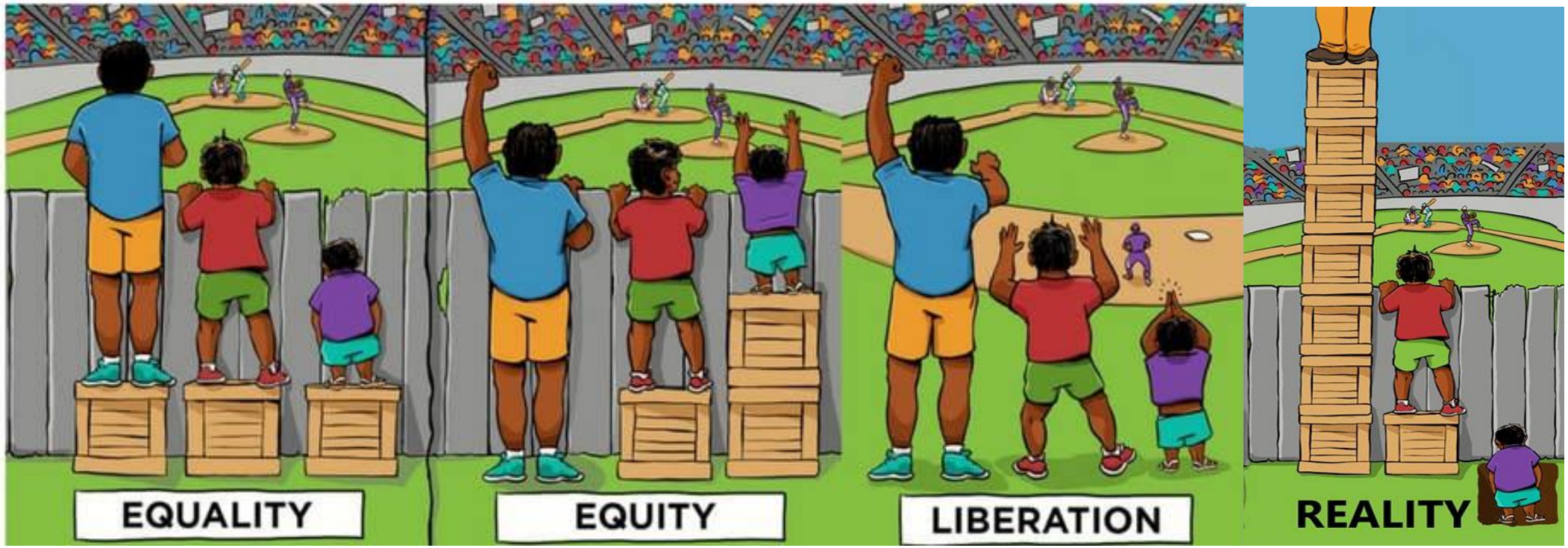
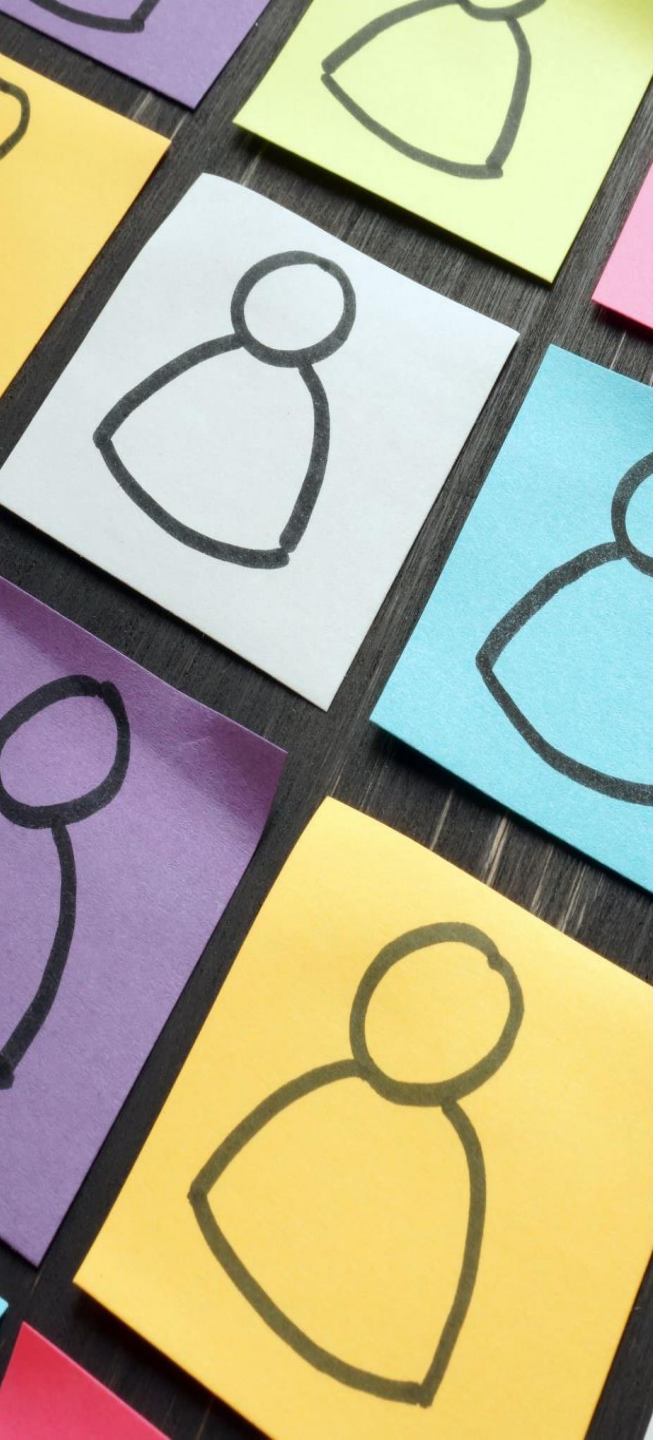
Practical Strategies to Promote Health Equity in Orthopaedic Surgery

Shani Fleming, MSHS, MPH, PA-C (she/her/hers)
Associate Professor
Graduate School Chief Equity, Diversity, and Inclusion Officer
UMB PA Program
PA Leadership and Learning Academy
MS Diversity, Equity, Inclusion Leadership|Intercultural Leadership Certificate





Learning Objectives

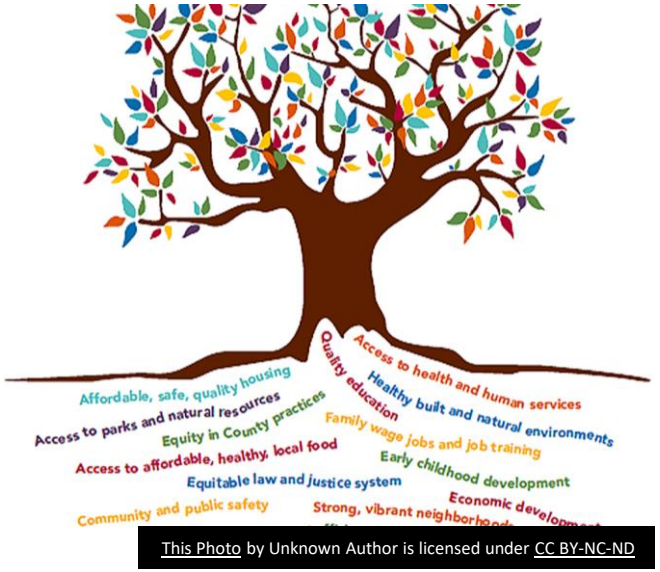
- Reflect on cultural diversity and cultural humility in clinical practice
- Reflect on identity development and center/margin theory
- Discuss the basics of implicit bias
- Discuss approaches to address institutional and structural inequities in our healthcare system
- Determine steps for personal action toward addressing health disparities and promoting health equity

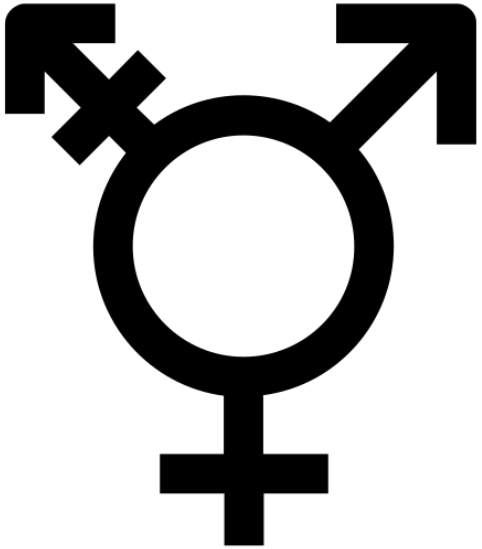
Why Orthopedic Surgery PA?

HEALTH EQUITY IS ALWAYS THE GOAL!

- ***"Of all the forms of inequality, injustice in health is the most shocking and inhuman."***

- ***- Martin Luther King, Jr.***





Is HEALTH a right or a privilege?

Health equity is achieved when every person has the opportunity to “attain his or her full health potential,” and no one is “disadvantaged from achieving this potential because of social position or other socially determined circumstances.” --CDC

What's Your Commitment to Health Equity?

- We are all individuals with multiple sociocultural identities that intersect and shape our worldview.

- How can we identify and minimize systemic forces, such as ableism, classism, racism, sexism, transphobia, and heterosexism, to create a safe environment for all of us?

- Let’s all commit to fostering respect for one another, practicing cultural humility, building community, and addressing structural barriers leading to health equity.

