




2021 ABIM FOUNDATION FORUM

PURSUING TRUST

Striving for Equitable Health Care

BACKGROUND PAPER

By Timothy Lynch, JD



For the fourth year, the ABIM Foundation will devote its annual Forum to exploring facets of trust. After considering how and why trust affects the health care system (2018), specific ways to enhance trust (2019), and trust and health equity in the midst of the COVID-19 pandemic (2020), the Foundation this year will turn to how health care organizations can act to advance diversity, equity and inclusion (DEI), and thereby engender trust among their clinicians and other employees, their patients, and the communities they serve. The stark health care inequities that have long existed in the United States are themselves primary evidence of structural racism and a legitimate basis for distrust; organizations that directly take on health equity as an explicit goal are taking a critical step to restore lost trust in the communities they serve. Forum participants will learn about how some organizations have acted to acknowledge and address injustice and disparities within their institutions, and how they have partnered with their communities to build trust.

Although there is no universally-accepted definition of health equity, one recent definition from the Robert Wood Johnson Foundation and researchers at the University of California San Francisco captures many of its facets: “Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.”<sup>1</sup>

Issues of trust and equity are at the heart of medical professionalism, as it is defined in the Physician Charter that guides the ABIM Foundation’s work. The Charter includes three fundamental principles that underlie medical professionalism. The first two are patient welfare and patient autonomy, which can be exercised only in the context of trusting relationships. The Charter says that professionalism is the basis of medicine’s contract with society, and states: “Essential to this contract is public trust in physicians, which depends on the integrity of both individual physicians and the whole profession.”<sup>2</sup> The Charter’s third fundamental principle is social justice. Here, the Charter calls for physicians to “work actively to eliminate discrimination in health care, whether based on race, gender, socioeconomic status, ethnicity, religion, or any other social category.”

This paper will begin with a few updates about the impact of last year’s Forum. It will continue with a discussion of how health systems and those who work within them can strive for equity, and thus build trust. This will include the stories of some of the organizations and individuals who will, during this year’s meeting, share their experiences and lessons learned. Participants who are interested in reading more about the trust and equity issues that are at the heart of these discussions are invited to review the [background paper](#) and [Kimball Lecture](#) from the 2020 Forum; the lecture, on COVID-19 and Communities of Color, was given by David Williams, PhD, the Florence & Laura Norman Professor of Public Health at Harvard University.

1 Braverman P, Arkin E, Orleans T, Proctor D, and Plough A. What is Health Equity? And What Difference Does a Definition Make? Princeton, NJ: Robert Wood Johnson Foundation, 2017.

2 ABIM Foundation, American College of Physicians, European Federation of Internal Medicine. The physician charter [Pamphlet]. Philadelphia: 2002. Available from: <http://abimfoundation.org/what-we-do/physician-charter>.

## 2020 FORUM

The discussions and ideas presented at last year's Forum have inspired continuing activity in the ensuing months. In February, the *Annals of Internal Medicine* **published an article** by Richard Baron, MD, the President and CEO of the American Board of Internal Medicine and the ABIM Foundation, and Dhruv Khullar, MD, MPP, a physician and assistant professor of health policy and economics at Weill Cornell Medical College. The article, entitled Building Trust to Promote a More Equitable Health System, highlighted promising strategies to promote equity that Forum participants offered.<sup>3</sup> These strategies included addressing biases that have distorted digital algorithms that influence care decisions, finding ways to build trust among vulnerable patients whose mistrust in the system was well earned, and developing public health approaches that are shaped by the perspectives of the populations and communities at risk.

Many 2020 Forum participants have continued to work in small groups they formed during the meeting, which focused on particular topics related to trust and equity, such as building links between public health and primary care, improving workforce diversity, and treating equity as a domain of patient safety. The ABIM Foundation made small grants available to support the work of those groups. Three projects have been funded – efforts to account for the patient safety consequences of racial, ethnic and language-based disparities, to create a playbook to help communities address firearm safety, and to better integrate public health and primary care.

We hope that this year's Forum inspires similar activities in the months and years that follow the meeting, such as through continuing conversations among a network of interested organizations that we hope to form.

## HEALTH CARE ORGANIZATIONS, EQUITY AND TRUST

As our society continues to grapple with racial and ethnic disparities and injustice, health care organizations can play a vital part in improving equity and restoring trust. In addition to providing care to members of their communities, they are often among the largest employers in cities and towns across America. It is fair to say, however, that systems' success in helping create a more perfect society remains a work in progress.

Racial disparities in health outcomes abound through our health system. Although COVID-19 drew renewed attention to this reality, these disparities are longstanding and are present in many areas of care. Four areas of medicine—oncology, cardiology, pain management and maternal health—illustrate the problem.

Blacks have had higher overall rates of cancer incidence and death than all other racial and ethnic groups for more than 40 years.<sup>4</sup> The disparity in the overall cancer death rate has narrowed. In 1990, Blacks had a 33 percent higher death rate; in 2016, it was 14 percent higher. Despite this progress, troubling signs remain. Black men are more than twice as likely as men of any other race or ethnicity to die from prostate cancer.<sup>5</sup> Black people also suffer from death rates from multiple myeloma and stomach cancer that are more than double the rate for whites.

