Antiracist Institutional Change in Healthcare

Institutional Antiracism and Accountability Project

MARCH 2023

IARA

INSTITUTIONAL ANTIRACISM AND ACCOUNTABILITY PROJECT

Antiracist Institutional Change in Healthcare

Institutional Antiracism and Accountability Project

MARCH 2023

About the Authors

Khalil Gibran Muhammad is Ford Foundation Professor of History, Race and Public Policy at the Harvard Kennedy School. Dr. Muhammad is Faculty Director at the Institutional Antiracism and Accountability (IARA) Project and the former Director of the Schomburg Center for Research in Black Culture, a division of the New York Public Library.

Angel Cardo Rodriguez is a Research Fellow at the Institutional Antiracism and Accountability (IARA) Project and coordinates the Health/STEM focus areas. Rodriguez's professional background and research expertise are in public health, race and policy, and history of science.

Acknowledgments

A PUBLICATION OF THE

Ash Center for Democratic Governance and Innovation
Harvard Kennedy School
79 John F. Kennedy Street
Cambridge, MA 02138
617-495-0557
ash.harvard.edu

Contents

Executive Summary

Introduction

Systemic racism is deeply embedded in U.S. healthcare and economic systems and remains pervasive in social policies and organizational practices that perpetuate oppression of Black, Indigenous, and people of color (BIPOC) and produce disparate quality of life outcomes.[1] In 2020, the outbreak of coronavirus disease (COVID-19) and the rising wave of racial justice demonstrations exposed these deeply embedded inequities in a new light and moved many organizations, including those in healthcare, to commit to racial equity and embark on a journey to become antiracist. Yet, few studies exist that address the impact of antiracist change in healthcare organizations and, more importantly, evaluate the evidence used to measure the progress of long-term transformation.

Scope

The Institutional Antiracism and Accountability (IARA) team conducted a one-year research study to examine antiracist interventions in healthcare and evaluate institutional change initiatives originating before 2020. The team's scope also included a comprehensive review of over 50 articles and publications to assess the landscape of research literature on health equity. IARA's qualitative case study analysis included 25 interviews at three separate healthcare organizations—the New York City Department of Health and Mental Hygiene, the Mount Sinai Health System, and the Southern Jamaica Plain Community Health Center—to evaluate evidence of antiracist change in three distinctly different healthcare settings.

Findings

Racial disparities are well documented in studies, but there is very little research on how to address them. IARA's analysis revealed that published research related to antiracism in healthcare focuses heavily on understanding and making visible acute racial health disparities in patient populations, with few published indicators for measurable evidence of impacts from organizational interventions.

Our case studies are a pioneering attempt to identify which organizational changes can close racial gaps in healthcare outcomes. The key findings of our case studies at each site revealed the following:

- A small-scale, community health program design in Jamaica Plain had a demonstrably positive impact on Mass General Brigham and the broader healthcare sector in Boston. Doctors who participated in clinic-based peer-learning exercises on how structural racism works, called **RacialRec**, gained knowledge and strategies to make the case for implementing departmental changes at the hospital and delivery of health services in two units, neurology and cardiology. This clinical work at the health center filled the lack of medical training on systemic racism.
- At Mount Sinai Health System, a coordinated strategic planning effort, called the **Task Force to Address Racism**, across the hospital system reinforced internal change efforts including "Addressing and Undoing Racism and Bias in the Medical School Learning and Work Environment" and the hospital's Office of Diversity and Inclusion to create a road map with specific recommendations for senior leadership. However, this strategy also encountered implementation challenges such as delegating these tasks and responsibilities across a large, complex system.
- The pioneering New York City's Center for Health Equity (CHE), founded by a health commissioner with a sharp vision for racial justice and backed by mayoral leadership, mobilized local government efforts to better coordinate health policy and community engagement. The CHE's **Race to Justice** initiative also experienced setbacks due to leadership turnover that resulted in shifting targets and changing objectives.

Cross-cutting thematic findings indicate that effective antiracism interventions require the following:

- **Buy-in and sustained engagement from leadership.** Senior and executive leadership (CEOs, executive directors, and board members) engagement throughout the entirety of the process is crucial to successfully implementing a racial equity intervention. This includes both defining the scope and goals as well as staying the course by engaging in training/workshops, meetings, and policy changes as well as rallying organizational-wide backing.
- **A shared understanding and use of explicit language to define structural racism.** This is achieved through developing a shared analysis of structural racism with staff and physicians. This new language must be used across the organization, from public-facing materials to internal staff and physician communications.
- **Effective organizational infrastructure.** Capacity and operation of the initiative is optimal when effectively placed in the organization and backed with institutional support, including department-wide integration, resources, and documentation to withstand external factors and organizational turnover, rather than being tied to individual diversity, equity, and inclusion (DEI) officer-led programs.
- **Clearly defined metrics.** Successful organizational change hinges on developing clear goals, outlining anticipated outcomes, and using data to measure ongoing impact along designated lengths of time and milestones. This process should be distinct from, yet tethered to, existing performance standards and manager-level accountability policies.
- **Building internal capacity and professional development.** Hiring outside consultants to provide antiracism training is useful as an initial step for capacity building, but it is significantly more effective when followed by sustained, internally driven learning, professional development, and peer-led dialogue and accountability groups.

IARA's findings indicate specific ways healthcare organizations can strategically plan and coordinate explicitly antiracist interventions. Yet, in all three case studies measurement was the weak link in a chain of sustaining organizational accountability, as shown in Figure 1. IARA also noted varying degrees of senior engagement with implementation, inconsistent training approaches, and abstract targets for desired organizational outcomes. The performance plot below indicates specific levers IARA evaluated to demonstrate a high degree of heterogeneity across the sites in how well they executed each component of change. Such heterogeneity requires more standard approaches that both attend to and advance strategies with each lever by what we know works best from the field.

Figure 1. Organizational levers of change and a low-high application for each case study site. Red is low, yellow is medium, and green is high.

Recommendations

Based on the cross-thematic findings from the qualitative data analysis and literature review, IARA proposes the following accountability compass in Figure 2 as a baseline to guide healthcare organizations. The compass follows a holistic, four-dimensional path for antiracist organizational change and accountability. Each dimension is composed of three levers from the qualitative grounded theory of the project and explained below.

Figure 2. IARA's accountability compass with corresponding levers of change.

Chart: This dimension supports the strategic planning and mapping of the antiracist commitments to align with organizational values, missions, and operational charts. This provides visibility and internal infrastructure to establish the intervention. Intentionally mapping the initiative strategy, using a road map, and having support from experienced racial equity consultants grounded in an antiracist power analysis is useful for implementing the racial justice initiative and charting the course for the three dimensions ahead.

Coordinate: This dimension encourages executing a coordinated effort to include parallel initiatives, practices, and top leadership of the organization. Creating a DEI committee, engaging senior leaders in the long term, and defining these roles from the start, along with developing in-house training and leadership development opportunities, ensures coordination among direct antiracism initiative stakeholders and organizational actors at large.

Measure: This dimension requires a tracking effort for the capacity and limitations of the intervention by monitoring incremental changes in the organization and developing measurement systems to inform progress. Community engagement is a direct measure of whether an initiative is accountable back to its communities served, including, and especially, BIPOC constituents. Moving beyond prioritizing demographic data within the organization, IARA emphasizes a closer evaluation of data internally in the organization as well as in its relationships to suppliers, contracts, and other partners. Disaggregating the data allows for specific attention to disparities and inequities as well as opportunities for results based on organizational accountability.[2] Additionally, building a foundational shared understanding of systemic racism by organizational actors, committees, or racial affinity spaces effectively strengthens the change muscle of the team and creates space for white accountability and peer support for BIPOC staff.[3]

Sustain: This dimension refers to creating robust policies to promote new reporting on performance data and incidents of racial discrimination as well as revisiting the original chart to ensure that changes sustain organizational transformation. Building infrastructure and an intentional placement of the initiative means creating a long-term strategy for its success as well as for resource generation and allocation—in people, money, space, and growth. Publications and reports provide the means to share findings with all stakeholders, especially community members, the board, and the public, both as an accountability mechanism and to provide best practices for the field. Competition for antiracism strategy should be avoided by all means.

Future research would benefit the healthcare industry's understanding of what works to achieve sustainable racial equity by increasing the organizational sample size and evaluating the implementation and impact of this suggested accountability framework for healthcare organizations to measure effectiveness in the field.

Introduction

> "These words I hear now, diversity, equity, inclusion, they're not bad words. But sometimes you'd think people are talking about color charts . . . and make it sound like we just want a spectrum of things without talking about power." Mary Bassett, *Former New York City Commissioner of Health*[4]

Measuring organizational antiracist interventions is essential—and challenging. The existing field of research on systemic racism in healthcare is largely focused on disparity data showing how racism impacts the social determinants of health and economic well-being of people and populations. New initiatives in healthcare have emerged recently, such as Rise to Health, which was formed in part by the Institute for Healthcare Improvement and the American Medical Association.[5] It calls for a larger narrative shift about equity to move the sector from "confusion and competition" to "collaboration and alignment."[6] Such equity initiatives are essential to address racism in healthcare, yet it is unclear what measures or performance metrics are available for healthcare organizations to support their accountability practices for achieving success and sustained impact.

Several ongoing initiatives to implement antiracist interventions in healthcare institutions offer us insight and understanding to inform the gap in research evaluating effective interventions. IARA's research on the organizational practices and institutional policy changes that directly address these inequities closes this gap. With funding from the Robert Wood Johnson Foundation (RWJF), IARA carried out a year-long study to document and analyze the racial justice journey of healthcare organizations committed to and engaged in change. The team assessed three case sites to evaluate interventions as well as a landscape review of pivotal research in the healthcare field related to antiracism. As a result of these findings, IARA synthesized the learning into cross-cutting thematic areas and developed a framework to serve as a guide for healthcare organizations to determine best practices that effectively advance institutional antiracist change. This report outlines in detail the scope of the project and accompanying findings and takes a deep dive into the thematic areas that inform this new accountability tool.

Background

In 2020, the worldwide outbreak of the COVID-19 virus acutely exposed structural inequities in the disproportionate impact on communities of color and disparate responses by health authorities and institutions to curb the impact of the pandemic in the United States. During the same year, the public murder of George Floyd and other Black Americans by police prompted sectors across society to recognize and reckon with the reality that structural racism was not a feature of the past, nor a matter of external crisis, but largely present within every current institution. Floyd's death and subsequent uprisings serve as a baseline for this project to evaluate organizational responses in healthcare set up to engage in antiracist work by learning from cases that started before 2020. It bears repeating that this study focuses on evaluating organizational interventions to address systemic racism, rather than most studies in medicine and public health that focus on health disparities or demographics of racialized populations. This report identifies key insights and levers of change in connection with the institutional missions and goals of the three healthcare organizations in their pursuit of dismantling racism.

This report is directed to those working in the healthcare sector and to decision makers in philanthropic organizations that support community organizing, public policy, social welfare, education, and

economic development—all of which profoundly shape human health. Additionally, this work builds upon existing research supported by RWJF studies on racial equity and quality improvement.[7]

About IARA

IARA uses research and policy to promote antiracism as a core value and institutional norm and to move organizations from words to action to accountability as it relates to policy, practice, and sustainable change. Antiracist change takes commitment and practice to adopt racial equity as a core driver where leadership and staff are accountable to one another and stakeholders. Given the history of failed diversity and inclusion efforts, IARA's purpose is to identify best practices that achieve long-term sustainable change in the field of antiracist institutional change.

IARA investigates a myriad of active mechanisms in use across various sectors that include healthcare, globalization, criminal justice, and philanthropic ventures to advance the standard practices to hold organizations accountable when they claim to stand for racial equity. This work is done with a focus on a comprehensive and in-depth evaluation of institutional policies and practices and looks at indicators such as retention, performance metrics, stakeholder accountability, power dynamics, and the impact of societal inequities.

IARA is uniquely positioned as an independent evaluator of organizational behavior. Most of the research on effective diversity and racial equity strategies are led by practitioners and academic researchers whose careers depend on access to high-quality data within firms. Other researchers are consultants who are contracted by firms. In both cases, private firms and often public agencies limit transparency and evaluation of their organizations.

IARA's work is grounded in historical methods, ethnic studies scholarship, and adopts a critical race framework to advance new and innovative research. Building on the United Nations sustainability (ESG) goals, IARA centers accountability as the key driver of organizational change rather than goodwill. This approach improves transparency and removes common barriers to making sustained change: a lack of accountability and a lack of skills in getting the work off the ground.

Methodology

This report draws on data and research gathered through an extensive literature review and qualitative analysis of key informant fieldwork interviews on three case study sites.

Literature Review

IARA conducted a comprehensive landscape review of healthcare literature, including collecting and analyzing 50 entries of articles, statements, and guidelines from scholars, public health practitioners, and trade organizations. The team identified publications using keyword searches including structural racism, antiracism, health inequities, antiracism intervention, and measurement, on databases including Academic Search Complete, EBSCOhost, and PubMed. Additionally, the team reviewed organizational statements in support of Black lives, published trade organizational guidelines for addressing racism in healthcare, and IARA's existing database, the Race, Research, and Policy Portal, which curates and summarizes articles, journals, and publications related to antiracism and accountability.[8] The articles that were used were limited to the publication years 2000–2022.

Qualitative Data Collection

Site Selection Criteria
IARA used a case study approach to analyze three field-based antiracist initiatives or programs. It specifically sought programs that were created before 2020, acknowledged the existence of health disparities, and committed to antiracist interventions to move or shift their institutions. The team selected each case study site based on 1) New England/Tri-State regional access; 2) samples from three distinctive organizational structures and clinical environments in the healthcare sector: an academic hospital, a public health/municipal health agency, and a community health center; and 3) available documentation of the antiracist change journeys.

IARA is cognizant of the selection bias that exists given that organizations with a record of failure would have an incentive to not participate in such a study. Until accrediting bodies and/or state and federal regulators require disclosure and compliance with new equity standards, all research on antiracist organizational change will be limited by selection bias. Nevertheless, IARA cross-referenced answers from interviews with publicly disclosed information and tested the veracity of responses among different individuals within organizations. Moreover, given the limitations of the sample size and selection process, there is still much to learn from these organizations given the scarcity of existing research on measurable antiracist change and institutional accountability. While these organizations do not capture the full range of the healthcare sector, the lack of existing research on effective mechanisms for organizational change necessitated choosing sites with a documented record of success and where access was granted to interview key stakeholders.

Over 13 months, the team conducted qualitative interviews in person and virtually by Zoom with a total of 25 representatives across each healthcare organization, including current and former staff, organizational leaders, interns, board members, and community members. The three sites include the Southern Jamaica Plain Community Health Center, the Mount Sinai Health System, and the New York City Department of Health and Mental Hygiene.

Interview Protocol
IARA developed a standard qualitative protocol script that was used across all interviews, in person and virtually. Questions were categorized into three thematic areas to document: the role of the participant and responsibilities at the organization, origins and development of the antiracist initiative, and the impact of the program on the institution, including policies, practices, and procedures (see Appendix 3). Audio files were transcribed and cleaned.

Analysis
Content analysis of the responses to the protocol were analyzed using a qualitative method that included a mixed-methods system of thematic analysis and grounded theory (see Appendix 4). Thematic analysis revealed key themes in the data, which were indexed and labeled as 18 coded categories, including 65 subcodes. The grounded theory approach, informed by IARA's ongoing accountability analysis of field-based interventions, also generated a set of levers (see Figure 3), by which each antiracist initiative was plotted and later evaluated based on a low-high range of application.

Figure 3. Levers of change generated from qualitative analysis code.

Initiative Strategy/ Road Map	Outside Consultant	DEI Officer/ Equity Committee	Senior Leadership Engagement	Language/ Framing	Training/ Workshops	Org. Infrastructure/ Policies	Community Partnerships	Historical Documentation/ Narrative	Metrics/ Reporting	Racial Affinity Spaces	Publications

Literature Review Findings

IARA's literature review from academic scholarship and emerging research across the United States and published in the last 20 years provides vital findings to evaluate racial equity interventions. One of the central findings from the landscape analysis was that measuring success of antiracist initiatives in healthcare was far less documented than identifying health disparities in patient populations. These strategies in healthcare organizations address health disparities and focus on increasing diversity and inclusion in the workforce, training clinicians in cultural competencies and implicit bias, and adapting evidence-based treatments to increase accessibility for the health needs of minority communities. Furthermore, existing research on the effectiveness of antiracist interventions in healthcare and the impact of these interventions reveals a gap related to implementation and measurement. Synthesis of the review indicates eight key salient findings on effective antiracism change initiatives in healthcare.

1. **Be explicit**
   An inability to speak explicitly about structural racism dilutes the impact of interventions aimed at dismantling oppression through organization-level initiatives. There is consensus among researchers and organizations that antiracist interventions must be explicit in their goals and focus on contesting institutional racism as much as health disparities.[9]

2. **Include education and awareness of the history of racism in healthcare**
   Learning about the legacy of racism in American medicine and public health helps build awareness for participating actors and provide tools to critically assess intervention actions. Yet, the literature also indicates that such educational efforts should be one part of larger comprehensive organizational efforts. Organizations should avoid implementing standalone individual-level training and instead shift their focus and resources to a multilevel approach, including addressing policies and practices, that seeks to dismantle institutional and systemic racism.[10]

3. **Focus on internal-facing forms of racism at healthcare organizations**
   Structural racism harms the health of community members as well as organizational staff. Analyzing disaggregated racialized data can elucidate disparities, gaps, and opportunities in patient care as well as employee satisfaction and performance. Organizations must invest time and resources into answering "how is racism operating here?" and not "is racism operating here?"[11]

4. **Be well positioned in the organization**
   Initiatives benefit from having a "change team" to guide the process of changing organizational culture and policies to influence the staff, organization, and ecosystem of the organizational system. However, for a change team to be effective, it must be empowered within and by the initiative and organizational structures. The change team must have power, and carrots and sticks, to incentivize and compel change.[12]

5. **Engage communities served**
   Community engagement is critical to the success and health of an antiracist change initiative. Establishing community alliances, collaborations, linkages, coalitions, and partnerships with community members, especially of marginalized groups, is an important component of any antiracist and anti-oppression strategy.[13]

6. **Be clear about the problem, goals, and objectives**
   When antiracist interventions fail to name the problem they are seeking to solve for and address, it may result in misalignment between goals and strategies and lead to failure to meet desired outcomes.[14]

7. **Include measurable outcomes and evaluation**
   Leading scientific and public health institutions recommend using measurable data and models when researching structural racism and addressing social inequity. The National Academy of Sciences contends that new data infrastructures are needed to harness validated measures and evidence for research on structural racism and health equity.[15] Likewise, the American Public Health Association recommends that to reduce the burden of racism and achieve racial equity, organizations must measure and evaluate progress in reducing health disparities.[16]

8. **Include accountability**
   One area not extensively discussed in the literature was accountability mechanisms associated with antiracist work. In 2023, the second report from the National Academies of Science, Engineering, and Medicine emphasized the value of creating accountability for results to drive antiracism and DEI in science, technology, engineering, math, and medicine (STEMM) organizations.[17] This is key to moving beyond diagnosing disparities to creating action-oriented impact for long-term transformation.[18]

Case Study Profiles

The following section describes the historical background of the selected antiracist change effort case studies, including the beginning of the organization, precipitating events and origin of the initiative, stated goals, and overarching strategy.

Southern Jamaica Plain Community Health Center

Introduction
The Southern Jamaica Plain Community Health Center (SJPHC) is a primary care and health clinic located in Greater Boston, Massachusetts. The SJPHC is a subsidiary organization of, and licensed by, Brigham and Women's Hospital (BWH), which in 2019 changed its corporate name from Partners Healthcare to Mass General Brigham (MGB). According to BWH, more than 10,000 patients in Jamaica Plain and surrounding communities make 45,000 visits every year to the health center.[19] Its principal focus is primary care delivery to the patient community that is physically distant from the main Boston health corridor, Longwood Health Center. Within SJPHC, the Health Promotion Center (HPC) coordinates health equity and social justice work that takes an approach based upon social determinants of health and strives to dismantle racism.[20]

History
The SJPHC's origins are rooted in the early 1970s, when the Brookside and Martha Eliot Health Centers united after years of a shared presence in Jamaica Plain. The SJPHC relocated to a storefront at 678 Centre Street in 1974 and continued to grow by expanding mental health and other services, eventually becoming a fully equipped community health center. In the late 1990s, the SJPHC moved to its current location at 640 Centre Street. Since 2001, it has collaborated with the South Street Youth Center on fundraising and program development focused on sexual education and community-based initiatives on food and fitness.[21] This youth-focused work, as a preventative health intervention, was an impetus for developing racial equity programming at SJPHC in subsequent years.

In 2010, the SJPHC opened a new space adjacent to the existing health center on 10 Green Street that became the HPC and launched an array of programs aimed at addressing the preventative and social health needs of its patients and community. It was here that Director of Social Programs Abigail Ortiz teamed up with trauma specialist Dennie Butler-MacKay to co-develop the **Racial Reconciliation and Healing Project** (**RacialRec**). Ortiz identifies as white of Polish ancestry, and Butler-MacKay as African American and Indigenous. Together they established **RacialRec** as the first program at the center to focus explicitly on structural racism and its impact on the Jamaica Plain youth and adult community.[22]

With additional space and a more modern facility, the SJPHC grew rapidly from serving 4,000 patients to over 12,000 by the end of 2004 and grew further to 15,000 in 2016. By the next year, in 2017 it received healthcare certification to become a level 3 patient-centered medical home. This designation was significant, elevating the SJPHC to national recognition as a health center providing comprehensive primary care to patients, with a focus on access to preventative care, management of chronic conditions, and racial justice.

