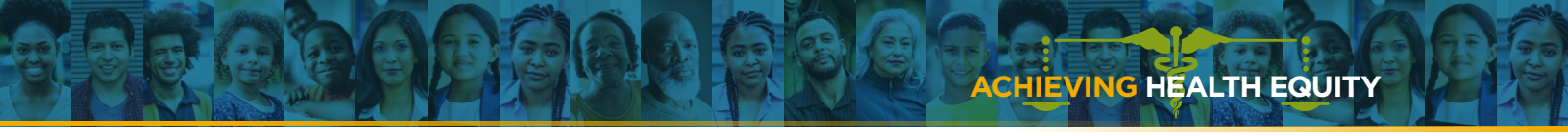
Guidance Document for the

Racial Equity in Healthcare Progress Report

June 2021



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Introduction & Purpose of Guidance Document

Equity is at the heart of IHA's vision for healthcare: "That ***all individuals and communities*** have access to high-quality healthcare at the right time, in the right setting, in order to support each person's quest for optimum health." The COVID-19 pandemic shined a spotlight on a grim reality that has been present for decades: people of color and communities of color suffer from unequal access to healthcare and disparate health outcomes. And in the midst of that pandemic, the tragic killing of George Floyd sparked outrage, grief and frustration among people from all backgrounds, and exposed once again the systemic racism, injustice, and inequality that still exist within our society. In response, the IHA Board of Trustees directed IHA to prioritize and intensify its efforts to assist member institutions to address racial health disparities.

The **Racial Equity in Healthcare Progress Report** is a critical part of that effort. Recognizing that progress and improvement require measurement and accountability, hospitals, health systems and other providers need a tool to assess their performance in addressing racial disparities in their provision of health care.

The **Racial Equity in Healthcare Progress Report** ("Progress Report") is a long-term accountability tool to document progress toward achieving racial health equity. It is meant to promote collective improvement, not to drive competition. It provides for a baseline self-assessment and then an opportunity to measure progress, assess their implementation of key strategies, understand provider and community assets in racial equity work, and identify areas of improvement.

Working together, Illinois hospitals and health systems have the opportunity to dismantle systemic racism in a way that no individual organization can. The Progress Report aims to highlight the important progress that organizations have already made as well as the work ahead. Therefore, we urge every Illinois hospital and health system to complete the Progress Report.

This Guidance Document is meant to facilitate completion of the Progress Report by providing relevant background information, such as …

- The purpose of the Progress Report.
- Detail regarding the development of the Progress Report.
- The structure of the Progress Report.
- Key terminology used in the Progress Report.
- Recommendations regarding a process for completing the Progress Report.
- Resources available on subjects related to racial health equity.

Purpose of the Progress Report

The Racial Equity in Healthcare Progress Report serves as a long-term accountability tool to document progress toward achieving racial health equity. It centers around five guiding principles:

Facilitate Collaboration

Each provider is at a different point on this journey. Using Progress Report data, the provider community will share best practices, celebrate growth, and set collective goals.

Focus on High Impact Metrics

This Progress Report uses fewer, but more impactful metrics across internal and external functions to avoid an overly broad scope and/or "analysis paralysis."

Mobilize Toward Action

It is important to start now and rapidly understand the baseline across a core set of metrics to get a sense of different providers' starting points. Do not let perfect be the enemy of good. We know the Progress Report will need to keep evolving, but that cannot stop us from starting.

Center on Racial Equity

This racial equity assessment focuses on the people of color most impacted by systemic racial inequities in healthcare: Black/African American, Hispanic/Latino/a/x, and Indigenous people.

Promote Organizational Growth

The first round of data will not be publicly available. We want organizations to assess where they are and how to grow. As providers gain more capability and resources to support this work, metrics will evolve in order to increase impact, and public reporting will be considered as this work evolves.

We invite providers to use this Progress Report as a baseline to inform their current practice and continue advancing their anti-racism and racial health equity work. Understanding that this process is a long journey, this Progress Report will continue to evolve just as provider capabilities and capacity will. **This initial Progress Report aims to help providers understand where they are now, where they can be a role model for others, and how they can grow.**

Development of the Progress Report

Origin

In response to the disparate COVID-19 infection and death rates in Black and Latino/a/x communities, in April of 2020, the City of Chicago convened West Side United, community leaders, and healthcare providers to form the Racial Equity Rapid Response (RERR) Team.

Following the murder of George Floyd, 40 healthcare providers from the RERR Team published a transformative statement declaring racism a public health crisis[15]. This healthcare collaborative committed to working together as an ecosystem to overcome systemic racism and the health care disparities it creates by pledging their institutions to seven commitments centered on dismantling racism and promoting racial health equity.

Initial Design

To transition their pledge into action, these 40 healthcare institutions initially worked with two pro bono partners, the Civic Consulting Alliance and Oliver Wyman, and then collaborated with the Illinois Health and Hospital Association (IHA), to create the Racial Equity in Healthcare Progress Report. A small working group comprised of individuals from the Rush University Medical Center, the University of Chicago Medicine, and the Civic Consulting Alliance produced an initial draft of the Progress Report.

