

Racial and Health Equity: Concrete STEPS for Health Systems

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

Developed in partnership with



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How Will This Toolkit Help Me?

Learning Objectives:

1. Identify ways to prepare your health system or large group practice for conversations about health equity, racial equity, racism, and anti-racism
2. Employ questions to engage other leadership, administrators, clinicians, patients, and other stakeholders in conversations about racial and health equity
3. Describe the importance of system-wide data and how to improve the quality of your data to further racial and health equity efforts
4. Explain how to advance racial and health equity in your health system using SMART goals and quality improvement efforts



Introduction



What is Health Equity?

The World Health Organization defines health equity as “the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification. ‘Health equity’ or ‘equity in health’ implies that ideally everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential.”¹ Another valuable definition comes from Paula Braveman: “Health equity is the principle underlying a commitment to reduce—and, ultimately, eliminate—disparities in health and in its determinants, including social determinants. Pursuing health equity means striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions. ...Health equity means social justice in health (ie, no one is denied the possibility to be healthy for belonging to a group that has historically been economically/socially disadvantaged).”² Ultimately, health equity means optimal health for all, and is a goal all health care organizations, big and small, can work toward through their day-to-day work.

How Can Health Systems Advance Health and Racial Equity?

As the commitment to advance health equity and racial equity grows across many sectors, motivated physicians in medium and large health systems—ranging from physician groups and integrated delivery systems to hospital-affiliated outpatient practices and emergency and inpatient 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?*

**For the purposes of this document, we use the term “health system-affiliated practice” to describe care delivered by a team of health care professionals within or closely affiliated with mid and large health care delivery settings. These settings range from large physician groups, clinically integrated networks, and integrated delivery systems to large hospital-affiliated outpatient practices and emergency and inpatient settings.*

- Does everyone in our practice and health system understand how institutionalized racism shapes clinical practice, patients' health outcomes, and the health of the community? How can we better understand or deepen our understanding?
- Do all patients feel equally welcome by our employees and comfortable in our clinic?
- Does our health system's payer mix reflect or even exacerbate institutionalized racism?

Leadership may desire to improve internal diversity, equity, and inclusion (DEI) initiatives, asking questions like:

- Do all employees feel equally welcome and comfortable at work?
- Do our recruitment and hiring practices consider diversity within our organization?
- Are our recruitment and hiring practices bringing in individuals who **represent the patient population** we serve?
- How do internal DEI efforts for employees relate to our pursuit of health equity and racial equity for our patients and community at large?

Since health equity and racial justice are not only desirable outcomes but also ongoing interrelated processes, this toolkit adapts a practice transformation framework to offer 5 STEPS that can help motivated leaders move health systems forward to embed racial justice in their practices and advance health equity for clinicians, for patients, and for the communities served. Recognizing that the **path to equity** and justice is a dynamic, long-term journey, this toolkit focuses on initial catalytic STEPS and associated resources to translate that commitment to equity into action and make meaningful improvements that can produce concrete benefits to patients, clinicians, and other colleagues in their health systems. These recommended STEPS are part of a larger cycle of continuous learning, improvement, and accountability envisioned in the American Medical Association's **Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity** that seeks to advance equity through transformation efforts at the patient, organizational, community, and societal levels.

“As health care organizations, payers, and others focus on social determinants and population health, we have a responsibility to ask: To what degree are our approaches grounded in a framework that addresses structural racism and equity? If we can't answer that question with rigor and candor, even our most innovative solutions might perpetuate inequity and illness, not prevent it.”³

—Rishi Manchanda, MD, MPH; President and Chief Executive Officer, HealthBegins

For leaders who wish to disseminate a focused toolkit to specific departments or divisions, or individuals wanting to learn how to implement racial and health equity strategies in a smaller or solo practice, visit the related AMA STEPS Forward™ toolkit, **Racial and Health Equity: Concrete STEPS for Smaller Practices**.

Five STEPS to Advance Racial and Health Equity in Your Health System

1. Commit as a Health System to Do the Work

2. Start Shifting Organizational Norms and Practices by Learning About What You Don't Know

3. Get a Handle on Your Data

4. Develop a Shared, Clear, Compelling Vision and Goals for the Entire System

5. Launch Targeted Improvement Efforts Across the System

1

Commit as a Health System to Do the Work

Like every organizational transformation effort, advancing racial justice 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.

