Illinois Health and Hospital Association

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## Guidance Document for the

# 2024 Racial Health Equity Progress Report

# Table of Contents



# Introduction & Purpose of Guidance Document

Equity is at the heart of IHA's vision for healthcare: "That ***all individuals and communities*** have access to high-quality healthcare at the right time, in the right setting, in order to support each person's quest for optimum health." The COVID-19 pandemic shined a spotlight on a grim reality that has been present for decades: People of color and communities of color suffer from unequal access to healthcare and disparate health outcomes. And in the midst of that pandemic, the tragic killing of George Floyd sparked outrage, grief and frustration among people from all backgrounds, and exposed once again the systemic racism, injustice, and inequality that still exist within our society. In response, the IHA Board of Trustees directed IHA to prioritize and intensify our efforts to assist member organizations in addressing racial health disparities.

The **Racial Health Equity Progress Report** (Progress Report) is a critical part of that effort. Recognizing that progress and improvement require measurement and accountability, hospitals, health systems and other providers need a tool to assess their performance in addressing racial disparities in their provision of healthcare.

The Progress Report is a long-term accountability tool to document progress toward achieving racial health equity. It is meant to promote collective improvement, not to drive competition. It provides for a baseline self-assessment and then an opportunity to measure progress, assess implementation of key strategies, understand provider and community assets in racial equity work, and identify areas of improvement.

***Working together, Illinois hospitals and health systems have the opportunity to dismantle systemic racism in a way that no individual organization can. The Progress Report aims to highlight the important progress that organizations have already made as well as the work ahead. Therefore, we urge every Illinois hospital and health system to complete this year's Progress Report, whether it is your first time participating or you've participated in the past. Individually and as a hospital community, we are at a pivotal point in understanding how much we've accomplished in just a few years and where we go next.***

This Guidance Document is meant to facilitate completion of the Progress Report by providing relevant background information around:

- The purpose of the Progress Report.
- The development of the Progress Report.
- The structure of the Progress Report.
- Key terminology used in the Progress Report.
- Recommendations regarding the process for completing the Progress Report.
- Resources available on subjects related to racial health equity.

# Purpose of the Progress Report

The Racial Health Equity Progress Report serves as a long-term accountability tool to document progress toward achieving racial health equity. It centers around five guiding principles:

**Facilitate Collaboration**
Each healthcare facility is at a different point on this journey. Using Progress Report data, the provider community will share best practices, celebrate growth and set collective goals.

**Focus on High-Impact Metrics**
This Progress Report uses fewer, but more impactful metrics across internal and external functions to avoid an overly broad scope and/or "analysis paralysis."

**Mobilize Toward Action**
It is important to start now and rapidly understand the baseline across a core set of metrics to get a sense of different healthcare facilities' starting points. Do not let the perfect be the enemy of good. We know the Progress Report will need to keep evolving, but that cannot stop us from starting.

**Center on Racial Equity**
This racial health equity assessment focuses on the people of color most impacted by systemic racial inequities in healthcare: Black/African American, Hispanic/Latino/a/x and Indigenous people.

**Promote Organizational Growth**
We want organizations to assess where they are and how to grow. As organizations gain more capability and resources to support this work, metrics will evolve in order to increase impact, and public reporting will be considered as this work evolves.

## Implementation

In 2021, IHA launched the inaugural Progress Report across Illinois and saw nearly 150 hospitals engage in the assessment. IHA continues to build on this success in hopes of fostering long-term accountability towards achieving racial health equity among hospitals and health systems across Illinois.

## National Pilot & Technical Expert Refinement

In 2021, IHA, Rush University Medical Center and University of Chicago Medicine secured a grant from The Commonwealth Fund for testing, scaling and disseminating the Progress Report. The grant allowed the Progress Report launched in Illinois to be tested at healthcare organizations across the country and refined by a Technical Expert Panel (TEP) comprised of health equity and measure development experts. The TEP was both surveyed and convened to

discuss the assessment's conceptual framework and the questions' relevance, clarity, impact and reliability. Based on guidance from the TEP and approval from IHA's Health Equity Leaders Workgroup, revisions were made to the 2024 assessment.

The 2024 Progress Report includes a voluntary opt-in for any hospital that wishes to participate in the ongoing National Pilot.

