Addressing Health Disparities Through Psychological Principles

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Roadmap: Racial Health Disparities

- **What are health disparities?**
- **Why do health disparities occur?**
- **What are the 5 psychological principles that may perpetuate healthcare disparities?**
  - Implicit Bias & Aversive Racism
  - Stigma & Stereotyping
  - Microaggressions
  - Color blindness
  - Medical Gaslighting
- **How do healthcare providers mitigate healthcare disparities?**
  - Best practices
  - Workplace Culture & DEI
  - Patient Centered-Care
- **Toolkit**

What are racial health disparities?

- Health disparities refer to the difference in health status among different racial and ethnic groups (Rose, 2021)
- These gaps in health status are preventable, however we see significant health disparities among socially disadvantaged populations (i.e. Black & Latinx)

Why do health disparities occur?

- The quality of the patient and provider interaction contributes to health disparities
- However, there are social inequities that surround the individual that contribute to health disparities and this is known as:
    - **Social Determinants of Health**

Social Determinants of Health (SDOH)

- Social determinants of health are, “conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes.” (CDC.gov)

Social Determinants of Health (SDOH) cont.

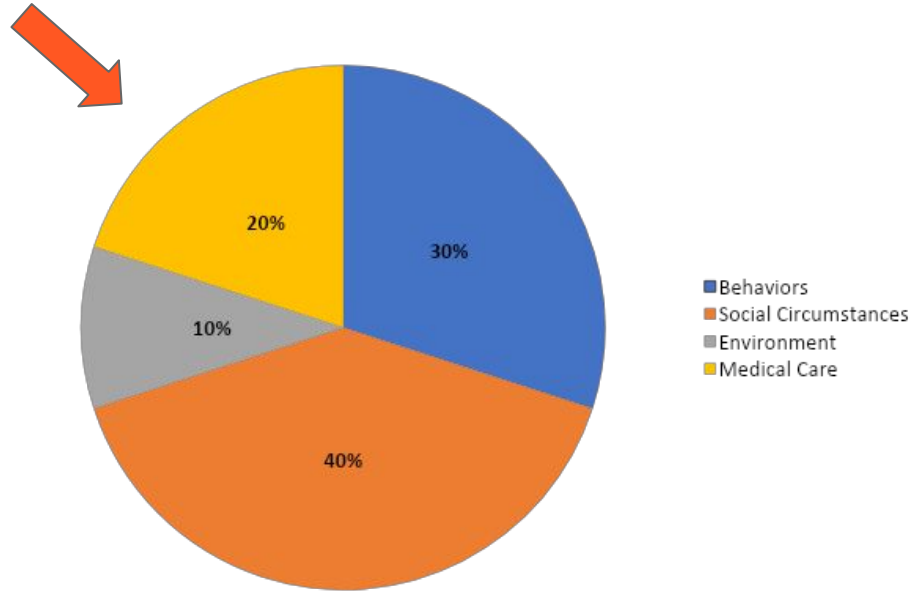
Structural Racism

- How our institutions are structured to produce racial inequalities between White and racial and ethnic minority people

Source: CDC.gov

Contributions of multiple determinants to health outcomes

- Of all the determinants of health, **accessibility and quality to medical care is a contributing factor to health outcomes.**



Source: Petaluma Health Care Center & Health Affairs (2014)

Where do we see health disparities?

Health Disparity: COVID-19 & Latinx

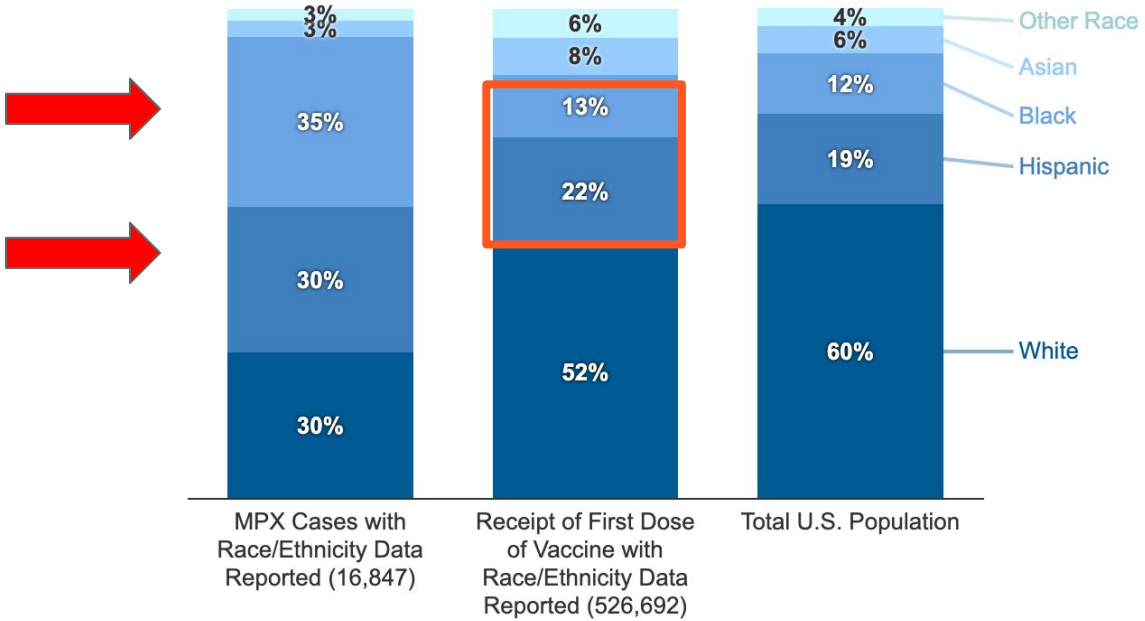
Race/Ethnicity	No. Cases	Percent Cases	No. Deaths	Percent Deaths	Percent CA population
Latino	3,774,914	45.3	40,524	43.0	38.9
White	2,108,563	25.3	33,265	35.3	36.6
Asian	849,853	10.2	10,343	11.0	15.4
African American	450,435	5.4	6,635	7.0	6.0
Multi-Race	83,431	1.0	1,435	1.5	2.2
American Indian or Alaska Native	38,446	0.5	466	0.5	0.5
Native Hawaiian and other Pacific Islander	63,490	0.8	587	0.6	0.3
Other	970,497	11.6	928	1.0	0.0
Total with data	8,339,629	100.0	94,183	100.0	100.0

