Addressing Institutional Racism in Healthcare: A Case Study

A Dissertation

SUBMITTED TO THE FACULTY OF THE

UNIVERSITY OF MINNESOTA

BY

Barbra S. Banks

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

Dr. Joshua Collins, Adviser

October 2020

ABSTRACT

The extent of health inequities plaguing our nation is well-documented, with Black Americans continuing to experience the largest gaps (U.S. Department of Health and Human Services, 2014). Healthcare organizations cannot achieve racial health equity until they are willing to address institutional racism. With the magnitude of health inequities, particularly racial inequities, healthcare organizations addressing institutional racism as a part of their health equity efforts becomes even more critical. This case study offers an in-depth description of a Midwestern urban hospital birth center's year-long equity education program, posing the question, "How does a large, urban hospital address institutional racism as a part of their health equity strategy?" Results show three outcomes of the department's intervention to address racial health inequity and institutional racism: 1) the central features of the intervention's framework and approach proved instrumental in individual development and change, 2) through double- and triple-loop learning, the department effectively addressed and began to dismantle institutional racism, and 3) the convergence of events leading to the intervention offered a "ripe" time for the creation, planning, and execution of the equity education program. Implications from this study contribute to healthcare, workplace diversity and inclusion, and human resource development scholarship and practice.

ACKNOWLEDGEMENTS

My doctoral experience and research were heavily influenced and supported by several people. To start, I want to thank Dr. Josh Collins for his support and guidance throughout this journey, and especially for calling me out and keeping me on track every time I would go too far into the weeds (which was often). He not only offered valuable mentoring but made it enjoyable along the way.

I also want to acknowledge Dr. Rachel Hardeman, my friend, mentor and superhero. From the moment we met, she has had faith in me, and the research I have wanted to do.

She helped me realize I do have something to contribute to both research and practice. Her dedication to achieving racial health equity for birthing people and their babies continues to be an inspiration to me.

Additionally, I owe special thanks to my work colleagues who were partners with me in this experience, and continually supported, pushed and stood by me as I followed my passion despite its challenges. Sidney, Rochelle, and Kari, I am grateful for your friendship and wisdom.

And lastly, I give immense appreciation to my parents, Carol and Warren, who were my rock during this journey, which really started decades ago. I owe everything to their truly unconditional love and acceptance of their weirdest child. Jumping from one shiny thing to the next, earning my doctorate is probably the only thing that I said I wanted to do as a young adult that I actually ended up accomplishing. But I have always known whatever I would do, or not do, would be supported by Mami and Papi.

DEDICATION

This work is dedicated to all those who have come before me, and will come after, fighting with deep commitment and passion to achieve racial justice.

Table of Contents

List of Tables viii

List of Figures ix

Chapter 1: Introduction 1

Background 1

Problem Statement 2

Purpose of Study 3

Research Question 3

Significance of the Study 3

Definitions of Key Terms 4

Chapter Summary 6

Chapter 2: Literature Review 7

Institutional Racism 7

Racial Healthcare Inequity 8

Antecedents of Racial Healthcare Inequity 8

Interventions for Racial Healthcare Inequity 11

Workplace Diversity and Inclusion 16

Evolution of Workplace D&I 17

D&I Trends and Issues 19

Human Resource Development 24

Training and Development 26

Organizational Development 29

Organizational Justice....32
Conceptual Framework....33
Chapter Summary....37
Chapter 3: Methodology....38
Research Design....38
Setting....39
Researcher Positionality....41
White Identity....42
Female Identity....44
Disability Identity....44
Researcher and Practitioner Identities....45
Participants....48
Data Collection....51
Interviews....51
Participant Observations....54
Document Analysis....56
Data Analysis and Trustworthiness....57
Integrity Measures....58
Chapter Summary....60
CHAPTER 4: FINDINGS....61
Pre-Intervention: Department Background & Context....62
The Department....62

The People 70

Participant Reflections on Pre-Intervention State of Department 70

Awareness and Understanding of Key Concepts 73

Hopes & Concerns 75

The Program 76

The Intervention: Experiences 86

Learning Session Experiences 87

Workteam Experiences 104

Participant Challenges 116

Post-Intervention: Impact and Outcomes 120

Department Outcomes 120

Workteam Two 124

Workteam Four 125

Participant Impact and Outcomes 128

Summary 145

Chapter 5: Discussion and Implications 146

Discussion 146

Conclusion 1 147

Conclusion 2 154

Conclusion 3 156

Implications 160

Future Research....168

Limitations....170

Conclusion....171

References....173

Appendix A....183

Appendix B....185

LIST OF TABLES

Table 1: Interview participants' demographics by race, gender, and role…….47

Table 2: Interview participants' workteam assignments by role……...48

Table 3: Interview participants pre-interview understanding of health equity and institutional racism……..……..71

Table 4: Overview of Intercultural Development Continuum ™……..79

Table 5: Overview of Learning Sessions……...96

Table 6: Interview participants' post-interview understanding of health equity and institutional research……123

LIST OF FIGURES

Figure 1 Overview of Interview and Intervention Participants……46

Chapter 1: Introduction

Background

The extent of health inequities plaguing our nation is well-documented, with Black Americans continuing to experience the largest gaps (U.S. Department of Health and Human Services, 2014). Compared to White Americans in the United States, Black Americans' health care experiences, treatments, and outcomes are widely disparate in a multitude of categories: lower cancer screening rates, poorer oral health, and higher rates of mortality, HIV/AIDS, chlamydia, stroke, and youth obesity (Minnesota Department of Health, 2014; U.S. Department of Health & Human Services, 2014; Wyatt, Laderman, Botwinick, Mate, & Whittington, 2016).

The state of maternal and child health shows even more staggering inequities. The United States is the most dangerous place to have a baby in the developed world. Every year an average of 700 mothers die, and 50,000 more are severely injured (Center for Disease Control, n.d.*a*). Experts believe nearly half of these deaths and injuries are avoidable (Center for Disease Control, n.d.*b*). Our healthcare system—more specifically our healthcare *organizations*—are failing our birthing people and babies. But not equally. Black birthing people and babies are disproportionately impacted, even when controlling for socio-economic status and education. Black infant mortality is more than twice greater than for White infants; maternal mortality is three to four times greater (Howell, et al., 2018). Racial health inequities are literally a life and death matter. Despite efforts to ameliorate such health inequities, progress remains stagnate. According to the Office of Disease Prevention and Health Promotion's Healthy People 2020 mid-course review,

Blacks had the worst progress on measured health objectives (National Center for Health Statistics, 2016).

Concurrently, organizations' diversity efforts remain a priority as demographics continue to shift and communities become increasingly diverse (Shifting demographics, 2007). Workplace diversity and inclusion (D&I) strategies are created to meet this need, and include recruitment, engagement, development, and retention efforts that emphasize the importance of an organization reflecting the community and building an inclusive environment where all employees are valued and leveraged for their contributions. These efforts align and contribute to equitable care strategies by increasing the representation, inclusion, and engagement of diverse employees (Hite & McDonald, 2010).

Problem Statement

Despite efforts to ameliorate such inequities, progress towards racial health equity remains stagnate. With the extent and quality of care as a critical social determinant of health, healthcare organizations play an integral role in acknowledging, addressing, and reducing racial health inequities. In fact, in the last decade, a surge of research has examined the role provider implicit bias plays in inequitable health experiences and outcomes (Burgess et al., 2015; FitzGerald & Hurst, 2017; Green et al., 2007; Hall et al., 2015; Oliver, Wells, Joy-Gaba, Hawkins, & Nosek, 2014; Penner et al., 2010; Sabin & Greenwald, 2012).

Conceptual discourse around institutional racism has been growing in public health, with a slower increase in Human Resource Development (HRD) (Acosta & Ackerman-Barger, 2017; Alfred & Chlup, 2010; Byrd, 2007; Gollust et al., 2018; Hall & Fields, 2013; Rocco, Bernier, & Bowman, 2014). However, there remains a gap in

empirical studies examining institutional racism in an organizational context in public health, D&I, and HRD literature and practice, all disciplines that are, ironically, well-positioned to address and support such organizational efforts. As such, there is a significant opportunity to examine how healthcare organizations are acknowledging, addressing, and trying to dismantle institutional racism as a part of their health equity efforts.

Purpose of Study

Healthcare organizations cannot achieve healthy outcomes for their patients until they are willing to address health inequity. Health equity cannot be achieved until institutional racism is addressed. With the extent of health inequities plaguing our nation, particularly *racial* health inequities, healthcare organizations addressing institutional racism becomes even more critical. The purpose of this study is to examine one hospital's efforts to reduce institutional racism as a part of their health equity efforts. More specifically, an in-depth exploration of a hospital birth center's equity education program will be studied.

Research Question

How does a large, urban hospital address institutional racism as a part of their health equity strategy?

Significance of the Study

The results of this study will contribute to the following: 1) public health and HRD scholarship, and 2) health equity, workplace D&I, and HRD practice. To start, this work will help fill a crucial gap by extending research and practice focused on institutional racism in an organizational context. Moreover, the results of this empirical

study will present a case on how a hospital's birth center acknowledges the staggering racial healthcare inequities in maternal and child health and intentionally attempts to address and dismantle institutional racism.

Additionally, this study will help advance current discourse around critical and radical HRD. Both frameworks offer a vital perspective that emphasize the need to examine power and privilege in the context of HRD research and practice. Where CHRD is considered as a separate "arm" of HRD, radical HRD places this criticality and social justice focus front and center, and inclusive of the entire discipline.

Finally, the results will inform health equity, workplace D&I, and HRD practice by providing key insights into a significant organizational change process that places at the center race, power, and systemic change. This case study serves as a valuable and unique opportunity to offer a real-world example that reveals this process, including the insights, successes, and challenges of the work.

Definitions of Key Terms

Birthing person is a term used in place of "mothers," "women," or "female," to refer to and recognize the diversity of gender identities that exist with individuals who are pregnant and give birth.

BIPOC refers to Black, Indigenous, and People of Color. This term replaces the previously used "people of color," and "highlights the unique relationship to whiteness that Indigenous and Black people have, which shapes the experiences of and relationship to white supremacy for all people of color within a U.S. context" (About Us, n.d.).

Black is the term used to describe BIPOC who identify as African American or Black U.S. Americans and is more inclusive by acknowledging a global community of people of African descent.

Diversity refers to "the differences, similarities, and related tensions and complexities that can characterize a collective mixture like the workforce. These similarities and differences can be demographic in nature (for example, race, gender, ethnicity, sexual orientation, and age), or they can represent behavioral variations (for example, thought, problem-solving approaches, or behavioral traits associated with personality)" (Thomas, 2011).

Health disparities are "population-based differences in health outcomes" (e.g., women have more breast cancer than men; Minnesota Department of Health, 2014, p.10).

Health equity is the opportunity for every person "to realize their health potential — the highest level of health possible for that person — without limits imposed by structural inequities" (Minnesota Department of Health, 2014, p. 11).

Health inequities are avoidable disparities in health between groups of people within countries and between countries; these "social and economic conditions, and their effects on people's lives, determine their risk of illness and the actions taken to prevent them becoming ill or treat illness when it occurs" (World Health Organization, n.d.).

Healthcare inequities are avoidable disparities in health attributed to inequitable, socially determined circumstances within the healthcare setting.

Inclusion is the practice of making people feel welcomed, valued, respected, and heard by colleagues and the organization (Brown, 2016).

Institutional racism is the "way in which institutional policies and practices create different outcomes for different racial groups" (Racial Equity Tools, n.d.).

Provider is the term used for all roles related to patient care (e.g. nurse, midwife, physician).

Social determinants of health are the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics (World Health Organization, n.d.).

Systemic racism is the "normalization of an array of dynamics — historical, cultural, institutional and interpersonal — that routinely advantage white people while producing cumulative and chronic adverse outcomes for people of color and American Indians" (Minnesota Department of Health, 2014, p. 6).

White is the term used to describe white (Caucasian) U.S. Americans.

Chapter Summary

This chapter provided an overview of the study, including the background, problem statement, research purpose, and research question. Additionally, significance of the study and definitions of the key terms were offered. The following chapter provides an in-depth overview of the literature on how several disciplines approach, or fail to approach, institutional racism.

Chapter 2: Literature Review

The literature review explores the extent to which three bodies of research and practice approach and address institutional racism. To start, a definition of institutional racism is explored, and contrasted with individual, personally-mediated racism. Thereafter, three bodies of work related to institutional racism are explored: 1) racial healthcare equity, 2) workplace D&I, and 3) HRD. Each section provides a review of relevant literature on how institutional racism is addressed, if at all. The chapter closes with an explanation of the study's conceptual framework.

Institutional Racism

Systemic racism remains an empirically overlooked factor in racial health inequities. Came and Griffith (2017) defined systemic racism as an "organized system, rooted in an ideology of inferiority that categorizes, ranks, and differentially allocates societal resources to human population groups" (p. 76). Systems include, but are not limited to, institutions such as government, legal, education, and healthcare.

One institution central to the discussion of institutional racism and racial health inequities is healthcare organizations. Jones (2000) defined institutional racism as "differential access to the goods, services, and opportunities of society by race" (p. 1212). She further stated institutional racism is "normative, sometimes legalized, and often manifests as inherited disadvantage, [and] codified in our institutions of custom, practice" (p.1212). Institutional racism differs from individual racism in its level of analysis; instead of conceptualized as attitudes, beliefs, and behaviors individuals hold and exhibit towards another, institutional racism is a set of policies, procedures, and practices an institution, such as a healthcare organization, has in place that implicitly or explicitly

advantages white U.S. Americans, and simultaneously disadvantages BIPOC. The pernicious nature of institutional racism is that intention is not required. In fact, many organizations would adamantly argue that they do not develop or enact racist policies; however, largely due to the historical nature and embeddedness of racism in the United States, these systems still exist and are supported, even if only implicitly, by those in power.

Racial Healthcare Inequity

The Minnesota Department of Health (2014) defined health equity as the opportunity for every person "to realize their health potential — the highest level of health possible for that person — without limits imposed by structural inequities" (p. 11). Thus, *racial* health equity exists when every person, regardless of race, can achieve the highest level of health possible, despite structural barriers. As one such structure, healthcare organizations have a significant role in ensuring racial health equity in its systems, policies, and provider care, referred to as racial health*care* equity. Healthcare organizations' examination of both individual and systemic antecedents of racial healthcare inequities is a critical first step in providing equitable care for all patients. (Minnesota Department of Health, 2014; Wyatt, Laderman, Botwinick, Mate, & Whittington, 2016).

Antecedents of Racial Healthcare Inequity

Research on antecedents of racial healthcare inequities focuses primarily on issues related to provider care, such as lack of access, undertreatment, incorrect referrals, and missed diagnoses (Hall & Fields, 2015). Moreover, notable studies have provided empirical evidence that white physicians' biases impact the type and degree of care

provided to diverse patients (Burke et al., 2015; Hagiwara, Dovidio, Eggly, & Penner, 2016; Lenton, Blair, & Hastie, 2006; Penner et al., 2010). While empirical studies are nearly obsolete, numerous conceptual papers discuss institutional and system factors impacting healthcare inequities.

Provider Racial Bias

Studies have not only shown the existence of implicit racial bias amongst healthcare providers (Burgess et al., 2015; Green et al., 2007; Hall et al., 2015; Oliver, Wells, Joy-Gaba, Hawkins, & Nosek, 2014; Penner et al., 2010), but also investigated the extent of harm caused by biased care (Green, Carney, Pallin, Ngo, Raymond, Iezzoni, & Banaji, 2007; Sabin & Greenwald, 2012; FitzGerald & Hurst, 2017). For example, in their study on the impact of implicit racial bias on physician decision-making, Green et al. (2007) found white physician bias was associated with being less likely to recommend Black patients' treatment for acute coronary syndromes. Sabin and colleagues (2008, 2012) found providers' implicit preference for white patients was associated with under-prescribing pain medications for Black patients, but not white patients. Furthermore, FitzGerald and Hurst's (2017) more recent systematic review of empirical studies published between 2003 and 2013 showed that all 25 correlational studies found an association between provider implicit bias and inequitable care.

Conversely, several studies have found no correlation between bias and provider behavior. For instance, even when implicit racial bias was present, it did not negatively affect provider decision-making (Dehon et al., 2017; Haider et al., 2015). In a systematic review of emergency department provider bias, only two of 42 studies found evidence of implicit racial bias impacting decision-making. However, most of these studies used

vignettes, and involved unambiguous and non-stressful settings. FitzGerald and Hurst (2017) argued that it is imperative to investigate implicit bias impact on behavior in real world settings that reflect the conditions and challenges providers face when interacting with patients.

Institutional Racism

As shown, scholars have extensively examined the impact of provider racial bias; however, several reasons exist that warrant the study of institutional racism as an antecedent to healthcare inequities, as well. First, healthcare is a complex system, and racism is a complex problem, thus a more complex analysis of factors is needed--more than just a look at personally-mediated racism can provide (Griffith, Childs, Eng, & Jeffries, 2007). Second, few empirical studies explore institutional racism in the context of healthcare organizations. Empirical research has focused on individual level factors, both from the patient and provider perspectives. Nearly all scholarly attention paid to institutional racism has been on the development, analysis, and critique of various theoretical and conceptual frameworks (Feagin & Bennefield, 2014; Griffith et al., 2007; Jones, 2000; Phelan & Link, 2015; Phillips, 2011). Little empirical examination exists regarding the influence of "cultural values, frameworks and meanings" on the shaping of organizational policies and practices (Griffith, Johnson, Ellis, & Schulz, 2010, p. 71).

With a recent surge of research and organizational approaches, systemic racism is being recognized within the healthcare community as a significant antecedent to health disparities (MDOH, 2014). Scholars across disciplines, including public health, medicine, and psychology, are urging more attention be paid to interventions that address systemic racism as a part of the focus on racial health inequities (Bailey, Krieger, Agénor, Graves,

Linos, & Bassett, 2017; Feagin & Bennefield, 2013; Ford & Airhihenbuwa, 2010; Griffith et al., 2007; Griffith et al., 2010; Jones, 2000; Phelan & Link, 2015). Thomas and colleagues' (2011) "fourth generation" of racial health inequities research demanded researchers move past "understanding data trends, factors driving inequities, and solutions" (p. 399), and toward a comprehensive approach that does not solely rely on individual factors to explain the persistent, pervasive racial health inequities the United States has been facing for centuries.

Interventions for Racial Healthcare Inequity

There is little variance in healthcare's efforts to address and reduce racial health inequities. Interventions mostly focus on individual change, including cultural competency, cultural humility, and implicit bias trainings, with very few focusing on organizational change or directly addressing institutional racism.

Provider Racial Bias Interventions

One key response to addressing racial health inequities has been to increase provider cultural competency, which has traditionally focused on providers' understanding of and sensitivity to different cultures (Truong, Paradies, & Priest, 2014). While conceptually there is value to increasing cultural competency, in practice, not only has there been mixed results as to the effectiveness in changing provider behavior and patient outcomes, there are significant concerns with focusing solely on individual awareness and change, particularly that which relies on cultural generalizations and patient stereotypes.

An alternative healthcare practice that has been leveraged to reduce provider bias is cultural humility. Cultural humility is a "lifelong commitment to self-evaluation and

self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and non-paternalistic clinical and advocacy partnerships" (Tervalon & Murray-Garcia, 1998, p. 117). Distinct from cultural competency's notion of a finite body of knowledge, the practice of cultural humility includes providers recognizing they do not know everything, and approach patient interactions open-minded, curious, and with a focus on asking questions and authentically listening and engaging with the patient to understand *each individual* patient better (Fahlberg, Foronda, & Baptiste, 2016; Foronda, Baptiste, Reinholdt, & Ousman, 2016; Tervalon & Murray-Garcia, 1998, p. 117). In other words, a central feature of cultural humility is not relying on and holding tentative stereotypical cultural characteristics that may or may not be accurate. Self-reflection and self-evaluation are also key aspects of this practice. More attention and emphasis on cultural humility, over cultural competency, has been paid by reputable national medical associations, such as the Institute of Medicine (2010), the National League of Nursing (n.d.), and the Society of Hospital Medicine (n.d.). Foronda, Baptiste, Reinholdt, and Ousman's (2016) conceptual analysis linked cultural humility to favorable outcomes including "mutual empowerment, partnerships, respect, optimal care, and lifelong learning" (p. 210).

While this practice holds promise, empirical studies have not examined the impact cultural humility could have on reducing provider bias or institutional racism. Moreover, even in examining the provider-patient relationship, there is an implicit assumption that in addressing this individual-level interaction, health equity will be achieved; however, this approach is myopic, and ignores critical systemic barriers that can contribute to racial healthcare inequities.

Another intervention that has experienced a recent surge is implicit bias. As discussed earlier, with the extent of research showing an association between provider bias and negative health outcomes, decreasing provider bias becomes a critical aspect of reducing healthcare inequities. As such, some healthcare organizations invest resources in bias trainings to help providers recognize and manage their implicit biases. This emerging trend in provider education has its benefits; however, like cultural competency, attention is only paid to individual level change. Again, what remains absent is a commitment and focus on uncovering and acknowledging the institutional racism as a factor in helping reduce racial inequities.

Institutional Racism Interventions

Interventions addressing institutional racism are not yet well studied or developed; however, as scholars have continued to discuss health inequities through the lens of systemic and institutional racism, some emerging efforts to create a new level of awareness among health care professionals are promising and have at its core an anti-racism praxis. Came and Griffith (2017) defined anti-racism praxis as "the educational process of training people to apply an anti-racism framework" (p. 2). Anti-racism praxis includes reflexivity, structural power analysis, and unlearning and relearning, with the goal to enact systems change. Unlike most existing training that focuses on individual-level attitude and behavior change, this framework emphasizes systems in place that have upheld racism, and the impact it has at both individuals and organizations.

One anti-racist framework for addressing health inequities is Ford and Airhihenbuwa's (2010) Public Health Critical Race (PHCR) praxis. In their quest to explain the relationship between racism and health inequities, they introduced the PHCR

praxis as an integration of public health, underscoring a scientific and practical based approach, and Critical Race Theory (CRT), which emphasizes the complex, systemic nature of health inequities that is based in a system of power and privilege. The convergence of approaches "move beyond merely documenting health inequities toward understanding and challenging the power hierarchies that undergird them" (Ford & Airhihenbuwa, 2010, p. 1390). This model includes four aspects: 1) contemporary patterns of racial relations, 2) knowledge production, 3) conceptualization and measurement, and 4) action.

Yonas and colleagues (2006) put forth a model for exploring and decreasing health inequities that integrated community-based participatory research (CBPR) principles. This anti-racism praxis emphasizes a community-academic partnership that focuses on co-learning between researchers and community members, differentiating it from the PHCR model. Similar to Dankwa-Mullan and colleagues' (2010) notion of the transdisciplinary approach, this collaboration provided a unique opportunity to transcend a traditional way of addressing health inequities by creating an integrated, practical approach focused on problem-solving, where both researchers and community members come together as "full partners in the research process" (Yonas et al., 2006, p. 1005). While perhaps more difficult to organize and manage, the value of this approach is in its ability to address a social determinant of health (e.g. healthcare) by engaging the community as full partners. This, in turn, allows for a greater opportunity to examine and address other socioeconomic factors, such as transportation and education.

Derived from community psychology rather than through a public health lens, another anti-racism praxis to address racial health inequities is the dismantling racism

intervention. Griffith and colleagues (2007) examined this systemic intervention "designed to illuminate where and how to intervene in a given healthcare system to address proximal and distal factors associated with healthcare disparities" (p. 381). They argued that systems change is necessary when organizations face "complex problems that require systematic, multi-level change" (Griffith et al., 2007, p. 382), like that of racial health inequities. Dismantling racism key elements include: 1) increasing infrastructure, accountability, and monitoring, 2) developing a common language and analytical framework, and 3) reorganizing power by strengthening relationships. The focus is on both process and product—equally important is the learning and engagement of health care professionals, and the interventions put into place to reduce systemic barriers to organizational change.

Finally, Metzl and Hansen (2014) provided a glimmer of hope in bridging the individual and organizational divide with their focus on structural competency, which they defined as:

> the trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases (e.g., depression, hypertension, obesity, smoking, medication "non-compliance," trauma, psychosis) also represent the downstream implications of a number of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of illness and health (p. 128).

With its extensive focus on awareness- and skill-building around system dynamics and barriers, the structural competency framework could prove valuable in addressing inequality in healthcare.

Only one study was found to have explored the effectiveness of a structural competency framework. Metzl, Petty, and Olowojoba (2017) compared an undergraduate pre-medical program containing traditional curriculum with an interdisciplinary pre-health program that integrated structural competency curriculum. Results showed that pre-health students had a greater, more nuanced understanding of the association between structural factors and health outcomes. Moreover, the pre-health students were able to articulate the connection between institutional racism, as part of a complex system of socioeconomic differences, discrimination and policies, and racial healthcare inequities. These findings exemplify that a focus on structural understanding, and not just at an individual level, is essential to addressing racial healthcare inequities.

While these four approaches—anti-racism praxis, PHCR, dismantling racism, and structural competency—have compelling theoretical and conceptual foundations, there remains scant empirical research that test them.

Workplace Diversity and Inclusion

A great deal of overlap exists between organizational health equity efforts and workplace D&I. While there still exists no common definition of diversity, in practice, diversity often refers to all the ways we are different (i.e. demographics such as race, gender, and age); whereas inclusion is the extent to which employees feel welcomed, valued, respected, and heard (Brown, 2016). Andrés Tapia stated “diversity is the mix; is making the mix work (Tapia, 2009, p. 12). For purposes of this study, the term “diversity and inclusion (D&I)” will be used to represent any organization practices focused on increasing representation, engagement and retention of underrepresented employees.

Evolution of Workplace D&I

Current workplace D&I approaches and practices reflect a progression stemming back decades. Historically, organizational diversity efforts began with and were defined by affirmative action. Stimulated by the civil rights movement in the 1960s, special attention was paid to address employment discrimination. As the result of federal efforts to outlaw discrimination, organizations created and staffed new compliance programs. As a part of proposing three historical paradigms of D&I, Thomas and Ely (2001) referred to this stage as "discrimination and fairness," marked by compliance and legislation. Established to remedy past wrongs, equal employment opportunity and affirmative action programs focused on "recruitment, mentoring, and training [that would] lead to minorities' and women's advancement" (Ewoh, 2013, p. 110). Together, these programs helped create policies and procedures, and plans, criteria, and trainings that would comply with law.

In response to a lack of consistent presidential support and enforcement during the 1980s and early 1990s, compliance programs began to transform into diversity management programs (Kelly & Dobbin, 1998). During this time, some employers were motivated by a reactive, legal compliance-based approach. To a much lesser extent, other employers were starting to view diversity management as a moral imperative, separate from the legal requirement.

By the mid-1990s, recruiting a diverse workforce was largely seen as good for business. This shift toward a resource maximization framework included articulating a business case for diversity that increased organizational effectiveness and productivity, and ultimately profitability. This change was also influenced by significant shifting of

U.S. demographics, and the globalization of markets (Kelly & Dobbin, 1998). Whether originally guided by law, as with compliance, or by the best interests of company profits, as with the resource maximization framework, these shifts still operated largely based on the best interest of the organization. It was not until more recent transformations in D&I that *employees'* interests and needs became a more significant part of the equation.

Alongside the structural evolution of workplace D&I over the past half century, there have been prominent shifts in function and approach, as well. Cox (1991) outlined a three-stage model of organizational diversity efforts based on dimensions and degrees of integration: monolithic, plural, and multicultural. A monolithic organization is highly homogenous, and white male dominated, with unequal representation of women and BIPOC in higher roles. Organizational norms, policies, and practices are based on the dominant White male majority, where assimilation is required of diverse employees.

Next, Cox (1991) described a plural organization as a heterogeneous environment, starting to become more inclusive, where a higher level of structural integration occurs. Considered an improvement over a monolithic organization, in a plural organization, policies and practices are created to advance women and BIPOC; however, they are still underrepresented in positions of power, like in the monolithic environment. This organization type is comparable to Thomas and Ely's (2001) access-and-legitimacy paradigm, where differences are celebrated but still considered separate and not equal. Additionally, Cox (1991) noted that due to increased integration and inclusion, there exists greater intergroup conflict.

The third type of organization Cox (1991) described is a multicultural organization, which is distinguished between "*containing* diversity and *valuing* it" (p.

39). He further stated, “the multicultural organization is characterized by pluralism, full structural integration, full integration of the informal networks, an absence of prejudice and discrimination, no gap in organizational identification based on cultural identity group, and low levels of intergroup conflict” (Cox, 1991, p. 39). At the time of publication, Cox’s concept of a multicultural organization was the preeminent model of organizational diversity; however, in the last couple decades, progress has been made regarding ideal workplace D&I. Most notably, Thomas and Ely’s (2001) leaning-and-effectiveness paradigm highlighted a shift in organization’s awareness and desire to leverage diverse employees as a competitive advantage. This era saw a broadening definition of diversity from just visible and primary dimensions like race and gender, to invisible, more inclusive dimensions like thinking and communication style, and personality (Kwon & Nicolaide, 2017). At the time, this paradigm shift was considered systemic, in that organizations were focused on integrating D&I into all parts of the business, including the strategic plan. However, despite its well-intentioned goal, little truly systemic progress has been made.

D&I Trends and Issues

There are a couple notable contemporary D&I best practices. One recent change is evidenced by the proliferation of the concept “inclusion.” Ferdman (2016) defined inclusion as “creating and embedding organizational, leadership, and interpersonal practices that result in a sense of safety, full belonging, participation, and voice across the range of diversity dimensions, without requiring assimilation or the loss of valued identities" (p. 599). The value placed on employees was highlighted. In other words, diverse employees were starting to no longer be seen purely as a means to an end—to

make money; their perspectives are incorporated into and enhance organizational strategy, goals, and execution.

Inclusion strategies often address attitude and behavioral change on an individual and interpersonal level (Ewoh, 2013). Organizations have experienced a recent surge in interest for implicit bias training focused on recognizing and managing biases and assumptions. Despite lack of evidence for a causal connection between diversity training, and decreasing bias and persistence (Paluck & Green, 2009), researchers offer some hope that long-term change in "breaking the prejudice habit" is possible (Devine, Forscher, Austin, & Cox, 2012; Forscher, Mitamura, Dix, Cox, & Devine, 2016).

Despite advancement and change over the past 50 years, there remains a large void in workplace D&I efforts. Notwithstanding the numerous paradigmatic shifts in D&I, one thing has remained constant—there still exists a micro-level focus on individual change. Even with recent theoretical frameworks beginning to address the need for structural change, compliance, diversity management, and inclusion *practices* remain focused on individual, micro-level change. The current focus of diversity and inclusions efforts on training, whether it be on implicit bias or cultural competency, exemplifies the weight given to individual-level learning and development. However, a couple of scholars offer hope.

Through Alison Konrad and Frank Linnehan's critique of the individual trait model of diversity, and their emphasis on power and intergroup relations, they added a different approach previously absent in workplace D&I (Konrad & Linnehan, 1995; Linnehan & Konrad, 1999; Konrad, 2003). With diversity being diluted and so broadly defined as to include *any* difference, diversity programs were moving away from the

original intent of the work to begin with—to create more access and equal opportunities for women and BIPOC to succeed and advance in the workplace. Moreover, treating all individual differences equally not only assumes all people are created equally, but a focus on such leaves unexamined critical issues of power and privilege. Linnehan and Konrad (1999) also pointed out limitations of the current business case for diversity, and stated, "some of the strategies that we—the diversity proponents—have used to achieve our success are now undermining the movement's effectiveness" (p. 400). Until such dynamics are addressed, diversity programs effectiveness will falter, and could continue to experience a greater backfire effect.

