INSTITUTE FOR HEALTHCARE IMPROVEMENT
INNOVATION REPORT

Health Equity as a System Property for Health Care

Wave 37: October- December 2015

I. Research and Development Team:

- Laura Botwinick
- Mara Laderman
- Kedar Mate
- John Whittington
- Ron Wyatt

II. Intent: Our goal is to decrease health disparities while increasing health for all. We want to facilitate a movement of health systems that sees health equity as a priority. Health equity is achieved when every person has the opportunity to "attain his or her full health potential.[1]" Our plan is to develop a framework to enable 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. Based on the development of our framework to date, we want to focus this cycle of research on understanding systemic racism in health care and making health equity a systems property.

III. Background:

Encouraged by the board and supported by leadership, IHI is focusing significant energy on health disparities and health equity. There are multiple strands of work at IHI on health equity: 100 Million Lives including Spreading Community Accelerators through Learning and Evaluation (SCALE), Better Health Lower Costs Collaborative, Triple Aim in a Community, IHI Diversity and Inclusion Council and R and D work which we will report on in this article.

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

During this past year we had 4 cycles of work that contribute to health equity. The first three cycles of work have been previously been reported.[2] [3] [4]

In summary, the first cycle of research, IHI wave 34, focused on the not for profit requirement for health systems to do a community health needs assessment (CHNA) and health benefit. Community benefit spending has traditionally focused on service delivery. The majority of CHNAs focused on service capacity issues, e.g. access to services and clinical care. There is opportunity to improve the CHNA process as a catalyst to work on population health improvement, and to link the CHNA findings and implementation strategy with community benefit spending. There were 6 recommendations:

1. Build will within hospitals and the community to pursue this work.
2. Conduct a CHNA that effectively captures the community's most pressing health needs as well as community assets.
3. Increase collaboration on community health assessments and implementation plans between multiple hospitals, public health departments, and community organizations.
4. Move beyond identification of needs to prioritize and select population health needs that will be the focus of the implementation strategy.
5. Better link CHNAs to the allocation of community benefit resources to address population health needs.
6. Measure impact with a mixed methods approach and a shared data system.

The second cycle of health equity research, IHI wave 35, concentrated on 4 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 of states and counties.
4. Identify a global measure of disparity that takes into account geography, gender, race/ethnicity and socioeconomic status.

---

[2] Linking Community Health Needs Assessments, Community Benefit, and Population Health Innovation Final Report Wave 34: January – March, 2015 IHI available on request

[3] Innovation Project Final Report: Exploration of Health Equity Wave 35: April - June, 2015 IHI available on request

[4] A Health System Focus on Health EquityWave 36: June – September 2015 IHI available on request

The third cycle of health equity research, IHI wave 36, built directly upon the work from the preceding cycle. We advanced 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. Health care represents 18% of the GDP and 10% of all employees in the US and therefore is an anchor organization in the community and has the opportunity to have some impact on the multiple determinants of health. We described four key drivers with secondary drivers, and a fifth has been added in the current wave:

1. Socioeconomic status
   –Recruit, Retain and Develop all, including rank and file employees.
   –Encourage procurement practices from suppliers that use a diverse workforce.
   –Build in deprived areas.
   –Use builders that have a diverse workforce.
   –Consider a living wage.

2. Physical Environment
   –Change physical plant.
   –Create community spaces.
   –Fund parks, walking trails, etc.
   –Make Health Care investments beyond community benefit that are invested back into the community.

3. Behaviors
   –Create Health Ambassadors.
   –Have neighborhood campaigns.
   –Develop partnerships for healthy activities

4. Healthcare
   –Make Health Equity a system property.
   –Decrease Systemic Racism in delivery of care
   –Improve Access - Build Trust.
   –Co design and co production
   –Primary Care

5. Community Partnership
   - Connect with community members, organizations, and leaders – “nothing about me without me”
   - Advocacy – Influence local, state, and federal policies that impact health equity

Because our focus in wave 36 was primarily on what health systems can impact directly, we did not include community partnerships initially. We believe strongly that community partnerships are important to improve health equity for the entire population of a community, but there is much that health systems can do even before factoring in the partnerships, so we wanted to emphasis the first 4 issues above.

