IG09: Achieving Equity in Health Care & Health Professions Education: Diversity and Beyond (Perfected Transcript)

George Lister: My name is George Lister and I'm the Chair of the interest group. This year, as you can see from the session title, we selected a critically important topic that is highly aligned with one of the themes of this year's annual meeting.

Before starting the presentations, I'd like to acknowledge other members of our program committee and thank each of them. Pam Davis, Dean America of Case Western Reserve; Vinnie Aurora, Dean for Medical Education at the University of Chicago and Catherine Lucy, Vice Dean for Education at UCSF. They provided rich ideas, hard work in planning and continued work today in running this symposium, as you will see.

Before I turn to Catherine Lucy to chair the session, I'd like to call your attention to the fact that we have biographies for each of the speakers. At the moment they're not as readily accessible, as I thought and you'll be able to write me at George.Lister@yale.edu if you are unable to get them; but we're not going to spend much time introducing this august group of educators, but rather use our time well to hear their ideas. With that in mind I'm going to turn the podium over to Catherine Lucy.

Catherine Lucey: Thank you, George, as Dr. Dzau just described our compounding health crises of the pandemic, epidemics of non-communicable disease, and the ongoing conditions of racism, poverty, climate change and more has energized to create truly unacceptable and unfathomable levels of morbidity and mortality.

What this pandemic has illustrated most clearly is that not all communities have equal opportunity to live healthy lives, benefit from the best health care, or enter into our storied professions.

To fulfill our obligation to improve the health of all people in all communities, regardless of their power, privilege, or political and economic voice, the health care professions and their educational systems must take deliberate steps to eliminate disparities in healthcare and in the educational systems that lead to that healthcare.

This work begins with diversifying all levels of our profession from learners to faculty and practitioners, but must continue with a thoughtfully engineered approach to eliminating the consequences of and the current manifestations of structural oppression that still exist in our systems. We must embark on this work without delay, and with the same sense of urgency that we used to redesign systems on the fly to respond to the pandemic. Our patients and our communities deserve no less.

In this interest group entitled Achieving Equity and Health Care and Health Professions, Education, Diversity and Beyond, we are truly fortunate to have four distinguished colleagues to share their expertise with us.

Leading off this interest group is Roberta Waite, Professor and Associate Dean for Community Centered Health Care and Wellness and Academic Integration and Executive Director of the Drexel University College of Nursing and Health Professions and Health Professions.

Dr. Waite will speak on supporting care providers from minority groups perspectives from nursing. Thank you.

Roberta Waite: Good afternoon, everyone, it is an honor to share some views on this important topic of health equity and health care, education and supporting clinicians this brief presentation will highlight some key factors for us all to reflect upon.

So really to get us started, we really need to turn the tide to achieve health equity and this is an imperative and it requires that we recognize, assess and eradicate social and structural systems that create injustice in the first place.

This illustration here nicely highlights a mapping of some key factors that we need to be cognizant of if we're desiring to eradicate health and equity and Professor Yearby, Co-founder and Executive Director of the Institute of Healing and Justice and equity at St Louis University has clearly illustrated leading factors impeding health equity in this diagram and structural discrimination, such as racism is the leading root cause of health inequities.

Laws are tools used to create these inequities and these laws are used to structure systems and discriminatory waves fundamentally legitimizing existing social structures, such as education, which is influenced by our tax structure and housing with rent mining and this influences outcomes of health and well-being for individuals, families, and communities.

And as we reflect, a leading champion and health equity, Dr Cooper, led with this quote and I wanted to include it here, and she says “To begin to achieve equity and care delivery institutional and interpersonal racism, including implicit bias, have to be addressed. And every aspect of healthcare and this included includes health professions, education and nursing and medicine and numerous other fields and intentionally threading work and fundamental areas is needed to advance this health equity work.”

And when we reflect on health professions’ education, knowing that students form their professional identities and internalize professional ethics and behaviors during their training, a health equity focus is requisite so that students can advance their critical consciousness and understand their role related to issues of social power and dominant social norms. Gaining knowledge and awareness about anti-racism, bias training and social and structural determinants of health is important. However, application of these principles by individuals, students, professionals, and organizational policies is necessary to create change; because essentially being informed, is not enough. Action is mandatory; and for nursing, specifically, this has been highlighted earlier this year, particularly with the release of the Future of Nursing Report 2020 – 2030 charting a path to achieve health equity and this report outlines key issues and goals for the profession of nursing over the next decade, with a central focus on reducing health care inequities and improving health outcomes.

And comparable to many clinicians such as in medicine, and many other fields, nursing, a key nursing tenant is to do no harm yet it's pervasive in our profession, but typically when we're looking at racism and organizations that we lead.

So we know that even with good intentions, nursing and medicine, are not immune to perpetuating oppressive practices, so we actually have an obligation to dismantle racism based on our social justice and ethical efforts.

And being intentional and doing this is going to be important, particularly being intentional with sustained actions will enable nurses to drive social and racial justice and equity in healthcare.

This means moving beyond diversity to critically interrogate our individual ideologies, our social structures, understanding power, and, specifically understanding how power works, to secure forms of domination that actually sustain health inequities that we experience.

In examining the healthcare workforce this role in advancing health equity, it's important to operationalize domains highlighted in this figure, specifically with measurement. It is also critical that we better understand the impact of different policies and programs on health equity through each of these six interconnected domains, which are the six darker circles that are in the middle.

And we want to advance these areas, for example, a diverse composition of healthcare workforce, the social mission of health professions' education, provider distribution according to population of need, and several other factors that are located within these dark circles.

So, when we think about supporting, let's just say a diverse composition of healthcare workforce in the future of nursing, Dr. Has Miller has been steadfast recognizing an increased need for diversity in the nursing workforce, the profession of nursing is predominantly white and female, and about 90% of nursing leaders in the US are white. So support is essential to foster inclusion and belonging and not token representation which really highlights key aspects on this specific slide.

