



Winnipeg Regional
Health Authority

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The Impact of Unconscious Bias on Patient Experience, Treatment, and Outcomes: Public and Staff Perspectives

Local Health Involvement Groups
June 2020

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When a patient, who has a disability, is elderly, or Indigenous seeks care will their experience in the health care system be the same as someone who is able bodied, younger, or White? For many, it will be profoundly different. It may involve not getting care right away (or any care at all), not being believed, and having assumptions made about their lives and their health condition. This could be the consequence of a bias that their health care provider had prior to ever meeting them. This report explores this critical issue.

*The complexity of this tiny word (bias) that is in everything we do and impacts everything we do.
How deep and fundamental it is.*

*Staff participant
South Winnipeg Staff Focus Group*

Background

Every year, members of the Local Health Involvement Groups (Appendix A) share ideas for topics that are a priority to them and these are presented to the Board for review. In June 2019, the Board approved their proposed topic -- *Unconscious Bias and Its Impact on Patient Experience, Treatment, and Outcomes*.

From October 2019 to March 2020 the Local Health Involvement Groups explored the issue of unconscious bias and provided recommendations to increase awareness and develop strategies to interrupt bias at the interpersonal, organizational, and systemic levels. For the first time, health care staff was invited to be part of this process. Their perspectives and involvement in developing recommendations in collaboration with members of the public is critical to address this issue.

This report includes the insights and recommendations shared by over 230 community and staff members. Thirty-seven engagement sessions were held.

Unconscious Bias in Health Care

- Biases are quick judgements, assessments of others based on their race, socio-economic status, health condition, weight, sexual orientation, gender, faith, age, and other social identifiers.
- Unconscious biases play out on a daily basis; on an entirely unconscious, emotional level.
- The impacts are felt not only by patients and families, but by staff as well.
- Unconscious bias gives some groups unearned advantage and other groups unearned disadvantage.
- There is a strong connection between unconscious bias and the quality and safety of care. Creating processes that help staff feel safe to talk about how bias impacts care is an essential part of creating a “just culture”.
- It is a health equity issue. Individuals and groups most impacted by unconscious bias experience structural disadvantage and worse health outcomes.
- The impacts of unconscious bias on care have been researched broadly, including a recent report from the Public Health Agency of Canada -- [*Addressing Stigma: Towards a More Inclusive Health System \(December 2019\)*](#)

Methodology

- A working group (Appendix B) of staff from across disciplines, programs, and sites was created to oversee the content and processes of engagement. This included staff from the Indigenous Health program that co-facilitated the first set of Local Health Involvement Group meetings, essentially workshops on unconscious bias.
- The second set of meetings of the LHIGs involved using 3 case scenarios of real events that were shared by community members and staff. Questions prompted discussion to explore unconscious bias and the possible ways to address.
- Nine engagement sessions were held with community area and hospital staff. Approximately 140 staff participated. These were co-facilitated with members of the working group and included a short workshop on unconscious bias and the same 3 case scenarios and discussion activity as the LHIGs
- Meetings were held with the Regional Patient and Family Advisory Council and the Ethics Public Engagement Group. The content was very similar to the staff engagement sessions.
- Joint meetings of the six LHIGs and staff were held in March. The focus of these sessions was to develop recommendations to address unconscious bias at the interpersonal, organizational, and system level. These were co-facilitated with members of the working group.
- The final part of the engagement process was impacted by the COVID 19 pandemic. The last 2 Joint meetings were held virtually and the Francophone Consultation that was planned for April was cancelled.

Moving this work forward

- The report will be presented to the Executive Committee and Board in June 2020 for discussion.
- It is recommended that the Unconscious Bias Engagement Working Group develop plans to move this work forward in the Winnipeg health region.
- The working group will present plans to Executive Committee and the Board for discussion and approval.

Key recommendations from the Report

Interpersonal Level

1. Develop education and training on unconscious bias for staff and volunteers. This training should be mandatory for anyone who interacts with patients.
2. Prioritize those who are impacted in multiple ways by bias – intersectionality – by engaging and building trust.
3. Ensure that the first staff or volunteer that a patient or family member connects with by phone or in person sets a positive and welcoming tone.
4. Establish clear goals of care with patient – for example, what is your primary concern? At end of appointment/interaction, did we address it?
5. Improve communication with family by proactively sharing updates, reports from specialists, etc.
6. Staff impacted by bias from patients – incidents need to be debriefed and staff should receive support from manager and co-workers. Make it clear to patients that their behaviour is unacceptable and if appropriate, develop safety plan/strategy to provide care to that patient.
7. There should be more regular feedback from patients to identify possible issues and provide information about how to work to resolve them.

