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Race, Racism and Health Inequity: What can we do about it?

HR Executive Forum

Metropolitan Ballroom

Minneapolis, MN

January 18, 2018

Stephen C. Nelson, MD

Children's Hospitals and Clinics of Minnesota

Hackman Consulting Group

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Goals

- Identify the problem
  - multifactorial
  - root causes
- Tools to address the problem
- Barriers to using the tools
- How to remove these barriers

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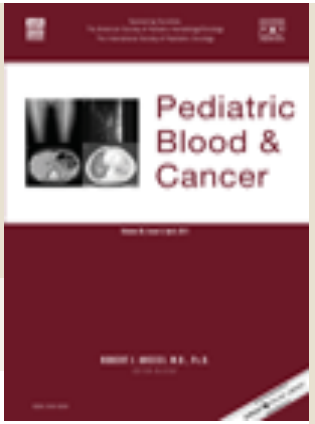

Pediatr Blood Cancer 2013;60:451–454

Race Matters: Perceptions of Race and Racism in a Sickle Cell Center

Stephen C. Nelson, MD[1]* and Heather W. Hackman, EdD[2]

Background. Health care disparities based on race have been reported in the management of many diseases. Our goal was to identify perceptions of race and racism among both staff and patients/families with particular attention to provider attitudes as a potential contributor to racial healthcare disparities. ***Procedure.*** A confidential survey addressing issues of race and health care was given to all patients with sickle cell disease and their families upon arrival to clinic. The survey was made available online to all staff in the hematology/oncology program. Free text comments were obtained. ***Results.*** We received completed surveys from 112 patients/families. Surveys were completed by 135 of 158 staff members (85% return rate). The majority (92.6%) of patients/families identified as black, while 94.1% of staff identified as white ($P < 0.001$). More patients/families felt that race affects the quality of health care for sickle cell patients (50% vs. 31.6%, $P = 0.003$). More staff perceived unequal treatment of patients, especially in the inpatient setting (20.9% vs. 10.9%, $P = 0.03$). ***Conclusions.*** Provider attitudes contribute to continued racial health care disparities. We propose training health care providers on issues of race and racism. Training should provide critical thinking tools for improving medical providers' comfort and skills in caring for patients who are of a different race than their own. Pediatr Blood Cancer 2013;60:451–454. © 2012 Wiley Periodicals, Inc.

Key words: health care disparity; race; sickle cell disease

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Pediatr Blood Cancer 2013;60:349–350

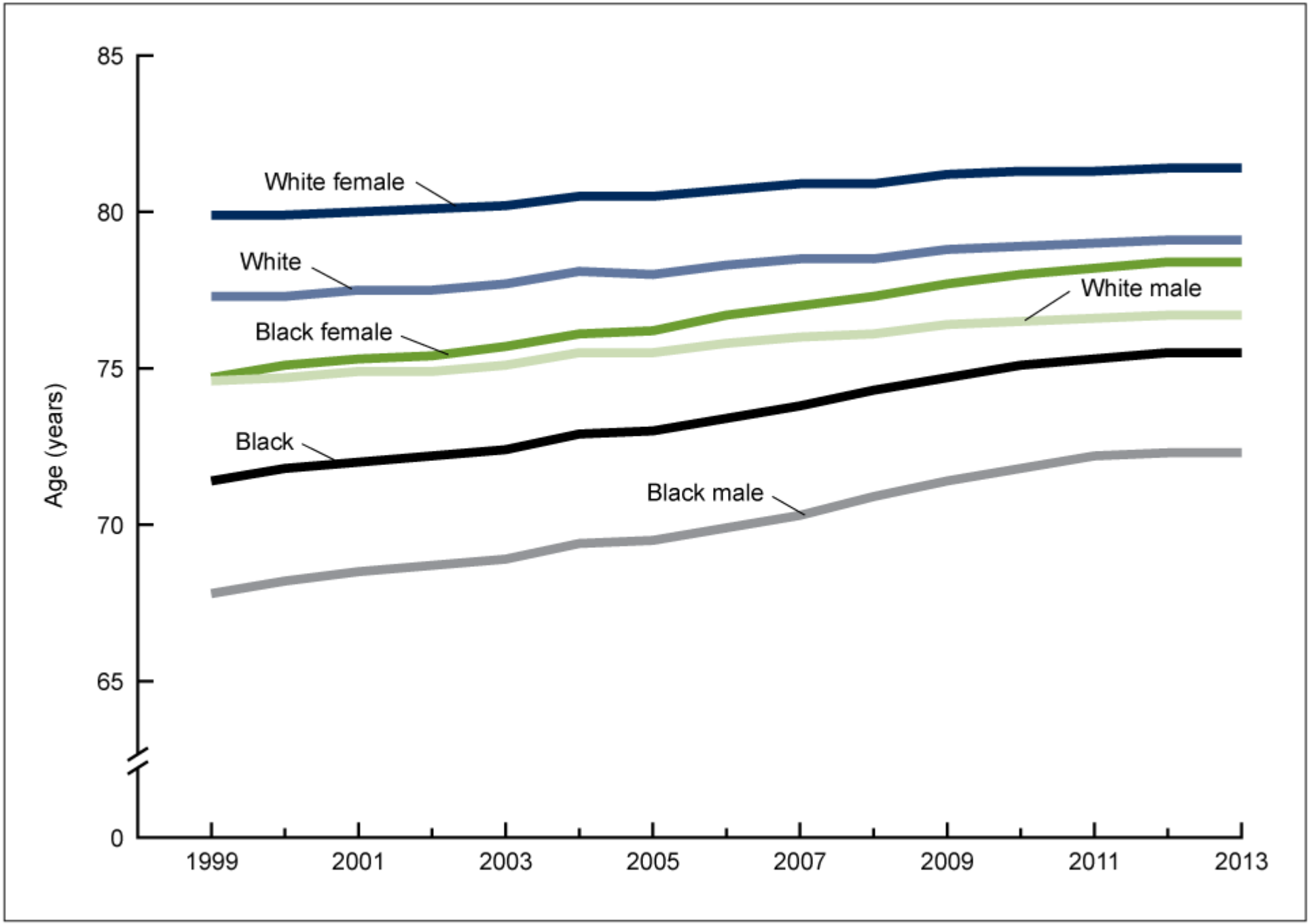
HIGHLIGHT

by Alexis A. Thompson, MD, MPH*

Sickle Cell Disease and Racism: Real or False Barriers?

"It is less useful to continue to characterize an insidious problem if these efforts do not result in the design and implementation of interventions that lead to meaningful change."

Figure 1. Life expectancy, by race and sex: United States, 1999–2013



SOURCE: CDC/NCHS, National Vital Statistics System, Mortality.

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Why?

- Genetics
- SES, insurance, access, education

- Racism, Unconscious bias, Stereotypes

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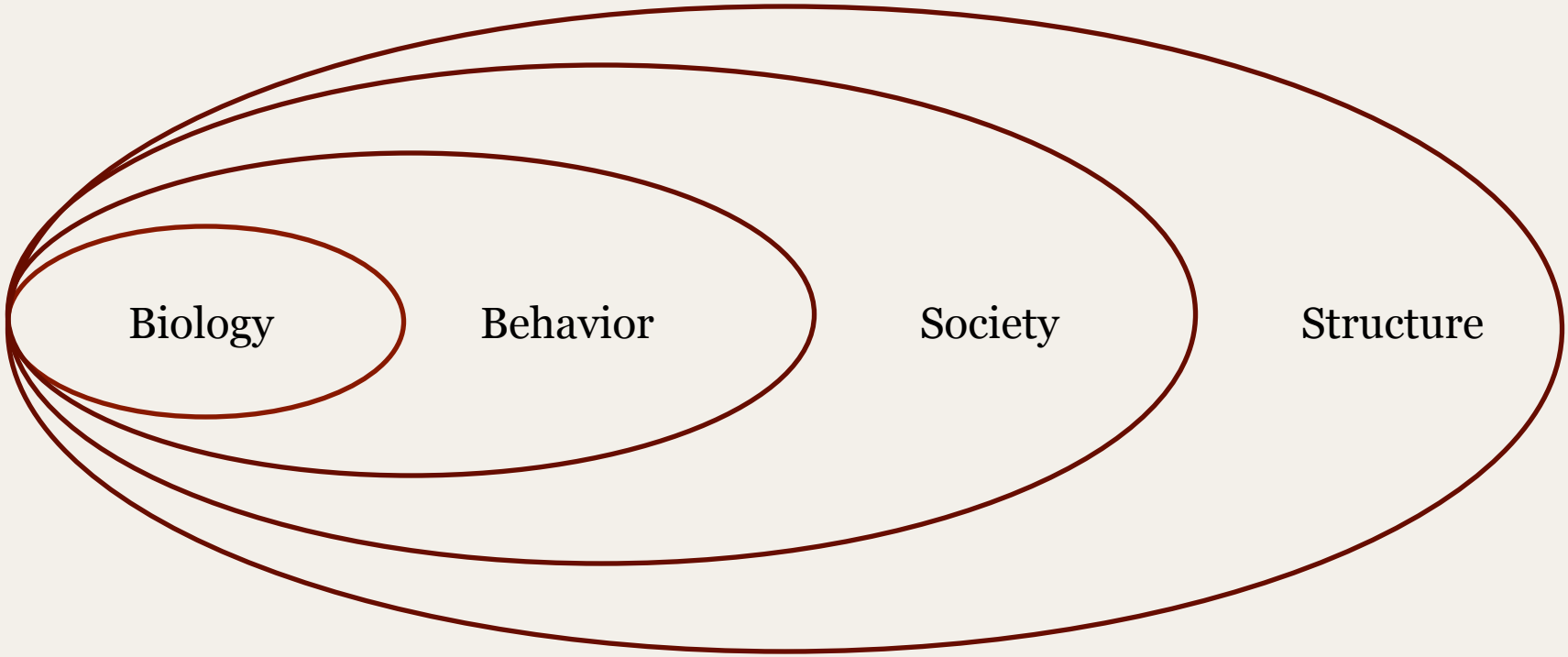
Health Care and Medical Education



DOWNSTREAM

UPSTREAM

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Why?

