

Building the Business Case for Health Equity Investment: Strategies to Secure Sustainable Support



Established in 2014, the [Health Care Transformation Task Force](#) brings together patients, payers, providers, and purchaser representatives to act as a private sector driver, coordinator, and facilitator of delivery system transformation. In addition to serving as a resource and shared learnings convener for members, the Task Force is also a leading public voice on value-based payment and care delivery transformation.

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Introduction

There is a very long-overdue focus in the current environment on the need to provide more equitable health care that promotes better population health for all, particularly in historically underserved communities. It is unconscionable that the United States health care system has functioned for so long in a manner that creates, and arguably deepens – either purposefully or through neglect – disparities and inequities that result in enormous gaps in health outcomes across populations. These gaps are not just critical to address from a social justice perspective; a recent study estimated that disparities in care cost the system approximately \$93 billion in excess medical costs, and \$42 billion in lost productivity per year.¹ The time has come to address this problem in a meaningful way.

The Health Care Transformation Task Force (Task Force) strongly believes everyone should have a fair and just opportunity to attain their highest level of health. The Task Force also believes that health care organizations and professionals can do better in addressing health disparities and inequities to contribute to healthier populations and communities.

Regardless of any societal or moral imperative to act to improve health equity, the reality is that most health care organizations operate in a business environment where care delivery initiatives must align with their business objectives in a financially and operationally sustainable way. In other words, subscribing to the notion that all people should be treated equitably is one thing; devoting new resources or re-distributed existing resources to ensure that equity goals are achieved is another. To do so, health equity leaders must engage with their Chief Financial Officers when designing scalable and sustainable interventions. While business considerations in health care do not always come down to the financial bottom line, that impact cannot be ignored. For health equity pursuits there are a number of key questions: (1) what are the business reasons for doing so? (2) what can the organization expect regarding defining and, operationalizing those investments and commitments, and (3) how does an institution sustain and scale the health equity initiatives emanating from those investments and commitments?

With the understanding that addressing health equity in a meaningful way will take significant resources, the goal of *Building the Business Case for Health Equity Investment: Strategies to Secure Sustainable Support* (the “Business Case”) is to offer practical examples and practices that support a business case for health care organizations and professionals to pursue health equity initiatives that benefit individuals and communities they serve. It makes the case for rethinking the traditional return on investment paradigm and instead considering the long term and systemic value that health equity initiatives bring forth for society. It advances the concept of promoting health and well-being for all individuals through trusted relationships not only across the spectrum of care delivery, but also with local community organizations and workers that support those in need. In the end, the challenge of pursuing health equity is one that should be embraced by the health care sector through their own initiatives as well as in partnership with like-minded, community-based organizations and workers who will benefit from collaborating with health care leaders to advance common goals and outcomes.

Background

While the following statement from the Health Affairs article titled "[Solving Disparities Through Payment and Delivery System Reform: A Program to Achieve Health Equity](#)" is now five years old, the sentiment still holds true today:

“ Too often, reducing health disparities has not been a priority for front-line health care organizations. As payments are cut and profit margins shrink, health care organizations increasingly concentrate on their perceived core business. As a result, efforts less immediately related to their bottom line, such as work to reduce disparities, become less salient to them. Many organizations lack the time and resources to address disparities seriously. ”

Health care in the United States has achieved many successes; over the past several decades the country has seen reductions in deaths from cancer² and from Chronic Obstructive Pulmonary Disease (COPD).³ Public health campaigns have reduced the rate of smoking significantly.⁴ And advancements in technology have turned HIV from a death sentence to a very manageable chronic condition.⁵ These are just a few recent achievements, and as positive as they are, the fact remains that millions of Americans suffer and die unnecessarily due to health inequities in our system. The disproportionate effects of COVID-19 on Black, Indigenous, and People of Color (BIPOC) and low-income communities is just the most recent example of the consequences of generations of inequality.

There are reams of literature on the extent to which systemic inequities create enormous gaps in health and health outcomes. These gaps are directly related to conscious and unconscious biases that impact care based on individuals' race, ethnicity, primary language, sexual orientation or gender identity, education, socio-economic status, and other variables that fuel discriminatory behavior. They are also inextricably connected to the broader structural issues that impact where people live, work, and recreate. A small reflection of this data includes:

- Black people continue to have the highest risk of cancer death (169 per 100,000 people). This increased mortality risk partly reflects a later stage of disease at diagnosis, as well as a lower stage-specific survival rate for most cancer types.⁶
- While genetic and hereditary factors play a role, evidence shows that racial disparities in cancer incidence and mortality rates are driven by a combination of structural, economic, and socio-environmental inequities that are rooted in racism and discrimination.^{7,8}
- Maternal mortality rates have increased steadily year over year, with the leading contributing factors being variation in quality of care, existence of chronic conditions, structural racism, and implicit bias. Mortality rates for these leading causes are five times higher for Black women than for white women.⁹
- Total cumulative data show Black, Hispanic, American Indian or Alaska Native (AIAN), and Native Hawaiian or Other Pacific Islander (NHOP) people have experienced higher rates of COVID-19 cases and deaths compared to white people when data are adjusted to account for differences in age by race and ethnicity.¹⁰
- Women with disabilities and People of Color (POC) with disabilities are less often believed about their pain than their counterparts who are white and male presenting, leading to not getting treatment as quickly when they do seek care and/or opting not to seek care.¹¹

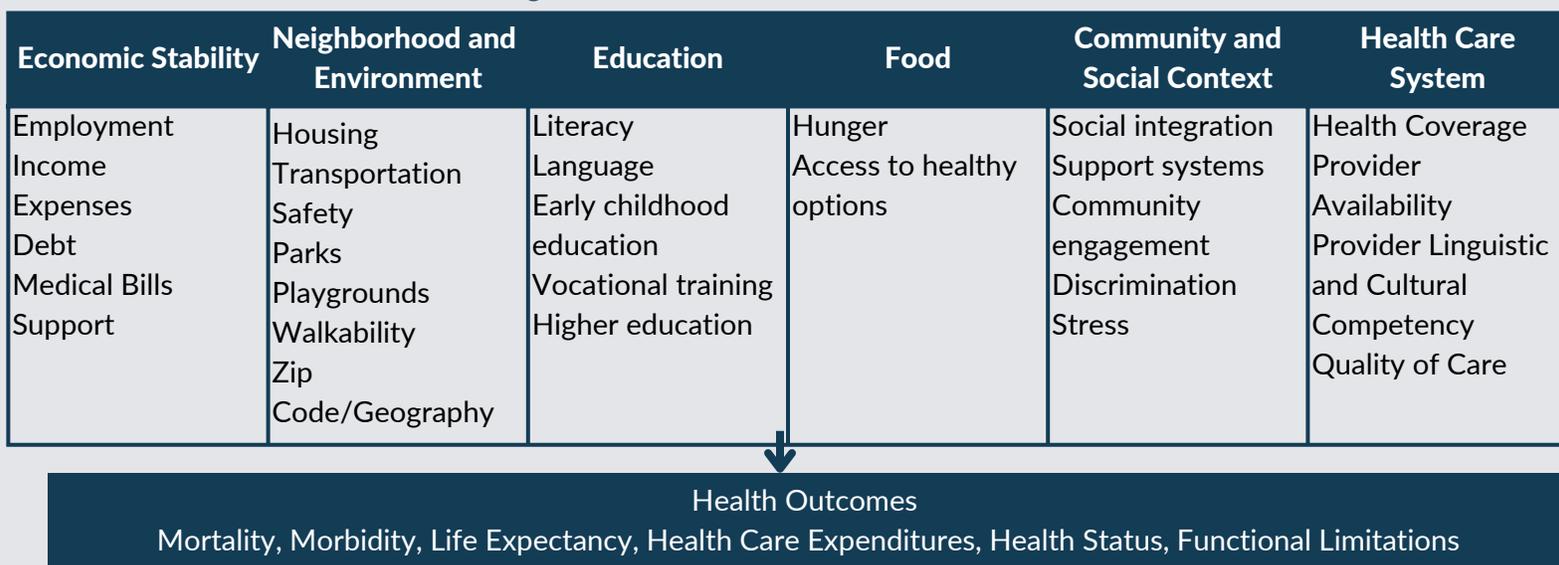
- The LGBTQ community exhibits higher rates of mental health problems, substance use, self-harm, and suicide; these rates are further impacted by the intersections of race and ethnicity geographic region, and socioeconomic factors. LGBTQ people describe discriminatory experiences by health professionals, as well as distrust and fear in the clinical setting.¹²

