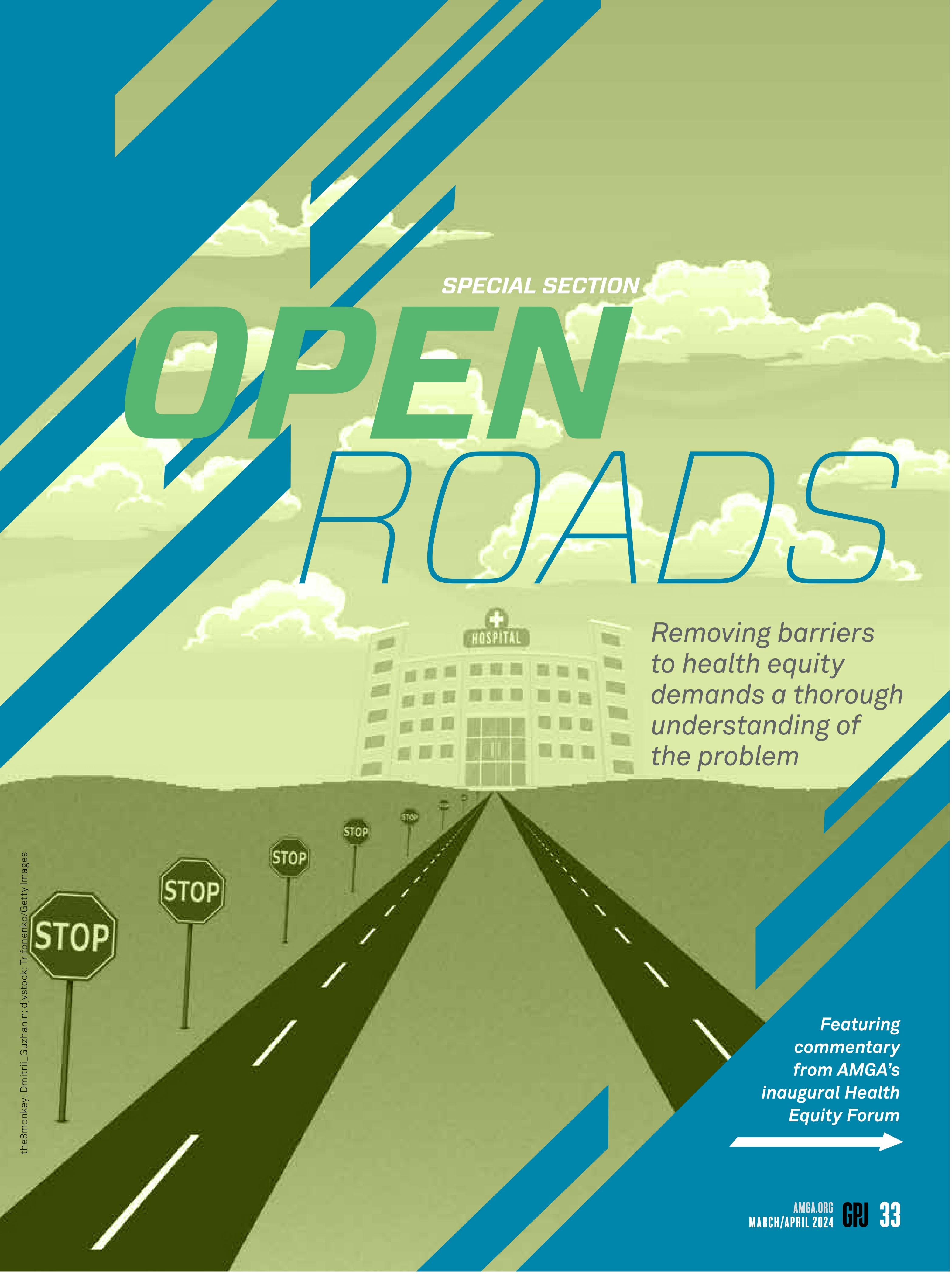
SPECIAL SECTION

OPEN ROADS



Removing barriers to health equity demands a thorough understanding of the problem

Featuring commentary from AMGA's inaugural Health Equity Forum

the8monkey; Dmitrii_Guzhanin; djvstock; Trifonenko/Getty Images

BrandyTaylor/Getty Images

On November 6 and 7, 2023, AMGA held its inaugural Health Equity Forum, bringing together health professionals from across the country to share best practices for improving health equity and bringing diversity, equity, and inclusion (DEI) strategies to life.

Danielle Casanova, vice president, population health initiatives and health equity, AMGA, welcomed participants as they looked ahead to a full day of interactive sessions on implicit bias, community partnerships, and common challenges. For example, what do the Centers for Medicare and Medicaid Services (CMS) 2024 reporting requirements for social drivers of health (SDOH) screening mean for the new year? How can organizations leverage data, like ZIP code information in their coverage area, to identify gaps and optimize resources?

"Health equity can feel huge, and it's challenging and a little bit daunting at times when you think of the whole picture of what needs to happen," Casanova said.