- Genetics
- SES, insurance, access, education

Pediatr Blood Cancer 2015;62:1819–1825

Racial/Ethnic and Socioeconomic Disparities in Survival Among Children With Acute Lymphoblastic Leukemia in California, 1988–2011: A Population-Based Observational Study

Renata Abrahão, MD, MSc,[1,2]* Daphne Y. Lichtensztajn, MD, MPH,[2] Raul C. Ribeiro, MD,[3] Neyssa M. Marina, MD,[4] Ruth H. Keogh, PhD,[5] Rafael Marcos-Gragera, MD, MSc, PhD,[6] Sally L. Glaser, PhD,[2,7] and Theresa H.M. Keegan, PhD, MSc[2,7]

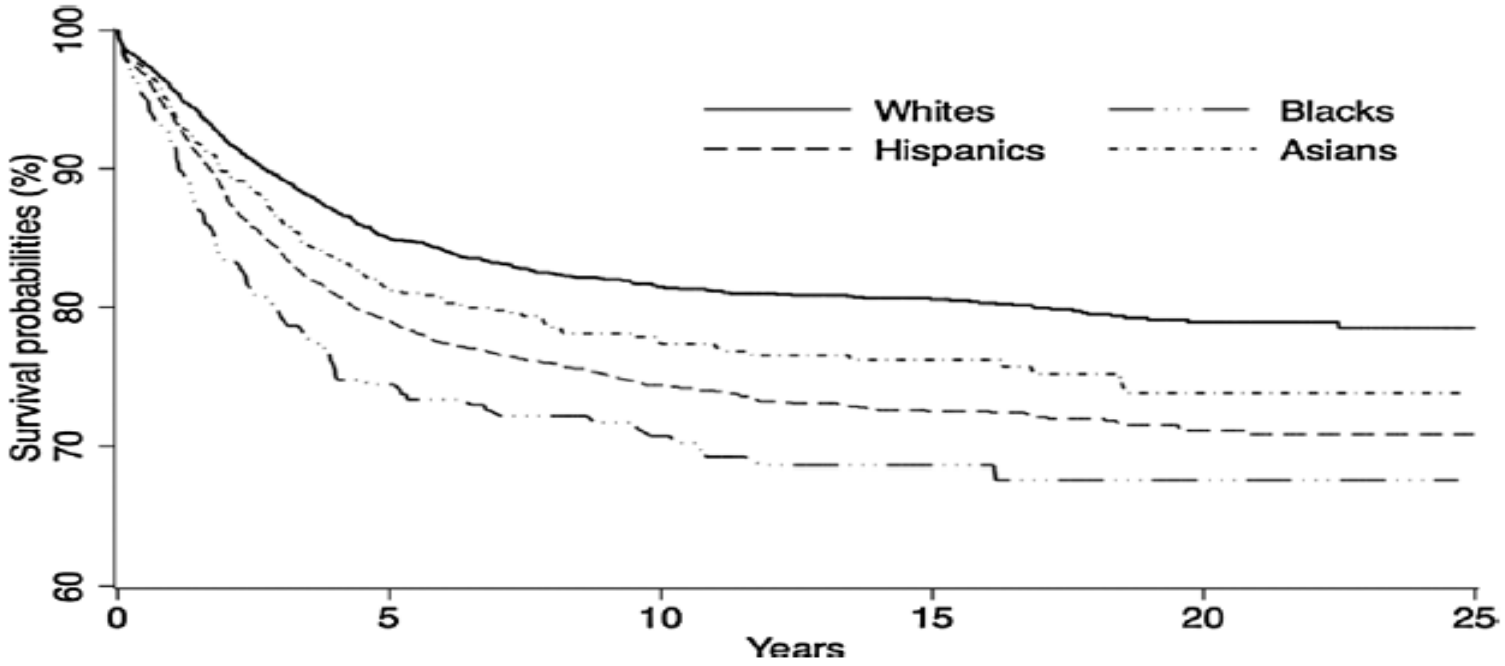

Fig 1. Overall survival by race/ethnicity among children (0–19 years old) diagnosed with acute lymphoblastic leukemia in California, 1988–2011.

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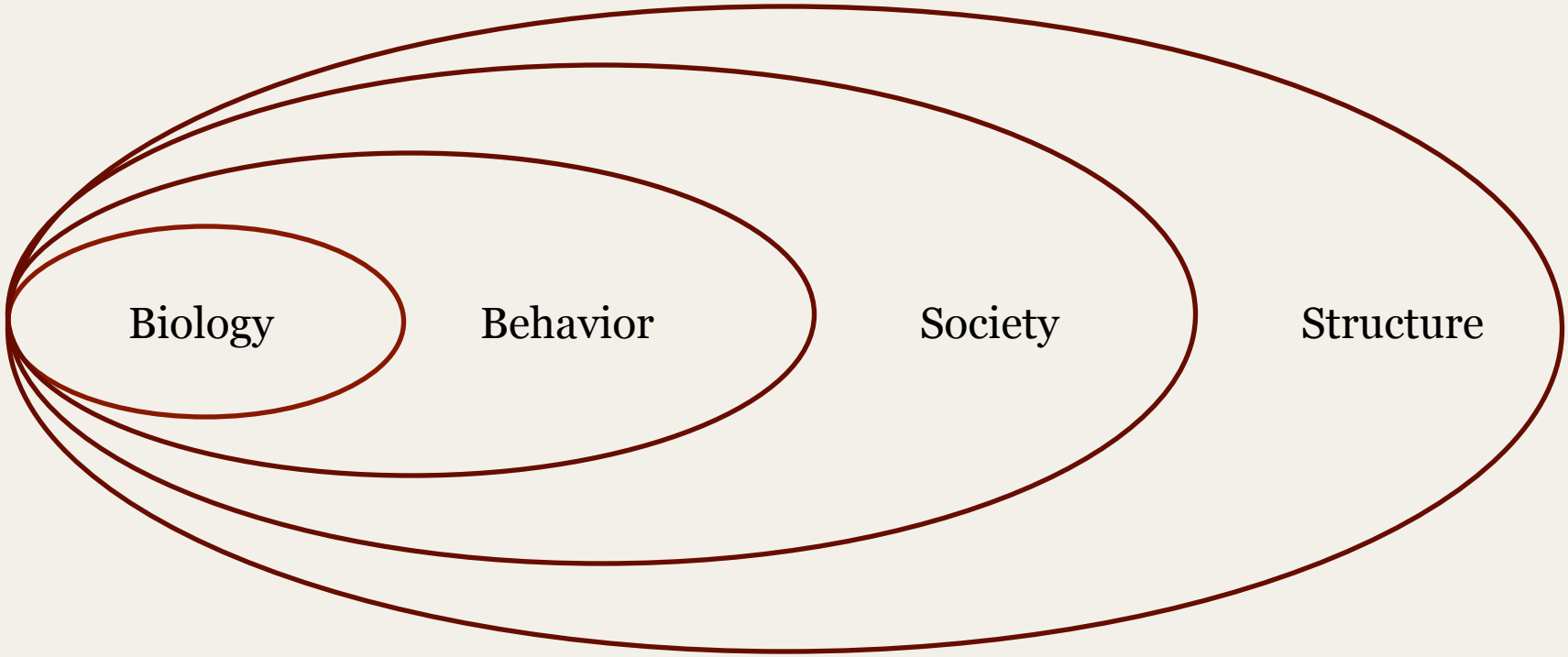
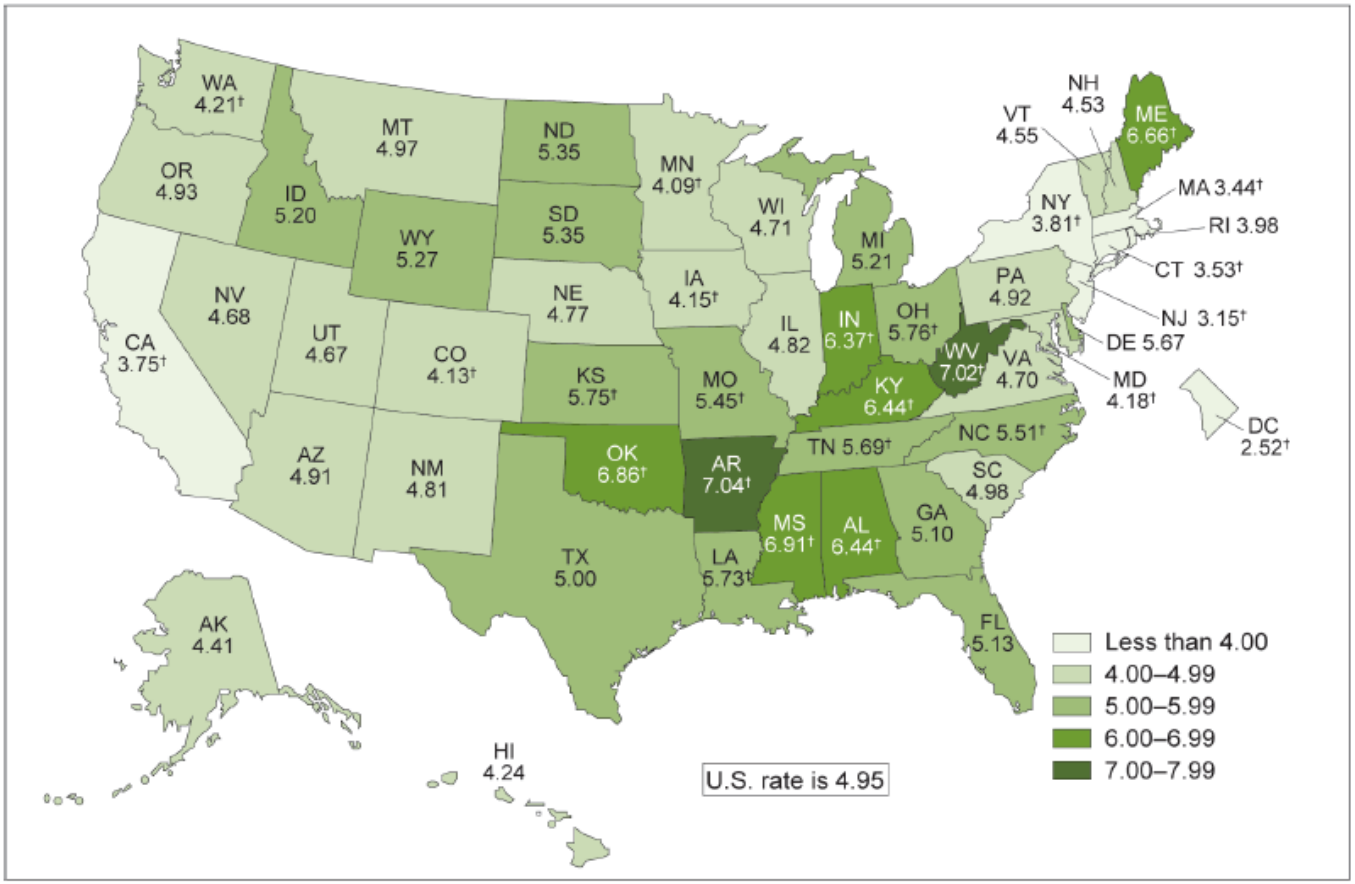
How are we doing in Minnesota?