As a solution, Konrad and Linnehan (1995) stressed the importance of creating an identity-conscious organization over an identity-blind organization. Identity-blind refers to policies and practices that are aimed at treating everyone the same. While this egalitarian and merit-based approach may sound appropriate, such a structure ignores human resource professionals' implicit biases, and systemic inequities. Additionally, organizational systems are culturally based, thus policies and practices reflect the dominant culture, to which all are measured up to, regardless of cultural differences that exist amongst the employee base.

Alternatively, identity-conscious organizations recognize and address race, gender, and cultural differences in the creation and implementation of organizational policies and practices. By adopting an identity-conscious structure, organizations can better achieve their diversity and inclusion related goals. In their investigation of over 100 organizations' human resources structures, Konrad and Linnehan (1995) found that when compared to identity-blind organizations, identity-conscious organizations were

associated with positive benefits for women and BIPOC. Moreover, differences were found in both antecedents and outcomes. Such findings show the differentiation between the two constructs, and the importance of focusing on building identity-conscious structures that acknowledge race as a way of effectively managing workplace diversity.

Among these current workplace D&I trends come several issues. To start, diversity as a concept has been diluted (Linnehan & Konrad, 1999). With the movement over the past couple decades to include *all* types of difference in the definition, such as Thomas's (2012) definition provided earlier, D&I becomes increasingly watered down, rendering the entire concept meaningless (Konrad, 2003; Linnehan & Konrad, 1999). In other words, the concept and practice of diversity has been white-washed.

Also, even with a seemingly progressive shift in focus from diversity to inclusion, this, for many, only represents a change in language, and not a change in practice (Roberson, 2006). Some organizations are under the false impression that changing a name can change and create a new the reputation, outlook, or set of behaviors.

But even if practices are progressing, workplace D&I can still suffer from being problem-focused (Stevens, Plaut, & Sanchez-Burks, 2008). In fact, Brookfield (2003) contended D&I initiatives that proclaim acceptance and inclusion of all viewpoints "unwittingly serve to reinforce an unfair status quo" (p. 274). Such "repressive tolerance," a term coined by critical theorist Marcuse (1965), gives employees the mistaken belief that they are welcomed and encouraged to share their diverse (i.e. marginalized) perspectives and ideas, when, in fact, those interactions are actually set up to reinforce the dominant ideology (Brookfield, 2014).

Additionally, there are several fatal flaws in the development and execution of diversity trainings. First, despite it being one of, if not the most, prevalent workplace D&I practices, seldom is academic literature or empirical research leveraged in training development or implementation (Konrad, 2003). Similarly, evaluations of diversity trainings, when they do exist, tend to be limited to participant satisfaction ratings (Roberson, Kulik, & Pepper, 2003).

When studies have examined D&I trainings, such as implicit bias, results of meaningful attitude and behavioral change are mixed at best (Kaiser et al., 2012; Lai et al., 2014; Maina, Belton, Ginzberg, Singh, & Johnson, 2015). Even worse are findings showing evidence of sustainable change (Lai et al., 2016). Researchers have shown these trainings produce backlash from dominant employees, the very individuals this work is trying to reach and to create change within (Smith, Brief, & Collella, 2010). Moreover, as Kaiser and colleagues (2012) found, the presence of D&I initiatives alone can create a false sense of equity by dominant groups (i.e. White U.S. Americans, men), and causes these dominant groups to legitimize the status quo by being more insensitive and harsher toward non-dominant groups.

Lastly, workplace D&I that continues to rely on individual level change, and ignores power dynamics will continue to struggle, and are far less likely to achieve equity. As Holck's (2016) Danish case study showed, even an organization's D&I efforts that have leadership buy-in can be derailed when there is a lack of attention paid to power and privilege. Until D&I theoretical frameworks (such as Cox's multicultural organization) are actualized, and D&I practitioners focus on power dynamics and systems-level awareness, a gap will remain in addressing and creating higher level

organizational change necessary to be fully inclusive and ensure healthcare organizations can provide equitable care to all.

In discussing workplace D&I trends, I would be remiss in not mentioning the recent local murder of George Floyd at the hands of police officers, and the subsequent events it stirred up locally and nationally. This flashpoint, while critical in its impact on how organizations addressed D&I, racial equity, and institutional racism, happened after the close of the study. As such, is not included in the literature review. However, its impact, in addition to another instrumental event, the COVID-19 pandemic, is discussed in Chapter Five.

Human Resource Development

Whether through individual or systemic change, D&I or health equity practices, when it comes to organizations addressing racial health inequities, HRD can serve as a vital theoretical and practical underpinning. As workplace D&I efforts increase alignment to human resource strategies, such as leadership development, organizational development, and engagement, it becomes even more critical for HRD professionals to better understand and provide effective coaching and support for diversity-related initiatives.

Like D&I, HRD does not have a universal definition. Some definitions focus on an organizational performance outcome. For instance, Swanson (2001) defined HRD as, "a process of developing and unleashing expertise for the purpose of improving performance" (p. 99). Whereas other scholars defined HRD as "the field of study and practice responsible for the fostering of long-term work-related learning capacity at the individual, group, and organizational level of organizations" (Watkins,1995, p. 2).

Watkins' (1995) focused on learning capacity shows a clear departure from the perf`ormance paradigm supported by Swanson (2001).

Varying definitions demonstrate a disagreement in the field as to which paradigm—performance or learning—is considered most central to HRD. However, scholars have offered definitions that reflect both paradigms, like McLagan's description of HRD as the "improvement of individual, group, and organizational effectiveness, through the integrated use of career development, organizational development, and training and development" (as cited in Watkins, 1995, p. 8). Improvement at the individual *and* organizational level show an emphasis and need for alignment to both learning and performance paradigms.

What has been overwhelming consistent over the years is HRD's primary functions. Referred to as the "holy trinity" (Bierema & Callahan, 2014), these central functions include organizational development, training and development, and career development. Both organizational development, and training and development, offer solid alignment to healthcare organizations' equitable care efforts, and each offer a unique opportunity to inform such efforts.

With various positive outcomes in academic settings, mentoring gained popularity in medical professions, and medical schools started to implement mentoring programs since the 1990s (Buddeberg-Fischer & Herta, 2006; Sambunjak, Straus, & Marusic, 2006). In the medical context, faculty mentors become a role model for student mentees and facilitate career advancement and skill development of young medical professionals (Buddeberg-Fischer & Herta, 2006). Feedback from mentors can also help mentees make an earlier specialty choice (Frei et al., 2010).

Training and Development

There is an important connection between health equity, workplace D&I, and T&D efforts. As discussed earlier, the majority of racial healthcare inequity reduction, and diversity research and practice, emphasize individual learning and development, whether through cultural competency development, sensitivity training or implicit bias reduction.

Diversity T&D interventions

A comparative investigation of training interventions provided several contributions regarding the effectiveness of bias reduction techniques (Lai et al., 2014). An analysis of 17 interventions found that over half were ineffective. Those most effective interventions were ones that included counterstereotypes, evaluative conditioning methods and provided specific bias-reduction strategies. Additionally, the largest effects were seen in techniques that leveraged multiple interventions; however, despite some of these interventions exhibiting an impact on attitudes, the study only tested attitudes directly after the intervention, and not attitude or behavior change over time.

Lai and colleagues (2016) addressed this limitation by taking the most effective interventions from their 2014 study and measuring attitude persistence. Findings did not show any significant long-term change in attitudes from any of the interventions tested. However, other studies have found lasting effects, such as when applying habit-breaking techniques (Forscher et al., 2012), offering some hope that bias reduction techniques could be both effective and persistent.

Contributing to ambivalent D&I training findings, an extensive literature review of over hundreds of studies on bias-reduction interventions also found mixed results. Paluck and Green (2009) found that more experiential-based learning, like increased intergroup contact and cooperative learning, had positive effects, while more passive learning approaches, such as diversity trainings (e.g. cultural competency, anti-bias, conflict resolution), did not.

In a recent meta-analysis of diversity training effectiveness, Bezrukova, Spell, Perry, and Jehn (2016) found varied results, as well. Their cutting-edge assessment of diversity trainings included over 200 samples and four training outcomes, in which all studies had control groups and pre-post design. Findings included diversity programs being less effective in changing attitudes, and when change was persistent, it was cognitive learning, over perception, attitude or behavior, that changed. Additionally, they found positive effects for trainings that focused on both awareness and skill building, as well as for trainings that were over a longer period (e.g. three-month course versus one-day course).

While a few studies showed promising outcomes, it is clear that no one model or intervention has proven successful in changing attitudes and behavior over time.

Triple-Loop Learning

A promising learning and development theory and model is triple-loop learning. To appreciate triple-loop learning (TLL), an understanding of single- and double-loop learning is necessary. Single-loop learning (SLL) exists when modifying an approach to reach current goal and includes minimal variation since one would apply their current understanding and knowledge to the decision (Foldy & Creed, 1999). In other words,

SLL is solving problems within the existing system (Kwon & Nicolaides, 2017). Double-loop learning (DLL) seeks a deeper level change by reframing the cognitive schema (Kwon & Nicolaides, 2017). DLL begins to interrogate assumptions that underlie behavior and trying to change those underlying assumptions. Employees reframe issues in new ways, which allows for the beginning of *individual* attitude and behavioral change. However, this employee change is still within the existing organizational structure and system, thus remains a critical component missing for *organizational* transformation.

TLL addresses a problem or goal from a systems level (Kwon & Nicolaides, 2017). Foldy and Creed (1999) articulated TLL exists when individuals "go beyond questioning their own values and consider the values of the societal tradition system in which their actions take place" (p. 213). Moreover, Flood and Romm (2018) pointed out that traditional systems theory is narrow and does not address the process of power, thus is inadequate to address the impact decisions can (and often do) have on marginalized people. TLL requires a radical paradigm shift to create an equitable workplace for all employees, thus provides a promising framework to consider when addressing the impact of institutional racism in organizations' racial healthcare equity efforts (Foldy & Creed, 1999; Kwon & Nicolaides, 2017; Peschl, 2001).

Kwon and Nicolaides (2017) applied SLL, DLL, and TLL to Thomas and Ely's (2001) D&I paradigm shifts. They stated that Thomas and Ely's discrimination-and-fairness paradigm shift to access-and-legitimacy exemplified SLL:

> in that there was no fundamental change in companies' understanding of diversity. Although the way companies responded to the problem had changed

> from compliance to accommodation, it still operated under the same assumption, that diversity was a marginal issue in business, and thus, the possibility of utilizing it as the key business strategy could not even be considered (Kwon & Nicolaides, 2017, p. 89).

Similarly, they claimed DLL explained the shift from access-and-legitimacy to learning-and-effectiveness. Companies had done away with their old mindset and transformed the way they viewed D&I. But again, while deeper change occurred, it was still within the existing system. While Kwon & Nicolaides (2017) discussed and proposed what a next-level D&I paradigm would look like if TLL were to be leveraged, they exclaimed that no empirical studies yet exist of such paradigm shift nor the extent of TLL's impact. Despite conceptual analyses of loop learning that exist in the literature, there is a gap in empirical studies, thus a need "to test and develop each of these conceptualizations (Tosey, Visser, & Saunders, 2012, p. 302).

Organizational Development

Organizational Development (OD) is the "the system-wide application and transfer of behavioral science knowledge to the planned development, improvement, and reinforcement of the strategies, structures, and processes that lead to organization effectiveness" (Cummings & Worley, 2008, p. 752). If T&D is about individual development and change, OD is about systems development and change.

One defining practice in OD is action learning (AL). Dewar and Sharp (2006) defined AL as "a process of learning and reflection that happens with the support of a group or set of colleagues working on real problems with the intention of getting things done" (p. 220). Three central components of AL include reflection, dialogue and action

(Dewar & Sharp, 2006; Fenwick, 2003; Yeo & Marquardt, 2015). The cyclical nature of these three processes allow for employees to construct meanings around their surroundings to help them generate new action patterns. Additionally, AL requires individuals to take control of their own learning and commit to reflect on their own thoughts, feelings and values (Dewar & Sharp, 2006). Interestingly, Foldy and Creed (1999) use AL interchangeably with single-, double-, and triple-loop learning.

Fenwick (2003) added a critical lens to AL literature by examining the extent to which the traditional action learning framework only furthers an organization's "power over" employees. She addressed how AL can contribute to individuals by emancipating them from their deeply held assumptions, as well as to change in larger organizational systems. She claimed that by focusing on employees' issues and concerns, as well as inequitable organizational practices, AL could be "radically enhanced" and lead to social transformation and equity (Fenwick, 2003, p. 620).

Not only does a strong overlap exist between T&D and D&I, alignment occurs between with OD and D&I, as well (Ferdman, 2014; Greene & Berthoude, 2015; Kaplan & Donovan, 2013; Shull, Church, & Burke, 2014). One noteworthy area of alignment is regarding core values. Employee engagement and empowerment, continuous learning, and driving positive change are foundational values of both OD and D&I practitioners (Shull, Church, & Burke, 2016).

Another area of alignment between OD and D&I is how organizational change efforts are driven from and inform D&I efforts. For instance, as workplace D&I efforts try to become more integrated into business strategies and organization change, Cummings and Worley's (2009) OD model of planned change can prove useful. The

model includes entering and contracting; diagnosing; planning and implementing change; and evaluating and institutionalizing change. D&I practitioners can leverage the same sequence of activities in defining, diagnosing and implementing change related to diversity.

Like the robust connection between OD and D&I, alignment exists between OD and institutional racism. Griffith et al. (2007) stated:

> In the context of institutional racism, systems theory describes how organizations can be oppressive and oppressed and how the levels of an organizational structure interact with one another. Actions that occur within one part of the system not only affect that particular unit but can have a 'ripple effect' through other organizational subsystems as well (p. 290).

Due to such organizational dynamics, it becomes imperative for OD professionals to pay attention to diversity, and specifically institutional racism, as a part of their organizational change management efforts.

Bendick, Egan, and Lofhjelm (2001) also pointed out a connection between OD and D&I. Their survey of trainers revealed that while only a modest effect for trainings focused on individual-level awareness, more comprehensive trainings that addressed systems barriers and change were most effective; however, only 25% of diversity trainers reported having implemented such comprehensive training, illustrating the gap between D&I in practice. Based on their findings, Bendick and colleagues developed nine benchmarks that reflect an organizational development approach. Some of these benchmarks, such as gaining leader support, creating a business case related to

organizational goals, explicitly addressing behavior change, and culture and systems change, show marked similarity to current workplace D&I practices discussed above.

While a divide still exists between OD and D&I, scholars have recognized their symbiotic relationship: one cannot practice OD without an understanding and appreciation of D&I, nor can one approach D&I without a holistic system perspective that OD offers (Ferdman, 2014; Green & Berthoud, 2015). As such, an opportunity exists to empirically study how such alignment could impact the effectiveness of organizational efforts.

Organizational Justice

With roots in organizational psychology, the concept of organizational justice has important implications for HRD research and practice. Organizational justice refers to employees' beliefs of the fairness of organizational processes and outcomes (Colquitt, 2012; Greenberg, 1987). Colquitt (2012) described four types of organizational justice: 1) distributive—the fairness of the decision or outcome, 2) procedural—the fairness of the process, 3) interpersonal—the extent to which the outcome is communicated in a respectful and appropriate manner, and 4) informational—decisions made using honest and truthful information.

Cropanzano, Bowen and Gilliland (2017) suggested that justice can serve as a core value that defines an organization, a system-wide commitment to build a "culture of justice" (p. 40). The authors provide several compelling arguments as to why justice could and should matter to an organization, including evidence that justice builds trust and commitment, improves job performance, fosters conscientious and altruistic employee behaviors, and build customer satisfaction and loyalty.

A taxonomy of organizational justice theories was developed by Greenberg (1987) that consisted of two independent dimensions: reactive-proactive dimension, and process-content dimension. As the terms suggest, proactive and reactive dimensions indicate an organization's attempts to attain justice, or redress injustice, respectively. The process-content dimension distinguishes between Colquitt's procedural and distributive aspects. Based on this model, racial healthcare equity efforts in the reactive-process dimension would consist of trying to address inequities already identified, and focusing on policy, process, procedure and practice to reduce and, ultimately, eliminate such inequities. Decades ago, Greenberg (1987) called for research to analyze how employees attempt to create fair policies and procedures, which, up until this point, have yet to be studied in a healthcare organization context.

It could be argued that healthcare organizations, whose missions, visions, and strategies focus on providing equitable care, should be particularly attuned to the importance of organizational justice. And yet, scant empirical studies exist that have examined organizational justice in a healthcare setting.

Conceptual Framework

A troubling aspect regarding T&D and OD research is the nearly non-existent HRD literature focusing on race and racism. Ironically, diversity has become white-washed; historically, workplace diversity was created to address the exclusion and wrong-doing of underrepresented, marginalized people, and now the opposite has occurred. Some would argue that D&I programs do not call out race and racism due to the perceived or actual backlash of white U.S. Americans feeling uncomfortable and excluded (Linnehan & Konrad, 1999). If nothing else, this 180-degree shift in now

protecting white U.S. Americans over BIPOC exemplifies the intractable hold of power and privilege in this country.

Over the last 15 years, since its first session at Academy of Human Resource Development's conference in 2002, and as a response to HRD's lack of focus on "organizational 'undiscussables' such as sexism, racism, patriarchy, and violence," some HRD scholars have pushed the field to address social justice and power relations in the workplace (Fenwick, 2005). Out of this came Critical HRD (CHRD). Bierema and Callahan (2014) defined CHRD as "the process of engaging human and organizational systems that relate, learn, change, and organize in ways that optimize human interest, organization advancement, and social impact" (p. 436). In their view of HRD "as a state of becoming," they contested the traditional HRD definitions and frameworks that privileges performativity and commodifies workers and advocated for a greater focus on organizational power dynamics. Additionally, Fenwick (2005) proposed a set of conditions as a foundation for CHRD, including exposing and challenging traditional HRD theories; focusing on power dynamics; and incorporating methods and practices that "challenge prevailing economic ideologies and power relations constituting organizational structures of inequity" (p. 229).

CHRD is heavily influenced by critical race theory (CRT), in particular. Solorzano and Yasso (2002) defined CRT "as a framework or a set of basic insights, perspectives methods, and pedagogy that seeks to identify, analyze, and transform those structural and cultural aspects of education that maintain subordinate and dominant racial positions" (p. 25). CRT has several core tenets, as outlined by Delgado (1995): a) racism is embedded, ordinary and natural; b) race is a social construct; c) "interest convergence,"

a concept developed by Derrick Bell, which means that the dominant group gains as much, if not more, when they advance the causes and interests of the nondominant group; and 4) the status quo is challenged through storytelling in an effort to change the dominant narrative. CRT's influence on the emergence of CHRD proves valuable in offering a tool to engage in meaningful discourse around race and racism, and its impact on HRD theory, perspectives, and practice.

As such, CHRD offers a needed framework for race and racism to exist as a vital part of HRD research and practice. Additionally, it offers important relevance to D&I. Due to the historical and current significance of race and racism in this country, workplace D&I, and diversity training, in particular, requires attention to be paid to "social structures, institutions, and ways of knowing and being. Without such an examination, discussions of diversity evolve into polite (or, in some cases, impolite) conversations that do little to transform institutions" (Ortiz & Jani, 2010, p. 190).

Despite the connection between CHRD and institutional racism, Alfred and Chlup (2010) argued that race has remained invisible in organizations and HRD. In their review of over 100 AHRD conference papers presented between 2006 and 2010, a mere 51 addressed diversity, and only nine of those papers focused on race. While a formal review of such proceedings has not occurred since 2010, if general trends in diversity and inclusion literature are any indication, one could assume that the past eight years has not seen a significant uptick.

While CHRD has made a place for itself as a subdiscipline in HRD, that progress has also led to critique. There has been a recent call by bold HRD scholars to position social justice at the center of HRD, rather than as a separate offshoot of it (Byrd, 2018;

Collins, 2018). Byrd (2018) stated, “a radical perspective of HRD departs from critical HRD by prioritizing social justice and valuing respectful treatment of people as the primary concern of workplaces, and actively speaking against economic, social, and political systems that advance other views” (p. 8). Collins (2018) posited that radical HRD can “place HRD on a better path towards a more equitable, just, and radial future” (p. 4). By marginalizing a critical perspective of HRD, are we not promulgating the very thing we are trying to address and reduce?

No longer can we be complicit in making race and racism invisible in scholarship or practice. CHRD—and radical HRD—offer a valuable integrative framework for the study of institutional racism, and can assist in aligning health equity, D&I, and HRD efforts, for the study of racial health inequities in healthcare organizations.

With little research on organizations’ efforts to address institutional racism in the context of health equity, there is an opportunity for an empirical examination of how CHRD, particularly in the context of workplace D&I, can influence such strategies. With the continued emphasis on eliminating racial health inequities, and creating diverse and inclusive environments, organizations need to find effective strategies for addressing and eliminating bias. This study proposes both an interpretive and pragmatic research design to examine a hospital’s journey to address institutional racism as a part of their racial healthcare equity strategy. As a result, it is anticipated this deeper understanding will impact how organizations address both interpersonal and systemic racial bias, thus bringing healthcare organizations closer to fulfilling their mission of providing an inclusive and equitable environment for employees and patients.

Chapter Summary

In this chapter, key literature was reviewed on several disciplines' approaches to addressing institutional racism and racial equity. First, racial healthcare equity was examined, including antecedents and interventions. Second, the evolution, trends, and issues of workplace D&I was discussed. Lastly, HRD, focuses on T&D and OD, were reviewed. The chapter culminated in CHRD being proposed as the conceptual framework to guide this study.

In the following chapter, research methodology is described, including research design, setting and participants, data collection and analysis procedures, and integrity measures. The chapter also extensively addresses researcher positionality for this study.

Chapter 3: Methodology

This chapter provides an in-depth explanation of the methodological approach to this study. There are seven sections that outline and discuss research design, setting, researcher positionality, participants, data collection and analysis methods, and integrity measures. The chapter concludes with an overview of how the findings will be presented.

Research Design

This interpretive-pragmatic study examined how a healthcare organization addressed institutional racism in the context of their health equity strategy, by elucidating the experiences of key stakeholders in rationalizing, designing, planning, and executing an equity education program (hereinafter referred to as the "intervention") for leaders. This interpretative research paradigm focused on human experiences in their natural environment, where findings were context-specific, and emerged through the researcher and participants collaboratively constructing meaning throughout the process (Lincoln & Guba, 1985). Equally relevant to and at the center of this study is a pragmatic underpinning, as it is anticipated much understanding and insights to a real-world issue of addressing racial healthcare inequities and institutional racism can be valuable for both future research and practice (Patton, 2015).

Within these paradigms, an instrumental case study was conducted. Stake (1995) identified instrumental case studies as a method to examine and provide insights on a particular issue, where the case itself is of lesser importance to the issue being examined. Darke, Shanks, and Broadbent (1998) sensibly suggested that the case study is useful in newer, less well-developed research areas particularly where examination of the context and the dynamics of a situation are important. This case study's main purpose was to

illuminate insights into the process by which institutional racism is addressed in an organizational context, and thus the case became the tool by which those insights were gained. The following research question was central to this study: How does a large, urban hospital address institutional racism in the context of their health equity strategy?

Setting

The study was situated within an urban Level 1 trauma center in the Midwest region of the United States. The hospital is in the center of a large city with a population consisting of 51% white residents and 16% Black residents, in a state that has the most Somali residents and second most Hmong in the United States (Race & Ethnicity, n.d.). While there is considerable racial diversity in this city, the state is one of the most racially segregated in the nation (Semuels, 2016), and ranked 2nd-worst in the U.S. for racial equality (Wagner, 2017).

The hospital is one of 17 companies within a larger healthcare system whose mission is "to improve health and well-being in partnership with our members, patients and community" ([Organization name withheld], n.d.). The healthcare system has been involved in health equity work for almost two decades. Progress had been made towards reducing inequities in care and outcomes, and such efforts have been recognized including the 2019 Centers for Medicare and Medicaid Services Health Equity Award, and the Leadership in Health Care Innovation award by Minnesota Community Measurement. As of 2019, sixty-seven percent of the hospital employees identified as white, while 17% identified as Black/African American.[1] Nearly identical, the hospital's patients were 68% white and 16% Black/African American.

[1] In tracking racial demographics, the hospital uses the term "Black/African American" in tracking racial demographics of employees and patients.

The organization recognized that in order to be successful in achieving their mission, measurably improving health equity by decreasing racial and payer (financial class) disparities was critical. Health equity was a part of the strategic plan, and thus a goal for every company in the organization. There were four components of the organization's health equity work: collect data and eliminate gaps in care; support language access; build an understanding of equity, diversity, inclusion and bias; and partner with communities.

The case study was conducted in the hospital's birth center, as a part of a greater vision and plan for the department created by the newly hired birth center director, and aligned and executed in conjunction with the department's plans to build and open a new birth center. The department had 175 employees, 12% of whom identified as Black or African American (and 32.3% total BIPOC employees). And while the hospital employee demographics reflect the hospital patient demographics, and are similar to the birth center employee demographics, the birth center's patient racial demographics were dramatically different than that of overall hospital, and that of the birth center employees. Twenty-four percent of birth center patients identify as Black or African American (and 59.8% total BIPOC patients), and 39.7% of birth center patients identify as White. Moreover, despite having considerably more racially diverse patients, the birth center employees had a higher percentage of white employees than the overall hospital: the department consisted of 70.6% white employees versus 66.7% white employees across the entire hospital.

The hospital's health equity work was aligned with that of the greater organization, and was led by the health equity director, with guidance and support from a

health equity committee. The committee was comprised of a cross-section of 30 hospital leaders, in both administrative and provider roles.

This setting was chosen based on my unique "insider" role. I was both the researcher, as well as an employee of the larger healthcare system of which this hospital is a part. My employment at this organization, as well as involvement in the birth center, provided both benefits and limitations to this research. One major benefit my "insider" role created was access. The contentious nature of conversations and work around institutional racism and racial healthcare equity can prohibit organizations allowing external researchers to peer into an organization's work. In fact, it could be a significant driver for so few empirical studies on addressing institutional racism in an organizational context. Further discussion of benefits and challenges of my dual role in this case study is provided below.

Researcher Positionality

"Wer reist, nimmt sich selber mit"

("He who travels, takes himself along")

-Ernest Bloch (1885-1977)

Identifying, reflecting on, and discussing researcher positionality is an integral part of research; however, in the case of this study where I had a unique, intimate practitioner role within the setting, it proved even more critical. "Positionality is…determined by where one stands in relation to 'the other' (Merriam, Johnson-Bailey, Lee, Lee, Ntseane, & Muhamad, 2001, p. 411). As Ernest Bloch stated in the opening quotation, there is no denying the impact I had on this research, nor would I want to deny such a thing. My involvement in this study was viewed from multiple identities: my race,

my gender, my disability, and my dual role as both researcher and practitioner. The impact from each of these identities is discussed, including both ways it impacted my work, as well as ways it might have impacted how others worked with me.

White Identity

I am white privilege personified.

I am the product of my white parents' liberal, colorblind racial perspective and attitudes. My dad's personal experiences growing up were positive due to his mother running a boarding house in their Alabaman home and accommodating many Black folks. However, being situated in the South still had a negative influence on how he experienced race and racism. Having grown up in rural Minnesota, my mom's experiences with race were, well, none. We never talked about race growing up, but as white people we never had to. I am the product of a gainfully employed father that allowed me to attend college that eventually led me to my current doctoral program. I am the product of my nearly all-white suburban environment growing up, but also the racially diverse urban cities I have lived in the past 20 years. I am a product of my middle-class socioeconomic status both growing up and as an adult.

My whiteness shows up when I want to speak out against racism, racial injustice, privilege, etc. I can do so without expecting or being concerned about the repercussions based on my skin color. My comments or questions are never judged as self-serving, thus dismissed or ignored. My whiteness allows me to leave this work whenever I want without any significant impact. I can actually leave this work and not deal with race or racism, not have it infringe on my life. My whiteness means I am congratulated for doing research on institutional racism, when it would be expected of BIPOC researchers, and

praised for going so in depth on reflection and discussion of my researcher positionality. By far the most central and dynamic identity I bring to my work—both research and practice—is being white, particularly in doing research around race and racism. The following is an example of tangible impact it had on interviewing.

My third pre-intervention interview in when I interviewed one of the two BIPOC participants. I had worked with them closely for the past year and a half on the birth center health equity goals and planning the equity education program. Several questions into the interview, I asked about their extent of understanding about institutional racism. One of the sub-questions I prepared was "what training, education or other learning experiences have you had regarding institutional racism?" In preparing my interview protocol it seemed like a relevant question, and I wanted to get a sense of the extent of training participants had prior to engaging in the equity education program. However, in the interview, as I started to ask it, I hesitated. I immediately felt awkward, as it sounded like I was asking a Black interview participant what training they had where they learned about institutional racism.

Here I am sitting in front of someone who is Black, asking what training taught them about institutional racism. There was a moment of awkwardness, at least on my part, as I stumbled to try to find a way to reword it in the moment. I couldn't tell if they were aware of what was going on for me. If they did, it felt like they gave me the benefit of the doubt and it did not seem to impact the remainder of the interview. I also wonder, if they did know what I was stumbling around, the extent our relationship might have made a difference in how they reacted to the situation. We had been working closely for over a year and really built a high level of trust and respect with each other. This was not

a huge deal, perhaps no deal to them at all, but it was impactful for me, in that it was another reminder about how my white identity shows up in my research—my bias towards white participants was revealed. As I prepared my second round of interviews, after the end of the equity education program, I was more intentional about how each of my questions might land with the participants, based on race, in particular.

Female Identity

For most of my life, I have not given much thought to my being a woman, especially in any negative way. I have been in a female-dominated work environment my entire career. Even as a diversity and inclusion practitioner, my gender has never been a central focus of my identity. However, this study gave me the opportunity to acknowledge and interrogate the role my gender identity had in my research. As a female practitioner and researcher within a predominantly female department, my shared gender granted me the privilege of being more accepted and trusted from the onset. With only two male intervention participants, I rarely thought my gender would work against me. Although, like having privilege can do, I was probably unaware of possible impact it had in engaging with the two males of part of this study. Overall, given the participants in this study, I believe my female identity was mostly a benefit to, and did not detract from, this research.

Disability Identity

Three months into data collection, I was diagnosed with major depression and anxiety. As a full-time practitioner, I took a medical leave. I also stepped away from my research. This was not only devastating to my work and dedication to the research, but had farther-reaching implications on my life, as whole. As someone still dealing with

mental illness and realizing the impact it has had and will continue to have on my life, I do know that it has changed me. Changed me in mostly positive ways. I am more mindful and centered. I have a new perspective on purpose and priorities. In fact, when little else mattered to me, it was my work and studies on institutional racism that gave me a needed motivator to re-enter the world after one of the most challenging three months of my life.

And as a result, it also changed my research. Not from a technical aspect—as my three-month departure from work and research did not impact my ability to observe the necessary learning sessions and workteam meetings—but from a place of who I am, the essence of me as a researcher.

Researcher and Practitioner Identities

To say that my dual role of researcher and practitioner was a vexing issue for me throughout the study would be an understatement. Upon the onset of identifying my research topic and setting, I knew that my dual role would provide both dynamic benefits and challenges. In this section I will describe the practitioner roles I carried in this study, as well as the impact it had on how I engage with the study, and the ways others engaged with me.

