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Michigan: Implicit (Unconscious) Bias

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Contact Hours: 3

Cost: $29

Course Objectives

Upon completion of this course, you will be able to:

1. Define implicit and explicit bias.
2. List 4 barriers or discrepancies in the access to healthcare in the United States.
3. Describe 3 reasons why a diverse healthcare workforce is important.
4. Contrast cultural sensitivity with cultural competence.
5. Relate 3 fallacies or beliefs that may indicate cognitive bias in healthcare professionals.
6. Relate 5 ways in which the historical impact of slavery and colonization has promoted implicit bias.
7. Explain 2 common tools used to measure implicit bias.
8. Describe 2 programs in Michigan whose goal is to improve health equity.

Course Summary

In Michigan, training on implicit bias is required as a condition for initial licensure or registration as well as renewal for healthcare professions. The training is in addition to any continuing education training required for each profession. Unlike the human trafficking training requirement, this is not a one-time training. Implicit bias training is required every time you renew your license. This rule took effect on June 1, 2022 and is described in the document, FAQs for Implicit Bias Training (Michigan.gov, September 24, 2021).

1. Bias, Implicit and Explicit

People have a tendency and need to classify individuals into categories, allowing us to quickly process information and make sense of the world. This mostly occurs below the level of consciousness using information developed from our life experiences.

Processing information in this way is efficient, requiring few mental resources and little conscious thought. Although efficient, automatic processing can lead to implicit and explicit biases.

Test Your Knowledge

You may find it helpful to try these 10 “True or False” questions first before reading the course. The answers are at the end of the question list.

1. **Implicit bias** is a conscious process based on intentional mental associations.
2. **Health equity** means that everyone has a fair and just opportunity to be as healthy as possible.
3. **Structural racism** refers to ideologies, practices, processes, and institutions that produce and reproduce differential access to power and to life opportunities along racial and ethnic lines.
4. **Cultural sensitivity** is a respect for another person’s strengths, culture, and knowledge.
5. A type of unconscious bias that occurs when our perception is skewed based on inaccurate and overly simplistic assumptions about a group or person is called **perception bias**.
6. Evidence shows that interventions focusing on social determinants of health rarely lead to better health outcomes.
7. **Perception bias** is a type of unconscious or implicit bias that occurs when our perception is skewed based on inaccurate and overly simplistic assumptions about a group a person “belongs” to.
8. Historically embedded structural racism is a fundamental cause of health inequities in the United States.
9. Measures of implicit bias rely on the assumption that automatic associations between two concepts will influence behavior in a measurable way.
10. Bias training has been shown to be more effective when the approach is multipronged, designed with context and professional identity in mind, and when people work and train together.

Answers: Questions 1 and 6 are False; all the others are True.

What is Implicit Bias?

Implicit bias is an attitude or internalized stereotype that affects an individual's perception, action, or decision-making in an unconscious manner. It can contribute to unequal treatment based on characteristics such as race, ethnicity, nationality, gender, gender identity, sexual orientation, religion, socioeconomic status, age, or disability (Michigan.gov, 2021, September 24).

Implicit biases influence our thinking and behaviors and can negatively affect clinical interactions and outcomes. Decades of research has demonstrated that discrimination, driven by implicit bias, impacts healthcare access, trust in clinicians, care quality, and patient outcomes (Dirks et al, 2022).

Implicit bias is widespread, even among individuals who explicitly reject prejudice. It persists through structural and historical inequalities that have been slow to change (Payne et al., 2019).

Although everyone has implicit biases, negative biases toward a particular group can be reduced through positive contacts with members of that group. Once recognized, individuals can control the likelihood that these biases will affect their behavior (DOJ, Nd).

What is Explicit Bias?

Explicit or **conscious** bias occurs when we are aware of our 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.

Explicit forms of bias include preferences, beliefs, and attitudes of which people are generally consciously aware, personally endorse, and can identify and communicate. Discrimination, directly related to bias, is the unequal treatment of individuals and communities related to general policies, practices, and norms (Vela et al., 2022).

Implicit Stereotypes, Attitudes, and Prejudices

Stereotypes are fixed, oversimplified beliefs about a particular group or culture. They occur when we categorize people by age, gender, race, or other criteria.

Stereotypes develop early in life and once established, can shape a person's attitudes and behaviors (Brusa et al., 2021). Stereotyping can lead to conventional, formulaic, and oversimplified conceptions and opinions. In the healthcare setting, it allows providers to categorize someone in a certain way, making no further effort to learn whether the individual in question fits the stereotype (Galanti, 2019).

Unconscious stereotypes can lead to implicit bias. This highlights what can be troubling for healthcare professionals: the possibility of biased judgment and biased behavior can affect patient care (FitzGerald et al., 2019).

Recognizing stereotypical thoughts can have a powerful impact on bias. Putting yourself in the shoes of the other person, creating a non-stereotypical alternative to a particular stereotype, and seeing the person as an individual help reduce bias.

Case Example

Jamie recently visited the dog park with her young dog. As she was watching her dog run around, she noticed a woman of Asian descent standing alone. All the other people in the park were White (including Jamie) and were clustered in small groups talking—mostly about their dogs. Jamie wondered why the woman was alone and decided to approach her.

Jamie immediately began to categorize the woman according to what she thinks she knows about various Asian cultures. She assumed the woman was of Japanese descent based on the woman's appearance. Jamie has a positive view of Japanese people and assumed the woman would be friendly, educated, liberal, and well-off. Based on the woman's age, Jamie wondered if the woman's parents had been taken to U.S. concentration camps during WW2. She wondered if the woman was born in Japan or spoke Japanese. She wondered if she was local or not.

Jamie struck up a conversation with the woman and noticed she didn't have an accent—most likely born in the United States, Jamie thought. She thought the woman's dog might be a purebred because she assumed people of Japanese descent were successful, status-conscious, and wealthy.

During their conversation, the woman mentioned she was born in Switzerland, spoke German as a child, and has always wanted to visit Japan because it reminded her of Switzerland. Her dog was a mutt, rescued from a dog shelter in Massachusetts. She had only recently moved to the area from Massachusetts and didn't know many people.

Jamie realized she had used stereotypes to place the woman into a recognizable category. She wondered what stereotypes the other woman assigned to Jamie. She wondered if she had made the woman uncomfortable or if she had successfully hidden her own unconscious stereotypes. Mostly, she wondered if her stereotyping was bad or wrong.

Can you identify some of the ways Jamie categorized and stereotyped this woman? Imagine Jamie (a nurse practitioner) meeting the woman in the healthcare setting. Do you think any of the characteristics Jamie attributed to the woman at the dog park would affect her clinical judgment? If so, how. Do you think Jamie being aware of her stereotyping would help her overcome any preconceptions she has about people of Japanese descent (or people from Switzerland)?

Definitions

- **Bias**: the unintended influence of factors that are not meant to be considered; a tendency to prefer one person or thing to another.
- **Diversity**: the ways in which people differ; encompasses all the characteristics that make one individual or group different from another.
- **Equality**: when every individual has the same rights, resources, and opportunities, regardless of their circumstance.
- **Equity**: being fair and impartial; providing resources and opportunities to create equal outcomes for all community members.
- **Explicit (conscious) bias**: a conscious attitude or belief about a person or a group.
- **Implicit (unconscious or hidden) bias**: a bias that is outside a person's consciousness; may directly contradict a person's stated beliefs and values. Expressed automatically, without conscious awareness.
- **Inclusion**: when the inherent worth and dignity of all people is recognized. Promotes and sustains a sense of belonging, values and practices respect for the talents, beliefs, backgrounds, and ways of living of its members.
- **Prejudice**: a bias or preconceived opinion, idea, or belief about something; an assumption, unfair feeling, or dislike for a person or group simply based on the person's membership in a particular social group.
- **Racial discrimination**: treating a person adversely due to that individual's race or characteristics associated with that race, such as hair texture, facial features, or skin color. National origin discrimination involves treating people unfavorably due to where they are from or their ethnicity or accent.
- **Structural racism**: Encompasses a history and current reality of institutional racism across all institutions combining to create a system that negatively impacts communities of color.
- **Stereotype**: beliefs and opinions about the characteristics, attributes, and behaviors of members of a group; a generalization, often exaggerated, or untrue.

2. Barriers and Disparities in Access to Healthcare

Health Equity

In the past, health equity focused on access to physicians, geographical proximity to services, and economic status (Bielińska et al., 2022). The concept of health equity has broadened over time to include social and economic factors (social determinants of health). This has led healthcare organizations and providers to recognize the need to address persistently poor health outcomes that affect certain groups (Towe et al., 2021).

Article 12 of the International Covenant on Economic, Social and Cultural Rights of 1966 established that "the right to healthcare is tightly connected to the right to health and that everyone has the right to the enjoyment of the highest attainable standard of physical and mental health" (Bielińska et al., 2022).

Despite this growing interest in health equity, many racial and ethnic minority groups continue to experience disproportionate rates of infectious and chronic diseases and their associated risk factors (Jibrel, 2021). These entrenched negative influences on health in some communities have compounded over generations (Towe et al., 2021).

Eliminating health disparities will save billions of dollars by reducing healthcare costs, improving productivity, and saving lives. Achieving health equity will eliminate gaps in healthcare access, quality of care, and, most importantly, the social and environmental determinants of health (MDHHS, 2019).

Did You Know. . .

A 2018 Kellogg Foundation report "*The Business Case for Racial Equity: Michigan*" estimated that disparities in health in Michigan represent $2.2 billion in excess medical care costs, $1.9 billion in untapped productivity, and 140,000 lost life years associated with premature deaths each year (MDHHS, 2019).

Social Determinants of Health

Social determinants of health are conditions in the environment that affect a person's health, functioning, and quality-of-life (ODPHP, 2022). Factors such as economic stability, transportation, quality education, healthy food, access to quality healthcare, and the built environment contribute to variability in lifespan and quality of life (Towe et al., 2021).

Social determinants of health are often grouped into the 5 domains illustrated above. Source: ODPHP. See References for citation and web address.

Disparities related to social determinants of health are hard to ignore:

- Black Americans are 5.1 times more likely than White Americans to be incarcerated.
- Black Americans earn 61 cents for every dollar White Americans earn (and Hispanic Americans earn 74 cents).
- Lower income people are more likely than higher income people to lack access to care and have poorer self-reported general health (Towe et al., 2021).

