

Structural Racism and Racial Inequities in Health: Summary of Focus Groups Commissioned by the Blue Cross Blue Shield of Massachusetts Foundation

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Meenakshi Verma-Agrawal
Joanna Gattuso
Leigh Haynes
Consultants

I. BACKGROUND: BLUE CROSS BLUE SHIELD OF MASSACHUSETTS FOUNDATION MISSION AND FOCUS AREAS

The mission of the Blue Cross Blue Shield of Massachusetts Foundation (the Foundation) is to improve access to care for people who have low incomes and are vulnerable. It organizes its work into three primary focus areas. From 2014–2020 those focus areas included: care and coverage; behavioral health; and social equity and health. In 2020, the Foundation identified structural racism and racial inequities in health as a new focus area approved by the Foundation Board of Directors.

In adopting this new focus area, the Foundation will incorporate a lens across all of its work demonstrating how individuals and communities that are economically, socially, ethnically, and racially marginalized experience disproportionate barriers accessing quality, affordable health care. These access challenges result from and are compounded by historical and structural racism, preventing people from achieving positive health outcomes and resulting in significant health inequities. Research published nearly twenty years ago as part of the Institute of Medicine’s report, *Unequal Treatment*,¹ demonstrated the impact of racism on health. This report included two important findings related to the Foundation’s work in this focus area: (1) racial bias in clinical care plays a key role in poor health outcomes for individuals and communities of color and (2) this is shaped by the policies and practices of health care systems and the legal and regulatory climate in which they operate. Consequently, the overarching aim of the Foundation’s work in the focus area on structural racism and racial inequities in health is to identify policies, practices, systems and structures within the health and health care sector that must be changed to eliminate racism and health inequities in the Commonwealth.

II. PROJECT GOALS, METHOD, AND APPROACH

To inform future work in this new focus area, the Foundation wanted to understand the challenges and opportunities of individuals and communities of color, immigrants, and other marginalized individuals across the Commonwealth with a particular focus on how racism—in all its forms²—impacts health and access to health care services. Ultimately, a key goal of this project is to use the qualitative information gleaned from these focus groups to generate broad, diverse, and innovative ideas to explore related to structural racism and inequities in health and shape the Foundation’s understanding and exploration of possible solutions to inform its grantmaking and policy/research agenda.

FORMS OF RACISM (as defined by the CDC)

Interpersonal/personally-mediated racism.

Prejudice and discrimination, where prejudice is differential assumptions about the abilities, motives, and intents of others by “race,” and discrimination is differential actions towards others by “race.” These can be either intentional or unintentional.

Systemic/institutionalized/structural racism.

Structures, policies, practices, and norms resulting in differential access to the goods, services, and opportunities of society by “race” (e.g., how major systems—the economy, politics, education, criminal justice, health, etc.—perpetuate unfair advantage).

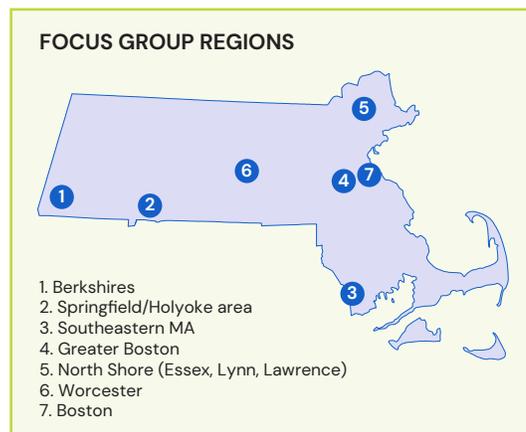
Internalized racism. Acceptance by members of the stigmatized “races” of negative messages about their own abilities and intrinsic worth.

1 Smedley BD, Stith AY, Nelson AR, eds. (2002). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: National Academy Press. Available at <https://www.nap.edu/catalog/12875/unequal-treatment-confronting-racial-and-ethnic-disparities-in-health-care>.

2 Racism can be expressed on three levels including interpersonal/personally-mediated racism, systemic/institutionalized/structural racism, and internalized racism.

A fundamental principle underlying this initiative was a commitment to listening and learning directly from the communities and community members experiencing racism and health inequities. Community organizations understand the experiences of the communities they serve and play a critical role in improving the overall health and well-being of individuals and communities they serve. Given this context, the Foundation sought to include established community-based organizations across the state for support in convening these focus groups.

