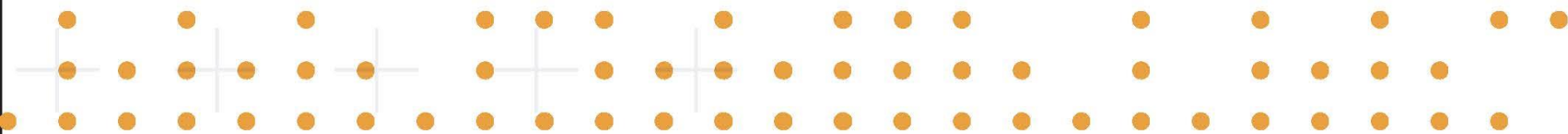


**NAPCRG**

**International Conference  
on Practice Facilitation**



# Using Facilitation to Promote Health Equity: Preliminary Thoughts on an Explicit Shift

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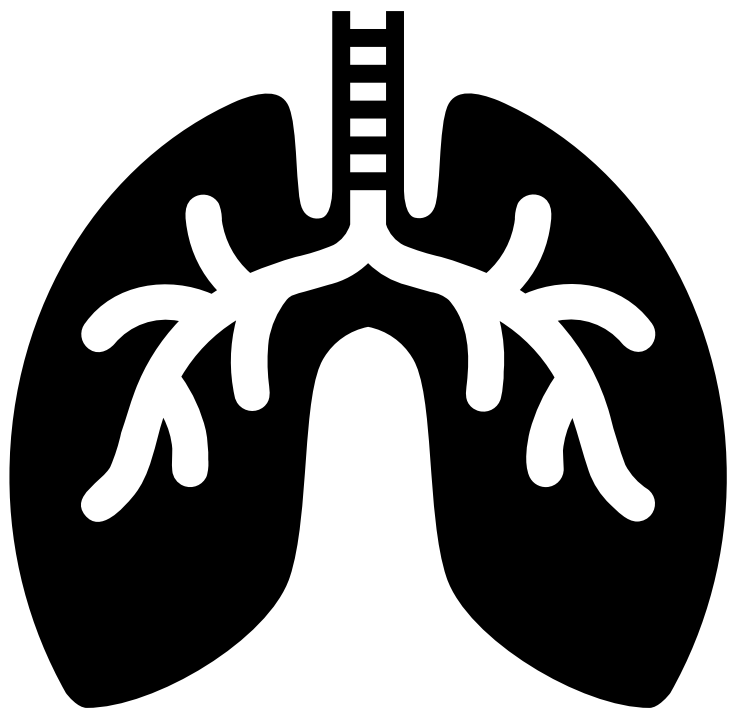
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# Acknowledgements & Disclaimer

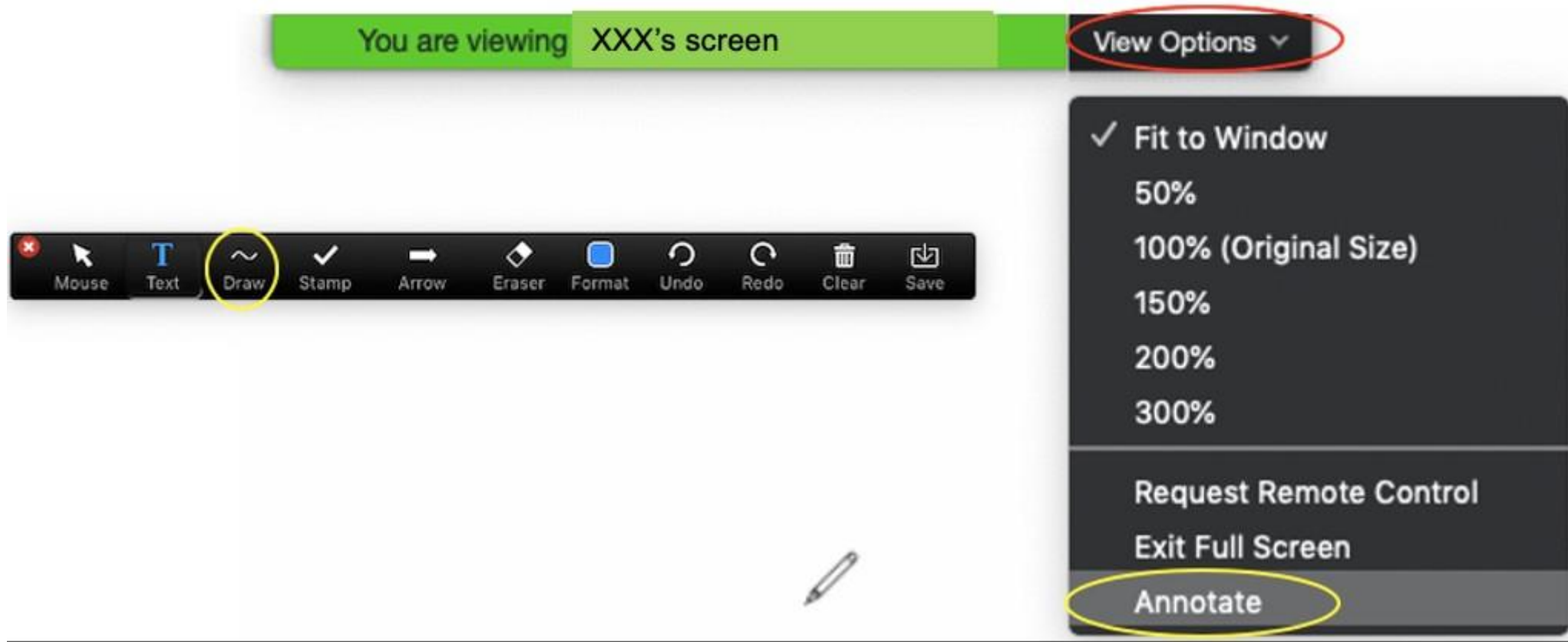
- Thank you for inviting me and being with me today!
- VA Office of Health Equity
- VA Career Development Award, Health Services Research & Development (IK2 HX003065)

