
Equitable Health Toolkit

MARCH 2021



WASHINGTON CHAPTER
AMERICAN ACADEMY OF PEDIATRICS

*We will not be turned around
or interrupted by intimidation,
because we know our inaction and inertia
will be the inheritance of the next generation.
Our blunders become their burdens.
But one thing is certain,
If we merge mercy with might,
and might with right,
then love becomes our legacy,
and change our children's birthright.*

– from the poem “The Hill We Climb.” By Amanda Gorman, National Poet Laureate
Performed on Inauguration Day 2021, Washington, District of Columbia

In the Summer of 2020, our country faced a reckoning: one that has been fermenting since before Native lands were taken, and black and brown bodies were deemed three-fifths of a person. The context of this reckoning has come dressed in many clothes and decrees over the centuries, but in 2020, its voice came through loudly in the refrain “Say their names!” From this, decries of racism swelled, and our country took to the streets in protest.

Many companies and organizations released statements in support of BIPOC communities and in opposition to racism. The Washington Chapter of the AAP did the same. But we felt the need to take this one step further, i.e. to convene a group of our members, after a statewide inquiry, who would meet and create an instrument of instruction for ourselves and each other, for our colleagues and organizations, to meaningfully affirm and uplift under-resourced communities we serve. This convening has led to this product. We hope you will interact and engage with this toolkit that focuses and challenges the work we do as pediatric providers, transforming it through a lens of anti-racism and equity, diversity, and inclusion.

There are 4 major sections/chapters to this toolkit, each meant to ask ourselves and our spaces of clinical practice “what more can we do to support our families and communities in a manner that leads to equitable care for children and adolescents?” The sections are meant to engage learners and thinkers at all levels, providing information and resources, as well as tangible practical tools that one can use to start to impact change today, tomorrow, and in strategic planning meetings for the next 3 years. The members of this toolkit felt that it was important to speak not only to the moment, but also transform the era of pediatric and adolescent medicine to come. We hope the content presented in the upcoming chapters of this toolkit inspires you to feel bold in having uncomfortable conversations safely (Provider Education), reimagine ways to develop your clinical space that affirms patients and families inclusively (Physical Space), expands the notion of our pattern recognition to clinch a diagnosis and develop a treatment plan (Safe and Effective Care), and advocate for systemic change within your organizational leadership in providing equitable care (Promoting Equity, Diversity, and Inclusion in Healthcare Organizations).

Finally, we hope that this toolkit is just the beginning of a journey for all of us as child health advocates. This toolkit is not meant to be a stagnant instruction manual without reiteration. The content presented in the coming pages is meant to continually engage the intersection of anti-racism and diversity, equity, and inclusion efforts – namely active, intentional, and ongoing work to reach our goals for a more perfect union.

Please join us.

Sincerely,

Peter Asante & Kathleen Kieran
Co-chairs & Co-editors

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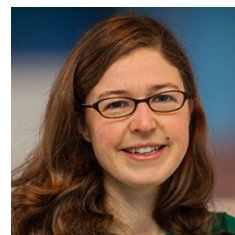
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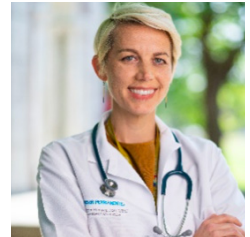
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Provider General Education

Racism affects the health of children and adolescents and the quality of healthcare they receive. It is imperative that pediatricians proactively understand implicit and explicit racism bias, actively dismantle structural racism, and create culturally competent medical practices so that we may better care for all children and families in Washington state. In order to work towards equity, we must first understand how racism affects mental, physical, and overall health of all children.

We must expand our vocabulary of relevant terms and concepts and examine our own biases. A willingness to have brave conversations, as well as ongoing self-reflection, is critical to advancing equity in our specialty. The comprehensive glossary of terms below can serve as a launching point to explore concepts and expand vocabulary on these issues. An extensive list of resources—including books, articles, podcasts, and videos—is also included to supplement each provider’s individual educational journey. Through maintaining an open mind, communicating, acting, supporting, and remaining dedicated to anti-racism, we will move closer to our goal of pediatric health equity.

1. EXAMPLE CASES

CASE 1:

A 5-year-old male comes to clinic for a follow up after two emergency department visits for respiratory distress. He presents to clinic accompanied by his mother, whose preferred language for medical communication is Spanish, and a Spanish language interpreter. After evaluation, he is diagnosed with asthma and the pediatric provider discusses the diagnosis and management plan with the mother. The pediatrician rushes out of the room as she is late for her next appointment, forgetting to hand the family a discharge handout about asthma that is routinely given for all new diagnoses. When the clinic nurse offers to print out the handout in Spanish for the family, the pediatric provider states, “Don’t worry about it, I talked about the diagnosis at length with them, and I think the mother has low literacy anyway.”

CASE 2:

A pediatric provider is seeing a 4-year-old girl for a routine well visit. The girl is accompanied to clinic by her father, who reports no concerns. After evaluation with a physical exam and a well-validated developmental screening tool, the provider has no concerns about her growth or development. As the visit is wrapping up, the father states that his daughter was recently expelled from her preschool due to “problem behavior” and asks for recommendations about other preschools in the area. The provider recalls that he has seen two other children recently who were also expelled from preschool for the behavior concerns. All three patients are children of color, and all of them are growing and developing as expected per their medical charts. The provider requests the father’s permission to speak with the preschool educators and gives the father contact information for the Washington Education Ombuds Office. What next steps should the provider consider?

CASE 3:

A Spanish-speaking father brought in his 8-year-old daughter for a complaint that was ongoing from a primary care appointment two weeks prior. The PCP prescribed a medication at that point, but when the family tried to pick it up at the pharmacy, they were told there was ‘a problem with the insurance’ and so they never got the medication. They were not clear why they could not get the medicine or what they needed to do. PCP had been on vacation since that appointment, so they were unable to follow up with questions.

Two weeks later, they presented to urgent care because symptoms were ongoing and worsening. This visit was conducted in Spanish. A new prescription was sent to the pharmacy on file. When the provider followed up with the pharmacist to ensure that family would be able to pick up medication this time, the provider was informed by pharmacist that this particular pharmacy did not accept Apple (Molina) health insurance, which is what the family had, and the prescription needed to be sent to a different pharmacy. The provider sent a new prescription to the other pharmacy and called the father on the phone to let him know why they had to travel to a different pharmacy, and assured the family that the child would finally receive the medication that she needed. The father was relieved and grateful for the troubleshooting and follow-up.

2. WHY?

2A. SURVEY FOR A LARGER GROUP OF PEDIATRICIANS

Ask yourself and your colleagues: Anonymous 5-point Likert scale survey of 5-10 questions

- Is inequitable care a problem in your clinic? In your community?
- Do you discuss racism with patients – White? Families of color?
- How important do you think it is to discuss racism with patients/families?
- How important is it for your organization to adopt culture of antiracism and equity?
- Would you like to be further educated on how to work toward anti-racism and equity?

2B. SUMMARY OF AAP POLICY STATEMENT ON “THE IMPACT OF RACISM ON CHILD AND ADOLESCENT HEALTH”

<https://pediatrics.aappublications.org/content/144/2/e20191765>

<https://www.healthychildren.org/English/news/Pages/AAP-Addresses-Impact-of-Racism-on-Children-and-Teens.aspx>

- “AAP calls on pediatric health providers to create welcoming, culturally competent medical practices, to advocate for policies that advance social justice, and to engage leaders in their communities to reduce health disparities.”
- Racism is a core social determinant of health that is a driver of health inequities.
- A growing body of research has found that racism harms children’s mental and physical health.
- Children and teens who are the targets of racism are impacted the most, but bystanders are also harmed.
- “Pediatric health providers must examine and acknowledge their own biases and embrace and advocate for innovative policies and cross-sector partnerships designed to improve medical, economic, environmental, housing, judicial, and educational equity for optimal child, adolescent, and emerging adult developmental outcomes.”

2C. UNDERSTANDING HEALTH DISPARITIES AND HEALTH INEQUITIES

Washington State data:

- <https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/data-tables/COVID-19MorbidityMortalityRaceEthnicityLanguageWASState.pdf>
- <https://www.doh.wa.gov/Emergencies/COVID19/DataDashboard>
- <https://kidscountwa.org/what-washingtons-kids-need-to-weather-the-challenges-of-the-covid-19-crisis-and-beyond/>

Recent Webinars:

- Addressing Racial Inequities in Our Own Community: Seattle Children's Hospital Grand Rounds on 11/12/2020 led by four Washington state pediatricians - Shaquita Bell, MD, FAAP, Anisa Ibrahim, MD, FAAP, Fabiola Movius, MD, MPH, FAAP and Christina Pease, MD, FAAP. URL: https://youtu.be/0X9cAFB4T_4
- Boyd, R., Johnson, T., Marbin, J., Trent, M. (2020, October 3). Peds 21: Fighting Racism to Advance Child Health Equity: A Call to Action. [Conference presentation]. 2020 AAP Virtual National Conference & Exhibition Pediatrics for the 21st Century.
- Anderson, A., Stevenson, H. (2020, October 4). Talking to Kids About Racism. [Conference presentation]. 2020 AAP Virtual National Conference & Exhibition Pediatrics for the 21st Century.