A total of seven focus groups, organized geographically, were held virtually. At each focus group, a total of eight to ten individuals participated, representing three to four organizations in each region. Focus group participants were selected based on the alignment of their organization's work with the Foundation's mission and focus areas. Organizations represented primarily served people of color and immigrant communities and the representatives who participated could speak from personal experience about the impacts of structural racism on health. To apply an intersectional lens, organizations working at the intersection of health and violence, education, trauma, re-entry/incarceration, youth, seniors, wealth-building, and advocacy were also included. More details on the process used to identify participating organizations can be found in [Appendix A](#) and the organizations that participated in focus groups are listed in [Appendix B](#).



All focus groups were led by a team of consultants including Meenakshi Agarwal-Verma, Leigh Haynes, and Joey Gattuso. Each focus group was recorded and detailed notes were taken by the consultants. Prior to the first focus group, Foundation staff and consultants collaboratively developed a semi-structured interview guide [[Appendix C](#)]. This was revised throughout the course of the project in an effort to ensure key issues and topics of interest to the Foundation—to inform its work in structural racism and racial inequities in health—were the main topics of discussion in the focus groups.

Upon completion of the focus groups, the Consultant team analyzed the recordings and notes from focus group discussions to identify key themes and findings. Key themes and findings based on the conversations and personal experiences that were shared in these focus groups are described in the section that follows.

III. FINDINGS

The main themes that characterized the focus groups can be organized under two main categories of findings, in alignment with two forms of racism highlighted at the outset of this report: racism as a barrier to quality health care services (interpersonal racism) and systemic and structural barriers that perpetuate racism and health inequities (systemic/institutionalized/structural racism). Key themes related to each of these levels of racism are identified and described below.

RACISM AS A BARRIER TO QUALITY HEALTH CARE SERVICES

Racist attitudes and personal biases of providers and staff at health care facilities result in inadequate health care services or poor treatment for people of color and immigrants seeking care.

Participants indicated that they felt biases among health system staff and providers and that serves as a barrier to receiving quality health care. These included biases against people of color and people who don't speak English, which lead to poor treatment upon seeking care. Participants identified these biases among staff at every level, from the attitudes of those answering the phone or opening doors at health care facilities to providers who directly deliver care.

According to the participants, the ability of a patient to advocate for themselves is diminished when a practitioner's implicit bias about a person's race or ethnicity inhibits patients and their families from participating in their own care. These biases result in not only lower quality services but also lack of services. One participant who worked in a health care setting offered her own experience being called in to provide language support for a client, despite her own perception that she does not have the necessary or appropriate language skills, as evidence of a patient receiving lower quality services than they merited because of their inability to advocate otherwise. She commented, "In the last two weeks, I've had multiple situations where...providers [were] calling me with a patient in their office. I don't speak fluent Spanish; I speak some to get by. But because I'm often working with Spanish people one-on-one, I'm a little bit more able to communicate than people speaking academic Spanish. As a stopgap, I was able to help, but it's ridiculous. It would be far better if it was a provider who was a fluent native speaker themselves, but number two, the interpreter line didn't work either."

Participants indicated this is especially common with respect to care for mental health and substance use disorder services (often referred to as behavioral health services). Participants noted providers may not always respond to concerns about the need for behavioral health services and that even when they do, the lack of providers of color and/or with cultural humility makes it very difficult to develop a therapeutic relationship with a provider. Finally, participants noted that as a result of these experiences of racism in their interactions with providers and staff, many people of color and people who are culturally and ethnically marginalized not may not seek health care services at all.

"The general lens of deficiency—that you're wrong, what you're doing is wrong, how you eat is wrong, how you think is wrong, everything you do is wrong—really keeps people [of color?] from even wanting to engage with the health system... People are just not even wanting to engage in a system that already sees them as broken and really needing justification."

"I think that the parents aren't heard when they say 'my child is not bad; my child is going through some stuff.' And when they are given a voice, when the referrals are made for treatment and/or supports, those people who they are referred to do not relate to the experience of the community, of the parent of the child, and rarely do they look like the child that is seeking services..."

It has far-reaching implications as to the development and trajectory of this child going forward...as a result of not receiving adequate mental health services and then parents not receiving the respect and courtesy due when they interact with those in authority [and] in a position to...impact their child's life."

