This is the third in a series of Issues Briefs framing the complex issue of affordability. These briefs can be used to initiate conversations with stakeholders in your community.

What is Health Equity?

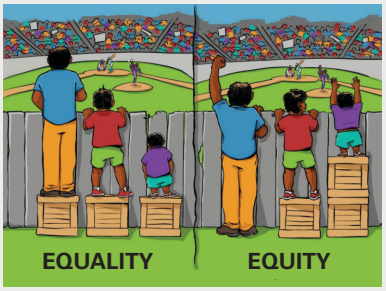
The best way to examine the connection between health equity and value is to start by understanding health equity. Health equity has been defined as the attainment of the highest level of health for all people.[1] It also has been described as a situation in which everyone has a fair and just opportunity to be as healthy as possible.[2]

Health equity is achieved by providing care that does not vary in quality by personal characteristics such as gender, ethnicity, geographic location and socioeconomic status. Therefore, achieving health equity requires a concerted effort to increase opportunities to be healthier for everyone, including those for whom obstacles are the greatest.[3] For example, efforts must encompass individuals facing poverty, discrimination or its consequences, and lack of access to good jobs with fair pay, quality education, housing and health care.[4]

The term health equity is often used synonymously with health disparities, and while closely linked, they are not the same. Health disparities reflect differences in health status between populations, for example, a higher burden of illness, injury, disability or mortality experienced by one group relative to another.[5]

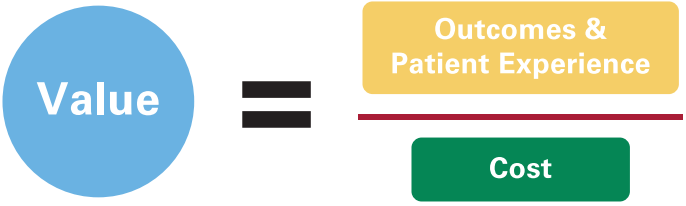
While health disparities are often viewed through the lens of race and ethnicity, they occur more broadly.[6] In fact, health disparities adversely affect groups of people who have systematically experienced greater obstacles to good health based on their religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.[7] Identifying and addressing health disparities is a central and critical way to measure progress toward health equity.[8] Put another way, we must, as a health care field, address health disparities to create health equity.

Illustrating Health Equity



The Interaction Institute for Social Change commissioned an artist to illustrate the difference between equity and equality.[9] This illustration highlights why equity is not necessarily the same as equality. **Equality** means that everyone gets the same size crate to see over the fence – leading to some individuals being able to see over the fence, while others cannot. **Equity**, however, means that everyone gets what they need in order to improve the quality of their situation. Here, this means that everyone gets a crate that is right-sized, allowing all individuals to see over the fence. When translated to health care, health equity means that all individuals receive the tools and resources they need to achieve health and well-being.

The Connection between Health Equity and Value



Research has shown that improvements in health equity can provide tremendous value to patients, hospitals and the health care delivery system. As we have discussed in previous issues briefs, AHA approaches the issue of value using a definition that incorporates not only the cost of care, but also quality outcomes and patient experience. Health equity and the health care disparities that contribute to inequity can impact both the cost of caring and quality components of the value equation, as discussed below.

- **Cost of Caring.** While hospitals and health systems have long addressed the issue of health equity on moral grounds, there also is an economic case for addressing health equity. Researchers estimated that health disparities amount to approximately $93 billion in excess medical care costs and $42 billion in lost productivity per year.[10] The same analysis estimated that our country would see a projected economic gain of $230 billion per year if these same disparities were eliminated by 2050.[11] Another analysis estimates that the economic burden of health disparities in the U.S. is projected to increase to $126 billion in 2020 and to $353 billion in 2050 if disparities remain unchanged.[12]

  Hospitals and health systems have implemented a variety of strategies to improve health equity and reduce cost. For example, hospitals are investing in cross-cultural training and professional medical interpreter services for patients with limited English proficiency. These patients tend to experience more medical errors, have longer lengths of stay, and may undergo more diagnostic tests as a result of language and cultural barriers.[13] By addressing these communication challenges, hospitals have been able to realize cost savings by ensuring better, more accurate ordering of tests, improved efficiency in the discharge process and decreased lengths of stay.[14]

- **Quality Outcomes.** Health equity and quality are intricately connected. Efforts to address health equity are, by definition, aimed at improving the quality of care received by all patients, regardless of race, ethnicity, or other personal characteristics. In addition, efforts by hospitals and health systems to improve quality outcomes often are focused on eliminating health disparities and reducing inequity.

