

Defining the Role of the Health Equity Officer

Guidance for Health Systems

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Executive Summary

The role of the health equity officer, a health care senior leader with responsibility for stewarding the crucial work of improving equity and health equity, has been emerging and evolving over many years. Due to the rapid acceleration of organizations hiring health equity officers, there is tremendous variation across many aspects of this role, including title, reporting position, internal and external responsibilities, and resources available to plan and execute on a vision.

Given this context, the intent of this publication is to provide guidance and support for the health equity officer (HEO) role, drawing on both research and information supplied directly from HEOs across the health ecosystem. Importantly, the guidance in this document seeks to move beyond the context of institutional human resources functions for advancing equity as an organizational priority, recommending that the role of the health equity officer is separate from that of the diversity, equity, and inclusion officer.

This publication:

- Provides background information on health equity and health equity leadership, including our current understanding of the role and function of the health equity officer.
- Defines the health equity officer role, functions, and values as well as the responsibilities and competencies required for both a health equity officer and their organization to effectively advance health equity.
- Presents the IHI Health Equity Leadership Framework that includes the individual and collective practices needed for a health equity officer to be effective and thrive in their role.

Introduction

The US Centers for Disease Control and Prevention (CDC) defines health equity as, “the state in which everyone has a fair and just opportunity to attain their highest level of health” while emphasizing that, “advancing equity requires ongoing societal efforts to address historical and contemporary injustices; overcome economic, social, and other obstacles to health and health care; and eliminate preventable health disparities.”¹ Camara Jones, an American physician, epidemiologist, and anti-racism activist, expands on that need, noting that improving health equity starts first with being able to define the problem(s), namely racism and other systems of power and oppression that advantage some and disadvantage many others.

Understanding how these systems of power and oppression drive mental models and the daily decisions that institutions make is essential to understanding the health of our nation on a systemic level. Even with longstanding and impactful contributions by many individuals and organizations to improve health care in the US, our systems still do not promote, protect, and ensure optimal health for everyone to their fullest capacity.

In health care, a designated senior leadership role to steward the crucial work of improving equity and health equity has been emerging and evolving over many years. There is tremendous variation, however, across many aspects of this role that require clearer definition and more is now known about critical factors for success.

The guidance and recommendations in this publication for the specific role of the health equity officer (HEO) build on the essential foundation established by diversity, equity, and inclusion leaders throughout health care over many years. Diversity, equity, and inclusion (DEI) is a conceptual framework to promote fair

Defining the Role of the Health Equity Officer

The guidance in this document seeks to:

- Move responsibility for advancing equity as an organizational priority beyond the context of institutional human resource functions, recommending that the role of the health equity officer (HEO) is separate from that of the diversity, equity, and inclusion officer.
- Reflect our current understanding of the HEO role and function while also recognizing a rapidly evolving environment.
- Articulate the health equity officer role, functions, values, responsibilities, and competencies required for both the HEO and their organization to effectively advance health equity.
- Enumerate the individual and collective care practices and frameworks needed for a HEO to be effective and thrive in their role.

treatment and full access to economic, social, and political opportunities in the United States, particularly among historically marginalized and minoritized populations.² Workforce diversity and inclusion alone are necessary, but not sufficient to advance equity within an institution. Focusing only on these aspects also misplaces the burden of effort to become a more equitable institution within only the human resources functions and departments, when all of an organization's functions and departments must apply an equity lens to drive their work.

The guidance in this document seeks to:

- Move responsibility for advancing equity as an organizational priority beyond the context of institutional human resource functions, recommending that the role of the health equity officer is separate from that of the diversity, equity, and inclusion officer.
- Reflect our current understanding of the role and function of the health equity officer while recognizing that the role, expectations, and environment are rapidly changing and will likely further evolve.
- Articulate the health equity officer role, functions, and values as well as the responsibilities and competencies required for both the HEO and their organization to effectively advance health equity.
- Enumerate the individual and collective care practices and frameworks needed for a HEO to be effective and thrive in their role – critical practices that seek to address the challenges that both individuals and institutions face in this work and are intended to preclude professional burnout.

We hope this guidance might serve as a tool for health care executives, hiring managers, and employee recruitment firms seeking to hire health equity officers.

Background

History of Health Equity

The history of health equity is a lengthy one and we are not attempting to provide a comprehensive review of that history. Instead, we offer a brief summary of some important events that have shaped ongoing efforts to improve health equity. In the United States, the global COVID-19 pandemic and an ongoing racial reckoning laid bare an essential truth: there are persistent and unjust differences in health status for varying identities, and these differences – these inequities – are the direct result of racism, sexism, classism, ableism, transphobia, and all other systems of power and oppression that serve to benefit some and harm the majority of Americans. These systems manifest in lack of access to care, poor quality care, and the historical disinvestment in neighborhoods, communities, and systems for food, housing, and other social drivers of health.

