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ABSTRACT Health-care organizations traditionally view accountability through punitive and performance-metric lenses, failing to address their responsibility to communities most impacted by health inequities. While research exists on organizational accountability in health care, little explores how Black, Indigenous, and People of Color (BIPOC) frameworks might transform health-care delivery toward justice and equity. This article examines how four BIPOC philosophical frameworks—right relations, Seven Generations, calling in versus calling out, and Emergent Strategy—can reimagine organizational accountability to advance health equity. The authors' findings reveal that combining BIPOC accountability frameworks with structural reforms in payment and care delivery systems enables health-care organizations to center relationship-building and long-term community impact. Concrete organizational examples demonstrate successful implementation of these principles through initiatives like the Robert Wood Johnson Foundation Advancing Health Equity program, while personal narratives illustrate their transformative potential in patient care. This work provides practical pathways for health-care organizations to move beyond punishment toward accountability models that prioritize immediate holistic care needs, health equity, and generational community well-being, fostering healing and justice.

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ACCOUNTABILITY—THE OBLIGATION OR willingness to take responsibility for one's actions—demands radical reimagining within health-care organizations. While traditionally viewed through a punitive lens, especially in Western corporate culture, we propose that the chance to rethink how we see and use the concept of accountability can serve as a powerful catalyst for advancing health equity and organizational healing.

Health-care organizations face mounting pressures: ethical challenges, market forces, resource constraints, and imperatives to address social drivers of health. These challenges present an opportunity to transform how we conceptualize and implement accountability at both structural and relational levels. Too often, accountability has been reduced to performance metrics and quality control, missing the deeper interconnections between organizational systems, health-care practitioners, and the communities they serve.

This narrow interpretation of accountability manifests in two primary ways, both focused inside the organization: high-level organizational oversight (boards, executives, shareholders) and individual responsibility for errors and inefficiencies. This binary inwards approach overlooks accountability of health-care organizations to communities and particularly underemphasizes the critical relationships between health-care organizations and the marginalized populations most impacted by structural inequities. Too often, the result is a work culture where accountability evokes fear that is stoked to further self-interested organizational goals, rather than inspiration for positive, mission-driven change improving the health and well-being of communities.

Drawing from Indigenous wisdom and Black, Indigenous, and People of Color (BIPOC) philosophies, we present an alternative framework, where accountability represents a "calling back to community" rather than punishment. This perspective reframes accountability as the foundation for relationship-building and healing at individual, organizational, and systemic levels. By integrating these traditional knowledge systems with contemporary health-care challenges, we can transform accountability from a source of apprehension into a catalyst for justice-centered practices.

Our exploration will provide practical examples for health-care practitioners at all levels—from clinicians to administrators—demonstrating how this reimagined accountability can enhance organizational decision-making while advancing health equity. In many cases, we are referring to the clinician-patient relationship, and we are clear when we are referring to other examples. We acknowledge the tension between capitalist health-care delivery and equity, and the mismatch between how corporate health care defines medicine and what patients and communities want for their health-care experiences and outcomes.

One of the most important factors in this discussion is the question of who gets to decide the definition of equity and what is equitable in health care delivery and in these systems. We make the case for why one of the core elements of

equity principles must guide our answer: it is always the most vulnerable in our society—those with the least amount of all types of power—whose perspectives and lived experiences should guide our definitions of equity. We include a brief explanation of why we center this principle and its origins.

Through this examination, we aim to inspire a transformation where accountability serves as the cornerstone of a more just and effective health-care system—one that genuinely delivers on the promise of equitable care for all.

Throughout this article, we will (1) examine the historical context of punitive accountability in health care; (2) present Indigenous and BIPOC models of accountability to relationships and long-term generational outcomes; and (3) explore examples of organizations successfully integrating these Indigenous and BIPOC models to guide relational, cultural, and structural changes that advance health equity. By reorienting our understanding of accountability from a tool of control to an instrument of collective growth and healing, health-care organizations can better address inequities while fostering a culture of genuine responsibility and ethical leadership.

Defining Accountability

Rooted in organizational psychology, traditional understandings of organizational accountability focus on performance and improvement. Accountability has long been defined as an expectation and responsibility to justify one's behavior, beliefs, or actions to others, particularly when they deviate from cultural norms (Brees and Ellen 2022; Wang, Waldman, and Ashforth 2019). Accountability is often subjective, met with rewards or punishment, and ultimately used as a tool to motivate individuals into behaving within an approved cultural and organizational context (Brees and Ellen III, 2022). Accountability can evoke a sense of defensiveness, with individuals blaming their mishaps on external factors to avoid taking accountability (Wang et al. 2019).