Feedback

The Civic Consulting Alliance shared that initial draft with and solicited input from over two dozen individuals including healthcare providers, national health equity groups, community leaders, and survey creation experts. In addition, the Civic Consulting Alliance hosted two voluntary working sessions for providers. Those who provided feedback during this entire process include:

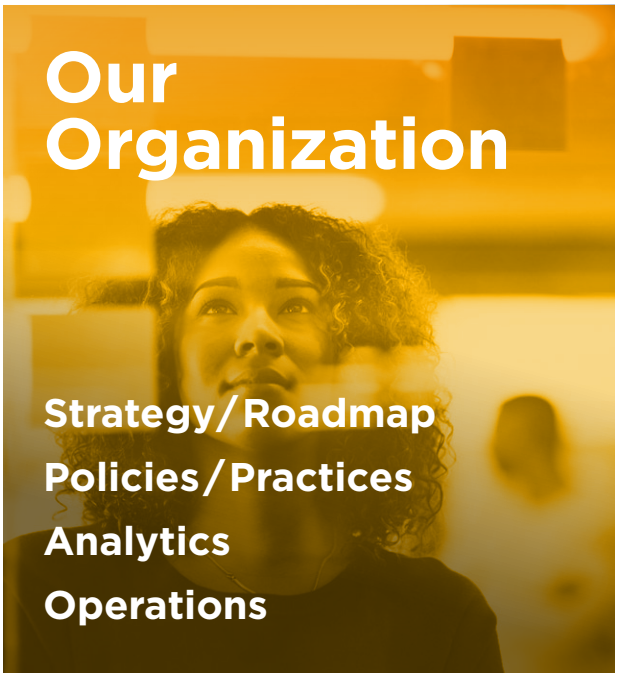
- America's Essential Hospitals
- American Hospital Association's Institute for Diversity and Health Equity (IFDHE)
- Centers for Medicare & Medicaid Services (CMS)
- Chicago Department of Public Health (CDPH)
- Democracy Collaborative / Healthcare Anchor Network
- Human Rights Campaign's Healthcare Equality Index
- Illinois Coalition for Immigrant & Refugee Rights
- Illinois Health and Hospital Association (IHA)
- Institute for Healthcare Improvement (IHI)
- Metopio
- Press Ganey
- Racial Equity Rapid Response Community Response Network
- Racial Equity Rapid Response Data Group
- Racial Equity Rapid Response Provider Working Group
- University of Illinois at Chicago School of Public Health
- U.S. Senator Dick Durbin's Office
- Vizient

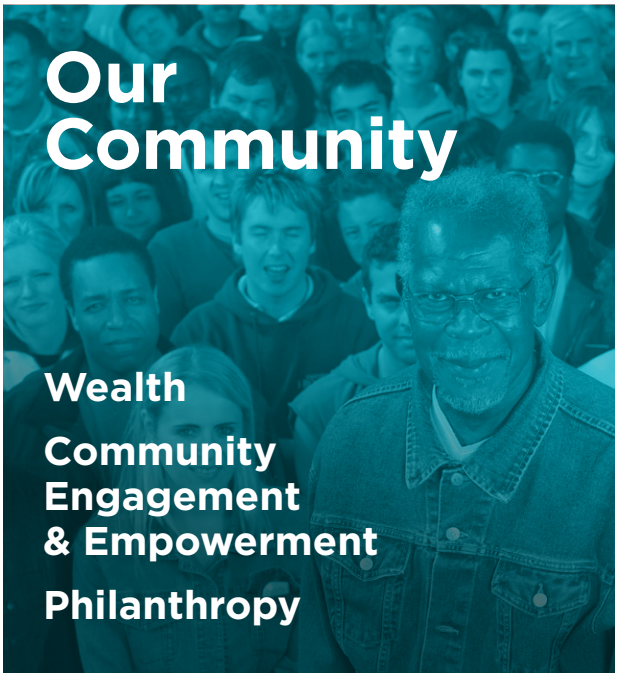
Pilot and Further Development

In partnership with the Civic Consulting Alliance, IHA piloted the Progress Report with organizations across the state of Illinois in late 2020 and early 2021. In January 2021, IHA assumed lead responsibility for the further development and implementation of the Progress Report. Hospitals, FQHCs and community based organizations who engaged in the pilots have provided invaluable feedback to our team and we have refined the Progress Report based on their input. The Progress Report has been greatly improved through our two pilot phases but we understand that continued revision of the questions and metrics will take place as the reach of the Progress Report expands.

Structure of Progress Report

The Progress Report focuses on four areas within an institution: its people, its patients, its organization, and its community. The following illustrates the four areas and broad categories within each.





Our People

This section focuses on board and leadership team demographics; employee engagement in anti-racist, implicit bias and racial health disparity trainings; and pay equity. Internal demographic data is particularly important to report and evaluate in order to compare to community and patient backgrounds. Homogeneity of race, sex, and socioeconomic status have been all too present in our healthcare systems, limiting an organization's development and contributing to health disparities[39]. Furthermore, it is projected that the United States population will grow by 12% in the next ten years, particularly from minority and immigrant populations[40]. This growth emphasizes the need for diversity and inclusion strategies to create a culturally competent workforce to serve the needs of patients in catchment areas and/or high economic hardship communities. A diverse board and staff promotes inclusion, better provider-patient communication and higher accessibility to all individuals compared to a homogenous workforce that further exacerbates current health disparities; it has also been found that higher employee perceptions of diversity and inclusion are positively correlated with employee engagement[39,32]. It is important to note that leadership should not engage in "checkbox diversity" consisting of a surface-level increase in diversity with virtually no other changes in organizational practice or engagement[3]. Actively listening and incorporating diverse opinions as well as constant reflection of internal biases and engagement in anti-racist programs/trainings need to be present at all levels for real progress within the organization. Specific resources to engage in these practices can be found in the Resource section of this document.