The pandemic emerging in 2019 and public murder of George Floyd in 2020 spotlighted how deeply embedded systems of power and oppression are in our institutions, yet the work to improve health equity is not new. In 1986, Margaret Heckler, then US Secretary of Health and Human Services in the Reagan Administration, highlighted a federal study that found more than 60,000 excess deaths each year among Black people in the US. In response, the Office of Minority Health (OMH) was created to address these so-called “disparities” in health outcomes. Herbert Nickens, MD, the first director of OMH, was charged with fostering and strengthening relationships among federal, state, territory, tribal, and community stakeholders and working collectively to improve the health of racially marginalized people, eliminate health disparities, and advance health equity.³ Over the next 25 years, many states and local governments also launched Offices of Minority Health in their health departments to lead efforts to close “disparity gaps” (as they were known) in health outcomes data.

Key Events That Shaped Health Equity in the United States

In the early 2000s, two landmark publications from the Institute of Medicine (IOM, now called the National Academies of Science, Engineering, and Medicine) helped set the agenda for improving health and health care in the US.

- The 2001 IOM report, *Crossing the Quality Chasm: A New Health System for the 21st Century*,⁴ codified six key aims for health care by declaring that care must be safe, effective, patient-centered, timely, efficient, and equitable. There has been significant progress, to varying degrees, in each of the first five domains. But improving equity has lagged far behind, leading many to refer to equity as the “forgotten aim.”
- The 2003 IOM report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*,⁵ highlighted the evidence of inequitable treatment by health care systems and the providers within them. The findings sent shock waves throughout the health ecosystem: these disparities and the reasons for them were both pervasive and deep. The report’s authors plainly stated that the disproportionate impact on people of color

was “unacceptable.” Recommendations stemming from the report include “improvements in medical care financing, allocation of care, availability of language translation, community-based care, and other arenas... as well as for data collection and research initiatives.”⁶ Still, progress is slow. In summer 2024, the National Academies of Sciences, Engineering, and Medicine will publish an update to the 2003 report that assesses the current state of racial and ethnic health care disparities in the US.⁷

Around 2006, individuals leading efforts to improve equity in public health such as Adewale Troutman, MD, Camara Jones, MD, Brian Smedley, PhD, and others championed a change in the terminology used in health and health care, from “disparities” to “inequities.” While the term “disparities” merely connotes differences, “inequities” clarifies that these differences in health outcomes are unjust and avoidable, and that efforts to eliminate them require recognizing and accounting for histories that have contributed and redistributing resources to communities and populations that need them most.⁸

History of Health Equity Leadership

In the early 2000s, health system leaders began recognizing that eliminating inequities required transforming institutional culture, policies, functions, and processes. This shift marked a significant turn toward focusing on systems and structures that perpetuate inequities. To support these efforts, leaders built capacity, provided training for staff, used geographically focused data, strengthened community engagement, and shaped policy to advance equity. For instance, California Department of Public Health launched an Office of Health Equity in 2012 and the New York City Department of Health and Mental Hygiene launched its Center of Health Equity in 2014.

In 2013, following the murder of Trayvon Martin and the acquittal of his killer, and the founding of Black Lives Matter, the Institute for Healthcare Improvement (IHI) renewed its focus on the “forgotten aim” of equity, driven by advocacy for this crucial issue at every level of the organization. This advocacy led to several research cycles using IHI’s innovation process, with findings published in *Achieving Health Equity: A Guide for Health Care Organizations* and subsequent Pursuing Equity collaboratives.⁹

Amid these new and renewed efforts to focus on health equity, large health care institutions also started to focus on increasing workforce diversity and inclusion alongside efforts to embed equity into quality and safety systems. In 2019, several health institutions such as the American Medical Association and Stanford Health Care began to hire chief health equity officers tasked with embedding equity throughout their institutions in support of advancing health equity for patients and populations. Around this timeframe, many health care organizations were also devoting significant resources to improving diversity and inclusion, hiring chief diversity and inclusion officers or other senior executives with this remit.

Chief diversity and inclusion officers have played a critical role in ensuring workforce diversity, workplace inclusion, and belonging. Human resources functions in countless health care organizations have been transformed by the explicit focus on diversity, equity, and inclusion.

The guidance in this document seeks to move beyond the context of institutional human resources functions. Focusing only on diversity and inclusion among the health care workforce misplaces the burden of effort to become a more equitable institution within a narrow human resources focus. Critically, it misses the opportunity to embed equity across the organization in everything that they do. Therefore, we recommend that the role of the chief diversity and inclusion officer is separate from that of the chief health equity officer.

