



THE FUTURE OF DIVERSITY AND INCLUSION IN HEALTH SERVICES AND POLICY RESEARCH:

A REPORT ON THE ACADEMYHEALTH
WORKFORCE DIVERSITY 2025 ROUNDTABLE

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Margo Edmunds, Ph.D., AcademyHealth; Clem Bezold, Ph.D., Institute for Alternative Futures; Charles Cinque Fulwood, MediaVision USA; Beth Johnson, M.P.H., AcademyHealth; and Hassan Tetteh, M.D., M.P.A, M.B.A., Uniformed Services University of the Health Sciences and Howard University

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Jameta Barlow, Ph.D., Assistant Professor, Department of Women and Gender Studies, Towson University

***Anne Beal, M.D., M.P.H.**, Chief Patient Officer, Sanofi

***Timothy S. Carey, M.D., M.P.H.**, Sara Graham Kenan Professor of Medicine and Social Medicine, University of North Carolina at Chapel Hill

Marshall Chin, M.D., M.P.H., Associate Professor of Medicine, University of Chicago

Deena J. Chisolm, Ph.D., Program Director, Patient-Centered Pediatric Research Program, Nationwide Children's Hospital

***Jose Escarce, M.D., Ph.D.**, Professor of Medicine, UCLA School of Medicine

***Darrell Gaskin, Ph.D.**, Associate Professor, Health Economics, Johns Hopkins Bloomberg School of Public Health

***Don Goldmann, M.D.**, Chief Medical and Scientific Officer, The Institute for Healthcare Improvement (IHI)

Carmen R. Green, M.D., Associate Vice President and Associate Dean for Health Equity and Inclusion, University of Michigan Health System

Rachel Hardeman, Ph.D., M.P.H., Assistant Professor, Research Program on Equity and Inclusion in Health Care, Mayo Clinic

Emily R. Holubowich, M.P.P., Senior Vice President, CRD Associates

***Elizabeth McGlynn, Ph.D.**, Director, Kaiser Permanente Center for Effectiveness and Safety Research

Felicia Mebane, Ph.D., M.S.P.H., CEO, Mebane Media Communications

Ernest Moy, M.D., M.P.H., Medical Officer, Center for Quality Improvement and Patient Safety, Agency for Healthcare Research and Quality

***Eduardo Sanchez, M.D., M.P.H.**, Deputy Chief Medical Officer, American Heart Association – National Center

***Karen A. Scott, M.D., M.P.H.**, Vice President for Quality and Patient Safety, New York Presbyterian Hospital

***Shoshanna Sofaer, Dr.P.H.**, Director of Strategic Research Planning for Health and Social Development, American Institutes for Research

***Paul Tang, M.D., M.S.**, Vice President, Chief Innovation and Technology Officer, Palo Alto Medical Foundation

***Joseph W. Thompson, M.D., M.P.H.**, Director, Arkansas Center for Health Improvement, Professor in the Colleges of Medicine and Public Health at the University of Arkansas for Medical Sciences, General Pediatrician

***Craig Thornton, Ph.D.**, Senior Vice President and Managing Director of Health Research, Mathematica's Health Services Research Division

Pamela Thornton, Ph.D., Program Director, National Institute of General Medical Sciences

Reginald Tucker-Seeley, Sc.D., Assistant Professor, Dana-Farber Cancer Institute, Harvard School of Public Health

***Paul J. Wallace, M.D.**, Chief Medical Officer and Senior Vice President for Clinical Translation, Optum Labs

Several AcademyHealth colleagues contributed to this report: Ellen Albritton; Bonnie Austin, J.D.; Dawn Ferdinand; Michael Gluck, Ph.D.; Erin Holve, Ph.D., M.P.H., M.P.P.; Tamika King, M.B.A.; Terry Mackey, Ph.D.; Enrique Martinez-Vidal, M.P.P.; Kate Papa, M.P.H.; Treva Pierre; Teasha Powell; Kristin Rosengren; Raj Sabharwal, M.P.H.; and Lisa Simpson, M.B., B.Ch., M.P.H., F.A.A.P.

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*Indicates a member of the AcademyHealth Board of Directors

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SUMMARY

Recognizing the persistence of systemic, institutional, and historical factors that work against diversity and equity in health services and policy research (HSR) and the larger health and health care workforce, the AcademyHealth Board of Directors provided funding for a new Center for Diversity, Inclusion, and Minority Engagement in January 2014 <http://www.academyhealth.org/Programs/ProgramsDetail.cfm?ItemNumber=6086>. To date, Center programs support training and mentoring for under-represented racial/ethnic minority (URM) students and junior faculty; promote resource exchange with well-established, more senior researchers in HSR programs; and provide information on diversity to the HSR field.

We recognize that aspects of diversity may include age, country of birth, disability, ethnicity, gender, gender identity, language, national origin, race, refugee status, religion, culture, sexual orientation, health status, community affiliation, and socioeconomic status. For purposes of our first report, we focused on URM to align with the current programs and funding of the Center.

AcademyHealth believes the moment is right for a different kind of conversation to find new solutions about race, privilege, and equity in HSR

In June 2014, AcademyHealth and the Institute for Alternative Futures (IAF) convened a multidisciplinary group of experts to develop actionable recommendations to increase workforce diversity and inclusion in HSR. The invited group included health services researchers; representatives of a variety of health professional organizations; government officials; and experts in disparities, change management, strategic communications, and mentoring programs for under-represented racial/ethnic minorities (URM), including diversity officers.

During a one-day roundtable discussion in Washington, D.C., the group analyzed and discussed the implications of four future scenarios and their potential impact on HSR workforce diversity by 2025, roughly 10 years in the future. Following the IAF aspirational futures approach, the scenarios incorporated drivers at three levels: (1) the macro level of the U.S. economic, social, and policy environments; (2) the health and health care

ecosystem, focusing on implementation of the Affordable Care Act (ACA) with an emphasis on trends in health coverage, access to care, and use of electronic health records (EHRs) for research; and (3) micro-level factors specific to the field of HSR, including the availability of research funding, public awareness and support for HSR, and the career pipeline for URM researchers.

After discussion, the group's overarching recommendation for AcademyHealth was to provide national leadership by taking five visible steps to promote workforce diversity and inclusion in the field of HSR. These steps include: (1) developing a diversity and inclusion plan for the field and sharing it publicly; (2) clearly communicating about our own commitment to diversity in goal statements, programmatic language, graphic images, and events; (3) collecting better data and publicly reporting on our progress in achieving diversity and inclusion goals; (4) promoting best practices for diversity and inclusion in the current HSR workforce; (5) and creating a more racially and ethnically diverse pipeline for the future HSR workforce.

AcademyHealth believes it is vitally important to continue its URM scholarships, fellowships, and mentoring programs. The organization must also take additional steps to promote diversity and inclusion in the HSR workforce, including URM researchers at all career stages. The imperative for diversity stems not only from the need to reflect the changing demographics in the U.S. population, given the shift in the proportion of minority and majority populations, but also from a need to ensure that the best talent from all backgrounds feels at home in HSR, contributes to a vibrant community of evidence producers and users, and advances the production and use of the evidence we need to improve health and the performance of learning health systems.

Roundtable Recommendations for AcademyHealth Actions

- Make a public commitment to diversity and inclusion
- Communicate clearly
- Collect better data and report it publicly
- Promote best practices
- Improve the pipeline



I: DIVERSITY PRODUCES BETTER EVIDENCE

The multidisciplinary field of health services and policy research (HSR) studies organizational, economic, social, and technological factors that influence health and health care systems and inform health policy and clinical decision-making. As the professional society for HSR, AcademyHealth works to improve health and the performance of the health system by supporting the production and use of evidence to inform policy and practice. One of the principles in our [strategic plan](#) is that “diversity of opinion and perspective produces better evidence.”

As part of its efforts, AcademyHealth is committed to promoting diversity and equity among its members and the field at large in terms of race, ethnicity, disability, sexual orientation, gender identity, and other backgrounds that are historically underrepresented in HSR and biomedical research.

AcademyHealth has been concerned with diversity and inclusion in HSR for several years. In 2004, with funding from the W. K. Kellogg Foundation, we conducted a qualitative study that explored ways to increase racial and ethnic diversity in HSR.¹ The study recommended a national strategy to promote HSR as a viable career option and also recommended a fellowship program for under-represented racial/ethnic minority (URM) researchers.

AcademyHealth has been concerned with diversity and inclusion in HSR for several years

In 2007, AcademyHealth convened an invitational summit *Health Services Researcher 2020*, with support from the Robert Wood Johnson Foundation (RWJF) and the Agency for Healthcare Research and Quality (AHRQ).² The summit recommendations for improving the size and composition of the field called for mentoring minority students and junior faculty, as well as improving awareness among URM researchers about opportunities to pursue HSR careers.

The first minority fellowship program at AcademyHealth was launched in 2010 with support from the Aetna Foundation and is still continuing. As of late 2014, nearly 75 URM researchers at more than 32 institutions in 21 states had participated as fellows, which included activities such as attending national

conferences; making presentations to a variety of audiences at academic and professional webinars, meetings and conferences; and meeting with a wide range of senior professionals from the field. Mentors come from many different areas of professional expertise and represent a variety of racial and ethnic backgrounds. The program is being evaluated by mentees, mentors, and program staff during the summer and fall of 2015.

In 2013, AcademyHealth confirmed that African American, Hispanic, and American Indian researchers were still underrepresented in the HSR field.³ Notably, HSR is not the only research field in which this is the case. A significant discrepancy in success rates has been reported for National Institutes of Health (NIH) research grant applications between White applicants and Black applicants, even after controlling for numerous observable variables.⁴ That finding led Dr. Francis Collins, the NIH director, to call for a Workgroup on Diversity in the Biomedical Research Workforce to develop recommendations for improving the number of URM scientists, which included a focus on mentoring, career preparation, and retention, as well as appointing a Chief Diversity Officer, re-evaluating the grant review process, and developing diversity/implicit bias training (see [Appendix E](#)).⁵

Recognizing the persistence of systemic institutional and cultural factors that work against diversity and equity in the HSR workforce as well as the larger health and health care workforce, the AcademyHealth Board of Directors provided funding for a

new Center for Diversity, Inclusion and Minority Engagement in 2013 (<http://www.academyhealth.org/Programs/ProgramsDetail.cfm?ItemNumber=6086>). The Center supports training and mentoring for URM students and junior faculty, promotes resource exchange between them and well-established, more senior researchers in HSR programs, and provides information on diversity to the HSR field.

The Center sponsored the Roundtable discussion on which this report is based in order to develop actionable recommendations to increase future diversity and inclusion within the HSR field. AcademyHealth plans to use these recommendations to expand its mentoring activities and take additional steps to build a more diverse HSR community by promoting workforce inclusion and equity.

Heckler Report Recommendation on Professional Development

“[HHS] discussions with the non-Federal sector should ... identify implementation strategies to address critical health professions educational issues, such as: increasing minority participation in the various training areas; strengthening training program curricula by making them more culturally sensitive to minority patients and minority health problems...; and providing continuing education programs for training on minority health issues.”

— *Report of the Secretary's Task Force on Black and Minority Health ("The Heckler Report"). Washington, DC: HHS, 1985. pp. 22-23.*





II: BUILDING A DIVERSE WORKFORCE

Previous approaches to diversifying the workforce in HSR and the health professions have involved individual recruitment, mentoring, and scholarship programs as well as organizational diversity programs to build awareness and support for diversity within an academic or organizational culture. While it is beyond the scope of this report to provide an exhaustive review, the next section highlights some examples of approaches and what is known about these efforts.

