lessons Learned

- People have different experiences and backgrounds. Health care organizations need to develop a common language and create mechanisms for having conversations about equity.
- This is a personal journey as well as a group and an organizational journey. Improving health equity is arguably more intense than improving quality and safety. Encourage leaders and staff to share personal stories to emphasize the importance of equity and the work the organization is doing to improve it.

Tools and Resources

- See Appendix A for a health equity glossary developed by HealthPartners; they first shared the glossary with board members and senior leaders, and now share it with all staff.
- Appendix B contains three tools to help build will and increase awareness and understanding of equity in your organization.

Strategy 2: Include Equity as a Priority in the Organization’s Strategic Plan and Department-Level Goals

Without clarity about how equity relates to the organization’s mission, vision, and values, staff will struggle to prioritize and operationalize equity as a critical part of their work. Pursuing Equity teams recognized the need to articulate equity in the organization’s strategic plan, as well as in department-level goals. Once an organization explicitly includes equity as a priority, then it can establish specific goals, priorities, resourcing, measurement, and accountability for improving health equity.

Examples of changes tested:

- HealthPartners in Bloomington, Minnesota, has a longstanding strategic focus on health equity and diversity and inclusion, with a strong commitment from its consumer-governed board of directors and senior leaders. Since 2005, the organization has included equity and the elimination of racial and financial class disparities in five-year stretch goals called Partners for Better Health Goals (see Figure 5) to improve the health and well-being of each member, patient, and the entire community.¹² To advance this priority, HealthPartners’ leaders focused on equipping employees with the knowledge and resources needed to provide appropriate care and services; engaging communities to learn how to best support them; and improving care through data-driven quality improvement.

Figure 5. HealthPartners: Partners for Better Health Goals 2020



- Main Line Health has included the identification and elimination of inequities in their fiscal year 2019 organizational strategic plan. To advance this priority, the health system’s leaders have articulated the need to improve service delivery, build a reliable data infrastructure, and train staff to recognize biases that lead to inequities in care (see Figure 6).

Figure 6. Main Line Health’s Articulation of Health Equity as a Strategic Priority

Community Health: Goals and Objectives	
Improve the health of the communities we serve	
Goals	Objectives
Seek, identify and eliminate disparities in care	a. Educate staff to recognize biases that result in disparities in care
	b. Provide resources for innovative interventions to support patient compliance in care treatment plans
	c. Improve collection and analysis of data used to determine particular types of health differences that are closely lined with social or economic disadvantages in our communities
	d. Improve language and health literacy services
	e. Build clinical teams with relevant skill sets to meet the needs of select underserved populations
	f. Develop programs for specific patient populations based on: racial or ethnic group; religion; socioeconomic status; gender; age; sexuality; mental health; cognitive, sensory, or physical disability; geographic location; home environment and preferred language

- Health equity cannot be improved within the walls of the health system alone. The mission of Chicago’s Rush University Medical Center (RUMC) is to improve the health of the individuals and diverse communities it serves through the integration of patient care, education, research, and community partnerships. Through this lens, RUMC established “community health equity” as one of the health system’s four key strategies, given its aim to improve health. RUMC talks about community health equity collaboratively throughout the health system and within the community through its community health needs assessment¹³ and community health implementation plan,¹⁴ both developed in partnership with the Alliance for Health Equity, and its anchor mission strategy. The anchor mission strategy aims to improve the economic vitality of Chicago’s West Side neighborhoods through four commitments to the community: hire locally and develop more local talent, buy and source locally, invest locally, and volunteer locally.¹⁵ Through these efforts, as well as through various publications and presentations, both internal and external, RUMC is committed to making health equity a living part of their organizational strategic plan and a vital endeavor within the broader community.

Challenges and Mitigation Strategies

Improving health equity is traditionally not top among the many competing priorities for health care organizations. To help mitigate this reality, Pursuing Equity organizations found value in clearly articulating equity in their strategic plans and linking equity to organizational goals to ensure a prioritized focus on equity amidst competing priorities.

