Session 3: What is a race/ethnicity and equity lens?

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Why Race Matters:
Applying a Health Equity Lens to Addressing Social Health and Early Childhood Wellness

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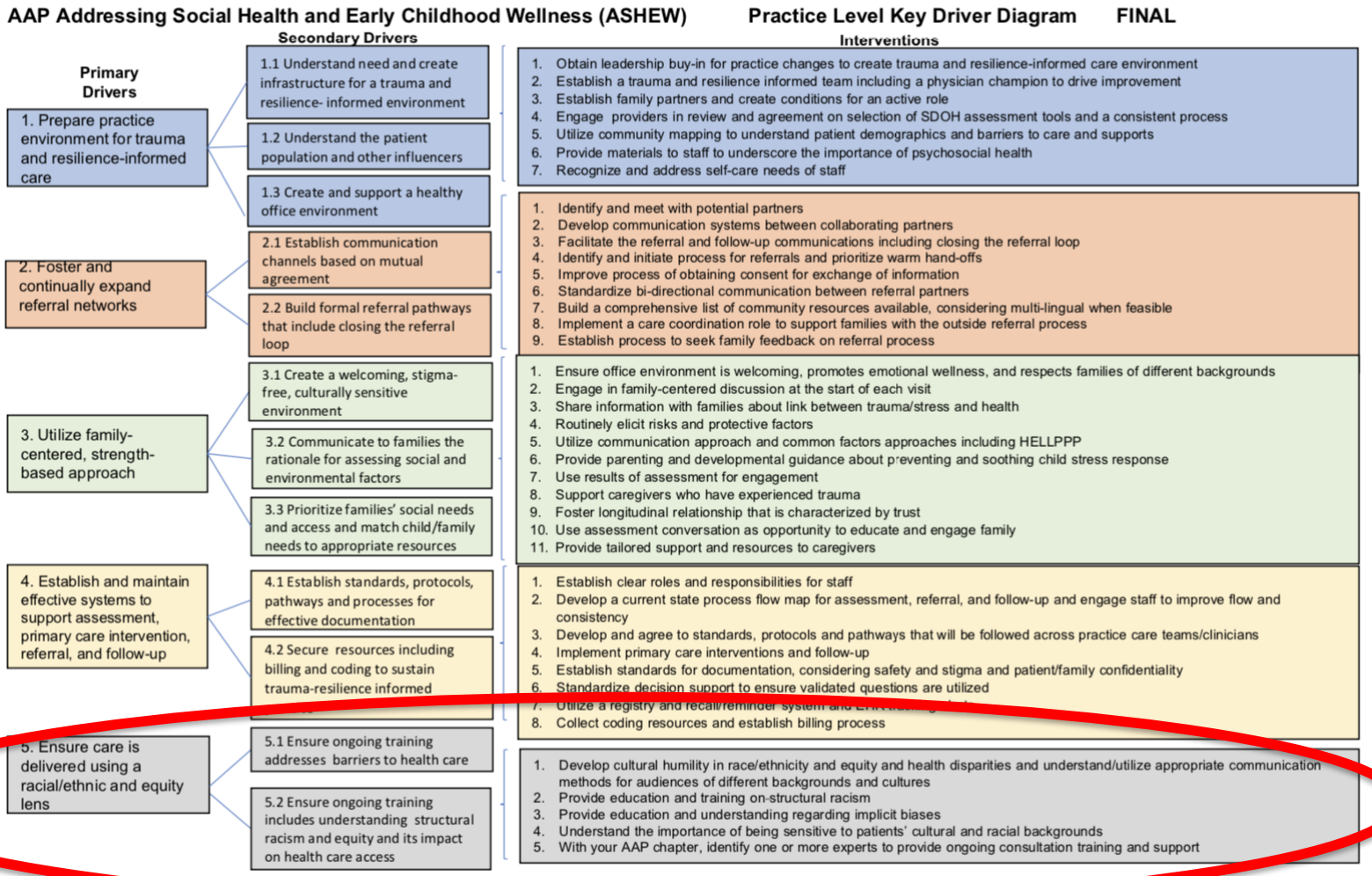
AAP Addressing Social Health and Early Childhood Wellness (ASHEW) Practice Level Key Driver Diagram FINAL
Primary Drivers
Secondary Drivers
Interventions
1. Prepare practice environment for trauma and resilience-informed care
1.1 Understand need and create infrastructure for a trauma and resilience- informed environment
1.2 Understand the patient population and other influencers
1.3 Create and support a healthy office environment
1. Obtain leadership buy-in for practice changes to create trauma and resilience-informed care environment
2. Establish a trauma and resilience informed team including a physician champion to drive improvement
3. Establish family partners and create conditions for an active role
4. Engage providers in review and agreement on selection of SDOH assessment tools and a consistent process
5. Utilize community mapping to understand patient demographics and barriers to care and supports
6. Provide materials to staff to underscore the importance of psychosocial health
7. Recognize and address self-care needs of staff
2. Foster and continually expand referral networks
2.1 Establish communication channels based on mutual agreement
2.2 Build formal referral pathways that include closing the referral loop
1. Identify and meet with potential partners
2. Develop communication systems between collaborating partners
3. Facilitate the referral and follow-up communications including closing the referral loop
4. Identify and initiate process for referrals and prioritize warm hand-offs
5. Improve process of obtaining consent for exchange of information
6. Standardize bi-directional communication between referral partners
7. Build a comprehensive list of community resources available, considering multi-lingual when feasible
8. Implement a care coordination role to support families with the outside referral process
9. Establish process to seek family feedback on referral process
3. Utilize family-centered, strength-based approach
3.1 Create a welcoming, stigma-free, culturally sensitive environment
3.2 Communicate to families the rationale for assessing social and environmental factors
3.3 Prioritize families' social needs and access and match child/family needs to appropriate resources
1. Ensure office environment is welcoming, promotes emotional wellness, and respects families of different backgrounds
2. Engage in family-centered discussion at the start of each visit
3. Share information with families about link between trauma/stress and health
4. Routinely elicit risks and protective factors
5. Utilize communication approach and common factors approaches including HELLPPP
6. Provide parenting and developmental guidance about preventing and soothing child stress response
7. Use results of assessment for engagement
8. Support caregivers who have experienced trauma
9. Foster longitudinal relationship that is characterized by trust
10. Use assessment conversation as opportunity to educate and engage family
11. Provide tailored support and resources to caregivers
4. Establish and maintain effective systems to support assessment, primary care intervention, referral, and follow-up
4.1 Establish standards, protocols, pathways and processes for effective documentation
4.2 Secure resources including billing and coding to sustain trauma-resilience informed
1. Establish clear roles and responsibilities for staff
2. Develop a current state process flow map for assessment, referral, and follow-up and engage staff to improve flow and consistency
3. Develop and agree to standards, protocols and pathways that will be followed across practice care teams/clinicians
4. Implement primary care interventions and follow-up
5. Establish standards for documentation, considering safety and stigma and patient/family confidentiality
6. Standardize decision support to ensure validated questions are utilized
7. Utilize a registry and recall/reminder system and
8. Collect coding resources and establish billing process
5. Ensure care is delivered using a racial/ethnic and equity lens
5.1 Ensure ongoing training addresses barriers to health care
5.2 Ensure ongoing training includes understanding structural racism and equity and its impact on health care access
1. Develop cultural humility in race/ethnicity and equity and health disparities and understand/utilize appropriate communication methods for audiences of different backgrounds and cultures
2. Provide education and training on structural racism
3. Provide education and understanding regarding implicit biases
4. Understand the importance of being sensitive to patients' cultural and racial backgrounds
5. With your AAP chapter, identify one or more experts to provide ongoing consultation training and support

OBJECTIVES

In this session participants will learn to:

1. Define levels of racism including institutionalized, personally mediated, and internalized

3. Describe the impact of different levels of racism on the health and wellness of children, families, and healthcare providers


