A FAIR AND JUST OPPORTUNITY FOR HEALTH

HOSPITALS CREATING HEALTH EQUITY IN MISSOURI

MHA

Executive Summary:

Health equity, and the role of social determinants of health, have moved beyond the philosophical and are getting the public's attention. These initiatives also are increasingly being cemented into interactions in care settings and hospitals' mission statements, with a stronger link between hospitals' work and the health of surrounding communities. The concept, however, is not new to health care providers. In 2001, the Institute of Medicine published *Crossing the Quality Chasm: A New Health System for the 21st Century,* introducing equity as one of the six pillars to improve quality and patient outcomes.[1]

Traditionally, the incentives for individual and community health improvement were misaligned, with hospitals and health systems shouldering investments in social interventions, while other actors in the health care sector accrued the returns. This market failure in health economics often is called "the wrong pocket problem."[2] This is beginning to change.

In the 2,087-page 2023 Hospital Inpatient Prospective Payment System final rule, the term "health equity" is included 259 times, "social determinant" 59 times and its shorthand "SDOH" 97 times.[3] In other words, the Centers for Medicare & Medicaid Services is leveraging its status as the single largest purchaser of health care in the U.S. to compel hospitals to the health equity table.

Beginning in calendar year 2023, hospitals will be required to attest to their organizational commitment to health equity promotion, with payment determination based on that attestation to begin in October 2024. CMS is following up with required reporting of screening measures for SDOH in CY 2024, with payment determinations tied to the screenings beginning in federal fiscal year 2026. Additionally, it is researching and requesting information surrounding the role of health equity and SDOH in the Hospital Readmission Reduction Program, maternal health outcomes, climate change and the overarching measurement of health disparities in quality reporting programs.

Health disparities in Missouri are ubiquitous — they are seen among the rural and urban, Black and white, marginalized and mainstream. Embracing fair and just opportunities for health, and intervening on health disparities, is both right and necessary — through the payment systems, and for hospitals to deliver on their community-supporting missions.

Many of the foundational elements for gathering, analyzing and addressing inequities or barriers to care are core to the community health needs assessment process required by not-for-profit hospitals to validate their tax-exempt status. With refined data sets, a better understanding of the impacts of social determinants on a patient's health outcomes and new strategies to address inequities, hospitals have an opportunity to leverage their CHNA process to create health equity within their communities.

Hospitals across Missouri are at different phases of health equity engagement. This resource is a tool for all hospitals to advance their health equity journeys. It offers consensus-driven standard definitions of several key concepts surrounding health equity and provides case studies from leaders in Missouri. Finally, it offers guidance on measuring health disparities, systems to engage with communities on collaborative approaches to health equity promotion and the important role of anchor institutions.

> ***As leaders, we have the responsibility of cultivating an environment that empowers caregivers and those who support their work. This includes strengthening cultural awareness and focusing on meeting patients where they are. When we begin to see past the health condition and look more broadly — with eyes that comprehend the complex mix of health and social challenges a patient brings to the venue of care — we can influence health and care, and improve outcomes.***
>
> *— Julie Quirin*
> *COO, Saint Luke's Health System*
> *Chair, MHA Health Equity Committee*

This health equity-centered resource is a working product of the Health Equity Committee of the Missouri Hospital Association. Formed by the MHA Board of Trustees in February 2021, the committee is comprised of 14 health care system leaders with expertise in community health. Committee members represent a diverse cross-section of Missouri's communities and hospitals.

Introduction:

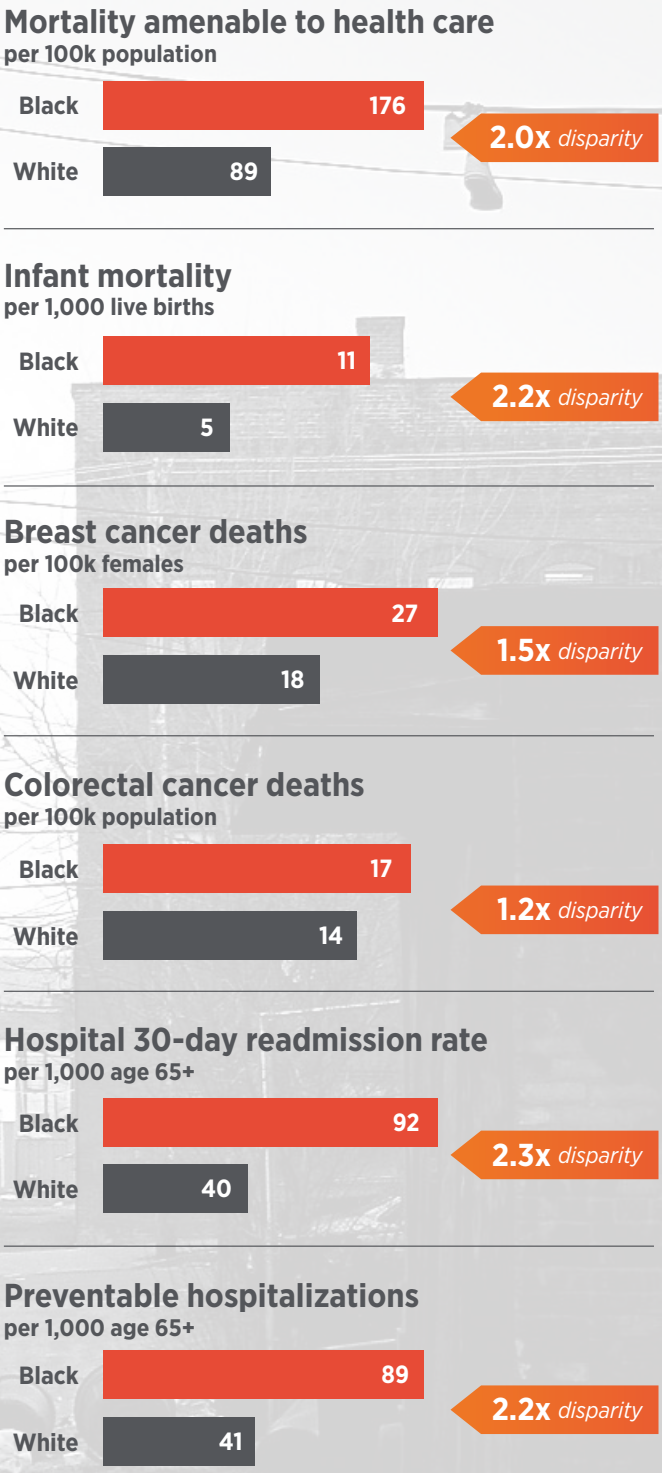
In its purest form, health equity is when every member of society has a fair and just opportunity to be as healthy as they choose, regardless of where they live, how they look or what resources are at their disposal. Unfortunately, opportunities for health in the U.S. too commonly are determined by assets, access, influence and environment, rather than an individual's desire for better health.

The poor health outcomes common with advancing age often are determined far upstream — in childhood. They are compounded or moderated by individuals' unique experiences throughout the sociobiologic cycle of health during one's life course.[4] A child's access to prenatal care, well-child exams, love, nurturing, nutrition, safe housing, healthy built environments, high-quality child care and primary education shares a known and pronounced association with how well and how long individuals live in adulthood. As Frederick Douglass prophetically stated in 1855, "It is easier to build strong children than to repair broken men."[5]

Health equity is not exclusively confined to racialized concepts of disparity for minoritized communities. However, race commonly is used to typify powerful examples of disparities (Figure 1). Today, Black mothers in Missouri die at triple the rate of their white neighbors during the year following childbirth, while new mothers with Medicaid are eight times as likely to die following childbirth compared to their neighbors with private health insurance.[6]

Figure 1.

Selected Health Disparities for Missouri Residents by Race



Source: *The Commonwealth Fund 2021. Achieving Racial and Ethnic Equity in U.S. Health Care.*

Seminal research has quantified a graded dose-response between the number of adverse experiences a child has before age 18, and premature morbidity and mortality.[7] Today, adverse childhood experiences remain ubiquitous, costly and unevenly distributed. Sixty-one percent of adults report having had at least one adverse experience in childhood, and the burden associated with ACEs costs an estimated $56 billion per year. More than 50% of individuals identifying as Asian report having experienced no ACEs compared to just 28.8% of individuals identifying as American Indian or Alaska Native.[8] As a result and driven by chronic exposure to toxic stress and trauma, in addition to historical displacement and divestment of marginalized communities, health disparity remains highly pronounced for socially vulnerable, indigenous and minoritized populations across social, economic, behavioral and physical health outcomes in Missouri.

Inequity drives significant disparities. For example, residents of the Ville Neighborhood in North St. Louis City — 97% of whom are Black — can expect to live 27 fewer years than their neighbors living just 10 miles southwest in the St. Louis County neighborhood of Webster Groves where only 1% of residents are Black.[9]

Further evidence of care differentials abound, resulting in disproportionate rates of uncontrolled diabetes and lower extremity amputations for residents of rural, low-income and communities of color.[10] The disparities are compounded as the cost of care results in higher rates of medical debt. Nearly one in three Black and Brown adults in Missouri have had their medical bills turned over to debt collection agencies, which can have devastating effects on opportunities for upward mobility. This is more than double the rate of medical debt in collections for their white neighbors.[11]