We invite healthcare facilities to use this Progress Report as a baseline to inform their current practices and continue advancing their health equity work. Understanding that this process is a long journey, the Progress Report can help organizations understand where they are now, where they can be a role model for others, and how they can grow.

# Structure of Progress Report

The Progress Report focuses on four pillars of racial equity in healthcare within an organization: its people, its patients, its organization and its community. The following illustrates the four pillars and broad categories within each.

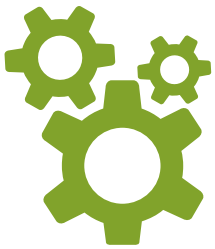




## Our People

This section focuses on board and leadership team demographics; employee engagement in anti-racist, implicit bias and racial health disparity trainings; and pay equity. Internal demographic data is particularly important to report and evaluate in order to compare it to community and patient backgrounds. Homogeneity of race, sex and socioeconomic status have been all too present in our healthcare systems, limiting an organization's development and contributing to health disparities[1]. Furthermore, it is projected that the United States population will grow by 12% in the next 10 years, particularly from minority and immigrant populations[2]. This growth emphasizes the need for diversity and inclusion strategies to create a culturally competent workforce to serve the needs of patients in catchment areas and/or high economic hardship communities. A diverse board and staff promote inclusion, better provider-patient communication and higher accessibility to all individuals compared to a homogenous workforce that further exacerbates current health disparities; it has also been found that higher employee perceptions of diversity and inclusion are positively correlated with employee engagement[4]. It is important to note that leadership should not engage in "checkbox diversity" consisting of a surface-level increase in diversity with virtually no other changes in organizational practice or engagement[3]. Actively listening and incorporating diverse opinions as well as constant reflection of internal biases and engagement in anti-racist programs/trainings need to be present at all levels for real progress within the organization. Specific resources to engage in these practices can be found in the Resources section of this document.



## Our Organization

This section focuses on plans and tools that organizations use to evaluate their efforts towards racial health equity. Engaging with different tools and trainings focused on this topic helps organizations better understand and engage with their patients who experience barriers to health access and care. Self-reported data relating to race, ethnicity, language (REaL), sexual orientation, gender identity (SOGI), and social determinants of health (SDoH) are vital in identifying and addressing inequities in care. With this data, providers can better serve their patient populations and implement needed services or programs. Due to the sensitivity of these topics, proper staff training and data protections must be put in place. Specific readings and tools can be found in the Resources section.

## Our Patients

This section focuses on patient experience and the organization's dedication to evaluating patient safety and health outcomes to unveil underlying disparities and implement care improvement projects. In this pillar, organizations are encouraged to deeply explore their patient population, asking if they have a strong handle on who they serve and what clinical inequities exist within those populations and communities. Specific resources can be found in the Resources section of this document.

## Our Community

This section focuses on ways organizations can engage with community partners to reduce health disparities. Community involvement within the healthcare sphere is not a new practice; collaboration and engagement with community members are "cornerstones of efforts to improve public health" involving diverse stakeholders, health professionals and service users[5,6]. This deliberate healthcare strategy allows officials to better understand their community's needs and focus on healthcare planning and implementation that address their specific community population[7,8]. People remain at the forefront of healthcare efforts and improvements, leading to long-lasting relationships of engagement and resilient health systems[6]. Resources to engage in these practices can be found in the Resources section of this document.

# Process Recommendations

The following recommendations are offered to facilitate the data collection and survey completion process.

## Who Should Be Involved

We recommend that one individual manage the survey and ensure its completion. This individual will be in charge of reaching out to others in the organization to gather the requested data. We predict that your organization will need to reach out to individuals who work in the following areas:

- Administration
- Board management
- Communications
- Community engagement
- Development
- External affairs
- Finance/Accounting
- Human resources
- Operations
- Patient data and quality/Data analytics
- Strategy

## What Resources Will Be Needed

Your organization should already have data on some questions asked in the Racial Health Equity Progress Report, as several of these questions are asked by other healthcare surveys. To limit the time used searching for data, we recommend having the following documents on hand:

- Your organization's strategic plan and/or annual report
- Community Health Needs Assessment
- Community Benefits Report
- Previous IHA Racial Health Equity Progress Report analytic reports (if available)
- The Institute for Diversity and Health Equity's Health Equity, Diversity and Inclusion Survey (if completed)

## Suggested Process

The socialization of this tool throughout your organization is critical. While the answers to the questions in the Progress Report are key to establishing a baseline, the questions can serve as powerful platforms for discussion.

