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Best Practices for Health Equity and Antiracism Curriculum for Healthcare Workers regarding SB 5229

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Abstract

Interpersonal racism, bias, and discrimination can often directly contribute to poor healthcare outcomes. Their correlation can be seen in infant mortality, maternal mortality, life expectancy, heart disease, cancer, and more (Bailey et al., 2017; Gee & Ford, 2011). The COVID-19 health pandemic reinforces this pattern of health inequity. Structural inequalities during the pandemic further emphasized racial and ethnic disparities in BIPOC populations. BIPOC populations are more likely to have conditions associated with increased risk of illness from COVID-19 relative to their white counterparts (Raifman et al., 2020). Barriers to achieving health equity include lack of policy addressing health inequities and inadequate training for providers to recognize the root causes of health disparities and create solutions. Recommendations by the Institute of Medicine addressing disparities and unequal treatment lack accountability and have yet to be consistently developed, implemented, and evaluated (Bailey et al., 2017).

In 2021, Washington Senate Bill (SB) 5229, also known as the Health Equity Bill, was passed. Starting January 1, 2024, licensed healthcare providers must complete health equity continuing education training every four years. Members of the Community Health Board Coalition (CHBC) in Seattle, Washington were instrumental in the writing of the bill, providing expertise, and testimony to legislators regarding the need for the bill. The health equity training curriculum requires standards and criteria based on available research and evidence. Currently, members of the CHBC are collaborating with stakeholders to provide curriculum structure and content for SB 5229. This project's goal was to provide evidence-based best practices and concepts for health equity anti-racism training aligned with SB 5229 requirements. Recommendations for curriculum include community involvement, education on historical causes of health disparities (racism, bias, social structures), provider self-reflection and implicit bias education, assessment and accountability, structural competency framework and more.

Keywords: health equity; disparities; structural competency; SB 5229; health equity curriculum

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Introduction

In 2002, the Institute of Medicine report "Unequal Treatment" determined that racial and ethnic inequities in healthcare exist, and healthcare providers and systems are major contributing factors (Betancourt et al., 2004). Interpersonal racism, bias, and discrimination often can directly contribute to poor healthcare outcomes (Bailey et al., 2017). The correlation between systemic racism and health inequalities and poor health outcomes are observed in many areas, including infant mortality, maternal mortality, life expectancy, heart disease, and cancer (Gee & Ford, 2011). There is growing consensus that the root cause of racial disparities, not accounted for by social and political determinants of health, and the prevalence of medical conditions can be attributed to structural racism within the history of the US and are a consequence of bias (Howell, 2018; Louis et al., 2015; Zestcott et al., 2016). Regardless, often there is resistance amongst healthcare providers in addressing these issues and acknowledging these findings. For example, a survey by the Society of Maternal-Fetal Medicine showed an inconsistency between providers' ability to acknowledge disparities in their practice (84%) and acknowledge the impact of their personal implicit bias (29%) (Howell, 2018). Provider education on health outcomes and inequities is recommended to change the narrative of health outcomes and bias (Howell, 2018; Jain, 2017).

The patterns of health inequity are re-iterated with the COVID-19 health pandemic. Structural inequalities further emphasized the racial and ethnic disparities in Black, Indigenous, and people of color (BIPOC) populations; they are more likely to have conditions associated with increased risk of illness from COVID-19 relative to their white counterparts (Raifman et al., 2020). As an example, racial and ethnic disparities in COVID incidence and outcomes are prevalent in Seattle and King County. Age-adjusted death rates of confirmed cases are highest among Native Hawaiian/Pacific Islander (749 per 100,000), American Indian/Alaska Native (452 per 100,000), Hispanic/Latinx (260 per 100,000), and

Black residents (219 per 100,000). Rates for most communities of color are higher, with statistical significance, than among White residents (106per100,000) (King County, Washington, 2021).

Gaps in knowledge have led to a lack of policy addressing health inequities and inadequate provider training to recognize the root of health disparities, reflect on their impact, and create solutions. Many professionals, including policymakers and scientists, are still skeptical of the notion that racism is the root cause of racial health inequalities. However, to address this issue effectively, it is imperative that those responsible for developing public awareness and shaping public discourse support this notion (Bailey et al., 2017). Recommendations given by the Institute of Medicine addressing disparities and unequal treatment lack accountability and have yet to be consistently developed, implemented, and evaluated. One of those recommendations includes educating healthcare professionals of the role of racism in said disparities. This entails increasing awareness of racial and ethnic disparities in health care and integrating health equity and anti-racist cross-cultural education into the training of all health care professionals.

The Washington Senate Bill 5229: Concerning health equity continuing education for health care professionals (SB 5229), otherwise known as the Health Equity Bill, passed in Spring 2021. Members of the Community Health Board Coalition (CHBC) were instrumental in the writing of the bill and providing subject matter expertise and testimony to legislators regarding the need for health equity training for health care providers in Washington state. By January 1, 2024, licensed healthcare providers must complete health equity continuing education training at least once every four years using standards and criteria based on available research and evidence.

