

# Racial and Health Equity: Concrete STEPS for Smaller Practices



Translate Your Commitment to Racial and Health Equity  
Into Action in Your Practice

DEVELOPED IN COLLABORATION WITH



Rishi Manchanda, MD, MPH  
Founder and President, HealthBegins

Marie T. Brown, MD, MACP  
Director of Practice Redesign, Professional Satisfaction,  
American Medical Association; Professor, Rush University

## How Will This Toolkit Help Me?

### Learning Objectives

- 1 Identify ways to prepare yourself and your team for conversations about health equity, racial equity, racism, and anti-racism with colleagues, patients, and other practice stakeholders
- 2 Describe the importance of data and how to improve the quality of your data to further racial and health equity efforts
- 3 Explain how to advance racial and health equity in your practice using SMART goals and quality improvement efforts



# Introduction

As the commitment to advance health equity and racial equity grows across many sectors, motivated physicians and other health care professionals in smaller practice settings may wonder how best to pursue these goals through their day-to-day work.

Now more than ever, you and your colleagues might be asking questions like:

- *Do preventive screening rates, treatment recommendations, or other measures of the quality of our patient care differ by race, ethnicity, and/or language?*
- *Does everyone in our practice understand how institutionalized racism shapes clinical practice and patients' health outcomes? How can we do better?*
- *Do all patients feel welcome by our team members and comfortable in our clinic?*
- *Does our practice's payer mix reflect or even exacerbate institutionalized racism?*



Since health equity and racial equity are not only outcomes but also ongoing inter-related processes, this toolkit adapts a practice transformation framework to offer 5 STEPS that can help move practices forward to advance racial and health equity for co-workers, for patients, and for the communities you serve. Recognizing that the path to equity is a dynamic, long-term journey, this toolkit focuses on initial catalytic steps and associated resources that motivated physicians and practices can use to translate that commitment to equity into action. These recommended STEPS are part of a larger cycle of continuous learning, improvement, and accountability that seeks to advance racial and health equity through transformation efforts at the practice, community, and societal levels.

Other resources to support your racial and health equity efforts are listed at the end of this toolkit in the Further Reading and References sections.

## Five STEPS to Advancing Racial and Health Equity in Your Practice

1. Commit to Do the Work

---

2. Start Shifting Group Norms by Learning About What You Don't Know

---

3. Get a Handle on Your Data

---

4. Develop a Shared, Clear, Compelling Vision and Goals

---

5. Launch Targeted Improvement Efforts

1

# Commit to Do the Work

Like every practice transformation effort, advancing racial and health equity requires leadership. It also requires courage—courage to approach this work with genuine respect, to facilitate and create a safe space for difficult conversations, to find comfort in discomfort, and to commit to meaningful action.

This effort may start with you whether you are the owner of your practice, medical director, or one of many colleagues working together in a small practice.

Talking about racism, racial equity, or health equity in clinical practice may make some of your colleagues, leaders, and other stakeholders uncomfortable. While it's important to approach conversations about racial equity with respect, expect discomfort and even some degree of conflict. After all, advancing racial and health equity in clinical practice necessarily involves challenging norms and interrupting patterns that maintain structural advantages and disadvantages—from patient-facing issues such as access to care and population health management to organizational issues such as hiring, advancement, and pay equity! To help leaders and colleagues in your practice become more comfortable with the discomfort inherent to racial equity work, share the ThemPra Social Pedagogy “Learning Zone” model with them and review this guide from the Southern Poverty Law Center.

A good place to start is by asking questions. Consider asking team members and colleagues questions that invite honest self-assessment as a practice:

- *Do we know whether access to care, preventive screenings, treatments, or other quality measures differ by patient race, ethnicity, and language?*

---

- *When was the last time we asked patients and team members whether and how racism has impacted their health and the care they've received over the course of their lives?*

---

- *If we don't have a plan to identify and reduce racial inequities for our patients and community, how do we know that our practice isn't contributing to the problem?*



These questions can help identify opportunities for improvement as well as secure leadership and team commitment to make this work a priority and devote dedicated time for teams to engage in learning and improvement efforts that seek to advance racial equity.



**A Tool Kit for Productive Conversations on Race**

Learn about the Mass General Brigham “See. Hear. Act.” approach to discussing race.