Goals and Strategy

The core programming of **RacialRec** is a year-long cohort-based model for young adults and adults. Yearly cohorts include, on average, 25 high school students recruited from Boston Public Schools and Brookline High School and 10 adult community members from Jamaica Plain and surrounding neighborhoods to serve as faculty-in-training. Participants commit for 12 months to meet weekly and engage in programming activities.

Ortiz and Butler-MacKay designed **RacialRec** intentionally to sequence learning, with the first six months focused on group work to interrogate assumptions and biases related to experiences with racism and the following six months working in the community to implement the learning. Funding for **RacialRec** originally came from a collaborative grant with the Boston Public Health Commission and the Kellogg Foundation.[23] This funding was used to compensate both youth and adult participants to incentivize the commitment to the year-long program with SJPHC staff. In 2022, the faculty-in-training stipend was $1,000.

The goal of **RacialRec** is to teach youth in Jamaica Plain to engage with internalized racism as a preventive health mechanism to improve the overall health of the community, "to intervene before they grow into adults."[24] The intervention is grounded in directly confronting the impact of racism in individuals whereby BIPOC people develop internalized ideas, beliefs, actions and behaviors of inferiority and white people internalize the same but of superiority.[25] Ortiz and Butler-MacKay developed the program's curriculum around strengthening this core objective, through teaching trauma response tools and strategies to identify and process internalized forms of racism in youth as a clinical intervention (see Appendix 5 for a snapshot of the guiding assumptions).

The curricular strategy applied in **RacialRec** involves developing containment skills to interrogate and dismantle high-risk trauma experiences rooted in racialized violence and oppression. This container methodology is a trauma-informed therapy practice that offers a sense of control and stabilization instead of avoiding or ignoring feelings and teaches the understanding of racism as a driver for stress, anger, high blood pressure, and triggering experiences of body memories, flashbacks, and nightmares as well as coping mechanisms. Containment provides a safe emotional space to engage in roleplay and affinity sessions to support and challenge attitudes and biases among and between BIPOC participants as well as white participants.

The leaders of **RacialRec** recently published their program strategy in collaboration with the Institute for Healthcare Improvement in the *New England Journal of Medicine*.[26] The following is a summary:

1. Build a "container" for your team—a safe and healing space—where team members can explore and collaborate on solutions;
2. Understand and share the history of inequities and racism in your local context; and
3. Assess the current state of health equity in your system.

   The aim of these efforts is for healthcare teams to counter white supremacy culture, to center historically oppressed voices, and to address their own institutional histories in a process of truth, reconciliation, improvement, and healing.[27]

The trajectory of the **RacialRec** program (Figure 4), from its onset, indicates how the program expanded its influence and impact over its tenure at the SJPHC. In its first three years, the program operated successfully with its youth and faculty-in-training cohorts. By 2009, Ortiz and Butler-MacKay invited peer groups from the larger Brigham hospital system to participate in the program, extending its reach to new participant pools. From 2009 onwards, the **RacialRec** strategy expanded from the cohort model to training staff and other groups from within the community health network.

Figure 4. RacialRec timeline created from 2020 source data from the SJPHC.

SJPHC Racial Justice Journey

| 2006 | 2008 | 2008 | 2009 | 2011 | 2014 | 2016 | 2017 |
| Leadership Engagement | Racial Healing and Reconciliation | Community Training and Partnerships | Staff Training and Healthy Equity Committee | Consultation to Organizations | Liberation in the Exam Room | Adaptive Leaders for Racial Justice | IHI Pursuing Equity Instituional Change |

In 2014, the "Liberation in the Exam Room" phase of work was introduced through a series of meetings with physicians and other medical professionals from Greater Boston to integrate racial justice frameworks into healthcare. This specialized programming was based on five steps created by the Racial Reconciliation and Healing team and the executive and medical directors at the SJPHC: 1) know the history of structural racism and white supremacy in medicine and public health; 2) know and train yourself, through key concept learning on racial identity, racism and health, racialized versus self-identification; 3) know your community's history and resources; 4) acknowledge implicit bias on your team; and 5) address structural racism in the exam room explicitly, through specific strategies— visual cues, ask better questions, deep listening, use measurement tools to advance racial equity.[28]

From 2016 to 2020, the SJPHC collaborated with the Institute for Healthcare Improvement in applying racial justice strategies from **RacialRec** and the "Liberation in the Exam Room" phase of work, expanding their utility to the Institute for Healthcare Improvement's national network of clinicians and health professionals.[29]

Findings and Discussion
IARA found that **RacialRec** met and exceeded its 2008 objective of demonstrating that trauma response work provides an effective healing practice to internalized racism and violence from oppression in the Jamaica Plain community. The antiracist program was designed, developed, and implemented within a community health center licensed to operate as a subsidiary in order to deliver primary care with a focus on social determinants of health to Jamaica Plain residents.

Two key insights from the SJPHC's racial justice journey offer understanding of its design and deployment model. First, the small design of this program is unique and strategic for building relationships and trust among community member participants, including youth and adults. Second, despite its subsidiary position within MGB, the SJPHC was able to enroll clinical staff and health professionals from across the MGB network, who participated and implemented changes in their own division and departments. The SJPHC fostered traction for affiliated medical staff to influence efforts in the parent organization and larger hospital systems that directly address racism.

The following sections present findings from the case study and discussion, which expand upon their implications.

Design Size

The **RacialRec**'s small design size is unique and worth replicating in other health settings. Multiple leaders at the SJPHC describe **RacialRec** and the antiracist work in the HPC as effective because of the "small is all approach."[30] This small, strategic position is notable given that the SJPHC sits as a subsidiary community health center within a larger hospital parent organization. Additionally, the program's small cohort size enables the cultivation of relationships and tailored learning for youth and adult participants, health staff, and clinical practitioners.

Ortiz and Butler-MacKay explained how this small-scale clinical approach allowed them to modify the initiative to the specific needs of the community health center first rather than to the larger hospital organization, which came second. The intentional small size builds an effective environment for participants to process traumatic experiences and create trust with other members. The HPC and staff, coordinated by Health Promotion Coordinator Evelyn Gallego, provided the physical environment to implement an approach that they consider successful because of the tailored small group work. As Ortiz described, "the primary thing is how much time it takes. It has to be highly relational, and that means that there has to be some role work, and it has to feel good, because nobody's gonna want to do it."[31] This model generates impact at a deep personal level and differs in strategy to programs that take a large (by design) or system-wide approach, which is typically the scope of organizations like MGB.

The small design supports building trust in affinity groups to challenge internalized forms of racism between those participants who identify as BIPOC and those who identify as white. As Ortiz explained, this approach is "radical in that we treat racism and healing as part of trauma response rooted deep in the body. It feels like you are literally getting a little bit closer to your liberation all the time, and because the white power base needs to do a real gut check around what's not working for them too."[32]

As a result, the SJPHC decided to expand **RacialRec** from a youth-only focused program to include adult participants as a strategy to build sustainability and strengthen the impact of the initiative. A SJPHC board member describes this shift and impact in the following way:

> They really started seeing the results of how they're training these young people, who then go out into the real world, but the adults are like, "no, we're not ready for you," it squashes their dreams and ideals completely. Because we as adults aren't ready to cope with that internalized racial trauma we noticed there is a need in the community, and if we're going to train our young people, we need to train our adults to be ready to take these young people into the workforce.[33]

Ultimately, the shift from starting small allowed growth of the **RacialRec** program and its effective practices to evolve and include participant groups that expanded beyond adult community members into clinical and health professional peer groups.

Community Impact on Clinical Staff and Larger Hospital System

This community-level work in Jamaica Plain has generated an impact on the broader healthcare sector in Greater Boston. One of the ways that SJPHC describes its impact is by sharing the work of clinical staff members affiliated with MGB who have applied **RacialRec** methods and strategies (from the SJPHC) to their clinical departments and divisions.

Findings indicate that physicians who participated in **RacialRec** were able to learn critical anti-racism analysis tools and then apply them to their clinical work in the hospital. A former senior medical director within MGB recalled: "I came to the community health center because it was an opportunity to be working with the Latinx community and the Learning Collaborative. [This was an outgrowth of] how we started as a health center, making that intentional pivot toward becoming a racial justice institution."[34] Physicians who participated in clinic-based SJPHC peer-learning exercises gained analysis about racism that was unavailable in medical school training and developed ways to implement this work in the hospital clinic. The outcome of these community-level driven efforts includes redirecting medical staff and resources to the Jamaica Plain community via the center and resulted in material impact on the accessibility and quality of health services rooted in racial justice.

Dr. Michelle Morse (now chief medical officer at the New York City Department of Health and Mental Hygiene) and Dr. Bram Wispelwey (instructor at Harvard Medical School and practicing hospitalist at MGB/Brigham Hospital) acknowledged that the SJPHC greatly influenced their peer group's foundational training and healing practices. This in turn led them to produce a study based on 10 years of MGB/Brigham Hospital data to demonstrate the organizational policies causing a disparity in services for cardiological care for Black and Latinx patients.[35] This 2019 study was followed by an article in 2021, entitled "An Antiracist Agenda for Medicine," in the *Boston Review* that called for a structural shift in racial equity work to hold healthcare institutions accountable to the underlying causes of racial health inequities and mitigate the impact of racism in medicine.[36]

The intervention by Morse and Wispelwey garnered institutional and national response from physicians and public supporters as well as white supremacist backlash when two dozen white nationalist neo-Nazis protested in front of MGB in January 2022.[37] The group denounced Morse and Wispelwey, claiming that the doctors promoted "anti-white genocidal policy."[38] This led MGB to increase security and publicly defend the physicians. Wispelwey pointed to the peer learning activities at the HPC as the bedrock for building his analysis on US racism and medicine: "One hundred percent, without those [SJPHC] meetings in 2016 this wouldn't have happened. I probably don't say that enough."[39]

The findings also indicated how clinicians who participated in the SJPHC **RacialRec** program applied these lessons and practices back in their home departments in MGB. One example includes a physician in the neurology department who, because of participating in the program, made the case for redirecting neurology services to the community health center in Jamaica Plain where they were not previously offered. As the physician, who is white, explained, the "Liberation in the Exam Room" sessions offered a strong model and tools to narrow the disparity in health services at the SJPHC. The physician continued, "my department chair is really into outcomes, numbers, data, that sort of thing. . . . So I think role playing and just getting the words out [in a container], and hearing other people talk about racism and how I reacted to them, and how the group reacted to them was really important to my success."[40] She directly shifted her clinical work to make specialty care services available with support from the Neurology department, which previously only provided neurological services at Brigham Faulkner Hospital, which is also located in Jamaica Plain but is a direct facility under MGB and not a community health center like the SJPHC.[41] As a result, the **RacialRec** methods, adapted for clinical and health professionals, supported her efforts and success in expanding neurological care to community members that depend on SJPHC for health services.

Not all physicians who have participated in the SJPHC programs rooted in **RacialRec** have gone on to make a similar contribution at their hospitals or clinics, yet interviews across this participant group indicated the effectiveness of the program in raising awareness and addressing internalized racism and harm to marginalized community members perpetuated by the professional environment of large healthcare institutions.

Challenges

While the SJPHC succeeded in its goal for creating a community health approach to racial justice, the structure of the center as a licensed subsidiary under MGB creates challenges, such as resource funding and allocation, geographic location and accessibility, and institutional visibility within a larger institution and the globally recognized healthcare ecosystem of Boston. As a community health center program, **RacialRec** depends on operational funding from the SJPHC clinic, which in turn must balance the resources provided by the parent organization, MGB. The team based at HPC does seek outside funding, but this is restricted for program-specific development and not operational development. For example, Boston Children's Hospital is providing $50,000 per year to **RacialRec** for the years 2022–2025.[42] More operational funding earmarked for racial justice work is needed from MGB to its subsidiaries like SJPHC. Additionally, greater buy-in from the larger institution is needed to sustain and reproduce the evidence-based successes at the health center.

Because of its location south of the main Boston healthcare corridor, the center does not attract as much foot traffic from physicians, especially those at city-based elite hospitals, outside of the immediate staff and community. The landscape in Longwood, where within a half-mile radius most major hospitals and medical schools such as Harvard Medical School are situated, is a sharp socioeconomic juncture from the Jamaica Plain community. Staff thus face a geographic, and segregated, barrier to enroll new physician participants in the antiracist program.

The HPC and **RacialRec** program have also faced challenges in organizational visibility, especially as awareness of the issue areas the program addressed has been redirected more recently to a newer MGB corporate initiative: United Against Racism.[43] This initiative, launched in 2021, draws on the practices and people who trained at the SJPHC, but in its communication it does not explicitly acknowledge the long-standing and direct practices rooted in SJPHC health work that occurs at the HPC. This limits the center's public visibility as a leader in racial equity, which then hinders further success as well as outside funding opportunities.

Mount Sinai Health System

Introduction

Mount Sinai Health System (MSHS), located in New York City, is one of the largest hospital and academic research centers in the United States, with over 45,000 employees. MSHS has a documented history of DEI programs starting as early as 2000 and more recent initiatives that gained institutionally significant momentum in 2016. While these racial equity change initiatives started almost 20 years ago, it was in June 2020 when Dr. Kenneth L. Davis, CEO of MSHS, and Dr. Dennis S. Charney, dean of the Icahn School of Medicine, came together in response to the racial disparities made visible by the COVID-19 pandemic and the public murder of George Floyd. They announced a new initiative, the **Task Force to Address Racism (Task Force)**. Dr. Gary C. Butts was appointed the new chair of the **Task Force** as well as the executive vice president and chief diversity and inclusion officer of MSHS. Previously, he served as dean for Diversity Programs, Policy, and Community Affairs at Icahn School of Medicine at Mount Sinai for 20 years.[44]

History

MSHS was founded in 1852 and remains one of the oldest and largest teaching hospitals in the United States. At the time of its opening, many other hospitals in New York City discriminated against Jewish people by not hiring them and by prohibiting them from being treated as patients in the hospitals' wards. Sampson Simson, a wealthy Jewish philanthropist, founded the hospital to respond to the expanding Jewish immigrant community in New York City and its needs for quality medical care.

Today, through the integration of its hospitals, laboratories, and education, MSHS is a comprehensive health system comprising approximately 7,300 primary and specialty care physicians; 13 joint venture outpatient surgery centers throughout the five boroughs of New York City, Westchester, Long Island, and Florida, and more than 30 affiliated community health centers.[45]

Goals and Strategy

In early 2018, the Icahn Medical School launched a "culture transformation initiative to eliminate racism and bias from its medical education program."[46] This initiative and its change management approach was published in a 2020 publication of *Academic Medicine* titled "Addressing and Undoing Racism and Bias in the Medical School Learning and Work Environment." The authors were Leona Hess, director of strategy and equity education programs, and Dr. David Muller, dean of medical education at the Icahn School of Medicine. The article captures the events at Icahn beginning in 2016 with student activists to the formation of an initiative that encompasses medical education.[47]

The **Task Force**, launched in 2020, was explicit about its aim to draw from leaders and the lessons learned at the Icahn Medical School because this initiative led to institutional changes in the school curriculum and program objectives, which determine what is taught and how it will be evaluated. According to Muller, "we've developed these program objectives specifically related to racism, oppression and bias, which doesn't sound revolutionary."[48]

The **Task Force** was set up to conduct an internal assessment to produce a road map for action with recommendations aimed at moving MSHS to become an antiracist healthcare and learning institution.[49] According to a general timeline provided to IARA (Figure 5), this effort occurred between July 2020 and December 2020 as a "hard look at [the] organization."[50]

The initiative had two core goals as indicated by the chair of the **Task Force**. The first goal was to define racism: "we had to reset our mindsets and the way in which we were thinking about our existing work on racism, being probably the most important undercurrent that was getting in the way of fully addressing diversity, equity and inclusion for us as an organization."[51] Essentially, the previous work characterized as DEI, which began around the year 2000, no longer effectively covered the range of systemic change efforts that the organization required 20 years later because it was focused narrowly on the medical school and not across the health system.

The second goal was to acknowledge racism: "we had to acknowledge all the important work that other leaders in the institution [MSHS] including research, HR, and others, [including] pipeline programs to figure out how we would come together to craft a different way."[52] The **Task Force** centered on these goals and served MSHS principally as a planning initiative to gather information and practices and to produce recommendations to address institutional racism.

The **Task Force** used a collective process to develop recommendations, into what was eventually named the Road Map. Specifically, this initiative drew on the Collective Impact model, a collaborative-based approach that brings people together, in a structured way, to achieve social change.[53] The **Task Force** enrolled 50 people who volunteered to participate in the initiative, which included staff, residents, medical students, faculty, department chairs, hospital presidents, and trustees. According to a timeline provided to IARA, the **Task Force** met diligently over the course of six months in 2020 to

produce the Road Map. From July to August, it learned about collective impact and reviewed data to define the problem as a system-wide organization and to identify existing MSHS activities and groups engaged in antiracism work. This led to building consensus and then identifying strategies to reach this goal. From September to October, the **Task Force** identified new and ongoing "mutually reinforcing activities" to develop a plan for shared measurement and ongoing improvement. Between November and December, it drafted the strategic structure and support systems with anticipated resource and budget needs. These efforts elicited feedback to reach consensus on a proposed Road Map.

Figure 5. Timeline table of general activities (July to December 2020) by the Task Force to produce the Road Map.[54]

Jul-20	Learning about Collective Impact
Jul-20	Reviewing the data and defining the problem (common agenda)
Jul-20	Identifying existing MSHS work, activities, initiatives, and groups that address racism
Aug-20	Building consensus around overarching goal (common agenda)
Aug-20	Identifying strategies to achieve goals
Sep-20	Identifying new and existing mutually reinforcing activities
Oct-20	Developing a plan for shared measurement and continuous improvement and learning
Nov-20	Designing a strategic structure and support
Nov-20	Identifying resource and budget needs
Dec-20	Eliciting feedback and achieving consensus of proposed Road Map

The generated Road Map is organized in nine sections, paraphrased below:

1. A problem statement acknowledging that hospitals and academic medical systems have institutionalized policies and practices that perpetuate a culture that maintains an unequal distribution of social and institutional power, hinders the advancement of people of color, supports discriminatory practices, and contributes to disparities in health outcomes.

2. An overarching goal to become an antiracist and equitable healthcare and learning institution that intentionally addresses all forms of racism and creates greater DEI for our workforce and for those we serve.

3. Guiding principles that reinforce the commitment to accountability and "an unwavering resolve to support the principles embodied by racial and social justice movements that are responsive to those who have been historically marginalized."

4. Eleven key strategic recommendations based on existing efforts and gaps in achieving the overarching goal.

5. An implementation approach to mutually reinforce activities or actions designed to achieve the key strategic recommendations.

6. An implementation approach that leverages existing structures and supports those that already exist.

7. A new governance structure to support and lead the implementation that includes a steering committee of executive diversity leadership board, advisors/decision-makers, backbone supporters; and partner-driven action (intervention and implementation).

8. Shared measurement system to identify metrics for tracking progress to share data, discuss learnings, and improve our strategy and action at MSHS.

9. Action steps for leadership such as approval for requested incremental funding to advance the overall project management and impact evaluation of the **Task Force** Road Map.[55]

Findings and Discussion

Our findings indicate that the **Task Force** met its objective of producing a strategic plan for senior leaders at MSHS with recommendations for a pathway to become an antiracist hospital system. Two key insights indicate challenges to the successful implementation of the Road Map recommendations. First, while strategic planning for a complex academic hospital like MSHS remained essential, it was also subject to the practical risks of missing targets, especially when they were not clearly defined. Second, the belief that MSHS is better positioned than most other healthcare organizations to successfully become antiracist due to internal, parallel change efforts is misguided because there are no official requirements for robust reporting on the progress of such health systems or hospital-centered antiracist initiatives. For example, MSHS had a DEI office program for 20 years before starting its newer antiracism initiative in 2020, yet it remains unclear how it demonstrated historic change and how that impact is accounted for in the latest iteration of this work. The following sections present findings from the case study and discussion that expands upon their implications.

Fundamental Importance of Strategic Planning for System-Level Change

The planning and road map successfully enabled an intentional approach to shift the direction of MSHS. As a strategic officer of the **Task Force** explained, "our process is to learn by doing it, because ultimately, we don't know what it will look like to be an antiracist institution."[56] Yet, the opaqueness in approach and overemphasis on planning without incorporating tracking systems to measure progress created misalignment and implementation challenges.

MSHS is one of the most complex academic hospital systems serving the City of New York. Moving on its commitment to antiracism in a system-wide approach required a reset of its operational alignment and how it viewed itself as an antiracist organization. The Road Map was a plan for setting strategic goals and guiding principles, yet it did not map the depth or breadth of the organizational restructuring that was required. Particularly because of the vague and broad targets set by the initiative, the Road Map lacked clarity as to what the actual goals were and how they were to be implemented following the initial onset of programming.

For example, the first Recommendation Strategy of the Road Map (see Appendix 7) focused on measurement. It emphasized data to be retrieved to "develop an equity scorecard to measure the organizational performance in order to identify success and detect limitations."[57] While an equity scorecard would serve as a valuable data tool to monitor and standardize organizational performance related to the proclaimed goals, it was unclear how or if this was ever implemented.

