Illuminating Invisible Inequities in Healthcare

Methods for Measuring and Combating Implicit Racial Bias

Authored by GLG Network Members

Amanda Canning, *Coauthor* Audrey McIntyre, *Coauthor* Lisa Harrison, *Panel Moderator*

Insights with Impact

Sponsored by GLG Social Impact, GLG Qualitative, and GLG Institute

I. INTRODUCTION

The coronavirus pandemic has shed a grim light on racial inequities in the healthcare system. As of June 2021, the U.S. Centers for Disease Control and Prevention reported that Black, LatinX, and Native Americans died of COVID-19 at more than double the rate of white Americans.[1] While this disparity is well documented, it is less clear what actions individuals and organizations can take to change things for the better.

As the World's Insight Network, GLG believes that the first step to solving a complex challenge is to gather the right expertise. Through our social impact program, we have connected experts with nonprofit organizations working on the front lines of COVID-19 relief and the fight for racial equity, providing crucial and timely insights pro bono. In 2020 alone, GLG supported more than 135 organizations in more than 40 countries, which collectively reach more than 100M people.

When it comes to racial inequities, healthcare organizations play an important role, but the problem is complex, and taking the initial steps toward a solution can be daunting. That is why GLG assembled a panel of experts to identify concrete steps healthcare institutions can implement to better measure and fight unconscious racial bias within their organizations. These experts had different backgrounds and experiences but shared a common vision for a more equitable future in healthcare. Their collective guidance on how to achieve that vision is captured here.

1. U.S. Centers for Disease Control and Prevention, Risk for COVID-19 Infection, Hospitalization, and Death By Race/Ethnicity (available **here**)

A. Methodology

On May 27-29, 2021, GLG hosted a three-day asynchronous virtual, written panel discussion, bringing together ten experts from across the healthcare industry:

- **Juliette Blount**, MSN, NP, Nurse Practitioner / Health Equity Speaker
- **Melva Thompson-Robinson**, DrPH, Professor of Social and Behavioral Health in the School of Public Health at the University of Nevada, Las Vegas
- **Willetta Shepherd Rucker**, JD, Independent DE&I consultant, former Head of Diversity and HR for the Houston Market at JPMorgan Chase Bank
- **Helene Clayton-Jeter**, OD, Optometrist/Founder/CEO of HealthScape LifeSciences, LLC, Professor of Health Policy and Management, NYU Robert F. Wagner School of Public Service, former National Health Equity Director, Boston Scientific, former CELP Director in the US FDA Commissioner's Office
- **Charlene Frizzera**, President of CF Health Advisors and former Acting Administrator of the Centers for Medicare and Medicaid Services
- **Preeti Kanodia**, MHS, former Director of Development at USCRI, former Senior Advisor at HRSA
- **Ekta Saroha**, MA, DrPH, former Country Lead, ASCEND project, New Delhi, India
- **Eve Higginbotham**, SM, MD, ML, Vice Dean for Inclusion, Diversity, and Equity and Professor of Opthalmology at the Perelman School of Medicine at the University of Pennsylvania
- DE&I Director at an American professional services firm
- Chief People and Diversity Officer at a regional healthcare network

This paper reflects the perspectives of the panelists on the topic of measuring and combating implicit racial bias in healthcare. After offering their perspectives, panelists could see others' responses and engage directly with one another to enhance dialogue and strengthen understanding.

B. Context

Although there are multiple drivers of racial disparities in health outcomes, many of which were identified by panelists, this conversation focused on implicit racial bias. Implicit bias can be defined as "attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner" (Juliette Blount). It is a basic component of human behavior that all people exhibit, forged by the unique circumstances of who we are (and are not) exposed to over the course of our lives and the unconscious conclusions we draw from those exposures. In other words, implicit bias is not a value statement about a person's goodness, nor a result of bad intent.

Nonetheless, the consequences of implicit bias, particularly in the delivery of healthcare, can be fatal. "If healthcare providers hold stereotypes about people of color — e.g., Black or Brown means the patient is therefore on Medicaid, drug seeking, malingering, has a high pain tolerance, etc. — they may miss important signs and symptoms of life-threatening conditions or be less likely to order necessary tests or procedures based on these beliefs" (Blount).

