Raising the Bar Implementation Guide:

How to Drive Equitable, High-Quality, Cost-Effective Health Care

April 2025

HEALTH CARE TRANSFORMATION TASK FORCE

Raising the Bar
Health Care's Transforming Role

Table of Contents

Support for this project is provided by the Robert Wood Johnson Foundation (RWJF). The views expressed here do not necessarily reflect the views of RWJF.

Executive Summary

All people benefit from high-quality health care and social support. Access to these services in the United States is often dependent on where a person lives, how much money they earn, what they look like, or how they identify. For the past 15 years, most health care organizations have sought to achieve the Institute for Healthcare Improvement's Triple Aim: Improve individuals' care experiences, improve the health of populations, and reduce per capita costs.[i] The Raising the Bar framework helps organizations to achieve the Triple Aim of health care while simultaneously making care more equitable for geographically isolated and marginalized groups.[ii]

This report summarizes what we learned from organizations that, with support from the Robert Wood Johnson Foundation, applied the Raising the Bar framework to design and implement steps to achieve the Triple Aim and health equity in their own organizations. The participating organizations include two health systems, a public health department, and a behavioral health system, each with different programmatic goals. Though participants varied widely in size and project scope, there were common themes in what facilitated and challenged their success.

While much progress has been made in advancing the Triple Aim and its North Star—health equity—this work is facing headwinds in 2025 with changes in federal funding and priorities. Ensuring the delivery of high-quality health care, providing access to services in the right place and at the right time, and collaborating with communities may be challenged by uncertainty and strained state and local budgets. Despite the swirling uncertainties in the political landscape, the need to increase the value of our health care services, partnerships, and investments has never been greater. Progress toward achieving the Triple Aim of health care and health equity is critical not only to the health of Americans, but also to the sustainability of our health care systems, our economic competitiveness, and global standing.

Introduction

Engaging and connecting with the diverse populations living in the United States is an important part of driving health care quality and value. Decades of health services research show that one-size-fits-all approaches to prevention practices, screening, treatment and referrals fail many people and result in a lot of wasteful health care spending. Raising the Bar's five principles guide an equity-centered approach to improving care quality, experience, and cost.[iii] By centering community voices, health care organizations can differentiate their approaches to services to improve their financial bottom line, quality ratings, and community reputation.[iv] Expanding strategies to consider health care's role not only as a provider, but also as an employer, community partner and advocate—roles defined in the Raising the Bar framework—also expands opportunities for health care organizations to increase their community impact. As providers, health care organizations can provide whole-person care to achieve health equity. As employers they can employ and support a diverse health workforce, which is important to engaging diverse populations. As partners they collaborate with organizations and residents to reach those populations that experience the worst health outcomes in new and more effective ways. As advocates they invest in the communities they serve and advocate for more equitable conditions that shape health.[v]

This report summarizes the experience of organizations that implemented the Raising the Bar framework with support from Robert Wood Johnson Foundation (RWJF)-funded coaches. This report also includes case studies on the participating organizations, which provide greater insights into their projects and outcomes (**Figure 1**).

Figure 1. Health Care Organization Roles in the Raising the Bar Framework

This report summarizes the experience of organizations that implemented the Raising the Bar framework with support from Robert Wood Johnson Foundation (RWJF) funded coaches. This report also includes case studies on the participating organizations, which provide greater insights into their projects and outcomes (**Figure 2**).

Figure 2. Summary of Participating Organizations and Projects

Though much progress has been made in advancing high-quality and high-value care and services over the past 15 years, achieving the vision of the Triple Aim and health equity will be challenged in 2025 with changes in federal funding and priorities. Delivering high-quality health care and providing access to services in the right place and at the right time collaboratively with communities will be more difficult when some organizations are immobilized by uncertainty or contemplating how to retool with fewer staff and resources. Despite the uncertainties in the political landscape, the need to increase the value of our health care services, partnerships, and investments has never been greater. Making progress on the Triple Aim of health care and its North Star—health equity—is critical not only to the health of Americans, but also to the sustainability of our health care systems and our economic competitiveness.

The Raising the Bar Framework

Raising the Bar represents a multiyear commitment by RWJF. In the first stage of the project, RWJF supported the development of the Raising the Bar framework, led by the National Alliance to Impact the Social Determinants of Health (NASDOH), working with several partners including the National Partnership for Women and Families (NPWF) and the Health Care Transformation Task Force (Task Force).[vi] The framework calls for health care entities to take concrete actions to improve equitable access to health care. In the second stage, RWJF partnered with NPWF to develop a guide to support providers in applying the framework to improve maternal health equity.[vii] In the third stage, RWJF supported five organizations in the development of health equity initiatives using the Raising the Bar framework. This document summarizes the experiences and lessons learned from the four organizations that participated in those initiatives to implement the framework.

The five cross-cutting principles of the Raising the Bar framework are as follows:

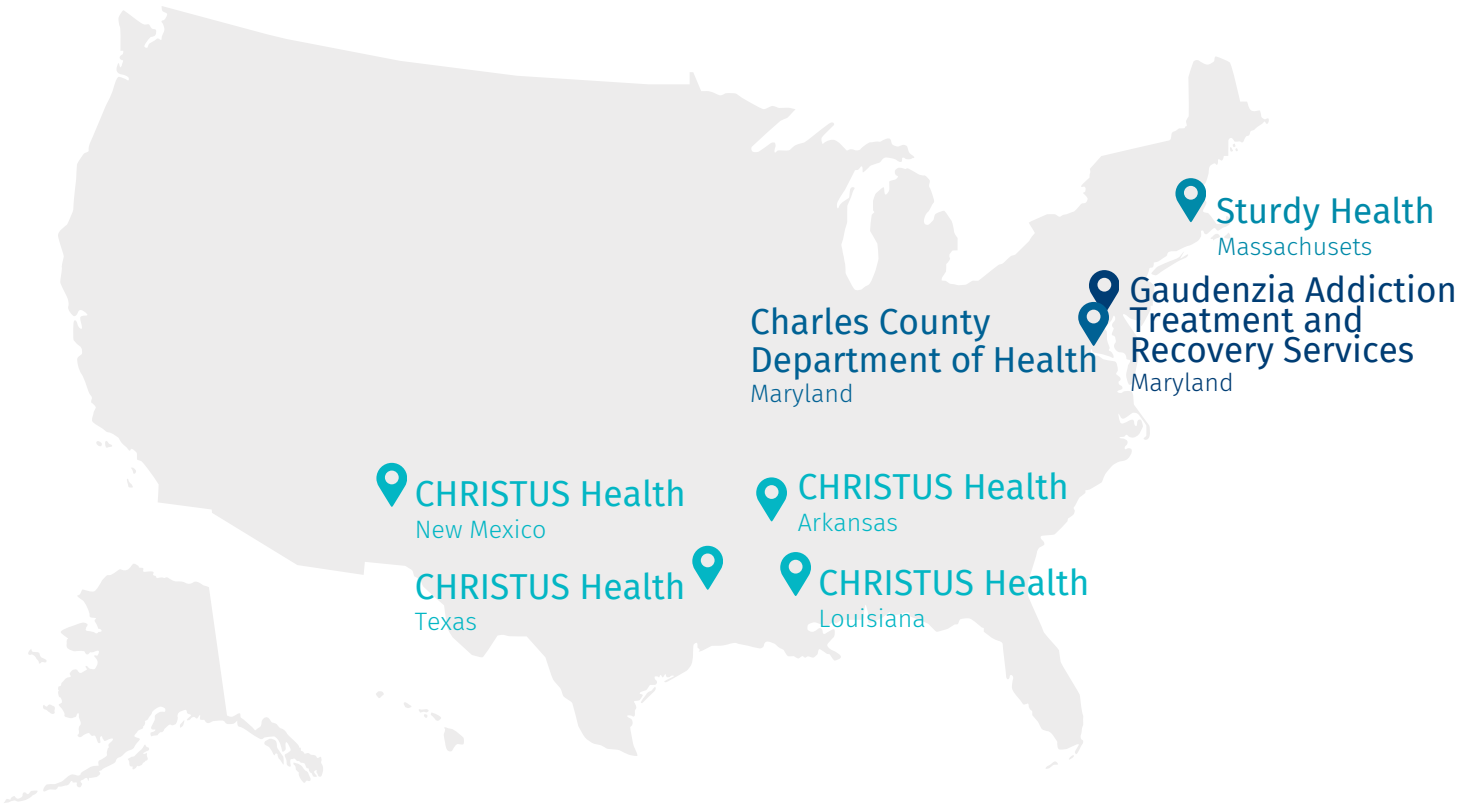
1. **Mission:** Commit to a mission of improving health and well-being
2. **Community:** Serve the community as an engaged, responsive, and proactive partner
3. **Trust:** Earn and sustain trusting relationships
4. **Equity:** Systematically pursue health equity, racial justice, and the elimination of discrimination
5. **Power:** Share and effectively use resources, influence, and power

The framework also defines four roles that health care organizations play: provider, employer, community partner, and advocate. For example, as a provider, an organization can provide holistic, effective high-quality care. As an employer, that same organization can employ and cultivate a representative and responsive workforce. As a partner, it can build trusting relationships with individuals and organizations in the community. Lastly, as an advocate, it can use its power to advocate for public policies that will support equitable access to health and social services. These four roles are synergistic. For example, a diverse workforce is important to individuals' experiences of holistic high-quality care. A culturally and linguistically responsive workforce will be better positioned to build trusting relationships with health care recipients, enabling these individuals to become more active in their own health. Partner organizations and individuals often hold the "key" to reaching disengaged communities. Finally, health care organizations can invest in meeting basic community needs, providing job opportunities, farmer's markets, and affordable housing. They can also use their power to advocate for laws, policies and conditions to strengthen community resources.

Raising the Bar Implementation

In 2024, RWJF supported five competitively selected health care organizations to implement initiatives applying the Raising the Bar framework. Under this project, Health Management Associates, Inc. (HMA) a national consulting firm with a focus on publicly funded health care—provided individualized technical assistance and coaching to help these organizations refine and implement their projects. Four sites completed their technical assistance projects, including a newly certified community behavioral health clinic, a public health department, and two health systems, each with distinct health equity goals and project contexts (Figure 3).

Figure 3. Locations of Raising the Bar Participating Sites



Note: *Note: One participating organization is located in the Southwest; the others are in Northeast and Mid-Atlantic states.*

This report summarizes each organization's Raising the Bar implementation steps. While implementing organizations varied widely in size, services and project scope, they shared common facilitators and challenges to their progress in advancing high value and equitable care through more community engaged practices, as shown in **Figure 4**.

Figure 4. Facilitators and Challenges in Implementing the Raising the Bar Framework

Facilitators

- Leadership Support
- Coaching Support and Resources
- Clearly Specified, Actionable Goals
- Community Engagement

Challenges

- Understanding the Importance of Equity-Centered Value-Based Care and "Wearing Too Many Hats"
- Time it Takes to Build Community Trust
- Worries About Sustainability

Many Task Force members also implemented programs to advance the Triple Aim, drawing on elements in the Raising the Bar framework. In 2024, the Task Force developed two resources outlining payer and provider strategies for advancing health equity, drawing on member efforts.[viii;ix] In 2023, the Task Force also released a Health Equity Business Case, which offers practical information on how to engage leadership in health equity investments.[x] This report incorporates findings from these resources in the sections below.

Facilitators

We identified four conditions that enabled organizations' efforts to implement their Raising the Bar projects. These include leadership support, coaching support and resources, clearly specified and actionable goals, and community engagement. We refer to these conditions as facilitators.

Leadership Support

To design and implement cross-cutting, comprehensive population health improvement strategies, buy-in and a firm commitment from leadership is critical to getting the right people to the table and creating a pathway for implementation. **The call to action from leadership allows people to collaborate to create a vision for community health and the specific tactics to put that vision into action.** Committed leadership allows teams to feel connected, work smarter, and effectively incorporate new strategies and approaches into their daily workflows.

It also creates the space for learning and growth across clinical, quality, community relations, information technology (IT), financial, and administrative departments.

Raising the Bar Implementation Examples

Leadership support among the Raising the Bar implementors varied from committed board members to team leaders who aligned the work with the organization's core mission. For one large health system, health equity was already at the core of its mission and organizational culture, allowing seamless integration of the Raising the Bar project into existing processes. This organization had the IT infrastructure to support the collection and stratification of demographic data to understand disparities in quality programs. It also had active health equity committees, training programs, and established partnerships with community organizations to support project goals. Strong leadership commitment was critical to the success of this large health system in the one-year project.