Most Americans are unaware of these social determinants, do not understand what causes them, and do not necessarily find them to be unfair. In 2008–2009, a national survey showed that 73% of respondents were aware of health differences between the poor and middle-class people, but less than half reported awareness of health differences between White and Black Americans. Many respondents placed the responsibility for poor outcomes on individual behaviors such as smoking, diet, and exercise, as well as access to clinical care, and less on the social determinants of health (Towe et al., 2021).

Gender is an important and often overlooked social determinant of health and the damage caused by gender inequality across the globe is immense (Alcalde-Rubio et al., 2020). It is one of the core social determinants of population health and health inequalities (Miani et al., 2021).

Gender becomes an important social determinant of health through a variety of social factors: health system discrimination and bias, inequitable societal norms and practices, differential exposure to disease, disability, and injuries, and biases in health research. On a global scale, the burden of gender inequality drives large-scale excess in mortality and morbidity (UCL, 2020).

Online Resource

Video: Social Inequalities in Health (NIH) [3:02]

https://www.youtube.com/watch?v=roAQHn5rEoQ

Barriers to accessing healthcare services are consistent across countries and disproportionally affect people with below-average income, immigrants, people with chronic conditions, and people with mental health conditions. Immigrants are more likely to experience multiple barriers, particularly after reaching care (Corscadden et al., 2018).

Structural racism, lack of health insurance, rural healthcare disparities, gender discrimination and violence, minority health disparities, and redlining and gentrification are some of the barriers faced in accessing health services. Adding to the picture, research, testing, and screening tools often fail to address the needs of ethnic and minority patients.

What is Structural Racism?

Structural racism means public policies, institutional practices, cultural representations, and other norms perpetuate racial group inequity. It is rooted in a hierarchy that privileges one race over another, influencing institutions that govern daily life, from housing policies to police profiling and incarceration. It is associated with social determinants of health and health disparities (Muramatsu and Chin, 2022).

Structural racism produces and reproduces differential access to power and to life opportunities due to race and ethnicity. Over centuries, structural racism has become entrenched, influencing the way medicine is taught and practiced as well as the functioning of healthcare organizations (Geneviève et al., 2020).

One example of structural racism in medicine has to do with pregnancy outcomes. A study published by Amnesty International found that some healthcare providers fail to consider the healthcare needs of women of color, treat them poorly, and sometimes even try to dissuade them from seeking medical care. Systemic factors such as these regulate access to healthcare services and ultimately influence the quality of care (Geneviève et al., 2020).

Online Resource

Video: **Dorothy Roberts: The problem with race-based medicine [14:27]**

https://www.ted.com/talks/dorothy_roberts_the_problem_with_race_based_medicine

Source: TEDMED, 2015

The effects of race-based medicine were evident during the COVID pandemic. A tool commonly used to assess a person's oxygen saturation appears to be more accurate for light-skinned patients than darker-skinned patients.

Pulse oximetry was used extensively during the COVID pandemic and critical treatment decisions were made partly based upon a person's oxygen saturation. For some patients, life-saving therapies were delayed because pulse oximeters **over-estimated** oxygen saturation levels in darker-skinned individuals. There is evidence that, for Black and Hispanic patients, undetected low oxygen levels led to delays in receiving therapies such as remdesivir and dexamethasone, and in many cases, led to no treatment at all (Fawzy et al., 2022).

Although pulse oximetry is a fundamental tool used in diagnosis and management decisions, the device's lack of accuracy in certain populations has not been adequately investigated. This is even though the issue has been recognized for several decades and was highlighted in a 2020 safety communication by the Food and Drug Administration (Fawzy et al., 2022).

Adding to the problems, pulse oximeters have migrated out of the acute care setting and are now available and affordable to the average consumer for home use. The expanded use of a differentially inaccurate device potentially exacerbates racial and ethnic health disparities (Fawzy et al., 2022).

Health Insurance

Lack of health insurance—or being under-insured—is a critical barrier to accessing healthcare services. Health insurance is a key factor in whether, when, and where people get medical care. Uninsured people are far more likely than those with insurance to postpone or forego healthcare. And being uninsured can have severe financial consequences, with many unable to pay their medical bills, resulting in medical debt (Guth and Artiga, 2022).

Despite most people of color having a full-time worker in the family, they are often employed in low-wage jobs that are less likely to offer health insurance. While private insurance is the largest source of health coverage for people across racial and ethnic groups, people of color are less likely to be privately insured than White people (Guth and Artiga, 2022).

Rural Healthcare

Rural populations make up around ~19% of the U.S. population. These areas have heightened mortality rates from several chronic diseases compared to urban populations (Nuako et al., 2022). A lack of rural hospitals and clinics, lack of access to specialty services, and high turnover rates among healthcare providers, are significant barriers for rural communities.

Rural-urban mortality disparities have grown over recent decades despite overall declines in mortality from chronic disease conditions. The causes of rural health disparities include higher rates of poverty, behavioral risk factors, larger proportions of older adults and people with disabilities, and lower rates of insurance and education (Nuako et al., 2022).

Gender Discrimination in Healthcare

Throughout history, women have been victims of bias and discrimination in medical diagnosis, treatment, and care. Women are less likely to be diagnosed with a non-psychosomatic illness, have their pain treated, and have their symptoms be taken seriously compared to men. Women were also excluded from clinical trials until the early 1990s (Luu, 2021).

Historically, women's physical complaints were believed to be connected to the female reproductive system. During the 18th and 19th centuries, female hysteria was a common diagnosis and illnesses experienced by women were often attributed to psychological problems (Luu, 2021).

Gender discrimination in healthcare is highlighted by findings described in several studies. For example—in Austria women undergoing hemodialysis were less likely to be treated via a vascular shunt and less likely to be referred for kidney transplantation (Shai, et al., 2021). Indigenous and non-White Hispanic patients have been stereotyped as being non-compliant with clinical health recommendations, having risky health behavior, and difficulty understanding or communicating health information (Dirks et al, 2022).

Women are less likely than men to be referred for cardiovascular testing and Indigenous women in particular report perceived discrimination by clinicians as a reason for not seeking recommended cancer screening (Dirks et al, 2022).

The recognition of gender bias in the clinical management of cardiovascular disease, has led to research into other health issues affecting women. In 2019, *Nature Communications* published a study analyzing health data for almost 7 million men and women in the Danish healthcare system over a 21-year period. The results showed that women were diagnosed later than men in more than 700 diseases (Alcalde-Rubio et al., 2020).

Did You Know. . .

> From the 1910s through the 1950s, and in some places into the 1960s and 1970s, tens of thousands—perhaps hundreds of thousands—of American women were detained and forcibly examined for sexually transmitted infections. The program was modeled after similar ones in Europe, under which authorities stalked "suspicious" women, arresting, testing, and imprisoning them.
>
> If the women tested positive, U.S. officials locked them away in penal institutions with no due process. While many records of the program have since been lost or destroyed, women's forced internment ranged from a few days to many months. Inside these institutions, the women were often injected with mercury and forced to ingest arsenic-based drugs, the most common treatments for syphilis in the early part of the century. If they misbehaved, or if they failed to show "proper" ladylike deference, these women could be beaten, doused with cold water, thrown into solitary confinement—or even sterilized.
>
> Scott W. Stern America's Forgotten Mass Imprisonment of Women Believed to Be Sexually Immoral, 2019

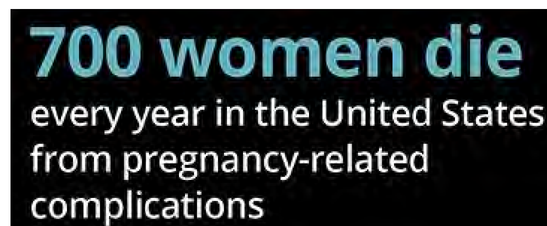
The Health Impacts of Violence Against Women

Exposure to physical and sexual violence in childhood and adulthood can have a profound and prolonged impact on a woman's health. Studies have shown an association between childhood abuse and cardiovascular, autoimmune, and metabolic diseases, chronic pain, and mortality in women. Biological changes have been noted in abuse survivors such as increased pituitary stress response, increased inflammation, and even DNA changes (Shai, et al., 2021).

Pregnancy-Related Health Disparities and Barriers

Structural racism can affect pregnancy outcomes. An Amnesty International publication reported that some healthcare providers fail to consider the healthcare needs of women of color, treat them poorly, and sometimes even try to dissuade them from seeking medical care. Systemic factors such as these regulate access to healthcare services and ultimately influence the quality of care (Geneviève et al., 2020).

More than 700 women die annually in the U.S. during pregnancy or its complications. During 2007–2016, Black and American Indian/Alaska Native women had significantly more pregnancy-related deaths per 100,000 births than did White, Hispanic, and Asian/Pacific Islander women. Disparities have persisted over time and across age groups and were present even in states with the lowest pregnancy-related mortality rates and among groups with higher levels of education (Petersen et al., 2019).



Source: CDC.

A review of maternal mortality in 13 states indicated that 60% of pregnancy-related deaths were preventable. Chronic diseases such as hypertension, which is associated with increased risk for pregnancy-related mortality, is more prevalent and less well-controlled in Black women (Petersen et al., 2019).

Gaps in healthcare coverage and preventive care, lack of coordinated healthcare and social services, and community factors such as transportation and housing contribute to pregnancy-related deaths. Addressing these factors and ensuring that pregnant women at high risk for complications receive specialized care in facilities can improve outcomes (Petersen et al., 2019).

Did You Know. . .

In 1970, the *Family Planning Services and Population Research Act of 1970*, led to nearly one in four Native American women of childbearing age being sterilized without their consent. This policy remained in effect until 1976. At the same time, the *Hyde Amendment* (first passed in 1976 and amended in 1993) made it illegal to use federal funds for abortion services and denied Native American women access to reproductive health services through lack of funding to Indian Health Services (Yellow Horse et al., 2020).

In states that have **not** implemented the Affordable Care Act Medicaid expansion, people can lose coverage at the end of the postpartum period. The *American Rescue Plan Act* includes a new option for states to extend pregnancy-related Medicaid coverage from 60 days postpartum to 12 months (beginning in April 2022), which could decrease the number of people becoming uninsured at the end of the 60-day postpartum period. At least 26 states plan to take up the *American Rescue Plan Act* option or otherwise extend postpartum coverage (Guth and Artiga, 2022).

Quality of Maternity Care

A national study of five specific pregnancy complications found a similar prevalence of complications among Black and White women, but a significantly higher case-fatality rate among Black women. Studies have suggested that Black women are more likely than are White women to receive obstetric care in hospitals that provide a lower quality of care (Petersen et al., 2019).