There is already significant evidence proving the existence of implicit bias and its negative impacts, but there are few tools or guides for organizations looking to do something about it. Over the course of the panel discussion, the experts sketched a roadmap leaders can follow to diagnose, measure, and mitigate the effects of racial bias on clinical treatment decisions and health outcomes. As one panelist stated, "If systems are given a road map of where to start and what to do, this important work will be normalized, made less shameful, and we will actually start to make some progress toward meaningful change" (Blount).

II. LEADERSHIP: MODELING CHANGE

While the panel discussion focused on measurement and training, the panelists repeatedly widened their lenses, echoing a consistent refrain: "Ownership and buy-in start with leadership" (Blount).

Panelists believe that a proactive and sincere commitment on the part of senior leadership is essential in propagating cultural change through to the individual provider and patient levels. To some extent, this is necessary to rebuild trust eroded by purely optics-focused initiatives put in place by some institutions, and the resulting cultural malaise. As a starting point, panelists encouraged leaders to refocus on the mission of healthcare itself, i.e., providing for the health of all humans. From that place, the system "can regain the trust needed to actively participate in patients' healthcare journey" (Charlene Frizzera).

It is also critical for senior leaders to role-model the behavior and cultural norms required to effect change. Panelists encouraged leaders to use their stature and authority to acknowledge the pervasiveness of the issue, normalize racial justice vocabulary, and ensure these issues remain in the spotlight. "Leaders need to be the example of what they expect to see in their employees" (Blount). This also includes humbly acknowledging they are still on their own self-awareness journeys. "It's important for leaders to begin this endeavor without assuming they a) know the full scope of the problem, or b) the solution" (Preeti Kanodia).

Finally, leaders should take great care in whom they select to lead racial equity initiatives. These individuals should embody diversity, exhibit competence about racism, bias, and discrimination, demonstrate personal investment in the issue, possess ample energy and passion, and carry sufficient organizational authority to drive impact. Assembling and empowering the right leaders is a critical first step, enhancing the effectiveness of the following recommendations on measurement, education, and accountability.

III. MEASUREMENT: ESTABLISHING A BASELINE

A. Why Measurement Is Important

Like any other business objective, making progress on racial equity requires measurement to diagnose issues and track progress. As the saying goes, "what gets measured gets managed." From a diagnostic perspective, this is particularly important given the unconscious and invisible nature of the way bias operates: "When biases are unconscious, the person can't correct without being told" (Willetta Shepherd Rucker). Data and identification of trends are also critical to validate concerns and focus resources on solutions.

Though several academic studies have aimed to measure levels of bias and its impact on patients (see Implicit Bias Measurement Approaches, below), best practices for measuring racial bias in real-world healthcare contexts have not been well established. This section aims to summarize recommendations from our expert panel considering the existing resources and knowledge about racial bias and the limitations thereof.

Panelists emphasized two key principles for designing measurement strategies for implicit bias. First, measurement needs to happen at both the institutional and individual provider levels. Just as we cannot assume providers are aware of their unconscious bias and how it impacts their patients, we cannot assume a hospital or larger medical system is aware. As highlighted in the previous section, measurement and accountability start with leadership before they can be implemented at the provider level. Acknowledging that the extent of racial bias within an institution is not well understood is a strong first step to designing a thoughtful measurement strategy.

Second, the expert panelists emphasized the importance of collecting both quantitative and qualitative data. There are limits to what can be measured quantitatively, and metrics don't always capture the full scope and depth of any issue. Qualitative inputs (e.g., from patient surveys) are important to surface information that may not yet be known, to provide context and nuance that cannot be captured in metrics, and to underscore the inherent importance of the patient experience in improving quality of care.[2]

Implicit Bias Measurement Approaches found in Academic Literature

1 Measurement of implicit attitudes

- **Implicit Association Test (IAT)** — This is the most widely known and validated tool for assessing implicit bias across both race and gender
- Other methods include the Assumption Method, Sequential Priming, virtual reality simulation tools, and self-reported surveys (more relevant for explicit bias)

2 Measurement of patient-provider interaction quality & differences by race

- **Subjective assessments: patient self-reports (surveys)** — In reviewed studies, patients rated providers on dimensions such as verbal effectiveness, supportive communication, and satisfaction/confidence in recommended treatments
- **Objective assessments: evaluation against objective criteria** — Metrics from reviewed studies include number of questions asked of patient, time spent talking vs. listening, use of anxiety-related words, and various others (Note: This may be more feasible in research settings than in real-world conditions)

3 Measurement of outcomes & differences by race

- **Provider treatment decisions** — e.g., number and type of tests ordered or recommended treatments for a particular condition
- **Patient outcomes** — e.g., treatment adherence, hospital readmission rate, recovery rate

