A Systems Approach to Nutrition and Health Equity - HOD Recorder Workbook

Fall 2020 House of Delegates Meeting October 15, 2020

These are the notes that were captured during the actual delegate discussions at the HOD meeting and have not been edited.

Day 1: Thursday, October 15

REPORT-OUT Dialogue #1: Come to consensus on one guiding principle that should be included in an Academy of Nutrition and Dietetics cultural humility tool for members

Table 1

No comments

Table 2

- an on-going process of self-awareness; 2 big themes: education (DPD), self-awareness; don't assume; ask the patient about practices, culture
- 2 main themes: The first was reforming education for DPD and DI programs to include cultural humility and health equity. The second was focusing on self awareness and self reflection.

Table 3

- Broad bias training (such as required self-awareness training) on all types of biases with immersion activities for the student/intern level and require recert every five years for professionals.

Table 4

- Start w/ personal assessment. Be aware of our own personal biases. Connect all the resources that are already available and then, carry it throughout the professional setting. This starts in our academic programs by infusing the education of students and teachers. And then, continues throughout our careers and across all settings. Making it evidenced based. And include a feedback loop.

- Come up with an implicit bias test that deals with food to learn more about implicit biases.

Table 5

- Develop a reference of guiding principles that helps dietitians ask culturally appropriate questions when working with Peoples/Individuals/Populations. This can help establish what conversations are valuable and suitable while keeping in mind potential personal biases.

Table 6

- Develop actionable steps to amplify voices of marginalized populations and increase diversity within our profession with cultural humility and continual self evaluation in a framework of emotional intelligence.

Table 7

- Minimizing microaggressions by creating a safe environment for learning. Use "ouch and learn" method (discussed above) to establish trust and strength relationships.

Table 8

- Building trust main point: provide how to and then examples of open ended questions.
- highlight what would be included: open ended questions and 2-3 other things it would include → will help build trust
- Provide a list of resources to find more information, self evaluations (what questions should I be asking)
- Self reflection is a personal choice- some may not think they need to/ are not ready to self reflect
- We need to challenge ourselves and members to move forward
- To make progress we have to own it
- Resources for self reflection to identify strengths and weaknesses to promote trust building with the understanding that some may not be ready - how can the Academy provide tools, resources and how-to's for members who are ready and may not be ready for self reflection (stuck in the precontemplation stage). How do we challenge ourselves and members to move forward on the health and nutrition equity issue, to make progress and own it.

Table 9

- Commitment to life-long learning and reflection to strive for "other-oriented," mindful communication and interactions

Table 10

- The tool should include a part of self reflection to assess our current status, both personally and as a whole organization , then develop tactics, scripts and tools that address the elements in our code of ethics,that enable us to walk the walk that meet and satisfy the ethical guidelines of cultural humility and nutrition equity.

Auditors Table 2

- Mandatory diversity & inclusion training, education and competency attainment for providing patient or client care and facilitate interaction with our professional peers (in addition to the ethics requirement)

Auditors Table 3

- Tag our political representatives to be in the forefront – lets fix them so that this doesn't continue to occur.
- Work on policies to allow for equal access to academy
- How can we bring existing resources together so that awareness is made for existing programs public/professional like central Florida

- Having the right tools
    a. Food frequency questionnaire
    b. Appropriate for ethnic groups
    c. Languages used – available in other languages

Dialogue #1: Cultural Humility Tool

Question 1: Thinking about the article *Practicing Cultural Competence and Cultural Humility in the Care of Diverse Patients* and Spark session by Winona and the self-reflection on the Implicit Bias Test on Race, what are the guiding principles that should be included in an Academy of Nutrition and Dietetics cultural humility tool for members?