At another health system, leadership encouraged staff to attend focus groups and join health equity committees to provide feedback on the Raising the Bar initiatives. **Another site noted that staff were motivated to engage in Raising the Bar efforts because they wanted to feel included after seeing their peers' involvement.** This organizational commitment to high-value and equitable care also increased the alignment of similar strategies and interventions across programs, departments, and service sites.

Task Force members also noted the importance of leadership support in developing a comprehensive population health improvement approach that considers the role of the organization as a provider, employer, community partner, and advocate. Leadership can help health care organizations make progress on multiple roles at once. **One regional health system shared that every member of the leadership team had health equity metrics included in their performance evaluations. Employed clinicians also had equity metrics linked to clinical process and outcome measures added into their risk-adjusted compensation.**

Task Force members found it was helpful to articulate the business case for an equity-framed approach to value-based care. The business case may include the potential return on investment (ROI), Stars rating or quality score improvements, or reputational benefits. The Task Force's Health Equity Business Case presents several messaging strategies for building buy-in among leadership.[xi] In addition to engaging C-suite executives, staff should include the governing body, and department leads relevant to health equity investments when appropriate.

The following messaging strategies resonated with Task Force members:

- Create a long-term vision and implementation plan for triple aim and health equity strategies.
- Clearly tie the work to the mission, vision, and strategic pillars of an organization.
- Frame opportunities to embed health equity strategies in existing programs, such as quality programs, that already have a budget and related business case.
- Be realistic about opportunities to realize financial or social ROI. Savings on health equity initiatives will accrue over time.
- Include stories from those who have experienced low value care.

Examples of tools that can support value-based and equitable care framing are the Commonwealth Fund's Calculator for Partnerships to Address the Social Determinants of Health, which was designed to calculate the savings that may result from their social service investment, and the Value of Health Care Redefined: Social Return on Investment, which offers promising practices for realizing social returns, which can help organizations understand and maximize the health and social benefits of health equity programs in addition to financial returns.[xii;xiii]

Coaching Support and Resources

Assigning a dedicated internal leader or a coach is integral to launching equity projects that involve cross-departmental assessments, planning, and coordination. Though this is particularly true for large complex organizations that might lack a mechanism to bring together cross-functional teams, it is also true for small organizations that may have limited staffing resources to accept new accountabilities.

Raising the Bar Implementation Examples

For all organizations, having dedicated coaches or staff who supported project activities was instrumental in making progress. This was particularly true for organizations that were new to this kind of work and were unsure where to start. Coaches brought tailored expertise relevant to each organization's challenges, from IT templates to information about aligned state resources. Coaches planned and facilitated meetings early on to help the teams get their work off the ground. They also helped to create evergreen processes that would be easy to continue after the support ended. Organizations looking to achieve the Raising the Bar goals can consider whether a coach—either an external partner or a dedicated internal lead—can provide their organization with the expertise and focus needed to enact and sustain change. For example, in one instance, leadership increased

the project lead from part-time to full-time so that the organization could achieve its Raising the Bar project goals.

Staff at one organization noted how HMA coaching supported its efforts. “The HMA team helped us to develop foundational documents like bylaws, an orientation slide deck, CAC meeting agendas, and a road map, which broke down the project into actionable steps,” said Shanna Johnson, Division Director at Gaudenzia. “These materials also helped staff effectively communicate about the CAC to interested participants.”

> “The HMA team helped us to develop foundational documents like bylaws, an orientation slide deck, CAC meeting agendas, and a roadmap, which broke down the project into actionable steps.”
>
> **Shanna Johnson**
> Division Director at Gaudenzia

The Task Force’s Health Equity Business Case recommends that organizations invest in project managers who are knowledgeable about implementing health equity efforts and who are accountable for its progress. The Business Case highlights the value of including staff who are skilled in community engagement to support project goals and leaders who can collect data to track the results of ongoing efforts. The Business Case also suggests that leaders should limit competing priorities and set clear expectations for these staff members. **Task Force members noted that when health equity work is assigned to a colleague who already has full-time responsibilities, that individual will have insufficient capacity to move the project forward.**

Clearly Specified and Actionable Goals

The importance of having clearly specified actionable goals cannot be overstated. W.E. Deming, the namesake of the Deming Prize for total quality management, is quoted as saying, "**What gets measured gets done.**"[xiv] Health care organizations all operate in quality frameworks with strategic, actionable goals and accountabilities for staff and governance. Equity initiatives must align with these same accountabilities to be durable.

Raising the Bar Implementation Examples

Setting specific and actionable goals kept the Raising the Bar teams on track and focused. All project sites developed goals that were specific, measurable, achievable, realistic, time-bound, inclusive, and equitable (SMARTIE) to guide their activities. Because the implementation period was limited to one year, project leads considered existing priorities and staff capacity to determine what they could achieve within that timeline.

Establishing specific goals from the start helped staff and leadership communicate about the project, appropriately delegate responsibilities, and dedicate resources to achieving success.

In considering the development of actionable goals, staff at one organization shared that knowing the community's needs helped to set their direction. "Understanding the patient population that you serve is the first step in addressing needs and closing gaps in care. Through our data dashboard, we were able to report out the specific needs of our population to our leadership and Board, who supported enhanced cultural competency trainings for our clinical staff," said Mel Reichelt, Health Care Equity Coordinator at Sturdy Health.

> "Understanding the patient population that you serve is the first step in addressing needs and closing gaps in care. Through our data dashboard, we were able to report out the specific needs of our population to our leadership and Board, who supported enhanced cultural competency trainings for our clinical staff."
>
> **Mel Reichelt**
> Health Care Equity Coordinator at Sturdy Health

To support progress toward setting and achieving actionable goals, the Task Force's Health Equity Business Case recommends organizations invest in data infrastructure and technology support to measure results. Task Force members shared that funding from health care payers can support these efforts. Providers who care for high-risk communities often operate on slim margins and lack funds to make initial investments. Payers can enable providers to implement outreach programs, collect and analyze data, and hire additional staff, such as community health workers (CHWs), social workers, and care coordinators. One large health plan provided a health equity dashboard for physicians to understand their patients' needs. These insights then helped frontline providers to engage patients more effectively with better prescribing, referrals, and wraparound supports.

Community Engagement

As reported in the Harvard Business Review, research shows that trust in the US health care system is declining.[xv] Reasons for this downturn include failures of leadership, growing inequality, political polarization, and increasing skepticism regarding our collective ability to tackle society's toughest challenges and advance well-being for all Americans.[xvi] Rebuilding public trust in the US health care system, which plunged during the pandemic, must be a priority. Community engagement is central to restoring trust in health care and public health systems, and strong, enduring relationships take time to develop. One project lead shared the proverb: **"If you want to go fast, go alone. If you want**

to go far, go together." Participating sites implemented communication strategies to engage community members and organizations to share information about the project and gather feedback to strengthen the work.

