TRIADS

Enhancing Equity and Empathy at Your Clinic

Table of Contents

Purpose

Provide organizations with specific examples of how to concretely and practically develop quality improvement goals around equitable and empathic care.

Introduction

What does it mean to be an empathic, equitable organization and to deliver empathic, equitable care?

This toolkit was developed by Elizabeth Morrison PhD, LCSW, an implementation coach in the California ACEs Learning and Quality Improvement Collaborative (CALQIC), with input from the CALQIC Clinical Advisory Council and Patient Community Advisory Board. This toolkit aligns with TRIADS [Trauma and Resilience-informed Inquiry for Adversity, Distress, and Strengths], which was developed during CALQIC to guide healthcare teams to talk supportively with their patients about adverse childhood experiences (ACEs) and to create healing relationships.

> *We hope this tool will inspire readers to consider many other concrete ways those in the healthcare field can work together towards the continual, purposeful practice of empathic and equitable care.*

Equity and empathy may be considered abstract, philosophical values that organizations use in mission or value statements. What does it mean to be an empathic, equitable organization and to deliver empathic, equitable care? How are equity and empathy practiced? How do we specifically demonstrate equitable and empathic behavior? What policies, practices, words, norms and environmental designs support and express equity and empathy; and, which ones (unintendedly) express racism, discrimination, stigma, implicit bias, and judgment?

This document addresses these questions by providing examples of practical quality improvement goals around empathy and equity. The logic model guiding these examples posits 1) racism, implicit biases and other discrimination are the root causes of health inequities and 2) that healing, resilience and thriving happen in the contexts of empathic relationships. The examples provide specific ways to both increase awareness of, and subsequently dismantle, systemic racism in clinic systems as well as enhance empathic, relational practices. We hope this tool will inspire readers to consider many other concrete ways those in the healthcare field can work together towards the continual purposeful practice of empathic and equitable care.

We grouped the examples into 7 categories: Empathic Environments for Patients and Employees; Policies, Procedures, Workflows; Equity Practices; Trauma Informed Care; Leadership; and Data/QI.

Empathic Environments

Calm, safe and welcoming for patients, families, and staff; staff receive robust training and support

EMPATHIC ENVIRONMENTS

Improvement Goal	Rationale	Example Strategies
Enhance empathy environmentally	Empathic care, including care conveyed through the physical environment, makes patients feel more valued and comfortable, which directly influences their trust in the health care system, leading to better health care outcomes.[1] [2] [3] A lack of environmental empathy is inconsistent with Trauma Informed Care principles. Patient discomfort and non-empathetic environments can lead to stress and frustration, which can escalate to argumentative and conflictual interactions.	Assess the clinic's current level of environmental empathy and develop a patient-engaged project plan to improve/enhance it (see row below). To engage patients in assessment, as well as planning, consider informal patient surveys, focus groups, suggestion boxes, supporting art therapy workshops and incorporating patient artists, etc. Put yourself in the patients' shoes to better understand their perspective - call the front desk anonymously, sit in the waiting room and observe interactions, journey map a patient's movement through the clinical space during appointments
	Visual indicators of multi-cultural and broad identity representation in physical environments enhance feelings of inclusion and acceptance, which have positive impact on relationship-building.[4] [5] [6] [7] [8]	Assess the clinic's cultural responsiveness in relation to the physical environment (i.e., does art reflect the culture and community of patients served?) and incorporate visual displays/information that reflect the cultures and communities the patients come from.
Develop a process to collaborate with patients on environmental changes	The waiting room is particularly important because it is a public space where patients spend a lot of time. All clinical areas, however, should be empathetic environments. When organizations partner with patients to create empathic environments, it mitigates power differentials, increases equity in decision making and can foster genuine "partner" relationships with patients. This process will have positive impacts on patients' engagement with health care, as well.	Develop a process for eliciting patient feedback and preferences on art, lighting, signage, etc. This can be done via survey, focus group, suggestion box or brainstorm event.
Improve reception and waiting experience by making goodwill greetings (empathic/ relational greetings) something that happens every time a patient comes into the clinic	Goodwill greetings are a core component of effective empathy conveyance. Goodwill greetings are often unevenly distributed, with those who look like ourselves sometimes receiving more than those who don't. Patients' experience of empathy, from the moment they walk into the organization, will influence their feeling of safety and inclusivity.	Be mindful to say a greeting such as "Good Morning," before giving instructions such as, "Sign in here," or, "Do you have an appointment?" Goodwill greetings can be measured and are great for quality improvement work. Consider empathic communication training specific to healthcare environments.

