Liberation in the Exam Room: How to Implement a Racial Justice Framework

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#IHISummit
Session Objectives

1. Identify shared definitions and context for why racial health inequities persist even after controlling for socioeconomic status and education.

2. Describe specific tools and frameworks to deepen their team’s understanding of the social determinants of health and oppression, as well as why and how working for racial equity improves outcomes for all.

3. Using case study, share strategies to orient and train members of your team in ways to advance racial justice, including the use of implicit bias data to impact policy, practice, and procedure.

4. Invite the heart into the room (not just the head) as a tool for lifelong engagement in racial justice and equity work.
I. A heart tool, intros and assumptions (10)
II. The framework that got us here (30)
III. Constructivist Listening (5)
IV. Liberation In the Exam Room (10)
V. Case Study at Boston Healthcare for the Homeless (15)
VI. Closing (5)
THE WINDOW OF TOLERANCE
INTRODUCTIONS

“In the past we may have talked about race as a descriptor of someone’s phenotypical or biological being. But it’s actually a set of practices. It’s a verb. It’s what people do to each other. We “race” people. And it’s very closely associated with a sense of who we are.”

— John A. Powell

Turn to a neighbor and please share your name, pronouns, racial and ethnic identities, your role in the health world and your number in the “window”.
SOME ASSUMPTIONS

I. Framework

II. Lead with race explicitly, but never exclusively. Intersectional thinking always.

III. Head and Heart

IV. Please don’t personalize the critique of systems
If you have come to help me you are wasting your time. But if you have come because your liberation is bound up with mine then let us work together.
In fact, racial inequity persists in every system across the country, without exception

<table>
<thead>
<tr>
<th>System</th>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child welfare</td>
<td>Disproportionality</td>
<td>Refers to the proportion of ethnic or racial groups of children in child welfare compared to those groups in the general population.¹</td>
</tr>
<tr>
<td>Health</td>
<td>Health disparity</td>
<td>Healthcare disparities refer to differences in access to or availability of facilities and services. Health status disparities refer to the variation in rates of disease occurrence and disabilities between socioeconomic and/or geographically defined population groups.²</td>
</tr>
<tr>
<td>Juvenile justice</td>
<td>Disproportionate minority contact (&quot;DMC&quot;)</td>
<td>Refers to the disproportionate number of minority youth who come into contact with the juvenile justice system ³</td>
</tr>
<tr>
<td>Education</td>
<td>Achievement gap</td>
<td>When one group of students (such as, students grouped by race/ethnicity, gender) outperforms another group and the difference in average scores for the two groups is statistically significant.⁴</td>
</tr>
<tr>
<td>Housing</td>
<td>Housing discrimination</td>
<td>Housing discrimination is discrimination in which an individual or family is treated unequally when trying to buy, rent, lease, sell or finance a home based on certain characteristics, such as race, class, sex, religion, national origin, and familial status.⁵</td>
</tr>
<tr>
<td>Economic Development</td>
<td>Historically underutilized businesses</td>
<td>Businesses that are disadvantaged and are deemed in need of assistance to compete successfully in the marketplace.⁶</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Period</th>
<th>Years (% of History)</th>
<th>Characteristics</th>
<th>Health system</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chattel Slavery</td>
<td>1619 - 1865 (62%)</td>
<td>Abolition of Atlantic Slave Trade (1808) – Black influx stopped; Black immigration since: scant</td>
<td>Disparate/inequitable treatment; poor health status and outcomes; “Slave health deficit” and “Slave health subsystem” in effect</td>
<td>1721 Cotton Mather and Zabdiel Boylston conduct first large-scale smallpox inoculation in the English-speaking world – inspired by enslaved African man, Onesimus</td>
</tr>
<tr>
<td>Jim Crow Segregation</td>
<td>865 – 1965 (25%)</td>
<td>13&lt;sup&gt;th&lt;/sup&gt;, 14&lt;sup&gt;th&lt;/sup&gt;, and 15&lt;sup&gt;th&lt;/sup&gt; Amendments virtually nullified; legal segregation implemented in 1896</td>
<td>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</td>
<td>1875 and 1915 Johnson and Graves on negro health are example of how health professions are place where racial ideology is created</td>
</tr>
<tr>
<td>Structural Racism</td>
<td>1965 – Today (13%)</td>
<td>School desegregation (1954), Civil Rights Act (1964), Voting Rights Act</td>
<td>Southern medical school desegregation (1948), hospital desegregation in federal courts (1964), disparate health status, outcome, services, discrimination in effect</td>
<td>1999 NEJM study is example of clear physician bias present across health systems</td>
</tr>
</tbody>
</table>