  One example is the significant work by the hospital field to reduce readmission rates among diverse populations. Research shows that patient characteristics such as race, ethnicity, language proficiency, or socioeconomic status, among others, may predict readmission risk and readmissions.[15] The Centers for Medicare & Medicaid Services found, through evaluations of its Hospital Readmissions Reduction Program, that minority and vulnerable populations are more likely than their white counterparts to be readmitted within 30 days of discharge for chronic conditions, such as congestive heart failure.[16] These findings have implications on both cost and quality, and hospitals and health systems have responded by implementing a variety of strategies to reduce readmissions among these diverse populations. Some steps include:

  - Providing early discharge planning and follow-up for patients at high risk for readmission;
  - Determining whether patients have a primary care provider, and if not, providing a referral and ensuring that patients are connected to a primary care provider; or
  - Connecting patients with community-based resources such as personal care, home-delivered meals and services that address social determinants of health and financial barriers.[17]

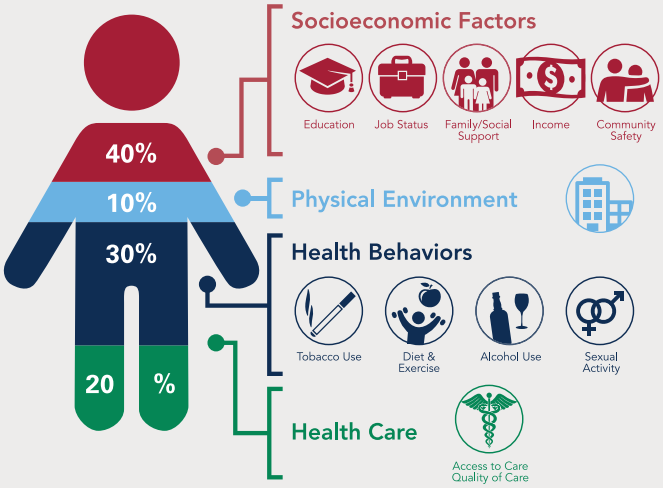
Societal Factors are Critical

Individuals' ability to attain their highest level of health is tied to more than just access to health care or the quality of health care services they receive. Eighty percent of an individual's health is tied to their physical environment, social determinants (where they live, work and play) and behavioral factors (e.g., exercise or smoking).[18] If an individual is homeless, lives in unsafe or unhealthy conditions or does not have transportation to get to needed medical appointments or access to food, it will impact his or her health. As a result, addressing these disparate societal factors will be critical to improving health equity and promoting value.

One example of hospitals and health systems coming together with their community to address the social determinants is the **Women Inspired Neighborhood (WIN) Network** in Detroit. That city's infant mortality rate has been among the highest in the nation for years. In 2008, area hospitals and health systems (including Henry Ford Health System, Detroit Medical Center, Beaumont-Dearborn Healthcare System and St. John Providence Health System) joined together to form the Detroit Regional Infant Mortality Reduction Task Force to address this issue.

The result was the creation of the WIN Network, which empowers mothers and their support partners to help babies thrive beyond their first birthdays. Community health workers guide expecting mothers through a safety net of social, emotional and clinical supports. In groups clustered by gestational age, participants learn the CenteringPregnancy® curriculum with an added focus on social determinants of health. Community health workers conduct home visits through babies' first birthdays and continuously guide women to resources. To date, the WIN Network has:

- Served 364 African-American women between the ages of 18-34, having zero preventable infant deaths and better-than-average rates of pre-term and low-birth weight deliveries.
- Helped more than 1,000 non-pregnant women improve knowledge around infant mortality, health literacy, healthy living and family planning.
- Provided health care equity training to over 500 providers and health care professionals.



Hospitals and Health Systems Improve Health Equity and Promote Value

Hospitals and health systems are employing a number of approaches to improve health equity and promote value. Examples of activities include developing strategic plans to reduce disparities, standardized collection of a patient's race and ethnicity, stratification of quality measures by race and ethnicity, improving diversity in leadership and governance, developing quality measurement tools to monitor for disparities and community-based efforts to improve primary care services and medical homes. In addition to these efforts, hospitals and health systems have implemented interventions to address disparities when they are found.

The Value Initiative *Members in Action* series highlights how some hospitals and health systems have implemented value-based strategies, including those that address health disparities, to promote value. For more information on these and other case examples, please visit *www.aha.org/TheValueInitiative*.

Sinai Health System in Chicago launched a program to address the growing number of children coming to the emergency department (ED) seeking asthma treatment. The community-focused initiative, Asthma CarePartners (ACP), is run by Sinai Urban Health Institute, Sinai Health System's research arm, and partners with Medicaid managed care organizations, health systems and private insurers to integrate community health worker (CHW)-led home asthma interventions into standard health care delivery. CHWs work with children, their caregivers and adults to improve their asthma control. They use education, support and guidance to empower patients. Patients enrolled in ACP miss fewer days of school, are more physically active and lose less time from work. They also have seen an approximately 60 percent reduction in asthma symptoms and the use of quick-relief medication, such as inhalers. In addition, the program reports ED visits have been reduced by 75 percent, hospital days reduced by 80 percent and urgent clinic visits reduced by 91 percent. Sinai estimates $3 to $8 in health care costs are averted for every $1 spent on the program. Building on ACP's success, Sinai expanded the CHW model to include diabetes care and breast health navigation.