Organizational Level

1. Every process needs to include reminder to check biases (on forms, charts, etc.) – from assessment to examination, diagnostics, referral, treatment decisions, and discharge.
2. Explore the development of a patient coordinator/lead care role in acute care settings.
 - a. One health care provider coordinates patient care and acts as a liaison to the family
3. The client relations role at acute, community, and long term care sites needs to be and enhanced and promoted to patients. Staff working in these roles can address issues involving unconscious bias and its impacts on care and the relationship with the health care provider.
4. Staff should be “called in” rather than “called out” when they show bias in their interactions with patients or co-workers. (A more supportive way to identify when bias is impacting patient care or interactions between staff)
5. Performance reviews of staff should include how staff members interact with patients, families, and co-workers.
6. Explore issue of sub-standard care, especially in geriatric care settings.
7. Explore how this work aligns with efforts to address health inequities and reduce health gaps.
8. Integrate these recommendations into existing processes, initiatives, etc. in the region. (See Appendix C)

System Level

1. Make awareness and the interruption of unconscious bias part of our organizational culture. Have discussions at leadership tables. Develop tools for decision-makers.
2. Measure and monitor the relationship between unconscious bias and poor health outcomes.
3. Explore link between unconscious bias and adverse outcomes in critical incident processes.
4. Survey all staff to get baseline assessments of perceptions of inclusion and belonging. Repeat after training and other recommendations have been implemented.
5. Board and senior leadership need to encourage discussions at a provincial level about the issues with the walk-in clinic model of care; at a minimum, the province needs to provide more oversight.
6. Advocate for increased funding for primary care provision in low income communities.
7. Walk in physicians should refer patients with chronic conditions to family doctor (part of Family Doctor Finder process)

Feedback on Unconscious Bias from the Local Health Involvement Groups and Staff

When and where does unconscious bias take place in health care interaction?

- LHIG members and staff were asked, “When does unconscious bias happen during an interaction in the health care system?” Their answer was unanimous – from the beginning to the end of all health care interactions.
- But, the effects and impacts of unconscious bias can be found before any interaction even begins. It impacts how services are planned and how policies are developed.
- Community members shared that the tone is set for their interaction with the first staff they connect with by phone or in person. It is critical that this person set a positive and welcoming tone.
- Staff identified that key moments where they need to acknowledge unconscious biases happen at their first meeting, assessment, intake, etc. with the individual. If their bias is not interrupted, assumptions about the patient/client may occur that will impact their assessment, diagnosis, the options and plans for treatment, and how they communicate and interact with them.
- Staff also identified that unconscious bias can occur when sharing and reviewing patient files. Because one person’s biases may impact how other staff perceive that patient.

Understanding impacts of unconscious bias and opportunities to address

- Working group members who facilitated the meetings shared an iceberg graphic at the session prior to LHIG and staff participants reviewing and providing feedback on the case scenarios. (Appendix C)
- The graphic shows the impacts of unconscious bias and the enablers at the interpersonal, organizational, and system levels.
- The case scenarios (Appendix D) were incidents shared by a community member, a public health nurse, and a home care administrator. These scenarios reflect the understanding and perspectives of the individuals who shared them. The events occurred in the Winnipeg health region within the last year. Two of the case scenarios involved patients (one elderly White female in a geriatric ward and one Indigenous woman at a walk-in clinic) being impacted by unconscious bias and one involved staff being impacted by bias (home care staff providing care to elderly White female client).
- Meeting participants responded to a set of questions that asked them to consider what was happening at the interpersonal, organizational, and system level.
- At the joint meetings of the LHIGs and staff, they discussed possible ways to interrupt and address unconscious bias at these 3 levels.

Interpersonal level (This level of the ice-berg illustrates what we can observe – the interactions between health care providers and patients)

Consequence of unconscious bias on patient experience, treatment, outcomes	Recommendations to interrupt unconscious bias in patient care
<ul style="list-style-type: none"> • Care is delayed or denied • Lack of referrals or improper referrals for diagnostics, treatment, etc. • Access to specialized care is limited 	<ul style="list-style-type: none"> • Mandatory staff training on unconscious bias • Staff should check their biases with every patient, every time so that they don’t take short cuts based on assumptions
<ul style="list-style-type: none"> • Misdiagnosis or lack of diagnosis • Missed health issues due to 	<ul style="list-style-type: none"> • Every process needs to include reminder to check biases (on forms, charts, etc.) – from assessment to examination,