Source: CA Department of Public Health, 2022

Health Care Disparity: MPX

Figure 2

Racial/Ethnic Distribution of MPX (Monkeypox) Cases and Vaccinations in the U.S. as of September 2022



Kates & Artiga et. al, 2022

Example of Structural Racism

- MPX

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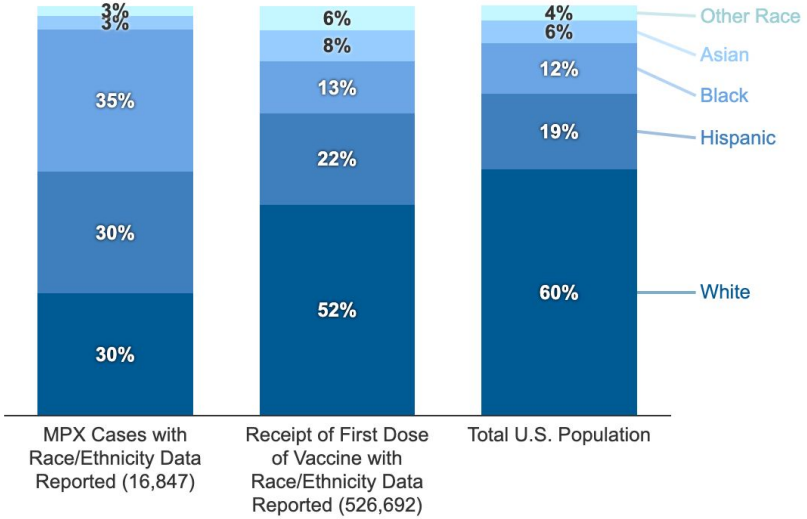
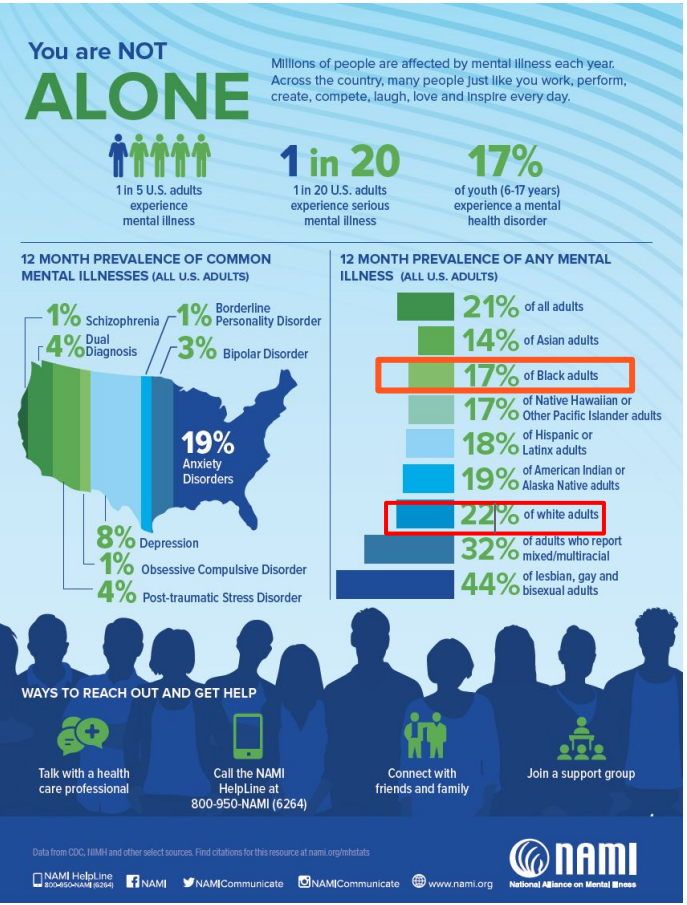
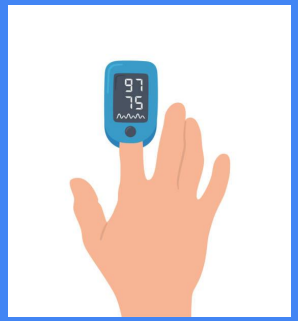


Health Care Disparity: Mental Health



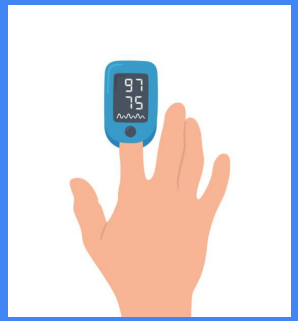
- Higher prevalence of mental illness in White adults than Black adults
- However, less accessibility of treatment for Black adults

Health Care Disparity: Medical Technologies



True or False:

Infrared thermometers and oximeters accurately measure temperature and oxygen levels of all patients regardless of skin tone.