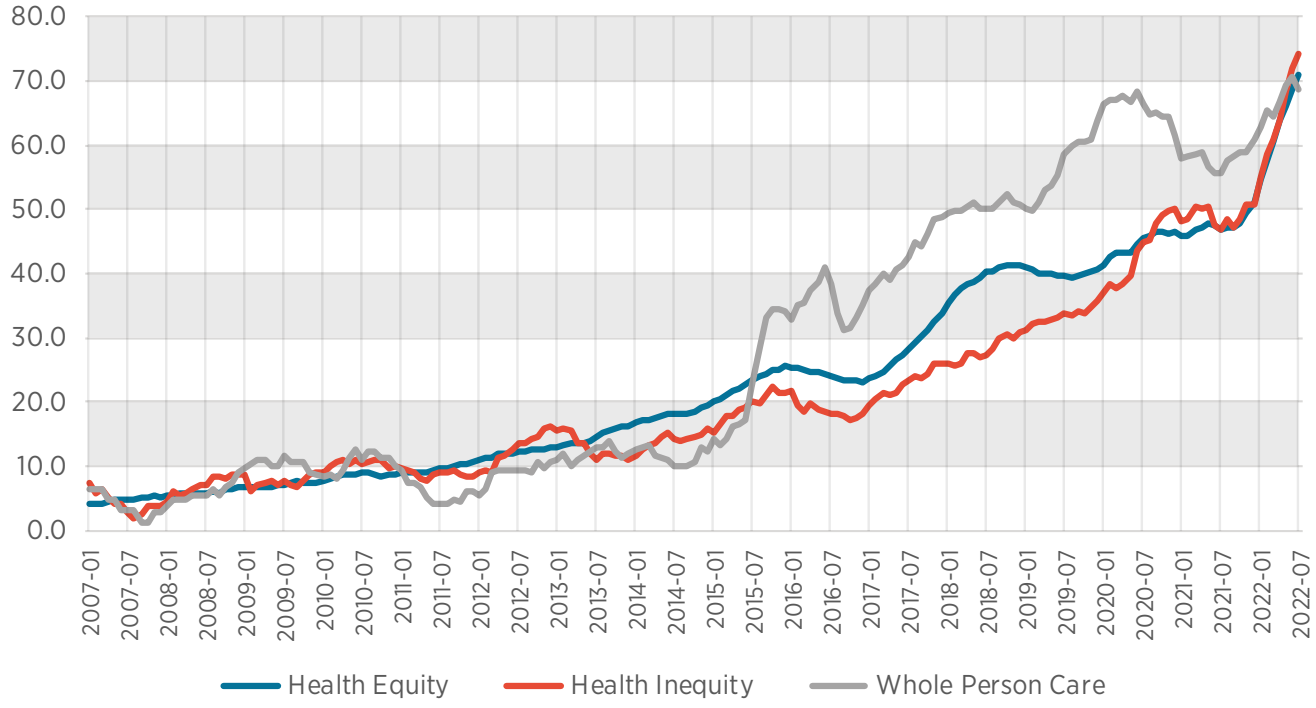
Additionally, emerging research surrounding implicit biases among physicians finds that a staggering portion of medical students and residents believe in racialized myths about the thickness of Black peoples' skin and their pain tolerance being higher relative to white patients.[12]

> ***Of all the forms of inequality, injustice in health is the most shocking and the most inhuman because it often results in physical death.***[13]
>
> *— Rev. Dr. Martin Luther King Jr.*

Figure 2.

Slope of Public Interest: Google Search Index Scores in the U.S. for Health Equity-Related Search Terms:

January 2007 -July 2022 (12-Month Moving Average)



Although much work remains to create a system that delivers health equity, there are many promising aspects of investments in this area. New research reveals a strong association between labor force retention and the extent to which organizations embrace diversity, equity, inclusion and belonging.[14] In addition, health equity is a concept that enjoys bipartisan support, as demonstrated by growth in the contemporary societal interest of this and associated concepts (Figure 2). In a 2021 poll of likely voters in Missouri, 64% of respondents across both aisles felt that addressing inequity in health care is very important, while another 20% felt it was somewhat important.[15]

Key Concepts and Definitions:

As health equity is a very complex subject that is experienced differently among organizations and communities, MHA's Health Equity Committee initiated the development of shared consensus-based definitions that can support thoughtful dialogue and serve as a foundation for meaningful action. As the committee considered its scope of work and how it might best support health care institutions across the state, two terms were identified for initial definition: health equity and anchor institution. A shared definition of health equity provides a baseline for discussion, planning and measuring progress, both in individual institutions and as a statewide effort. A shared definition of anchor institution provides common language for exploring the possible roles that different types of health care institutions might play in advancing health equity in their communities.

What is Health Equity?

Taken independently, health is defined as "the condition of being sound in body, mind or spirit," while equity is "justice according to natural law or right."[16] Taken together:

> ***Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This 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.***
>
> *— Robert Wood Johnson Foundation*[17]

A variety of definitions for health equity exist in the surrounding literature. The Centers for Disease Control and Prevention, as an example, defines health equity as being "achieved when every person has the opportunity to 'attain his or her full health potential' and no one is 'disadvantaged from achieving this potential because of social position or other socially determined circumstances.'"[18]

While most of the competing definitions of health equity from authorities in the space are highly similar, nuances exist, and the importance of developing consensus around concepts as simple as defining aspirational terms cannot be overstated. For example, missing from the CDC's definition are the adjectives "fair" and "just" to describe the shared subject "opportunity." Unfortunately, opportunities are not fair and just by default.

