The Health Care Institution, Population Health and Black Lives

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The ongoing existence of institutionalized racism and discriminatory practices in various systems (education, criminal justice, housing, employment) serve as root causes of poor health in Blacks Lives. Furthermore, these unjust social structures and their complex interplay result in inefficient utilization of health services and reactive or futile interactions with medical providers. Collectively, these factors contribute to racial disparities in health and treatment represents a significant portion of the nation's health care expenditures. In order for health care systems to optimize population health goals, racism must be recognized as a determinant of health. As anchor institutions in their respective communities, we offer hospitals and health systems a conceptual framework to address the issue within internal and external constructs.

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INTRODUCTION

While some may assert we live in a post-racial era, a body of scholarship corroborates the presence of structural racism in contemporary settings.[1–5] Most recently, a series of events have elevated social consciousness about the Black experience in America.[6] Consequently, the *Black Lives Matter* movement gained momentum in 2012, serving as a "call to action and a response to the virulent anti-Black racism that permeates our society.[7]" The mission specifically focuses on addressing "ongoing and widespread devaluation of Black Lives and the social, political, and economical structures that result in unequal opportunity.[7]" Such forms of injustice have a profound effect on communities of color and are manifested through inequities in common correlates of health, including access to quality education, healthy foods, livable wages, and affordable housing.

Moreover, a substantial body of evidence highlights the relationship between race, racism and health status.[8–12] Blacks are disproportionately burdened by poorer access and lower quality of care even when controlling for factors, such as income, education, and insurance.[8,13] They also represent higher rates of morbidity and premature mortality when compared with white counterparts. Some of the starkest differences can be found in hypertension, diabetes, and asthma rates, resulting in higher frequencies of treatment for comorbidities and ambulatory care sensitive conditions.[14–19] Such racial disparities have a significant financial impact and are estimated to cost $35 billion in excess health care expenditures and $10 billion in illness-related lost productivity.[20]

In response to these disparities, many health care institutions have demographically stratified and analyzed health outcome data and incorporated best practices to create interventions to reduce or eliminate disparities in care. However, due to broader structural contexts, significant disparities persist. We assert that these trends will remain intractable until structural racism and its effects (bias, discrimination) are recognized as root causes of poor health. This approach is especially relevant as health reform is incentivizing health care leaders to find new and more creative ways to promote wellness, reduce readmissions, and manage the health of populations. By applying a racial equity lens in how they are governed and operated, hospitals, as anchor institutions, can advance their population health goals.[21]

Using health reform as a springboard, we articulate why this approach is important and close with a conceptual framework to stimulate thought and organizational practices that (1) promote racial equity within health care settings; and (2) contribute to the advancement of historically marginalized communities of color.

HEALTH EQUITY AND BLACK LIVES

In light of the magnitude and long-term psychological impact of racism, coupled with a history of implicit and explicit injustices imposed on those of African descent, two definitions in the literature inform our interpretation of health equity within the context of Black Lives. In 2003, Braveman and Gruskin defined health equity as a goal of eliminating systemic disparities in health or in the major social determinants of health (i.e., education, housing, employment) between social groups who have different levels of underlying social advantage and disadvantage –

that is, different positions in the social hierarchy.[22] Camara Jones construes health equity as the assurance of the conditions for optimal health for all people, which requires valuing all individuals and populations equally, rectifying historical injustices, and addressing contemporary injustices by providing resources according to need.[23] Consequently, we assert that it is important for health care leaders to recognize institutionalized injustices in their own communities and carefully examine how they impact the health of the populations they serve.

Note:

The focus of this commentary is on Black Lives; we also use "minorities" and "communities of color" interchangeably based on contextual language.