Upon beginning this research, my primary role related to this study was that of practitioner. Moreover, I carried three types of practitioner roles. First, as a full-time diversity and inclusion consultant who had worked with the hospital for four years prior to the start of the study. Additionally, and as the result of my diversity and inclusion consultant role, I was a member of the program planning committee that created and executed the intervention. Finally, as the result of both above roles, I was assigned as an equity coach to three of the six workteams engaged in the intervention.

There were numerous benefits to the study as a result of these roles. To start, working at the hospital gave me intimate knowledge of and familiarity with the organization, hospital, and department. Additionally, I had access to nearly all documents and data that might not otherwise have been shared, or if so, would have been more challenging to obtain (e.g. demographics of patients, demographics of employees). Moreover, I had existing professional relationships with two of the program planning committee members and executive leaders. This proved beneficial in that trust and rapport was already built, allowing for more open and candid conversations, as well as access to the hospital executives. Finally, my "insider" role at the hospital likely increased acceptance.

My role as a program planning member also played a valuable role. Far before deciding to conduct a case study, I was a key partner in the development of what would be the intervention. For a year prior to the intervention, discussions occurred about how to integrate diversity and inclusion training in the birth center equity strategy. Without even a glimmer of an idea about conducting a study, I proceeded through the planning with a 100% practitioner lens.

Finally, being an equity coach for three of the six workteams also had an impact on the study. I was able to informally observe far more interaction in the workteams than I would have if only attending and observing the six designated meetings. This allowed for a richer description of these three workteams' experiences and allowed greater insight into the impact the learning sessions was or was not having for the participants.

Conversely, there were challenges to these "insider" and "outsider" roles, as well. For example, participants may not have revealed as much in interviews or meetings as they might have with an external researcher. This is particularly pertinent around engagement

and dialogue on topics of race and racism. Additionally, there existed what felt like a constant battle to ensure that the dual roles of researcher and practitioner were not unintentionally or inappropriately in conflict with each other. To offset this, I identified two "rules" I would leverage at any point I struggled with these roles, which I discuss below. Finally, despite the fact that I did not lead the intervention or facilitate the training, there is no denying that my dual role in the study could have impacted the extent to which my biases played a part. Despite my intentional practices to recognize and mitigate bias when possible, there are inevitably times that biases go unchecked. In a study *without* dual roles, biases can have an impact. But being an insider, as well, just compounds the likelihood of this influence.

Acutely aware of my researcher and practitioner roles, I reflected on and prepared two "rules" that would serve as both a statement of my priorities, but also a practice in the event challenges occurred as the result of these dual roles. My central responsibility was to the effectiveness of the equity education program. In other words, if any conflict arose, my practitioner role would take precedence. That being said, I took every effort to abide by my professional responsibilities while maintaining the integrity of the research. An example of this occurred towards the end of the study. Originally, the last learning session—and the close of the intervention—was scheduled for December. As such, I scheduled all post-intervention interviews for later that month. However, in assessing the progress of the equity projects, the program planning committee (of which I was a member of) recognized that the workteams needed more time to prepare for the final learning session. We made the decision to postpone the final session, and reschedule for six weeks later. As a result, all my post-intervention interviews needed to be rescheduled.

Not only did that mean a significant amount of extra work, it resulted in my not being able to finish my dissertation and graduate in May.

The other priority was regarding confidentiality. If issues of confidentiality or other concerns arose due to my dual role, I consulted with my adviser. For example, during an interview, I heard a participant's comment that was pivotal to the success of the program. I was conflicted about what to do: as a researcher, holding participants' confidence is of central importance. And as a practitioner, I knew there would be significant consequences impacting the effectiveness of the program if I did not bring it forward. Ultimately, after reflection and advisement, I shared with the planning committee the overarching theme of what I heard in an interview, ensuring it was de-identified and without any detail that would allude to who it was.

Overall, while challenges existed due to my many identities and roles related to this study, I believe that the benefits far outweighed these. Additionally, by intentionally employing multiple practices and techniques, as have been described, I have confidence in the integrity of this research.

Participants

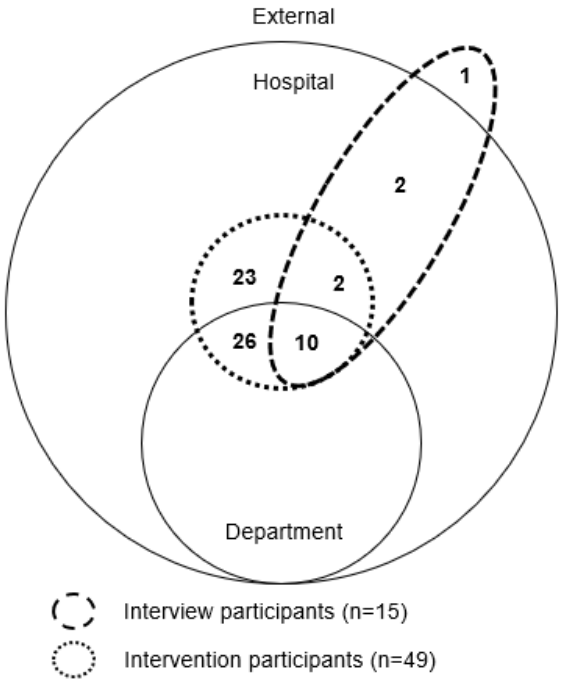
There were two types of participants in this case study. "Intervention participants" consisted of 49 leaders who engaged in the intervention. This was a cross-section of 26 birth center department leaders (e.g. physicians, midwives, nurses, administrative), and 23 department partners (e.g. health equity, human resources, patient experience).

A total of 15 "interview participants" were interviewed before and/or after the intervention. Thirteen of the 15 interview participants did both pre- and post-intervention

interviews. One intervention participant was invited and agreed to a post-intervention interview as an exemplary case. The facilitator only participated in the pre-intervention interview. The 15 total interview participants had different roles related to the department. Of the 15, there were 12 intervention participants, two hospital executives and one facilitator. Except for the facilitator, all interview participants were hospital employees. Figure 1 illustrates the different types of participants, as well as their role in relation to the department.

Figure 1

Overview of Interview and Intervention Participants



Prior, and not related, to the start of the study, the intervention participants were assigned to one (or more) of six workteams, three with an administrative focus, and three with a care-delivery focus. As stated above, these workteams were created for the

purpose of previously identified goals related to the opening of a new birth center the following year.

Table 1

Interview Participants Demographics by Race, Gender, and Role

Role	Race		Gender	
	White	Black/African American	Female	Male
Physicians	3	1	3	1
Nurse/Midwife	5	0	5	0
Administrative	4	1	5	0
Total	12	2	13	1

Note. Only includes interview participants in the department; the facilitator was not included.

Table 2

Interview Participants Workteam Assignment by Role

Role	Care delivery-focused workteam	Administrative-focused workteam
Physician	2	5
Nurse/Midwife	3	4
Administrative	2	4
Total	7	13

Note. Some interview participants were members of more than one workteam, thus the total workteam participation is higher than the number of interview participants.

To ensure a diverse group of interview participants by race, gender, and role, purposeful sampling of intervention participants was employed. Purposeful sampling is leveraged to engage intervention participants and hospital leaders whose experiences "are 'information rich' and illuminative…[and] offer useful manifestations of the phenomenon of interest" (Patton, 2015, p. 46). As a result, a diverse cross-section of interview participants was selected. Tables 1 and 2 show the demographic breakdown of the interview participants and workteam breakdown by role, respectively.

Data Collection

Case studies typically include a variety of data collection methods to fully capture multiple aspects of and experiences within a case (Patton, 2015; Stake, 1995). As such, several collection methods were employed in this study, consisting of interviews, both pre- and post-intervention, participant observations, and document analysis. Each of these are described in detail below.

Interviews

Semi-structured interviews were conducted to capture a thick description of the experiences, perspectives and insights of 15 individuals closely connected to and involved with the intervention (Patton, 2015). Additionally, grounded in critical race theory (Delgado, 1995), the use of participant stories helped make sense of complex interconnected situations and explored the way people interpret the world and their place within it, which can often be difficult to assess through other means. Experiences solicited from interviews with those who hold structural power provided valuable clues and insights into dynamics that underlie an organization's overt and/or subtle resistance

to look at internal structural systems that limit or inhibit the goal of true inclusion and equity.

Pre-intervention interviews

Prior to the start of the intervention, an initial introductory email was sent by the department director announcing that I will be conducting research on their experience with the intervention over the next year. She stated this would include my observing learning sessions and workteam meetings, as well as requesting interviews. As the result of purposeful sampling, the department director provided a list of diverse leaders to invite (i.e. diversity of race, gender, and role).

I sent an email from my personal email to request participation in the study. I intentionally sent the email from my personal account and not my work account to reinforce that the request was coming from my role as a researcher, not as a work colleague. After sending the original email invitation, and two subsequent follow-up emails, there were not enough participants who agreed, nor a good cross-section of roles represented. Therefore, a second recruitment tactic was employed: an email invitation was sent to all the remaining intervention participants. As the result of this second email, three more intervention participants agreed to interviews, and provided the needed roles to fill the gap. Additionally, I sent personal email invitations to two hospital executive leaders, as well as a request to the facilitator. All three agreed to be interviewed. As the result of all email invitations, 14 pre-intervention interviews were conducted: 11 intervention participants, two hospital executives, and one facilitator.

Pre-intervention interviews were conducted the month prior to the intervention start date.

The audio-recorded interviews were conducted in settings most comfortable and convenient for each participant. This contributed to creating a safe space for sharing personal perspectives and experiences that can be emotionally challenging. To ensure strict confidentiality, interview participants' names were de-identified. Each participant was assigned a name at random. Another confidentiality measure employed was to use gender neutral pronouns when referring to participants.

Interview questions for each type of participant (e.g. participant, planning committee member, hospital executive) included questions central to the program, and asked of all interview participants, as well as questions specific to their type of involvement. For example, planning committee members were both program participants, and a part of the program planning; therefore, in addition to the core set of questions asked of everyone, they were asked about their experience both as participants and planners of the program. For the pre-intervention interview protocol, see Appendix A.

Demographic information was requested of each key informant after the interview: pronouns, gender, and race. Participants were given the opportunity to decline answering any of these questions. One interview participant declined to provide their race.

Helping to ensure quality and trustworthiness, all recorded interviews were immediately reviewed to ensure the recording was successful. Interviews were digitally recorded, and transcribed verbatim. Consistent with member checking procedures, for anything that remained unclear, the participant was contacted in a timely manner to seek clarification (Patton, 2015). This occurred once when a participant was asked permission (and subsequently gave consent) to include something they said after the recording had

stopped. All pre-intervention interviews were coded and analyzed prior to the beginning of the intervention to minimize the extent of research bias of interpretations once the intervention started.

Post-intervention interviews

Two months prior to the end of the intervention, a post-intervention interview request was emailed (again, from my personal email account) to all pre-intervention interview participants, except for one—the facilitator. Additionally, one more intervention participant was invited as an exemplary case. This intervention participant was a part of a workteam I had observed numerous times, and as such, I witnessed a significant change in awareness, understanding and behavior. All participants agreed to the post-intervention interview.

The post-intervention interview protocol and process was executed in the same manner as the pre-intervention interviews. For example, all interviews were scheduled at a time and location preferable to the participant; interview questions consisted of both central questions asked of all participants, as well as questions specific to their role (e.g. planning committee member, hospital executive); and member checking was conducted. However, unlike the pre-intervention interviews, the post-intervention interviews were transcribed using a professional transcription service adhering to strict confidentiality standards. See Appendix B for post-intervention interview protocols.

Participant Observations

Observations were conducted throughout the intervention year to gain a deeper understanding of both the training sessions, and workteam meetings. My unique position as both the investigator and employee informed the approach I took as a participant-

observer. Evered and Louis (2001) suggested two types of paradigms when conducting participant-observations: “inquiry from the outside” and “inquiry from the inside.” The former is a detachment from the setting, whereas the latter includes a personal involvement by the researcher in the process. They concluded the knowledge acquired through ‘inquiry from the inside’ is inherently more valid and relevant to the participants and organization.

I conducted moderate participant-observations. Spradley (1980) outlined five types of participant-observation roles: 1) non-participatory, 2) passive, 3) moderate, 4) active, and 5) complete. Spradley (1980) described the moderate participant observer as carrying both insider and outsider roles, while maintaining a balance between participant and researcher. He suggested this balance allows for just enough involvement, but with necessary detachment so as not to put objectivity at risk. As a result, I was able to participate as needed, but also take field notes in real time.

Participant observations were made at learning sessions and workteam meetings. Specifically, observations were conducted at all five learning, as well as at three meetings for each of two workteams (Workteam Two and Workteam Five), totaling six workteam observations.

Observations of one meeting from each of the six workteams was originally planned. However, after the first workteam observation, it was determined more to be more valuable to observe the process and development of fewer workteams, versus just one “point in time” of each workteam. Therefore, six observations were of two workteams. These workteams were selected based on the assigned workteams I had as an equity coach, and observation dates were selected in advance. So, while three official

observations were conducted for each of two workteams, as an equity coach, I attended almost every meeting. Therefore, some findings reported were based on meetings I did not officially observe, rather based on observations within my role as equity coach.

Observations of Workteam Two were in schedule for March, April and September, and Workteam 5 observations were scheduled twice in March and once in September.

Jottings and scratch notes from observations were written up and reflected on within 24 hours of each observation. By quickly conducting the write-up, I was able to record and reflect on "fresher, more detailed recollections," as well as "release" the weight of what has just been experienced (Emerson et al., 1995, p. 40). Additionally, write-ups and memoing of observations were conducted prior to any subsequent observations (Erickson, 1986).

Observations and subsequent memoing were also made at times other than those six meetings. By nature of my equity coach role as described above, I attended nearly every meeting of three workteams. As such, observations were noted informally and contributed to data collected.

Document Analysis

A third data collection method consisted of a review of organizational and departmental documents. Information contained in documents helped further describe the context in which the participants operated, contributed to the knowledge base, and revealed additional questions to ask, or observations considered (Bowen, 2009). Patton (2015) referred to records, documents, artifacts, and archives as "'material culture'…[with] a particularly rich source of information about many organizations and

programs" (p. 376). In conjunction with other data collection methods, documents further strengthened the experiences, perspectives and insights of the case (Bowen, 2009).

The case study included the following documents:

a. Planning committee meeting minutes and notes
b. Formal and informal correspondence relating to program development and execution
c. Other organizational and departmental documents, such as strategic plans, reports, internal and external websites, and videos
d. Trainer's curriculum and other supporting material

Data Analysis and Trustworthiness

Data analysis was conducted through a critical lens and included reflection and interrogation of analysis and interpretations throughout the study. Inductive, vertical within-case analysis was conducted on the interviews, participant-observations and organization documents (Corbin & Strauss, 2015). Inductive analysis is one of the most common types of analysis in qualitative research and allows for themes and patterns to emerge (versus deductive analysis where the researcher identifies key themes prior to coding and analyzing data for these themes) (Corbin & Strauss, 2015). Vertical within-case analysis refers to comparing themes across multiple data sources within the same case (Corbin & Strauss, 2015). This included comparisons within each of the three data collection sources of interviews (e.g. planning committee members, hospital executives), as well as across interviews, observations, and organization documents.

For all data sources, pen coding was used to explore and identify initial concepts. Data was reviewed to verify initial concepts. Once initial themes were identified,

horizontal deductive analysis was conducted with the remaining data based on initial themes developed thus far (Corbin & Strauss, 2015). The constant comparison method was also leveraged and regularly referred to initial data and themes to ensure no new themes had emerge based on new data (Corbin & Strauss).

The above-described analysis process was used for both pre-intervention and post-intervention interviews with one exception. As in the first round of interviews, the transcripts were coded and themed by hand. However, at that point a database was created to contain all codes, themes, subthemes, and related exemplar quotations. As such, I was able to search and organize the document by participant, code, theme, or subtheme. While this process was laborious, it allowed for an efficient and effective organization and retrieval of key themes, subthemes and exemplars leveraged in Chapter Four. It proved so instrumental, I went back and created the same formatted database the pre-intervention interview data, as well.

Integrity Measures

Lincoln and Guba (1986) outlined numerous features of trustworthiness of qualitative research, including credibility and transferability. Techniques in this study met the authors' criteria in many ways. To start, a prolonged engagement and persistent observation, as well as triangulation and member checks, were leveraged to increase credibility. Triangulation is a way to increase trustworthiness by leveraging multiple methods to compare against each other (Patton, 2015). Interviews, moderate participant-observations, and document analysis were three methods utilized to increase trustworthiness.

As another measure to ensure trustworthiness, member checking was conducted at the conclusion of the study. Member checking is the process by which a researcher circles back with key informants to review and confirm the key informant's perspectives are appropriately captured (Patton, 2015). Member checking consisted of providing interview participants key themes from the interviews.

Bracketing, memoing and journaling were other techniques employed to increase the integrity of this study. Bracketing is a self-reflection and self-discovery technique conducted throughout a study that attempts to lessen the impact of biases and assumptions that could weaken the research process (Tufford & Newman, 2010). In this study, bracketing was leveraged through memoing, journaling, and conversations with outside sources. Memoing allowed for a more complex analysis of concepts that arose, and was conducted throughout the study, immediately after each interview and observation (Corbin & Strauss, 2015). This process allowed for deeper reflection throughout the study. Tufford and Newman (2010) stated these practices help suspend bias; however, I do not agree that bias can ever be completely suspended or removed. Rather, a researcher's biases and assumptions need to be acknowledged, interrogated, and understood in relationship to their study. Therefore, bracketing was both relevant and valuable. For example, after experiencing an awkward moment in asking an interview question with a Black participant, I journaled and reflected on what that was underneath the surface in that situation. It was at that point that it became clear my interview questions were biased towards white participants. And as such, I reviewed all interview questions for any further evidence of bias and adjusted the remaining interviews conducted.

Important to note, analysis of data within public health critical race promotes race consciousness and can include shifting the dominant narrative. As such, race conscious personal reflection was a critical aspect of analysis and provided additional rich insights. Thus, throughout the coding process, I engaged in regular journaling. This ongoing reflection of my coding and meaning-creation also included significant reflection that allowed me to see how I, as a white researcher, was impacting the process, as well as how the process was impacting me. As a white researcher, it was integral for me to be aware of and understand the cultural lens and potential bias I brought to the research, particularly work focused on experiences and perspectives around institutional racism and racial healthcare inequity. Throughout this process, I specifically included reflections on what biases, assumptions and perspectives that my white, dominant identity brought to my analysis and interpretations.

Chapter Summary

In this chapter, I presented the research design, setting and participants, and data collection and analysis procedures. Also discussed was the many facets of my researcher positionality. The chapter concluded with an overview of the presentation of findings in the next chapter.

CHAPTER 4: FINDINGS

This chapter reports findings from data collected through interviews (both before and after the intervention), learning session and workteam meeting observations, and analysis of hospital and department records and documents. While the central aspect of the case study was the intervention, the scope of the case also encompassed what led up to, and happened as the result of, the intervention. Therefore, findings are organized in three main sections: pre-intervention, intervention, and post-intervention.

Pre-intervention findings centered on the department background and context, broken down by department, people and program. The department background and context include a brief history of health equity work in the hospital, and leadership commitment and support. The people background and context include participants' awareness and understanding of health equity, institutional racism, and the rationale for department's focus on racial health inequity, as well as hopes and concerns about the intervention. The section ends with the evolution of the intervention.

Next, findings are reported related to the intervention. This section includes the structure, purpose and key components of the intervention, followed by the learning session and workteam experiences, and wraps up highlighting departmental and participant challenges gleaned from interviews and observations.

Lastly, the post-intervention section reveals findings related to the impact and outcomes of the intervention, for both the department and the people. Department outcomes focus on policies and practices that changed as the result of the intervention. The people outcomes focus on both change awareness and understanding of racial bias and institutional racism, as well as behavioral change.

Since there was only one male interview participant, findings are reported using the gender-neutral pronouns “they,” “them,” and theirs.” This was considered necessary as a part of maintaining participants’ confidentiality but was deemed appropriate since no findings based on gender were found.

Pre-Intervention: Department Background & Context

While the central aspect of this case study is the intervention, the boundaries of the case also encompass what led up to, and happened as the result of, the intervention. Findings are organized in three sections: the department, the people and the intervention. The first section includes a brief history of the health equity work in the department and hospital, and a description of hospital leadership commitment and support of health equity. The second section covers participants’ reflections on the pre-intervention state of the department, awareness and understanding of key concepts, and hopes and concerns for the intervention. Finally, the intervention is described through an explanation of what led to the creation of the intervention, as well as an overview of the interventions’ structure, purpose and intended outcomes; framework and theory of learning and change; and key components.

The Department

The following includes a brief history of the health equity work in the hospital, and the leadership commitment and support that led to establishing the intervention.

Brief History of Health Equity Work in the Hospital

Health equity work was not new to the hospital. For decades, the hospital had focused on addressing racial disparities. Maxine shared:

> I think the birth center has been focused on health equity for a very long time. I don't know how far it goes back, but for sure, and this sounds interesting actually as I'm saying it aloud, for sure this goes back to prior to 2000 when we opened the birth center in 2000 . . . even back then, the birth center had I believe at that time, a higher proportion of diversity in the birth center than our hospital overall. And that's the way it is today, as well. Um, so we did some work with the Hmong community back in '98 that's when a lot of our Southeast Asian communities started growing. And we really didn't have a clue on preferences for our Hmong moms and babies, whether it came to dietary restrictions, or families present in the birth process, those types of things. So we did some focus groups with the Hmong community and learned quite a bit and really tried to be that welcoming place. And so, I feel like we have always been trying to be focused on it, but I think increasingly in the last five years or eight years.

Despite past efforts to address and reduce health inequities, it seemed the work was not as much of a priority as it has been recently. Maxine also shared:

> I think the difference now is that what we're hearing from our black patients is 'we don't want you to just come in while you're building a building, and then go away.' Because we did a lot work with the Hmong community but then it was like it turned into a project, and once we got up and open and running, and it felt like we had to get a certain level, we didn't have that longitudinal relationship. So now what we're saying is we want a longitudinal relationship with all of our moms, but particularly our moms who are American-born Black women are a majority of the minority, and because of the social determinants of health, we don't want a

> relationship with you just during your two or three day stay delivering. We want to make sure we're helping your pre-delivery, after delivery, and having a longitudinal relationship with you.

The hospital was learning from past poor practices, and approaching this work in a more enlightened, authentic way.

As a part of this more recent health equity priority, in 2017, the hospital hired a new birth center director that had a defined vision of addressing health inequity and institutional racism within the department that aligned with, but not solely bound within, existing plans to open a new birth center in 2020. This vision included three core pillars of care: highly reliable, family centered, and equitable. The building of a new birth center was considered a great opportunity to shift the culture of the department. Lila stated:

> The hospital is embarking on building a new building for the birth center which is a really great opportunity for us to test different models of care, and really try to influence how we deliver care in a new way. Our team is going through a lot of change anyway, so the fact that we have a patient population that is important to think about. We also have a change catalyst that will allow us to change models of care in a way that we think would be better. Just equals the right time for us to do it. And I think we have a lot of energy.

The new birth center being built was seen not as the reason to change, rather the means to a greater end: a culture change.

For the purposes of the larger birth center strategy six workteams were established prior, and not related, to the intervention, to create and/or re-evaluate policies, practices and processes. The workteams had either a care-delivery or administrative focus.

Regardless of the specific focus of each workteam, they all had in common the purpose of interrogating existing or yet-to-be defined policies and practices that would be employed when moving into the new birth center.

As one of the three key pillars of the vision, health equity—and specifically racial health equity—was an integral part of the vision and strategy for several reasons**.** To start, the patient demographics warranted a stronger focus on experiences and health outcomes of BIPOC patients. With BIPOC consisting of more than 60% of birth center patients, a focus on racial health inequity was integral. Julia pointed out the high percentage of BIPOC patients in comparison to the rest of the hospital, and stated, "[the birth center is] at the forefront of the demographic shift that's happening not only in this hospital, but in this region and across the country."

Secondly, leaders were aware of staggering racial disparities in maternal outcomes, with studies showing maternal morbidity is three to four times greater for Black birthing people in the U.S. These, and other similar disparities, became more widely known due to growing national and local media attention (Richert, 2019; Salam, 2018; Woodruff & Nawaz, 2018; Young, 2018).

Lastly, the hospital had been suffering from a longstanding poor reputation in BIPOC communities. Five participants referenced this issue as it related to historical and current experiences of BIPOC patients. For example, Darnisha revealed, "women are choosing not to come to [the hospital] because they do not feel welcome, they do not feel safe. They do not feel like they were heard or respected." Fiona shared they "don't want to come here because culturally things are done different here than they might be back in the country where they came from. And if they're a new immigrant, that makes it hard for

them," and Gabriella reported, "[the hospital] has an uphill battle in the community because they have a reputation as being a place that has been biased against minority groups, particularly African American community." Maxine pointed out the historical nature of the issue:

> So, I feel like there is some learned behavior generation over generation which has merit or it is logical that people don't seek care places they don't feel safe. Or that there is not the awareness of the prevention because we haven't reached those communities in ways that we've reached white communities.

Nausheena spoke about what she heard from a Black patient:

> She says 'so you all, you know the black community doesn't trust you, right?' I mean she just…[laughs]…and it was like whew! Thank you for saying…you know I mean, your first reaction was like ah, crap, she's saying that on the microphone in front of media. But it was like okay, right in your face, kick ya in the pants.

It was widely known amongst patients and staff how deep the resentment and antipathy for the hospital was. In fact, during the intervention, an article was published highlighting a previous hospital patient who their experience with racism in the birth center (Richter, 2019).

In summary, the national statistics on appalling racial disparities in maternal and infant outcomes, the department's patient racial demographics, especially compared to the department's employee racial make-up, and the longstanding lack of trust and respect in the BIPOC communities, all played a role in the call to address health equity and institutional racism in the department.

Leadership Commitment and Support of Health Equity

Another key aspect that laid the groundwork for the intervention was hospital leadership commitment and support, particularly that of executives and the birth center director. Over the last couple years, in particular, hospital executives had re-committed to addressing health inequities. Executive leaders understood the need to prioritize racial health equity, in particular. Maxine shared not only their understanding of the current state of racial disparities, but the power they had as the hospital leader to do something about it:

> It's about today and it's about tomorrow. So today already 60% of the babies born in [the] birth center are not white—are babies of color. And we have an increasing socioeconomic gap many of those moms and babies are either uninsured or on Medicaid. So, there's disparities there inherently in terms of the social determinants of health. And then the majority of that minority is Black, and that's where we think we continue to have that trust gap.

A desire to continue to learn more came from the top. Maxine shares their personal growth and development:

> I've just done a lot more reading related to community health needs assessment and gaps between various groups, whether it be ya know again any kind of diversity: age, children's health initiative and disparities in children's health. Um, just recognizing that there are a lot of findings now that talk about those social determinants of health and how much more powerful those are at determining someone's health than what we do in our clinics and hospitals. Um, so that's kind of all the different touch points there, but I would say the other issue for me that

> has been really impactful is hearing um directly, for example, from our Black community how there is a trust gap just based on the issue of institutional racism where even if we think we're providing the care that's accommodating that we may not be. And that it has as much to do with the experience as it does the technical healthcare processes.

But it was the leader's deepening understanding leading to their commitment to addressing the racial inequity that was most impactful in creating equity an explicit priority of the hospital. Maxine shared:

> In my role, I only get to choose two or three things that I'm saying in addition to us being a hospital that delivers great care. What is it that we need to care about? And so for me, equity is in the top two. It's like we got to get this figured out. We're a level one trauma hospital in a metropolitan area. And we're not meeting the needs of our community and we can do better. But it's like I've chosen that and it's going to be longitudinal…

So not only was there an explicit commitment to equity expressed, it was designated as one of only two hospital priorities. Thus, support of the department work in addressing racial health inequity and institutional racism existed, as well. Both hospital executives indicated their excitement and support for the department's intervention, and the integration of it within the great birth center strategy, in particular. Nausheena shared:

> I also am in favor of the direction that you guys are taking in terms of, we've kind of tried to treat equity in past years as a separate project. And it's just gotta be a part of the lens and filter of everything we do.

Leadership commitment also came from the birth center director. As stated before, they came to the organization less than two years prior to the start of the intervention with a commitment and overarching strategy for addressing racial health inequities and institutional racism. This priority was put into action through the creation and execution of the larger birth center equity strategy, as well as the intervention, specifically. Nausheena shared the impact the director's unrelenting commitment to address racial health inequity had on them:

> I really think it took a new leader's fresh set of eyes, someone to kick me in the pants perhaps" … And it's hard as a VP to know all of the details of what's going on unless there's big glaring things that are like "hey, this is a problem" you can unfortunately get in the mode of no news is good news, and I don't need to do anything . . . .and I think I really attribute it to [the birth center director] coming . . . She kind of created that and pushed it along, and it's the absolute right thing to do.

In addition to the birth center director's influence in being a fresh, new leader making this a departmental priority, one interview participant commented on how the director being Black might have influenced the work, as well:

> I think one interesting thing is that the patient population hasn't changed in years, and the people, the other leaders, who have bought into the vision that we've created, have been here for a while. I think there was a catalyst in a Woman of Color coming in, in a leadership position, who had this as a goal or perspective. And also had the opportunity to push it as an agenda that has also made it move a little bit. I think there's a piece there, and it's weird to call it out, but I think that

> that speaks to People of Color being in leadership positions, where some of these things can be addressed (Maxine).

While reasons varied as to how the director's commitment and prioritization of equity in the department influenced the work, there was agreement by many interview participants that she was a central factor in the creation of the intervention. Moreover, agreement existed that leadership commitment and support from multiple leaders was critical. Julia summarized it:

> I think it was just the ripeness of the situation that we had been tending the soil, that we had the right gardeners show up, that the sun came out, that we had bought the right seeds, and that all stated to come together and something great started to grow out of it.

The hospital and department leadership priority were just as instrumental to the launch of the intervention as the momentum of previous health equity work, and the necessity to address national, local and hospital disparities.

The People

Several findings emerged from pre-intervention interviews: 1) reflections on state of the department leading up to the intervention, 2) extent of awareness and understanding of health equity and institutional racism, and 3) hopes and concerns about the upcoming intervention. This section's findings specifically relate to the "state of the people," versus last section's "state of the department."

Participant Reflections on Pre-Intervention State of Department

First, pre-intervention interviews revealed reflections on the current state of health equity and institutional racism individually, and within the department (and

organization). Additionally, data revealed both positive and challenging aspects of the current environment. Leveraging different analogies, multiple participants mentioned the timing was right and "serendipitous," (Julia). Participants highlighted a convergence of national attention on maternal and infant racial disparities, the planning for the new birth center opening, hiring of a new birth center director, and the CEO naming equity as one of two key priorities for hospital, that all led to the opportunity to create programming around racial health inequity and institutional racism. Some indicated the organization had moved beyond cultural competency, ready for what was next.

> We've kind of gone from cultural competency, we've kind of moved beyond that…in that we need to learn preferences of each individual and while yes, it's great to know some general themes of preferences in each of our communities, we're never going to be able to know everything (Maxine).