Our Organization

This section focuses on plans and tools that organizations use to evaluate their efforts towards racial health equity and anti-racism. Engaging with different tools and trainings focused on these topics help organizations better understand and engage with their patient/customer population who experience barriers to health access and care. Self-reported data relating to race, ethnicity, language (REaL), sexual orientation, gender identity (SOGI), and social determinants of health (SDoH) are vital in identifying and reporting inequities in care[19]. With this data, providers can better serve their patient populations and implement needed services or programs. Due to the sensitivity of these topics, proper staff training and data protections must be put in place. Specific readings and tools can be found in the Resource section.

Our Patients

This section focuses on the patient experience and the organization's dedication to evaluating patient safety and health outcomes to unveil underlying disparities and implement care improvement projects. In many communities, Black and Latinx individuals tend to face higher rates of uninsurance when compared to their non-Hispanic White counterparts[41]. Therefore, improving financial accessibility to medical institutions can be important to addressing racial health disparities. Furthermore, underpayment by government health programs underfinances institutions in lower-income communities, which often tend to be communities of color due to historic disinvestment in these neighborhoods. This underpayment by government health programs contributes to diminished access to care[33]. Consequently, it is important to know an organization's payer mix percentage for inpatient and all outpatient and ambulatory services. Specific resources can be found in the Resource section of this document.

Our Community

This section focuses on ways healthcare organizations can engage with community partners to reduce health disparities. Community involvement within the healthcare sphere is not a new practice due to its ability to widen organizational possibilities for care improvement; collaboration and engagement with community members are "cornerstones of efforts to improve public health" involving diverse stakeholders, health professionals and service users[8,9]. This deliberate healthcare strategy allows officials to better understand their community needs and focus on healthcare planning and implementation that address their specific community population[17,25]. People remain at the forefront of healthcare efforts and improvements, leading to long-lasting relationships of engagement and resilient health systems[9]. Resources to engage in these practices can be found in the Resource section of this document.

Process Suggestions

The following recommendations are offered to facilitate the data collection and survey completion process.

Who Should be Involved

We recommend that one individual manage the survey and ensure its completion. This individual will be in charge of reaching out to others in your organization to gather the requested data. We predict that your organization will need to reach out to individuals who work in the following areas:

- Administration
- Board management
- Communications
- Community engagement
- Development
- External affairs
- Finance / Accounting
- Human resources
- Operations
- Patient data and quality / Data analytics
- Strategy

What Resources Will be Needed

Your organization should already have data on some of the questions asked on the Racial Equity in Healthcare Progress Report, as several of these questions are asked by other healthcare surveys. To limit the time used searching for data, we recommend having the following documents on hand to ease your data search process:

- Your organization's strategic plan and/or annual report
- Community Health Needs Assessment
- Community Benefits Report
- Health Equity Report (if available)
- The Institute for Diversity and Health Equity's Health Equity, Diversity, and Inclusion Survey (if completed)

Suggested Process

The socialization of this tool throughout your organization is critical. While the answers themselves to the questions in the Progress Report are key to establishing a baseline, the questions themselves can serve as powerful platforms for discussion.

1. Disseminate the Progress Report to leaders throughout your organization, sharing with them that your leadership team is in the process of filling out the Progress Report.
2. The point person responsible for the submission of the Progress Report should call a meeting with key individuals and leaders so you can discuss as a team the answers your organization will provide in the Progress Report.
3. We recommend that you call this meeting for 60-90 minutes and that you read through each question in the Progress Report with your team. Discussing at a high level where you think your answers may fall and which team members are ultimately responsible for providing the answers to specific questions.
4. Depending on the size of your organization, it may take you a few weeks or more to gather the right individuals and pull the data you need to fill out the Progress Report. Take advantage of the editable pdf provided. Share that document with team members who are assigned to specific questions and ask them to fill out the editable pdf and then send it back to the point person who can upload the data to the Progress Report survey monkey.
5. Once the point person has submitted your answers for the Progress Report through survey monkey, your organization will receive an analytic report detailing how you scored. This report will showcase areas you are stronger in and areas where you may have opportunity for improvement. We encourage you to reconvene the team and review your analytic report, using it as a catalyst to action for your organization.
6. Remember, the first time you fill out the Progress Report you will simply be establishing your organization's baseline. This will give you a strong sense of where you can focus action, but engaging in the Progress Report on an annual basis will ensure that your organization is committed to advancing racial equity over time.

Progress Report Links

- **The Progress Report Survey:** To complete the pilot process, you must submit your answers through the Progress Report Survey online platform. Please note that you can save your responses in the survey at any time and return at a later date or edit responses. To go back to saved responses, you must utilize the same device and same web browser used to start the survey.
- **Guidance Document**: To support you while completing the survey, this document you are reading will provide background information on the Progress Report, resources to guide future work, and definitions to ground everyone in similar terminology. ***Please read through the guidance document before completing the survey.***
- **Progress Report PDF**: We recommend that you use the pdf document to draft and compile your answers with your team. This will make it easier to then input your final data into the online Progress Report Survey portal.