Aristotle's earliest understanding of accountability is framed through misconduct, and the foundation of much organizational psychological research around accountability builds on Tetlock's social contingency model, which posits that individuals behave and act based on how they perceive those around them will respond (Lerner and Tetlock 1999; Wang et al. 2019). When fear of judgment and the expectation that negative consequences will occur if one "gets it wrong" predominate, it is no surprise that individuals shy away from accountability. Thus, fear and avoidance of accountability can be the context for organizational accountability tactics such as performance reviews and improvement plans.

How can we expect individuals to see accountability as an internal and interpersonal responsibility to others? Health care faces difficult challenges, including increased costs and financial pressures, new technology and tools, and depersonalization of care (Hendee 2008). What should accountability look like and to whom? How can we build a sense of personal accountability and see it as a virtue

that guides our responsiveness and responsibility to others? Fortunately, BIPOC philosophies have long viewed accountability in this way, in part rooted in the experience of living in a world that has marginalized those communities and deemed them as less than or even invisible. Below, we introduce four Indigenous and BIPOC frameworks that provide perspective on how health-care providers and organizations can shift their mindset and lean into ways of being accountable that ultimately center community, love, and respect.

RIGHT RELATIONSHIPS AND THE SEVEN GENERATIONS PRINCIPLE

"Right relations" is an Indigenous concept that has guided how individuals interact with one another and the environment and animals around them for centuries. The grounding principle of right relations is that all beings, entities, and the environment exist in a state of relationality. Relationality refers to the reciprocal responsibilities and sustainable resilience between humans and the natural world around them (Johnson et al. 2016). All of us have a responsibility to deepen our understanding of our own experiences and histories, and how they relate to those around us. The concept of right relationship claims that we must acknowledge how colonialism and its legacy of oppressive systems prevents us from existing in relationships of mutual respect and reciprocity (Gram-Hanssen et al. 2022). Colonizers exploited Indigenous communities and enslaved peoples for resources and power, often maintaining that power through a hierarchical societal structure of racist and xenophobic laws, policies, and cultural norms. Eugenics, redlining, and disparate health outcomes for people of color and low-income individuals are rooted in exploitative views that White, European-descended individuals with means are worthy of a life of dignity, while all others are deemed expendable. Living with right relationship means that we see every interaction and opportunity as a moment to deepen our responsibility to one another and work to reverse colonialism's cultural and structural effects.

The concept of right relationship helps to underpin the "Seven Generations" principle. This principle dates back to the Haudenosaunee Confederacy (Iroquois Nation), where it was believed that those living on this land today are borrowing it from those in the future (Haudenosaunee Confederacy 2024). The Iroquois believed that we have a responsibility to consider the impact of our actions on those who are not yet born but will inherit the world from us. By considering the sustainability of our actions, we can attempt to strike a balance between short-term needs and long-term impact.

How might our interactions with one another and the world around us shift when we consider how we maintain right relations with those around us and how we are impacting those several generations from us?

Leaning In With Love: Calling In versus Calling Out

Loretta J. Ross (2020), cofounder of Sister Song, activist, and professor, leads the conversation on calling in vs. calling out. The past several years have seen the rise of "cancel culture,"— where individuals lose support, trust, or prominence based on something they did or said that was offensive or is not socially acceptable. Cancel culture implies that individuals cannot grow, learn, or even repent for something they have said or done that is deemed socially unacceptable. Cancel culture contributes to individual anxiety about engaging in challenging conversations on complex topics, pushing accountability further and further away.

Cancel culture calls people out. When someone does or says something socially unacceptable, we meet them with anger and frustration to hold them accountable. We say things like, "You're racist. How can you say that?" (Ross 2021) This approach invites conflict rather than shared dialogue and learning; public humiliation can make the other person walk away uninterested in seeing our point of view. The desire to hold someone accountable for harm they have done has been present in civil rights movements for centuries; however, Ross calls upon us to reflect on how the shift from anger, frustration—maybe even hate—to love and grace could dramatically change our perceptions of accountability and foster real change. Ross recalls: "One of my students once said, 'A call-out is not an invitation for growth. It's the expectation that you've already grown.'"

So what is calling someone in? And why do we need to meet one another with love and grace, when we very well may be angry and hurt? "Calling in" is a phrase invented over 10 years ago by activist and writer Loan Tran (2013), a Vietnamese migrant hailing from North Carolina and a longtime collaborator with Ross. Calling in has the same final goal as calling out, but it is done with love and grace (Ross 2021). It sounds like "What you just said is interesting, can you tell me more about that?" or "I heard you say XYZ—is that what you meant to say?" Calling in takes the conversation out of ego and pride and opens up a conversation with mutual respect. Tran (2013) states that calling in works best when it is done with people we have "reason to trust or with whom we have common ground." In other words, calling in works best when we presume the other individual is not intentionally trying to be malicious, harmful, or violent towards us. To be truly successful, calling someone in requires a love ethic.