As our society continues to grapple with racial and ethnic disparities and injustice, health care organizations can play a vital part in improving equity and restoring trust.

3 Baron R, Khullar D. Building Trust to Promote a More Equitable Health Care System. *Annals of Internal Medicine*. April 2021. doi:10.7326/M20-6984. Available from: <https://www.acpjournals.org/doi/abs/10.7326/M20-6984>

4 The State of Cancer Health Disparities in 2020. *ACCR*. 2020. Available from: <https://cancerprogressreport.aacr.org/disparities/chd20-contents/chd20-state-of-cancer-health-disparities-2020/#burdenaa>

5 DeSantis C, Miller K, Sauer AG, Jemal A, Siegel R. Cancer statistics for African Americans, 2019. *CA Cancer J Clin*. 2019 May;69(3):211–233.

We also see significant disparities in cardiovascular disease. In general, Blacks and Hispanics have a higher prevalence of heart failure than whites, with Black women having the highest prevalence of any group. Blacks of both genders, particularly those aged 35–64, die from heart failure more than other groups. According to a study published last year in *BMJ*, deaths from heart disease in 2018 accounted for 3.8 million potential years of life lost, with 30 percent greater life years lost for Black than white men, and 60 percent more for Black than white women.<sup>6</sup> In addition, women and members of ethnic and racial minorities are less likely to receive appropriate medical therapies and to be included in clinical trials.<sup>7</sup>

Pain management provides another example, as Blacks and Hispanics are less likely than white patients to receive pain medication despite similar symptoms, and are more likely to receive lower doses of pain medication when they do receive it despite higher pain scores.<sup>8</sup> One possible source for this disparity is clinicians' false beliefs about Black people's experiences with pain. A 2016 study found that half of a sample group of white medical students and residents subscribed to false beliefs about biological differences between Blacks and whites, such as the idea that Blacks have thicker skin.<sup>9</sup> Other studies even found disparities in treating pain among children, with children from minority groups less likely to receive optimal pain reduction and more likely to be discharged in significant pain.<sup>10</sup> One study found that Black children in severe pain from acute appendicitis received opioid painkillers only 20 percent as often as white ones.<sup>11</sup>

As a final example, there are severe disparities in maternal health. The U.S. has considerably higher rates of maternal and infant mortality than similarly wealthy nations, with disproportionately high mortality rates among members of some underserved populations.<sup>12</sup> Pregnancy-related mortality rates among Black women are more than three times higher than among white women, and rates among American Indian and Alaska Native women are twice that of whites.<sup>13</sup> Black and Hispanic women are significantly more likely to develop severe maternal medical conditions, such as preeclampsia.<sup>14</sup> Infants born to Black women are also more than twice as likely to die within their first year of life than babies born to white women.<sup>15</sup>

Perhaps unsurprisingly, Black and Hispanic patients recognize that they are receiving worse care. Even amidst the renewed national focus on addressing racism that was spurred by last year's police killings of George Floyd, Breonna Taylor and other Black citizens and by the disproportionate impact of COVID-19 on members of underserved groups, substantial numbers of Black and Hispanic patients continue to report facing discrimination when they seek

- 6 Shah N, Molsberry R, Rana JS, Sidney S, Capewell S, O'Flaherty M, Carnethon M, Lloyd-Jones DM, Khan SS. Heterogeneous trends in burden of heart disease mortality by subtypes in the United States, 1999–2018: observational analysis of vital statistics. *BMJ* 2020;370:m2688. Available from: <https://www.bmj.com/content/370/bmj.m2688>
- 7 Breathett K. Latest evidence on racial inequities and biases in advanced heart failure. *American College of Cardiology*. October 2020. <https://www.acc.org/latest-in-cardiology/articles/2020/10/01/11/39/latest-evidence-on-racial-inequities-and-biases-in-advanced-hf>
- 8 Wyatt R. Pain and Ethnicity. *Virtual Mentor*. 2013;15(5):449–454.
- 9 Hoffman KM, Trawalter S, Axt JR, Oliver NM. Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites. *PNAS*. April 2016, 113(16): 4296–4301. Available from: <https://www.pnas.org/content/113/16/4296>
- 10 Goyal MK, Johnson TJ, Chamberlain JM, Cook L, Webb M, Drendel AL, Alessandrini E, Bajaj L, Lorch S, Grundmeier RW, Alpern ER. Racial and Ethnic Differences in Emergency Department Pain Management of Children with Fractures. *Pediatrics*. May 2020, 145 (5). Available from: <https://pediatrics.aappublications.org/content/145/5/e20193370.long>
- 11 Goyal MK, Kuppermann N, Cleary SD, Teach SJ, Chamberlain JM. Racial Disparities in Pain Management of Children with Appendicitis in Emergency Departments. *JAMA Pediatrics*. 2015;169(11):996–1002. Available from: <https://jamanetwork.com/journals/jamapediatrics/fullarticle/2441797>
- 12 Singh G. Maternal Mortality in the United States, 1935–2007: Substantial Racial/Ethnic, Socioeconomic, and Geographic Disparities Persist. A 75th Anniversary Publication. *Health Resources and Services Administration, Maternal and Child Health* (2010).
- 13 Peterson EE, Davis NL, Goodman D, Cox S, Syverson C, Seed K, Shapiro-Mendoza C, Callaghan WM, Barfield W. Racial/Ethnic Disparities in Pregnancy-Related Deaths – United States, 2007–2016. *Morbidity and Mortality Weekly Report* 68, no. 35 (September 2019): 762–765. Available from: <https://www.cdc.gov/mmwr/volumes/68/wr/mm6835a3.htm>
- 14 Liese KL, Mogos M, Abboud S, Decocker K, Koch AR, Geller SE. Racial and Ethnic Disparities in Severe Maternal Morbidity in the United States. *Journal of Racial and Ethnic Health Disparities*. (March 2019): 790–98.
- 15 Artiga S, Pham O, Orgera K, Ranji U. Racial Disparities in Maternal and Infant Health: An Overview. *Kaiser Family Foundation*. November 2020. Available from: <https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-maternal-infant-health-overview/>