AAP Agenda for Children 2017-2018
DEDICATED TO THE HEALTH OF ALL CHILDREN™
Health Equity
Medical Home
Profession of Pediatrics
Addressing Bias and Discrimination
Physician Health and Wellness
Poverty and Child Health
Access
Quality
Finance
Planning
Implementing
Integration/Integrated
American Academy of Pediatrics
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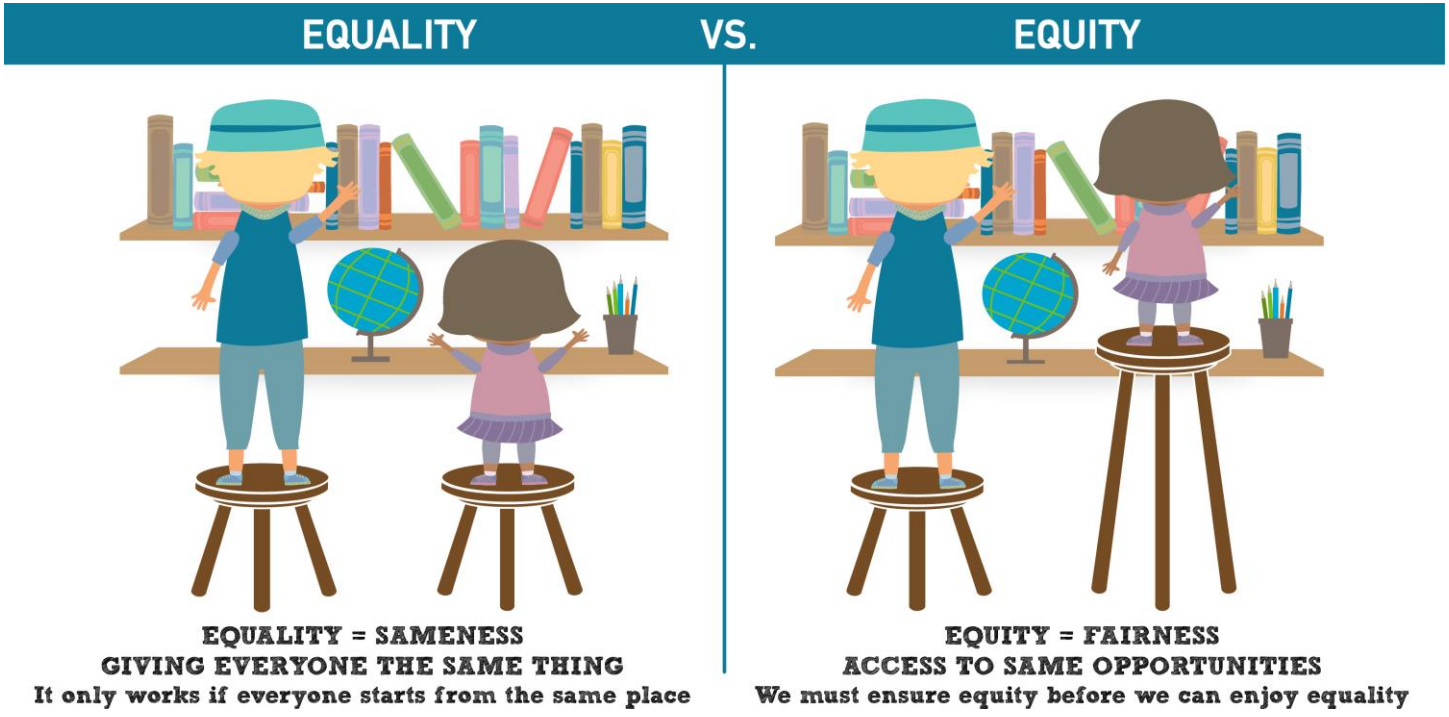
AAP Task Force on Addressing Bias & Discrimination

Health Equity

Equity is the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other means of stratification.

World Health Organization


EQUALITY
VS.
EQUITY
EQUALITY = SAMENESS
GIVING EVERYONE THE SAME THING
It only works if everyone starts from the same place
EQUITY = FAIRNESS
ACCESS TO SAME OPPORTUNITIES
We must ensure equity before we can enjoy equality

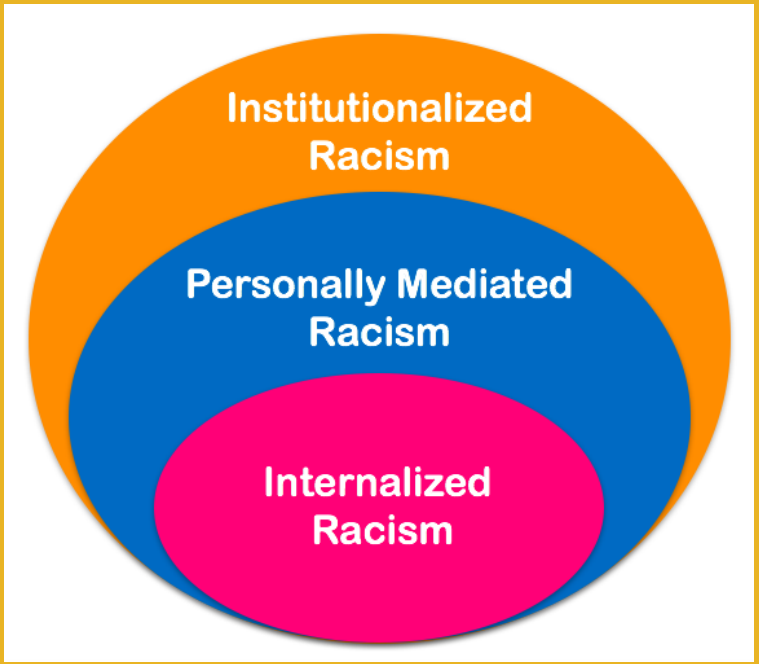
RACISM

" A system of structuring opportunities and assigning value based on the social interpretation of how one looks that

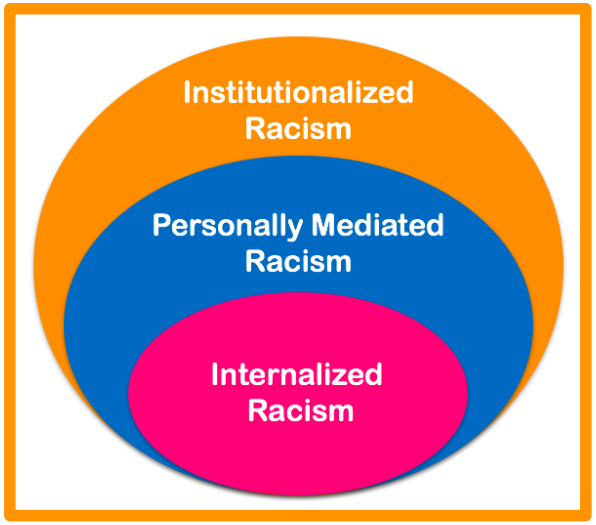
- Unfairly disadvantages some individuals and communities
- Unfairly advantages other individuals and communities
- Saps the strength of the whole society through the waste of human resources"

Jones CP. Confronting Institutionalized Racism. Phylon 2003

INSTITUTIONALIZED RACISM



Institutionalized Racism



- Operationalizes itself though policies, laws, and regulations
- Results in differential access to goods, services, and opportunities of society by race

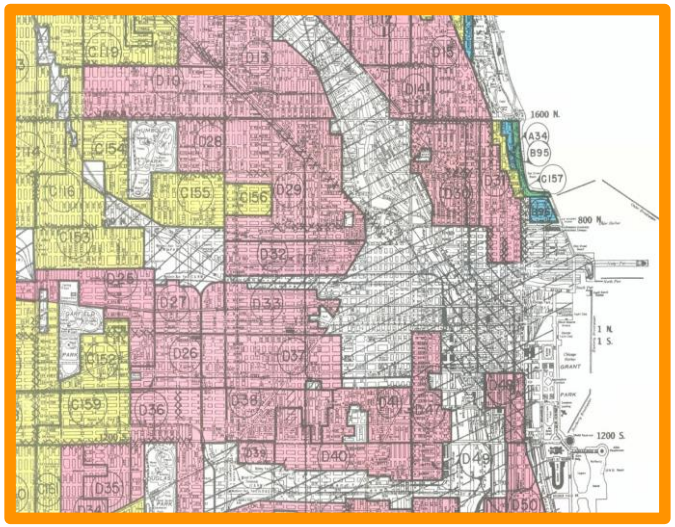
Jones, AJPH, 2000

Institutionalized Racism: Impact on Children and Adolescents

- Where they live
- Where they learn
- What they have
  - Access to safe playgrounds and nutritious foods
  - Economic opportunities across the life course
- How their rights are executed
  - Over policing in black and brown communities

Where Children Live: Redlining

- Marking neighborhoods based on racial demographics as hazardous
- Led to
  - Systematic denial of capital investments
  - Denial of services such as mortgage lending, healthcare, supermarkets, and transportation
- Of neighborhoods redlined as “hazardous” 80 years ago
  - 74% are low to moderate income neighborhoods today
  - 64% are minority neighborhoods today



