CIN

CONNECTIONS

Winter 2022 Issue:

Centering Equity in Health Care Improvement

CONTENTS

Reflections from a CIN Managing Partner

Nicole Howard, MPH

In my role as a public health professional, I have some 30 years of experience developing interventions to improve the quality of care and the well-being of patients. Although much of this time has been in primary care settings with services delivered by Federally Qualified Health Centers, I had not considered how my work, while yielding improvements for many patients, might widen disparities among populations that have been systematically marginalized.

This realization was a central takeaway for me from the California Improvement Network (CIN) partner meeting November 2 and 3. This edition of *CIN Connections* provides highlights from the event that offer new mindsets and strategies to methodically apply a health equity lens to our quality improvement (QI) work. I hope that you will find the learnings impactful and will join me in embracing this long-overdue evolution of quality improvement.

Dr. Ron Wyatt discussed how health disparities rooted in inequity are systemic, avoidable, and unjust. Such disparities can be traced to such factors as racism, sexism, ageism, and ableism, and it is troubling to think that some
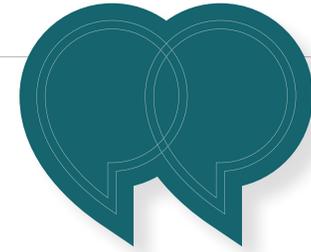
> …it is troubling to think that some of our QI work to date has perpetuated these systemic biases."

of our QI work to date has perpetuated these systemic biases.

As health care professionals, we need to include design features in our improvement efforts that examine the causes of these disparities, and work to ensure that the gaps between subgroups do not widen. Both Dr. Wyatt and Dr. Michelle-Marie Peña, in her talk on practical application of equity-focused QI concepts, cautioned us to look for and guard against unintended consequences and declining quality for specific groups of individuals.

Reflections from a CIN Managing Partner

"As health care professionals, we have an obligation to foster equity by looking past the data and remembering that the numbers reflect the lived experiences of real people.
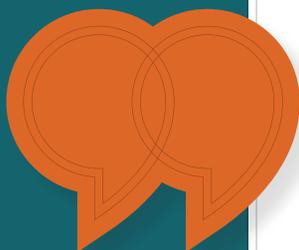
In a presentation about the federal government's pandemic response under the Biden Administration, Dr. Cameron Webb of the White House COVID-19 Response Team presented inspirational examples of what we can achieve by going all in together.

And in his example from behavioral health services, Dr. Ritchie Rubio outlined his strategy of adding an I and E for inclusion and equity to SMART (specific, measurable, achievable, realistic, and time-bound) goals. I will encourage my organization to incorporate these SMARTIE goals so equity is always central in our initiatives.

To better develop goals that have inclusion and equity built in from the beginning, Health Quality Partners (HQP) and its parent company, Health Center Partners of Southern California (HCP), are identifying vendors who can help with market research to amplify the patient voice in our health equity priorities. The desired goals of this project include documenting the patient voice, collecting primary and secondary data on health outcomes and disparities in the region, gathering quantitative and qualitative data on health inequity in the region, collecting primary and secondary data on patient preferences for accessing health care and other community support services, and documenting

stakeholder perspectives on gaps and priorities for addressing health disparities and promoting health equity. This research will be particularly critical as Health Center Partners builds its Center for Health Equity.

As health care professionals, we have an obligation to foster equity by looking past the data and remembering that the numbers reflect the lived experiences of real people. My goal is to bring these learnings back to my organization and support the next generation's capacity to advance quality improvement by doing it even better within a health equity framework.

Sincerely,

Nicole Howard, MPH
Executive Vice President,
Health Quality Partners of Southern California
Chief Advancement Officer,
Health Center Partners of Southern California

Related Resources:

See the CIN website for the recordings of all presentations and the resources page.

Three Lessons from the White House on Health Equity

Health equity work has not previously been a focus in the federal government, noted Dr. Cameron Webb as he described his arrival at the White House to lead the charge to create a more equitable pandemic approach nationwide. Webb shared the ways the Biden Administration has approached data collection, accountability, community engagement, strategic interventions, and evaluation. His wide-ranging presentation addressed everything from testing, tracing, and vaccination distribution to long COVID, mental health, and health care access.

