Improving Capacity of Physician-led Practices to Prevent, Mitigate and Treat COVID-19: Elevating Best Practices in the Care of Minoritized Populations

Request for Proposals

Submission Deadline – Friday, October 1, 2021; 11:59 PM ET

Project Period: November 1, 2021 – July 31, 2022

RFP Application Informational Webinar – Wednesday September 8th at Noon ET

I. Background

The COVID-19 pandemic has and continues to exacerbate inequities in care access and service quality for minoritized populations. Through an award provided by the US Department of Health and Human Services' Centers for Disease Control and Prevention, The American College of Preventive Medicine (ACPM) is partnering with the American Medical Association's Center for Health Equity to create care coordination pilots that enhance the capacity of physician-led practices to implement COVID-19 prevention, vaccination, testing, and treatment strategies that improve the health of populations that have been disproportionately impacted by the pandemic, racial injustice, and other forms of oppression. This project aims to document best practices in care coordination for **minoritized communities (i.e., Black, Indigenous, Persons of Color (BIPOC), people that identify as Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ+), Asian American Pacific Islanders (AAPI), people with disabilities, and other minoritized groups, including populations that have been marginalized based on economic circumstances and/or other determinants of social inclusion**, and to share key lessons that will allow healthcare settings to better prepare for and respond to future pandemics.

More than 39 million people have tested positive for SARS-CoV-2, the virus that causes COVID-19 and there have been more than 648,000 COVID-19-related deaths in the United States alone.[1] Data consistently show that American Indian and Alaska Native (AIAN), Black, and Hispanic people have experienced disproportionate rates of illness and death due to COVID-19. Black, AIAN, Hispanic people, Native Hawaiian, and other Pacific Islander (NHOPI) in the US, had over three times the number of premature excess deaths per 100,000 people in 2020 compared to White or Asian people. South Asian Americans who were already vulnerable, whether due to immigration status, domestic violence or unsafe working environments have been most directly impacted by the pandemic.[1a.] In June 2020, the New York City's health department found that 7.6 percent of the city's coronavirus victims were of Asian descent. The Bangladeshi community, which makes up less than 8 percent of NYC's Asian population, accounted for about 20 percent of those deaths.[1a] The COVID-19 pandemic has disproportionately affected people living with disabilities.[1b] In early 2020, 18-74 year old with intellectual and developmental disabilities who contracted the virus were twice as likely to die compared to those without disabilities.[1b] According to a CDC report released in February 2021, LGBTQ+ people have higher rates of self-reported underlying conditions associated with severe covid-19 outcomes, including asthma, cancer, heart disease, obesity, kidney disease and stroke, than heterosexual people.[1c] The National Center for Health Statistics released provisional life expectancy estimates for 2020, which indicate that compared to 2019, life expectancy at birth for the total US population was 77.3 years compared to 78.8 in 2019. COVID-19-related deaths represented 73.8% of the decrease in life expectancy from 2019 to 2020 and were the biggest driver of the 1.5-year decline. Life expectancy decreases were greatest among minoritized men, especially Black and Hispanic men, who experienced decreases in life expectancy at 3.6 and 4.6 years, respectively. Higher rates of illness and death among people of color reflect increased risk of exposure to the virus due to living, working, and transportation situations; increased risk of experiencing serious illness if infected due to higher rates of underlying health conditions; and increased barriers to testing and treatment due to existing disparities in access to health care.[2]

Beyond the direct health impacts of the virus, the pandemic has taken a disproportionate toll on the financial security, mental health and well-being of people of color, low-income people, LGBTQ+ people, and other under resourced groups. For example, survey data from February 2021 showed that about six in ten Hispanic adults (59%) and about half of Black adults (51%) reported their household lost a job or income due to the pandemic, compared to about four in ten White adults (39%). Adults with a household income under $40,000 were three times as likely as those with a household income of $90,000 or more to say they have had trouble paying for basic living expenses in the last three months (55% vs. 19%).[3] Further, communities that have been mistreated and marginalized by healthcare and government systems continue to hold high levels of mistrust in healthcare, COVID-19 treatments, and vaccines.[4]

It is well established that robust primary care is essential to a high-value health care system.[5-6] However, the US primary care system faces considerable challenges.[6-8] Medical practices have grappled with inadequate resourcing to adapt to the rapidly changing care landscape and enact comprehensive strategies that address the underlying structural drivers impacting their patients. Many providers, including **small, independent, rural, and safety net providers** face financial barriers to implementing practice transformation. These challenges are felt particularly harshly by small practices facing time and resource constraints and independent practices often lacking access to data experts to assist with generating reports for quality improvement activities.

In response, ACPM aims to fund **10-15 physician-led practices**[9] from November 1, 2021 – July 31, 2022 to implement strategies that center equity and aim to improve the health of **communities (i.e., BIPOC, LGBTQ+, AAPI, people with disabilities, and other minoritized groups) disproportionately affected by COVID-19, particularly those at increased risk due to social and economic circumstances (i.e., predominantly low-income, Medicaid or uninsured, underinsured, immigrant, rent-burdened, unstably housed, etc.)**. Projects proposed should focus on capacity-building in the following strategic domains (see below).

Strategic domains:

1. **Care coordination** of COVID-19 testing, prevention, treatment[10] (i.e., deliberately organizing patient care activities and sharing information among all participants concerned with a patient's care to achieve safer and more effective care).

2. **Addressing social determinants of health** (i.e., screening for and addressing the social needs of patients affected by COVID-19 and/or patients at increased/higher risk of developing COVID-19 due to marginalization, chronic illness and/or the conditions in which they live/work.

3. **Collaborative data and knowledge management** (i.e., data quality improvement strategies) including collection (e.g., tracking of demographic data such as race, ethnicity, gender identity, etc.), user friendliness, reciprocity, and use of community data to reduce disparities within patient populations disproportionately affected by COVID-19.

4. **Developing/maintaining clinical-community linkages/partnerships** with local public health partners, quality improvement organizations, community-based organizations, preventive medicine residency programs and/or prevention research centers to help inform interventions provided to patients disproportionally impacted by COVID-19.

Projects are further encouraged to **focus efforts within priority regions**. While definitions of priority will vary nationally based upon geography, population density and other local factors, applicants are strongly encouraged to apply either 1) The Center for Disease Control and Prevention's (CDC) and Agency for Toxic Substances and Disease Registry's (ATSDR) **Social Vulnerability Index (SVI)** tool to their applications (*The CDC/ATSDR SVI tool uses U.S. Census data to determine the social vulnerability of every census tract. ATSDR's Geospatial Research, Analysis & Services Program (GRASP) maintains the CDC/ATSDR SVI to help public health officials and local planners better prepare for and respond to emergency events like hurricanes, disease outbreaks, or exposure to dangerous chemicals.*); or 2) a **similarly intended local index that best represents each applicant's region of focus**. Applicants should **apply the most recent and complete dataset available** (e.g., 2020 census), as applicable for their region.