Articles:

- Goyal MK, Johnson T, Alpern RM, Casper TC, Funai T, Alessandrini E, Bajaj L, Grundmeier RW, Gerber JS, Lorch SA, Chamberlain JM, and PECARN. *Racial and Ethnic Differences in Antibiotic Use for Viral Illnesses in Emergency Departments*. Pediatrics. September 2018.
- Johnson TJ, Hickey RW, Switzer GE, Miller E, Winger DG, Nguyen M, Saladino RA, Hausmann LRM. *The Impact of Cognitive Stressors in the Emergency Department on Physician Implicit Racial Bias*. Academic Emergency Medicine. 2016 March;23(3):297-305.
- Dyrbye L, Herrin J, West CP, Wittlin NM, Dovidio JF, Hardeman R, Burke SE, Phelan S, Oyeador IN, Cunningham B, van Ryn M. *Association of Racial Bias With Burnout Among Resident Physicians*. JAMA Netw Open. 2019 Jul 3;2(7):e197457. doi: 10.1001/jamanetworkopen.2019.7457. PMID: 31348503
- Johnson TJ, Winger DG, Hickey RW, Switzer GE, Miller E, Nguyen MB, Saladino RA, Hausmann LR. *Comparison of Physician Racial Bias Towards Adults Versus Children*. Academic Pediatrics. 2017 March;17(2): 120-126.
- Maina I, Singh A, Ginzberg S, Belton T, Johnson TJ. *A Decade of Studying Implicit Racial/Ethnic Bias in Healthcare Providers using the Implicit Association Test*. Social Science & Medicine. 2017 May;17(1):303-9.
- Young K, Punnett A, Suleman S. *A Little Hurts a Lot: Exploring the Impact of Microaggressions in Pediatric Medical Education*. Pediatrics. 2020 Jul;146(1):e20201636.

- New York Times Article on Racism in Medicine
<https://www.nytimes.com/2020/06/17/health/many-medical-decision-tools-disadvantage-black-patients.html>

Online Learning:

- Molina Healthcare's Training for Healthcare Providers and Staff | Video modules
<https://www.molinahealthcare.com/providers/wa/medicaid/resource/cme.aspx>
 - Five modules (approx. 5-10 min each) available as YouTube videos discussing Cultural Competency, Health Disparities, Specific Population Focus – Seniors and Persons with Disabilities, LGBTQIA+ and Immigrants/Refugees
- HHS Office of Minority Health's A Physician's Practical Guide to Culturally Competent Care
<https://cccm.thinkculturalhealth.hhs.gov/>
 - E-learning program including Cases and Did You Know?

3. HOW?

HOW DO WE CENTER EQUITY IN PEDIATRIC CARE?

In the following section, we present four ways to begin the work of providing equitable care: 1) learning the vocabulary, 2) examining our biases, 3) having brave and vulnerable conversations, and 4) ongoing self-reflection.

3A. LEARNING THE VOCABULARY

“The difference between the almost right word and the right word is really a large matter— ’tis the difference between the lightning bug and the lightning.” - Mark Twain

Following is a glossary of terms that help frame understanding of and discuss issues of health equity. The glossary is by no means comprehensive, but we hope it gives you a place to start. We invite you to explore the references and resources in this section to deepen your understanding beyond the terminology.

*NOTE: terms with an * are in reference to source citation at the end of the glossary.*

Able-bodied: This term is 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.

Ableism: The individual, cultural, and institutional beliefs, practices, and policies that discriminate against and systematically oppress persons with disabilities. A system that places value on people’s bodies and minds based on societally constructed ideas of normalcy, intelligence, and excellence.

Accessibility: The quality of being possible to get into, use, make use of.

Afflicted with/stricken with/suffers from: These terms carry the assumption that a person with a disability is suffering or has a reduced quality of life. Not every person with a disability suffers, is a victim or is stricken. It is preferable to use neutral language when describing a person who has a disability, simply stating the facts about the nature of the disability. For example: “He has muscular dystrophy.” **Agender:** Describes a person who identifies as having no gender.

AI/AN:* American Indian/Alaska Native.

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.

API:* Asian and Pacific Islander. Asian ethnicities include Chinese, Asian Indian, Filipinx, Vietnamese, Korean, Japanese, Laotian, Pakistani, Cambodian, Hmong, and Thai. Pacific Islanders include Native Hawaiian, Samoan, Guamanian or Chamorro, Tongan, Fijian, and Marshallese. More recently, some institutions separate out the categorization API into “Asian Americans” and “Native Hawaiians and Other Pacific Islanders” (NHOPI) to better understand the difference in inequities between these subgroups.

Anti-racism: The work of actively opposing racism by advocating for changes in political, economic, and social life. Being anti-racist is to actively make choices in our daily lives to identify and end racial inequities. This contrasts with being “non-racist” (see below). Being anti-racist or non-racist is not a static identity but rather, it is a dynamic set of choices, behaviors, and practices that individuals consciously engage in.

Asexual: Describes a person who experiences little or no sexual attraction to others. Asexuality is not the same as celibacy.

Assigned sex at birth: The sex (male or female) assigned to a child at birth, most often based on the child’s external anatomy. Also referred to as birth sex, natal sex, biological sex, or sex.

Binding: The process of tightly wrapping one’s chest in order to minimize the appearance of having breasts. This is achieved through use of constrictive materials such as cloth strips, elastic or non-elastic bandages, or specially designed undergarments.

BIPOC: Black, Indigenous, and People of Color.

Bisexual: A sexual orientation that describes a person who is emotionally and sexually attracted to people of their own gender and people of other genders.

Black lives matter: A political movement to address systemic and state violence against African Americans; “a Black-centered political will and movement building project called #BlackLivesMatter... in response to the acquittal of Trayvon Martin’s murderer, George Zimmerman. An ideological and political intervention in a world where Black lives are systemically and intentionally targeted for demise. It is an affirmation of Black folks’ humanity, our contributions to this society, and our resilience in the face of deadly oppression.”

Bottom surgery: Colloquial way of describing gender-affirming genital surgery.

Chicano/a: Someone who is native to, or descends from, Mexico and lives in the United States.

Cisgender: A person whose gender identity and assigned sex at birth correspond (i.e., a person who is not transgender).

Classism: The institutional, cultural, and individual set of beliefs and discrimination that assigns differential value to people according to their socio-economic class; and an economic system which creates excessive inequality and causes basic human needs to go unmet.

Colorblindness: The belief that we don't see color or race, that we see people and that we are all the same. The belief that group membership should not be taken into account or noticed as a strategy for managing diversity and intergroup relations. It allows the dominant group to deny ongoing discrimination and oppression that stigmatized racial groups in the United States experience.

Cripple/crip: Merriam-Webster defines the noun "cripple" as "a lame or partly disabled person or animal" and as "something flawed or imperfect." It is also used as a verb. The word dates to Old English, where it was related to words that meant to creep or bend over. The term became offensive in the early 20th century and was replaced by "handicapped" and then by "disabled." Recently, some disability activists have reclaimed the word, but not all disability activists agree with this. Ask the person how they would like to be described; otherwise, avoid using "cripple" as either a noun or verb.

Cultural appropriation: Theft of cultural elements for one's own use, commodification, or profit, including symbols, art, language, customs, etc., often without understanding, acknowledgement, or respect for its value in the original culture.

Differently-abled: This term came into use as an alternative to "disabled," "handicapped" or "mentally retarded." Currently, it is not considered appropriate (and for many, never was). Some consider it condescending, offensive or simply a way of avoiding talking about disability. "Person with a disability" is a more neutral term than "differently-abled."

Disability: An umbrella term for impairments, activity limitations and participation restrictions referring to the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors).

Discrimination: The unequal treatment of members of various groups based on personal characteristics – including, but not limited to – race, gender, social class, sexual orientation, physical ability, preferred language, religion, and other categories that disadvantages members of that group.

Differences of sex development (DSD): Group of rare conditions where the reproductive organs and genitals do not develop as expected. Some DSDs include Klinefelter Syndrome and Androgen Sensitivity Syndrome. Some people prefer to use the term Intersex.

Diversity: Includes all the ways in which people differ, encompassing all characteristics that make one individual or group different from another, including but not limited to race, ethnicity, gender, age, national origin, religion, disability, sexual orientation, socioeconomic status, education, marital status, language, physical appearance, ideas, perspectives, and values.

Dominant narrative: A set of dominant cultural assumptions about what is good, normal, or appropriate that reflects white Western European world views and dismisses or demonizes other world views.

Ethnicity: Denotes groups that share a common identity-based ancestry, language, or culture. It is often based on religion, beliefs, and customs as well as memories of migration or colonization. Ethnicity is not biological, but like race, is a social construct.

Ethnocentrism: The tendency to perceive and interpret from the standpoint of one's own culture. In epidemiology and health sciences research, the tendency is reflected in the practice of using the white population as the norm or standard.

Gay: A sexual orientation that describes a person who is emotionally and sexually attracted to people of their own gender. It can be used regardless of gender identity but is more commonly used to describe men.

Gender-affirming hormone therapy: The administration of hormones for those who wish to match their physical secondary sex characteristics to their gender identity.

Gender affirming surgery (GAS): Surgeries used to modify one's body to be more congruent with one's gender identity.

Gender binary: The idea that there are only two genders, male and female, and that a person must strictly fit into one category or the other.

Gender dysphoria: Distress experienced by some individuals whose gender identity does not correspond with their assigned sex at birth. Manifests itself as clinically significant distress or impairment in social, occupational, or other important areas of functioning. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) includes gender dysphoria as a diagnosis.

Gender fluid: Describes a person whose gender identity is not fixed. A person who is gender fluid may always feel like a mix of the two traditional genders, but may feel more one gender some days, and another gender other days.

Gender identity: A person's internal sense of being a man/male, woman/female, both, neither, or another gender.

Genderqueer: Describes a person whose gender identity falls outside the traditional gender binary. Other terms for people whose gender identity falls outside the traditional gender binary include gender variant, gender expansive, etc.

Handicap/handicapped: The Oxford English dictionary defines a handicap as "a condition that restricts a person's ability to function physically, mentally or socially." The term has fallen out of favor in the disability community. Avoid using "handicap" and "handicapped" when describing a person. Instead, refer to the person's specific condition or use "person with a disability." The terms are still widely used and generally acceptable when citing laws, regulations, places, or things, such as "handicapped parking," although many prefer the term "accessible parking."