B. Cameron Webb, MD, JD
Senior Policy Advisor for Equity, White House
COVID-19 Response Team, Executive Office
of the President

Webb also gave CIN participants a glimpse into the workings of the COVID-19 Health Equity Task Force, established on the second day of the Biden Administration. The task force has issued over 300 recommendations to reduce disparities by better allocating resources, disbursing relief funds, collecting data, and implementing culturally aligned messaging and outreach.

The lessons Webb shared apply to everyone advancing health equity, no matter the size or scope of their institution. He emphasized that the time is now to push for health equity, when there is energy and resources behind these efforts due to the pandemic and the growing social awareness of structural racism and its negative impact on health outcomes.

1 Lesson 1: Invest in Data to Support the Work

As the White House COVID-19 Response Team began their work in January 2021, the inequity trends were clear: Cases, hospitalizations, and deaths among Black, Latinx, and American Indian and Alaska Native populations were disproportionately high.

Three Lessons from the White House on Health Equity

They soon discovered that a key strategic tool for addressing these disparities — the data — was lacking. How could they advance equity in the pandemic response and vaccination plans when just 52% of race and ethnicity data was reported for vaccinations in general? Insufficient data was due to inconsistent collection processes, people opting out, and uneven reporting across systems.

Webb sees data collection in support of health equity as an important factor in two ways: The data make visible what issues need to be worked on, and the process of data collection and reporting creates transparency and accountability. Institutions need to develop and enforce a data ecosystem across institutions that promotes equity-driven decision making.

The strategies implemented by the COVID-19 Response Team include expediting and streamlining data collection, identifying high-risk communities to track resource distribution and evaluate effectiveness, increasing reporting of federal data, expanding data collection for commercially insured populations, and reaffirming privacy protections. Between 70% and 80% of their data is now encoded with race and ethnicity information.

2 Lesson 2: Interventions Must Prioritize the Most Disadvantaged

Social and economic factors that drive other health outcomes can help explain the disproportionality of COVID-19's impact. Webb reviewed data sets that align communities of color with every driver of worse COVID-19 outcomes **(see Figure 1)**. Based on this, the White House team turned to incorporate "disadvantage indices" into their process of targeting interventions.

Originally developed to help identify community-level vulnerability to the negative impacts of natural disasters, disadvantage indices give a clearer picture of where resources are best deployed. Indices that focus on regions or states are particularly valuable. The following are some frameworks used to prioritize resources and minimize inequities:

- Social Vulnerability Index (SVI)

- COVID-19 Community Vulnerability Index

- Area Deprivation Index

- California Healthy Places Index

By identifying social vulnerabilities and prioritizing the needs of those who are the hardest

hit and at the highest risk, resources to promote equity for the most disadvantaged can be provided. For example, interventions can increase the share of resources such as medical supplies, tailor the messaging for outreach, redirect the locations for services, and monitor uptake.

3 **Lesson 3: Deploy Strategies Large and Small** The Biden Administration's health equity plan included strategies to increase vaccine demand and accessibility through a wide range of efforts.

The large-scale efforts were designed to efficiently hit significant swaths of people. Strategies were based on locations in large states and high-risk areas, according to a mix of data that included SVI scores and size:

- **Community Vaccination Centers:** Launched 36 mass vaccination sites in high-risk areas, with 60% of doses going to people of color.

- **Federal Retail Pharmacy Program:** Through 21 pharmacies, directly allocated over 133 million doses to over 41,000 locations.

- **Federally Qualified Health Centers:** Sent doses directly to 870 locations, with 76% of doses going to people of color.

- **Dialysis clinics:** Directly allocated vaccines to reach high-risk, majority-minority (34% Black and 19% Hispanic) end-stage renal disease patients.

