Institute *for* Healthcare Improvement

Pursuing Equity Action Community

Lessons Learned and Team Summary Reports

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Executive Summary

Between January 2023 and June 2024, the Institute for Healthcare Improvement launched its third cohort of the Pursuing Equity initiative, with a focus on building on the learning from previous cohorts and reaching more health systems. This third cohort featured two parallel efforts to support health care delivery organizations at all levels of their health equity journey: an Action Community that engaged 10 health care organizations in elevating their health equity and racial justice work through clinical equity improvement efforts, and a Learning Network that engaged 58 organizations working together to build the foundations for radical equity work.

This report:

- Describes the Pursuing Equity Action Community in detail, including its focus, goals, key learning, and challenges; and
- Summarizes the experiences and learning of each of the 10 health care organizations, including approach, progress and key successes, critical moments, challenges, and next steps.

Pursuing Equity Action Community

There is no health care quality without equity. Inequities are systematic, avoidable, and unjust and prevent us from achieving the missions of our institutions and from having a thriving health care workforce and community. Systemic racism and white supremacy culture is at the root of, and perpetuates, these inequities in the United States. Creating a health care system that is equitable for all requires radical change to the current system.

The Institute for Healthcare Improvement (IHI) has more than 30 years of experience utilizing improvement science to improve health and health care. We are committed to leveraging our unique skills and network of experts to push the boundaries of equity and racial justice in partnership with health care organizations and communities. Through applying improvement methods and creating a collaborative network, IHI has begun to push those boundaries in domestic and international health care settings.

Background on Pursuing Equity

In 2017, IHI launched the first cohort of the Pursuing Equity initiative, partnering with eight pioneer US health care systems to accelerate the role of health care in improving equity. During the two-year initiative, the eight teams made strides to embed a culture of equity by making health equity a strategic priority, facilitating conversations and actions to address structural racism, and testing numerous changes to improve equity in their systems and communities.

In 2020, IHI launched the second cohort of Pursuing Equity, an 18-month initiative with 22 participating health care organizations that aimed to increase equity and racial justice in two areas: one clinically focused, to close specific equity gaps, and one strategically focused, to impact culture or infrastructure. IHI highlighted key lessons and results from previous Pursuing Equity initiatives in several published guidance documents and case studies.[1]

In 2023, IHI launched the Pursuing Equity Action Community, the third cohort of the initiative, as described in detail below.

Goals of Pursuing Equity

Pursuing Equity is designed to foster systemic action by health care delivery organizations to achieve improvements in equity and become liberated in their racial justice efforts. In pursuit of these goals, IHI provided the following types of support to Pursuing Equity initiative participants:

- Build community and trust among participating organizations;
- Maintain a communication system among participants to support rapid learning, connections, and relationship building with like-minded organizations;
- Engage leading subject matter experts in equity, racial justice, and improvement science to support participating organizations;
- Design and implement a messaging and dissemination plan to publicly highlight the learning and successes of participating organizations; and

- Leverage improvement methods and tools, plus IHI's Achieving Health Equity Framework,[2] the IHI Psychology of Change Framework,[3] and the Community of Solutions Framework.

Focus of the Action Community

Between January 2023 and June 2024, IHI led its third cohort of Pursuing Equity with a focus on building on previous lessons learned and reaching more health systems that are willing and ready to do this challenging, yet rewarding, work at a critical time when injustices nationally are highlighted in an ever-changing political landscape. The third initiative featured two parallel efforts to support health care delivery organizations at all levels of their health equity journey: an Action Community and a Learning Network (see Table 1).

- **Action Community:** Among numerous applicants, 10 health care organizations with established equity efforts were selected to participate, with the goal of elevating their anti-racism work through clinical equity improvement efforts.
  - Cleveland Clinic (Cleveland, Ohio and Miami, Florida, USA)
  - Dartmouth Health (Lebanon, New Hampshire, USA)
  - Hospital Israelita Albert Einstein (São Paulo, Brazil)
  - Lakeridge Health (Durham, Ontario, Canada)
  - Legacy Health (Portland, Oregon, USA)
  - San Francisco Health Network (San Francisco, California, USA)
  - TidalHealth (Salisbury, Maryland, USA)
  - UCLA Health (Los Angeles, California, USA)
  - University Hospitals of Leicester (Leicester, United Kingdom)
  - WellSpan Health (York, Pennsylvania, USA)
- **Learning Network:** A community of 58 health care organizations that worked together to build the foundations for radical equity work.

In the Action Community, participating organizations established multidisciplinary teams, comprising three to seven individuals who were ready to improve equity and racial justice and commit to dismantling white supremacy culture. Organizations were encouraged by IHI to include the following team members:

- Individuals with a lens on quality improvement, equity, and patient-facing care;
- Executive leaders (e.g., chief health equity officer, chief medical officer, chief quality officer)
- Representatives from data departments, equity or Diversity Equity and Inclusion (DEI) teams, clinicians, and frontline staff; and

- Representatives from existing community partnerships who can support the team's efforts throughout the initiative.

Table 1. High-Level Overview of the Pursuing Equity Action Community and Learning Network

	Action Community	Learning Network
Fee	Participation fees were covered thanks to a grant from Genentech, a member of the Roche Group	
Timeframe	Began January 2023 / Concluded June 2024	
Size	10 teams	58 teams
Goals	Teams would demonstrate an improved culture of equity and progress on clinical equity improvement project(s)	Teams would be equipped to bring tools, skills, and a deep understanding of equity and racial justice back to their organizations and be prepared to launch equity improvement projects by the conclusion of the initiative
Virtual and In-Person Supports	Learning- and discussion-based virtual meetings, in-person Learning Sessions, virtual coaching sessions, racial justice affinity groups, and a leadership workgroup	Regular learning- and discussion-based virtual meetings, as well as suggested activities to help bring concepts to life
Application Requirements	An online application, a letter of commitment from the organization's CEO and Board Chair, and a video from the team	An online application and a letter of commitment from the organization's CEO
Other Trainings	Both included participation in Racial Equity Institute's (REI) virtual Groundwater Training on systemic racism, which provided a foundation for the equity and anti-racism work in both cohorts. There was an optional meet-up for all who attended the IHI Forum in December 2023.	

Goals of the Action Community

Small, close-knit cohorts came together in the Pursuing Equity Action Community to make progress on measurable clinical equity improvement projects and advance the overall culture of equity at their organizations, including the following:

- Improve outcomes in at least one clinical area;
- Routinely monitor stratified data;
- Practice racial justice framing and communication;
- Embody a clear understanding of white supremacy culture;
- Leverage community partnerships; and

- Design systems and processes for multiracial and multicultural groups experiencing inequities to positively impact their systems.

These advancements were supported throughout monthly learning- and discussion-based virtual meetings, virtual and in-person Learning Sessions, individualized team coaching sessions, racial justice affinity groups, and a leadership workgroup. Additional opportunities for networking were also introduced throughout the Action Community.

This small community was designed to promote regular data and progress tracking, collaborative idea adaptation, professional relationship building, group problem solving, and collective network building.

Expected Outcomes for Participating Teams

The Action Community was designed to help participating teams make progress on measurable clinical equity improvement projects and advance the culture of equity at their organizations.

Culture change takes time, and undoing structural racism in our health systems and communities will take decades. With a vision of equitable care in the long term, teams worked toward progress on the following milestones over the 18 months they participated in the Pursuing Equity Action Community:

- Progress toward desired clinical equity outcomes at the project level;
- Progress on process measures at the population level;
- Greater results, such as going to scale with an intervention or demonstrating the ability to sustain improvements;
- Capacity to measure and sustain improvements in health equity results, including a long-term plan to take their work to scale; and
- Capability to close equity gaps.

In addition to monthly virtual calls and three Learning Sessions, teams participated in one-to-one coaching sessions and submitted Monthly Action Updates (MAUs). Through the MAUs, teams shared learnings, stories, data, areas of progress, and setbacks related to their clinical equity project and the culture of equity they were working toward building.

