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Health Equity Integration Checklist

The **HealthBegins Health Equity Integration Checklist** helps guide quality improvement projects in addressing health disparities* by ensuring key steps are followed:

1. **Disparity Identification:** Recognize and describe health disparities among different population groups.
2. **Data Analysis:** Collect and analyze relevant data to understand the causes of disparities.
3. **Stakeholder Engagement:** Involve affected communities, families, and/or patients to validate findings and inform interventions.
4. **Intervention Design:** Develop targeted interventions linked to desired outcomes with necessary resources.
5. **Monitoring and Evaluation:** Track progress, adjust interventions, and communicate results to stakeholders.
6. **Sustainability:** Ensure long-term success by integrating strategies into ongoing programs and securing needed resources.

This checklist ensures a comprehensive approach to health equity, from identification to long-term sustainability, and can be utilized by practices and independent physician association associations (IPAs) to integrate health equity within quality improvement projects.

***Health Disparity:** A health difference linked to social, economic, or environmental factors. Health disparities can affect groups of people who have historically faced greater obstacles to health. Factors that can contribute to health disparities include race or ethnicity, socioeconomic status, age, mental health, disability, sexual orientation, geographic location, discrimination, and poverty. Health disparities are the metric used to measure progress toward achieving health equity. (Source: Office of Disease Prevention and Health Promotion)*

1. Identify Disparities	Yes	No
Describe the identified disparity or disparities that your project will address. Identify the population(s) affected by this disparity. ***Guidance:** To identify a disparity, compare data across different groups within a population, looking for statistically significant differences in outcomes. These differences are often based on race, ethnicity, socioeconomic status, gender, or geographic location.*	☐	☐
2. Data Analysis	**Yes**	**No**
Evaluate data: Assess the sources needed for analysis and outline data analysis methodology. Collect data: Gather relevant data on the outcome of interest and stratify the data by geography, race, ethnicity, income level, gender identity, language, etc. Analyze data: Use statistical methods to compare the rates or proportions of the outcome across different groups.	☐	☐

Interpret results: Look for significant differences in outcomes between groups, considering whether the disparity is large enough to be meaningful and potentially avoidable or unjust. A fishbone diagram (p. 16), or cause-and-effect diagram, is a visual tool used to identify, analyze, and display the possible causes of a specific problem. It is shaped like a fish skeleton, with the problem at the "head" and potential causes branching out like fish bones. The fishbone diagram is widely used in quality management and process improvement, helping teams identify issues and develop effective solutions.		
Conduct a Root Cause Analysis (RCA) Use the data collected and analyzed to understand the 'why' behind the differences in outcomes between population groups. ***Guidance:*** *Conducting an RCA will provide insights into the underlying reasons for disparities in outcomes among population groups. These insights will inform the development of targeted intervention objectives for the project's priority population.* ***Example:*** *Colorectal cancer screening data was collected and analyzed by race, comparing screening rates among different racial groups. The analysis revealed a statistically significant difference in screening rates between Black or African American and Asian populations, indicating a disparity, with one group being significantly more likely to be screened than the other. To better understand the factors contributing to this disparity, an RCA was conducted.*	☐	☐
3. Stakeholder Engagement	**Yes**	**No**
Conduct stakeholder engagement to confirm RCA findings related to disparities before developing an intervention design. External stakeholders include the community, families, and/or patients. Internal stakeholders include operations, clinical, administrative, and other staff. ***Guidance:*** *Engagement tools for gathering feedback may include focus groups, community advisory panels, and patient and family advisory councils to validate RCA findings. These approaches promote active community involvement, including patient participation, in health-related decision-making. By fostering open communication, building trust, and equipping individuals with the necessary information and resources, these efforts empower community members to take an active role in their care, ultimately enhancing health outcomes for the entire community.*	☐	☐
4. Intervention Design	**Yes**	**No**
Clearly outline your intervention design and activities, ensuring a direct connection between the intervention and the desired outcome. This serves as	☐	☐

your test of change to measure improvement effectively. The Plan-Do-Study-Act (PDSA) method on pages 22-30 provides a structured approach to testing and refining changes. By following its four-step process, teams can systematically break down tasks, assess outcomes, make improvements, and repeat the cycle for continuous improvement. ***Guidance:*** *For example, if a disparity in colorectal cancer screening rates is identified within a low-income population, review the RCA findings to understand the underlying reasons for the low screening rates. Select one or more identified factors and design an intervention aimed at closing the disparity gap.*		
Identify needed infrastructure, resources (including key personnel), and project support capacity. ***Guidance:*** *Identifying the necessary resources, infrastructure, and capacity is crucial for reducing disparities. This includes staffing, time allocation, budget, technology, equipment, supplies, data infrastructure, and community partnerships. Assessing these needs is essential not only for the project's short-term success but also for its long-term sustainability.*	☐	☐
5. Monitoring and Evaluation Plan	**Yes**	**No**
Determine the metrics you will use to monitor your progress *(e.g., process measures) to meet the outcome of reducing disparities amongst selected population groups.*	☐	☐
Determine how often you will make changes to the intervention design to monitor the impact. ***Guidance:*** *30-60-90 days is the standard monitoring practice timeline.*	☐	☐
Define how you plan to communicate progress on disparity reduction efforts and the frequency of updates with internal and external stakeholders through the process initiated in step 3 (stakeholder engagement). Continue to iterate based on feedback and the results of the intervention.	☐	☐
6. Sustainability	**Yes**	**No**
Determine how the success of this project will be incorporated into permanent programmatic processes. Identify resources, capacity, and infrastructure necessary to support sustainability efforts. ***Guidance:*** *Identify the needed resources, infrastructure, and capacity, such as staffing capacity, time allocation, budget, technology, equipment, supplies, data infrastructure, community partnerships, etc. If barriers exist in these areas, develop a plan to address them. See the appendix for guidance on an example mitigation plan.*	☐	☐