The bill includes structural competency and cultural safety as guiding frameworks. Part of the aims of SB 5229 are to include, but are not limited to, the following course topics: (1) strategies for recognizing patterns of health care disparities on an individual, institutional, and structural level and eliminating factors that influence them; (2) intercultural communication skills training, including how to

work effectively with an interpreter and how communication styles differ across cultures; (3) Implicit bias training to identify strategies to reduce bias during assessment and diagnosis; (4) methods for addressing the emotional well-being of children and youth of diverse backgrounds; (5) ensuring equity and antiracism in care delivery pertaining to medical developments and emerging therapies; and (6) structural competency training addressing five core competencies. There is a need for an evidence-based curriculum that aligns with its requirements and goals.

Furthermore, the bill details that the rule-making authority shall consult with patients or communities with lived experiences of health inequities or racism in the health care system, relevant professional organizations, and the department to develop these rules. The CHBC and its members remain engaged and interested in having an impact on the curriculum. They have been collaborating with stakeholders to provide curriculum structure and content for SB 5229.

Structural Competency

Structural competency models urge everyone to shift towards directly challenging systemic causes of health disparity through an equitable partnership with disadvantaged communities. The structural competency framework may be used in a curriculum to get practitioners talking about racial issues in health. These issues include racism, healthcare access, and clinical outcomes for people of color, as well as how structural factors are related to health inequalities (Khazanchi et al., 2021, Godley et al., 2020; Metzl et al., 2018).

Cultural Safety

Cultural safety is defined as the “effective nursing practice of a person or family from another culture, as determined by that person or family" in the Nursing Council of New Zealand Guidelines for Cultural Safety (Doutrich et al., 2012). Cultural safety was developed as a nursing reaction to the bicultural connection between Māori, New Zealand's Indigenous people, and other New Zealanders in Aotearoa, New Zealand. The recurring themes of cultural safety from nurses engaged in education and

clinical practice were investigated in research concerned with meaning and lived experience. The themes uncovered in this study included “Reflection is key,” “Know where you come from,” “Learn to walk alongside,” “Getting it right,” and “Change over time” as the evolving nature of cultural safety (Doutrich et al., 2012). Cultural safety foregrounds power differentials within society. It requires health professionals to reflect on interpersonal power differences (their own and the patients') and how the transfer of power within multiple contexts can facilitate appropriate care for Indigenous people and, likely, all patients. Researchers of health inequities have noted that cultural safety can better address the inequalities resulting from racism, poverty, and historical and other structural factors because power lies within the community to define appropriate health care services (Doutrich et al., 2012). Healthcare authorities should be accountable for providing culturally safe care as defined by patients and their communities. Furthermore, it may be used to measure progress towards achieving health equity (Curtis et al., 2019).

Project Purpose and Setting

As mentioned, members of the Community Health Board Coalition (CHBC) were instrumental in the creation and passing of SB 5229. The CHBC is composed of 16 Black, Indigenous, and people of color (BIPOC) health boards with the mission of increasing health equity in their communities, through advocacy and policy work. The purpose of this project is to collaborate with the CHBC community organization’s policy work on SB 5229 by providing recommendations addressing the need for an evidenced-based curriculum aligned with the requirements and goals of the Health Equity Bill that will catapult health equity into practice.

This project aims to identify the best practices and concepts that fulfill the requirements of SB 5229 regarding a four-hour health equity anti-racism training for healthcare professionals in Washington state. Following data analysis, a proposal of evidence-based practice recommendations will be given to the CHBC and possibly the Washington State Department of Health.

Methods

This project process consisted of two steps: a systematic literature review followed by subject matter expert interviews. Findings from the literature review and interviews were compared to assess for resonance, congruence, and identification of gaps.

Literature Review

Design, Data Collection, and Analysis

A librarian was contacted to guide the selection of relevant databases, article selection inclusion criteria, and search terms. Librarian-recommended databases included CINAHL, PubMed, PsychArticles, ProQuest, and Academic Search Complete. Articles for evidence-based recommendations met the following criteria: peer-reviewed; publication within the last ten years (with the exception of Smith et al., 2007); English language; search terms (anti-racism, bias, cultural safety, curriculum, education, equity, health, healthcare, implicit bias, inequity, structural competency, structural racism, methods, provider, racism, training); and geographical area: United States. A total of 54 articles were reviewed and 13 articles were selected based on the criteria. Annotated literature and an Individual Evidence Summary Tool table were utilized to detect common themes, recommendations, and gaps in existing evidence.

Subject Matter Expert Interviews

Institutional Review Board

This project was determined to be Non-Human Participant Research by the Seattle University Institutional Review Board (IRB), thus did not require further IRB review regarding subject matter expert interviews.

Recruitment Plan and Participants

Participants were recruited by a convenience sampling of health equity subject matter experts in Washington state. via email. Subject matter experts were selected based on both personal and

professional experience with health inequities. Subject matter experts' inclusion criteria also consisted of those who have worked with historically racialized groups and have some knowledge of the Washington State legislative bill SB 5229.

Interview Design, Data Collection, and Analysis

Based on literature results and the goals of SB 5229, an interview guide was made. Subject matter expert interviews were conducted over Zoom meeting audio or video calls. They were audio taped and transcribed using fully compliant Zoom services for accurate documentation of interviewee responses. Zoom Live Transcription is fully compliant with ADA, FCC, WCAG 2.1, HIPAA, SOC 2, HECVAT, VPAT, and GDPR. Transcribed audiotaped interviews were qualitatively analyzed based on common concepts, overarching themes, and patterns for each interview question using in vivo content analysis. Rather than a definite answer, this qualitative analysis sought an understanding of racial health inequity.

