Health Equity Action Plan Toolkit

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MASSACHUSETTS FOUNDATION

manatt

Bryant Torres
Elizabeth Lazarus
Manatt Health

ABOUT BLUE CROSS BLUE SHIELD OF MASSACHUSETTS FOUNDATION

The mission of the Blue Cross Blue Shield of Massachusetts Foundation (the Foundation) is to ensure equitable access to health care for all those in the Commonwealth who are economically, racially, culturally, or socially marginalized. The Foundation was founded in 2001 with an initial endowment from Blue Cross Blue Shield of Massachusetts. It operates separately from the company and is governed by its own Board of Directors.

ABOUT MANATT HEALTH

Manatt Health integrates legal and consulting expertise to better serve the complex needs of clients across the health care system. Combining legal excellence, first-hand experience in shaping public policy, sophisticated strategy insight, and deep analytic capabilities, Manatt provides uniquely valuable professional services to the full range of health industry players. Manatt's diverse team of more than 160 attorneys and consultants from Manatt, Phelps & Phillips, LLP, and its consulting subsidiary, Manatt Health Strategies, LLC, is passionate about helping its clients advance their business interests, fulfill their missions, and lead health care into the future.

Design: Madolyn Allison

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The Blue Cross Blue Shield of Massachusetts Foundation (the Foundation) recognizes that structural racism is a public health issue and that access to affordable, quality health care is a racial and social justice issue.

In 2021, the Foundation published a primer on health disparities in Massachusetts to serve as a foundational resource to broaden collective understanding of racial and ethnic health inequities and disparities in the Commonwealth. The primer showed that while disparities in health outcomes across racial and ethnic groups are often narrower in the Commonwealth than they are in the nation, clear disparities persist.

The Foundation engaged Manatt Health to develop a vision and proposed plan for action—collectively a Health Equity Action Plan—for achieving a racially and ethnically equitable health care delivery system in Massachusetts. To inform the development of the Health Equity Action Plan, Manatt facilitated two focus groups in the spring of 2023 and conducted a state and national landscape scan between February 2023 through April 2023 of over 100 research articles, reports, and organizational policies/practices to identify best practices and examples for operationalizing and achieving such a system. The landscape scan also includes examples identified through stakeholder interviews conducted by Manatt in the summer/fall of 2023 with close to 40 stakeholders representing diverse perspectives on Massachusetts' health care delivery system and the national health equity landscape.

The landscape scan, interviews, and consumer focus groups reinforced our understanding that the health care delivery system alone can only go so far. Long-lasting, systemic change requires action from all of government (across agencies and areas of focus), health care providers, health plans, the social service sectors, philanthropy, and other stakeholders. The focus of this work is on ***racial and ethnic*** inequities in the ***health care delivery system*** and therefore can be considered a first phase in a larger system-wide effort to eliminate all inequities that affect people's health.

This Health Equity Action Plan Toolkit (Toolkit) includes an illustrative set of interventions, policies, and programs identified through the landscape scan and interviews that providers, health care delivery system leaders, and other implementation stakeholders can deploy to help achieve a racially and ethnically equitable system in Massachusetts.

HEALTH EQUITY ACTION PLAN FRAMEWORK

The Toolkit is organized around the Foundation's Health Equity Action Plan Framework. The framework includes six essential components of a racially and ethnically equitable health care delivery system that if attained, can help achieve the vision of all people in Massachusetts experiencing high-quality, accessible, and timely care from providers who understand and respect their culture.

KEY TERMS

There is not a standardized set of health equity terminology. This is a persistent barrier to understanding, effectively communicating about, and developing solutions to address racial and ethnic inequities and disparities in health. This Toolkit uses the following definitions:

- **Health equity**[1] is the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally, with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.
- **Health disparity**[2] is a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.
- **Health care delivery system** refers to the network of institutions, providers, resources, and processes that enable the delivery of health care services; this includes things like doctor's offices, health centers, emergency rooms, hospitals, and behavioral health (including mental health and substance use disorder treatment).
- **Racism**[3] is a system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call "race") that unfairly disadvantages some people and communities, unfairly advantages other people and communities, and undermines realization of the full potential of our whole society through the waste of human resources. Racism can be expressed on three levels:
  - **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.
- **Structural inequities/inequalities**[4] are disparities in wealth, resources, and other outcomes that result from discriminatory practices of institutions such as legal, educational, business, government, and health care systems.

BARRIERS TO HEALTH EQUITY

WHAT ARE THE BARRIERS TO HEALTH EQUITY?

The root causes of health inequities among racial and ethnic minority groups are multifactorial, complex, and persistent. Barriers to achieving health equity include:

STRUCTURAL/SYSTEMIC/INSTITUTIONAL RACISM AND DISCRIMINATION

American society and its systems for supporting the public good have often been designed or evolved to tilt in favor of those historically in power, including White men and their families, people who are affluent, and others favored by social and cultural norms.[5]

LACK OF ACCESS TO CARE/SERVICES DELIVERED WITH CULTURAL COMPETENCY AND HUMILITY

Limited access to health care, including insurance coverage, financial barriers, availability of culturally competent providers, geography, transportation, health literacy, and language barriers, prevent people from receiving the care they need and achieving optimal health.[6]

POVERTY AND UNMET SOCIAL NEEDS

Many of the social factors that contribute to poor health—such as poverty, housing instability, and food insecurity—are the result of structural/systemic racism and economic policies that have historically marginalized communities of color and prevented opportunities for wealth creation.[7]

MISTRUST OF THE SYSTEM

The medical establishment has a long history of mistreating people of color (e.g., unethical research practices, medical procedures without consent/knowledge, discrimination, disregard for patient/parental rights, and lack of culturally relevant care). This history has resulted in a deep mistrust of the health care delivery system, prevents people from getting care, and ultimately reinforces disparities in health outcomes.[8]

WHAT TYPES OF DISPARITIES EXIST IN MASSACHUSETTS?

The Foundation's 2021 primer on health disparities in Massachusetts catalogued the racial and ethnic inequities in health that persist across the Commonwealth:

UNMET SOCIAL NEEDS

People of color in Massachusetts are more likely to have one or more unmet social need(s) than are White people.

For example, Black and Hispanic people in Massachusetts are more likely than White people to:[9]

- Have **incomes below 138% of the federal poverty level**
- Be **food insecure**
- Live in **rented units** (as opposed to owner-occupied units)

Hispanic people are four times more likely than White people and two times more likely than Black people **to have less than a high school diploma**. Black and Hispanic people are **less likely** than their White counterparts **to have received a bachelor's degree or higher**.

ACCESS TO CARE

Black and Hispanic people in Massachusetts face more barriers to accessing care as compared to White people. For example, Black and Hispanic people in Massachusetts are:[10]

- **Two times more likely to be uninsured** than White people
- **More likely to experience disruptions** in care
- **More frequently told a doctor/clinic doesn't accept their insurance**
- **Experience greater unmet need for vision care**

Hispanic people are two times more likely to lack a usual source of care, and experience higher levels of unmet need as a result of cost, as compared to other groups.

EXPERIENCE OF CARE

People of color are **more likely to experience barriers and discrimination** while seeking care, which leads to **adverse health outcomes**.[11]

Black and Hispanic people in Massachusetts often confront a **workforce that does not reflect their racial, ethnic, and cultural background or experience**.[12]

People with **limited English proficiency (LEP) often experience worse quality** of care than those who speak English "well" (e.g., lower satisfaction with care and a higher incidence of medical errors).

HEALTH OUTCOMES

Racial and ethnic disparities in health outcomes persist for people of color, particularly Black and Hispanic people. For example, these racial groups:[13,14]

- Have **higher rates of chronic conditions** (e.g., diabetes and asthma)
- Are **less likely to report "excellent or very good" health**
- Have **higher infant mortality rates** (including American Indian and Alaskan Native populations)
- Have **higher rates of "fair or poor" mental health** (self-reported)
- Are **more likely to be diagnosed with or die from HIV** than White people
- Are **more likely to visit the emergency department** for non-emergency conditions[15]

HEALTH EQUITY ACTION PLAN TOOLKIT

SUMMARY OF BEST PRACTICES FOR A RACIALLY AND ETHNICALLY EQUITABLE HEALTH CARE DELIVERY SYSTEM

Best practices are organized around the Foundation's Health Equity Action Plan Framework. The Framework includes six, equally weighted, essential components of a racially and ethnically equitable health care delivery system that, if attained, can help achieve the vision of all people in Massachusetts experiencing high-quality, accessible, and timely care from providers who understand and respect their culture.

BEST PRACTICES

COMMUNITY POWER MOBILIZED	ACCESSIBLE AND AFFORDABLE CARE THAT IS EASY TO NAVIGATE	DIVERSE AND HEALTHY WORKFORCE AT EVERY LEVEL OF HEALTH CARE DELIVERY ORGANIZATIONS	DATA-INFORMED ACTIONS TO ADDRESS HEALTH DISPARITIES	COMMUNITY INVESTMENTS THAT ELIMINATE STRUCTURAL INEQUITIES	ABSENCE OF RACISM AND BIAS IN CLINICAL TRAINING AND CARE DELIVERY
1.1 Prioritize power sharing and decision making with communities/ consumers	2.1 Bring sites of care to the community	3.1 Establish a culture of equity	4.1 Refine data collection, analysis, and infrastructure	5.1 Implement strategies to uplift community conditions and build trust between the health care delivery system and the communities served	6.1 Eliminate bias in care delivery and treatment models
1.2 Root work in co-design principles	2.2 Design equitable telehealth strategies/ programs	3.2 Diversify boards and leadership teams	4.2 Integrate health equity into quality improvement strategies	5.2 Partner with community-based organizations (CBO) and build their capacities	6.2 Assess/eliminate race-based adjustments in clinical algorithms
	2.3 Invest in primary care	3.3 Improve and measure progress on diversity/equity-related recruitment efforts	4.3 Measure progress on equity initiatives		
	2.4 Improve access to behavioral health care	3.4 Enhance retention efforts and leadership development programs			
	2.5 Screen people for unmet social needs and connect them to resources	3.5 Increase the health care workforce minimum wage			
	2.6 Diversify participation in clinical trials	3.6 Invest in the behavioral health and LTSS non-clinical workforce			
	2.7 Improve access to and quality of long-term services and supports (LTSS)				

COMMUNITY POWER MOBILIZED

BEST PRACTICE #1

Health care delivery system leaders and other stakeholders can mobilize community power by:

1.1 Prioritizing power sharing and decision making with communities/consumers, and

1.2 Rooting work in co-design principles.

BEST PRACTICE 1.1

Health care delivery system leaders and other stakeholders can mobilize community power by **prioritizing power sharing and decision making with communities/consumers served**.