The recent Supreme Court ruling overturning Roe v. Wade has already impacted pregnancy-related healthcare for many women. It has also impacted OB/GYN training in the 26 states that have restricted or are poised to restrict abortion services. This means hospitals will no longer offer vital training used to manage miscarriages and other pregnancy-related complications.

Did You Know. . .

Black and American Indian/Alaska Native people are more likely to die while pregnant or within a year of the end of pregnancy compared to White people. One study estimated that a total abortion ban in the U.S. would increase the number of pregnancy-related deaths by 21% for all women and 33% among Black women (KFF, 2022).

Minority Health Disparities

> Disparities in healthcare and health outcomes exist in both publicly and privately funded health programs. Racial and ethnic minority populations experience worse outcomes than the general population for almost every health condition.
>
> Michigan Department of Health and Human Services, 2019

The *National Institute on Minority Health and Health Disparities* has designated certain groups as most affected by health disparities in the United States: Blacks/African Americans, Hispanics/Latinos, American Indians/Alaska Natives, Asian Americans, Native Hawaiians and other Pacific Islanders, as well as socioeconomically disadvantaged populations, underserved rural populations, and sexual and gender minorities (Mapes et al., 2020).

Many people in these groups experience disparities and barriers related to financial concerns and unemployment. Lack of health literacy and communication and language barriers add to the picture. Cultural factors, discrimination, and structural factors such as lack of transportation create sometimes unsurmountable barriers to care (Mapes et al., 2020).

Disparities Cause by Redlining and Gentrification

Redlining and gentrification are social practices that we may not consider as contributing to gaps in health. Redlining is a practice in which lenders deny mortgages to eligible buyers solely because of their race. This practice, once widespread, assured that people of color were denied the right of home ownership and upward economic mobility that millions of White people enjoyed. Redlining has been succeeded by gentrification, whereby middle-class White people move into urban areas and displace Black people who have lived in a neighborhood for years (Julian, Hardeman, and Huerto, 2020).

Both redlining and gentrification perpetuate poverty in communities of color. As such, many Black and low-income Americans live in communities where clean water isn't guaranteed, and social distancing is nearly impossible in crowded homes. In this way, redlining and gentrification impact the racial inequities seen during the COVID-19 pandemic (Julian, Hardeman, and Huerto, 2020).

Resources that enhance quality of life, such as safe and affordable housing, access to education, public safety, availability of healthy foods, local health services, and environments free of life-threatening toxins can have a significant influence on population health outcomes (ODPHP, 2022).

The LGBTQ+ Community

Clinicians may harbor implicit prejudices that negatively impact healthcare quality and access for lesbian, gay, bisexual, transgender, and queer/questioning individuals. Although implicit healthcare biases may be largely unintentional, they operate at interpersonal, institutional, and societal levels (Dirks et al, 2022).

LGBTQ+ individuals face significant disparities in physical and mental health outcomes. Compared to their heterosexual counterparts, LGBTQ+ patients have higher rates of anal cancer, asthma, cardiovascular disease, obesity, substance abuse, cigarette smoking, and suicide (Morris et al., 2019).

Sexual minority women report fewer lifetime Pap tests, transgender youth have less access to health care, and LGBTQ+ individuals are more likely to delay or avoid necessary medical care compared to heterosexual individuals. These disparities are due, in part, to lower healthcare utilization by LGBTQ+ individuals (Morris et al., 2019).

Perceived discrimination from healthcare providers and denial of healthcare altogether are common experiences among LGBTQ+ patients and have been identified as contributing factors to health disparities. Disparities in healthcare access and outcomes experienced by LGBTQ+ patients are compounded by vulnerabilities linked to racial identity and geographic location (Morris et al., 2019).

3. Serving a Diverse Population

> We have long known that diversity, including gender diversity, is key to effective, innovative organizations. In the for-profit world, diversity relates directly to sales and profits. In global health, where organizations are striving to create a healthier world, it is even more critical to embrace diversity as a mechanism to maximize our ability to deliver on our missions.
>
> Catherine Ohura
>
> The Global Health Innovative Technology Fund

Serving a diverse population and achieving cultural competency in healthcare is the stated goal of most U.S. healthcare organizations. However, achieving this goal in today's healthcare environment, filled with diverse patient and provider populations, is no easy task. This creates the ideal breeding ground for conflict and misunderstanding, which can result in tension among the staff and inferior patient care (Galanti, 2019).

To provide the best possible care for all patients, regardless of race, gender, or ethnic origin, culturally competent education is essential. It is not possible to know everything about every culture, but the first important step is an awareness of the fact that different cultures have different rules of appropriate behavior (Galanti, 2019).

Workforce Diversity

A racially and ethnically diverse healthcare workforce provides better access and care for underserved populations, promotes research that focuses on marginalized communities, and better meets the health needs of an increasingly diverse population. People of color, however, remain underrepresented in several health professions, despite longstanding efforts to increase diversity (AHRQ, 2021, December).

Several studies have shown the importance of a diverse medical workforce. Black and Hispanic physicians are more likely to care for underserved populations, including racial minorities and uninsured patients. Physician diversity has also been linked to better patient outcomes in primary care (Lett, Orji, and Sebro, 2018).

Gender diversity is also important. Women currently account for three-quarters of full-time, year-round healthcare workers. Although the number of men who are dentists or veterinarians has decreased over the past two decades, men still make up more than half of dentists, optometrists, and emergency medical technicians/paramedics, as well as physicians and surgeons (AHRQ, 2021, December).

Decolonization, Inclusion, and Equity

The COVID-19 pandemic, the *Black Lives Matter* and *Women in Global Health* movements, and ongoing calls to decolonize* global health have all created space for uncomfortable but important conversations that reveal serious asymmetries of power and privilege that permeate all aspects of global healthcare systems (Abimbola et al., 2021).

***Decolonize**: To free a people, profession, or area from colonial status: to relinquish control of a subjugated people or area.

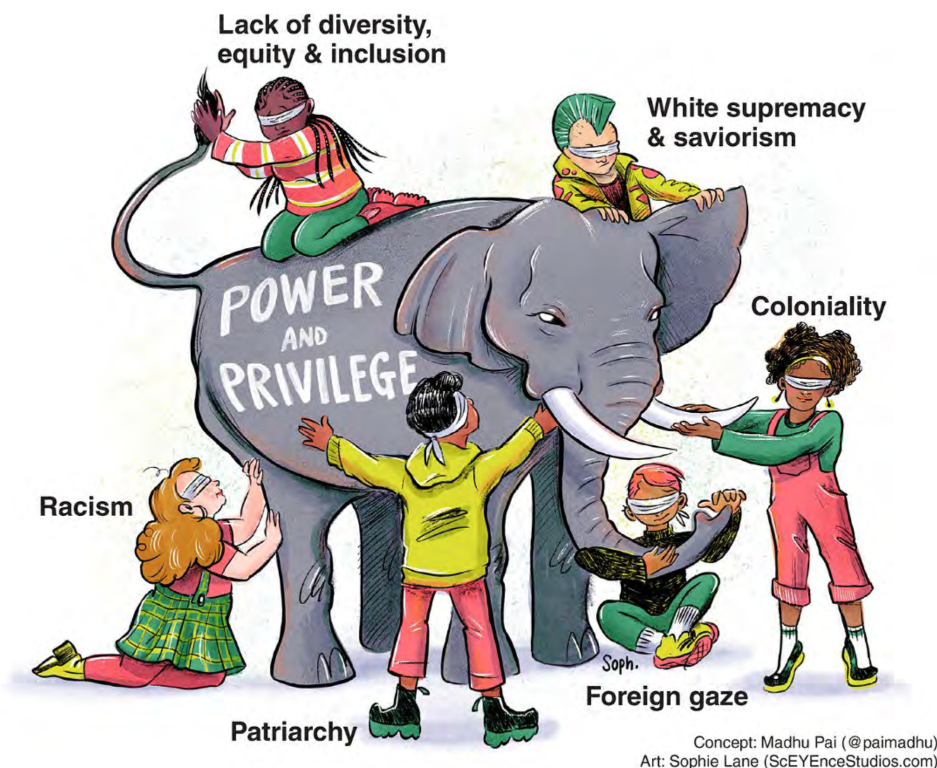
Factors such as lack of diversity, equity, and inclusion; White supremacy and saviorism[1]; colonialism, racism, and patriarchy; and the "foreign gaze"[2] impact healthcare providers throughout the world. The shadow of colonialism[3] continues to impact healthcare education, diversity, and equity.

[1]**Saviorism**: A policy that frames a group of people as needing to be saved, providing help in a self-serving manner. Often referred to as "White saviorism."

[2]**Foreign gaze**: more than looking at a person—there is an implied imbalance of power or unequal power dynamic; the gazer is superior to and objectifying the object of the gaze. Also: male gaze, imperial gaze, medical gaze.

[3]**Colonialism**: the policy or practice of acquiring full or partial political control over another country, occupying it with settlers, and exploiting it economically.

At the individual level, there is a need to "decolonize" our minds from the colonial conditionings of our education. At the organizational level, global health organizations must practice real diversity and inclusion and localize their funding decisions. And at both the individual and organizational levels, there is a need to hold ourselves, our governments, and global health organizations accountable to these goals (Abimbola et al., 2021).



Global health has many asymmetries in power and privilege, including lack of diversity, white supremacy, racism, patriarchy, coloniality, and the foreign gaze. Image source: Madhukar Pai, with artwork by Sophie Lane. Reprinted under the terms of the Creative Commons Attribution License.

Diversity, Equity, and Inclusion (DEI) Initiatives

> Diversity is where everyone is invited to the party. Inclusion means that everyone gets to contribute to the playlist. Equity means that everyone has the opportunity to dance.
>
> University of Michigan Chief Diversity Officer Robert Sellers

Diversity, equity, and inclusion (DEI) initiatives are offered to healthcare personnel in most healthcare organizations in the United States. These programs promote an appreciation and respect for differences and similarities in the workplace, including encouraging respect for the perspectives, approaches, and competencies of coworkers and clients. Inclusion helps people feel valued for their unique qualities while promoting collaboration within a diverse group.

Michigan Initiatives

Source: National Cancer Institute.

Diversity, equity, and inclusion programs are springing up in just about every industry and company. The Michigan Diversity Council provides training in a variety of areas related to diversity and inclusion, including a diversity certification program. Its goal is to help organizations develop individual, team, and organizational strategies to improve diversity, equity, and inclusion.

The *Department of Civil Rights in Michigan* (MDCR) provides resources and training solutions that focus on race, systemic advantages and disadvantages, and how these issues intersect or interact. MDCR encourages organizations to develop action plans that endorse equity and inclusion and implement equitable practices, policies, and procedures (MDCR, 2022).