The current challenges were revealed to a greater extent. Participants highlighted both individual and organizational challenges currently faced, some of which were directly impacting patient interactions. Individual challenges included defensiveness and resistance to discussing racial health inequity and institutional racism, including resistance to using the word "racism" itself. And when it *is* used, because it was starting to be used more frequently, leaders thought they were further along than they were. Several participants indicated a lack of confidence, comfort and/or knowledge in speaking up about institutional racism, in particular. One participant shared in reference to the department "[there are] a lot of really good-hearted people who do not have a lot of insight into their own whiteness at all" (Gabriella). Gabriella also shared an example of how racism showed up:

> [For example] people monitoring how many juices their kids are drinking…I was sitting at the desk and there was a family who had a c-section who were very pleasant, ya know, they weren't causing a big ruckus in recovery, even if they had, that's not the issue, but they weren't. And they had young kids, and the kids were drinking juices out of the refrigerator. I don't know how many. They weren't like selling them, do you know what I mean? [laughs] They were drinking maybe three juices out of the refrigerator; the young kids were. And the nurses started commenting on how the family was eating out of our refrigerator, and the fact is, if that same family had been white, everyone would've thought their kids were so cute. Nobody would've been monitoring the number of juices, but there is this feeling that people are freeloading, so we look for ways that they might be freeloading, and then we talk about it. And you hear it all the time.

Gabriella's story revealed a potentially greater issue regarding the overall biased culture of the department. Other individual challenges referenced directly impacting patients, such as commonly making assumptions, and not naming or discussing lived racism, rather only as it relates to genetics.

In additional to individual challenges, organizational and systems challenges were expressed. Participants revealed the lack of resources (people and dollars), being short-sighted versus long-term focused, and the fact that the system is designed for the dominant, all as current issues within the department and hospital that uncover the lack of priority and commitment that existed for addressing and reducing health inequity.

Awareness and Understanding of Key Concepts

Participants' understanding of health equity and institutional racism varied and seemed to align with their race and role. Their ability to define and describe health equity and institutional racism varied from understanding, to misunderstanding to not understanding at all.

Health Equity. Overall, most participants reported a decent understanding of health equity (n=10). The Minnesota Department of Health (2014) defines health equity as the opportunity for every person "to realize their health potential — the highest level of health possible for that person — without limits imposed by structural inequities" (p. 11). Participants indicated their understanding of health equity by sharing definitions and descriptions of health equity that included equal access to healthcare and that a patient's race (or other dimensions of diversity) should not be a factor of health outcomes. For example, Annika described health equity as "…having equal access and abilities to healthcare, education, opportunities, for everyone. And so for, and it shouldn't change based on your race or your class or your gender or anything along those lines."

> Participants also differentiated equitable versus equal care.
>
> And so, it's that issue around it's not treating everybody equally. It's equally understanding the various needs are in our diverse communities and trying to match that with ways in which we can make sure everyone has the same opportunity to get preventive health services or to know when to seek healthcare (Maxine).

While these participants varied in which aspects of health equity they highlighted, there was an overall sense of understanding.

There were three participants that did not understand health equity. Two of which had a misunderstanding of the term, confusing equity with equality. For instance, stating "my initial thought is that it's providing the same level of care" (Carol). And one of which admitted not being familiar with the term at all: "I really wasn't sure to be honest with you. I was like 'what is this?'" (Holly).

Institutional Racism. A different pattern emerged regarding participants' understanding of institutional racism. Institutional racism is defined as "differential access to the goods, services, and opportunities of society by race" (Jones, 2000, p. 1212). Less than half of participants indicated an understanding of institutional racism (n=5). Six participants misunderstood the term, all of whom confused it for (individual) racial bias. Two participants admitted not understanding the concept at all. See Table 3 for a summary of participant understanding of health equity and institutional racism.

Regarding understanding by race and role, three of four physicians misunderstood, as well as one hospital leader and one program planning member; both participants of color had a sophisticated understanding of health equity and institutional racism. For example, Julia shared:

> I think institutional racism is almost a redundant term because racism itself isn't like 'I don't like you because you look, because you're Latina, or Asian' or anything like that. Racism is a larger system at play of disparities being brought among people based on class and race, not by individuals, but by large organizations, governments, governing bodies and that sort of thing.

Table 3

Interview Participants pre-intervention understanding of health equity and institutional racism

Hopes & Concerns

Finally, interviews revealed a variety of expectations about the upcoming intervention—both hopes and concerns. The majority of expectations reported were positive in nature: hopeful and excited. Most responses reflected anticipation for individual and interpersonal learning and development. Comments consisted of more self-reflection and self-awareness; better understanding of and ability to talk about institutional racism; learning from others' experiences and perspectives, particularly through stories; and bringing an equity lens to interactions with patients and colleagues. Additionally, there were a few expectations at the system level: decrease racially disparate outcomes, "redo who we are and what we are" (Nausheena), and increase reputation in the Black community.

Concept	Understands	Misunderstands	Doesn't Understand
Health Equity	10	2	1
Institutional Racism	5	6	2

While many expectations were positive, there were several concerns voiced. Participants revealed concern over individual resistance—their peers not taking this work seriously. Other comments were around the difficulty in changing behavior, and concern that the training won't be effective in doing so. One participant expressed fear the training will backfire.

The Program

Once leadership decided to create a learning experience around diversity, equity, and inclusion, planning commenced to determine what was going to be offered, how it would be designed, and who would deliver it. What ended up as the equity education program intervention was not what was originally discussed. This section describes that evolution and provides an overview of the structure, purpose, and key framework and concepts of the intervention.

Evolution of the Intervention

As a result of multi-level leadership support, and the need to focus on racial health equity, the equitable care pillar of the birth center strategy included two overarching goals: (1) growth as a hospital birth center – trusted and known partner in the community; and (2) understand how to deliver better care – implement changes to meet the needs of our diverse patient populations.

The tactic employed to achieve equitable care goal number two was to design and execute the intervention, a central focus of this case. However, the final design of the intervention was the result of an iterative process that started with the birth center director's desire to have diversity and inclusion training for the leaders of these six workteams.

To start, a small planning team was formed to brainstorm approaches. This included me, as the diversity and inclusion consultant, the health equity director, the medical/surgical specialty care director, a project manager, and the birth center director. Each planning team member had a specific purpose and value to their involvement. As Lila stated:

> I think that our roles were really important. I think it was really important to have somebody from your perspective and your focus on diversity and inclusion in being in that kind of … role here at [the hospital]. I think it was really important that we had [the health equity director] …ya know, she's been laying bricks for us to get to this point for a really long time… I think I was an important piece as an operations leader who actually cared about it as a topic. I think having a project manager is really important, also, because I just think that they add that level of connectedness and really bringing people together. And for [obstetrics] specifically I think [the medical/surgical specialty care director] was really important to just get the doctors to kind of buy in and go along with that approach.

Not only were the planning team members valuable to the intervention development, so were others to whom the committee reached out:

> I think we as a group, we approached the topic really humbly and just saying we're not really sure what's needed. I think we reached out to people like [the patient and guest experience manager], who, from patient experience perspective, gave us some historical knowledge that we didn't have, and what had worked before and what didn't work, and that I think helped drive it. Really have a key partner in the community clinic. Just because that's their whole focus, and kind of, she gave us, I think, some really tactical options for really playing some of our work out (Julia).

Participants also indicated other planning committee dynamics that contributed to the group's effectiveness, such as authentic and aligned passion and commitment for

racial justice, the right number of planning committee members, and not meeting too often to avoid burnout, yet meeting enough to keep momentum,

The planning committee's initial discussions centered on how to have the department participate in the existing implicit bias training offered by the organization. There was a desire to have birth center employees trained on implicit bias as a part of the overall department strategy. In essence, it was discussed as a "one-off," separate from the main birth center work, even separate from the larger department leadership conversation about how to approach the racial health equity work.

However, it was not long before the conversation shifted. As the birth center director explained to the planning committee more details about the six workteams that formed as a part of the greater strategy, a lightbulb clicked for the health equity director, and they suggested that, true to the overall organization's diversity and inclusion philosophy, the committee should try to *integrate* diversity, equity, and inclusion learning into the work that was already happening. In other words, attach it to the work of the six workteams. As a planning committee member, I reflected and journaled about that lightbulb moment:

> I mean it was a lot of things that had to come together for this, but there was a moment. There was a spark that happened…and it was [the health equity director] and I meeting in [the health equity director's] office, I don't remember when this was, I remember just recently that week or sooner I had met with [the birth center director] and [a nursing educator] because [the nursing educator] was doing some stuff that was kinda related to what I was trying to do with diversity training, all related to the birth center, and so [the birth center director] is like 'let's get

> together.' So we were making some connections in that meeting, and started to go wait a minute, maybe we can look at this work differently. But then it was soon after that I met with [the health equity director] and [the health equity director] said 'what about instead of this one-off, we looked at how we can build this equity lens into the work that's happening already?' I don't remember exactly how they posed it, but I remember the moment. And I remember it was that thought from [the health equity director], that I was like, because I remember in the moment feeling like 'dang, I missed that, I should've come up with that.'

As soon as that shift in perspective happened, it did not take long for the desired key aspects of the intervention to emerge, such as a cohort model, learning over the course of a year, and action learning through the workteams At that point, discussion focused to answering questions like who will deliver it, and how. Based on a recommendation from the birth center director, I (in my role as a planning committee member), met with a local consultant who facilitated anti-racism trainings. Based on my and the health equity director's previous experiences, we met with a second local consultant who specialized in intercultural organizational development. There was even discussion whether the facilitation should be provided by someone internally. As such, this proved to be a challenging phase, with multiple approaches and facilitators to consider. Lila described the experience:

> I think it was challenging to figure out how we approach it—like what's the correct way to do it. Do we choose one person to come in and do the training, do we do like, I don't know…I think that was the biggest challenge for us—how do we really deliver the education that hasn't been delivered before in the hospital.

Despite this challenge, a decision was finally made. The planning committee selected to work with the second consultant, whose approach most closely aligned with the hospital. As a white, queer Jew, she had been working in the area of intercultural development and equity for decades and had a specific framework and approach to engage clients of which the health equity director and myself were familiar with. And so arose the intervention.

Important to note, while the original implicit bias training considered at the beginning stages of planning was no longer the central focus of the intervention, it was not ignored entirely. The planning team chose to engage the department leaders in this two-hour session as a precursor to the start of the intervention. As such, this session was conducted prior to the onset of the study, thus not included in the findings.

Overview of the Intervention

An overview of the intervention is provided, including the structure and purpose, framework and approach, and key components.

Structure, Purpose, and Intended Outcomes. The structure of the one-year intervention included two central components: learning sessions and workteam meetings. The five learning sessions were scheduled throughout the year, with approximately two to three months in between each session. These sessions engaged the entire cohort of 49 leaders (hereinafter referred to as "intervention participants") in learning, activities, discussion, and practice. The sessions varied in length: the first session was eight hours, the second session was four hours, sessions three and four were two hours, and the final session was three hours.

In between each of the learning sessions were the workteam meetings, with each workteam having their own meeting rhythm—from weekly to bimonthly to monthly.

Again, these meetings were scheduled prior to and not for the purpose of the intervention. The purpose of these meetings was to address policies, processes and practices related to the overall work of the new birth center that would be opening. As mentioned earlier, the action learning was integrated into these existing meetings to teach leaders how to apply an equity lens to the work they were already charged with doing. So as not to overwhelm the leaders, the program planners decided to ask that only one policy or practice be chosen to bring an equity lens to, for the purpose of the intervention (however, it was the hope of the planners that it might naturally extend to other discussions and planning, as well).

The last learning session included a "share-out" where executive leaders were invited to hear about each of the workteams' equity project and how their individual learning led to creating equitable policies and practices within the birth center. Additionally, this last session included dedicated practice time to keep building leaders' confidence in talking about racial health equity and responding to racially biased comments.

Aligned with the six workteams already formed as a part of the overall birth center strategy, the purpose of the intervention was stated as follows:

> As a part of our overall planning and preparation for the new building opening in spring 2020, the [hospital] is serving as a pilot area for a comprehensive equity education program for staff and providers. Leaders from each of the birth center work teams will come together for a year-long equity education experience designed to equip decision-makers with a racial equity lens through which they can address birth center system, process and policy changes. The education also

> weaves in and aligns with [the organization's] diversity and inclusion messages and concepts" (Organization document, 2018).

The intended outcomes were (a) increasing awareness of one's own culture and its impact on our interactions and decision-making (awareness); (b) deepening understanding of racial health equity (understanding); (c) applying intercultural learning to work team goals (competence); and (d) growing confidence as a culturally responsive leader (confidence) (Organization document, 2018).

Metrics were established by the planning committee to measure the extent to which the intended outcomes were met. This included pre and post self-report surveys, and evaluations administered after the first two learning sessions. These metrics were created and collected as a part of the department's planning, *not* data collected as a part of this study. However, through document review, these metrics included in the findings.

Framework and Theory of Learning and Change. One aspect of the intervention was the facilitator's framework and approach, which integrated her theory of learning and change. As described earlier, the facilitator brought with her an approach aligned with the goals for the department's health equity strategy. The facilitator highlighted "I ground my work in well-researched, validated, and reliable developmental models that come from the fields of intercultural psychology, organizational development, adult learning theory, and community organizing analyzes of power" (Zemsky, 2019). Her focus on intercultural organizational development was described as:

> …a process of linking an organization's overall strategic development with its strategic diversity, inclusion and equity goals in order to become more effective in recruiting and retaining staff, board and volunteers, building effective

> multicultural collaborations, serving the diverse needs of our constituents, and impacting the long-term changes we wish to see for our communities…Intercultural Organizational Development brings together vision, skill building, the development of policies and procedures, structural support, and coaching (Beth Zemsky, n.d.).

Having found her previous approach of anti-racism training ineffective, she moved toward an approach designed to meet people where they were at, with tailored messages and learning experiences. The Intercultural Development Continuum (IDC™) provided the foundation for her theory of learning and change, which focused on both individual and interpersonal awareness and development, as well as that of underlying systems.

The IDC™ is a framework showing different mindsets when interacting across difference, from monocultural to intercultural (The Intercultural Development Continuum™, n.d.). Adapted from the Developmental Model of Intercultural Sensitivity originally proposed by Milton Bennett, this continuum includes five orientations: Denial, Polarization, Minimization, Acceptance, and Adaptation intercultural (The Intercultural Development Continuum™, n.d.). A short description of each orientation is shown in Table 4.

Table 4

Overview of Intercultural Development Continuum™ Orientations

Reprinted from Bennett, J., & Yalowitz, D.C., 2018, *Using a developmental perspective in training design*. Summer Institute of Intercultural Communication, Portland, OR.

The IDC™ framework was leveraged in two ways. First, it helped better understand where on the continuum the group landed, allowing the facilitator to tailor delivery methods and activities to, as the facilitator said, "meet people where they are at and bring 'em along" (Zemsky, 2019). The second use of the IDC™ was to teach the framework to help in participants' own intercultural development. More specifically, the facilitator indicated that it was a tool to help participants "develop the skill to deconstruct just the way [they] do things around [there], to see what were the assumptions, often unconsciously, that [they] embedded in [their] policy, practice, systems" (Zemsky, 2019).

Orientation	Description	Example
Denial	Misses difference	I've never had to think about racism
Polarization	Judges difference	Even though I'm speaking their language, they're still rude to me.
Minimization	De-emphasizes difference	Customs differ, of course, but when you really get to know them, they're pretty much like us.
Acceptance	Deeply comprehends difference	Since I am aware that I have a culture, and that culture may give me privilege, I get nervous when I am with people from other groups, since I don't know how to behave.
Adaptation	Bridges across difference	To solve this dispute, I need to change my behavior to account for the different in status between me and my counterpart from the other culture.

Key Components. The facilitator's approach and theory of learning and change included the following components central to the intervention.

Cohort Model. Unlike what often happens when trainings are attended on a one-by-one basis, this learning experience allowed for the same group of leaders to move

through the program together. The intention was to create a common language and experience that would serve as a foundation for continued work within the birth center but also would allow for personal stories and perspectives to be shared from which to learn.

Learning Over Time. Another important component of the program was that the learning and development would not be in just one training, rather over the course of an entire year. Though initially discussed, the planning committee was intentional about steering away from the one-off diversity and inclusion training. New concepts, approaches and perspectives were scaffolded—each learning session building on the previous one. The premise was learning and behavioral change can be more effective when training is offered over a longer period of time.

Action Learning. With hopes of creating tangible behavioral change, action learning was another central aspect of the intervention. The facilitator's website stated:

> Action learning is a continuous process of learning and reflection, supported by colleagues, with the intention of getting things done. Through action learning, individuals learn with and from each other by working on real problems and reflecting on their own learning experience. Adult learning theory suggests that adults learn best when they are provided with new information and concepts, opportunities to reflect and increase self-awareness, and meaningful activities through which they can apply the new concepts and skills they have learned in a supportive environment (Beth Zemsky, n.d.).

As such, practice with the concepts and approaches was infused into existing workteam meetings of which all participants led or attended. Between three and six workteam meetings were scheduled between each of the give learning sessions.

Equity Coaches. In typical consulting work, the facilitator would attend and serve as a coach for the action learning meetings that are conducted in between the learning sessions. However, due to lack of funding (and ability) to have the facilitator serve in this role for all six workteams' meetings, the planning committee, in consultation with the facilitator, developed an alternative approach. Since two of the planning committee members were intimately familiar with the IDC™ framework and approach, they were designated as "equity coaches" for the workteams. The health equity director and I served as equity coaches for three workteams each, to help ensure participants were appropriately and effectively leveraging and practicing in the workteam meetings content from the learning sessions.

The Intervention: Experiences

This section includes findings regarding participants' experiences with the learning sessions and workteam equity projects. Participants' challenges during the intervention are also shared. Findings were derived from two sources of data: interviews, and observations of learning sessions and workteams (which included participants a part of the intervention, but who were not interviewed). As such, two designations will be used: interview participants to denote the former, and intervention participants to denote the latter.

Learning Session Experiences

For each of the five learning sessions, findings are shared related to intervention participants' experiences gleaned from observations and post-intervention interviews, as well as feedback from evaluations emailed after the first two sessions. Evaluations emailed to intervention participants were not a part of this study but included as a part of document review. As such, evaluation feedback quotations will be designated generic identifiers (e.g. Evaluation Participant 1, Evaluation Participant 2). Lastly, challenges participants reported facing throughout the intervention will be highlighted.

Session One

The first session was the longest of all sessions at eight hours. It included an overview of the year-long program, expectations, and starting to outline the framework—the Intercultural Development Continuum. While interaction and activities were dispersed through the session, the focus was to provide a solid understanding of intercultural competence, diversity, inclusion and equity, and begin to introduce concepts such as universal design and marginalization. This first session of the intervention set the stage for the remainder of the year and was by far the longest session. As such, a more in-depth description of this session and the corresponding experiences is provided.

Several foundational concepts were introduced in the first session: action learning; universal design; intercultural competency and the IDC™; levels of oppression\systemic change; the equity project. First, the facilitator shared the Kolb Action Learning Model, and explained how this work is centered around the concept of action learning—and that it differentiates her work from a lot of in-classroom training that focuses on increasing knowledge without providing an opportunity to practice the

new behaviors. She introduced and discussed the action learning process they would be experiencing.

At that point, the facilitator introduced the equity project. She described this as one topic related to each workteam's focus area with which they would intentionally use to practice bringing an equity lens. The purpose of this was to create an opportunity where leaders could apply what they're learning to real situations within their department.

Next, universal design was presented, a concept from the Disability Rights Movement (Zemsky, 2019a). This resonated with the intervention participants, as it was the exact opposite of how they looked at decisions up to that point. Normally, when trying to make decisions, they would apply the 80-20 rule: determine a solution that would work for at least 80% of individuals. However, universal design is looking at decision-making from the perspective of the 20%: "by designing something for those who are most marginalized, we design something that actually benefits everyone" (Zemsky, 2019a). The facilitator used curb cuts as an example. Creating curb cuts was in response to disability accommodation—for wheelchair access. However, everyone benefits from them: people with strollers, heels, bikes, physical disability, etc. The facilitator further stated, "the key is to determine who is the most marginalized, determine their needs, and then design strategies utilizing an equity lens to increase access or remove barriers" (Zemsky, 2019a). Survey Annika shared:

> I think looking at everything and planning for our most vulnerable, versus the 80/20 usual plan. We need to do better for those who need us the most, even if it is the smallest group; Design for the most marginalized, the term diverse should

> be avoided, greater awareness of my own biases; we tend to think of issues or designing workflows looking at the 80/20 rule however we should approach more situations looking at the path of least resistance.

After concluding comments, the facilitator presented the central framework and approach to this work: intercultural competency and the IDC™. She described intercultural competency as both a deeper cultural self-understanding, as well as deeper cultural other-understanding. Additionally, she shared that intercultural competency is developmental, how we make sense of our experience, and our capacity to shift behavior and mindset based on the cultural context. In conjunction with her description, she provided a model that showed a continuum of one's intercultural competency: the IDC™. As stated earlier, the IDC™ is a framework identifying five different mindsets when interacting across difference. The intervention participants were given definitions and explanations for each of the five mindsets. In the post-session evaluation, participants highlighted the impact of learning this new framework, including appreciation for the different mindsets people can have, and the progression; and interest in learning about different mindsets from the dominant culture perspective versus another culture. Lila also shared the impact of the nonthreatening approach, particularly as it related to conversations about race:

> Because when we talk about race, I think it just incites fear and confusion, and just people don't open up as much. But I think if you take it through that model, what I noticed is that people felt a little more comfortable in conversations, if that makes sense. So that was a good learning for me because I think initially we talked about when we were doing planning and I was like, 'Well why isn't [the facilitator] just going to go straight to race and talk about,' I really wanted her to

> go there and I know that you helped me temper that request and [the facilitator] helped me temper that request and I thought that was important because I think now I see the value that came from that.

They came to understand the facilitator's framework, which initially seemed too indirect in discussions of race and racism, and thus less effective, but was indeed appropriate and effective in opening participants up to these conversations.

The facilitator also led the intervention participants through activities that exemplified each mindset. For example, one activity called "Stereotype Wall" included having two volunteers stand on either side of the room looking at each other, one assuming the role of an 18-year-old patient, the other a physician. Intervention participants were asked to name stereotypes, biases, and preconceived notions that get in the way of seeing the person for the person and NOT in association with the group in which they have an alliance. For each stereotype or bias mentioned, the facilitator would have an intervention participant stand between the two volunteers and represent that bias that existed for either the patient or physician. Eventually, so many biases were identified, the view the patient and physician had of each other was blocked. This experience gave participants the opportunity to name, acknowledge and normalize bias, prejudice and preconceived notions; identify the impact of perceptions; and acknowledge perceptions are real because they are real in their consequences.

Two interview participants recalled this activity in their post-interview interviews, revealing how impactful it was. Fiona stated:

> I think the biggest, I don't want to call it tool, but the biggest impact that I can just clearly remember was the date that she, this was with [the facilitator], she had

> [another intervention participant] and I starting out together as two people who could see each other, a nurse and a patient. And then took a person and said, here's this. And by the time she finished there was 14 roadblocks and you couldn't even see that person anymore because you were blindsided by everything that was in between. And I just think that that was really impactful because you can talk about it, but I think conceptually just to visualize it, that was really key for me.

Holly expressed:

> The activity provided a visual representation of biases people carry and the barriers those can create. It was the "visual of just being more open minded and don't let things block your way" that left an impression.

This activity proved powerful in helping participants visualize the impact of biases providers carry towards patients, even if unintentional.

The last major concept the facilitator introduced was around systems: institutional and structural. While the vast majority of the eight-hour session was focused on personal and interpersonal development, there were times the facilitator would introduce a systems perspective. In the discussion of the IDC™, she suggested there are four types of focus on developmental learning regarding oppression: personal, cultural, institutional, and structural. She highlighted:

> Personal centered around prejudice, bigotry and bias; cultural included norms, values or standards assume by the dominant culture that maintains status quo; institutional was discriminatory treatment, unequal opportunities, and disparate outcomes propagated by powerful institutions; and structural included interaction

> between institutions, policies, practices, culture and history that support chronic systemic inequity (Zemsky, 2019a).

She also shared a quote from Dr. Harry S. Green, from the University of Chicago, that resurfaced in almost every learning session thereafter: “every system is exquisitely designed to produce the results it gets” (Zemsky, 2019a).

One defining issue was revealed in the session, as well as from participant interviews and evaluation feedback gathered after the session. Several intervention participants expressed apprehension and offensiveness to some of the facilitator’s language and political references. During the session the facilitator, in describing herself, used the terms “dyke,” “queer,” and “Jew.” An intervention participant expressed in the large group that they were confused about the facilitator using those terms, as they thought the facilitator was offensive. They exclaimed, “I didn’t think you can say Jew.” At that, another intervention participant said “queer, too. I’m not comfortable with that.” The facilitator responded that she was using words for communities for which she was a part, and then said, “If you’re not a participant of that group, you can’t use certain language.”

Additional comments about this issue were revealed in the post-intervention interviews, as well as survey feedback collected by email immediately following the session. Remarks indicated further reactions to the facilitator’s use of “dyke” “Jew” and “queer,” saying she “seems to be biased herself, not truly open to all people’s beliefs.” Darnisha reflected in their post-intervention interview:

> And the one thing that I was surprised by is, and this isn't a criticism of [the facilitator], but she assumed that everybody was somewhere in the room and not

> everybody was there. And that assumption I think got her off track in the beginning with a portion of the participants . . . .it was clear, and this was feedback from some of the nursing people who were participating. It was clear to them that you couldn't have a conservative viewpoint and be respected and honored in that room . . . [they] came to me and were like, 'this didn't feel good, this didn't feel right' . . . [T]hat's not how I read it, but it was certainly, I could see it after they said it, oh yeah, you probably didn't feel very validated in that room during the whole time. And as we talk about diversity and inclusion and respecting all opinions, it's more than just thinking about the color of our skin, it's also diversity in thought. And so having that respect for that piece of the puzzle was, I think what was missing for some of those girls. And I was like, 'wow, okay. I didn't really think about it that way.'

In addition to concern over the use of some identifiers that the facilitator used, a few intervention participants reported an issue with political references she made, as well. They stated she "grossly misused her title and time to communicate a politically charged message…[that] was very unprofessional and inappropriate" and the "use of slurs (racial, sexual, religious) was inappropriate and very uncomfortable. It was frankly unprofessional and if any of us in the room were ever to say anything similar in the workplace, disciplinary action would be taken" (Evaluation Participant 1). Another intervention participant reported "the presenter gave very biased examples of how her research/theory should be applied [stating] 'if the country had this information the outcome of the last election would have been different.' This implied that the only correct way to think was the way that she thought" (Evaluation Participant 2).

While several intervention participants expressed strong disagreement with what she said, others shared a different perspective. One comment from the evaluation feedback included “I was alarmed by what she said but it did not offend me” (Evaluation Participant 3), and another mentioned:

> I liked [the facilitator’s] presentation style and provocativeness; I could see that that style may not have worked for everyone though. However, I think it was good if there was discomfort as we need some discomfort to lead the way to changes! (Evaluation Participant 4).

During the post-intervention interview, Annika shared how they tried to address their colleagues’ concern after the session, and the impact that conversation had on them:

> It was after the first one, I remember, and hearing what they said about certain things and how they felt uncomfortable about some stuff. And I'll say, ‘Well, why did you feel uncomfortable? What made you . . .’ [colleague cut her off and stated] ‘I didn't like that the facilitator called herself a Jew.’ I'm like, ‘Well, if that's how she identified herself, why do you have a problem with it?’ And just talking about it, I'm like, ‘This is great. I don't know what happened, but I want to go next time.’ And so I liked it a lot. I enjoyed it.

Annika’s experience exemplifies how participants moved through the conflict, and even used it as a teaching moment. Despite harsh criticism of the facilitator’s language and style by a few, the majority of intervention participants relayed in the session evaluation benefits and valuable takeaways from the session. Including the idea of focusing on the most marginalized, the need to get comfortable with being uncomfortable, the facilitator’s style, and handouts.

Session Two

Two and a half months later the intervention participants gathered again for their second learning session. This session was four hours, and intervention participants were asked to sit at tables with their workteam members. The session opened with each team sharing where they are at with their equity topic. Some workteams had identified their equity project, while others were still discussing options. Examples of projects included:

- examining the toxicology screening process.
- determining how patients would be designated to the limited number of special rooms
- examining the hospital's existing "warm welcome" practice

Details on the equity projects are provided in the next section.

Next, the facilitator had each small group discuss what stood out to them from the last session, called "re-grounding." (Zemsky, 2019b). Several leaders from the workteam I joined admitted they could not quickly recall all that was discussed at the first session. They refreshed their memories by reviewing their participant packets and a discussion ensued. At the large group share out, concepts that resonated with the intervention participants included universal design, flipping the 80-20 practice, that people can have good intent and still be biased, and it was difficult to talk about and share with others the experience with those not a part of the intervention.

At that point, the facilitator addressed the feedback that was given to her regarding her language and comments from the first session. She acknowledged the strong reaction by some and the impact it can have on learning and working together. She apologized for bringing political examples to the conversation and said she would be

careful about not doing so going forward. She then gave some context to her use of language. She shared that using certain words to define yourself is up to that individual, further stating that no one has the right to tell someone else how that person can identify or the words they choose to do so. A part of her (and others in those communities) using those charged words is about reclaiming words that have been historically used to disparage, denigrate and divide. With that, an intervention participant asked, "can you tell us what queer means to you?" and the facilitator proceeded to share what *her* version was, ensuring that others knew that she is only speaking for herself.

In my observation, it seemed the intervention participants understood and appreciated what the facilitator said, evidenced by a lot of nodding heads, and utterances like "ahh" and "I see." Darnisha recalled in their post-intervention interview "…the next time that we came together, and Beth did that reset, I think it changed the tone from then on for the other sessions." Even Holly, who had a strong negative reaction to the incident, stated:

> I think Beth is amazing at what she does and it kind of opened your eyes. a lot of examples of what to do or what to say. Is she always right? Probably not. Just for her even talking about her sexuality. I mean it just, I can't think of a specific thing. I just found her very interesting. Did I find her annoying at sometimes? Yes. But I did find her for the most part very interesting. Informative.

Even if intervention participants who were initially negatively impacted by the facilitator's comments, they did not seem to carry it with them throughout the year and let it impact their views of the experience overall.

The remainder of the session included an activity focused on "mattering versus marginality"—reflecting on experiences related to feeling valued, as well as feeling devalued; large and small group discussion on the IDC™'s Minimization stage and how it shows up in their work; and a brief introduction by the facilitator on how to bring a system lens to individual behaviors.

The engagement was evident. I observed participants leaning in, many nodding their head in agreement, and robust conversations at tables. Carol reflected on what it felt like in this session:

> I think of those that were participating, there was so much interest and buy-in to what we were doing that I think the people involved really set up a way for those around them, I think we all did that for each other, to feel comfortable in sharing and thus helping the rest of us learn from things that were offered and experienced.

And even though I also observed a couple physicians struggling with the concepts, overall, I witnessed a sense of curiosity and commitment from participants.

Session Three

Session three was two months later and two hours in length. As was done in session two, the facilitator "re-grounded" the group--reviewed the key concepts and content from the previous session—taking about one-third of the session time. As a transition, the facilitator leveraged one of the key learnings—intent versus impact—and expanded discussion on it. The remainder of the time was spent introducing and discussing types of power, including referent power, "the desire for a feeling of oneness

and acceptance in a valued relationship (Zemsky, 2019c); and systemic racism, including a short animated video that explained systemic racism.

A greater extent of engagement and participation was observed in this session. As the conversations and topics drilled down to the department more, it seemed the discussions grew deeper and more robust. Voices were heard from participants who had not shared before. Sparks in learning were revealed. Gabriella spoke out in the large group:

> I'm still trying to sit with this and figure it out, but it strikes me that it hits home for us in the birth center and the work we're doing, and thinking about the data we got from our first month of the surveys and that the African American women over and above said that their worst experiences were with pediatric care, social work and special care nursery. And I think immediately we think of that personally. And I think that we need to think of that from this mismatch of personal and system power because over and above African American woman have their babies removed from their custody by the systems we have in place. So, they come with that experience to our department. And so any place where they would feel threatened about their ability to mother or that somebody may be looking to take their baby away, all of those things come not with just how kind we are or how much we're trying to use our personal power they experience our power as coercive.