A love ethic, coined by the late and amazing bell hooks, is an ethical foundation that guides how we move through our lives. hooks (2018) states:

> Embracing a love ethic means that we utilize all the dimensions of love—"care, commitment, trust, responsibility, respect, and knowledge"—in our everyday lives. We can successfully do this only by cultivating awareness. Being aware enables us to critically examine our actions to see what is needed so that we can give care, be responsible, show respect, and indicate a willingness to learn. (94)

Living one's life with a love ethic helps us to understand that calling someone in is a way to demonstrate respect and care for that individual. With care and respect present, we are saying to the other person, "I believe you can grow, I believe you can change, and I believe you have the capacity to care for me too." Ross, Tran, and hooks all identify the demonstration of care, respect, and love as a powerful tool for systemic change that invites growth and presumes a future where we can work together to bring our vision of a more just and equitable world to fruition.

UNDERSTANDING INTERCONNECTEDNESS: EMERGENT STRATEGY

The "Emergent Strategy," developed by adrienne maree brown (2017), builds on components of design thinking in ways that center human experience for transformative change. Emergent Strategy is informed by phenomena we see in the natural world on a daily basis—how the natural world finds its footing without the bureaucracy of planning meetings, fundraising, and strategic conversations. How mycelium under the ground grow together and strengthen their bonds, such a seemingly small thing with a big impact. brown sees an opportunity for humans to mimic this experience, strengthen our bonds, and work together to create a world where everyone can thrive. Emergence is the way systems and patterns come to fruition in seemingly small interactions (brown 2013). These patterns are essentially how we create, sustain, and even destroy relationships with one another.

There are four core principles of Emergent Strategy most relevant to understanding accountability and how we are interconnected:

> Small is good, small is all. (The large is a reflection of the small.) . . .
> Trust the People. (If you trust the people, they become trustworthy.) . . .
> Move at the speed of trust. Focus on critical connections more than critical mass—build the resilience by building the relationships.
> What you pay attention to grows. (brown 2017)

These four principles outline a way of being that prioritizes relationship. For us to move equity and justice work forward, we have to lean out of the preplanned expectations and into the emergence that strong, healthy relationships can foster.

"Small is good, small is all" is a call for us to recognize that our actions, impact, and legacy are a culmination of our smaller interactions and moments with others. Maya Angelou stated that "People will forget what you said, people will forget what you did, but people will never forget how you made them feel." One may be lauded as a champion for equity, but the true determination of their commitment is seen in the small moments with no audience. People are trustworthy when you trust them. Far too often, we doubt the realities of those existing at the margins of our society. We refuse to trust their truths because we cannot un-

derstand them. This ultimately removes them from the decision-making process. And because we have not demonstrated that we are trustworthy, the marginalized may further disengage from us. We may be left with gaps and misunderstandings about the problems of the marginalized that we will be unable to solve.

What you pay attention to grows can feel like an enigma. We all know how watching a pot of water boil just seems to extend the time we perceive it takes to boil. However, brown reminds us that we can often find the solutions to our problems if we pay attention to the complexities in front of us. But none of this can happen if we are moving faster than the pace at which trust is being built within our relationships. In too many instances, we drive toward a solution through a false urgency that can cause harm to those we are aiming to help. This drive often dismisses those most impacted by our decisions and assumes we have a level of understanding that may not be present. By prioritizing the relationships necessary to do meaningful work, the impact of our interactions can be deepened, well-informed, and powerful.

Individual Stories

When we shared our thinking on accountability influenced by these BIPOC philosophies with our networks, a few personal stories emerged that we feel are worth sharing. Below, we include narratives from recipients of care that illustrate when accountability frameworks were profoundly absent or came to life. We hope to incite imagination for how both individuals and systems could hold themselves to a level of accountability that centers relationship and sustained impact and that, when applied, could be a driver of health equity. To ensure anonymity, we have removed names and identifying information from the stories to protect those involved.

Story 1: Reimagining Systems

Recently, I was scheduled for what was supposed to be a routine outpatient hysterectomy. Due to the anatomy of the offending fibroid, what started as laparoscopic converted to a difficult abdominal hysterectomy, which lasted over six hours and caused dangerous blood loss, a three-night hospital stay, and several postoperative complications. Healing was slow, in part because my renal-ureter drainage system was compromised during the operation. Subsequently, I have had two other surgical procedures to restore proper functioning of my abdominal organs. In between and as I healed, I made numerous trips to medical offices for lab work, scans, follow-up appointments, and pharmacy runs. This plight was costly in direct medical expenses and in lost wages and productivity for myself and those who cared for me. My journey to health continues; I still experience flank pain and find it hard to shake my physical and psychological fatigue. I am also still working to recover economically, as I plod through the state short-term

disability bureaucracy in order to receive the partial-salary disability pay to which I am entitled.