Fuentes, M. A., Zelaya, D. G., & Madsen, J. W. (2021). Rethinking the Course Syllabus: Considerations for Promoting Equity, Diversity, and Inclusion. *Teaching of Psychology*, *48*(1), 69–79. https://doi.org/10.1177/0098628320959979

Start with Self

Cultural Humility

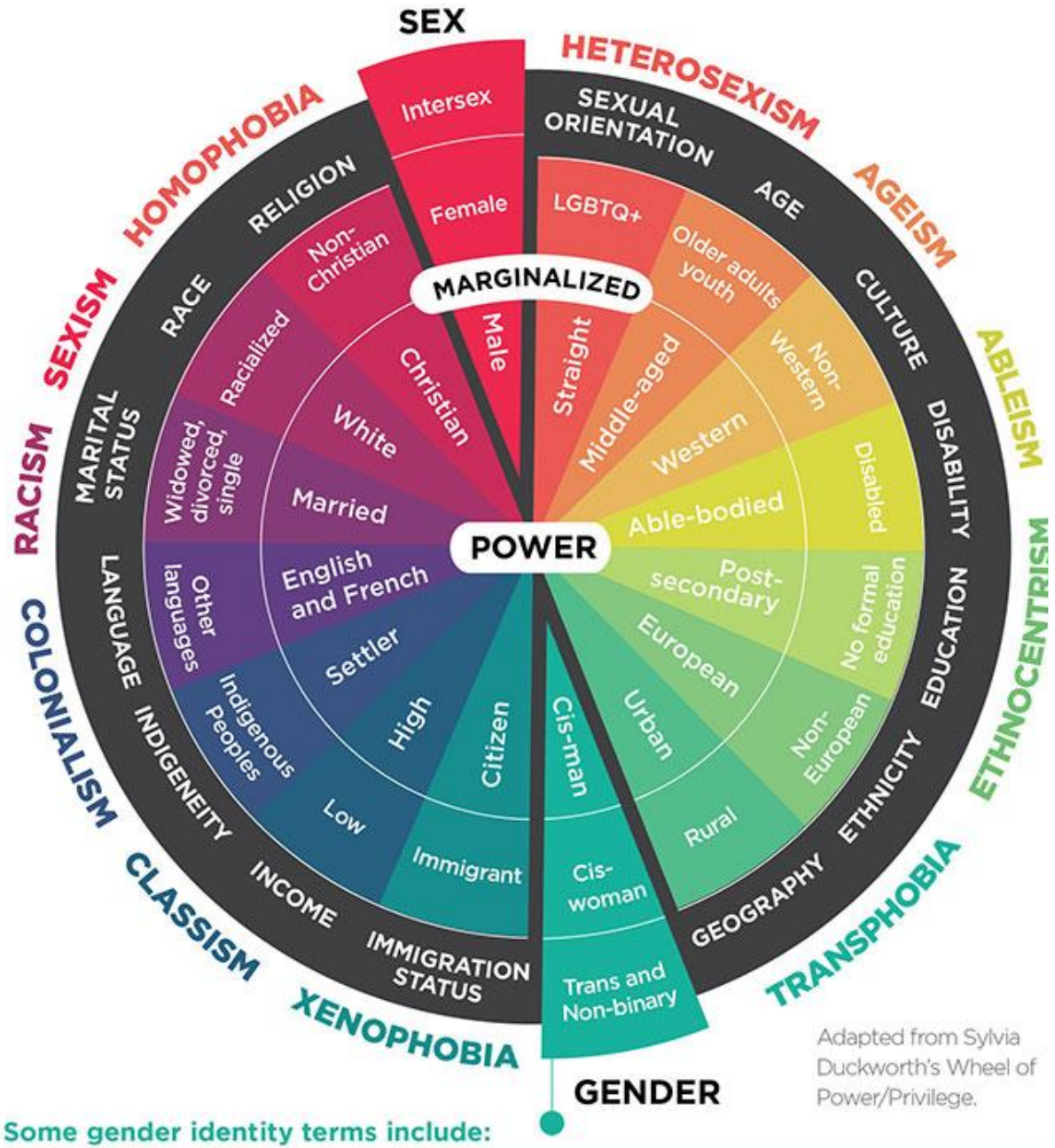
practice of self-reflection on how one's own background and the background of others, impacts teaching, learning, research, creative activity, engagement, and leadership

and

commitment to work individually and with others to end injustice

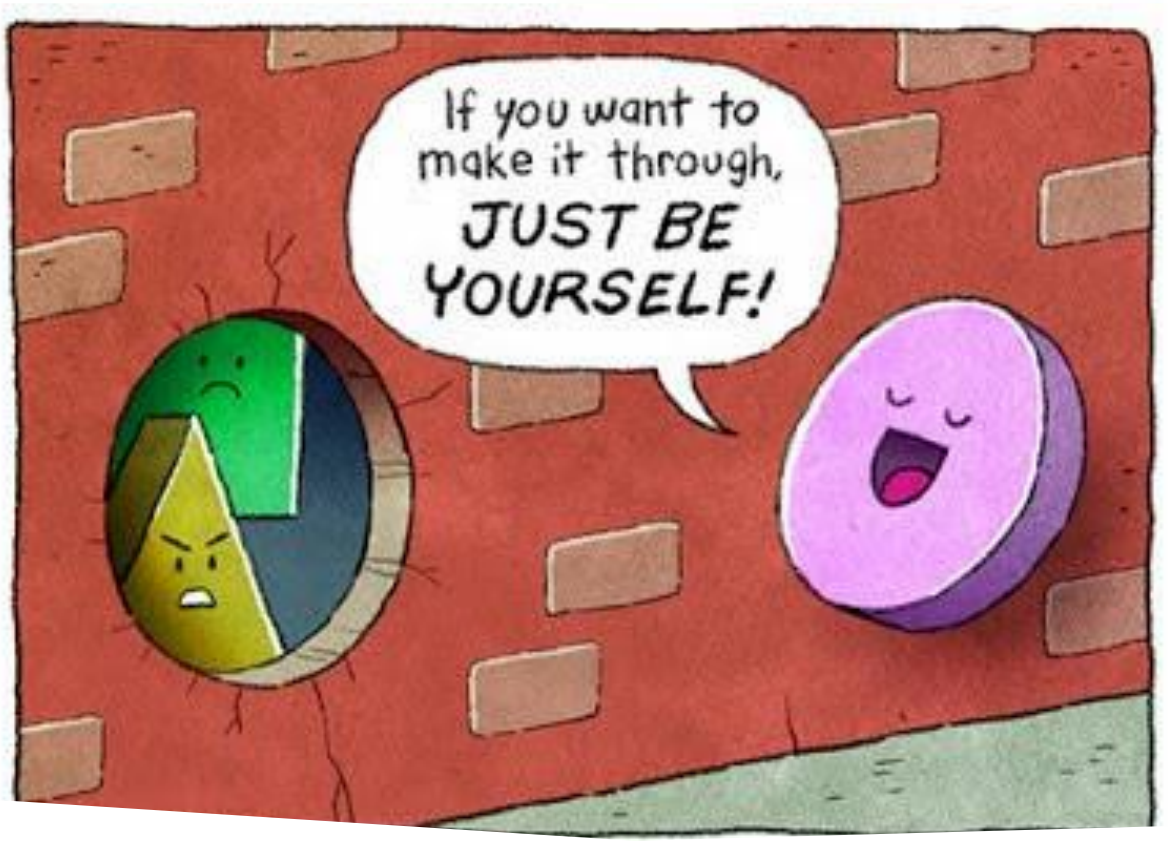
Tervalon, M., Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. Journal of Health Care for the Poor and Underserved, 9, 117-125.

Reflect on the various identities where you hold marginalized vs. privileged identities



Some gender identity terms include:

Agender	Genderfluid	Gender neutral	Transgender man
Bigender	Genderqueer	Non-binary	Transgender woman



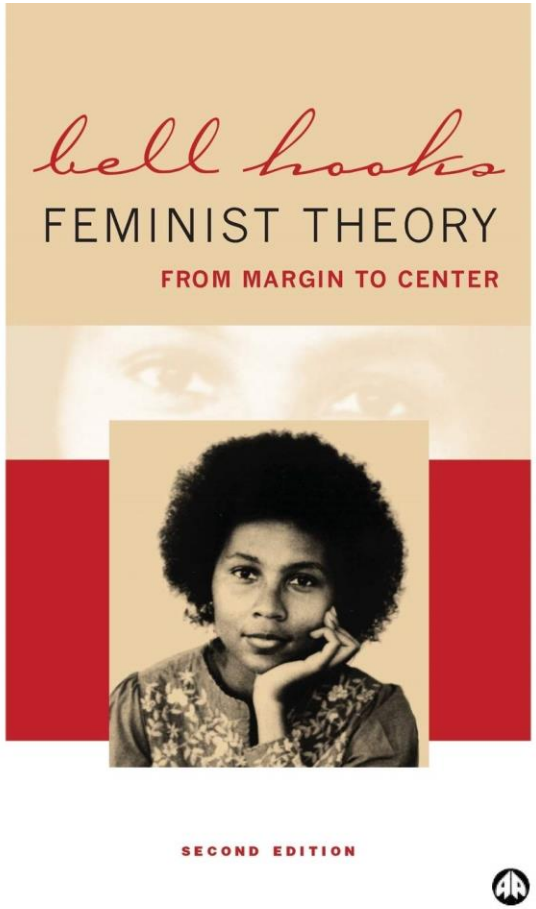
Institute of Gender and Health. Meet the Methods Series. Quantitative Intersectional Study Design and Primary Data Collection. February 2021 https://cihr-irsc.gc.ca/e/52352.html; Adapted from Sylvia Duckworth's Wheel of Power/Privilege

What **TWO** identities are you most aware of in the work environment?

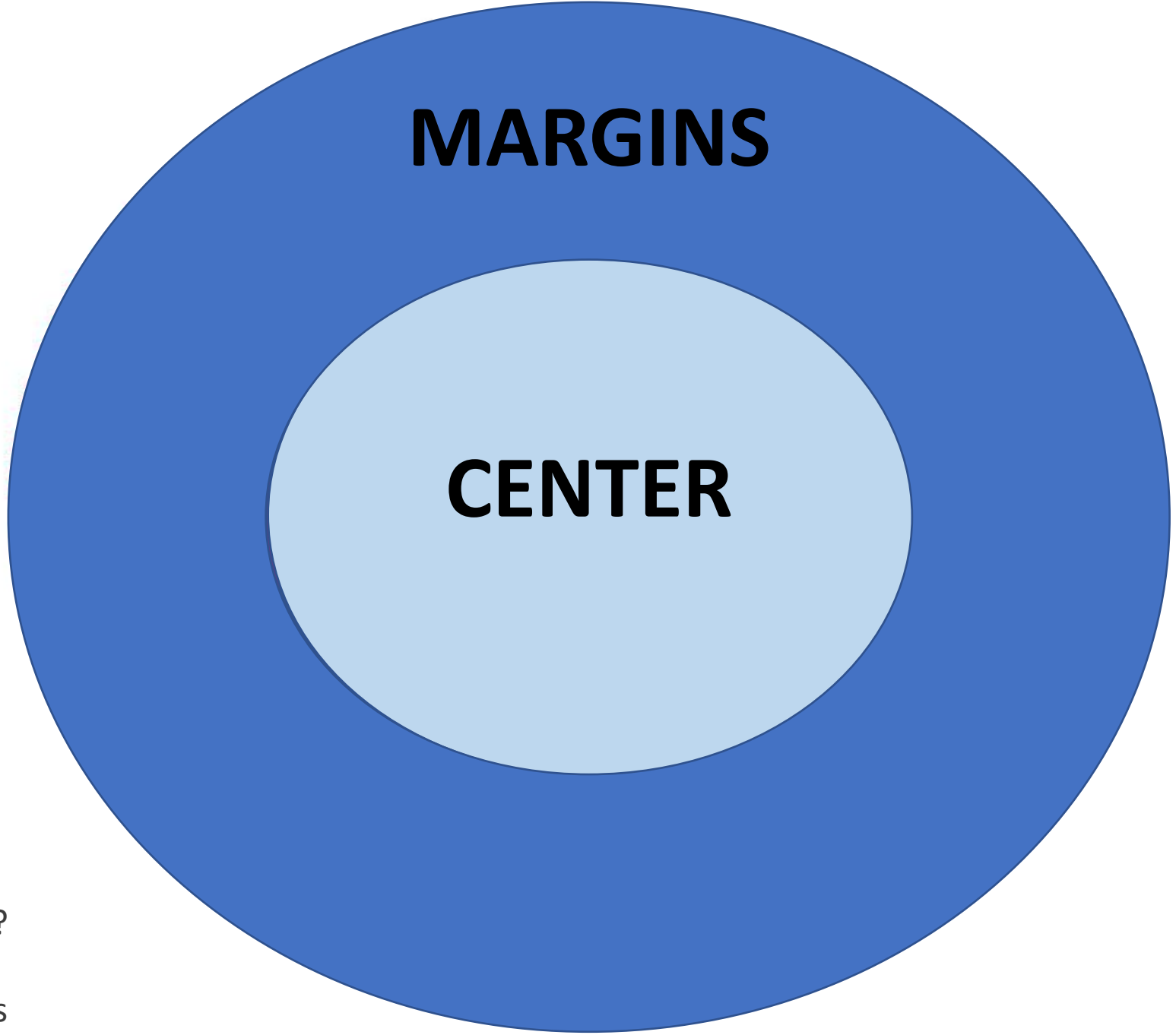
Identity	Marginalized	Power/Privilege
Age	Older adults, Youth	Middle-aged
Culture	Non-Western	Western
Disability	Disabled	Able-bodied
Education	No formal education	Post-secondary
Ethnicity	Non-European	European
Geography	Rural	Urban
Gender	Trans and Non-binary, Cis-woman	Cis-man
Immigration Status	Immigrant	Citizen
Income	Low	High
Indigeneity	Indigenous People	Settler
Language	Other languages	English and French
Marital Status	Widowed, divorced, single	Married
Race	Racialized	White
Religion	Non-Christian	Christian
Sex	Intersex, Female	Male
Sexual Orientation	LGBTQ+	Straight

