Race, Racism, and Medicine

MPHA
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Bush Medical Fellow, 2008-2009

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Health Care and Medical Education

DOWNSTREAM

Biology

Behavior

Society

Structure

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

Stephen C. Nelson, MD\textsuperscript{1}\textsuperscript{*} and Heather W. Hackman, EdD\textsuperscript{2}

\textbf{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. \textbf{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. \textbf{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\%, $P = 0.03$). \textbf{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.

\textbf{Key words:} health care disparity; race; sickle cell disease
“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.”
U.S. Death Rates-2009

- Black deaths
  - Crude death rate: 286,928, 924 per 100K

- Asian deaths
  - Crude death rate: 49,508, 413 per 100K
U.S. Black Deaths

- 128,248 excess deaths per year
- 10,687 deaths per month
- 2466 deaths per week
- 351 deaths per day
- 14 deaths per hour
- 1 death every 5 minutes
Why?

- Genetics
- SES, insurance, access, education
- Racism, Unconscious bias, Stereotypes
Human Genome Project

- 1990s
- > 60 families’ genes analyzed
- NO people of African descent
- Howard University belatedly invited

- Race has no genetic basis
- Human subspecies do not exist
- Most variation is within, not between “races”
- www.understandingrace.org
“racial disparities health”
1981-present

4925 citations!!
150 per year
almost 3 articles per week
Esophageal cancer treatment/outcomes

5 year survival

- Whites 60%
- Blacks 37%

Black race independent factor

- Controlled for age, sex, tumor location, histology
Arthritis-related hip/knee surgeries

Older blacks much lower rates of surgery
  – HR = 0.38 (95%CI = 0.16-0.55)

Race held as a factor when correcting health and economic differences
341,487 hysterectomies
- 295,857 abdominal
- 45,630 laparoscopic

Blacks less likely to have laparoscopic
- Odds Ratio 0.44 (95% CI 0.42-0.45)

Race was an independent association
Delivering Next Generation Care

J Am Col Surgeons Sep 2008

- Surgical mortality after major hepatectomy
  - 17,794 patients
  - Blacks had 2-fold greater mortality
    - Odds Ratio 2.22 (95% CI 1.38-3.57)
  - Clinical factors, insurance status, and hospital factors do not account for this
    - Odds Ratio 2.15 (95% CI 1.28-3.61)
Surgical resection non-small cell lung CA

- 3056 patients

- Surgery
  - White 63.4%
  - Black 44.7%

- Controlled for SES, comorbidity, tumor factors
  - Odds Ratio 0.43 (95% CI 0.34-0.55)
Opioid prescribing in US EDs (1993-2005)

Pain-related visits (42% of ED visits)

Patients who received opioids
- White 31%
- Black 23%
- Latino 24%

Opioid prescribing increased in all pts by 2005
- White 40%
- Black 32%
Am J Emerg Med
2012 in press

- ED wait times
- NHAMCS data 2003-2008
- General patient, SCD, long bone fracture
- SCD wait 25% longer than general sample
  - explained by black race
- SCD wait 50% longer than LBF group
  - even after correcting for race
Racial Disparities in Surgical Care
April 1990-December 2011
88 articles
Over 1.3 million patients
Almost all articles reported racial disparity
32 articles looked at independent factors
22 (70%) race was an independent factor
2012 National Healthcare Disparities Report

Figure H.10. Overall quality of care, preventive care, acute care, and chronic care, by state

Overall Quality of Care

Overall Quality
- Lowest Quality Quartile
- Second Quartile
- Third Quartile
- Highest Quality Quartile
OVERALL HEALTH SYSTEM PERFORMANCE FOR LOW-INCOME POPULATIONS

Source: Commonwealth Fund Scorecard on State Health System Performance for Low-Income Populations, 2013.
White population
NHDR Results

- Race is an independent factor
Advancing Health Equity in Minnesota: Report to the Legislature January 15, 2014

Figure 10: Per capita income in the past 12 months, Minnesota 2012

- Black or African American: $14,820
- American Indian: $17,014
- Asian: $25,121
- Hispanic*: $15,569
- White: $32,750

Total Minnesota per capita income: $30,529

*Note: Hispanic data may include persons of any race.
### TABLE 1
The black and white gap
Differences in unemployment rates for African Americans, broken down by subgroups, since start of Great Recession