Action Community Highlights of Success

- Cleveland Clinic made great progress adding and including race, ethnicity, and language (REaL) data into its systems and dashboards, which laid a foundation for progress toward their equity goals.
- Dartmouth Hitchcock Medical Center (DHMC) successfully added a column about language access needs to their daily flow schedule to facilitate access to their Video Remote Interpreter (VRI). This allowed their team to plan ahead and ensure that a VRI was available at the front desk as soon as a patient required it. DHMC also made progress in translating consent forms and patient materials into multiple languages.
- Hospital Israelita Albert Einstein successfully implemented demographic data questions at their emergency care unit, representing the first time in the hospital's history that they have accurate demographic data.
- Lakeridge Health gained a deeper understanding of staff attitudes about and experiences with patients with sickle cell disease (SCD) and patients' experiences receiving care for SCD in Lakeridge Health's facilities. This allowed them to begin planning ways to improve the patient experience.
- Legacy Health began routinely analyzing breast cancer screening trends by race and improving their ability to collect relevant data.
- San Francisco Health Network successfully updated several of their A3 templates, including the completion and implementation of a new equity-transformed quality improvement process and A3 template.
- TidalHealth implemented multiple changes within their system to address white supremacy culture characteristics, successfully made health equity a topic for monthly leader meetings, and advanced their capacity to collect and analyze race, ethnicity, language, and gender identity (REaL-G) data.
- UCLA Health geocoded patients' home addresses to identify the Centers for Disease Control and Prevention's Social Vulnerability Index score for their neighborhoods, enabling them to focus on reducing unplanned readmissions for the most vulnerable neighborhoods.
- University Hospitals of Leicester analyzed late maternity bookings data across their system, identifying five themes for improving service to increase early bookings for Black patients.
- WellSpan Health conducted community outreach and listening sessions to understand why the urine test component of kidney health screenings was not taking place and developed an algorithm to increase urine specimen collection rates.

Key Learning

For participating organizations, the Pursuing Equity Action Community has been a significant step forward as they seek to address health inequalities and promote equity within their health systems. The initiative introduced a robust set of tools to recognize and acknowledge inequities and disparities as the result of entrenched systemic racism (and associated ideologies and behaviors), implicit bias, and other factors. Through their participation, teams have made important strides toward more equitable health care by focusing on data-driven interventions, community engagement, and pursuing systemic change.

For health systems seeking to embark on their own health equity journey or seeking to improve health equity in their own practices, the lessons learned from the participating teams — and the challenges they faced — can be informative and illustrative.

- **Data Collection and Stratification:** Many teams focused on improving the collection of patient demographic data by race, ethnicity, and preferred language (REaL data). In doing so, several discovered they needed to add or modify these demographic fields in the electronic health record (EHR) and subsequently in the system dashboards. Once collected, REaL data enabled teams to stratify population-level data to better identify disparities, identify inequities in the system, and monitor whether changes they implemented led to improvement.

- **Organizational Culture Change and Ongoing Education:** Many organizations encountered resistance from staff and leadership in recognizing and acknowledging health inequities, systemic racism, and other sensitive topics. At the start of the Pursuing Equity Action Community, organizational culture at many health systems was not yet comfortable explicitly discussing the structural racism within their systems. Teams worked to build psychological safety and organizational trust while introducing trainings on topics such as white supremacy culture, health equity, and implicit bias.

- **Leadership Commitment Is Essential:** Strong leadership commitment is critical for advancing health equity. When leadership prioritizes and integrates equity into organizational goals, it provides the necessary resources, attention, and momentum for sustained progress.

- **Need for Multidisciplinary Teamwork:** Because equity work is often siloed, several teams stressed the need for collaboration across departments, which can help to coordinate appropriate interventions and ensure sustainability of equity efforts. Multidisciplinary teams that include diverse perspectives from across the organization and include teamwork and collaboration across departments help to break down silos and create comprehensive strategies.

- **Community Engagement and Partnerships:** Multiple teams emphasized the importance of engaging with community members and partners to understand barriers and co-

design solutions. To this end, several teams conducted listening sessions, interviews, or surveys with those involved with target populations to better understand the issues at the center of their clinical projects. Collaboration with external community resources is also important when seeking to address the impact of structural racism on social determinants of health such as food insecurity, transportation, and housing.

- **Cross-Cultural and International Collaboration:** Action Community teams spanned four countries on three continents. The cross-cultural and international collaboration that resulted during the Action Community was incredibly beneficial to all involved. Despite similar broad goals, each team had unique patient populations, local demographics, and challenges. Participants were able to explore how racism is defined and approached in different areas and cultures. As a result, teams had to learn how to communicate with each other and adapt concepts for the language of their specific system and culture, leading to an extraordinary and profound amount of collaborative problem solving.

Challenges

Pursuing Equity Action Community teams encountered common challenges that highlight the need for ongoing commitment, sustained efforts, and continued innovation to achieve lasting change.

- **Fear of Examining Existing Data:** Several teams reported an initial fear or resistance to examining internal data on inequalities due to uncertainty or discomfort about what it would reveal.
- **Data Collection:** Many teams noted difficulties with data collection, such as small sample sizes for certain populations or the lack of robust, integrated data systems that can effectively stratify data by race, ethnicity, language, and other relevant demographics. Data collection challenges made it difficult to identify and monitor inequalities accurately and hampered the ability to measure progress. Similarly, teams described challenges with adapting EHR systems to collect or include relevant data for patients within the scope of their clinical projects.
- **Resistance to Acknowledging Inequity and Disparities:** Many teams experienced resistance from colleagues due to individual and systemic discomfort around discussing issues like white supremacy culture, systemic racism, implicit bias, and the existence of inequities within their own institutions. Furthermore, acknowledging issues like resistance to change as characteristics of entrenched white supremacy culture is also a significant barrier.
- **Engagement and Buy-In:** Several organizations reported that engaging staff in equity initiatives is often challenging. Action Community participants found that their colleagues outside of Pursuing Equity sometimes found it challenging to engage with

anti-racism due to workload, skepticism, denial, or resistance to adding complexity to clinical protocols. While many organizations developed and committed to strong equity initiatives in response to nationwide anti-racism demonstrations in 2020, continued prioritization of anti-racism and equity efforts has been a recurring challenge.

- **Siloed Thinking and Fragmentation:** Many organizations struggle with siloed approaches to equity work, where different departments work in isolation rather than in a coordinated, system-wide effort. This fragmentation limits the effectiveness and scalability of equity interventions. Pursuing Equity attempted to combat siloing by recruiting teams with cross-department teams and emphasizing the importance of top-down and bottom-up system changes.
- **Sustainability and Spread:** Several organizations reported challenges or barriers to sustaining and spreading their equity work beyond those involved directly in the project (team members, patients, etc.). Many continue to work to develop ways to embed the learnings into existing processes and structures.
- **Communication and Trust-Building with Communities:** Building trust and effectively communicating with diverse patient populations is a challenge, particularly in areas with high levels of mistrust in the health care system due to longstanding systemic racism. This can be exacerbated when language barriers and cultural differences are not adequately addressed.

Conclusion

The journey of the 10 teams participating in the Pursuing Equity Action Community highlights the progress that can be made when health systems commit to addressing health inequalities and promoting equity. The experiences of the participating organizations underscore the importance of data-driven approaches, leadership commitment, multidisciplinary collaboration, and community engagement.

At the same time, the teams' respective journeys also highlight the challenges that arise when undertaking these significant endeavors, both the challenges known at the outset and those that were unforeseen. The specific challenges many teams faced — such as resistance to acknowledging inequalities, difficulties in collecting data and adapting EHR systems to include the data needed to achieve change, and sustaining momentum — reveal that the path to health equity is not without obstacles.

As health systems continue to strive for more equitable care, the lessons learned from this initiative serve as a valuable guide. In that way, the experiences of the Pursuing Equity Action Community's participating teams can provide a roadmap for many of the considerations health systems will need to consider as they begin or work toward their own equity improvement efforts. Progress on improving health equity requires not only technical solutions but also deep cultural shifts within organizations, ongoing education, and a commitment to long-term change.

By addressing these challenges head-on and learning from the experiences of others, health systems can move closer to realizing the goal of more equitable health care for all.

Team Summary Reports

Pursuing Equity Action Community Team Summary Reports

The 10 teams participating in the Pursuing Equity Action Community faced radically different circumstances, from the ultimate goals of and existing progress toward their organization's equity work, to the demographics of the patient population they serve, to the organizational culture, among many other variables. As a result, each team brought a unique perspective and approach to addressing health inequities within their respective health systems. Each team embarked on its own health equity improvement journey, focusing on specific clinical and cultural equity challenges within their respective organizations.

Through the collaborative experience of the Pursuing Equity Action Community, however, these teams were able to share their learning and challenges within the broader initiative, leveraging the unique experiences and feedback of all teams as they worked toward measurable improvements in patient outcomes and organizational practices to improve health equity.

In this section, the team summary reports provide an overview of each team's experience, highlighting their unique approaches, successes, critical moments, challenges, and next steps as they continue to advance equity within their health systems now that their participation in the Pursuing Equity Action Community has concluded.

The summary reports offer valuable insights into the diverse ways health systems can begin to tackle systemic inequities. The experiences of these teams underscore the importance of tailored interventions, community engagement, and the ongoing commitment required to drive meaningful change in health equity.

The summaries highlight common themes — resilience, innovation, and the power of collaborative action — and showcase the tangible outcomes achieved by each team, providing a roadmap for other organizations seeking to embark on their own equity improvement journeys.