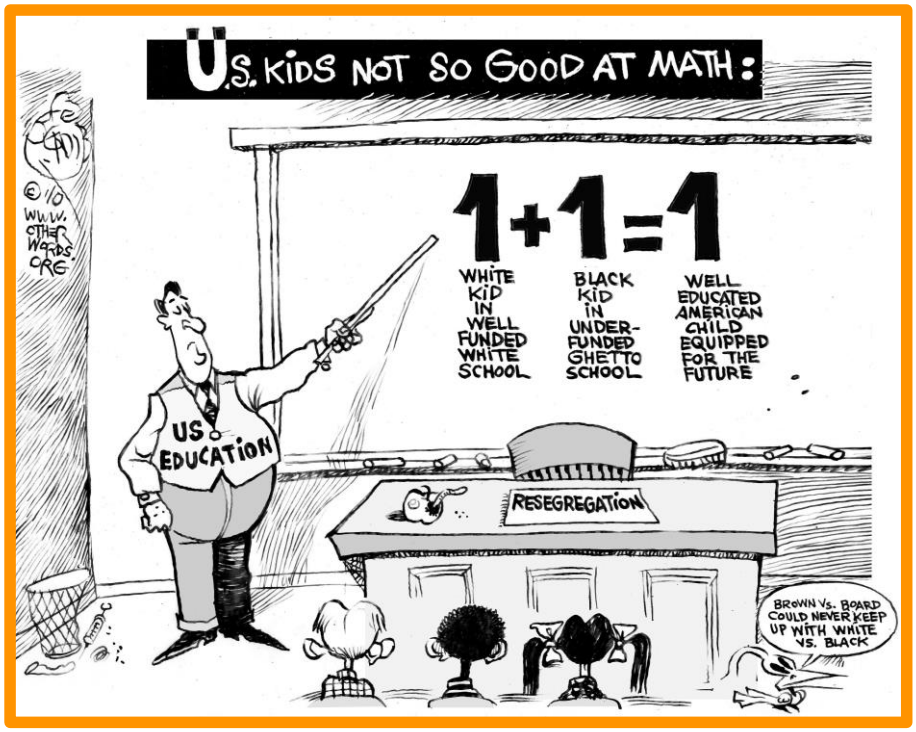
- NCRC Redlining Maps
- A Home Owners' Loan Corporation map of Chicago- Mapping Inequality: Redlining In New Deal America

Impact of Gentrification

- Displaced populations more likely to experience
  - Food deserts
  - Less walkable streets
  - Further distances to commute for work
  - Industrial pollutants
  - Social losses

CDC, Health Effects of Gentrification, 2009

Where Children Learn



Inequitable funding in the education system impacts:

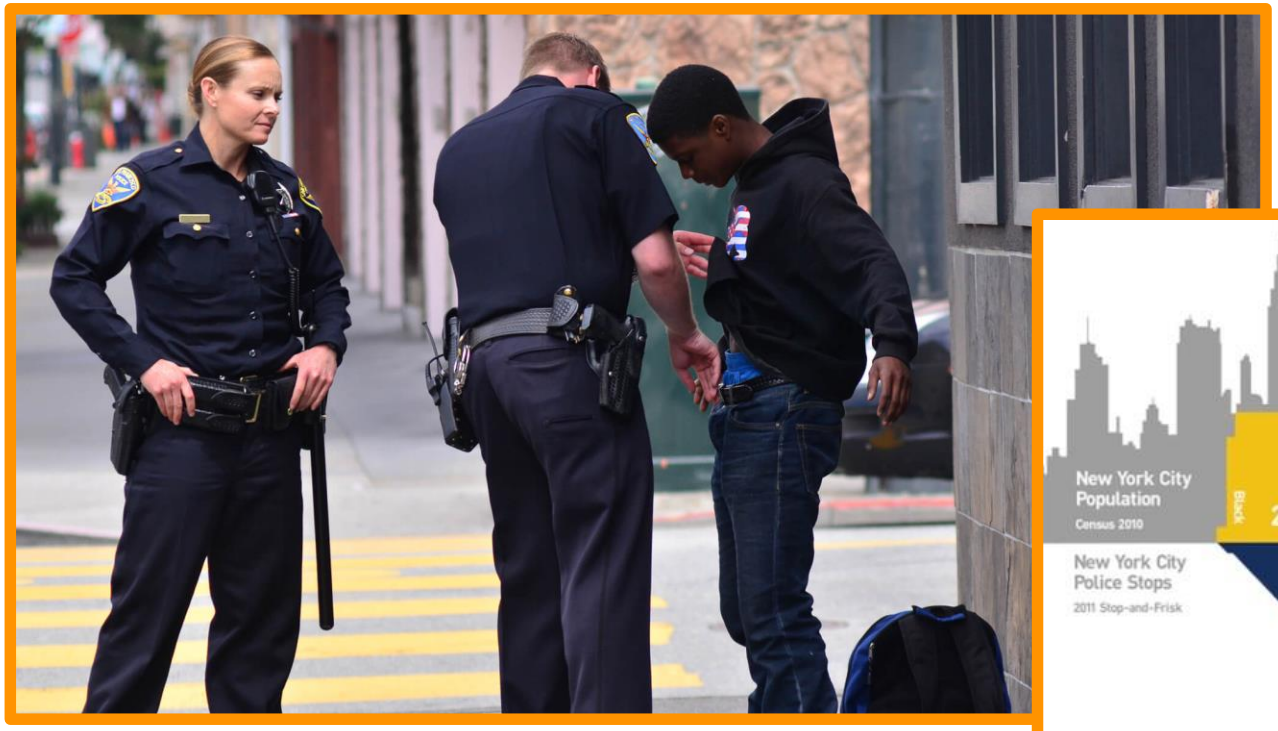
- experience of teachers
- rigor of curriculum
- resource allocation

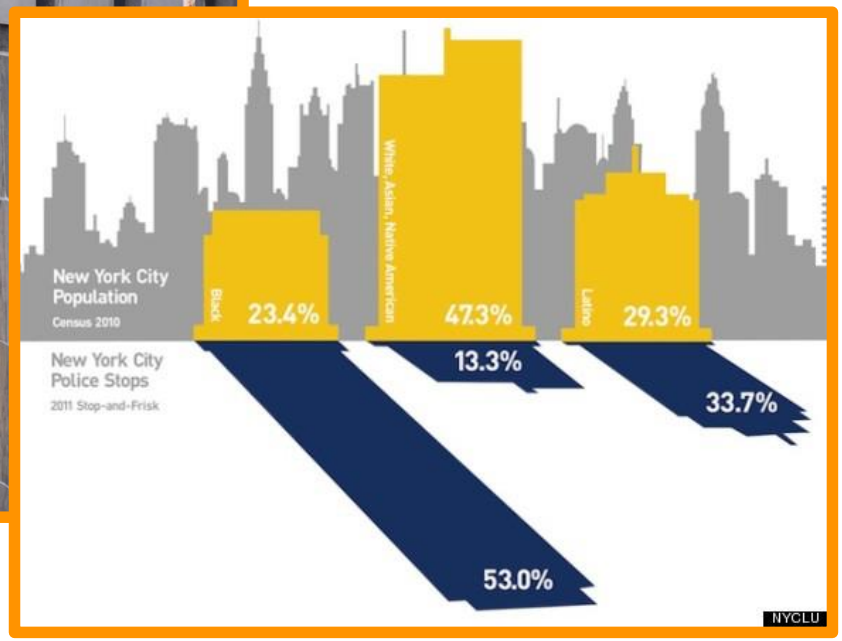
Bottoms, J Applied Soc Psychol, 2004; Goff, J Pers Soc Psychol, 2014
US Dept of Education. Equity of Opportunity

