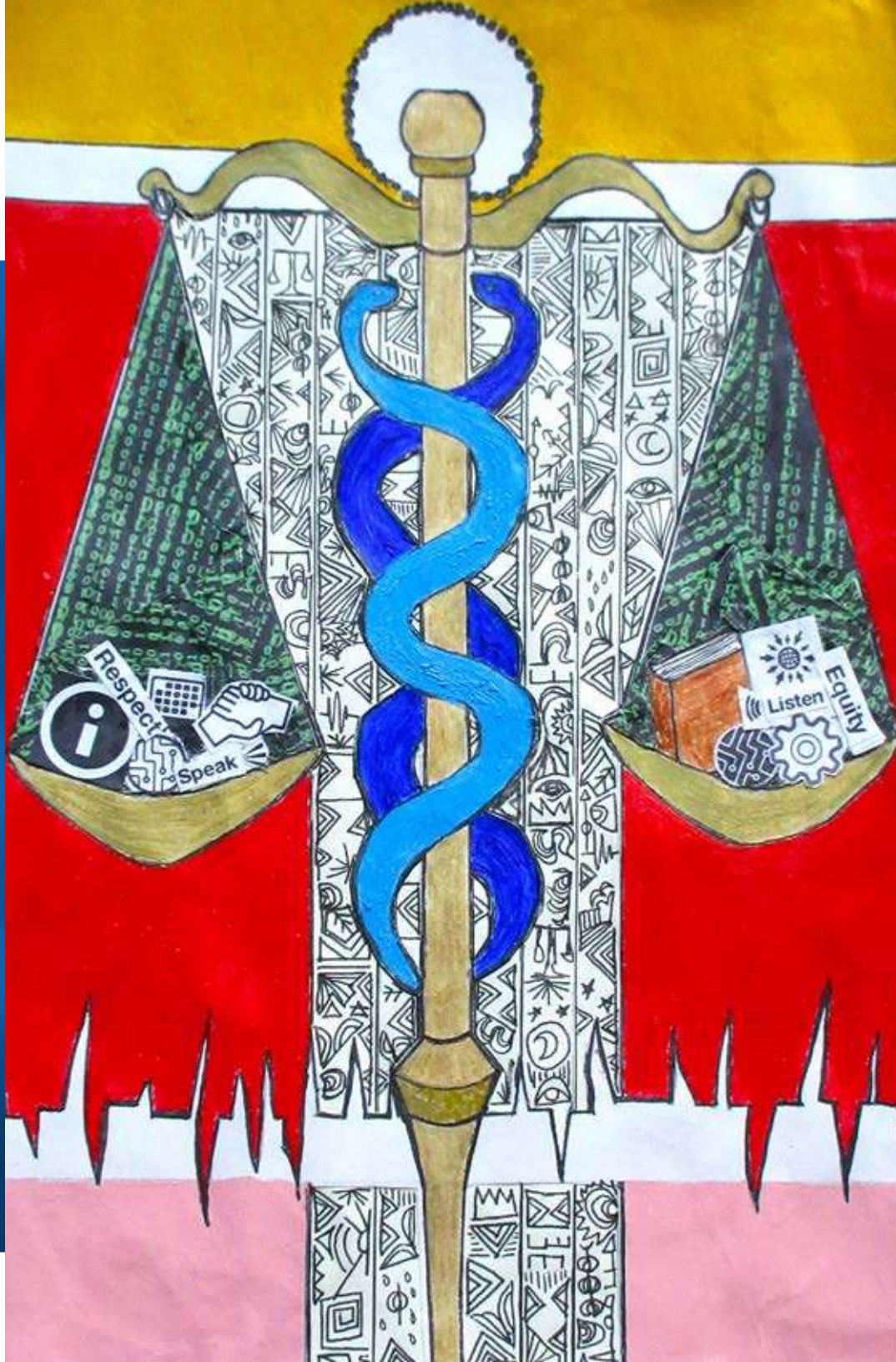




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Health Equity in Academic Medicine: Recommendations From an AAMC Community Roundtable in Washington, D.C.

DECEMBER 2021



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Cover art: “Foundational Rites/Rights,” by Amber Robles-Gordon

The AAMC (Association of American Medical Colleges) is a nonprofit association dedicated to transforming health through medical education, health care, medical research, and community collaborations. Its members are all 155 accredited U.S. and 17 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America’s medical schools and teaching hospitals and the millions of individuals employed across academic medicine, including more than 186,000 full-time faculty members, 94,000 medical students, 145,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Additional information about the AAMC is available at [aamc.org](https://www.aamc.org).

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This publication is the result of an AAMC virtual meeting held July 29-30, 2020, and subsequent meetings with several key stakeholder groups in October and November 2020. The meetings provided a forum for discussing the current landscape, ongoing work, and opportunities for the academic medicine community to address local health and health care inequities in the Washington, D.C., metropolitan area.

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LAND ACKNOWLEDGMENT

This report discusses approaches for academic medicine to advance health equity in Washington, D.C. The AAMC headquarters is located in Washington, D.C., the traditional homelands of the Nacotchtank, Piscataway, and Pamunkey people. We are mindful of the impact of the intentional genocide and displacement of Indigenous communities in Washington, D.C., and the disproportionate health inequities that exist in Indigenous communities in the United States today because of systemic racism. We celebrate the resilience and strength that all Indigenous people have shown in this country and worldwide. The AAMC understands that while the goal of health equity is inclusive of all communities, it cannot be achieved without explicit recognition and reconciliation of our country's injustices.

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FOREWORD

The COVID-19 pandemic has highlighted myriad U.S. public health challenges in every sector, with structural racism at the forefront of our societal and health care crises. The injustices within communities of color and the ongoing issues in the health care system that often result in disproportionate morbidity and mortality rates demonstrate a desperate need to direct our focus and resources to reducing persistent health inequities. Because of the pandemic and the growing awareness of the relationship between community health and our nation's history of structural racism, addressing the social determinants of health, such as access to affordable and quality health care, education, and housing, have garnered more attention. This new reality puts the AAMC in a unique position to be a leader in strengthening medical education, research, advocacy, and community engagement efforts aimed at alleviating health inequities.

To fulfill our mission to improve the health of people everywhere, academic medicine must collaborate with communities and multidisciplinary stakeholders to implement innovative ideas and strategic approaches that acknowledge, support, and seek community voices and leadership. The AAMC hosted a meeting, the Community Roundtable: Health Equity in Academic Medicine, to leverage the knowledge and experiences of our community partners and regional stakeholders for two primary reasons: to initiate the dialogue necessary for developing a regional health equity framework and to explore avenues for a more collaborative approach in advancing health equity. The roundtable provided a forum for representatives from eight academic medical institutions and six community organizations in the Washington, D.C., metropolitan area to discuss how their institutions are tackling health inequities and opportunities for establishing and implementing additional efforts that align with local government and nonprofit initiatives aimed at meeting community needs and promoting social justice.

Although this initial roundtable included only individuals from the Washington, D.C., area, this report outlines the current landscape and obstacles that can inform how we expand or modify programs, policies, and practices within other regions where multiple medical schools and teaching hospitals are located. This report summarizes the discussions and several recommendations from roundtable participants to build the momentum we need to take measurable actions toward social change. It provides promising practices that foster collaboration across the academic medicine community and highlights the vital role of effective community engagement.

The AAMC is grateful for the opportunity to engage in meaningful dialogue with local member institutions, community-based organizations, and government partners to catalyze the development of effective solutions to eliminate health inequities and create systemic change within academic medicine and health care. Our hope is that this report encourages medical schools, teaching hospitals, and health systems to revisit their approaches to addressing health inequities and to question the status quo. This will require evaluating our intentions and engagement with community members, broadening efforts to embed equity across mission areas, and prioritizing cross-collaboration within and outside medicine. We cannot delay transforming our health care system through bidirectional partnerships with and investments in local communities to achieve health equity.

