Race, Place, and Structural Racism: A Review of Health and History in Washington, D.C.

Prepared for the DEIJ Task Force
May 10, 2023

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Objectives

- Describe social determinants of health and how they affect cancer outcomes
- Explain 10 Key Components of Healthy Equitable Communities
- Explain what reciprocal community partnerships look like
- Describe community engagement, continuous improvement and accountability [review DCHA 'Ensure Accountability' Strategies and 'Purchase and Invest Locally' Strategies]
- Assess organization's community engagement through team discussion and consensus

Why is this topic so important?

WE'RE OVER HERE

Life expectancy at birth, years

WESTERN EUROPE IS HERE

JAPAN, KOREA ARE HERE

84
82
80
78
76
74
72

jpn
che
ita
aus
swe
can
esp
isl
fra
aut
nzl
fin
deu
lux
nor
grc
prt
kor
gbr
bel
irl
nld
dnk
cze
mex
pol
svk
tur
hun

0
1000
2000
3000
4000
5000
6000
7000
8000

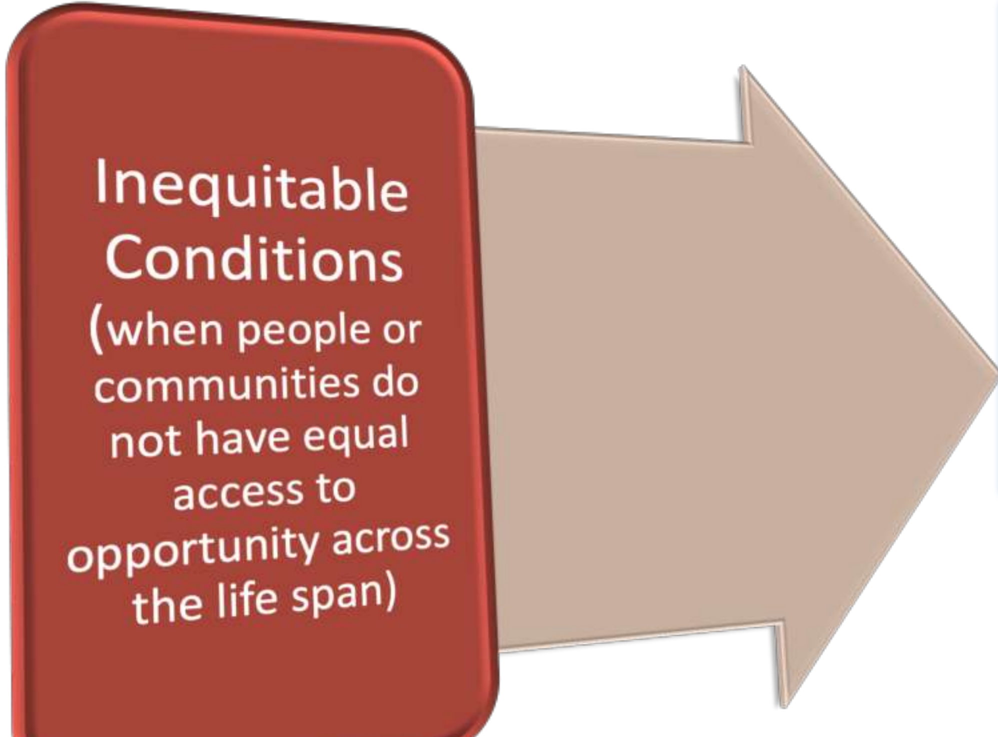
Total expenditure on health per capita, US $ PPP

Health spending per capita (USD PPP)

Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en; World Bank for non-OECD countries.