Consequence of unconscious bias on patient experience, treatment, outcomes	Recommendations to interrupt unconscious bias in patient care
<ul style="list-style-type: none"> • assumptions because of their age, race, mental health status, gender, etc. • Initial bias determines their whole path of care 	<ul style="list-style-type: none"> • diagnostics, referral, treatment decisions, and discharge • Use health equity approach during assessment to understand the context of the patient’s life • Ensure that patient and family are engaged in decision-making
<ul style="list-style-type: none"> • Lack of communication • Not believing patient • Lack of trust of health care staff 	<ul style="list-style-type: none"> • Staff need to move from awareness about unconscious bias and its impacts to behaviour and communication that interrupt bias • Patient centred care takes time. Should there be a change in policy to allow for more time for staff to interact/provide care? • Establish clear goals of care – what is your primary concern? At end of appointment/interaction – did we address it? • Have empathy, listen, ask questions, build relationship with patient • What do I need to know about you to provide you with the best possible care? • Better communication with family – share updates, reports from specialists • Summarize what patients share with you to ensure you received that information correctly – ask them to add anything you might have missed – ask them if there is anything else they would like to share or that is important to know about them • Tips for patients – “How to share what’s happening with you to a health care provider”
<ul style="list-style-type: none"> • Pathologizing patient – for example – assuming that a patient in geriatric care has dementia or assuming that a patient is drug seeking because of their race • Intersectionality – individuals who are subjected to multiple forms of stigma are most vulnerable to the impacts of bias on their experience, treatment, and health outcomes (and their negative experience is compounded) 	<ul style="list-style-type: none"> • Need to prioritize those who are impacted in multiple ways by bias – intersectionality • Engage those most impacted by bias -- through surveys that are on-line and immediate in person feedback • Need to explore ways to engage and build trust with people who no longer seek care because of a negative experience
<ul style="list-style-type: none"> • Micro-aggressions 	<ul style="list-style-type: none"> • Staff must be aware of how their actions impact others and accept responsibility • Must focus on the impact of a micro-aggression – need to believe patients and staff who share that they were on the receiving end of a micro-aggression (whether or not the micro-aggression was intended) • Staff can “call in” others when they observe micro-aggressions – a more positive way to acknowledge when a co-worker’s bias is impacting how they are interacting with a patient

Consequence of unconscious bias on patient experience, treatment, outcomes	Recommendations to interrupt unconscious bias in patient care
<ul style="list-style-type: none"> • Onus put on patients to know what good care is and to advocate for themselves • Patients are punished for advocating for themselves 	<ul style="list-style-type: none"> • Ensure patients know where to go and who to talk to if they have a concern with their experience. • Client relations staff need to be trained in unconscious bias and able to support patients and staff in resolving issues
<ul style="list-style-type: none"> • Very poor outcomes – because of misdiagnosis and inappropriate treatment 	<ul style="list-style-type: none"> • Get feedback from patients – How did the interaction/appointment go? How are you feeling? • Leaders need to look for ways to measure and track the relationship between unconscious bias and poor health outcomes • Include exploration of link between unconscious bias and adverse outcomes in critical incident processes.

Organizational level (Below the surface, what we can't observe, how bias and stigma manifest at the organizational level – policies, practices, and workplace culture that both enable and encourage behaviours at the interpersonal level)

Consequence of unconscious bias on patient and staff experience, treatment, outcomes	Recommended policies, processes, etc. to interrupt it
<ul style="list-style-type: none"> • Normalization of substandard care that can include micro-aggressions and denial or delay of care • Lack of proper protocols and sharing – assessment, treatment, discharge • Grooming of staff 	<ul style="list-style-type: none"> • Unconscious bias training mandatory for staff • Identify what is happening for staff that is resulting in sub-standard care being provided. • Is this a resource or staffing issue? • Identify what drives a team to meet goals and provide good care • Audit charts to identify possible issues • Acknowledge compassion fatigue • Engage staff by recognizing good work, giving positive shout outs during shift changes, and being open about challenges • Analytics – ways of capturing patterns of care – collect information from clinical supervision – what are their challenges? These are learning opportunities. Gather information from multiple sites so discussion is not judgemental or specific in targeting a particular staff member.
<ul style="list-style-type: none"> • Care is not patient-centred • Communication with patient and family is poor • Lack of policy for answering patient and family's questions about care • Family unable to connect directly with doctors on wards 	<ul style="list-style-type: none"> • Develop <u>patient coordinator/lead care role</u> in acute care settings <ul style="list-style-type: none"> ○ One health care provider coordinates patient care and acts as a liaison to the family ○ Ensure discharge plan is completed and follow-up care is arranged ○ They advocate and address issues of bias, etc. ○ They ensure patient has opportunity to provide feedback on their experience

Consequence of unconscious bias on patient and staff experience, treatment, outcomes	Recommended policies, processes, etc. to interrupt it
<ul style="list-style-type: none"> • Lack of self-reflection/ organizational reflection on the care provided • Lack of personal responsibility/accountability • Some staff may feel that they can get away with not providing good care because most vulnerable patients will not speak up for themselves 	<ul style="list-style-type: none"> • Team discussions • Workplace culture – create supportive processes to identify when co-workers make assumptions based on bias • Staff should be “called in” rather than “called out” when they show bias in their interactions with patients – create more supportive ways to identify when bias is impacting patient care. • Performance and accountability of staff should include how staff interact with patients and family