Health disparities: Differences between the health of one population and another in measures of who gets disease, who has disease, who dies from disease, and other adverse health conditions that exist among specific population groups in the United States.

Healthcare disparities: Differences among populations in access to or availability of facilities and services.

Health equity: The opportunity for everyone to attain their full health potential. No one is disadvantaged from achieving this potential because of their social position (e.g. class, socioeconomic status) or socially assigned circumstance (e.g. race, gender, ethnicity, religion, sexual orientation, geography, etc.).

Health inequities: Differences in health status and mortality rates across population groups that are systemic, avoidable, unfair, and unjust. These differences are rooted in social and economic injustice, and are attributable to social, economic, and environmental conditions in which people live, work, commune, and play.

Heteronormativity: The assumption that everyone is heterosexual, and that heterosexuality is superior to all other sexualities.

Hispanic: Someone who is native to, or descends from, a Spanish-speaking country.

Implicit bias: Learned stereotypes and prejudices that operate automatically and unconsciously when interacting with others. Also referred to as unconscious bias.

Inclusion: Authentically and actively bringing traditionally excluded individuals and/or groups into processes, activities, and decision/policy making in a way that shares power.

Indigeneity: Indigenous populations are composed of the existing descendants of the peoples who inhabited the present territory of a country wholly or partially at the time when persons of a different culture or ethnic origin arrived there from other parts of the world, overcame them by conquest, settlement, or other means, and reduced them to a non-dominant or colonial condition; who today live more in conformity with their particular social, economic, and cultural customs and traditions than with the institutions of the country of which they now form part, under a state structure which incorporates mainly national, social, and cultural characteristics of other segments of the population which are predominant.

Institutional racism: Discriminatory treatment, unfair policies and practices, and inequitable opportunities and impacts within organizations and institutions, based on race.

Internalized racism: The set of private beliefs, prejudices, and ideas that individuals have about the superiority of whites and the inferiority of People of Color. Among People of Color, it manifests as internalized racial oppression and acceptance of negative messages about their own abilities and intrinsic worth. Among whites, it manifests as internalized racial superiority.

Interpersonal racism: A form of racism that is experienced between members of the dominant social group and members of a stigmatized racial minority. They are interactions occurring between individuals that often take place in the form of harassing, racial slurs, or telling of racial jokes.

Intersectionality: The idea that identities are influenced and shaped by race, class, ethnicity, sexuality/sexual orientation, gender/gender identity, physical disability, national origin, etc., as well as by the interconnection of all of those characteristics.

Latino/a: Someone who is native to or descends from a Latin American country. This does not include those who were born in or descended from Spain. Not all Brazilians identify themselves as Latino/a, but some do. Thus, Hispanic refers more to linguistic heritage, while Latino/a/x refers more to cultural and colonial heritage. It is important to note that this term is also a relic of a shared colonial history and tends to homogenize a very diverse group of peoples and cultures.

Latinx: The gender-neutral term to refer to a Latino/a individual.

Lesbian: A sexual orientation that describes a woman who is emotionally and sexually attracted to other women.

LGBTQIA+: Lesbian, Gay, Bisexual, Transgender, Queer, Asexual and Allies – an acronym meant to encompass non-heterosexual identities that often experience greater health threats due to social and structural inequities.

Location of self (LOS): Self-generated disclosure of one's own social and self-perceived identities. Disclosure of LOS invites a conversation about how similar and different identities between persons and groups might inform perceptions, interpretations, experiences, and biases.

Men who have sex with men/Women who have sex with women (MSM/WSW): Categories that are often used in research and public health settings to collectively describe those who engage in same-sex sexual behavior, regardless of their sexual orientation. However, people rarely use the terms MSM or WSW to describe themselves.

Microaggressions: Everyday verbal and nonverbal subtle but offensive comments or actions, whether intentional or unintentional, which communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership.

Minority stress: Chronic stress faced by members of stigmatized minority groups. Minority stress is caused by external objective events and conditions, expectations of such events, the internalization of societal attitudes, and/or concealment of one's sexual orientation messages to target persons based solely upon their marginalized group membership.

Neurodiversity: The range of differences in individual brain function and behavioral traits, regarded as part of the normal variation in the human population (used especially in the context of autism spectrum disorders). "The idea that there is one 'normal' or 'healthy' type of brain or mind, or one 'right' style of neurocognitive functioning, is a culturally constructed fiction, no more valid...than the idea that there is one 'normal' or 'right' ethnicity, gender or culture." [Walker, Loud Hands: Autistic People Speaking]

NHOPI: Native Hawaiians and Other Pacific Islanders.

Non-racist: Someone who defends policies and customs that create racial inequity, but when challenged, will say, "I'm not racist." In contrast, anti-racism is an active process of recognizing, challenging and eliminating systemic racism and inequity by changing systems, institutional structures, policies, and practices.

Pangender: Describes a person whose gender identity is comprised of many genders.

Pansexual: A sexual orientation that describes a person who is emotionally and sexually attracted to people regardless of gender.

People-first language: People-first language avoids defining a person in term of his or her disability. In most cases, this entails placing the reference to the disability after a reference to a person, as in "a person with a disability," or "a person living with a disability," rather than "the disabled person."

People of Color: Often the preferred collective term for referring to non-White racial groups. Racial justice advocates have been using the term "People of Color" (not to be confused with the pejorative "colored people") since the late 1970s as an inclusive and unifying frame across different racial groups that are not White, to address racial inequities. 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.

Polyamorous: Describes a person who has or is open to having more than one romantic or sexual relationship at a time, with the knowledge and consent of all their partners. Sometimes abbreviated as poly.

Power: Power is unequally distributed globally and in U.S. society; some individuals or groups wield greater power than others, thereby allowing them greater access and control over resources. Wealth, whiteness, citizenship, patriarchy, heterosexism, and education are a few key social mechanisms through which power operates. Although power is often conceptualized as power over other individuals or groups, other variations are

power with (used in the context of building collective strength) and power within (which references an individual's internal strength). Learning to “see” and understand relations of power is vital to working towards more equitable healthcare systems.

Prejudice: A preconceived judgment or assumption without just grounds or before sufficient knowledge about the abilities, motives, and intentions of others according to their race, ethnicity, socioeconomic status, gender, or culture.

Privilege: Advantages and immunities enjoyed by one (usually powerful) group or class, especially to the disadvantage of other groups.

QPOC: An acronym that stands for Queer Person of Color or Queer People of Color.

Queer: An umbrella term used by some to describe people who think of their sexual orientation or gender identity as outside of societal norms. Some people view the term queer as more fluid and inclusive than traditional categories for sexual orientation and gender identity. Due to its history as a derogatory term, the term queer is not embraced or used by all members of the LGBTQIA+ community.

Questioning: Describes an individual who is unsure about or is exploring their own sexual orientation and/or gender identity.

Race: A socially constructed way of grouping people, based on skin color and other apparent physical differences, which has no genetic or scientific basis. This social construct was created and used to justify social and economic oppression of People of Color by whites.

Racial justice: Proactive reinforcement of policies, practices, attitudes, and actions that produce equitable power, access, opportunities, treatment, impacts, and outcomes for all.

Racism: A system of advantage and oppression based on race. Inherent to racism is the understanding that a power differential exists between two or more groups, and that racism involves the differential treatment of a less-empowered group on the basis of race. Racism is different from racial prejudice, hatred, or discrimination in that it is also systemic. Racism involves one group having the power to carry out systematic discrimination through the institutional policies and practices of the society and by shaping the cultural beliefs and values that support those racist policies and practices.

Same gender loving (SGL): A term used as an alternative to the terms gay and lesbian. SGL is more commonly but not exclusively used by members of the African American/Black community.

Sexism: The individual, cultural, and institutional beliefs and discrimination that systematically oppress women.

Sexual orientation: How a person characterizes their emotional and sexual attraction to others.

Stereotype: A standardized mental picture that is held in common about members of a group that represents an oversimplified opinion, attitude, or unexamined judgment, without regard to individual difference.

Structural racism: Racial bias across institutions and society over time. It is the cumulative and compounded effects of an array of factors such as public policies, institutional practices, cultural representations, and other norms that work synergistically to perpetuate racial inequity.

Top surgery: Colloquial way of describing gender-affirming surgery on the chest.

Trans man/transgender man/female-to-male (FTM): A transgender person whose gender identity is male may use these terms to describe themselves. Some will just use the term “man.”

Trans woman/transgender woman/male-to-female (MTF): A transgender person whose gender identity is female may use these terms to describe themselves. Some will just use the term “woman.”

Transfeminine: Describes people who were assigned male at birth but identify with femininity to a greater extent than with masculinity.

Transgender: Describes a person whose gender identity and assigned sex at birth do not correspond. Also used as an umbrella term to include gender identities outside of male and female. Sometimes abbreviated as trans.

Transition: For transgender people, this refers to the process of coming to recognize, accept, and express one’s gender identity. Most often, this refers to the period when a person makes social, legal, and/or medical changes, such as changing their clothing, name, sex designation, and using medical interventions. Sometimes referred to as gender affirmation process.

Transmasculine: Describes people who were assigned female at birth but identify with masculinity to a greater extent than with femininity.

Transphobia: The fear of, discrimination against, or hatred of transgender or gender non-conforming people or those who are perceived as such.

Transsexual: Sometimes used in medical literature or by some transgender people to describe those who have transitioned through medical interventions.

Tucking: The process of hiding one’s penis and testes with tape, tight shorts, or specially designed undergarments.

Two Spirit: A contemporary term that connects today’s experiences of LGBTQIA+ Native American and American Indian people with the traditions from their cultures. The term incorporates sexual identity and sexual preference. “A Two Spirit person is a male-bodied or female-bodied person with a masculine or feminine essence. Two Spirits can cross social gender roles, gender expression, and sexual orientation. Within most tribes there is a term, in their language, to describe a Two Spirit person” [Terra Matthews-Hartwell, NativeOut].