Committing to do the work—and then actually doing it—may start with you, whether you are a C-suite leader of a major health system, the manager or medical director of a division or department, or a frontline clinician within the health system.

Health system commitment occurs in 2 phases that could take place simultaneously or sequentially.

Phase 1: Establish Where You Are by Asking Questions

A good place to start is by asking questions. Talking about racism, racial justice, or health equity in clinical practice may make some of your colleagues and other stakeholders uncomfortable. While it's important to approach conversations about racial equity with respect and candor, expect discomfort and even some degree of conflict. After all, advancing racial justice and health equity in clinical practice involves challenging norms and interrupting patterns that maintain structural disadvantages from patient-facing issues such as access to care and population health management to organizational issues such as hiring, advancement, and pay equity.⁴

One way to overcome the discomfort inherent to racial equity work is to spend some time absorbing the **Learning Zone model** or reviewing this **guide** from the Southern Poverty Law Center. With this foundation, you may gain confidence to have open, honest, and potentially uncomfortable conversations about racial justice and health equity as you lead your organization towards a more equitable practice.



Consider asking employees and colleagues questions that invite honest self-assessment within and across clinical and administrative departments:

- *Do we know whether access to care, preventive screenings, treatments, quality, or outcome measures differ by patient race, ethnicity, and language?*
- *When was the last time, if ever, that we asked patients and employees 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 while increasing engagement and commitment among leadership and employees.

Phase 2: Identify a Champion

With the aforementioned questions in mind, the next phase of commitment is to identify champions for advancing racial and health equity work within your organization and across departmental or practice settings. Identify and convene champions across administrative departments and centers (eg, Quality & Safety, Population Health Management, Human Resources, DEI, community benefits), clinical departments, and patient support services. Champions should be trusted, respected voices who have a strong motivation and commitment to racial justice and health equity. If you're reading this, you may be one of these champions.

It is critically important for health system leaders at all levels to understand and avoid [tokenism](#), which overemphasizes representation at the expense of authentic inclusion, and other unfair practices when identifying champions. For example, Black professionals across many industries report a common pattern in which executives appoint a junior person of color to be a “champion” or lead for racial equity-related work, provide them little or no resources, and then ask them to solve the problems of racism in their organizations that they neither created nor benefit from. In some cases, Black, Latinx, and other people of color are expected to serve as “[cultural ambassadors](#),” which leaves them to do 2 jobs: “the official one the person was hired to do, and a second one as champion for members of the person’s minority group.”⁵ Instead of giving the illusion of an organizational commitment to racial justice, health system leadership should invest time and resources to engage in this work, starting with providing authentic, meaningful support for champions.

As a reflection of the organization's formal commitment to this work, this cross-departmental group of champions should have an [official charter](#) with clear executive sponsorship and support.

Many organizations are taking their commitment a step further by establishing formal Centers for Health Equity and hiring a Chief Equity Officer. By creating an infrastructure and allocating financial and human resources to your initiatives, your organization is far better positioned to create long-term, radical change. If you need support in deciding how to begin transformation or engage your leadership, watch a few videos like [this one](#) in the AMA's [Prioritizing Equity](#) series.

A Tool Kit for Productive Conversations on Race

Learn about the Mass General Brigham “See. Hear. Act.” approach to discussing race. (PDF, 5,231 KB)

Q&A

[My colleagues and I work long hours. What can I do to support colleagues and employees having these difficult conversations?](#)

Like other significant initiatives that seek to improve patient outcomes and advance the medical profession, advancing racial justice and health equity through your day-to-day work is not a small project. This initiative will require transformative changes to both your practice and overall health system. Therefore, 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 justice and health equity.

Setting aside time and space can be challenging for leaders in [toxic workplaces](#) or those in predominantly fee-for-service settings where incentives are often not aligned with population health outcomes and where clinical team members may be used to coming up with solutions or plans for individual patients within limited amounts of time. Health system leaders at all levels—from enterprise executives to

department leads—should recognize and help explain that this brief mode of conversation doesn't work when it comes to the deeper dialogue and ongoing work of understanding and addressing the legacy of racial injustice and health inequity as a team, department, and system.

2

Start Shifting Organizational Norms and Practices by Learning About What You Don't Know

Name it, frame it, explain it.