Figure 1: Drivers of COVID Inequity

JH Farley et al. *Gynecologic Oncology,* 158 (2020) 25-31.
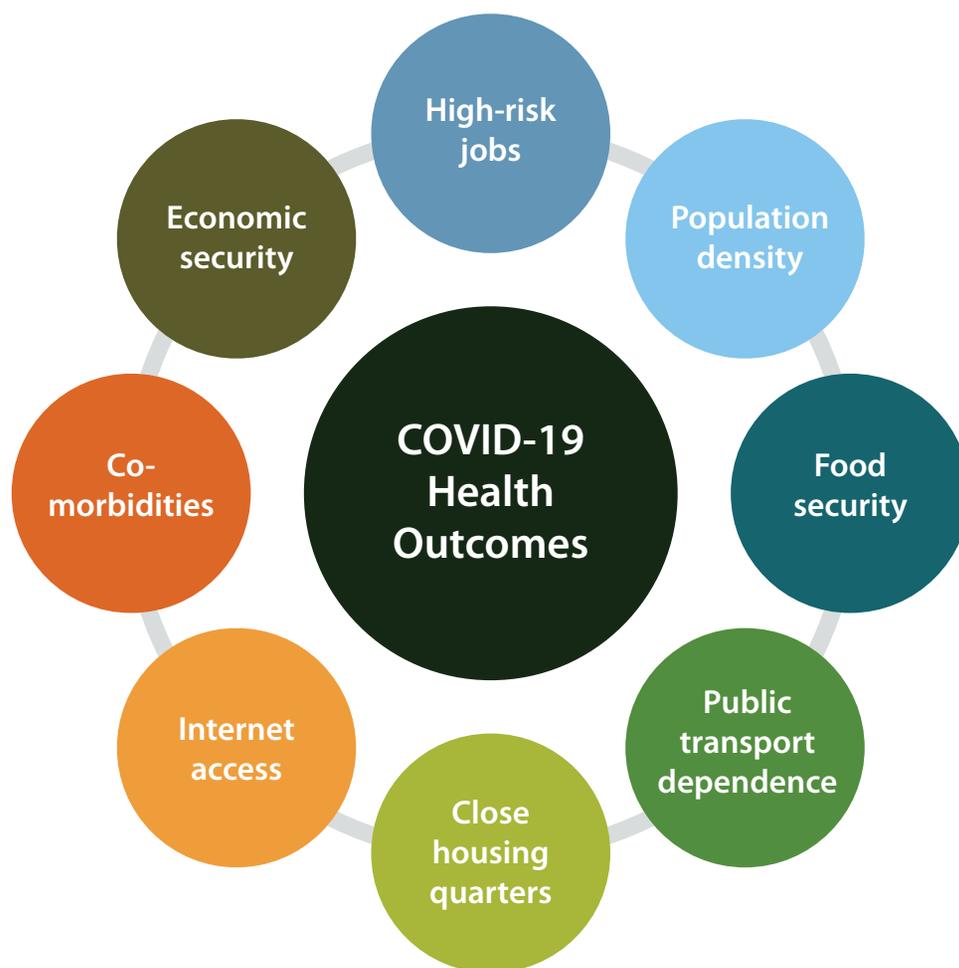
Three Lessons from the White House on Health Equity

The smaller efforts focused on people with more limited access to health care institutions. Such outreach can be especially important for addressing disparities because of its capacity to target high-risk subgroups. Through "Shots at the Shop," people were educated about vaccines and offered shots at barber shops and hair salons, mobilizing culturally relevant places that connect people. Another program offered up to four hours of free childcare so family members could make time to get vaccinated.

While these smaller-scale tactics don't have as much impact on their face, they are still impactful for the few thousand people that took advantage of the vaccine. When looking for strategies to increase equity, these are naturally going to be smaller segments of the population, and it will be necessary to do many more of these narrowly targeted strategies.

Health Happens Where People Live and Work

The three lessons offered by Webb involve applying an equity framework to address one particular disease, and relying on data collection, accountability, community engagement, strategic interventions, and evaluation. Health organizations cannot enter communities and focus on single issues, however, because wellness happens in a community context. Investment in holistic, community-led solutions is necessary to address health equity.

Webb was once asked why, "People are coming to my door to talk about the vaccine, but nobody ever reaches out to me to talk about my high blood pressure or my mental health." Others commented that their communities live every day with gun violence.

While COVID-19 will remain a point of focus for the foreseeable future, the chronic diseases and other public health issues that afflict communities require attention. "We don't defund the military in times of peace," said Webb. "We need to keep investing in our health care system, not just for COVID, but for all these conditions."

> "Through Shots at the Shop, people were educated about vaccines and offered shots at barber shops and hair salons, mobilizing culturally relevant places that connect people.

Related Resources:

**See the latest details of President Biden's COVID-19 Action Plan.**

The data make visible
what issues need
to be worked on,
and the process of
data collection and
reporting creates
transparency
and accountability."

Principles for Achieving Health Equity

Source: Cameron
Webb, MD, JD.

■ Collect, analyze, and report data disaggregated by age, race, ethnicity, gender, disability, neighborhood, and other socio-demographic characteristics.

