



Spring 2021 Issue:

Addressing Racism to Improve Health

BETTER IDEAS
for CARE DELIVERY

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Reflections from a CIN Managing Partner

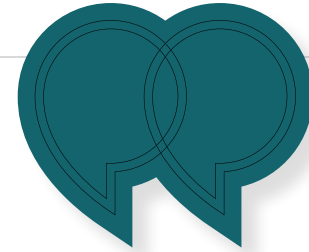


When I first came to L.A. Care Health Plan, I was thrilled to join a mission-driven organization impacting the health care of over two million vulnerable members. Staffed by dedicated people and awash in data, it seemed certain we had the tools to better understand health disparities and to address them.

Then COVID-19 hit and made manifest just how exposed our member population was based on their social determinants, living conditions, race, and employment.

As I pondered our approach as a health plan and industry, I became increasingly disquieted. While we were working as hard as we could to keep our members informed and ensure access to care, the routine functions and processes of traditional managed care organizations were clearly inadequate to stem the tide of morbidity and mortality we were facing.

What is the ultimate impact of our work on the lives of the people we serve? During the worst public health emergency in the past one hundred years, can our communities attest to the impact of our efforts on their lives and survival? If essential workers are living in crowded conditions and at a higher risk from



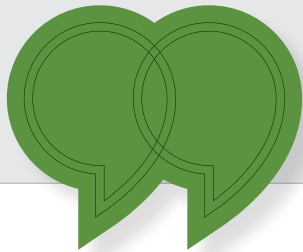
Then COVID-19 hit and made manifest just how exposed our member population was based on their social determinants, living conditions, race, and employment.”

COVID-19, how do we impact this situation to protect their families? If Black women across all economic and educational levels are at the highest risk for maternal mortality, does assuring the credentials of their physicians offer meaningful protection? If children are vulnerable to the life-altering risk of lead exposure, is monitoring their testing status enough?

At L.A. Care, we answer no, it's not enough. And we are acutely aware that health plans

Reflections from a CIN Managing Partner

“We are actively investigating and removing structural practices that are racist and moving to center equity in all our work. We are not there yet, but we won’t give up; I hope that you will join us.



can’t do the job by themselves. We are seeking collaborations to ease homelessness, protect essential workers, address hate in our society, and challenge the unhealthy environments that plague our members. We are actively investigating and removing structural practices that are racist and moving to center equity in all our work. We are not there yet, but we won’t give up; I hope that you will join us.

This issue of *CIN Connections* contains strategies and reflections from health care leaders as they likewise grapple with how to abolish racism to improve health and remove roadblocks to real health equity. Learn from Dr. Rhea Boyd, Director of Equity and Justice for the California Children’s Trust and Chief Medical Officer of 2-1-1 San Diego, about how structural racism impacts health across generations, and how health care organizations can work toward becoming actively anti-racist. Hear how California Improvement Network (CIN) partner organizations, including L.A. Care, are dismantling organizational policies that perpetuate inequities and are integrating equity into efforts to address social needs that impact health.

Lasting change will require engagement and an intersectional collaboration of the business, education, law enforcement, and health systems like we have never accomplished

before. It will require the development of more meaningful metrics to assure that we are measuring impact, not just process. It will require creative policy at all levels of government to undo the structural impediments to abundant living for poor and marginalized people in our state. It will require us to ask uncomfortable questions of ourselves, our organizations, and in venues such as CIN.

It is time to imagine what we may have never seen, to dream about what some have thought impossible, to climb to heights heretofore thought too high.

Dig in! Question! Seek with an insatiable appetite for impact! And don’t rest until we get there.

Sincerely,

A handwritten signature in black ink, appearing to read 'James Kyle, Jr.', written over a light gray rectangular background.

