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CARDI·OH
Ohio Cardiovascular and Diabetes Health Collaborative

Addressing Racism to Achieve Equity in Health Care

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Urgent approaches are needed to address the multifaceted impact of racism on health.

Overall, Ohio's rates of diabetes and cardiovascular disease for all races/ethnicities are higher than national averages. Compared to other racial/ethnic groups, Non-Hispanic Black populations have disproportionately higher rates of overall cardiovascular disease mortality (Table 1) and preventable cardiovascular deaths (Table 2).[1]

Table 1. Total Cardiovascular Disease Death Rate per 100,000, 35+, All Races/Ethnicities, Both Genders, 2017-2019

Race or Ethnicity	Total Cardiovascular Disease Death Rate per 100,000	
	Ohio	U.S.
All Races/Ethnicities	479.6	419.2
Black (Non-Hispanic)	576.6	553.6
White (Non-Hispanic)	475.8	424.4
Hispanic	245.4	307.1
American Indian and Alaskan Native	133.5	370
Asian and Pacific Islander	222.6	248.1

Table 2. Avoidable Heart Disease and Stroke Death Rate per 100,000, All Races/Ethnicities, Both Genders, 2017-2019

Race or Ethnicity	Avoidable Heart Disease and Stroke Death Rate per 100,000	
	Ohio	U.S.
All Races/Ethnicities	65.1	58
Black (Non-Hispanic)	104.5	100.7
White (Non-Hispanic)	61.7	55.7
Hispanic	37.9	43
American Indian and Alaskan Native	25.8	69.7
Asian and Pacific Islander	23.8	32.3

Adapted from *Interactive Atlas of Heart Disease and Stroke.*

As demographics across the state and nation continue to change, racial and ethnic diversity is increasing. Primary care clinicians need to acknowledge and understand the depth and complexity of how individuals and communities experience racism and take action to advance health equity.

Working collectively to advance racial health equity will improve the health of the overall population. Several U.S. health systems, and medical, professional, and bioscientific organizations have named racism as a public health threat and have promised to identify and reverse racist policies and practices in their institutions and organizations.[2–14]

Ohio Department of Medicaid released a special message, *Race as a Social Construct: Serving the Needs of All Individuals*, which can serve as a strong starting point for discussions of race and racism:

> ***Race is a social construct broadly used to categorize people based on physical characteristics, behavioral patterns, and geographic location. Race is not a proxy for biology or genetics. Data regarding race is typically based on self-identification and data collection routinely allows respondents to select more than one race. Racial and ethnic groups that have historically faced discrimination are at a higher risk for cardiovascular disease and diabetes. Ohio Department of Medicaid recognizes that social inequality, not genetic differences, produce these racial and ethnic health disparities. Examining health access, health care quality, and health outcome data by race and ethnicity allows the health system to address the factors contributing to inequity and ensure that the health system serves the needs of all individuals.***
>
> *October 2021*
> *cardi-oh.org/special-message/odm/race-as-a-social-construct*

For more information, watch Cardi-OH's webinar on Race and the Clinical Management of Cardiovascular Health.

The scientific literature on the historical basis of racism, discrimination, and public health consequence is broad and nuanced. There are many details that cannot be covered in this brief document. We provide some foundational resources and encourage health care workers to make serious personal and organizational commitments to a process of learning, beginning with the resources and references we have summarized.

Racial Equity

"Racial equity is a process of eliminating racial disparities and improving outcomes for everyone. It is the intentional and continual practice of changing policies, practices, systems, and structures by prioritizing measurable change in the lives of people of color."[15] As we continue to move away from "sick care" and toward value-based health care models, advancing racial equity in primary care is a key pillar to improving the health of our entire society. Community engagement and partnership with bi-directional design and development of policies and programs are key elements of addressing all forms of racism.[16]

> ***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 advantage other individuals and communities, and sapping the strength of the whole society through the waste of human resources.***[17]
>
> *Camara Jones, MD, PhD, MPH*

