

Equity and Performance Improvement: A Novel Toolkit That Makes Using an Equity Lens the Default

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Performance improvement methodologies do not currently include any structures that encourage analysis of how bias, inequity, or social determinants of health (SDOH) contribute to outcomes. The Montefiore Center for Performance Improvement developed a novel quality improvement (QI) toolkit that ingrains issues of diversity, equity, and inclusion (DEI) and SDOH into the Institute for Healthcare Improvement's tools. The toolkit prompts QI teams to evaluate DEI and SDOH at each step of the journey, including an updated charter and stratified baseline tool, a new fishbone diagram for the discovery phase with a tail to include DEI and SDOH, and additions in the Study and Act sessions of the Plan-Do-Study-Act worksheet to address these issues. After development and dissemination of this toolkit, the authors conducted a pre-post analysis of projects conducted by QI fellows in their institution. Prior to introducing the new toolkit, 22.9% of projects from 2016 to 2021 incorporated DEI/SDOH into any stage of the QI process. After implementing the amended tools, this increased to 88.9% in the 2022 fellowship. These results show that this simple approach can hardwire consideration of DEI and SDOH into improvement projects.

There have been recent calls to action to reduce disparities in health care, but knowledge of the problem is not new. Soon after the 2001 landmark publication *Crossing the Quality Chasm: A New Health System for the 21st Century*,¹ the Institute of Medicine (IOM) detailed accounts of racial and ethnic bias in the way health care is delivered in *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*.² In 2010, responding to the lack of action and identification of equity as the “forgotten aim,” the IOM went on to publish another report, titled *How Far Have We Come in Reducing Health Disparities*.³ However, despite progress in many areas of health care quality, progress to reduce disparities has remained slow.

Quality improvement (QI) methods are widely used in health care. However, most do not currently include prompts or structure to encourage analysis of the role and contributions of bias, inequity, and social determinants of health (SDOH) in improving outcomes.

Without attention to such variables, QI projects have the potential to inadvertently widen or perpetuate existing disparities. QI projects can affect disparities in three ways.⁴ First, if the intervention disproportionately benefits the group with worse outcomes, the disparity is decreased.⁵ Second, if the QI intervention benefits all groups at the same rate, outcomes will be better, but the disparity is maintained.⁶ Third, and most concerning, if the QI intervention disproportionately benefits the group with better outcomes, it will increase the disparity or widen the gap.⁷ Most commonly, QI projects do not assess for disparities related to

SDOH and diversity, equity, and inclusion (DEI) issues, perpetuating an inequitable system.

In this article, we describe how we integrated methods and tools within a QI fellowship program to ensure inclusion of equity as an integral part of all QI projects and prevent the unintentional exacerbation of existing disparities within each QI project.

TOOL DEVELOPMENT

The Montefiore Center for Performance Improvement (MCPI) runs a yearlong nonclinical fellowship in QI for physician, nursing, operational, and pharmacy leaders from around the Montefiore Health System. During the application process, each fellow submits a proposed project with an explanation of why it is important to patient care and how it aligns with institutional goals and a statement of support from their leadership. The program teaches the Institute for Healthcare Improvement's (IHI) Model for Improvement⁸ and uses their associated toolkit.⁹ All MCPI fellows receive 16 hours of classroom-style education combined with at least biweekly coaching on a high-impact QI project. Through the year, fellows walk through the IHI Model for Improvement and complete the toolkit with their teams and the QI coach. Each participant submits these tools as part of their homework for the fellowship, and MCPI keeps records and completed toolkits for all fellowship projects. This provided a repository of projects with complete information and allowed us to study projects done in the past. The current fellowship program allowed us to study the impact of amending the tools.

