Systemic Racism in Healthcare

Sheryl L. Garland, MHA, FACHE,
Chief of Health Impact for VCU Health System
Jason Callahan, M.Div., MS, BCC,
Palliative Care Chaplain

Palliative Care Project ECHO | August 24, 2020

JA Accreditation & Credit Designation Statements – LIVE Activities

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1.00 ANCC contact hours

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This activity was planned by and for the healthcare team, and learners will receive **1.00 Interprofessional Continuing Education (IPCE)** credit for learning and change.

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The following Planning Committee and Presenting Faculty Members report having **no relevant financial relationships**:
Danielle Noreika, MD; Egidio Del Fabbro, MD; Diane Kane, LCSW; Tamara Orr, PhD, LCP, PMHNP-BC; Brian Cassel, PhD; Felicia Barner, RN; Candace Blades, JD, RN; Jason Callahan, M.Div.

No commercial or in-kind support was provided for this activity

Presenters: Sheryl L. Garland, MHA, FACHE, Jason Callahan, M.Div., MS, BCC (nothing to disclose)

Introductions

Our ECHO Team: Planning Committee

Clinical Leadership	Egidio Del Fabbro, MD VCU Palliative Care Chair and Program Director Danielle Noreika, MD, FACP, FAAHPM Medical Director/Fellowship Director VCU Palliative Care
Clinical Experts	Candace Blades, JD, RN – Advance Care Planning Coordinator Brian Cassel, PhD – Palliative Care Outcomes Research Jason Callahan, MDiv – Palliative Care Specialty Certified Felicia Hope Coley, RN – Nurse Navigator Diane Kane, LCSW – Palliative Care Specialty Certified Tamara Orr, PhD, LCP – Clinical Psychologist
Support Staff	Teri Dulong-Rae & Bhakti Dave, MPH – Program Managers David Collins, MHA – Telemedicine Practice Administrator Frank Green – IT Support

Introduction
Dr. Danielle Noreika

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THANK YOU SHERYL and JASON

- This is a foundational topic to our program and I have not given it the attention it deserves
- At any given time approximately 40-45% of the patients we care for here at VCU in the palliative care program are African American
- There are an incredible number of barriers to care that I was not aware of in the beginning of my practice and many more that I still don’t know or understand
- How do we build a better system of care for all of our patients?

Mr. M

- For those of you from VCU, this case is drawn from a number of patients I have cared for over the years and is not any particular patient. The biases reflected here are solely my own.

- 48 yom with metastatic pancreatic cancer, followed at VCU for the past 6 months after release from prison at diagnosis

- Has missed multiple outpatient appointments, my first encounter was third hospital admit which was for intractable pain

- Some escalated encounters during ED stay so security was sitting outside of the door during my first eval, “why should I talk to you it’s not like you’re going to give me pain medicine anyway”

Mr. M

- Short hospital stay, difficult to get to know patient as often were multiple family members around
- Pt without insurance, not employed, several different living arrangements, no transportation
- LNOK best we could tell would have been 2 sons in early 20’s, patient asked to think about who he would want to make decisions, someone left a Virginia Advance Directive form
- Reiterated importance of multiple oncology follow up appointments but never specifically discussed what the patient’s goals were

Mr. M

- Readmitted 2 weeks later with worsening pain, weight loss. CT scan with progression and new clots in multiple locations. Admitting provider focused great deal of time on patient's history with pain medications asking about running out early and multiple providers

- Substance abuse team was consulted which angered patient and several days spent working this out

- In the meantime patient began to decompensate, first time patient was asked about goals was during an RRT (no family present) and was taken to ICU

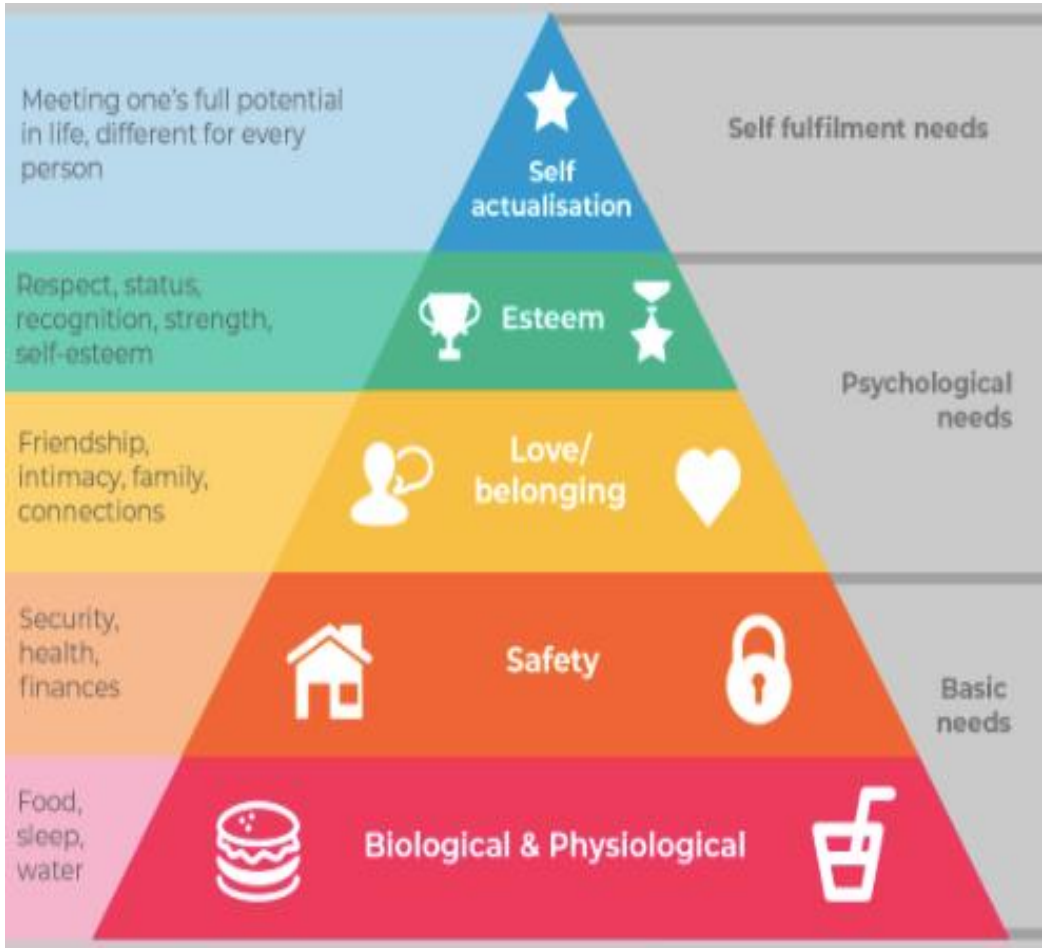
- One son did not come to the hospital answered the phone periodically, other did and did not want to discuss withdrawal of life prolonging measures despite worsening course. Mother and sisters at the bedside frequently