Additionally, Pursuing Equity teams have had success with engaging leaders from across their organizations, at all levels, in efforts to improve health equity. This ensures that equity improvement has leadership support, does not become solely the responsibility of junior staff, and that all staff understand how improving equity relates to their daily work.

Lessons Learned

- Efforts to improve health equity cannot be siloed in one department. For equity to be strategic, it must be part of an organization’s culture, which requires leadership engagement at all levels and departments and staff throughout the organization to work together.
- IHI’s five-component equity framework helps structure organizations’ strategic planning and equity improvement efforts. Using the framework promotes the formation of relationships between departments, such as a health equity team and the quality department, to work toward achieving organizational goals for improving equity.

Tools and Resources

Consider these questions:

- Is equity articulated in your organization’s strategic plan? Is equity included in department-level strategic plans and goals? Why or why not?
- How might improving equity enhance the stated aims of the organization and departments?
- Do all senior leaders and board members understand the importance of making health equity a strategic priority? If not, how might you engage with them in discussions on this topic?

Strategy 3: Demonstrate Senior Leader Ownership for and Commitment to Improving Health Equity

Senior leaders demonstrate their commitment to improving health equity through their actions and behaviors, such as courageously engaging in discussions about equity with staff, patients, and the community; and by creating a safe environment for staff to raise issues related to equity at any level of the organization. Additionally, tying executive compensation to health equity improvements is one way to ensure that senior leaders are accountable for achieving equity goals.

Signal Commitment to Health Equity with Leadership Behaviors and Communication

Leaders in Pursuing Equity organizations tested the ideas described below to signal their commitment to improving health equity in their organizations and communities.

1) Institute equity-advancing policies in your organization.

Leaders signal their commitment to creating a just and safe workplace by instituting equity-advancing policies. Review organizational policies and decisions from an equity perspective: reflect on “Who benefits?” and “Who is excluded by this policy or decision?” and adjust as needed.

Examples of changes tested:

- More than a decade ago, Main Line Health instituted a policy to protect staff against discrimination. Before this policy existed, patients were able to request a new health caregiver based on racial preference and their requests may have been granted; health system leaders subsequently recognized that this practice was contrary to their organizational values. By instituting the anti-discrimination policy, leaders indicated their commitment to equity and creating a culture that rewards those who speak up for equity.

- Vidant Health leveraged its position as the largest employer in their rural eastern North Carolina community to improve health equity and positively impact socioeconomic status, starting with its own employees. Vidant Health leaders increased the minimum wage for employees and encouraged healthy behaviors;¹⁶ African American women, in particular, were most affected by the wage increases.¹⁷ Health care organizations are often the largest employer in many communities. By addressing the economic stability of its own employees, Vidant leaders aim to create a more joyful and healthy workforce through efforts to improve equity in the workplace and in the community.

2) Communicate the importance of equity.

Leaders articulate the importance of equity through ongoing communication with staff, patients, and the community. For example, leaders in Pursuing Equity organizations have written to their staff to stand for or against federal policies, encourage activism among staff, and after racist events in their community have occurred. See Appendix C for examples of letters from two leaders of Pursuing Equity organizations.