Now we are prepared to work more on the two big issues during this cycle of activity: making health equity a system property and reducing systemic racism. These issues in part are opposite sides of the same coin. When health equity becomes a system property we are reducing systemic racism and discrimination. For example, today we are often unknowingly using quality improvement skills that have the potential to increase the disparities within a group. It would not be unusual for us to design a certain process to improve the health of 80% with a plan to develop a special design for others who don't fit that plan. We might even be hopeful that we will accomplish goals that get our quality measures to 95% of what we are trying to accomplish. But what we have learned over the years is that 5% of the population drives 50% of the cost. We must start our design by thinking about individuals who are at the margins and figuring out how to be successful for them.

Building on this research we have worked on understanding more about systemic/ institutional racism and developing some guidance on what a health organization needs to do to make health equity a systems property and we will discuss that in this report.

IV. Description of Work to Date: Interviews, presentations, literature

Deliverables:
1. We are going to continue work on measurement- Mara
2. We will work more to understand Rhode Island, to look at what is possibly causing their improvement- TBD if we can get to this
3. We will do more county-level analysis- TBD if we can get to this
4. We want to identify a set of activities that lead to or perpetuate systemic racism within health systems
5. We want to identify good examples and principles making health equity a systems property

Activities:
1.Visit with IHI Fellows in Memphis, presented on health equity October 5th
2. Participated in the AIAMC collaborative October 16th and 17th Chicago, Illinois on Health Equity and subsequent follow-up call.

3. WIHI: How Health Care Organizations Can Create Equity in the Community October 29th
4. Visit to Akron Ohio for IHI Triple Aim in a community November 2nd-3rd
5. Discussion with AAHC regarding collaboration on Health Equity on November 4th
6. Conversation with Ascension November 5th - Tamarah Duperval-Brownlee, MD, MPH, MBA, FAAFP
7. Presentation to BHLC community on health equity November 10th. Follow-up conversation with BC/BS, Medicaid TN, and Northwest Colorado Visiting Nurse Association
8. Visit to Marion County, Florida, Triple Aim November 12th and 13th
9. Strategic Partner Meeting with Kaiser, November 17th - Presented the 2015 year of IHI R and D research on health equity.
10. Support of the N.E. Wisconsin Regional Council Poverty Reduction Initiative October 19th, November 9th and November 23rd
Vice President, Care Excellence
11. Presentation to Primary Care Behavioral Health Collaborative December 3rd
12. Discussion with Andrea Werner, VP, about Bellin's work on health equity. We have been sharing back and forth on IHI research and their work.

V. Results of the 90-Day Scan:

We will include three sections in our results. First, a section on what we learned by interviewing patients and attempting to understand systemic/institutional racism, second, a section on defining health equity as a system property and thirdly, a section on what we learned from various activities during this cycle of research.

1. Lessons from Interviews with Patients and Family Members

To get a better understanding of what institutional racism looks like in health care, we wanted to view the system through the experience of patients of color. We interviewed a patient, and obtained videos of patients from the AMA's Committee to End Health Care Disparities. We also talked with three health care providers of color who care for underserved populations (two physicians and one nurse). These three clinicians have led focus groups and interviewed patients of color, so their observations reflect patient and community input.

As a reminder, in trying to better understand structural/institutional racism for this R and D wave, we want to describe what structures, norms, rules, regulations, and policies *that health care organizations have control over* contribute to health disparities. What follows are issues that come from our interviews to help illustrate what institutional racism looks like in health care organizations.

- **Unconscious Bias**. There is a growing literature about unconscious bias in health care. David R. Williams and other scholars have contributed to building this evidence base. A full discussion of this issue is beyond the scope of this paper, but it is a critical issue, and so we have built this into the driver diagrams for addressing health equity. In interactions with patients, unconscious bias can manifest in how patients are treated by:

    - Healthcare providers and staff. This manifests in how patients are treated, in terms of communications, with respect to treatment protocols, and even for pain.
    - Receptionists and other greeters. One person described the disrespect by the receptionist to the patient that was at the a clinic for care.
    - People in financial billing. One person described an interchange related to a billing issue where the individual felt that a white person would not have been treated with the same disrespect.

  Unconscious bias also impacts the hiring and promotion of staff, clinicians, and faculty. It impacts the priorities of health care organizations that leaders select. It is a phenomenon that can be addressed and countered if we become aware of our unconscious bias and take actions to redirect our responses.

  There is also the related issue of internalized racism. This is described in black communities with the saying that " the white man's ice is colder". This kind of thinking leads people of color to buy into the dominant race's view of the stigmatized race. Dr. Camara Jones discusses this phenomenon in her paper, *The Gardener's Tale.* It in part explains how individuals of color in positions of power can also act in racist ways.