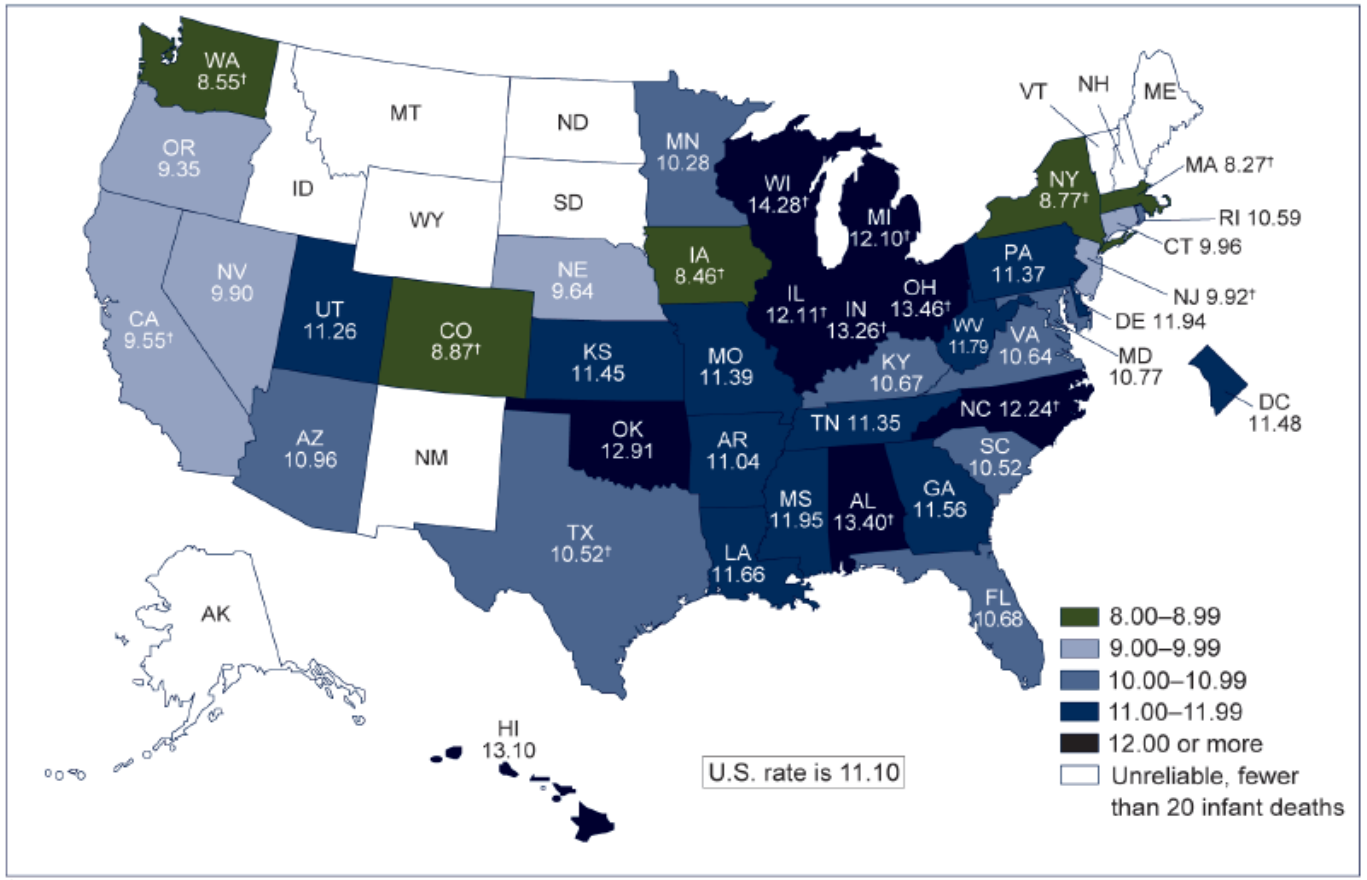
DOWNSTREAM UPSTREAM

Figure 2. Infant mortality rates for infants of non-Hispanic white women, by state: United States, 2013–2015



† Significantly different from the U.S. rate.
NOTES: Rates ranged from 2.52 to 7.04 per 1,000 live births.
Access data table for Figure 2 at: https://www.cdc.gov/nchs/data/databriefs/db295_table.pdf.
SOURCE: NCHS, National Vital Statistics System.

Figure 3. Infant mortality rates for infants of non-Hispanic black women, by state: United States, 2013–2015



† Significantly different from the U.S. rate.
NOTES: Rates ranged from 8.27 to 14.28 per 1,000 live births.
Access data table for Figure 3 at: https://www.cdc.gov/nchs/data/databriefs/db295_table.pdf.
SOURCE: NCHS, National Vital Statistics System.

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Pediatric Emergency Care

Volume 28, Number 11, November 2012

- Children with long bone fracture
- ED 1-yr period
- N=880 with pain scores
- Time from injury to arrival in ED
  - White 8.3 hours
  - Black 10.7 hours *p=0.014*
  - Biracial 11.9 hours *p=0.004*
  - Native American 18.4 hours *p=0.025*

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Pediatric Emergency Care • Volume 28, Number 11, November 2012

- 76,931 ED encounters
- Mar 2, 2009- Mar 31, 2010
- Wait Times
  - White 32 minutes
  - Black 37 minutes
  - Native American 41 minutes
  - Hispanic 39 minutes

$P<0.001$

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Pediatric Emergency Care • Volume 28, Number 11, November 2012

- 76,931 ED encounters
- Mar 2, 2009- Mar 31, 2010
- Odds Ratio of LWCET
  - Black 2.04
  - Native American 3.59
  - Hispanic 2.15
  - Biracial 2.77

$P<0.001$

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Pediatric Emergency Care

Volume 29, Number 4, April 2013

- Children with long bone fracture
- ED 1-yr period
- N=878
- Opioid-containing prescription
  - White 67.4%
  - Black 47.1% RR 0.59
  - Hispanic 47.9% RR 0.61
  - Native American 58.3% RR 0.93
  - Biracial 40.3% RR 0.45

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NACHRI
National Association of Children's Hospitals and Related Institutions

NACHRI October 2011

- Chart review long bone fractures
- Jan 1 2008-Dec 31 2010
- 2206 patients
  - 1386 M 820F
- Bone
  - Radius/ulna 1116
  - Humerus 566
  - Ankle 189
  - Tib/fib 173
  - Femur 162

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NACHRI
National Association of Children's Hospitals and Related Institutions

NACHRI October 2011

- Mean time to getting pain med 50.3 min
- Black 64 minutes
- White 45 minutes
- IV narcotics
  - White 57.8%
  - Black 48.4% p <0.001

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NACHRI
National Association of Children's Hospitals and Related Institutions

NACHRI October 2011

- Conclusions
  - Racial and cultural differences need study to identify:
    - Variable tolerance to pain
    - Hesitation to reporting pain based on culture or poor health care literacy

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Barriers to Equity

- System
  - Whiteness/lack of diversity
  - Poor access
  - Social Determinants of Health
  - transition to adult care
  - research and support money
  - Racism
- Patients
  - Poor health literacy
  - Fear and mistrust
  - Internalized racism
- Community
  - advocacy
  - public awareness
- Providers
  - Implicit bias/stereotyping
  - Power

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Implicit Bias

- What is it?
- How do I know?
- Does this really affect care?
- How do I avoid it?