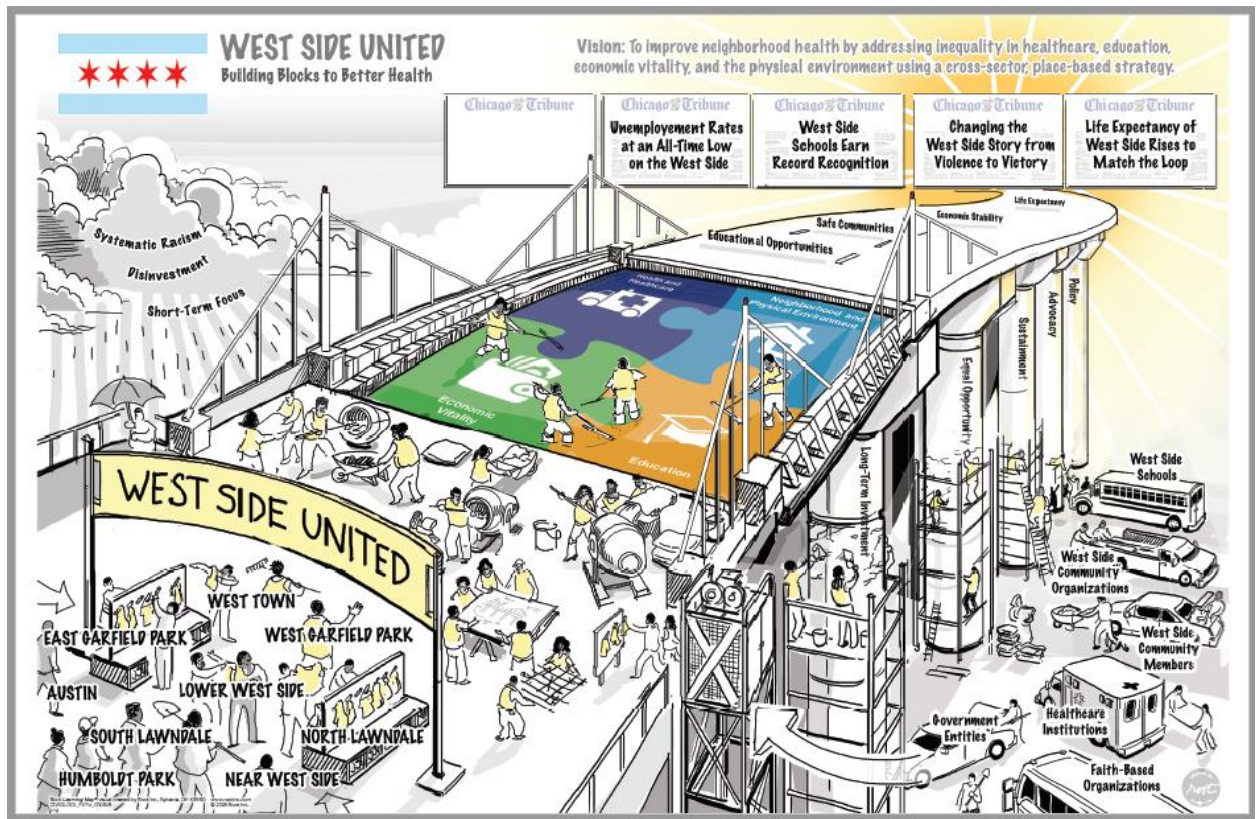
3) Co-develop a shared vision for equity with the community.

Equity messaging and communication should not only happen when there are specific events that occur in the organization, community, or world that prompt an email or meeting. The process of working together to develop and articulate a vision for equity helps both the health care system and the community understand and communicate their shared goals for equity.

Example of changes tested:

- Rush University Medical Center articulated its vision for equity with their community through its role as a founding member of West Side United, a collaborative partnership among residents and organizations aimed at improving health and life expectancy on Chicago's West Side.¹⁸ Figure 7 depicts what stakeholders in the West Side United collaborative identified as assets and opportunities in the nine neighborhoods to improve health and create a more equitable future for Chicago's West Side.¹⁹ This visual is used by RUMC leadership to communicate their shared vision and the partnership within the community that is needed to improve equity.

Figure 7. West Side United: A Visual from the *Root Learning Map*® Experience Is a Metaphor for a Shared Future State Vision of Better Health on Chicago’s West Side



Be Accountable and Transparent in Pursuit of Health Equity

Leaders need to be accountable for equity goals either by tying executive compensation to equity improvements and/or by embedding equity into system-wide annual performance reviews.

1) Tie executive compensation to equity goals.

Example of changes tested:

- HealthPartners includes two equity measures in its executive incentive plan:
 - Workforce diversity: This measure focuses on diversity at the leadership level (supervisor or above roles) and diversity at the professional level (all roles that require a college degree at HealthPartners). These two elements of the workforce diversity measure constitute a total of 10 percent (5 percent for each element) of a HealthPartners executive’s annual incentive payout.
 - Colorectal cancer screening for patients of color: This measure supports one of the organization’s health equity priorities and goals.

2) Review equity data annually, at a minimum.

