AMGA QuIC Health Equity Quality and Innovation Collective (QuIC)

Health Equity: Successful Themes, Interventions, and Tips

*In 2023, AMGA brought together nine medical groups, health systems, and academic institutions for the **Health Equity Quality and Innovation Collective (QuIC)**. The program facilitated participant involvement in discussions and activities focused on the implementation of effective health equity initiatives.*

The following sections present the interventions and recommendations from participants, categorized by successful themes.

Community Partners

Concord Hospital: *Improving Vaccination Rates for New Americans*

Intervention **Building Community Relationships to Bridge Disparities in Preventive Health Vaccine Management**

Partnered with community leaders of the New American population to build trust and rapport, and ultimately create a channel of delivery for pneumococcal vaccination.

Built rapport with community leaders and connected via local events to explore perceptions of healthcare interactions and challenges experienced by the New American community. Next steps set up for reoccurring connections at the New American bimonthly meetings at the local community center.

Approach the start of the work with a grassroots-informed approach/health equity-centered design to highlight the key stakeholder population.

Johns Hopkins University: *Social Drivers of Health (SDOH) Screening of Hospitalized Patients*

Intervention **SDOH Screening of Hospitalized Patients by Community Health Workers**

1. Community health workers (CHWs) were trained in SDOH screening questionnaire and data gathering.

"QuIC" Tip

Ensure constant feedback from CHWs on cultural appropriateness of SDOH questions and delivery.

2. Insight into disease management that is attenuated by SDOH factors evolved from growing database.

"QuIC" Tip

Screening for SDOH variables and identifying strong associations with certain diseases holds the ability to improve health outcomes.

Sanford Health: *Obstetrical Care Services for Native Americans*

Intervention **Families First is a collaborative effort among Northern Minnesota's healthcare systems, addressing pregnancy care challenges in rural communities, with a specific emphasis on indigenous women.**

Services include culturally sensitive prenatal classes, specialist care access, home visiting nurse programs, virtual care expansion, and transportation assistance. The program prioritizes emergency response improvement, empowers women with low-intervention births, and respects cultural beliefs, breaking barriers and reducing costs to ensure healthier futures for mothers, babies, and their families across generations.

"QuIC" Tip

Attaining consensus among partners for every major decision the network makes results in a unanimously positive, collaborative experience for all partners.

Utilizing a Data-Driven Approach

Scripps Health: *Assessing and Improving Disparities in Breast Cancer Screening*

Intervention **Scripps leaders assessed various ambulatory quality measures with a health equity lens, leading to breast cancer screening (BCS) as a priority.**

Variation in quality measures by language in BCS for Spanish-speaking women was observed and a digital outreach intervention was launched, successfully closing the gap.

"QuIC" Tip

Apply a health equity lens to your current priorities and processes, including quality measures. Ask the obvious questions.

University of Alabama Health Services Foundation: *Health and Community Assessments in Under-Resourced Neighborhoods.*

Intervention **Addressing Mental/Behavioral Concerns**

1. Surveyed churches in top 10 under-resourced areas to identify health needs within their congregation and surrounding communities. Mental and behavioral health, including anxiety and depression, were identified as #1 concern in Black community.
2. Partnered with a national 503c, The Confess Project, to provide mental health identification and resource training.

Collaborate and share your data with your community partners to create mutually agreed-upon impactful programs.

UC San Diego Health: *Hypertension Disparity among African American/Black Patients*

Intervention **Health Equity Dashboard**

The health equity dashboard allows users to track performance on priority quality metrics and filter by various equity topics for real-time data analysis. Specific areas for improvement can be easily identified and the information is shared at a system and clinic level for visibility and education.

Utilized this weekly dashboard to monitor hypertension control for primary care patients by division, clinic, and provider.

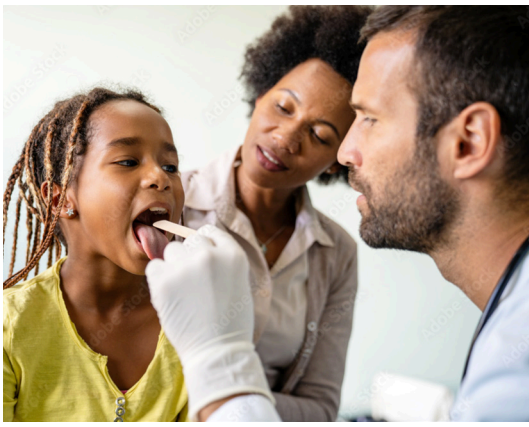
Analyzing the data is important to understanding the population. It can assist in identifying opportunities for developing multipronged strategies that may be necessary to address some health disparities and make improvements.

Provider Education

Guthrie Medical Group: *Diagnosis of Obesity in Pediatric Patients*

Intervention **Provider Education of System Resources**

Met virtually with key provider groups across the system to show the current data and discuss barriers to diagnosis and treatment. Had great conversations about what the Weight Loss Clinic does for new patients. Forming collaborations with engaged providers on education materials and creating group activities with their patients.



Come to providers with data on the current state of pediatric obesity in their population and be open to working with them on the barriers to improvement.

HealthPartners: *Organizational Approach to Hypertension Management with a Focus on Disparity*

Intervention **Hypertension Maintenance of Certification and Continuing Medical Education (MOC-CME): Reducing Health Disparities & Improving Hypertension Management**

1. Clinic Emphasis on Patients with Hypertension

   Focused on clinician role, use of organizational tools and SDoH resources to support improving hypertension management and health outcomes. Utilized all available resources, especially within the clinic itself, to achieve local, organizational, and state goals related to hypertension management.

Focus on how clinics engage with their hypertensive patients and support patient education.

Tie compensation for clinicians to meeting specific care goals at the clinic level, not through individual patient panels.

2. Importance of Patient/Clinic Interactions and SDOH

   Focused on payer and race populations and later applied broadly to all patient populations.

   SDOH-related interventions included:

   - Addressing transportation issues by incorporating more phone/video visits.
   - Encouraging home blood pressure monitoring and education; simplifying health literacy to help in understanding food options that are affordable and sustainable.

Understand SDOH to enhance shared decision making for primary care teams in improving hypertension control.

Henry Ford Health: *Provider Education and Patient Engagement Strategies for African American Residents of Detroit, MI, over the Age of 50, at High Risk for Peripheral Artery Disease (PAD) and Related Complications*

Intervention **To increase community capacity, proposed Heart to Heart Program will provide training to at least 50 volunteer faith community nurses, community health workers (CHWs), health ministers, and community health advocates to equip them with the knowledge, skills, and toolkits needed to encourage high-risk community members to complete PAD screenings and seek higher levels of care, if needed.**

Ensure appropriate funding is available not only to launch, but sustain the program.

Ensure community educators receive training on the specific materials that will be shared.

Ensure barriers to screening follow-up appointments are addressed before the initiative launch; specifically, health insurance coverage barriers.