Raising the Bar Implementation Examples

All of the implementing organizations strategized how to create the conditions to increase community engagement. One participating entity prioritized building a relationship with a racial minority group that had been disconnected from health care services for decades. By intentionally engaging with leaders of this community, the project team began to understand the needs and priorities of community members and started to build a relationship for future collaboration. Responding to community input, the team translated resources into different languages and used local bulletin boards to share news to increase community access to information. The organization also was able to align communication strategies with those of other community organizations to amplify their messages and services.

Participants acknowledged that engaging communities takes time and resources, not only from the health care organization, but also from the community organizations or community members it wants to engage. Though health care organization staff can do outreach and community meetings as part of their jobs, the time may be uncompensated for community members who may also need assistance with transportation or childcare costs. Some organizations offered incentives, like gift cards, for community members who participated in meetings or focus groups. Though these incentives increased community participation, public entities shared worries about sustained funding for gift cards because of federal and state restrictions on offering incentives. One Raising the Bar participant repurposed existing resources in goodie bags with wellness items like scales, thereby skirting restrictions on using public funding for incentives. Most organizations provided food during meetings and convened them at locations and times that were most convenient for community members. They also looked for locations near public transportation and provided the option of participating virtually to increase attendance.

One organization employed CHWs to identify and address community needs. The use of CHWs is an evidence-based best practice for engaging geographically isolated and marginalized communities. Many Task Force members have well-established CHW programs and hire CHWs to work directly with patients to identify social needs and refer patients to community resources. Some health systems also embed staff at community-based organizations (CBOs) to track patient referrals, so the health care organizations know the outcome of the referral, commonly known as a "closed-loop referral process."

Community Advisory Councils are an important way to engage with communities and build trust. Most health systems and plans have community advisory boards and federally qualified health centers, and CCBHCs must have community advisory committees and governance that reflects the communities they serve. The Task Force's Health Equity Business Case highlights how payers and providers can implement patient or patient-family, enrollee, and community advisory councils to expand community engagement and create opportunities for patients and their families to jointly assess community needs, set priorities, and design and evaluate targeted interventions with hospital, health plan, or clinic staff.

Challenges

Three common conditions that challenged progress in the Raising the Bar initiatives included understanding the importance of equity-centered, value-based care and "wearing too many hats"; having the time it takes to build community trust; and concerns about sustainability.

Understanding the Importance of Equity-Centered Value-Based Care and "Wearing Too Many Hats"

Staff from the front desk to the C-suite play important roles in providing high-value, equity-centered care. Experiences with call lines, front desk registration, nurse screening for vital signs, clinical interactions, billing departments, referral staff, and procedure or medication authorization staff all influence a person's health care experience. Health care organizations' staff sometimes have a limited understanding of how they personally can advance equitable care, especially those professionals who are not patient facing. **Organizations participating in health equity initiatives found that when they educated staff at different levels of the organization about the changes that were being made to improve health care experiences, quality, and outcomes, staff were supportive and offered significant insights into how care could be improved.**

Task Force members who implemented equity initiatives also emphasized the value of engaging staff at all levels of the organization. One hosted an Undoing Racism training provided by the People's Institute for Survival and Beyond to educate staff on the history of race and racism in the United States. The training helped staff better understand anti-racist health care practices. The organization also educated staff on how patient-reported data on race, ethnicity, sexual orientation, and gender identity helps ensure cultural competency and responsiveness to patients.

Many organizations focused **communication strategies on shared goals and values that were tailored to the locations where they operate.** Framing one project as a strategy to address rural health disparities and preserve the dignity of patients resonated with staff. In another project, a focus on food access and transportation barriers tapped into a shared understanding of the drivers of health disparities. This specificity in language resonated more with communities than discussing health equity more broadly.

Engaging staff in anything new that adds to full-time responsibilities will usually be challenging without some accommodation from leadership and supervisors to take on new work. Otherwise, staff may feel they are "wearing too many hats." To address this barrier, one organization implemented a whole new service line at the same time they implemented the Raising the Bar community engagement project.

Time it Takes to Build Community Trust

Participating organizations noted that change moves at the speed of trust. Engaging community members and CBOs is essential to understanding how to increase access to high-quality care, but relationship building takes significant time and a sustained commitment. In some cases, participating organizations worked to overcome mistrust created through historical harms. Many of the participating organizations sought feedback from the community to ensure that their work was responsive to community members' needs. Organizations built trust slowly over the year. **They started to shift power dynamics, providing space for people to meet and share feedback and demonstrating how people's feedback was being incorporated.**

One tactic that Task Force members used to build trust and access was to partner with communities to deliver services outside of traditional health care settings. **Several members suggested offering health education, vaccines, and testing at community events, such as those organized by faith-based organizations and local schools.** Other members established clinics in underserved communities and invested in mobile clinics to bring primary care and preventive services to specific neighborhoods. Multiple health systems also built ties with the community through their role as employers and purchasers, for example, by hiring community members as CHWs and by purchasing food and supplies from local businesses. These efforts led to greater trust with their neighbors.

The Health Equity Business Case highlights how CHWs can foster trust and bridge the divide between communities and health care organizations. CHWs often live in the communities where they work and have a deep understanding of the health beliefs, priorities, and care barriers that shape health engagement. People are often more comfortable sharing their needs with CHWs than other health care staff.

Worries About Sustainability

For comprehensive approaches to equity-focused value-based care to be sustainable, organizations may need to consider how to reallocate resources to support infrastructure development and staff time. Layering more responsibilities and accountabilities on overextended staff will prove unsustainable. **Furthermore, one organization noted the importance of integrating their work into activities already in the fiscal year budget to avoid delays while waiting for the next budget cycle to begin.**

The launch of the Raising the Bar projects was supported by RWJF-funded coaching and technical assistance that helped get the projects off the ground. Several organizations devoted a large portion of the year to project planning, including relationship building with community members and engaging internal staff. One organization established a new service line and shared that it should have set smaller recruitment targets for participation in the community advisory committee, with the understanding that the entity could continue building relationships and increase engagement over time.