CULTURAL HUMILITY

The National Institutes of Health (NIH) defines cultural humility as "a lifelong process of self-reflection and self-critique whereby the individual not only learns about another's culture, but one starts with an examination of her/his own beliefs and cultural identities."

Approaches to health care that ignore an individual's history and culture as context for their health condition and health history serve as barriers to receiving care.

Participants across several focus groups explained that a lack of cultural understanding perpetuates racism and contributes to inequities in the health system. Participants described the difficulty of “not being heard by doctors” when explaining their health conditions. They also discussed the challenge of overcoming the application of a white, European lens to health care which does not take into account the historical, cultural and migratory context which shapes the health of people in their communities. Participants noted that this extends to other front-line providers such as administrative staff at health care facilities and emergency/crisis responders.

“...it almost feels like in the health care system for immigrants, whether you're educated or not, people feel like they cannot participate in their own health. And it's...maybe unconscious bias from providers [that] they know what's good for you...you almost feel as if they're saying, 'I'm helping you here; I'm doing you a favor. There are some services that maybe you didn't even have in Africa. I know what I'm doing.' And that becomes a problem because for most people in Africa, our perception of health is very different from [in the United States].”

SYSTEMIC AND STRUCTURAL BARRIERS THAT PERPETUATE RACISM AND HEALTH INEQUITIES

The health care system fails to place those in most need at the center, causing unnecessary difficulty in accessing care and worsening health conditions.

Focus group participants overwhelmingly shared the conviction that the health care system as a whole contributes to health inequities in their communities and perpetuates racism. Focus group participants referred, for example, to public health funding allocations as perpetuating racism. One focus group participant stated, “A lot of the structural racism is really based in the actual funding mechanisms that fund healthcare and public health and what's been really disturbing about the recent attention is that there hasn't been willingness necessarily at the state level to change the way those funds are directed...”

Participants also cited the fragmented nature of the health care system, with traditional facilities (such as doctor's offices, community health centers, or hospitals), stand-alone urgent care centers, multiple places to go to fill prescriptions, etc., leading to lack of understanding about what options are available for health care or other services. Lack of person-centered care, and disconnects within the health care system, do not support the needs of those who are marginalized. This contributes to stress as well as health conditions that go untreated; focus group participants noted this was especially true for mental health.

Focus group participants also indicated the challenges that arise due to the health care system being structured with hospitals at the center. In this structure, hospitals are usually the first point of contact for health services. When these hospitals are dissolved or bought by larger corporations (that cut services or close the hospital), communities lose their primary source of health care. Focus group participants stressed that there should be a shift to community-based organizations being the main point of contact with the health care system.

The lack of providers and administrators of color or from diverse backgrounds at all levels results in failure to recognize priority health issues and concerns of communities of color.

A theme above points to the manifestation of interpersonal racism resulting from people not being heard by a provider or having their concerns be dismissed by a provider; another related theme raised was the way

in which structural racism—precluding people of color or immigrants from all levels of administration and leadership—results in health care systems failing to recognize and respond to health care needs of individuals and communities of color. As a result of lack of representation in these positions, health care systems fail to provide quality health care services responsive to the needs of communities of color.

Participants indicated that a lack of people of color at the upper levels of administration in hospitals and other medical establishments, where decisions about what happens on the hospital floor, in clinics, and ultimately in people’s lives and communities, serves as a barrier to quality care in line with people’s needs. Participants felt strongly that providers and administrators should reflect the populations they serve. However, participants were careful to note that only taking steps to ensure that providers of color are hired will not address the problem alone; diversity or cultural humility training should be a part of ongoing training and review.

The complexity of the public and private health insurance systems and their inequities related to cost and coverage perpetuate racism and health inequities.

The health insurance system arose as an important barrier that contributes to structural racism and health inequities among people of color and immigrant populations due to its complexity, cost, and disparities in coverage. Focus group participants noted that members of their communities have had to refuse service because of lack of clarity around coverage and cost; in several examples, it was unclear if their insurance would cover a service, and consequently what it might cost the person seeking services, forcing an individual to forego the care.

