STFM DEIA Curriculum Toolkit Implementation Guide

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OVERVIEW

This toolkit is intended to serve as a resource for medical educators and learners aiming to newly implement or update existing curricula to include Diversity, Equity, Inclusion, Anti-Racism, and Accessibility (DEIA) clinical topics and perspectives. This work needs to be owned by all working in medical education, not just a single impassioned champion, or people of color. Accordingly, our target audience are faculty (including clinical, behavioral health, ethics, pharmacy, social work, etc), students, and residents, as well as any staff who contribute to medical education. Though created from the lens of family medicine residencies, the resources provided in this toolkit should be helpful for those who are looking to incorporate or update DEIA curricula for Undergraduate Medical Education (UME) and other specialty residency training programs. This toolkit provides a diverse range of topics and resources, of which programs can choose to implement or adapt part or all into their curricula.

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"Simply put, racism is the root cause of inequity, not race. Yet, methods of teaching and practicing medicine have not kept pace with this truth, and many learners and practitioners continue to extrapolate a biological underpinning for race." Edgoose, et al, 2022

Overview, Rationale and Structure of the Toolkit

Racial health disparities in the US health system contribute to shorter life spans, higher burden of chronic disease, poorer health outcomes and a general mistrust of healthcare by people and communities of color. This impact also applies to women, gender minorities, people with disabilities, and other marginalized populations. The American College of Graduate Medical Education (ACGME) mandates that residencies work to mitigate these injustices. To reverse historical and current disparities, medical education must address Diversity, Equity, Inclusion, Anti-Racism, and Accessibility (DEIA) in multiple ways. Some opportunities include: creating diverse faculty, leadership, and learner pipeline programs; developing proactive recruitment of and systems of support for underrepresented groups; ensuring safe spaces for learners, patients, colleagues, and staff of diverse backgrounds; and adapting the content of what we teach to reflect the needs of diverse groups. **This toolkit focuses on supporting medical schools and residencies to adapt their clinical curricula to be more diverse, equitable and inclusive by providing clinically relevant learning objectives, resources, activities, and reflection points.** Though this toolkit was designed from the lens of family medicine residency programs, the breadth of family medicine education makes it generally applicable to many specialties and educational settings.

This toolkit has been developed by a team of family medicine physicians and behavioral health faculty, learners, and a medical librarian, from across the United States who are actively engaged in DEIA work in medical education. It provides a framework and guide as well as a smorgasbord of learning objectives, materials, resources, and activities that faculty can use to integrate DEIA principles into all facets of the curricula for residency programs.

Intended audience

This toolkit is intended to serve as a resource for medical educators aiming to newly implement or update existing curricula to include DEIA topics and perspectives. This work needs to be owned by all working in medical education, not just a single impassioned champion, or people of color. Accordingly, our target audiences are faculty (including clinical, behavioral health, ethics, etc), students, and residents, as well as any staff that contribute to medical education. Though created from the lens of family medicine residency, the resources provided in this toolkit should be helpful for those who are

looking to incorporate or update DEIA curricula for Undergraduate Medical Education (UME) and other specialty residency training programs.

This resource can be used as a companion to the excellent Starfield II: Health Equity Summit toolkit (see Resources section for link) which provides a big picture of health equity and medical education. We also recommend the excellent STFM Teaching about Racism Toolkit which introduces the basic concepts of the impact of racism on health. Both of these toolkits provide definitions of basic concepts ffwe will not repeat. This toolkit is not about policy and public health concepts of the impacts of DEIA on health, rather it is about creating a curriculum for the clinical application of those concepts.

A Key Ingredient

One of our faculty members was once told by their supervisor that their program was "not ready" to teach about anti-racism, LGBTQIA+ care, disability medicine, or physician advocacy because it was a new program and teaching DEIA is "like icing on the cake and our cake isn't completely baked yet." We believe that the devastating impact of racism, homophobia and other "isms" on health makes these topics so important they are key ingredients of the complex cake that is the practice of medicine.