True or False:

Infrared thermometers and oximeters accurately measure temperature and oxygen levels of all patients regardless of skin tone.

What are the 5 psychological principles involved in racial health disparities?

5 Psychological Principles that Perpetuate Health Disparities

1. **Implicit Bias & Aversive Racism**
2. Stigma & Stereotyping
3. Microaggressions
4. Color blindness
5. Medical Gaslighting

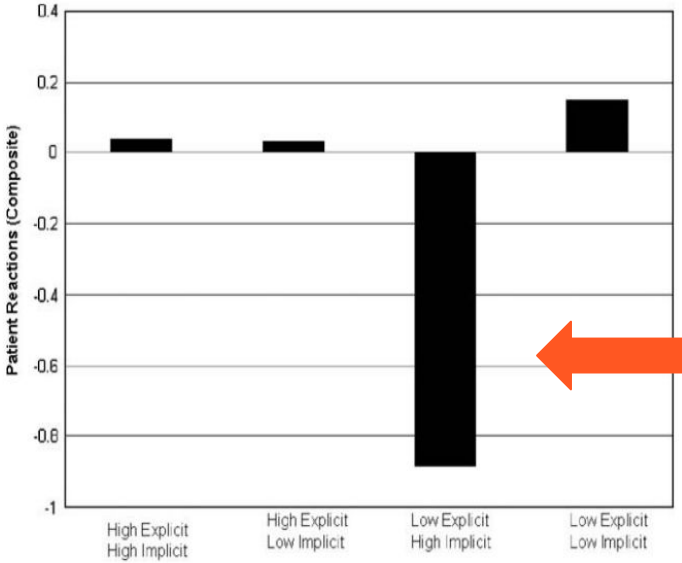
Implicit Bias & Aversive Racism

- **Implicit/Unconscious Bias**
  - In the context of race, it is the **negative associations** we have towards an individual or group based on cultural, ethnic, and racial stereotypes
  - The mere existence of cultural and racial stereotypes is enough to have implicit bias towards non-White individuals and groups (Chapman, 2013)
    - **We all have unconscious bias & negative associations!**

Implicit Bias & Aversive Racism cont.

- **Aversive Racism**
  - Aversive racism is when someone is high in implicit bias, but they are low in explicit bias (Penner & Dovidio, 2009)
    - An aversive racist will want to come across as non-racist, but they still hold racist attitudes (implicit bias)
    - For example, a provider who may not appear outwardly prejudiced, may feel uncomfortable in the presence of a patient of color, and may discriminate against them

How does implicit bias & aversive racism affect patient care?



Aversive Racism

Fig. 1. Predicted mean composite patient reactions to four groups of physicians: high explicit–high implicit, high explicit–low implicit, low explicit–high implicit (aversive racist profile) and low explicit–low implicit.

(Penner & Dovidio, 2009)

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Stigma & Stereotyping

- Stigma is a social process that involves associating negative characteristics to an identity
- This includes: labeling, stereotyping, and separation, leading to status loss and discrimination, **all occurring in the context of power** (Nyblade, 2019)
    - Non-stigmatized identity stigmatizes others because it socially benefits them

Stigma & Stereotyping cont.

- Stigmatization creates the following barriers in health care:
  - Delays in help-seeking
  - Early discontinuation of treatment
  - Suboptimal therapeutic relationships
  - Poorer mental and physical health care

Example of Stigmatization

- A White medical provider encounters a Black patient
- Stereotype: Black people are less cooperative, less compliant, and less responsible in the medical context (Hall & Chapman, 2015).
    - Due to this stereotype, providers may hold a stigma towards Black patients
    - This stigmatization may lead to the provider to not prescribe medication and treatment that the Black patient needs