Medicaid and Medicare as Inclusion Initiatives

Medicare and Medicaid were created to cover people who did not have health insurance. They have played an important role in addressing limited healthcare access for racial and ethnic minority populations. Medicare funding provided powerful financial leverage for the early and proactive efforts of the *Department of Health and Human Services Office for Civil Rights* to secure the racial integration of hospitals (Yearby, Clark, & Figueroa, 2022).

These programs have encouraged physicians, hospitals, and other providers to serve underserved communities. The programs reflect however, the racial paradox of the safety net: It is a product of a structurally racist health system in which racial and ethnic minority groups were disproportionately excluded from employer-sponsored health insurance, yet it is also an important, if limited, tool for filling this gap (Yearby, Clark, & Figueroa, 2022).

Medicaid remains the largest public health insurance provider in the U.S., with more than 80 million enrollees. The racial composition of Medicaid enrollees underscores its importance in addressing racial inequity in healthcare. Nationwide, 30% of nonelderly Medicaid beneficiaries are Latinx, 20% are Black, and nearly 10% are part of other minority racial or ethnic groups (Commonwealth Fund, 2022).

Because Medicaid is highly fragmented and decentralized—with the federal government, states, and even localities making decisions about how to fund, design, and administer it—there are numerous places where inequities can occur. For example, state programs vary in terms of:

- Benefits offered.
- Waivers required for work-reporting requirements.
- Provider payments.
- Outreach efforts.
- Program administration (Commonwealth Fund, 2022).

Each of these variations have implications for how benefits are distributed across racial groups and for how policies interact with preexisting social and economic disadvantages. Yet, policymakers make many of these decisions without clear consideration of the repercussions their choices have for racial inequity (Commonwealth Fund, 2022).

Currently, Medicaid and the *Children's Health Insurance Program* (CHIP) are the primary sources of coverage for many children of color. Medicaid covers about 30% of Black, American Indian/Alaska Native, and Native Hawaiian or Other Pacific Islander nonelderly adults, and more than 20% of Hispanic nonelderly adults, compared to 17% of their White counterparts (Guth and Artiga, 2022).

For children, Medicaid and CHIP cover:

- More than 50% of Hispanic, Black, and American Indian/Alaska Native children.
- Nearly half of Native Hawaiian or Other Pacific Islander children.
- About 27% of White children (Guth and Artiga, 2022).

The Affordable Care Act

In 2014, the *Affordable Care Act* expanded Medicaid to adults with incomes up to 138% of the federal poverty level ($18,754 annually for an individual in 2022). Medicaid expansion has been linked to increased access to care, improvements in some health outcomes, and reductions in racial disparities in health coverage (Guth and Artiga, 2022).

As of February 2022, 12 states have not yet adopted Medicaid expansion. In these non-expansion states, more than 2 million people fall into a coverage gap, with incomes too high to qualify for Medicaid but too low to qualify for marketplace subsidies (Guth and Artiga, 2022).

Nearly six in ten people in the coverage gap are people of color. Uninsured Black adults are more likely than their White counterparts to fall into the gap (15% vs. 8%) because most states that have not expanded Medicaid are in the South where a larger share of the Black population resides (Guth and Artiga, 2022).

The *American Rescue Plan Act*, enacted in March 2021, includes a temporary fiscal incentive to encourage states to take up the expansion. While no state has newly adopted expansion since ARPA was enacted, this incentive reignited discussion around expansion in a few state legislatures. Also, in some states, advocates are pursuing expansion via ballot initiatives (Guth and Artiga, 2022).

The *Build Back Better Act* would temporarily close the Medicaid coverage gap. It would make low-income people eligible for subsidized coverage under the *Affordable Care Act* in states that have not expanded Medicaid (Guth and Artiga, 2022).

> A recent Los Angeles Times article reported that Medicaid (Medi-Cal) patients experience a lack of access through the University of California's health systems. This despite nearly 33% of California residents being insured through Medi-Cal.
>
> The main reason given by UC administrators is the failure of Medi-Cal reimbursements to cover the cost of treatments. The situation is worse for medical specialties such as neurology, orthopedics, and cardiology, which often do not accept Medi-Cal insurance (Wilkes and Schriger, 2022).

In Michigan, more than 985,000 people receive health insurance through the *Healthy Michigan Plan*. A sizeable proportion of beneficiaries are young (18-34 years of age), and most work in low wage or seasonal jobs that do not provide insurance (Michling, 2022).

Michigan entered the COVID-19 pandemic with an expanded Medicaid program and a smaller percentage of its residents uninsured compared to several other states. Michigan's Medicaid expansion was well established and intertwined with other health insurance coverage options, creating a higher baseline coverage. Michigan's relatively aged population (ranking eighth nationally for the number of Medicare beneficiaries) was likely more insulated from pandemic-related insurance or income loss (Michling, 2022).

4. Cultural Sensitivity and Cultural Competence

> We each serve as a unique link in a chain of knowledge that reaches back into the past through the millennia and pushes forward into future. Each person is responsible to their community for the knowledge that they receive as learners and eventually pass on as knowledge keepers. The survival of our communities is predicated on the integrity of this interconnected knowledge cycle.
>
> Keeta Gladue, Indigenous Academic Integrity, 2020

Health and well-being are fundamentally influenced by culture. Developing this self-awareness means recognizing that all forms of knowledge and practice are influenced by culture (Napier et al., 2017).

Cultural Sensitivity

Cultural sensitivity is a respect for another person's strengths, culture, and knowledge. It means a person understands that cultural differences exist and can affect values, learning, and behavior. People who are culturally sensitive have a set of skills that allows them to understand and learn about people whose cultural background is not the same as their own.

Cultural Competence

Cultural competence occurs when knowledge, attitudes, and skills are **integrated** into a person's daily actions. Cultural competence requires a self-examination of one's own cultural and professional background and encourages healthcare providers to manage prejudices and stereotypes that may affect their behavior when interacting with someone from a different culture (Gradellini et al., 2021).

Cultural competence is a critical component of health equity and importantly, can offer new models of care that account for more than just biology and medicine. An awareness of culture helps us understand the relative nature of values we often assume to be universal. It allows us to understand the influences of diverse but interrelated issues, such as socioeconomic status, environmental conditions, age, gender, religion, sexual orientation, and level of education (Napier et al., 2017).

In recent years, the quality of cultural competence training has improved, although problems remain:

- Lack of consensus on what should be taught
- Timing of training
- Lack of standard references
- Limited and inconsistent formal evaluation of interventions (Gradellini et al., 2021)

A commonly used tool for analyzing and improving intercultural sensitivity is *Bennett's Developmental Model of Intercultural Sensitivity*. It suggests that individuals move from "ethnocentrism" meaning that an individual's own culture is experienced as central to reality to "ethnorelativism" meaning that an individual's culture is experienced in the context of other cultures. This involves six stages, starting with denial and moving on to defense, minimization, acceptance, adaptation, and finally, integration.

Online Resource

Video: Bennett's Developmental Model of Intercultural Sensitivity (DMIS) [9:51]

https://www.youtube.com/watch?v=6vKRFH2Wm6Y&t=32s

5. Remedying the Impact of Implicit Bias

To remedy the impact of implicit bias, we must consider factors that can be changed and improved, such as opportunities for quality education, good paying jobs, access to quality clinical care, healthy foods, green spaces, and secure and affordable housing. In Michigan, as in other states, differences in a range of health factors emerged from unfair policies and practices for people with lower incomes and communities of color at many levels and over many decades (UW, 2020).

How Bias Impacts Perception

> Well, I found out that race runs deeply throughout all of medical practice. It shapes physicians' diagnoses, measurements, treatments, prescriptions, even the very definition of diseases. And the more I found out, the more disturbed I became.
>
> Dorothy Roberts
>
> University of Pennsylvania

Perception bias is a type of unconscious or implicit bias that occurs when our perception is skewed based on inaccurate and overly simplistic assumptions about a group a person "belongs" to. This may include biases or stereotypes about age, gender, and appearance. These attitudes, beliefs, or stereotypes can affect our ability to make sound decisions.

How we perceive others can affect non-verbal behavior towards others, such as frequency of eye contact and physical proximity. Perception biases can create a conflict between what a person believes and wants to do, for example, wishing to treat everyone equally, and the hidden influence of negative implicit associations such as perceiving Black patients to be less competent and thus deciding not to prescribe certain medications (FitzGerald and Hurst, 2017).

Healthcare professionals tend to view data as if it exists in isolation from the human decision maker. Recognizing and overcoming bias is related to our underlying perception of bias. Professionals may feel they can overcome biases through sheer will power. They may feel that bias does not occur in professionals and experts—they are impartial and immune to bias. They may also perceive bias as:

- Associated with corrupt or malicious people.
- Associated with "bad apples" rather than systemic issues.
- Eliminated by technology, instrumentation, automation, or artificial intelligence (Dror, 2020).

Decision Making and Diagnostic Bias

> The use of racial terms to describe epidemiologic data perpetuates the belief that race itself puts patients at risk for disease, and this belief is the basis for race-based diagnostic bias. Rather than presenting race as correlated with social factors that shape disease or acknowledging race as an imperfect proxy for ancestry or family history that may predispose one to disease, the educators we observed portrayed race itself as an essential—biologic—causal mechanism.
>
> Amutah, et al., 2021
>
> New England Journal of Medicine

Healthcare providers are vulnerable to a range of biases when making decisions, particularly diagnostic and treatment decisions. Many biases have been described in the healthcare literature, and many of these have been shown to influence decisions. Issues associated with the process of clinical reasoning can have a serious impact on the services provided (Featherston et al., 2020).

Bias affects patient-provider interactions, treatment decisions, patient adherence to recommendations, and patient health outcomes. Bias in decision-making can be expressed directly (explicitly) or indirectly (implicitly). This can lead to an unintentional form of discrimination that affects decision-making structurally and systematically and is hard to identify and uncover (Nápoles et al., 2022).

Reasoning biases challenge the assumption that humans make logically correct decisions when they are provided with sufficient information. Cognitive shortcuts can be efficient and accurate but are vulnerable to reasoning errors. For instance, cognitive shortcuts can produce biases because the most readily retrievable information may not be the most accurate or appropriate information to support the decision being made. It may, for example, simply reflect how recently the information was obtained (Featherston et al., 2020).

Cognitive biases can influence human decision making. Other biases arise from the interplay between cognition and emotion, as well as the external social context; a person's emotional state can influence decision outcomes (Featherston et al., 2020).