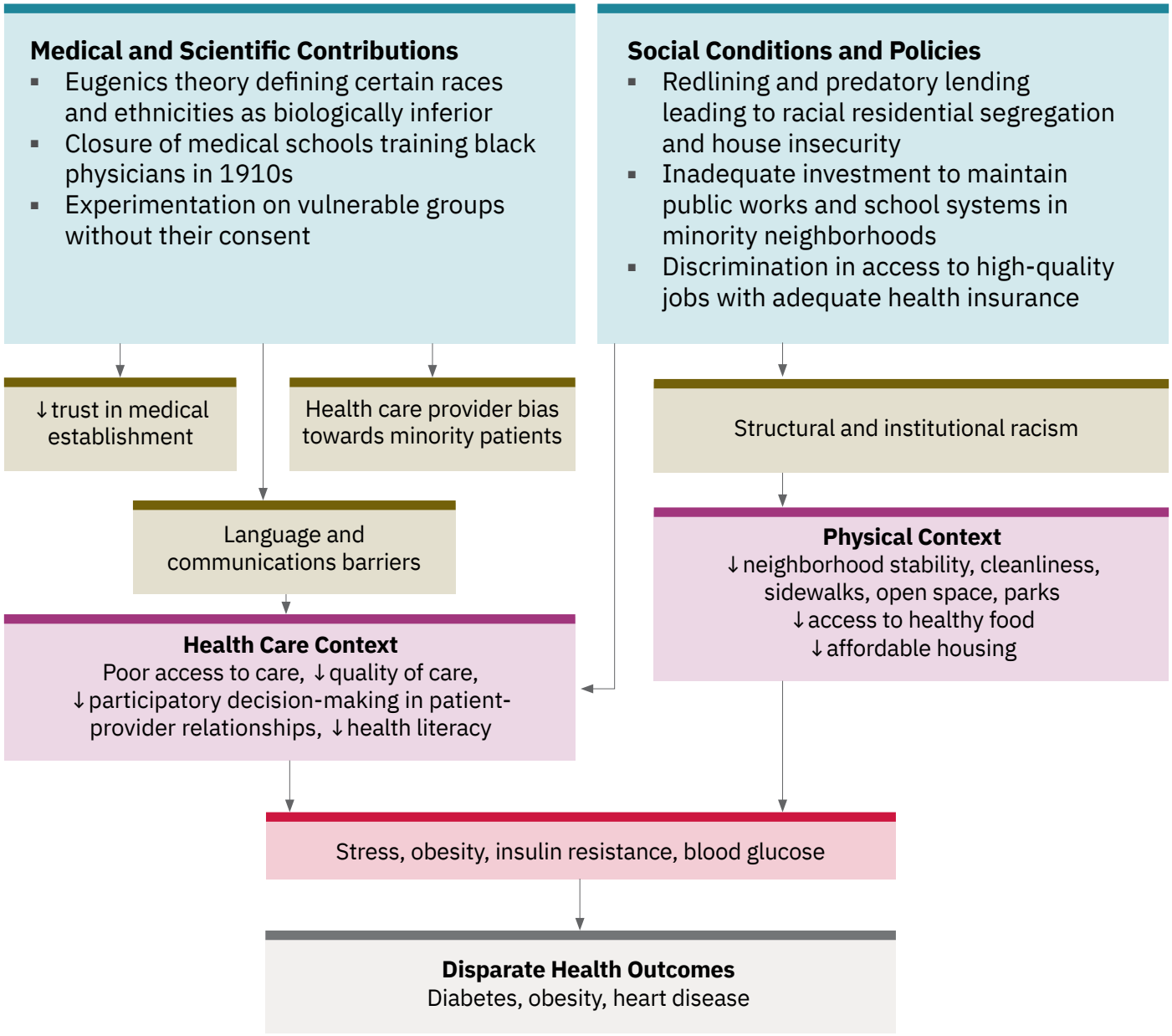
Racism in Health Care

Four main types of racism and how they can be manifested in health care are presented below:

Table 3. Levels of Racism

Type of Racism	Definition	Impact on Health Care
Internalized racism	Lies within individuals based on their private beliefs and biases about race and racism. This involves prejudice towards individuals of a different race, negative beliefs about oneself (internalized oppression) or beliefs about superiority (internalized privilege).[15]	Impacts patient care through internalized privilege among some and internalized oppression in minoritized populations. For example, most literature on this area is focused on the impact of unconscious biases in health care. Racial and ethnic implicit biases of clinicians impede effective care and hinder progress towards health equity.[14,18–20] Large racial and ethnic differences in access to quality clinical care exist in the U.S. for cardiometabolic and cardiovascular diseases.[21–24]
Interpersonal racism	Occurs between individuals when their personal racial beliefs affect their public or private interactions. This involves an individual's exposure to racist interactions.[15]	Shows up in health care through microaggressions and explicit biases, as seen in patient interactions and medical charting.[18,25,26]
Institutional racism	Occurs within institutions and is mediated through unfair policies and discriminatory practices resulting in inequitable outcomes for racial/ethnic minority individuals and advantages for White (Non-Hispanic) individuals.[15]	Impacts policies, practices, procedures, and outcomes, making it less likely individuals will receive outpatient specialist referral or specialist care in the hospital.[27–30]
Structural racism	Occurs across institutions and society (at local, state, and federal levels) that is embedded in laws, policies, and practices of society and interactions among its institutions to systematically provide advantage to racial groups deemed as superior while differentially oppressing, disadvantaging racial/ethnic minority groups.[15]	Occurs through institutional and community policies that impact a patient's ability to thrive. For example, growing literature has described the detrimental impact of 1930s redlining on health outcomes today (Figure 1).[31–33] Redlining refers to the exclusion of households from receiving home loans based on their geographic residence. In Ohio, neighborhoods with any Black residents were 41 times more likely to be redlined.[34]