Systemic level (The systemic level is located at the deepest level of the iceberg and is characterized by the dominant values and beliefs that maintain policies, practices, and workplace culture)

Consequences and issues of unconscious bias at the system level	Recommended Strategies and Approaches
<ul style="list-style-type: none"> • The impact of unconscious bias is not considered at leadership levels in direct patient care, process and policy development, and organizational culture 	<ul style="list-style-type: none"> • Leadership needs to accept that unconscious bias exists and impacts patient experience, treatment, and health outcomes – and that it needs to be addressed • Governance and senior leadership should participate in unconscious bias, diversity, cultural safety training • Governance and senior leadership explore ways to spend more time with patients/clients • There needs to be a financial commitment to support training and education on unconscious bias • How can we make awareness and interruption of unconscious bias part of our organizational culture? – need to have discussions at leadership tables. Build and maintain a culture of empathy • Decision-making/planning <ul style="list-style-type: none"> ○ Tools for decision-makers – checklist and reflection to identify biases they may have about an issue and to ensure bias is interrupted – like “conflict of interest” process ○ Make talking about potential bias in decision-making part of the process, normalized ○ Ensure that strategic planning and the development of operating plans is checked for bias ○ Accessibility issues – ensure they are part of the discussion ○ Equity – that an equity lens is used in all decision-making – does the decision build equity or increase inequities? • Outcomes – include monitoring impact of bias – identify possible indicators to measure bias and track if bias is being addressed or not

Consequences and issues of unconscious bias at the system level	Recommended Strategies and Approaches
<ul style="list-style-type: none"> • Are societal values and biases (like less value placed on older population, Indigenous population, low income population) reflected in how governments and the health region allocate and prioritize resources? • Focus on patient flow over quality of care – not patient-centred • Streamlining of system to make it more efficient, go through patients, open up beds – seems to be decreasing quality and impacting outcomes • Patient flow versus longer appointments with fewer patients – is focus on patient flow instead of patient care impacting outcomes? 	<ul style="list-style-type: none"> • Open discussions at leadership levels about values, priorities, and bias • Survey all staff to get baseline assessments of perceptions of inclusion and belonging – repeat after training and other recommendations have been implemented
<ul style="list-style-type: none"> • “One complaint per visit” system – this process determines how care is provided and is not patient-centred care • Fee for service model encourages physicians to see more patients in shorter appointments – this is does not encourage providers to provide quality care or patient-centred care 	<ul style="list-style-type: none"> • Board and senior leadership encourage discussions at a provincial level about the impact of current fee for service model on patient care • While the overall model for care may not change much, health care staff should not be penalized for taking the necessary time to care for their patients as people (rather than treating a diagnosis)
<ul style="list-style-type: none"> • Walk in clinic model/private fee for service physicians – lack of oversight, accountability, critical incident process, etc. <ul style="list-style-type: none"> ○ Funded regardless of the quality of care they provide ○ Very difficult for patients to provide feedback • Not adequate number of family doctors to provide care in poorer communities where many community members have complex and chronic health conditions and are impacted profoundly by unconscious bias 	<ul style="list-style-type: none"> • Board and senior leadership need to encourage discussions at a provincial level about the issues with the walk-in clinic model of care – that at a minimum the province needs to provide more oversight • There needs to be a higher level of accountability, more regulations for walk-in care • Support more funding for primary care provision in low income communities • Walk-in clinics may require more support • Walk in physicians should refer patients with chronic conditions to family doctor (part of Family Doctor Finder process)

Consequences and issues of unconscious bias at the system level	Recommended Strategies and Approaches
<ul style="list-style-type: none"> Walk in clinics – immediate versus preventative or primary care – cannot provide proper care for those with chronic or serious health issues – band aid care – not going to dig too deep to find out what’s going on 	
<ul style="list-style-type: none"> Differential impacts of bias that increase inequities and gaps in health outcomes 	<ul style="list-style-type: none"> The issue of intersectionality (where individuals experience bias as a result of multiple social identifiers) needs to be prioritized as it speaks to the compounded impact of bias on the most vulnerable and marginalized individuals Build a more representative workforce including leadership Ensure that a representative workforce includes one that is inclusive to people with disabilities. Develop policy/process to engage and build trust of those most impacted by bias Ensure public and staff input on big decisions and when large scale change in the health care is being considered Employee engagement – ensure all points of view are represented during key decision-making (levels of staff, sites, etc.)

Recommended education, training, and other processes to build understanding about bias and its impacts

- Education and training was identified as a priority by both staff and LHIG members
- It should be mandatory for anyone interacting with patients
- There should be standard education and competencies that must be met
- There can be stand-alone workshops on unconscious bias that can be in person or on-line
- Training and education on unconscious bias go hand in hand with health equity. As such, work should be done to explore how to align this work with the existing work being done in the region to address health inequities and reduce health gaps.
- Key components about unconscious bias can be added to existing training, like health equity workshops, cultural safety workshops, and new staff orientation sessions.
- LHIG members recommend that the Declaration of Patient Values be included in these sessions as it speaks directly to how to provide care by interrupting bias.
- Staff suggested that role-playing and case scenarios be used in the training.