I expected that my body's systems would require nearly all my energy to heal; but I did not expect the extent of the psychological costs nor how much effort I would expend to advocate for myself to receive critical treatment. In the midst of healing from the first surgery, I pushed for a diagnosis of a blockage, sped scheduling for corrective surgery, and advocated for preemptive procedures in the interim. I had to seek assistance with the treatment for the symptoms of sudden and full-blown menopause, by definition a predictable "side effect" of hysterectomy but otherwise not considered as part of my recovery plan. In a system where physicians each attend to their specialty and where the focus is on rapid intake-outtake, the complications that lie between specializations or that spill from one specialization (gynecological surgery) to another (urology) often go unattended. This leaves the patient as their own case manager, or, more personally, as their own body manager.

As my own body manager, I learned that what happened in one part of my body impacted another. The health-care system is siloed, but our bodies are not. Thankfully, by now the surface wounds have healed from the incisions, my kidney levels show restored function, and my hormones have stabilized. But who is to tend to my ongoing flank pain, brain fog, and fatigue? I've needed a case manager who actually understood medical science, anticipated how interconnected the body is, and how to work the system.

Getting back to wellness has been like ordering from an unfamiliar restaurant without a menu. Since my last procedure, I have guessed at and advocated for therapies that I hoped would help me feel better in the short and long term. I requested access to the pain management clinic to see if acupuncture might alleviate pain the surgeons could not explain. I inquired about nutrition counseling to help me recover from so many courses of antibiotics. I sought physical therapy to learn how to restore core strength and protect my pelvic floor. None of these were offered by my care providers, and all had to get approved by insurance for partial coverage.

I imagine this journey if I did not hold the identities I do as a well-connected, English-speaking, otherwise able-bodied, White woman with white-collar employment who lives in an urban setting in close proximity to health-care facilities. At every turn, I relied upon relatives with medical degrees to validate my concerns and to help me gauge whether the treatment I was receiving was aggressive enough. What would have been had I not had that social capital? I am keenly aware that I hold tremendous privilege in this regard and still feel my experience could have been improved if my care were not so siloed and myopic, and if there were a model of medicine that was designed by a more holistic and equitable approach to recovery and well-being.

In my research on my diagnosis and treatment, I discovered that Black women are more likely, two to three times, to have leiomyomas (uterine fibroids) than any other racial group in the United States. By the time they reach menopause, more than 80% of Black women will have leiomyomas. Although not everyone is symptomatic, 80% is an astounding statistic. And for those who do have symptoms, they are also twice as likely as White women to get hysterectomies as treatment, less likely to have laparoscopic hysterectomies that promise easier recovery, and more likely to have postsurgical complications similar to or worse than those I experienced. This racial disparity exists even when controlled by access to health care (Eltoukhi et al. 2014). A systemic solution to this racial inequity must be prescribed.

Despite leiomyomas being the most common benign pelvic tumors in women, with Black women bearing a disproportionate burden in frequency and severity, our current health-care system fails to adequately address when the condition becomes a malady. A transformative approach to care could prioritize both prevention and comprehensive treatment by restructuring physician payment models, measuring long-term health outcomes particularly among Black women, and reimagining success metrics to include patient experience, early intervention, and the reduction of racial disparities. This systemic overhaul would not only address patients' immediate symptoms but also prevent potential and costly complications in bladder function, fertility, pregnancy, and menopause, while fundamentally improving the standard of care through the lens of those most affected.

Using the lens of accountability as suggested by the thinkers outlined in this exploration, I rewrite this story. There would be research on what contributes to the rapid growth of fibroids and an understanding of why Black women have higher occurrences. That research would inform public health measures aimed to prevent the prevalence of troublesome fibroids currently and in the next generations. A system that prioritized prevention would reward doctors for advising me on what nutrition, supplements, or behaviors would reduce the risk of problematic levels of growth. Even if catching fibroids sooner and preventing surgery were not possible, and even if complications from a hysterectomy were inevitable, my experience would have been different in a system designed with the influence of thinkers like bell hooks and adrienne maree brown. The payment system and accountability metrics would support and incentivize clinicians who express and demonstrate a sense of responsibility and commitment to ongoing healing and holistic well-being of the persons and communities in their care.