### As part of a relatively small practice, how can I start improving our efforts to advance racial and health equity?

The first step involves identifying a leadership-supported and empowered champion for this work within your practice. Champions should be a trusted, respected voice. The good news is that, if you're reading this, that champion is likely you. If you need support in deciding whether and how to begin transformation or engage your leadership, watch a few videos like [this one](#) in the AMA's [Prioritizing Equity](#) series and talk with a peer who can discuss the benefits and challenges of beginning the work. The additional STEPS and resources listed in this toolkit can also help.

### My colleagues and I work long hours. What if there isn't enough time to talk about this?

Like other significant initiatives that seek to improve patient outcomes and advance the medical profession, advancing racial and health equity through your day-to-day work is not a small project—it will require transformation and changes to your practice. Therefore, as a practice, leaders will need to allocate time and create meaningful space for all clinical and administrative team members to have these conversations and participate in improvement efforts for racial and health equity. This can be challenging for leaders in fee-for-service practices where clinical team members might be used to coming up with solutions or plans for individual patients within limited amounts of time. Practice leaders should recognize and help explain that this brief mode of conversation doesn't work when it comes to the ongoing work of understanding and addressing racial inequity. Leaders must demonstrate a commitment to addressing the harm that gets uncovered in these conversations, with a focus on re-designing their systems for their teams and patients (and avoiding individual blame).

## 2

## Start Shifting Group Norms by Learning About What You Don't Know



Name it, frame it, explain it.

Before making a plan to improve racial and health equity, it's important for everyone in your practice to develop a better, shared understanding of racism and anti-racism. This process requires a combination of individual and group learning to [find out what you don't know](#). Read and share articles and resources like those listed below. Use dedicated time as well as informal opportunities at work to talk with colleagues.

Review the ways white supremacy culture influences [organizational culture](#). Approach conversations with respect, listen and be open to questions, and be sure to discuss the difference between institutionalized racism and interpersonal racism. Share lessons from “bright spots”—other practices that have started the journey to racial equity. Consider hiring an experienced consultant to facilitate group conversations and normalize a commitment to racial equity. If your budget doesn't allow you to hire a facilitator, resources in this toolkit can assist you.

Here are some questions you may consider using during the patient visit:

## In the Exam Room

Questions for the first visit. Goal: Make the implicit, explicit.

- 1 “I don’t want to assume anything about your identities. How do you identify racially, ethnically, and culturally, and what are your pronouns?”
- 2 “Many of my patients experience racism in their health care. Are there any experiences you would like to share with me?”
- 3 “What have your experiences been within the health care system?”
- 4 “Have there been any experiences that caused you to lose trust in the health care system?”
- 5 “It is my job to ‘get’ you. You shouldn’t have to work to ‘get’ me. If I miss something important or say something that doesn’t feel right, please know that you can tell me immediately and I will thank you for it.”
- 6 Put up visual cues of a safe space, such as Black Lives Matter (BLM) signage or a rainbow flag in support of LGBTQ movements.
- 7 Acknowledge and honor what patients are already doing—“Wow, you’re already doing so much.”
- 8 “What’s happened to you?” vs “What are you doing?”
- 9 Curiosity can feel like colonizing language. Not “Can you explain to me why...?”; instead, “There is something I don’t know that I really need to understand.”

*Courtesy of Southern Jamaica Plain Health Center, Boston, MA.*

### Q&A

#### We have talked about these issues informally during breaks. Is that enough?

While informal “water-cooler” conversations are important, that’s not enough. More often than not, informal discussions focus on lived, personal experiences with race and racism. Advancing racial equity requires going beyond personal conversations; it requires getting educated about the way racism impacts our institutions and practices and making a plan to move forward.

#### What are some key concepts I can read more about and share with colleagues in my practice?

We’ve listed several resources and articles below. These cover some key concepts related to racial health equity, including:

- Definitions of health equity, racial equity, and different forms of racism
- A history of racism in the US, including organized medicine’s historic role in perpetuating racial discrimination and structural racism

- Why we need to stop using disproven theories about biological or genetic factors to explain racial differences in health outcomes
- Why an understanding of structural racism is so essential to health care efforts that seek to “move upstream”

### What is the difference between interpersonal and institutionalized racism?

Per Camara Jones, MD, MPH, PhD, interpersonal or “personally mediated” racism is defined as 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.’”<sup>2</sup> To illustrate what prejudice looks like, consider a 2015 study in which nearly half of Black (48%) and Latina (47%) professional women in science, technology, engineering, and math (STEM) reported that they have been mistaken for janitors and administrative staff, compared to 32% and 23% of their White and Asian counterparts, respectively.”<sup>3</sup>