These issues have not gone unnoticed. Many efforts are underway that focus on improving the health care delivery system, with important new initiatives aimed specifically at achieving health equity. While advocates have long argued for advancing health equity as a moral imperative, this work is increasingly becoming a business imperative for the healthcare ecosystem. Even for those who may not feel a moral pressure to address disparities in access and care delivery and improve outcomes and health for all, the country’s changing demographics alone should be a major motivating factor.

Definitions

- **Health Equity:** Everyone having a fair and just opportunity to be as healthy as possible which requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.¹³
- **Health Inequity:** Unjust and avoidable differences in the distribution or allocation of resources between marginalized and dominant groups that lead to disparities.¹⁴ These can be inequities stemming from external factors such as SDOH or from inequities due to bias and structural issues in health care.
- **Disparities:** Differences in health status and mortality rates across population groups, which can sometimes be expected, such as cancer rates in the elderly versus children.¹⁵ Disparities are distinct from health inequities.
- **Social Drivers of Health (SDOH):** SDOH (sometimes referred to as Social Determinants of Health) are the non-medical factors that influence health outcomes; the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life, including economic policies and systems, development agendas, social norms, social policies, and political systems.¹⁶ More information can be found in Figure 1 below.
- **Intersectionality:** The way in which systems of inequality based on gender, race, ethnicity, sexual orientation, gender identity, disability, class and other forms of discrimination intersect to create unique dynamics and effects.¹⁷

Figure 1: The Social Drivers of Health



*Adapted from Kaiser Family Foundation's graphic

In 2021, the U.S. was more racially and ethnically diverse than it was in 2010. Between 2010 and 2021, the share of the population that identified as Hispanic/Latino increased 2.5 percentage points to 18.9 percent. The white (non-Hispanic) population had the largest decrease, dropping 4.5 percentage points to 59.3 percent.¹⁸ The system must transform to be responsive to the needs of future marketplace populations. And health inequities create financial costs for the system; both the \$93 billion in waste as noted in the introduction, as well as the costs that come from not achieving accreditation status from

bodies such as the Joint Commission and the National Coalition for Quality Assurance (NCQA), both of which are making health equity a central focus of their accreditation standards.

As more research is done on SDOH and health equity, it is clear that health outcomes are not only a result of the clinical care received (or not received). One study found that clinical care only accounts for 10-20 percent of improved health care outcomes, whereas 80-90 percent are decided by SDOH.¹⁹

So why does the health care sector have a responsibility to step forward and address the external factors a patient faces, as well as the bias that occurs within the clinic or institutional environments? Health care is one of the only institutions in a community that every single person will likely interact with at some point in their life. As a common point of community engagement, health care organizations and medical professionals are well positioned to respond to what a patient needs based on their life outside the four clinical walls – also referred to as “whole person care” – and to connect patients with needed community-based resources to help improve well-being under those circumstances. The impact of a lifetime of not accessing necessary health care due to social factors (such as lack of access to primary and preventive health care, residing in a food desert, and housing insecurity) can lead to detrimental health outcomes. In addition, there is evidence that individuals with chronic disease spend more time and resources managing their conditions than their healthcare teams, and their environment has an enormous impact on how that management occurs.²⁰

Regarding clinical care, both care delivery and existing algorithms created to determine adequate levels of care are proving to exacerbate inequalities. A 2019 study identified racial bias in an unnamed algorithm used to determine high-risk patients in need of extra health care services.²¹ The algorithm relied on past health care costs to determine those individuals most at risk. As Black individuals historically have lower health care costs due to systemic issues (lower income, lack of access to care, etc.), the algorithm poorly captured Black individuals that needed care. For example, among patients classified as very high-risk, Black individuals had 26.3 percent more chronic illnesses than white individuals, despite having similar risk scores. Recent studies have also brought to light racial bias in determining anemia levels in pregnant individuals²² (which has since been adjusted by ACOG), and racial bias in algorithms determining care for patients with chronic kidney disease.²³ These are only a few among the many, and these embedded biases result in inequitable care delivered to certain populations.

A recently released Task Force blog titled [“In the Effort to Improve Health Equity, Terminology Matters”](#) delves further into the concept and definition of health equity, and the importance of individuals and organizations being precise and consistent when using related terminology. This followed up a 2019 Task Force-authored Health Affairs blog [“When Talking About Social Determinants, Precision Matters.”](#)

Addressing health equity is not just within the purview of health systems and medical professionals. Payers have multiple opportunities and levers that they can use to achieve equitable outcomes. A recent Health Care Payment Learning and Action Network (LAN) resource notes that payers are positioned to push for redesign of care delivery; offer payment incentives for health equity; and measure performance related to inequities and disparities. Within each of these categories are numerous specific actions that payers can take.²⁴