Before making a plan to improve racial justice and health equity, it's important for everyone in the health system to develop a better, shared understanding of racism. This includes developing an understanding of the 4 types of racism in medicine (structural, institutional, interpersonal, internalized)—and anti-racism. (For more on the 4 types of racism in medicine, see Figure 1 on page 15 of the AMA's [Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity](#) for definitions.) Gaining this understanding requires a combination of individual and group learning to find out what you don't know. Provide dedicated time as well as informal opportunities at work to talk with colleagues. Leadership should not only facilitate the dissemination of information but take an active role in engaging groups and individuals in the learning process.

Review the ways white privilege and white supremacy influence [organizational culture](#). Approach conversations with respect, listen, and be open to questions in yourself and your health system, then consider how this approach may influence culture and patient care.

Learn from the experiences of others:

- Talk with other leaders and colleagues about the benefits and challenges of beginning the work
- Read about the experiences of other health systems advancing [health equity](#) and [racial justice](#)
- Read and share AMA's landmark [Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity](#)
- Share lessons from “bright spots”: other health systems, organizations, or practices that have started the journey to racial equity
- Partner with internal DEI leaders and consider hiring an experienced consultant to facilitate group conversations and normalize a commitment to racial justice and health equity
- Pursue opportunities to engage and support patients, community members, and local leaders, especially those who belong to historically marginalized communities, in this conversation

There are even some questions you can consider using during patient visits:

Figure 1. Questions to Ask In The Exam Room

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.

[Advancing Health Equity: A Guide to Language, Narrative and Concepts](#), designed for physicians and other health care professionals, provides guidance and promotes a deeper understanding of equity-focused, person-first language and why it matters

Q&A

What are some key concepts I can read more about and share with colleagues?

The AMA's [Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity](#) covers key concepts, 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 forms of racism, especially interpersonal and institutionalized racism?

“The most common understanding of racism in our country is limited to the 'interpersonal' level—the personal prejudice and intentional bias in our individual interactions across different races.” This statement from [Race Forward](#), a national racial justice training and research organization, summarizes a widespread yet oversimplified assumption, including among many in medicine.

As the AMA's landmark [Strategic Plan to Embed Racial Justice and Advance Health Equity](#) (page 15, Figure 1) outlines, however, there are actually 4 types of racism. These forms are interrelated and compounding. There is:

- **Internalized racism**, which refers to “acceptance by members of stigmatized races of negative messages about their own abilities and intrinsic worth.” This form of racism **lies within individuals**.
- **Interpersonal racism**, which occurs and is “the expression of racism **between individuals**.”
- **Institutionalized racism**, which refers to “discriminatory treatment, unfair policies and practices, and inequitable opportunities and impacts **within organizations and institutions**, based on race.”
- **Structural racism**, which “refers to the totality of ways in which societies foster racial discrimination through mutually reinforcing systems.” As such, structural racism represents the deep and compounding impact of racial bias **across institutions and society**, which in turn shapes and reinforces the patterns and experiences of other forms of racism. One of the classic examples of structural racism is 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**.” The segregation caused by redlining continues to have long-term, cascading impacts on racial inequities across sectors—in economic opportunity, health, and justice.

Because this toolkit focuses on concrete STEPS you can take to advance racial equity within your health system, let's spend a moment to better understand institutionalized racism in the context of health care and how it differs from the more common understanding of interpersonal racism.

Per Camara Jones, MD, MPH, PhD, “interpersonal 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.’”⁶ It is, as the AMA describes, the expression of racism **between individuals**, through prejudice and discriminatory behavior. To illustrate how prejudice can manifest, consider a [2015 study](#) in which nearly half of Black and Latina professional women in science, technology, engineering, and math (STEM) reported that they have been mistaken for janitors and administrative staff.

In contrast, “institutionalized racism manifests through discriminatory treatment, unfair policies and practices, and inequitable opportunities **within organizations and institutions**, based on race.” It is, as Dr Jones explains, “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.”⁶ For an example of institutionalized racism in medicine, consider the accumulating evidence of the dangers associated with incorporating race in diagnostic algorithms and practice guidelines across disciplines, including cardiology, nephrology, obstetrics, and urology. As Darshali Vyas and colleagues have noted in the *New England Journal of Medicine*, [race-based algorithms](#), which erroneously perpetuate the harmful idea that race is biological rather than a social construct, may direct more clinical “attention or resources to white patients than to members of racial and ethnic minorities.”

