



**PART I: PATIENT OUTCOMES  
& EXPERIENCE**

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**Health Equity  
Roadmap for  
Health Care CEOs**

# About This Report

The Health Equity Roadmap for Health Care CEOs – Part I: Patient Outcomes & Experience was developed by Health Evolution Forum Fellows participating in the Work Group on Leveraging Data to Improve Health Equity and Health Evolution Forum staff, including Caleb Flint and Lesley Bristol with supporting subject matter expertise and guidance from Blue Cross Blue Shield of Massachusetts and Charnice Payten; and with research support from Ford Shaper.

The Health Evolution Forum is a collaboration among over 200 CEOs and other executives of payer, provider, and life science organizations and other industry thought leaders designed to bring about near-term impact across the health care industry. The Forum is organized into Roundtables and Work Groups that make industry recommendations on specific topics.

The goal of the Work Group on Leveraging Data to Improve Health Equity is to enable payer, provider and life science CEOs to identify racial/ethnic disparities and manage the impact of prevention and clinical care on outcomes.

Please note that the views in this document represent the collective views of the Fellows and do not represent the individual views of any specific Fellow or organization, including organizations and individuals providing supporting subject matter expertise, guidance, and research, within the Forum or of Health Evolution.

## Work Group Fellows

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### WORK GROUP CO-CHAIRS

**Carrie Byington**, Executive Vice President, University of California Health

**Laurie Zephyrin**, Vice President, Delivery System Reform, The Commonwealth Fund

### INDUSTRY ADVISER

**Tim Suther**, SVP & General Manager, Data Solutions, Change Healthcare



### PARTICIPATING FELLOWS

**Tosan Boyo**, SVP of Hospital Operations, John Muir Health

**Christopher Chen**, CEO, ChenMed

**Matthew Eyles**, President & CEO, America's Health Insurance Plans

**Denise Gonick**, Former President & CEO, MVP Health Care

**Nzinga Harrison**, Co-Founder & CMO, Eleanor Health

**Nimesh Jhaveri**, President, Community Pharmacy, McKesson Corporation

**Barbara Joers**, President & CEO, Gillette Children's Specialty Healthcare

**Alexa Kimball**, CEO & President, Harvard Medical Faculty Physicians

**Mark Smith**, Founding President & Former CEO, California Health Care Foundation

**Richard Shinto**, President & CEO, InnovaCare Health

**Michael Uchrin**, CEO & Co-Founder, Monogram Health

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### FORUM UNDERWRITER



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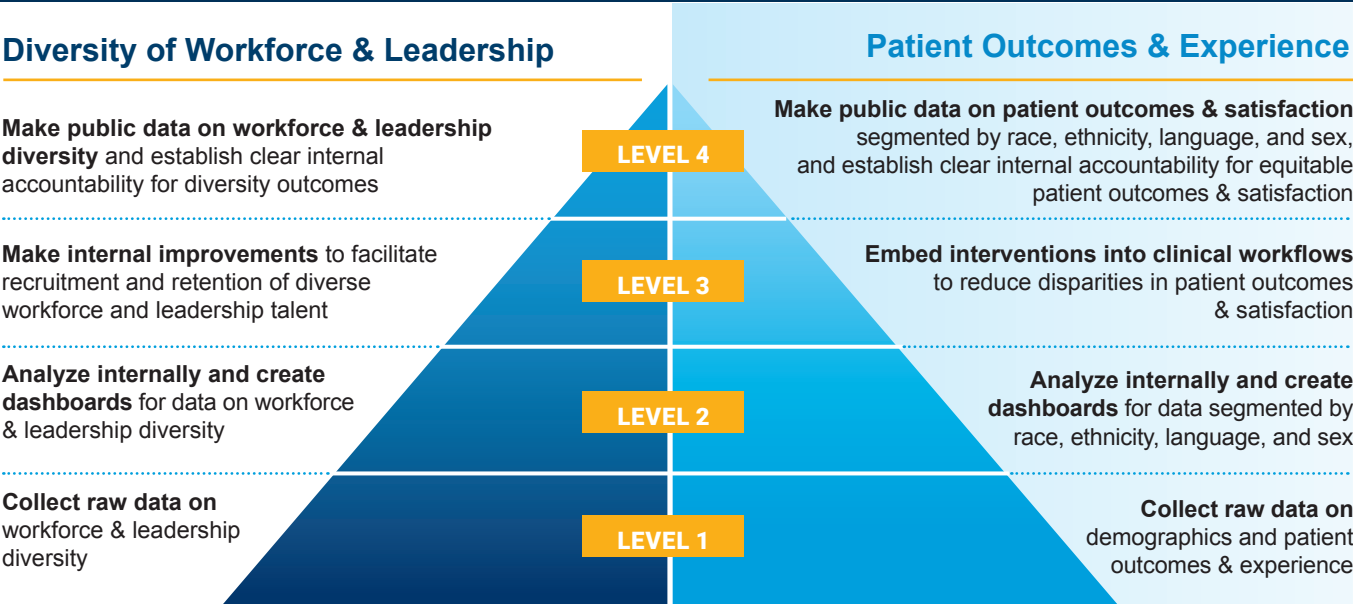
**Deep-rooted disparities exist throughout the U.S. health care system,<sup>1, 2, 3</sup> but many health care organizations have struggled to develop a methodical approach to identifying, quantifying, and taking action to address those disparities. The Health Equity Roadmap for Health Care CEOs, as developed by Fellows of the Health Evolution Forum Work Group on Leveraging Data to Improve Health Equity, provides a guide for organizations who are seeking to develop an effective enterprise-wide strategy to advance health equity.**