Cleveland Clinic

Cleveland, Ohio, USA (Integrated Health Delivery System)

Background

The Cleveland Clinic is a global integrated health delivery system providing all levels of care, ranging from primary care to specialized care within its 23 hospitals and 276 outpatient locations. The system cares for 3.3 million patients annually, with 15.1 million patient encounters in locations around the globe.

In Northeast Ohio, the Cleveland Clinic's patient demographic comprises more than 4.4 million people, with 12 of 18 postal codes in its service area having a greater than 50 percent Black population. These counties also have a higher percentage of people without high school diplomas, higher rates of poverty for Black and Hispanic residents, and an unemployment rate above the US average.

The Cleveland Clinic team participating in the Pursuing Equity Action Community was a multi-department team that included physicians, quality improvement specialists, DEI leaders, and executive leaders.

Approach

Clinical Equity Improvement Project Aim

Partner with our patients, caregivers, and community resources to reduce readmissions disparities by 50 percent while continuing to drive improvement at five hospitals with the highest opportunity gap, by completing post-discharge follow-up visits by June 2024.

In August 2022, the Cleveland Clinic discovered Black patients had a higher rate of readmissions than white patients. To identify which hospitals were experiencing the greatest disparities, the team created a ratio comparing the observed readmission rate for an identified population with the expected likelihood of the patient returning to the hospital within 30 days. This enabled them to determine that across the enterprise, Black patients readmitted at a higher observed-to-expected (O:E) ratio than white patients.

Using this O:E ratio, the Cleveland Clinic team identified five hospital sites with the greatest opportunity to reduce disparities in patient readmissions: Euclid, Indian River, Main Campus, Mercy, and Weston. They also looked at the hospital sites that were among the best performing and attempted to identify the best practices at those sites that might be disseminated elsewhere.

Progress

At the beginning of the Action Community, the Cleveland Clinic team sought to understand differences in outcomes for patients of different races. This required the team to overcome organizational hesitancies and internal fears around what examining the data would reveal. During their participation in the initiative, the team successfully overcame that fear to identify a problem, craft and implement solutions, and ultimately share that data outside the organization.

At one hospital with a small percentage of Black patients, the physician lead began a weekly review to ensure that all Black patients had a follow-up appointment scheduled — one of the main change ideas that the Cleveland Clinic team developed. Between September 2023 and March 2024, this reduced the Black patients O:E ratio to below the hospital's target and in line with the O:E for white patients.

The hospital with the strongest signal of improvement established a "command center" where the three services involved in admitting a patient to the hospital — the case manager, whose job it is to divert the patient to another level of care, if eligible; the nurse leader, who is responsible for assigning the patient into a bed; and the physician leader, who is involved in writing the admission order — were placed into a shared office space instead of in three separate offices. This increased coordination to ensure that patients were getting the appropriate care.

Key Successes

- Included race data in many of the Cleveland Clinic's dashboards, although its use remains limited.
- Included a column for race data in the EHR system for providers to add this information.
- Race data is now available in Outcomes Review.
- Created run charts for each site, including target sites, enabling review using the available data while also improving the data quality.
- Identified sites where O:E Readmission Rate shows a disparity between different races (i.e., hospitals warranting intervention).
- Identified sites where O:E Readmission Rate does not show a significant disparity (i.e., hospitals with potential best practices).
- Launched a community health worker pilot on the main campus.

Critical Moments

One critical moment that the team identified was giving hospital leadership an opportunity to discuss their priorities, which the Pursuing Equity team was able to align with their own priorities and work. This, in turn, enabled the team to focus on more bespoke solutions for each facility instead of a one-size-fits-all approach to implement across the entire enterprise.

Another critical moment arose in mid-2023 when the team was able to add a race column to patient records within their EHR system. Prior to this, there was no succinct way to see race and a 30-day scheduled follow-up appointment.

A third critical moment came when the team saw the organization transition from a fear of what the data would reveal to other areas of the organization (e.g., hospitals, disease cohorts, and service lines that were not a focus of the team's work during this project) to other departments consulting the Pursuing Equity team about the tools, learning, and data sources gained through their work in the Action Community as part of their own pursuit of reducing disparities and increasing equity.

Challenges

A major challenge that the Cleveland Clinic team experienced from the outset, and especially in the early stages of the project, was getting colleagues to accept that disparities existed, even though external and internal data indicated otherwise. This presented obstacles such as the need to add a race filter to patient records, enabling the team to more easily identify patients who might need follow-up care.

Another challenge was getting colleagues to understand that the root cause of the problems being discussed was one of racial equity and not any of several other factors (e.g., poverty, chronic conditions, access).

Next Steps

In the short term, the Cleveland Clinic team plans to continue exploring promising interventions such implementing "command centers," aiming to find another site in the next year to test the command center model where the three internal positions indicated above are already operational.

In the medium term, the Cleveland Clinic team hopes to see more of their Black patients completing follow-up appointments due to the changes made at the system level. Additionally, behavior change among providers to get curious about inequities in their patient populations and the processes that support them is another early signal of a culture shift that will ideally lead to best practice implementation at the provider level.

Dartmouth Hitchcock Medical Center

Lebanon, New Hampshire, USA (Academic Medical Center and Health System)

Background

Dartmouth Hitchcock Medical Center (DHMC), New Hampshire's only academic medical center, includes a system of community hospitals, clinics, and health care services across New Hampshire and Vermont. In addition to a 460-bed hospital covering more than 2 million square feet, the DHMC system includes locally-focused community hospitals and clinics, a cancer center, and the state's only children's hospital. Vermont comprises 40 percent of DHMC patients, making the health system the second-largest provider of care to Vermont residents.

DHMC Obstetrics and Gynecology (OB/GYN) provides comprehensive reproductive health care at many locations and environments of care. As a department of an academic health system, DHMC OB/GYN serves communities from remote rural areas in the northern part of the state through urban centers in the south.

The team members participating in the Pursuing Equity Action Community included DHMC OB/GYN physicians, nurses, managers, and social workers. The team, however, recognized that they were engaging in the Action Community as representatives of the entire Dartmouth Health system, so they focused their equity improvement efforts on a broader topic with larger potential impact across the entire organization.

Approach

Clinical Equity Improvement Project Aim

100 percent of DHMC OB/GYN patients in Lebanon, NH, receive linguistically appropriate services by June 30, 2024. Sub-aims are to have 100 percent of DHMC OB/GYN patients screened for language and communication access needs and offered language access services, if needed.

Although the area that Dartmouth Health serves exhibits little racial and ethnic diversity, these demographics are rapidly changing. With these changing demographics, significant language barriers arise when a non-English-speaking patient requires care since traditionally the hospital used English as the default and, in many cases, only language (e.g., signage, announcements, interactions).

Progress

Because Dartmouth Health is in a rural area, it has proven difficult to find in-person interpreters, specifically for the variety of languages that DHMC patients require. Thus, the health system had to rely largely on video remote interpretation (VRI) services. At the beginning of the project,

the team started by interviewing patients to better understand their experience with the interpretation services and how the team can improve awareness of and engagement with the services.

The team also interviewed providers and staff to ask about their comfort level with the interpreter services and get a sense of their knowledge about how to access them.

Key Successes

- Moving access to language interpretation services from the exam room to the check-in desk.
- Generating awareness of the interpretation services so patients know they are available at no cost (e.g., updating website, phone line options, signage).
- Holding trainings for providers and other support staff on best practices in working with interpreter services.
- Translating consent forms and other patient materials into the most encountered languages.
- Adding a column for preferred language to the daily printed provider schedule to indicate if interpreter services will be needed.
- Changing the automated phone message to include a choice to contact interpreter services.
- Adding an emoticon survey after each interpreted visit to collect information about the quality of interpreter services.

Critical Moments

One key moment for the Dartmouth Health team was when they realized that the need for interpretation services started well before the patient arrived in the clinic exam room; by beginning the offering of interpreter services at check-in and providing the VRI machine at the reception desk, the DHMC team can ensure that more of the patient experience is aided by interpretation services when necessary.

For example, one patient delivering a baby had to be transferred to the neonatal intensive care unit. Because of language barriers, this transfer took place without the ability to explain to the mother where the baby was going and why intensive care was required. That left the mother fearful and uncertain at a critical and difficult moment.

Another critical moment occurred when the team experienced firsthand the value of the exercises that were part of the Action Community curriculum to address difficult topics and overcome challenges. This brought the group closer together personally and professionally.

Challenges

Because of Dartmouth Health's rural location, the team reported a widespread belief that the system didn't serve a large population requiring interpreter services. Through the Action Community work, the team ultimately began to recognize this as a byproduct of white supremacy culture. Thus, one of the first items that the DHMC team had to address was recognizing that even if the number of patients needing interpreter services is small, it is significant enough that they must offer those services because they're needed. This manifested itself in organizational resistance to making "preferred language" a mandatory field in the patient health record, which would provide crucial insights into which patients need interpretation services during their care journey.