How has institutionalized racism shaped health care?

Modern medicine has a long, 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 (eg, blindness, mental illness, and death) for study subjects and their children.

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.

The legacy of institutionalized racism continues to shape health care and health outcomes and has led many professional **associations** and organizations to finally **commit to action**.

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

Absolutely. For example, consider asking this question during routine physicals and visits: “Many of my patients experience racism in their health care. Are there any experiences you would like to share with me?” And check out Liberation in the Exam Room, a tool developed by the Southern Jamaica Plain Health Center, to learn about practical and meaningful ways to act on the responses you receive (see Figure 1).

Your health system or clinical department can also work with community leaders to **convene patients and community members** to discuss the history of institutionalized racism in medicine, including your own institution's history, as well as ways to advance racial justice and health equity. For example, read more about the “acknowledgment, redress, and closure” or **ARC model**, a pilot initiative at Brigham and Women's Hospital. These are helpful ways to build patient and community trust and **institutional accountability** for racial justice and health equity work.

“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.”⁷

—Aletha Maybank, MD, MPH; Chief Health Equity Officer, American Medical Association

3

Get a Handle on Your Data

To chart a course forward on racial equity, it's essential to understand your organization's data on a granular level and a population level. Ask 2 basic questions within and across your departments:

- What does our patient data tell us about racial inequities in quality, access, health outcomes, and health-related social needs among our patients?
- What does data from our community tell us about these patient and community-wide inequities?

One **commentary** proposes a 4-tiered sequential pragmatic framework that your health system and/or department could use to begin to assess for patterns of inequity among your patients (Figure 2).

Figure 2. Example of a Sequential, Pragmatic Framework to Measure Inequity



Adapted from Sivashanker K, Duong T, Resnick A, Eappen S. Health care equity: from fragmentation to transformation. NEJM Catalyst. September 1, 2020. Accessed September 27, 2021. <https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0414>

As more accrediting and **oversight** organizations focus on health system commitments to identify and address health inequities, it is important to routinely collect and analyze patient and department-level performance data, as well as employee data, by **race, ethnicity, and primary language (REAL)**.

The COVID-19 pandemic has revealed that many hospitals and health care systems, as well as state and federal governments, fail to consistently capture REAL demographic information about patients. The omission of data on race, ethnicity, and language is just one-way institutionalized racism manifests in health care. Support patient self-recording of race, ethnicity, and language data through the use of patient-facing tools online and/or at the point of service in your practice.⁸ As your department begins to collect and analyze REAL data, leverage other data such as age, sexual orientation and gender identity, income, and occupation as “filters” to help discover additional hidden patterns of inequity. This is also a good moment to discuss and consider whether the [data algorithms](#) and software your health system uses for risk stratification, predictive, and/or prescriptive analytics are perpetuating institutional racism. Consider requesting or conducting an equity [audit](#) of your algorithm, and review and discuss emerging recommendations for ethical approaches to issues of algorithmic bias in machine learning.

To help identify additional social and structural drivers of these health inequities, apply aggregate-level patient-level data on health-related social needs, such as food insecurity or housing instability, to your analysis. Where feasible, leverage internal and external expertise to geocode and [analyze EHR data](#) to identify [geographic](#) patterns or clusters of health inequity. Compare the insights from that analysis of patient data with community-level data to further understand these inequities as they manifest within and outside the walls of your health system.

Many large health systems conduct Community Health Needs Assessment (CHNA). These assessments are typically performed every 3 years in collaboration with local public health departments and community input. The report is publicly available on the website of each hospital and includes information about the population served, and identifies disparities and prioritized health issues of concern.

Example CHNA Report

This document is the 2019 Rush University Medical Center and Rush Oak Park Hospital Community Needs Assessment and corresponding 2020-2022 Community Health Implementation Plan. (PDF, 5,781 KB)

Q&A

[My health system department is already inundated with data. How do we focus?](#)

Clinical and administrative leaders in your department should focus on a few actionable measures to identify and target racial health inequities. Here are some suggestions:

- Identify 2 to 3 clinical process, outcome, or patient experience measures that are meaningful to you, your employees, and your clinical or administrative department based on current clinical and strategic priorities. For example, depending on your department, this might include improving diabetes management, COVID-19 testing, Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, cancer treatment or early diagnosis rates, no-show rates, or transitions of care measures.
- If this is your first time looking at measures in this way, start small. For example, you might consider a review of curative treatment rates among 100 patients diagnosed with early-stage lung cancer in your institution over the last several years (this example is directly inspired by [a large interventional study](#)).
- Use REAL data to analyze care delivery and practice performance to identify inequities and [visualize the findings](#) with graphs and charts.
- Decide on 1 specific measure that can serve as a constant reminder that certain populations are disproportionately impacted or neglected (eg, percentage of patients who receive curative treatments for early-stage lung cancer stratified by REAL measures).
- 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 or accreditors but not reviewed in team meetings).
- Share data transparently with employees and other departments, engaging everyone in improvement.