- Patient died in ICU almost 2 weeks later following unsuccessful code

Highlights of My Own Bias

"Non-compliance"

- Housing
- Transportation
- Help with physical care
- Access to healthy food
- Insurance
- Lack of phone/internet
- Navigating health system
- etc



Highlights of My Own Bias

- Pain assessment and treatment, on just about every level

shown). Pediatricians who reported that White patients rather than African American patients were generally more medically compliant were more likely to agree with prescribing a narcotic medication for pain for the White patient but not the African American patient. For the White patient, the measure

Sabin et al, *Am J Pub Health,* 2011.

Table 3

Estimated effect sizes using random effects model

Group	Outcome†	Number of Studies	Odds Ratio (95% Confidence Interval)	*P* Value	I^2 (*P Value*)
Blacks vs Whites	Prescription of "any" analgesia	17	0.77 (0.68–0.88)		0.000*
	Prescription of opioids†	15	0.70 (0.62–0.80)		0.000*
	Prescription of "non-opioids"	10	1.07 (0.80–1.43)		0.618

Meghani et al, *Pain Medicine,* 2012.

Highlights of My Own Bias

- Advance Care Planning

SECTION I: APPOINTMENT AND POWERS OF MY AGENT

(CROSS THROUGH THIS SECTION I IF YOU DO NOT WANT TO APPOINT AN AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU.)

A. Appointment of My Agent

I hereby appoint _____ _____
Name of Primary Agent E-mail Address

_____ _____
Home Address Telephone Number

as my agent to make health care decisions on my behalf as authorized in this document.

If the primary agent named above is not reasonably available or is unable or unwilling to act as my agent, then I appoint as successor agent to serve in that capacity:

_____ _____
Name of Successor Agent E-mail Address

_____ _____
Home Address Telephone Number

I grant to my agent full authority to make health care decisions on my behalf as described below. My agent shall have this authority whenever and for as long as I have been determined to be incapable of making an informed decision.

Third-order theme	*Quotations from participants in primary studies*
Trust and mistrust	**"As a black man, I am subject to receive less care and attention than a white man, and if I had a living will, they might not care for me at all."[66]** **"I want to get the best [medical] care out there, and I believe if doctors know what treatments we want, they will do all that they can to make sure we get it."[66]** **"For African Americans, a good, trusting family member or friend or a pastor is the way to go. These people are my contract for life-and-death options."[75]**

Sanders et al, *J Palliat Med,* 2016

ACP in African Americans with Advanced Cancer

ACP outcomes at 12 months	
Advance directive/living will in patient's chart	1 (4.6)
Medical power of attorney in patient's chart	8 (36.4)
Out-of-Hospital Do-Not-Resuscitate order in patient's chart	2 (9.1)
Patient seen in palliative care clinic	8 (36.4)
Patient referred to hospice	6 (27.2)
Died	12 (57.1)
Location of death if known	
Home	2 (13.3)
Hospital	10 (66.7)
Nursing home	0 (0)
Hospice	0 (0)
Median time to death from baseline assessment, days	79 (20-361)

Rhodes et al, *Am J Hosp Palliat Med,* 2019

VCU Health

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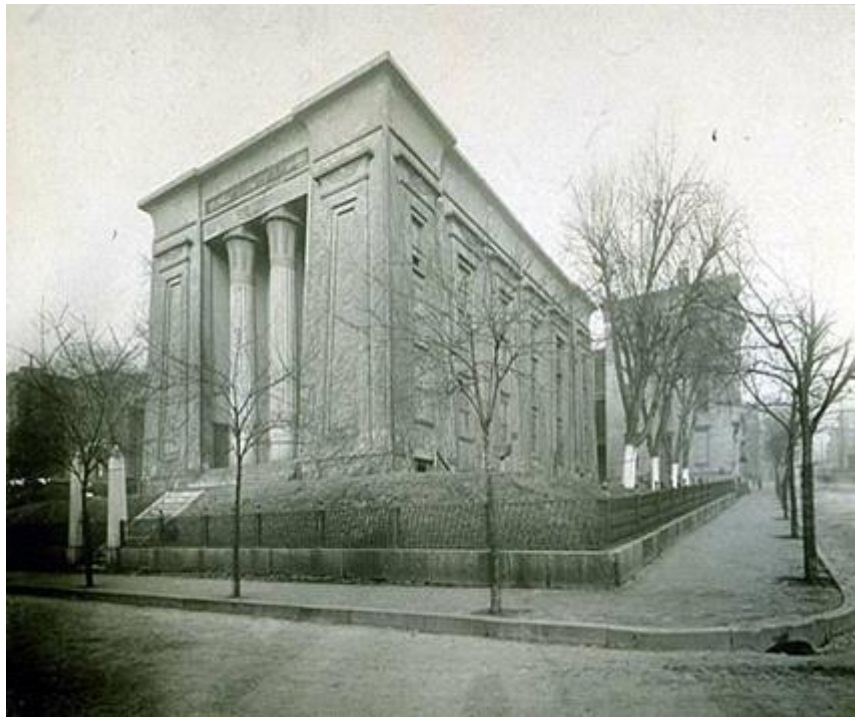
Learning Objectives