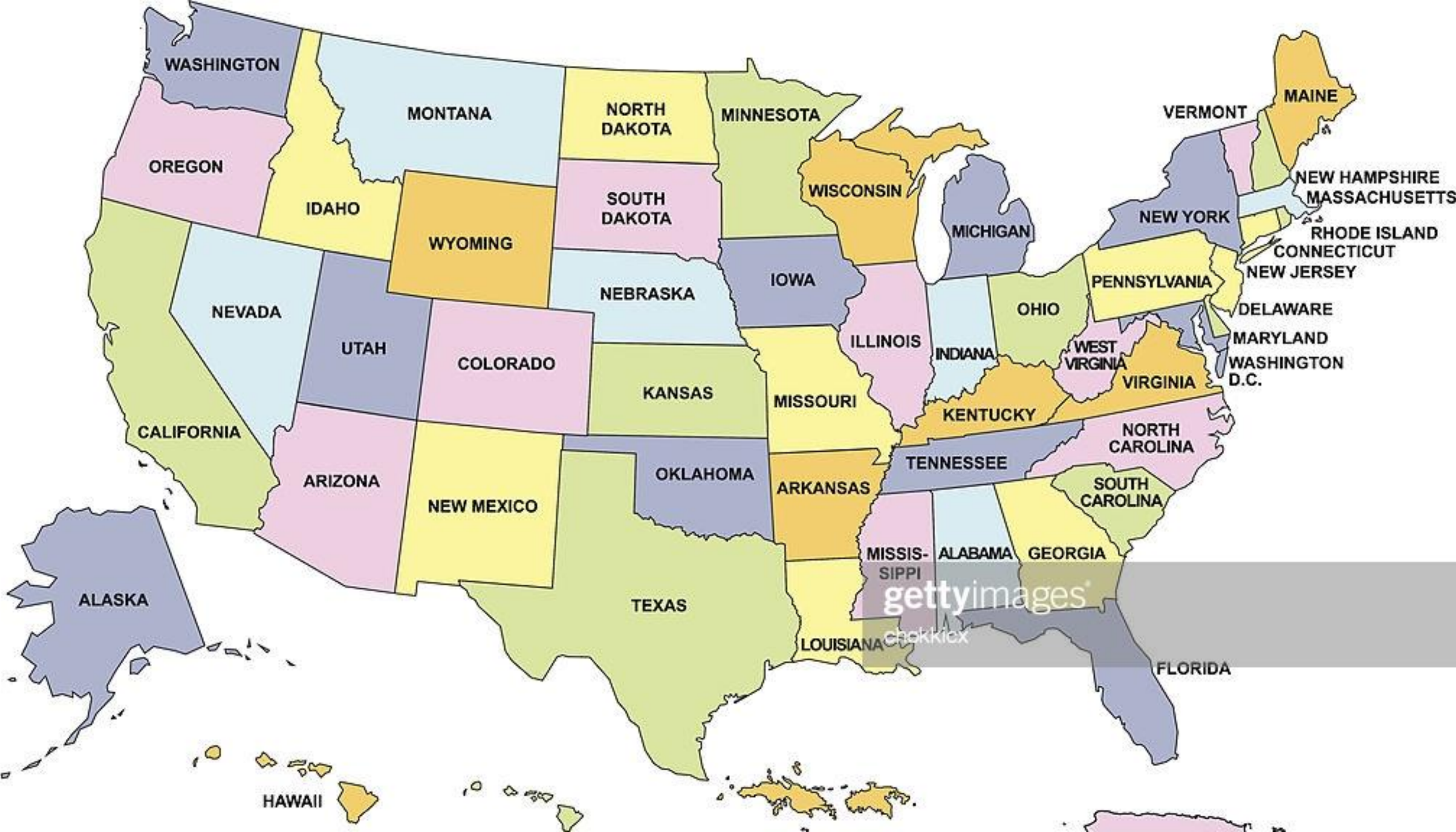
The views expressed in this presentation do not necessarily reflect the position or policy of the Department of Veterans Affairs or the United States Government.