Results

Literature Review

Curriculum Content and Design

According to the literature, regarding health equity and it's encompassing themes, there is not a standard methodology of education or content matter. However, there is a large consensus on a few themes and methods that should be included in the curriculum. To start, conceptual frameworks are necessary for molding a health equity curriculum (Doubeni et al.,2020; Gonzalez et al., 2018; Hsia et al., 2021; Khazanchi et al., 2021; Metzl et al., 2018; Perdomo et al., 2019; Smith et al., 2007). Structural competency, in addition to others, such as transformative learning theory, guided the curriculum design (Godley et al., 2020; Gonzalez et al., 2018; Hsia et al., 2021; Khazanchi et al., 2021; Metzl et al., 2018).

Interdisciplinary approaches and nonmedical expertise in topics, such as societal structures, politics, economics, and culture, are important in creating curriculum (Metzl et al., 2018; Perdomo et al., 2019). Historical education and present-day data should be included in health equity curricula. Historical

education includes the connection and cause between societal structures, racism, and health disparities. Present-day evidence should include population health outcomes data, the magnitude of healthcare disparities, and evidence of the impacts of racism and bias on health outcomes (Metzl et al., 2018; Perdomo et al., 2019; Smith et al., 2007). For healthcare professionals to better understand the populations they serve, the curriculum should be orchestrated via community collaboration and the curriculum content should include learner-community experience (Dennis et al., 2019; Khazanchi et al., 2021; Metzl et al., 2018). To promote structural competency, university, health system, and community stakeholders must be engaged in curriculum development, implementation, and evaluation using didactic lectures and reflective writing assignments (Khanzanchi et al., 2021). Learner-community experience can be incorporated into the curriculum through student community service learning, translation services in low-income clinics, and legislative policy attendance (Metzl et al., 2018). An essential aspect of a health equity curriculum is to integrate a community's historical experiences with structural racism and assess how these historical experiences shape health outcomes (Dennis et al., 2019; Metzl et al., 2018; Permodo et al., 2019; Smith et al., 2007).

Reflection, especially the process of provider self-reflection, is imperative to acknowledging and accepting health disparities and action toward solutions promoting health equity (Dennis et al., 2019; Perdomo et al., 2019; Smith et al., 2007). A health equity curriculum should support providers' self-reflection on their backgrounds, beliefs, conscious and unconscious attitudes and biases, their impact on healthcare interactions, and the impact of racism on health and health care. Self-reflection can be encouraged through guided imagery, perspective taking, meditation, and storytelling (Dennis et al., 2019; Charon et al., 2021; Gonzalez et al., 2018; Neff et al., 2017; Perdomo. et al., 2019; Smith. et al., 2007). In addition to provider self-reflection, an effective health equity curriculum includes interdisciplinary patient case studies and health topics that incorporate equity, social structures, and

bias content that aligns with the population and health condition of each case (Hsia et al., 2021; Metzl et al., 2018; Perdomo et al., 2019).

Learning Environment

Recognizing ways in which institutional climate and culture contribute to awareness of health disparities and structural biases is an integral part of a health equity curriculum (Doubeni et al., 2020; Gonzalez et al., 2018; Metzl et al., 2018). Outside of content itself, curriculum facilitators play a powerful role in the success of learners (Gonzalez et al., 2018; Smith et al., 2007). Facilitators must have personable characteristics and provide an environment that is safe, supportive, and promotes discussion (Hsia et al., 2021; Perdomo et al., 2019; Smith et al., 2007). Facilitator status (clinical v nonclinical, education level, equity experience), peer-learner relationship, and identity can impact learner experience and curriculum success (Gonzalez et al., 2018; Hsia et al., 2021; Perdomo et al., 2019; Smith et al., 2007). As far as a learning modality, mixed methods/blended learning (lectures, workshops, reflection, synchronous discussion (in person and online), community engagement were found to be effective in curricula (Dennis et al., 2019; Hsia et al., 2021; Metzl et al., 2018).

Gaps in Literature

There are areas of literature that need further research. Methods of community collaboration in developing curriculum may vary; however, a standard was not identified. In addition, the community's response to learners' presence within the community was not always addressed in articles that included community engagement as part of the health equity curriculum.

There are barriers and gaps in the literature regarding standard validated tools to evaluate the effectiveness of curriculum, structural competency in learners, or health equity competence in healthcare workers overall. Barriers noted were funding, methodological, and logistical (Smith et al., 2007). Based on pre-existing assessment frameworks and learner surveys, assessment tools were modified to assess curriculum effectiveness and learner understanding.

Objective Structured Clinical Examinations (OSCE) was used by both Hsia et al. (2021) and Smith et al. (2007). Metzl et al. (2018) developed the Structural Foundations of Health Survey in 2016 to assess and compare students' recognition of ways structural and institutional factors shape health outcomes. Hsia et al. (2021) used a learner's experience questionnaire and created a validated tool, The Structural Competency Instrument, based on Metzl's Structural Foundations of Health Instrument. To assess successful training, Smith et al. (2007) recommended assessing attitudes (subconscious bias, stereotyping, etc.), knowledge of healthcare disparities, and skills (communication and cross-cultural interaction) of learners.

