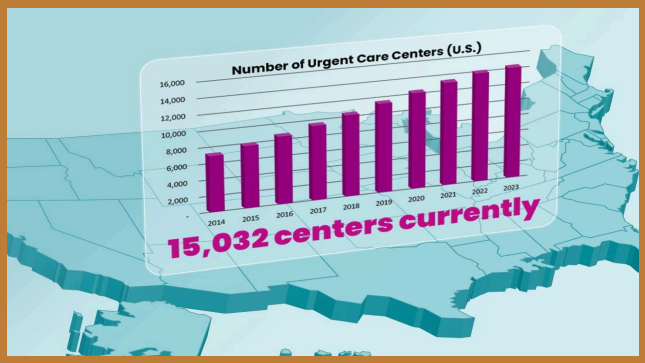
URGENT CARE



Toolkit

Health Disparities

HEALTH DISPARITIES IN URGENT CARE

EXECUTIVE SUMMARY

It has been estimated that only 10-20% of health outcomes are related to medical care a patient receives (Braveman & Gottlieb, 2014). The remaining portion has to do with environmental, social, and economic factors that each patient is subject to, or social determinants of health. These factors lead to disparities that prevent patients from having equitable outcomes. It is therefore incumbent on the clinician to consider more factors than simple disease processes when caring for patients. The role urgent care plays in the health care ecosystem continues to grow annually with more than 15,000 centers nationwide and an estimated 200 million patient visits per year (urgentcareassociation.org, n. d.). While we practice episodic care and acknowledge there are limitations to how much we can impact health disparities, it is important for clinicians to become familiar with the non-medical factors impacting outcomes.

The Health Disparities Taskforce of the College of Urgent Care Medicine was created in July of 2024 to further efforts for advancing health equity in urgent care. After creating a charter, our members agreed to create a toolkit to focus efforts on areas including health equity, social determinants of health, implicit bias, cultural competency, and health literacy all while engaging and partnering with others in the medical field who share our vision. The toolkit will include specific modules to train clinicians to enhance patient centered care for vulnerable populations. Content will include an explanation of

the problem, defining of terms, background information on each topic, and curated resources from experts to further advance knowledge of providing equitable and inclusive care. In addition, the toolkit advocates for robust data collection as a major component to address health disparities.

While some clinicians may be well versed in health equity, others may be hearing about these topics for the first time. Practicing with a health equity lens improves outcomes, enhances patient centered care, and impacts patient satisfaction (Ford-Gilboe et al., 2018). Urgent care is a unique practice setting with its own challenges for addressing health disparities. However, considering our reach, we collectively can have a great impact on patients who seek care in our practices from vulnerable groups. In our current state of healthcare, many patients lack a usual source of care and given primary care shortages in many communities, patients turn to urgent care for their healthcare needs. This toolkit is full of resources to guide the urgent care clinician to address health disparities.

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WELCOME LETTER

This toolkit is full of resources to guide the urgent care clinician to address health disparities. While we practice episodic care, and acknowledge there are limitations to how much we can impact health disparities, this toolkit offers several approaches that may not have been previously considered. Some clinicians may be extremely well versed in health equity and already apply some of the tools to everyday practice, while others might be hearing terms like cultural humility and social determinants of health for the first time. Wherever you are on that spectrum, welcome, and we hope that you find something to apply to your practice or reinforce the work you are already doing to address health disparities in our urgent care patients.

Practicing with a health equity lens improves outcomes, enhances patient centered care, and impacts patient satisfaction. However, it requires an unflinching reflection on our own personal practice habits and implicit biases. It requires a level of humility and a desire to do better now that we know better. Urgent care is a unique practice setting with its own challenges for addressing health disparities. However, considering that urgent care has an estimated 200,000,000 encounters a year, we collectively can have a great impact on patients who seek care in our practices from vulnerable groups. Even small changes can incrementally impact these populations for improved outcomes given the large reach of urgent care. In our current state of healthcare, many patients lack a usual source of healthcare and with primary care shortages in many communities, patients present to urgent care for their healthcare needs.

Patients experiencing health disparities are more likely to report negative encounters with the healthcare system. These small changes implemented across the industry may create more positive interactions for patients, improve feelings of inclusivity, and ultimately impact outcomes. You could be the clinician who restores someone’s faith in the system!! That seems worthwhile.

But ultimately, this is a call to action: find something in this toolkit that resonates with you and act on it. Maybe you will endeavor to improve your communication with your patients for health literacy, advocate for improved reimbursement from Medicaid so that more patients can access Urgent Care Services, or maybe you are ready to take a hard look at your personal attitudes that may be affecting the way you care for certain populations and commit to change. If you are an organization, perhaps you want your organization to begin collecting demographic data regarding race, ethnicity, sexual orientation, and gender identity and commit to sharing that data so that high quality urgent care research can identify gaps in caring for these populations.

Thank you in advance for the work you will do on behalf of our vulnerable patients. We look forward to partnering with you in this important work.

The Health Disparities Taskforce

INTRODUCTION

Urgent care serves as a vital component of the current healthcare ecosystem by delivering immediate and accessible healthcare to diverse populations. However, significant health disparities persist, influenced by social determinants, implicit bias, and systemic inequities that adversely affect community health and patient outcomes.

This project introduces an innovative toolkit designed to equip clinicians with essential strategies for recognizing, addressing, and reducing these disparities, ensuring equitable and patient-centered care in urgent care settings.

