Advisory Board

Health equity measurement discussion guide

Eight conversations to have when measuring health equity

User guide

Purpose: To guide discussions with key stakeholders about creating a plan for measuring health equity opportunities at your organization.

Who it's for: These conversations will be most productive between representatives from a variety of departments in your organization. These functions might include health equity or DEI, community engagement, strategy, finance, data and analytics, and partnerships. In most cases, we recommend these conversations be held at the director or VP level, with the resulting decisions or recommendations shared with senior leadership and the rest of the organization.

When to use it: We suggest beginning by reviewing the Health Equity Measurement Cheat Sheet for a grounding in the principles reviewed in this presentation. Then, this deck can be used to guide conversations, make decisions, and generate recommendations for senior leadership as needed.

How to use it: This presentation outlines the conversations you should discuss with your cross-functional team, questions to help guide the conversation, and implementation considerations to help you make decisions that align with your organization's goals and capabilities. We also include case studies from organizations that have taken a data-driven approach to demonstrate how to operationalize health equity measurement.

Starting definition

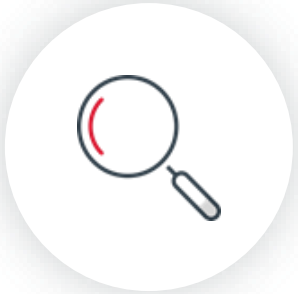
Health equity

Health equity is achieved when every person has the opportunity to attain his or her health potential and no one is disadvantaged from achieving this potential due to socially determined circumstances.

Source: "Health Equity," CDC, March 2020, https://www.cdc.gov/chronicdisease/healthequity/index.htm.

Why do you need a health equity measurement strategy?

An unstructured approach to health equity measurement can lead to:

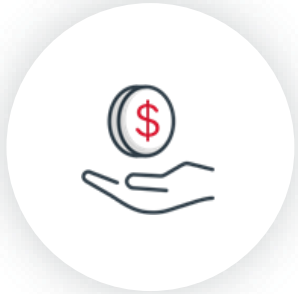


Limited direction

Failure to leverage data can lead to the maintenance of the status quo

Perpetuated inequities

Poorly defined measures can introduce bias and unintentionally worsen outcomes



Unsustainable projects

Overly targeted or scoped analyses can pave the way for "passion projects"

Analysis paralysis

Collecting too much data without a plan can lead to inaction

Advisory Board interviews and analysis.

Eight conversations for measuring health equity

01	Defining the question	05	Prioritization of opportunities
02	Data needs	06	Timeline for measurements
03	Analysis protocols	07	Downstream impacts
04	Demographic groups considered	08	Activating insights

Advisory Board interviews and analysis.

01 Defining the question

Conversation:

What questions do we need to define in order to conduct meaningful analyses?

Discussion questions and considerations:

1. Define the question(s) that you need to address before approaching data collection and analyses.
   - Consider the health equity investment and prioritization decisions you need to make and identify what answers you need in order to make those decisions. Make these questions as specific as possible.
     - For example, based on your experience with your community and historical knowledge, you may hypothesize that there are a disproportionate number of Black children presenting to the ED with asthma. You can define the question that you want to answer based on your hypothesis and allow these questions to guide the data that you need to collect or have access to and your analyses. Questions might include:
       - *What is the prevalence of childhood asthma by race?*
       - *What is the ED utilization among children with asthma by race? What is the comparison group to determine whether racial disparities exist – the healthiest group or the majority?*
   - Aim to focus questions on a specific problem or issue that is scoped to your community needs.
     - Conduct background research using primary and/or secondary resources to supplement knowledge about industrial and historical forces influencing inequities affecting given populations.

02 Data needs

Conversation:

What data do we need to conduct our desired analyses, and where are our data gaps?