In August 2022, **Task Force** members announced the creation of an equity scorecard to meet the first goal. Based on the press release, IARA found that the data tool was designed to record race and ethnicity to identify and measure existing differences based on patient data. This example was featured in the announcement: "If Black patients made up half the patient population, but accounted for 75% of urinary tract infection discharges, the Equity Index would identify a potential disparity that should be explored."[58]

While the tool is effective for MSHS to detect further health disparities, it does not provide the structural guidelines for organizational change goals as stated in the Road Map summary as it was not designed for monitoring institutional behavior at MSHS. This is a missed opportunity for MSHS and the **Task Force** to establish a metric system for activity related to the Road Map. In planning for antiracist transformation at the academic hospital organization, the planning effort would have been more effective in providing scaffolding for its success by establishing concrete accountability standards including tools like required performance assessments.

The tenth recommendation strategy from the Road Map specified that "enhanced leadership learning, capacity, knowledge, engagement, and accountability so that all leaders are able to participate fully in antiracism and equity efforts," communicating that internal leadership development and

engagement, in addition to outside consultants, was essential to success. As Butts contended, "it does require outside consultation, or expertise, to change the way because it's hard to be in the middle of it, leading it and then responsible for all the moving pieces."[59]

Outside expertise was an important capacity-building decision but was only viable in the short term because the organization did not develop new institutional practices and policies to hold its leaders or itself accountable. To emphasize the difference between designing and deploying institutional transformation, IARA draws on an expression by Dean Muller who said, "to me, it feels like there is a profound difference in terms of launching, implementing, and sustaining something like this [Road Map]."[60] It is important to distinguish between the implications of each step of antiracist interventions because plans are one thing, implementation another, and sustaining that change, as Muller indicated, requires its own commitment.

Parallel Racial Equity Efforts Reinforced Health System Improvement
MSHS has a history with antiracist change efforts across education divisions, residency programs, and clinical departments reaching back at least 20 years. The existence of parallel change efforts led **Task Force** leaders to believe that MSHS was "certainly better positioned than most diversity work and larger [health] institutions to be particularly thoughtful and how we want to organize and then advance our work across specificity."[61] Key to this organizational approach was the expectation that parallel change efforts map seamlessly onto system-wide planning strategies that are actually unsupported at an institutional level.

The **Task Force** planning effort did succeed in acknowledging and identifying past activities by MSHS staff across different divisions of the academic hospital. For a system-wide approach, this reinforced the organizational commitment and demonstrated a track record of intent to contest racism in their healthcare institution. By not centering the ongoing and past efforts, as noted above regarding the DEI work started in 2000, MSHS would have unintentionally erased these past efforts and eliminated any lessons learned or best practices generated from them. Any academic hospital committed to this work will gain significant institutional knowledge and garner momentum when coordinating parallel and past antiracist work. However, our findings indicate that the coordination of these efforts was limited by the absence of an official policy requiring programmatic or activities-based progress to be reported as part of internal antiracist work.

The value and emphasis on coordination efforts under the umbrella of the **Task Force**'s work also exposed funding gaps for internal antiracist work. Dr. Steve Itzkowitz, professor of medicine and head of the gastroenterology division, arranged several People's Institute for Survival and Beyond (PISAB) workshops at MSHS. PISAB is a national, multiracial, antiracist collective of organizers and educators, dedicated to building a movement for social transformation that started in 1980.[62] At MSHS, Itzkowitz led a hospital residency program and exposed his program to PISAB's power analysis approach for racial justice. Although he and his program carried out these activities, he was not required to provide a standard report or evaluation of their impact. He admitted that the chair of the department at the time, Dr. Barbara Murphy, "is the one who sort of authorized us. She paid for the workshop, even ironically, she herself never took the workshop."[63] Eventually, the workshops ceased due to economic feasibility according to Itkowitz. Because there were no official requirements for robust reporting and leaders who authorized the program did not attend, it is difficult to evaluate the true value of the training and how it can be expanded systematically.

The Icahn School's change targets are compelling as structured examples of applying metrics to the work of antiracism, yet they were not emulated across other system actors.[64] In 2016, Icahn School leaders introduced a tracking system to support structural change by following a series of 20 change targets. And by 2020, these change targets became publicly available online and were published by the

Icahn Medical School Guiding Coalition. The 2020 report focused on 24 change targets, compartmentalized in three categories: relational, structural, and transformative change, as an effort to advance the school's vision to become a health system and professional school "with the most diverse workforce, providing health, education, and research that are free of racism and bias."[65]

A notable example of the change targets listed by the Icahn School included "Change Target 5: structural—eliminate disparities in academic and career outcomes for medical students and medical education staff."[66] This target was created from results of a student-facing survey, which produced a set of 15 policies (identified in number but not listed). "Change Target 5" is described by the Icahn School leaders as an "equity audit" engaging with students, student affairs, curricular affairs, and the director of quality, compliance, and accreditation.[67] Although featured in the 2022 report, this specific change target has not been implemented, and according to the report, it is to begin in 2023.

Another key target of the Icahn School is "Change Target 18: relational—enhance engagement and sustained community conversation across the medical and graduate schools to respond to the myriad and intersecting ways oppression impacts our institution and daily lives." This metric centered on the importance of dialogue between graduate students (did not include faculty) that took place at three town halls where nearly 100 attendees participated.[68] Ultimately, the Icahn School reported that "no indication that anyone is better off due to the town hall, with participants reporting that they felt like being in an echo chamber."[69]

Despite this notable effort at the Icahn School, and the impact model it offers to other medical schools, little evidence exists that the best practices and strategies of its initiative mapped on sufficiently to the system-wide planning strategy under the MSHS **Task Force.** IARA interviewed Leona Hess, Director of Strategy, who explained that from a strategic standpoint, the medical school effort was feasible for the size of Icahn and focused on specific targets, while the **Task Force** initiative was broader and system-wide.[70]

The expectation by MSHS leadership that coordinating parallel change efforts would be a seamless and efficient mechanism did not account for the reality that MSHS does not have an official policy requiring the measurement, evaluation, or reporting of progress of internal antiracist programs or interventions. Therefore, IARA found that the **Task Force**'s unofficial approach to integrating racial equity and leveraging parallel efforts is limited as an effective method for determining which practices or procedures are effective across the system-wide implementation without such built-in measures.

Challenges
While MSHS was effective in organizing support from leadership and advanced a coordinated effort within the health system to include parallel activities across hospital residency programs and the Icahn School of Medicine, there remains the question of continuity and what has changed for MSHS between the past 20 years of work by the office of DEI under Butts and the rest of this decade based upon the **Task Force** and its Road Map.

As a result of the **Task Force**, the explicit nature of language changed in MSHS and its public communications, whereas now "racism" appears and has started to replace the term "race." Race, historically, has been used by physicians and scientists to determine a category when capturing data about human health, but this use eliminates or makes invisible the structural nature of racism in medicine. Butts made this point when he reflected on his training: "we are more comfortable with the term racism now, but I still remind folks that when I was in training, I can remember in medical school, anybody mentioned the term racism, you looked over your shoulders."[71] Despite these material changes to using racism instead of race, language alone is insufficient for organizations to build capacity and accountability practices for sustained transformation.

New York City Department of Health and Mental Hygiene

Introduction

Dr. Mary Bassett was appointed New York City health commissioner on January 16, 2014, and led the Department of Health and Mental Hygiene (DOHMH) explicitly on the charge to treat racism as a root cause of illness and death and as a key measure by which public health institutions are held accountable. This directive was in response to the Staten Island grand jury decision in late 2014 to not indict the police officer involved in the death of Eric Garner.

Writing in the *New England Journal of Medicine* in 2015, Bassett raised the question "should health professionals be accountable not only for caring for individual Black patients but also for fighting the racism—both institutional and interpersonal—that contributes to poor health in the first place?"[72] In her role as commissioner, she placed emphasis on the professional training of public health workers as most effective when rooted in racial justice.

Bassett inaugurated the **Race to Justice** initiative within the newly established Center for Health Equity (CHE), explicitly stating this was a political decision and designed to improve the population's health focused on racial equity.[73] The goal for the DOHMH under Bassett's leadership was to become explicit about racism and its mechanisms as the problem internal to institutions as well as external to the social life of New Yorkers. This antiracist change effort would be overseen by Dr. Aletha Maybank, Deputy Commissioner at the time, whom Bassett appointed.

History

The City of New York is organized into 30 health districts (often referred to as health center districts) and is composed of 354 health areas. The DOHMH was formed in response to an eastern seaboard yellow fever outbreak in 1793. By 1866, at the suggestion of the New York Academy of Medicine, New York City organized the Metropolitan Board of Health, which became the first modern municipal public health authority in the United States.[74] Today, the DOHMH is among the largest public health agencies around the world.

Goals and Strategy

The CHE and its **Race to Justice** initiative define racism as a system of power and oppression that assigns value and opportunities based on race and ethnicity, unfairly disadvantaging people of color while unfairly advantaging white people.[75] According to the **Race to Justice** toolkit, which is a set of public materials and information on the initiative, the program's goal is to create internal reforms that help staff learn and improve practices to better address external racial health gaps and improve health outcomes for all New Yorkers.[76] Since 2016, the internal reforms have involved a series of explicit discussions and activities to target structural racism and its historical persistence in the United States, especially in New York City. Internally, the DOHMH organized mandatory workshops and training, created new staff positions dedicated to advancing racial equity and support, and developed an operating infrastructure under the CHE to support capacity and coordinate activities.

In 2018, the DOHMH led a public health education exhibit called *Undesign the Redline* to highlight the impact of federal housing discrimination that barred Black people and other people of color from government mortgage subsidies. The DOHMH's exhibit set up a public pictorial timeline and history of redlining to make explicit the ways in which structural racism impacted housing and public health in the Tremont, Bronx, residential neighborhood office. This exhibit was documented and surveyed to track the public responses, which was later published in the *Journal of Public Health Management and Practice*.[77]

In 2020, the DOHMH released a public statement declaring racism as a public health emergency and calling on sister agencies to address structural racism. This public statement garnered support

internally and publicly and ultimately resulted in the NYC Board of Health passing a resolution to declare racism a public health crisis, as shown in Figure 6.[78] This resolution aligns with the origins of the board as an institution that emerged in response to the pandemic, with the difference that this was the first time that antiracism and public health were directly linked, evidenced by credits to **Race to Justice** and its "commitment to uprooting white supremacy and its impact on health and wellbeing while shifting resources and power" (see Figure 6).[79]

Figure 6. Excerpt of resolution to declare racism a public health crisis in NYC.[80]

Board of Health Passes Resolution Declaring Racism a Public Health Crisis

WHEREAS, NYC aims to address structural racism and longstanding inequities and seeks to build upon existing efforts such as the annual Social Indicators Report and Standard Equity Metrics created by Executive Order No. 45 (dated May 8, 2019), and the establishment of the City's Taskforce on Racial Inclusion and Equity created by Executive Order No. 80 (dated September 13, 2021), to address the disparate impact of COVID-19 in BIPOC communities; and

WHEREAS, the first declaration of racism as a public health crisis was developed in 2018 by a Black woman, Ms. Lilliann Paine, while she was Director At Large of the Wisconsin Public Health Association, and more than 200 similar declarations have been made across the country since, including from the Centers for Disease Control and Prevention; and

WHEREAS, in 2016, the NYC Health Department launched Race to Justice to build the Health Department's capacity to address structural racism and health inequities, and has committed to uprooting white supremacy and its impact on health and wellbeing while shifting resources and power to the communities that bear the greatest burden of marginalization, racism, and health inequities; and

WHEREAS, the NYC Health Department initially declared racism a public health crisis on June 8, 2020 and now seeks to expand on this declaration through direct actions across the Health Department; and

WHEREAS, Take Care New York is a comprehensive health plan for NYC that lays out the Health Department's priorities to advance anti-racism public health practice, reduce health inequities, and strengthen NYC's collective approach to ensuring that all New Yorkers can realize their full health potential, regardless of who they are, where they are from, or where they live;

WHEREAS, settler colonialism, Indigenous genocide, and enslavement of Africans are part of the history of our nation; and

WHEREAS, the City of New York is situated on Lenape, Rockaway, and Canarsie land; and

WHEREAS, these original injustices have been without comprehensive restitution or redress;

WHEREAS, race is a social and political construct, based on the social interpretation of how one's identity is perceived, with no biological or genetic basis.

Findings and Discussion

IARA found that the DOHMH met its goal of building internal capacity for staff as a catalyst to improve public health work with a sharp focus on racial justice. It pioneered the CHE and implemented the **Race to Justice** initiative, which led to staffing a major municipal policy resolution and subsequent public health programming that centered on racism as a public health crisis.

The findings indicate two key insights, discussed below about the DOHMH case study. First, new leadership was important to kicking off **Race to Justice** but also subjected it to external influences. That is, deploying **Race to Justice** within the CHE enabled the initiative to operate with institutional capacity, but each time it shifted on the organizational chart, so did the target goals and objectives, which limited the DOHMH's ability to demonstrate measurable progress over time. Second, prioritizing training workshops in **Race to Justice** before drafting a strategic plan complicated the process of accounting for identities beyond race (gender/sexuality) in the initial program design. The following sections expand on and discuss these findings.

Leadership Turnover Was Important to Race to Justice's Kickoff and Also Created Vulnerabilities for Tracking Target Goals and Objectives

The DOHMH's **Race to Justice** initiative marks a divergent approach to the work of public health in a major municipality. However, tracing the journey of the racial justice initiative exposed unforeseen challenges related to leadership turnover and the shifting target objectives of the CHE. When Bassett set out to lead the DOHMH through antiracist transformation in late 2015, the first step was hiring more Black health officers who would be capable of leading a new departmental-wide platform under the CHE. A former staff member explained that "I will say that moving [**Race to Justice**] into the chief operating office was helpful because it made everything much more concrete. Everything was tied to the agency's goals that were already being measured and monitored by that officer."[81] Having the chief operating officer oversee the initiative allowed the organization to map existing performance indicators onto those set up by the CHE to provide different ways for tracking impact. However, our findings do not indicate any available information on these indicators.

Beginning in 2019, after Bassett's departure, **Race to Justice** and the CHE moved around the organizational chart at the DOHMH due to leadership changes. With the inauguration of Michelle Morse as chief medical officer in 2021, there was another shift across the organization. The CHE shifted on the organizational chart once more and was placed under the leadership of Morse, while the **Race to Justice** initiative was separately placed under the leadership of chief equity officer Dr. Torian Easterling. Easterling recalled the following:

> When the former commissioner Dave Chokshi stepped in, he also asked that I serve as the chief equity officer, one, to signal that embedding an equity lens was very important to all of the work that we do, and so wanted to make sure that the first deputy commissioner also held the title of the chief equity officer. And number two, it was also to think about how we would operationalize our equity work across the agency. And in the past, a lot of the equity work has fallen on specific deputy commissioners that led a division. And so it was important to bring it to a higher level, really to signal . . . that this had to be an agency priority.[82]

Easterling was in his seventh year working with the DOHMH at the time of this project and explained, "I joined the agency because Dr. Bassett was Commissioner and had been boldly stating that structural racism was the driver of the health inequities that we've seen in this country."[83] This move of the initiative in the organizational chart affected its consistency and target goals.

Senior leadership, including the NYC mayoral administration, was not the only external factor that affected **Race to Justice**. The outbreak of COVID-19 moved the DOHMH to respond and reorganize resources as a frontline emergency response institution, which also showed its resilience. The pressure of COVID-19 on the agency creation of new roles to ensure that the health emergency was managed with a sharp focus on racial justice. John Yates, director of racial equity and social justice in the Office of Emergency Preparedness and Response, serves in this role and explained, "the vision was to figure out how we do equity in emergencies."[84] The pandemic led the DOHMH to expand the objective of **Race to Justice** beyond workshops and training about systemic racism, with more attention on developing strategies for advancing racial equity in a health emergency. From this perspective, Yates reiterated that "what **Race to Justice** succeeded at was demonstrating the need to have full time, paid staff that think about antiracism as part of their full-time job."[85]

Action before Planning Left Out Key Voices
Our findings indicate that when the DOHMH launched **Race to Justice** to support staffing for more diverse positions, it also sought to manage the internal training workshops on racial equity in health-care. While this immediate goal was the desired outcome as set by Bassett, the DOHMH had not yet produced a strategic plan or clear markers of success. In part, Bassett envisioned the goal to set new organizational norms and create internal change as a strategy for external impact in public health. However, due to the bureaucratic structure of a public agency like the DOHMH, the implementation experienced setbacks and barriers, especially as expressed by stakeholders with competing equity priorities. For example, employees working on different equity issues felt like they were boxed in to make a joint decision without effective integration on intersectional issues of oppression including ethnicity, gender, and sexual orientation. One staff member noted the following:

> Well, actually, even within the Center for Health Equity, there was a slight move, because of the move into **Race to Justice**, there was kind of a rupture, or earthquake there. This was bringing together those two different initiatives within CHE. And it highly affected the work and the initiative itself, trying to bring those two teams, the LGBTQ plus core team and the **Race to Justice** core team together at the time, it was hard to get people to try and come together from an intersectional perspective, because both sides felt like they were losing something. And both sides felt like they were being pushed into making a decision.[86]

Putting action before planning and lack of provision of a clear framework for race, gender, and sexual orientation to be adequately seen and accepted both internally and externally left gaps in the implementation, and resulted in limited success. Ultimately, a pool of staff members felt that intersectional interventions were not prioritized.

Race to Justice was effective in shifting the DOHMH toward major structural attention to racial justice, which led to an increase in capacity for mechanisms to inform new practices and policies for public health work in NYC. Leadership change and developing target objectives posed challenges to measuring progress and the long-term impact to the municipal health department in addressing institutional racism.

Cross-Cutting Thematic Findings

This research generated a codebook system (see Appendix 4) to evaluate field data and produce a data table of organizational levers of change to plot the application at each case study site. These levers are institutional activities, not individual behaviors, related to antiracist structural change (see Figure 1). The colors indicate the actions taken by the organization on a low, medium, or high degree of application.

Figure 1. Organizational levers of change and a low-high application for each case study site. Red is low, yellow is medium, and green is high.

Levers of Change	Southern Jamaica Plain Health Center	Mount Sinai Health System	New York City Health Department
Initiative Strategy/ Road Map	green	green	yellow
Procure Consultant Services	red	green	yellow
DEI Officer/ Equity Committee	red	green	green
Senior Leadership Engagement	yellow	yellow	green
Language/ Framing	green	yellow	green
Training/ Workshops	green	yellow	green
Infrastructure Policies	red	red	yellow
Community Partnerships	green	yellow	yellow
Historical Documentation/Narrative	red	yellow	red
Metrics/ Reporting	red	red	red
Racial Affinity Spaces	green	yellow	yellow
Publications	green	green	yellow

Five Levers of Change for Healthcare Organizations Implementing Antiracist Change Initiatives

Findings generated from data across the three case studies emphasize five key areas to advance institutional transformation. These cross-thematic areas are explained with supporting evidence of best practices from the organizational analysis and indicate what supports are required for healthcare change efforts to be successful.

1. Buy-In and Sustained Engagement from Leadership

All three initiatives attributed buy-in from their leadership and board members—senior and executive leadership (CEOs, executive directors, board members)—as essential for the process to be successful. This includes defining the scope and goals as well as staying the course of engaging in training/workshops, meetings, and policy changes and rallying organizational-wide backing.

At the SJPHC, senior leaders engaged in the racial justice journey from the beginning by supporting the HPC and its staff. Jaime De Zengotita, Medical Director at SJPHC at the time of the project, emphasized that "our work will kind of follow two tracks. One was internal, which was training everybody. Remember, it is just a framework, trying to make our efforts take that justice into account. This second track was sort of external-like, encouraging and participating with the Department of Medicine

and the Brigham and MGB and partners about racial justice work."[87] Buy-in to this dual approach by the medical director during the breadth of the whole initiative led to an increase in the number of participating medical staff and engagement in learning about how to initiate antiracist change.

Additionally, the SJPHC board was a key driver of **RacialRec**'s success. The board was composed mostly of community members and was separate from the MGB board of directors, which enabled SJPHC to have autonomy and direct a network of stakeholders beyond the community residents to support change from the beginning of their racial justice journey. This direct, enthusiastic, and sustained engagement by senior leaders was in sharp contrast to MSHS, where executive leadership's buy-in was necessary to launch or "charge" the **Task Force** yet over time slowly dissipated. For example, Butts explained that "the CFO owns the business strategy. The chief learning officer owns the learning strategy. The chief learning officer also happens to be a hospital president. Another [unidentified] president, who was the chief medical officer, owns the medical system."[88] While these executives "owned" the strategies, it is unclear what that fully entails, what resources are available to solve problems, or how MSHS leadership delegates critical stakeholders in driving the work.

The **Race to Justice** intervention illustrates that without full support from the mayor and health commissioner, the intervention would not have been successful. Our findings indicate that Bassett was clear in learning from her prior work as deputy, which had focused more on employee representation than on structural change. Mayor Bill De Blasio provided Bassett with the authority to bring together "people who shared our values."[89]

Bassett also started at the top and created a team that was racially diverse: "in the first time in the department's history we had a non-white majority leadership team . . . when I joined there were no African Americans or Latinos."[90] This new cadre of health officers included Aletha Maybank as deputy commissioner, who "empowered these officers through the [CHE] to do antiracist work."[91] Bassett provided Maybank with the capacity and resources to build up each neighborhood center and launch the **Race to Justice** initiative. Support from the senior director was critical for the success of the initiative and for junior directors to have both cover and role-based capacity to implement programming and procedural changes.

While leadership is a constant changing variable in all healthcare organizations, the DOHMH offers insight into the political turnover of a municipal agency and the challenges for embedding continuity the agency can sustain.