White fragility: Discomfort and defensiveness on the part of a white person when confronted by information about racial inequality and injustice.

Whiteness: Whiteness refers to the specific dimensions of racism that serve to elevate white people over people of color. Whites are theorized as actively shaped, affected, defined, and elevated through their racialization and the individual and collective consciousness’ formed with it. Whiteness is thus conceptualized as a constellation of processes and practices rather than as a discrete entity (i.e. skin color alone). Whiteness is dynamic, relational, and operating at all times and on myriad levels. These processes and practices include basic rights, values, beliefs, perspectives, and experiences purported to be commonly shared by all, but which are actually only consistently afforded to white people.

White privilege: Unquestioned and unearned set of advantages, entitlements, benefits, choices, and immunities bestowed on people in society solely because they are white.

A NOTE ON THE CENSUS DEFINITIONS OF RACE*

- The US Census Bureau offers following options for describing race: White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander. Ethnicity is categorized by the US Census as either “Hispanic or Latino” or “Not Hispanic or Latino.” Individuals defined by the census as “Hispanic or Latino” include a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.
- Per the <http://Census.gov> website, “The racial categories included in the census questionnaire generally reflect a social definition of race recognized in this country and not an attempt to define race biologically, anthropologically, or genetically.”
- These terms are not all-inclusive; one example is the lack of a category that encompasses peoples of North African or Middle Eastern descent. Furthermore, the clustering of disparate groups under one category often hides characteristics of and disparities experienced by individual groups.

A NOTE ON TRANSGENDER TERMS

Experts in the field of LGBTQIA+ Education and LGBTQIA+ Health recommend replacing the following outdated terms with the suggested terms below:

Outdated, sometimes offensive terms:	Replace with...
Berdache	Two Spirit
Hermaphrodite	Intersex/differences of sexual development
Homosexual	Gay or lesbian
Sexual preference	Sexual orientation
Transgendered/ A transgender/ Tranny	Transgender
Sex change	Gender affirmation surgery

A NOTE ON DISABILITY TERMS

There are two different schools of thought on disability terminology: person-first language and identity-first language. Proponents of person-first language suggest putting the person before the disability, in recognition that an individual is not limited to their disability. On the other hand, proponents of identity-first language feel that disability identifiers help individuals celebrate or own their disability, instead of distancing themselves from it. An example of person-first language is “a child with autism” whereas identity-first language would be “an autistic child.” In both schools of thought, people agree that words suggesting a person is victim of their disability should be avoided. If unsure, you should ask the patient or their family how they like to be described.

Outdated, sometimes offensive terms:	Replace with...
Abnormal/Differently-abled	Person with a disability
Crip/cripple/Physically challenged	Person with a physical or mobility disability or physically disabled person
Emotionally disturbed	Person with a mental health disability or mentally disabled person
Mentally retarded	Person with an intellectual or cognitive disability or intellectually disabled person
Wheelchair bound/ Confined to a wheelchair	Person who uses a wheelchair, wheelchair-user
Normal	Person without a disability or non-disabled

*Sources

The Impact of Racism on Child and Adolescent Health:

Trent M, Dooley DG, Dougé J, AAP Section on Adolescent Health, AAP Council on Community Pediatrics, AAP Committee on Adolescence. The Impact of Racism on Child and Adolescent Health. Pediatrics. 2019;144(2):e20191765

American Psychological Association. Choosing Words for Talking About Disability:

“AAP Home Page <http://www.abfp.com/aafp>.” PsycEXTRA Dataset, 1997, doi:10.1037/e307212004-021. <https://www.apa.org/pi/disability/resources/choosing-words>

Glossary of terms relating to ethnicity and race: for reflection and debate

Bhopal, R. (2004). Glossary of terms relating to ethnicity and race: for reflection and debate. Journal of Epidemiology & Community Health, 58(6), 441-445. <https://jech.bmj.com/content/58/6/441>

GLAAD Reference Guide:

"GLAAD Media Reference Guide - Lesbian / Gay / Bisexual Glossary Of Terms." GLAAD, 26 Oct. 2016, www.glaad.org/reference/lgbtq

Location of Self:

Watts-Jones TD. Location of self: opening the door to dialogue on intersectionality in the therapy process. *Fam Process*. 2010 Sep;49(3):405-20. doi: 10.1111/j.1545-5300.2010.01330.x. <https://pubmed.ncbi.nlm.nih.gov/20831768/>

LGBTQ2S Advocacy, and Nativeout:

Matthews-Hartwell, Terra, et al. "Creating a National Native Telebehavioral Health Network: The IHS Telebehavioral Health Center of Excellence." *Partnerships for Mental Health*, 2015, pp. 77–88., doi:10.1007/978-3-319-18884-3_6. https://www.ihs.gov/sites/telebehavioral/themes/responsive2017/display_objects/documents/slides/lgbt/lgbtnativeout.pdf

National Center on Disability and Journalism. Disability Language Style Guide:

"National Center on Disability and Journalism." <https://ncdj.org/style-guide/>

National Conference for Community and Justice:

"Ableism." NCCJ, <https://www.nccj.org/ableism>

National LGBT Health Education Center, Glossary of Terms:

"[Http://ljournal.ru/Wp-Content/Uploads/2017/03/a-2017-023.Pdf](http://ljournal.ru/Wp-Content/Uploads/2017/03/a-2017-023.Pdf)." Glossary of LGBT Terms for Health Care Teams, 2017, doi:10.18411/a-2017-023. https://www.lgbtqihealtheducation.org/wp-content/uploads/LGBT-Glossary_March2016.pdf

National Youth Leadership Network. Respectful Disability Language: Here's What's Up!:

"[Http://jillesite.org/Sayilar/7/7.Pdf](http://jillesite.org/Sayilar/7/7.Pdf)." *Journal of Language and Literature Education*, vol. 2, no. 7, 2013, doi:10.12973/jlle.11.207. https://www.aucd.org/docs/add/sa_summits/Language%20Doc.pdf

Racial Equity Tools, Glossary of Terms:

"Racial Equity Tools." Definitions, 2019, doi:10.32388/882199. <https://drive.google.com/file/d/1-h0EWxqHAZUfheFvuFRtVpEz5ODSxul6/view>

Seattle Children's Health Equity Rounds. Glossary of Terms:

Seattle Children's Health Equity Rounds Team. *Seattle Health Equity Rounds Glossary*, 2010, pp. 139–205., doi:10.1007/978-1-4302-2666-6_4. https://docs.google.com/document/d/1-02HX3PIZEiY30-kFwo3cWup_qO7SUMxX-t7GJRmCF8/edit

World Health Organization. World report on disability 2011. World Health Organization, 2011.

Seelman, Katherine D. "The World Health Organization/World Bank's First World Report on Disability." *International Journal of Telerehabilitation*, vol. 3, no. 2, 2011, pp. 11–14., doi:10.5195/ijt.2011.6076. https://www.who.int/disabilities/world_report/2011/report.pdf

INTERACTIVE ACTIVITIES

- *Racial Justice Dominoes*: An interactive activity created by the Western States Center to allow individuals to learn some of the above equity terms in a group setting using a few simple materials. The activity takes approximately 40 minutes. It is a great way to build shared language and analysis around equity issues in your practice setting.
URL: <https://www.resource-sharingproject.org/racial-justice-dominoes>
- *The Gender Unicorn*: An interactive graphic created by the Trans Student Educational Resources (TSER) organization that allows you to explore different dimensions of gender identity, gender expression, biological sex, and sexual orientation.
URL: <https://transstudent.org/gender/>
- *Experience Firsthand*: Various interactive activities that give a sense of what it feels like to be a child with a learning disability, developed by PBS. Accompanies the Misunderstood Minds documentary.
URL: <https://www.pbs.org/wgbh/misunderstoodminds/intro.html>

3B. EXAMINING OUR BIASES

“Not everything that is faced can be changed, but nothing can be changed until it is faced.” - James Baldwin

- *Implicit Bias: Peanut Butter, Jelly and Racism*: A 2-minute clip by the program POV on PBS that provides an overview of the implicit bias.
URL: <https://www.pbs.org/video/pov-implicit-bias-peanut-butter-jelly-and-racism/>
- *Addressing Implicit Bias, Racial Anxiety, and Stereotype Threat*: Implicit bias toolkit created by the King County Office of Equity and Social Justice. Includes a facilitator and participant guide to be used for small group discussions about implicit bias and having effective conversations about equity issues.
URL (Facilitator Guide): https://www.kingcounty.gov/~media/elected/executive/equity-social-justice/2015/AddressImplicitBias-FacilGuide_KC-ESJ_Jan15.ashx?la=en
URL (Participant Guide): https://www.kingcounty.gov/~media/elected/executive/equity-social-justice/2015/AddressImplicitBias-ParticipantGuide_KC-ESJ_Jan15.ashx?la=en
- *Implicit Association Tests (IAT)*: These measures were developed by psychologists at Harvard University, University of Virginia, and University of Washington. They measure unconscious, or automatic, biases that all of us hold along various dimensions of race, gender, disability, sexuality, and others. While initially used for research, the IATs are increasingly used by many individuals and organizations as a jumpstart to start recognizing and thinking about our unconscious biases.
URL: <https://implicit.harvard.edu/implicit/>
- *What Is Bias? And What Can Medical Professionals Do to Address It?*: A 5-minute video by the Institute for Healthcare Improvement that provides an overview of explicit and implicit bias and strategies to address biases.
URL: https://www.youtube.com/watch?v=E_qERP-Y0Jw&feature=emb_logo

