Beyond Racial Disparities in Healthcare:

Bridging the Gap, Breaking the Stigma and Building Black & Brown Communities

Access, Culture & Equity

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BLACKWELLNESS NETWORK

About Me

Dr. Valarie Cunningham

CEO & Founder of The Synergy Health Center

BlackWellness Network

- Founder and CEO of Synergy Health Center (SHC) 2003
- Founder and CEO of the BlackWellness Network (2023)
- 23+ Years at the forefront of advocating for mental health, substance abuse, and support services in Health & Human Services with a focus on patients of color.
- Doctorate-Level Expertise in Healthcare, Leadership & Equity Proven Track Record of Transforming Organizations & Policies Engaging, Thought-Provoking, and Actionable Keynote addresses and symposiums throughout Kalamazoo, the U.S. and internationally.

Objectives

- 1. Expose the root causes of racial and ethnic health disparities.
- 2. Reframe healthcare narratives by shifting from a deficit-based approach.
- 3. Mobilize health leaders and practitioners to become change agents who actively bridge racial gaps in care through authentic engagement and anti-racist practice.

Goals for Today

- **NOT to make you feel bad**
- **NOT to shame you**
- **NOT to blame you**
- **NOT to attack you**

- IS to get you to THINK critically
- IS to DISRUPT you current thought process
- IS to think about yourself, your FAMILY & your COMMMUNITY
- IS to create a NEW narrative

Understanding Key Terms

Acces
s

The ease in which individuals can obtain resources and opportunities.

Culture

Shared attitudes, values, goals, and practices that characterizes an institution or organization

Equity

Fair treatment, access, and opportunities for ALL.

Racial Disparity

The unequal treatment of different racial groups in a society.

Cultural Competence

The ability to work and interact with people from different cultures.

Racism

When a person is treated worse, excluded, disadvantaged, harassed, bullied, humiliated or degraded because of their race or ethnicity.

Root Causes

- - Structural racism in healthcare
- - Implicit biases in clinical settings
- - Socioeconomic determinants of health
- - Underrepresentation in medical research


Racism

BlackWellness Network

Racism

Not always conscious
Not always visible
Not always explicit

Racism, not race itself, is a social determinant of health and a fundamental cause of health inequities and, as a social construct, is the primary driver of racial health disparities.

AFRICAN AMERICAN CITIZENSHIP STATUS: 1619-2021

Time Span:	Status:	Years:	% U.S. Experience:
1619-1865	Slaves: **"Chattel"**	251	61.2%
1865-1964	**Jim Crow: virtually no Citizenship rights**	103	24.6%
1964-2024*	"Equal"	61	14.2%
1619-2024	"Struggle" "Unfairness"	406	100%

*** USA struggles to transition from segregation & discrimination to integration of AA's**

Byrd, W. M. & Clayton, L. A. (2001). An American Health Dilemma: Race, Medicine, and Health Care in the United States.1900-2000. New York: Taylor & Frances, Routledge

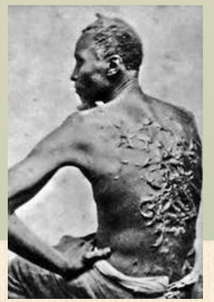

Reflection

Structural Racism

Anglo-American medical and mental health care systems heavily influenced culture, and its history of racial injustice was heavily influenced by Anglo-American culture and its history of racial injustice, according to Nuriddin et al. (2020).)

Racial Healthcare Disparities: Historical Context

1800's



Drapetomania (noun)

(drăp″ĕt-ō-mā′nē-ă) [Gr. (δραπέτης + μανία) **drapetes**, runaway, + **mania**, madness]
Wandering behavior; an uncontrollable urge to travel.
Archaic: An overwhelming urge to flee servitude.

Origin: Coined in the 1851 treatise *Diseases and Peculiarities of the Negro Race* by Samuel A. Cartwright, MD as a medical term for the mental illness that caused slaves to flee captivity.

1900's

2000's

Institute of Medicine

- Extensive Study assessing racial and ethnic disparities in health care.
- Committee found that, within the U.S., even among individuals with access to care, significant racial and ethnic disparities indeed existed and were related to historic and contemporary social and economic inequality, discrimination, and a fragmented US system of health care

Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care

Alan Nelson, MD
Washington, D.C.

Editor's note: National Medical Association President Lucille Norville-Penn invited American Medical Association Past President Alan Nelson, MD to contribute his opening speech from the March 22, 2002 briefing of the Institute of Medicine in Washington, DC as the guest editorial in this issue of JNMA.

On behalf on the Institute of Medicine and my colleagues on the committee, I would like to outline the major findings and recommendations of our report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. First a little background information. This study was done at the request of Congress, which asked the Institute of Medicine to assess the extent of racial and ethnic differences in the quality of health care received by patients, not attributable to known factors such as access to care, ability to pay, or insurance coverage; evaluate potential sources of these disparities, including the role of bias, discrimination, and stereotyping at the provider, patient, institutional, and health system levels; and lastly, to provide recommendations regarding interventions to eliminate health care differences.