Evidence shows that putting more power in the hands of more people, including those most impacted by structural inequities, results in systemic changes in the ways people make decisions that benefit all.[16] Rather than simply seeking feedback or hosting one-way conversations, those who have traditionally held power in health care (government agencies, providers, health plans) should listen to and learn from communities, partnering with them in ways that build their capacity and power to gain greater control over the factors that affect their lives.

	EXAMPLES		
HOW TO OPERATIONALIZE THE BEST PRACTICE	**ORGANIZATION**	**APPROACH**	**RESULTS/IMPACT**
Acknowledge and be guided by community needs, priorities, and voices. **Identify and create opportunities for communities to contribute.** **Join a table that the community creates.** **Help communities do the case-making for issues they face.** **Community-based participatory research.**	Cincinnati Children's	When developing its 2015 strategic plan, Cincinnati Children's Hospital Medical Center met with community contributors over several months of listening and building trust. Parents from the communities with the poorest child health outcomes talked about what their hopes were for their children and the barriers that dimmed them.[17]	• Cincinnati Children's broadened its vision to address social drivers of health and the greatest areas of need within the community, launching the All Children Thrive collaborative in partnership with 100 community groups, which helped decrease hospitalizations by 20%, inpatient bed days by 18%, and increase third grade reading level by 30% in certain areas of the state.
	KANSAS CITY / CCO	Recognizing that the Kansas City, Missouri, Health Department community engagement efforts were siloed and traditional, the Department executed a memorandum of understanding with Communities Creating Opportunity (CCO), a largely faith-based community organizing group. With over 100 faith-based leaders and their respective congregations as members, CCO had the ability to take the pulse of the community, develop local leaders, and mobilize them around key issues.[18]	• Social justice and health equity are now part of daily conversation for the Department. • Numerous policy wins of short-term and long-term target measures. • Improvements in the social determinants of health in Kansas City.

BEST PRACTICE 1.1

Health care delivery system leaders and other stakeholders can mobilize community power by **prioritizing power sharing and decision making with communities/consumers served**.

HOW TO OPERATIONALIZE THE BEST PRACTICE	EXAMPLES: ORGANIZATION	APPROACH	RESULTS/IMPACT
Acknowledge and be guided by community needs, priorities, and voices.	Boston Medical Center	Boston Medical Center created the Health Equity Accelerator program to expedite the timeline between discovering inequities and implementing actions to address them. As part of this, Boston Medical Center created the "patient engagement manager" and "Vice President of Community Engagement and External Affairs" positions to establish collaborative relationships and trust with community members and community-based organizations (CBOs) which inform the design and implementation of interventions aimed to reduce health disparities.[19]	• Increased trust with consumers and community members. • Consumer driven solutions via focus groups, interviews, and 1:1 calls.
	CHA Cambridge Health Alliance	Cambridge Health Alliance developed a Health Improvement Team (HIT) that works together with health care providers, residents, CBOs and city leaders to assess health status, determine priorities, and build action plans to address health issues impacting the community.[20]	• Team is identifying social and environmental factors that influence health and working to build equitable programs, policies, and systems that support every person to reach their best health.
Prioritize power building over the long term.[21,22] Funding entities (e.g., philanthropic entities and well-resourced delivery system institutions) are well positioned to support power building and sharing in collaboration with providers, government, and other stakeholders. Health care delivery system leaders and other stakeholders prioritize power-sharing with communities served over the course of long-term initiatives.	The California Endowment	Building Healthy Communities (BHC) was an innovative, 10-year, 14-community initiative of The California Endowment (TCE) to achieve more equitable health outcomes in California. Partners focused their organizing and advocacy on policy and systems change, rather than program development and implementation, and proactively deployed communication and narrative change strategies.[23]	Outcomes from this initiative include: • A new health equity dialogue in California. • A richer understanding of power-building that starts with community organizing and builds connections to other sources of influence. • Policy "game changers" that affected millions of lives, often achieved through a cumulative capacity-building approach to systems change. • The beginning of a new ecosystem approach to realizing health equity.

BEST PRACTICE 1.2

Health care delivery system leaders and other stakeholders can mobilize community power by **rooting work in co-design principles**. Co-design is designing with, not for. It is a process focused on learning and developing solutions together.

	EXAMPLE		
HOW TO OPERATIONALIZE THE BEST PRACTICE	**ORGANIZATION**	**APPROACH**	**RESULTS/IMPACT**
Co-design. The four principles of co-design are:[24] • **Share power.** When differences in power are unacknowledged and unaddressed, people with the most power have the most influence over decisions. To change that, we must share power in research, decision making design, delivery, and evaluation. • **Prioritize relationships.** Co-design isn't possible without relationships, social connection, and trust among co-designers, funders, and organizers of co-design. • **Use participatory means.** Co-design provides many ways for people to take part and express themselves through visual, kinesthetic, and oral approaches. • **Build capability.** Many people require support and encouragement to adopt new ways of being and doing, learning from others and having their voices heard.	FORESIGHT Designing a Future for Health	FORESIGHT[25] is a nationwide initiative of 17 philanthropic partners led by The Rippel Foundation, created in partnership with the Blue Shield of California Foundation and focused on developing a vision for a new, more equitable future for health and well-being. From 2018–2021, FORESIGHT engaged community members, professionals, and sector leaders from a wide variety of backgrounds to jointly develop a vision for an equitable future and identified the below as key steps in the process:[26] 1. **Design, approach, and process**—e.g., identify core values, make space for learning/imperfection, comfort with uncertainty, share power and let go control of the process, co-create shared norms, build trust, remain accountable 2. **Working equitably with community**—e.g., build relationship with intent and continue to invest, listen before speaking, be brave/vulnerable/generative, interact with humility/empathy, include the broadest set of voices 3. **Resources and skills**—e.g., include diversity of expertise and cross/sector thinkers, have dedicated staff/capacity/financial resources, use facilitators who reflect people engaged	• Nearly 8,000 Americans looked at trends and emerging issues on the horizon and shared a vision for the future grounded in equity, justice, and care for the planet. • Over 1,000 people proposed action steps towards achieving the vision.

ACCESSIBLE AND AFFORDABLE CARE THAT IS EASY TO NAVIGATE

BEST PRACTICE #2

Health care delivery system leaders and other stakeholders can make care more accessible, affordable, and easy to navigate by:

- 2.1 Bringing sites of care to the community,
- 2.2 Designing equitable telehealth strategies/programs,
- 2.3 Investing in primary care,
- 2.4 Improving access to behavioral health care,
- 2.5 Screening people for unmet social needs and connecting them to resources,
- 2.6 Diversifying participation in clinical trials, and
- 2.7 Improving access to and quality of LTSS.

BEST PRACTICE 2.1

Health care delivery system leaders and other stakeholders can make care more accessible, affordable, and easy to navigate by **bringing sites of care to the community**.

To advance health equity, the health care delivery system must work to address the access barriers that prevent communities of color from receiving the care they need. Health insurance coverage and affordability are foundational to ensuring individuals have access to care. However, even when coverage is not an issue, barriers persist, including insufficient availability and distribution of providers.[27]

	EXAMPLES		
HOW TO OPERATIONALIZE THE BEST PRACTICE	**ORGANIZATION**	**APPROACH**	**RESULTS/IMPACT**
Use equitable development/expansion strategies. Provider networks and hospital systems often build facilities in more affluent areas to seek market share and a favorable payer mix. By building in less affluent areas of the community and ensuring the facilities are accessible by public transportation, these organizations can better serve underserved populations. Provider systems should bring an equity lens to expansion strategies that inadvertently reinforce health inequities and implement deliberate strategies to promote greater access to care for under-resourced communities.[28]	Church Health Making Quality Health Care Accessible	Church Health Center in Memphis, Tennessee, relocated its entire health care facility to a long-vacant 150,000-square-foot retail building in the city, to better serve the community.[29]	New state-of-the-art location providing greater access to the community; includes[30] • Free parking, and • 70% increase in "wellness spaces," e.g., YMCA that includes community programs and nutrition hub.
Leverage clinical-community partnerships. Programs that leverage clinical-community partnerships can greatly impact underserved communities by delivery of preventive-focused evidence-based programs.[31]	CDC NATIONAL DIABETES PREVENTION PROGRAM	Many studies have shown that largely due to social determinants of health (SDOH), diabetes impacts racial and ethnic minority and low-income adult populations disproportionately. The Centers for Disease Control and Prevention (CDC) National Diabetes Prevention Program partners with community organizations (e.g., barber shops and churches) to screen for diabetes and lifestyle factors.[32]	Various studies show the return on investment and improvements in health for this program, including[33] • Savings of $278 per member/quarter for Medicare fee-for-service population and a decrease of nine inpatient stays and nine emergency department visits per 1,000 members.

BEST PRACTICE 2.1

Health care delivery system leaders and other stakeholders can make care more accessible, affordable, and easy to navigate by **bringing sites of care to the community**.

	EXAMPLES		
HOW TO OPERATIONALIZE THE BEST PRACTICE	**ORGANIZATION**	**APPROACH**	**RESULTS/IMPACT**
Leverage the Community-Based Workforce. **Community health workers (CHWs) and Peer Support Specialists** are supported by decades of research.[34] Individuals in these positions have existing social networks and cultural competencies that enable them to build trusted relationships with consumers and connect them to needed services. Providers should seek to incorporate these positions into their offices/ operations.	HENRY FORD HEALTH	The Henry Ford Health System-led a multisector collaborative effort on reducing infant mortality, the Women-Inspired Neighborhood (WIN) Network: Detroit brings care to the community by using CHWs, who offer mentoring, make home visits, help women with education and life planning, and connect them to community resources to address the social determinants of health.[35]	An analysis of 288 births since 2016 showed:[36] • 93% full-term births, compared to 85.4% of all Detroit births in 2019, • 6% of the births were low birthweight, compared to 14.9% of all Detroit births in 2019, and • 96% of all mothers initiated breastfeeding.
Mobile Clinics have also been a successful tool in creating access to care for vulnerable populations and building trust in the community. One study found that people screened for high blood pressure via mobile clinics showed better numbers in follow-up visits, reducing their risk of heart attack and stroke.[37]	THE FAMILY VAN Wellness Within Reach™	Harvard Medical School's Family Van reduces health disparities in Boston by bringing curbside screenings, health coaching, and referrals for health and social services to people in their communities.[38]	• 93% of clients served are people of color.[39] • Delivered preventive health screenings and health education. • Reduced unnecessary emergency department visits, totaling an estimated $2.8M in savings over five years.[40]
	Mobile Health Map	Harvard Medical School also runs Mobile Health Map, which aggregates data on mobile clinics across the country.[41]	Data from 1,139 clinics shows that in a given year there is:[42] • $22 return for every $1 investment, and • 3,133 life years saved.