2. A Shared Understanding and Use of Explicit Language to Define Systemic Racism
All three sites adopted explicit language to describe and explain the goals of their antiracism initiatives to various degrees. Raising awareness was achieved through a shared analysis of racism that normalized an organizational-wide terminology among staff and clinicians and was reflected in public-facing materials, internal meetings, and documentation. The value of this shared understanding was that it allowed the organizations to situate their objectives to address structural causes of poor health outcomes.

As SJPHC community director Abigail Ortiz explained, "the intentionality of the [intervention] design is that you look like, you talk like, you rock like the denominator population in the community, and that you are rooted to make the implicit, explicit."[92] For decades, SJPHC centered community health in a framework that has gained more currency in the field only recently as "social determinants of health." The introduction of **RacialRec** as a racial justice program presented a need to explicitly develop an intervention framed with the specific nature of systemic racism of the broader community health framework. Ortiz affirmed that "so I would say that some of the fundamentals that have come from the health center directly into our program are being explicit."[93]

For the DOHMH, explicit language for talking about systemic racism in New York City was necessary to create a shared understanding for shifting the practice of public health within a local

government agency. Easterling emphasized that "we often talk about [for our racial justice initiatives] the vision as . . . folks need to have the shared language and shared analysis of why . . . what caused those inequities and what is a clear direction we can go in. So this idea of normalizing how we talk about race and racism. And two, this is a new field . . . so we need to understand the infrastructure needed to advance these initiatives."[94]

This normalizing effect was different at MSHS, where explicit language did appear in public literature but the **Task Force** did not provide an action-oriented suggestion to how its 42,000 employees could use explicit language. The second guiding principle (see Appendix 6) produced by the **Task Force** is "safety to name, confront, and engage in conversations about racism," which "ensures a safe environment where all are encouraged to speak up."[95] Encouragement is simply broad and vague, whereas the SJPHC and the DOHMH placed an emphasis on education and training to adopt shared language effectively and explicitly.

3. Effective Organizational Infrastructure

All three of the organizations relied heavily on internal infrastructure to drive their antiracist work even if only two of them used the word "infrastructure." The capacity and operations of antiracist initiatives yielded the greatest change effort when they were effectively placed in the organization and backed with institutional support including department-wide integration, resources, and documentation to withstand leadership and organizational turnover. This ultimately proved more sustainable than when tied to an individual DEI officer.

For the DOHMH, establishing an infrastructure—the CHE—to house the antiracism work enabled more impact than hiring an individual DEI director/manager with little to no authority. As a deputy commissioner explained, "understanding antiracist interventions is also understanding the infrastructure that's needed to even advance these interventions. If you talk to any organization that has a Chief Equity Officer, you are only talking to one person?"[96]

The SJPHC does not use the word "infrastructure" to describe the operational capacity for the **RacialRec** initiative. However, its operational capacity at-large depends greatly on the HPC, where **RacialRec** is housed and its activities take place, as well as the people who manage and maintain its programming. HPC enables what the **RacialRec** leaders describe as "relational building," or fostering linkages between individuals living in Jamaica Plain. This relational approach is smaller and more intimate and relies heavily on community trust, which was not described in the definitions of infrastructure from the other organizations. As Ortiz and Butler-MacKay explained, "people get the tactics and the outcomes, but they don't understand that nobody feels each other yet. Nobody trusts each other."[97]

The Road Map recommendations at MSHS indicated intentions for "a centralized infrastructure, a dedicated staff, and a structured process that leads to a common agenda, mutually reinforcing activities, shared measurement, and continuous communication."[98] However, the **Task Force** has not implemented this specific recommendation at the time of the writing of this report, and thus this goal cannot be assessed. This is backed by key findings from the literature review (see Appendix 1) that indicates that antiracist work must be well positioned in an organization with staff, funding, and resources to succeed.[99]

4. Clearly Defined Metrics

All three organizations struggled to describe the metrics for measuring the progress of their initiative, thereby creating challenges for evaluating success and demonstrating change by comparison. Sustained, institutional transformation hinges on developing target goals, outlining anticipated outcomes, and measuring ongoing impact along designated lengths of time and milestones. This process must be distinct from, yet tethered to, existing performance requirements and human resources accountability practices of healthcare organizations.

A former staff member at the DOHMH explained that "we did this staff survey so we had a base-line of what people's experiences were because we wanted to find, ultimately, after time, a reduction in people's experiences of discrimination in a very tangible, significant way."[100] Although this survey was conducted to produce a baseline, it was not made available internally to the staff nor was it revisited at later dates to determine progress. It was also not published or included in the **Race to Justice** toolkit on the DOHMH website.

The **Task Force** recommended to senior leaders at MSHS that a scorecard be developed to track metrics and change targets. One possible template can be drawn from the parallel efforts at the Icahn School of Medicine, which does actively publish metrics on its antiracist initiative, but MSHS leaders have not officially incorporated this dashboard into the Road Map.

The SJPHC did not provide any dashboard or standard metric system for measuring the progress of **RacialRec** or any programs at the HPC. It does publish testimonials from past program participants on the website about the impact it has had on youth and adults. Furthermore, findings from the literature supports the claim that antiracist interventions must include measurable outcomes and evaluation pro-cedures to reduce the burden of racism as a data-driven endeavor (see Appendix 1).

5. Building Internal Capacity and Professional Development
IARA found that all three organizations emphasized building capacity and professional development as part of the antiracist initiative, with two of the three choosing to procure outside consultants as the principal driver for initiating this capacity building through training workshops. These decisions illustrate that hiring outside consultants to provide antiracism training is useful as an initial step but is significantly more effective when followed by a sustained, internally driven program for peer learning, professional development, and internal dialogue through groups.

Hiring a racial equity training group was effective for the DOHMH as an immediate, action-oriented first effort to build up infrastructure and develop shared language around structural racism in public health practice. Once this infrastructure formed, the long-term effect of outside sup-port proved unsustainable due to cost and limited resources for the public agency. To overcome this limitation, **Race to Justice** adapted by coordinating and training internal staff to lead workshops, which reduced this immediate cost, but more challenges emerged for staff who wanted to support the con-tinued training but were not compensated for extra work. A former DOHMH staff member explained that "I was doing all this work while I was a senior research and evaluation analyst, but it [was] rapidly becoming more and more of my work, ultimately ended up becoming about 30% of my time and with-out it really being acknowledged, compensated, or appreciate it in the same way . . . and it was primarily people of color doing and leading this work."[101] One year passed before full-time positions focused on health equity were created under the **Race to Justice** initiative. Due to the shift from outside consul-tants to internal-driven training, the DOHMH made the health equity work more cost-effective but conflicted from an equity perspective with staff capacity and compensation despite this group valuing the work and its importance.

The **Task Force** leaders at MSHS hired an outside consultant, the Mary Francis Winter Group, to support the "backbone" of the initiative.[102] This is notable because MSHS had 20 years of operating DEI programs under the leadership of Butts.[103] As mentioned earlier in the report, Butts admitted that "it does require outside consultation, or expertise, to change . . . you need that outside perspective and energy."[104] In sharp contrast, the SJPHC did not hire outside consultants to support the antiracism initiative, but it did depend heavily on training adult facilitators who may not necessarily be clinical or health staff and supported SJPHC staff with program activities.

Concluding Discussion

IARA found that each case study was effective in planning and coordinating antiracist initiatives within their existing organizational structure yet struggled to demonstrate progress with measurable evidence, which is the weak link in a chain of sustaining organizational accountability. Without a standard data and performance metric system specific to antiracist interventions, organizations will continue to be limited in their ability to evaluate progress on antiracist impact. Heterogeneity in the different types and complexity of healthcare organizations requires a more standardized approach to both attending to and being strategic with each lever of change based on what interventions work most effectively. The ability to measure progress and create new internal reporting policies, specifically antiracist performance indicators, is necessary for learning what works and what does not and for practicing institutional accountability and sustainability. Therefore, despite the explicit nature of naming racism and making public commitments to racial equity, without accountability, tangible and sustainable antiracist change is unlikely.

In each of the 25 interviews with organizational leadership and staff, IARA asked participants to describe how accountability is embedded in the initiative. There were widely different answers provided; no reporting or regulatory requirements were mentioned as part of the antiracist initiatives nor were clearly defined responsibilities to observe such metrics. This wide variance in defining accountability and demonstrating accountability practices indicates a major knowledge gap area for deeper study and development.

Recommendations

IARA's Accountability Compass

Based on the cross-thematic findings from the qualitative data analysis and literature review, IARA proposes the following accountability compass as a baseline for guiding healthcare organizations. This compass (Figure 2) traces a holistic, four-dimensional path for antiracist organizational change and accountability. The design was inspired by existing antiracist change frameworks from the field, including the ten frameworks recommended in the recent 2023 study on Antiracism by the National Academies of Science, Engineering, and Medicine.[105] One distinction is that IARA's compass is specific to the healthcare sector and developed from this report's findings, which evaluated existing mechanisms used by current initiatives.[106]

Figure 2: Accountability compass with corresponding levers of change.

The four dimensions in Figure 2 consist of three levers derived from the qualitative grounded theory of the project. They are explained below.

Chart: This dimension supports the strategic planning and mapping of the antiracist commitments to align with organizational values, missions, and operational charts. This provides visibility and internal infrastructure to establish the intervention. Intentionally mapping the initiative strategy, using a road map, and having support from experienced racial equity consultants grounded in an antiracist power analysis is useful for implementing the racial justice initiative and charting the course for the three dimensions ahead.

Coordinate: This dimension encourages executing a coordinated effort to include parallel initiatives, practices, and top leadership of the organization. Creating a DEI committee, engaging senior leaders in the long term, and defining these roles from the start, along with developing in-house training and leadership development opportunities, ensures coordination among direct antiracism initiative stakeholders and organizational actors at large.

Measure: This dimension requires a tracking effort for the capacity and limitations of the intervention by monitoring incremental changes in the organization and developing measurement systems to inform progress. Community engagement is a direct measure of whether an initiative is accountable back to its communities served, including, and especially, BIPOC constituents. Moving beyond prioritizing demographic data within the organization, IARA emphasizes a closer evaluation of data internally in the organization as well as in its relationships to suppliers, contractors, and other partners. Disaggregating the data allows for specific attention to disparities and inequities as well as opportunities for results based on organizational accountability.[107] Additionally, building a foundational shared understanding of systemic racism by organizational actors, caucus, or racial affinity spaces effectively strengthens the change muscle of the team and creates space for white accountability and peer support for BIPOC staff.[108]

Sustain: This dimension refers to creating robust policies to promote new reporting on performance data and incidents of racial discrimination as well as revisiting the original chart to ensure that changes sustain organizational transformation. Building infrastructure and an intentional placement of the initiative means creating a long-term strategy for its success as well as for resource generation and allocation—in people, money, space, and growth. Publications and reports provide the means to share

findings with all stakeholders, especially community members, the board, and the public, both as an accountability mechanism and to provide best practices for the field. Competition for antiracism strategy should be avoided at all means.

Conclusion

The healthcare literature reviewed for this report focused heavily on understanding and measuring acute racial disparities in patient and population health outcomes, with few indicators to measure organizational antiracist interventions. IARA's fieldwork to evaluate organizational commitments and strategies for antiracist interventions in healthcare filled a significant gap in this landscape by documenting and demonstrating the successes, limitations, and lessons from current antiracist change efforts and levers that work.

Our findings indicate that organizations are successful in raising awareness and coordinating initiatives within their existing organizational structure when they engage levers proven to be effective and rooted in an analysis of systemic racism and power. At the same time, the findings point to a persistent struggle to demonstrate progress with measurable evidence, which IARA identifies as the weak link in a chain of sustaining organizational accountability.

When organizations can measure and evaluate their own antiracist change efforts using data and evidence, it becomes feasible to establish new official requirements to report this progress. IARA observed that unofficial policies or practices to maintain internal change efforts across a complex health system did not yield the expected results of efficacy when robust reporting policies remained absent. The adoption of policies that require such reporting will greatly support organizations' efforts to establish accountability practices and ensure more equitable responsibility for long-term, sustainable transformation.

Based upon these findings, IARA presented a new accountability compass to guide healthcare organizations on their racial justice journey starting with planning, coordinating, and emphasizing measuring and sustainable transformation. Descriptive levers of change correspond to each dimension of the compass and can support the application of the framework across a diverse range of healthcare organizational structures including community health centers, large hospital systems, and public health agencies. This dynamic and flexible guide is designed for the diversity of organizations in the healthcare sector.

Future research would be useful to assess the implementation and integration of the IARA Compass framework and to document the development of new performance reporting metrics as well as to identify policy changes to support such ongoing and integrated robust reporting. IARA also suggests future research to consider the role of accreditation standards and industry regulations akin to ESG goals in the corporate sector that would begin to standardize antiracist organizational best practices and to accelerate the elimination of systemic racism and racial disparities in healthcare.

Appendix 1: Literature Review

In an extensive scoping review of antiracism interventions in healthcare settings, Hassen et al. (2021) declare that healthcare institutions are still grappling with using the word "antiracism." However, since 2020—after the killing of George Floyd and Breonna Taylor—and the visible impact that COVID-19 had on communities of color, this is changing. More organizations and jurisdictions are embracing antiracism language, have released statements against racism, or have declared racism a public health priority.

The American Public Health Association (APHA) found that, as of August 2021, 209 governmental declarations of racism as a public health crisis had passed in 37 states (APHA). More than a third have committed to identifying specific activities to increase diversity and incorporate antiracism principles across leadership, staffing, or contracting; to forming and strengthening partnerships with community groups and organizations that are addressing racism; to advocating at the local, state, and federal levels for policies that directly address systemic racism; and/or to advocating for policies that improve health for communities of color. Hospital systems like Mount Sinai and Mass General Brigham, national organizations like the American Medical Association and the American Psychological Association, and countless educational institutions have released statements against racism or have implemented new interventions to address racial inequities among the populations and communities they serve (American Medical Association 2022; American Psychological Association 2022; Mass General Brigham 2022; Mount Sinai 2021). For example, on June 19, 2020, 36 organizations in Chicago released a letter in which they stated: "we must double down on our efforts. Systemic racism is a real threat to the health of our patients, families, and communities" (UChicago Medicine 2020).

Race and Health: A Historical Context
While the explicitness of antiracism language may be a more recent development, the existence and persistence of racialized health disparities have long been documented in the United States. As Bailey et al. (2021) state, "[there] has never been a time in the United States without racial health disparities." The Centers for Disease Control and Prevention (CDC) define health disparities as preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations (CDC 2011).

In the United States, the US Department of Health and Human Services has reported health disparities since 1985, when the *Report of the Secretary's Task Force on Black and Minority Health* (Heckler Report) marked the first comprehensive study of racialized health outcomes. According to the 1985 report, "[although] tremendous strides have been made in improving the health and longevity of the American people, statistical trends show a persistent, distressing disparity in key health indicators among certain subgroups of the population." The opening of the report states that Black, Latino, Native American, and Asian/Pacific Islander communities "have not benefited fully or equitably from the fruits of science or from those systems responsible for translating and using health sciences technology" (US Department of Health and Human Services 1985).

Addressing racial health disparities as a national priority is not new. In 1998, the Clinton administration established a national goal of eliminating disparities "in six areas of health status experienced by racial and ethnic minority populations" by the year 2010 (US Department of Health and Human Services 1998). These areas included infant mortality, cancer screening and management, cardiovascular disease, diabetes, HIV infection/AIDS, and immunizations. One goal of their plan was to achieve a "meaningful improvement in the lives of minorities who now suffer disproportionately from the burden of disease and disability."

Structural Racism and Health

Racial Health Disparities Persist Today

Racial health disparities persist today, despite efforts over the past 20 years to prioritize addressing health disparities. According to the Agency for Healthcare Research and Quality (AHRQ), in the United States, compared to white populations, Black populations received worse care in 43% of quality measures, American Indian/Alaska Native populations in 40% of quality measures, Latinx populations in 36% of quality measures, and Asian and Native Hawaiian/Pacific Islander populations in about 30% of measures (while receiving better care in 30% of measures as well; see AHRQ 2021). According to Braveman, "[the] largest and most consistent racial/ethnic health disparities generally have been observed when comparing Black people and (when data are available) American Indians with Whites" (Braveman 2021). The Office of Minority Health and Equity reports that communities of color in the United States experience higher rates of poor health than white populations in several health domains, notably diabetes, hypertension, obesity, asthma, and heart disease (Office of Minority Health and Equity 2022). The COVID-19 pandemic has offered an important case study into these disparities. National data shows that Black, Latinx, American Indian, and Alaska Native populations in the United States have experienced higher rates of hospitalization and death compared to white populations (Office of Minority Health and Equity 2022).

These disparities are systemic and are also experienced at the individual level. In "An Antiracist Agenda for Medicine," Wispelwey and Morse (2021) describe how even with federal actions—namely reparations—some racial disparities would persist. These disparities include a lack of racial diversity among faculty and staff at academic medical centers and hospitals, undertreatment of pain for Black patients, longer wait times for patients of color, underfunded research for conditions with poorer health outcomes like sickle cell disease, and poorer quality care received by Black patients, even when seen at the "same facility, by the same provider, for the same condition, and with the same health insurance as white patients" (Hoffman et al. 2016; López and Jha 2013; Ray et al. 2015; Strouse et al. 2013; Weiner 2020).

Racism as a Social Determinant of Health

A wealth of research has focused on the social determinants of health, the factors apart from medical care that can be influenced by social policies and shape health in powerful ways. According to many public health scholars, racism—interpersonal and structural—is a root cause of many health disparities in the United States, because it affects individual and population health (Institute of Medicine 2012; James 2003; Paradies 2006; Williams et al. 2019). As such, that racism is a social determinant of health is not a new. In an 1899 article published in *The Philadelphia Negro*, W. E. B. DuBois described the ways in which "the living and working conditions of Black people in the United States shaped their exposure to factors that determined their risk for disease" (Du Bois 1899). Williams et al. (2019), highlight similar findings in more recent work and state that "[the] persistence of racial inequities in health should be understood in the context of relatively stable racialized social structures that determine differential access to risks, opportunities, and resources that drive health." If health outcomes are as historians claim "an index of the cost of racism through the ages," then eliminating health disparities cannot be achieved without first undoing racism (Hammonds and Reverby 2019).

Race, Not Racism, Has Dominated Health Research

Even though there is wide acknowledgment that racism is a driver of health disparities, most research on disparities report racialized health outcomes without discussing racism, and even fewer studies focus on the impact of structural or systemic racism on health. A study by Bailey et al. (2020) provided

a quantified analysis of this difference when they found 47,855 articles when searching for "race" with the words "health," "disease," "medicine," or "public health," but only found 195 articles when they replaced "race" with "structural or systemic racism."

While government efforts to address health disparities have been well documented, organizational efforts to improve health outcomes for racialized individuals have seldom been reported in existing literature or in peer-reviewed research. A *Health Affairs* article noted that, "despite racism's alarming impact on health and the wealth of scholarship that outlines its ill effects, preeminent scholars and the journals that publish them, including *Health Affairs*, routinely fail to interrogate racism as a critical driver of racial health inequities" (Boyd et al. 2020).

Beyond Reporting Disparities

In its groundbreaking report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, the Institute of Medicine (IOM) recommended that "collection, reporting, and monitoring of patient care data by health plans and federal and state payers should be encouraged as a means to assess progress in eliminating disparities, to evaluate intervention efforts, and to assess potential civil rights violations'' (IOM 2003). However, some have proposed that focusing on health disparities as outcomes alone draws attention away from the root cause of the issues. For decades, the focus has been on reporting health disparities without interrogating the role of racism and the inequities that drive these disparities. As Jones (2000) comments in the *Levels of Racism: A Theoretic Framework and a Gardener's Tale*, "race-associated differences in health outcomes are routinely documented in this country, yet for the most part they remain poorly explained." Bhopal (1998) posits that focusing on presenting data designed to highlight differences when minorities are compared with the majority population portrays minority groups as weaker. Chowkwanyum et al. (2020) expand on this issue, asserting that health disparity data absent of explanatory context may reproduce false assumptions and beliefs that deter the efforts of closing health gaps and eliminating inequities.

Movement toward Antiracism in Healthcare

According to Jones (2000), a leading antiracism in health scholar, "[if], indeed, racism is a root cause of observed race-associated differences in health outcomes, it is vitally important that we develop a detailed understanding of the characteristics and manifestations of racism." Jones (2000) establishes three levels at which such racial disparities are produced: differential care within the healthcare system, differential access to healthcare, and differences in exposure and life opportunities that create different levels of health and disease.

There is a shift happening toward an explicit antiracism approach. For example, on February 7, 2022, *Health Affairs* published a special issue focused on structural racism and health in which author Weil (2022) wrote that the "racism and health issue not only focuses on the discussion of the topic with the latest scholarship, but includes forward-looking pieces to help shape the future research and policy agenda." The attention and space given by a mainstream health journal to the topic of structural racism and its impact on health and health equity represents a major shift in understanding the importance of focusing on the topic of racism within health.

The attention to structural racism in *Health Affairs* is not an exclusive case. In September 2021, *The Lancet* issued a call for papers on the topic of "advancing racial and ethnic equity in science, medicine, and health." This call was accompanied by a commitment on behalf of the journal to "dedicate a theme issue to advancing racial and ethnic equity in science, medicine, and health, to be published in late 2022 or early 2023" (Chew et al. 2021).

A similar trend can be observed outside of academic publishing spaces and within clinical health-care settings. In July of 2021, the American Hospital Association (AHA) also released a statement on racism as a public health issue. In this announcement it explicitly stated that "our goal is an equitable and just healthcare system that is not racist, promotes improved outcomes for all, and honors the dignity of every patient. To that end, we commit and hold ourselves accountable to increasing access to care, enhancing the diversity of our workforce, providing care with cultural humility, and empowering patients and families to achieve optimal health" (AHA 2021).

