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Codifying DEIJ values in a National Research-informed Training Effort

Abstract

Translating DEIJ values into practice presents significant hurdles, particularly in embedding these values into workplace culture, institutional practices, and research methodologies. Nevertheless, numerous opportunities remain available to enact meaningful change. This methods paper outlines the strategies employed to integrate institutional values of diversity, equity, inclusion, and justice (DEIJ) into the development of the *Two in One: HIV and COVID-19 Screening and Testing Model*, a national research-informed training effort. Named for its goal to routinize both COVID vaccine and HIV screening and testing in one primary care visit, the Two in One team prioritized DEIJ principles to collectively produce innovation, excellence, and applicability. Highlighting the deliberate translation of DEIJ institutional values, this paper emphasizes the significance of an intentional approach to cultivate equitable and inclusive research and training practices. By adopting a DEIJ perspective and acknowledging the communities most affected, we demonstrate how the Two in One Model purposefully incorporated DEIJ values into the development of our program and research initiatives.

This methods paper explains the strategies used to translate diversity, equity, inclusion, and justice (DEIJ) institutional values into the design of the *Two in One: HIV and COVID-19 Screening and Testing Model*, a national research-informed training effort designed to eliminate the stigma and discrimination attached to HIV and COVID prevention via standardized screening conversations for all patients in primary care settings. Our goal is to enhance the ability of primary care practitioners to routinely engage in culturally responsive and nonjudgmental communication about COVID vaccination and HIV screening and testing with their racially, ethnically, sexually, and gender minoritized patients. Below are examples of how we upheld our DEIJ values, prioritized affected populations, and mitigated harm in our research and program efforts amidst ongoing challenges.

Diversity

An institutional value for diversity is not merely focused on *any* form of difference. Would a research team consisting of a statistician, clinician, chemist, and mathematician be considered diverse? To answer this question, we need to observe ***representational diversity*** that only exists when a range of social identities are present.[1-3] The call for representational diversity is necessary for a range of perspectives, worldviews, and values to collectively produce innovation, excellence and applicability.[4,5]

- ***Positionality Statement*:** Our first team publication included a positionality statement to inform readers of the collective social, cultural, and professional identities the team brought to the writing.[6] Positionality statements make visible the factors that shape your stance as well as biases present in the work.
- ***National Advisory Board:*** We curated a committee of experts representing specific content knowledge in areas such as health and racial equity, as well as COVID and HIV. We selected a range of perspectives, including patients, residents, faculty, government employees, and clinicians across a range of racial, sexual, and gender identities.
- ***Images and Messages*:** We purchased stock photos of patients, clinicians, teams, and community members diverse in age, race/ethnicity, gender, and sexual orientation to use in all public media. Our flyers included names, pronouns, and

headshots of all speakers to make visible the range of invited experts (e.g., community organizers, patients managing HIV, researchers, clinicians, government officials).

Equity

An institutional value for equity focuses on identifying and removing barriers to ensure everyone has a fair opportunity. The politicized rhetoric of a zero-sum view on equity produces a belief that some groups lose something by redistributing more resources to other groups.[7,8] On the contrary, equity is squarely focused on repairing policies and the conditions in which people live, not repairing socially disadvantaged groups. Achieving this requires eliminating obstacles such as poverty, discrimination, and their consequences: powerlessness, lack of access to fair compensation, quality education, housing, healthcare, and safe environments.[9] In discussions of equity, everyone benefits.[9,10]

- ***Compensated Time****:* We paid everyone who served on the national advisory board as well as webinar and course speakers for their time and expertise. We did not value clinician time more than a community organizer or patient – everyone was paid the same amount of money for the same amount and type of work.

- ***Population Framing****:* People of color are the global majority. What accounts for their classification as minorities? 'Minority status' is not solely based on numerical status, but social status as well. In other words, people of color are minoritized. We used this language to describe the patient populations who experience historic disadvantages given their racial, ethnic, sexual, and gender identities.
- ***Voice Equity****:* Student researchers on our team were adequately supported to take on leadership roles in research processes. For this reason, we ensured that they earned credit for the work they led by serving as first authors on publications and presentations.

Inclusion

Diversity efforts fall flat without an institutional value for inclusion. To disrupt the tendency to default to the views, interests, and preferences of the dominant group, there must be careful attention to share power across all groups.[11,12] Empowering diverse groups in decision-making fosters validation and safety, enhancing belonging.[13-15]

- ***Program Values****:* We publicly acknowledged the fullness, complexity and within-group differences of minoritized groups on our website, drawing from theoretical models such as queer theory,critical race theory and disability critical race theory to inform our work on heterosexism, racism and ableism. For instance, our research began by focusing on patient stories rather than solely the published literature, aligning with our intentional centering of historically excluded voices.
- ***Branding****:* When creating the program mark/logo, we intentionally used vibrant colors from the LBGTQIA+ flag. We used this mark on all flyers, PowerPoint slides, and the recorded videos that branded the program.
- ***Collaborative Work****:* Our website lists all 19 collaborators who agreed to support our training and program efforts. We also included members of our national advisory board in conference presentations, podcast episodes, and peer-reviewed manuscripts; therefore, our board members were not tokenized but meaningfully engaged.

Justice

Regarding an institutional value for justice, attention must be paid to naming historical and contemporary harms and righting such wrongs. While there are many forms of justice, at the center lies a decolonizing aim to repair injustice and the enduring trauma and intersectional oppression that persists.[16-18] At the root of injustice are macro social ills such as patriarchy, colonialism, and white supremacy, to name a few.

- ***Decolonized Knowledge***: We believe it is necessary to name and dismantle colonialism to push back against those whose knowledge and points of view are validated then banked.[19,20] As such, our live training series included Black women, patients and community organizers as thought leaders, change agents, and subject matter experts on HIV and COVID-19 prevention who can inform medical education and clinical practice.
- ***Antiracist Model****:* We relied on a cross-cultural communication model we call culturally responsive communication that included the impact of racism on health. [21] Our resources and training content extended beyond the culture of patients to include the culture of racism and need to antiracist healthcare practices.

Challenges

Translating DEIJ values is especially challenging when measurably codifying them into workplace culture, institutional practice, and research processes. Challenges include:

- **Resistance to change**

- **Politicizing of DEIJ**
- **Fatigue from structural racism, bias, and prejudice**
- **Buy-in from across institutions and sectors**
- **Time and capacity to make change**
- **Resources**

Conclusion and Next Steps

Though change is not linear and takes time, it is possible through coalition and community building. As more folks reflect on their privilege and bias, they can maximize their impact by removing barriers and creating opportunities within their spheres of influence to mentor and support burgeoning leaders who will champion DEIJ efforts within the foreseeable future. Doing so will allow institutions to live out their social mission, remove inequities that cause prevention efforts to fall flat, and get that much closer to the nation's health goals to achieve health equity.

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