BEST PRACTICE 2.2

Health care delivery system leaders and other stakeholders can make care more accessible, affordable, and easy to navigate by **designing equitable telehealth strategies/programs**.

The COVID-19 pandemic showed how telehealth can be used to address in-person access barriers and while there are clear benefits to telehealth such as cost-effectiveness and convenience, this modality has the potential to exacerbate inequities among people in underserved communities. For many in Massachusetts, as is the case across the country, lack of broadband access, phones with adequate data plans, and digital literacy are barriers to receiving care via telehealth. While many of these challenges require policy solutions and investment beyond the health care delivery system, the delivery system can take many steps to embed equity into its telehealth strategies/programs.[43]

Best practices for designing equitable telehealth strategies in the health care delivery system include:[44]

- Use inclusive intake forms that ask about access to technology and consumer preferences.
- Call people ahead of telehealth visits to confirm they are able to attend and are comfortable with and have access to the necessary technology.
- When possible, provide an option to have the visit by phone (landline or cell phone) if needed instead of videoconferencing.
- Encourage staff to learn how to broaden telehealth access. Consider sending internal news and progress related to accessibility.
- Look for skills and experiences within your team, including connections to the local community and fluency in languages other than English.
- If the telehealth platform provides built-in privacy and security, identify free internet hotspots (such as libraries, parks, and community centers) and give this information to people before their telehealth visit. Make sure to take the necessary steps to protect peoples' health information.

BEST PRACTICE 2.2

Health care delivery system leaders and other stakeholders can make care more accessible, affordable, and easy to navigate by **designing equitable telehealth strategies/programs**.

	EXAMPLES		
HOW TO OPERATIONALIZE THE BEST PRACTICE	**ORGANIZATION**	**APPROACH**	**RESULTS/IMPACT**
Include accessibility options within telehealth programs. **Allow extra time in virtual visit appointments.** **Look for skills and experiences within existing team.**	Boston Medical Center	Boston Medical Center provided blood pressure cuffs and a QR code to mothers who had recently given birth and were at risk for hypertension. The new mothers monitored their blood pressure remotely each day for six weeks. The program provided instructions on using the cuff and submitting blood pressure scores to the web portal in simple terms and three languages. The team ensured that features were simple and required little data, in the event data plans of new mothers were limited, or their cell phones didn't support videoconferencing. The organization provided web portal support by high-risk obstetric nurses who could triage and provide technical troubleshooting.[45]	• Significant decrease in readmission rates for postpartum mothers with high blood pressure.
	Nemours Children's Health	During the pandemic, the health system offered staff as digital health navigators who helped people/families with various technology challenges like completing online forms, troubleshooting connectivity issues, and accessing telehealth visits.[46]	• Redeployed staff and equipped them with new skills. • Patients/families reported smoother experiences and satisfaction.
	Community Care Cooperative	Community Care Cooperative (C3), a nonprofit accountable care organization governed by Federally Qualified Health Centers (FQHC) in Massachusetts, addressed telehealth access by launching a Telehealth Navigator Program to support their member FQHCs. For participating FQHCs, telehealth navigators helped to identify and address patients' digital access needs. Additionally, some member FQHCs analyzed telehealth utilization data by race, ethnicity, and language to identify inequities in telehealth access and inform the navigators' role.[47]	• Increased telehealth utilization. • Targeted efforts to address racial/ethnic disparities in telehealth usage.

BEST PRACTICE 2.3

Health care delivery system leaders and other stakeholders can make care more accessible, affordable, and easy to navigate by **investing in primary care**.

- For populations experiencing health inequities, high-quality primary care can offer a usual source of care and provide access to needed services like chronic disease management, vaccinations, and preventive services and screenings. Primary care has been shown to increase life expectancy and can have an impact on lifelong health.[48,49] These benefits are particularly important for the elderly and economically marginalized groups who experience the highest burdens from preventable illness, chronic disease, and negative outcomes associated with unmanaged, uncontrolled disease. In prenatal and early childhood care, primary care providers can seek to identify children who are at risk for developmental delays, and physical/social needs early in life and connect them with the needed supports and services.
- Primary care is well positioned to identify and help address social needs. One study of primary care practices found improvements in blood pressure and cholesterol levels for individuals who received referrals to community-based resources that addressed common unmet needs like food, transportation, and housing.[50,51] (See section on screening for unmet social needs on page 22.)
- Monitoring of primary care spending rates across commercial and publicly funded health care is gaining traction in the United States and can help identify areas that need strengthening (e.g., workforce, access).[52] In 2023, the Massachusetts Center for Health Information and Analysis (CHIA) in collaboration with Massachusetts Health Quality Partners published the first-ever dashboard of metrics to monitor the health of the primary care system in the Commonwealth.[53]

BEST PRACTICE 2.3

Health care delivery system leaders and other stakeholders can make care more accessible, affordable, and easy to navigate by **investing in primary care**.

	EXAMPLES		
HOW TO OPERATIONALIZE THE BEST PRACTICE	**ORGANIZATION**	**APPROACH**	**RESULTS/IMPACT**
Integrate primary and behavioral health care. Integration can take many forms. As a starting point, primary care practices can implement mental health screenings. One study found that in a large health system, implementation of universal depression screenings in primary care practices was associated with a substantial increase in screening rates among groups at risk for undertreatment of depression and reduction in disparities for screenings across racial/ethnic groups.[54,55] Furthermore, embedding care for more common mental health problems like depression and anxiety into primary care helps address many of the barriers in access to mental health care experienced by Black and Hispanic individuals, including stigma around mental health care, mistrust, location, and transportation.[56]	AIMS CENTER Advancing Integrated Mental Health Solutions	The Collaborative Care Model, developed at the University of Washington AIMS Center, is an evidence-based health intervention that is often used in primary care and has been shown to improve health outcomes for people with depression.[57] It is a team-based approach where a primary care provider collaborates with a care manager and mental health practitioner to proactively manage a person's mental health.	• A randomized trial of individuals with depression under the care of a primary care physician showed the collaborative care model can reduce disparities of mental-health–related quality of life,[58] including for pregnant people.[59]
	Boston Children's Hospital	The Behavioral Health Integration Program (BHIP) is a collaboration between the Department of Psychiatry and Behavioral Sciences at Boston Children's Hospital and the Pediatric Physicians' Organization at Children's. The program enables primary care practices to receive education and consultation, operational support for behavioral health integration, and on-site clinical behavioral health services.[60]	• A study exploring the five-year outcomes of BHIP's model suggest that integrating behavioral health in the pediatric setting increased the proportion of total behavioral health visits delivered within BHIP practices from 35.8% (2013) to 41.6% (2015–2017).[61] • More than 90% of surveyed primary care physicians and behavioral health clinicians believed that BHIP participation enables effective management of mild and moderate behavioral health problems in pediatric primary care.[62]

BEST PRACTICE 2.3

Health care delivery system leaders and other stakeholders can make care more accessible, affordable, and easy to navigate by **investing in primary care**.

	EXAMPLE		
HOW TO OPERATIONALIZE THE BEST PRACTICE	**ORGANIZATION**	**APPROACH**	**RESULTS/IMPACT**
Prioritize robust care coordination/ management. Primary care practices play an important role in coordinating care across all elements of the delivery system, including specialty care, hospitals, home health care, and community services and supports. More coordinated primary care is associated with reduced racial and ethnic disparities in preventable emergency department visits and improved blood pressure control.[63,64]	Hennepin Health	Hennepin Health is a county-based safety-net Accountable Care Organization (ACO) in Minneapolis, Minnesota, involving four organizations: a public health department; a public hospital and safety net medical system; a FQHC; and a health maintenance organization that serves Medicare and Medicaid enrollees.[65] The ACO's care model is anchored in patient-centered medical homes and a multidisciplinary care coordination team, including care coordinators and CHWs. Care teams function across the continuum of care—primary care, specialty clinics, emergency departments, and community settings.	• Reductions in system costs, emergency department visits, and hospital visits. • Increases in primary care utilization. • Improved consumer satisfaction and health outcomes.

BEST PRACTICE 2.4

Health care delivery system leaders and other stakeholders can make care more accessible, affordable, and easy to navigate by **improving access to behavioral health care**.

People of color are more likely to require behavioral health services and less likely to access them—and more likely to have poor clinical outcomes.[66] Research shows that Black, Indigenous, and People of Color (BIPOC) receive lower-quality mental health care, which in turn may drive them to leave treatment prematurely.[67] There are also documented disparities in behavioral health diagnoses by race and ethnicity, with clinicians being more likely to misdiagnose BIPOC and refer them to inappropriate treatments.[68] A lack of culturally sensitive screening tools that detect mental illness, coupled with structural barriers may contribute to underdiagnosis of mental illness among people of color. Moreover, symptoms of mental illness or substance use disorder among people of color are more likely to be labeled as disruptive or criminal compared to their White counterparts.[69]

	EXAMPLES		
HOW TO OPERATIONALIZE THE BEST PRACTICE	**ORGANIZATION**	**APPROACH**	**RESULTS/IMPACT**
Increase behavioral health screenings.	First responders in various states	Many states, including South Carolina, South Dakota, Montana, and Oklahoma, have expanded behavioral health assessment capacity by supplying computer tablets to first responders (law enforcement or emergency medical services), allowing them to connect directly with behavioral health clinicians.	• Supports rural communities in accessing behavioral health supports, reducing unnecessary hospital transports and allowing for direct consultation with psychiatrists.
Implement behavioral health response teams.	B HEARD	The Behavioral Health Emergency Assistance Response Division (B-HEARD) is a New York City pilot program that dispatches alternative care workers instead of police for nonviolent emergency situations. B-HEARD teams consist of emergency medical technicians (EMT)/paramedics and social workers from NYC Health + Hospitals Health System. The goals of this pilot are to redirect emergency mental health calls to B-HEARD response teams when appropriate and increase connection to community-based care, reduce unnecessary transports to hospitals, and lessen unnecessary use of police resources.[70]	In the first year of implementation, B-HEARD response efforts have resulted in: • Fewer unnecessary hospitalizations: 54% of people assisted by B-HEARD were transported to a hospital, compared to 87% through traditional response processes. • Increased community-based care: 36% of people served by B-HEARD received community-based or social service care. • Quick assistance to individuals in need of behavioral health support: B-HEARD's average response time is under 16 minutes, aligned with traditional response efforts.