StatLink http://dx.doi.org/10.1787/888932916040

Inequitable Conditions and Health Disparities



Health Disparities

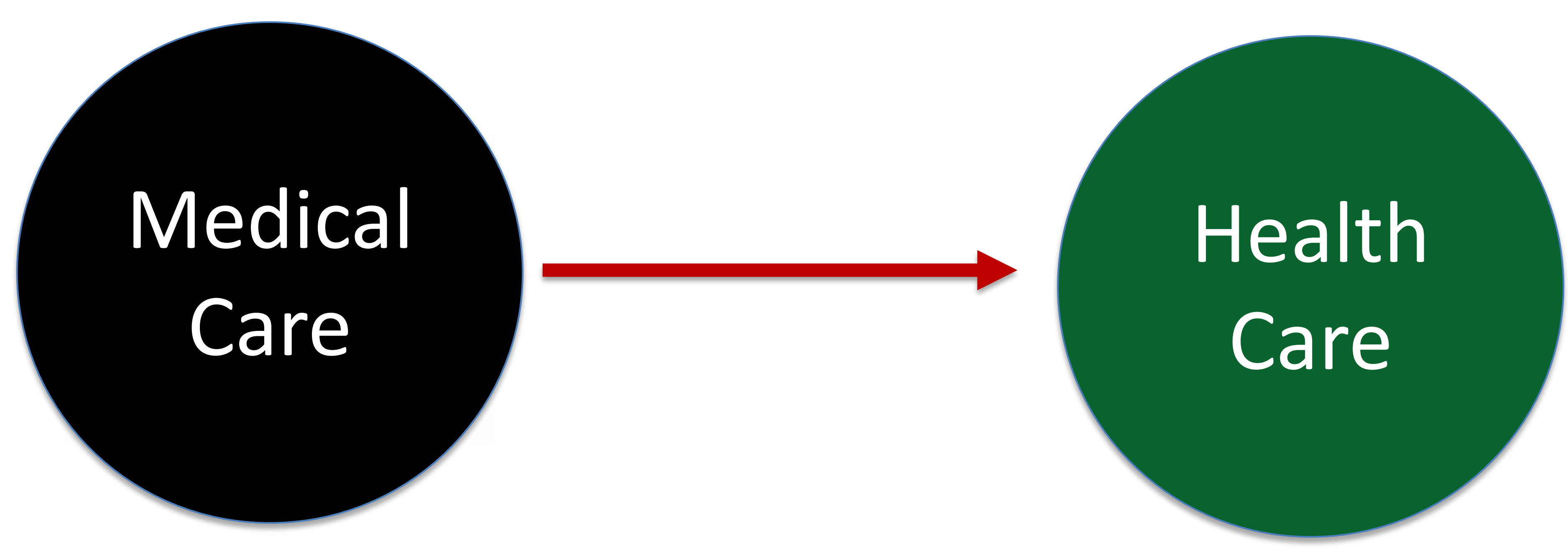
"Measurable differences in the incidence, prevalence, mortality, and burden of diseases and other adverse **health** conditions that exist among specific population groups."

- Institutes of Medicine

Estimated Cost: $93B

$42B

https://altarum.org/sites/default/files/uploaded-publication-files/WKKellogg_Business-Case-Racial-Equity_National-Report_2018.pdf



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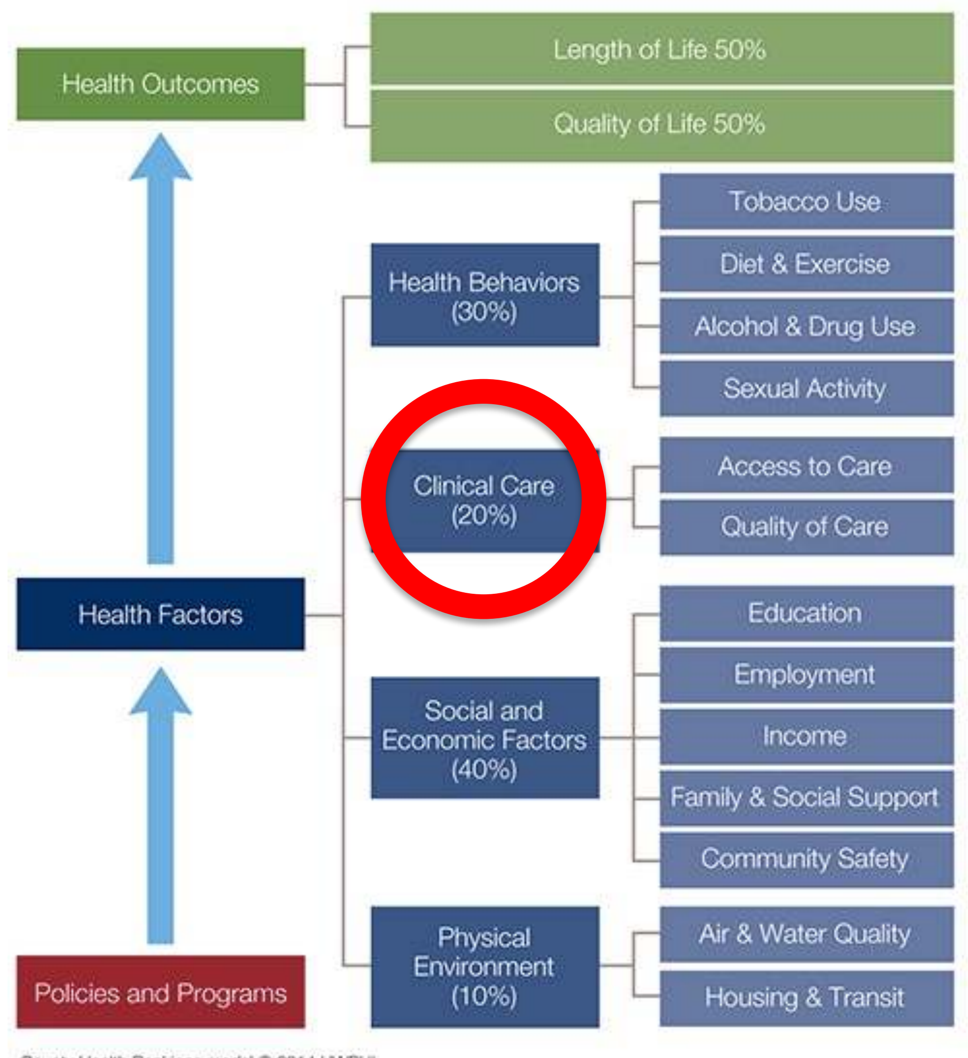
What Shapes Our Health?