James Kyle, MD, MDiv

Medical Director,
Quality, Diversity, Equity & Inclusion
L.A. Care Health Plan

Racism Kills: Uprooting Systems of Racism that Drive Health Inequities

Dr. Rhea Boyd, Director of Equity and Justice for the California Children's Trust and Chief Medical Officer of 2-1-1 San Diego, spoke to CIN partners at the January 13, 2021 partner meeting about the mechanisms of structural racism and how they manifest across health care. According to Boyd, structural racism, i.e., "how racism gets baked into policies, laws, and procedures," should be seen as the principal driver of health inequities.

Developing a framework for talking about the relationship between racism and health in a clinical setting is vital, and Boyd highlighted three concepts:

1

Toxic Stress

Racism acutely dysregulates our protective/adaptive response. In moments of stress, this dysregulation can throw off our adaptive immune response and bathe our system in cortisol.¹

2

Allostatic Load

Exposure to cortisol has a cumulative effect on physiology over time, leading to chronic disease and damage to vital organs.²



Rhea Boyd, MD, MPH, is the Director of Equity and Justice California Children's Trust and Chief Medical Officer of 2-1-1 San Diego

3

Weathering

The shortening of the telomeres at the ends of our DNA from chronic stress leads to premature aging through early cell death.³

"Inherited Disadvantage": Racism and Intergenerational Well-being

"Not only does racism impact our health as individuals, but also the health of our children, and our children's children," said Boyd, citing a study by Raj Chetty of Harvard University's

Language Matters

Health disparities are population-level differences in health. **Health inequities** are population-level differences in health that are avoidable, and thus unjust. Health inequities often arise from inequitable distribution of protections (preventing illness) and the inequitable distribution of support (treating illness once it arises).

Race is not the risk factor driving racial health inequities; **racism** is. Inadequate access to life-affirming resources is one mechanism by which racism harms health.

White refers to a racial status based on an individual's perceived skin tone. **Whiteness** is a term that captures a structural apparatus: the laws, policies, and norms that empower and favor White people as a population.

Structural racism, in the words of Dr. Camara Jones, "often manifests as inaction in the face of need."⁴ To eliminate harm caused by racism, healthcare organizations must be actively, intentionally **anti-racist**.

Opportunity Insights, which found that across comparable neighborhoods with similar parental income, family structure, and educational attainment, Black males earn less in adulthood than White males.⁵ This outcome is the case even when these Black and White children are living on the same city block and attending the same schools.

Intergenerational gaps in economic mobility are smallest in those areas with less racial bias amongst White residents and in Black neighborhoods with higher "father presence."

This in turn, said Boyd, means that even casual forms of racism must be confronted, such as what *The Root* journalist Michael Harriot has termed, "white caller crime," where police are called on Black people for "simply existing in public." If an individual is harmed, killed, or imprisoned because of that encounter with the police, the resulting absence of a caregiver shapes intergenerational economic mobility for the children who live in that community, particularly if that caregiver is a father.

"That's how racism works; it's never just that it impacts the individual harmed; it reverberates within the family and communities affected as well."