To determine the baseline frequency of inclusion of aspects of bias, inequity, or SDOH in past fellowship projects,

we reviewed all documents and toolkits from 2016 to 2021. We defined *bias, inequity, or SDOH* to mean any mention of factors that could contribute to or fall under one of these terms. We were intentionally overinclusive and did not require demonstration of a disparity. We defined *included* to mean any mention of patient factors such as race, ethnicity, or language or any analysis or mention of a SDOH. Inclusion of SDOH was defined as mentions of any of the 14 categories used in the existing tool to screen patients for needs relating to SDOH needs at Montefiore¹⁰ (Appendix 1, available in online article). Each project charter, process map, fishbone diagram, driver diagram, Pareto analysis, and Plan-Do-Study-Act (PDSA) worksheet was reviewed for the 61 projects. Tools were reviewed separately by at least three QI specialists from MCPI. Any lack of agreement was discussed, agreed on, and rereviewed by another specialist. There was initial disagreement about whether a project included SDOH in 14 of the 366 tools (3.8%), but all were resolved on second review. Disagreements largely concerned how to classify financial aspects when insurance issues affect the hospital but not the patient.

Because not all projects have an equal opportunity for equity issues, we also created a standardized framework to designate projects as either low or medium/high opportunity (Appendix 1). To create these designations, MCPI once again mimicked the existing questions used at Montefiore to screen patients for needs related to SDOH.¹⁰ This included 14 questions about SDOH. This tool uses a five point Likert scale for the potential impact of various SDOH on the project. In addition, we used a binary yes/no if there were concerns that inequity or bias could affect the project (for example, race, ethnicity, gender). Projects that had more than 32 points were designated as medium/high opportunity. We wanted to allow projects with consistently lower ratings (a 1 or 2 out of 5) on the 14 questions to be designated as “low opportunity” and then looked at the distribution of how the projects were rated. This cutoff made sense based on how the historical projects ultimately fell. Each project was reviewed separately by at least three QI specialists from MCPI. Specialists were asked to think about the scope of the project and to use their judgment to decide if bias or patient demographics could affect the project. Surprisingly, there were no discrepancies between the reviewers on the binary yes/no and no discrepancies on the ultimate designation of the projects as low or medium/high opportunity. However, there was variability in the numbers chosen on the Likert scales. We did not pursue efforts to establish further inter-rater reliability on the Likert scale because it would not affect the way projects were designated and the raters found it easier to rate the potential impact of SDOH along a spectrum. An example of a project assigned as low opportunity is one designed to decrease lab turnaround time, and a project designed to reduce 30-day heart failure readmissions rates was assigned as medium/high opportu-

nity. We created this framework before testing any modifications to the tools because we wanted a way to separately analyze those projects that were most likely to be affected and therefore have a sense of whether our changes were encouraging the inclusion of relevant equity issues as intended.

As described above, we performed a five-year retrospective analysis of previous fellowship projects to determine how bias, inequity, and SDOH issues were incorporated into QI projects using the standard IHI tools. This retrospective analysis discovered that inclusion of bias, inequity, and SDOH issues was generally low across the board. The tool that most commonly included bias, inequity, or SDOH issues was the fishbone diagram, and that was found in only 16.4% of the historical projects.

We also interviewed past fellows whose projects were designated as having a medium/high opportunity. Qualitative data obtained from these interviews revealed that many assumed that improvements in their outcome measure meant that care was improving for all communities. Past fellows also consistently reported that it was easy to move through the traditional tools without paying specific attention to equity issues.

We used the 2022 fellowship cohort for successively larger PDSA cycles to modify the verbiage and placement of new sections dedicated to bias, inequity and SDOH. After we gained confidence in the effectiveness and usability of a new tool, we brought it out to other QI initiatives and educational programs across Montefiore.

TOOL DESCRIPTION

Charter

A charter is created at the start of a project and can be referenced over time. It helps with planning and proactively identifying project scope and any potential barriers. The charter allows for people working on a project to have a shared mental model about goals and key stakeholders. This tool was amended to add a dedicated space for potential bias and inequity concerns and impact of SDOH under the project scope (Figure 1). The section titled “Social Determinants of Health, Bias, and Equity” is new, and the remainder of the charter is unchanged from the traditional tool.