Studies have shown that implicit racial bias profoundly influences clinical decision-making. Its affects nonverbal behaviors such as eye contact and posture and has been shown to influence the quality of physicians' interpersonal communication with African American patients and, in turn, patients' trust and perceptions of their physicians (van Ryn et al., 2015).

Effective Communication

Effective health communication means providing information to an individual in an understandable and accessible way. Access to information is not enough; patients need understandable information that is also culturally and linguistically appropriate. Increasing knowledge about prevention and maintenance of good health can positively influence an individual's health behaviors and attitudes. This involves verbal, written, and nonverbal communication (HHS, 2022).

Communicating Across Cultures and Groups

There is a high degree of linguistic diversity in the United States with more than 59 million residents speaking a language other than English at home. Among these, more than 25 million people live in "linguistic isolation"—a term coined by the U.S. Census Bureau—in which no one in a household over 14 years of age speaks English very well (NCCC, Nd).

Good cross-cultural communication skills allow healthcare providers to understand the needs, values, and preferences of their patients. Cultural differences in communication, such as preferences regarding how and when interactions take place, tone, eye contact, and other factors should be considered, even when using an interpreter (HHS, 2022).

Cross-cultural communication skills can be improved when a provider is aware of language differences, avoids assumptions about a person's cultural or linguistic background, and avoids jargon. These factors should be considered when communicating in writing and when designing written material for patients.

Online Resource

Video: Components of Intercultural Communication [3:06]

https://www.youtube.com/watch?v=NLFjgylSXZA

Culturally and Linguistically Appropriate Services (CLAS)

Prior to 2000, only a few independently developed standards were available for the evaluation of cultural competence and linguistically appropriate services in healthcare. In 2000, the U.S. Office of Minority Health developed the *Culturally and Linguistically Appropriate Service (CLAS) Standards*, which serve as a national standard for healthcare in the United States (CDC, 2014).

Updated in 2013 *National CLAS Standards,* CLAS Standards are grounded in a broad definition of culture, encompassing not only race and ethnicity but also language, spirituality, disability status, sexual orientation, gender identity, and geography to ensure a strong platform for health equity (CDC, 2014).

The Standards are divided into 3 sections: (1) Principle Standard, (2) Governance, Leadership, and Workforce, and (3) Communication and Language Assistance. They provide a blueprint for individuals and healthcare organizations to implement culturally and linguistically appropriate services (OMH, 2022).

The entire CLAS Standards can be accessed here:

https://thinkculturalhealth.hhs.gov/clas/standards

Language Assistance Services

Language assistance services facilitate communication between patients and the various points of contact within an organization. Examples of language assistance services include oral interpretation, translation of written documents, signage, and wayfinding symbols. Individuals with language needs include those with limited English proficiency and those who are deaf or hard of hearing. Language assistance services should be provided at no cost to the patient (HHS, 2022).

When interpretation and translation services are not provided, there is strong evidence that patients with limited English proficiency are adversely impacted. Poor communication contributes to a patient's lack of understanding of their health condition and recommended treatment. Other adverse impacts can include:

- Incomplete and inaccurate health history
- Misdiagnoses of health and mental health conditions
- Misuse of medications
- Repeat visits to physician offices or emergency room
- Lack of informed consent (NCCC, Nd)

In the example that follows, the failure of an organization to provide language assistance services (or the doctor's failure to use available services) led to a frustrating experience for the doctor, the hospital, and the patient.

Case: Mr. Louis and His Granddaughter

Mr. Louis just celebrated his 70th birthday with his family and neighbors with lots of great food, music, and dancing. Mr. Louis kept everyone up late, telling stories about his childhood in Haiti. Mr. Louis was grateful to have so many loved ones close by, but he still misses Haiti after moving so many years ago.

Soon after his birthday, Mr. Louis visited his physician for a checkup. After his physician sent him for additional testing, Mr. Louis was diagnosed with prostate cancer. Let's see what happens during Mr. Louis' appointment with the oncologist, Dr. Emily Parker.

The Initial Appointment

Mr. Louis brought his granddaughter, Suzy, to his oncology appointment at the hospital to help him speak with the oncologist, Dr. Parker. He knows some English, but he was worried that he would not understand everything that the doctor might say. Plus, Mr. Louis was nervous, he wanted his granddaughter there for support.

Once the appointment began, though, Dr. Parker and Suzy did all the talking. Mr. Louis did not get a chance to speak, and he did not understand most of what Dr. Parker and Suzy were saying. After a few minutes, Suzy seemed to be arguing with Dr. Parker. This embarrassed Mr. Louis, and he stayed quiet.

After the First Appointment

After the appointment, Suzy explained to her grandfather in French that, to treat his cancer, he would undergo a procedure the next week that would implant radioactive seeds. Suzy told Mr. Louis that the procedure was simple, painless, and without side effects. She did not mention what else the doctor said or what she seemed they seemed to be arguing about during the visit.

Back at home, Mr. Louis started getting worried about this procedure. He researched the procedure online and talked with his friends about it. He learned that the procedure did have side effects, including the possibility of incontinence. Remembering how Suzy had argued with the doctor, Mr. Louis wondered if she had told him the truth about her conversation with Dr. Parker.

The Surgical Appointment

The next week, Mr. Louis and Suzy arrived at the admissions office at the hospital. "No surgery," said Mr. Louis firmly. The admissions clerk looked up in surprise, and Suzy quickly started talking to her in English. She explained that Mr. Louis did not really understand the issue and that he really did want the surgery.

Suzy asked to sign the papers for her grandfather, but the admissions clerk explained that without legal standing, Suzy was not eligible to do so. Mr. Louis continued to quietly say, "No surgery." The admissions clerk had no idea what to do. The surgical staff called to say that they were waiting for Mr. Louis. Suzy glared at her grandfather.

The clerk spent almost half an hour trying to find a hospital staff member who spoke French, but no one was available. The surgery staff called again, saying that if Mr. Louis did not arrive shortly, they would have to reschedule his procedure.

Exasperated, Suzy insisted that Mr. Louis undergo the procedure. She said, "The hospital has people ready to do this. All those people's time will just be wasted. Come on, just sign the paper and we can get you upstairs." Mr. Louis said again, "No surgery." Suzy had no choice but to take him home.

Mr. Louis's Response

"I depended on my granddaughter to help me with my oncology appointment. But she did not tell me the truth about the surgery and my options to treat my illness. I am really angry that I came very close to having a surgery I did not want! It was so frustrating to not be able to communicate directly with my doctor. All I wanted was someone who could listen to me and explain my options."

Mr. Louis's Doctor Responds

"These days, I see a lot of patients who don't speak English very well or at all. I'm used to communicating with a family member or friend instead of the patient. In fact, I ask patients to bring someone who can interpret for them. It's so much easier that way!

"But when I heard about Mr. Louis' situation from our admissions clerk, I was shocked! I did not recommend the procedure that Suzy scheduled for her grandfather. I actually suggested "watchful waiting" as Mr. Louis' treatment option. But, during the consultation, his granddaughter insisted that Mr. Louis undergo the procedure. "Now that I think about it, I didn't speak much with Mr. Louis since Suzy seemed to be in charge. I thought I was doing the right thing by speaking with the family member that Mr. Louis brought with him. Now knowing that Mr. Louis did not want surgery scares me. I wish I had been able to speak directly with Mr. Louis without his granddaughter interfering."

Conclusion

Offering language assistance services, including a competent medical interpreter, helps patients with limited English proficiency understand and make informed decisions about their medical care. Unfortunately, Mr. Louis almost had a surgery that he did not want, and the surgery could have caused side effects about which he had not been informed. Operating on a patient who did not want surgery or who was not aware of potential adverse effects could have serious liability implications for the doctor and the hospital.

Furthermore, the hospital had a surgery team and room sitting idle because a patient was scheduled for a procedure that he did not want. In this case, the cost of providing a trained interpreter would have been significantly less than the costs that the hospital incurred from this.

Think About It

- How would you feel if this happened to you or a family member?
- Could this happen at your organization?
- Does your workplace offer communication assistance?

Source: HHS, 2022

Health Literacy

Health literacy means a person can obtain, process, and understand basic health information and services needed to make appropriate health decisions. Research by the Institute of Medicine (IOM) indicated that over 90 million people residing in the U.S. have difficulty understanding and acting on health information (NCCC, Nd).

The IOM study shifted the view of health literacy as solely the domain of the patient to include the ability of healthcare professionals and the capacity of healthcare systems to provide health information. To improve health literacy, healthcare organizations must remove systemic barriers when communicating health information to patients and the community and understand the broader socio-cultural contexts in which health literacy is experienced (NCCC, Nd).

Healthcare media must consider how racism and other forms of discrimination unfairly disadvantage certain groups and lead to social and health inequities. Implying that an individual or community is responsible for increased risk of adverse outcomes is counterproductive. Some members of disproportionately affected groups cannot follow public health recommendations due to inequitable resource allocation or a lack of inclusive infrastructure (CDC, 2021, August 24).

Developing Public Health Communications

When developing public health communications, avoid jargon and use straightforward, easy to understand language. Hire people from the communities you serve and work with community partners to identify priorities and strategies (CDC, 2021, December 9).

Avoid using images of people in traditional or cultural dress or images that reinforce inequalities in status, such as a person of color with a White doctor. Do not display caricatures of any racial or ethnic minority group or displaying images that perpetuate unhealthy body images. (CDC, 2021, December 9).

Consider the gender, ability, and race or ethnicity of the people in the images used in communications. Gender representation should be diverse. Include people with visible disabilities in any communication, not just those focused on ability status (CDC, 2021, December 9).

Language Assessment

Assessing an individual's language needs is an essential first step toward ensuring effective healthcare communication. More than half of those who speak another language at home speak English very well but asking about a person's preferred language provides a window into their health beliefs and practices. Having this information for each patient ensures the quality of services in subsequent encounters, in analysis of healthcare disparities, and in system-level planning (e.g., determining the need for interpreters and matching patients to language-concordant providers) (AHRQ, 2018).

Understanding the languages spoken most frequently in the service area is important as well. A single list may not be enough because the most common non-English languages vary greatly from area to area. For instance, Spanish is in the top ten languages in nearly all U.S. counties, while Turkish is in the top ten in 12 U.S. counties, Laotian in 125, Navaho in 74, Serbo-Croatian in 58, and Portuguese in 229 (AHRQ, 2018).

Case: Katherine and Her Mother in Spain

My mother came to visit me when I studied abroad in Spain. One rainy day while we were sightseeing, she slipped on some marble steps and fell to the ground, hitting her head. She was in pain and seemed disoriented, so I decided we should go to the hospital.