Recruiting, Mentoring, and Retention Programs for Individual Researchers

Successful efforts to promote diversity have focused on individuals at different phases of the research career pipeline, including K-12 education; mentoring and supportive interventions at the college and graduate school levels; mentoring and minority fellowships for postgraduate and postdoctoral professionals; and faculty development programs for junior faculty. Some are supported by national organizations, and others are specific to an individual institution.

Successful efforts to promote diversity have focused on individuals at different phases of the research career pipeline.

The STEM (Science, Technology, Engineering, Mathematics) programs initiated by the U.S. Department of Education may be the best example of these pipeline programs for K-12 (<http://www.ed.gov/stem>). College and postgraduate programs are also available across the country. Some of the best-developed mentoring programs are at Historically Black Colleges and Universities (HBCUs), such as Morehouse, Meharry, and Howard, where active mentoring is embedded in the organizational culture.⁶

In academic medicine, there is some evidence that multi-component URM faculty development and mentoring programs increase retention, academic productivity, and promotion rates.^{7,8} There is anecdotal information from AcademyHealth's own experience that these programs make a meaningful difference in the lives of the people who participate, particularly junior faculty, and also have a positive impact on

their mentors through expanding their professional networks and deepening their understanding of the value of diversity.

However, URM faculty retention is still a challenge. A recent study using the Association of American Medical Colleges (AAMC) Faculty Roster database found that the percentage of URM faculty in medical schools increased by only 1.2 percent over the 10 years between 2000 and 2010. In part, this was because only one out of three schools had minority faculty development programs as of 2010, and of those schools, only those that had been in existence for longer than five years and also had multiple program components showed a significant increase in URM representation.⁹ While change takes time, this finding suggests that mentoring programs alone will not be sufficient to diversify the workforce enough to reflect the demographics of the U.S. population, and that programs will have a greater impact when they include additional components such as networking and cultural events, organizational diversity strategies, and changes in promotion and tenure processes.

Organizational Diversity Initiatives

Mentoring programs are an important first step toward diversity, but they do not directly address racial bias or the discrimination mentees may encounter in or from predominantly white institutions (PWIs). Thus, individual-focused programs need reinforcement from organizationally-based programs to build a culture of diversity and inclusion across the institution, which may be defined as valuing diverse perspectives and backgrounds as an asset and making all participants feel engaged and respected.¹⁰

Mentoring programs will have a greater impact when they include additional components such as networking and cultural events, organizational diversity strategies, and changes in promotion and tenure processes.

In the larger biomedical research community, after uncovering a systematic bias against funding URM researchers,¹¹ the NIH director called for a complete review of all NIH grantmaking and review functions by an internal working group. The group recommended many strategies relevant to HSR, ranging from a focus on mentoring, career preparation and retention to appointing a Chief Diversity Officer at NIH, which occurred in 2014 (see [Appendix E](#)).

Mentoring programs are an important first step toward diversity, but they do not directly address racial bias or the discrimination mentees may encounter in or from predominantly white institutions.

In another example from the research community, the National Science Foundation (NSF) now provides training to reduce implicit bias among grant reviewers and senior faculty as one strategy to directly address bias and provide more opportunities for women and people of color to enter the STEM fields.¹² Broadening participation and promoting diversity was one of the performance areas NSF needed to improve under the Government Performance and Results Act (GPRA), making the agency accountable for creating opportunities and innovation to help maintain the US position of “world leadership in science and technology.”¹³



In both of these large, leading research organizations, the impetus for systemic change came from outside the organization after information about their patterns of discrimination and lack of diversity was made public.

Diversity programs are driven not only by recognition of changing demographics, but also because the organizations value the variety of perspectives that diversity brings.

In contrast, several universities, such as Harvard (<http://diversity.harvard.edu/>), University of Chicago (<http://diversity.uchicago.edu/>), University of Michigan (<http://www.diversity.umich.edu/>), University of North Carolina-Chapel Hill (<http://diversity.unc.edu/>), University of California-Berkeley (<http://diversity.berkeley.edu/>), and University of Southern California (https://www.usc.edu/schools/GraduateSchool/diversity_programs.html) have developed diversity and inclusion programs for an entire campus. These programs are driven not only by recognition of changing demographics, but also because the organizations value the variety of perspectives that diversity brings. Many of these diversity programs have been in place for several years, and most have dedicated websites, sponsor and produce events, and report publicly on their progress.

Communities of Practice

While some communities are institutional or geographic, others are virtual. For example, a professional community of disparities researchers has developed around National Health Disparities Summits convened by the Department of Health and Human Services (HHS) in 2002, 2006, 2009, 2011, and 2014. Over time, organizers hope that many connections made at these meetings will lead to increased citations of work presented there, as well as new collaborations among researchers with similar interests.

Similarly, the AcademyHealth Disparities Interest Group has more than 800 members who conduct disparities research, present their work at the AcademyHealth Annual Research Meeting, are active in an online community, publish findings, and share information throughout the year. The American Public Health Association meeting also provides annual opportunities for HSR presentations and professional networking around health disparities and minority health. Each of these virtual communities has achieved significant engagement by URM students and faculty.

Contact with a community of peers and senior researchers in the field can make a big difference in an individual's career path.



Based on anecdotal information from its minority scholars and fellows, AcademyHealth knows that contact with a community of peers and senior researchers in the field, along with the ability to present findings at professional meetings, can make a big difference in an individual's career path. AcademyHealth is currently evaluating its programs to find out more about their career impact and relationship to institutional culture changes. The organization is also seeking input on further changes fellows believe would support equity in promotions and improve retention rates at their respective institutions.

AcademyHealth is particularly interested in the impact of building a URM community of practice where previous and current fellows can interact and exchange ideas on their research, and in what would encourage them to continue to be engaged with the larger AcademyHealth community, including long-term mentoring and networking opportunities.

Diversity in the Health Professions

In 2000, the health professions implemented National Standards for Culturally and Linguistically Appropriate Services (CLAS Standards) (<https://www.thinkculturalhealth.hhs.gov/content/clas.asp>), which have been incorporated into continuing education programs, Joint Commission and NCQA accreditation, and even legislation in some states. They are intended to advance health equity, improve [healthcare] quality, and help eliminate health disparities.¹⁴

In a 2006 review of evidence, The Bureau of Health Professions at the Health Resources and Services Administration (HRSA) concluded that greater workforce diversity improves population health by improving access and quality of care for racial and ethnic minority populations.¹⁵ Notably, the HRSA-funded National Health Services Corps, a loan repayment program, has trained 40,000 primary care clinicians over 40 years to serve in Health Professional Shortage Areas (HPSAs), many of which are low-income communities of color. The NHSC clinicians are more diverse than the national workforce, and many grew up in communities similar to the ones they now serve.¹⁶

Greater workforce diversity improves population health by improving access and quality of care for racial and ethnic minority populations.

The AAMC has developed a “roadmap to diversity” to help medical schools achieve diverse student bodies through institution-specific, diversity-related admissions policies.¹⁷ These strategies apply to those who are interested in academic careers, and many are clinicians who also conduct HSR and clinical research. As another example, the *Finding Answers: Disparities Research for Change* program has developed an equity self-assessment questionnaire for medical schools to help them identify concrete actions to address equity among students and faculty, with an additional goal of reducing health care disparities through advocacy and systems level changes.¹⁸



PWIs and mainstream medical culture may have moved beyond the shocking exploitation of African Americans by white medical researchers that was documented by Harriet Washington in *Medical Apartheid*¹⁹ and others. However, the ramifications of such injustices play an important role in the overall health and well-being of many African American communities. There is a growing body of evidence that suggests implicit and often unconscious biases about minority patients lead white physicians to inadvertently provide poorer quality care to those patients.^{20,21} Despite the widespread implementation of the CLAS standards, studies show patterns of discrimination and poor communication about pain management, levels of care, and other treatment biases that have a significant impact on health outcomes.²²

Without awareness, individuals who grew up exclusively in majority culture and its privileges are making discriminatory decisions about people who are not like them.

As described by health services researchers at Kaiser Permanente (KP) Colorado, the national legacy of overt racism and open discrimination takes a subtle and common form of discrimination that is often unintentional and can't be measured with standard self-report survey questions, precisely because individuals are unaware

they are doing it.²³ As an example, the KP researchers suggest bias might manifest as a tendency for a white male physician to perceive an elderly African American patient with hypertension as being non-adherent, based on implicit assumptions and stereotypes about African Americans, rather than the physician adjusting the medication, as he might do for a white male patient.

Thus, racism and discrimination are not always obvious either to an observer or even to the person making discriminatory judgments in a single incident or over time.²⁴

The evidence shows that health disparities are not only due to communities of color being disproportionately disadvantaged in terms of economics and education, insurance coverage, and other social determinants of health. Health disparities are also due to widespread but often subtle discrimination by white people against people of color, even against those who are well-educated and affluent.

It therefore seems likely that the same implicit biases may be at work in admissions, promotion, and tenure decisions in HSR, similar to most workplaces.²⁵ Without awareness, individuals who grew up exclusively in majority culture and its privileges are making discriminatory decisions about people who are not like them.²⁶

While much of the attention to diversity has been on individually mediated discrimination and racism, the authors believe that a more comprehensive model is needed. Perhaps the most relevant example for AcademyHealth and the field of HSR to demonstrate



a commitment to workforce diversity comes from the diversity section of the Accreditation Criteria for Schools of Public Health, developed by the Council on Education for Public Health (<http://ceph.org/assets/SPH-Criteria-2011.pdf>). It requires that each school develop a learning environment in which “self-awareness, open-minded inquiry and assessment, and the ability to adopt to cultural differences” are defined and evaluated (see [Appendix F](#)).

Diversity and Health Equity Research

Recommendations to increase the diversity of the HSR workforce and health professions have been made as a strategy to help reduce health disparities and promote health equity. In 2002, the Institute of Medicine (IOM) report *Unequal Treatment* (<http://iom.nationalacademies.org/Reports/2002/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care.aspx>) presented clear evidence that differences in outcomes are related to social determinants of health, including high rates of poverty and unemployment, and also are related to bias, discrimination, and stereotyping on the part of majority culture.²⁷ That report and a subsequent IOM report entitled *In the Nation’s Compelling Interest: Ensuring Diversity in the Healthcare Workforce* (<http://www.nap.edu/openbook.php?isbn=030909125X>) both called for an increase in the diversity of the health care and research workforces as one key strategy in an overall commitment to promoting health equity.²⁸

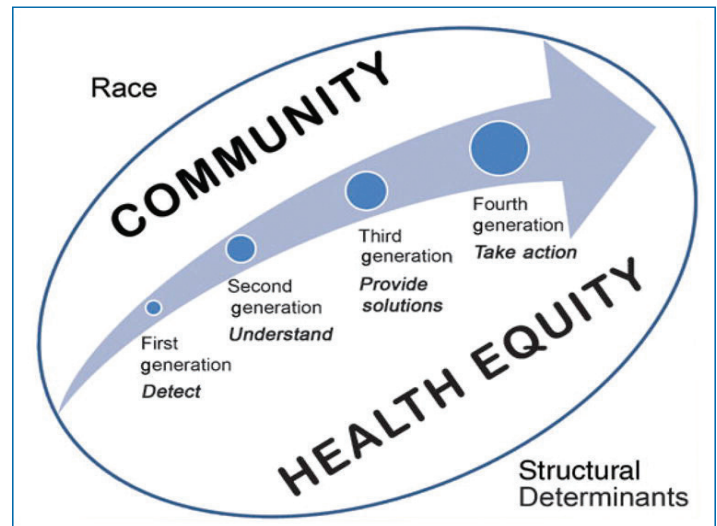
IOM Report on Unequal Treatment: Racial and Ethnic Disparities in Health Care

“The IOM concluded that many factors are complicit in health care disparities, including policies and practices of health care systems and the legal and regulatory climate in which they operate. But the report also found strong evidence that racial bias, discrimination, stereotyping, and clinical uncertainty also play a role.”