As the DHMC team sought to expand their learning beyond the OB/GYN department, they discovered a desire to provide the VRI machine to a patient when they enter the building, instead of when they reach the reception desk. Even though use of VRI machines has dramatically expanded the amount of time that a patient can carry interpreter services with them, there remain several areas where the need for coordination with other departments leaves a gap in the continuity of care (e.g., getting labs/ultrasound done, navigating the building).

Next Steps

In the immediate future, the DHMC team will continue the work started with their clinical project, using the results and their experience thus far as a teaching tool to inform and educate colleagues about the ways in which white supremacy culture and inequities manifest themselves (e.g., the belief that translation services are not a priority because of the demographic makeup of the area).

After the Action Community project formally concludes, the team will transition to monthly meetings to not only continue building on the work within the OB/GYN Department, but also to provide resources to other departments so they can easily and efficiently begin to address language access barriers.

The team will also continue to drive the work that has been started by continuing the monthly interviews with patients who utilize interpreter services, both through live interviews and by using the emoticon survey after the interpreted visit.

Dartmouth Health OB/GYN was also recently accepted to participate in "Raising the Bar for Moms and Babies," an 18-month learning cohort with other health systems.

Hospital Israelita Albert Einstein

São Paulo, Brazil (Hospital System)

Background

Hospital Israelita Albert Einstein provides health care services to both the public (government-supported) and private sectors. Approximately 46 percent of the hospital's patients are from the public sector, with the services comprising 16 primary care clinics, three hospitals, and one emergency department. The hospital's private sector services are utilized by approximately 90 percent of white upper-class Brazilians.

The hospital has three teams (with five to six people per team) participating in a pilot project to address equity issues: the maternal care unit, the pediatric unit, and the emergency department. All three teams are diverse in composition (team members include nurses, doctors, administrative assistants, and other health care workers) as well as in backgrounds and identities.

The team participating in the Pursuing Equity Action Community primarily comprised equity specialists, DEI leaders, and other health system leaders.

Approach

Clinical Equity Improvement Project Aim

Increase patient satisfaction for LGBTQIA+ patients, patients with disabilities, and elderly patients in Campo Limpo Emergency Care Unit.

Hospital Israelita Albert Einstein's Campo Limpo UPA is a 24/7 emergency center that has received several reports of discrimination. While possibly unintentional, these acts reflect that the hospital's systems are designed to perpetuate discrimination toward these populations. In last year's reflection, Einstein saw that the populations suffering the most as patients and collaborators are LGBTQIA+ individuals, individuals with disabilities, and the elderly, for various reasons.

Thus, Einstein's aim was to increase the percentage of employees who believe they are making a positive impact on the culture related to diversity, equity, and inclusion in their work unit from 8.53 percent to 9 percent between April 2022 and June 2024. During this same timeframe, the team also aimed to reduce disparities by 5 percentage points for individuals with disabilities, members of the LGBTQIA+ community, and different ethnic groups compared to the overall average response to the statement, "I feel I belong in my work team."

Outcome indicators for the identified patient populations experiencing inequities include the following:

- Increase LGBTQIA+ patient satisfaction at the Campo Limpo UPA by 30 percent between April 2022 and June 2024.
- Increase satisfaction for patients with disabilities by 30 percent between April 2022 and June 2024.
- Increase the identification of high-risk elderly patients by 40 percent between April 2022 and June 2024.

Progress

Einstein's work on their clinical equity improvement project began nearly a year before they were accepted into the Pursuing Equity Action Community. Around January 2022, Einstein conducted an anti-racist and health equity training for the hospital's leaders, which enabled the hospital to begin deconstructing the structural oppression that has led to existing inequities. Following the training, the Einstein team further sought to understand the inequities by reviewing customer experience surveys and interviewing patients and partner community members to determine the most vulnerable populations on which to focus to address inequities. The outcome of those reviews and discussions led the team to choose individuals with disabilities, LGBTQIA+ individuals, and the elderly — all groups that are severely impacted by racism and inequities.

In June 2022, the team began engaging more people in the working group to ensure that units had local ownership and autonomy to improve equity with tools and support. Between June and December 2022, the team implemented Equity Weeks, where they invited patients and workers from each of the three units into discussions to understand and use the science of improvement to identify where and how inequities in care were occurring. They also used these tools to co-design improvement ideas and prioritize specific areas.

Key Successes

- Including demographic data such as racial identity in the new electronic health record system for public sector care will enable Einstein to look at quality and safety indicators stratified by race, sexual/gender identity, age, and disability status. While questions were optional for the first several months of the pilot, leading to a small sample size, they became mandatory in April 2024.
- An overall strengthening in the unit's culture has resulted from more fluid communication on issues and deepening the team's engagement in learning how to approach tasks, while also considering the differences between the patient populations they are prioritizing. Leaders have expressed great pride in the project and those who are not involved maintain a perspective of fairness.
- The intentional co-design method has contributed to completely transforming the way that the UPA approaches actively listening to the populations experiencing inequities.
- By intentionally testing new work protocols, the Einstein team has identified specific practices aimed at promoting equity in the units. This is an important step toward ensuring that their actions are aligned with the fundamental principles of justice and inclusion.
- Development of line of care, reception, and support flow diagrams for specific populations in the emergency room, including LGBTQIA+ individuals, transgender/non-binary individuals, and individuals with autism spectrum disorder.

Critical Moments

Each June, Hospital Israelita Albert Einstein holds an Equity Week for all staff, where the teams focus on equity issues they are working to address and use the psychology of change to engage colleagues in the topics and deeper conversations. These dedicated weeks also provide an opportunity to bring in members of the populations experiencing inequities to discuss their interactions and challenges with the health care system.

Through these Equity Weeks, and the questions and discussions that occurred through them, team members discovered that inequities were a result of systems that were not designed to consider diverse populations, rather than poor intentions.

Challenges

One of the biggest challenges that the Hospital Israelita Albert Einstein team faced was that their systems are not set up appropriately for data stratification, especially for clinical data.

While they ask racial demographic questions and collect sexual orientation and gender identity (SOGI) data, that information isn't necessarily used by a clinician.

Another challenge was physician engagement; because some doctors are hired only for the hours they work, this creates challenges for training and incorporating them into the programs. Furthermore, the team described encountering institutional resistance when advocating for population-specific trainings; because there are already so many other issues to be trained on, many colleagues did not believe they needed specific trainings for the different populations selected as the subject of the Einstein equity team's work.

Lastly, unlike other teams participating in the Action Community, the Einstein team noted that an emergency unit has a somewhat complicated context in which to conduct improvement projects because patients usually stay only a short time and the network isn't usually as integrated as it could be to monitor the patient's care after the visit to the UPA.

Next Steps

A priority for the future is ensuring that Einstein's equity work in the emergency care unit is sustainable and will remain in place even if the core team members leave or assume new positions within the organization or elsewhere. They plan to incorporate equity into various staff trainings and other learning opportunities to help ensure continuity.

The team also plans to expand their work beyond the Campo Limpo UPA to three primary care units, one psychological care unit, and another emergency care unit. This will enable them to test the learning beyond the emergency care unit that has been the focus of their efforts thus far.

Lakeridge Health

Durham, Ontario, Canada (Hospital System)

Background

With five hospitals, four emergency departments, three critical care units, a long-term care home, a full range of medical and surgical specialties, and more than 20 community health care locations, Lakeridge Health serves the region with some of the broadest and most comprehensive acute care, ambulatory care, and long-term care services in Ontario.

The Durham region has one of the fastest growing populations in Canada, increasing from 247,473 in 1976 to an estimated 699,460 in 2019. More than 70 percent of the region's population growth within the last five years has been through immigration. Lakeridge Health serves a large and diverse population that includes the second largest Black and third largest Indigenous population groups in Ontario; Durham region's town of Ajax has the highest Black population percentage of any major Canadian city.

The Lakeridge Health team participating in the Pursuing Equity Action Community included DEI leaders, executives, administrators, and managers.

Approach

Clinical Equity Improvement Project Aim

Eliminate racism in the Ajax/Pickering emergency department (ED) for patients with sickle cell disease (SCD).

The Lakeridge Health team did not have complete data on race, ethnicity, and language, so they had to find another way to focus in on a population commonly experiencing racism and disparities in the health system. Because SCD predominantly affects individuals who are Black and these individuals often experience racism and anti-Black racism during patient encounters, this patient population is at the intersection of racism and the health care system, which negatively impacts the quality of care they receive.