For example, under the Emergency Medical Treatment and Labor Act of 1986, everyone has an equal opportunity to seek emergency care in hospital emergency departments; however, the amount of out-of-pocket costs associated with that care varies widely based on patients' access to health insurance. Additionally, the binary use of "his" and "her" pronouns in the CDC's definition would be seen as noninclusive to individuals from minoritized gender identity groups.

By contrast, the RWJF definition acknowledges a fair and just opportunity for everyone, without exclusion. It also indirectly acknowledges individual choice, in that being "as healthy as possible" will carry different meanings for different individuals based on personal preferences and genetics. It also underscores the need to remediate the pernicious effects of SDOH to fully achieve health equity. It is for these reasons that after careful consideration of competing definitions of health equity in the literature, and decomposing the subtle nuances conveyed by each, that the MHA Health Equity Committee selected the RWJF interpretation as the consensus-based standard definition of health equity from which to use as the foundation of future work.

What are Social Determinants of Health?

Again taken independently, social is defined as "of or relating to human society, the interaction of the individual and the group, or the welfare of human beings as members of society," while determinant is "an element that identifies or determines the nature of something, or that fixes or conditions an outcome."[19] Taken together, SDOH are:

> ***The nonmedical factors that influence health outcomes. They are 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.***
>
> *— World Health Organization*[20]

While the MHA Health Equity Committee has not formally endorsed a definition of SDOH, the WHO's interpretation above is the most-commonly cited in health care services research. Additionally, SDOH are so deeply intertwined as the primary drivers of health disparity, the concept deserves socialization.

SDOH include constructs such as economic stability, neighborhood and physical environment, education, food, community and social context, and the health care system.[21] Estimates vary on the portion of health outcomes that are attributable to SDOH, genetics, and individual choices or risk behaviors that influence health and well-being. A recent decomposition of the County Health Rankings data suggest socioeconomic status accounts for 47% of individuals' health outcomes in life, while access to quality clinical care accounts for 16% and the physical environment contributes an additional 3%.[22]

Taken as a whole, these findings suggest the upstream conditions in which we're born, grow, work, live and age explain 66% of the downstream health outcomes in terms of morbidity and mortality that we'll experience later in life. In other words, SDOH explain two-thirds of how well and how long we live.

In the following case study, you can learn more about work underway at University Health in Kansas City, Mo., that is designed to promote health equity by addressing SDOH.

CASE STUDY

Driving Health Equity at University Health:

University Health is the Kansas City area's only essential safety net hospital, providing "care for all" regardless of ability to pay. Many of UH's patients find themselves in a daily struggle with the complex social needs known to directly affect health. Poverty, homelessness, food insecurity, language barriers and other social issues faced by many of the patients are known to create disparities in health, treatment and access to care. UH is committed to identifying and addressing these factors, both within the walls of the organization and in collaboration with others in the community at large.

UH is utilizing a multifaceted approach to address health equity in Kansas City. Below are key strategies.

Collaborative Community Efforts – UH is collaborating with other health care and community organizations in the Kansas City metro area to strengthen communication and create plans of action between organizations.

- **Kansas City Health Equity Action Community:** UH is working together with other organizations throughout Kansas City to develop and implement plans of action to "catalyze and sustain equity-centered and culturally responsive health care that yields equitable health outcomes for all."
- **KC Health Collaborative**: UH staff participates in this collaborative with the goal of developing and implementing a communitywide plan of screening, referral and follow-up for the SDOH faced by those they serve. Individuals on this committee represent numerous health systems, schools and social service agencies.
- **Mattie Rhodes Health Literacy Committee**: UH sits at the table with other community agencies and health centers to address health literacy within the Kansas City community.

Dr. Mark Steele, University Health Executive Chief Clinical Officer, along with other UH physicians, visited public locations such as libraries and museums to hand out free masks during the height of the COVID pandemic.

Community Engagement:

The Community Health Strategies & Innovation department strategically partners with community stakeholders to develop sustainable programs that achieve impactful outcomes. The department consists of three branches: Community Health, Nutrition Education and Education Services.

- The Community Health division implements initiatives such as immunization clinics, weight loss challenges and chronic disease self-management classes. Solutions are tailored to the health issues of the community, allowing community members to advocate for their own health while taking the proper steps to reduce the risk of chronic disease and emergency department visits.
- Nutrition Education and the Healthy Harvest Mobile Market implement a "classroom on wheels" to travel throughout the community with a focus on assisting individuals in acquiring knowledge and changing behaviors necessary for living a lifestyle of healthy nutrition practices.
- The Education Services branch of the CHS&I department aims to expose high school students to different career opportunities within the health care industry.
- COVID-19: The CHS&I department, in partnership with 20-plus community centers and churches in low-income areas, worked to bring no-cost fruits and vegetables to individuals in targeted ZIP codes, helping to relieve hunger for over 140,000 community members during the COVID-19 pandemic. The community team screened 1,286 community members for COVID-19 and provided 969 COVID-19 vaccines to families in these targeted areas.