When advancing health equity work, the need for self-care is paramount, specifically collective self-care, and we all know this particularly with many of the issues that we've been encountering with the pandemic over the past two years, it truly has been amplified over the past two years, particularly with historically excluded groups.

And this slide lays out some suggestions to reflect upon when we think about enhancing self-care, and I would dare to say that what we really need is radical self-care. Radical self-care is key, especially when individuals and populations endure the most unimaginable forms of violence and are required to engage in contexts that may be stressful, oppressive, and debilitating.

As Angela Davis shared, anyone who was interested in making a change in the world today also has to learn how to take care of herself/himself or their selves. And myself as a nurse I've been challenged in this way and making sure that I'm practicing self-care. We must remind ourselves that the norm, of being extremely busy which many of us are given the work that we do it's not a badge of honor.

Then when we've been pushed too far, exhaustion is not a sign of excellence, so promoting self-care, being introspective, reflective dynamic and restorative that is going to be key for us to be able to accomplish what we want to do in the space of advancing health equity.

And even specifically when supporting racially black and brown conditions, we have to be very mindful of promoting mental wellness and well-being.

We also have to acknowledge and promote strategies to tackle racial trauma, as well as racial battle fatigue; as clinicians we encounter these things directly personally.

And we also encounter these things indirectly when we're working with patients and communities, so vicarious trauma from others. So, these things have to be looked at and they have to be assessed and addressed as well. These are elements that I would say that all of us need to consider when strategizing self-care. For many of us, we give ourselves, you know we give ourselves consistently and we carry many others' burden. As people and professionals in healthcare, we must learn to abide by the directions that we've all heard on airlines. And that is give ourselves the oxygen mask first, before giving the oxygen masks to others, if we want to survive. So, learning to care for oneself must be deemed to be so important that it assumes a radical nature. It is a priority to nourish our minds, our bodies, our spirit, as well as our soul, through the investigation of self-care strategies that meet our own individual and unique needs. And, as I mentioned earlier, some of these are highlighted here; but truly intentionalize your plan by scheduling your self-care activities into your day.

We all have calendars and we have to make sure that we put these things in their personalized your self-care by selecting strategies and routines that will benefit you. So, it's not a one size fits all; so rather reflecting and saying what are those things that I really enjoy what will help me nourish my soul, nourish my spirit. Those are the things that we have to attend to, and then I also have several other examples here,

But I will say the takeaway from this short presentation is to truly be strategic and unapologetic with implementing self-care practices, because we must do that if we really want to achieve and work towards health equity and give of ourselves in the way that we can.

So, I thank you for your attention; these are some references that you can use to gain more information, and I also have my contact information here for further questions.

Thank you so much.

Catherine Lucey: Thank you, Dr. Waite for an amazing way to lead off this section.

Next is Dr. Anita Blanchard, Professor of Obstetrics and Gynecology. Dr. Blanchard is the associate Dean for Graduate Medical Education at the University of Chicago Pritzker School of Medicine and Dr. Blanchard will speak today on institutional success unique to graduate medical education. Welcome, Dr. Blanchard.

Anita Blanchard: Thank you so much.

I always find that first few minutes of a presentation to be the most terrifying, so I am just going to try to share my slides with you now. All right, thank you so much, and I want to just thank the committee for allowing me to participate in this panel.

I have practiced at University of Chicago for my entire medical career and I'm currently the Associate Dean for Graduate Medical Education. In this capacity I've always tried to reflect on what it means to be

a citizen of this community, a learner, a healthcare provider, and even a patient, as someone who has had five children at this institution.

When I grew up actually on the South side of Chicago, I actually spent my first educational years right here in the city. I live only about 10 minutes from the University of Chicago which is located in a predominantly black community.

But with all the time that I've spent in Chicago I was not prepared as a first gen medical student for the sense of otherness. I felt like an outsider when I stepped on the campus; there were only eight black medical students out of 400 total and even less Latinx students.

Most other students were from families of privilege, I only had three black professors in the first two clinical years; I wondered if I could fit in and succeed.

Now, as we know, this really has created and emphasized the importance of diversity and the importance of well-being not only is this something that's emphasized here at the University of Chicago but it's infinitely emphasized nationally at ACGME.

When I reflect back on the years that I spent here in Medical School, I really thank Dr James Bowman, who was my first mentor, sponsor, and even therapist for my success here at the institution. And I think through all these years, all the lessons that I learned from him have really helped me in emphasizing and implementing a program here at University of Chicago.

So, I'm going to tell you a little bit about my journey; I'm going to tell you a little bit about the things that we have found that have been successful and the road that we still have to travel in creating more success in health equity diversity and inclusion.

So why does GME matter? Well, one in seven residents, one seven of our residents are fellows.

We have over 1000 students and residents and fellows at University of Chicago and, according to our own exit study we graduate 330 residents each year, 55 who stay in Chicago, but less than 20% that remain on the South side of Chicago where there are deficits of providers, too many food shortages, and poor patient outcomes.

The life expectancy estimates for people on the South side of Chicago in some neighborhoods are a full 30 years less than neighbors just eight miles north in the city. Despite this disparity, we have the least concentration of physicians practicing on the South side.

Through our partnerships, we have achieved about 27% under-represented in medical school and about 14% in GME at University of Chicago, but we are still working on further improvements, including more residents, a more diverse faculty and more providers who stay in the area to practice.

So, we have developed strategies for success and some of these are pretty basic. First, we asked an important question. And when I started, four years ago, as DIO, one was simple, I asked about the demographics of our residents and fellows to find that we didn't necessarily accurately measure them. So, the first thing I learned and the first thing we did on our journey together is to measure what matters.