The Health Equity Business Case notes that improving equity-centered health care quality, patient experience, and costs may require more time to produce an ROI than clinical or operational interventions. Organizations may experience resistance to securing and sustaining investments that do not produce immediate results. **Rather than focusing solely on a short-term, financially focused ROI calculation to assess the impact of new approaches to community engaged value-based care, organizations can broaden their measurement to include changes in experience measures (i.e., Consumer Assessment of Healthcare Providers and Systems), plan enrollment, community reputation, outcomes from targeted interventions, relationships with CBOs, and avoidable utilization.** In addition to assessing traditional indicators like emergency department (ED) utilization, one hospital assessed the impact on clinical revenue, health care expenditures, and operational efficiencies. Social impact assessment tools can be valuable in assessing progress and understanding process outputs.

Looking Forward

The Raising the Bar framework is a resource to support equity-centered, value-based care across different organization types and locations. The organizations reflected in the case studies below include two health systems, a public health department, and a behavioral health clinic. The case studies provide more detailed insights into these organizations' projects and expand upon the common themes highlighted above. These insights can help other organizations interested in incorporating the Raising the Bar framework.

CHRISTUS Health

Case Study

Location: Several sites across Texas, Louisiana, Arkansas, and New Mexico, and Latin America

Project Goal: Develop a strategic roadmap to embed equity throughout the organization

CHRISTUS Health is a Catholic, not-for-profit health care system with a network of over 600 centers across Texas, Louisiana, Arkansas, New Mexico, Chile, Colombia, and Mexico. Its diverse facilities—including long-term care facilities, community hospitals, walk-in clinics, and health ministries—are committed to improving the health and well-being of the people they serve. With more than 51,000 associates, including over 15,000 physicians, CHRISTUS Health provides exceptional care while adapting to the evolving needs of its patients.

Rooted in a rich heritage and a tradition of service that spans more than 160 years, CHRISTUS Health continues the transformative work of its three sponsoring congregations—the Sisters of Charity of the Incarnate Word of Houston and San Antonio, TX, and the Sisters of the Holy Family of Nazareth. These visionary sisters pioneered modern health care by establishing health centers globally. inspire the organization's commitment to meeting patients where they are and advancing health equity through strategic partnerships.

CHRISTUS Health implemented the Raising the Bar framework in the development of its first systemwide health equity strategic road map. This road map, spanning six years from its initial development efforts in April 2024 through 2030, is designed to integrate a culture of health equity throughout all aspects of the organization and its operations. Although health equity work was already under way prior to the institution of the RWJF project, this initiative presented an opportunity to create both an internal and community movement, dismantling longstanding silos. The road map lays out a unified approach to fostering collaboration across departments, disciplines, and community partners to better address the needs of the most vulnerable patients and enhance their care.

Facilitators

Using the Raising the Bar framework four primary roles—clinician and care team (provider), employer, partner, and advocate—CHRISTUS Health aligned each role with specific strategies, goals, and deliverables, ensuring that all leaders were involved in the process. This alignment enables stakeholders to understand their contributions to the

larger health equity puzzle and how they can influence the outcomes through the initiatives managed by their teams.

To gather valuable data on the challenges and successes of delivering equitable, high-quality health care, CHRISTUS Health's Health Equity, Diversity, and Inclusion and Community Health team collaborated with HMA partners for technical assistance. HMA conducted 12 key stakeholder interviews with CHRISTUS leaders, including several C-suite members and a member of the board, to incorporate a range of perspectives into the creation of the system health equity road map. HMA also facilitated in-person and virtual focus groups with leaders, community health workers, and community partners from various areas served, elevating the voices of CHRISTUS associates and patients in the process.

A significant milestone in this journey was the in-person kickoff and the culminating Health Equity Roadmap Summit, both of which took place at CHRISTUS Health's System Office in Irving, TX. The Summit featured health equity stories from CHRISTUS Health's ministries, as well as inspiring messages from CEO Ernie Sadau and other senior executives, some of whom will serve as executive champions for the four Raising the Bar roles. Mr. Sadau's address resonated deeply with the attendees, reaffirming CHRISTUS Health's true calling. "Investing in patients, communities, and associates is at the core of our founding sister congregations," he said. "Through our commitment to the strategic road map, we are working together to build a future where everyone is treated with dignity, respect, and compassion, and where all have the opportunity to live their healthiest lives."

> "Through our commitment to the strategic roadmap, we are working together to build a future where everyone is treated with dignity, respect, and compassion, and where all have the opportunity to live their healthiest lives."
>
> **Ernie Sadau,**
> CEO of CHRISTUS Health

Overall, this journey involved more than 90 stakeholders from across the system and the communities that CHRISTUS serves, showcasing the power of collaboration and the importance of listening in the development of health equity strategies.

Lessons Learned

CHRISTUS Health shared key lessons learned, opportunities, and actionable insights from this health equity road map development journey.

1. *Engage Stakeholders Early and Often*
   Health equity is a multidimensional issue that involves various stakeholders, including community members, health care providers, public health agencies, policymakers, and social services organizations. CHRISTUS Health learned the importance of continuous engagement throughout the process. While stakeholders are often engaged at the beginning and end of a journey, it is crucial to involve them throughout. Early and continuous engagement ensures that the road map remains relevant and actionable. CHRISTUS Health is now focused on maintaining bidirectional communication feedback loops and knowledge sharing with leaders, associates, and community partners.

2. *Create a Shared Vision and Collective Responsibility*
   Health equity must be framed as a shared responsibility that extends beyond the Health Equity, Diversity and Inclusion, and Community Health team. Every partner, community leader, and stakeholder must feel ownership of the vision. To ensure shared responsibility and commitment, CHRISTUS Health emphasized involving key voices early in the process, particularly underrepresented voices from marginalized communities, CHWs, and people experiencing health care inequities. By reflecting the values, challenges, and aspirations of those most affected, the road map will be more inclusive and sustainable.

3. *Incorporate Community-Driven Solutions*
   Top-down approaches can fail to resonate with the communities they seek to serve. CHRISTUS Health involved community members in co-designing solutions, ensuring that the outcomes were both effective and sustainable. CHWs, local leaders, and grassroots organizations played a key role in the design, implementation, and evaluation of health equity initiatives. In addition, CHRISTUS Health sought to elevate the voices of associates at all levels, from executive leadership to mid-level management and frontline staff. The insights gathered from these diverse perspectives ensured that solutions were both relevant and feasible.