Note: Metrics need to be disease or condition-specific to be meaningful

In the research, metrics are often used in combination — e.g., correlating IAT scores with metrics from areas 2 & 3

Source: GLG review of published studies on implicit racial bias in the delivery of healthcare, including the following articles: 1) *A decade of studying implicit racial/ethnic bias in healthcare providers using the implicit association test*, Maina et al. 2017. 2) *Implicit bias in healthcare professionals: a systematic review*, Fitzgerald & Hurst, 2017. 3) *Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review*, Hall et al. 2015. 4) *A Systematic Review of the Extent and Measurement of Healthcare Provider Racism*, Paradies et al. 2013. 5) *Detecting implicit racial bias in provider communication behaviors to reduce disparities in healthcare: Challenges, solutions, and future directions for provider communication training*, Hagiwara et al. 2019.

B. Measurement Recommendations

1. THE IMPLICIT ASSOCIATION TEST

There is no perfect way to measure the presence and impact of implicit racial bias. The most commonly cited and well-validated tool for assessing the presence of bias at the individual level is the Implicit Association Test (IAT), a psychological test that measures the latency of response time when pairing race-related images.[3] However, IAT results tend not to meet scientific confidence levels for reliability and validity, making it an inappropriate diagnostic tool. As such, many experts believe the IAT is most appropriately used as a tool for introspection and self-reflection within a broader education and training program.[4] Used in this context, the IAT can help individuals understand where they may unknowingly harbor bias, though it is critical that administrators protect participant confidentiality.

Another limitation of the IAT within healthcare is that, even if it did precisely measure biased attitudes, it does not prove that those attitudes affect the quality of patient care. For example, some panelists noted that certain areas of healthcare may be more susceptible to the impact of racial bias, including where treatment plans are more subjective and less standardized. There also may be differences among providers in the degree to which biased attitudes translate to behavioral differences that are harmful, as opposed to differences that may be neutral or even be perceived as more culturally competent.

For these reasons, panelists highlighted other approaches to assessing the impact of bias, emphasizing the importance of using multiple methods.

2. TREATMENT DECISIONS AND HEALTH OUTCOMES

The analysis of patient outcomes and how they vary across racial groups is key to diagnosing broader issues of racial inequity in healthcare. These metrics could include, for example, morbidity/mortality rates, rates of hospital readmission, rates of undergoing certain procedures, number and type of diagnostic tests ordered, medicines prescribed, etc.

These metrics would need to be designed with particular disease groups in mind, as meaningful comparisons around treatment decisions and clinical outcomes can be made only when comparing patients presenting similar conditions (except when measuring standards for preventive care, e.g., rates of screenings for colon cancer). This creates some complexity in metric design and analysis and highlights the need to involve a variety of specialist clinicians in the design of measurement strategies. This also highlights the importance of ensuring patient data and records are created in a way that allows for analyzing aggregate trends in a streamlined way (e.g., patient chart reviews using electronic medical records, Patient-Reported Outcome Measures (PROM) collected via patient surveys).

2. Panelists pointed out that current systems of measurement are flawed in that they tend to focus only on numbers and perceive the lived experience of marginalized populations to be less important or less valid. With a charged subject like race, racism, and bias, it is especially important to capture both quantitative and qualitative data.
3. "The IAT requires participants to rapidly pair two social groups with either positive or negative attributes. In the race IAT, participants pair photos of Black and white faces with good or bad words like *pleasure* or *agony*. Depending on the latency in response time and frequency of errors, the IAT measures the strength of association of each pairing such that more strongly associated categories are easier to pair, reflected by faster responses and fewer errors. For example, participants who categorize white faces with positive words more quickly and with fewer errors than when categorizing Black faces have an implicit pro-white bias." Social Science and Medicine, "A decade of studying implicit racial/ethnic bias in healthcare providers using the implicit association test." (available **here**)
4. Some panelists advocated for collecting anonymized IAT scores across an organization, department, or job type as an organizational accountability metric (see Taking Action below), particularly if used to assess effectiveness of interventions over time.

Example measurements

Provider treatment decisions: what tests are ordered, what drugs and procedures are prescribed

Patient outcomes: morbidity/mortality, adherence to treatment, hospital readmissions

All panelists emphasized the importance of health outcomes as the ultimate metric of success vis-a-vis racial equity and quality of care. In addition, outcome metrics provide the most objective evidence of racial disparities, and therefore can help drive alignment and buy-in about the extent of structural racism and the importance of addressing it (e.g., to motivate provider participation in racial equity initiatives). This type of measurement is also the most feasible in real-world healthcare settings because of the ease of data collection and analysis.