1. Disseminate the Progress Report to leaders throughout your organization, sharing with them that your team is in the process of filling out the Progress Report.
2. The point person responsible for submitting the Progress Report should call a meeting with key individuals and leaders so you can discuss as a team the answers your organization will provide in the Progress Report.
3. We recommend that you call this meeting for 60-90 minutes and that you read through each question in the Progress Report with your team. Discuss at a high level where you think your answers may fall and which team members are ultimately responsible for providing the answers to specific questions.
4. Depending on the size of your organization, it may take you a few weeks or more to gather the right individuals and pull the data you need to fill out the Progress Report. Take advantage of the Progress Report Planning Form provided. Share that document with team members who are assigned to specific questions and ask them to fill out the planning form and then send it back to the point person who can upload the data to the online Progress Report survey.
5. Once the point person has submitted your answers for the Progress Report through the online link, your organization will receive an analytic report detailing how you scored within 3-4 months. This report will showcase your organization's strengths and areas where you may have opportunity for improvement. We encourage you to reconvene the team and review your analytic report, using it as a catalyst to action.
6. Remember, the first time you fill out the Progress Report you will simply be establishing your organization's baseline. This will give you a strong sense of where you can focus action, but engaging in the Progress Report on an annual basis will ensure that your organization is committed to advancing racial health equity over time.

# Selecting Responses

There are a variety of response options that you will find in the Progress Report Survey. For many questions you will be asked to select a range of percentages that reflect your organization's response. Please select the range that most closely aligns with your organization.

For other questions, there will be an option to select a responses on a scale from 0–5. To help you select the response that most closely aligns with the processes in your organization, please reference the table below:

| | | |
|---|---|---|
| **0** | **Not in Place** | No current plans on this process have been discussed. |
| **1** | **Internal Socialization** | This process has been discussed, but no action has been taken. |
| **2** | **Initiation** | This process is being discussed by key leaders or within meetings and action steps are being developed. |
| **3** | **Piloting** | This process is being piloted, but is not fully standardized or implemented across all target patient demographics. |
| **4** | **Implementation** | This process has been implemented across all targeted patient demographics and is standardized. |
| **5** | **Best Practice** | Our organization has implemented this process, is tracking process and outcome data, and would consider our process and data to be a best practice. |

# Progress Report Resources

- **Progress Report Survey:** You must submit your answers through the Progress Report Survey online platform. Please note that you can save your responses in the survey at any time and return at a later date to enter or edit responses. **To go back to saved responses, you must utilize the same device and same web browser used to start the survey.**
- **Guidance Document:** To support you while completing the survey, this document you are reading will provide background information on the Progress Report, resources to guide future work, and definitions to ground everyone in similar terminology. ***Please read through the guidance document before completing the survey.***
- **Progress Report Planning Form:** We recommend that you use the pdf document to draft and compile your answers with your team. This will make it easier to then input your final data into the online Progress Report Survey.

Please do not hesitate to email healthequity@team-iha.org if you have questions or need support while completing the Progress Report Survey.

# Analytics

Within 3–4 months after your organization completes the Progress Report you will receive analytics from IHA that will give you a sense of the greatest areas of opportunity in your organization. Your Progress Report data will not be shared with anyone outside of your organization. From an analytic perspective, the questions from the Progress Report are organized into 10 key composite metrics:

## Analytics Section: 10 Key Composite Metrics

| Area | Composite Metric | Metric Description | Progress Report Questions |
|---|---|---|---|
| **Our People** | **Metric 1** | Board, Management & Workforce Resemble Our Community | 1, 2 |
| | **Metric 2** | Patient Demographics | 3 |
| | **Metric 3** | Diversity and Inclusion Training in Our Workforce | 4, 5, 6, 7, 8 |
| **Our Organization** | **Metric 4** | Leadership and Organizational Practices to Advance Racial Equity | 9, 11, 12, 13 ,14, 15 |
| **Our Patients** | **Metric 5** | Patient Assessment | 16, 17, 18 |
| | **Metric 6** | Patient Supports for Social Determinants of Health | 19, 20, 21, 22 |
| | **Metric 7** | Quality Improvement Practices | 23, 24, 25, 26, 27 |
| | **Metric 8** | Access to Free and Discounted Care | 28 |
| **Our Community** | **Metric 9** | Investment in the Community | 29, 30, 31 |
| | **Metric 10** | Partnerships with Patients and Community | 32 |