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83% = slavery or segregation

Thoughts?

This article is about **6 months** old

DC ranks high on list of healthiest cities across the country

Gigi Barnett | gbarnett@wtop.com
April 4, 2022, 3:05 PM

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D.C. is outpacing most other cities when it comes to healthy living.

A new WalletHub survey released Monday reviewed four key categories that promote wellness, including the quality of health care, food, fitness and the amount of green spaces.

And D.C. ranked No. 10 overall in WalletHub's rankings.

Researchers discovered the District ranks high in three of those four categories. D.C. scored highest in the food category, meaning the District has many places — such as farmers markets — to buy a variety of fruits and vegetables.

The Health of the African American Community in the District of Columbia:
DISPARITIES AND RECOMMENDATIONS

Prepared for the DC Commission on African American Affairs
2016

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Health Disparities in the Black Community:

An Imperative for Racial Equity in the District of Columbia

2020

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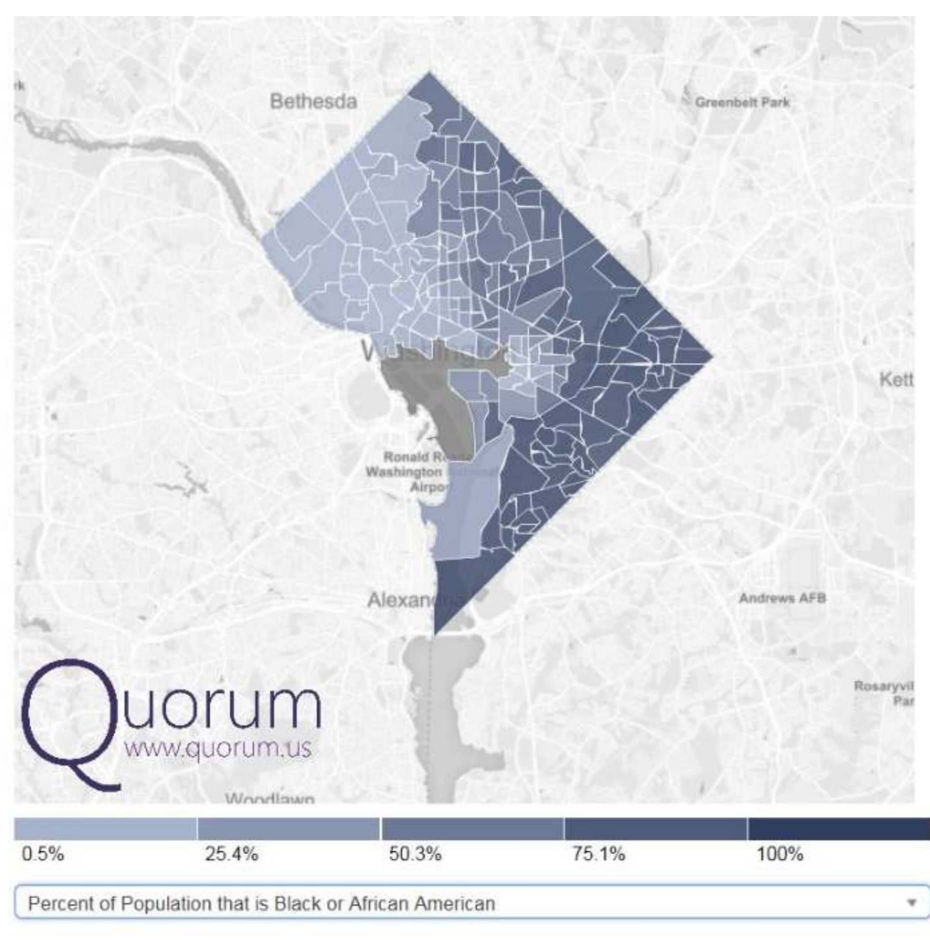
Description of the African American Community