INSTITUTIONALIZED RACISM AND ITS EFFECTS

In order to be effective in improving health through a racial equity lens, it is important to recognize how the health care institution is a subset of a larger ecosystem with vestiges of institutionalized racism, stemming as far back as the 1600s.[9] The legacy continues to influence how low income communities of color are structured and resourced.[23,24] *Institutionalized racism* is defined as "the structures, policies, practices, and norms resulting in differential access to the goods, services, and opportunities of society by race. It is structural, having been codified in our institutions of custom, practice, and law, so there need not be an identifiable perpetrator.[23]" Despite the passage of prominent legislation that makes explicit forms of racism illegal, remnants of historically grounded policies and practices that perpetuate poor health in contemporary settings are evidenced through racial segregation and unequal distribution of resources.[24,25]

The consequences of these injustices are multifactorial and detrimental to the well being of society, but for the purposes of this commentary, we focus on the relationship between institutionalized racism and health. More specifically, a growing body of evidence suggests racism as a social determinant of health.[24,26] For example, chronic exposure to discrimination creates a physiological or hormonal response (survival stress) that may stimulate or exacerbate chronic disease conditions – making it challenging to improve individual health.[24,26–28] This recognition is especially important to providers as a newly insured cadre of persons enter systems of care – many of whom have low income – encountering day-to-day psychosocial barriers that emanate from discriminatory policies and practices.

Within a historical context of medical care, persons of color have had a profoundly unique experience. Countless numbers of Blacks were medically exploited and subjected to inhumane and traumatic experiences. While the Tuskegee experiment is widely referenced in the literature, it is an isolated depiction of a more systemic, robust and pervasive agenda to advance medicine at the expense of Black Lives.[29] The legacy and trauma associated with the atrocities have deeply affected Black Americans' perceptions about the health care system and how they consciously or subconsciously interact with providers.[8,30] For example, scholars have found Blacks more likely than Whites to distrust the health care system and more likely to prefer racially concordant providers.[30–35] Such distrust, coupled with underrepresented people of color in medicine,[36] impede patient engagement and may be culpable for late stage diagnoses and/or exacerbation of chronic disease conditions in persons of color.[30]

In addition to distrust at the patient-level, providers are susceptible to decision-making based on implicit biases – attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner.[8,12,37–39] Documented occurrences of racially driven decision-making in clinical settings have not been characterized as intentional but partially attributed to subconscious perceptions that emanate from exposure to high frequencies of negative portrayals of Black Lives at a societal level.[40–42] Consequently, actions that stem from biases compromise quality of care through error, miscommunication, no referral or inappropriate referral to specialty care or medical procedures, and misdiagnosis of medical conditions.[10,12,43,44]

POPULATION HEALTH

The gravity of these dynamics must be recognized within the context of *population health* – a term that has progressively increased in the literature since 2010.[45] While the interpretation and its utility tend to vary depending on discipline or profession, health care institutions are likely to perceive population health as clinically managing the patients under the auspices of their care. However, health outcomes for these patients are heavily influenced by structural conditions and the quality of assets that are available across the life span. Therefore, we advocate for a more comprehensive interpretation.

In 2003, Kindig and Stoddart defined the term as "the health outcomes of a group of individuals, including distribution of such outcomes within the group."[46] They posit, "the field of population health includes health outcomes, patterns of health determinants, and policies and interventions that link the two."[46] Young describes

population health as a "framework for thinking about why some populations are healthier than others" including policy, research, and resource allocation.[47] By normalizing these interpretations through a racial equity lens, health care organizations have the potential to advance population health goals by improving the patient experience as well as the social conditions in which they live.

CONCEPTUAL FRAMEWORK

Hospitals are components of a larger ecosystem; they cannot take sole responsibility for addressing complex and intersectional inequities that perpetuate poor health in communities of color. However, as health care providers, they can be instrumental in eliminating racial disparities within clinical settings, and as anchor institutions, they can be socially impactful — using their business models to create opportunity and stimulate investments in historically marginalized communities. To incite a more strategic approach to population health improvement within the context of Black Lives, we offer a conceptual framework based on a bifurcated approach (Figure 1).

