JONISHA BROWN, MD, MPH, AND REBECCA BEESLEY, MD, MPH

It's Time: Six Steps to Creating an Anti-Racist Clinic

Health care professionals can perpetuate racial disparities even without intending to. These evidence-based strategies can put clinics on a solid path to change.

© ISTOCK.COM / FATCAMERA

Tragic events in recent years, including the very public murder of George Floyd coupled with the COVID-19 pandemic's disproportionate effects on communities of color,[1,2] have spurred a renewed national focus on racial disparities and an urgency to address the problem.

Many health care organizations are examining systemic issues — deeply established practices, policies, beliefs, or attitudes — that may contribute to racism and health disparities even without the awareness or intent of individuals operating within the system.[3] For example, cancer is more often fatal for Black patients, which may be related to delays in diagnosis due to inequities in insurance coverage, poorer access to quality medical care in certain locations, or higher

ABOUT THE AUTHORS

Dr. Brown is an assistant professor in the Department of Family Medicine at Atrium Health in Charlotte, N.C. Dr. Beesley is an assistant professor in the Department of Family Medicine at Atrium Health and medical director of Elizabeth Family Medicine in Charlotte. The authors would like to thank Keyona Oni, MD, Kenny Lin, MD, MPH, and Hazel Tapp, PhD, for their assistance with this manuscript. Author disclosures: no relevant financial relationships.

rates of comorbidities, as well as differential clinical treatment.[4]

The American Medical Association and the American Academy of Family Physicians have created strategic plans to address structural racism within medicine.[5,6] At the same time, these issues must be actively addressed at the individual clinic level for adequate, equitable care to be attainable for all. While solutions to long-running societal problems are complex, current research provides a wealth of ideas for addressing racial discrimination in health care and fostering long-term changes.[7] Here are six evidence-based steps clinics can take.

Clinics should strive to hire employees who share the cultural similarities and languages of their patient population.

1. DIVERSIFY THE WORKFORCE AND LEADERSHIP

Patient outcomes improve when members of the health care team look like the patients they serve.[8] Increased diversity in all positions is critical to the patient experience, so clinics should strive to hire employees who share the cultural similarities and languages of their patient population. Recruiting broadly within the community to capture regional diversity can help with this.

If possible, create diverse committees to recruit and hire.[9] Monitor diversity within executive leadership positions to avoid uneven distribution of power. Racial inequity in the upper level of an organization's workforce could be seen as hypocritical and inhibit anti-racist work,[10] while racial diversity within leadership can amplify the voices of historically marginalized staff, patients, and communities and build trust.[7,9]

2. SHARE POWER WITH PATIENTS

This can be both operational and clinical. On the operational side, consider creating a patient advisory board, a committee of patients from your clinic who represent the population you serve. This can help ensure that clinic decisions are more meaningful to your patients and interventions are appropriately tailored to their communities. Give the board clear objectives with some real power (e.g., the ability to approve or disapprove decisions) to maintain integrity.

On the clinical side, employ shared decision making, a strategy that emphasizes a patient's choice and ability to decide what treatment plan works best for them.[11] When presenting recommended preventive care guidelines, let the patient decide the order in which needed services are completed. And solicit feedback from patients and follow up on information given.

By supporting the patient's choice, you can make the doctor-patient relationship less paternalistic and build trust with patients who might initially be skeptical due to historical mistreatment of minorities in health care.[12]

3. SEE EACH PATIENT AS AN INDIVIDUAL

Building trust between clinicians and patients has been shown to improve patient self-efficacy, adherence to therapeutic regimens, and ultimately outcomes.[1] However, building trust and understanding can be more difficult when individuals do not share the same culture, in part because it makes implicit bias, or unconscious prejudice and stereotypes, more likely.

A key psychological tool clinicians can use to mitigate the effects of implicit bias is individuation. This is a cognitive strategy in which a person intentionally learns about and focuses on the individual attributes of another person during communication to begin from a more neutral, empathic foundation rooted in

KEY POINTS

- Systemic factors are at the root of many health disparities and can cause harm even if individuals working within the system don't intend to.
- Evidence-based strategies, such as establishing patient advisory boards that reflect the diversity of a practice's patients, can decrease racial disparities and improve health outcomes.
- Thinking critically about the use of race-based treatment algorithms and medical calculators is key because many are not founded in fundamental physiological differences.

commonalities that build rapport.[13] (See "Conversation starters to establish commonalities.") Seek opportunities to learn what makes your patient unique, and then share appropriate information about your life that your patient can relate to.