In addition, applicants are strongly encouraged to **factor regional rates of COVID-19 into their prioritization process**. Rates should be examined on a 7-day rolling average and per 100,000 residents (as applicable). Applicants should refer to their local health department website for the most relevant state, county, and/or territory data for their region. This includes but is not limited to:

- **Percent Positive:** Percent of people tested who test positive (PCR molecular tests)
- **Confirmed Case:** Positive result from a molecular test, such as a PCR test. Unless specifically labeled as "probable cases," data on cases are for confirmed cases only.
- **Hospitalizations:** People hospitalized within 14 days of diagnosis.
- **Confirmed Deaths:** Deaths with a positive molecular test.
  - A death is classified as confirmed if the decedent was a local resident who had a positive molecular test for the virus that causes COVID-19.
  - A death is classified as probable if the decedent was a local resident (or residency pending) who had no known positive molecular test for the virus that causes COVID-19 but the death certificate lists “COVID-19” or an equivalent as a cause of death.
- **Probable Case:** Defined as any of the following:
  - Positive antigen test result.
  - Person has symptoms and was exposed to a confirmed case.
  - Person died and their cause of death on the death certificate is COVID-19 or similar, but a positive molecular test is not on record.

II. Award

ACPM aims to fund a total of two million dollars to be distributed among **10-15 physician-led practices** who identify within **one of two tiers** described below. Each unique **tier 1** site will be **awarded $250,000 (two hundred and fifty thousand dollars)**. Each unique **tier 2** site will be **awarded $150,000 (one hundred and fifty thousand dollars)**. Large health systems are welcome to apply for a **maximum of 2 sites or a total award of $500,000 (five hundred thousand dollars)**.

1. Award determinations will be made by an independent review committee and awarded contracts will be provided directly to successful applicants by ACPM.
2. The independent review committee will actively review and score applications using a standardized, weighted scoring process.
   a. **ACPM and AMA assembled an evaluation committee in advance of release of this award to support review of proposals and promote a fair process**.
   b. Evaluation committee members shall not at any time during the RFP process discuss the subject matter including ascertaining any questions from potential applicants. For applicants, a public frequently asked questions (FAQ) document will be created. Members of the Evaluation Committee shall refrain from discussing the evaluation proceedings with non-members. Scoring is not to be discussed during the scoring period with any other persons. Evaluation of the proposals must be made independently of any external influence. Any violation of the above confidentiality rules shall be cause to exclude an evaluation committee member from further participation in the proceedings and the disqualification of that member’s vote.
3. **Preference will be given** to projects that:
   a. **Fill service gaps in priority regions** (see above);
   b. Demonstrate diverse staffing that is representative of the community served by the applicant, including in leadership roles. This includes organizations with majority **BIPOC, LGBTQ+, AAPI, people with disabilities, and other minoritized groups disproportionately affected by COVID-19.**

4. Application scoring will be weighted, as such, we cannot guarantee an equal number of sites will be chosen from each tier.
5. Selected recipients must be prepared to sign a fixed-price contract with ACPM and complete the project deliverables in the timeline described in the 'Project Timeline' section (see below).
6. Selected recipients should be prepared to develop invoices, and receive/process check payments.
7. Selected recipients must participate in the evaluation and data collection activities described below.
8. Selected recipients will be notified by: **Monday October 18th by 5:30 PM ET**.

III. Submission Requirements

Deadline to complete application: Friday, October 1, 2021, 11:59 PM ET

Interested and qualified applicants that can demonstrate ability to implement capacity building projects centered in equity that align with the 4-category model *(see scope of services)* of this RFP are invited to submit a proposal provided they meet the following requirements (see below).

1. Applicants are strongly encouraged to attend the virtual the information session.
    a. Information session to be held **Wednesday, September 8th at Noon ET.** After registration, a confirmation email will be sent with information on how to join the session. Participants will have the option to join by computer and/or telephone.
        i. **Register in advance for this meeting:** **https://us02web.zoom.us/meeting/register/tZAlc-uurT8tGNVNKWw36XkGVBxatW05byeW**
        ii. This session will cover details of the award opportunity including application scoring criteria. Interested applicants are welcome to submit questions in advance at grants@acpm.org. Deadline to submit questions: **Tuesday September 7th at Noon ET.**
        iii. For those unable to attend the live session, a recording of the info session will be publicly available later that day at: **https://www.acpm.org/Initiatives/Physician-Led-Practices**
        The recording will also be sent to all those who register for the info session.
2. To submit an application, applicants must:
    a. **Access the online application.**
        i. **Please note: The application form, once initiated, does not save automatically. To save your work, be sure to use the 'save and continue' button on the top right corner of the application form prior to exiting.** This will allow you to continue the same application at a later time.
        ii. For your reference only, a PDF version of the complete application is available in the appendix**.**
    b. **Download and complete the work plan, budget with justification, and data management plan excel template.**
        i. Complete **all three** tabs. If any of the tabs are not completed, your application will be considered non-responsive.
    c. Upload the completed excel template within the online application and submit the completed application; other formats will be considered non-responsive.
    d. Deadline to complete application: **Friday October 1, 2021 11:59 PM ET.**
    e. Applicants are strongly encouraged to submit their applications at least 48 hours prior to the due date. This will allow sufficient to resolve any technical issue with the submission. Late applications will not be accepted. Incomplete applications will not be reviewed.

        f. Applications will not be accepted via e-mail.

3. Applicants must submit a budget with justification. One of the three tabs in the excel template is the budget tab.
    a. Complete the budget and justification to demonstrate how funds will be used to fulfill project goals. If applying as a single physician-led practice, budgets may not exceed:
        i. **Tier 1: $250,000 (two hundred and fifty thousand dollars)**.
        ii. **Tier 2: $150,000 (one hundred and fifty thousand dollars)**.
    b. If applying as a health system supporting 2 distinct sites within one network, projects are assumed Tier 1 and budgets may not exceed: **$500,000 (five hundred thousand dollars)**.
    c. If proposing to allocate more than 50% of the total budget for equipment purchases such as electronic health records, telemedicine supports, digital health software, registry and or database infrastructure, etc., practices must be prepared to discuss how such procurements promote sustainability of equity efforts and align with equitable access to care and/or improved delivery of care.
    d. ACPM reserves the right to request additional documentation (such as proof of approved indirect rate), as needed.
    e. Post-selection, ACPM reserves the right to suggest revisions to project budgets and/or work plans to ensure project success. AMA will provide technical assistance in this area as needed.

