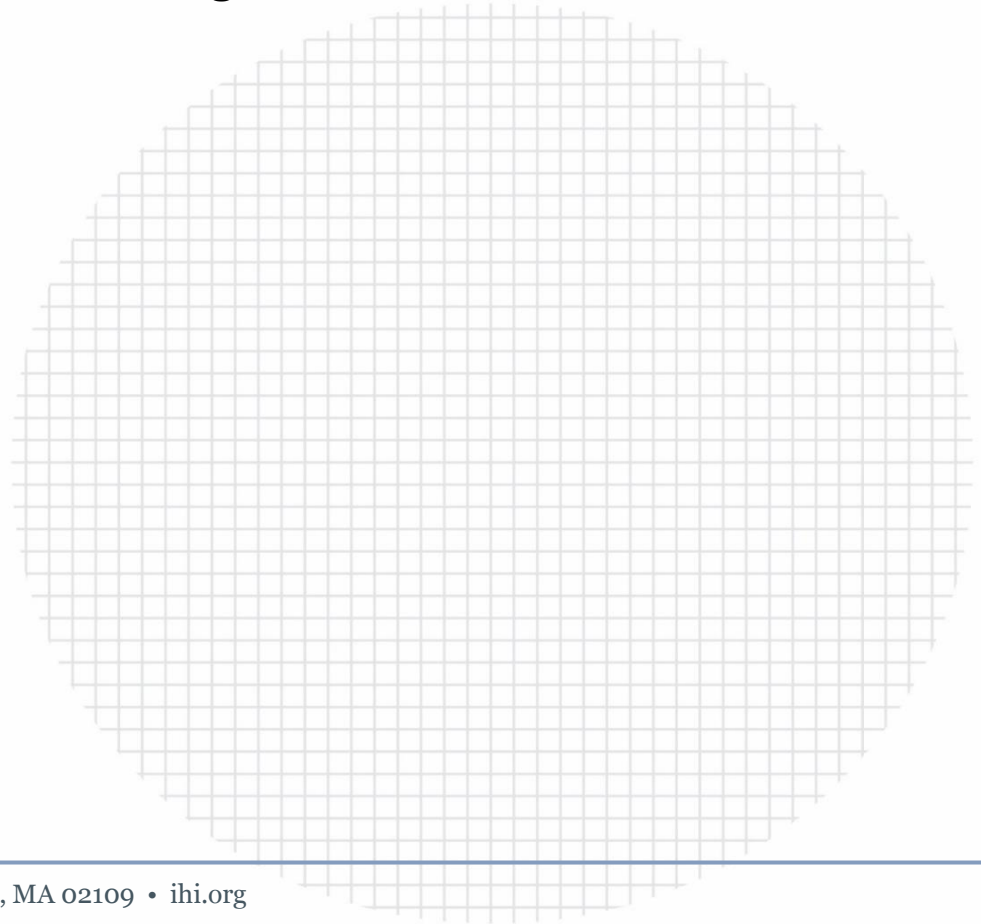




Improving Health Equity: Eliminate Racism and Other Forms of Oppression

Guidance for Health Care Organizations



AN IHI RESOURCE

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IHI has deep appreciation for the eight health care organizations and individuals working with us in the Pursuing Equity initiative: Brigham and Women's Hospital Department of Medicine and Southern Jamaica Plain Health Center (Jamaica Plain, Massachusetts); HealthPartners (Bloomington, Minnesota); Henry Ford Health System (Detroit, Michigan); Kaiser Foundation Health Plan and Hospitals (Kaiser Permanente) (Oakland, California); Main Line Health (Newtown Square, Pennsylvania); Northwest Colorado Health (Steamboat Springs, Colorado); Rush University Medical Center (Chicago, Illinois); and Vidant Health (Greenville, North Carolina).

Without their pioneering work and generosity in sharing what they are learning, this guide would not be possible. The authors are also grateful for the thought leadership provided by IHI leaders and faculty for the Pursuing Equity initiative, and we thank Jane Roessner and Val Weber of IHI for their guidance in developing and editing this guide.

The initiative aimed to reduce inequities in health and health care access, treatment, and outcomes by implementing comprehensive strategies to create and sustain equitable health systems. The eight health systems — diverse in size, geographic location, and patient populations served — worked with IHI to apply practical improvement methods and tools, spread ideas in peer-to-peer learning, and disseminate results and lessons to support an ongoing national dialogue and action for improving health equity.

For more than 25 years, the Institute for Healthcare Improvement (IHI) has used improvement science to advance and sustain better outcomes in health and health systems across the world. We bring awareness of safety and quality to millions, accelerate learning and the systematic improvement of care, develop solutions to previously intractable challenges, and mobilize health systems, communities, regions, and nations to reduce harm and deaths. We work in collaboration with the growing IHI community to spark bold, inventive ways to improve the health of individuals and populations. We generate optimism, harvest fresh ideas, and support anyone, anywhere who wants to profoundly change health and health care for the better. Learn more at ihi.org.

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Executive Summary

Inequities in health and health care persist despite improved medical treatments and better access to care. Health care organizations have a critical role to play in improving health equity for their patients, communities, and employees. In 2016 the Institute for Healthcare Improvement (IHI) published *Achieving Health Equity: A Guide for Health Care Organizations*, a white paper that presents a five-component framework to guide health systems in their efforts to improve health equity. Subsequently, in 2017, IHI launched the Pursuing Equity initiative to learn alongside eight US health care organizations that used the framework to identify and test specific changes to improve health equity.

This guide describes strategies and lessons learned from the eight health care organizations that have tested changes in the framework's fourth component: Eliminate Racism and Other Forms of Oppression.

