Institute for Healthcare Improvement

INSTITUTE FOR HEALTHCARE IMPROVEMENT
SUMMARY REPORT: 90-DAY PROJECT

Seeing with New Eyes:
An Approach to Identify and Address Institutional Racism And Other Forms of Discrimination Within Healthcare

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II. Intent:

We cannot achieve the Triple Aim until we are willing to address health equity. And we cannot achieve health equity unless we are willing to address institutional racism. Institutional racism is difficult to see, particularly for those who are benefiting from it. But its effects are clear. Racial disparities in health care have been well documented across all areas of health care services and in relation to life expectancy. Black/white mortality due to racial disparities in health care amounts to 260 more deaths of black people per day[1].

How can we effectively respond to this reality? How can we see all the structures and processes within our health care system that result in inequitable outcomes? Institutional racism pervades our culture. This innovation wave is dedicated to helping all of us "see" and address institutional racism.

III. Background:

[1] Williams, DR & Wyatt R, Racial Bias in Health Care and Health Challenges and Opportunities, JAMA, August 11, 2015 Volume 314, Number 6.

Unequal treatment of black people and other people of color has been documented and described in research.[2] We know that many of the disparities in health care stem from structural issues in our health care institutions as well as society at large. Here are just a few of the statistics: Infant mortality for black people is 2.5 times higher than for white people; low-income and uninsured adults are less likely to rate the quality of their care as excellent or very good; black people are 3 times more likely to die from asthma than white people[3]; and more black males applied for medical school in 1976 than today.[4]

Institutional racism is rooted in long-standing societal issues related to economics, politics, and the history of this country. To address it, we have to learn to see it and the forms it takes in our institutions and society. Change must come at many levels of society, from policy to organizational practices, to individual interactions. This paper will address institutional racism in health care organizations as a key part of the effort to achieve health equity.

The demographics of the U.S. are changing. By 2040 the U.S. will be a "majority minority" nation.[5] This reality makes it even more critical for today's institutions to revise policies and practices to respond to these changing demographics. And indeed, doing so will even make them more competitive in the future.[6]

Dr. Camara Jones, Senior Fellow at the Satcher Health Leadership Institute, Morehouse School of Medicine, and Past President of the American Public Health Association explains: "Institutionalized racism is defined as differential access to the goods, services, and opportunities of society by race. Institutionalized racism is normative, sometimes legalized, and often

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[2] Institute of Medicine; Smedley BD, Stith AY, Nelson AR (eds). Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: National Academies Press; 2003.

[3] IHI slide on Inequitable Care and Health Outcomes, 2017

[4] Howard University President @HowardU Aug 3 @HUPrez17 shares interesting, alarming trends at the @NatUrbanLeague Conference. See also Association of American Medical Colleges (AAMC) report: the number of Black men in medical school was higher in 1978 than in 2014, Altering the Course: Black Males in Medicine, 2015, https://members.aamc.org/eweb/upload/Black_Males_in_Medicine_Report_WEB.pdf

[5] By 2040, the U.S. will be majority people of color. Currently, states such as California, Texas, Arizona, and Hawaii, as well as many major cities such as Dallas, Texas, and Durham, North Carolina, are already majority people of color. By 2019, a majority of youths under 18 will be of color, and by 2030 a majority of young workers will be people of color. Already today, the majority of babies born in the U.S. are children of color. PolicyLink: The Competitive Advantage of Racial Equity
http://www.policylink.org/sites/default/files/The%20Competitive%20Advantage%20of%20Racial%20Equity-final_0.pdf

[6] Ibid

manifests as inherited disadvantage. It is structural, having been codified in our institutions of custom, practice, and law, so there need not be an identifiable perpetrator."[7]

The terms "institutional racism" and "structural racism" are sometimes used interchangeably. However, some writers refer to institutional racism as related to the *organization*, and structural racism as related to the many systems existing in the larger society (education, housing, transportation, criminal justice, etc.). Structural Racism is "a system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity."[8]

For the purpose of this work, we will use the term institutional racism to refer to the structures, processes, rules and norms in place in health care organizations. However we will also refer to structural racism in health care, since health care is a system (like education and housing are systems). Structural racism in health care includes policies, practices and norms that exist outside the health care organization itself, such as housing segregation, food deserts, pay inequity, and other policies and norms that contribute to health inequity.

For additional information on how racism is embedded in the policies and norms of U.S. society, see *Racism Without Racists: Color-Blind Racism and the Persistence of Racial Inequality in America, 5th edition*, by Eduardo Bonilla-Silva. The author points out the importance of identifying the structures that are causing disparities in contemporary times. He states, "the elements that comprise this new racial structure are the increasingly *covert* nature of racial discourse and racial practices…"[9] An example of this is mass incarceration, where people of color are disproportionately incarcerated compared to whites, which has the effect of denying freedom and, in many states, even rights of citizenship such as voting to people of color.

While health inequity is caused by structural racism in multiple sectors of society, our focus for this innovation wave of work will remain on health care and health care organizations, as it was

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[7] Jones CP. Levels of racism: A theoretic framework and a gardener's tale. American Journal of Public Health. 2000;90(8):1212-1215.

[8] Glossary for Understanding the Dismantling Structural Racism/Promoting Racial Equity Analysis https://assets.aspeninstitute.org/content/uploads/files/content/docs/rcc/RCC-Structural-Racism-Glossary.pdf

[9] Bonilla-Silva, E, Racism Without Racists: Color-blind racism and the persistence of racial inequality in America, 5th edition, 2018, page 18

with the IHI report, *Achieving Health Equity: A Guide for Health Care Organizations*[10]. As noted in the paper, there is much that health care organizations can do internally, and also much they can do to impact other sectors that influence health, such as employment, education, and community safety.

People may ask why we are initially focusing on people of color as opposed to other issues like sexism, LGBTQ equity, or issues faced by people with disabilities, to name a few. We chose this because racism is historically rooted and deeply embedded in systems and social structures. If we can identify an approach to effectively address racial inequities in the health care system, we will be impacting the system that negatively impacts many marginalized groups. And we believe the approach can be applied to other forms of discrimination. We understand people have intersectional identities (e.g., an individual can be low income, black, gay, and a woman). These identities intersect, and the systems that cause inequity in relation to each of those identities intersect. Thus, addressing racial inequities will impact many sectors of the population, and understanding systems of oppression will help us address inequities across multiple identities. Our goal is to address racism and other forms of discrimination.