IV. Eligibility Criteria

Interested and qualified applicants that can demonstrate ability to implement capacity building projects centered in equity that align with the 4-category model *(see scope of services)* of this RFP are invited to submit a proposal, provided they meet the following requirements:

1. Applications must identify a physician-led practice and clearly outline the population of focus served by the practice.
    a. This opportunity will support a range of physician-led practices including:
        i. Primary care providers including health care homes, tribal primary and behavioral health providers, rural health providers, federally qualified health centers, or a group of primary care providers seeking to integrate care.
        ii. General hospitals licensed by the State Department of Health under Article 28 of the State Public Health Law.
        iii. Diagnostic and treatment centers and clinics licensed by the State Department of Health under Article 28 of the Public Health Law.
        iv. Physicians or providers licensed under local State Education Law and authorized by Executive Order to perform COVID-19 testing services.
        v. Outpatient mental health clinics licensed or granted an operating certificate by the local State Department of Health Office of Mental Health under Article 31 of the Mental Health Law.
2. Applications will also be accepted from organizations working jointly with a physician practice or as part of a coalition. If applying through a partnership or coalition, all organizations on the application should be prepared to assume liability for this project. Any proposed sub-awarding of funds should be clearly outlined and justified in the budget. It is the responsibility of the applicant to ensure that required information is included in their application. The lead applicant should be prepared to provide, at minimum their EIN/Tax ID, so that ACPM can receive their invoices and process their award disbursements. Further information will be included in the award letter of selected grantees.
3. Applications must include a designated physician advisor to oversee the project.

4. Applicants must be willing to comply with all regulatory requirements outlined by the CDC as a condition of receiving funding for this project. (see appendix 4)

Practices may vary in size, scope, patient population, operational capacity and infrastructure. To accommodate this variation, activity commitments are proposed in two tiers. Physician-led practices are encouraged to **apply to the tier that best represents their current infrastructure and capacity state at the time of application**. Practices can qualify for submission in either tier so long as they meet **at least one of the criteria** listed below. **If you feel your practice could qualify for either tier, pick the most appropriate category for the scale of your proposed project.**

TIER 1 **(AWARD THRESHOLD $250,000)**	**TIER 2** **(AWARD THRESHOLD $150,000)**
Physician-led practice in an urban or rural area that is either: ● A Federally Qualified Health Center (FQHC) or similar community-based healthcare organization that does not specifically serve in a medically-underserved area (MUA) as defined by the Health Resources and Services Administration (HRSA), and/or; Part of an integrated health systems, and/or; ● Contains more than 15 clinicians (not all clinicians are MD/DO), and/or; ● Has a total operating budget of $1 million dollars or more, and/or; ● Has a demonstrated history of implementing equity-approaches aimed to reduce disparities and improving health outcomes	Physician-led practice in an urban or rural area that is either: ● An FQHC or FQHC-look-a-like organization that serves in a medically underserved area (MUA) or medically underserved population (MUP) as defined by the Health Resources and Services Administration (HRSA), and/or; ● Contains fewer than 15 clinicians (not all clinicians are MD/DO), and/or; ● Has a total operating budget less than $1 million dollars, and/or; ● Is not currently implementing equity approaches to improve patient health outcomes; or has embraced an equity framework but has struggled to implement it due to staffing and/or other resources constraints

V. Scope of Services

Activities below are intended to enhance care quality and patient health outcomes related to COVID-19.

Tier 1: *Practices will be required to implement* ***one activity from three of the four domains (a total of 3 activities)****.*

Tier 2: *Practices will be required to implement* ***two activities from any of the four domains (a total of 2 activities).***

DOMAIN	TIER 1	TIER 2
CARE COORDINATION	1) Identify promising health equity practices for reducing disparities and improving testing, vaccination, and treatment within minoritized groups (BIPOC, LGBTQ+, AAPI, people with disabilities, and other	1) Identify and implement one or two health equity-based strategies that can be used to reach priority populations at risk for worsening COVID-19 outcomes.

	disproportionately affected by COVID-19). 2) Identify promising practices within one's health system and/or existing value-based payment models which could lead to improved health and cost outcomes, demonstrate active efforts to improve care coordination and effect change for health conditions associated with worsening COVID outcomes.	
ADDRESSING SOCIAL DETERMINANTS OF HEALTH	1) Assess social needs barriers using existing tools (e.g., PRAPARE). This includes translation and/or adaptation of tools into additional languages prior to implementation (e.g., a culturally representative native practice and/or a local partner committing to act as certified translators in additional native languages and/or create and/or modify culturally relevant patient education materials). 2) Address social needs barriers within communities at risk for worsening COVID-19 health outcomes by providing community referrals to patients and tracking the uptake/impact of the referrals. 3) Identify mechanisms by which funds are made available to healthcare providers to support the implementation and sustained operations of interventions to address social needs of (BIPOC, LGBTQ+, AAPI, people with disabilities, and other minoritized groups) disproportionately affected by COVID-19); within the context of value-based payment models.	1) Identify, plan and implement use of a social needs and barriers assessment tools (e.g., PRAPARE). 2) Identify and address at least one social need risk/barrier. 3) Serve as certified translators to promote and enhance sharing of best practices across cultures/regions and/or identify promising practices for creation and dissemination of culturally sensitive patient content/educational materials.

COLLABORATIVE DATA AND KNOWLEDGE MANAGEMENT	1) Identify opportunities and barriers to collecting additional patient demographic data (e.g., race, ethnicity, SOGI, etc.). 2) Identify promising practices to collecting/completing missing demographic data (e.g., utilizing physician tracking tool, process flow, electronic record assessment and/or modification). 3) Identify sources of and promising practices to collect and utilize community-level data.	1) Identify opportunities/ strategies to collect demographic data and/or reduce missing data (e.g., race, ethnicity, SOGI, etc.). 2) Identify and utilize at least one tool to improve the collection of demographic data. 3) Identity and utilize at least one relevant source of community-level data to better address the COVID-19 priorities within the site.
CLINICAL-COMMUNITY LINKAGES/ PARTNERSHIPS	1) Measure the strength of existing partnerships to deliver clinical services to support COVID-19 mitigation efforts; measure the strength of existing partnerships with state, local health departments. 2) Partner with a preventive medicine residency program (using residents' help with data collection/analysis, identify policies to improve access or to ensure the delivery of essential public health services to support COVID-19 mitigation efforts for (BIPOC, LGBTQ+, AAPI, people with disabilities, and other minoritized groups disproportionately affected by COVID-19). 3) Identify or demonstrate best practices for engaging local partners to enable access to, as well as facilitate broader reach/impact of information and tools to improve minoritized patients' COVID identification/care/recovery.	1) Identify community partnership opportunities that enhance equity strategies to support COVID-19 mitigation efforts. 2) Initiate or strengthen partnerships with at least 1-2 jurisdictional public health organizations. 3) Partner with a preventive medicine residency program (where residents can help with data collection/analysis or ensure the delivery of essential public health services to support COVID-19 mitigation efforts for under resourced communities) (Note: This option will be dependent on an applicant's proximity to a preventive medicine program). 4) Disseminate resources to at-risk patients on COVID-19 vaccination/mitigation/treatment (e.g.: disseminate existing culturally sensitive materials to patients).