4. *Remain Nimble in Tailoring Solutions to Local Context*
   CHRISTUS Health learned that there is no universal health equity strategy. What works in one area or demographic may not work in another. With over 600 centers across the globe, each ministry, and even each hospital, must tailor the road map to the unique needs of their patients, communities, and associates. Solutions should be context-

specific, taking into account local culture, geography, infrastructure, and health care services available.

5. Design Accountability Mechanisms

Clear accountability structures are essential for ensuring progress toward health equity. Without them, efforts can stagnate. CHRISTUS Health assigned executive champions to each strategic pillar and workgroup, such as the chief clinical officer for clinician and care team, the chief human resources officer for employer, the chief mission integration officer for partner, and the chief compliance officer for advocate. These champions will play a vital role in shepherding and guiding initiatives forward, fostering accountability, providing support, and maintaining clear communication to keep everyone on track and maintain momentum. forward.

Moving forward, CHRISTUS Health will focus on advancing the work of its four Raising the Bar role areas and their respective workgroups. Each workgroup will meet to discuss potential strategies and prioritize them using an impact-effort matrix. Based on the feedback gathered, the Health Equity, Diversity, and Inclusion and Community Health teams will collaborate with their executive champions to phase the strategies in (Phase 1, Phase 2, Phase 3, etc.). CHRISTUS Health plans to create a scoring dashboard to track progress toward achieving health equity goals and measure success. Additionally, the organization intends to explore the development of a health equity strategic road map for its Latin American ministries, applying the lessons learned from this process in the United States to its mission and journey abroad.

CHRISTUS Health extends its heartfelt gratitude to RWJF, the Raising the Bar framework, and HMA for their invaluable partnership and support in advancing this important work. The organization and the health equity, diversity, and inclusion and community health teams are especially honored to be part of this exceptional cohort and looks forward to learning from each other's projects and learnings.

Sturdy Health

Case Study

Location: Southeastern Massachusetts

Project Goal: Develop a health equity dashboard to identify and address patient needs

Sturdy Health is a nonprofit health system, which includes Sturdy Memorial Hospital and 26 primary and specialty care locations across southeastern Massachusetts. Sturdy Health serves hundreds of thousands of patients annually. Sturdy Health is also the largest employer in Attleboro, MA, with more than 2,000 staff members. Sturdy Health's most recent community health needs assessment reveals a significant Hispanic and Asian population as well as community needs related to housing, education, and poverty.

Sturdy Health developed a health equity dashboard to better understand their patient population and to support targeted population health interventions. The dashboard supports data stratification by demographics, so that Sturdy Health can close gaps in care. Sturdy Health also used their dashboard to expand their cultural competency training to their clinical staff, to advance health equity.

Facilitators

Sturdy Health hired a project lead to develop the health equity dashboard and expand clinical training. What began as a part-time position was expanded to full-time, reflecting leadership's commitment to advancing health equity and their understanding of the effort required to implement the project. In addition to having a full-time staff member committed to the project, having HMA staff support the work increased the project's visibility and added authority to the project lead's recommendations.

With support from leadership, the project lead engaged both clinical and non-clinical staff to receive ongoing input. The project lead communicated goals and updates in Sturdy Health's employee newsletter. Through the newsletter, staff were encouraged to participate in the health equity committee, which was composed of departmental leaders to learn more about the project and offer feedback. Committee members provided input on the initial dashboard and made recommendations to make it more actionable. Sturdy's communication strategy helped to build trust and buy-in among staff while working to develop a product that was responsive to staff feedback.

Given the limited timeline for implementation, Sturdy Health staff knew they had to work efficiently to develop a working dashboard by the end of 2024. Rather than waiting for perfect data before building the dashboard, they developed an initial iteration and worked to strengthen it over time. Sturdy Health staff initially worked with the health equity committee to understand what data were already being reported regularly and incorporated these figures into the dashboard on an ongoing basis. The dashboard continues to be a work in progress, even as it provides actionable insights in its current form.

"Understanding the patient population that you serve is the first step in addressing needs and closing gaps in care. Through our data dashboard, we were able to report out the specific needs of our population to our leadership and Board, who supported enhanced cultural competency trainings for our clinical staff," said Mel Reichelt, Health Care Equity Coordinator at Sturdy Health. "Through staff trainings, we're better able to care for people at higher fall risk or in need of ASL [American Sign Language] translations."

> "Understanding the patient population that you serve is the first step in addressing needs and closing gaps in care."
>
> **Mel Reichelt**
> Health Care Equity Coordinator at Sturdy Health

By better understanding the patients it serves, Sturdy Health is now able to use its data to respond to patient needs. Through the dashboard, Sturdy Health identified a growing Creole population, specifically an increase in Haitian migrant families. The health system was then able to incorporate increased language translation services for this population. Sturdy Health also identified mobility challenges as a leading concern among patients who self-reported their disability status, and prioritized fall risk and elder mobility accommodation, education, and training for clinical staff.

In addition to patient needs, the dashboard highlights missing data, so staff can increase trainings on best practices at locations with lower rates of data capture. Moreover, the dashboard helps Sturdy Health understand how closely the demographics of its employees match the demographics of its patients. These insights are invaluable for implementing clinical improvement efforts.

Lessons Learned

Leadership buy-in from both clinical and administrative staff was critical to the success of this project. To obtain data for the dashboard, staff were asked to collect data from patients, requiring changes in workflows. The trainings also required staff time and engagement. While these types of changes can be met with resistance, the Sturdy Health project team shared that having clinical leadership support helped increase buy-in among clinical staff. Clinicians who attended regular in-person meetings were also able to provide feedback and build support for the work.

Another key element of the project was setting clear and achievable goals from the start. Because systems like Sturdy Health serve in many roles as both health care providers and employers in their communities, staff noted that it was tempting to set similarly broad goals that encompass many elements of the Raising the Bar framework. To successfully apply the framework, however, it was critical that Sturdy Health set an achievable project scope with goals that align with its staff capacity and timeframe. By focusing its goals of developing a dashboard and strengthening staff training, Sturdy Health was able to focus its efforts on advancing those specific projects.

Achieving organization-wide commitment to health equity work is challenging. Despite having leadership buy-in, Sturdy Health learned that time and education are required to build a culture of health equity across a complex organization. The pace of culture change can also depend on the broader context in which an organization is operating. To increase staff buy-in, Sturdy Health focused on addressing specific needs such as housing, transportation, and insurance coverage. Leadership also informed staff of the ways in which the cultural competency trainings could directly improve care for the populations they serve, which helped to generate stronger engagement.