We advocate for a longitudinal approach to integrating DEIA topics into medical education curricula instead of relying on occasional lectures or workshops. We believe interweaving DEIA concepts into clinical education is key as it promotes the hidden curriculum that DEIA impacts all aspects of clinical medicine. This toolkit provides educators and learners with a framework and resources to integrate DEIA learning goals, objectives and activities into the curricula of all rotations in family medicine residency.

Hidden Curriculum

The framework of hidden curriculum suggests what is not explicitly taught can be as important as what is explicitly taught. Though the concept has been utilized in other fields of education since the 1960s, the concept was applied to medical education by Hafferty and Franks in the mid 1990s. It was originally applied to teaching ethics in medicine, but has since been applied to the learning environment with many other subsets of topics related both to clinical teaching, student experience, and student speciality choices. We would argue confining learning about DEIA topics to workshops or occasional lectures promotes the message that these topics are not central to medicine. Such a view would be comparable to limiting the discussion of hypertension to a few lectures/year and not teaching about it in clinic, cardiology, inpatient medicine etc., even though the decrease in life expectancy for African Americans based solely on race is similar to the decrease of life expectancy for a White person when they have a diagnosis of hypertension. We posit rather than confining DEIA education to one lecture per year or just a community medicine rotation, that education about these topics be present wherever they are relevant to patient care including outpatient medicine, inpatient medicine, obstetrics, pediatrics, etc.

We have inherited an educational system created on the foundations of our nation's racist colonialist past. If every system is perfectly designed to get the results it receives, then we are part of a system that was designed (sometimes consciously, sometimes unconsciously) to create poorer outcomes for large

segments of our society. Though it is a complex problem with many changes needed, changing the content of what we teach is an important step towards the outcomes we want to have.

We acknowledge just changing the content of curriculum will not be enough to eradicate racism, sexism, ableism, ageism, homophobia, and other biases from medical education. To meet the goal of health equity, we will need institutional change at every level. This includes, but is not limited to, resource allocation, clinical experiences, leadership priorities, diversity in learners and teachers, and climate of safety, etc. For example, Gaufberg et al studied narrative reflections of third year medical students and revealed "power hierarchy issues and patient dehumanization" on the wards as key sources of hidden curriculum. This toolkit focuses on creating a formal curriculum to address health disparities and we hope to see future toolkits address institutional organization, culture, and other key factors of disparities in medical education.

Goals for and Structure of this toolkit

Our group surveyed the members of the Association of Family Medicine Residency Directors (AMFRD) listserv as part of a needs assessment for this project. Time and expertise were most frequently listed as the major obstacles implementing curricular change. **This toolkit aims to simplify this process by providing an abundance of premade materials that can easily be plugged into existing curricula. The toolkit is not meant to be adopted *en masse*, but rather to be a smorgasbord of resources that programs can pick and choose from to meet their needs to either create new curricula or update existing materials.**

It would be impossible to cover every way in which inequities impact health, but we attempted to provide resources that could be incorporated across medical disciplines and settings to reflect the needs of many communities. The toolkit is designed to give programs the opportunity to address DEIA principles in all of the major areas in medical education. It is broken into four major clinical areas: outpatient adult medicine, inpatient adult medicine, pediatrics, and OB/GYN. Each major area is broken into relevant themes. For each theme, there are multiple objectives to choose from. Many concepts overlap in different curricular areas. The resources can be adapted for use in different rotations. Each objective is written using Bloom's taxonomy in a SMART format. They are linked to relevant resources and contain possible points for reflection. The resources are multi-modal with a mix of online modules, video and audio materials, medical journals, sections from books, blogs, magazines, TED talks, news articles, and patient narratives. For example: Here is an objective that programs could integrate into an inpatient medicine rotation:

Theme:	Possible Rotations	Objectives	Resources	Reflection points
Ableism	ICU; inpatient medicine PGY1, PGY2, PGY3; ER; General Surgery	Define ableism and describe how this can result in health disparities for people with disabilities	• Background reading: Three Things Clinicians Should Know About Disability | Journal of Ethics | American Medical Association (ama-assn.org) • Patient story (listen or read): https://www.npr.org/2020/07/31/896882268/one-mans-covid-19-death-raises-the-worst-fears-of-many-people-with-disabilities) • Personal reflection exercise: brief-abled-privilege-checklist-mar-2016.pdf	• Whose decision should it be to withdraw life sustaining therapy from patients with disabilities? • During your inpatient rotations, take note of the language used to describe patients with disabilities. Does it differ from that used to describe others?