Table 1

- form genuine relationships with patients to bridge gap and increase equity
- working in partnership and eliminate power differentials; simulate partnership with patients
- PARTNERSHIP with patients
- self assessment for cultural humility + action plan section to tie into learning code and portfolio to evaluate properly
- question own biases as humans; socialized to have biases; reflect on those in order to have an effective partnership with patients
- once take bias test, reflect on it; take multiple tests
- Ethics requirement:
    - Start in school in training (DI)- have students do similar tests to avoid future biases
    - embedded into different communities; students immersed in cultural diversity; lifelong processes of curiosity of other peoples cultures and experiences.
    - Students aware of different types of biases; until you're aware of a problem- cant fix it until pointed out to you
- pg. 49: eliminating power dynamic; training dietitians to be better communicators with patients to view situations from patients perspective

Table 2

- cultural humility tool for members?
- reflection needs to be on-going and a life-long concept
- awareness of personal biases
- continue to reflect and think about what events have occurred that may be influencing their thoughts/ biases/ interactions with others
- knowing your community (academy creating a map of the geographical areas and demographic profile of the area)
- scripting / case studies to appropriately ask those types of questions
- The implicit bias test was eye-opening; important for RDs to take the test! There is opportunity to recognize implicit bias
- cultural humility > cultural competence
- allowing yourself to become comfortable with being uncomfortable; recognizing privilege and internal biases, learning to navigate unexpected results and becoming more aware of biases
- buildup others; putting yourself one step ahead and focusing on positivity; have positive self-esteem and self confidence to move forward
- opportunity to educate/motivate one another
- go to the community that you live/work in as a first step of building up cultural competence/humility
- emphasis on understanding community better (barriers, strengths)
- focus on dietetic interns (competency about biases?); building a foundation for the incoming RDs
- realize that you bring your own biases; don't put assumptions on others
- incorporate more cultural diversity
- listen more than you speak, look for resources, ask for help, function as a community working towards the same outcomes
- assessment tool available for RDs to provide awareness
- acknowledge the historical oppression / awareness
- incorporating more cultures into the nutrition curriculum
- valuing individual experiences
- promotion of trust, respect, etc.
- tools for self-awareness, self-reflection and ongoing self-critique are needed for RDNs to engage in cultural humility (it's an ongoing process involving life-long learning and experiences)
- RDNs will need tools that help them work across sectors and advocate for social justice; we can't focus only on skills related to individual client communication
- importance of shared decision making; value what clients/communities bring to the process and honor it

Table 3

- what is the Academy doing foundationally; how can this be incorporated in education for students
- some schools already have cultural competency certificate programs, but these questions may be stereotypical; compared to the Winona session on cultural humility
- we need to focus on internships and DPDs, training the next generation of dietitians in these topics and biases

- not only education, but life-long learning/training ourselves as professionals is important
- nutrition professionals should build accountability within our profession/the Academy by making these trainings/learning topics required as mandatory contracts, so
- making all education pieces required makes for an equal playing ground and exposes students and professionals to various topics
- we need to do more than a webinar; how do we help to change students mind/change attitude
- self-reflection of members, we all have biases that we do or do not recognize
- look at how students are selected for different internship locations; many times chosen based on biases (even if subconsciously); how can we change this?
- have bias training required for all dietitians; every dietitian could take an IAT in various topics
- this could be one way to bring topics of diversity to the forefront of our minds, so they understand where they are with their biases (on weight, gender, race, etc.)
- just like the health at every size movement impacted weight, training for inclusion on every level should be inquired
- self-reflection is one thing and self-critique could be a step further; we should partner with other groups so we don't try to reinvent the wheel on inclusion and diversity; we must ensure that the Academy displays more humility toward other cultures and populations
- we must be challenged in our thinking by being exposed to various environments, cultures, peoples, etc.
- education for future RDs and self-reflection and life-long learning for current RDs
- we must have a growth mindset over fixed mindset; empathy instead of sympathy
- more than just ethnicity needs to be addressed if we are seriously going to address bias
- requiring educational programs for DPD, internships at the educational level and CPE requirement (discussing to use IAT training as credit) and incorporating this as a competency at the professional level
- not only about incorporating bias education sessions or webinars, because this may not be enough!; we need to travel within our communities, in order to see different environments; hands-on activities could be incorporated; experience is so important; immersive activities
- at the local level, we can partner with community organizations; at the national level, the Academy can partner with national organizations
- we should not look at people as projects, but we should partner with the people to help them; we can learn from each other as people, have conversations and not just always try to fix the problem
- to do good is not enough--we must be good ourselves
- incorporation of the following is vital: broad bias training, educational piece, immersion activities, and member interaction training
- the above activities should not just be boxes to be checked off, but there should be an interaction and involvement in our daily practice

