



# A Toolkit to Advance Racial Health Equity in Primary Care Improvement

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APRIL 2022



# Credits



Suggested citation: Rishi Manchanda, Roza Do, and Nasaura Miles. *A Toolkit to Advance Racial Health Equity in Primary Care Improvement*. California Improvement Network, California Health Care Foundation, Healthforce Center at UCSF, April 2022.

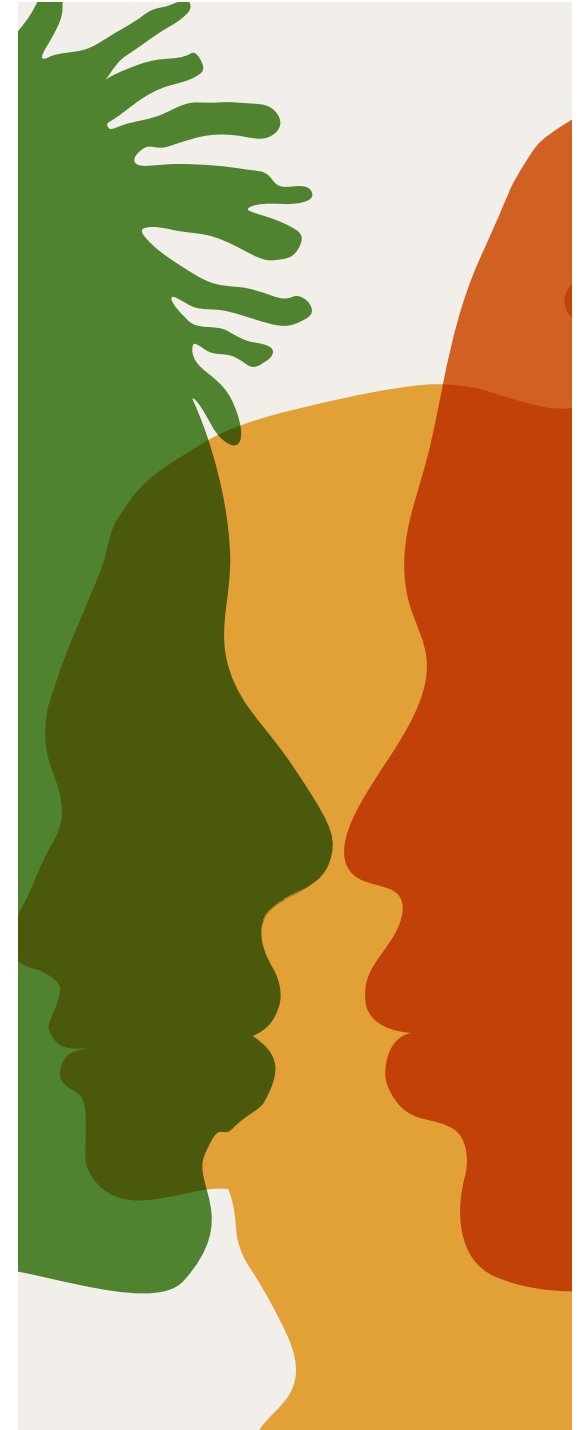
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The [California Improvement Network \(CIN\)](#) is a learning and action network that aims to advance the quadruple aim by identifying and spreading better ideas for care delivery, and by strengthening relationships between commercial and safety-net provider and health plan communities in California. CIN is a project of the [California Health Care Foundation](#), an independent philanthropy, and is managed by [Healthforce Center at UCSF](#), an organization dedicated to helping health care organizations drive and navigate change.

This toolkit is the result of a collaboration of the CIN, its Racial Health Equity Workgroup, and [HealthBegins](#), a national mission-driven consulting and training firm committed to driving radical transformation in health equity.

For details on the co-design and development of this toolkit, see the Acknowledgements section.

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# Quick Start Guide

This toolkit is designed to help those who provide, pay for, or support primary care translate their commitment to racial health equity into reality. Regardless of where you sit in an organization, there are concrete opportunities to act and advance health equity. The audience for this toolkit includes, but is not limited to, administrators, clinical directors, practice managers, quality improvement managers, and frontline clinicians and care team members.

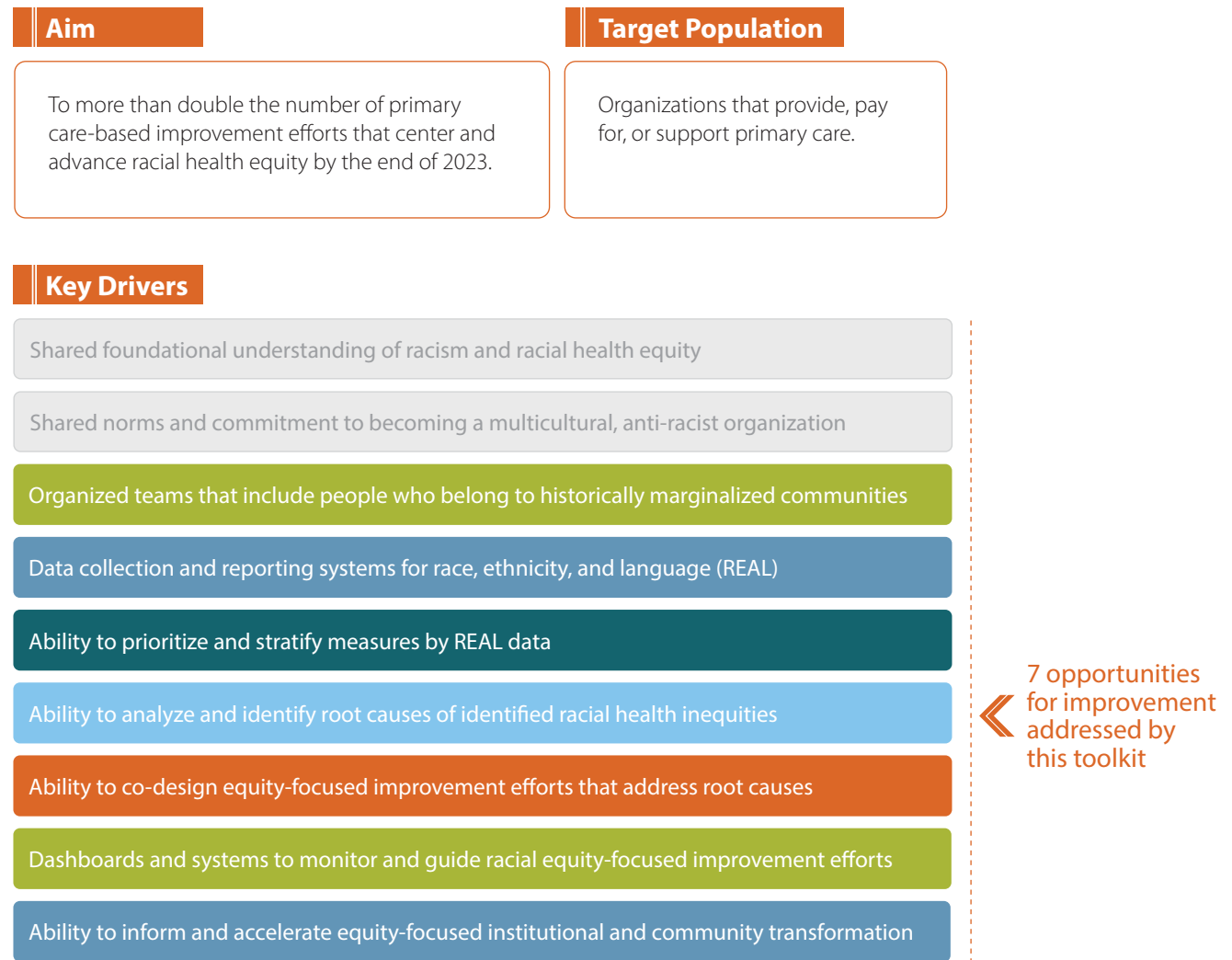
Racial health equity can be viewed as both an outcome and a process requiring continuous learning and improvement. As such, these materials are intended to help organizations dramatically increase the number of primary care improvement efforts that center and demonstrably advance racial equity.

Nine key drivers or essential capabilities were identified as critical to advancing this aim. (See Figure 1.) This toolkit focuses on seven of these key drivers, treating each as a discrete opportunity for continuous improvement. We present these opportunities in the “Roadmap for Improvement.” (See Figure 2.)

## Identify Key Drivers and Opportunities

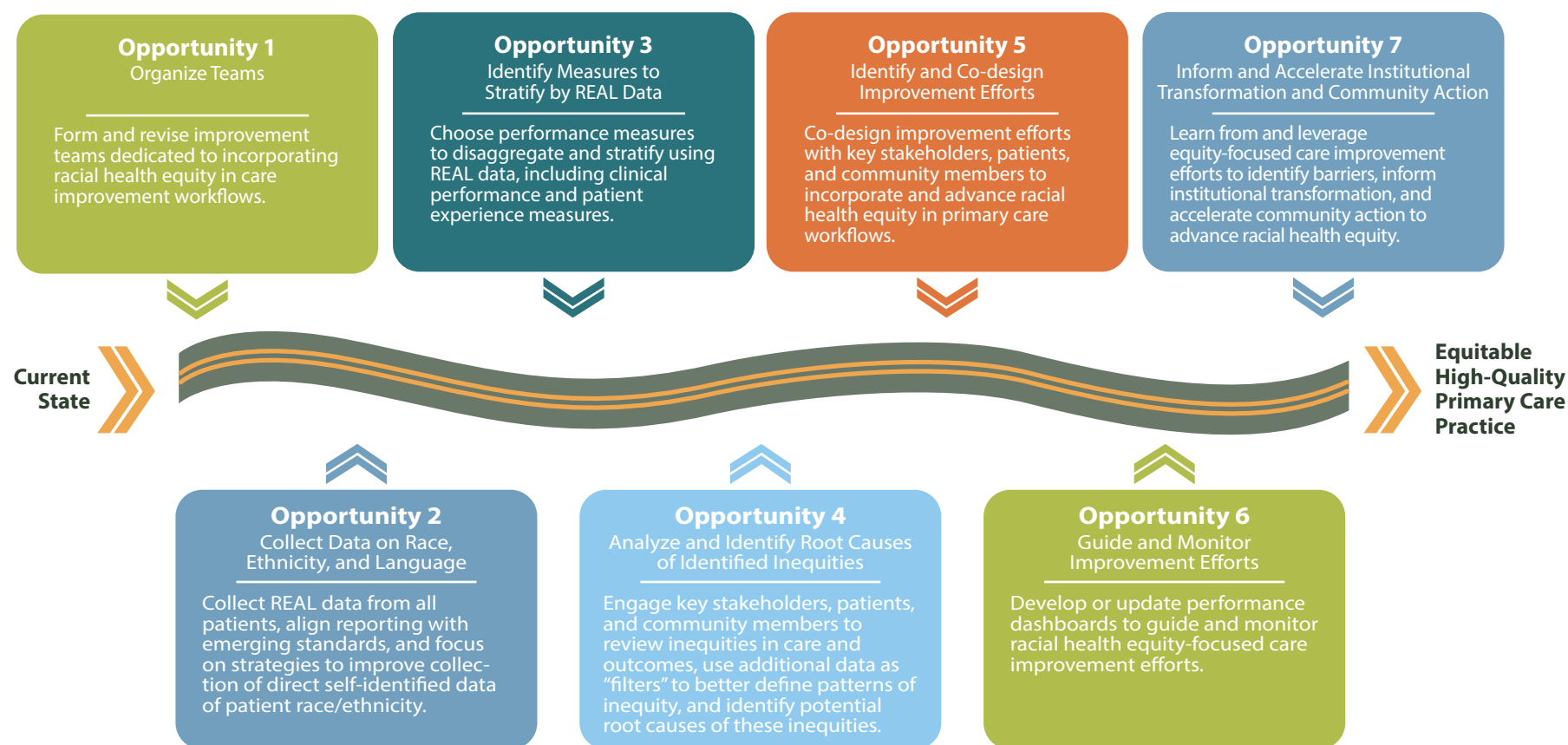
1. Review each of the key drivers for advancing racial equity in primary care with your colleagues (see Figure 1).
2. On a scale of 1 to 5, assess how well developed these key drivers are within your organization (where 1 is poorly developed and 5 is well developed).

**Figure 1: Drivers Diagram**



3. Prioritize key drivers that are not well developed or effectively implemented (that is, scores 3 or below).
4. Review corresponding opportunities for improvement (see Figure 2).
5. Pursue at least one opportunity over four to six months as a formal part of your organization's quality and performance improvement strategy, using the recommendations and resources found in this toolkit. Each section provides an overview of an improvement opportunity, a stepwise set of key recommendations for implementing the opportunity, tips to address common challenges, and links to relevant resources and tools for further guidance.
6. Revisit and repeat steps 2 through 5 above at least every four to six months to pursue other opportunities for improvement.
7. Regularly discuss how your foundational understanding, norms, and commitment to racial equity are informing continuous improvement efforts and vice versa.

**Figure 2: Roadmap: Seven Opportunities on the Road to Improvement**



# Background & Vision



## The California Improvement Network (CIN)

is a learning and action network committed to identifying and spreading better ideas for care delivery to improve the patient and provider experience and the health of populations while lowering the cost of care. Informed by the CIN Racial Health Equity Workgroup and developed in partnership with HealthBegins, this practical toolkit is designed to help CIN partner and member organizations and other health care organizations — which includes those that provide and pay for health care as well as those that support health care delivery systems — **to integrate racial health equity into care improvement efforts in primary care settings.**

This toolkit's vision of more just, equitable, well-resourced, and effective primary care rests on two foundational beliefs:

- Primary care cannot improve the health of patient populations without simultaneously advancing health equity; and
- Health equity, including racial health equity, is core to high-quality primary care. High-quality care is equitable care.<sup>1</sup>

The following key terms and concepts inform these foundational beliefs:

- **Health disparities** are differences in health status rates between population groups.

- **Health inequities** are those disparities that are due to differences in access to social, economic, environmental, or health care resources. Simply put, health inequities are health disparities that are unfair and unjust.
- **Health equity** is achieved when everyone has the opportunities and resources they need to be as healthy as possible and no one is disadvantaged due to social circumstances or policies.<sup>2</sup> Because structural racism has systematically denied opportunities and resources based on race, health equity is inextricably linked to racial equity.
- **Racism** is a system of structuring opportunity and assigning value based on phenotype, that unfairly disadvantages some individuals and communities and unfairly advantages others, according to Dr. Camara Phyllis Jones. There are [four levels of racism](#). **Internalized racism** refers to "acceptance by members of stigmatized races of negative messages about their own abilities and intrinsic worth" and exists *within individuals*. **Interpersonal racism** is "the expression of racism *between individuals*," through discrimination, harassment, or slurs. **Institutionalized racism** refers to "discriminatory treatment, unfair policies and practices, and inequitable opportunities and impacts *within organizations and institutions*, based on race." **Structural racism** represents the deep and compounding

impact of racial bias across institutions and society, which in turn shapes and mutually reinforces the patterns and experience of other forms of racism.

- **Racial equity** is “the systematic fair treatment of people of all races, resulting in equitable opportunities and outcomes for all. It is not just the absence of discrimination and inequities, but also the presence of deliberate systems and supports to achieve and sustain racial equity through proactive and preventative measures.”<sup>3</sup>

Because health equity, including racial health equity, is shaped by social and structural factors, we must support primary care’s capacity to identify and help improve the structural, institutional, and social drivers of health equity at community, system, and individual levels. This means building practice-

level capacity to integrate behavioral health and social care, supporting internal transformation of institutional norms and policies, and participation in cross-sector community-level efforts to address social and structural drivers of health equity.<sup>4,5</sup>

This toolkit is designed to help translate these foundational beliefs and concepts into reality by describing a roadmap for improvement — a set of concrete opportunities for primary care practices to incorporate and advance racial health equity in care improvement efforts. Case studies that highlight what this work looks like in practice are included at the end.

# Getting Grounded

Before pursuing this journey of improvement, primary care providers, leaders, and teams must ground their racial equity efforts in a shared understanding of racial injustice in America and its implications for primary care. Drawing on long-standing scholarship and research, several essential principles are highlighted below. This toolkit is not intended to educate stakeholders about racism or develop a foundational

level of professional awareness and commitment to advancing racial equity. However, such foundational work is critical, and readers are encouraged to develop an understanding of racism's impact on health and health care and to build and normalize an organizational commitment to advancing racial equity. The source material to support that work is listed in the appendix.