The toolkit's objectives are sixfold: to enhance clinician awareness of health disparities, to provide training in cultural competency and health literacy, to foster collaboration with organizations focused on health equity, to utilize data and research for identifying health inequities, to establish evidence-based best practices tailored for urgent care, and to evaluate the toolkit's impact on patient outcomes through a novel scoring system.

The framework, Partner, Educate, Engage, and Research (PEER,) emphasizes partnering with key organizations for systemic change, educating clinicians on patient-centered care, engaging in advocacy efforts within urgent care organizations, and promoting research on health disparities.

Urgent care is uniquely positioned to disrupt health inequities in real-time. This toolkit offers a practical, action-oriented framework that ensures every patient, regardless of background, receives high-quality, equitable care. By transforming awareness into action, we redefine the role of urgent care in advancing health equity and improving health outcomes for all communities.

QUINTUPLE AIM

This important framework in healthcare consists of five core goals: improving the individual experience of care, improving the health of populations, reducing cost of care, improving the experience of healthcare professionals, and advancing health equity as a distinct aim. The addition of health equity recognizes the need to address persistent disparities affecting underrepresented and marginalized groups, elevating it from other aims to a central focus of healthcare transformation.

The quintuple aim is increasingly adopted by health centers and health systems to guide organizational priorities with the explicit goal of preparing healthcare professionals to address all five aims in practice.The Quintuple Aim reflects a consensus in the medical literature that sustainable improvement in healthcare requires not only attention to patient outcomes, provider well-being, and cost, but also a deliberate commitment to equity in health and healthcare delivery.

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DEFINITIONS

Health Equity: RJWF 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.

CDC definition: Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health.

Health Disparity: Health disparities are preventable differences in the burden of disease, injury, violence, or opportunities. Health disparities are directly related to unequal distribution of social, political, economic, and environmental resources. (CDC)

Health Inequities: Health inequities are differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age. Health inequities are unfair and could be reduced by the right mix of government policies. (WHO)

Social Determinants of Health: Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. (HHS, healthy people 2030)

Cultural Competency: Cultural competence in health care describes the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs. (commonwealth fund)

Cultural Humility: Goes beyond cultural competency to admit that as clinicians we cannot become experts in every patient's lived experiences and cultures, but instead practice with empathy and humility, avoid assumptions, and treat patients with dignity regardless of background. It calls on the clinician to participate in self-reflection of our beliefs in order to develop beneficial partnerships with our patients. (Schiavo, R. (2023).

Embracing cultural humility in clinical and public health settings: a prescription to bridge inequities. *Journal of Communication in Healthcare*, *16*(2), 123–125. https://doi.org/10.1080/17538068.2023.2221556)

Personal Health Literacy: the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others. (HHS, HP 2030)

https://www.ahrq.gov/health-literacy/improve/precautions/index.html

Organizational Health Literacy: the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others. (HHS, HP 2030)

https://www.ahrq.gov/health-literacy/publications/ten-attributes.html#leadership

https://www.nih.gov/institutes-nih/nih-office-director/office-communications-public-liaison/clear-communication/health-literacy

Implicit Bias: attitudes and beliefs about race, gender, disability, sexual orientation, age, and other characteristics that operate outside of conscious decision making that can impact the way the clinician delivers care. These biases exist without intent and can lead to disparities in healthcare delivery.
https://www.nejm.org/doi/full/10.1056/NEJMp2201180

Urgent Care: bridges the gap between primary care and emergency care, providing evaluation and care for urgent, but not emergency conditions. An urgent care center typically delivers medical care for minor illnesses and injuries in an ambulatory medical facility outside of a traditional emergency department (ED), whether hospital-based or freestanding. (NERUCA)

HEALTH EQUITY

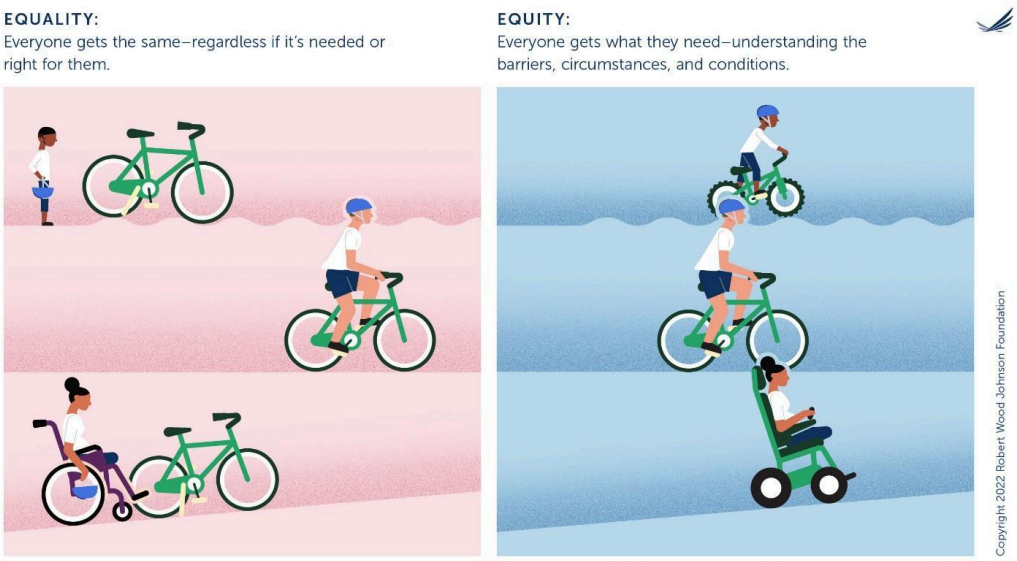
What is health equity?

