Profound disparities in COVID-19 infection and mortality and acts of violence against racial and ethnic minority groups have galvanized many academic medical centers and health systems to bolster efforts surrounding diversity, inclusion, and health equity. New offices, committees, or positions have commonly been established to lead these efforts, often all falling under a single umbrella. But there is a pervasive conflation of the goal of workforce diversity, inclusion, and equity with the goal of equity in patient care and the health of surrounding communities. Disentangling this conflation could facilitate adoption of more effective approaches, incorporating the appropriate and distinct expertise, infrastructure, and leaders needed to tackle unique institutional and societal problems.

Workforce diversity efforts in academic medicine have focused primarily on structural diversity (such as representation of socially marginalized groups among learners, faculty, and leaders), psychological climate (such as reported experiences of discrimination), or behavioral dimensions (such as mentorship). The emergence of diversity and inclusion offices in academic health centers builds upon the tradition of multicultural or minority affairs offices in higher education, which first appeared in the late 1960s and early 1970s in the setting of increasing numbers of students from racial and ethnic minority groups entering predominantly White institutions. Black students, in particular, demanded environments supportive of their educational experience. Similarly, the Association of American Medical Colleges has led this charge since 2009 in its inception of the Group on Diversity and Inclusion, which provides guidance and direction to medical schools and teaching hospitals.

Medical education accreditation standards require academic health centers to implement strategies addressing the multiple dimensions of diversity, including compositional, curricular, and institutional climate. Thus, many centers have developed executive positions to direct and manage their diversity agendas. These individuals are often the face of diversity efforts, yet have varying administrative titles, academic ranks, backgrounds, reporting relationships, budgets, staff, and proportion of time allocated to these roles. Such diversity officers engage in a range of affinity group or issue-oriented efforts, with many focused upon individuals underrepresented in medicine. Some oversee efforts for the entire school, whereas others work within departments or clinical divisions.

The field of health disparities research, which is distinct from workforce diversity and inclusion efforts, has evolved over the past 30 years. It initially focused on descriptive studies of disparities in disease burden and quality of health care, but now includes intervention trials targeting multiple levels, ranging from patient biological and behavioral factors and family and social network characteristics to organizational factors, community characteristics, and policy-level factors.

Over time, researchers have highlighted the importance of using a health equity lens to create a broader vision of social justice, in which disparities are tracked to measure progress toward achieving better health for all, with greater improvements in the health of our society’s least advantaged groups. Health equity experts have also called for asset models of community engagement, an approach that “values the capacity, skills, knowledge, connections, and potential in a community,” as opposed to a deficit model, which focuses on “needs, problems, and deficiencies.” Asset-based models build a community’s capacity to meet its own needs and its capacity to advocate for and leverage resources.

Most scholarly work on health equity has occurred within research units at academic medical centers. Over the past decade, many centers have also established offices focused on health equity.
that are connected to offices on workforce diversity, or to offices on population health or quality and safety that focus on improving care for the health systems' patients. Although these medical centers may track patient data as part of their health system's initiatives, most do not target the broader population surrounding their institution. Their initiatives might even target support of minority or female-owned businesses for contracts with the health system, or enhanced outreach to racially and ethnically diverse patient populations. Some programs aim to enhance the delivery of culturally sensitive, contextually appropriate, and unbiased patient care. However, health system interventions rarely target reduction of disparities in health care quality or outcome metrics for patients from socially at-risk groups, and infrequently engage in efforts that extend beyond the institution to improve population health within the institution's geographic area.

Limited collaboration between researchers and operations groups also means that health equity programs based in offices of diversity and inclusion may not use the latest evidence-based interventions, community engagement strategies, or metrics. Without such collaboration, they may fail to demonstrate effects on outcomes such as community trust, access to care, population health, or health disparities.

Many faculty who conduct health equity research are also involved in educational programs to train practitioners in how to deliver care in an equitable manner to vulnerable populations. On occasion, faculty are asked to inform or support health system efforts to address disparities in care and population health. However, few academic institutions provide financial support or professional recognition to faculty engaged in such efforts. Although the potential benefits of partnerships between academic and health system operations programs in health equity are enormous, best practices for these partnerships have not been clearly articulated and efforts remain siloed.

To distinguish efforts aimed at workforce diversity from those targeting equity in patient care delivery and health of surrounding communities, we recommend health systems take the following steps:

- Develop and disseminate clear and distinct institutional definitions of (1) workforce diversity, inclusion, and equity efforts and (2) efforts to advance health and health care equity and community or population health
- Highlight both efforts as core to the mission of the institution; recognize and reward excellence in both domains
- Clarify that leaders and programs within the institution are accountable for achieving both goals
- Appoint people with specific expertise, leadership skills, and demonstrated values and commitment to the work, not just identities that align with the target groups
- Equip both efforts with resources they uniquely require, including infrastructure for assessment and monitoring of progress and use of data to improve programs and services
- Provide capacity-building, consultative, and coordinating services for other units in the institution, and for the community
- Use rigorous evidence-based approaches for this work as in other aspects of the institution's mission.

Although workforce diversity and inclusion share some of the same solutions as health or health care equity, they are not the same thing. They require different sets of strategies—at the levels of federal and local policies, multisector and community-academic partnerships, institutional policies and practices, individual and social group attitudinal and behavioral change—and targeted interventions to address not only organizational but also broader social and environmental influences on health.

The COVID-19 pandemic and increased awareness of the harms of racism have brought with them a long overdue sense of urgency to address injustices in medicine and health. Clinicians and scholars working in this area are overtaxed, health disparities have worsened from their prepandemic levels, and societal trust in health care and science have been threatened. Academic medical centers and other health care organizations are actively seeking to enhance workforce diversity and equity in health care. For each of these challenges, they should take the time to engage...
appropriate stakeholders, listen respectfully, and develop strategies informed by evidence and best practices. Avoiding the conflation of health care workforce diversity and health equity efforts will bring needed attention and resources to both of these urgent societal imperatives.