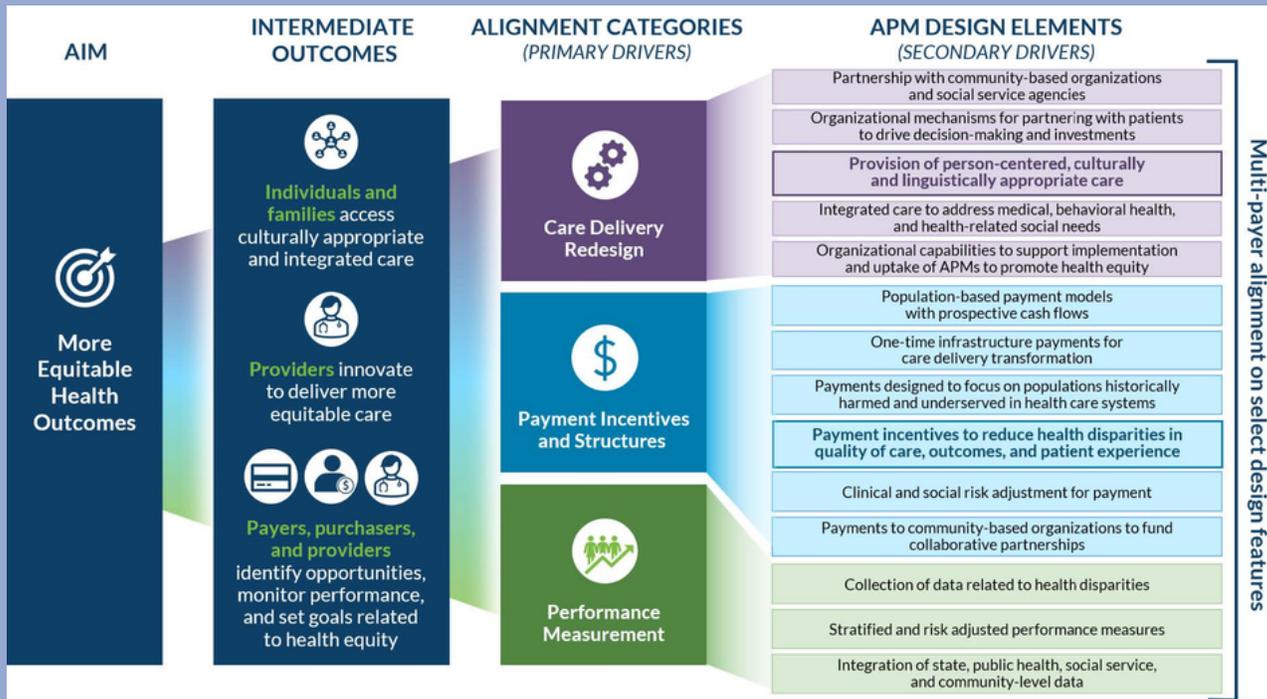


Figure 2: LAN Theory of Change Model for Payers Addressing Health Equity

Learning how to address and fix both external factors and clinical inequities is more important than ever as America shifts towards becoming a 'majority-minority' country. By 2045, it is predicted that over half of America's population will be made up of individuals from racial and ethnic minority communities.²⁵ If a health care organization seeks to maintain consistent or grow market share, it is imperative that a system learns how to best serve this emerging population. This includes not only addressing trends in race and ethnicity demographics, but also the role that intersectionality plays in compounding inequality. Taking an intersectional approach to health care is reflected in a system that creates specific and inclusive studies to find medical solutions; creates processes that apply to everyone – regardless of gender, race, nationality, disability status, sexual orientation, or gender identity – and appreciates and respects the unique and lived experiences of individuals.²⁶

Raising the Bar on Health Care

Over the past few years, the Task Force contributed to developing The Robert Wood Johnson Foundation's Raising the Bar framework. The Raising the Bar (RtB) project is supported by The Robert Wood Johnson Foundation and led by National Alliance to Impact the Social Determinants of Health and the National Partnership for Women & Families. Collaborating with health care leaders and other stakeholders, the RtB Core Team developed a holistic framework for advancing health equity and improving care quality. The published materials outline the roles and actions health care can take to successfully execute the principles and framework.

The Raising the Bar framework defines four Transforming Roles that health care organizations can play and offers 14 specific Transforming Actions for payers, providers, partners, and advocates to take. The roles and actions provide a guide for ways health care organizations and stakeholders can impact health equity, and can serve as a starting point for this work.

The Business Case: Piecing Together the Puzzle

The Task Force’s Business Case resource is organized into three sections:



1.

Making the Case for Investment:

- What rationale and/or messages resonate with C-Suite leadership and governing bodies who are integral to approving the operational commitment and investments in long-term efforts? What internal culture change investments are necessary to make health equity efforts succeed?

2.

Operationalizing the Investment:

- **Fostering a Culture of Partnership:** What strategies can organizations employ to establish a culture that prioritizes building trust with patients and family/caregivers, and fostering partnerships both within an institution and with the community? How can organizations ensure patients are respected, included, and valued? How can external partnerships be leveraged to help organizations tackle health equity?
- **Building Data Capabilities:** What are the operational challenges to collecting patient-level data? How can data best be collected, used, reported, and shared? How can the culture of partnership support this effort? How do data collection requirements for Joint Commission, NCQA, and other accrediting bodies affect the need for data exchange capabilities?
- **Creating the Infrastructure:** What are the operational steps necessary to design and implement programs and models that address health equity gaps both within the health system and in the broader community? What structures – staffing, training, engagement with the community, data infrastructure etc. – are necessary to make these efforts succeed?

3.

Long-Term Success and Sustainability:

- How can support – both via a dedicated team, and consistent funding - be established in a sustainable way, given the long-time horizon that health equity efforts require to create noticeable improvements? What role does progress measurement play in sustainability, and what are tools for assessing progress?

The Role of Key Stakeholders in Addressing Health Equity

Health equity must be addressed through the individual actions of stakeholders, as well as collaboration across the entire range of health care stakeholders. The Business Case identifies three key groups of stakeholders and the roles – as well as interaction between stakeholder groups - they play in addressing health equity. Below is a brief overview of each group and their roles:

- **Decision Makers** (C-suite individuals, governance boards): This group sets the direction for addressing health equity including making the necessary investments in policies and programs that mitigate structural discrimination and address SDOH; providing support to the implementers to achieve these policies and programs; and promoting culture change from the top down in an organization. All of this cannot be done without listening to the voices on the ground such as patients, caregivers, and community organizations.
- **Implementers** (providers, payers, community organizations/health workers): This group serves to implement the guidance from the decision-makers. This includes building trust with the patients and communities served; achieving a culture shift in the organization to center patients and caregivers; and amplifying voices on the ground.
- **External Drivers** (purchasers and employers): This group can advocate for health equity through negotiating the structure of health benefits and health plans for employees.

Setting up accountability measures and goals is imperative to this work being implemented and executed upon. Accountability can be assigned to any of the above stakeholder groups.



1. Making the Case for Investment

Leadership support is a critical step in establishing the operational commitment and funding for health equity. For mission-driven institutions, connecting the work of addressing health equity to the organization's goals and strategic vision may be very straightforward. Many health care organizations and medical groups have made enormous strides in the past several years in terms of understanding that quality health care delivery should have equity at its core. Yet, there are still organizations and medical groups for which making these connections will require more in-depth discussion, persuasion, and convincing.

Regardless of the organization and its mission, making the case for long-term operational commitment and budget support requires more than just an understanding of the problem. It requires data, design, and a plan for how these investments will be used for appropriate initiatives and interventions, and how the organization will track progress to ensure that these activities are achieving their goals.

In Task Force discussions about the challenges of securing investments to address health equity, the test of developing a strong return on investment (ROI) was repeatedly raised. Members noted that it difficult to calculate an ROI when the intervention includes elements and factors that exist outside of the health care organization's walls and control. There is no denying that health equity efforts require significant resources, and with allocation of resources there is undoubtedly a need to calculate a return on investment. The Commonwealth Fund's [Calculator for Partnerships to Address the Social Determinants of Health](#) was designed for use by health systems, payers, clinical providers, social service providers, and community-based organizations to allow for structuring and planning sustainable financial arrangements to support delivery of services to high need, high cost patients. Health Care Transformation Task Force members shared the following sentiments regarding the overall concept of ROI in the context of health equity:

- Health equity work should be core to any organization's business; it should not be viewed as a "nice to have."
- Investments in health equity should not be held to a higher ROI expectation than other investments.
- "Return on commitment" may be a more useful concept for assessing health equity actions. This is due both to the challenge of quantifying ROI for some investments, and to the recognition that these efforts often cut across departments and divisions.