Additionally, addressing system change for the most marginalized populations can change systems in ways that benefit the rest of the population. For example, the cut-outs in street curbs that were mandated by the Americans with Disabilities Act benefit all people. All of us benefit from these slopes in sidewalks as we cart groceries, luggage and baby carriages. An example from the health care field is the work of HealthPartners in Minneapolis to redesign mammography screening for low-income women. They coordinated screening appointments with other medical visits to make the best use of women's time, which was a redesign that benefits all women. Finally, the reason we focus on the most marginalized among us is because we all are impacted when people around us suffer. It may affect those not directly impacted in terms of the sadness they feel - the assault to one's humanity - as they walk by those who are suffering. It impacts everyone in terms of public health as diseases spread if the population is not healthy, and in terms of the economy as greater numbers of people fall further behind and health and wealth gaps widen.[11]

Finally remember this work fits in the context of the larger work that we have written about in the IHI report*: Achieving Health Equity: A Guide for Health Care Organizations*. That work is summarized with Figure 1. We left the description for section 4 purposefully blank because that is the work of this paper.

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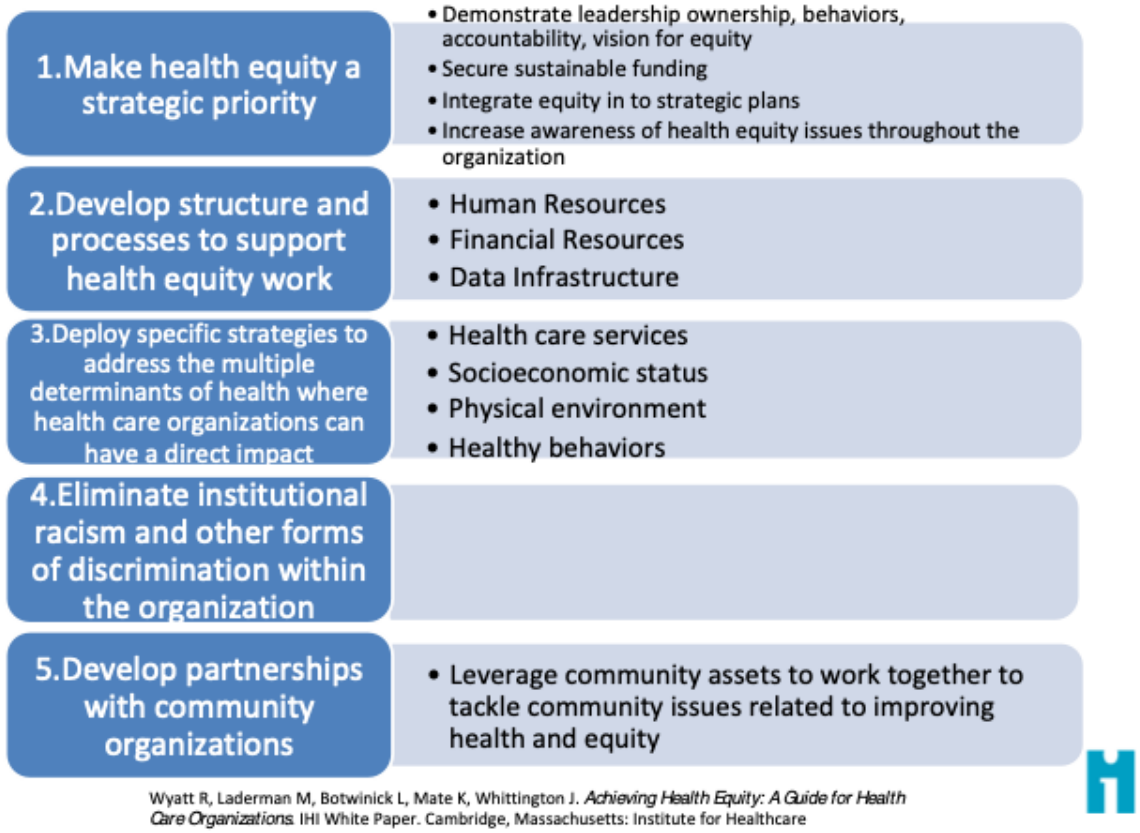
[10] Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. *Achieving Health Equity: A Guide for Health Care Organizations*. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016. (Available at ihi.org)

[11] The Birth of the New American Aristocracy - The Atlantic, June 2018 https://www.theatlantic.com/magazine/archive/2018/06/the-birth-of-a-new-american-aristocracy/559130/

Figure 1 Framework for Health Care Organizations to Improve Equity



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

IV. Description of Work to Date:

This 90-Day Scan involved review of literature, conversations with experts, reflecting on the work of the IHI Pursuing Equity collaborative and other IHI equity initiatives, and interviewing organizations that are currently doing work to help organizations recognize and address institutional racism. A large list of entities (see Appendix A) was identified, and of those, we selected five organizations to interview. We have familiarity with several others on the list. The organizations we spoke with represented professional associations, small consulting organizations, and larger non-profits that we knew were doing innovative work in this area:

1. Association of American Medical Colleges - Health Equity Research & Policy
2. Center for Health Care Strategies Inc.
3. Democracy Collaborative
4. Heather Hackman Consulting Group
5. Race Forward

The number of entities doing consulting to assist organizations with implicit bias is even longer. Implicit bias is "the bias in judgment and/or behavior that results from subtle cognitive processes (e.g., implicit attitudes and implicit stereotypes) that often operate at a level below conscious awareness and without intentional control." Implicit bias can influence institutional racism in policies and procedures if we are not aware of it. [12] In the wake of the news about Starbucks doing company-wide training on racial bias, NPR's Marketplace reported on this segment of the consulting industry. They said that implicit bias training is now a multi-billion dollar business. We believe this makes it even more important to make the point that a few training sessions is not going to bring the change we need. Just as in quality improvement (QI) work, we must change structures and processes to make sustainable change. Identifying and changing the structures and processes that maintain the current status of disparities by race is a critical aspect of health equity work.