The specific aims of Lakeridge Health's Pursuing Equity Action Community project were twofold:

- By June 30, 2024, 100 percent of individuals with SCD report they are receiving care in a health system that is free from racism, anti-Black racism, discrimination, and stigma.
- By June 30, 2024, 100 percent of patients with SCD who present to the emergency department with Vaso-Occlusive Acute Pain Episodes (VOAE) and assigned a CTAS score of 1 or 2 have treatment started within 30 minutes of triage.

This work was important to align with one of Lakeridge Health's overall strategic directions around inclusion, diversity, equity, accessibility, and anti-racism (IDEAA). In developing this approach, the team saw an opportunity to improve the experience of individuals with SCD, a racialized disease, through implementing evidence-based quality statements specific to quality standards that contain specific strategies to address anti-Black racism.

Progress

Using EHR data and reports, 37 patient visits for SCD were identified at the Lakeridge Health Ajax/Pickering (LHAP) ED between January 1, 2022, and April 30, 2023. The average Physician Initial Assessment (PIA) time for these visits was 114 minutes and the average time from arrival to pain medication administration was 173.5 minutes (the fastest was 28 minutes and the longest was 418 minutes).

The Lakeridge Health team also surveyed LHAP ED staff members on their experience caring for patients with SCD; 37 ED staff members responded to the online survey designed to evaluate their needs/assets and collected their recommendations for improving care for the SCD patient population. On a scale of 1 (low) to 10 (high), the average ED staff member comfort level in caring for patients with SCD was 6.57 and the level of general knowledge about SCD was 6.22. The survey also looked into common beliefs of patients with SCD, opinions on SCD health-related stigmas (e.g., some patients with SCD exaggerate pain to inappropriately seek medications), staff implicit biases when caring for patients with SCD, and staff recommendations for designing a better system to support patients with SCD.

The Lakeridge Health team also interviewed patients with SCD about their experience in the LHAP ED; 5 of the 24 patients identified participated in patient interviews. While none of these patients said they experienced racism, stigma, or discrimination throughout their patient experiences, only 40 percent believed they received timely and efficient care for SCD.

Key Successes

- Implementing FYI flags in the EHR for all patients who visited LHAP ED for SCD treatment from 2021 to present, providing a visual cue in the record that the patient has SCD and will need expedited care.
- Organizing comprehensive education days for LHAP ED nurses and physicians that focuses on the intersection of anti-Black racism and SCD, and emphasizes implicit bias awareness and the importance of listening to patient self-reported pain levels. According to surveys conducted after the education days, ED triage nurses reported significant improvements in their knowledge of SCD, comfort level in caring for patients with SCD, knowledge of what implicit biases include, and knowledge of the impact that implicit biases have on patient care and outcomes.
- Collaborating with Ontario Health to develop a playbook to tackle anti-Black racism within the context of SCD, aiming to confront systemic inequities and promote inclusivity in health care as well as share institutional experiences to inform the provincial SCD community of practice.
- Partnering with Durham Community Health Centre to pioneer a Black Health-Sickle Cell Disease Clinic, addressing health care disparities and improving access to tailored care for Black individuals with SCD.

Critical Moments

One critical moment arose from a challenge: The team had a significant personnel change midway through the Action Community. When the current iteration of the team started, they expressed some challenges in getting everyone on the same page, but once that happened they were able to move forward in a meaningful way.

Another critical moment occurred when the Lakeridge Health team held their first education day with LHAP ED triage nurses: The education program was well received by the nurses and that gave the team a much-needed spark of momentum.

Challenges

There was significant turnover among team members in the middle of the Action Community. That required the new team to quickly build the trust required to undertake this work and get caught up with the other Action Community teams.

Team turnover also led to significant challenges around physician engagement, which a team member noted that they lacked since the first team changed over. Because SCD requires the prescription of narcotics, a physician must be present. Without physician buy-in, nurses must assume the responsibility of advocating for the patient.

Next Steps

In the short-term the team is completing their LHAP ED pilot and will then review the data and lessons learned to determine how to duplicate the successes across the other three EDs and scale up improvements to other hospital programs.

The team will continue to facilitate education sessions for the remaining LHAP ED nursing staff and the ED IDEAA champions. They also plan to seek more physician engagement, confirming the education plan with LHAP ED physicians.

Legacy Health

Portland, Oregon, USA (Integrated Health System)

Background

Legacy Health is a locally owned nonprofit, seven-hospital health system that includes a full-service children's hospital, a 24-hour mental and behavioral health services center, and more than 70 primary care, specialty, and urgent care clinics. The system provides comprehensive health care services across the metropolitan areas of Portland, OR, and Vancouver, WA, as well as Oregon's mid-Willamette Valley, serving communities as far north as Southwest Washington and as far south as Silverton, Oregon. Legacy Health also has a massive footprint as one of the largest employers in the area, with 14,000 employees and nearly 3,000 health care providers. From rural areas to urban centers, Legacy Health plays a critical role in the lives of 2.5 million people.

Legacy Health joined the Pursuing Equity Action Community after participating in a previous IHI program and seeing an opportunity to build on that initial work, as well as engage others in the organization in the important equity work that was underway.

The Legacy Health team that participated in the Pursuing Equity Action Community included a cross-section of leaders and executives from across the organization, from areas as varied as population health, Medicaid strategy, quality improvement, and DEI.

Approach

Clinical Equity Improvement Project Aim

By June 30, 2024, 85 percent of Black or African American patients with breasts 50 to 74 years of age who are covered under a Legacy Health value-based agreement in Oregon and Washington will be screened for breast cancer and the disparity gap will be within 1 percent of the eligible white population.

Through their involvement in Pursuing Equity, Legacy Health focused on mammography screening with their Black and African American patients, based on an awareness that these populations experience higher mortality rates and that oftentimes breast cancer in these populations goes undiagnosed. This could be in part due to screening recommendations from the US Preventive Services Task Force (USPSTF), which until very recently (after this project began) didn't recommend screening for average risk patients until age 50 and did not call out Black patients as being in a high-risk group. White patients peak in breast cancer diagnosis in their early 70s, but peak presentation for Black patients is in their late 40s.

Progress

Throughout the Action Community, the Legacy Health team found that the more they showcased the work they were doing, the more people wanted to be involved. They were able to make connections with community partners and internal stakeholders to support their change theory process. After conducting one Plan-Do-Study-Act (PDSA) cycle, stakeholders were ready to engage and work with the team to support their aim. By September 2023, the team met with a radiology manager who was fully supportive of the work and committed to helping.

By October 2023, the team also reported progress on the Pursuing Equity Action Community's goals of embodying a clear understanding of white supremacy culture by beginning to challenge themselves on how they interacted with organizational leaders in support of this work and around addressing white supremacy culture more broadly. That resulted in leaders eager to lean into the challenging conversations around Legacy Health's history.

Team members also reported that the Action Community's 18-month time period gave them the opportunity to build a highly functional team with deep levels of trust, as well as skills and knowledge that they can use to advance the equity work focused on mammography screening as well as other services.

Key Successes

- Began routinely reviewing the trend in breast cancer screening by race at clinics in the clinical equity improvement project.
- Began routinely reviewing quality measures stratified by race, ethnicity, language, and gender.
- Began proactively collaborating with both states (Oregon and Washington) on new regulations for REaL and SOGI data collection.
- Began actively looking for new opportunities to improve health equity in partnership with the DEI department, for example, in patient discharge and throughput.
- Disseminated learning from disparities reporting via a highly attended DEI series.

Critical Moments

The first critical moment that the Legacy Health team can identify in retrospect was the decision to participate in the Action Community. While preparing their application materials, questions arose as to whether the team had the capacity to commit to the rigorous time demands that the Action Community would entail; one team member also reported personally questioning the ability to take on an additional responsibility given an already heavy workload.

A second critical moment came during the first on-site Learning Session in March 2023 when they selected their clinical project. While many other Action Community teams knew specifically where they wanted to focus their work, the Legacy Health team remained among the last to determine where to dedicate their efforts. Ultimately, the team selected breast cancer screening because they saw an opportunity to make tangible progress and impact based on their ability to identify patients and leverage community partnerships in this work.

Challenges

Throughout their participation in the Pursuing Equity Action Community, the Legacy Health team reported several challenges, the most significant of which include the following:

- Difficulties getting an adequate sample population for patient interviews;
- Internal barriers as they sought to provide incentives for patients volunteering to provide an interview;
- Challenges coordinating with external partners and connecting with key managers on the work; and
- Issues gaining traction with internal teams needed to move forward with their Direct Scheduling PDSA test.

Other challenges arose due to the demographics of the area; because the Portland area lacks major ethnic and racial diversity, as the team stratified their population it became increasingly smaller.

Another major unforeseen challenge arose in the middle of the process when Legacy Health announced it was in discussions with the Oregon Health & Science University (OHSU) to unite as one health system, becoming a formal merger announcement in May 2024. The merger contributed to uncertainty about what the future organization would look like and where equity work would fit in its plans.