Task Force members identified several strategies and supporting rationale for messaging that resonate with C-suite leadership, governing bodies, and other staff that can persuade these individuals to make investments to address health equity:

- Place health equity strategies in a long-term strategic context, noting the demographic and societal pressures that will make a lack of investment a losing battle for market share.
- Clearly tie health equity work to the mission, vision, and strategic pillars of an organization. "No organization wants to say that its mission is to provide high quality, affordable, but inequitable care."

- Identify the risks to the organization of not addressing health equity, including higher costs from untreated illnesses, losing and/or not attracting employees, and losing significant market share in the coming years.
- Frame opportunities to incorporate health equity investments into existing projects that already have a budget and related business case.
- Be up front and realistic about the short- and long-term impact and savings that are likely to result. Savings from many health equity initiatives may not materialize for a long period of time, so clear expectations from the beginning are important.
- Include voices and stories from the ground in conversations with C-suite leaders. Examples include community health workers, patients, and others who have experienced inequities in care firsthand and can share the detrimental consequences.

When it comes to delivering these messages, Task Force members believe it is critical to: (1) identify all departments and individuals who may be involved in the financing decision-making process, (2) understand their concerns and aspects of any given financing strategy to which they are accountable, and (3) include them in the entire process. While the players will differ based on the individual organization or medical practice, Task Force members and literature describe the importance of including not only the C-Suite, but also where appropriate the governing body, and key stakeholders such as community health and benefits director, executive director of the area in which the program or initiative will reside, and other local organization leaders (both clinical and community-based). Governance support will be important to establishing an effective culture of partnership.

A report by the American Hospital Association, “[Investing in Community Health: A Toolkit for Hospitals](#)” provides a number of key questions for leadership to consider when determining funding and the extent to which it will commit resources to the effort:

| | |
|---|--|
| <p>Community Priority and Need</p> | <ul style="list-style-type: none"> • Is the work a priority in the community as demonstrated in the community health needs assessment? • Has the community identified a need? • Is the idea adding stability to the neighborhood or community? Does it advance equity? • Are there community organizations that are potential partners already in place? |
| <p>Financial Review</p> | <ul style="list-style-type: none"> • What financial resources are available? • Has financial risk been mitigated? • Does the approach expose the organization to the least possible risk? |
| <p>Organizational Alignment</p> | <ul style="list-style-type: none"> • Does the work align with strategic organizational goals around health equity, community health and/or population health? • Does it align with the system’s local market goals and priorities as demonstrated through the CHNA? • Is it good for patients and/or health plan members? (if applicable) • Does the work advance racial equity goals? |

Source: [American Hospital Association Community Investment for Health Report](#)

Beyond these framing questions, Health Leads has created a business case process through its Collaborative to Advance Social Health Integration (CASHI). Their report What We're Learning About Delivering Whole-Person Care shares a "Business Case Technical Assistance Approach" for how to analyze current costs, funding, and benefits to inform and justify future funding asks. This approach²⁷ includes:

A Value Proposition

- Developing a thesis for the value the intervention will demonstrate and to whom.

The Total Cost

- Analysis of funds required, including what drives costs and potential efficiencies to be gained.

Funding and Revenue Sources

- Identify how the institution will cover these costs.¹

Measurement and Data Collection

- How will the institution demonstrate value?

The Centers for Medicare and Medicaid Services (CMS) developed a resource making the case for sustaining investment in interventions focused on addressing health equity and social risk factors. This resource highlighted the experience of Reading Hospital, a participant in the Center for Medicaid and Medicare Innovation (CMMI) Accountable Health Communities (AHC) model. Under AHC, Reading Hospital created the Community Connections Program (CCP) through which it conducts screening, referral, and community service navigation for Medicare and Medicaid patients. When it sought to extend the CCP beyond the five-year period of AHC funding, it prepared a case study that assessed the CCP's Return-on-Investment. The case study reported that hospital staff worked closely with internal business intelligence analysts to determine how the CCP significantly reduced avoidable Emergency Department (ED) visits among patients with chronic conditions. Next, working with the hospital's finance department, the team quantified the cost savings that resulted from the ED reductions, and estimated \$1 million in savings over one year.²⁸

¹Sources of funding and revenue may include grants, incentive payments in value-based contracts, and an institution's own long-term operating funds.

The Importance of Transforming Culture to Transform Care

It is important to not only bring C-suite level leaders on board, but to shift the entire organizational culture to one that prioritizes and addresses health equity, and continuously defines and refines health care's role in achieving health equity. This requires an ongoing effort – which can use many of the same messages listed above – to reframe care in a way that places the patient and their care team at the center. Culture change does not stand alone in making the case for investment; but, it is an important component that should continuously be addressed.

Culture change does not only apply to the patient facing side of care, it also applies to internal staffing structures. For example, depending on the underpaid labor of environmental services and other hourly staff, many of whom which may face social risk factors, creates internal inequities that are anathema to any organization's attempts to address these challenges. Leadership must analyze the organization's own staffing structures to determine any inequities faced, and develop a culture change strategy.

Reading Hospital had a period of data from which to draw, given that the CCP was funded via the AHC model. However, the “script” that Reading Hospital used in its discussions with C-suite leaders and other decision-makers to extend the program with internal funding is generalizable to scenarios in which a model does not necessarily have community-specific data on which to draw:

Hospital Leader Question

How does Health-Related Social Needs (HRSN) screening, referral, and navigation impact the hospital's finances?

How does screening, referral, and navigation benefit clinical staff?

What is the risk of discontinuing screening, referral, and navigation activities?

Intervention Leader Response

The internal assessment we conducted estimated the program saved the hospital \$1 million in one year by reducing avoidable ED visits.

Because nurses and other clinical staff may not be trained or have the time to address HRSNs, CCP screeners and navigators provide special expertise and knowledge of community resources to support these care teams.

Payers that provide value-based payments increasingly make eligibility for these arrangements contingent on the provider's ability to understand and address social drivers of health. Without the expertise of the CCP team, the hospital may not be eligible or prepared to enter into such agreements in the future.



2. Operationalizing the Investment

Fostering a Culture of Partnership

A first step towards operationalizing an investment in health equity is establishing a culture of trust between the health care organization and the patient and their caregivers/family, as well as between the organization and external entities (such as community-based organizations, public health associations, and more) to provide needed social services to patients. It should also be noted that organizational investments can go exponentially further in addressing gaps when they support existing community infrastructure that already has buy-in among stakeholders.

Building Trust with Patients and their Family/Caregivers

Building trust is neither easy nor a quick process. It requires a culture shift and training of staff at all stages of the care delivery process in cultural competency and concordance, humility and active listening, responsiveness, and affirmation of patients' needs and preferences. It also requires establishing connections and sharing decision making in terms of design and implementation with those who are already connected with the community, such as community health workers (CHWs), patient navigators, and leaders of community-based organizations (CBOs).

