INSTITUTE FOR HEALTHCARE IMPROVEMENT
INNOVATION REPORT

A Health System Focus on Health Equity
Wave 36: June – September 2015

I. Research and Development Team:

- John Whittington
- Mara Laderman
- Kedar Mate

II. Intent:

Our intent is to develop a framework for health systems to impact the multiple determinants of health on which they have significant impact in order to decrease disparities and provide better health equity. Our goal is to facilitate a movement of health systems that see health equity as a priority. Health equity is achieved when every person has the opportunity to "attain his or her full health potential.[1]" Health equity must become a system property for health care.

III. Background:

This cycle of activity is built off of the preceding 90 days of research. During that cycle we focused on four issues:

1) How to do a better job of communicating what creates health;
2) Identify an overall framework to organize our interventions;
3) Discover where progress has been made in improving health equity through outlier analysis;
4) Identify a global measure of disparity that takes into account geography, gender, race/ethnicity and socioeconomic status.

For more detail please see the final innovation report from Wave 35,, "Exploration of Health Equity."

Health equity is produced by multiple determinants, some of which are far upstream from health care. This is a very broad field and it would be easy to get lost. Based on interviews and discussion, we propose that IHI should help health care systems work on the multiple determinants of health that they can directly influence.

IV. Description of Work to Date:

1. Identify health care organizations that work on multiple health determinants and collect examples of their work. - completed

[1] http://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/overview/healthequity.htm

2. Work with and test ideas with health care organizations that are interested in working on health equity. – in progress
3. Build a basic change package and opportunity assessment tool. This may include a modified driver diagram. - in progress

4. Pursue additional outlier analysis work at the county level, including additional exploration on Rhode Island, which has had the largest decrease in the black-white disparity in mortality rates from 2000 - 2013. – We are holding off on this for now.
6. Support work around identifying a global measure of disparity. – on hold for now
7. Support work around low income elderly housing in Montgomery County, Maryland. – See Appendix A

We conducted interviews with 28 individuals who are involved in health care equity and read books and other literature on this subject.

- Ed Rafalski — Methodist Healthcare in Memphis
- Tyler Norris — KP
- Monica Peek — University of Chicago
- Kohar Jones — University of Chicago
- Brenda Battle — University of Chicago
- Ron Wyatt — Joint Commission
- Kimberlydawn Wisdom — Henry Ford
- Beth Waterman — HealthPartners
- Patricia A. Oceanic — Nemours
- Concepcion Trevino James — Contra Costa
- Anna Roth — Contra Costa
- Duffy Newman — Contra Costa
- Arthur Kaufman — University of New Mexico
- Cheri Wilson — RWJ Hospital System-just starting
- Knitasha Washington — Independent Consultant
- Michael Griffin — Daughters of Charity
- Jamahal Boyd — Mercy- Cincinnati
- Lemuel L. Dent — RWJ Health Policy Fellow
- Rob Kahn — CCHMC
- Dawn Dinno — CCHMC
- J Lloyd Michener — Duke
- David Labby — Healthshare Oregon
- Matt Stiefel — KP
- David Baker — Joint Commission
- Patty Kehoe — Molina Healthcare of New Mexico
- Eugene Sun — Blue Cross Blue Shield of new Mexico
- Roger Strasser — Northern Ontario School of Medicine

- Steven Wartman Association of Academic health Centers

In addition, we have supported work in Montgomery County, Maryland around low income elderly housing and we are doing work in Green Bay on poverty (see Appendix).

V. Results of the 90-Day Scan:

Health care needs to do a better job of providing quality health care for all, and they need to do more in closing health care disparity gaps, but that is not enough. For example, health care can expand its role in both prenatal care and early childhood care from a typical medical model to a model that looks at this period of time as part of life course, identifying children who are at risk for social, developmental and physical needs. They need to have hiring practices that facilitate the inclusion of women and minorities. They need to work with their own employees, some of whom live near poverty, such as housekeepers and custodians. They can improve the career tracks for lower educated employees. Health care organizations can think about where they build facilities and who builds those facilities for them. Many health systems are physically located in very poor areas and they need to be more involved in supporting their adjacent neighborhoods (geographic service area) and not just their market service area. Health care organizations need to work with their procurement department so they consider suppliers who are providing jobs to women and minorities. Many health systems have significant capital that they invest in traditional investments: stocks, bonds and other investment tools. However, some are now starting to invest money in their communities for both financial gain and community improvement. This is beyond the typical community benefit model, though community benefit may be a part of this.