4. EDUCATE STAFF ON THE CAUSES OF HEALTH DISPARITIES

A lack of awareness among health care professionals of how health disparities are created increases their potential to worsen them. Physicians and staff, particularly those who work in underserved communities, can benefit from dedicated education about health care disparities and their multifactorial causes, including implicit bias, systemic racism, and social determinants of health.

Several resources can help. For example, the AAFP has created the EveryONE project,[14] which includes educational toolkits and CME to facilitate learning about health disparities and their causes (see "AAFP Resources"). Education about social determinants of health (education, income, pollution, housing, etc.) and the specific challenges at-risk patients face can equip health workers with the knowledge to improve patient outcomes and close the gap between different racial and ethnic minority groups.[15] Consider carving out dedicated time for employees to engage with these educational materials and to learn about your community's specific challenges and disparities.

5. REEVALUATE THE USE OF RACE-BASED ALGORITHMS AND TREATMENT CALCULATORS

Analyze the underlying assumptions of race-based algorithms and calculators before using them to inform clinical decision making. (See examples on page 26.) Many clinical recommendations based on race are not founded in fundamental physiological differences, but rather are crude proxies for social differences or evolutionary variation based on regional ancestry. Haphazardly using these tools can perpetuate health disparities by mistakenly guiding clinicians to offer certain treatment options to one patient but not another.[16]

Race "corrections" have been removed from some of these clinical tools, such as the risk calculator for vaginal birth after cesarean. But in others, they remain. It is important to not ignore race but to understand it is a social, not biological, construct and to challenge yourself when deciding to include it in clinical decision making. The authors of a 2019 editorial published in *JAMA* proposed the following standard: "Using race to guide clinical care is justified only if 1) the use confers substantial benefit; 2) the benefit cannot be achieved through other feasible approaches; 3) patients who reject race categorization are accommodated fairly; and 4) the use of race is transparent."[17]

6. ADVOCATE FOR BETTER METRICS

A new approach to health care focused on patient-centered goals and true value-based care could help close health care disparities. In theory, value-based care models should reward practices that produce better health outcomes for all patients, but many of these programs aren't measuring the right things.[18]

Efforts to reduce health disparities should be viewed as an integral part of improving clinical outcomes,

CONVERSATION STARTERS TO ESTABLISH COMMONALITIES

To establish commonalities based on familial roles/responsibilities or local residency:

- Who is important to you in your life?
- Who lives at home with you?
- How long have you lived in this city?

To establish commonalities based on personal interests:

- When you are not working, what do you enjoy doing?
- Are you a fan of (local sports team)?
- What restaurants around here do you like?

To establish commonalities based on daily routine:

- What do you do for a living?
- What keeps you busy during the day?

AAFP RESOURCES

- Cultural Sensitivity: The Importance of Cultural Sensitivity in Providing Effective Care for Diverse Populations - https://www.aafp.org/about/policies/all/cultural-proficiency-position-paper.html
- The EveryONE Project Implicit Bias Resources (training guide, customizable slides, patient videos) - https://www.aafp.org/family-physician/patient-care/the-everyone-project/toolkit/implicit-bias.html
- Anti-Racism: Tools for Change (online CME course): https://www.aafp.org/cme/all/health-equity/anti-racism.html
- Center for Diversity and Health Equity (including "The Complicated History of Medicine and Black/Brown Bodies" training video): https://www.aafp.org/family-physician/patient-care/the-everyone-project/aafp-center-for-diversity-and-health-equity.html

similar to preventive care or chronic care, and should be incentivized. Encourage health care leadership to use metrics that require a comparison of the quality of care between patients based on racial and ethnic demographics to ensure equitable care across the board.

A SUSTAINED APPROACH

The road to becoming an equitable, patient-centered practice for all should be seen as a continuum and not just another box to check. There will be many barriers and mistakes. Novel ways to measure outcomes and increase sustainability will be required, which will be challenging but also rewarding. Through the careful incorporation of the six steps described above, your clinic can begin a journey that will ultimately lead to improved health in your community, the elimination of health care disparities, and lower health care costs for all.[19] FPM

1. Prince ADP, Green AR, Brown DJ, et al. The clarion call of the COVID-19 pandemic: how medical education can mitigate racial and ethnic disparities. *Acad Med*. 2021;96(11):1518-1523.