Examples of changes tested:

- HealthPartners has strong board-level commitment to improving health equity. Equity is a standard discussion item on board meeting agendas, including reviewing performance

metrics stratified by race, ethnicity, and language (REaL data), sexual orientation and gender identity (SOGI data), or other sociodemographic factors. Additionally, board members routinely discuss key terminology related to equity, diversity, inclusion, and racism. An example of HealthPartners board meeting prework includes these resources:

- Take the Implicit Bias test from [Project Implicit – Harvard University](#)
 - Read the IHI White Paper, [Achieving Health Equity: A Guide for Health Care Organizations](#)
 - Read [Population health equity: Rate and burden, race and class](#) (*JAMA* article)
 - Read [Structural racism and health inequities in the USA: Evidence and interventions](#) (*The Lancet* article)
- One way Main Line Health holds itself accountable for equity goals is through its annual Health Care Disparities Colloquium. Every year for the past seven years, the health system tasked its clinical investigators to look for potential racial, ethnic, gender, and sexual orientation disparities across the system. The evidence-based findings are then presented to senior leaders and staff. This self-evaluation enables the organization to identify areas for improvement and provides direction for leaders for establishing system-wide equity goals.

Challenges and Mitigation Strategies

In many organizations, the impetus for improving health equity may originate from junior staff and attaining leadership buy-in may be a challenge. Mitigating strategies include engaging respected champions in the organization who will push equity work forward; highlighting equity efforts at other leading health care organizations and the equity rewards and recognition they receive; and using patient data and stories to create a sense of urgency in your organization.

Lessons Learned

- In leadership communication about equity, name racism explicitly. If you do not name racism, you cannot address it.
- Incentivizing senior leaders who set equity goals and instate organizational policies can be a strong lever to implement change.

Tools and Resources

- See Appendix C for examples of leadership communications about health equity.

Conclusion

Inequities in care contribute to poor health outcomes, high costs for the health system and the individual, and low-quality care.²⁰ There is a moral and financial case for health care organizations to improve health equity. A critical first step is for health systems to make health equity a strategic priority in their organizations. Based on IHI's work alongside eight health care organizations participating in the Pursuing Equity initiative, we hope the recommendations, examples, and tools shared in this guide help health care organizations advance their efforts to make health equity a strategic priority.

Appendix A: HealthPartners Glossary of Health Equity Terms

Population health: Defined in a 2003 article in the *American Journal of Public Health* by David Kindig, MD, PhD, and Greg Stoddart, PhD, as “the health outcomes of a group of individuals, including the distribution of such outcomes within the group.” Health care organizations generally define population in two different ways: either the communities in their geographic service area or the patients actually seen in their organization.

Social determinants of health: Defined by the World Health Organization (WHO) as “the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.”

Health equity: To define health equity, we turn to the work of Professor Margaret Whitehead, head of the WHO Collaborating Centre for Policy Research on the Social Determinants of Health. Most countries use the term “inequalities” to refer to socioeconomic differences in health — that is, health differences “which are unnecessary and avoidable but, in addition, are also considered unfair and unjust.” Whitehead goes on to state that, when there is equity in health, “ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, no one should be disadvantaged from achieving this potential, if it can be avoided.”

The terms “equity” and “equality” are sometimes used interchangeably, but while these concepts are related, there are also important distinctions between them. Equality aims to promote fairness and justice by giving everyone *the same thing*. Equality can only work if everyone starts from the same place and has the same needs. Equity involves trying to understand and give people *what they need* in order to thrive. Equity acknowledges that since people are starting at different places in their education, socioeconomic status, health, etc., they may have different needs, which may mean differentiating resources in order to ensure everyone thrives.

Health disparity and health inequity: Health disparity is defined as the difference in health outcomes between groups within a population. While the terms “health disparity” and “health inequity” may seem interchangeable, they are different. Health disparity denotes differences, whether unjust or not. Health inequity, on the other hand, denotes differences in health outcomes that are systematic, avoidable, and unjust.

Health care disparity: Defined by the Institute of Medicine as “racial or ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention.”