School to Prison Pipeline

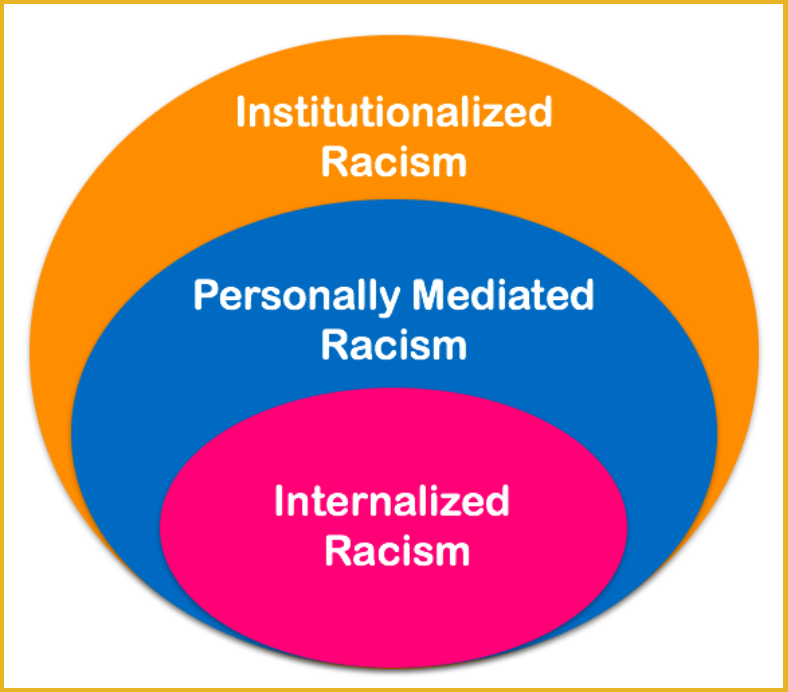
Disciplinary policies and practices in schools that lead to criminalizing youth, increasing their contact with law enforcement, and funneling them into the criminal justice system

How Children's Rights Are Executed





PERSONALLY MEDIATED RACISM



Overt Discrimination

"The practice of unfairly treating a person or group of people differently from other people or groups of people."

US Commission on Civil Rights, 1970

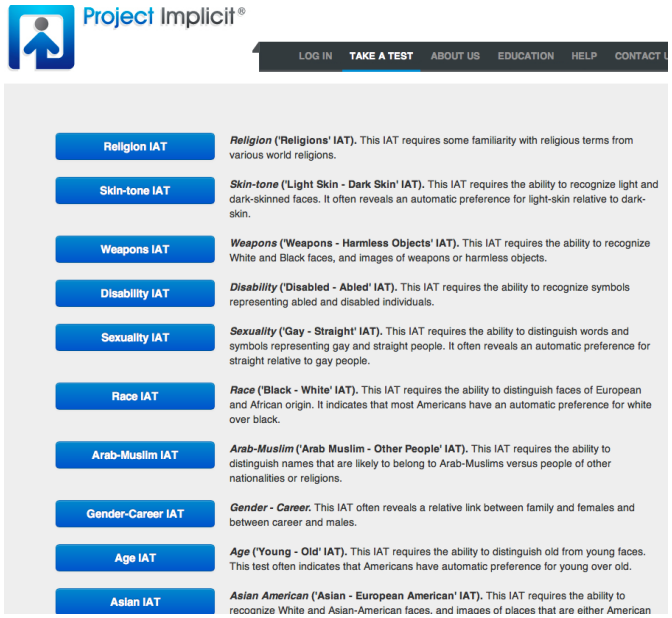
Bias

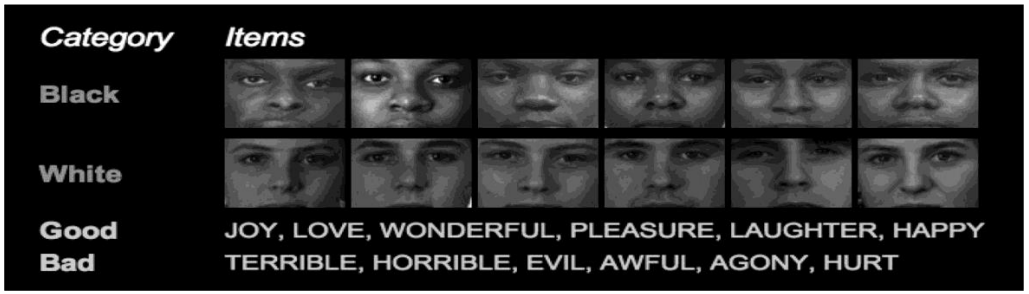
"A tendency to believe that some people, ideas, etc, are better than others that usually results in treating some people unfairly."

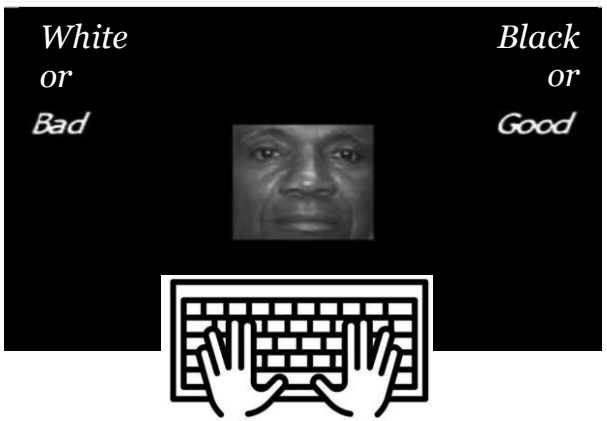
Explicit Bias: Conscious attitudes that can be self-reported

Implicit Bias: Unconscious attitudes that lie below the surface, but may nevertheless influence behaviors

Measuring Implicit Bias: The Implicit Association Test (IAT)







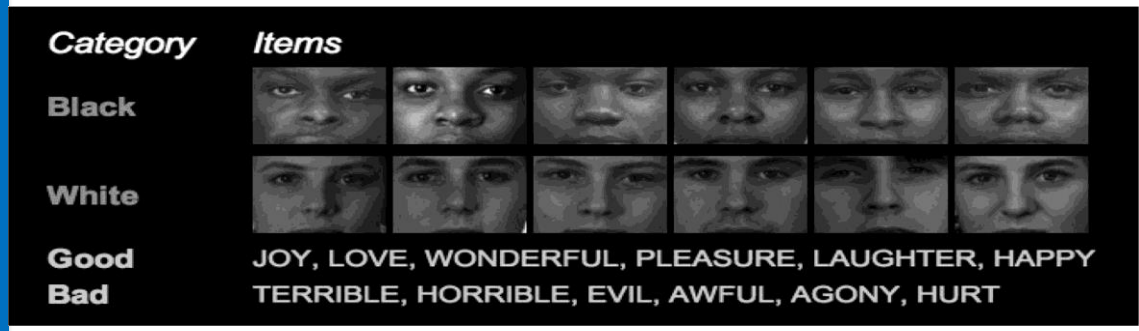
Bias Towards Children

Johnson, *Acad Ped*, 2017

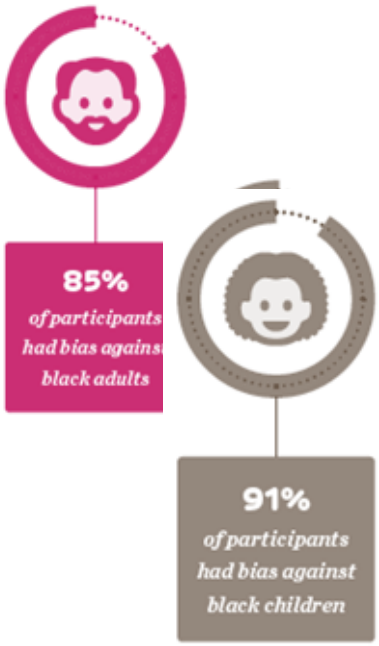
DISPARITIES

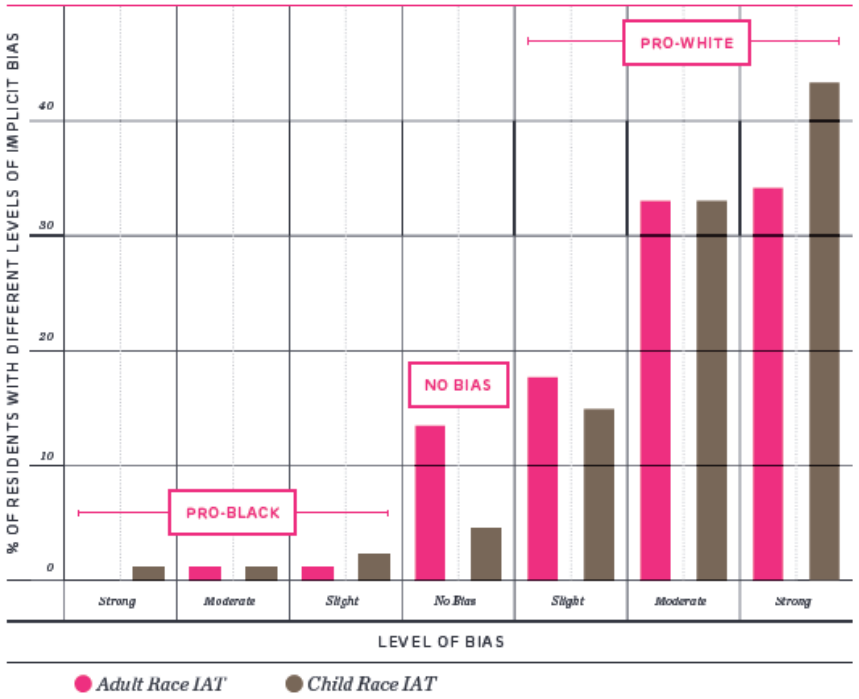
Comparison of Physician Implicit Racial Bias Toward Adults Versus Children