We Have a Syndemic: COVID-19, Racism, and Police Violence

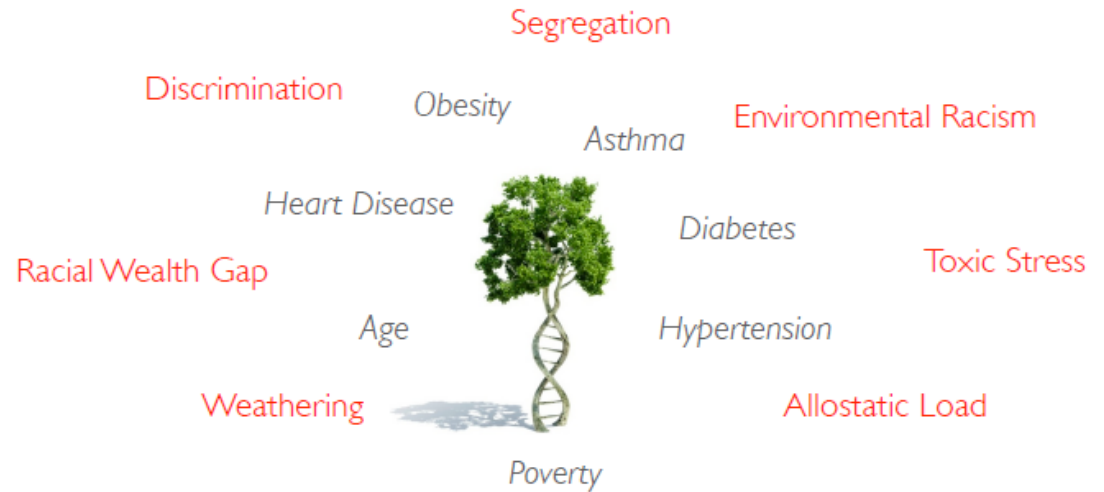
Rather than thinking of the COVID-19 pandemic and the concurrent public health crises of racism and police violence as parallel phenomena, it is important to acknowledge the ways that these epidemics compound each other as a syndemic, where the epidemics of racism and police violence contribute to COVID-19 racial health inequities. While there is a greater risk of complications from COVID-19 due to chronic conditions, "poverty" or "underlying illness" do not adequately describe the drivers of these inequities at the population level. Instead, segregation, discrimination, and environmental racism shape the racial distribution of conditions like heart disease, hypertension, and chronic lung disease.

Public disinvestment in minority communities also impacts access to common infection prevention tools such as hand washing. In fact, Black and Latinx households are twice as likely as White households to lack access to clean water in their homes. Indigenous populations are 19 times as likely to lack this access.⁶

As Boyd put it, these conditions are "driven by legacies and current practices of racial exclusion, discrimination, and violence that concentrate

Racism Kills: Uprooting Systems of Racism that Drive Health Inequities

“In short, racism kills people, and we know that; the data tells us that.



Structural Racism refers to *differential* access to goods, services, opportunities, by race.

Image by Rhea Boyd based on concepts by: Jones CP. Levels of racism: a theoretic framework and a gardener's tale. *Am J Public Health*. 2000;90(8):1212-1215. Williams DR, Lawrence JA, Davis BA. Racism and Health: Evidence and Needed Research. *Annu Rev Public Health*. 2019;40:105-125.

disadvantage, create adversity, shape population-level opportunities for health, and provide conditions for disease.” For Black men and boys, police violence is especially deadly: Black men and boys have a 1 in 1,000 chance of being killed by the police in their lifetime.⁷

Police violence is community violence; research demonstrates that residents of lethally surveilled communities have a greater risk of high blood pressure and obesity.⁸ A study of Mexican-born women, for example, shows a

higher risk of hypertension and diabetes due to Immigration and Customs Enforcement (ICE) fears.⁹ This police reach begins early; one in three public K-12 students attend a school that has a police officer but no on-site psychologist, nurse, social worker, or counselor.¹⁰ Further upstream, an estimated 1 out of 2 Black children will experience a CPS investigation by the age of 18 years old, and they are much less likely than White children to be placed with relatives or to be returned to their families once in foster care.¹¹

Racism Kills: Uprooting Systems of Racism that Drive Health Inequities

The Need for Action by Healthcare Leaders: Anti-Racism vs. Non-Racism

Common approaches to health services research fail to provide the language to talk about race as a product of racism and racial inequity, nor do they offer tools to confront how this inequality is constructed and perpetuated. Historically, clinical researchers have been uncomfortable with confronting Whiteness and institutionalized racism, which, according to research by Dr. Rachel Hardeman at the University of Minnesota, manifests in two ways:

1

Racial categories are presented as “immutable biological fact.”