Stigma and its Direct Impact on Overall Health

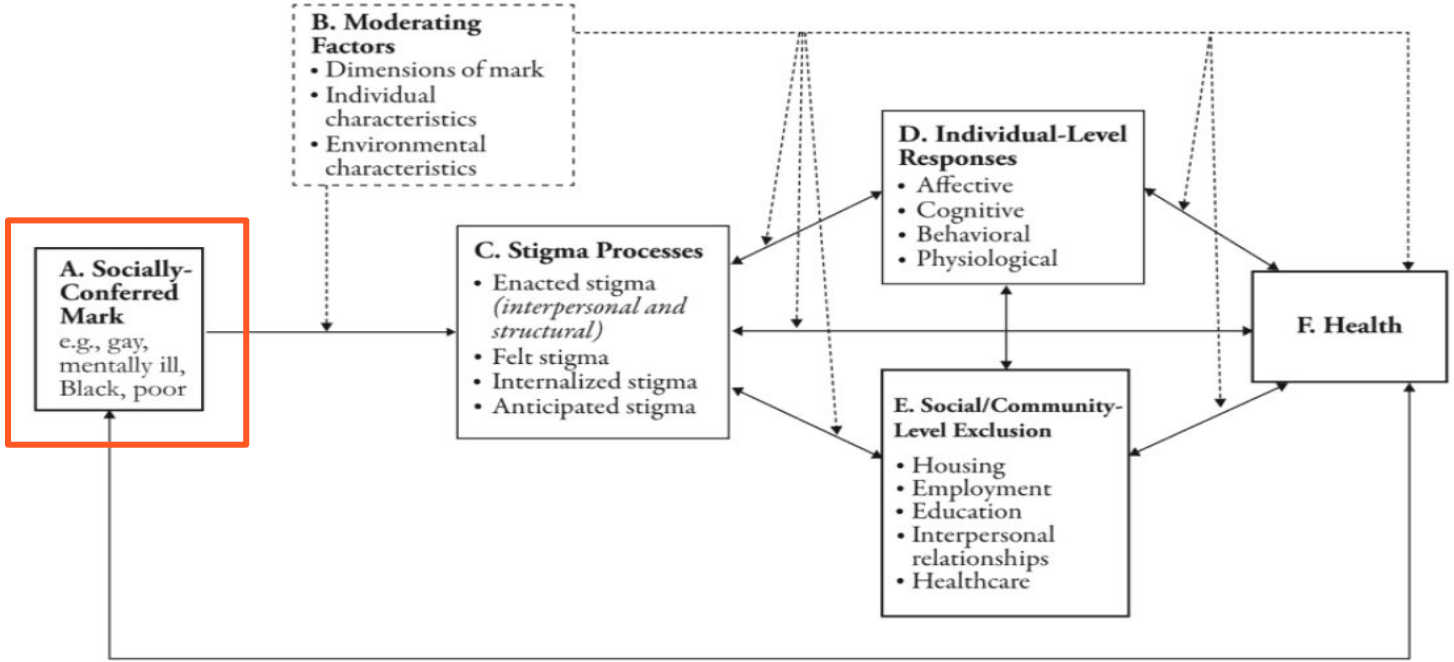
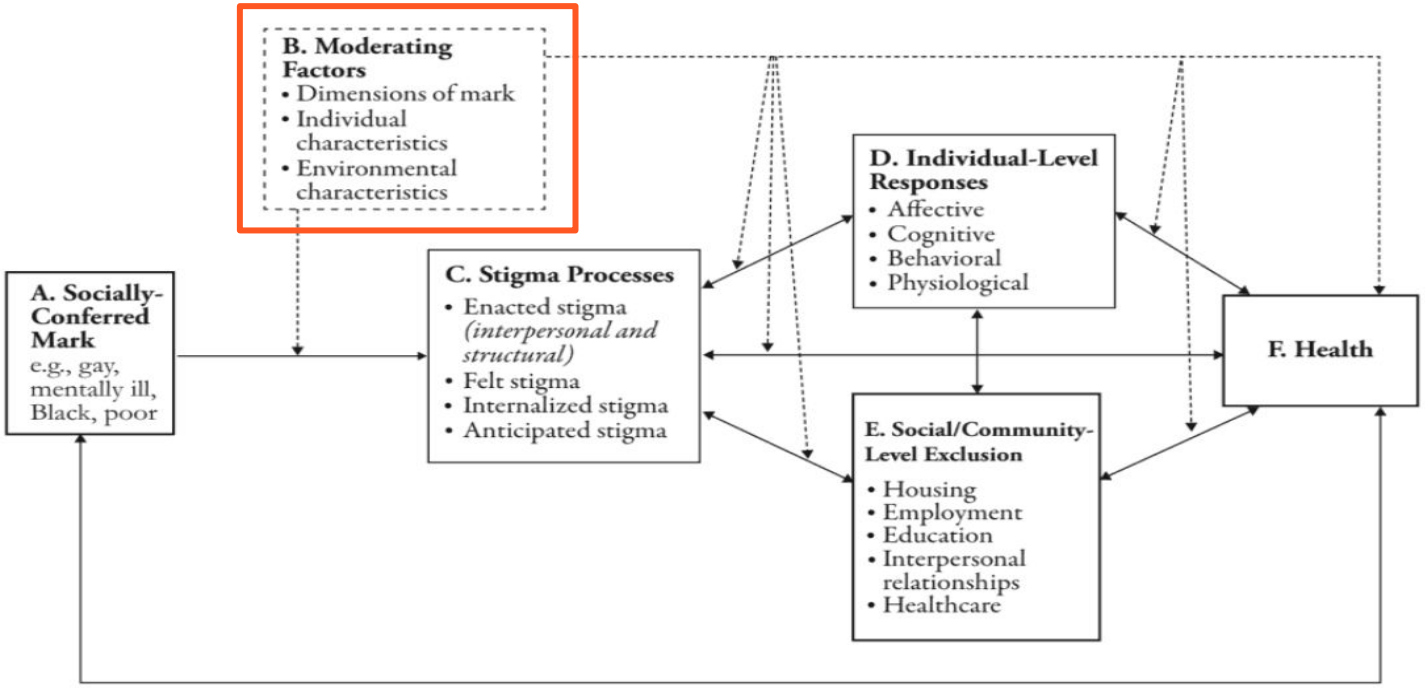


Figure 1.1 Conceptual model representing the effects of stigma processes on health. Variables and the pathway in solid-line boxes and arrows represent the focus of the current chapter.