— Brian D. Smedley, *The Lived Experience of Race and Its Health Consequences*, *American Journal of Public Health*, May 2012, Vol 102(5), p. 933.

In 2004, the Sullivan Commission on Diversity in the Healthcare Workforce also called for an increase in diversity of the health care and research workforce, noting that the workforce was not keeping pace with changing demographics and that access to a health professions career “remains largely separate and unequal.”²⁹ The Commission, chaired by former HHS Secretary Louis Sullivan, was supported by a grant from the Kellogg Foundation

Figure 1: Health Disparities Research



to Duke University School of Medicine. Its goal was to convene health, education, and business leaders and hold public hearings across the country to gather testimony about the lack of diversity in medicine, nursing, and dentistry as a means of addressing the growing body of evidence of health disparities.

Over the same period of time that the health professions workforce community has been calling for more diversity, the health disparities research community has evolved through three stages: (1) making the case for disparities by documenting them; (2) determining reasons for the disparities; and (3) suggesting solutions for reducing or eliminating disparities through social action based on the available evidence.³⁰

Stephen Thomas of the University of Maryland is one of many disparities researchers to suggest that we have entered a fourth stage of using comprehensive interventions to address culture, racism, and structural discrimination, including intentionally addressing the researcher’s own biases.³¹ This fourth stage is one of moving evidence into action by explicitly acknowledging the effects of social determinants as well as the historical context for racism and discrimination on the basis of race (see Figure 1). While research and the published literature are replete with evidence addressing the first two stages – detecting and understanding – there are far fewer examples of the development and deployment of effective interventions to reduce disparities.



Need for a Comprehensive Framework

In addition to the HSR work on racial disparities in health, several frameworks about racial differences and racism have been developed to describe discrimination related to education, employment, housing, income, incarceration, surveillance, environmental exposures, voting rights, and other areas of daily life. For purposes of increasing diversity in the HSR workforce, it is useful to think about racism on three levels: individual, institutional, and structural or systemic.^{22,32}

As described by Camara Jones in 2000, racism is a system of structuring opportunity and assigning value based on physical appearance in a way that creates differential access to power, information, resources, and voice.³³ In her description, individualized prejudice and racism can be both intentional and unintentional and are expressed in a myriad of ways, including disrespect, avoidance, suspicion, devaluation, and dehumanization (e.g., police brutality). Individuals create organizations in which there is differential access to goods, services, and opportunities based on race, creating “inherited disadvantages” which are codified into social structures, practices, and laws. Thus, institutionalized racism and structural factors in society perpetuate historical injustices. Jones called for a national conversation and design of interventions to eliminate the differences.

Building on the work of Jones and others, Brian Smedley also proposed that racism operates at individualized, institutional, and structural levels.³⁴ Writing in 2012, Smedley described applications of the transdisciplinary methodology of Critical Race Theory to understand how racism operates at individual, clinical, and neighborhood levels. Thomas used the same theoretical underpinning when he proposed the fourth generation of health equity research (see Figure 1).

An emerging view in the public health community and HSR is that ethnicity and race interact with gender, socioeconomic status, geography, and other factors, and that an intersectional analysis is needed to not only understand how these factors interact and impact people of color but also to understand how they impact white people. In other words, intersectionality analysis is an approach to understanding and addressing structural or systemic racism that is gaining momentum in HSR and related fields of research.³⁵

It is useful to think about racism on three levels: individual, institutional, and structural or systemic

These three levels of racism — individualized, institutional, and systemic — correspond to the three levels used to build and drive the futures scenarios for AcademyHealth’s roundtable discussion, which are described in the next section of this report. For example, mentoring is primarily an individualized approach to promoting diversity, and evidence shows that it is more effective when it is accompanied by organizational supports, such as multi-component programs involving community-building, public events, and policies for retention and promotion (see Accreditation Criteria for School of Public Health, 2011, [Appendix F](#)). While structural and systemic drivers must be acknowledged, responsive actions that show a commitment to HSR workforce diversity need to be defined at the organizational or institutional level.

As a transdisciplinary organization, AcademyHealth is actively looking for ways to continuously bridge multiple disciplines and constituencies.

As a transdisciplinary organization, AcademyHealth is actively looking for ways to continuously bridge multiple disciplines and constituencies. To help better address these systemic challenges, AcademyHealth invited a group of experts from inside and outside of its immediate community to advise on next steps. The process and recommendations are described in the next sections.

AcademyHealth believes it is an important time to take these steps. The imperative for diversity is not only to reflect the changing demographics in the U.S. population, given the shift in the proportion of minority and majority populations, but also to ensure that the best talent from all backgrounds feels at home in HSR. Only through an honest internal reflection will AcademyHealth and the field of HSR be able to see what we need to change.

III: THE ASPIRATIONAL FUTURES APPROACH

To help develop actionable recommendations on workforce diversity, AcademyHealth engaged the Institute for Alternative Futures (IAF) to use a different approach to advancing the dialogue. Through the use of scenarios, a racially and ethnically diverse group of multidisciplinary experts and leaders in HSR from different career stages, along with experts from outside the HSR field, engaged in discussions to consider possible futures for HSR and how HSR workforce diversity might be increased.

This use of scenarios to consider and develop recommendations is part of IAF's "aspirational futures approach" (see Figure 2) that focuses on expectable, challenging, and visionary or aspirational pathways to the future. IAF has developed scenarios for many sectors, including the environment, transportation, and social and economic vulnerability.³⁶ In health care, IAF scenarios have addressed the elimination of disparities as a goal and have focused on primary care, nursing, many physician specialties (e.g., surgeons, gastroenterologists, and radiologists), and public health.^{37,38,39}

IAF has found that working through a group process with scenarios can help participants find more creative options than those typically found when planning is based only on the past and present, because participants re-evaluate their assumptions and consider emerging issues and possibilities.

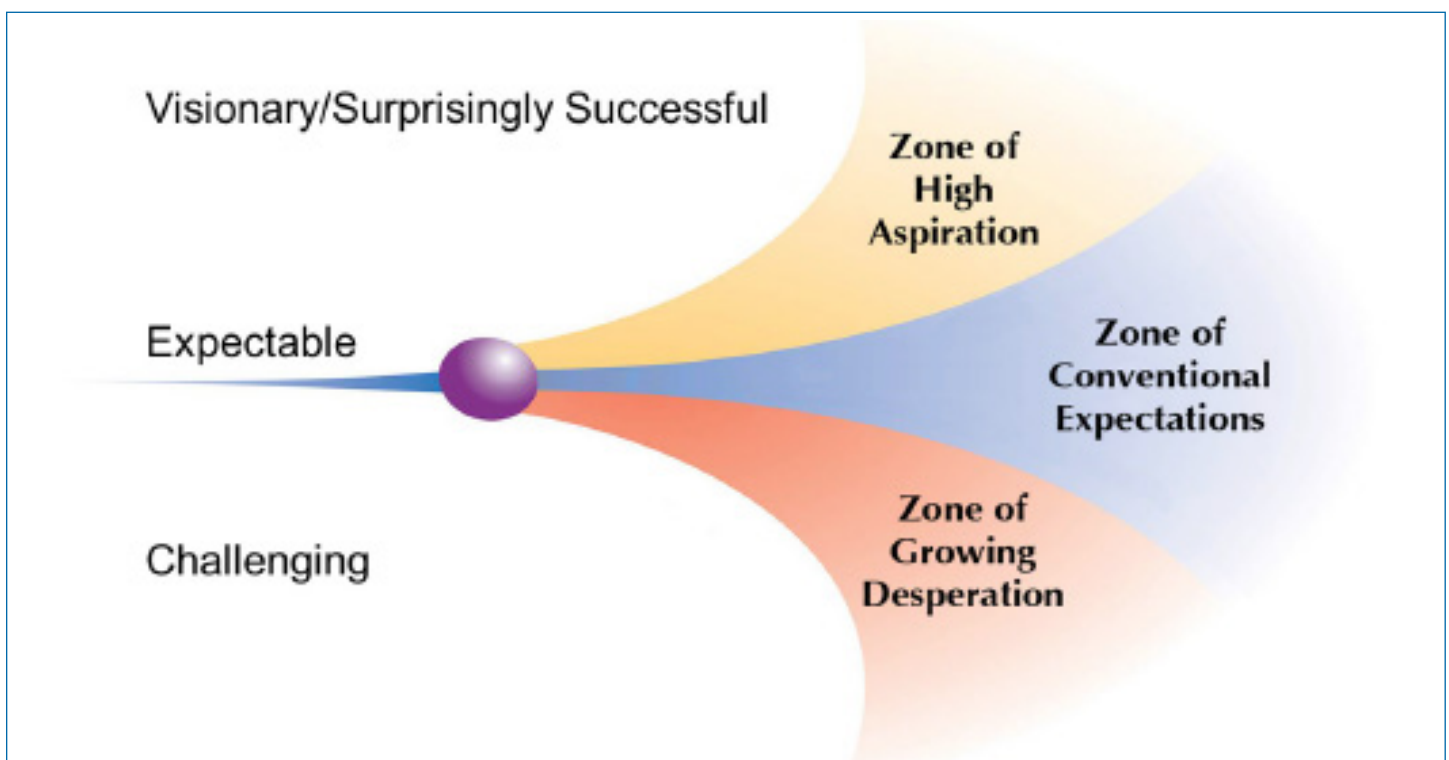
In using scenarios at a workshop, IAF often has a "visual recorder" or "visual journalist" to capture the discussion using a combination of words and images. This helps participants to visualize the relationships among evolving ideas as they emerge in discussions (see Figure 3).¹

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Developing Scenarios Based on Drivers of Change