They also noted inequities in financial reimbursement, quality of care, and access to services (including wait times, and access only to community health centers rather than doctor offices which they reported are better funded). Moreover, focus group participants noted that the private health insurance system is inaccessible to many. This is a result of systemic racism which has caused diminished opportunities for education and employment, often due to discrimination, leaving people without access to employer-sponsored insurance and unable to afford purchasing private coverage on their own. Programs to address this gap in terms of services and providers covered by commercial insurance versus what services and providers are covered by public insurance programs like MassHealth were viewed as insufficient, allowing many people to fall through the cracks.

“So, if somebody who looks like me is not at the decision making table, then the people who are not familiar with me as a person of color are ignorant of my needs... they don’t live with me, they typically don’t have an experience of me or somebody who looks like me, so whatever is intended or unintended around how this system is designed I am the recipient of it. And I don’t have the power [to change or adjust it] because I’m not at the table as a patient... And so my ability to inform the system is very limited.”

“People are forced to sign a piece of paper saying that they will be responsible for anything that their insurance doesn’t cover. But how does the individual patient know what the insurance will cover?... How’s the person supposed to, while they’re deciding what their medical care will be, also supposed to decide whether they can make a financial decision that they don’t know the price of?... That’s a problem for everyone but that’s a racist policy in my mind, also because of how it in our country affects people disproportionately.”

Lack of funding, resources, and access to programs and services that are key social determinants of health (food, housing, transportation, etc.) continues a cycle of poor health outcomes in communities of color and immigrant communities.

Focus group participants called attention to the disconnect between public health funding and the priorities and needs of communities. Not only is funding misdirected thematically (i.e., not being allocated to the programs or services most needed in the community), it also overlooks community-based programs and organizations, with funding and resources usually directed at larger organizations that can provide a wider range of services which don't necessarily address community needs. Smaller, community organizations struggle to acquire funding and thus struggle to provide services and to retain workers native to the communities they serve.

The health outcomes and health inequities witnessed in these communities, participants remarked, are very much due to lack of access to services critical to the social determinants of health. Focus group participants noted that many health services are not located in or close to where they live. Thus, residents must have their own transportation or rely on public transport to access health care and social services which is not always feasible considering, for example, travel times and ability to take time off work. Where there may be a community clinic in the neighborhood, focus group participants indicated resources at these clinics are strained and do not always have capacity to meet community health needs. Moreover, many community residents are poor or have incomes that fall at or below the poverty line, which underlies many other challenges these communities face, and drives health inequities.

“We have a great Community Health Center, but it just doesn't have the resources or capacity... In the last week, we've had two people we wanted to refer for mental health support...in both cases, there's a couple month waiting list. It's not practical for a lot of people to drive 30 minutes away.”

Inequities in access to information for people of color and immigrants contributes to poor quality care or lack of care.

Having access to information necessary to seek care or social services arose as a barrier to receiving health care services. With regard to language, focus group participants noted that providers and staff often only speak English (in person or on the telephone) and many times interpreters are not available. Focus group participants also explained that documents are usually only in English and Spanish, neglecting the language needs of a large portion of the population.

Beyond language, participants explained that inequities lie in how and where information is available. Information is often only written and requires a written response which is an impossible barrier to overcome for a person who cannot read or write, especially in English. Additionally, the majority of the information and portals for services are online which excludes individuals who do not have internet access.

“Our [health care system] is just not equipped to handle anyone other than a white person who has insurance who knows how to navigate the system. So, you call up any office, there's no one who speaks your language...you have to order a mammogram, ...there's interpreter services but it needs to be requested. You walk into an emergency room and you don't have insurance, you sign away your rights, it's not always in your language. I mean, it's as if nobody has ever had to manage somebody who didn't speak the language and who didn't have insurance, and it's a huge access issue.”

Federal immigration law and policy makes immigrant populations hesitate to access health and social services.

Participants identified federal immigration law and policy as perpetuating health inequities among immigrant populations. Individuals often stay in unsafe—and unhealthy—situations due to fear of involving authorities if the immigration status of an involved party may be a concern. Immigration laws and regulations, such as the “public charge” rule, and enforcement of these tends to have a chilling effect on people’s willingness to use health care services due to the threat of deportation or denial of residency permits.

IV. FOCUS GROUP PARTICIPANT RECOMMENDATIONS

Based on their own experiences in communities, with state and federal agencies, and with funders, participants in focus groups offered recommendations on ways to address systemic and structural racism in health care and combat its detrimental effects in immigrant communities and communities of color. These recommendations include guidance for the types of programs and services that need support in communities, direction for the Foundation’s policy work, and considerations for grantmaking programs and processes.