Story 2: Reimagining Relationship

All things considered, I am a relatively young, healthy woman. But for almost two-thirds of my life, I've dealt with endless abdominal pain. An omnipresent pain that would spike on some days and fade into the background of everyday living on others. I'd visited countless doctors since I was in my teens, and they all

came to one of the two following conclusions: I was obese (based on my body mass index [BMI], despite the fact that BMI was never historically created by a physician or for women, let alone a woman of color like myself), or I was perfectly healthy, and it was all in my head (the good old anxiety diagnosis). For many years these conclusions fueled a lack of self-esteem as I felt the constant pressure to lose weight, and a level of craziness where I gaslit myself into believing my pain wasn't real. As I got older, and it began to have a bigger impact on my life with worsening symptoms, I knew I had to figure out what was going on.

I want to share two uniquely different experiences with my health-care providers. The first was three years ago. I had been seeing a new gastroenterologist, the fourth in my healing journey, and I was scheduled to have a colonoscopy. I am immensely afraid of needles and getting an IV in, going under anesthesia, or doing any of this without a loving and supportive family member by my side. However, on the day that I had my procedure I was unable to be escorted into the waiting area (we were still in the height of COVID restrictions). I got dropped off and sat anxiously in the lobby until they called my name. Upon getting to the back, a kind nurse introduced herself and explained to me what would be happening over the next few hours. I paid attention, but my anxiety was getting the best of me and tears started to well in my eyes.

I was hoping the nurse hadn't noticed. She noticed. After asking me what was wrong, I couldn't hold my tears back any longer. I shared my fears and anxiety with her, and said softly, "I know it's very busy in here, and you all have a lot of people to take care of, but can you please hold my hand while they put the IV in, I've never had to do this without someone here before." She grabbed my hand and promised me that she would take great care of me. When a bed finally opened up, she walked me over and introduced me to another kind nurse who held my hand and distracted me while the initial nurse inserted my IV. I had never felt so safe and cared for in a health-care setting before. I thanked her profusely. My colonoscopy results came out clean; I was perfectly healthy.

That story feels like an immense contrast to my second experience. Two years ago I found a new gastroenterologist (the fifth, as I had moved to a new state). At this point, I had already done my colonoscopy, and she was suggesting another, along with an endoscopy. This may not be a surprise, but my results came back perfectly healthy. I was gutted. I couldn't help but feel defeated that once again I'm being told I'm healthy when I am experiencing life-interfering pain on a daily basis. I began to cry. I remember what she said to me next, "I feel like you just want me to tell you something is wrong with you when there isn't." I was stunned. I responded, "No. I don't expect you to tell me that something is wrong. But I do expect that my pain is acknowledged as real, and that I am not dismissed simply because this one procedure didn't flag anything." She responded defensively, referring back to the clean results from my procedure as proof that my lived experience was not accurate. Needless to say, I didn't go back to her

practice. I moved along to a sixth, and hopefully final, provider who met me with empathy, affirmed my feelings and my pain, and introduced a care plan including x-rays, medication, and other tests that no other provider had even offered me.

When I reflect on these two unique experiences through the lens of the BIPOC frameworks discussed earlier in this article, I can't help but see distinct opportunities for accountability to show up. In the first experience, the nurse that helped me didn't have to slow down or take time to comfort me. But she did. She demonstrated, albeit maybe unconsciously, a desire to be in right relationship with me. Her actions reflected a level of accountability to ensure that I felt safe and protected so that I could receive the best care possible. I teared up while writing this as I recalled the immense kindness and care that was given to me simply because the other person's actions demonstrated a desire to be in right relationship with me.

In the second experience, none of these frameworks showed up. In the dismissal from this provider, I attempted to advocate for myself; I attempted to call her in. Her defensive response was an immediate shutdown of any opportunity for us to be in community with one another. She was adamant that her job was done, because in her siloed view of my health, I was fine. Not only did this dissolve any trust I had in her care delivery. As adrienne maree brown would remind us, small is good, small is all. If small represents the large, what does this one small interaction with me mean for how this provider delivers care more broadly? Is she dismissing all her patients? How could we build trust when it was clear my provider felt that they had delivered quality care because my scans were clean, but made no effort to consider my health from a holistic perspective or even offer me a path forward toward relief? What kind of health-care system supports, encourages, and rewards providers who think that performing colonoscopies and endoscopies competently is the definition of quality care, neglecting caring for patients in pain and not understanding their lived experiences?

This provider's behavior felt immensely different from my experience with that kind nurse three years ago. These experiences together reveal a tough reality. It will be hard to achieve health equity if we are not open to building the relationships necessary for health to thrive and creating care systems that support and value these types of interactions among patients, clinicians, and other members of the health-care team.