Stratified Baseline Tool

Measurable outcome and process measures are at the core of a successful QI initiative. These are defined in the IHI key driver diagram.⁹ We created a new tool to serve as an appendix and overlay for the IHI key driver diagram. Our stratified baseline tool (Figure 2) requires stratification of the baseline outcome and process data to help uncover inequities that exist at the start of the project. We chose to not prescribe which demographics or SDOH are used for

Project Charter

<p><u>Project Title:</u> Click here to enter text.</p>	<p><u>Lead:</u> Click here to enter text.</p>
<p><u>Problem Statement:</u> Click here to enter text.</p>	<p><u>Sponsor:</u> Click here to enter text.</p> <p><u>Champion:</u> Click here to enter text.</p> <p><u>Coach:</u> Click here to enter text.</p>
<p><u>AIM Statement:</u> Click here to enter text.</p>	<p><u>Social Determinants of Health, Bias, and Equity:</u> What are some social determinants of health (Behavioral, Environmental, Social, Economic) that may contribute to the problem? Click here to enter text.</p> <p>List potential or anticipated DEI issues or anticipated disparities in care: Click here to enter text.</p>
<p><u>Measures</u></p> <p><u>Outcomes:</u> Click here to enter text.</p> <p><u>Process:</u> Click here to enter text.</p> <p><u>Balancing:</u> Click here to enter text.</p>	<p><u>Proposed Intervention(s):</u> Click here to enter text.</p>
	<p><u>Project Scope</u></p> <p><u>Start Date:</u> Click here to enter text.</p> <p><u>Location(s):</u> Click here to enter text.</p>

Figure 1: The project charter tool was amended to add a dedicated space for potential bias and inequity concerns and impact of social determinants of health under the project scope. DEI, diversity, equity, and inclusion.

Social Determinants of Health, Bias, and Equity

Stratify Data for Outcome and Process Measures

Examples: Race, Ethnicity, Language, Gender, Insurance, other relevant demographic indicators (e.g., geographic region, zip code)

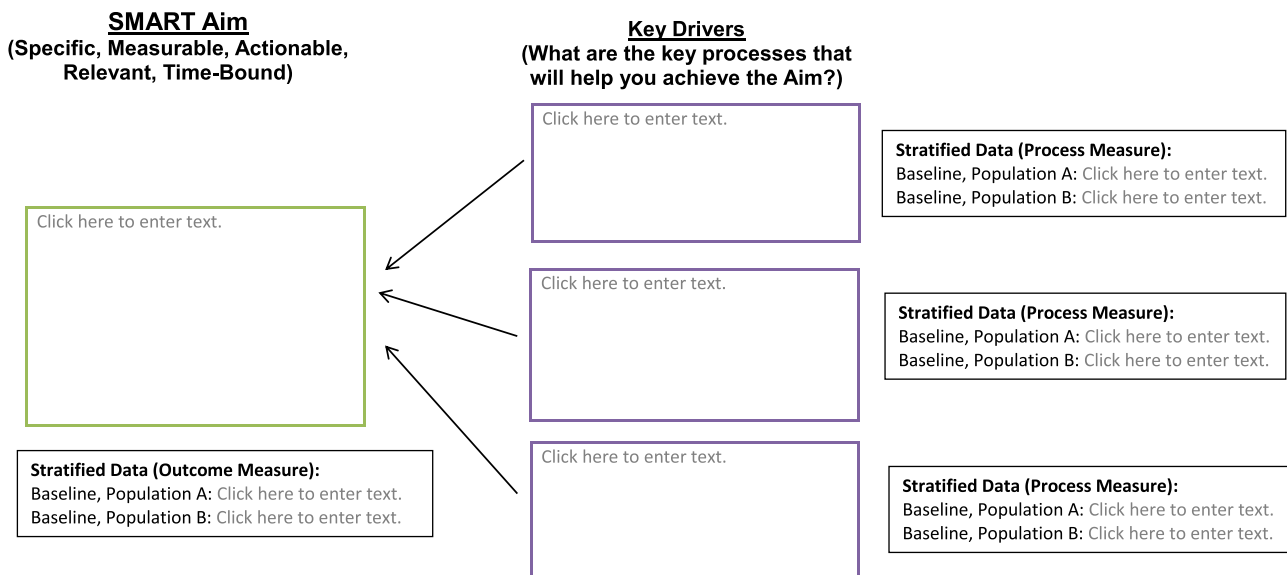


Figure 2: The stratified baseline tool requires that the baseline outcome and process data are stratified to uncover inequities that exist at the start of the project.