While we were waiting to be seen by the doctor, I was so scared. I had asked the women at the front desk if there was anyone who spoke English, but they said no. Even though I had been studying in Spain for several months, I hadn’t learned anything about medical issues and felt uncomfortable speaking in Spanish with the staff. As I waited for her name to be called, I kept looking up medical terms in Spanish on my phone and writing them down in case I needed them. I was afraid my mother had a concussion from hitting her head during the fall. Knowing that any errors I made in Spanish could possibly affect the doctor's decisions really upset me.

During the consultation, I was the mediator between my mother and anyone who came into the examination room. I could tell my mother was frustrated and worried by her inability to communicate with anyone, and I was afraid that I wasn't using the correct terms to describe what happened to her with the medical staff.

The doctor mentioned something about medical tests and medications she would prescribe, and so we're waiting in the intake room again with all the other patients. How can I be sure they correctly understand what happened? I'm not sure what's going to happen next. My mother is so important to me. I just want to be sure she is healthy and that there were no complications.

Think About It

- How would you feel if this happened to you?
- Do you think someone could have a similar experience when seeking care at your organization? If so, who would that person be?
- What would happen if someone with language assistance needs entered your organization today?
- Would their story sound like Katherine and her mother's? (HHS, 2022)

6. Historical Consequences of Implicit Bias

> If you find race-specific medicine surprising, wait until you learn that many doctors in the United States still use an updated version of a diagnostic tool that was developed by a physician during the slavery era, a diagnostic tool that is tightly linked to justifications for slavery.
>
> Dorothy Roberts
>
> University of Pennsylvania

Historical and structural inequalities are closely tied to bias. Historical power imbalances have had profound consequences on certain racial and ethnic groups: early deaths, unnecessary disabilities, and enduring injustices and inequalities (Global Health 50/50, 2020).

What is Colonial Medicine?

Colonial medicine has been a critical element of colonialism. It has historically focused on protecting European health, maintaining military superiority, and supporting extractive industries*. Colonial medicine emphasized malaria, yellow fever, sleeping sickness, and other specific diseases, focusing on bacteriological approaches to disease control (Global Health 50/50, 2020).

***Extractive industries**: companies and activities involved in the removal of resources for processing and sale such as oil, sand, rock, gravel, metals, minerals, and other material.

While colonial physicians and scientists made substantial contributions to medicine, they worked almost entirely on health issues that were unique to the colonies. In doing so, they established a focus on infectious diseases exclusive to the colonies—an interest that has been inherited by global health today (Global Health 50/50, 2020).

Anti-cholera vaccination, Calcutta, 1895. Wellcome Collection. Public domain.

In the colonial and post-colonial periods, European and American special interest groups have followed this pattern, using their leverage to shape a continuing focus on diseases through, for example, public-private partnerships for drug development. Virtually all major pharmaceutical manufacturers either produced or have evolved from firms that supplied medicines to sustain colonialism (Global Health 50/50, 2020).

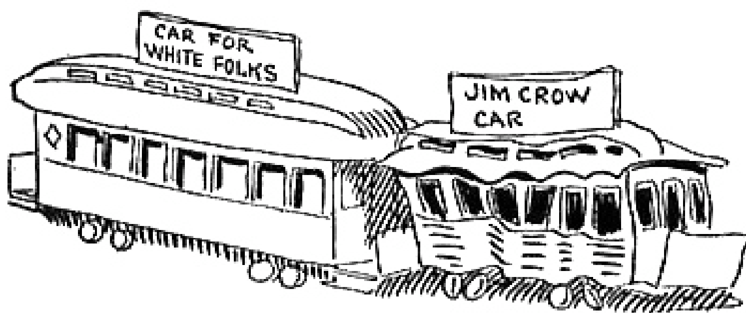
The Development of the U.S. Healthcare System

The U.S. healthcare system began to be developed in the mid-1800s, partly due to the impact of the Civil War. With the end of slavery and the onset of the Jim Crow era*, racism implicitly and explicitly became a part of the structuring and financing of the U.S. healthcare system (Yearby, Clark, & Figueroa, 2022). Despite Jim Crow's legal pretense that the races be "separate but equal" under the law, non-whites were given inferior facilities and treatment.

***Jim Crow era**: Statutes and ordinances established in 1874 to separate the White and Black races in the American South. Hospitals, and orphanages, and prisons were segregated as were schools and colleges.

Jim Crow had a tremendous impact of the structure and functioning of the U.S. healthcare system. For more than a century following the Civil War, non-white people experienced a lack of services, discrimination, and the adverse effects of a healthcare system that provided inferior healthcare to minorities, people of color, and Indigenous people.

Separate but equal became the law in 1896, when the Supreme Court ruled in *Plessy v. Ferguson* that state segregation laws for public facilities were legal. In practice, the services and facilities for Blacks and other minorities were consistently inferior, underfunded, and more inconvenient as compared to those offered to Whites—or did not exist at all. And while segregation was literal law in the South, it was also practiced in the northern United States via housing patterns enforced by private covenants, bank lending practices, and job discrimination, including discriminatory labor union practices (Howard University, 2018).



1904 caricature of "White" and "Jim Crow" rail cars by John T. McCutcheon. Source: Wikipedia. Public domain.

The *National Labor Relations Act of 1935* expanded rights for workers, resulting in higher wages, benefits, and health insurance for those represented by unions. The Act did not apply to service, domestic, and agricultural workers, and it allowed unions to discriminate against racial and ethnic minorities employed in industries such as manufacturing. These workers were more likely to be relegated to low-wage jobs that failed to provide health insurance (Yearby, Clark, & Figueroa, 2022).

In the mid-1940s, the federal government began to fund construction of public hospitals and long-term care facilities. Although the funding included a mandate that healthcare facilities be made available to all without consideration of race, it allowed states to construct racially separate and unequal facilities (Yearby, Clark, & Figueroa, 2022).

In 1960, federal programs such as the *Medical Assistance for the Aged* program (Kerr-Mills), extended medical benefits to a new category of "medically indigent" adults aged 65 or over. Eligibility and benefit levels were left largely to the States, meaning the poorer the state, the poorer the program. By linking medical assistance for the aged with public assistance, Kerr-Mills inadvertently created a program associated with social stigma and institutional biases. Nevertheless, Kerr-Mills served as an important precursor to Medicaid.

The Impact of Slavery

> The systemic discrimination that has impacted Black health dates to the first ships carrying enslaved Africans across the Atlantic. The colonial narrative of hierarchy and supremacy exists to this day, and has translated, centuries later, into gaping health disparities.
>
> Meghana Keshavan, *STAT Health*, June 9, 2020

It has been many years since the abolition of slavery, yet its legacy remains. Social injustices related to historical trauma, institutional racism, and structural inequities continue to negatively impact the health of many low income and minority communities. These mechanisms contribute to high disease burdens, difficulties accessing healthcare, and a lack of trust in the healthcare system (Culhane-Pera et al., 2021).

In American medical research, there has been a long history of unethical treatment of Black research subjects. Cases of medical malfeasance and malevolence have persisted, even after the establishment of the Nuremburg code* (Jones, 2021).

***Nuremburg code**: A set of medical ethical principles developed after World War II and subsequent trials for crimes against humanity.

Medical ethicist Harriet A. Washington details some of the most egregious examples in her book “Medical Apartheid.” In the notorious *Tuskegee Study of Untreated Syphilis in the Negro Male*, the government misled Black male patients to believe they were receiving treatment for syphilis when, in fact, they were not. That study went on for a total of 40 years, continuing even after a cure for syphilis was developed in the 1940s (Jones, 2021).

Group of men who were test subjects in the Tuskegee Syphilis Experiments. Source: Wikimedia. Public domain.

Perhaps less widely known are the unethical and unjustified experiments J. Marion Sims performed on enslaved women in the United States. in the 1800s, the experiments earned Sims the nickname the “father of modern gynecology.” Sims performed experimental surgery on enslaved women without anesthesia or even the basic standard of care typical for the time. Historian Deirdre Cooper Owens elaborates on this case and many other ways Black women’s bodies have been used as guinea pigs in her book “Medical Bondage” (Jones, 2021).

> **J. Marion Sims experimented on Anarcha, a 17-year-old slave, over 30 times. His decision not to give anesthesia was based on the racist assumption that Black people experience less pain than their white peers—a belief that persists among some medical professionals today (Jones, 2021).**

Impact of Colonization and Slavery on Indigenous People of the Americas

> Early travelers to the American West encountered unfree people nearly everywhere they went—on ranches and farmsteads, in mines and private homes, and even on the open market, bartered like any other tradeable good. Unlike on southern plantations, these men, women, and children weren't primarily African American; most were Native American. Tens of thousands of Indigenous people labored in bondage across the western United States in the mid-19th century.
>
> Kevin Waite
>
> The Atlantic, November 25, 2021

When European explorers arrived in the Americas in the late 1400s, they introduced diseases for which the Indigenous peoples had little or no immunity. The impact was rapid and deadly for people living along the coast of New England and in the Great Lakes regions. In the early 1600s, smallpox alone (sometimes intentionally introduced) killed as many as 75% the Huron and Iroquois people.

The impact of colonization on the health of Indigenous peoples has been atrocious. It has led to loss of cultural practices, language, traditional medicines, and ways of knowing and being. With forced assimilation, health inequities grew while traditional healing practices were forcibly replaced by "patriarchal healthcare systems" (Coen-Sanchez et al., 2022).

The exploitation and loss of tribal lands reflects the lasting impact of historical racist policies. Indigenous Peoples have been exposed to racist reproductive policies, limited access to reproductive health services, and environmental contamination (Yellow Horse et al., 2020).

The Health Impact of Extractive Industries

Extractive industries have had a lasting impact on the health and well-being of Indigenous communities worldwide. Even during normal operations of mining and energy projects, community health is often a concern. During the COVID pandemic, conflicts over the implications of extractive industries for community health intensified. The physical and mental health implications of environmental contamination, potential new diseases acquired from transient workers, disruptions to community relationships, and changes to local lifestyles have become community concerns (Bernauer and Slowey, 2020).

Did You Know. . .

Historically, uranium extraction has significantly affected some Indigenous communities. There is substantial evidence that living near an abandoned uranium mine is associated with reproductive damage. The presence of abandoned uranium mines is not only associated with environmental contamination, but also closely related to structural inequalities such as a higher percentage of households without complete plumbing and access to safe water (Yellow Horse et al., 2020).