■ Include the people most affected by health and economic challenges in decision making, and benchmark progress based on their outcomes.

■ Establish and empower teams dedicated to promoting racial equity in response and recovery efforts.

■ Proactively identify and address existing policy gaps while advocating for further federal support.

■ Invest in strengthening public health, health care, and social infrastructure to foster resilience.

A Tool for Equity-Focused Quality Improvement

I n practical terms, how can primary care providers and other health organizations adapt their improvement practices to center health equity?

Michelle-Marie Peña, MD, shared a framework developed with her colleagues for "equity-focused quality improvement" (EF-QI) that improvement professionals can use to ensure they are targeting health disparities effectively.[1] This means developing projects in ways that are inclusive and collaborative, that prioritize and address the needs of groups experiencing disparities, that are action-oriented, and that use EF-QI principles throughout the effort.

The EF-QI framework outlines eight key steps, as shown in **Table 1,** "Applying equity-focused quality improvement concepts to practice."

To illustrate how these eight steps are taken, Peña discussed a case study of show rates for neonatal follow-up program (NFP) appointments at Children's Hospital of Philadelphia. These follow-up appointments are intended to ensure that parents and babies are receiving support, infant development is being tracked, and families are getting appropriate referrals

Michelle-Marie Peña, MD
Research Fellow and Clinical Attending, PolicyLab, Division of Neonatology, Children's Hospital of Philadelphia

for support services after being discharged from the neonatal intensive care unit.

The project's aim was to increase initial NFP show rates for Black patients from 63% to 70%. The NFP engagement rate was deemed a good candidate for this improvement effort because it is a "disparities-sensitive measure," having been established in the literature as a known disparity, being a care decision that can be impacted by provider behavior and discretion, being a communication-sensitive process, and being impacted by social determinants of health.

Table 1: Applying Equity-Focused Quality Improvement Concepts to Practice

CONCEPT	PRACTICAL APPLICATION	
1. Foster a culture of equity.	■ Incorporate equity into all discussions about existing and future initiatives.	■ Similar to safety, striving for equity should be everyone's work.
2. To address a disparity, it must first be identified.	■ Analyze data considering PROGRESS-Plus variables including race/ethnicity, preferred language, country of origin or neighborhood.	■ Investigate how race, ethnicity and sociodemographic data are locally collected.
3. Incorporate equity into the design of QI initiatives.	■ Incorporate equity into the selection of measures, development of SMART aim, root cause analysis, key driver diagram and study design.	
4. Families and community partners are critical stakeholders.	■ Families and community partners should have a seat at the table to provide input on project design and planning.	■ Conduct qualitative work to allow family and community voices to inform SMART aims, key driver diagrams and change ideas.
5. Consider alternative comparator groups.	■ The reference group can be selected based on specific criteria, such as size of group and performance of the group depending on the EF-QI measure.	
6. Focus of work should be on the evaluation of root causes and modification of systems and processes.	■ Be careful when analyzing race-stratified data and ensure you understand what the race variable is serving as a proxy for.	■ Approach disparities using systems thinking and QI tools to evaluate root causes and systemic contributors to problems. Avoid focusing on individual behaviors.
7. Adapt existing data visualization tools to emphasize disparity trends over time.	■ Display run charts and statistical process control charts stratified by REaL data at a minimum and other characteristics as defined by project aims.	
8. Approach dissemination of data from an equity perspective.	■ Disseminate data and findings to all involved stakeholders using plain language summaries to increase community capacity-building.	■ Share lessons learned and best practices with other units and organizations, acknowledging limitations in generalizability.

A Tool for Equity-Focused Quality Improvement

1 Foster a culture of equity. Discussions about racism are challenging, but they must be taken head-on as a necessary first step to identify racial bias in health care institutions. Peña and her colleagues quote the National Quality Forum (NQF): "A culture of equity recognizes and prioritizes the elimination of disparities through genuine respect, fairness, cultural competency, the creation of environments where all individuals, particularly those from diverse and/or stigmatized backgrounds, feel safe in addressing difficult topics, e.g., racism, and advocating for public and private policies that advance equity." [2]

2 To address a disparity, it must first be identified. QI staff must dig deeper into data sets to identify disparities. This project used stratified data based on socioeconomic factors to isolate subgroup measures for improvement. Peña briefly contextualized how structural racism manifests in health outcomes and its intersectionality with social determinants of health. When looking at data by race, it's important to understand that "race" is a social construct and therefore a proxy for racism.