- **Diversity in hiring at all levels of the organization.** This is a critical issue that impacts care of patients, activities of the health care organization, and experience of staff.
    - Leadership teams and Boards need representation of people of color. While this may seem harsh to say, having a majority of white decision makers needs to be viewed as institutional racism. This is about access to power, the power to make decisions about the community being served. Access to power is a component of institutional racism.
    - Organizations need to actively attend to hiring a diverse workforce. Then once hired, they need to support and mentor staff of color to assist them in moving into progressively more responsible positions and positions of leadership in the organization.

- Diversity on teams, committees and panels. We were encouraged to engage white people in discussions of how systems of privilege are enforced, as it is helpful for people to hear from people who have similar backgrounds. Attention can be focused on how certain norms are so readily accepted, such as how can it be acceptable to have an all white panel of experts, or an all white team working on important issues? What are our behaviors, assumptions, and beliefs?
- The race and ethnicity of health care providers need to be representative of the community. There is a phenomenon is called "provider concordance". Lack of patient–physician race and ethnic concordance is linked with racial and ethnic disparities in health care. (Commonwealth Fund, Cooper and Powe, 2004). One study using the Implicit Association Test (IAT) examined responses of 2535 self-identified physicians. Seventy percent revealed they implicitly preferred whites to blacks. White physicians, most of this sample, revealed the strongest implicit white preference. Black physicians showed no implicit preference for white or black Americans (Sabin, Nosek, Greenwald & Rivara, 2000).

- **Physical Space – Buildings and Design**. The issue of the physical space came up in all our conversations. It came up in terms of the design of the buildings, the condition of the buildings, the difficulty in getting to the health care organization, the parking facilities, and even which patients get cared for in which buildings. Health care organizations need to think about whether they are creating a welcoming atmosphere for poor patients and patients of color.
  - Access to the health care organization via public transportation may be difficult.
  - The décor of the facility may be welcoming of not. Signage might send messages that patients are not trusted or welcome. The interior design might reflect the culture of the neighborhood being served, or not.
  - Parking can be a big issue. For inner-city hospitals, the charge for parking can be beyond what poor people can afford.
  - Cleanliness of the health care facility can be an issue, particularly in areas of the facility where primarily poor patients and patients of color receive care.
  - Wait times can be an issue. Regarding waiting time in the ER, "We can wait for hours in the ER waiting room and then get back into the ER and there is no one in back".
  - Design of the buildings themselves. Many older hospitals were built for the ease of the physicians to access their offices, not for the patients to access health care. The buildings are difficult to navigate, and the ER can even be tucked in difficult to reach areas of campus.

- When new wings or new buildings are built, the patients with diseases that are more lucrative to the institution may get housed in the shiny new facilities. The poor patients and patients with chronic disease have commented that they feel they are going to the old hospital because they are poor.
- Many hospitals have special access for VIPs, and wealthy patients. These special services may even be provided in a nicer setting, and are provided with the convenience of patients as the priority.

- **Location of Service.** There is increasingly more discussion about "place-based strategies" in addressing disparities, that is, providing care for patients "where they live, work, play, and pray". Providing care only in our institutions is a structural issue that promotes disparities. In addition, demanding patients come to us can be viewed as an act of privilege as it is an expression of power. Getting beyond the walls of the health care organization and into the community is a way to counteract structural issues. A greater focus on population health management is helping organizations think differently about how they deliver health care. Health care organizations participating in shared savings models are now seeing a business case for population health management. This is causing organizations to think in new ways about how to reach the poor and people of color. We heard from our interviewees:
  - "Young black men of a certain age don't think about health care. They are concerned with other matters related to survival. How do you get young men to care about their health?" We are now seeing better examples of how to reach these hard-to-reach populations.
  - "Different strategies are needed for reaching young women of color than for reaching young men."
  - "Poor people don't have experience with accessing the health care system. People who have never had insurance don't know how to establish relationships with providers, or even how to refill prescriptions."

- **Insurance Plans**. Another structural issue that came up in our interviews was the type of insurance that the organization decides to accept. The passage of the Affordable Care Act enables many more people to have access to health insurance, but it does not necessarily result in people having access to health care organizations.

  - Health care systems are making decisions about which insurance to accept and which not to accept. In many cases, poor patients and patients of color are being denied access to health care by virtue of the type of insurance that is accepted.