<table>
<thead>
<tr>
<th>Unemployment rate for...</th>
<th>Fourth quarter 2007</th>
<th>Second quarter 2009</th>
<th>Second quarter 2011</th>
<th>Difference between African Americans and whites for respective groups in second quarter 2011 (in percentage points)</th>
<th>Change since start of Great Recession (fourth quarter 2007 to second quarter 2011)</th>
<th>Difference in change since start of Great Recession between African Americans and whites for respective groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>8.4</td>
<td>14.8</td>
<td>16.1</td>
<td>8.2</td>
<td>7.7</td>
<td>3.8</td>
</tr>
<tr>
<td>White</td>
<td>4.0</td>
<td>8.3</td>
<td>7.9</td>
<td>3.9</td>
<td>3.0</td>
<td>3.0</td>
</tr>
<tr>
<td>African American men</td>
<td>9.2</td>
<td>18.0</td>
<td>18.3</td>
<td>10.0</td>
<td>9.1</td>
<td>4.9</td>
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<tr>
<td>White men</td>
<td>4.1</td>
<td>9.2</td>
<td>8.3</td>
<td>4.2</td>
<td>4.2</td>
<td>4.2</td>
</tr>
<tr>
<td>African American women</td>
<td>7.6</td>
<td>12.1</td>
<td>14.1</td>
<td>6.7</td>
<td>6.5</td>
<td>3.0</td>
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<tr>
<td>White women</td>
<td>3.9</td>
<td>7.2</td>
<td>7.4</td>
<td>3.5</td>
<td>3.5</td>
<td>3.5</td>
</tr>
<tr>
<td>African American, no high school</td>
<td>13.6</td>
<td>26.7</td>
<td>26.0</td>
<td>14.0</td>
<td>12.4</td>
<td>7.2</td>
</tr>
<tr>
<td>White, no high school</td>
<td>6.8</td>
<td>13.6</td>
<td>12.0</td>
<td>5.2</td>
<td>5.2</td>
<td>5.2</td>
</tr>
<tr>
<td>African American, high school</td>
<td>7.3</td>
<td>13.9</td>
<td>15.9</td>
<td>7.5</td>
<td>8.6</td>
<td>4.1</td>
</tr>
<tr>
<td>White, high school</td>
<td>3.9</td>
<td>8.5</td>
<td>8.4</td>
<td>4.5</td>
<td>4.5</td>
<td>4.5</td>
</tr>
<tr>
<td>African American, college</td>
<td>3.0</td>
<td>7.6</td>
<td>6.9</td>
<td>3.0</td>
<td>3.0</td>
<td>3.0</td>
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<tr>
<td>White, college</td>
<td>1.8</td>
<td>4.1</td>
<td>3.9</td>
<td>2.1</td>
<td>2.1</td>
<td>2.1</td>
</tr>
<tr>
<td>African American, 35 to 44</td>
<td>6.4</td>
<td>12.2</td>
<td>12.6</td>
<td>6.1</td>
<td>6.2</td>
<td>2.8</td>
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<tr>
<td>White, 35 to 44</td>
<td>3.1</td>
<td>6.9</td>
<td>6.5</td>
<td>3.4</td>
<td>3.4</td>
<td>3.4</td>
</tr>
<tr>
<td>African American, 65+</td>
<td>4.4</td>
<td>6.9</td>
<td>9.4</td>
<td>3.5</td>
<td>5.0</td>
<td>2.3</td>
</tr>
<tr>
<td>White, 65+</td>
<td>3.2</td>
<td>6.2</td>
<td>5.9</td>
<td>3.7</td>
<td>3.7</td>
<td>3.7</td>
</tr>
</tbody>
</table>

Note: All unemployment rates are in percent. All changes and differences are in percentage points.

The unemployment rate of African Americans increased substantially faster than that of whites, regardless of breakdowns by gender, education, and age, since the start of the Great Recession.