Department of Equity, Diversity and Inclusion:

UH's Department of Equity, Diversity and Inclusion's mission is to provide EDI expertise and programmatic support to UH leadership and staff to advance UH as an equitable and inclusive place to receive health care, to work and to learn. The vision of this work is to create a diverse, equitable, inclusive and welcoming environment for UH's patients, staff, suppliers and the community that results in positive health care outcomes. EDI activities supporting this vision include the following.

- Provide coaching, development and training.
- An annual compliance module on EDI practices focuses on bias in medical care.
- In-person workshops are offered to teams and departments on bias in health care and microaggressions.
- An Ambassadors Council was developed that is open to front-line and administrative staff. Members receive nine months of EDI development that prepares them to return to their teams/departments and serve as a liaison for EDI matters in their assigned areas.
- An EDI Council was established within the nursing shared governance structure.
- Project LEAD, a 12-month pilot program, has a goal of increasing diversity in the leadership of the organization by broadening the pool of diverse candidates.
- An overview of the EDI department is highlighted during new hire orientation, including support provided to staff and departments throughout the organization.
- The Health Equity Committee brings together representation from numerous areas of the hospital to explore existing practices and develop plans of improvement in the areas of collection and use of race, ethnicity and language data, a review of policies and practices using an equity lens, clinical practices, and development and monitoring of a health equity plan.

Social Determinants of Health Screening:

UH developed a screening methodology for its clinics to screen patients for the most identified challenges.

- Provided nearly $3.4 million in housing stabilization assistance annually, including rent, utilities, etc.
- Assisted approximately 150 clients per year in securing competitive employment.
- Partnered with Preservation of Affordable Housing, a nonprofit developer, owner and operator of more than 12,000 affordable homes, to promote resiliency in affordable housing through trauma-informed interventions in property management, resident services and physical design.

The Healthy Harvest Mobile Market is a "classroom on wheels," providing fruits and vegetables as well as information aimed at helping people create healthy nutrition habits.

Cultural Health Navigators serve as language interpreters for patients as well as the patient's advocates.

Cultural Health Navigation:

The organization created a hybrid position, which allows for medical interpreters to also serve as the patient's advocates and navigators.

Food Equity Grant Committee:

With funding assistance from the Health Forward Foundation, UH invites and facilitates the efforts of an increasing number of representatives from Kansas City's health care and community support organizations to learn together and develop programming that serves to support the nutritional needs of the immigrant, refugee and disadvantaged populations they serve.

On-site Food Pantry:

To provide immediate assistance to those experiencing hunger, UH, in partnership with Harvesters, opened "One World Pantry," an on-site food pantry providing immediate assistance to both patients and staff members alike.

What is an Anchor Institution?

Beginning again with the root derivation of the term, anchor is defined as "a reliable or principal support: mainstay," while an institution is "an established organization or corporation (such as a bank or university) especially of a public character." Institutions also can refer to significant societal practices, relationships and organizations, or something firmly associated with a place.[23] Taken as a whole:

> ***Anchor institutions are large, usually nonprofit organizations tethered to their communities, like universities, medical centers or local government entities. They are deeply rooted economic engines in the communities they serve, holding significant social capital. They are often trusted leaders in the communities, well positioned to help lead multisector work aimed at eliminating health disparities. By leveraging their economic power, good will and human resources, anchor institutions can make significant advancements in the promotion of health equity.***
>
> *— National Academies of Science, Engineering and Medicine* [24]

In the context of addressing health equity in Missouri, "large" is a relative term. Rural community and critical access hospitals are significant economic engines that commonly are the largest employers and purchasers of goods and services in the community. This gives even the smallest rural hospital a significant economic lever, in addition to social and political capital, within its service area.

Additionally, while this definition specifically names nonprofit organizations, addressing health equity in Missouri will require partnerships and collaborations with both for-profit and nonprofit organizations. It was with these caveats in mind that the MHA Health Equity Committee selected the NASEM interpretation as the consensus-based standard definition of anchor institution.

In the following case study, you can learn more about work underway at BJC HealthCare in St. Louis designed to promote health equity through an anchor institution model.

CASE STUDY

BJC HealthCare Community Health Improvement:

BJC HealthCare in March 2022 introduced its community health improvement strategic plan, leadership team and first regional partnerships to alleviate health inequities across the St. Louis region.

"Research and reports, such as *For the Sake of All*, repeatedly point to socioeconomic factors, including poverty, education, housing and inequality, as having the greatest impact on health," says Rich Liekweg, BJC HealthCare President and Chief Executive Officer. "One of the jarring data points cited in that report is that people in affluent communities live an average of 18 years longer than those in under-resourced communities just a few miles away. At BJC, we are committed to changing disparities like that."