Gabriella's realization hit home the difference facilitator's lesson about the difference between personal and institutional experiences and power, and how providers tend to operate from a place of personal power—trying to be really nice, for instance—when

patients are coming from a place of institutional power and experiences that no amount of "being nice" would address.

Particularly notable was observing participants' positive reactions to watching the systemic racism video. The White participants dominated the conversation, but in a way that seemed appropriate and constructive. White participants were sharing "ah-ha" moments having been explained something they never realized before. Based on the comments voiced in the large group, it seemed White participants were accepting this new information, and not showing defensiveness. Post-intervention interviews revealed how impactful this moment was for some White participants, exemplified by Carol's reflection:

> When you hear from your peers, the people you pass in the hall every day, and you hear about some of the things that they have been part of, witnessed, lived. I really think that sometimes is the biggest gut check because it's the most connected and close . . . I think that makes a huge impact on people and something along those lines could be a way to connect with people who might otherwise not be super excited about sitting in hour long educational sessions over the course of a year.

Post-intervention interviews also revealed the impact this had on the Black participants:

> So once they got shocked, and once they could reflect on themselves, and once they learned a little bit more than I wasn't surprised that they would then turn and say, 'Yeah, actually, I do want to work on this' (Lila).

While Lila noted the experience of witnessing a new investment by their white peers, Annika reflected on their initial biased reaction and how they moved through that:

> Because when we talk about race, I think it just incites fear and confusion, and just people don't open up as much. But I think if you take it through that model of [IDC™] what I noticed is that people felt a little more comfortable in conversations, if that makes sense. I think one of the most compelling things was there's the video about redlining and I know about redlining, but hearing the reaction of others like, 'Oh my,' like the surprise. And I'm like, so part of me was like, 'Why don't you know about . . .' And then another part's like, 'Okay, well now you know…' It's my own bias. I'm like, 'Why doesn't everybody know about this? Why don't . . . So it's like, okay, here we are, this is where we're at. People were just shocked. I'm like, "Well, okay. Good, now that you know. . .' Now I'm like, 'Okay and now you know.'

And still, other voices in the session heard reflected a different understanding by some: "if we had greater diversity, I think things would be better," and "the goal is to treat everyone the same" and "provide equal care." There seemed a minority of participants who were not at the same level of understanding and acceptance. Or at least not articulating as such. I recall wondering to myself if the weight that was being given to what was being said, versus not said. A similar reflection was shared by Darnisha in their post-intervention interview, "do you go with what's voiced or what is not voiced? Yeah, that's interesting. And whether or not there was expectation of conformity." This reflected the curiosity around group dynamics, and how to gauge a group's level of understanding and development. Do you leverage what was being said as evidence of the claim, or is it more telling what is not being said?

Session Four

The fourth learning session was conducted approximately eight months into the intervention. As with sessions two and three, the facilitator reviewed with the group the previous session's concepts and key points. Most of the two-hour session was focused on exploring implications of individual, cultural, institutional and structural issues on patient interactions. This session had the greatest focus on systems-level dynamics thus far. Time in small groups with workteam members was spent in practice and application to their workteam equity projects. One quote stood out from this session, "Don't process impact as a complaint" (Zemsky, 2019d), driving home the difference between intent and impact discussed in earlier sessions.

Observations showed participants thoroughly engaged in their small group work, which continued to focus on integrating learning into their workteam equity projects. Brittanie noted:

> [there was] a fair amount of collaboration…their engagement was really high, and their willingness to look at proper processing of discussion, to get to an end, and to have an outcome that actually worked, was really nice to see. And they were tackling problems, that we've been trying to tackle for a long time, but they have just kind of fallen into chaos in trying to deal with them.

The learning environment allowed for the time and commitment needed to address intractable challenges within the department. At this point, the equity projects were well under way and I noticed participants were formally and informally sharing with each other how it was

Table 5

Overview of Learning Sessions

Session	Length	Key Concepts	Key quotation(s)
1	8 hours	IDC™ framework Diversity, Inclusion, Equity, & Intercultural Competency Universal Design Marginalization Action learning Stereotype Wall activity	"By designing something for those who are most marginalized, we design something that actually benefits everyone." "The key is to determine who is the most marginalized, determine their needs, and then design strategies utilizing an equity lens to increase access or remove barriers." "Every system is exquisitely designed to produce the results it gets."
2	4 hours	"Re-grounding" Intent versus Impact Mattering v marginality activity IDC™ Minimization Identified equity projects Relationship between individual and systems lens	"Platinum rule: treat others how *they* want to be treated." "When you see marginalized patients' behaviors, think about how this might be the result of a cue from the environment, and not necessarily the result of you."
3	2 hours	"Re-grounding" Types of power Systemic racism video Levels of oppression Patient scenarios activity Aligning intent versus impact	"Intent is what you meant rooted in your history; impact is how they are affected rooted in their history." "Impacting attitudinal change requires referent power."
4	2 hours	"re-grounding" IDC™ Adaptation Institutional and systemic racism Patient scenarios activity	"Adaptation is a goal-directed behavior, developing a reflective practice to learn from interactions."
5	2 hours	Poster session share out Practice and role play activities	"putting theory to action" "comfort is being privileged"

Retrieved from observations, and Zemsky (2019a; 2019b; 2019c; 2019d; 2019e)

going. Comments heard showed challenges that they were facing in bringing a racial equity lens to their work, though communicated in a way that exemplified a continued curiosity and commitment to the work.

Session Five

The fifth and final session was conducted almost exactly one year after Session One. This session was divided into two parts. The first hour was a poster session where intervention participants shared their equity project journey with each other, and with several hospital executives that were invited to attend this portion of the session. This served as an opportunity for participants to reflect on their experience and learnings, as preparation for their poster share-out, as well as inform hospital executives of participants' key experiences and outcomes. I observed an incredible amount of engagement and conversation as I observed the different groups. The language intervention participants were using to describe their learning journey and outcomes of the process reflected not only their understanding, but ability to speak to—to put into practice—key concepts gained over the past year. I observed visibly moved hospital executives both during the poster share out, as well as in comments they made afterwards.

The second part of the session was dedicated practice time that was scheduled due to overwhelming informal feedback from intervention participants that they were feeling more competent, but still lacked the confidence to bring a racial equity lens to their work. More practice time was provided to role play responding to microaggressions and bias, and in establishing their "elevator speech" to explain to others why racial health equity is critical to their work. Carol shared the impact of that activity:

> I think we did some of that, where we did the role playing and things like that, and I felt like it was helpful. I personally feel like I need more of that and sometimes it is some more observation of technique.

The session (and entire intervention) ended with a presentation of the facilitator's best practices (which weaved in key concepts from the intervention) and closing remarks from the birth center director. Table 5 provides an overview of timing, length, key concepts and quotes of each session.

Workteam Experiences

Findings are shared from four of the six workteam. Only four workteam experiences are provided due to limited data from interviews, and no observations conducted of the other two workteams.

Workteam One

The equity project for Workteam One addressed the policy and practice of patient toxicology screening. Similar to Workteam One, the topic was met with a bit of resistance: "at first when that was brought up, I'm like, 'Are you kidding me?'" (Holly). However, progress throughout the year was made as the workteam continued the exploration. Brittanie shared this process, which included:

> …recognizing that we had a bias and how we applied it. And I think that conversation went from defensiveness, like, "Why I'm thinking I'm applying this appropriately, or while you're not." to, "Oh, okay, you're right. I see how to do that . . . How do I do that?" The conversation moved really quickly into, how would I have, in this case, a tox screen, and tell the patient she's going to have

> that, or she qualifies for that without offending her. And they got quickly into that discussion, into how that happens, and how to avoid it.

The workteam grappled with implicit bias, intent versus impact, focusing on the most marginalized patients, all concepts scaffolded in the learning sessions throughout the year. Darnisha expanded on how the concept of intent versus impact discussed in the learning sessions played out in their workteam conversations:

> Our intent was that we wanted to make sure that everybody was screened who needed to be screened so we could take really good care of the baby. But the impact of that is sometimes you're marginalizing people by doing the right thing and it's all in the manner of how you present it and how you explain it that takes that marginalization away…[recognizing] they've had some a history, but really being cognizant of, okay, we know that our intent is wonderful, but we really got to make sure that the impact of how we're rolling this out, there's not a negative impact for people that we don't want it to have a negative impact on. I think that was probably our team's biggest learn overall.

Brittanie spoke at length about becoming aware of how implicit racial bias played a role in the existing practice. They stated a medical provider not in the intervention:

> Did a good job at showing specific patient examples where, this person should have been screened and she wasn't, and this person was screened, and she should have been. But the only difference between those two people . . . well, there's a lot of differences but one of the differences is race, 'Is that why you didn't choose to screen, the sum of which, clearly says, this is somebody we would screen with that?' And then coming back to a group like we do with Workteam One and

> talking about that specific data with things, and then exploring through what we did with our training.

Brittanie made a connection between the workteam and the learning session experiences. This sentiment was shared by Darnisha, who also spoke to the long-term impact for the unit:

> And that was impressive to see how intentional the training was because it was like a little separate break off of our main workteam…for the nursing training to get all of our mat nurses up and running. And so just how [the workteam leaders] actually took what we did in the whole cohort and then in our team meetings and then just to branch it off and really be intentional about making this, how our policy is. That to me is how this is going to get disseminated, and how it's going to become part of our culture and how it's going to start to become part of the intent of how we're working for things.

What emerged out of some initial resistance to the equity project progressed into significant learning expressed by participants. Form Holly, who shared they initially had resistance, further stated, “but now I do see the connection.”

Workteam Two

The purpose of Workteam Two was to ensure the department provides the highest quality care while supporting and keeping moms and babies with increased care needs together, even in the setting of increased medical acuity. The first meeting the workteam discussed equity, included the workteam leader, a midwife, three physicians (only one of whom had attended the first full-day learning session), two other leaders in the program, and two registered nurses who were not a part of the intervention. For the most part, the

physicians were sitting on one end of the long table, the nurses together on the other end, with the workteam leader and me across from each other in the middle.

As the equity coach for the workteam, I introduced myself and explained my role as the equity coach. Knowing that not everyone on the workteam was a part of the program (or able to attend the first learning session), I explained the equity goal, universal design, and how to identify and plan for the most marginalized patient. I shared that my role as an equity coach was to support the workteam leader and the group bring a racial equity lens to the policies and practices being developed for the special rooms. Not much was said after that, so it was difficult to determine how much of it resonated with the group.

The first conversation about equity was about what patients would be eligible to be in these rooms, as well as how decisions would be made on who gets them when there is more need than rooms available. An interesting dynamic emerged; the physicians were controlling the conversation, cutting others off, and making dismissive comments. The nurses present did not say anything, except when the workteam leader turned and specifically asked for their input. The workteam member—a midwife—most vocal in their understanding and need for equitable care was by far the one most cut off and dismissed.

Further into the discussion, the vocal midwife expressed that given the equity lens they were to be bringing to this work, perhaps they need to look at how they monitor babies who are proven to have racial inequities. This comment was met by a physician who stated, “we do not focus on race, we treat everyone equally” and “no data supports Black babies should be treated differently,” followed by another physician who

exclaimed “studies show that the infant and maternal racial disparities are really about access. So, we’re not dealing with these issues when they’re in our care.” Conversation quickly halted after that. Ilse later reflected on that exchange:

> I did find it challenging … when I had very educated providers that just couldn't get it. I felt like they're kind of very black and white thinkers and they couldn't yet incorporate anything else into their thought. That was frustrating to me. I struggled with that a little bit and trained to how to get them to . . . like, I would try to use different examples of things that I had been a part of to try to put it clinically for them so they could see it in their world. I mean, I tried various things, and sometimes I could just see it was not . . . It would just kind of not hit the right thing in them.

This experience exemplifies the continued resistance some participants—in this case physicians—had early in the intervention.

In the second learning session the following month, each workteam sat together in small groups. At one point, the facilitator asked each small group to discuss “how, if at all, has minimization shown up in our work team meetings?” The discussion included several ideas:

- Assuming everyone wants the special room
- Racial disparities in how we make assessments
- The intended outcome of the special room is to decrease separation, increase breastfeeding, and increase bonding. So, the question is “who is at more risk from those things not happening when separating the baby and mother?”

- A concern that they might create equitable policies, but still have inequitable practices.

Despite a robust conversation, an interesting dynamic arose around a difference in perspective and understanding on how race impacts patient outcomes. The two midwives in discussion were, once again, trying to express this to the physician, but seemed closed off, cutting them off several times and shutting down the conversation. Soon after, the physician left the session early.

Just a few days later the workteam had another meeting and the topic of equity resurfaced. Some progress in conversation was made as the group discussed how bias could show up in how the special rooms are designated. Throughout the meetings the workteam leader was building a better understanding of how to bring a racial equity lens to discussions and decision-making in the group. I noticed an increased confidence from the workteam leader. They no longer looked to me before speaking—no more implicit asking for help or permission to say something. She showed an ability to explain her thoughts in a clear, succinct manner, and use stories to exemplify her points.

One moment stood out during my observation. During a discussion, a physician continued to push back on how race does not make a difference, mentioning "data has nothing to do with minimizing inequities…there's a standard policy…just follow that and we'll be good" (Transcript, September 19, 2019). I saw the workteam leader make a quick movement to respond, but then another workteam member—a physician on the phone—spoke up and challenged the colorblind comment. Despite not sharing their insights until after the physician spoke, they spoke with confidence and relayed an experience about how they used to think the same thing, but in digging into the racial

disparities, and learning more about institutional racism, they understand things differently. The workteam leader encouraged and facilitated the continued discussion. Overall, it resulted in a productive dialogue where various perspectives were voiced, where group members respectfully challenged and disagreed with each other.

Another example of Ilse's increased confidence and competence came after the meeting ended, but while I was still audio recording. While leaving the room, Ilse and a physician (an intervention participant) were talking, and I was just listening at that point. They were discussing how to approach decision-making on who gets or does not get the special room, and bringing an equity lens to the discussion and decision. Ilse shared that sometimes her decisions are made when she is on the phone, when racial data is not available. The following is the exchange:

Ilse: So when I am making assignments, I'm strictly doing it off of diagnosis, and I don't know their race ever

Me: But should we?

Ilse: That's what I'm saying, we don't know that, it's blind to us. We don't see that patient before they come to us. We have no clue, unless we look in the computer which I don't think people tend to look for that.

Physician: And which way is actually more equitable, is blinding more equitable or is profiling more equitable?

Ilse: This is an interesting conversation

Ilse then shared a story of an experience with a Black patient whose mother (also Black) was angry because Ilse assigned them to the worst room. The mother had seen an open room that was in much better condition, and said that her daughter was assigned that

room because Ilse is racist. Ilse shared that in the moment they challenged the claim because there was a legitimate reason why the nicer room was not assigned—that section of the unit was closed due to low staffing. Ilse continued to share what that experience was like at that time, including how upset and defensive they were. However, they shared afterwards, they started to think more about it and could see the patient's and mother's perspective. "If they've been marginalized it's just one more time from their perspective. And I really had to dig deep to come there. That was really hard for me." I responded with making a connection between intent and impact, and how even with the best intent, there can still be a negative impact.

Physician: It's hard when you're on the receiving end of that.

Ilse: It was a game changer for me, to see it differently.

Physician: And then there's other people who will play that card, ya know, people with addiction problems play that card on me from time to time, and I'm like 'well….' It's hard. I'm not withholding oxycodone because of your skin color; I'm withholding it because it's a good idea, for all these medical reasons…

Ilse: …yeah….

Physician: Yeah it gets…it has an impact on us, and then trying to come back and build a therapeutic milieu and rapport to help people set them up for success

Ilse: The funny thing about that experience. Yes, in the moment, I didn't love it [laughs], not gonna lie, but it did make me….

Physician: [tries to interrupt]

Ilse: [continues saying] …it did make me think differently going forward. It did.

Physician: it does make you pause for reflection.

Ilse: And then after I was like maybe I should look at skin color, maybe that does matter.

Physician: It's really powerful when you realize when a lot of people might be interpreting actions, even if they're well intended, that way.

Not only did this exemplify an overall increased competence and confidence, but as a nurse manager responding to a physician, it exemplified a troubling cultural norm about the power divide between physicians and nurses.

Throughout the subsequent workteam meetings, equity conversations continually waxed and waned, from not being addressed at all at some meetings, toward the end being the entire meeting agenda. And as the conversation progressed, so did the workteam's overall understanding, acceptance, and use of a racial equity lens. What Ilse shared about their experience exemplifies this progression:

> One of the physicians was saying, as a hospitalist how, before you couldn't get that person to even say that equity was an issue...but this time I felt like he was a little bit . . . He was even giving some examples of how we could see it. And he hadn't done that before. Or I didn't see him doing it before. To a point where I think sometimes he would talk a little because he knew he was supposed to. But I don't think the meaning was behind it. But actually this time mostly, that's when it feels a little genuine.

They also shared thoughts they had toward the end of the intervention:

> I feel like the last meeting we've just had a couple of weeks ago, that's a first time I feel like everybody that was in that meeting had some awareness. Like, sometimes you have a handful and then there was one that didn't. It never seemed

> like at any given point that everybody was online all the time. And you would see some people come in and out of it. I felt like this last one was the first time I've saw where everybody started to realize, 'Oh, okay.' And could even put it into some context that was meaningful to their work.

Based on my observations, and the experiences shared by Ilse, as the workteam leader, this group made huge strides in their awareness, acknowledgement and applicability of racial inequities and institutional racism.

Workteam Four

The purpose of this workteam was to lead and coordinate decision-making around the future birth center's new physical space. This included, but was not limited to, decisions regarding the floor plan, furniture, artwork, and lighting. Unlike the other workteams, this workteam had been meeting prior to the intervention. The equity project they selected to examine the use of care boards—the signage in each patient's room that includes pertinent information for both the care providers, as well as patient and family (e.g. patient name, pain scale). Initial workteam discussions around the care boards were met with some resistance. For example, "How can a board on the wall be racist?" (Darnisha), and "We were just like 'care boards? Like what's the big deal? Just do a care board, write the name'" (Holly).

Participants' interviews revealed how the workteam approached the equity project. Julia revealed what the discussions entailed:

> Are we centering the most marginalized as we're talking about this, about this new policy, about this new practice, about the design of this care board, and to do that going forward. We've talked about what will work for us as nurses, but now

> let's stop and pause and turn and say, how will this impact patients and not all patients, but how will it impact the most marginalized patient? What are the differences that make a difference here, and really design from that starting point I think will make a huge difference going forward.

Further, Darnisha shared another dynamic aspect of their conversations:

> And then the more they talked about it and like, how do you communicate with people? What information do you put on there? Do you make sure that it's in a way that the person who's reading it can understand it? Then I got it. It's like, oh yeah . . . Why is that important? And it's really about just change in how your focus or your lens is about. Oh, yeah, that could be, if you're writing everything in English and the person only speaks Spanish, how meaningful is it for them to have that care board up there? It's not meaningful. That's very true. It's not meaningful whatsoever. Unless it's meaningful to the person who's utilizing it, which is the intent is for the patient to be the one who utilizes it.

Participants' reflections on this process illustrated how discussions shifted, which included changing the lens through which they looked at it—focusing on the perspectives of the patient, and not the provider. Holly pointed out that "the care boards was a huge thing for us…just to be more in tune, more sensitive."

Workteam Five

The purpose of Workteam Five was to ensure all patients and guests feel welcomed and have a positive experience at every point in their continuum of care. As with the Workteam One, this workteam included on the agenda a discussion about bringing a racial equity lens to the group's work. In their initial brainstorming session,

several different possible ideas emerged, including patient education; disparities in pain control and medication for Black patients; and inconsistency with communication leading to lack of trust.

Later in the meeting when discussing how to ensure everyone entering the hospital feels welcome and included, the director of housekeeping and guest experience asked if their "warm welcome" is actually "warm" to everyone. A meaningful conversation ensued, including recognition that there currently did not exist an actual definition of "warm welcome," though their appeared common understanding in the workteam of what it meant. However, there also seemed an agreement that there have probably been assumptions made about what patients and guests would want it to be.

Interestingly, the next meeting two weeks later took a shift. After I, as the equity coach, brought this topic up again, attitudes expressed were starkly different. In fact, interestingly, the same leader that posed the question around a biased warm welcome the last meeting, defended that idea that it is indeed appropriate. The conversation was tabled until next meeting, when the workteam leader would be present, as well as feedback available from rounding, asking patients how they felt about being welcomed. With the workteam leader back, and results from patient rounding on what a "warm welcome" means to them, the group once again agreed that this was the appropriate equity project with which to focus.

An additional impact this equity experience had on the workteam was in creating a partnership with Workteam Six as they were designing the first of several staff orientations to the new birth center. These two groups aligned in incorporating

recognizing and mitigating implicit bias into the orientation, specifically calling it out as a critical practice to ensure they provide equitable care.

Participant Challenges

In addition to workteam experiences, findings also revealed participants' challenges within the intervention. These challenges expressed consisted of resistance and defensiveness; discomfort, guilt and fear; provider ego; and trying to engage in conversations with peers outside the cohort. Notably, though perhaps not surprisingly, participants' reports of these challenges were all directed at other white participants and peers.

Resistance was expected by some participants, and surprising to other participants. Gabriella shared their surprise at the resistance:

> I was surprised at some of the resistance and surprised at some of the levels. Just all the comments I would hear about people, not the ones who are in the larger I don't know what to call it, but the [facilitator's] process. But the ones where everyone went to the one-hour training that the department did on the implicit bias training. Hearing nurses all the time say, 'Yeah, I've got to go to that thing where they're going to tell me how racist I am.'

While Lila discussed disappointment, they were not surprised:

> I mean, when people resisted that's always kind of like disappointing when they resist the conversation or when they resist the principles that we're trying to teach. That was disappointing, but not surprising. I think I expected that.

Resistance also showed up as frustration and anger at times; though, interestingly, while not explicitly acknowledged, Holly revealed resistance and defensiveness herself:

> We don't treat everyone the same and our most marginalized people are noticing that. But I also feel like people act to be the victim. Do you know what I mean? Sometimes I feel like people walk in and you walk in the room and they're already on the defense. Like she's not going to be nice to me because you're an African American family . . . .I felt like I had to kiss her butt for eight hours to make up for other people's, how she felt she was not treated right. And that was mentally exhausting for eight hours. So parts of me feel like I did everything I can, but still it wasn't good enough.

This participant seemed to still be working through a new level of awareness and understanding, evidenced by acknowledging the concepts of equity and marginalized experiences, but still holding onto racist attitudes.

Fear, discomfort, and guilt were also expressed as a challenge by some. Carol admitted:

> I think there's some inherent discomfort in any discussion about institutional racism or our current . . . As a hospital as you look at like, well, here's what we do. It's some of those moments you stop and you're just like . . . Something I've done every day for 10 years, when you stop and look at it from this other perspective, it's a little gut wrenching. Sometimes you'll be like, how did we not realize that that maybe wasn't the best way to do that.

With similar sentiments, Darnisha emphasized the experience of "turning the lens on yourself:"

> It's hard to turn the lens upon yourself because you realize that you have not been perfect throughout all of the time that you've been practicing and taking care of

> women. You know that you've made missteps. And to have that lens put upon yourself can be really hard sometimes.

However, despite acknowledging this challenge, participants were not deterred from being vulnerable and pushing through these emotions, and pointed out that the intervention's tools helped them process.

Finally, participants revealed that interacting with peers not involved in the intervention was challenging. Five participants shared examples of how conversations with peers not a part of the intervention was difficult, and tension-filled. This included not having a common language or experience to connect on, and being resistant to the existence, or lacking an understanding, of the racial health inequity and institutional racism. Despite the challenge, interview participants shared that engaging with peers not in the intervention offered an opportunity to practice speaking to concepts learned and new understandings gained. The following interview participant reactions exemplify this:

> I think people were like, the first staff meeting we had because we did a couple of different ones. The first one, nobody had an example of [equity]. And so, then I gave a couple of examples. Then people started to say, 'Oh, okay.' I don't think they knew quite what I was talking [about]. So it was really interesting because some of the people on our work team weren't part of the equity training…For some of the nursing staff that I worked with on that team, different than any of the other nursing staff that I was talking about earlier, they were like, 'Well, we don't have a problem. We know how to ask these questions.'

Interestingly, as participants were sharing these challenging experiences, every one of them focused more on how they met and overcame that challenge, some of them providing a play-by-play of how they approached it. For instance, Ilse shared:

> Actually, it was really good . . . Not everybody got it so I had to give them some, 'Well, what do you think about this? Do you think this promotes or it doesn't?' And then I gave them some examples. And then one or two would come up with something. So, I think it's just helping people see it.

Eve also focused on the importance of meeting the challenge, stating "So, I think some of that was a little bit of tension, but it was good in that sense too to think we have to have those conversations." In response to her peers claim that "they don't have a problem," Darnisha revealed how she responded to these comments:

> 'But do you ask them in a place that's protected? Do you ask them in a way that's understanding? Do you ask them in a way that is away from their family so that their family isn't brought into judgment on this?' Then I think that there was some light bulb moments . . . to like, 'oh, now I get what you're talking about.' Why do we care about this? Because you know what? We should ask it in a way that's confidential and respectful and keeps that person in a lane that they're a little bit protected, instead of talking about it in the middle of the hallway as you're walking somebody to the bathroom, 'Oh, here's your urine cup. Give me your urine sample because I'm going to check it because I'm doubting whether or not you're clean.' That's what people think of. And you have to frame it in a way as, this is the best care for everybody, mom and baby. And so getting that language was important in that work team. So that was good. And then since everybody's

talking about it, it's easier to talk about it. But taking that and then translating it to another situation where not everybody is used to talking about it or wants to talk about it, that can be the challenge.

Ultimately, while initially challenging, interacting with a peer who was not a part of the intervention was a valuable experience for intervention participants to practice what they were learning, but also, as Darnisha articulated, necessary in order for this work to continue and be sustainable.

Post-Intervention: Impact and Outcomes

Findings in this section focus on what change was reported as the result of the intervention. The impact and outcomes are shared from four workteams. The scope of findings varied based on the extent to which interview participants shared their workteam experiences, if at all, and observations from two workgroups. Findings are shared through two lenses: changes at the department level, and changes at the people—the individual—level.

Department Outcomes

From a departmental—or system—perspective, the intervention resulted in multiple new or revised policies and practices that were created by the leaders using a racial equity lens. As an equity coach for the program, I was assigned to attend all meetings for half of the workteams. This provided me the opportunity to leverage what Spradley (1980) referred to as a "moderate participant-observer" role: being a part of the group at the same time as observing the process, as well as verbal and nonverbal behaviors. As such, robust findings are reported Workteam Three and Workteam Five,

with briefer findings reported from two other workteam that were based on interview data.

Workteam One

As described earlier, Workteam One's equity project focused on interrogating existing toxicology screening policy and practices. The outcome of this project included both a revised policy, as well as a new approach and language used in communicating with patients about the screening requirement. Darnisha discussed the shift in language:

> We can agree that we should do drug screening because it's important. But then to come up with a plan about how to have the language reflect in a respectful, patient-centered way that we're not just assuming anything based on anything, we just start,' this is the reason why we screen. You've met the criteria for the reason why we're screening today because you have preterm contractions. We do it for everybody. It helps us provide great care for moms and babies.' And really reinforcing that language I think was really what got our team to move forward. 'You know what? Let's figure out how we can respectfully have the conversation so that we can gain the data that we need to take care of the patient.' And so that retraining and that restructure.

The experience Darnisha shared exemplified a shift to a more racially equitable practice, which does not always mean the practice that is needed to provide safe care for the birthing person and their baby, but with the awareness of what that marginalized patient might be coming into the hospital with, doing it in a way that is more respectful and equitable. Julia spoke to that same experience, explicitly connecting it to institutional racism:

> I think it addressed institutional racism in that we really did get to a point where we were looking at how our systems and our policies and our procedures were built in such a way to sort of keep some folks marginalized or. . . by focusing on the majority, which is interesting in the birth center, because the majority is of color, but the dominant culture I think and the culture of the caregivers versus that of the patients, so to have teams actually looking at what samples they were sending for toxicology screening, but then also how they were having that conversation with patients and what patients were bringing to that conversation that might create a very different impact with one patient than another. All those things are related. Systems are built by people, which is why the self-awareness piece is important, and what our intent is doesn't always match what the impact is on others, and that's where we need to try to get closer. So 'other' focus is important, but then we're in the position of power to build the systems, to write the policies, to enact the policies.

Another outcome of the equity project was in the effectiveness in sharing this new racial equity lens with others. Darnisha shared how they were able to address resistance from non-intervention peers, and successfully bring them on board:

> So it was really interesting because some of the people on our work team weren't part of the equity training, which was okay. But for some of the nursing staff that I worked with on that team, different than any of the other nursing staff that I was talking about earlier, they were like, 'Well, we don't have a problem. We know how to ask these questions.' But do you ask them in a place that's protected? Do you ask them in a way that's understanding? Do you ask them in a way that is

> away from their family so that their family isn't brought into judgment on this? Then I think that there was some light bulb moments for the nursing staff who came through who weren't [in cohort] . . . To like, oh, now I get what you're talking about. Why do we care about this? Because you know what? We should ask it in a way that's confidential and respectful and keeps that person in a lane that they're a little bit protected, instead of talking about it in the middle of the hallway as you're walking somebody to the bathroom, 'Oh, here's your urine cup. Give me your urine sample because I'm going to check it because I'm doubting whether or not you're clean.' That's what people think of. And you have to frame it in a way as, this is the best care for everybody, mom and baby. And so getting that language was important in that work team. So that was good.

Darnisha revealed its effect; Eve shared in a bit more detail how that happened, specifically the impact of the equity coach:

> Really break it down to 'okay, what does it look like when the patient comes in the door? Then what happens? Things that you just are part of your day so you don't think about it anymore.' When you're trying to explain the problem that you're trying to solve to someone else, it's valuable to slow it down and take it step by step. She was the one who brought the whole intent versus impact up in that we felt like we'd already been thoughtful about how we wrote our policy even prior to the work as a whole. But then even taking that one step further and then actually what we found with the [workteam] was we had more of an impact issue to try to address at the bedside on an individual level, not even on the policy level. And so, in helping with even just scripting or how to have a conversation for

> people who aren't as comfortable. And she was helpful in helping you look through it from someone else's point of view in the sense of I look at the conversation about a toxicology screen from the perspective of a physician who's been in practice for a while. So, it's not a conversation that I really fear or get myself worked up about anymore. But probably did when I was a resident and a new nurse out of school and how to get people off on the right foot. So, I thought she was really helpful in kind of pulling us back to that . . . .But you could see over time that she had to do a little less of it because hopefully, the ball was rolling a little bit more . . . .it's good to know that the resources are there if we're feeling stuck or you just want to run something by, especially if it's a big initiative.

The departmental outcomes of this workteam's efforts to bring a racial equity lens to decision-making around patient toxicology screening was evident in both the new policy and practice developed, as well as the ability to take the learning and experience from the intervention and cascade the learnings to peers not a part of the intervention.

Workteam Two

This workteam's outcome took a different shape than other workteams. Their outcome landed in a different place because they started from a different place. Unlike other workteams working with existing policies and practices, this group was dealing with a new aspect of care that the birth center had never provided before. As such, there was no existing policy or practice to interrogate; rather, they were charged with creating new policies and practices that did not exist—within the hospital, but also in other healthcare systems, as this new level of care is offered in very few other hospitals.