*Twin Cities unemployment divide for black, white people is nation's widest*

*Laura Yuen, Minnesota Public Radio October 12, 2011*
Disparities in Education
NAEP Percentage of All Students At or Above Proficient in 4th Grade Reading: 2009

Source: National Assessment of Educational Progress

Top Ten States
Bottom Ten States
Middle States

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Disparities in Education
NAEP Percentage of Black Students At or Above Proficient in 4th Grade Reading: 2009

Top Ten States
Bottom Ten States
Middle States
No Data

Source: National Assessment of Educational Progress
### Table 11: High school students graduating on time by racial and ethnic group, Minnesota 2012

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percent</th>
<th>Disparity Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black or African American</td>
<td>51.0</td>
<td>1.6</td>
</tr>
<tr>
<td>American Indian</td>
<td>45.5</td>
<td>1.8</td>
</tr>
<tr>
<td>Asian</td>
<td>74.0</td>
<td>1.1</td>
</tr>
<tr>
<td>Hispanic</td>
<td>53.0</td>
<td>1.6</td>
</tr>
<tr>
<td>White (non-Hispanic)</td>
<td>83.9</td>
<td>1.0</td>
</tr>
</tbody>
</table>
Figure 13: Incarceration rate disparity ratio, Minnesota as of July 1, 2013\textsuperscript{76}
Minnesota Uninsurance Rates by Race/Ethnicity

Source: Minnesota Department of Health, Minnesota Health Access Survey
Health Care and Medical Education

Biology  Behavior  Society  Structure

DOWNSTREAM  UPSTREAM
Minnesota Infant Mortality Rate / Disparity Ratio Comparison

*per 1000 births
Life Expectancy in Minnesota
- White 81.1 years
- Black 75.4 years

Cancer deaths per 100,000 American men
- White 217.8
- Black 281.5

Cancer deaths per 100,000 Minnesota men
- White 205.5
- Black 295.0
http://www.bcbsmnfoundation.org/
10. Mortality rates* by race and ethnicity, Twin Cities 7-county region

- American Indian: 814
- Black, U.S.-born: 704
- Southeast Asian, Foreign-born: 275
- ALL: 248
- White, non-Hispanic: 232
- Black, foreign-born: 225
- Hispanic: 213
- Asian, other: 132

* 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).
12. Median household income by ZIP code, 2000


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Life expectancy by ZIP code

- 83 + years (16)
- 79 to 82.9 years (69)
- 75 to 78.9 years (39)
- 70 to 74.9 years (8)
- No data (0)
17. Mortality rates* by race within median household income group of ZIP codes

- American Indian
- Black
- White, non-Hispanic
- Hispanic
- Asian

[Graph showing mortality rates across different income groups and race categories]
Twin Cities Mortality-Wilder Study

- Race is an independent factor
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 \(p=0.025\)
- 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
• 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

\[ P < 0.001 \]
- 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
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
- 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
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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Health Care and Medical Education

DOWNSTREAM

Biology  Behavior  Society  Structure

UPSTREAM
Health Care Barriers

- **System**
  - insurance
  - poverty
  - geography
  - transition to adult care
  - research and support money

- **Patients**
  - lack of knowledge
  - fear
  - trust

- **Community**
  - advocacy
  - public awareness

- **Providers**
  - bias
  - attitudes/expectations
<table>
<thead>
<tr>
<th>Country</th>
<th>Life Expectancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Japan</td>
<td>82.4</td>
</tr>
<tr>
<td>Switzerland</td>
<td>81.7</td>
</tr>
<tr>
<td>Italy</td>
<td>81.4</td>
</tr>
<tr>
<td>Iceland</td>
<td>81.2</td>
</tr>
<tr>
<td>Australia</td>
<td>81.1</td>
</tr>
<tr>
<td>Spain</td>
<td>81.1</td>
</tr>
<tr>
<td>Sweden</td>
<td>80.8</td>
</tr>
<tr>
<td>Canada</td>
<td>80.7</td>
</tr>
<tr>
<td>France</td>
<td>80.7</td>
</tr>
<tr>
<td>Norway</td>
<td>80.5</td>
</tr>
<tr>
<td>New Zealand</td>
<td>80.1</td>
</tr>
<tr>
<td>Austria</td>
<td>79.9</td>
</tr>
<tr>
<td>Germany</td>
<td>79.8</td>
</tr>
<tr>
<td>Ireland</td>
<td>79.8</td>
</tr>
<tr>
<td>Netherlands</td>
<td>79.8</td>
</tr>
<tr>
<td>Greece</td>
<td>79.6</td>
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<tr>
<td>Belgium</td>
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<tr>
<td>Finland</td>
<td>79.5</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>79.5</td>
</tr>
<tr>
<td>Luxembourg</td>
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<tr>
<td>Korea</td>
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<td>Portugal</td>
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<td>Denmark</td>
<td>78.4</td>
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<tr>
<td>United States</td>
<td>78.1</td>
</tr>
</tbody>
</table>
OECD countries’ health care spending and longevity