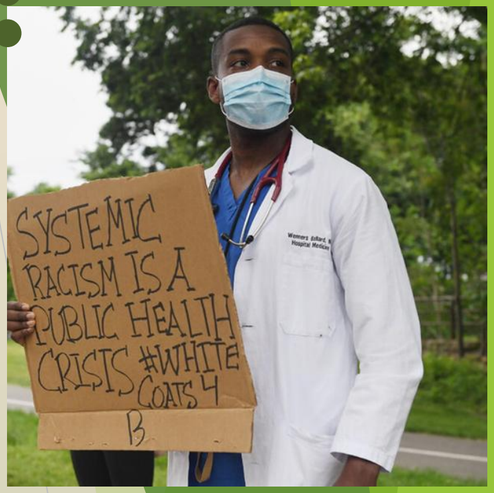
Our 15-member committee met five times during the course of a year, reviewed all the relevant literature, gained further insights from commissioned papers, and convened four workshops to gain additional information from the public. Information also was gathered from a series of focus groups, roundtable discussions, and technical liaison panels.

As the committee dug deeper into its work, it became clear that there are many complex sources of racial and ethnic disparities in health care. This is reflected in the committee's findings and recommendations. Our key findings include the following:

- Racial and ethnic disparities in health care exist even when insurance status, income, age, and severity of conditions are comparable. And because death rates from cancer, heart disease, and diabetes are significantly higher in racial and ethnic minorities than in whites, these disparities are unacceptable.
- These differences in health care occur in the context of broader historic and contemporary social and economic inequality and persis-

© 2002. Opening statement from March 22, 2002, briefing of the Institute of Medicine, Washington, DC.

2010's



2016 MEDICAL STUDY:

- 40% of first- and second-year white medical students believe “black people’s skin is thicker than white people’s”
- Black people are not as sensitive to pain as white people and were less likely to treat black people’s pain appropriately.
- Black people’s blood coagulates more quickly than white people
- Half of the medical trainees believe that at least one or more of these false beliefs were true

Racial Healthcare Disparities: Historical Context, cont...