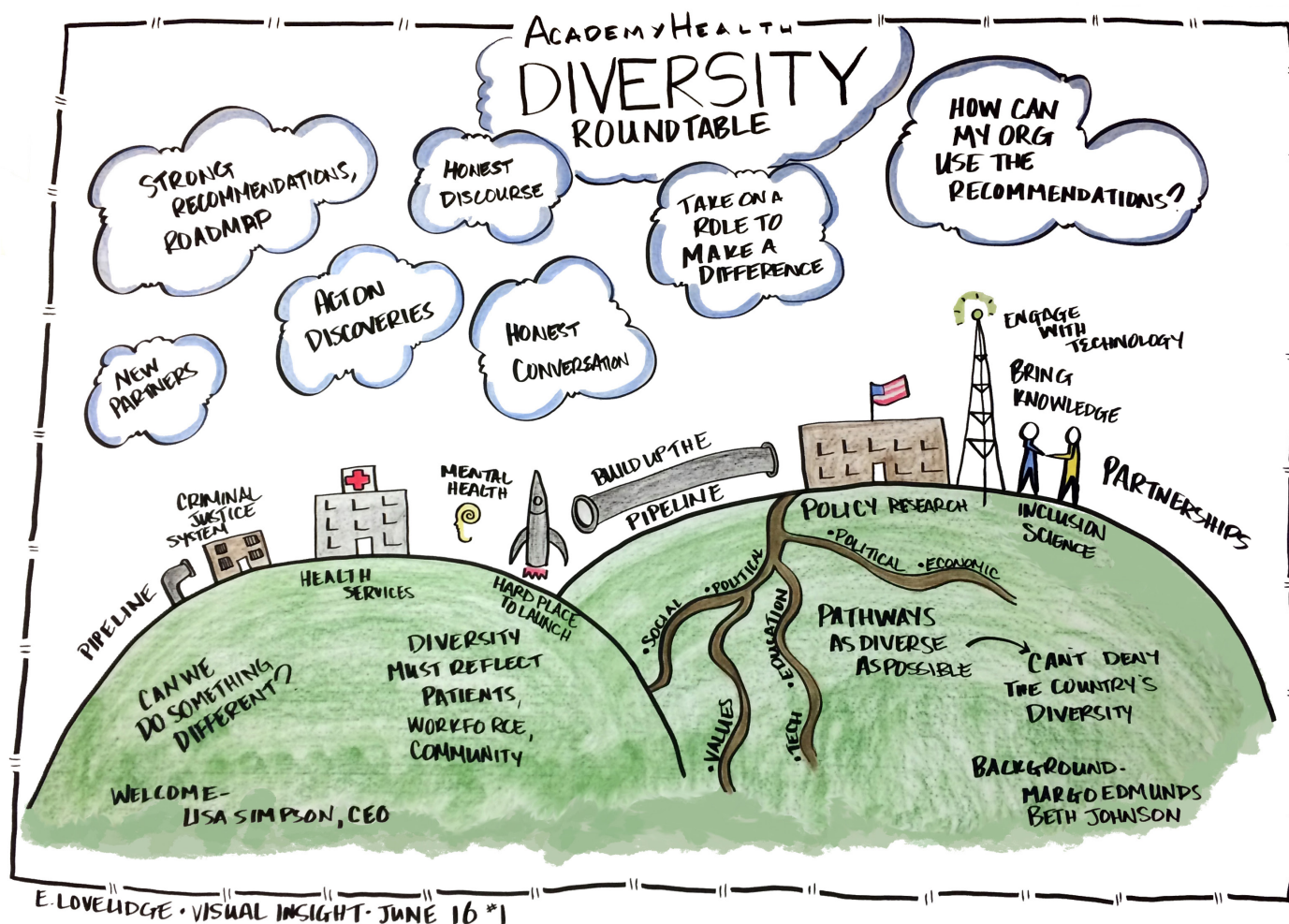
To develop the Roundtable agenda, AcademyHealth and IAF formed a joint planning committee that included the co-authors of this report and additional advisors, some of whom were from outside of HSR. The planners began with an environmental scan

Figure 2: IAF's Aspirational Futures Technique



1. Figure 3 was produced at the workshop by Ellen Lovelidge from Visual Insight.

Figure 3: Visual Description of Issues Discussed at Diversity Roundtable



of factors in the “macro” environment (economic, social, and demographic); the “operating” environment of health and health care; and the “micro” environment of HSR. As a result of the scan, the scenarios focused on the key drivers shown in Table 1 below.

Following the IAF model, participants considered the directions (expectable, challenging, and visionary) for these drivers of diversity and then constructed four scenarios that were considered to be:

1. Most likely or “expectable” path for HSR diversity;
2. A challenging path that considers some of the many things that could go wrong;
3. A visionary or surprisingly successful path driven by internal movements toward HSR workforce diversity within the field; and
4. A second visionary pathway, this one driven more by external forces.

In terms of external forces built into scenarios, planners reviewed current demographic and descriptive information about the U.S. population using federal sources of data on racial/ethnic and geographic distribution of the population, disparities in employment, income inequality, and patterns of racial segregation, which have been associated with disparities in healthcare access and utilization at both the individual and community levels.⁴⁰

The scenario designers built in variations around sources and availability of HSR funding, public support for research and science, and the increasing availability of health data through electronic health records as direct influences on the HSR job market.

In developing the scenarios, planners also discussed some well-known, successful examples of promoting diversity outside of the health care industry. These included the desegregation of the U.S. military after World War II and the more recent activities of two private-sector companies, IBM and Denny's restaurant chain, whose experiences are widely taught as case studies in business schools.^{41,42}

Discussion and Deliberation of Future Scenarios

We held a one-day convening of a multidisciplinary, racially and ethnically diverse group of 25 health services researchers, representatives of health professional organizations, government officials, and experts in change management, strategic communications, and mentoring programs for under-represented racial/ethnic minorities, including diversity officers.

The day began with a presentation of the four scenarios to the full group, and then participants met in two small groups with facilitators. Each small group considered two scenarios and then developed recommendations for what would need to happen in order to achieve diversity, considering the positive and challenging drivers of change embedded in their scenarios. After the groups reconvened as a whole and reported out to each other, the entire group worked to synthesize and agree on the recommendations presented in Figure 3.

Subsequently, the authors and members of the Board and staff of AcademyHealth reviewed the recommendations and put them into more detailed and actionable statements. These revised recommendations were presented to the AcademyHealth membership and Board in June 2015 and their comments and suggestions have been incorporated into the final set of recommendations, as presented in Section IV.

Table 1: Drivers of Diversity In The HSR Workforce

1. Macro-Environment: Economic, social, and policy environment

1. Demographics and social determinants of health (e.g., racial/ethnic distribution of the population; residential segregation)
2. Economic factors (e.g., income distribution, labor market and employment disparities, technology trends)
3. Policy environment (e.g., political and social views toward science, diversity, and equity)

2. Operating Environment: Health and health care

1. Changes in health coverage and access to care related to the implementation of the Affordable Care Act (ACA)
2. Use of electronic health records (EHR) and other emerging data for clinical practice and reusing clinical data for research
3. Disparities in health status for racial and ethnic minorities

3. Micro Environment of HSR

1. Funding for research, primarily from federal sources (AHRQ and PCORI)
2. Public awareness and support for HSR
3. HSR training programs and pipeline



IV: RECOMMENDATIONS



Recommendations

1. Formally develop a plan and make a public commitment to promoting diversity and inclusion in HSR and at AcademyHealth
2. Communicate clearly about goals for increasing diversity and inclusion
3. Publicly report on progress toward meeting diversity goals
4. Promote best practices for diversity and inclusion in the current HSR workforce.
5. Create a more diverse pipeline for HSR by helping expand training opportunities and recruitment strategies with communities of color

As described in Section III, the scenarios were designed with the recognition that HSR is a relatively small field embedded in the larger fields of medicine, public health, and health care delivery, which in turn are affected by larger-scale social, economic, technological, and political forces and trends. In particular, the scenario designers built in variations around sources and availability of HSR funding, public support for research and science, and the increasing availability of health data through electronic health records as direct influences on the HSR job market. The scenarios also included shifts in demographic trends, including residential segregation, income and employment disparities, and health disparities to provide a larger context for discussion.

After discussion, roundtable participants focused on five critical areas with specific steps that can be made immediately by AcademyHealth, with the long-term goal of achieving diversity, inclusion, and equity in the HSR workforce. The five areas involve making a public commitment to promote diversity, communicating clearly about that commitment, reporting progress, training the current workforce, and expanding HSR employment opportunities for URM researchers.

Recommendations From The Diversity Roundtable

AcademyHealth envisions working with these recommendations to develop a process to build and adopt a culture of diversity.

It will begin with the AcademyHealth Board, senior leadership, and staff and will expand to include AcademyHealth Board, senior leadership, and staff and expanding to include AcademyHealth Interest Groups, organizational affiliates, and other partner organizations.

1. Formally develop a plan and make a public commitment to promoting diversity and inclusion in HSR and at AcademyHealth. Include the following steps:

- a. Convene a racially/ethnically balanced AcademyHealth diversity and inclusion working group and provide it with visibility, resources, and support to develop diversity and inclusion policies and programs for AcademyHealth and the field. The group should include Board members and staff members at all levels of the organization.

The working group should develop a strategy to engage with AcademyHealth individual members and thought leaders, including Interest Groups (IGs) and Organizational Affiliates, about how we can promote diversity and inclusion in the field.

- b. The working group should review existing frameworks for promoting diversity and equity and reducing disparities, such as the *Finding Answers Roadmap to Reduce Disparities*,¹⁸ the *AAMC Roadmap to Diversity*,¹⁷ the *Accreditation Criteria for Schools of Public Health (Appendix F)*, and the NSF/AAAS guide on measuring diversity for STEM graduate program leaders (available at <http://www.nsfagep.org/files/2011/04/MeasuringDiversity-EvalGuide.pdf>).
- c. The working group should review, coordinate with, and learn from the efforts of the NIH Office on Diversity to support diversity and inclusion, assess implicit bias, and report on the success of its efforts.
- d. The working group should complete the review, develop the proposed strategy, and present it to the full Board by December 2015.

2. Communicate clearly about goals for increasing diversity and inclusion.

- a. Include language about diversity and inclusion in AcademyHealth guiding documents such as the strategic plan and annual operational goals, policy statements, calls for abstracts, and other communications.
- b. Ensure that graphic images reflecting diversity are used on websites and other reports and work products.
- c. Publicly recognize leaders from the AcademyHealth membership who make a contribution to diversity and inclusion through awards, published interviews and blogs on the website, and other means. For example, AcademyHealth could invite organizational affiliates to submit a summary of their diversity practices and successes and include these profiles in monthly partner e-mails.
- d. Create opportunities for meaningful discussion and engagement about what language is acceptable and appropriate for AcademyHealth and the field. Aim to use specific language that acknowledges racial/ethnic bias and the cumulative effects of discrimination, exclusion, and racism.
- e. Engage a variety of organizational leaders, including current and previous Board Members, Interest Group chairs, and others to become public champions for diversity and inclusion. Provide

them with talking points and resources (e.g., a toolkit) relevant to diversity and inclusion in the HSR workforce and encourage them to make public statements and engage in public discussions about AcademyHealth's diversity goals. Ask them to provide feedback to AcademyHealth about their experiences and any additional action steps they recommend, including successful experiences of other professional membership organizations.

3. Publicly report on progress toward meeting diversity goals.

- a. Begin a conversation with members and leaders of all Interest Groups about a core set of measures that would reflect diversity in all AcademyHealth activities and events. AcademyHealth could also work with the Education Council, the Corporate Council, the HSR Leadership Consortium, and other key experts to identify a core set of standards and measures of diversity and inclusion. These measures would include representation in all leadership committees, other planning and advisory groups, and all professional development programs such as scholarships and fellowships. AcademyHealth staff could help the IGs track progress as one of their activities and report at the Annual Research Meeting (ARM).
- b. Develop an awards and certification program for achieving a diverse and inclusive health services and policy research workforce, based on existing best practices in the diversity field. As appropriate for individual institutions, criteria should include recruitment/retention of faculty and staff, research conducted, personnel policies, service activities, training, and awards and certification programs. Models for these practices include the AAMC Healthcare Executive Diversity and Inclusion Certificate Program, The Council on Education for Public Health Accreditation Criteria, the CLAS standards for health care providers, and other roadmaps, such as the Robert Wood Johnson Foundation program, *Finding Answers*.

4. Promote best practices for diversity and inclusion in the current HSR workforce.

- a. After completing the evaluation of mentoring activities being conducted in summer 2015, assess the effectiveness of current mentoring activities at reaching URM at all career stages. As needed, enhance the recruitment of peer and senior mentors for URM at all career stages and from many areas of expertise, including HSR and other related areas (e.g., health economics). Publicize the results of the evaluation with AcademyHealth members.