We asked the organizations we interviewed a set of questions (Appendix B).

Key areas of work were identified from the interviews, the literature, conversations with experts, and from our experience in the Pursuing Equity collaborative. See Appendix C for themes emanating from the interviews and our other work.

We organized these themes into drivers on a Driver Diagram. These drivers are reflected in Figure 2. This figure and the accompanying text is the IHI Approach to Seeing and Addressing Institutional Racism that is described in this innovation paper.

IHI has much experience with organizational improvement and transformation. We know that transformation requires changes at all levels of the system, as Don Berwick describes in A *User's Manual for the IOM's "Quality Chasm" Report* - from the patient level, to the microsystem level, to the organization level, to the environment level.[13] Other colleagues have written about the different levels required for system transformation, such as Marshall Chin and Don Goldmann, who describe six levels that need to be impacted: Policy, health care delivery entity, microsystem, clinician, patient/family, and community.[14]:

With our knowledge about what enables system change, we understand that a comprehensive approach that touches on all levels of the system is needed. Health care organizations have a

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[12] Casey PM, Warren RK, Cheesman FL, Elek JK. Helping Courts Address Implicit Bias. Williamsburg, VA: National Center for State Courts; 2012. www.ncsc.org/~/media/Files/PDF/Topics/Gender%20and%20Racial%20Fairness/IB_report_03 3012.ashx

[13] Berwick, DM, A user's manual for the IOM's "Quality Chasm" Report. Health Affairs. 21(3):80-90, 2002.

[14] Chin M and Goldmann D, Meaningful Disparities Reduction Through Research and Translation Programs, Journal of the American Medical Association, January 26, 2011—Vol 305, No. 4x

major role to play. Not only are they a major component of the larger system, but they can influence what happens in the other components; for example health care organizations can influence policy at the local, state and national levels. We recommend health care organizations implement organization-wide initiatives on the scale of what we suggest in this paper. However, we also know from experience that improvement work in parts of an organization begins to impact culture and create buy-in for additional work. Change can be made in all organizations, not just those few with leaders willing to make the organizational commitment to becoming anti-racist organizations. We will describe the primary and secondary drivers to system change as we see them. We encourage individuals to take on the work to begin to dismantle institutional racism, even if they are working in one part of the larger system.

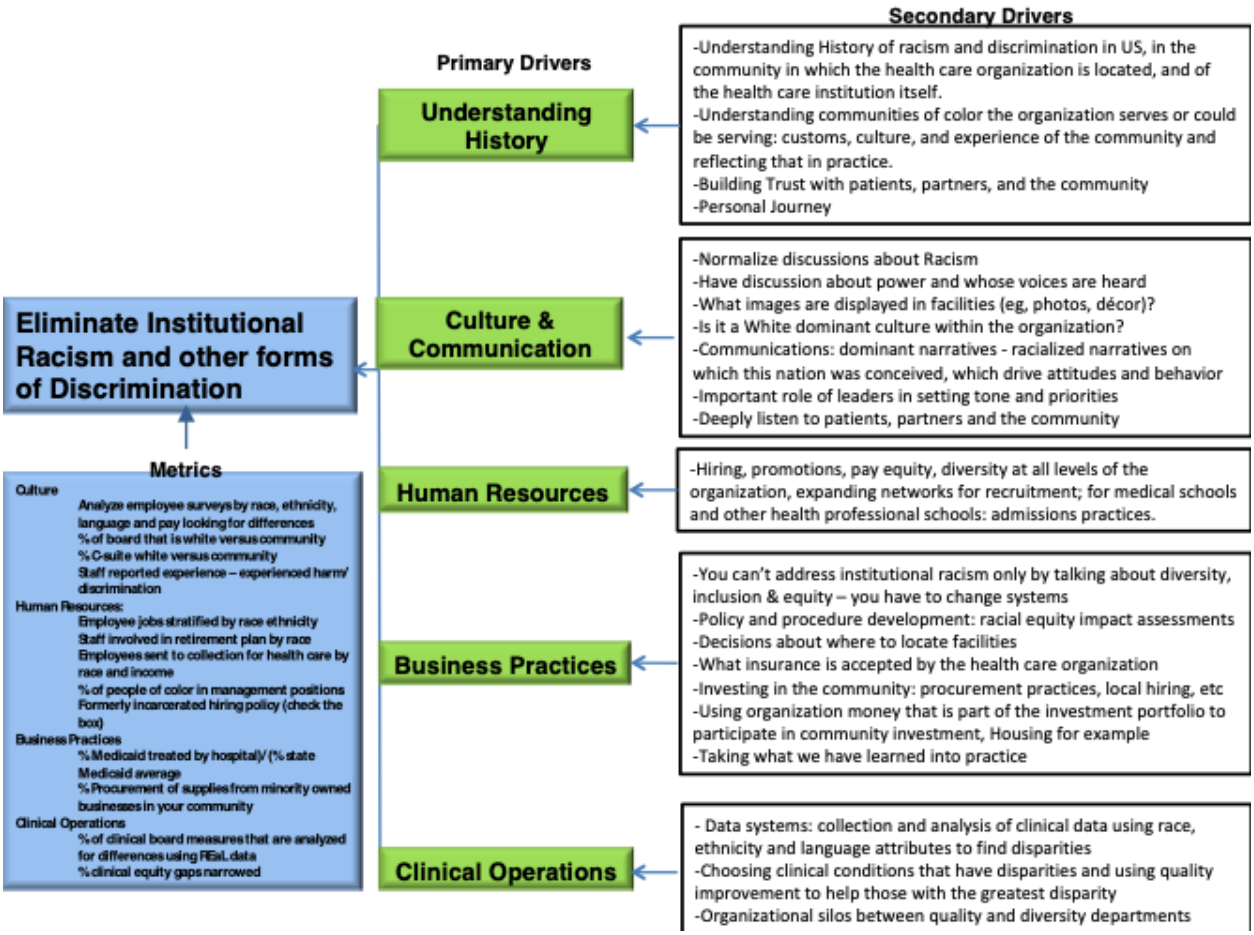
V. Results of the 90-Day Scan:

Our Approach

Based on our review of the literature, our interviews, and our experience working with organizations on achieving health equity, and specifically on addressing institutional racism, we have identified the key areas of work as:

1. Understand the history of racism in the country, community and organization, and consider one's own personal experience with institutional racism
2. Organizational culture and communications as it relates to institutional racism
3. Human resource practices at all levels of the organization
4. Business practices of every department/section/business unit in the organization
5. Clinical operations for all aspects of care provided

Figure 2 Eliminating Institutional Racism: Drivers and Measures to Support this Work



The focus of this 90-day wave is "Seeing Institutional Racism" and taking steps to dismantle it. The work of seeing and dismantling institutional racism is seeing and redesigning the structures and processes that maintain it. This happens by working on all 5 drivers listed above.

Understanding History. This driver has to do with learning the history of the U.S., the city or town in which the institution is located, and of the institution itself. Understanding struggles of people of color and the ways that people have systemically been denied freedom, access to jobs, housing, schools, food, etc. builds empathy and an understanding of how the current state came to be. Understanding the advantages that white people have benefited from often is transformative, and helps people see and commit to changing the underlying unfair systems that cause discrimination and disparities.[15]

[15] Color-Blindness Is Counterproductive, The Atlantic Monthly, by Aida Harvey Wingfield, Sept 2015; accessed Sept 9, 2018 https://www.theatlantic.com/politics/archive/2015/09/color-blindness-is-counterproductive/405037/

As we learn the history of this country and our local setting, we also need to reflect on our own personal journey and how we have been impacted by systemic racism. This is part of the work that each of us must do to understand our racial identity and how the past may be impacting our actions in the present. People of color might think about the impact of internalized racism on their lives. White people might think about how they experienced the world growing up white in America. Biracial people have the complex history of multiple identities to sort out. Understanding one's own racial identity development and how we respond to these issues and discussions is an important part of addressing institutional racism.[16]

Understanding history also helps explain the distrust that communities of color may have for health care institutions. In the *Achieving Health Equity* paper, we noted that the trauma of the Tuskegee syphilis experiment on American Blacks is passed on over generations in towns across America[17], as is the story of Henrietta Lacks whose tissue sample was taken for profit to develop the first cell line for research. The history of medical experimentation and abuse regarding people of color is not limited to black people. Genetic research was conducted using DNA samples without informed consent on the Havasupai Tribe in Arizona[18] causing them to avoid the academic medical center that did the research. The birth control pill was tested in high doses in Puerto Rico before being put on the market[19], and there are many other examples.

Knowing the history of a place also helps us understand the structural racism that exists in our own location, for example in Memphis we learn that the bus system was built to transport black people to work in white communities, and in Chicago and other cities we learn about how redlining impacted where black people could live, which impacted the quality of schools in those neighborhoods because schools are funded by property taxes. These structural issues contribute to present-day health disparities.

We mean this to include recent history as well if, for example, the health care organization participated in gentrification, or if there was a recent battle over something important to the

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16 Summary of Stages of Racial Identity Development, Interaction Institute for Social Change http://www.racialequitytools.org/resourcefiles/Compilation_of_Racial_Identity_Models_7_15_11.pdf

17 Tuskegee is the most well-known example. Many more examples are provided in Washington HA, Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present, 2006.

18 Sterling RL. Genetic research among the Havasupai: A cautionary tale. AMA Journal of Ethics. 2011;13(2):113-117.

19 "Guinea pigs or pioneers? How Puerto Rican women were used to test the birth control pill." Washington Post, May 9, 2017 https://www.washingtonpost.com/news/retropolis/wp/2017/05/09/guinea-pigs-or-pioneers-how-puerto-rican-women-were-used-to-test-the-birth-control-pill/?utm_term=.48b3494bee82

community, or if the institution has a reputation of not being a welcoming place for people of all races.

In improvement terms, understanding history contributes to understanding "what matters" to the members of the community who are at the margins. The history of Tuskegee matters tremendously to African Americans throughout the U.S. It even can be thought of as the *context* in which we do our improvement work, since we all know by now, an improvement intervention that works in one place may not work in another, because context matters.

We placed the concept of Trust in this driver because history has much to do with lack of trust in the health care system. However, it should be noted that all the drivers contribute to building Trust with the community.

Culture and Communications. The improvement community understands culture as "the way we do things around here." The culture of the health care organization must be one in which we enable conversations about race and racism, and look for and eradicate the ways that racism is embedded in our systems. It is also a conversation about power and privilege. All of these can be difficult conversations and that is why some organizations will choose to use outside help. Many would prefer not to talk about these issues, and even believe that we should be colorblind in all activities. But we, and many others doing health equity work, believe that to change systems and processes that are causing health disparities, we must have these conversations. David Ansell, a Pursuing Equity organization leader at Rush University Medical Center, speaks about the importance of "Naming the Problem," as institutional and structural racism. He refers to it as the "root cause" and makes the analogy to other improvement work where we have to understand the root causes of a problem in order to fix it. Another Pursuing Equity organization leader, Abigail Ortiz from Southern Jamaica Plain Health Center, speaks about the issue of white dominant cultures[20], and what that means for health equity; for example, it can put up barriers for staff in communicating with each other and with the community.

The Culture and Communications driver also includes having an understanding of implicit bias, and how to counteract it, which is important not only for clinicians, but also for staff at all levels, including staff at reception desks and those who interact with patients about health care bills.