VI. Project Timeline and Deliverables

TIME	ACTIVITY	DELIVERABLE
October 2021	Applicants will be notified if they are among the 10-15 sites selected for funding. Funded sites will receive: ● An award letter outlining requirements ● Contract for signature ● Feedback on proposed budget and work plan	N/A
October 2021	Funded sites will sign the contract and return it to ACPM. Funded sites will revise the work plan and budget based on feedback from ACPM	Signed contract. Submit information about site to be uploaded to ACPM project website. Revised work plan and budget
November 2021	Begin implementing the project based on the final work plan.	
November 2021	Participate in monthly technical assistance call/ inaugural call.	Participate in first qualitative interview with AMA (tentative date). Complete pre-assessment (ACPM/AMA will share the link).
December 2021	Participate in quarterly call with all funded sites, ACPM, AMA, the advisory group.	Quarterly data template (ACPM/AMA will share the template and process to upload data into an open-share data repository).
January 2022	Participate in monthly technical assistance call.	
February 2022	Participate in monthly technical assistance call.	
March 2022	Participate in quarterly call with all funded sites, ACPM, AMA, the advisory group.	Quarterly data template (ACPM/AMA will share the template and process to upload data into project repository).
April 2022	Participate in monthly technical assistance call.	Participate in second qualitative interview with AMA (tentative date).
May 2022	Participate in monthly technical assistance call. Sites help ACPM and AMA prepare for presentation at the ACPM Annual conference in June 2022 (Funded sites and advisory group members are not required to be present at the annual conference).	

June 2022	Participate in quarterly call with all funded sites, ACPM, AMA, the advisory group. ACPM/AMA present at a session of the annual conference.	Complete post-assessment (ACPM/AMA will share the link). Final quarterly data template (ACPM/AMA will share the template and process to upload data).
July 2022	Sites complete project implementation.	Submit end-of-the-project narrative report (ACPM/AMA will send the report template). Submit one case study (tentative date – ACPM/AMA will advise on format).

VII. Resources and Technical Assistance

ACPM and the AMA will provide aid (see below) to funded sites to support implementation and enhance project impact.

- Technical Assistance through monthly calls with sites.
- Opportunities to participate in multiple evaluation activities.
- Access to evidence-based, curated resources from federal government and national organizations including ACPM and AMA.
- A data repository where the sites can upload their existing resources and access a story bank.
- Quarterly calls with all funded sites to brainstorm and learn from one another.
- Sites' findings and lessons learned will be presented by ACPM and AMA at the ACPM's annual conference, Preventive Medicine 2022, to be held in Denver in June 2022. Sites and the Advisory Council members are not required to attend the conference.
- Final report (to be developed by ACPM and AMA) including the lessons learned and scalable promising practices. (This will be available only after the project period has ended).

VIII. Evaluation

Award recipients are **expected to participate in quantitative and qualitative data collection to document capacity building processes and project progress**. All data collection methods affiliated with this project will be conducted in accordance with CDC and federal guidelines. As funding is provided through a CDC cooperative agreement, recipients should be aware that **ACPM/AMA will produce a version of aggregated, de-identified project data that can be publicly shared with CDC**.

The team at ACPM and AMA will leverage **partnership with an institutional review board to support evaluation of program activities** affiliated with demonstration projects that fall within CDC Cooperative Agreement OT18-1802. AMA/ACPM will submit a program evaluation application to an Office for the Protection of Research Subject's Institutional Review Board to ensure methods proposed for data capture are ethical, secure, and do no harm. **All data collection and analysis activities proposed within the scope of this project are for the purpose of program evaluation and do not fall under human subjects' research**. The project team will make best efforts to limit collection and use of sensitive data, and instead rely on aggregate data to support evaluation, whenever possible. All data collection methods employed will comply with the recommendations of the institutional review board. This includes review and approval of all data collection protocols, collection tools and participant consent forms. Only staff who are specifically named on the project will be responsible for transfer of the data to password protected folders, using encrypted portable media (if portable media are necessary). Data collected electronically will be stored in a secure password protected database and exported directly to password protected folders on password protected devices. **Project data will be used to: 1) describe the overall performance of physician practices receiving technical assistance and implementing equity-focused capacity building strategies, 2) describe patterns in the needs of populations treated at**

and within the communities where physician practices are located, 3) recognize the unique and shared experiences of practice staff and their patients (BIPOC, LGBTQ+, AAPI, people with disabilities, and other minoritized groups disproportionately affected by COVID-19)), and 4) inform planning, prevention, treatment and mitigation strategies for future COVID-19 surges or future public health emergency.

All recipients must:

- Complete a pre/post-assessment survey.
- Participate in monthly technical assistance calls and quarterly grantee calls.
- Participate in 2 (1 hour) key informant interviews.
- Compile and upload program data into a repository at least once every 3 months (template to be provided).
- Submit at least one a case study highlighting equity-focused strategies implemented to improve health outcomes in disproportionately affected communities (guidance on format and examples will be provided by the evaluation team).
- Host 1 best practice/lessons learned presentation for fellow awardees.

Physician practices are strongly encouraged to **develop data management plans using the suggested metrics table below in alignment with the project domains they select**. Practices are also **welcomed to submit their own specific measures** that best align with their current work; particularly if building upon and/or strengthening an existing project. Unique and final data management plans will be developed with awarded practices in partnership with AMA. Technical assistance will be provided through regular technical assistance calls as well as needed throughout the project period.