With the development of their data dashboard, Sturdy Health is now able to better understand their patient population. Staff share data-driven findings with their leadership and use data to inform their cultural competency trainings. While the project funding period is over, Sturdy Health is continuing to iterate upon their data dashboard to strengthen its capabilities. Sturdy Health staff are now working to automate the incorporation of the data into the dashboard to increase efficiency and sustainability.

Charles County Department of Health

Case Study

Charles County Department of Health (CCDOH) offers a variety of health services and education resources to improve the health of county residents. Black, Indigenous, and People of Color (BIPOC) comprise 67 percent of the Charles County population. The county also has one of the largest Native American populations in the state. Despite its proximity to Washington, DC, many areas of Charles County are rural, with some residents living 30 miles from the closest grocery store.

Location: Charles County, Maryland

Project Goal: Develop community partnerships to create inclusive programming and services

"This project was a way for us to think about how we can start to incorporate equity in a way that is meaningful and involves our community, and is not just a check-the-box exercise," said Amber Starn, Director of Community Health and Evaluation at CCDOH. "From the beginning, we considered how to build our department's capacity to engage with community members to create more inclusive programming for everybody who lives here."

> "This project was a way for us to think about how we can start to incorporate equity in a way that is meaningful and involves our community, and is not just a check the box exercise."
>
> **Amber Starn**
> Director of Community Health and Evaluation at CCDOH.

CCDOH established partnerships with community organizations—with a focus on BIPOC communities and organizations—and built a health campaign with robust health education materials. By partnering with community organizations, CCDOH can better align public health programming with community needs. CCDOH's initial goal was to develop eight community partnerships. The department ultimately exceeded this goal by engaging 11 new partners. These partners joined CCDOH's health improvement coalition to provide ongoing insights to inform CCDOH's programming.

Facilitators

To expand community engagement for BIPOC residents, CCDOH began by mapping out its goals and determining staff roles. By developing SMARTIE goals, staff were able to develop a project plan that incorporated equity from the outset. CCDOH also included community members in the project planning phase and encouraged input on the SMARTIE goals to align CCDOH priorities with community needs.

Once the project goals were set, CCDOH accelerated its efforts to engage community members and partners. CCDOH specifically focused on developing relationships with the Native American population in the western part of the county. CCDOH met with local Tribal leaders about programming targeted toward the Native American population by seeking their support for implementation.

In meetings with both Tribal leaders and local CBOs, CCDOH found that many were engaging in similar work. By hosting a forum for regular meetings across organizations, they could combine efforts and reach more people with their programming. CCDOH invited these partners to participate in a local health improvement coalition as part of an ongoing engagement strategy.

CCDOH also hosted several focus groups to better understand community needs. Focus groups convened in easily accessed locations and close to public transportation. Attendees were offered both monetary and nonmonetary incentives, such as gift cards, meals, and goodie bags with scales and other wellness-related items. CCDOH noted that these strategies led to significant engagement and feedback from focus group participants. The focus groups also doubled as information sessions where CCDOH shared information about programming and resources available to the community. After hearing from community members, CCDOH then revised its initial SMARTIE goals by incorporating sub-goals to reflect the community input.

CCDOH also strengthened its communication strategy. As part of the focus groups, they asked community members about the best methods of communicating. Community members in rural areas with limited access to internet shared that flyers pinned to nearby bulletin boards would be more effective than emails or online updates. CCDOH worked to translate their materials into multiple languages across both their website and other written materials. Their website now allows users to select between English, Chinese, French, and Spanish. Receiving community input from the start strengthened the department's efforts to engage with the community.

Lessons Learned

One of CCDOH's most meaningful takeaways is that all aspects of community engagement work require time—from planning to ongoing implementation. CCDOH recommends starting with focus groups before project planning to ensure that health equity projects align with community needs from the start. This level of collaboration is sometimes impossible because of grant funding and time constraints but may lead to greater buy-in among residents.

Furthermore, communities are composed of people with different needs. CCDOH created different engagement opportunities for residents, Tribal leaders, and community organizations. Though CCDOH's work focused on connecting with older residents, it would have been beneficial to hear more from younger residents, which would have required a different engagement strategy. Moreover, trust and relationship building are integral to community engagement and often build slowly over time. In some cases, organizations must also work to overcome the distrust that resulted from previous harms.

CCDOH encourages organizations to think beyond their existing processes. Organizations can prevent duplicative efforts and better respond to community needs by collaborating with community members and CBOs. This work also helps to build trust between people and the organizations that serve them. Community members are the key to successful relationships and health improvement efforts. Going forward, CCDOH plans to continue engaging with its project partners to strengthen its relationships and programming.

Gaudenzia Addiction Treatment and Recovery Services

Case Study

Location: Baltimore, Maryland

Project Goal: Develop a Community Advisory Committee to meet SAMHSA requirements for Certified Community Behavioral Health Clinics

Gaudenzia Addiction Treatment and Recovery Services (Gaudenzia) is one of the largest nonprofit addiction treatment and recovery services providers in the northeastern United States, serving Pennsylvania, Delaware, Maryland, and Washington, DC. In 2024, Gaudenzia opened a SAMHSA-funded Certified Community Behavioral Health Clinic (CCBHC) in Park Heights, Baltimore. The clinic serves Baltimore City, which is 58 percent Black, 32 percent White, and 8 percent Hispanic/Latino. Gaudenzia's CCBHC provides comprehensive behavioral health services, including care coordination, to individuals regardless of ability to pay.

Gaudenzia developed a strategy to launch a Community Advisory Committee (CAC)—a federal requirement for CCBHCs. Gaudenzia sought to use the CAC to ensure that its behavioral health services respond to community needs. To support this goal, Gaudenzia designed recruitment materials and information sessions, recruited and trained participants, developed a leadership structure, and designed agendas for CAC meetings. As a result, Gaudenzia launched a CAC composed of both community partners and individuals with lived experience, including former clients.

Facilitators

Gaudenzia began the project by hosting strategy sessions with leadership and the HMA coaches to determine the steps needed to implement a CAC and assign staff roles. Because of limited federal guidance on how to effectively implement a CAC, Gaudenzia sourced external resources, such as Harvard's Community Health Center Community Advisory Board Toolkit, to inform member recruitment, develop a leadership structure, and prepare for meeting facilitation.[xvii] These planning materials will inform the development of CACs across Gaudenzia's CCBHCs nationwide.