To accomplish this, BJC is working alongside groups that make up the fabric of under-resourced neighborhoods and is striving to bring a holistic approach to improving physical, mental and financial well-being. Addressing the root causes of health problems, especially those that disproportionately affect ZIP codes where there has been under-investment, will lead to increased wellness and greater overall quality of life.

BJC is working with communities in the City of St. Louis and North St. Louis County most impacted by inequities and will focus support around four areas significant to health and well-being: financial investment in the community, diabetes and healthy food access, infant and maternal health, and school health and wellness. BJC went through a very robust planning process with engagement from internal stakeholders and the community to determine these focus areas.

"We cannot improve community health without the community," says Jason Purnell, Ph.D., MPH, BJC Vice President of Community Health Improvement. "This inclusive process gave us time to authentically listen and learn. We are committed to acting on what we heard and are excited to work in partnership with the communities we serve to address these issues."

In September 2021, BJC HealthCare's board of directors and executive leadership team endorsed the plan.

BJC recruited a talented and diverse leadership team to advance its commitment to community health improvement. Joining Dr. Purnell's leadership team are Karlos Bledsoe, Director, Strategy and Operations; Doneisha Bohannon, Director, Community Health Partnerships and Collaboration; and Christopher Nolan, Director, Anchor Initiatives. This team is primarily responsible for working collaboratively throughout BJC and with community partners and residents to co-design and amplify efforts that address health inequities.

BJC cannot do this work alone or in a silo. It has developed and expanded relationships with partners in the community to help advance efforts in these focus areas while addressing other critical needs. "Our work is well underway in a number of areas," noted Dr. Purnell. "We've responded to urgent needs in the community during the pandemic by partnering with various churches, businesses and community organizations across St. Louis to deliver COVID-19 vaccinations equitably."

Some of the other initial partnerships include Midwest BankCentre and St. Louis Community Credit Union, two financial institutions that have a shared mission of improving health and economic well-being. BJC recently developed a depository relationship with these two local institutions to address a historic lack of investment in the City of St. Louis and North St. Louis County. The deposits will be used to create loans to invest in these communities, including support for entrepreneurs to start and grow businesses and for individuals to realize the dream of home ownership. BJC also is partnering with colleagues at Christian Hospital, and community partners North Sarah Food Hub by Holistic Organic Sustainable Cooperatives, Operation Food Search and

> ***"Similar to the American Hospital Association's definition, I define health equity as "'the attainment of the highest level of health for all people.'" To reach that, it is imperative to find a way to dismantle the historic systems and structures that make achieving those realizations difficult and, at times, seemingly impossible. We must acknowledge the lived experience of those most profoundly impacted while bringing forward the undeniable data that presents a call to action. Anchor institutions, specifically health care organizations, must establish bold strategic priorities that will eliminate such glaring inequities. Otherwise, health disparities will continue to worsen and disproportionately impact our most vulnerable communities, most often our communities of color and of lower social economic status."***
>
> *— Steven Player, PharmD, MBA, CDM, VP Diversity, Equity and Inclusion, BJC HealthCare*

(L to R) *BJC president and CEO Rich Liekweg and BJC vice president of community health improvement Jason Purnell joined Midwest BankCentre Chairman and CEO Orvin Kimbrough to announce a new BJC depository relationship designed to spur financial growth in historically under-resourced communities.*

My Blooming Health Lab to provide healthy meals, nutritional counseling and social needs assistance to address food insecurity and uncontrolled diabetes in North St. Louis.

St. Louis Community Credit Union and BJC are also partnering on a depository relationship to facilitate greater opportunity for loan support for businesses and homebuyers in North St. Louis communities. Pictured left to right are BJC director of anchor initiatives Christopher Nolan, BJC chief investment officer and treasurer Joseph Thomas, SLCCU president and CEO Kirk Mills, SLCCU vice president of community development Paul Woodruff, BJC president and CEO Rich Liekweg and BJC vice president of community health improvement Jason Purnell.

When the Be Well Farmers Market opened for the season at the corner of Salisbury Street and North Florissant Avenue in the Hyde Park neighborhood of North St. Louis, fitness instructors from Move by BJC were on hand to offer tai chi and yoga demonstrations among the samplings of flavorful teas, fresh herbs, locally grown produce and handmade items from local vendors. BJC CHI is partnering with the Be Well Farmers Market in 2022 to increase access to healthy and affordable food, along with access to free exercise demonstrations and health screenings. The market brings together urban farmers and growers, artisans, health providers, and food trucks.

"These early partnerships help to address the wealth and health gap, food insecurity, and diabetes disparities," said Dr. Purnell. "We are meeting people in their neighborhoods and working collaboratively with partners to address disparities. We are continuing to identify partners and build relationships across our region to help move the needle in these focus areas."

"We recognize that to focus on improvement of community health is to focus on a long-term goal," Liekweg adds. "We envision a thriving bistate region in which all people have an equal opportunity to live their healthiest lives."

Learn more about BJC's ongoing community health improvement work, and how to get involved.