- *Strategies to Reduce Implicit Bias*: A short article by the Institute for Healthcare Improvement on specific strategies to use to counter implicit biases. These include stereotype replacement, counter-stereotypic imaging, individuation, and perspective-taking among others. These strategies can be consciously implemented at an individual and at an organizational level. URL: <http://www.ihl.org/communities/blogs/how-to-reduce-implicit-bias>

3C. HAVING BRAVE AND VULNERABLE CONVERSATIONS

“When we speak, we are afraid our words will not be heard or welcomed. But when we are silent, we are still afraid. So it is better to speak.” - Audre Lorde

- *Identifying and Addressing Microaggressions*: Dr. Roberto Montenegro, child and adolescent psychiatrist at Seattle Children’s Hospital, discusses microaggressions, microtrauma, and strategies for addressing them in medical settings, using the D.E.A.R (“Describe, Express, Assert, Reinforce”) technique.
URL (article): <https://ascopost.com/issues/january-25-2017/addressing-discrimination-and-bias-in-medical-education/>
URL (radio interview): <https://kuow.org/stories/yes-i-m-taking-care-you-right-now-it-s-exhausting-how-microaggressions-affect-health>
- *Implicit Bias Module Series*: Modules reviewing the underpinnings of implicit associations, how to uncover your own biases and strategies for addressing implicit biases. Developed by the Kirwan Institute for the Study of Race and Ethnicity at Ohio State University.
URL: <http://kirwaninstitute.osu.edu/implicit-bias-training>
- *Being an Active Bystander*: A 2-page document that provides strategies on how to challenge everyday explicit and implicit biases in interpersonal interactions. Strategies include using humor, asking questions, inviting discussion, and using direct communication among others and provides some examples on how to carry these out.
URL: <http://kirwaninstitute.osu.edu/wp-content/uploads/2018/07/Being-an-Active-Bystander-2017.pdf>
- *Bystander Intervention 101*: An adaptable group training that focuses on ways to intervene in public instances on racist, anti-Black, anti-Muslim, anti-Trans, and other forms of oppressive interpersonal interaction. The training provides scenarios to practice through discussions or role-plays. Developed by the People’s Response Team in Chicago, that focuses on supporting families impacted by police brutality.
URL: https://www.afsc.org/sites/default/files/documents/bystander_intervention_final.pdf

3D. ONGOING SELF-REFLECTION

“Knowledge emerges only through invention and re-invention, through the restless, impatient, continuing, hopeful inquiry human beings pursue in the world, with the world, and with each other.” - Paulo Freire

Articles

- *Implicit Bias in Pediatric Academic Medicine*
Johnson, Tiffani J., et al. “Implicit Bias in Pediatric Academic Medicine.” *Journal of the National Medical Association*, vol. 109, no. 3, 2017, pp. 156–163., doi:10.1016/j.jnma.2017.03.003.

- *The Death of George Floyd: Bending the Arc of History Toward Justice for Generations of Children*
Dreyer, Benard P., et al. "The Death of George Floyd: Bending the Arc of History Toward Justice for Generations of Children." *Pediatrics*, vol. 146, no. 3, 2020, doi:10.1542/peds.2020-009639.

Books

- *So You Want to Talk About Race?* by Ijeoma Oluo
- *Me and White Supremacy* by Layla Saad
- *This Book is Anti-Racist* by Tiffany Jewell
- *Disability Visibility* by Alice Wong
- *On Intersectionality* by Kimberle Crenshaw

Children's Books

- *Meet Clarabelle Blue* by Adiba Nelson
- *The Day You Begin* by Jacqueline Woodson
- *When We Were Alone* by David Robertson
- *Benny Doesn't Like to Be Hugged* by Zetta Elliot
- *A Map into the World* by Kao Kalia Yang
- *My Papi has a Motorcycle* by Isabel Quintero
- *Sometimes People March* by Tessa Allen
- *We Are Grateful: Otsaliheliga* by Traci Sorell
- *When Aidan Became a Brother* by Kyle Lukoff

Websites

- "Talking About Race" by the National Museum of African American History & Culture
URL: <https://nmaahc.si.edu/learn/talking-about-race>
- *Racial Healing Handbook: Practical Activities to Help You Challenge Privilege, Confront Systemic Racism, and Engage in Collective Healing*
URL: https://nmaahc.si.edu/sites/default/files/downloads/resources/racialhealinghandbook_p87to94.pdf
- *Embrace Race: Tools, resources, and discussion spaces to nurture resilience in children of color and raise children who think critically about racial inequity.*
URL: <https://www.embracerace.org/>

Podcasts

- *The Praxis - Racism and Medicine:* Podcast hosted by a University of Washington scholar, Edwin Lindo, JD, on examining the effects of racism on health and collectively working toward health justice.
URL: <https://clime.washington.edu/teaching-resources/podcasts/the-praxis/>
- *Code Switch:* NPR podcast hosted by journalists of color discussing how race impacts our daily lives in various domains in different ways.
URL: <https://www.npr.org/sections/codeswitch/>
- *Momentum: A Race Forward* podcast about stories, strategies, and ways to move forward in the work for racial justice.
URL: <https://www.raceforward.org/media/podcast/momentum-race-forward-podcast>

- *Nice White Parents*: A New York Times 5-part podcast series on the relationship between white parents and the American public school system.
URL: <https://www.nytimes.com/2020/07/30/podcasts/nice-white-parents-serial.html>
- *School Colors*: A narrative podcast discussing how race, class, and power shape American cities and schools. This podcast preceded *Nice White Parents* and the podcast team consists predominantly of People of Color.
URL: <https://www.schoolcolorspodcast.com/the-team>

Videos

- *Addressing Racial Inequities in Our Own Community*: Seattle Children's Hospital Grand Rounds led by four Washington state pediatricians: Shaquita Bell, MD, FAAP, Anisa Ibrahim, MD, FAAP, Fabiola Movius, MD, MPH, FAAP, and Christina Pease, MD, FAAP.
URL: https://www.youtube.com/watch?v=0X9cAFB4T_4&feature=youtu.be
- *The Intersection of Race and Disability with ChrisTiana ObeySumner*.
URL: <https://www.youtube.com/watch?v=8m-zRjBGMvQ>
- *Let's Get to the Root of Racial Injustice*: A 20-minute TEDx talk by University of Washington scholar Megan Ming Francis.
URL: <https://tedxseattle.com/talks/lets-get-to-the-racial-injustice/>
- *5 Tips for Being an Ally with Franchesca Ramsey*.
URL: https://www.youtube.com/watch?v=_dg86g-QIM0&feature=youtu.be
- *Allegories on Race and Racism*: A 20-minute TEDx talk by Camara Jones, MD, MPH, PhD.
URL: <https://ed.ted.com/on/emYm0MBq>

PHYSICAL SPACE

HOW DO OUR CLINICAL SPACES OF PRACTICE AFFIRM THE LIVED EXPERIENCE OF THE PATIENTS WE SERVE?

The physical environment patients and families encounter when seeking care has a multifactorial impact on their experience. Not only is it relevant to the healing process and overall patient well-being but it also serves as an entry point for the patient-provider relationship, which is fundamental to patient outcomes. Health care facilities serve a diverse patient population with unique and variable needs. As a result, there is no one size fits all prescription for how to design a welcoming clinical physical environment for all. In fact, decisions with the intent to welcome one community might inadvertently impact another.²

In this section of the toolkit, we hope to guide providers and clinics through a process of exploring the question of clinical space design as it relates to your own community and physical space. The intent of this section is to promote conversation and change from a variety of levels: as simple as the imagery, labels, and handouts on clinic walls to overall assessment of clinic layout, design, and workflow. This section provides suggestions for how to start a collaborative process of clinical space design with specific ideas to consider in order to promote an inclusive, welcoming environment.

Key Words: Inclusive design. Physical space. Community engagement. Needs assessment.

CASE STUDY:

In the Canadian province of Saskatchewan, the only standalone children's hospital serves a wide geographic region. The hospital recognized that many of the families would be traveling significant distances to receive care. They developed a comprehensive community engagement strategy with families, parents, teens, and children to create a space that feels welcome to the communities the hospital serves. The design team began by visiting children and caregivers in their home communities, eliciting perspectives and input on preliminary designs. This ensured that the final hospital was not simply a building to provide care but a welcoming environment that also met the cultural needs of patients and families. The full story of how this was done is here:

[Engaging Rural Communities in the Design of Jim Pattison Children's Hospital](#)

By Kari Thorsen

1. WHO ARE THE PATIENTS WE SERVE?

Start by gathering demographic data about your community.

Ways to do this:

- Query your EMR to aggregate clinic data on language, race, etc. Consider how these data are collected and potential for inaccuracies if answers are not patient-generated.
- Utilize national data available from [US Census data](#) or [Data USA](#).

2. HOW DO WE SOLICIT FEEDBACK FROM OUR COMMUNITY?

How do you – in reference to your clinic/practice team – engage community members in this conversation?

- Start by asking, “How are we doing right now? Do we have any existing experience survey results?”
- Then think about whom do you want to ask for additional data? Staff? Families? Patients? Interpreters? Is this group representative of your community? Who are the more and less visible stakeholders?
- Do you want to create an advisory group? Perform a needs assessment?
- Are there community members in your location who are not coming to your practice? How do you plan to solicit their feedback?
- What type of feedback do you want to get from your communities?
 - One way to get information from your community is through patient satisfaction surveys. This is a process your clinic might already use to solicit feedback on patient and family experience. Consider adding these questions to your patient satisfaction surveys to understand how your clinic physical space meets your patient’s needs.
 - What about our clinic/practice space – waiting room, exam rooms, and hallways/ other shared spaces – makes you feel welcomed to bring your child(ren) to clinic and/or “put off”?
 - What are some ways you feel we can make our clinic/practice space more welcoming, that shows your children that we value caring for them?
 - A needs assessment is another way to specifically solicit feedback on a topic or area of interest.

