Health Equity Strategies
Moving from Concept to Action

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

SUPERIOR HEALTH
Quality Alliance

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SECTION 1: INTRODUCTION

Advancing Health Equity

As a quality improvement organization, Superior Health Quality Alliance (Superior Health) is committed to improving health and health care for all, across all care settings. This means being intentional in advancing health equity, which is a key priority for Superior Health. We work towards achieving health equity by implementing three foundational strategies:

REDUCE HEALTH DISPARITIES	PROMOTE CLAS	STRENGTHEN PERSON AND FAMILY ENGAGEMENT
Measuring and working to reduce health disparities, which are differences in health outcomes. This includes addressing social influencers of health (SIOH) - which are conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes – impacting health equity. The work of identifying and addressing health disparities ensures everyone has a fair and just opportunity to be as healthy as possible.	Promote culturally and linguistically appropriate services (CLAS) as a way to improve the quality of services provided to all individuals, which will ultimately help reduce health disparities and achieve health equity.	Ensure that patients, residents, and families from all backgrounds are equal and active partners in their health care and in the way in which we work to improve health care. Person and Family Engagement (PFE) strategies ensure person-centered care - putting individual needs, perspectives, interests, values and beliefs first.

Health equity means ensuring that everyone has the opportunity to live a healthy, quality life, regardless of their background and where they live. Intentionally advancing health equity requires coordination and commitment from partners in all settings including payers, providers, policy makers, regulators, community-based organizations and communities. Superior Health believes that through strategic alignment and strengthened collaboration, communities can work together to provide more equitable and person-centered care and services by moving health equity strategies from concept to action!

SECTION 2: BACKGROUND AND PURPOSE

Framing the Need for Health Equity Community Conversations

Lack of progress addressing long-standing health inequities—and in many cases widening disparities—has led to a nationwide focus on being intentional in advancing health equity. Taking meaningful action to address health and health care disparities requires a better understanding of barriers being faced across all settings. Challenges that prevent action to drive change in our communities from being successful include structural, institutional, political, financial and analytical barriers. We need to work on overcoming these barriers together to make progress in reducing health disparities.

To support organizations in addressing these barriers, Superior Health launched the Health Equity Community Conversations Series: Practical Concepts to Practice during May – August 2024. This series brought health care and community-based organizations together to share strategies and best practices for implementing health equity concepts into practice.

The Health Equity Community Conversations series provided a space for sharing, brainstorming and confronting real challenges that hinder progress. Participants and Superior Health shared best practices, tools, resources and lessons learned to overcome barriers to implementing health equity strategies. The series included four 1-hour virtual sessions designed as peer-driven virtual learning opportunities to support providing high quality, equitable care and support services to community members including Medicare beneficiaries in Michigan, Minnesota and Wisconsin.

Throughout the sessions, we focused conversations on key strategies needed to drive progress in advancing health equity across our communities, regardless of organization type.

HOW TO USE THIS PLAYBOOK

Informed by learnings from the Health Equity Community Conversations series, as well as our experience guiding implementation of Health Equity initiatives, Superior Health developed this playbook to compile key take-aways, resources and tools to help inform how a variety of settings can work together to move health equity strategies to action.

Users are encouraged to use this playbook to:

1. **Review insights and key take-aways offered in the playbook.**
2. **Use the resources and tools to inform your actions! No need to recreate the wheel.**
3. **Assess how your organization is currently implementing these health equity strategies (e.g., across your governance, leadership, staff and community partnerships).**
4. **Determine how you can form meaningful partnerships to drive action on these strategies, leveraging the strengths, skills and knowledge of partners across your networks.**

Key Strategies for Advancing Health Equity

SECTION 3: CALL TO ACTION

Working Together to Move Health Equity Strategies from Concept to Action

Organizations and partnerships should focus on understanding community needs and collaboratively designing action-driven solutions to address these needs. Superior Health has summarized strategies and themes from the four Health Equity Community Conversations series sessions to help inform opportunities for action at your organization as well as guide alignment and collaboration around those strategies across your community network.

In addition to the key strategies on the previous page, consider these cross-cutting principles as you work to move health equity strategies to action.

- Embedding equity across organizational culture, systems, policies and practices.
- Integrating an equity lens from the outset – implementing frameworks that embed equity across the design, implementation and evaluation of programs, services and quality improvement efforts.
- Ensuring health equity initiatives and action plans are community-driven – designed by, with and for communities – including outlining shared vision, goals, priorities and measures of success.
- Working together to bridge implementation gaps that improve operationalizing equity strategies across your organization and community through awareness, alignment, advocacy and accountability.