One main focus was health disparities knowledge. The disparities education component of the Association of American Medical College's (AAMC) Tool for the Assessment of Cultural Competence Training was recommended for assessing this portion. However, the AAMC's Tool for the Assessment of Cultural Competence Training may be controversial as cultural competency has been argued as an inadequate theory for addressing health disparities and cultural incongruence (Curtis et al., 2019).

Subject Matter Expert Interviews

Below is a theme analysis summary for various interview questions according to their question category. For the entire Interview Theme Table, see Appendix A.

Health Equity Curriculum

What strategies do you think are effective in increasing health equity promoting behaviors among healthcare providers? The interviewees discussed strategies that they believed were effective in increasing health equity promoting behaviors among healthcare providers. Implicit bias training and promoting health care equity was the theme in this interview. One provider stated, "People who understand implicit bias need to be the ones that elevate it and hold others accountable." Another provider shared that promoting health care equity among providers started with providers' reflections on anti-Blackness. They stated, "Anti-Blackness was the foundation, and then everything else was sort of

built on top of that foundation" when discussing health inequity.

What can be done to better support what is already working? Supporting reflection and the ability to have "painful" dialogues were thought to be critical components of improving what is already working in health care. Another option considered was demanding implicit bias training and accountability. Having "allies" who are ready to take a step back and reflect on their own actions and interference in health equity can help keep the momentum. An additional way to better support what is currently working in the healthcare system is to continue to have a better understanding of the history of oppression and the consequences of being dehumanized. On the other hand, it was also mentioned that it is essential to recognize how people have championed racial justice, people who did not need to, and how both white people and people of color have worked together.

What challenges are you noting in promoting health equity behaviors among healthcare providers? A viewed challenge in promoting health equity behaviors among healthcare providers was related to the capacity for a healthcare provider or organization to take on the issue of health inequity. Provider burnout was another challenge mentioned, including witnessing primary trauma and suffering from secondary trauma. The psychological load of this trauma must also be addressed so that implicit bias training and health equity training are not perceived as burdensome. When healthcare providers of color encounter health inequities, they report experiencing trauma and feeling "demoralized." As our society becomes more anti-racist and anti-passive, healthcare providers require protected time and psychological assistance similar to core competency training.

Given these challenges, do you have suggestions for developing a health equity curriculum? One interviewee mentioned the importance of understanding the history of structural racism, interpersonal racism, and racism in healthcare. Internal emotional management skills were also noted as something that should be incorporated into a health equity curriculum to avoid potential problems and harm that a heightened emotional state can cause. It was also suggested that this curriculum focus and

have a dialogue on power and privilege; otherwise, implicit bias training, anti-racism training, and equity training will "fall short."

Are there paradigm changes necessary for health equity training to be effective? Understanding anti-indigeneity and, specifically, anti-Blackness was explained by one interviewee as important and easy ways to begin understanding equity. Also, understanding racism in a professional context and acting to reverse it and put learning into practical expression was described as a paradigm change needed for health equity. An important paradigm shift that is needed is recognizing that everyone is a part of the inequity that exists in health care; therefore, everyone can play a role in either improving or not improving it. Another interviewee mentioned the critical role of hospital leadership in speaking about the importance of providers learning and applying health equity education in their practice.

Structural Competency

Have you heard of the theory of Structural Competency? If you have heard about Structural Competency, what are your thoughts about it? Structural competency was described as a powerful way to look at health equity beyond just social determinants of health because it allows one to see what contributes to disease beyond just where one is in life. It was also described as an excellent framework that people should understand as a basis for their work and for creating anti-Blackness and anti-racist policies. Alternatively, another interviewee believed that a framework of humility or curiosity would be a better way to approach health equity.

Racism

What gaps (in general and in the literature) do you note in current health equity and anti-racism education for healthcare providers and workers? The depersonalization of racism and not realizing how racism impacts a provider's practice was noted as a gap in existing education. For example, there is a lack of understanding of how racism shows up in the lives of individuals and as an actor within

the healthcare system. A lack of accountability was also mentioned as a gap in current health equity and anti-racism education for healthcare providers. One interviewee stated, "we don't actually get to the meat of how racism plays out" due to training being sensitive to triggering people and "people's fragility." It was also mentioned that further harm could be done by participating in a system that causes harm to others; this is a gap that exists within health equity and anti-racism education for healthcare providers. Lastly, another point mentioned was the importance of recognizing the nuances within racial groups and affirming critical historical contexts rather than viewing groups as a monolith.

Discussion

Congruent themes recognized in the literature review and interviews were the importance of provider reflection and education on the history of race, oppression, and their correlation to poorer health outcomes. These two topics were thought to be imperative to the success of health equity whilst also being the root causes of health disparities seen today. There were interesting points noted in the literature review regarding what is called the “resistant learner.” One category of the resistant learner was “learner disbelief.” Learner disbelief ranged from disbelief in racial disparities and unequal treatment by providers due to personal biases; it also includes the belief that racial issues were anecdotal and did not pertain to healthcare (Gonzalez et al., 2018; Smith et al., 2007). The addition of historical education, health disparity data, and present-day evidence of the impact of racism and implicit bias may help against the resistant learner who is skeptical of bias, health outcomes, and health care disparities.

