Diagnose Root Causes
Fishbone Diagram Instructions

Advancing Health Equity
Leading care, payment, and systems transformation

Instructions The Fishbone Diagram is a tool for conducting a Root Cause Analysis (RCA). It allows you to identify specific drivers of a health or healthcare inequity in a single chart. It is important that multiple key stakeholders participate in completing the RCA, including patients and their caregivers, community representatives, state Medicaid and Medicaid managed care organization representatives, and a variety of care team members (e.g., physicians, nurses, community health workers, medical office assistants, registration staff, and patient service representatives). Consulting a variety of stakeholders increases the chances of your team uncovering gaps in care they may not have previously considered. Below, find seven steps to help you conduct an RCA utilizing a fishbone diagram.

Step 1: Review "Diagnosing Disparity: Key Considerations" at the end of this document. Keep in mind its tips and guidelines as you complete your root cause analysis.

Step 2: State the health or healthcare inequity in the form of a question. Place the question at the head of your fishbone diagram. The problem should align directly with an inequity you identified through stratifying (e.g., by race, ethnicity, primary language, sexual orientation, disability, geography) and analyzing your health and healthcare data (Ex.: Why do our health plans and providers provide low rates of foot examinations for our Black patients with diabetes?).

There are two ways to fill out the diagram:

- **Starting with a health outcome** will allow you to be as inclusive as possible and to see the big picture. It can take longer to see a reduction in health outcome inequities than it would to change processes of care.
- **Starting with a clinical process** can yield early wins that inspire the team to continue working toward improving health outcomes, and may be a part of your overall strategy to reduce inequities in health outcomes.

Step 3: **Label the other boxes** that comprise the body of the fish with *categories* that answer the question, "What might be contributing to this problem?" Some commonly used categories include but are not limited to: people (Ex.: staff, patients, leadership, other stakeholders), policies, procedures/workflows ((Ex.: There are a low number of referrals given for foot care), equipment/supplies, and environment

Step 4: **For each category ask, "Why does that happen?"** List possible *causes* and attach them to the appropriate "bones" of the fish. (Ex.: Foot care referrals are difficult for patients to access.) See the 5 Whys graphic below for more information.

Step 5: **For each cause ask, "Why does that happen?"** Attach the answer to another, smaller bone. Keep asking "Why?" and attaching smaller bones until your team agrees that you've arrived at a root cause. Don't stop asking "Why?" too early, or you may end up focusing on a superficial issue rather than the underlying problem.

- After you've repeatedly asked "Why?" you may come to a point when you've identified causes that are social drivers of health (SDOH) such as poverty or lack of education. The health care sector can play an important role in mitigating SDOH. Think about how your organization, or a team of organizations, can work with community partners and policymakers to address systemic causes of health disparities and health inequity.

Step 6 **Apply an equity lens.** Think about which root causes contribute to the difference in quality in care and outcomes, not just overall low quality. Highlight the root causes on your fishbone diagram that uniquely impact the population(s) identified in the question at the head of your fishbone. AHE recommends using the Key Considerations resource to help you think of specific issues related to culture, communication, and context that typically

play a role in generating and maintaining various inequities. For example, racial bias can influence the quality of care that communities of color receive and heterosexism or gender biases can affect the quality of care that sexual and gender diverse communities receive.

Step 7 **Apply an intersectional and anti-racist lens.** Each one of us has multiple, intersecting identities that create unique circumstances of power and privilege in terms of how we experience the world around us, as well as how others perceive us. Various markers of identity such as race, ethnicity, sexuality, age, or socioeconomic status, combine to impact one's life in myriad ways and may come to bear at different moments of your day, week, or life. One day, your identity as a highly educated, upper-class woman may impact how you are regarded. The next day, it might be your identity as an elderly woman of mixed racial ancestry that is most salient, Care and payment transformation will account for how those intersecting identities may influence the priority population being served.

For example, consider a root cause analysis investigating why a health plan and its contracted providers are giving fewer foot examinations to rural patients living with diabetes compared to all other patients. Deliberately applying an intersectional lens requires asking if people with other identities who have diabetes living in rural areas might have different experiences. For example, are the experiences of older people with diabetes in rural areas different from others? Are the experiences of people living with diabetes in rural areas who also have low incomes different? Applying an intersectional lens might reveal that patients with diabetes and a disability living in rural areas have the lowest rates of foot examinations overall and that they face different or additional barriers. If an intersectional lens is not applied, inequities experienced by people living with a disability might be overlooked.

Utilizing an anti-racist lens requires ongoing effort to remain accountable and responsive to issues of race and racial bias at every level of the health system, including when conducting RCAs. In the example above, using an anti-racist lens means stratifying healthcare quality and outcome data by race and ethnicity as well as consistently looking for how answers to the "Why?" questions when completing the RCA might be different for patients of color. Investigating the experiences of people of color will likely reveal many opportunities to reduce inequities in healthcare and outcomes.