NEEDED PROGRAMS AND SERVICES

Focus group participants stressed the need for prevention programs to promote physical health and behavior change. Often programming encompasses health education only. However, programs that support overcoming practical barriers (such as being able to afford a gym membership, transportation to doctor appointments, access to healthy food) and prevention should be prioritized. In addition, an effort should be made to bring health services to communities (e.g., health vans, vaccine clinics, etc.).

POLICY AND RESEARCH

With respect to the Foundation’s policy and research agenda, focus group participants overwhelmingly recommended that the Foundation’s work be aimed at health system reform. Reforms should be aimed at leveling the playing field in terms of who has access to health care and work towards eliminating health inequities. Focus group participants suggested the Foundation might support research focused on financial investment in an equitable health care system, policies to identify necessary changes in what health insurance covers, and the system, practice, and policy changes necessary to get more people covered through health insurance (note: several participants voiced support for policy focused on universal health insurance and health care). Participants further recommended policy work and research around improved guidelines and policies as to who qualifies for social services, particularly with the goal of aligning policies across health and social service programs.

Participants recommended policy work focused on ensuring access to programs and services that support the social determinants of health. This included crafting law and policy to prioritize human life and well-being including education, housing, health centers and hospitals, accountability to the public, as well as social, political and economic rights.

Focus group participants also emphasized that efforts should be made to increase the number of people of color and immigrants who work in health care as providers, administrators, and staff. Such efforts might include incentives for people to work in their communities after higher education or training, improved

and equal access to education and careers in social and health services for immigrants and people of color, and support for community-based organizations to pay competitive wages. Together, the above two recommendations could begin to build trust in the health care system and encourage people to seek services they need.

Finally, participants recommended that, in order to inform its policy and research work, the Foundation should gain a deeper understanding of community challenges through visiting communities and speaking to residents to get a glimpse of day-to-day life. The Foundation might also use this understanding to raise awareness about community needs in fora in which these communities do not typically have access.

GRANTMAKING

Participants in focus groups also made clear recommendations for institutional change at the Foundation with respect to grantmaking practices. The goals of these recommendations are to eliminate or change practices or policies which perpetuate structural racism, with the goal of ultimately advancing health equity.

Participants noted that a more equitable funding structure is necessary. They recommended that people of color and immigrants be included in decision making pertaining to allocation of grant dollars and that the Foundation review funding opportunities with people from the community.

Focus group participants also recommended that the grantmaking structure be more accessible to smaller, community-based organizations, led by and serving immigrants and people of color. Suggestions included making the process less laborious, removing the requirement that the grantee have 501(c)(3) status, and promoting collaboration, rather than competition, among organizations, for example through joint proposals. Focus group participants also suggested the Foundation might also allow organizations to reallocate funding if/when organizational needs change due to unforeseen circumstances, like an emergency. Participants perceive that well-resourced organizations without strong ties in the community continue to get funding based on their promise of impact in the community. They should be required to show evidence of progress toward substantial change as opposed to the promise of change.

“Small organizations that have the best relationships with the consumers that need the most support are typically the ones to not get the contracts because there tends to be a funding structure that really wants to go for the mega agency that can provide the one-stop-shop option. And that leaves out those agencies that are on the ground at the front door, have built the relationships. They don’t get those opportunities and that typically is applying to not majority white agencies, but to agencies of color.”

The Foundation should also make a significant and meaningful effort to provide financial support to organizations led by people of color and immigrant communities. This might include incorporating due diligence research about organizational leadership into funding procedures, partnering with community organizations which are usually small and led by community members (themselves people of color or immigrants who reflect the communities they serve), and funding the work already being done in communities that address community-identified priorities.

Participants stressed that ideas and opportunities gleaned during processes, such as the instant data collection through focus groups, should not be co-opted by those outside the community. These ideas and opportunities should be funded and supported as the people who have the ideas also have the passion, understanding, and reputation to get results.

V. CONCLUSION AND NEXT STEPS

The goal of this project for the Foundation was to inform future work focused on structural racism and racial inequities in health. The Foundation sought to understand the challenges and opportunities of individuals and communities of color, immigrants, and other marginalized individuals across the Commonwealth with a particular focus on how racism impacts health and access to health care services. The findings from these focus groups, described above, reinforce that interpersonal and systemic racism persist, perpetuating disproportionate barriers in accessing care for people of color and immigrants as well as health inequities.