Reforming Health-Care Systems to Adhere to Seven Generations

Right relations are essential for organizational accountability for justice and health equity, and reforming the health-care system to adhere to the principles of Seven Generations is equally important. The health-care system in the US is a vast network of various systems, both private and public, with each system having its

own challenges, successes, and approaches. And while there may be small pockets of the system that embody nontraditional forms of accountability, the vast majority of the system does not.

Understanding how to incorporate these principles requires us to ground some fundamental truths about health care in the US. A key challenge is that the system is not designed to optimize the health and well-being of persons and communities (Chin, Dale and Hernandez-Cancio 2024). The system is set up to reward short-term financial gains for the organization and shareholders rather than long-term value to society. Health-care delivery organizations are incentivized to increase their payor mix of high-reimbursing patients with private insurance and to avoid caring for uninsured and underinsured patients, such as those with low-reimbursing Medicaid insurance (Eschliman et al. 2023). Much of the health-care system is still built upon a fee-for-service chassis that rewards provision of high volumes of services, procedures, and surgeries, rather than prevention of illness and measures of health and well-being. Value-based payment systems that attempt to reward the value of care tend to include traditional clinical performance metrics as their markers for quality of care, such as hemoglobin A1c for patients with diabetes. While these metrics capture some elements of quality of care, they do not capture more global, holistic markers of patient health and well-being, such as healthy days at work. When considering value, many health-care delivery organizations prioritize costs rather than benefits, a trend that is worsening with the increased role of private equity, which siphons profits to shareholders, potentially worsening quality of care and patient outcomes (Bruch et al. 2024; Kannan et al. 2023).

Fixes to support and incentivize health-care delivery organizations to lead with the principles of right relations and Seven Generations will require action by policymakers. Mission and values are critical, but they must be accompanied by payment and care policies that enable this to occur. In particular, policies should support optimizing social return on investment, with the health and well-being of persons and communities measured globally and holistically (Chin, Dale and Hernandez-Cancio 2024; HCP LAN 2024). For example, broadening access to insurance and increasing Medicaid reimbursement rates would give health-care delivery organizations an incentive to provide high-quality care for these patients, rather than avoid caring for or undertreating them because they lose money on them (Eschliman et al. 2023). Policies should adjust payment to health plans and health-care delivery organizations to provide the additional funds necessary for caring for patients with higher social risk and to avoid perverse incentives to avoid caring for them (HCP LAN 2022; National Academies 2017). In addition, addressing health-related social needs should be paid for and rewarded, and funding should be flexible so that health-care delivery organizations can address medical and social issues that impact a patient's outcome in ways that are integrated and efficient (Fernandez and Chin 2024).

Payment and care delivery systems should also create stronger incentives to improve the outcomes of communities and geographic populations over the long term. Alternative payment models—such as accountable care organizations, which hold health-care delivery systems responsible for an attributed population—can be designed in ways that intentionally support the care of marginalized populations to advance health equity (HCP LAN 2022). Also, payment systems that make health-care delivery systems accountable for the total cost of care, as the state of Maryland does, provide stronger incentives for managing the global health and well-being of populations and communities. These systems reward prevention and wellness rather than the treatment of costly disease complications requiring procedures and surgeries (Wang et al. 2023).

In addition, sensible regulation of private equity in health care is necessary to ensure sufficient societal value (Cai and Song 2023). Regulations should include improved oversight of mergers and acquisitions, increased transparency, protections for patients and clinicians, and reduction of risky financial practices (Cai and Song 2024).

While health-care policy changes are necessary to maximize social return on investment, organizations can still do much today. In 2024, the University of Chicago Pritzker School of Medicine and UChicago Medicine (UCM) received the Association of American Medical Colleges Spencer Foreman Award for "demonstrated profound commitments to improving the health and well-being of all individuals who call the South Side of Chicago home" (AAMC 2024). This award reflects work over two decades to intentionally advance health equity. Cultural and structural changes occurred in the way UCM and the medical school operate, care for patients, and train students.

After new leadership was recruited in 2010, UCM created a diversity, equity, and inclusion (DEI) office to catalyze health equity efforts. Its approach was informed by concepts consistent with right relations and Seven Generations, including critical theory and relational-cultural theory (Todić et al. 2022). Structural change occurred throughout the organization. For example, equity was integrated with quality improvement and data analytics and incorporated into UCM's Lean and E3 leadership management systems (Todić et al. 2022). UCM made equity dashboards available to all employees that stratified quality measures by race, ethnicity, ZIP code, gender, language, and payer status (Connolly et al. 2021).