Ishikawa Diagram/Fishbone Diagram

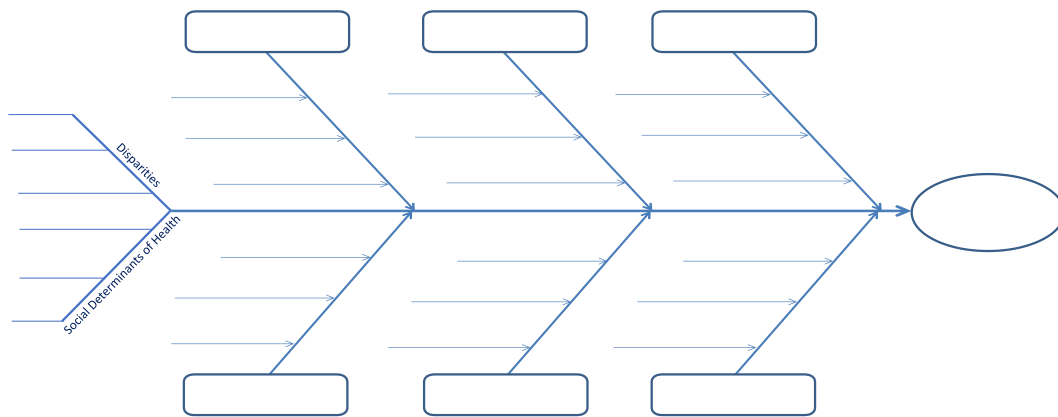


Figure 3: The fishbone diagram was modified by the addition of a tail, labeled “Disparities / Social Determinants of Health,” which prompts teams to think through and discuss all the ways they believe bias, inequity, or social determinants of health could affect the project’s goals.

stratification. However, at a minimum, we recommend stratifying the key outcome measure by race, ethnicity, and language. We chose to recommend these factors because they are key to understanding disparities in care. In addition, this information is typically found in discrete fields in the medical record system and is often easier to obtain than information about other demographics or SDOH. However, if the project lead has reason to suspect disparities or issues with SDOH factors based on the scope of their project, they are encouraged to do additional stratification.

Fishbone Diagram

A fishbone diagram (also known as Ishikawa or cause and effect diagram)⁹ allows visualization of all the potential causes of a problem and identification of root causes. It is best used during brainstorming sessions with various stakeholders to ensure that all possible perspectives and issues are uncovered. The first step is to clearly identify the problem you are trying to solve and place that at the head of the fishbone. The next step is to decide on the key categories you will explore, and those go at the end of the fishbones. Most com-

PDSA Worksheet



Team Leader:	Click or tap here to enter text.	Test of Change Start Date:	Click or tap to enter a date.
Champion:	Click or tap here to enter text.	Test of Change End Date:	Click or tap to enter a date.
SMART Aim:	Click or tap here to enter text.	PDSA (Change Concept) #:	Choose an item.
		PDSA Cycle #:	Choose an item.

Plan	
Describe your test of change.	
Click or tap here to enter text.	
List individual tasks and persons responsible necessary to conduct this test of change.	
Click or tap here to enter text.	
What are your predictions for what will happen when this test is carried out?	
Click or tap here to enter text.	

Study	
How do your process/outcome measures compare to your predictions for this test of change?	
Click or tap here to enter text.	
What did you learn from this test of change?	
Click or tap here to enter text.	
Did this test of change have a disproportionate effect on different populations as determined by Social Determinants of Health, Bias, or Equity issues?	
Click or tap here to enter text.	

Do		
Was this test of change carried out as planned?	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>
Record your process measures from the test as well as any unexpected observations:		
Click or tap here to enter text.		

Act	
<input type="checkbox"/> Adopt: adopt the test of change and spread. <input type="checkbox"/> Change: change the test of change and continue to test before spreading. <input type="checkbox"/> Trash: abandon the test of change and move on to the next concept.	
Describe what modifications, if any, to the plan will be made for the next cycle from what you learned:	
Click or tap here to enter text.	
If your test of change affected different populations (SDoH, Bias, Equity) how will you adjust the test of change to mitigate that?	
Click or tap here to enter text.	

Figure 4: The Plan-Do-Study-Act (PDSA) worksheet was modified into a one-page document with additional questions designed to make the team pause and evaluate how the intervention affected different groups at each step.

monly, people use the templated groupings People, Process, Machine, Material, Measurement, and Environment, but this can be easily adopted for unique issues.