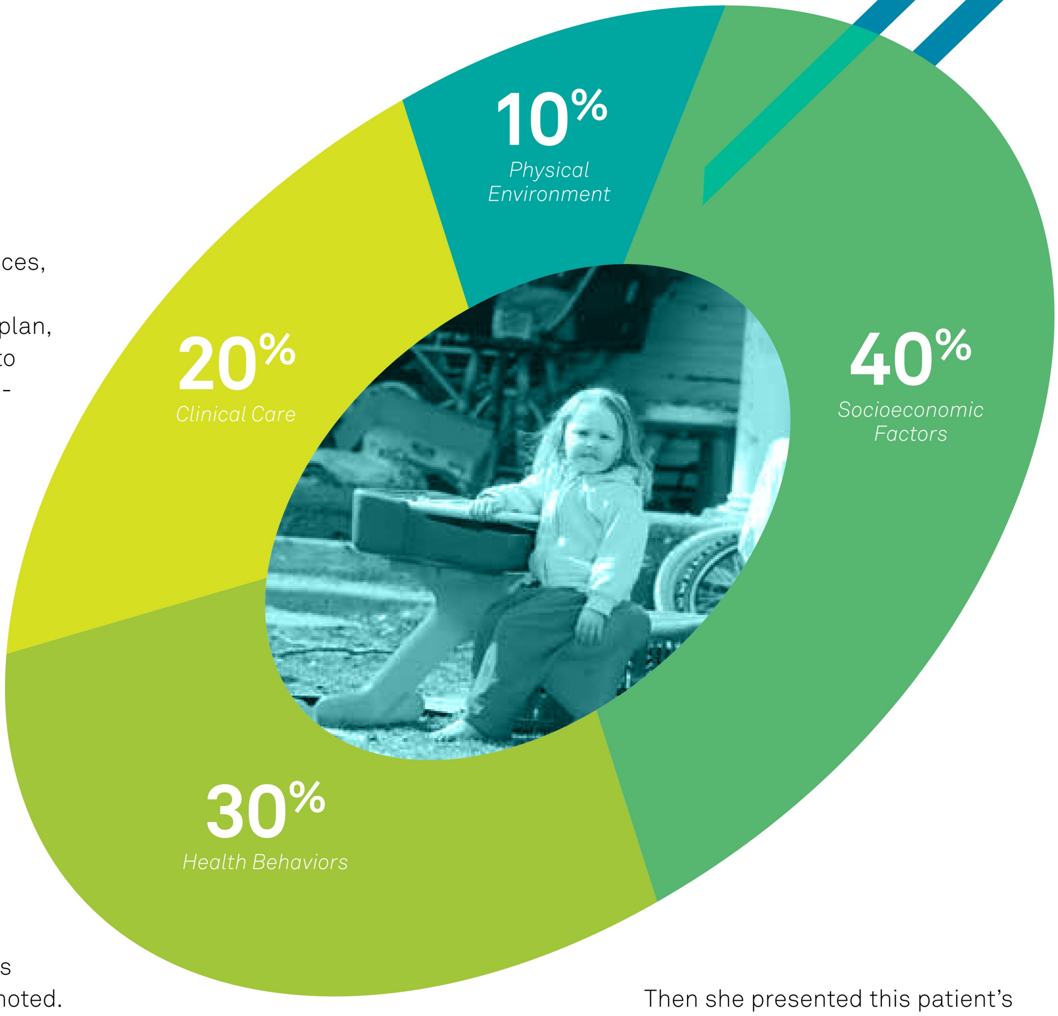
"Changes won't happen in a day, week, or year, because inequity didn't happen in a day, week, or year," she continued. "Don't focus on all of the changes that need to happen at once, but focus on the small incremental steps you can take within your organization."

She thanked the AMGA board and leaders "for not only being passionate but showing action" and introduced AMGA President and CEO Jerry Penso, MD, MBA, who provided a brief background and context for the efforts leading up to this forum.

"AMGA has been working on this for years," Penso said, providing a brief overview on how health equity and measurement have been built into research, education,

Figure 1

Know What Affects Health



quality collaboratives, conferences, and analytics.

"Now that it's in our strategic plan, it becomes an all-AMGA effort to dedicate resources and incorporate accountability into all of the work we do, to make sure we don't just have pretty conversations, but outcomes that show impact."

"We have a lot of work to do," he declared. "I'm impatient, because right now in America, your ZIP code determines your health outcomes and longevity. That's not acceptable, and we have to change that."

AMGA members, the organizations nationwide that take care of 1 in 3 Americans, are in an ideal position to do this work and drive this change, he noted. "In my opinion, we're making history."

Equity Belongs to Everyone

Alisahah Jackson, MD, President of the Lloyd H. Dean Institute for Humankindness & Health at CommonSpirit Health, began her presentation with an anecdote about "Mr. Smith," a 69-year-old male patient with uncontrolled diabetes who was not exercising or adhering to his medications. "He's just noncompliant," she remembers overhearing the care team remarking.

"If you take anything away from today, take that term out of your vocabulary," she said. "I don't believe in noncompliant patients. I don't believe anyone wakes up and says, 'I want to be as unhealthy as possible.' We all have barriers to achieving great health."

Jackson asked participants to consider a few questions. Did the team take the time to know Mr. Smith's story, such as where he lives and whether he has transportation? Did they inquire about his financial and social situation?

Then she presented this patient's reality. Mr. Smith was a retired teacher on a fixed income in a neighborhood with no grocery stores. He had to take two buses just to buy food. His wife did all the cooking at their home, but she had recently passed away. "So, he's dealing with grief on top of all of the other things," Jackson said.

"There are decisions we make every day that impact our health. But there are also decisions being made for us every day that impact our health as well," Jackson stated. To address both, "we must consider the physical and socioeconomic environment and not be afraid to ask questions or get uncomfortable."