- History of how systemic racism is affecting the health of the Black community in RVA
- History of MCV practices and policies at MCV and VCUHS and influence on care of African American population
- Recognition of implicit bias and how it impacts care in the future
- Case studies that highlight the impact of Palliative Care for African American patients

MCV has been a major part of the healthcare landscape of Richmond for 180 years

- 1838 - Medical College of Virginia (MCV) established as the medical branch of Hampden-Sydney College
- 1861 -Commonwealth took ownership of MCV
- 1866 – Freedman's Bureau began to support a dispensary/public teaching hospital in the VCU Egyptian Building



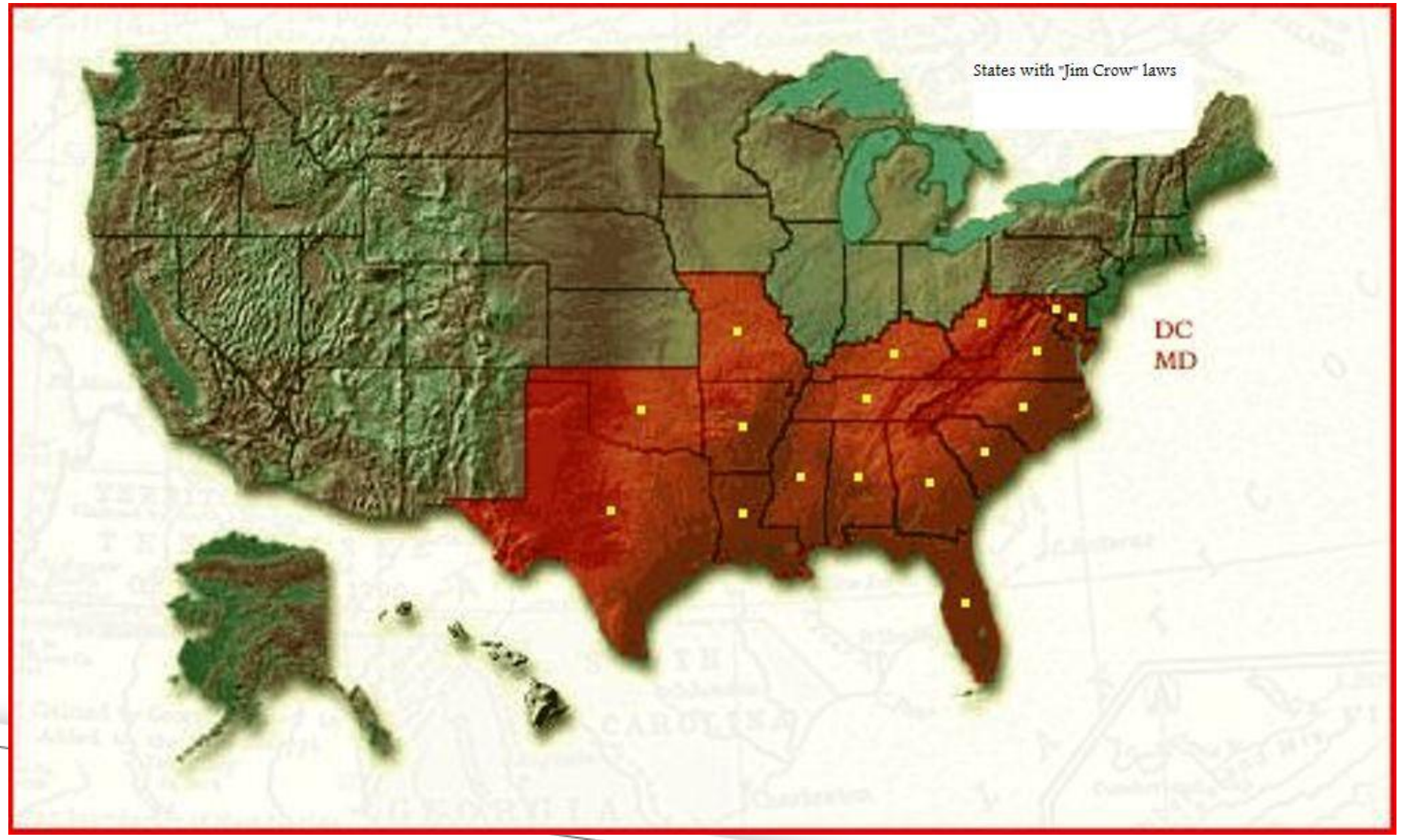
H. McGuire, Jr., "Medical College of Virginia Hospitals: 125 Years of Health Care 1861-1986

Throughout our Nation's history health disparities between Blacks and Whites have been documented

- In 1868, Black mortality rates **were twice as high as whites**
  - Disparity in infant mortality rates was larger.
- Health Conditions for Blacks in the early 1900's
  - Average life expectancy was **12 years less** than Whites
  - Blacks were **3 times** more likely to die from TB than Whites

Rice, M. and Jones, W., Public Policy and the Black Hospital: From Slavery to Segregation to Integration, Greenwood Press, 1994, p. 9.