These 10 composite metrics are the driving metrics we recommend that your organization focuses on. The metrics are aligned within the four pillars of the Progress Report. We are using fewer but more impactful metrics across internal and external functions to avoid an overly broad scope or "analysis paralysis".

# Terminology Used in the Progress Report

**Anti-racism**[9]: The active and conscious effort to work against multidimensional aspects of racism.

**Barriers in Access to Care**[10]: Factors that prevent the access to comprehensible, quality health services. These may include monetary costs and a lack of (or inadequate): insurance coverage, available services and transportation, and/or culturally competent care.

**Charity Care Policies**[11]: Policies that provide "free care" to patients who are uninsured for the relevant, medically necessary service, who are ineligible for governmental or other insurance coverage, and who have family incomes not in excess of a specified level.

**CLAS Standards**: Culturally and Linguistically Appropriate Services in Health and Health Care[12]

The National Center for Cultural Competence created 15 standards to promote health equity and quality through the use of culturally and linguistically appropriate services. These standards and goals help provide clear, implementable strategies aimed to eliminate various health disparities present across our country:

1. Provide effective, equitable, understandable, respectful, and quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
2. Advance and sustain governance and leadership that promotes CLAS and health equity.
3. Recruit, promote, and support a diverse governance, leadership, and workforce.
4. Educate and train governance, leadership, and workforce in CLAS.
5. Offer communication and language assistance.
6. Inform individuals of the availability of language assistance.
7. Ensure the competence of individuals providing language assistance.
8. Provide easy-to-understand materials and signage.
9. Infuse CLAS goals, policies, and management accountability throughout the organization's planning and operations.
10. Conduct organizational assessments.
11. Collect and maintain demographic data.
12. Conduct assessments of community health assets and needs.
13. Partner with the community.
14. Create conflict and grievance resolution processes.
15. Communicate the organization's process in implementing and sustaining CLAS.

**Community/Service Area**: As determined by each provider, but generally referring to the immediate community area(s) surrounding the clinic or hospital.

**Community-Based Participatory Research** (CBPR)[13]: A collaborative process that equitably involves all partners in the research process and recognizes the unique strengths that each brings in order to combine knowledge and create actionable social change to improve health and eliminate health disparities in the community.

**Community Engagement Work**[14]: A process of developing relationships that enable stakeholders to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes.

**Community Health Needs Assessment** (CHNA)[15]: A state, tribal, local, or territorial health assessment that identifies key health needs and issues through systematic, comprehensive data collection and analysis.

**Community Investment**[16]: An entity's practice of investing money in public services and social institutions that aim to improve an individual's quality of life.

**Cultural Responsiveness**[17]: The ability to understand and consider the different cultural backgrounds of the people you engage with and/or provide services to.

**Culturally and Linguistically Appropriate**: Health services that are respectful of and responsive to the health beliefs, practices and needs of diverse patients and can help close the gap in health outcomes.

**Cultural Humility**: A process of reflection and lifelong inquiry that involves self-awareness of personal and cultural biases as well as awareness and sensitivity to significant cultural issues of others. Core to the process of cultural humility is the researcher's deliberate reflection of her/his values and biases. Cultural humility encourages developing an attitude of not knowing and learning from the patient. It is an ongoing active process for the healthcare provider.

**Demographic Data**[18]: Socioeconomic information including gender, race/ethnicity, socioeconomic status, employment, education, income and other factors. Often used to learn more about population characteristics.

**Employee Group Definitions**[15,19]: Below are definitions and distinctions between different leadership positions within an organization. It should be noted that different organizations may categorize these roles differently and/or have positions that overlap between groups.

- Senior Leadership: Body of leaders including Chief Executives and other senior managers in charge of establishing the goals, responsibilities and accountabilities of the organization.
- Management: Leaders of clinical and non-clinical staff who are responsible for fulfilling the responsibilities and/or accountabilities of the organization.
- Non-Clinical Staff: Individuals who are engaged in the non-medical or non-patient-based care of the clientele including administrative roles.