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the ONION Store

America's Finest Shopping Experience

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Unconscious biases

- Common
- Rooted in stereotyping
  - cognitive process where we use social categories to acquire, process, and recall information about people
- Helps us organize complex information
- Heavy cognitive load
  - rely on stereotyping to process information
  - consciously reducing this is hard work

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The Cost of Technology

Elizabeth Toll, MD

JAMA, June 20, 2012—Vol 307, No. 23

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"The problem with stereotypes is not that they are untrue, but that they are incomplete. They make one story become the only story."

-Chimamanda Ngozi Adichie
Nigerian American novelist

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Implicit Bias

- What is it?
- How do I know?
- Does this really affect care?
- How do I avoid it?

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Implicit Bias

- Human
- Implicit Association Test
  - https://implicit.harvard.edu

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Power/Bias

- Gender
- Race
- Language
- Religion
- Sexuality
- Education
- Income
- Obesity
- Smoking
- Disability
- Deaf/Hard of hearing

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Implicit Bias

- What is it?
- How do I know?
- Does this really affect care?
- How do I avoid it?

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"Crisis"

- http://www.youtube.com/watch?v=FuelQDBOxXI
- CRISIS: Experiences of people with sickle cell disease

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Implicit Bias

- What is it?
- How do I know?
- Does this really affect care?
- How do I avoid it?

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Provider Training

- Diversity Training
  - Awareness
  - Appreciation
- Cultural ~~Competency~~ Humility
  - Cross-cultural communication
  - Information gathering
  - Skills training

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Provider Training

- Social Justice
  - Oppression
  - Power
  - Societal resources
  - Structural barriers
  - Race/racism/whiteness
  - Implicit bias

Pediatr Blood Cancer 2015;62:915–917

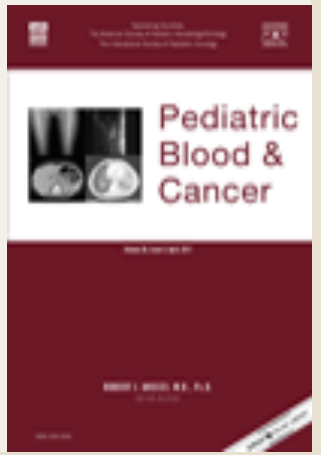
BRIEF REPORT

Training Providers on Issues of Race and Racism Improve Health Care Equity

Stephen C. Nelson, MD,[1,2]* Shailendra Prasad, MD, MPH,[3] and Heather W. Hackman, EdD[2]

Race is an independent factor in health disparity. We developed a training module to address race, racism, and health care. A group of 19 physicians participated in our training module. Anonymous survey results before and after the training were compared using a two-sample *t*-test. The awareness of racism and its impact on care increased in all participants. White participants showed a decrease in self-efficacy in caring for patients of color when compared to white patients. This training was successful in deconstructing white providers' previously held beliefs about race and racism. Pediatr Blood Cancer 2015;62:915–917. © 2015 Wiley Periodicals, Inc.

Key words: health care disparity; race; unconscious bias



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Individual Tools

- Recognize
  - Cognitive dissonance
  - Aversive racism
  - Catch yourself seeking alternate explanations
- Discomfort
  - Emotional regulation
  - Be in the moment
- Lean in

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AJPH
A PUBLICATION OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

Levels of Racism: A Theoretic Framework and a Gardener's Tale

Camara Phyllis Jones, MD, MPH, PhD

American Journal of Public Health August 2000, Vol. 90, No. 8

www.youtube.com/watch?v=GNhcY6fTyBM

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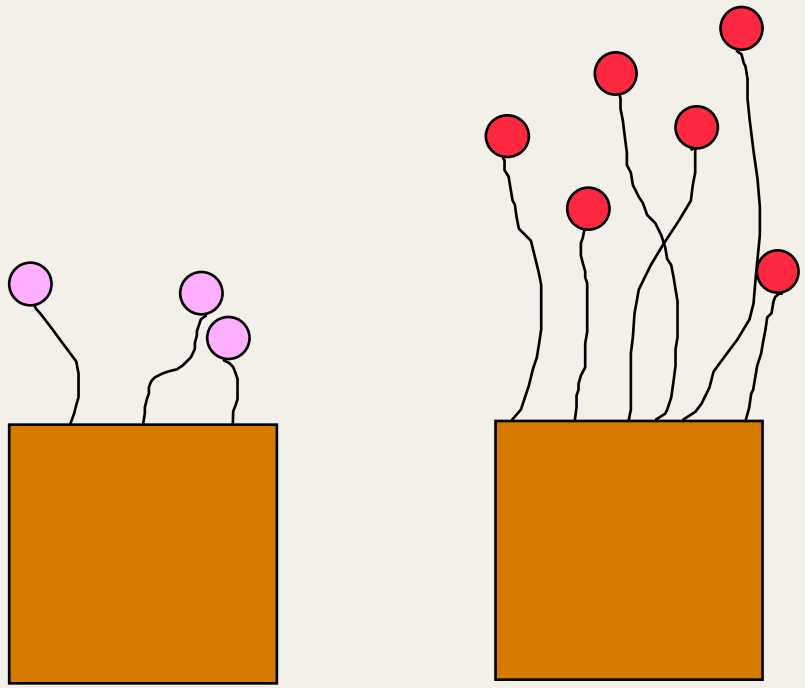
Institutionalized racism



- Initial historical insult
- Structural barriers
- Inaction in face of need
- Societal norms
- Biological determinism
- Unearned privilege

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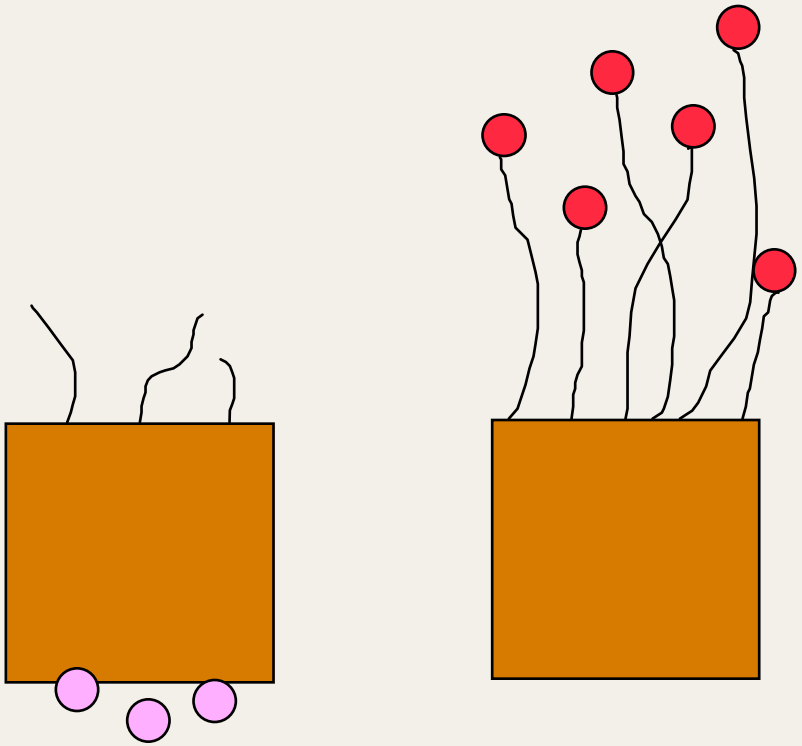
Personally-mediated racism



- Intentional
- Unintentional
- Acts of commission
- Acts of omission
- Maintains structural barriers
- Condoned by societal norms