Jim Crow laws laid the foundation for the modern U.S. Health Care System



Impact of Jim Crow on Health Care

- Black patients were primarily cared for in all-Black hospitals, whose number nationwide had decreased from 202 in 1923 to 124 in 1944
- By 1940, the South contained 76.6% of African Americans and 54.1% of rural Americans
  - The region had the nation's worst rates of morbidity, mortality, and wartime draft rejections.
- Surgeon General in FDR’s administration called the South "[t]he number one health problem of the Nation."

Thomas, K., The Hill-Burton Act and civil rights: expanding hospital care for black southerners, 1939-1960, Journal of Southern History, November 1, 2006, http://www.thefreelibrary.com.

Disparities in Care in Southern Hospitals

In 1916 -

"The present facilities at Memorial Hospital for colored patients are thoroughly inadequate and further are non-hygienic. These quarters are in the basement of the building with low pitched rooms and many of these rooms are below the grade level of the street…"

Minutes, Executive Committee of MCV Board of Visitors, March 28, 1916, p. 242.

St. Philip Hospital opened in 1920 to serve Black patients

St. Phillip Hospital
1920

Black physicians were not given privileges to this Hospital
Black nurses were not allowed to work in the facility until 1921.

1922 MCV Hospital Ad

The Dooley Hospital

"Used temporarily for white children under twelve years of age."

The Memorial Hospital

"For white patients exclusively."

The Saint Philip Hospital

"For negro patients exclusively"

THE DOOLEY HOSPITAL
Marshall and 13th Streets
Used temporarily for white children under twelve years of age.

THE MEMORIAL HOSPITAL
Broad and 12th Streets
For white patients exclusively.

THE SAINT PHILIP HOSPITAL
Marshall and 13th Streets
For negro patients exclusively

The Medical College of Virginia

HOSPITAL DIVISION
Richmond, Va.

All Hospitals are admirably located on the brow of Broad Street hill within easy reach of all depots, hotels, and the business section, and in a most quiet part of the city.

Fully equipped Bacteriological, Chemical, Pathological, Pharmaceutical and Roentgen Ray Laboratories, Delivery and Operating Room Suites, affording facilities for the most scientific study and modern treatment of all diseases.

School of Nursing at the Dooley and Memorial Hospitals for training white women between twenty-one and thirty-five years of age for the profession of nursing.

School of Nursing at the Saint Philip Hospital for training negro women between twenty-one and thirty-five years of age for the profession of nursing.

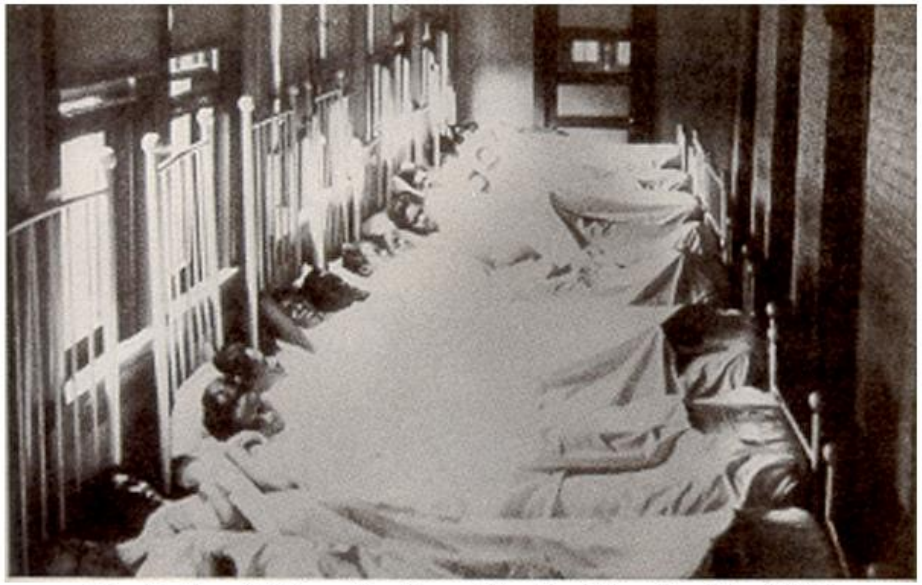
Accommodations in General Wards and Private Rooms to meet the financial condition of all patients.

Patients will be met with Hospital ambulance. Communications should be addressed to:

FREDERIC B. MORLOK,
Superintendent.

Separate but Equal Facilities

Charity Hospital in New Orleans, La.