1 "The US is a [segregated and stratified society](#) in which people are geographically separated by racism and classism. This social structure affects many facets of life, including the health policies the nation creates.<sup>6</sup> This social structure affects the way health care, including primary care, has been designed, paid for, distributed and delivered in the U.S. After all, "the development of medical care, like other institutions, takes place within larger fields of power and social structure."<sup>7</sup>

2 "Racial health inequities [in health care] are not signs of a system malfunction: they are the byproduct of health care systems functioning as intended."<sup>8</sup> Health care institutions — and the industry itself — have not been held accountable for their failure to systematically prioritize and eliminate racial health inequities among the patients and communities they serve. Even fewer health care institutions have considered or provided redress for the harms caused by institutionalized racism.

3 "We got here because we live in a country established by indigenous dispossession and genocide. Because slavery and the racial ordering of humans and goods it established constructed a political economy predicated on devaluing Black labor, demeaning Black bodies, and denying Black humanity."<sup>9</sup>

4 The four interrelated forms of racism — structural, institutionalized, interpersonal, and internalized — manifest as racial inequities in health care. US health care professionals and organizations have historically perpetuated and exacerbated them.<sup>10,11</sup>

5 The harms of structural and institutionalized racism have been — and continue to be — primarily directed at Black, Latinx, Indigenous, Asian and other people of color. Through exploitative labor practices and policies of social disinvestment, however, structural racism and classism also wreak social, economic, and environmental havoc on middle- and lower-income White Americans.<sup>12</sup> As such, racism and White supremacy are "a self-defeating form of exclusion, a determination not to share resources even if the ultimate result is that everyone suffers."<sup>13</sup>

6 Despite abundant evidence of structural racism, some "White Americans do not like to talk about these facts. Research suggests that some [go out of their way to avoid the subject](#)." This may be due to strategic "colorblindness" — the avoidance of talking about race in an effort to avoid the appearance of bias.<sup>14</sup> In a society segregated by structural racism, however, the choice to be "colorblind" not only serves as a way to disengage from conversations about racism and dismiss the lived experiences of many people of color, "it also suggests that racism does not exist so long as one ignores it."<sup>15</sup>

7 Implicit biases against people of color are as prevalent among clinicians as they are among the general population.<sup>16</sup> National surveys have shown that non-Black physicians have a level of implicit racial bias toward Black Americans that is at least as high as the level of bias found in the general US population.<sup>17</sup>

8 "Anti-racist" practice is an active process of naming and confronting racism by changing systems, organizational structures, policies, and attitudes so that power is redistributed and shared equitably.<sup>18</sup>

- Implicit bias training is insufficient. "The reality is, even if we could reliably reduce individual-level bias, various forms of institutional racism embedded in health care (and other organizations) would likely make these improvements hard to maintain."<sup>19</sup>
- Anti-racist efforts to advance racial health equity must therefore address the social, economic, political, legal, educational, and health care systems that maintain structural racism.<sup>20</sup>

9 America is more racially and ethnically diverse today than it ever has been, is projected to be even more diverse in the coming decades, and more Americans view this long-term rise in racial and ethnic diversity positively than negatively. Still, according to Pew Research, only 14% of White Americans believe that this long-term increase in racial and ethnic diversity is a good thing for the country, although this figure has increased since 2016.<sup>21</sup>



### At the heart of this toolkit — and this primary care improvement journey — is a decision.

Based on a foundational understanding of racism, its impact on health outcomes, and America's growing racial and ethnic diversity, those who work for organizations that provide, pay for, or support primary care face a fundamental choice.

As Dr. Ibram X. Kendi describes:

*“The opposite of racist isn’t ‘not racist.’ It is ‘antiracist.’ What’s the difference? One endorses either the idea of racial hierarchy as a racist, or racial equality as an antiracist. One either believes problems are rooted in groups of people, as a racist, or locates the roots of problems in power and policies, as an antiracist. One either allows racial inequities to persevere, as a racist, or confronts racial inequities, as an antiracist. There is no in-between safe space of ‘not racist.’”<sup>22</sup>*

Adapting Dr. Kendi’s question — Will those who provide and support primary care allow racial inequities in care to persevere within racist institutions, or will they confront racial inequities as anti-racist organizations?

Racial justice scholars and practitioners have developed a [continuum](#) to describe six phases of becoming an anti-racist multicultural organization, progressing from being an exclusive (phase 1) and passive institution (phase 2) to progressing to symbolic change (phase 3) and identity change (phase 4), and ultimately advancing to structural change (phase 5) and being a fully inclusive, anti-

racist multicultural organization (phase 6).

That document has become a helpful resource for health care leaders who seek to advance and center racial health equity in their organizations. In a related theory of change developed by the [Government Alliance on Race and Equity \(GARE\)](#), organizations are encouraged to normalize (conversations about race), organize (internally and externally), and operationalize (new behaviors and policies), to transform institutional norms and practices.<sup>23</sup> This approach has helped government agencies in over 180 jurisdictions advance racial equity.

**All organizations that deliver, pay for, or support primary care should strive to become anti-racist multicultural organizations.** Equity-oriented improvements in specific primary care workflows will be neither sufficient nor sustainable if surrounding institutional norms and systems are not transformed as well.

Primary care leaders can use the anti-racist continuum, the GARE *normalize, organize, operationalize* model, or other frameworks for organizational transformation to assess and improve where their institutions are on the journey to becoming anti-racist organizations.

A foundational understanding of racism’s impact and the work of normalizing multicultural anti-racism are fundamentally important (see box on page 10). So too is an unwavering professional commitment to engage in continuous learning and improvement that supports racial health equity.



Those who work for organizations that deliver, pay for, or support primary care face a fundamental decision: Will you collectively allow racial inequities to persist, as a racist institution, or will you confront racial inequities, as an anti-racist organization?

### Mandating Physician Training on Racial Health Equity

While **North Carolina** does not mandate racial health equity training for physicians, **Cone Health** in Greensboro requires all physicians with privileges at its hospitals to complete two trainings on racial equity, cultural competence, or health equity every two years as part of their CME recredentialing cycle. This requirement, approved in 2019 by the Cone Health Medical Executive Committee, is part of a larger process of [redress for historical discrimination](#).

Physicians are encouraged to choose specific topics that align with the populations they care for. For example, a pediatrician might elect to complete training related to adverse childhood events and racial health equity. Other examples include courses about religious and cultural differences, social determinants of health, unconscious bias, and racial equity.

Since this requirement took effect, physicians have reported an increased awareness of racial justice, criminal justice disparities, health care disparities, and other issues that touch on equity in health care. Their increased awareness has translated into several quality improvement efforts at Cone Health addressing racial health disparities in patients diagnosed with post-partum hypertension and those diagnosed with pneumonia. The trainings are also helping physicians employ anti-racist principles such as transparency of data and accountability for action as they examine patient outcomes.

Cone Health partners with the Greensboro-based [Racial Equity Institute](#) to make [Groundwater Trainings](#) available to all providers and staff. These trainings help participants better understand racism in its institutional and structural forms, as well as how personal and organizational practices are affected by feelings of internalized oppression, feelings of inferiority and superiority, and racial identity development.

An important part of Cone Health's equity approach to training is to position itself to the community as a learner. When deciding to make racial equity training available to its entire staff, Cone Health prioritized contracting with local community partners and organizers. The Racial Equity Institute is a local, Black-owned business staffed by a multicultural team of trainers and organizers.

# Who Should Use This Toolkit

**Four types of stakeholders** can use this toolkit to identify opportunities to incorporate and advance racial equity in primary care.

While enterprise-wide transformation of organizational anti-racist norms and practices is critically important, these stakeholders — from executives and senior leaders to clinicians, care teams and practice managers — do not necessarily need to wait for the completion of organization-wide efforts before pursuing opportunities to incorporate and advance racial health equity in care improvement projects. Indeed, such opportunities should be viewed and framed as part of the enterprise-wide efforts to operationalize commitments to racial equity.

## What can relatively smaller or under-resourced organizations manage to do?

Smaller organizations may face unique challenges when trying to embed and advance racial equity in primary care improvements. **Do whatever you can with what you have.** Motivated leaders from smaller organizations can start by focusing on a reduced number of recommendations from this toolkit based on capacity. They may also find other [guides](#) and networks for smaller practices settings to be helpful.

Being in a relatively smaller organization doesn't preclude leaders from making bold, necessary moves to advance racial equity. Case Study 1 from OHSU Family Medicine at Richmond shows how much can be accomplished with more limited resources.

### Primary care clinician or care team member



- Initiate or advance a dialogue with colleagues and patients about ways to center racial health equity in primary care.
- Help develop and participate in racial health equity-directed care improvement efforts.

### Manager of departments, practices, or teams that provide primary care



- Convene, motivate, and support staff to discuss opportunities to center racial health equity in care improvement projects.
- Dedicate time and resources to support racial health equity-directed improvement efforts.
- Invite colleagues from other departments or offices to participate (such as QI, PHM, IT).

### Executive or senior leader of an organization that provides or pays for primary care



- Guide, motivate, and support practice managers and clinical staff to identify and work on specific racial health equity-directed improvement projects.
- Align incentives and accelerate broader efforts to normalize, organize, and operationalize a commitment to racial equity within your institution.

### Manager or staffing organization that supports organization that supports or provides technical assistance to primary care practices



- Guide, motivate, and support the executives, senior leaders, practice managers, and clinical staff you work with to incorporate and advance racial health equity in care improvement efforts.

# How to Use This Toolkit

## **This toolkit is designed to help primary care stakeholders advance racial health equity in care improvement efforts**

regardless of where they sit in an organization and where an organization is on its journey. Specifically, it helps identify opportunities and concrete steps to incorporate and advance racial health equity in improvement efforts for primary care settings. The recommendations and tips can be used as change ideas to test and adapt to work within organizations.

This toolkit organizes practice-level opportunities and corresponding recommendations, tips, and resources to strengthen and center racial health equity in **care improvement efforts** — defined as systematic, patient-centered approaches that are guided by data and experience to improve the quality and safety of health care delivery.

Nine key drivers or essential capabilities were identified as critical to advancing this aim. This toolkit focuses on seven of these key drivers, treating each as a discrete opportunity for continuous improvement. (See Figure 1.) We present these opportunities in the “Roadmap for Improvement.” (See Figure 2.)

Seven major opportunities for improvement among organizations that deliver, pay for, or support primary care are described below. While primary care leaders and staff are strongly encouraged to participate in enterprise-wide efforts to develop a shared foundational understanding of racism, promote anti-racist norms, and reform institutional practices, it is not necessary to wait for the transformation

to be complete before pursuing the opportunities identified. These opportunities are presented as a roadmap wherein a journey may be started at any point based on your current priorities and level of readiness (see Figure 2). The following sections provide details on each opportunity with specific tips and challenges outlining how to approach and put these opportunities into practice.

While continuous learning and improvement are not necessarily linear processes, they are iterative. As such, opportunities for improvement are presented on a roadmap, illustrating that some opportunities help inform and enable those that follow. If you identify similar gaps across key drivers (for example, multiple key drivers with self-assessed scores of 1), prioritize taking action on an opportunity that appears earlier on the roadmap.

## **Performance and Accountability Systems**

Historically, health care institutions — including those that provide, pay for, and support primary care — have not been held accountable for their failure to systematically prioritize and eliminate racial health inequities among patients. Even fewer health care institutions have considered or provided redress for the harms caused by institutionalized racism. That said, the landscape of external accountability systems\* is rapidly evolving, as public and private payers, accreditation bodies, and federal and state regulators seek to define and update equity-based performance measures and incentives. This evolving landscape will undoubtedly shape the strategic

priorities of institutions in the future that provide, pay for, and support primary care.

While this toolkit does not outline needed changes to external accountability systems, it does describe opportunities to strengthen **practice-level performance and accountability systems** that shape primary care improvement efforts. These include the systems, incentives, dashboards, and tools that primary care practices use to:

- Collect and analyze data
- Stratify, track, and report on key performance measures, including measures stratified by race, ethnicity, and language
- Inform key stakeholders (e.g., patients, payers, community members)
- Hold key stakeholders accountable (e.g., executives, practice managers, clinicians, care teams)

Pursuing these practice-level opportunities will help primary care organizations develop the capacity to better respond to equity-oriented changes in external performance requirements and accountability systems.

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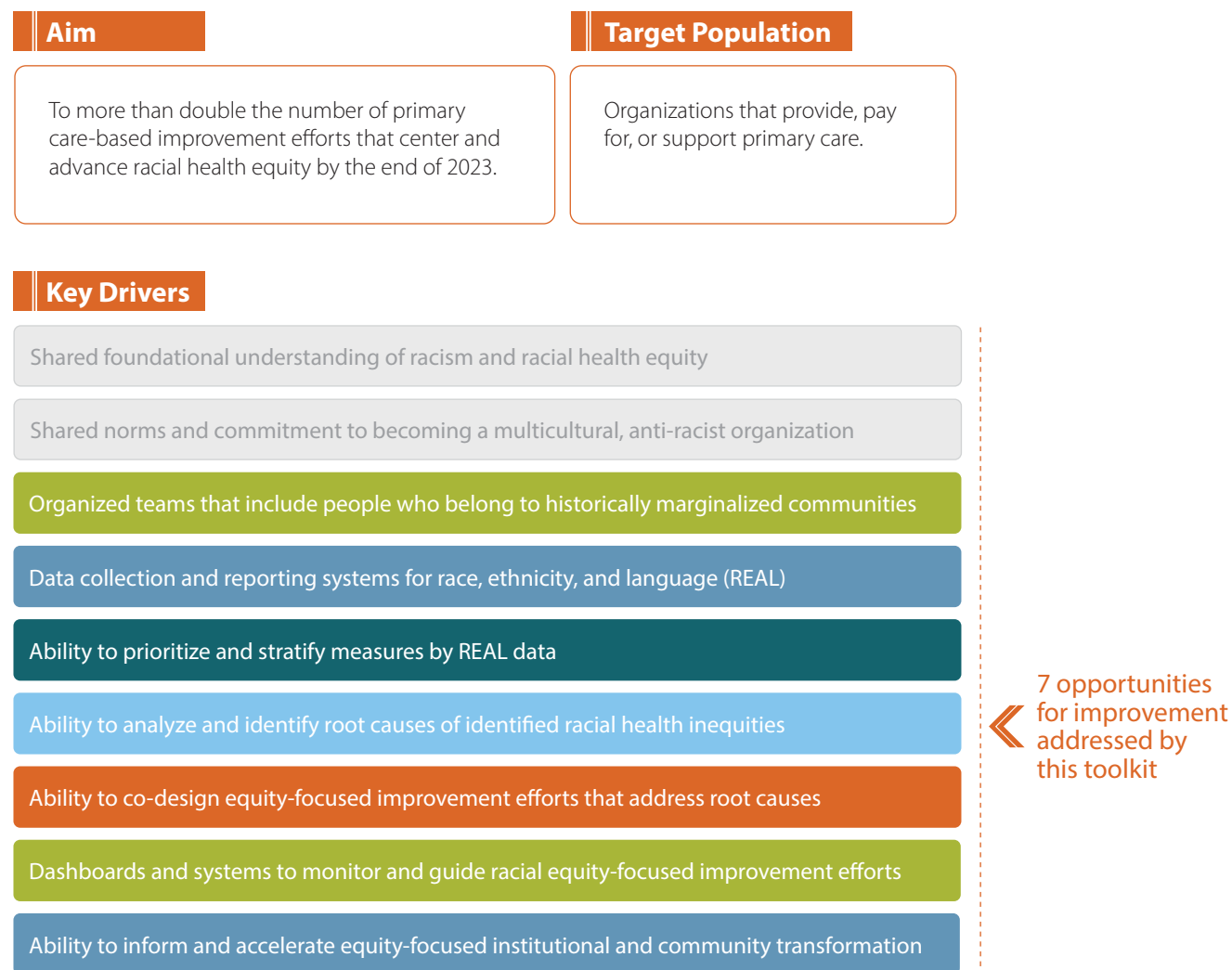
\* External performance and accountability systems include the systems, incentives, dashboards, and tools that external stakeholders (e.g., public and private payers, accreditation bodies, regulators) use to:

- Collect and analyze primary care data.
- Review and track reports of key performance measures, including measures stratified by race, ethnicity, and language.
- Inform key stakeholders (e.g., policymakers, regulators, payers, patient, and provider groups).
- Hold key stakeholders accountable (such as providers, clinics, networks and provider groups, health care delivery systems).