care. In a national survey that was conducted in November 2020, 36 percent of Black and 35 percent of Hispanic adults reported that they or their household members who had seen a health care professional during the previous 12 months had experienced one or more forms of discrimination.<sup>16</sup>

The impact of this discrimination may be reflected in the results of a separate recent survey, sponsored by the ABIM Foundation and conducted by the National Opinion Research Center (NORC) at the University of Chicago. In that survey, Blacks (71 percent) and Hispanics (67 percent) were less likely than whites

(77 percent) to say that their doctor cares about them, or that they trust what their doctor says (76 percent among Black respondents, 77 percent among Hispanics, 86 percent of whites).<sup>17</sup>

For their part, physicians are split about the seriousness of the problem. According to the NORC survey, 51 percent of physicians said that the health care system discriminated against people “not at all” or “very little,” while 29 percent said the system discriminated “somewhat/moderately” and 21 percent “a great deal” or “a good amount.”<sup>18</sup>

Health systems have room for improvement not only in their delivery of care but as employers. Put simply, our health care system as a whole lacks diversity, particularly when it comes to the physician workforce. Among active physicians, only 5.8 percent identify as Hispanic and 5 percent as Black or African American.<sup>19</sup> Black men are particularly under-represented in medical practice; the proportion of Black male graduates declined 39 percent between 1986 and 2015.<sup>20</sup> These numbers fall behind the Black and Hispanic share of the population by a significant margin, as Hispanics constitute more than 18 percent of the U.S. population and African-Americans account for 13 percent.<sup>21</sup>

Unfortunately, immediate improvement does not appear to be on the horizon. Although gender diversity in the pool of medical students has increased dramatically over the last 40 years, with female applicants now outnumbering male ones, racial imbalances have stubbornly persisted.<sup>22</sup> In 2018–19, Blacks made up 8.4 percent of medical school applicants, 7.1 percent of matriculants, and 6.2 percent of graduates. Hispanics constituted 6.2 percent of applicants and matriculants, and 5.3 percent of graduates. (Eight percent of 2019 graduates identified themselves as being of multiple races.)

Observers have suggested a number of approaches that health care organizations—both in their roles as caregivers and employers—could take to address these persistent equity concerns and enhance diversity, equity and inclusion.

Health systems could serve patients more equitably by providing better training for their clinicians in recognizing bias and avoiding consequent discrimination. The National Academy of Medicine has made a number of recommendations for combating bias, including tracking patterns of care by race and ethnicity; teaching and discussing stereotyping and bias at every level of undergraduate and graduate medical education and including faculty physicians in that effort;

Health systems could serve patients more equitably by providing better training for their clinicians in recognizing bias and avoiding consequent discrimination.

- 16 Bleich SN, Zephyrin L, Blendon RJ. Addressing Racial Discrimination in US Health Care Today. *JAMA Health Forum*. March 2021. doi:10.1001/jamahealthforum.2021.0192. Available from: <https://jamanetwork.com/channels/health-forum/fullarticle/2777406>
- 17 NORC at the University of Chicago, Surveys of Trust in the U.S. Health Care System. AmeriSpeak Survey (December 29, 2020–January 26, 2021). Available from: [https://buildingtrust.org/wp-content/uploads/2021/05/20210518\\_ABIM\\_Foundation\\_Topline1\\_Public-Survey.pdf](https://buildingtrust.org/wp-content/uploads/2021/05/20210518_ABIM_Foundation_Topline1_Public-Survey.pdf)
- 18 NORC at the University of Chicago, Surveys of Trust in the U.S. Health Care System. Physician Survey (January 22–February 5, 2021). Available from: [https://buildingtrust.org/wp-content/uploads/2021/05/20210518\\_ABIM\\_Foundation\\_Topline1\\_Physician-Survey.pdf](https://buildingtrust.org/wp-content/uploads/2021/05/20210518_ABIM_Foundation_Topline1_Physician-Survey.pdf)
- 19 Diversity in Medicine: Facts and Figures 2019. Association of American Medical Colleges. Available from: <https://www.aamc.org/data-reports/workforce/report/diversity-medicine-facts-and-figures-2019>
- 20 At a Glance: Black and African American Physicians in the Workforce. Association of American Medical Colleges. February 20, 2017. Available from: <https://www.aamc.org/news-insights/glance-black-and-african-american-physicians-workforce>
- 21 United States Census Bureau, Quick Facts. <https://www.census.gov/quickfacts/fact/table/US/PST045219>
- 22 <https://www.aamc.org/data-reports/workforce/report/diversity-medicine-facts-and-figures-2019>

and discontinuing the practice of automatically labeling patients by race in the initial description of them in the examination room.<sup>23</sup> Other suggestions for how systems can counteract bias include establishing chief equity officer positions, developing measures to assess bias, devoting more resources to interpreters and translation services, and diversifying the health care workforce.<sup>24</sup>