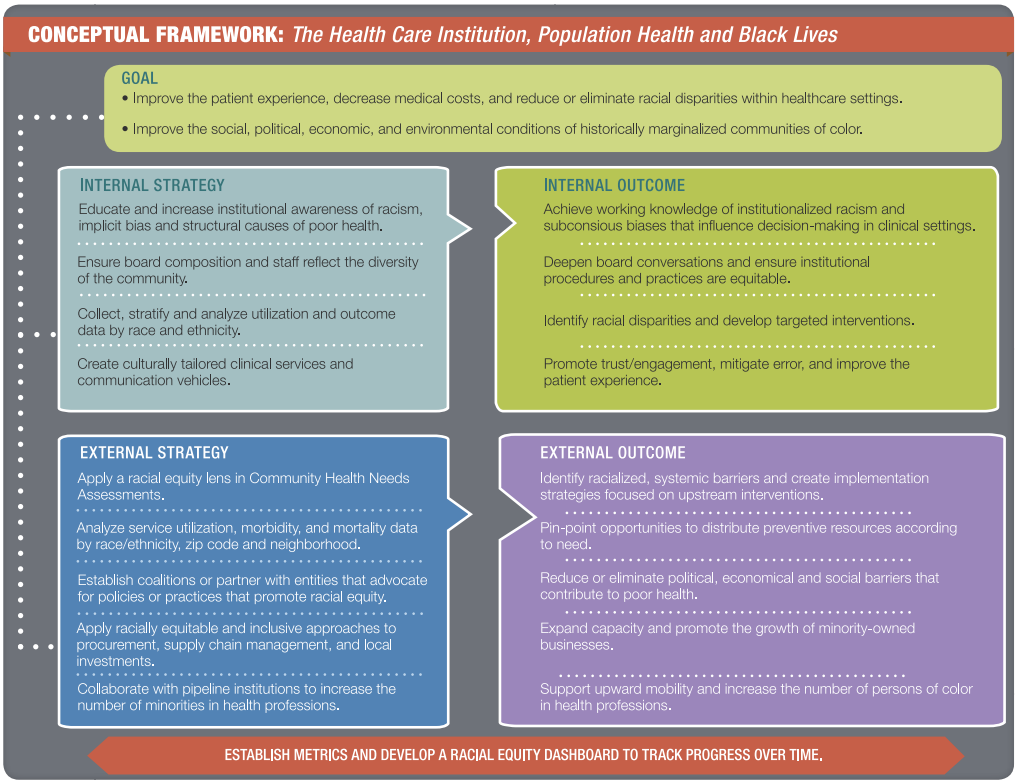
Internal strategies focus on operational practices, including how clinical systems and services are organized and structured. External strategies focus on the community at-large, including how the health care institution, as an "anchor institution" supports or invests in upstream factors, resulting in equitable access to opportunity. While institutional capacity and community dynamics vary, we provide examples of strategies for both constructs, as well as their associated outcomes, and how the efforts stimulate systemic change.

Internal strategies

Since racial differences within clinical settings are substantiated in quantitative and qualitative research designs, we define internal process activities as practices and guidelines within the health care institution that promote consistency in the patient experience, regardless of race, as well as allocation of support resources according to need. To achieve this objective, the relationship between race, racism, and health[48] must first be understood, internalized and normalized by the organization's governing board and employee population. Furthermore, a carefully structured approach is necessary to help the groups identify their own biases and how those biases translate into unconscious decision-making within governance and practice contexts.

The Implicit Association Test (IAT) is a validated instrument that can provide structure around this approach. Developed in 1998, the IAT allows participants to assess bias or preference for specific demographic identities (race,

Figure 1. Conceptual framework. The health care institution, population health and Black Lives.



gender, religion, etc.).[49] Since its development, it has been used in various settings to raise individual and collective awareness around unconscious bias and its impact on communities of color. Through a carefully guided process, the IAT opens the door for safe and constructive dialogue that can heighten institutional awareness – helping board and staff cognitively intercept biased defaults. The benefits are numerous and can inform core business areas, such as board recruitment processes and general hiring practices, marketing and planning approaches, as well as quality, safety and patient experience metrics.