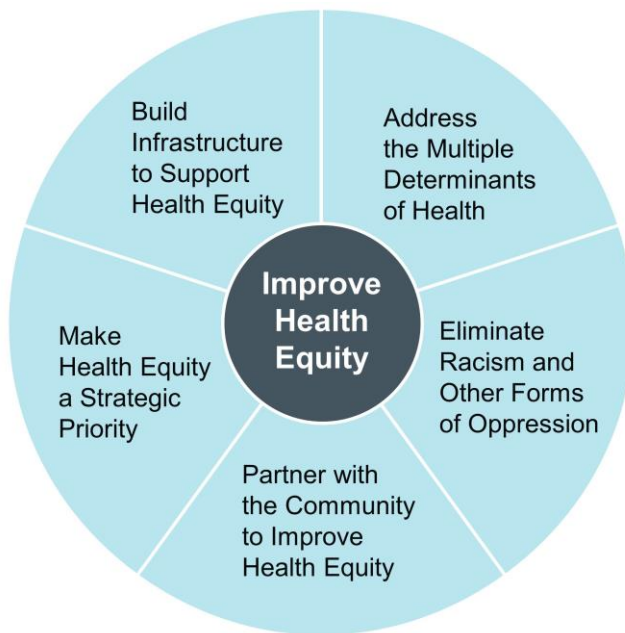
The guide includes:

- **Five strategies** for eliminating racism and other forms of oppression in health care organizations;
- **Examples of changes** the eight Pursuing Equity organizations have tested; and
- **Common challenges** that arise and strategies for mitigating them.

Introduction

In April 2017 the Institute for Healthcare Improvement (IHI) launched the two-year Pursuing Equity initiative to learn alongside eight US health care delivery systems that are working to improve equity at their organizations. The five-component framework presented in the IHI White Paper, *Achieving Health Equity: A Guide for Health Care Organizations*,¹ serves as the initiative's theory for how health care organizations can improve health equity. IHI continues to update and refine this theory based on learning in the initiative and the experience of the eight organizations; for example, we have updated some terminology in the original framework to reflect additional learning and clarity (see Figure 1).

Figure 1. IHI Framework for Health Care Organizations to Improve Health Equity



- **Make Health Equity a Strategic Priority**

Organizational leaders commit to improving health equity by including equity in the organization's strategy and goals. Equity is viewed as mission critical — that is, the mission, vision, and business cannot thrive without a focus on equity.

- **Build Infrastructure to Support Health Equity**

Operationalizing a health equity strategy requires dedicated resources, including human resources and data resources, as well as an organizational infrastructure.

- **Address the Multiple Determinants of Health**

Health care organizations must develop strategies to address the multiple determinants of health, including health care services, organizational policies, the organization's physical environment, the community's socioeconomic status, and encouraging healthy behaviors.

- **Eliminate Racism and Other Forms of Oppression**

Health care organizations must look at their systems, practices, and policies to assess where inequities are produced and where equity can be proactively created.

- **Partner with the Community to Improve Health Equity**

To support communities to reach their full health potential, health care organizations must work in partnership with community members and community-based organizations that are highly engaged with community members.

IHI developed a guide for each of the five components of the equity framework. There is not a sequential order for using the guides, but it is important to note that work in all five components is needed to improve health equity. Guides for the other four framework components are available on IHI's website.²

How to Use This Guide

This guide describes strategies and lessons learned from the eight health care organizations participating in the Pursuing Equity initiative that have tested changes in the framework's fourth component: Eliminate Racism and Other Forms of Oppression. Lessons learned, resources, and examples from the participating health care delivery systems are described.

Five strategies for eliminating racism and other forms of oppression in health care organizations have emerged:

- Understand the historical context for racism and other forms of oppression;
- Address institutional racism and its impact on health equity through culture and communication;
- Establish policies and practices to promote workforce diversity and racial equity;
- Implement business practices that support and promote racial equity; and
- Improve clinical processes and outcomes to narrow equity gaps and improve equity for all.

The guide is organized by these five strategies and includes real examples, tips, and tools. We encourage you to read a section with your team and discuss where your organization may have opportunities to integrate these strategies.

It is also important to establish explicit definitions of terms used in this guide.

- **Health equity:** IHI uses the United States Centers for Disease Control and Prevention definition for health equity: “Health equity is achieved when every person has the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.”³
- **Health inequity:** Differences in health outcomes that are systematic, avoidable, and unjust.³
- **Racism:** A system of advantage and disadvantage based on race, grounded in the presumed superiority of the white race.⁴
- **Internalized racism:** Conscious and unconscious acceptance of a racial hierarchy in which white people are consistently ranked above people of color,⁵ leading to internalized oppression for people of color and internalized superiority for white people.⁶
- **Interpersonal racism:** Racial “prejudice and discrimination, where prejudice means differential assumptions about the abilities, motives, and intentions of others according to their race, and discrimination means differential actions toward others according to their race. This is what most people think of when they hear the word ‘racism.’”⁶
- **Institutional (or institutionalized) racism:** The differential access to the goods, services, and opportunities of a society by race.⁶ Operates through the policies, procedures, and practices of the institutions in our society. Racism is built into the policies, procedures, and everyday practices of health care organizations and the health care system, of schools and the education system, etc. It operates both systematically and without the need for individual racist acts. People can simply be following the rules and produce outcomes that benefit white persons and harm persons of color because the rules are set up to reproduce racism.⁷