In health,

David A. Acosta, MD

Chief Diversity and Inclusion Officer
AAMC

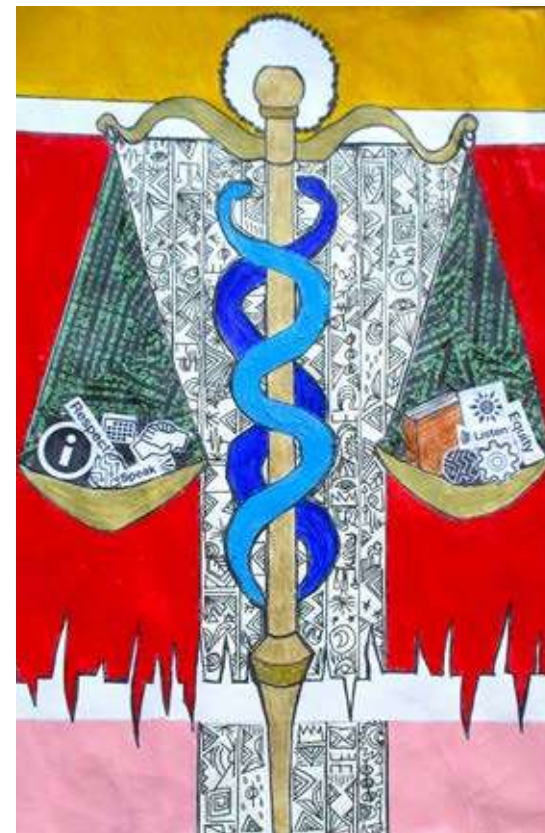
ABOUT THE ARTIST

Amber Robles-Gordon is a mixed-media visual artist. Her creations are visual representations of her hybridism: a fusion of her gender, ethnicity, cultural, and social experiences. She has more than 15 years of exhibiting, art education, and exhibition-coordinating experience. Known for recontextualizing nontraditional materials, her assemblages, large sculptures, installations, and public artwork emphasize the essentialness of spirituality and temporality within life. Driven by the need to construct her own distinctive path, innovate, and challenge social norms, her artwork is unconventional and nonformulaic. The underpinnings of her creations reveal racial injustice and the paradoxes within the imbalance of masculine and feminine energies within our society.

Robles-Gordon received a bachelor of science in business administration in 2005 from Trinity University and a master of fine arts (painting) in 2011 from Howard University in Washington, D.C. She has exhibited nationally and in Germany, Italy, Malaysia, England, and Spain. Her exhibitions and artwork have been reviewed or featured in the *Washington Post*, the *Washington City Paper*, the *Washington Informer*, the *Washington Examiner*, WAMU, WPFW, MSNBC, TheGrio, *Hyperallergic*, *Ebony*, the *Houston Chronicle*, the *Miami Herald*, HuffPost, *BmoreArt*, *Callaloo*, *Sugarcane Magazine*, Support Black Art, and other outlets.

Robles-Gordon has been commissioned to create temporary and permanent public art installations for numerous art fairs and agencies, such as the DC Commission on the Arts and Humanities, the Northern Virginia Fine Arts Association, the Humanities Council of Washington, DC, the Howard University James A. Porter Colloquium, the Schomburg Center for Research in Black Culture, Washington Project for the Arts, Salisbury University, Martha's Table, the DC Department of General Services, and Democracy Fund. She has taught workshops, given commentary, and presented about her artwork for the Smithsonian Anacostia Museum, Luther College, WETA, Al Jazeera, WPFW, WAMU, The Kojo Nnamdi Show, the David C. Driskell Center for the Study of the Visual Arts and Culture of African Americans and the African Diaspora, the Phillips Collection, the African American Museum in Philadelphia, McDaniel College, Salisbury University, American University, the Harvey B. Gantt Center for African-American Arts + Culture, and the National Museum of African American History and Culture.

Throughout her career, Robles-Gordon has served as an advocate for the Washington, D.C., area arts community. From November 2004 through July 2012, she was an active member of Black Artists of DC (BADC), serving as exhibitions coordinator, vice president, and president. BADC, a 20-year-old member organization of individuals of Black-Afrikan ancestry, includes artists, arts administrators, educators, dealers, collectors, museum directors, curators, gallery owners, and arts enthusiasts. Robles-Gordon is also the co-founder of the Delusions of Grandeur Artist Collective.



EXECUTIVE SUMMARY

In July 2020, the AAMC hosted the two-day Community Roundtable: Health Equity in Academic Medicine, a virtual meeting of eight academic medical institutions, DC Health, and six community organizations in the Washington, D.C., metropolitan area. The roundtable was designed to foster collaboration across the academic medicine community in the region to catalyze the development of community-informed solutions to address health and health care inequities through education, policy, and practice. The roundtable discussions centered on six critical levers of change that affect the advancement of health equity: Medical Education; Diversity, Equity, and Inclusion (DEI); Community Engagement and Corporate Social Responsibility; Advocacy and Policy; Research; and Clinical Care and Quality Improvement.

This report details participants' descriptions of several promising practices, critical challenges, and points for future collaboration among the academic medicine community and local organizations addressing health inequities in the region. Synthesizing the findings across all sessions resulted in four recommendations for medical schools, teaching hospitals, and residency programs wanting to deepen and integrate their health equity work:

- 1. Develop equity-centered, community-engaged didactic and experiential learning opportunities within medical schools and residency programs.**
- 2. Explicitly link DEI values, efforts, and outcomes to institutional culture, policies, and programs.**
- 3. Leverage the roles, expertise, and enthusiasm of learners and of leaders and staff in offices of community engagement and government affairs to partner with local communities to address social determinants of health and advocate for change.**
- 4. Critically examine research and clinical care practices for evidence of equity-centeredness in design, implementation, and outcomes.**



The COVID-19 pandemic with its glaring health inequities and the social justice uprisings of 2020 forced institutions in the Washington, D.C., metropolitan area to imagine new, collaborative opportunities for addressing health inequities and their roots in structural racism and other systems of oppression. Though academic medical institutions already partner with each other and their local communities to promote health equity, they are primed to expand their local and national impacts. The roundtable was a critical first step in creating a future collaborative framework for advancing health equity in the district. The AAMC will continue to engage regional stakeholders in developing and refining the framework to create a replicable model for regional engagement across the country.



1 | Introduction

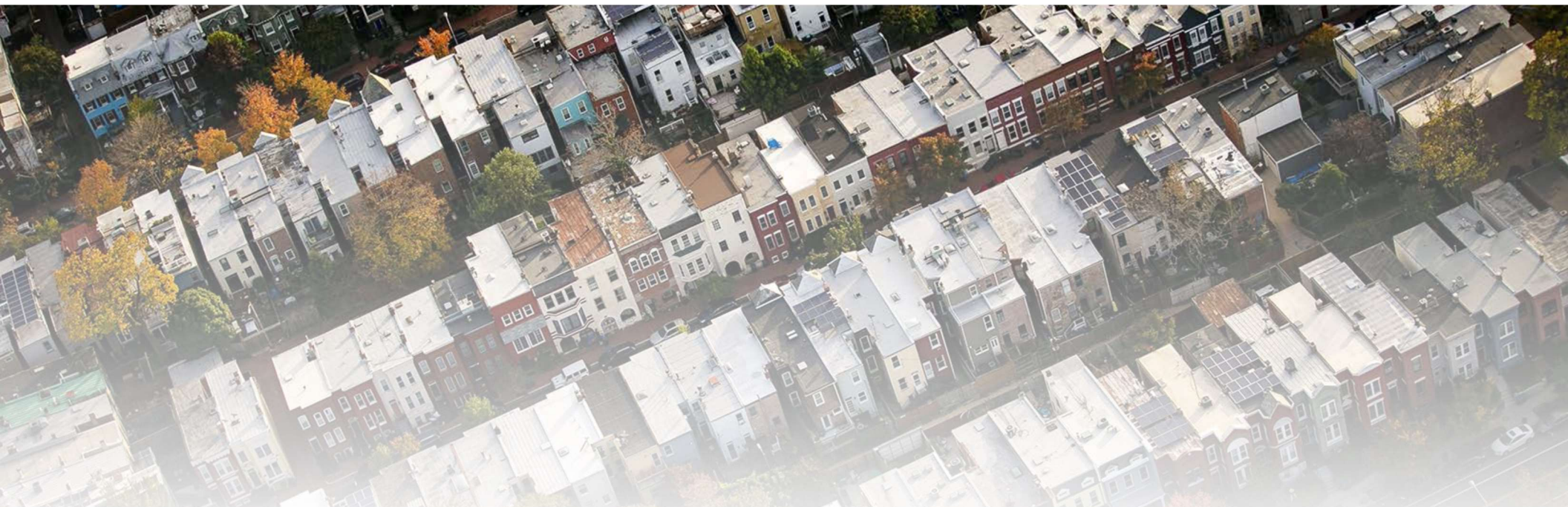
Systemic inequities in U.S. social institutions, such as education, health care, and housing, have long resulted in health inequities for historically marginalized populations. The COVID-19 pandemic has further exacerbated these inequities, with its disproportionate impact on the health outcomes of people of color.