In addition, focus group participants provided thoughtful and specific suggestions as to areas and ways in which the Foundation can focus its work to aid in dismantling racism and supporting policies that will begin the process of eliminating inequities. Many of the suggestions raised by focus group participants are in alignment with the Foundation's scope and roles, and some are immediately actionable. For example, in launching its new grant program, *Racial Justice in Health*, the Foundation incorporated suggestions from focus group participants to make the application process less laborious and more accessible to organizations led by people of color and immigrants (e.g., the initial Letter of Interest phase to be screened for moving forward in the grant process was brief, only including four questions of applicants and no additional attachments). At the same time, some of the issues and recommendations surfaced in these discussions (e.g., federal immigration policy) fall outside of the Foundation's focus within the health care system and policy space; nonetheless, these are captured in this summary report to ensure all issues raised in these focus group are elevated and shared so that other organizations may learn from this important initiative.

The findings from this qualitative research endeavor have provided helpful insights to shape the Foundation's policy and research and grantmaking work in its focus area of structural racism and racial inequities in health. Participants shared painful stories and innovative solutions. The Foundation is grateful to participants for their willingness to share their stories, and often relive painful moments, with the goal of advancing policy solutions to these problems. This work has reinforced the importance of hearing directly from marginalized communities to best understand issues and challenges and also the need to involve these communities and individuals in shaping the solutions to address longstanding inequities. The Foundation looks forward to doing so in its work ahead; there is much work to be done to dismantle centuries of structural racism and the health inequities that have resulted.

APPENDIX A. PROCESS FOR FOCUS GROUP PARTICIPATION/ RECRUITMENT

SELECTION OF CONVENING (HOST) ORGANIZATIONS

In an effort to ensure each regional focus group included representation from local organizations with strong community connections and that the diversity of populations within a given community was represented, the Foundation developed a novel process to recruit for focus group participation. First, Foundation staff identified a “host” organization in a particular geographic region based largely on referrals from other organizations or funders. Each host organization chosen was able to demonstrate their knowledge of the community, their strong ties with representative organizations and groups within their community, and track record of working with people of color led organizations. In addition, each host organization was selected based on illustrating a positive reputation, organizational credibility, community trust, and authenticity as well as the ability to identify ways in which the selected participating organizations’ work intersects with health. (Note: the host organization did not need to be a health organization.)

Each host organization was provided a small grant for the following activities: identify 3–4 local organizations with strong community ties and work related to the Foundation’s mission or focus; describe the role of these organizations to understand the community ecosystem and ensure representation within each geographic priority area; and coordinate participation in the focus group.

SELECTION OF FOCUS GROUP PARTICIPANTS

The focus groups conducted for this study were organized by geography and included representation from a host organization as well as representation from four local organizations. Each participating organization was asked to identify 1–2 leaders to participate in the focus group, for an estimated focus group size of 8–10 participants in each session. Each participating organization was provided a stipend for participation in the focus group.

In addition to geography, focus groups were selected based on the alignment of their work with the Foundation’s mission or focus areas (structural racism and health, access, and behavioral health care). Further, particular consideration was given to organizations whose work intersects with the BCBSMA Mission of health care access and coverage, social determinants of health, and/or behavioral health. In order to apply an intersectional lens, the thematic focus expanded to include structural racism related to violence, education, trauma, re-entry/incarceration, youth, seniors, health care, wealth-building, and advocacy.

Participating organizations selected primarily serve BIPOC and immigrant communities, and representatives who participated in the focus groups included people who could speak to health care barriers from personal experience. The participation of organizational leaders in these focus groups demonstrates strong connections to the communities where they work, and a firm understanding of the unique or particular challenges and/or experiences of those individuals impacted by the organization’s work. The vision for the focus groups was to rely on these organizational leaders’ close connections and relationships with communities to elevate voices that might otherwise not be uplifted or considered and to better understand the challenges and solutions for particular populations within communities.