We hope this toolkit will mitigate the barriers of time and desired expertise so all programs can easily **adapt their curricula to teach themselves and their learners how to begin to reverse historical health inequities.**

DEIA Curriculum Project Background–Development of the Toolkit

This project started with the Minority/Multicultural Health Collaborative of the Society of Teachers of Family Medicine. Participants were recruited from the STFM listserv and in person at topic of interest meetings at our national conferences. Thus, all participants have worked in family medicine education

roles. Participants represent all regions of the United States of America and a couple of participants are from Canada. Participant roles include family medicine physicians, behavioral health faculty, medical librarian, residents and medical students. Participants represent both Undergraduate Medical Educators and Graduate Medical Educators. There were approximately forty participants, though the level of engagement varied. Our group is diverse, representing many races, cultures, religions, gender identities, ages, and ability status. The team met monthly via Zoom beginning in the fall of 2021.

We began with conversations regarding perceived gaps in clinical education about DEIA clinical topics. We conducted a literature review to better understand what is currently being taught. We then submitted a survey to the Association of Family Medicine Residency Directors (AFMRD) listserv to better understand the current teaching climate.

Using this needs assessment as a foundation, we developed the curriculum writing skills of our participants with a series of workshops on curriculum design led by experienced faculty. These workshops leaned heavily on the book Curriculum Development for Medical Education: a Six Step Approach, by Kern, et.al. We created a template for the tables and a format for each objective to be created with SMART goals, using Bloom's taxonomy, linked to resources and reflection points. Resources were intentionally diverse to engage the interest of our Gen Z learners and to step outside the walls of our academic institutions to learn from the world at large.. Participants were encouraged to critically assess and use high quality materials from scholarly articles from PubMed, but also Institute of Medicine white papers, the MedEd Portal, the CDC website, websites and materials from non-profits, TED talks, podcasts, online modules, YouTube videos (from reputable sources,) the TRIP database, books, magazines, the news and more.

We divided the content matter into four main categories (Inpatient Adult Medicine, Outpatient Adult Medicine, Pediatrics, and OB/GYN) and divided the content into subgroups, who developed the materials. These subgroups met regularly. When this work was completed, teams were switched and asked to critically review the materials. This work was presented at the STFM Annual Spring Conference and feedback was incorporated.

Though we attempted to be comprehensive in clinical topics covered, the field of medicine is vast and there are many important areas that have not yet been included. We encourage readers to expand and create their own curricula to meet the needs of their specific programs, communities, and patient populations using this approach. If you have ideas for objectives that were not covered, please send them to monica.demasi@providence.org because this document will be updated periodically.

Tips for Implementation

The Role of DEIA Faculty Champions

Change is hard. Sustaining change is even harder. In many ways changing your medical education program requires the same models of change we might use with a patient who wants to improve their health. We assess readiness for change and use SMART goals to break up change into achievable steps.

One finding from our needs assessment was programs that already had more DEIA topics in their curricula also had a "Diversity Champion." For meaningful outcomes, the Diversity Champion cannot simply be someone interested in DEIA topics working on their own time. This person must have **protected** time. Good intentions are a good place to start, but effective change requires someone (or ideally multiple stakeholders) with ownership of the issue. We must acknowledge the pervasive "minority tax" that exists, where DEIA work is led and carried out by champions from minority identity groups who do not have enough time or support to do this work. It is important for all medical educators to improve DEIA education, especially those of us from majority identity groups who are not necessarily called upon to do this work due to privileges afforded by our identities. Even better than a single champion is a team or committee that has regular meetings, clear goals, and regularly collects data. Please see the section "Implementation examples" to see how one family medicine residency used their DEIA committee to structure curricular and programmatic engagement with DEIA.