Health systems could also help address patient concerns about discrimination by making it easier for patients to provide feedback about their experiences through existing mechanisms like patient satisfaction surveys. This information could then be compiled and made public. Hospitals could also work with their health care professionals to analyze the data and sponsor interventions designed to address prejudice.<sup>25</sup>

Diversifying the clinician workforce, a good in its own right, could also help create a more inclusive institutional culture that would benefit patients. There is evidence that engaging a diverse workforce can reduce bias and improve the cultural competence of health care professionals.<sup>26</sup> On the physician side, almost all medical schools have adopted holistic admissions approaches that seek to evaluate applicants as individuals rather than relying purely on test scores and grades.<sup>27</sup> Additional steps could involve a concerted effort to shape the pipeline of applicants, such as through support of premedical programs—including efforts to engage Black men and others from under-represented communities—and engaging with community colleges and high schools to identify and encourage students who might pursue medical careers.<sup>28 29</sup>

Creating a more diverse pool of clinicians is only part of the challenge; retention is also critical, and there is evidence of higher attrition rates among both women and minorities, at least in academic settings.<sup>30</sup> Creating an inclusive environment could offer an answer to this retention challenge.<sup>31</sup>

In one study, researchers asked members of the health care workforce about factors that contribute to inclusive work and learning environments, and how they think health care organizations can be more inclusive. Participants came from six hospitals, four health sciences schools, and outpatient facilities in a university-based health care system.<sup>32</sup> Respondents were primarily staff, academic faculty and trainees/students, with each group representing about one-third of the sample.

- 23 Smedley BD, Stith AY, Nelson AR. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: National Academies Press; 2003. 1–764.
- 24 Agrawal S, Enekeuchi A. It's Time to Address the Role of Implicit Bias Within Health Care Delivery. *Health Affairs Blog*. January 2020. Available from: <https://www.healthaffairs.org/doi/10.1377/hblog20200108.34515/full/>
- 25 Bleich SN, Zephyrin L, Blendon RJ. Addressing Racial Discrimination in US Health Care Today. *JAMA Health Forum*. March 2021. doi:10.1001/jamahealthforum.2021.0192. Available from: <https://jamanetwork.com/channels/health-forum/fullarticle/2777406>
- 26 Saha S, Guiton G, Wimmers PF, Wilkerson L. Student body racial and ethnic composition and diversity-related outcomes in US medical schools. *JAMA*. 2008;300(10): doi:10.1001/jama.300.10.1135. Available from: <https://jamanetwork.com/journals/jama/fullarticle/182528>
- 27 Diversity in Medicine: Facts and Figures 2019. Association of American Medical Colleges. 2019. Available from: <https://www.aamc.org/data-reports/workforce/interactive-data/fostering-diversity-and-inclusion>
- 28 Morgan HK, Haggins A, Lypson ML, Ross P. The Importance of the Premedical Experience in Diversifying the Health Care Workforce. *Academic Medicine*. 2016;91(11):1488–91. Available from: [https://journals.lww.com/academicmedicine/Fulltext/2016/11000/The\\_Importance\\_of\\_the\\_Premedical\\_Experience\\_in.14.aspx](https://journals.lww.com/academicmedicine/Fulltext/2016/11000/The_Importance_of_the_Premedical_Experience_in.14.aspx)
- 29 Agrawal S, Enekeuchi A. It's Time to Address the Role of Implicit Bias Within Health Care Delivery. *Health Affairs Blog*. January 2020. Available from: <https://www.healthaffairs.org/doi/10.1377/hblog20200108.34515/full/>
- 30 Cropsey KL, Masho SW, Shiang R, Sikka V, Kornstein SG, Hampton CL, Committee on the Status of Women and Minorities, Virginia Commonwealth University School of Medicine, Medical College of Virginia Campus. Why do faculty leave? Reasons for attrition of women and minority faculty from a medical school: four-year results. *J Womens Health (Larchmt)*. 2008 Sep; 17(7):1111–8.
- 31 Shore LM, Randel AE, Chung BG, Dean MA, Ehrhart KH, Singh G. Inclusion and diversity in work groups: A review and model for future research. *Journal of Management*. 2011;37(4):1262–1289. doi:10.1177/014920631038594. Available from: <https://ideas.wharton.upenn.edu/wp-content/uploads/2018/07/Shore-Randel-Chung-Dean-Holcombe-Ehrhart-Singh-2011.pdf>
- 32 Aysola J, Barg FK, Martinez AB, Kearney M, Agesa K, Carmona C, Higginbotham E. Perceptions of Factors Associated with Inclusive Work and Learning Environments in Health Care Organizations. *JAMA Network Open*. 2018 Aug; 1(4): e181003. Available from: <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2695077>

The researchers identified six factors that characterized interviewees' perceptions of whether their environment was inclusive:

- The presence of discrimination, such as microaggressions and unequal performance standards that favored white males.
- The prevalence of the “silent witness,” in which bystanders to discriminatory conduct disclosed worrying about their job security and well-being if they said something.
- The effectiveness of organizational leaders and mentors, who can either foster discriminatory practices or promote inclusion.
- The prevalence of respondents who reported being treated differently based on their status within the organization (e.g., type of position, level of education, gender, seniority).
- Support (or lack thereof) of work-life balance, such as flexibility for working from home and enabling employees to take leave without negative consequences.
- Perceptions of exclusion from inclusion efforts among those who did not think their institutions' perception of inclusion applied to them.