- **Structural racism:** “A system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing, ways to perpetuate racial group inequity. It identifies dimensions of our history and culture that have allowed privileges associated with ‘whiteness’ and disadvantages associated with ‘color’ to endure and adapt over time. Structural racism is not something that a few people or institutions choose to practice. Instead it has been a feature of the social, economic, and political systems in which we all exist.”⁸
- **Racial equity:** When race no longer predicts outcomes and access to opportunity through the elimination of policies, practices, attitudes and cultural messages that reinforce differential outcomes by race or fail to eliminate them.⁸ Everyone benefits from a more just, equitable system.
- **Implicit bias:** Attitudes that unconsciously affect our decisions and actions.⁹
- **Oppression:** Unjust use of power and authority. Eradicating oppression ultimately requires struggle against all its forms, and building coalitions among diverse people offers the most promising strategies for challenging oppression systematically.⁴
- **Power:** The ability to act with purpose; produced by a set of interdependent relationships that can be leveraged to achieve a specified aim.¹⁰
- **Privilege:** A set of advantages systemically conferred on a particular person or group of people.⁹
- **Marginalized communities/populations:** Groups and communities that experience discrimination and exclusion (social, political, and economic) because of unequal power relationships across economic, political, social, and cultural dimensions.¹¹

Getting Started

IHI developed an assessment tool to help organizations evaluate their current health equity efforts and determine where to focus their improvement efforts.¹² Teams use this assessment to provide direction for building an equity strategy and promote equity conversations within teams. We encourage you to use the assessment findings to inform your efforts to eliminate racism and other forms of oppression.

Five Strategies for Eliminating Racism and Other Forms of Oppression

The purpose of this guide is to provide real-life examples from organizations striving to improve health equity and share their best practices for eliminating racism and other forms of oppression. Each of the five strategies includes a brief description, key recommended actions, and examples of specific changes that organizations have tested. We address challenges and mitigation strategies, lessons, and additional tools and resources at the end of the document.

Based on the experience of organizations participating in the Pursuing Equity initiative, there is not a sequential order for implementing the five strategies for eliminating racism and other forms of oppression (i.e., they do not need to be implemented in the order in which they are presented in this guide). Many Pursuing Equity organizations have found it best to start where they have the

most resources and leadership motivation to do the work, others have found it is critical to start with understanding history. Improving health outcomes for all and narrowing the gap requires health systems to address racism and other forms of oppression.

Strategy 1: Understand the Historical Context for Racism and Other Forms of Oppression

We suggest that health care practitioners learn about the historical context for racism and oppression in both the country and city in which the health care institution is located, in addition to the history of the health care institution itself as it relates to perpetuating and aiming to dismantle systems of oppression. Understanding the struggles of people of color and the ways that many marginalized populations have systemically been denied freedom, access to health care, jobs, housing, schools, food, and more builds empathy and an understanding of how the current context evolved.

It is from a shared foundation of understanding context, history, and root causes for racism and oppression that health care practitioners and organizations can begin to improve health equity. Understanding the advantages that white people have benefited from often is transformative, and helps people see and commit to changing the underlying systems that cause discrimination and inequities.

Historical experience has contributed to a lack of trust in the health care system among many communities of color in the US. Context also includes more recent history, for example, if the health care organization participated in gentrification or has a reputation of not being a welcoming place for communities of color, low-income communities, transgender communities, or other marginalized populations. As health care practitioners begin to learn about national, local, and institutional history, it's also important to reflect on their own personal experiences with systemic racism. Individuals' identities and experiences are likely to affect how they engage in work to improve health equity.

Described below are specific changes that health care organizations participating in the Pursuing Equity initiative have tested to better understand and discuss their current and historical context for racism and other forms of oppression. The three key components of Strategy 1 discussed in this section create a foundation for learning and action, to enable health care teams to work together to create more equitable systems.

1) Learn the history of racism and oppression in the US, in the community where the health care institution is located, and of the health care institution itself.

Pursuing Equity teams tested the following changes:

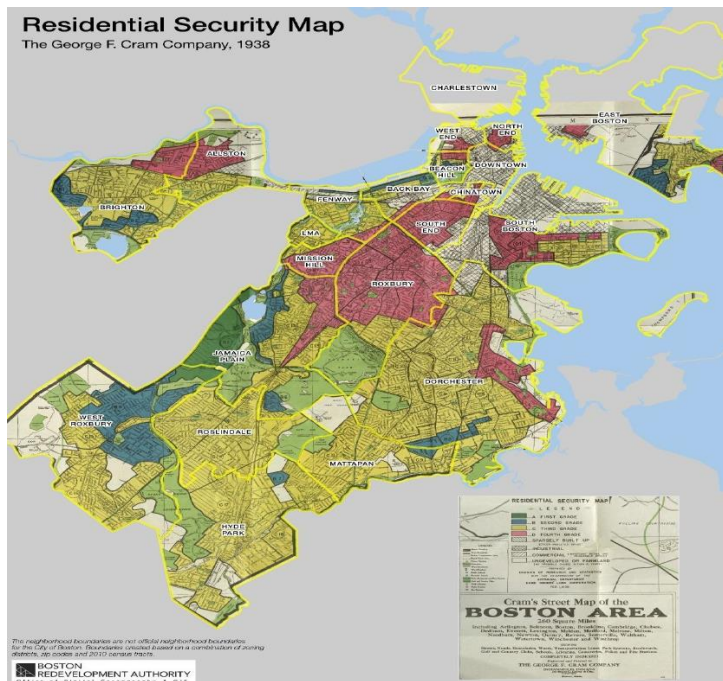
- Research past and present discriminatory practices in the community.
- Invite local historians to meetings with health care practitioners to provide an overview of racism and oppression in the community.
- Research the history of racism in medicine and offer forums for discussion among staff.
- Participate in trainings offered by organizations such as Race Forward and the Racial Equity Institute to understand the history of racism in the United States and in medicine.