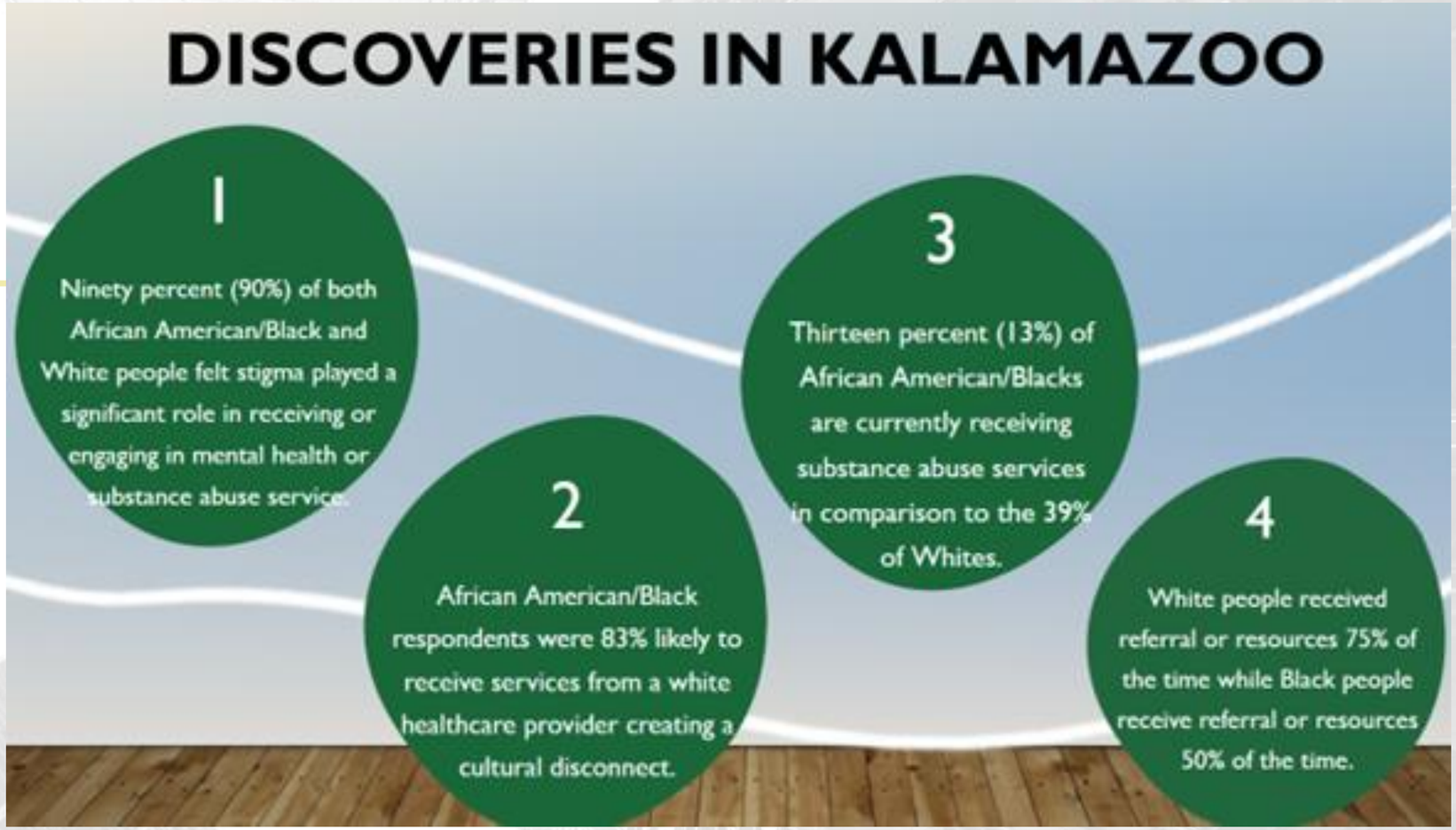
1800's

1900's

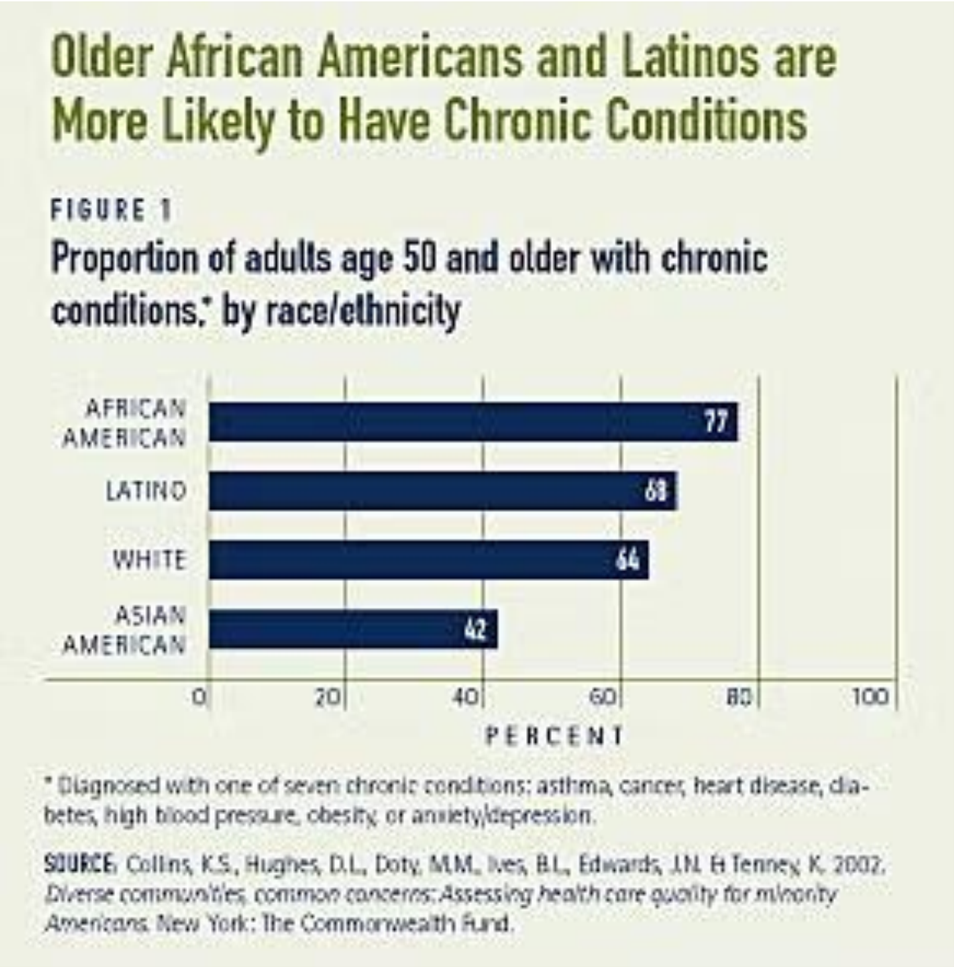
2000's

2010's

2020's



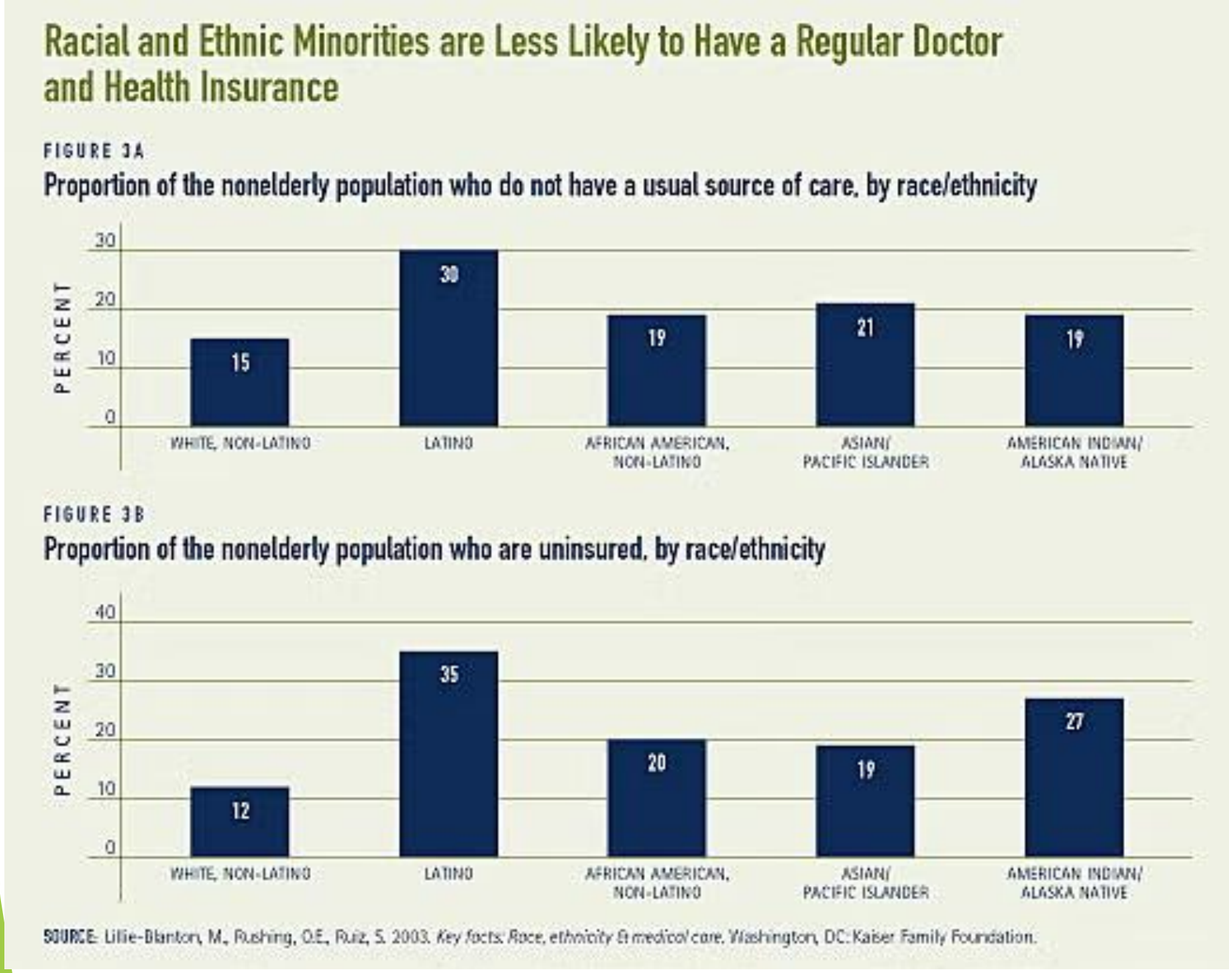
Access to Health Care Differs by Race & Ethnicity, cont…



- Racial and ethnic minorities have higher morbidity and mortality from chronic diseases.
- Among older adults, a higher proportion of African Americans and Latinos, compared to Whites, report that they have at least one of seven