Per capita spending US$
Sickle Cell Disease: A Question of Equity and Quality

Lauren A. Smith, Suzette O. Oyeku, Charles Homer and Barry Zuckerman

*Pediatrics* 2006;117;1763-1770
<table>
<thead>
<tr>
<th>Variable</th>
<th>SCD</th>
<th>Cystic Fibrosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>US prevalence</td>
<td>80,000</td>
<td>30,000</td>
</tr>
<tr>
<td>Federal support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NIH fiscal-year 2004 funding, in millions of dollars</td>
<td>90</td>
<td>128</td>
</tr>
<tr>
<td>NIH funding per person with disease, $</td>
<td>1125</td>
<td>4267</td>
</tr>
<tr>
<td>No. of federal grants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of grants funded in 1968c</td>
<td>22</td>
<td>65</td>
</tr>
<tr>
<td>No. of grants funded in 1972, after Sickle Cell Anemia Control Act</td>
<td>215</td>
<td>80</td>
</tr>
<tr>
<td>No. of grants funded in 2004</td>
<td>331</td>
<td>459</td>
</tr>
<tr>
<td>Private philanthropic support, $</td>
<td></td>
<td></td>
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<tr>
<td>Cystic Fibrosis Foundation 2003 annual revenue</td>
<td></td>
<td>152,231,000</td>
</tr>
<tr>
<td>Sickle Cell Disease Association of America 2003 annual revenue</td>
<td></td>
<td>498,577</td>
</tr>
<tr>
<td>Revenue per person affected with disease, $</td>
<td>6</td>
<td>5074</td>
</tr>
<tr>
<td>Total NIH and private support, in millions, $</td>
<td>90.4</td>
<td>280.2</td>
</tr>
<tr>
<td>Total support per person affected with disease, $</td>
<td>1130</td>
<td>9340</td>
</tr>
</tbody>
</table>
- Funding per patient
  - NIH 3.8-fold higher for CF
  - Foundation 350-fold higher for CF
  - Combined 11-fold greater for CF

- NIH Career Development Awards
  - same

- New Drug Approval (2009-2013)
  - CF 5
  - SCD 0

- Publications (2005-2010)
  - 2:1 CF:SCD
Health Care Barriers

- **System**
  - insurance
  - poverty
  - geography
  - transition to adult care
  - research and support money
- **Patients**
  - lack of knowledge
  - fear
  - trust
- **Community**
  - advocacy
  - public awareness
- **Providers**
  - bias
  - attitudes/expectations
Race and Health Care

- The legacy of slavery, segregation, and racism can make it difficult for African-Americans to trust the health care system
  - Experimentation on slaves 1619
  - Tuskegee experiment 1932-1972
  - Involuntary sterilization 1974
  - Attitudes about AIDS present
Dying While Black
Vernellia Randall, J.D.

An indepth look at a crisis in the American healthcare system.
Health Care Barriers

- **System**
  - insurance
  - poverty
  - geography
  - transition to adult care
  - research and support money

- **Patients**
  - lack of knowledge
  - fear
  - trust

- **Community**
  - advocacy
  - public awareness

- **Providers**
  - bias
  - attitudes/expectations
FDA

- FDA approved drugs
- HIV-1981

37
FDA

- FDA approved drugs
- Sickle Cell disease – 1910
Why is this true?

- Whites
  - NHF
  - ACT UP
- Blacks
  - SCDAA
- System
- Power
- Money
“We hope that work on the safety of hydroxyurea in children with sickle cell disease will show soon that they can also be treated safely with the drug.”