Communicating about institutional racism includes having common definitions for terms such as racism, institutional racism, structural racism, and equity. Earlier in the paper we defined institutional racism and structural racism. Structural issues are the focus of this paper, but it is important to name the other forms of racism. There is also personally mediated racism and internalized racism, which should be understood as important concepts but separate from the

[20] Gulati-Partee, Gita and Potapchuk, Maggie (2014) "Paying Attention to White Culture and Privilege: A Missing Link to Advancing Racial Equity," The Foundation Review: Vol.6: Iss.1, Article 4.

structural concepts. Internalized racism as defined by Camara Jones is "acceptance by members of the stigmatized races of negative messages about their own abilities and intrinsic worth."[21] Just as white people need to grapple with the advantages they have received growing up in the U.S., people of color may need to do internal work as well, understanding how messages they have received as they grew up have impacted them. As Amy Reid, Director of Health Equity initiatives at IHI stated, "We each bring our own baggage, story, and history to this work and the work we each need to continue to do as individuals cannot be understated as critical to advancing racial equity."

Another key element of addressing institutional racism, often communicated by Doug Eby from Southcentral Foundation in Alaska, is to deeply listen to the community, and ensure everything about the organization is built around their needs and norms.[22] The organization culture must be one that is oriented toward listening and responding to the needs, norms, and preferences of the community. The physical environment should reflect the rich diversity and culture of the populations served.

The institution must understand the lived experience of people in the community most impacted by inequities, their customs and culture, and partner with them. Among people of color, there are many different identities. For example, the Somali community of Minneapolis is different from the African American community of Minneapolis. Among Latinx people, there are many cultures – Puerto Rican, Cuban and Mexican, for example. Recognizing and appreciating these differences is essential in building community relationships and trust.

Human Resources. Matters related to the people working in the health care organization are particularly important in achieving health equity. Many organizations do not have a strategy for recruiting diverse talent.[23] This strategy should involve developing diverse panels of applicants when hiring staff and clinicians at all levels. Once hired, the organization must have retention strategies including professional development opportunities, mentoring, and promotional opportunities.

The organization must attend to the demographics of the executive team and board. Regarding demographics, when the staff, clinicians and organization leaders reflect the racial and ethnic demographics of the community, in general, decisions will be made with greater sensitivity to the

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[21] Jones, CP, "Levels of racism: a theoretic framework and a gardener's tale," Am J Public Health. 2000 August; 90(8): 1212–1215 .

[22] Customer-Ownership in Equity-Oriented Health Care DOUGLAS K. EBY October 2018 The Milbank Quarterly pp1-3

[23] Boris Groysberg, Nitin Nohria,Claudio Fernández-Aráoz The Definitive Guide to Recruiting in Good Times and Bad https://hbr.org/2009/05/the-definitive-guide-to-recruiting-in-good-times-and-bad

needs of the historically under-represented groups in the community[24] and the community will trust the organization to a greater extent when there is concordance of personnel to their own demographics.[25] Having a staff, clinicians, c-suite, and board that are representative of community demographics is also important because it redistributes power, which is a key element of addressing institutional racism.

This driver also includes key points such as staff reported experience of discrimination, procedures for assessing performance, fair wages and pay equity, analyzing demographics of disciplinary actions and how organization benefits such as retirement plans are utilized by low wage staff, etc.

Within the Human Resources driver we acknowledge and highlight the excellent work in the U.K. on development of the Workforce Race Equality Standard (WRES).[26] The WRES includes multiple components they call indicators, and is the result of a multi-year effort of the National Health Service, led in part by Yvonne Coghill, RN who brought the standard to IHI's attention in 2015. The WRES has been published and is today being implemented and enforced. We have borrowed from this work and included WRES measures as part of our Human Resources driver.

Business Practices. This driver addresses the importance of looking at the specific internal policies and practices that impact health equity, beyond Human Resources, which is addressed in a separate driver. The decision about which insurance to accept and where to build new facilities are key business practices that impact equitable care. Conducting Racial Equity Impact Assessments (REIAs)[27] as new policies are considered is a key business practice recommended in this driver. Other business practices that impact equity are investments in community violence and trauma recovery support services.[28] And health care organizations are beginning to invest in

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[24] Hospital Leadership Diversity and Strategies to Advance Health Equity, Herrin et al, The Joint Commission Journal on Quality and Patient Safety, Volume 44, Issue 9, September 2018, Pages 545-551 https://authors.elsevier.com/c/1XdVH5XHhBl2tV

[25] Saha, S., Komaromy, M., Koepsell, T. D., & Bindman, A. B. (1999). Patient-physician racial concordance and the perceived quality and use of health care. Archives of Internal Medicine, 159(9), 997.

[26] https://www.england.nhs.uk/wp-content/uploads/2017/03/wres-technical-guidance-2018.pdf See the 9 indicators on page 18.

[27] https://www.raceforward.org/practice/tools/racial-equity-impact-assessment-toolkit

[28] https://www.cdc.gov/violenceprevention/pdf/yv-technicalpackage.pdf

housing as a way to impact the health of people with complex social needs.[29] Strategies for keeping low income people from losing their homes to gentrification are being explored.[30] This driver also includes strategies of the Anchor Institution movement that have to do with directing resources toward the community, such as procuring services locally, and specifically from minority businesses; hiring locally; and investing part of the organization's financial portfolio in the community. The Democracy Collaborative's Hospital Tool Kit[31] is an excellent resource for this driver.

In addition, Derek M. Griffith[32] notes that decision processes must be transparent to staff and to the community. This builds trust within the organization and with external stakeholders.

Clinical Operations. Since the goal of this paper is to understand how to impact health to improve health equity, we need to address clinical operations of a health care organization. This driver includes stratifying quality data by race, ethnicity and language (REaL) and by socio-economic status/pay, and identifying clinical conditions where disparities are observed and working to reduce disparities and improve health for all. It also means that people of color have access to services provided, even by the big profit centers in hospitals (procedures such as cardio and hip and knee and bariatric surgery, for example). It is not enough to identify racial disparities in care for those who have managed to access to the system. The organization should proactively assure that people at the margins have access to services.