DOMAIN	HYPOTHESES	SUGGESTED METRICS (DATA MANAGEMENT PLAN)
CARE COORDINATION	Offering and referring to local health-promoting servicesand resources will increase patient participation in these services and improve care quality.	• Number of COVID-19 tests administered among patient population, by race/ethnicity and SOGI if being measured • Number of COVID-19 cases identified among patient population, by race/ethnicity • Percent of people tested who test positive among patient population, by race/ethnicity • Number of COVID-19 vaccines administered among patient population, by race/ethnicity • Change in percent difference in COVID-19 testing rate by race/ethnicity among patient population (calculated) • Change in percent difference in COVID-19 vaccination rate by race/ethnicity among patient population (calculated) • Number of patients receiving treatment for COVID-19 (or other priority health outcome) • Number of patients reporting barriers to treatment • COVID-19 (or other priority health outcome), by race/ethnicity • Average cost per patient related to COVID-19 (or other priority health outcome), by race/ethnicity readmission rate • Number of health equity-based strategies implemented • Number of practices reporting the implementation of strategies to disseminate culturally sensitive educational materials • Number of patients and/or unique individuals receiving culturally sensitive educational materials and yes/no if this material includes or excludes often invisible populations (e.g., some smaller Asian communities, LGBTQ+) • Increase in access to comprehensive care services • Number of referrals to specialty clinical care services • Number of referrals to social services (housing stability, employment, legal, education, financial, and transportation services, and food assistance) • Number of referrals to dental care services • Number of referrals for quarantine support services

ADDRESSING SOCIAL DETERMINANTS OF HEALTH	Increasing identification of and addressing social needs will lead to improved health outcomes for historically marginalized populations.	● Number of practices adopting PRAPARE (or other applicable screening tool) ● Number of languages PRAPARE (or other applicable screening tool) translated into, relative to primary languages spoken in patient population ● Number of patients with completed social needs assessment ● Number of patients with at least one social need risk or barrier identified, by race/ethnicity ● Number of new community-based organization-clinical practice linkages ● Number of physicians equipped to make referrals to/from community-based organizations (self-report) ● Number of referrals made to/from community-based organizations, by type (bidirectional) ● Number of patients referred to/from community-based organizations, by race/ethnicity (bidirectional) ● Number of patients connected to referred service ● Number of patients that received needed support, by race/ethnicity, SOGI etc. ● Number of identified mechanisms by which funds are made available to healthcare providers to support the implementation and sustained operations of interventions to address social needs of *(BIPOC, LGBTQ+, AAPI, people with disabilities, and other minoritized groups disproportionately affected by COVID-19)*; within the context of value-based payment models
COLLABORATIVE DATA AND KNOWLEDGE MANAGEMENT	Strengthening data collection processes will lead to improved identification of *(BIPOC, LGBTQ+, AAPI, people with disabilities, and other minoritized groups disproportionately affected by COVID-19)*, their needs, and the creation of comprehensive strategies to tailor care and interventions that meet their needs.	● Number of patients with complete race information among the: a) overall patient population, b) patients with a positive SARS-CoV-2 test, c) patients receiving a COVID-19 vaccination ● Number of patients with complete ethnicity information among the: a) overall patient population, b) patients with a positive SARS-CoV-2 test, c) patients receiving a COVID-19 vaccination ● Number of patients with complete sexual orientation and gender identity information among the: a) overall patient population, b) patients with a positive SARS-CoV-2 test, c) patients receiving a COVID-19 vaccination ● Completed assessment of barriers to collecting comprehensive patient demographic data (yes/no) ● Completed assessment of COVID-19 priorities within site ● Number of community-level data sources incorporated into practice
CLINICAL-COMMUNITY LINKAGE AND	Connecting practices with new partners, convening decision-	● Number of formal partnerships developed between physician practices and public health entities ● Number of new or existing programs or projects

PARTNERSHIPS	making coalitions, and investing in partnerships will shift power and strengthen partner relationships.	implemented in collaboration with local or public health partners ● Number of meetings between physician practices and local or public health partners ● Number of meetings led by local or public health partner organizations ● Number of practices reporting the implementation of strategies to disseminate culturally sensitive educational materials ● Number of patients and/or unique individuals receiving culturally sensitive educational materials and if this material includes or excludes often invisible populations (e.g., some smaller Asian communities, LGBTQ+) ● Changes in perceptions of trust, collaboration, and/or engagement among practice partnerships with local and public health entities ● Number of practices reporting the implementation of strategies or guiding principles for partnership with public health entities, (e.g., shared leadership, collaborative decision-making processes) ● Number of practices who report utilizing the state, local, tribal, or territorial health department in the delivery of evidence-based strategies for preventing COVID-19 among populations at highest risk ● Number of proposed joint policy convenings/# of proposed partner policy actions ● Number of practices reporting increased sense of community (social cohesion) ● Number of partnership/coalition charters modified to reflect revised partnership values

Disclaimer: This Request for Proposal is supported by the American College of Preventive Medicine through a cooperative agreement CDC-RFA-OT18-1802 with the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services (HHS). The contents are solely the responsibility of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CDC/HHS, or the U.S. Government.

IX. APPENDIX

1. **PDF version of the online application (FOR REFERENCE ONLY)**
    a. **Excel Template (work plan, budget with justification, data management plan)**

2. **Preventive Medicine Residency Directory**

3. **Resources**

    a. Centers for Disease Control and Prevention: https://www.cdc.gov/coronavirus/2019-ncov/index.htmlhttps://www.cdc.gov/coronavirus/2019-ncov/index.html
    b. CDC Health Equity Style Guide - https://ehe.jhu.edu/DEI/Health_Equity_Style_Guide_CDC_Reducing_Stigma.pdf
    c. American College of Preventive Medicine: https://www.acpm.org/initiatives/covid-19-resources/
    d. American Medical Association: https://www.ama-assn.org/delivering-care/public-health/covid-19-2019-novel-coronavirus-resource-center-physicians
    e. National Medical Association: https://www.nmanet.org/page/COVID-19-Resources
    f. National Hispanic Medical Association: https://www.nhmamd.org/covid-19-update-and-nhma-call-to-action
    g. GLMA – Health Professionals Advancing LGBTQ Equality - http://www.glma.org/index.cfm?fuseaction=Feature.showFeature&featureID=853
    h. Association of American Indian Physicians - https://www.aaip.org/
    i. National Council for Asian Pacific Islander Physicians - http://ncapip.org/resources/COVID19/index.html
    j. National Association of City and County Health Officials - https://www.naccho.org/blog/articles/covid-19-news-and-resources-updated-weekly
    k. Association of State and Territorial Health Officials - https://www.astho.org/covid-19/
    l. Public Health Communications Collaborative - https://publichealthcollaborative.org/
    m. Trust for America's Health - https://www.tfah.org/story/tfahs-portal-of-covid-19-resources/
    n. American Public Health Association - https://www.apha.org/covid19
    o. CDC Foundation - https://www.cdcfoundation.org/coronavirus
    p. Black Coalition Against COVID-19 - https://blackcoalitionagainstcovid.org/
    q. DeBeaumont Foundation - https://debeaumont.org/changing-the-covid-conversation/