Example of changes tested:

- To better understand the history of Boston, Massachusetts, and surrounding neighborhoods, Brigham and Women’s Hospital Department of Medicine and Southern Jamaica Plain Health Center reviewed the Boston Residential Security Map of 1938 (see Figure 2).¹³ The Home Owners Loan Corporation created a City Survey Program in the 1930s, which examined the risk levels for real estate investment in cities across the United States, including Boston. The maps used four color-coded categories to indicate each neighborhood’s risk level, with red being the most hazardous and riskiest for lenders. This became known as “redlining”: the process of financial divestment in communities that were primarily people of color, while simultaneously investing in communities that were white and wealthy. Redlining also impacted predominantly white immigrant populations, yet those groups often deserted their communities, perpetuating racial divisions in devalued areas.

The effects of these racist policies are still felt in Boston and all other major US cities today. Brigham and Women’s Hospital Department of Medicine and Southern Jamaica Plain Health Center, both located in one of these historically “redlined” Boston-area neighborhoods, know that access to transportation, health care, food, housing, and education all effect a person’s health. These health care organizations are thus working to deepen their partnership with key organizations and leaders in these communities to help citizens directly affected by these policies achieve their full health potential.

Figure 2. Boston Residential Security Map of 1938



2) Gain an understanding of the historically marginalized populations in the community where the health care institution is located.

As part of their efforts to improve equity, health care institutions need to have a better understanding of the demographics, histories, needs, and experiences of the people of color and other marginalized populations (e.g., low income, LGBTQ) that the institution currently serves or could be serving.

Pursuing Equity teams tested the following changes:

- Utilize staff surveys and stratified responses by race, sexual orientation, veteran status, and other sociodemographic factors to help identify inequities staff have experienced in the workplace.
- Participate in community events that provide opportunities to speak with and listen with humility to community members, to learn about their experiences navigating the health care system and identify ideas for improvement.
- Build partnerships with community-based organizations that work with marginalized communities, with the goal of working together to improve community health and wellbeing outcomes and fostering trust and relationships with these communities.
- Facilitate discussions with staff and the broader community on national and local events that impact marginalized communities (e.g., the shooting of Philando Castile, a person of color who was pulled over while driving and fatally shot by Minnesota police; the proposed transgender military ban) to demonstrate the health system's values and commitment to equity principles.

Example of changes tested:

- Leaders of Vidant Health in North Carolina meet with community leaders and faith-based leaders frequently, which helps them stay aligned with the needs of the communities based on their thoughts and the needs they identify. Vidant also includes community leaders in meetings and board education sessions. Two examples of this include:
 - During a meeting with the local leader of the Association of Mexicans in North Carolina (AMEXCAN), Vidant was asked about Spanish-speaking telephone lines. This was a profound turning point for Vidant to realize that their telephone access points were not bilingual nor had the ability to be so, which led them to change other language access services platform.
 - When Vidant first met Jermain McNair, NC CIVIL Founding Director, and began meeting with him in the community, it was clear that the community was less interested in health fairs and more interested in developing job opportunities. This led to Vidant to work with NC CIVIL to do “pop-up” job fairs right in the community.

3) Commit to ongoing personal learning and transformation regarding race, racism, and equity.

Pursuing Equity teams tested the following changes:

- Individuals reflect on and share personal stories of racism, discrimination, oppression, and privilege in their lives.
- Utilize resources to support growth and understanding of one's own racial identity and how that impacts each person's role in improving equity in the health system and the community.
- Read books and articles and watch videos to increase knowledge on race, racism, and equity.

Example of changes tested:

- In national presentations, Dr. David Ansell, Senior Vice President for Community Health Equity at Rush University Medical Center in Chicago, shares openly about his personal process of learning and transformation as a white man becoming aware of his racial identity and privilege. He discusses themes of shame, fear, loss, and ownership of his voice to work with other white people to dismantle structural racism and other inequities.

Strategy 2: Address Institutional Racism and Its Impact on Health Equity Through Culture and Communication

To begin addressing institutional racism, a health care organization must acknowledge that such racism exists and how it impacts health and health care. An important first step is to establish an organizational culture that enables conversations among staff about racism and other forms of oppression, and then proactively identify the ways in which that racism is embedded in the institution's systems and seek ways to eradicate it. Conversations about racism also need to include discussions about power and privilege, both within society as a whole and within the institution itself. These topics can often lead to difficult conversations; consider enlisting external facilitators with expertise in such discussions to provide a shared foundation of knowledge for staff and begin to form relationships from which to have challenging conversations.

It is important for clinicians and staff at all levels, including staff who interact with patients (at reception, about health care bills, etc.), to have an understanding of implicit bias and how to counteract it. Communicating about racism includes having common definitions for terms such as racism, institutional racism, structural racism, and equity.

While institutional racism in the health care organization and broader health care system is the focus of this guide, it is also important to name other forms of racism such as personally mediated racism and internalized racism, which are important but separate from the structural forms of racism. Internalized racism as defined by Camara Jones is “acceptance by members of the stigmatized races of negative messages about their own abilities and intrinsic worth.”⁶ In addition, white people experience internalized racism as internalized superiority. Just as white people in the US may need to grapple with the advantages they received, people of color in the US also need to understand how negative messages they received throughout their lives have impacted them.

Another key element of addressing institutional racism is to establish a culture within the health care organization that deeply listens and responds to the needs, norms, and preferences of the people in the community. The health care physical environment should also reflect the rich diversity and culture of the populations served.

The organization must understand the lived experience of people in the community most impacted by inequities, their customs and culture, and partner with them to design solutions. Among people of color, there are many different identities. For example, the Somali community of Minneapolis is different from the African American community of Minneapolis. Among Latinx people, there are many cultures (e.g., Puerto Rican, Cuban, Brazilian, Argentinian, Mexican). Recognizing and appreciating these differences is essential for building relationships and trust between the health care organization and the community it serves. It is also important to understand the culture of white supremacy — one where values such as perfectionism, paternalism, urgency, individualism, and either/or thinking are normalized and perpetuated¹⁴ — and how that plays out in the workplace and in the community.