Tiffani J. Johnson, MD, MSc; Daniel G. Winger, MS; Robert W. Hickey, MD; Galen E. Switzer, PhD; Elizabeth Miller, MD, PhD; Margaret B. Nguyen, MD; Richard A. Saladino, MD; Leslie R. M. Hausmann, PhD



Results





IAT scores did not vary by resident demographics characteristics

Systematic Review

Soc Sci Med, 2017

Social Science & Medicine xxx (2017) 1–11

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

A decade of studying implicit racial/ethnic bias in healthcare providers using the implicit association test

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Health disparities

ABSTRACT

Disparities in the care and outcomes of US racial/ethnic minorities are well documented. Research suggests that provider bias plays a role in these disparities. The implicit association test enables measurement of implicit bias via tests of automatic associations between concepts. Hundreds of studies have examined implicit bias in various settings, but relatively few have been conducted in healthcare. The aim of this systematic review is to synthesize the current knowledge on the role of implicit bias in healthcare disparities. A comprehensive literature search of several databases between May 2015 and September 2016 identified 37 qualifying studies. Of these, 31 found evidence of pro-White or light-skin/anti-Black, Hispanic, American Indian or dark-skin bias among a variety of HCPs across multiple levels of training and disciplines. Fourteen studies examined the association between implicit bias and healthcare outcomes using clinical vignettes or simulated patients. Eight found no statistically significant association between implicit bias and patient care while six studies found that higher implicit bias was associated with disparities in treatment recommendations, expectations of therapeutic bonds, pain management, and empathy. All seven studies that examined the impact of implicit provider bias on real-world patient-provider interaction found that providers with stronger implicit bias demonstrated poorer patient-provider communication. Two studies examined the effect of implicit bias on real-world clinical outcomes. One found an association and the other did not. Two studies tested interventions aimed at reducing bias, but only one found a post-intervention reduction in implicit bias. This review reveals a need for more research exploring implicit bias in real-world patient care, potential modifiers and confounders of the effect of implicit bias on care, and strategies aimed at reducing implicit bias and improving patient-provider communication. Future studies have the opportunity to build on this current body of research, and in doing so will enable us to achieve equity in healthcare and outcomes.

Implicit Bias and Communication

Physicians with higher implicit bias demonstrate:

- Higher verbal dominance
- Less interpersonal treatment
- Less supportive communication
- Less patient ratings of satisfaction
- Greater patient reported difficulty with following recommendations

Racial Microaggressions

"Brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory or negative racial slights and insults towards people of color."

Microaggressions in Healthcare

- During recorded interviews of pediatric acute care office visits, physicians were less likely to ask black children to answer questions during a visit than white children, independent of the child's age and socioeconomic status.
- The authors hypothesized that these disparate interactions were due to physicians attributing less competence to black children than to white children.

Sivers, *Social Psychology Quarterly*, 2007

Microaggressions in Healthcare

Patient self reported experiences of micro-aggressions during the clinical encounter

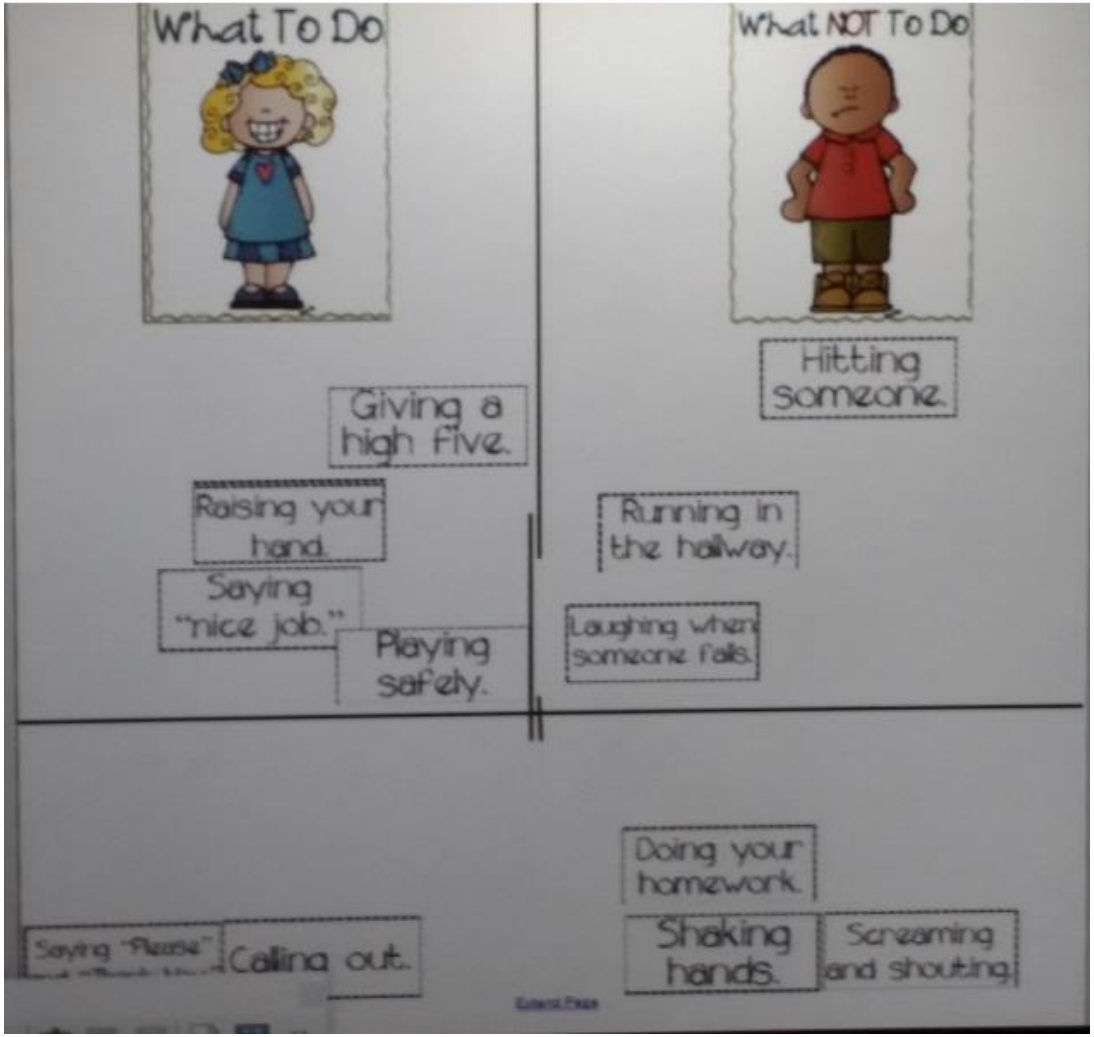
- Avoided discussing or addressing cultural issues
- Sometimes was insensitive about my cultural group when trying to understand or treat my issues
- Seemed to deny having any cultural biases or stereotypes
- At times seemed to over-identify with my experiences related to my race or culture
- At times seemed to have stereotypes about my cultural group, even if he or she did not express them directly
- Sometimes minimized the importance of cultural issues