The issue of trust can be viewed from two perspectives: patients' lack of trust in the system, and the overall perception that the system itself is untrustworthy. Both create several challenges. First, it makes it difficult to significantly improve the rate of person-level data collection. This applies to both demographic data (e.g., race, ethnicity, language, sexual orientation, gender identity, and other demographic factors) and data on social drivers of health. There is also consensus that a major speed bump in improving rates of person-level data collection is patients' lack of understanding – and trust of providers and payers – in terms of understanding why they want these data and for what purpose it is going to be used. We dive into this issue in more detail on page 14 (Building Enhanced Data Capabilities).

Further, there is erosion in the ability to deliver care in a way that respects intersectionality. The provision of culturally competent care that understands and respects all aspects of an individual's identity is imperative in delivery equitable care. A case study by the National LGBTQIA+ Health Education Centered "[Affirmative Services for Transgender and Gender Diverse People – Best Practices for Frontline Health Care Staff](#)" offers promising practices and guidance for frontline health care staff on how best to serve transgender and gender diverse patients. This is but one example of how providers and health care organizations can and should be more culturally competent and aware of a patient's different identities. Cultural humility – self-reflection and self-critique whereby the individual not only learns about another's culture but starts with an examination of their own beliefs and cultural identities²⁹ – is equally as important when providing care. Respect is imperative at all stages of care from when a patient is checked in by a receptionist to being seen by a clinician during the visit.

Intersectionality is the way in which systems of inequality based on gender, race, ethnicity, sexual orientation, gender identity, disability, class and other forms of discrimination intersect to create unique dynamics and effects.

Engaging patients in the process of identifying ways to improve patient experience and offer first-hand feedback to leadership is another critical strategy for building trust. This engagement, through Patient or Patient-Family Advisory Councils (PFAC) in providers settings, and Enrollee Advisory Councils (EAC) within payer organizations, creates an opportunity for individuals to serve in a governance capacity, allowing consumers, patients, and families to jointly set priorities with organization staff. Organizations should view PFACs, EACs, and similar bodies as key opportunities to improve and build trust between institutions and patients and their family and/or caregivers.

In addition to prioritizing cultural competency and respect among health care organization staff, another key strategy is developing a network of CHWs and patient navigators (who live within the community) who can bridge the divide between the health system and patients. Community members serving in these roles can bring a level of immediate trust to the relationship that can be hard for a doctor or nurse to develop with the patient. This unique relationship can be leveraged to better connect with the patient about what they hope to achieve in terms of outcomes and ability to resume their lives. The following section discusses the importance of engaging with the community in its entirety, not just by bringing individuals into the health care organization but by building networks with the community, to better address health equity.

Developing and Supporting External Partnerships

The health care system has a responsibility to address inequities in care delivered and to address social risk factors and SDOH, yet that responsibility does not rest within the health care ecosystem alone. Task Force members shared examples of how health systems and organizations are partnering with CBOs to serve consumers and patients in accessing needed social services. Investing in establishing these partnerships and supporting existing organizations can often be a more efficient strategy than a health system or organization attempting to provide non-clinical services.

The Raising the Bar project notes health care's role as a partner with the community in addressing health equity. This role is operationalized by three actions organizations can take:

1. Meaningfully involving individuals from the community in governance and decision making.
2. Building trusting relationships with individuals and organizations in the community.
3. Respecting and building on the expertise and power of individuals and organizations in the community.

A more detailed analysis of the actions and their supporting operational steps can be found [here](#).

A valuable strategy that health care organizations should be aware of in terms of establishing effective and efficient connections with community-based organizations is the concept of the CBO network. A prime example of this work is being led by the Partnership to Align Social Care, which convenes work groups comprised of leaders from community-based organizations, payers, health systems, national associations, and federal agencies. These work groups develop efficient and sustainable CBO networks that use aligned core competencies, billing codes, contracting processes, information technology standards, best practices for sustainable financing strategies, and overall, execute against a common vision for achieving and sustaining an "ideal state" or health and social care alignment.

The Importance of the Patient Voice

Individuals and communities bring their unique lived experience to the delivery and payment reform process and can and should be called upon when developing programs and policies to serve consumers and patients. Promising practices in individual and community engagement are highlighted in the following resources:

- Health Leads [Collaborative to Advance Social Integration](#) describes how Northwell Health, located in New York, funded more staff and training at their community-based organization (CBO) partners to enable these CBOs to provide more support closer to patients' homes.
- The Task Force's "[Stories from the Field: Implementing Principles of Person-Centered Care](#)" includes examples from Trinity Health and Sun River Health, two organizations that developed strong connections with their communities.

Another example of a model that seeks to coordinate efforts among CBOs is the Agency for Health Research and Quality (AHRQ) "[Pathways to Community HUB Model](#)," a community care coordination strategy that allows public and private stakeholders to work in coordination to identify high-risk individuals, document health, social, and behavioral health factors, and address these risks.

One of the most important points to keep in mind is that community organizations and individuals bring their own lived experiences and expertise to the table. Sometimes the best way for health care organizations to aid them in their mission is to step back and help sustainably fund the community organization, instead of trying to take direct action in an area with which they may be unfamiliar or ill-equipped to address.

Building Enhanced Data Capabilities

The actions and efforts described in this resource would be extremely challenging to pursue without person-level data. However, amassing this data is not easy for many reasons, including:

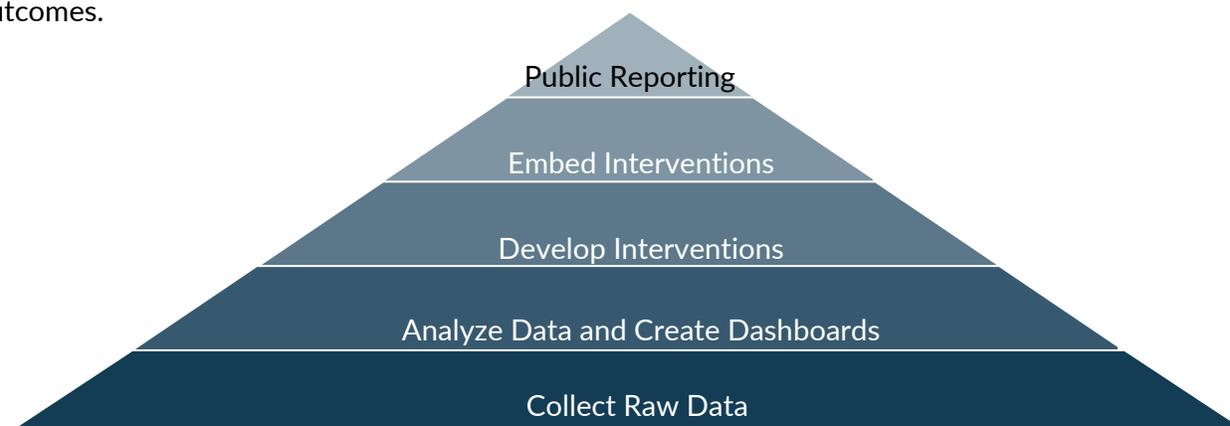
- Lack of standardized tools for data collection, analysis, and reporting.
- Gaps in education and training – for both patients and for those requesting the data – on: 1) how social drivers and demographic factors affect health; and 2) uses of the data to improve patient-level and population-level health.
- Challenges of measuring impact over time and accounting for unintended consequences.
- Patients are not required to provide data on race, ethnicity, sexual orientation and gender identity, or language, which has contributed to a low volume of person-level data. While 77 percent of Medicaid recipients identify their race and ethnicity, the percentage of individuals reporting in the commercial sector and Medicare is much lower.