3 Incorporate equity into the design of QI initiatives. Peña's team began by examining conventional "no-show" rates for neonatal follow-up visits. After considerable reflection, they reframed the health disparity question from a "Black deficit" framing to a strength-based framing: *improvement targets were redefined from reducing no-show rates to improving show rates.* This type of conscious reframing imbues the effort with equity.

4 Families and community partners are critical stakeholders. The patient voice and diversity of lived experiences are critical data inputs that guide how inequity may be examined and how improvement interventions should be developed. QI efforts must consciously shift the "discourse's starting point from a majority group's perspective, which is the usual approach, to that of the marginalized group or groups" — that is, to "center the margins." [3] Tactics to accomplish this include involving patient family councils in the project and including members of the target population as part of the project team. Patient interviews, informally asking patients questions, or using qualitative surveys also surface the patient voice.

"Sharing learnings reinforces community members 'as partners rather than subjects.' Sharing with other organizations contributes to the overall advancement of the health equity field.
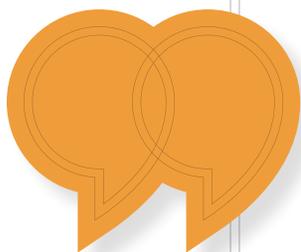
5 **Consider alternative comparator groups.** When working with data sets to identify a health disparity, it is important to carefully consider the comparator group that is selected. Typically, the White population comprises the default comparator group — also understood as a "White racial frame."[4] Case by case, examine which group is the best comparator and be explicit about the reasons for making this choice. Consider other factors such as population size or volume, performance, and data quality. Be explicit about how and why the comparator group is selected.

6 **Focus of work should be on evaluation of root causes and modification of systems and processes.** What made it difficult for a family to attend a neonatal follow-up visit? Did the family understand the purpose of the appointment? What would have made the appointment easier to attend? Understanding the obstacles for patients can shine light on racism and bias in the process and support strategies that enable attendance. Peña's team created a process map to illustrate the many steps that were involved, and learned that many of those steps

were not reliably happening **(see Figure 2)**. Notably, the diagram color codes drivers that may be related to racial bias. With this information, the team created an impact-effort matrix to prioritize process improvement ideas.

7 **Adapt existing data visualization tools to emphasize disparity trends over time.** Peña's team is working to adapt an existing "value stream map" model to map the actual process, show the flow of people over time, and highlight how obstacles impact outcomes.[5] The map can show how improvements are seen over time in the data. She recommended using the tools and data that are available at the start and adapting them to suit the project as it progresses.

8 **Approach dissemination of data from an equity perspective.** The data and findings from an EF-QI effort should be shared with other health care organizations and community members. This is an essential step, especially sharing with those directly impacted by the improvement work. Sharing learnings reinforces community members "as partners rather than subjects." Sharing

Figure 2: Drivers of NFP Initial Visit Show Rates

OUTCOME MEASURE

Goal: To increase NFP initial visit show rates of Black patients from 63% to 70% by June 2022.

KEY

■ **Blue:**
Not tested yet

■ **Orange:**
Potential driver of disparities in care (racism and bias in care)

■ **Green:**
Addressed/ Implemented

Source: Michelle-Marie Pena, MD.

KEY DRIVERS

- Medical team knowledge of NFP eligibility
- Parental understanding of the purpose of NFP
- Scheduling appointment prior to discharge for all eligible patients
- Communicating appointment to families before discharge
- Remembering appointment date/time
- Primary care provider understanding purpose of NFP
- Getting to appointment
- Variation in process between two hospitals

SECONDARY DRIVERS

- Clear NFP eligibility criteria available
- NFP education during stay
- NFP education during discharge
- Appt date selection: role of parent availability, appt clustering, complex scheduling
- NFP emails appt to front line clinician
- Front line clinician understands NFP, urgency to schedule before discharge, checks email regularly, adds to paperwork and communications
- Parents told about appt at discharge, discharge summ, handout (nursing aware, bias)
- NFP staff calls to confirm, adjustment due to COVID screening call
- Awareness and communication with primary care provider about NFP and purpose
- Family has details for appt logistics and support (transportation, childcare, time off work)