We modified this tool by adding the tail (Figure 3). The tail is labeled “Disparities / Social Determinants of Health” and prompts teams to think through and discuss all the ways they believe bias, inequity, or SDOH could affect the project’s goals. This can foster early recognition of issues and help teams incorporate them into chart reviews, data capture, and change concepts down the road. Of all the tools, this one went through the most PDSAs. Initial attempts to embed it within each category and general requests to consider DEI and SDOH issues frequently led to confusion or incomplete documentation. Having the tail as a separate place to list bias, inequity, or SDOH factors led to the most consistent use without additional questions or issues.

PDSA Worksheet

PDSA worksheets⁹ allow teams to plan and document each PDSA cycle. In addition to providing structure and organization for PDSA cycles, the PDSA worksheet documents what did and did not work. This allows future teams to reference the experience and assists during spread of initiatives. PDSA cycles start small and then progressively scale to more and more patients. The traditional structure can allow for inequity to be masked due to the limited ability to see trends

on small numbers. And after an intervention is thought to be successful, it is scaled up, often without attention to demographics. Therefore, we modified the PDSA worksheet into a one-page document and added questions designed to make the team pause and evaluate how the intervention affected different groups at each step (Figure 4). With each scaling up and successive cycle, they are prompted to look for the impact on different populations. When change concepts are found to either cause or widen disparities, the PDSA worksheet provides a planning area for ideas to mitigate this effect.

HOW TO

These tools are designed to be used in the same way as the original tools included in the IHI Model for Improvement. They are simply substituted for the current toolkit and have the advantage of having a place and structure for conversation and investigation concerning the SDOH/Bias/Equity questions in the project charter, fishbone diagram, data, and PDSA templates.

RESULTS AND LESSONS

The use of the amended toolkit during the MCPI fellowship program was associated with a significant increase in the evaluation and inclusion of equity issues or SDOH in QI projects at Montefiore (Figure 5). Fisher’s exact test