Map of DC Wards

16 FS grocery stores

Ward 3: 5%, 14%, 81%
Ward 4: 24%, 45%, 31%
Ward 1: 21%, 21%, 58%
Ward 5: 8%, 31%, 61%
Ward 2: 18%, 13%, 69%
Ward 6: 13%, 38%, 49%
Anacostia River
Ward 7: 3%, 5%, 92%
Ward 8: 4%, 4%, 92%

3 FS grocery stores

Sources: Life expectancy estimates are from the US Small Area Life Expectancy Estimates Project, 2018; see note 17 in the text. For racial distribution data, see note 6 in text. For infant mortality data, see note 18 in text.

Morbidity / Mortality

Hypertension 2x higher

Deaths due to coronary heart disease 2.7x higher

Deaths due to stroke 2x higher

Deaths due to diabetes 8x higher

Black residents when compared with White residents (2018 -2020)
Source: DCHealthMatters.org

Cancer Mortality

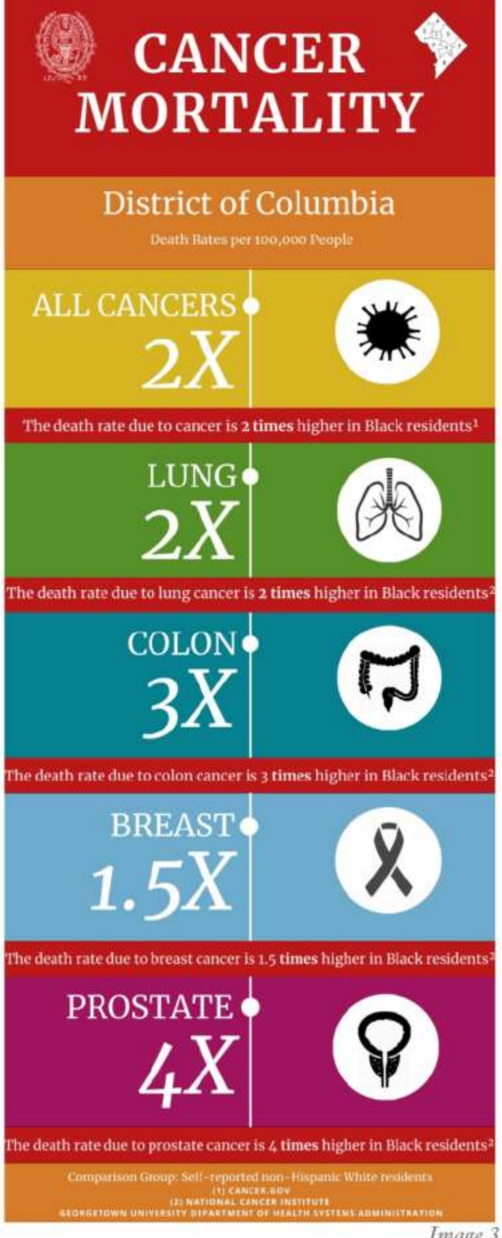


Image 3

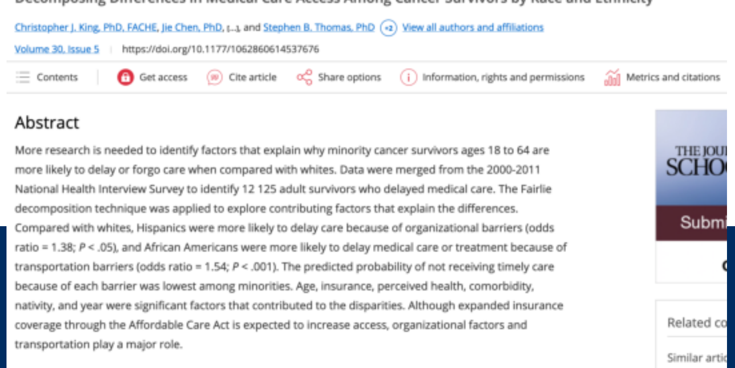
Explanatory Factors

SYSTEMIC

- Cost / Insurance
- Operational barriers
- Transportation
- Bias/Discrimination
- Systemic racism (within and beyond the institution of medicine)