EMPATHIC ENVIRONMENTS

Improvement Goal	Rationale	Example Strategies
Improve reception and waiting room experience for both patients and staff by educating and supporting front office staff to enhance their comfort and confidence in connecting with patients, through purposeful connecting talk, outside of the transactional tasks associated with checking in for a visit.	How friendly and warm the waiting room is affects both staff and employees. Receptionists spend their whole days in the waiting room, and patients typically spend more time in the waiting room than they do with a medical provider.[9] [10] Despite this, receptionists typically get the least training, development, or resourcing of any staff member. Providing supportive learning and development (interactive training) to support skillful interpersonal interactions sets the tone for the office visit (and the screening).	Traditional customer service training typically focuses only on the "customer" experience. Engage in those additional training programs that go deeper, such as trauma-informed customer service, focusing on enhancing communication to improve both employee and patient experience.[11]
Improve telehealth environmental experience.	The telehealth environment has special considerations regarding establishing goodwill relationships, conveying empathy and respect.	Develop specific guidelines for establishing empathy via video and separately for telephone, or adopt existing guidelines that are congruent with trauma-informed practices. This could include wearing a name badge, using a professional or calming background, and always starting the conversation by asking if the patient is alone or with others.

Employee Equity & Experience

Trauma and resiliency-informed values; clinic champion(s); buy-in from organizational leadership; interdisciplinary team-based care; community partnerships; patient/family engagement; commitment to health equity

EMPLOYEE EQUITY & EXPERIENCE

Improvement Goal	Rationale	Example Strategies
Address racial inequities in leadership make-up, promotion patterns, and pay.	Employee experience and patient experience are so closely related, they can be used as proxy measures for each other. When racial inequities go unacknowledged and unaddressed in the workplace, this will be reflected in the patients' experience of the organization as well. If there is not cultural diversity in hiring, promotion and retention, cultural responsiveness of the organization may suffer.	Review all organizational salary and position data by race/ethnicity and gender to identify specific inequalities. Develop strategic priorities, goals, and strategies to address inequities in staffing and pay.
Implement ongoing equity-focused workgroups to ensure all voices and perspectives from employees are heard.	The process and the outcome of developing diverse equity workgroups that represent all voices and perspectives are important for organizations deeply committed to addressing structural racism and other forms of discrimination in the workplace.[12] Addressing this in healthcare organizations is necessary to addressing health inequities for the patients we serve.	Establish a process for group participation; identify champions to facilitate group growth and activities. Develop group policies and processes to ensure collaboration and decision-making capacity; develop written policies to ensure equity work is compensated fairly (e.g., it is not just another volunteer committee that staff are expected to add on to their existing workloads); develop collaboration processes and practices, including the group's decision-making capacities. Ensure leadership demonstrates (through action) support of these groups.
Increase low-wage employees' compensation.	Poverty is a social determinant of health, a barrier to leaving abusive relationships, and can cause chronic worry, resulting in toxic stress. Lowest-wage employees in healthcare organizations are largely women of color, making this an important equity issue.[13] [14]	Form and support a task force that can establish goals and develop timelines for correcting and equitably distributing employee compensation.
Implement flexible work options for all hourly employees.	Flexible work schedules are directly related to emotional and physical health, with research showing impacts on sleep, exercise, diet, depression, parenting stress, preventative appointments and productivity at work. Over 80% of employees desire flexible work schedules.[15] Low wage workers typically have the least flexibility.[16]	Develop a task force to identify goals and objectives to advocate and promote flexible work options that are available for all levels of positions.