The Impact of COVID-19 on Native American Communities

The COVID-19 pandemic exposed disparities in Asian, Black, Latinx, and Indigenous communities related to policies and practices that resulted in members of these communities living in multigenerational households, having greater reliance on public transportation, and having more front-line occupations with higher risk of COVID-19 exposure (Diop et al., 2021).

COVID-19 case and death rates among Native Americans communities fluctuated through the course of the pandemic. Throughout the U.S., counties with higher population proportions of Native Americans had much higher death rates in May and June of 2021. Death rates tended to be lower after vaccine boosters became available (Bergmann et al., 2022).

Considering the role of racism in understanding how COVID-19 has disproportionately affected Indigenous communities is critically important, particularly structural factors such as lack of access to safe water for frequent hand washing and a shortage of personal protective equipment (Yellow Horse et al., 2020).

Although rates varied depending on which COVID-19 surge was occurring, American Indian, Alaska Native and Native Hawaiian persons had the highest incident cases and deaths per 100,000 population of any race/ethnicity in the United States. Throughout the country, Native Americans were more likely to be hospitalized and die than White patients. This remained true over every “surge” or sharp increase in cases (Bongiovanni et al., 2022).

San Francisco State University Associate Professor of Biology Wilfred Denetclaw, a Navajo man raised in the traditional Navajo way of life and teachings, shared the story of the Navajo Nation’s resilience during the pandemic. The Navajo government closed reservation borders during the height of the pandemic, instigated weekend curfews, and reached out to the University of California San Francisco and Health, Equity, Action, Leadership for health worker reinforcements.

When vaccines became available, Navajo president Jonathan Nez advocated strongly for vaccinations using Navajo culture to emphasize the importance of vaccination as a protective shield against COVID-19. The community took the message to heart and now vaccination rates are among the highest across the United States (Rajan, 2022).

> At the start of the pandemic, the Navajo Nation had the highest COVID-19 infection rate anywhere in the United States. Intergenerational trauma, social isolation, lack of transportation, crowded multigenerational households, shortages in funding and supplies, widespread poverty, and an overworked healthcare workforce contributed to this disparity.
>
> Now, the Navajo Nation is one of the safest places in America, due to its emphasis on collective responsibility, high vaccination rates, and public health measures. According to Jonathan Nez, Navajo Nation president, "While the rest of the country were saying no to masks, no to staying home, and saying you're taking away my freedoms, here on Navajo, it wasn't about us individually," he said. "It was about protecting our families, our communities and our nation."
>
> Rachel Cohen, How the Navajo Nation Beat Back COVID
>
> The Nation, January 14, 2022

7. Research on Implicit Bias in Access and Delivery of Healthcare

Research looks at how biases can arise in information processing, decision-making, and behavior in ways that are reinforced by historical, cultural, institutional, and interpersonal factors. Interventions consider the importance of the broader social context and address forces that contribute to inequities (Elek and Miller, 2021).

The *All of Us* Research Program is a national effort to accelerate health research by exploring the relationship between lifestyle, environment, and genetics. The goal is to build a national database from at least one million participants (Mapes et al., 2020).

All of Us has formally designated the following groups as historically underrepresented:

- Those who have inadequate access to medical care.
- People under the age of 18 or over 65.
- People with an annual household income at or below 200% of the federal poverty level.
- People with cognitive or physical disabilities.
- Those with less than a high school education or equivalent.
- Members of a sexual or gender minority or are intersex.
- People living in rural or non-metropolitan areas (Mapes et al., 2020).

The *UNITE* initiative was established by the *National Institutes of Health* to identify and address structural racism within the scientific community. UNITE aims to establish an equitable and civil culture within the biomedical research enterprise and reduce barriers to racial equity in the biomedical research workforce. To reach this goal, UNITE identifies opportunities, makes recommendations, and develops and implements strategies to increase inclusivity and diversity in science. (NIH, 2022, March 2).

Measuring Implicit Bias

Measures of implicit bias rely on the assumption that automatic associations between two concepts will influence behavior in a measurable way (e.g., reaction time, sweat). Two of the most common implicit measures are (1) the *Implicit Association Test* (IAT) and (2) *sequential priming procedures* (Elek and Miller, 2021).

The Implicit Association Test

Implicit bias, which can influence provider communication patterns and clinical decision-making is often measured with the *Implicit Association Test* (IAT), a publicly available response latency test that pairs images and value-laden words (Gonzalez et al., 2021).

The IAT is primarily used in research studies but is often used in educational settings as an interactive exercise intended to illustrate implicit bias. A variety of IATs (e.g., on gender, sexuality, race, religion, weight, skin tone, age, disability, and more) are available for free from Harvard's *Project Implicit* (Elek and Miller, 2021).

Project Implicit: Identifying Bias

Project Implicit has developed a series of Implicit Association Tests that are designed to measure attitudes and beliefs that people may be unwilling or unable to report.

IATs are designed to measure associations that either reinforce or contradict your conscious beliefs. An IAT may suggest that you have implicit associations based on race, religion, sexual orientation, age, disability, or other criteria. IATs can be a useful tool in identifying potential biases, attitudes, and associations, but these tests alone should not be expected to overcome the impact of biases of the test taker.

How do IATs Work?

The IAT measures the strength of associations between concepts (e.g. African American people, gay people) and evaluations (e.g. good, bad) or stereotypes (e.g. athletic, clumsy). When performing an IAT, you are asked to quickly sort words into categories that are on the left- and right-hand side of the computer screen by pressing different keys.

A person is said to have an implicit preference for thin people, for example, if the person is faster to respond when the word "thin" is connected to "good" words, such as "happy" or "wonderful," rather than "bad" words, such as "painful" or "terrible."

What Should I Know Before Taking the IAT?

Project Implicit recommends that IATs should be used as an educational tool to develop awareness of implicit preferences and stereotypes, not as a tool for making judgments, such as whether to hire a person. However, research has shown that individuals who are made aware of their implicit biases may be motivated to avoid letting the biases affect their behaviors.

Source: DOJ, Nd

Sequential Priming Procedures

Sequential priming procedures are based on evidence demonstrating that when two concepts are associated in a person's memory, the presentation of one of those concepts facilitates the recall or recognition of the other. For example, when people are presented with one concept (e.g., a picture of an apple), they are faster at identifying the next concept (e.g., a picture of a banana) when they associate the two concepts in memory (e.g., as fruits). Priming procedures work even if the primes are flashed on a screen so quickly that they are not consciously detected by the respondent (Elek and Miller, 2021).

In one common use of this tool, respondents are briefly presented with a Black or White face immediately before a positive or negative target word appears on the screen. They must then identify, as quickly as possible, the meaning of the presented word as "good" or "bad." Respondents with racial bias more quickly identify negative words as "bad" and more slowly identify positive words as "good" when that word appears immediately after the presentation of a Black face (Elek and Miller, 2021).

Bias Questionnaires

A simple questionnaire can be used to assess individual biases (NCCC, Nd).

<table>
<tr><td>Do my biases:</td><td>1. Impact the amount of time I spend with patients?
____ Yes ____ No
2. Influence how I communicate with patients and their families?
____ Yes ____ No
3. Hamper my capacity to feel and express empathy toward my patients?
____ Yes ____ No
4. Affect the types of treatment and medications I recommend?
____ Yes ____ No
5. Interfere with my capacity to interact positively with my patients and their families?
____ Yes ____ No</td></tr>
<tr><td colspan="2">Do you ever perceive that you are less comfortable with patients who are of a different race than you? ____ Yes ____ No</td></tr>
<tr><td colspan="2">Do you know whether (or believe that) your colleagues and other staff with whom you routinely work think that your attitudes and behaviors demonstrate bias? If so, are you open to discussing these issues with them to elicit their point of view? ____ Yes ____ No</td></tr>
<tr><td colspan="2">Have patients or their families, directly or through surveys, raised concern about your attitude or the way you communicate with them? ____ Yes ____ No</td></tr>
</table>

Answering yes to any of these questions indicates that you could benefit from interventions to confront and mitigate the impact of bias within your practice setting.

8. Programs to Reduce Disparities

Since the concept of implicit bias was first introduced in 1995, it has permeated almost all aspects of equity, diversity, and inclusion training programs (Sukhera, 2020). These programs often focus on individual healthcare providers, but because of long-standing systemic health inequities, bias training directed toward an individual is only one part of a program to address disparities. Addressing the challenges and complexities associated with a rapidly changing healthcare system is an important part of an overall strategy to reduce bias.

Improving Attitudes, Reducing Disparities

Training to reduce implicit bias should provide concrete strategies that focus on improving provider communication, particularly non-verbal skills (Dirks et., 2022). When people are exposed to or are invited to think about traits or behaviors that counter their stereotypes, they became less prejudicial toward that social group. Equality of status, social and institutional support, pleasant contact, and intergroup cooperation often produce positive results (Brusa et al., 2021).

A Multipronged Approach

Sustaining the effects of bias training requires changes in policy and visible support of organizational leaders. Rather than focusing exclusively on training others, leaders must consider their own approaches to equity and diversity. Leaders who model a more inclusive approach and integrate bias training with other initiatives to enhance inclusion and belonging within their organization are more successful than those who rely on training alone (Sukhera, 2020).

Bias training is most effective when the approach is multipronged, when people work and train together, and when it is designed with context and professional identity in mind. Training in teams helps individuals feel comfortable sharing their biases and accepting their vulnerabilities. Training that enhances collaboration and openness reinforces behavioral change (Sukhera, 2020).

Applying a Health Equity Lens

Despite efforts at the federal, regional, state, and local levels, health disparities persist. Researchers continue to examine how policies, both historic and contemporary, perpetuate these disparities (Douglas et al., 2019).

Applying a "health equity lens" means intentionally looking at the potential positive and negative impacts of training materials and policies. This means communication planning, development, and dissemination must be inclusive and avoid bias and stigmatization.

When applying a health equity lens:

- Identify the health equity issue and affected population.
- Analyze the policy impacts and opportunities for improvement.
- Develop research strategies in partnership with community stakeholders.
- Evaluate policy outcomes and their impact on heath disparities.
- Disseminate findings to stakeholders, including policy makers, communities, public health officials, and healthcare providers.

(Douglas et al., 2019)

Applying a health equity lens to media can influence attitudes towards members of different social groups. Media can reinforce prejudices and stereotypes but can also raise awareness and influence attitudes. A number of studies have shown that implicit racial stereotypes are decreased when people are exposed to news stories countering those stereotypes (Brusa et al., 2021).

Source: University of Michigan, used with permission.