The Health Equity Roadmap is designed to help CEOs and other health care executives guide their organizations through the levels of the Health Equity Pyramid, pictured below. The pyramid is organized into two complementary sides: *diversity of workforce & leadership*, and *patient outcomes & experience*. Organizations should seek to make progress on both sides of the pyramid to successfully advance health equity within their organizations. On each side of the pyramid, organizations should (1) put in systems to collect necessary raw data, (2) analyze the data internally and create dashboards, (3) embed interventions into clinical workflows or HR processes, and (4) make the data public and establish clear internal accountability for equitable outcomes.

The following guidance is for part I of the Health Equity Pyramid, patient outcomes & experience. It was initially developed in the 2020-21 Forum Fellowship year by the Work Group on Leveraging Data to Improve Health Equity, with guidance on diversity of workforce & leadership to be developed in future Fellowship years. This guidance aims to embed equity into quality improvement and interventions with a focus on impacting care delivery, the patient and member experience, and outcomes.

## HEALTH EQUITY PYRAMID

Organizations should seek to make progress on both sides of the pyramid to successfully advance health equity



# Overview of Recommendations

## LEVEL 1

### **Collect raw data on demographics and patient outcomes & experience.**

- Organizations should collect race, ethnicity, language, and sex (REaLS) data from all of their patients/members.
- To optimize response rates and accuracy of data, organizations should follow best practice guidelines for collecting, storing, and exchanging demographic data.
- Organizations should stratify patient/member outcomes and experience measures that are most likely to show where meaningful disparities exist.

## LEVEL 2

### **Analyze internally and create dashboards for data segmented by race, ethnicity, language, and sex.**

- A senior leader in the quality department who reports to the C-suite should ensure regular aggregation and tracking of information on disparities in patient/member outcomes.
- Dashboards should be clear, comparative, and interactive.
- The dashboard should be shared with the CEO, C-suite executives, and senior clinical leaders at regular intervals.

## LEVEL 3

### **Embed interventions into clinical workflows to reduce disparities in patient outcomes & experience.**

- Perform a root cause analysis of why a disparity exists and determine what role an organization has in affecting that disparity.
- Build teams based on intervention needs, design and implement an intervention, and measure the intervention's impact on change.
- Ensure that the steps of the Health Equity Pyramid framework up to this point are repeated on a consistent basis.

## LEVEL 4

### **Make public data on patient outcomes & experience segmented by race, ethnicity, language, and sex, and establish clear internal accountability for equitable patient outcomes & experience.**

- Designate a senior quality leader and senior DEI officer dyad as jointly responsible for reducing health disparities.
- Create a balanced scorecard to tie senior leadership evaluations, goals, and compensation to company performance metrics.
- Create a public-facing dashboard with objective measures of clinical health equity outcomes for individual departments and programs.
- Structure payer-provider agreements to reward the elimination of health disparities over time versus a given baseline.