However, this category of metrics provides evidence only for outcomes rather than for their root causes. As previously discussed, racial disparities identified could be driven by myriad factors unrelated to (or in addition to) implicit bias — for example, health insurance status or other social determinants of health. As stressed by Dr. Thompson-Robinson, "Where huge discrepancies are identified, further assessment needs to be done to determine if there are other factors at play that may have an impact, such as insurance coverage."

3. THE PATIENT EXPERIENCE

There is significant evidence from peer-reviewed literature, and validated by our expert panelists, that implicit racial bias affects the quality of patient-provider interactions, and concomitant patient outcomes. Panelists offered a number of real-world examples of how this happens in healthcare settings.

- The provider does not offer the best options (for diagnosis and/or treatment) due to assumptions about the patient (e.g., the patient will be noncompliant, will not come to their appointments, may be on Medicaid, etc.).
- The patient experiences disrespect or lack of comfort with the provider (e.g., in the form of scolding, lecturing, judging, not being taken seriously) that discourages them from adhering to recommendations and/or from seeking healthcare in the future.
- The provider engages in a less thorough or collaborative discussion with the patient, leading to a less robust understanding of the patient's condition and less informed decisions about treatment.

Though ultimate outcomes may be more clearly detectable through the types of metrics discussed above, direct assessments of patient-provider interactions are useful in better understanding the degree to which provider bias may be playing a role.[5] For example, short electronic post-visit surveys can be given to patients about their interaction with the provider and overall health system to assess the quality of their experience and any negative perceptions. This can include questions to assess their perceptions of being treated with respect, likelihood of returning to the same provider, and whether they were given clear explanations about their condition and treatment options. In addition to providing a more direct (though still imperfect) indication of potential bias, this approach also emphasizes the importance and effectiveness of patient-centered care.[6]

Like outcome metrics, the results of patient survey data also need to be interpreted with care before drawing conclusions. Patient surveys are often based on what is expected as opposed to what the healthcare provider can or should do. Additionally, data would also need to be assessed for over-inflation of negative feedback given that there may be selection bias in who is motivated to report after a provider visit.

4. BUILD ON EXISTING DATA SYSTEMS

Healthcare organizations already have systems to capture patient outcome data, and most likely systems to conduct patient surveys as well. Panelists noted that organizations should build on these existing data systems when designing strategies for measuring the impact of bias.

For example, healthcare systems already use electronic medical records, and any systems receiving federal funding already have data reporting requirements (e.g., from U.S. Centers for Medicare & Medicaid Services, U.S. Health Resources and Services Administration, etc.). Measurement standards and tools created by organizations like U.S. Agency for Healthcare Research and Quality and the Joint Commission on Accreditation of Healthcare Organizations can be leveraged. Post-visit patient surveys can also be built upon to incorporate elements that address bias and culturally competent care.[7]

Healthcare systems may be further along than expected in developing the measurement systems to support a racial equity initiative. One approach would be to start by analyzing existing data to create a baseline — and determine what is and/or is not possible within current data collection — before making changes to the systems in place. Upon identifying patterns and issues, surveys and qualitative methods can then be used for in-depth examination of these issues and improvements can be made to broader electronic systems for capturing additional patient data.

5. To the knowledge of panelists, there are no standardized tools for this purpose; however, many examples of approaches exist in academic literature and through organizations that specialize in measuring quality of care. See resources list below for more information.
6. The panelists also stressed the importance of designing patient surveys in consultation with both providers and community members to address the specific needs of patient populations (e.g., translation services for non-English speakers, sensitivity to conditions prevalent in certain communities).
7. See *Relevant Resources Cited by Panelists* below for a list of organizations, measurement standards, and tools as relevant to data systems design.

It is also important to ensure that current processes for collecting race, ethnicity, ancestral, and language (REAL) data are thorough and consistent as well as appropriately designed to capture relevant categories. One panelist noted that the "collection of race/ethnicity data has improved with COVID, but has generally been inconsistent" (Blount). Others emphasized that the way racial categories are currently defined (e.g., by the U.S. government) is limited and may not include all distinctions that are relevant for a particular healthcare system[8] (Ekta Saroha). The design of a measurement strategy should ensure that patient demographic data is captured in a way that appropriately reflects the communities being served, and that any patient concerns around disclosing their racial identity are appropriately addressed (e.g., disclosing confidentiality and anti-discrimination policies, communicating goals around racial equity).