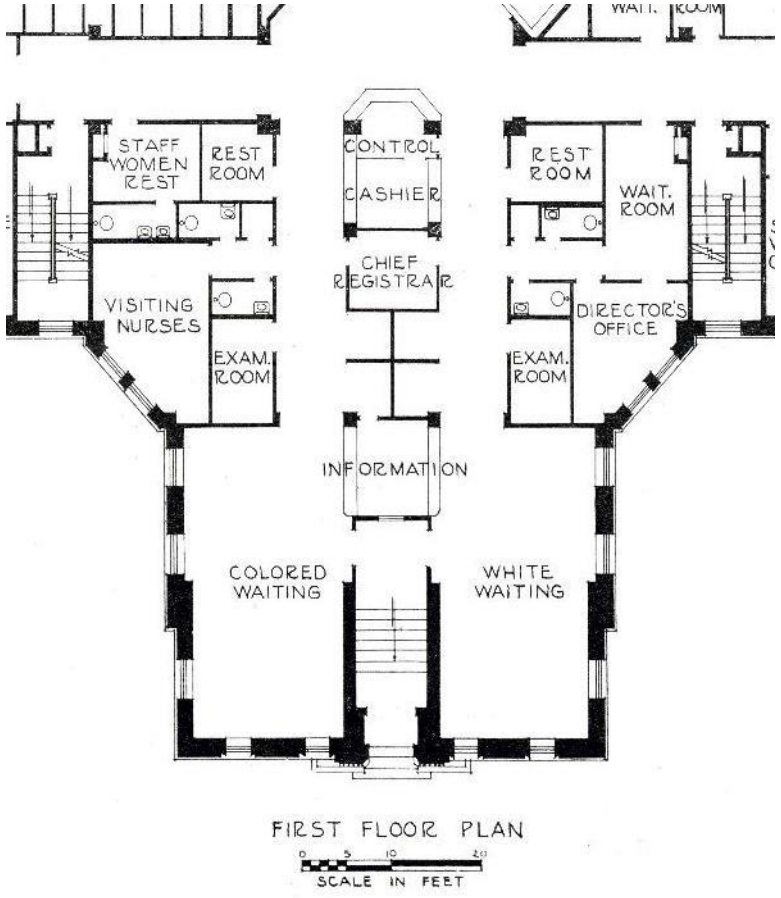


Charity Hospital "overflow" ward for black females, late 1920's with two patients per bed in a closed-in porch.

Ward for Black Females, late 1920s

Charity Hospital general ward, 1916, in the "white female" wing.

Ward for White Females, 1916



A.D. Williams Clinic

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Hospitals grew in the 1940's and 1950's under a segregated model

1938 Architect's rendering for West Hospital

“Equal”, but Inadequate Health Care

- Many African Americans were too poor to afford preventative health care
- Hospital facilities provided were in poor condition
- Until the late 1950’s, Black patients treated in White hospitals in Richmond relegated to basement facilities or segregated wards

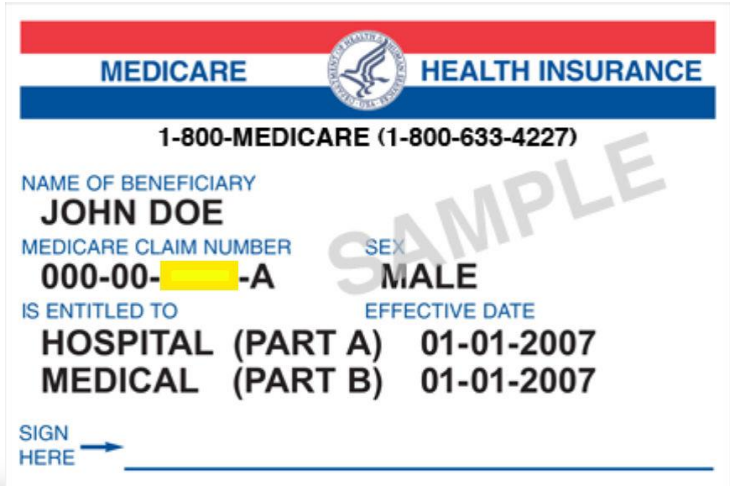
Separate waiting room - Memorial Hospital, ca 1930

Title VI of the Civil Rights Act of 1964

"No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

Medicare Act of 1965

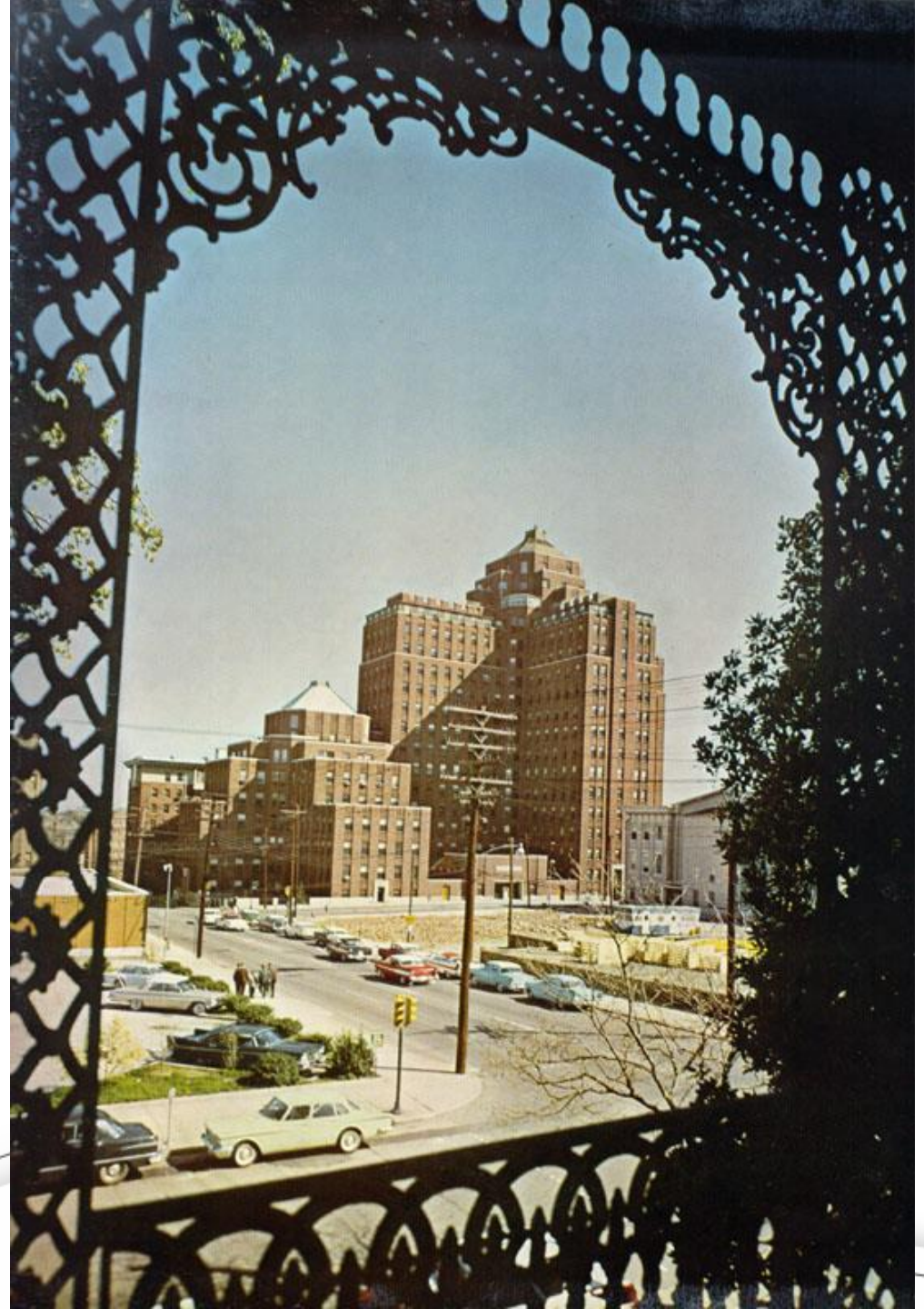
- July 30,1965, President Johnson signed a law that established Medicare and Medicaid
- Hospitals and nursing homes that wanted to receive federal funding through Medicare and Medicaid would no longer be able to discriminate.