Table 4

- Whenever you come to the conclusion of using the tool, determine next steps, and how to know if those next steps are effective.
- #13 from article. Inquire about what the patient feels would be helpful, including previous practices/home remedies and their results.
- Ask whether the patient will be compliant and have a good conversation about why. If not, come together with new recommendations. Don't assume whether they will or not.

- Decide together what would be the best treatment versus just giving recommendations.
- Provide concrete practical examples of how it applies in practice.
- Helping patients make decisions/come to a conclusion for themselves.
- When giving suggestions, meeting patients where they are at. Listen to patients and don't put them in a box. We can't standardize things (can't have a list of x, y, and z to reduce lipids)
- Have to be prepared to be culturally diverse.
- Making broader statements when talking with patients to individualize care. Check first what patients are taking for their disease state and understand.
- Use tools with students and their understanding.
- Can't create a standard type of tool, rather guidelines for interviewing.
- Similar to IAT, use tools to show where we may have biases or lost constructs of humility. Once you take assessment, guide for a webinar or something to improve.
- When interviewing, figure out what is known to them but not known to us. i.e. using herbal supplements rather than medication.
- Come up with an implicit bias test that deals with food to learn more about implicit biases. i.e. What do we assume if someone is overweight?
- Whenever you come to the conclusion of using the tool, determine next steps, and how to know if those next steps are effective.
- Overall, didn't care for the tool (IAT). Seemed like more of a skill to figure out the buttons.
- Start w/ personal assessment. Be aware of our own personal biases. Connect all the resources that are already available. Then, carry it throughout the professional setting. Student to professional to preceptor. This starts in our academic programs (or in teaching and training).
    - Need to then follow through with self education and tailor it to each professional
    - Should be evidenced based and include a feedback loop to ensure it was effective.
- We don't know what we don't know. We need to be aware.
- Focus on health disparities and counseling different populations.
- Working at the patient level, seek first to understand. Make sure that you have the right person in front of you. Find their preferred language and use motivational interviewing.
- Learning about a culture isn't enough to prepare you to work with that community. Need to realize there can't be a cookie cutter approach.
- Evidence based. We need to identify that there is evidence to support it.
- Getting to know your individuals. Using case based training as dietitians and for students. Without being stereotypical.
- Patients may walk away because the food is not available to them. Makes dietitians seem less credible.
- Ask, acquire, don't assume.
- Shouldn't turn into a "how to counsel tool".
- It isn't about teaching counseling.

Table 5

- Cultural humility including many facets; disabilities face more inequity in healthcare than other populations
    - Focused on personal needs
- Definition of cultural competence vs humility & awareness
- Patient centered care

- Include Empathy -- how individual feels about personal care
    - how culture & beliefs impacts patient response
- How to openly ask questions regarding people's cultural experience in an appropriate manner
    - interpretation, listening & response
    - ways to practice cultural humility in a professional setting
- Examples of potential biases & ways to avoid offending individuals
- Focus on shared characteristics and build off similarities rather than differences
    - humility -- not assuming one knows everything about the individual
- Finding comfort level with others & build on shared information
    - not confronting them, but gaining a better understanding in a professional and comfortable way
- Integration of humility by setting a predetermined precedent of operation.
    - Questionnaire to avoid assuming a shared cultural interest
- A professional definition of "Culture" -- what captures a culture while celebrating those differences
- How to learn & acknowledge your own personal biases
- How to communicate to a patient / client to establish the relationship with their cultural outlook in mind
- Training--A way to openly & appropriately ask the right questions to not portray microaggressions
- Communication Skills-- How to talk about differences, even if the conversation is uncomfortable
- Motivational Interviewing talking points -- Dos & Don'ts