## **Level 1: Collect raw data on demographics and patient outcomes & experience.**



### **A. Organizations should collect race, ethnicity, language, and sex (REaLS) data from all of their patients/members.**

#### **Race and ethnicity**

Organizations should follow the race data collection standards of the Office of Management and Budget (OMB)<sup>4</sup> in order to ensure that patients/members are able to identify themselves as accurately as possible and also to ensure the standardization of data collection across the health care industry.<sup>5</sup> In addition to these standards, an additional “Some other race” category should be included, as well as the reporting of more granular ethnicity categories depending on the population served.<sup>6</sup> The additional levels of granular ethnicity should not serve as a replacement for other required data fields and should aggregate back into them if needed. Organizations should also be sure to allow patients/members to report multiple races or ethnicities.

#### **Primary language**

Organizations should ask questions concerning both spoken English language proficiency and spoken language preferred in the health care setting. Data on the languages spoken in an organization’s geographic location should inform the categories collected for preferred language. An “Other, please specify” option should always be included.<sup>7</sup>

## Sex

Organizations should ensure that they are collecting full and accurate sex data. While most organizations likely already collect these data as part of the medical record, they should ensure it is stored in the same format as other demographic data so that it can be analyzed in subsequent steps.

## Additional categories

Organizations should strive to collect additional categories of demographic data from their patients/members when possible, to further reveal where disparities may exist. Some additional categories of data to begin collecting include: age, ZIP code, income, sexual orientation, gender identity, and highest level of education achieved.<sup>8</sup> Organizations may also consider using the US Area Deprivation Index (ADI) to analyze disparities in outcomes.<sup>9</sup> Where possible, organizations should also collect provenance data (e.g. self-reported vs. observed demographic data origin information) in order to develop a hierarchy of accuracy and to reconcile potentially conflicting data.

### CASE EXAMPLE

One California-based hospital noticed that its no-show rate for appointments was very high in its Asian population. Looking further into this issue, they discovered that they were reaching out to patients in Chinatown with appointment reminders in English. When they changed the language of these communications to Cantonese and Mandarin, they saw a stark increase in show-up rates. In this circumstance, the Asian race category was not sufficient to determine a solution for the quality gap that this hospital observed, and additional analysis of more detailed fields such as ethnicity, preferred spoken language, and ZIP code data proved to be beneficial.



**B. To optimize response rates and accuracy of data, organizations should follow best practice guidelines for collecting, storing, and exchanging demographic data.**

**How to collect demographic data**

Organizations should ask patients/members or designees to voluntarily self-report demographic data; it should not be collected through staff observation.<sup>10,11</sup> Voluntary self-reporting can increase accuracy of responses and mitigates potential for respondent mistrust that may result with mandatory self-reporting. When a respondent expresses hesitancy to provide responses, it can be helpful to explain why the information is being collected and what it will be used for. There should be on-going opportunity for respondents to ask questions or provide feedback regarding demographic data collection. Any questions that staff have about collecting data should also be addressed in training to ensure proper collection methods.

Statistical imputation methods, geo-coding, and surname data<sup>12</sup> should be used to fill interim self-reported data gaps for a more complete REaLS dataset. These approaches can be especially helpful for payer organizations that experience barriers in collecting demographic data.<sup>13,14</sup> However, voluntary, self-reported responses should be considered the gold standard source for analysis and for comparison against other demographic data sources that may be used. Due to potential granular-level inaccuracies, datasets with a significant portion of imputed data should only be used for aggregate-level analysis and not for determining specific care or treatment recommendations. Organizations should set a target to collect at least 50% of patient/member voluntarily self-reported data, including REaLS and other demographic characteristics, with a long-term goal of 90% or more self-reported data collected.

