Health Equity Strategies from the Accountable Health Communities Model

Health equity is achieved when everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes. The Centers for Medicare and Medicaid Services are working to advance health equity by designing and operationalizing policies that support the health of all people served by its programs. This commitment to reduce—and ultimately, eliminate—avoidable differences in health outcomes requires action to improve the social and structural drivers of health inequities.

Advancing health equity is critical to optimizing population health and improving the quality of healthcare while potentially reducing costs. A comprehensive approach to addressing health equity both improves health outcomes through enhanced access to community resources and seeks to address the underlying structural drivers of health. Without a focus on equity within health-related social needs interventions, underlying inequities can persist. Drawing from the experiences of awardees participating in the CMS Accountable Health Communities (AHC) Model, this tip sheet provides a multi-level framework for understanding health equity and actionable strategies related to social needs interventions that organizations such as health systems, payers, and community service providers can leverage to improve health equity.

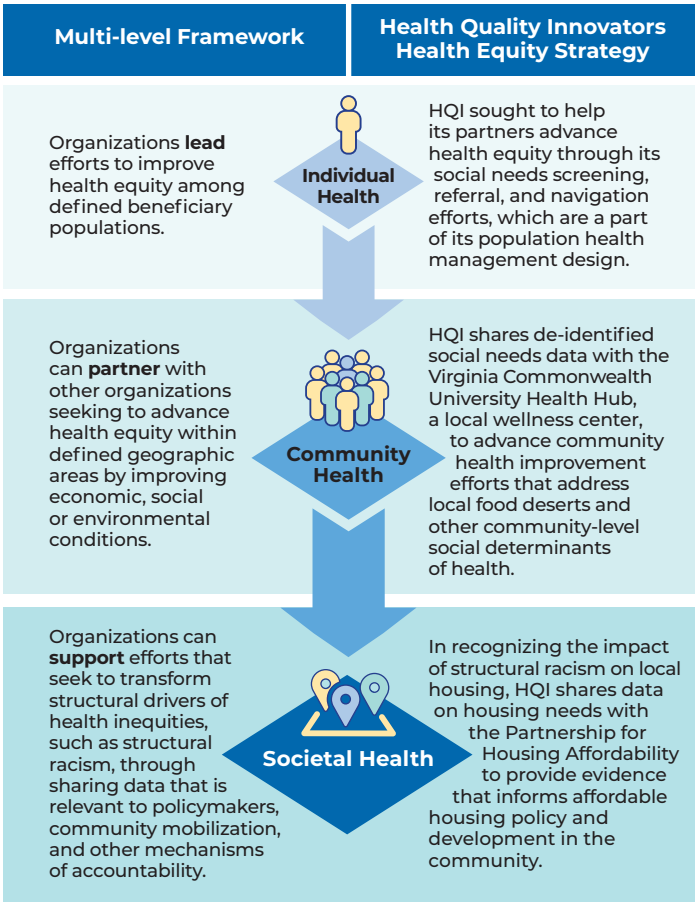
EMPLOYING A MULTI-LEVEL FRAMEWORK TO IMPLEMENT HEALTH EQUITY STRATEGIES

A multi-level framework, such as the one developed by HealthBegins, can guide organizations toward opportunities to lead, partner, and support actions that address:

1. **Individual-level** social risk factors and social needs–such as food insecurity.
2. **Community-level** *social drivers* of health and the underlying social, economic, and physical conditions in which people live—such as food deserts.
3. **Societal-level** *structural drivers* of inequity and the mechanisms that shape broad, historical power structures—such as structural racism and supermarket redlining.

The strategies highlighted in this tip sheet are organized by individual, community, and societal health to help organizations understand how they can advance health equity at each level and develop a comprehensive health equity strategy. For example, **Health Quality Innovators** is an AHC Model awardee based in Richmond, Virginia, that uses a multi-level framework to provide local healthcare organizations with quality improvement solutions. This focused framework also helps Health Quality Innovators and its partners address the social and structural drivers of health equity (Figure 1).

Figure 1. Multi-level Framework Informs Health Quality Innovators' Health Equity Strategy



INDIVIDUAL HEALTH

Strategy 1: Collect and stratify social needs data to identify and document health inequities. Improving health equity relies on high-quality, individual-level data on race, ethnicity, and language (REaL), in addition to data on sexual orientation, gender identity, income, disability status, immigration status, and geography. With this information, organizations can disaggregate data to identify and document what disparities exist to inform how to address them. When designing and implementing improvements for data collection, consider these strategies:

- Align data categories with the standards and certified health information technology (IT) requirements of the Office of the National Coordinator for Health IT.
- Elevate the voices of residents and staff from communities who have been historically marginalized to inform culturally appropriate data collection.
- Provide patients with context for why information is being collected, how data will be shared, and how privacy concerns will be addressed.

In addition to stratifying key performance measures to identify racial inequities, using REaL data to stratify social needs data—such as an individual's need for housing, food, or transportation—can reveal patterns that identify inequities and refine the understanding of the drivers of those inequities. By developing or updating data dashboards using REaL data, organizations can identify opportunities for community investments to address inequities, work to close gaps in healthcare outcomes, and track their performance in closing social needs gaps.

Embedding Equity into Staffing at CHRISTUS Santa Rosa

CHRISTUS Santa Rosa, a not-for-profit health system and AHC Model awardee in Texas, employs ED Navigators who guide patients and families to health and social services and coordinate community-based care referrals. During the hiring process, CHRISTUS focuses on identifying candidates that are bilingual and have experience working with populations that have been historically marginalized. Many of the ED Navigators working with CHRISTUS are also Latina/o. As a direct result of their lived experience and comfort communicating with patients from different backgrounds, ED Navigators at each of CHRISTUS's clinical sites support other staff and provide training and guidance to interns. They are also instrumental to the successful provision of community service navigation to patients. Cultural humility and responsiveness are ingrained in training as CHRISTUS strives to implement health equity in every aspect of beneficiary care.

