

Conducting a Root Cause Analysis with an Equity Lens: Key Considerations

A Root Cause Analysis (RCA) is a tool that helps participants explore factors that contribute to a health or healthcare inequity across various levels of the healthcare system: individual, interpersonal, organizational, community, and policy, among others. This document supports equity-focused RCA brainstorming and idea generation, providing tips and equity-focused questions, as well as introducing several topics that organizations should consider.

ADOPT:

- A culture of trust that does not encourage blame or fault finding
- An openness to vulnerability and allow yourself to be present, listen, and meet people where they are
- Processes to ensure appropriate stakeholders are present and can meaningfully contribute to the conversation
- The floodlight/flashlight metaphor: As you complete the RCA think of it in terms of a flood light (how it illuminates approaches from a larger perspective) and a flashlight (how it can focus on a specific area of concern)

AVOID:

- Blaming individuals or populations for health inequities. Instead, explore the health system's role in generating health inequities (e.g., past and current actions the engender mistrust).
- Making assumptions. Try to include information that references participants' direct experiences as they complete the RCA. Using unverified information means the RCA—and potentially, the intervention—is more likely to be based on inaccurate information.
- An overly narrow focus. There are many opportunities for health plans, government agencies, and other systems-level stakeholders to address equity in addition to direct care interventions at hospitals and clinics.

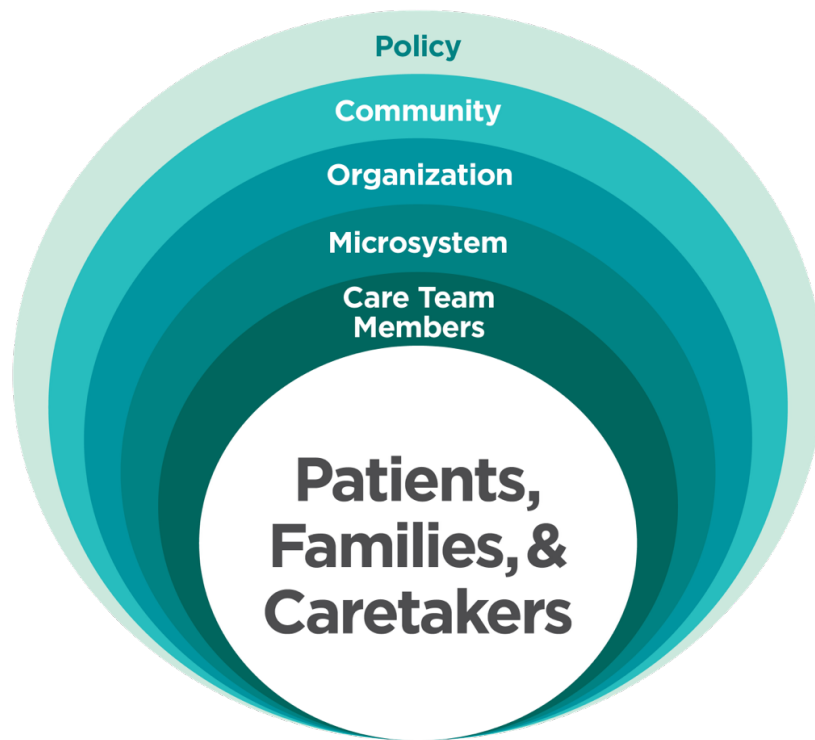
Key Questions for Consideration

- Does the dominant medical model conflict with patients' cultural traditions that encourage the use of alternative and/or complementary medicine?
- How has your team engaged the impacted communities so the strengths and experiences of those communities are part of the solution?

- How is the organization or the healthcare system meeting—or not meeting—the various needs of its constituents, patients, or community at large?
- How might the root causes of the inequity be different when considered from the perspective of different aspects of identity such as race, ethnicity, class, sexuality, or age? What about when the inequity is considered from the perspective of people who hold multiple, intersecting marginalized identities?
- How much does your organization actively support evidenced-based care? Are there evidenced-based models of care not covered by health plans or other payers (e.g., dental care)?
- How strong is your organization's or system's relationship with the community it serves? How could it be stronger?
- What is the healthcare system's historical and current reputation for treatment of patients of color?
- What unspoken value systems of the people who work in the healthcare system determine its current structure?
- Who benefits from the current structure? How might the current system cause unintentional harm to the communities you serve?
- Whose input and perspective is missing from the RCA?

Considerations Across Different Levels:

There are multiple levels of a health system to consider when planning a healthcare delivery transformation. All are important and require different kinds of attention. Thinking through each specific level and the different concerns that influence them will help you create a more well-rounded intervention with greater chances of success.



Policy

- Laws, legislation, regulations, and resource allocation that create and maintain health and healthcare inequities.
- Foundation funding and grant programs that hinder or fail to advance health and healthcare equity.
- Local, regional, and national representatives that do not take action within their sphere of influence to advance health equity.