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Appendix

Example Mitigation Plan for Addressing Resource, Infrastructure, and Capacity Barriers to Ensure Long-Term Sustainability

Sustainability Barrier	Challenges	Mitigation Strategies
Resources	• Staffing shortages or lack of skilled staff • Resource Prioritization • Financial constraints or budget limitations • Workforce challenges *(e.g., cultural competency and responsiveness, workforce diversity, staff burnout, lack of bi-/multilingual staff, etc.)*	• Reskill and upskill by investing in training and development programs to upskill existing employees and address skill gaps. • Optimize resource allocation by using level loading principles to allocate resources more efficiently, prioritizing critical tasks. • Consider pooling resources across departments or organizations to increase flexibility and optimize usage. • Prioritize resources towards programs that promote health equity, such as outreach services, transportation assistance, or other social services. Look for ways to optimize clinic operations to ensure resources are used efficiently. • Apply for grants and seek partnerships with philanthropic organizations, government programs, or corporate sponsors to fund health equity initiatives. Public health agencies and nonprofits often offer funding for underserved populations. • Focus on recruitment and training for diversity, leadership, and Management development.

Infrastructure	• Insufficient technological tools or equipment *(e.g., data systems, IT support, informatics, etc.)* • Inaccessible clinical locations *(e.g., physical access challenges)* • Community engagement and Health-Related Social Needs (HRSN) barriers • Lack of electronic health record (EHR) interoperability • Inadequate health information systems for tracking or reporting of metrics and/or demographics	• Seek government funding or grants for infrastructure improvements, particularly for public or community-facing projects. • Update EHR systems to capture key equity metrics, including race, ethnicity, language preference, socioeconomic status, and insurance status. • Collaborate with public health departments, health plans, IPAs, Community-Based Organizations (CBOs), and local nonprofit organizations to share, access, and aggregate health equity data. • Build partnerships with local CBOs, schools, churches, and social service agencies to extend outreach efforts. • Integrate social support services *(e.g., food assistance, housing support, transportation assistance, utility assistance, financial counseling, etc.)* within the clinic or collaborate with external agencies to address HRSN. • Collaborate with local transit systems or offer transportation support/services for patients facing mobility barriers. To mitigate access challenges, consider implementing ride-share partnerships or providing shuttle services for vulnerable populations.
Capacity	• Limited operational capacity *(e.g., inadequate clinical or administrative staff, high turnover rates, insufficient training, outdated/inadequate IT infrastructure, inefficient workflows,*	• Conduct process mapping and identify workflow bottlenecks or inefficiencies. Implement lean healthcare or Six Sigma techniques to streamline workflows.

	financial constraints, inefficient patient flow, etc.) • Overwhelming demand and/or inability to meet growth or scale needs and goals • Workflow bottlenecks or process inefficiencies	• Make staffing adjustments, such as looking into temporary staff positions to handle peaks in workload. • Consider cross-training staff to improve flexibility. • Implement standard work practices for repetitive tasks to increase efficiency. • Implement standing orders to delegate repetitive or low-complexity tasks to other qualified staff. Standing orders can free physicians to focus on more critical, higher-priority tasks. • Be proactive in planning for capacity needs and expand staff capacity through skill development, cross-training, and level-loading techniques.

Resources

5 Ways to Hold Institutions Accountable for Health Equity, HealthBegins, 2022.

A Toolkit to Advance Racial Health Equity in Primary Care Improvement, California Improvement Network, Racial Health Equity Workgroup & HealthBegins, 2022.

Bringing Light & Heat A Health Equity Guide for Healthcare Transformation & Accountability, HealthBegins, Health Leads, Human Impact Partners, JSI & SIREN, UCSF, 2021.

CPT Evaluation and Management (E/M) Guidelines: Implications for Patient Social Risk Data and Health Equity, AMA Ed Hub™ & HealthBegins, 2022.

HealthBegins Upstream Training and Education, HealthBegins & AMA Ed Hub™, 2023.

Improvement Coaching Workshop Workbook, California Quality Collaborative, 2023.

Racial and Health Equity: Concrete STEPS for Smaller Practices, HealthBegins & AMA, 2021.

The Compass for Health Equity Transformation: A Tool to Move from Compliance to Impact, HealthBegins, 2023.

Credits

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HealthBegins is a mission-driven consulting firm that drives radical transformation in health by helping Medicaid-managed care plans, health systems, and social sector clients advance health equity and improve the social and structural drivers that put patients and communities in harm's way.