The chief health equity officer role continues to gain momentum and support. California, for example, has mandated that all Medicaid plans hire CHEOs. The shifting trend toward hiring for the CHEO role is a reflection of several factors:

- Equity is an institutional imperative – both moral and business.
- Situating the CHEO role within the C-suite is necessary to ensure commitment and accountability from the highest level of the institution to optimize depth and spread throughout the institution.
- Broader efforts to advance equity at the institutional level call for organizations to focus on internal transformation of culture, policies, processes, and management as well as external considerations and partnerships.
- Systems of power and oppression rooted in institutions that produce inequities and differences in health outcomes need to be named and institutions held accountable to change.

As interest in the role grows, we need to leverage learning from existing HEOs to more clearly define the role and the institutional supports required for success. It is imperative for institutions to recognize the magnitude of this work and both the opportunity and burden that is placed on those who take it on. Importantly, transformation to create more equitable systems is not dependent on a single role, function, or team – it is a collective responsibility.

Due to the rapid acceleration of organizations hiring health equity officers, there is tremendous variation across many aspects of this role, including title (e.g., chief equity officer, chief health equity and strategy officer), reporting position, internal and external responsibilities, and resources available to plan and execute on a vision. This lack of clarity typically results in outsized scopes and intense pressure for those in the HEO role.

Given this context, this publication seeks to provide guidance and support for the health equity officer role, drawing on research and information supplied directly from HEOs across the health ecosystem. Collectively, this group has illuminated the individual and institutional competencies needed to support this role along with the critical institutional investments and accountability needed to ensure its success.

Research Methods

The initial research that informs this publication originated from IHI's innovation process¹⁰ using 90-day cycles for discovery and theory building, aimed to identify the roles, responsibilities, and competencies of the health equity officer (HEO) role. As the research progressed, it became clear that there was also a need to articulate the institutional supports required for this role.

The IHI 90-day innovation project included the research activities described below.

- **Literature Scan:** A literature scan to understand the responsibilities of health equity officers involved a thematic analysis of job descriptions from both health systems and other institutions.
- **Interviews:** A total of 14 individuals were interviewed to gather information to inform job roles, duties, and expected competencies. The first round of interviews focused primarily on health equity officers in health care settings.
- **Focus Groups:** Focus group discussions with health equity officers sought to obtain their feedback on an initial job description and theory of change. Both the focus groups and the individual interviews confirmed the elements of the job description and theory of change, while also providing more depth and nuance.
- **Broader Interviews and Advisory Group:** While the participants were initially conceived to be those with health equity officer roles within health care delivery systems, the information gathered from the individual interviews and focus groups highlighted the need to expand the role description to include HEOs other parts of the health ecosystem. Thus, the research team also interviewed an additional 22 professionals doing some of the jobs of a health equity officer, including equity officers in health-related organizations and those outside of care delivery settings. This group formed an “advisory group of HEOs” from the broader health ecosystem and included representatives from pharmaceutical companies, foundations, public health departments, health technology companies, health care delivery systems, organized medicine, medical journals, and other organizations. These experts graciously provided additional feedback and information via interviews.

Defining the Role of the Health Equity Officer

Based on IHI's research findings and analysis of health equity officer job descriptions, available in the public domain or emailed to IHI following individual interviews, we identified six core components for the role.

- **Vision and Strategy:** Develop a vision, strategy, and framework to ensure that equity is at the center of the organization's work and practices.
- **Systemwide Coordination:** Partner with leaders across the system to create a pathway to incorporate equity into all parts of the system.
- **Communication:** Develop internal communication mechanisms to raise awareness internally and identify and address equity issues impacting patients, residents, and staff.
- **Data and Measurement:** Develop, operationalize, and monitor a measurement strategy to track progress in closing inequity gaps and health equity improvement efforts.
- **Community Partnerships and Advocacy:** Lead outreach and civic engagement strategies to better understand the needs of marginalized communities and advocate for policies that improve outcomes.
- **Research:** Investigate best practices in health equity on an ongoing basis and incorporate them into the organization's culture and practices.

As one interviewee noted, health equity officers are responsible and accountable for overseeing the process (e.g., the six elements above); however, the entire system is responsible for outcomes.

Diversity, Equity, and Inclusion Officer vs. Health Equity Officer

The research suggests that there is much variation in this role, including the role's title; where this position sits within the organization and who they report to; the size of their team and resources available; and the scope of the role. Most notably, there is variance across organizations on the roles of health equity officer and diversity, equity, and inclusion (DEI) officer.

Historically, the primary role of the DEI or D&I officer is to ensure that the organization's workforce is diverse and the workplace is inclusive and psychologically safe. The DEI or D&I role is typically focused on improving the internal climate of the institution, even with external needs and actions to support recruitment from the external environment.