Institutionalized racism: Differential access to the goods, services, and opportunities of society by race. Institutionalized racism is normative, sometimes legalized, and often manifests as inherited disadvantage. It is structural, having been codified in our institutions of custom, practice, and law, so there need not be an identifiable perpetrator. (Camara Jones, Research Director on Social Determinants of Health and Equity and the CDC)

Diversity: All the ways in which we are unique as individuals, encompassing both visible and invisible differences. Some dimensions of diversity include but are not limited to age, gender, race, ethnicity, physical ability, personal/thinking styles, strengths, nationality, relation, socioeconomic

factors, health, religion, sexual orientation, veteran status, marital status, education, language, geographic location, job function, etc.

Inclusion: The practice of intentionally utilizing the unique strengths and talents within each person to drive innovation and support individual, team, and organizational success. It's about engaging, collaborating, and partnering with others. It is about creating a safe, positive, and nurturing environment where everyone feels valued.

Bias: The tendency of our minds to fill in the gaps and make judgments about a thing, person, or group compared with another, usually in a way that's considered to be unfair. Biases may be held by an individual, group, or institution and can be both conscious or unconscious. Everyone has bias.

Unconscious bias (sometimes referred to as *implicit bias*): Refers to the stereotypes and preferences, both negative and positive, that exist in our subconscious, meaning we are either unwilling or unable to articulate them, but they affect our behavior. Unconscious bias is rooted in the fact that the human brain has evolved to instantaneously process thousands of pieces of information by categorizing like things, filling in gaps with our own information, relying on past knowledge/experiences in order to determine whether something was safe and dangerous. The unconscious associations we harbor in our subconscious cause us to have feelings and attitudes about other people based on characteristics such as race, ethnicity, age, and appearance. These associations develop over the course of a lifetime, beginning at a very early age, through exposure to direct and indirect messages and can influence our thoughts, feelings, and actions.

Micro-aggression/Micro-inequity: The everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, which communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership.

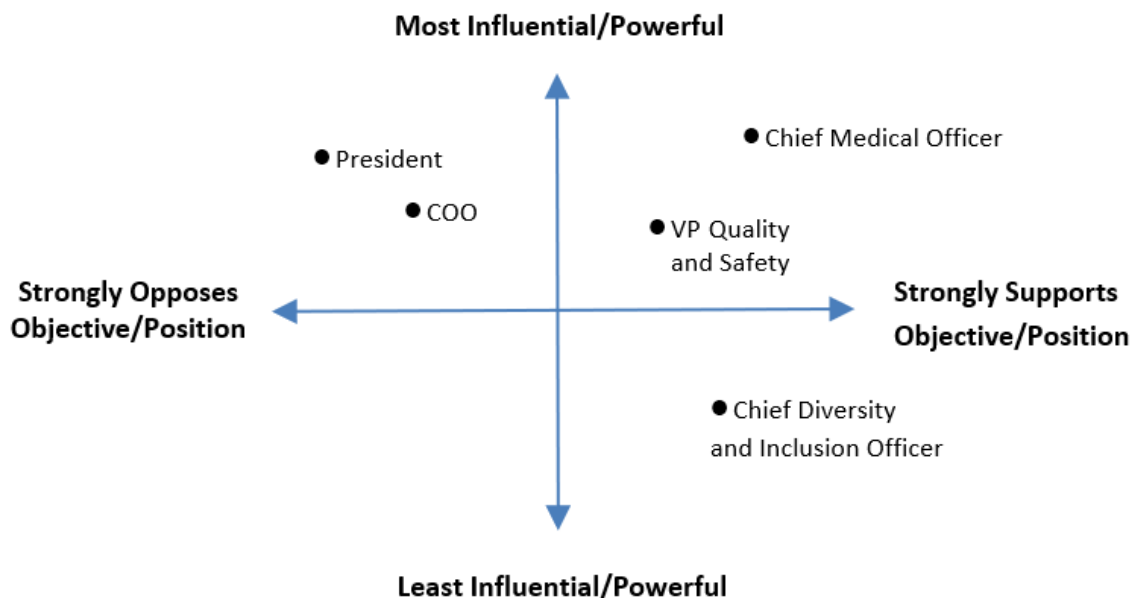
Appendix B: Tools for Building Will to Improve Health Equity

Power Map of Key Stakeholders

This activity will help your organization or team map key individuals in the organization from whom you need buy-in and senior leader commitment to improve health equity. Additionally, this activity will help identify key allies in leadership as well as emerging leaders (e.g., residents).