Discussion questions and considerations:

1. Where are we comfortable extrapolating data to understand directionality, versus where do we need to collect more data?
   - Few demographic data sets (if any) cover 100% of a given population. For aggregated analyses (ex. analyzing disparities across counties, zip codes, or census tracks), applying a representative data sample across a larger population may suffice. For individual-level analyses, there are inherent risks to using modeled data.
   - For example, Sutter Health has found individual-level data (e.g., on race, ethnicity, socio-economic status, sexual identity, etc.) is crucial for measuring equity. In their analyses, they don't ignore the part of the population for which they don't have data; rather, they group those individuals as a distinct "other" category and test if the group registers as an outlier in their analysis.

02 Data needs cont.

Discussion questions and considerations:

2. How can we fill any data gaps in a sustainable way such that we ground our health equity strategy in valid, reliable data?
    - Data-sharing partnerships (ex. between a provider and a health plan; between provider organizations; or between a health plan and a community partner) can supplement existing data, but often for only part of the population you serve.
    - Collecting self-reported data from your employees and your customers may offer the highest quality, most actionable data, but these can be time- and resource-intense to collect and may require a nuanced communication strategy to make people feel comfortable reporting their data.

02 Data needs cont.

Discussion questions and considerations:

3. How often should we refresh our data?
   - While real-time data may be the ideal from a data quality standpoint, more frequent data refreshes generally require greater resourcing – both in obtaining, cleaning, and processing the data.

4. How should we staff our health measurement efforts to ensure a continuous approach over time?
   - Select organizations outsource health equity-related data collection and analysis to a third party. Depending on your organization, this may be more or less expensive than upskilling existing staff and assigning health equity measurement as one of their responsibilities; it may also bring a deeper specialization in this work to your analyses. Some organizations partner with health equity consultants for a one-time (or periodic) analysis of their performance; others hire data aggregation platforms as more permanent component of a larger approach.
   - Some organizations prefer to hold a council representing key internal (and often external) stakeholders responsible for developing and implementing health equity-related decisions. Others prefer to hold all senior executives, or all organizational leaders, accountable for advancing health equity-related goals. Consider leadership buy-in, existing decision-making structures and processes, and available accountability tools when choosing the right option for your organization.

Publicly available data can help fill demographic gaps

Blue Shield of California

Headquartered in Oakland, Blue Shield of California is a nonprofit health plan that serves over 4.5 million Californians. Blue Shield and its affiliates provide health, dental, vision, Medicaid and Medicare health care service plans.

Neighborhood health dashboard centralizes publicly available health data

- Blue Shield of California recognized that a lack of readily available neighborhood level data made it difficult for hospitals, physicians, community organizations, and more to understand the health of the community and address neighborhoods' health needs.
- Blue Shield of California created The Neighborhood Health Dashboard to consolidate publicly available data on approximately 125 metrics into a single, publicly available tool.
  - Prioritized metrics that are frequently updated and allow users to drill down into meaningful levels of granularity (e.g., census tracks) and focus on both SDOH[1] and the intersections of health.
  - The Neighborhood Health Dashboard directly advances Blue Shield of California's goals of democratizing data and helping organizations develop their CHNAs.[2]
- Blue Shield of California often layers data from The Neighborhood Health Dashboard onto their own claims data to guide internal social determinants of health initiatives aimed at improving health equity in neighborhoods statewide

1. Social determinants of health.
2. Community health needs assessment.

Advisory Board interviews and analysis.

03 Analysis protocols

Conversation:

How do we design standardized protocols that avoid introducing biases in our collection and analysis of health equity-related data?

Discussion questions and considerations:

1. How do we ensure all our data analysts are using the same definitions, asking the same questions, and using similar dashboards when they're engaging with this data?
   - Trainings, shared data platforms, reporting structures, and centralized teams are all potential solutions to consider.

2. Can we create a rubric for evaluating the quality of our data sets, the ways our data sets are layered together, and any algorithms that use our data?
   - Datasets require continual monitoring to ensure the best quality. A variety of stakeholders (ex. data analysts, data scientists, front desk staff, and clinical researchers) may contribute to data collection, cleaning, and processing, so creating a rubric for evaluating the data will ensure that all workstreams are compatible and efficient.

Advisory Board interviews and analysis.