Concurrently, the Pritzker School became a leader in health equity and community engagement. An elective health equity course was so popular that it became required for first-year students in 2008. The course covers interpersonal issues relevant for caring for diverse marginalized patients, such as implicit bias and how structural racism and other systems of oppression affect health inequities (Peek et al. 2020; Vela et al. 2008). Much learning occurs in experiential small-group exercises and discussions (Chin, Pace-Moody et al. 2024), including community-based projects.

The Spencer Foreman Award recognized the Pritzker School and UCM's partnership and engagement with the community that built on their prior cultural and structural health equity work. Examples include the first-year Health Equity, Advocacy, and Anti-Racism course; six student-run free clinics, pipeline training programs (Fritz et al. 2016); the Community Champions program, which trains residents to partner with the community on health projects; an NIH Clinical Translational Science Award with strong community partnership; and community grand rounds that educate community members on health topics. The award has recognized the establishment of a level 1 trauma center, which implements holistic solutions for preventing violence and caring for persons and families impacted by violence (Strong et al. 2024), and the creation of the South Side Healthy Community Organization, which organizes coalition partners to increase the number of primary care physicians and obstetricians, improve access to specialists, recruit community health workers and care coordinators, and develop a connected care data platform (HFS 2021).

Putting It All Together

A national program of the Robert Wood Johnson Foundation (RWJF), Advancing Health Equity: Leading Care, Payment, and Systems Transformation (AHE) brings together multiple partners (state Medicaid agencies, Medicaid managed-care organizations, health-care delivery organizations, community-based organizations) to align payment and care transformation to address medical and social needs to advance health equity, within an anti-racist culture of equity (AHE 2024; Cook et al. 2023; Thorndike et al. 2023). Building on prior work by RWJF health equity programs, the AHE team found it was essential to have a business case from the perspective of each partner and payment reform that would support and incentivize the desired care transformations (Chin 2016, 2021; Chin et al. 2012; DeMeester et al. 2017). It also became clear that creating cultures in which equity was truly valued and prioritized would be critical: marginalized work by a siloed DEI committee would have limited effect. We developed a roadmap that guides identification and root-cause analysis of the causes of inequities, the design of a care transformation that addresses those root causes, and the development of a payment system that supports those care transformations (Chin et al. 2012). We learned the hard way that there were no shortcuts: if you did not work simultaneously on culture change, it would be very difficult to develop and implement technical operational payment and care delivery reforms that would be sustainable at scale (Vela et al. 2022).

The AHE's National Program Office, led by the University of Chicago with partners Center for Health Care Strategies and Institute for Medicaid Innovation, initially worked with seven state teams. The AHE National Program Office had significant experience working with health-care delivery organizations, Medicaid

managed-care organizations, and state Medicaid agencies. A second cohort of five state teams began in 2022. In discussion with RWJF, AHE added components addressing structural racism and other intersectional systems of oppression that impact health equity. The program felt that these were important drivers of health inequities that manifested in structures and cultures in health-care organizations that harm marginalized groups (Cook et al. 2023; Singletary and Chin 2023).

While the AHE National Program Office has experience and skills in providing diversity, equity, and inclusion training (Cook et al. 2023; Todić et al. 2022), it sought an additional partner to specifically focus on addressing structural racism and relational and cultural factors to help organizations transform. Thus, The Justice Collective (TJC), a social impact consultancy that transforms organizations through a relationship-centered approach, joined the AHE National Program Office team. TJC has helped lead equity work internal to the AHE team. With a variety of partner organizations, AHE had to realign its mission to create a shared vision for our work with state teams. This effort is not singular or time-bound. We continue to tend to the culture of equity within our partnership, by asking ourselves what values we hold dear, which of those values are critical to achieve the AHE mission, and what we can expect from one another as we go about our work. We ask ourselves how these values should be expressed in internal team meetings, in how we provide technical assistance to our state teams, and in how we help state teams work with the communities they serve.

Members from TJC routinely call in others on our AHE team (and expect to be called in as well) when moments of challenge arise. They don't shy away from hard conversations, both publicly and privately, while always centering the relationship above all else. They push us to slow down the work when trust isn't present or may have been violated and to make space for all voices to be heard throughout the team.

TJC and the wider AHE team have helped each state team develop the relational and cultural skills outlined in this article. Building a team charter, talking about how to make decisions and to align around shared values—we offer these to each state team as part of our Foundational Activities in the Roadmap. These structures, processes, and discussions are critical for building the interpersonal relationships necessary for relational accountability.