2

White patients become the normative group to which all other populations are compared.¹²

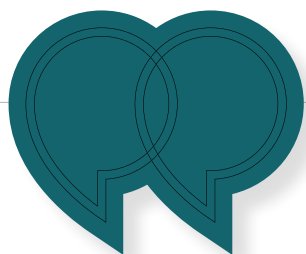
What Hardeman terms “White racial framing” prevents researchers from acknowledging that racism, not race, shapes risk for disease. It also prevents researchers from confronting factors that shape health outcomes for White patients, including White supremacy. Failing to name the

mechanisms by which racism harms health leads to tacit participation in patient blame, which is often conflated with mistrust.

While racism, not patient mistrust, drives adverse health outcomes, mistrust is still a factor that needs attention. Boyd cited a case study by the Kaiser Family Foundation which found that 35% of Black respondents say they definitely or probably won’t get the COVID-19 vaccine.¹³ About half (47%) of these respondents cited a general distrust of vaccines as the central reason they would opt out.

It is also critical to acknowledge that the concept of Whiteness can harm White populations, particularly when individuals politically invest in forms of exceptionalism that reinforce the corrosive logic of White racial dominance (for example, agitating against Medi-Cal expansion as a means of limiting care for undocumented populations, leading to reduced resources for everyone, including White people).

Racism Kills: Uprooting Systems of Racism that Drive Health Inequities



...because part of what makes whiteness and white supremacy so normative is that we don't talk about it."



Image copyright 2020 by Nicolás E. Barceló and Sonya Shadravan (Artist: Aria Ghallii) Barceló NE, Shadravan S. Race, Metaphor, and Myth in Academic Medicine. *Acad Psychiatry*. 2020 Oct 21.

Abolishing Racism

To integrate an anti-racist approach, health care leaders must begin by centering at the margins, placing themselves in the shoes of the marginalized and imagining their life experience.¹⁴ These populations may be unaware of what resources are even available.

Becoming anti-racist entails a new awareness, remaining alert to previously ignored moments of inequity at all levels of an organization. Boyd invited CIN partners to track and identify every time they saw something

in their organizations that might drive a racial inequity (she referred to this as “clocking”). Individual accountability ultimately translates to institutional change, “because part of what makes whiteness and white supremacy so normative is that we don’t talk about it. We allow ourselves to bathe in these power structures that shape who has resources and who has rights and we remain silent about it.”

Racism Kills: Uprooting Systems of Racism that Drive Health Inequities

Boyd also encouraged contemplating the ways that providers and systems harbor mistrust of their patients. “There is a common inclination among providers to want to make decisions for patients, particularly patients of color. Often, this inclination stems from paternalism and it is a sign that we don’t trust certain patients to make decisions that is in their best interest,” she said. Instead, a provider’s responsibility is to gather the information patients need to make the best decision for themselves and their families.

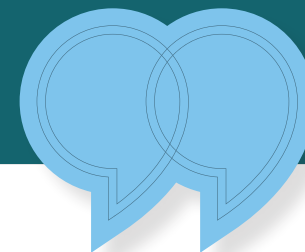
Creating Sanctuary for Patients, and for Safe Dialogue

One anti-racist approach within the health care setting is to build spaces of sanctuary for patients where they are insulated from various forms of racism. For example, Boyd is working towards police-free hospitals,¹⁵ acknowledging that the health care infrastructure relies on the same coercive systems as racialized policing.

In the breakout group conversations following Boyd’s talk, there was consensus of a need for another kind of sanctuary: the safety to have honest dialogue at all levels of health care organizations, from front-line staff to the highest levels of leadership.

One CIN partner, Rebecca Boyd Anderson, Director, Population Health, Partnership HealthPlan of California, expressed the challenge simply: “I think the conversation is uncomfortable, and we have to have it.”

“Incessant, persistent racial health inequities across nearly every major health index reveal less about what patients have failed to feel and more about what systems have failed to do . . . Eliminating racism ends health inequities.