As discussions around racial equity have gained traction around the country in the aftermath of the Black Lives Matter movement, there has also been an increased focus on discussing and publishing on racism within medicine and in the healthcare space. Publications ranged from the role of race and racism in the lack of universal health coverage to the role of racism in clinical perceptions of patients, marking a departure from earlier disparities within health (Interlandi 2019). This includes structural analysis for antiracism within medicine that is more holistic and explicit when considering health equity, health advocacy, and frameworks for measuring equity within health policy.

Contemporary Antiracism Interventions in Healthcare
Addressing health disparities requires investment beyond national or government interventions. Wis-pelwey and Morse (2021) suggest that national interventions (reparations) must be supplemented by localized antiracist institutional change because many existing racial health inequities persist even after controlling for socioeconomic factors, and trust between patients and providers is a prerequisite for equitable care, which cannot be achieved with federal interventions alone.

Legha and Miranda (2020) summarize most strategies in healthcare to address health disparities as focused on increasing diversity in the workforce, training clinicians in cultural competence and implicit bias, and adapting evidence-based treatments to address the health needs of minority communities. Many fields from ophthalmology, mental health, and pediatrics have recommendations about incorporating antiracism in health (Vaughn 2021; Legha and Miranda 2020; Jones 2021; Corneau and Stergiopoulos 2012). Jones (2002) offers three simple recommendations to public health scientists: name racism, ask how racism operates here, and mobilize for action. Others have offered recommendations to physicians directly on how to address racism in their practice (Hardeman et al. 2016; Rodríguez et al. 2021).

Though not specific to health settings, in "Continuum on Becoming an Anti-Racist Multicultural Organization," Jackson et al. (2006) establish that antiracist multicultural organizations in a trans-formed society have the following characteristics: an institution and wider community has overcome systemic racism and all other forms of oppression; an institution's life reflects full participation and shared power with diverse racial, cultural, and economic groups determining its mission, structure, con-stituency, policies, and practices; members across all identity groups are full participants in decisions that shape the institution, and diverse cultures, lifestyles, and interest are included; there is a sense of restored community and mutual caring; allies work with others to combat all forms of social oppres-sion; and organizations work in larger communities (regional, national, global) to eliminate all forms of oppression and to create multicultural organizations.

The literature shows several recommendations specific to addressing racism in health for organi-zations. In *Inaction Is Not an Option: Using Antiracism Approaches to Address Health Inequities and Racism and Respond to Current Challenges Affecting Youth*, Svetaz et al. (2020) offer the following recommendations: focus on activation, promote antiracism education, build alliance using participatory processes, honor language that does not stigmatize, respect alternative healing strategies, practice advocacy and social justice/activism in parallel, and foster reflexivity for those who care and for those who are cared for.

Bailey et al. (2021) offer four recommendations for public health practitioners to help dismantle racism. The first is the need to document racism, which includes recommendations to funders, editors,

and reviewers to acknowledge that racism and inequities in social determinants of health more generally are valid research topics. The second recommendation is to improve the availability of data that include race and ethnicity and the tools to measure structural racism. Third, they suggest that medical and public health organizations must turn a lens on themselves, both as individuals and as institutions, to reflect and recognize the harms associated with using racial categories uncritically, and connecting the history of racism with the healthcare field. Faculty and students need a more complete view of the ways in which medicine and public health have participated, and continue to participate, in racist practices throughout U.S. history. Finally, the authors conclude that mass social movements are a necessary tool to dismantle racism in healthcare delivery and public health. Health inequities cannot be separated from the broader, antiracism movement.

In *Structural Racism and Supporting Black Lives—The Role of Health Professionals*, Hardeman et al. (2016) also offer four recommendations for clinicians and researchers who wish to dismantle racism. These include learning about, understanding, and accepting the United States' racist roots; understanding how racism has shaped our narrative about disparities; defining and naming racism; and (4) "centering at the margins" or shifting the locus from that of the majority group perspective to the underrepresented group. Centering at the margins includes "diversifying the workforce, developing community-driven programs and research, and helping to ensure that oppressed and under-resourced people and communities gain positions of power" (Hardeman et al. 2016).

There are some commonalities that arise among these interventions, which are explored below.

Antiracism work must be explicit.
According to Hassen et al. (2021), not being explicit in these efforts waters down interventions and skirts the work of dismantling racism. There appears to be consensus among researchers and organizations alike that antiracist interventions must be explicit in their goal and focus on dismantling racism, not just health disparities (Braveman 2021; Hassen et al. 2021; Legha and Miranda 2020).

New York City's Department of Health and Mental Hygiene's (DOHMH) Undesign the Redline offers an example of a health department identifying creative ways to engage the community to explicitly name racism as a threat to healthy communities. DOHMH has sought opportunities to educate and engage in discussion about historical and current structural racism (Shiman et al. 2021).

Efforts must include education and awareness of the history of racism in healthcare.
Many antiracism interventions incorporate education and training, which is an important component for building awareness of how racism impacts health and healthcare delivery. According to the 2003 IOM report, "[cross-cultural] curricula should be integrated early into the training of future healthcare providers, and practical, case-based, rigorously evaluated training should persist through practitioner continuing education programs" (IOM 2003). Legha and Miranda (2020) also recommend that individuals learn the legacy of racism in U.S. medicine (and beyond) to avoid perpetuating it.

Beyond awareness, efforts should focus on action.
Educational efforts, however, should be part of comprehensive efforts and not stand alone initiatives. Educational approaches have demonstrated limited effectiveness in reducing or eliminating healthcare disparities, especially when they are not coupled with policy or organizational change efforts (Griffith et al. 2007). Organizations should avoid implementing standalone individual-level training and instead shift their focus and resources to policies and practices that seek to dismantle pervasive institutional and systemic racism through a multilevel approach.

Antiracism work must include internal research or "looking within."
According to Bailey et al. (2021), structural racism harms health in ways that can be described, measured, and dismantled. This is true within organizations as well because looking at racialized disparity data can elucidate gaps and opportunities in patient care. Organizations should invest time and resources into answering the question how is racism operating and not *if* racism is operating. They should assume that it is because racism is pervasive and present everywhere (Hassen et al. 2021; Jones 2002).

Antiracism work must be well positioned in the organization.
In their scoping review of antiracist interventions in healthcare, Hassen et al. (2021) recommend meaningful involvement of leaders at different levels of an organization in antiracism interventions. According to the Government Alliance for Racial Equity (2022), jurisdictions need to be committed to the breadth and depth of institutional transformation so that impacts are sustainable; this can be applied to organizations as well. Griffith et al. (2007) propose that this work should be driven by a change team. They state that "the Change Team guides the process of changing organizational culture and policies that can have an effect on the staff, the organization, and the extra-organizational system and environment. Their efforts are focused on making sure the overall organizational system and culture shifts, not just that individuals or problematic policies change" Griffith et al. (2007). However, for a change team to be effective, it must be empowered within the organizational structure.

Antiracist interventions must engage communities served.
Community engagement is a common theme in antiracism efforts and recommendations. Hardeman's "center at the margins" is an anchor point with the Government Alliance for Racial Equity's recommendation to partner with other institutions and communities (Government Alliance on Race and Equity 2022; Hardeman et al. 2016). Svetaz et al. (2020) also state that "establishing and developing community alliances, collaborations, linkages, coalitions, and partnerships with other oppressed groups is an important component of any antiracist and anti-oppression strategy."

Efforts should be clear about the problem, goals, and objectives.
When the problem is not well defined in antiracist interventions, it may result in misalignment between goals and lead to failure to meet the desired outcomes (Hassen et al. 2021).

Organizations must invest in the intervention with staff, funding, and resources.
Hassen et al. (2021) note the need for dedicated funding for the implementation and evaluation of each antiracism intervention. For example, lack of funding to cover staff training is a barrier to participation in training.

Antiracist interventions must include measurable outcomes and evaluation.
The APHA recommends that to reduce the burden of racism and achieve racial equity, organizations must measure and evaluate progress in reducing health disparities (2021). The Government Alliance for Racial Equity (2022) recommends that jurisdictions be data driven. While specific to governments, this recommendation is consistent for health organizations.

Accountability cannot be left out.
One area that was not extensively present in the literature was accountability mechanisms associated with antiracism work. The Government Alliance for Racial Equity (2022) states that "building in institutional accountability mechanisms via a clear plan of action will allow accountability." Griffith et al. (2007) suggest that "power inequities are a fundamental aspect of racism in organizations, and creating accountability and more equitable distribution of power is a key to reducing healthcare disparities."

Measuring Success of Antiracism Interventions in Health

Even less researched than the impact of racism in health is the effectiveness of antiracism interventions in healthcare or how the success of these interventions should be measured. Hassen et al. (2021) state that "[our] review revealed limited literature on policies used to tackle antiracism in healthcare settings, suggesting a gap in the implementation, uptake or evaluation of this type of intervention."

As Chowkwaynyun and Reed (2020) argue, "disparity figures without explanatory context can perpetuate harmful myths and misunderstandings that actually undermine the goal of eliminating health inequities." Zimmerman (2019) also recommends that health equity metrics should encompass the "full array of social exclusion in a population" because health disparities are ultimately defined by the researcher. Therefore, it is not enough to report disparities or decreases in disparities as proof of successful antiracist interventions in healthcare. Meaningful consideration should be given to how organizations measure the success of their interventions. There is agreement among antiracism advocates that no two organizations or their communities are identical, so there are no prescriptions for metrics out there. However, there are some broad frameworks that can be used to measure the success of antiracist interventions. In addition to appropriately defining the problem and goals, Choo (2020) says organizations must define target outcomes in order to measure them over time, and further states that "[data] should be both quantitative and qualitative to track progress and capture the lived experiences of healthcare workers and patients. A data-driven approach will allow organizations to be systematic in their path to equity."

Bailit and Kanneganti (2022) offer four types of health equity performance metrics: (1) data infrastructure measures that assess how providers, payers, and states capture information; (2) process and outcome measures stratified by subpopulation that take existing measures and stratify them by disability status, rurality, and other variables; (3) process and outcome measures targeted at specific subpopulations with a denominator defined as the subpopulation of interest; and (4) process and outcome measures targeted at strategies intended to reduce inequities that focus on measuring performance for interventions intended to reduce inequities.

The Office of Minority Health offers two examples for assessing health impact: Health Impact Assessments (HIAs) and Community Health Improvement Plans (CHIPs). HIAs aim to protect and promote health and reduce inequities in health during a decision-making process by encouraging decision makers to consider the needs of underserved populations in policy and program development and implementation. CHIPs are "long-term, systematic efforts to address public health problems based on the results of community health assessment activities and the community health improvement process" (Hoyer et al. 2022).

In addition to collecting outcome and impact data, organizations should also prioritize internal and external accountability measures by collecting data on patient and staff experiences of racism. Griffith et al. (2017) recommend the following accountability measures: data on job satisfaction, perceived racial climate, perceived cultural competence of staff, adequacy of resources for staff, job stressors, client and staff demographics, adequacy of policies and procedures, and organizational needs and challenges.

Appendix 2: Research Interview Protocol

Interview Script
Antiracist Interventions in Healthcare

Approximately 60–90 minutes

Consent Provided:
☐ *Audio*
☐ *Video*

Script: *Thank you for meeting with us today. We are currently working on a project, "Antiracist Interventions in Healthcare," to survey the healthcare landscape to understand the impact of innovative practices and organizational leadership in addressing systemic racism. Our goal is to help inform government, nonprofit, and private organizations so they can operationalize and implement their commitments to antiracism and health equity.*

As mentioned in our email, as a part of our research project we have a consent form from our university for participants and to get your permission to record this interview. Confirming this is OK with you?

Great, I will start the recording now.

Background Information
1. By way of introduction, please tell us a bit about what your role is/was at [Organization]

Script: *Now we're going to talk about the interventions related to antiracism at _____ (name of intervention) _____ .*

History and Context
2. Can you give a sense of the history and what led to the intervention that started in _____ (year) _____ ?
3. What was the vision and goals of the intervention? How were these determined? Who shaped the framework of the intervention?
   a. (Who were the decision makers? Who was responsible for ensuring implementation, compliance, and completion? How long did the visioning, framing process last?)
   b. What was your role in the process?
4. When the intervention was designed, what were the measures of success for the intervention?
5. Can you walk me through what the intervention is and what it aims to do? What are the components of the intervention?
   a. How was it operationalized?
   b. What kind of training or workshops did leadership, and/or staff go through to implement your program? Did the board (if applicable)?

Script: *Great. This has been super helpful in understanding the context and origin story of this program. Thank you so much. Now I'm going to focus a bit more specifically on what change you have seen and what the challenges and impact have been.*

2. Where have you seen the needle move in your work? Where have you seen the most significant impact? How did this intervention change or impact the culture of the organization?
3. In your role specifically, what levers have you seen the intervention impact?
   a. Were there any unintended outcomes?
4. What were the challenges and barriers?
   a. What got in the way of success?
   b. How did the organizers deal with any resistance encountered?
5. How was the intervention received by the leadership, and staff? How was it received by the board (if applicable)?
6. Were there community stakeholders or partners? How was the intervention received by community partners?
   a. How was the community involved in the creation or implementation of the intervention?
7. How has success been communicated to the community or external partners?
8. How did/do you establish accountability for these interventions?
9. How has the work been sustained?

Script: *Thank you, this is so helpful. We've seen enormous shifts in commitments throughout the US following the murder of George Floyd and subsequent protests, and other developments. I'm interested in pivoting now to hear how the intervention has shifted and changed over time.*

Today
10. How has the intervention changed over time? Have the goals changed or components? What caused the changes?
    a. More specifically, how did the events and activism surrounding the murder of George Floyd impact your intervention? What about the impact of COVID-19?
11. How do you measure success today? How has it changed at all since the original design which you told me about earlier?
    a. What specific metrics can you point to internally or externally to indicate whether the program was/is meeting its objectives?
    b. Over what period of time are you measuring these outcomes?
12. Who is pushing the work forward? Who ensures it keeps going?

Takeaways and Learning
1. What were some of the lessons learned by the intervention or staff?
2. Are there lessons or recommendations that were not taken up in your organization?
3. What advice would give another organization working to address systemic racism?

Policy (Optional)
1. Can you point to any reforms or changes in public policy related to systemic racism that occurred because of the intervention?
2. What policy or political barriers did you have to overcome to implement this intervention?

Appendix 3: Coding System and Categories

Code	Full Name	Subcode	Description
Org. Mission	Organizational Mission		Mission of the healthcare organization at-large
Initiative	Racial Equity Initiative		Design and identity of the racial equity intervention
		Initiative.History	History and origin of what led to the initiative, including initial event that sparked the organizational change intervention; what catalyzed the change
		Initiative.Mission	Vision of the racial equity initiative for change
		Initiative.Goals	Racial justice initiative goals; the original goals or desired outcomes for making change from the initiative within and outside the organization
		Initiative.External Impact	External events that changed the course of the initiative (through disruption or otherwise) i.e., George Floyd's murder, COVID-19 pandemic
		Initiative.Leadership Change	Leadership or staffing changes in history of initiative
		Initiative.Timeline	Timeline of initiative and its implementation; how the initiative itself changed over time
Disparities	(Existing) Racial Disparities in Health Sector		Referenced metrics of racialized inequality within the healthcare sector
Consultant	DEI/Racial Justice Consultants		External organizational support brought in to provide operational or content expertise on racial equity to further the goals of the intervention
		Consultant. Programming	The guided practice of racial equity training by paid subject-matter experts
DEI Committee	Working Group/Task Force/DEI Committee		A coalition of members of an organization committed to leading the initiative, and identifying and advancing racial equity, diversity, equity, inclusion

Code	Full Name	Subcode	Description
		DEI Committee.Volunteer	Unpaid work or participation in DEI programming
DEI Officer	DEI Officer or Chief Equity Officer		Reference to DEI officer including their tasks, etc.
		DEI Officer.Established	When the DEI role was formally established or hired; when individual in the role started getting paid; when the role became an official designated position and received a budget, etc.
		DEI Officer.Influence	Influence the role has on the organization, decision making, and power
Senior	Senior Leader Buy-In		Involvement of senior leaders in the initiative and their buy-in for implementation
		Senior.Board	Reference to involvement of the board and other highly influential decision makers (that do not manage the daily operation of the initiative)
Operationalize	Operationalize		Mechanisms to advance change and operationalize desired outcomes of the initiative, including the practices and organizational policies utilized by the racial equity initiative to advance its goals and record its progress in general; how they did the work
		Operationalize.Roadmap	Creation of roadmap for the initiative
		Operationalize.Workshops	Workshop activities meant to further the goals of the initiative including specific content area and dialogue
		Operationalize.OrgDesign	Any changes to the organization to advance the work of the racial equity initiative, including embedding the effort so it is an established part of the organization; organizational design, including new departments; strategic organizational design change mapping; identity of center
		Operationalize.Publications	Publication of tool kits, and reports of initiative—communicating its activities to others internally or externally

Code	Full Name	Subcode	Description
		Operationalize.Affinity	Creation and use of affinity/caucus spaces of groups based on racialized, historical, or cultural experience due to the initiative
		Operationalize. Partnerships	Development or leverage of partnerships with other local nonprofits, local government, etc.
		Operationalize. Recommendations	Recommendations made from the initiative to senior leaders, etc.
		Operationalize.Data	Use of existing data sources to inform action
Community	Community		General reference to community engagement/stakeholdership
		Community.Partnerships	Community and public engagement through coalition building; community partnerships
		Community.Volunteers	Community members involved as volunteers, etc.
Transform	Transformation of Organization		Institutional transformation as a result of the initiative, including impact on other parts of the organization
		Transform.Infrastructure	More strategic placement of racial equity initiative within the organization
		Transform.Staffing	Hiring, promotions, salary and positions (rank and compensation); pay for DEI staff
		Transform.Resolution	Declaration of public health as racism, or related resolution
		Transform.Understanding/ Beliefs	Understanding and knowledge established/ changed for staff at organization on racism/ consciousness
		Transform.PublicPolicy	Influence on local or state policy related to systemic racism/health equity
		Transform.Terminology	Change of language and terminology used in organization—including in documents, meetings, marketing materials, and communications—emails, etc.

Code	Full Name	Subcode	Description
		Transform.OrgCulture	Change in organizational culture (including dominant ways of operating); decision making in meetings and operations changed because of the initiative
		Transform.InternalPolicy	Changes to organizational policies and procedures
		Transform.Patients/Clients	Changes to how staff interact with patients and clients (from the community) receiving health services
		Transform.Metrics	Metrics and/or data collection tools
Impact			
		Impact.Health outcomes/ Disparities	How the initiative reduced disparities/health outcomes in the community population
		Impact.Lessons Learned	Lessons learned; learning that occurred from the initiative
		Impact. CollectiveLimitations	Limitations to success of initiative— understood generally
		Impact. LimitationsIndividual	Limitations to success of initiative— referenced by individual interviewed
		Impact.Success	Participant referred to metrics, measures or benchmarks used to define success of the intervention (for example, decrease in inequality); how success of the initiative was defined
		Impact.Sustainability	Sustainability and impact of the initiative
Challenges			Challenges (or barriers) to the success of the initiative, including initiative not having enough resources, etc.
		Challenges.Resistance	Challenges to the intervention by others, including resistance to the intervention (such as desired outcomes and vision) exhibited at any level of the organization and including leadership not buying in; attempts to shut down intervention, etc.
Views	Views on the initiative		Perspectives of organizational members (at large) on the initiative including BIPOC and white members

Code	Full Name	Subcode	Description
		Interviewee	Individual interview participant's role; reference to individual's key insights and understanding of the initiative
Identity	Other identities and intersectionality		Intersectionality of other oppressed identities as related to the work of the initiative
		Identity.BIPOC	Reference to BIPOC identit(ies)
		Identity.Black	Reference to Black American identity
		identity.Indigenous	Reference to Native and/or Indigenous identity
		Identity.Latinx	Reference to Latinx identity
		Identity.POC	Reference to people of color identit(ies)
		Identity.LGBTQ	Reference to sexuality and LGBTQ identity
		Identity.Gender	Reference to gender (including pronouns)
		Identity.Disability	Reference to disability
		Identity.White	Reference to white identity
Accountability			Accountability mechanism set up as a result of the initiative; new, required practices incorporated by the healthcare organization
Antiracism			Explicit use of the word "antiracism"
		Antiracism.Expertise	Subject-matter experts on racial equity practices
Professional			The social identity associated with the professional position in healthcare (i.e., physician, nurse, researcher, commissioner)
		Professional.Advancement	Reference to modes of promotion and opportunity within the healthcare sector and health profession
		Professional.Reputation	Reference to social value designated as the widespread recognition or belief
Trainings			Training Activities implemented or undertaken including workshops and seminars

Code	Full Name	Subcode	Description
		Training.Emergency	Emergency response practice for disease outbreak
		Training.Youth	Youth-centered practice
		Training.Volunteer	Unpaid participants in specific training
		Trainings.DEI/Racial Justice	Guided practices on topics specific to racial justice and DEI initiatives

Appendix 4: RacialRec Guiding Commitment Agreements

Six guides to form a WORKING RELATIONSHIP with everyone in the RacialRec cohort:[109]

1. You commit that this group will always be safe (no one is yelling/screaming or throwing chairs), but you also commit to feeling the discomfort.
2. You commit to say what you feel and feel what you say. You can't control how it is received.
3. You commit to hearing what comes back as a result of what you have said, as it needs to be.
4. You commit to the fact that your ability to be true and honest is not conditional on the reactions of others. We can't make it all seem nice.
5. You understand that you may hurt other people, but recognize that this happens all the time out in the "real world" and that here it can actually be addressed. Therefore . . .
6. You commit to making the implicit explicit.