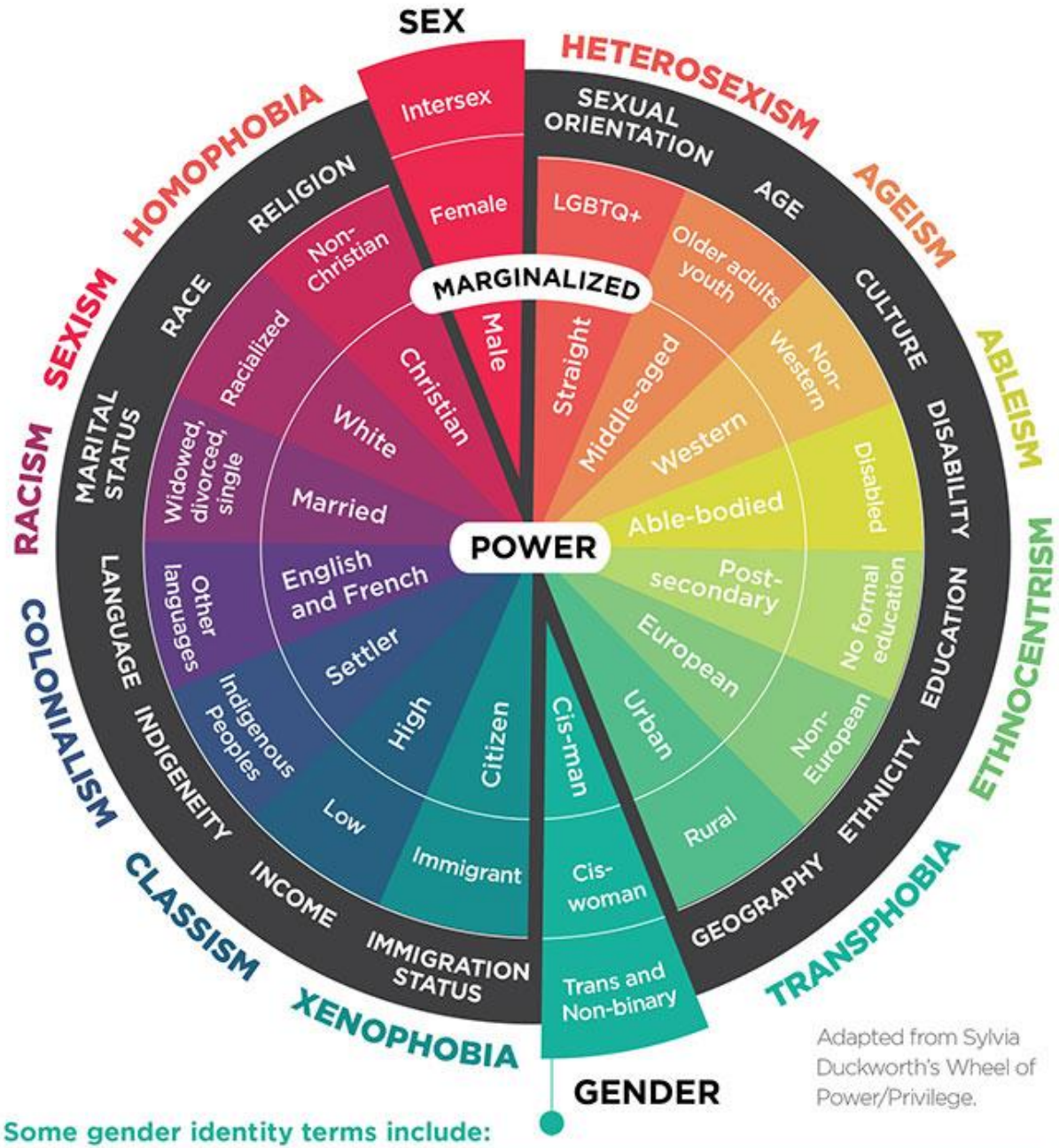
Identities

Intersectionality: the complex, cumulative way in which the effects of multiple forms of discrimination (such as racism, sexism, and classism) combine, overlap, or intersect, especially in the experiences of marginalized individuals or groups.--Merriam-Webster



1. Where am I located?
2. Who occupies the center?
3. How can I move within this structure?
4. Who can assist me in moving?
5. What level of risk do I take to move within power structures and why?





Adapted from Sylvia Duckworth's Wheel of Power/Privilege.

Some gender identity terms include:

Agender	Genderfluid	Gender neutral	Transgender man
Bigender	Genderqueer	Non-binary	Transgender woman

- How do individuals with different identities face barriers within orthopedic surgery?
  - Providers/Staff
  - Patients
- What systemic changes (policies, practices, norms) can you address within your "sphere of influence"?

Institute of Gender and Health. Meet the Methods Series. Quantitative Intersectional Study Design and Primary Data Collection. February 2021 https://cihr-irsc.gc.ca/e/52352.html; Adapted from Sylvia Duckworth's Wheel of Power/Privilege

Health Disparities

- **Health disparities:**
  - preventable differences in
    - the burden of disease, injury, violence,
    - opportunities to achieve optimal health
  - experienced by socially disadvantaged racial, ethnic, and other population groups, and communities.

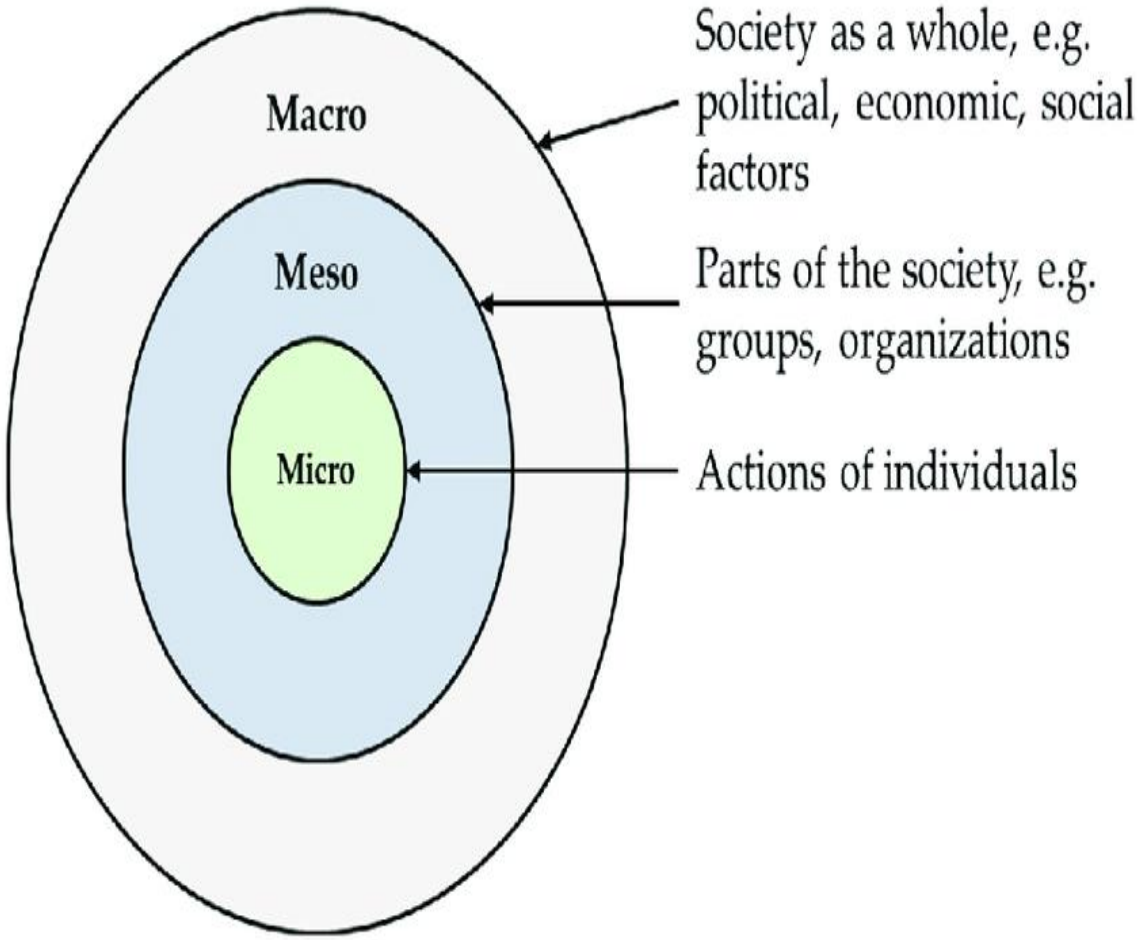
--CDC

Structural Barriers

What causes Health Disparities?