chronic conditions — asthma, cancer, heart disease, diabetes, high blood pressure, obesity, or anxiety/depression. These rank among the most costly medical conditions in America.
- African Americans and American Indians/Alaska Natives are more likely to be limited in an activity (e.g., work, walking, bathing, or dressing) due to chronic conditions.

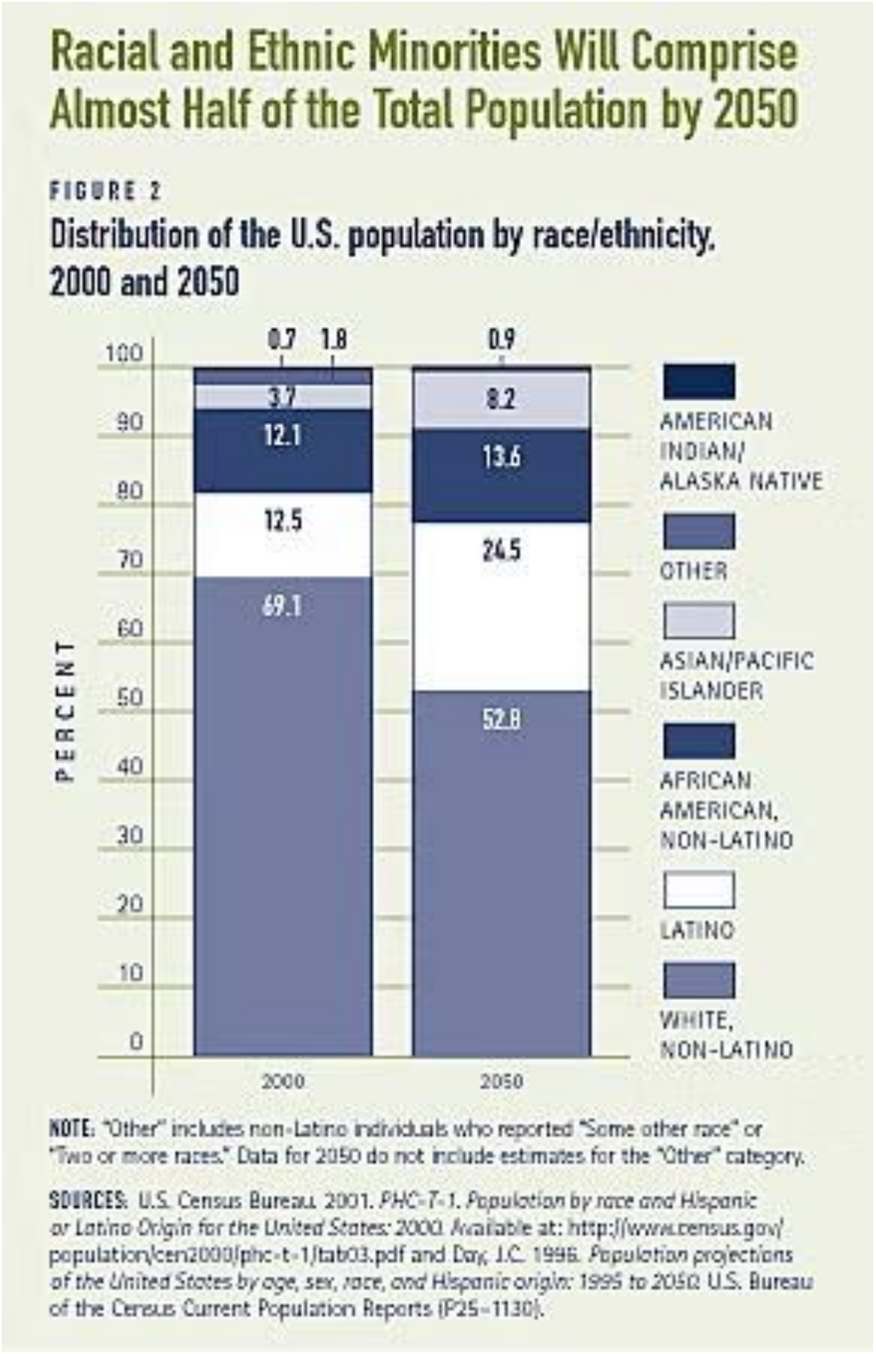
Reference: Georgetown University Heath Policy Institute