Listening to and sharing more real life stories (like the case scenarios) should be part of training health care workers and the public about unconscious bias and its impacts.

Participant at Joint Meeting of St Boniface/St Vital LHIG and staff

Recommended process for patients, clients, family members to connect with when they feel that bias impacted their care

- Both LHIG members and staff felt strongly that the client relations role with acute sites and community needs to be promoted so that patients are aware of where to go when they have a concern and enhanced so that staff working in these roles can address issues involving unconscious bias and its impacts
- Client relations
 - Clarify role of client relations – should be playing role to assist patients and families
 - Promote role – provide photo and contact information of client relations staff for patients, families, etc. – make more visible/known
 - Train client relations staff in unconscious bias – focus on impact of unconscious bias – not intention – that it was not intentional (for example)
 - Develop set of questions, use active listening
 - Get patient feedback on whether or not their experience was respectful and made them feel worthy (there are a set of questions that are used by psychologists in getting feedback from their clients after care)
 - Ensure process addresses what happened and lets the individual know how it was followed up
- Patient feedback
 - Impact versus intent – need to focus on the impact of unconscious bias and not whether or not it was intended
 - There should be more regular feedback from patients to identify possible issues and provide information about how to work to resolve
 - Discharge interview – how were you treated? How could we have done better?
 - How did the interaction/appointment go?
 - Ensure interpreters are available to assist those with language barriers
 - Intersectionality -- those who may be treated with bias on multiple fronts because of race, gender, health behaviours, income, etc. need safe environment and empathetic staff to talk to about their experiences

Recommended process to support staff to reflect, resolve, and learn

- LHIG members and staff were asked what would be important when developing a process that would support staff who are impacted by bias – either by patients or by other staff
- **Staff impacted by bias from patients**
 - Many staff who are impacted by unconscious/conscious bias of patients have normalized it – this needs to be discussed
 - Staff need to debrief situations and receive support from their manager and co-workers
 - Make it clear to patients that their behaviour is unacceptable
 - Develop safety plan/strategy to provide care
 - If a patient is showing bias through comments and behaviour – need to connect with them to explore where the behaviour is coming from
 - Develop and use contracts to provide care when necessary
- **Staff impacted by bias from other staff members**
 - There needs to be culture within the team that makes staff feel safe to share

- Staff need to first talk to each other – try to resolve it first – if not, then would have to share with manager, leader
 - Debrief – support and listen to staff who are impacted by bias
 - Managers should use resolution resources for staff from Human Resources to help facilitate conversations between staff if needed
 - Develop and implement an anti-discrimination policy
 - Build organizational and team culture to foster good interpersonal relationships within teams
 - Encourage cooperation between diverse groups in the workplace
 - Accountability – in review process, performance management, provide more incentives to address and change behaviour
- Changes at the team and organizational level
 - Address burnout of staff impacted by unconscious/conscious bias – rotate to other roles, sites, etc.
 - Create communities of champions at each site
 - Staff should be encouraged to watch out for each other and find ways to overcome these issues
 - Standing check-in with team about care issues – focus on bias and how they are managing it – be more open about it
 - Staff – review feedback from patients
 - Create spaces to have conversations
 - Use case scenarios to discuss unconscious bias, share ideas of how to interrupt it, etc.

Creating a “just culture” in health care

There is a strong connection between unconscious bias, health equity, and the quality and safety of care. Addressing this issue is an essential part of creating a “just culture”.

A just culture is an atmosphere of trust in which healthcare workers are supported and treated fairly when something goes wrong with patient care. It is important to patient safety as it creates an environment in which people (healthcare workers and patients) feel safe to report errors and concerns about things that could lead to patient adverse events.

Alberta Health Services

How unconscious bias impacts patient safety

- If health care providers make assumptions about a patient’s health condition because of a bias that they are not aware of, the quality of care they provide will be impacted and at worst it will impact the health outcome for that individual. This is a patient safety issue.
- Unconscious bias of staff can result in misdiagnosis or a lack of diagnosis, inappropriate or lack of referrals (diagnostics and specialized treatment).
- The provider may not believe what the patient is telling them and the care they provide will not be patient-centred.
- The possibility that the conscious or unconscious bias of staff impacted a patient’s outcome, should be explored in near miss and critical incident cases
- In these cases, patient care and patient safety are at risk

Address unconscious bias in order to create a “just culture”

- The culture of patient safety, of creating a just culture is about making it safe for health care staff and patients to share, report, and learn from incidents when something went wrong with patient care.
- Unconscious bias negatively impacts care. Staff members need to feel comfortable and safe to report when it impacts a patient’s experience, treatment, or outcome. And, patients need to feel safe to report as well.
- Discussions about the impacts of unconscious bias should become normal, routine.
- Successes with patient care should be celebrated.
- It should be part of a learning culture. Unconscious bias is normal; it is something that we all have. We have to be aware of it and interrupt it so that it doesn’t negatively impact others; how we provide care.