With leaders across the institution, we develop strategies at every level to educate and to change the culture. We also were intentional in our efforts, including creating a nurturing environment, making sure

that students, residents, learners, and healthcare providers felt welcomed and valued. Collecting, analyzing, and sharing, our data and then using this data to drive continuous improvement to affect health equity, diversity, and inclusion.

We also partnered with existing teams throughout the university to build a structural competency curriculum that was longitudinal. Each department now has to build a diversity plan and chairs are accountable for progress; we also have leaders, based in GME focused in health equity, diversity, and inclusion and we work in four main areas infrastructure, people, climate, and community.

And Roberta did a wonderful job talking about the importance of self-care and, of course, that is a priority of ours. But we also found that was really important to give our residents and fellows the tools they need to be successful, especially in a pandemic, where our residents and fellows are on the front lines of activity working up to 80 hours per week. So, we really reevaluated our resident resources, making sure that they had adequate resilience training. Making sure that we're attending to their functional and basic needs, communicating and connecting with our residents and capitalizing on continuing resources in the institution.

This is just one example of our fifth annual Resilience Week that we have every year and we have over 600 residents, fellows, faculty, and staff participate. We try to focus on practical things that will really give our residents tools for change and it's a way of opening the door to evaluate more resources. We also are creating a nurturing climate, we have an inclusion menu, which gives tools for implicit bias training that people recognize micro-aggressions we have resource groups, and we have pathway programs, we also host. We have a house staff diversity committee, as well as meals and care packages for our residents.

Also, with the pandemic, the continuing story of health inequities were accentuated, so we wanted to give our residents and fellows the opportunity to say it's okay to say I'm not okay. So, we have looked at combining resources, creating both small space and large slice opportunities to have difficult discussions, including our Reflect, Respond, Reset series.

We also are not just focusing on programs, but are using data to drive results and here's just one example of information we have gotten from our applications are matching our ranking to help our programs work toward more diversity of their residents and, as you can see, we have had some success and our last match, we had an increase in underrepresented in medicine from 14% to 24% in just one year.

The efforts that we use were both institutional and at a program level, including institutional showcases, social media, efforts to feature our House staff diversity committee, highlighting all the efforts that we've had, and subsidizing visiting rotations for medical students, again programs use implicit bias training for teams, holistic reviews of applications, and including a diverse presence in the interview process.

I'm also proud to say that during the pandemic we launched an important program as well, Community Champions. We are building networks in our community and we actually have partnered with the urban health initiative, which is our hospital engagement enterprise. Residents are now actively participating in education initiatives from radio shows to community grand rounds and vaccine clinics.

The urban health initiative provides the infrastructure for these engagement opportunities.

And by connecting residents and sending them to work in the community with leaders they got to know people in the community, they see their neighbors as more than just patients with diagnoses but people with real-world challenges like poor transportation, lack of jobs, and adequate housing and other determinants of health.

We also hope to connect residents with the newly funded South side transformation project a multi-million-dollar government investment in providing better healthcare access on the South side of Chicago.

We also are partnering with other teams at University of Chicago, including our clinical excellence team led by Steven Weber, our CMO and our new Medical School Dean, Dr Vinnie Aurora, by using an equity lens to help us assess all of the many efforts to ensure the health equity is central to the goals strategies and tactics.

So, finally, I think I have just briefly gone over how we've developed a comprehensive strategy with many allies.

And ultimately, we hope to continue moving forward in the GME space, creating continuing opportunities with that lesson that I learned from the beginning of creating a sense of belonging, for all of our residents, fellows, students, faculty, and staff. Thank you so much for your time.

Catherine Lucey: Thank you, Dr Blanchard and congratulations on your success in this work.

Our next speaker is Dr. Karen Hauer, the Associate Dean for Competency Assessment and Professional Standards and Professor of Medicine at the University of California, San Francisco. Dr. Hauer, will speak on equity and assessment better for learning and better for patient care, thank you, Dr. Hauer.

Karen Hauer: Thank you for including me today; I'm already learning a lot from the fantastic presentations we've heard. While there is great enthusiasm to recruit diverse trainees into medical schools and residencies, however, there remains a troubling gap between recruitment successes as we've heard and the physician workforce that we need. It is our obligation not only to bring in more diversity, but also to ensure that all trainees will become physicians prepared to provide the care that our patients and populations need.

Of course, there are many causes and contributors to shortcomings and efforts to diversify the health professions. I will focus on the important problem of inequity in assessment of our learners which shapes their career options. I will argue that diversity in medical school and residency without equity and assessment will not achieve our goals. I'll outline three components of equity and assessment and conclude with strategies to promote equity.

Increasing diversity among healthcare providers improves patient care access and quality. Patient/ physician race ethnicity concordance improves care measures, as shown on this slide.

And yet disturbing health disparities persist. Minoritized race, ethnic populations suffer higher rates of infant mortality, chronic illness, and premature death; so even with access to health care, patients may find it difficult to find a physician who shares their background.

The medical professions' efforts to diversify its own workforce have shown some progress. However, though, the overall population of students has become more diverse these gains are not shared equally among groups and progress has been slow. The AAMC of the Association of American Medical Colleges Diversity Report from 2019 shows the data here. We still see a small percentage of black students applying, being accepted to, and graduating from Medical School. Similarly, for Latinx populations. About half the level of their representation in the population as a whole.

Among practicing physicians, particularly academic faculty, we fall even shorter of our goals with about two-thirds of those populations being white physicians, and under 4% black, under 3% Latinx.

Some say we just need to be patient and wait until today's medical students enter their careers, but examination of assessment data suggests that our current approaches may be holding us back from our minoritized learners becoming part of the physician workforce.

Inequity in assessment starts early in medical education. For example, data published from Yale University by Boatwright and colleagues shows racial disparities among applicants to residency programs across specialties at Yale University with applicants who were black or Asian being less likely to AOA on their residency application and important honor society membership, even after controlling for their step scores and other extracurricular accomplishments.