Let's get present

# How to annotate in Zoom





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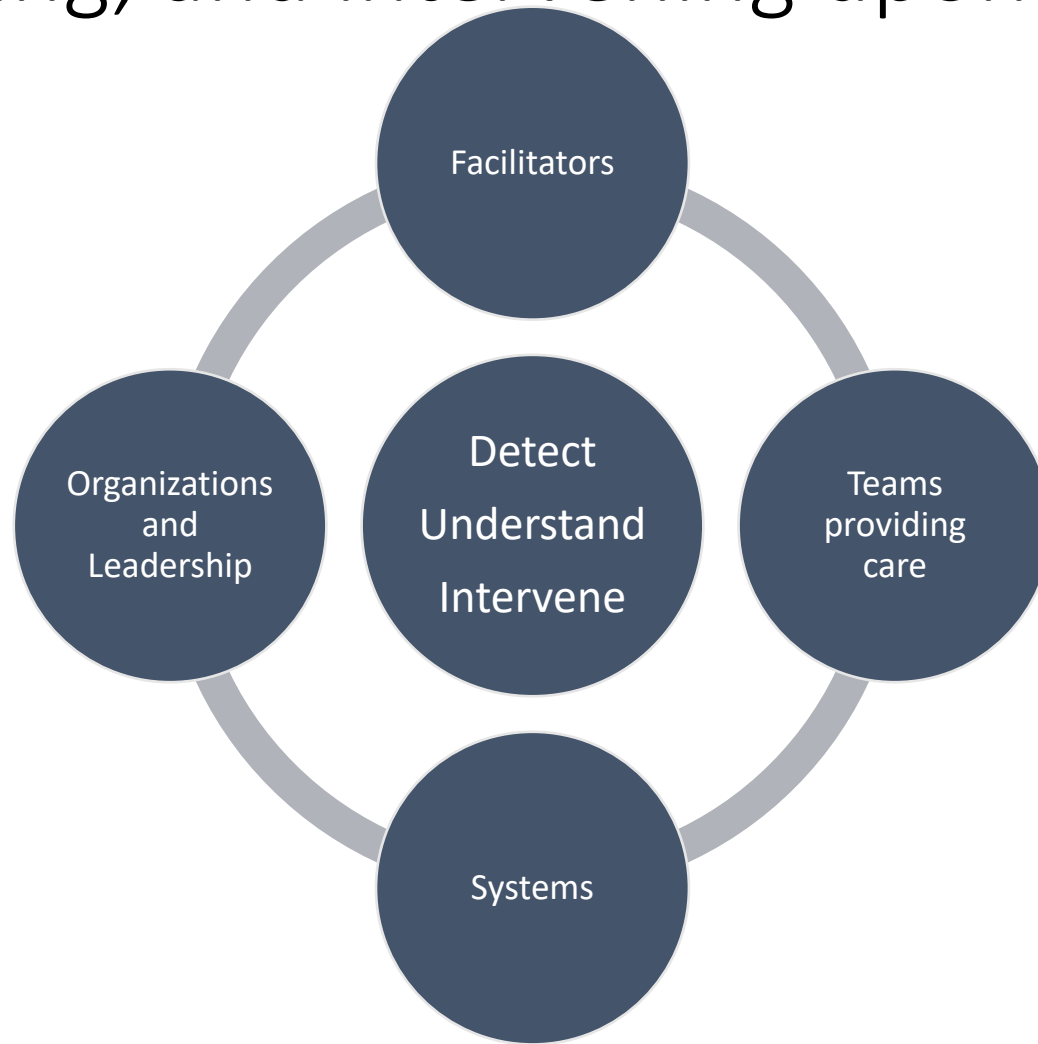
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<b>Health differences</b>	<b>Health disparity</b>	<b>Health equity</b>
differences in health outcomes between two groups, based on a specific characteristic such as height, income <sup>1</sup>	“Not all health differences are health disparities;” health disparities are concerned with social injustice <sup>2</sup>	“Health equity is the principle underlying a commitment to reduce, and ultimately, eliminate disparities in health and in its determinants, including social determinants.” <sup>2</sup>

We can facilitate with an eye toward equity by detecting, understanding, and intervening upon disparities