For health systems to have a larger impact on health disparities, an "all in" strategy is necessary, which brings together financial investments, human resources, information technology, procurement and building policies, community health needs assessment, community benefits and leadership, to work on health equity.
The following is a list of opportunities that a health organization should consider as they work on the multiple determinants of health to improve health equity. While it is not an exhaustive list, these are some examples of strategies that can be used to address each determinant. The goal is to improve health equity.

- Healthcare
    - Make health equity a system property.
    - Decrease systemic racism in the provision of health care.
    - Improve access - build trust.
    - Co-design and co-produce health and care with patients.
- Socioeconomic status
    - Recruit, retain and develop all staff, including non-clinical support staff .
    - Encourage procurement practices from suppliers that employ a diverse workforce.

    - Build in deprived areas.
    - Use builders that that employ a diverse workforce.
    - Consider a living wage.
    - Work with adjacent neighborhoods when hiring and building facilities.
- Behaviors
    - Create health ambassadors.
    - Have neighborhood campaigns around engaging in healthy behaviors.
    - Partner with community businesses (such as barbershops) to encourage healthy behaviors and seeking preventative health care (e.g. cancer screening).
    - Develop partnerships for healthy activities.
    - Improve the health behaviors of your own employees through multiple methods of support.
- Physical Environment
    - Change physical plant.[2]
    - Create community spaces.
    - Fund parks, walking trails, etc.
    - Make health care investments beyond community benefit that are invested back into the community.

Limitations: One problem with a list is that it does not show the interaction between the various components. As we discussed in the previous paper on health equity, those models that do show the interaction become fairly complex and overwhelming, so we'll continue to use a list of opportunities as a method to facilitate uptake of these change ideas. Another problem with this list is that it does not give prioritization to any one idea. Health care organizations should consider the work on health care equity as a top priority. Lastly, the list of ideas above is not meant to be exhaustive, but as a starting point for health organizations to consider the full range of opportunities to improve health equity.

Draft Change Package

The following are some practical steps for health organizations working on health equity that form the basis of a basic change package that will continue to be tested and refined.

Step One:

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[2]Redesigning the Hospital as a Community Health Network http://www.rwjf.org/en/culture-of-health/2015/09/redesigning_the_hosp.html

Analyze: Study the variation (re: equitable outcomes) in your service population today and see where the biggest gaps are. This requires a data system that tracks race, language and ethnicity, or at least some of these elements. Tracking patients' socioeconomic status (household income, education) would also be very useful.

Analyze: Look at HR practices to assess support for recruitment, retention and development of the work force. Are you paying a living wage for all employees? Are your suppliers and builders employing a diverse work force? Are you and your suppliers and builders employing members of the local community?

Analyze: What work are you are doing with either community health workers, health ambassadors or faith based network partners? What impact is it having on health behaviors in the community? How are your own wellness programs doing with your employees?

Analyze: Where do you choose to build facilities? What impact is that having on the neighborhood? How is your physical plant impacting the community? In what ways do you impact the surrounding neighborhoods?

How do you coordinate HR, investments, community benefits, community health needs assessments, and information systems to achieve results for health equity? Do you have a committee structure that supports collaboration between these disparate groups? Do you have a department dedicated to health equity?

Step Two:
Action: After doing this baseline assessment, you should be able to develop a strategic portfolio of work that will improve health equity. Use the list of opportunities from page 2 and 3 to measure the breadth of work that you can accomplish. It would be better to focus on just a few at first.

Action: The next step is obvious, but hard, and that is to implement the portfolio and measure and evaluate its impact over time.

VII. Conclusions and Recommendations:
The time is good for IHI to engage health systems on health equity. There are several organizations actively pursuing health equity and many have expressed interest in this area.

Opportunities to apply what we are learning:

1. In the next 90 days we will start working with AIAMC on a health equity collaborative- this will be low key.

2. In November there is a meeting with a strategic partner that wants to focus on health equity.-

3. We will have a call with the Association of Academic Health Centers to discuss possible work together.

4. On October 29th, we will have a WIHI on this subject to build interest and find health organizations that want to work on this together.