- Clinical Staff: Individuals who provide patient care in the organization/hospital system. In a hospital, this role consists of medical staff such as physicians, nurses and other licensed independent practitioners who contribute to the leadership of the organization.

**Equity**[20]: The fair treatment, access, opportunity, and advancement of all individuals and the elimination of barriers that have limited, and continue to limit, all of these; or the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically.

**Health Disparities**: Differences in health outcomes among groups of people. Disparities can occur across many dimensions, including race/ethnicity, socioeconomic status, age, location, gender, disability status and sexual orientation. Health disparities are one way we can measure our progress toward achieving health equity.

**Health Equity**: Definitions of health equity vary across sectors and organizations. Listed are three definitions.

- Equity is the absence of avoidable, unfair or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, geographically or by other means of stratification. "Health equity" or "equity in health" implies that ideally everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential.
- The state in which everyone has the chance to attain their full health potential, and no one is disadvantaged from achieving this potential because of social position or any other defined circumstance.
- A fair and just distribution of the resources and opportunities needed to achieve well-being.

**High-Spend Categories**: Refers to budget categories that are critical to the functioning of an organization, are frequently in demand and that comprise a substantial portion of the organization's spending. Examples of high spend categories include: Professional Services, Construction Tier 1 and Construction Tier 2.

**Implicit and Explicit Bias**[21]: The unconscious and conscious attitudes and beliefs an individual has towards another person or group. Both biases impact behaviors and a person's affect.

**Life Expectancy Gap**[22]: The difference between minority and white life expectancy due to social, economic and institutional barriers that predominantly affect the Black, Non-Latinx population.

**Minority-Owned Business**[23]: The U.S. Small Business Administration defines these firms as businesses that are owned and controlled at least 51% by socially and economically disadvantaged individuals including those who identify as:

- American Indian or Alaskan Native
- Asian
- Black or African American
- Hispanic or Latinx
- Native Hawaiian or other Pacific Islander

**Organizational Measures**:

- Employee Engagement[24]: The emotional commitment an employee has to their organization and its goals.
- Feelings of Inclusion[25]: A sense of belonging and trust between a pair of individuals or within a group based on everyday interactions, policies and/or behaviors.

**Patient Advisory Board**[26]: Groups of individuals from management, staff members and providers who collaborate with each other and the patient in decision-making processes to provide unique perspectives and improve the quality of care to their patients.

**Patient Experience**[27]: Interactions that patients have within the healthcare system including with members of their medical team, staff members and other healthcare facilities.

**Pay Equity**[28]: The equal compensation of employees who perform the same or similar job responsibilities while accounting for factors such as experience level and job performance.

**Pay Equity Analysis**[29]: A method of researching pay rates within an organization and assessing pay differences across age, race, gender, job responsibilities and other associated factors.

**Quality of Life Plans**[30]: The development of a comprehensive plan to strengthen the community through collaboration with public and private entities and an emphasis on organizing needed social services. In Chicago, LISC has supported the development of Quality of Life Plans in 27 communities.

**Racial/Ethnic Category Descriptions**[31]:

- American Indian or Alaskan Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.
- Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.
- Black or African American: A person having origins in any of the Black racial groups of Africa.
- Hispanic or Latinx: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.
- Native Hawaiian or Other Pacific Islander: A person having origins in any of the peoples of Hawaii, Guam, Samoa or other Pacific Islands.
- Two or More Races: All persons who identify with more than one of the above five races.
- White: A person having origins in any of the original peoples of Europe, the Middle East of North Africa.

**REal (Race, Ethnicity and Language)**[31,32]:

- Race: The U.S. Census Bureau defines race as a category of humankind that often has distinctive physical attributes that are associated with biology. Individuals may self-identify with one or more social groups.
- Ethnicity: Social groups that have a common cultural origin or background tied to language, religion, race and/or nationality.
- Language: A system of conventional spoken, manual (signed), or written symbols by which members of a social group and participants in its culture express themselves.

**Self-Reported Data Collection**[33]: Research design when participants give their responses to a given set of questions that ask about individual behaviors, beliefs, attitudes, or intentions.