EMPLOYEE EQUITY & EXPERIENCE

Improvement Goal	Rationale	Example Strategies
Provide access to virtual behavioral health support for employees.	Supporting employees is a direct path to improved patient experience, which impacts self-disclosures and responses to self-disclosures. Often, our patients have better and quicker access to behavioral health support than our employees do, creating a "mission gap" where they are asked to treat patients better than they are being treated. Having integrated BH in clinics is not sufficient, unless providing services for staff is explicitly written into the integrated teams' job description. This service should not be provided by BH clinician-employees; instead, dedicated BH resources for employees are required.	Hire or contract a BH specialist to work in the HR department, consulting on trauma informed environment for staff, population based emotional wellness interventions and direct services to employees.

Policies, Procedures & Workflows

Trauma and resiliency-informed values; clinic champion(s); buy-in from organizational leadership; interdisciplinary team-based care; community partnerships; patient/family engagement; commitment to health equity

POLICIES, PROCEDURES & WORKFLOWS

Improvement Goal	Rationale	Example Strategies
Integrate process communication into all verbal and written workflows, including connecting statements.	Well-researched communication strategies show that connecting statements result in higher levels of trust, subsequent disclosures and activation in self-management of illnesses and increasing other healthy behaviors.[17] [18] Also, when staff engage in higher levels of skill in communication with patients, this decreases patient frustration and critical incidents.	Utilize health care communication experts/ systems/companies to assist in the integration of communication prompts such as using patient name, introducing oneself, smiling, using connecting statements (humor, small talk, compliments, expressions of happiness to see them, etc.) into all screening, check-ins, and other clinic workflows. Let patients know about the clinic process in a culturally and linguistically appropriate way. For example, through using an interpreter and/ or providing ACEs patient materials and videos in waiting rooms in several different languages. Ensure all staff are trained in best practices to elicit clinically relevant details about racial/ ethnic identity, gender identity/pronouns and sexual orientation.
Enhance relationship and connection by humanizing and elevating individual staff.	Through uniforms, language (non-clinical staff and/or staff/providers), lack of norms around introducing selves, etc. many people who work as receptionists, call center or medical assistants are not fully viewed by patients as members of the medical team, causing high levels of verbal abuse to reception staff. This causes a similar cascade of “othering” and non-empathetic communication toward patients, resulting in bi-directional de-humanizing.	Provide business cards for all receptionists, MAs, billing staff, etc. Consider providing voicemail boxes for all staff, to enable patients to contact them directly. Encourage all staff to introduce themselves by name and role in all first interactions with patients.
Engage a Diversity, Equity, and Inclusion (DEI) focused task force to develop specific policies and practices around the organization’s relationship with ICE, law enforcement and other like government agencies.	Many people have misconceptions about how a healthcare clinic does or does not communicate with law enforcement and immigration entities. As providers, we often only need to know information about someone’s legal/immigration background to the extent that it is going to impact the resources/ services provided, and providers should be conscious of their own bias about working with people involved with the immigration or justice systems. Contacting and interacting with law enforcement about a patient without a valid reason (i.e., non-emergencies) can also be a breach of HIPAA.	Make concrete decisions around when law enforcement will be called, vs. what can and should be handled clinically (intoxication, property theft). Clarify policies and practices around what is considered a crime and what is reported, to lower incidences of individual decision making that may be driven by racism, bias or stigma (conscious or not).

POLICIES, PROCEDURES & WORKFLOWS

Improvement Goal	Rationale	Example Strategies
	Careful guidelines should be given to staff about how to document legal/immigration matters in medical records, and if/when to share it, as well, keeping in mind the "minimum necessary rule" to protect sensitive information.	Consider enrolling in de-escalation training, exploring partnerships with spiritual care workers and expanding crisis behavioral health and community safety teams to reduce reliance on police and/or security.
Develop policies to guide decision-making around patient requests from health care team members for letters.	Many patients request letters from medical and behavioral health providers to assist in advocacy in deportation proceedings, custody or other family issues, children's school-related issues, etc. Left to individual discretion, chances are high that racism and other discrimination will play into decision making about when providers agree or not to write these letters.	Broadly create policies that address advocacy letters in general, clarifying the organization's position. Identify the danger of individual discretion, and develop decision making processes and supports for ensuring equitable advocacy.
Ensure all patient-facing educational and survey materials and forms reflect equity for gender and sexual identity.	Often once patient-facing materials are created or purchased, they are not revised for inclusivity. When patients do not "see" themselves represented in materials, it likely impacts how welcome, cared for, and connected they feel to the organization.[19]	Ensure in addition to "Male/Female" on forms, make space for non-binary, 'other' and no answer. Ensure illustrations represent all gender representations.
Ensure all staff are trained and comfortable in best practices to elicit racial/ethnic identity and gender identity/ pronouns and sexual orientation.	Because of deep systemic racism in our country, and subsequent laws, policies and practices that disproportionately negatively impact people of color, asking about race/ ethnicity if done unskillfully can wound relationships with patients and deter them from disclosing important health information in the future.	Place eliciting racial/ethnicity, gender identity and pronouns, and sexual orientation information in the "sensitive screening" category. Develop effective supports for this, including interactive workshops, role plays and videos.