Social determinants of health drive more than **80%** of health outcomes

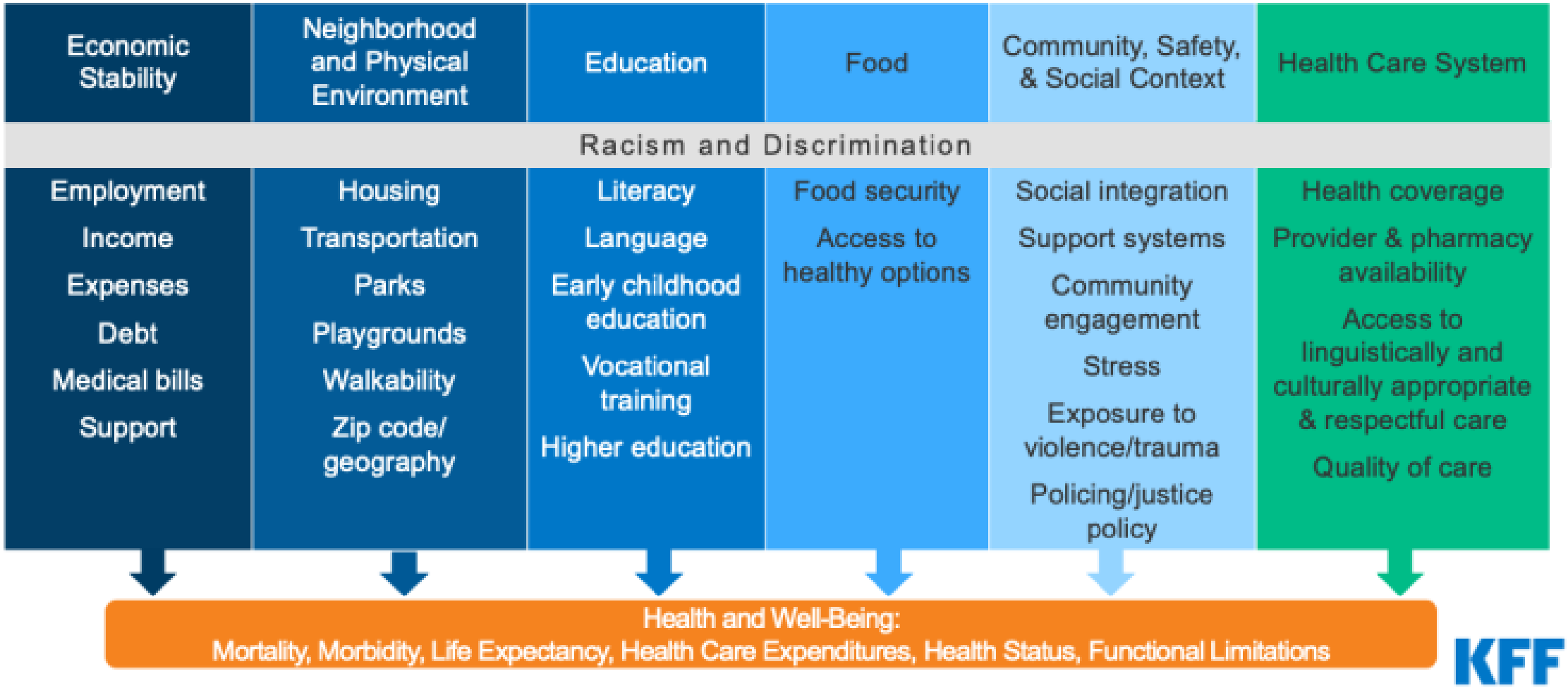
- non-medical factors that influence health outcomes
- conditions in which people are born, grow, work, live, and age
- the wider set of forces and systems shaping the conditions of daily life



Adapted from Courtney Jones Carney. Intercultural Center. University of Maryland Baltimore

Figure 1

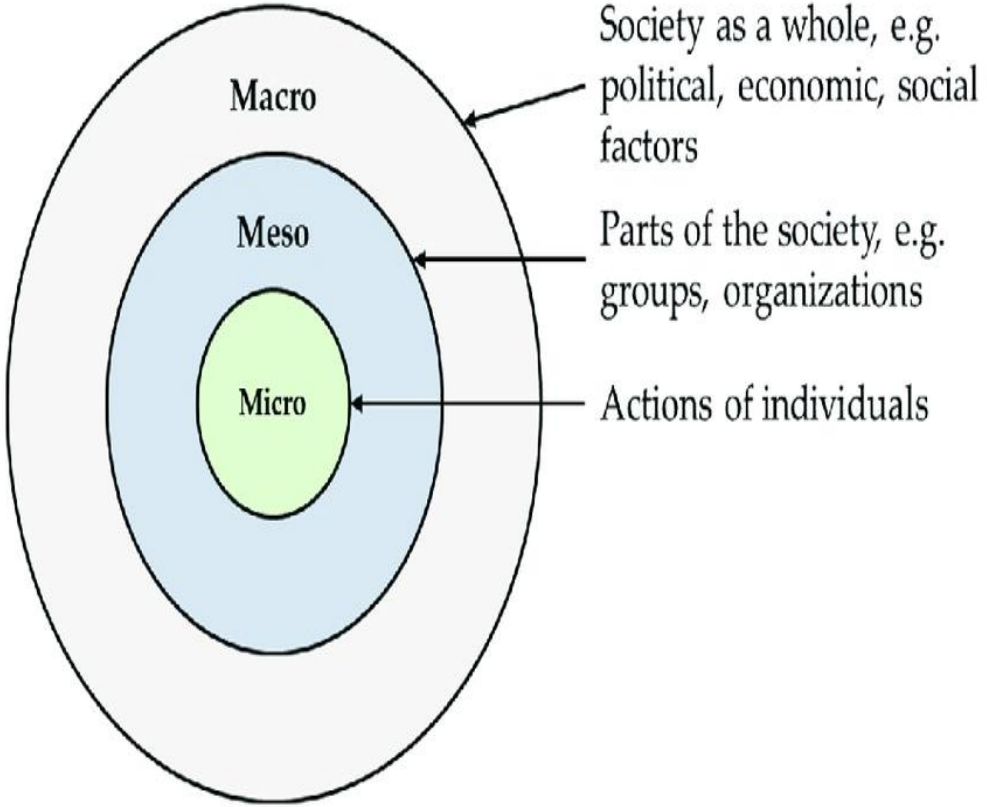
Health Disparities are Driven by Social and Economic Inequities



Disparities in Health and Health Care Diagram: https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/

Multifactorial

- Structural-Level
  - Economic Barriers
  - Environmental Barriers
  - Neighborhood-Community
  - Access to Care
- Health Care Systems-Level
  - Lack of interpretation and translation services
  - Time pressures in clinical encounters
- Patient-Level
  - Patient preferences
  - Care-seeking behaviors and attitudes
  - Clinical appropriateness of care
- Provider-Level
  - **Bias**
  - Clinical uncertainty
  - Beliefs/stereotypes about the behavior or health of minoritized patients



Smedley, B.D. , Stith, A.Y. & Nelson, A.R. (2003). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* Washington, D.C.: The National Academies Press.


Same Injury. Same Hospital. Same Provider.
AAPA
Which Patient Gets 50% Less Pain Medication At Discharge?
for more information: www.stop-disparities.org


Chest Pain. Identical Symptoms. Matching Histories.
AAPA
Which Patient Doesn't Get the Appropriate Tests?
for more information: www.stop-disparities.org


Unconscious Racial Stereotyping = Unequal Treatment.
AAPA
Which Patient Gets Your Best Care?
for more information: www.stop-disparities.org

Citation	Purpose of the Study	Assessment of Implicit Bias Among Professionals
2013 Bean et al.[25]	To examine implicit stereotyping of Hispanic American patients among nursing and medical students	Sequential priming examined Hispanic/Latino/Latina vs White faces associated with words related to good and bad patients. Participants were faster in recognizing noncompliance (d = 0.68*), risk (d = 1.53*), and **general stereotype words** (d = 0.88*) after exposure to Hispanic/Latino/Latina faces vs White faces.
2013 Blair et al.[26]	To assess implicit and explicit bias against Hispanics/Latinos and Black Americans among primary care providers and community members	Race IAT examined Black vs White faces and associated them with positive and negative words. Physicians showed moderate pro-White, anti-Black bias (Mean IAT D = 0.27; SD = 0.34). Race IAT examined Hispanic/Latino/Latina vs White faces associated with positive and negative words. Physicians showed moderate pro-White, **anti- Hispanic/Latino/Latina bias** (Mean IAT D = 0.33; SD = 0.38)
2009 Fitzsimmons[27]	To examine the extent to which implicit racial bias against students of color exists in nursing faculty teaching in baccalaureate programs in nursing	Skin tone IAT examined associations between dark- vs light-skinned faces and positive and negative words. Nurses showed **moderate bias against dark-skinned faces** (mean IAT D = 0.35; SD = 0.42).
2009 Sabin et al.[28]	To measure implicit and explicit attitudes about race among medical doctors	Race IAT examined Black vs White faces associated with positive and negative words. Physicians showed moderate **pro-White, anti-Black bias** (Mean IAT D = 0.39; SD = 0.47).
2009 White-Means et al.[29]	To examine race and skin tone preferences among preprofessional health care providers	Race IAT examined Black vs White faces associated with positive and negative words.100% of Hispanics/Latinos/Latinas, 94% of Whites, 76% of Asians, and 62% of Blacks showed a preference for White over Black people. Overall, students showed moderate **pro-White, anti-Black bias** (Mean IAT D = 0.40; SD not reported). Skin tone IAT examined associations between dark- vs light-skinned faces and positive and negative words. 100% of Hispanics/Latinos/Latinas, 85% of Asians, 83% of Whites, 41% of Blacks, and 51% of mixed race (Black and White) were more likely to **prefer light skin to dark skin**. Overall, students showed a **moderate bias against dark-skinned people** (mean IAT D = 0.31; SD not reported).

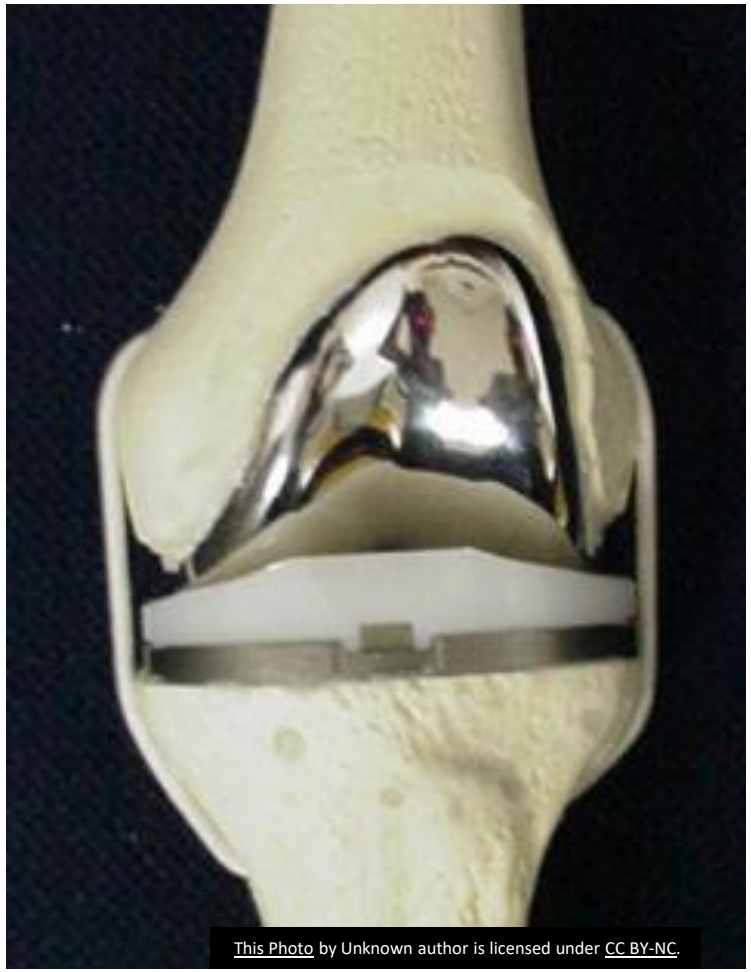
William J. Hall et al. “Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review”, *American Journal of Public Health* 105, no. 12 (December 1, 2015): pp. e60-e76.

