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Advancing health equity through organizational change: Perspectives from health care leaders

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Background: Published literature on health care administration, management, and leadership and its impacts on health systems' programs to address health care inequities is limited, as is information about how organizations integrate health equity in their cultures, missions, and strategic plans.

Purpose: The aims of this study were to identify the key components necessary for health systems to implement systematic organizational change to promote health equity and to describe approaches organizations have implemented.

Methodology/Approach: We conducted an environmental scan to identify central principles for implementing lasting change in health systems and experts working to advance health equity through organizational change. We interviewed 19 experts in health equity and hospital executives in 2020. Using iterative thematic analysis, we identified common themes.

Results: Consistent with the literature on organizational change, interviewees described a variety of systematic approaches to change, all of which involve the following core components: (a) committed and engaged leadership; (b) integrated organizational structure; (c) commitment to quality improvement and patient safety; (d) ongoing training and education; (e) effective data collection and analytics; and (f) stakeholder communication, engagement, and collaboration.

Conclusion and Practice Implications: There is no "one-size-fits-all" approach to advancing health equity. Decisions about which components require the most attention vary depending on an organization's internal and external environment. Understanding those environments and identifying which levers will be most effective are essential. As provider organizations strive to develop more strategic and systematic approaches to addressing disparities, long-term vision and commitment are necessary to achieve sustainable organizational change.

Key words: disparities, health equity, health system, hospital, organizational change, provider

Disparities in health that exist across communities are evidence of differences in health care access and treatment, and the social conditions and physical environments in which people live. More specifically, race, ethnicity, socioeconomic status, age, sexual orientation and gender identity, disability, and geographic location are examples of characteristics that influence health outcomes (Baptiste-Roberts et al., 2017; Meade et al., 2015; Singh et al., 2017).

In 1979, the federal government released the first Healthy People initiative, a large-scale public health strategy presenting national health objectives and goals for disease prevention and health promotion among Americans (Centers for Disease Control and Prevention [CDC], 1989; Healthy People, 2020b). By 1990, the national strategy, then titled Healthy People 2000, cited disparities reduction as one of its three overarching goals (CDC, 2009). The intervening decades saw new public health problems emerge that exposed and exacerbated health disparities. Acknowledging the evolving challenges, Healthy People's improvement agenda not only retained a focus on disparities but also expanded to "eliminating disparities, achieving health equity and improving health of all groups" (Healthy People, 2020a; Koh et al., 2011).

Although Healthy People 2020 clearly articulates the twin goals of reducing disparities and achieving equity, the published literature on individual hospitals and health systems' programs to address health disparities and persistent inequities is relatively limited (Bourgois et al., 2017; Horwitz et al., 2020). Until recently, there were few examples in the literature of the approaches that hospitals and health systems have used to prioritize health equity in their institutional cultures, missions, and strategic plans, much less lessons learned. In the past 5 years, multiple organizations, including the Institute for Health Improvement and the Healthcare Anchor Network, have undertaken initiatives and developed guidance to support health systems in working to advance health equity (Ubhayakar et al., 2017; Wyatt et al., 2016). These and other efforts reflect an increasingly active role some health care organizations are taking to identify and implement strategies

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to advance health equity and address disparities. Hereinafter, we use "provider organizations" to refer to hospitals, health systems, and other provider entities delivering health care services.

The aims of this qualitative study were to identify and consider the core components necessary for provider organizations to implement systematic organizational change to address health disparities and promote health equity and to describe approaches some provider organizations have implemented. Our findings are of particular interest to local, state, and federal health care stakeholders, seeking opportunities to develop programs that support efforts to systematically and sustainably combat disparities. In addition, the COVID-19 pandemic has both exacerbated existing disparities and stimulated further discourse on the role provider organizations can and should play in addressing the multitude of factors and social contributors that influence health. The pandemic's disproportionate impact on communities of color underscores the need for swift and increased action for provider organizations to assume a role in addressing the underlying and pervasive forces driving health disparities (Artiga et al., 2020; CDC, 2020).