In contrast, “institutionalized racism is normative...It is structural, having been codified in our institutions of custom, practice, and law, so there need not be an identifiable perpetrator. [It] manifests itself both in material conditions and in access to power.”<sup>2</sup> For an example of institutionalized racism, consider redlining, a practice dating back to the 1930s, which led to the systematic denial of various services—including mortgages—“by federal government agencies, local governments as well as the private sector, to residents of specific, most notably black, neighborhoods or communities.”<sup>4</sup> The segregation caused by redlining continues to have long-term impacts on racial inequities in economic opportunity, health, and justice.

### How has institutionalized racism shaped health care?

Modern health care has a long and troubling history of institutionalized racism. In the Tuskegee syphilis experiment (1932-1972), for example, doctors from the US Public Health Service intentionally withheld treatment from Black men farmers for 40 years—leading to severe health problems for study subjects (eg, blindness, mental illness, and death) and their children.<sup>5</sup> In another example, James Marion Sims—credited as the “father of modern gynecology” and a former president of the American Medical Association—achieved his success by conducting research on enslaved Black women without anesthesia.<sup>6</sup> The legacy of institutionalized racism continues to shape health care and health outcomes and has led multiple professional associations and organizations to finally commit to action.<sup>7</sup>

### Can practices like mine engage patients in conversations to develop a better, shared understanding of racism and racial equity?

Absolutely. Clinicians can use a series of open, respectful, and thoughtful questions to open up honest, meaningful conversations with patients about racism. For example, consider asking this question during all routine physicals—“Many of my patients experience racism in their health care. Are there any experiences you would like to share with me?” Your clinical practice could also convene patients and community members to discuss racism, health care, and ways to advance racial and health equity. These are helpful ways to build patient and community trust in your practice.

## 3

## Get a Handle on Your Data

To chart a course forward on racial equity, it's important to know where you are. This STEP starts by discussing a basic question as a practice—what does our data tell us about racial health disparities among our patients?

It is important to routinely collect and analyze patient and practice performance data by race and/or ethnicity. The COVID-19 pandemic has revealed that many clinics and health care institutions, as well as state and federal governments, fail to consistently capture race and ethnicity demographic information on patients. The omission of data on race is just one way that structural racism manifests in health care. Support patient self-recording of race and ethnicity data through the use of patient-facing tools online and/or at the point of service in your practice.<sup>8</sup>

“

We must commit to finding ways to structure and standardize the collection of all types of demographic data, of information not only about race and ethnicity, but also gender identity, sexual orientation and preferred language that have made people more vulnerable to the blows of public health emergencies.<sup>9</sup>

”

—Aletha Maybank, MD, MPH

### Q&A

#### My practice is already inundated with data. How do we focus?

Clinical and administrative leaders in your practice should focus on a few actionable measures to identify and target racial health disparities. Here's how:

- Identify 2-3 measures that are meaningful to you, your team, and your practice based on current patient care-related priorities, like improving diabetes management, COVID-19 testing, annual wellness visits, hypertension management, or flu shots.
- If this is your first time looking at measures in this way, start small. For example, review patients 30-65 years old with uncontrolled hypertension.
- Using those measures, analyze care delivery and practice performance to identify disparities by race, ethnicity, and language (REAL) data.<sup>10</sup> Use graphs and charts to visualize the data.<sup>11</sup>
- Decide on one specific measure that can serve as a constant reminder that certain populations are disproportionately impacted or neglected (eg, percentage of patients who have well-controlled and uncontrolled hypertension, stratified by REAL data).
- Address challenges in data collection and getting the right data to the right place (eg, data on race may be included in reports to health plans but not reviewed in team meetings).
- Share data transparently with team members, engaging everyone in improvement.

#### As a clinical practice, is there a way to assess if our payer mix is contributing to racial inequity?

In addition to measures of care delivery described above, practices can choose and adopt other organizational measures to racial inequities in access to care. For example, practices can measure “the

difference between the percent of Medicaid and/or uninsured patients treated by a health care institution and the total percent of Medicaid and/or uninsured individuals in the relevant city, state, or region.”<sup>12</sup> Also assess differences in payer mix across physicians and practitioners within your practice. For example, does one physician in your practice have a much smaller proportion of Medicaid and/or uninsured patients compared to their peers? If so, has your practice discussed the racial justice implications of this payer mix?