Described below are specific changes that health care organizations participating in the Pursuing Equity initiative have tested to address institutional racism through culture and communication.

1) Health care practitioners help to normalize discussions about racism, oppression, advantage, and power by defining it and naming it as a root cause of inequities.

Pursuing Equity teams tested the following changes:

- Create a glossary of health equity terms, including racism, through which staff may build a foundation of shared language.
- Identify the white dominance in the health care organization's culture.
- Invite both people of color and white people to play meaningful roles in setting priorities and building a culture of equity and inclusion.
- Host "Brown Bag" lunches to encourage conversations on equity topics relevant to the community.
- Identify opportunities to name racism as a root cause of health inequities in the health system and in the community.

Examples of changes tested:

- Since 2003, the YWCA of Minneapolis, Minnesota, has hosted annual "It's Time to Talk: Forums on Race™" events in an effort to engage diverse people in creating understanding that leads to action and ultimately leads to change. For many years, HealthPartners has engaged employees from across the organization to participate in the events, and the organization has more recently become a sponsor. Due to interest in engaging staff and the community in similar conversations, HealthPartners launched its own event called "Let's Talk about Race," with a focus on building awareness about racism through dialogue within the organization and the community and identifying how racism impacts the health care work environment and care delivery for both patients and staff.
- In 2015, HealthPartners' Diversity and Inclusion team relaunched this work under the name "It's Time to Talk," expanding the focus to align with the organization's definition of diversity that includes race, ethnicity, physical ability, language, gender, gender identity, sexual orientation, age, religious beliefs, and socioeconomic status. "It's Time to Talk" is currently internally-focused, with the plan to also re-engage the community in these discussions.
- Shared language and definitions are also important in order to normalize discussions around racism, oppression, advantage, and power. Southern Jamaica Plain Health Center's "Liberation in the Exam Room: Glossary of Terms" provides one example.¹⁵

2) Health care leaders set the tone and organizational priorities to explicitly address racism.

Pursuing Equity teams tested the following changes:

- Explicitly name racism as a root cause of health inequities.
- Discuss institutional racism in board meetings.
- Health care leaders and other senior staff attend anti-racism trainings.

Examples of changes tested:

- David Ansell, MD, MPH, Senior Vice President for Community Health Equity at Chicago's Rush University Medical Center, speaks about the importance of "naming the problem" as institutional and structural racism. He refers to it as the "root cause," making the analogy to other improvement work where root cause analysis is used to understand the causes of a problem in order to fix it.
- In internal and external meetings and other types of communication, senior leaders at Vidant Health in North Carolina regularly discuss racism and other forms of oppression as drivers of equity gaps in their community and health system.

3) Health care practitioners and leaders listen to patients, partners, and communities to understand their experiences and partner on solutions.

Pursuing Equity teams tested the following changes:

- Provide trainings to practitioners to give them the tools necessary to have conversations about racism with their patients and in the community.
- Hold town hall meetings to hear feedback, concerns, and ideas for improvement from community members.
- Work with communities of color to understand barriers to care.

Example of changes tested:

- Vidant Health holds town hall meetings for staff every spring and fall. Equity and inclusion have been components of the last four meetings, connecting into the themes of "Everyone's Experience Matters," "All That We Share," "Walk the Walk," and "We Are Vidant." These meetings help practitioners and staff understand the experiences and impact of race and racism within both their institutions and communities.

Below are some proposed measures to assess progress in this area:

- Stratify employee survey response data by race, ethnicity, language, and pay levels to identify differences that may represent inequitable gaps
- Percentage of community members by race (e.g., white, people of color, Latinx) compared to the percentage of the health system's board members and C-suite senior executives by race (to identify gaps and ensure health system leadership is representative of the community served)
- Percentage of employees who have reported experiencing discrimination within the health care organization, tracked over time

Strategy 3: Establish Policies and Practices to Promote Workforce Diversity and Racial Equity

Human resources policies and practices to hire, develop, retain, promote, and ensure a thriving and representative workforce are necessary to address racism. It is insufficient for health care organizations to only establish policies to increase staff diversity; they must concurrently work on other strategies outlined in this guide, and likely others, to change the organizational culture,

reform systems that are reproducing inequitable results, and catalyze efforts to improve equity that impact the larger community.

1) Set specific targets for health care workforce diversity, at all levels, that is representative of the community served.

To begin increasing the diversity (including by race, gender, and other dimensions) of the health care workforce at all levels of their organizations, Pursuing Equity teams tested the following changes:

- Set aims that the senior-most positions in the organization are representative of the community served in terms of race, gender, and other dimensions.
- Review racial demographics for the community and for the organization's staff and senior leaders to understand workforce representation as it relates to community demographics.
- Ensure that the composition of the organization's board of directors reflects the community served in terms of race, gender, and other dimensions.

2) Ensure that organizational policies and practices promote racial equity.

Review the health care organization's policies and practices to ensure that they do not create barriers that disproportionately impact communities of color, and proactively correct for historic imbalances that disproportionately impact communities of color and other marginalized groups.

Pursuing Equity teams tested the following changes:

- Increase the wages of the lowest paid health care organization employees, a group that often has an overrepresentation of women of color.
- Resource professional development and leadership development programs for employees to create career pathways and opportunities for marginalized and underrepresented groups.
- Review job application requirements to reduce barriers for people of color and people from low-income communities.
- Enable staff access to professional development funds to pay for enrollment in approved opportunities, instead of employees having to pay out of pocket and then get reimbursed.