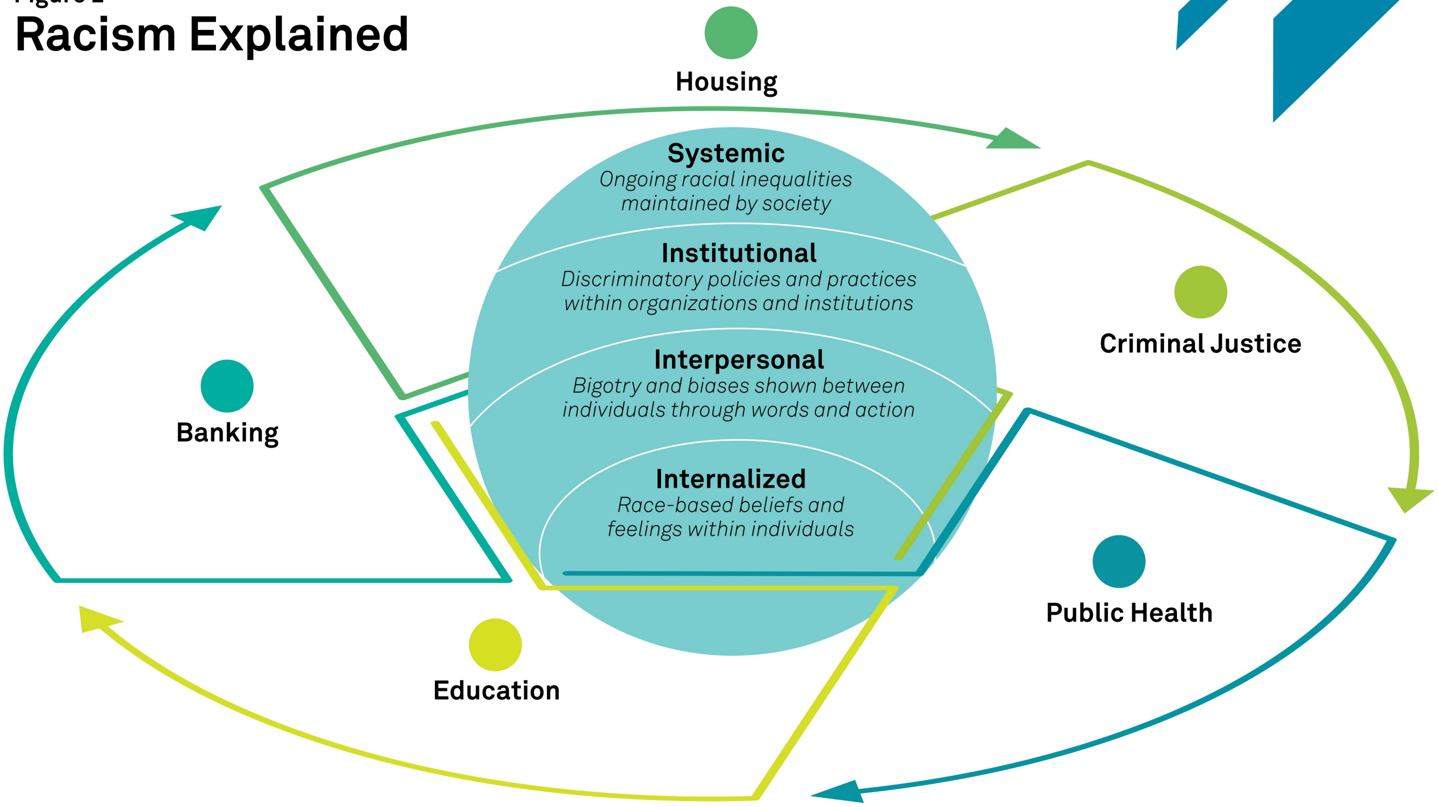
Everyone is affected by socioeconomic factors, Jackson declared. She walked the audience through a show-of-hands exercise, ticking off various health disparities, to illustrate.

"Every single last one of us can be segmented into a group, even white males who are married with two kids and a dog and life in a certain ZIP code. It's not about 'those people over there' or 'those communities.' It's about all of us."

BrandyTaylor/Getty Images

Figure 2

Racism Explained



Morgan, J.D., et al. (2018, May). What Racism looks like: An infographic. Frank Porter Graham Child Development Institute. University of North Carolina at Chapel Hill.

Health disparities have their root in multiple “isms,” she explained: racism, classism, sexism, and beyond. “It’s important that we understand history,” she said. “Racism is a huge driver of the disparities we see in education, criminal justice, housing—you name it.”

Redlining, a practice from the 1930s, still affects African American communities today. “Banks weren’t investing in certain communities, and those areas had the least amount of home ownership. Why is this important? There’s a significant correlation between health and wealth, and home ownership is among the biggest drivers of wealth.”

Racism exists at multiple facets and levels: internalized race-based beliefs and feelings held by individuals, interpersonal bigotry and biases between individuals, institutional discriminatory policies and practices, and systemic, ongoing racial inequalities perpetuated by society.

“The policies and practices that perpetuate disparities are where we need to fight.”

> **“Every single last one of us can be segmented into a group, even white males who are married with two kids and a dog and life in a certain ZIP code. It’s not about ‘those people over there’ or ‘those communities.’ It’s about all of us.”**
>
> **—Alisahah Jackson, MD**

So, how do we all move forward?

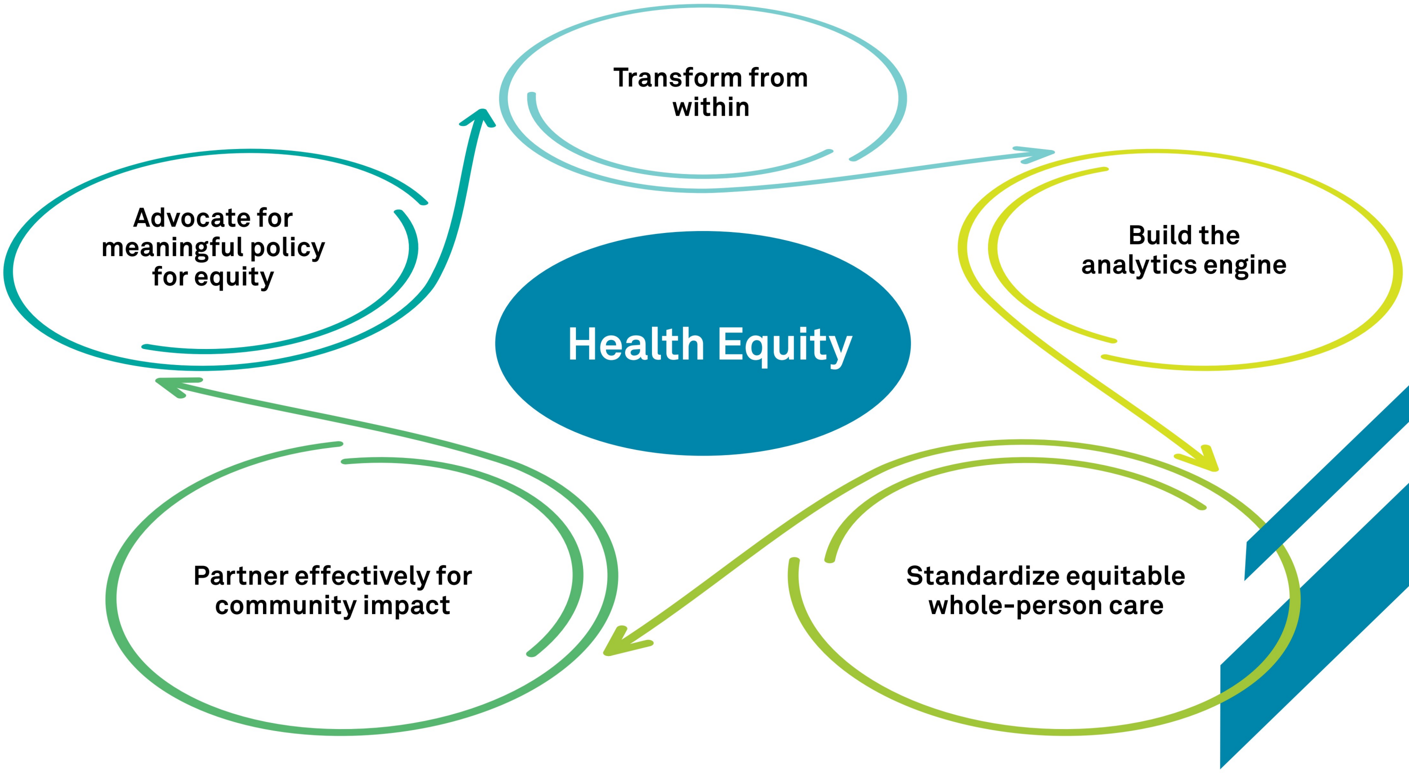
“Decades of science already exist,” Jackson said. “The next step is implementing it, and this involves more than just putting one person in a DEI role.” Organizations need supporting infrastructure, strategy, resources, and accountability, with partnerships and human connection throughout.