We recommend that clinics/practices interested in (re-)creating their physical spaces to celebrate the diversity of their patient populations use the following [Needs Assessment](#) to evaluate ways to improve upon the quality of the space.

Consider performing a needs assessment of your clinic’s/practice’s physical space(s), and create a plan

that addresses the following:

- 1) Visual cues – e.g. artwork, signs/posters, photos
- 2) Patient education
- 3) Waiting room layout

How do you use the information received from patients and families? What are the concepts you should be thinking about?

- What is your ideal state?
- Are there changes you can make that do not involve cost?
- What resources are needed to achieve a culturally inclusive space, given the feedback received from community?
- How do you elevate awareness without creating additional barriers?

3. ASPECTS TO CONSIDER

1. CLINIC DESIGN

- Could you have a designer create prospective designs, then gather feedback from patients/families?

2. CLINIC/PRACTICE EDUCATIONAL MATERIALS

- Are the anticipatory guidance posters relevant?
- What languages do you offer handouts in?
- How do you display these resources, and which language is most prominently displayed?
- Are you offering access to resources/information that disproportionately affects certain patient populations?
- Are you providing resources on food insecurity? Can your team discuss how to de-stigmatize hunger, and encourage families to talk with their healthcare team, by having resources visible and readily accessible?
- How does your clinic/practice convey messages? Patient announcements?
- Are educational materials accessible to families in a way that promotes dignity and respect? (For example, are materials on food insecurity or financial concerns widely available, or only by request?)

3. PHYSICAL SPACE DESIGN ELEMENTS

Artwork

- Does imagery reflect the patient population served?
 - Consider BIPOC representation on signs/posters.
 - Do you have representation of kids with abilities and disabilities?
 - Do you have ally signs in your clinic spaces?
- Do you have a low-sensory space for children with Autism? For example, a space that is not overwhelming with color or images. Are simple colors and pattern design used to create a low-stimulation environment?

Furniture

- Is the physical space welcoming and accommodating for all body types and sizes?
- Is it possible to have furniture in different shapes/sizes/armless chairs/arms that flip up?

Labeling

- Are signs in a format that patients can understand with regards to language, use of visuals and pictures, rather than words?
- Do you have braille room labels?
- Who is “honored”/represented in the physical space? What names are used for the clinic, rooms, elevators, floors, etc.?

4. PHYSICAL SPACE ARCHITECTURE

- Does the clinic/practice have physical accessibility? Do you have areas accessible at a lower height for young kids, areas that are wheelchair accessible, space for wheelchair users in your patient rooms, space for people to easily move around a wheelchair user or seated person? Does seating and accommodations allow for people of all body shapes and sizes to have access and comfort?
- Have you created gender-neutral spaces? For example, do you have family bathrooms instead of multi-stall bathrooms? Gender-inclusive restrooms?
- How have you incorporated sensory design? Consider having a low light/low stimulation environment.
- Is there a private space for prayer?

5. BOOKS

- Do the books you give out reflect your diverse patient population?
- Are you able to partner with [Reach Out and Read](#) to create a more diversely representative book library?
- What books/magazines are available for patients to read in the lobby?
- How can you engage community members to donate/contribute books that are representative of their culture experience for inclusion in the clinic/practice lobby?

6. STAFF WORKFORCE

Staff workforce is part of the physical space, and how you interactively facilitate the clinical experience for patients and families.

- Is the workforce representative of the patients we serve? See [Promoting Equity, Diversity, and Inclusion in Healthcare Organizations](#) in this toolkit.
- Have you posted the names, roles, and images of providers in the clinic, so that patients can see the people who will be serving them?
- Consider unintended messages from, for example, buttons and religious symbols your clinic/practice team wears, and how these can unintentionally exclude. How do we balance this desire for neutrality with the right to maintain and express our identity?
- If you have a website, do the images reflect the values of the communities the clinic/practice serves? Are the roles and images of staff visible?

7. LOCATION

- How do patients transport themselves to your clinic?
- Are there well-located bus stops? Can you partner with our local government to ensure easy public transportation access?
- Is there accessible parking? What is the cost of parking at your facility?

4. RESOURCES

References:

Healing Environment: A Review of the Impact of Physical Environmental Factors on Users

Huisman, E.R.C.M., et al. "Healing Environment: A Review of the Impact of Physical Environmental Factors on Users." *Building and Environment*, vol. 58, 2012, pp. 70–80., doi:10.1016/j.buildenv.2012.06.016.

Small Details, Big Impact. Examining key drivers for creating inclusive designs in children's hospitals

Thorson K. "Small Details, Big Impact. Examining key drivers for creating inclusive designs in children's hospitals. In progress.

Adolescent Health Initiative

Brauer, Rachel. "Home." Adolescent Health Initiative, Adolescent Health Initiative, 24 Feb. 2021, <https://www.umhs-adolescenthealth.org/>

Resources:

[King County Health Equity Planning Toolkit](#)

[Microsoft Inclusive Design Project](#)

While technology-focused, many broadly applicable recommendations to design within a space.

[Mismatch: How Inclusion Shapes Design by Kit Holmes](#)

Research on equity in the physical classroom environment. The author "served as the Principal Director of Inclusive Design at Microsoft from 2014 to 2017 and led that company's executive program for inclusive product innovation. As an executive at Google and, currently, Salesforce, Holmes continues to advance inclusive development for some of the most influential technologies in the world."

[Scholastic: Classroom Organization Physical Environment](#)

Website that helps teachers achieve a warm, well-run classroom with tips to create physical layout that reflects teaching style.

[Best Practices in Educational Equity](#)

Hanover Research report discussing expert-recommended strategies to create an equitable learning environment.

[Commonsense EDI Resources for Classrooms](#)

Top Picks for Diversity, Equity, and Inclusivity Resources for Classrooms.

[Education Northwest: Equity Assistance Center](#)

Organization which partners with schools and organizations to incorporate educational equity into policies, procedures, and classroom practices.

[NSRF Top Ten Equity Websites Classroom](#)

National School Reform Faculty highlighting equity resources for teachers.

5. ASSESSMENT

Creating Equity Inclusive Spaces

Use the following score key to rank your clinic as 0, 1, or 2 for each item of the assessment below.

0 = Not yet implemented

1 = Partially implemented

2 = Fully implemented

Example Prompt:

Clinic has names, photos, and the roles of the providers and staff visibly posted in the waiting areas.

Scoring Example:

0 = Does not have names, photos, and roles of the providers and staff visibly posted in the waiting areas.

1 = Has names of the providers posted in the waiting area.

2 = Has names, photos, and the roles of the providers and staff visibly posted in the waiting area.

Please evaluate your clinic using a similar scale in answering the questions below.

- [] Has multiple visual cues to indicate that people from diverse backgrounds and abilities are welcomed and valued. Preferred locations include throughout the waiting area, in exam rooms, and/or check-in/check-out materials provided to patients.
- [] Has comfortable and inclusive décor to indicate that patients from all races, ethnicities, gender identities, sexual orientations, religions, abilities, and body types are welcome.
- [] Has zones to accommodate children with different developmental abilities, physical abilities, and body types.
- [] Has an ADA-accessible, all-gender restroom that is visible and available to patients.
- [] Has high-quality education materials displayed in the clinic, in the languages that patients speak, at a reading level that promotes health literacy.
- [] Has graphics and art displayed throughout the clinic and exam rooms that feature local artists from diverse backgrounds.
- [] Has a selection of books and reading materials in the waiting area and exam rooms that represent the diverse experiences of the patients served in our clinic.
- [] Has names, photos, and the roles of the providers and staff visibly posted in the waiting areas.

NOTE: This Needs Assessment adapted from adapted from the University of Michigan Adolescent Health Adolescent Health Initiative "Adolescent Centered Environment – Assessment Process" Tool.

SAFE AND EFFECTIVE CARE

SAFE AND EFFECTIVE CARE

“A sixteen-year-old Black female is being discharged from shoulder surgery after being injured in a motor vehicle accident. The doctor prescribes three oxycodone 5 mg tablets. When her mom asks if she can have more, and questions why this is much less than what she got when she had her wisdom teeth pulled, she’s denied any more medication and told she will need to call to get any more.”

Encounters like this are too common in our pediatric practices. Our medical training was biased and inadequate in addressing key health equity challenges and has caused or perpetuated racist attitudes, stereotypes, and actions.

To provide safe, high-quality care, we must continually educate ourselves about the evolving needs of our patients - the learning journey is lifelong.


We have created a [dynamic resource of board-style questions](#) that will build awareness and competence in caring for diverse pediatric patients and promote skills in reducing health disparities in one’s clinical practice.




1. PLATFORM



Questions are case-based, and answers are embedded in a multiple-choice quiz.

Our vision is that after engaging with these questions, fellow WCAAP members will feel inspired to contribute content to the initial Q-bank, with support from members of the WCAAP Equity Work Group.

After the user answers the question, the correct answer is displayed along with resources.



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Striving to Provide Safe, High Quality Care: Learning from Experience

"A sixteen-year-old Black female is being discharged from shoulder surgery after being injured in a motor vehicle accident. The doctor prescribes three oxycodone 5 mg tablets. When her mom asks if she can have more, and questions why this is much less than what she got when she had her wisdom teeth pulled, she's denied any more medication and told she will need to call to get any more."

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In order to provide safe, high-quality care, we must continually educate ourselves about the evolving needs of our patients - the learning journey is lifelong.

We have created a dynamic resource of board-style questions that build awareness and competence in caring for diverse pediatric patients and promote skills in reducing health disparities in one's clinical practice. Click on the links to the right for examples provided by our WCAAP community.

Share your knowledge, all authors and reviewers encouraged!