03 Analysis protocols cont.

Discussion questions and considerations:

3. Can we create a rubric for how we share and present data to ensure we do not stigmatize or marginalize any communities?
    - When you evaluate and present data, it's important to incorporate how your methodology may introduce bias. Some organizations prioritize using "standardized" language when presenting data to ensure that there is a common language throughout the organization.
    - Interpretation of data points is as important as the data points themselves. Consider your audience (ex. internal health care experts versus community partners) when you share your findings and consider if the language used (ex. medical terminology) or accessibility of your insights (ex. a reliance on p-scores) could isolate anyone in your audience.

03 Analysis protocols cont.

Discussion questions and considerations:

4. Which data is best collected through self-reported methods? How do we make individuals feel safe sharing their data with us?
   - Many organizations report that the quality of self-reported data is higher than that relayed from one person to another; however, it can be harder to standardize the collection of this data, leading to fewer responses being collected. We have not found one best practice, but we've heard of organizations training clinical staff; simplifying tech support; testing appropriate framing of questions; building processes to reconcile incongruous data; and experimenting with providing time and platforms for individuals to self-report their data such as patient surveys embedded into EHR platforms.

03 Analysis protocols cont.

Discussion questions and considerations:

5. What are the limitations of our datasets? Given these, what considerations do we need to incorporate when we generate insights and set priorities coming out of our data analysis?
   - Understanding your data's vulnerabilities (ex. sample size, modeled data, inconsistencies, etc.) and articulating how these shortcomings impact your findings (including any types of conclusions they may preclude you from drawing) may be more practical than trying to find a better dataset.

> We recognized that we had work to do in improving the quality of our race and ethnicity data, but we also knew that we could begin to look at disparities with the data we currently had. If we did find a health disparity, it was likely to be real. If we did not find a disparity, we would have to acknowledge that a disparity may be hidden by the bias of our race and ethnicity data collection.
>
> Data and Analytics Leaders
> Intermountain Healthcare

Source: Blagev, et al, "On the Journey Toward Health Equity: Data, Culture Change, and the First Step," NEJM Catalyst Innovations in Care Delivery, July 2021.

Standardize data collection and analysis protocols to minimize bias

Intermountain Healthcare

A not-for-profit health care system based in Utah comprised of 24 hospitals, a Medical Group with more than 2,400 physicians and advanced practice clinicians at about 160 clinics, a health plans division called SelectHealth, and other health services.

Frameworks can create a "common language" and minimize bias

- To mitigate biases in the AI[1] algorithms they use to predict risk among their patient population, Intermountain's data and analytics team created a framework to prevent their algorithms from learning and perpetuating biases.
- The data and analytics team also wrote a 10-pager DEI playbook that outlines empathetic design, how to incorporate DEI into their product, how to disaggregate race and ethnicity data, and guidance on how they can limit bias and ensure that they don't marginalize groups when presenting their data.
- On the clinical side, Intermountain created a framework to ensure they're collecting equity-related demographic data and using it in a standard fashion. Each department is responsible for displaying its data via dashboards using the same definitions to prevent misuse and create a common language.

Superimposing an equity lens on data combats perpetuating inequities

- Partnering with Vizient, a third-party vendor, allows Intermountain to benchmark performance metrics, quality metrics, and health outcomes with a health equity lens. This data enables analyses around race, ethnicity, language, and sex.

1. Artificial intelligence.

Advisory Board interviews and analysis.

Mitigate bias by collecting self-reported patient data

Sutter Health

Sutter Health is a not-for-profit integrated health delivery system headquartered in Sacramento, California, serving more than 100 communities in Northern California including Sacramento, San Francisco, and Modesto. It operates 24 acute care hospitals and over 200 clinics.

Self-reported data improves data reliability and validity

- Sutter collects SDOH[1] and demographic data through various channels:
  - Providers can collect patient information on non-clinical and social factors such as housing security, food security, and domestic violence through their electronic medical records. The standardization of data collection within clinics will be implemented in 2022.
  - Outpatient facilities collect SDOH and demographic self-reported data at the point of patient encounter and via patient online portal. Asking prior to or during a clinical encounter gives patients the opportunity to ask questions and discuss concerns with their provider.