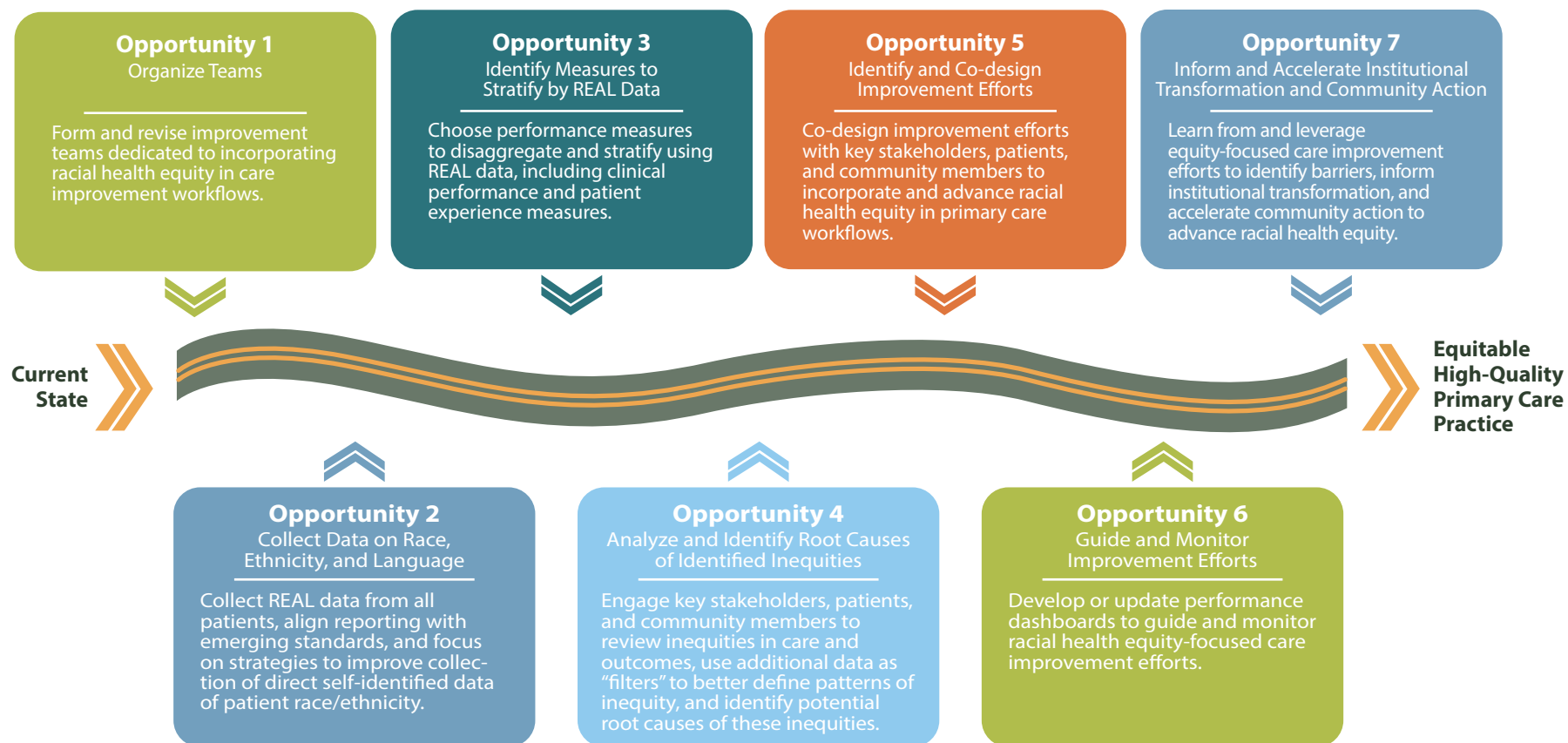
## Identify Key Drivers and Opportunities on the Roadmap

1. Review each of the key drivers for advancing racial equity in primary care with your colleagues (see Figure 1).
2. On a scale of 1 to 5, assess how well developed these key drivers are within your organization (where 1 is poorly developed and 5 is well developed).
3. Prioritize key drivers that are not well developed or effectively implemented (that is, scores 3 or below).
4. Review corresponding opportunities for improvement (see Figure 2).
5. Pursue at least one opportunity over four to six months as a formal part of your organization's quality and performance improvement strategy, using the recommendations and resources found in this toolkit. Each section provides an overview of an improvement opportunity, a stepwise set of key recommendations for implementing the opportunity, tips to address common challenges, and links to relevant resources and tools for further guidance.
6. Revisit and repeat steps 2 through 5 above at least every four to six months to pursue other opportunities for improvement.
7. Regularly discuss how your foundational understanding, norms, and commitment to racial equity are informing continuous improvement efforts and vice versa.

**Figure 1: Drivers Diagram**



**Figure 2: Roadmap: Seven Opportunities on the Road to Improvement**





# Opportunity 1: Organize Teams

## Overview

Well-defined teams are responsible for designing and launching improvement efforts that drive practice- and system-level transformation and should meet regularly to review progress. At a minimum, teams should be multidisciplinary, multicultural, and include people with lived experience, individuals with QI expertise, and where possible, individuals with population health performance responsibility across different levels of seniority within an institution. This ensures an equitable representation of racial diversity, decision-making authority, and roles that impact primary care improvement efforts.

## Key Recommendations

- A. Leverage quality and performance improvement programs, structures, and incentives to embed and advance racial health equity.** Make racial health equity a strategic priority for all departments, including QI departments. Dedicate QI expertise, data analytics, and IT staff and resources to support this effort. [Tie executive compensation to improvements](#) in racial health equity.
- B. Include patients, families, and community members with lived experience on the team,** not as bystanders or informants, but as co-designers and leaders of improvement efforts from the beginning to establish shared

goals and team norms. People with lived experience include those individuals who have experienced racial health inequities and self-identify as belonging to historically marginalized communities. They can also include individuals most likely to benefit from equity-focused care improvement efforts.<sup>24</sup>

- Compensate patients and community members for their time and expertise. Be clear about expectations and minimize barriers to participation, such as internet access, transportation, meeting schedules, and childcare.
  - Support patients and community members who are interested in strengthening their quality improvement skills. Leverage existing patient family advisory boards to recruit team members or consider establishing them.
  - Partner with trusted community leaders, including community health workers/promotores, faith-based groups, and neighborhood coalitions, to engage patients, families, and community members (see [Engaging People with Lived Experience Toolkit](#) in Resources for additional strategies).
- C. Set clear roles, responsibilities, and expectations for all team members.** Document this information into the team charter to clarify how each member brings experience, expertise, and value to your improvement project. Review [resources](#) for creating quality improvement teams and clarifying team roles. Ensure that patients with lived experience can meaningfully participate.

## D. Develop an equity-focused team charter.

Remember that team charters are different from QI project charters.\* Team charters help teams discuss and agree on:

- Objectives, such as incorporating racial health equity in care improvement workflows
- Team roles and responsibilities
- Shared definitions, terms, and values: Ensure the team shares an understanding of key concepts related to racial health equity (see Getting Grounded section).
- Principles of how the team will work together
- When, where, and how often the team meets
- How to address team member needs and accessibility concerns, including the needs of patients and residents with lived experience
- Expectations for communication to external stakeholders and partners

## Challenge

Creating a safe space for open communication, shared values, and collaborative action on racial health equity can be challenging.

## Tips:

- A. Use facilitation tools like the [Window of Tolerance](#) to help identify how each team member is feeling in the present.

\* Project charters outline high-level project description and requirements, while team charters establish team values, agreements, and operating guidelines such as communication guidelines, decision-making criteria, conflict resolution processes, and meeting guidelines.

- B. Encourage individuals who work in health care to communicate without the use of jargon.
- C. Define commonly used terms and acronyms together.
- D. Include discussion of historical context in the work.
- E. Predict, sit with, and learn from discomfort.
- F. Provide direct, one-on-one support of patient, family, and community partners.
- G. Take time for reflection during meetings and provide opportunities for vulnerability and support.<sup>25</sup>

### Challenge

While enterprise-wide transformation in organizational anti-racist norms and practices is critically important, some teams may operate in organizations where anti-racist practices are not yet widely adopted or with key stakeholders at varying levels of readiness to center and advance racial health equity in care improvement efforts.

### Tips:

Do not necessarily wait for comprehensive organization-wide anti-racist strategies to be designed and launched before building teams to pursue specific improvement projects focused on racial health equity.

- A. Identify opportunities to build upon existing care improvement initiatives and recruit cham-

pions and early adopters. Help colleagues see this work as part of your organization's commitment to racial equity and to being a "learning health system."<sup>26,27</sup>

- B. Start small and identify early wins to build momentum.
- C. Conduct a baseline assessment by asking yourselves:
  - How well do you collect and validate Race, Ethnicity, and Language (REAL) data?
  - What is the quality of your data for key primary care performance measures (e.g., HEDIS measures)?
    - » Access and Availability of Care
    - » Quality and Effectiveness of Care
    - » Experience of Care
    - » Utilization of Care
    - » Integration of Care (e.g., Behavioral Health and Social Care)
  - Have you ever stratified objective (such as diabetes control) or subjective (such as patient experience) measures by REAL data to identify racial health inequities among patients?
  - How often have you defined equity-oriented aim statements or goals? How well have you done in the past?

### Resources

- To learn more about how health systems are tying executive pay to health equity metrics, see this article from [Healthcare Innovation](#).
- To see a sample team charter, visit the [Quality Improvement Team Charter worksheet](#) from the Tribal Evaluation Institute.
- For additional resources on creating quality improvement teams and QI plans, see the [Practice Facilitation Handbook](#) from the Agency for Healthcare Research and Quality.
- To learn more about including people with lived experience in improvement efforts and teams, read [Seven practices for pursuing equity through learning health systems: Notes from the field](#), the [Engaging People with Lived Experience Toolkit](#), and the [Liberation in the Exam Room](#) initiative.
- To help colleagues in your practice become more comfortable with the discomfort inherent in racial equity work, share ThemPra Social Pedagogy's "[Learning Zone](#)" model and review this [Let's Talk](#) guide from the Southern Poverty Law Center's Teaching Tolerance project.
- To learn more about the [Window of Tolerance](#) facilitation tool and its relevance in team discussions about racial equity, [watch this webinar from HealthBegins](#).



## Opportunity 2: Collect Data on Race, Ethnicity, and Language

### Overview

Primary care practices should collect and validate self-identified race, ethnicity, and primary language (REAL) data from all patients as a foundation for providing more equitable care. Staff can be engaged from diversity, equity, and inclusion (DEI), patients' registration, data analytics, IT, quality and safety, community outreach, and enabling services to help validate and support REAL data collection.

In California, growing calls for the state to require that health plans collect standardized race/ethnicity data across all regulated lines of business means that primary care practices are likely to face increased downstream pressure to improve direct data collection of patient self-identified race/ethnicity.<sup>28</sup>

"All the big payers . . . are looking at and will ask you, 'Are you collecting race, ethnicity, and language data? Are you stratifying it?'"

Dr. Ron Wyatt, VP and Patient Safety Officer, MCIC Vermont, at [CIN Partner Meeting, Nov. 2021](#)

### Key Recommendations

**A. Align ethnicity data categories with minimum standards** developed by the Office of Management and Budget (OMB). The US Department of Health and Human Services

(HHS), including the Center for Medicare and Medicaid Services (CMS), is required to comply with these OMB categories for ethnicity:<sup>29</sup>

- Hispanic or Latino
- Not Hispanic or Latino

**B. Provide patients with the option of self-identifying** based on OMB racial categories, such as:

- White
- Black or African American
- American Indian or Alaska Native
- Asian
- Native Hawaiian or Other Pacific Islander

**C. Allow patients to "Select all that apply" and "Choose not to respond."**

**D. Collect more granular data** to reflect California's racial, ethnic, and linguistic diversity, with the following considerations:

- HHS has developed data standards that provide additional granularity within the OMB standard categories of Asian and Native Hawaiian or Other Pacific Islander, as well as for respondents who are of Hispanic, Latino/a, or Spanish origin.<sup>30</sup> Make sure the more granular categories can be aggregated back to the minimum OMB categories defined above.<sup>31</sup>
- Use local and state census data to identify relevant racial and ethnic data categories.<sup>32</sup>
- Use established race and ethnicity coding systems. The CDC, for example, has a large codeset.<sup>33</sup>

**E. Validate your current REAL data.**

- Accuracy: Are the data self-identified and correctly recorded?
- Completeness: Are REAL data captured across all practice areas? What is the percentage of unknown, other, or declined data?
- Uniqueness: Are individual patients represented only once? Are there multiple points where the data might be collected or recorded? How are the data consolidated?
- Timeliness: How often are data updated?
- Consistency: Are the data internally consistent, and do the data reflect the patient population being served?<sup>34</sup>

### Challenge

Individuals are the source of truth regarding their race and ethnicity information, but collecting this information for health care purposes has been challenging. Audits have shown discrepancies between patients' self-reported demographic information and data previously recorded in electronic health records (EHR), particularly for smaller populations (see UC San Diego Health example on page 20).<sup>35,36,37</sup> Patient, provider, and technical factors have been proposed as causes for these discrepancies.

- Patients may be reluctant to self-identify. This reluctance may stem from long-standing concerns about privacy and discrimination.
- Clinicians or care team members may feel uncomfortable or fail to perceive the value of asking patients about their race and ethnicity, leave fields

## Opportunity 2: Collect Data on Race, Ethnicity, and Language

blank or marked “unknown,” or make assumptions about patients instead of asking specific questions.

- Technical factors, such as a lack of alignment between a practice’s EHR data fields for race/ethnicity and the OMB data categories, can pose challenges to accurate, standardized data collection, reporting, and analysis.

### Tips:

- A. Set clear practice-level annual goals (and system-wide goal where possible) to collect REAL data.
  - Although some industry groups are establishing more [conservative goals](#), a stretch goal to collect REAL data for at least 80% of your patient population within one year can align your practice with recent [direct data completeness thresholds developed by the National Committee for Quality Assurance \(NCOA\) for health plan-reported HEDIS measures](#), as well as similar targets developed by exchanges, such as Covered California.
  - As health plans consider provider incentives to increase direct data collection and reporting for patient race and ethnicity information, primary care practices that improve performance in this area may be better positioned to receive extra payments.
- B. Provide patients with context for why REAL information is being collected and how it will be used (and will not be used).
  - Tell patients that REAL information is needed to ensure and monitor quality of care. This is a proven tactic for improving patient communication and direct data collection.<sup>38</sup> Use phrases such as: “We ask everyone to share this information to review the treatment patients receive and ensure that all patients receive the highest quality care.”<sup>39</sup>

- Adjust questionnaires to require patients to “actively opt out” of responding (see “Choose not to respond” option in recommendation C, above).
- Ensure questionnaires allow patients to select multiple responses to race and ethnicity (as opposed to using a “multi-racial” category).

- C. Provide trainings and scripts to staff, including registration staff and care managers.<sup>40</sup>
- D. Contact your EHR vendor to ask for resources and join an EHR user health equity workgroup to learn about ways to improve race and ethnicity data collection and reporting. If such a workgroup doesn’t yet exist, advocate that the EHR vendor create one.

### Challenge

Quantitative data alone are insufficient to understand inequities associated with race, ethnicity, and language.

### Tip:

- A. Use strength-based framing and participatory methods to generate qualitative data when asking questions around race, ethnicity, and identity. For example, the Behavioral Health Services program (BHS) of the San Francisco Department of Public Health (SFDPH) has used qualitative data to inform quality improvement efforts by increasing cultural match between behavioral health providers

and clients (see Case Study 2). Dr. Ritchie Rubio and other team members employed a strength-based approach to ask questions about race and ethnicity in their workforce survey, meaning that respondents were given an open field and asked to identify their race and ethnicity in their own words. The data is harder to code, but richer and more culturally responsive. Rubio and his team are now working to change the clients’ version of the survey to a strength-based model mirroring the provider survey.