EMBARKING ON YOUR HOSPITAL'S JOURNEY:

While some hospitals and health care systems in Missouri have formally committed to leveraging their role as an anchor institution in their communities, others are in the early stages of considering their role in health equity. MHA's Health Equity Committee invites hospitals to consider building partnerships to pursue one or more of the following strategies, regardless of whether they formally consider themselves an anchor institution.

Importantly, efforts aimed at establishing an anchor institution model should begin with a deep evaluation of data surrounding health disparities faced by various population segments within the primary service area. The MHA Health Equity Committee's public-facing health equity dashboards are rich sources of data on health and social outcomes for populations across Missouri's counties and ZIP codes.

Secondly, the importance of engaging early and often with the community served cannot be overstated. Community-based stakeholders such as the business community, nonprofit community-based organizations such as the faith-based community, and critically, residents of the community all can help prevent the risk of unintended consequences. For example, hospital campus renovation projects that encroach on occupied housing units unintentionally can produce a chilling effect of gentrification in the form of property taxes that are prohibitive to existing homeowners in the surrounding community. These and other unintended consequences largely can be averted by engaging with and listening to the voices of the community.

The Healthcare Anchor Network offers the following potential strategies for achieving health equity.

Inclusive Local Hiring & Workforce Development

Outside In: Strategies to Foster External Workforce Solutions — Prepare local residents for high-quality, high-demand front-line jobs that are connected to job pipelines.

Inside Up: Approaches to Cultivate Existing Staff into New Roles — Connect front-line workers to pathways for career advancement.

Inclusive Local Sourcing

Creating Connections: Connect existing local, diverse vendors to contracting opportunities within your institution.

Building Capacity: Build up the ability of the local business community to meet health system supply chain needs.

Place-Based Investing

Local Investment: Designate a percentage of investable assets for local development.

Upstream Community Benefit: Use discretionary operating dollars to address disparities.

Facilitating Meaningful Conversations:

Health equity is a complex topic and understanding its significance requires one to observe the consequences of health inequity. However, our perceptions of health inequities are distorted, or sometimes hidden from us, because our understanding about what is considered "fair" or "just" opportunities for health is based on our own lived experiences and observations of the health of those we know best — those who comprise the communities in which we live and work.

Begin with approaching the conversation about health equity as an invitation to better understand this complex topic, whether with boards of directors, front-line staff or community stakeholders. The definitions included in this document and questions below can provide a starting point for the conversation. For example, you might begin to better understand health equity in your community by opening with this statement:

Health equity means that everyone has a fair and just opportunity to be as healthy as possible.

Questions to ask might include:

- Do we believe that it's important for everyone to have a fair and just opportunity to be as healthy as possible?
- What are the consequences of people *not* having an opportunity to be as healthy as possible?
- Why is it important to us?
- What might it produce for our hospital and community if everyone had a fair and just opportunity to be as healthy as possible?
- Have you seen situations where people haven't had this opportunity?
- What caused them to *not* have this opportunity?
- What might have helped?
- How might a commitment to this statement affect our work?
- How might it influence our interactions with patients?

Then move to the more expanded definition:

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This 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.

Questions to ask might include:

- As we read this expanded definition of health equity, are there aspects of this definition that provide language or context that reflect our experience?
- What questions does it raise for us — personally, organizationally and as a community?
- What pieces of this definition might be useful for us as an organization/department/system?
- In what ways might this perspective on health equity influence our work?

If your institution has not already identified itself as an anchor institution or is just beginning to consider how to leverage its role, the Committee recommends beginning with a conversation about the strategies that anchor institutions employ to address the broader social issues that affect health and health equity. It is not necessary to formally identify as an anchor institution to participate in advancing health equity.

The process might begin with an inventory of the ways your institution already is involved in one or more of the following efforts.

Questions to explore about inclusive **Local Hiring & Workforce Development** might include:

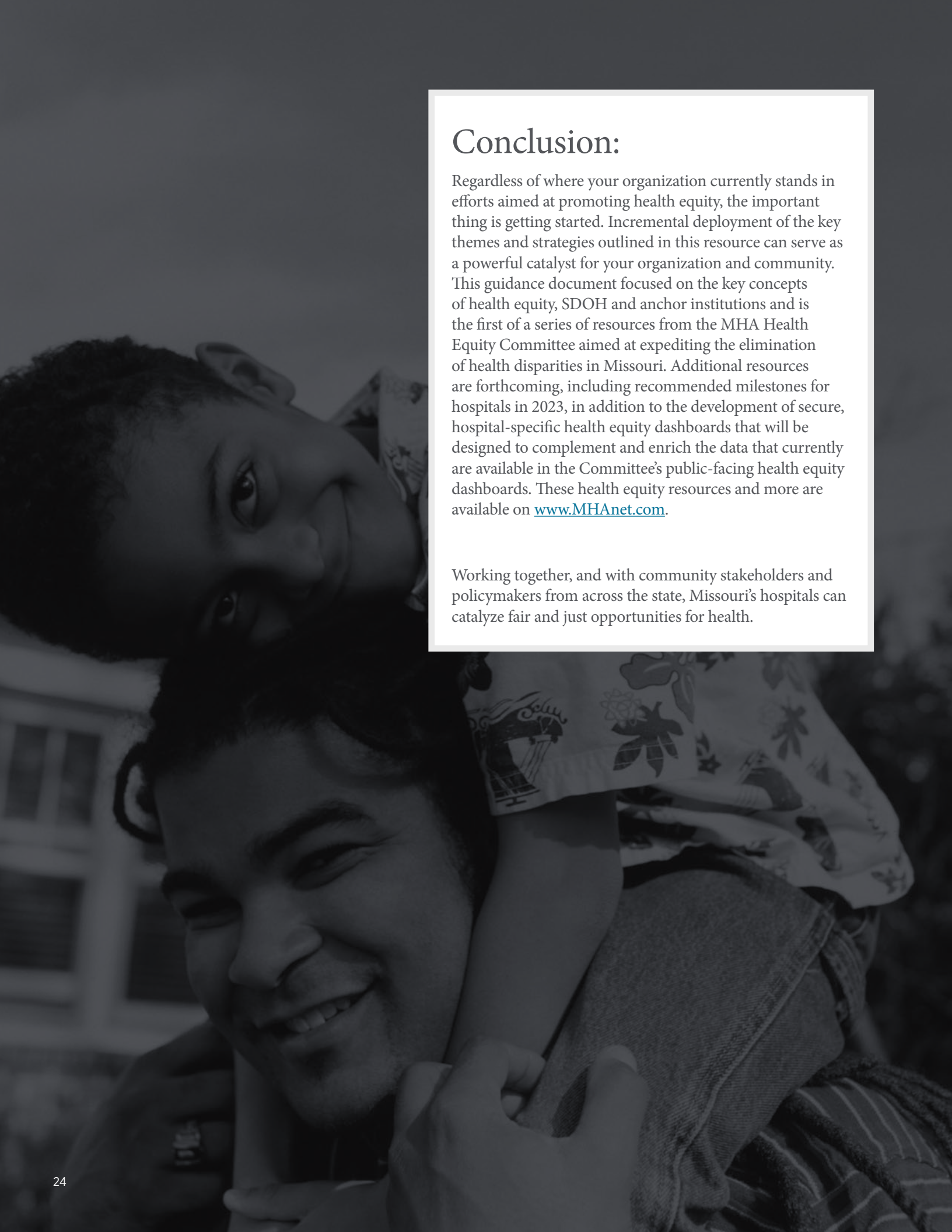
- Have we optimized our local hiring and workforce development efforts to produce a diverse and inclusive workforce?
- How might we deepen our commitment to that effort? With whom might we partner?

Questions to explore about **Inclusive Local Sourcing** might include:

- Do we source locally?
- How much do we source locally?
- Could we do more?
- Do our local sources represent a diverse group of suppliers?
- What might be needed to expand the number and diversity of our local sources?
- With whom might we partner?

Questions to explore about **Place-Based Investing** might include:

- What is our level of investment locally?
- What kinds of organizations do we support?
- How are those organizations involved in addressing health disparities?
- Are there organizations that are influencing health disparities beyond the health care system — e.g., housing, jobs, food access, education?
- How might we support their efforts?
- Are there investments in property or other specific tangible items that would address the social issues that impact health?



Conclusion:

Regardless of where your organization currently stands in efforts aimed at promoting health equity, the important thing is getting started. Incremental deployment of the key themes and strategies outlined in this resource can serve as a powerful catalyst for your organization and community. This guidance document focused on the key concepts of health equity, SDOH and anchor institutions and is the first of a series of resources from the MHA Health Equity Committee aimed at expediting the elimination of health disparities in Missouri. Additional resources are forthcoming, including recommended milestones for hospitals in 2023, in addition to the development of secure, hospital-specific health equity dashboards that will be designed to complement and enrich the data that currently are available in the Committee's public-facing health equity dashboards. These health equity resources and more are available on www.MHAnet.com.

Working together, and with community stakeholders and policymakers from across the state, Missouri's hospitals can catalyze fair and just opportunities for health.

About the Health Equity Committee of the Missouri Hospital Association:

Throughout the last several years, MHA has led a multitude of initiatives addressing various outcomes of health disparities, including substance use and maternal mortality. Most recently, MHA partnered with Alive and Well Communities, a nonprofit Midwest organization based in Missouri, to advance equity-centered, trauma-informed care, with an emphasis on racial discrimination and related health effects. In addition, MHA has published many reports with extensive data analysis of health care disparities. These efforts demonstrate program focus, while revealing a lack of a comprehensive strategic vision.

In February 2021, the MHA Board of Trustees committed to a broader health equity strategy and approved the formation of a Health Equity Committee to advance these efforts.

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2022 Missouri Hospital Association Health Equity Committee

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