INDIVIDUAL

- Culture / attitudes
- Social support
- Nativity / language/ cculturation barriers
- Education
- Distrust
- Employment / lifestyle barriers



Decomposing Differences in Medical Care Access Among Cancer Survivors by Race and Ethnicity

Christopher J. King, PhD, FACHE, Jie Chen, PhD, [...] and Stephen B. Thomas, PhD View all authors and affiliations

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Abstract

More research is needed to identify factors that explain why minority cancer survivors ages 18 to 64 are more likely to delay or forgo care when compared with whites. Data were merged from the 2000-2011 National Health Interview Survey to identify 12 125 adult survivors who delayed medical care. The Fairlie decomposition technique was applied to explore contributing factors that explain the differences. Compared with whites, Hispanics were more likely to delay care because of organizational barriers (odds ratio = 1.38; $P < .05$), and African Americans were more likely to delay medical care or treatment because of transportation barriers (odds ratio = 1.54; $P < .001$). The predicted probability of not receiving timely care because of each barrier was lowest among minorities. Age, insurance, perceived health, comorbidity, nativity, and year were significant factors that contributed to the disparities. Although expanded insurance coverage through the Affordable Care Act is expected to increase access, organizational factors and transportation play a major role.

Place Matters

Image 2: Displays disparities in socioeconomic conditions and health outcomes between two vastly different Wards.

COVID Mortality

How do we explain these trends?

HealthAffairs

COVID-19 Topics Journal Forefront Podcasts

ANALYSIS | HEALTH EQUITY

HEALTH AFFAIRS > VOL. 41, NO. 2: RACISM & HEALTH

ANALYSIS

Race, Place, And Structural Racism: A Review Of Health And History In Washington, D.C.

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AFFILIATIONS

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SECTIONS VIEW ARTICLE PERMISSIONS SHARE TOOLS

Abstract

Recent events have amplified the debilitating effects of systemic racism on the health of the United States. In an effort to improve population health and dismantle more than 400 years of racial injustice, retrospective examinations of policies, practices, and events that have sustained and continue to undergird racial hierarchy are necessary. In this historical review we feature Washington, D.C.—a city with a legacy of Black plurality. We begin with an overview of contemporary place-based health and socioeconomic disparities. To express the etiology of the trends and uncover opportunities to undo the damage, we reflect on the national landscape as well as on policies and events that socially, economically, and politically disenfranchised Black residents, yielding stark differences in health outcomes among Washington, D.C., populations. In the spirit of atonement in policy and practice, we hope that this approach will inspire policy makers and practitioners in communities across the nation to conduct similar examinations.