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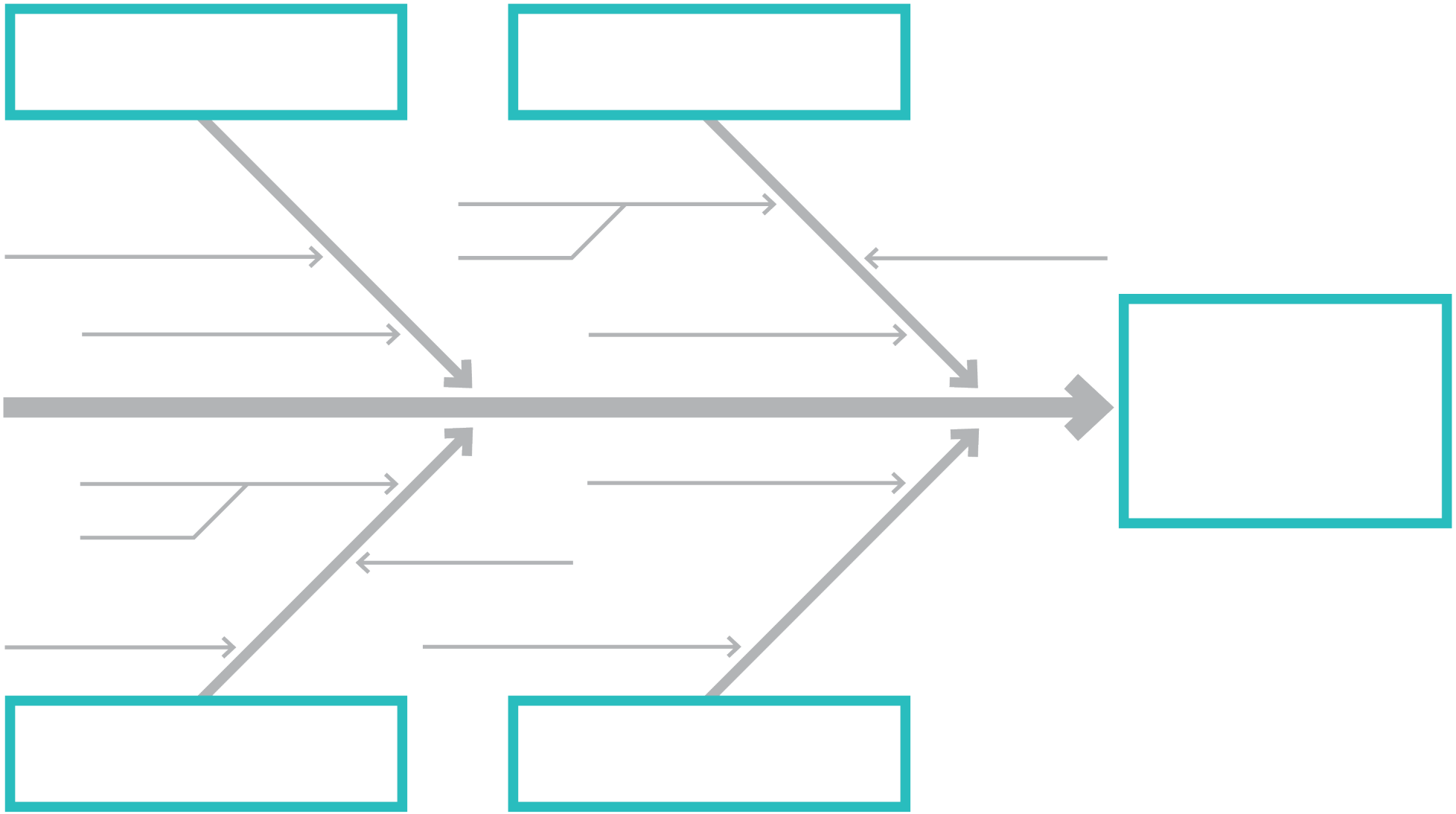

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The Importance of Asking The 5 Whys.

A simple—yet deceptively complex—question, "Why?" can help your team drill down to the source—or root—of a problem. In the example below, we use **The 5 Whys** tool to utilize an equity lens with an anti-racist focus.

Why are we less successful keeping our Black children with asthma out of the hospital compared to other children with asthma?

1	2	3	4	5
WHY?	**WHY?**	**WHY?**	**WHY?**	**WHY?**
BECAUSE We have not adequately helped Black children keep their symptoms under control.	**BECAUSE** We have not adequately taught asthma management.	**BECAUSE** We have provided sub-optimal care.	**BECAUSE** Black families have reported in focus groups that they often do not feel comfortable in our clinics.	**BECAUSE** They have experienced bias. In addition, we have very few Black team members and our education materials for children and their families do not feature Black people nor highlight their experiences.