Walls, J Amer Board Fam Med, 2015

Environmental Microaggressions

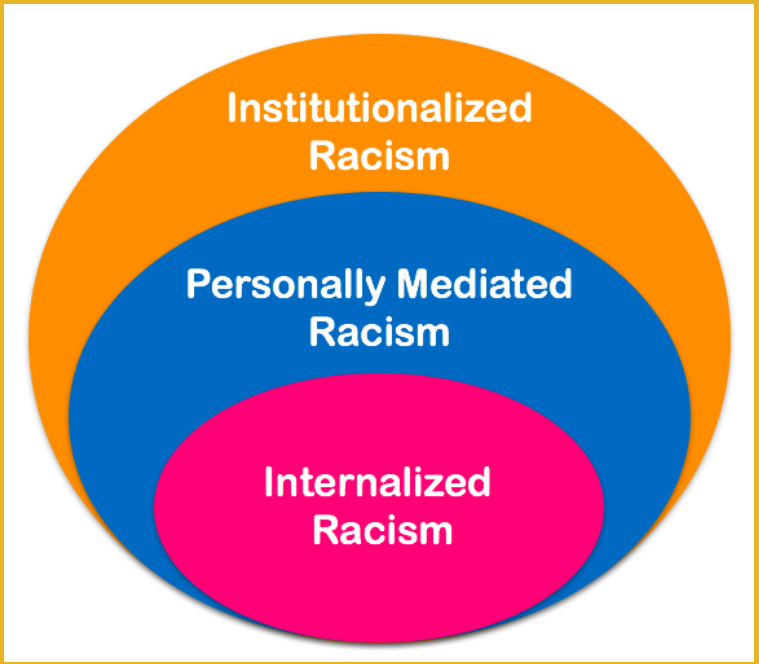
"Racial assaults, insults, and invalidations which are manifested on systemic and environmental levels."

Sue, American Psychologist, 2007

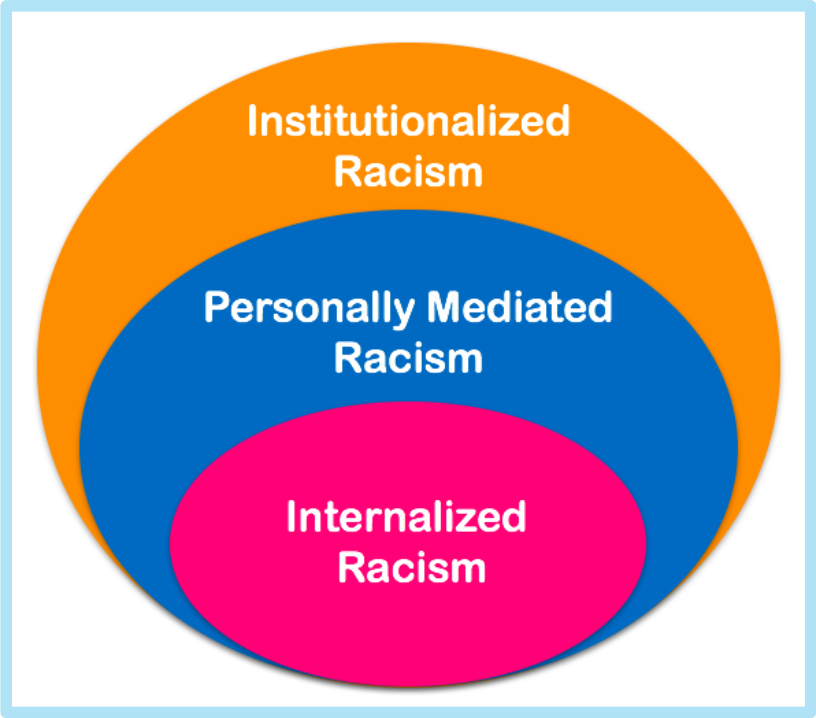

What To Do
What NOT To Do
Giving a high five.
Hitting someone.
Raising your hand.
Running in the hallway.
Saying "nice job."
Playing safely.
Laughing when someone falls.
Doing your homework.
Saying "Please"
Calling out.
Shaking hands.
Screaming and shouting.


Be Cool, Follow The Rules
Not Cool
POOL RULES
Not Cool
Cool
Not Cool
Not Cool
Cool
Not Cool
American Red Cross

INTERNALIZED RACISM



INTERNALIZED RACISM



- When members of stigmatized groups accept negative messages about their own abilities and self-worth
- May be manifested as
  - Poor school/job performance
  - Engagement in high risk behaviors

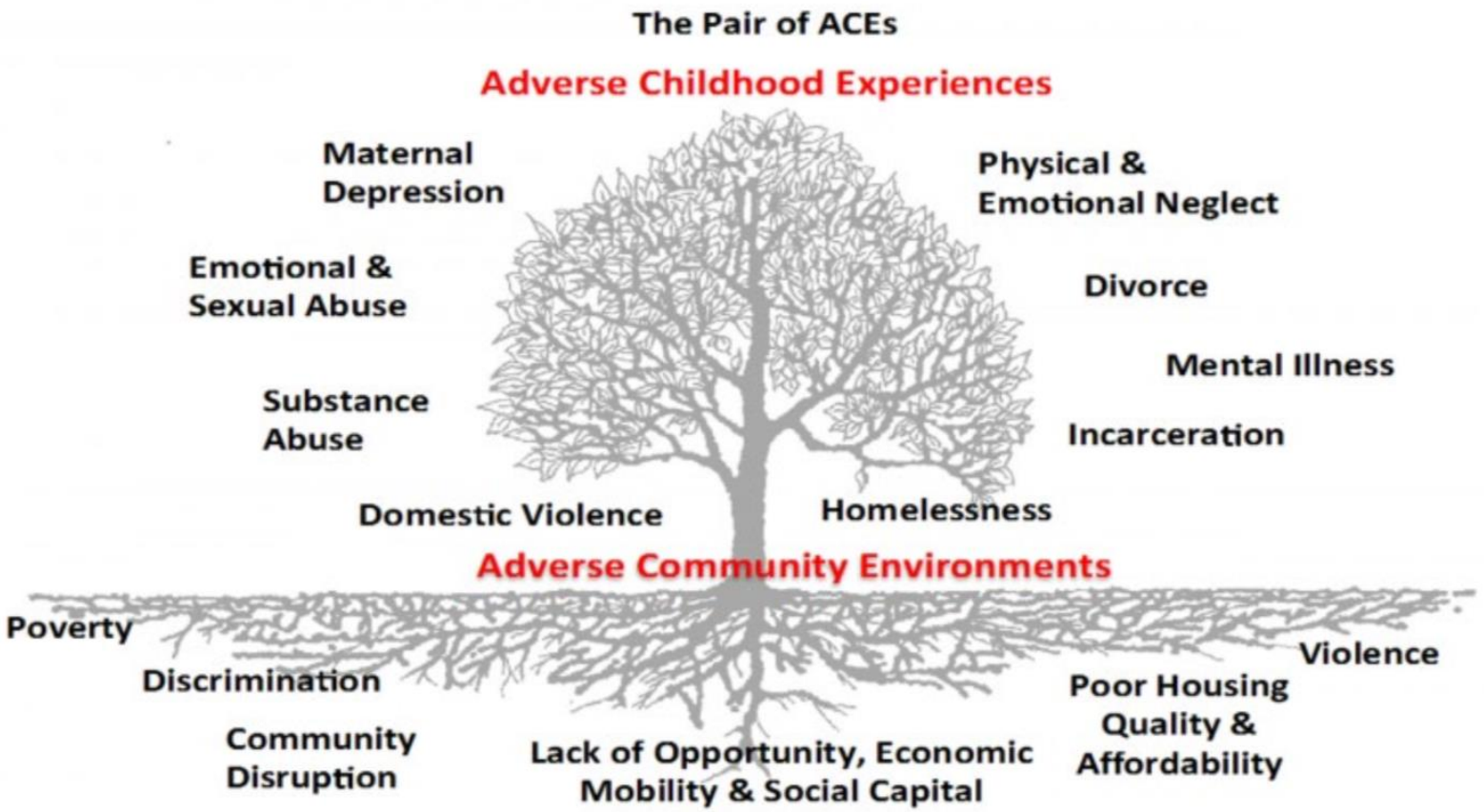
Jacoby-Senghor, J Exp Soc Psychol, 2016

Clark Doll Studies

- 1939 study: 67% of black children preferred the white doll over black doll
- CNN Replication 2010