Example of changes tested:

- Vidant Health established targets to increase racial diversity among its workforce and to ensure that organizational policies and practices promote racial equity and do not create barriers. When the organization reviewed its workforce data by race, they saw less racial diversity in the senior-most-level positions. Vidant tracks workforce diversity data in an ongoing way; the Chief Human Resources Officer and Chief Experience Officer, reporting to the Chief Executive Officer, have accountability for the work.

The organization reviewed its policies to identify opportunities to reduce barriers to employment, including employing returning citizens/previously incarcerated individuals, and removing educational requirement barriers for positions for which the requirements could not be validated. Leaders are considering establishing an on-campus GED lab for team members who have not completed their high school education. The core team working to improve workforce diversity and equity made both a moral case and a business case for

increased wages, predicting an increase in retention and ability to fill positions as well as improved reputation in the community, in addition to contributing to the overall wellbeing of their staff.

Below are some proposed measures to assess progress in this area:

- Percentage of employees involved in contributing to the retirement plan, stratified by race and ethnicity
- Wage gaps (in dollars), stratified by race and ethnicity
- Percentage of employees sent to collection for health care, stratified by race, ethnicity, and income
- Percentage of employees in management positions in the health care organization, stratified by race and ethnicity
- The organization has a hiring policy for previously incarcerated individuals (“Ban the Box”): Yes or No
- Percentage of employees who take advantage of professional development/career pathways (such as tuition reimbursement, tuition remission, etc.), stratified by race, ethnicity, and level in organization
- Employee turnover/separation rates, stratified by race, ethnicity, and level in organization

Strategy 4: Implement Business Policies and Practices That Support and Promote Racial Equity

This strategy addresses the importance of reviewing current and developing new business policies and practices that support the elimination of racism and other forms of oppression beyond the human resources department. For example, decisions such as which health insurance to the health care organization accepts and where to build new health care facilities are key business practices that impact equitable care.

1) Use a racial equity lens to develop or revise policies that impact business decisions and practices.

Pursuing Equity teams tested the following changes:

- Use a Racial Equity Impact Assessment Toolkit from Race Forward to analyze current and proposed policies with a racial equity lens, for example, to examine policies for when health care staff call police to assist with patients. The tool walks through a series of questions to ultimately understand who benefits and who is burdened by a decision or policy. This enables teams to pause and understand the differential impact on racial groups, to then inform potential opportunities to revise policies and proactively design for racial equity.
- Use a racial equity lens to assess policies that limit the percentage of Medicaid patients the health care institution serves.

In addition, health systems should use a racial equity lens to decide where to locate facilities. Organizations may consider locating health care facilities in areas that are currently underserved, which often have a disproportionately high population of people of color. Organizations need to

also consider which types of facilities they locate where (e.g., making it easier for people of color to access specialty services, not only primary care). Additionally, health care organizations need to evaluate their locations for equitable availability and access to services such as free parking and appointments outside regular hours.

Example of changes tested:

- For teaching hospitals, recruitment of residents is essential to maintaining business vitality. The Pursuing Equity team from Boston’s Brigham and Women’s Hospital Department of Medicine and Southern Jamaica Plain Health Center noted a dearth of faculty and residents from underrepresented in medicine (UIM) backgrounds. They recognized that this is in part due to implicit and explicit biases held by departmental and residency leadership. For example, implicit criteria for recruitment include individuals with erudite diction, trained in elite institutions, and who generally demonstrate “Brigham Fit.” These factors are rooted in the discriminatory practices that lay at the foundation of many hospitals, including Brigham and Women’s Hospital. Further, the history of racism in Boston may contribute to the difficulty of attracting top academic talent to these health care facilities.

Thus, the Pursuing Equity team worked with the Diversity and Inclusion Committee to learn about perceptions of race in Boston through a survey distributed to residency program applicants who participated in the applicant revisit. Several respondents commented on the lack of diversity amongst faculty and residents. Some stated they did not sense that diversity was emphasized at our institution. To address this, the DOM now has a policy requiring all faculty who interview residency applicants to participate in implicit bias training. Additionally, two Diversity and Inclusion Committee members are now involved with reviewing all UIM residency applications to ensure that no strong applicants fall through the cracks during the recruitment process. The residency program directors also participated in racial justice training sessions hosted by the BWHDOM/SJP team. These activities have led to an increase in the number of incoming UIM residents compared to prior years.

2) Invest in the community.

Pursuing Equity teams tested the following changes:

- Set aims for the amount spent with businesses owned by women and people of color in the community.
- Participate in community investment in housing and other social needs.
- Partner proactively with community-based organizations, including community colleges, to establish employment pipelines to hire from the community.

Example of changes tested:

- Rush University Medical Center is the largest employer on the West Side of Chicago, Illinois, and recognizes its power to improve the economic vitality of that community. To act on this, Rush has developed an Anchor Mission Strategy to channel their economic power to improve the health and well-being of neighborhood residents. The Anchor Mission Strategy includes commitments to hire locally and develop more local talent, buy and source locally, invest locally, and volunteer locally. Specific activities related to these aims include developing career advancement programs for entry-level employees, purchasing goods and services from local vendors, partnering with local community development finance institutions to make “impact investments” business loans available to community-based organizations and

projects, and developing a paid volunteer time off policy to enable staff to contribute to community-building work.

Proposed measures to assess progress in this area:

- Difference between percent of Medicaid patients treated by the health care institution and the total percent of Medicaid recipients in the state
- Percent of supplies or services the health care organization procures from minority-owned businesses in the community

Strategy 5: Improve Clinical Processes and Outcomes to Narrow Equity Gaps and Improve Equity for All

Health care organizations need to understand how their clinical operations are contributing to equitable care (or not) and ensure that equity is included as a key component of care quality. A focus on equity entails decreasing gaps in equity, with a particular focus on marginalized populations, while also improving care systems for all populations.