What about sharing a bias I have and how it impacted care that I provided? Would I feel safe to share and learn from it?

Staff participant

Appendix A
Local Health Involvement Groups Membership (2019-20)

Downtown and Point Douglas

Mohamed Behi
Jodi Bond
Susan Cameron
Laura Dahl
Tidi Gaamangwe
Allen Mankewich
Athena Moanyao
Gerry Pearson
Randy Ranville
Barbara Scheuneman
Carey Sinclair
Ashley Volpi
Adrienne Winfield
James Wright

Community Area Director – Sharon Kuropatwa

River East and Transcona

Gloria Bednar
Kathryn Dyck
Merle Fletcher
Joseph Geodisco
Ursula Hartel
Bob McIntyre
Reetul Patel
Justine Panganiban
Sem Perez
Matthew Quaye
Simran Saggi

Community Area Director – Debra Vanance

River Heights and Fort Garry

Judy Anderson
Deloris Ankrom
Melanie Cardinal
Heather Cordona
Carol Ellerbeck
Patricia Eyamba
Sarah Gravelines
Darlene Hildebrand
Mark Holdsworth
Lola Iyogan
David Laird
Thania Martis
Bob Newman
Sandra Sukhan
Bill Wickstrom

Community Area Director – Natalie Imbrogno

Seven Oaks and Inkster

Gurleen Aulakh
Hicham Bagui
Roy Bechard
Rita Costa
Olia Katchanovski
Walter Murray
Victoria Ponomets
Jay Punji
Laryssa Sawchuk
Sukhy Sidhu
Diana Szymanski
Kathy-Lynn Teles
Rose Troia

Community Area Director – Pat Younger

St Boniface and St Vital

Adekanmi Akinlade
Melanie Allard
Chris Ashley
Helene Beauchemin
Linda Campbell
Noah Kennedy
Judy Kidd
Sarah McGimpsey
Martin Landy
Pedro Proano
Mia Schorpion
Deanna Waters
Michael Wedin
Sharon Wickman

Community Area Director – Bria Foster

St James-Assiniboia and Assiniboine South

Sheila Austman
Tessera Ball
Shirley Canty
Matthew McBurney
Tim Mclsaac
Jennifer Patryluk
Todd Pennell
Claudine Salumu
Darlene Searcy
Lynn Silver
Marlene Simmons
Eleanor Single

Community Area Director, St James/
Assiniboine South - Eve Omar

Chief Operating Officer, Winnipeg West
Integrated Health & Social Services --
Kellie O'Rourke

Appendix B

Unconscious Bias Engagement Working Group

- Aboriginal Health and Wellness Centre (Monica Cyr)
- Centre for Healthcare Innovation (Amy Henderson)
- Community Health Services and Community Development (Claire Meiklejohn)
- Critical Care (Basil Evan and Dr Kendiss Olafson)
- French Language Services (Joel Lafond)
- Health Equity (Hannah Moffat)
- Human Resources (Brent Kreller)
- Indigenous Health (Doretta Harris)
- Organizational Staff Development (Sheila Betker, Susan Hologroski, Stefanie Pielahn)
- Population and Public Health (Shelley Marshall and Lea Mutch)
- Professional Advisory Committee and Ethics (Jennifer Dunsford)
- Public and Patient Engagement (Colleen Schneider)
- Quality and Patient Safety (Wendy Singleton)
- Women's Health Clinic (Nadine Sookermany)

Appendix C

Using existing initiatives, policies, and processes to move the issue of unconscious bias forward in the region

Accessibility Policy and Training

- These policies and training can address biases by educating staff about biases and assumptions about people with disabilities and how to address barriers and deliver equitable care
- Raises awareness of implicit and explicit bias about people with different kinds and levels of disabilities

Anti-discrimination Policy (for staff)

- Important – person who experienced discrimination must feel safe to report – focus of work
- Having this policy recognizes that any behaviour that is discriminatory is unacceptable
- Anyone who acts in discriminatory way will be held accountable
- Also provides a way to approach a co-worker about discriminatory/bias behaviour or attitude

Client feedback processes

- Does the patient have appropriate access to receive a survey?
- It can be intimidating to give feedback especially if patient is concerned will affect future care.
- Patients don't hear feedback from the surveys? What happened with their feedback?
- Sometimes person who has a legitimate complaint won't have a voice – share what happened
- Ideas to help – like peer to peer feedback, empowering staff to support patients to bring complaints forward
- Invites and involves the family and patients to participate in surveys and ways to improve patient care
- Feedback provided by those affected is used to make changes at the organizational level – programs, practices, and policies

Critical Incident Review Process

- Critical incident – should be documenting input from family members
- Bias effects response to critical incidents
- Go back to incident and identify why it happened – see if unconscious bias was involved.
- Used as a tool to improve processes and procedures
- Review panels should consider unconscious bias as part of review
- Awareness of the role bias plays in the normalization of substandard care should be addressed. If there were trends in these reports, they would be more easily identified.