Source: Adapted from WM Byrd and LA Clayton’s “American Health Dilemma”
In 1996 and 1997, Cardiologists shown videos of matching patients to test for consistency recommendation of a cardiac catheterization (a medically beneficial procedure)

Patients matched on age, gender, occupation, symptoms, medical history, demeanor

Physicians attributes controlled for gender, race, an physician perception of patient personality traits

Study Design:

Findings:

Race and sex of patients independently influence physicians' recommendations for the management of chest pain.

Decision making by physicians may be an important factor in explaining differences in the treatment of cardiovascular disease with respect to race and sex.
These beliefs have been around for a long time in our history. They were once used to justify slavery and the inhumane treatment of black people in medicine.

What’s so striking is that, today, these beliefs are not necessarily related to individual prejudice. Many people who reject stereotyping and prejudice nonetheless believe in these biological differences.
Race matters because racism matters.
Racial Justice $\neq$ Diversity  
(Diversity = Variety)

Racial Justice $\neq$ Equality  
(Equality = Sameness)

Racial Justice = Equity  
(Equity = Fairness, Justice)
Racism: “A system of advantage based on race”. D. Wellman

- **INTERNALIZED**
- **INTERPERSONAL**

- **INSTITUTIONAL**
- **STRUCTURAL**

Adopted from the Applied Research Center
Be careful using “Racism Lite” (Dr. Cogburn) terms when you are really talking about racism. They detract from our structural understanding.
Constructivist Listening Pair Share: (2 minutes per person)
1. Fiery statements!
2. What are you chewing on?
3. What will you take with you?
History of the Liberation Project

1. Southern Jamaica Plain Health Center’s Racial Justice Journey
2. Our call to action summer of 2016
3. Who came and why?
4. Where we are going now?
VALUES

- presence
- compassion
- authenticity
- honesty/being upfront
- righteousness
- justice
- community
- diligence
- accountability
- heart
- humility
- kindness
- curiosity
- connection
- mindfulness
- solidarity
- risk
- sharing across identities
<table>
<thead>
<tr>
<th>Knowledge of Self</th>
<th>Knowledge of Community</th>
<th>In the Exam Room</th>
<th>On the Team</th>
</tr>
</thead>
</table>
| • History of (and current) white supremacy and eugenics in medicine/research  
  • Racial Identity Development stages and a self diagnostic  
  • Race as a social construct  
  • “The patients’ reality trumps your physiology” – Dr. Nancy Oriol, HMS  
  • Personal areas of implicit bias  
  • Social Justice Motivational Interviewing  
  • Understanding your own racial/gender/identity location and clarity about skin in this game. Lets all get free from these unhealthy systems.  
  • Don’t personalize the critique of systems. Good people working in systems that produce racial inequities every day. | • Key inequities in SDOH areas in your zip code  
  • Use community scavenger hunts led by local organizer  
  • History of communities relationship with medical outlets  
  • History of racial redlining in community, how it got that way  
  • Data by race, gender, SES, etc  
  • “if immediate needs aren’t addressed first, no health care can get done” | Next slides for specific questions…... | • Implicit bias acknowledgement and counteraction  
  • Sharing of identities within the team  
  • Share a Glossary of Terms with team and when you hire  
  • Data for each doc’s patient panel – look across race/ethnicity data.  
  • Racial Justice PDSAs and sharing the mistakes and accomplishments  
  • Frank discussion of micro aggressions and the difference between intent vs. impact. Explicit conversation about why the people in target groups are not responsible for the education of people in privileged group. |
In the Exam Room