“Hydroxyurea is a well-known drug, however its use in sickle cell disease is relatively new and must be approached with caution.”
“A single randomized trial (MSH) of 299 patients with follow up of 21 months demonstrated that compared to placebo, Hydroxyurea was associated with lower annual rates of pain crises, longer time to first and second pain episodes and need for transfusions and reduce frequency of acute chest syndrome.

Droxia, the prescription form of hydroxyurea, was approved by the FDA in 1998 and is now available for adult patients with sickle cell anemia.

Hydroxyurea is also used in children.”
Hydroxyurea Timeline


- Phase III MSH trial [16]
- Phase I/II trial in infants (HUSOFT) [22]
- SWITCH trial enrollment begins
- Prevention of organ damage [48-54,57,59]

1984:
- Proof of Principle studies [11-14]

1992:
- Phase I/II trial in adults [15]

1995:
- Phase I/II trial in children (HUG-KIDS) [21,23,24]

1997:
- Short-term pediatric efficacy [17-20]

1999:
- Follow-up to MSH [29]
- Prevention of secondary CVA [58]

2001:
- BABY HUG enrollment begins

2003:
- Lowering TCD velocities [55,56]
- BABY HUG extension [28]

2004:
- HUSOFT extension [28]

2005:
- Twitch trial begins

2006:
- BABY HUG Results
Health Care Barriers

- **System**
  - insurance
  - poverty
  - geography
  - transition to adult care
  - research and support money

- **Patients**
  - lack of knowledge
  - fear
  - trust

- **Community**
  - advocacy
  - public awareness

- **Providers**
  - bias (racism)
  - stereotyping
  - attitudes/expectations
Race and sex of a patient independently influence how physicians manage chest pain.

Provider Barriers to Hydroxyurea Use in Adults with Sickle Cell Disease: A Survey of the Sickle Cell Disease Adult Provider Network

Sophie Lanzkron, MD; Carlton Haywood Jr., MA; Kathryn L. Hassell, MD; and Cynthia Rand, PhD
Unpacking Racism and its Health Consequences

April 2011

THE IMPACT OF RACISM ON CLINICIAN COGNITION, BEHAVIOR, AND CLINICAL DECISION MAKING

Michelle van Ryn et al.

Dept of Family Medicine and Community Health
University of Minnesota
Stereotypes Are A Real Time-Saver
Unconscious biases

- Normal
- 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
“Crisis”

- [http://www.youtube.com/watch?v=FuelQDBOxXI](http://www.youtube.com/watch?v=FuelQDBOxXI)

- CRISIS: Experiences of people with sickle cell disease
“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.”
UNEQUAL TREATMENT

CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

Delivering Next Generation Care
“Unequal Treatment”

- Institute of Medicine
- March 2002
- Findings
  - Racial disparities exist and are unacceptable
  - These exist within broader social inequalities
  - Multifactorial
  - Bias, stereotyping and prejudice on the part of health care providers contribute to racial and ethnic disparities
  - Small number of patients refuse therapy, this does not fully explain disparities
IOM Recommendations

- Raise awareness of disparities
- Legal, regulatory and policy changes
- Health systems changes
- Help patients navigate the system
- Cross-cultural education for providers
- Collect data on race, SES, language
- Research sources of disparities and interventions
Provider Training

- Diversity Training
  - Awareness
  - Appreciation

- Cultural Competency
  - Cross-cultural communication
  - Information gathering
  - Skills training
Provider Training
Racism

- 138 employed physicians
- 56 completed survey
- 1222 person-years of practice
- 295 hours “racism training”
  - 5.3 hours per person or 14.5 minutes/person-year
- 130 hours were actually “diversity/cultural competency training”
- 29 hours of specific racism training
  - 52 minutes per person or 1.4 minutes/person-year
The amount of race/racism training that physicians receive is very low.

Twenty-seven (48%) of the physicians reported no specific instruction on issues of race/racism.