Appendix 5: MSHS Guiding Principles in Road Map[110]

The following guiding principles were developed by the Task Force to be used at all levels to guide the Health System's collective action toward our goal:

1. Commitment and Accountability: an unwavering resolve to support the principles embodied by racial and social justice movements that are responsive to those who have been historically marginalized.

2. Safety to Name, Confront, and Engage in Conversations about Racism: a commitment to ensuring a safe environment where all are encouraged to speak up about racism and have the opportunity to engage in dialogue about the various manifestations of racism—interpersonal, cultural, institutional, and structural—in order to transform the policies, systems, and practices that produce equity.

3. Systemic Analysis: a commitment to understanding the ways in which history, systems, policies, practices, and the distribution of power and privilege work together to create and reinforce racial inequities and injustices.

4. Shifting Power Dynamics and Privilege: a commitment to a rebalancing of power, privilege, and resources in order to advance antiracism and equity. This includes leaders leveraging their privilege and power to prioritize and proactively support voices and communities most impacted by inequity, as well as their commitment to call on others to actively participate in antiracist and racial equity efforts. A commitment to humility, self-awareness, and recognizing when it is best to listen, learn, and champion others to lead.

5. Accountability, Transparency, and Communication: a commitment to creating meaningful accountability structures at all levels, transparency with regard to performance, and consistent and omni-directional communication.

6. Sustained Commitment: a commitment to long-term, sustained investment of time, money, resources, and people to see this through over the long term.

Appendix 6: Key Strategic Recommendations for Task Force Road Map[111]

The Task Force identified 11 key strategic recommendations for consideration:

1. Develop an equity scorecard to measure performance in order to identify where we have observed success and where more, or different, efforts are needed.
2. Unify and integrate clinical practices where possible, while advocating for payment and regulatory reforms that would allow for the full integration and unification of clinical practices regardless of insurance status.
3. Enhance community partnerships and accountability.
4. Build connection and community within the MSHS to adopt a racial equity culture.
5. Forge new, and leverage existing, strategic partnerships and networks within the MSHS to accelerate and spread anti-racism and equity efforts.
6. Develop a sustained financial investment in racial equity and anti-racism.
7. Examine and redesign business structures with an anti-racist and equity lens.
8. Increase recruitment efforts, hiring, and retention of Black and other underrepresented minority (URM) staff and faculty, and ensure that they are represented in all levels of leadership, including high-impact leadership roles in the system.
9. Promote equity in mentorship.
10. Enhance leadership learning, capacity, knowledge, engagement, and accountability so that all leaders are able to participate fully in anti-racism and equity efforts.
11. Provide anti-racism education and resources throughout the MSHS in order to foster a learning community at all levels and to help advance an anti-racism and equity culture.

Appendix 7: Board of Health Passes Resolution Declaring Racism a Public Health Crisis—NYC Health[112]

RESOLUTION OF THE NYC BOARD OF HEALTH DECLARING RACISM A PUBLIC HEALTH CRISIS

WHEREAS, the mission of the New York City (NYC) Department of Health and Mental Hygiene (Health Department) is to protect and promote the health of all New Yorkers and its vision is a city where all New Yorkers can realize their full health potential, regardless of who they are, where they are from, or where they live; and

WHEREAS, there is a long history of structural racism impacting services and care across all institutions within our society; and

WHEREAS, Black, Indigenous, and People of Color (BIPOC) New Yorkers have suffered from disproportionately high rates of COVID-19 infection and death, including a disproportionate drop in life expectancy for Black and Latino New Yorkers, and Black and Latino New Yorkers have inequitably low rates of COVID-19 vaccination, and

WHEREAS, the NYC Health Department has extensively documented racial inequities in rates of HIV, tuberculosis, maternal mortality, infant mortality, mental health conditions, chronic disease prevalence and mortality, gun violence and other forms of physical violence, premature mortality, among others that existed prior to the COVID-19 pandemic; and

WHEREAS, our country has a long history of anti-Asian violence including the Page Exclusion Act, the Chinese Exclusion Act, and Japanese internment, which created some of the conditions for current rising anti-Asian discrimination; and

WHEREAS, involvement with law enforcement has grown markedly in the US in recent decades, and studies have shown these interactions are associated with poorer health outcomes, including injuries and fatalities; and

WHEREAS, NYC's investments have reduced the jail population and reformed law enforcement practices in communities; and

WHEREAS, structural racism systematically excludes, marginalizes, and harms BIPOC across NYC through discriminatory housing, employment, education, healthcare, criminal legal, and other systems, all of which result in avoidable and unjust health outcomes (health inequities); and

WHEREAS, NYC aims to address structural racism and longstanding inequities and seeks to build upon existing efforts such as the annual Social Indicators Report and Standard Equity Metrics created by Executive Order No. 45 (dated May 8, 2019), and the establishment of the City's Taskforce on Racial Inclusion and Equity created by Executive Order No. 80 (dated September 13, 2021), to address the disparate impact of COVID-19 in BIPOC communities; and

WHEREAS, the first declaration of racism as a public health crisis was developed in 2018 by a Black woman, Ms. Lilliann Paine, while she was Director At Large of the Wisconsin Public Health Association, and more than 200 similar declarations have been made across the country since, including from the Centers for Disease Control and Prevention; and

WHEREAS, in 2016, the NYC Health Department launched Race to Justice to build the Health Department's capacity to address structural racism and health inequities, and has committed to uprooting

white supremacy and its impact on health and wellbeing while shifting resources and power to the communities that bear the greatest burden of marginalization, racism, and health inequities; and

WHEREAS, the NYC Health Department initially declared racism a public health crisis on June 8, 2020 and now seeks to expand on this declaration through direct actions across the Health Department; and

WHEREAS, Take Care New York is a comprehensive health plan for NYC that lays out the Health Department's priorities to advance anti-racism public health practice, reduce health inequities, and strengthen NYC's collective approach to ensuring that all New Yorkers can realize their full health potential, regardless of who they are, where they are from, or where they live; and

WHEREAS, settler colonialism, indigenous genocide, and enslavement of Africans are part of the history of our nation; and

WHEREAS, the City of New York is situated on Lenape, Rockaway, and Canarsie land; and

WHEREAS, these original injustices have been without comprehensive restitution or redress; and

WHEREAS, race is a social and political construct, based on the social interpretation of how one's identity is perceived, with no biological or genetic basis; and

WHEREAS, racism is a system of structuring opportunity and assigning value based on how one's appearance is perceived, which unfairly advantages some individuals and communities, unfairly disadvantages other individuals and communities, and saps the strength of the whole society; and

WHEREAS, racism is a race-explicit system and anti-racism requires race-explicit strategies; and

WHEREAS, BIPOC-led organizations and communities have been fighting racism for generations and making sacrifices to ensure progress toward a racially just future; and

WHEREAS, intersectionality, which acknowledges the unique impact and experience of oppression when a person or community holds multiple marginalized identities, is a critical strategy to fight the public health crisis of racism, is a central tenet of critical race theory,[21] and is a key framework for data analysis; and

WHEREAS the crisis of racism in this country is longstanding and our nation's response will need to span generations; and

WHEREAS, the work of undoing racism is grounded in love, as well as science and civic duty. This love is not sentimental, rather it is what James Baldwin called "the tough and universal sense of quest and daring and growth."

NOW THEREFORE, BE IT RESOLVED that the NYC Board of Health (BOH):

1. Declares that racism is a public health crisis;
2. Acknowledges the work done to date to address the health impacts of racism in NYC including but not limited to launching Race to Justice and improve reporting of race and ethnicity data during and after COVID-19 and requests that the NYC Health Department expand that work to develop priorities and next steps for a racially just recovery from COVID-19 and other actions—including resource allocation—to address this public health crisis in the short and long-term;
3. Requests that the NYC Health Department research, clarify, and acknowledge examples of its historic role in divesting and underinvesting in critical community-led health programs, and participate in a truth and reconciliation process with communities harmed by these actions when possible;

4. Requests that the NYC Health Department establish a Data for Equity internal working group to ensure the Health Department apply an intersectional, anti-racism equity lens to public health data and provide annual guidance to other NYC Mayoral agencies on best practices to collect and make available to the Health Department relevant data to track and improve health equity;

5. Requests that the NYC Health Department make recommendations on anti-racism, health-related NYC Charter revisions to the Mayoral Racial Justice Commission to strengthen NYC's effort to combat racism;

6. Requests that the NYC Health Department continue collaborations with sister agencies to report on fatalities, injuries, health conditions, by race, gender, and other demographics, to improve data quality and care;

7. Requests that the NYC Health Department. in consultation with relevant community organizations. perform an anti-racism review of the NYC Health Code to identify any existing provisions that support systemic and structural racism and bias and recommend new provisions to dismantle systemic and structural racism and bias;

8. Requests that the NYC Health Department partner with NYC agencies and relevant organizations, consistent with Local Law 174 (dated October 13, 2019) and Executive Order 45 (dated May 8, 2019), to advise on assessments of structural racism within policies, plans and budgets related to all determinants of health (transportation, education, housing, land-use and siting, economic opportunities, civic participation and healthcare delivery contexts) and make recommendations to mitigate harm due to the cumulative impacts of these determinants within a public health context; and

9. Requests that the NYC Health Department report twice per year to the BOH to promote the work associated with this resolution and to ensure NYC Health Department accountability on progress.

Dated: October 18, 2021

Notes

1. Paula A. Braveman, Elaine Arkin, Dwayne Proctor, Tina Kauh, and Nicole Holm, "Systemic and Structural Racism: Definitions, Examples, Health Damages, and Approaches to Dismantling," *Health Affairs* 40, no. 2 (2022).

2. Erika Bernabei, Government Alliance for Racial Equity, "Racial Equity: Getting to Results," 2017, https://www.racialequityalliance.org/wp-content/uploads/2017/09/GARE_GettingtoEquity_July2017_PUBLISH.pdf.

3. Ali Michael, and Ellie Fitts Fulmer, "Becoming an Anti-Racist White Ally: How a White Affinity Group Can Help," *Perspectives on Urban Education* (2009): 56.

4. Mary Bassett interview, by Angel Rodriguez, July 2022.

5. Matthew Gavidia, "IHI Announces National Coalition Aiming for Systemic Change in Health Equity," *American Journal of Managed Care*, December 7, 2022.

6. Matthew Gavidia, "IHI Announces National Coalition Aiming for Systemic Change in Health Equity."

7. Marshall H. Chin, Amanda R. Clarke, Robert S. Nocon, Alicia A. Casey, Anna P. Goddu, Nicole M. Keesecker, and Scott C. Cook, "A Roadmap and Best Practices for Organizations to Reduce Racial and Ethnic Disparities in Health Care," *Journal of General Internal Medicine* 27, no. 8 (2012).

8. Race, Research, and Policy Portal, "About RRAPP," accessed February 2023, https://rrapp.hks.harvard.edu/about/.

9. Paula Braveman, "Abandon 'Race.' Focus on Racism," *Frontiers in Public Health* 9 (2021): 8; Rupinder K. Legha and Jeanne Miranda, "An Anti-Racist Approach to Achieving Mental Health Equity in Clinical Care," *Psychiatric Clinics of North America* 43, no. 3 (September 2020): 451–469, https://doi.org/10.1016/j.psc.2020.05.002.

10. Ruqaiijah Yearby, Brietta Clark, and José F. Figueroa, "Structural Racism in Historical and Modern US Health Care Policy," *Health Affairs* 41, no. 2 (February 2022): 187–194, https://doi.org/10.1377/hlthaff.2021.01466; Derek M. Griffith, Mondi Mason, Michael Yonas, Eugenia Eng, Vanessa Jeffries, Suzanne Plihcik, and Barton Parks, "Dismantling Institutional Racism: Theory and Action," *American Journal of Community Psychology* 39, no. 3 (June 1, 2007): 381–392, https://doi.org/10.1007/s10464-007-9117-0; W. Michael Byrd and Linda A. Clayton, "Race, Medicine, and Health Care in the United States: A Historical Survey," *Journal of the National Medical Association* 93, no. 3 (March 2001): 11S–34S.

11. Nadha Hassen, Aisha Lofters, Sinit Michael, Amita Mall, Andrew D. Pinto, and Julia Rackal, "Implementing Anti-Racism Interventions in Healthcare Settings: A Scoping Review," *International Journal of Environmental Research and Public Health* 18, no. 6 (March, 2021): 2993, https://doi.org/10.3390/ijerph18062993; Camara P. Jones, "Confronting Institutionalized Racism," *Phylon* 50, no. 1/2 (2002): 7, https://doi.org/10.2307/4149999.

12. Rachel C. Shelton, Prajakta Adsul, April Oh, Nathalie Moise, and Derek M. Griffith, "Application of an Antiracism Lens in the Field of Implementation Science (IS): Recommendations for Reframing Implementation Research with a Focus on Justice and Racial Equity," *Implementation Research and Practice* 2 (January 2021), https://doi.org/10.1177/26334895211049482; Derek M. Griffith, Mondi Mason, Michael Yonas, Eugenia Eng, Vanessa Jeffries, Suzanne Plihcik, and Barton Parks, "Dismantling Institutional Racism: Theory and Action."

13. Betsy E. Havens, Michael A. Yonas, Mondi A. Mason, Eugenia Eng, and Vanessa D. Farrar, "Eliminating Inequities in Health Care: Understanding Perceptions and Participation in an Antiracism Initiative," *Health Promotion Practice* 12, no. 6 (November 2011): 848–857, https://doi.org/10.1177/1524839910370423; Maria V. Svetaz, Romina Barral, Michele A. Kelley, Tina Simpson, Vinny Chulani, Marissa Raymond-Flesch, and Tamera Coyne-Beasley, "Inaction Is Not an Option: Using Antiracism Approaches to Address Health Inequities and Racism and Respond to Current Challenges Affecting Youth," *Journal of Adolescent Health* 67, no. 3 (September 2020): 323–325, https://doi.org/10.1016/j.jadohealth.2020.06.017.

14. Betsy E. Havens, Michael A. Yonas, Mondi A. Mason, Eugenia Eng, and Vanessa D. Farrar, "Eliminating Inequities in Health Care: Understanding Perceptions and Participation in an Antiracism Initiative"; Heather Came and Derek Griffith, "Tackling Racism as a 'Wicked' Public Health Problem: Enabling Allies in Anti-Racism Praxis," *Social Science and Medicine* 199 (February 2018): 181–188, https://doi.org/10.1016/j.socscimed.2017.03.028.

15. Committee on Population, Division of Behavioral and Social Sciences and Education, and National Academies of Sciences, Engineering, and Medicine. 2022. "Structural Racism and Rigorous Models of Social Inequity: Proceedings of a Workshop." Edited by Linda Casola. Washington, D.C.: National Academies Press. https://doi.org/10.17226/26690.

16. American Public Health Association, "Achieving Health Equity in the United States," Accessed February 6, 2023, https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database

/2019/01/29/achieving-health-equity; Toolkits for Equity in Scholarly Publishing Project Volunteers. "Using Measurement and Metrics," August 25, 2021, https://doi.org/10.21428/77410d6b.332dc728.

17. Committee on Advancing Antiracism, Diversity, Equity, and Inclusion in STEM Organizations, Board on Behavioral, Cognitive, and Sensory Sciences, Division of Behavioral and Social Sciences and Education, and National Academies of Sciences, Engineering, and Medicine. 2023. "Advancing Antiracism, Diversity, Equity, and Inclusion in STEMM Organizations: Beyond Broadening Participation." Edited by Gilda A. Barabino, Susan T. Fiske, Layne A. Scherer, and Emily A. Vargas. Washington, D.C.: National Academies Press. https://doi.org/10.17226/26803.

18. Martha Hostetter and Sarah Klein, "Confronting Racism in Health Care: Moving from Proclamations to New Practices," The Commonwealth Fund, October 18, 2021, https://doi.org/10.26099/kn6g-aa68; Derek M. Griffith, Mondi Mason, Michael Yonas, Eugenia Eng, Vanessa Jeffries, Suzanne Plihcik, and Barton Parks, "Dismantling Institutional Racism: Theory and Action."

19. Southern Jamaica Plain Health Center, "To Our Patients," accessed November 10, 2022, www.brighamandwomens.org/medicine/general-internal-medicine-and-primary-care/southern-jamaica-plain-health-center/overview.

20. Southern Jamaica Plain Health Center, "To Our Patients."

21. Abigail Ortiz, "RJ Work at SJPHC," received by Angel Rodriguez, July 8, 2022.

22. Abigail Ortiz and Dennie Butler-MacKay, SJPHC interview, by Angel Rodriguez, July 2022.

23. Abigail Ortiz and Dennie Butler-MacKay, SJPHC interview, by Angel Rodriguez, July 2022. NB: RacialRec uses "racial justice" and "liberation" as operational goals and terms, rather than "antiracism."

24. Abigail Ortiz and Dennie Butler-MacKay, SJPHC interview, by Angel Rodriguez, July 2022.

25. Maggie Potapchuk, Sally Leiderman, and Donna Bivens, "Flipping the Script: White Privilege and Community Building," 2005, https://www.mpassociates.us/uploads/3/7/1/0/37103967/flippingthescriptmostupdated.pdf. As Biven notes, "because internalized racism (for BIPOC people) is a systemic oppression, it must be distinguished from human wounds like self-hatred or 'low self-esteem,' to which all people are vulnerable. It is important to understand it as systemic because that makes it clear that it is not a problem simply of individuals. It is structural."

26. Amy Reid, Rebecca Brandes, Dennie Butler-MacKay, Abigail Ortiz, Sara Kramer, Karthik Sivashanker, and Kedar Matem, "Getting Grounded: Building a Foundation for Health Equity and Racial Justice Work in Health Care Teams," NEJM Catalyst 3, no. 1 (2022), https://doi.org/10.1056/CAT.21.0320.

27. Amy Reid, Rebecca Brandes, Dennie Butler-MacKay, Abigail Ortiz, Sara Kramer, Karthik Sivashanker, and Kedar Matem, "Getting Grounded: Building a Foundation for Health Equity and Racial Justice Work in Health Care Teams."

28. Dennie Butler-MacKay, Abigail Ortiz, "Join the Movement: Liberation in the Exam Room for Racial Justice and Equity in Healthcare," 2017, Southern Jamaica Plain Community Health Center.

29. Amy Reid, Rebecca Brandes, Dennie Butler-MacKay, Abigail Ortiz, Sara Kramer, Karthik Sivashanker, and Kedar Matem, "Getting Grounded: Building a Foundation for Health Equity and Racial Justice Work in Health Care Teams."

30. Abigail Ortiz and Dennie Butler-MacKay, SJPHC interview, by Angel Rodriguez, July 2022.

31. Abigail Ortiz, SJPHC interview, by Angel Rodriguez, August 2022.

32. Abigail Ortiz, SJPHC interview, by Angel Rodriguez, August 2022.

33. Meenakshi Verma, SJPHC interview, by Angel Rodriguez. August 2022.

34. Jaime De Zengotita, MD, SJPHC interview, by Angel Rodriguez. August 2022.

35. Lauren A. Eberly, Aaron Richterman, Anne G. Beckett, Bram Wispelwey, Regan H. Marsh, Emily C. Cleveland Manchanda, et al., "Identification of Racial Inequities in Access to Specialized Inpatient Heart Failure Care at an Academic Medical Center," Circulation: Heart Failure 12, no. 11 (2019): e006214, https://doi.org/10.1161/CIRCHEARTFAILURE.119.006214.

36. Boston Review, "An Antiracist Agenda for Medicine," Accessed February 2, 2023, https://www.bostonreview.net/articles/michelle-morsebram-wispelwey-what-we-owe-patients-case-medical-reparations/.

37. David A. Ansell, David A., Brittani James, and Fernando G. De Maiom, "A Call for Antiracist Action," New England Journal of Medicine 387, no. 1 (July 2022), https://doi.org/10.1056/NEJMp2201950.

38. Phillip Martin, "Neo-Nazis Target Anti-Racist Doctors at Brigham and Women's Hospital, Calling Them 'Anti-White,'" WBGH, January 22, 2022, https://www.wgbh.org/news/local-news/2022/02/02/neo-nazis-target-anti-racist-doctors-at-brigham-and-womens-hospital-calling-them-anti-white.

39. Bram Wispelwey, interview, by Angel Rodriguez, July 2022.

40. Angeliki Vgontzas, MD, interview, by Angel Rodriguez, July 2022.

41. "Department of Neurology: Brigham and Women's Faulkner Hospital," accessed February 6, 2023, https://www.brighamandwomensfaulkner.org/programs-and-services/neurology/default.

42. Abigail Ortiz, SJPHC interview, by Angel Rodriguez, August 2022.

43. Mass General Brigham, "Mass General Brigham Expands Mobile Vaccination Efforts Initiative to Increase Access for Vulnerable Communities," May 25, 2021, https://www.massgeneralbrigham.org/en/about/newsroom/press-releases/mass-general-brigham-expands-mobile-vaccination-efforts-initiative-increase.

44. Gary Butts, MD, MSHS interview, by Angel Rodriguez, July 2022.

45. Mount Sinai, "Mount Sinai Receives Landmark Gift from Royalty Pharma to Advance Health Equity, May 16, 2022, https://www.mountsinai.org/about/newsroom/2022/mount-sinai-receives-landmark-gift-from-royalty-pharma-to-advance-health-equity.