4. **CDC Terms and Conditions for Selected Recipients**

    a. Comply with all applicable terms and conditions of award, including, but not limited to, those terms and conditions set forth in the Notice of Award NU38OT000289-03-08, Notice of Funding Opportunity, federal laws, regulations, and policies. Further, recipients shall comply with the applicable terms and conditions found at https://www.cdc.gov/grants/federal-regulations-policies/index.html/ including the General Terms and Conditions for Non-Research Grant and Cooperative Agreements document (https://www.cdc.gov/grants/documents/General-Terms-and-Conditions-Non-Research-Awards.pdf). All such applicable terms and conditions are incorporated herein.

    b. Organizational language Note: Title 2 of the United States Code Section 1611 states that an organization described in Section 501(c)(4) of the Internal Revenue Code that engages in lobbying activities is not eligible to receive Federal funds constituting a grant, loan, or an award. Note recipients must ensure compliance with Administrative Requirement-12 (Anti- Lobbying) when engaging in all activities, especially those related to laws, policies, and regulations. https://www.cdc.gov/grants/documents/Anti-Lobbying-Restrictions.pdf

c. Required Disclosures for Federal Awardee Performance and Integrity Information System (FAPIIS): Consistent with 45 CFR 75.113, applicants and recipients must disclose in a timely manner, in writing to the CDC, with a copy to the HHS Office of Inspector General (OIG), all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Subrecipients (or sub awardee) must disclose, in a timely manner in writing to the prime recipient (pass through entity) and the HHS OIG, all information related to violations of federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the federal award. Disclosures must be sent in writing to the CDC and to the HHS OIG at the following addresses: CDC, Office of Grants Services Damond Barnes Grants Management Specialist Centers For Disease Control and Prevention (CDC) Office of Grant Services (OGS) 2930 Brandywine Rd, Atlanta, GA 30341 Email: xhp5@cdc.gov AND U.S. Department of Health and Human Services Office of the Inspector General ATTN: Mandatory Grant Disclosures, Intake Coordinator 330 Independence Avenue, SW Cohen Building, Room 5527Washington, DC 20201 Fax: (202)-205-0604 (Include "Mandatory Grant Disclosures" in subject line) or Email: MandatoryGranteeDisclosures@oig.hhs.gov. Failure to make required disclosures can result in any of the remedies described in 45 CFR 75.371. Remedies for noncompliance, including suspension or debarment (See 2 CFR parts 180 and 376 and 31 U.S.C. 3321).

d. Coronavirus Disease 2019 (COVID-19) Funds: A recipient of a grant or cooperative agreement awarded by the Department of Health and Human Services (HHS) with funds made available under the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (P.L. 116-123); the Coronavirus Aid, Relief, and Economic Security Act, 2020 (the "CARES Act") (P.L. 116-136); the Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139); and/or the Consolidated Appropriations Act, 2021, Division M – Coronavirus Response and Relief Supplemental Appropriations Act, 2021 (P.L. 116-260), agrees, as applicable to the award, to: 1) comply with existing and/or future directives and guidance from the Secretary regarding control of the spread of COVID-19; 2) in consultation and coordination with HHS, provide, commensurate with the condition of the individual, COVID-19 patient care regardless of the individual's home jurisdiction and/or appropriate public health measures (e.g., social distancing, home isolation); and 3) assist the United States Government in the implementation and enforcement of federal orders related to quarantine and isolation. In addition, to the extent applicable, Recipient will comply with Section 18115 of the CARES Act, with respect to the reporting to the HHS Secretary of results of tests intended to detect SARS–CoV–2 or to diagnose a possible case of COVID–19. Such reporting shall be in accordance with guidance and direction from HHS and/or CDC. HHS laboratory reporting guidance is posted at: https://www.hhs.gov/sites/default/files/covid- 19-laboratory-data-reporting-guidance.pdf.

5. Glossary of Terms

Able-Bodied: A term used to "describe someone who does not identify as having a disability. Some members of the disability community oppose its use because it implies that all people with disabilities lack "able bodies" or the ability to use their bodies well. They may prefer "non-disabled" or "enabled" as being more accurate." [11] Some disability rights groups use the term

"Temporarily Able-Bodied" with the acknowledgment that many people who today are able-bodied will not always remain so in the duration of life.

Ally: Someone who makes the commitment and effort to recognize their privilege (based on gender, class, race, sexual identity, etc.) and work in solidarity with oppressed groups in the struggle for justice. Allies understand that it is in their own interest to end all forms of oppression, even those from which they may benefit in concrete ways. [12]

Anti-racism: The active process of naming and confronting racism by changing systems, organizational structures, policies and practices and attitudes, so that power is redistributed and shared equitably. Per Ibram X. Kendi: "The opposite of racist isn't 'not racist.' It is 'antiracist.' What's the difference? One endorses either the idea of racial hierarchy as a racist, or racial equality as an antiracist. One either believes problems are rooted in groups of people, as a racist, or locates the roots of problems in power and policies, as an antiracist. One either allows racial inequities to persevere, as a racist, or confronts racial inequities, as an antiracist. There is no in-between safe space of 'not racist.'" [13] Antiracism is a strategy to achieve racial justice. An anti-racist is someone who is supporting an antiracist policy through their actions or expressing antiracist ideas.

Capacity Building: Capacity building is an intervention that strengthens an organization's ability to fulfill its mission by promoting sound management, strong governance, and persistent rededication to achieving results. Furthermore, having the ability to fulfill a capacity building mission means that an organization has (a) sufficient numbers of staff who possess the necessary knowledge and skills, (b) appropriate and adequate technical and management systems, (c) suitable physical infrastructure, and (d) ample financial and other resources. Thus, capacity building is not limited to training personnel or the provision of TA, but may include overhauling systems, remodeling physical infrastructure, recruiting new personnel, and improving the efficiency of the use of existing resources.[14]

Care Coordination: Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient. Care coordination in the primary care practice involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. The main goal of care coordination is to meet patients' needs and preferences in the delivery of high-quality, high-value health care. This means that the patient's needs and preferences are known and communicated at the right time to the right people, and that this information is used to guide the delivery of safe, appropriate, and effective care.[15]

Centering (Voices): Uplifting, trusting, and valuing the lived experiences of the people most impacted by the issue(s) and inequity(ies) you want to address; the process of centering the voices of those who have been marginalized.