(Major & Dovidio, 2018)

Stigma and its Direct Impact on Overall Health



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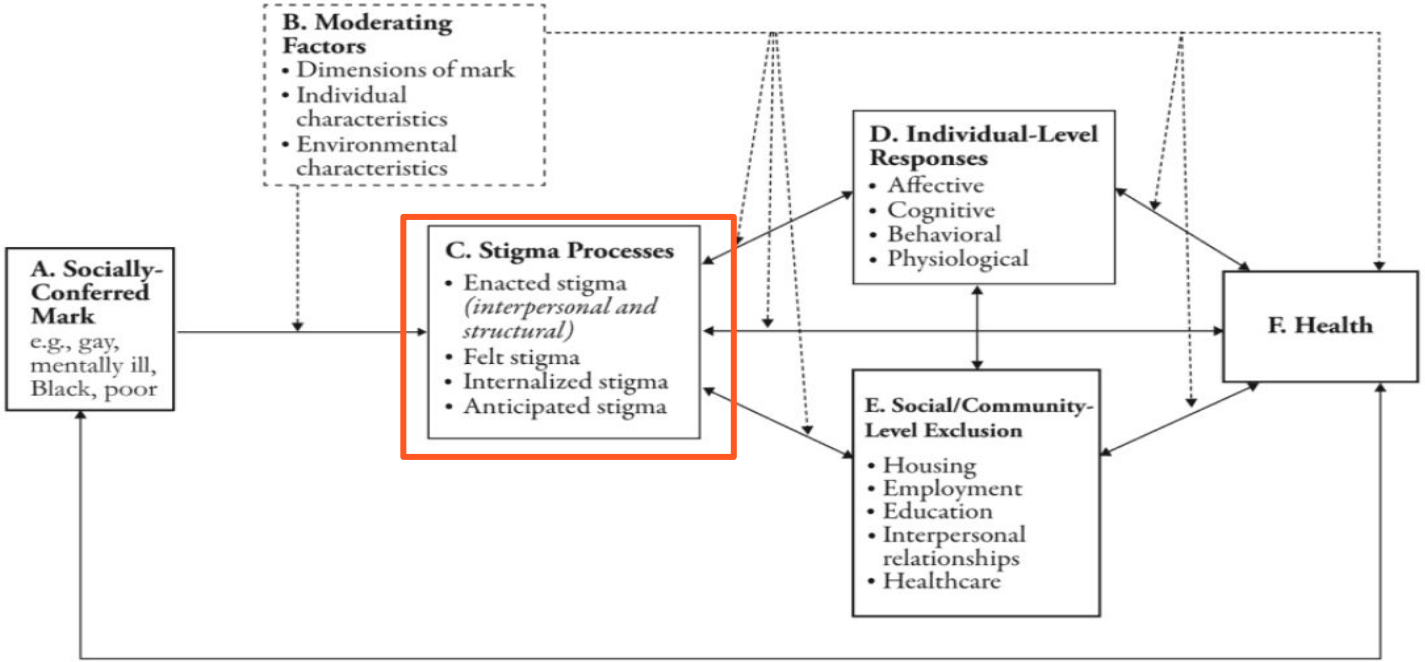

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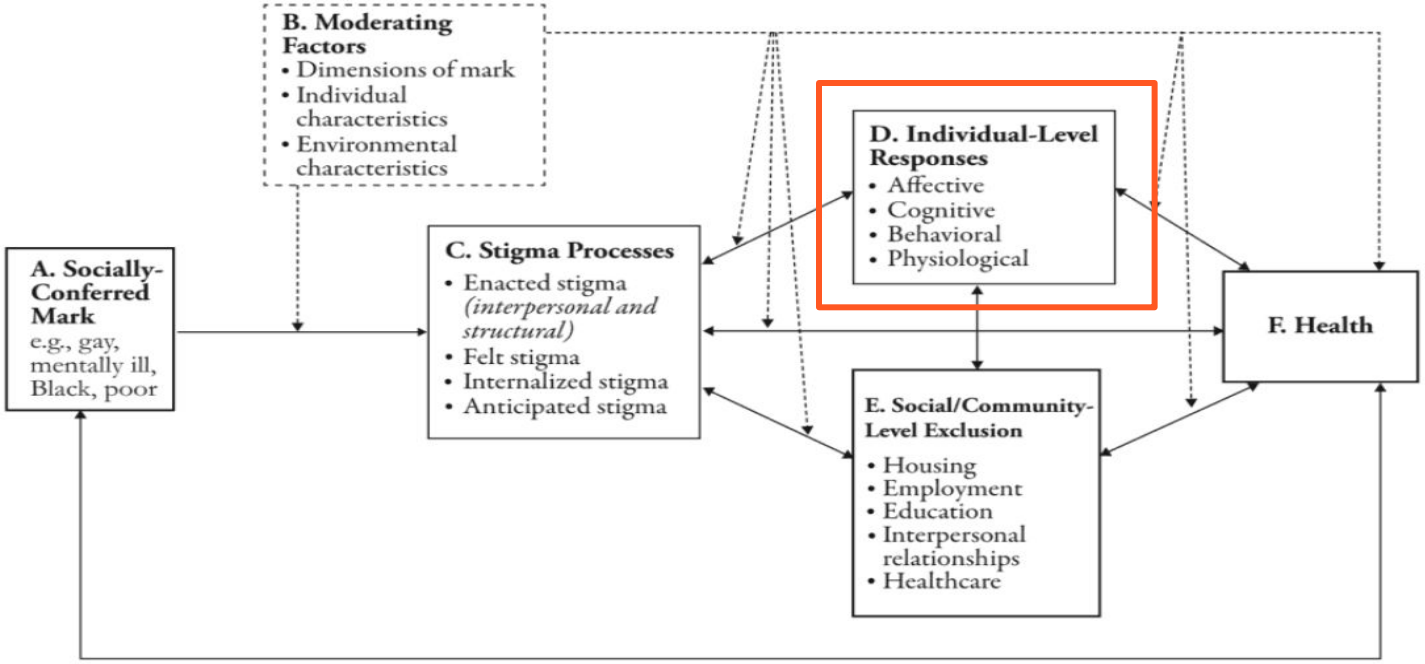