Table 6

- Lifelong learning, plan to continue studying about other cultures
- Be a forever student, in terms of cultures and your ability to be adaptable
- Emotional intelligence, captures being self aware
- Hard to understand cultural humility, therefore participating in tools will help understand and inform implicit bias (readings can be helpful).
    - Resources should be available for different levels of cultural humility (beginner, intermediate, etc.)
- It is important to look at all the cultures we are exposed to because the cultures can vary on location (there can be more diversity within a culture)
- Video training for FNCE was informative
- A lot of research used is Eurocentric, we need to figure out how to look at nutrition research in a broader context.
- Representation in the Academy, recognize it and give more platforms to minority groups.
- Developing communication skills in terms of cultural humility.
- Knowledge and resources are very important, but it can be hard to put thoughts into action
    - Participation from under represented groups is necessary.
- Work on ourselves first to open up , it is not other's problems to fix.
- Have actionable goals, this will show progress.
- Look at policies within the Academy that may exclude
    - Masters degree as a requirement. Look at ways to support students financially; scholarships, future model format (4+1 model), inform students and families about Dietetics in healthcare. Diversity rates differ from undergrad to the internship.

- Emotional intelligence has many crossovers with cultural humility

Table 7

- Everyone has implicit bias. It may be an eye opening experience to realize your own implicit biases. This should be recognized as something that can begin in childhood. Self reflect on your implicit biases and be honest with yourself about this.
- Interesting to use "good" and "bad" words in the Implicit Bias Test instead of perceptions of actual events. Test may be too general, maybe would be good to combine this test with another activity or resource. The test has been questioned in terms of accuracy, so we need to include multiple resources. Possibly a test that is more self reflective and asks more open ended questions.
- Cultural competence vs. cultural humility. Important to know the difference between these and have experience and knowledge with both. Need to know how humility moves beyond competence. Nuances in the definitions are important and need to be explained. Add differences between equity and equality. Give examples of each term to better explain differences.
- Listening to others and what they value rather than making assumptions. RDNs may tend to want to simply give nutrition info without fully understanding the culture of the person. RDNs should take the time to gain understanding about the person they are working with. Listen intently and use empathy to experience through the lens of the person you're talking to, not through your own. Ask probing questions to be able to understand the person and be sure to engage in active listening.
- Microaggressions: would be good to have examples of these. Microaggressions may not be intentionally harmful, but can be harmful when seen through the eyes of the receiving person. Talking points about how to back out of that, how to apologize and continue after accidentally committing microaggression. Pt and provider relationship is not equal in power, so pt may not interrupt to tell the RDN without the RDN beginning the conversation. RDN should start this conversation to establish trust between pt and provider. Say something similar to, "This is a learning environment for both of us, I might say something you don't agree with and please let me know If I say something that hurts or stings you. Say 'ouch' so I can learn from you and your experiences." The "ouch and learn" model/idea facilitates asking the client/patient questions so a relationship can be built on trust instead of misunderstanding. Opening a dialogue between the patient and provider will foster a health, trusting relationship. Staying attentive to body language of patient/client will help a provider grasp the gravity that a conversation may hold for a patient. If a patient reacts to a statement, ask if that statement was harmful in any way. Allow a patient to share their experiences with the provider in a space free of judgement. Building a new level of trust between patients and providers will strengthen empathy and compassion for one another.
- Conversation about including delegates for each member interest group.
- Complete the circle by sharing results of Diversity mini grants and promotion grants with Diversity Liaisons and members. What are the outcomes of these grants? What works, what does not work? What are we learning?

Table 8

- Q1. What were your initial reactions to the implicit bias tool for race?