For the educator

DEIA topics are complex and can be challenging to discuss. You do not have to be a content expert in health disparities to have meaningful conversations with your colleagues and learners. Taking on the challenge of committing to a lifelong journey of exploring and learning about DEIA is a first step to implementing them in your program. As an educator, you are in an optimal position to model using an **equity lens** to your role as a professional in a medical setting. Lectures can be helpful opportunities for learners to gain knowledge about how social inequities impact patient care. However, we believe engaging with these topics during inpatient rounds and while precepting outpatient clinics may be the most meaningful way to teach our learners how to reverse historic inequities to support diverse patients. In doing so, you will be sending a message to your residents that these topics are clinically relevant factors that they need to include into their conceptualizations and treatment plans of their patients.

We encourage you to be flexible in your implementation of the toolkit, and to emphasize a sense of curiosity and exploration when discussing these topics. Importantly, implementing DEIA curricula in any program is challenging, and there are likely going to be moments of disappointment or frustration during this process. Each time you bring up DEIA topics in lectures or during patient care scenarios you are "planting a seed" of DEIA topic consciousness in your residents. There is a tremendous amount of value in this process. Below are some suggestions to keep in mind when using this toolkit:

1. **Explore your own self**: A great starting point before using this toolkit is to take a moment to self-assess your thoughts and feelings about DEIA topics. Questions you can ask yourself may include:
    a. What are some facets of my identity (e.g. gender, race, age, body type, family structure, personal beliefs) which will be important to be mindful of when discussing DEIA topics?
    b. Are there topics I feel more or less comfortable discussing, and why is that the case?
    c. When attempting to teach medical students and residents, how can I use communication strengths to discuss DEIA topics?

   d. What is my comfort level with disclosing my feelings and thoughts about these topics, and what are some areas I want to keep private vs. being more open to discussing with residents and medical students?
   e. We all carry subconscious biases: consider taking an implicit bias test to better understand yours: https://implicit.harvard.edu/implicit/

2. **Know your program**: Each program in medical education falls somewhere on the spectrum of DEIA curriculum implementation, from DEIA being a point of emphasis in each rotation throughout training to no discussion of DEIA topics at any point during training. Explore the history of your program with implementing a DEIA curriculum. It may be helpful to talk to graduates of your program, current learners, staff, patients, and faculty to understand their thoughts and feelings about DEIA topics. What have they found helpful vs. unhelpful in the past? This kind of exploration may highlight existing strengths of DEIA curriculum in your program and areas for improvement. **Consider doing baseline surveys of learners and or faculty as a needs assessment so you can track the effectiveness of your interventions.**

3. **Evaluate your program:** The AFMRD's Diversity and Health Equity Task Force proposed DEI Competency Milestones in February 2021 (below) which could be used to evaluate where on the spectrum of implementation your program lies. You will find descriptors of curricular elements corresponding to various levels of competency goals. Consider engaging multiple raters and compare their perspectives. Recognizing where your program lies along this continuum may serve to demonstrate relevance, instill motivation and inform change efforts. (For information on additional DEI Competency Milestones regarding Institutions, Personnel, Program Evaluation and Evaluation Process, see the Reference section.)

Diversity, Equity, and Inclusion Competency Milestones

Developed by the Association of Family Medicine Residency Directors' Diversity and Health Equity Task Force
February 2021

AFMRD

Curriculum				
Level 1	Level 2	Level 3	Level 4	Level 5
Images and cases portray individuals of varied gender, sexual orientation, age, ethnicity, skin color Standardize use of judgment free terminology (e.g. transgender vs transsexual, intellectual disability vs mental retardation") Include lectures on social determinants of health, community medicine. Identifies that DEI are an important component of patient care	Use inclusive language across all curricula Avoid use of value-laden terminology Training in unconscious bias and role in clinical decision making Identifies that DEI are an important component of family medicine education Knowledge of system to report bias and microaggressions Addresses social determinants of health	Addressing issues of bias involved in race as a risk factor Discuss systemic racism in medicine Active participation in discrimination reporting process Integration of non-clinical staff in DEI education	Utilization of Anti-racism and anti-oppression curriculum Address use of race-based clinical algorithms	Curricula in inclusion, antiracism, structural oppression is integrated longitudinally throughout the entire curriculum Develop content/serve as a model for health system related to DEI Engage community partners to develop curricular content
☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Comments:				
			Not Yet Completed Level 1 ☐	