The CDC defines health equity as “the state in which everyone has a fair and just opportunity to attain their highest level of health.”
https://www.cdc.gov/health-equity/what-is/index.html

Like it or not, health is often defined by the environments into which we are born, live, and grow. Not everyone has an equitable chance for their health to reach its full potential. Some of the reasons are environmental, some are structural, some are born out of years of misconceptions and bias. Some are obvious and others, many of us may not have considered, but they all limit the possibilities for our patients to reach their full health potential. The Robert Wood Johnson Foundation expands on the simplified CDC definition with some of these structural impacts to health equity.

> “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.”
>
> https://www.rwjf.org/en/insights/our-research/2017/05/what-is-health-equity-.html

A common misconception is that equality and equity are the same, they are not. We do our patients a disservice when we assume they need to be treated equally. Part of Health Equity is meeting patients where they are. Maybe they are in need of language assistance, culturally competent care, or perhaps financial assistance. As clinicians, we should focus on providing equitable care to our patients.



SOCIAL DETERMINANTS OF HEALTH

Social Determinants of Health or SDOH go hand in hand with health equity. These are the non-medical factors that influence health outcomes. While everyone experiences illness and disease, not everyone will have the same outcomes. Factors such as education, transportation, food insecurity, health literacy, access to care, structural racism, systemic bias will all impact health outcomes. Healthy People 2030 has defined 5 domains of SDOH.

Social Determinants of Health

Social Determinants of Health
Copyright-free

Healthy People 2030

IMPLICIT BIAS

Implicit or unconscious bias is defined as “bias in judgment and/or behavior that results from subtle cognitive processes that often operate at a level below conscious awareness and without intentional control.” This bias, while inadvertent, has profound impacts on patient provider interactions, patient centered care, and attitudes about healthcare. As clinicians we endeavor to care for our patients without bias, however, these unconscious ways that we interact with patients can impact outcomes.

In the landmark study Unequal Treatment released in 2003, it was clearly identified that certain groups of patients experience different care than others. Patients were treated with different levels of pain medications for similar injuries, fewer cardiac catheterizations were done, and fewer AA patients were referred from ICU to hospice. And this doesn’t just extend to racial and ethnic groups, studies have shown that this applies to gender, age, sexual orientation, and even physical characteristics and traits. Early in our medical careers as students, we have developed these shortcuts and stereotypes, but false beliefs have also been perpetuated in medicine. As recently as 2016, a study done at University of Virginia determined that at least 50% held false beliefs about pain perception amongst African American patients, a widely debunked theory. While we have taken oaths as clinicians to treat patients with fairness and dignity, it has been shown that clinicians do not experience any less implicit bias than the general population.

This has grown out of years of experiences, messaging, and stereotypes that all come together to create shortcuts in our brain for processing information. Unfortunately, many of these shortcuts are wrong and bias us in our decision making in ways that we are unable to recognize.

“Once doctors recognize that there are both conscious and subconscious forces at work in their relationships with patients, they can take steps to mitigate them.” (Seeing patients, p. 242)

While it may seem to be an oversimplification to say the way to change this is self-awareness, it is one of the few tools we have at this time. Some suggestion on how to overcome implicit bias include:

1. Research and make attempts to have a basic understanding of the cultures your patients come from.
2. Individuate your patients rather than see them as a stereotype.
3. Recognize and accept the power of unconscious bias. You are not immune.
4. Be aware of situations that may amplify your implicit bias
5. Know and apply the National CLAS standards for communication

6. Practice evidence-based medicine at all times.

Studies have shown that implicit bias training doesn't make much of a difference. It is difficult to overcome a lifetime of messages and stereotypes that are hardwired into our brains. This is the value of data and research, to expose our biases so that we can impact them in a meaningful way. We must be willing to take an unflinching look at our practice habits.

FRAMEWORK (PEER):

- **Partner:** Engage with key organizations to drive systemic change.
- **Educate:** Training in patient centered care with a focus on cultural competency, preferred language, LGBTQ+ Population and health literacy.
- **Engage:** Advocacy with constituent organizations of Urgent Care to support equity in urgent care.
- **Research:** Promote research on health disparities and best practices.

CULTURAL COMPETENCE

In 2003, the groundbreaking study *Unequal Treatment* was released, taking a look at health disparities in racial and ethnic minorities. The study identified that in almost every metric, racial and ethnic minorities experienced worse outcomes than their counterparts. An update to the study was released 20 years later which found that despite the identification of these disparities, little had changed in outcomes. Some of these disparities are caused by structural barriers like lack of insurance or SDoH, but even when controlling for such issues, these groups still experience worse health outcomes at a disproportionate level.

Culturally competent care has been viewed as a foundation to reducing disparities in marginalized groups. Cultural competence considers the whole patient including the contributions of language, religion, attitudes, beliefs, and behaviors to health outcomes. It is a complex dynamic that is not always easy to define. While some definitions of cultural competence have a narrow scope, including only racial and ethnic minorities, cultural competence includes 3 groups susceptible to health disparities including racial and ethnic minorities, patients with disabilities, and the LGBTQ+ population. Ultimately, cultural competence is meant to reduce the cultural, linguistic, stigmatizing, and physical barriers that interfere with healthcare delivery and prevent provision of equitable care.

Cultural competence exists at many levels of the health care delivery system. At the provider level, organization level, and system or policy level. The system level is beyond the scope of this discussion, however organizational and provider level cultural competence is relevant in the urgent care setting.