Please do not hesitate to email healthequity@team-iha.org if you have questions or need support while completing the Progress Report Survey.

Analytics

Once your organization completes the Progress Report you will receive analytics from IHA which will give you a sense of where the greatest areas of opportunity are in your organization. Your data from the progress report will not be shared with anyone outside of your organization. From an analytic perspective, we organized the Progress Report into 10 key composite metrics:

Racial Equity in Healthcare Progress Report: 10 Key Composite Metrics

DEMOGRAPHIC PROFILES
(5 questions, these 5 questions will be represented by a bar graph)

1. **Board, Management & Workforce resemble our community**
   Questions 1, 2
2. **Patient Demographics**
   Questions 3, 4, 5

OUR PEOPLE
(6 questions)

3. **Diversity and inclusion in our workforce**
   Questions 6, 7, 8, 9, 10, 11

OUR ORGANIZATION
(3 questions)

4. **Leadership practices to advance racial equity**
   Questions 13, 14, 15

OUR PATIENTS
(12 questions)

5. **Patient Assessment**
   Questions 16, 17, 18
6. **Patient Supports for Social Determinants of Health**
   Questions 19, 20, 21
7. **Quality improvement practices**
   Questions 22, 23, 24, 25, 26
8. **Access to free and discounted care**
   Question 27

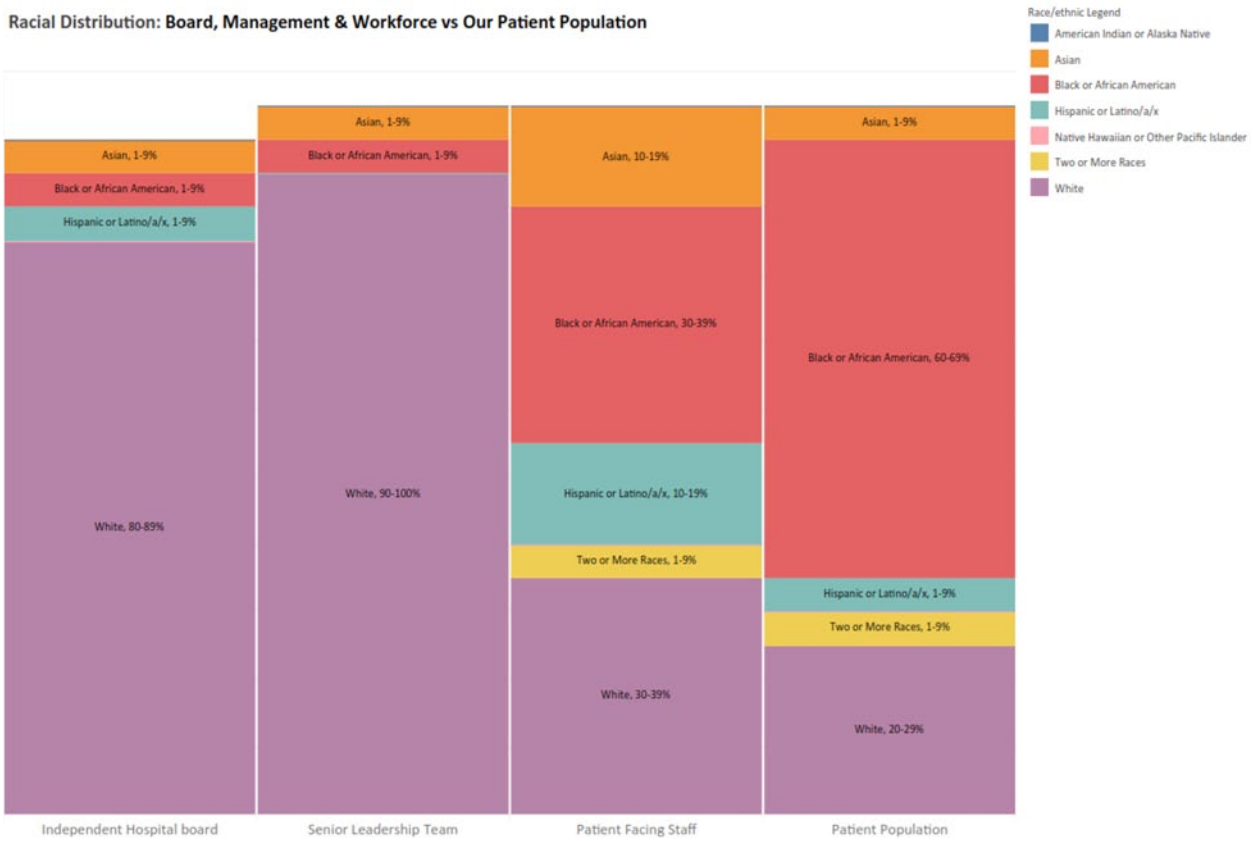
OUR COMMUNITY
(4 questions)

9. **Investment in the community**
   Questions 28, 29, 30
10. **Partnerships with patients and community**
    Question 31

These 10 composite metrics will be the driving metrics we recommend your organization focuses on. The metrics are aligned within the four pillars of the Progress Report. We are using fewer, but more impactful metrics across internal and external functions to avoid an overly broad scope or “analysis paralysis”. We will be framing your answers in the Progress Report around a 6 point Likert scale. This will allow us to identify where the gaps across the state are and the analytic reports will serve as a compass to action for your organization. The mock analytic report below gives you a sense of the data picture we will be providing after your organization has filled out the Progress Report.