Culture: Set of shared attitudes, values, goals, and practices that characterize an institution, organization or group. Culture is transmitted and reinforced through tradition, art, language, and ritual, among other practices. It has also been defined more broadly as a social system of meaning and custom by a group of people to assure its adaptation and survival.

Cultural Competence: A component of medical education for the past 30 years. The cultural competence frameworks seeks to promote "culturally sensitive" practice, and describes the trained ability of a clinician to identify cross-cultural expressions of illness and health.[16,17]

However, this umbrella term has been criticized on several grounds: it presents overly reductionist, simplistic, and static depictions of culture, often reduced to race/ethnicity, and frames culture and race/ethnicity as residing only in the “Other,” normalizing dominant white culture. Perhaps most negatively, cultural competence “is understood as something that can be attained, individualizing failure to do so. This misconstrues structured power relations which cannot be altered individually. Worse yet, competence is measured in terms of learner confidence and/or comfort, which may have little to do with working effectively across differences.”[18]

Diversity: Refers to the identities we carry. There are many kinds of diversity, based on race, gender, sexual orientation, class, age, country of origin, education, religion, geography, physical or cognitive abilities, or other characteristics. Valuing diversity means recognizing differences between people, acknowledging that these differences are a valued asset, and striving for diverse representation as a critical step towards equity.[28]

Equity: Refers to fairness and justice and is distinguished from equality. While equality means providing the same to all, equity requires recognizing that we do not all start from the same place because power is unevenly distributed. The process is ongoing, requiring us to identify and overcome uneven distribution of power as well as intentional and unintentional barriers arising from bias or structural root causes.

Ethnicity: Social construct and category based on shared geography, language, ancestry, traditions, or history.[19] The boundaries of authenticity (that is, who or what “counts” in recognizing members of an ethnic group) are often changeable and dependent on generational, social, political and historical situations.

Federally Qualified Health Centers: FQHCs are safety net providers for services typically from an outpatient clinic. SSA Section 1861(aa) allows additional FQHC Medicare payments. FQHCs include:

- Community health centers
- Migrant health centers
- Health care for the homeless health centers
- Public housing primary care centers
- Health center program “look-alikes”
- Outpatient health programs or facilities a tribe or tribal organization or an urban Indian organization operates

Gender: Conventionally, refers to the “social, psychological, and emotional traits, attitudes, norms and behaviors, often influenced by society’s expectations, that classify someone as man, woman, both, or neither.”[20] A term associated primarily with social and cultural differences that more broadly denotes a range of identities that do not correspond to established ideas of the cisgender male and female. Self-determination of gender identities has significant implications for health outcomes.

Gender Expression: “The way in which someone expresses their gender, either consciously or unconsciously. This can encompass everything that communicates our gender to others, including clothing, hairstyle, body language, manner of speaking, social interactions, and gender roles. Most people have some blend of masculine and feminine qualities that comprise their gender expression, and this expression can also vary depending on the social context. There is not always a direct translation between gender identity and gender expression. A person’s gender expression may or may not align with the way people attribute gender to that person.”[21]

Gender Identity: How people conceptualize themselves as gendered beings, including one's innate and personal experience of gender. This may or may not align with one's gender expression or biological sex.

Health Disparities: Refer to a higher burden of illness, injury, disability, or mortality experienced by one group relative to another. In some uses, including in *Healthy People 2020*, the term is explicitly linked to economic, social, or environmental disadvantage), but in many cases the term is used to refer to simple mathematical differences (and as such, has fallen out of use in contemporary health equity discourse).[22] Health "inequities," in contrast, are explicitly defined as health differences that are avoidable, unnecessary, unfair, and unjust.[25] As used in public health and medicine, the term health disparities often ignores the historical context, political processes, and unjust nature of some health outcomes, thereby preventing a structural analysis of root causes.

Health Equity: Defined by the WHO as "the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification. 'Health equity' or 'equity in health' implies that ideally everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential."[23]

Other valuable definitions include that of Paula Braveman: "Health equity is the principle underlying a commitment to reduce—and, ultimately, eliminate—disparities in health and in its determinants, including social determinants. Pursuing health equity means striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions…. Health equity means social justice in health (i.e., no one is denied the possibility to be healthy for belonging to a group that has historically been economically/socially disadvantaged)."[22] Another is from Camara Jones: "Health equity is assurance of the conditions for optimal health for all people. Achieving health equity requires valuing all individuals and populations equally recognizing and rectifying historical injustice, and providing resources according to need."[24]

Health equity, defined as optimal health for all, is a goal toward which our AMA and AAMC will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity[23]; influencing determinants of health; and voicing and modeling commitment to health equity.

Health Inequity: Differences in health outcomes that are systematic, avoidable, unnecessary, unfair, and unjust.[22,25]

Inclusion: Refers to how our defining identities are accepted in the circles that we navigate. Belonging evolves from inclusion; it refers to the extent to which individuals feel they can be authentic selves and can fully participate in all aspects of their lives.

Intersectionality: Leading feminist and social justice theories and practices acknowledge that intersectionality, first coined by Kimberlé Crenshaw, as legal terminology to recognize the unique experiences and legal challenges of Black women, whom as a group experienced both racism and sexism.[26] It is the ongoing examination of the overlapping systems of oppression and discrimination that communities face based on race, gender, ethnicity, ability, etc. It is our role to continuously examine the multiple forms and kinds of intersectional exclusions. The call for an anti-racist health care system—one which recognizes and addresses the intersectionality of systems of oppression—amplifies every day.

Justice: Describes a future state where the root causes (e.g., racism, sexism, class oppression) of inequity have been dismantled and barriers have been removed. It is an achievable goal that requires the sustained focus, investment, and energy of leaders and communities working together holding each other accountable to redesign our structures, policies, and practices to deliver the high-quality and safest possible conditions that allows for everyone to reach their highest potential.

Latinx: A relatively new term that to describe people who are of or relate to Latin American origin or descent. It is a gender-neutral and nonbinary alternative to Latina/Latino. While awareness and acceptance of Latinx is thought to be low, there is growing acceptance of the term Latinx in the US, due to its inclusivity. Of note, many Hispanic, Latina/Latino/Latinx members prefer to identify using other terms including national or ethnic origin (I.e., Argentinian, Mexican, Puerto Rican). Furthermore, other terms like Chicano or Chicana are used historically and politically to signal social justice and advocacy inclusion and people still identify with this term. Finally, the term Spanish is used regionally to identify descendants of Spain who also have other ethnic and national origins. Preferred terms vary regionally. Best practice is to consult the specific communities involved in discussion to ask their preference.