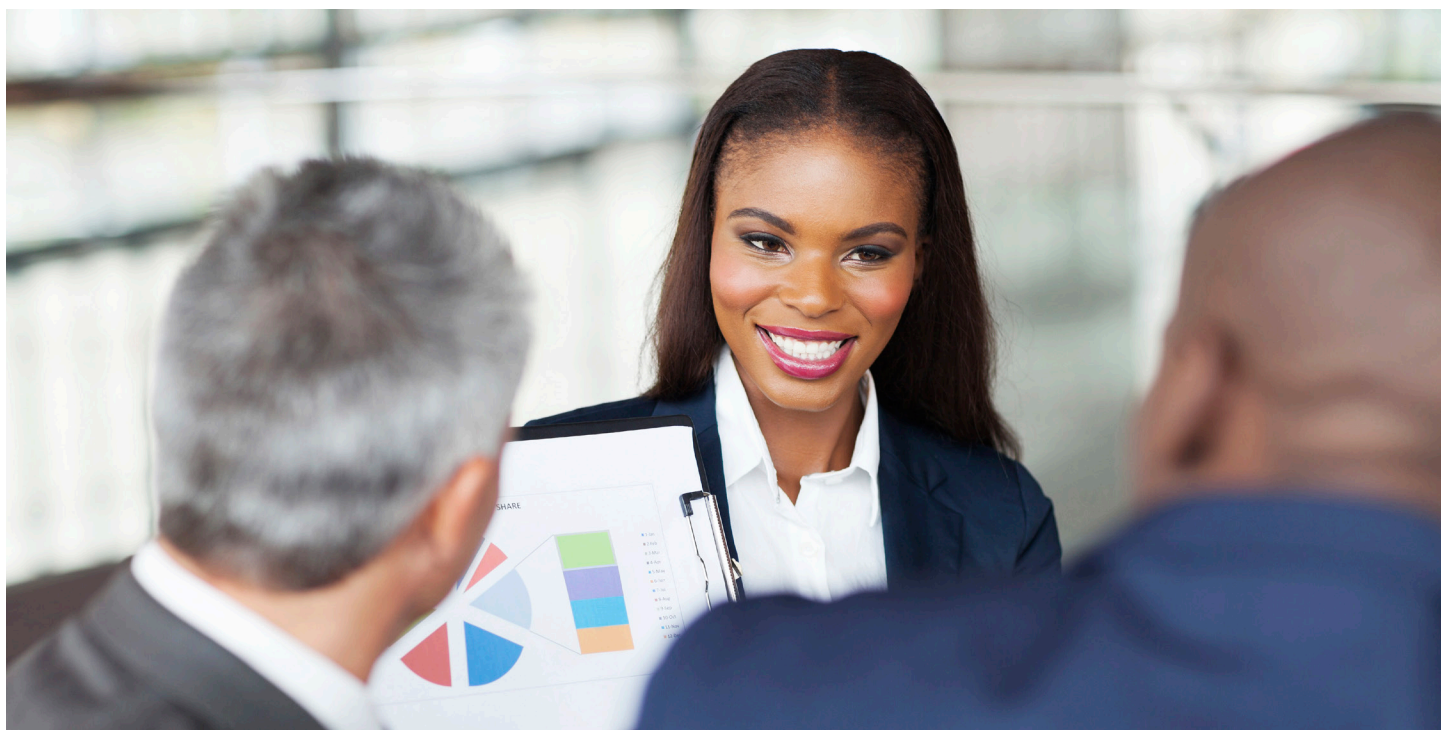
- b. Conduct a scan of diversity policies at undergraduate and graduate professional schools, as well as medical, nursing, pharmacy, and public health schools. Create a “Leadership Circle” of AcademyHealth member organizations with model diversity practices and make links to their policies available on the AcademyHealth website for members to adapt at their own institutions.
- c. Develop and promote AcademyHealth standards and promising practices for diversity strategies modeled after those used by member organizations. For example, The Department of Health Policy and Management at University of North Carolina-Chapel Hill has developed specific policies on diversity and inclusion in alignment with the UNC institution-wide policies for diversity and multi-cultural affairs.
- d. Use, and promote the use of by others, the 2025 scenarios from this report as discussion and training materials in organizational meetings, conferences, and in undergraduate and graduate courses. Identify other materials, such as case studies, that could be made available online for both synchronous and asynchronous learning.
- e. Assist member organizations with diversity recruiting by expanding the online AcademyHealth career center/job board.
- f. Encourage every member of AcademyHealth to go through diversity training, either in a course developed by AcademyHealth or through their home institutions. For

example, NIH and NSF both require all staff to undergo training on implicit bias. It will be important to identify training products that have been evaluated and found to be successful in changing organizations and systems as well as individual behavior.

5. Create a more diverse pipeline for HSR by helping expand training opportunities and recruitment strategies with communities of color.¹

- a. Build and support student chapters at Historically Black Colleges and Universities (HBCUs) and Hispanic Serving Health Professions Schools. Encourage AcademyHealth leadership, including Board members, to speak at chapter meetings and get involved with chapter activities.
- b. Foster community engagement and citizen science⁴³ among URM communities as a pathway for increasing diversity in HSR and related professions, such as epidemiology.

For example, a pilot HSR program could be modeled after STEM and Saturday Morning Science programs, which aim to increase interest among middle and high school students in biomedical sciences, technology, mathematics, and engineering.⁴⁴ If the program results were promising, AcademyHealth could develop a toolkit for organizational affiliates to use in their communities to support community-level engagement in citizen science by collaborating with existing STEM and related programs.



V: CONCLUSIONS AND NEXT STEPS

These recommendations reflect a set of principles, values, and strategies offered by a multidisciplinary and racially/ethnically diverse group of experts from different fields to help build and adopt a culture that values diversity in general and that takes steps to increase diversity and inclusion within the field of HSR.

Taken together, these recommendations can help AcademyHealth and the field of HSR to develop and implement policies and programs that will promote accountability for ensuring that diversity and inclusion in our field lead to meaningful changes that better reflect the changing demographics and perspectives in the United States.

AcademyHealth believes the moment is right for a different kind of conversation to find new solutions about race, privilege, and equity in HSR—solutions that will lead to a truly diverse workforce that is fully competent and ready to develop and disseminate evidence on the full range of problems addressed by HSR.

AcademyHealth has begun with URM because that is where the organization has already demonstrated a public commitment and received external support. A next step is to expand the diversity conversation to include LGBT people and people with disabilities.

The leadership of AcademyHealth believes that diversity is an asset that benefits everyone and helps produce better evidence to improve health and healthcare. The conversation about the role of ethnicity, race, and racism in HSR begins now.

The imperative for diversity stems not only from the need to reflect the changing demographics in the U.S population, given the shift in the proportion of minority and majority populations, but also from a need to ensure that the best talent from all backgrounds feels at home in HSR, contributes to a vibrant community of evidence producers and users, and advances the production and use of the evidence we need to improve health and the performance of learning health systems.



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APPENDIX A: ACADEMYHEALTH DIVERSITY ROUNDTABLE AGENDA

June 16, 2014 | 9:00 am–4:00 pm

Objectives

- Present and discuss future scenarios for diversity in the field of health services and policy research
- Develop recommendations – including potential activities, programs, and partnerships – to inform AcademyHealth’s Center for Diversity, Inclusion, and Minority Engagement strategic plan

AGENDA

9:00 am	Networking Breakfast
10:00 am	Welcome Lisa Simpson
10:15 am	Background and Introductions Margo Edmunds, Beth Johnson <i>What would make today a great success for you?</i>
11:00 am	Overview of 2025 Future Scenarios Clem Bezold, Margo Edmunds
12:00 pm	Lunch and Scenario Breakout Groups Facilitators
2:00 pm	Break
2:15 pm	Group Report Back Clem Bezold, Facilitators
3:00 pm	Group Breakout: Recommendations
3:30 pm	Report Back: Recommendations Clem Bezold
3:50 pm	Closing Remarks and Next Steps Margo Edmunds

APPENDIX B: LIST OF PARTICIPANTS

Mayra Alvarez, M.H.A.

Associate Director
Office of Minority Health, HHS

Natasha Amjed, M.P.H., M.A.

Research Associate
AcademyHealth

Clement Bezold, Ph.D.

Chairman
Institute for Alternative Futures

Marie Briones-Jones, M.S.H.S.A.

Director, Kaiser Permanente Burch
Minority Leadership Development
Program
Institute for Alternative Futures

Lisa Chambers, M.B.A., M.H.A.

Director of Membership
AcademyHealth

Margo Edmunds, Ph.D.

Vice President, Evidence Generation and
Translation
AcademyHealth

Jose Escarce, M.D., Ph.D.

Professor of Medicine and Health Policy
and
Management
University of California, Los Angeles/
RAND

Charles Cinque Fulwood

President
MediaVision USA, LLC

Darrell Gaskin, Ph.D., M.S.

Deputy Director, Center for Health
Disparities Solutions and Associate
Professor, Health Economics
Johns Hopkins University

Don Goldmann, M.D.

Chief Medical and Scientific Officer
Institute for Healthcare Improvement

Carmen Green, M.D.

Associate Vice President and Associate
Dean for Health Equity and Inclusion
University of Michigan Health System

Marianne Hamilton Lopez, M.P.A.

Senior Manager
AcademyHealth

Nicole Jarrett, Ph.D.

Senior Policy Analyst
The Council of State Governments Justice
Center

Beth Johnson, M.P.H.

Senior Manager
AcademyHealth

Ellen Lovelidge

Graphic Artist and Illustrator
Health Futures Group

Enrique Martinez-Vidal, M.P.P.

Vice President, State Policy and Technical
Assistance
AcademyHealth

Marc Nivet, Ed.D.

Chief Diversity Officer
Association of American Medical Colleges

Herminia Palacio, M.D., M.P.H.

Director and Senior Program Officer,
Human Capital and Leadership
Robert Wood Johnson Foundation

Kate Papa, M.P.H.

Director, Public Health Systems Research
AcademyHealth

Teasha Powell, M.A.

Director, Human Resources
AcademyHealth

Michelle Quinteros de Czifra, M.S.

Executive Director
Hispanic Serving Health Professions
Schools

Elena Rios, M.D.

President & CEO
National Hispanic Medical Association

Murray Ross, Ph.D.

Director, Institute for Health Policy
Kaiser Permanente

**Lisa Simpson, M.B., B.Ch., M.P.H.,
F.A.A.P.**

President & CEO
AcademyHealth

Hassan Tetteh, M.D., M.P.A., M.B.A.

Physician Health Policy Advisor
US Navy Bureau of Medicine and Surgery

Trevor Thompson

Futurist/Foresight Professional
Institute for Alternative Futures

Angela Whatley, Ph.D.

Presidential Management Fellow
Office of Research and Development
Department of Veterans Affairs

Tricia Lee Wilkins, PharmD, Ph.D.