Racial Equity in Healthcare Progress Report Mock Dashboard

Target Status	Definition		Score Range
Best Practice	Organization has implemented this process, is tracking process and outcome data and would consider our process and data to be a best practice.		4.1 – 5
Implementation	This process has been implemented across all targeted patient demographics and is standardized.		3.1 – 4
Piloting	This process is being piloted, but is not fully standardized or implemented across all target patient demographics.		2.1 – 3
Initiation	This process is being discussed by key leaders or within meetings and action steps are being developed.		1.1 – 2
Socialization	This process has been discussed but no action has been taken.		0.1 – 1
Not in Place	No current plans on this process have been discussed.		0



3	Diversity and Inclusion in our Workforce	
Survey Questions: 3, 4, 5, 6, 7, 8, 30		
Your Score: 87	Highest Possible Score:195	44%
1.3 : Initiation		
4	Leadership practices to Advance Racial Equity	
Survey Questions: 9, 10, 11		
Your Score: 45	Highest Possible Score: 75	60%
3.4 : Implementation		
5	Patient Assessment	
Survey Questions: 12, 13, 14		
Your Score: 17	Highest Possible Score: 40	42%
2.4 : Piloting		
6	Patient Supports for Social Determinants of Health	
Survey Questions: 15, 16, 25		
Your Score: 50	Highest Possible Score: 55	90%
4.8: Best Practice		
7	Quality Improvement Practices	
Survey Questions: 17, 18, 19, 21, 27		
Your Score: 7	Highest Possible Score: 90	7%
0.3 : Socialization		
8	Access to Free and Discounted Care	
Survey Question: 26		
Your Score: 4	Highest Possible Score: 10	40%
1.5 : Initiation		
9	Investment in the Community	
Survey Questions: 20, 28, 31		
Your Score: 45	Highest Possible Score: 50	90%
4.8 : Best Practice		
10	Partnerships with Patients and Community	
Survey Question: 29		
Your Score: 0	Highest Possible Score: 5	0%
0 : Not in Place		

Terminology Used in the Progress Report

Anti-racism[18]: The active and conscious effort to work against multidimensional aspects of racism.

Barriers in Access to Care[2]: Factors that prevent the access to comprehensible, quality health services. These may include monetary costs and a lack of (or inadequate): insurance coverage, available services and transportation and/or culturally competent care.

Charity Care Policies[6]: Policies that provide "free care" to patients who are uninsured for the relevant, medically necessary service, who are ineligible for governmental or other insurance coverage, and who have family incomes not in excess of a specified level.

CLAS Standards: Culturally and Linguistically Appropriate Services in Health and Health Care[29]

The National Center for Cultural Competence created 15 standards to promote health equity and quality through the use of culturally and linguistically appropriate services. These standards and goals help provide clear, implementable strategies aimed to eliminate various health disparities present across our country:

1. Provide effective, equitable, understandable, respectful, and quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
2. Advance and sustain governance and leadership that promotes CLAS and health equity.
3. Recruit, promote, and support a diverse governance, leadership, and workforce.
4. Educate and train governance, leadership, and workforce in CLAS
5. Offer communication and language assistance.
6. Inform individuals of the availability of language assistance.
7. Ensure the competence of individuals providing language assistance.
8. Provide easy-to-understand materials and signage.
9. Infuse CLAS goals, policies, and management accountability throughout the organization's planning and operations.
10. Conduct organizational assessments.
11. Collect and maintain demographic data.
12. Conduct assessments of community health assets and needs.
13. Partner with the community.
14. Create conflict and grievance resolution processes.
15. Communicate the organization's process in implementing and sustaining CLAS.

Community / Service Area: As determined by each provider, but generally referring to the immediate community area(s) surrounding the clinic or hospital.

Community Based Participatory Research (CBPR)[23]: A collaborative process that equitably involves all partners in the research process and recognizes the unique strengths that each brings in order to combine knowledge and create actionable social change to improve health and eliminate health disparities in the community.

Community Engagement Work – A process of developing relationships that enable stakeholders to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes. SOURCE: World Health Organization https://www.who.int/publications/i/item/9789240010529

Community Health Needs Assessment (CHNA)[35]: A state, tribal, local, or territorial health assessment that identifies key health needs and issues through systematic, comprehensive data collection and analysis.

Community Investment[20]: An entity's practice of investing money in public services and social institutions that aim to improve an individual's quality of life.

Cultural Responsiveness[11]: The ability to understand and consider the different cultural backgrounds of the people you engage with and/or provide services to.

Culturally and Linguistically Appropriate: Health services that are respectful of and responsive to the health beliefs, practices and needs of diverse patients can help close the gap in health outcomes.