- Providers have different tracks for Medicaid patients and others. They establish a certain number of slots for Medicaid patients, and those patients have to wait for appointments in that queue. Others can get right in.
- Medicaid pays less than Medicare or private insurance, so health care organizations speak about "improving their patient mix." "Improving patient mix" is a euphemism for denying care to poor people and people of color. This issue of the financials is difficult, because there are policies at the state and federal government level that health care organizations have no control over. But it would be important to evaluate how organizations can respond to those policies in a way that promotes equity. And health care organizations can commit to advocating for changes in laws and policies that are promoting health disparities.
- The new insurance plans and options are very confusing. One knowledgeable community member said she spent time with the Health Navigators who were charged with explaining the plans, and they could not explain them well, and sometimes gave incorrect information. Health care organizations can do more to help explain these plans to their constituents.

- **Trust in the health care system**. Patients of color talk about the lack of trust in the health care system.
  - Patients of color wonder if white people are getting better care. "I always wonder, am I getting the recommended treatment."
  - It is about "who do you know" if you want to access the right doctors, services and treatments. Poor people of color don't have access to those connections.
  - "Researchers go into communities and treat them like a petri dish." This promotes distrust in the health care organization.
  - A black woman went to the gynecologist with fibroids and was given only the option of a hysterectomy. She had researched the condition and knew there were other alternatives but her physician would not discuss them with her, even when she asked about it.
  - Every Black family knows about the Tuskegee experiment. It is part of the conversation in every Black family, and it gets passed down through generations.
  - The story of Henrietta Lacks is also well known throughout the black community.

Another issue that came up in this R and D wave was about the terminology that we use when we discuss the sensitive topic of racism in health care. We received cautions about using this language so we don't alienate people from the start by talking about

institutional racism. It was suggested that we could increase openness to discussion by framing the issue in terms of "lack of a stratified patient-centered approach to care." Health care leaders thinking about population health outcomes may be open to the message that "systems designed for healing of many may not satisfy the needs of the few; and there can be a drag on the outcomes for all if we don't address the needs of the few."

Our team has discussed this issue of terminology and feels that it is important to talk about racism directly. However, we understand the need for everyone wanting to address disparities to be strategic and to understand their audiences. Even major professional association publications insist on using language like "racial bias" instead of racism. Perhaps in some cases there may be a need to engage people using less direct language at first, and eventually get to the issue of racism. Perhaps we all will get more comfortable talking about racism as we use the words, and as the evolution of current events changes the conversation. David R. Williams discusses racism in terms of it being a part of being human. He said that we all have grown up in a culture that is imbued with racial stereotypes and we are all impacted by them. We need to become comfortable discussing racism and learn how to see racism in our institutions in order to do something about it.

2. Health equity as a system property for health care.

The health disparity related to race, economic status, and geography is astounding in the US. Any health organization that is serious about tackling these issues must come prepared to make health equity a system property. This is not an issue that can be delegated away. It will take a major commitment. Many organizations just have too many issues to deal with right now. However, for a few who believe they are prepared, we want to explain what we mean by system property.

We identified 6 concepts that would make health equity a system property for health care. Keep in mind that in the previous cycle of research we focused on all of the multiple determinants of health and a broad approach that health care could take with each of them. In this wave we are focusing more on health care and how we can directly decrease disparities related to health care gaps.

1.Health Equity is a strategic priority for the health care organization
2.Organizational committee structure is in place to support health equity with the technical expertise to close the gaps in disparity. This requires a budget that provides an adequate level of resources to address health equity.
3.Race, language and ethnicity data is collected on all encounters with the healthcare organizations. Resources are supported to analyze variation and to decrease disparities in health care outcomes that are found.
4 Quality improvement work is started always by first considering underserved and how the improvement might benefit them. The resources needed to achieve equal outcome

will not be equal for all populations and the organization is willing to build that into the work.
5.Build in consideration for the multiple determinants of health when designing quality improvement work.
6. Training on institutional racism- raising consciousness-diversity considerations when hiring employees are all taken into consideration.

In the following sections we will build out each of these concepts that we just listed. Only a strategic priority will get the leadership commitment that is needed to sustain this work and effort. Because of the magnitude of the issue, it needs to be strategic. For example, Bernard Tyson, CEO for Kaiser Permanente, has been a strong advocate for the elimination of health care disparities. Healthcare organizations need a voice at the top advocating for change. If it is strategic, it will require sustainable funding. Traditional business models such as fee for service are ineffective for this type of population effort. Funding methods such as those used for accountable care organizations are a start in the right direction because they reward population level interventions. Even more robust reward models such as full capitation will probably be needed. As health systems take on population level financial risk, decreasing disparities in health outcomes is no longer seen as something nice to do, but as a requirement for managing the financial risk of populations.