Impact of the Civil Rights Act and Medicare

- January 1965- Assurances signed indicating MCV's compliance with the Civil Rights Act
- MCV Hospitals was integrated in 1965 and St. Philip Hospital was closed
- "Integration proceeding in an orderly fashion."*

*Report from Hospital Administrator, MCV Board Minutes, October 8, 1965.



MCV Takes Another Step To Integration

The Medical College of Virginia has taken another step toward implementing integration of its hospitals, according to Vice President Charles P. Caldwell Jr.

Effective to day all room assignments will come from two central offices—one for private patients and one for staff patients—rather than from offices separated by race.

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Redesignated MCV Hospitals

West Hospital (formerly MCV Hospital)

East Hospital (formerly St. Philip Hospital)

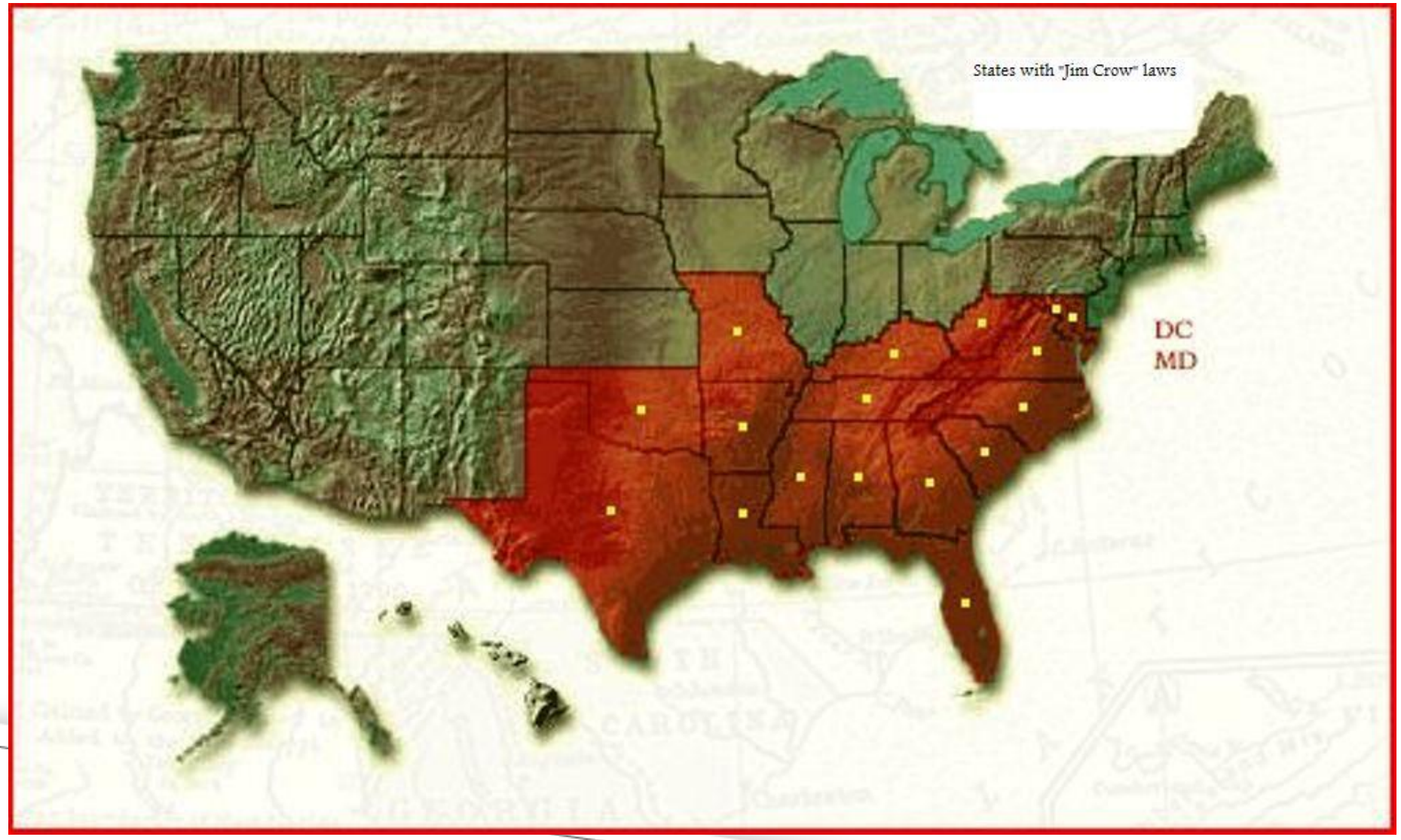
North Hospital (formerly E.G. Williams Hospital)