BEST PRACTICE 2.4

Health care delivery system leaders and other stakeholders can make care more accessible, affordable, and easy to navigate by **improving access to behavioral health care**.

	EXAMPLES		
HOW TO OPERATIONALIZE THE BEST PRACTICE	**ORGANIZATION**	**APPROACH**	**RESULTS/IMPACT**
Implement certified community behavioral health clinics. *(requires state action)* *Note: Massachusetts has several CCBHCs operating today.*	Various states	The Certified Community Behavioral Health Clinic (CCBHC) model is designed to ensure access to coordinated comprehensive behavioral health care. CCBHCs are required to serve anyone who requests care for mental health or substance use, regardless of their ability to pay, place of residence, or age—including developmentally appropriate care for children and youth.[71] CCBHCs can be supported through the Section 223 CCBHC Medicaid Demonstration, through SAMHSA-administered CCBHC Expansion (CCBHC-E) Grants, or through independent state programs separate from the Section 223 CCBHC Medicaid Demonstration.	• CCBHC status enables clinics on average to serve more than 900 more people per clinic than prior to CCBHC implementation, or a 23% increase.[72] • CCBHCs provide access to mental health and substance use care much faster than the national average wait time of 49 days, with the vast majority offering access within a week or less.[73]
Expand community partnerships.	ADDICTION POLICY FORUM	Addiction Policy Forum and the Foundation for Opioid Response Efforts (FORE) partnered to create pilot programs that expanded telehealth support to justice-involved populations with a substance use disorder in 16 states nationwide.	• Participants who engaged in Georgia's pilot program, which provides virtual connection to recovery support services, therapy, and proactive engagement, saw a reduction in behavioral health symptoms and a decrease in risky behaviors.[74]

BEST PRACTICE 2.4

Health care delivery system leaders and other stakeholders can make care more accessible, affordable, and easy to navigate by **improving access to behavioral health care**.

	EXAMPLE[75,76]		
HOW TO OPERATIONALIZE THE BEST PRACTICE	**ORGANIZATION**	**APPROACH**	**RESULTS/IMPACT**
Provide a multifaceted and accessible infrastructure.	Mass.Gov	The Roadmap for Behavioral Health Reform aims to help Massachusetts residents access mental health and substance use care and supports when and where they need it. The Roadmap is a multi-year blueprint, based on listening sessions and feedback from nearly 700 individuals, families, providers, and other stakeholders who identified the need for expanded access to treatment, more effective treatment, and improved health equity. Roadmap initiatives include: • Expansion of behavioral health crisis evaluation and intervention services. • Increased/simplified/more convenient access to behavioral health services (e.g., 24/7 Behavioral Health Help Line, a statewide network of Community Behavioral Health Centers, and designated Behavioral Health Urgent Care Centers).	• 25 Community Behavioral Health Centers (CBHCs) covering every city and town in the Commonwealth officially launched in January 2023.[77]

BEST PRACTICE 2.5

Health care delivery system leaders and other stakeholders can make care more accessible, affordable, and easy to navigate by **screening people for unmet social needs and connecting them to resources**.

Evidence suggests that health care's relative contribution to health outcomes is only approximately 16%, with the remainder due to multiple, nonmedical determinants: socioeconomic factors (47%), health behaviors (34%), clinical care, and the physical environment (3%).[78] The delivery system alone does not have the power to improve all of the multiple determinants of health but can have a role in screening for social needs and connecting individuals to resources.

	EXAMPLES		
HOW TO OPERATIONALIZE THE BEST PRACTICE	**ORGANIZATION**	**APPROACH**	**RESULTS/IMPACT**
Use standardized screenings and technology-enabled referrals. Several standardized screening tools have emerged to support clinicians in screening people for unmet social needs, and there are several technology companies that have digitized rosters of CBOs/social service providers and enabled digital referrals for social determinants of health-related services.	KAISER PERMANENTE®	Since 2019, Kaiser Permanente has teamed up with the health IT company Unite Us to launch its Thrive Local initiative, which will link its members with services that address social needs. An algorithm flags individuals for social needs screenings; individuals are screened and referred for services. Thrive Local includes an online directory of available community-based programs and services—plus access to a network of organizations that accept electronic referrals for services.[79]	• TBD.
Leverage the community-based workforce, community health workers (CHWs), and peer support specialists.	Boston Children's Hospital	Boston Children's Accountable Care Organization has dedicated community-centered staff (e.g., CHWs, social workers) that help families apply for services/supports to address food, housing, and other social needs.[80]	• Increased referrals and utilization of social supports and services.

BEST PRACTICE 2.6

Health care delivery system leaders and other stakeholders can make care more accessible, affordable, and easy to navigate by **diversifying participation in clinical research trials**.

In 2020, 75% of U.S. Food and Drug Administration (FDA) trial participants were White, 11% were Hispanic, 8% were Black or African American, and 6% were Asian.[81] Historically, clinical trial participants included primarily White individuals, which has contributed to deficiencies in comprehending preventive factors, diseases, conditions, and treatment effectiveness and widening health disparities.[82,83] To rectify this and address the diversity of lived experiences and exposures of various populations, clinical research should be inclusive of racial and ethnic minority groups.[84]

	EXAMPLES		
HOW TO OPERATIONALIZE THE BEST PRACTICE	**ORGANIZATION**	**APPROACH**	**RESULTS/IMPACT**
Diversify the clinical trial workforce.	IMPACT-AD Institute on Methods and Protocols for Advancement of Clinical Trials in ADRD	Institute on Methods and Protocols for Advancement of Clinical Trials in Alzheimer's disease and related dementias was formed to diversify the clinical trial workforce to attract a more diverse study population.[85]	• The program has trained over 90 professionals.
Increase decentralized clinical trials (DCTs). The COVID-19 pandemic has resulted in elements of research conduct (drug delivery imaging, assessment, etc.) being delivered remotely from clinical trial sites and closer to a participant's home or provider's office. DCTs allow more diverse groups to participate in clinical research trials.[86]	GSK	GSK solidified a four-year deal with Medable (a software company) to use its platform for DCTs and recruit more diverse trial populations.[87]	• TBD.

BEST PRACTICE 2.7

Health care delivery system leaders and other stakeholders can make care more accessible, affordable, and easy to navigate by **improving access to and quality of LTSS**.*

The COVID-19 pandemic put a spotlight on the disparities faced by people in long-term care. For example, nursing homes serving populations significantly composed of African Americans and Latinx individuals were twice as likely to face a COVID-19 outbreak compared to facilities with a majority White population.[88] The trends driving these disparities, including workforce challenges and variation in quality of care, predate COVID-19. Nursing homes that serve predominantly Black and Hispanic residents have been associated with lower levels of staffing, higher numbers of government-cited nursing home deficiencies, and lower quality of life, among other quality measures, and the gap is increasing over time.[89] These disparities are not unique to institutional care settings like nursing homes: a growing body of research shows racial and ethnic differences also exist in home- and community-based settings.[90]

The following have been identified as promising practices:

- **Increase awareness of LTSS programs.** Targeted strategies are especially important for individuals experiencing homelessness and to reach enrollees with limited English proficiency and communities of color. Recent research on the Program of All-inclusive Care for the Elderly (PACE), for example, revealed that Black and Latinx older adults were less aware of the program because they did not receive information about it from trusted sources like their primary care providers.[91,92]
- **Build household-type facilities[93] that are smaller or make smaller spaces within large institutions that allow individuals to speak their first language with other residents and staff, enjoy familiar meals, games, and songs just as they once did at home.**[94,95] Household-type facilities are designed to operate like a family home. There's usually a grouping of 6 to 10 residents around a living/dining area. A self-managed team oversees each household and is trained as "universal care partners," providing personal care, meal preparation, laundry, light housekeeping, and companionship. Staff report feeling more satisfied with this type of setting compared to institution-style facilities.[96]
- **Meet consumers and their families where they are in the community.** The pandemic underscored the importance of understanding and accounting for differences in individuals' beliefs, behaviors, and needs. Rather than putting the onus on the most vulnerable to navigate challenges that impede their pursuit of better and healthier lives, leaders in long-term care should tailor interventions and programs around them. For example, some

* Note: Previous research related to best practices aimed at improving health equity for those with LTSS needs is limited, but this is now an active area of research (e.g., Evidence for Action: Addressing Systemic Racism Across Long-Term Services and Supports and Improving the Access and Outcomes of HCBS Use Among Older Adults of Color).

BEST PRACTICE 2.7

Health care delivery system leaders and other stakeholders can make care more accessible, affordable, and easy to navigate by **improving access to and quality of LTSS**.*

(continued)

providers opted to go directly into communities to administer the COVID-19 vaccine to homebound and ill older adults when it became clear the most vulnerable were facing challenges accessing it.[97]

- **Address the specific unmet social needs for this population.** Clinicians in hospitals and outpatient facilities can only rely on self-reported data when it comes to participants' social needs, but caregivers in the home can observe the member's environment firsthand, allowing them to step in and connect their members to resources. For example, older adults living in the community and dealing with social isolation should be connected to local community-based supports.[98]
- **Address language and health literacy**, especially for those in the community/home care settings—for example, matching participants with caregivers who speak their language, ensuring tools are in multiple languages, in home/point-of-care translation services.[99]
- **Strengthen data collection, analysis, and reporting.** Having disaggregated data by demographic variables like race and ethnicity and accounting for intersectionality—or overlapping identities of multiple demographic categories such as age, gender, education, and geography—in data analyses and research will enable LTSS providers to better detect and understand the root causes of disparities and develop targeted policy interventions and programs.[100]

* Note: Previous research related to best practices aimed at improving health equity for those with LTSS needs is limited, but this is now an active area of research (e.g., Evidence for Action: Addressing Systemic Racism Across Long-Term Services and Supports and Improving the Access and Outcomes of HCBS Use Among Older Adults of Color).