Next Steps

In the short term, the team will continue to meet and conduct their PDSA cycles. They are especially energized to continue their work to increase scheduling mammograms, in addition to working with community partners to develop better messaging for Black and African American patients about breast cancer screening. This messaging will be designed to help this population understand how their risks may be different, when mammography screenings should be happening, and what conversations on these topics might look like.

In the medium term, the merger with OHSU Health presents many unknowns. However, the team seeks to take their learning from this experience and determine how to continue the momentum by identifying other equity projects they can begin and engaging others in the health system who care about these issues in developing the same skills and tools. In so doing, the team hopes that equity work can be seamlessly woven into the fabric of the organization.

San Francisco Health Network

San Francisco, California, USA (Public Health Care System)

Background

The San Francisco Health Network (SFHN), the health care delivery arm of the San Francisco Department of Public Health, cares for a population of approximately 90,000 patients who are largely low-income, Medicaid, or uninsured. The health system consists of 14 primary care clinics, dozens of specialty clinics, Zuckerberg San Francisco General (ZSFG), and Laguna Honda Hospital and Rehabilitation Center. The SFHN primary care network is situated throughout the city and county of San Francisco, located largely in communities of color where their patients reside.

The team from SFHN participating in the Pursuing Equity Action Community included equity leaders, care experience managers, and other primacy care leaders.

Approach

Clinical Equity Improvement Project Aim

Create a new, equity-focused quality improvement infrastructure with a focus on redesigning the A3 template.

The San Francisco Department of Public Health (SFDPH) uses quality improvement methods including Lean, A3 Thinking, and PDSAs to improve all aspects of work, including operations, staffing, and the effective use of resources.

Using the A3 Thinking approach to problem solving, A3 templates are a primary method that SFDPH uses to plan quality improvement efforts. However, SFDPH's current A3 framework and training fails to sustainably and effectively focus on equity. Thus, the San Francisco Health Network team sought to redesign their A3 template and training to incorporate equity, anti-racism, and justice concepts and frameworks, with the goal of creating effective equity improvement and yielding more institutional changes.

Progress

The SFHN team set out to create a new equity-focused A3 template by the end of 2023 that could be operationalized throughout their primary care clinics and within the broader San Francisco Department of Public Health. To achieve this, they are establishing communication channels with primary care managers, updating old A3 templates as appropriate with new quality improvement processes and tools (including the Food Pharmacy and Hypertension Equity A3s), and creating a new Bias Free Care A3. The team is also establishing regular communication with other offices and meeting with other SFDPH sections.

Key Successes

- Completion and implementation of a new equity-transformed quality improvement process and an A3 template and tools that incorporate equity and justice concepts and frameworks.
- Identification of robust processes for collecting SOGI and REaL data; due to the robust data collection processes, SFHN is easily able to stratify their data for almost any metric based on SOGI and REaL data.
- Started equity workshops that include discussion about white supremacy culture with primary care management teams, with plans for future workshops on how to address this topic.
- Started clinic-focused trainings.
- Partnered with community stakeholders relevant to the clinical equity project, including Community Health Equity and Promotion Branch, Food Is Medicine Collaborative, and the Bayview Pop-up Village around Black/African American women and perinatal care.

Critical Moments

The primary critical moment was the first Action Community Learning Session, which provided the opportunity for the team to focus exclusively on their goals and the planning required to achieve them via a dedicated time and space. In this dedicated space, the team could focus on integrating equity work and anti-racism with quality improvement processes instead of keeping them separate.

Challenges

The SFHN team faced challenges with coordinating and communicating the concepts that the team was developing during dedicated working sessions to align frameworks and understanding across the rest of the section and department. Because the SFHN is a large government organization, it can be difficult to coordinate with the vast universe of other teams and transmit the learnings and other information arising from the SFHN team's work in the Action Community.

Another challenge — unexpected at the outset — was that while many department members were excited about the team's work and committed to carrying it forward, others displayed hesitancy. Those team members were concerned that radically changing the model could create unintended consequences that would be detrimental to the organization's overall mission.

Next Steps

In the short term, the team wants to ensure that they can continue the work, renewing their strategic goals and plans every year. This starts with using their new processes in primary care and ensuring that primary care staff and the workforce are aligned to the goals that they've outlined based on the redesigned processes. In addition, the team is working with other offices in the department to determine how to disseminate the equity work and processes.

As the largest department within the city and county of San Francisco, the team recognizes that widespread changes will take time to achieve and moving the work forward will likely require further adjustments.

TidalHealth

Salisbury, Maryland, USA (Hospital System)

Background

TidalHealth serves a diverse rural, geographically widespread, and underserved community of approximately 30,000 residents in the Lower Eastern Shore of Maryland and Sussex County, Delaware — a region bordered by the Chesapeake Bay and the Atlantic Ocean. Significant socioeconomic barriers exist throughout the region, including poverty, illiteracy, limited access to the Internet and transportation, food deserts, and unstable housing. The region also has a growing population of Haitian and Hispanic immigrants.

The hospital system has made health equity a strategic priority and tied performance metrics to addressing disparities. It previously formed a Diversity, Equity, and Inclusion Task Force, which participated in a previous 18-month IHI Pursuing Equity initiative.

The TidalHealth team participating in the Pursuing Equity Action Community included leaders in population health, equity, and data and measurement.

Approach

Clinical Equity Improvement Project Aim

Reduce food insecurity in underresourced communities of Sussex County through strategic, data-guided, community-integrated approaches.

Beginning in 2021, TidalHealth leadership identified health equity as a strategic priority and set goals related to equity. Shortly thereafter, the Centers for Medicare & Medicaid Services and The Joint Commission established standards for hospitals to screen for and address five social determinants of health (SDOH): food insecurity, interpersonal safety, housing insecurity, transportation insecurity, and utilities. In 2023, health care organizations voluntarily screened for these risk drivers, but as of January 1, 2024, screening became mandatory. Thus, TidalHealth developed processes for all population health teams to screen and address SDOH.

To further this effort, TidalHealth sought and received grant funding to support community-integrated strategies to address upstream SDOH.

Progress

TidalHealth’s original aim statement was to increase screening of social determinants of health among their inpatient population at a smaller hospital, because those screenings weren’t being done routinely. However, during their participation in the Pursuing Equity Action Community, the team revised their aim statement to reduce food insecurity disparities among African American and Hispanic patients.

Key Successes

- Advanced capacity across the system to collect REAL-G (race, ethnicity, age, language, and gender identity) data and analyze it through a health equity lens. Population Health reviews key performance indicators stratified by REAL-G data monthly.
- New strategic plan and FY2025 goals include the expectation that all epartments will identify two key indicators to stratify by REAL-G, identify two areas of disparity, and develop and implement an action plan with evaluation by June 30, 2024.
- Implemented changes to address white supremacy culture characteristics, including recognizing time as an authority and making a systemwide change to automatically have all 30-minute meetings switch to 25-minute meetings and all 1-hour long meetings switch to 50-minute meetings; this allows time for transition between meetings and personal time.
- Implemented changes to promote an equitable culture by addressing risk and adverse behavior at a system level instead of at a personal level.
- Updated corporate handbook to revise the appearance section about hair and remove the word “combed.” Whereas the old rule stated that “hair must be clean, combed, and neat,” the proposed revision states “hair must be clean and neat.”
- Made health equity a topic for monthly leader meetings since February 2023, with each presentation building on the prior presentation. Team members Lady Johnson and Kat Rodgers facilitate a Diversity, Equity, Inclusion, and Belonging (DEIB) training quarterly for all new leaders of the organization, with annual training available throughout the entire health system.

Critical Moments

Outside of the clinical space, a critical moment arose when the TidalHealth team began stratifying data, which they could then present to the leadership team. That presentation provided the momentum to get in front of the organization’s Executive Board, where they submitted a proposal on how they could further incorporate DEI in TidalHealth’s practices.

Another critical moment occurred when a team member realized that colleagues within the organization, but outside of the people department and population health, were starting to do this work. Following a presentation to all leadership in early 2023, disparities, health equity, and DEI became a standing agenda item for all leadership meetings every other month. This created awareness, resulting in colleagues from other departments seeking input and advice on how to begin to incorporate equity principles, identify disparities, and stratify data.

Challenges

While health equity is an organizational strategic initiative, funding or other major resources have not been allocated to the work. Similarly, while there are groups within the organization's leadership who are passionate about these topics and support the work, there has not yet been enough time, attention, or strategy around creating a governance structure to formalize it. As a result, equity work remains fragmented with individual projects occurring in different departments instead of a systemwide approach to DEIB. To counteract this dynamic, the team recommended creating an officer role or office to oversee equity initiatives and metrics, make recommendations, and implement additional protocols throughout the health system.