LGBTQ: An acronym for “lesbian, gay, bisexual, transgender and queer.” Other forms of the term include LGBTQIA “lesbian, gay, transgender, queer or questioning, intersex, and asexual”, LGBTQ+ to recognize the growing understanding of sex and gender and to include allies, and LGBTQQIP2SAA, for “lesbian, gay, bisexual, transgender, questioning, queer, intersex, pansexual, two-spirit (2S), androgynous and asexual.” It is a developing term, shifting regularly.

Marginalization: Process experienced by those under- or unemployed or in poverty, unable to participate economically or socially in society, including the labor market, who thereby suffer material as well as social deprivation.

Medically Underserved: Medically Underserved Areas/Populations are areas or populations designated by HRSA as having too few primary care providers, high infant mortality, high poverty or a high elderly population. Health Professional Shortage Areas (HPSAs) are designated by HRSA as having shortages of primary medical care, dental or mental health providers and may be geographic (a county or service area), population (e.g., low income or Medicaid eligible) or facilities (e.g., federally qualified health center or other state or federal prisons).[27]

Minority: Term to define the status of a population by what they are not and the lack of some characteristic held by those in the dominant category. Defining people of color as “minorities” is not recommended because of changing demographics and the ways in which it reinforces ideas of inferiority and marginalization of a group of people.[28]

People of Color: Term used mostly, but not exclusively, in the U.S. to describe people not considered “white”. The term emphasizes shared experiences of structural racism and opposes reference to people as “non-white” or “minority.” In recent years, the related term BIPOC (Black, Indigenous, and People of Color) has also been used. Not to be confused with the pejorative “colored people”. Per Race Forward: “While “people of color” can be a politically useful term, and describes people with their own attributes (as opposed to what they are not, e.g.: “non-White”), it is also important whenever possible to identify people through their own racial/ethnic group, as each has its own distinct experience and meaning and may be more appropriate.” [28]

Population Health: The health outcomes of a group of individuals, including the distribution of such outcomes within the group. The field of population health includes health outcomes, patterns of health determinants, and policies and interventions that link them.[29,30]

Prevention / Preventive Medicine: Traditionally, in public health, measures to prevent the occurrence of disease and illness that are focused on changing individual (risky) behavior through health promotion policies or marketing activities, primarily associated with making choices. Also refers to broad types of regulation (of environments, housing, medications, support for vaccinations) to ensure the public is adequately protected. Although prophylactic in nature, these forms of prevention do not attempt to end the generation of inequities in the distribution of disease and illness by focusing on the structures of power that create economic and social conditions. Those conditions are generally not under control of the individual. Similarly, preventive medicine involves medical practices designed to avert and avoid disease, disability, and death. For example, screening for hypertension and treating it before it causes disease. It emphasizes a proactive approach to patient care and focuses on the health of individuals and communities. Problems arise, however, with relying on either approach for eliminating health inequities.

Race: System of categorizing people that arises to differentiate groups of people in hierarchies to advantage some and disadvantage others. Stated another way, race is a social construct or “a symbolic category (actively created and recreated…rather than pre-given), based on phenotype or ancestry and constructed to specific racial and historical contexts, that is misrecognized as a natural category.”[31] While often assumed to be a biological classification, based on physical and genetic variation, racial categories do not have a scientific basis.[28] Camara Jones explains: “the variable race is only a rough proxy for socioeconomic status, culture, and genes, but it precisely captures the social classification of people in a race-conscious society such as the United States. The race noted on a health form is the same race noted by a sales clerk, a police officer, or a judge, and this racial classification has a profound impact on daily life experience in this country. That is, the variable ‘race’ is not a biological construct that reflects innate differences, but a social construct that precisely captures the impacts of racism.”[32] Race is a concept forged by oppressive systems of race relations, justified by ideology, in which one group benefits from dominating other groups, and defines itself and others through this domination and the possession of selective and arbitrary physical characteristics (for example, skin color).[33] Race, more perniciously, is a political construction created to concentrate power with white people and legitimize dominance over non-white people.[34,35]

Racism: As defined by Camara Jones, “racism is a system of structuring opportunity and assigning value based on phenotype (“race”), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and undermines realization of the full potential of the whole society through the waste of human resources”[36] Racism can operate at different levels: structural, institutional, interpersonal, and internalized.

> ***Structural:*** As defined by Zinzi Bailey et al, structural racism “refers to the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources.”[37] Structural racism results in systemic variation in opportunity according to race or ethnic background – including differentials in access to health care based on race.[37-39] It is a deep-seated and core form of social injustice and oppression seen across society, perpetuating cumulative advantage for whites throughout life.
>
> ***Institutional:*** Discriminatory treatment, unfair policies and practices, and inequitable opportunities and impacts within organizations and institutions, based on race. Individuals within institutions take on the power of the institution when they act in ways that advantage and disadvantage people, based on race.

Interpersonal: The expression of racism between individuals. These are interactions occurring between individuals that often take place in the form of harassing, racial slurs, or racial jokes. It may also take more subtle forms of unequal treatment, including micro-aggressions.

Internalized: Acceptance by members of stigmatized races of negative messages about their own abilities and intrinsic worth.[32]

Sexual Orientation: An inherent or immutable enduring emotional, romantic or sexual attraction to other people. Note: an individual's sexual orientation is independent of their gender identity.

Social Determinants of Health: Refer to the underlying community-wide social, economic and physical conditions in which people are born, grow, live, work and age.

Social Determinants of Health Inequities: Refer to the connection between social determinants of health (SDoH) *and* place-specific levels of health inequities. This acknowledges that while underlying community-wide social, economic and physical conditions in which people are born, grow, live, work and age affect individual level health they also influence patterns of health inequities within and between communities.[40] A focus on health equity calls for addressing the determinants of health (social and medical) that put particular social groups at a disadvantage for good health outcomes socioeconomic, political and cultural context; daily living conditions; and individual health-related factors. These determinants and their unequal distribution according to social position, result in differences in health status between population groups that are avoidable and unfair.

Social Justice: The state of social, economic and political equality and realizing "the institutional conditions necessary for the development and exercise of individual capacities and collective communication and cooperation."[41] It is a standard concerned primarily with outcomes not process. The structure of power relations in a society determines the opportunities to achieve social justice.

Social Needs: The individual-level material resources and psychosocial circumstances required for wellbeing of one's physical and mental health. These also include social risk factors, or specific adverse social conditions that are associated with poor health, including social isolation, food insecurity, or housing instability.[42]

Vulnerable Population: Term often used to describe groups that have increased susceptibility to adverse health outcomes as a result of either inequitable access to resources or poor living conditions. It unnecessarily stigmatizes these groups are *made* vulnerable due to various forms of oppression.

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