She shared examples of such implementation in action, from organizations launching health equity institutes to partnerships for a more diverse workforce. Throughout, she reminded participants that change will require new systems. It will require motivation, collaboration, and innovation to accelerate research into action.

Jackson transitioned into the audience discussion with a quote from legendary tennis player and civil rights activist Arthur Ashe: “Start where you are. Use what you have. Do what you can.”

Figure 3

A Health Equity Blueprint for Action



One participant noted that conversations about health equity can be "like talking politics; sometimes the message doesn't resonate."

In response, Jackson talked about the curve of change management. "There's always 10% who won't get on board and change, and I'm okay with that. It's the other 90%—that's where I focus my time, effort, and energy."

She also shared her experiences introducing frameworks around personal and institutionalized racism. "I've had a lot of people say, 'I never thought of that this way.' Education is important."

We have data around health outcomes, she reminded the audience. When someone poses a disagreement, "I just go back to the data."

Participants noted that return on investment (ROI) is especially important today, "when DEI is among the first things to get cut."

"If I could solve that problem, I wouldn't be here," Jackson responded.

"It's such a hard question," she continued. While plenty of research exists about the ROI of eliminating health disparities, making the business case work is challenged by how healthcare is financed in the United States.

"A lot of ROI is on the cost savings side, and organizations are not in enough value-based contracts to make cost savings work or be viable," Jackson explained. Progress may lie in the policy landscape, which puts the onus on health equity practitioners to understand the payment landscape and help drive change.

Common Spirit

Upcoming SDOH Mandates

With a CMS 2024 mandate less than two months away, SDOH screening measures were top of mind for many participants. A representative from CMS shared slides about the mandate and highlights from the agency's work.

As of January 2024, providers will be required to screen patients for the following five SDOH: food insecurity, housing instability, transportation problems, utility difficulties, and interpersonal safety. "It's not just screening; we're looking for the percentage who screen positive," the representative explained, and hospitals will need to attest to activities within these five domains. "CMS will give no partial credit."

She walked through updates related to Medicare Advantage, marketplace payers, Medicaid, and Children's Health Insurance Program (CHIP), as well as CMS initiatives in areas like the Accountable Health Community (AHC) model and various tools that are available to support work related to the 2024 SDOH requirements.

These include:

- An AHC health-related social needs tool
- The Mapping Medicare Disparities (MMD) tool, which explores data such as the prevalence of diabetes in Arlington County, VA, to the national average
- Resources and roadmaps for understanding Z codes and putting them to work in data collection

The presentation sparked a robust round of comments and questions. In terms of challenges, participants noted that staffing is often too lean to meet the requirement to screen patients within 24 hours of admission. In readmissions, this requirement often causes "patient fatigue."

In terms of questions, participants asked about things on the horizon they should prepare for. Are any requirements pending for screening in the emergency department, for example? And what about the practicalities of implementation in a busy and budget-conscious healthcare organization? How does an organization reimburse providers and staff for time spent coding? Participants were also curious about CMS' plans to provide resources to smaller and under-resourced groups.

Participants have been adding SDOH questions to their intake sheet, health equity index, and social needs screenings, in settings from emergency departments and primary care to dialysis centers. They've also been leveraging digital tools and virtual solutions.

One participant noted an 80% completion rate by putting the questions in MyChart for patients to fill out themselves. On the other end of the technology spectrum, another noted the effectiveness of one-on-one conversations. "Patients appreciated having someone to talk to."

Roles and responsibilities have varied. Some organizations have been getting undergraduate students involved, others have leveraged physicians to engage other doctors to build up trust, and another had a virtual employee handle behavioral intake tasks, which significantly reduced follow-up times.

While SDOH screening helps with care delivery, resources must be available when a need is identified, both in the healthcare organization itself and in the community. Examples include shelter options and wraparound services for people experiencing homelessness, behavioral health services, and community health workers to help patients.

"The scale of investment doesn't match the needs of the screening," one participant observed.

Tough Questions

Some patients appreciate being asked about their lives—or even consider it a lifeline, as one organization's experience with a domestic violence survivor demonstrated. But many patients find such questions about their living conditions, family relationships, and economic situations invasive. Cultural differences make things even more complicated. For example, will Somali women be able to answer these questions openly and comfortably with male family members present? Finally, many patients don't understand what SDOH are and why they are being screened in the first place.

Forum participants offered a number of solutions:

- **Family meetings to build relationships and trust**
- **Focus groups to find out how to make the experience better**
- **Educating the community as a whole through providers and community organizations**