DIVERSE AND HEALTHY WORKFORCE AT EVERY LEVEL OF HEALTH CARE DELIVERY ORGANIZATIONS 

BEST PRACTICE #3

Health care delivery system leaders and other stakeholders can create a diverse and healthy workforce at every level of of health care delivery organizations by:

- 3.1 Establishing a culture of equity,
- 3.2 Diversifying boards and leadership teams,
- 3.3 Improving and measuring progress on diversity/equity-related recruitment efforts,
- 3.4 Enhancing retention efforts and leadership development programs,
- 3.5 Increasing the health care workforce minimum wage, and
- 3.6 Investing in the behavioral health and LTSS non-clinical workforce. *(LTSS includes long-term care)*

BEST PRACTICE 3.1

Health care delivery system leaders and other stakeholders can create a diverse and healthy workforce at every level of health care delivery organizations by **establishing a culture of equity**.

A culture of equity includes identifying and acting on the organizational dynamics that exacerbate health inequities and building the power of communities that have been historically harmed by structural racism. Equity-focused culture transformation should be integrated into all "workstreams" and corners of health care entities to prevent silos of diversity/equity teams. Evidence has shown that organizational culture is critical for the success of equity-related interventions.[101]

	EXAMPLE[102]		
HOW TO OPERATIONALIZE THE BEST PRACTICE	**ORGANIZATION**	**APPROACH**	**RESULTS/IMPACT**
Embed equity into strategic plans and organizational priorities. This includes:[103] • Identifying the community's most urgent unmet needs (e.g., through organizational and state/local data and community health needs assessments). • Defining actions to address those needs. • Identifying meaningful metrics to measure progress. • Determining who's accountable for progress and reporting on progress.	AT THE FOREFRONT UChicago Medicine	UChicago Medicine implemented five interconnected strategies to build a culture of equity: • Grounding diversity, equity, and inclusion efforts in critical theory, which examines dominant social structures and processes that perpetuate inequities, and acts to challenge systems of power. • Ensuring training goes beyond cultural competency and humility to include critical consciousness, which is the ability to critically analyze the social and organizational contexts that produce health inequities and act to transform them. • Strengthening growth-fostering relationships. • Empowering an implementation team that models a culture of equity. • Aligning equity-focused culture transformation with equity-focused operations changes to support transformative praxis.	• Integration of equity in the UChicago Medicine Vision 2025 strategic plan. • Annual operating plan integrates diversity, equity, and inclusion (DEI) goals into employee, consumer, and quality and safety pillars. • Human resource metrics to gain insight into culture change (e.g., addition of several subscales from the Diversity Engagement Survey to the annual employee engagement survey). • Employee engagement and inclusion scores increased from 2013 to 2019. • Stratification of 82 quality measures by race, ethnicity, ZIP code, gender, language, and payer status and making that information available to the entire organization via an interactive equity and opportunity dashboard.

BEST PRACTICE 3.1

Health care delivery system leaders and other stakeholders can create a diverse and healthy workforce at every level of health care delivery organizations by **establishing a culture of equity**.

	EXAMPLE[104]		
HOW TO OPERATIONALIZE THE BEST PRACTICE	**ORGANIZATION**	**APPROACH**	**RESULTS/IMPACT**
Resource equity teams.[105,106] Many health care entities have DEI teams to advance equity goals throughout the organization. However, these teams are often not appropriately supported to execute these goals (e.g., limited staff or staff split across equity-focused initiatives and other duties). Additionally, doing this work often involves trading off time that could otherwise be spent on other activities—a trade-off that can negatively impact career progression if it is not appropriately valued, recognized, or resourced.	Highmark Health	Highmark Heath integrates all its DEI initiatives in one blended organization to ensure DEI implementation and evaluation across the entire health system. This differs from common models, where DEI is housed in the Human Resources department.	• Introduction of a chief clinical DEI officer and two vice president leaders. • "Inclusivity resets" where workforce team units will determine their members' sense of belonging and inclusion. • The DEI team created a six-pillar framework that addresses social justice, equity, and structural racism and other social "-isms." • A third-party assessment to gain insight on the current state of DEI initiatives within the health system. • Employee-led business resource groups.

Note: The Centers for Medicare & Medicaid Services' Health Equity Technical Assistance Program helps health care organizations ready themselves to take action to address health care disparities by providing personalized coaching and resources to help embed health equity into a strategic plan; help with data collection and analysis; and help in developing a language access plan and ensuring effective communication with individuals, families, and caregivers.

BEST PRACTICE 3.2

Health care delivery system leaders and other stakeholders can create a diverse and healthy workforce at every level of health care delivery organizations by **diversifying boards and leadership teams**.

Diverse health care boards and senior leaders are better positioned to understand the needs of their community. Evidence shows that diversity on health care boards and leadership teams is correlated with enhanced quality of care, community relations, and health outcomes. White men and women are more likely to hold executive health care positions than non-White men and women, respectively: in 2019, 89% of all hospital Chief Executive Officers were White.[107] Recruitment, promotion, development, and advancement of diverse executives should be prioritized by health care entities to build racial and ethnic diversity in health care leadership.[108]

	EXAMPLES		
HOW TO OPERATIONALIZE THE BEST PRACTICE	**ORGANIZATION**	**APPROACH**	**RESULTS/IMPACT**
Set targets and timelines for greater diversity on boards and leadership teams. Health care organizations should set targets and timelines to increase diversity of their boards and leadership teams.	MHA	In 2021, the Massachusetts Health & Hospital Association (MHA) called on all health care organizations across the Commonwealth to improve the diversity of their governing boards.[109]	• Since 2017, MHA's board has grown from 7% to nearly 25% racially/ethnically diverse.[110] *Governing board diversity at member hospitals is unknown.*
	RWJBH	Robert Wood Johnson Health System, Barnabas Health (RWJBH), a network of providers in New Jersey, implemented a systemwide initiative "Ending Racism, Together." This initiative includes goals for consumers, the workforce, communities, and operational processes "to identify and eliminate racism by modifying organizational structures, policies, practices, procedures, and attitudes."[111]	• Requires that at least 50% of final leadership candidates, for director-level positions and above, are diverse in both race and ethnicity.[112] • 6% increase in ethnic minority hiring from 2017 to 2020.[113]
Create leadership development programs. Health care delivery system leaders and other stakeholders should create/implement leadership development programs to increase board and leadership diversity.	HIGHMARK HEALTH	Highmark Health has committed $1.5 million to increase diverse leadership in Pittsburgh, Pennsylvania, through the Advanced Leadership Institute, a nonprofit organization to help build pipelines to senior leadership positions for African Americans in the Pittsburgh area.[114]	• Approximately 80% of the participants either have received a promotion or have added significant higher-level assignments to their work responsibilities.[115]

BEST PRACTICE 3.2

Health care delivery system leaders and other stakeholders can create a diverse and healthy workforce at every level of health care delivery organizations by **diversifying boards and leadership teams**.

	EXAMPLES		
HOW TO OPERATIONALIZE THE BEST PRACTICE	**ORGANIZATION**	**APPROACH**	**RESULTS/IMPACT**
Create equity-centered competency/ development models. Leadership and equity training programs that use an equity-centered curriculum can improve health care leadership competencies.	CLINICAL SCHOLARS	Clinical Scholars (CS) uses an equity-centered leadership framework to teach leadership strategies to health care professionals, imparting skills to impact health inequities in their communities and organizations. Participants grow their mastery of key competencies in four domains: personal, interpersonal, organizational, and community and systems.[116]	• 162 CS Equity-Centered Leaders across 28 states and territories have participated in the program.[117] • Each participant has been better prepared to:[118] – Understand their leadership style and grow in effectiveness leading, managing, and collaborating with others. – Advocate for positive change within their environments. – Promote creative thinking, innovation, and thought diversity. – Understand how to appraise, synthesize, and use the best evidence to guide practice and inform policy. – Communicate, engage, and negotiate in a manner that creates win-win outcomes for all.
Adjust performance dashboards and compensation models to promote equity. Compensation adjustments and performance-based outcome dashboards can drive equity in boards and leadership teams.	Penn Medicine	In October 2020, Penn Medicine announced that the top 600 executives in the organization would have their pay (10-40% of total compensation) tied to the system's performance on consumer satisfaction, reduction in health care-acquired infections, and health disparities.[119] For example, executive pay is being tied to reducing maternal morbidity and mortality among Black and Brown populations and increasing colorectal screening among the Black population.	• In the first year after implementation, there was a 29.4% reduction in severe pregnancy-related complications among Black women.[120] *(per interview with Chair of Obstetrics and Gynecology, Perelman School of Medicine; evidence/analysis of causal relationship unavailable)*

BEST PRACTICE 3.3

Health care delivery system leaders and other stakeholders can create a diverse and healthy workforce at every level of health care delivery organizations by **improving and measuring progress on diversity/equity-related recruitment efforts**.

Diversity of the health workforce is critical for health equity as it brings various perspectives needed to identify and address the complex structural biases embedded in the health care delivery system. A diverse health care workforce can improve health access, quality, and outcomes for people of color. Evidence demonstrates Black, Hispanic/Latinx, and Native American health professionals are more likely to practice in underserved communities and when physicians and consumers share the same race or ethnicity, this improves time spent together, medication adherence, shared decision-making, consumer perception of treatment decisions, and health outcomes.[121,122]

	EXAMPLES		
HOW TO OPERATIONALIZE THE BEST PRACTICE	**ORGANIZATION**	**APPROACH**	**RESULTS/IMPACT**
Diversify candidate pool. Health care organizations should develop relationships and create pathway programs for high schools, historically Black colleges and universities (HBCUs), and public universities to diversify the candidate pool.	UNCF HEALTHCARE WORKFORCE DIVERSITY PROGRAM	In 2021, the United Negro College Fund (UNCF) partnered with a biopharmaceutical company to launch the UNCF Health Care Workforce Diversity Program to support Black individuals in their pursuit of careers in health care.[123]	• This comprehensive HBCU health care pipeline program aims to support 800 students through scholarship, academic, and career development support.[124]
	MAYO CLINIC COLLEGE OF MEDICINE AND SCIENCE	Mayo Clinic College of Medicine and Science promotes diversity through 24 pathway programs for students from diverse backgrounds to explore clinical and nonclinical careers in health care.[125]	• Pathway programs that span the educational life cycle starting from high school, college, medical school, residency, and fellowship and that serve students from under-resourced communities, first-generation, and historically underrepresented students.[126] • The programs provide mentorship, college/post-graduate preparation, clinical shadowing opportunities, academic support, and other offerings.[127]
Measure DEI recruitment efforts. Health care entities should set and track recruitment metrics through various tools.	Luminis Health	Luminis Health implemented a DEI scorecard and dashboard that tracked hiring practices, promotions, disciplinary actions, aggregate diversity, and diversity of job classifications.[128]	• After two years of implementation, the diversity of Luminis Health's clinical professionals grew from 33% to 40%, the diversity of management grew to 26%, and the diversity of executive leadership grew from 14% to 17%. Diversity in new nurse hires also grew from 19% in March 2018 to 38% in June 2020.[129]

BEST PRACTICE 3.3

Health care delivery system leaders and other stakeholders can create a diverse and healthy workforce at every level of health care delivery organizations by **improving and measuring progress on diversity/equity-related recruitment efforts**.