- Step 1: Draw an X-axis that marks “Strongly Opposes Our Health Equity Objectives” on one end and “Strongly Supports our Health Equity Objectives” on the other.
- Step 2: Draw a Y-axis labeled “Least Influential/Powerful” on one end and “Most Influential/Powerful” on the other.
- Step 3: Identify key stakeholders. Place a dot on the map for each stakeholder to represent their influence in the organization, and the extent to which they do (or don’t) support the health equity objectives. Consider what their priorities are and where they align or misalign with the work.
- Step 4: Once all key stakeholders are on the map, make a plan to have one-to-one meetings to explore each stakeholder’s priorities and how to engage them more directly in the organization’s work to improve health equity.

Example Power Map:



One-to-One Meetings

Building will requires developing relationships and understanding what people value, and how equity connects to those values. It also requires inviting people to engage directly in the organization's work to improve health equity. One approach is to identify specific individuals for one-to-one meetings.²¹ The Marshall Ganz five-step practice of one-to-one meetings²² is a helpful tool for individuals preparing for a one-to-one meeting.

As you conduct a one-to-one meeting, progress through these five steps:

- 1) **Set-Up:** The organizer of the meeting gets another person's attention to dedicate intentional time together.
- 2) **Purpose:** At the start of the meeting, the organizer transparently describes the purpose of the meeting, articulates energy and appreciation, and confirms the end time in order to bound and pace the conversation.
- 3) **Exploration:** This is the heart of the conversation, in which the organizer asks open and honest questions and listens deeply (see below). In an improvement context, the focus is on learning what matters to and motivates people to unleash intrinsic motivation. The organizer of the meeting listens 80 percent of the time, taking mental notes about the other person's values, interests, and assets, while sharing about herself in the remaining 20 percent. This step establishes a basis for an authentic relationship (especially when combined with other practices below).
- 4) **Exchange:** Explicitly name the information, support, challenges, and insights the two people are exchanging during the conversation and explore a possible shared purpose. Invite the other person's view of what is possible; co-production is at play here.
- 5) **Commitment:** A successful one-to-one meeting ends with a clear commitment (i.e., who will do what, by when) to engage in a strategic and mutual exchange of assets.

Approach each one-to-one meeting with the following questions in mind:

- What does this person **value**? What is the person's history of acting on his or her values?
- What **interests** does this person have? How can the work to improve health equity support his or her interests?
- What **skills** and **assets** does the person bring to the improving health equity work?
- What are our opportunities to make a **mutual exchange** (e.g., a possible shared purpose)?
- What **specific commitment** are we making to take action and continue building this relationship?

Words to Describe Your Organization's Culture

This team-based activity will help determine how your organization's culture might advance or hinder efforts to improve health equity. Facilitate this exercise with a group of staff, senior leaders, the board, or other groups in your health care system. This activity was developed by Aswita Tan-McGrory, MBA, MSPH, Deputy Director, The Disparities Solution Center.

- **Step 1:** Each person writes down three words that they think best describe the organization's culture. Consider how each word (or aspect of your culture) interacts with an aim to improve health equity: will it facilitate or hinder health equity improvement? How?
- **Step 2:** One at a time, each person shares one word and briefly discusses how they believe the word impacts the organization's equity goals. Continue going around the group until each person has shared their three words.
- **Step 3:** Finally, include time for large group discussion. Consider how certain cultural factors augment efforts to improve health equity and discuss ways to mitigate cultural factors that impede progress of equity goals.

Alternatively, if you have a large group, have each person write their words on sticky notes, one word per note. Post all sticky notes on a wall. Facilitate an open discussion about the words and how they will impact efforts to improve health equity.

Appendix C: Leadership Communication Examples

Example 1

Vidant Health's Chief Executive Officer, Mike Waldrum, wrote the email below to all employees following a social media post containing racist remarks by a Vidant Health employee.