Studies of grades earned in Medical School clerkships at three universities have been published: UCSF, University of Washington, and Washington University in St Louis, all showed that across departments students from minority backgrounds were less likely to earn top clerkship grades.

We took a deep dive into these data at UCSF, prompted by one of our medical students who said that it looked to him, like the students selected for AOA were more white and less diverse than the class as a whole and, indeed, he was right. Over a four-year period, our students from backgrounds underrepresented in medicine earned clerkship summary evaluation scores a 10th of a point lower across departments than their non-minority counterparts.

This very tiny difference in assessed performance lead minoritized students to be half as likely to earn clerkships and a third as likely to be selected for AOA.

We call this the amplification cascade in which small differences in assessed performance led to large differences in outcomes that drive one's opportunity to match into a competitive residency or a chief faculty status someday.

We use the quality improvement approach shown by the fish bone diagram here to understand this differential attainment of desired outcomes. We found that many factors drive a student's likelihood of earning a top clerkship grade and only some of those factors relate to the student many relate to who they work with or the setting in which they work. The important point here is that the factors shown in dark blue are additional factors that disproportionately affect minoritized learners, things like stereotype threat, unconscious bias among the people with whom they work.

To achieve equity and assessment, we need to think broadly. Equity entails intrinsic, contextual, and instrumental aspects of assessment.

I'll walk you through those intrinsic refers to the way that we conduct our assessment.

Many of us with physician or scientific backgrounds, want to believe that numbers are objective, precise psychometrically rigorous; however, I've already shown you the flaws in that thinking around assessment of learner performance.

When we look at narrative data about our learners, we also see troubling findings. In this study of almost 90,000 written evaluations of medical students at Brown University and UCSF, investigators looked at word choice differences to describe learners from backgrounds underrepresented in medicine or not. In the upper right of the slide, you see words use differentially to describe learners under-represented in medicine, who earned honors- integral, higher, native. We might call this faint praise.

In the upper left words use differentially to describe non-minoritized learners who earned honors or more- superlative, exceptional, outstanding, stellar.

These findings echo literature on Letters of recommendation across industries women and minorities individuals tend to be described more with faint praise words and based on their personality or effort.

In contrast, men and non-minoritized individuals tend to be described with more superlatives and comments about their knowledge, competence and leadership ability.

I'll move now to discuss contextual aspects of equity and assessment this aspect refers to the learning opportunities and the learning environment. To be assessed well, you must be given the opportunity to perform well. Attendings and residents may give students, for example, different patients to see different opportunities to perform procedures or present in front of attendings. Without the right learning opportunities, a learner cannot show their best and be assessed at their best.

Instrumental aspects of equity and assessment refers to the way that we use assessment information to make decisions, this is an important area where inequity arises. For example, a clerkship exam score or a licensing exam score is based on an exam designed to ensure minimal competence in medical knowledge. When we use that score to select someone to earn a top grade or be included in a residency program, that's an instrumental use of a score for a purpose that it was not designed to be used for.

These uses often promote inequity tracing back to long-standing, structural problems in our educational system. To address these problems with inequity and assessment, we must be ready for transformative change a change in our culture in the medical environment.

The medical culture has long viewed itself as a meritocracy; we know well that a meritocracy view promotes inequity. Many faculty believe that, although they understand the occurrence of implicit bias, that they uniquely can identify the best and the brightest. This is a trap that often leads people to identify and support people who remind them of themselves.

We must shift toward a growth mindset for our learners and for ourselves. A learning environment in which the students shown and read in the upper right of this slide is motivated to identify their learning gaps and move to the next rung of the ladder of success, rather than focusing on how they can beat out their peers on either side.

A definition of equity and assessment from a recent Macy Foundation conference captures our goals.

“Equity and assessment are present, when all learners have fair and impartial opportunities to learn be coached and receive feedback be assessed and graded, be advanced and graduated and be selected for subsequent training and job opportunities.”

With that vision in mind, I'll conclude with recommendations. As you've already heard today from Dr Blanchard, it's critically important to examine your own data to identify inequities that may be hidden and unrecognized.

Think of assessment as a system and make sure that you design assessments to fit you to fit your purpose, including the important purpose of diversifying the physician workforce and expect that the system will require continuous improvement.

Attend to the context of learning by recruiting and training faculty. Align leadership, from the very top of the institution to the frontline teachers, in the equity vision and attend to the learning environment educate faculty and residents, how to respond to micro-aggressions knowing that they will occur.

And lastly, regarding instrumental uses of assessment, be part of the culture change, for example, the recent change in step one scoring to pass/fail. View that as an opportunity to look for new ways to implement holistic selection processes in the UME to GME transition and be part of the change by participating in discussions like todays to achieve the physician workforce our patients need.

Thank you.

Catherine Lucey: Thank you, Dr. Hauer.

And now to provide some final comments for our before we open it up to question our final speaker is Dr. Valerie Montgomery-Rice.

She needs no introduction, but I will say that she is the President and CEO of Morehouse School of Medicine and has decades of experience working towards equity in health care and health professions, education, thank you for joining us Dr. Rice.

Valerie Montgomery Rice: Thank you for having me, and I hope you can hear me.

So, thank you to my colleagues for such wonderful presentations; the presentations were just outstanding and I am going to try to capture a little bit of what they said and what I heard you all with that we must recognize, assess and eradicate social systems that lead to have inequities, that we should use data to inform our plans and our decisions.

That we should create an equitable learning environment that values both the learner and the teacher that we have to have objectives assessments to fit our purposes.

That we must support our black and brown providers, but we also must promote self-care of all of our providers, and then we have to understand our why- why are we doing this work.

So, when I think about this, you all, and this is becoming, I guess my life's work to make sure that we create a pipeline and a pathway, if we think about it, everybody claims to already be doing this, right; they have mentor programs and pipeline initiatives they're spreading the word.