One major topic of ensuring health equity is accountability. Incorporating accountability and measures for behavior-based outcomes and evaluations was a recurring theme in the interviews. Community assessment of individual providers, as well as corrective action by health institutions and providers based on community assessments, was an evaluation method suggested by the interviewees. An interviewee stated that linking provider and hospital loss of accreditation (for example, Joint

Commission on Accreditation of Healthcare Organizations [JCAHO]) with anti-racist outcomes was a critical point.

One interesting topic that was brought up in the discussion of race-based health inequities was intersectionality, specifically with gender and orientation within racial inequity. As stated by a subject matter expert, "...until a black trans person can come in and get the same care that a white cis-hetero person can, then we still have work to do." This is an area of health that deserves equitable solutions and should be added to health equity education.

Recommendations

Based on best concepts and effective practices found in the literature review and knowledge shared from subject matter experts, the following are recommendations for health equity anti-racism curriculum content for healthcare professionals in Washington state who need to fulfill the training requirements of SB 5229 as well as recommendations noted for health equity overall.

Recommendations for Curriculum

- Community involvement in curriculum design and process
- Molding curriculum structure from a conceptual framework
  - Structural competency is beneficial when addressing health inequities and racial disparity origins and outcomes.
  - Specific learning framework needs further research; the Transformative Learning theory was noted more than once.
- Interdisciplinary topics and expertise (politics, economics, history, psychology, social work and services, gender, social structures, etc.)
- Curriculum content should include the following:
  - History of social structures, racism, and bias
  - Historical causes of population health disparities

- ➢ Current health outcome data and disparities
- ➢ Evidence of implicit bias impact on health outcomes
- ➢ Reflection practices, most importantly provider self-reflection activities (in safe spaces)
  - ■ Activities: guided imagery, perspective taking, meditation, and storytelling
- ➢ Small group discussions in safe, supportive environments
- ➢ Specific patient population/health topic cases aligned with social structure, equity, and bias context. Real patient cases are preferred.
- ➢ Community engagement with caution of community approval of interaction
- ➢ Mixed method/blended learning modality

- ❖ Promote provider awareness of their institution/practice environment's attitude surrounding health equity, bias, and education
- ❖ Recommendations for assessment of learner understanding and assessment of curriculum itself are limited. The OSCE basis for learner evaluation may be beneficial.
  - ➢ Mandatory training and provider-learner assessment (provider self-assessment or tool assessment)

Recommendations for Health Equity Promotion Overall

- ❖ Mandatory trainings and accountability measures across all health organizations should be enacted and fully funded.
- ❖ Burnout relief, specifically, addressing psychological burden and trauma providers experience.
- ❖ Affinity groups/caucuses for healthcare workers debrief along with whole group discussions to shed light on concerns and promote solutions.

- ❖ Accountability via behavior-based outcomes (i.e., institutional and provider consequences such as financial penalties, discreditation, etc.) for racist actions, inability to improve practice, or community disapproval.

Conclusion: Implications for Practice

The findings and recommendations of this project may serve as a starting ground for the CHBC curriculum development and a basis for further research for future DNP students. The goal is for healthcare providers to (1) gain the ability to identify individual and system-mediated incidences of implicit bias or racism in clinical scenarios, (2) identify interventions to mitigate acts of inequity in clinical settings, and (3) advocate at the policy level for more equitable health care policies, thus creating better health outcomes for BIPOC people. After taking the SB 5229 Health Equity Training, the ultimate goal is for providers to have the ability to recognize instances of health inequity, note solutions, and mitigate their impacts on the individual and system at the micro and macro level.

References

Bailey, Z. D., Krieger, N., Agénor, M., Graves, J., Linos, N., & Bassett, M. T. (2017). Structural racism and health inequities in the USA: evidence and interventions. *The Lancet,* 389(10077), 1453–1463. https://doi.org/10.1016/s0140-6736(17)30569-x

Betancourt, J. R., & Maina, A. W. (2004). The Institute of Medicine report "Unequal Treatment": implications for academic health centers. *Mount Sinai Journal of Medicine,* 71(5), 314–321. https://pubmed.ncbi.nlm.nih.gov/15543432/

Charon, R., Irvine, C., Oforlea, A. N., Colón, E. R., Smalletz, C., & Spiegel, M. (2021). Racial justice in medicine: narrative practices toward equity. *Narrative*, 29(2), N.PAG. https://doi-org.proxy.seattleu.edu/10.1353/nar.2021.0008

Cordes, C. C. (2021). Developing anti-racist integrated health professionals. *Families, Systems, & Health*, 39(2), 404–407. https://doi-org.proxy.seattleu.edu/10.1037/fsh0000625

Curtis E, Jones R, Tipene-Leach D, Walker C, Loring B, Paine SJ, Reid P. Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. *Int J Equity Health*. 2019 Nov 14;18(1):174. DOI: 10.1186/s12939-019-1082-3. PMID: 31727076; PMCID: PMC6857221.

Dennis, S. N., Gold, R. S., & Wen, F. K. (2019). Learner reactions to activities exploring racism as a social determinant of health. *Family Medicine*, 51(1), 41–47. https://doi-org.proxy.seattleu.edu/10.22454/FamMed.2019.704337

Doubeni, C. A., Fancher, T. L., Juarez, P., Riedy, C., Persell, S. D., Sandvold, I., . . . Sochalski, J. (2020). A framework for transforming primary care health care professions education and training to promote health equity. *Journal of Health Care for the Poor and Underserved*, 31(4), 193-207. doi:http://dx.doi.org/10.1353/hpu.2020.0150

Doutrich, D., Arcus, K., Dekker, L., Spuck, J., & Pollock-Robinson, C. (2012). Cultural safety in New Zealand and the United States. *Journal of Transcultural Nursing*, 23(2), 143-150.