The Michigan Health Equity Project

In Michigan, the Centers for Medicare & Medicaid Services has provided funding for the *Health Equity Project* in five Michigan counties (Washtenaw, Genesee, Jackson, Kent, and Livingston). The *Health Equity Project* helps these counties reduce health disparities associated with social needs such as housing instability, food insecurity, transportation, health system complexity, and other socioeconomic factors (U of M, 2021).

The Health Equity Project:

- supports efforts to connect people from historically disadvantaged populations to needed social services,
- shares data between relevant health and social service providers to facilitate improved care,
- provides population-based data to analysts, stakeholders, and policymakers, and
- engages with, and reflects on, the views of community members with lived experience (U of M, 2021).

Michigan Social Health Interventions to Eliminate Disparities (MSHIELD)

> In traditional health care systems, we go to the doctor when we're sick; if we have a chronic condition, we get treatment for that. But, for me, when we talk about healthcare, we have to talk about education, employment, quality of housing, the food people have access to—all of those are health issues, too.
>
> Kirk Smith, President, CEO of the Greater Flint Health Coalition

The *MSHIELD* program seeks to eliminate healthcare disparities by working with existing community programs in four Michigan geographic regions* to address the needs of high-risk medical and surgical patients. The program employs community health workers and care managers to help patients navigate complex healthcare and social services systems (MSHIELD, 2022).

*Kent County's Health Net of West Michigan, Jackson Care Hub, Livingston and Washtenaw Counties' Michigan Community Care, Genesee Community Health Access Program.

Evidence shows that interventions focusing on social determinants of health lead to better health outcomes and lower costs. This *MSHIELD* program tries to identify patients with unmet social needs who are at high risk for receiving costly, low-value care. Failure to address unmet social needs directly contributes to health inequities and low-value care (MSHIELD, 2022).

9. Concluding Remarks

Implicit bias, lack of cultural competency, structural racism, and intentional historical discriminatory policies have affected equal access to healthcare for many groups of people in the United States. Until recently, many of us have been unaware of the attitudes and prejudices that have created these barriers and disparities.

The COVID pandemic brought healthcare inequities into sharp focus as illness and deaths rapidly mounted in minority communities, nursing homes, rural communities, Indigenous communities, and among frontline workers, disproportionately represented by women, minorities, and people of color.

As the population of the United States becomes more and more diverse, the need for culturally competent training has increased. The importance of workforce diversity within the healthcare system has become an imperative.

From a practical standpoint, implicit bias and lack of cultural competence affect outcomes and cost money. Eliminating health disparities will save billions of dollars by reducing healthcare costs, improving productivity, and saving lives.

Research has shown that addressing implicit bias and improving cultural competency is possible. Understanding the effects of colonial medicine, slavery, and Jim Crow provides a basis for examining structural issues that have been slow to change. Using a multipronged approach that targets individuals and institutions can improve attitudes and reduce disparities in the delivery of services.

In Michigan, several counties have implemented programs that connect people from historically disadvantaged populations to needed social services. The *MSHIELD* program seeks to eliminate healthcare disparities by working with existing community programs in four Michigan geographic regions to address the needs of high-risk medical and surgical patients. The program employs community health workers and care managers to help patients navigate complex healthcare and social services systems.

Through individual training and institutional change, Michigan is moving forward in its effort to address implicit bias in healthcare and improve access and outcomes for historically disadvantaged groups within the state.

[Continue to next page for references]

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[Continue to next page to start quiz]

Quiz: Michigan: Implicit Bias

1. **Implicit bias is a conscious process based on *intentional* mental associations.**
   A. True
   B. False

2. **Health equity means that everyone has a fair and just opportunity to be as healthy as possible.**
   A. True
   B. False

3. **Social determinants of health are:**
   A. Do not significantly affect a person's health or quality-of-life.
   B. Are conditions in the environment that affect a person's health, functioning, and quality-of-life.
   C. In the U.S., are not generally responsible for health disparities.
   D. Are related to income but not to other factors such as education or health access.

4. **Historically embedded structural racism is a fundamental cause of health inequities in the United States.**
   A. True
   B. False

5. **Despite most people of color having a full-time worker in the family, they are often employed in low-wage jobs that are less likely to offer health insurance.**
   A. True
   B. False

6. **Exposure to physical and sexual violence in childhood and adulthood can a profound and prolonged impact on a woman's health, including cardiovascular, autoimmune, metabolic diseases, and chronic pain issues.**
   A. True
   B. False

7. Reducing pregnancy-related discrepancies in Black and American Indian/Alaska Native women can be accomplished by:

A. Identifying and addressing implicit bias and structural racism in healthcare and community settings.

B. Engaging communities in prevention efforts.

C. Supporting community-based programs that build social support and resiliency

D. All of the above.

8. Diversity in the medial workforce is important because:

A. A racially and ethnically diverse healthcare workforce provides better access and care for underserved populations.

B. Black and Hispanic physicians are more likely to care for underserved populations.

C. Physician diversity has been linked to better patient outcomes in primary care.

D. All of the above.

9. Factors such as lack of diversity, equity, and inclusion; White supremacy and saviorism; colonialism, racism, and patriarchy; and the "foreign gaze" impact healthcare providers throughout the world.

A. True

B. False

10. Diversity, equity, and inclusion means:

A. Everyone is invited to the party.

B. Everyone gets to contribute to the playlist.

C. Everyone has the opportunity to dance.

D. All of the above.

11. The *Affordable Care Act* Medicaid expansion is linked to increased access to care, improvements in some health outcomes, and reductions in racial disparities in health coverage.

A. True

B. False

12. Cultural sensitivity is a respect for another person's strengths, culture, and knowledge.

A. True

B. False

13. A type of unconscious bias that occurs when our perception is skewed based on inaccurate and overly simplistic assumptions about a group or person is called perception bias.

A. True

B. False

14. Studies have shown that implicit racial bias rarely influences clinical decision-making.

A. True

B. False

15. The adverse impact on patients with limited English proficiency, when interpretation and translation services are not provided, can include:

A. Incomplete and inaccurate health history.

B. Misdiagnoses of health and mental health conditions.

C. Misuse of medications.

D. All of the above.

16. Colonial medicine focused on:

A. Protecting European health.

B. Maintaining military superiority.

C. Supporting extractive industries.

D. All of the above.

17. Social injustices impact the health of many low income and minority communities, contributing to high disease burdens, difficulties accessing healthcare, and a lack of trust in the healthcare system.

A. True

B. False

18. The impact of colonization on the health of Indigenous peoples has led to loss of cultural practices, language, traditional medicines, and ways of knowing and being.

A. True

B. False

19. Implicit association tests measure the strength of associations between concepts and evaluations or stereotypes.

A. True

B. False

20. Prejudices and hostilities are reduced when members of different groups have contact with one another.

A. True

B. False

21. Bias training has been shown to be more effective when the approach is multipronged, designed with context and professional identity in mind, and when people work and train together.

A. True

B. False

22. Applying a health equity lens means:

A. Thinking about your own personal attitudes about health equity.

B. Encouraging your staff to read about implicit bias.

C. Intentionally looking at the potential positive and negative impacts of proposed messages, training materials, and policies.

D. Turning off TVs in waiting rooms so patients are not exposed to negative racial stereotypes.

23. Evidence shows that interventions focusing on social determinants of health rarely lead to better health outcomes.

A. True

B. False

[Continue to next page for answer sheet]

Answer Sheet: Michigan: Implicit Bias, 3 units

Name (Please print) ______________________________

Date ______________________________

Passing score is 80%

1. ________	12. ________
2. ________	13. ________
3. ________	14. ________
4. ________	15. ________
5. ________	16. ________
6. ________	17. ________
7. ________	18. ________
8. ________	19. ________
9. ________	20. ________
10. ________	21. ________
11. ________	22. ________
	23. ________

[Continue to next page for course evaluation]

Evaluation: Michigan: Implicit Bias

Please use this scale for your course evaluation. Items with asterisks * are required.

1 = Strongly agree 2 = Agree 3 = Neutral 4 = Disagree 5 = Strongly disagree

*Upon completion of the course, I was able to:

1. Define implicit and explicit bias.	1 2 3 4 5
2. List 4 barriers or discrepancies in the access to healthcare in the United States.	1 2 3 4 5
3. Describe 3 reasons why a diverse healthcare workforce is important.	1 2 3 4 5
4. Contrast cultural sensitivity with cultural competence.	1 2 3 4 5
5. Relate 3 fallacies or beliefs that may indicate cognitive bias in healthcare professionals.	1 2 3 4 5
6. Relate 5 ways in which the historical impact of slavery and colonization has promoted implicit bias.	1 2 3 4 5
7. Explain 2 common tools used to measure implicit bias.	1 2 3 4 5
8. Describe 2 programs in Michigan whose goal is to improve health equity.	1 2 3 4 5
*The author(s) are knowledgeable about the subject matter.	1 2 3 4 5
*The author(s) cited evidence that supported the material presented.	1 2 3 4 5
*Did this course contain discriminatory or prejudicial language?	Yes No
*Was this course free of commercial bias and product promotion?	Yes No
*As a result of what you have learned, will make any changes in your practice?	Yes No

If you answered Yes above, what changes do you intend to make? If you answered No, please explain why.

*Do you intend to return to ATrain for your ongoing CE needs?

_____Yes, within the next 30 days. _____Yes, during my next renewal cycle.

_____Maybe, not sure. _____No, I only needed this one course.

*Would you recommend ATrain Education to a friend, co-worker, or colleague?

_____Yes, definitely. _____Possibly. _____No, not at this time.

*What is your overall satisfaction with this learning activity? 1 2 3 4 5

*Navigating the ATrain Education website was:

_____Easy. _____Somewhat easy. _____Not at all easy.

*How long did it take you to complete this course, posttest, and course evaluation?

_____60 minutes (or more) per contact hour _____59 minutes per contact hour

_____40-49 minutes per contact hour _____30-39 minutes per contact hour

_____Less than 30 minutes per contact hour

I heard about ATrain Education from:

_____Government or Dept of Health website. _____State board or professional association.

_____Searching the Internet. _____A friend.

_____An advertisement. _____I am a returning customer.

_____My employer. _____Social Media

_____Other_______________________________________

Please let us know your age group to help us meet your professional needs

_____18 to 30 _____31 to 45 _____46+

I completed this course on:

_____My own or a friend's computer. _____A computer at work.

_____A library computer. _____A tablet.

_____A cellphone. _____A paper copy of the course.

Please enter your comments or suggestions here:

[Continue to next page for registration and payment form]

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*Card number: ____

*CVS#: _____________ *Expiration date: ____________________