Step 1: Identify and Understand the Challenges Using Data

Identified Opportunities: Closing Equity Data Collection and Standardization Gaps.

Data drives action, and we must use data to understand the scope of the problem, which in turn informs resource allocation and intervention design. However, gaps in actionable and complete data, along with a lack of standardized methods for data collection, storage, analysis and use, can present challenges for individual organizations and across community partnerships.

Consider the following tactics to address analytical barriers and use data more effectively across the community:

KEY CONSIDERATIONS AND TACTICS

- ☐ Design and standardize processes for data collection and analysis that help to understand inequities and the root causes of disparities. This will help improve shared understanding of what health equity looks like in the communities you serve, and the disparities that need to be addressed.
  - Use data tools to identify health disparities and monitor progress toward achieving health equity.
  - Identify a person or team to be accountable for regularly monitoring this data.
  - Leverage quality improvement tools (e.g., PDSA) and choose structure, process and outcome measures to evaluate progress.
- ☐ Leverage qualitative data in addition to quantitative data (for example, qualitative = personal experience and stories, quantitative = readmission rates).
  - Seek community voices that represent personal experiences, goals, and perceived gaps, and what the community feels is important to improve on.
- ☐ Improve collection, validation and use of key demographic data, including Race, Ethnicity and Language (REaL), Social Drivers of Health (SDOH), Sexual Orientation and Gender Identity (SOGI), disability status and veteran status through:
  - Self-reported collection methods - Self-identification and patient-reported information are the preferred means of obtaining information and allow patients to answer in a way that better reflects their identity. We should never make assumptions based on a person's name or appearance.
  - Provide training and ongoing support for staff who collect patient demographic data and training for staff on how to use it.
  - Work with staff and patients so they understand why this data is important to collect, why and how to self-report and privacy and confidentiality.
- ☐ Ensure there is collaboration across partnerships when designing, collecting data and interpreting community health assessments (CHAs) and community health needs assessments (CHNAs). This will help to align initiatives with the most pressing health needs.
- ☐ Seek insight and input from communities impacted by disparities to understand root causes.

Step 2: Assess Capacity and Solutions

Identified Opportunities: Closing gaps between what is working, what isn't working and what you have to work with.

Resources are limited and communities are grappling with both a lack of human and financial capacities. We must work together to better understand what is currently being done to address disparities through programs, services, and resource allocation to evaluate if the current solutions are effective in addressing disparities and improving outcomes.

Consider the following tactics to address institutional and political barriers and determine current capacities:

KEY CONSIDERATIONS AND TACTICS

- ☐ Reflect on your own organization's understanding, perceptions and knowledge of disparities and your initiatives working to address them.
- ☐ Assess what is being done to address disparities across your community.
- ☐ Evaluate wider community factors (e.g., statewide, regional) such as existing partnerships, key players, state and local quality improvement collaboratives and efforts, policy measures, quality measures and available resources.
- ☐ Based on this evaluation, determine priorities to choose feasible and relevant strategies and goals.
- ☐ Leverage data to evaluate if current services, programs and initiatives are driving the change you want to see – using the right data is key!

Step 3: Design and Implement with Equity in Mind

Identified Opportunities: Closing gaps in organizational and community infrastructures and capacity.

Building organizational and community infrastructures (e.g., health equity committees, equity in staff role responsibilities, equity in policies and practices) and capacity to advance health equity is critical to success, yet many challenges remain. Lack of resources to support adequate staffing and structures, workforce shortages and turnover are just a few barriers impacting successful operationalization of health equity strategies.

Consider the following tactics to address structural and institutional barriers and create structures and interventions with equity in mind:

KEY CONSIDERATIONS AND TACTICS

- ☐ Make equity a strategic priority across your organization and your partnerships and ensure dedicated resources are provided to support equity as a priority.
- ☐ Educate, train and support staff to understand health equity principles.
- ☐ Embed equity into all existing staff roles and structures. Work towards developing active health equity teams and committees within your organization.
- ☐ Develop a comprehensive, coordinated and aligned plan for an equity-focused data infrastructure (e.g., equity dashboards, equity-centered data collection, analysis and use) both within your organization and across your partnerships.
- ☐ Incorporate equity in design and implementation of all quality improvement interventions, programs, and services.
- ☐ Strengthen engagement with community partners, patients, residents and families to inform interventions that improve health and well-being and consider lived experiences.
- ☐ Build culturally and linguistically appropriate services (CLAS) into all quality improvement efforts.
- ☐ Develop communication practices and strategies informed by equity concepts, cultural humility and health literacy considerations.
  - Use person-centered language – centering the person rather than the disease or condition, for example using "person with diabetes" rather than "diabetic."
  - Have translation services available.
  - Train staff on CLAS Standards and implement CLAS Standards.
- ☐ Build adaptive, effective systems that can be regularly evaluated and adjusted to achieve and maintain desired long-term results.