Questions for first visit goal is to make the implicit, explicit:
1. “I don’t want to assume anything about your identities. How do you identify racially, ethnically, culturally and what are your pronouns? Have you had negative experience in the health care system as a result of any of these identities?”
2. “Many of my pts experience racism in their health care. Are there any experience you would like to share with me?”
3. What have been your experiences with the healthcare system?”
4. “Have there been any experiences that caused you to lose trust in the healthcare system?”
5. “It is my job to get you. You shouldn’t have to work to get me. If I miss something important or say something that doesn’t feel right please know you can tell me immediately and I will thank you for it.”
6. “Put up more visible cues for safe space: BLM, Flag, etc.
7. “Being curious” can feel like colonizing language: Not, “can you explain to me why….?” instead “there is something I don’t know that I really need to understand…..”
A Case from the Clinic
Implementing a Racial Justice Framework in an HIV Clinic: The Boston Healthcare for the Homeless Experience

Starting with data
The Context: US HIV Care Cascade by Race/Ethnicity

Figure 2. Percentage of persons with HIV engaged in selected stages of the continuum of care, by race/ethnicity -- United States

Looking at our own Data

• Analyzed HIV outcomes (HIV viral load, retention in care) for our cohort of approximately 200 HIV positive patients by

  • Race
  • Ethnicity
  • Housing status
  • Primary Language (English/Spanish)
Findings
## HIV Outcomes by Race

### Retention

<table>
<thead>
<tr>
<th>Race</th>
<th># retained</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>88</td>
<td>(88/102) 86%</td>
</tr>
<tr>
<td>White</td>
<td>40</td>
<td>(40/46) 87%</td>
</tr>
<tr>
<td>More than 1 race</td>
<td>15</td>
<td>(15/23) 65%</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>(4/5) 80%</td>
</tr>
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*P value .09

### HIV Viral Suppression

<table>
<thead>
<tr>
<th>Race</th>
<th># suppressed</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>110</td>
<td>(95/110) 86%</td>
</tr>
<tr>
<td>White</td>
<td>45</td>
<td>(45/55) 82%</td>
</tr>
<tr>
<td>More than 1 race</td>
<td>25</td>
<td>(25/29) 86%</td>
</tr>
<tr>
<td>Other</td>
<td>49</td>
<td>(49/55) 89%</td>
</tr>
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</table>

P value .79
## HIV Outcomes by Race/Ethnicity

### Retention

<table>
<thead>
<tr>
<th>Retention</th>
<th># retained</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic Black and/or more than one race</td>
<td>20</td>
<td>(20/31) 64.5%</td>
</tr>
<tr>
<td>Hispanic White</td>
<td>9</td>
<td>(9/11) 82%</td>
</tr>
<tr>
<td>Non-Hispanic Black</td>
<td>83</td>
<td>(83/94) 88%</td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>31</td>
<td>(31/35) 89%</td>
</tr>
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### HIV Viral Suppression

<table>
<thead>
<tr>
<th>HIV Viral Suppression</th>
<th># suppressed</th>
<th>%</th>
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<tbody>
<tr>
<td>Hispanic Black and/or more than one race</td>
<td>31</td>
<td>(31/37) 84%</td>
</tr>
<tr>
<td>Hispanic White</td>
<td>11</td>
<td>(11/12) 92%</td>
</tr>
<tr>
<td>Non-Hispanic Black</td>
<td>89</td>
<td>(89/102) 87%</td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>34</td>
<td>(34/43) 79%</td>
</tr>
</tbody>
</table>