Clinician Level

Cultural Competence Training: The mainstay of cultural competence at the provider level is training. A universal approach to cultural competence has been suggested focusing on empathy, provider awareness, active listening, implicit bias, and behaviors leading to cultural insensitivity. Improving provider knowledge of health disparities common in different groups.

Patient Experience: Though very little research has been done to determine if health outcomes improve with culturally competent care, it has been shown to improve the patient experience which is important for adherence to treatment and follow up

Improved provider/patient interactions: Culturally Tailored interventions

Patient Safety: Organizational Level

Barrier Free Care: Consider cultural competence in navigation of your organization: Simplifying intake, extended hours, forms in patient preferred language. Leadership commitment to Cultural Competence. Hiring practices that consider the community. Provision of Interpreter Services.

LGBTQ+ CULTURAL COMPETENCY

The NIH recognizes the LGBTQ+ and sexual minority populations as a "health disparity population." At least 7% of the population identifies as LGBTQ+ and 1 in 5 members of Gen Z identify as a sexual and gender minority. While some patients have never had issues with access to care or faced discrimination in the health care space, others have had different experiences leading to avoidance of health care and health care providers. LGBTQ+ populations are more likely to report being in fair to poor health than their counterparts, have less private insurance coverage, and are less likely to report a usual source of care. Of those who report a usual source of care, **13% report that source is an urgent care** or retail clinic.

When interacting with clinicians, LGBTQ+ patients were more likely to report negative experiences (60% vs 31%), 12% have experienced discrimination, and 39% report being treated unfairly. LGBTQ+ patients report that clinicians dismiss their concerns, make assumptions about them, or assume they aren't truthful during the visit. 29% report issues with provider communication. These reports of negative interactions and discrimination lead some patients to delay care or avoid care altogether leading to adverse consequences and worse outcomes.

The clinician must be prepared to competently care for this diverse patient population who have unique health care considerations and potential history of poor interactions with the healthcare system.

LGBTQ+ Health Disparities

- Same Sex partners not eligible for health insurance
- Verbal/physical harassment
- Higher levels of Depression, Suicidality

- Higher levels of alcohol and tobacco use
- Risk of HIV and other STIs
- Unequal access to health care systems
- Lack of knowledgeable providers

Most health disparities are linked to discrimination and minority stress. However, this is exacerbated by past negative encounters with healthcare providers. Fears of being outed by healthcare professionals, and lack of cultural competence in providers.

In the past, the term cultural competency was used to refer to racial and ethnic minorities, however, more recently is has been used in relationship to LGBTQ+ populations. Cultural competence is defined as "the intricate integration of knowledge, skills, attitudes, and behaviors that improve cross-cultural communication and interpersonal relationships." Enhancing the four aspects of knowledge, skills, attitudes, and behaviors is the core of cultural competency with the goal of improved patient-provider interactions, improved outcomes, and more patient centered care.

It is estimated that on average, clinicians receive approximately 5 hours of training in the care of LGBTQ+ patients while in school. In fact, as many as 33% of professional training programs reported no specific training in LGBTQ+ specific medical care. Clinicians who are mid to late career may have not received any direct training on care of this population. A limited number of resources are available for post graduate professionals. The Agency for Healthcare Research and Quality has called for more specific guidelines and definition of cultural competency and LGBTQ+ populations. The agency has also asked for better assessments of the impact of cultural competency on patient-centered care and recommends more training for clinicians in this area. The results of lack of cultural competency vs. a clinician practicing with cultural competency are highlighted in Figure 1.

