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Academic Health Focus

Key Concepts in Eliminating Healthcare Inequities for Academic Health Systems and Teaching Hospitals: Social Determinants of Health and Racial Health Equity

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Disparities in COVID-19 brought national attention to racism and discrimination as root causes of health inequity. Leaders from a growing number of cities have responded by calling out racism as a public health threat,[1] while teaching hospitals made sure equity concepts were embedded into their system strategies. Two years later, academic healthcare leaders and practitioners are refining two fundamental goals: to address social determinants of health (SDOH) and improve racial health equity (RHE). To be effective, it is important to recognize SDOH and RHE as integrated pursuits that together drive successful strategies.

What Are Social Determinants of Health?

SDOH is a social medicine concept that has been broadly adopted within the health sector. SDOH are defined as "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health issues, the ability to function, and quality-of-life outcomes and risks."[2] Pioneers in primary care and population health built and implemented many strategies to address non-clinical factors—such as food insecurity—that impact health outcomes. Many have followed.

The Kaiser Family Foundation (KFF) model in **Exhibit 1** (on the following page), shows how racism and discrimination span six domains of SDOH. Said another way, racism and discrimination are the root causes of disparities in physical and mental health

1 Sophia Tareen, "Cities Declare Racism a Health Crisis, but Some Doubt Impact," *Associated Press*, October 5, 2020.
2 "Social Determinants of Health, How Does Healthy People 2030 Address SDOH?," U.S. Department of Health and Human Services.

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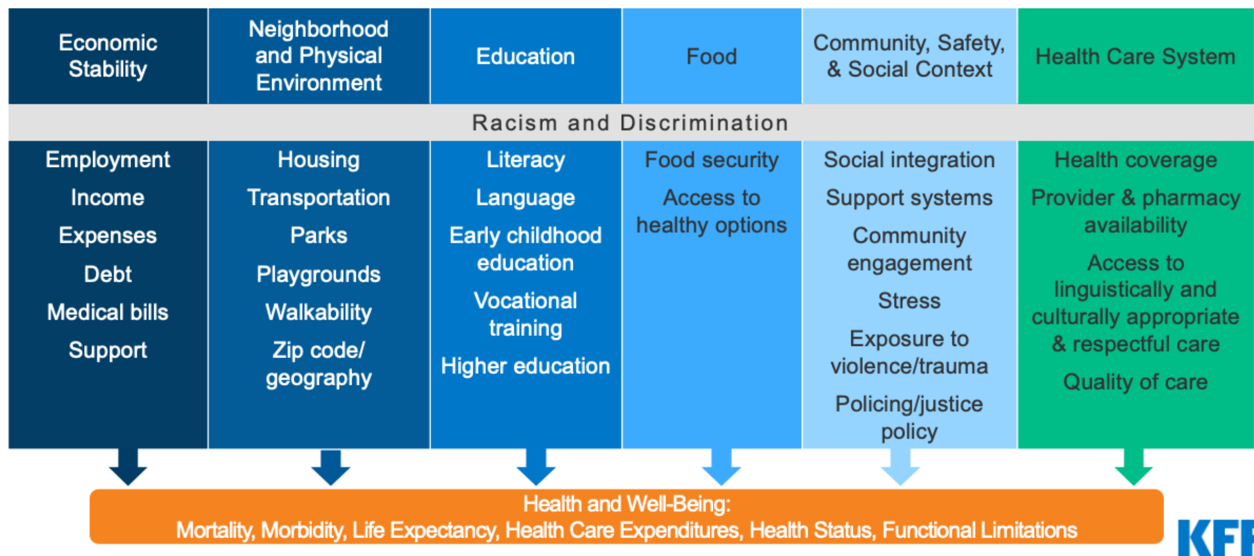
Exhibit 1: KFF SDOH Model



Source: Nambi Ndugga and Samantha Artiga, "Disparities in Health and Health Care: Five Key Questions and Answers," Kaiser Family Foundation, May 11, 2021.

outcomes because they create unequal access to education, housing, employment, and the environments in which we live.

What Is Racial Health Equity?

Today, academic healthcare leaders and practitioners are broadening their social needs interventions to include a health equity lens. This means examining issues with a focus on discriminatory policies and practices that evolved from racist systems and structures. It requires acknowledgment of and a commitment to addressing the historical inequities that create and compound SDOH for Black, indigenous, and other people of color.

The CDC states that "health equity is achieved when every person has the opportunity to attain [their] 'full health potential' and no one is 'disadvantaged from achieving this potential because of social position or other socially determined circumstances.'"[3] Achieving health equity is not a one-size-fits-all approach. Due to the complexity of

3 "Health Equity," Centers for Disease Control and Prevention.