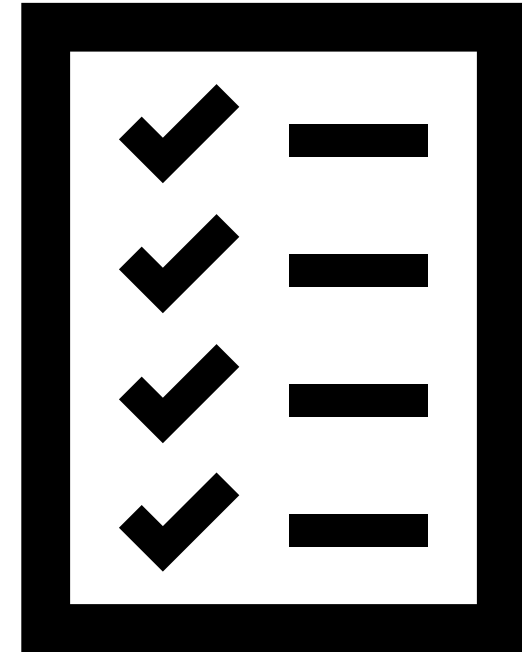


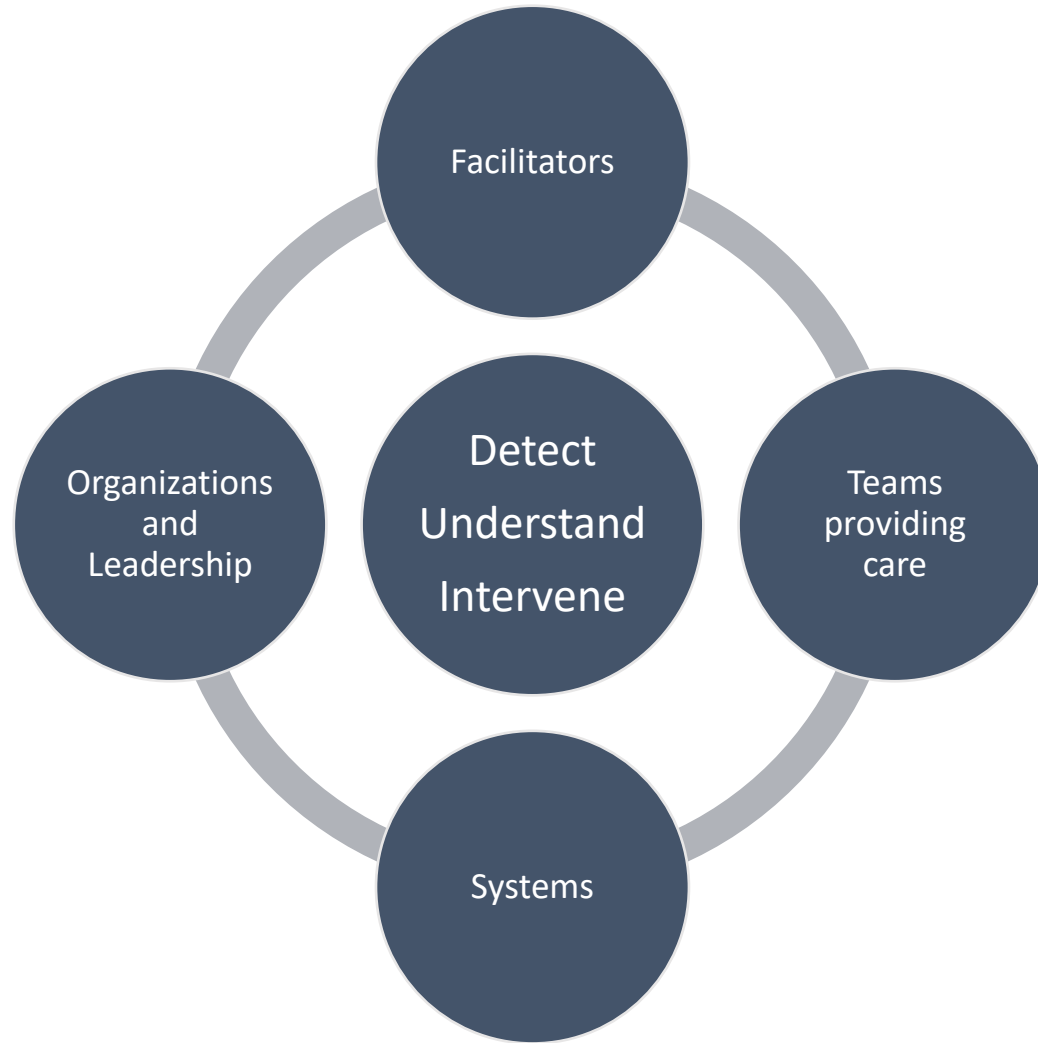
**Workforce of facilitators with diverse lived experiences**



# Listing Activity: Use the Chat Box

What are the top two barriers facilitators might have in addressing disparities and promoting equity?





**Workforce of facilitators with diverse lived experiences**



+



1. Detect a disparity  
in implementation



# Implementation / Healthcare Disparities

Significant differences between groups, not due to selection bias, in:

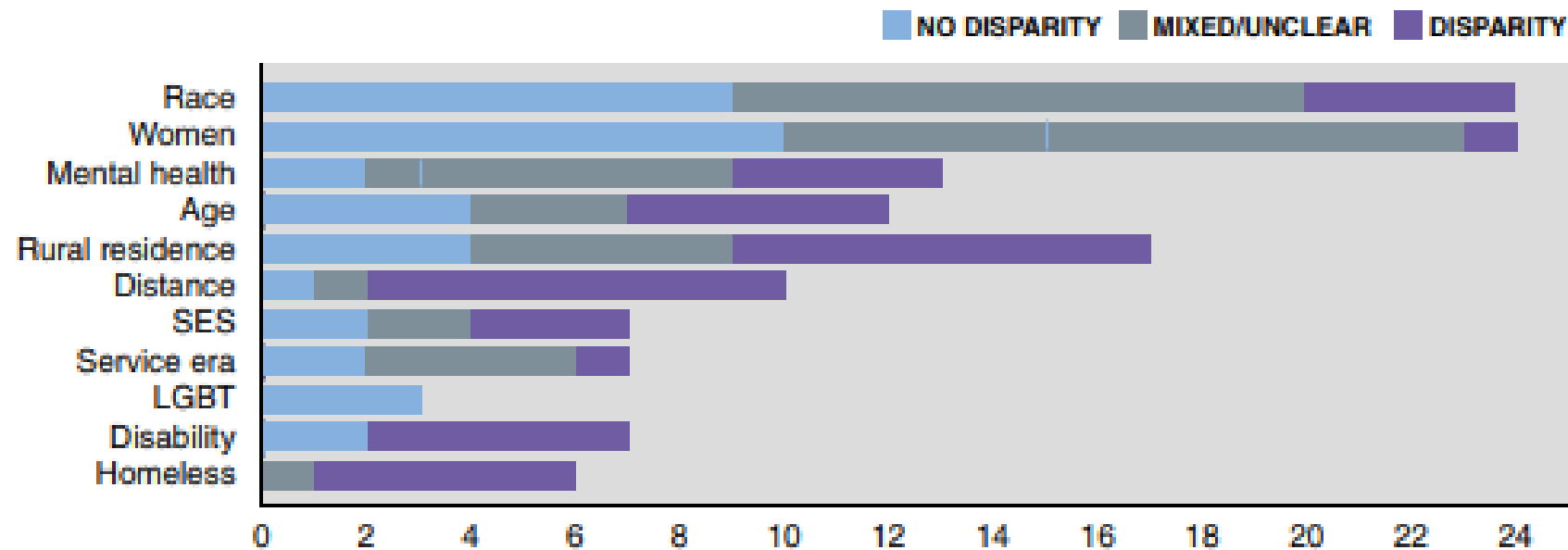
- access to,
- receipt of, or
- quality of, or
- outcomes of healthcare interventions.<sup>1</sup>

One group typically experiences societal disadvantage and marginalization.