Step 4: Collaborate, Invest and Sustain

Identified Opportunities: Closing gaps on long-term equity investments.

Developing effective multi-sector partnerships across the community is critical for sustainability and long-term investment in programs. A challenge shared across communities and organizations is the fact that equity programs and services are programmatically funded and not systematically funded. For example, programs and services may be grant-funded but not built into the funding structure of organizations or community collaboratives.

Consider these tactics to address financial and political barriers and sustain health equity work:

KEY CONSIDERATIONS AND TACTICS
☐ Create a business case for health equity, meaning data-informed equity approaches and evaluation metrics that communicate both short-term and long-term success.
☐ Come together to advocate at the community and state levels for long-term investment in resources, services and programs.
☐ Create effective partnerships and leverage strengths and resources across settings (e.g., health care, health departments, payers, private sector) to drive investment in health equity.

SECTION 4: KEY TAKEAWAYS

Health Equity Community Conversations Series

Outlined below are key takeaways from each session of the Health Equity Community Conversations series that can provide additional insight and support in how to deploy practices and strategies needed to advance health equity.

- **Session 1: Getting the Conversation Started**
- **Session 2: A Conversation about Cultural Competence and Inclusion**
- **Session 3: A Conversation with the Community Health Disparities Reduction Partnership (CHDRP) Initiative County Teams**
- **Session 4: Building Programs with Sustainability in Mind**

Session 1: Getting the Conversation Started

The series kicked off with presentations from Superior Health's Quality Improvement Advisors (QIAs) and one of our analysts about health equity, health disparities and data, as well as key strategies and resources for collecting social and demographic information.

This session addressed the following strategies for advancing health equity:

- Shared understanding of what health equity looks like in the communities we serve.
- Consistently asking patients/residents to self-report basic demographic/linguistic information.

KEY TAKE-AWAYS

- Health equity means social justice in health – no one is denied the possibility to be healthy for belonging to a group that has historically been economically/socially disadvantaged.
- **Health equity is a goal** (everyone has a fair and just opportunity to be as healthy as possible), a **process** (removing social and economic obstacles to health) and a **measurement** (reducing and eliminating disparities in health and drivers of health that impact certain groups).
- **Health disparities are the metric used to measure progress toward achieving health equity.**
- We must understand community contexts before creating interventions. That starts with mindful measurement to identify disparities and engaging the communities we serve to come to a shared understanding of health equity.
- Health equity is a federal initiative. Collecting REaL, SOGI and SDOH information is not only the right thing to do to support providing more patient-centered care, but there are also regulations that include collecting this information.
- **Collecting information** itself doesn't reduce disparities or improve care; it does **help identify gaps in access to health care and health care coverage,** identify health disparities, improve language and accessibility support and tailor care and resources to peoples' cultural needs and preferences.
- Key strategies for collecting patient information include defining data collection goals, engaging leadership, involving frontline staff, identifying needed resources, staff training and education for patients.
- Find resources shared during Session 1 in the **appendix**.

Session 2: A Conversation about Cultural Competence and Inclusion

The second session featured a presentation from Judy Lewis, Lead Trainer and Tabling Manager with MiGen – Michigan LGBTQ+ Elders Network, and Superior Health Person and Family Advisory Council member. Judy spoke about the why and how of cultural competence and inclusion with a focus on policies, intersectionality, and resources for LGBTQ+ older adults. This session addressed the following strategies for advancing health equity:

- Regular health equity staff training/professional development.
- Organizational/strategic plans that incorporate health equity.
- Shared understanding of what health equity looks like in the communities we serve.