It is not as simple as focusing on identifying whether Black patients are differentially impacted compared to White patients. One of the most important elements of anti-racism is an understanding of “intersectionality”—“the understanding that individual or group experiences of oppression cannot be distilled into a single identity, such as either female or Black or Black women.”<sup>13</sup> This means that race, as a sociopolitical construct, intersects with multiple aspects of people’s identities, including gender, sexuality, and ethnicity. Clinicians have used this understanding to analyze data with filters that help reveal inequities that would otherwise remain hidden.<sup>11</sup> Some may question if “intersectionality” is contradictory to using REAL data, as mentioned earlier in this toolkit. The two differ in that intersectionality requires a more sophisticated analysis beyond simply looking at “Black versus White” data.

As an illustrative example, when identifying potential disparities in outcomes among adults with hypertension, analyzing your data using multiple demographic REAL variables might help you identify that monolingual Spanish-speaking Latino men between 40-60 years of age and adult Black women who work two jobs experience significantly worse outcomes compared to other groups. If your practice collects data on health-related social needs like financial insecurity, food insecurity, or housing insecurity, add that as an additional “filter” to identify hidden patterns of racial, economic, and health inequity.

Expand your analysis to identify potential racial disparities in your workplace. Encourage your clinical and administrative colleagues, including those in Human Resources, to review employee-facing REAL data—including data on employee hiring, advancement, and pay equity—to identify racial disparities in the workplace.



## 4 Develop a Shared, Clear, Compelling Vision and Goals

With a focus on a few key actionable measures, the next step is to create a shared vision and goals to reduce or eliminate racial disparities in care delivery and practice performance. There are 2 components to remember when developing a compelling vision and goal for racial equity:

1. First, work with a small group of your most motivated colleagues to develop a draft quality-improvement-based project charter. Be sure to involve and ask at least one practice leader to review the draft charter and serve as an executive sponsor.
2. Second, draft SMART (Specific, Measurable, Achievable, Relevant, and Time-Bound) goals based on your data analysis. Using our illustrative example of patients with uncontrolled hypertension for example, we could set the following SMART goals—Within 12 months, we will:
  - a. Achieve a 20% increase from baseline in hypertension control among all adult patients ages 30-65, including Black women and Latino men and,
  - b. Decrease disparities in uncontrolled hypertension rates between Black women, Latino men, and other groups by 20% from baseline.

Keep racial equity front and center as you develop your project charter. A key element of being an anti-racist clinical practice is “centering the margins.” This means “making the perspectives of socially marginalized groups,

rather than those belonging to the dominant race of culture, the central axis around which discourse on a topic revolves.”<sup>14</sup> To center your project charter in “the margins,” invite individuals from socially marginalized groups—including patients, team members, and/or community residents—to discuss and review your charter and to validate or invalidate your practice’s ideas about how to reduce racial health disparities.

## Q&A

### Do we need to involve everyone in the practice or limit our racial equity project to a small team?

Advancing racial equity requires practice transformation and the evidence from thousands of practice transformation efforts is clear—“all staff in the practice, regardless of how big or small it is, must coordinate their work to succeed.”<sup>15</sup> Use team meetings, huddles, and other forms of communication to engage everyone in your practice. Get feedback, review why this work matters, and ensure that all clinical and administrative members understand their role in the project. Through newsletters, highlight and recognize informal and formal leaders in your practice who are helping advance racial equity for patients and team members. And be sure to celebrate even small successes! Share letters of congratulations as the team makes progress.

## 5

## Launch Targeted Improvement Efforts

Instead of simply identifying and accepting that racial health inequities exist, the preceding steps will help everyone in your practice expand a shared understanding of why they exist and develop a shared commitment and plan to eliminate them. The next step in practice transformation is to launch focused quality improvement (QI) efforts that explicitly aim to advance racial and health equity.

Several studies have demonstrated the positive impact of disparities-targeted quality improvement on improving racial equity in care delivery and practice performance.<sup>16</sup> For example, in the landmark national Health Disparities Collaborative, community health centers used quality improvement to reduce racial, ethnic, and socioeconomic disparities in care over the short-term (1-2 years) and key health outcomes over longer 2-4 year periods.<sup>17</sup> Similarly, health systems have also deployed disparities-targeted QI efforts to reduce racial health disparities for a range of issues, from COVID-19 care to cancer treatment.<sup>11,18</sup> The key is not to use a “one-size-fits-all” approach in which quality improvement interventions are broadly targeted to the general population.