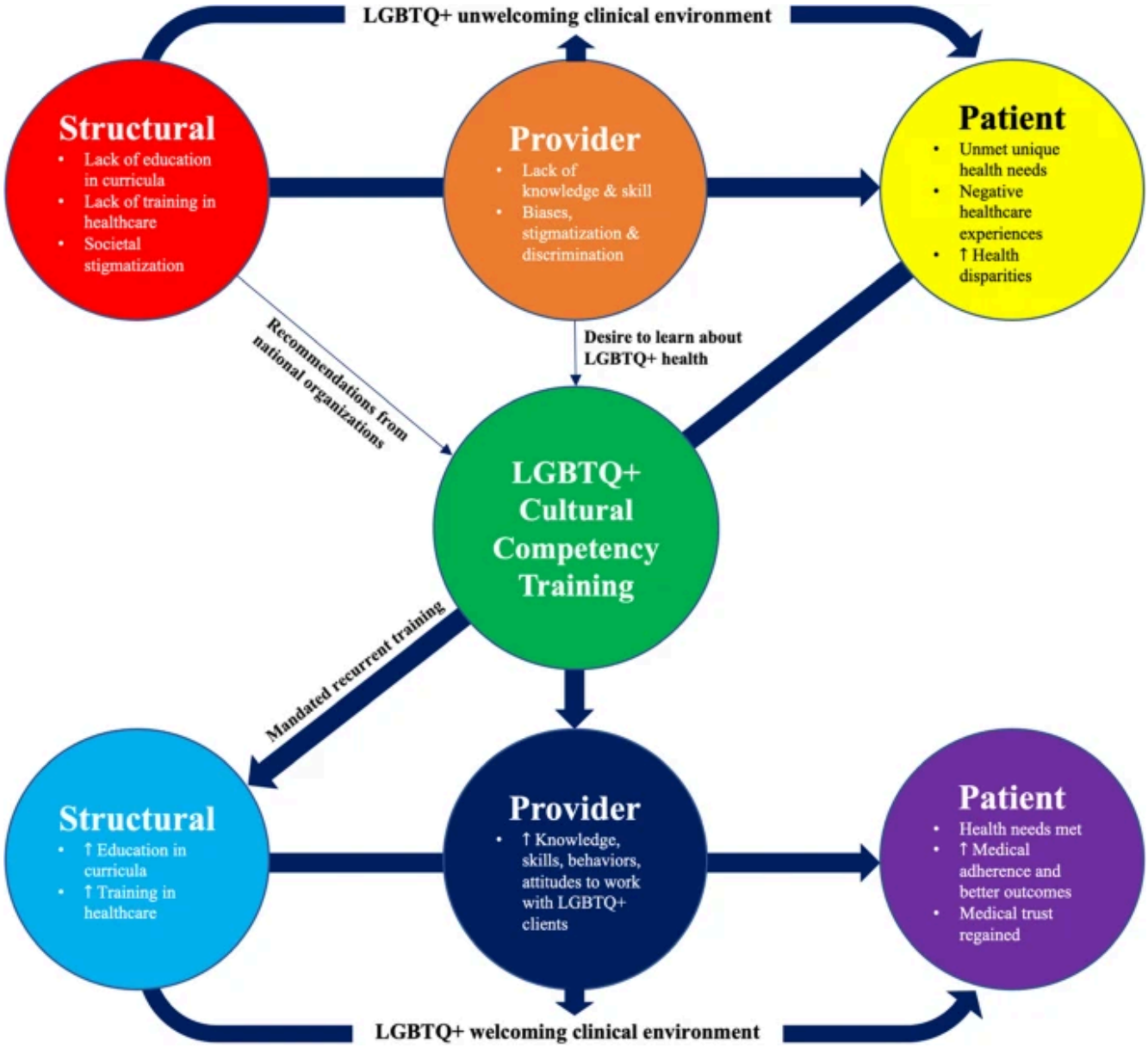

LGBTQ+ unwelcoming clinical environment
Structural
Lack of education in curricula
Lack of training in healthcare
Societal stigmatization
Provider
Lack of knowledge & skill
Biases, stigmatization & discrimination
Patient
Unmet unique health needs
Negative healthcare experiences
↑ Health disparities
Recommendations from national organizations
Desire to learn about LGBTQ+ health
LGBTQ+ Cultural Competency Training
Mandated recurrent training
Structural
↑ Education in curricula
↑ Training in healthcare
Provider
↑ Knowledge, skills, behaviors, attitudes to work with LGBTQ+ clients
Patient
Health needs met
↑ Medical adherence and better outcomes
Medical trust regained
LGBTQ+ welcoming clinical environment

Figure 1

How to Create an Environment of Inclusivity for LGBTQ+ Patients

Organizational level

1. Commitment to affirming care at all levels including forms, signage, and office practices
2. Post non-discrimination policies in the facility
3. Train non-clinical staff in cultural competency. Use the patient's chosen name and pronouns.
4. Patient forms should reflect inclusivity and diversity in patient demographics
5. Collect SOGI data on intake forms
6. Display brochures or materials on LGBTQ+ health topics with other patient information
7. Understand and adopt CLAS standards in the organization
8. Demonstrate ongoing leadership commitment to LGBTQ+ patient population

Clinician level

1. Educate clinicians on fostering a welcoming environment
2. Cultural competency training and awareness of LGBTQ+ health topics
3. Take detailed, nonjudgemental sexual histories on all patients
4. Reflect on your own attitudes that may impact your provision of care
5. When taking a history, ask open-ended questions. Instead of asking "Are you married?" ask "Do you have a partner?" or "Are you in a relationship?"
6. Understand that cultural competency is not a terminal training, but on ongoing process of education on cultural and health issues that are important to your LGBTQ+ patients
7. Be aware of community level resources for LGBTQ+ patients

Cultural competency training outcomes: Most training programs impacted knowledge. Very few changed attitudes. Impacting attitudes toward LGBTQ+ individuals and care should be a focus of future training programs and education. With a limited number of studies, very few had long term data on lasting impacts to practice.

HEALTH LITERACY

What is Health Literacy

Personal Health Literacy is the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

Organizational Health Literacy is the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

According to the National Assessment of Adult Literacy, only 12% of the US population would be considered proficient in Health Literacy.

The skill of critical appraisal also needs to be considered as more and more people seek medical information on social media and other sources that are not peer reviewed.

Healthy People 2030

While the Healthy People initiative has always included Health Literacy, in Healthy People 2030, Health Literacy is included as an overarching goal.

> ***"Eliminate health disparities, achieve improved health for all, and attain health literacy to improve the health and well-being of all."***

Six specific objectives have been identified in regard to Health Literacy

- Increase the proportion of adults whose health care provider checked their understanding — HC/HIT-01
- Decrease the proportion of adults who report poor communication with their health care provider — HC/HIT-02
- Increase the proportion of adults whose health care providers involved them in decisions as much as they wanted — HC/HIT-03
- Increase the proportion of people who say their online medical record is easy to understand — HC/HIT-D10
- Increase the proportion of adults with limited English proficiency who say their providers explain things clearly — HC/HIT-D11
- Increase the health literacy of the population — HC/HIT-R01

Navigating the increasingly complex medical system including scheduling, insurance, appointments, provider communication, digital communication, and follow up requires a level of literacy that many patients lack. Vulnerable populations are at even higher risk of experiencing challenges accessing and using the healthcare system. It is incumbent on clinicians and organizations to attempt to simplify these systems or provide support to effectively utilize services for best outcomes.