*Voluntary self-reporting can increase accuracy of responses and mitigates potential for respondent mistrust that may result with mandatory self-reporting.*

## How to store and exchange demographic data

Organizations should create a mandatory field in the electronic health record (EHR)/member files for each of the REaLS categories to ensure that the data is uniform and can easily be pulled for analysis. More granular categories should be included, but they should be capable of aggregation back into the OMB categories for race and ethnicity. The HL7 Fast Healthcare Interoperability Resources (FHIR) standard should be used to exchange demographic data.<sup>15</sup> The HL7 code systems for race and ethnic group are also recommended to categorize race and ethnicity in alignment with federal standards.<sup>16</sup> Data should be fully collected every 5 years at a minimum to ensure the most accurate data over time and to reflect demographic changes.<sup>17</sup>

## Checklist for Health Care Leaders

### Does your organization...

- Allow patients/members to voluntarily self-report data?
- Train staff to collect data and answer questions about demographic data collection?
- Store demographic data as a mandatory field in EHR/member files?
- Use HL7 FHIR standard and race/ethnic group code systems?
- Estimate data where it is unavailable using imputation, geo-coding, and surname data?

## More Resources

**The Gravity Project**, launched by the Social Intervention and Evaluation Network (SIREN) with funding from the Robert Wood Johnson Foundation and in partnership with EMI Advisors LLC, is “a national collaborative effort to develop structured data standards to help reduce barriers to documentation and exchange of social risk and protective factors within the health care enterprise and with other sectors.” The Gravity Project develops consensus-based recommendations and guidance for collecting, aggregating, and exchanging social and demographic data elements.

**The Commissioned Paper on Health Care Disparities Measurement**, developed by the Disparities Solutions Center at Massachusetts General Hospital and by Harvard Medical School, with sponsorship by the National Quality Forum, provides research, methods, and guidance on “selecting and evaluating disparity-sensitive quality measures; methodological issues with disparities measurement; and to identify cross-cutting measurement gaps in disparities.” Information and recommendations included in the report provide a foundation for disparities-focused data collection and measurement.

Sources: (September 2020) The Gravity Project: A National Collaborative to Advance Interoperable Social Determinants of health Data; Commissioned Paper: Healthcare Disparities Measurement. (October 2011). The Disparities Solutions Center at Massachusetts General Hospital and Harvard Medical School.



### C. Organizations should stratify patient/member outcomes and experience measures that are most likely to show where meaningful disparities exist.

Organizations should actively seek to identify and track quality and experience measures in which there are likely to be disparities to be addressed, rather than selecting measures in which disparities might be less evident in order to put the organization in a better light. In doing so, organizations should focus on a combination of three types of measures: (1) the top quality or access metric being tracked by each business line, department, or division, (2) the list of core quality measures identified below for payers, providers, and life science organizations, and (3) additional disparity-sensitive measures customized to the population served and geography covered by the health care organization.

#### Encourage each department within your organization to stratify its top quality or access metric as a starting point.

In order to improve coordination of equity efforts across the enterprise and allow for greater organizational engagement in equity work, each business line, department, or division should stratify its own top metric by demographic data. For example, a hospital security team may stratify use of force by race and ethnicity. Organizations should track the percentage of reported stratified metrics and should set goals to improve over time, with a target to stratify demographic data for 90% of major business lines and/or departments/divisions of adequate size.



#### Collect and stratify the following core quality measures.

##### Payers

- Utilization rates of primary and specialty care services
- Net Promoter Score (NPS) or member experience ratings

##### Providers

- Infant and maternal mortality rates
- Cardiology: Controlled blood pressure
- Diabetes: A1c in target range
- Cancer: Colorectal cancer screenings
- Behavioral health measure
- Pain medication administration measure
- COVID patient mortality rate
- Patient satisfaction rating

##### Life Sciences Organizations

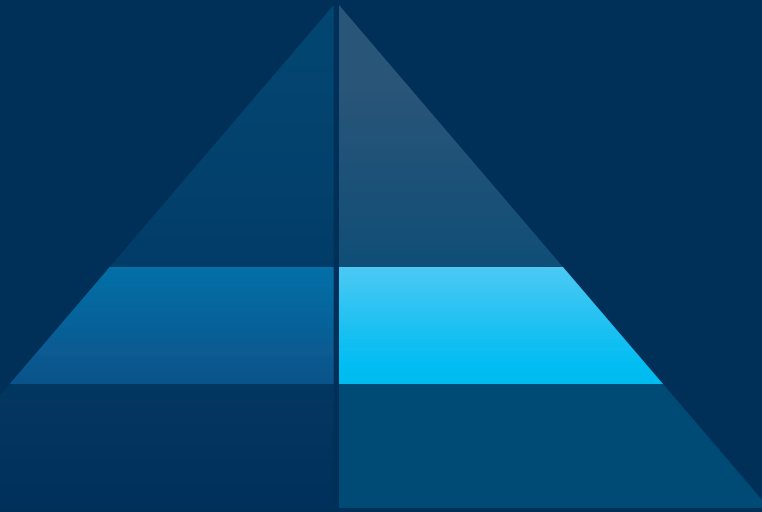
- Medication adherence rates
- Clinical trial participation rates