The researchers noted a number of themes that the interview responses revealed, including the toxic effects of a lack of inclusion on workforce wellness and engagement, and the lack of effective formal channels to address challenges. They also reported on the respondents' proposed system-level interventions to foster an inclusive organizational culture, which included:

- Efforts targeted at system leaders, such as mandatory education for organizational leadership and mentors about how to accept that they have implicit biases, and on how to combat them.
- Creating a culture that supports advocacy from those who witness discrimination/incivility.
- Expanding collegial networks, such as mentorship programs and support groups.
- Revisiting organizational policies, such as family leave or observed religious holidays, to ensure they meet the needs of a diverse workforce.

### Organizational Framework, Including Community Engagement: the IHI Approach

Health care organizations can play a vital role in building equity not only by how they treat patients when they visit to receive care and through their efforts to build diverse and inclusive environments for their workforce, but also through their involvement in their communities. The Institute for Healthcare Improvement (IHI) [published a framework](#) in 2016 that provides a roadmap for how health care organizations can best build equity inside and outside their institutions.<sup>33</sup> This framework includes five key components, which IHI has continued to refine. Some components apply more to organizations' internal operations while others relate to work they can do outside their institutions' walls to improve health and equity. The components are:

- **Make health equity a strategic priority:** Equity should be included in organizations' strategy and goals, and should be viewed as 'mission critical,' meaning that the mission, vision and business cannot thrive without a focus on equity. This can be reflected through steps such as considering achievement of equity goals in compensation for senior leaders, and advocating for payment models that incentivize reducing disparities in health outcomes.

33 Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. Achieving Health Equity: A Guide for Health Care Organizations. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016.

- **Develop structure and processes to support health equity work:** This work requires dedicated resources, including human and data resources, as well as organizational infrastructure. This could include steps such as budgeting resources for, and creating a governance committee to oversee, equity work.
- **Deploy specific strategies to address the multiple determinants of health on which health care organizations can have a direct impact:** This includes delivery of health care services, organizational policies, the organization’s physical environment, the community’s socioeconomic status, and healthy behaviors. The report noted the status of many health care organizations as “anchors” in their communities, enabling them to influence the economic health of their community in a variety of ways.
- **Decrease institutional racism within the organization:** Organizations must look at their systems, practices and policies to assess where inequities are produced and how equity can be created proactively. This can be as simple as considering how parking fees at a hospital affect low-income patients, and as complex as determinations about what kinds of insurance plans to accept. It also includes efforts to address implicit bias, as noted above.
- **Develop partnerships with community organizations to improve health and equity:** Collaborate with community members and community-based organizations on areas that influence health and well-being.

IHI tested the framework through a two-year Pursuing Equity program, in which eight health systems participated. IHI **reported** that the eight systems “made strides to institutionalize a culture of health equity, including making health equity a strategic priority, conversations and actions to address structural racism, gaining buy-in to advance equity, and testing numerous changes to improve equity in both their health systems and their communities.”<sup>34</sup> Specific lessons included:

- Systems should work at both the macro level (through policies and infrastructure) and the micro level (through equity improvement pilot projects).
- Leaders should regularly communicate about equity’s importance and promote conversations about structural racism.
- Stratified and actionable data is needed to measure and make inequities visible, but imperfect data should not stop organizations from acting.
- Health care organizations have to operate outside the confines of the health system to improve health equity, addressing social determinants of health.
- Improving health equity is a long-term job.
- There is no particular order in which systems need to proceed through the framework.

IHI continues to expand the reach of the framework and its Pursuing Equity program. In October 2020, it launched the Pursuing Equity Learning and Action Network, which includes an additional 25 health care organizations.

34 Pursuing Equity: A Learning and Action Network to Close Equity Gaps in Health Care. Institute for Healthcare Improvement. <https://cdn2.hubspot.net/hubfs/241684/IHI%20Pursuing%20Equity%20Prospectus%202020-2021.pdf>



## HEALTH SYSTEM ENGAGEMENT: VIEWS FROM THE FIELD

The IHI framework offers useful perspective as we consider how organizations can create equity. We can also learn from the stories of some of those who will be speaking at this year's Forum, including organizational leaders focused on making diversity and equity driving forces at their institutions and clinicians and students working 'outside the four walls' of their institutions to address community needs. The remainder of the paper will recount the experiences of four people who will join us at this year's Forum, offering examples of organizational approaches to enhancing equity that will be presented in greater detail at the meeting.

### Mass General Brigham

As noted above, experts have suggested that health systems seeking to advance equity within their institutions and communities should consider appointing an equity officer. Thomas Sequist, MD, MPH is the Chief Patient Experience and Equity Officer at Mass General Brigham (MGB). In this position, he oversees both the system's quality and safety efforts and its promotion of equity. "If you're going to commit to equity as a system, it's really important that the people leading the charge are empowered to oversee a lot of other important operations," Dr. Sequist said. "My job is working from the inside to promote equity."