Although there may be different answers to each question from different team members, asking **The 5 Whys** will help your team spot inconsistencies and gaps in care they may not have previously considered.

DIAGNOSING THE DISPARITY: KEY CONSIDERATIONS

There are many causes of disparities. Every root cause analysis (RCA) should consider multiple levels of influence that may contribute to low quality care and disparate health outcomes. To help you focus your equity lens as you conduct the RCA, we've provided some key considerations and examples.

PATIENTS, FAMILIES, AND CARETAKERS

- Comfort discussing personal/private health issues with provider and/or peers
- Family influences and norms (e.g., highly involved family members in the decision-making process, care of the family prioritized over care of personal health, avoiding open discussion of health issues)
- Food norms (e.g. cooking methods and ingredients)
- Health literacy
- The intersection of faith-based norms and health behaviors
- Language
- Literacy
- Medical/healthcare norms in home country/culture
- Norms for interacting with authority figures (e.g. deferring to providers, not wanting to question a provider's diagnosis)
- Knowledge and skills to implement behavior change (e.g. How to prepare food that follows a provider's recommendations without violating familial and cultural norms).

- Trust in the healthcare system (e.g. silently avoiding provider recommendations because of distrust that the provider has their best interest in mind)

PROVIDER AND CARE TEAM

- Clinical inertia
- Limited knowledge about disease
- Limited knowledge about how disease may present differently for underrepresented, at-risk, or otherwise marginalized populations (e.g. tailored screening protocols)
- Limited knowledge about various cultural norms in the local community
- Limited knowledge about how community environment and available resources may influence a patient's ability to manage their health/chronic illness (e.g. poor public transportation infrastructure, food deserts, close proximity to generators of high pollution)
- Limited health/medical fluency in languages other than English. Use of non-certified medical interpreters.
- Low comfort engaging patients on issues related to minoritized status (e.g. race, culture, sexual orientation, gender identity, class, sex, and/or age).
- Inadequate understanding of intersectional identity markers
- No follow-up communication with patients that have complex or long-term treatment protocols
- Unrecognized and/or unresolved prejudices and biases

MICROSYSTEM: THE IMMEDIATE CARE TEAM

- Ineffective referrals (e.g. eye exam results do not find their way to PCP, or referred specialist has no available appointments for six months)
- Limited case management and other supports to assist patients in navigating the healthcare system
- Lack of member-specific, team-based communication (e.g., between primary care providers and specialists, inadequate health record documentation, lack of team- based member reviews/rounds)
- Missing knowledge or skills (e.g. community health worker or psychiatrist's expertise is needed)

ORGANIZATION

- Clinic schedule (e.g. limited evening or weekend hours)
- Existence, capacity and influence of your organization's community advisory board Limited time allotted for appointments
- Inconvenient location (e.g., proximity to public transportation)
- Limited specificity of race/ethnicity data (e.g. diverse European immigrant populations all captured as "white" in data)
- Limited staff (no Certified Diabetes Educators, for example)
- Low-quality population of race/ethnicity data at point of entry or registration
- No opportunity to assess member satisfaction or implement feedback mechanisms with effective follow-up
- Organizational effectiveness implementing Culturally and Linguistically Appropriate Services (CLAS) standards

- Presence of comprehensive orientation and ongoing training for all staff to be comfortable with the cultural values, beliefs, and issues important to patients
- Staff familiarity with applicable internal and external resources such as behavioral health services, support/educational groups, community-based organizations, or financial assistance

COMMUNITY

- Availability of reliable public transportation
- Food deserts
- The healthcare organization's history and reputation as perceived by the community or communities it serves. Poor perception of the organization hinder member trust of care team members and other staff.
- Mutually beneficial partnerships with community-based organizations (e.g. churches, fitness centers, park districts, schools, social services)
- Safety/Security (e.g. parents reluctant to let children play/exercise outdoors due to safety concerns).
- Variety, convenience, and safety of local health-related resources (e.g. gyms, walking paths, parks)

HEALTH PLANS, MUNICIPALITIES, AND STATES

- Contracting supporting equity-focused healthcare delivery reform
- Equity-focused technical assistance and capacity building services
- Inter-agency partnerships and collaboration to address social drivers of health (e.g., increasing affordable housing, decreasing food deserts, pollution reduction and elimination)
- Needed services not reimbursed (e.g. dietician)
- Pay-for-performance or other incentive-based payment models encourage cherry-picking or dumping patients."
- State and municipal support for healthcare programming and infrastructure support (e.g. reduced drug assistance program funds, reduced electronic health record development and implementation funds).
- State-level health insurance legislation and reform efforts (e.g. changes in Medicaid benefits levels or eligibility, changes in reimbursement rate affecting provider's willingness to accept certain payers)