It also has to do with making equity a key part of all QI initiatives. This means assuring that we are decreasing the disparities gap as we improve systems. It also means that we focus on populations at the margins. As noted in recent guidance for health care leaders, "Quality improvement often focuses on populations where success is most easily achieved. But if we are going to start reducing disparities, we need to start with the "last" population – one that may be more challenging and just not thriving – and partner with them to develop improvements. The

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[29] Fraze T, VA Lewis, HP Rodriguez, and ES Fisher. 2016. Housing, Transportation, And Food: How ACOs Seek To Improve Population Health By Addressing Nonmedical Needs Of Patients. Health Affairs (Project Hope). 35 (11):2109-2115. See also: University of Illinois Hospital recommits to providing housing to chronically homeless emergency department patients, UIC Today, January 2018, updated April 2018. https://today.uic.edu/university-of-illinois-hospital-recommits-to-providing-housing-to-chronically-homeless-emergency-department-patients. Also https://nextcity.org/daily/entry/how-marginalized-communities-are-getting-control-over-development?mc_cid=f97c62b42d&mc_eid=2bfd24b8e0 Also http://www.wbur.org/commonhealth/2018/06/27/boston-medical-center-affordable-housing?mc_cid=f97c62b42d&mc_eid=2bfd24b8e0

[30] "The Right to Stay Put" https://www.washingtonpost.com/opinions/the-right-to-stay-put/2018/09/21/395cc5d8-b90f-11e8-94eb-3bd52dfe917b_story.html?utm_term=.c70ca4bee677&wpisrc=nl_ideas&wpmm=1

[31] https://hospitaltoolkits.org

[32] Griffith, DM, "Dismantling institutional racism: theory and action." 2007

reward for health care organizations is that even though these populations may be small, they can incur great costs to the health system. And if we can solve problems for those at the margins, we may come up with solutions that work better for all."[33]

Measures

We have identified a set of measures that will quantify institutional racism. We are breaking these measures down into 4 domains: Culture, Human Resources, Business Practices and Clinical Operations. We will describe each measure.

Culture

1. Analyze all employee surveys by race, ethnicity, language (REaL) and pay looking for differences between various groups within the health system. This does not require the organization to create a new employee survey.
2. Conduct a survey to assess perceptions of racial discrimination in the work place (yes/no).
3. Compare the % of the health care organization board that is white versus the percentage in the community.
4. Compare the % C-suite that is white versus the percentage in the community.
5. Consider staff reported experience – experienced harm/discrimination. In the NHS they use the following questions to measure this: In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/team leader or other colleagues[34]

Human Resources:

1.Employee job classification stratified by REaL data. An organization may have good diversity overall, but generally speaking you will find people of color in lower paying jobs.
2. Staff involved in retirement plan stratified by REaL data
3. Employees sent to collection for health care stratified by REaL data
4. % of people of color in management positions
5. Formerly incarcerated hiring policy (check the box)

Business Practices

1. (% Medicaid treated by hospital)/(% state Medicaid average). This measures a health system's willingness to not discriminate various payment types in their community. In the

[33] http://www.ihi.org/communities/blogs/improving-health-equity-5-guiding-principles-for-health-care-leaders

[34] https://www.england.nhs.uk/wp-content/uploads/2017/03/wres-technical-guidance-2018.pdf

ideal situation the number should be 1. Anything less than 1 indicates some form of discrimination for payer mix.
2. % Procurement of supplies from minority or women owned businesses in your community

Clinical Operations

1. % of clinical board measures that are analyzed for differences using REaL data. This measures whether REaL data is used to analyze important clinical measures.
2. % clinical equity gaps narrowed. Using those same clinical board measures as noted in item number 1 you would look for the initial REaL gaps in care and follow the % improvement over time.
3. Stratify your top three income producing procedures by REaL data to look for disparities.

Note that when segmenting data by REaL, the categories can be further segmented; for example, black people can be segmented by African American, Haitian, and Somali, if relevant to the health care organization employee population and community served.

Case Examples

Below are case examples to illustrate the work described above. All three are participating in IHI's Pursuing Equity collaborative.

- Vidant Health, North Carolina
- Rush University Medical Center, Chicago, Illinois
- Southern Jamaica Plain Health Center, Boston, Massachusetts

Vidant Health – Vidant Health is a health system in eastern North Carolina that serves 29 counties representing a third of the state's population. Their flagship hospital is in Greenville, North Carolina and is a 900-bed academic medical center in a city of 90,000 people. We describe changes they have made in the area of **Human Resources** to illustrate what can be done to impact that driver.

Since Vidant Health is such a large employer in the region, they realized that if they focused on health equity within their own organization they would impact health equity in the region. In addition, they felt that their workforce needed to represent the diversity of the population they serve, and to do this they needed to attract a diverse workforce. They raised the starting wages to be higher than other employers in town so they would be the employer of choice. They raised starting wages to $12 per hour for 1,736 employees, costing them $2.8 million a year. This was significantly more than the minimum wage in North Carolina of $7.25 per hour. This action not

only impacted the financial well-being and morale of the workforce, but it impacted the economy of the region, and the image of the health system from the community's perspective.

Another way Vidant addressed **Human Resources** was to change requirements for low wage positions. They realized that requiring a high school diploma or certification for certain positions made low income workers ineligible to apply. Such individuals couldn't afford to take off time from their current jobs to enroll in courses to get their GED or certification. Vidant changed the policy and brought in excellent workers who are able to earn their GED's and certification while working at Vidant. Vidant Health is also investing in further education of employees, investing in educating youth and others in the community to create a pathway for future employment at the organization.

To learn more about Vidant Health's equity initiatives, see the blog post by Vidant Health Chief Experience Officer, Julie Kennedy Oehlert, RN on ihi.org.[35]

Some additional comments about hiring practices. Two more are noted here. One practice is not to ask prospective employees if they have a criminal record. This is known by a movement called "ban the box," which refers to eliminating the check box on job applications where people have to declare that information. Henry Ford Health System a pursing equity participant along with other health systems in Detroit have agreed to do this. They still do background checks but the goal is to employ our returning citizens from prisons into jobs. Tougher sentencing laws and racial bias in the criminal justice system have resulted in larger proportions of people of color in prisons, so asking about this is discriminatory. Another practice is not to ask for previous salary on job applications. Setting a new salary based on previous salary is a common practice/norm that we hardly question because it is "just the way things are done." But it is a discriminatory practice that perpetuates wage inequities. Lower salaries for women and people of color are based on structural racism and sexism, so continually setting new salaries based on those earlier salary levels continually extends the wage gaps.