46. Mount Sinai Today, "Mount Sinai Rolls Out Its Anti-Racism Program to Other Medical Schools," Updated June 30, 2022, https://health.mountsinai.org/blog/mount-sinai-rolls-out-its-anti-racism-program-to-other-medical-schools/.

47. Leona Hess, Ann-Gel Palermo, and David Muller, "Addressing and Undoing Racism and Bias in the Medical School Learning and Work Environment," *Academic Medicine* 95, no. 12S (December 2020): S44–S50, https://doi.org/10.1097/ACM.0000000000003706: "The authors assert that racism and bias in the learning and work environment of medical school can be mitigated only through a formal change management process that leads to change that is institutionally transformational and individually transformative."

48. Leona Hess and David Muller, MSHS interview, by Angel Rodriguez, July 2022.

49. Mount Sinai, "Addressing Racism: A Road Map for Action. Mount Sinai, 2021," Accessed on November 8, 2022, https://www.mountsinai.org/about/addressing-racism.

50. Gary Butts, MD, MSHS interview, by Angel Rodriguez, July 2022.

51. Gary Butts, MD, MSHS interview, by Angel Rodriguez, July 2022.

52. Gary Butts, MD, MSHS interview, by Angel Rodriguez, July 2022.

53. Sarah Stachowiak and Lauren Gase, "Does Collective Impact Really Make an Impact?" Stanford Social Innovation Review, August 9, 2018, https://ssir.org/articles/entry/does_collective_impact_really_make_an_impact.

54. Mount Sinai, "General Timeline," accessed January 6, 2023, https://www.mountsinai.org/about/addressing-racism/road-map/general-timeline.

55. Mount Sinai, "Collective Impact Approach and Process," accessed January 6, 2023, https://www.mountsinai.org/about/addressing-racism/road-map/impact-approach-process.

56. Leona Hess and David Muller, MSHS interview, by Angel Rodriguez, July 2022.

57. See the appendix for a handout of the MSHS Road Map summary and recommended strategic goals.

58. Mount Sinai Daily, "Tracking Our Work: Equity Dashboards," August 4, 2022, https://onfirstup.com/mountsinai/mountsinai/articles/tracking-our-work-equity-dashboards-1.

59. Gary Butts, MD, MSHS interview, by Angel Rodriguez, July 2022.

60. Leona Hess and David Muller, MSHS interview, by Angel Rodriguez, July 2022.

61. Gary Butts, MD, MSHS interview, by Angel Rodriguez, July 2022.

62. "About Us—PISAB," accessed January 3, 2023, https://pisab.org/about-us/.

63. Steve Itzkowitz, MD, MSHS interview, by Angel Rodriguez, July 2022.

64. Leona Hess and David Muller, MSHS interview, by Angel Rodriguez, July 2022: "We're going to fall short, we're going to find out halfway through the year that the change target we chose for a particular area is completely flat, and we're going to course correct, and retool that change target, and give ourselves grace."

65. Icahn Medical School Guiding Coalition, "Leading toward Transformational Change: 2022 Year in Review" Racism and Bias Initiative. https://changenow.icahn.mssm.edu/change-targets/.

66. Ibid, p. 22.

67. Ibid, p. 22.

68. Ibid, p. 38.

69. Ibid, p. 38.

70. Leona Hess and David Muller, MSHS interview, by Angel Rodriguez, July 2022.

71. Gary Butts, MD, MSHS interview, by Angel Rodriguez, July 2022.

72. Mary T. Bassett, "BlackLivesMatter—A Challenge to the Medical and Public Health Communities," *The New England Journal of Medicine*, March 19, 2015.

73. Jan Sundin, "Public Health Is Politics," *Interchange* 50, no. 2 (May 1, 2019): 129–136, https://doi.org/10.1007/s10780-019-09367-z.

74. Charles E. Rosenberg, *The Cholera Years: The United States in 1832, 1849, and 1866* (Chicago: University of Chicago Press, 1987).

75. Department of Health and Mental Hygiene, "Race to Justice Action Kit," p. 6, https://www.nyc.gov/assets/doh/downloads/pdf/dpho/race-to-justice-action-kit-faq.pdf.

76. "Race to Justice Action Kit."

77. Lauren J. Shiman, Kim Freeman, Jane Bedell, and Mary T. Bassett, "Making Injustice Visible: How a Health Department Can Demonstrate the Connection Between Structural Racism and the Health of Whole Neighborhoods," *Journal of Public Health Management and Practice* 27, no. 5 (October 2021): 442–448, https://doi.org/10.1097/PHH.0000000000001259.

78. Karen Zraick, "Racism Is Declared a Public Health Crisis in New York City." *The New York Times*, October 19, 2021, https://www.nytimes.com/2021/10/19/nyregion/nyc-racism-healthcare-system.html.

79. NYC Health, "Board of Health Passes Resolution Declaring Racism a Public Health Crisis—NYC Health." Accessed October 18, 2021. https://www.nyc.gov/site/doh/about/press/pr2021/board-of-health-declares-racism-public-health-crisis.page.

80. NYC Health, "Board of Health Passes Resolution Declaring Racism a Public Health Crisis," October 18, 2021, p. 2 (see Appendix 8 for full resolution), https://www.nyc.gov/site/doh/about/press/pr2021/board-of-health-declares-racism-public-health-crisis.page.

81. Former staff member, DOHMH interview, by Angel Rodriguez, July 2022.

82. Torian Easterling, DOHMH interview, by Angel Rodriguez, July 2022.

83. Torian Easterling, DOHMH interview, by Angel Rodriguez, July 2022.

84. John Yates, DOHMH interview, by Angel Rodriguez, July 2022.

85. John Yates, DOHMH interview, by Angel Rodriguez, July 2022.

86. Former staff member, DOHMH interview, by Angel Rodriguez, July 2022.

87. Former staff member, DOHMH interview, by Angel Rodriguez, July 2022.

88. Gary Butts, MD, MSHS interview, by Angel Rodriguez, July 2022.

89. Mary Bassett, DOHMH interview, by Angel Rodriguez, August 2022.

90. Mary Bassett, DOHMH interview, by Angel Rodriguez, August 2022.

91. Mary Bassett, DOHMH interview, by Angel Rodriguez, August 2022.

92. Abigail Ortiz, SJPHC interview, by Angel Rodriguez, August 2022.

93. Abigail Ortiz, SJPHC interview, by Angel Rodriguez, August 2022.

94. Torian Easterling, DOHMH interview, by Angel Rodriguez and Erica Licht, August 2022.

95. Mount Sinai, "Addressing Racism: A Road Map for Action," accessed January 2, 2023, https://www.mountsinai.org/about/addressing-racism/road-map.

96. Former staff member, DOHMH interview, by Angel Rodriguez, July 2022.

97. Abigail Ortiz, SJPHC interview, by Angel Rodriguez, August 2022.

98. Mount Sinai, "Addressing Racism: A Road Map for Action."

99. Derek M. Griffith, Mondi Mason, Michael Yonas, Eugenia Eng, Vanessa Jeffries, Suzanne Plihcik, and Barton Parks, "Dismantling Institutional Racism: Theory and Action."

100. Former staff member, DOHMH interview, by Angel Rodriguez, July 2022.

101. Former staff member, DOHMH interview, by Angel Rodriguez, July 2022.

102. Gary Butts, MSHS interview, by Angel Rodriguez, July 2022.

103. Gary Butts, MSHS interview, by Angel Rodriguez, July 2022: "We have been at the business of DEI, addressing DEI, for 20 years already . . . that's why I was called upon and given the opportunity to lead in a more specific way with the task force to allow us to think about what it will take to develop that backbone."

104. Gary Butts, MSHS interview, by Angel Rodriguez, July 2022.

105. Committee on Advancing Antiracism, Diversity, Equity, and Inclusion in STEM Organizations, Board on Behavioral, Cognitive, and Sensory Sciences, Division of Behavioral and Social Sciences and Education, and National Academies of Sciences, Engineering, and Medicine. 2023. "Advancing Antiracism, Diversity, Equity, and Inclusion in STEMM Organizations: Beyond Broadening Participation." Edited by Gilda A. Barabino, Susan T. Fiske, Layne A. Scherer, and Emily A. Vargas. Washington, D.C.: National Academies Press. https://doi.org/10.17226/26803.

106. Erika Bernabei, Government Alliance for Racial Equity, "Racial Equity: Getting to Results," 2017, https://www.racialequityalliance.org/wp-content/uploads/2017/09/GARE_GettingtoEquity_July2017_PUBLISH.pdf; Maggie Potapchuk, MP Associates, n.d., "Operationalizing Racial Justice," 2017; Equity in the Center, "Awake to Woke," 2020, https://equityinthecenter.org/wp-content/uploads/2020/09/eic_aww-pub_wip_final.pdf; Interaction Institute for Social Change, "Mapping the Territory: Exploring Dimensions of Organizational Life," 2023, https://interactioninstitute.org/; Joe Bardnt and Crossroads Ministry, "Continuum on Becoming an Anti-Racist Multi-Cultural Institution," 2013.

107. Erika Bernabei, "Racial Equity: Getting to Results."

108. Ali Michael, and Ellie Fitts Fulmer, "Becoming an Anti-Racist White Ally: How a White Affinity Group Can Help," *Perspectives on Urban Education* (2009): 56.

109. Butler-Mackay, Dennie, "RacialRec Commitment Agreements." December 19 2022, PowerPoint Presentation.

110. Butts, G. et al., "Guiding Principles of the Task Force to Address Racism," Task Force Recommendations, Accessed on February 28, 2023, https://www.mountsinai.org/about/addressing-racism/road-map/recommendations?accordionAction=accordion-jump_link-67961266.

111. Butts, G. et al., "Strategic Recommendation of the Task Force to Address Racism," Task Force Recommendations, Accessed on February 28, 2023, https://www.mountsinai.org/about/addressing-racism/road-map/recommendations?accordionAction=accordion-jump_link-67961266.

112. NYC Health, "Board of Health Passes Resolution Declaring Racism a Public Health Crisis - NYC Health." Accessed October 18, 2021. https://www.nyc.gov/site/doh/about/press/pr2021/board-of-health-declares-racism-public-health-crisis.page.

Bibliography

Agency for Healthcare Research and Quality. *National Healthcare Quality and Disparities Report.* Rockville, MD: Agency for Healthcare Research and Quality, 2021.

Alsan, Marcella, and Marianne Wanamaker. "Tuskegee and the Health of Black Men." *The Quarterly Journal of Economics* 133, no. 1 (2018): 407–455. https://doi.org/10.1093/qje/qjx029.

Alsan, Marcella, Owen Garrick, and Grant Graziani. "Does Diversity Matter for Health? Experimental Evidence from Oakland." Working Paper. NBER, August 2019. https://www.nber.org/papers/w24787.

American Heart Association News. "Access to Cardiac Units May Explain Racial Gap for Heart Failure Patients." American Heart Association News, October 29, 2019. https://www.heart.org/en/news/2019/10/29/access-to-cardiac-units-may-explain-racial-gap-for-heart-failure-patients.

American Medical Association. "Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions H-65.951." American Medical Association. Updated June 8, 2021. https://policysearch.ama-assn.org/policyfinder/detail/racism?uri=%2FAMADoc%2F-HOD.xml-H-65.951.xml.

American Hospital Association. "Statement on Racism as a Public Health Issue." American Hospital Association, July 14, 2021. https://www.aha.org/2021-07-14-statement-racism-public-health-issue.

American Medical Association, and AAMC Center for Health Justice. "Advancing Health Equity: A Guide to Language, Narrative and Concepts." Accessed December 2022. https://www.ama-assn.org/about/ama-center-health-equity/advancing-health-equity-guide-language-narrative-and-concepts-0.

American Medical Association. "The AMA's Strategic Plan to Embed Racial Justice and Advance Health Equity." Accessed October 12, 2022. https://www.ama-assn.org/about/leadership/ama-s-strategic-plan-embed-racial-justice-and-advance-health-equity.

American Public Health Association. "Analysis: Declarations of Racism as a Public Health Crisis." Accessed October 2022. https://www.apha.org/-/media/Files/PDF/topics/racism/Racism_Declarations_Analysis.ashx.

——. "Racial Equity and Public Health Fact Sheet." Accessed December 2022. https://www.apha.org/-/media/Files/PDF/advocacy/SPEAK/210825_Racial_Equity_Fact_Sheet.ashx.

American Psychological Association. "APA's Commitment to Addressing Systemic Racism." Accessed October 12, 2022. https://www.apa.org/about/apa/addressing-racism.

Ansell, David A. *The Death Gap: How Inequality Kills.* Chicago: University of Chicago, 2017.

Bailey, Zinzi D. "Structural Racism and Health Inequities in the USA: Evidence and Interventions." *The Lancet* 389 (2017): 1453–1463.

Bailey, Zinzi D., Justin M Feldman, and Mary T. Bassett. "How Structural Racism Works—Racist Policies as a Root Cause of U.S. Racial Health Inequities." *The New England Journal of Medicine* 6 (2021).

Bailit, Michael, and Deepti Kanneganti. "A Typology For Health Equity Measures." Health Affairs Forefront, March 21, 2022. https://www.healthaffairs.org/do/10.1377/forefront.20220318.155498/.

Bassett, Mary T. "Tackling Structural Racism." *Journal of Public Health Management and Practice* 28 (2022): S1–S2.

Betancourt, Joseph R. "Eliminating Racial and Ethnic Disparities in Health Care: What Is the Role of Academic Medicine?" *Academic Medicine* 81, no. 9 (2006): 788–792.

Bhopal, Raj. "Spectre of Racism in Health and Health Care: Lessons from History and the United States." *BMJ* (1998). https://doi.org/10.1136/bmj.316.7149.1970.

Bleich, Sara N., Laurie Zephyrin, and Robert J. Blendon. "Addressing Racial Discrimination in US Health Care Today." *JAMA Health Forum* 2, no. 3 (2021): e210192. https://doi.org/10.1001/jamahealthforum.2021.0192.

Boyd, Rhea W., Edwin G. Lindo, Lachelle D. Weeks, and Monica R. McLemore. "On Racism: A New Standard for Publishing on Racial Health Inequities." Health Affairs Forefront, July 2, 2020. https://www.healthaffairs.org/do/10.1377/hblog20200630.939347/full/.

Braun, Lundy. *Breathing Race into the Machine: The Surprising Career of the Spirometer from Plantation to Genetics.* 1st edition. Minneapolis: University Of Minnesota Press, 2014.

Braveman, Paula. "Monitoring Equity in Health and Healthcare: A Conceptual Framework." *Journal of Health, Population and Nutrition* 21, no. 3 (2003): 181–192.

——. "Abandon 'Race.'" Focus on Racism." *Frontiers in Public Health* 9 (2021): 8.

Braveman, Paula, Elaine Arkin, Tracey Orleans, Dwayne Proctor, and Alonzo Plough. *What Is Health Equity? And What Difference Does a Definition Make?* Princeton, NJ: Robert Wood Johnson Foundation, 2017.

Braveman, Paula, and Laura Gottlieb. "The Social Determinants of Health: It's Time to Consider the Causes of the Causes." *Public Health Reports* 129 (2014): 19–31. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3863696/.

Brown, Cortlyn, Kimberly Brown, Italo Brown, and Rosny Daniel. "Dear White People in Emergency Medicine." *Annals of Emergency Medicine* 78, no. 5 (2021): 587–592. https://doi.org/10.1016/j.annemergmed.2021.08.004.

Browne, Annette J., Colleen Varcoe, Josée Lavoie, Victoria Smye, Sabrina T. Wong, Murry Krause, David Tu, Olive Godwin, Koushambhi Khan, and Alycia Fridkin. "Enhancing Health Care Equity with Indigenous Populations: Evidence-Based Strategies from an Ethnographic Study." *BMC Health Services Research* 16, no. 1 (2016): 544. https://doi.org/10.1186/s12913-016-1707-9.

Byrd, W. Michael, and Linda A. Clayton. *An American Health Dilemma: A Medical History of African Americans and the Problem of Race: Beginnings to 1900.* 1st edition. Oxfordshire, England: Routledge, 2012.

Caldwell, Leon D., and Katrina L. Bledsoe. "Can Social Justice Live in a House of Structural Racism? A Question for the Field of Evaluation." *American Journal of Evaluation* 40, no. 1 (2019): 6–18. https://doi.org/10.1177/1098214018815772.

Centers for Disease Control and Prevention. "Health Disparities." Accessed October 12, 2022. https://www.cdc.gov/healthyyouth/disparities/index.htm.

——. *CDC Health Disparities and Inequalities Report–United States, 2011.* Washington, DC: Centers for Disease Control and Prevention, 2011. https://www.cdc.gov/mmwr/pdf/other/su6001.pdf.

Chandra, Amitabh. "Who You Are and Where You Live: Race and the Geography of Healthcare." *Medical Care* 47, no. 2 (2009): 135–137. https://doi.org/10.1097/MLR.0b013e31819a4c5e.

Chandra, Amitabh, Jonathan Gruber, and Robin McKnight. "The Impact of Patient Cost-Sharing on Low-Income Populations: Evidence from Massachusetts." *Journal of Health Economics* 33 (2014): 57–66. https://doi.org/10.1016/j.jhealeco.2013.10.008.

Chandra, Amitabh, Michael Frakes, and Anup Malani. "Challenges to Reducing Discrimination and Health Inequity through Existing Civil Rights Laws." *Health Affairs* 36, no. 6 (2017): 1041–1047. https://doi.org/10.1377/hlthaff.2016.1091.

Chew, Mabel, Pamela Das, Mandip Aujla, and Richard Horton. "Advancing Racial and Ethnic Equity in Science, Medicine, and Health: A Call for Papers." *The Lancet* 398 (2021): 1287–1289. https://doi.org/10.1016/S0140-6736(21)02095-X.

Chin, Marshall H., Amanda R. Clarke, Robert S. Nocon, Alicia A. Casey, Anna P. Goddu, Nicole M. Keesecker, and Scott C. Cook. "A Roadmap and Best Practices for Organizations to Reduce Racial and Ethnic Disparities in Health Care." *Journal of General Internal Medicine* 27, no. 8 (2012): 992–1000.

Chomilo, Nathan T. "Building Racial Equity into the Walls of Health Policy." Health Affairs Forefront, December 1, 2020. https://www.healthaffairs.org/do/10.1377/hblog20201119.508776/full/.

Choo, Esther. "Seven Things Organisations Should Be Doing to Combat Racism." *The Lancet* 396, no. 10245 (2020): 157. https://doi.org/10.1016/S0140-6736(20)31565-8.

Chowkwanyun, Merlin, and Adolph L. Reed. "Racial Health Disparities and Covid-19—Caution and Context." *New England Journal of Medicine* 383, no. 3 (2020): 201–203. https://doi.org/10.1056/NEJMp2012910.

Corneau, Simon, and Vicky Stergiopoulos. "More Than Being against It: Anti-Racism and Anti-Oppression in Mental Health Services." *Transcultural Psychiatry* 49, no. 2 (2012): 261–282. https://doi.org/10.1177/1363461512441594.

DuBois, W. E. B. *The Philadelphia Negro: A Social Study.* Philadelphia: University of Pennsylvania Press, 1899.

De Souza, Ryan, and Lakshmi Iyer. "Health Care and the Competitive Advantage of Racial Equity." PolicyLink and FSG, April 2019.

Duerme, Ryan, Alan Dorsinville, Natasha McIntosh-Beckles, and Stacey Wright-Woolcock. "Rationale for the Design and Implementation of Interventions Addressing Institutional Racism at a Local Public Health Department." *Ethnicity and Disease* 31 (2021): 365–374. https://doi.org/10.18865/ed.31.S1.365.

Eberly, Lauren A., Aaron Richterman, Anne G. Beckett, Bram Wispelwey, Regan H. Marsh, Emily C. Cleveland Manchanda, Cindy Y. Chang, et al. "Identification of Racial Inequities in Access to Specialized Inpatient Heart Failure Care at an Academic Medical Center." *Circulation: Heart Failure* 12, no. 11 (2019): e006214. https://doi.org/10.1161/CIRCHEARTFAILURE.119.006214.

Estrella, Rachel, Traci Endo Inouye, and Heather Lewis-Charp. "Centering Race in Health Equity Advocacy: Lessons Learned." The Colorado Trust, January 2019.

Evans, Michele. "Health Equity—Are We Finally on the Edge of a New Frontier?" *New England Journal of Medicine* 383 (2020): 997–999. https://www.nejm.org/doi/full/10.1056/NEJMp2005944.

Goldberg, Michelle. "The Absurd Side of the Social Justice Industry." *The New York Times*, November 16, 2021. https://www.nytimes.com/2021/11/15/opinion/diversity-equity-inclusion.html.

Government Alliance on Race and Equity. "Our Approach." Accessed October 13, 2022. https://www.racialequityalliance.org/about/our-approach/.

Gravlee, Clarence C. "Systemic Racism, Chronic Health Inequities, and COVID -19: A Syndemic in the Making?" *American Journal of Human Biology* 32, no. 5 (2020). https://doi.org/10.1002/ajhb.23482.

Griffith, Derek M., Mondi Mason, Michael Yonas, Eugenia Eng, Vanessa Jeffries, Suzanne Plihcik, and Barton Parks. "Dismantling Institutional Racism: Theory and Action." *American Journal of Community Psychology* 39, no. 3 (2007): 381–392. https://doi.org/10.1007/s10464-007-9117-0.