While it can be difficult and time-consuming to collect qualitative data, the stories gathered can be extremely helpful for QI efforts, particularly those that emphasize large, robust quantitative data sets. Given the relative lack of self-identified REAL data, these quantitative approaches may omit the voices of those most impacted by health inequities. And while increasing the collection of direct self-identified REAL data from patients is vital, the use of listening sessions, focus groups, surveys, and other story-sharing and insight-generating methods to collect and share qualitative data from these underrepresented voices centers their experiences.

## Opportunity 2: Collect Data on Race, Ethnicity, and Language

### Resources

These recommendations align with relevant health care reports and recommendations related to data collection for racial health equity, including:

- Aligning Forces for Quality (2009). [Reducing Disparities: The Importance of Collecting Standardized Data on Patient Race, Ethnicity and Language](#) — This excellent training resource can help primary care practices navigate key decision points for REAL data collection.
- The National Committee for Quality Assurance (NCQA) has identified [proposed changes](#) and [key HEDIS® measures for race/ethnicity stratification in measurement year 2022](#).
- Health Evolution Forum (2021) — [Work Group on Leveraging Data to Improve Health Equity in California](#). This industry group created a pledge to accelerate greater health equity by collecting, stratifying, and reviewing data on race, ethnicity, language, and sex.
- Manatt Health (2021) — [Unlocking Race and Ethnicity Data to Promote Health Equity in California: Proposals for State Action](#). Prepared with support from Blue Shield of California, this report outlines statewide recommendations to improve race and ethnicity data collection and reporting.
- Covered California (2019) — [Covered California Holding Health Plans Accountable for Quality and Delivery System Reform](#). As of 2019, Covered California has required contracted insurers to report on disparities for 14 measures related to asthma, depression, diabetes, and hypertension. Covered California is now proposing to incorporate some of these measures (hypertension, diabetes, colorectal cancer screening, and childhood immunizations) into [future plan contracts](#), tying race/ethnicity reporting and improvements in associated disparities to financial consequences. In addition, they will require contracted plans to achieve at least 80%-member self-identification of race and ethnicity data.
- State Health & Value Strategies (2020) — [Exploring Strategies to Fill Gaps in Medicaid Race, Ethnicity, and Language Data](#). This resource describes federal standards and recommendations and strategies to improve race and ethnicity data collection and reporting.
- [CIN Connections, Winter 2022 — Centering Equity in Health Care Improvement](#) summarizes how to implement QI efforts that intentionally advance health equity in primary care.
- [Health Evolution Forum's Health Equity Pledge to Collect, Stratify, and Review REaLS Data Across Top Quality and Access Metrics](#).

### Improving the Collection and Accuracy of Patients' Race, Ethnicity, and Language Data

In 2016, **UC San Diego Health** set out to investigate racial health disparities in cardiovascular health and discovered that — according to the data in its electronic health record (EHR) — almost none of the patients in its system identified as Latino. This was difficult to understand, given that 30% of residents in San Diego County identify as Hispanic or Latino. This significant discrepancy led the health system's Department of Population Health to investigate reasons why data on race, ethnicity, and language (REAL) were often inaccurate or incomplete. They took three steps to improve its own data collection:

- **Formed a governance committee to better understand where problems with data collection existed, incorporating the perspectives of everyone who interacted with patient demographic data.** The stakeholders included people from registration, revenue cycle, health information management, information services, quality, and operations. The chief medical information officer for population health visited stakeholder worksites to observe their workflows and discuss their questions and concerns.
- **Added new questions and response options to the EHR to better capture the nuances of patients' identities.** The new standard patient registration process included broad categorizations for race and Hispanic ethnicity where patients could list multiple categories for race. A new ethnic background question included 127 categories drawn from a larger CDC code set that varied in granularity, such as Guatemalan, Cuban, Hmong, Chinese, Arab, or European, and allowed multiple responses for one patient. An additional question recorded a patient's preferred language for communication.
- **Improved training and methods of data collection.** Missing or inaccurate REAL data is frequently the result of staff discomfort in asking patients about their race and ethnicity, and — as a result — either defaulting to categories such as “unknown” or making assumptions about patients' identities. Registration staff received training and a script to help them ask patients these questions. Patients were also encouraged to enter their own demographic information directly into eCheck-In and through a link on the MyChart home screen.

Within two years of launching this initiative, UC San Diego Health increased its rates of complete REAL data documentation from 27% to over 94%, enabling clinicians and researchers to better use EHR data to identify racial disparities in care. For example, the Department of Population Health stratified eight key quality metrics by race, ethnicity, preferred language, sexual orientation, and gender identity. They discovered that tobacco screening and follow-up was completed by 97% of patients overall, but by only 94% of Black patients. The health system then added automated processes to standardize the tobacco screening and follow-up workflow, effectively eliminating the disparity in care.

Source: “[Epic Share: Laying the Groundwork to Identify and Address Healthcare Disparities](#),” Epic Systems Corporation, Sept. 6, 2021.

## Opportunity 3: Identify Measures to Stratify by Race, Ethnicity, and Language

### Overview

As organizations improve REAL data collection, they do not need to wait to start to disaggregate data and stratify existing measures using available qualitative (e.g., patient experiences, stories) and quantitative data. Data disaggregation and stratification can reveal key differences between subgroups and reveal hidden patterns of inequity.

#### Why disaggregate and stratify data?

Disaggregating and stratifying data by race and ethnicity can ensure that trends across the wider population are not [masking](#) those for subgroups.

For example, as Dr. Stella Yi and her colleagues described in a recent [Health Affairs article](#), an analysis of mortality rates among Asian American showed cancer to be the leading cause of death. But when data were disaggregated, heart disease, not cancer, was the leading cause of death for Asian Indians.<sup>43</sup>

### Key Recommendations

#### A. Choose at least five measures to disaggregate and stratify by REAL data.

- At a minimum, these should include existing clinical performance and patient experience measures. Other measures can align with your organization's defined priorities. Consider these guiding questions:
- What priority measures are you already tracking or

addressing in current care improvement efforts?

- Which of these measures may be most impacted by racial inequities? (See resources below and use these questions, adapted from a [2008 National Quality Forum report](#), to guide your internal discussion).
    - » How prevalent is the disease or condition targeted by this measure among the populations most impacted by racial inequities?
    - » What is the impact of this condition on the health of the populations most impacted by racial inequities — for example, on mortality, quality of life, years of life lost, disability, stigma — relative to other conditions?
    - » How strong is the evidence (including from community-based and public health partners) linking improvement in this measure to improved outcomes for any group, and particularly for members of populations most impacted by racial inequities?
    - » How large is the gap between the group with the lowest performance compared to the group with the highest performance for the selected measure? Prioritize measures associated with larger gaps.<sup>41</sup> (Besides using your own data, contact insurers or reference publicly available local- or state-level datasets to help answer this question)
  - Which of these measures is most feasible to stratify within the next three months? Your organization may select structural, process or outcome measures that relate to one or more of the following primary care measurement domains: Access and Availability of Care; Quality and Effectiveness of Care; Experience of Care; Utilization of Care; Integration of Care (see Figure 3).
- #### B. Select meaningful, “disparities-sensitive” measures.
- Consider using these criteria from the NQF:

“Alignment of measures is more important than using the best measures.”

Alice Hm Chen, MD, MPH, Chief Medical Officer, Covered California. Covered California Board Meeting, Jan. 20, 2022

- **Measures with a known racial health inequity.** For example, review emerging state-level measure sets or consider one or more of NCQA's HEDIS measures for Measurement Year 2022, selected for race and ethnicity stratification (see Resources section):
  - » Colorectal Cancer Screening
  - » Adolescent Well Care Visits
  - » Controlling High Blood Pressure
  - » Prenatal and Postpartum Care
  - » Hemoglobin A1c Control for Patients with Diabetes
- **Measures of care decisions impacted by clinician behavior.** For example, clinicians often make care decisions for situations in which explicit protocols don't exist. These decisions may be more prone to variation based on implicit bias among clinicians and care team members. Measures such as those from the CAHPS® [Experience of Care and Health Outcomes](#) (ECHO) Survey may help identify whether variation exists.
- **Measures of communications-sensitive processes.** For example, consider including measures of [Culturally and Linguistically Appropriate Services \(CLAS\)](#) and items from the [Communication Climate Assessment Toolkit \(C-CAT\)](#).
- **Measures impacted by social and structural drivers of health inequity.** For example, diabetes or heart disease-related measures may be impacted by food insecurity, asthma and depression measures may be impacted by housing instability, and cancer treatment adherence or access measures may be impacted by transportation barriers.



## Opportunity 3: Identify Measures to Stratify by Race, Ethnicity, and Language

- C. Identify additional measures to stratify based on clinical needs and strategic priorities informed by key stakeholders**, including payers, clinicians and care teams, patients, and community residents and leaders belonging to historically marginalized communities.
- D. Identify how a chosen performance measure is distributed within each demographic group and compare the distribution in one group against the distribution in another** For example, “How is quality within one group different from quality in another group?”<sup>42</sup>

- B. As a team, review practice priorities based on:
- Clinical needs, identified by patients with lived experience
  - Care gaps, including gaps in behavioral health care
  - Unmet social needs
  - Key performance indicators (KPIs) tied to payer mix, revenues, and incentives
  - Community and public health priorities
- C. Review emerging equity-oriented measure sets from state and federal regulators and accreditation bodies. For example, these include:
- California Department of Managed Care (DMHC): [AB 133 Health Quality and Equity Measures development](#)
  - [2020 DHCS Health Disparities Report](#)
  - [Managed Care Accountability Set \(MCAS\)](#) are performance measures that DHCS selects for annual reporting by Medi-Cal managed care health plans (MCPs)
  - [Covered California Quality Transformation Initiative \(QTI\) Measures 2022](#)
  - NCQA: [Stratifying HEDIS Measures by Race & Ethnicity stratification requirements 2022-2024](#); [Health Equity Accreditation](#), effective 2023
  - National Quality Forum (NQF) [Measure Applications Partnership \(MAP\) Health Equity Advisory Group](#)

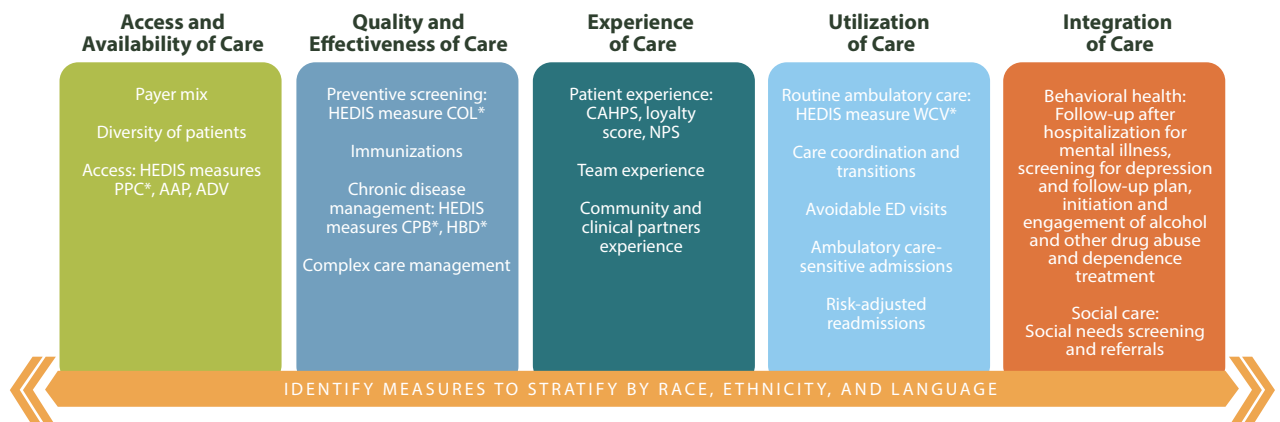
### Challenge

Selecting and prioritizing measures to stratify by REAL data can be challenging due to data limitations, competing priorities, and evolving measure sets from payers and regulators.

### Tips:

- A. As your organization disaggregates REAL data and uses that data to stratify key measures, you might find that REAL data collected are insufficient or inconsistent. As you continue to develop improvement efforts, consider investing in strategies to collect self-identified REAL data more effectively. (See Opportunity 2.)

**Figure 3: Selecting Measures to Stratify by REAL Data**



Source: Adapted from *Primary Care Performance Measure Domains*. HealthBegins, 2021.

\* NCQA has identified and recommended these specific measures for race and ethnicity stratification for measurement year 2022: Colorectal Cancer Screening (COL, COL-E); Adolescent Well Care Visits (WCV), Controlling High Blood Pressure (CBP); Prenatal and Postpartum Care (PPC); Hemoglobin A1c Control for Patients with Diabetes (HBD). <https://www.ncqa.org/wp-content/uploads/2021/06/2021-0622-Future-of-HEDIS.pdf>

## Opportunity 3: Identify Measures to Stratify by Race, Ethnicity, and Language

- Health Care Payment Learning and Action Network (HCP-LAN) [Health Equity Advisory Team \(HEAT\)](#)
  - [CMS Equity Plan](#) for Medicare & CMMI Strategic Objective - “[Advancing Health Equity](#)”
- D. Document, be transparent, and communicate the criteria and rationale your practice used to select measures for stratification to:
- Patients and community members with lived experience (e.g., via Patient and Family Advisory Councils)
  - Practice clinicians, care teams, managers, and organization leaders
  - Other external stakeholders as needed (e.g., payers, regulators, accreditation bodies)
- [Using Data to Reduce Disparities and Improve Quality](#) —Developed by Advancing Health Equity (a national program based at the University of Chicago and conducted in partnership with the Institute for Medicaid Innovation and the Center for Health Care Strategies), this resource outlines how health care providers and multi-stakeholder collaboratives can use data to reduce inequities.
  - [Healthcare Disparities Measurement](#) — This comprehensive 2011 paper from the Disparities Solutions Center at Mass General Brigham provides guidance on selecting and evaluating disparity-sensitive quality measures, describes methodological issues with disparities measurement, and identifies cross-cutting measurement gaps.
  - [Challenging racism in the use of health data](#) and [The Mutually Reinforcing Cycle Of Poor Data Quality And Racialized Stereotypes That Shapes Asian American Health](#) — Learn more about the importance of disaggregating and stratifying data from these two articles from the *Lancet* and *Health Affairs*.

### Resources

- [2008 National Quality Forum report](#) on National Voluntary Consensus Standards for Ambulatory Care — Measuring Healthcare Disparities.
- [Culturally and Linguistically Appropriate Services \(CLAS\)](#) and the [Communication Climate Assessment Toolkit \(C-CAT\)](#) are example measures to assess provider-patient communication.
- [HEDIS Race and Ethnicity Stratification for MY 2022](#) describes NCQA's approach to race and ethnicity stratification in measurement year 2022. This includes an update to align race and ethnicity data reporting with federal Office of Management and Budget (OMB) categories and identification of five HEDIS measures for race and ethnicity stratification.

## Opportunity 4: Analyze and Identify Root Causes of Identified Inequities

### Overview

Primary care practices should review disparities in their processes and outcomes to identify root causes of racial health inequities, including social and structural drivers. Practices should work with partners to understand and analyze patient- and community-level data. QI leaders, managers, and clinical champions can facilitate this process with the support of data analytics, IT staff, and external community partners.

### Key Recommendations

#### A. Engage key stakeholders and partners to help review all inequities identified by REAL stratification of selected measures.

These may include, but not be limited to, individuals on your team. (See Opportunity 1.)

- Engage patients and community residents representing the groups experiencing identified racial health inequities.
- Engage staff and leaders from different departments.
- If resources are available, engage in-house and external experts to evaluate if identified inequities are statistically significant.

#### B. Identify and review cases in which one or more patients had negative outcomes or experiences associated with an identified inequity. Leverage and adapt your internal collaborative case review or adverse event review process to engage staff in identifying root causes. (See highlight box for an example

from Cambridge Health Alliance's Malden Care Center.)

#### C. Choose comparator groups intentionally (e.g., choose the socially advantaged population with the best health outcomes, compare two less socially advantaged populations, or use an all-patient average as a benchmark).<sup>44</sup> Don't automatically assume White patients to be the default reference group for all comparisons. This risks reinforcing White supremacist structures and framing. Instead, use your stratified data to identify the racial, ethnic, or linguistic groups that experience the best outcomes for each of your selected measures.<sup>45</sup>

#### D. Benchmark current data against historical data from within the organization or against comparison data from other practices or organizations. Work with payers, local or state primary care associations, or other health care networks to seek comparison data.