#### Collect and stratify additional disparity-sensitive measures customized to your organization's population.

A disparity-sensitive measure has been proven or is suspected to be more likely to contain significant disparities when stratified by demographic data. By focusing on the most disparity-sensitive measures, organizations ensure that they have the highest likelihood of uncovering a quality area to be improved within their organization. Disparity-sensitive measures should be identified through a combination of (a) the analysis of aggregated national quality data, such as the NQF set of disparity-sensitive measures, (b) quality data from organizations in your community, and (c) testing a quality metric that is suspected to reveal disparities in your patient/member population.

## **Level 2: Analyze internally and create dashboards for data segmented by race, ethnicity, language, and sex.**



### **A. A senior leader in the quality department who reports to the C-suite should ensure regular aggregation and tracking of information on disparities in patient/member outcomes.**

As a senior leader, the individual should have visibility into the company and be able to collect adequate data that will produce meaningful results. By placing responsibility for tracking disparities with a senior leader in the quality department who reports to the C-suite, an organization strengthens the tenet of equity as a key component of overall quality of care. There should also be intentional touchpoints of collaboration between quality and diversity, equity, and inclusion (DEI) leadership in reviewing disparities to drive complementary and more effective equity efforts (for more details on this collaboration, see level 4 recommendations).

It is important to dedicate support to tracking disparities rather than simply adding to the responsibilities of an existing role. New resources should be made available to the quality department to manage the maintenance of data collection and analysis. Where applicable, organizations should also engage the support of their research departments and/or academic groups to track and analyze disparities. Disparities in care should be tracked at the same interval that quality metrics are analyzed.

*Organizations should strive to have interactive dashboards that staff can easily interpret and use.*

## **B. Dashboards should be clear, comparative, and interactive.**

### **Compare data against multiple groups and at multiple levels for more rigorous analysis**

Outcomes should be measured against multiple groups to assess the magnitude and depth of disparities for specific populations, including through varying levels of granularity. The broadest approach should be through comparing specific population outcomes against outcomes for the overall patient/member population. If available, the quality ratings of the group potentially experiencing a disparity should be measured against the group with the highest quality ratings.<sup>19</sup> A mix of relevant non-health data for groups impacted by disparities, including social driver data, should be incorporated into stratification and review,<sup>20</sup> particularly to compare more granular populations that may otherwise share similarities.

### **Track relative and absolute changes over time**

When tracking a change in disparities, both relative and absolute data comparisons should be calculated, and if they conflict, both should be shown.<sup>21</sup> For example, if there were two groups, one with better outcomes in a specific measure and one with worse outcomes, and the outcomes for these two groups improved by the same amount, there would be no change shown in the absolute difference, but the relative difference would increase. It is important to track these subtle differences, because while it may appear that a given intervention is improving quality across an organization, it may actually be allocating efforts and resources to inappropriate areas and increasing disparities.

### **Present interactive data**

Organizations should strive to have interactive dashboards that staff can easily interpret and use. A well-designed dashboard allows different areas of an organization to compare equity progress and outcomes against each other, as well as track longitudinal changes and hypothesize interventions to target specific disparities in care. The success of targeted interventions should be tracked by the change in disparities over time. The more often these data are updated, the better.

**C. The dashboard should be shared with the CEO, C-suite executives, and senior clinical leaders at regular intervals.**

A senior leader in the quality department should share and report out on the dashboard regularly (at least quarterly) to the CEO, other C-suite executives, and to senior clinical leaders to present progress that has been made on disparities and where the organization should focus its resources. Dashboards should be updated at the same cadence as quality data results. Increasing the cadence of dashboard updates and reporting can result in deeper leadership involvement and more focused execution to achieve equity goals. CEOs should then share these dashboards with their boards at least once a year. The most up-to-date data should be made available as a digital tool that can be easily accessed, and organizations should increasingly strive toward making this tool more openly available to anyone in the organization with the ability to impact disparities.