Rush University Medical Center – Rush is an academic medical center that comprises three hospitals and 30 locations throughout the Chicago area. We will highlight activities of Rush that relate to the **Culture/Communications**, **Business Practices,** and **Clinical Operations** drivers. In a presentation to IHI's Leadership Alliance in September 2018, David Ansell, MD, Senior Vice President, Community Health Equity, described current activities to address institutional racism. He said that it has been important to have conversations about racism – personally mediated racism, institutional racism, and structural racism. He called it "Naming the Problem."

[35] http://www.ihi.org/communities/blogs/are-love-and-empathy-the-keys-to-health-equity

He said that at Rush they believe it is important to get to the root causes of health inequities, and that means to name structural racism. They are normalizing these conversations at all levels within the institution, including with Trustees and among the senior leaders.

Dr. Ansell described Rush's 4-step approach to addressing institutional racism:

1. Naming racism as a root cause of inequity.
2. Ask how is it being perpetuated in our organization, for both employees and patients.
3. What strategies do we have in place to eliminate institutional racism in our organization.
4. Partner with other organizations to improve community health.

One of their key strategies is to accept their role as an Anchor Institution by making serious investments in the financial viability of the part of Chicago in which they are located, Chicago's west side. They are working with the Democracy Collaborative as a part of the Healthcare Anchor Network. A document called the Anchor Mission Playbook[36] has been published which provides details of this work. They also are participating in a regional initiative called West Side United[37], where they are partnering with other health care systems and the community on the West Side to further these investments, address the social determinants of health, and coordinate health and wellness initiatives. The aim of the collaborative is to reduce the life expectancy gap between Chicago's Loop (downtown) and the Westside neighborhoods by 50% by 2030.

Regarding **Clinical Operations**, Rush has been stratifying quality data by REaL and working to reduce disparities identified in the data. They have taken measurement a step beyond by analyzing the findings by physician and giving the data to them about disparities in their practice.

Southern Jamaica Plain Health Center – Southern Jamaica Plain Health Center is a community health center that is a part of Brigham & Women's Hospital, located in Boston, Massachusetts. Southern Jamaica Plain Health Center may be best known for its landmark "Liberation in the Exam Room" initiative, which describes anti-racist practices in primary care visits.[38] They also have an Adaptive Leadership training program that illustrates the **Understanding History** and **Communications/Culture** components of the framework.

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[36] Anchor Mission Playbook, prepared by Rush University Medical Center with support from Chicago Anchors for a Strong Economy (CASE), the Civic Consulting Alliance, and The Democracy Collaborative, Version 2.0, June 2017 https://www.rush.edu/sites/default/files/anchor-mission-playbook.pdf

[37] https://www.rush.edu/about-us/rush-community/west-side-united

[38] Commonwealth Fund, "in Focus, Reducing Racial Disparities in Healthcare by Confronting Racism, September 27, 2018, https://www.commonwealthfund.org/publications/newsletter-article/2018/sep/focus-reducing-racial-disparities-health-care-confronting?omnicid=%25%25jobid%25%25&mid=%25%25emailaddr%25%25

The history of racism in the U.S. is a key part of the training. The program shows how blacks have been oppressed first by slavery, then Jim Crow laws, and then by modern day systems of oppression such as mass incarceration, systemic bias in home loans, bias in hiring, and poor schools. They describe how systems of oppression operate in all the key sectors of society, from the criminal justice system, to banking, to transportation, to education, to health care. Understanding racism in U.S. history is a key part of the UnDoing Racism training, and other health equity trainings as well.

The program also addresses organization culture, and helps participants understand how mainstream values such as traditional professional attire and hair styles marginalize others. The program explores how feelings and emotion are undervalued in the work place. Many office cultures still defer to white males and traditional office hierarchies to the detriment of good patient care.

Guidance on How to Begin

The IHI has extensive knowledge and experience on how to begin organization transformation. We can use that knowledge and apply it to the transformation process for addressing institutional racism. Change needs to happen at every level of the organization, from leadership to middle management, to front line workers. Getting front line workers involved can unleash the creativity of individuals who know how the work is actually done. Their efforts need to be supported and enabled by actions of leadership.

An article that has been referenced in this paper that was particularly useful was by Derek M. Griffith from 2007 titled "Dismantling institutional racism: theory and action."[39] He and his colleagues described the theoretical underpinnings of this work from a variety of academic perspectives. He then describes the approach called Dismantling Racism.

> Dismantling racism is a systems change intervention designed to change the underlying infrastructure within an institution to be more fair, just and equitable. The overall goal of the dismantling racism intervention is to create an organization in which it can be demonstrated and it is perceived that all who seek health services are given equal, high quality care.

From our literature review, interviews, experience with Pursuing Equity and other IHI initiatives around health equity, and knowledge about transformation, here are key steps organizations can take to begin addressing institutional racism in their organizations:

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[39] Griffith, DM, "Dismantling institutional racism: theory and action." 2007

1. Create a diverse oversight group to guide the work.
2. Conduct an employee survey to learn if staff and clinicians experience workplace discrimination; ask about their knowledge of health disparities; stratify results by race, ethnicity, language, and salary level.
3. Look at your data with a racial equity lens. Review both quality outcomes and data related to your own employee's experience by race, ethnicity and language. This can be a powerful mechanism for building will for change. Narrow the Gaps.
4. Have conversations about race and racism; develop a common language; conduct organization-wide training, perhaps with outside consultants with skills in facilitating these difficult conversations since the topic is sensitive and organizations are not likely to have experts who can constructively facilitate dialogue on race. This training should include the history of racism in the US, and how it is systematically carried out in every sector of society to this day. This should not be simple unconscious bias and cultural competence training, although that is important too.
5. Create mechanisms to begin and sustain doing the work of changing systems and processes within the organization; encourage every single department to identify ways to address institutional racism so all business and clinical practices are considered.
6. Discuss health equity and organization results at Board meetings.
7. Start with the organization's own employees as Rush and Vidant Health did.
8. Strengthen interpersonal relationships within the organization and with the community to build trust, change power dynamics, and build commitment for the need and will to change.
9. Make systems and the reasons for decisions more transparent to staff and to the community to build trust and share power.
10. Ensure diversity of leadership (c-suite and the board), staff and clinicians and retain, develop, and promote people of color into leadership positions.