Access to Health Care Differs by Race & Ethnicity



- People who do not have a regular doctor or health care provider are less likely to obtain preventive services, or diagnosis, treatment, and management of chronic conditions.
- Health insurance coverage is also an important determinant of access to health care. Higher proportions of minorities compared to Whites do not have a usual source of care and do not have health insurance.

Reference: Georgetown University Heath Policy Institute



MAJOR Health Care Crisis on the Horizon!!!

- Chronic conditions increase with age.
- In 2000, 35 million people — more than 12 percent of the total population — were 65 years or older.
- By 2050, it is expected that 1 in 5 Americans — 20 percent — will be elderly, and racial/ethnic minorities will comprise 35 percent of the over 65 population.

Reference: Georgetown University Heath Policy Institute

“The time for health care (*CHANGE*) for Black Americans is long overdue”

Louis-Jean et al., 2020

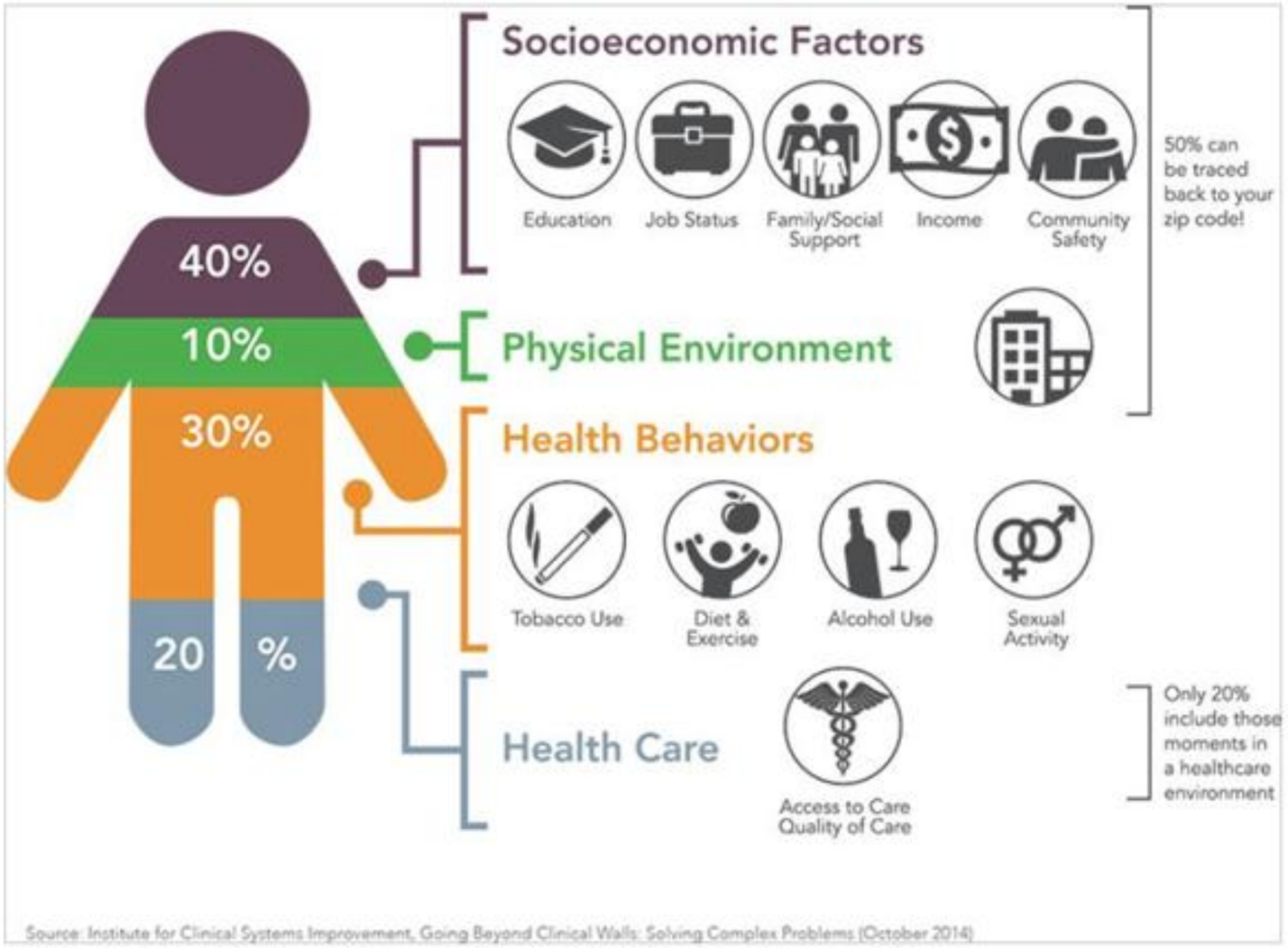
Reframing the Narrative

Reframing the narrative means shifting the way we talk about, understand, and respond to racial disparities in healthcare. It moves us from a *blame-based*, *deficit-focused*, and *individualized lens* to one that centers **justice, systems, community power**, and **collective healing.**

Why treat people's illnesses without changing the conditions that made them sick?