APPENDIX B. PARTICIPATING ORGANIZATIONS

Berkshires

1. Volunteers in Medicine
2. 18 Degrees Family Services for Western MA
3. Berkshire Interfaith Organizing
4. Multicultural BRIDGE
5. ROPE—Rites of Passage + Empowerment

Springfield/Holyoke

1. Public Health Institute of Western MA
2. Martin Luther King Jr. Family Services
3. New North Citizen's Council Stavros
4. Women of Color Health Equity Collective/
The Collective
5. Stavros

Southeastern MA

1. Health Imperatives
2. Cape Verdean Women United
3. Immigrants' Assistance Center
4. Quincy Asian Resources, Inc.
5. YWCA Southeastern Massachusetts

Greater Boston

1. GreenRoots
2. La Colaborativa
3. The Neighborhood Developers
4. CAPIC
5. MGH

North Shore

1. Essex County Community Organization
2. Lynn United for Change
3. Lawrence Community Works
4. Straight Ahead Ministries
5. Cambodian Mutual Assistance Association

Worcester

1. YWCA Central Massachusetts
2. Massachusetts Organization of African
Descendants
3. Southeast Asian Coalition
4. Latino Education Institute
5. Brazilian American Center

Boston

1. Resilience Sisterhood Project
2. Asian Women for Health
3. The Guild
4. Mattapan Food and Fitness
5. New Beginnings Reentry Services

APPENDIX C. FOCUS GROUP SEMI-STRUCTURED INTERVIEW GUIDE

WELCOME SCRIPT:

[READ THE FOLLOWING TEXT ALOUD TO PARTICIPANTS. WHILE READING, THE TECH MONITOR WILL SHARE THEIR SCREEN TO SHOW SLIDES THAT CONTAIN THE TEXT FOR ACCESSIBILITY PURPOSES.]

Hello! Thank you for joining us today. We truly appreciate your time and value your input in this conversation. Each of you are here because you were identified as a strong advocate for health justice in the communities you serve.

My name is [NAME] and I am an independent consultant working with the Blue Cross Blue Shield of Massachusetts Foundation on this project. Myself and my colleagues on the call today, who will introduce themselves in a moment, do not work for the Foundation, but have been hired as third-party facilitators for these focus groups. Please pop in your name and organization to the chat.

[OTHER CONSULTANTS INTRODUCE THEMSELVES. EACH CONSULTANT SHARE THEIR ROLE FOR THE DAY (TECH MONITOR OR NOTE-TAKING)]

If you are not familiar with Blue Cross Blue Shield of Massachusetts Foundation, their mission is to expand access to health care for low-income and vulnerable people in the Commonwealth. The BCBSMA Foundation organizes its work into three main focus areas within this mission: care and coverage; behavioral health care; and structural racism and racial inequities in health. Structural racism and racial inequities in health is a new focus area approved by the Foundation Board of Directors in Spring 2020. The Foundation believes that health care is a racial and social justice issue. We also want to be explicit about what we mean when we say structural racism and be clear that we are interested in learning more about solutions to addressing racism in the health care system and the inequities it causes. [SHOW SLIDES]

The purpose of this focus group today is to engage communities in helping the Foundation identify solutions to change the systems, policies and structures that perpetuate racial inequities in health in Massachusetts. The input that you offer today will help the Foundation understand how they can leverage funds, relationships, and influence to meaningfully participate in eliminating racial inequity in the Commonwealth. As compensation for today's call, your organizations have been offered a \$2,000 stipend from the Foundation. Our host organization, who supported the Foundation with recruitment for this focus group, received a \$4,500 stipend.

Today's Zoom call will be recorded. The recording will not be shared with anyone outside of the team of consultants (Meenakshi, Joanna and Leigh) and will only be used to reference your responses and check against our notes. At the conclusion of this project in July 2021, all recordings will be deleted. If you prefer not to appear on the recording, you have the option to keep your video off and rename yourself with a pseudonym or with your initials. We otherwise request that you please keep your video on (if that is accessible to you) to help increase engagement and participation during the session. We also ask that you remain on mute while you are not speaking to avoid any feedback or background noise. If you have any technical difficulties, you can always send a private chat to [TECH MONITOR] for support.

Please know that your responses today are confidential.

Your responses will be shared with the rest of the Foundation team as a collection of themes, quotations and patterns. When quotations are shared, they will be anonymized. There are no right or wrong answers to our questions. You are not obligated to answer any questions and can always choose to “pass”. Additionally, the chat feature will remain open and you may always add your input there. The chat transcripts will be saved, downloaded and incorporated into our analysis.