	EXAMPLES		
HOW TO OPERATIONALIZE THE BEST PRACTICE	**ORGANIZATION**	**APPROACH**	**RESULTS/IMPACT**
Build pipeline programs.	Berkshire Health Systems	Berkshire Health System developed pipeline programs/community college partnerships that allow staff to earn a living wage while going to school to become a medical assistant, licensed practical nurse (LPN), or registered nurse.[130]	• 10+ classes of medical assistant graduates. • Career ladder for nursing careers: Fully paid LPN program launched in 2022 and includes full pay while in training.
Update policies and procedures to eliminate barriers to diversity.	Lawrence General Hospital	Lawrence General reviewed and overhauled internal human resources policies and procedures to eliminate barriers to diversifying the workforce.[131]	• Hired bilingual recruiters. • Revised job descriptions where systemic racism had prevented promotion. • Developed a mentorship program.

BEST PRACTICE 3.4

Health care delivery system leaders and other stakeholders can create a diverse and healthy workforce at every level of health care delivery organizations by **enhancing retention efforts and leadership development programs**.

In health care, like other sectors, diversity rates decline at the higher echelons of an organization.[132,133] Achieving greater diversity at all levels requires supporting retention and promotion of talent.

	EXAMPLES		
HOW TO OPERATIONALIZE THE BEST PRACTICE	**ORGANIZATION**	**APPROACH**	**RESULTS/IMPACT**
Instill a culture of sponsorship (versus mentorship) to actionably advocate for the career of diverse candidates.[134,135]	COLUMBIA	In 2018, two advisory committees were assembled at Columbia University Vagelos College of Physicians and Surgeons to assess the current environment for women and diverse faculty and make recommendations to support faculty success in the future. There was a need identified to expand capacity in career development and sponsoring for women.[136]	• Established the Office for Women and Diverse Faculty to provide more effective outreach to women and diverse faculty.[137] • The Office for Women and Diverse Faculty peer mentoring groups, led by advisory deans, for new faculty launched in 2021.[138]
Form affinity groups. Health care organizations should prioritize retention of a diverse workforce by forming affinity groups for their employees.[139]	Robert Wood Johnson University Hospital	Robert Wood Johnson University Hospital created employee-led resource groups to support key populations, focusing on employee and consumer engagement, outreach, and cultural competency education.[140]	• 70% of the employee-led resource group members reported that this initiative added value to the employee experience.[141] • Increase in promotions, broadened job roles and responsibilities, and enhanced business acumen and visibility among employee resource group leaders.[142]
	RWJBarnabas HEALTH	RWJBarnabas Health has over 30 affinity groups, which are employee-led groups or employee networks defined by shared characteristics and life experiences.[143]	• Spaces that foster career development and contribute to cultural sensitivity in the work environment.

BEST PRACTICE 3.5

Health care delivery system leaders and other stakeholders can create a diverse and healthy workforce at every level of health care delivery organizations by **increasing the health care workforce minimum wage**.

Health care workers earning low wages in the United States face challenges at the intersection of class, race, gender, and immigration status. Commitment to health equity demands higher pay, improved benefits, and more workplace protections for these workers. People of color, who make up 39% of the labor force in the United States, are heavily concentrated in direct care occupations,[144] which include personal care aides, home health aides and nursing assistants.[145] In Massachusetts, as is the case across the country, low-wage direct care jobs are dominated by women and people of color. Massachusetts is estimated to have over 146,000 direct care workers, and a majority (59% in 2020) of those workers are people of color.[146] Wages in these segments of health care leave many workers living in poverty or in near-poverty conditions.[147]

	EXAMPLES		
HOW TO OPERATIONALIZE THE BEST PRACTICE	**ORGANIZATION**	**APPROACH**	**RESULTS/IMPACT**
Implement an increased minimum wage (can be done with or without government action)	CareSouth MEDICAL & DENTAL	Care South, a Federally Qualified Health Center, created an inclusion council to cultivate accountability in the health center's approach to tackling institutional racism and encourage the development of tangible initiatives.[148]	• Parity adjustments so that employees were paid at or above the minimum wage.[149] The health center intends to have senior-level management who match the community by race and ethnicity in the next four years.[150]
	NOVANT HEALTH	Novant Health, a 15-hospital system based in North Carolina, has raised its living wage—a rate based on local costs of living over and above the state-mandated minimum wage—in the last six years. As of January 2023, the system is again raising its minimum wage, which will apply to over 4,400 of the lowest-paid staff.	• The move, combined with salary increases for 2023, represents an investment of more than $100 million.

BEST PRACTICE 3.6

Health care delivery system leaders and other stakeholders can create a diverse and healthy workforce at every level of health care delivery organizations by **investing in the behavioral health and LTSS non-clinical workforce**.*

Both the LTSS direct care workforce and the non-clinical behavioral health workforce are predominantly comprised of women, people of color, and immigrants. Historical underinvestment in these positions—and in the providers who employ them—has suppressed worker wages, benefits, and other supports and created long-standing challenges with recruitment and retention in these demanding and in-demand professions.[151,152]

The following promising practices have been identified:

- **Increase wages and standardize occupational wages** for those with similar educational requirements.[153]
- **Provide mental/emotional support** to reduce worker burnout for taxing occupations.[154]
- **Improve access to training, education, and career ladder programs** to support advancement.[155]
- **Include workforce indicators in quality measures**, e.g., measure turnover, retention, and workforce practices.[156]
- **Support investment in LTSS jobs in communities experiencing worker shortages.**[157]
- **Explore and expand opportunities for nurse delegation.**[158]

* Note: Previous research related to best practices aimed at improving health equity for those with LTSS needs is limited, but this is now an active area of research (e.g., Evidence for Action: Addressing Systemic Racism Across Long-Term Services and Supports and Improving the Access and Outcomes of HCBS Use Among Older Adults of Color).

DATA-INFORMED ACTIONS TO ADDRESS HEALTH DISPARITIES

BEST PRACTICE #4

Health care delivery system leaders and other stakeholders can advance data-informed actions to address health disparities by:

- 4.1 Refining data collection, analysis, and infrastructure,
- 4.2 Integrating health equity into quality improvement strategies, and
- 4.3 Measuring progress on equity initiatives.

BEST PRACTICE 4.1

Health care delivery system leaders and other stakeholders can advance data-informed actions to address health disparities by **refining data collection, analysis, and infrastructure**.

To improve health equity, organizations first need to understand where disparities exist. This requires accurate and comprehensive data collection and analysis, including the collection of race, ethnicity, and language (REAL) data and the resources to analyze it.[159] Across and within organizations, approaches vary for capturing REAL data, which results in missing and inconsistent data. Refining data collection processes requires overcoming potential discomfort individuals may have with providing the data. **Individuals who collect REAL data should be trained to request this information in a culturally sensitive manner** to improve collection rates and avoid perpetuating harm.[160,161] Additionally, **data collection tools may need to improve** to capture the breadth of possible racial and ethnic definitions and to allow for the **interoperability** needed for **analysis**. Once health systems collect REAL data, they need to analyze it to identify disparities in care and, more importantly, health outcomes.

	EXAMPLE		
HOW TO OPERATIONALIZE THE BEST PRACTICE	**ORGANIZATION**	**APPROACH**	**RESULTS/IMPACT**
Refine data collection, analysis, and infrastructure.	HEALTH EVOLUTION	Various health entities have signed Health Evolution Forum's Health Equity Pledge[162] to meaningfully strengthen the collection, stratification, and review of race, ethnicity, language, and sex data.	The pledge is ongoing; organizations make the pledge with these objectives: • Collect REAL and sex data for at least 50% of the organization's consumers. • Stratify and regularly review these collected data by the top-priority quality or access metrics. • Participate in the Health Evolution Health Equity Learning Lab by sharing stratified data for select measures to facilitate anonymized benchmarking and to identify best practices for reducing disparities.

BEST PRACTICE 4.1

Health care delivery system leaders and other stakeholders can advance data-informed actions to address health disparities by **refining data collection, analysis, and infrastructure**.

	EXAMPLE		
HOW TO OPERATIONALIZE THE BEST PRACTICE	**ORGANIZATION**	**APPROACH**	**RESULTS/IMPACT**
Integrating race, ethnicity, and language data collection across health systems.	MASSACHUSETTS	Blue Cross Blue Shield of Massachusetts is engaged in a major effort to collect self-reported race, ethnicity, and language preference data from members directly. As part of their commitment to health equity, each year they gather and publish their market-wide data using measures widely leveraged by health plans and clinicians to monitor health care quality. Their 2023 Health Equity Report examines data from more than 1.4 million commercial Massachusetts members.[163]	• The data collected has revealed racial and ethnic inequities, such as severe maternal mortality rates among Black women (6.50%) compared to their White counterparts (2.90%).[164] The data also found Hispanic members were less likely than White and Asian members to receive appropriate mental health care in a wide range of measures.[165] • This information is publicly available and is being used to inform meaningful change such as grant funding and other support for local health care organizations' health equity work.[166]

BEST PRACTICE 4.2

Health care delivery system leaders and other stakeholders can advance data-informed actions to address health disparities by **integrating health equity into quality improvement strategies**.