In Washington, D.C., Black, Hispanic or Latinx, and Asian residents account for a staggering 88% of all COVID-19 deaths.¹ Black residents alone account for 77% of COVID-19 deaths and 52% of all COVID-19 infections in the district,¹ despite making up only 44% of the population.² Even as vaccines have become readily available to the public, disparities in vaccine uptake persist. In September 2021, the fully or partially vaccinated rate for Black D.C. residents (38.3%) was lower than rates for Hispanic or Latinx (54.9%), Asian or Pacific Islander (50.6%), and White (43.1%) D.C. residents.³ These trends are not unique to the district — national data indicate similar trends across the country, with some racial and ethnic populations less likely to be vaccinated.⁴

As the capital of the United States, Washington, D.C., was an epicenter of protests and demonstrations as a national reckoning with institutional and

systemic racism unfolded in 2020. Calls to action included declaring racism a public health issue. The dual crises of the COVID-19 pandemic and the growing awareness of health inequities and the impact of racism in society and in medicine sparked the AAMC, which is based in the district, to convene stakeholders in the academic medicine community to articulate and strengthen a regional approach for addressing and eliminating health inequities.

In July 2020, the AAMC hosted a two-day virtual meeting, the Community Roundtable: Health Equity in Academic Medicine. The roundtable brought together representatives from the region's medical schools, teaching hospitals, and teaching health centers (residency programs based in community outpatient settings, such as Federally Qualified Health Centers) to discuss approaches to align work aimed at improving health outcomes



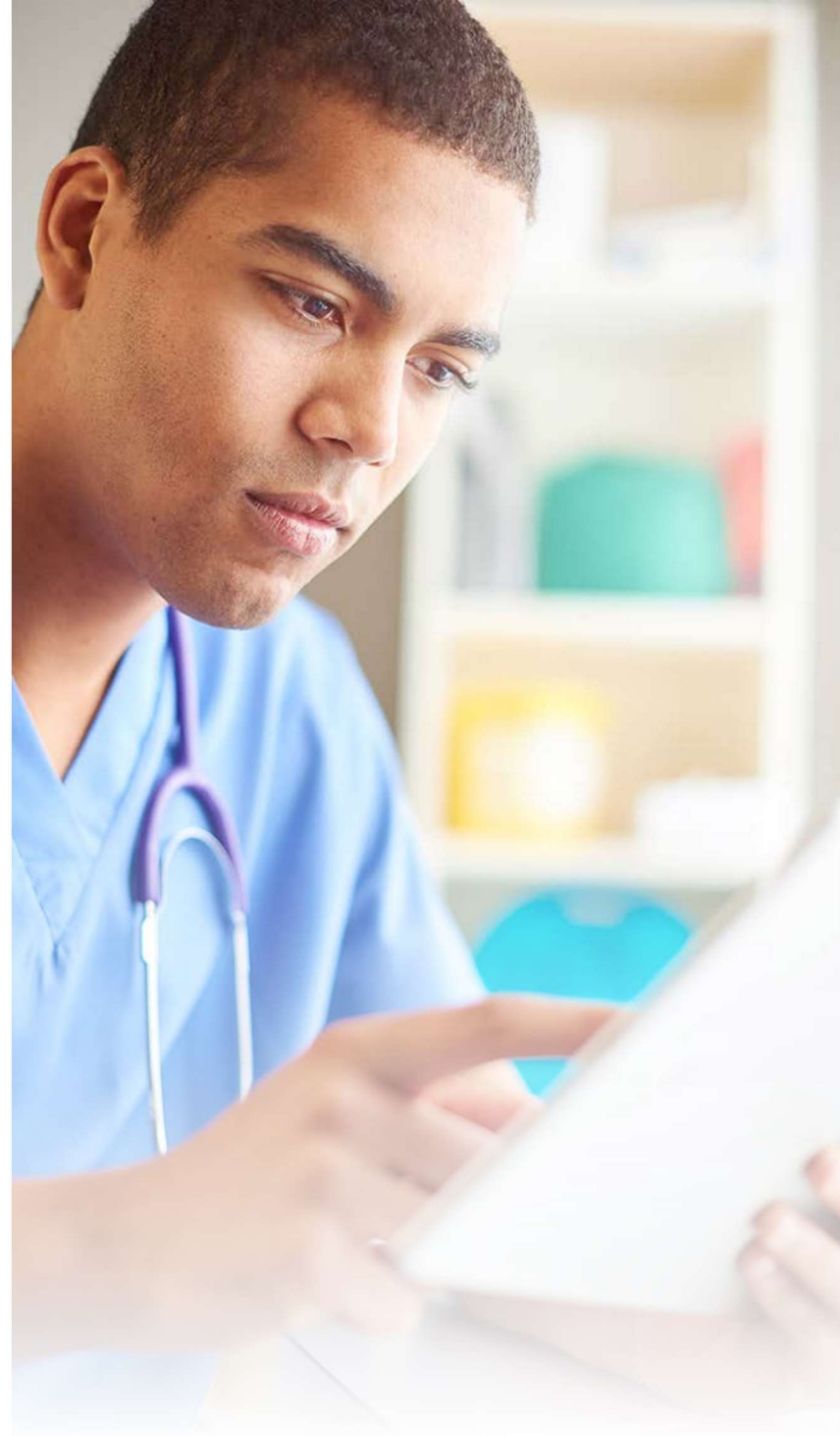
for marginalized populations in the district. Historically, participating institutions — each with its own unique mission, role, and history in the region — have collaborated to varying degrees. The roundtable, which grew out of preexisting community engagement and health equity work at the AAMC, provided an opportunity for institutions to reexamine and clarify academic medicine’s role in promoting health equity on local and national scales. The AAMC designed the roundtable to help the academic medicine community catalyze the development of community-informed solutions that address health and health care inequities through education, policy, and practice. Throughout the meeting, institutions highlighted current work, discussed gaps in ongoing approaches, and identified opportunities for future collaboration.

BUILDING A REGIONAL HEALTH EQUITY FRAMEWORK

The roundtable is an initial engagement in a long-term strategy to co-develop a regional health equity framework with the academic medicine community and partner organizations in the Washington, D.C., metropolitan area. The framework could eventually be a model in regions across the country. We envision the framework will include several goals:

- Build an academic medicine learning collaborative that promotes knowledge sharing, capacity building, and coordinated institutional approaches.
- Strengthen community and academic partnerships to address local community needs.
- Support multidisciplinary relationships and investments in local communities to advance health equity.
- Maximize the community impact and sustainability of academic medicine’s institutions as anchor institutions and change agents for social and economic improvements.

This report, which can be a foundation for further development of the framework, offers recommendations for deepening and integrating health equity work at medical schools, teaching hospitals, and health systems that incorporate insights, evidence, and interventions from local institutions, community leaders, and public health officials.





Share

Discuss current and emerging institutional practices within Washington, D.C., area medical schools and teaching hospitals to address health and health care disparities.



Connect

Provide a forum for academic medicine colleagues in the Washington, D.C., area to develop ongoing community and academic partnerships.



Ideate

Brainstorm new ways to overcome common barriers to achieving meaningful change in our local patient populations and communities.



Build

Disseminate approaches to help other AAMC-member institutions with citywide and regional efforts to improve health and health care disparities.

ROUNDTABLE PLANNING

The roundtable was framed around four goals: Share, Connect, Ideate, and Build. These goals guided the discussions about the current landscape, ongoing work, and short- and long-term opportunities for specific action steps to advance health equity.