Health Literacy and Health Disparities

According to a fundamental study on Health Literacy by the US Institute of Medicine, 1/3 to ½ of the US population has low health literacy which is defined as a “limited capacity to obtain, process, and understand basic health information and services to make informed health decisions. This was confirmed by a follow up study in 2006.

Risks for Low Health Literacy are those in vulnerable populations, including:

- Older Adults
- Patients with disabilities
- Patient with lower socioeconomic status (SES)
- Racial and Ethnic minorities
- Patients with Limited English Language Proficiency
- Patients with limited education

Outcomes related to Low Health Literacy as compared to those with Adequate Health Literacy

- Medication errors
- Poor health
- Higher rate of chronic disease
- Two Fold increase in mortality rate
- More likely to experience health disparities in health and access to healthcare services
- Lower rates of screening and preventative services
- Experience a greater degree of unmet medical needs leading to increased ED utilization and hospitalization
- Poorer knowledge of disease process, medication adherence, and inadequate skills to manage their disease
- Less effective communication with healthcare professionals
- More passive during patient encounters and ask fewer questions
- Less ability to participate in Shared Decision Making
- Linked to excess health care expenditures of $100 billion annually

Some research even consider Health Literacy to be a SDoH because it is so tightly linked to health disparities. However, we should remember that these are not intrinsic qualities of vulnerable populations, but rather the outcome of structural inequalities and differences in exposures. Optimistically, improving Health Literacy has been shown to have a positive impact on SDoH and health outcomes, so it is worthwhile to focus on this topic even in Urgent Care. It is a powerful mediator of SDoH. Health Literacy can be viewed as a risk factor, whereby low levels contribute to poorer outcomes, but also as an asset, meant to empower individuals in managing their health.

Suggestions to improve for Health Literacy in the Urgent Care Setting

1. **Do not make assumptions** regarding a patient's level of understanding, use universal precautions in Healthcare communications
2. **Use simple language** that is free from medical jargon. When in doubt use a Plain English dictionary
3. **Speak slowly**, ensuring that your communication is respectful and clear
4. **Use "Teach Back"** method to determine patient understanding of visit. Ask them in their own words to repeat information back to you.
5. **Ask open ended questions** rather than Yes/No
6. **Use models or drawings** rather than only verbal communication to demonstrate concepts to patients.
7. Communicate in the patient's **preferred language**

RESEARCH AND DATA

"What gets measured gets improved." -Peter Drucker

Brilliant in its simplicity, but more difficult to achieve, robust data collection, analysis, and research have been identified as significant ways to impact Health Disparities. We can make many assumptions about the populations we are serving, but unless we collect data, health disparities will go unnoticed and cannot be addressed. We need data to determine where disparities exist, how to create opportunities to improve, and measure progress. In other words, **identify, investigate, and intervene**. This strategy has been suggested by the American Hospital Association as a basis for using data to address health disparities.

> **Identify:** Use data to find disparities and inequities. This requires robust data, and without it, inequities remain unseen
>
> **Investigate:** Use data, root cause analysis, and research
>
> **Intervene:** Set goals, implement programs for change, measure outcomes and track progress

In addition, organizations should compare groups based on quality indicators and benchmarks. This is another opportunity in urgent care, as few widely accepted benchmarks and metrics have been universally adopted and tracked.

Recognizing that not every patient experiences the health care system the same way, collecting and analyzing data can determine where inequities exist and create

accountability. This also creates awareness that certain populations face greater challenges with health and healthcare access that can adversely affect outcomes. The most recent and obvious example of this was during the COVID-19 pandemic when morbidity and mortality were significantly different in certain populations vs. the general population.

The CMS Framework for Health Equity has identified the expanded collection, reporting, and analysis of standardized data as its first priority. The AHRQ emphasizes not only collecting data, but collecting in a cohesive way so that data is able to be used by other entities. Urgent care should follow the example of both of these agencies and commit to collecting data and utilizing it across the industry to impact health disparities.

Role of research in Health Equity

It has been estimated that only 10-15% of outcomes are directly related to medical care received. The remaining influencers are environment, health habits, and social determinants of health. So why is so little funding and research directed to these other drivers? In the previous section we discussed the importance of data collection and analysis. This is a limitation to research. Most health disparities are tied to quantitative and qualitative elements. If we already have limited success in collecting the most basic data, adding qualitative factors will add further complexities, especially in the setting of urgent care.

In addition, health disparities populations are impacted by social factors, increased rates of chronic disease, limited access to care, worse health outcomes, and discrimination in the healthcare system. Thus, research would need to focus on the interplay between inequities in the system, along with biological and social factors that contribute to health outcomes. It is no longer enough to simply recognize health disparities; we need to determine ways to move beyond recognition to intervention.

Important Considerations for research:

The size of the disparity identified

Is there an actionable intervention

Has root cause been identified

Has health information and data from EHR been fully leveraged

How can we address systemic issues in a meaningful way

Topics to consider for research in urgent care would include prescribing disparities, bounce backs, utilization of imaging and point of care testing, and patient experience surveys in identified populations.

Research should be aimed at identifying gaps in our current understanding of health disparities and promoting actionable interventions for improved outcomes. Health equity should be viewed as a fundamental right, and more and more organizations are looking at outcomes with a health equity lens.