# Healthcare Disparities in Receipt / Use in VHA

*Kondo et al*

*Medical Care* • Volume 55, Number 9 Suppl 2, September 2017



**FIGURE 4.** Evidence map: utilization by population. LGBT indicates lesbian, gay, bisexual, or transgender; SES, socioeconomic status.

# Disparities earlier in the continuum of care are often part of a cascade of injustice

Children of color screened less frequently for autism than White<sup>1</sup>



Diagnosed less frequently than White<sup>1</sup>



Treatment is delayed by 3 years<sup>2</sup>



Fewer specialty services, higher unmet services needs than White<sup>3</sup>

# Ask, analyze, and read to detect disparities

1

**Ask** stakeholders if there are patient groups who are “higher need,” “left out,” “underserved”

2

**Analyze** clinic data for key metrics across patient groups

3

**Read** existing reports on health conditions for your context, looking for any disparities by population

- County-level documents
- Hospital reports
- National reports



- + • 2. Understand why implementation disparity exists



Use a framework to explicitly focus on and organize determinants of implementation inequity: What are our barriers and why?

Find every implementation framework at the « D&I Models Webtool » [www.dissemination-implementation.org](http://www.dissemination-implementation.org))

 Implementation Science

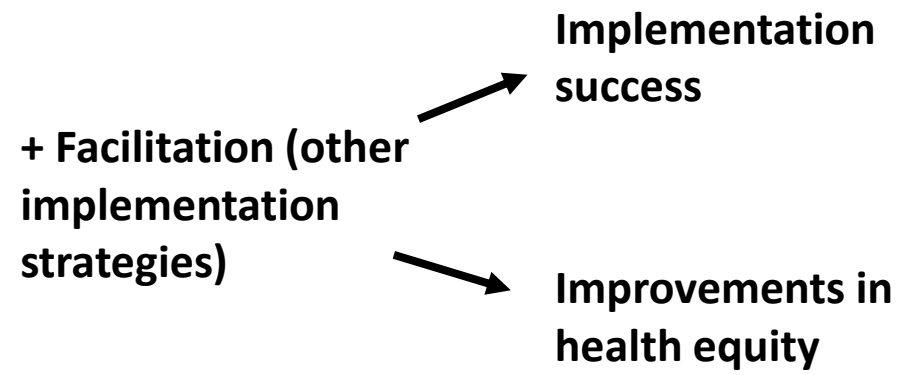
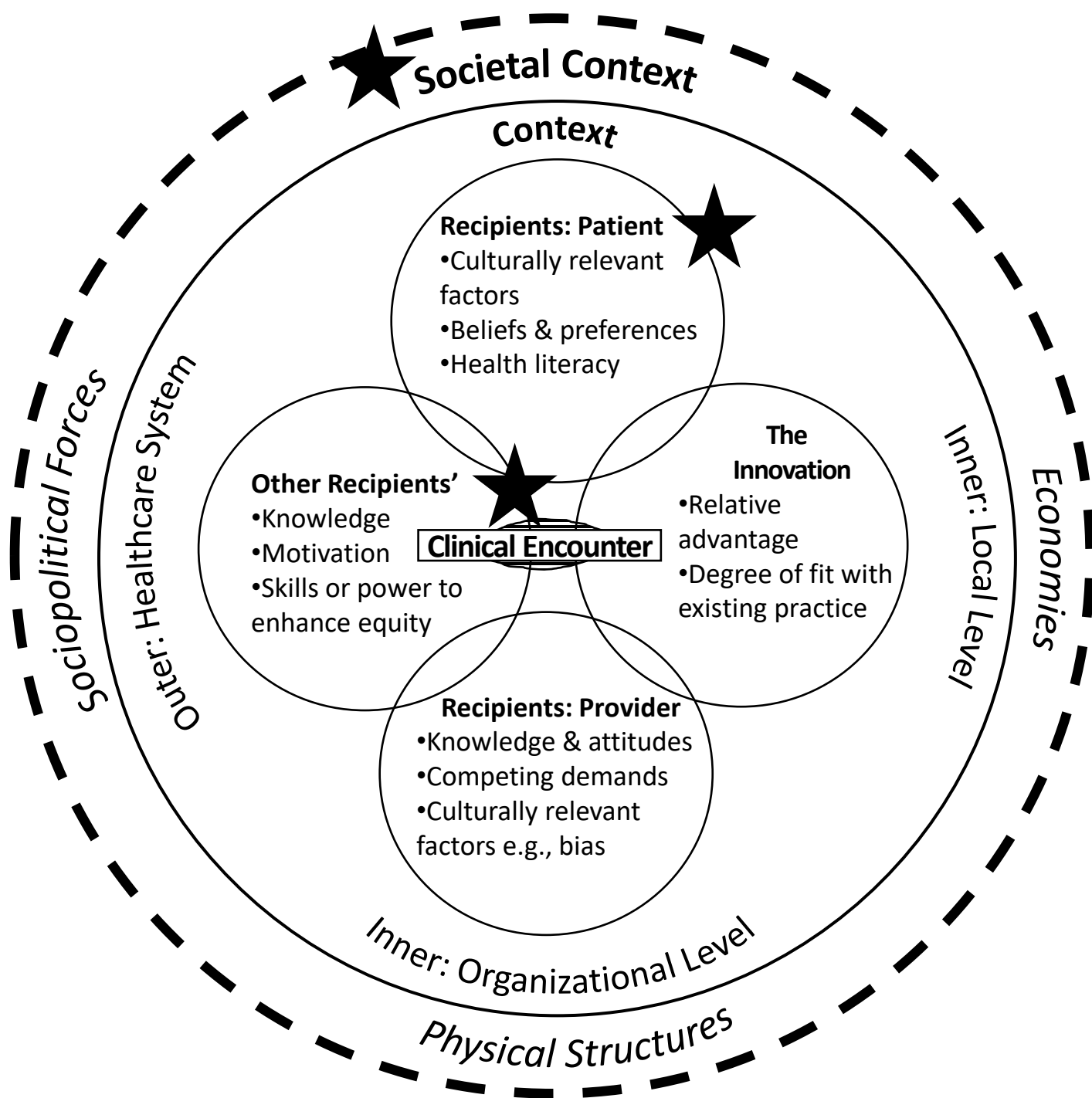
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Methodology | [Open Access](#) | [Published: 12 March 2019](#)