Theory

Transforming an organization's culture and ingraining health equity as a strategic priority necessitate organization-wide strategic and operational changes. We conducted key informant interviews with health care industry experts and individuals representing provider organizations to explore this hypothesis. We aimed to understand (a) their experience and expertise pertaining to moving beyond individual interventions to address health disparities toward implementing a systematic, coordinated, and sustainable organization-wide approach and (2) how their organizations approached embedding the concept of health equity into the entity's mission and strategy. We conducted an environmental scan to gain a better understanding of the central principles of organizational readiness when embarking on widespread, systematic change in health care and used this understanding to frame the discussions with the interviewees.

The research team identified multiple well-established change models through the environmental scan. We selected Kotter's eight-step model for leading change to guide our work given its focus on helping leaders—across industries, including health care—establish practices for creating sustained and long-lasting changes while encouraging them to think beyond a one-time change event (Kotter, 1995). To adapt Kotter's model to the advancing health equity context, we leveraged research conducted by Eckstrand et al. (2017). Eckstrand et al. conducted a review of 10 change models focused on addressing health disparities experienced by women and racially and ethnically diverse communities; they identified five core and overlapping components of these change models. Using the components that Eckstrand et al. identified and Kotter's eight-step model, we developed a novel conceptual framework for this study (see Figure 1). The core components identified in this framework were the organizing principles for the key informant interview discussion guides.

Core components necessary to implement and sustain organizational change to address health disparities and promote health equity include the following:

- *Committed and engaged leadership:* To prioritize health equity, it is critical to have dedicated leaders capable of leading the organization through change. Sustaining change requires leaders to commit financial and human resources to ongoing change efforts and to serve as champions for the transformation efforts.
- *Integrated organizational structure:* An organization must have patience for the work of integrating organization-wide change and commitment to identifying and eliminating internal silos.
- *Commitment to quality improvement (QI) and patient safety:* Both quality and safety improvement involve creating high-value and safe patient experiences across all populations. Focusing on identifying and narrowing gaps in quality and safety for different segments of a population is an important step, which can also serve to engage staff at all levels of an organization in advancing health equity.
- *Ongoing training and education:* Employees and managers often need to learn new skills and acquire a shared terminology when an organization is undergoing change. From coaching on individual self-awareness to large-scale team building activities, continuous training and education can empower staff to act on a common vision and is a vital step toward institutionalizing new approaches.
- *Effective data collection and analytics:* Building a data infrastructure to collect patient self-reported race and ethnicity data as well as information on individual social needs can help a provider organization better understand the communities it serves. Having an understanding of how to analyze patient-level data alongside contextual information on community resources and needs is important.
- *Stakeholder communication, engagement and collaboration:* Ongoing, transparent communications and collaboration across stakeholder groups—employees, patients, families, and caregivers—help identify, promote, and sustain change around new norms and behaviors within the organization. Direct connection with community stakeholders and listening to their needs lay the foundation for effective partnerships that will be instrumental in facilitating change within and outside an organization's walls.

Methods

This qualitative, exploratory study was designed to synthesize published research about organizational change with the experience of health care experts and executives to impart lessons learned. Following a scan of peer-reviewed and gray literature focused on the key components needed to implement systematic change in a health care setting, we conducted 16 key informant interviews with 19 individuals. They represented a purposive sample of experts in health equity and executives from provider organizations whose leaders were also focusing on advancing health equity.

Sample Selection

We scanned publications, news releases, reports and articles, and key organization websites to identify United States-based health system experts and provider organization executives recognized for their expertise on reducing health disparities or taking a systematic approach to advancing health equity. We defined experts as individuals with unique experiences and qualifications related to addressing health disparities and issues of health equity, including academic researchers, leaders at prominent membership organizations, and leaders at various health care organizations. Considering the experts
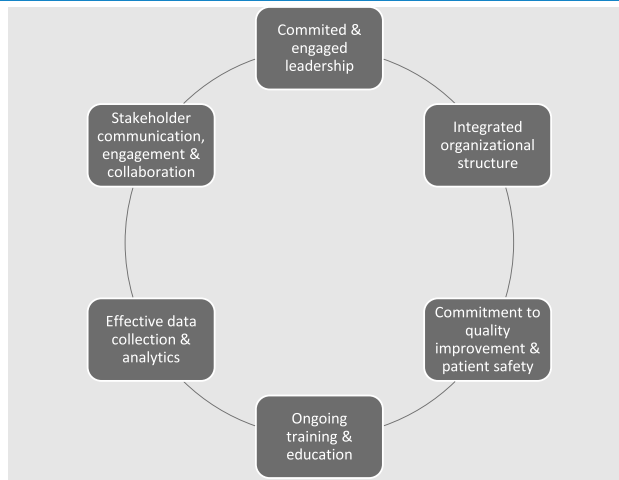
Note: This framework was adapted from Kotter's 8-step model (1995) and Eckstrand, Lunn, and Yehia (2017).