A health equity strategy requires an organizational structure that can manage the work. Since so many elements are needed: hiring, procurement, planning for new buildings, internal training, and care management redesign, a committee structure is required to enable people to work together. Tyler Norris from Kaiser Permanente has said they need an “all in” strategy to make this happen. At one level health equity should be everyone’s business. However, without a director it is doubtful that the resources and attention will be adequate to make a significant impact. Kimberly Dawn Wisdom, Senior Vice President of Community Health & Equity and Chief Wellness Officer at Henry Ford Health system provides leadership to a department that has the significant resources to impact health equity.

The third of our fundamental components deals with the acquisition and analysis of race, language and ethnicity data and resources to do the analysis of this data. This data is basic to understanding healthcare disparities. This data has not always been available in health care organizations. Through the American Recovery and Reinvestment Act of 2009 incentives were put in place to promote the adoption and meaningful use of interoperable health information technology by hospital and eligible health care professionals. Stage 1 implementation required recorded demographic data which included: preferred language,

gender, race, ethnicity and date of birth.[5] Now that health systems have this data they need to look for disparities both in care and more importantly health outcomes. A nice example of understanding disparity and closing that gap comes from the work by HealthPartners in Minnesota, which identified significant gaps in mammography and colonoscopy rates and worked to decrease these disparities. "As a result, screening gaps for breast cancer have been reduced by four percentage points between racial groups and five percentage points between insurance types; and for colorectal cancer have dropped by 13 percentage points between racial groups and two percentage points between insurance types."[6]

Quality improvement can sometimes make health disparities worse.[7] This can happen when quality is improved for one racial group, and stays the same or worsens for others; thus, the gap between them is then widened. Therefore, if we don't want to widen the gap, we should at least start our improvement work by considering the needs and issues that underserved populations face. Starting with the underserved and seeing the big disparity issues based on data analysis should lead to focused opportunities to work on disparity. In some cases, the improvements may even result in better process for all, such as in the HealthPartners example where the improvement involved providing multiple services during a single visit. In the past we have often based improvement work by starting with the patients who were the easiest to work with. Once we were successful with this group then we planned to expand to the most difficult. However, by the time we got to the majority, we lost energy to work on the underserved and our initial improvement design was inadequate to help the most underserved. This brings up the other issue, that different population groups, particularly the underserved, are going to need differential inputs to accomplish the same outcome. IHI has been running a collaborative for the past two years assisting organizations to support complex patients, generally the 5% of the population that account for 50% of healthcare costs. In this work they have focused on patients with high needs and designed new approaches that include the identification, assessment and engagement of a small number of at risk patients into new care designs that can support their complex needs. This work required more resources to be used for complex patients compared to the general population.

The 5th element of this work is to consider the multiple determinants of health when working on quality improvement for health care. This means that healthcare

---

[5] https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/ehrincentiveprograms

[6] http://seminar2015.mncm.org/innovation-transparency-awards/

[7] Green AR, Ran-McGrory A, Cervantes MC & Betancourt JR. Leveraging quality improvement to achieve equity in health care. Joint Commission Journal on Quality and Patient Safety. 2010;36(10): 435-442.

organizations need to think about where someone is living, what their financial constraints might be, what level of education they have, what kind of transportation they have, etc., when improvement work is done. For example, working on hypertension in an underserved population of black males who are not insured or underinsured would require a design that took the cost of hypertensive medications into account, along with access issues such as transportation. You would need to consider the safety of their community if you wanted to increase exercise with as simple an intervention as walking.

The final element of our 6 concepts deals with training on institutional racism. Our goal is not indoctrination into a particular ideology, but helping health care see the systemic barriers it creates. We have to realize that trust between health care and patients in underserved communities is still an issue. In one interview, a black woman shared that "every Black family knows the Tuskegee experiment and they know about Henrietta Lacks." We need to go beyond training. We need to hire diverse workforces. But we need to go even beyond that. Healthcare needs a pipeline to education so that students of underserved populations will see the need and opportunity to have a career in healthcare. In 1910 2.5% of the doctors and medical students in the US were black in 2006 that number was 2.2%. [8]

In summary, these 6 concepts are part of a systems approach to healthcare equity. They are not a standalone package. They fit into the larger framework that we outlined in the background section of this paper and primarily the work that we did in wave 36 of the IHI R and D cycles.