4. *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9017255/

5. **Create an environment of curiosity and empathy:** Whether you are giving a lecture or discussing DEIA topics during inpatient rounds, remember to ask open ended questions which lend themselves to having open and constructive conversations. It can be helpful to model a sense of vulnerability related to these topics (e.g. recognizing biases that you have identified within yourself that you feel comfortable disclosing), and also identify when you may have said something that is insensitive or dismissing of others thoughts and feelings. Creating a sense of vulnerability and openness to recognizing one's biases is fundamental to DEIA topic awareness and credibility. Open conversations with ground rules to help ensure that the group creates both a "safe space" where harm will not be caused to group members, but also a "brave space" where differing opinions can be voiced and challenging conversations can be had. The STFM Toolkit for Teaching about Racism provides a helpful list of group norms. During the conversation, validation of expressed feelings and reflecting back what participants disclose are valuable tools that can help create an environment of exploration and safety. There may be times when it is helpful for a facilitator to clarify statements from others, restate what was heard, or ask for input. However, it is often helpful to sit silently and wait for conversation to begin organically.

You should be a co-learner in this space as well. Be open to learning from your colleagues, learners, patients, and staff. If your program does not have DEIA expertise, consider gaining it through faculty development, outside trainers, speakers, or individual learning. See the section, "Getting Others on Board" on page 13 for suggestions on generating buy-in and collaboration from colleagues.

6. **Check in with yourself during challenging moments**: There will likely be uncomfortable moments during your attempt to use these tools such as confused looks, eye rolling from members of your audience, and long moments of silence which may only be a few seconds but feel like they are lasting hours. This is normal—remember to breathe and read the room/situation. If there is tension, roll with it. That being said, biased or false statements need to be addressed directly at the time they occur. Explore what may be causing the tension in a non judgemental manner. Also, while there does not have to be a "resolution" to a DEIA topic discussion, there is value in encouraging learners to think more about the topics you discussed, while making a commitment to potentially discuss the topic at a later time.

7. **Be a change agent**. As a champion for DEIA you want to influence others to change their practices. Use your motivational interviewing and change readiness skills. To change behavior, a person must believe it is important or meaningful to do so. If you are reading this implementation guide, you are likely already convinced of the importance of DEIA curriculum. Others may not be there yet; identifying what might drive them to see this as important is part of the champion's task. However, securing personal motivation alone is not enough. Understanding your organization and colleagues and having the necessary tools to succeed are key. Access to the curated DEIA content and this implementation guide are two tools meant to enhance your sense of personal ability and that of others. (Additional sources which can aid change efforts are social and structural. For more information on engaging these sources to sustain behavior change, we recommend the books Crucial Influence and Switch.)

8. **Recognize your power and privilege.** As a faculty member in medical education, it is essential to acknowledge the various ways in which you possess power over your learners, staff, junior colleagues, and the systems and institutions in which we work. We need to utilize our power appropriately by demonstrating respect and value for our trainees. Instead of exerting our power, we should strive to exercise our power alongside our colleagues and trainees. Those of us from majority groups need to proactively share power with those from minority groups and make active efforts to include them as key members in this process. If we witness bias and do not make efforts to change it, we make ourselves complicit in that bias.

9. **Remember culture change is often slower than we would like.** Do not be disheartened if your program isn't ready to integrate DEIA principles into all learning experiences. Incremental change is still moving in the right direction. Apply motivational interviewing and change readiness skills to your program in the same way you help move your patients towards positive changes. For example, if your program doesn't currently do any DEIA work, it might be helpful to use some of

these resources to begin with lectures or workshops. If they are thinking of change, but haven't made any steps, use some of these objectives in a rotation to get started. Start with one or two rotations. Learn from early adoptees what works well, what doesn't and adjust accordingly.