As a health system, 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 address 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.”

Also assess differences in payer mix across physicians at the system, department, and practice levels. For example, does one group of physicians or a department in your health system have a much smaller proportion of Medicaid and/or uninsured patients compared to their peers? If so, has your health system discussed the racial justice implications of this disparity in payer mix?

Why is it important to apply data filters to uncover patterns of inequity?

It is not as simple as focusing on identifying whether the care of Black patients is differentially impacted compared to White patients. One of the most important elements of anti-racism is an understanding of “intersectionality,” or “the understanding that individual or group experiences of oppression cannot be distilled into a single identity, such as either female or Black for Black women.”⁹⁻¹⁰ This means that race, as a sociopolitical construct, intersects with multiple aspects of people’s identities, including gender, sexuality, and ethnicity. Clinicians have used filters to **reveal inequities** that would otherwise remain hidden. This application of “intersectionality” is complementary to the goal of collecting and analyzing REAL data. Intersectionality requires a more sophisticated analysis beyond simply looking for “Black vs White” differences in data.

To illustrate intersectionality, analyzing your data using REAL variables along with other demographic data might help you uncover that adult Black men and women, especially those who live in a defined cluster of census tracts, experience significantly lower enrollment and treatment adherence rates for early-stage lung and breast cancer as well as worse outcomes compared to other patients. If your department or system collects data on health-related social needs like financial insecurity, food insecurity, or housing instability, adding this information as an additional filter can help reveal hidden health-related and place-based patterns of racial, economic, and social inequity. You might find, for example, that the inequities in cancer treatment rates and outcomes described above are more severe for patients with low-wage jobs and/or food insecurity, and especially high among those patients who reside in specific historically marginalized neighborhoods.

Expand your analysis to identify potential racial inequities in your own workplace. Encourage your clinical and administrative colleagues, including human resource managers, to review employee-facing REAL and economic data—including data on employee hiring, advancement, pay, benefits, financial hardship (eg, evidenced by hardship loans)—to first identify racial, ethnic, linguistic, and wage-based disparities within your workforce. Then encourage and participate in institutional efforts to investigate why those racial and/or economic inequities exist within your workplace and implement policies to address them.

4

Develop a Shared, Clear, Compelling Vision and Goals for the Entire System

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 inequities in care delivery and performance, both within your department and across the entire system.

There are 2 components to remember.

1. First, under the auspices of an enterprise-wide group of leaders who represent various administrative departments and centers, clinical departments, and patient support services (eg, a “health equity and racial justice task force or workgroup”), each department should develop its own equity-focused, quality

improvement-based **project charter**. One leader in each department should serve as their department team's executive sponsor, with direct reporting requirements to the taskforce and C-suite executives, who in turn provide resources and communicate why this work aligns with the mission and values of the entire organization.

Keep racial justice front and center as you develop your department's team charter. A key element of being an anti-racist health system 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.”¹¹ To center your team charter in “the margins,” invite and support individuals from historically marginalized groups. With trusted and trained facilitators, invite and provide financial support to patients, employees, and community residents to discuss and review your charter and to validate or invalidate your health system's approach and ideas about how to reduce racial inequities.

Here are 2 examples of how different health systems are using charters and task forces in their endeavor to become anti-racist organizations:

- Leaders at Brigham and Women's Hospital designed a program—called the **Healing ARC** (*acknowledgment, redress, and closure*)—and centered Black and Latinx patients and community members most impacted by unjust heart failure management to inform clinical interventions as well as institutional restitution for historic patterns of racial inequity in the health system's own care and treatment of heart failure patients.
- Mt. Sinai Health System created a task force to address racism in the wake of George Floyd's murder and the surge of support for the Black Lives Matter movement. The task force includes 51 team members across all levels of the organization. With input from all departments, the task force developed a **road map** to advance 11 institutional strategies. Founding the Institute for Health Equity Research and expanding leadership development opportunities are among the changes the system has already implemented.
 2. Second, each department should draft a quality improvement-based project charter, including SMART (Specific, Measurable, Achievable, Relevant, and Time-Bound) goals based on your data analysis and identified inequities. Using our example of patients with early-stage lung cancer, a racial equity team based in a health system's oncology department could define a project charter with the following SMART goals.