Citation	Purpose of the Study	Assessment of Implicit Bias Among Professionals
2013 Blair et al.[30]	To examine if clinicians' explicit and implicit racial/ethnic bias is related to Black and Hispanic/Latino/Latina patients' perceptions of their care in established clinical relationships	Race IAT examined Black vs White and Hispanic/Latino/Latina vs White faces associated with positive and negative words.66% of physicians showed some level of bias. 51% of physicians had moderate-to-strong levels of **bias against Hispanics/Latinos/Latinas**. 43% of physicians had moderate-to-strong levels **of bias against Black people**. IAT D score not reported.
2014 Blair et al.[31]	To determine the relationship between implicit racial/ethnic bias among primary care providers and treatment processes and outcomes related to hypertension among Black and Hispanic/Latino/Latina patients compared with White patients	Race IAT examined Black vs White and Hispanic/Latino/Latina vs White faces associated with positive and negative words.70% of physicians showed some level of implicit bias against Black people and Hispanics/Latinos. 51% of physicians had **moderate-to-strong levels of bias against Hispanics/Latinos/Latinas**. 42% of physicians had **moderate-to-strong levels of bias against Black people**. IAT D score not reported.
2012 Cooper et al.[32]	To examine associations of clinician's implicit attitudes about race with visit communication and patient ratings of care	Race IAT examined Black vs White faces associated with positive and negative words. Physicians showed slightly moderate **pro-White, anti-Black bias** (Mean IAT D = 0.26; SD = 0.49). Medical Compliance IAT examined Black vs White faces associated with compliant and reluctant patients. Physicians showed **moderate association of White race with compliance** (Mean IAT D = 0.29; SD = 0.41).
2007 Green et al.[33]	To test the presence of implicit race bias among physicians and assess its prediction of thrombolysis recommendations for Black and White patients with acute coronary syndromes	Race Preference IAT examined Black vs White faces associated with positive and negative words. Residents showed moderate **pro-White, anti-Black bias** (Mean IAT D = 0.36; SD = 0.40). Race Cooperative IAT examined Black vs White faces associated with general cooperativeness. Residents showed moderate association of **White race with cooperativeness** (mean IAT D = 0.30; SD = 0.39). Race Medical Cooperative/Compliance examined Black vs White faces associated with medical cooperativeness. Residents showed moderate association of White race with cooperativeness (mean IAT D = 0.22; SD = 0.40).

William J. Hall et al. "Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review", *American Journal of Public Health* 105, no. 12 (December 1, 2015): pp. e60-e76.

Citation	Purpose of the Study	Assessment of Implicit Bias Among Professionals
2013 Hagiwara et al.[34]	To examine how non-Black primary care physician's explicit and implicit racial bias and Black patients' perceived past discrimination affected physician–patient talk time ratio during medical interactions and the relationship between this ratio and patients' subsequent adherence	Race IAT examined Black vs White faces associated with positive and negative words. Physicians showed a very slight pro-Black, anti-White (Mean IAT D = −0.10; SD = 0.36).
2011 Haider et al.[35]	To estimate unconscious race and social class bias among 1st-year medical students and examine the association of these biases with clinical assessments	Race IAT examined Black vs White faces associated with positive and negative words. No implicit bias among 17% of medical students. 69% of students demonstrated preference for White over Black. 14% of students demonstrated preference for Black over White. Students showed moderate pro-White, anti-Black bias (Mean IAT D = 0.32; SD = 0.33).
2015 Hausmann et al.[36]	To examine implicit racial bias of SCI physicians and its association with functioning and well-being for individuals with SCI	Race IAT examined Black vs White faces associated with positive and negative words.100% of SCI physicians show some level of implicit bias toward Black people. Physicians showed strong pro-White, anti-Black bias (Mean IAT D = 0.62; SD = 0.35).
2010 Penner et al.[37]	To examine the relationship of non-Black physicians' implicit and explicit racial bias to their perceived behavior and their perceptions of their interactions with Black patients	Race IAT examined Black vs White faces associated with positive and negative words. Physicians showed slight pro-White, anti-Black bias (Mean IAT D = 0.10; SD not reported).
2012 Sabin et al.[38]	To assess implicit racial bias among pediatricians	Race Attitude IAT examined Black vs White faces associated with positive and negative words. Physicians showed slight pro-White, anti-Black bias (Mean IAT D = 0.18; SD = 0.44). Race and Compliant Patient IAT examined Black vs White faces associated with compliant and reluctant patients. Physicians showed a moderate implicit association between compliancy and White faces (Mean IAT D = 0.25; SD = 0.42). Race and Quality of Medicine IAT examined Black vs White faces associated with preferred and acceptable medical care. Physicians showed a moderate association between preferred care and Black faces (Mean IAT D = −0.21; SD = 0.33).
2012 Sabin and Greenwald[39]	To examine the association between attitudes and beliefs about race among pediatricians and treatment recommendations for asthma, ADHD, UTI, and pain	Race IAT examined Black vs White faces associated with positive and negative words. Physicians showed slight pro-White, anti-Black bias (Mean IAT D = 0.18; SD = 0.44). Medical Compliance IAT examined Black vs White faces associated with compliant and reluctant patients. Physicians showed a moderate pro-White implicit race and compliance bias (mean IAT D = 0.25; SD = 0.42). Race-Quality of Care IAT examined Black vs White faces associated with preferred and acceptable medical care. Physicians showed a moderate implicit association of Black patients with preferred medical care (Mean IAT D = −0.21; SD = 0.33).

Ortho Surgery Health Disparities



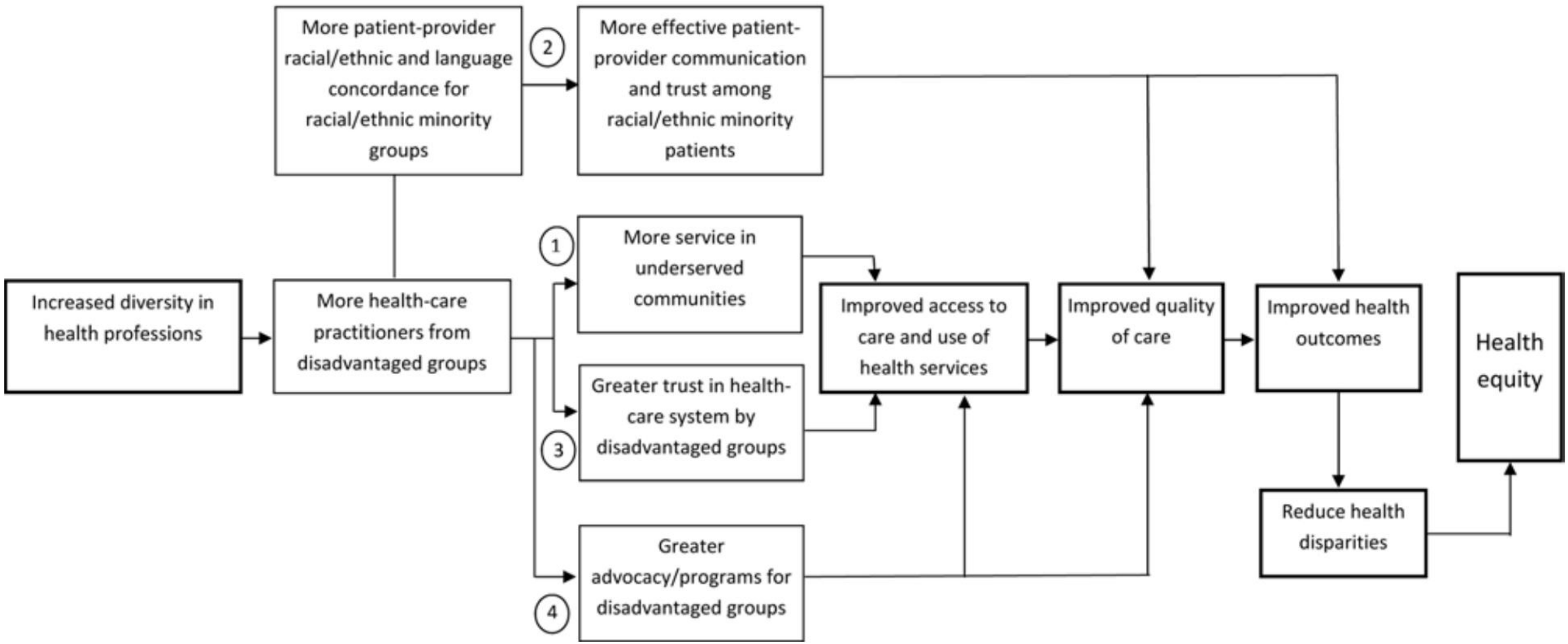
- Access to care due to insurance
  - 8.8 x more likely with private insurance vs Medicaid (Rotator cuff)
  - 2.2 x more likely with private insurance vs Medicaid (Hand flexor tendon)
  - 30.1% (Medicaid) vs 96% (Medicare) vs 100% (private)—Knee arthroplasty
- Outcomes in Total Joint Arthroscopy
  - Readmission rates for Blacks 24% higher than white patients
  - Mortality and complication rates higher for Black and mixed-race patients
  - Black patients higher odds ratio for PE within 90d of discharge
- Who receives Total Joint Replacement
  - Rates of 4.82 white men, 3.46 Hispanic men, 1.84 Black men (per 1000)
- Outcomes in Hip Fracture Care
  - Higher mortality and worse mobility for nonwhite patients
  - Black patients with the longest time to surgery compared to all races
  - Economic disparities were associated with an increased risk of readmission and revision following hip fracture surgery and infection and readmission following ankle fracture surgery.
- Total Hip Arthropathy
  - patient undergoes total hip arthroplasty (THA) after a diagnosis of osteoarthritis. THA is associated with disparities among race, gender, primary insurance, and social deprivation

Ortho Surgery Health Disparities

- Access to care due to Race, Ethnicity, and Sex
  - Female-22% vs 78% referral for surgical consultation (shoulder injury)
  - White (70%) vs Black (5%) account for total shoulder arthroplasty procedures
- Racial disparities in communication between orthopedic surgeons and patients.