Drevdahl, D., Canales, M., & Dorcy, K. (2008). Of goldfish tanks and moonlight tricks: can cultural competency ameliorate health disparities? *Advances in Nursing Science,* 31(1), 13-27

Gee, G. C., & Ford, C. L. (2011). Structural racism and health inequities. *Du Bois Review: Social Science Research on Race*, 8(1), 115–132. https://doi.org/10.1017/s1742058x11000130

Godley, B. A., Dayal, D., Manekin, E., & Estroff, S. E. (2020). Toward an anti-racist curriculum: incorporating art into medical education to improve empathy and structural competency. *Journal of Medical Education & Curricular Development,* 1–6. https://doi-org.proxy.seattleu.edu/10.1177/2382120520965246

Gonzalez CM, Garba RJ, Liguori A, Marantz PR, McKee MD, Lypson ML. How to make or break implicit bias instruction: implications for curriculum development. *Academic Medicine.* 2018 Nov;93(11S Association of American Medical Colleges Learn Serve Lead: Proceedings of the 57th Annual Research in Medical Education Sessions): S74-S81. DOI: 10.1097/ACM.0000000000002386. PMID: 30365433; PMCID: PMC6211195.

Hansen, H., & Metzl, J. (2017). New medicine for the U.S. health care system: training physicians for structural intervention. *Academic Medicine*, 92(3), 279-281. https://doi.org/10.1097/ACM.0000000000001542

Hsia, S. L., Landsfeld, A., Lam, K., & Tuan, R. L. (2021). Implementation and evaluation of a 10-week health equity curriculum for pharmacy students. *American Journal of Pharmaceutical Education*, 85(9), 924–933. https://doi-org.proxy.seattleu.edu/10.5688/ajpe8579

Institute of Medicine (IOM). 2003. Unequal treatment: confronting racial and ethnic disparities in health care. Washington, DC: *The National Academies Press*.

Khazanchi, R., Keeler, H., Strong, S., Lyden, E. R., Davis, P., Grant, B. K., & Marcelin, J. R. (2021). Building structural competency through community engagement. *Clinical Teacher,* 18(5), 535–541. https://doi-org.proxy.seattleu.edu/10.1111/tct.13399

Metzl, J. M., Petty, J., & Olowojoba, O. V. (2018). Using a structural competency framework to teach structural racism in pre-health education. *Social Science & Medicine*, 199, 189–201. https://doi-org.proxy.seattleu.edu/10.1016/j.socscimed.2017.06.029

Neff, J., Knight, K. R., Satterwhite, S., Nelson, N., Matthews, J., & Holmes, S. M. (2017). Teaching structure: a qualitative evaluation of a structural competency training for resident physicians. *Journal of General Internal Medicine, 32*(4), 430–433. https://doi.org/10.1007/s11606-016-3924-7

Perdomo J, Tolliver D, Hsu H, He Y, Nash KA, Donatelli S, Mateo C, Akagbosu C, Alizadeh F, Power-Hays A, Rainer T, Zheng DJ, Kistin CJ, Vinci RJ, Michelson CD. Health equity rounds: an interdisciplinary case conference to address implicit bias and structural racism for faculty and trainees. *MedEdPORTAL: the journal of teaching and learning resources*. 2019 Nov 22;15:10858. DOI: 10.15766/mep_2374-8265.10858. PMID: 32166114; PMCID: PMC7050660.

Race and ethnicity data dashboard. Race and ethnicity data dashboard - King County. (n.d.). Retrieved October 17, 2021, from https://kingcounty.gov/depts/health/covid-19/data/race-ethnicity.aspx.

Raifman MA, Raifman JR. Disparities in the population at risk of severe illness from COVID-19 by race/ethnicity and income. *American Journal of Preventive Medicine*. 2020 Jul;59(1):137-139. DOI: 10.1016/j.amepre.2020.04.003. Epub 2020 April 27. PMID: 32430225; PMCID: PMC7183932.

Smith WR, Betancourt JR, Wynia MK, Bussey-Jones J, Stone VE, Phillips CO, Fernandez A, Jacobs E, Bowles J. Recommendations for teaching about racial and ethnic disparities in health and health

care. *Annals of Internal Medicine*. 2007 Nov 6;147(9):654-65. DOI: 10.7326/0003-4819-147-9-200711060-00010. PMID: 17975188.