Figure 1. Advancing health equity: elements required to support change.

and provider organization leaders separately, we ranked candidates on the extent to which their individual expertise or institutional program(s) aligned with the objectives of our study. From the refined candidate list, we conducted outreach by phone and e-mail and recruited eight individual experts to participate in the study.

Concurrently, we identified provider organizations taking a systematic approach to advancing health equity. We conducted brief semistructured screening calls with individuals at the prospective provider organizations to confirm our understanding of their body of work. From the refined candidate list, we selected eight provider organizations. We conducted outreach by phone and e-mail to recruit specific individuals based on their role as leaders in advancing health equity within their organization. These provider organizations represented institutions with a diversity of organizational structures, religious and academic affiliations, geographies, sizes, and degree of integration across care settings. For example, the organizations from which we recruited leaders in equity include a 750+-bed academic medical center in the Midwest, a health system with over 20 hospitals on the East Coast, and a health system representing a 30-hospital network spanning three states in the South. The names of these organizations and the titles of their respective interviewees are provided in Table 1.

The complete sample consisted of 16 interviews with 19 individuals: 8 health care experts and 11 leaders representing eight provider organizations. Each interviewee consented to be recorded during the interview and later consented to be identified and acknowledged for their participation. Table 1 provides information about each interviewee, including their organizational affiliation. A summary of interviewees' roles is provided in Table 2.

Data Collection
We conducted a total of 16 semistructured telephone interviews during February and March 2020. Through these discussions, we explored whether the framework we developed

was suitable for understanding organizational readiness to integrate health equity and whether any additional core components or refinements to the framework were needed. We elicited interviewees' insights into the facilitators and barriers organizations encounter in their efforts to advance health equity, and we asked about tools and strategies organizations have employed to support enterprise-wide advancement of a health equity agenda.

Interviews delved into the core components crucial to implementing organizational change as organizations shift from individual and sometimes single initiative-based approaches to strategies systematically promoting equity work across the organization. The questions were structured to elicit practical insights into what components were necessary to implement organizational change and tactics the organization used to integrate health equity into its broader patient care, patient experience, quality, and safety priorities. We also asked them to reflect on the successes and challenges their teams encountered.

All interviews were led by a senior researcher who was accompanied by a second senior researcher to assist with follow-up questions. A research assistant took transcript-style notes of each discussion. Interviews were recorded and lasted 60–90 minutes. The recordings were used to finalize the interview notes, which were aggregated for analysis. We developed a database to facilitate sorting of key themes and synthesis of findings.

Data Analysis
We employed a structured thematic analysis that integrated aspects of an immersion approach (Borkan, 1999). After each interview, the research team debriefed to discuss the initial findings and identify emerging trends. Secondary analysis involved reviewing all the interview notes to identify additional themes and patterns. Subsequently, we used an iterative analytic process to further develop each theme. The team carefully considered and discussed each theme for its relevance across the interviews. As