"The HMA team helped us to develop foundational documents like bylaws, an orientation slide deck, CAC meeting agendas, and a road map, which broke down the project into actionable steps," said Shanna Johnson, Division Director at Gaudenzia. "These materials also helped staff effectively communicate about the CAC to interested participants."

> "The HMA team helped us to develop foundational documents like bylaws, an orientation slide deck, CAC meeting agendas, and a roadmap, which broke down the project into actionable steps."
>
> **Shanna Johnson**
> Division Director at Gaudenzia

Gaudenzia then began recruitment efforts, with the goal of having 51 percent of its CAC composed of individuals and family members with lived experience and 49 percent of community partners and community members. A key challenge was finding volunteers with lived experience in substance use and mental illness and who met the participation criteria. To overcome these challenges, Gaudenzia staff contacted its network of community partners to make referrals, as well as former clients, to assess interest. Gaudenzia's marketing team also developed materials to inform the broader community of the opportunity. The organization then hosted meetings to share the purpose of the CAC, engagement expectations for participants, and training for committee members.

Sustained engagement with CACs is challenging because of participants' time and financial constraints. Gaudenzia staff began by hosting in-person CAC meetings. To better engage and retain participants, staff provided meals for participants and allowed participants to bring their children to events. These strategies helped to increase attendance, but participants sometimes were unable to attend meetings consistently. Staff found that offering hybrid meetings provided greater flexibility and increased attendance and participation.

Lessons Learned

Trusted relationships between providers and community members are essential to build successful and lasting partnerships. Although Gaudenzia has offered drug and alcohol treatment in Maryland since 2004, many community partners were unaware that Gaudenzia opened a CCBHC to address primary care and mental health needs in 2024. As a result, recruiting for the CAC was particularly challenging. Staff were only beginning to develop community partnerships and had not yet become established as a trusted provider among community members. Additionally, Gaudenzia staff were stretched across multiple large projects associated with launching the CCBHC.

Looking back, Gaudenzia staff shared that they could have better marketed the new CCBHC, starting with building strong relationships with community outreach staff at partner organizations to accelerate CAC recruitment efforts. By tapping into existing CBOs that already had developed trusting relationships with the community, the introduction

likely would have been more effective. In addition, the organization would have focused on establishing the CAC with a smaller group of participants. Initially, staff set a goal of recruiting at least 19 CAC participants. In retrospect, it would have been more feasible to begin with three community members and two partners, which would have allowed the organization to form the CAC and establish participation norms while continuing to recruit new members.

Developing CACs is time intensive and reliant on building trust between a provider and the community. Without a longstanding relationship with the community, Gaudenzia's CCBHC had to be intentional in its planning, outreach, and recruitment efforts. Taking time at the beginning to develop an effective project plan and tapping into community partnerships were keys to success. Going forward, Gaudenzia plans to continue CAC recruitment efforts and scale its process to develop CACs across Gaudenzia.

Acknowledgements

The Task Force would like to thank the Robert Wood Johnson Foundation for funding the Raising the Bar project and the National Alliance to Impact the Social Determinants of Health for leading the development of the framework. The Task Force also thanks Health Management Associates, Inc., for providing technical assistance. We also extend our thanks to the following organizations for implementing the Raising the Bar framework and for providing interviews for this report:

- Charles County Department of Health
- CHRISTUS Health
- Gaudenzia Addiction Treatment and Recovery Services
- Sturdy Health

We acknowledge the efforts each organization has made to provide equitable, patient-centered care to the patients and communities they serve.

References

i. Berwick DM, Nolan TW, Whittington J. The Triple Aim: Care, Health, and Cost. Health Affairs. 2008;27(3). doi: 10.1377/hlthaff.27.3.759.

ii. Robert Wood Johnson Foundation. Raising the Bar: A Framework for Promoting Equity and Excellence in Healthcare. 2022. Available at: https://rtbhealthcare.org/.

iii. Ibid.

iv. Deloitte Center for Healthcare Solutions. The US $2.8 Trillion Opportunity: How Better Health for All Can Drive US Economic Growth. September 25, 2024. Available at: https://www2.deloitte.com/us/en/insights/industry/health-care/health-equity-economic-impact.html.

v. Raising the Bar: A Framework for Promoting Equity and Excellence in Healthcare.

vi. Ibid.

vii. National Partnership for Women & Families. Raising the Bar for Maternal Health Equity and Excellence. 2023. Available at: https://nationalpartnership.org/health-justice/raising-the-bar/report/.

viii. Health Care Transformation Task Force. Payer Strategies for Advancing Health Equity Through Value-Based Care. August 15, 2024. Available at: https://hcttf.org/payer-strategies-for-advancing-health-equity-through-value-based-payment/.

ix. Health Care Transformation Task Force. Provider Strategies for Advancing Health Equity Through Value-Based Care. October 24, 2024. Available at: https://hcttf.org/provider-strategies-for-advancing-health-equity-through-value-based-care/.

x. Health Care Transformation Task Force. Building the Business Case for Health Equity Investment: Strategies to Secure Sustainable Support. January 24, 2023. Available at: https://hcttf.org/building-the-business-case-for-health-equity-investment/.

xi. Ibid.

xii. Health Begins. The Return on Investment (ROI) Calculator for Healthcare Partnerships to Address Social Needs. 2023. Available at: https://roi.healthbegins.org/welcome.

xiii. Health Care Payment Learning & Action Network. Value of Health Care Redefined: Social Return on Investment. November 2024. Available at: https://hcp-lan.org/wp-content/uploads/2024/11/HCPLAN-Social-ROI-Publication_vFinal.pdf.

xiv. Oss ME. What Gets Measured Is What Gets Done: Keys to Selecting Measures for Performance Management. Open Minds. June 18, 2019. Available at: https://openminds.com/market-intelligence/editorials/what-gets-measured-is-what-gets-done-keys-to-selecting-measures-for-performance-management/.

xv. Isaacs RS. 5 Steps to Restore Trust in U.S. Health Care. Harvard Business Review. September 8, 2022. Available at: https://hbr.org/2022/09/5-steps-to-restore-trust-in-u-s-health-care.

xvi. Ibid.

xvii. Harvard Implementation Science Center for Cancer Control Equity. Community Health Center, Community Advisory Board Toolkit. Available at: https://hsph.harvard.edu/wp-content/uploads/2024/10/Community-Health-Center-Community-Advisory-Board-Toolkit.pdf.