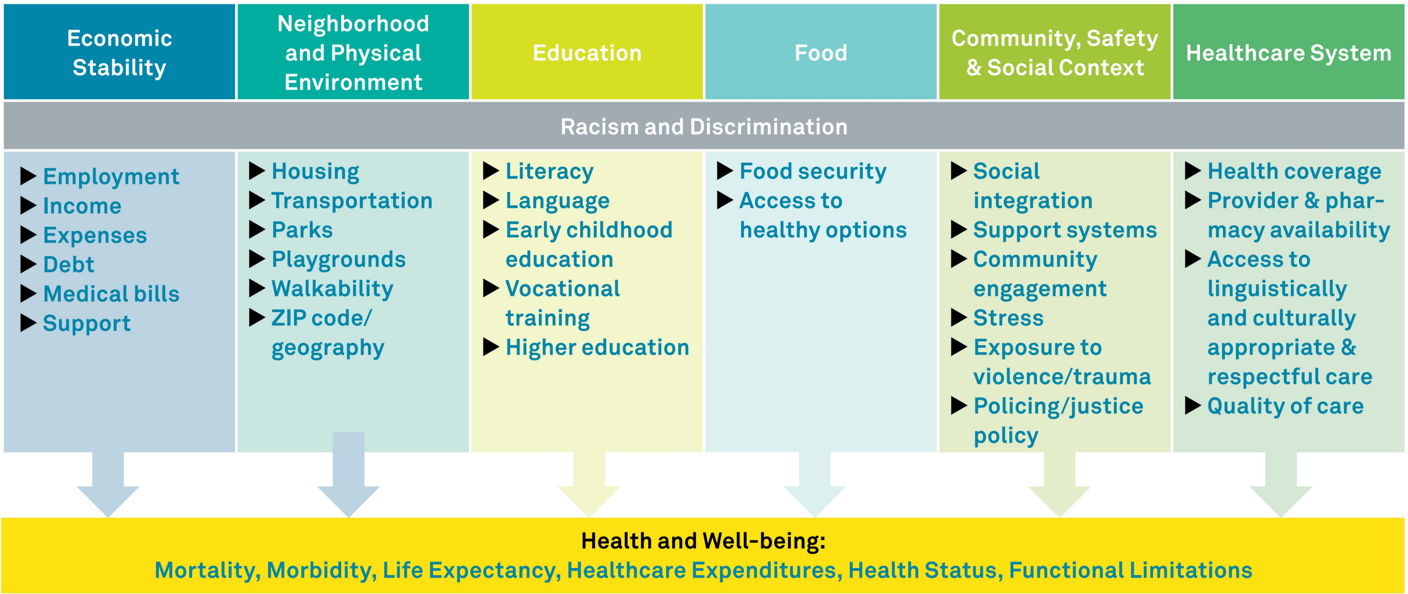
In short, SDOH screening is a fine balance. On one hand, organizations need patients who are actively engaged in their care to create a comprehensive risk profile. But patient burnout is a very real risk. "You shouldn't ask patients multiple times if SDOH is already in the system," one participant declared.

The manner of asking matters as much as the message. "It makes a difference if patients feel like someone cares about you," one participant remarked. Another noted that "being empathetic goes a long way." In short, "You need to explain it well to the patient and let them know that we ask because we care."

Diamond Dogs/Getty Images

Figure 4

Disparities in Healthcare Driven by Social and Economic Inequities



Economic Stability	Neighborhood and Physical Environment	Education	Food	Community, Safety & Social Context	Healthcare System
▶ Employment ▶ Income ▶ Expenses ▶ Debt ▶ Medical bills ▶ Support	▶ Housing ▶ Transportation ▶ Parks ▶ Playgrounds ▶ Walkability ▶ ZIP code/ geography	▶ Literacy ▶ Language ▶ Early childhood education ▶ Vocational training ▶ Higher education	▶ Food security ▶ Access to healthy options	▶ Social integration ▶ Support systems ▶ Community engagement ▶ Stress ▶ Exposure to violence/trauma ▶ Policing/justice policy	▶ Health coverage ▶ Provider & pharmacy availability ▶ Access to linguistically and culturally appropriate & respectful care ▶ Quality of care

Community partners need to be notified of the new requirements, multiple participants emphasized. Even so, many nonprofits will lack the capacity to accommodate surges in use or the infrastructure and know-how to navigate billing and coding requirements.

Not being able to help as needed has been taking a toll on care teams, many participants said. And adding SDOH screening to already overburdened schedules is just perpetuating burnout, especially in areas like the emergency department. “It’s a disservice to ask this of our front lines,” one participant declared.

There’s been pushback due to the nature of the questions themselves. “Some people don’t even want to ask about race and ethnicity, and now we’re going to be asking patients about abuse?” one participant remarked. “Primary care in particular is not built for social work and therapy,” another noted.

Finally, there’s the challenge of tracking progress. “Just because we’re collecting data doesn’t mean that it is automatically meaningful and useful,” was one observation. “Data collection is just a process if you aren’t looking at outcomes.”

Reimbursement was among the biggest topics of discussion, with one participant describing the mandate as “compliance until the dollars come.”

As a stopgap, participants suggested connecting SDOH screening to quality reporting or patient experience and with Net Promoter Scores. But vagueness in terms of targets and penalties complicates matters. “How do you build a business case for a full-time employee without knowing the target?”

Finally, participants were concerned about the mandate’s scope. The new SDOH screening requirements risk “overwhelming community organizations or asking health systems to do things they’re not set up to do.”

Cultivating Strategic Partnerships with the Community

Presenters from five organizations from across the country shared highlights from their work.

1 Johns Hopkins Medicine Office of Population Health

Cara Goldstein, MSW, director of Community Health, Office of Population Health, Johns Hopkins Health System, and Kristin Topel, MEd, MPH, executive director the Johns Hopkins University School of Medicine, Hopkins Community Connections, discussed using data to scale SDOH-related services. The program started in 2006 as Health Leads and has evolved under the following mission: connecting patients with the basic resources they need to be healthy.

“We put together partnerships in response to the screening questions we were asking,” Goldstein said. “Now that we’ve been screening for a while, we’re hoping to use data to refine, continue to build, and pivot.”

Food insecurity is the greatest need, affecting about 60% of patients, and Johns Hopkins addresses this need in one of

Johns Hopkins operates food pantries in multiple Baltimore locations.

the most direct ways possible: providing food at the time of care through on-site food pantries.

Johns Hopkins launched its pilot pantry in 2018 in the emergency department, then worked with Maryland Food Bank on a site at the Harriet Lane Clinic, which opened right as the COVID pandemic hit. To scale rapidly to meet the need, 2021 brought pantries to the Comprehensive Care Practice, Children's Medical Practice, East Baltimore Medical Center, and PICU. "We learned how to be nimble and flexible and how to adapt," Topel said.

Johns Hopkins welcomed two new partnerships in 2022, with Hungry Harvest and DHS SNAP for outreach, and 2023 brought two new pantries, at the Johns Hopkins Outpatient Center and in the GYN/ONC department. "Sometimes it's us doing the work. Other times, it's our bringing in people who do it well," Goldstein said.

The benefits go beyond meals and groceries for patients, Johns Hopkins, and the community. "Food delivery at point of appointment is a rapport-building appointment," according to Topel. "It also allows for wonderful community engagement with our system."