Equity Practices

Role of implicit bias and racism; relational healing; resilience; recognition of diverse experiences of adversity and racism

EQUITY PRACTICES

Improvement Goal	Rationale	Example Strategies
Address the role of implicit bias and racism in the health and well-being of patients and employees.	ACE screening is entirely dependent on self-disclosures. Self-disclosures are dependent in large part on whether patients feel cared about, listened to, safe and respected. Research on implicit bias demonstrates clearly that indications of empathy, such as connecting statements, compliments, eye contact, not interrupting, etc., are most often used within our own affinity groups, and are utilized significantly less with those we have implicit bias towards.[20] The level of unaddressed implicit bias is, and will continue to, directly impact self-disclosures, as well as patient adherence to response recommendations.	Initiate implicit bias learning and development activities and discussion groups, starting with trainings that provide an overview and advancing to anti-racism learning and development activities. Include classroom training, experiential workshops and ongoing multi-racial and multi-cultural discussion groups in addition to safe space discussion groups for certain ethnicities/races. Integrate suggested scripts for various sensitive or high-value interactions with patients that may be compromised by racism, power differentials and/or implicit bias to model awareness of, and mitigation of these factors.
Develop a Diversity, Equity and Inclusion (DEI) task force and ongoing work groups, goals, metrics and related activities.	Similar to above	Engage Black, Indigenous, and other Person of Color (BIPOC) employee representatives from all levels of the organization as primary stakeholders in the development of this group. Ensure the “time tax” is voluntary and compensated.
Develop empathic inquiry/conversational screening protocols that prioritize relational healing.	People make decisions on what to self-disclose based on their appraisal of whether or not the query is based in goodwill and appropriate for the time and place; and if their disclosures will be received without judgment and will be respected and protected. If these factors are not clearly demonstrated by staff and providers, people will often choose not to share important health information.	Elicit from staff/providers their levels of confidence and comfort in empathic communication and sensitive screening practices. Develop or identify interactive workshops including “real-play” (practicing screening on each other) and supportive materials, including videos.
Develop resilience/ strength eliciting questions to accompany ACE questions.	When people feel perceived as strong, whole people, actions are received as empathic. Developing questions that elicit strengths demonstrates that we care about patients as whole people and we are not just concerned with “fixing” problems.	Develop or identify at least 2-3 questions that empathically elicit patient or caregiver strengths. Test asking the questions before and after administering the ACE and continue to alter/shift for maximum connection. Examples of questions used in CALQIC include: What are some of your child’s strengths? What are your strengths? Who helps you? How have you bounced back after illnesses or difficult experiences? How did you find the strength to come to clinic today with everything else that you are dealing with right now?

EQUITY PRACTICES

Improvement Goal	Rationale	Example Strategies
Develop specific talking points to acknowledge to patients that ACE screening is not inclusive of all adverse experiences.	Acknowledging that ACE questionnaires do not capture all potentially traumatic events can reduce the possibility that patients would feel dismissed, ignored, ashamed or "unseen" when their traumatic experience is not queried. By sharing directly that the list is not comprehensive, we can increase the chances that someone will trust us to disclose trauma that is not represented on the screeners.	Staff and clinicians can explain that the ACE questionnaires do not encompass all adverse experiences that one may have faced but include many that are known to have lasting impacts of health and wellbeing. Clinics can consider whether to add additional trauma and resiliency screening questions, or combine the ACE screen with other existing screens performed by the clinic.
Develop specific talking points to acknowledge to patients that ACE screening may not address all forms of institutional harm (in schools, workplaces, etc.), and/or state-sponsored harm (such as police violence).	Similar to above: we know racism-based trauma can have significant and compounding effects on other ACEs. If we don't directly acknowledge its absence on the ACE screen - that it, is indeed an area of trauma for many people may not trust us to disclose racism-based trauma.	Similar to above, around race-based or other discrimination-based trauma.