#### E. Add filters using other patient data characteristics to better identify intersectional patterns of health inequity among patient populations.<sup>46</sup> These additional characteristics can include:

- Sexual Orientation
- Gender Identity
- Age

- Ability
- History of or experience with serious mental illness (SMI) or serious substance use disorder (SUD)

#### F. Analyze root causes, including the social and structural drivers of health inequity, by querying your data and asking the following questions:<sup>47</sup>

- How are patients' unmet **social needs** contributing to the identified racial health inequity? Are there racial inequities in patients' unmet social needs? How well do these gaps correlate with the identified racial health inequity?
  - » Use social needs screening data and patient interviews or focus groups to assess available patient-level data (quantitative or qualitative) on unmet health-related social needs, including food insecurity, housing instability, transportation barriers, and social isolation.
  - » Note that a growing number of states and insurers are requiring providers to collect social need data or creating incentives for them to do so. As of January 2022, for example, [Covered California has proposed a requirement](#) that contracted insurers collect information on food insecurity using the [Accountable Health Community Health-Related Social Needs Screening Tool](#).
- How are **institutional policies** or practices contributing to the racial health inequity we've identified?
  - » Assess institutional drivers such as clinic hours and accessibility, staffing models and resources, and financial policies, including debt collection practices. Your data may reveal that minoritized patients experience higher [missed appointment rates](#) due to structural racism and unmet social



## Opportunity 4: Analyze and Identify Root Causes of Identified Inequities

needs (e.g., transportation barriers). Does your practice provide access to care solely through routinely scheduled weekday clinic appointments, or do you also provide walk-in access, home visits, and telemedicine options? (Telemedicine visits have been shown to help close racial gaps in [visit completion rates](#).)

- How are **community-level, social and geographic determinants of health** (e.g., food deserts, housing code violations) or other **markers of structural racism** (e.g., [state laws](#) or county policies) contributing to the identified racial health inequity?

Clinicians and researchers at Cincinnati Children's Hospital Medical Center developed a "geomarker of asthma-related medication adherence" based on data from a pharmacy chain and tested it against asthma utilization. Specifically, we calculated a Pharmacy-level Asthma Medication Ratio (Ph-AMR), which examined the balance of rescue versus preventive medication use. Our ratio runs parallel to the patient-level Asthma Medication Ratio, a nationally recognized quality metric, but is based on the census tracts in which pharmacies were located. Adjusted analyses illustrated that census-tract Ph-AMR was inversely related to population-level asthma utilization rates (emergency visits plus hospitalizations). For every 0.1 increase in Ph-AMR, the census-tract asthma utilization rate decreased by approximately 10 events per 1,000 children.

We expect that targeted medication adherence interventions (for example, home delivery or self-management programs) could be developed for those in high-risk areas. Hospital-pharmacy partnerships could also be expanded to direct attention toward both high-risk populations and individual patients."

Source: Andrew F. Beck et al., [Mapping Neighborhood Health Geomarkers To Clinical Care Decisions To Promote Equity In Child Health](#), Health Affairs 36, no. 6.(June 2017): 999-1005 doi: 10.1377/hlthaff.2016.1425.

- » For example, if a racial health inequity varies significantly by census tract, then social or structural determinants (e.g., supermarket or transportation redlining) might be driving the health inequity. However, if the racial health inequity is consistent across census tracts and income levels, it may suggest that the health care system is driving the health inequity.
- » To help answer this question, cross-examine patient data with geographic, place-based population-level data. Work with geographic information systems (GIS) experts to:

Geocode disaggregated patient data from your EHR, using appropriate data security and privacy measures.

Cross-examine geocoded patient data with community-level data on the social, economic, and health service environment (e.g., "[geomarkers](#)"), or with area-based social risk indices such as the Area Deprivation Index (ADI) and the Social Vulnerability Index (SVI). This can help assess whether racial health inequities in the patient population vary from or follow markers of social vulnerability and structural racism at the census tract level. See highlight box for an example of how to link and assess patient- and community-level data.

While the use of area-based social risk indices that include race variables (such as SVI) can directly [benefit](#) historically minoritized communities, this approach may face [legal challenges](#) if public funds are used. California's Prop 209, for example, prohibits allocating certain kinds of public resources based on race and ethnicity. Use of the ADI (which does not include race) or the [California Healthy Places Index \(HPI\)](#) (which includes racial breakdown as an informational layer at the census tract level) may be used by Prop 209-eligible programs without legal concern.

### Challenge

Primary care leaders can find it challenging to communicate results of data stratification, benchmarking, and root cause analysis to diverse stakeholders, including patients and community members with lived experience.

### Tips:

- A. Use stories, visual tools such as charts and infographics, or dashboards (see resources below) to share and review results of measure stratification and analysis with staff, leaders, patients (including patient and family advisory councils), community partners, and payers.
- B. Create collaborative spaces and opportunities (e.g., focus groups) for diverse stakeholders, including staff, patients, and community partners, to understand the story behind the data, interrogate the data analysis, and generate hypotheses. See SFDPH highlight box and Case Study 2.

### Resources

- [Cause and Effect \(Fishbone\) Diagram](#) — This video from the Institute for Healthcare Improvement (IHI) describes a classic method for engaging stakeholders to identify potential contributors or causes of observable issues or problems.
- [What Is Root Cause Analysis?](#) — This five-minute video from ThinkReliability describes a root cause

## Opportunity 4: Analyze and Identify Root Causes of Identified Inequities

analysis and how it relates to another common interrogative technique known as the Five Whys.

- [Data Equity Walk](#) — This resource from The Education Trust describes a 45–90 minute activity for any size audience to engage with data — first individually, then collectively — and discuss equity issues.
- Data Storyboard/ Storytelling — See Highlight box and Case Study 2 of the Behavioral Health Program at the San Francisco Department of Public Health.
- Learn more about [Covered California’s proposed requirement](#) for contracted insurers to collect information on food insecurity using the [Accountable Health Communities Health-Related Social Needs Screening Tool](#).
- See examples of institutional practices driving racial health inequities in [missed appointment](#) and [visit completion rates](#).
- Learn more about a [comprehensive database of state laws that are explicitly or implicitly related to structural racism](#), with the goal of evaluating their effect on health outcomes among marginalized racial and ethnic groups.
- Learn more about community-level data sources, including geomarkers and the [California Healthy Places Index \(HPI\)](#), as well as the [benefits](#) and [challenges](#) of using area-based indices.

Dr. Ritchie Rubio and his colleagues in the Behavioral Health program at the San Francisco Department of Public Health look at data as a storyboard. “When we see the data, we tend to approach it by asking questions such as, ‘What do the numbers mean? But using a storyboard approach, one can instead ask questions that we customarily use around stories: ‘What’s the story here? Who are the protagonists in this story? Are there antagonists? What are the conflicts in the story? What does this story make you feel?’”

To help staff and patients better understand a pattern of low behavioral health engagement rates among Asian Pacific Islanders, the team used data storyboarding and data reflection circles to get at the story behind the pattern of inequity they identified.

See Case Study 2 for details.

### Re-envisioning Morbidity and Mortality Rounds to Focus on Equity

In 2016, **Cambridge Health Alliance's Department of Family Medicine** reinvented its model of Morbidity and Mortality Rounds for faculty and residents, replacing them with Quality, Equity and Safety Rounds. Whereas traditional M&M Rounds examine cases of adverse outcomes and seek to learn from mistakes made, the QES rounds examine everyday practices and their inequitable outcomes.

The monthly rounds, mandatory for residents, are open to anyone at the Alliance's Greater Boston area clinics and hospitals. Dr. Laura Sullivan, chief of family medicine, who co-created and co-facilitates QES Rounds, explains that, like M&M rounds, they often include case stories, but examine the patient's experience from a systems level, assessing factors such as transportation barriers, immigrant experiences, or systemic racism. Attendees also read articles and examine data, says Dr. Sullivan: "Just really questioning what we're doing and what we're considering normal. What are the unintended consequences that we might not even see?" In addition to analyzing cases, attendees explore broader topics, such as diabetes rates or dialysis referrals, and consider the root causes of inequities. When they discuss more traditional M&M concepts, such as the "Swiss cheese" model of how accidents happen, they examine how these interplay with equity.

Since making the change, Dr. Sullivan has seen its impact on the language used with patients and the conversations in the exam room, with more providers working to create a safer space and asking patients about their health care experience rather than working off assumptions. Attendees of the QES Rounds have encouraged institutional leaders to abandon the traditional health care practice of factoring race into the diagnosis of chronic kidney disease and vaginal birth after C-section, and are now engaging senior leaders in conversations about potential changes in spirometry and hypertension prescription practices.

Dr. Sullivan shares these lessons for making QES Rounds effective:

- **Create a safe space for difficult conversations**, approaching the discussion from both a head and a heart perspective. "Often if there's not discomfort, there's not change." Facilitators should be prepared to acknowledge and manage tension in the room. Dr. Sullivan and her co-facilitator begin each session with a grounding exercise in compassionate discourse, emphasizing the importance of "calling in" rather than "calling out" and differentiating intent versus impact. They also use the Window of Tolerance tool to monitor their own personal response to the content.
- **Employ facilitators of different races or backgrounds** to help make the conversation more open and accessible and to amplify different voices.
- **Be prepared to equip participants to act.** Often participants are very motivated to do something based on the conversations they have had. Facilitators should be ready to help them think through avenues for action, and QES Rounds explicitly include discussions about change management and systems change. Sullivan adds, "We also highlight that we are all on a journey. Self-reflection and growth are key. Some of the action is actually within ourselves."

## Opportunity 5: Co-design Improvement Efforts

### Overview

Engage key stakeholders to co-design equity-focused improvement efforts, including the establishment of clear goals to advance racial health equity and the development of internal and external partnerships to address the social, institutional, and structural drivers of identified racial health inequities.

### Key Recommendations

- A. Engage QI leaders and staff** to review results of data stratification and analysis, identify racial equity-related learning needs, and commit time and resources to developing equity-focused quality improvement efforts.
- B. Engage and compensate patients with lived experience** (e.g., via Patient Family Advisory Councils) to review results and, where feasible, join the improvement team. (See Opportunity 2 for resources like the [Engaging People with Lived Experience Toolkit](#) to create meaningful spaces to engage people with lived experience).
- Start with patients seen in the primary care practice (“recruiting from the waiting room”), while also recognizing that these patients are not representative of all patients.
  - Recruit empaneled patients who do not regularly show up. While convenience sampling might be an easy way to engage, it may not be reflective of the perspectives of those most affected or impacted by health inequities (i.e., those who show up in clinic may not represent all practice patients).

- C. Design equity-oriented quality improvement goals.** Identify types of measures (process, outcome, or intervention) to track. Process and outcome measures show an impact on patients (positive or negative) and should include the measures that were stratified to find racial health inequities in the first place.<sup>48</sup> (See Opportunity 3.)

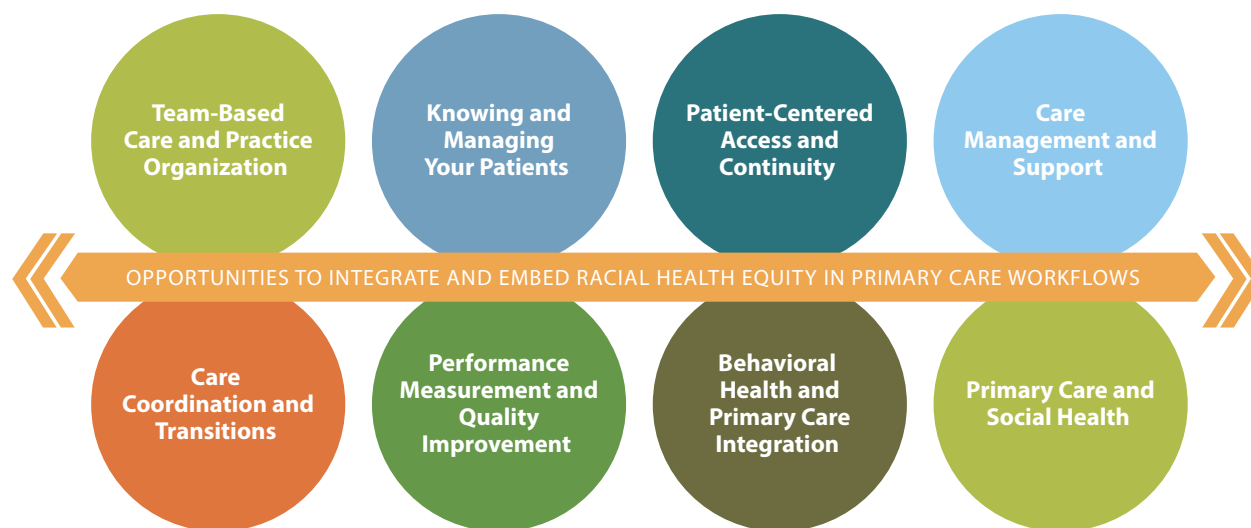
For each measure, develop goals in terms of:

- The same population before and after the intervention (e.g., a 10% increase in LDL screening rates)
- A comparison to another group (e.g., equal rates between Latinx and Asian American patients)

- A comparison to a benchmark outside of the practice (e.g., 80% of the national rate for this measure)

- D. Frame QI goals from a strength-based perspective** to avoid reinforcing “racism and White supremacy, suggesting a Black deficit, and subtly reinforcing a narrative and a story that is privileged over other stories.”<sup>49</sup> A [strength-based approach](#) to goal setting focuses on achieving positive outcomes for teams and systems rather than assigning blame to individuals, and intentionally focuses on ensuring each person involved in an improvement effort can identify and apply their

**Figure 4: Primary Care Workflows**



Source: Adapted from Primary Care Performance Measure Domains by HealthBegins.  
Note: The first six of these eight workflows map to NCQA's Patient-Centered Medical Home (PCMH) Standards.

strengths to a shared goal. See highlight box for an example from Dr. Michelle-Marie Peña at the University of Pennsylvania.

- E. Engage community partners** (e.g., local nonprofit social service providers, place-based health improvement coalitions, public health department, advocacy groups) to help develop and review a driver diagram for your equity-focused improvement effort.

### Challenge

Primary care practices may face skepticism that equity-focused improvement efforts can address existing performance requirements and accountability standards.

### Tips:

- A. Choose measures and goals that are linked to strategic priorities and emerging equity measure sets from regulators and accreditors. (See Opportunity 3.)
- B. Choose measures and goals that align with relevant primary care performance measures and workflows such as NCQA's patient-centered medical home (PCMH) framework. (See Figure 4.) Relevant goals for Behavioral Health & Primary Care Integration, for example, might include reducing identified racial health inequities in access to medication-assisted treatment (MAT) services, detoxification, and recovery support.<sup>50</sup> For Primary Care and

Social Health Integration, goals might include reducing racial inequities in food insecurity and related rates of diabetes control among adults who are diabetic.

### Challenge

Primary care practices may find it challenging to develop goals that address social and structural drivers of health equity.

### Tips:

- A. Become familiar with key definitions and levels of social and structural drivers of health equity. (See Figure 5.)
- B. Identify potential community partners. Review the HealthBegins Upstream Strategy Compass (see resources below and Figure 6) to discuss probable social and structural drivers of the racial health inequity you've identified. Identify opportunities to collaborate on upstream, equity-focused improvement efforts; that is, where each of your organizations will lead and where you will partner and support the other.

### Resources

- Learn more from this Gallup article about [how to use a strengths-based approach to goal setting](#).
- [Centering Equity in Quality Improvement \(November 2021\)](#) — This presentation from Dr. Michelle-Marie Peña to a CIN Partner Meeting outlines her team's work at University of Pennsylvania developing equity-focused quality improvement initiatives and describes how her team applied a strengths-based approach to defining goals.

Dr. Michelle-Marie Peña and her colleagues at the University of Pennsylvania worked with a diverse group of staff and patients with lived experience to identify racial health inequities in appointment no-show rates among Black children and families discharged from the NICU compared to White children and families.