Community

- Access to affordable, healthy food options and clean drinking water
- Air quality
- An insufficient number of community based organizations (CBOs) to address health-related social needs
- Availability of affordable child care
- Availability of multiple modes of reliable public transportation

- Availability of safe and affordable housing
- Community safety/security
- History and/or presence of collective systems of support
- History and/or presence of segregation, discrimination, and other forms of overt racism
- Mutually beneficial partnerships with community-based organizations such as churches, social services, schools, park districts, or fitness centers
- Political engagement and activism among community members
- The reputation a healthcare organization has with the community it serves, hindering trust (e.g. a history of exploiting local resources or ignoring community needs; a popular job accelerator program)
- Variety and convenience of local places to be physically active such as safe walking paths, parks, green space, or gyms

Organization

- Confusing systems that make it difficult for patients to find information (i.e., multiple phone transfers, long hold times, reception only in English)
- Crowded, unfriendly, or otherwise inaccessible reception or waiting areas that communicate a lack of value placed on welcoming people and making them comfortable
- Existence, capacity, and influence of your organization's community governance or advisory board
- Inconvenient location for members (e.g., limited or otherwise unreliable public transportation options)
- Lack of comprehensive all-staff orientation and ongoing training to understand the cultural values, beliefs, and issues important to patients and how to respond appropriately to differences in culture and worldview.
- Limited time allotted for appointments or long wait times on telephone calls for assistance
- Limited specificity in demographic data such as narrow or singular options for race/ethnicity and lack of information regarding country of origin, sexual orientation, gender identity, other demographic information
- Limited specificity of race/ethnicity data (e.g., diverse immigrant Black or Hispanic/Latine populations captured under one race or ethnicity).
- Limited staff (e.g. no Certified Diabetes Educators, no health plan navigators, inadequate customer service support)

- Little-to-no opportunity to assess patient/member satisfaction and feedback or gaps in populations reflected in satisfaction surveys (e.g., surveys only available in English).
- Low-quality input of race/ethnicity and/or sexual orientation and gender identity (SOGI) data at point of entry or registration
- Minimal or ineffective follow-up on patient/member feedback.
- Organizational effectiveness implementing Culturally and Linguistically Appropriate Services (CLAS) standards
- Service hour schedules at clinics (e.g. Do they accommodate walk-ins, evening or weekend hours, have strict cancellation policies or financial burdens for being late or missing appointments?), health plans, and governmental agencies.
- Staff familiarity with applicable internal and external resources such as: behavioral health, support/educational groups; community based organizations; financial assistance; or difficulty following-up on referrals to those resources

Organization: Health Plans, Municipalities, and States

- An insufficient number of community based organizations to address health-related social needs, state-level health insurance legislation, and reform efforts (e.g. changes in Medicaid benefits levels or eligibility or changes in reimbursement rates affecting provider's overall willingness to accept certain payers)
- Contracting supporting equity-focused healthcare delivery reform
- Emphasis in encounters in documentation and billing, rather than on relationship-building, trust, and connection.
- Equity-focused technical assistance and capacity-building services
- Inter-agency partnerships and collaboration to address social drivers of health such as increasing affordable housing, decreasing food deserts, and pollution reduction and elimination
- Payment model/design encourages cherry-picking or excluding members
- Unreimbursed, necessary services such as behavioral health or nutrition services

Microsystem: The immediate care team

- Inadequate team communication (e.g., between primary care providers and specialists; between health plan departments and teams; inadequate health record documentation; lack of team-based patient reviews/rounds)
- Ineffective referrals (e.g. eye exam results do not find their way to the PCP, referred specialist is unavailable for weeks or months)

- Limited case management and other supports to assist members in navigating the healthcare system
- Missing knowledge or skills (e.g. community health worker or psychiatrist's expertise is needed)

Care Team Members

- Barriers to communication due to lack of translation services, use of non-certified medical interpreters, or use of interpreters over the phone where an in-person translator would add value
- Clinical inertia
- Difficulty changing processes or outdated processes that do not reflect evidence-based interventions
- Discomfort and limited experience engaging with patients from different environments (rural, urban, suburban) and/or those with minoritized identities (e.g. race, culture, sexual orientation, gender identity, class, immigration status, language, age)
- Inadequate knowledge of specialized aspects of healthcare or knowledge of how and where to refer (e.g. PCP does not know how to manage depression; OB-GYN is unsure of how to treat depression in a pregnant patient; referral services not having available appointments for weeks or months)
- Limited knowledge about how social drivers of health impact patients' health and access to healthcare (e.g. poor public transportation infrastructure, food deserts, close proximity to generators of high pollution)
- Limited knowledge of cultural practices in the areas served
- Limited to no follow-up communication with members who need complex or long-term treatment
- Few, if any, care team members live in the communities they serve
- Unaddressed prejudices and biases, including Othering patients or assuming patients are "abusing the system"

Patients, Families, and Caretakers

- Accessibility of health materials and resources in plain language at appropriate reading levels
- Availability of certified medical interpreters
- Comfort discussing personal/private health issues with provider and/or peers

- Conflict between dominant medical model with the practice of alternative and/or complementary medicine specific to patients' cultural background
- Conflicts between standard Western medicine practices and how cultural upbringing influences patients' families', and caretakers' health beliefs, practices, and decisions
- Family influences and cultural norms (e.g. family members can be highly involved in decision-making, caregivers may prioritize family responsibilities over personal health and wellness)
- The intersection of faith-based norms and health behaviors
- Norms for interacting with authority figures (e.g. deference, fearful of asking questions)
- Other important priorities in the lives of patients and families that may take precedent over health issues
- Previous negative or harmful interactions with the healthcare system
- Rapport between patients, families, and caretakers with the clinical team

Advancing Health Equity: Leading Care, Payment, and Systems Transformation (AHE) is a national program supported by the Robert Wood Johnson Foundation and based at the University of Chicago. AHE 's mission is to discover best practices for advancing health equity by fostering payment reform and sustainable care models to eliminate health and healthcare disparities.