Ham, Chris. "Retracing the Oregon Trail: The Experience of Rationing and the Oregon Health Plan." *BMJ* 316, no. 7149 (1998): 1965–1969. https://doi.org/10.1136/bmj.316.7149.1965.

Hammonds, Evelynn M., and Susan M. Reverby. "Toward a Historically Informed Analysis of Racial Health Disparities Since 1619." *American Journal of Public Health* 109, no. 10 (2019): 1348–1349. https://doi.org/10.2105/AJPH.2019.305262.

Hardeman, Rachel R., Eduardo M. Medina, and Katy B. Kozhimannil. "Structural Racism and Supporting Black Lives—The Role of Health Professionals." *New England Journal of Medicine* 375, no. 22 (2016): 2113–2115. https://doi.org/10.1056/NEJMp1609535.

Hardeman, Rachel R., Patricia A Horman, Tongtan Chantarat, Bridgette Davis, and Tyson Brown. "Improving the Measurement Of Structural Racism to Achieve Antiracist Health Policy." *Health Affairs* no. 41, no. 2 (2022). http://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01489.

Harshbarger, Andre M. Perry, Jonathan Rothwell, and David. "The Devaluation of Assets in Black Neighborhoods." Brookings, November 27, 2018. https://www.brookings.edu/research/devaluation-of-assets-in-black-neighborhoods/.

Hassen, Nadha, Aisha Lofters, Sinit Michael, Amita Mall, Andrew D. Pinto, and Julia Rackal. "Implementing Anti-Racism Interventions in Healthcare Settings: A Scoping Review." *International Journal of Environmental Research and Public Health* 18, no. 6 (2021): 2993. https://doi.org/10.3390/ijerph18062993.

Hoffman, Kelly M., Sophie Trawalter, Jordan R. Axt, and M. Norman Oliver. "Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs about Biological Differences between Blacks and Whites." *Proceedings of the National Academy of Sciences* 113, 16 (2016): 4296–4301. https://doi.org/10.1073/pnas.1516047113.

Hogarth, Rana. *Medicalizing Blackness: Making Racial Difference in the Atlantic World, 1780–1840.* Chapel Hill: University of North Carolina Press, 2017.

Hoyer, Deborah, Elizabeth Dee, Meghan S. O'Leary, Megan Heffernan, Katherine Gelfand, Rachel Kappel, and Catharine Q. Fromknecht. "How Do We Define and Measure Health Equity? The State of Current Practice and Tools to Advance Health Equity." *Journal of Public Health Management and Practice* 28, no. 5 (2022): 570–577. https://doi.org/10.1097/PHH.0000000000001603.

Hunter New England Health Aboriginal and Torres Strait Islander Strategic Leadership Committee. "Closing the Gap in a Regional Health Service in NSW: A Multi-Strategic Approach to Addressing Individual and Institutional Racism." *New South Wales Public Health Bulletin* 23, no. 3–4 (2012): 63–67. https://doi.org/10.1071/NB12069.

Institute of Medicine. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* Edited by Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson. Washington, DC: The National Academies Press, 2003. https://doi.org/10.17226/10260.

———. *How Far Have We Come in Reducing Health Disparities?: Progress Since 2000.* Washington, DC: National Academies Press, 2012. https://pubmed.ncbi.nlm.nih.gov/23193624/.

Interlandi, Jeneen. "Why Doesn't the United States Have Universal Health Care? The Answer Has Everything to Do with Race." *The New York Times Magazine*, August 14, 2019. https://www.nytimes.com/interactive/2019/08/14/magazine/universal-health-care-racism.html.

Jackson, Bailey, Rita Hardiman, Andrea Avazian, Ronice Branding, and Melia LaCour. "Continuum on Becoming an Anti-Racist Multicultural Organization," n.d. 2006. Accessd December 2022. https://philanos.org/resources/Documents/Conference%202020/Pre-Read%20PDFs/Continuum_AntiRacist.pdf.

James, Sherman. "Confronting the Moral Economy of US Racial/Ethnic Health Disparities." *American Journal of Public Health* 93, no. 2 (2003): 189.

Johnson, Shawn, Ayotomiwa Oyo, and Haider J. Warraich. "Academic Health Centers' Antiracism Strategies Must Extend to Their Business Practices." Annals of Internal Medicine, February 2021. https://www.acpjournals.org/doi/10.7326/M20-6203.

Jones, Camara P. "Levels of Racism: A Theoretic Framework and a Gardener's Tale." *American Journal of Public Health* 90, no. 8 (2000): 1212–1215. https://doi.org/10.2105/AJPH.90.8.1212.

———. "Confronting Institutionalized Racism." *Phylon (1960–)* 50, no. 1/2 (2002): 7. https://doi.org/10.2307/4149999.

———. "Addressing Violence against Children through Anti-Racism Action." *Pediatric Clinics of North America* 68, no. 2 (2021): 449–453. https://doi.org/10.1016/j.pcl.2021.01.002.

———. "Invited Commentary: 'Race,' Racism, and the Practice of Epidemiology." *American Journal of Epidemiology* 154, no. 4 (2021): 299–304. https://doi.org/10.1093/aje/154.4.299.

Kader, Farah, Lan N. Doan, Matthew Lee, Matthew Chin, Simona C. Kwon, and Stella S. Yi. "Disaggregating Race/Ethnicity Data Categories: Criticisms, Dangers, and Opposing Viewpoints." Health Affairs Forefront, March 25, 2022. https://doi.org/10.1377/forefront.20220323.555023.

Kakani, Pragya, Amitabh Chandra, Sendhil Mullainathan, and Ziad Obermeyer. "Allocation of COVID-19 Relief Funding to Disproportionately Black Counties." *JAMA* 324, no. 10 (2020): 1,000–1,003. https://doi.org/10.1001/jama.2020.14978.

Kennedy, Randall. "Overcoming Racism as a Black Medical Student Then a Working Physician." *Washington Post*, September 18, 2015. https://www-washingtonpost-com.ezp-prod1.hul.harvard.edu/opinions/overcoming-racism-as-a-black-medical-student-then-a-working-physician/2015/09/17/7161405a-50bf-11e5-933e-7d06c647a395_story.html.

Legha, Rupinder Kaur, and Jeanne Miranda. "An Anti-Racist Approach to Achieving Mental Health Equity in Clinical Care." *Psychiatric Clinics of North America* 43, no. 3 (2020): 451–469. https://doi.org/10.1016/j.psc.2020.05.002.

Legha, Rupinder, David Williams, Lonnie Snowden, and Jeannie Miranda. "Getting Our Knees Off Black People's Necks: An Anti-Racist Approach to Medical Care." Health Affairs Forefront, November 4, 2020. https://www.healthaffairs.org/do/10.1377/forefront.20201029.167296/full/.

Liburd, Leandris C., Jeffrey E. Hall, Jonetta J. Mpofu, Sheree Marshall Williams, Karen Bouye, and Ana Penman-Aguilar. "Addressing Health Equity in Public Health Practice: Frameworks, Promising Strategies, and Measurement Considerations." Annual Review of Public Health 41 (2020): 417–432.

López, Lenny, and Ashish K. Jha. "Outcomes for Whites and Blacks at Hospitals That Disproportionately Care for Black Medicare Beneficiaries." *Health Services Research* 48, no. 1 (2013): 114–128. https://doi.org/10.1111/j.1475-6773.2012.01445.x.

Lui, Meizhu, Barbara Robles, Betsy Leondar-Wright, Rose Brewer, and Rebecca Adamson. *The Color of Wealth: The Story Behind the US Racial Wealth Divide.* Illustrated edition. New York: The New Press, 2006.

Mass General Brigham. "United against Racism." Accessed October 12, 2022. https://www.massgeneralbrigham.org/en/about/diversity-equity-and-inclusion/united-against-racism.

Matthew, Dayna B. *Just Medicine: A Cure for Racial Inequality in American Health Care.* Reprint edition. New York: New York University Press, 2015.

McFarling, Usha L. "Healt Equity Tourists: How White Scholars Are Colonizing Research on Health Disparities." STAT News. September 23, 2021. https://www.statnews.com/2021/09/23/health-equity-tourists-white-scholars-colonizing-health-disparities-research/.

Michener, Jamila. "A Racial Equity Framework for Assessing Health Policy." The Commonwealth Fund. January 20, 2022. https://www.commonwealthfund.org/publications/issue-briefs/2022/jan/racial-equity-framework-assessing-health-policy.

Miller, Andrew C., Ziad Obermeyer, and Sendhil Mullainathan. "A Comparison of Patient History- and EKG-Based Cardiac Risk Scores." *AMIA Summits on Translational Science Proceedings* 2019 (2019): 82–91. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6568098/.

Morse, Michelle, and Joseph Loscalzo. "Creating Real Change at Academic Medical Centers—How Social Movements Can Be Timely Catalysts." *New England Journal of Medicine* 383, no. 3 (2020): 199–201. https://doi.org/10.1056/NEJMp2002502.

Mount Sinai. "A Road Map for Action." Mount Sinai Health System, July 2021. https://www.mountsinai.org/about/addressing-racism/road-map.

Nelson, Alondra. *Body and Soul: The Black Panther Party and the Fight Against Medical Discrimination.* Minneapolis: University of Minnesota Press, 2013.

Nguyen, Bich-May, Jessica Guh, and Brandi Freeman. "Black Lives Matter: Moving from Passion to Action in Academic Medical Institutions." *Journal of the National Medical Association* 114, no. 2 (2022): 193–198. https://doi.org/10.1016/j.jnma.2021.12.009.

Obermeyer, Ziad, Brian Powers, and Christine Vogeli. "Dissecting Racial Bias in an Algorithm Used to Manage the Health of Populations." *Science*, October 25, 2019. https://www.science.org/doi/abs/10.1126/science.aax2342.

Office of Minority Health and Equity. "Impact of Racism on Our Nation's Health." Accessed October 13, 2022. https://www.cdc.gov/minorityhealth/racism-disparities/impact-of-racism.html.

Paradies, Yin. "A Systematic Review of Empirical Research on Self-Reported Racism and Health." *International Journal of Epidemiology* 35, no. 4 (2006): 888–901. https://doi.org/10.1093/ije/dyl056.

Paradies, Yin, Jehonathan Ben, Nida Denson, Amanuel Elias, Naomi Priest, Alex Pieterse, Arpana Gupta, Margaret Kelaher, and Gilbert Gee. "Racism as a Determinant of Health: A Systematic Review and Meta-Analysis." *PLOS ONE* 10, no. 9 (2015): e0138511. https://doi.org/10.1371/journal.pone.0138511.

Pelton, M. Lee. "How a Community Health Center Became a Racial Justice Organization." The Boston Foundation, 2018. https://www.tbf.org/news-and-insights/newsletters/2018/june/community-health-center.

Piana, Ronald. "The Doctor Who Championed Patient Navigation in Harlem: A Conversation with Harold P. Freeman, MD." The ASCO Post, February 15, 2013. https://ascopost.com/issues/february-15-2013/the-doctor-who-championed-patient-navigation-in-harlem/.

Pierson, Emma, David M. Cutler, Jure Leskovec, Sendhil Mullainathan, and Ziad Obermeyer. "An Algorithmic Approach to Reducing Unexplained Pain Disparities in Underserved Populations." *Nature Medicine* 27 (2021): 136–140. https://www.nature.com/articles/s41591-020-01192-7.

Rabin, Roni Caryn. "Why Racial Inequities Still Persist in Health Care." *The New York Times*, August 17, 2021. https://www.nytimes.com/2021/08/17/health/racial-disparities-health-care.html.

Ray, Kristin N., Amalavoyal V. Chari, John Engberg, Marnie Bertolet, and Ateev Mehrotra. "Disparities in Time Spent Seeking Medical Care in the United States." *JAMA Internal Medicine* 175, no. 12 (2015): 1983. https://doi.org/10.1001/jamainternmed.2015.4468.

Reid, Amy, Rebecca Brandes, Dennie Butler-MacKay, Abigail Ortiz, Sara Kramer, Karthik Sivashanker, and Kedar Mate. "Getting Grounded: Building a Foundation for Health Equity and Racial Justice Work in Health Care Teams." *NEJM Catalyst* 3, no. 1 (2022). https://doi.org/10.1056/CAT.21.0320.

Roberts, Dorothy. *Killing the Black Body.* New York: Penguin Random House, 2014.

Rodríguez, José E., Kendall M. Campbell, and Judy C. Washington. "Dismantling Anti-Black Racism in Medicine." *American Family Physician* 104, no. 6 (2021): 555–556.

Rothstein, Richard. *The Color of Law: A Forgotten History of How Our Government Segregated America.* Illustrated edition. New York: Liveright, 2017.

Saini, Vikas. "Where Are the 'Hot Spots' of Hospital Overuse in the US?" Lown Institute. Accessed November 12, 2021. https://lownhospitalsindex.org/publication/where-are-the-hot-spots-of-hospital-overuse-in-the-us/.

Sarker, Sonia. "Control in Healthcare: History and Reclamation of Bodily Autonomy." Nonprofit Quarterly, July 18, 2022. https://nonprofitquarterly.org/control-in-healthcare-history-and-reclamation-of-bodily-autonomy/.

Sexton, Sumi M., Caroline R. Richardson, Sarina B. Schrager Marjorie A. Bowman, John Hickner, Christopher P. Morley, Timothy F. Mott, Nicholas Pimlott, John W. Saultz, and Barry D. Weiss. "Systemic Racism and Health Disparities: A Statement from Editors of Family Medicine Journals." *Journal of Family Practices* 70, no. 1 (2021): 3–4. https://www.mdedge.com/familymedicine/article/229774/diversity-medicine/systemic-racism-and-health-disparities-statement.

Shelton, Rachel C., Prajakta Adsul, April Oh, Nathalie Moise, and Derek M. Griffith. "Application of an Antiracism Lens in the Field of Implementation Science (IS): Recommendations for Reframing Implementation Research with a Focus on Justice and Racial Equity." *Implementation Research and Practice* 2 (2021): 263348952110494. https://doi.org/10.1177/26334895211049482.

"Shibboleth Authentication Request." Accessed October 13, 2022. https://login.ezp-prod1.hul.harvard.edu/login?qurl=https://www.healthaffairs.org%2fracism-and-health.

Shiman, Lauren J., Kim Freeman, Jane Bedell, and Mary T. Bassett. "Making Injustice Visible: How a Health Department Can Demonstrate the Connection between Structural Racism and the Health of Whole Neighborhoods." *Journal of Public Health Management and Practice* 27, no. 5 (2021): 442–448. https://doi.org/10/gmd6fw.

Signal, Louise, Jennifer Martin, Papaarangi Reid, Christopher Carroll, Philippa Howden-Chapman, Vera Keefe Ormsby, Ruth Richards, Bridget Robson, and Teresa Wall. "Tackling Health Inequalities: Moving Theory to Action." *International Journal for Equity in Health* 6, no. 1 (2007): 12. https://doi.org/10.1186/1475-9276-6-12.

Smedley, Brian D., Adrienne Y. Stith, and Alan R. Nelson. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* Washington, DC: National Academies Press, 2003.

Southern Jamaica Plain Health Center. "Community Health Needs Assessment and Implementation Plan" Brigham and Women's Hospital Report. 2016. Accessed February 2023. https://www.brighamandwomens.org/assets/BWH/about-bwh/pdfs/2016-CHNA-Report.pdf.

Stone, Jeff, and Gordon B. Moskowitz. "Non-Conscious Bias in Medical Decision Making: What Can Be Done to Reduce It?" *Medical Education* 45, no 8 (2011): 768–776. https://doi.org/10.1111/j.1365-2923.2011.04026.x.

Strouse, John, Katie Lobner, Sophie Lanzkron, and Carlton Haywood, Jr. "NIH and National Foundation Expenditures for Sickle Cell Disease and Cystic Fibrosis Are Associated with Pubmed Publications and FDA Approvals." *Blood* 122, no. 21 (2013). https://ashpublications.org/blood/article/122/21/1739/13008/NIH-and-National-Foundation-Expenditures-For.

Svetaz, Maria Veronica, Romina Barral, Michele A. Kelley, Tina Simpson, Vinny Chulani, Marissa Raymond-Flesch, Tamera Coyne-Beasley, Maria Trent, Kenneth Ginsburg, and Nuray Kanbur. "Inaction Is Not an Option: Using Antiracism Approaches to Address Health Inequities and Racism and Respond to Current Challenges Affecting Youth." *Journal of Adolescent Health* 67, no. 3 (2020): 323–325. https://doi.org/10.1016/j.jadohealth.2020.06.017.

The Bridgespan Group for the Greensboro Healthcare Disparities Collaborative. "A Case Study in Antiracist Organizing: Closing Healthcare Disparities in Greensboro by Focusing on Structural Racism." June 2022. https://mangoconsultingcompany.com/wp-content/uploads/2022/07/GHDC-case-study-June-2022-2.pdf.

Tweedy, Damon. "The Case for Black Doctors." *The New York Times*, May 5, 2015a. https://www.nytimes.com/2015/05/17/opinion/sunday/the-case-for-black-doctors.html.

——. "Being Black Can Be Bad for Your Health: Race, Medicine and the Cruelest Unfairness of All." Salon. October 11, 2015b. https://www.salon.com/2015/10/11/being_black_can_be_bad_for_your_health_race_medicine_and_the_cruelest_unfairness_of_all/.

——. "Bridging The Death Gap." *Health Affairs* 36, no. 6 (2017). https://doi.org/10.1377/hlthaff.2017.0574.

——. "Medical Schools Have Historically Been Wrong on Race." *The New York Times*, July 27, 2020. https://www.nytimes.com/2020/07/27/opinion/sunday/coronavirus-medicine-blackness.html.

UChicago Medicine. "It Is Undeniable: Racism Is a Public Health Crisis." UChicago Medicine, June 19, 2020. https://www.uchicagomedicine.org/forefront/news/it-is-undeniable-racism-is-a-public-health-crisis.

US Department of Health and Human Services. *Report of the Secretary's Task Force on Black and Minority Health.* Washington, DC: US Department of Health and Human Services, 1985.

——. "DHHS Report on Health Disparities. Eliminating Racial and Ethnic Disparities in Health: Response to the Presidential Intervention on Race." *Public Health Reports* 113, no. 4 (1998): 372–375. https://www.jstor.org /stable/4598312.

——. *HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care.* Washington, DC: US Department of Health and Human Services, 2011.

Vaughn, Deonna. "Addressing Structural Racism: Towards an Organization-Theoretical Approach." *American Journal of Ophthalmology* 232 (2021): PA1–A3.

Villarosa, Linda. "How False Beliefs in Physical Racial Difference Still Live in Medicine Today." *The New York Times*, August 14, 2019. https://www.nytimes.com/interactive/2019/08/14/magazine/racial-differences-doctors. html.

Washington, Harriet A. *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present.* Reprint edition. New York: Anchor, 2008.

Weil, Alan R. "Racism and Health: Editor-in-Chief Alan Weil Highlights Articles in the February Issue of Health Affairs Which Focused on Racism and Health." *Health Affairs* 41, no. 2 (2022): 157. https://doi.org/10.1377 /hlthaff.2022.00033.

Weiner, Stacey. "Black Men Make up Less than 3% of Physicians. That Requires Immediate Action, Say Leaders in Academic Medicine." AAMC News. November 23, 2020. https://www.aamc.org/news-insights/black-men -make-less-3-physicians-requires-immediate-action-say-leaders-academic-medicine.

White, Kellee, and Luisa N. Borrell. "Racial/Ethnic Residential Segregation: Framing the Context of Health Risk and Health Disparities." *Health and Place* 17, no. 2 (2011): 438–448. https://doi.org/10.1016/j.healthplace .2010.12.002.

Williams, David R., Jourdyn A. Lawrence, and Brigette A. Davis "Racism and Health: Evidence and Needed Research." *Annual Review of Public Health* 40, no. 1 (2019): 105–125. https://doi.org/10.1146/annurev -publhealth-040218-043750.

Williams, Michele. "Juneteenth Can Jumpstart Recognition of America's Racial Health Disparities." *The Boston Globe*, June 25, 2021. https://www.bostonglobe.com/2021/06/25/opinion/juneteenth-can-jumpstart -recognition-americas-racial-health-disparities/.

Wispelwey, Bram. "Premature Black Deaths: The Role of American." HuffPost. Updated October 8, 2016. https:// www.huffpost.com/entry/premature-black-deaths-the-role-of-american-medicine_b_8250624.

Wispelwey, Bram, and Michelle Morse. "An Antiracist Agenda for Medicine." *Boston Review*, March 17, 2021. https:// bostonreview.net/articles/michelle-morsebram-wispelwey-what-we-owe-patients-case-medical-reparations/.

Wispelwey, Bram, Regan Marsh, Michael Wilson, Sula Mazimba, Scott Heyshell, Imoigele Aisiku, Akshay Desai, Cassandra Georges, and Michelle Morse. "Leveraging Clinical Decision Support for Racial Equity: A Socio-technical Innovation." *NEJM Catalyst*, July 25, 2022. https://catalyst.nejm.org/doi/full/10.1056/CAT .22.0076.

Zambrana, Ruth Enid, and David R. Williams. "The Intellectual Roots Of Current Knowledge on Racism and Health: Relevance to Policy and the National Equity Discourse: Article Examines the Roots of Current Knowledge on Racism and Health and Relevance to Policy and the National Equity Discourse." *Health Affairs* 41, no. 2 (2022): 163–170. https://doi.org/10.1377/hlthaff.2021.01439.

Zimmerman, Fred J. "A Robust Health Equity Metric." *Public Health* 175 (2019): 68–78. https://doi.org/10.1016 /j.puhe.2019.06.008.