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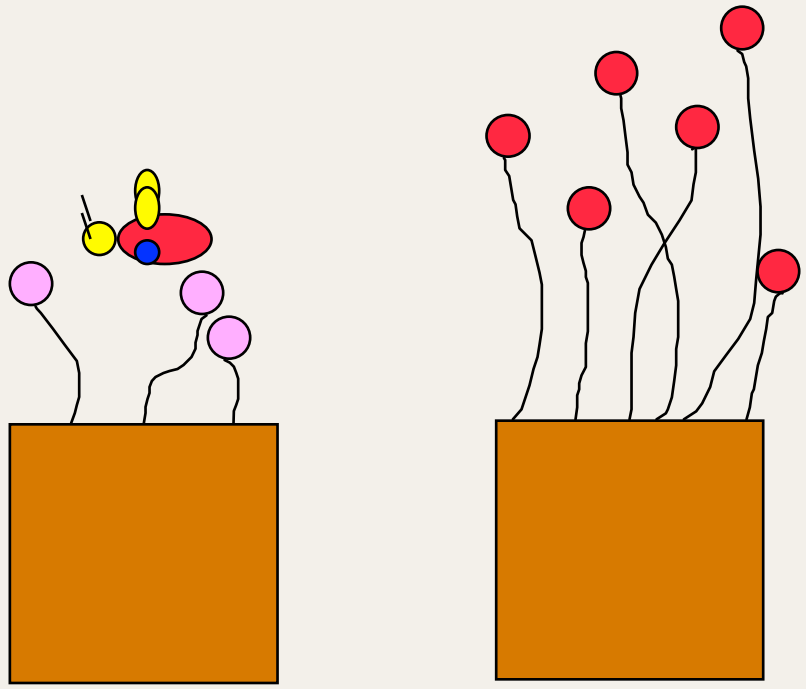
Internalized racism



- Reflects systems of privilege
- Reflects societal values
- Erodes individual sense of value
- Undermines collective action

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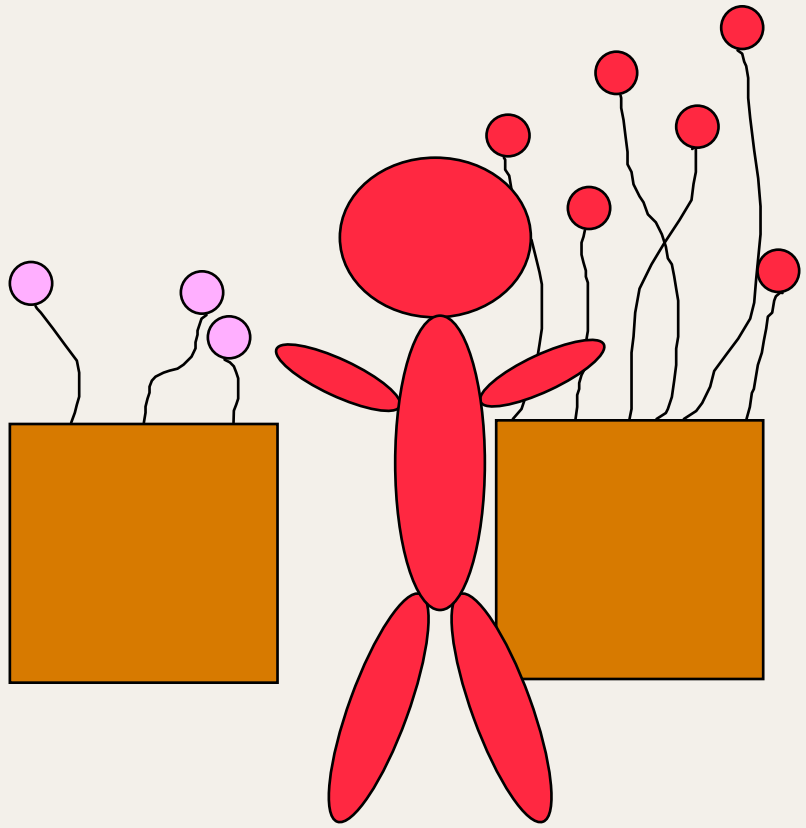
Who is the gardener?



- Government
- Power to decide
- Power to act
- Control of resources
- Dangerous when:
  - Allied with one group
  - Not concerned with equity

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Cases

- Institutional
- Interpersonal
- Internalized

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Barriers to Social Justice Work

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1

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EXHIBIT ES-1. OVERALL RANKING

COUNTRY RANKINGS

- Top 2*
- Middle
- Bottom 2*

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING (2013)	4	10	9	5	5	7	7	3	2	1	11
Quality Care	2	9	8	7	5	4	11	10	3	1	5
Effective Care	4	7	9	6	5	2	11	10	8	1	3
Safe Care	3	10	2	6	7	9	11	5	4	1	7
Coordinated Care	4	8	9	10	5	2	7	11	3	1	6
Patient-Centered Care	5	8	10	7	3	6	11	9	2	1	4
Access	8	9	11	2	4	7	6	4	2	1	9
Cost-Related Problem	9	5	10	4	8	6	3	1	7	1	11
Timeliness of Care	6	11	10	4	2	7	8	9	1	3	5
Efficiency	4	10	8	9	7	3	4	2	6	1	11
Equity	5	9	7	4	8	10	6	1	2	2	11
Healthy Lives	4	8	1	7	5	9	6	2	3	10	11
Health Expenditures/Capita, 2011**	$3,800	$4,522	$4,118	$4,495	$5,099	$3,182	$5,669	$3,925	$5,643	$3,405	$8,508

Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.
Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund *National Scorecard 2011;* World Health Organization; and Organization for Economic Cooperation and Development, *OECD Health Data, 2013* (Paris: OECD, Nov. 2013).

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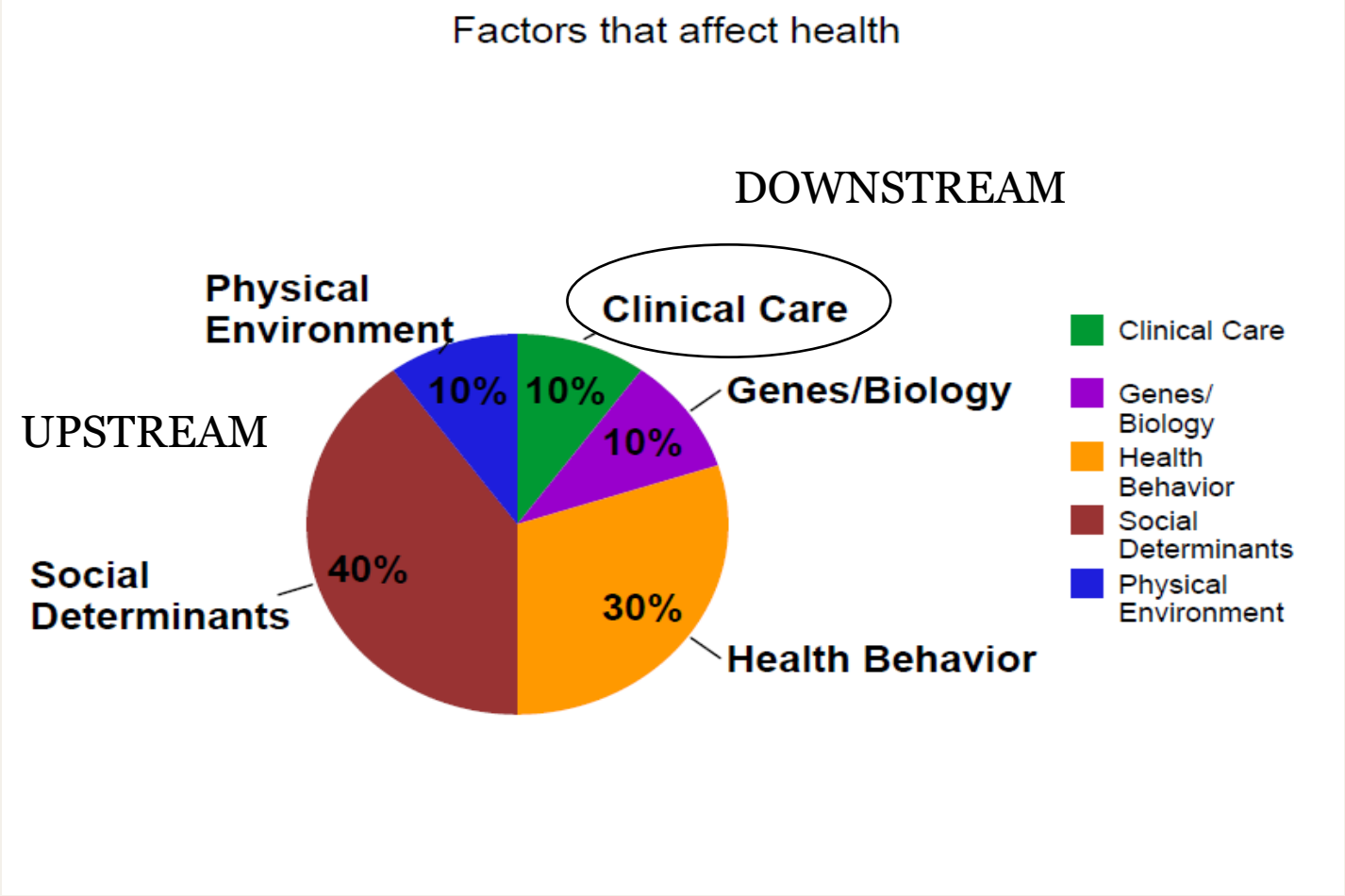
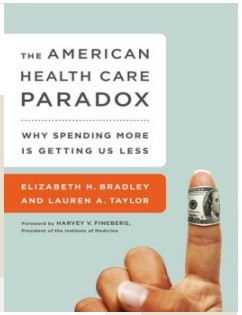