The health equity officer role can be much broader in scope and is rooted in the belief that for an institution to fully uphold and commit to equity, the sum and strength of the internal equity efforts will influence the sum and strength of the external equity efforts. Therefore, the HEO has both an internal and external role that facilitates an inside-out strategy that impacts both equity and health equity. In some organizations, one person is asked to fulfill both roles. In others, these are two distinct roles; for instance, with both individuals reporting to the CEO. However, IHI's research found that separating these two roles is a best practice since they require different competencies and skill sets.

Advice for Health Equity Officers in the First 100 Days

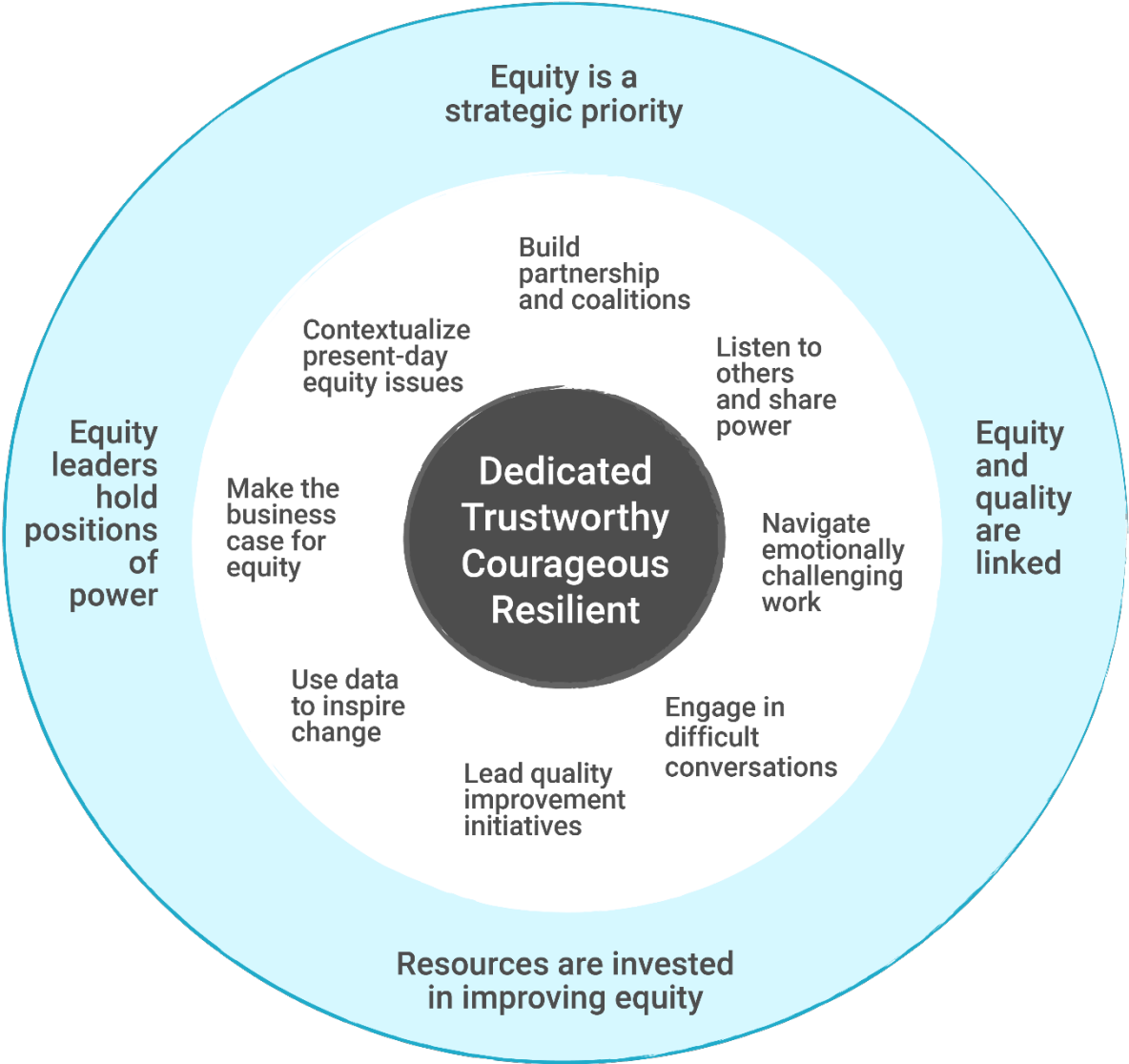
When asked, "What should HEOs do in their first 100 days in the role?" the experts that IHI interviewed unanimously provided the same advice: listen to understand the strategic needs of the organization. It's imperative for the organization to create pathways for trust and power to be instilled in the HEO as the person in this role performs an internal landscape analysis, including requests for meetings with staff and access to information. Some suggested activities for HEOs follow.