Clark & Clark. J Soc Psychol. 1939;591-599

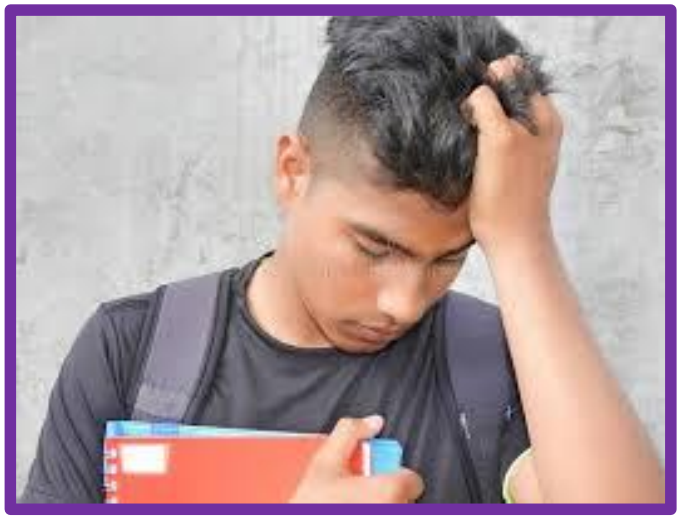
IMPACT OF RACISM ON HEALTH & WELLNESS



Ellis, W., Dietz, W. (2017) A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience (BCR) Model. Academic Pediatrics. 17 (2017) pp. S86-S93. DOI information: 10.1016/j.acap.2016.12.011

Emotional Outcomes

- Emotional distress
- Depressive symptoms
- Stress
- Anxiety
- Hopelessness & powerlessness



J Pers. 2003, 71(6):1197-1232; Devel and Psychopathology 2002,14(2):371-393; J Adolesc. 2004, 27(2):123-137; Int J Epidemiol. 2006,35(4):888-901

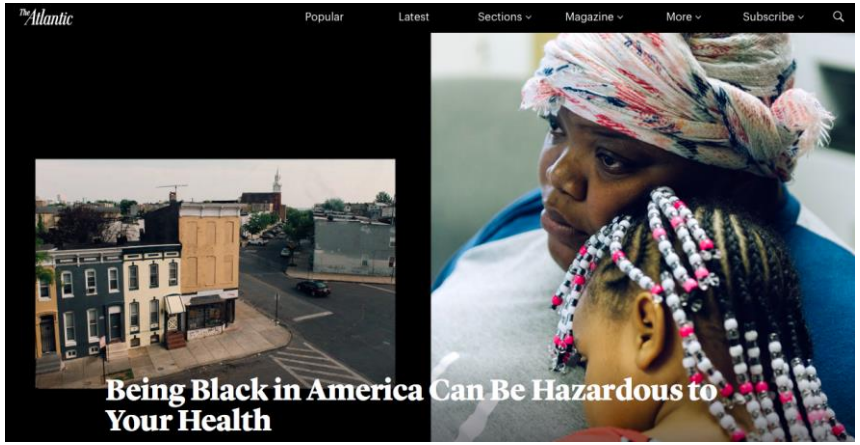
Youth Academic Outcomes

- Disparities in disciplinary actions
- Poor school engagement
- Poor academic motivation

Appl Dev Sci. 2009;13(2):51-73.
J Pers. 2003;71(6):1197-1232.

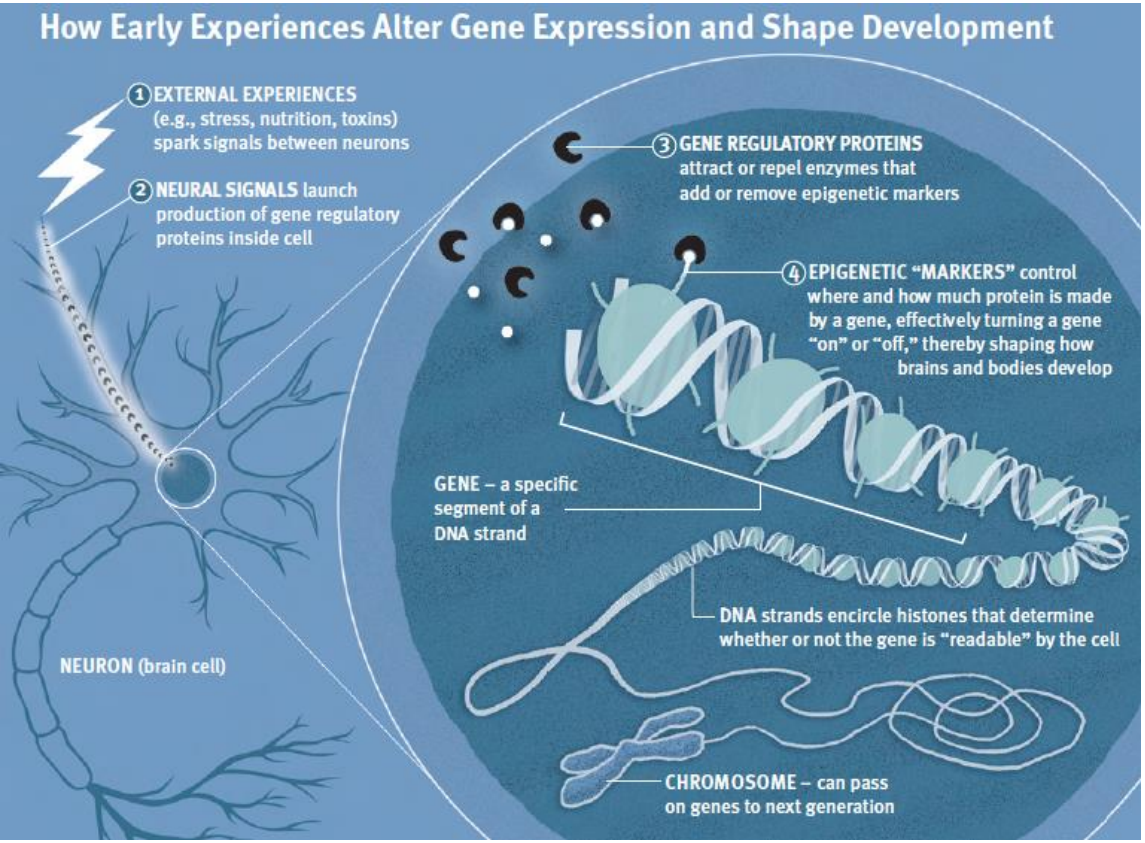
Health Outcomes

- Poor self-reported health status
- HTN and cardiovascular disease
- High cortisol→ obesity, increased waist circumference
- Poor glucose regulation
- Inflammatory response
- Weakened immune system
- Difficulties with memory/concentration



Am Psychol. 1999,54(10):805-816; Annu Rev Psychol. 2007,58:201-25; Soc Sci Med. 2000,51(11):1639-53; Pharm Biochem Behav. 2007,86(2):246-62; Ann Behav Med. 2006,32(1):1-9; Am J Pub Health. 2003,93(2):243-8.

EPIGENETICS



- Racism/bias spark neuronal signaling
- Production of gene regulatory proteins
- Enzymatic impact on epigenetic markers
- Turning 'on or off' of gene expression
- DNA/chromosome incorporation

Adapted from the Harvard Center on the Developing Child

THE TREATMENT PLAN:

Groundbreaking AAP Policy Statement on Racism

Trent, *Pediatrics*, 2019

POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

The Impact of Racism on Child and Adolescent Health

Maria Trent, MD, MPH, FAAP, FSAHM,[a] Danielle G. Dooley, MD, MPhil, FAAP,[b] Jacqueline Dougé, MD, MPH, FAAP,[c] SECTION ON ADOLESCENT HEALTH, COUNCIL ON COMMUNITY PEDIATRICS, COMMITTEE ON ADOLESCENCE

The American Academy of Pediatrics is committed to addressing the factors that affect child and adolescent health with a focus on issues that may leave some children more vulnerable than others. Racism is a social determinant of health that has a profound impact on the health status of children, adolescents, emerging adults, and their families. Although progress has been made toward racial equality and equity, the evidence to support the continued negative impact of racism on health and well-being through implicit and explicit biases, institutional structures, and interpersonal relationships is clear. The objective of this policy statement is to provide an evidence-based document focused on the role of racism in child and adolescent development and health outcomes. By acknowledging the role of racism in child and adolescent health, pediatricians and other pediatric health professionals will be able to proactively engage in strategies to optimize clinical care, workforce development, professional education, systems engagement, and research in a manner designed to reduce the health effects of structural, personally mediated, and internalized racism and improve the health and well-being of all children, adolescents, emerging adults, and their families.