METHODS

AAMC staff emailed chief executive officers (CEOs), deans, and other senior leaders at the eight AAMC-member institutions serving the Washington, D.C., metropolitan area and six community organizations with longstanding partnerships with the academic medicine community, inviting their institutions to participate in the roundtable (Tables 1 and 2). Recognizing that senior leadership support is imperative for sustainability, the AAMC asked CEOs, deans, and senior leaders from the institutions and organizations to nominate representatives to attend the roundtable. Participants included leaders working with six critical levers of change for advancing health equity: Medical Education; Diversity, Equity, and Inclusion; Community Engagement and Corporate Social Responsibility; Advocacy and Policy; Research; and Clinical Care and Quality Improvement. The AAMC used this approach for several reasons: 1) to ensure leaders of local academic medical institutions were aware of the roundtable's goals, 2) to promote the roundtable as a gathering of peer institutions, and 3) to engage the most qualified people to speak about institutional efforts at a granular level.

The roundtable consisted of six 90-minute virtual sessions held July 29-30, 2020. Each session focused on one of the six levers of change and was facilitated by either a health equity leader from the American Public Health Association or a medical education leader from the AAMC. Before the meeting, participants submitted one-page summaries outlining their institution’s current efforts to address health and health care disparities. The facilitators guided each session using targeted questions (Appendix B), resulting in conversations that elevated effective ongoing practices, articulated common barriers to promoting health equity work, and identified ways to increase collaboration in the district.

Following the roundtable, the AAMC convened leaders from DC Health (the district’s public health agency) and medical students recruited through a community partner organization, Mentoring in Medicine, in two separate, 60-minute virtual sessions on Oct. 22, 2020. The aim of these sessions was to gain additional perspectives on health equity work in the district and feedback on preliminary roundtable findings. On Nov. 10, 2020, the AAMC presented an executive summary highlighting major themes at a follow-up webinar with the institutional representatives. During the November session, participants identified topics and key points for inclusion or emphasis in this final report. This report details examples of the participating academic medical institutions’ current health equity efforts and recommendations for achieving greater collaborative impact, and it concludes with challenges and opportunities that arise when addressing health and health care inequities in the district. This series of roundtable activities can be a model for multi-institutional, regional engagement around health equity that can be replicated nationally. The AAMC hopes this report prompts leaders in academic medicine across the nation to develop, strengthen, and scale up community-engaged partnerships to address health equity in their local and regional contexts.

TABLE 1. Roundtable Participating Academic Institutions

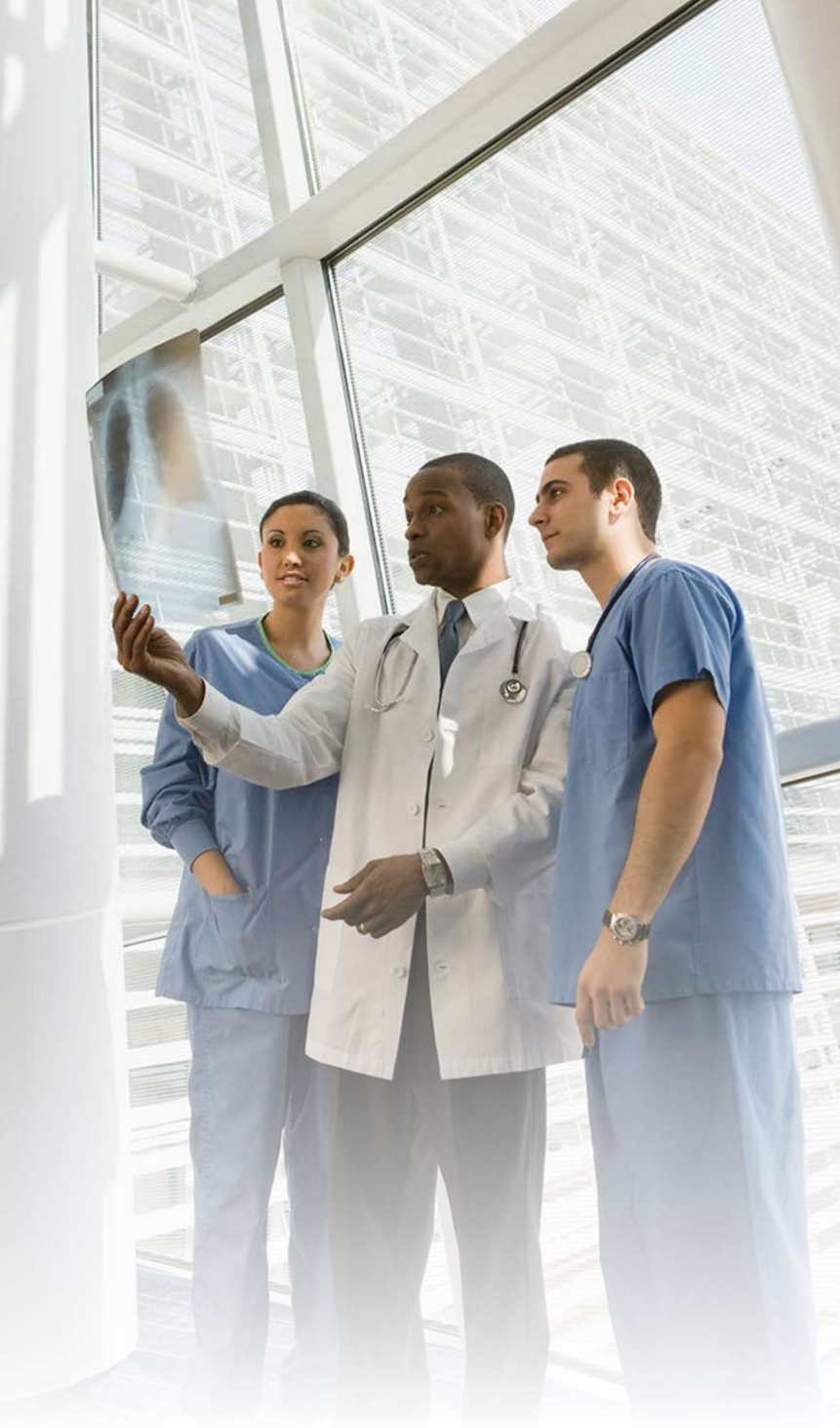
Institution	Medical School	Teaching Hospital	Teaching Health Center
Children’s National Hospital		✓	
Howard University College of Medicine	✓		
Georgetown University School of Medicine	✓		
MedStar Health		✓	
The George Washington University School of Medicine and Health Sciences	✓		
The George Washington University Hospital		✓	
Uniformed Services University of the Health Sciences F. Edward Hébert School of Medicine	✓		
Wright Center for Graduate Medical Education at Unity Health Care			✓

TABLE 2. Roundtable Participating Community Partner Organizations

Organization	Nonprofit Partner	Local Government
AAMC Community Advisory Group	✓	
D.C. Behavioral Health Association	✓	
DC Health (District of Columbia Department of Health)		✓
Food & Friends	✓	
Mary’s Center	✓	
Mentoring in Medicine	✓	



2 | Terminology



The following terms were used throughout the roundtable and in this report.