For the learner

Building your medical knowledge base and ability to create and execute treatment plans have likely been central to your medical training. Learning and honing your skills in these areas are fundamental components of your training as a clinician. Being able to incorporate DEIA topics into your work will deepen the quality of your medical care and is likely to improve the outcomes for your patients. For many years DEIA curriculum in medical education was nonexistent, token, or insufficient, yet recent national discussions on these topics highlight the need to make DEIA a central topic of discussion in the training of clinicians. This is best accomplished by having constructive discussions about DEIA topics in all components of your training including outpatient and inpatient clinical experiences. There is a lot of information to cover in a DEIA curriculum and the goal is not to learn every possible angle of this vast and growing literature. Instead, our hope is that continually addressing DEIA topics in your medical training can help you develop an awareness of the need to consider issues of DEIA in your work as a medical professional. Discussing and learning about DEIA topics can feel daunting. That is a normal part of this process. Below are some suggestions to help you begin to explore the tools from this toolkit:

1. Reflect on your thoughts about DEIA: Everyone will fall somewhere along a spectrum in terms of how much they think about DEIA topics in their lives. Take a moment to reflect on areas you would like to initially explore as you begin to review the DEIA toolkit. Are there topics which are particularly relevant to you given the geographical location you plan to practice in? What health disparities have impacted your own family, community, or patients? Perhaps there are biases you may have identified in your past training which can be good starting points for your DEIA topic exploration. Who are some people in your program that you feel most comfortable with initially discussing issues related to DEIA?

2. Roll with the discomfort: discussing DEIA topics can provoke discomfort, and people tend to avoid situations which arouse these feelings. Embracing these feelings while having constructive discussions with others and yourself about DEIA topics may be the most important part of a DEIA curriculum. You will likely become more comfortable with the anxiety of discussing issues of DEIA as you continuously review these topics in your training. Give yourself credit for using this toolkit when you can in your training and don't focus on the "outcome" of these discussions. Remember, the goal of a DEIA curriculum is to help medical students and residents embrace the importance of DEIA in their work, not to have you become an expert in DEIA. It is also possible you are already comfortable discussing DEIA issues and you are facing the **discomfort of others** as a barrier to change. You might fear unpleasant impacts on your work relationships or career if you engage in this work. Your faculty might not have learned about DEIA issues in their medical education. Some of your colleagues and faculty might not have experienced bias in their lives and might not recognize the impact of bias on health disparities. It might make them feel uncomfortable to confront DEIA issues. These are challenging issues which need to be acknowledged. Please see the sections below on getting others on board and about embracing your power to get started.

3. Embrace your inner teacher/mentor: One of the best ways to learn is to teach. Review a tool from the toolkit and bring it up during inpatient rounds with your peers. Take a moment to ask a medical school student rotating with you about their thoughts on an issue of DEIA with a patient they are seeing. These are just examples of ways you can begin to use your role as a teacher/mentor to help you incorporate DEIA training into your discussions with others at your training site.

4. Remember you have power: Learners might feel they do not have power to change their education; this is not true. You are the end consumers of medical education. Most educational organizations want to (or are mandated to) include your voice. Some ways you can share your voice:

- Volunteer for the curriculum committee and other important committees at your residency or medical school.
- Medical Students: Fill out evaluations for your courses or rotations and mention lack of DEIA curriculum.
- Residents: Fill out evaluations for your courses or rotations and mention lack of DEIA curriculum AND mention it on your annual program evaluation survey from the ACGME
- Meet with like-minded learners and come as a group to key faculty members. (For medical school it might be a dean or a course director, for residency it might be your program director or Designated Institutional Official.) Consider a letter signed by as many allies as you can find to demonstrate that this is of interest to a large percentage of learners.
- Document places in the curriculum where you see bias to share with your program to ask for change.
- Find faculty allies/champions to support and guide your work and to help move it forward after you graduate.

Getting others to participate

You may already have colleagues or institutional leaders you can identify as allies, but resistance and hesitation on the part of others is to be expected. This might be related to resource competition. It might also be due to different lived experiences, cultural values, and differing levels of privilege, awareness of privilege, fear of loss of privilege, or lack of recognition of the scope of the impact of bias on health outcomes. Whether you present your proposal to incorporate DEIA content to an individual or a group, give some thought to how you will approach the conversation.