Challenges to data collection

- Reluctance of staff to collect data on race, ethnicity, preferred language, sexual orientation, and gender identity
- Reluctance of patient to answer questions related to race, ethnicity, preferred language, sexual orientation, and gender identity.
- No consistent structure for data collection.
- A major driver of health disparities are Social Determinants of Health and Urgent Care is not set up as an easy place to collect that type of data
- Bias in data collection
- Incomplete data collection
- Lack of medical home leading to fragmented data collection
- Demographics and pertinent data is collected in one system that doesn't fully integrate with EHR

MEASUREMENT TOOL

What is this tool?

This toolkit is a resource for all healthcare professionals working in Urgent Care settings. It serves as a practical guide to promote initiatives focused on health equity in Urgent Care.

How to use this Health Equity assessment tool:

This measurement tool is designed for individual and/or organizational use, serving as a baseline and for tracking progress as you work towards addressing health equity within your organization. It includes a scoring system that identifies specific areas where the organization can focus efforts and decide on strategies for improvement short-term, mid-term, and long-term.

This tool is not intended to provide a specific score reflecting achievement in health equity, but to guide your organization in domains that can reduce health disparities.

Topic 1: Your Urgent Care has clear, shared commitments to health equity such as health equity statements, resources dedicated to health equity, and employees committed to health equity and the community they serve.				
Pre-Contemplation Score=1	Preparation Score=2	Action Score=3	Maintenance Score=4	Rating
My Urgent Care does not have any health equity commitments	My urgent care has begun discussions about health equity but has not made any clear or shared commitments	My urgent care has some commitment to health equity but has no resources dedicated to health equity	My urgent care has integrated their commitment to health equity into our practice and has dedicated resources to address health equity	Select your Score. ☐ Score=1 ☐ Score=2 ☐ Score=3 ☐ Score=4
Topic 2: Your Urgent Care has health equity embedded across the organization's operational practices with clear goals and metrics.				
Pre-Contemplation Score=1	Preparation Score=2	Action Score=3	Maintenance Score=4	Rating
Health equity is not a part of operational practices in my urgent care	Discussions regarding integrating health equity into our operational	Health equity is expected to be a part of our operational practices, but	My urgent care has integrated health equity across our entire	Select your Score. ☐ Score=1 ☐ Score=2

	practices have begun	implementation is not yet complete	practice and operations	☐ Score=3 ☐ Score=4
Topic 3: Your Urgent Care collects and analyzes disaggregated patient data across racial/ethnicity groups including language (REAL Data)				
Pre-Contemplation Score=1	Preparation Score=2	Action Score=3	Maintenance Score=4	Rating
My urgent care does not collect or analyze patient data on race, ethnicity, or language	My urgent care has begun discussions about collecting data on patient race, ethnicity, or language	My urgent care has begun collecting some data on patient race, ethnicity, or language	My urgent care collects and analyzes patient data regarding race, ethnicity, and language on at least 95% of patients	Select your Score. ☐ Score=1 ☐ Score=2 ☐ Score=3 ☐ Score=4
Topic 4: Your Urgent Care collects and analyzes disaggregated patient data on Sexual Orientation and Gender Identity (SOGI Data)				
Pre-Contemplation Score=1	Preparation Score=2	Action Score=3	Maintenance Score=4	Rating
My urgent care does not collect or analyze patient SOGI data	My urgent care has begun discussions about collecting patient SOGI data	My urgent care has begun collecting some patient SOGI data	My urgent care collects and analyzes patient SOGI data on at least 95% of patients	Select your Score. ☐ Score=1 ☐ Score=2 ☐ Score=3 ☐ Score=4
Topic 5: Your Urgent Care shares collected, disaggregated patient data with other organizations				
Pre-Contemplation Score=1	Preparation Score=2	Action Score=3	Maintenance Score=4	Rating
My urgent care does not share collected, disaggregated patient data with other organizations	My urgent care has begun discussions about sharing collected, disaggregated patient data with other organizations	My urgent care has begun to share some collected, disaggregated patient data with other organizations	My urgent care collects and shares disaggregated patient data with other organizations	Select your Score. ☐ Score=1 ☐ Score=2 ☐ Score=3 ☐ Score=4
Topic 6: Your Urgent Care has identified vulnerable populations at greater health risk				
Pre-Contemplation Score=1	Preparation Score=2	Action Score=3	Maintenance Score=4	Rating

My urgent care has not identified vulnerable populations at greater health risk in our community	My urgent care has begun discussions about how to identify vulnerable populations in our community	My urgent care has started to identify vulnerable populations in our community	My urgent care has identified vulnerable populations in our community to address their specific healthcare needs	Select your Score. ☐ Score=1 ☐ Score=2 ☐ Score=3 ☐ Score=4
Topic 7: Your Urgent Care has established partnerships with other healthcare organizations, community groups, and other stakeholders representing vulnerable populations or groups at greater health risks				
Pre-Contemplation Score=1	Preparation Score=2	Action Score=3	Maintenance Score=4	Rating
My urgent care has not established any partnerships or engaged with any community based organizations or stakeholders	My urgent care has begun discussions to engage with and establish partnerships with community based organizations or stakeholders	My urgent care has started to engage with and establish partnerships with community based organizations or stakeholders	My urgent care regularly engages and partners with community based organizations and stakeholders	Select your Score. ☐ Score=1 ☐ Score=2 ☐ Score=3 ☐ Score=4
Topic 8: Clinicians in your Urgent Care have been trained in implicit bias, cultural competency, and health literacy				
Pre-Contemplation Score=1	Preparation Score=2	Action Score=3	Maintenance Score=4	Rating
My urgent care has no training available for clinicians in health equity topics including implicit bias, cultural competency, and health literacy	My urgent care has started discussing training for clinicians in health equity topics including implicit bias, cultural competency, and health literacy	My urgent care has established some training in health equity topics including implicit bias, cultural competency, and health literacy	All clinicians in my urgent care are trained in health equity topics including implicit bias, cultural competency, and health literacy	Select your Score. ☐ Score=1 ☐ Score=2 ☐ Score=3 ☐ Score=4
Topic 9: Your Urgent Care utilizes your Electronic Health Record (EHR) to identify and address health disparities in your practice				
Pre-Contemplation Score=1	Preparation Score=2	Action Score=3	Maintenance Score=4	Rating