2. Risk for COVID-19 infection, hospitalization, and death by race/ethnicity. Centers for Disease Control and Prevention. Updated May 25, 2023. Accessed June 13, 2023. https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html

3. Yearby R, Clark B, Figueroa JF. Structural racism in historical and modern U.S. health care policy. *Health Aff (Millwood)*. 2022;41(2):187-194.

4. Hill L, Ndugga N, Artiga S. Key data on health and health care by race and ethnicity. Kaiser Family Foundation. March 15, 2023. Accessed June 8, 2023. https://www.kff.org/racial-equity-and-health-policy/report/key-data-on-health-and-health-care-by-race-and-ethnicity/#HealthStatus

5. AMA releases plan dedicated to embedding racial justice and advancing health equity. American Medical Association. May 11, 2021. Accessed April 25, 2023. https://www.ama-assn.org/press-center/press-releases/ama-releases-plan-dedicated-embedding-racial-justice-and-advancing

6. Institutional racism in the health care system. American Academy of Family Physicians. 2019. Accessed April 25, 2023. https://www.aafp.org/about/policies/all/institutional-racism.html

7. Hassen N, Lofters A, Michael S, Mall A, Pinto AD, Rackal J. Implementing anti-racism interventions in healthcare settings: a scoping review. *Int J Environ Res Public Health*. 2021;18(6):2993.

8. Snyder JE, Upton RD, Hassett TC, Lee H, Nouri Z, Dill M. Black representation in the primary care physician workforce and its association with population life expectancy and mortality rates in the US. *JAMA Netw Open*. 2023;6(4):e236687.

9. Rosenkranz KM, Arora TK, Termuhlen PM, et al. Diversity, equity, and inclusion in medicine: why it matters and how do we achieve it? *J Surg Educ*. 2021;78(4):1058-1065.

10. Choo E. Seven things organisations should be doing to combat racism. *Lancet*. 2020;396(10245):157.

11. Holmes-Rovner M, Valade D, Orlowski C, Draus C, Nabozny-Valerio B, Keiser S. Implementing shared decision-making in routine practice: barriers and opportunities. *Health Expect*. 2000;3(3):182-191.

12. Washington HA. *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans From Colonial Times to the Present*. Doubleday; 2007.

13. Burgess D, van Ryn M, Dovidio J, Saha S. Reducing racial bias among health care providers: lessons from social-cognitive psychology. *J Gen Intern Med*. 2007;22(6):882-887.

14. The EveryONE Project. American Academy of Family Physicians. Accessed April 25, 2023. https://www.aafp.org/family-physician/patient-care/the-everyone-project.html

15. Healthy People 2030: Social Determinants of Health. U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Accessed April 26, 2023. https://health.gov/healthypeople/objectives-and-data/social-determinants-health

16. Vyas DA, Eisenstein LG, Jones DS. Hidden in plain sight — reconsidering the use of race correction in clinical algorithms. *N Engl J Med*. 2020;383(9):874-882.

17. Eneanya ND, Yang W, Reese PP. Reconsidering the consequences of using race to estimate kidney function. *JAMA*. 2019;322(2):113-114.

18. Garber J. Value-based care has an equity problem. Lown Institute. March 28, 2021. Accessed April 26, 2023. https://lowninstitute.org/value-based-care-has-an-equity-problem/

19. LaVeist TA, Gaskin DJ, Richard P. The economic burden of health inequalities in the United States. Joint Center for Political and Economic Studies; 2009.

EXAMPLES OF RACE-BASED ALGORITHMS AND CALCULATORS

Race "corrections" in these clinical algorithms and calculators should be scrutinized before use because they are not based on true biological differences and can exacerbate health disparities when used haphazardly.

- Eighth Joint National Committee (JNC-8) guidelines for managing hypertension
- Atherosclerotic cardiovascular disease (ASCVD) 10-year risk calculator
- Estimation of glomerular filtration rate
- Approved medications for heart failure
- Spirometry results

For more information, see Westby A, Okah E, Ricco J. Letters to the editor: race-based treatment decisions perpetuate structural racism. *Am Fam Physician*. 2020;102(3):136-137.

Send comments to **fpmedit@aafp.org,** or add your comments to the article online.