Appendix A

SUBJECT MATTER EXPERT INTERVIEWS THEME TABLE		
Ethnic/Racial/Cultural backgrounds: African American, Asian, Black, Black/Biracial, Hispanic, Pacific Islander Communities: African American Health Board, Baha'i community, BIPOC ecosystem, Nonbinary, Queer Professions: Director of Health Equity, Midwife, Physician, Communications		
Question	**Themes**	**Quotes/Responses**
Health Equity Curriculum		
What strategies do you think are effective in increasing health equity promoting behaviors among healthcare providers?	**Implicit bias training Accountability** **Anti-Blackness reflection** **Acknowledge behavior and attempt to repair** **Hire people who know how to move in racialized communities** **Remove people exhibiting racist behavior.** **Need restorative justice** **Need accountability** **People need to understand the nondominant perspective**	"People who understand implicit bias need to be the ones that elevate it and hold others accountable." "Anti-Blackness was the foundation, and then everything else was sort of built on top of that foundation." "We shouldn't be hiring medical professionals that don't know how to move in community white, black, brown, native, and Vietnamese." "Folks need to actually understand the history of their field and not just white." "There's a knowledge gap because of epistemicide and the destruction of indigenous."
What can be done to better support what is already working?	**Support reflection (self and historical)** **History education: oppression, white ally triumphs, intercultural/racial collaboration** **Implicit bias training and accountability requirements**	Painful conversations that will have the effect of derailing, intentional reflective practices on racism are essential for having these conversations People need to have a history of what has happened, the trauma, oppression, and the consequence of being treated as less than human. People also need to know how people have championed racial

	across the board **Allies taking a step back from leadership/co-opting** **Prioritizing Community-based answers** **White savior reflection** **Link accreditation with anti-racist outcomes** **Racist actions lead to the loss of accreditation by JCAHO.** **Support those who have an equity analysis** **Tokenization: healthcare financial system is set up**	justice who didn't need to and how white people and other people have worked together. "The biggest strategy is like we just need to be given money to build our own things from the ground up." “I think that hospitals and clinics should lose their accreditation after it has been consistently shown by the community to be having racist impact." "Folks should lose accreditation when they're found to be participating in harm." “Pay those people more, provide them support and training to ensure that those people actually have an analysis." “There's that one person that is like you know the system will love and care about, and they're that token person, and they can be the one in the role they could be the one making decisions, but often the way it works is they've now got to like, basically sell out the rest of their people in small and or big ways in order to retain that quote-unquote power."
What challenges are you noting in promoting health equity behaviors among healthcare providers?	**Burnout** **Lack of insight or capacity to understand [inequity, racism]** **False barriers** **Complicated system**	Paraphrase: HCP witnessing primary trauma and suffering from secondary trauma. For HCP that are POC- seeing health disparities is demoralizing. Recommendation: Attend to psychological burden so that implicit bias training and health equity training aren't seen as just another thing to do. Comparable to core competency training - HCP need protected time and psychological support as we start to really become an anti-racist society, an anti-oppressive society

		How much capacity do they have to take in the problem? Some people are too early in their understanding to be useful, and others are more advanced, so they can. "Creates these false barriers that like I can't do x y z thing for you because insurance won't pay for it, or this visit doesn't cover it and it's often then, well it's out of my hands as a provider." "The system is so complicated that even when you try and bring stuff into a grassroots community space, it's how you got to spend weeks and weeks just deconstructing like what the problem is the nuance is so that people can support and advocate, and often it's so convoluted and disconnected from people's daily experience that it's hard to get critical mass and community to speak up on the really specific things that need to be changed within the system."
Given these challenges, do you have suggestions for the development of a health equity curriculum?	**Internal emotional management** **History or structural, interpersonal, and healthcare racism** **Power - the concept of power and privilege** **Affinity groups or caucuses**	"...skills to avoid potential problems and harm that can be caused by emotional state." "...have those conversations [about power and privilege] or else implicit bias training, anti-racism, training equity training is gonna fall short."
What are, in your opinion, the absolute requirements of a health equity training for healthcare providers?	**Assessing yourselves and holding yourself accountable** **Behavior-based outcomes and Evaluations**	"Forget training, [focus on] assessment!" "There should be behavior-based outcomes tied to each of these trainings, and there should be an evaluation."

	Practice shifts should be included in the evaluation. **Historical Reckoning** **Power Analysis**	"There is an intention for you to shift how you practice, not just what you know, and so those practice shifts should be included in people's evaluation, and that should be tied to their money." "A whole like a historical reckoning of how racism, classism, etc. has shown up in that field so like really specifically field by field practice, by practice, like the training, needs to be developed with that very intentional history." "There needs to be a power analysis done after that history is built on, so that people understand how messed up the power dynamics are, both on an individual basis, but also structurally across the system."
Do you have suggestions for embedding accountability into the training?	**<u>Scorecards</u> with diversity equity inclusivity** **360* Accountability to promote no blind spots** - on all levels (supervisor, lateral positions, and people who report to you - all can hold you accountable) **Self-qualitative assessment**	"Diversity, equity, and inclusivity have become a major pillar in their scorecard…Have they [health organizations] done their due diligence of making sure that they have a hiring process in place? That's actually filtering and highly qualified candidates from diverse areas." "of course, your manager says your supervisor, your director says whoever it is…then if it's a lateral person and then it's a person that reports to you… it's harder in that sense to have a blind spot." "...have to submit [self-qualitative assessments] to professional learning development departments…Somewhat like an... essay… learning journal you do after a case in school, but you do that for the year…what have you done."
Are there paradigm changes	**Prioritizing anti-Blackness and**	"To begin to understand equity, we