My urgent care does not utilize our EHR to address health disparities	My urgent care has started discussing how to use our EHR to address health disparities	My urgent care sometimes utilizes our EHR to analyze and address health disparities	My urgent care fully utilizes our EHR to perform data analytics to identify and address health disparities in our practice	Select your Score. ☐ Score=1 ☐ Score=2 ☐ Score=3 ☐ Score=4
Topic 10: My urgent care incorporates practice cultural competence, inclusivity, and usage of preferred language into patient experience surveys				
Pre-Contemplation Score=1	Preparation Score=2	Action Score=3	Maintenance Score=4	Rating
My urgent care does not consider health equity in patient experience surveys	My urgent care has started discussing inclusion of health equity in patient experience surveys	My urgent care uses some health equity metrics in patient experience surveys	My urgent care has fully incorporated health equity metrics into patient experience surveys	Select your Score. ☐ Score=1 ☐ Score=2 ☐ Score=3 ☐ Score=4

LIST OF RESOURCES

Health Equity

- https://www.rwjf.org/en/insights/our-research/2017/05/what-is-health-equity-.html
- https://www.ama-assn.org/about/ama-center-health-equity
- https://www.nationalcollaborative.org/about-us/partners-and-coalitions/
- https://jamanetwork.com/journals/jama/fullarticle/2788483

Implicit Bias

- https://implicit.harvard.edu/implicit/takeatest.html
- https://www.chcs.org/media/Words-Matter-Strategies-to-Reduce-Bias-in-Electronic-Health-Records_102022.pdf
- https://www.ihi.org/library/blog/how-reduce-implicit-bias#:~:text=Strategies%20to%20Reduce%20Implicit%20Bias&text=Counter%2Dstereotypic%20imaging%20%E2%80%94%20Imagining%20the,doctor's%20office%20or%20health%20center)
- https://thinkculturalhealth.hhs.gov/clas/standards
- https://news.virginia.edu/content/study-links-disparities-pain-management-racial-bias

Cultural Competence

- https://thinkculturalhealth.hhs.gov/education/physicians
- https://thinkculturalhealth.hhs.gov/education (for administrators)
- https://www.clchpa.org/#welcome (self assessment for culturally competent care)

LGBTQ+ Cultural Competence

- https://www.lgbtqiahealtheducation.org/courses/foundations-of-lgbtqia-health/
- https://www.lgbtqiahealtheducation.org/courses/foundations-of-lgbtqia-health-for-clinicians/
- https://www.lgbtqiahealtheducation.org/courses/achieving-health-equity-for-lgbtqia-people-2020/
- https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/lgbt

- https://www.kff.org/report-section/lgbt-peoples-health-status-and-access-to-care-issue-brief/
- https://www.acpjournals.org/doi/10.7326/M14-2482
- https://www.lgbtqiahealtheducation.org/wp-content/uploads/2021/05/Ten-Strategies-for-Creating-Inclusive-Health-Care-Environments-for-LGBTQIA-People-Brief.pdf

Health Literacy

- https://www.ahrq.gov/health-literacy/improve/precautions/tool4e.html (plain language dictionary)
- https://www.ahrq.gov/health-literacy/improve/precautions/tool4b.html (self assessment tool for patient communication)
- https://www.chcs.org/resource/what-is-health-literacy/
- https://www.nnlm.gov/guides/intro-health-literacy
- https://www.chcs.org/resource/improving-health-literacy-for-more-equitable-health-outcomes/
- https://thinkculturalhealth.hhs.gov/clas/standards

Research and Collecting Data

- https://www.cms.gov/about-cms/agency-information/omh/downloads/data-collection-resources.pdf
- https://www.ihi.org/library/blog/create-data-infrastructure-improve-health-equity#:~:text=Provide%20Staff%20Training%20and%20Support,patients%20to%20collect%20REaL%20data.
- https://assets2.hrc.org/files/assets/resources/Tip_Sheet_for_Collecting_SOGI_Data.pdf
- https://www.lgbtqiahealtheducation.org/publication/ready-set-go-a-guide-for-collecting-data-on-sexual-orientation-and-gender-identity-2022-update/

Disclaimer

This Health Disparities Toolkit is a **work in progress** and is currently under development. The content has not yet undergone peer review, and portions may be revised or expanded as new evidence, guidelines, and expert feedback become available.

The toolkit is intended as an **educational and reference resource** to support clinicians, educators, and healthcare leaders in addressing health disparities and advancing equitable care. It should not be considered a definitive or final source of guidance at this stage.

We welcome engagement, feedback, and collaboration as we continue to refine and strengthen this resource. Our goal is to ensure that the final version reflects the most current evidence and best practices while remaining practical and impactful in supporting high-quality, equitable care for all patients.