Cultural Humility: A process of reflection and lifelong inquiry involves self-awareness of personal and cultural biases as well as awareness and sensitivity to significant cultural issues of others. Core to the process of cultural humility is the researcher's deliberate reflection of her/his values and biases. Cultural humility encourages developing an attitude of not knowing and learning from the patient. It is an ongoing active process for the healthcare provider.

Demographic Data[12]: Socio-economic information including gender, race/ethnicity, socioeconomic status, employment, education, income and other factors. Often used to learn more about population characteristics.

Employee Group Definitions[36,42]: Below are definitions and distinctions between different leadership positions within an organization. It should be noted that different organizations may categorize these roles differently and/or have positions that overlap between groups.

- Senior Leadership: Body of leaders including Chief Executives and other senior managers in charge of establishing the goals, responsibilities and accountabilities of the organization. Also referred to as Senior Leadership.
- Management: Leaders of the clinical and non-clinical staff who are responsible for fulfilling the responsibilities and/or accountabilities of the organization.
- Non-Clinical Staff: Individuals who are engaged in the non-medical or patient-based care of the clientele including administrative roles.

- Clinical Staff: Individuals who provide patient care in the organization/hospital system. In a hospital, this role consists of medical staff such as physicians, nurses, and other licensed independent practitioners who contribute to the leadership of the organization.

Equity[13]: The fair treatment, access, opportunity, and advancement of all individuals and the elimination of barriers that have limited, and continue to limit, all of these or the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically.

Health Disparities: Differences in health outcomes among groups of people. Disparities can occur across many dimensions, including race/ethnicity, socioeconomic status, age, location, gender, disability status and sexual orientation. Health disparities are one way we can measure our progress toward achieving health equity.

Health Equity: Definitions of health equity vary across sectors and organizations. Listed are three definitions.

- Equity is the absence of avoidable, unfair or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, geographically or by other means of stratification. “Health equity” or “equity in health” implies that ideally everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential.
- The state in which everyone has the chance to attain their full health potential, and no one is disadvantaged from achieving this potential because of social position or any other defined circumstance.
- A fair and just distribution of the resources and opportunities needed to achieve well-being.

High Spend Categories: Refers to budget categories that are critical to the functioning of an organization, are frequently in demand, and that comprise a substantial portion of the organization’s spending. Examples of high spend categories include: Professional Services, Construction Tier 1, and Construction Tier 2.

Implicit and Explicit Bias[30]: The unconscious and conscious attitudes and beliefs an individual has towards another person or group. Both biases impact behaviors and a person’s affect.

Life Expectancy Gap[7]: The difference between minority and white life expectancy due to social, economic and institutional barriers that predominantly affect the Black, Non-Latinx population.

Minority Owned Business[24]: The U.S. Small Business Administration defines these firms as businesses that are owned and controlled at least 51% by socially and economically disadvantaged individuals including those who identify as:

- American Indian or Alaskan Native
- Asian
- Black or African American
- Hispanic or Latinx
- Native Hawaiian or other Pacific Islander

Organizational Measures:

- Employee Engagement[21]: The emotional commitment an employee has to their organization and its goals.
- Feelings of Inclusion[45]: A sense of belonging and trust between a pair of individuals or within a group based on everyday interactions, policies and/or behaviors.

Patient Advisory Board[5]: Groups of individuals from management, staff members and providers who collaborate with each other and the patient in decision-making processes to provide unique perspectives and improve the quality of care to their patients.

Patient Experience[44]: Interactions that patients have within the healthcare system including with members of their medical team, staff members and other healthcare facilities.

Pay Equity[27]: The equal compensation of employees who perform the same or similar job responsibilities while accounting for factors such as experience level and job performance.

Pay Equity Analysis[4]: A method of researching pay rates within an organization and assessing pay differences across age, race, gender, job responsibilities and other associated factors.

Quality of Life Plans[31]: The development of a comprehensive plan to strengthen the community through the collaboration with public and private entities and an emphasis on organizing needed social services. In Chicago, LISC has supported the development of Quality of Life Plans in 27 communities.

Racial Equity Analysis – A Racial Equity Impact Analysis helps to identify what those strategies should be or how to alter existing policies and practices in order to achieve greater results for all groups. SOURCE: https://viablefuturescenter.org/racemattersinstitute/resources/racial-equity-impact-analysis/

Racial / Ethnic Category Descriptions[1]:

- American Indian or Alaskan Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.
- Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- Black or African American: A person having origins in any of the black racial groups of Africa.
- Hispanic or Latinx: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.
- Native Hawaiian or Other Pacific Islander: A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- Two or More Races: All persons who identify with more than one of the above five races.
- White: A person having origins in any of the original peoples of Europe, the Middle East of North Africa.

REal (Race, Ethnicity and Language)[1,10]:

- Race: The U.S. Census Bureau defines race as a category of humankind that often has distinctive physical attributes that are associated with biology. Individuals self-identify with one or more social groups.
- Ethnicity: Social groups that have a common cultural origin or background tied to language, religion, race and/or nationality.
- Language: A system of conventional spoken, manual (signed), or written symbols by which members of a social group and participants in its culture express themselves.

Self-Reported Data Collection[22]: A method of research design when participants give their responses to a given set of questions which ask about individual behaviors, beliefs, attitudes, or intentions.