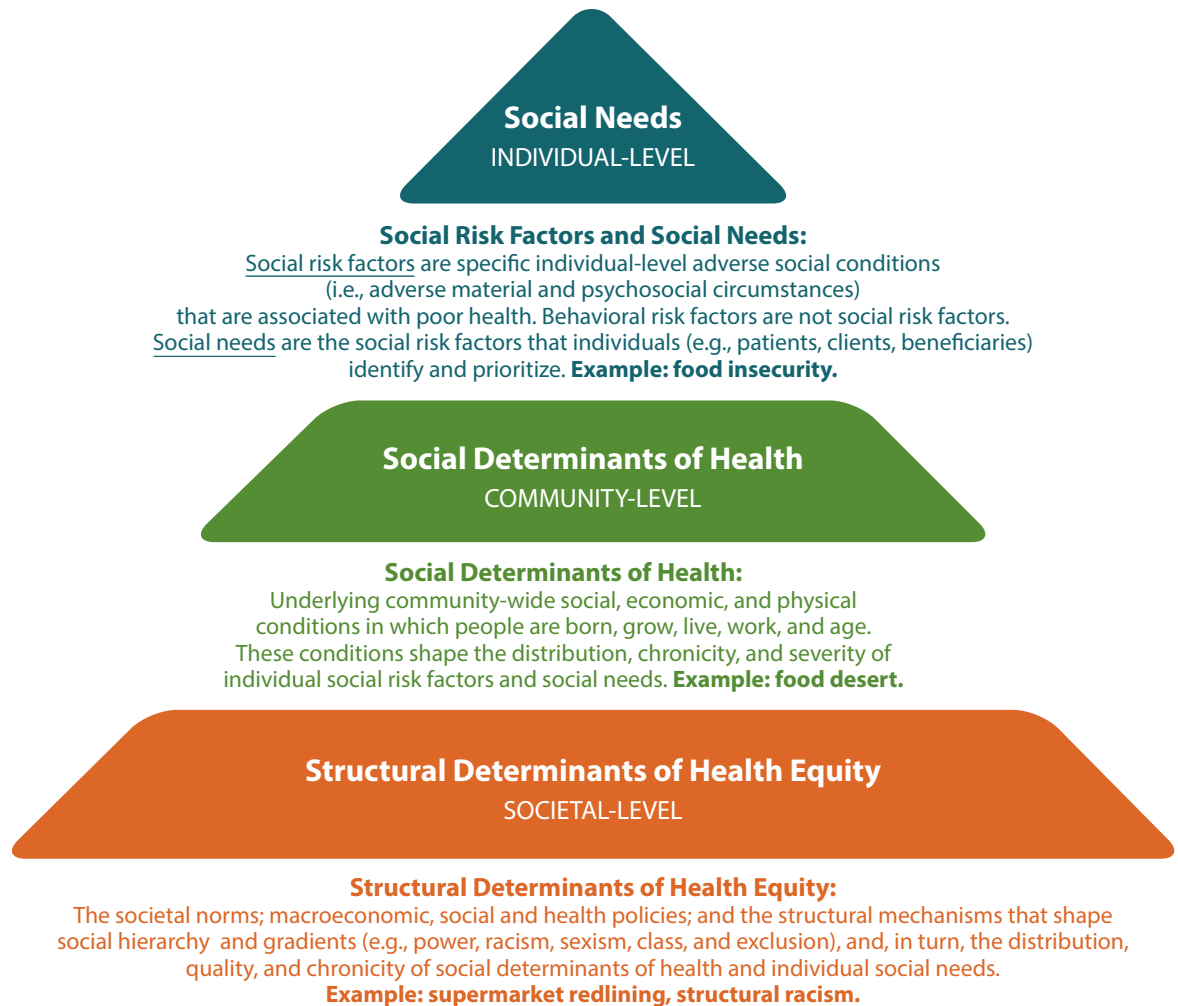
As they learned about the potential drivers of this inequity, they identified transportation barriers as an unmet social need. They also decided to adopt a strengths-based approach to framing goals for their equity-focused improvement effort, in order to avoid reinforcing negative racial biases and stereotypes.

Instead of "reducing **no-show** rates," their revised aim statement became "increase neonatal follow-up **show** rates for Black patients from 63% to 70% by June 2022."

Source: Presentation by Michelle-Marie Peña, MD, [CIN Partner Meeting](#), November 2021.

- [Seven practices for pursuing equity through learning health systems: Notes from the field](#) — This report from practitioners and researchers affiliated with Cincinnati Children's Hospital Medical Center describes ways to embed equity within improvement work (see Practice 4: "Co-produce").
- [HealthBegins Upstream Strategy Compass](#) — This matrix from HealthBegins helps identify barriers and opportunities, including the social and structural drivers of health equity, across different levels of action and prevention. (See Figure 6.)

**Figure 5: Social and Structural Drivers of Health Equity**



Source: *Upstream Communication Toolkit*, HealthBegins, February 2022.



### Lessons Learned in Co-Designing Improvement Efforts

Two health care organizations working to advance racial equity shared lessons they have learned about working with communities to co-design care improvement efforts.

#### **Hold listening sessions as a first step. Community members' stories are the data that should shape and lead improvement efforts.**

In 2017, Solano County, California, received a CityMatch grant to develop strategies for improving equity in healthy births for African American/Black babies and their families. County officials spent a year hosting community listening sessions to identify root causes of infant mortality, prematurity, and low birth weight among African American/Black babies in the county, and to brainstorm strategies to improve those outcomes. Out of 129 potential strategies identified during these meetings, community members voted on the top nine and spent several months discussing each in detail before voting again on their top three: mental health education and resources for African American/Black women of reproductive age, exclusively African American/Black group prenatal care programs, and education for providers and health systems to address racism and structural racism in health care. The county then funded these three solutions through its [Solano HEALs](#) initiative. Starting with listening sessions not only maximized opportunities for community input in the solutions, but centered relationship-building and power sharing as main goals of the initiative.

#### **Develop and formalize a co-leadership model with community members.**

At the Oregon Health and Sciences University Family Medicine Clinic, Richmond (OHSU Richmond), a federally qualified health center in Southeast Portland, Oregon, all racial health equity initiatives operate with a shared leadership model between staff and the community. Core teams of staff and community members are established before the start of a project and work together from design to implementation. In 2021, OHSU Richmond launched the Community Health And Racial Justice (CHARJ) initiative specifically to eliminate racial inequities in diabetes. Its operations are run by a core staff team including clinicians, a community organizer, an SDOH project coordinator, a data analyst, and clinic administrators. But it is also led by a team of community members who participate in planning sessions, advise staff, and lead community organizing activities related to the project. The community core team members live in the five neighborhoods where racial inequities in diabetes are greatest, have lived experience and expertise of structural oppression, want to work with others for change, and can commit to semi-regular meetings.

#### **Compensate community members for their time and expertise.**

OHSU Richmond has secured funding from a local foundation to pay community members, including members of the CHARJ team described above, to co-design initiatives, facilitate community listening sessions, and lead organizing activities. This has built trust and disrupted the power dynamics that arise when academic institutions engage community members (where staff are paid for their time and expertise, while community members are expected to volunteer). When hosting community listening sessions, OHSU Richmond also provides food and childcare to participants to help facilitate their participation.

#### **When inviting input and designing programs, meet communities in spaces where they are most comfortable.**

The listening sessions that Solano HEALs staff hold with community members are always held in community spaces, and feedback from community members informs where Solano HEALs hosts programming. For example, parenting groups happen after work hours in settings such as community centers and libraries, separate from health care facilities and county office buildings which can deter people from participating because of associations with other government offices in the same buildings and because they have metal detectors. Simple steps like dressing casually, not wearing county badges, and designing a website that is warm and distinct from the county's website help build trust. These steps are in response to feedback from community members.

# Opportunity 6: Guide and Monitor Improvement Efforts Using Dashboards

## Overview

Primary care practices should leverage existing quality measurement tracking tools and dashboards to guide and monitor racial health equity-aligned care improvement efforts. These dashboards are essential for continuous improvement.<sup>51</sup>

## Key Recommendations

- A. Establish a baseline for measures relevant to your organization's equity-focused improvement goals by collecting existing data (e.g., encounter data) in the prior calendar year.
- B. Present data on racial health equity performance measures in a visually meaningful way using an analytic dashboard. For each measure, aim to:
  - Track year-to-date performance for the group experiencing identified racial health inequities and for the comparator group.
  - Display (monthly or quarterly) trends over the past year, using linear graphs to visually compare groups.
  - Display change on an annual, and where helpful, semi-annual basis.
- C. Make results accessible to stakeholders, including patients with lived experience (see Opportunity 4 for more information about engaging people with lived experience).
  - Use these [12 Tips for Data Visualization](#)
  - Review this [guide for developing community dashboards](#)

- D. Use dashboard views to generate stakeholder input, test hypotheses about key drivers, and update and target equity-focused goals and efforts.
- E. Leverage dashboards, combined with stories and qualitative data, to advocate to internal leaders, payers, and policymakers for greater support to address racial health equity, including social and structural drivers of equity.

## Challenge

A dashboard may not provide information that is timely enough for equity-focused care improvement teams to conduct rapid-cycle tests of change such as Plan-Do-Check-Act cycle.

## Tip:

- A. Engage internal and external QI leaders and experts to develop statistical process control techniques such as [run charts](#) to track measures more regularly over time and move beyond single-point dashboards. (See Pediatric Health Equity Dashboard from [Children's Minnesota](#) in the Resources below.)

## Challenge

Organizations that serve a disproportionately higher number of patients from historically marginalized communities tend to have fewer resources and may [worry about being unfairly penalized](#) for poorer health equity outcomes among populations who

are socially at risk due to structural racism.

## Tips:

- A. Work with internal and external health IT and data analytics partners to visualize area-level indices of social risk (such as the [Area Deprivation Index](#)) alongside individual-level patient data on social needs and racial health inequities.
- B. Where feasible, use the combination of area-level social risk data and individual-level social need data to display the impact of risk-adjustment on equity-based performance measures.
- C. Engage internal and external staff (including prospective vendors) to develop dashboards and visual analytic reports that provide insights on the impact of social risk adjustment. Using this analysis, advocate that payers and regulators use social risk adjustment to assess prospective payments to primary care practices that disproportionately care for historically marginalized communities.
- D. A growing number of research institutions and data analytic vendors are exploring how to apply social risk adjustment to clinical data. For example, Massachusetts Medicaid supplemented area-level social risk data with individual-level information from medical records and claims to increase reimbursement



## Opportunity 6: Guide and Monitor Improvement Efforts Using Dashboards

to managed care organizations that serve socially and medically high-risk patients.<sup>52</sup> Where feasible, use open source datasets to understand social risk data at the community level (e.g., the American Community Survey, Community Commons, the California Health Interview Survey).

### Resources

- [On the Journey Toward Health Equity: Data, Culture Change, and the First Step](#) — This article in NEJM Catalyst describes Intermountain Healthcare's experience during the initial months of the pandemic as they moved to rapidly organize and analyze their data to identify racial inequities. See Figure 1 in the article for an example of a dashboard of clinical outcomes with disaggregated data on race, ethnicity, and sex.
- [Accountability Through Measurement: Using a Dashboard to Address Pediatric Health Disparities](#) — This article in *Pediatrics* describes the experience of QI leaders at Children's Minnesota developing dashboards to track and address racial inequities in pediatric outcomes.
- [12 Tips for Data Visualization](#) — This article from the Center for Care Innovations outlines tips for visualizing and sharing data with stakeholders, including [how to use run charts](#) to track measures over time.
- [A Guide to Develop and Implement a Community Dashboard to Improve Lives and Close Disparities](#) — This resource from Finding Common Purpose presents a checklist of practices and processes to develop and implement a community dashboard.
- [Accounting for Social Risk Factors in Medicare Payment](#) — This report from the National Academies of Sciences, Engineering, and Medicine (NASEM) provides guidance on data sources and strategies for collecting data on social risk indicators that can be accounted for in Medicare quality measurement and payment programs.
- [Adjusting Medicare Payments For Social Risk To Better Support Social Needs](#) — This Health Affairs Forefront blog post summarizes the opportunities to use area-based social risk datasets to inform prospective payments.
- Learn more about using area-level indices of social risk like the [Area Deprivation Index \(ADI\)](#) from the University of Wisconsin School of Medicine and Public Health.
- See perspective piece from the New England Journal of Medicine on [alternative payment models and incentives and disincentives for treating high-risk patients](#).



### Developing a Dashboard to Determine Correlations Between Social and Medical Needs

**The MetroHealth System in Cleveland, Ohio,** created a Social Determinants of Health (SDoH) dashboard to view social needs data alongside medical and demographic data. Developed by the health system's **Institute for H.O.P.E.™**, an in-house catalyst for efforts to reduce social risk factors, it was spearheaded by two full-time data analysts and is patent-pending. The dashboard allows users to analyze data on patients' social needs alongside their race, ethnicity, zip codes, and EHR data on patients' insurance status, primary hospital/CHC, medical information (comorbidities, health conditions, labs, vitals), and utilization rates and appointment no-shows.

By toggling menus and options on the dashboard's single-screen view, users can visualize and break down the data to see which issues most affect different populations and which social needs programs might help improve health outcomes. For example, Black patients at MetroHealth are 25% more likely to have issues with digital connectivity, 99% more likely to have housing issues, and have significantly higher rates of food insecurity, physical inactivity, and transportation issues when compared to their White counterparts. The dashboard also tells the user which social needs are most likely to occur together.

Staff initially populated the dashboard with data through social-needs screening before primary care, OBGYN, and geriatric visits via MyChart, plus paper screeners at vaccine clinics. But the patients screened this way skewed disproportionately White, suburban, and high-speed-internet-connected. To reach a broader range of patients, MetroHealth is shifting toward in-person screening tools, using direct patient interviews, a paper-based form, and a tablet or a computer interface for clinic visits. MetroHealth is also partnering with organizations in Cleveland to incorporate other data sets on such measures as housing quality, home liens, and tax delinquency.

MetroHealth finished building and piloting the dashboard in late 2021, with the primary goal of using the aggregated data to inform the development of programs that meet patients' social needs. For example, the dashboard showed that smoking and food insecurity increased together, so staff secured a grant for a pilot program to address these issues in tandem. Because the social needs data can also be analyzed by insurers, MetroHealth plans to use it to pursue funding from various insurers for programs that will most help those people they insure. Currently, the two data analysts are the primary users of the dashboard and report on trends to other staff. But the institute aims to expand access to a broader range of staff, allowing them to review data relevant to their areas of expertise, review equity measures, and to tweak and develop programs.

# Opportunity 7: Inform and Accelerate Institutional Transformation and Community Action

## Overview

Learn from and leverage equity-focused care improvement efforts to identify system and policy barriers and accelerate institutional transformation and community action to advance racial health equity.

## Key Recommendations

- A. Convene meetings with equity-focused improvement teams and community partners** to identify and catalog program, institutional, and policy barriers that emerge during the design and implementation of care improvement efforts focused on racial health equity.
- B. Use the HealthBegins' Upstream Strategy Compass (see Figure 6)** to help health care and community partners identify barriers and opportunities to improve health equity, including the social and structural drivers of health equity, across different levels of action and prevention.<sup>53,54</sup>
- C. Review institutional barriers to racial health equity with internal colleagues and leaders** to spur, inform, and support enterprise-wide efforts toward becoming an anti-racist multicultural organization.
- D. Lend active support to community partners to address policy and structural barriers related** to the patterns of racial health inequity your organization identified among patients.

**Figure 6: Opportunities to Address Social and Structural Drivers of Racial Health Inequities for Diabetes Mellitus and Food Insecurity**

Upstream Strategy Compass™	Level of Intervention Individual and Services	Level of Intervention Institutional and Community	Level of Intervention Structural and Societal
<b>Primary Prevention</b>	Financial literacy, support, and nutrition programs for low-income families with strong family history of DM	Provide on-site farmers' market, gym, walking trails, or financial counseling for employees and dependents	Support ban on trans fats or a tax on refined grain products with added sugar, with subsidy support for healthier foods
<b>Secondary Prevention</b>	Screening and assistance for patients with DM at risk of end-of-month hypoglycemia	Subsidize vouchers to a farmer's market, incorporate the diabetes prevention program into benefits plan for prediabetic employees	Change timing and content of WIC and school food programs to avoid food insecurity among people with DM
<b>Tertiary Prevention</b>	Reduce hospital use among people with diabetes who are high utilizers with medically tailored meals	Coordinate with local banks, collectors, lenders, to reduce debt burden for users with diabetes	Support legislation and regulations to provide financial investments and support services to those in redlined areas

Source: Upstream Strategy Compass™. Manchanda R. HealthBegins. Adapted from Chokshi and Farley (2012); Gottlieb et al. (2013); Cohen and Swift (1999); and Leavell and Clark (1965).