Workteam Two's outcome started with the movement they made in all getting on the same page. By the end of the intervention, the group—once divided—agreed on the importance of using a racial equity lens to approach the new policies and practices they would be developing. They also recognized the need to capture more data that had currently not been available that should influence future decisions. Racial data, in particular, would provide useful in seeing how policy was actually being practiced. So, while arguably a different type, they nonetheless had an impactful outcome.

Workteam Four

In addition to the new way of thinking by workteam members that initially showed resistance and defensiveness, a positive outcome occurred that impacted the department. With a focus on addressing care boards from a racial equity lens, the workteam was able to address its existing issues in not always meeting patients' diverse needs. Fiona explained a meaningful part of that process:

> I would say the most impactful two things that went with the care boards was putting up a mock board and getting patient feedback so that we heard from multitudes of everyone. Shape, size, color, whatever. And then we spent what was supposed to be a short meeting and it turned out to be quite a lengthy meeting with the interpreter services and really got background as to why culturally some things should or shouldn't be on the board.

Recognizing the need for input on the decisions was a crucial part of their work, and led to a new care board practice. As the result of the input and feedback from both patients and culturally diverse group of interpreter services employees, they added language inserts with multiple different language that can be inserted into the care board. So, for

example, if the patient's first or preferred language is Karen, the patient and nurse name are in both English and Karen. Fiona shared the impact this can have on patients, and shared other aspects of change to the care boards:

> So that minimally, somebody would come in and at least see something familiar and hopefully would give them just a wee bit of peace knowing they're leaving their baby, they're trusting us. They don't even know us and they're trusting us with their most precious thing . . . .and so for the other boards definitely were way simplified their language. We took away the pictorials thinking as nurses, we don't need smiley and sad faces to say pain. And then what we heard back from both the feedback from families using it and from the interpreter services is that those pictorials need to be there, for the non-English-speaking. And so those were added back in. But removing language, removing things that some cultures may not want other people to know, all cultures may not want people to know. Not everybody wants their guests to know if they've decided to have a circ or if they've decided to not have a vaccine or something like that. And so those kinds of things we left off. They can be written in if people are okay with that … a place for families to write.

The iterative process was meaningful in that it allowed the group to test different assumptions, and adjust as needed when feedback called for change. Not only did this workteam create institutional change in how care boards are created from an equitable lens, but they addressed other aspects of the building structure, as well. For instance, decisions around room designs and wall art were looked at and made through the same

lens. Carol spoke about how someone not a part of the intervention, not even aware of their work, shared the noticeable difference of the space:

> I had a great conversation actually last night with one of the midwives who she went on the hardhat tour and had been out for a couple of months and was like, 'It's amazing because you could actually see the commitment to inclusion in the physical structure of this building.' And then as we were sitting down in our current space, we were like, there's nothing in where we are sitting right now that looks like anything other than just your standard set of hospital rooms. And the fact that we put effort into making comfortable family areas, regardless of where you are, regardless of whether you are waiting for your C-section, regardless if you are waiting to deliver your stillbirth, regardless if you are planning a water birth, or, as we like to joke, a land birth. There's equal attention . . . Equals probably not the right word. There's appropriate attention paid to each of those different potential experiences within that space. And it doesn't normalize or marginalize any one thing.

So, the outcome of Workteam Four's equity project was not only tangible to them, but was felt and expressed by others not a part of the work.

Workteam Five

As the result of continued discussions and planning throughout the year, several enhancements were made to ensure patient and guest felt welcome and included in a way that is meaningful for them: (1) the warm welcome was redefined through an equity lens, and a definition was created reflecting as such; (2) the warm welcome theme was extended throughout all patient touchpoints that were discussed and planned by the

workteam; (3) required customer service training developed with a focus on warm welcomes; and (4) produce a warm welcome video produced to supplement the training. The video would the newly defined warm welcome concept as well as implicit bias. Patient stories were leveraged to show the impact implicit bias can have on expressions of a warm welcome.

Participant Impact and Outcomes

"What we've done is, there's a spark" (Lila).

In addition to department changes reported above, interview participants shared the impact the intervention had on them individually. This section highlights findings regarding participant "sparks" in awareness and understanding of racial health equity and institutional racism, as well as "sparks" in their behavior.

Sparks in Awareness & Understanding

The participants' experiences with the intervention led to changes in awareness and understanding around two aspects: one's own racial bias and/or privilege, and health equity and institutional racism.

First, there was apparent change in awareness about one's own racial bias and privilege. White participants who started out stating "I'm never that person, I'm never that person to judge people. Never that person to be rude to people," and "this is crazy, I feel like we treat everyone the same" (Holly), and "how can a board on a wall be racist?" (Darnisha), were expressing at the end of the intervention how they have become more aware of racial bias—sometimes even their own—and privilege. Additionally, White participants were more cognizant of how their privilege and racial biases can impact patient experiences and care. Multiple interview participants shared this shift in

awareness and understanding. Holly admitted how she became aware of her own racial bias:

> But then in doing this, I figured I am that person that judges someone before I come into a room. She's 23 having her eighth baby. She lives on the streets. Now, I have a different mindset when I walk in and I'm like, 'Oh my gosh, this poor thing has eight kids, lives on the street.' Where before I would go, 'For God's sake, quit having babies.'

Similarly, Fiona revealed her new awareness regarding their privilege and its impact on patients:

> When [a Black peer] was in tears, just saying that bias had really impacted how she grew up. I guess that's the privilege I've known and not really thought about before . . . How can I judge them when I don't know what their options are? How can I judge their choices when I don't know what their options were?

A Black interview participant shared the change they witnessed in white participants' perspectives:

> That kind of change takes so long in time, but I think that there have been little movements…I think just the recognition of that some patients' experiences, they're not angry, they're not these combative people. They just . . . Life has been hard based on systems at play that had nothing to do with them individually (Annika).

Holly shared a poignant "ah-ha" moment when initially not believing her Black peers' experiences:

> But just hearing some examples, the thing last week, is there's no way anyone ever said that. And then Annabel was there and she said, "Oh yeah, actually this did happen." Like wow. So it just makes you really think. And it makes you look at other people too that you work with. Like, 'You can't say that.' . . . I feel like we weren't that way, but then to find out, yes, we probably were that. I felt like we were always nice to everybody, but then I feel like I too place judgment I shouldn't place.

A shift in awareness and understanding emerged from Brittanie, as well:

> Recognizing that we had a bias and how we applied it. And I think that conversation went from defensiveness, like, 'why I'm thinking I'm applying this appropriately, or why you're not' to, 'Oh, okay, you're right. I see how to do that . . . How do I do that?'

They reported how this resulted in a desire to take action—a need to change their behavior as a result of the new awareness.

Second, evidence of a deeper understanding of health equity and institutional racism was revealed. Post-intervention, 13 of the 14 interview participants reported an understanding of health equity, and only one still misunderstand by conflating it with individual racial bias. That exemplified a 15% increase from understanding reported pre-intervention (from 76.9% to 92.8% of participants understanding what health equity is). A greater increase in understanding of institutional racism was found post-intervention. The percentage of interview participants who understood institutional racism post-intervention had increased nearly 50%, from 38.4% to 85.7%. The same two participants who did not understand prior to the intervention, still did not understand at all or

misunderstood what institutional racism means. Annika spoke to participants conflating the terms:

> I think it has been eye-opening for a lot of people in terms of what equity is because I don't think that people realize exactly what it is and what equity versus bias versus racism or . . . and are. I think that people just thought it was either racist or not racist and didn't see the large gaps of a whole lot in between that.

Table 6 summarizes the extent of interview participants' post-intervention understanding of health equity and institutional racism.

Table 6

Participants' Post-intervention Understanding of Health Equity and Institutional Racism

Concept	Understands	Misunderstands	Doesn't Understand
Health Equity	13	1	0
Institutional Racism	12	1	1

Not only did the number of participants understanding health equity and institutional racism increase, the depth of understanding grew, as well. Interview participants who shared they had already known what institutional racism was, and some that even had used that systemic lens in trying to create change, found this experience expanded their understanding even more. Julia revealed:

> I feel like I've learned a lot, where I think prior to going through the program I had in my mind institutional racism and just all of those different concepts, but maybe hadn't ever examined it in the way that we did through the training. For example, when you think of even institutional racism on processes or guidelines or protocols, I never really thought of it to that level.

Similarly, Eve shared:

> You think you have some policy written the right way because you've even thought about institutional racism, but then you dig more and you go, 'Okay, we still have some work to do here.'

These interview accounts illustrate the extent of change in and deepening of these two concepts central to the intervention. In fact, four participants' experiences were so profound, they spoke to having an entirely new mindset, as a result.

While nearly all participants relayed a new and/or deepened sense of awareness and understanding around racial health equity and institutional racism, not all responses indicated new growth and development. Two participants in particular shared attitudes and experiences that did not reflect progress. Comments included "I don't care what your color skin is . . . It doesn't even register other than the fact that it registers as a color," "I think my biggest concern right now with it is that I see people being selected into positions, from my point of view, based on the color of their skin. And the qualifications aren't there," "but I also feel like people act to be the victim. Do you know what I mean? . . . Sometimes I feel like people walk in and you walk in the room and they're already on the defense. Like she's not going to be nice to me because you're an African American family," and:

> It's hard for me because you know, [our leader] talks about those picker scores or all these things and it's like, 'But we do give really good care.' So I feel offended by, and I feel like people always will complain. And sometimes they just come in with an attitude…

These sentiments were expressed by participants who also shared a new awareness and understanding, showing that progress can take different shapes, and do not always come in "ah-ha" moments.

Sparks in Behaviors

Positive outcomes as the result of the intervention not only impacted awareness and understanding, but in behaviors, as well. Three types of change that emerged from interviews included patient care, colleague interactions, and human resources practices.

Patient care. First and foremost, eight participants shared specific examples of how they approach patient care differently as a result of their experience. These changes consisted of taking time to ask more questions and listen, being less defensive, and acknowledging they do not know everything. The following excerpts exemplify these changes.

> On listening and asking more questions:
>
> And so if I have somebody that has a lot of mistrust, has a lot of all sorts of stuff, I'm going to talk about a few more things while I have you here . . . I'm like, 'Okay, well since you're here, let's talk about this, this, this, this and this. Have you been doing okay?' (Annika).
>
> [W]e do a lot of assuming because we're always busy and we're always trying to get things done, task oriented. But [take time] to stop and listen (Holly).

And not to have any preconceived notions about what they need, but to ask them what they need instead of assuming, oh, this person, I know that they need this because this is what they look like. You can't do that. You have to, ‘what is it you need from us? (Darnisha).

And it really is just the very first time that you meet them to try to get a sense of what they are and who they are and what their life is like. And that little bit of investment in the first time that you meet them pays off the rest of the pregnancy. It always does…can't just care about one part of a person because the people aren't just parts . . . Because if you approach a patient like that, I think I'm more open-minded. I don't place judgment before I walk in a room. I find out the story. I'm pretty good about finding out people's story. Yeah. (Holly).

And I think just that ability to say either I don't know, or I do feel this way and I want to figure out why, or I see something that I can identify as inappropriate, or inequitable, or whatever it might be, and I want to fix that. And also saying I don't know how, or asking for help to say, what are the other ways to approach this? I think it's more just the, the ability to admit and acknowledge what we know and don't know and what we feel (Carol).

On not being defensive:

[When a patient says] ‘Well, here's why we don't like you. This is why you've been doing badly…I never really feel bad when somebody says that, because, one, I always think we can do better. And secondly, none of this discussion is about me in particular. It's about . . . I walk into the ER and I get my hat off to the side, and then wear my pants a certain way, and I have a certain earring on, and

> people are making assumptions by the way they're looking at me in such a way, and I don't feel comfortable saying, 'I've got this problem. I want it taken care of.'… I might add, it's hardly ever about you. No matter what it is. When somebody is upset, they're hardly ever upset at you as a human being. They're upset at the thing in front of them. They might vocalize it to you, but humans are usually dealing with the problems that are right in front of them. And what they're more concerned about is the problem (Brittanie).
>
> I also felt like it's not worth taking any of it personally because we as a society just you have to own that it's there (Eve).

In addition to participants' views that changes were starting to impact patient care, Brittanie noted feedback received from patients that they were seeing and feeling the change:

> [I]n caring for patients, they told me they feel sort of a palpable difference here in welcoming whatever it is that made people feel more comfortable coming to Regions….So, there was actually quite a change in the community, in our reputation with things, and I think that fed on itself with the staff and the patients we're taking care of, begin to feel more welcome.

Finally, Ilse shared a time when they brought an equity lens to a decision they made in-the-moment, that thry might not have without this recent experience. A nurse had come to them about an issue they were having with a patient. Ilse directed the nurse to do what was more equitable, versus going with policy.

> It violated our policy. I was worried the day shift was going to chew me out for allowing it because now I broke a rule and now they're going to have to deal with

> that or the next night. But I knew it was the right thing to do. I mean, that's exactly it. Like, we have certain things that are . . . And it's not always policy.

Ilse understood that providing equitable care would not be possible under current policy.

Colleague Interactions. Changes in colleague interactions were also significantly impacted. Some of the same behavior changes interacting with patients, were also reported when engaging with colleagues, for instance, being open-minded, and not getting defensive. However, by far the most discussed behavioral change by participants was being more comfortable and intentional about discussing and calling out racial bias and racial inequity. Participants stated a "sense that I had to correct it…to acknowledge this…I couldn't just let it slide" (Ilse), "I just continue to find my voice and promise to try and name things" (Gabriella), "I'm more intentional in meetings to just use the word equity…I might have thought it but I wouldn't have intentionally called it out so directly" (Ilse).

Gabriella shared a story about how they tried to call out racially biased behavior:

> I was working in the clinic and there were two medical assistants and I happened to overhear one saying, 'Oh yeah, thanks for drawing blood. I just didn't like the way she looked at me.' Then I realized that what I overheard was I was talking about them, they were talking about my patient who happened to be an African American woman. And I just said to them, 'Let's just stop for a minute. Let's think about this for a little minute.' Because the other MA who had drawn the blood, she's like, 'Oh, no problem, she was really nice,' and things like that. So I said, 'Let's just stop and think about what went on that made you feel like you didn't want to go back in that room to draw her blood and what her experience of that

> might be like. And what does it take for a black woman to walk into our clinic and what might she be carrying that would make her feel defensive.' So anyways, we just started being curious about that and we ended up having a really good conversation kind of. I think the MAs both appreciated it in the end, they didn't get defensive, but just taking a moment to stop and reflect on.

Gabriella's experience exemplified several positive colleague behaviors, including taking the time to be curious and reflect, and not feel defensive when being questioned. While another participant explained how the experience provided tools to help in such interactions:

> With the leadership training actually, there are tools that you remember, things that I have found useful. Like going up to someone and saying, 'I think you said this to me. This is what I think you meant? What did you mean?' (Brittanie).

Lila shared how they noticed these changes and stated

> what I've noticed as a change in our department when I'm rounding and stuff, is that I don't think people are afraid to recognize differences in people out loud…I think it's palpable to me that we talk about people different, and that it's not as acceptable to be on the floor and really be derogatory or judgmental.

The other theme that arose from interviews was around comfort. Participants expressed "I'm more comfortable now" (Kelly), "I have become very comfortable" (Ilse), and "I feel far more comfortable" (Carol), as the result of their experience. They reported an increase in comfort talking about racial bias and racial equity, and being an advocate for their colleagues. Kelly revealed:

> "I'm more comfortable [talking about racial equity] now that I went through the training… I would say before I was comfortable, it was more conceptual. Maybe not conceptual, but more in the back of my mind kind of a thing, where now it's a little bit more in the forefront, just understanding some of like we've already talked about, some of these deeper understanding in some of these areas. You don't know what you don't know, but then when you start learning about it, it's like, "Oh, wait a minute. I saw this come up in this area."

Increasing participants' confidence was a central objective of the intervention. Participants' reports of being more comfortable in bringing up and having conversations around race, racism and racial equity reflects confidence, and meeting the objective.

Human Resource Practices. Finally, five participants shared how the experience impacted several different human resources practices, including hiring and interviewing, and performance management. Changes in how interviews are conducted, as well as how hiring practices are discussed and decided were both mentioned. Julia shared how critical it is to examine hiring practices from a racial equity lens, and "by looking at each specific process and looking at the intent versus impact of that." Kelly shared about a meeting that exemplified this:

> We talked about even just different HR practices…where they kind of scan your resume looking for keywords how when you look at that from the outside, that is a way that can also very push forward that systematic stuff by looking for very specific keywords is more you might not be opening yourself up to other candidates, or maybe a candidate who speaks a different language, things like that. So that came up. Things around where different positions are advertised.

Gabriella also shared a personal experience:

> So really that process led us into a pretty deep discussion about what it means to live our values with equity and what does it mean to not just hire somebody from a particular community, but then to also support them as they're realizing that they are going to encounter those microaggressions and systemic racism.

Whether through discussions, or actual interviews, participants revealed the impact of bringing a systems and racial equity lens had on hiring practices, stating they "wouldn't before bring issues like this in interviewing, but now I do talk about it" (Brittanie). Ilse shared details about how they integrated direct discussion of racial bias:

> When I interview too another thing I ask often is I asked, how do you handle it when you have to deal with somebody from another culture or when you've been discriminated because of your culture? And I usually I ask every nurse that and many of the nurses that I've been interviewing lately are from another culture and they all say, 'Yeah, it happens to me all the time.' And then they give me their story about that. So it's something I do ask them because I think . . . And I tell them I know that happens. I know what's there. So I try to pretend it doesn't exist. I don't try to pretend. I try to acknowledge that there is a lot of discrimination . . . .I think it lets them know that I care because when I say that I say, 'I'm sorry, that it happens. I can't say it's not going to happen here because we're dealing with the public. But I want to support you if you need to. But tell me how you handle that.' Then I want to see how to handle it. And I say, 'I know this happens. Have you experienced that? How do you handle it?'

One of the participants shared how a performance review had been impacted by her experience over the last year.

> I just did a review right before here. And it was with somebody who I have some concerns about her biases…I was trying to figure out how to have this conversation with her in a way that she could hear it . . . And it's just her biases are very subtle, but they come through and she's not aware of it… And she was saying it very publicly and it was very judgmental about the person that hit her. They were ethnic and they probably didn't have insurance. I don't think she had any perception at all in that moment of how biased she was sounding. And so I had to stop her in the moment and just say, 'You can't talk like this. This is not okay.' I mean, she gave me the blank stare like she couldn't understand why I had an issue with that. So today when we were talking, actually one of her Peer 360, somebody mentioned that she does come across biased. And she was taken aback by that. She didn't understand it. So I had to give her some examples of some of the things that I've seen that would represent bias. I don't think I completely broke the mold today, but I don't think she's ever been given that feedback before by a leader or by her peers . . . .so I had to coach her . . . I would have tackled it any way. But this time, I was just very more intentional about how I even brought it up in a review, the words I used to address it….I might have said judgment. But I think bias is a little more powerful to what I'm really talking about. I might have skirted around it a little bit more in language. If I had said [judgmental] to her, she wouldn't have identified that I was connecting race with that though. Because

> that's something a little bit different. And really what I was saying is, 'Sometimes you come across racist' (Ilse).

Black Participants' Intervention Experiences

As a study grounded in CHRD and CRT, it is essential to reveal findings of participants' understanding, attitudes, hopes and concerns based on participant race. A central tenet of CRT is giving voice to those often unheard, where status quo is challenged through storytelling in an effort to change the dominant narrative (Delgado, 1995).

Several themes emerged regarding Black participants' attitudes toward and reaction to the intervention experience. Black participants shared being victims of racism, particularly within healthcare, the impact of sharing those experiences with White peers; both the benefit and added pressure of being a Black leader; the impact of attending a training (not a part of the intervention) led by a Black facilitator; discomfort experienced bringing up race and racism with certain audiences, and the ability to connect with and care for Black patients. I will elaborate on a few of these.

Annika shared how they can feel invisible as a provider of care, and how white peers do not see them as the same as their Black patients.

> People don't sometimes see me. I'm a black woman. I'm a black woman, just like this patient that didn't get any prenatal care or whatever. We're pretty similar in our experiences because the world doesn't see me as a, I am a black female physician. I'm a black woman, a big black girl that's probably angry and whatever. So those perceptions that you have for the patients, you are going to have them for me if you took away the extra stuff, if you took away the fact that you know who

> I am, you know what I do. And so trying to show people we're the same person and so how you treat me is how you should treat her.

Additionally, benefits and challenges related to being a Black leader in this work were expressed. Lila commented on the impact of a Black leader driving:

> I think one interesting thing is that the patient population hasn't changed in years, and the people, the other leaders, who have bought into the vision that we've created, have been here for a while. I think there was a catalyst in a woman of color coming in, in a leadership position, who had this as a goal or perspective. And also had the opportunity to push it as an agenda that has also made it move a little bit. I think there's a piece there, and it's weird to call it out, but I think that that speak to people of color being in leadership positions, where some of these things can be addressed.

Though a challenge with being a Black leader was also highlighted:

> I think that's what scares me a little bit, is how do you lead through that kind of muck, ya know? And I think there's, if I can just be completely honest, I think there's a little bit of danger for me to do that. I have to say. I feel that. Because I don't know everything. Because I'm not competent to talk about these topics really well, I think it feels dangerous because I think it's expected…and not surprising that I would want to talk about, just because of my race, that I would want to make race a thing. And that if it doesn't go well, because I'm not equipped to lead it, do you know what I'm saying, there's this leadership kind of uncomfortableness that I have that I'm willing to accept I think right now, but I think there's also this level of, gosh, if I don't do it right. Personally what does

> that say about me as a leader, but really what does that say about me as a leader of color (Lila).

They are grappling with the expectations of them as a Black woman leading this work, feeling that because they are Black, it's expected they knows what to do and how to do it, and with such high demands, the stakes are even higher.

Black participants also revealed thoughts related to intervention focus on addressing and understanding institutional racism. On the one hand, Lila shared their appreciation for the IDC™ framework, particularly as it related to the impact for white participants:

> I appreciate the developmental model and how it is a nonthreatening approach to getting people to have an outward mindset about their own experiences and who they are, if that makes sense. Because when we talk about race, I think it just incites fear and confusion, and just people don't open up as much. But I think if you take it through that model of IDI, what I noticed is that people felt a little more comfortable in conversations.

On the other hand, Lila also expressed a concern about addressing institutional racism:

> I think racism and institutional racism is so deeply embedded in healthcare that I think just because I care about this department and I care about the patients that we take care of, I don't want it to backfire in a way that is not…that doesn't help us grow.

While much of what these participants shared was about their reaction to *others'* experiences, they did share some of their own learnings, as well. For instance, they reported an increased empathy for the good intentions and pace of growth and

development of their white peers. Prior to the intervention, Lila stated they were more impatient, but the intervention "tempered my urge to move people really quickly…this education has taught me is that we can get there, but you probably need to give some people some time to have some foundational understanding." They also shared how the experience reinforced what they already knew about racial inequity and institutional racism, but also furthered their own learning and increased their confidence in addressing race and racism, particularly with audiences they considered risky.

In reflecting on the entirety of the experience and providing an overview of what the birth center went through over the last year, Lila shared how their expectations were and were not met:

> So, I think we got to the place that we needed to get to. I think we brought up race, but we didn't dig into racism in our organization yet. I'm okay with it because I think like everything else, we've now set a foundation. So, our whole strategy has been let's get some data so that we can shock people. I see this model kind of coming together for healthcare. We get some data to really get clinicians who are so black and white to shock them and say there's an urgency around us having this discussion. Then we talk about implicit bias as an introduction to say, 'Don't you recognize that you maybe have some of your own perspectives that you bring into every interaction that you have?' And then I think you layer that with the IDI and say, 'But not only do you have layers that you bring in from your experiences, but actually as an aggregate, as a group, we all do,' and that's where our systems institutions, that's what they're built on. So now you have people understanding the layers and then I think we got through IDI and we started to

> address how that impacts, how racism can be tied back to that, how we view the big aggregate and how systems are built. To where I think we're a good place, at least within our leadership team, to start truly talking about anti-racist work. I think so. And it wouldn't be foreign to people and it wouldn't be shocking to them, they've already worked through all of those stages of acceptance, if you know what I mean. Although I don't think we got into racism in the way that I thought we were going to, I think we're a good spot to do it as our next step.

Lila reveals disappointment in not addressing race and racism in a way that they wanted or expected. But that, despite that, and other challenges faced, individually and as a department, where the department landed at the end of the intervention was exactly where it needed to be.

Both similarities and differences were revealed between their experiences and that of their white peers. Black interview participants' stories shine a light on how they, as racially marginalized individuals, experienced a program centered on race and racism. For the most part, these two participants shared sense of hopefulness: "There's still a long way to go, but at least there's been a crack" (Annika).

Summary

Key findings were reported in this chapter based on pre-intervention, intervention, and post-intervention results. Pre-intervention findings included an overview of the department, the people, and the intervention. Intervention findings consisted of the learning session and workteam meeting experiences, as well as participant challenges. Finally, post-intervention department and participant impact and outcomes were reported, including a focus on Black participants' experiences.

Chapter 5: Discussion and Implications

This study looked at how a birth center department within a large urban hospital addressed institutional racism as a part of its health equity strategy. With organizational, regional and national maternal and infant disparities at the forefront, this case study focused on what led up to, happened within, and resulted from an intervention centered on a developmental process and action learning. Results emerged from interviews, observations of the learning sessions and workteam meetings, and document review. The pre-intervention results shared background and context as it related to the department, the people and the evolution of the intervention. The intervention findings reported the content of and experiences with the year-long equity education program, and included the structure, purpose and key components; learning session and workteam experiences; and participant challenges. Post-intervention findings focused on impact and outcomes for the department and the participants. From these findings, three conclusions were drawn about this study.

This chapter includes a discussion of the three conclusions, including implications for research and practice. Additionally, limitations of the study were identified, followed by concluding remarks.

Discussion

As the previous chapter presented, numerous findings emerged from this case study, including impact before, during, and as the result of the intervention. Learning, development and change occurred both at the individual and departmental levels. But what does this mean for the department? And for the leader's goal of bringing a racial equity lens to the policies, practices and processes of the department? And was

institutional racism addressed and dismantled as a result of this? The following is a discussion of the interpretation of findings centered on three conclusions that answer these questions.

Conclusion 1

The central features of the intervention's framework and approach proved instrumental in individual development and change.

The first defining feature that emerged was the facilitator's theory of learning and change driven by the IDC™ framework. The foundational theory of learning and change centered on a developmental model, provided by the IDC™ The IDC™ offers a framework to show the extent to which individuals (and groups) can progress in their knowledge, skills, and capability to effectively interact across difference. A key feature of the IDC™ is in its focus on developmental on the individual, interpersonal *and* system level. Additionally, this framework included a facilitation approach that relied on messaging and activities that "met people where they are at" (Zemsky, 2019). Unlike other approaches that are not tailored, this framework placed learners at the center and allowed customized content and experiences that strengthened development and progression through the IDC™ stages of development (Intercultural Development Inventory, n.d.). And despite few interview participants referencing, or even remembering, the specific IDC™ language (e.g. intercultural development, minimization), the continuum proved essential to participants' understanding and progression. They did not need to remember the specific language in order to effectively practice using the concepts learned.

There were several concepts the facilitator's theory of learning and change introduced and particularly meaningful to participants, including universal design, marginalization, and intent versus impact. These concepts were useful in and of themselves, but the value to participants was in leveraging them not just as concepts, but as tools in their bringing a racial equity lens to their workteam discussions and equity projects. For example, participants used the idea of focusing on marginalized patients as a way to disrupt existing dialogue that typically ended conversations about the impact of race on patient experience and outcomes. In concert with the notion of universal design, that states by designing for those most in need, everyone benefits, participants proved effective at shifting the course of conversation to one that centered around and did not dismiss racial inequity.

The second central feature of the intervention's learning and change theory was the cohort model. Participants' responses revealed the value of an in-tact team experiencing the intervention together. Having a shared experience, common language and dedicated space to learn and grow with and from each other key benefits of participating in intervention as a team. Also instrumental was the ability to share in a space of discomfort and vulnerability for many and struggling together around challenges related to race and racism, including the challenge of even talking about it to begin with. The department went from rarely, if ever, talking about race and racism, to having a space dedicated just for that. Darnisha shared "Since everybody's talking about it, it's easier to talk about it."

One cannot overestimate the value of having open conversations about race for both white and Black participants. For instance, white participants discussed a new

perspective gained by hearing about their Black peers' personal and professional experiences with racism. Black participants shared the impact it had to speak to and have their white peers' attitudes and assumptions shift. While each had a different impact, both white and Black participants found value in engaging in conversation about race and racism.

Critical action learning was the third essential feature of the study. Introduced in the 1940s by Reg Revans, action learning is "a process of learning and reflection that happens with the support of a group or set of colleagues working on real problems with the intention of getting things done (Dewar & Sharp, 2006). It is a cyclical process involving an exchange between both reflection and action. Reflection and discourse are rendered meaningless if individuals are not given the opportunity to apply theories and concepts to real-world situations and challenges. A key aspect of action learning is a commitment and responsibility from the learner to acknowledge and question their values, attitudes and assumptions that arise within the process (Dewar & Sharp, 2006; Yeo & Marquardt, 2015), which was an integral part of the intervention.

More recently, scholars have suggested the importance of critical thought and practice related to action learning (Fenwick, 2003; McCray, Warwick & Palmer, 2018). Originally coined by Hugh Wilmott, critical action learning (CAL) was established as a way to address a gap in Revans' action learning and focus on power and politics (Brook, Pedler, Abbott, & Burgoyne, 2016). Brook, Pedler, Abbott, and Burgoyne (2016) claimed "through harnessing critical social theory and deepening critical thinking and questioning of 'daily realities,' CAL aspires to understand and to challenges the effects of organizational power relations on action and learning" (p. 372).

This case study demonstrated CAL in its application of learning and practice centered on addressing inequitable policies, processes and practices at the systems level. Learning occurred in the sessions, and also from practice within the workteams. The equity project assignment for each workteam ensured the practice of bringing a racial equity lens would not intentionally or unintentionally stay stuck in conceptual understanding, rather forced participants to engage with it as they pursued developing new and revising existing policies and practices to be equitable. This is the epitome of CAL.

Together, these three components—the IDC™, cohort model, and action learning—played a valuable role in further participants' learning and development. To exemplify the components' impact on participants' growth, let us revisit Ilse's experience from last chapter. Deconstructing the conversation between Ilse and the physician (who was an intervention participant) will illustrate how features of the framework and approach were leveraged not just as concepts, but as tools, in engaging in a conversation about racial equity and racism. Important context to this situation must be provided. The physician in this interaction had been observed earlier struggling to understand and legitimize the existence of racial inequities in patient care, stating that racial inequity exists only outside the hospital walls.

Ilse: So, when I am making assignments, I'm strictly doing it off of diagnosis, and I don't know their race ever.

Me: But should we?

[At this point I know what Ilse is thinking and where they are going with this. They are not saying this as a way to make a point about how race should not matter. In fact, the opposite.]

Ilse: That's what I'm saying, we don't know that, it's blind to us. We don't see that patient before they come to us. We have no clue, unless we look in the computer which I don't think people tend to look for that.

Physician: And which way is actually more equitable, is blinding more equitable or is profiling more equitable?

[One could say that the physician might be aligned and trying to make the same point, but his use of the word "profiling"—which carries with it a negative connotation, implicitly indicates he think "blinding" is more equitable. The physician's "blinding" preference is indicative of being colorblind, sentiment most often shared by White people that expresses they do not see color, because seeing color would be bad. This is considered a classic perspective from those in the IDC™ stage of Minimization.]