Here are some considerations for developing equity-focused quality improvement goals and interventions:

1. If a QI effort only assesses potential improvements in baseline measures for a patient subgroup without comparing to others, it may have no impact on actual gaps in care between patient populations and may even inadvertently worsen racial health disparities.
2. Don’t involve a large number of patients in your quality improvement effort right out of the gate. The Model for Improvement takes the standard Plan, Do, Study, Act (PDSA) cycle from continuous quality improvement and emphasizes the goal of rapid cycle improvement—testing an intervention on a small group of patients to allow assessment and then revision of an intervention.<sup>17,19</sup>

Q&A

**As a practice, how do we avoid potential pitfalls when using quality improvement efforts to advance racial equity?**

In an example of a potential pitfall based on the first consideration listed above, a systematic review of nearly 300 diabetes-related, randomized, controlled quality improvement effort studies found that less than one-third of these efforts focused on equity, limiting the relevance and applicability of their data to disadvantaged populations.<sup>20</sup>

To avoid that problem, use REAL data to demonstrate gaps in care by comparing a quality measure among two or more groups. Then, set a goal of achieving better quality of care for marginalized populations *and* a decrease in the gap between groups. In our illustrative example, this is why we chose 2 related SMART goals—Within 4 months, we will:

- Achieve a 10% improvement in hypertension control from baseline among all eligible patients ages 30-65, including Black women and Latino men;
- and*
- Decrease disparities in uncontrolled hypertension rates between Black women, Latino men, and other groups by 10% from baseline.

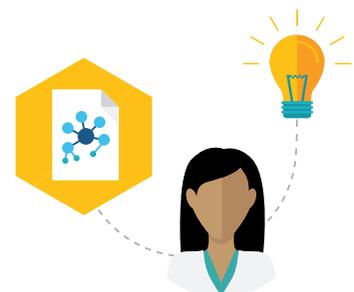
As you plan PDSA cycles remember to start small: pick a clear measure that is useful and might provide an “early win” rather than trying an approach that is poorly-defined, vague, or too broad. Remember, it is important for maintaining the team’s energy to finish a cycle of improvement and then analyze. Usually, no more than 6 weeks is helpful. For example, you can limit your initial PDSA by limiting the age range—“Over the next 6 weeks, we will increase outreach calls to Black women aged 40-50 and with a history of uncontrolled hypertension by 10%.” Note the metric here is outreach calls. Once you have achieved a higher rate of calls, the next PDSA cycle can look at, for example, increasing the percentage of calls that lead to scheduled visits (virtual, telephonic, and/or in-person).

**What if my practice wants to get more involved in broader, community- and societal-level efforts to advance racial equity?**

By all means, please do. Advancing racial and health equity requires coordinated action at all levels—by individuals, by organizations and institutions, by communities, and by society as a whole. Think about the HealthBegins “lead, partner, support” model for upstream action. The concrete STEPS outlined here can help your practice **lead** efforts to improve racial and health equity for patients and colleagues. Along the way, think about concrete opportunities for your practice to **partner** with other clinics as well as local nonprofits, advocacy groups, local businesses, and your public health department to advance racial equity in your community. Finally, even as a relatively small physician practice, you can add your collective voice in **support** of broader efforts to dismantle structural racism and advance health equity in our nation. [AMA Center for Health Equity](#) is a robust resource in this regard, as well.

## Conclusion

These 5 STEPS are meant for clinicians ready to work with their practice colleagues, patients, and communities to advance racial equity. This toolkit can help you develop shared understanding and commitment, set data-driven goals, and embark on a journey of continuous learning and improvement for racial and health equity.





## AMA Pearls

- Clinicians can use a series of open, respectful, and thoughtful questions to open up honest, meaningful conversations with patients about racism. For example, consider asking this question during routine physicals: “*Many of my patients experience racism in their health care. Are there any experiences you would like to share with me?*”
- Before making a plan to improve racial equity, it’s important for everyone in your practice to develop a better, shared understanding of racism and anti-racism. This requires a combination of individual and group learning to find out what you don’t know. Read and share articles and resources like those listed in this toolkit.
- Clinical and administrative leaders in your practice should focus on a few actionable measures to identify and target racial health disparities. Identify 2-3 measures that are meaningful to you, your team, and your practice based on current patient care-related priorities, like improving diabetes management, COVID-19 testing, annual wellness visits (AWVs), hypertension management, or flu shots. Using those measures, analyze care delivery and practice performance to identify disparities by race, ethnicity, and language (REAL) data. Celebrate your team’s efforts in studying the issue—even if they didn’t succeed in improving it. Reflect on what did and did not work and try again.