Strategy 2: Build staff capacity and strengthen an equity-focused mindset. To improve health equity at the population health level, staff must understand the impacts of health-related social needs, show empathy toward patients, and navigate cultural differences while being aware of implicit bias. Consider the following strategies to facilitate individual and group learning to determine equity barriers (such as institutionalized racism) and build staff capacity for equity work:

- Establish a shared understanding of key equity terms.
- Incorporate staff's lived experience into training for care delivery to encourage empathy and bring cultural context to interactions with patients.
- Assess and enhance staff comfort communicating with patients with different backgrounds.
- Encourage staff wellness through trauma-informed engagement.

COMMUNITY HEALTH

Strategy 3: Identify geographic clusters of health inequity. Structural drivers of health inequity have created geographic differences in social drivers of health that persist today. For example, researchers with the U.S. Department of Health and Human Services have associated neighborhood-level redlining with a nearly 60 percent increase in breast cancer mortality. To improve these community-level social, economic, and environmental conditions, organizations must understand geographic patterns of inequity by:

- Overlaying beneficiary-level social needs screening data with community-level geographic data on social risks and social drivers of health to better define the focus of equity efforts.
- Using social needs screening and geographic data to align the community in allocating resources based on geographic areas of need.

Mapping Inequity at NewYork-Presbyterian Hospital

NewYork-Presbyterian Hospital, an AHC Model awardee based in New York City, used various area-based indicators to identify "high disparity communities." It analyzed community health data and resource utilization risk data using Neighborhood Tabulation Areas (NTAs), which aggregate census tracts into neighborhoods. It then cross-walked the zip codes in its service area to the NTAs to identify neighborhoods of highest need. These neighborhoods were the geographic target area for social needs screening, referral, community service navigation, and community partnerships.

- Leveraging existing area-based social risk indices, which use U.S. Census and other public health data to identify geographies more likely to be affected by social and structural drivers of health using U.S. Census and other public health data. These data are available via state and local health departments, state Medicaid agencies, and community partners. Consider using the Minority Health Social Vulnerability Index, developed by the Centers for Disease Control and Prevention and U.S. Department of Health and Human Services, and the Area Deprivation Index, developed by the U.S. Health Resources and Services Administration and maintained by researchers at the University of Wisconsin-Madison.

Strategy 4: Strengthen data and information sharing relationships with partners and community members. Health equity requires mechanisms to ensure those most impacted are involved in making and monitoring decisions so that inequities are not ignored, perpetuated, or exacerbated. Sharing data and information with community partners and residents from communities that have been historically marginalized can improve organizations' decision-making.

- Develop data dashboards and reports that are frequently shared, accessible, and understandable by both clinical and community partners. At a minimum, these reports can be shared at an aggregate level while partners develop data use agreements and other formalized mechanisms to share more granular data.
- Engage residents and community organizations through formalized representation on committees and advisory boards to inform equitable interventions. This representation can lead to increased trust, more community buy-in and culturally competent support in designing tools, such as customizing screening and navigation workflows and verbal scripts for engaging patients.
- Elevate the voice of community service providers in the selection of health IT products such as referral platforms. Efforts to share data between clinical and community partners are most impactful when partners have the resources to use data effectively.

Data-Driven Community Engagement at United Healthcare Services

United Healthcare Services, a nationwide insurer operating as an AHC Model awardee in Hawaii, develops and shares a quarterly report with community residents and partners that includes aggregated data on social needs, beneficiary engagement, and COVID-19 public health emergency impacts by zip code. Community partners use the data in grant applications that fund social needs interventions. The data also inform community partners of the most salient health-related social needs. Although local community advocates had long assumed that homelessness was the predominant HRSN, data generated from the AHC Model and shared with partners revealed that food insecurity was more pervasive.

SOCIETAL HEALTH

Strategy 5: Build systems of accountability for advancing equity. As organizations commit to advance a comprehensive health equity strategy, it is important to demonstrate how they will be held accountable to achieve their equity goals. This guide, developed by HealthBegins and partners, outlines mechanisms to support and hold healthcare institutions accountable for advancing health equity. Communities can ensure institutions share easily accessible data on health inequities, strengthen community involvement and responsibility in governance structures (that is, beyond advisory roles), and both provide and solicit feedback on a rationale for decisions or actions taken to address social needs inequities.

Establishing Accountability at Allina Health

Allina Health, an AHC Model awardee, is a not-for-profit health system based in Minnesota. In response to George Floyd's murder in May 2020, one mile from its headquarters, Allina Health developed a multipronged approach to embed equity across its system with the goal of providing equitable care and holding itself accountable. Allina Health shared health disparity data with the community to build trust through transparency, and to drive action on issues presented by the community. To measure its progress toward advancing equity, Allina Health integrated equity-related metrics into its internal performance scorecards.

Learn more about CMS's Health Equity Approach

Please visit the CMS Innovation Strategic Direction webpage which lists health equity as a core strategic priority. The CMS Innovation Center aims to embed health equity in every CMS Innovation Center model and increase focus on underserved populations. The webpage includes the slides and a transcript from the recent roundtable on the CMS Innovation Center Health Equity Strategy. Submit questions or feedback on the strategy to CMMIStrategy@cms.hhs.gov. To stay up to date on CMS efforts to improve health equity, subscribe to the CMS Office of Minority Health's Health Equity Quarterly Listserv.

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