Regarding the steps above, we know that successful transformations often begin with establishment of an oversight group that includes executive sponsor involvement, the conduct of an employee survey, and a review of the organization's data. IHI itself established a Diversity, Inclusion and Equity Committee, and has learned much on its equity journey by surveying staff and then stratifying results by race. We know from past work that patient safety improvement in health systems often begins with a patient safety culture survey. To achieve health equity, the employee survey could be about whether staff and clinicians experience discrimination in the workplace and knowledge about health disparities. Henry Ford Health System began its transformation with a survey related to the extent of knowledge about health disparities. An employee climate survey can create a burning platform that drives further work. A useful resource, while not specific to health equity, is IHI's "How-to Guide on Running a Successful

Campaign in Your Hospital."[40] This guide was developed for the 100 Million Lives Campaign in 2005, and is still a helpful guide for getting started on organization-wide improvement.

What we have seen from analyzing various approaches to addressing institutional racism is that there are a number of similar elements in all of them. The question for us became, how could IHI communicate a framework that would galvanize the improvement community around eliminating institutional racism in health care organizations. Our approach builds on concepts and language that are already familiar to the improvement community, and then adds critical new elements that will push the work forward.

VI. Conclusions and Recommendations:

As noted above, the key elements that we believe are important to communicate in an IHI framework are the following:

- Understand History
- Culture and Communications
- Human Resources
- Business Practices
- Clinical Operations

We believe that the best approach is for an organization to embark on *an organization-wide* commitment to eliminating institutional racism supported by leadership and implemented at every level of the organization. However, we also believe that incorporating elements of this model in pockets of the organization by willing and courageous individuals could begin to change the climate within the organization, and begin to make an impact.

VII: Appendices:

Appendix A: Organizations or Resources that work on Health Equity

Advisory Board
Aspen Institute, Roundtable on Community Change - Project on Racial Equity and Community Building
Association of American Medical Colleges - Health Equity Research & Policy
Center for Health Care Strategies Inc
Center for Health Progress

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[40] Running a Successful Campaign in Your Hospital – How-to Guide, http://www.ihi.org/resources/Pages/Tools/HowtoGuideRunningSuccessfulCampaign.aspx

Community-Campus Partnerships for Health
Democracy Collaborative
Dismantling Racism Works (dRworks)
DiversityRx
Essential Hospitals Institute
Families USA
Finding Answers - University of Chicago
George Washington University - Center for Health Care Quality
Health Leads
Health & Medicine Policy Research Group's Center for Public Health Equity
Health Resources in Action
Heather Hackman Consulting Group
Highmark Health
Human Impact Partners
Indigenous Reconciliation Group
Institute for Diversity in Health Management (Affiliate of AHA)
Just Health Action out of Seattle
MGH Disparities Solutions Center
Minnesota Doctors for Health Equity
National Center for Healthcare Leadership
National Equity Project
National Fund for Workforce Solutions (CareerSTAT)
Northwestern Medicine - Center for Healthcare Studies
Paradigm
PolicyLink Center for Health Equity and Place
Prevention Institute
Public Health Institute
Race Forward
Race Matters
Racial Equity Institute
Reos Partners
ReThink Health
Southern Jamaica Plain HC - Racial and Social Justice Work
Telligent Community Initiative
The People's Institute for Survival and Beyond

Appendix B: Interview Questions

Introduction (opening comments on phone interviews)

IHI is working on its next wave of R&D. Building off of the white paper on Achieving Health Equity, we are diving deeper into how to help organizations see and dismantle institutional racism. As part of that process, we are looking to see who else is doing this and what tools are available for the public. Whatever we produce will be in the public domain.

Before we place a call, check their website and have familiarity with their work.

Interview Questions

1. What resources do you offer to assist health care organizations to see and address institutional racism (IR)?

2. What do you think are the main elements (i.e., categories, drivers, buckets of work) that will help organizations see and address IR.

3. Have you created any tools to help health care organizations see and address IR? This could be an assessment tool, and/or useful resources or guides to help organizations identify and address specific aspects of the problem.

4. Are you aware of any assessment tools created by other organizations?

5. Who else should we talk to? Who else is doing work in this space?

Appendix C: Notes from Interviews

1. Human resources: Hiring practices, promotional opportunities, mentoring opportunities, pay equity, diversity at all levels of the organization. Expanding networks for recruitment; for medical schools and other health professional schools: admissions practices.
2. Understanding history of racism and discrimination: history of the U.S., of the community in which the health care organization is located, and of the health care institution itself.
3. Understanding the lived experience of people in the community most impacted by inequities, their customs and culture, and partnering with them.
4. Investing in the community through procurement practices, local hiring, etc.
5. Investing the organization's financial assets in community opportunities such as housing (being intentional about investment portfolios)
6. Building partnerships with the community
7. Decisions about where to locate facilities

8. Normalizing discussions about racism
9. Discussion about power/privilege and whose voices are heard
10. Taking what we have learned into practice
11. Data systems: collection and analysis of clinical data using race, ethnicity and language attributes to find disparities
12. Communications: dominant narratives, racialized narratives on which this nation was conceived, which drive attitudes and behavior; you can't address institutional racism by talking about diversity
13. Implicit bias training and cultural competence training.
14. White dominant culture within the organization
15. For policy and procedure development: racial equity impact assessments (existing and future policies and procedures)
16. Use of external consultants to help with facilitating discussions about race and racism
17. Making health equity a strategic priority; important role of leaders
18. What images are displayed in facilities.
19. What insurance is accepted by the health care organizations. And how do they provide access for people without insurance.
20. Building Trust with patients, partners, and the community
21. Actively listen to patients, partners and the community
22. Identifying clinical conditions that have disparities
23. Internal organizational silos between quality and diversity departments.
24. Understanding one's own racial identity development

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