Health care organizations, especially large systems/organizations, are well versed in quality improvement work—looking at performance/outcomes and developing strategies to address deficiencies. These organizations should take a similar approach to advancing health equity by **integrating health equity indicators and measures into quality improvement strategies,**[167,168] **stratifying existing and new quality process and outcome measures by subpopulations** to identify disparities and assess the impact of interventions to reduce disparities,[169] and **identifying geographic clusters of health inequities**.[170] The Institute for Health Care Improvement recommends organizations **focus first on populations experiencing the worst health outcomes** and using data to **identify specific high-leverage opportunities** for improvement, **taking into consideration the resources available to particular populations** such as where they live and their financial situation, level of education, and access to transportation.[171]

	EXAMPLES		
HOW TO OPERATIONALIZE THE BEST PRACTICE	**ORGANIZATION**	**APPROACH**	**RESULTS/IMPACT**
Integrating equity into quality improvement strategies.	AMA	The American Medical Association, Brigham and Women's Hospital, and The Joint Commission launched the Peer Network for Advancing Equity through Quality and Safety to help health care delivery systems apply equity to their quality and safety practices.[172]	• Systematically identify and measure the widespread impact of structural racism and other inequities on the health of consumers, health care workers, and communities. • Highlight the essential role of health care organizations in preventing inequities. • Incorporate equity into the operational fabric of health care delivery and innovation. • Promote high-quality, safe, and equitable outcomes for consumers served.
	Robert Wood Johnson Foundation	Robert Wood Johnson Foundation's Expecting Success program was a hospital quality improvement collaborative created to improve the care of people with heart disease in health settings with large African American and/or Latinx populations.[173]	• Seven of 10 hospitals demonstrated significant improvement on composite quality measures. • Four of the 10 hospitals were able to eliminate documented racial or ethnic cardiac care disparities.

BEST PRACTICE 4.2

Health care delivery system leaders and other stakeholders can advance data-informed actions to address health disparities by **integrating health equity into quality improvement strategies**.

	EXAMPLES		
HOW TO OPERATIONALIZE THE BEST PRACTICE	**ORGANIZATION**	**APPROACH**	**RESULTS/IMPACT**
Integrating equity into quality improvement strategies.	HEALTH EQUITY Accelerator BOSTON MEDICAL CENTER	The Health Equity Accelerator at Boston Medical Center is working to transform health care to eliminate gaps in life expectancy and quality of life among different races and ethnicities by leveraging research to understand the contributors of adverse outcomes in people of color.[174] Priority areas include: pregnancy, cancer care, infectious disease, chronic conditions, and behavioral health. The Accelerator incorporates three foundational areas into their work: research, clinical care, and community, including the social drivers of health.	• The initiative has addressed maternal and child health by employing quantitative "Community Insights" surveys with communities of color to better understand the rate of severe maternal morbidity for mothers of color compared to White mothers and the relationship between race and babies who are born small for gestational age.
Utilizing financial incentives to advance health equity.	MASSACHUSETTS	Blue Cross Blue Shield of Massachusetts is the first health plan in Massachusetts, and among the first in the nation, to create a financial payment model ("Pay for Equity") that launched in 2023 and rewards Massachusetts clinicians for reducing racial and ethnic inequities in care (with greater financial rewards for larger reductions in inequities and maximum payment when inequities are eliminated completely).[175] The new payment contracts focus on measuring and rewarding equity in care in several clinical areas where inequities have been identified, including colorectal cancer screenings, blood pressure control, and care for diabetes.	• Five health care delivery systems have signed the Blue Cross agreements: Steward Healthcare Network, Beth Israel Lahey Health, Boston Accountable Care Organization, Mass General Brigham Health, and Tufts Medicine. Together, these systems provide care to over 500,000 Blue Cross members, and the effort has the potential to affect many more patients.

BEST PRACTICE 4.3

Health care delivery system leaders and other stakeholders can advance data-informed actions to address health disparities by **measuring progress on equity initiatives**.

DEI scorecards and dashboards allow entities to track internal and external equity initiatives and outcomes (e.g., progress on addressing health disparities across populations, workforce diversity, community partnerships).

HOW TO OPERATIONALIZE THE BEST PRACTICE	EXAMPLE		
	ORGANIZATION	APPROACH	RESULTS/IMPACT
Use equity dashboards.	IFDHE AHA Institute for Diversity and Health Equity	The Institute for Diversity and Health Equity (IFDHE), part of the American Hospital Association (AHA), created a health equity, diversity, and inclusion measures dashboard template for hospitals and health system leadership teams.[176] The AHA IFDHE also created a health equity roadmap that includes a transformation model, transformation assessment, and action library for organizations to drive improvement in health care outcomes, equity, diversity, and inclusion.[177]	Comprehensive dashboard template available for use, complete with information related to desired outcomes/measures, intent of measures, operationalization of measures, and supporting tools and resources.[178] Dashboard domains/metrics include:[179] • Data collection, stratification, and use: – Percentage of workforce (staff and clinicians) trained regarding collection of self-reported REAL data. – Percentage of records with REAL data preference complete with opportunity for verification at multiple points of care, beyond just registration. • Cultural competency training: – Percentage of individual and family complaints related to cultural competency. – Rate of consumer satisfaction scores, pre- and post-cultural competency training stratified by race, ethnicity, and language preferences. – Percentage of employees and clinicians who have completed unconscious/implicit bias training. • Diversity and inclusion in leadership and governance: – Percentage of emerging leaders who represent diverse and inclusive backgrounds. • Strengthening community partnerships: – Percentage of community partners that align with strategic priorities of the hospital or health system or a community health needs assessment. Organizations can use the transformation assessment tool to determine where in the continuum their organization falls across various domains.[180]

BEST PRACTICE 4.3

Health care delivery system leaders and other stakeholders can advance data-informed actions to address health disparities by **measuring progress on equity initiatives**.

	EXAMPLES[181]		
HOW TO OPERATIONALIZE THE BEST PRACTICE	ORGANIZATION	APPROACH	RESULTS/IMPACT
Use equity dashboards. DEI scorecards and dashboards allow entities to track internal and external equity initiatives and outcomes.	UCLA Health®	University of California Los Angeles (UCLA) Health created health equity dashboards to identify inequities and find ways to mitigate them. These dashboards detect variations in health care quality or health outcomes and monitor the health system's hiring, promotion, training, and contracting practices. These dashboards will be reviewed monthly by leaders such as the UCLA Equity Council and the health system's president.	• TBD
	Lawrence General Hospital	Lawrence General reports their performance on health outcomes, stratified by race/ethnicity, and internal equity metrics and shares results across the organization to inform strategies to reduce health disparities and advance equity.[182]	• Monitors progress on an ongoing basis. • Targets met for 2023.

COMMUNITY INVESTMENTS THAT ELIMINATE STRUCTURAL INEQUITIES

BEST PRACTICE #5

Health care delivery system leaders and other stakeholders can make community investments that eliminate structural inequities by:

5.1 Implementing strategies to uplift community conditions and build trust between the health care delivery system and the communities served, and

5.2 Partnering with CBOs and building their capacities.

BEST PRACTICE 5.1

Health care delivery system leaders and other stakeholders can make community investments that eliminate structural inequities by **implementing strategies to uplift community conditions and building trust between the health care delivery system and the communities served**.

Well-resourced health care delivery institutions, often called "anchor institutions," can play an important role in uplifting community conditions and building trust between the health care delivery system and the communities they serve through a series of strategies, including workforce development, living-wage jobs with benefits, increasing access to care, supporting unmet social needs, and many others.[183]

	EXAMPLES		
HOW TO OPERATIONALIZE THE BEST PRACTICE	**ORGANIZATION**	**APPROACH**	**RESULTS/IMPACT**
Lean into anchor institution role. Anchor institutions are large, usually nonprofit organizations tethered to their communities, like universities, medical centers, or local government entities; two types of anchor institutions—hospitals and universities—employ 8% of the U.S. labor force and account for more than 7% of U.S. gross domestic product.[184] A 2018 study focused on identifying best practices for implementing an anchor mission found that success depends on (1) a strong anchor mission and narrative; (2) robust partnerships with community institutions that have the readiness, capacity, and commitment to engage; (3) willingness to commit years of time engaging key internal and external audiences because "change happens at the speed of trust"; and (4) identifying collaborative projects attractive enough to gain private and public funding.[185] One tool for monitoring impact of anchor institutions is the Democracy Collaborative's anchor institution community benefit dashboard, which includes proposed outcomes, indicators, and data sources to measure progress across four domains (economic development; community building; education; and health, safety, and environment).	ProMedica	In 2009, ProMedica, a not-for-profit health system headquartered in Toledo, Ohio, embraced an "all-in" anchor mission.[186]	• In 2013, ProMedica addressed hunger and nutrition through various initiatives such as screening hospital patients for food insecurity, collaborating with food sites, and providing nutrition education.[187] • In the past several years, ProMedica has expanded its SDOH screening (inpatient and outpatient) as well as other efforts to address education, employment, financial security, housing, transportation, and violence.[188]
	Dignity Health.	Dignity Health provides financial investments in nonprofit community organizations to benefit low-income families, women, children, and people with mental or physical disabilities.[189]	• This health system provides loans and lines of credit at or below market rate to nonprofit borrowers, and contributes to loan funds that increase employment and support community development.[190] • Since 1990, the Dignity Health Community Investment Program has created $164 million worth of loans to assist 55 small business SDOH initiatives such as healthy food projects, affordable housing, assisted living facilities for seniors, and homeless shelters.[191]

BEST PRACTICE 5.1

Health care delivery system leaders and other stakeholders can make community investments that eliminate structural inequities by **implementing strategies to uplift community conditions and building trust between the health care delivery system and the communities served**.

	EXAMPLES		
HOW TO OPERATIONALIZE THE BEST PRACTICE	**ORGANIZATION**	**APPROACH**	**RESULTS/IMPACT**
Lean into anchor institution role.	Western Mass Economic Development Council	Western Mass Anchor Collaborative includes some of the largest businesses in the region, including Baystate Health, and is working to address inequities in neighborhoods with limited opportunities due to a history of disinvestment and structural racism. The Collaborative was formed with leadership from the Western Mass Economic Development Council.[192]	• The Collaborative set targets for local, diverse hiring and career advancement and diverse purchasing, particularly for minority and women-owned vendors.
Redirect a portion of investment portfolio towards communities.	UMass Memorial Health	UMass Memorial Health (UMMH) redirects a portion of their investable reserves (e.g., from stocks and bonds) into the community as low interest loans and seed funding for CBOs.[193]	• As of early 2021, UMMH has deployed around $2.4 million in five different community investment projects. To date, the majority of these projects have been related to affordable housing and economic and program development in underserved communities.

BEST PRACTICE 5.2

Health care delivery system leaders and other stakeholders can make community investments that eliminate structural inequities by **partnering with CBOs and building their capacity**.