- **Listening Tour:** A listening tour helps to build relationships throughout the organization and is crucial in the early days of a new HEO's role. Understanding who's who in the organization, their priorities, and opportunities and avenues of synergy are all part of surveying the internal landscape. The listening tour also helps the HEO understand the organization's culture and context, without making any rudimentary assumptions, and fosters connections with stakeholders across the organization, especially frontline staff who will be doing the work in communities to improve equity. Listening tours also provide an opportunity to hear directly from racially diverse staff within the organization, to benefit from their perspectives as both health care providers and individuals with lived experience.
- **Develop a Strategy for Health Equity:** Define what success looks like for the organization and specific aims for improving health equity; use these to inform and develop an organization-wide strategy for health equity. In the early days of the HEO role, it's important to identify allies and opportunities in the organization – individuals who already support health equity improvement efforts and existing work that might be leveraged to foster more significant alignment and change. A strategy for the work is essential to communicate the organization's vision and goals, while also supporting the HEO in building consensus and authority.

IHI Health Equity Leadership Framework

Based on IHI’s research, three components that are necessary for success in the health equity officer role emerged – core ways of being (values), skills to cultivate, and conditions for success – as well as critical elements within each of these components, as summarized below. Figure 1 is a visual representation of the theory of change stemming from IHI’s research and represents the IHI Health Equity Leadership Framework that includes these critical success factors for the HEO role.

Figure 1. IHI Health Equity Leadership Framework



Core Ways of Being (Values)

The core ways of being represent the values of the health equity officer role. They are at the center of the IHI Health Equity Leadership Framework (see Figure 1). Critical elements for this component include the following:

- **Dedicated: Committed to equity and anti-racism** – Without this critical element, any support around skills to cultivate equity and anti-racism will miss the mark.
- **Trustworthy: Integrity, humility, and leading with love and humanity** – Integrity and authenticity are themes that emerged in the interviews. Given the historical context of racism, trust is crucial – between health care organizations and the communities they serve – and likely requires strengthening or rebuilding in most health systems, particularly given the HEO role’s interaction with communities. Integrity, humility, and leading with love set the tone for rebuilding trust and co-creating a better, more equitable future.
- **Courageous: Lead and act with courage** – The HEO role is about being a change agent and, to do that successfully, one must lead and act with courage.
- **Resilient: Cultivate endurance, resilience, and renewal** – Many interviewees noted that the HEO role is challenging. Cultivating endurance, resilience, and renewal is thus necessary to continue leading change for the long term.

The routine and ongoing practice of self-reflection is important for a HEO’s own internal accountability. These values can also be affirmed through performance goals and measures that provide demonstrative evidence of these values.

Skills to Cultivate

Depicted in the second circle in Figure 1, eight key skills are required for success in the HEO role as described in more detail in Table 1. As several interviewees noted, individuals often do not possess all of these skills as they take on this role. Skills can be developed and cultivated, both for the individual in the HEO role as well as for members of the broader health equity team.

Table 1. Key Skills for the HEO Role

Skills to Cultivate	Description
Contextualize Present-Day Equity Issues	Equity is a skillset that is critical to have and to strengthen, including the historical knowledge and perspective of racism (“this role cannot be ahistorical”), white supremacy tactics and culture, and health, and how this persists to this day. One interviewee noted, “Until recently, younger Black physicians did not know about Tuskegee (US Public Health Service Untreated Syphilis Study at Tuskegee); let’s start there.” Others also noted the importance of lived experience in this role.

	<p>The HEO needs to have a strong equity analysis grounded in historical perspective. That means they must be able to understand and analyze narratives, mindsets, actions, and systems that perpetuate inequities, both in the past and the present, the systems of power and oppression that produce them such as racism, and the harm they caused. One way to achieve this is to learn and understand the history of racism in the United States and how deeply it is rooted throughout our systems, creating and perpetuating the inequities we see today.</p>
<p>Lead Quality Improvement Initiatives</p>	<p>This includes two elements: the “what” and the “how.”</p> <p>The “what” is about the intrinsic link between equity and quality. As the Henry Ford Health System coined in 2007, “There is no quality without equity.” And as another interviewee stated, “And there’s probably no equity without quality.” The knowledge, ability, and skill to interweave quality and equity together in a system is important for the HEO role.</p> <p>The “how” includes the skills of quality improvement (QI) and systems transformation, using QI skills to understand root causes and lead systems change in health equity.</p>
<p>Use Data to Inspire Change</p>	<p>Across the board, interviewees emphasized the importance of data analysis for the HEO role and the role of data to lead change. This involves a measurement strategy tied to quality metrics and stratifying data, finding gaps, and making change to close these gaps.</p> <p>Beyond data analysis, others spoke about the skill of using data for building narrative and storytelling to create change. One interviewee said, “Narrative + Data + Action = Change.”</p> <p>There was variance across the interviewees on whether they had a data analytics person on their team or not. Another spoke of the importance of “linking this work to metrics that have already been determined to be strategic priorities.”</p>
<p>Build Partnerships and Coalitions</p>	<p>To enact change, coalition building and partnerships are critical skills. One interviewee noted, “[This role] requires understanding the importance of collaborating with stakeholders,” which often also includes the importance of lived experience in the community. This links back to the core ways of being, plus building specific skills of partnership and coalition building, with one interviewee specifically pointing at IHI’s work around the psychology of change.¹¹</p>
<p>Listen to Others and Share Power</p>	<p>Visioning is critical because of the aim of this work around health equity. To vision you must excel at listening to others and be able to share power. As one interviewee shared, it is fundamentally about the “transfer of power.” This involves the adaptive skill of being able to listen differently, and then “follow that listening with a transfer of power” through responsive action.</p>