(WHO Commission on Social Determinants of Health, 2008)

FACTS to Consider

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.



We are often asked…which Social Determinants to improve?

Every community is different:

- Because of the SYNDEMIC nature of SDOH, we need to schedule a time-table for on-boarding interventions that address all of the Social Determinants

- Begin where you reach consensus
  - Where the community has the most strength or greatest will (i.e., Education, Transportation, Employment, Housing, etc.)

art james

Deficit-Based Discussions

(Focus on individual or community "failings" and ignore structural context)

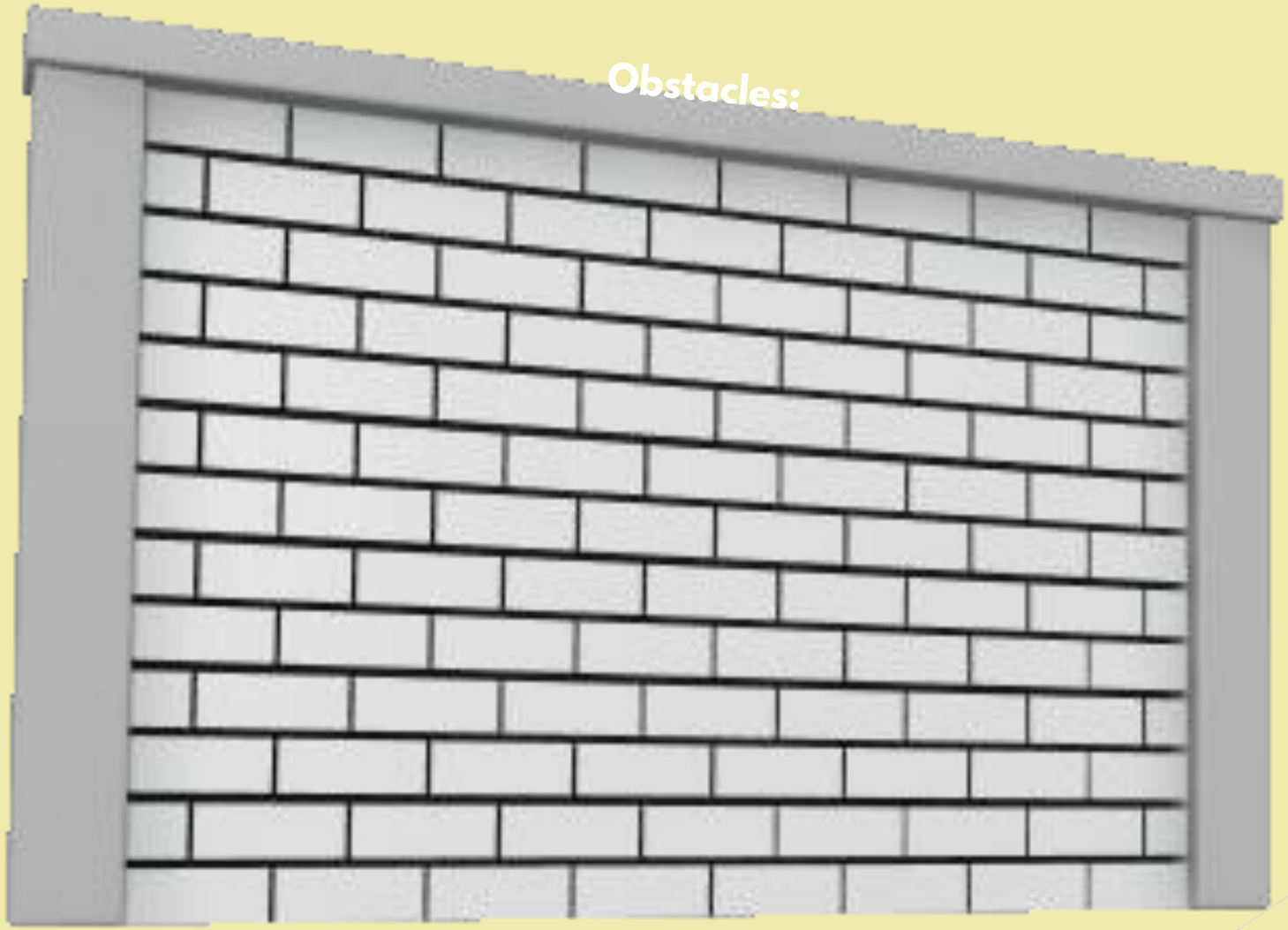
Deficit-Based Framing	Why It's Problematic
"Black patients don't trust doctors."	Ignores the historical and ongoing causes of mistrust like unethical treatment and exclusion.
"Low-income families don't value healthcare."	Assumes ignorance or irresponsibility rather than acknowledging barriers to access.
"People of color have more comorbidities due to lifestyle choices."	Blames the individual without addressing food deserts, stress from racism, or lack of preventive care.
"We need to educate these communities."	Suggests a lack of knowledge when the system has failed to make care culturally responsive and accessible.
"They just don't show up to appointments."	Overlooks transportation, job inflexibility, child care, or negative healthcare experiences.