3. Observation from the various activities during this research cycle

1. Presentations:

During the past three months there have been 4 opportunities to do public presentations for IHI on our research to date. The response has been supportive to the framework we have described in this article along with the previous work, wave 36. When we presented to the BHLC collaborative, two organizations asked for more help. During the presentations we try to be clear that part of this work does involve the recognition of systemic/institutional racism. We recognize that this can be an emotional issue for some, so during the presentation we try to present this in a calm and non-judgmental manner illustrating how these events can occur.

[8] Byrd WM, Clayton LA. An American Health Di- lemma: Race, Medicine, and Health Care in the United States, 1900-2000. New York, NY: Routledge; 2002.page 584

2. Interactions with healthcare organization

We have had a chance to interact directly with three health systems. The goal here is to be able to help them accelerate their work on health equity by sharing our ideas with them and learning from them as they work on their goals. With two of them we shared a presentation of our work and with one just some of the concepts. We are hopeful that these relationships will mature.

3. Healthcare graduate education

The Association of Independent Academic Medical Centers launched a national initiative that focuses on the disparity component of the ACGME's clinical learning environment program. Their first meeting was held in Chicago on October 16th and 17th. During that meeting they presented a mixture of academic talks along with front line sessions around work on disparity and community. 29 organizations are participating in this collaborative. Following the meeting there are calls each month for the organizations to present on the progress of their project. Representatives from IHI participated in both the Chicago meeting along with a monthly call.

4. Communities

IHI is working with a number of communities in the US. This work is not exclusively focused on either healthcare or health equity, however there are learning opportunities in this work that are applicable for health equity. Some summary observations to date:

1. Communities tend to be resource rich and coordination poor. They also are data rich and information poor. Coordination and information are often not applied to assist the underserved and to identify disparities for them.

2. Putting together a governance structure takes time. We think the jury is still out on how much value this brings. The governance structure moves slowly and does not tend to represent the underserved. And it can get very tricky, the larger the region becomes. It takes a great deal of skill and energy to navigate the local politics of a community. All of these issues can impact any work that attempts to reduce health disparities.

3. Quality improvement skills are lacking in the community. Service organizations tend to focus on operation and the people they serve which is commendable but if we are going to make headway, we need to improve operations and find ways to serve more.

4.Taking work to scale in a community does not appear overall to be well thought out. At a recent community visit, whenever we asked them how many needed the service, it appeared as if they had never thought about that. What they had thought about was how

many did they need to reach according to the funding they were allocated. The number for that was around 50 to 100. And yet, when we did back of the envelope calculations with them, the numbers were more like 1000-3000 who could use a service. If we are going to close the disparity gap full scale, implementations are needed that can take the work to scale.

VII. Conclusions and Recommendations:

Health care has seen successive focuses on organizational change. In the 80s there was a focus on quality improvement. In the 90s and into the early 2000s there was the identification of safety that was seen as important. In recent years a focus on populations and caring for them around the Triple Aim has risen in importance. A logical extension of the Triple Aim for populations is a focus on health equity. In this article we have summarized our work over the past 9 months prior to this cycle of activity. During this cycle we have focused on understanding issues that individuals face, developed a set of guiding principles for healthcare and shared some activities in which we have used these ideas.

We would like to conclude with a set of questions for organizations to consider in regards to health equity:

1. Is health equity a strategic priority? Why or why not? What would it take to make this a strategic priority for your organization?

2. Do you have the internal governance structure to make progress on this work?

3. What data do you have and what is the quality of the data around race, language and ethnicity? Have you trained staff to do a good job in collecting this data? Do you use this data to discover disparities?

4. Are you using this disparity data to drive quality improvement? Are you starting quality improvement by first considering the underserved? In your design do you consider the resources of the underserved? Will they be able to afford the medication that you are choosing for your project or the procedures? Are there language and transportation barriers to care that need to be considered, etc.?

5. Do you have a primary care system that is committed to closing disparity gaps? What five health disparities are you trying to close with better primary care?

6. Have you implemented training to help individuals spot equity/disparity gaps in your organization to decrease structural racism?

VIII. Open Questions:

1. Can we somehow quantify the impact of working on health equity as a motivator for organizations? Doing things out of the goodness of their hearts is one thing – and some are doing this – but what is the return on investment (ROI) in terms of outcomes and costs for them to work on equity?