Further development we need to do:
1. More analysis of our data
2. More work on measures
3. I think we might want to tackle more about systemic racism in healthcare and work on practical steps to alleviate it. I think maybe the opposite side of this issue in a positive way is " to make health equity a system property for health organizations." What did the VA do right that led to

lower all-cause mortality and incidence of coronary heart disease among black veterans compared to white veterans?[3]

VIII. Open Questions:
Something that we should continue to think about is:
*Allostatic load=Hazard * (Vulnerability – Resources)*
Where Allostatic load "the wear and tear on the body" which grows over time; Hazard is a condition posing the threat of harm; Vulnerability is the extent to which persons or things are likely to be affected; and Resources are those assets in place that will diminish the effects of hazards. [4]

IX: Appendices:

Appendix A Montgomery County Summary

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[3] http://circ.ahajournals.org/content/early/2015/09/18/CIRCULATIONAHA.114.015124.abstract

[4] http://svi.cdc.gov/

Montgomery County, Maryland is an affluent county outside of Washington, DC with approximately 50% minority residents and a high immigrant population. Many residents have low English proficiency and either no primary care physician or a poor relationship with their PCP.

The Montgomery County Housing Opportunity Commission (HOC) runs seven buildings for approximately 2-3 thousand low-income elderly (65+) and some disabled residents, many of whom are dually eligible for Medicare and Medicaid. The buildings are independent living, so residents generally receive health care and social services elsewhere. Each building has a counselor, who is usually a social worker, and a manager who runs the building. A few years ago, the HOC did some initial work to connect one building's (~120 residents) counselors with hospitals to work on medication management. There were no extra funds associated with this project. This work has continued over the past few years and is now more formal and organized. The HOC wants these buildings to be a model of the built environment that also provide services that are accessible to residents. There is still no extra money for this work, but it is their mission and increasing access to the health care field has been very valuable for this group. Tom Nolan has been supporting this effort.

The HOC recently created a steering committee (H.E.A.L.T.H. Partners) of the building managers and executives to define the needs of their residents – not just about health. There are different stakeholders at the table, including hospitals, physicians, pharmacists, and various service providers. Their "customers" are the residents and the building's counselors. The group is enthusiastic about working together. As this steering committee defines need for health care and social services in the county, how will this affect equity in the county? This provides an interesting test for whether we can analyze available community data and identify vulnerable community members' needs, and how we might be able to address equity through learning and improvement. The next step, of course, is how to connect these identified needs with services in the community.

They have some good data sources, namely from EMS about emergency calls to any of the buildings. The building counselors receive a daily alert from EMS with the previous day's calls and the reasons for the calls. Additionally, the area QIO provides data on admissions, readmissions, and other measures, and the Maryland all-payer database is coming online.

Using data from the Montgomery County Fire and Rescue Services, we compiled different data displays and analyses to assist the steering committee in understanding how the building's residents interact with EMS and hospitals. These included:

1) Identifying the hospitals to which residents from each building are transported.
2) Common complaints that resulted in EMS calls among residents across buildings.
3) High utilizers of EMS services for each building for targeting.
4) Run charts of EMS calls from 2014 through present for each building
5) Standardized EMS calls for each building to facilitate comparisons across buildings
6) EMS calls and transports per month for each building, to identify buildings where residents called EMS but were not transported

The charts and other data are included in the appendix of the innovation report.

These data were well-received and will be used to support additional inquiries and several different tests to be run by members of the steering committee. Some recommendations put to the committee include:

- Testing and learning
    - What is driving the increase in calls at Forest Oak? Is it an improvement for residents or waste?
    - Hospitals and social service agencies use EMS time series to learn about effectiveness of relevant programs
- Resident centered
    - Investigate in depth the two high utilizers at each building. What needs are not being met? What services and support are best for each? Test a customized approach. (Nexus Montgomery?)
    - Develop and test a process for using daily alerts
- Measurement infrastructure and spread
    - Develop the infrastructure, including responsibility, for collecting, publishing, and analyzing EMS data at various geographical levels
    - Spread to other buildings in HealthPartners

As this work continues we will identify additional areas in which we can support this group, and will follow along to see how the tests they run and the learning system Tom is supporting can help the steering committee identify the needs of their residents and work on improving equity among these underserved elderly residents in Montgomery County.

Appendix B Poverty reduction drivers from Green Bay Workshop.
The figure is the output of community work on poverty reduction for North East Wisconsin.

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Driver Diagram: July 21st Poverty Reduction Initiative Stakeholder Meeting