**CASE EXAMPLE**

A midwestern health system leading in diversity and health equity efforts has embedded reviews of patient outcomes dashboards into its regular meetings. For example, it holds a several-hour-long “Diversity Forum” with its CEO and other senior leaders each quarter to review patient outcomes data as well as other diversity and equity issues. It also incorporates a standing agenda item to discuss patient outcomes by demographic groups in its monthly data review meetings with VPs across the organization.



## **Level 3: Embed interventions into clinical workflows to reduce disparities in patient outcomes & experience.**



### **A. Perform a root cause analysis of why a disparity exists and determine what role an organization has in affecting that disparity.**

#### **Determine the impact that your organization has on a disparity**

Review points of care or interaction with a patient/member and determine where your organization has an impact. Are the causes of the disparity mostly upstream (societal and socio-economic factors that the organization has more limited impact on) or downstream (impact that falls “within the four walls” of the organization)? In other words, is this a *health care* disparity, meaning that it is a direct result of health care that has been or has not been received by the patient, or is it a broader *health* disparity that is primarily caused by external factors?<sup>22</sup> Although the distinction between upstream and downstream causality is not absolute, organizations should do their best to separate the two where possible. While organizations should track all disparities in health, this particular guide focuses on interventions to address disparities with causality largely within an organization. For information and guidance on addressing health inequity in the community setting, please reference the Health Evolution Forum Work Group on Building Scalable Models and Community Partnerships to Address Social Determinants of Health (SDOH).

## Clearly establish the group that should benefit from an intervention<sup>23</sup>

Criteria to define and establish the group should include:

- Prevalence of the disparity to be addressed within the group;
- The magnitude of the disparity when compared against the overall population, the group with the highest quality ratings, or more granular populations that may otherwise share similarities, if applicable;
- The strength of evidence in connecting the potential intervention's impact to improving outcomes for the group; and
- The feasibility of implementing the intervention for the group experiencing the disparity.

## Utilize a systematic approach to perform the root cause analysis<sup>24</sup>

A small team with diverse skill sets and at different seniority levels within the organization is needed to perform the root cause analysis. To perform an effective analysis, there must be a focus on system causes to avoid blame in determining why a disparity or poor outcome has occurred. It should also be acknowledged that there are usually multiple factors that have contributed to the disparity.

## Six Steps for a Root Cause Analysis

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The **Institute for Healthcare Improvement (IHI)** has identified six common steps to perform a root cause analysis after establishing the analysis team:

- 1 Identify what happened accurately and completely
- 2 Determine what should have happened in ideal conditions
- 3 Determine causes by “asking why five times”
  - Use tools such as the fishbone/cause and effect diagram to determine causes
- 4 Develop causal statements to explain how factors contributed to poor outcomes
- 5 Create a list of recommendations to prevent poor events or outcomes in the future
- 6 Summarize the analysis and share with key stakeholders

**B. Build teams based on intervention needs, design and implement an intervention, and measure the intervention's impact on change.**

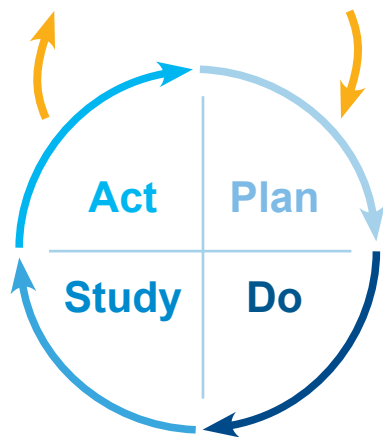
**Form teams that will meet the needs of the intervention and that can promote equity-driven change, including educating staff on disparities that exist and what their role is in making care more equitable<sup>25</sup>**

There should be a clearly defined team that leads the intervention effort and serves a champion in driving change, which includes communicating the purpose of the intervention, its contribution to reducing targeted disparities, and how other staff will contribute to equity efforts. Based on the intervention, the team should include members that hold necessary clinical, technical, and operational skills. The team should also include a leadership member who can serve as a sponsor by advocating for the intervention at the executive level and obtaining necessary resources and support.<sup>26</sup>