Figure 1. Present-Day Impact of Historical Discrimination and Racism on Obesity and Diabetes



Medical and scientific practices, social conditions, and policies contribute to race/ethnic disparities in diabetes and obesity. Prior experimentation on vulnerable populations without their consent, perpetuation of eugenics theory, and lack of Black and other diverse physicians in the workforce have resulted in residual bias in the health care system and trust violations contributing to poor health care quality for minoritized communities. Policies resulting in racial residential segregation; lack of investment in public works, businesses, and school systems in minority neighborhoods; and discrimination in housing loans and high-quality jobs contribute negatively to social determinants of health, influencing metabolic disease outcomes. Adapted with permission from *Casting a health equity lens on endocrinology and diabetes*.[31]

Emerging Best Practices and Practical Solutions

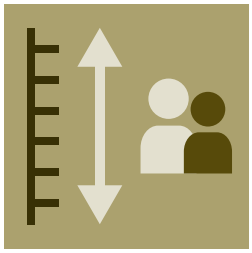
Advancing racial equity and addressing racism require education and engagement in activities focused on anti-racism and evaluation of policies, practices, and procedures that lead to inequitable outcomes. In addition, quality improvement and policy change is necessary to redress and reform current inequitable practices and empower those who are marginalized or oppressed.[35,36]

Several useful frameworks, standards, and solutions for advancing racial equity and eradicating racism and are described below.

Implicit Bias Training

Racial and ethnic implicit biases of clinicians impede effective care and hinder progress towards health equity.[14,18–20] Implicit bias training is one approach to learning mitigation strategies for these biases, which include common identity formation (i.e., "common ground" or shared narrative approaches whereby persons with observable differences focus on shared cultural similarities), cultural humility, perspective taking, considering the opposite, and countering stereotypical exemplars.[37] To affect change, health care organizations should commit to continuous learning as opposed to one-time trainings. Efforts to identify, reflect on, and address biases among health care workers are necessary though not entirely sufficient. Similar to other transformation efforts, advancing equity requires leadership, commitment to a culture of change, and implementing meaningful action in organizations and communities.[38]

Racism Measurement Framework



Opportunities exist to measure all levels of racism, but specifically internalized and interpersonal racism. The Racism Measurement Framework comprehensively depicts the disparities caused by racism within Ohio and can be used to monitor and evaluate the effectiveness of anti-racist efforts implemented across the state.[39] It is critical that institutions develop reporting processes for patients, clinicians, trainees, and staff.

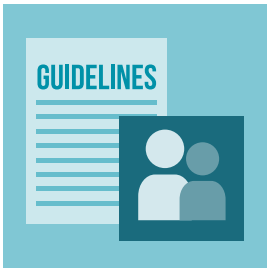
Culturally and Linguistically Appropriate Services (CLAS) Standards

The U.S. Department of Health & Human Services has developed a blueprint for Culturally and Linguistically Appropriate Services (CLAS) standards. The standards and tools were specifically designed to promote effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.[31,40]

Plan, Do, Study, Act Cycle

The Plan, Do, Study, Act (PDSA) cycle is an essential tool for health care quality improvement. Hospitals and health systems have special obligations to serve as anchor institutions to their communities. They must be at the forefront of evaluating and addressing policies, procedures, and outcomes that are impacted by institutional racism. At the clinic level, this may include activities such as examining outcomes based on race and ethnicity, working to understand what policies, practices, and procedures are impacting a specific outcome.

Use of Race in Clinical Guidelines and Decision Making



The use of race in estimated glomerular filtration rate calculation has been evaluated and determined to have inequitable impact on the care of Black patients. Examples of inequities include differential access to kidney transplantation and specialist care.[39–42] This led to the development of new equations that exclude race by the National Kidney Foundation and American Society of Nephrology.[39–42] Other race-based clinical guidelines are currently being evaluated.[14,41–44] Health system laboratories are currently evaluating changes to their laboratory-based equations and reporting in consideration of the national recommendations.