South Hospital (formerly Memorial Hospital)

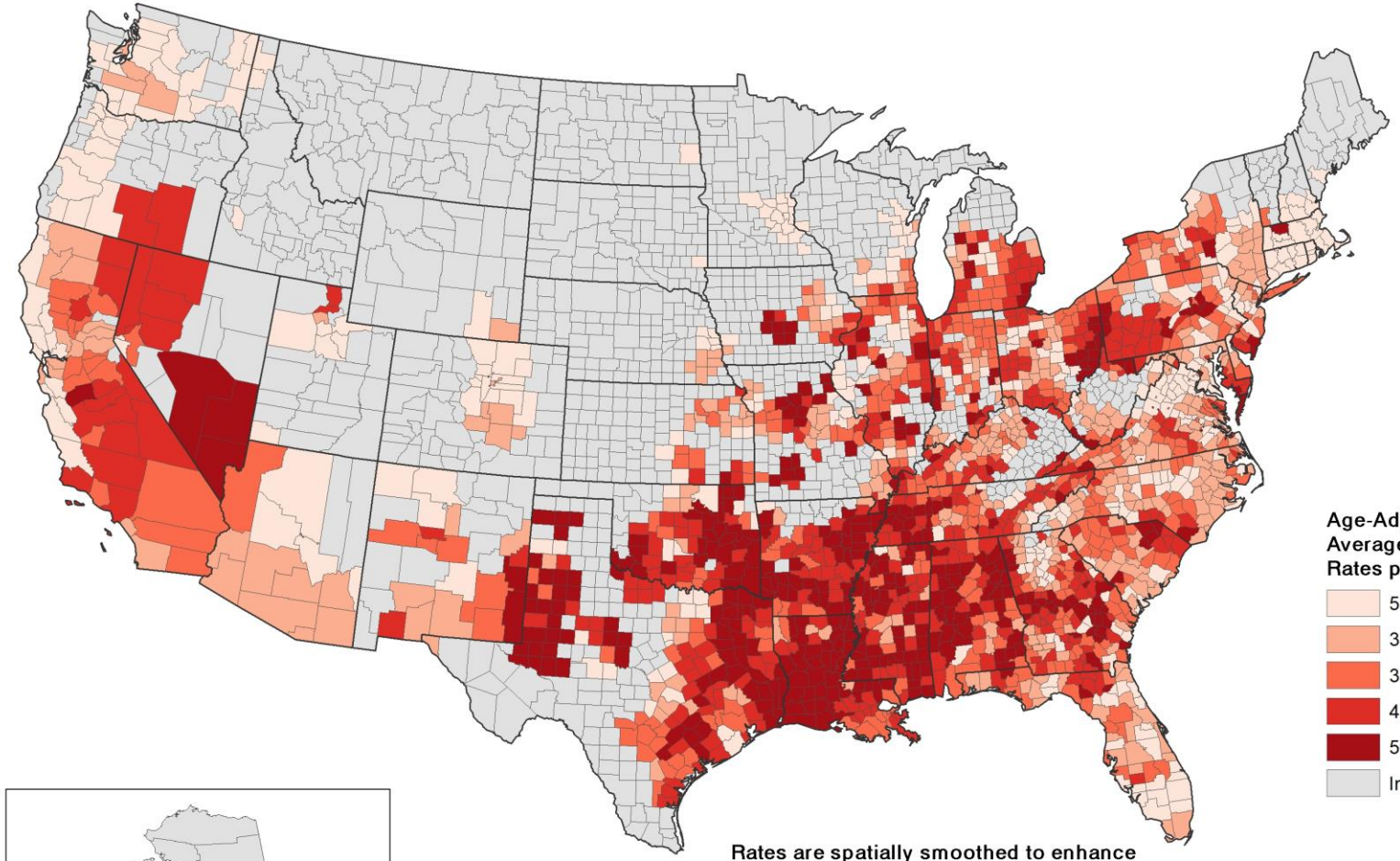
Why is this historical perspective important?

- Provides an understanding of the mistrust that many minority patients have for health care systems and providers
- Provides an explanation for the systemic root causes of many of the health disparities that exist today
- Demonstrates the impact of the social determinants of health (ex., inadequate housing, access to nutritional food, poverty levels, education gaps, etc.)
- Highlights the importance of providing education regarding an institution's history and its relationship with communities served

States with Jim Crow laws



Heart Disease Death Rates, 2015-2017
Black (non-Hispanic), Ages 35 +, by County



Rates are spatially smoothed to enhance the stability of rates in counties with small populations.