Inspired by George Ella Lyon's I Am From Project (2024), TJC's first training with the state teams included an exercise called, "I am from . . . ." This exercise called on participants to share who they were, what made them who they are, and how that shows up in the world around them. Not only did this exercise become the foundation upon which inter-team relationship-building was able to thrive, but it was a synergistic complement to the support the AHE team had already been giving state teams. The foundational health equity work simply would not be successful if we did not focus simultaneously on the relationships, culture, and interdependence that exists within the collaborative.

One team comprised of a state Medicaid agency, a managed-care organization (MCO), and a network of multiple community health centers (CHCs) serving diverse communities across the state successfully wove the AHE approach into a partnership. This cross-functional partnership recognized that to champion health equity as a state, they needed to build an internal learning engine. Discerning that the patients and communities served by each CHC were impacted by particular health inequities, the team designed an equity learning collaborative, wherein each CHC identified what was most pertinent to their community. Within a coordinated cross-agency and statewide approach, each CHC studied which interventions might have the greatest impact based on local disparity data and community input. CHCs that chose similar focus areas connected with peers and exchanged strategies in ongoing learning cohorts. Notably, the AHE team provided the CHCs with a series of educational sessions that dealt with how to identify and diagnose disparities, select interventions, and incorporate patient and community perspectives. The MCO's upfront investment in this type of capacity building and their willingness to rearrange how to pay network CHCs was vital. Typically funding for such initiatives is provided once targets are met, but in this case the MCO increased efficacy and accountability by giving CHCs a no-risk advance on their earned value, so they could build a stronger foundation for their initiatives. Going forward, the project aims to transition to a payment model that gradually increases provider accountability over three years. CHCs will be paid to complete health equity assessments (year 1), to develop interventions to address identified disparities (year 2), and to have an impact on identified disparities (year 3). Out of this effort, the MCO has developed an assessment tool to ensure equitable decision-making and encouraged the other partner organizations to adopt it. Woven throughout this initiative has been the cultivation of a culture of equity, with each partner called upon to maintain its equity lens and to stay accountable to the communities it serves.

Conclusion

An overarching question that must be addressed is who gets to decide the definitions of equity, fairness, and human-centered behavior. Our foundational principle is that in all equity and culture-building work, it is the most vulnerable and those with the least amount of power who must define what is equitable, what is just, what is fair, and what is truly going to be effective. This principle shows up across many Black feminist frameworks and is described in bell hooks's *Margin to Center* (2015). By bringing those on the margins to the center, we improve outcomes for everyone. We now see this concept driving other practices, such as universal design and disability justice movement work.

As we have described, the journey toward health equity demands more than incremental change—it requires a fundamental reimagining of how health-care organizations understand and embody accountability. Through the Indigenous

wisdom of right relations, the transformative power of calling in with love, and the organic growth of Emergent Strategy, we find a path forward that honors both immediate healing and generational transformation. These relational and cultural forms of accountability, combined with structural reforms that reward health-care organizations for improving the health and well-being of all persons can lead us to health equity.

Cultural change in organizations often starts with small but meaningful shifts. These include thoughtful meeting practices that ensure all voices are heard, establishing agreements that create psychological safety, and developing facilitation skills across teams regardless of seniority. By focusing on these relational approaches instead of transactional ones, we can create more equitable environments where everyone can contribute and grow. Clinician-patient relationships benefit when clinicians lead with behaviors that demonstrate values rooted in deep care, relationship, and empathy. Pausing before relying on protocol to determine how policies and practices center shared values and expectations can shift how health care is delivered and experienced profoundly, sometimes making all the difference we need.

These frameworks show us that accountability is not merely a tool for oversight but a sacred commitment to community well-being. When health-care organizations embrace accountability as a relationship rather than punitive regulation, they create space for the kind of healing that ripples through generations. This shift requires us to move at the speed of trust, to value small moments as much as systemic change, and to recognize that true health equity emerges from thousands of daily choices to center human dignity and connection.

The stories shared here—of both struggle and breakthrough—illuminate how theoretical frameworks translate into lived experience. They remind us that every interaction between provider and patient, every policy decision, and every institutional practice can either perpetuate harm or foster healing. When we view these moments through the lens of relational accountability, we can bring about a collective transformation that reorients our health-care system towards the health and well-being of all persons and communities, rather than short-term financial gains.

As we look toward the future of health care, we should dare to imagine organizations where accountability flows from a deep sense of interconnection rather than fear of punishment, where success is measured not just in quarterly profits but in generational health outcomes, and where every decision considers its impact seven generations hence. The path forward requires courage and humility: courage to challenge entrenched systems that prioritize profit over people, and humility to learn from traditions that have long understood health as a relationship between community and environment, past and future, body and spirit. By embracing accountability as a catalyst for justice-centered healing, health-care organizations can fulfill their deepest purpose: not just treating illness, but allowing a collective well-being to flourish.

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