Institute for Healthcare Improvement

INSTITUTE FOR HEALTHCARE IMPROVEMENT
SUMMARY REPORT: 90-DAY PROJECT

Guiding Principles for Health Care Executives on Health Equity

September 30, 2017

I. Research and Development Team:

- John Whittington
- Jill Duncan
- Laura Botwinick
- Ron Wyatt
- Jim Diegel

II. Intent:

IHI's White Paper, Achieving Health Equity: A Guide for Health Care Organizations, provides a comprehensive approach to health equity for health care. The intent of the guidelines we created in this paper are meant to be a supplement to the white paper for leaders. Our approach was to consider the challenges of the CEO and other C-Suite leaders. Leaders face at least two challenges. One is fear and the other is ignorance. Some executives are afraid to take a strong stand on health equity because they see it as a no win situation. Executives who take a stand face challenges in convincing their organization that they have a problem with disparities and health equity.

III. Background:

Health equity is a strategic focus for IHI. We spent a year developing the IHI white paper that outlines a framework that organizations can use:

-Make health equity a strategic priority.
-Develop structure and processes to support equity work.
-Deploy specific strategies to address the multiple determinants of health on which health care organizations can have a direct impact: health care, the physical environment, healthy behaviors, and socioeconomic status.
-Decrease institutional racism within the organization.
-Develop partnerships with community organizations.

Pursuing Equity, a two-year initiative that aims to reduce inequities in health and health care access, treatment, and outcomes by implementing the above strategies to create and sustain equitable health systems, is another example of IHI focus on equity. It involves eight health care organizations—diverse in size, geography, and patient populations served— that are working

with IHI in a learning community. We see from our work with these organizations that support for leadership is important.

Past work on leadership at IHI has shown that senior executives and leaders at all levels are pivotal in creating the culture of improvement, safety, and patient centeredness. It is just a short step to the leaders' role in building the behaviors and norms for equity. The mental models and general leadership behaviors with the highest leverage for this type of change are known as well, and outlined in the High Impact Leadership White Paper.[1] In this present work we focused on some specific issues for health equity.

IV. Description of Work to Date:

This work consisted of interviews with 18 different health care leaders along with selected readings. See appendix for specific questions that we developed for the interviews. The guiding principles were then shared with leaders and others for feedback. The work will continue with opportunity to test these ideas within IHI Leadership Alliance and Pursuing Equity Initiative. In the following results section, we describe these principles and have used them as a stand-alone document.

V. Results of the 90-Day Scan:

Guiding Principles for Health Care Executives on Health Equity

In 2016, IHI published Achieving Health Equity: A guide for health care organizations. It included 5 pillars: make health equity a strategic priority, develop structure and processes to support the work, deploy specific strategies to address the multiple determinants of health on which health care organizations can have a direct impact, decrease institutional racism within the organization and develop partnerships with community organizations to work together on community issues related to improving health and health equity. The intent of this present work is to develop specific guidance to help health care executives. Leaders face at least two challenges. One is fear and the other is ignorance. Some executives are afraid to take a strong stand on health equity because they see it as a no win situation. Executives who take a stand face challenges in convincing their organization that they have a problem with disparities and health equity. Based on interviews, reading and observation, we thought the best advice is a set of

[1] Swensen S, Pugh M, McMullan C, Kabcenell A. High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2013

guiding principles[2]. Guiding principles support the purpose of work or the business purpose. They are intentional but flexible. Here are the 5 that we think are most important:

1. We need substance over show on health equity.
People can smell tokenism if health equity is not taken seriously. Work done should meaningfully impact the lives of people. Health equity is an authentic expression of an individual or organization's commitment to the ideals of social justice, respect, access, and dignity. Health equity initiatives must be action-oriented and embedded in the authenticity of an organization. It requires culture change in most organizations. It is a way of "being" as well as a way of "doing," meaning it must make a difference in the community and in the lives of people. A health system in the south raised the wages of 1700 employees costing them 7 million dollars a year to give them a living wage. That was not a token effort.

2. **Everyone gets to play a part.**
In a health system, there are many departments that can impact health equity: quality, safety, HR, IT, community relations, purchasing, and the physical plant development. Because of the connection of the social determinants of health to health and wellbeing, every department can have a role in improving the lives of patients, employees, and people in the community. We need good organizational oversight and coordination for this work at multiple levels of the organization. This type of coordinated effort requires "tone from the top." The board, CEO, and senior leadership must be committed to this work and evidence such in their work and actions. It is a walk-the-talk effort.