	Race	Excellent	Very Good	Good/Below	*P*
a. Treating you like you're on the same level; not "talking down" to you	W	84.8	13.8	1.4	<0.0001
	AA	64.4	23.5	12.1	
b. Letting you tell your story and listening	W	78.7	17.4	3.9	<0.0001
	AA	62.6	23.0	14.4	
c. Showing interest in you as a person	W	77.8	17.2	5.0	<0.0001
	AA	65.9	19.7	14.4	
d. Discussing options with you and offering choices	W	77.7	17.0	5.3	<0.001
	AA	61.4	20.5	18.1	
e. Letting you help decide what to do	W	74.6	19.4	6.0	<0.001
	AA	58.4	16.9	24.7	
f. Encouraging you to ask questions	W	70.6	19.6	9.8	<0.001
	AA	58.5	19.9	21.6	
g. Answering your questions clearly	W	80.9	15.8	3.3	<0.0183
	AA	71.5	22.1	6.4	
h. Explaining what you need to now about your problems, how and why they occurred and what to expect next	W	77.8	16.6	5.6	<0.0027
	AA	69.4	17.7	12.9	
i. Using language you can understand when explaining your problems and treatments	W	82.6	14.4	3.0	<0.0009
	AA	71.7	20.2	8.1	
j. Discussing how your problem or treatment impacts on your daily life	W	73.2	19.3	7.5	<0.0001
	AA	60.7	17.8	21.5	
k. Taking all your medical history into account when considering your current problem or treatment	W	76.9	18.1	5.0	<0.0001
	AA	64.8	17.6	17.6	

Figure 2. Expanded conceptual model linking health professions diversity to health disparity and health equity outcomes, 2012[a]



[a]Adapted from: Department of Health and Human Services (US), Health Resources and Services Administration, Bureau of Health Professions. The rationale for diversity in the health professions: a review of the evidence. Rockville (MD): HHS; 2006.

Percentage of Certified PAs by Race

Race		2019	2015
White	85.8%	91.1%	91.1%
Black/African American	1.9%	2.1%	2.2%
Asian	3.8%	3.7%	3.5%
Native Hawaiian/Pacific Islander	0.3%	0.3%	0.4%
American Indian/Alaska Native	0.3%	0.2%	0.3%
Other		2.5%	2.6%
TOTAL		**100.0%**	**100.0%**

Percentage of Certified PAs by Gender

Gender		2019	2015
Female	52.7%	51.6%	49.5%
Male	47.3%	48.4%	50.5%
TOTAL		**100.0%**	**100.0%**

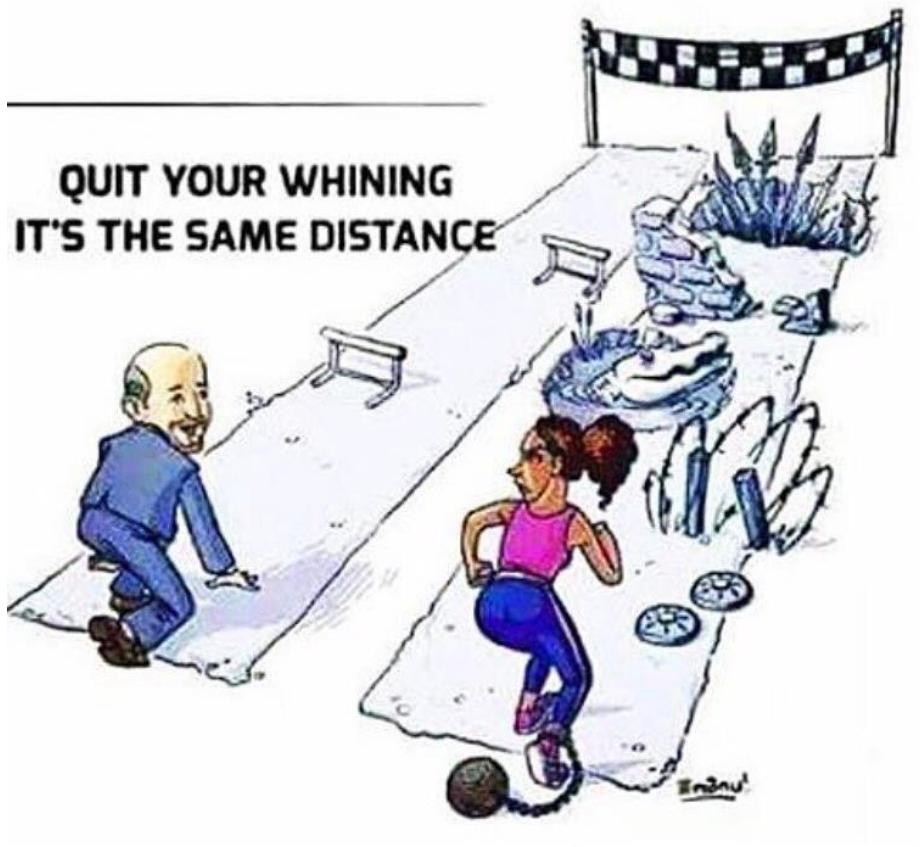
Ethnicity: Percent who indicated they are **Hispanic**

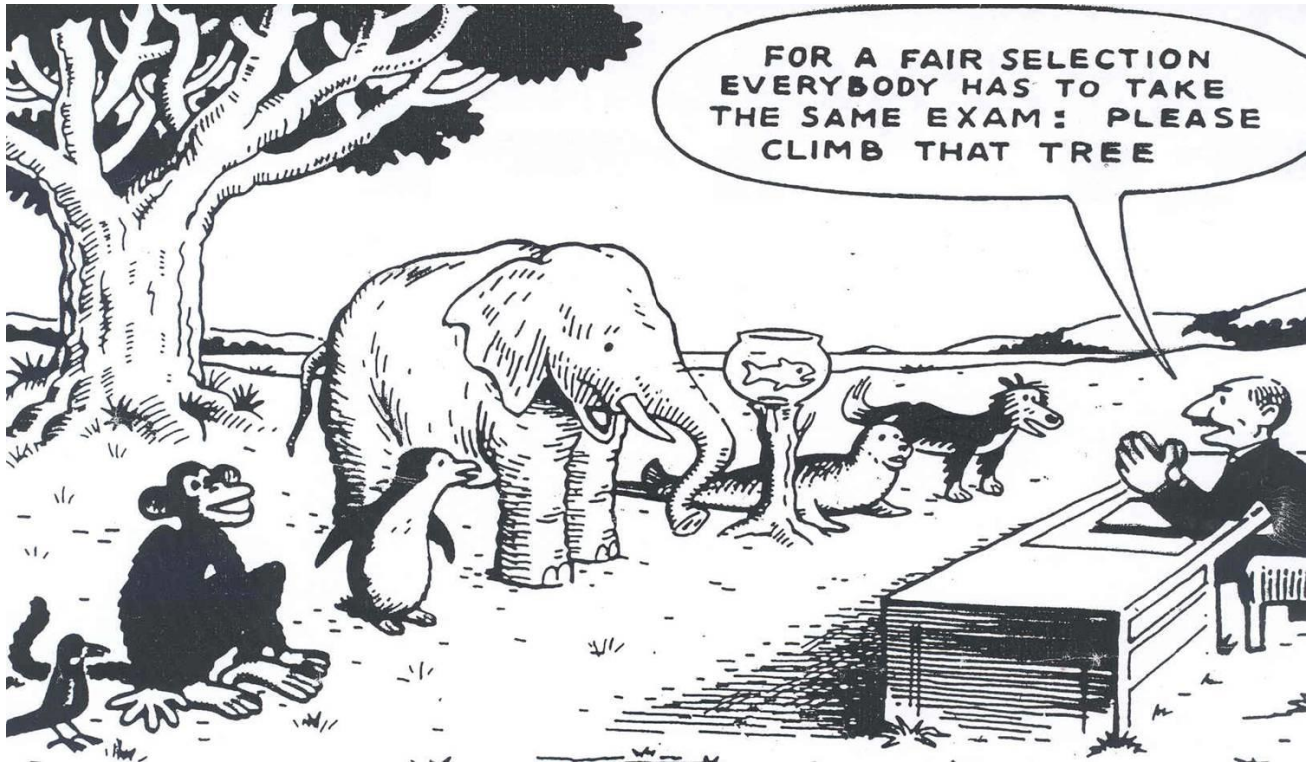
2019: **4.9%**

2015: **4.2%**

5.0%

“I treat everyone the same”
Meritocracy





Let’s talk about individual bias

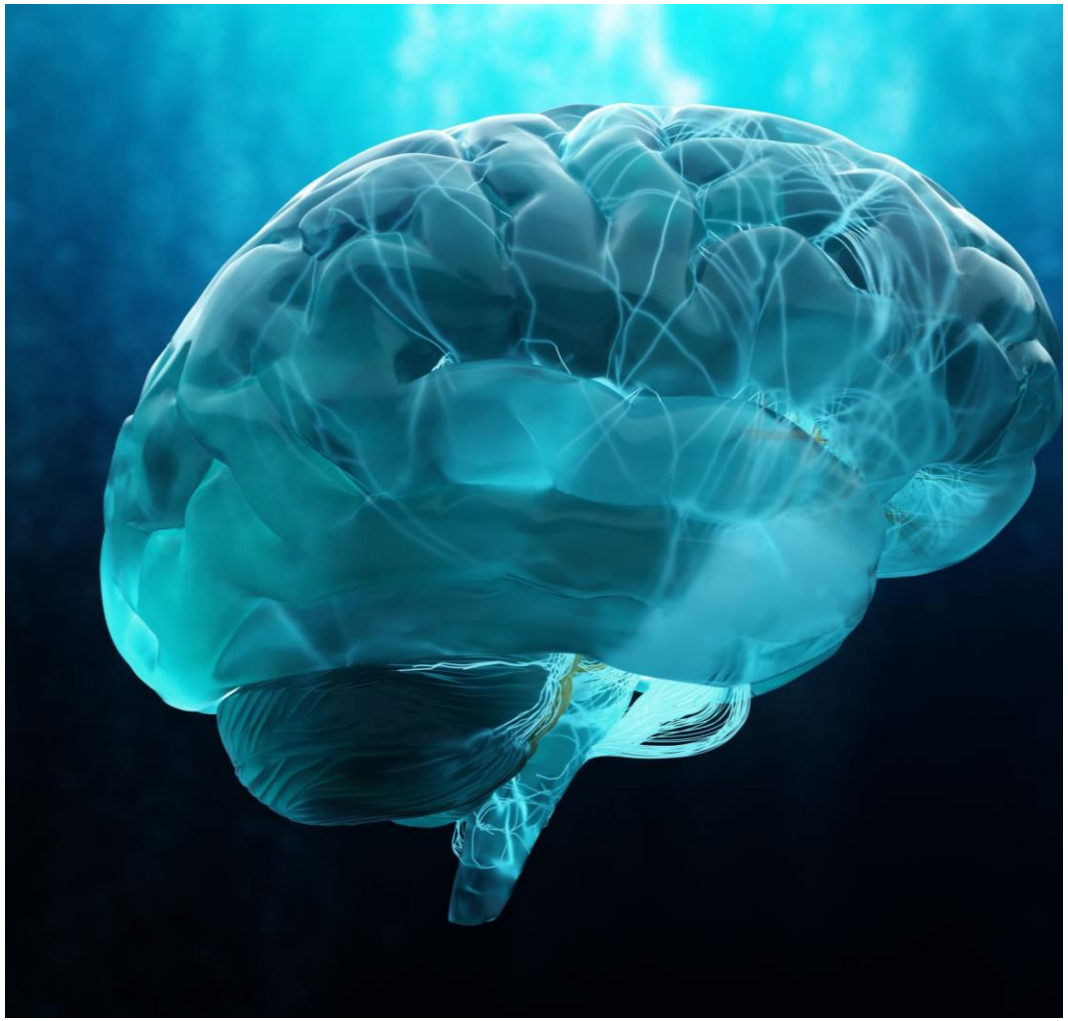
1. An implicit bias is a positive or negative mental attitude towards a person, thing, or group that a person holds at an unconscious level.