Trauma Informed Care

Health care that recognizes and responds to the signs, symptoms, and risks of trauma to better support the health needs of patients

TRAUMA INFORMED CARE

Improvement Goal	Rationale	Example Strategies
Lower the number of escalations and critical incidents, and minimize the harm of those that do occur. Ensure the processes and practices around critical incidents is consistent with relational healing and equity goals.	Over 65% of medical office receptionists are verbally abused in any given year; this is both in-person and on the phone.[21] When an organization does not invest in de-escalation systems, including training, tracking incidents, empathic and supportive de-briefing, and root cause analysis, it replicates a family system that ignores when a member is being abused. It is important for our employees that we name abuse, state unequivocally that it is unacceptable, and provide support for prevention and post-incident de briefing. Additionally, when a patient yells, swears, knocks over a chair in the waiting room, all the patients in that waiting room experience it, making escalation incidents ripple throughout the organization's patients and employees.	Collaborate with reception staff in developing and adopting widespread trauma informed de-escalation training and related practices. Engage health system leadership (individual clinic, hospital) to enact health system actions and policies that support de-escalation. Adopt a system to capture, measure, track and prevent and respond to all escalations as critical incidents. Implement a formal trauma informed debriefing protocol for all critical incidents (empathic, anti-racist, respectful, and equity-based). Be intentional about planning for how debriefing time will be protected, how far out from the incident it will occur and who is responsible for ensuring this occurs.
Ensure billing practices and protocols are consistent with relational healing goals and trauma-informed care principles.	Chronic fear about money may be experienced as toxic stress and have a myriad of associated harmful impacts on health and wellbeing. When organization billing materials are confusing, difficult to read, sharp or cold in tone, they create more fear and erode trust between patients and the organization.	Assess patient-facing billing materials for trauma informed/relational healing congruence and develop project plans to alter as needed or at least help patients feel supported understanding and responding to them (e.g., *larger font; pleasant and colorful images; warm greeting, thank you/gratitude sentiment for trusting the organization with their health; clear explanations of the bill; clear and easy instructions for contacting in case of questions, etc.)* Ensure all billing staff who interact with patients are trained in TIC communication. Have clinic resources that connect patients to resources to support social needs like 2-1-1.
Ensure clinic/hospital policies impacting patients reflect relational healing.	While it is important to address staff boundaries (such as having to stay late if patients arrive late, or not discharging repeatedly verbally abuse patients), most late policies and patient discharge policies are often punitive and unevenly applied, wounding relationships with patients.	Assess patient late policies, patient discharge-from-care policies, and other potentially punitive patient policies and develop strategies to enhance congruence with empathic, anti-racist, respectful and equity-based policies.

Leadership

Trauma and resiliency-informed values; clinic champion(s); buy-in from organizational leadership; interdisciplinary team-based care; community partnerships; patient/family engagement; commitment to health equity

