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Viewpoint In-Press Preview

Addressing racism from within health care is critically important to creating an equitable society. Here, we provide an actionable framework that can be implemented to build a culture of antiracism in health care systems.

Toward an equitable society: Building a culture of antiracism in health care

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In the late spring of 2020, outcry about the brutal killings of George Floyd, Ahmaud Arbery, and Breonna Taylor led to widespread protests by diverse groups in support of the Black Lives Matter movement and demands to end police brutality. These uprisings generated unprecedented corporate and institutional acknowledgements of solidarity. In the health care setting, thousands of providers across the United States knelt for 8 minutes and 46 seconds during 'White Coats for Black Lives' demonstrations, and many institutions issued public statements denouncing racism.

These events unfolded against a global COVID-19 pandemic which has to date resulted in approximately 11.6 million cases and 539,000 deaths worldwide. Consistent with a long history of significant racial disparities in health outcomes (1), Black patients have been diagnosed with and died from COVID-19 at significantly higher rates than white patients (2,3). Further, Black Americans have borne a disproportionate brunt of the economic fallout of COVID-19, including higher rates of job loss (4).

Racism is a root cause underlying widespread disparities in social, economic, and health outcomes, including the ability to stay alive (5). Yet, the insidious and pervasive nature of racism, along with the uncomfortable recognition that some groups benefit from how society is currently organized, make it a challenging and complex problem. Health care is not immune. Health care systems wield enormous power and often play an oversized role in the local economies where they reside. For these reasons, addressing racism in all of its forms - interpersonal, institutional, and structural - from within health care is critically important to creating an equitable society. In the context of the pandemic and protests, health care institutions are now actively seeking approaches to translate symbolic gestures into meaningful action.

What would a culture of antiracism in health care look and *feel* like? Short term goals would include: appointing leaders and teams to drive these efforts, integrating antiracism in training and education, supporting research to test these efforts, financially incentivizing clinical metrics to align with eliminating disparities, and altering existing policies and practices. Longer-term efforts would require changing race-based ideologies that have been in place for more than 400 years. Addressing racism requires changing how resources, opportunity, and power are distributed, which will feel uncomfortable and challenging for some. Many Black healthcare providers and patients could experience a sense of belonging and being treated fairly for the first time. These difficult but important changes from within health care could enable a more equitable and healthier society for all. This Viewpoint provides an actionable framework that can be implemented to build a culture of antiracism in health care systems.

Establish a network of supported leaders to oversee health system antiracism efforts

Most health care organizations have a single office or individual responsible for diversity and inclusion efforts. However, this work is often divorced from other aspects of health system operations, including the core clinical, education, and research missions. A network of endowed leadership positions in all clinical and non-clinical departments is needed to amplify the work of these offices and to explicitly

promote antiracism. These leaders need authority and resources to oversee a process to move policies, procedures, and operations toward a culture of antiracism.

Empower existing health system teams to leverage strengths to address racism

Historically, health system leaders have not backed down from addressing complex problems, including the current COVID-19 pandemic. In a matter of weeks, most organizations dramatically revised operations, shifted to remote work, deployed telehealth, reimagined research protocols and productivity (6), and crowdsourced personal protective equipment. A similar all-hands-on-deck approach is needed to address racism. Specialized teams, with guidance from experts in race, racism, and antiracism, can apply their skill sets to antiracism efforts. For example, innovation centers can use agile design thinking (e.g. contextual inquiry, exploration of divergent approaches, rapid low-cost experiments) and quality and safety teams can deploy tools such as Plan-Do-Study-Act and root-cause analyses towards these efforts.

Implement antiracism focused training and education

Training and education are central to the art of medicine and should be leveraged to address racism. Enhancing awareness of racism involves using ideas, words, and actions to deliberately interrupt the norms supporting structural and institutional racism (7). In this context, mandatory annual antiracism training should be implemented for all health system employees. Additionally, the current biomedical learning model from graduate medical education to professional board certification and maintenance includes little to no dedicated focus on race and racism. Related topics of health disparities and equity are more common, but often lack historical context, and are relegated to brief and separate modules. Instead, structural competency and antiracism should be thoroughly integrated into all synchronous (e.g. lectures, journal clubs, grand rounds, case reviews) and asynchronous training models (8). For training institutions, additional efforts should include supporting underrepresented trainees with mentorship, professional development, and networking to address the impacts of racism.