2. Schema influenced by gender, racial, and cultural stereotypes

3. Dual Process Theory: System One vs System Two

Bias

- **95 percent** of brain activity is unconscious
- Human Brain
  - conscious brain (40/sec)
  - Unconscious (11 million/sec)
- Order, Understanding, Interactions, Decisions
  - But it can sometimes fail us

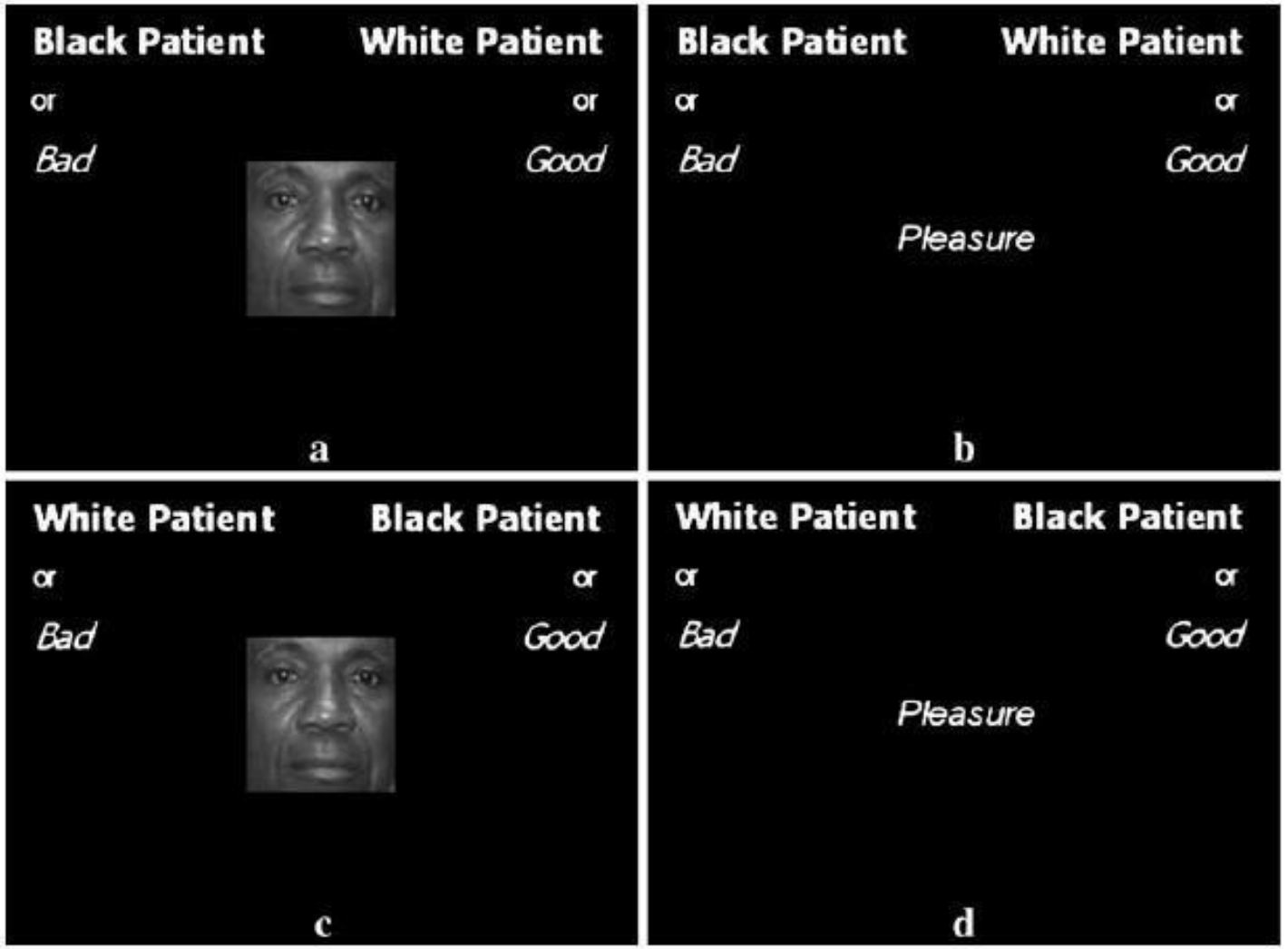


Start with self – Self-awareness training

Harvard Project Implicit Bias

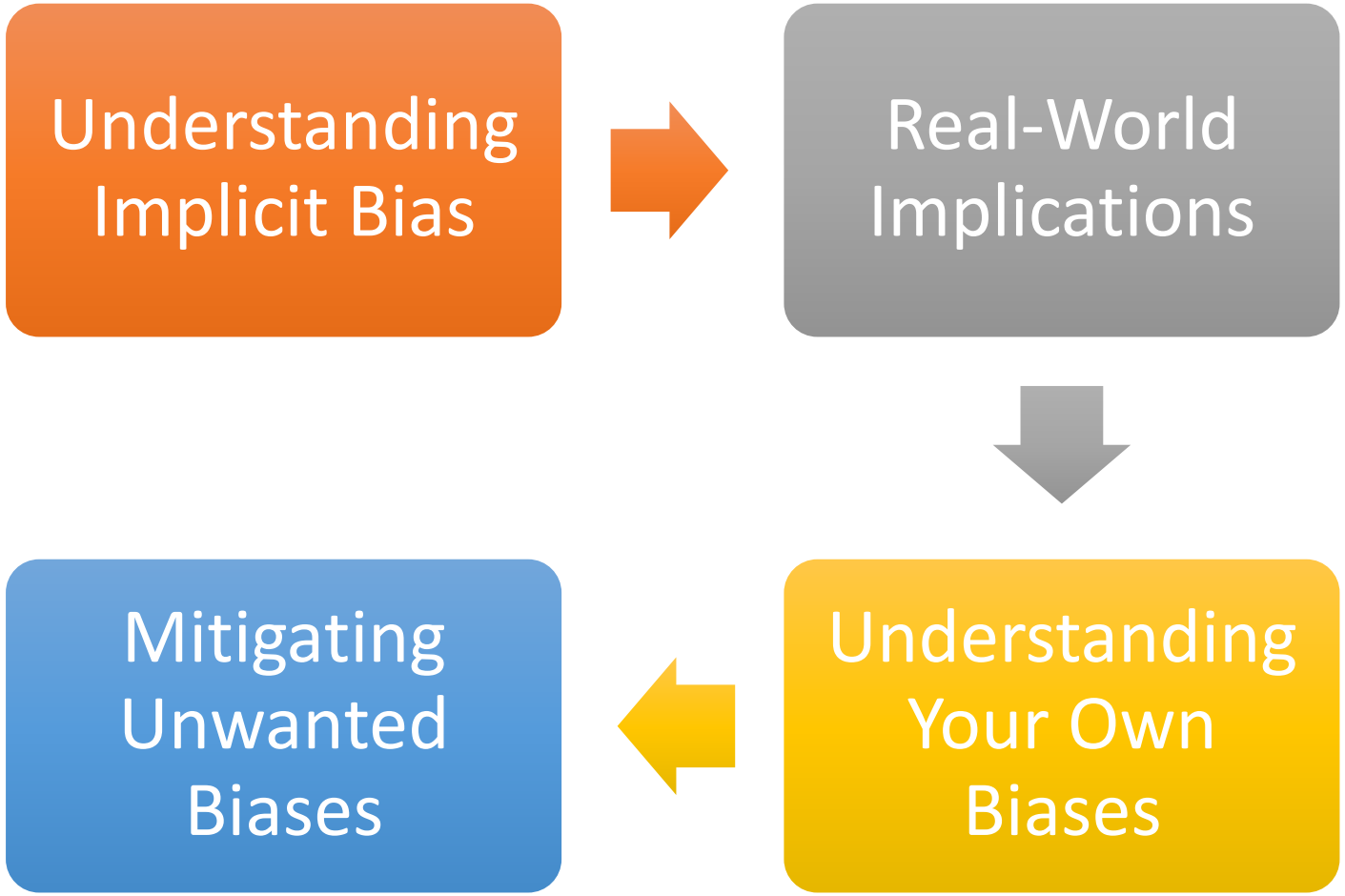
Kirwan Institute Implicit Bias Modules

Implicit Bias



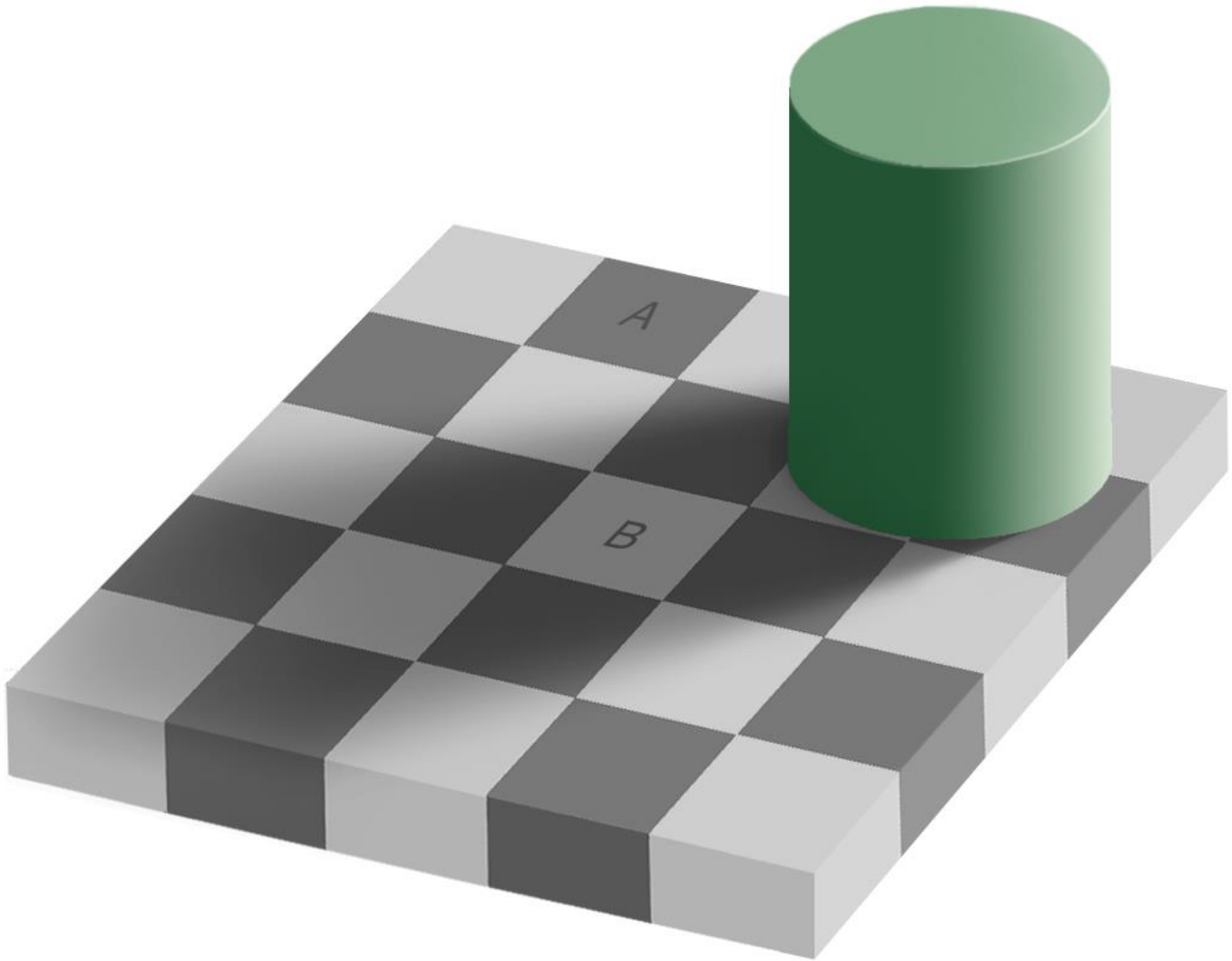
http://thesituationist.files.wordpress.com/2007/08/iat-image.jpg

Implicit Bias Modules

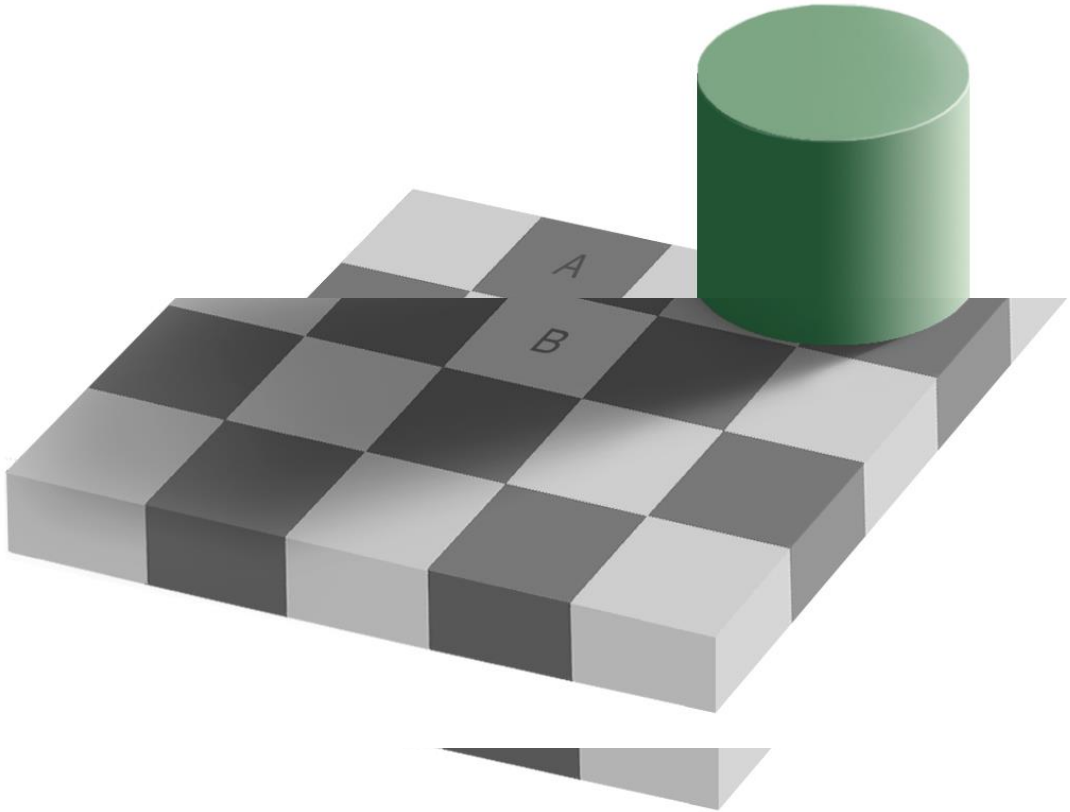


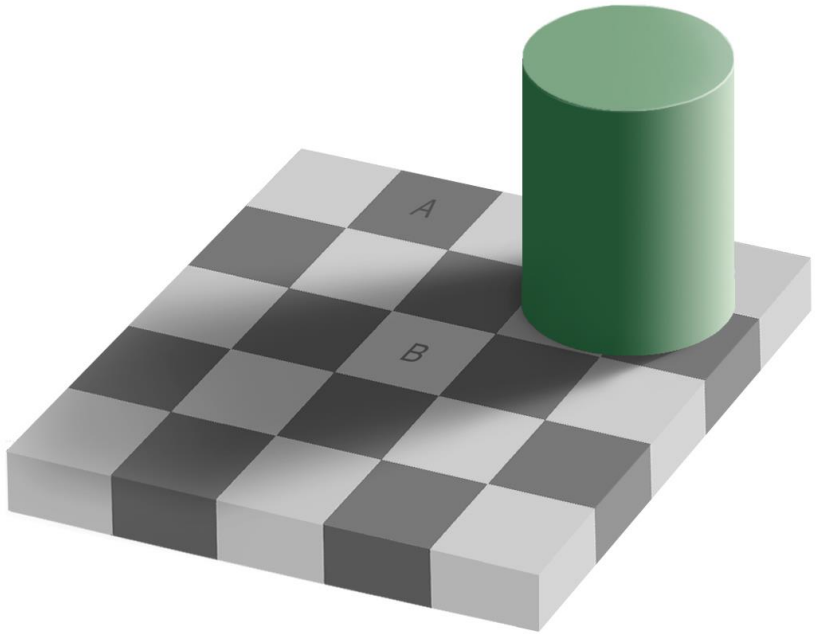
Kirwan Institute for the Study of Race and Ethnicity. Implicit Bias Module Series. http://kirwaninstitute.osu.edu/implicit-bias-training/

Knowledge is Power! Or is it?