TidalHealth's clinical equity improvement project, which aimed to reduce food insecurity in underresourced communities in Sussex County, also experienced a number of challenges and setbacks. The team hoped to establish an agreement with the Delaware Food Bank to provide food vouchers to patients who screen positive for food insecurity. When that food distribution agreement was put on hold, the team distributed food bags to this population in the interim and made referrals to a community health worker to connect patients to resources in the community.

Next Steps

The TidalHealth team is developing recommendations and a proposed charter for structuring equity improvement work in a more systematic way, which will be presented to the vice president of the people department and the vice president of population health. These leaders will consider the recommendations and develop a proposal that will be presented to TidalHealth's CEO.

UCLA Health

Los Angeles, California, USA (Academic Medical Center)

Background

UCLA Health is among the most comprehensive and advanced health care systems in the world. It is a tertiary/quaternary health system that offers an integrated network of primary and specialty care services at more than 280 clinics across Southern California and at five medical centers and hospitals.

Situated in one of the most diverse cities in the nation, UCLA Health serves patients of all demographic and social identities. In addition, it serves as a regional center for patients of all payer statuses that require complex primary care and/or high-level specialty care. In total, each year UCLA Health sees 3.6 million outpatient clinic visits, 787,100 unique patient visits, 79,500 emergency department visits, and 38,500 inpatient hospitalizations.

Approach

Clinical Equity Improvement Project Aim

Reduce unplanned readmissions for patients living in the most vulnerable neighborhoods (defined as in the bottom 25 percent of neighborhoods, or those with a Centers for Disease Control and Prevention Social Vulnerability Index [SVI] score of 75 to 100) by 3 percentage points (13.8 percent to 10.8 percent) by July 2026.

At the beginning of the UCLA Health team's engagement in the Pursuing Equity Action Community, their initial clinical equity improvement project topic was focused on Black birthing patients in their OB/GYN department. After discovering that the OB/GYN department would have difficulties undertaking basic clinical quality improvement during the Action Community, the team shifted the aim to reducing unplanned readmissions across the system, with a specific goal of reducing the gap in unplanned readmission rates for those living in the most vulnerable neighborhoods.

Progress

To date, much progress has not been realized because the team is still very early in the process of implementing their interventions. However, during their participation in the Action Community the team reported progress in a number of areas.

Key Successes

- Developed a strategic alignment framework to identify equitable readmissions as an institutional aim, and specifically focused on eliminating the gap in unplanned readmissions for patients in the most vulnerable neighborhoods (defined as in the bottom 25 percent of neighborhoods, or SVI score of 75 to 100).
- Geocoded all patients' home addresses to identify their neighborhood SVI score and percentile.
- Reviewed multiple data sources to identify the reasons patients were readmitted to UCLA Health hospitals. Data sources included patient interviews, staff feedback, data from social determinants of health assessments, and patient demographic data.
- Implemented universal health literacy screening to address data that indicates that more than 46 percent of readmitted patients demonstrate poor health literacy.
- Developed "Meds to Beds" program to deliver patient prescriptions and provide education about medications at the bedside before discharge; this addresses findings that approximately 65 percent of readmitted patients are identified as having issues with medications.

Critical Moments

Joining the Pursuing Equity Action Community allowed the UCLA Health team to focus on some of the organization's longstanding equity goals in a structured way, with dedicated time and resources. The executive commitment to Pursuing Equity also provided the team with the resources it needed to bring together several multidisciplinary stakeholders to make progress toward a tangible result by developing a timeline and specific plans for how to achieve their aims.

Challenges

One of the biggest challenges that the UCLA Health team experienced early on arose from the team's status as an office that leads with influence across the organization, but which doesn't own any processes or manage any part of the workforce outside of their own office.

Another challenge, particularly early in the project, was getting colleagues to see equity as a fundamental part of the work to reduce readmissions, instead of two separate issues that each needed to be addressed.

Next Steps

As part of the plans the UCLA Health Team developed toward their aim, in the third quarter of FY 2024, the team plans to implement small tests of changes to identify successful tactics. In the fourth quarter, they plan to finalize a set of interventions for systemwide use. In FY 2025, the team aims to decrease unplanned readmissions by 100 cases per year, and in FY 2026, the aim is for these changes to further decrease unplanned readmissions by an additional 100 cases per year. Those 200 fewer cases per year in the most vulnerable neighborhoods will represent a 3 percent drop in unplanned readmissions.

University Hospitals of Leicestershire

Leicester, Leicestershire, UK (Acute Secondary Care and Tertiary Services Hospital)

Background

University Hospitals of Leicester (UHL) is one of the biggest and busiest NHS Trusts in the United Kingdom, serving one million residents of Leicester, Leicestershire, and Rutland. The area's history is rooted in migration, with 23 percent of Leicester's citizens born outside the UK and almost 50 percent of the population having Asian, Black, minority-ethnic, or mixed-race ethnicity. Recent data shows that more than 180 languages are spoken in Leicester's schools. Outside of the city, Rutland's demographics lack racial and ethnic diversity, with only 2 percent coming from minority ethnic groups. Over a third of UHL's workforce is from Black, Asian, minority-ethnic, and mixed-race backgrounds.

Approach

Clinical Equity Improvement Project Aim

Reduce the number of late bookings for antenatal care for women from Black and ethnic minority groups at Leicester General Hospital.

Because of the demographics of the area, UHL's maternity unit sees a diverse patient population, including a high population of Asian women, a roughly 6 percent population of Black women, as well as Eastern Europeans and white British. After reviewing data on their maternity bookings, the team determined that there was a significant disparity with 51.6 percent of Black African or Black Caribbean patients booking their initial maternity appointment "late" (more than 71 days' gestation at booking), compared to only 27 percent of white British patients. This has a health implication because many of the screening tests that the organization offers are conducted in the first trimester.

Progress

To begin working toward achieving their aim, the UHL team needed to better understand the reasons that certain patient populations were booking their antenatal care appointments beyond 71 days' gestation. Baseline data showed that 27 percent of white British and 33.6 percent of Asian Indian, Bangladeshi, or Pakistani patients were booking appointments at 71+ days' gestation, compared to 51.6 percent of Black African or Black Caribbean patients.

To understand why, the team developed a questionnaire in conjunction with partners to gather the necessary data, contacting all Black birthing people who booked for care in 2023. One major finding was that the community did not realize they were booking late by the hospital's standards.

Key Successes

- Conducted a systemwide analysis of antenatal care bookings at 71+ days' gestation to provide the evidence base across the local population, which suggested that outcomes for both mother and baby were at greater risk in Black and Asian families.
- Determined via initial data analysis that health disparities were related to social determinants rather than ethnicity.
- Identified five themes for improvement of service that would increase early booking and address drivers (trust, communication, information, empathy, and cultural competence).
- Held a Health Equity Summit in July 2024, open to all of the organization's 20,000 employees, which provided an opportunity to workshop directly with communities about co-designing solutions.

Critical Moments

The team reported that participation in the Pursuing Equity Action Community set them up to accomplish two important achievements. As a result of Pursuing Equity and the narrative that arose from it, the team incorporated health equity as an underpinning foundation for strategic goals when they refreshed the organizational strategy in 2023. They also anticipate that the 2024 Health Equity Summit will provide the foundation for many necessary conversations and, with time, will be reflected on as a critical moment.

Challenges

Capturing the required data via survey responses was one of the team's biggest challenges. To obtain the highest number of responses, the team provided multiple avenues for patients to provide feedback, including in person, by telephone, or online.

Another challenge was coming to terms with exactly how steep the curve for achieving their aim would be.

The NHS junior doctors' strike presented yet another challenge, slowing down the team's equity improvement project because team members were needed to help the organization conduct day-to-day operations and keep people safe rather than focus on the improvement work. This

made it difficult, for example, for the team to conduct weekly check-ins because team members needed to focus instead on delivering direct clinical care.

Next Steps

Communication is a key focus area for the team. Whereas the city's Black Caribbean population is now in its second or third generation of residency, the city's migrants from Africa have grown up in a completely different health care environment. They are unfamiliar with the processes required to access care services, so the UHL team must undertake foundational communication work to help them get into the system and understand the services offered.

Another immediate next step for the team is to begin the work around systemic racism and education within the UHL's workforce. They need to center that work in maternity care, using Pursuing Equity as the springboard for that conversation, which began during the Health Equity Summit in July 2024.

WellSpan Health

York, Pennsylvania, USA (Integrated Health System)

Background

WellSpan Health is a nationally recognized, integrated health system serving the communities of South Central Pennsylvania and Northern Maryland. Their primary service region comprises six counties, with a total population of nearly 1.5 million residents; WellSpan serves more than half of this population. With 23,000+ team members across more than 250 patient care locations, WellSpan is the region's largest employer.