2 Joe Samuel Ratliff Lifelong Learning Center

At Brentwood Baptist Church in Houston, healthcare is a part of outreach. Health equity is core to this mission—and an urgent priority.

"Despite substantial progress in healthcare, discrepancies continue to occur," said Augusta Green, MSc, who heads the church's Joe Samuel Ratliff Lifelong Learning Center. "By actively engaging with these communities and tailoring services to the unique needs of minorities, the healthcare industry can build trust and partnerships that lead to improved healthcare access and outcomes."

Green walked through the elements that bring these partnerships to life:

- Active engagement with community leaders and residents to understand needs and concerns, augmented by cultural competency training for providers, especially around culturally sensitive care and specific health challenges
- Health education in areas such as cancer, cardiovascular disease, and diabetes that disproportionately impact African American patients, with language accessibility "to ensure that English is not a barrier to healthcare access"
- Screenings and clinics in accessible locations for preventative care and checkups, with health navigation services to guide patients through the system, so they have necessary support and resources
- Policy advocacy with community leaders, as well as support for community initiatives, including financial and logistical, that directly address local health needs. "This helps Brentwood stand at the forefront," said Green.
- Diversity in leadership, so that executives at the top reflect the patient population

Shifting into High Gear

Organizational maturity levels at the forum varied, from some participants just starting out in the strategic phase and others implementing programs and working through execution.

Participants noted that the overwhelming nature of the work often created silos or a lack of cohesion and that managing centralized versus decentralized programs was "a balancing act." Insights from patient surveys and community health workers have been valuable for resource prioritization.

Challenges ranged from COVID-related delays to leadership buy-in. What if top-level leadership isn't empowering the DEI officer? Having a more diverse C-suite helps with situations like these, one participant advised.

As in the general panel discussion, funding and sustainability were a central thread—and concern. "ROI calculations are real, and we do run a business," one participant stated. "If change is project-based and grant-funded, it isn't sustainable," another declared. Organizations need to build a business case for health equity work and bring the conversation around to value-based care.

Organizations can forge truly beneficial partnerships and trust by sharing data, connecting partners with each other, and creating opportunities for mutual alignment. "It's important to understand the interconnectedness of everything we do," one participant said.

Sashkinw/Getty Images

One central philosophy underlies it all. “Involvement within the community is all about being a true partner,” Green said, from listening to community needs to building trust. “It’s about fostering respect and transparency and working hand in hand with diverse stakeholders toward common goals.”

Advocate Medical Group’s Love Your Heart hypertension screening program operates from the Imani Village outpatient clinic on the South side of Chicago.

3 Metabolic Health Practitioners/ Advocate Health

Advocate Health is the third-largest integrated nonprofit health system in the United States.

Advocate Health works with food banks and local grocery stores to connect patients to healthy, affordable food, with Spanish-language coaching on healthy shopping habits in some areas and stores. Meanwhile, its mobile vans are busily crossing the organization’s expansive coverage area, and community groups and businesses are on the ground helping to address SDOH through screenings, educational workshops, community events, and more. This is with the mindset that we need to meet people where they are.

Imani Village provides one example. Love Your Heart, the Advocate Medical Group Imani Village hypertension program, brings health professionals, clinical leaders, and community leaders together for a self-management blood pressure program designed to promote positive health behaviors.

Advocate Aurora Enterprises is another initiative, supporting personal wellness and aging in place through community partnerships and technology. One partner, Foodsmart, is a personalized digital nutrition platform leveraging a national telenutrition network of registered dietitians. Another, Senior Helpers, connects patients to services from specialized care for chronic diseases to assistance with daily activities.

4 Health Advocates In-Research and Reach (HAIR)

Health outreach through Black-owned barber shops and salons made national headlines during the COVID pandemic with the White House’s “Shots at the Shop” initiative. Health Advocates In-Reach and Research (HAIR) extends this vision into a full spectrum of public health and medical education and services, through a growing network of barbershop and salon partners.

HAIR is a community-based intervention developed by Dr. Stephen B. Thomas and a team of researchers from the Maryland Center for Health Equity at the University of Maryland’s School of Public Health in College Park.

“HAIR builds upon the rich and powerful history of barbers and beauticians as trusted entrepreneurs providing essential services to the African American community,” the program’s website explains. Katrina Randolph talked about how her company, Tre Shadez Hair Studio, has worked with the initiative during the pandemic and for ongoing wellness.

“We set up vaccine clinics to dispel misinformation and build confidence,” Randolph said. And she’s witnessed people come in across generations, like an 80-year-old who wanted to support their vaccination-hesitant grandchild. “One client was hesitant to go to a medical clinic but considered the salon a trusted site.”

Another priority is colorectal cancer, a leading cause of disability and premature death in the African American community. HAIR is involved in both screening and increasing awareness. “We aim to use barber shops and beauty salons for health education,” Randolph explained.