MGB, formerly Partners HealthCare, includes 16 institutions, including academic medical centers, specialty and community hospitals, a physician network, locations for urgent and community care, and other components. Dr. Sequist currently leads United Against Racism, an anti-racism initiative that spans the entire system and focuses on three main topics: workforce diversity and inclusion, the patient experience and community.

The workforce plank includes multiple elements. First, MGB is seeking to improve the diversity of individuals serving in leadership roles, including board members, executive leaders, and clinical leaders. MGB is also focused on promoting an anti-racism culture among its workforce. This includes establishing a reporting system that will enable employees and patients to report racism they witness or experience directly, modeled on systems that encourage reporting of patient safety concerns. The system will encompass incidents between staff, from staff to patient and vice versa, and between patients and families. All employees will also receive anti-racism training.

The patient experience portion of this work is broad. Dr. Sequist said that MGB wants to improve how it measures patient experience by race, ethnicity and language, and gain a deeper understanding of its patients' social determinants of health, such as food and housing. It also will focus on a set of issues related to access to care, including financial access (including reviewing how its payer contracting strategies affect access), language access (with an expansion of interpreter and translator services) and digital access for the underserved (including providing tablets to patients and hiring staff to work with them on accessing virtual care). MGB also seeks to expand access by creating mobile units to deliver primary care, behavioral health and substance abuse treatment in the communities it serves.

This area of work also includes a concerted effort to eliminate what Dr. Sequist called "racialized medicine," such as the improper use of race in 'clinical calculators' that determine what kinds of treatment to provide. It also will shape MGB's advocacy agenda, which will include support for public policies that benefit the system's more vulnerable patients, such as eviction reform and broadband internet access.

*"If you're going to commit to equity as a system, it's really important that the people leading the charge are empowered to oversee a lot of other important operations."*

*-Thomas Sequist, MD*

The community portion of the United Against Racism agenda has some overlap with the patient experience section, such as the establishment of mobile units to deliver care. It also includes investing in training and education, with the goal of creating health career pathways for youth that will ultimately benefit the community, from public health researchers to clinicians to leaders of community health centers.

On the clinical side, MGB has required its clinical departments to launch an equity improvement project. For example, the emergency medicine department measured the use of physical restraints by race, ethnicity, and language spoken by the patient and found concerning inequities. It now has a project to reduce use of restraints. Pediatrics is seeking to improve access to autism care, while urology is working to improve access to prostate cancer screening, diagnosis and treatment for underserved patients through a virtual clinic. In all, there are 18 such projects.

“The strategic and implementation plan for improved health care delivery had to be based on the evidence linking the tenets of diversity, health literacy and cultural components to improved health outcomes.”

*-Jennifer Mieres, MD*

### Northwell Health

Northwell Health, the largest health system and private employer in New York state, offers another example of a health care organization focused on equity as an employer, care provider, and community member. Northwell was an early leader in this area, launching a Strategic Plan for Diversity, Inclusion, Health Literacy and Health Equity in 2010. Jennifer Mieres, MD, Northwell’s Chief Diversity and Inclusion Officer and a professor of cardiology, has led this work since its inception and will also join us at the Forum to discuss it.

Dr. Mieres said that she and her team took a holistic approach to implementing Northwell’s diversity and inclusion efforts. “My personal philosophy, having practiced cardiology for more than two decades, was that the strategic and implementation plan for improved health care delivery had to be based on the evidence linking the tenets of diversity, health literacy and cultural components to improved health outcomes,” she said. “Therefore, looking from a clinical eye, we thought that the programs had to be comprehensive and involve everyone in all aspects of health care. You can’t just focus on clinicians; it has to be a multidisciplinary approach and the whole health care team needs to be involved. Diversity, inclusion and health equity have to be linked to how we deliver health care in the 21st century.” Dr. Mieres said that Northwell aligned its strategic plan with the recommendations of the U.S. Prevention Council’s [2011 National Prevention Strategy](#) and the American Hospital Association’s [Equity of Care Pledge](#).

Northwell’s comprehensive approach includes seven core pillars:

- **Leadership commitment**, with an executive council that oversees all of the system’s DEI activities and that includes the organization’s CEO and COO, the dean of the medical school, and the dean of the nursing school.
- **Education and development**, in partnership with the Center for Learning and Innovation, including a customized curriculum for all members of the care team that addresses cultural competency, unconscious bias, microaggressions, health literacy and other topics.
- **Language access**, to enhance effective communication the experience of the nearly 50 percent of the system’s patients whose preferred language is not English; this has included translating 80 vital documents into 22 languages.
- **Community partnership**, such as a medical-legal partnership program that aims to eliminate legal barriers preventing patients from receiving timely and effective care, and partnerships with 60 churches in underserved communities to offer free COVID-19 diagnostic and antibody testing and vaccines.