3. **The last will be first**
Quality improvement often focuses on populations where success is most easily achieved. If we are going to start closing disparities, we need to start with the "last" population that may be more challenging and just not thriving. The reward for health care organizations is that even though these populations may be small, they can incur great costs to the health system. Also, it is often the case that if we can solve problems for those at the margins, we come up with solutions that work better for all. Health equity, by definition, is activity focused upstream on the most vulnerable populations so that the downstream disparities are eventually narrowed. This requires a reprioritization of where upstream investments are made—not just to populations where a demonstrated metric can be easily generated. Health equity work is generational and cannot be

---

[2]*Guiding principles reflect theories (preferably evidenced based) about what changes are necessary
*Guiding principles are less prescriptive than specific changes and therefore leave room for local innovation and adaptation
*Guiding principles should focus on theories for design rather than execution (e.g. start small and scale up; measure results)
*"Should be limited to a handful (about 4)"
(Donald Sull, MIT Workshop, January 2016)

just an initiative for the next 2 years. That's why authentic commitment starts at the top and requires culture change and structural change, so activities are not dependent on a single charismatic leader.

4. **We need to see with new eyes the barriers that exist**
Institutional racism/discrimination is prevalent in all organizations. It may be completely unintended, but needs to be seen and addressed. For most, we don't have the vision to see it right away. We will need to learn to see it. Acknowledging and calling out the ugliness of the unspoken may be a first step to owning that the barriers exist and that an organization is committed to understanding why the barriers exist and how to eliminate that aspect of their culture.

5. **This is a personal journey that needs to be done as a group**. (Employees, physicians, board members)
There is an emotional component to health equity work that is much more intense than other work such as quality and safety. We need to realize that from the beginning and acknowledge that it will be a journey for all of us that will have more emotion than the quality, safety and population management journeys of the past. It cannot just be a personal journey. It needs to be a group journey too that brings the organization along. And, the journey should involve those who have experienced the adversities of health inequity. In other words, many can empathize with health inequity, but a smaller number have personally experienced it. This is where we can learn from others within our organizations.

Glossary

Population health: Defined as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group."[3]

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."[4]

[3] Kindig D, Stoddart G. What is population health? American Journal of Public Health. 2003;93(3):380-383.

[4] World Health Organization. "Social Determinants of Health." www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/

Health equity: When all people have "the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstance". [5]

Health disparity and health inequity: Health disparity is defined as the difference in health outcomes between groups within a population. While the terms may seem interchangeable, "health disparity" is different from "health inequity." "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.[6]

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."[7]

VII. Conclusions and Recommendations:

The US health care performance continues to fall further behind other developed countries.[8] Health care inequity is a major contributor to this poor performance. Until we address health equity as a system priority across the US, we will continue to lag behind other developed countries. We have previously outlined, in the IHI white paper on health equity, a basic plan that organizations can use to work on health equity. In this paper we tried to outline some complementary guidance that can be used by executives to implement the white paper.

VI. Open Questions:

1. We need help and tools to see with new eyes the barriers in our organizations that are discriminating against various populations. And then we may need some new approaches that we have not developed to remove those barriers.

---

[5] CDC Definition https://www.cdc.gov/chronicdisease/healthequity/index.htm

[6] Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. Achieving Health Equity: A Guide for Health Care Organizations. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016

[7] 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.

[8] E. C. Schneider, D. O. Sarnak, D. Squires, A. Shah, and M. M. Doty, Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care, The Commonwealth Fund, July 2017.

2. We need a better understanding of effective ways to organize a health system to support this work. This relates to the guideline that everyone gets to play a part.

VIII: Appendix. Questions that were used for leadership interviews

1.What was it that started or held your organization back on its journey to decrease disparity and improve health equity? Was there an event related to disparities, pressure from the community, or some other situation that you can identify?

2.What will it take to make health equity strategic for an organization? Is health equity reflected in your organization's strategic planning process and if so how?

3.What questions are the most difficult to discuss with the leadership team, or the board?

4.What structures or processes have you put in place to move this forward?

5. Improving diversity in leadership is a challenge for most health care organizations. Do you have any suggestions to improve diversity?

6. Are there any equity measures that you hold yourself and leadership accountable for? If so, what are they?

7. One issue that leaders will face on health equity and disparities involves discussion and improvement on institutional/structural discrimination based on economic status, race and gender, often referred to as institutional racism. These can be emotionally charged topics. Have you dealt with this topic in your organization? If so, what have you learned?

8.What are good examples of communication strategy for health equity in a health system?

9.What advice would you give to other leaders about how to get started and/or advance this work?