As you are preparing yourself, consider these points:

1. Adopt a helpful frame of mind. You want to convey enthusiasm and positivity and start from the belief this is the first of many conversations which will ultimately lead to a successful outcome.
2. Find mutual purpose. You have your reasons for thinking DEIA education is vital, but those reasons may not seem as compelling to others. Stay open and curious, exploring their concerns and what they perceive as barriers or downsides. Acknowledge the concerns and together, try to brainstorm ways of addressing those. Often the concern is that change presents a threat to something which is also valuable. For example, demands on faculty

time or the challenge of creating space for new educational content. Acknowledging that shared concern doesn't stop the conversation. It starts the creative process, making space for change while minimizing any perceived negative impact.

3. Point out how implementation could address a need IMPORTANT to your audience or a particular individual. Addressing educational milestones? Equipping residents to identify and mitigate inequities in patient care? Meeting a specific community need in your area? Increasing program interest among applicants? Determine what matters to the individual and see if the implementation of the DEIA curriculum could be seen as a potential response to that need.
4. People naturally resist change because until you are on the other side of that change it is difficult to envision benefits you have yet to experience. The negativity bias is a cognitive bias which makes it easier for us to give more weight to negative possibilities than positives. It can help to remind people of an earlier time when change was resisted, and the end result turned out to be positive. Invite them to consider this experience may turn out the same way.
5. Enlist colleagues who are well-respected and/or in a leadership role. Their buy-in will likely influence others.
6. Colleagues may have different levels of interest in changing practices. Begin by enlisting those who are most enthusiastic.
7. Faculty and learners asking for change <u>together</u> is more powerful than either group alone.
8. Use the content in the toolkit. It contains a lot of data and narrative stories about disparate health outcomes and the impact of bias on medicine.

<u>Suggested Practical Applications</u>

This toolkit provides learning objectives, resources, and reflection points to integrate into your curriculum. Every medical school and residency has a unique curricular structure, thus different programs will use these materials differently. We recommend tracking the DEIA elements you intend on incorporating in a table such as the one suggested in the subsequent section. Some suggestions on ways to weave the materials into your program are listed in Table 1. Be sure to collect data on your process and outcomes.

Table 1. Strategies and Suggestions for Weaving DEIA into your Curriculum

Strategies	**Suggestions/Examples**
Add DEIA objectives to most rotations	● Choose materials from the toolkit to copy and paste directly into your written curricula
Have a separate community medicine or health equity rotation, elective, or week	● Learn about needs and resources for specific populations in your community—immigrant, unhoused,

	etc ● Have learners meet with social work, case management, community health workers, resources in your community, etc ● Teach about the role of physician advocacy ● Look at the impact of environmental health factors on your community and who they are impacting most ● Use your EMR to look at patient panel demographics ● Read your health system's Community Health Assessment
Plus one slides in all talks: *every talk given is expected to have at least one slide about DEIA topics related to issues.*	● Use resources in the toolkit on specific topics. ● Discuss race based calculators. ● Morbidity and Mortality conferences should consider equity issues that might have impacted outcomes. ● Consider how race, disability, gender, or other types of bias might impact relevant topics.
Regular workshops	● Teach basic concepts of micro and macro aggressions and implicit bias. ● Address how learners can report personal experiences of bias in your program. ● Teach about how to be an "upstander" instead of a bystander.
Consider creating an equity track	● Learners could choose a series of elective rotations with linked themes such as policy, advocacy, addictions, health disparities, planetary health, street medicine, etc..
Encourage quality improvement and scholarly projects on DEIA topics	Some examples: ● Resident project to collect or create clinical forms in different languages ● Learners use EMR to find patients most at risk for heat related illness. ● Projects focusing on improving quality metric goals such as cancer screenings or dental varnish for minority patients. ● Implement gender inclusive clinical intake forms.
Proactive teaching about equity topics in clinical precepting.	● Familiarize yourself with the concepts and data in the toolkit. ● Make it an expectation that relevant equity issues are presented for every patient.