- **Workforce**, in partnership with its Human Resources department, including the establishment of seven employee resource groups with mentorship and leadership development programs for members of under-represented groups and the creation of a Racial Equity Resource Center for employees.
- **Supplier diversity**, advanced by the creation of a council to help small women-, LGBTQ- and minority-owned businesses navigate procurement opportunities with the system.
- **Gender disparities and women’s health**, with the Katz Institute for Women’s Health pursuing a mission of improving the health of women through the delivery of sex- and gender-based clinical care, community partnership and health education targeting prevention and well-being, professional education and the support of sex- and gender-specific research.

Northwell also partners closely with the leadership of the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell, which it operates in a 50–50 partnership with Hofstra University, to improve diversity. This work includes a pipeline program that works with high school students from under-represented populations to foster their interest in medicine and faculty education on cultural competency and principles of equity.

Dr. Mieres stressed the importance of educating and dispelling misperceptions among employees and clinical staff. “Anybody approaching this work really needs to have the evidence to support it,” she said. “At first, there was a lack of understanding of the link between the tenets of diversity, health literacy and health equity and the practice of medicine and health care delivery; there were so many misperceptions about what equity is. We needed to make a compelling case to show how inequity adversely affected health care.” Dr. Mieres said that stressing the impact of external factors on health outcomes was critical in engaging clinicians, and that nurses were a particularly instrumental partner because patients trust them.

Improving community relationships, Dr. Mieres said, required building trust. When Northwell’s work began, she said, “in certain communities, especially underserved communities, there was a lack of trust.” “Members of the community did not see us as a true trusted partner or as invested in their health,” Dr. Mieres said. “They thought that Northwell was a fair weather partner and only approached the community when there was a need for votes to expand the health system footprint, or to perform health screenings and leave without follow-up or truly establishing a community health partnership.” She said that the COVID-19 pandemic actually enabled Northwell to establish a Department of Community and Population Health (led by community health expert Dr. Deb Salas Lopez) and begin to build a foundation of trust with the communities it serves. “We had to eat some humble pie, with people asking ‘why are you showing up now?’” she said. “But communities now know we are with them for the long haul and are their trusted partners on the journey to community health equity.” Northwell’s 2021 strategic priorities include a focus on the data and metrics to identify health care delivery disparities and the establishment of a dashboard linking equity to quality.

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35 Northwell Health, Center for Diversity, Inclusion and Health Equity Report. Available from: <https://www.northwell.edu/sites/northwell.edu/files/2018-11/Center-for-Diversity-Inclusion-and-Health-Equity-Report.pdf>

“I always joke that I feel like the work of integrating the tenets of diversity and health equity into health care delivery is akin to climbing Mount Everest,” Dr. Mieres said. “We’ve been kicked back down many times but we’ve made it to the first summit and the rest is ahead. We’re pursuing a goal with no finish point.”

## MetroHealth

The IHI framework recommends that health systems focus on strategies to address social determinants of health where they can have a direct impact, and partner with community organizations to improve health and equity. Cleveland’s MetroHealth has done both of those things effectively.

MetroHealth is the safety net system for Ohio’s Cuyahoga County, which includes Cleveland. It serves more than 300,000 patients, two-thirds of whom are uninsured or covered through Medicare and/or Medicaid.<sup>36</sup> MetroHealth has set a goal of becoming as good at preventing disease as treating it. To achieve that goal, it has focused on the role it can play in positively influencing social determinants of health, such as affordable housing, a cleaner environment, economic opportunity, and access to fresh food.

Brook Watts, MD, Senior Vice President and Chief Medical Officer, Community & Public Health, joined MetroHealth three years ago because of its work in the community. “Our vision is to create a safe space and be part of building health, which is much broader than providing medical care,” Dr. Watts said. “We want to solve challenges that impact the community on a daily basis.”

MetroHealth’s Institute for Hope is a key part of this work. Through the institute, the system forms partnerships with community organizations that can address patient needs. “We don’t have to own social determinants of health, but we have to be the partner if we really care about the overall health of our community and our patients,” Dr. Watts said.

MetroHealth seeks to be strategic in capturing information about its patients’ nonmedical needs. For example, Dr. Watts said that hospital volunteers visited with patients during their recovery periods after receiving a COVID-19 vaccine, asking them about their housing needs, food insecurity, concerns about home safety and other topics. MetroHealth refers patients with needs to community partners that can help address them. “We want to be present in the community, not just within our walls,” Dr. Watts said.

In addition to connecting patients with community organizations, MetroHealth seeks to improve its patients’ economic opportunities through direct investment. It recently invested \$60 million in Cleveland’s Clark-Fulton neighborhood to fund new housing for people at varying income levels, academic and workforce training programs, other resident services, a job-training center and retail spaces. In addition, through the Community Responsive Care Institute, MetroHealth has joined with the State of Ohio and other major area health systems and universities to focus on increasing employment. As part of this project, the system helped Spanish-speaking community members to become certified in medical translation and obtain jobs as translators and interpreters.

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-Brook Watts, MD

Dr. Watts said that MetroHealth’s community engagement builds trust among its patients. As an example, she discussed the system’s work to provide COVID-19 testing at shelters and parking lots around Cleveland for people experiencing homelessness. MetroHealth operated six such testing sites each week, and the nurses who staffed

36 Connecting with our community. MetroHealth. July 2019. Available from: <https://news.metrohealth.org/connecting-with-our-community/>

them began talking with patients about vaccination early in the pandemic. After vaccines were approved, Dr. Watts said the shelter residents and staff they had come to know from the testing sites eagerly embraced the opportunity to receive them, enabling MetroHealth to quickly exhaust the 500 doses it had obtained. (The system then acquired additional doses to meet demand.) “One of our physicians said we were at that place of acceptance of the vaccine because we had worked with this group through the pandemic,” she said. “Our consistency, presence and approach built trust.”

