Dismantling Institutional Racism to Achieve Health Equity: New Framework

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Tuesday, October 22, 2019
Session B9 1:45 – 2:15 pm

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Session Description

Health equity is a key aim of quality health care, but serious disparities still exist. Health status and life expectancy among the poorest compared to other neighborhoods in cities across the U.S. show huge gaps. This session focuses on institutional racism - the structures, processes and norms that result in inequitable care and outcomes. Dismantling institutional racism is one of the elements of the five-part framework in the Institute for Healthcare Improvement's paper on Achieving Health Equity published in 2016. The presenter is a co-author of that paper, and has been faculty for IHI programs about health equity. We recently developed a framework specifically related to Dismantling Institutional Racism in Health Care Organizations, which will be shared in this session.

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Session Objectives

1. Recognize institutional racism in health care organizations, and understand the harm caused to patients, providers and staff and the community.

2. Discuss racism and unconscious bias, and build will for seeing how it manifests in your organization and how to address it.

3. Apply lessons from case studies of organizations that have been working to implement the framework from the IHI Achieving Health Equity paper.

4. Discuss and compare the experience of health care organizations in the U.S., South Africa and other countries regarding institutional racism in health care.

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Inequitable Care & Health Outcomes in the United States

- Black women have lower rates of breast cancer but are more likely to die from the disease
- Women with disabilities are less likely to receive screenings for breast and cervical cancer
- Blacks are 10 times more likely to have AIDS; Hispanics are 3 times as likely
- American Indian/Alaska Natives twice as likely as whites to have frequent mental distress
- 2.5 times more Hispanics as whites report having no doctor
- Adolescents and adults with disabilities are more likely to be excluded from sex education
- LGBT inequities related to oppression and discrimination - youth more likely to be homeless, 2-3 times as likely to attempt suicide, lack health insurance and lack knowledgeable health care providers

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Inequitable Care & Health Outcomes in the United States

- Minority groups (except Asians) more likely to report health as fair or poor
- Infant mortality for blacks 2.5 times higher than for whites
- Low-income and uninsured adults are less likely to rate the quality of their care as excellent or very good
- Blacks are 3 times as likely to die from asthma than whites
- American Indian/Alaska Natives twice as likely to have diabetes
- Homeless populations experience unsafe discharges

2014 National Healthcare Quality & Disparities Report. June 2015. Agency for Healthcare Research and Quality, Rockville, MD.
CDC Health Disparities and Inequalities Report, 2013.
HealthyPeople 2020.
WHO disability and health fact sheet.
Commonwealthfund, Racial and Ethnic Disparities in US Health Care: A Chartbook, 2008.
Commonwealthfund, Achieving Better Quality of Care for Low-Income Populations. The Role of Health Insurance and the Medical Home for Reducing Health Inequities. May 2012.

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Maps Show Life Expectancy Gaps

Chicago neighbor-hoods along the Chicago public transit system (red line train, green line train, and orange line train.

https://societyhealth.vcu.edu/work/the-projects/mapschicago.html

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David R. Williams PhD, MPH
Harvard T.H. Chan School of Public Health

Longtime researcher on racial and socioeconomic differentials in health

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Ronald Wyatt, MD / Amy Reid, MPH/ John W. Whittington, MD

Dr. Ron Wyatt is a leader in the work to achieve health equity.

Amy Reid leads efforts to advance health equity at the Institute for Healthcare Improvement (IHI).

John W. Whittington, MD, Quality Leader, Innovator, Senior Fellow, IHI

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Crossing the Quality Chasm - Six Aims for Improvement

- Safety
- Timeliness
- Effectiveness
- Efficiency
- Equity
- Patient-Centeredness

(STEEEP)

IOM Crossing the Quality Chasm: A New Health System for the 21st Century, 2001

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Alternative IOM Framework

Crosscutting Dimensions	Components of Quality Care	Type of Care		
		Preventive Care	Acute Treatment	Chronic condition management
EQUITY / VALUE	Effectiveness			
	Safety			
	Timeliness			
	Patient/family-centeredness			
	Access			
	Efficiency			
	Care Coordination			
	Health Systems Infrastructure Capabilities			

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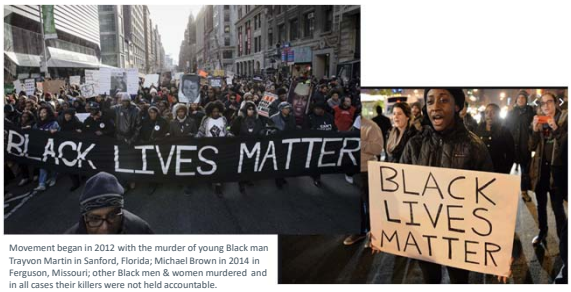
Black Lives Matter Movement



Movement began in 2012 with the murder of young Black man Trayvon Martin in Sanford, Florida; Michael Brown in 2014 in Ferguson, Missouri; other Black men & women murdered and in all cases their killers were not held accountable.