<u>Documenting and Tracking your DEIA implementation</u>

As mentioned earlier, programs and faculty champions are free to adopt whatever curricular elements meet their needs. As you examine topics and begin to decide what, when and how to introduce these in your educational program, it will be helpful to outline a plan and track completion of the education for the academic year. One example of an implementation tracker is provided in Table 1. We recommend this be a shared document with other faculty who will likely be involved or impacted by the incorporation of new elements or educational requirements for medical students and residents on certain rotations. Ideally working together and coming to agreement regarding implementation of DEIA into your curriculum will help ensure your success.

Implementation Examples

A Family Medicine Program Ready for Change: Program A is a family medicine residency which has received feedback from some of its residents that DEIA topics are not being adequately addressed. Though there have been occasional didactic talks on implicit bias, there hasn't been a robust look at DEIA in the curriculum. The Curriculum Committee decided to take on integration of DEIA topics as one of their major projects for the academic year. Before getting started, they surveyed the residents on their satisfaction with DEIA in the curriculum and asked for suggestions. Using this toolkit, faculty were able to add objectives linked to readings/resources (by simply copying and pasting) to existing curricula for most of the rotations. They looked through the materials and picked resources that seemed most relevant, or just the easiest to get started. Using New Innovations to track if residents read the curriculum, they saw at least 50% of them opened the documents. This seemed unsatisfactory—though an improvement from no topics being covered. Faculty were asked to also read the objectives and more proactively discuss the topics listed in rounds and clinics as relevant to cases. This led to some rich conversations and increased faculty confidence in teaching DEIA topics in clinical settings. Over time, it became expected that DEIA impacts on patient care were regularly discussed. The curriculum committee did an annual survey and residents' satisfaction with DEIA topics being taught slowly increased. They tracked the number of objectives being taught. They changed the form for residents' evaluation of clinical rotations to add a question about safety of learning space and if DEIA topics were adequately addressed in patient care.

A Residency Program with Significant Obstacles: Program B is an established program in a racially diverse city that has not historically addressed DEIA topics at all. A few of the residents and faculty members have asked for changes, but received pushback from the department chair that "we need to focus on medical knowledge first" who felt uncomfortable with residents being "forced" to learn DEIA topics. Residents and faculty interested in DEIA topics collectively demanded change. They were granted permission to create a Health Equity Elective which they made with the materials in the DEIA curriculum and also referenced other toolkits such as the STFM teaching about Racism toolkit and the Starfield Summit toolkit.

A Program Using a DEIA Committee to organize change: The Providence Family Medicine residency Program in Portland OR, made progress by establishing a DEIA committee with residents and faculty champions that meets monthly. The committee led faculty and learner sessions on implicit bias. All other committees in the program were asked to come up with their own SMART goals for DEIA. The DEIA committee tracks this progress and offers ongoing support via bi-annual check-ins. In this way everyone is doing the work, but with support from faculty and resident champions. There is an annual survey of the residents tracking the impact of the work as well as tracking SMART goals. Here are some examples of what has come out of this work:

- The Recruitment Committee changed their scoring rubrics with an equity lens.
- The Medical Student Committee created a scholarship for out of town Underrepresented Minority students to be able to do Sub-internships.
- The Curriculum Committee started a new Community Medicine Rotation, and added safety of learning space to resident rotations of evaluations.
- The Inpatient Medicine Committee removed race-based calculators and had DEIA topics as required agenda items for their teaching sessions and meetings.
- The OB Committee changed rounds in a way that included the patients and team members more actively using the TeamSteps program.
- The Quality Committee added projects that addressed racial and LGBTQIA+ health disparities
- The Clinical Concerns Committee completed training on bias in evaluations and re-wrote their evaluation rubric to decrease bias.
- “Plus one” slides became an expectation for all noon reports, grand rounds, morbidity, and mortality, and case-based-learning sessions.
- Annual surveys were implemented assessing resident experience of micro and macro aggressions on each rotation and in the program overall. Residents are given the opportunity to rate the effectiveness of all DEIA interventions and make anonymous suggestions.

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Other toolkits:

- Starfield II: Health Equity Summit: http://www.starfieldsummit.com/starfield2
- STFM Toolkit for Teaching About Racism in the Context of Persistent Health and Healthcare Disparities: https://resourcelibrary.stfm.org/viewdocument/toolkit-for-teaching-about-racism-i