Racism Kills: Uprooting Systems of Racism that Drive Health Inequities

Article Footnotes

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- 14 Image copyright 2020 by Nicolás E. Barceló and Sonya Shadravan (Artist: Aria Ghalili). Nicolás E. Barceló and Sonya Shadravan, "Race, Metaphor, and Myth in Academic Medicine," *Academic Psychiatry*. October 21, 2020.
- 15 DPH Must Divest: Proposed Safety Alternatives. <https://www.dphmustdivest.com>

From the Back Office to the Front Lines: Ensuring Equity at L.A. Care and Kaiser Permanente

Addressing health inequities and structural racism takes uphill work and requires programmatic and administrative change, as well as uncomfortable dialogue and decision-making. Dr. James Kyle of L.A. Care Health Plan and Jenn Frost of Kaiser Permanente shared their experiences of working to dismantle systems of racism and increase equitable access to resources with CIN partners.

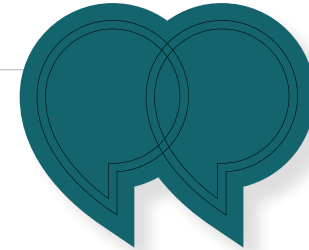
Assessing Vendor Diversity at L.A. Care Health Plan

James Kyle, MD, MDiv, Medical Director for Quality, Diversity, Equity & Inclusion at L.A. Care Health Plan

Like many of its peer organizations, L.A. Care has begun evaluating its policies and operations to assess diversity and ensure equity. During an internal conversation about the social determinates of health, Kyle asked, “Are there worthy minority- or women-owned businesses that we never do business with because our policies, credit standards, or procurement functions only cater to large, mainstream vendors?”

One staff member suggested contracting with Homeboy Electronics Recycling, a Homeboy Industries social enterprise that works with other large health care organizations in the region.

According to Kyle, “98% of incarcerated people are eventually released back to our communities, where they encounter a tangled web of bias, fear, distrust, and legal restrictions that make it difficult to reintegrate back into society, especially with respect to finding quality employment.” Homeboy Electronics



Racial equity and justice require an intentional obsession. It is the constant questioning about not only our motives, but our effectiveness. It is the quest for impact, not platitudes. It is asking uncomfortable questions: the ones that make people wish you would just go away.”

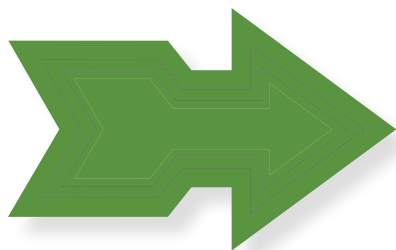
From the Back Office to the Front Lines: Ensuring Equity at L.A. Care and Kaiser Permanente

Recycling provides job opportunities to this population, and helps bridge the digital divide in lower-income neighborhoods by giving access to free and low-cost equipment.

The suggestion of this partnership led to questions. Why wasn't L.A. Care doing business with more companies like this? Only 7% of L.A. Care's contracts were vetted to minority-owned businesses. "We are looking to remove barriers to small businesses in our procurement process. Small and minority-owned businesses may lack the capital or credit for a

large procurement," said Kyle, "So we are modifying our procurement requirements to not disadvantage these companies."

Kyle evoked the image of a 10-year-old child living in poverty and impressed urgency above all. "If it takes me 10 years to make any kind of appreciable change, now they're disadvantaged at an even higher level. Perhaps our times call for us to augment or even abandon incrementalism for disruptive creativity focused on impact . . . Change delayed is change denied for those who wait."



Lessons Learned at L.A. Care:

- **Hold your organization accountable.** Track your progress and look for measurable impact on a routine basis.
- **Assess your pace of change.** Are the changes you are making substantive enough and fast enough to make a difference?
- **Ask questions.** Ask patients if they feel your efforts have changed their lives for the better. Question your internal policies with an eye toward justice and equality.
- **Mix local- and policy-level efforts.** "While we work in the grassroots, we need to also work at the treetops to change policy."