Ilse: This is an interesting conversation.

[I can sense Ilse's wheels turning. At this point we exchange looks—we seem to be on the same page—and that's when they started to share their previous experience of the patient and mother calling them racist.]

Ilse: "If they've been marginalized it's just one more time from their perspective. And I really had to dig deep to come there. That was really hard for me."

[Here, three things are exemplified: a commitment to sticking with the conversation, despite the power dynamic—a nurse manager versus physician; the concept of personal

versus institutional power; the common language of "marginalized" gained as the result of the intervention.]

Physician: It's hard when you're on the receiving end of that.

Ilse: It was a game changer for me, to see it differently.

[Again, Ilse is trying to drive home the point that she was not relaying the story to exemplify their own perspective of intent, rather tried to reinforce that the "ah-ha" moment for them was seeing it through the impact lens.]

Physician: And then there's other people who will play that card, ya know, people with addiction problems play that card on me from time to time, and I'm like 'well….' It's hard. I'm not withholding oxycodone because of your skin color; I'm withholding it because it's a good idea, for all these medical reasons…

[Now, multiple things are going on with this statement. First, the physician started out referring to someone with an addiction "playing the card," but in the next sentence is referring to skin color. Implicitly, the physician conflating race and addiction—a likely clue of their racial bias.]

Ilse:….yeah….

[Ilse's "yeah" was not an "I agree with you," yeah, it was a placeholder word as she continued to grapple with how to respond to the physician. It came across as a sign of frustration.]

Physician: Yeah it gets…it has an impact on us, and then trying to come back and build a therapeutic milieu and rapport to help people set them up for success

Ilse: The funny thing about that experience. Yes, in the moment, I didn't love it [laughs], not gonna lie, but it did make me….

She is at it again. Relentless in her pursuit to break through to this physician.

Physician: [tries to interrupt]

Ilse: [continues saying]…it did make me think differently going forward. It did.

Again, Ilse is not deterred by the positional power at play, and continued without letting the physician interrupt.

Physician: it does make you pause for reflection. For sure, yeah.

[And after over 10 minutes in conversation with him, she made a direct statement:]

Ilse: And then after I was like maybe I should look at skin color, maybe that does matter.

Physician: It's really powerful when you realize that a lot of people might be interpreting actions, even if they're well intended, that way.

The physician expressed understanding of the concept of intent versus impact, despite some resistance to that earlier in the conversation.

This interaction exemplified not only Ilse's increased confidence and competence as the result of the intervention, but contrary to initial reactions, showed individual development of the physician, as well. Remember, the physician initially refuted the notion that racial inequity was a patient care issue. A battle emerged between his original stance and the new information he is gaining as a part of this experience. This battle—cognitive dissonance—exemplified a shift, though more nuanced compared to Ilse. This physician's development came from a place of new curiosity and growth of understanding. And despite these two individuals being in different places in their journey of understanding racial equity, they both reflected mind shifts.

Conclusion 2

Through double- and triple-loop learning, the department effectively addressed and began to dismantle institutional racism.

Two key elements of this conclusion will be discussed: 1) DLL and TLL learning, including the overlap with AL and CAL; and 2) addressing and dismantling institutional racism.

First, let us revisit loop learning. Single loop learning is described as change in a behavior within the existing system, with minimal variation of method; whereas, double loop learning (DLL) is marked by a change in individuals' underlying assumptions and beliefs (Foldy & Creed, 1999; Kwon & Nicolaides, 2017). Developed later, triple loop learning (TLL) is like double loop learning in that it results in a deep transformation; however, unlike double loop learning where that change occurs with an individual, triple loop learning is transformation in the system.

DLL and TLL have the same three key features: 1) reflection, 2) experience/practice, and 3) discourse (Foldy & Creed, 1999; Kwon & Nicolaides, 2017). Literature on loop learning shows overlap between AL and loop learning, as they both include the same key aspects. There is no agreement among scholars on the definition of DLL and TLL, nor whether action learning and loop learning are indeed the same (Kwon & Nicolaides, 2017). In this study, the program planners intentionally incorporated action learning as a part of the intervention; however, what resulted—DLL and TLL—was an outcome of action learning, so for purposes of this study, the terms are considered different. However, it is acknowledged that there is overlap, and indeed some scholars who refer to it as the same (Foldy & Creed, 1999).

Numerous studies exist that have examined SLL, DLL and TLL learning. However, much of the research involved addressing only one level of loop learning, rendering them distinct from each other. Foldy and Creed (1999) suggested the power of loop learning diminished by looking at each level of learning as distinct from the others. They purported the value of this action-learning framework was in examining them in relationship to and interacting with each other. This study exemplifies Foldy and Creed's contention and recognizes both DLL and TLL in concert with each other contributed to individual and systemic transformational change. These changes were not separate or distinct from each other. The process of individual reflection, practice and discourse is not linear. One does not start with self-reflection, then move to discussion with others, and finally engage in action learning; rather it is an iterative process, with each component influencing further development and momentum of the others. The synergy between both levels of development produced the environment necessary for robust changes in awareness, attitudes, *and* policies. It is this cyclical process that gives the loop learning its power and led to the impact and outcomes of this case study, not the least of which was dismantling institutional racism.

This study showed how action learning is a practice that results in TLL (i.e. an outcome). TLL is alone is not necessarily important from an organizational perspective, rather TLL becomes significant when it results in a strategy or goal achieved, such as in this case study. In other words, the department's practice of action learning allowed for both DLL and TLL triple loop learning.

The second key element of this conclusion is institutional racism. Institutional racism refers to the ways in which an organization's policies, processes, and practices

disproportionately harm BIPOC and advantaging white people. Institutional racism does not have to be intentional, and often is not. However, its impact is just as insidious. In fact, the lack of intention is one of the reasons why it is so challenging for white people to understand and acknowledge it. The notion of racism as an explicit, intentional individual act has been so engrained in us, it confounds white people. In order to address it, there must be an understanding and acknowledgement of what it is, and that it indeed exists. However, addressing institutional racism does not in itself lead to change in the system. To dismantle it requires tangible changes to the organization's practices and policies to that which are equitable.

Given these definitions and understanding, it can be said that the birth center department indeed addressed and started to dismantle racism, evidenced by the changes in and creation of new policies and practices that participants described. Dismantling institutional racism is an ongoing process, which is why it is stated that the department "started to" dismantle institutional racism. By no means did participants indicate the work was done. In fact, most shared their concerns about how much more work there is to do. However, their experience provided the awareness, understanding and tools necessary to continue the work.

Conclusion 3

The convergence of events leading to the intervention offered a "ripe" time for the creation, planning, and execution of the equity education program.

Multiple synchronous components merged together at just the right time. These instrumental aspects entailed the hospital's health equity efforts up to that point,

leadership's recent commitment and priority for health equity, and having the right people at the right time.

The birth center's planning and execution of the equity education program was not happenstance; it did not arise out of an individual thought from the director, perhaps as much of work can and does in a department. The first defining aspect contributing to the intervention was the work the hospital had been doing over the past five years, in particular. This included creating a director of health equity position, and a hospital-wide, cross-functional health equity committee, and hiring a woman of color with a strong racial health equity commitment as birth center director.

These actions were not in themselves where the commitment was exemplified. Rather, they were necessary means to an end—the end having been deeper work in addressing and reducing health inequities based on race, language and payer type. The hospital systematically collected data on race, ethnicity, and language preferences directly from patients and members in a variety of ways, all of them voluntary. The data was used to continually monitor the quality of care delivered and patient experience by race and language, as well as identify strategies to reduce health disparities in treatment, outcomes, and service. For example, the health equity committee, through the leadership of the newly designated health equity director, focused on and over time showed improvement in disparities in readmission rates for Black patients, and mental health length-of-stay for Black patients and patients whose first language is not English.

The second defining aspect of the convergence of work was in the emergent commitment to racial health equity by the CEO of the hospital and the birth center director. Maxine shared the journey of understanding they had been going through, and

their increased awareness resulted in a strong commitment. Change management theory and practice states that leadership commitment is a key factor in the success of any change effort (Cummings & Worley, 2009), and this study proved no exception.

The last factor related to the convergence was having the right people at the right time. As Julia stated "we had the right people at the table," and Lila shared, "we had [the health equity director] as a really great partner…we had a project manager who was helping with the operational planning [of the new building], and then we had…you [researcher] working in the role of diversity and inclusion." Each of the program planner roles was critical in successful creation and execution of the intervention.

It is necessary to point out that the convergence of these events was serendipitous. While there was a connectedness between them, they each also had an independent aspect. In other words, they were not a part of a single strategy meant to converge into the equity education program. This is an important dynamic in that it highlights that even with the best laid plans, there was still an aspect of convergence that was uncontrolled. Each of the efforts alone were related to diversity, inclusion and equity, but the spark igniting the creation of the intervention…the whole was greater than the sum of its parts.

Why does this matter? Because no matter how intentional leadership was in their change management efforts, there still lied this element—this serendipitous convergence—that could not be planned. This is indicative of the difference between theory and practice. HRD theories and principles do not incorporate serendipity, for instance, as a part of organizational or individual learning, development, and change.

As just discussed, these three conclusions reveal how a birth center in an urban Midwest city addressed and started to dismantle institutional racism, and did so without a

direct, explicit "anti-racist" approach. Unlike other trainings that place race and racism front and center, like the dismantling racism approach Griffith and colleagues (2007) studied, this case study centered on what could be referred to as an indirect intervention. This approach positioned learning within non-confrontational space that nurtured vulnerability and authenticity and did not lead with potentially triggering language like institutional racism and white privilege. It met the learners where they were at and brought them along the intercultural development path. At first glance, this indirect approach might seem counter to what institutional racism wants to achieve—explicitly calling out and interrogating systems of power and oppression, and to what scholars and practitioners might consider exemplary of privilege in itself by not addressing race and racism head on—but what this case study demonstrates is that effectively addressing and changing racially oppressive systems does not have to come by way of a direct, antagonistic approach.

To dissenters and critics, of which I would have considered myself as prior to this study, who believe trainings should be explicitly centered on race and racism, I ask a question, as a practitioner in this work I have often asked myself, "do you want to be *right* or do you want to be *effective*?" Perhaps an approach that is explicitly centered on race and racism is "right" in that it exemplifies countering white privilege by not allowing the possible negative reactions of learners upon hearing charged words like institutional racism and white privilege; however, if in doing so, learners shut down and do not take change their thoughts, attitudes or behaviors, what is the point? Yes, you were "right," but was it effective? I contend the purpose of addressing race, racism, and institutional racism, in particular, is to dismantle existing systems of power that are

creating and allowing for racial injustice and inequity. I do not think the purpose of addressing racism is in itself the end—just to address it. Rather it is a means to the end—changing the racially oppressive system. As such, what this case study shows us is that perhaps the means to that end should not be devalued or dismissed because they do not meet a certain standard, rather should be assessed based on the ability to achieve its intended outcome—to dismantle institutional racism. As such, the findings of this case study do indeed show how an organization can address systems of power create racial inequity, effectually dismantling institutional racism.

I don't think the department's work is done, in fact they just go their first taste of experiencing a systemic approach, and effectively dismantling institutional racism in some cases. As the participants remarked in their post-intervention interviews, there is just the beginning—from an individual and departmental perspective. Learning, development, and change is a continual process and don't have—or at least shouldn't have—an end point. And while momentum was created through this dynamic intervention, strategic and intentional action needs to continue in order for change to continue, but also keep individuals and the department from backsliding.

Implications

This case study contributes to discourse on pedagogical approaches to D&I and anti-racism trainings. One aspect is regarding the notion of discomfort in learning. D&I, T&D, and anti-racism practitioners specifically address white people's comfort, with many believing white people need to start being comfortable with being uncomfortable for any change to happen, individually or otherwise. I subscribe to this. Taylor (2008) stated the neurobiological approach to transformational change suggests that one

requirement is discomfort. But I also think there are different levels of discomfort, as well as different ways to bring about discomfort when working in the area of anti-racism and racial justice. They can be depicted on a continuum that ranges from comfort to discomfort to agitation. On one end of the continuum is the direct, more antagonistic approach with which People's Institute for Survival and Beyond's learning approach adheres. Their delivery style is meant to invoke discomfort, but to an extreme it can end up doing more harm than good. It causes so much discomfort it leads to agitation. Additionally, their mainly lecture-style approach to learning and change centers on understanding and acknowledging systemic racism and white privilege. Their one-and-done workshop can bring about new awareness for white folks, but does not attend to the learner, or engage them in any sustainable, longer-term way.

Near the other end of the comfort spectrum is implicit bias trainings that, as already discussed, have been widely leveraged across U.S. for-profit and non-profit companies. In my experience as a D&I practitioner, implicit bias trainings soften the notion of our assumptions and stereotypes by focusing on how we all have biases, will always have biases, and to try to recognize and mitigate them. Anecdotally, as a facilitator I have hardly seen any discomfort in these sessions, even in activities where participants are starting to realize biases they have been carrying that they never realized. Participants' reactions include how great the training is, and how much they liked it. At first glance, a practitioner should seem to revel in that; however, what does that say about the level of deeper understanding that happens (or doesn't happen)? How much discomfort was present if participants walk away with smiles on their faces and claims of excitement? Just like the notion that D&I work is white-washed, I think that unconscious

bias training in the workplace has become that way, too. It's a feel-good approach that rarely focuses on racial bias, let alone institutional racism. Perhaps this is related to studies that have shown mixed results of behavior change as the result of these trainings. Not only are they delivered in a one-and-done (okay, maybe two-and-done or even three-and-done) way that does not incorporate action learning or any other true practice, but it barely stirs anything up in participants. It skirts around the issues of race and racism, like workplace D&I efforts in general. Where there is no discomfort, there is no transformational change. Where there is no transformational change, there is no behavioral or systemic change.

My contention is this case study falls somewhere in the middle of this comfort spectrum—at a place of "discomfort." It certainly brought about more discomfort than implicit bias trainings typically do, but not as aggressive as anti-racism trainings. This intervention was able to address both racial bias and institutional racism (and create behavioral change in these) with a developmental approach that understands where learners are in their intercultural journey and meeting them where they are at in order to move them along the developmental continuum. Discomfort within this approach was strategic and intentional. Unlike bias training where there is hardly any push at all, and anti-racism praxis that provides a "one-size-fits-all" approach that is all push, the IDC™ approach is designed to be just enough pull, but not too much push.

Another implication of this study centers on the application of a critical lens to HRD and workplace D&I research and practice. Bierema (2010) stated critical OD is "an intentional, systemic process of facilitating change to improve an organization's well-being…by challenging the status quo and replaces it with more democratic and equitable

practices, policies, and structures" (p. 27). The work of the birth center demonstrates a critical OD approach, despite its lack of explicit intention from the program planners. But while critical OD was not a concept intentionally employed, there was great intention and purpose by the program planners to indeed increase equitable practices, policies, and structures by addressing the status quo. What this suggests is that HRD and D&I practitioners can and should play a vital role in an organization's focus on addressing and dismantling institutional racism.

However, there still remains a significant barrier for practitioners. As Bierema (2012) pointed out, HRD and D&I practitioners are asked to "think outside the box" when approaching change management and T&D. Inherent in that is an expectation " to challenge the status quo and innovate, yet to do so within a traditional, dominant White male system" (p.32). This poses a dilemma similar to what Marcuse (1965) referred to as repressive tolerance. Marcuse argued (as cited in Brookfield, 2007):

> An all-embracing tolerance of diverse views in both curriculum and classroom discussions always ends up legitimizing an unfair status quo. Such tolerance for Marcuse is repressive, not liberating. Broadening the perspectives reviewed in a curriculum makes lecturers think they are giving equal weight to radical ideas, when in fact placing them alongside mainstream ones always dilutes their radical qualities. Repressive tolerance ensures that adults believe they live in an open society characterized by freedom of speech and expression, while in reality their freedom is being constricted further and further. (p. 558).

In other words, the dominant white organization provides the illusion that it is open to and seeks diverse views and perspectives, but only in comparison to the existing

system's framework, so that HRD and D&I practitioners (and employees) are given a voice, but that voice falls on deaf ears, in that there is inherently no inclination from the system that anything with actually change. The organization "granting permission" to think outside the box is only in words, but not in action. For as soon as ideas surface that challenge status quo, they are shut down in order to maintain the existing system.

Again, as mentioned earlier, the system is too powerful to change without its consent. And being open to diverse views is not consent for change, but just to acquiesce to the need of those marginalized have to be heard. Similar to institutional racism, explicit intent is not required for repressive tolerance. In fact, I would argue that in organizations like this hospital, there is an explicit interest and desire to be more inclusive of diversity; however, implicitly, the organization has no desire to actually create the kind of change necessary to be truly equitable.

Therefore, in order systemic change that truly embraces diversity and inclusion, it is argued that a more radical approach is needed. To combat repressive tolerance, education and training needs to place non-dominant, marginalized theories and practices at the center, not giving voice to the status quo at all. This is aligned with what Collins (2018) referred to as radical HRD, a step further from CHRD. Though I think it would be hard to achieve, like that of institutional racism, it should not be ignored as a vision strived for within organizations and the HRD profession.

There is also another critical element that arose from this study, specifically related to the conclusion regarding the serendipity of events leading to the intervention. While there indeed was a level of serendipity, I am not sure it holds as much prominence as originally proposed. Perhaps more important is the revelation that the case unintentionally and

unknowingly aligned with Kotter's eight-step change management model. So much alignment that some of the exact language and wording in his eight steps were voiced by participants. This [brings about} an additional connection between about OD and change management. HRD and OD are both large-order systems-wide interventions, whereas I see change management one *practice* within the larger HRD and OD consulting that focuses on the *people*. I wonder if, just as scholars have done with HRD and OD, there exists an opportunity to add a critical lens to change management-- "critical change management"--what that would look like, or what the implications would be.

Lastly, there were unexpected events that happened in the months after the study's end that will likely have an impact on both research and practice in both racial health equity and institutional racism. These two huge events with local and national implications occurred (and still happening as I write) are the COVID-19 pandemic and the murder of George Floyd at the hands of police officers.

In the spring of 2020, the United States—and the rest of the world—was hit by the COVID-19 pandemic. The country was basically shut down for a period of time, as we tried to stop the spread of the virus. There were (and still are) many impacts of this pandemic on Americans' lives, and in healthcare, in particular. One being the proliferation of racial health disparities of this virus for the Black community. At the onset, people were referring to COVID-19 as the "great equalizer;" however, as data started coming in about who was contracting and dying from the virus, it was clear this pandemic would not escape racial inequities that exist in nearly every other facet of healthcare. Within the hospital, as well as locally, regionally, and nationally, people were shining a light on the insidious disparities. However, much like that of other media

attention about racial disparities, there were mixed perspectives as to whether these were indicative of systemic or personally-mediated issues.

As if dealing with a global pandemic was not enough, another situation occurred creating the racial justice flashpoint. On May 26, 2020, in Minneapolis, MN, George Floyd, in police custody outside a local convenience store for allegedly using a counterfeit $20 bill, was murdered by Minneapolis police officers who laid their knees on his neck and back until he could no longer breathe (New York Times, 2020). Shortly after the incident, cell phone recordings of bystanders who witnessed this event were posted on social media, causing national outrage over what was seen another lynching of a Black man at the hands of law enforcement. Protests, looting, and rioting ensued for weeks after, locally, nationally, and internationally. Despite countless other Black lives who experienced the same fate as George Floyd, and subsequent outrage and protests from BIPOC communities in just the past six years alone, something shifted in the white community as the result of Floyd's death, in particular. A tipping point, perhaps, that awoke white people to the racial injustice the Black community has been facing for generations.

Unlike ever seen before, companies were making statements, taking a stand, and starting to change behaviors related to racial justice and anti-racism, specifically. In my 20 years of anti-racism and D&I work, I had never witnessed anything like it. I had never seen so many individuals and companies create commitment statement taking a stand against racial injustice, let alone even use the term anti-racism. I have been in the D&I professional space for two decades where D&I was white-washed, never allowing race or racism to be centered in the discourse and work (a topic central to this study). And now,

white people were clamoring to learn more about anti-racism and what they can do to fight the racial injustice. Book clubs were being scheduled, local neighborhood groups were forming, and organization anti-racism commitment statements were being crafted.

While the George Floyd flashpoint happened three months after the study ended, the impact it has had on racial equity and institutional racism in organizations could not go unaddressed. As a D&I practitioner I can attest to what I have experienced and seen firsthand regarding the impact to this work. The healthcare organization I work for has been one of the many companies who have made anti-racism proclamations, shifting its organizational and D&I-specific strategic plan to incorporate 'becoming an anti-racist organization,' with race and racism centered in the D&I conversations and planning.

Not only has there been a visible shift in the work, but the environment feels different, as well. Despite the fact that the majority of the non-care providers in the organization are working remotely due to the COVID-19 pandemic, there is a sense of a culture shift. What I am hearing from others, what I can say freely without fear of repercussions, what I can explicitly push back on as the result of this shift is palpable and unlike anything I've experienced since the beginning of my career working for an organization whose mission was to eliminate racism.

Though, questions remain. How long will this sudden surge in anti-racism and racial equity last? Will organizational leaders truly commit to and change practices? Do they even know what they are committing to? Will professed anti-racism commitments by these company leaders crumble when faced with *actually making* systemic change? Will employees within the organizations, particularly BIPOC, be let down once again by a lack of true, systemic change? And how will organizations deal with the impact? Has

enough passion and energy erupted from employees to impact the trajectory and sustainability of racial justice efforts? Will researchers have better access to organizations to conduct studies on organizational anti-racism and racial equity efforts? All of these questions remain to be seen. Only time will tell if true organizational change happens as the result of the racial justice flashpoints created by COVID-19 and the murder of George Floyd. But public health, HRD, and D&I scholars and practitioners have a central opportunity to leverage these current events to influence sustainable change.

No one knows the extent to which this current movement will maintain momentum and lead to sustainable change for individuals, organizations, or society, if at all. Only time will tell. Despite understandable skepticism by some BIPOC, cautious optimism by many is felt. We could be experiencing a defining moment in workplace D&I that could forever shift how this work is approached. Though none of these ultimately matter if the change does not lead to dismantling institutional racism and achieving racial equity.

Future Research

There are several opportunities for future research as the result of this study. First, more research on how organizations approach institutional racism is needed. The 2020 racial justice flashpoints discussed above may provide an opportunity to leverage a multiple case study method. With the dramatic increase in organizations' proclamations around anti-racism and racial justice efforts, not only could barriers to accessing organizations for the purposes of research be lessened, but perhaps findings would be even more robust.

Second, further research is warranted with a less complex researcher positionality. While not devaluing the positive impact of my positionality to this case study, there is a need to conduct similar studies from a purely external researcher lens. This would provide a great opportunity to compare and contrast findings and could further elucidate the impact of the powerful insider-outsider role I had in this study.

Third, further research is needed with different populations and settings (both within and outside of healthcare). For example, this case study centered on department leaders. How might findings compare if engaging non-leaders in the department, or other departments in the hospital that do not have the extent of BIPOC patients? Additionally, studies in other healthcare organizations would be beneficial in illuminating how a particular organization's culture, for instance, might impact the approach and effectiveness of such change. Would the same approach and framework offer the same results in a different healthcare organization? Then what would that tell us about the role organization culture has in impacting the individual and systems change? In other words, to what extent was this hospital's success in addressing and starting to dismantle racism the result of the approach itself or the existing culture and leadership support, for instance? And how does this work within healthcare compare to non-healthcare settings?

Lastly, similar studies could be conducted using a quantitative approach. If given the necessary access, an empirical study on an organization's work to address and dismantle racism could provide further findings of a causal nature, as well as findings that can be generalized to other settings. Together with qualitative findings, this additional research could be a great compliment that would strengthen the results and implications for both theory and practice.

Limitations

There were several limitations of this study. First, the nature of qualitative case study design lends itself to researcher bias. Both my worldview and role in the organization could have influenced the research process and decisions, from data collection methods to analysis to interpretation. As such, journaling was even more critical to ensure a continual reflexive practice about what biases and assumptions might be impacting the study.

Another limitation of the qualitative design is in its lack of revealing causal connection or generalizability. Findings and conclusions drawn from this study, including individual and systemic change, suggest a correlation to the intervention, however true causation is not known. Additionally, the case study design was meant to elucidate experiences of those within the case, where findings were context specific. Thus, results cannot be assumed to generalize to other environments.

However, Lincoln and Guba (1985) offered the notion of transferability for qualitative research design and recommended practices that were employed in this study. For example, I provided explicit, thick descriptions developed in context, where the reader can decide the extent of applicability of the case. It is hoped that while this case study is context specific, both researchers and practitioners are inspired by these findings and leverage concepts to study and practice in other environments.

My unique role as both researcher and employee was both an asset and potential limitation to this study. As an “insider,” I have established relationships with several of the participants and can leverage those relationships in gaining trust with the participants that I have not yet worked with. These relationships can be valuable in helping ensure

participants trust the confidentiality of what is shared in interviews, trainings and meetings, as well as provide safety needed to be candid and authentic. Conversely, my "insider" status has limitations, as well. For example, my relationship with participants might have caused social desirability effects; participants might have altered their comments in interviews and observed sessions and meetings, or restricted comments altogether, as the result of my presence. To address this, the data collection and analysis techniques employed were chosen specifically to minimize any negative impact my role as both a researcher and employee (e.g. triangulation of data methods, member checking, bracketing and journaling).

Also related to my positionality is a potential limitation being a White woman studying racial inequity and institutional racism. As discussed earlier, while my White identity may have helped in building rapport and trust with White participants, allowing for more authentic and trustworthy data to be captured, that same identity may have hindered BIPOC's willingness to share their authentic feelings and experiences. Additionally, despite diligent practices to bring to awareness, acknowledge, and mitigate my biases throughout the study, there is still a likelihood that as a White person there were unconscious and unidentified impacts.

Conclusion

This case study, guided by CRT, set out to explore how an urban hospital's birth center addressed institutional racism as a part of their health equity strategy. Findings showed substantial changes both at the individual and systemic level. The intervention's framework and approach, cohort model, and action learning component together led to DLL and TLL and resulted in the department's success in starting to dismantle

institutional racism. While these conclusions have significant implications for both research and practice, there is also great opportunity to address the study's limitations by conducting further research around organizations addressing institutional racism, particularly in light of organizations' new commitments to anti-racism, racial justice and racial equity sparked by the global pandemic and George Floyd's murder. Gone are the days of only conceptual literature on the importance of addressing institutional racism in creating racial equity. Let this study be a needed spark for the research and practitioner communities to join efforts in providing more empirical studies on how to change the racial equity and institutional racism conversation to action.

References

Acosta, D., Ackerman-Barger, K. (2017). Breaking the silence: Tim to talk about race and racism. *Academic Medicine, 92*(3), 285-288. doi: 10.1097/ACM.0000000000001416

Alfred, M. V., & Chlup, D. T. (2010). Making the invisible, visible: Race matters in human resource development. *Advances in Human Resource Development, 12*(3), 332-351. doi: 10.1177/1523422310375027

Bailey, Z. D., Krieger, N., Agénor, M., Graves, J., Linos, N., & Bassett, M. T. (2017). Structural racism and health inequities in the USA: Evidence and interventions. *Lancet, 389,* 1453-63.

Bendick, M., Egan, M. L., & Lofhjelm, S. M. (2001). Workforce diversity training: From anti-discrimination compliance to organizational development. *Human Resource Planning, 24*(2), 10-25.

Bennett, J., & Yalowitz, D. C. (2018, July 23). *Using a developmental perspective in training design*. Summer Institute of Intercultural Communication, Portland, OR.

Beth Zemsky. (n.d.). *Methods and approaches*. Retrieved January 12, 2020, from https://bethzemsky.com/approach/

Bezrukova, K., Spell, C. S., Perry, J. L., & Jehn, K. A. (2016). A meta-analytical integration of over 40 years of research on diversity training evaluation. *Psychological Bulletin, 142*(11), 1227-1274. http://dx.doi.org/10.1037/bul0000067

Bierema, L.L. (2010). *Implementing a critical approach to organization development*. Krieger Publishing Company.

Bierema, L., & Callahan, J. L. (2014). Transforming HRD: A framework for critical HRD practice. *Advances in Human Resource Development, 16*(4), 429-444. doi: 10.1177/1523422314543818

Bowen, G. A. (2009). Document analysis as a qualitative research method. *Qualitative Research Journal, 9*(2), 27-40. doi: 10.3316/QRJ0902027

Brookfield, S. (2007). Diversifying curriculum as the practice of repressive tolerance. *Teaching in Higher Education, 12*(5-6), 557-568. doi: 10.1080/13562510701595085

Burgess, D. J., Phelan, S., Workman, M., Hagel, E., Nelson, D. B., Fu, S. S., Widome, R., & van ryn, M. (2014). The effect of cognitive load and patient race on physicians' decisions to prescribe opioids for chronic low back pain: A randomized trial. *Pain Medicine, 15,* 965-974. doi: 10.1111/pme.12378

Burke, S. E., Dovidio, J. F., Przedworski, J. M., Hardeman, R. R., Perry, S. P., Phelan, S. M., . . . van Ryn, M. (2015). Do contact and empathy mitigate bias against gay and lesbian people among heterosexual first-year medical students? A report from the medical student CHANGE study. *American Medicine, 90*(5), 645-651. doi: 10.1097/ACM.0000000000000661

Byrd, M. Y. (2018). Does HRD have a moral duty to respond to matters of social injustice? *Human Resource Development International, 21*(1), 3-11. doi: 10.1080/13678868.2017.1344419

Came, H., & Griffith, D. (2017). Tackling racism as a "wicked" public health problem: Enabling allies in anti-racism praxis. *Social Science and Medicine*, 1-8. http://dx.doi.org/10.1016/j.socscimed.2017.03.028

Center for Disease Control (n.d.*a*). Pregnancy-related deaths. Retrieved from https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm

Center for Disease Control (n.d.*b*). Severe maternal morbidity in the United States. Retrieved from https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html

City of Saint Paul. (n.d.). *Race and Ethnicity*. Retrieved August 18, 2018, from https://www.stpaul.gov/books/race

Collins, J. C. (2018). A more radical human resource development: The time is now. *Human Resource Development International, 22*(4), 405-411. doi: 10.1080/13678868.2018.1506649

Colquitt, J. A. (2012). Organizational justice. In S. W. J. Kozlowski (Ed.). *The Oxford handbook of organizational psychology, vol. 1* (526-547). *New York, NY: Oxford University Press.*

Corbin, J., & Strauss, A. (2015). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (4th ed.). Thousand Oaks, CA: Sage

Cox, T. (1991). The multicultural organization. *The Executive, 5*(2), 34-47.

Cropanzano, R., Bowen, D. E., & Gilliland, S. W. (2007). The management of organizational justice. *Academy of Management Perspectives, 21*(4), 34-48.

Cummings, T., & Worley, C. (2015). *Organization development & change* (9th ed.). Stamford, CT: Cengage Learning.

Dankwa-Mullan, I., Rhee, K. B., Stoff, D. M., Pohlhause, J. R., Sy, F. S., Stinson, N., & Ruffin, J. (2010). Moving toward paradigm-shifting research in health inequities through translational, transformational, and transdisciplinary approaches. *American Journal of Public Health, 100*(S1), S19-S24. doi:10.2105/AJPH.2009.189167

Darke, P., Shanks, G, & Broadbent, M. (1998). Successfully completing case study research: Combining rigour, relevance and pragmatism. *Information Systems Journal, 8*(4), pp. 273-289.