We want to make sure every person involved in pediatric care in Washington is represented. Patients, parents, medical staff, non-clinical staff--everyone is encouraged to share their stories so we can all learn. Please send your case, responses, and references to: _____ Or if you would like to participate as a case reviewer, please contact: _____

Inequities in Healthcare

Here are some cases to learn from:

- Contraception for a 16-year-old
[Read More](#)
- Transgender care for a 14-year-old
[Read More](#)
- Short stature in a 7-year-old
[Read More](#)
- Eye findings in a 13-year-old
[Read More](#)
- Sleep problems in a 16-year-old
[Read More](#)
- Complex care for a non-English speaker
[Read More](#)

The open-ended question at the end of the answer and resources will help us determine if our platform will effectively change the way people interact with their patients and colleagues.

2. DATA COLLECTION

This workgroup will evaluate the data collected from the platform, to help direct us on the frequency in which the questions should be released and how they will be promoted to the WCAAP members. It will help guide our question and content authors and reviewers, and determine usefulness to WCAAP members.

Once the answer is submitted, the following questions are asked of the user:

- How relevant is this to your practice?
- How will you change your practice based on this question?
- Rate this question.
- What feedback/concerns do you have about this question?

The responses to these questions will allow WCAAP to collect data on visitors to our platform as well as measure how the visitors' answers change over time.

3. GENERATING QUESTIONS

The initial set of six (6) questions were generated by members of the WCAAP Equity, Inclusion, and Diversity work group. Questions will be published on the [WCAAP website](#) and also linked in WCAAP's monthly e-newsletter, *Developments*.

Our workgroup will engage with providers, clinical staff, community representatives, and patients (with permission) to provide questions that will allow this question bank to grow over time, with encouragement to think broadly about settings beyond outpatient primary care.

We do not impose word limits on the questions or answers, to allow authors to best illustrate their case. We also do not impose resource criteria or standards for the answers, to allow authors to use a wide variety of resources. We recognize that what is currently considered as medical literature includes books and journals that lack articles dedicated to this topic.

Our workgroup will actively recruit members of the WCAAP, clinical staff, and patients to review questions and will continually seek feedback on the content and ensure that it accurately and respectfully reflects the experiences of communities we serve. We invite questions to be submitted anonymously or with information about the author if authors would like to share their motivations for submitting a question.

4. SAMPLE QUESTIONS

- [Contraception for a 16-year-old](#)
- [Short stature in a 7-year-old](#)
- [Eye findings in a 13-year old](#)
- [Sleep problems in a 16-year-old](#)
- [Complex care for a non-English speaker](#)

5. MONTHLY NEWSLETTER INSERT

Each month in WCAAP's e-newsletter, *Developments*, you can find a link to the case of the month: **WCAAP Journey to Pediatric Health Equity.**

INEQUITIES IN HEALTHCARE: CASE OF THE MONTH

We have created a dynamic resource of board-style questions that build awareness and competence in caring for diverse pediatric patients and promote skills in reducing health disparities in one's clinical practice.

Click on the [link](#) to see the case of the month.

PROMOTING EQUITY, DIVERSITY, AND INCLUSION IN HEALTHCARE ORGANIZATIONS

PROMOTING EQUITY: A THREE STEP APPROACH

Assess, Act, and Amplify

This section of the toolkit prompts pediatric practices to “Assess, Take Action, and Amplify” their efforts to promote equity. Recognizing that many pediatric practices are now part of larger health care institutions, we interviewed management personnel who supervise Diversity, Equity and Inclusion activities at Seattle Children’s Hospital, Harborview Medical Center, Kaiser Permanente Washington, and Providence Health Care to learn about their best practices and challenges. A summary of these findings is listed in the second part of this section of the toolkit.

CASE EXAMPLE:

How clinics can help promote career ladders for their staff but institutional Human Resources policies can create barriers that still limit staff diversity.

Our primary care pediatric practice had an excellent medical assistant who was a refugee from East Africa and a single mother. She decided to go to nursing school and entered a program through a local college, while continuing to work at our clinic part-time. She received help with her nursing studies from our clinic nurses, who scheduled regular study times with her. When she graduated, she worked for a year at an affiliated hospital doing shift work. As a single mom, she needed a daytime job and another pediatric clinic wanted to hire her because her language skills would be very useful with their patient clientele. We gave her strong recommendations, but the HR policies at the institution that the other clinic was affiliated with would not process her application because she did not have a master’s degree in nursing.

1. ASSESS

OBTAIN INFORMATION:

FOCUS ON PATIENTS AND FAMILIES SERVED

1. Practices need accurate data for race, ethnicity, primary language spoken in the home, preferred spoken and written language, and gender identity on patients. (See [Resource Section](#) for reference on how to collect this data.) In addition, practice-based information on children/families impacted by adverse childhood experiences (ACEs), housing and income insecurity, sensory and physical disability, and gender preference informs the needs of individuals and the

community served. Is this information available to providers/triage in the electronic health record, and in aggregate form to your practice?

2. Do an “equity analysis” by race, gender, language for common conditions/issues encountered in your own practice and monitor these issues over time. Some large institutions track these data in an equity dashboard (see the Resources for an example).

Examples of data you might track include hospitalizations, missed appointments, immunizations status, and specialty referrals. Review your findings with your entire staff and develop plans to address any inequities you find.

3. Do an “equity analysis” of recent changes in clinic protocols/practices. Consider how they impact different racial/ethnic groups, lower income families, LGBTQIA+ people, and families with limited English proficiency (LEP) that you serve. The COVID-19 changes in your practice protocols are a good place to start.
4. Do an “equity analysis” on the policies and procedures for the human resources department of the institution that does hiring for your practice looking closely at degree, literacy, and language competency requirements for different roles. Determine whether the value of life experiences and cultural and language competencies reflective of your clinic populations is clearly evident in job descriptions. Assess barriers for Black, Indigenous and People of Color (BIPOC) and LEP individuals to submit job applications and successfully navigate the interview process.

FOCUS ON PROVIDERS AND STAFF

Some questions to ask include:

- *Is there gender-based bias in benefits offered to employees?*
 - o Does your organization provide equivalent same- and different-sex spousal medical benefits and “soft” benefits?
 - o Does your organization provide health coverage for transgender individuals without exclusion for medically necessary care?
- *Does your organization require diversity, equity, and inclusion training for all staff and physicians? If so, what is the nature of the training and how long is it? How often is it mandated? (See Resources section for an article reviewing the evidence of the limited behavioral change from such training.)*
- *Does your organization sponsor and support affinity groups, caucuses, and/or a diversity council? If so, what is their structure?*
- *Does your executive leadership receive routine reports on the race, ethnicity, and disability status of employees, in both patient-facing and leadership roles? How are these data used to promote a workforce reflective of the patients and families you serve?*
- *What internal programs does your institution have to promote and sponsor educational advancement for BIPOC employees? Are there partnerships with community colleges, technical colleges, or universities?*
- *Does your institution pay a living wage (\$15/hour minimum) to the lowest paid workers? E.g., environmental services and security staff?*

2. ACT

BRAINSTORM ACTIONS YOU CAN TAKE TO BETTER SERVE THE DIVERSE COMMUNITIES IN YOUR PRACTICE:

Potential Actions

1. LOOK FOR OPPORTUNITIES TO INCREASE DIVERSITY IN YOUR STAFFING

Structure roles to deepen your understanding of the challenges faced by your patients and families and offer meaningful support in the community setting. Examples include:

- **Hiring**
 - Community health workers to make home visits, do community health education, and work with high need families.
 - Interpreters/Cultural Educators/Cultural Mediators to promote culturally appropriate care. Parent or Teen Peer Counselors, especially for patients/families with chronic health challenges and for developing gender-affirming care practices.
- Financially incentivize employees in key roles with confirmed bilingual competencies.
- Create mentorship programs for staff from diverse backgrounds who seek educational or career advancement.
- Offer tuition subsidies and/or flexible scheduling for staff from diverse backgrounds who are enrolled in technical or academic programs to advance their career.
- Partner with local community colleges

2. DEVELOP A PARENT OR TEEN ADVISORY BOARD THAT REPRESENTS THE DIVERSITY OF YOUR PRACTICE

These groups might be charged with review of existing programs, practices, and health education offerings; informing the development of new initiatives; and providing community feedback when specific equity conflicts arise.

NOTE: Recruiting and sustaining substantive involvement of community members may require stipends for participation to offset cost of travel, childcare, and time away from work. Flexible meeting times that accommodate school/work schedules will also encourage participation.

3. PROMOTE HEALTH CAREER OPTIONS FOR TEENS IN YOUR PRACTICE AND IN THE COMMUNITY

- School presentations on health careers
- Formal or informal mentorship programs for teens interested in health careers
- Support teen peer counselors' programs in your practice or the communities you serve.

3. AMPLIFY

SEEK OUT ADVOCACY INITIATIVES

1. ADVOCATE FOR PROVEN INTERVENTION PROGRAMS TO SUPPORT COMMUNITIES OF COLOR, LGBTQIA+ IMMIGRANT, LEP, AND LOWER INCOME FAMILIES AT THE PRACTICE, SYSTEM, AND/OR LOCAL AND STATE GOVERNMENT LEVELS

Key health-related interventions include strengthening families by preventing loss of parents and supporting families from pregnancy through the first 1000 days of a child's life. Some examples include:

- Expansion of nurse or community health worker home visiting programs.
- Expand the range of working people who qualify for paid family leave in Washington state.
- Free or increased subsidies for childcare.
- Diversion programs for substance abuse related offenses & bail bond reform

2. HELP WCAAP ADVOCATE FOR STATEWIDE PROGRAMS THAT INCREASE EQUITY.

Current equity foci (2021) include expanding Medicaid prenatal and behavioral health coverage, expansion of Temporary Assistance for Needy Families (TANF) benefits, and funding a state Working Family Tax Credit that would complement the federal Earned Income Family Credit and expand the number of families that qualify for a sales tax refund. Learn more about WCAAP advocacy and how you can get involved: <https://wcaap.org/advocacy/>

4. BEST PRACTICES & CHALLENGES OF SELECT WA STATE HEALTH CARE SYSTEMS

To better understand current state of equity initiatives at a health care systems level, members of the Equity Work Group interviewed management personnel who supervise Diversity, Equity and Inclusion activities at Seattle Children's Hospital, Harborview Medical Center, Kaiser Permanente Washington, and Providence Health Care. A summary of their self-reported best practices and challenges is listed below.