Relevant Resources Cited By Panelists

Panelists cited several resources and existing agencies that health systems can draw from when designing measurement strategies

U.S. Health Resources and Services Administration (HRSA)

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

Intercultural Development Inventory (IDI)[9]

Diversity Engagement **Survey**

U.S. Agency for Healthcare Research and Quality (AHRQ)

U.S. Department of Health and Human Services, Office of Minority Health, National Culturally and Linguistically Appropriate Services (CLAS) standards

National Quality Forum (NQF)[10]

8. There was disagreement among panelists about the accessibility and accuracy of race-related data. According to some, race data is collected and available for nearly all healthcare systems in the US. Two panelists disagreed, stating, "There is a lack of consistency within healthcare organizations with respect to the collection of patient racial/ethnicity data" (Blount).
9. The Intercultural Development Inventory is a non-healthcare specific bias assessment tool that could substitute or supplement the use of the IAT.
10. The NQF suggests four patient-reported outcome sets that could be included in patient-survey data collection: quality of life/functional status, symptoms, care experience, and health behaviors.

IV. EDUCATION AND TRAINING: UNWINDING THE HARMS OF IMPLICIT BIAS

At the core of implicit bias are unconscious stereotypes. Because these beliefs are outside the cognitive view of the holder, bias awareness education and training programs aspire to update our deeply ingrained systems of pattern recognition. In a safe and well-designed education program, participants will integrate contemporary, data-based understandings (and behaviors) about race and identity. To do that, training tends to require repeated, structured introspection exercises and conversations over time. To that end, the panelists offered suggestions to strengthen training programs aimed at reducing bias.

A. Bias Awareness Training Best Practices

Within the context of an effective training program, panelists identified helpful best practices to evolve race-based perspectives and behavior.

- **Establish a common language:** Core objectives of an effective training program would include introducing participants to foundational concepts and language about race, racism, implicit bias, and health equity. For most, a deeper understanding of the historical context and pervasive and structural nature of racism is also missing. When participants understand implicit bias as a cultural and societal condition internalized on an individual level, they tend to be less defensive.
- **Dispel race-based myths/misinformation:** Especially in healthcare, education is crucial to dispelling unfounded, race-based myths and misinformation (e.g., Black people feel less pain) and to filling in the gaps within specialties under-indexed on race-appropriate training (e.g., dermatology textbooks presenting limited instruction/images in diagnosing skin conditions, especially melanoma, on diverse bodies).
- **Contextualize the larger issue:** In their unique position at the front lines of human health, healthcare systems would benefit from deeply versing their providers and staff in culturally competent care, the social determinants of health (discussed below), and the primary contributors to relevant disease processes, versus relying on non-medical stereotypes.
- **Establish a personal baseline:** Trainings have the greatest impact when they give participants an opportunity to make their unconscious beliefs visible to themselves. As discussed, the IAT is a helpful pre-training individual assessment tool to help participants establish their own internal baseline. Readministering the IAT following the training can also provide participants with personal insights into changes in their perspective.
- **Make the experience personal:** Because unconscious beliefs are deeply personal, trainings should similarly facilitate introspection to raise the awareness and consciousness of the individual. By helping participants understand the implications of unconscious perceptions, subsequent behaviors, and potential adverse results, practitioners may be able to self-monitor and course-correct.
- **Build empathy:** Offering exercises such as mindfully taking the perspective of another individual, identifying one's self with the outgroup, and exposure to counter stereotypical exemplars can serve as effective habit-breaking experiences.
- **Lead by example:** Panelists also emphasized the importance of senior leaders' role-modeling and sharing. When "leaders share their stories about breakthrough moments of understanding or acknowledging their own unconscious bias," other members of the organization more broadly will feel invited to take responsibility for their own unconscious beliefs (Shepherd Rucker).

B. Training Structure Recommendations

Panelists offered a variety of suggestions for designing and implementing unconscious bias training programs

Frequency: There was universal agreement across the panel that a single sensitivity training is insufficient. Instead, panelists recommended that education and training be an ongoing organizational commitment, with regular follow-up sessions to raise awareness and implement solutions.

Provider: Panelists recommended that the bias awareness trainer be someone from outside the organization (or otherwise neutral) as well as someone who is a member of a marginalized community.