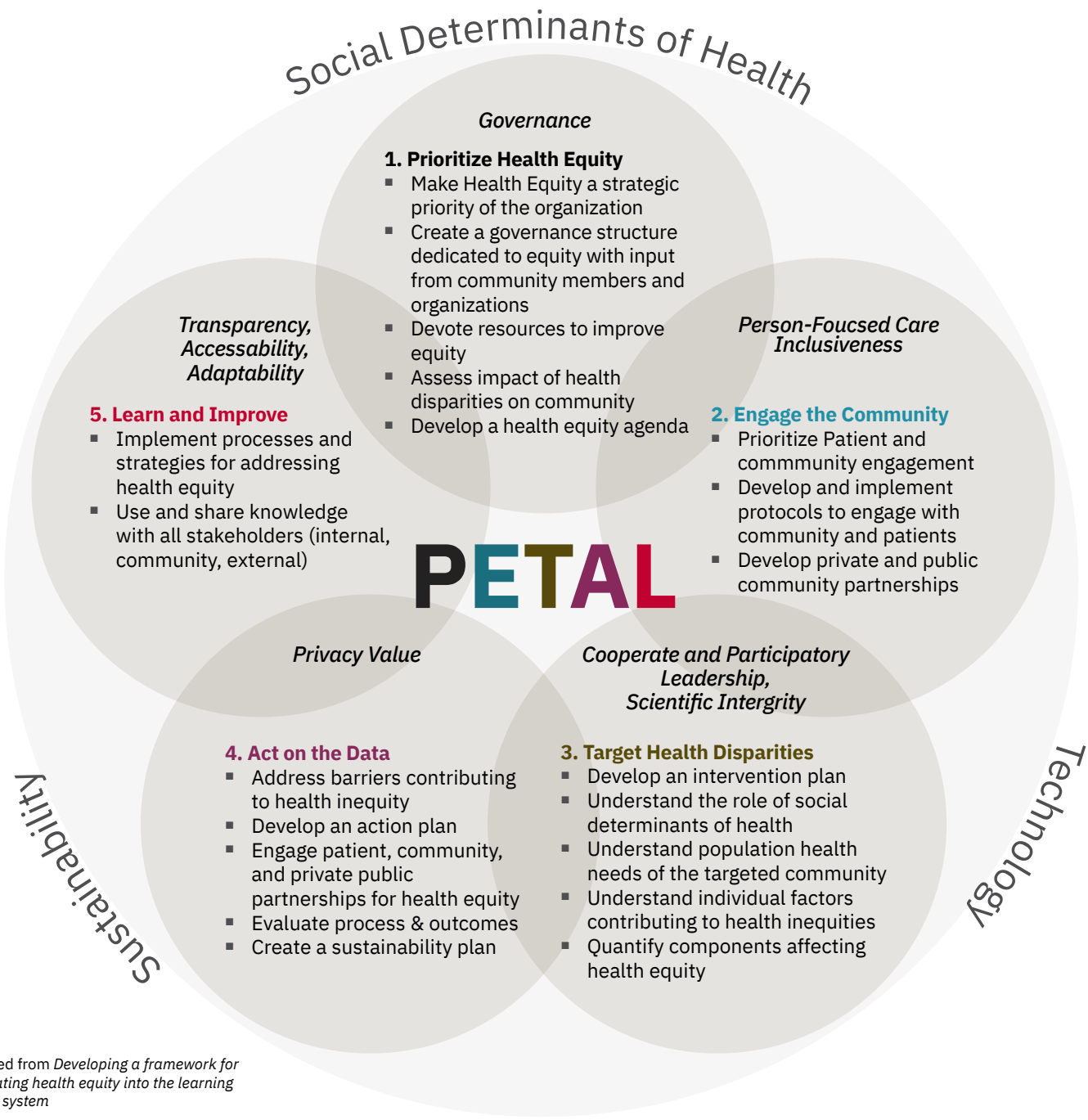
Ohio Opportunity Index

The Ohio Opportunity Index can be used to understand structural racism in Ohio.[45] The resource measures neighborhood conditions and opportunities, known to be associated with health and well-being, across a variety of domains into a single index score that can be used to assess overall neighborhood conditions, target interventions, and adjust evaluations for neighborhood-level risk. Effective and equitable reforms include the need for changing policies in society to address structural racism and other social determinants of health. Anchor institutions and clinics advocating for policy change are a core component to improve the environment. Additionally, it is critical to screen for and address the social needs of patients experiencing barriers to health due to the environments in which they live.

PETAL Framework

The PETAL (**P**rioritize Health Equity, **E**ngage the Community, **T**arget Health Disparities, **A**ct on the Data, **L**earn and Improve) framework (Figure 2) is an evidence-based tool to address health equity.[46] Taking the perspective of a learning health system, the framework places an emphasis on multi-stakeholder inclusivity to connect resources, including data and technology, in a sustainable manner.

Figure 2. The PETAL Framework for Integrating Health Equity into the Learning Health System



Adapted from *Developing a framework for integrating health equity into the learning health system*

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