TABLE 1: Key informant interviewees

Name of institution	Type of institution	State/ region	Interviewee title
Brigham and Women's Hospital	Academic hospital	MA	Medical Director of Quality, Safety, and Equity
Christus Health	Health system	TX	Vice President for Health Equity, Diversity and Inclusion
Johns Hopkins Health System	Health system	MD	Co-Chair, Health Equity Steering Committee
MetroHealth System	Health system	OH	President, Institute for H.O.P.E.
Northwell Health	Integrated delivery network	NY	Senior Vice President and Community Health Investment Officer
Rush University Medical Center	Academic medical center	IL	Senior Vice President for Community Health Equity
Rush University Medical Center	Academic medical center	IL	Co-Director, Center for Community Health Equity
Sutter Health	Health system	CA	Chief Medical Officer Health Equity Program Manager, Office of Patient Experience
University of Pittsburgh Medical Center	Academic medical center; health plan	PA	Program Administrator, Center for High Value Health Care Director of Government and Business Relations
Accreditation Council for Graduate Medical Education	Accreditation body	National	Chief Sponsoring Institution and Clinical Learning Environment Officer
American Hospital Association	Health care association	National	Senior Vice President and Chief Medical Officer
Association of American Medical Colleges	Health care association	National	Senior Director for Health Equity Research and Policy
Institute for Healthcare Improvement	Quality improvement institution	National	Director, Pursuing Equity Initiative
University of California San Francisco	University	National	Director, Social Interventions Research and Evaluation Network
University of Chicago and Robert Wood Johnson Foundation	University; philanthropy	National	Quality Improvement and Care Transformation Strategist, Department of Diversity, Inclusion and Equity, University of Chicago Medicine and Biological Sciences Co-Director, Advancing Health Equity: Leading Care, Payment, and Systems Transformation
University of Michigan	University; policy center	National	Director, Institute for Healthcare Policy and Innovation
University of Wisconsin	University; policy center	National	Professor, School of Medicine and Public Health Director, Center for Health Disparities Research

needed, we returned to the primary data to verify or better understand the subject matter.

Results

The six components in our study framework were confirmed by experts and provider organization executives alike as the core components an organization needs to have in place in order to implement systematic change to address health disparities and advance health equity. Our analysis of the discussions with the interviewees did not elucidate different core components to integrate into the framework. The approaches and lessons learned that the interviewees associated with prioritizing health equity in their institutional culture, missions, and strategic plans offer meaningful additions to the literature.

Advancing Health Equity Requires Leadership Commitment and Resources

All but one executive with whom we spoke asserted that institutionalizing a "culture of equity" means leaders at the highest level (i.e., the C-suite) must be dedicated to ensuring that equity-focused values are integrated into all aspects of provider organization operations. The one "outlier" interviewee

TABLE 2: Distribution of interviewees by role	
Distribution of interviewees by role	**n**
Senior executive or physician leader at provider organization	7
Project director/program manager at provider organization	3
Other leadership role at provider organization	1
Expert at academic or research institution	4
Expert at quality improvement institution	1
Expert at accreditation body	1
Expert at national health care association	2
Total interviewees (some interviewed together)	*19*

reaffirmed leaders' essential role in articulating equity as an organizational priority, though this executive asserted that having the support of key patient safety and QI leaders and a chief medical officer can be sufficient to bring about significant and positive change. Interviewees also noted that a hallmark of engaged leadership is supporting strategic priorities with the necessary financial resources, infrastructure, and staff to systematically advance programs and activities that align with the stated goals.

Integrated Organizational Structure and Accountability

Most interviewees emphasized the importance of building and supporting processes that actively facilitate integration of equity work into a provider organization's existing workflows; doing so can mitigate resistance to broader organizational change. They cautioned that, in any provider organization, there is a risk of unintentionally limiting equity-focused work to designated departments or entities at the expense of fostering a broader culture of equity and a sense of joint responsibility throughout the organization.

Most of the individuals we interviewed in provider organizations have an office of diversity and inclusion and/or an office focused on health equity; in some instances, these organizations also have separate offices focused on community-facing activities. Based on their firsthand experience, interviewees emphasized the need for integration of equity work across functional departments, such as patient safety, quality, population health, communications, and clinical leadership (e.g., nursing and emergency departments). Broad, cross-cutting work promotes collaboration within the organization while also reducing the fragmentation associated with having separate, uncoordinated equity initiatives underway within the organization. Breaking down "silos of excellence" within a mission-driven organization also mitigates barriers to advancing an organization-wide culture of equity.

Governance structures designed to support health equity can bolster a provider organization's focus and accountability and, at the same time, encourage integration across divisions and departments. Such mechanisms are particularly significant given that provider organizations' health equity programs often span different functions of the organization, including academic and research arms, population health, and community outreach. Executives we interviewed described different types of oversight and governance structures that were designed to create accountability and ascertain progress toward meeting goals. One large provider organization requires that each of its divisions, including its health plan, reports to a community-facing inclusion board. As part of its organizational change strategy, another provider organization established a health equity committee of leaders from its medical divisions, QI, nursing, administration, and one of its major community health centers to provide direction and ensure accountability. A third provider organization created a center for health equity that included a research arm, as well as a health equity steering committee, to guide the entire organization's work.