Format: Panelists encouraged the importance of personalizing the participants' experience by keeping trainings small and preferably in person to better read body language/tone and offer 1:1 feedback to mitigate defensiveness.

Teaching techniques: Suggestions were made to balance didactic techniques (teaching concepts) with experiential approaches (hands-on learning experiences such as vignettes, videos, role plays). Some creative formats might include Diversity Theater (where outside actors come in and do vignettes with post-performance participatory discussions) or bias- and diversity-focused TED talks followed by discussions.

Participation: Multiple panelists suggested that trainings be mandatory, especially for senior leadership.

Data collection: Consistent with a vital measurement strategy, panelists encouraged data collection to measure training effectiveness. Suggestions included using pre- and post-training surveys and quizzes to better understand retention, and incorporating this information when designing timelines and structures for subsequent trainings.

Scope: Some panelists suggested trainings should more broadly address "othering" (beyond Black/white) to include multi-racial, multi-ethnic, and social identities.

To summarize thus far, panelists emphasized that reducing implicit bias is most possible when senior leadership commits to organization-wide bias reduction and assembles the right leaders to drive the initiative. We have further explored how an organization can use metrics to establish a baseline understanding of racial inequities (including but not limited to those resulting from implicit bias), can build upon existing data systems to strengthen ongoing measurement of these issues, and can design and implement effective training experiences to reduce the impact of bias on patients.

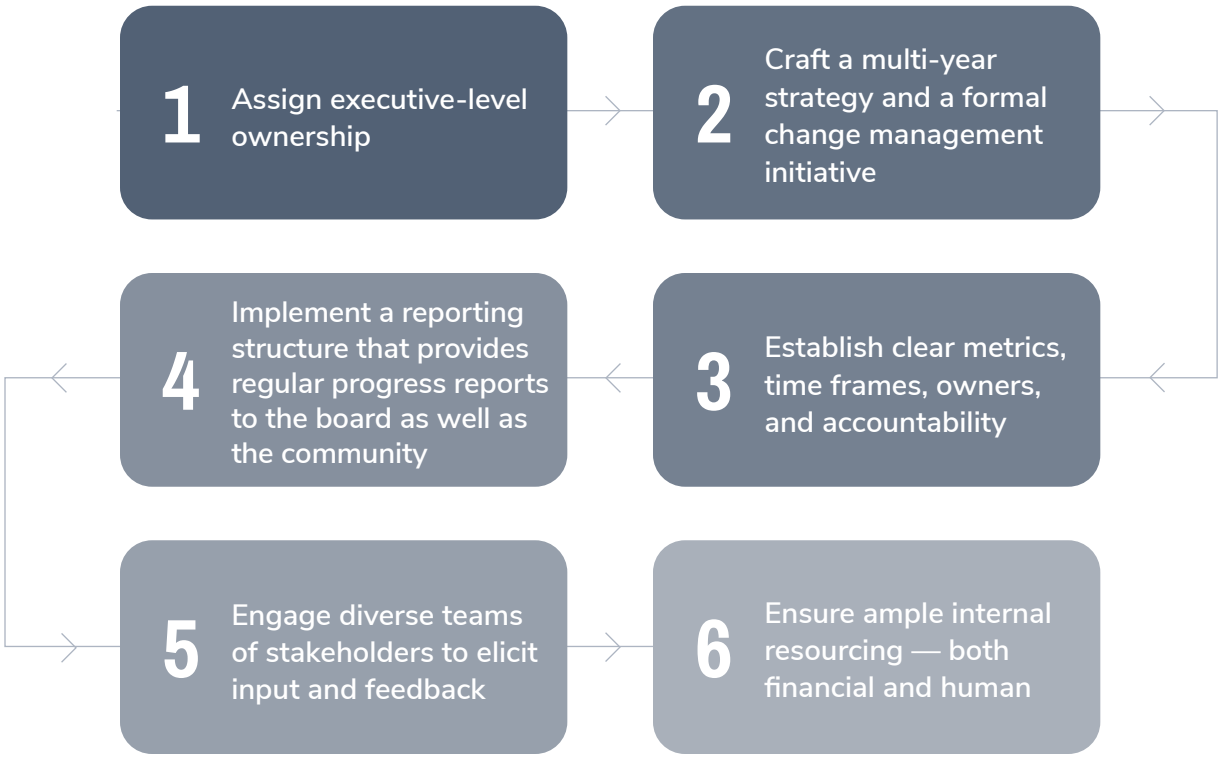
Finally, panelists explored the need for accountability to achieve genuine progress.