Indeed, MetroHealth’s commitment to diversity, equity and inclusion is central to the medical care it provides, as well as to its work to address social determinants. Another aspect of its approach to COVID vaccination is revealing. MetroHealth was committed to vaccinating Black and white patients at comparable rates. Dr. Watts said that she came to see the idea of ‘vaccine hesitancy’ that was attributed to Black patients as racist, and as a major obstacle toward achieving parity. “If you use hesitancy as an excuse for not ensuring access, you don’t get equity,” she said. “We placed clinics in diverse neighborhoods and the clinics are all full. This is about access and trust.” With this approach, MetroHealth achieved its goal of achieving the same vaccination rates for Black and white patients, although Dr. Watts noted that an additional 10 percent of white patients received a vaccine from other sources.

### We Got Us

Forum participants will also learn about how trainees and medical students are engaged in community efforts. LaShyra (Lash) Nolen, a second year Harvard Medical School student who will be a Forum panelist, offers an extraordinary example. Earlier this year, she founded the We Got Us Empowerment Project, a Boston-based collective of Black community members, health professional students, and allies dedicated to empowering the Black community through education about medical racism, COVID-19, and the vaccines—and advocating for increased vaccine access in these communities.

The project includes more than 90 student volunteers from various Boston-area medical schools, undergraduate institutions and high schools. Their community partners include more than 20 organizations, from medical institutions to seasoned grassroots organizations in Boston and Brockton. Project members have hosted community events, done phone banking and ‘text banking’, and gone door-to-door in neighborhoods to provide information about the COVID-19 vaccine and offer assistance in registering people to receive it. They also visit community hubs like grocery stores, providing masks and sanitizer along with information.

The project also sponsors virtual “empowerment sessions” that are national in scope and are often done in coordination with other organizations, such as Black sororities or churches. These sessions provide information about COVID-19 and the vaccine, and address issues about the Black community’s experiences in and treatment by the health care community. Ms. Nolen said the sessions are intended not just to educate participants but to inspire the creation of coalitions in other regions.

Ms. Nolen said she had two motivations in starting the organization. The first was to add nuance to the discussion about “vaccine hesitancy” that was being ascribed to Black people and attributed to historic discrimination that the Black community had experienced. “I wanted to validate not just the past but also the present and future concerns of the Black community,” she said, noting the structural racism the community continues to face.

*“If you use hesitancy as an excuse for not ensuring access, you don’t get equity. We placed clinics in diverse neighborhoods and the clinics are all full. This is about access and trust.”*

*-Brook Watts, MD*

Her second motivation was to create “intentional spaces where Black people can come together and ask questions without judgment or fear.” She noted that she understood the community’s concerns about the health care system, but was also now a part of that system. “As a Black woman and a medical student, I had my feet in both worlds,” she said. “I wanted to work with other people with their feet in both worlds to help people make the best decision for themselves and their communities.”

Ms. Nolen said she thought the most important thing health care systems can do to build trust is to acknowledge the role they have played in contributing to harming marginalized communities, offering as an example the rising housing costs poor people can face when systems purchase large tracts of land in their communities. She also noted the tremendous health disparities that persist in the Boston area despite its prominent health care institutions and high per capita rate of physicians. “In the last year, many systems have talked about how disparities exist but not about how they contribute to them,” she said. “Once they do that, communities will see that it’s not just ‘lip service’ and that institutions are really doing the work to make health care accessible and of the highest quality possible.”

For individual clinicians, Ms. Nolen said, listening is the most important way to build trust. “If clinicians could take more time to listen to their patients, they’d really start to understand why it is they didn’t take their diabetes meds, or the stresses in their patients’ lives that would make it beneficial to have a mental health professional on their care team,” she said. She also said that clinicians should reflect and think about how they might unconsciously perpetuate racism, and engage in the “hard work of anti-racism through reflection and action.”

Ms. Nolen sees a continuing role for We Got Us and like-minded organizations after the pandemic ends. Although COVID-19 prompted her to start We Got Us, she said the problems that led to its creation—such as deficiencies in access to trustworthy information and tools to take agency for one’s health, and low numbers of Black physicians—will still need to be addressed. She described her own experiences accompanying family members to medical visits and raising questions they didn’t know to ask. “How do we make every Black person in America feel like they have a cousin, sister or daughter in medicine?” she asked. “We need a living model for bringing communities and health empowerment together.”

## CONCLUSION

The health system continues to grapple with the impact of the extraordinary events of the last 18 months—from police violence to COVID-19 to increasing gun violence—and their disproportionate impact on Black Americans and others from historically marginalized communities. These events have raised critical questions about the role of health care organizations in building trust, diversity, equity and inclusion. Over the course of the Forum, participants will learn more about how some organizations are addressing these pivotal issues, and will have the opportunity to discuss potential solutions with one another. We hope this background paper, and the stories it shares, offer food for thought as you prepare to participate in this meeting.