Project Officer
Office of the Chief Medical Officer,
Office of the National Coordinator for
Health Information Technology

APPENDIX C: SCENARIO MATRIX

	SCENARIO 1: CONVENTIONAL EXPECTATION	SCENARIO 2: CHALLENGING	SCENARIO 3: HIGH ASPIRATION A	SCENARIO 4: HIGH ASPIRATION B
ECONOMIC, SOCIAL, AND POLICY ENVIRONMENT				
Economy (Recession, taxes, debt)	Modest growth, but economic indicators are mixed	Recessions in 2015 and 2020 led to strains in all sectors of the economy	Return to effective slow growth; federal and state governments are able to raise revenues	Return to effective slow growth; federal and state governments are able to raise revenues
Social Climate	Geographic variation: some areas will continue to be mono-cultural and others will diversify	Congress becomes very hostile toward science and research	National vision of a diverse society that values and respects science and research	National vision of a diverse society; More CEOs and elected officials are diverse, reflecting the population demographics
Diverse communities	Residential segregation continues; more younger families are blended	Residential segregation is worse than in 2015	Blended residential demographics in most parts of the country	Blended residential demographics in most parts of the country
HEALTH AND HEALTH CARE ECOSYSTEM				
Creating EHRs for data; converting from paper to electronic health records (EHRs)	Variability; some areas will develop new methods and others will still use paper records	Meaningful use Stages 2 and 3 funding incentives withdrawn due to industry pressures; HIE/ interoperability fails	90% of health systems in US are electronic and are able to exchange information for clinical and research purposes	90% of health systems in US are electronic and are able to exchange information for clinical and research purposes
Health coverage and access to care (success of the ACA)	90 percent of the population has health insurance	ACA requirements and funding reversed; Health insurance marketplaces fail in all but 15 states;	98 percent of the population has health insurance; HSR puts more emphasis on chronic care management	98 percent of the population has health insurance; ACOs support the triple aim and address social determinants of health
MICRO (HSR) LEVEL CHANGE				
AHRQ Funding	AHRQ budget and functions are questioned by Congress	Only NIH and VA survive as federal funders of HSR (PCORI and AHRQ lose funding)	AHRQ provides new direction and fulfills its mission, so Congress preserves its \$400 million in funding	AHRQ, PCORI, and the Canadian Institute of Health Policy and Health Services Research collaborate on a national HSR plan beginning in 2015
PCORI Funding	GAO reports mixed results in 2015; uncertainty continues	Only NIH and VA support HSR (PCORI and AHRQ lose funding by 2016)	Reauthorized by Congress in 2019 for another 10 years; Supports all 3 of the triple aim objectives	Reauthorized in 2019 with no expiration date; Supports all 3 of the triple aim objectives
MICRO (HSR) LEVEL CHANGE				
Attitudes toward/support for health services research	Growth in demand for HSR spawned by ubiquitous and enhanced EHRs (including genomics, biomonitoring, place data); Big data aggregations require more HSR workers to analyze	Anti-science ideology prevails	Citizen science increases; but advocacy for HSR and PHSSR (Public Health Services and Systems Research) succeeds in record levels of federal funding; the HSR workforce grows significantly and diversity grows even more; public understands that the ACA worked (insurance matters; health care delivers – they save lives)	Citizen science becomes widespread, adds to potential HSR workforce; Advanced degrees not required for entry to HSR jobs; High level of public support for community-based and academic HSR because it uses a scientific process (generates evidence) to solve medical problems, and that's very appealing
HSR Training and Workforce	Diversity of HSR workforce stays at 2014 levels among underrepresented groups	People of color drop out of AcademyHealth membership; Its Board does not renew funding for diversity initiatives	Field of HSR develops new diversity/cultural competency guidelines for health services researchers and actively promotes their adoption; Alumni of the Minority Scholars Program become HSR “rock stars” and hold leadership positions in leading delivery systems	Every college campus has an equity, diversity and inclusion program

APPENDIX D: FULL TEXTS OF SCENARIOS



Scenario 1: Keep on Keepin' On (expectable, or status quo)

Scenario 2: Stormy Weather (worst case scenario)

Scenario 3: Do the Right Thing (aspirational with change from within the field)

Scenario 4: We are the World (aspirational with change from outside the field)

Scenario 1: Keep on Keepin' On (expectable, or status quo)

Over the twenty years leading up to 2025, recurring uncertainty about the U.S. economy and lack of public understanding about the importance of science and research in general contributed to uncertainty about public sources of funding for health services research (HSR). While the economy showed modest growth overall, economic indicators were mixed, and consumer spending was flat.

In 2015, the Agency for Healthcare Research and Quality (AHRQ), the largest source of HSR funding, was the subject of a series of Congressional hearings to determine whether its budget should be reduced.

Also in 2015, another source of HSR funding, PCORI (The Patient-Centered Outcomes Research Institute) got a mixed review under its Congressionally-mandated report by the U.S. Government Accountability Office, resulting in a series of two-

year reauthorizations beginning in 2019. For health services researchers in academic settings, funding uncertainties around the work supported by AHRQ and PCORI raised major questions about the viability of the field of HSR.

Surprisingly, the director of the HSR portfolio at NIH worked with leaders of the field to define HSR as part of a research continuum in which HSR was about “real-world” research questions that led to actionable results for policy and delivery system reform. This shift in messaging emphasized the unique value of HSR and also distinguished the HSR portfolio and its grantees’ contributions from those of biomedical research.

The yearly National Healthcare Quality and Disparities Report continued to be released annually by AHRQ, documenting incremental improvements in most geographic areas and significant reductions in disparities in other areas.

Over the same time period, PCORI caught up with early lags in reporting findings of its grantees working on comparative effectiveness research (CER) and patient-centered outcomes research (PCOR). PCORI’s media strategy emphasized the positive findings on the impact of patient engagement on improving clinical outcomes within a learning health system. Personal stories were used to illustrate key findings and build public support for continuing funding, particularly among patient groups who were actively and publicly advising PCORI on its research portfolio.

Even though there was no major “game-changer” within the field in terms of research method breakthroughs, the gradual shift to more “real-world” research questions was a significant development in HSR culture. The shift was influenced in part by the growing visibility and credibility of community-based participatory research, a partnership approach involving community members in all phases of research in order to produce outcomes the communities can use to promote healthy neighborhoods and population health.

Looking back, however, the shift in HSR culture was even more influenced by the implementation of the coverage provisions of the Affordable Care Act. With 90 percent of the population insured and able to access health care consistently, including through face-to-face and remote encounters enabled by telehealth, health care data became available to researchers on a much larger scale. After 80 percent of providers had implemented electronic health record systems (EHRs), new analytics tools and research methods for “big data” helped researchers understand patterns of chronic illness, the critical role of patient engagement in clinical outcomes, and the impact of systems issues such as governance and information flow on patient outcomes.

Once legal provisions for data sharing under HIPAA were updated and streamlined, the availability of electronic health data provided new opportunities for collaboration and increased researchers’ capacity to ask and answer innovative questions based on very large data sets combined from multiple institutions. Analytics capabilities also increased in organizations outside of academia, especially in the large health care delivery systems and independent research firms in the technology and life sciences sectors. While some delivery systems developed their own research capacity, others developed partnerships with academic health centers to help scale and spread innovations that could improve the quality of care through increasing patient engagement and other delivery system reforms.

The increasing availability of clinical data from electronic health records (EHRs) not only created a huge new data source for HSR but also opened up new job opportunities in delivery systems.

The increasing availability of clinical data from electronic health records (EHRs) not only created a huge new data source for HSR but also opened up new job opportunities in delivery systems, particularly for nurses and medical technicians with experience in Health IT and informatics. The increasing availability of a racially

and ethnically diverse and experienced clinical workforce familiar with electronic health data was accompanied by a broadening of the definition of health services research to include activities that were previously considered to be “quality improvement” and reporting requirements for health systems. Online informatics training programs began to include more research methods in continuing education courses for delivery system employees. These delivery system employees doing HSR displaced some members of the traditional academically-based HSR community.

Health services researchers in some areas of the country, particularly those with strong academic health centers participating as hubs with Accountable Care Organizations (ACOs), started to develop new research methods using electronic health data and publishing results through online, open access journals. In part because of PCORI’s requirement to release research findings within 90 days of completing a project, the field came to expect that information on “what works” would be available in a much more timely and media-friendly way. As HSR training on communications was put into practice by HSR workers public awareness of new findings on what works in health care increased.



However, geographic variations continued in the adoption and use of EHRs and availability of electronic health data for research. There were still many small hospitals and clinical practices in rural areas that never implemented EHRs and were still using paper records. While the ACA was a significant step toward health equity in many parts of the country, a disproportionate number of low-income and racially and ethnically diverse people in some geographic areas were still experiencing severe disparities in access and quality of care, with poor health outcomes.

Diversity of the HSR workforce increased slightly because of the entry of health care workers into HSR via on-the-job training, and the commitment to active diversity recruitment and training program by some health care systems. Yet the proportion of racially and ethnically under-represented membership in national professional organizations such as AcademyHealth increased by only a small percentage over 2015 levels, as most of these new workers are not supported by their employers to join such organizations.

Scenario 2: Stormy Weather (worst case scenario)

After the 2016 election, a hostile political climate led to severe funding cuts for most research sponsored by government agencies. Funding for health services research (HSR) was particularly affected after the Agency for Healthcare Research and Quality (AHRQ) was eliminated, and all grants in progress were phased out by the end of 2018. Academic HSR project leaders laid off research and administrative staff and began to look for other sources of funding to support ongoing training and research programs. There was a significant drop in the number of student stipends for graduate programs, and diversity recruitment programs began to close down.

The Patient-Centered Outcomes Research Institute (PCORI), which once held great promise for HSR, got a bad review from the U.S. Government Accountability Office (GAO) in its Congressionally-mandated 2015 report. The GAO cited PCORI's lack of transparency, time lags to report findings to the public, and the lack of strategies to improve uptake of findings by delivery systems among its criticisms. After media coverage of the report

led to a national backlash at the amount of funding that was not producing actionable results, Congress reduced 2019 PCORI reauthorization funding to \$400 million, roughly the size of the 2014 AHRQ budget and a fraction of PCORI's previous budget.

There was a significant drop in the number of student stipends for graduate programs, and diversity recruitment programs began to close down.

One of the few bright lights in the funding arena was the maintenance of HSR funding for the Veterans Health Administration (VA), which had an established model of internal research networks collaborating across sites to improve clinical quality and outcomes. The scandal about veterans dying while on waiting lists for care and poor quality of care that broke in 2014 under Former Secretary Shinseki continued into a full-scale Congressional investigation leading up to the 2016 election. After the election, a rare bipartisan agreement among key leaders on the House and Senate Committees of Veterans Affairs protected the VA research budget and provided continuing oversight, which the media covered more or less continuously.

The National Institutes of Health budget also was protected after the 2016 election, but with less Congressional oversight and more discretion to shift funds into biomedical research. NIH put an increasing emphasis on genomics and other "hard" sciences and invested less in HSR and implementation research.



Many health services research training programs were phased out, especially those that partnered with HBCUs and focused on hiring under-represented minorities. The proportion of racially and ethnically under-represented membership in national professional organizations such as AcademyHealth and the American Public Health Association decreased steadily from 2015 levels, reaching new lows in 2025.

Many health services research training programs were phased out, especially those that partnered with HBCUs and focused on hiring under-represented minorities.

The field of HSR was not the only target for budget cuts. The recessions of 2015 and 2020 led to strains in all economic sectors. The federal government instituted a 10 percent across the board cut in all programs in 2017, then followed with a further 10 percent cut in entitlements in 2023. The cuts led to even more challenges for Medicaid and Medicare beneficiaries in finding providers and long wait times for appointments.