Bradley EH, Elkins BR, Herrin J, *et al. BMJ Qual Saf* (2011). doi:10.1136/bmjqs.2010.048363



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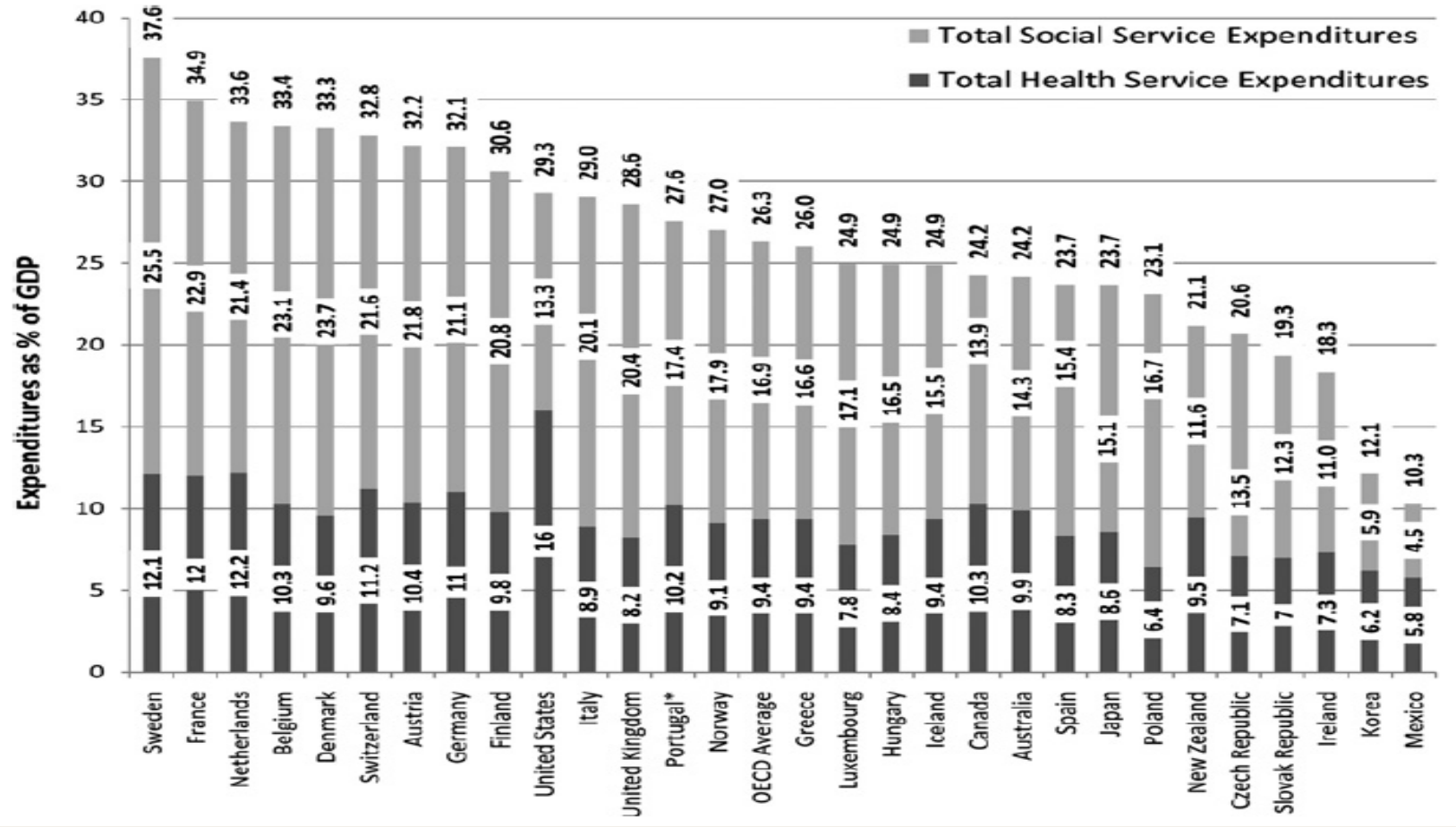

OECD Health Data 2009

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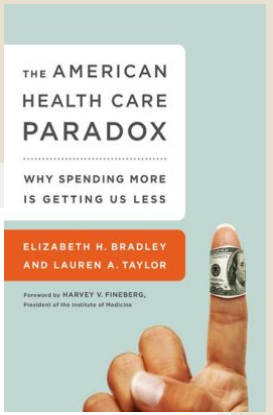
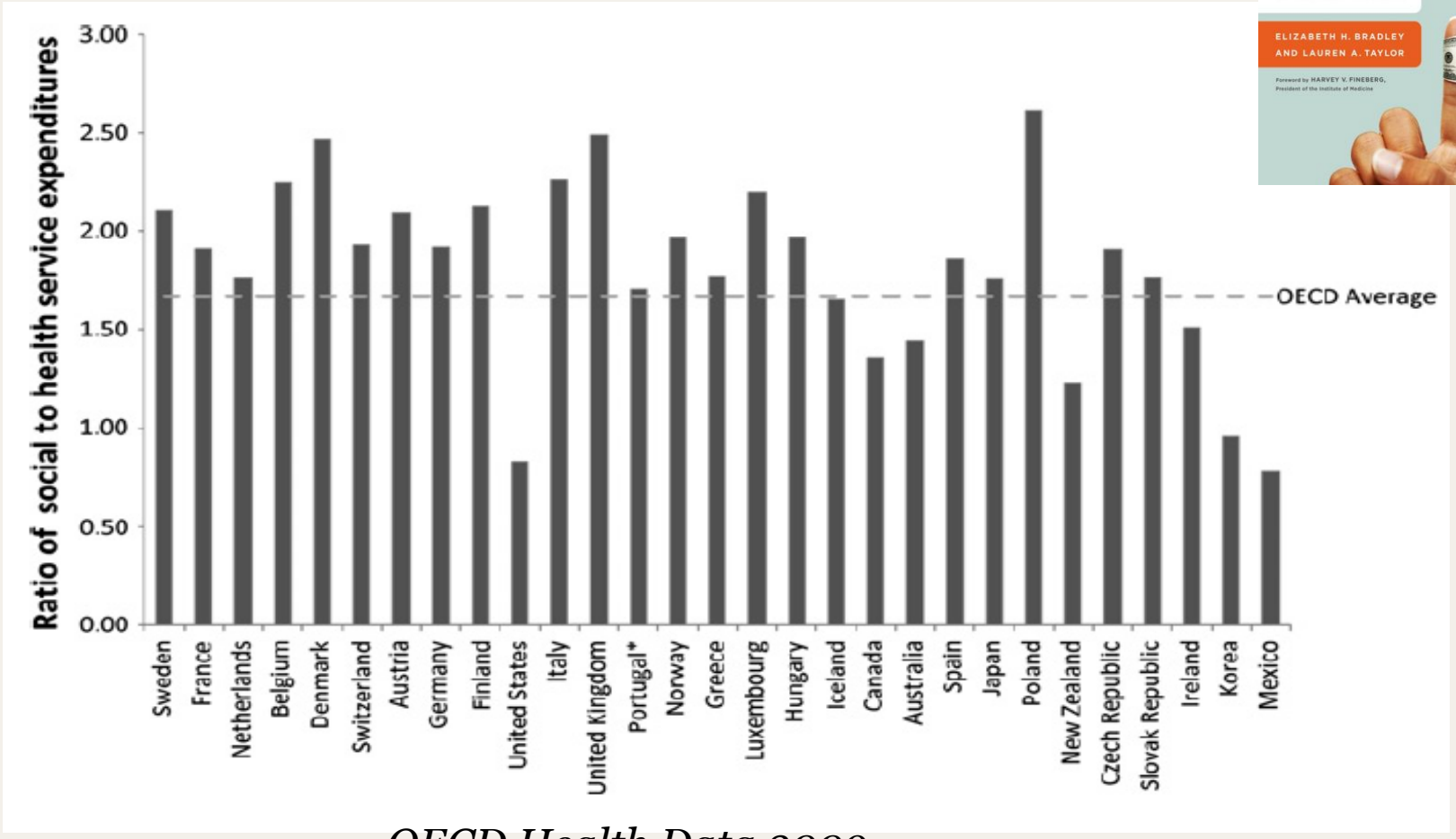
Bradley EH, Elkins BR, Herrin J, *et al. BMJ Qual Saf* (2011). doi:10.1136/bmjqs.2010.048363