LEADERSHIP

Improvement Goal	Rationale	Example Strategies
Ensure congruence between the organizations values around equity and relational healing and written organizational goals.	When integrating a specific focus on equity into the organization's strategic plan and/or stated mission and values, it is vital that the organization then develops specific strategies and measures to operationalize these values. It is an important message to employees, patients, and the larger community that it is acceptable, and even encouraged, to talk about and address racism and other forms of discrimination. This ultimately aids in meaningful care for patients (and staff) regarding experiences with racism and other toxic stress.	Develop equity goals and relational healing goals to integrate into the organizations' strategic plan, mission and values. Develop a process, metrics and timeline to review congruence of policies and actions with stated goals.
Build organizational leadership that is representative of employees and the community the organization serves in terms of racial and LGBT+ identity.	While this may be a somewhat difficult and audacious goal, the process that it entails generates its own good, including increasing effective tolerance for uncomfortable conversations, developing a conscious way of making decisions about representative leadership, and enhancing purposefulness about this goal.	Assess whether executive leadership is congruent with the racial representation of patients served and/or community and develop strategic goals to address it.
Ensure there is time, money and energy dedicated to equity goals.	While health equity must be integrated in all organizational processes, positions and cultural indicators, creating a position to address health equity within the organization signals to employees and patients that the organization is willing to dedicate resources directly to the work.	Develop and fund a position on executive leadership to address health equity of staff and patients and equip this position with sufficient authority and resources to meaningfully advance equity.
Integrate equity and relational qualities, characteristics and behaviors into all job descriptions.	Most job descriptions are not relationship-centered, focusing instead on transactional tasks, as opposed to important relationship building behaviors and practices. By transforming all job descriptions to explicitly include relational aspects (e.g., skillful empathic communication, conflict resolution and building of genuine relationships with coworkers and patients) and health equity (e.g., competency to work with individuals	Integrate health equity and relationship-centered qualities and skills into all job descriptions and employee evaluations.

LEADERSHIP

Improvement Goal	Rationale	Example Strategies
	from diverse backgrounds, ability to partner with diverse teams), job descriptions become one of the important building blocks of trauma informed systems.	
Ensure interview, selection, hiring and training processes reflect relational healing principles. Ensure inclusion of specific questions to assess candidates' understanding of, and commitment to a relational workplace, and Diversity, Equity, and Inclusion (DEI) aims and principles.	Interviewing procedures, without purposeful intent to make consistent with trauma informed care, can be fear-producing, based on sharply defined power-differentials, and patriarchal in nature. These hiring and interviewing processes indicate, through social learning, what is expected of employees, influencing their relationship with patients.	Engage Black, Indigenous, and other Person of Color (BIPOC) employee representatives from all levels of the organization as primary stakeholders in the development of this group. Ensure the "time tax" is voluntary and compensated.
Ensure termination processes, policies and practices are consistent with trauma informed care.	Termination, whether voluntary leavings or firings, are rituals, and as such they have particular power in defining and driving culture. Terminations are often secret, leaving a feeling that people "disappear." They often are not discussed, which can feel like an unspoken family secret. Leavings or endings of any kind often have deep meanings and can be traumatic to experience or witness.	Assess current termination processes and practices against relational healing and equity ideals and practices. Develop task force and plan to address the gap.

Data/Quality Improvement

Use race and ethnicity data at all levels of the organization to identify and address disparities

Improvement Goal	Rationale	Example Strategies
Decrease health care variation and disparities in care and responses by race/ethnicity *(we recognize this as an enormous goal and include it here to give concrete examples on how to take steps towards this).*	Organizations often have disproportionate complaints due to poor patient experience, from historically marginalized or stigmatized populations.[22] [23] [24] By using complaint data to identify "cold spots," where empathy is not being effectively conveyed, specific action can be taken, resulting in increases in better patient comfort, trust, and relationships. When we disaggregate by race/ethnicity, it is possible to see if one demographic group has higher rates. While there are likely many reasons for disparity, one race/ethnic group may feel less welcomed, respected, and connected when they come to the clinic, resulting in variations of care access and utilization. This could lend itself to specific intervention strategies.	Disaggregate all documented data on negative feedback (complaints) by race/ethnicity and develop a quality improvement project based on the findings. Look at missed appointment rates, patient ratings data, CAHPS scores, etc. by race/ethnicity. Develop QI project plan to address disparities.
Be transparent about health inequity and inequity in care by reviewing at all levels of the organization health outcomes and other data by race/ethnicity.	While most of us see national and state data indicating people of color, especially Black people, have worse access to health care, worse health care when they do get it, and worse health outcomes, few of us run our own data reports this way. By beginning to do this with highly tracked measures like HA1C or blood pressure, it gives organizations practice in how to run, interpret, share and make meaning out of equity data.	Disaggregate all currently tracked health outcomes (hA1c; depression scores; blood pressure; etc.) by race/ethnicity and develop QI projects based on the findings.
Develop new peer review formats for all licensed providers, which include assessment of variations in care decisions by race/ethnicity of patient.	Racism and other discrimination show up in sometimes big, sometimes small differences in how care is delivered. Peer review protocols which are embedded in all medical systems offer an opportunity for peers to assess each other's care decisions with a health equity lens, including assessing variability in responses to ACE screening.	Develop a task force of clinical leaders who are DEI committed to revamp peer review forms and processes to include assessment of variation of care and race/ethnicity of patient. Implement post-review discussion meetings to present findings in a way that avoids right/wrong and defensiveness and enhances mutual self-reflection.