Declaration of Patient Values

- Eliminate or minimize effect of unconscious bias – self-evaluating staff's treatment of patients (using D of PV)
- Adhere to and follow patient values for everyone - -then there will be no room for bias
- Can be used to develop procedures to make patient journey better
- Use as a training tool for staff
- Post in hospitals, clinics so clients are aware of it as well

Harm Reduction

- There could be on-going stereotypes – if health care providers see on their chart even after they have stopped using

Health Equity

- Increase awareness among health care students
- Need to set specific policies to recognize bias, education about cultural expectations and increase understanding
- Provide staff with training about health equity and determinants of health

- Have a health equity focus in planning and operations

Human Resources

- Calls to action – actionable items, part of performance review (is the supervisor competent to review staff)
- Accountability of HR to ensure that the processes are not biased – in favour of some groups and against others
- Is there a safe place to report issues?
- Should train more than leaders – should be open to all
- Ensure leaders apply policies/practices which are inclusive – i.e. gender, quality, culturally diverse

Indigenous Health Cultural Safety Education & Training

- Health care practitioners/staff should take this training early on in their careers
- Used as a tool for health care providers to challenge them to face bias in the system in their practice
- Indigenous history, culture
- Awareness that the health care provider’s unconscious bias can have a significant impact on patient care – patient being treated inhumanely

Performance Measures

- Shows the quality of care given and whether unconscious bias exists
- Shows where improvement is needed with respect to unconscious bias
- Number of courses taken by staff on unconscious bias, etc.
- Re-admissions (might be symptom of bias and assumptions impacting proper diagnosis and treatment)
- How to measure change? This can be a form of bias depending on who and what is being measured
- complaints are documented
- critical incidents
- diversity of staff

Population Health and Wellness priority population (Indigenous)

- Address the fact that there is existing bias – which leads to poor quality of care – should be addressed in new policies
- This initiative aims to deal with unconscious bias and improve health outcomes
- Putting more focus on how cultural factors can be interplay – source of unconscious bias
- How will this happen? Listen for understanding. Follow with appropriate action. Treat people as individuals. Staff representing the community it serves.