These challenges are exponentially more difficult for small, rural, and safety net providers, as well as for CBOs and social service organizations.

The strategies and messaging related to financing and investing in health equity can be applied specifically to the investments needed to address the gaps in data collection. This section therefore focuses on operational issues for consideration by all key stakeholders. Task Force members offered the following ideas for action in this area:

- Develop and test a script that meaningfully facilitates patients' ability to self-report data. The script should include answers to why the data is being requested and how it will be used and protected. Secure protection of data includes both how data are protected from a security standpoint, as well as with whom it will and will not be shared.
- Once a script is tested and validated, ensure its use in a standardized way by all members of a care team, including Community Health Workers, social workers, nurses, and others who interact with the patient.
- Standardize digital infrastructure to collect the data.
- Implement equity incentives (similar to quality incentives) in value-based contracts to create accountability for data collection.
- Analyze data to fix existing policies and programs, as well as to create and implement new health equity initiatives.
- Develop motivational interviewing techniques that engage patients and inform them of the positive spillover effects of health equity interventions, concurrent with messages on the importance of having a broad lens and not focusing solely on the patient/member population.

The Health Evolution Forum's [Health Equity Roadmap for Health Care CEOs, Part 1: Patient Outcomes and Experience](#) offers a health equity framework pyramid that provides a visual representation of the fundamental importance of data collection to addressing health equity. Data is the key to identifying and understanding the root causes of inequities and disparities in processes and outcomes.



Source: [Health Evolution Framework Report](#)

The Health Evolution Forum notes, and the Task Force agrees, that “a demonstrated commitment to data collection reflects the organization’s commitment to equity.”

Supporting the Conversation Between Payers, Providers, and Patients in Collecting Person-Level Data

- [Mount Sinai/Press Ganey Webinar](#): A webinar detailing Mount Sinai’s training for staff on how to gather meaningful patient data
- [Do Ask, Do Tell](#): A Toolkit for collecting data on sexual orientation and gender identity in clinical settings
- [Ready, Set, Go! Guidelines and Tips for Collecting Patient Data on Sexual Orientation and Gender Identity](#)

This list is not inclusive of the tools in the field, or all the data that should be collected. As mentioned previously, it is important to collect a range of demographic data including socioeconomic status, veteran status, disability, age, and more, in addition to Race, Ethnicity, and SOGI data.

Creating the Infrastructure

Many organizations have already developed at least a core team of staff to lead health equity efforts, typically to organize around a process for making the case for financing. However, securing financing is the first step in a long process that also includes design, implementation, assessment, and revision of health equity initiatives and interventions. Having the necessary infrastructure on board to achieve each of these steps is critical. Much of the dedicated financing will go toward building and sustaining this infrastructure – whether it be the human capital or technology resources necessary to design and run the effort. Investing in the resources necessary to design and run the effort can happen concurrently with building the data infrastructure needed to adequately track health equity programs and policies.

Staffing: It is critically important to have strong leadership able to grasp the complexities of any effort’s purpose and goals, as well as to communicate the efforts using clear messages to multiple and diverse audiences. Equally vital is investing in project managers who are knowledgeable about and dedicated to a given intervention or initiative and are accountable for its progression. Several Task Force members noted that any project that is assigned to someone who already has full-time responsibilities in other areas will not move forward, at least without the necessary expediency.

“ 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. ”

Finally, and equally important, is investing in staff who either have experience and background in collaborating with community-based organizations and are skilled in community engagement, or staff who demonstrate strong relationship-building skills to be able to develop in these areas. It is important that this work does not fall only to the Diversity, Equity, and Inclusion team; administering whole-person care requires buy-in and support from all staff at all organizational levels. For organizations who may not have the resources to build a Diversity, Equity, and Inclusion team, executive leadership buy-in and commitment to lead is even more important to advance this work.

A [report](#) by the Health Evolution Forum’s Work Group on Leveraging Data to Improve Health Equity describes the following components of strong team composition:

- A team built based on the project’s needs, design, and implementation.
- Inclusion of a senior quality leader and a senior Diversity, Equity, and Inclusion (DEI) officer, with joint accountability.
- A senior leader in the quality department who is accountable for collecting data that tracks results and ongoing disparities.

Establishing an Accountability Structure: An accountability structure is the organizational framework that depicts the different players contributing to a project and/or partnership. It assigns each player specific roles and responsibilities, describes the processes that will be followed, clearly states the roles of senior management and governance, and outlines staff and supports necessary to function effectively. Accountability structures are critical to establishing clarity not only about roles and responsibilities, but also decision-making sequencing and authority. A comprehensive guide to the why and how of creating an accountability structure is available in the [Building an Accountability Structure Toolkit](#), developed by Strive Together.

Data Infrastructure: Distinct from the topic of data collection, the infrastructure issue related to data comprises the following actions:

- Having infrastructure that enables performance of root cause analysis to understand why inequities exist and determining what role an organization can play in addressing them.
- Demonstrating commitment to data collection that aligns with standards set by the Office of Management and Budget (OMB) to ensure that patients can identify themselves as accurately as possible.
- Creating a system that allows patients to have trust in the privacy standards to which their self-reported data on race, ethnicity, language, sexual orientation and gender identity, and other demographic variables will be held.

Technology: Beyond the realm of patient data collection is the web of technology infrastructure needed to support patient screening of social drivers of health; referrals of patients to community-based organizations and other non-clinical supports; and communications pathways that allow providers in both the clinical and community spheres to coordinate and collaborate on an individual's care needs. There are several existing technology platforms available today, such as [Find Help](#) (formerly known as Aunt Bertha) that connect health systems with CBOs. Even with an existing platform, however, an organization should invest considerable resources into integrating this platform into its own electronic health record (EHR) system, training staff on how to use it, and ensuring that it becomes a routine component of staff workflow.



3. Long Term Success and Sustainability

Any effort related to health equity will likely require a much longer time horizon to produce a return compared to traditional clinical or other operational efforts. Establishing one-time grants or short-term pilots rather than planning for a long-term investment, can affect any efforts success and sustainability. Thus, securing the investment is not the only obstacle; demonstrating progress and making the case for sustaining the investment can also be challenging. Another perspective is to identify and quantify (to the extent possible) the “Return on Value” or as noted earlier, “Return on Commitment,” rather than the ROI. The Return on Value/Commitment can be understood as how a strategy or program leads to improvements in population health, which in theory, reduce long-term spending.

While there is not a consensus-based ROI methodology yet, there are qualitative and quantitative indicators, as well as other accountability strategies that are being used by organizations to track progress. Value-based payment (discussed more in the last section) is also a strategy to sustain efforts related to health equity.