- response- found difficult to do. Don't like following rules and I don't like classifying faces as good or bad. May have been slower at hitting the buttons for the black and bad- it felt bad.
- Second time taking this- I had some messages popping up on screen which may have affected response time. Results are different.
- Felt a little on guard, nervous. Didn't like hitting the bad associating with the black faces. Felt like I had to answer it how they wanted it to be answered.
- Analysis was all about the speed. Were you quicker making one association than the other?
- disappointed that there was not more analysis on the questions we answered- unclear whether these answers were included in the analysis.
- Thought some questions were subjective. Strongly conservative may have led to some conclusions/ lead in one direction. Were optional- interesting to see if the results would differ with/without them.
- Knowing it is an explicit bias test may lead you down a certain path.

- Q2. Thinking about the article *Practicing Cultural Competence and Cultural Humility in the Care of Diverse Patients* and Spark session by Winona and the self-reflection on the Implicit Bias Test on Race, **what are the guiding principles that should be included in an Academy of Nutrition and Dietetics cultural humility tool for members?**
  - Building of trust- collaborate with groups, communities, organizations
    - look at knowledge base
  - With cultural humility being based on self reflection, one of the things needed in the tool kit are **tools for members to do self reflection**- you need a start to get a sense of what you are.
  - tools to know your audience/ population/ community (eg. Native American)
  - Reminders of the definitions. Two sides to the article: 1. look at individuals, 2. look at social determinants of health.
    - Look and reflect on how social determinants of health impacts both individuals and populations
  - Respect for one's culture, beliefs, religion (holidays, holy days, etc), and language
  - We need the "how to" concepts for practitioners
    - include open ended questions
  - Nothing is in isolation- to understand cultural humility in a systematic approach is just one element. suggestion is: the tool demonstrates humility is only one piece of the puzzle in nutrition and health equity.
  - Tools for people to recognize their bias and use it as conversation starters.
  - When you approach a community or individual and you think you have the answers, it turns people off. **Ask open ended questions** and get as much out of individuals as possible when trying to make nutrition recommendations.
  - Become comfortable with lack of knowledge and in silence. Be comfortable listening and use others to use that space to express themselves.
  - Try to incorporate the voice of the patient/ client/ customer/ community (stakeholders)- often these voices are left out.
  - "how to": understand how to talk with leaders and how to reach out to others to provide this "how to"

- Provide a list of resources
- We need to be careful that resources don't keep people from performing self evaluation. (no quick shortcuts).

Table 9

- Guiding principles as practitioners towards clients/patients - but the principles can be invoked with colleagues and students
  - Principles should be implemented in development of programs and services
  - difficult topic that every health professional should review
- Practicing cultural humility is something that you have to keep doing and keep improving on - stay open to new information and points of views --- **ongoing nature**
  - evaluation tool or checklist to pay attention to **self-critique** - one specifically for those you struggle to relate with
- Cultural humility requires listening, understanding, putting yourself in other people's shoes; it's difficult to change people's minds and biases
- "**Other-oriented**" - thinking about the other person's attitudes, beliefs, and concerns
- Race IAT: helpful - if someone is practicing cultural humility & committed to growth, it can still be hard to determine their implicit biases
  - Room for improvement on how you perceive yourself - how you perceive yourself may not be the reality - **be reflective**
  - Questions to consider: When you took the IAT, were you surprised? What did you learn that plays a role in the way a tool is developed? How do we approach practices from other cultures?
  - How do the results shape what to add into our toolkit to improve cultural humility?
- Tools to increase open **communication** - teach/learn how to have an open conversation; how can we help people using the tools they have from their own culture?
  - More **culturally sensitive communication**
  - **Respectful communication** - clear, respectful, targeted toward individual
- **Mindfulness** - stop and listen, check yourself - when you take the time to check yourself you're less inclined to jump into something inappropriate
  - **"what you don't know" approach** - a stronger approach to cultural humility is to think about what don't you know about a culture instead of basing it on a stereotype
- Competemility - intersection between cultural competence and cultural humility - what does this mean to practitioners?
- Microaggressions: take into consideration the way we say things, the questions we ask, the way we educate our clients
- Political discourse can cause mindfulness to be paralyzing and confusing → toolkit can help with this issue
- Desire to learn to about beliefs, customs, and values
  - engagement and interaction needs to be focused on their culture instead of trying to change an individual to be more like you - encompass their culture & work with them from their culture's point of view → "other-oriented"

Table 10

- Several aspects of principles (Code of ethics) we need to be aware of as health professionals. How do we "walk the walk" or practice what we preach.