Team Members,

Any form of hate, racism, discrimination or harassment is absolutely unacceptable. This is especially true in health care and at Vidant Health — which draws strength from the diversity of team members and those we proudly serve.

I was hurt, disappointed and shocked when I learned that a now former team member posted offensive and inappropriate comments yesterday on social media. I want to be very clear: hateful words have absolutely no place in our society, and definitely not at Vidant. We have zero tolerance for discrimination of any kind, which is why we immediately conducted an internal investigation once we were made aware of the situation. After meeting with the individual who admitted to making the comments, the decision was made to terminate her employment.

Unfortunately, this incident is a stark reminder of the racism that is present in our country, including eastern North Carolina. This is a reality that I cannot accept and will always work to change.

While we don't have all of the solutions to these longstanding issues, I have been and remain steadfast in my commitment to an equitable and inclusive environment — free of any harassment or hostility. We all deserve to be in environments that are supportive and caring. That is why we have Experience as one of our operational imperatives and why we have the initiative of Pursuing Equity.

At Vidant, we have more than 12,000 team members whose diverse backgrounds contribute to our inclusive culture and success. I have the privilege of seeing our Values exemplified daily — it's in the compassionate care you deliver, how you interact with other team members and how you serve those in need — no matter your role at Vidant. Thank you for living our values and standing with me against hate and racism.

We take pride in hearing everyone's voice because every voice matters, and I wanted you to hear my views on this critical issue as we continue to work together to improve the health and well-being of eastern North Carolina.

Thank you,

*Mike Waldrum, MD, MSc, MBA
CEO
Vidant Health*

Example 2

HealthPartners President and Chief Executive Officer, Andrea Walsh, wrote the following email to employees on Martin Luther King Day.

Today we remember the life and work of the Rev. Dr. Martin Luther King, Jr. This morning, millions are taking time for conversations and reflection about race and equity in our communities, our workplaces and in our everyday lives. I hope you will, too.

At HealthPartners, we commit to “every person welcomed, included and valued.” For me, our focus on diversity and inclusion is some of our most important work. Every day, with every interaction, we can build trusting relationships with our members, patients and colleagues, and help create a healthier community where all people are respected and thrive.

I spent a morning last week with a family medicine clinician as he cared for and built trust with four patients, none of whom shared his skin color. The clinic lobby was bustling with patients of different race and ethnicity, and our team was welcoming to all. Later in the week, I watched our interpreters skillfully bridge language barriers for a hospital patient and family member. And I attended a meeting in the community, where HealthPartners, as part of the Itasca Group, is sponsoring an effort to make our region’s workplaces more diverse and inclusive.

Each of these encounters reminds me of what we have in common as people. We all want connection, health, and to make our community and our lives better. At the same time, we are diverse in race, language, gender identity and many other things that make us unique. Sometimes our differences make it hard for us to understand each other and work together. Meeting these challenges, together, makes us stronger and better equips us to provide the best care and coverage for our patients and members. No matter who we are, it’s up each of us do more each day to understand, respect and support each other with compassion and humility.

We are making real progress, and there is much more to do. Dr. King’s dream continues to challenge and inspire us. Living our commitment is an important way to play a part, helping to fulfill our mission of improving health and well-being for everyone. Thank you for all you do to keep our commitment to those we serve and to each other.