Outcome Indicators: As referenced above in the Reading Hospital example, quantitative indicators such as avoidable ED utilization (particularly when stratified by admitting condition), and others such as total health care utilization, infant mortality rates, can all be translated into cost drivers and cost savers.³⁰ Other sources of value that can be articulated as outcome indicators include:³¹

- Increased clinical revenue
- Decreased healthcare expenditures
- Increased operational efficiencies

Increased operational efficiencies can comprise cost savings achieved through more efficiently deployed resources, including multidimensional care teams. For example, a model that adds CHWs, social workers, and health navigators to the clinical care team, thereby allowing nurses more time for clinical care delivery, may demonstrate lower costs for the care of a patient overall, despite the cost of additional staff. Analyzing this data is not just important for sustainability and progress monitoring; analyzing the costs of different services allow institutions to make evidence-based decisions about how to deploy resources to achieve the greater impact, as well as forecast the cost of scaling interventions to other populations or geographies.³¹

Process Outputs: Less quantifiable, but of equal importance, are the goals and outcomes that indicate value being added to the community. For example, building trusted relationships between clinical institutions and community-based organizations is difficult to measure, but requires

Potential Regulatory Barriers to Implementing Health Equity Programs and Policies

Payers and providers that seek to develop programs or policies that specifically target one racial, ethnic, or other specific demographic population may face federal or state regulatory barriers related to non-discrimination clauses. Ironically, while these regulations were designed to prevent discrimination against minority populations, they could also be interpreted as not allowing for specific benefits to go to only those populations who are identified as experiencing inequities in care or outcomes. Further work is needed to develop clarity in state and federal policy on how payers can create incentives to reduce disparities.

investments in both time and money, and can pay enormous dividends. Examples of such dividends include investments in community health and well-being, and improving overall community transportation, all of which have a positive impact on regional economies. Additional outputs and their effects are detailed in *Raising the Bar Framework in Practice: Bright Spots*.

Task Force members noted that Social Impact Assessment (SIA) tools can be a valuable tool in assessing progress and understanding process outputs. SIAs can help institutions: (1) identify possible impacts – both positive and negative – on the community; (2) provide projections about future efforts which inform all involved in the project, including planners, funders, the community, and policymakers; and (3) identify opportunities to further engage communities and establish risk mitigation strategies, including strategies to ensure that the intervention does not benefit one population at the detriment of another.³²

The Role of Value-Based Payment and Contracting

Over the last several years, health systems, medical groups, and other organizations have increasingly sought to identify health inequities and implement meaningful actions to address them and improve outcomes for underserved individuals, and in the process have recognized that a major roadblock is the fee-for-service (FFS) payment model. Traditional FFS payment does not reimburse clinical care providers for any services that link patients to community-based support services, or supporting efforts to address social drivers of health. There are significant financial disincentives for providers in a fee-for-service model to commit the staff and resources required to perform these services in a meaningful way. Stakeholders across the system acknowledge that the fee-for-service model is not designed to support the kinds of services and policies that deliver both proactive, coordinated health care and provide individuals with access to non-clinical services.

Value-based payment (VBP) models offer a way to address the underlying SDOH and health inequities that result from decades of structural racism and other systems of oppression. Advanced value-based payment models incent proactive and coordinated care by supplying care delivery stakeholders with a set payment rate to care for a patient. Providers that keep the costs of care under the allotted payment receive shared savings, and those that provide care whose costs exceed the allotted payment are penalized with shared losses (usually divided between a payer such as CMS and the participating provider). The risk of shared losses incentivizes the provider to provide the highest quality patient care at an efficient cost. This results in more proactive outreach to patients from multidisciplinary care teams, better systems in place to identify high-need patients to manage their chronic conditions, and enhanced data collection and sharing across organizations.

Payers in particular hold unique levers to address health equity, as they can contract with providers using value-based payment to prioritize outcomes via equitable, coordinated, high quality care.

The LAN's Theory of Change Model for Payers Addressing Health Equity (Figure 2, page 5) describes the three primary drivers and multiple secondary drivers that payers can leverage to drive health equity, including many strategies that are described throughout this resource. It is critical for payers to act upon and amplify the importance of all three primary drivers in the change model; here we are focusing specifically on the primary driver "Payment Incentives and Structures," and the role that VBP must play in this work. Task Force members urge payers to use these levers, and for providers, policymakers, and partners to advocate for them and support their implementation. These include:

- Designing and implementing population-based payment models with prospective cash flows.
- Administering infrastructure payments for care delivery transformation.
- Payments designed to focus on populations historically harmed and underserved in health care systems.
- Payment incentives to reduce disparities in quality, outcomes, and patient experience
- Clinical and social risk adjustment for payment.
- Payments to community-based organizations to fund collaborative partnerships.

There are a number of examples of payers that are operationalizing these drivers. One example from the commercial sector is Blue Cross Blue Shield of Massachusetts' (BCBS MA) [Health Equity Partnership](#). Through this model, which started in late 2022, BCBS MA is using value-based payment contracts to reward clinicians for eliminating racial and ethnic inequities in care. Currently four of the state's largest health care systems are participating in this model, which will affect nearly 500,000 covered lives. In the public sector, many states, in their role as payer, have implemented [Medicaid ACOs](#) using Section 1115 waiver authority, 1115A innovation waivers, or state plan amendments to better coordinate care, often with a health equity focus at the forefront.³³ The National Committee for Quality Assurance (NCQA)'s [Health Equity Accreditation and Health Equity Accreditation Plus](#) programs offer additional guidance and a framework for payer actions.

At a more granular level, VBP models can be designed to specifically measure and adjust for health equity, and further, health equity VBP design elements should be included in multi-payer alignment strategies to allow for a coordinated approach across private and public sector payers. Industry leaders have offered [important strategies](#) for payers and providers to embrace health equity in the design and implementation of value-based models, including selection of equity-focused quality measures, implementing fundamental changes in payment and performance measurement to address health inequities, and empowering health care organizations to address social needs. Linking performance on measures of health equity to payment will make promoting equity not only the proper course of action, but also one that further the health care organization's business interests.

The days of designing VBP models without acknowledging and interweaving equity into the fabric of the design and implementation should be over. A value-based payment and care delivery infrastructure that incentivizes the health care system to focus on whole-person care, encourages collaboration to address the social drivers of health, and holds payers and providers accountable for quality and cost outcomes is critical to advancing the health equity policy objectives. In order to achieve this, it is critical to move toward incorporating social risk adjustment into payment

contracts.³⁴ While VBP contracts offer the flexibility that is needed to develop care delivery systems that can reduce health disparities, the field is becoming increasingly aware of the fact that providers who care for underserved populations and those with complex clinical and social needs, are often the least able to participate in VBP models. Applying a social risk adjustment methodology, in addition to traditional risk adjustment variables such as clinical risk and age, is a necessary path in this transformation journey if the field is move toward value-based care that elevates health equity as a core goal.

Conclusion

Simply stated, action speaks louder than words when it comes to health care organizations and professionals enacting programs and models to address health inequities. Without stable and sustainable commitment and investment, the difficult work of putting those words into action, and meaningfully moving the needle will not be successful. The business imperative to address health equity gains more traction every day as the data continues to clearly show gaps in care and outcomes based not on genetics but on demographics. The health care ecosystem must commit to building the infrastructure and operational supports needed to successfully serve all populations, and work to ensure that all individuals are not only equally able to access necessary and appropriate care at the right time and in the right setting, but that the delivery at point-of-care is as free from bias – conscious or unconscious – as possible. The Health Care Transformation Task Force believes this Business Case resource provides important support for this work, which is critical to the overall health of the country's entire population and of the health care system itself.