1. Social determinants of health.

04 Demographic groups considered

Conversation:

How will we prioritize the different identity groups and intersectional groups we want to analyze in our data without becoming mired in analyses?

Discussion questions and considerations:

1. What different demographic data do we have access to? How reliable are these data?
   - Consider underlying factors of identify rather than just REGAL data, such as immigration status, gender identity, etc. See "Taking a Data-Driven Approach to Identifying and Reducing Disparities" for more on the types of demographic lenses to consider.

2. What group should we use as our comparison group?
   - We commonly hear of three comparison groups:
     - The group with the best desired health outcome – this is the group we recommend using as your comparison.
     - The whole population – finding the average outcome of the whole is easier than finding the average for a subgroup. But while setting the overall average as the goal may help reduce disparities, it doesn't put you on a course for truly achieving health equity.
     - White people, and even more specifically, white males – this group is often assumed to have the best desired health outcome. That may often be true, but it is not always, which is why we recommend using the group with the best desired outcomes instead.

04 Demographic groups considered cont.

Discussion questions and considerations:

3. What intersectional lenses do we want to use in our analyses?
   - Stratifying metrics using one layer of demographic data is a good start, but overlapping multiple demographics simultaneously is best practice for revealing hidden disparities. Conducting secondary research, collecting community expertise, understanding the size of different intersectional groups, and looking for disparity patterns across your analyses can help you set hypotheses to inform which intersections you prioritize.

04 Demographic groups considered cont.

Discussion questions and considerations:

4. How do we prioritize between the endless combinations of identity groups in a principled way?
   - An intersectional analysis allows organizations to identify groups most at risk and better design targeted interventions to address those inequities.
     - For example, an organization might stratify by ethnicity and reveal that Black patients have disproportionately lower vaccination rates. This population is still broad, so the organization overlays vaccination rates among Black patients with more categories, such as place of birth, age, and gender. Because of this added layer, they discover that male Black non-U.S. born patients experience higher rates compared to female Black U.S. born patients. Without an intersectional approach, this disparity would have remained hidden, and the organization's efforts would not have been as targeted, and thus, effective.

05 Prioritization of opportunities

Conversation:

How will we objectively prioritize between different inequities that surface in our measurements so that we avoid spreading resources too thinly to make an impact?

Discussion questions and considerations:

1. Which prioritization metrics would best align with our organizational values, goals, and strategies?
   - There is no one-size-fits-all approach to prioritizing disparities since organizations have different values, goals, and strategies to shape their future commitments. They also have varying historical legacies with modern-day manifestations (racism, intergenerational poverty, medical abuse) that have shaped their present-day community needs. Given finite resources, these factors need to be weighed when deciding which disparities to address first.
   - Satisfying at least four of the following five factors should help ensure you are prioritizing disparities that are both aligned to your community's needs and feasible to sustainability address.
     - Is this disparity a priority for my organization's broader community?
     - Does my organization have the infrastructure and resources to address the disparity?
     - Will I focus on addressing the most disparate outcomes that have the most significant impact on health status in the short and long-term?
     - How many people will be impacted if I reduce this disparity?
     - Will addressing this disparity drive financial value for my organization?

05 Prioritization of opportunities cont.

Discussion questions and considerations:

2. Should we weight prioritization metrics differently?
   - Consider if and how you'll weigh priorities relative to each other before applying your prioritization criteria to the outcomes of your health equity measurements.
   - For example, an organization struggling to free up budget or drum up leadership support for health equity efforts may ascribe higher value to efforts that align with their strategic plan or that have neutral or positive modeled financial ROI[1]. An organization under intense public scrutiny might apply greater weight to the size of the impacted population.

3. How do we account for qualitative metrics in our prioritization?
   - To strengthen data collection and fill in gaps of knowledge, supplement quantitative data with qualitative insight (ex. feedback collected from advisory councils and focus groups, trends identified in patient interviews or freeform answers in patient surveys, and more.) This adds context to trends that might not be as apparent in numbers and statistics alone.
   - The key is to still consider qualitative information in a uniform way during your prioritization, and not to allow isolated anecdotes to sway a decision—a common error since many of us are easily influenced by stories.