that need to occur in order for health equity training to be effective?	**anti-indigeneity** **Mindfulness for emotional regulation and management of discomfort** **Understanding history and what has gone right** **Understanding coupled with action.** **White allies supporting colorblindness** **Dissociation from the problem** **Shift away from behavioral causes of disease towards realizing the impacts of structural racism** **Role of Hospital leadership in health equity**	cannot start without understanding anti-indigeneity and anti-Blackness, emphasizing anti-Blackness specifically." "Provider impatience is part of the problem." "Understanding racism in a professional context and acting in a way to reverse this and put learning into practical expression. Work is not ended with a deeper understanding but is completed when it's ended with action." "...a paradigm shift of *'I am not part of this,'* and if you're alive, you're part of it, you can either make it better or not." "... one of the most hurtful and most impactful places of growth we can have is that our White allies stop saying sentiments that support being colorblind..." "... moving the needle with that points that somebody's own behavior cause them to have this disease versus Realizing that the impacts of structural racism. [for example] redlining, the history of medical racism, all these different things. have played a huge role in leading to the health disparities as we see them today." "I think about hospital leadership like, you know, top-level administrators and folks in that space. We are not hearing a lot from them at all about the stark importance of providers writ large learning this stuff, absorbing it and applying it in the practice."
Structural Competency		

Have you heard of the theory of Structural Competency? If you have heard about Structural Competency, what are your thoughts about it?	Some interviewees were unfamiliar with in-depth details of structural competency. **Positive idea but hesitation with the wording – the word "competence" is inadequate in terms of DEI.** **Humility or Curiosity over Competence***	"Interesting way to look past SODH…that's *powerful* because you stop looking at the disease, and you start looking at that what causes the disease past just where they are in life." "I strongly have an opinion about competence…Just because you achieve it, does that mean you're done? Never…humility is probably a better way to go about it or curiosity." Paraphrase: Structural competency is a very good framework that people should have an understanding of as a basis for their work…Understanding the policies that were created for anti-Blackness and racist policies
What are your suggestions for the evaluation of structural competence?	**Community assessment of provider and hold provider accountable**	
Racism		
What is the role of structural racism in addressing health equity effectively?	**Significant, critical role**	**"**You cannot do equity without anti-racism, just like you cannot save a dying patient without the ABCs of resuscitation."
What gaps (in general and in the literature) do you note in current health equity and anti-racism education for healthcare providers and workers?	**Qualitative data** **Delivery of care** **Interdisciplinary knowledge (social work, services, psychology)**	Paraphrase bedside implementation…" providers need to gain capacity to give patients *knowledge and options…*this promotes *trustworthiness* to reduce disparities." "...look at what social work, services, psychology fields are doing in this because there is a wealth of knowledge that doesn't cross over into what we can consider hard medicine." "I think here in America; it's the heart of it."

	Depersonalizing Racism	"In current health equity, and anti-racism for health care providers or workers, it's just woefully lacking like there's a lot of box-checking on general terms and again, there's not field-specific things that help people apply or see how racism is playing out in their individual practice as tied to them. People are allowed to depersonalize racism in a really unhelpful way. There's not an understanding of how the individual shows up and is an actor within the system like it's often just about like here is what racism looks like out there".
	Lack of accountability	"And there's no accountability to apply it to like how am I as a black woman showing up and being anti-Black sometimes, how am I sure up as an able-body person and being ableist?
	Fragility	Like, how am I right? All of those things? I feel like the training is so afraid to trigger people's fragility that we don't actually get to the meat of how racism plays out."
	Ownership	"And somehow that's like a bad word for us to be any of those things, but the reality is, if we live in this country, we're all participating in systems. We're causing harm just by the way we live our lives. However, unintentionally are however much not our fault, so I think it doesn't allow for that ownership".
	Nuances vs. Monolith	"I would also say that for sake of brevity like we try to make all black people, all

	Important historical contexts	Asian people, all white folks, for that matter, a monolith, and there are nuances. That are important historical contexts". "In our individual ethnicities and histories that matter to how we get to well-being that matter to our individual visions of what well-being is."
Providers		
What are your thoughts about ethnic/racial concordance between healthcare providers and the individuals or communities they serve?	**Concordance promotes advocacy and better health outcomes.** **Quite important but not the final solution**	Paraphrase: Due to implicit bias and a tendency to favor and understand those of similar background, hiring people of similar background to the community served unintentionally promotes better health outcomes; patients are provided with more health knowledge, testing, and care options "it's about time. We're past due…[however,] not all skin folk are kinfolk…So you can't say that this is [going] to be your magic bullet."
How can we promote self-reflection and motivation on the health care provider part regarding their role in perpetuating implicit bias?	**Required and Funded self-reflection**	
Concluding Question		
What is your ideal conception or recommendations for a health equity curriculum?	**Reflection: historical, structural, interpersonal, and healthcare racism** **Mindful meditation**	"I don't think I can answer that by myself…we can come up with a start, and it shouldn't be one person answering that it should be a community…the ideal conception of it should come out of the

	Internal emotional management **Community developed and comes from marginalized populations**	most marginalized…" Paraphrase: 5 points: 1.) first thing is that people need to understand history of structural racism and understand there's different topics within … 2.) interpersonal racism, second…3.) racism in health care, third … 4.) there also has to be some reflective dimension…mindfulness is a practice that I think people also need to be taught so that they know their normal reaction is going to be an unhelpful reaction… [and] 5.) internal emotional management skills because their [providers] emotional state will be a problem and will cause harm.
Is there anything you would like to add that hasn't been asked?	**Intersectionality**	"...not have such a singular lens of race, because there are so many other marginalized identities inside of race itself…until a black trans person can come in and get the same care that a white cis-hetero person can, then we still have work to do."