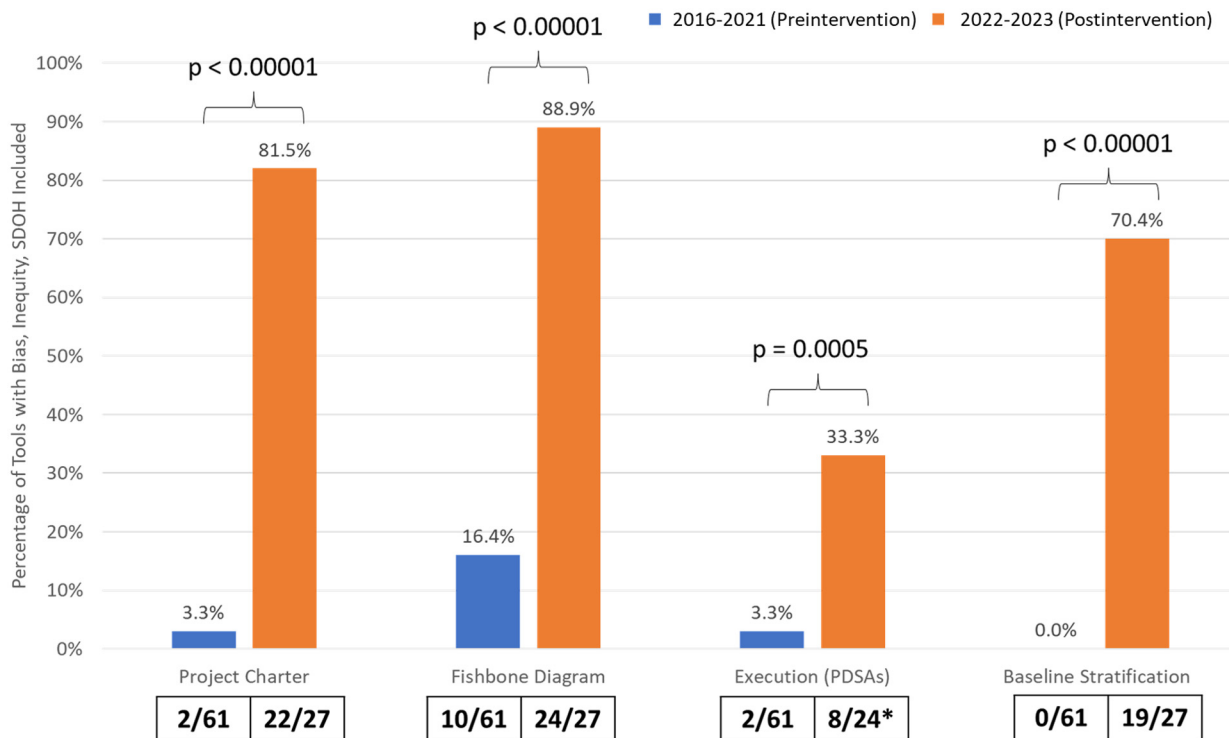


Figure 5: This chart shows that the inclusion of bias, inequity, and social determinants of health (SDOH) into the project charter, fishbone diagram, Plan-Do-Study-Act (PDSA), and baseline stratification tools statistically improved for each tool postintervention (2022–2023) compared to the projects preintervention (2016–2021) for all projects.

* Some 2023 Performance Improvement Fellowship projects are not fully in execution phase, so the denominator is reduced by 3.

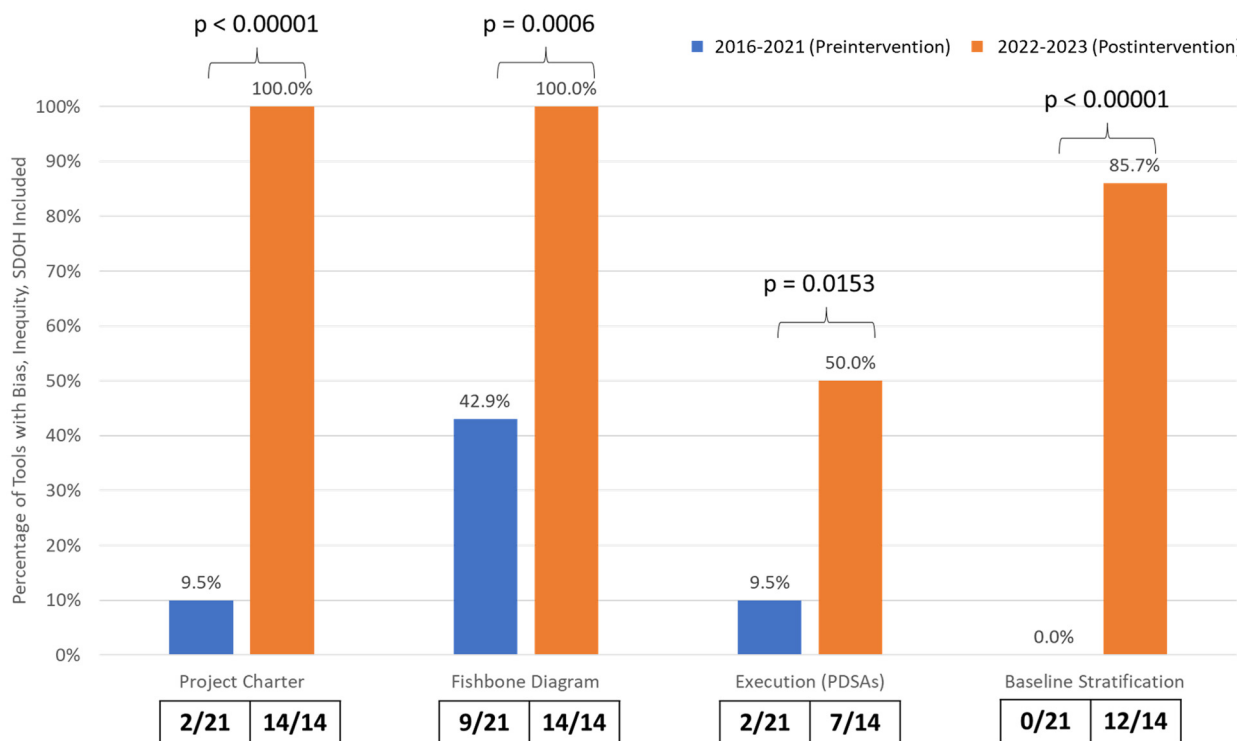


Figure 6: This chart shows that the inclusion of bias, inequity, and social determinants of health (SDOH) into the project charter, fishbone diagram, Plan-Do-Study-Act (PDSA), and baseline stratification tools statistically improved for each tool postintervention (2022–2023) compared to the projects preintervention (2016–2021) for medium and high opportunity projects.