As we move through the focus group today, I will be asking a series of questions. For some questions, we may ask for responses from everyone, in which case I will call on participants to answer in the order in which they appear in the Participants List. For other questions, we will ask for volunteers to answer. To volunteer, you may use the “Hand Raise” button (found in the Participants List) to indicate your desire to speak. We will call on you one by one. [PAUSE HERE TO CHECK FOR UNDERSTANDING]

Lastly, we recognize you may be juggling many priorities right now, including childcare, home-schooling or otherwise. If you need to use the restroom, step away from your computer, or take a break for any reason, please do not hesitate to do so on your own accord. Today’s session will last 90 minutes and we will not take a formal break. To indicate to us that you are away from your computer, simply turn off your camera and/or use the “Away” button (found in the Participants List) to show you are not available. When you return, turn your camera back on and unclick the “Away” button. [PAUSE HERE TO CHECK FOR UNDERSTANDING]

What additional questions do you have about today’s focus group?

Now, we will begin. The recording is being started now. [TECH MONITOR BEGINS RECORDING]

FACILITATOR INSTRUCTIONS:

- As we go, the tech monitor will type each question into the Zoom Chat for participant reference.
- Questions should be read in order. Ideally, time should be made for all questions to be asked within the timeframe of the focus group.
- Probing Questions can be asked when the facilitator feels the need to dig deeper or mine for more detailed/specific information. If the probe is answered without asking explicitly, the probe can be skipped.

Group Agreements:

Before we ask our first question, there are a few ground rules I’d like us to follow today.

1. We have limited time together and want to hear from everybody. To ensure this, we encourage folks to keep their responses concise and to be conscious of the space they are taking. There may be moments when the facilitators intentionally offer space to those who haven’t yet spoken.
2. Please allow others to complete their thoughts before joining the conversation. If many people want to speak at once, the facilitators will call on folks in the order they raise their hand.
 - a. In the interest of time, the facilitators may move on from a question before you’ve had the opportunity to share your thoughts. Please type your contribution into the chat if this happens.

Interview Questions:

- I. For our first question, we will simply ask you to introduce yourself. In the interest of being explicit about the identities and experiences we bring to the table today, we will ask you to share your *name*, *gender pronouns*, *race/ethnicity* and *role*. I will read off names one by one to call on you to share.

For our next question, we're going to use the chat feature only.

- II. In the chat, please tell us what are two words you would use to describe what you love about your community? We encourage you to think of community broadly, not just as your geographic community, but your neighbors, your neighborhood, people of your ethnicity or heritage, people with whom you live, work, school, play/socialize.
 - a. PROBE: What makes your community strong and resilient?
 - b. PROBE: How does your work (or your organization's work) contribute to helping your community thrive?

There is a great deal of evidence that racial inequities in health exist. Structural racism is a major factor in driving these inequities. We want to know more about the ways in which racism impacts the health care system and the experience individuals have when seeking care.

- III. In your experience, are there particular practices, policies or structures in the health care system that perpetuate racism and inequities in health in your community?
 - a. PROBE: In your experience, has racism been a barrier to receiving quality health care services that are responsive to the needs in your community? If so, what does that look like?

For this next question, we are going to try something a bit different. I'd like to ask that we take a moment to close your eyes or gaze softly forward. You can turn off your camera for a few moments if you like, as you listen to my voice. I'd like you to imagine what the health care system looks like some time in the near future, in your lifetime. In this near future, people trust the health care system and feel it treats them holistically, respectfully, and in alignment with their cultural and ethnic identities. Racism is no longer a determinant of someone's health status or access to quality care. The health care system works for all people.

- IV. Using the chat, tell us a few words about what you see in this vision.

Now, think about what has to change now in order to make this future a reality.

- V. What do you see as the role of an organization such as the BCBSMA Foundation in supporting this change? As a reminder, the Foundation seeks to support system change through both its grantmaking activities *and* its policy and research work.
 - a. PROBE: Are there existing programs, services or initiatives that are already making the type of change you wish to see. What can the Foundation learn from their efforts?
- VI. What other suggestions or ideas do you have for how the Foundation can leverage funds, relationships and influence to address racial inequities in health in Massachusetts?
 - a. PROBE: What other organizations or individuals should we be speaking with?

PROBE: Any last thoughts you'd like to share?



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