Sexual Orientation (SO) and Gender Identity (GI)[38]:

- Sexual Orientation: An individual's internal emotional, romantic and sexual attraction to other people.
- Gender Identity: An individual's self-identification as being a boy/man/male, girl/woman/female, neither (non-binary, gender non-conforming) or other. Someone's gender identity may not align with their sex.

Social Determinants of Health (SDoH)[37]: Conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes as defined by the Center of Disease Control. See the U.S. Department of Health and Human Services' definition for SDoH here. Below, see links to the U.S. Department of Health and Human Services' definitions for the five SDoH categories that are specified in the Progress Report:

- Economic Stability
- Education Access and Quality
- Health Care Access and Quality
- Neighborhood and Built Environment
- Social and Community Context

Resources

Pillar 1: Our People

The resources in this section focus on Board and leadership team demographics; employee engagement in anti-racist, implicit bias and racial health disparity trainings; and pay equity.

A diverse Board and staff promotes inclusion, better provider-patient communication and greater accessibility to all individuals compared to a homogenous workforce that further exacerbates current health disparities. Actively listening and incorporating diverse opinions, as well as constant reflection of internal biases and engagement in anti-racist programs/trainings, needs to be present at all levels for real progress in an organization. Specific tools and resources are identified below.

- American Hospital Association:

  Recruiting for a Diverse Health Care Board

  Health Equity Resource Series: Training and the Culture of Learning

  Becoming a Culturally Competent Health Care Organization

  4 Ways Health Care Organizations Can Utilize the Implicit Association Test (IAT)

- Next Generation Health Workforce & Workplace: Diversity Best Practices guide examining challenges in the workforce and strategies to increase diversity and inclusion in the workplace.
- CLAS Standards: Centers for Medicare & Medicaid Services' practical guide to implementing the Culturally and Linguistically Appropriate (CLAS) Standards.
- Conscious & Unconscious Biases in Health Care: This course focuses on conscious and unconscious biases in healthcare and their impact on people who are disproportionately affected by disparities in health and healthcare. It offers an array of innovative activities, based on current evidence and best practices, that are intended to diminish the negative impact of biases.
- American Academy of Family Physicians: Implicit Bias Facilitator Guide and Associated Activities
- The Association of American Medical Colleges (AAMC)'s Anti-racism in Medicine Collection to provide tools for healthcare teams to fight racism and confront biases.
- The Society for Human Resource Management: The Importance of Pay Equity
- Lucidchart Blog: A Guide to Pay Equity Analysis

Pillar 2: Our Organization

The resources in this section focus on plans and tools that organizations use to evaluate their efforts toward racial health equity and anti-racism. Engaging with different tools and trainings focused on these topics help organizations better understand and engage with their patients who experience barriers to health access and care.

Self-reported data relating to race, ethnicity, language (REaL); sexual orientation, gender identity (SOGI); and social determinants of health (SDoH) are vital in identifying and reporting inequities in care. As a result, providers can better serve their patients and communities and implement needed services or programs. Specific tools and resources are identified below.

- American Hospital Association

  Health Equity Resource Series: Data-Driven Care Delivery – Data Collection, Stratification and Use

  Addressing Health Care Disparities through Race, Ethnicity and Language (REaL) Data

  Health Equity, Diversity & Inclusion Measures for Hospitals and Health System Dashboards

  How Advancing Racial Equity Can Create Business Value

  Inclusive, Local Hiring: Building the Pipeline to a Healthy Community

- America's Essential Hospitals' Resources on Structural Racism. America's Essential Hospitals has compiled resources on advancing population health and addressing structural racism.
- Racial Equity Action Plan: "How-to" manual for a racial equity action plan from the Government Alliance on Race and Equity.
- Racial Health Equity and Anti-Racist Action Plans: Racial Equity Tool's compilation of existing racial health equity action plans.
- Supplier Diversity: Association for Healthcare Resource and Materials Management's guide to increasing supplier diversity through the use of action steps and plans.
- Healthcare Anchor Network: A national collaboration of 60 leading healthcare systems building more inclusive and sustainable local economies, including readiness checklists for Local Hiring Pathways and Local Sourcing Efforts.
- U.S Centers for Disease Control and Prevention: Social Determinants of Health.
- SOGI – The Most Important Terms to Know. BestMedicine by Renown Health.

Pillar 3: Our Patients

The resources in this section focus on the patient experience and an organization's dedication to evaluating patient safety and health outcomes to unveil underlying disparities and implement care improvement projects. Specific tools and resources are identified below.

- Agency for Healthcare Research and Quality: What Is Patient Experience?
- American Hospital Association: "Screening for Social Needs: Guiding Care Teams to Engage Patients"
- Illinois Health and Hospital Association: Charity Care and Financial Assistance resources to help ensure patients can access needed healthcare and obtain financial assistance.
- Creating a Toolkit to Reduce Disparities in Patient Engagement
- National Academy of Medicine: Patient and Family Engaged Care: An Essential Element of Health Equity.

Pillar 4: Our Community

The resources in this section focus on ways healthcare organizations can engage with community partners to reduce health disparities and achieve health equity.

Community engagement is fundamental to creating lasting change and improvements in the healthcare system because of its ability to widen organizational possibilities for care improvement. Without the collaboration and consideration of unique, diverse perspectives, healthcare planning and implementation falls to the wayside. Resources and tools to engage in these practices are identified below.