## Further Reading

### Journal Articles and Other Publications

#### Race, racism, and equity: General

- Learning for Justice (formerly Teaching Tolerance). Let’s talk: discussing race, racism and other difficult topics with students. Accessed April 10, 2021. <https://www.learningforjustice.org/sites/default/files/general/TT%20Difficult%20Conversations%20web.pdf>
- The Eliminating Disparities in Child and Youth Success Collaborative, the Coalition of Communities of Color, and All Hands Raised. Tool for organizational self-assessment related to racial equity. October 2013. Accessed April 10, 2021. [https://nhchc.org/wp-content/uploads/2019/08/organizational-self-assessment-related-to-racial-equity\\_oct-2013.pdf](https://nhchc.org/wp-content/uploads/2019/08/organizational-self-assessment-related-to-racial-equity_oct-2013.pdf)
- Jones K, Okun T. White supremacy culture. In: *Dismantling Racism: A Workbook for Social Change Groups*. ChangeWork; 2001. [http://www.csworkshop.org/PARC\\_site\\_B/dr-culture.html](http://www.csworkshop.org/PARC_site_B/dr-culture.html)
- Wilkerson I. America’s enduring caste system. *New York Times*. July 1, 2020. Updated January 21, 2021. Accessed April 12, 2021. <https://www.nytimes.com/2020/07/01/magazine/isabel-wilkerson-caste.html>
- Saad LF. Do the work: an anti-racist reading list. *The Guardian*. June 3, 2020. Accessed April 12, 2021. <https://www.theguardian.com/books/booksblog/2020/jun/03/do-the-work-an-anti-racist-reading-list-layla-f-saad>
- Kijakazi K, Schwabish J, Simms M. Racial inequities will grow unless we consciously work to eliminate them. Urban Wire: Race and Ethnicity, the blog of the Urban Institute. July 1, 2020. Accessed April 12, 2021. <https://www.urban.org/urban-wire/racial-inequities-will-grow-unless-we-consciously-work-eliminate-them>

#### Race, racism, and equity: Health care

- Sivashanker K, Gandhi TK. Advancing safety and equity together. *N Engl J Med*. 2020;382(4):301-303. doi:[10.1056/NEJMp1911700](https://doi.org/10.1056/NEJMp1911700)

- Endo, JA. Addressing race in practice. Institute for Healthcare Improvement blog. September 27, 2016. Accessed April 10, 2021. <http://www.ihl.org/communities/blogs/addressing-race-in-practice>
- Williams JC. Double jeopardy? An empirical study with implications for the debates over implicit bias and intersectionality. *Harv J L & Gend.* 37;2014:185-242. [https://repository.uchastings.edu/faculty\\_scholarship/1278/](https://repository.uchastings.edu/faculty_scholarship/1278/)
- Southern Jamaica Plain Health Center. Liberation in the exam room: racial justice and equity in health care. Institute for Healthcare Improvement. Accessed April 12, 2021. <http://www.ihl.org/resources/Pages/Tools/Liberation-in-the-Exam-Room-Racial-Justice-Equity-in-Health-Care.aspx>

## Other

- AHRQ Quality Indicators Project Toolkit. Instructions: project charter. Agency for Healthcare Research and Quality (AHRQ). Accessed April 12, 2021. <https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/qitoolkit/d2-projectcharter.pdf>

## Videos and Webinars

### Race, racism, and equity: General

- Gross T. A ‘forgotten history’ of how the U.S. government segregated America. *NPR Fresh Air.* May 3, 2017. Accessed April 12, 2021. <https://www.npr.org/2017/05/03/526655831/a-forgotten-history-of-how-the-u-s-government-segregated-america>
- ABC7 News Bay Area. What are structural, institutional and systemic racism? July 9, 2020. Accessed April 10, 2021. <https://www.youtube.com/watch?v=GtOOj5YvMyc>
- Race Forward YouTube page. Accessed April 12, 2021. <https://www.youtube.com/user/racialjustice>