<p>Engage in Difficult Conversations</p>	<p>Because the HEO role is about leading change, the skill of coaching, communication, and facilitating difficult conversations is critical. As one interviewee stated, “This role is fundamentally one of provocateur and team player. It’s also making sure you’re a family member; you can’t alienate your team and peers, but you do need to coach and lead your team toward equity.”</p> <p>Another added, “Being able to work with individuals who may not want to work with you is critical” and added the necessity of “being able to have critical and challenging conversations about racism.” Thus, in addition to communication skills, the skills of coaching and leading difficult conversations are also critical.</p>
<p>Navigate Emotionally Challenging Work</p>	<p>Interviewees spoke about the emotional nature of this work, thereby making emotional intelligence critical for the role. One interviewee noted the difference in this work from other roles, saying, “There is huge emotional overlay... the need to equip people to address the emotional aspect,” which includes defensiveness and emotional pushback, in moving the work forward.</p> <p>Another interviewee noted, “The biggest skill that you need to have is the internal skill set to do your internal work. You have to be somebody who is conscious and conscientious in terms of how you show up into a space and being able to be reflective in your understanding.”</p>
<p>Make the Business Case for Equity</p>	<p>For success in leading this work, it is important for the HEO to articulate and communicate the financial and business case for health equity. An interviewee said, “An understanding (similar to the IHI Triple Aim) of equity and how it is reflected in resource allocation” is necessary to “have a conversation with financial leaders about what inequity is costing us.” Another interviewee stated, “The resources we get are never enough; there are power dynamics in each system that this role must navigate.”</p> <p>One way to show the business case and importance of health equity, note interviewees, is to “Link this work to metrics that have already been determined to be strategic priorities – for example, if the health system stands to gain great reimbursements around the rates of controlling hypertension or diabetes, this can be linked to disparity gaps seen in analytics, for instance, for younger African American men – this improves the health of the population and HEDIS goal, which translates into dollars and cents.”</p>

Conditions for Success

Depicted in the outer circle in Figure 1, these elements focus on the organizational supports required for an individual's success in the health equity officer role.

Equity Is a Strategic Priority

Organizations that have made equity a strategic priority exhibit a sense of organizational readiness around equity prior to hiring a health equity officer and have demonstrated support for equity from both senior leadership and governance boards.

Organizational Readiness

- Organizations need to demonstrate a clear commitment to improving equity prior to hiring the HEO. In addition to ensuring that the required resources and broader health equity team are both in place (see resources in Appendix A), the organization also needs to have cultivated a willingness to identify and address equity issues by engaging in conversations related to racism, sexism, ableism, and other societal inequities and the effect these inequities have on both internal and external work. For example, demonstrating a clear commitment to dismantling the systems of white supremacy instead of taking a middle-of-the-road approach, and making equity a strategic priority by establishing the infrastructure and building a portfolio of work to support equity improvement efforts.
- There are a number of resources that outline the steps organizations may take to undergo their own equity journey. The Continuum on Becoming an Antiracist Multicultural Organization from the Crossroads Ministry (see Appendix B) illustrates the journey that organizations undertake as they examine their own history and embed equity into their work more explicitly. The IHI White Paper, *Achieving Health Equity: A Guide for Health Care Organizations*, also provides a framework for organizations to implement changes to directly address inequities.¹²
- Organizations should also be prepared with language and data to answer questions about what success in health equity looks like, what infrastructure is currently available to help collect data and track metrics, and what kind of support the HEO will receive.
- Organizations must also demonstrate an understanding that health equity work is a long-term, multiphase, complex commitment that will impact, and enhance, the legacy of the institution.

CEO and Board Commitment

- Bold, brave leadership and leadership commitment to equity, particularly from the CEO, is critical to this work, given the challenges of improving health equity and establishing the supports necessary to ensure HEO success.
- Health system governance boards have a responsibility to ensure that the organization provides high-quality, safe care. Since equity is inextricably linked to quality, it's imperative for equity to also be a focus and priority for the board. One interviewee noted that in some health systems, executive compensation is tied to health equity metrics: "At the highest level, part of leaders' compensation and bonus is equity" – which sets the stage for equity being prioritized across the organization. Nonetheless, this should not be the most compelling incentive for action on equity; our moral, ethical, and professional commitment to achieving health equity is at the heart of what truly matters.