They have experiential learning opportunities or research opportunities for underrepresented minority students, they have scientific enrichment programs and programs that are exposing students to health-related careers, but we're not seeing the change that we expect. So, what do we need to do differently?

And I would say let's be aspirational. Now, if anyone knows me my aspirations are always a pretty practical: you got to be able to see it, to believe it, and then to get it done. And so, let's go where the money is; if I was going to rob a bank I would do it because that's where the money.

If I needed the money, I would go to the place where the money, yes, and so I'm going to harp on something that's always been a challenge for me and that's the black male challenge. I'm just going to use this as an example.

Many of you all have seen this because I've talked about it so many times - the number of black male matriculants in medical school and I think in 2019 we are somewhere around 600 out of 1626 black male and female matriculants; but that's out of the 21,863 matriculants, and we know that this is a pipeline.

We know it is a pipeline issue and we know that we're focused on in the medical education profession in this area that's in the circle, but you can see, is systemic; it goes through out the lifespan of an individual.

We know ourselves what are our gatekeepers, it is the MCAT and it is the GPA, because we continue to still use those and I, say we use those instruments, those scores, for what they were not purposed for. They were not necessarily purposed to tell us whether or not somebody was going to be a great doctor or whether they can really actually be successful. Because they were meant to show some minimum competency so we've talked about what has to be done, as we now think about going to pass fail. But we also, as Anita says, we got to use data, guys, and I'm going to look at this from the perspective, let me go back here of this minimum score that we've been tracking and what happens with black applicants to Medical School. We know they tend to score lower than their white or Asian counterparts; now there's a whole bunch of systemic reasons for that.

And, by the time a student gets to an MCAT, you can't necessarily correct for all of the systemic challenges that may have influenced their performance; but we also can demonstrate that we can shift those curves; we know, we do it every day at Morehouse Medicine.

We looked at the scores, you all, when they were two-digit scores in 2011 and looked at our mean MCAT score and then we looked at what was happening in 2018, about a score between for 490 and 505. And we found that there was a significant number of students who were African American who were not getting into medical school with those scores, even though we had shown that they can be successful.

We then went back and looked at all of our data over a period of time and we looked at the scores of those students and we looked at their pass rates for the Step One, and you can see that even with students and we took a chance on, there weren't many, 490-493 early on, we had 100% pass rate for those students and you can see that none of these get down below, 94% of every one of these students

pass it on the second pass. So, we know that you can shift the curve, based on the learning environment that you create.

We also, we were to go back and look at national data, this is the national data from the impact validity study. And it is looking at GPA and MCAT scores and looking at pass rates on Step One and the blue shading is 90 to 100% the green shading is 80 to 89% and you can see that you can have students to still be successful in these lower scores, this is national data, you are so we have been allowing the MCAT in the GPA to be more than what they were intended. They should guide us in a holistic way as we look at students and their potential to be great healthcare professionals and great healthcare providers.

And then, if we look at students as individuals, we can help create a learning environment and a learning plan that can cause them to be successful; many of us have done it over and over again.

So, if we look at the acceptance rate of underrepresented minorities, particularly that are the black male, we know that they have a lower success rate of getting into Medical School compared to others. And so, we asked some basic question what would happen in a given period of time if we had the success, we just had equal acceptance rate of black students to that are white students. First of all, that would translate to 586 more under-represented minorities of which 162 would be African American and 84 will be African American males.

We also say what would happen if we accepted more students at MCAT scores between 495 and 505 because we've demonstrated that they can be successful. That would translate, you all, to 1000 more African American matriculants and approximately 340 more African American males over a period of time. So, one bold solution is that we have 155 LCME-accredited medical schools. If each of them just increased their US-born black male enrollment that would really result in 310 additional black male matriculants. If the top 20 producers of medical schools, would it increase their US black male matriculants, the results would be 100 to 200 more US-born black male matriculants.

Now you're going to say, well, how do we do this; here's a practical solution not rocket science. We've got 105 HBCUs undergraduate schools. 15 years ago, the applicant pool who came to Medical School were black, 24% of them came from HBCUs, if we just went back to that 24% right, we could get 200 more matriculants per year.

But we can even do better than that, guys, if we look at the fact that in 2002 28% of all black applicants to the Medical School came from an HBCU and that 28% only accounted for 3% of all of the degrees awarded at HBCUs; 40% of students at HBCUs start out as some type of STEM major. And 60% of our 40% STEM majors are interested in healthcare so, the opportunity is two-fold, increase the number of black students who maintain the interest in STEM and help to reduce and you could lead to an increase in the number of black males and we've modeled it out.

So, in 2017 there were 220 7000 students enrolled in HBCUs and 4000 of them were black males 40% of these students were STEM majors that would project that about 33,600 black male STEM majors.

If you do the 60%, 20,000 of them thought they wanted a health career; what we just increase the retention of those students in the undergraduate experience to stay as a STEM major.

This is what the opportunity looks like over time you start to increase the number of students who would potentially be able to apply to Medical School or get a PhD and get a PA degree or get a nursing degree.

Now, what do we have to do as academic leaders? If we know that those students may be coming let's prepare, let's partner with the HBCUs let's help them with improving the curriculum, helping them to address the misalignment of GPA with the MCAT, what is it that we are missing, how can we identify the major gap that impact academic success.

Many of us believe it is the counsel that students are given. Let's look at what's happening with the MCAT and ask why are they not prepared to do as well on the MCAT. Is there something that is in the curriculum that needs to be strengthened and can we support those providers; and, yes, we need to improve the counseling.

An equitable learning and very, very clear and when we talk about an equitable learning environment, what I heard our speakers saying, it's not about giving everybody, the same thing.

It's about looking at the needs of those individuals, based on what they bring to the table to have them to reach their maximum potential. Health equity is about giving people what they need when they need it; they need to reach their optimal level of health and equitable learning environment is looking at our learners as individuals and asking what is it that this learner needs, based on their circumstances in order to reach their maximum potential.