The health insurance marketplaces that were a centerpiece of the Affordable Care Act (ACA) succeeded only in 15 states. In other states, technology problems with enrollment, political opposition to “Obamacare,” underfunding, and less than full participation of local health systems meant there was little consumer interest in participating and too many challenges for consumers who wanted to find affordable, high-quality options. The high premium prices in the majority of marketplaces led the U.S. Congress to enact a series of temporary delays on the ACA’s individual health insurance mandate. Eventually, the delays amounted to a functional repeal of the mandate.

The disinterest of most health systems in population health and prevention meant that health problems in low-income communities of color remained largely undocumented, invisible, and unaddressed.

The requirement for “meaningful use” capacity of Health IT systems was withdrawn due to industry pressures and Congressional opposition, thwarting the national goal of interoperable health information exchange of data for clinical and research purposes. Geographic variations continued in the adoption and use of EHRs and availability of electronic health data for research. There were still many small hospitals and clinical practices in rural areas that never implemented EHRs and were still using paper records as of 2025.

The disinterest of most health systems in population health and prevention meant that health problems in low-income communities of color remained largely undocumented, invisible, and unaddressed. The residents of these communities were not insured and in many areas where there were no safety net providers, they were not receiving care. So available health data from clinical encounters presented only a limited perspective on population health, focusing on the insured population whose providers had EHR systems.

Social determinants of health were not mentioned much, even after cuts in social and healthcare entitlement programs increased the homeless population. Because of the economic recessions, there were higher rates of unemployment, violent crime, depression, and substance abuse. Chronic illness became more prevalent because millions of Americans did not have access to regular sources of care and public investments in public health and prevention eroded further. Health disparities became even more pronounced as health care safety nets were dismantled and emergency rooms were closed. Job loss, disruption from extreme weather events, cuts in social services, SNAP and other support payments put many families in dire situations. “Critical resource theft” (stealing food, water), became almost commonplace in most major urban and suburban areas. The downward economic spiral was accompanied by regressions in American politics, civil society, and public health systems.

Social media and online network users in part fueled this regression by spreading misinformation and vitriolic propaganda against government programs, bringing back the takers not makers” rhetoric of the 2012 election.

Positive framing for diversity and equity more generally either faded from visibility or were active targets of criticism in the media. Health care providers and other organizations did little and by 2025 there were fewer HSR workers overall, but particularly fewer people of color.

Scenario 3: Do the Right Thing (aspirational with change from within the field)

No one agreed on exactly how or when it started to happen, but sometime after the 2016 election “common sense” began to return to politics at all levels of government – national, state, and local. Certainly Seattle Mayor Ed Murray’s 2014 proposal to raise the minimum wage was a catalyst, especially given that 100 other cities had already done so.

Lives literally had been saved, and millions of people gained a new understanding of the role of government in supporting access to health care and improvements in personal health.

But another factor in the return to “civil society” was success of the state health insurance exchanges in increasing the number of Americans who had health coverage through Medicaid and private providers. By the time the exchanges had enrolled 20 million people, it was clear that the Affordable Care Act had been the right thing to do. Nearly every American had heard about someone who was previously uninsured and who had been able to get the care they or their family members needed after they got their new coverage. Lives literally had been saved, and millions of people gained a new understanding of the role of government in supporting access to health care and improvements in personal health.

Demographics were also changing rapidly during that time period. As Baby Boomers began to retire from leadership positions in the public and private sectors, the younger individuals who replaced them in the workforce were generally more comfortable with racial and ethnic diversity and more familiar with technology. They were also more respectful about lesbian, gay, bisexual, transgender, and questioning (LGBTQ) rights, and saw a clear role for government and private sector activism in support of equity and fairness in the late 2010s.

By the mid 2020s, political scientists described a new social contract that had emerged in the U.S. over the previous decade and a new recognition of the role of government in providing for the public good. After the public debate on Net Neutrality resulted in the FCC ruling for equal Internet access at the same speed for all regardless of income (“no toll roads”), Americans had come to expect their government to be bipartisan, efficient, and transparent. They were willing to pay taxes to support the rebuilding of the nation’s decaying infrastructure, and were also supportive of using technologies to automate government operations and continuously innovate to do more good at less expense.

As Baby Boomers began to retire from leadership positions in the public and private sectors, the younger individuals who replaced them in the workforce were generally more comfortable with racial and ethnic diversity and more familiar with technology.

The demographic change and shift in values helped to transform politics. The voter apathy of the mid 2010s was replaced by historic levels of voter participation, after federal legislation eliminated restrictive state Voter ID laws; extended voting rights to all, including those who had served time for felony crimes; restored early voting; and also moved elections to Saturdays.



The economy resumed its slow growth, with some minor recessions. Federal finances gradually improved, and state and local budgets were also in better shape as Medicaid budgets stabilized. At the same time, however, the effects of globalization, automation, and knowledge technologies fundamentally changed the economic reality for the U.S. workforce, and structural unemployment continued to grow. Robotics, 3D printing, and digitization had taken over many manufacturing and service jobs by the mid 2020s, leaving fewer jobs in many of the largest cities and severe job shortages in rural areas.

As structural unemployment grew, millions of Americans and their communities turned to themselves and to each other to produce and co-produce basic necessities for sustaining their households – including food, home repairs, child care, and other shared services. To a certain extent, this trend had already been foreshadowed in the 2010s with an increase in the number of experienced Baby Boomers who responded to layoffs by taking on second careers as self-employed consultants and entrepreneurs. Many more small businesses were formed, as retirees hired recent college graduates who had large debts and few job opportunities, and many of those businesses were virtual – so geographic location was not a barrier to employment.

The health care labor market was heavily influenced by information technology and particularly by the near-universal adoption of electronic health records (EHRs). The second generation of EHRs developed in the late 2010s were much smarter and easier to use for both clinical and research purposes,

as well as for quality reporting. By 2020, 90 percent of health systems were electronic and able to exchange clinical information with partners outside their systems. Thousands of chart abstractors and clinical coders who had contributed to quality reporting in paper systems were laid off. Some were retrained in informatics, given the demand for trained Health IT specialists to help coordinate the exchange of electronic health information among organizations (regional information exchange).

The game allowed players to role-play the lives of different hypothetical residents – from the most privileged to the more vulnerable – in virtual communities.

The growth of predictive analytics and simulations that took off after the 2009 HITECH investments also contributed to the spread of games that changed communities' awareness of and commitment to achieving health. One such game, named PRIVILEGED, quickly went viral after 2020 and prompted a major public conversation about fairness. The game allowed players to role-play the lives of different hypothetical residents – from the most privileged to the more vulnerable – in virtual communities. Players thus explored their degree of privilege and hardship, and worked with other players to devise equity-enhancing strategies. Although communities varied widely in the needs and goals that they identified, factors that emerged most often included: support for mixed-income neighborhoods and



community development, employment, community resilience, and the promotion of alternative community economic models such as self-production, co-production, community and home gardening, and Time Dollar exchanges (alternative currency where the “person-hour” is the unit of exchange).

By 2020, 98 percent of the population was insured and the majority of patients had online access to their personal health records. PCORI was reauthorized by Congress in 2019 for another 10 years, and became a major force in changing delivery system culture by emphasizing all three of the Triple Aim objectives (i.e., enhancing patients’ experiences of care, reducing per capita health care costs, and improving population health).

AHRQ shifted a significant amount of extramural funding into innovations in reducing disparities in chronic disease conditions and chronic care management, which had been a recognized

opportunities for undergraduates increased significantly, creating a more diverse pipeline for advanced training in HSR and other social and behavioral sciences. Funders reinstated programs that had been previously dropped (e.g., Kellogg Scholars, Barbara Jordan Scholars, Aetna Minority Scholars) and renewed their commitment to strengthening the pipeline for health services and policy research. Some newly formed campus diversity programs were modeled after large-scale programs in private industry, such as IBM, while others, modeled after the Haas Institute for Equity, Inclusion, and Diversity at UC-Berkeley, which brings together researchers, policymakers, and other stakeholders, grew organically from local culture.

After the White House Conference on Diversity called for new partnerships, the number of HBCUs partnering with mainstream academic health centers and businesses tripled within 18 months.

A gradual shift in the awareness of the need for more racial and ethnic diversity in HSR leadership, including diversity among conference organizers and presenters, led to the development of new diversity/cultural competency guidelines for HSR, modeled after cultural competency for health care providers. The new guidelines were promoted by alumni of a variety of minority scholars programs in HSR and other health professions, and were adopted and implemented by every HSR program by 2020.

Scenario 4: We are the World (aspirational with change from outside the field)

For most Americans looking back at the bitter health care debates of the 2010s, there is pride in having transformed health care, making it more affordable and effective. The health insurance exchanges mandated by the Patient Protection and Affordable Care Act in 2010 (ACA) enrolled millions of previously uninsured and underinsured Americans, and in 2025, 98 percent of the population has meaningful coverage, access to acute care, and help managing chronic illnesses.

The Accountable Care Organizations (ACOs) created by the ACA fully supported the “Triple Aim” (i.e., enhancing patients’ experience of care, reducing per capita health care costs, and improving population health) as the national goal, and public health agencies were fully integrated into the ACOs. Many former health department staff now serve as the ACOs’ patients’ virtual



problem for at least two decades. With funding from several of the leading private philanthropies, the field of HSR began to align its research agenda to the needs of communities, with an emphasis on rapid-cycle evaluations and ways to measure short-, medium- and long-term improvements in population health.

After the White House Conference on Diversity called for new partnerships, the number of HBCUs partnering with mainstream academic health centers and businesses tripled within 18 months. While most of the undergraduate training partnerships had traditionally focused on STEM and biomedical and clinical research, new pathways opened up for undergraduates interested in health services and policy research. The number of underrepresented minority internships and on-the-job training

health coaches, using videoconferencing, digital platforms, and smartphones to help promote healthy personal behavior change. The broadband investments made more than a decade earlier by the FCC and USDA made it possible to build a national telehealth network to provide remote visits, and no one goes without care when they need it.

The philanthropies were first to actively cultivate the emerging value changes around racial and ethnic diversity at all levels of society and in all geographies.

The disruptive technologies developed throughout the 2010s put more and more control of health and health care into the hands of consumers and families. New smartphone “apps” monitored a person’s diet, physical activity, and sleep patterns, and collected this data in personal health records (PHRs) that could be easily integrated into their providers’ electronic health records (EHRs). New wearable biomonitors that measured blood pressure, blood chemistry, and even blood flow noise within the body could alert people to changes in their health. Lab tests conducted by a device at home (e.g. “lab-on-a-chip”), or collected by the consumer and sent by mail to a lab, provided a low-cost alternative to similar services previously provided in clinics and other health care settings. Social networks, both in large population platforms like Facebook and Google, and in targeted networks like PatientsLikeMe, helped to formalize and extend the informal relationships that had always provided a large share of people’s health-related information.

Thousands of new jobs were created by solar, wind, and other new technologies as well as by the re-emergence of community-based programs competing to meet energy conservation goals.

Student loans were forgiven, and the loan program was overhauled so that future student loans would be made at the same interest rate that corporations pay. Thousands of new jobs were created by solar, wind, and other new technologies as well as by the re-emergence of community-based programs competing to meet energy conservation goals.



Funding for health services research increased by 10% over 10 years. AHRQ shifted a significant amount of its extramural funding into innovations in reducing disparities in chronic care management, which had been a recognized problem for at least two decades. PCORI was reauthorized in 2019 with no expiration date. The surprising collaboration between the Canadian Institutes of Health Research (CIHR), AHRQ, and PCORI, launched in 2015, significantly accelerated the process of evidence generation and translation into practice and helped transform the delivery system as set out by the Triple Aim. The collaboration including a significant investment in HSR training programs at the undergraduate and graduate levels, and more master’s prepared health services researchers entered the workforce.