Equity Leaders Hold Positions of Power

When the HEO reports directly to the CEO, the importance of equity and its centrality to the overall strategic plan is highlighted and reinforced. It is also key to empower the HEO with authority and a level of decision-making.

Structure and Reporting

- Organizations need to design reporting structures that allow HEOs to be in positions of power. This will not only enable HEOs to move work forward but also keep appropriate parties accountable. To whom the HEO reports within the organization is important and can impact the individual's power and influence. When the HEO reports directly to the CEO, the importance of equity and its centrality to the overall strategic plan is highlighted and reinforced. One interviewee noted, "Too often, HEOs are not given the power and influence to make institutional and systemic changes." Other interviewees stated, "Reporting directly to the CEO is key." One interviewee who did not report directly to the CEO spoke of the challenges that posed.
- Where this role "sits" within the organization is also vital. Several interviewees noted that the current best practice is for the HEO role to exist outside the human resources (HR) department. One interviewee stated, "It's not about diversity and people in seats; it's about inclusion and equity and justice. Traditional HR is too confining in terms of the work getting done." Another stated, "When I see [this role] in HR, that's when I worry. The role has to influence HR, but doesn't have to be part of HR." Several interviewees also noted the important connection within the organization between equity and clinical care, HR and diversity, and population health and the community. "The HEO needs to be part of a team that involves the safety and quality officer; [otherwise], there is a danger of being discounted without leverage," said one interviewee.

Accountability

- The organization needs to hold people accountable to metrics aligned with the equity strategy developed by the HEO. A good model is to establish an accountability structure for equity for senior leaders, with clearly articulated decision-making responsibility, and communicate this across the organization. It is key to empower the HEO with authority and a level of decision-making over organizational areas that may not report directly to this role.

Resources Are Invested in Improving Equity

Resources, including a broader equity team and budget, are critical for HEOs to get the work done.

Team and Budget

- Resources, including a broader equity team and budget, are critical for HEOs to get the work done. There is wide variation in the resources that organizations commit to support health equity efforts, as reflected by feedback from the HEO interviewees: several discussed not having enough resources to achieve the vision of their work, and a small minority spoke with pride about how much their organizations have invested in health equity – which is what drew them to accept the new position. One interviewee noted that individuals fail in this role because “they are expected to change the world and don’t have a team to move in this space.”

Equity and Quality Are Linked

“There can be no quality without equity.”

Equity Is Seen as a Quality Issue

- As previously stated, health care leaders have stated that “there can be no quality without equity.” When examining quality metrics, stratifying data may reveal discrepancies and inequities between different groups. These inequities should be seen as low-quality care in the same way patient safety is framed as a quality issue.

Conclusion

This foundational work provides insight into the considerations and conditions for success of health equity officers across the ecosystem. It provides concrete areas of focus: internal ways of being, skills to cultivate, and conditions for success to guide these leaders and the organizations who hire them.

We recognize that these roles are not homogeneous and that they will continue to evolve as the need for HEOs and the work to improve equity continues to grow. Additional factors may emerge that will shape and impact the work and HEO role.

The guidance in this publication serves to provide a functional framework to support the dynamism and context of the HEO role. We are in a moment of opportunity. As organizations commit to seriously pursuing equity through the hiring of health equity officers, it is important that the role is defined and that expectations are made clear. Organizations need to hire people that exhibit key values and bring needed skills. More importantly, organizations must provide proper support for health equity officers to guide meaningful change.

We hope that organizations will use this guidance to understand the role of health equity officers in their organizations and help equity leaders advocate for the support they need.

Appendix A: Resources

- Institutional Antiracism and Accountability Project: Antiracist Organizational Change in American Healthcare <https://iara.hks.harvard.edu/work/antiracist-organizational-change-in-american-healthcare-institutions/>
- Urban Institute: Catalyzing Leadership for Equity <https://www.urban.org/research/publication/catalyzing-leadership-equity>
- California Department of Public Health, Office of Health Equity: Organizational Assessment for Equity Infrastructure <https://www.cdph.ca.gov/Programs/OHE/Pages/Baseline-Organizational-Assessment-for-Equity-Infrastructure.aspx>
- Association of American Medical Colleges: Advancing Diversity, Equity, and Inclusion in Medical Education <https://www.aamc.org/about-us/equity-diversity-inclusion/advancing-diversity-equity-and-inclusion-medical-education>
- STAT: Chief health equity officers are growing more common. But experts say companies need to empower them <https://www.statnews.com/2022/12/15/health-tech-chief-equity-officer/>
- Stanford Social Innovation Review: Recognizing Leadership in All Its Forms https://ssir.org/recognizing_leadership_in_all_its_forms
- Racial Equity in Health: A Health System Built on Racial Equity <https://racialequityinhealth.org/#the-system-we-want>
- Modern Healthcare: New health equity execs strive to shape the future, confront the past <https://www.modernhealthcare.com/providers/health-equity-executives-inequalities-disparities-umms-alleggheny-health>
- Ragan: Advancing Health Equity In and Out of the Workplace <https://www.ragan.com/advancing-health-equity-within-and-outside-the-workplace/>
- AHIP: The Rise of the Chief Health Equity Officer <https://www.ahip.org/news/articles/the-rise-of-the-chief-health-equity-officer>
- White Supremacy Culture: White Supremacy Culture Characteristics <https://www.whitesupremacyculture.info/characteristics.html>