- American Hospital Association
  - A Playbook of Fostering Hospital-Community Partnerships to Build a Culture of Health
  - Building Hospital-Community Partnerships: Leveraging strengths to improve community health
  - Creating Effective Hospital/Community Partnerships to Build a Culture of Health
  - Societal Factors that Influence Health: A Framework for Hospitals
- Center for Disease Control and Prevention: Health Equity Guide: Meaningful Community Engagement in Health and Equity
- Healthcare Anchor Network: Community Investment Checklist
- The George Washington University: Principles to Consider for the Implementation of a Community Health Needs Assessment Process - NNPHI
- DePaul University: What is Asset Based Community Development
- University of California, Berkeley: Community-Based Participatory Research: A Strategy for Building Health Communities and Promoting Health through Policy Change
- Child Welfare Information Gateway: Community-Based Resources: Keystone to the System of Care
- World Health Organization: Community Engagement for Quality, Integrated, People-Centered and Resilient Health Services
- Healthy Chicago 2025: Chicago Department of Public Health presentation of findings from the recent community health assessment and a framework for action in the next five years

Introductory or Individual Tools and Resources

The following resources could be shared with an entire workforce, used in department/division settings or on an individual basis.

- TED Talks Playlist: The Link Between Health and Racism. Nine videos (less than 20 minutes each) that explore various aspects of racial health disparities. One or more videos could be used as a primer or as discussion starters.
- What Is Health Equity, and Why Does It Matter? Produced by the Institute for Healthcare Improvement, this is a 30-minute interview with David R. Williams, PhD, MPH, Professor of Public Health at the Harvard T.H. Chan School of Public Health. It's a good primer and discussion starter.
- IHI Video Series. This is the same interview with Williams, but broken into eight shorter segments. Links to transcripts as well as discussion questions are included.

- TED Talk: How Inequality Kills, with Dr. David Ansell, Senior Vice President of Community Affairs, Rush University Medical Center, author of The Death Gap, and Co-Chair of IHA's Health Equity Leaders' Workgroup. With a specific focus on Chicago, but applicable in all regions, this 15-minute video is a good primer and discussion starter.
- TEDx Talk: Allegories on Race and Racism. Dr. Camara Jones, a physician and leading speaker on racism in healthcare, shares four allegories on "race" and racism. She hopes that these "telling stories" empower you to do something different and that you will remember them and pass them on.
- TED Talk: Social Determinants of Health, with Dr. Claire Pomeroy, president of the Albert and Mary Lasker Foundation. 15-minute video.
- Disparities in Health and Health Care: 5 Key Questions and Answers. Produced by the Kaiser Family Foundation, this is approximately 15 pages of printed material with some charts that provide basic, foundational information about health disparities.
- The American Medical Association's Prioritizing Equity Video Series. The Prioritizing Equity series illuminates how COVID-19 and other determinants of health uniquely impact marginalized communities, public health and health equity, with an eye on both short-term and long-term implications.
- The American Medical Association's Strategic Plan to Embed Racial Justice and Advance Health Equity. Download the PDF of the AMA's plan. While it is over 80 pages, you can use parts of it as a primer or discussion starter. For example, see the Executive Summary or Section 1 – Background and Primer.
- The New England Journal of Medicine: How Structural Racism Works. This six-page article identifies and explores racist policies as the root cause of racial health inequities in the United States. Download the PDF as a primer or discussion starter.
- The Biden Administration Presidential Orders on racial and sexual equity:

  Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government

  Executive Order on Preventing and Combating Discrimination on the Basis of Gender Identity or Sexual Orientation

  Memorandum Condemning and Combating Racism, Xenophobia, and Intolerance Against Asian Americans and Pacific Islanders in the United States

Additional Resources

Below are additional organizations with resources that highlight the work of the Racial Equity in Healthcare Progress Report, but please note this list is not exhaustive:

Alliance Chicago: Aims to improve public health through collaboration, health information technology, and health research and education. You can explore their current research projects focused on education, training, infrastructure and more.

Chicago Department of Public Health (CDPH): Offers many resources including its Together We Heal Initiative Toolkit which includes educational resources, self-guided trainings, podcasts and more focused on racial healing and learning throughout Chicago.

Government Alliance on Race and Equity (GARE): Provides a tools and resources page with resource guides and papers for organizations to use to achieve racial equity.

Healthcare Anchor Network: Is supported by The Democracy Collaborative and promotes action and collaboration within the healthcare sector. They offer various toolkits, infographics and more focused on ways hospitals and healthcare systems can tackle social determinants of health and promote local purchasing, hiring and investing.

Human Rights Campaign: Created the Healthcare Equality Index aimed to promote inclusive and equitable care to the LGBTQ+ community and offers more educational resources related to LGBTQ+ health and inclusivity in the workplace such as Health Disparities Among Bisexual People and Advocating for LGBTQ Equality in Your Workplace.

Institute for Healthcare Improvement (IHI): Aims to improve health and healthcare worldwide. They offer an abundance of resources and publications of interest such as A Data-Driven Approach to Addressing Racial Disparities in Health Care Outcome.

Press Ganey: Is dedicated to supporting health care providers in improving the quality and delivery of health care. Their resource database provides articles, briefs, webinars and more focused on patient experiences and workforce engagement.

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