As noted in some guidance for health care leaders, “Quality improvement often focuses on populations where success is most easily achieved. But if we are going to start reducing disparities, we need to start with the ‘last’ population — one that may be more challenging and just not thriving — and partner with them to develop improvements. The reward for health care organizations is that even though these populations may be small, they can incur great costs to the health system. And if we can solve problems for those at the margins, we may come up with solutions that work better for all.”¹⁶

Strategy 5 includes stratifying quality data by race, ethnicity, and language (REaL) and by socioeconomic status/income, as well as working to reduce inequities and improve overall clinical processes. Health care organizations also need to look at access to services stratified by these same factors, to ensure that people of color have equitable access to all services provided, including high-cost procedures such as cardiology services, hip and knee replacements, and bariatric surgery, for example. It is not enough to identify racial inequities in care for those who have managed to access to the system. The organization needs to proactively ensure that all populations, particularly marginalized ones, have equitable access to services.

1) Build data systems that can inform where equity gaps exist in clinical outcomes and track equity over time.

Pursuing Equity teams tested the following changes:

- Integrate an equity lens into existing clinical dashboards that stratifies data for key measures by REaL factors.
- Design and utilize a specific equity dashboard, which is a distinct product that complements other dashboards. An equity dashboard might feature data for measures where the largest inequities exist, whereas a dashboard with an equity lens contains typical clinical quality measures stratified by REaL factors.
- Distribute reports containing data on equity gaps to clinical providers.

- Implement a process to provide on-demand stratification of requested clinical data by REaL factors.

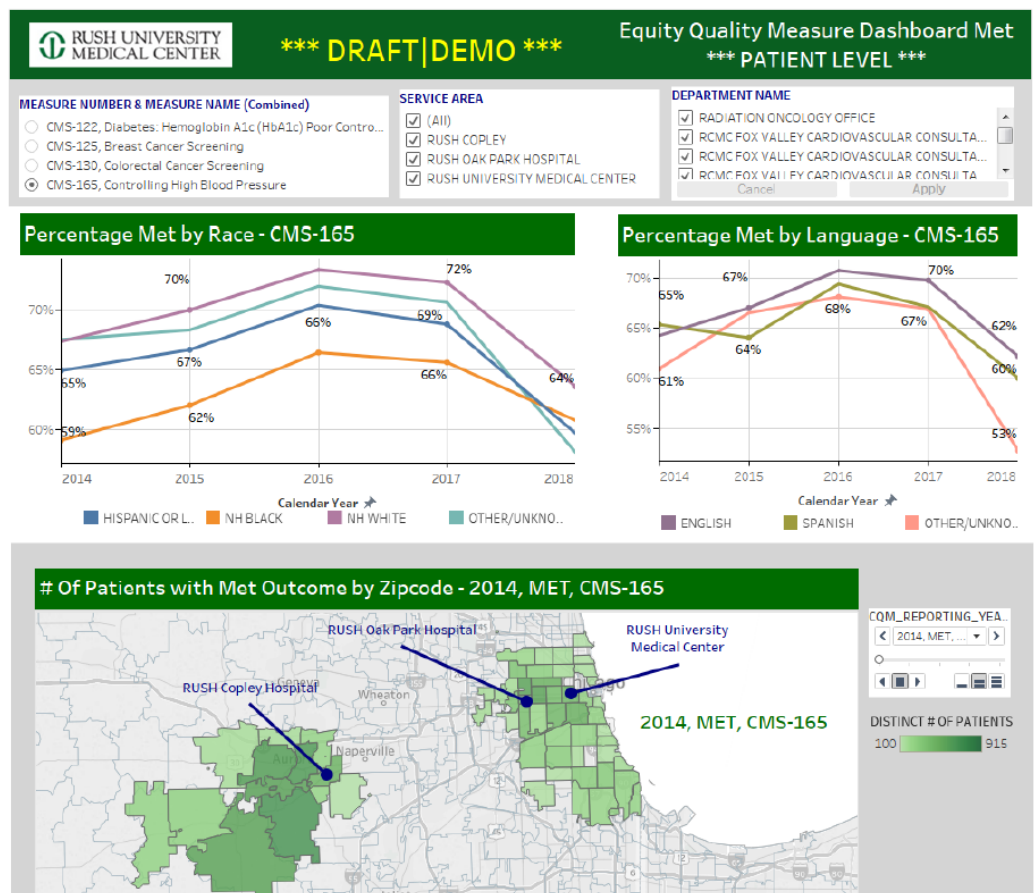
For additional information on building data infrastructure and equity data displays and dashboards, see the guide for the second component of the IHI framework, Build Infrastructure to Support Health Equity.²

Example of changes tested:

- To develop the most effective equity dashboard, in the design process the team at Rush University Medical Center in Chicago asked several key questions: Who is the dashboard’s intended audience? What are users trying to accomplish using the dashboard information? How will we know that the dashboard is helping users achieve their aims?

The initial version of the equity dashboard was used by Rush’s Pursuing Equity team, which included a senior leadership sponsor, physician champions, population health practitioners, quality and performance improvers, IT managers, and representatives from the Rush Center for Community Health Equity. The team selected four ambulatory clinical measures (diabetes, breast cancer screening, colorectal cancer screening, blood pressure) and then stratified data for these measures by race, ethnicity, language, and zip code (see Figure 3). The team tested and refined the equity dashboard using multiple iterative Plan-Do-Study-Act (PDSA) cycles to evolve the dashboard from an initial wireframe, through multiple draft versions, and then to a final dashboard that was shared and used more widely throughout the organization.

Figure 3. Example Equity Dashboard from Rush University Medical Center



2) Identify clinical outcomes where inequities exist and use quality improvement to narrow equity gaps and improve care for all.