KEY TAKE-AWAYS

- Intersectionality is a term created by Kimberlé Crenshaw, an attorney, and a concept that many things contribute to making us who we are (e.g., religion, nationalities, disabilities, family structures).
- Some factors of intersectionality are fluid (e.g., religion) and other factors are core pieces of who we are that we cannot change (e.g., race, age, sexual orientation, gender identity).
- Gender identity is how you feel inside, who you are with regard to the rest of the world. Sexual orientation is who you are attracted to.
- The Kinsey continuum had six points – heterosexual, homosexual, bisexual, or in the middle of these points. Now: we know things can be fluid and people have created many (178) self-identifiers.
- Identifying disparities: According to several National Institute of Health (NIH studies), the LGBT population is at higher risk for substance abuse, sexually transmitted diseases, cancers, cardiovascular disease, diabetes, Alzheimer's and other dementias, obesity, bullying, isolation, anxiety, depression, and suicide as compared to the general population. We've discovered much of this is based on a constant state of stress – minor stress or people being in situations where they feel unsafe or unsure of what to do and then close off.
- **Allies save lives.** Some ally actions can include:
  1) Intervening when overhearing a homophobic or transphobic remark (e.g., "No, that's not appropriate. Not here, not now, not ever").
  2) Organizations making it clear they are LGBT friendly and inclusive (e.g., visual cues like wearing rainbow pins, lanyards, rainbow stickers).
  3) Expressing there are no traditional gender roles in society, rather dream your dream and achieve it.
- **What you can do:**
  1) Training.
  2) Applications and forms (ask sexual orientation and gender identity questions, but NOT only out of curiosity).
  3) Organizational policies (if you enumerate race, religion and disability, put sexual orientation and gender identity in there as well).
  4) Look for non-verbal cues from clients.
  5) Provide verbal cues (e.g., having recordings in the phone call menu like "if you or someone you know would like LGBT resources, please don't hesitate to let us know.") at intake asking sexual orientation and gender identify questions and who their special someone is, and in parentheses (married, widowed, divorced, single) to understand if there's been someone in their life for 45 years and then they can engage as well.
- Find resources shared during Session 2 in the **appendix**.

Session 3: A Conversation with the Community Health Disparities Reduction Partnership (CHDRP) Initiative County Teams

The third session featured presentations from County Teams part of the Community Health Disparities Reduction Partnership Initiative, an initiative launched by Superior Health during May 2023-September 2024 to invest in projects to advance health equity in three counties in our region. County Teams spoke with the group about their projects in Wayne County (MI), Ramsey County (MN), and Milwaukee County (WI).

This session addressed the following strategy for advancing health equity.

- Shared understanding of what health equity looks like in the communities we serve.

KEY TAKE-AWAYS

- Utilizing trusted partners is key.
- Getting the population's organizational leadership to be willing to be a part of the message is important.
- **Asking your participants what they want** and not just providing a service without asking.
- Providing opportunities for peer support has been helpful. Community health workers who are **older adults can relate to their peers in the community** and connect them with the support needed to age in place.
- Regularly gathering feedback from those who are going through training, engaging in programs, etc. is important for informing and guiding improvements to programming.
- Partnerships are powerful, and **uniting around a common goal** can help partners convene and can guide collective work.
- Health disparities can be a guide for bringing programming to where it is needed. For example, there were few diabetes interventions targeted to the urban American Indian community in Ramsey County, and this project addressed that gap.
- Consider using a variety of communication strategies to get the word out about programming.
- Find resources shared during Session 3 in the **appendix**.

Session 4: Building Programs with Sustainability in Mind

The fourth and final session featured presentations from Superior Health staff about tools and strategies for building health equity programs with sustainability in mind, including incorporating community perspective and fostering accountability.

This session addressed the following strategies for advancing health equity:

- Active health equity teams and committees.
- Dedicated and sufficient funds to work on health equity.

KEY TAKE-AWAYS

- Building the foundation for active health equity teams and committees **takes internal work for systems change**:
  - Measure success and impact.
  - Collect voices of the unheard.
  - Culture – practice empathy during communication. People remember how you made them feel!
  - Support your teams. Actively seek and update resources.
- Multi-sector collaboration to advance health equity takes **external work for alignment across strategy, funding and approaches to equity:**
  - Prioritizing and planning early for sustainability with key partners.
  - Community engagement – how do we do it better?
  - Actively evaluate if current resources and services are meeting your community's needs.
- Acknowledge and address barriers.
- **Experiences matter** and impact sustainability.
- Conduct environmental scans to identify staffing models, data sources, partners and funding sources.
- Hold systems accountable that prevent sustainability. **There is power in collective voices advocating for change.**
- A roadmap for planning ahead includes Now, Near, and Far elements:
  - **Now –** short term actions, narrowed down focus.
  - **Near –** mid-term, wider focus.
  - **Far –** long-term organizations and systems change, "future state," big picture.
- Find resources shared during Session 4 in the appendix.

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