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U.S. National Initiatives - Examples

Not-for-Profit Health Care Organizations
- Institute for Healthcare Improvement (IHI) – Pursuing Equity – link to site and to case studies

Health Care Professional Organizations
- American Public Health Association https://www.apha.org/topics-and-issues/health-equity
- American Hospital Association - #123forEquity http://www.equityofcare.org
- American Pediatric Association – Call for Action https://www.aap.org/en-us/about-the-aap/aap-press-room/Pages/AAP-Addresses-Racism-and-Its-Health-Impact-on-Children-and-Teens.aspx

U.S. Government Agencies
- Centers for Medicare and Medicaid Services (CMS) – Equity Plan https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/equity-plan.html

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What is Health Equity?

Health Equity

When all people have the opportunity to attain their **full health potential** and no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstance.

Health Inequity

A difference or disparity in health outcomes that is **systematic, avoidable, and unjust** that is tied to social, economic, or environmental disadvantage.

- Braveman, P.A., Monitoring equity in health and healthcare: a conceptual framework. Journal of health, population, and nutrition, 2003. 21(3): p. 181.
- Kawachi, I., A glossary for health inequalities. Journal of Epidemiology and Community Health, 2002. 56(9): p. 647.
- Whitehead, M. and Whitehead, The concepts and principles of equity and health. Health Promotion International, 1991. 6(3): p. 217.

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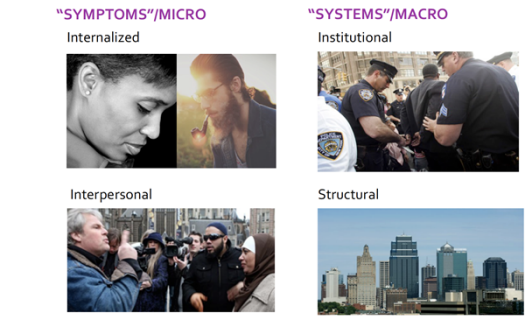
Different Dimensions of Racism



race forward | RACEFORWARD.ORG | RACEFORWARD | ©2015 RACE FORWARD

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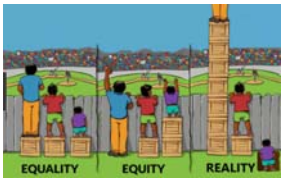

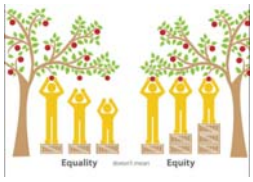

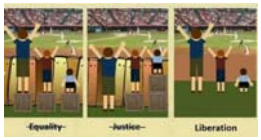

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What is Implicit Bias?

Attitudes and stereotypes that influence judgment, decision-making, and behavior in ways that are outside of conscious awareness and/or control.

- Normal cognitive process
- Impact our behavior and we're unaware
- Result of how we are socialized
- Shapes expectations, how information is shared, how we act, how we communicate verbally and nonverbally, and what we recommend
- Become aware so you don't perpetuate racism

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What is Racism?

4 level of racism: internalized, interpersonal, institutional, structural

Differential access to goods, resources, and opportunities of society by race.

A system of advantage based on race.

Camara Phyllis-Jones, MD. Levels of Racism: a theoretical framework and a gardeners tale. AJPH
David Wellman, Portraits of White Racism

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Minimizing Bias

Slide Credit: Deborah Burnett, MD

- Recognize that you (we!) are subject to influence of bias
- Take the Implicit Association Test (IAT) https://implicit.harvard.edu - Attitudes related to race, gender, mental health, weight & other issues
- Diversify your search committee!
  - Diverse perspectives can help counteract tendency to unconscious bias
  - Broadens social network for active search

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What is Institutional Racism?

Institutionalized racism is defined as differential access to the goods, services, and opportunities of society by race. Institutionalized racism is normative, sometimes legalized, and often manifests as inherited disadvantage. It is structural, having been codified in our institutions of custom, practice, and law, so there need not be an identifiable perpetrator.