Culture Change Through QI and Patient Safety

Multiple interviewees affirmed that, for organizations with quality as a core value, embedding health equity work within the QI and patient safety structure is a "natural fit" and promotes a systematic rather than an episodic approach to advancing equity. Health care experts and executives described two organizational prerequisites for integrating equity with QI: a strong QI infrastructure and an effective quality and safety team. Organizations with these resources have opportunities to identify disparities and inequities in the context of QI and patient safety. One interviewee advised that hospitals should stratify their QI and safety results by patient race, ethnicity, geography, and socioeconomic factors to ensure that health disparities are not overlooked.

Ongoing Health Equity Training and Education

Interviewees emphasized the role of training in developing the skills necessary not only to deliver culturally competent care but to engage in discussions about sensitive and sometimes difficult topics related to health equity. Absent this education, it is challenging for clinicians and health care staff to discuss, for example, the influence of implicit and explicit systemic issues and biases on health disparities. Interviewees advised that staff members' own experiences with institutional inequities, including systemic racism, have potential to undermine the credibility and effectiveness of efforts to foster the cultural and organizational components required for successful change if not acknowledged directly and thoughtfully. Executives described ongoing work in their organizations inherent to cultivating the courage and willingness to engage in discussions about individual and organizational biases. The interviewees specified that efforts to create a culture of openness to discuss health disparities and to affect culture change must be iterative and continual, rather than episodic. Executives noted that their respective organizations' work has evolved and acknowledged that there is still much to learn. All concurred that integrating equity values into provider organizations' culture, strategies, and business and clinical practices is

an endeavor that requires an extended time horizon and dedication to ongoing training.

Several provider organization leaders described ongoing training and education initiatives to teach staff about examining the patient care experience through an equity lens. Leaders explained educational opportunities as having dual goals: (a) to initiate an internal dialogue about how the organization is working to advance equity for their patients and identify opportunities for improvement and (b) to better understand how well the organization is serving the community.

Investing in Data Collection and Analysis

All of the provider organization leaders we interviewed emphasized the importance of capturing granular, patient-reported demographic data at the point of care and the need for ongoing monitoring through data analysis. However, some interviewees tempered their emphasis on data collection. They cautioned against the inclination to continually collect and analyze data at the expense of taking action and suggested that provider organizations take a more intentional approach to data analysis. Interviewees postulated that answering the questions "What is the organization trying to achieve?" and "What measures are the most meaningful?" should precede efforts to conduct analyses just because data are available. An interviewee offered the example of an organization that stratifies every quality measure and asked rhetorically whether this effort provided meaningful information.

Multiple leaders at provider organizations emphasized the value of investing in the ability to collect data on race, ethnicity, and language (REAL) through an electronic health record system. Most leaders also indicated that they still have a significant amount of work ahead to improve this type of data collection, noting that implementation of effective data collection mechanisms can take 5 years or more.

Recognizing the impact of social factors on patients' ability to access and use health care services effectively, many of the experts and provider organization interviewees also described how provider organizations have begun to collect information about individual patients' social needs (e.g., housing, transportation, access to food, and ability to pay for prescriptions). Provider organizations have developed different tools and approaches for collecting and responding to these data, and several interviewees noted challenges related to patient mistrust, leading to data collection difficulties. Patients often do not understand why an organization is asking for information about their social needs and may be reluctant to disclose it depending on how the inquiry is made. Moreover, although some hospitals collect REAL and social needs data through their electronic health record systems and make referrals to community organizations that aim to address specific social needs, fragmentation and duplication within and across provider organizations persist. Several interviewees also pointed out that, once social needs are identified, "closing the loop" to determine if a patient's social needs are successfully addressed remains challenging. Data on the outcomes of social needs referrals can shed light on whether linkages are being made to organizations with the capacity to address the identified needs.

In addition to understanding social needs at the individual patient level, all interviewees discussed the importance of provider organizations understanding the broader hardships experienced within their communities. This entails assessing how social determinants of health (SDOH), which include structural and economic factors, impact the organization's ability to provide equitable care. Interviewees emphasized the value of obtaining local input on issues related to housing, transportation, and food security, as well as other social contributors that influence health disparities. Gathering data about the context and needs of the communities around the provider organization is especially important not only as part of a community health needs assessment but also for leveraging resources and relationships to address SDOH.