Clinch Valley Medical Center in Richlands, Va., started its Bridge Program in partnership with a local not-for-profit, Appalachia Agency for Seniors Citizens (AASC), as a way to better transition patients from the hospital to home to renewed health. A core team of 10 staff members from Clinch Valley and AASC, including case workers, pharmacists, respiratory therapists and representatives from administration and a primary care clinic, make home visits to recently discharged patients to address upstream health issues and social determinants of health that may hinder patients' recovery and well-being. These home assessments uncover health disparities such as an inability to afford prescriptions, no heat in the home, lack of food, a gap in understanding discharge instructions, and other social or environmental barriers. Since the program began in 2012, approximately 165 patients have been served. The program has shown positive benefits. For example, avoidable readmissions for these patients decreased from 11.8 percent to 7.8 percent. And, one patient's monthly cost for prescription drugs decreased from $1,700 to $200.

Allina Health in Minneapolis created its LifeCourse Program to address the upstream challenges patients face when reaching the late stages of serious illness. Since 2012, it has helped patients and their families navigate the complexities of serious illnesses, such as cancer, Parkinson's disease and advanced heart failure. Patients are selected for this program based on a cast-finding tool and health care provider input. Allina Health employs more than 20 lay health care workers as "care guides," who collaborate with clinical care teams and community partners to support patients. LifeCourse provides longitudinal support not just for days and months, but years as people live with advancing serious illnesses. Patients receive a monthly visit from a care guide, typically in the patient's home. Care guides also are able to accompany

patients to medical appointments. During the first three years of the LifeCourse Program, patients reported an improved quality of life and a better patient care experience. In addition, patients participating in the program had 16 percent fewer emergency department visits; 27 percent fewer inpatient days and 57 percent fewer stays in the intensive care unit. Allina estimates a cost of care savings of $959 per-member, per-month and an 8:1 return on investment.

Building Strategic Alliances

While hospitals and health systems have taken steps to address value and health equity, they alone cannot achieve health equity. Partnerships with others stakeholders in their community is crucial in addressing social needs. To that end, the AHA is forming strategic alliances at the national level with outside stakeholders to advance health equity in communities across the nation.

> **Addressing disparities is no longer just about morality, ethics and social justice: It is vital to performance excellence and improved community health. As hospitals face greater responsibilities to manage community health, equity of care is essential.**
>
> National Call to Action to Eliminate Health Care Disparities. A partnership between the AHA, America's Essential Hospitals, Association of American Medical Colleges, American College of Healthcare Executives, and the Catholic Health Association of the United States.

National Urban League (NUL). The AHA is working with the NUL to advance health equity and diversity in health care leadership in communities across the nation. This effort includes matching hospitals and health system CEOs with local NUL leaders interested in opportunities to serve on their governing boards. The alliance also is creating resources for the field and sharing best practices on how hospitals and health systems can integrate CHWs as part of their care teams. Additionally, AHA serves on the NUL's Washington Bureau Urban Solutions Council, which collaborates with partners to advance aligned policy solutions.

UnidosUS (previously known as the National Council of La Raza). This alliance seeks to increase diversity among health care executives and improve the health of communities. The organizations will connect health care CEOs with UnidosUS leaders for governance opportunities at AHA-member hospitals and health systems, foster a culture of health through a new UnidosUS advisory committee, and share effective programs to prevent youth violence and provide post-trauma support.

Commit to the Equity of Care Campaign

America's hospitals and health systems are working hard to ensure that every person in every community receives high-quality, equitable and safe care. To accelerate progress on these efforts, the AHA in 2015 launched its **#123forEquity Pledge Campaign**, which asks hospital and health system leaders to begin taking action to accelerate progress on the following areas:

- Increasing the collection and use of race, ethnicity, language preference and other socio-demographic data;
- Increasing cultural competency training;
- Increasing diversity in leadership and governance; and
- Strengthening community partnerships.

Hospitals and health systems also can take the pledge and commit to working on efforts within their organization or in the community related to health equity and diversity and inclusion, even if the efforts do not fit clearly under one of the pledge goals listed above. To date, more than 1,500 hospitals have signed the 123forEquity Pledge and have taken measurable steps to improve diversity, inclusion and health equity.

Many of these hospitals and health systems also have demonstrated comprehensive gains in addressing health disparities in the communities they serve, including AHA's 2018 Equity of Care Award winner, **Navicent Health** in Macon, Ga. Since committing to the 123forEquity Pledge in 2015, Navicent Health has committed to documenting health outcomes by evaluating race, ethnicity and language preference data collected at the time of admission in patients with certain conditions. In addition, Navicent Health has created programs to help influence social determinants of health and improve condition-specific access to clinics for diabetes, heart failure and chronic obstructive pulmonary disease (COPD).

Navicent Health has resolved readmission health disparities among African-American patients with COPD, heart failure and diabetes, as well as health disparities among females with diabetes. In addition, it is improving the overall readmission disparity among African Americans. Navicent Health's dedication to health equity also resulted in the development of a cultural competency and engagement program, which supported patients, employees, associates, physicians, vendors and other partners in 2017.

For more information and/or to commit to the equity campaign, visit: *www.equityofcare.org*.

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