Equity-Centered Reframing
(Focus on systemic solutions, cultural strength, and justice)

Equity-Based Reframing	Solution Pathway
“We must earn the trust of communities harmed by medical racism.”	Address historical trauma, invest in trust-building, diversify workforce, and ensure transparency.
“Let’s remove structural barriers to access.”	Expand Medicaid, offer mobile clinics, extend clinic hours, and improve public transit to care centers.
“Racism—not race—is a risk factor.”	Design interventions that dismantle racism in clinical guidelines, provider bias, and care delivery.
“Elevate community expertise and lived experience.”	Use community-based participatory research, hire navigators, and co-create health solutions.
“Design systems that flex around people’s real lives.”	Integrate care into schools, workplaces, and neighborhoods; provide telehealth; invest in wraparound services.

A Social Determinants approach:

challenges us to “eliminate the obstacles”



“Racism in all of its forms is a public health issue.”

Washington Medical Commission

Structural Racism

Anglo-American medical and mental health care systems heavily influenced culture, and its history of racial injustice was heavily influenced by Anglo-American culture and its history of racial injustice, according to Nuriddin et al. (2020).)

1. Policy & Organizational Strategy

Strategy	Description
Adopt an Equity-Centered Strategic Plan	Align organizational mission and goals with equity principles (e.g., AMA's 2021 Equity Plan).
Mandate Anti-Racism Policies	Include anti-racist language in hiring, governance, and service delivery practices.
Review and Reform Institutional Policies	Audit policies for unintended racial harm (e.g., billing, access to care, discipline policies).

2. Clinical Practice Transformation

Strategy	Description
Implement Implicit Bias Training	Regular, evidence-based training for staff to mitigate unconscious bias in care.
Integrate Social Determinants of Health (SDOH) Screening	Routinely assess food insecurity, housing, safety, etc., and refer to resources.
Culturally Tailored Care Models	Use culturally and linguistically relevant practices in care delivery.

Implicit Racial Bias

Implicit bias is a form of bias that occurs automatically and unintentionally, that nevertheless affects judgments, decisions, and behaviors.

Implicit racial bias can cause individuals to unknowingly act in discriminatory ways. This does not mean that the individual is overtly racist, but rather that their perceptions have been shaped by experiences and these perceptions potentially result in biased thoughts or actions.

Explicit Racial Bias

Explicit bias occurs when our perception is distorted due to preferences and beliefs that we consciously hold about others.

Explicit racial bias is the traditional conceptualization of bias. With explicit bias, individuals are aware of their prejudices and attitudes toward certain groups. Positive or negative preferences for a particular group are conscious. Overt racism and racist comments are examples of explicit biases.

Research

Facts & Data:

- **Implicit bias in healthcare is an emerging field of study.**
- **Almost all studies found evidence for implicit biases among physicians and nurses.**
- **3 studies found a significant correlation between high levels of physicians implicit bias against blacks on IAT scores and interaction that was negatively rated by black patients**

Implicit Bias Among Physicians

Physicians' unconscious biases may contribute to racial/ethnic disparities in use of medical procedures such as thrombolysis for myocardial infarction.

Impact on Healthcare

Racial bias:

Providers may subconsciously associate certain racial groups with higher pain tolerance or lower adherence to treatment, resulting in disparities in pain management.

Weight bias:

Healthcare professionals may judge patients based on their weight, leading to dismissals of their concerns or lack of attention to their needs.

Ageism:

Providers may unconsciously assume that older patients are less capable or compliant, leading to undertreatment or inappropriate recommendations.

Sex and gender bias:

Providers may respond differently to complaints of pain depending on a patient's sex or gender, potentially leading to misdiagnosis or undertreatment.