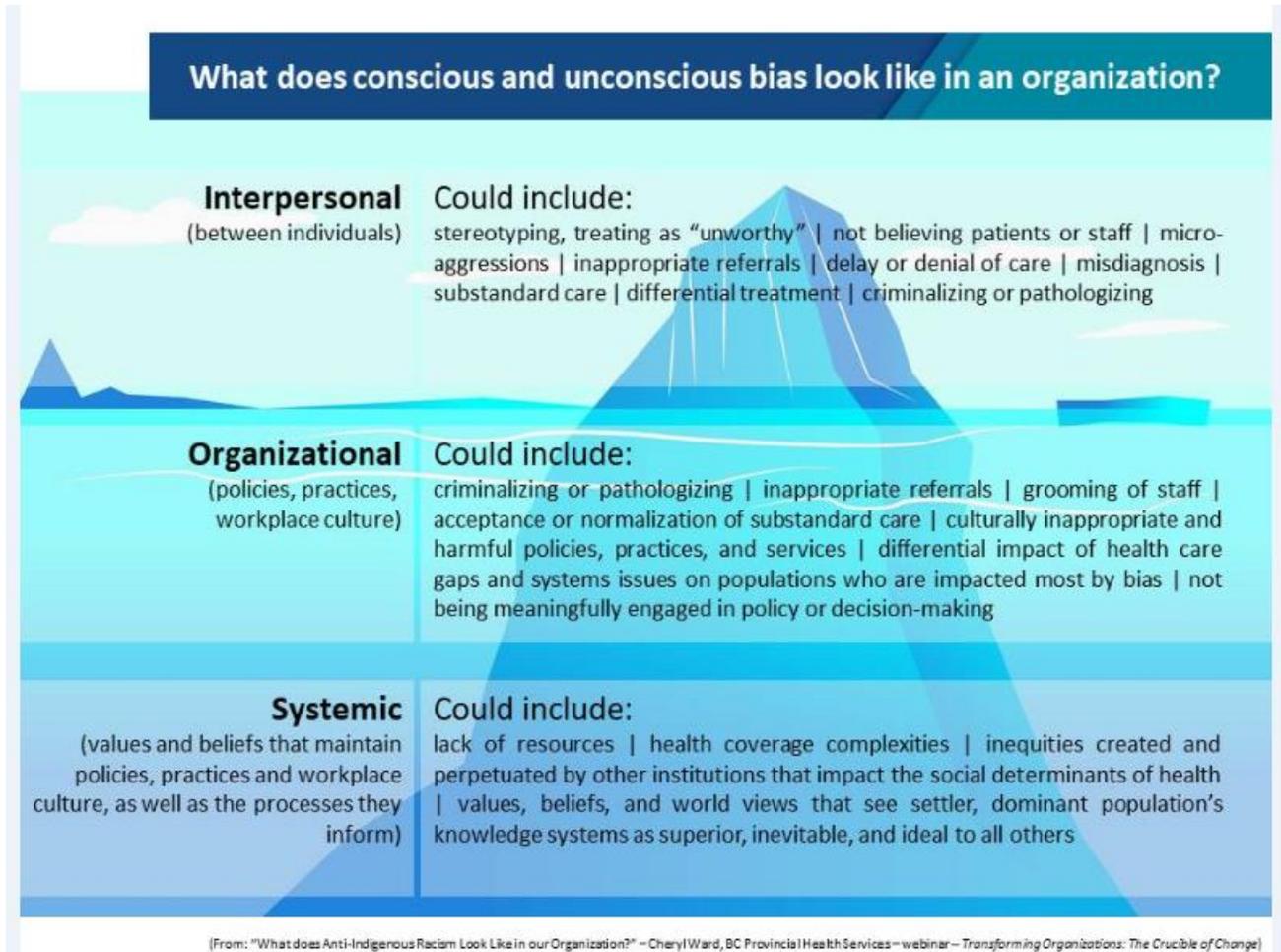
Quality Improvement Processes

- Bias impacts quality of care and quality improvement processes can be informed by patient and family feedback
- This process can address bias by enhancing accountability for staff and learning from the process
- Use recommendations from patients and families – use to extract information about how unconscious bias is prevalent – and ideas to address
- Make sure that they acquire feedback from diverse backgrounds of users of the system
- To provide multiple formats to gather information from families – immediate and frequently – consider language, vocabulary, time it takes to complete
- Surveys, interview for feedback

Truth and Reconciliation Implementation Committee

- Workplace and federally driven training – cultural awareness, treaty awareness, other ways to address unconscious bias
- Having someone at that level of the organization who is Indigenous –
- Have staff who are Indigenous work with staff who are not to increase understanding and address bias

Appendix D The Iceberg



Appendix E

Case Scenarios

Case Scenario #1 Elderly patient on geriatric ward

- A white woman who was 99 years old was admitted to a geriatric ward with patients who had mental health issues.
- She had been having episodes of convulsing, shaking, and being somewhat delirious (was saying strange things).
- Prior to being admitted, she lived on her own and was fully independent
- She stayed in hospital for a total of 12 days. Her sons visited with her daily, in shifts between 8 am and 9pm.
- The patient was a former nurse and was fully aware of what was happening with her.
- They paid for someone to sit with her at night because the nurses wouldn't come when she called for them.
- Family not communicated with – wasn't able to connect with doctor.
- She was discharged without diagnosis or follow-up treatment.
- The sons attempted to meet with the manager of the ward.
- They felt that if she had been younger she would have been seen, diagnosed, and been provided with proper care.

Case Scenario #2 Indigenous woman with chronic pain

- An Indigenous woman was experiencing severe lower back pain and went to a walk-in clinic.
- The physician did not examine her or provide a referral for diagnostic testing. They gave her a prescription for Tylenol 3.
- Over the next 5 months, she continued to experience severe pain and continued to go back to the same walk-in clinic for care, never getting examined, referred, or having her pain addressed properly.
- The physician only doubled her prescription for Tylenol 3.
- She continued to work and look after her family.
- A WRHA public health nurse saw her one day and noticed that she was dragging one leg when she walked.
- This nurse felt that something was seriously wrong and encouraged her to see a different physician.
- She saw another physician. They ordered an urgent MRI for her. She was diagnosed with stage three pancreatic cancer.

Case Scenario #3 Home Care Staff

- A Home Care specialty program in collaboration with an agency partner provides services to an 85 year old white woman.
- Her only family, a daughter, lives in Scotland and visits infrequently but calls her every day.
- She is very reliant on home care in order to stay living in the community.
- The home care program finds her very challenging to provide services to as she is verbally abusive and physically strikes out, in particular when non-white staff provide services.
- Many direct service staff have left her home without providing service because of her behaviour towards them and her outright refusal to allow them to provide care.
- It is felt that the client would be best served in a personal care home environment, but she has been refused by several homes due to concerns around her behavior. Her daughter, while supportive of her mom, is not in a position to intervene and does not appreciate the limitations her mom's behavior has on the services being provided.
- One Personal Care Home has agreed to admit the client, but the client, who is competent, has refused to accept offer of admission.