was used for the statistical analysis. We compared the frequency of inclusion of variables such as equity or SDOH in projects in the 2016–2021 cohorts (preintervention) and the 2022–2023 cohorts (postintervention). Compared to the preintervention phase, the postintervention phase had a higher percentage of projects including these variables within charters (3.3% vs. 81.5%, $p < 0.00001$), projects including them in fishbone diagrams (16.4% vs. 88.9%, $p < 0.00001$), and projects that stratified their baseline (0% vs. 70.4%, $p < 0.00001$). Of those projects that stratified their baseline, disparities were found in 36.8%. Use of the amended toolkit also increased the percentage of projects in which PDSA cycles targeted disparities or SDOH from 3.3% to 33.3% ($p = 0.0005$). These projects did not have an initial goal of reducing disparities, but when the team leaders noted the importance of these issues, they understood the importance of including bias, inequity, and SDOH.

We performed a subset analysis to evaluate projects that had higher opportunities for bias or impact of SDOH (Figure 6). We used the predefined definition described above to separate projects into low vs. medium/high opportunity. We once again compared the frequency of inclusion of variables such as equity or SDOH between the preintervention and postintervention cohorts. For the subset of projects designated as medium/high opportunity, the percentage of projects including these variables in

the tools was even higher. Compared to the preintervention phase, the postintervention phase included these variables within charters (9.5% vs. 100.0%, $p < 0.00001$), in fishbone diagrams (42.9% vs. 100.0%, $p = 0.0006$), and projects that stratified their baseline (0% vs. 85.7%, $p < 0.00001$). Of the projects that stratified their baseline, disparities were found in 41.7%. For the projects designated as medium/high opportunity, the percentage of projects that ran PDSAs targeting disparities or SDOH increased from 9.5% to 50.0% ($p = 0.0153$).

An example of a project that used the traditional IHI tools is one that was designed to improve delays in MRI start times. A significant contributor to delays was found to be time spent finding parking. A PDSA that provided free valet parking substantially improved the outcome measure. Presumably, those patients with cars parked more easily and had their timeline improved, but those patients who came by public transportation or walking had no change. After the valet parking intervention was put in place, no additional transportation-related PDSAs were implemented. Although improving delays due to parking is a good thing, it is likely that this intervention increased disparities and may have unintentionally created further delays for those walking or coming by public transportation. Expediting service for those with cars could have potentially caused those cases to be taken earlier than those arriving on public transportation. Because this was not considered

at the time, we are unable to know either the baseline inequity or the impact of the change concept on the different populations.

Another example illustrating the impact of the new toolkit is a project designed to increase the percentage of stroke patients discharged home after a rehabilitation stay. By stratifying patients using race and zip code at baseline, staff identified disparities in the disposition plans for patients. Chart review identified examples in which patients from lower income areas had the mobility scores and appropriate resources to be discharged home (for example, a patient with family members at home who are nurses) but were still referred to a nursing home. When investigating the cause for the racial and zip code disparities, the team realized that placement discussions were often started before interdisciplinary rounds when documented mobility assessments were discussed. This caused the team to restructure their processes. Now, interdisciplinary conversations including initial mobility assessments and goals of care take place earlier in the rehabilitation stay and prior to any placement discussions. This approach minimizes decision-making based on assumptions about the patient and their home situation and minimizes the opportunity for implicit bias.

We received qualitative feedback on the fishbone diagrams with an equity tail in a project to reduce same-day case cancellations at an ambulatory surgery center. They completed the traditional fishbone without any mention of bias, inequity, or SDOH. When testing the novel fishbone, we asked them to complete the new tool and give feedback. They added multiple factors known to be associated with an increased rate of same-day case cancellations at Montefiore¹¹ and explained that they did not think to include these factors with the traditional fishbone. The structural inclusion of the equity tail prompted the inclusion of important factors already known to be relevant issues for the target population (for example, race, insurance type, mental health issues, transportation needs). This project ultimately developed preoperative screening programs for anxiety and transportation needs and matched the patients with relevant services.