Anti-racism is “a process of actively identifying and opposing racism. The goal of anti-racism is to challenge racism and actively change the policies, behaviors, and beliefs that perpetuate racist ideas and actions.”⁵

Community engagement is “the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the wellbeing of those people.”⁶

Health care inequity is “a measurable, systemic, avoidable, and unjust difference in health care access, utilization, quality, and outcomes between groups, stemming from differences in levels of social advantage and disadvantage.”⁷

Health inequity is “a measurable, systemic, avoidable, and unjust difference in health between groups, stemming from differences in levels of social advantage and disadvantage.”⁷

Health disparity is “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group;

religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”⁸

Social determinants of health are “the conditions in which people are born, grow, work, live, and age and the wider set of forces and systems shaping the conditions of daily life. [They include] economic policies and systems, development agendas, social norms, social policies, and political systems.”⁹ Social determinants of health can be grouped into five domains: economic stability; education access and quality; health care access and quality; neighborhood and built environment; and social and community context.¹⁰

Social needs are the immediate and critical needs as prioritized by individuals, such as access to healthy food.¹¹

Social risk factors are “the adverse social conditions associated with poor health, such as food insecurity and housing instability.”¹²



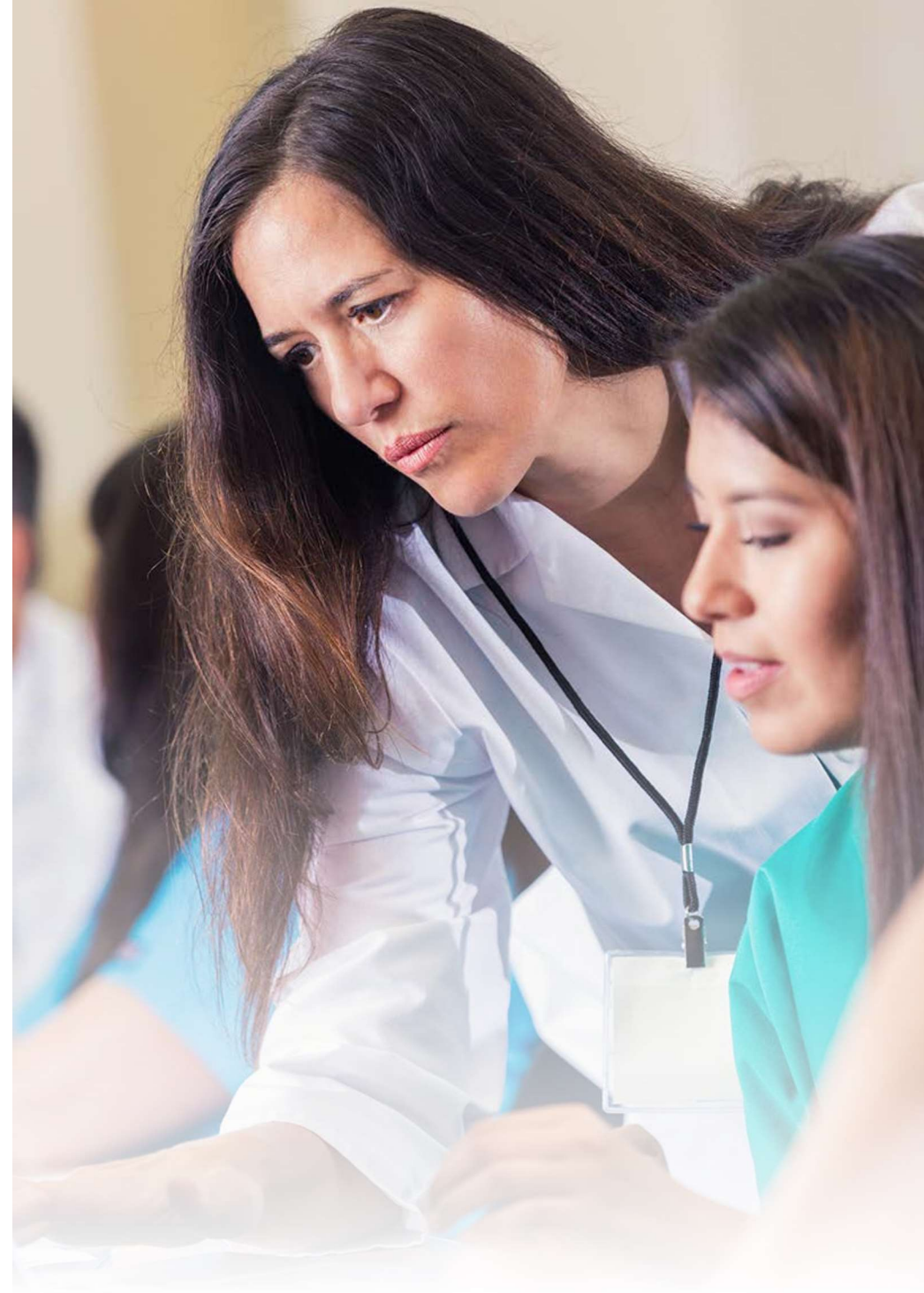
3 | Recommendations: Promising Strategies for Addressing Health and Health Care Inequities in the District of Columbia

This section summarizes key findings and the recommendations for medical schools, teaching hospitals, and residency programs derived from the roundtable discussions between the participating medical institutions and local community partners for addressing health and health care inequities in the District of Columbia. We also highlight current initiatives at several participating institutions as examples that align with the recommendations.

RECOMMENDATION 1: Develop equity-centered, community-engaged didactic and experiential learning opportunities within medical schools and residency programs.

- Engage community members in developing educational opportunities.
- Offer required, elective, and volunteer opportunities for learners.
- Explore opportunities to collaborate locally and regionally with the health department, community organizations, and other medical schools and residency programs.
- Include health equity measures in existing and new learner assessments.

D.C.-area institutions use multiple approaches to apply an equity lens to medical student and resident education, including implementing or exploring the integration of an anti-racism lens into the curriculum. Participants shared approaches that spanned elective, required, and volunteer learning opportunities that emphasized social determinants of health and health inequities. They also underscored the importance of co-designing service-learning experiences with community partners, eliciting community feedback throughout and at the conclusion of courses, and ensuring shared goals for the community partner and academic institution.





George Washington University’s [Clinical Public Health Summits](#) engage learners with health care, policy, and research leaders, as well as patient, advocacy, and community-based organizations to creatively address real-world public health issues.¹⁸ Held each year of the medical school program, the multiday summits use applied-learning experiences to expand and deepen learner knowledge about public health research and practice.

Unity Health Care’s [National Family Residency Program](#) emphasizes education and training in health disparities and the social determinants of health. The program demonstrates its commitment to health equity by requiring community-oriented primary care modules throughout all three years of residency in concert with a health equity focus.¹⁶

Participants promoted strategies such as including community members on curricular advisory boards to assist in the design of the curriculum and developing locally relevant competencies and learning objectives. Others recommended inviting community members as guest speakers to highlight patients’ lived experiences and to humanize and contextualize what learners encounter in lectures and textbooks. Learner participants wanted more practical experiences and learning materials that demonstrate an inclusive curriculum showing the full range of disease presentations across all races and ethnicities.

Institutions in the region offer a variety of health equity-related curricula. Some offer specific courses, programs, or tracks related to health equity (Table 3). Offerings in population health¹³ and health justice,¹⁴ interdisciplinary ethics and jurisprudence,¹⁵ and multiyear required courses in community-oriented primary care¹⁶ and patients, populations, and systems¹⁷ help students identify barriers to care for marginalized populations. Participants suggested exploring the possibility of developing a collaborative regional approach to medical education that aligns with priorities set by DC Health as the chief health strategist for the district. This approach could enhance educational experiences through partnerships with districtwide initiatives and learning about the agency’s role in promoting public health and health equity.

TABLE 3. Health Equity-Related Courses, Programs, and Tracks

Course, Program, or Track	Institution
<ul style="list-style-type: none"> Population Health Scholar Track Health Justice Scholar Track Patients, Populations, and Policy Course 	Georgetown University School of Medicine
Introduction to Health Care Ethics and Jurisprudence	Howard University
Community-Oriented Primary Care Program	Unity Health Care
Patients, Populations, and Systems Courses	The George Washington University School of Medicine and Health Sciences

Participants recognized the need for more health equity assessment tools in medical education. Some institutions incorporate health equity into written exams or objective structured clinical examinations (OSCEs). Other evaluative tools measure the impact of the curriculum on behavior changes in students, such as increasing their referrals to social services, choosing a different specialty, or engaging in advocacy work after an educational program.



RECOMMENDATION 2: Explicitly link diversity, equity, and inclusion (DEI) values, efforts, and outcomes to institutional culture, policies, and programs.

- Embed DEI values across all institutional mission areas, including prioritizing them in curriculum, research, and faculty development and advancement policies.
- Foster a more diverse and prepared health and research workforce to improve the quality of care.
- Engage institutional stakeholders, including learners and faculty, as leaders in advancing DEI goals.
- Ensure institutional and leadership accountability metrics include outcomes centered on DEI.