- Patients need to be able to see themselves in the profession. Providers are not diverse.
- (Education standpoint) How to recruit a diverse student population?
- To have sample communication scripts in the toolkit.
- Research dietetic practice group there is not a lot of diversity. How can we recruit more diverse subjects into these subject groups?
- Representation from multiple demographics and people groups. Advertise in a culturally appropriate manner.
- Become more self aware about how culturally competent you truly are. As well as self reflection about the topic. Self reflection first and raising our own personal awareness of our cultural competence and understanding.
- Policies and practices need to have an active effort to improve employment and educational opportunities.

Auditor Table 1

- Identify our biases within the tool first
- Include terminology and resources within the tool
- Tool to enter into conversations with each other with inclusion of active learning strategies
- Create safe spaces to promote open conversations

Guiding principles

- Ensure members are acting professionally
- Self-knowledge is important but also acknowledgment of how our baggage affects others
- How to make our self reflections an essential practice and part of our strategic planning
- Systems approach in to assure we take this to the next level
- Strategies for the individual are important but need a unified approach to make an impact
- How do we activate our membership to address and advocate “justice” for all people?
- Include self-evaluation and self-reflection in all we do and include as a lifelong goal
- Systems approach to assure sustainability and cultural change

Auditor Table 2

- Group discussed implicit bias test and our results and how we felt about them.
  - Group felt that the test seemed to be “training us” to think a certain way.
  - One person thought that switching the “roles” helped teach us to think differently and group liked that point. When your mind is occupied with a certain activity, you need to focus to switch your way of thinking.
  - Point made that it this tool helped them to realize that if you are engrossed in your work that it is helpful to take a step back to switch your thinking.
- Discussion on whether group members were familiar with the term “cultural humility” before today’s presentation
  - Most group members were familiar with the term due to employer focus and/or role at work

    - Group hoping to be able to bring more information and knowledge related to cultural humility back to her peers and students
- Dialogue on our core question:
    - Something similar to the implicit bias tool as part of the Academy toolbox, require members to take test. Or create tool more related to food and nutrition professionals.
    - Suggestion to create more open tool than one focused on food and nutrition to keep us from keeping our members in a "box". Look more holistically at the issue.
    - Outpatient world - we don't spend enough time on assessing social determinants of health. Language is also not inclusive (example: non-compliant is a poor choice) - recommendations include percentage of compliance, or other more inclusive language which shows that we are looking at the whole patient
        - This could be included in our dietetic curriculum
    - Work to require diversity training as part of state licensure requirements (like the academy which requires 1 credit of ethics training) - consider adding similar requirements nationally - a few members in the HOD have suggested that.
    - Is cultural desire part of cultural humility - is the person interested and willing to learn about the other person's culture. The two are very closely aligned. Without desire, humility is not going to come naturally.
        - Self reflection will help keep cultural humility as a key part of day to day interactions
        - We cannot practice cultural humility unless we have the desire to do so
    - Cultural competency has many levels - learning, understanding biases in ourselves and our system, practice (the more encounters and practice in cultural competence and humility, the more equipped someone is)

Auditor Table 3

(Take Away)

- continual learning process starting at standard level to professional; booklets, videos.
- cultural humility being a process that will not happen overnight.
- broad bias training – age, weight, race, gender, student/ intern level, immigrants, activity training every 3-5 years.
- personal assessments- state with education programs through RD/ NDTR career – feedback loop
- develop references of diversity principles and share on the Academy's website – need a one-stop-shop area for any and all related to diversity.
- actions steps to decrease demoralization of disenfranchised
- microaggression – minimize or elevated in ways we maybe unintentional
- Ouch and learn or ouch and educate
- Acknowledge hard work, okay to struggle but we will get through it
- identify resources for self-reflection, tools and resources
- commit to lifelong learning
- self-reflection