Historical Timeline: The District of Columbia

1790
Founding of District of Columbia

1801
Taxation Without Representation

1852
St. Elizabeth's Hospital

1862
Taxation and Education

1890
Race and Suffrage

1933
FHA Redlining

1940
Demolition of Barry Farms

1950s – 1970s
White Flight

1960s - 1970s
Urban Renewal

1980s – 1990s
Crack Epidemic

2001 - 2020
Closure of Hospitals

1775 1800 1825 1850 1875 1900 1925 1950 1975 2000 2025

AMERICAN SLAVERY

SEGREGATION

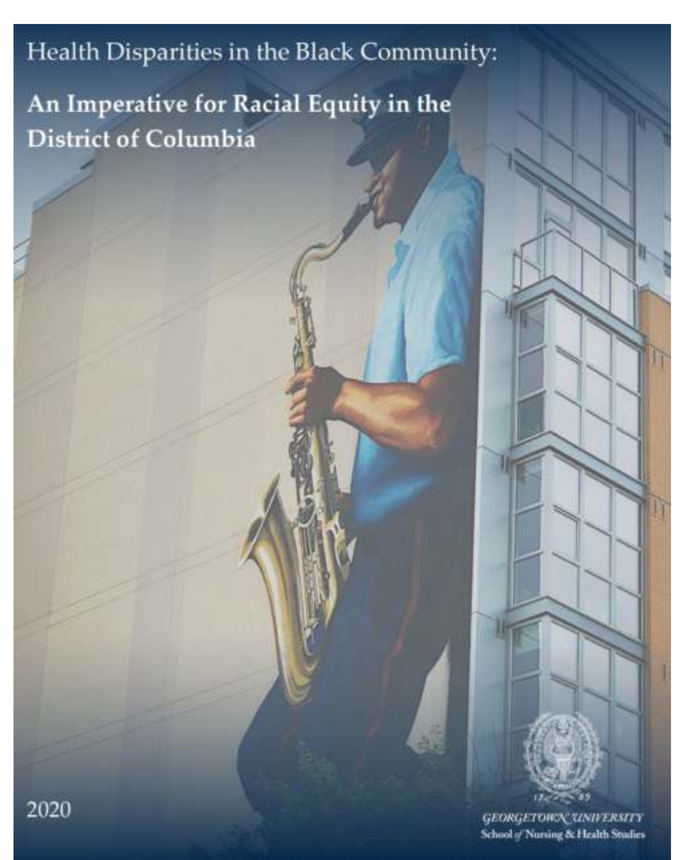
TAXATION WITHOUT REPRESENTATION

https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01805

Implications

The narrative around a historical timeline helps explain the impact of systemic racism as well as policies that harmed and disenfranchised Black residents, whether intentional or unintentional.

- Inform the argument for DC Statehood
- Inform opportunities to operationalize reparations and/or economic/restorative justice efforts
- Identify and remove landmarks and icons rooted in racism
- Improve the relationship between patients and medical providers



Take inventory and critically audit protocols and practices

The paradigm shift: How do we do better?

- Cultural Competence > Cultural Humility
- Create > Cocreate
- Biomedical > Biopsychosocial
- Implicit Bias > Systemic Bias

Health Equity Workgroup

Conceptual Framework for Commitments & Strategies

OUR COMMITMENTS:

- To deliver equitable and inclusive care to eliminate health disparities and improve health outcomes for patients and communities.
- To approach our patient-centered care with humility that is culturally responsive to all who seek our services.
- To improve patient experiences and health outcomes by applying health equity concepts in how services are organized and delivered.
- To address social and economic conditions in collaboration with patients and partners to strengthen communities and promote health and well-being.
- To create a culture of diversity and inclusivity within our workforce that is supported by accountable executive and board leadership.

ENSURE ACCOUNTABILITY	INTERNAL STRATEGY	EXTERNAL STRATEGY	OUTCOMES
Hold leadership accountable for measuring and addressing disparities in hospital/system performance.	• Develop structure to support accountability including performance goals for all staff, with emphasis on mid-level management, senior leadership and the Board of Directors, as well as mechanisms to measure progress. • Define structural and process measures that drive toward achievement of outcomes.	• Leverage measures to assess community perceptions and opportunities for improvement. • Disseminate health utilization trends to prioritize community based programming and inform broader efforts to achieve health equity.	• Within one year, evaluate, build, and empower the structure (e.g., committees, goals, compensation plans, definitions, metrics) to collaboratively hold individuals and the organization accountable for achieving progress and adopting best practices to achieve improvements in health equity, diversity, and inclusion. • Within three years, achieve measurable improvement in identified metrics and identify additional areas of improvement to support health equity, diversity, and inclusion.

MITIGATE BIAS	INTERNAL STRATEGY	EXTERNAL STRATEGY	OUTCOMES
Create a culture and environment of inclusion that mitigates implicit bias and protects staff and patients, with Board/leadership support.	• Create a culture of inclusion through consistent communication from leadership (president/CEO) and through other identified best practices. • Provide ongoing curriculum-based education/training on implicit bias and cultural humility competence for all associates, progressing in complexity of discussion areas over time. • Audit the environment (art, photos, building names, etc.) for inclusivity and to ensure it is representative of the community and is culturally competent. • Evaluate and improve policies and procedures to ensure they are unbiased toward patients and community, eliminating racial and economic disparities. • Address associates' bias based on comparison of public vs private insurance (e.g., balance billing, stigma, level and types of care offered).	• Elevate awareness of ways history of the hospital has impacted public opinion and trust in health care, and incorporate these perceptions into training, communications and delivery of care. • Review community perception survey results to implement strategies to elevate the voice of the patient around the delivery of care.	• Within one year, begin building the infrastructure to support a culture of equity by performing environmental evaluations and needs assessments and identifying key metrics for tracking and measuring success modeled after national multicultural distinction programs. • Within three years, leverage the tools and structure developed to achieve measurable improvements in the identified outcomes to support a culture of equity.