Within 12 months, this department will work with key stakeholders, including patients and individuals from historically marginalized communities, to:

 - *Achieve at least 20% increase from baseline in curative treatment rates among all adult patients, including Black men and women;*
 - ***and***
 - *Decrease inequities in curative treatment rates between Black men and women and other groups by at least 20% from baseline.*



Q&A

Do we need to involve everyone in the health system or limit our racial justice and health equity work to a small team?

Advancing racial justice and health equity requires practice and system transformation. And the evidence from thousands of practice transformation efforts is clear: “all staff in the health system, regardless of how big or small it is, must coordinate their work to succeed”.¹² As racial equity-focused teams form within and across different departments, use health system all-hands meetings, departmental meetings, huddles, and other forms of communication to inform and engage everyone in your organization. Get feedback, review why this work matters, and ensure that all clinical and administrative team members understand their role in the project. And be sure to celebrate even small **successes!** Share letters of congratulations as the team makes progress. Through newsletters, highlight and recognize informal and formal leaders in your health system or department, or even individual practices, who are helping advance racial equity for patients and employees.



5

Launch Targeted Improvement Efforts Across the System

Instead of simply identifying and accepting that racial health inequities exist, the preceding STEPS will help everyone in your health system to develop a shared understanding of why they exist and a shared commitment and plan to eliminate them. The next STEP in system transformation is for teams within and across departments to launch focused quality improvement (QI) campaigns that explicitly and specifically aim to advance racial justice and health equity.

Several studies have demonstrated the positive impact of equity-targeted quality improvement on improving racial equity in care delivery and practice performance.¹³ 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 to 2 years) and key health outcomes over longer, 2- to 4-year periods.¹⁴ Similarly, health systems have also deployed disparities-targeted quality improvement to reduce racial health disparities for a range of issues, from COVID-19 care to **cancer treatment**. The key is not to use a “one-size-fits-all” approach in which quality improvement interventions are broadly targeted to the general population. See below for an example of how to develop equity-focused quality improvement goals and interventions.

Here are some vanguard examples of health system-based initiatives to embed racial justice and advance health equity.

- **The ACCURE Trial** identified and intervened to improve racial equity in 5 cancer centers across the US, nearly eliminating existing inequities in treatment and outcomes for Black patients with early-stage lung and breast cancer. This intervention was the inspiration for the illustrative examples described in this toolkit.
- Northwell Health created the **Center for Diversity, Inclusion and Health Equity** and leveraged existing departmental structures to help identify health inequities and integrate equity into daily functions across the health system. For example, the Center reviews and updates the system's Language Access Plan to improve equity for persons who have limited English proficiency. In 1 year, the system provided more than 260 000 language interpretation calls.
- NYC Health + Hospitals recently launched the **Medical Eracism** initiative, led by its Office of Quality & Safety and its new Equity & Access Council. The initiative has already prompted the health system to discontinue the use of 2 race-based clinical assessments for kidney function and vaginal delivery after C-sections to help reduce racial biases in care.

- In 2016, UW Medicine formed a multidisciplinary committee to advance health care equity. The following year, the committee released an enterprise-wide [Healthcare Equity Blueprint](#). By 2019, the committee expanded the use of health care equity dashboards system-wide. In 2020, health system leaders merged this and other efforts and created an Office of Healthcare Equity to advance this work.

Q&A

As a health system, what are the pitfalls in using quality improvement to advance racial equity?

First, if a quality improvement 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. For example, [a systematic review](#) of nearly 300 diabetes-related randomized controlled quality improvement studies found that less than one-third of these efforts focused on equity, which not only limits the relevance and applicability of their data to disadvantaged populations but also ignores and potentially widens gaps in care. This caution is also relevant for QI-based efforts that seek to improve patients' behavioral health and/or health-related social needs. Without an explicit equity-based analysis or set of goals, even those types of quality improvement initiatives may improve quality for more advantaged patients without actually reducing inequities experienced by patients belonging to historically marginalized groups.