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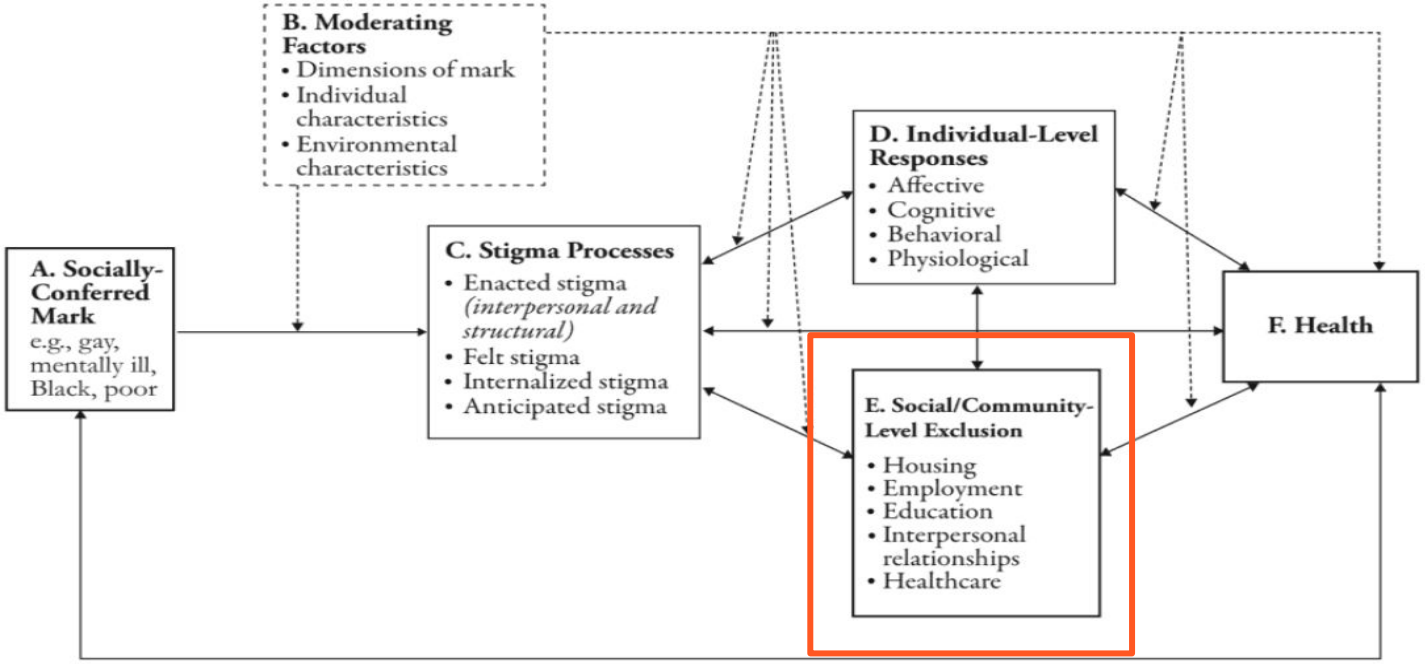

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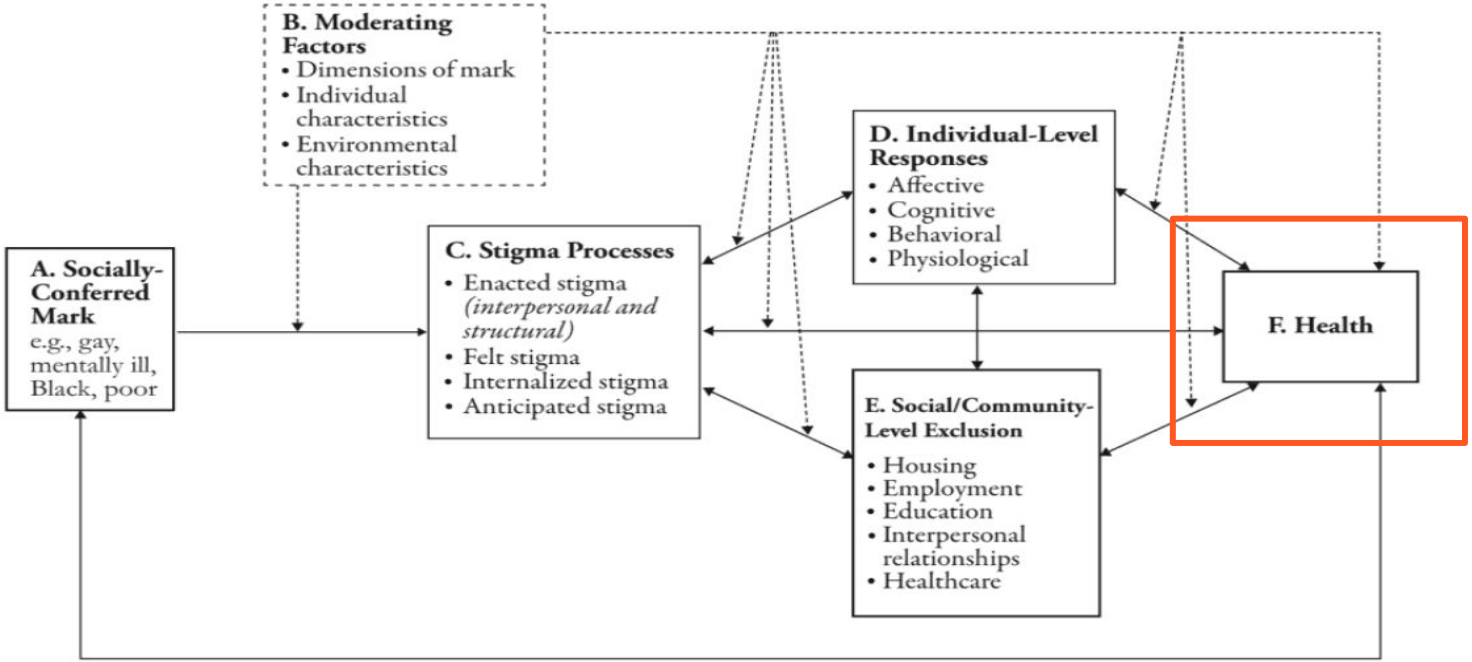