Anita talked about it, first of all, they have to have a sense of belonging, they have to feel that they are wanted and that we want them to be there and that we see them as an individual and that we were able to address our unconscious biases that influence our ability to welcome them in a holistic way.

We cannot, as well want to talk about not really be cognizant of the fact that we have social inequities, a social system that has led to health inequities and that much of the challenge falls on black and brown clinicians and educators in these environments where we're expected to do all and to be all for those students. So, we have to affirm and acknowledge that racial trauma exists and how it impacts on mental health and wellness.

We have to recognize that we as black and brown providers are fatigued. Imagine how many of us feel right now doing this pandemic; imagine how many talks I have given on vaccine hesitancy in multiple settings; imagine how many talks I have given on social inequities and racial injustice.

Imagine how many times you have heard me talk about the lack of black males in medicine.

There is fatigue here. We also have this ethical responsibility to promote self-care and we've shown himself who would benefit from this achievement of health equity; we all will. It is important that you know that and, finally, I say change will not come if we wait for some other person or some other time, we are the ones we've been waiting for, we have to change that we see.

Catherine Lucey: Thank you to Dr. Montgomery Rice.

Dr. Aurora and Dr. Davis, are there questions for our panelists?

Dr. Aurora: Catherine, and on behalf of the planning Committee, I just wanted to also provide my immense thank you to all of the panelists for this *tour de force* on the topic at hand, which is moving health professions' education beyond diversity. I have the luxury of asking the first question, which will go to all of the panelists and sort of strikes a theme that I heard which was really around the racial trauma and micro-aggressions in our environment and I know this is a very hot topic.

I know that we have many leaders, also on the line from a variety of academic institutions, and so what strategies do you suggest, when the climate of the community to be served is not aligned with a climate that you have wish to foster as you increase diversity, equity, and inclusion of the health professionals you're training. Maybe we can go ahead and start in order with Roberta first.

Roberta: That's a great question. I think many of the communities now, particularly I think about academia, and I'm also in a health center are challenged in orally and verbally in talking about wanting to create that change. I believe now it's about applying strategies and being consistent. And really aligning values with policies and expectations for carrying it out. So, it's new and I will probably say first, people have to learn because you can't change what you don't know. And you can't see what the mind doesn't know. So much of what we've been talking about as it relates to racial justice, structural competency, many in schools have not been taught about that; these are terms and content that's come after we've gotten out of school and many people have a choice or a desire or they're called to learn more about this because it's aligned with their values and the populations that they care about. So, there's a lot of education that needs to take place among professionals.

We have to become literate and then we also have to become vulnerable in understanding where are our biases; where do we need to grow and how do we incorporate that into us as a nurse citizen, a physician citizen, whoever we are there's a lot of growth that has that has to take place, as well as applying these principles.

Anita Blanchard: Yes, I completely agree with where Roberta has said, but I also think that marginalized communities are tired of waiting. Some of the health care disparities that we're talking about have been written about over 100 years ago by W.E.B. DuBois, but I think what we really need is a call to action and really, we need to speak with results.

And I think that's why we focused on showing data, because in some instances, these issues are not even being measured, so we don't even have good metrics for success.

So, I feel like this isn't an incredible moment and an opportunity, but let's not waste it let's make sure that the end we actually have some achieved goals that everyone can agree on.

Karen Hauer: We have looked at the experience of micro-aggressions for our residents and student learners and also for our faculty and found that one area that people benefit from training around is talking about the anticipation of micro-aggressions before they happen, so at the start of a time working together hearing from the learner. What would provide you with support with allyship, what can I do, how can I respond in a way that would help you. I think that the training for faculty combined with a

discussion with students and residents has been helpful. We certainly don't want to put the burden of managing this problem on our learners. And yet we have found that many of our learners are willing to speak up for another learner and say, you know, can we stop and talk about what I just heard so, really, creating a team environment where everyone on the team, regardless of perceptions about hierarchy, can speak up and invite discussion is important. And then, lastly, I'll say it's super hard, just as the other speakers have said, to manage these situations, so faculty need more than just a one-time training, they need a lot of ongoing practice with this.

Valerie Montgomery Rice: So again, it has to be a priority for the institution. I happen to be in one of the four historically black medical colleges and people think that we don't have the challenges, yes, we do. We just named our first Chief Diversity and Inclusion Officer who is reporting to me, as the President and CEO, because we might have a lot of diversity but we have inclusion challenges, all the time. We have equity issues we have to worry about age discrimination, about gender challenges and LGBTQ issues. And so, it's real and it has to be conversations that are met at the top, and then we have to hold people accountable.

And Anita talked about this holding people accountable to results and, yes guys, sometimes that means, you have to set targets. You have to set goals that are real true numbers and you have to have people to reach those goals and when they do not, you have to re-examine what did we miss in supporting you to get there. But there needs to be clarity with our chairs and needs to be clarity with our center director institute directors, that you need to come there with some numbers about how many students that we enroll, how many students that we matriculate, and how many residents we are selecting and if we rank them. I love the fact that Anita talked about looking at the rank and, if we rank them and they didn't choose us then that gives us another viewpoint, right, to say okay, what is it about our environment- we're ranking starting to represent minorities, but they're not choosing us; maybe they are seeing something that you are not aware of. And so, holding people accountable to direct goals is really important. I know people get uncomfortable with this term, quota, well I don't know what else you can do that you're not going to say we're going to set a target.

We need evidence because we believe that gets us to an environment where people feel safer or they feel more included or they feel more seen or valued, because they have other persons that look like them. We see that with patient outcomes and so we know that this matters, and so we got to get ourselves comfortable with holding people accountable to the deliverance.

Pamela Davis: They were very informative answers. I have a question directed mostly at Dr. Hauer, but I'd be interested if others would chime in. Dr. Hauer, you've clearly thought about equity in evaluation of learners and I would imagine that you've implemented some of the those the changes in that direction, what has been the impact of that on the students and also on the faculty.