To avoid this problem, use REAL data to demonstrate gaps in care or outcomes by comparing a quality measure among 2 (or more) groups. Then, set 2 related goals—first, to achieve better quality of care and outcomes for marginalized populations AND second, to decrease the gap between subgroups.

Using the previous example evaluating disparities in cancer care, consider this template to start—replacing bracketed text with your chosen criteria:

Within [time period], we will:

- achieve at least [target]% increase from baseline in [measure] for [patient population]*
- decrease inequities in [measure] between [patient population subgroups being compared] by at least [target]% from baseline*

Second, don't involve lots of patients in your quality improvement effort right out of the gates. 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 with a small group of patients to allow assessment and then revision of an intervention.¹⁴

As you plan [PDSAs](#), remember to start small. Pick a measure that is useful and might provide an “early win” rather than trying an approach that is poorly defined, vague, or too broad. Remember, in order to maintain your team's energy, it is important to finish a cycle of improvement and then analyze. Usually, no more than 6 weeks is helpful. For example, based on your equity-based goals, you can restrict your initial PDSA by limiting the age range: “Over the next 6 weeks, we will increase outreach calls to Black women aged 40 to 50 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 health system wants to get more involved in broader, community- and society-level efforts to advance racial equity?

By all means, please do! With authentic leadership, transparent goals, and collaborative partnerships, your health system can move towards a more racially equitable and just practice. Advancing racial justice and health equity requires supporting and taking coordinated action to improve the social and structural drivers of health equity at all levels: by improving services and outcomes for individuals, by mobilizing change within and across institutions, and by driving community and societal-level investments that

dismantle and transform harmful structures and environments. HealthBegins defines this work as “moving upstream.”

Think about the HealthBegins “**lead, partner, support**” approach and strategy compass for upstream action. The concrete STEPS outlined in this toolkit can help your health system **lead** efforts to improve racial justice and health equity within your institutions for patients and colleagues. This work includes acknowledging and reducing harm and racial health inequities exacerbated by institutional practices. As you progress on this journey, pursue concrete opportunities for your system to **partner** with other health systems, health plans, as well as local nonprofits, community-based advocacy coalitions, local businesses, and your public health department in multi-sector collaboratives and initiatives that work to address structural drivers of racial injustice and inequity in your community. Finally, leverage the resources and civic role of your health system and seek ways to share, cede, and help build power in **support** of broader policy efforts and movements to dismantle structural racism and advance health equity in our nation. The [AMA Center for Health Equity](#), for example, has resources in this regard as well.



Conclusion

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



AMA Pearls

- Before making a plan to improve racial equity, it's important for everyone in your health system to develop a better, shared understanding of racism and anti-racism. Recruit and support leaders and start or reinvigorate a cross-departmental task force or council to move this work forward while avoiding tokenism.
- Identify 2 to 3 core racial equity-related measures that are meaningful to you, your health system, and your community based on current patient care-related priorities.
- Consider measures that seek to reduce racial inequities in access, quality of care, transitions of care, health-related social needs, and treatment outcomes.
- Always use REAL data to analyze care delivery and practice performance to identify disparities.

Further Reading

Journal Articles and Other Publications

Race, racism, and equity: General

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Videos and Webinars

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- 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.
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Article Information

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The AMA Professional Satisfaction and Practice Sustainability group is committed to making the patient–physician relationship more valued than paperwork, technology an asset and not a burden, and physician burnout a thing of the past. We are focused on improving—and setting a positive future path for—the operational, financial, and technological aspects of a physician's practice. To learn more, visit <https://www.ama-assn.org/practice-management>.

About HealthBegins

HealthBegins is a national, mission-driven consulting and training firm dedicated to improving the social and structural drivers of health equity for patients and communities. Founded by physicians and public health experts, HealthBegins provides strategic consulting, training and education, technical assistance, and advocacy to help vanguard health care, public health, and community organizations improve the “upstream” social, environmental, and economic conditions that make people sick, especially in historically marginalized communities. HealthBegins has emerged as a leading network for “Upstreamists”—health care professionals with the responsibility and skills to systematically integrate, transform, and lead clinical care and community health efforts to advance health equity. To learn more, visit <https://healthbegins.org/>.

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