With funding incentives from several of the nation's leading private philanthropies, the field of HSR began to align its research agenda to the needs of communities, with an emphasis on rapid-cycle evaluations and ways to measure short-, medium- and long-term improvements in population health.

The philanthropies were the first to actively cultivate the emerging value changes around racial and ethnic diversity at all levels of society and in all geographies, and they required racially and ethnically diverse advisory groups and research staff who were familiar with the issues in the communities where they worked.

In April 2014, a small town called Harrison, Arkansas held a "Funeral for Racism" hosted by the town's Martin Luther King, Jr. Commission. Over the summer, there were three mass shootings carried out by young white males. Combined with the number of severe summer storms and record-breaking floods and tornadoes in across the country, which had a disproportionate impact on communities of color, there was an awakening of awareness not unlike the post-Katrina recognition about the role of racism in health.

In the fall of 2014, Archbishop Desmond Tutu continued his climate change awareness campaign and made a series of speeches in U.S. communities along the route of the Keystone XL Pipeline, demanding that the United States stop the inter-related violence, racism, and polluting. These speeches had similar themes to those in his Alberta, Canada speech in late May 2014 about the pipeline and its violent and racist impact on indigenous people. Tutu

again called for an "anti-apartheid style boycott" against the fossil fuel industry and cited the letter he and other Nobel Laureates wrote President Obama in April 2014 calling for him to reject the Keystone XL Pipeline as a moral imperative.

Communities with active local networks such as the CDC-funded Healthy Communities program or other health, economic, or social justice organizations were the first to take up Tutu's call for action and community discussion. Community leaders realized that oppressed minority groups would not be capable of full participation in 21st century society if their contemporary and centuries-old wounds continued to be left untended. Many communities thus undertook a courageous process of "truth and reconciliation" of the nation's racial past and present. These initiatives launched an open discussion of the long-lasting impacts (for both people of color and for white people) of slavery and other forms of oppression. As the local movement grew, more people began to call for a national truth and reconciliation commission that would redress the grievances of all groups who had suffered or been damaged by discrimination and its legacy.

As the Truth and Reconciliation movement grew, the National Medical Students Association and American Medical Students Association partnered with Health Care Without Harm to develop new social media campaigns for the health care sector to move away from fossil fuels, and to promote new models to increase the use of local, organic produce in hospitals.



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APPENDIX E: RECOMMENDATIONS FROM NIH REPORT ON DIVERSITY IN THE BIOMEDICAL WORKFORCE

Advisory Committee to the NIH Director: Working Group on Diversity in the Biomedical Workforce (see <http://acd.od.nih.gov/dbr.htm>)

1. The NIH must ensure that appropriate resources are allocated for the systematic tracking, reporting, and evaluation of the immediate and long-term outcomes of all trainees, including those supported on all research project grants.

2. The NIH should take a direct leadership role in developing the interest and curiosity of greater numbers of K-12 and undergraduate URM students in biomedical and behavioral sciences through the design and dissemination of NIH-specific activities; providing an increased number of research experiences for high school students and their teachers; and by advocating for and promoting cooperative efforts across Federal agencies and with private and philanthropic organizations.

3. NIH should increase number of scholarships for undergraduates (building on the NIH intramural Undergraduate Scholarship Program) that include s in biomedical and behavioral sciences through tearch experience, and additional fellowships for the anticipated increased numbers of URM graduate students in biomedical research.

4. The NIH should assess the reason(s) for the disparity in the frequency of awards to African American applicants for postdoctoral positions on T32 training grants and F32 fellowships (Figure 7 (top)), and take appropriate remedial actions once the reason(s) for this disparity have been determined.

5. NIH, through NIMHD serving the coordinating function, should partner with established minority scientific and professional groups and other trusted organizations to implement a system of mentorship “networks” for underrepresented minority students that will provide career guidance throughout their career development. The mentorship networks would be expected to make available a cadre of investigators who would, among other mentoring activities, provide workshops in grant writing, grant presentations, and optimal participation in editorial and NIH review processes.

6. Establish a working group of the ACD, of racially and ethnically diverse scientists, to provide regular input to the Director of NIH, and the Institutes and Centers, regarding the state-of-the-art in effective programs that overcome or reduce disparities in research awards.

7. Investigators whose applications are unscored should be provided with a more detailed explanation of the factor(s) that led to this determination, thus enabling an applicant to better understand the areas of concern leading to the decision about his or her proposal. Ideally, these comments from the peer reviewers should help the applicant decide whether he or she should “resubmit or rethink” an unscored application.

8. Under the leadership of NIMHD, and in coordination with other STEM initiatives underway in HHS and across other Federal government agencies, NIH should undertake a bold, well-funded, multi-year, incentive-based, competitive grant process to support infrastructure development in those comparatively under-resourced institutions with a documented track record of producing and supporting URM scientists as well as stimulating creative partnerships among these institutions and, where appropriate, including more resource-rich institutions.

9. The NIH should expeditiously establish a new Working Group of the ACD comprised of experts in behavioral and social sciences and studies of diversity with a special focus on determining and combating real or perceived biases in the NIH peer review system. In particular, this new Working Group should:

- Oversee the collection and analyses of quantitative and qualitative data relevant to the research project grant review and grant-making decision process.
- If this additional analysis provides evidence of bias, provide guidance and insight on potential actions that the NIH could take to combat bias.
- Provide oversight to an analysis of the discourse content from peer review sessions so as to contribute to the understanding of potential bias.
- Provide expert oversight to a text-based analysis of the commentary on individual grant reviews, including R01s and a subset of applications for those awards (career awards, fellowships, smaller research project grants, and others) most likely to precede an investigator submitting a R01 application.
- Oversee other efforts that investigate potential effects of unconscious bias in peer review.

10. The NIH should first, pilot different forms of validated implicit bias/diversity awareness training for NIH scientific review officers and program officers to determine the most efficacious approaches. Once the best training approaches have been identified with NIH staff, pilot these programs with members of study sections to ascertain if their value is sustained. If they are, provide to all study section members.

11. NIH should design an experiment to determine the effects of anonymizing applications with respect to applicant identity as well as that of an applicant in institution. The WGDBRW understands that the nature of implicit bias cuts across processes, structures, organizations, and societal groups. The prospect of bias in the NIH peer review process is a serious matter that calls for deliberative action in a timely fashion.

12. Appoint a Chief Diversity Officer (CDO) and establish an Office of Diversity with a suitable budget. The CDO should be an established biomedical scientist with considerable expertise in diversity in academic and academic medical settings.

13. Using the trans-NIH Earl Stadtman Investigator search process as a model, and learning from its experience, the NIH should institute a more comprehensive search process for tenure-track investigators to ensure the identification of a diverse pool of candidates.

Source: <http://acd.od.nih.gov/dbr.htm>

APPENDIX F: ACCREDITATION CRITERIA, SCHOOLS OF PUBLIC HEALTH (COUNCIL ON EDUCATION FOR PUBLIC HEALTH, 2011)

(See <http://ceph.org/assets/SPH-Criteria-2011.pdf>, p. 11-12)

1.8 Diversity. The school shall demonstrate a commitment to diversity and shall evidence an ongoing practice of cultural competence in learning, research and service practices.

Interpretation. Recognizing that graduates of public health schools may be employed anywhere in the world and work with many different populations, schools should provide a learning environment that prepares their students with broad skills regarding diversity and cultural competence, within the context of their own institution's mission statement. Systematic, coherent and long-term efforts to incorporate elements of diversity are expected at all levels including faculty, staff, students, curriculum, research and service. Schools can accomplish these aims through a variety of practices including incorporation of diversity and cultural competency considerations in the curriculum; recruitment/retention of faculty, staff and students; policies that are free of harassment and discrimination; reflection in the types of research conducted; and cultural considerations in service or workforce development activities.

Cultural competence, in this context, refers to skills for working with diverse individuals and communities in ways that are appropriate and responsive to relevant cultural factors. Requisite skills include self-awareness, open-minded inquiry and assessment and the ability to recognize and adapt to cultural differences. Reflecting on the public health context, recognizing that cultural differences affect all aspects of health and health systems, cultural competence refers to the skills for recognizing and adapting to cultural differences. Each school must define these terms within its own context.

Aspects of diversity may include age, country of birth, disability, ethnicity, gender, gender identity, language, national origin, race, refugee status, religion, culture, sexual orientation, health status, community affiliation and socioeconomic status.

CEPH understands that the definition of diversity in international settings, as well as the ability to track such data, differs greatly from that in the United States. This does not, however, relieve international institutions from the obligation to demonstrate efforts and outcomes related to diversity and cultural competency.

Required Documentation. The self-study document should include the following:

- i. A written plan and/or policies demonstrating systematic incorporation of diversity within the school. Required elements include the following: Description of the school's under-represented populations, including a rationale for the designation.
- ii. A list of goals for achieving diversity and cultural competence within the school, and a description of how diversity-related goals are consistent with the university's mission, strategic plan and other initiatives on diversity, as applicable.
- iii. Policies that support a climate free of harassment and discrimination and that value the contributions of all forms of diversity; the school should also document its commitment to maintaining/using these policies.
- iv. Policies that support a climate for working and learning in a diverse setting.
- v. Policies and plans to develop, review and maintain curricula and other opportunities including service learning that address and build competency in diversity and cultural considerations.
- vi. Policies and plans to recruit, develop, promote and retain a diverse faculty.
- vii. Policies and plans to recruit, develop, promote and retain a diverse staff.
- viii. Policies and plans to recruit, admit, retain and graduate a diverse student body.
- ix. Regular evaluation of the effectiveness of the above-listed measures.

1. Evidence that shows the plan or policies are being implemented. Examples may include mission/goals/objectives that reference diversity or cultural competence, syllabi and other course materials, lists of student experiences demonstrating diverse settings, records and statistics on faculty, staff and student recruitment, admission and retention.
2. Description of how the diversity plan or policies were developed, including an explanation of the constituent groups involved.
3. Description of how the plan or policies are monitored, how the plan is used by the school and how often the plan is reviewed.
4. Identification of measurable objectives by which the school may evaluate its success in achieving a diverse complement of faculty, staff and students, along with data regarding the performance of the program against those measures for each of the last three years. See CEPH Data Template 1.8.1. At a minimum, the school must include four objectives, at least two of which relate to race/ethnicity. For non-US-based institutions of higher education, matters regarding the feasibility of race/ethnicity reporting will be handled on a case-by-case basis. Measurable objectives must align with the school's definition of under-represented populations in Criterion 1.8.a.
5. Assessment of the extent to which this criterion is met and an analysis of the school's strengths, weaknesses and plans relating to this criterion.

ABOUT THE AUTHORS

Margo Edmunds, PhD, is Vice President for Evidence Generation and Translation at AcademyHealth

Clem Bezold, PhD, is founder and chairman of the Institute for Alternative Futures

Charles Cinque Fulwood is President of MediaVision USA, LLC

Beth Henry Johnson is Senior Manager at AcademyHealth

Hassan Tetteh, MD, MBA, FACHE is currently a U.S. Navy Commander in the Medical Corps and Physician Health Policy Advisor, US Navy Bureau of Medicine and Surgery (BUMED)



1150 17th Street, NW | Suite 600
Washington, DC 20036

202 292 6700 PHONE
202 292 6800 FAX

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