DIVERSIFY LEADERSHIP	INTERNAL STRATEGY	EXTERNAL STRATEGY	OUTCOMES
Ensure Board composition and leadership reflect the community's diversity.	• Develop pipeline (succession planning) to transition and support ongoing governing bodies and leadership staff that reflects the community's diversity. • Evaluate how Board members are chosen and what competencies are considered. • Foster the advancement and development of Black and Brown populations and other underrepresented individuals as health care leaders through an inclusive environment.	• Work with the local community to cultivate and support future leaders from marginalized communities and other underrepresented populations. • Collaborate with the community to leverage opportunities to create a pathway to Board roles in health care.	• Within one year, engage Board and community leadership to understand current methods and structures for succession and talent development. • Within three years, develop structures (e.g., recruitment, bylaws, accountability etc.), partnerships, and programs to create a pipeline for Board and leadership roles, resulting in greater representation of Black and Brown populations and other underrepresented individuals in Board membership and high-level leadership positions.

DEVELOP WORKFORCE PIPELINES	INTERNAL STRATEGY	EXTERNAL STRATEGY	OUTCOMES
Support recruitment, retention and promotion to increase representation of Black and Brown and other underrepresented individuals in the hospital workforce.	• Develop initiatives/programs that support retention, recruitment and promotion of diverse staff within hospitals, including provision of physical and psychological safety (e.g., freedom to express thoughts, concerns), respectful treatment and values. • Develop a catalog & baseline data describing what is available now (e.g., Coursera, DC Summer Youth Employment Program, Association for University Programs in Health Administration, UDC).	• Collaborate with educational institutions to ensure underrepresented students have access to internships, mentors and volunteer opportunities. • Partner with affinity groups (e.g. NAHSE) to strengthen recruitment, retention, and promotion of diverse talent.	• Within one year establish partnerships to support workforce development opportunities and a workforce development pipeline. • Within three years develop a program or leverage existing programs that provide both clinical and non-clinical certification, degrees, and opportunities that result in improvements in the diversity, recruitment and retention of a patient centered, culturally responsive health care workforce.

PURCHASE AND INVEST LOCALLY	INTERNAL STRATEGY	EXTERNAL STRATEGY	OUTCOMES
Apply equitable and inclusive approaches to contracting, purchasing and investment decisions.	• Evaluate contracting, invoicing and accounting processes to ensure they do not disadvantage or exclude small, minority and women-owned businesses. • Make equitable and inclusive purchasing and investment decisions to include small, minority and women-owned businesses.	• Work with community and local business leaders to identify existing and emerging small, minority and women-owned businesses to support and respond to purchasing opportunities. • Develop mechanisms and outreach to ensure that local, small, minority and women-owned businesses are aware of opportunities to contract with hospitals.	• Within one year, develop metrics and goals, assess current relationships, engage with partners (e.g., Healthcare Anchor Network), and develop plan for outreach to local community businesses to promote collaboration opportunities and establish sustainable partnerships. • Within three years, achieve measurable improvement in identified goals to increase local purchasing, investments, and partnerships.