CHANGE IDEAS

- Update appt process and card for Hosp of Univ of Pennsylvania
- Connect NFP with families during NICU stay reliably, e.g. therapists
- Involve family in appt time, cluster appts at Hosp of Univ of Pennsylvania (complex scheduling?)
- If appt post discharge: NFP follow up to ensure appt made
- Front line clinician education on NFP, email timing goal, check email (orientation?) CC others on schedule
- Nursing NFP education: purpose, discharge counseling (separate handout)
- Make multiple calls to remind and confirm the appt time works. Include education on NFP
- Supporting high-risk/many no-show families — who calls? Social worker?
- Primary care provider education
- Identify transportation assistance — insurance, hospital? Telehealth option for first visit

A Tool for Equity-Focused Quality Improvement

with other organizations contributes to the overall advancement of the health equity field.

Though the example presented is from a hospital setting, Peña emphasized that the EF-QI approaches can be adapted to many medical settings, health conditions, and patients of all ages. Based on their findings, changes her team is making to reduce disparities include: streamlining how appointments are made prior to discharge; providing more NFP education to families, nurses, residents, and fellows; and making additional reminder calls to the families. The team will continue to report on results as the project progresses.

Peña closed her presentation with this encouragement: This work takes time to execute in thoughtful and careful ways that engage the patients and the community, but it is worth it.

Related Resources:

For more information, see the website for recordings of Peña's two presentations.

Endnotes

1 Vicky Reichman et al., "Using rising tides to lift all boats: Equity-focused quality improvement as a tool to reduce neonatal health disparities," *Seminars in Fetal and Neonatal Medicine* 26, no.1 (Feb 2021).

2 *A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity,* National Quality Forum (NQF), Sep 2017.

3 Chandra L. Ford and Collins O. Airhihenbuwa, "Critical Race Theory, Race Equity, and Public Health: Toward Antiracism Praxis," *American Journal of Public Health* 100, no. S1 (Apr 2010): S30-S35.

4 Rachel R. Hardeman and J'Mag Karbeah, "Examining racism in health services research: A disciplinary self-critique," *Health Services Research* 55, no. S2 (Oct 2020): 777–780.

5 Sandhya S. Brachio et al., "Improving Neonatal Follow-up: A Quality Improvement Study Analyzing In-hospital Interventions and Long-term Show Rates," *Pediatric Quality & Safety* 5, no. 6 (Nov-Dec 2020).

How to Build a Measurement System to Improve Equitable Care

Ron Wyatt, MD, MHA, grounded his presentation to CIN partners and colleagues with this working definition: "'Health inequity' denotes differences in health outcomes that are systematic, avoidable, and unjust." Health equity improvement can be seen as using data to isolate meaningful differences among groups that are under-resourced and marginalized, and then designing interventions to address these differences.

To do this, primary care providers must build a system to look at data for differences in outcomes enabled by institutional structures and processes, and identify where social risk factors are built into the systems in order to redesign the systems.

During his presentation, Wyatt discussed a wide variety of case studies, examining disparities in outcomes for congestive heart failure, asthma management, hypertension management, diabetes management, colorectal cancer screening, breast cancer screening, pediatric immunizations, hospital readmissions, and prenatal visits. Regardless of the condition or intervention, the key principles for building and using measurement systems to improve equitable care remained consistent.

Ron Wyatt, MD, MHA
Vice President and Patient Safety Officer, MCIC Vermont

Start with the data you already have and partner with the community. Where can one achieve the most impact with the least implementation effort? Wyatt encourages clinicians and staff to start with the data they already have — such as data elements that are mandated or required. Stratify these data to indicate a population or subgroup to focus on. From there, seek out community engagement and embrace what they are saying. It requires humility for professionals to truly listen and understand what is important to a community. For example, if the buses don't run on time, no-show rates will be higher. Without engaging with the community to understand root
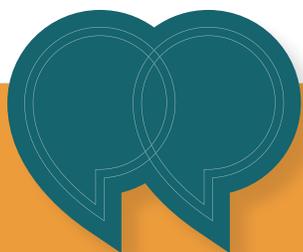
Hope is not a plan, soon is not a time, and some is not a number."

causes, interventions may completely ignore a key problem.