From the Back Office to the Front Lines: Ensuring Equity at L.A. Care and Kaiser Permanente

“We want to be deliberate and mindful that we are building a community asset, so we are not leaving equity to chance.



Building Infrastructure to Ensure Equity: The Kaiser Permanente Thrive Local Program

Jenn Frost, MPA, National Director, Kaiser Permanente Thrive Local Program

Kaiser Permanente launched the Thrive Local initiative in 2019, partnering with Unite Us to systematically connect members and patients to resources in their communities. “Thrive Local is fundamentally about equity, as we are endeavoring to eliminate socioeconomic and systemic barriers that prevent people from optimal health,” explained Frost. “It’s hard to be healthy if you don’t have a safe place to live, healthy food, meaningful social connections, and other essentials.”

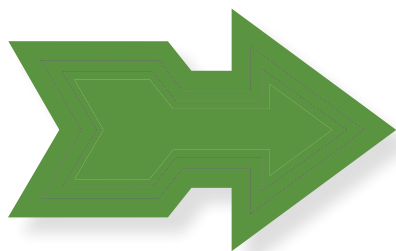
To demonstrate the power of this model of care delivery where a patient’s social health is addressed alongside their physical and mental health, Frost related how a Kaiser Permanente community health navigator named Rykken was able to connect a new patient, Phillip, with an array of resources to help his family through a COVID-related financial crisis (the patient’s name has been changed for his privacy).

When Phillip’s daughter – the primary income earner for the family that included Phillip, his wife, and five grandchildren – came down with COVID-19, she was unable to work, and subsequently had her shifts significantly reduced. By the time Rykken met Phillip, the family had been unable to pay their rent for several months.

While as Micronesians, Phillip’s daughter and wife were able to live and work in the United States without a visa, they were ineligible for most federal benefits, including Medicaid and SNAP, making Kaiser Permanente’s own Medicaid-dependent resources inaccessible. But when Rykken learned that Phillip’s grandchildren were US citizens and had a Medicaid plan with another local insurer, she facilitated a connection with a case manager at that health plan, who helped the family pay their rent.

In subsequent weekly check-ins, Rykken was able to connect Phillip with other community resources, such as food, gift cards, and even help with his water bill, on which he had also fallen behind.

From the Back Office to the Front Lines: Ensuring Equity at L.A. Care and Kaiser Permanente



“He was practically in tears he was so grateful,” said Frost. “I love this story because it shows the safety net in action. Creating this broader infrastructure of coordinated care that includes health systems, social service providers, and

other agencies as one social care team is the vision for Thrive Local.”

Frost emphasized that her team is constantly learning as they move forward; “We have lots of opportunity for growth.”

Lessons Learned at Thrive Local:

- **Build on what is already working.** “To successfully implement Thrive Local with our community partners, Kaiser Permanente first needed to recognize and then integrate with efforts already underway, protecting long-standing institutions relied upon by the community.”
- **Prepare to be surprised.** Working locally can take time, and an attitude of constant improvement is essential, as well as a level of comfort that missteps may happen along the way.
- **Create *with* the community, not *for* the community.** The infrastructure being built must reflect the people who will use it. “We need to be informed by our partners and support the organizations they want, including those that might be small and dedicated to serving specific underrepresented populations.”
- **Understand capacity.** To do local work at scale can require looking at the data, paying attention to where referrals are declined based on the capacity of referred organizations. “We can add more organizations to the network to accept referrals in the categories where we’re seeing the most activity.”

Real-Time Improvement: Becoming an Anti-Racist Health Care Organization



Incorporating the lessons of the day, CIN partners identified concrete next steps to move their organizations from being non-racist to being actively anti-racist, and to intentionally design interventions addressing social needs that impact health so that they also address racism as a root cause of poor health. Several themes emerged, which are shared here so that you too can take action at your organization to improve health by addressing racism.