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5 Psychological Principles that Perpetuate Health Disparities

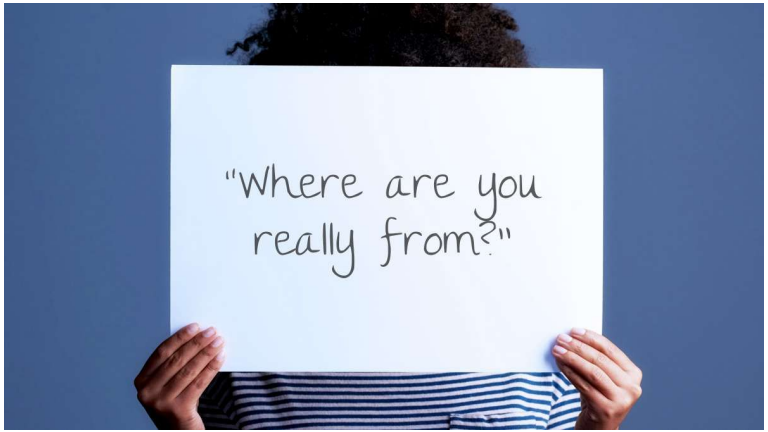
1. Implicit Bias & Aversive Racism
2. Stigma & Stereotyping
3. **Microaggressions**
4. Color blindness
5. Medical Gaslighting

Microaggressions

- Microaggressions are everyday verbal and nonverbal expressions that convey hostile, derogatory, or negative racial insults to the oppressed target person or group (Kanter, 2020)
- Microaggressions stem from implicit bias
    - Similar to stigmatization and stereotyping, MA's lead to detriments to the health of racial minorities, leading to health disparities (Kanter, 2020)

Patients of Color Experiences with Microaggressions

- When race status differences are present, patients are more likely to experience microaggressions (Miller & Peck, 2020)
  - White providers & patients of color
- MA's lead to:
  - Patients have a lack of trust with their provider
  - Early discontinuation of treatment
  - MA increases stress reaction in patients
    - MA contributes to health disparities



Examples of Microaggressions Between Patients and Providers

Microaggression	What it Really Means...
• “You speak English really well!” or “Where are you from?”	• Assumes POC folks are foreign-born/immigrant
• “I am not racist, I actually treat a lot of Black patients!”	• Provider denial of unconscious racial bias
• “When I look at my patients, I do not see color!”	• Using color blindness to deny unconscious racial bias & health inequities

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Color blindness

- Color blindness is a mode of thinking about race, that is characterized by the effort to not see or acknowledge racial differences (Cunningham, 2018)
- **Ex. “I am not racist…” or “I do not see race…”**
    - When medical professionals use the color blind approach to healthcare, it denies:
        - Accountability for having racial unconscious bias (that everyone has!)
        - The lived experience of structural racism as a person of color
        - The reality that not everyone has an equal opportunity to access quality health services

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Medical Gaslighting

- The term "medical gaslighting" is used to describe patients who have felt that their symptoms were arbitrarily dismissed as insignificant or labeled as primarily psychological by doctors (advisory.com)
- Examples
  - Long COVID patients - experiences were dismissed, delayed diagnosis, lack of treatment (sciencedirect.com)
  - OB/GYN -
    - Essure Birth Control - 26k reports of patients ignored by providers (nbc.news)
      - Cramping, blood clots, fever, severe and constant pain
    - Obstetrics - Women viewed as “vessel” in which a child manifests, rather than human (sciencedirect.com)
      - Denial of:
        - Humanity
        - Knowledge
        - Judgements
        - Feelings

How can providers mitigate healthcare disparities?

How do healthcare providers mitigate health care disparities?

- **Medical providers should integrate these skills as a lifelong process.**
- Cultural competency
  - “the ability to understand, appreciate and interact with people from cultures or belief systems different from one's own” (apa.org)
- Cultural humility
  - “Cultural humility is a life-long commitment to self-evaluation and self-critique in an effort to address power imbalances and to advocate for others.” (Masters et. al, 2019)
- Critical consciousness
  - “The ability to critically analyze conditions in the organizational and broader societal contexts that produce health inequities and act to transform them” (Todic, 2022)

Best Practices for Providers

- Inclusive Language
- Workplace Culture (Diversity, Equity, and Inclusion)
- Patient Centered Care
- Assessments and Acronyms to Remember

Inclusive Language

- Medical providers must dismantle barriers, beginning with inclusive language
- For instance, if providers consider the identities represented by LGBTQ+ members, they can be intentional in ensuring inclusive language/practices
- Forms and Environment - Signs, posters, pamphlets, name tags
- Providers/staff should:
  - Confirm pronouns (if mistakes are made, correct them immediately)
  - Problem solve regarding insurance issues with transgender pt's/name changes
  - Avoid labeling based on behaviors (sexuality/gender)
- Training should be continuous, and evolve as the society changes meanings and connotations of language