Interviewees described several challenges associated with data use in counterpoint to significant efforts to spur organizational transformation aimed at advancing health equity. Difficulties with data collection and limited or no systems interoperability across entities within provider organizations were among the most prevalent obstacles mentioned. Specifically, consistency, accuracy, and completeness of data elements collected by individual hospitals and providers remain an elusive goal for provider organizations. Interviewees described a lack of interoperability of information systems within larger provider organizations as an ongoing challenge. Several interviewees also noted that the lack of common data collection standards across states and the lack of requirements in hospital accreditation systems to ensure an equity lens is incorporated into quality and safety plans limit the incentives for provider organizations to address data barriers. Interviewees also remarked that implementing population health interventions and aggregating data at the population level without first considering the needs of certain subpopulations can be problematic. Interventions that are not appropriately tailored can exacerbate rather than narrow the disparities gap for segments of the population, despite yielding improvements for majority populations.

Stakeholder Communication, Engagement, and Collaboration

Stakeholder engagement was described by interviewees as a principal component of any provider organization's approach to advancing health equity. All those we interviewed emphasized the importance of engaging employees throughout the organization, as well as patients and community partners to holistically identify and address disparities.

Capturing patient perspectives, experiences, and knowledge was viewed as essential to informing an organization's decisions about how resources are allocated. Experts and executives described patients as active agents of change for organizations via patient advisory councils and community boards and asserted that patients should not be viewed simply as the targets of enhanced health services and care delivery models.

All of the provider organization leaders we interviewed articulated the importance of fostering partnerships with organizations in their respective communities. Interviewees

emphasized the concept of "looking at the provider organization through a community lens" rather than vice versa; some leaders use this principle to prioritize organizational resources internally and leverage community investments. External partnerships described by interviewees included local government agencies, coalitions, and community-based organizations. As one executive maintained, an organization's population health strategy must be aligned with the community's concerns in order to positively change public health outcomes.

Discussion and Practice Implications

In order to determine ways to intervene on disparities and promote equity, provider organizations must first commit to better understanding the differences in the care provided to their patient population and subpopulations, and their health outcomes. However, provider organizations are at different stages in the process of recognizing, understanding, and addressing health disparities and promoting health equity. Some provider organizations, such as those discussed in this article, are at more mature phases in the change process and have learned valuable lessons and developed strategies that organizations at earlier stages can adapt and adopt. Although there is no "one-size-fits-all" approach to this work, insights from the interviews we conducted offer actionable strategies that shed light on where provider organizations could invest their energies and resources to begin to more systematically implement changes that advance health equity. Health care leaders emphasized that there are different pathways organizations can take to systematically advance health equity; the optimal pathway depends on the specific needs and resources of the organization and the community it serves. All of the pathways, however, require a provider organization to take a broad view of their community and SDOH, understand and leverage their role as an economic engine of the community, and empower staff to use QI processes. Improving collection and analysis of self-reported (REAL and social needs) data, as well as information on neighborhood needs and resources, is a starting point.

In addition, oversight organizations play a key role in monitoring how provider organizations progress toward meeting expectations that are required by regulators. By working with policymakers, these entities could support policies requiring enhanced and more consistent data collection and stratified quality reporting so that provider organizations become aware of and address disparities in care delivery and outcomes. Policies could also be designed to encourage provider organizations to more effectively leverage community benefit dollars, for example, by coordinating the provider organization's efforts with broader neighborhood, community, and regional improvement planning. Developing consistent expectations and standards across oversight organizations, coupled with federal and state policies, would facilitate the work of creating the lasting change necessary to address health disparities and achieve health equity.

Although the team identified a diverse group of provider organizations, leaders, and experts focusing on advancing health equity and organizational change, the study results are limited by the small number of interviews. The identification

of potential respondents was limited by the availability of public data. It is plausible that qualified organizations and interviewees were not considered because of an absence of publicly available information about their efforts and that another cohort of provider organizations with different cultural and organizational characteristics could yield somewhat different themes. The results of this study reflect these, and the other inherent limitations associated with a limited set of qualitative interviews.