- Camara Phyllis Jones, MD, MPH, PhD, Past President American Public Health Association

https://www.apha.org/events-and-meetings/webinars/racism-and-health

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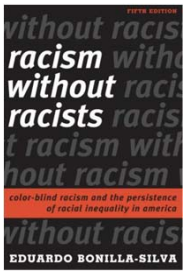
Why talk about Race? Why not be Color-blind?

"colorblindness ... Ignore[s] the ongoing processes that maintain racial stratification in schools, neighborhoods, health care, and other social institutions. Can color consciousness draw attention to these issues? The research demonstrates that it can lead to more understanding of our racially stratified society and can give rise to a willingness to work for change."
https://www.theatlantic.com/politics/archive/2015/09/color-blindness-is-counterproductive/405037/

See also *Racism without Racists - Color-Blind Racism and the Persistence of Racial Inequality in America*, Fifth Edition, by Eduardo Bonilla-Silva



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Ten Things Everyone Should Know about Race

1. Race is a modern idea.
2. Race has no genetic basis.
3. Human subspecies don't exist.
4. Skin color really is only skin deep.
5. Most variation is within, not between, "races."
6. Slavery predates race.
7. Race and freedom were born together.
8. Race justified social inequalities as natural.
9. Race isn't biological, but racism is still real.
10. Colorblindness will not end racism.

https://www-tc.pbs.org/race/images/race-guide-lores.pdf

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Institute for Healthcare Improvement

WHITE PAPER

Achieving Health Equity:
A Guide for Health Care Organizations

Framework for Health Care Organizations to Achieve Health Equity

Source: Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. Achieving Health Equity: A Guide for Health Care Organizations. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016. (Available at ihi.org)

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Framework for Health Care Organizations to Achieve Health Equity

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Framework for health systems

- Health equity is mission critical
- Develop structure and processes to support health equity work
- Deploy specific strategies to address the multiple determinants of health
- Eliminate institutional racism and other forms of oppression
- Partner with community organizations

Adapted from: Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. *Achieving Health Equity: A Guide for Health Care Organizations*. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016. (Available at ihi.org)

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Eliminating Institutional Racism: Drivers and Measures to Support this Work

Eliminate Institutional Racism and other forms of Oppression

Metrics

Culture
- Analyze employee surveys by race, ethnicity, language and pay looking for differences
- % of board that is white versus community
- % C-suite white versus community
- Staff reported experience – experienced harm/ discrimination

Human Resources:
- Employee jobs stratified by race ethnicity
- Staff involved in retirement plan by race
- Employees sent to collection for health care by race and income
- % of people of color in management positions
- Formerly incarcerated hiring policy (check the box)

Business Practices
- % Medicaid treated by hospital/(% state Medicaid average
- % Procurement of supplies from minority owned businesses in your community

Clinical Operations
- % of clinical board measures that are analyzed for differences using REaL data
- % clinical equity gaps narrowed

Primary Drivers	Secondary Drivers
Understanding History	-Understand the history of racism and other forms of oppression in the country, in the community in which the health care organization is located, and of the health care institution itself in relation to the community. -Understand communities of color the organization serves or could be serving: customs, culture, and experience of the community. -Build Trust with patients, partners, and the community. -Look inward, as this work requires a Personal Journey.
Culture & Communication	-Normalize having conversations about racism. -Have discussion about power and whose voices are heard. -Change visual displays in facilities to be inclusive (e.g., photos, décor). -Question norms about hairstyles, attire, and ways of interacting in the office. -In communications, question dominant narratives that are racialized and that drive attitudes and behavior (e.g., non-compliant patients) -Recognize the important role of Leaders in setting anti-racist tone and priorities. -Deeply listen to patients, partners and the community.
Human Resources	- Address equity in hiring, promotions and pay; diversity in leadership (demographic parity); for medical schools and other health professional schools, change practices to achieve equity in admissions.
Business Practices	-Diversity, inclusion & equity activities must involve changing systems, not just education and training. -Revise policy and procedures, conduct racial equity impact assessments as part of policy development. -Consider equity in decisions about where to locate facilities and what insurance is accepted by the health care organization. -Invest in the community: procurement practices, local hiring, etc -Use organization funds in the investment portfolio to participate in community investment, in housing for example
Clinical Operations	- Collect and analyze clinical data using race, ethnicity and language(REaL) attributes to identify disparities. -For clinical conditions that have disparities use quality improvement to eliminate gaps. -Eliminate organizational silos between Quality Improvement and departments dedicated to Diversity, Equity & Inclusion.