1. CONSISTENT COLLECTION OF ACCURATE DEMOGRAPHIC DATA

a. Types of data collected on patients, and availability in aggregate form by service site:

- Collect consistent information on race, ethnicity, and primary language that can be aggregated by service sites.
- Develop an Equity Dashboard embedded in the electronic health record, and utilized across its entire enterprise (ambulatory clinics and hospitals). Screen at time of entry to

the system or hospital admission, with links to the data available at subsequent encounters. Provide these data to leaders of hospitals and clinics throughout the system.

- Collect data on “preferred” spoken and written language.
- Query patients about preferred personal pronouns and gender identification.
- Collect information on housing security.
- Screen for ACEs at well child visits or specialty clinics. Identify sensory impairments and disability on registration data.

b. Turn data into action:

- Use race/language data to evaluate aggregate outcomes and uncover disparities in diagnosis/condition-specific quality of care and research
- Assign responsibility to implement practice changes based on these data.
- Explore mechanisms to include patient and community representatives in reviewing areas of disparity.
- Allocate case management services by social workers or community resource workers to address issues identified through data collection and analysis.
- Mine DEI data longitudinally for improvement initiatives to feed process and outcome metrics (e.g. access, screening and treatment for mental health issues in target populations).

2. HUMAN RESOURCES POLICIES AND PRACTICES THAT ADVANCE EQUITY IN THE HEALTHCARE WORKFORCE:

Recruiting and retaining a diverse workforce requires ongoing focus and commitment. Physicians are often hired and promoted through a separate process and organization from other health system employees. Some best practices and challenges include:

a. Outreach to communities that are under-represented in their workforce

Best practices

- Advertise and recruit job applicants at educational institutions with higher proportions of BIPOC students. This often necessitates recruitment out of state for professional degree positions.
- Cast a “wide net” in recruitment at every level, to attract a diverse applicant pool.
- Offer focused training in BIPOC communities on how to access and fill out job applications to advance through the initial screening.

Challenges

- Requiring a master’s level or above training greatly decreases the diversity of applicants and might be re-evaluated in some job settings.
- Nurturing a workplace culture supportive of staff/faculty from diverse backgrounds.

b. Screening and interviewing of job applicants

Best practices

- Establish thresholds for the percentage of BIPOC candidates to be included in the initial applicant pool.
- Ask persons doing the initial screening to justify their decision on whom to interview in order to prevent nepotism and racial bias.

- Ask specific questions at the interview to elicit the candidate's knowledge and attitudes on equity in the workplace. For example, "How can you contribute to our organization's ability to advance health equity?"
- Require hiring managers and recruitment teams to go through "inclusion" training.
- Ensure that the interview panel, as well as the applicant pool, is diverse.

Challenges

- Race/ethnicity may not be available on initial screening of applicants, based on organizational interpretation of current federal standards for hiring practices.
- Unless included in the job description, language, culture, and life experience are not part of the initial screening.

c. Programs to promote educational/career advancement for BIPOC employees

Best Practices

- English medical terminology training offered to multilingual immigrant employees of institutions serving LEP populations.
- Tuition-supported Medical Assistant program for lower SES students; guaranteed employment; coaching/mentoring of graduates who wish to further their education, advance careers.

Challenges

- Low retention rate of BIPOC staff and leaders, perhaps reflecting racism in the work environment/culture.

d. Retention of diverse staff

Best practices

- Identify leaders to champion DEI efforts, and offer salary support for this role.
- Develop mechanisms to provide support for caregivers experiencing microaggressions in the workplace that originated either from patients or from other staff.
- Promote support systems and mentoring to make new recruits from diverse backgrounds comfortable, and to help welcome them to the community both at work and where they will live.

3. DIVERSITY, EQUITY, AND INCLUSION TRAINING OFFERED TO STAFF

Best practices

- Mandate diversity, equity, and inclusion (DEI) training for staff at different levels.
- Embed an equity evaluation into development and deployment of clinical guidelines and protocols.
- Leverage professional board maintenance of certification (MOC) requirements to promote involvement of physicians in equity/diversity-focused quality improvement projects.
- Incorporate DEI training into on-boarding of all new hires.

Challenges

- Allocation of organizational resources and attention to mandate DEI training for all employed and medical staff.

4. SUPPORT FOR EMPLOYEE AFFINITY GROUPS/DIVERSITY COUNCILS

Best practices

- Develop “anti-racism listening sessions” that provide safe spaces for staff of different races, ethnicities or gender identities.
<https://crossroadsantiracism.org/wp-content/uploads/2020/08/Racial-Identity-Caucusing-Strategy.pdf>
- Implement an employee survey to solicit staff experience of bias and racism in the workplace both from fellow staff and from patients.
- Empower “caregiver resource groups” by providing executive sponsorship, administrative support in creating charters, quarterly reports to DEI Council, event planning, and marketing/communications support.
- Develop structures/relationships to promote networking and support, build community and sense of belonging.

5. REACHING OUT TO OBTAIN THE PATIENT PERSPECTIVE

Best practices

- Include patient representation in DEI activities.
- Incorporate patients’ voices or “patient partners” into new or existing programs (e.g. disease management; telehealth)
- Partner with community and governmental organizations, schools, and universities to identify and address issues that disproportionately impact targeted populations.

Challenges

- Optimizing opportunities to recruit and maintain patient representation in program/process development

6. OUTREACH TO BIPOC, LEP, AND LGBTQIA+ COMMUNITIES

a. Community health needs assessments

Best practices

- Leverage demographic data to do a systematic “community health needs assessment,” focus on the gaps in our systems, and develop action items to guide clinical guidelines, services, and collaboration with community organization. The Affordable Health Care Act required all non-profit hospitals to do a community health assessment every 3 years. Here is a sample of Washington State institutions:

Kaiser Permanente Washington:

<https://wa.kaiserpermanente.org/static/pdf/public/about/chna-2019.pdf>

UW Medicine/ Harborview are included in King County Assessment:

<https://www.navos.org/wp-content/uploads/2018-2019-Joint-CHNA-Report.pdf>

UW Medicine NW Hospital:

<https://www.providence.org/providence?region=WA&la=en>

UW Medicine Valley General Hospital:

https://www.valleymed.org/uploadedFiles/valleymedorg/About_Us/Valley%20Medical%20Center%202020%20CHNA%20Report_FINAL_5-14-2020.pdf

Providence Health Care:

<https://www.providence.org/about/annual-report/chna-and-chip-reports>

Seattle Children's Hospital:

<https://www.seattlechildrens.org/globalassets/documents/about/community/2019-community-health-assessment-cha-executive-summary.pdf>

MultiCare:

<https://www.multicare.org/community-health-needs-assessment/>

- b. Operating school-based teen health centers and locating primary care clinics in BIPOC neighborhoods, especially in regions of the state where BIPOC communities represent a smaller percentage of the population.
- c. COVID-19 education, testing and outreach in communities with high rates of COVID-19 infection.
- d. Partnerships with community organizations to engage BIPOC communities in research.

7. ACTIVITIES OF WHICH DEI LEADERS WERE MOST PROUD:

While all of the institutions interviewed have included a focus on anti-racism, health equity, or diversity, equity, and inclusion in their institutional values or strategic plans over the past few years, much work remains. Increased visibility and attention to these areas at all levels of the organization, the creation of DEI departments supported by increased staff FTE, with budget line items to support their work, and increasing awareness of bias within respective systems and structures are all important steps forward on an ongoing journey to developing truly anti-racist organizations.

OTHER RESOURCES:

Obtaining accurate data on your patient population to evaluate for disparities:

<https://ifdhe.aha.org/hretdisparities/collecting-data-nuts-bolts>

Racial Identity Caucusing is a model for employee affinity groups to safely share their experience of racism in the workplace:

<https://crossroadsantiracism.org/wp-content/uploads/2020/08/Racial-Identity-Caucusing-Strategy.pdf>

This is a detailed description of how one health clinic reaches out to their local and state communities to attract a more diverse workforce:

Toolkit for Hiring a Diverse Health Workforce from Berkeley Health Services:

https://diversity.berkeley.edu/sites/default/files/recruiting_a_more_diverse_workforce_uhs.pdf

This is how a large institution uses an Equity Dashboard to help identify and monitor health disparities over time:

Hester G, Nickel AJ, Griffin KH. Accountability Through Measurement: Using a Dashboard to Address Pediatric Health Disparities. *Pediatrics*. 2020;146(6):e2020024448

<https://pediatrics.aappublications.org/content/146/6/e2020024448>

These two articles summarize evaluation of implicit bias training programs and the lack of evidence that they lead to meaningful changes in behavior of individuals who participate in the training:

1. Green TL, Hagiwara N. The Problems with Implicit Bias Training. *Scientific American*, 8/2020.

<https://www.scientificamerican.com/article/the-problem-with-implicit-bias-training/>

2. Dobbin F, Kavel. Why doesn't diversity training work? *Anthropology Now*, 10:48-55, 2018.

<https://anthronow.com/uncommon-sense/why-doesnt-diversity-training-work>

The Agency for Health Care Research and Quality of DHHS has an excellent list of resources for addressing Disparities and Improving Quality that is regularly updated:
<https://nhqrnet.ahrq.gov/inhqrdr/resources/info>