Appendices

Appendix A: Acknowledgements

The Health Care Transformation Task Force wishes to acknowledge and thank the members of the Health Equity Advisory Group for their significant contributions to this resource:

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Appendix B: Resource Bank

Case Examples:

- [RWJF Raising the Bar: Framework in Practice – Bright Spots](#) (Raising the Bar)
- [Community-Investment-for-Health: Findings from Six Health Systems Investing in Affordable Housing](#) (AHA, 2021)
- [Making the Business Case for Addressing Health-Related Social Needs](#) (CMS)
- [Place-based Investing: Creating Sustainable Returns and Strong Communities](#) (RWJF Hospitals Aligned for Healthy Communities Series, 2017)
- [Industry Initiatives: Collaboration Can Spur Healthcare Innovation](#) (Blue Shield of California, 2022)
- [New York State of Health Pilot Yields Increased Race and Ethnicity Question Response Rates](#) (State Health & Value Strategies, September 2021)

Consumer Engagement and Trust Building Tools:

- [Target: BP Webinar: How to Collect Accurate and Complete Race/Ethnicity Data – A Step Toward Improving Health Equity](#) (AHA, August 2020)
- [Choosing Health Equity Portfolio of Patient and Family Engagement Resources](#) (National Partnership for Women & Families, 2021)
- [We Ask Because We Care Campaign](#) (New York Presbyterian Dalio Center for Health Justice)
- [Targeted Universalism Policy and Practice](#) (HAAS Institute for a Fair and Inclusive Society, May 2019)
- [North Carolina Care 360 Data Screening Tool](#) (NCDHHS)
- [Affirmative Services for Transgender and Gender Diverse People - Best Practices for Frontline Health Care Staff](#) (National LGBTQIA+ Health Education Center, March 2020)
- [Learning Resources: Collecting Sexual Orientation and Gender Identity Data](#) (National LGBTQIA+ Health Education Center and the Fenway Institute, May 2022)
- [Do Ask, Do Tell: A Toolkit for Collecting Data on Sexual Orientation and Gender Identity in Clinical Settings](#) (The Fenway Institute and the Center for American Progress)

COVID-19 and Health Equity:

- [The Role of Health Care Systems in Bolstering the Social Safety Net to Address Health Inequities in the Wake of the COVID-19 Pandemic](#) (JAMA, June 2022)

Data Bias:

- [Addressing Social Determinants of Health with FHIR Technology](#) (NIH, October 2019)
- [Artificial intelligence predicts patients' race from their medical images](#) (Massachusetts Institute of Technology, May 2022)
- [AI Recognition of Patient Race in Medical Imaging: A Modeling Study](#) (The Lancet, June 2022)
- [Racial Bias Found in a Major Health Care Risk Algorithm](#) (Scientific American, 2019)

Data Resources:

- [Using Population Health Indices to Support Health Equity in Value-Based Payment](#) (Health Care Transformation Task Force webinar, July 2022)
- [Best Practices for Gathering and Analyzing Person-Reported Race/Ethnicity Data](#) (Health Care Transformation Task Force webinar, July 2022)
- [Strategies to Reduce Bias in Electronic Health Records](#) (Center for Health Care Strategies, October 2022)
- [Advisory to States: Leveraging Fiscal Relief, Public Health, and Social Care Funding to Advance Data Modernization and Interoperability](#) (NASDOH, 2021)

Federal and Administration-Level Policy:

- [HHS 2022 – 2026 Strategic Plan Goal 3: Strengthen Social Well-being, Equity, and Economic Resilience](#) (HHS)
- [CMS Framework for Health Equity 2022 - 2032](#) (CMS)
- [Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status](#) (The Office of Minority Health, HHS)
- [New CMS Rule Increases Payments for Acute Care Hospitals and Advances Health Equity, Maternal Health](#) (CMS)

Governance and Accountability Structures:

- [Building an Accountability Structure Toolkit](#) (Strive Together, 2015)

Health Equity Toolkits and Conceptual Models:

- [Welcome to the Return on Investment \(ROI\) Calculator for Partnerships to Address the Social Determinants of Health](#) (Commonwealth Fund)
- [Capturing Value Social Health Developing Business Case Primary Care](#) (Commonwealth Fund, January 2022)
- [Investing in Community Health: A Toolkit for Hospitals](#) (Center for Community Investment, November 2020)
- [Institute for Health Innovation Health Equity Toolkit](#) (IHI, 2021)
- [Assessing Meaningful Community Engagement: A Conceptual Model to Advance Health Equity through Transformed Systems for Health](#) (National Academy of Medicine, February 2022)
- [Health Evolution Forum: Part 1: Patient Outcomes and Experience: Health Equity Roadmap for Health Care CEOs](#) (Health Evolution, September 2021)
- [The Collaborative to Advance Social Health Integration](#) (Health Leads, January 2020)
- [Center to Advance Palliative Care Health Equity Toolkit](#) (Center to Advance Palliative Care)
- [Creating the Business Case for Achieving Health Equity](#) (Journal of General Internal Medicine, February 2016)

Impact of Policy on Equity:

- [A Racial Equity Framework for Assessing Health Policy](#) (Commonwealth Fund, January 2022)

SDOH Screening:

- [Prevalence of Screening for Food Insecurity, Housing Instability, Utility Needs, Transportation Needs, and Interpersonal Violence by US Physician Practices and Hospitals](#) (JAMA Network Open, September 2019)

Terminology:

- [When Talking About Social Determinants, Precision Matters](#) (Health Affairs, October 2019)
- [Advancing Health Equity: A Guide to Language, Narrative and Concepts](#) (AMA)
- [Visualizing Health Equity: One Size Does Not Fit All](#) (RWJF, June 2017)
- [Words Matter: How Language Used in Health Care Settings Can Impact the Quality of Pediatric Care](#) (Center for Health Care Strategies, February 2022)

Value-Based Payment and Health Equity

- [Aligning Value-Based Payments with Health Equity](#) (JAMA Viewpoint, August 2022)
- [Making Inequities Visible: New Payment Models](#) (Blue Cross Blue Shield of Massachusetts, September 2021)
- [Advancing Primary Care Innovation in Medicaid Managed Care: A Toolkit for States](#) (Center for Healthcare Strategies, August 2022)
- [Solving Disparities Through Payment And Delivery System Reform: A Program To Achieve Health Equity](#) (Health Affairs, June 2017)
- [Health Equity and Value-Based Payment Systems: Moving Beyond Social Risk Adjustment](#) (Health Affairs, July 2021)
- [The Future of Risk Adjustment: Supporting Equitable, Comprehensive Health Care](#) (Duke, June 2022)
- [Using Social Determinants of Health for Risk Stratification](#) (Health Payer Intelligence, May 2018)
- [Supporting the Future of Primary Care in California Through Aligned Hybrid Payment Models](#) (Manatt Health, funded by Blue Shield of California, November 2021)
- [Two Opportunities to Leverage Research to Promote Health Equity through Payment](#) (AcademyHealth, March 2022)
- [Advancing Health Equity Through APMs: Guidance on Social Risk Adjustment](#) (Health Care Payment Learning and Action Network)
- [Advancing Health Equity Through APMs: Guidance for Equity-Centered Design and Implementation](#) (Health Care Payment Learning and Action Network)

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