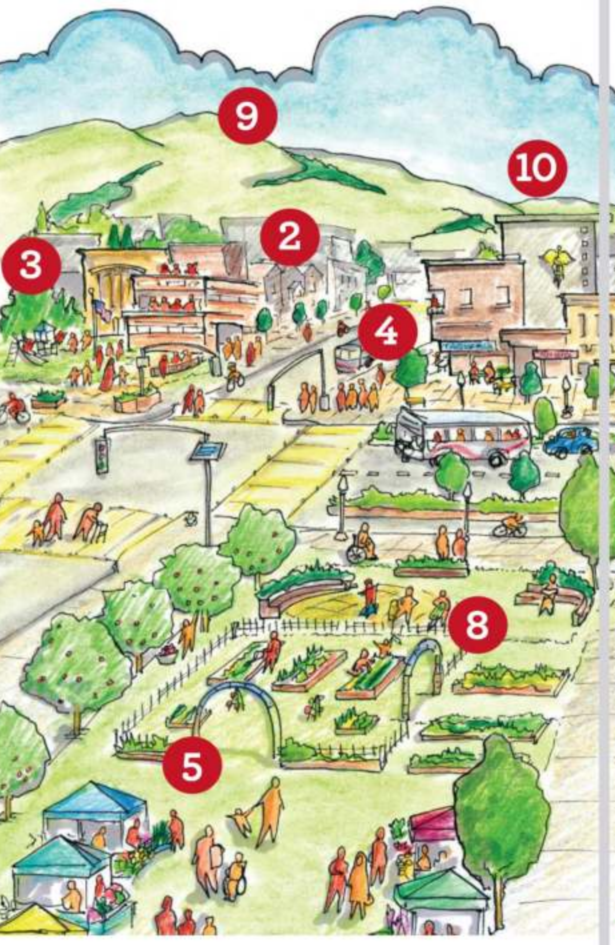
ADDRESS SOCIAL NEEDS	INTERNAL STRATEGY	EXTERNAL STRATEGY	OUTCOMES
Address SDOH and trauma among patients and staff and integrate ongoing SDOH measurement tools into regular practice.	• Develop mechanisms for hospitals to invest in the community (e.g., hospital with farmer's market, child care, renovated housing). • Develop process to implement tools to assess and communicate SDOH (e.g., PRAPARE, Z-codes).	• Select specific SDOH/preventive care areas for initial focus (e.g., meals/food access, transportation, violence). • Strengthen the capacity of the CBO non-profit sector through board service, volunteering, and capacity building.	• Within one year, review community health needs assessments and similar tools to understand current state, achieve consensus on select common priorities for action, and map existing resources (e.g., non-profits) to support addressing these priorities. • Within three years, leverage collective impact of the hospitals to begin implementing a city-wide strategy, with consensus across hospitals, to address social needs.

Updated February 8, 2022

Key Components of Healthy, Equitable Communities

All the components represented promote the following themes: Accessibility, Affordability, Equity, Diversity, and Safety

1. **Healthy, Stable and Affordable Housing:** Socially integrated stable and affordable housing, housing near transit, energy-efficient housing, housing for all income and age levels, healthy indoor air quality, and free of pests, mold, tobacco, and similar negative conditions.
2. **Complete Neighborhoods and Communities:** People-centered design with housing, businesses, services, schools, jobs, recreation, and public transit in close proximity. Easy access to open space, affordable healthy foods, and thriving small businesses. High-quality infrastructure and street design with good lighting and landscaping to support public transit and walkability.
3. **High-Quality Education System:** Strong programs from K-12 to college level and trade schools, universal childhood and enrichment programs, affordable afterschool programs and childcare, youth career and skill development, and adult education.
4. **Thriving and Inclusive Economy:** Diverse local small businesses, economic opportunities with family supportive wages/benefits, fair labor practices, job skills trainings, and community support of new and current businesses.
5. **Healthy Food Access:** Affordable, fresh, local, and culturally appropriate foods at grocery stores and farmers markets; space and resources to grow food in schools and neighborhoods; accessible clean drinking water; and access to school gardens and garden-based education for children.
6. **Active Transportation Options:** Affordable and accessible transportation options for all ages, such as walking, biking, and public transit; innovative, easy-to-use, fast, well-connected, and efficient transit located near jobs, housing, and retail; and quality bike and pedestrian infrastructure.
7. **Safe and Diverse Public Places, Parks, and Open Space:** Public places (plazas, mini-parks, etc.) in convenient locations across neighborhoods for people to be active, relax, socialize, and host community events; and age and culturally appropriate programs and amenities such as benches and community gardens.
8. **Sense of Community where Everyone Feels like they Belong and are Safe:** Safe and socially cohesive neighborhoods; opportunities for the community to connect; local leadership that is representative of community demographics; and empowered residents who are involved in decision-making, social and civic engagement.
9. **Clean Environment:** Clean air, soil, water, and natural systems; plentiful green space; ample permeable land to filter water and reduce flooding; healthy trees; and affordable, sustainable energy and drinking water supplies.
10. **Community-based Public Services and Infrastructure for All People:** Affordable childcare; high-value healthcare and access to mental health and substance use prevention and treatment, where the right care is provided at the right time and place; age in place opportunities; culturally and linguistically supportive services; and accessible libraries, recreation facilities, and patient-centered medical centers.



This vision and 10 components were developed from 5 community workshops throughout San Mateo County. See www.GetHealthySMC.org/Planning.

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