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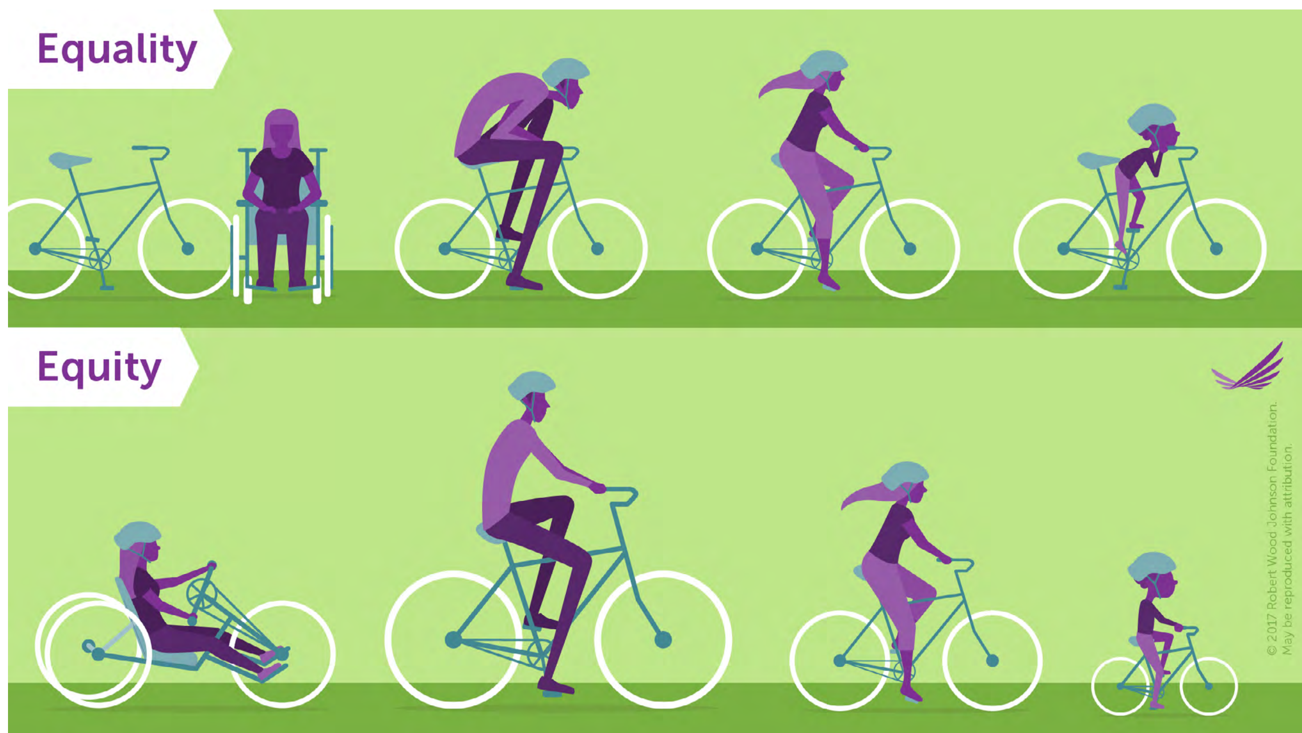
these issues, solutions are multifaceted and must be tailored to the unique needs of specific disadvantaged populations.

Equity is not equality. There are many illustrations that distinguish equality (all things equal) from equity (meeting individual needs to create an equal state). **Exhibit 2** shows how an equitable solution requires different equipment for each individual to bring about a desired state (in this case, riding a bike). If the desired state is health for all, then we have to get away from the notion that the same care model or intervention will work universally, because that is like expecting everyone to be able to ride the same bike.

Exhibit 2: Equality versus Equity



Source: "Visualizing Health Equity: One Size Does Not Fit All Infographic," Robert Wood Johnson Foundation, June 30, 2017.

The Relationship between SDOH and RHE

There is a benefit to understanding how SDOH and RHE differ and overlap. Solutions that target issues within the overlap will have the most significant and sustainable impact on eliminating inequities in access, treatment, and outcomes. Interventions more narrowly focused on SDOH or RHE may be appropriate, but there needs to be

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awareness that 1) underlying social issues may persist without a focus on equity and 2) focusing on equity alone may not improve health outcomes.