V. ACCOUNTABILITY: TAKING ACTION

A. Organizational-Level Accountability

Panelists consistently reinforced the importance of avoiding superficial, optics-centered approaches to bias awareness and improvement, particularly in securing stakeholder support. “If the efforts are perceived as equitable and authentic, there will be less pushback” (Blount). This involves ensuring healthcare institutions give their change initiatives real “teeth” in the form of organizational accountability.

One approach would be to treat an implicit bias reduction initiative like any other key business priority. Such a rollout might look something like the following:



Another way to promote accountability would be to broadcast these commitments publicly and make organizational metrics transparent.[11] "Highlight both negative and positive racial biases within the system and how it can adversely impact not only marginalized races but also privileged races," both internally with staff and externally with the community (Saroha). Include metrics of racial equity in annual reports. And through the exposure of painful truths, have leaders model and acknowledge "that culture change is challenging and uncomfortable, but it is necessary and literally lifesaving for patients" (Blount).

In addition to the public broadcast approach, panelists emphasized the importance of providing formal and informal mechanisms for stakeholders to provide their input back to the organization. The organization can hold itself accountable to its goals "by offering real ways the community (internal and external) can speak up about concerns" (Kanodia). Examples might include regular town hall meetings, public feedback surveys, the inclusion of employees and patients in steering committees, online discussion forums, and anonymous means of reporting bias-related incidents.

Finally, part of organizational accountability involves the boardroom. Large players in the healthcare system can reinforce organization-level accountability by, for example, tying aggregate bonus pools to racial equity improvements, establishing a racial equity committee, including racial equity metrics in quarterly meetings, or mandating independent audits of key processes from reputable DE&I consultants.

B. Staff-Level Accountability

Individual accountability is a natural extension of organizational accountability. One panelist remarked, "A systematic and well thought-through plan will convince employees that the institution is serious and is willing to help them overcome it" (Saroha). In this context, panelists recommended that bias reduction be embedded into human resources practices at all employment touch points, such as hiring, training (e.g., mandatory bias reduction trainings), performance management (annual reviews), and feedback processes (internal and patient-facing).

Panelists particularly stressed the effectiveness of performance-based incentives, such as tying bias reduction metrics to performance reviews, promotion evaluations, and/or compensation decisions. To demonstrate efficacy of incentives, one panelist highlighted, "Until 2019, the slow adoption rate of telehealth services was abysmal; but once the CMS stepped in with changes in policies that included equitable reimbursements for virtual and in-office visits, providers found a way to augment workflow patterns to accommodate this change" (Helene Clayton-Jeter). Panelists advocated for measures such as incorporating peer-review programs and patient feedback from external surveys into provider quality scores. "If providers are not providing value-based, culturally competent care to patients based on survey results, then they should not be incentivized with bonuses, raises, or promotions"[12] (Clayton-Jeter). In short, when providers are properly incentivized, behavior changes.

11. "Lack of transparency doesn't change the actual facts concerning disparity. It merely serves to hide them and leave them unaddressed" (Blount, quoting Aiko Bethea, *Dare to Lead* podcast, transcript **here**).
12. Validated by other panelists, one expert shared the inequitable burden she experienced in past roles as a healthcare provider who was more culturally versed than her colleagues. Because of her language and cultural competency, she effectively became a triage doctor for multiple practice areas (e.g., seeing patients with greater complexity, requiring more time per patient). Consequently, her performance was disadvantaged against counterparts who prioritized expediency and greater patient loads — they therefore excelled against "health economic quantity measures" rather than "quality measures and good patient outcomes" (Clayton-Jeter). "My wall was plastered with certificates of appreciation from my patients but my performance evaluation was full of bean-counting measures that corresponded with an under-performer, i.e., behind schedule, writes prescriptions off formulary, frequent referrals, etc." Id.

VI. BEYOND BIAS: OTHER FACTORS DRIVING INEQUITIES

Implicit racial bias is one of many potential drivers of health inequities. While this project focused specifically on measuring and combating implicit bias, our expert panelists voiced the importance of defining racial equity strategies that account for the broader set of factors perpetuating structural racism within healthcare. Though a deeper look into these adjacent factors was out of this project's scope, we note here key considerations raised by the panelists that call for further attention.