Collect REaL, SOGI, and telehealth data. Primary care providers must be sure to collect racial, ethnicity, and language (REaL) data; sexual orientation and gender identity (SOGI) data; and geographic data. Analyzing and stratifying these data that are increasingly required by regulatory and accreditation entities will give clues about inequity in the system. Some organizations need to consider building capacity for their data collection processes. For example, if most patients speak Spanish, the intake staff need to be propor-tionally language concordant. As telehealth use increases, providers need to build data systems around this format.

Create a data collection plan with time-bound measurable goals and owners for each stream of work. Wyatt outlined how to create a data collection plan and work toward improvement goals: be clear about who on staff is responsible for each step in the process, clearly define the measure of focus, set a numerical improvement goal and timeline, collect and analyze the data, and review the process to redefine goals as necessary. He emphasized the importance of being as specific as possible when establishing measures and

targets with the adage: "Hope is not a plan, soon is not a time, and some is not a number." Who is responsible for collecting the data, what is the process, and who is accountable for this process? Organizations must revisit these questions periodically to make sure there is no breakdown in the collection process.

Leverage the data sets required for value-based purchasing (VBP), HCAHPS, and other payment models. VBP contains domains with risk-adjusted mortality rates that, when stratified for REaL and SOGI data, for example, can spotlight inequities. In addition, the five measures in the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) questionnaire that is a focus of VBP can be used to stratify the data for areas of improvement. Too often, alternative payment models have punished people who are socially at risk, cherry-picking lower-risk patients and therefore placing less priority on disparity improvement. Wyatt advised, "Equity collaboratives are increasingly being heavily supported by payors who have explicit deliverables that are all data-driven around health care disparity and health equity as expectations for either payment or penalty."

Wyatt listed three measurable pathways for value-based care and promotion of health

'Health inequity' denotes differences in health outcomes that are systematic, avoidable, and unjust."

equity: (1) align and integrate equity in pay for performance; (2) create more robust community health interventions; and (3) redesign community impact investments to eliminate disparities.

Identify the "missing patients" who are not receiving a required health service.
Once a disparity is determined as a gap to be closed, it is helpful to frame the group of interest as "missing patients" in terms of clinical services and system-level processes. Then determine the approaches that will have the greatest impact for the least investment by asking what can be done to include those missing patients.

In closing, Wyatt recommended care providers ensure health equity by tackling the structural opportunities that they can identify. His five key steps are (1) identify a multidisciplinary team to evaluate each disparity; (2) apply a quality improvement methodology; (3) look for internal operational and system level opportunities; (4) engage with the community to co-produce solutions ("what matters"); and (5) learn as you go and have fun!

Related Resources:

"Summary of the Health Equity Measurement Approaches Identified by the Literature Review," "Revised Criteria for Evaluating Health Equity Measurement Approaches," and more, in Developing Health Equity Measures (RAND Health Care for ASPE Office of Health Policy, May 2021).

Achieving Health Equity: A Guide for Health Care Organizations by R. Wyatt et al, (Cambridge: Institute for Healthcare Improvement, 2016).

Narrowing Disparities in Behavioral Health through Racial and Cultural Concordance

Ritchie Rubio, PhD, of San Francisco's Department of Public Health's Children, Youth and Family Mental Health Services provided insights on nurturing equity in behavioral health care for an urban, multicultural, and widely diverse population.

To reduce disparities in behavioral health, providers must align their methods and staffing to be more racially, ethnically, and culturally concordant and responsive. Rubio recommended anchoring quality improvement initiatives within an organization's values and existing practices. He presented five central "pillars": ensuring racial equity, applying trauma-informed care, incorporating collaborative (as opposed to hierarchical) therapeutic assessment, cultural humility and responsiveness, development of competencies around QI approaches (LEAN and Six Sigma, data analytics, etc.), and implementing robust evaluation efforts. Below are key takeaways from his presentation; see the complete recording for details and the question-and-answer section.

Adapt Western-based tools for greater relevance and value with other cultural groups. Many existing frameworks and approaches that determine the effectiveness

Ritchie J. Rubio, PhD
Director of Practice Improvement and Analytics, Children, Youth and Family Mental Health Services San Francisco Department of Public Health

of health care services may not culturally translate or resonate with people of non-White, non-Western backgrounds. To address this, Rubio's team expanded and adapted the models they use. For example, they adapted the LEAN method of process mapping to arrive at a clinical intervention incorporating the indigenous concept of a journey stick, which is an aboriginal collection of mementos picked up to record the journey. Once people shifted to talking about the data in storytelling terms, not only did they learn more, but also they could convey meaning that achieved greater engagement with staff and clients.