For example, a teaching hospital seeking to provide more culturally and linguistically appropriate care as well as a better learning environment for non-white medical students and residents/fellows takes the steps necessary to increase faculty diversity. Not only is it necessary for the faculty to be role models, trainees should also be able to feel comfortable that the organization in which they are receiving their training values their own background and encourages diversity, equity, and inclusion (DEI) in practice. This arguably will also increase the teaching program's ability to retain its graduates and enable the program to more sensitively treat a broad and diverse population of patients. Additionally, this is an important step toward building equity because minority patients have been found to benefit from having minority doctors, including producing higher patient experience scores.[4]

➜ Key Board Takeaways

Boards of academic health systems and teaching hospitals should consider marrying social interventions with actions focused on eliminating racial disparities to improve equity:

- **Foundational goals:** For SDOH initiatives to succeed, underlying inequities associated with communities of color must also be addressed.
- **Access to care:** Without a focus on RHE, those who are most vulnerable and disenfranchised will continue to have unmet healthcare needs.
- **Distinct but not separate concepts:** To be effective, academic healthcare leaders should know whether initiatives are aimed at addressing SDOH, RHE, or both.
- **Competitive advantage:** Quality and financial performance can be improved by addressing structural, institutional, and interpersonal racism and developing a diverse and inclusive workforce.
- **Clinical learning environment:** In accordance with LCME and ACGME requirements, attention on DEI initiatives is imperative to not only ensure ongoing academic accreditation but also elevate the educational experience of the trainees and create an environment in which they develop cultural competence to treat a diverse patient population.

4 Junko Takeshita, M.D., Ph.D., et al., "Association of Racial/Ethnic and Gender Concordance between Patients and Physicians with Patient Experience Ratings," *JAMA Network Open*, November 9, 2020.

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➜ Questions for the Board

- Are we as a board comfortable in naming poverty and racism as a root cause of healthcare inequity?
- Do we as a board have the cultural competencies necessary to meaningfully address health equity, or is further board development needed?
- How can our efforts toward improving SDOH be strengthened by acting to address underlying racism and discrimination?
- What are our organizational goals for increasing provider workforce diversity and training opportunities for people of color?
- Who are the key educational and community partners who can help us to address health equity?
- Are our key community partners appropriately engaged by the academic health system when potentially affected by strategic or operational decisions?

Unfortunately, in the current workforce, diversity among physicians is limited. Given that, an organization may make a commitment to its medical school affiliates that it will expand training opportunities for the next generation of diverse providers. For example, teaching hospitals may offer priority access to clerkship opportunities or participate in focused recruiting at medical schools that have expressed a commitment to training underrepresented minority students. Organizational awareness of barriers in the provider workforce pipeline can grow when the organization addresses a SDOH need. These barriers are rooted in systemic and institutional racism and require action among various stakeholders to remedy.

Another way of improving health equity at the intersection of SDOH and RHE is through housing. In this example, a health system connects patients experiencing homelessness or housing insecurity to public housing. Public housing meets the social need for safe and affordable housing, and health outcomes improve slightly, but a fundamental inequity still exists. Through an RHE lens, it becomes clear that historical policies, such as redlining (defined as "the illegal practice of refusing to offer credit or insurance in a particular community on a discriminatory basis"), has contributed to housing instability.[5]

5 "Redlining" definition, *Merriam-Webster's Collegiate Dictionary*.

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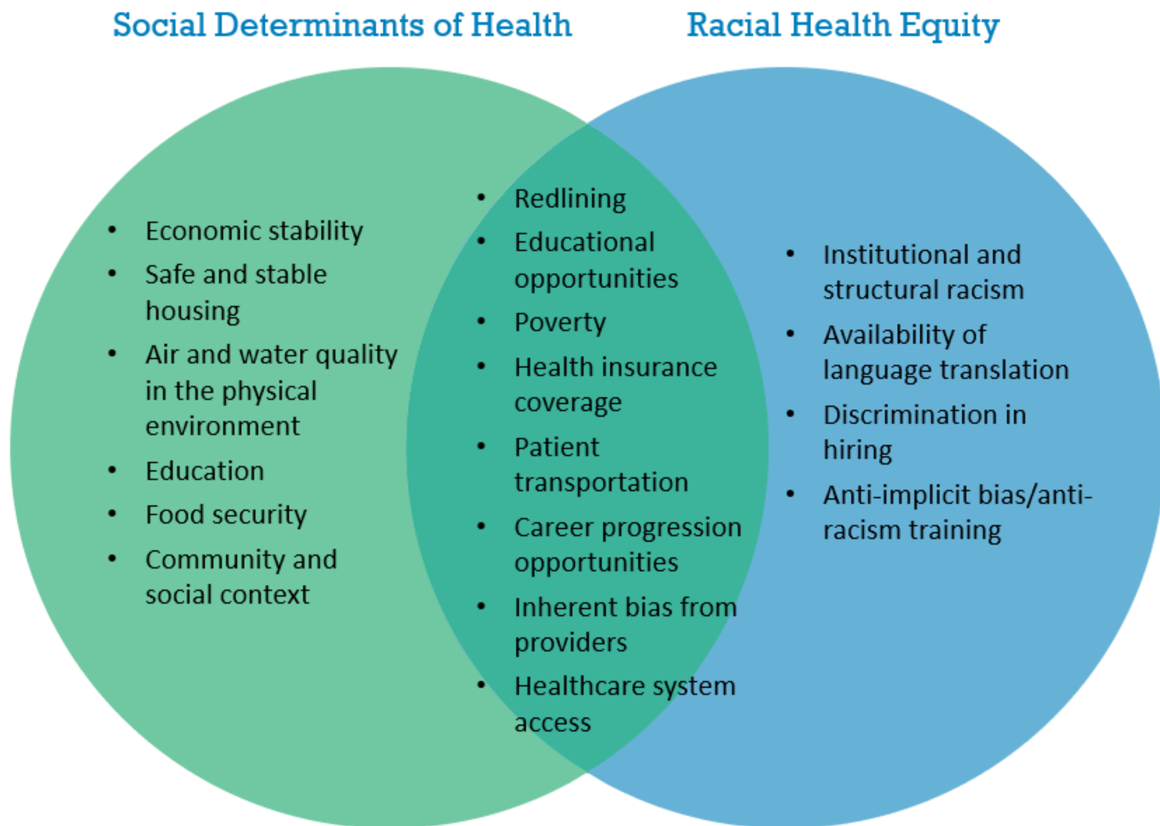
Exhibit 3: SDOH and RHE Are Not Separate but Distinct