Participants described how momentum is increasing around several DEI areas that are necessary to advance health equity: senior leader acknowledgment of institutional racism, commitment to dismantling institutional barriers for marginalized groups, and development of DEI accountability metrics for senior leaders with the hope that this will lead to sustained institutional change. Participants emphasized the importance of conceptualizing DEI work as integral to the mission rather than considering it a peripheral endeavor. This can be achieved by protecting budgets for this work. Moreover, participants noted embedding this commitment into strategic plans with tangible action steps allows institutions to continue leveraging efforts that have been effective in removing barriers to entry, retention, and advancement of students and faculty. Examples of how DEI values, efforts, and outcomes can be linked to institutional culture, policies, and programs include targeted outreach and recruitment, mentoring and development programs, and the adoption by all departments of accountability metrics based on DEI goals.

Institutions in the district are developing structures and cultures that embrace health equity through strategic alignment with institutional DEI goals. Participants reported that institutions often rely on DEI offices to advance institutional DEI goals, though with limited resources and support. These offices are typically charged with diversifying the physician workforce, improving institutional culture and climate, and creating equitable policies for learners, faculty, and staff that may ultimately drive health equity improvements within the patient population and local community. Although these DEI efforts contribute to a goal of achieving health equity, they are often carried out in isolation, without the benefit of partnerships with other institutional offices and departments that have similar health equity goals. Improving departmental coordination and distribution of institutional resources is needed to achieve greater impact of those efforts within institutions and communities.

Two primary ways local institutions aim to improve health equity locally is to produce a diverse physician and research workforce and embrace learners as key institutional stakeholders and change agents in their academic and community environments. Participants emphasized the importance of recruiting students from backgrounds underrepresented in medicine and from the district. They also acknowledged that learners model and pass down a legacy of community engagement and commitment to improving health outcomes in marginalized communities to incoming classes each year. Therefore, institutions should leverage learners' passion for health equity and advocacy by aligning learners' educational experiences with districtwide health equity priorities. Discussions highlighted the ongoing need to prepare, train, and partner with current and future talent to fulfill the institutional DEI goals and mission.



Georgetown University, The George Washington University, and Children's National Hospital play active roles on the D.C. Career and Technical Education Industry Advisory Board for Health Sciences, coordinated by the Office of the State Superintendent of Education. Through that involvement, they organize programs and internship opportunities for D.C. public and charter high school students to explore health career pathways while also demonstrating early on how they can apply their knowledge and skills to address community health needs as students and future trainees.

The [Mentoring in Medicine Program \(MIM\)](#) program, from which the learner participants in the roundtable were recruited, provides programming, resources, and mentoring to students who have been historically marginalized and are underrepresented in medicine.¹⁹ National programs with a multicity emphasis, such as MIM, that intentionally diversify the health care workforce may also help improve provider-patient relationships and rebuild trust between marginalized communities and the medical profession. When providers have the same lived experiences or cultural backgrounds as those they serve, emphasizing this common bond can help bridge long-held distrust between underserved populations and the medical community.

The **Uniformed Services University of the Health Sciences** realized that although people of color are the numeric majority in enlisted ranks of the U.S. armed forces, they remain underrepresented in terms of who pursues and completes a medical degree. As a result, the university created the [Enlisted to Medical Degree Preparatory Program](#) to provide pathways into medical school for active duty enlisted people who have a bachelor's degree.²⁰ As the program's first cohort graduates from medical school in 2021, the university will follow which specialties graduates pursue and the populations they choose to serve so it can measure the program's impact on advancing health equity.



RECOMMENDATION 3: Leverage the roles, expertise, and enthusiasm of learners and of leaders and staff in offices of community engagement and government affairs to partner with local communities to address social determinants of health and advocate for change.

- Coordinate engagement approaches internally and leverage the expertise of community engagement and government affairs offices.
- Partner with community organizations and residents and prioritize their concerns in the advocacy efforts of academic medicine.
- Provide dedicated time for students and residents to receive training and experiences in advocating for health equity.

Proactive, bidirectional engagement among community and government partners, academic medical institutions, and other multidisciplinary stakeholders generates opportunities for them to co-create and advocate for solutions, services, and interventions to improve health equity locally. Opportunities for meaningful engagement with local communities exist across academic medicine's mission areas. Participants emphasized the importance of collaboration among community engagement and government affairs offices, learners, and communities to address social needs, reduce social risk factors, and jointly advocate for policies to advance health equity. Currently, local institutions focus on addressing social needs at the bedside, reducing social risk factors through referrals and partnerships with community-based organizations, and supporting advocacy efforts to address

upstream social conditions for marginalized populations. Participants strongly expressed their interest in addressing social determinants of health through coordinated, community-centered approaches.

Community engagement offices can be centralized hubs for organizing and coordinating engagement efforts across institutional mission areas, which can decrease work traditionally done in silos. In addition to improving the coordination and visibility of community efforts, institutions should increase the efficacy of those efforts and measure their impact on health equity. These offices can increase the efficacy and visibility of districtwide initiatives and advocacy at the local and federal levels by working with partnering entities in the district and the D.C. metropolitan region, including community-based organizations, academic medical institutions, and DC Health.



Children's National Hospital was the first U.S. pediatric hospital to launch a hospital-based department focused on child health advocacy. The [Child Health Advocacy Institute \(CHAI\)](#) works to achieve health equity through community engagement, data, education, and policy.²¹ As part of the CHAI, the Leadership in Advocacy, Under-resourced Communities and Health Equity (LAUnCH) track is for medical residents interested in advocacy and community health care delivery.²² Residents align their work in the community with the CHAI's health policy agenda. The hospital adopted a unique leadership approach by having one medical director oversee the work in both the CHAI and the residency program. This means advocacy can be a prominent component of the curriculum through LAUnCH while clinical experiences are informing policy development and advocacy efforts.

Underscoring **Unity Health Care's** commitment to supporting advocacy as a part of the curriculum is their leadership and advocacy rotation, which gives residents dedicated time to gain experiences addressing social risk factors such as domestic violence and food insecurity. Residents also attend D.C. Council meetings and have opportunities to advocate on Capitol Hill. The track includes an applied research project where learners propose solutions to identified critical health needs. In recent years, one resident partnered with DC Health and DC Greens, a nonprofit dedicated to advancing food justice, to advocate for and assess the Produce Rx program. This program provides prescriptions for fresh, nutritious foods to residents in Wards 7 and 8, areas that experience high poverty rates and food deserts. Other residents have advocated for increasing bike-share access in under-resourced communities and providing funding for hotel stays during the COVID-19 pandemic.

Collaborating on equity efforts regionally can decrease the unintended harm often caused by the unsustainable or duplicative efforts of isolated institutional approaches. While some AAMC-member institutions collaborate on community health needs assessments, others do not. The opportunity is ripe for a collective focus on improving equity through tangible and sustainable efforts aligned with the strategic needs and priorities developed by DC Health for the district.¹⁹

Informed by deeper relationships with community members, community advisory councils, and the local health department, medical schools' and teaching hospitals' advocacy agendas, led by their government affairs offices, can be broadened to include policy and legislation related to addressing social determinants of health. In addition, providers' and patients' formal and informal testimony to policymakers can build on and amplify the local advocacy efforts of community organizations and residents. Participants emphasized the importance of designating and protecting time for learners to develop the advocacy and leadership skills they will need as physicians to contribute to legislative and policy work.

Participants also mentioned the need for institutions to demonstrate their commitment to building, maintaining, and modeling bidirectional partnerships through ongoing discussions with community partners and health care stakeholders about institutional practices related to quality of care, inclusion, respect, and anti-racism and other identity "isms."

RECOMMENDATION 4: Critically examine research and clinical care practices for evidence of equity-centeredness in design, implementation, and outcomes.

- Underscore the value of health equity in research through faculty development and policy change.
- Revise clinical practices and policies to address health disparities, social determinants of health, and social risk factors.
- Center community voice and feedback in all research and clinical endeavors to improve health equity.