OECD Health Data 2009

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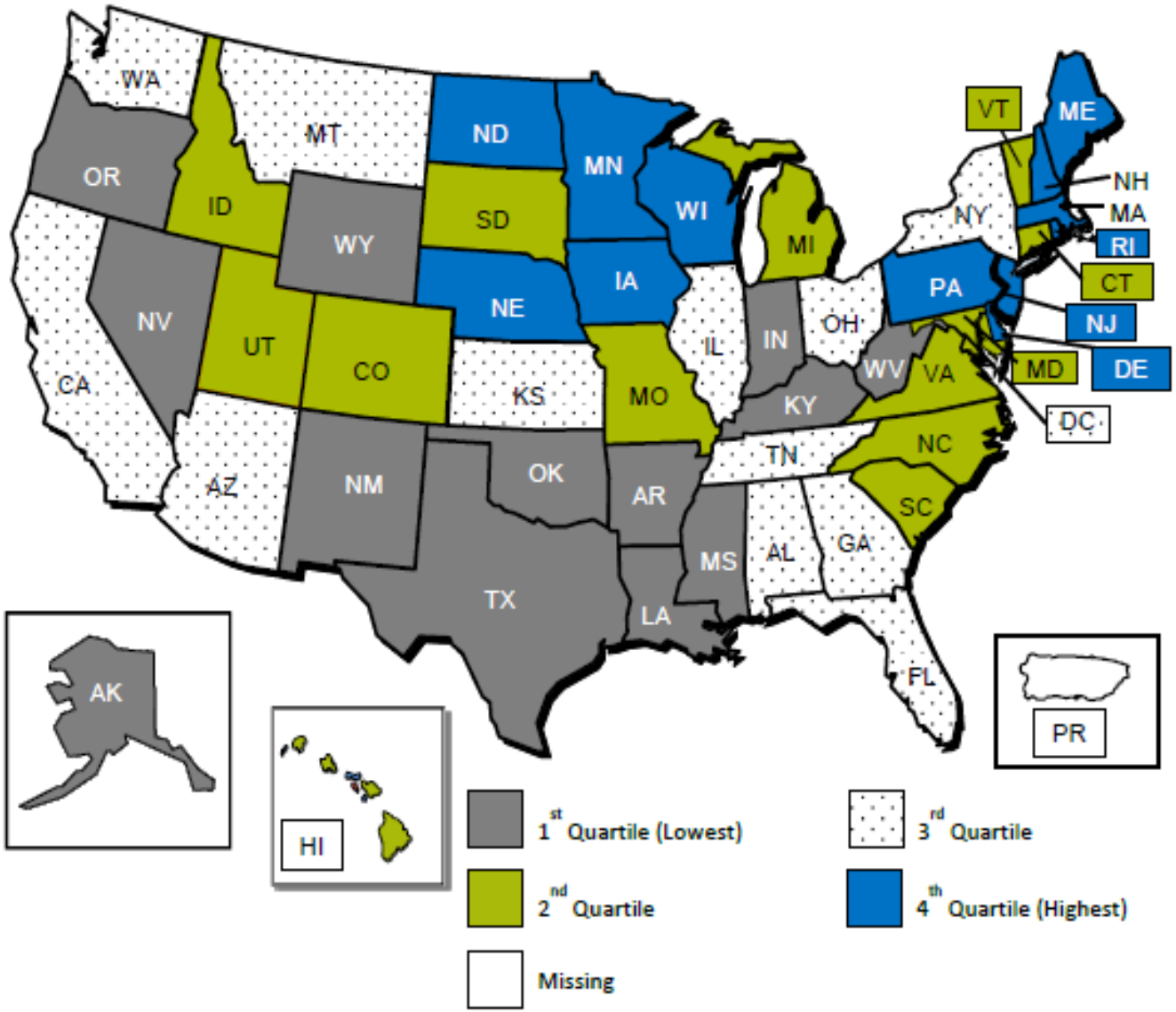
Time

- Cognitive load
  - Stereotype default
- Curriculum
  - More important things to learn
- Culture of Medicine

2016
National Healthcare
Quality
and Disparities
Report

www.ahrq.gov

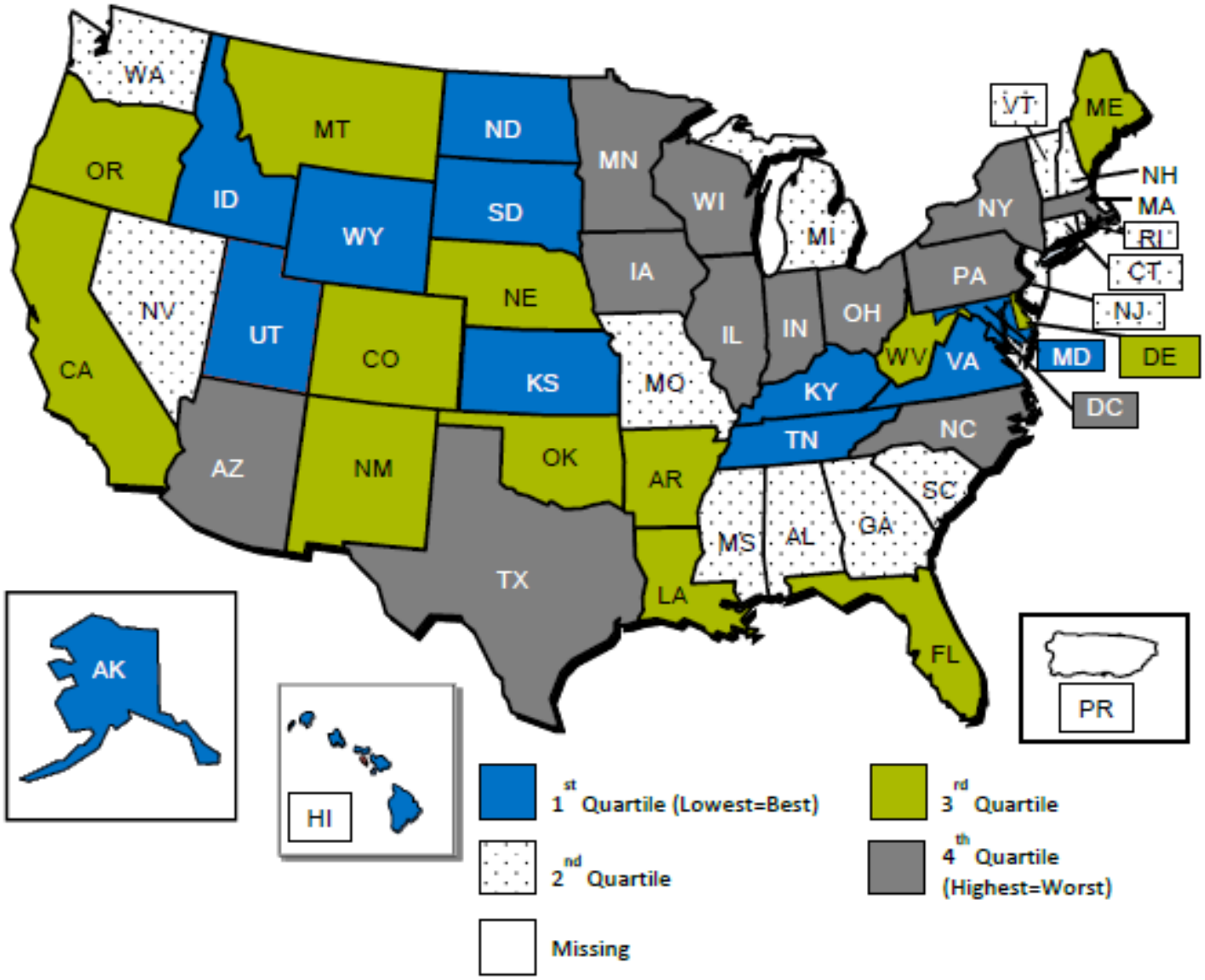
Figure 7. Overall quality of care, by state, 2014-2015



2016
National Healthcare
Quality
and Disparities
Report

www.ahrq.gov

Figure 8. Average differences in quality of care for Blacks, Hispanics, and Asians compared with Whites, by state, 2014-2015



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MN Community MEASUREMENT
Measure Up To Better Health

2016 Health Equity of Care Report

Stratification of Health Care Performance Results in Minnesota by Race, Hispanic Ethnicity, Preferred Language and Country of Origin

mncm.org/wp-content/uploads/2017/02/2016-Health-Equity-of-Care-Report-2.2.2017.pdf

“I treat everyone the same”

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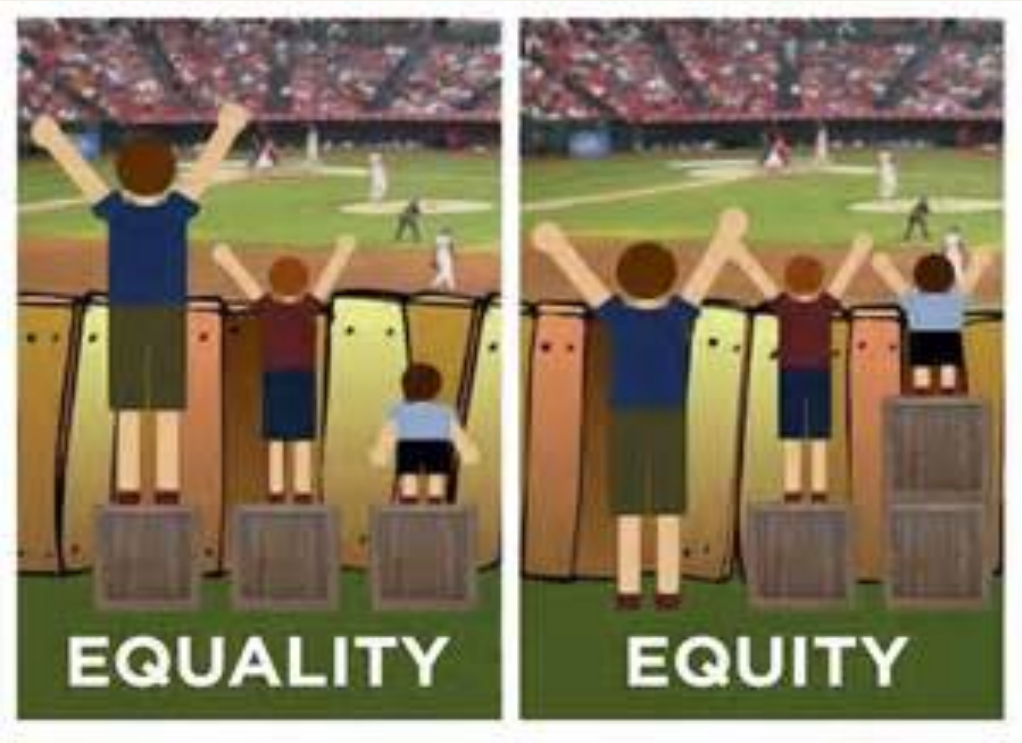
Equality ≠ Equity