## The health equity implementation framework: proposal and preliminary study of hepatitis C virus treatment

[Eva N. Woodward](#) , [Monica M. Matthieu](#), [Uchenna S. Uchendu](#), [Shari Rogal](#) & [JoAnn E. Kirchner](#)

*Implementation Science* **14**, Article number: 26 (2019) | [Cite this article](#)



# Assess 3 health equity factors + typical implementation factors

- ★ 1. Culturally relevant factors of recipients (patients, providers, staff)
- ★ 2. Clinical encounter
- ★ 3. Societal context (economic factors, social norms, policies, laws, physical structures, social determinants of health)
- 4. Plus typical implementation factors (innovation itself, other recipient factors, inner context, healthcare system)

## Factor

### 1. Culturally Relevant Factors of Recipients

- Demographic match patient-provider
- Provider bias
- Patient mistrust
- Patient health literacy
- Many more

## Sample Measures and Methods

- Chart reviews to calculate demographic match patient-provider
- Implicit Association Test
- Medical Mistrust Index
- Health literacy scale: [PhenX Toolkit](#)
- Individual interviews

## Factor

### 2. Clinical Encounter



Surprise planning tool!

## Sample Measures and Methods

- Audio record encounters - Roter Interaction Analysis System
- Observe sample of encounters
- Interviews of patient and provider perceptions
- Chart review of documentation
- Interview Satisfaction Questionnaire

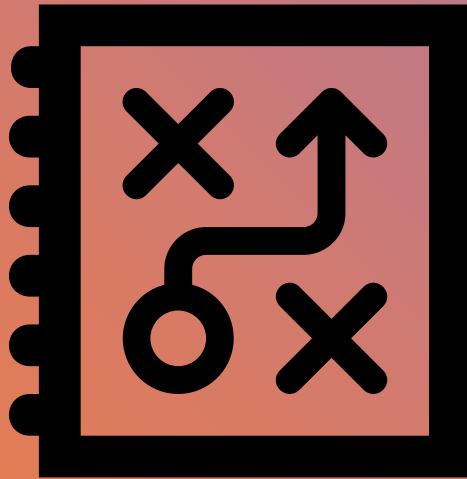
## Factor

### 3. Societal Context

- Economies
- Physical structures
- Sociopolitical forces
- Social determinants of health

## Sample Measures and Methods

- Insurance claims data
- Observation of physical structures
- Document review of organizational policies
- State-Level Racism Index
- Social determinants: [PhenX Toolkit](#)



+



3. Intervene on implementation disparity (using facilitation and other strategies)

# Equality

Facilitation as usual



# Equity

Facilitation tailored toward equity and justice







# Select, tailor, and monitor strategies that have preliminary or theoretical evidence they work

Some strategies to consider:

- Engage patients in the implementation effort<sup>1</sup>
- Adapt innovation for recipients experiencing disparity<sup>2</sup>
- Repair harm and address trust for people who have been marginalized<sup>3</sup>
- Enhance cultural competence and reduce unconscious bias of providers/staff
- Target barriers preventing organizations from addressing disparities or inequities<sup>4</sup>
- Enhance structural competence of clinics, medical centers, and systems<sup>5</sup>
- Monitor for changes that would signal disparity reduction or widening

1. Woodward et al., under review; [Glandon et al 2017](#)
2. [Baumann, Cabassa, Wiltsey Stirman 2017 book chapter](#)
3. [Shelton et al., 2021](#)
4. [Spitzer-Shohat & Chin 2019](#)
5. [Metzel & Hansen 2014; Shattuck, Willging, Green 2020](#)

# Breakout Discussions

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What is one next step for your focus on equity in healthcare delivery?

What will be your biggest challenge?

# Thank you for listening!

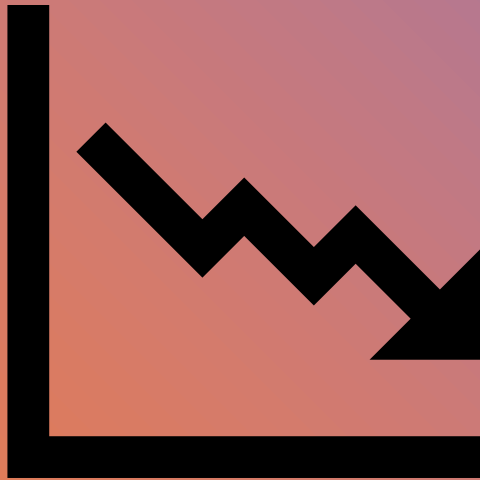
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Extra Slides with Other Notes  
of Interest



+

•

4. For researchers -  
Evaluate whether  
facilitation reduced  
disparities or improved  
equity

○

# 3 Types of Implementation Science Frameworks

1. Determinant - What are barriers and why?
2. Process – Planning: How is this thing going to get implemented?
3. Evaluation - Did implementation succeed or fail?