## Challenge

Primary care practices may not have well-developed relationships with place-based improvement initiatives led by local public health departments or multi-stakeholder community health collaboratives. This can undermine the confidence and participation of primary care clinicians and staff in community-level action to address the social and structural drivers of racial health equity.

## Tips:

- A. Leverage data and insights from the design, implementation, and evaluation of equity-focused care improvement efforts to engage with community forums.
- B. Use the HealthBegins Upstream Strategy Compass to engage public health departments, community partners, advocacy coalitions, and policymakers to coordinate strategies to address specific racial health

## Opportunity 7: Inform and Accelerate Institutional Transformation and Community Action

inequities. Practices can share de-identified data from equity-focused improvement efforts to inform and identify locally relevant opportunities to lead, and partner or support efforts at different levels of action (micro, meso, macro) and prevention (primary, secondary, tertiary).

- C. Expand or formally engage community advisors in primary care improvement teams (see Opportunity 1) and update charters to reflect and track how your organization is advancing specific equity goals by participating in cross-sector, place-based upstream improvement efforts.
- D. Work with partners to identify and take specific institutional and community-level actions to address the social and structural drivers of racial health inequities that impact your patients or members.

### Challenge

Primary care practices may find it challenging to dedicate the staff time and resources required to engage in or support activities to advance equity, in particular at the macro level, given immediate priorities and demands on their time.

### Tips:

- A. Start small and leverage insights from existing care improvement efforts to identify potential pathways and resources needed to move upstream to support institutional and community-level action.
- B. Hire individuals with social work and community organizing backgrounds, and contract with local community organizing groups to assist your staff in developing capacity, skills, and confidence to engage in community-level health equity improvement efforts. See Case Study 1 from OHSU Family Medicine at Richmond for an example of how one organization developed this capacity.
- C. Identify and test solutions that can lead to early wins in order to demonstrate value and build internal momentum to engage in broader efforts to advance racial health equity at the institutional and community levels.

### Resources

- [Communities in Action: Pathways to Health Equity](#) — This 2017 report from NASEM reviews root causes and structural barriers to addressing health inequities, as well as policies to support change at multiple levels. The report includes concrete examples of how participation by stakeholders, including primary care organizations, in community-level action advances health equity.
- [Southern Jamaica Plain Health Center \(SJPHC\) Racial Justice approach](#) — This presentation hosted by the Center for Health Care Strategies (CHCS) highlights helpful resources and programs from SJPHC, a Federally Qualified Health Center in the Boston area that has worked for a decade to transform itself into a racial justice organization. See slide 45 to learn more about the domains of racial justice they use to ground their continuous learning and improvement efforts.

### Creating a Transportation Department to Reduce Racial Health Inequities

To reduce inequities in care due to transportation access, **Cone Health in Greensboro, North Carolina** created a transportation hub for patients within its population health and health equity division. Patients use a phone number to schedule rides to appointments in any department across the health system, including primary care. They can also use the free service to pick up prescriptions after appointments. The transportation department currently receives an average of 127 calls per day systemwide.

The genesis of the transportation hub was data implicating transportation as a barrier for patients seeking cancer treatment. This disproportionately affected people of color, particularly Black patients who lived in neighborhoods with unreliable access to public transportation. In 2019, Cone Health Cancer Center [piloted a transportation hub](#) focused on patients living in two zip codes in the southeast portion of Greensboro where appointment no-show rates were four to five times higher than in other zip codes.

During the pilot, all patients in these zip codes were screened to see if they had missed appointments or not sought health care services in the last year because of transportation problems. If they answered “yes,” they were offered a phone number to request rides via a variety of rideshare and medical transportation services that would be charged to Cone Health Cancer Center. The biggest barriers to implementation were not costs, but rather risk and compliance issues related to working with rideshare programs, [which the Cone Health Cancer Center team worked extensively to overcome](#). At the end of the four-month pilot, appointment no-show rates for those two zip codes dropped from 12 and 15%, respectively, to 1.2 and 1.3%.

After seeing the impact of the pilot program, the health system expanded the transportation hub systemwide into a permanent service available to all patients for all appointment types.

# Case Study 1: Marrying Data with Community Organizing to Improve Diabetes Care

Oregon Health Sciences University (OHSU) Family Medicine, Richmond

*In thinking about how to integrate racial equity into its care improvement efforts, OHSU Family Medicine, Richmond designed an approach to diabetes care that marries medical, social, and structural solutions, while centering community voices in program design.*



This case study illustrates the pursuit of Opportunities 1,2,4,5,6, and 7.



## Community Health and Racial Justice Initiative

In 2021, data analysts at OHSU Family Medicine, Richmond (OHSU Richmond), a community health center in Southeast Portland, geomapped patient data on race, home address, and a variety of medical factors (comorbidities, health conditions, labs, vitals) to determine what racial health inequities existed among clinic patients and where. The data was pulled from Epic, the health center's electronic health record, and visualized in Tableau. The analysis revealed that the starkest racial health inequities were related to diabetes. Relative to population size, BIPOC patients had higher rates of diabetes than their White counterparts (13% versus 9%) and higher rates of uncontrolled diabetes (17% versus 12%). These disparities were even wider in the five neighborhoods in Southeast Portland with the highest percentages of BIPOC residents. Significantly, according to OHSU Richmond's social needs screenings, the same five neighborhoods had disproportionately higher rates of unmet social needs, including around income, housing, and employment. (The SDOH screening data is not currently documented in Epic and was analyzed separately).

In response, OHSU Richmond launched the Community Health And Racial Justice (CHARJ) initiative at the end of 2021, specifically to eliminate inequities in diabetes by developing a place-based, neighborhood-led effort that aligns quality improvement, SDOH screenings, and community organizing efforts.

CHARJ is one illustration of the health center's broader approach to racial health equity that centers long-term relationship building, community organizing, and power sharing — in efforts both to address structural determinants of health and clinical improvement.

## Emphasis on Community Organizing in Health Equity Work

Health equity work frequently focuses on convening "experts" who are already in positions of power and who have specific educational and professional credentials. OHSU Richmond's broader approach to healthy equity work prioritizes centering people with lived experience and seeks leadership from these individuals.

OHSU Richmond views long-term relationship building with communities as the primary goal of its racial health equity work, and takes the unusual step of employing a full-time community organizer on its staff. Listening sessions and community organizing are central components of every OHSU Richmond health equity initiative. Projects are designed with a shared staff-community leadership model, where goals are co-created and community members are compensated for their expertise and time. Funds from a local foundation allow the team to compensate community members when seeking initial advice on how to develop a particular program (like CHARJ), as well as pay community members when they lead community organizing activities, such as co-facilitating a listening session.



## Case Study 1: Marrying Data with Community Organizing to Improve Diabetes Care

OHSU Richmond will publish a toolkit in summer 2022 that details how to create a relational, flattened hierarchy with patients and community members. This approach has been used to inform the CHARJ initiative.

### Structuring Staff and Resources to Support the CHARJ Work

CHARJ will be led by:

**A. An advisory board** made up of patients and community leaders from the five identified Southeast Portland neighborhoods will guide CHARJ's strategy. Their time — for participating in planning sessions, advising health center staff, and leading community organizing activities — will be compensated with funding from the foundation. Advisory board members must meet three criteria. They (1) have lived experience and expertise of structural oppression; (2) want to work with others for change; and (3) are able to commit to semi-regular meetings with the childcare, food, and stipends provided by OHSU Richmond. Potential advisory board members are identified and referred to the CHARJ operational team by Richmond providers or staff or by Health Equity and Leadership at Richmond (HEAL-R) members — the clinic's community organizing team, comprised of patients, community members, and staff. OHSU Richmond's community organizer then has a one-to-one meeting with those so referred to discuss their participation. The advisory board is being assembled.

**B. An operational team (OT)** consisting of six to eight OHSU Richmond employees, who, in coordination with the advisory board, will implement CHARJ's strategy. Much of the operational team is comprised of members of the health center's broader health equity subcommittee, which includes one FTE community organizer and team members — including clinicians, an SDOH project coordinator, a data analyst, and clinic administrators — who have protected time for their committee work. Their work, values, and approach are laid out in the CHARJ Operational Team's [project charter](#).

### CHARJ Goals and Activities: Aligning Medical, Social, and Structural Responses

A cornerstone of the CHARJ initiative is that it coordinates the health center's response to diabetes inequities at the medical, social, and structural levels. The same staff-community leadership team oversees work in all three areas. Now that the initiative's initial data analysis is complete, the next step will be to hold community listening sessions in spring 2022 to establish potential root causes of identified inequities based on the data.

The following preliminary activities and goals have been identified, but the Operational Team won't embark on these efforts until after neighborhood listening sessions are complete. While long-term relationship-building remains the principle focus, the success of the CHARJ initiative will be measured by progress in the following areas:

### A. Medical Responses

- **Improvement of the racial health disparity itself:** CHARJ patients' HbA1c levels will be measured and tracked over two years and the results will be analyzed for reductions in racial inequities across the five neighborhoods. The goals are the complete elimination of disparities within those two years; and improvement in whatever community members identify as their goal(s) during upcoming listening sessions.
- **Place-based neighborhood panels:** Data analysts will create a racial equity data dashboard to empanel BIPOC patients in the five "hotspotted" neighborhoods. OT will identify patients who may benefit from more intensive care coordination and mobile health or home visits.
- **Quality improvement:** OT will identify rapid-cycle, shorter-term goals for improving clinic processes to narrow racial inequities in diabetes prevalence and poorly controlled diabetes.

### B. Social Responses

- Social needs screening: OT will screen all CHARJ patients at regular intervals and identify barriers to addressing frequently identified social needs.
  - » Two-year goal: Screen 90% of CHARJ patients for social needs, eliminating racial inequity in screening rates.dsss
- Social supports: CHWs, mobile services, and telehealth services will be enhanced to bridge the distance between patients, clinic, and social needs interventions for CHARJ patients.
  - » Two-year goal: An SDOH asset map will be developed for CHARJ neighborhoods and distributed — in partnership with community-based organizations — to clinic staff and community members to ensure that everyone in the community is aware of the assets in the

## Case Study 1: Marrying Data with Community Organizing to Improve Diabetes Care

neighborhood. A local community partner — Unite Oregon and MercyCorps Northwest — has already created an [asset map](#) in the neighborhoods in which CHARJ will be operating, and the goal is to overlay the CHARJ data onto that map.

### C. Structural Responses

- **Community organizing/advocacy:** The health center's community organizer will conduct neighborhood listening sessions to identify key structural factors for health, pair with available data, and partner with patients and community members to organize campaigns for longer-term policy change and sustained economic development in local neighborhoods.
- **Coalition building:** The CHARJ advisory board and OT will build coalitions with neighborhood members and community-based organizations to increase awareness of existing racial health inequities in neighborhoods and develop longer-term racial justice and health equity strategies.
  - » Two-year goals: (1) The CHARJ advisory board governance structure will be documented to be used as a guide for other clinics and communities. (2) At least 10 CHARJ patients will have completed the HEAL-A leadership development program. (3) At least one academic-community partnership will be in progress with the explicit aim of addressing a community-identified structural or policy issue.

### Lessons Learned

1. **Transformation is about relationships, not just operations.** Trying to transform systems without transforming the people and relationships inside of them is a pathway to burnout and poor outcomes. To make more than incremental change, campaigns must be

built that go beyond data and procedures to shift the values that drive the work — the sense of collective why. Such relational approaches should involve pairing data with stories; building trust, connection, and bravery; and shifting traditional power dynamics.

#### 2. Start every project with listening sessions.

Community members' stories should be the data that shape health equity projects, and that data should be collected before defining a project or its goals and activities. Listening to community members' stories is the first step in understanding what problem should be addressed and how. And making this the first step allows for relationship building and power sharing.

#### 3. Compensate community members for their time and expertise.

OHSU Richmond pays community members to co-design initiatives, facilitate community listening sessions, and lead organizing activities. This has built trust and disrupted typical power dynamics that arise when academic institutions engage community members (where staff are paid for their time or expertise, while community members are expected to volunteer).

[See Postscript: A Note on OHSU Richmond and Racial Equity \(page 52\).](#)



## Case Study 2: Better Engage Clients in Behavioral Health with Cultural Matching

Children, Youth, and Family Mental Health Services, San Francisco Department of Public Health

*In thinking about how to integrate racial equity into its care improvement efforts, the San Francisco Department of Public Health's (SFDPH) Children, Youth, and Family (CYF) Mental Health Services stratified data on race and ethnicity and used process mapping to increase access and community engagement with behavioral health services.*



This case study illustrates the pursuit of Opportunities 2,3,4,5, and 6.



### Background

The state of California regularly audits city public health departments across a variety of metrics related to health disparities. One of the metrics is how well departments are able to improve the community's access to and engagement with mental health services. For many years, the San Francisco Department of Public Health's behavioral health program had the lowest access rates for this metric among the Asian Pacific Islander community. In 2016, the QI team did a [root cause analysis](#) to better understand why. They found that low rates of cultural match — when a client sees a provider who identifies with the same race, ethnicity, or primary language — were a large part of the problem. Many different communities, in fact, did not feel that the staff and providers of the behavioral health system represented them. This discovery was the beginning of a practice improvement effort aimed to increase cultural match and normalize conversations around race and ethnicity between providers and clients.

### Disaggregating Data to Better Understand Rates of Cultural Match

SFDPH CYF asks its clients to identify their race, ethnicity, and primary language during intake and tracks that information in their electronic health record. It asks its workforce for the same information in a yearly survey that all CYF programs and contracted community-based organizations (CBOs) are required to complete. That information is stored in the Cultural Competence Tracking System, a database that

documents the racial and ethnic diversity as well as language capability of the behavioral health workforce. Using both sets of data, the demographics of clients and providers were compared to see where gaps existed. In its analysis, the SFDPH disaggregated the data around race and ethnicity, revealing disparities that were otherwise obscured. For example, when looked at in aggregate, it seemed that they had enough providers in the system who identified as Asian or Pacific Islander to meet the needs of clients who identified in the same way. However, when they disaggregated the data and looked at subgroups, they saw that most of these clients were Chinese, but the system lacked Chinese-identifying providers to meet or mirror that need.

### Improving Rates of Cultural Match

After reviewing the literature on cultural matching, the CYF QI team conducted a meta-analysis of the impact that cultural match has on care and found a significant impact on access and initial engagement. It is known that when a client first enters a health system, they are more likely to access services if they feel the community of providers reflects their own race or ethnicity. Little evidence existed, however, that therapeutic outcomes improve as a result of racial or ethnic matching. To explore this further, CYF QI analyzed data from their clients' [Child and Adolescent Needs and Strengths \(CANS\) assessments](#) for the impact of cultural match on long-term care results. Clinicians complete the CANS assessment on their clients every six months.

## Case Study 2: Better Engage Clients in Behavioral Health with Cultural Matching

This initial exploratory study found that cultural matching was associated with improved behavioral health outcomes for certain racial and ethnic groups. For example, Latinx clients who were culturally matched with their provider showed greater improvement across a number of domains, including risk factors, traumatic stress symptoms, and behavioral and emotional needs. Cultural match was especially important to care outcomes when a client's trauma was related to experiences around discrimination, racism, or cultural stress.

This resulted in the first QI tactic: **Change provider recruitment strategies.** The data was shared with human resources to help create and implement new requirements and efforts toward recruiting a workforce that better mirrors clients' cultural composition.

The CYF QI team also wanted to better understand if there were opportunities to match clients that were being missed, and used [process mapping](#) to examine client experiences from the first point of contact to whether or not they engaged services. They realized that families were not asked questions consistently during the initial call about their degree of comfort around the provider's race or ethnicity, the client's preferred language, or the provider's preferred language.

This resulted in the second QI tactic: **Ask potential clients different questions when they first call.** Potential clients are now asked if they have preferences for the race, ethnicity, or language of their provider when they first inquire about services.

### Improving Care Where Matches Can't Be Made

Many structural barriers exist to hiring a workforce that fully mirrors a health system's clients, and employers must contend with high rates of provider burnout. The CYF division is looking at ways to improve retention rates and care outcomes where cultural matches cannot be made, consulting qualitative data from the EHR to help them better understand how.