Narrowing Disparities in Behavioral Health through Racial and Cultural Concordance

> "…cultural matching is most important when mental health services are first initiated by a client. One reason for this is that having a provider who reflects more closely that client's identity may help reduce the stigma associated with seeking help.
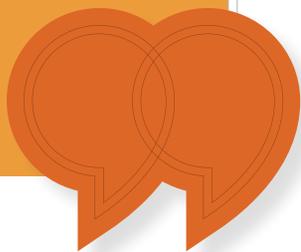
Carefully stratify client and workforce data to ensure clients can be racially and culturally matched with clinicians. To advance equitable outcomes for all people, a health workforce that mirrors the client population is needed. To ensure racial and cultural matching between providers and clients, Rubio's team's first look at their data indicated that they had appropriate numbers of staff who aligned with their client population for all but Latin/a/o/x/e people. Upon stratifying their data further, however, they found that they were understaffed in other areas, lacking, for example, adequate numbers of Chinese providers within the broad Asian category. They also came to understand with their own client assessments that, in alignment with literature review using aggregated data, cultural matching is most important when mental health services are first initiated by a client. One reason for this is that having a provider who reflects more closely that client's identity may help reduce the stigma associated with seeking help. On the other hand, while literature suggests that cultural matching does not significantly impact client outcomes, Rubio's evaluation suggests a positive influence of cultural matching for certain race/ethnic groups

on some behavioral health presentations such as cultural stress, trauma, and risk behaviors. Armed with this information, Rubio's team has begun implementing plans to improve cultural matching and strengthen the cultural responsiveness of providers.

Build competency in trauma-informed care specific to the experience of racial discrimination. Rubio's department has long incorporated an understanding of trauma in client intake, assessment, and treatment, with the goal of achieving and maintaining clients' sense of stability and safety through implementation of Trauma-Informed Systems (TIS). They have discovered, however, that many clinicians hold limited competence with the trauma from racism experienced by people of color. Rubio shared ways that his team is adapting cognitive behavioral therapy to be more culturally relevant and holding trainings about how to talk about race and cultural differences with clients. A trauma-informed perspective can contextualize external problematic behaviors as symptoms of feelings underneath the surface, such as reactions to abuse and neglect. Because staff were already familiar with this framework, expanding it to include to the effects of discrimination and racism was not difficult.

Narrowing Disparities in Behavioral Health through Racial and Cultural Concordance

Apply a health equity lens to common models of quality improvement. As quality improvement efforts home the finer issues of disparities, tools are needed to filter for more granular impacts. For example, Rubio described this equity-adapted model for improvement on the classic Plan-Do-Study-Act (PDSA) cycle with some small changes that can have large, positive consequences:

■ "What are we trying to accomplish?" Also consider: "In which populations? Experiencing what barriers?"

■ "How will we know that a change is an improvement?" Also consider: "For whom? Under what circumstances? Who might we miss?"

■ "What change can we make that will result in improvement?" Also consider: "Are there unintended consequences? Do all receive the benefits of the change equitably? Will the changes worsen inequities?"

Get buy-in and resources to support racial health equity work. Rubio encouraged the audience to build momentum and ensure buy-in by clearly aligning equity efforts with leadership's overall strategic plan and priorities. To make progress on racial health equity work, staff need to secure ongoing support and resources by demonstrating the value of these efforts and building trust among the people involved.

These are just some of the ways that an organization providing behavioral health services to children, youth, and families in a culturally diverse urban setting is advancing health equity in its community.

Related Resources:

For tools on behavioral health services diversity, trauma, and telehealth, check out the San Francisco Health Network's Tools to Improve Practice (TIPs) website for working with children, youth, and families.

See the CIN website for the recordings of all presentations and the resources page.

CIN is a project of the California Health Care Foundation and is managed by Healthforce Center at UCSF.

Join Us

Sign up here.

Join CIN to get the latest quality improvement resources, events, tips, and tools delivered straight to your inbox.

Have you tested out any of the quality improvement recommendations or tools included in this issue? Tell us how it went. We are here to answer your questions or connect you to additional resources. Email us at CIN@ucsf.edu.

Contact Us

HEALTHFORCE CENTER AT UCSF:

490 Illinois Street, Floor 11, San Francisco CA 94143

(415) 476-8181 ◼ CIN@ucsf.edu