1. Return on investment.

06 Timeline for measurements

Conversation:

What timelines should we use in our measurements?

Discussion questions and considerations:

1. What timeline will align with our business needs and goals?
   - Longer timelines stand a better chance of showing positive change, but they allow for the introduction of confounding variables that make it harder for changes to be attributed to the health equity investment.
   - For example, Vienna Medical Center has found that it can recoup a large part of most of its health equity investments in a one- to two-year timeline; however, truly realizing positive financial ROI requires them to consider a five- to ten-year timeline—if a positive financial ROI is even feasible.

2. How do we maintain accountability for progress when goals will require long timelines?
   - Create milestone goals within your established timeline to promote accountability, course correct as necessary, and help inform important decision points. These can also help you highlight progress, thus driving stakeholder engagement and sustaining buy-in.

07 Downstream impacts

Conversation:

What impacts beyond patient outcomes do we want to include when we measure "return" on our health equity investments?

Discussion questions and considerations:

1. Beyond improvement in equity of outcomes, are there any other expected benefits of health equity improvement initiatives that we want to measure?
   - Discuss financial and non-financial factors that your organization values that should be factored into your analyses (e.g., lower readmissions, lower ED utilization, etc.).
     - Remember that positive financial ROI is not necessary for an initiative to be successful. For example, one organization saw a net neutral financial ROI on a health equity investment but considered their investment successful because it improved patient outcomes.

2. What ancillary impacts and outcomes for the target group should we include in our analyses?
   - Health equity initiatives can have unintentional or indirect impacts on the target group that could positively or negatively impact both patient outcomes and revenues. For example, improving breast cancer screening rates could lead to stage migration, improved outcomes, and long-term decreased reimbursement for this group—which of those impacts will you include in your financial ROI?
   - Types of ancillary impacts to consider include impact on PR, staff morale, consumption of other types of care, case mix, payer mix, patient/member experience, etc.

07 Downstream impacts cont.

Discussion questions and considerations:

3. Should we consider the impact, positive or negative, that our efforts might have on other demographic groups?
   - Sometimes a rising tide raises all boats, but sometimes it could have negative impacts on those who have benefited from inequities (i.e., improving access for one group might worsen access for another group, unless we commensurately expand capacity). Are we comfortable acknowledging that? How should it factor into a business plan and ROI analysis?

4. What confounding factors should we control for in our analyses to help verify that returns are attributable to the health equity investment?
   - It may not be possible to control for every confounding factor, but it is still important to acknowledge the limitations to increase the reliability and validity of your analyses.
   - Types of potential confounders to consider: policy changes, demographic factors, hospital characteristics, other health equity investments or programs currently in place.

Advisory Board interviews and analysis.

Unintended consequences impact realized ROI

CareSource

Headquartered in Dayton, Ohio, CareSource is one of the nation's largest Medicaid managed care plans.

Accounting for unintended consequences can lead to a more realistic financial ROI

- CareSource invested in a workforce development program called CareSource JobConnect™ to help improve financial stability for targeted members.
- Initially, their financial ROI saw a reduction in ED use, as well as the total cost of care for targeted members, and cost of the program.
- In practice, they did see those predicted results, but they also found that the program unintentionally led to increased pharmacy utilization believed to be resulting from working with a life coach and better adherence to prescribed medication.
- Although increased pharmacy utilization was positive from a treatment adherence perspective, CareSource had not considered the indirect costs of filling these prescriptions when they modeled financial ROI for the CareSource JobConnect™ program during the business planning stage, and it impacted their overall financial ROI.
- This experience pushed CareSource to think more broadly about the impact their programs will have and include ancillary consequences in their financial ROI calculations.

Advisory Board interviews and analysis.

08 Activating insights

Conversation:

How do we translate our measurements into actionable insights and accountability by sharing data and metrics in a meaningful way within and outside our organization?