Although our findings are based on a limited sample, they nonetheless offer important insights. We ensured representation of individuals with different professional backgrounds whose institutions serve different geographies and represent a range of organizational structures. Future research with a larger sample may illuminate additional key components required to support organizational change and explore the value proposition for provider organizations to conduct and sustain work in advancing health equity.

Although systematic, coordinated approaches to reducing health disparities remain nascent in many provider organizations, the national dialogue around social justice issues and the further disparities highlighted by the COVID-19 global pandemic serve to magnify the need for provider organizations to adopt a systematic approach as they work to achieve the promise of high-value, equitable, and safe health care for all.

References

Artiga, S., Garfield, R., Orgera, K. (2020). *Communities of color at higher risk for health and economic challenges due to COVID-19*. Retrieved April 7, 2020, from https://www.kff.org/disparities-policy/issue-brief/communities-of-color-at-higher-risk-for-health-and-economic-challenges-due-to-covid-19/

Baptiste-Roberts, K., Oranuba, E., Werts, N., Edwards, L. V. (2017). Addressing health care disparities among sexual minorities. *Obstetrics and Gynecology Clinics of North America*, 44(1), 71–80.

Borkan, J. (1999). Immersion/crystallization. In Crabtree, B. F., Miller, W. L. (Eds.), *Doing qualitative research* (pp. 179–194). Sage.

Bourgois, P., Holmes, S. M., Sue, K., Quesada, J. (2017). Structural vulnerability: Operationalizing the concept to address health disparities in clinical care. *Academic Medicine: Journal of the Association of American Medical Colleges*, 92(3), 299–307.

Centers for Disease Control and Prevention. (1989). *Health objectives for the nation*. Retrieved June 22, 2020, from https://www.cdc.gov/mmwr/preview/mmwrhtml/00001462.htm

Centers for Disease Control and Prevention. (2009). *Healthy People 2000 review, 1995–96 shows progress in almost half of objectives*. Retrieved June 22, 2020, from https://www.cdc.gov/nchs/pressroom/96facts/hp2knchs.htm

Centers for Disease Control and Prevention. (2020). *COVID-19 in racial and ethnic minority groups*. Retrieved August 9, 2021, from https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html

Eckstrand, K. L., Lunn, M. R., Yehia, B. R. (2017). Applying organizational change to promote lesbian, gay, bisexual, and transgender inclusion and reduce health disparities. *LGBT Health*, 4(3), 174–180.

Healthy People. (2020a). *Foundation health measures archive: Disparities*. Retrieved June 22, 2020, from https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

Healthy People. (2020b). *History & development of healthy people*. Retrieved June 22, 2020, from https://www.healthypeople.gov/2020/About-Healthy-People/History-Development-Healthy-People-2020

Horwitz, L. I., Chang, C., Arcilla, H. N., Knickman, J. R. (2020). Quantifying health systems' investment in social determinants of health, by sector, 2017–19. *Health Affairs*, 39(2), 192–198.

Koh, H. K., Piotrowski, J. J., Kumanyika, S., Fielding, J. E. (2011). Healthy People: A 2020 vision for the social determinants approach. *Health Education & Behavior*, 38(6), 551–557.

Kotter, J. P. (1995). Leading change: Why transformation efforts fail. *Harvard Business Review*. Retrieved on June 22, 2020, from https://hbr.org/1995/05/leading-change-why-transformation-efforts-fail-2

Meade, M. A., Mahmoudi, E., Lee, S. Y. (2015). The intersection of disability and healthcare disparities: A conceptual framework. *Disability and Rehabilitation*, 37(7), 632–641.

Singh, G. K., Daus, G. P., Allender, M., Ramey, C. T., Martin, E. K., Perry, C., Reyes, A. A. L., Vedamuthu, I. P. (2017). Social determinants of health in the United States: Addressing major health inequality trends for the nation, 1935–2016. *International Journal of MCH and AIDS*, 6(2), 139–164.

Ubhayakar, S., Capeless, M., Owens, R., Snorrason, K., Zuckerman, D. (2017). *Anchor mission playbook*. Rush University Medical Center and The Democracy Collaborative. https://healthcareanchor.network/2019/11/the-anchor-mission-playbook/

Wyatt, R., Laderman, M., Botwinick, L., Mate, K., Whittington, J. (2016). *Achieving health equity: A guide for health care organizations*. Institute for Healthcare Improvement. (Available at ihi.org)