Karen Hauer: Thank you for that question, we have made changes to how we do assessment. I think the most visible and we talk about change is that, after years of trying to improve students' perceptions of grading and the core clerkships, we were prompted by our equity data to stop using grades in the core

clerkships. Equity was an important driver, along with fundamental issues of fairness and fairness incorporates equity, also the impact on learning and well-being for our students; and you've heard a lot about well-being today.

All of those measures, improved with eliminating core clerkship grades our students asked, and we agreed that we don't just eliminate grades and start stop looking at data they said, you know, what if we're just now hiding differences in assessed performance, so we still look at the exam scores, at the supervisor scores for all students. We shifted our focus toward assessment for learning with a greater focus on feedback direct observation of students and our recent data shows that performance in our fourth year required sub-internship does not show any equity differences. So, we interpret that to mean that if you give everyone a learning year where they can receive feedback, discuss it with a coach, and incorporate that feedback, that everyone can come up to speed, even if some may have had greater advantages at the very start of those core clerkships.

Pamela Davis: Would anyone else, like to address that. No, okay, thank you.

Dr. Aurora: I'll take the next question from the chat and thank you to Carlos del Rios for asking this question, which actually was a great theme among many of the presentations and was touched upon in our first question and answer and was about the use of data and how we need to use data to drive change and, particularly if people could dive in deep a little bit into the metrics and what metrics you are using either at your institution or that you recommend that health professions and educators use at their institution, and perhaps we can start with Valerie and then Anita given some of the some of the comments around data there.

Valerie Montgomery Rice: So, I definitely would be very interested in seeing what Anita and Karen say about this, because they are really still on the ground.

Thinking about how do we link these metrics to our ideal outcomes, and so one of the things that I will say that I am hopeful that we, and I see us move into this or having the students to have experiences as care providers and care recipients and then for them to help us craft the metrics that they think that they should be judged against which aligns with being an outstanding provider. Really, meeting the patients, where they are so one of the things that we are.

So, one of the things we are trying to shape more of at Morehouse School of Medicine is beyond just cultural competence you all, but this social awareness. This really is social conscious, a consciousness of understanding how the environment really does influence the patient in the immediacy of what's happening with them and, then, how do we help them to think about what's going to happen longer term. And so that would be my answer to that and I think there are some ways to develop metrics, but we should have the learner involved with understanding what those metrics mean and how we are looking at them in alignment with the type of provider that we hope that they want to become.

Anita Blanchard: Yes, I'm reading the chat from Carlos del Rios and it's rare that I see someone in the chat and find that I've fallen in love with them, because everything he's saying is right on, righteous brother.

So, I agree we should focus; I'm not saying we should get rid of US News and World Report, but let's change the ranking; let's incorporate things like the environment, climate. Look at metrics not just reporting the under-represented in medicine, but using that as part of the hierarchy of what we use for change. And what we've been doing in GME, is we are looking at where we are losing other residents to and why. We also are looking at best practices; so, though it takes some to get some, right, looking at best practices in those programs that have under-represented in medicine and what are they doing differently, and, frankly, making sure that there is a presence.

I think being a black woman DIO has been incredibly instrumental in helping us increase diversity from 14% to 24% in one year. So, we're using every tool at our disposal. And, just so you know, our next step is looking at what happens to our residents, when we graduate them and how many of them stay on at the University of Chicago. What is the demographic and, if they leave asking important questions of why.

Karen Hauer: And that comment from Carlos del Rios that clearly touched a nerve for all of us, I think, points out the fact that the metrics that you use matter and the recent Forbes ratings about colleges that put UC Berkeley at the top ahead of elite private institutions, I think, was derived from using Pell Grant recipient data as a marker of success, so I think it's critically important that we think about this question and think about what metrics that we use beyond the easy ones, like step scores.

It's important to think that the way that you use the data fits your purpose and just like Valerie was saying, we need to know that people will pass step one but we don't need to necessarily put forward as our measure of success, how many people got a high score however we define that.

So, I think that the metrics that need to be used require us to think more broadly and creatively about what data we have available or what data, we need to collect so different ways of demonstrating that a student has learned what they need to learn in a clerkship beyond just a grade. So, it may be more work, but we have found that when you explain to people why you're doing this work they're willing to come forward and participate, making sure you're not putting a tax on some people over others.

In looking at the learning environment we collect data on this treatment and it requires a lot of work with students around their fear of retaliation if they report something so providing multiple mechanisms and ensuring that they have trusting relationships with someone that they're willing to talk to, and giving them flexibility about the timing of when they report something, like before or after they've been graded have all been critically important nuances that make a big difference. We recently had a discussion that if we know students are reporting this treatment that probably means your system is broken; and that's a lovely ideal to think there would be no micro-aggressions and no mistreatment, but that's probably not possible and you want a system in which students have enough trust to report.

And then I would advocate as well, for attending to qualitative data, you know, to really understand the why or the how about something that is happening in your numerical data. You need to talk to people,

so having structured ways of surveying people or doing focus groups or interviews is important to really understand the numerical data that you're collecting.

Roberta Waite: I would just add from a nursing perspective, I think that the environmental component is really, really important, because we have a lot of students who come in to nursing but the retention is not there. I definitely think the environmental climate perspective is key; we've done some climate surveys, but it's also acting on that information that you get. And one of the things that I found to be very useful are listening sessions that have been started with groups at all different roles, at all different levels. And so, I think, those are important and how we act on that data into integrating and creating change is really impactful, but they need to be done, consistently as well.

Valerie Montgomery Rice: I'd like to comment on this US News and World Report because all the years that I was a dean we've talked about this so many times, Pam knows, and we have tried several times; and essentially, we have just let US News and World Report hijack us, right and they are making their profit off of the fact that they can get some of our students to submit this information and students and others still use it.