Discussion questions and considerations:

1. Which metrics should we share?
   - Internally – consider sharing metrics that reflect your organization's values, mission, and goals to encourage transparency and accountability.
     - Example: metrics required for members of a broader network (e.g., Healthcare Anchor Network[1]) or for grants and other sources of funding, metrics that support organizational DEI goals (e.g., diversity in leadership roles and hiring statistics) and clinical goals.
   - Externally – consider your organization's comfort with sharing metrics that may cast you in an unfavorable light. This can create additional urgency and accountability but may be something your board or leadership prefer to avoid or to work up to. Some groups of organizations agree to report on a common set of metrics to help push through this discomfort and to hold each other accountable.
     - Some organizations also prioritize sharing metrics used by ranking institutions (e.g., U.S. News, World Report) and government agencies (e.g., CMS, NQS[2]).

1. The Health Anchor Network creates a space for health systems to convene and share best practices for addressing the structural drivers of poor health outcomes.
2. The National Quality Strategy is a government entity that aims to improve health care by aligning public- and private-sector stakeholders.

"About the Healthcare Anchor Network," Healthcare Anchor Network, https://healthcareanchor.network/about-the-healthcare-anchor-network/. "About the National Quality Strategy," National Quality Strategy, November 2016, https://www.ahrq.gov/workingforquality/about/nqs-fact-sheets/fact-sheet.html

Advisory Board interviews and analysis.

08 Activating insights cont.

Discussion questions and considerations:

2. How can you display insights and data in a standard way so that it creates a common language?
   - Consider a tool, such as a dashboard, that can be easily shared either internally or externally. A shared tool that displays data in a similar fashion allows departments to easily examine data from a different perspective.

3. Who will be responsible for sharing and updating data internally and/or externally?
   - Consider establishing a council or other centralized body that will regularly meet to keep track of progress. This can help keep stakeholders accountable and facilitate the sharing of best practices to streamline and improve health equity efforts.

Advisory Board interviews and analysis.

Dashboards and councils democratize data and promote accountability

Intermountain Healthcare

A not-for-profit health care system based in Utah comprised of 24 hospitals, a Medical Group with more than 2,400 physicians and advanced practice clinicians at about 160 clinics, a health plans division called SelectHealth, and other health services.

Internal and external councils promote organizational accountability

- Intermountain data analysts have incorporated demographic data, including disaggregated race, ethnicity, sex, and language, into all existing key performance indicators and clinical dashboards. This makes it easy for any stakeholder across the system to easily analyze health equity across any business unit or strategy.
- Intermountain established internal and external councils to promote accountability and to create a feedback loop.
  - They recently launched a Health Equity Advisory Council that includes stakeholders from the community and strives for co-leadership.
  - Their internal equity steering committee promotes transparency and helps hold their organization accountable by calling out areas of improvement or areas where potential biases might exist and unintentionally perpetuate disparities.

Advisory Board interviews and analysis.

Internal and external dashboards provide transparency into most relevant data

Rush University System for Health

Rush comprises Rush University Medical Center, Rush University, Rush Copley Medical Center and Rush Oak Park Hospital, as well as an extensive provider network and numerous outpatient care facilities.

Dashboards encourage transparency and accountability within the organization and throughout the community

- Rush University System for Health created both an internal and an external dashboard to promote accountability across the organization and within the community. Each dashboard centralizes metrics that they prioritize to keep track of progress across different domains:
  - Their internal dashboard tracks metrics within the following domains: Health Anchor Network, employees, patients, and organization. This dashboard is only available to individuals internal to Rush University System for Health.
  - Their external dashboard tracks metrics such as life expectancy, but Rush Health is actively conducting CHNAs[1] to establish additional community-centered metrics to include in this dashboard. This dashboard also shares data with the community and compares Rush's progress with institutions across their area.

1. Community health needs assessments.

More resources on how to measure health equity opportunities at your organization.

All resources are available on **advisory.com**

OUR TAKE

Take a Data-Driven Approach to Identifying and Reducing Disparities

TEMPLATE

Equity Impact Assessment (EIA) Template

CASE STUDY

How Seattle Children's Created a Data Infrastructure to Advance Health Equity

Advisory Board interviews and analysis.

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