Dehon, E., Weiss, N., Jones, J., Faulconer, W., Hinton, E., & Sterling, S. (2017). A systematic review of the impact of physician implicit racial bias on clinical decision making. *Academic Emergency Medicine, 24*, 895-904. doi: 10.1111/acem.13214

Delgado, R. (1995). *Critical race theory: The cutting edge*. Philadelphia: Temple University Press.

deMunck, V. C., & Sobo, Elisa J. (1998). *Using methods in the field: a practical introduction and casebook*. Walnut Creek, CA: AltaMira Press.

Devine, P. G., Forscher, P. S., Austin, A. J., & Cox, W. T. (2012). Long-term reduction in implicit race bias: A prejudice habit-breaking intervention. *Journal of Experimental Social Psychology, 48*, 1267-1278. doi: 10.1016/j.jesp.2012.06.003

Dewar, B, & Sharp, C. (2006). Using evidence: How action learning can support individual and organisational learning through action research. *Education Action Research, 14*(2). doi: 10.1080/09650790600718092

Enoksen, E. (2015). Examining the dimensionality of Colquitt's organizational justice scale in a public health sector context. *Psychological Reports, 116*(3), 723-737. doi: 10.2466/01.PRO.116k26w0

Erickson, F. (1986). Qualitative methods in research on teaching. In Wittrock (Ed.) Handbook of research on teaching v3, 119-161. New York: Macmillan.

Evered, R., & Reis, L. M. (2001). Alternative perspectives in the organizational sciences: 'Inquiry from the inside' and 'inquiry from the outside.*'Academy of Management Review, 6*(3), 385-395.

Ewoh, A. I. (2013). Managing and valuing diversity: Challenges to public managers in the 21st century. *Public Personnel Management, 42*(2), 107-122. doi: 10.1177/0091026013

Fahlberg, B, Foronda, C., & Baptiste, D. (2016). Cultural humility: The key to patient/family partnerships for making difficult decisions. *Nursing,* 46(9), p. 14-16. doi: 10.1097/01.NURSE.0000490221.61685.e1

Feagin, J., & Bennefield, Z., (2014). Systemic racism and U.S. healthcare. *Social Science and Medicine, 103,* 7-14. http://dx.doi.org/10.1016/j.socscimed.2013.09.006

Fenwick, T.J. (2003). Emancipatory potential of action learning:Aa critical analysis. *Journal of Organizational Change Management, 16*(6). doi 10.1108/09534810310502568

Fenwick, T. (2005). Conceptions of critical HRD: Dilemmas for theory and practice. *Human Resource Development International, 8*(2), 225-238. doi: 10.1080/13678860500100541

Ferdman, B. (2014). Towards infusing diversity and inclusion as core elements of OD. *OD Practitioner, 46*(4), 44-46.

Ferdman, B. (2016). Diversity and organizational change/performance. In J. G. Kendell (Ed.), *The wiley blackwell encyclopedia of race, ethnicity and nationalism* (pp. 598-600). West Sussex, UK: John Wiley & Sons.

FitzGerald, C. & Hurst, S. (2017). Implicit bias in healthcare professionals: A systematic review. *BMC Medical Ethics, 18*(19), 1-18. doi: 10.1186/s12910-017-0179-8

Flood, R. L., & Romm, N. R. A. (2018). A systemic approach to processes of power in learning organizations: Part I - literature, theory, and methodology of triple loop learning. *The Learning Organization, 25*(4), 260-272. doi: 10.1108/TLO-10-2017-0101

Flood, R. L., & Romm, N. R. A. (1996). Plurality revisited: Diversity management and triple loop learning. *Systems Practice, 9*(6), 587-603.

Foddy, E. G., & Creed, W. E. (1999). Action learning, fragmentation, and the interaction of single-, double-, and triple-loop change: A case of gay and lesbian workplace advocacy. *The Journal of Applied Behavioral Science, 35*(2), 207-227.

Ford, C., & Airhihenbuwa, C. O. (2010). The public health critical race methodology: Praxis for antiracism research. *Social Science and Medicine, 71*, 1390-1398. doi: 10.1016/j.socscimed.2010.07.030

Foronda, C., Baptiste, D., Reinholdt, M.M., & Ousman, K. (2016). Cultural humility: A concept analysis. *Journal of Transcultural Nursing, 27*(3), p. 210-217. doi: 10.1177/1043659615592677

Forscher, P. S., Mitamura, C, Dix, E. L., Cox, W. T., & Devine, P. G. (2017). Breaking the prejudice habit: Mechanisms, timecourse, and longevity. *Journal of Experimental Social Psychology, 72*, 133-146. doi: 10.1016/j.jesp.2017.04.009

Gollust, S. E., Cunningham, B. A., Bokhour, B. G., Gordon, H. S., Pope, C., Saha, S. S….Burgess, D. J. (2018). What causes racial health care disparities? A mixed-methods study reveals variability in how health care providers perceive causal attributions. *The Journal of Health Care Organization, Provision, and Financing, 55*, 1-11. doi: 10.1177/0046958018762840

Green, A. R., Carney, D. R., Pallin, D. J., Ngo, L. H., Raymond, K. L., Iezzoni, L. I., & Banaji, M. R. (2007). Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients. *Journal of General Internal Medicine, 22*, 1231-1238. doi: 10.1007/s11606-007-0258-5

Green, K. (2014). Doing double dutch methodology: Playing with the practice of participant observer. In D. Pairs & M. T. Winn (Eds.) *Humanizing research: Decolonizing qualitative inquiry with youth and communities* (147-160). Thousand Oaks, CA: Sage Publications.

Green, R. D., & Berthoud, H. (2015). OD is diversity. *OD Practitioner, 39*(2), 36-41.

Greenberg, J. (1987). A taxonomy of organizational justice theories. *Academy of Management Review, 12*(1), 9-22.

Griffith, D. M., Childs, E. L. Eng, C., & Jeffries, V. (2007). Racism in organizations: The case of a county public health department. *Journal of Community Psychology, 35*(3), 287-302.

Griffith, D. M., Johnson, J., Ellis, K. R., & Schulz, R. J. (2010). Cultural context and a critical approach to eliminating health inequities. *Ethnicity and Disease, 26*, 71-76.

Hagiwara, N., Dovidio, J. F, Eggly, S., & Penner, L. A. (2016). The effects of racial attitudes on affect and engagement in racially discordant medical interactions between non-Black physicians and Black patients. *Group Processes & Intergroup Relations, 19*(4), 509-527.

Haider, A. H., Schneider, E. B., Sririam, N., Dossick, D. S., Scott, V., K., Swoboda, S. M., . . . Freischlag, J. A. (2015). Unconscious race and social bias among acute care surgical clinicians and clinical treatment decisions. *JAMA Surg, 150*(5), 457-464. doi: 10.1001/jamasurg.2014.4038

Hall, J. M., & Fields, B. (2015). "It's killing us!" Narratives of Black adults about microaggression experiences and related health stress. *Global Qualitative Nursing Research*, 1-14.

Hall, J. M., & Fields, B. (2013). Continuing the conversation in nursing on race and racism. *Nurse Outlook, 61*(3), 164-173.

Hall, W. J., Chapman, M. V., Lee, K. M., Merino, Y. M., Thomas, T. W., Payne, B. K., Eng, E., Day, S. H., & Coyne-Beasley, T. (2015). Implicit racial/ethnic bias among health care professionals and its influence on health care outcomes: A systematic review. *American Journal of Public Health, 105*(12), 60-76.

Hite, L. M., & McDonald, K. S. (2010). Perspectives on HRD in diversity education. *Advances in Developing Human Resources, 12*(3), 283-294. doi: 10.1177/1523422310374974

Hirsch, A. T., Hollingshead, N. A., Ashburn-Nardo, L., & Kroenke, K. (2015). The interaction of patient race, provider bias, and clinical ambiguity on pain management decisions. *The Journal of Pain, 16*(6), 558-568. doi: 10.1016/j.jpain.2015.03.003

Holck, L. (2016). Putting diversity to work: An empirical analysis of how change efforts targeting organizational inequality failed. *Equality, Diversity and Inclusion: An International Journal, 35*(4), 296-307. doi: 10.1108/EDI-12-2015-0107

Howell, E. A., Janevic, T., Hebert, P. L., Egorova, N.N., Balbierz, A., & Zeitlin, J. (2018) Differences in morbidity and mortality rates in black, white, and Hispanic very preterm infants among New York City hospitals. *Journal of the American Medical Association 172*(3), 1902-1910. doi:10.1001/jamapediatrics.2017.4402

Institute of Medicine Committee on Quality of Health Care in America. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, D.C.: National Academy Press.

Institute of Medicine Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. (2003). Unequal Treatment Confronting Racial and Ethnic Disparities in Health Care. Retrieved from https://www.nap.edu/read/10260/chapter/1

Institute of Medicine. (2010). *The future of nursing: Leading change, advancing health*. Washington, DC: National Academies Press.

Intercultural Development Inventory (n.d.). The intercultural development continuum. Retrieved August 23, 2020, from https://idiinventory.com/generalinformation/the-intercultural-development-continuum-idc/

Jones, C. P. (2000). Levels of racism: A theoretical framework and gardener's tale. *American Journal of Public Health, 90*(2), 1212-1215.

Kaiser, C. R., Major, B., Jurcevic, I., Dover, T. L., Brady, L. M., & Shapiro, J. P. (2012). Presumed fair: Ironic effects of organizational diversity structures. *Journal of Personality and Social Psychology, 104*(3), 1-16. doi: 10.1037/a0030838

Kaplan, M., Donovan, M., & EBSCOhost. (2013). *The inclusion dividend: Why investing in diversity & inclusion pays off*. Brookline, MA: Bibliomotion.

Kelly, E., & Dobbin, F., (1998). How affirmative action became diversity management: employer response to antidiscrimination law, 1961 to 1996. *American Behavioral Scientist. 41*(7), 960-984.

Konrad, A. M., & Linnehan, F. (1995). Formalized HRM sructures: Coordinating equal employment opportunity or concealing organizational practices? *The Academy of Management Journal, 38*(30), 787-820.

Konrad, A. M., (2003). Defining the domain of workplace diversity scholarship. *Group and Organization Management, 20*(1), 4-17. doi: 10.1177/1059601102250013

Kwon, C., & Nicolaides, A. (2017). Managing diversity through triple-loop learning: A call for paradigm shift. *Human Resource Development International, 16*(1), 85-99. doi: 10.1177/1534484317690053

Lai, C. K., Marini, M., Lehr, S. A., Cerruti, C., Shin, J. L., Joy-Gaba, J. A., … Nosek, B. A. (2014). Reducing implicit racial preferences: I. A comparative investigation of 17 interventions. *Journal of Experimental Psychology: General, 143*, 1765-85.

Lai, C., Skinner, A., Cooley, E., Murrar, S., Brauer, M., Devos, T., . . . Gauthier, I. (2016). Reducing implicit racial preferences: II. Intervention effectiveness across time. *Journal of Experimental Psychology: General, 145*(8), 1001-1016. http://dx.doi.org/10.1037/xge0000179

Lenton, A., Blair, I., & Hastie, R. (2006). The influence of social categories and patient responsibility on health care allocation decisions: Bias or fairness? *Basic and Applied Social Psychology*, *28*(1), 27-36.

Lincoln, Y.S., & Guba, E.G. (1986). But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. In D. D. Williams (Ed.) *Naturalistic Evaluation.* New Directors for Program Evaluation, 30. San Francisco, CA: Josey-Bass.

Linnehan, F., & Konrad, A. (1999). Diluting Diversity. *Journal of Management Inquiry*, *8*(4), 399-414.

Maina, I. W., Belton, T. D., Ginzberg, S., Singh, A., & Johnson, T. J. (2015). A decade of studying implicit racial/ethnic bias in healthcare using the implicit association test. *Social Science in Medicine, 199*, 21-229. doi:

Marcuse, H. (1965). Repressive tolerance. In R. P.Wolff, B. Moore, Jr.,&H. Marcuse (Eds.), *A critique of pure tolerance* (pp. 81-123). Boston: Beacon.

Merriam, S. B., Johnson-Bailey, J., Lee, M. Y., Lee, Y., Ntseane, G., & Muhamed, M. (2001). Power and positionality: Negotiating insider/outsider status within and across cultures. International Journal of Lifelong Education, 20(5), 405-416.

Metzl, J. M., & Hansen, H. (2014). Structural competency: Theorizing a new medical engagement with stigma and inequality. *Social Science & Medicine, 103*, 126-133. http://dx.doi.org/10.1016/j.socscimed.2013.06.032

Metzl, J. M., Petty, J., & Olowojoba, O. V. (2017). Using a structural competency framework to teach structural racism in pre-health education. *Social Science & Medicine*, 1-13. http://dx.doi.org/10.1016/j.socscimed.2017.06.029

Minnesota Department of Health. (2014). *Advancing Health Equity in Minnesota: A report to the legislature.* http://www.health.state.mn.us/divs/chs/healthequity/ahe_leg_report_020414.pdf

National Center for Health Statistics. (2016). Chapter III: Overview of Midcourse Progress and Health Inequities. Healthy People 2020 Midcourse Review. Retrieved from https://www.cdc.gov/nchs/data/hpdata2020/HP2020MCR-B03-Overview.pdf

National League for Nursing. (n.d.). *Mission/goals/core values*. Retrieved from http://www.nln.org/about/core-values

New York Times. (May 28, 2020). *What we know about the George Floyd murder in Minneapolis.* Retrieved from https://www.nytimes.com/2020/05/27/us/george-floyd-minneapolis-death.html

Oliver, M. N., Wells, K. M., Hawkins, C. B., Nosek, B. A., & Joy-Gaba, J. (2014). Do physicians' implicit views of African Americans affect clinical decision making? *Journal of the American Board of Family Medicine, 27*(2), 177-188. doi: 10.3122/jabfm.2014.02.120314

[Organization name withheld] (n.d.) Quick facts. Retrieved from [website withheld]

[Organization withheld]. (2018). *Overview of birth center equity education* [organization document]. Location: Author.

[Organization withheld]. (2019). *[Workteam __] agenda* [organization agenda]. Location: Author.

[Organization withheld]. (2019). *[Workteam __] agenda* [organization agenda]. Location: Author.

Ortiz, L., & Jani, J. (2010). Critical race theory: A transformation model for teaching diversity. *Journal of Social Work Education, 46*(2), 175-193. http://dx.doi.org/10.5175/JSWE.2010.200900070

Paluck, E. L., & Green, D. P. (2009). Prejudice reduction: What works? A review and assessment of research and practice. *Annual Review of Psychology, 60*, 339-367. doi: 10.1146/annurev.psych.60.110707.163607

Patton, M. Q. (2015). *Qualitative Research and Evaluation Methods* (4th ed.). Thousand Oaks, CA: Sage.

Penner, L. A., Dovidio, J. F., West, T. V., Gaertner, S. L., Albrecht, T. L., Dailey, R. K., & Markova, T. (2010). Aversive racism and medical interactions with Black patients: A field study. *Journal of Experimental Social Psychology, 46*(2), 436-440. doi: 10.1016/j.jesp.2009.11.004

Peschl, M. F. (2007). Triple-loop learning as foundation for profound change, individual cultivation, and radical innovation. Construction processes beyond scientific and rational knowledge. *Constructivist Foundations, 2*(2-3), 136-145.

Phelan, J., & Link, B. (2015). Is racism a fundamental cause of inequalities in health? *Annual Review of Sociology, 41*, 311-330. doi: 10.1146/annurev-soc-073014-112305

Phillips, C. (2011). Institutional racism and ethnic inequalities: An expanded multilevel framework. *Journal of Social Policy, 40*(1), 173-192. doi:10.1017/S0047279410000565

Racial Equity Tools (n.d.). *Glossary*. Retrieved from https://www.racialequitytools.org/glossary#institutional-racism

Regions Hospital (2016). *About regions hospital*. Retrieved from https://www.regionshospital.com/ucm/groups/public/@hp/@public/documents/documents/cntrb_027095.pdf

Richert, C. (2019, August 19). For black mothers and babies, prejudice is a stubborn health risk. *Minnesota Public Radio*. https://www.mprnews.org/story/2019/08/19/for-black-mothers-and-babies-prejudice-is-a-stubborn-health-risk

Roberson, Q. M. (2006). Disentangling the meanings of diversity and inclusion in organizations. *Group & Organization Management, 31*(2), 212-236. doi: 10.1177/1059601104273064

Rocco, T. S., Bernier, J. D., & Bowman, L. (2014). Critical race theory and HRD: Moving race front and center. *Advances in Development Human Resources, 16*(4), 457-470. doi: 10.1177/1523422314544294

Sabin, J. A., & Greenwald, A. G. (2012). The influence of implicit bias on treatment recommendations for 4 common pediatric conditions: Pain, urinary tract infection, attention deficit hyperactivity disorder, and asthma. *The American Journal of Public Health, 102*(5), 988-95. doi:10.2105/AJPH.2011.300621

Sabin, J. A., Rivara, F. P., & Greenwald, A. G. (2008). Physician Implicit Attitudes and Stereotypes About Race and Quality of Medical Care. *Medical Care, 46*(7), 678-685.

Salam, M. (2018, January 11). For Serena Williams, childbirth was a harrowing ordeal. She's not alone. *New York Times*. https://www.nytimes.com/2018/01/11/sports/tennis/serena-williams-baby-vogue.html

Semuels, A. (2016, July 12). Segregation in paradise? *The Atlantic*. https://www.theatlantic.com/business/archive/2016/07/twin-cities-segregation/490970/

Shifting U.S. demographics and development models: Immigration, economy and the workforce. (2007, Spring). *Real Estate Issues*, *32*(1), 7+. Retrieved from http://login.ezproxy.lib.umn.edu/login?url=http://go.galegroup.com.ezp2.lib.umn.edu/ps/i.do?p=EAIM&sw=w&u=umn_wilson&v=2.1&it=r&id=GALE%7CA165807359&asid=64b5591a88a8b7b34c638c4cae8df994

Shull, A. C., Church, A. H., & Burke, W. W., (2014). Something old, something new: Research findings on the practice and values of OD. *OD Practitioner, 46*(4), 23-30.

Smith, A. N., Brief, A. P., & Colella, A. (2010). *Bias in organizations.* In J. F. Dovidio, M. Hewstone, P. Glick, & V. M. Esses (Eds.) *The SAGE Handbook of Prejudice, Stereotyping and Discrimination* (451-456). London: SAGE Publications Limited. doi: 10.4135/9781446200919.n27

Society of Hospital of Medicine (n.d.). *The 5 Rs of cultural humility: Overview*. Retrieved from https://www.hospitalmedicine.org/practice-management/the-5-rs-of-cultural-humility/

Solórzano, D. B., & Yosso, T. J. (2002) Critical race methodology: Counter-storytelling as an analytical framework for educational research. *Qualitative Inquiry, 3,* 23-44. https://doi.org/10.1177%2F107780040200800103

Spradley, J. (1980). *Participant observation*. New York: Holt, Rinehart and Winston.

Stake, R. E. (1995). *The Art of Case Study Research*. Thousand Oaks, CA: Sage Publications, Inc.

Stevens, F. G., Plant, V. C., & Sanchez-Burks, J. (2008). Unlocking the benefits of diversity: All-inclusive multiculturalism and positive organizational change. *The Journal of Applied Behavioral Science, 44*(1), 116-133. doi: 10.1177/0021886308314460

Swanson, R. A. (2009). The theory of human resource development. In R. Swanson & E. Holton (Eds.) *Foundations of human resource development, 2nd ed* (pp. 93-111). San Francisco, Calif.: Berrett-Kohler.

Tapia, A. (2009). *The inclusion paradox: The Obama era and transformation of global diversity*. Lincolnshire, IL: Hewitt Associations.

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved, 9*(2), p. 117-125. doi: 10.1353/hpu.2010.0233

The BIPOC project. (n.d.) *About Us*. Retrieved August 21, 2020, from https://www.thebipocproject.org/about-us

Thomas, David A., & Ely, Robin J. (1996). Making differences matter: A new paradigm for managing diversity. (diversity in the workplace). *Harvard Business Review, 74*(5), 79-90.

Thomas, S., Quinn, S., Butler, J., Fryer, C., & Garza, M. (2011). Toward a Fourth Generation of Inequities Research to Achieve Health Equity. *Annual Review of Public Health, 32*, 399-416.

Tosey, P., Visser, M., & Saunders, M.N.K. (2012). The origins and conceptualizations of 'triple-loop' learning: A critical review. *Management Learning, 43*(3), 291-307. doi: 10.1177/1350507611426239

Tufford, L., & Newman, P. (2010). Bracketing in qualitative research. *Qualitative Social Work, 11*(1), 80–96. doi: 10.1177/1473325010368316

Truong, M., Paradies, Y., & Priest, N. (2014). Interventions to improve cultural competency in healthcare: A systematic review of reviews. *BMC Health Services Research, 14*(1), 99-115. http://www.biomedcentral.com/1472-6963/14/99

U.S. Department of Health and Human Services. (2014). *2013 National Healthcare Inequities Report.* Rockville, MD: Agency for Healthcare Research and Quality.

Wagner, J. (2017, August 22). Minnesota ranked 2nd-worst in U.S. for racial equality. *CBS Minnesota*. https://minnesota.cbslocal.com/2017/08/22/minnesota-racial-inequality/

Watkins, K. (1995). Workplace learning: Changing times, changing practices. *New Directions for Adult and Continuing Education, 68*, 3-16.

Woodruff, J. & Nawaz, A. (April 18, 2018). What's causing high mortality rates for black moms, infants? [TV series episode]. In Dana Roberson (Executive Producer), *PBS NewsHour*. WNET.

World Health Organization (n.d.). About social determinants of health. Retrieved from http://www.who.int/social_determinants/sdh_definition/en/

Wyatt, R., Laderman, M., Botwinick, L., Mate, K., & Whittington, J. (2016). *Achieving Health Equity: A Guide for Health Care Organizations*. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement. Retrieved from http://www.ihi.org/resources/Pages/IHIWhitePapers/Achieving-Health-Equity.aspx

Yeo, R.K., & Marquardt, M.J. (2015). (Re)Interpreting action, learning, and experience: Integrating Action Learning and Experiential Learning for HRD. *Human Resource Development Quarterly, 26*(1). doi: 10.1002/hrdq.21199

Yonas, M., Jones, A., Eng, N., Vines, E., Aronson, A., Griffith, I. … DuBose, D. (2006). The art and science of integrating undoing racism with CBPR: Challenges of pursuing NIH funding to investigate cancer care and racial equity. *Journal of Urban Health, 83*(6), 1004-1012. doi:10.1007/s11524-006-9114-x

Young, A. (2018, July 26). Hospitals know how to protect mothers. They just aren't doing it. *USA Today*. https://www.usatoday.com/in-depth/news/investigations/deadly-deliveries/2018/07/26/maternal-mortality-rates-preeclampsia-postpartum-hemorrhage-safety/546889002/

Zemsky, B. (2019a). *Birth Center Equity Education*. PowerPoint presentation at the meeting of [name withheld], Saint Paul, MN.

Zemsky, B. (2019b). *Birth Center Equity Education*. PowerPoint presentation at the meeting of [name withheld], Saint Paul, MN.

Zemsky, B. (2019c). *Birth Center Equity Education*. PowerPoint presentation at the meeting of [name withheld], Saint Paul, MN.
Zemsky, B. (2019d). *Birth Center Equity Education*. PowerPoint presentation at the meeting of [name withheld], Saint Paul, MN.
Zemsky, B. (2019e). *Birth Center Equity Education*. PowerPoint presentation at the meeting of [name withheld], Saint Paul, MN.

Appendix A

Pre-Intervention Interview Questions for Program Participants

1. [i] *Share a bit about yourself, including your position and work at the Regions Birth Center.
2. *What does health equity mean to you?
    a. What training, education or other learning experiences have you had regarding health equity?
3. *Why do you think the birth center is focusing on racial health inequity?
4. *How would you describe institutional racism?
    a. How does institutional racism relate to health inequity?
    b. How does institutional racism show up in your organization, if at all?
    c. What training, education or other learning experiences have you had regarding institutional racism?
5. To what extent are you comfortable talking about racial health equity at work? Institutional racism?
6. Based on what has been shared with you so far, what are your expectations of what this work and equity education program will be like?
7. What thoughts, curiosities, and/or concerns do you have about it?
8. *Is there anything else you'd like to share that hasn't already been covered?
9. *Would you be willing to share with me the following:
    a. what race or ethnicity you self-identify as?
    b. the gender you self-identify as? Your preferred gender pronouns?
    c. the generation you considered yourself a part of? (offer names and dates of each, if needed)

Pre-Intervention Interview Questions for Planning Committee Members

1. *Please share a bit about yourself, including your position and work at the Regions Birth Center.
2. *What does health equity mean to you?
    a. What training, education or other learning experiences have you had regarding health equity?
3. *Why is the birth center focusing on racial health inequity?
4. *How would you describe institutional racism?
    a. How does institutional racism relate to health inequity?
    b. How does institutional racism show up in your organization, if at all?
    c. What training, education or other learning experiences have you had regarding institutional racism?
5. From your perspective, what led to the birth center focusing on health equity and institutional racism.
    a. What or who instigated it?
    b. What challenges or barriers were experience, if any?
6. Now, regarding the actual planning process:
    a. Tell me about the planning committee, for example, what role did the committee serve, what was your role on the committee, how often did you meet, etc.?

b. What are the intended outcomes for this equity education program?
c. How did you come to create a plan/program that would achieve the expected outcomes?
d. What worked, what didn't, and what would you do different?

7. What thoughts, curiosities, and/or concerns do you have about the equity education program?
8. Is there anything else you would like to share that hasn't already been covered?
9. *Would you be willing to share with me the following:
    a. what race or ethnicity you self-identify as?
    b. the gender you self-identify as? Your preferred gender pronouns?
    c. the generation you considered yourself a part of? (offer names and dates of each, if needed)

Pre-Intervention Interview Questions for Executive Leaders

1. *Please share a bit about yourself, including your position and work at the Regions Birth Center.
2. *What does health equity mean to you?
    a. What training, education or other learning experiences have you had regarding health equity?
3. *Why is the birth center focusing on racial health inequity?
4. *How would you describe institutional racism?
    a. How does it relate to health inequity?
    b. How does it show up in your organization, if at all?
    c. What training, education or other learning experiences have you had regarding institutional racism?
5. From your perspective, what led to the birth center focusing on health equity and institutional racism.
    a. What or who instigated it?
    b. What challenges or barriers were experience, if any?
6. What thoughts, curiosities, and/or concerns do you have about the equity education program?
7. Is there anything else you would like to share that hasn't already been covered?
8. *Would you be willing to share with me the following:
    a. what race or ethnicity you self-identify as?
    b. the gender you self-identify as? Your preferred gender pronouns?
    c. the generation you considered yourself a part of? (offer names and dates of each, if needed

Pre-Intervention Interview Questions for Trainer

1. Tell me a bit about yourself and how and why you got into this work.
2. Please describe the Intercultural Organizational Development and Action Learning work you do with organizations.
    a. What are the biggest challenges or barriers organizations face in doing this work?
    b. What are some successes organizations have had in addressing and/or overcoming barriers?
    c. Why do you think organizations are resistant to address institutional racism?
3. What thoughts, curiosities, and/or concerns do you have about the Regions birth center equity education program/work

Appendix B

Post-Intervention Interview Questions for Program Participants

1. Tell me about your experience with the equity education program.
    a. What resonated most?
    b. What was the most challenging part(s)?
    c. What, if anything, surprised you?
2. In light of this experience, how would you answer what health equity mean to you?
3. How would you describe institutional racism?
    a. How does it relate to health equity?
    b. How does it show up in your organization, if at all?
4. To what extent are you comfortable talking about racial equity at work? About institutional racism?
5. Thinking back on what you thought this experience would be like, in what ways were your expectations met or not met?
6. Is there anything else you'd like to share that hasn't already been covered?

Post-Intervention Interview Questions for Planning Committee Members

1. Tell me about your experience with the equity education program.
    a. What resonated most?
    b. What was the most challenging part(s)?
    c. What, if anything, surprised you?
2. In light of this experience, how would you answer what health equity mean to you?
3. How would you describe institutional racism?
    a. How does it relate to health equity?
    b. How does it show up in your organization, if at all?
4. To what extent are you comfortable talking about racial equity at work? About institutional racism? Has that changed at all since before this program?
5. Thinking back on what you thought this experience would be like, in what ways were your expectations met or not met?
6. Now, regarding your experience as a part of the planning committee:
    a. What, if anything, surprised you this past year?
    b. What worked, what didn't, and what would you do different?
    c. Do you think the program's intended outcomes were met? Why or why not?
7. What thoughts, curiosities, and/or concerns do you have, if any, about the what happens now that the program is completed?
8. Is there anything else you would like to share that hasn't already been covered?

Post-program Interview Questions for Executive Leaders

1. Please share your thoughts about this past year's equity education program.
    a. What do you think were the biggest successes?
    b. What do you think were the biggest challenges?
    c. Knowing what you know now, is there anything you would do differently?

    d. What advice to you have for others (internal or external to the organization) interested in addressing institutional racism as a part of their racial equity work?
2. Considering the program's intended outcomes, as well as your own perceptions before the program started, to what extent were outcomes and/or expectations met or not met?
3. What thoughts, curiosities, and/or concerns do you have, if any, about the what happens now that the program is completed?
4. Is there anything else you'd like to share that hasn't already been covered?

Post-Intervention Interview Questions for Planning Committee Members

Remind informant of purpose of research/study: how does a large, urban hospital address institutional racism in the context of their health equity efforts?

- You can stop your participation in the study at any time with any repercussions
- You can choose not to answer any question in either interview.
- Each interview will be audio-recorded;
- The transcripts will remain confidential and data will be de-identified—your name will not be associated with what you say
- You will be given a chance to review my interpretation and key to ensure perspectives are appropriately captured.

Part one: as equity education participant

1. Tell me about your experience and learning journey with the equity education program.
    e. What resonated most?
    f. What, if anything, surprised you?
    g. What was the most challenging part(s)?
9. How would you describe health equity?
10. Why do you think the organization is working on racial health inequity?
11. How would you describe institutional racism?
    a. How does it relate to health equity?
    b. How does it show up in your organization, if at all?
12. To what extent are you comfortable talking about racial equity at work? About institutional racism?
13. How do you see the relationship between your race and ability to provide equitable care?
14. To what extent has this experience impacted how you approach decision-making?

Part 2: as a planning committee member

15. Now, regarding your experience as a part of the planning committee:
    a. What, if anything, surprised you this past year?
    b. What worked, what didn't, and what would you do different?
    c. Program goals were centered on awareness, understanding, competence and confidence. Do you think these goals were met? Why or why not?
16. What thoughts, curiosities, and/or concerns do you have, if any, about the what happens now that the program is completed?
17. What else would you like to share that hasn't already been covered?

Post-Intervention Interview Questions for Executive Leaders

1. From your perspective as a leader and sponsor of this work, but not intimately involved, describe your perspective on this past year's equity education program.
    a. What do you think were the biggest successes?
    b. What do you think were the biggest challenges?
    c. Anything surprise you?
    d. Knowing what you know now, is there anything you would do differently?
2. To what extent do you think racial health inequity was addressed in this work? To what extent do you think institutional racism was addressed?
3. What advice do you have for others (internal or external to the organization) interested in addressing institutional racism as a part of their racial equity work?
4. What thoughts, curiosities, and/or concerns do you have, if any, about the what happens going forward?
5. Is there anything else you'd like to share that hasn't already been covered?

---

[i] * = core question asked of all key informants