The only way that we will ever get to not allow this to be the case is that we would not report, and there are some of us who do not report. So, we have not at Morehouse School of Medicine submitted anything in the last 10 years and, as long as I am president, we will not. Because no matter, even if we changed whatever they grade you on, even if we try to increase our patient volume, increased our MCAT scores, etc., whatever, we would never move up to whatever their ranking is because this is a biased assessment. And so, I think, that we just need to identify other means by which we can engage our future learners. And then get them to understand what we want to grade them on to use as metrics to advance their career paths and, so hopefully, we can have many more outlets to engage with them beyond US News and World Report.

Pamela Davis: And I would point out that our colleagues, the dentists, started out refusing to contribute to US News and World Report and they are not ranked so there is some precedent for that, but I think it only works and what we found at the at the Council of Deans and it only works if a majority of the schools participate and the dentists were united in solidarity and were able to accomplish that.

But I'm interested in another question from the chat, we know that there's a huge and Valerie you talked about this there's a huge minority tax on our minority colleagues in academia and what are your suggestions for avoiding that because it's so precious to add these exemplars for our minority students and it's very comforting for our students to see people that look like them in what are considered successful roles. Roberta, you talked about retention I think it's critically to retain people, and there is very leaky pipeline in academia, especially for women, and how do you how do you think we ought to approach that for faculty of color.

Valerie Montgomery Rice: Well, I will tell you that you have to have great mentorship and sponsorship, I was tenured as an associate professor in the department of ObGYN at the University of Kansas, and that was because I had a mentor, who was a white male, Paul Terra Nova, who protected me.

Essentially, he worked with my chair, he worked with others and said OKAY early phase of her career she can only be on one committee institutional committee, this is what she has to do in the lab and so he wrote out a prescription right and we had a contract, and we stuck to it, and so you got to have good sponsorship and mentorship of people who understand what it takes to for people to be promoted and advance.

And you have to create an environment where others understand that you are protecting an advance in this person's career. And a lot of time our underrepresented minority faculty don't have that when they are majority environments. But it's bi-directional; they also have to recognize that that type of sponsorship and mentorship may not come from someone looks like you. And that does not mean it's going to be less than, in fact, it broadens your exposure and understanding; we have to tell our minority faculty at these majority institutions to be open to who actually cares and sees the potential in you. And then Pam, when we're in these leadership roles we have to have some guidelines that also require that we protect our junior faculty, our women faculty. We have to think about we've been very restrictive in, you know, how many years you have to be on this track, and if you fall off, then you really fall off. Well really? I mean does that really align with the environment that we're trying to create to continue to have advancement and people's learning in their ability to contribute, so I think that we have to look at some of our policies and procedures that are really forcing the issue of what it means for people to show excellence across all of our missions that allows them to be promoted and say does that need to be revisited.

Roberta Waite: And I would actually agree, I had something in my slides about the minority tax, and I agree, exactly with what Valerie is saying. And I would add to that if you don't get it in your institution get it from other support and professional organizations, where you can get that sponsorship and support in different ways, so that you can learn how to navigate and set boundaries. I would also say what Valerie said is important because we need to have other allies and accomplices to sponsor us, to really step out and support us, so that we can be successful because that does not always take place. It's an anomaly but when it does take place, it can be very powerful; because, again, it broadens your network, it encourages relationships with individuals who may not have had contact with but we also need to have more of a collective support network, and so we need to have, you know, some of our senior members who may be white really taken on that sponsorship role and be dedicated and authentic in that space as well.

Anita Blanchard: I would agree with those comments, but I would say that allyship is incredibly important and I've certainly had many leaders, mentors outside of the institution, who are not under-represented. But I think that until we get a critical mass, there's going to be a bit of a minority tax that we all have to accept, and I think that's part of our burden and part of what we owe to generations before us; but the key thing is make that value toward promotion, reduce the clinical load if this is part of it, and make it on par with research goals and accomplishments so that the tax can also pay toward

promotion. And I think that's another way of thinking about it differently, because until we get a critical mass, you're always going to be asked to do a bit more.

Karen Hauer: I would echo those comments. At UCSF there is a diversity statement as part of our promotions packet and recently criteria were developed to say, well, what actually should be in that or what is it promotions committee really going to be looking for so that the work that people are doing that may put them at risk of minority tax is actually expected and rewarded in that process, not just extra or on the side. And I think as well if people are spending a lot of time in service toward the equity mission that they should be funded and supportive to do that, so I would credit Catherine Lucy with being a great advocate for creating new leadership positions for junior and mid-level minority faculty so that the contributions that they're making are things that they actually have time to do, alongside their clinical work.

Dr. Aurora: Okay, thank you for that really robust discussion and it's hard to believe that half an hour has already passed by so quickly, and I do know that several of our speakers have some pressing engagements over the course of the day, and so I do want to, on behalf of the Committee again thank everybody here for really just a wonderful foray into this topic and really challenging us, as well as the those who provided questions in the chat for challenging us to do a much better job. I think your words definitely resonate that this is something that has been.

People have been talking about institutions, but why haven't we seen a difference and so a year from now, when we convene, I would challenge, all of us on this call to understand and reflect on what are we going to do differently so that a year from now, when we come together as an interest group we can take this call to action back to our institutions and say that we are doing something better for improving health equity, diversity, and inclusion and so with that I'm going to turn it back over to George and see if there's any last comments that we need to make before we adjourn.

George Lister: So just a few comments, first let me also express my incredible gratitude to the speakers. I thought the comments were penetrating, personal, passionate, and practical, and, did set high bar for all of us; and I agree with Vinnie, we need to come back in a year or less to see where we stand and where we've made progress and also realize, not everybody needs to do the same thing at every institution. Every institution becomes its own experiment as long as we actually look at the data, rather than have it fit some preconceived notions.

Thank you.