STATEMENT OF THE PROBLEM

Racism is a "system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call 'race') that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources."[1] Racism is a social determinant of health[2] that has a profound impact on the health status of children, adolescents, emerging adults, and their families.[3–8] Although progress has been made toward racial equality and equity,[9] the evidence to support the continued negative impact of racism on health and well-being through implicit and explicit biases, institutional structures, and interpersonal relationships is clear.[10] Failure to address racism will

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Drs Trent, Dooley, and Dougé worked together as a writing team to develop the manuscript outline, conduct the literature search, develop the stated policies, incorporate perspectives and feedback from American Academy of Pediatrics leadership, and draft the final version of the manuscript; and all authors approved the final manuscript as submitted.

Policy statements from the American Academy of Pediatrics benefit from expertise and resources of liaisons and internal (AAP) and external reviewers. However, policy statements from the American Academy of Pediatrics may not reflect the views of the liaisons or the organizations or government agencies that they represent.

The guidance in this statement does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

All policy statements from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

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Address correspondence to Maria Trent, MD. E-mail: mtrent2@jhmi.edu

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Optimizing Clinical Practice

- Create a culturally safe medical home
- Train clinical and office staff in culturally competent care
- Assess patients for stressors and SDOH often associated with racism

Trent, *Pediatrics*, August 2019

Confronting Racism in Clinical Practice: Anticipatory Guidance

Bright Futures™

prevention and health promotion for infants, children, adolescents, and their families™

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RACIAL SOCIALIZATION

THE OFFICIAL NEWSMAGAZINE OF THE AMERICAN ACADEMY OF PEDIATRICS

AAP News

Volume 36 • Number 8
August 2015
www.aapnews.org

Commentary

Helping families navigate race issues should be ongoing conversation

by Ashaunta T. Anderson, M.D., M.P.H., M.S.H.S., FAAP, and Angela M. Ellison, M.D., M.Sc., FAAP

As pediatricians, we have committed our lives to assuring the well-being of all children. We have taken a stand against health hazards such as childhood poverty and gun violence. However, when it comes to race-based violence, we have remained silent.

Although the Academy has provided resources on toxic stress on its website (http://bit.ly/1R7RAU9), additional advocacy, education and action need to be initiated, given the recent series of race-based deaths. It is time for us, as pediatricians, to take a strong stand against the violence that is claiming the lives and sense of security of our young black patients.

Pediatricians occupy a strategic position between families who fear race-based victimization and the medical establishment charged with protecting all children. As providers within complex systems, we understand that broken systems often pose a greater threat than the imperfect people within those systems. A systems-level problem must be addressed with systems-level solutions. The current crisis has presented a crossroads at which the pediatric institution may leverage its critical position and substantial influence on the behalf of all racially and ethnically marginalized children.

One promising approach that pediatricians can employ to address these issues of discrimination is called racial socialization. Studied for decades in the social sciences literature, racial socialization refers to the process by which children learn to navigate race issues. It has chiefly been explored as the work mainly minority parents do to help their children adjust to a racially biased world.

However, there is a role for each of us to play, minority and non-minority, parent and non-parent alike. Children receive race-laden messages, both verbal and nonverbal, from a variety of sources. The recent coverage of violence against black men, women and children has certainly communicated a negative and racially charged message. Unfortunately, silence and inaction communicate a message as well, one of indifference at best or apathy at worst.

The good news is that negative messages about race may be addressed with healthy racial socialization messages. These themes can be integrated into the usual anticipatory guidance that pediatricians provide for families. For instance, one well-studied racial socialization strategy is called cultural pride reinforcement. This strategy helps children to learn and value their cultural heritage. It has been associated with improved academic, behavioral and mental health outcomes for children of all ages. Discussions of screen time might probe how parents help children understand the stereotyped images of people of color. Providers may offer that parents introduce positive cultural representations in the content they use to boost child school readiness.

A second racial socialization strategy is called preparation for bias. In addition to warning children about the potential for race-based bias, this strategy requires the discussion of coping tactics. The research is mixed on outcomes for young children, but studies show that adolescents benefit academically and emotionally. Pediatricians can discuss this information with parents whose children screen positive for race-based bullying or differential treatment.

It is important to note that a different kind of racial socialization — promotion of mistrust — provides warnings of cross-race interactions without coping strategies. This has been found to be detrimental for children of various ages. Parents should be guided away from promotion of mistrust, intentional or unintentional.

Just as conventional anticipatory guidance spans several office visits with iterative dialogue, helping parents and children navigate race issues should be an ongoing conversation. Providers should strive to assess family needs in this area and provide resources. Some parents may prefer mainstream socialization approaches that prioritize individual characteristics over cultural affiliation or silence on the subject of race, but the evidence base is less clear for these topics.

Many groups offer assistance and support to parents and families who are either victims of racial violence or experience difficulty navigating racial issues, including the NAACP, Children's Defense Fund and the National Urban League. Collaboration also is needed with other groups of child health professionals such as psychologists, nurse practitioners and family medicine physicians. Partnering with these groups can diversify our outreach efforts and assist us in building stronger and more harmonious communities. The formation of these partnerships warrants further exploration.

As pediatricians, our core values recognize the inherent worth of every child. We call upon the leadership of AAP committees to ensure the development of policies and anticipatory guidance that address issues of discrimination with all patients and families. When pediatricians engage these difficult topics with parents, we begin the important work of transforming a negative dialogue of racialized victimization into a collective celebration of this country's increasing diversity.

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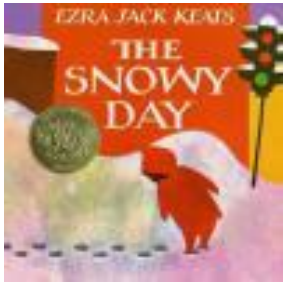
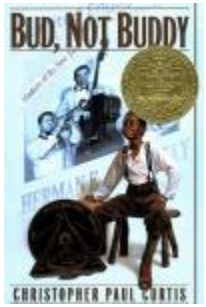
- Cultural Pride Reinforcement
  - Improved academic, behavioral, and emotional outcomes
- Preparation for bias
  - Adolescents benefit academically & emotionally
- Promotion of mistrust
  - Negative impacts on children

Anderson AT & Ellison A. *AAP News*, August 2015:11.

Encourage Books with Diverse Characters





https://www.commonsensemedia.org/blog/help-your-kids-find-books-with-diverse-characters \
https://www.commonsensemedia.org/lists/books-with-characters-of-color

Addressing Equity in Quality Improvement

- REaL Data: ensure race, ethnicity, and preferred language data is documented consistently and accurately across the organization
- All QI data should be stratified by race/ethnicity, language, insurance, and SES
- Reducing inequities in care should be an *integral* component of QI efforts, not an afterthought
- Partnerships between QI analysts, disparities researchers, clinicians, and families are needed to reduce inequities in care

The Case for Diversity

- Greater student body diversity and institutional climate associated with:
  - Endorsement of health equity
  - Enhanced self-efficacy among all students
- Minority patients who have a choice are more likely to select health care professionals of their own ethnicity

Confronting Implicit Racial Bias

- Perspective taking *(Galinsky 2000)*
- Focusing on common identities *(Hall 2009)*
- Using counter-stereotypical exemplars *(Lai 2015)*
- Multicultural training *(Castillo 2007)*
- Individuation *(Devine 2012)*
- Increased Opportunity for cross-cultural contact *(Castillo 2007)*
- Mindfulness meditation *(Lueke 2015, Leuke 2016, Kang 2014, Keng 2016, Parks 2014, Stell 2015)*

"I Am Not a Racist" is Not Enough Advocating for Anti-Racism and Social Justice

Confronting Institutionalized Racism: Anti-Racism Policies

- Promote policies that fuel social determinants
  - **Live:** fair housing, healthy food markets
  - **Learn**: equitable education systems
  - **Work**: support economic vitality, employ from disadvantaged communities
  - **Play**: safe playgrounds
- Build partnerships to enable patients, families, and community members to play a meaningful role in developing solutions

Addressing Law Enforcement Violence as a Public Health Issue

1. Eliminate policies and practices that facilitate disproportionate violence against specific populations (including laws criminalizing these populations)
2. Institute robust law enforcement accountability measures
3. Increase investment in promoting racial and economic equity to address social determinants of health
4. Implement community-based alternatives to addressing harms and preventing trauma
5. Work with public health officials to comprehensively document law enforcement contact, violence, and injuries

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Take a Closer Look at Your Organization/Practice

- What policies, procedures, and regulations are in place that may inadvertently perpetuate inequities in care?
- What are some aspects of the organizational culture that may undermine relationships with patients and families from underrepresented backgrounds?
- What is your organization/practice doing to make racial equity a strategic priority?

Questions & Discussion