South Central Pennsylvania is one of the fastest growing regions in the state and its population is predicted to grow by 3.7 percent over the next five years. The community is currently composed of several ethnicities, including 81.73 percent white, 10.39 percent Hispanic/Latino, 7.98 percent Asian, 0.29 percent American Indian or Alaska Native, 0.03 percent Native Hawaiian or Other Pacific Islander, and 1.85 percent who identify as Other.

The WellSpan Health team participating in the Pursuing Equity Action Community included a variety of executives from across different departments of the organization, including community health and engagement, quality and patient safety, DEI, primary care, quality improvement, and behavioral health.

Approach

Clinical Equity Improvement Project Aim

Increase the percentage of WellSpan attributed patients ages 18 to 85 years old with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year to 58.57 percent.

As part their health equity journey over the past several years, WellSpan Health has focused on preventative screenings for issues where data show that disparities between different racial and ethnic groups commonly exist, including colorectal cancer, breast cancer, and hypertension. As part of their work in the Pursuing Equity Action Community, the team added a fourth focus on kidney health for diabetic patients. Preventative kidney health screenings can prevent patients with diabetes from developing chronic kidney disease, which requires costly ongoing dialysis and reduces patient quality of life.

Progress

The WellSpan team conducted outreach to community members, holding numerous listening sessions from January to October 2023 for both providers and patients, to understand the

existing barriers that prevent certain populations from undergoing preventative kidney health screenings.

As a result of the listening sessions and analysis of available data, the team discovered that the urine test component of kidney health screenings was not occurring consistently. The WellSpan team thus developed an algorithm that they are working to implement across all primary care practices to ensure that urine tests are added as a health maintenance topic within their EHR system. This will remind providers that patients are due for a urine screening at the appropriate time. The WellSpan team also implemented a process to ensure that patients ask to have a urine screen completed.

In July 2023, when they began this process, data showed that the WellSpan system was exhibiting a 5 to 8 percent collection rate for urine specimens, which they saw increase to between 9 and 15 percent. The team also found a 2 percentage point difference in overall screening rates for people of color compared to overall screening rates, and by January 2024 they had closed that gap to where both populations were screened at a rate of roughly 60 percent.

Key Successes

- Improved REaL data accuracy to reduce the number of patients with race listed as “other” due to lack of patient-reported data collection.
- Conducted several listening sessions and community meetings to identify key areas for improvement, including urine sample collection and patient education on kidney disease.
- Developed a standard algorithm for urine sample reminder alerts in the health system’s EHR, resulting in a 4 to 7 percent increase in urine specimen collection.
- Succeeded in closing the gap in completed kidney disease testing between white patients and patients of color by January 2024, resulting in a screening rate of approximately 60 percent for both populations.

Critical Moments

One critical moment was seeing their health system become more comfortable with talking about important but uncomfortable topics, namely racism, systemic racism, and white supremacy culture. In the past, those topics were not regularly discussed and especially were not discussed using common and clear terminology.

The team also described community involvement throughout the project as a critical. Through their work directly with community members, the team learned firsthand about the barriers that

prevented care and the various ways systemic racism plays a role in treatment and outlooks on health care.

Challenges

A key challenge was, in some instances, siloed thinking, which made it difficult for the WellSpan team to see how their various screening initiatives were interconnected. Because the screening goals for breast cancer, colorectal cancer, and kidney health were approached as separate improvement projects, the team has not been able to develop holistic interventions that address common factors between the various health conditions.

Next Steps

In the short term, the WellSpan health team plans to continue elevating conversations around systemic racism and white supremacy culture within their smaller groups, with a larger goal of determining how to discuss these topics across the organization. In so doing, they can acknowledge these issues in productive ways while creating learning opportunities to really understand what they mean and what their role is in helping to dismantle white supremacy culture or systemic racism. The team acknowledged that continuing to drive these conversations will require intentionality on their part because these discussions are unlikely to happen organically.

The team also aims to continue building deep relationships with community advisory team members. These trusted community members can then share WellSpan’s equity improvement work with the wider community, such as including the voices of marginalized communities in the interventions the team is developing.

Appendix A: Glossary

Term	Pursuing Equity Definition
Health equity	Health equity is achieved when every person has the opportunity to attain their full health potential. It means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. It also requires creating opportunity proactively.
Health inequity	Differences in health outcomes that are systematic, avoidable, and unjust. Disparities and inequities are created when barriers prevent individuals and communities from accessing conditions for well-being.
Implicit bias	Also known as unconscious or hidden bias, implicit biases are negative associations that people unknowingly hold. They are expressed automatically, without conscious awareness. Many studies indicate that implicit biases affect individuals' attitudes and actions, thus creating real-world implications, even though individuals may not even be aware that those biases exist within themselves. Notably, implicit biases have been shown to trump individuals' stated commitments to equality and fairness, thereby producing behavior that diverges from the explicit attitudes that many people profess. The Implicit Association Test (IAT) is often used to measure implicit biases with regard to race, gender, sexual orientation, age, religion, and other topics.[4]
Liberation	Liberation is about working together in new ways that are self-reflective and rooted in history to address structural racism in health care — and to go beyond providing services, to our own personal roles as health care team members in dismantling oppression.
Oppression	Unjust use of power and authority.
People of color	A political construct created to describe people who are generally not categorized as white.
Plan-Do-Study-Act (PDSA) cycle	The PDSA cycle is a simple way to learn about the efficacy of a change: first by planning it, then trying the plan, observing the results, and acting on what you learn. This cycle for learning has its origins in the work of Walter A. Shewhart and W. Edwards Deming. It is an essential component of the Model for Improvement, developed by Associates for Process Improvement.[5]
Race, ethnicity, and language (REaL) data	REaL data capture patient- and community-level information that can be used by US health systems to understand the unique needs of patients and communities, as well as to monitor inequalities in

Term	Pursuing Equity Definition
	care across race, ethnicity, and language categories. REaL data categories in use in US health systems typically align with the US Census designated race and/or ethnicity categories. Countries outside the US may or may not gather comparable data. Standardized tracking of REaL data is a key initial challenge in tracking the efficacy of efforts to reduce inequalities in health care settings.
Racial justice	The creation and proactive reinforcement of policies, practices, attitudes, and actions that produce equitable power, access, opportunities, treatment, and outcomes for all people.
Racism	A system of advantage and disadvantage based on race, grounded in the presumed superiority of the white race, where we see differential distribution of goods, services, and opportunity based on race. It operates at individual, interpersonal, institutional, and structural levels.
Institutional racism	Discriminatory treatment, unfair policies and practices, and inequitable opportunities and impacts within organizations and institutions, based on race.
Internalized racism	The set of private beliefs, prejudices, and ideas that individuals have about the superiority of whites and the inferiority of people of color. Among people of color, it manifests as internalized racial oppression. Among whites, it manifests as internalized racial superiority.
Interpersonal racism	The expression of racism between individuals. These are interactions occurring between individuals that often take place in the form of harassing, racial slurs, or telling of racial jokes.
Systemic racism	The ways in which interlocking systems create advantage for white populations and disadvantage for communities of color. It is the normalization and legitimization of an array of dynamics — historical, cultural, institutional, and interpersonal — that routinely advantage whites while producing cumulative and chronic adverse outcomes for people of color. It is a system of hierarchy and inequity, characterized by white supremacy — preferential treatment, advantage, and power for white people at the expense of people of color. Structural racism is not something that a few people or institutions choose to practice. Instead, it has been a feature of the social, economic, and political systems in which we all exist, dimensions which endure and adapt over time.
Social determinants of health (SDOH)	SDOH are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Social

Term	Pursuing Equity Definition
	determinants have a major impact on people's health, well-being, and quality of life. SDOH also contribute to wide health inequities. For example, people who don't have access to grocery stores with healthy foods (or don't have the money to pay for food) are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods. Promoting healthy choices alone won't eliminate these and other health inequities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.
Stratification of data	Stratification is a way to organize or divide data into different layers or groups based on specific characteristics or criteria. Stratification of clinical and patient experience data by REaL categories enables health systems to identify if there are persistent differences in care experience and outcomes associated with these categories. If persistent differences are observed in stratified data, interventions can be designed to reduce inequities between groups while improving outcomes for all.
White supremacy culture	White supremacy culture is the widespread, historically based, and institutionally perpetuated ideology baked into the beliefs, values, norms, and standards of our groups (many if not most of them), our communities, our towns, our states, our nation, teaching us both overtly and covertly that whiteness holds value, whiteness is value. White supremacy culture trains us all to internalize attitudes that do not serve any of us. For instance, a belief that we can be perfect, or should be perfect, raises the questions: Who decides what perfect is? Why would we want to be perfect? Read more about the characteristics: https://www.whitesupremacyculture.info/characteristics.html

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