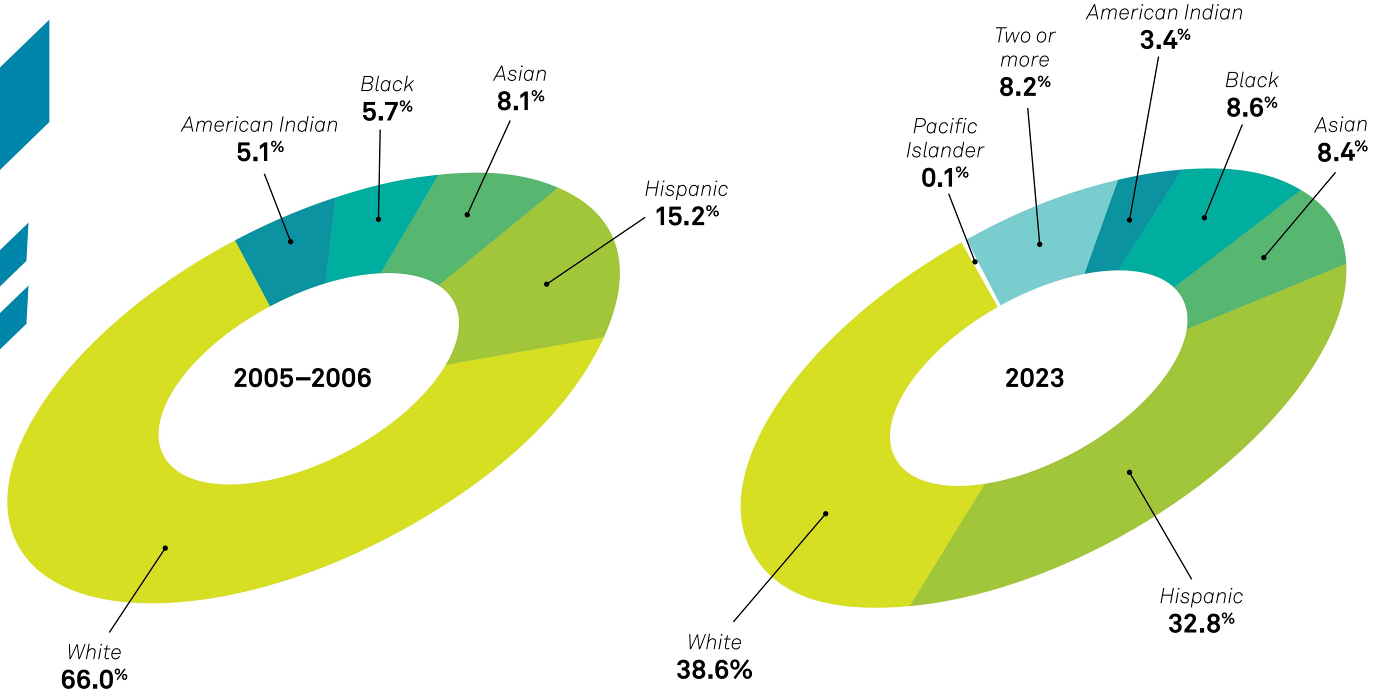
HAIR recently trained barbers and stylists on prediabetes lifestyle coaching. “People want to hear what stylists have to say before medical professionals,” Randolph said. “They handle misinformation and help people make lifestyle changes.” To keep services in touch with community needs, HAIR has launched a new Wellness Warriors initiative that convenes at the beginning of each week to share what the community’s been talking about.

“This is the place where people have trust and relationships,” Randolph said.

Health Advocates In-Reach and Research (HAIR) is the brainchild of Stephen B. Thomas, PhD, professor of health policy and management director of the Maryland Center for Health Equity at the University of Maryland School of Public Health.

Figure 5

Understanding the Why: Prevea's Patient Demographics



5 Prevea Health

Prevea Health serves an area of Wisconsin that is both growing and changing demographically. Vice President of Diversity and Inclusion Renita Robinson, EdD, talked about the organization's efforts to "move the needle" to serve its patients and address health disparities.

Prevea Health's health equity journey began with providers who might be thinking about SDOH for the first time. "We had to start from a foundation of education," Robinson said. "Because we started talking about it early, people were more receptive to our inserting this work into their workflows."

COVID was also a catalyst for change, she said. From collecting data to translating materials, "we learned more about needs that hadn't been addressed and barriers to equity, and now we're doing better on all of these things."

The need to scale was both a challenge and an opportunity to partner with entities "doing the same work but with more capacity and bandwidth." These partnerships led to a health equity coalition of more than 30 agencies in Brown County, as well as collaboration with the public health department to host a now-annual conference on community response to domestic violence.

"Safety is one of the SDOH focuses," Robinson said. "We talked about implicit bias related to people seeking healthcare and offered a slate of workshops. It elevated the conversation, and there was a tremendous turnout."

Her advice for others? Be prepared to learn from mistakes and be uncomfortable. "In talk of best practices, we also have to talk about failing forward."

In a Q&A session that followed, presenters talked more about their programs, from adding services like food pantries and mental health coaching to finding ways to anticipate needs. Johns Hopkins has care managers already engaged with patients for chronic disease management. "This work also identifies unmet social needs," Goldstein said.

One audience member mentioned a news story about barbershops and mental health training. Is this something HAIR has on its radar, especially in the areas of trauma and childhood adversity? "We're definitely interested," Randolph said. "We hear those conversations every day."

Audience members also wanted to know more about partnering with faith-based institutions. "Our goal is to inspire church leaders to understand the concept and involve others," Hampton said about his efforts with Advocate Health. "They have an audience already." Green noted that "there's a comfort zone in the church."

One overarching line of questioning involved paying for it all. Goldstein talked about grant funding at Johns Hopkins related to the hiring of community health workers, and Randolph shared her concerns about compensating HAIR's barbers and stylists. "A lot of this work takes time away from their families."

Figure 6

What Is the Narrative?

Black women are subjected to gender-based and racial microaggressions at work.

70% of Black women are disengaged at work.

Black women earn 39% less than their White male counterparts.

As a result, more Black women have left the workforce since 2019 than ever before.

67% of employees are disengaged at work.

1 million U.S. workers are absent daily due to stress.

$51 billion is spent by U.S. businesses on depression-induced absenteeism.

Employee turnover can cost up to 2x an employee's annual salary.

A disproportionate percentage of individuals of color receive government benefits.

50% of seniors who are eligible for SNAP do not receive it.

25% of individuals do not take Rx as prescribed.

SNAP saves $1,700–$4,200 in healthcare costs.

$100 billion annual U.S. healthcare costs are attributed to patients not taking their medications.

Lack of food leads to poor health outcomes.

In our organization…

XX% of employees are engaged, as evidenced by employee engagement scores, active participation in town halls, absenteeism, etc.

XX% employee retention and turnover rates; $$ spent on annual turnover

Qualitative data gleaned from third-party exit interviews, reviews, etc.

Number of patients and employees who are food insecure

…all by sociodemographic category

Assessing and Addressing Implicit Bias with Providers and Staff

"We all know why we're here," DeAnna Minus-Vincent, MPA, Founder and Managing Director, The Outcomes Architect, declared to launch this session. "We spend $8 billion a year in this country on diversity education. But we're still struggling with poor outcomes, for patients and for staff," she said.

Black and Hispanic patients experience more adverse patient safety events than their White counterparts. Language barriers correlate with poorer health outcomes and reduced quality of care. Inside healthcare organizations, most employees are disengaged, and most C-suites lack meaningful diversity. "It's like siphoning a pool with a syringe," Minus-Vincent said. "This work is tiring, so how are we going to solve for it?"

She walked through a few ideas, starting with rethinking one-and-done, one-size-fits-all education. "You can't just take implicit bias training off the shelf and fit it into the organization. It has to be iterative, part of a whole," she said. "And you can't take the training and say you're done." Instead, there needs to be ongoing conversations and targeted professional development, coaching, and mentoring, with engaged leadership and frontline employees brought into the conversation.