### Race, racism, and equity: Health care

- American Medical Association. Prioritizing Equity video series: The root cause & considerations for health care professionals. June 17, 2020. <https://www.ama-assn.org/delivering-care/health-equity/prioritizing-equity-video-series-root-cause-considerations-health>
- American Medical Association. Prioritizing equity video series. <https://www.ama-assn.org/delivering-care/health-equity/prioritizing-equity-video-series-root-cause-considerations-health>

## Websites

### Race, racism, and equity: General

- Smith D. The 10 R’s of talking about race: how to have meaningful conversations. Net Impact. June 3, 2020. Accessed April 10, 2021. <https://www.netimpact.org/blog/talking-about-race>
- ThemPra Social Pedagogy. The learning zone model. Accessed April 10, 2021. <http://www.thempra.org.uk/social-pedagogy/key-concepts-in-social-pedagogy/the-learning-zone-model/>
  - The model’s “comfort, stretch, panic” framework assumes that to learn and improve, we all have to venture out from our comfort zone, where familiar norms and practices remain unchallenged, into a learning zone, where we can make new discoveries. That’s essential for racial health equity, which is a continuous learning process.
- Racial Healing and Reconciliation Project. The work. <http://www.racialrec.org/work/>

### Race, racism, and equity: Health care

- American Medical Association. AMA Center for Health Equity. Accessed April 10, 2021. <https://www.ama-assn.org/topics/ama-center-health-equity>

# Disclaimer

AMA STEPS Forward™ content is provided for informational purposes only, is believed to be current and accurate at the time of posting, and is not intended as, and should not be construed to be, legal, financial, medical, or consulting advice. Physicians and other users should seek competent legal, financial, medical, and consulting advice. AMA STEPS Forward™ content provides information on commercial products, processes, and services for informational purposes only. The AMA does not endorse or recommend any commercial products, processes, or services and mention of the same in AMA STEPS Forward™ content is not an endorsement or recommendation. The AMA hereby disclaims all express and implied warranties of any kind related to any third-party content or offering. The AMA expressly disclaims all liability for damages of any kind arising out of use, reference to, or reliance on AMA STEPS Forward™ content.

# References

1. Hecht B. Moving beyond diversity toward racial equity. *Harv Bus Rev*. June 16, 2020. Accessed March 15, 2021. <https://hbr.org/2020/06/moving-beyond-diversity-toward-racial-equity>
2. Jones CP. Levels of racism: a theoretic framework and a gardener's tale. *Am J Public Health*. 2000;90(8):1212-1215. doi:[10.2105/ajph.90.8.1212](https://doi.org/10.2105/ajph.90.8.1212)
3. Wade L. Nearly half of Black and Latina scientists are mistaken for janitors or assistants. The Society Pages Sociological Images. July 2, 2015. Accessed April 12, 2021. <https://thesocietypages.org/socimages/2015/07/02/nearly-half-of-black-and-latina-stem-workers-mistaken-for-janitors-and-assistants/>
4. Lee E. Redlining & health equity: how health systems can help dismantle structural racism. HealthBegins. April 10, 2020. Accessed April 12, 2021. <https://healthbegins.org/redlining-health-equity-how-health-care-can-help-dismantle-structural-racism/>
5. Nix E. Tuskegee experiment: the infamous syphilis study. History.com. Accessed April 12, 2021. <https://www.history.com/news/the-infamous-40-year-tuskegee-study>
6. Holland B. The 'father of modern gynecology' performed shocking experiments on enslaved women. History.com. Accessed April 12, 2021. <https://www.history.com/news/the-father-of-modern-gynecology-performed-shocking-experiments-on-slaves>
7. O'Reilly KB. AMA: Racism is a threat to public health. American Medical Association. November 16, 2020. Accessed April 12, 2021. <https://www.ama-assn.org/delivering-care/health-equity/ama-racism-threat-public-health>
8. Polubriaginof FCG, Ryan P, Salmasian H, et al. Challenges with quality of race and ethnicity data in observational databases. *J Am Med Inform Assoc*. 2019;26(8-9):730-736. doi:[10.1093/jamia/ocz113](https://doi.org/10.1093/jamia/ocz113)
9. Maybank A. The pandemic's missing data. *New York Times*. April 7, 2020. Accessed April 12, 2021. <https://www.nytimes.com/2020/04/07/opinion/coronavirus-blacks.html>
10. Health Research & Educational Trust. A framework for stratifying race, ethnicity and language data. October 2014. Accessed April 12, 2021. <http://www.hpoe.org/Reports-HPOE/REAL-data-FINAL.pdf>
11. Sivashanker K, Duong T, Ford S, Clark C, Eappen S. A data-driven approach to addressing racial disparities in health care outcomes. *Harv Bus Rev*. July 20, 2020. Accessed April 12, 2021. <https://hbr.org/2020/07/a-data-driven-approach-to-addressing-racial-disparities-in-health-care-outcomes>