Some health systems are nationally recognized for governance and operational activities aimed at improving the patient experience, eliminating treatment disparities by race, and promoting economic advancement in communities of color. For example, Main Line Health is known for its approach to achieving board and staff diversity and the integration of social factors in clinical care.[50] Through its Health Disparities Solution Center, Massachusetts General Hospital aims to eliminate racial disparities in care through a series of workforce development and quality improvement initiatives.[51] Georgetown University Medical Center's Kid Mobile Clinic provides comprehensive pediatric care and spearheads advocacy initiatives to promote health in historically underserved Black communities in the District of Columbia. Henry Ford Health system's "best in class" supplier diversity initiative has yielded more than 300 active minority and women-owned businesses in its supply chain management database.[52]

External strategies

In the wake of health reform, the changing landscape is positioning hospitals with new opportunities to demonstrate their tax-exempt worthiness through community health improvement and community building activities.[53] The shift in resources presents a profound opportunity to identify racial inequities and invest in neighborhoods that have borne the brunt of decades of failed social policies and practices with racism at their core. Determining key health issues and the dynamics that contribute to those issues is the first step and the mandated triennial Community Health Needs Assessment (CHNA) for not-for-profit hospitals can be instrumental in facilitating the process. By conducting a race-conscious CHNA, hospitals will achieve better insight on how institutionalized racism impacts health outcomes in the communities they serve.

Race conscious strategies may include designing quantitative and qualitative data collection measures aimed at assessing if or to what extent persons of color perceive or experience racism. Examining the history of the community or policies that have or continue to perpetuate differences in the distribution of resources will also be strategic. The process can also include assessment of community assets (institutional or organizational) for strategic partnerships since health care organizations are not likely to have the expertise nor the resources to assume a lead role within the racial equity space. Other CHNA strategies may include assessing the hospital's own data and honing in on morbidity and mortality racial disparities at the neighborhood level. Findings offer clues for more targeted interventions and how resources can be more equitably distributed.

Based on CHNA findings, hospitals must identify health priorities and work in partnership with the community to develop an implementation plan that addresses the issue. Some health systems have made considerable progress in shifting their approach to community benefit through bold, unconventional tactics. Bon Secours Health System and its partners have invested in dilapidated row homes and converted them into 119 affordable apartments in West Baltimore.[54] University Hospitals, Cleveland Clinic and its partners have pooled resources to finance a wealth building initiative – the Evergreen Cooperatives, a network of employee-owned businesses that hire from systematically underserved neighborhoods.[21] St. Joseph's Health System supports activities to build capacity at the grassroots level through community organizing, leadership development, and coalition building.[21] MedStar Health and Seattle Children's Hospitals work with youth in communities of color – providing mentoring, job shadowing, and internships to promote healthy development and cultivate a pipeline to increase the number of underrepresented persons of color in health care.[55,56]

Goal

Population health incentives are challenging health care institutions to value prevention and be more accountable to their communities. Moreover, it is clear that institutional racism and its effects (within the health care institution and beyond the health care institution) continue to have a negative impact on health outcomes of Black Americans and other persons of color. Therefore, we argue that a health care system's population health goals can be optimized by 1) employing internal strategies to improve the patient experience and reduce or eliminate racial disparities within health care settings; and 2) employing external strategies to improve the social, political, economical, and environmental conditions of communities of color. For accountability purposes, a racial equity dashboard based on internal and external process measures can be helpful in documenting and tracking the breadth of the institution's capacity to effect change. Collectively, these strategies will support systemic change that is critical

for improving the quality of health care and advancing local and national population health goals.

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