<b>MODEL FOR IMPROVEMENT</b>
<b>What are we trying to accomplish?</b>
<b>How will we know that a change is an improvement?</b>
<b>What change can we make that will result in improvement?</b>

**Target a particular quality metric and demographic group and set clear goals for change<sup>27</sup>**

The Model for Improvement<sup>28</sup> should serve as the framework in quality intervention design and implementation. The Model's three fundamental questions and Plan-Do-Study-Act (PDSA) cycle will set aims, define the target intervention group, identify the quality improvement actions needed to make change, and determine measures to track the intervention's impact. At the enterprise level, it should be clearly communicated that equity efforts are embedded in quality improvement processes, and that equity work should be from the quality or performance improvement perspective.



**Use data based on its impact in measuring whether change is leading to improvement<sup>29</sup>**

Due to the cyclical nature of the quality improvement process, data collection and analysis related to the intervention should be narrowed to assessing change. Methods to collect data that are within the intervention's scope include sampling to track performance and integrating measurement into relevant daily workflows. Data should be plotted to identify trends or patterns over time. Both quantitative and qualitative data that are relevant to the intervention should be collected.

Source: How to Improve. Institute for Healthcare Improvement.

**C. Ensure that the steps of the Health Equity Pyramid framework up to this point are repeated on a consistent basis.**

**Constantly improve the collection of demographic data**

When demographic data are less accurate, the distribution of certain characteristics is more random, and thus disparities may appear to be less extreme. As the quality of data improves, disparities in certain groups where data collection was previously insufficient may present themselves.<sup>30</sup> Furthermore, as more granular demographic data are available, interventions can be developed to target specific groups more directly with one or more unique characteristics.

**Collect data for more quality metrics and engage in deeper analysis**

Analysis of outcomes regarding the same quality metric for multiple demographic groups can reveal that a positive absolute change for a group is in fact a negative relative change or an unintended consequence of an intervention for other populations. Collecting and analyzing data across more disparity-sensitive quality metrics will provide the opportunity to develop more interventions and reconcile potential impacts or consequences of addressing other disparities.

**Re-evaluate which interventions should be prioritized, and which continue to be successful**

While maintenance of the earlier levels of the Health Equity Pyramid framework should be ongoing, attention should be given to tracking changes in disparities that have been targeted by interventions. As improvement occurs over time for a certain disparity, other disparities may become more pressing. Evaluation, development, and refinement of interventions should remain dynamic to address high-priority disparities, including for those within more granular demographic groups.

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*When demographic data are less accurate, the distribution of certain characteristics is more random, and thus disparities may appear to be less extreme.*



**Level 4: Make public data on patient outcomes & experience segmented by race, ethnicity, language, and sex, and establish clear internal accountability for equitable patient outcomes & experience.**



**A. Designate a senior quality leader and senior DEI officer dyad as jointly responsible for reducing health disparities.**

**Ensure that the designated individuals have access to the C-suite**

As noted in level 2 of the framework, it is integral that the individuals responsible for tracking and reducing health disparities collaborate at the intersection of quality and DEI, and have access to the organization's C-suite to report findings and gain leadership support for interventions. These distinct yet complementary roles also ensure that there is always a voice advocating for health equity when executive-level decisions are made. These individuals should be given the opportunity to review management decisions to consider possible unintended consequences on equity within the organization.

## Create an equity council to drive efforts across the enterprise

Organizations should also consider forming a health equity council that has a regular (ideally, monthly) meeting cadence to engage employees from across the organization and that represents various seniority levels. Equity council members should represent clinical and non-clinical areas, and a flattened hierarchy approach should be used in dialogue and decision making. Leaders of employee resource groups and organizational caucuses can serve as effective council members.



### CASE EXAMPLE

A west coast health system identified improving equity as a core organizational goal. To strengthen enterprise-wide equity efforts and to address disparity and inclusion-related needs, the system created a health equity council with members ranging from executive leadership to frontline staff. The council oversees efforts in achieving measurable equity progress, and communicates with health system and community stakeholders regarding equity initiatives.