# Evaluation: Did it work? How did implementation affect equity outcomes?

PERSPECTIVE ARTICLE

Front. Public Health, 12 May 2020 | <https://doi.org/10.3389/fpubh.2020.00134>

## An Extension of RE-AIM to Enhance Sustainability: Addressing Dynamic Context and Promoting Health Equity Over Time

International Journal for  
Equity in Health

 Rachel C. Shelton<sup>1\*</sup>,  David A. Chambers<sup>2</sup> and  Russell E. Glasgow<sup>3,4</sup>

RESEARCH

Open Access

Some ideas in Table 3



Conceptual framework of equity-focused implementation research for health programs (EquIR)



See Table 3!

J. Eslava-Schmalbach<sup>1,2</sup>, N. Garzón-Orjuela<sup>1,2\*</sup> , V. Elias<sup>3</sup>, L. Reveiz<sup>3</sup>, N. Tran<sup>4</sup> and E. V. Langlois<sup>5</sup>



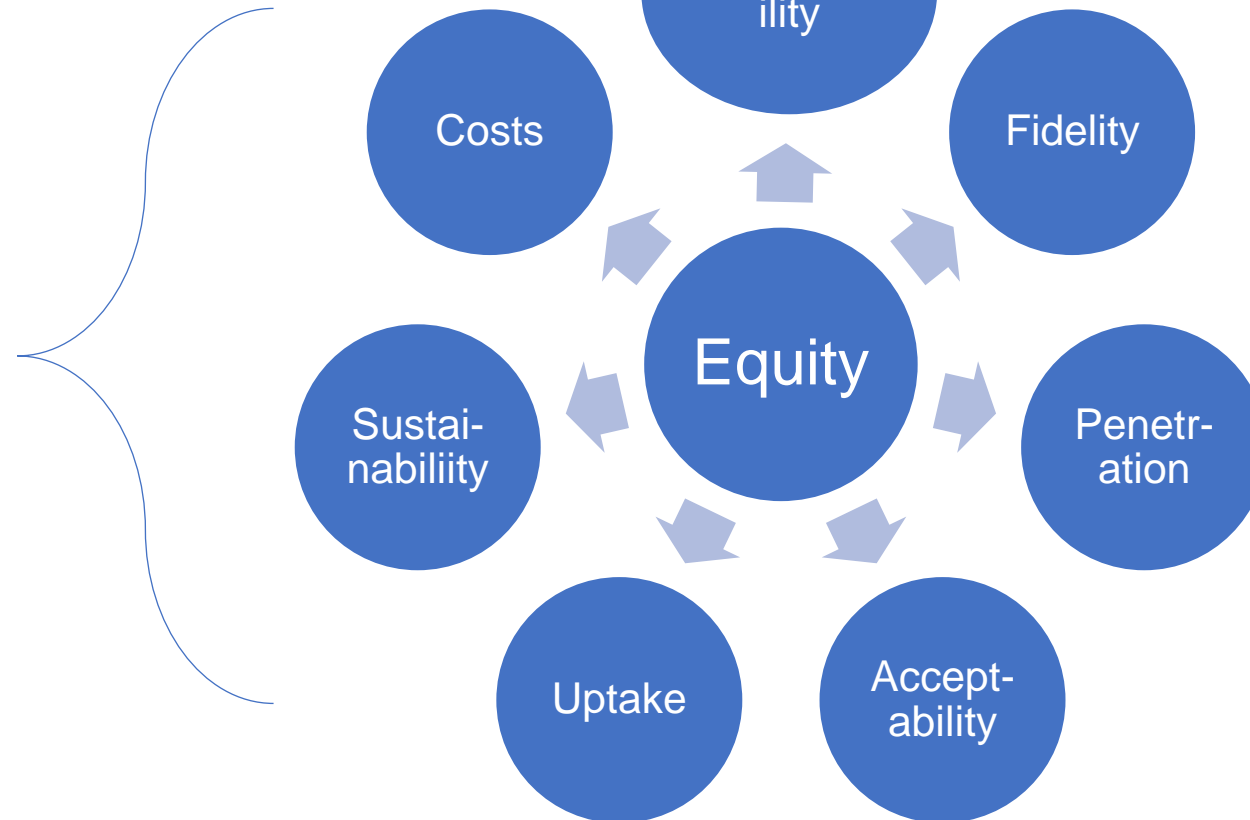
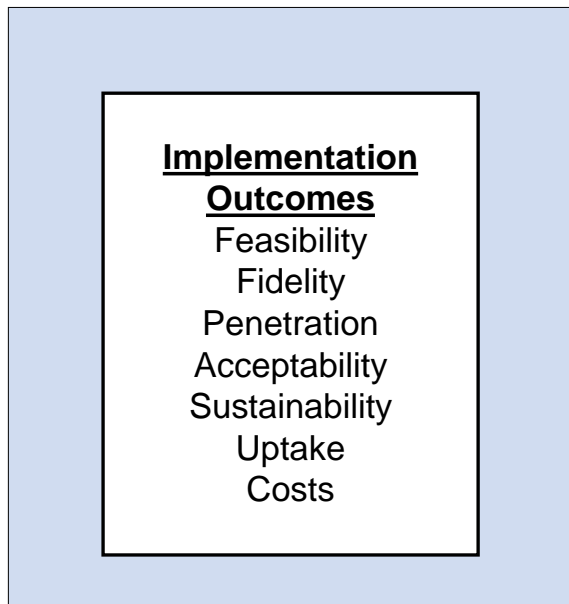
# Evaluation (continued)