Institutions are broadening efforts to embed equity across clinical care and research mission areas to strengthen community-academic partnerships and create collaborative solutions that center communities' voices. Participants outlined an ongoing need for institutions to provide professional development in health equity, review research policies and practices, and require evidence of equity in research design to transform how research is developed, conducted, and disseminated. To improve clinical care, the group discussed opportunities for continuing education and training in the social determinants of health, the use of stratified data to inform practice, and the transformation of payment models to support improved population health. Participants said a key element in driving change is aligning promotion and tenure processes with efforts to achieve health equity. This includes giving credit for community-engaged research and service in faculty advancement and allocating institutional resources to support faculty and staff in community-focused practice.

Using an equity lens in research and clinical care requires a transformation in how data are collected and used for care delivery and how findings are translated within communities to achieve better health outcomes. Participating institutions described quality-improvement examples, such as disaggregating data by race and ethnicity to identify health care inequities among patient population groups and increasing health system investment in electronic systems to capture and evaluate the stratified clinical population data. Equity in clinical settings should also include coordinated access to high-quality care in historically

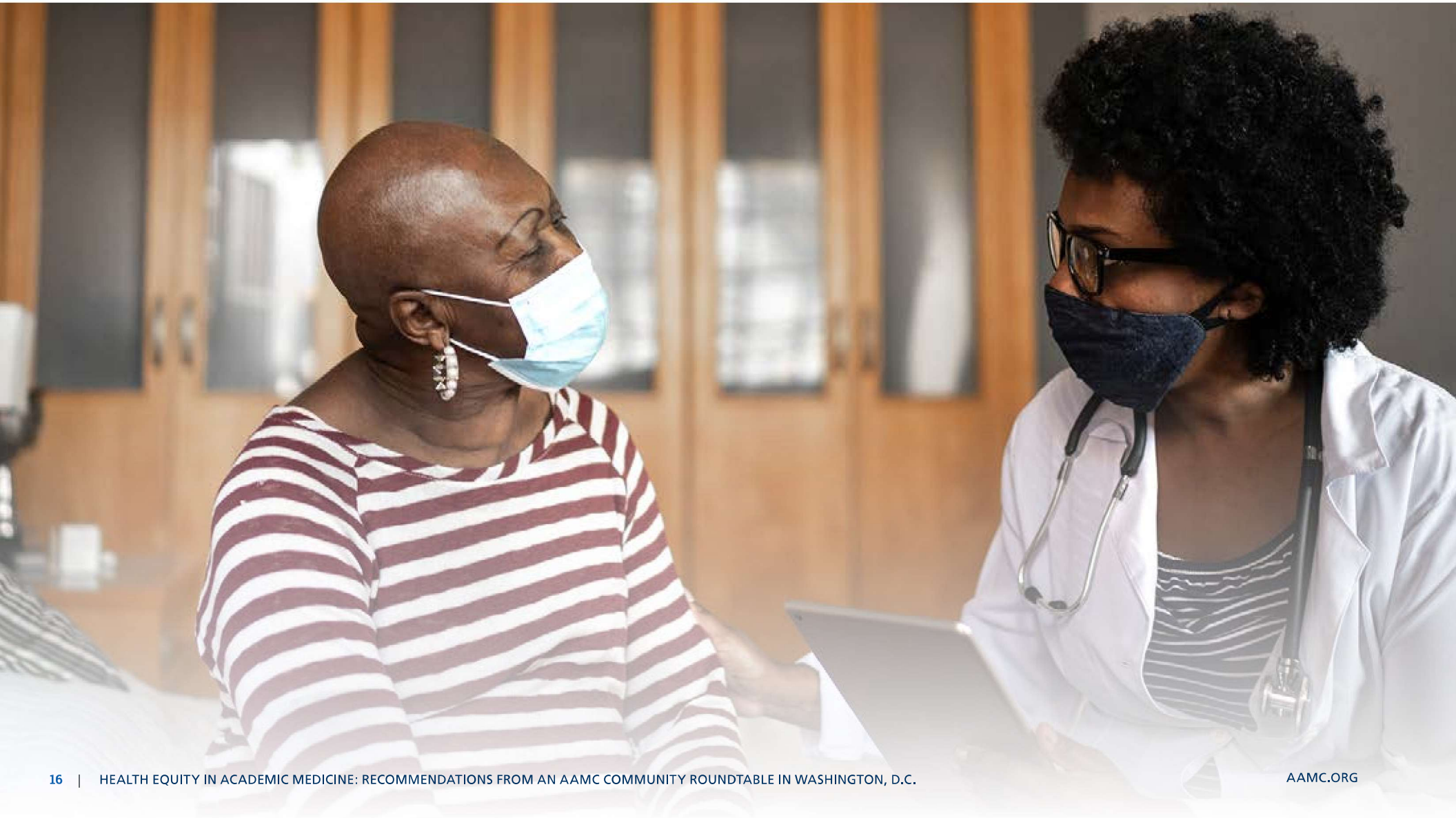


For community-based research efforts, **Unity Health Care's** proposal-review process helps researchers understand the impacts of their research design on health equity. Using a point system based on the priorities of community partners, the institution asks researchers to address community concerns in their proposal. Factors include unintended negative consequences of the research, the impact on care delivery, the amount of undue burden on patients, and whether the research specifically addresses inequities. Pushing researchers to consider community stakeholders at all stages of the research process will result in research designs that are more equity based.

underserved and under-resourced communities such as D.C. Wards 7 and 8, whose population is more than 90% Black or African American.^{23,24} Participants agreed about the importance of incorporating community voices, experiences, perspectives, and priorities at the outset of all clinical and research endeavors. This is a critical component of building longstanding and trustworthy community-academic partnerships, identifying potential gaps, and solidifying continuous feedback loops that promote shared leadership when working to advance health equity.

Participants wanted to understand and respond to the social needs of patients but noted the lack of a consistent approach across health

systems or other health-related organizations within D.C. Participants expressed interest in financial models that reward and thus prioritize addressing social determinants of health in the clinical setting. Moreover, participants suggested institutions consider integrating digital platforms for addressing social needs (e.g., Aunt Bertha’s findhelp.org) into their work and partnering with other organizations in the district that have a longstanding history of effectively addressing these needs (e.g., Mary’s Center, Food & Friends, Capital Area Food Bank). The district has an opportunity to implement these approaches through developing a coordinated network of ambulatory health care services, including primary and specialty care, as plans develop for new integrated care facilities in Wards 7 and 8 to improve health equity for all residents. DC Health encouraged institutions to make financial investments — beyond those reported to the Internal Revenue Service for not-for-profit hospitals — that focus on addressing social determinants of health and, specifically, the areas of focus highlighted in the *Health Equity Report: District of Columbia 2018*.²⁵





4 | Conclusion and Next Steps

The COVID-19 pandemic and racial justice uprisings of 2020 forced institutions in the Washington, D.C., metropolitan area to upend “business as usual” and imagine new ways to collaboratively address health inequities and systemic racism.

Though academic medical institutions have partnered with each other and the community to promote health equity and build a more diverse health workforce, they are primed to continue increasing their local and national impact. This begins with recognizing and addressing the barriers that prevent a broad emphasis on health equity: uncoordinated relationships with local communities and DC Health, duplicate efforts across academic medical institutions in Washington, D.C., without fostering collaboration, and lack of emphasis on health equity as a core value of the institution.

Despite these barriers, there is ample opportunity to explore new and deepen existing partnerships with stakeholders in the region. Leveraging DC Health’s knowledge and experience could not only strengthen institutions’ research, education, and clinical efforts but also help create a more unified approach to addressing health inequities across the district. Further alignment could be achieved by adopting a regional approach to medical education. Exploring creative consortia or co-sponsored courses and degree programs that go beyond traditional programmatic and institutional boundaries may increase the potential for collective impact by decreasing the duplication of effort in offering similar courses, programs, and tracks and increasing collaboration among the region’s institutions. Additionally, local academic medical institutions could explore formally developing a community-academic partnership for equity to generate measurable, collective impacts on equity and coordinate efforts across medical education, research, clinical care, advocacy, diversity, and community engagement activities.