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U.S. History: Slavery, Jim Crow Segregation, Structural Racism

Period	Years (% of History)	Characteristics	Health system
Chattel Slavery	1619 - 1865 (62%)	Abolition of Atlantic Slave Trade (1808) – Black influx stopped; Black immigration since: scant	Disparate/inequitable treatment; poor health status and outcomes; "Slave health deficit" and "Slave health subsystem" in effect
Jim Crow Segregation	1865 – 1965 (25%)	13th, 14th, and 15th Amendments virtually nullified; legal segregation implemented in 1896	Absent or inferior treatment and facilities; *de jure* segregation / discrimination in South, *de facto* throughout most of the health system; health system recreates racial ideology
Structural Racism	1965 – Today (13%)	School desegregation (1954), Civil Rights Act (1964), Voting Rights Act	Southern medical school desegregation (1948), hospital desegregation in federal courts (1964), disparate health status, outcome, services, discrimination in effect

Slide Credit: Bay Love, Abigail Ortiz, and Nashira Baril

Source: Adapted from WM Byrd and LA Clayton's "American Health Dilemma"

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U.S. and South African History of Racism

Period	U.S	South Africa		
Chattel Slavery	1619 – 1865 Abolition of Atlantic Slave Trade (1808) – Black influx stopped	1658 – 1834* Chattel Slavery ended in S.A. *1838 really because there were 4 more years of transition phase.		 Sign from Apartheid era, S.A.
Laws Enacted that Result in Subjugation of Blacks	1865 – 1965 Jim Crow Segregation in the U.S.; Laws enacted to keep whites & Blacks separate and deny resources	1948–1991 Apartheid	1913 Land Act in S.A. passed – 87% of land in hands of whites; 13% to Africans forced to separate reserves	 Sign from 1950's in U.S.
Structural Racism	1965 – Today	1991 – Today		
Resistance	1960's Civil Rights Movement	1962 Nelson Mandela imprisoned.	1976 Soweto; 1990 Mandela released	

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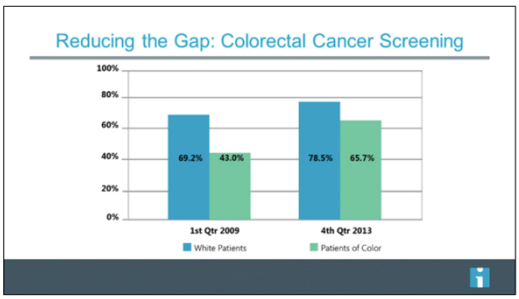
Measure the "Gap" – Improved Scores AND Reduced Gap



This slide features the work of HealthPartners in Minnesota, a large non-profit health care organization in the U.S. with a mission to improve health and well-being in partnership with members, patients and the community.

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Determinants of Health - University of Wisconsin Population Health Institute

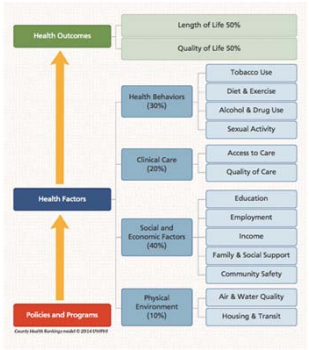
30% Health Behaviors

20% Clinical Care

40% Social and Economic Factors

10 % Physical Environment

http://www.countyhealthrankings.org/our-approach



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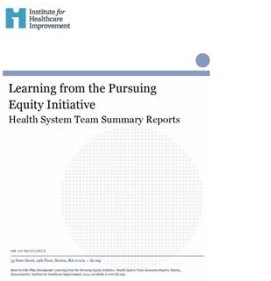
Case Studies

Read the case studies for the eight Pursuing Equity organizations at:

http://www.ihi.org/resources/Pages/Publications/Improving-Health-Equity-Guidance-for-Health-Care-Organizations.aspx



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Discussion

1. We have described how the history of slavery in the U.S. has lead to the health inequity we have today. How is the history of Apartheid still impacting South African health care and health outcomes today?
2. For attendees from other countries, how are these themes relevant to you and how are you addressing institutional and structural inequities to improve health?
3. What specific changes have been tested or implemented to address institutional racism in your organization, enterprise, or community?

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Thank you!

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