- **Social Determinants of Health (SDOH)[13]:** While many SDOH fall outside the mandate of the healthcare system, it is critical to understand and engage with patients on these key factors affecting their overall health. Incorporating SDOH into patient data collection and care will facilitate better patient education, better data on drivers of health inequities, and more proactive engagement with patients on possible steps to mitigate risks.
- **Intersectionality:** Race is not the only dimension of structural discrimination and implicit bias. Other examples include bias based on socioeconomic status, sex, gender, sexual orientation, language, religion, or disability. The intersection of multiple dimensions can amplify the risk and negative impact of bias — a phenomenon known as "intersectionality."[14] The same outcome and patient survey measurements that can be used to analyze racial inequities can be used to analyze inequities along other dimensions.
- **Employment Diversity:** A key lever for reducing bias and improving health equity is to have a diverse staff. If the healthcare system is taking racial equity in patient care seriously, making efforts to improve diversity in hiring and retention practices would go hand in hand.
- **Creating an Ecosystem of Change:** Expert panelists also discussed how other organizations outside of healthcare delivery systems can affect positive change.

Examples of ways that government agencies (e.g., CMS) can help include:

- Develop, monitor, and publish a nationally standardized index score for all practitioners that includes culturally competent care scores
- Collect the right data to make it clear when, where, and how racial bias occurs, and distribute the data; when the government makes data transparent, healthcare providers change behavior and the healthcare sector engages in better discussions on best practices
- Design and implement federal programs, such as tax incentives, free and accessible educational resources, and supporting infrastructure

Examples of ways that accreditation or standard-setting organizations (e.g., the Joint Commission on Accreditation of Healthcare Organizations) can help include:

- Make bias reduction a part of accreditation of hospitals and health systems
- Incentivize healthcare systems with culturally competent care certifications tied to already in place value-based care incentives
- Encourage JCAHO to take a more active role in assessing the presence of racial bias as a key component of its audit process

13. SDOH are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDOH are categorized into five groups: 1) economic stability, 2) education access and quality, 3) healthcare access and quality, 4) neighborhood and built environment, and 5) social and community context. See U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, **Healthy People 2030**.

14. UCLA and Columbia law professor Kimberly Crenshaw coined the term "intersectionality" nearly 30 years ago. In a February 20, 2020, interview with ***Time* magazine**, she described it as follows: "It's basically a lens, a prism, for seeing the way in which various forms of inequality often operate together and exacerbate each other. We tend to talk about race inequality as separate from inequality based on gender, class, sexuality, or immigrant status. What's often missing is how some people are subject to all of these, and the experience is not just the sum of its parts."

VII. CONCLUSION: COMMITTING TO MEANINGFUL CHANGE

Committing to measuring and combating implicit racial bias will require boldness, patience, and vulnerability. Panelists emphasized that this will be a long-term effort including many pain points along the way and will require commitment to stay the course. It will be necessary to listen to the community, learn from mistakes, and adjust course as needed throughout the process.

Nonetheless, the panelists were confident that with the right guidance, this process could generate meaningful change. Through proper leadership, informed and nuanced measurement, regular education and training, and organization-wide accountability, any healthcare system can begin to overcome implicit bias and ensure greater equity in its services. In doing so, they will be directly responsible for increasing the quality of life of not just their patients but also their employees, partners, and others in their community.

Especially during an unprecedented moment of awareness and social engagement on issues of structural racism, GLG and its expert panelists are united in their call to healthcare leaders to seize this unique moment of receptivity to make high-quality healthcare accessible to everyone.

RESOURCES AND REFERENCES

"Creating Transformative Cultures," Dare to Lead, Brown & Bethea, 2021.

"Implicit bias in healthcare professionals: a systematic review," Fitzgerald & Hurst, 2017.

"Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review," Hall et al. 2015.

"A Systematic Review of the Extent and Measurement of Healthcare Provider Racism," Paradies et al. 2013.

"Detecting implicit racial bias in provider communication behaviors to reduce disparities in healthcare: Challenges, solutions, and future directions for provider communication training," Hagiwara et al. 2019.

"A decade of studying implicit racial/ethnic bias in healthcare providers using the implicit association test," Maina et al, 2017.

"She Coined the Term 'Intersectionality' Over 30 Years Ago. Here's What It Means to Her Today," Steinmetz, 2020.

"Risk for COVID-19 Infection, Hospitalization, and Death By Race/Ethnicity," U.S. Center for Disease Control and Prevention, 2021.

"Social Determinants of Health," U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion, retrieved 2021.