ENDNOTES

1 The relationship between physician empathy and disease complications: an empirical study of primary care physicians and their diabetic patients in Parma, Italy

2 Empathy in medicine: what it is, and how much we really need it: https://pubmed.ncbi.nlm.nih.gov/31954114/

3 Why empathy has a beneficial impact on others in medicine: unifying theories: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4294163/

4 Designing safety-net clinics for cultural sensitivity: https://www.chcf.org/wp-content/uploads/2017/12/PDF-DesigningClinicsCulturalSensitivity.pdf

5 Putting patients first: designing and practicing patient-centered care: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5060259/

6 Visual art in hospitals: case studies and review of the evidence: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2996524/

7 Chasing the rainbow: lesbian, gay, bisexual, transgender and queer youth and pride semiotics: https://www.tandfonline.com/doi/abs/10.1080/13691058.2016.1251613?journalCode=tchs20

8 Cross-cultural design and healthcare waiting rooms for indigenous people in regional Australia: https://journals.sagepub.com/doi/abs/10.1177/0013916520952443

9 Qualtrics healthcare PAI in index 2019: https://www.qualtrics.com/m/assets/wp-content/uploads/2019/11/Healthcare_PI_Report.pdf

10 The relationship between patient's perceived waiting time and office-based practice satisfaction: https://www.ncmedicaljournal.com/content/ncm/67/6/409.full.pdf

11 Trauma-informed customer service: https://www.pacesconnection.com/g/kansas-aces-connection/blog/trauma-informed-customer-service

12 Centers for Disease Control and Prevention, a practitioner's guide for advancing health equity: community strategies for preventing chronic disease:x https://www.cdc.gov/nccdphp/dch/pdf/healthequityguide.pdf

13 Wages and Women in Health Care: The Race and Gender Gap: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6336052/

14 Wages and women in health care: the race and gender gap: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6336052/

15 The IWG global workspace survey: https://assets.regus.com/pdfs/iwg-workplace-survey/iwg-workplace-survey-2019.pdf

16 Lower-wage workers and flexible work arrangements: https://scholarship.law.georgetown.edu/cgi/viewcontent.cgi?article=1000&context=legal

17 Effects of empathic and positive communication in healthcare consultations: a systematic review and meta-analysis: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6047264/

18 The role of empathy in health and social care professionals: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7151200/

19 The role of culture in healthcare: https://www.annualreviews.org/doi/full/10.1146/annurev.publhealth.25.101802.123000?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%3Dpubmed&

20 Understanding the Patient Experience Through the Lens of Racial/Ethnic and Gender Patient-Physical Concordance; https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2772680

21 Abusive behavior experienced by primary care receptionists: A cross-sectional survey: https://academic.oup.com/fampra/article/21/2/137/509490

22 Understanding the patient experience through the lenses of racial/ethnic and gender patient-physician concordance; https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2772680

23 Racial/ethnic discrimination in health care: impact on perceived quality of care https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2855001/

24 Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: systemic review: https://pubmed.ncbi.nlm.nih.gov/23490450/

The research articles included here are just selections from a deep and robust body of research on empathy and equity. For a more comprehensive bibliography of research that underlies the examples in this document, see Elizabeth Morrison's annotated bibliography at: https://www.rsourced.com/download/annotated-resources-stigma/ Additional resources on trauma-informed, resilience-focused and equity in health care are available via the TRAIDs Implementation Approach: https://cthc.ucsf.edu/triads/organizational-change/implementation-approach/

TRIADS

Learn more at cthc.ucsf.edu/triads

A project of

UCSF Center to Advance Trauma Informed Health Care