**Sexual Orientation (SO) and Gender Identity (GI)**[34]:

- Sexual Orientation: An individual's internal emotional, romantic and sexual attraction to other people.
- Gender Identity: An individual's self-identification as being a boy/man/male, girl/woman/female, neither (non-binary, gender non-conforming) or other. Someone's gender identity may not align with their sex.

**Social Determinants of Health (SDoH)**[35]: Conditions in the places where people live, learn, work, and play that affect a wide range of health and quality of life risks and outcomes as defined by the Centers for Disease Control and Prevention. See the U.S. Department of Health and Human Services' definition for SDoH here. Below, see links to the U.S. Department of Health and Human Services' definitions for the five SDoH categories that are specified in the Progress Report:

- Economic Stability
- Education Access and Quality
- Health Care Access and Quality
- Neighborhood and Built Environment
- Social and Community Context

# Resources

## Pillar 1: Our People

The resources in this section focus on Board and leadership team demographics; employee engagement in anti-racist, implicit bias and racial health disparity trainings; and pay equity.

A diverse Board and staff promote inclusion, better provider-patient communication and greater accessibility to all individuals compared to a homogenous workforce that further exacerbates current health disparities. Actively listening and incorporating diverse opinions, as well as constant reflection of internal biases and engagement in anti-racist programs/trainings, needs to be present at all levels for real progress in an organization. Specific tools and resources are identified below.

- American Hospital Association:
  Recruiting for a Diverse Health Care Board
  Health Equity Resource Series: Training and the Culture of Learning
  Becoming a Culturally Competent Health Care Organization
  4 Ways Health Care Organizations Can Utilize the Implicit Association Test (IAT)
- CLAS Standards: Centers for Medicare & Medicaid Services' practical guide to implementing the Culturally and Linguistically Appropriate (CLAS) Standards.
- Conscious & Unconscious Biases in Health Care: This course focuses on conscious and unconscious biases in healthcare and their impact on people who are disproportionately affected by disparities in health and healthcare. It offers an array of innovative activities, based on current evidence and best practices, that are intended to diminish the negative impact of biases.
- American Academy of Family Physicians: Implicit Bias Facilitator Guide and Associated Activities
- The Association of American Medical Colleges (AAMC)'s Anti-racism in Medicine Collection to provide tools for healthcare teams to fight racism and confront biases.
- The Society for Human Resource Management: The Importance of Pay Equity
- Lucidchart Blog: A Guide to Pay Equity Analysis

## Pillar 2: Our Organization

The resources in this section focus on plans and tools that organizations use to evaluate their efforts toward racial health equity and anti-racism. Engaging with different tools and trainings focused on these topics help organizations better understand and engage with their patients who experience barriers to health access and care.

Self-reported data relating to race, ethnicity and language (REaL); sexual orientation and gender identity (SOGI); and social determinants of health (SDoH) are vital in identifying and reporting inequities in care. As a result, providers can better serve their patients and communities and implement needed services or programs. Specific tools and resources are identified below.

- American Hospital Association

  Health Equity Resource Series: Data-Driven Care Delivery – Data Collection, Stratification and Use

  Addressing Health Care Disparities through Race, Ethnicity and Language (REaL) Data

  Health Equity, Diversity & Inclusion Measures for Hospitals and Health System Dashboards
- America's Essential Hospitals' Resources on Structural Racism. America's Essential Hospitals has compiled resources on advancing population health and addressing structural racism.
- Racial Health Equity and Anti-Racist Action Plans: Racial Equity Tools' compilation of existing racial health equity action plans.
- Supplier Diversity: Association for Healthcare Resource and Materials Management's guide to increasing supplier diversity through the use of action steps and plans.
- U.S Centers for Disease Control and Prevention: Social Determinants of Health

## Pillar 3: Our Patients

The resources in this section focus on the patient experience and an organization's dedication to evaluating patient safety and health outcomes to unveil underlying disparities and implement care improvement projects. Specific tools and resources are identified below.

- Agency for Healthcare Research and Quality: What Is Patient Experience?
- Illinois Health and Hospital Association: Charity Care and Financial Assistance resources to help ensure patients can access needed healthcare and obtain financial assistance.
- Creating a Toolkit to Reduce Disparities in Patient Engagement
- National Academy of Medicine: Patient and Family Engaged Care: An Essential Element of Health Equity

## Pillar 4: Our Community

The resources in this section focus on ways healthcare organizations can engage with community partners to reduce health disparities and achieve health equity.