[The CANS Assessment](#) includes a question about cultural stress and requires that the provider add a narrative comment in the EHR identifying the source of the stress if a client has a rating of 2 or 3 on a scale of 0 to 3. For example, the provider might make a note that the stress is related to race, ethnicity, sexual orientation, gender identity, language needs, or socioeconomic status. Analysis of narrative comments in the EHR related to this cultural stress question revealed that many providers are hesitant to talk with clients about race and ethnicity and typically wait for their clients to broach the topic.

This resulted in the third QI tactic: **Train providers to talk to their clients about race and ethnicity, especially during their first sessions.** The CYF division implemented training for providers to initiate conversations about race and ethnicity during their first sessions and to ask questions like, "How does it feel for you as a Black/African American client to meet with me as your counselor, and I am White?" Qualitative data reveal that training providers to talk

to their clients about race is helpful whether someone is culturally matched or not.

### Lessons Learned

Dr. Ritchie Rubio, the SFDPH's CYF director of practice improvement and analytics, [shared the following lessons from their QI efforts](#) to improve rates of access to and engagement with mental health services.

- 1. When reflecting on data as a team, ask story-oriented questions, not data-oriented ones.** Rubio facilitates and encourages the use of data reflection circles to get at the underlying stories behind the data and to identify potential QI efforts from those stories. When presenting any data for QI purposes — to providers, staff, or executive leadership — he prefers not to ask questions such as, "What does this data tell us?" in lieu of story-oriented questions. "What's the story here? Who are the protagonists and villains? Where did this story begin?" This helps staff to think in more patient-centered ways and think more about the root causes of issues.
- 2. Collect more qualitative data.** While it can be harder and more time-consuming to collect and analyze qualitative data, it's worth the investment. Moving forward, CYF wants to incorporate more client-centered data in its cultural match work, through listening sessions, focus groups, and surveys. "I want to hear from clients themselves," said Rubio. "I don't think we

## Case Study 2: Better Engage Clients in Behavioral Health with Cultural Matching

have enough avenues by which we hear the clients' voice around this. So even, for example, in the thematic coding we did, that's from our EHR from the perspective of the clinician. So for me, that's still different from how a client would actually talk about what's going on around cultural match experiences."

3. **Be less rigid about the data used in QI efforts.** "Quality improvement work can place a big emphasis on whether or not there is data to support this," said Rubio. "But when you think about race and ethnicity especially, a lot of voices are forgotten simply because they are so limited in the number of data that can be captured from them. For example, it disappoints me to see API data and you see the Pacific Islander data really lost in any data reporting. And for me, that's a significant piece. Sometimes you may hear just one story from one client, and for me that could be sufficient to motivate some quality improvement effort. You don't always need statistically significant results from big data as evidence that we need to work on something. So, for me, it's about an effective balance. When you think of QI, we should not immediately think of big, robust quantitative data, but also think about the importance of qualitative stories and how you could really strike a balance in holding both when you do any form of quality improvement work."

4. **When asking questions around race, ethnicity, and identity, strength-based framing often results in better data.** The CYF QI team uses a strength-based approach to asking questions about race and ethnicity in their workforce surveys. Respondents are given an open field and asked to identify their race and ethnicity in their own words. The data is harder to code and analyze later, but is richer and more culturally responsive. Clients, on the other hand, are identified in the EHR with a checklist of options and "other" category, following citywide guidelines created by SFDPH's Community Assessment, System/Program Evaluation and Research (CASPAR) Workgroup. Long term, the CYF QI team wants their client question to mirror how the provider question is asked.
5. **Quality improvement tools are often very linear and Western in how they are designed.** Process mapping is linear, but some cultures have less linear ways of figuring out pathways or processes. Dr. Rubio often employs alternative culturally responsive metaphors as he leads groups through process mapping exercises. One that he uses comes from both Native American and Aboriginal culture. "Journey sticks have been used as a visual representation of journeys. So, when you enter a journey, you have a journey stick and then you pull objects from the environment to represent each part of your journey, and then are asked to use those objects to prime and capture the memory out of that journey."



## Case Study 3: Going Upstream to Reduce Lead Exposure in Children

### MetroHealth System

*The MetroHealth System knows that it is impossible to achieve equity in care improvement efforts without addressing social and structural barriers to care. One of the ways that the health system is addressing racial equity is by co-designing a new preventative program to detect lead exposure in pregnant women and reduce children's exposure to lead by remediating housing problems before they are born.*



This case study illustrates the pursuit of Opportunities 5 and 7.



### Background

Cleveland's percentage of children with elevated blood lead levels is among the highest of any US city. This is due in part to its old housing stock and use of lead-based paint until the 1970s. The problem disproportionately impacts Black and brown children because structural racism and discriminatory policies, such as redlining, have forced these communities into older housing stock and left them with fewer financial resources to address and remediate unsafe housing issues.

Reducing lead poisoning is a big priority at both the city and health system levels. The Cleveland City Council recently passed an ordinance requiring every rental property built before 1978 be issued a Lead Safe Certificate from the Department of Building and Housing. Inspections and certifications are proceeding by zip code. With this structural intervention underway, the MetroHealth System is preparing to launch a pilot to screen all pregnant women at its main campus OBGYN clinic for lead exposure, and to use new workflows to refer them for services to remediate lead in housing when it is detected.

### Pilot Intervention

The new workflow in the pilot requires communication and handoffs between multiple health professionals and agencies, unfolding as follows:

1. At their first OB nurse visit, all expectant mothers are asked three screening questions about lead exposure and a lead test is added to their blood draw.
2. If a woman's blood lead level is elevated or she answers yes to any screening question, a referral to MetroHealth's community health worker (CHW) dedicated to lead work is automatically triggered in the Epic EHR system.
3. The CHW follows up with the patient to assess the woman's current environmental risk (as an elevated blood lead level is not necessarily indicative of current environment), provide education, and schedule an inspection by a community-based partner if needed. If children in the household need additional blood work, the CHW schedules it in the Epic system, and the child's pediatrician is notified automatically.
4. If an inspection takes place, the CHW documents all findings in Epic.
5. If lead is discovered in the home, MetroHealth provides a lead cleaning kit or refers the family to external resources for more significant remediation if needed.

### Measuring Success

MetroHealth's goals for the first year of the pilot are to screen every pregnant patient receiving care at its main campus OB clinic, to remediate lead contamination wherever possible, and by

## Case Study 3: Going Upstream to Reduce Lead Exposure in Children

doing so, to reduce or eliminate exposure to lead by children in the community. The larger goal, however, is to better understand the scope of the problem. It is hard to predict how many women will screen positively, nor how many of the women who screen positively will have an actual housing risk, as opposed to having been exposed to lead in another way or during childhood. MetroHealth leadership is treating the pilot as a learning process and will use the data to refine interventions over time.

### Lessons Learned

#### 1. Bring the whole team to the table, across departments and community agencies.

A critical aspect of the pilot was bringing the right people together from the beginning and ensuring that their perspectives were heard. Multiple departments within MetroHealth were involved in co-designing workflows and navigating the complicated compliance and legal issues presented by the project. The initial planning team was divided into a working committee and an advisory committee.

The working committee included clinicians, administrative staff, a social worker, a community health worker, and a representative from the local community development corporation. This group met monthly to design the workflows.

The advisory committee was comprised

of representatives from the health system's compliance and legal departments, team members from its community health advocacy initiative, and a variety of partners from community-based organizations. All parties could speak to potential barriers that patients and the health system might face during the pilot. For example, the compliance department is still sorting through whether covering the \$200 cost of a housing inspection for a patient is considered an inducement.

MetroHealth has a [medical-legal partnership](#) with the Legal Aid Society of Cleveland, which has done essential work providing information about patients' legal options when lead is present, including negotiating with landlords, preventing potential evictions, and understanding leases. The [Lead Safe Cleveland Coalition](#) has been part of the advisory committee from the start, as has [Metro West CDC](#), a local community development corporation with staff members who are certified lead inspectors. The expectation is that MetroHealth will carry this collaboration forward by contracting Metro West CDC to do inspections; however, the health system is required to get three bids for all services before awarding a contract.

#### 2. Include someone from the EHR team in conversations from the beginning.

One MetroHealth department that was missing from the early planning sessions was the Epic

ERH team. Figuring out the details of Epic workflows is critical to ensuring everything from proper ordering to proper reporting. Natalie Harper, manager of the community health advocacy initiative at MetroHealth, said that this piece has been the most time-consuming part of launching the pilot. The EHR team is heavily involved now, but she wished they had been involved in the conversations from day one. Having someone at the table who speaks that language — which reports to run, where to include a narrative comment in a lab report, when do lab results go to the department of health — is essential.



# Appendix: Sources for Getting Grounded



This appendix provides the source materials for the Getting Grounded chapter of this toolkit. Readers are encouraged to develop an understanding of racial injustice in America and its implications for health status and health care, and to build and normalize an organizational commitment to advancing racial equity.

## How To Develop a Foundational Understanding of Racism, Anti-Racism, and Racial Health Equity

- Race Forward. [Four Levels of Racism](#)
- American Medical Association (2021). [Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity](#)
- American Medical Association (2021). [Advancing Health Equity: A Guide to Language, Narrative and Concepts](#)
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## How to Develop Capacity to Becoming an Anti-Racist, Multicultural Organization

- [Continuum on Becoming an Anti-Racist Multicultural Institution](#)
- Government Alliance on Race and Equity (GARE). [Racial Equity Toolkit: An Opportunity to Operationalize Equity](#).

## How to Use a Strategic Process to Embed and Advance Racial Equity

- HealthBegins (2021). [Bringing Light & Heat: A Health Equity Guide for Healthcare Transformation and Accountability](#)
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# Acknowledgements

This toolkit is the result of a broad collaboration of groups and individuals committed to effectively advancing racial health equity throughout California and beyond. Driven by needs identified by California Improvement Network (CIN) partners, CIN prioritized racial health equity in 2020 and convened members in a Racial Health Equity Workgroup.

The CIN Racial Health Equity Workgroup launched in March 2021 with 30 individuals representing clinical practice, administration, quality improvement, and health equity advancement. The members represented 20 organizations, ranging from provider groups and coalitions, health plans, quality improvement organizations, and state government.

The workgroup's clear purpose was increasing the capacity of health organizations to approach their work with a racial equity lens. In April, the workgroup was surveyed to understand current efforts within their organizations and what type of support would be beneficial. The survey results pointed to a need for this type of toolkit and contributed to a co-design process that was responsive to actual needs in the field:

- Organizations were actively working to address racial health inequity, and they were in various stages of this work.
- Respondents were actively looking for practical resources and tools to galvanize action.

- Respondents indicated the greatest need for support with discovery, design, and intervention.

Meeting over many months, workgroup members provided their collective wisdom to develop a vision for this toolkit and contributed their time in discussion and iteration of the most useful content.

In October 2021, CIN selected HealthBegins to develop and write the toolkit with workgroup members. [HealthBegins](#) is a national mission-driven consulting and training firm committed to driving radical transformation in health equity. As a pioneer in the upstream movement, HealthBegins specializes in helping health care and community partners use continuous improvement and systems change methods to advance equity and improve the social and structural drivers of health equity for patients and communities.



HealthBegins built off the needs the workgroup identified, established essential questions to drive the creation of the toolkit, canvassed the field for complementary and informing resources, identified exemplars to highlight, and generated the toolkit text with CIN and workgroup members.

## Exemplar Contributors

These leaders from exemplar organizations across the country participated in interviews, shared valuable insights, and informed the case studies and highlights in this toolkit.

- Cambridge Health Alliance – Malden Care Center: Laura Sullivan
- Cone Health System: Erica Bryant, Jamilla Pinder, Laura Vail
- MetroHealth System: Kevin Chagin, Natalie Harper, Mark Kalina, James Misak, Brant Silvers
- Oregon Health and Sciences University Family Medicine Clinic, Richmond: Erik Kirk, Bethany Linscott-Lowe, Doug Maresh, Brian Park, Lia Sebring
- San Francisco Department of Public Health: Ritchie Rubio
- Solano HEALs: Angelique Anderson, Shandi Fuller
- UC San Diego Health

# Acknowledgements

## CIN Racial Health Equity Workgroup Members

This toolkit would not have been possible without the vision, guidance, and comments from the CIN Racial Health Equity Workgroup members and the support of their organizations:



California Department of Health  
Care Services  
Patricia Lee, Priya Motz, Sohrab Sidhu



California Health Care Safety  
Net Institute  
Amanda Clarke, Giovanna Giuliani,  
Thuy-Ann Lee



California Primary Care Association  
Lizbeth Bayardo, Liz Oseguera



California Quality Collaborative  
Kristina Mody



Centene  
Haleta Belai



Central California Alliance for Health  
Michelle Stott



Community Clinic Association  
of Los Angeles County  
Amy Kim



Golden Valley Health Center  
Myisha Reed



HealthNet  
Pooja Mittal, Humaira Theba



Health Outreach Partners  
Cindy Selmi



Health Plan of San Joaquin  
Lakshmi Dhanvanthari, Andrea Swan,  
Catherine Talongwa, Setar Testo



Health Quality Partners  
Lauren Abrams, Marty Adelman,  
Nicole Howard, Kristine Ortwine



Hill Physicians Medical Group  
Annie Hou



Kaiser Permanente  
Fanny Tsang, Michelle Wong



LA Care Health Plan  
Marina Acosta



Latino Coalition for a  
Healthy California  
Mar Velez



Marin County Behavioral Health  
and Recovery Services  
Jei Africa



Partnership HealthPlan of California  
Rebecca Boyd Anderson, Erika Robinson,  
Catherine Thomas



Redwood Community Health Coalition  
AnaMarisa Lopez



San Francisco  
Department of Public Health  
Ayanna Bennett



Sharp Community Medical Group  
Lloyd Kuritsky, Lynne Milgram

# Acknowledgements

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## About the Funder and Program Office

The [California Improvement Network](#) (CIN) aims to advance the Quadruple Aim by identifying and spreading better ideas for care delivery, and by strengthening relationships between commercial and safety net provider and health plan communities in California. CIN is a project of the California Health Care Foundation and is managed by Healthforce Center at UCSF.

The [California Health Care Foundation](#) (CHCF) is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. CHCF works to ensure that people have access to the care they need, when they need it, at a price they can afford.

At [Healthforce Center](#), we believe that people are the most important element in health care. Our mission is to equip people with the workforce knowledge, leadership skills, and network connections to create a collective force for health, equity, and action. We envision an effective and responsive health care ecosystem that is driving progress toward more equitable health outcomes for all. We provide research, programming, consulting, and evaluation in support of these goals.

## Join CIN

Membership in the California Improvement Network is open to all and free of cost thanks to the support of CHCF. [Join CIN](#) to hear about the latest strategies, stories, events, and tools for improving health care delivery through our monthly newsletter.

For more information, visit [www.chcf.org/cin](http://www.chcf.org/cin).

For questions and feedback, contact [CIN@ucsf.edu](mailto:CIN@ucsf.edu).

## Postscript: A Note on OHSU Richmond and Racial Equity (July 2022)



The purpose of Case Study 1 is to demonstrate and share patient-facing activities that illustrate how primary care practices can engage patients and community members to advance racial equity in health outcomes. The OHSU Richmond's CHARJ initiative is part of a broader, longstanding internal organizing effort involving staff and community members. Staff first brought together patients and community members in 2015 and then facilitated staff listening sessions in 2017 to advance racial justice and health equity for patients and employees. Beyond work to narrow the harmful impacts of power differentials while centering the voices and expertise of individuals most harmed by systems, this organizing work led to the formation of the CHARJ initiative at OHSU Richmond, which aims to address the social and structural drivers of health inequities impacting OHSU Richmond patients and community.

Complaints of employee discrimination and institutional racism at OHSU Richmond became public in 2022 (well after the CHARJ initiative launched) and are being addressed by OHSU leaders at the system level and executives at OHSU Richmond itself. To our knowledge, there are no outstanding complaints about patient discrimination at OHSU Richmond. As publishers of this report, we view this as an opportunity to highlight that a commitment to racial equity, which affects patients, employees, and communities served by primary

care practices, requires hard work on all levels. As a process and not just an outcome, the work of racial equity is never done. Case Study 1 demonstrates successful approaches and best practices for engaging patients and community members in this work, while acknowledging that work to improve racial equity for employees is also essential. Leaders of the OHSU Richmond CHARJ effort have affirmed their belief in the role of organizing approaches within the health care system—as a means to address both institutional oppression within their walls and social drivers of injustice outside of it.