Appendix B: Continuum on Becoming an Anti-Racist Multicultural Organization

Continuum on Becoming an Anti-Racist Multicultural Organization

MONOCULTURAL ==> MULTICULTURAL ==> ANTI-RACIST ==> ANTI-RACIST MULTICULTURAL					
<i>Racial and Cultural Differences Seen as Deficits ==> Tolerant of Racial and Cultural Differences ==> Racial and Cultural Differences Seen as Assets</i>					
Exclusive	2. Passive	3. Symbolic Change	4. Identity Change	5. Structural Change	6. Fully Inclusive
An Exclusionary Institution	A "Club" Institution	A Compliance Organization	An Affirming Institution	A Transforming Institution	Anti-Racist Multicultural Organization in a Transformed Society
<ul style="list-style-type: none"> Intentionally and publicly excludes or segregates African Americans, Native Americans, Latinos, and Asian Americans Intentionally and publicly enforces the racist status quo throughout institution Institutionalization of racism includes formal policies and practices, teachings, and decision making on all levels Usually has similar intentional policies and practices toward other socially oppressed groups such as women, gays and lesbians, Third World citizens, etc. Openly maintains the dominant group's power and privilege 	<ul style="list-style-type: none"> Tolerant of a limited number of "token" People of Color and members from other social identity groups allowed in with "proper" perspective and credentials. May still secretly limit or exclude People of Color in contradiction to public policies Continues to intentionally maintain white power and privilege through its formal policies and practices, teachings, and decision making on all levels of institutional life Often declares, "We don't have a problem." Monocultural norms, policies and procedures of dominant culture viewed as the "right" way" business as usual" Engages issues of diversity and social justice only on club member's terms and within their comfort zone. 	<ul style="list-style-type: none"> Makes official policy pronouncements regarding multicultural diversity Sees itself as "non-racist" institution with open doors to People of Color Carries out intentional inclusiveness efforts, recruiting "someone of color" on committees or office staff Expanding view of diversity includes other socially oppressed groups <p><i>But...</i></p> <ul style="list-style-type: none"> "Not those who make waves" Little or no contextual change in culture, policies, and decision making Is still relatively unaware of continuing patterns of privilege, paternalism and control Token placements in staff positions: must assimilate into organizational culture 	<ul style="list-style-type: none"> Growing understanding of racism as barrier to effective diversity Develops analysis of systemic racism Sponsors programs of anti-racism training New consciousness of institutionalized white power and privilege Develops intentional identity as an "anti-racist" institution Begins to develop accountability to racially oppressed communities Increasing commitment to dismantle racism and eliminate inherent white advantage Actively recruits and promotes members of groups have been historically denied access and opportunity <p><i>But...</i></p> <ul style="list-style-type: none"> Institutional structures and culture that maintain white power and privilege still intact and relatively untouched 	<ul style="list-style-type: none"> Commits to process of intentional institutional restructuring, based upon anti-racist analysis and identity Audits and restructures all aspects of institutional life to ensure full participation of People of Color, including their worldview, culture and lifestyles Implements structures, policies and practices with inclusive decision making and other forms of power sharing on all levels of the institutions life and work Commits to struggle to dismantle racism in the wider community, and builds clear lines of accountability to racially oppressed communities Anti-racist multicultural diversity becomes an institutionalized asset Redefines and rebuilds all relationships and activities in society, based on anti-racist commitments 	<ul style="list-style-type: none"> Future vision of an institution and wider community that has overcome systemic racism and all other forms of oppression. Institution's life reflects full participation and shared power with diverse racial, cultural and economic groups in determining its mission, structure, constituency, policies and practices Members across all identity groups are full participants in decisions that shape the institution, and inclusion of diverse cultures, lifestyles, and interest A sense of restored community and mutual caring Allies with others in combating all forms of social oppression Actively works in larger communities (regional, national, global) to eliminate all forms of oppression and to create multicultural organizations.

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