Words Matter

A guide to disability language etiquette

*Based on suggestions from various groups of people living with disabilities.
We recognize there are personal preferences, and our list continues to evolve.

to be like me

PLEASE DON'T SAY	INSTEAD, PLEASE SAY
"That Down syndrome kid" (disability-first language)	"A person/individual with Down syndrome" (person-first language)
Wheelchair-bound, confined to a wheelchair	Wheelchair user, person who uses a wheelchair
Handicapped parking	Accessible parking
Handicapped, crippled	Disability, Special needs *(sometimes acceptable for younger kids)*
Retarded, mentally challenged	Intellectual disability, IDD - Intellectual & Developmental Delays
Able-bodied, normal	People without disabilities
High/low functioning	Needs maximum support, moderate support, minimal support (describe level of support needed)
Hearing impaired	Deaf, hard of hearing
Learning problem	Learning difference
Non-verbal, mute	Communicates non-verbally, non-verbal communicator
Suffering from/afflicted with [name of disability]	Living with/has [name of disability]

If you don't know, it is OK to politely ask,
"How would you like me to refer to your disability?"

thankyou!

Breaking Down Inclusive Language

“A person-with Down-Syndrome” rather than “Down-Syndrome Person”		Uses person-first language, meaning that the disability is not used as a descriptor of the person, but rather a person *with* one.
“Accessible Parking” rather than “Handicapped Parking”		Accessible parking is not limited to people who are just handicapped, but for everyone who may experience any form of disability.
“People without disabilities” rather than “Able-Bodied, Normal”		It changes the stigma that it is not normal to have a disability.

Definition of DEI

- What is DEI?
  - Diversity, Equity, and Inclusion (DEI)
    - **Diversity: Increasing diversity** to include “race and ethnicity, gender and gender identity, sexual orientation, socioeconomic status, language, culture, national origin, religious commitments, age, (dis)ability status and political perspective” (U of Michigan)
    - **Equity: Becoming equitable to have equal opportunity for all persons** regardless of “race, color, national origin, age, marital status, sex, sexual orientation, gender identity, gender expression, disability, religion, height, weight, or veteran status” (U of Michigan)
    - **Inclusion: Creating a space where differences are embraced, different perspectives are heard, and every individual feels a sense of belonging and inclusion.** By creating an environment of inclusivity, we can effectively leverage the resources of diversity to advance our capabilities (U of Michigan)
- Why is it important in healthcare?

Why is DEI important in healthcare?

- Advancing DEI initiatives in healthcare to eliminate health disparities, address structural racism and other injustices in the medical field (Battle, 2022)
  - Diversity
  - Equity
  - Inclusion
- Lay the groundwork for innovation towards better health care & health care access for all

Workplace Culture & DEI

- University of Chicago Medicine
  - Adapted health care to include DEI initiatives from the individual employee to stakeholders and external influences
- UCSF
  - Anti-racism Initiative
  - Native American Graves Protection and Reparations
  - Pronouns Matter
- Johns Hopkins University
  - Roadmaps in place to address DEI at institution, as well as with faculty, students, and community as a whole.
  - Research that helps understand health disparities

Patient-Centered Care vs. Standard Patient Care

“Patient-centered care is considered fundamental to cultural competence and theoretically has the potential to reduce racial/ethnic disparities in health care quality, because it directly addresses many of the hypothesized mechanisms by which a patient's race/ethnicity may affect clinician behaviors” (Beach, 2007).

- Considers the patients from all perspectives rather than narrowing options
  - Culture
  - Religious beliefs
  - Lived experiences
- Autonomy of health care decisions
- Health education for informed decisions
- Open-ended, rather than yes/no

Toolbox

Acronyms for the Toolbox

- The 5 R’s of Cultural Humility

The 5 R's of Cultural Humility

Reflection

Respect

Regard

Relevance

Resiliency

Reflection

The 5 R's of Cultural Humility

Respect

Regard

Aim: Clinicians will approach every encounter with humility and understanding that there is always something to learn from everyone.

Ask: What did I learn from each person in that encounter?

Relevance

Resiliency

The 5 R's of Cultural Humility

Regard

Aim: Clinicians will hold every person in their highest regard, be aware of, and not allow unconscious biases to interfere in any interactions.

Ask: Did unconscious biases drive this interaction?

Aim: Clinicians will embody the practice of cultural humility to enhance their personal resiliency and global compassion.

Ask: How was my personal resiliency affected by this interaction?

The 5 R's of Cultural Humility

Resiliency

Aim: Clinicians will expect cultural humility to be relevant and apply this practice to every encounter.

Ask: How was cultural humility relevant in this encounter?

The 5 R's of Cultural Humility

Relevance

Respect

The 5 R's of Cultural Humility

Aim: Clinicians will treat every person with the utmost respect and strive to preserve dignity at all times.

Ask: Did I treat everyone involved in that encounter respectfully?

Commitment to DEI (from institution to individual)

- Individuals that are willing to engage in change should implement it in their lives
- Departmental level actions that contribute to effective DEI initiatives
  - Leadership Support
  - Recruitment and Membership
  - Purpose and Guidelines
  - Short and Long Term Goals
  - Communication/Collaboration
  - Continuous Evaluation

Commitment to DEI (individual to institution)

- Personalized Patient Activation and Empowerment
  - Activation: knowledge, skill, confidence to manage health care
  - Empowerment: self efficacy and capacity to make informed decision
  - Both concepts needed in order for patients to act on their health care
- Allows patient autonomy
- Availability and accessibility of healthcare and education

Thank you!

Q&A

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