> **"Equity is everybody's responsibility. It should be built into the strategic plan and woven in throughout the organization. This is not rocket science. We just need the will and to get beyond the fear."**
>
> **—DeAnna Minus-Vincent, MPA**

Throughout it all, Minus-Vincent said, organizations should always ask: Who cares?

There's a big need to change the narrative when talking about health equity, she declared, and provided an example to illustrate. An argument begins with a general statistic about microaggressions, which didn't resonate as strongly, and morphs into an organization-specific business case related to employee engagement and retention, which garnered greater engagement.

Data can make a story more compelling but be aware that there are many flaws in the current state of data collection, Minus-Vincent cautioned. On forms asking for self-identification of race, for example, a patient suffering a heart attack might be logged as "refused to answer." Someone who identifies as Black and Indigenous might be logged as merely "two races."

"That doesn't tell anyone anything," Minus-Vincent said. "We need to collect data in a different way and train staff that it's okay to ask."

Do what you can to ensure race, ethnicity, ancestry, and language (REAL) and sexual orientation and gender identity

(SOGI) data, and SDOH information is consistently collected, she advised. Make sure it's accurate and based on evidence-based practices. Supplement this with unbiased, third-party qualitative and quantitative data from employees, patients, and other key stakeholders.

Then put all of this information to work to guide training, coaching, and mentoring opportunities, Minus-Vincent said. Regularly track progress against outcomes, setting clear metrics that are aligned to policies, procedures, performance measures, and incentives. Designate a team to drive the change, with sufficient resources to do the work. Understand anticipated short- and long-term outcomes. And, critically, hold all stakeholders accountable.

"Equity is everybody's responsibility," Minus-Vincent said. "It should be built into the strategic plan and woven in throughout the organization."

"This is not rocket science," she concluded. "We just need the will and to get beyond the fear."

Participants talked about the importance of hiring. "If you look like the people you're serving, you're more apt to serve the needs of the community." They shared examples of how they've been changing their hiring processes, like removing applicant names and other characteristics from initial screenings and reinforcing actions like this through the organization's culture. This includes "allowing people to speak in a forum and safe space" and "don't make people pretend it's OK when it's not."

For recruiting medical students, one organization halted the use of admission scores. Reviewers instead look at factors such as the distance a student had traveled to arrive at this point.

Improved Vision

During the audience discussion in the session hosted by DeAnna Minus-Vincent, MPA, one participant asked about equity in succession planning. How has Minus-Vincent addressed this?

A standard nine-box assessment model resulted in "all candidates looking like existing leaders," she replied. "It's human nature to choose someone who looks like you."

Her team tried something different and instead reached out to employees with the following question: How do you want to grow in this organization? This tactic engaged employees "who may not be so vocal or be out on the golf course." What's more, she continued, "We had a cadre of skill sets and were able to grow as an organization."

Another audience member asked how to convince people that implicit bias is a real phenomenon and that it's important.

"Continue to tell our stories," Minus-Vincent advised. "But stories aren't enough." Organizations also need ongoing conversations, training tailored to the communities they serve, and metrics for measuring progress.

Training, both mandatory and voluntary, was frequently discussed. Participants noted that these efforts can "feel like checking a box" and may not yield optimal results in a real-world scenario, like a member of the care team experiencing bias or problematic behavior from a patient.

One suggestion to counteract this: Conduct focus groups, interviews, and have conversations with frontline staff to collect data before any training takes place. Incorporate metrics into the program. Extend education beyond implicit bias into broader areas like cultural nuances and compassion.

"You can teach compassion—research shows this," one participant noted. "Churches and schools used to be places for teaching kindness."

Participants cited the need for system-based efforts, especially in outpatient settings "where most care happens." They're also looking at microaggressions, "understanding the environment," and connecting unbiased care with compensation ("putting your money where your mouth is"). Leadership needs to be engaged, participants agreed, and health equity needs to be part of the organization's DNA.

Because "you get data but don't know why," participants cited a need for more intentional strategies and analysis. This includes bidirectional data for more insight into decisions and technologies such as electronic health record (EHR) tabs and tools and artificial intelligence (AI).

Participants saw some uses for AI, such as gauging patient experience and net promotor scores and evaluating speech in real time for potential missteps. But they had questions, as well: "Where does the training come from? And how do we mitigate bias in the AI itself?"

One tactic has been simply listening to employees, especially those on the front lines. "Staff reported that no one had ever talked to them about their experiences," one participant related. "Having a space to voice concerns and challenges was important in addition to taking action."

One organization has a "DEI corner" every Friday morning open to every employee as a place to have conversations. "It's implicit bias training but just not called that." Others are using book clubs and movie nights as opportunities for conversations and leveraging business resource groups as safe spaces for asking questions.

In such efforts, consistency matters. So do the words used to describe initiatives. One participant noted that the term "implicit bias"

fotolgahan/Getty Images

AvailableLight/Getty Images

can have negative connotations and that this can result in pushback. “Focus on why implicit bias is bad for outcomes and have that be the focus rather than the bias itself.”

The Road Ahead

Casanova convened participants to talk about what’s next for 2024, including updated resources, a new infrastructure-focused playbook for driving equity, and continued collaboration about needs, priorities, and strategies.

Participants spoke highly of the interactive format (“I’ve felt like I’ve made 50 new friends”) and shared “golden nuggets” they plan to take home to their organizations.

Some of these included addressing implicit bias at the patient’s bedside, catching verbiage that might be insensitive (“I won’t be using ‘nonadherent’ again”), and leveraging resources within the community. “How do we scale and not burn folks out?”

Other key takeaways: the importance of telling patients why organizations are collecting SDOH information, how kindness and goodwill generate value and ROI, and prioritizing collaboration and accountability.

“This is not the problem for just the people in DEI to solve,” one participant said. “Everyone needs to be part of the solution.”

“Our work is not done, but we don’t have to do it alone,” another declared. GPJ

AMGA is fully committed to tackling health inequities and disparities, and we are determined to equip our member groups with the necessary tools. From research to education, quality collaboratives, conferences, and analytics, health equity and measurement have been integrated into every aspect of AMGA for many years now. Discover more of resources on our Health Equity Focus Area at **amga.org/focus-areas/health-equity**.