CBOs/social services organizations can play a significant role in addressing social factors that drive health disparities and poor health outcomes, given their role as trusted entities in the community, knowledge of community needs, and expertise in addressing social service needs. As highlighted throughout the Toolkit, the delivery system and others (government, funders, health plans) can **partner with CBOs to fund and implement health-related initiatives as well as connect individuals to social supports (e.g., housing, food)**. However, CBOs are often operating within constrained operational and financial environments, which may impact their ability to scale services. **Well-resourced health care delivery entities as well as government and philanthropic entities should consider investing in CBO capacity building initiatives**, including but not limited to strategic planning, financial management structures, policy and procedure developments, applying for grants, and program design.[194]

HOW TO OPERATIONALIZE THE BEST PRACTICE	EXAMPLES		
	ORGANIZATION	APPROACH	RESULTS/IMPACT
Partner with CBOs.	JASA / Wyckoff Heights Medical Center	The NYC Jewish Association of Aging (JASA) delivers a wide array of services to older adults and has developed a service line to address issues related to care transitions for high-risk individuals recently discharged from the hospital. The CBO aimed to formally partner with hospitals whose consumers could benefit from their services. To determine hospital targets, the organization reviewed various public data sources, including readmissions data, CMS readmissions penalties, and a free data tool called Data2GO.NYC.[195]	• The CBO developed a business proposition and shared it with the chief executive officer of Wyckoff Heights Medical Center. Wyckoff contracted with JASA, and 30-day readmissions have sharply declined.[196]
	MassHealth	Through its 1115 demonstration waiver, MassHealth provided $149 million statewide for the state's Flexible Services Program (FSP), where accountable care organizations partner with CBOs (called social services organizations [SSOs]) to provide nutrition- and housing-related services to enrollees with food or housing insecurity and substantial health needs.[197]	• SSOs receive funding for administrative costs associated with delivering services (e.g., set up costs for new partnerships, technology, ongoing maintenance).[198] • 658 adult MassHealth members and 173 pediatric members were enrolled in FSP between March 2020 and July 2021. • Of the adults enrolled in FSP between March 2020 and July 2021, 584 (89%) received nutrition and/or housing supports.[199]

BEST PRACTICE 5.2

Health care delivery system leaders and other stakeholders can make community investments that eliminate structural inequities by **partnering with CBOs and building their capacity**.

	EXAMPLE		
HOW TO OPERATIONALIZE THE BEST PRACTICE	**ORGANIZATION**	**APPROACH**	**RESULTS/IMPACT**
Build CBO capacity.	CDC Foundation Together our impact is greater	CDC Foundation technical assistance officers work with CBOs to assess and address their unique needs. For example, BABY B.A.C.K. INC. (BBI), a community health and wellness organization in Syracuse, NY, requested support to establish a partnership with the Onondaga County and the New York State Health Departments. The technical assistance officer arranged and hosted introduction meetings between BBI and both the local and state health departments and provided information on ways to prepare the organization to receive funding.[200]	• BBI was invited to join the Onondaga County Health Department's COVID Community Task Force as well as a partnership to provide community outreach and awareness and increase vaccination rates.[201] • BBI received an additional $125,000 in grant funding.[202]

ABSENCE OF RACISM AND BIAS IN CLINICAL TRAINING AND CARE DELIVERY

BEST PRACTICE #6

Health care delivery system leaders and other stakeholders can help achieve the absence of racism and bias in clinical training and care delivery by:

6.1 Eliminating bias in care delivery and treatment models

6.2 Assessing/eliminating race-based adjustments in clinical algorithms.

BEST PRACTICE 6.1

Health care delivery system leaders and other stakeholders can help achieve the absence of racism and bias in clinical training and care delivery by **eliminating bias in care delivery and treatment models**.

Implicit bias has the potential to impact not only outcomes of care but also whether people will return for services or even seek care in the first place.[203] Studies have found Black Americans are consistently undertreated for pain relative to White people; one study revealed half of medical students and residents held one or more false beliefs about supposed biological differences between Black and White people, such as that the former have a higher pain tolerance than the latter.[204]

	EXAMPLES		
HOW TO OPERATIONALIZE THE BEST PRACTICE	**ORGANIZATION**	**APPROACH**	**RESULTS/IMPACT**
Integrate quality, safety, and equity.	Brigham and Women's Hospital Founding Member, Mass General Brigham	Brigham & Women's Hospital takes an integrated approach to quality, safety, and equity by examining patient safety reports and case reviews to identify instances where bias, discrimination, or racism contributed to adverse patient events or errors. They evaluate structural, institutional, and interpersonal causal factors, including human performance or behavior. The team consists of three medical directors of quality, safety, and equity, trained physicians, risk managers, and quality/safety specialists.[205]	• Cases are aggregated, trended, reported to hospital leadership, and used to create awareness and tools to eliminate these types of occurrences.
Bring an equity lens to the medical school curriculum. Educators should bring an equity lens to their curriculum and training process, and clinicians should avoid perpetuating these false beliefs. Providers can take steps to ameliorate the effects of bias, e.g., targeted screening, prevention, and treatment programs.	BU Boston University School of Medicine	In May 2019, Boston University's School of Medicine commissioned the formation of the Vertical Integration Group (VIG). The VIG is comprised of students and faculty who conducted a thorough analysis on how systemic racism has influenced the curriculum and cultural climate of the school.[206]	• VIG findings were used to support the Medical Education Office's efforts to create a longitudinal health equity curriculum that was integrated into the standard medical school curriculum in 2022.

BEST PRACTICE 6.1

Health care delivery system leaders and other stakeholders can help achieve the absence of racism and bias in clinical training and care delivery by **eliminating bias in care delivery and treatment models**.

	EXAMPLES		
HOW TO OPERATIONALIZE THE BEST PRACTICE	**ORGANIZATION**	**APPROACH**	**RESULTS/IMPACT**
Require unconscious bias training. Health care organizations should ensure recruitment teams have completed various forms of bias training.	CHRISTUS Health	CHRISTUS Health provides ongoing cultural competency training that focuses on unconscious bias.[207]	• More than 2,000 of the health system's leaders, including the president and chief executive officer, attended mandatory unconscious bias trainings.[208]
Require cultural humility training. Cultural humility involves recognizing and understanding the role culture plays in health care and adapting care delivery strategies to meet consumers' social, cultural, and linguistic needs.	Penn Medicine	Cultural humility was the focus of Penn Medicine's 2021 Penn Medicine Experience campaign. This campaign helps reinforce a consistent set of standards for service excellence across the health system through highlighting various programs and trainings.[209]	• Cultural humility was added as a Penn Medicine Experience Standard and was aligned with the health system's Action for Cultural Transformation plan.[210]
Analysis and updates to policies/ procedures.	Baystate Health	Baystate Health conducted a two-year organization wide analysis to identify and address bias, racism, and discrimination.[211]	• Changes to policies, practices, and systems to remove barriers and advance equity in several dimensions (e.g., recruitment, promotion, retention, leadership, and providers).

BEST PRACTICE 6.1

Health care delivery system leaders and other stakeholders can help achieve the absence of racism and bias in clinical training and care delivery by **eliminating bias in care delivery and treatment models**.

	EXAMPLE		
HOW TO OPERATIONALIZE THE BEST PRACTICE	**ORGANIZATION**	**APPROACH**	**RESULTS/IMPACT**
Design interventions to eliminate structural racism.	Healing ARC Eliminating Inequities in Patient Care for People of Color	The Healing ARC Campaign was established in Massachusetts by health care experts to shape interventions that eliminate structural racism in the health care delivery system.[212] The three-stage process of Healing ARC—acknowledgement, redress, and closure—requires health care providers and institutions to acknowledge how racism has contributed to inequitable health outcomes; to redress the harm by providing restitution to the marginalized population (including access to services and care that have historically been denied); and to facilitate closure through reconciliation and agreement that the harm has been redressed.[213] Through this campaign, community-based Wisdom Councils centers the voice of impacted community members, recruits racial equity organizers from communities of color, and convenes to collaborate on the three components of the Healing ARC framework.[214]	• Various interventions using the Healing ARC framework and other race-conscious work have resulted in improved health outcomes.[215] • For example, Brigham and Women's Hospital used the Healing ARC framework to develop a computerized clinical decision support system for specialist inpatient cardiology care to address health inequities for Black and Latinx people with heart failure.[216]

BEST PRACTICE 6.2

Health care delivery system leaders and other stakeholders can help achieve the absence of racism and bias in clinical training and care delivery by **assessing/eliminating racial-based adjustments in clinical algorithms**.

The use of racial adjustments in clinical algorithms may perpetuate or even amplify health inequities. There are examples in cardiology, nephrology, obstetrics, and urology of "race-based medicine" rather than "evidence-based medicine"—that is, where racial adjustments are made that suggest Black people presenting with the same symptoms as White people are at lower risk for certain conditions. For example, Black people being deemed at lower risk of kidney stones when presenting with flank pain (pain on the side of the back just below the rib cage and above the waist)—even though there is no biological or empirical evidence for the adjustment.[217]

	EXAMPLE		
HOW TO OPERATIONALIZE THE BEST PRACTICE	**ORGANIZATION**	**APPROACH**	**RESULTS/IMPACT**
Analyze/correct algorithms that include race correction.[218,219]	Multiple schools of medicine	One example of "race-based medicine" is the Modification of Diet in Renal Disease (MDRD) equation, which is used to calculate a person's estimated glomerular filtration rate (eGFR).[220] In 2018, the strength of the evidence underlying the inclusion of race in eGFR calculations was questioned by medical students and faculty at several universities. Student advocacy led to iterative assessments of new approaches for eGFR testing. At one university, faculty from the Department of Family Medicine, the Department of Laboratory Medicine, and the Division of Nephrology all participated in the assessment of eGFR approaches. After investigation of eGFR calculations, the interdisciplinary team determined that the use of race in the biomedical environment is an imprecise tool and does not meet the scientific rigor the health enterprise expects of diagnostic tools.[221]	• In 2020, laboratories at some universities transitioned from the MDRD equation to the Chronic Kidney Disease Epidemiology Collaboration (CKD-EPI) equation to calculate eGFR. The new protocol for CKD-EPI excludes race as a variable. Removal of race from the eGFR calculation at several medical institutions prompted the National Kidney Foundation and the American Society of Nephrology to convene a task force to assess the formal removal of race as a criterion in eGFR calculation.[222,223]

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