While the racist policies that once prevented Black Americans from purchasing homes in economically viable and environmentally safe communities are gone, their legacy continues. Academic health systems and teaching hospitals that recognize this can deploy mobile care units, develop greenspace in partnership with the community, and pursue other remedies for the damage redlining has done.

At the extreme, SDOH interventions alone can be viewed as Band-Aid solutions. Alternatively, addressing SDOH and RHE together leads to better solutions. **Exhibit 3** illustrates the issues that are distinctly SDOH or RHE and those that overlap.

Increasing Diversity Through Training Programs

The Liaison Committee on Medical Education (LCME), which accredits allopathic medical schools, includes several accreditation standards related to cultural competence, disparities, and diversity in a medical school setting (i.e., undergraduate

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medical education [UME]). Additionally, the Accreditation Council for Graduate Medical Education (ACGME), the accrediting body for graduate medical education (GME) training programs, has placed increasing importance on DEI within residency programs.[6] The ACGME revised its institutional and program requirements to include DEI as a priority. It also recently launched the ACGME Equity Matters initiative that includes asynchronous teaching modules on DEI concepts.[7] Not only do these programs mean teaching medical students, residents, and fellows DEI concepts in didactic lessons, it also means ensuring that program leaders and faculty exhibit behavior that supports a model of care that embodies these important tenets. It is important for both UME and GME programs to include a diverse and inclusive body of teachers, as it may create implicit bias in the selection of candidates and in the trainees' selection of programs if they do not feel a sense of inclusion when considering how their teachers represent different cultures, races, ethnicities, sexual orientations, and other diverse backgrounds.

To implement DEI initiatives, many academic medical centers and medical schools are developing formal infrastructure to support these activities, for example:

- The Office for Diversity in House Staff and Faculty Affairs at Vanderbilt University Medical Center was founded to "seek out, recruit, and incorporate diverse medical students into the ranks of [the hospital's] house staff program. Furthermore, this office will work collaboratively with all of [their] major departments (clinical and research) to identify potential new faculty members and department chairs."
- The University of North Carolina School of Medicine has developed the Resident Diversity Initiative to "promote minority representation in the hospital's various training programs and to support a culture that cherishes and values diversity in the hospital."

Concluding Thoughts

For academic medical centers and teaching hospitals, the tripartite mission of clinical care, research, and education is paramount. SDOH, RHE, and DEI sit at the intersection of these three missions. It is critical for the providers of the future to have the clinical skills necessary to treat their patients, and equally necessary is the ability to focus on patient-centered care. This includes the ability to consider the whole patient, including

6 "Diversity, Equity, and Inclusion," ACGME.
7 "Equity Matters," ACGME.

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their unique cultural needs, background, and past experiences. Learning patient-centered care and cultural competence begins long before trainees are independent practitioners; instead, these concepts become inherent parts of a provider's practice pattern starting on the first day of medical school and well into their training as residents and fellows. Addressing the health equity of patients, then, begins with ensuring that medical schools focus on DEI within their curricula and that teaching hospitals offer an environment in which providers are trained by a diverse and inclusive faculty who can be role models for DEI concepts.

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