Community engagement is fundamental to creating lasting change and improvements in the healthcare system because of its ability to widen organizational possibilities for care improvement. Without the collaboration and consideration of unique, diverse perspectives, healthcare planning and implementation falls to the wayside. Resources and tools to engage in these practices are identified below.

- American Hospital Association
  - A Playbook for Fostering Hospital-Community Partnerships to Build a Culture of Health
  - Building Hospital-Community Partnerships: Leveraging strengths to improve community health
  - Creating Effective Hospital/Community Partnerships to Build a Culture of Health
  - Societal Factors that Influence Health: A Framework for Hospitals
- The George Washington University: Principles to Consider for the Implementation of a Community Health Needs Assessment Process
- DePaul University: What is Asset Based Community Development
- Healthy Chicago 2025: Chicago Department of Public Health presentation of findings from the recent community health assessment and a framework for action in the next five years.

## Introductory or Individual Tools and Resources

The following resources could be shared with an entire workforce, used in department/division settings or on an individual basis.

- TED Talks Playlist: The Link Between Health and Racism. Nine videos (less than 20 minutes each) that explore various aspects of racial health disparities. One or more videos could be used as a primer or as discussion starters.
- What Is Health Equity, and Why Does It Matter? Produced by the Institute for Healthcare Improvement, this is a 30-minute interview with David R. Williams, PhD, MPH, Professor of Public Health at the Harvard T.H. Chan School of Public Health. It's a good primer and discussion starter.
- TED Talk: How Inequality Kills, with Dr. David Ansell, Senior Vice President of Community Affairs, Rush University Medical Center, author of The Death Gap, and Co-Chair of IHA's Health Equity Leaders' Workgroup. With a specific focus on Chicago, but applicable in all regions, this 15-minute video is a good primer and discussion starter.

- TEDx Talk: Allegories on Race and Racism. Dr. Camara Jones, a physician and leading speaker on racism in healthcare, shares four allegories on "race" and racism. She hopes that these "telling stories" empower you to do something different and that you will remember them and pass them on.
- TEDx Talk: Social Determinants of Health, with Dr. Claire Pomeroy, president of the Albert and Mary Lasker Foundation. 15-minute video.
- Disparities in Health and Health Care: 5 Key Questions and Answers. Produced by the Kaiser Family Foundation, this is approximately 15 pages of printed material with some charts that provide basic, foundational information about health disparities.
- American Medical Association's Prioritizing Equity Video Series. The Prioritizing Equity series illuminates how COVID-19 and other determinants of health uniquely impact marginalized communities, public health and health equity, with an eye on both short- and long-term implications.
- American Medical Association's Strategic Plan to Embed Racial Justice and Advance Health Equity. Download the PDF of the AMA's plan. While it is over 80 pages, you can use parts of it as a primer or discussion starter. For example, see the Executive Summary or Section 1 – Background and Primer.
- Biden Administration Presidential Orders on racial and sexual equity:

  Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government

  Executive Order on Preventing and Combating Discrimination on the Basis of Gender Identity or Sexual Orientation

  Memorandum Condemning and Combating Racism, Xenophobia, and Intolerance Against Asian Americans and Pacific Islanders in the United States

## Additional Resources

Below are additional organizations with resources that highlight the work of the Progress Report. Please note this list is not exhaustive:

Chicago Department of Public Health: Offers many resources including its Year of Healing 2022 Toolkit which includes educational resources, self-guided trainings, podcasts and more focused on racial healing and learning throughout Chicago.

Healthcare Anchor Network: Supported by The Democracy Collaborative and promotes action and collaboration within the healthcare sector. They offer various toolkits, infographics and more focused on ways hospitals and healthcare systems can tackle social determinants of health and promote local purchasing, hiring and investing.

Press Ganey: Supports healthcare providers in improving the quality and delivery of healthcare. Their resource database provides articles, briefs, webinars and more focused on patient experiences and workforce engagement.

# References

[1] The Importance of Diversity in Health Care: Medical Professionals Weigh In. St. George's University. December 2018

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