There were several lessons learned as we developed and tested the new toolkit. First, we found that equity concerns need to be introduced at the beginning of a project. When there was a delay in identifying disparities, the relevant information was often not collected during chart reviews, and other parts of discovery and investigations for the causes of the disparities were put off. In addition, after the team anchored on a change concept, it was difficult to steer the project back to focusing on the disparity.

Second, data collection was the most frequent barrier to implementing the new toolkit. Information needed to stratify the baseline often had to be collected manually, as efforts to stratify all larger data sets had not matured and there was limited confidence in the accuracy of all the de-

mographic data in the electronic health record. In addition, SDOH factors were not in discrete fields. Third, some fellows struggled to determine which factors they should use to stratify their data. We recommended that all projects used REaL (race, ethnicity, and language) data at a minimum. However, deciding which SDOH or other demographics to consider was difficult for many of the fellows. For those projects we found that using the brainstorming tools such as the modified fishbone or other discovery tools with their team helped to identify the additional factors.

SUMMARY AND NEXT STEPS

MCPI developed a novel QI toolkit that ingrains equity considerations into the IHI Model for Improvement. These amended tools provide a consistent structure that prompts inclusion of these issues in QI methodology. The MCPI QI fellowship provided a unique opportunity to mine a repository of previous fellowship projects and their completed tools. We found that the use of the novel toolkit was associated with a significant increase in the inclusion of SDOH or elements that could lead to inequity and bias in performance improvement projects in our fellowship.

There are some limitations to our analysis. We did not do a specific evaluation to understand the inter-rater reliability of assigning projects as low or medium/high opportunity for equity issues. Because our goal was to develop a toolkit that would be used by all projects, we felt that the assignments were needed only for our internal analysis when developing the tools. In addition, we saw very little disagreement using the tool and felt that further analysis was not necessary.

Another limitation is that we performed this work during a time when there were many public discussions about the killing of George Floyd, Ahmaud Arbery, and Breonna Taylor. Data suggest that there was a temporary decline in public statements of negative Black sentiment and an associated increase in awareness of structured racism during that time.¹² It is possible that some of the increased inclusion of bias and inequity was due to an increased focus on these issues across the nation. In addition, awareness of racial disparities in COVID-19 cases and deaths and new reporting and equity requirements from the Centers for Medicare & Medicaid Services and The Joint Commission have raised consciousness and caused health care organizations to build structures for stratifying data. It is possible that this accounts for some of results we saw in our postintervention group.

Despite these limitations, we are encouraged by the changes seen in our fellowship. Previous and current fellows have consistently expressed that the tools are easy to use and facilitated mindfulness and inclusion of factors that affect equity and SDOH in their tools and projects. When we brought these tools to our other ed-

educational workshops, we noted that the discussions on generic examples were different from our past experiences. For example, when using a generic example for a project designed to increase the percentage of employees who get to work on time, brainstorming tools like the fishbone/Ishikawa diagram now consistently include potential issues such as childcare, public transportation, and financial ability to stop for breakfast. Prior to introduction of the new tools, these conversations never mentioned these factors.

The Montefiore Center for Performance Improvement found that use of our amended toolkit was associated with a significant increase in the number of projects in our fellowship that looked for disparities and incorporated SDOH into their work. Now that we have gained confidence in the usability and relevance of the new toolkit, next steps will be evaluating how to implement the tools most effectively and scale their use across the institution for all QI projects. Future work will need to evaluate the disparities that exist at the start of projects and study whether the use of a toolkit that ingrains equity components is effective in closing these disparities. We believe that identifying and documenting these issues is an early and necessary step to improving equity in performance improvement. We urge other health care systems to evaluate and adapt their tools and methodologies to ensure that inclusion of bias, inequity, and SDOH is the default in any performance improvement initiative.

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Conflicts of Interest. All authors report no conflicts of interest.

SUPPLEMENTARY MATERIALS

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.jcjq.2023.11.003.

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