*P value: <.0001
# HIV Outcomes by Race/Ethnicity

## Retention

<table>
<thead>
<tr>
<th>Retention</th>
<th># retained</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>20</td>
<td>(20/31) 64.5%</td>
</tr>
<tr>
<td>Black/More than 1 race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All other groups</td>
<td>164</td>
<td>(164/188) 87%</td>
</tr>
</tbody>
</table>

*P value .003

## Viral Suppression

<table>
<thead>
<tr>
<th>Viral Suppression</th>
<th># suppressed</th>
<th>%</th>
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<tbody>
<tr>
<td>Hispanic</td>
<td>31</td>
<td>(31/37) 84%</td>
</tr>
<tr>
<td>Black/More than 1 race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All other groups</td>
<td>185</td>
<td>(185/212) 87%</td>
</tr>
</tbody>
</table>

*P value <.0001
# HIV Outcomes by Housing Status

<table>
<thead>
<tr>
<th>HIV Viral Suppression</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housed</td>
<td>163</td>
<td>90.1</td>
</tr>
<tr>
<td>Not Housed</td>
<td>51</td>
<td>77.3</td>
</tr>
</tbody>
</table>

*P-value: 0.0163

<table>
<thead>
<tr>
<th>Retention in Care</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housed</td>
<td>190</td>
<td>87</td>
</tr>
<tr>
<td>Not Housed</td>
<td>29</td>
<td>66</td>
</tr>
</tbody>
</table>

P-value: 0.15

*Statistically significant P value

**Housed = assisted living, housing with or without support and transitional housing
# HIV Outcomes by Language

<table>
<thead>
<tr>
<th>HIV Viral Suppression</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>182</td>
<td>86</td>
</tr>
<tr>
<td>Spanish</td>
<td>61</td>
<td>88</td>
</tr>
<tr>
<td><strong>P-value:</strong></td>
<td></td>
<td>0.61</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Retention</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>162</td>
<td>85</td>
</tr>
<tr>
<td>Spanish</td>
<td>52</td>
<td>81</td>
</tr>
<tr>
<td><strong>P-value:</strong></td>
<td></td>
<td>0.34</td>
</tr>
</tbody>
</table>
Processing Findings

• Create space and time to process and discuss findings with staff and consumer advisory board (CAB), invite in the heart

• Engage staff and CAB in conversations about why inequities in outcomes might exist, and next steps for further investigation and intervention

• Addressing push back
BHCHP HIV Team Interventions

• Multidisciplinary team elects to take Implicit Association Test and discuss results, debrief led by team social worker

• HIV staff now attend weekly meetings with security team to help inform practice and policy and discuss concerning incidents

• HIV Team places our Intern who speaks Spanish in the waiting room to help manage the milieu

• Discuss implementation of identities/discrimination question with CAB members

• Begin encouraging HIV team staff to integrate this question into practice and document results in charts

• Started integrated housing clinic on site for HIV patients on weekly basis to facilitate getting patients out of homelessness faster
Disseminating Interventions Beyond the Team

• Begin conducting peer teaching activities with other BHCHP physicians, encouraging them to ask patients about their identities and experiences of racism and discrimination in health care.

• Integrate racial equity into every talk I give on care of homeless people to peers and trainees, including identities/racism question.

• Include identities/racism question in our social determinants of health template in the EHR.

• Engage senior leadership at BHCHP in conversations about health equity, and assessing for structural racism and other forms of discrimination program wide.
Next Steps

• Reanalyze data to test for any changes as a result of current interventions (racial justice PDSA)

• Conduct chart reviews to assess the extent to which providers on team are documenting racial identities/experiences with discrimination

• Considering additional data gathering through patient focus groups and possibly patient interviews
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Designing with the Margins

http://prezi.com/cjuhkonf-w2q/?utm_campaign=share&utm_medium=copy&rc=ex0share