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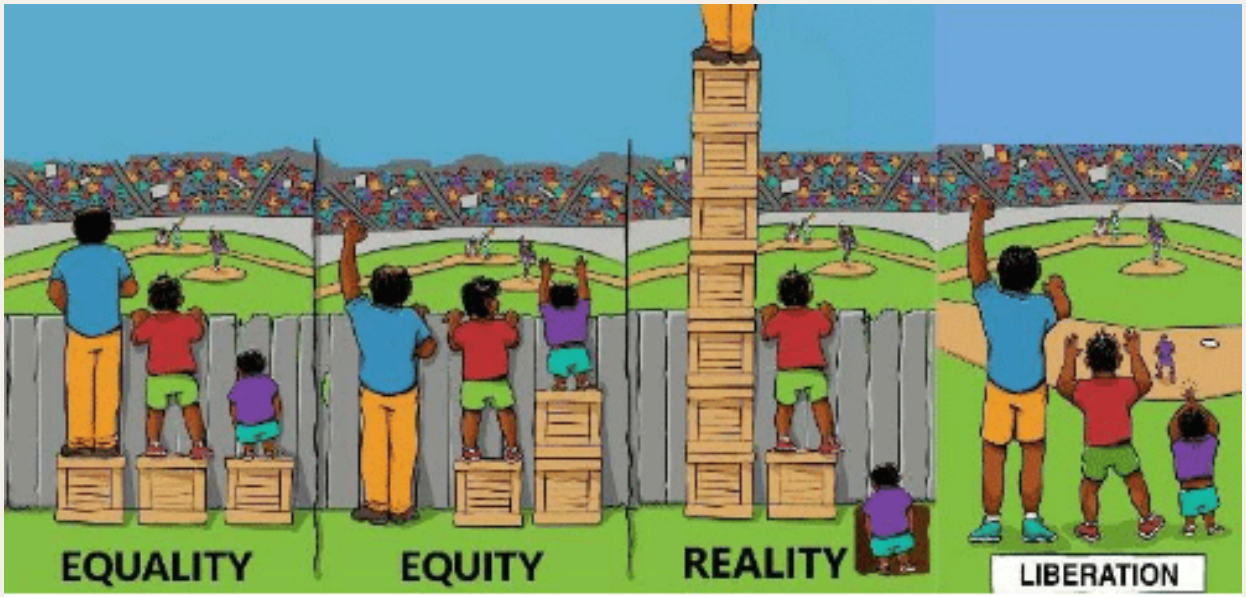

Liberation

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“I believe in personal responsibility”

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The Unequal Opportunity Race

https://www.youtube.com/watch?v=vX_Vzl-r8NY

"This is an insult to my intelligence"

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"I do not think I'm God. God-like, yes, but not God."

"It helps doctor's morale. Each one gets to put themselves up on a pedestal for a day!"

“Are you calling me a racist?”

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Racism without Racists

Aversive Racism

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Pitfalls of Race

- Individualistic
- Legalistic
- Tokenistic
- Historical/Ahistorical

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Pitfalls of Race

- Individualistic
- Legalistic
- Tokenistic
- Ahistorical
- Fixed

Deflection

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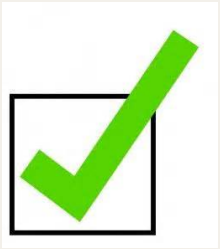
- Let's talk about "differences"
- Didn't we already do that?
- D vs CC vs SJ



Whiteness

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Whiteness

- Whiteness (WN) is the overwhelming presence of White centrality, White normativity, White privilege and White supremacy in our society.

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Whiteness = WP + WS

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White Privilege

- White Privilege (WP) is the **system** of advantages and benefits that White folks receive as a result of WN and racism in our society.

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White Privilege

- Unearned
  - Dalton, 1998: “White skin privilege is a birthright, a set of advantages one receives simply by being born with features that society values highly.”

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White Privilege

- Whites are actively taught not to see their privilege
  - McIntosh, 2002: “An invisible package of unearned assets which I can count on cashing in each day, but about which I was ‘meant’ to remain oblivious.”

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Supremacy

- The habit of believing or acting as if your life, your love, your culture, your self has more intrinsic worth than those of people who differ from you.

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White Supremacy

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White Supremacy

- White Supremacy (WS) is the ideology (values, beliefs, ideals, behaviors and cultural markers) that justifies the system of racial oppression and how it benefits White people in our society.

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The first rule of White Club is you do not talk about White Club…

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"Whiteness is slick and endlessly inventive. It is most effective when it makes itself invisible, when it appears neutral, human, American."

-Michael Eric Dyson

Tears We Cannot Stop

2017

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White Innocence

- "Whiteness claims its innocence so loudly because it is guilty…."
  - Guilt can be intense
  - Accepting accountability is terrifying

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White Fragility

- Discussion of whiteness
  - Battering
  - Intolerable
  - Fear, anger, guilt
  - Argue or silence or leave the room

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Tools to chip away at the edifice

What's your mission/vision?

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Our vision is *to be every family's essential partner in raising healthier children.*

Personal motivation/core values?

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Why did you become a doctor/ nurse?

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Equity Climate = Safety Climate

Raise awareness

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Data Data Data

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PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

http://pnhpminnesota.org/

Minnesota Doctors for Health Equity

https://www.mdhealthequity.com

Address the ego

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- White fragility/White innocence
- Active listening
  - validation
- Personal narrative
  - Felt, Found, Feel

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Don’t make it personal

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Racism ≠ Bad People

Find Allies

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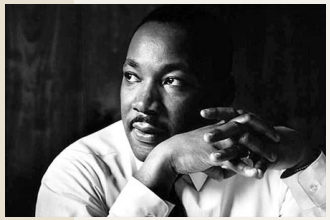
Thank you

"Of all forms of inequity, injustice in healthcare is the most shocking and inhumane."



Martin Luther King, Jr.

National Convention of the Medical Committee for Human Rights

Chicago- 1966

"Not everything that is faced can be changed. But nothing can be changed until it is faced"

James Arthur Baldwin

novelist, essayist, playwright, poet

(August 2, 1924 – December 1, 1987)

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The Distress of the Privileged

https://www.youtube.com/watch?v=PqgiqpKMtWg/

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Historical Moments of Black Progress

- Reconstruction
- Modern Civil Rights Movement
- Obama Presidency

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Followed By…

- Jim Crow and Lynchings
- Fights against integration/busing
- Trump Presidency

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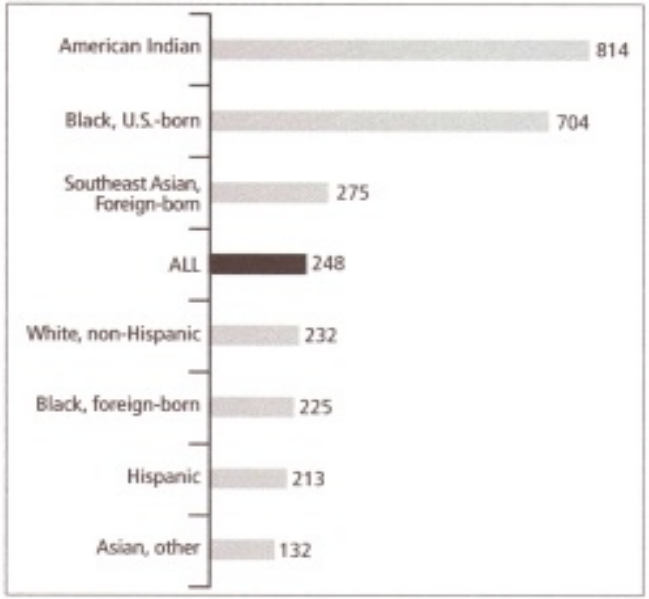
Whiteness

- Who teaches us?
  - White physicians
  - 8% faculty AA, Latino, Native American (AAMC 2013)
- What are we taught?
  - Evidence-based protocols developed by majority white researchers, using majority white patients, carried out by the majority white health care system
- White normativity
  - Lab values
  - White and non-white

AMHERST H. WILDER FOUNDATION

Blue Cross and Blue Shield of Minnesota Foundation

10. Mortality rates* by race and ethnicity, Twin Cities 7-county region



* Age-standardized deaths per 100,000, among the population age 25-64 during the years 2005 to 2007.
Source: Minnesota Department of Health (mortality rates calculated by Wilder Research).

http://www.bcbsmnfoundation.org

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