12. Sivashanker K, Duong T, Resnick A, Eappen S. Health care equity: from fragmentation to transformation. *NEJM Catalyst*. September 1, 2020. Accessed April 12, 2021. <https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0414>
13. Morse M, Finnegan A, Wispelwey B, Ford C. Will COVID-19 pave the way for progressive social policies? Insights from critical race theory. *Health Affairs Blog*. July 2, 2020. doi:[10.1377/hblog20200630.184036](https://doi.org/10.1377/hblog20200630.184036)
14. Ford CL, Airhihenbuwa CO. Critical Race Theory, race equity, and public health: toward antiracism praxis. *Am J Public Health*. 2010;100 Suppl 1(Suppl 1):S30-S35. doi:[10.2105/AJPH.2009.171058](https://doi.org/10.2105/AJPH.2009.171058)
15. Transforming Clinical Practices Initiative. Change package in action. Centers for Medicare and Medicaid Services (CMS). December 2019. Accessed April 12, 2021. <https://innovation.cms.gov/files/x/tcpi-changepkg.pdf>
16. Green AR, Tan-McGrory A, Cervantes MC, Betancourt JR. Leveraging quality improvement to achieve equity in health care. *Jt Comm J Qual Patient Saf*. 2010;36(10):435-442. doi:[10.1016/s1553-7250\(10\)36065-x](https://doi.org/10.1016/s1553-7250(10)36065-x)
17. Chin MH. Quality improvement implementation and disparities: the case of the health disparities collaboratives. *Med Care*. 2010;48(8):668-675. doi:[10.1097/MLR.0b013e3181e3585c](https://doi.org/10.1097/MLR.0b013e3181e3585c)
18. Hostetter M, Klein S. In focus: reducing racial disparities in health care by confronting racism. The Commonwealth Fund. September 27, 2018. Accessed April 12, 2021. <https://www.commonwealthfund.org/publications/2018/sep/focus-reducing-racial-disparities-health-care-confronting-racism>
19. IHI Open School. Quality improvement 102: the model for improvement: your engine for change. Institute for Healthcare Improvement. 2012. Accessed April 12, 2021. <http://www.ihf.org/education/ihfopenschool/Courses/Documents/QI102-FinalOnePager.pdf>
20. Lu JB, Danko KJ, Elfassy MD, Welch V, Grimshaw JM, Ivers NM. Do quality improvement initiatives for diabetes care address social inequities? Secondary analysis of a systematic review. *BMJ Open*. 2018;8(2):e018826. doi:[10.1136/bmjopen-2017-018826](https://doi.org/10.1136/bmjopen-2017-018826)

DEVELOPED IN COLLABORATION WITH  HEALTH BEGINS

HealthBegins is a mission-driven consulting and technology firm dedicated to improving care and the social determinants of health. Founded by physicians and public health experts, HealthBegins believes that healthcare is better when it routinely addresses “upstream” social and environmental conditions that make people sick, especially for our most vulnerable patients and communities. HealthBegins has emerged as a leading network for healthcare “Upstreamists,” professionals who systematically integrate clinical care and community health efforts. HealthBegins builds system capability and supports practice redesign through strategic consulting, technical assistance, education, and training solutions.

#### About the AMA Professional Satisfaction and Practice Sustainability Group

The AMA Professional Satisfaction and Practice Sustainability group has been tasked with developing and promoting innovative strategies that create sustainable practices. Leveraging findings from the 2013 AMA/RAND Health study, “Factors affecting physician professional satisfaction and their implications for patient care, health systems and health policy,” and other research sources, the group developed a series of practice transformation strategies. Each has the potential to reduce or eliminate inefficiency in broader office-based physician practices and improve health outcomes, increase operational productivity, and reduce health care costs.