The roundtable was a critical first step in creating a collaborative regional framework for advancing health equity in the district. The AAMC will continue to engage key stakeholders in developing and refining a framework to create a replicable model for regional engagement across the country. This work aligns with our 10 bold plans for action in the AAMC Strategic Plan to lead and serve our members across four mission focus areas: learning, discovery, health care, and community collaborations.²⁶





People in academic medicine should consider several key points when adopting a regional approach to advancing health equity:

- 1. Build on preexisting relationships and shared local context:** Identify and leverage partnerships in new or enhanced directions to achieve common goals.
- 2. Engage senior leaders:** Gain support for collaborative discussions to address challenges that arise.
- 3. Prioritize inclusivity:** Consider whose voices and perspectives are missing from the discussion, invite them to participate at the outset, and be responsive to their contributions.
- 4. Focus discussions on successes and failures:** Deepen the potential for innovation by sharing not only promising practices and achievements but also unsuccessful approaches, barriers, and unmet needs.

This report highlights the continued need for institutions to intentionally embed community engagement in advocacy, clinical care, education, and research efforts. Academic medicine is well-suited to help increase awareness, instill a sense of urgency, and recommend actions to address the social determinants of health through bidirectional partnerships with organizations in the region that regularly develop and implement solutions focused on issues such as food insecurity, affordable housing, economic stability, and access to transportation. An emphasis on advocacy efforts among communities, academic medicine, community-based organizations, government and public health entities, and other multidisciplinary stakeholders is central to addressing health care access and other social and structural determinants of health that affect population health outcomes for marginalized communities. Achieving health equity and a healthier future for all requires a collective intention to listen to and learn from communities and center community expertise and voices when developing and implementing policy, practice, and program solutions across mission areas in the District of Columbia and beyond.



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6 | Appendices

APPENDIX A. Full List of Recommendations

- 1. Develop equity-centered, community-engaged didactic and experiential learning opportunities within medical schools and residency programs.**
 - Engage community members in developing educational opportunities.
 - Offer required, elective, and volunteer opportunities for learners.
 - Explore opportunities to collaborate locally and regionally with the health department, community organizations, and other medical schools and residency programs.
 - Include health equity measures in existing and new learner assessments.
- 2. Explicitly link diversity, equity, and inclusion (DEI) values, efforts, and outcomes to institutional culture, policies, and programs.**
 - Embed DEI values across all institutional mission areas, including prioritizing them in curriculum, research, and faculty development and advancement policies.
 - Foster a more diverse and prepared health and research workforce to improve the quality of care.
 - Engage institutional stakeholders, including learners and faculty, as leaders in advancing DEI goals.
 - Ensure institutional and leadership accountability metrics include outcomes centered on DEI.
- 3. Leverage the roles, expertise, and enthusiasm of learners and of leaders and staff in offices of community engagement and government affairs to partner with local communities to address social determinants of health and advocate for change.**
 - Coordinate engagement approaches internally and leverage the expertise of community engagement and government affairs offices.
 - Partner with community organizations and residents and prioritize their concerns in the advocacy efforts of academic medicine.
 - Provide dedicated time for students and residents to receive training and experiences in advocating for health equity.
- 4. Critically examine research and clinical care practices for evidence of equity-centeredness in design, implementation, and outcomes.**
 - Underscore the value of health equity in research through faculty development and policy change.
 - Revise clinical practices and policies to address health disparities, social determinants of health, and social risk factors.
 - Center community voice and feedback in all research and clinical endeavors to improve health equity.

APPENDIX B. Roundtable Topic Area Sample Moderator Questions

Roundtable Topic Area	Questions
Medical Education	<ul style="list-style-type: none"> • How has your institution integrated health and health care disparity topics into undergraduate and graduate medical education curricula? • How do you balance what is elective or supplementary education versus what is required for all students? • Are there any examples of community-informed education in your curriculum? • What opportunities do we have to engage faculty in curriculum development and programming? • What role(s) have students or residents played in curriculum redesign and development to enhance teaching about public and population health principles? • What ongoing efforts, if any, are in place to build or sustain relationships with K-12 education partners to enhance educational opportunities? • What enhancements or additions, if any, did your institution make to the curriculum to address the health disparities related to COVID-19?
Diversity, Equity, and Inclusion	<ul style="list-style-type: none"> • How is your DEI work linked to institutional efforts to reduce health and health care disparities? • Are there examples of efforts to attract, recruit, retain, and support underrepresented and marginalized students, residents, faculty, and staff that are linked to improved health outcomes or reduced health disparities? • How is your office's strategic plan tied to the institutional mission? • How have you evaluated your work and used these outcomes data to facilitate increased institutional support? • What practical tools do you use to promote awareness and training about bias and discrimination in the health care system and learning environment? • What ongoing efforts, if any, are in place to build or sustain relationships with K-12 education partners to enhance educational opportunities? • What's the level of integration between departments to minimize silos? • How was the office of DEI leveraged to respond to the disparities seen in the COVID-19 pandemic?
Community Engagement and Corporate Social Responsibility	<ul style="list-style-type: none"> • What does community engagement look like for your institution (e.g., limited to a specific area such as research or advocacy or embedded throughout)? • How is community engagement and, specifically, corporate social responsibility tied to local community health needs assessments? • How have you leveraged hiring practices, procurement, and investments to address social determinants of health locally? • What specific population data are you collecting to identify and address health disparities? • What ongoing efforts, if any, are in place to collaborate with local nonprofit partners to eliminate health and health care disparities? • What opportunities exist for learners and residents to engage in programming? • How does your institution measure social impact? • How has the community engagement work shifted during the current pandemic?

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APPENDIX B. Roundtable Topic Area Sample Moderator Questions (continued)

Roundtable Topic Area	Questions
Advocacy and Policy	<ul style="list-style-type: none"> • How has your institution engaged with local, state, and federal elected officials and agencies on issues related to health disparities and social determinants of health? • How does your policy agenda link to the community health needs assessment? • How, if at all, does your institution collaborate with community organizations to form your policy agenda? • What opportunities exist to engage learners and residents in advocacy and policy? • How does an institution best position itself to make an impact on the local, state, and federal levels? • How has the policy agenda regarding health disparities shifted during the current pandemic?
Research	<ul style="list-style-type: none"> • What drives your institution’s research agenda, and in what ways is it community informed? • How do you build and sustain community trust and buy-in? • In what ways have research findings been used to inform policy changes at the local, state, and national levels? • What resources are available to connect with other researchers or inform recruitment and mentorship initiatives? • How do we shift from detecting and understanding disparities to implementing appropriate interventions and strategies? • What challenges or barriers do researchers from your institution encounter when pursuing research questions related to health or health care disparities? • How have the research studies and overall research agenda been affected by the disparities highlighted within the pandemic?
Clinical Care and Quality Improvement	<ul style="list-style-type: none"> • What are common opportunities or barriers to applying an equity lens in the quality-improvement work of your institution? • What specific patient population data are you collecting to identify and address health care disparities? • How aware is your institution of health care disparities within the patient population? • What strategies have you employed to address identified health care disparities? • How have you addressed or worked to change institutional culture and values to eliminate health care disparities? • What organizational work groups or task forces are in place to improve transparency of health care disparities and ways to reduce them? • What opportunities exist for learners and residents to engage in efforts to reduce health care inequities? • Is there a relationship between the community health needs assessment and the clinical work to reduce health inequities within the patient population? • How has the clinical care and quality-improvement work of your institution been affected by the disparities highlighted by the pandemic?

APPENDIX C. Community Stakeholder Sample Survey Questions

1. What types of clinical and social services does your organization provide?
2. Which of the following teaching hospitals or medical schools have you partnered with on strategic initiatives? Please select all that apply.
3. What are your current challenges or barriers in providing health care and/or addressing social determinants of health for your client population?
4. In an ideal world, what more would you like to see done to reduce health disparities in Washington, D.C.? Are there stakeholders that are untapped but available?
5. What opportunities do learners and residents have to engage in programming?
6. How has your institution engaged with local, state, and federal elected officials and agencies on issues related to health equity and social determinants of health?
7. Do you participate in health disparities research? How has your organization's health care work benefitted from research by local medical schools or teaching hospitals?
8. In what way(s) do you think local medical schools and teaching hospitals are best positioned to help Washington, D.C., advance health equity?



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