Re-evaluate institutional policies and practices with a lens of antiracism

Many policies and practices of health care institutions, intentionally or not, have produced outcomes that systematically favor employees and patients from the majority population and place members of the minority community at a disadvantage. A central focus of building a culture of antiracism should be to assess patterns of hiring, salary, retention, advancement, and leadership appointments for all health system employees, and development of a plan to rectify disparities. In particular, workforce diversity for physicians, nurses, and all members of health care teams is vital to building an equitable and healthy society for all (9). Additional efforts can focus on changing the cultural representations within health systems to be more inclusive, including building names, the portraits hanging on walls, and the images and messages in informational material.

Deploy accountable systems for racism reporting, feedback, and intervention

The experience of micro- and macro- aggressions occurs on a near-daily basis for many Black providers and patients yet most go unreported (10). Just as safety net systems have been widely deployed for quality improvement, needed are accessible systems that can collect, investigate and address patient, trainee, and employee complaints of racism. An example may be a smart-phone app that allows optionally anonymized easy entry of real time experiences. Similar to the morbidity and mortality conference model, reports of racism can be synthesized, anonymized, and reviewed in discussion forums with associated credit (e.g. continuing medical education). Individuals or departments that show consistent problems can be the focus of interventions.

Parallel efforts are needed to identify and rectify racial disparities in patient experience and outcomes. Population level racial disparities have been well documented across a range of health conditions (1). However, disparities in experience and outcomes within an institution are generally not evaluated as part of quality improvement efforts or reported to providers. Building a culture of antiracism would involve codifying and regularly reporting disparities to departments, providers, and the communities they serve.

Reconfigure health systems as key actors in addressing structural barriers

A fundamental structural barrier to health is the striking wealth gap between Black and Latino compared to white households (11). Health care institutions can implement sustainable wealth building opportunities for minority communities through clinic-located or virtual financial health services and tax-preparation, employment and job training, and examination of procurement practices. Health care systems should also ensure a living wage, equitable benefits, and advancement opportunities for all support staff.

Interventions targeting structural barriers in housing, education, criminal justice, and neighborhood environment (12, 13) should be implemented in partnership with communities and supported through long-term funding. Community health workers (CHWs) are a vital and often underutilized workforce that can bridge the gap between health care institutions and the communities they serve (14). CHWs are trusted individuals who share life experiences with patients, and help address social and structural needs. Finally, health systems can also play a role in empowering communities to vote in local and national elections as a way of having a voice in shaping policies and practices which directly impact the health of individuals and communities (15).

Reorganize power structures and accountability in support of antiracism

A fundamental strategy to disrupt the current power structure of health care institutions is to revamp the boards of trustees' selection process, making it more inclusive of underrepresented minority leaders as well as leaders of local community organizations. The lived experience of both groups, represents an underutilized resource to guide institutions toward meaningful change.

Accountability should be a guiding principle of creating a culture of antiracism. Clear metrics of success for all initiatives should be determined and transparent reporting to institutional leaders is vital. Just as

health systems are incentivized to reach clinical productivity targets, antiracism strategies should be established in parallel with departmental level financial consequences in place for successes and shortcomings.

Support scientific research focused on addressing and eliminating racism

While the outcomes associated with racism are well documented, including lack of representation among health care providers and widespread health disparities across many diseases, the evidence-base for interventions targeting racism is limited (16). Research institutions should prioritize developing and evaluating interventions to address interpersonal, institutional, and structural racism with the same level of funding and support as other areas of scientific inquiry. Dedicated pilot funding can support new multidisciplinary teams to compete for federal funding. Further, all new initiatives should be rigorously evaluated. Efforts that do not produce the desired outcomes after sufficient time should be revised.

The time for action is now

With the same urgency that health care institutions shifted resources, programs, and leadership roles in previously unimaginable ways in response to COVID-19, health systems must now act to build a culture of antiracism. Talking about racism, along with shifting how funding, opportunity, and power are distributed within health care organizations, may be hard and uncomfortable for many individuals and institutions. The economic consequences of COVID-19 present an additional difficulty, as almost all hospitals are experiencing considerable financial difficulties and many small and rural facilities are on the brink of closure (17). Despite the potential challenges, inaction is no longer an option. Achieving an equitable society, one in which Black lives really do matter, requires building a lasting culture of antiracism within health care.

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