Debate | [Open Access](#) | Published: 12 March 2020

## Reframing implementation science to address inequities in healthcare delivery

[Ana A. Baumann](#) & [Leopoldo J. Cabassa](#) 

*BMC Health Services Research* **20**, Article number: 190 (2020) | [Cite this article](#)



Example of understanding  
barriers to inequitable  
implementation

# Another Example if Needed



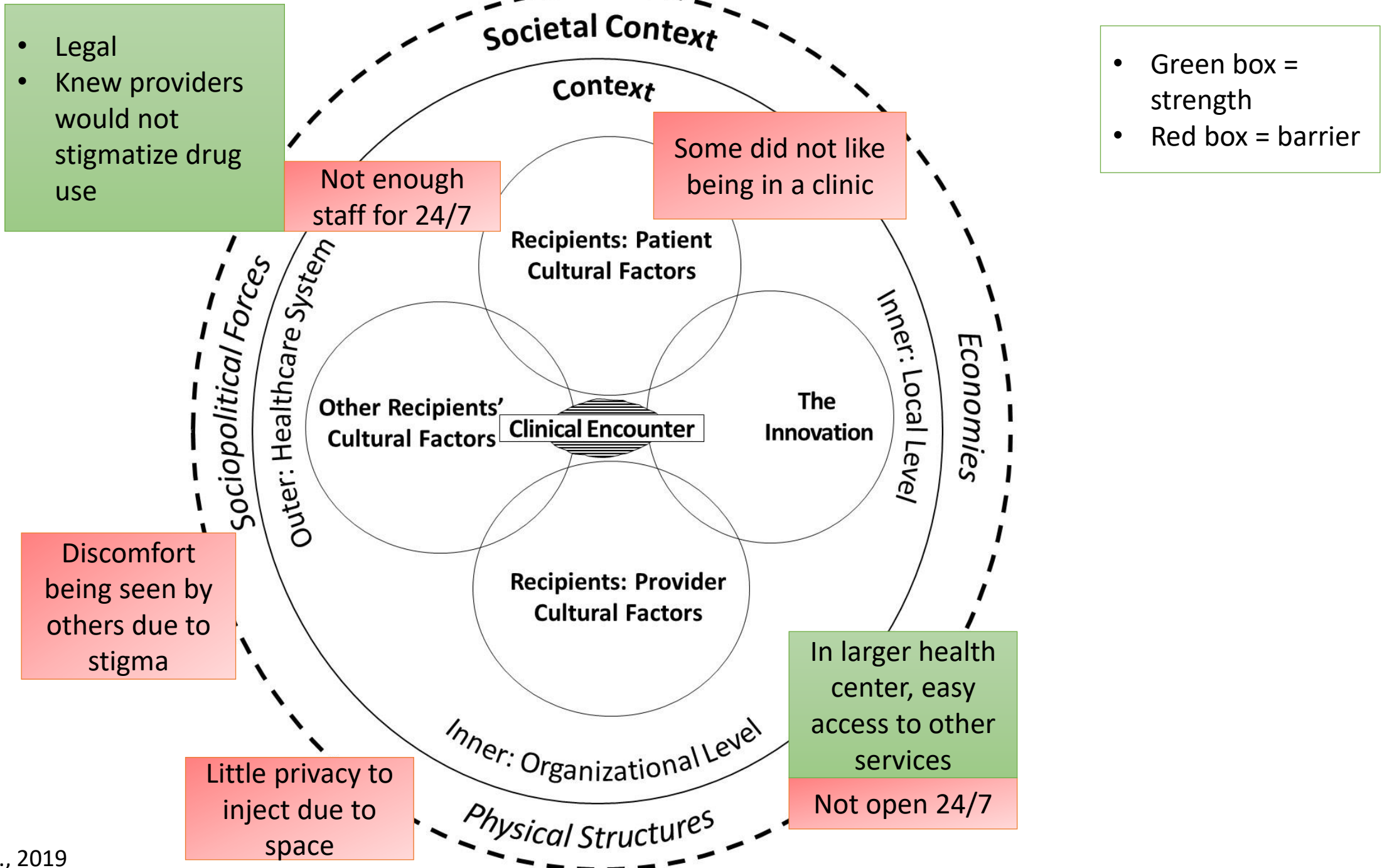
Health & Place  
Volume 61, January 2020, 102245



## “That's a double-edged sword”: Exploring the integration of supervised consumption services within community health centres in Toronto, Canada

Geoff Bardwell <sup>a, b</sup> ✉, Carol Strike <sup>c</sup>, Sanjana Mitra <sup>a, d</sup>, Ayden Scheim <sup>a, f</sup>, Lorraine Barnaby <sup>g</sup>, Jason Altenberg <sup>h</sup>, Thomas Kerr <sup>a, b</sup>

- Supervised services for people who inject drugs
- >50% Indigenous Canadians or people of color
- Ongoing implementation (process evaluation)



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For International Conference on Practice Facilitation, August 5 and 6, 2021

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