## More Resources

The Disparities Solutions Center at Massachusetts General Hospital, with support from the Robert Wood Johnson Foundation, created **Improving Quality and Achieving Equity: A Guide for Hospital Leaders**. Key information in the guide includes recommended activities, resources, and case examples for hospital leaders to initiate an equity agenda from the lens of quality, cost, risk management, and accreditation.

Source: Betancourt, J., Green, A., King, R.R., Tan-McGrory, A., Cervantes, M., Renfrew, M. Improving Quality and Achieving Equity: A Guide for Hospital Leaders. The Disparities Solutions Center at Massachusetts General Hospital.

## **B. Create a balanced scorecard to tie senior leadership evaluations, goals, and compensation to company performance metrics.**

### **EXAMPLE OF HOW TO CREATE A BALANCED SCORECARD**

- **Create 10-15 strategic objectives**

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- **Create 1-2 measures per objective**

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- **Create 0-2 initiatives for every objective**

## **Identify relevant goals to build a foundation for leadership evaluation**

Before evaluating senior leadership performance, goals that are feasible, relevant, and meaningful to the organization and its departments should be defined. A potential pipeline to develop leadership evaluation against progress towards identified goals includes first establishing a goal-based foundation, then determining key performance indicators (KPIs) and payment structures for goal performance. The magnitude of required change to achieve identified goals should be considered when measuring progress. Finally, goals and KPIs should be tied to a balanced scorecard for leadership evaluation.

## **Develop and longitudinally track scorecard KPIs that reflect pivotal health inequities to be addressed**

KPIs should focus on the core competencies, processes, decisions, and actions that have the greatest impact on patient experience and outcomes. There should be a designated team, ideally comprised of the senior quality leader and senior DEI officer dyad responsible for reducing health disparities, that creates, maintains, and presents scorecard KPIs to C-suite leadership.

### **CASE EXAMPLE**

A southeastern medical center has created a scorecard that links senior leadership performance evaluations and compensation to metrics that include health equity, DEI, and SDOH outcomes. Additionally, primary care physician compensation is partially linked to patient experience and documentation compliance of SDOH domains. The medical center is also trialing a behavioral health-focused approach to complete data collection related to SDOH and preventative quality metrics. Physicians will earn points that are directly tied to compensation based on the timeliness and completeness of data collected.

*It is important to complement dashboard data with context as to why disparities that are being addressed exist and the organizational guidance, strategies, and interventions that have been developed in response.*

**C. Create a public-facing dashboard with objective measures of clinical health equity outcomes for individual departments and programs.**

**Adapt internal-facing dashboards for public display and provide scorecard visibility to employees**

Organizations should use elements of their internal dashboards (see level 2 for recommendations on creating a comparative and interactive dashboard) to create a clear and concise public-facing dashboard that assesses equity progress against national level benchmarks or other similar institutions, based on available and comparable data. When ready, public dashboard data should be included on the organization's website, annual report, or 10-K if a public company. In addition to a public-facing dashboard, organizations should display the equity-focused balanced scorecard on its internal homepage to transparently share progress with employees in achieving equity goals across departments and initiated programs.

**Provide context for public dashboard data**

It is important to complement dashboard data with context as to why disparities that are being addressed exist and the organizational guidance, strategies, and interventions that have been developed in response. Providing this information provides greater transparency and can build engagement and trust with stakeholders who are interested in and have been impacted by health disparities.

## **D. Structure payer-provider agreements to reward the elimination of health disparities over time versus a given baseline**

### **Set clear expectations for payers and providers under agreement**

Payers and providers should collaboratively define the measures that will be included in assessing health disparities reduction. The calculation to determine performance should also be agreed upon by both parties. There should be clear provisions that outline the obligations for payers and providers regarding data collection and reporting. Contracts should also award appropriate modalities of care that are accessible and that address disparities for disadvantaged populations, such as providing care services via landline telephone call for patients that do not have access to a computer or smartphone.



#### **CASE EXAMPLE**

A northeast-based payer's race and ethnicity data needs are directly related to driving health equity strategy. The payer has embarked on a multi-channel outreach effort to collect voluntary, self-reported race and ethnicity data from its members. Depending on the level of self-reported data collected (considered to be gold standard), the payer aims to launch a health equity incentive program for providers in the near future. Providers will be given a year to confidentially report results related to health equity measures, then will have financial responsibility for these measures at later phases of the program.

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