ACTION 1: Promote learning about racism as a cause of poor health

1 Although education can deepen understanding of racism as a root cause of poor health, CIN partners acknowledged the challenge of tangibly integrating this understanding into efforts to address social needs. As one partner put it, “What does anti-racist social needs work actually look like? [Especially] knowing that addressing social needs does not equal addressing racism?” Another voiced the need to design thoughtful and intentional strategies at every level, “How do we think about every program we have with the intent of how it may be influenced by institutional racism?” Many partners expressed the need

for ongoing education and dialogue as a foundational step.

To help accelerate this foundational learning, visit the CIN Resource Page: **Integrating Equity in Social Needs Efforts.**

ACTION 2: Create sanctuary

2 The recognition of racial and social injustice has spurred a movement to create and offer sanctuary in multiple forms. In addition to the need to create sanctuary for patients from police violence and from excessive systems involvement (e.g., evaluating CPS referrals), there is an emerging call for respectful and honest conversation about the impacts of racism within health care organizations. Organizations that create sanctuary for both patients and employees will ultimately bolster their diversity, equity, and inclusion efforts. One partner commented that “racial inequity is deadly” and that their

Real-Time Improvement: Becoming an Anti-Racist Health Care Organization

organization recognizes that creating sanctuary is key, including creating “micro-sanctuaries.” Another partner discussed their plan to promote a “speak-up culture,” where employees can name what needs to change without fear of retaliation. Another reflected on the need to do more anti-racist work beyond the individual and HR approaches, especially when leadership is ready to make meaningful, organization-wide changes.

ACTION 3: Engage in dialogue

3

Many CIN partners recognized the need for safe and open dialogue across their organizations, and that leadership must be at the center of this dialogue. One partner committed to monthly staff trainings with accompanying dialogue. Another is exploring virtual forums for discussion of racism and other topics that impact care delivery. As one partner observed, the events of 2020 have provided an opportunity for awakening, and for some predominantly White organizations to take a harder look at the impact of racism. “It’s important to discuss Whiteness, and it takes work; it can’t be just a memo. We need to be deliberate about seeding power and noticing the way patterns have been ingrained.”

ACTION 4: Evaluate existing practices and policies

4

Many partners cited existing practices and policies that – however unintentionally – promote racism and committed to examining and dismantling these roadblocks to progress. One partner organization is examining recruitment practices for their board of directors to ensure equitability. Another plans to evaluate their screening practices for adverse childhood events (ACEs) to identify possible disparities in who is being screened. Another will revisit how they work to in order to create an intentional space for anonymous feedback. And another partner committed to looking into vendor policies to understand if organizational practices result in exclusion of vendors who are BIPOC (Black, Indigenous, and People of Color). These handful of examples highlight a multitude of areas ripe for scrutiny and change.

Real-Time Improvement: Becoming an Anti-Racist Health Care Organization



ACTION 5: Hold your organization accountable

5

Accountability is crucial to real progress, and CIN partners brainstormed ways to hold themselves accountable to take actions addressing racism and improving health. The consensus was that regardless of how accountability mechanisms happen, they must happen.

Try these accountability mechanisms:

- Educate up, across, and down in your organization.
- Identify champions for the work of anti-racism.
- Create a month-by-month work plan with goals, milestones, and workstream owners.
- Schedule dedicated time for trainings, dialogue, and other specific activities to address racism.
- Incorporate anti-racist priorities into your strategic plan.
- Dedicate resources (e.g., funds for a consultant, time for staff) to the work.

“Every month, reviewing what type of commitments we’ve made . . . that will help us make an impact in the long run.”

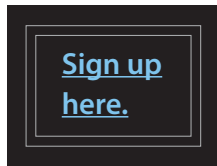
Ariel Cooper, MPH, Provider Services Manager, Community Health Center Network





CIN is a project of the California Health Care Foundation and is managed by Healthforce Center at UCSF.

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