Andrea

*Andrea Walsh
President & CEO
HealthPartners*

References

- ¹ Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. *Achieving Health Equity: A Guide for Health Care Organizations*. IHI White Paper. Cambridge, MA: Institute for Healthcare Improvement; 2016. <http://www.ihl.org/resources/Pages/IHIWhitePapers/Achieving-Health-Equity.aspx>
- ² *Improving Health Equity: Guidance for Health Care Organizations*. Boston: Institute for Healthcare Improvement; 2019. <http://www.ihl.org/resources/Pages/Publications/Improving-Health-Equity-Guidance-for-Health-Care-Organizations.aspx>
- ³ *NCHHSTP Social Determinants of Health: Definitions*. Centers for Disease Control and Prevention. <https://www.cdc.gov/nchhstp/socialdeterminants/definitions.html>
- ⁴ Jones CP. Levels of racism: A theoretic framework and a gardener's tale. *American Journal of Public Health*. 2000 Aug;90(8):1212-1215.
- ⁵ *Improving Health Equity: Assessment Tool for Health Care Organizations*. Boston: Institute for Healthcare Improvement; 2019. <http://www.ihl.org/resources/Pages/Publications/Improving-Health-Equity-Guidance-for-Health-Care-Organizations.aspx>
- ⁶ Cohen S. *The Concentration of Health Care Expenditures and Related Expenses for Costly Medical Conditions, 2009*. Statistical Brief #359. Rockville, MD: Agency for Healthcare Research; February 2012. https://meps.ahrq.gov/data_files/publications/st359/stat359.shtml
- ⁷ Green AR, Tan-McGrory A, Cervantes MC, Betancourt JR. Leveraging quality improvement to achieve equity in health care. *Joint Commission Journal on Quality and Patient Safety*. 2010 Oct;36(10):435-442.
- ⁸ *Rush in the Community: Working for Health Equity*. Rush University Medical Center. <https://www.rush.edu/about-us/rush-community>
- ⁹ *Mapping Inequality: Redlining in New Deal America 1935–1940*. American Panorama: An Atlas of United States History. Digital Scholarship Lab, University of Richmond. <https://dsl.richmond.edu/panorama/redlining/#loc=12/42.3264/-71.1028&opacity=0.8&sort=221,222&city=boston-ma&adview=full>
- ¹⁰ Bell L, Roberts R, Irani K, Murphy B. *The Storytelling Project Curriculum*. The Storytelling Project, Barnard College; February 2008. http://www.racialequitytools.org/resourcefiles/stp_curriculum.pdf
- ¹¹ *Liberation in the Exam Room: Racial Justice and Equity in Health Care*. Southern Jamaica Plain Health Center. <http://www.ihl.org/resources/Pages/Tools/Liberation-in-the-Exam-Room-Racial-Justice-Equity-in-Health-Care.aspx>
- ¹² *Partners for Better Health Goals 2020*. HealthPartners. <https://www.healthpartners.com/hp/about/partners-for-better-health/partners-diagram/index.html>

- ¹³ *Rush Community Health Needs Assessment Report*. Chicago: Rush University Medical Center; June 2016. <https://www.rush.edu/sites/default/files/rush-chna-2016.pdf>
- ¹⁴ *Rush Community Health Implementation Plan 2017–2019*. Chicago: Rush University Medical Center; 2016. <https://www.rush.edu/sites/default/files/community-health-implementation-plan.pdf>
- ¹⁵ Ubhayakar S, Capeless M, Owens R, Snorrason K, Zuckerman D. *Anchor Mission Playbook*. Chicago: Rush University Medical Center; June 2017. <https://www.rush.edu/sites/default/files/anchor-mission-playbook.pdf>
- ¹⁶ Galvin G. Changing health care from the inside out. *U.S. News and World Report*. April 13, 2018. <https://www.usnews.com/news/healthiest-communities/articles/2018-04-13/vidant-health-workforce-diversity-promotes-good-patient-experiences>
- ¹⁷ Galvin G. Changing health care from the inside out. *U.S. News and World Report*. April 13, 2018.
- ¹⁸ West Side United. <https://www.rush.edu/about-us/rush-community/west-side-united>
- ¹⁹ *West Side United: Building Blocks to Better Health*. <https://westsideunited.org/about-us/mission/#jp-carousel-144>
- ²⁰ Institute of Medicine; Smedley BD, Stith AY, Nelson AR (eds). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: National Academies Press; 2003. <https://www.nap.edu/read/12875/chapter/1>
- ²¹ Hilton K, Anderson A. *IHI Psychology of Change Framework to Advance and Sustain Improvement*. Boston: Institute for Healthcare Improvement; 2018. <http://www.ihl.org/resources/Pages/IHIWhitePapers/IHI-Psychology-of-Change-Framework.aspx>
- ²² Ganz M. *Organizing: People, Power, Change*. Harvard University; 2014.