An understanding of racism was lacking as almost one half of physicians reporting some training confused racism training with diversity and cultural competency trainings.
Provider Training

- Social Justice
  - Oppression
  - Power
  - Societal resources
  - Structural barriers
  - Race/racism/whiteness
Provider Trainings

- Address the definition of race/racism and history of the social construction of race
- Differentiate among diversity, cultural competency, and social justice
- Explore our current health care system (racial make-up of providers, how insurance became tied to employment, what we’re taught/not taught in school, evidence-based medicine, racial disparities)
- Examine racism/whiteness in our society, including examples of racism/whiteness in medicine
- Examine how race affects each of the Institute of Medicine's six measures of quality care, and provide trainees tools for understanding these effects
- Introduce critical thinking tools for improving medical providers’ comfort and skills in caring for patients of color
Pilot Training

- N=19, Family Medicine residents
- 5 M, 14 F
- 10 white, 7 Asian, 2 black
- Mean age 31.9 years
  - M= 32.8 yrs
  - F= 31.6 yrs
- Hours of prior racism training
  - 24 hrs total
  - 1.26 hrs/person
  - 13 of 19 had NO training (68%)
  - One person reported 10 hrs of racism training
Assessment

- 1. My awareness level of issues of racism in the U.S. is:

- 2. The impact of racism on health care delivery is:

- 3. I am as effective at caring for white patients as I am at caring for patients of color.

- 4. I feel well equipped to care for patients of color.

- 5. The impact of racism on my ability to deliver quality care is:
# Results

<table>
<thead>
<tr>
<th>Statement</th>
<th>Pre</th>
<th>Post</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Awareness of racism</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALL WHITE</td>
<td>3.40</td>
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<td>3.40</td>
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<td><strong>Impact of racism on health care</strong></td>
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POC = person of color
Discussion

- Awareness of racism and its impact on delivering quality care increased significantly in all participants.

- Deconstructed white providers’ previously held beliefs about race and racism.
  - first step in working on our own racism and unconscious biases.

- This was a small cohort.

- Further study is warranted to define and refine the best training methods.
<table>
<thead>
<tr>
<th>Pattern</th>
<th>GENDER</th>
<th>CLASS</th>
<th>AGE</th>
<th>N</th>
<th>S</th>
<th>Survival Rate</th>
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<td>23</td>
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</table>

Total 2,201 711 32.2
“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)
got privilege?
Special Thanks

Bush Foundation
Keri Rateliff, MSN, RN, NE-BC
Liz McDonough, RN
Nicole Leonard, RN
Jane Hennessy, RN, CNP, MPH
Kristin Moquist, RN, CNP
Kim Jacobson, RN, CNP
Linda Litecky, RN
Patients and Families
Disparities in quality of care are common:

- Blacks received worse care than Whites for 41% of quality measures.
- Asians and American Indians and Alaska Natives (AI/ANs) received worse care than Whites for 30% of measures.
- Hispanics received worse care than non-Hispanic Whites for 39% of measures.
- Poor people received worse care than high-income people for 47% of measures.
Disparities in access are also common:

- Blacks had worse access to care than Whites for 32% of access measures.
- Asians had worse access to care than Whites for 17% of access measures.
- AI/ANs had worse access to care than Whites for 62% of access measures.
- Hispanics had worse access to care than non-Hispanic Whites for 63% of measures.
- Poor people had worse access to care than high-income people for 89% of measures.
Uncertain Suffering
RACIAL HEALTH CARE DISPARITIES AND SICKLE CELL DISEASE
12. Median household income by ZIP code, 2000


Delivering Next Generation Care
16. Life expectancy by educational group of ZIP codes

<table>
<thead>
<tr>
<th>Education Level</th>
<th>% of Population</th>
<th>Age-standardized Deaths per 100,000 for those aged 25 - 64</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very low education (&lt;12% with BA)</td>
<td>10.1%</td>
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</tr>
<tr>
<td>Low education (12-17% with BA)</td>
<td>27.1%</td>
<td>255</td>
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<tr>
<td>Medium education (17-30% with BA)</td>
<td>36.2%</td>
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<tr>
<td>High education (30-40% with BA)</td>
<td>18.7%</td>
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<tr>
<td>Very high education (40%+ with BA)</td>
<td>7.9%</td>
<td>164</td>
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</table>

Note: Black line represents average life expectancy at birth during the period 1998-2002 in the Twin Cities (79.4 years).
Training providers on issues of race and racism to improve health care equity

**Wednesday, September 10th**
Basement Conference Center G053
1:00 - 4:00

**Wednesday, October 22nd**
Basement Conference Center G053
2:00 - 5:00

**Wednesday, December 3rd**
2nd Floor Education Center
1:00 - 4:00