Pursuing Equity teams tested the following changes:

- Stratify clinical process and outcomes data by REaL factors to identify where gaps in care exist.
- Based on this data analysis, initiate quality improvement efforts to narrow gaps in identified areas (e.g., emergency department admissions, complete childhood vaccination, routine medical procedures and screenings such as colorectal cancer screening and mammography).

Example of changes tested:

- The Brigham and Women’s Department of Medicine (DOM) team identified equity gaps in the treatment of and outcomes in congestive heart failure (CHF) patients, a condition that accounts for the highest number of medical discharges in their hospital. Research initiated through the DOM Health Equity Committee documented differences in access to specialty care and the impact on readmissions rates for CHF patients. Patients receiving inpatient treatment under medical team coverage had poorer outcomes and higher readmissions rates; patients receiving treatment under cardiac team coverage had better outcomes (see Table 1).

Table 1. Brigham and Women’s Hospital CHF Patient Outcomes: Medical Team vs. Cardiac Team Coverage

	CHF Patients with Medical Team Coverage	CHF Patients with Cardiac Team Coverage
Cardiology clinic follow-up	25%	51%
7-day readmissions	10%	5%
30-day readmissions	24%	17%

By analyzing their data, the Brigham and Women’s team identified that white patients are more likely to be admitted under the care of a cardiac team than patients of color, older patients, and women, creating a gap in equitable care. This gap is compounded by the fact that CHF is known to have a higher prevalence and incidence in black patients, who are 1.5 times more likely to develop CHF than white patients.

The Brigham and Women’s team sought to identify the structures and processes contributing to this equity gap and address it by standardizing patient bed assignment processes; engaging emergency medicine, cardiology, general medicine, and the heart failure service; improving heart failure care on the general medicine service; eliminating discrepancy in cardiology clinic discharge follow-up between medicine and cardiology services; and addressing structural drivers of inequity. In addition, it was critical that, as a team, they had a shared analysis of this as a systems issue and an example of race-based advantage leading to inequities.

3) Break down silos between departments to engage and motivate clinical teams to work together to reduce equity gaps.

Pursuing Equity teams tested the following changes:

- Transparently share clinical data stratified by REaL factors with clinical teams.

- Attend trainings together to gain a shared understanding of racism and other forms of oppression so clinical teams can work together from a shared foundation.
- Present equity data and information in meetings with clinician groups.
- Include quality improvement staff in equity improvement efforts and teams.

Example of changes tested:

- To reduce silos and provide strategic guidance, Henry Ford Health System in Detroit, Michigan, launched a health equity steering committee comprising senior leaders, including the Senior Vice President for Population Health and the Chief Medical Officer of Primary Care, day-to-day team members, and equity content experts. The committee is co-chaired by the Senior Vice President of Community Health & Equity and Chief Wellness & Diversity Officer, and the Chief Quality Officer. The committee works with the equity and community health, quality and safety, and population health teams to focus specifically on how these teams can align strategies to improve health equity.

Below are some proposed measures to assess progress in this area:

- Percentage of clinical outcome measures reported to the board that are analyzed for differences using REaL data
- Percentage reduction in equity gaps over time for the same board reported clinical outcome measures stratified by REaL data
- Stratify the top three income-producing clinical procedures by REaL data to identify potential inequities

Challenges and Mitigation Strategies

- It is challenging to begin discussions about racism and other forms of oppression within an organization because staff have many perspectives on what oppression means as well as different personal experiences and life stories. To mitigate this, Pursuing Equity teams brought in trainers and facilitators to establish shared definitions among staff and to create the working agreements and norms required to have these important discussions.
- Staff can feel overwhelmed by the enormity of the problem of addressing racism and other forms of oppression. Pursuing Equity teams took a few approaches to mitigate this. First, they used small tests of change to help staff get to the point where they feel they can take a first step. Second, framing the work as difficult, but joyful and rewarding, and helps build a sense of optimism and hope. Having a community of colleagues within the health system, or a network of others outside the health system, who are engaged in the work to improve equity identifies a group from which to draw motivation and rejuvenation to continue on the long journey of improving equity and justice.
- The need for a new way of working together allows for vulnerability in the health care workplace. We must be able to say we don't know, we aren't sure, and to share our personal stories of growth. Leaders and other team members can model the courage and vulnerability required to advance equity.

Lessons Learned

- Human resources team members have a role to play in creating policies and practices that promote equity, and they need to be part of the equity team in an organization.
- Formalized trainings with expert facilitators help team members gain an understanding of racism and how systems of oppression function.
- This work has starts and stops, wins and failures, with learning along the way. It is critical to celebrate the wins and to find the lessons in the failures.
- Naming racism explicitly, along with other forms of oppression, helps ensure that these important elements are not left out of the discussion and serves as a powerful reminder to engage those who have been marginalized by our systems directly in the work.
- When leaders at all levels normalize conversations on racism and oppression, they demonstrate to staff that discussions on racism, and the ways in which it contributes to inequities, are encouraged so that the organization can begin to improve in this area.

Tools and Resources

- Race Forward: [Racial Equity Impact Assessment Toolkit](#)
- Some selected organizations that offer trainings:
 - [The People's Institute for Survival and Beyond: Undoing Racism](#)
 - [The Racial Equity Institute](#)
 - [Race Forward](#)
- Showing Up for Racial Justice: [The Characteristics of White Supremacy Culture](#)

Conclusion

Racism and other forms of oppression are causes of health inequities that are often difficult to identify at first glance. Eliminating inequities requires digging deeply into the entrenched policies, practices, and culture of an organization and uncovering often uncomfortable truths. By addressing historical context, institutional policies and practices, and clinical inequities, health care organizations can improve health and health care equity for their employees and the populations they serve. We hope the strategies and examples described in this guide aid health care organizations as they seek to eliminate racism and other forms of oppression in their efforts to improve health equity.

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