AMA | STEPSforward®

Companion Content

from the "Racial and Health Equity: Concrete STEPS for Health Systems" Webinar

Recommended Resources

Articles and Handouts

- Advancing Health Equity: A Guide to Language, Narrative and Concepts glossary

Podcasts

- Health Equity: The Importance of Building Trust

Toolkits

- Racial and Health Equity: Concrete STEPS for Health Systems
- Racial and Health Equity: Concrete STEPS for Smaller Practices
- Social Determinants of Health
- Basics of Health Equity
- Historical Foundations of Racism in Medicine: An Introduction
- Prioritizing Equity: Building Alliance & Sharing Power to Achieve Health Equity

Videos and Webinars

- HealthBegins: How a Health System Acknowledged Historic Racism to Build Community Trust
- AMA Center for Health Equity's Prioritizing Equity Video Series
- Social Determinants of Health Success Story

>> See page 2 for highlights from the Audience Q&A

Questions from the Audience

I applaud the internal focus or the STEPS effort. Social determinants of health (SDOH) are recognized as the larger driver of health inequity. SDOH needs to be addressed upstream with multiple stakeholders across the community. Health systems may not be the entities best position to advance multi-stakeholder efforts. How do health systems determine their collaborative roles?

To achieve health equity for all, it is essential to focus on solutions to the multiple drivers of social determinants of health (e.g., discriminatory policies and systems, food insecurity, housing, and so forth) and social needs. As sources of care, health systems are some of the best and most practical entities to advance multi-stakeholder efforts due to their unique positioning in the care ecosystem. Health systems have the financial and personnel resources to lead and implement across their community. In addition, health systems are centers of data due to the natural collection of information in electronic health records during the course of care. This data can be analyzed and leveraged to identify gaps in care and needs for a population of people. A health system can determine their own strengths and unique position within a community, but in most circumstances the health system can serve as the initiator and leader amongst other community members.

The AMA STEPS Forward® toolkit, Racial and Health Equity: Concrete STEPS for Health Systems, provides specific examples of how practices like yours are engaging and collaborating with their communities.

Also, check out the Racial and Health Equity: Concrete STEPS for Health Systems webinar.

Are there any current best models/exemplars for regionwide community–health system collaboration in this?

The associated toolkits on Racial and Health Equity and Social Determinants of Health provide many examples of health systems and communities collaborating together on improvement initiatives. Please see below for examples of toolkits:

1. Mass General Brigham—A Toolkit for Productive Conversations on Race
2. Leaders at Brigham and Women's Hospital designed a program—called the Healing ARC (*acknowledgment*, *redress*, and *closure*)—that focused on Black and Latinx patients and community members most impacted by unjust heart failure management to inform clinical interventions as well as institutional restitution for historic patterns of racial inequity in the health system's own care and treatment of heart failure patients.
3. Mt. Sinai Health System created a task force to address racism in the wake of George Floyd's murder and the surge of support for the Black Lives Matter movement. The task force includes 51 team members across all levels of the organization. With input from all departments, the task force developed a road map to advance 11 institutional strategies. Founding the Institute for Health Equity Research and expanding leadership development opportunities are among the changes the system has already implemented.

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Any suggestions regarding how to deal with external forces that resist reality of data and outcomes?

Sharing multiple, concrete examples of successful initiatives makes denial increasingly difficult. Sound initiatives with specific metrics tracked consistently from baseline to completion support real-world proof of success and progress. Many examples can be found throughout the Racial and Health Equity: Concrete STEPS for Health Systems toolkit.

If sharing specific examples is not successful, you may alter your approach by encouraging an open dialogue of respectful inquiry to understand the perspective of the opposing party. The answer may be different than one assumes. Using resources such as the Mass General Brigham toolkit and the Racial and Health Equity: Concrete Steps for Health Systems toolkit can help serve as conversation starters.

You may also approach conversations of health equity by way of discussing social determinants of health and providing SDOH initiatives, metrics, and impact. Sometimes this approach is more easily understood.

How does unconscious bias play a role in the prior questions?

Unconscious or implicit biases are innate to all human beings. Biases are an individual's attitudes or beliefs about certain topics that are formed from unique experiences and circumstances. All human beings have biases, and it is important to understand one's own biases in order to develop awareness of unconscious perceptions. By understanding your own biases, you and your team can become more engaged, empathetic, and culturally competent. A free assessment is available through Project Implicit. This assessment is a series of questions on 14 different implicit association-task (IAT) tests that identify potential biases related to attributes, such as gender, skin tone, and religion.

What are some practical ideas for our individual caregivers to use in overcoming social determinants of health?

Solutions to addressing health equity and social determinants of health (SDOH) are possible at all levels of care. The first steps are to create a safe, respectful environment for all and to understand the current attitudes and challenges within your practice. If possible, review your Community Health Needs Assessment (CHNA) and identify gaps in population needs. Use these identified opportunities to start small on targeted initiatives, either at the practice level or system level.

It is also important to understand the terminology and relationship of health equity vs. social determinants of health (SDOH).

- **Health Equity**—The absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other means of stratification. Equity in health implies that everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential.

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- **Social Determinants of Health (SDOH)**—Social determinants of health are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems that shape the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems. Also known as social and physical determinants of health, they impact a wide range of health, functioning, and quality-of-life outcomes.

  Example of SDOH: Number of grocery and food options in the area, local housing policies and availability of housing, quality of educational system, air quality, minimum wage standards.

- **Social Need**—Social needs refer to the immediate needs of an individual or family and often consist of real time connection of an individual to a resource, such as a food bank, ride-transportation services, or housing.

  Example of Social Need: Access to healthy meals, risk of eviction, transportation to doctor's appointment

The Social Determinants of Health toolkit is specifically designed to address and help practices implement SDOH initiatives regardless of practice size, budget, or resources.

Data collection is a challenge. Do you have any recommendations on where to start?

Data can be collected in a variety of ways. If you are not sure where to start, review existing data that is readily available to your practice. Data may come from the following common sources:

- Health System Electronic Health Record
- Community Health Needs Assessment (CHNA)
- Practice questionnaire/polling of team for known common patient needs

About the AMA STEPS Forward® Practice Innovation Strategies

The AMA STEPS Forward program offers practice innovation strategies that allow physicians and their teams to thrive in the evolving health care environment by working smarter, not harder. Physicians looking to refocus their practice can turn to AMA STEPS Forward for proven, physician-developed strategies for confronting common challenges in busy medical settings and devoting more time to caring for patients. This collection offers more than 70 online toolkits and other resources that help physicians and medical teams make transformative changes to their practices, including in the areas of managing stress, preventing burnout, and improving practice workflow.

The AMA STEPS Forward® Innovation Academy expands on the program to give participants the flexibility to customize their practice transformation journey. The Innovation Academy offers a spectrum of opportunities to learn from peers and experts, including webinars, telementoring, virtual panel discussions, boot camps, and immersion programs.

Learn more at stepsforward.org.