Source: Implicit vs. Explicit Bias in Healthcare

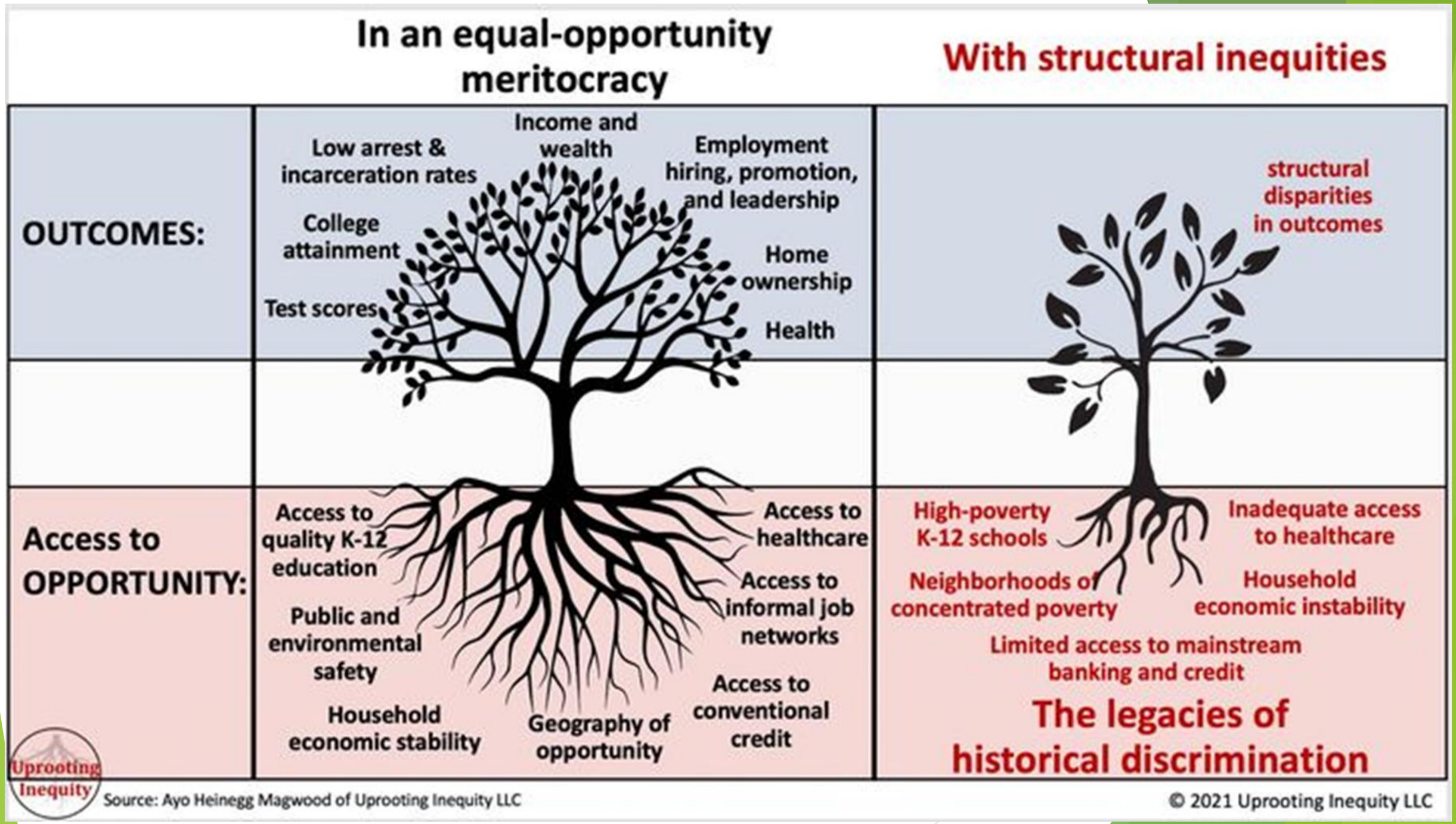
Thoughts about Behavioral Health Racial Disparities

We continue to find excuses to avoid eliminating racial disparities… But, we must muster the courage to go through this door.

Arthur R. James MD

3. Workforce & Leadership

Strategy	Description
Diversify Hiring and Leadership	Recruit and retain Black and Brown professionals in all roles—especially in decision-making.
Create Equity Leadership Roles	Designate Chief Equity Officers or Equity Task Forces with authority and budget.
Support Equity Champions	Identify and empower individuals within departments to lead and model equity practices.


In an equal-opportunity meritocracy
With structural inequities
OUTCOMES:
Low arrest & incarceration rates
Income and wealth
Employment hiring, promotion, and leadership
College attainment
Home ownership
Test scores
Health
structural disparities in outcomes
Access to OPPORTUNITY:
Access to quality K-12 education
Access to healthcare
Access to informal job networks
Public and environmental safety
Household economic stability
Geography of opportunity
Access to conventional credit
High-poverty K-12 schools
Inadequate access to healthcare
Neighborhoods of concentrated poverty
Household economic instability
Limited access to mainstream banking and credit
The legacies of historical discrimination
Uprooting Inequity
Source: Ayo Heinegg Magwood of Uprooting Inequity LLC
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Community Level Partnerships

Addressing Treatment Inequities

1)Increase trust and decrease stigma – Community-wide Anti-Stigma Campaign in Black communities

2) Develop Culturally responsive treatment – engage black churches and organizations serving the black community.

3) Standard of care in medication treatment, which is responsive to their cultural, psycho-behavioral, and social needs.

Regarding Racial Disparities

Our job is to stand in the gap!!!
To LOVE each other
To save more Black and Brown Lives

Until the gap is repaired!!!
Until EQUITY is achieved.

We MUST will never give up.

art james

Q & A

References

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Thank You