Data Source:
National Vital Statistics System
National Center for Health Statistics

www.cdc.gov/dhdsp/maps

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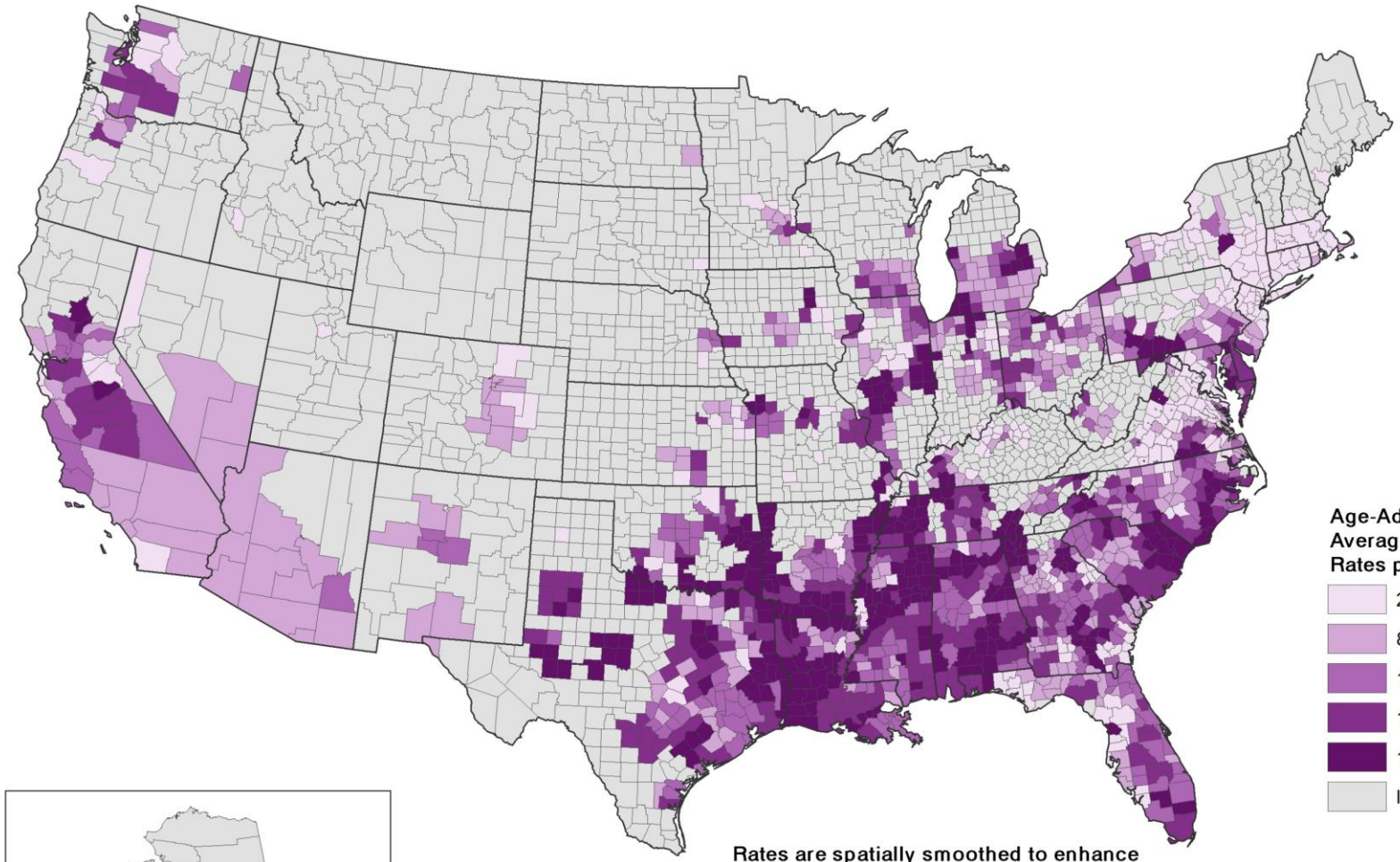
Stroke Death Rates, 2015 - 2017
Black (non-Hispanic), Ages 35+, by County



Rates are spatially smoothed to enhance the stability of rates in counties with small populations.

Data Source:
National Vital Statistics System
National Center for Health Statistics

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Case Presentation

Mr S

- 31
- Metastatic pseudomyogenic hemangioendothelioma of the brain and bone
- Seizure disorder
- No Advance Care Plan
- Has 2 sons and stays at various homes

- Sporadic work history with minimal education
- He is aware that chemotherapy has the potential to extend his life, however would prefer to remain as symptom free as possible

Mr S

- Left AMA multiple times to get high
- In and out of jail
- Can’t keep a job
- Angry/violent/aggressive
- Doesn’t trust doctors or follow their plan

- Gets anxious when he thinks he might die soon, seeks comforts
- Former inmate, served his time
- Struggling to manage medical needs versus role in family
- Emotionally stunted due to medical and social factors
- Hasn’t felt heard, communication deficits

Ms J

- 76
- Metastatic cancer unknown primary, brain and bone
- AMS, weight loss, non-communicative
- Chemo off table, comfort goals
- No advance care plan

- Sporadic work history
- Dropped out of school to model
- Daughter arrived after attempting to find her over some time
- Neighbor initially put us in contact with estranged cousin in California

Ms J

- Family triangulation throughout stay
- Daughter accused staff of racism and sought legal counsel for treatment
- Staff consistently went to cousin per neighbors request, prevented daughter from visiting
- Security asked daughter to leave bedside upon initial arrival
- After return, daughter would only talk to chaplain
- Pt was unable to have dying wishes met, bereavement followup indicates ongoing therapy associated with PTSD from end of life experience

THANK YOU!

We hope to see you at our next ECHO