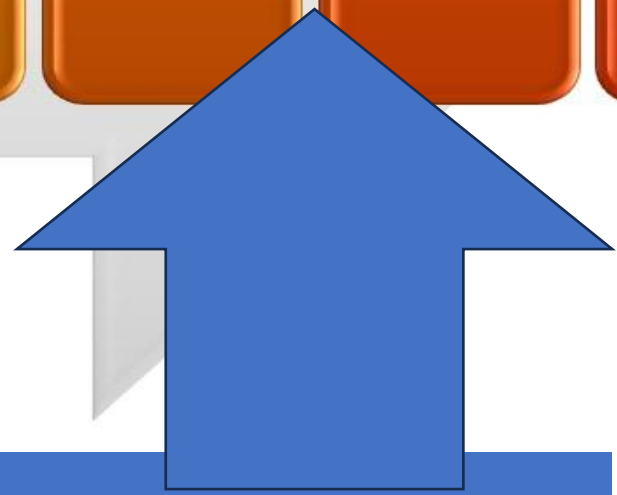


Knowledge is Power! Or is it?





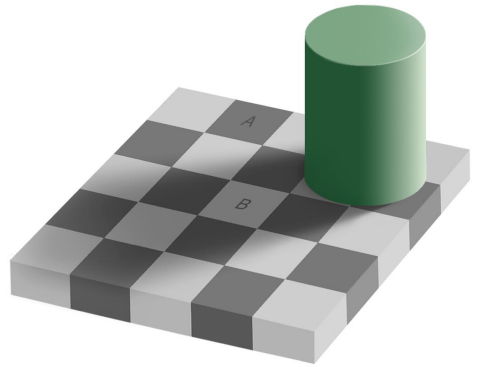
Action Continuum



https://uh.edu/lgbtq/resources/_files/action-continuum.pdf

What can we do?

- Recognize and accept you have bias
- Awareness: IAT
- Critical Reflection
- Common In-group
  - Work together as a team
- Counter-stereotypic characteristics
  - Extended practice---look for counterevidence



Eberhardt, J. Fiske, S. (1998) Confronting Racism: The problem and the response. Thousand Oaks, California: SAGE.
Stone, J. & Focella, E. (2011). Hypocrisy, dissonance and the self-regulation process that improve health. *Self and Identity, 10(3),* 295-303.
Whitley, B. E., & Kite, M.E. (2010). The psychology of prejudice and discrimination. Belmont, CA: Wadsworth.

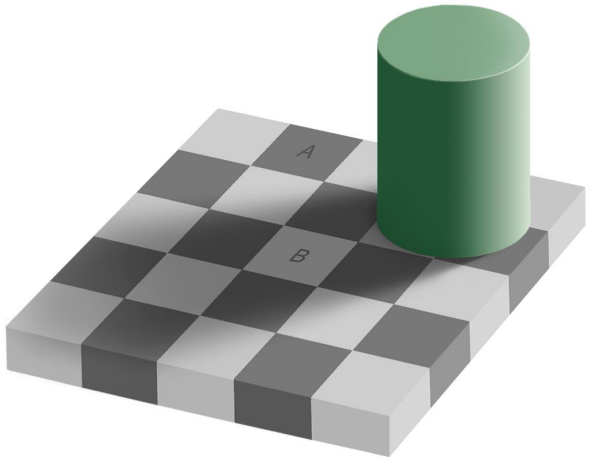
What can we do?

- Mindfulness
  - Pay attention in the present moment
  - Engage our self-regulatory process

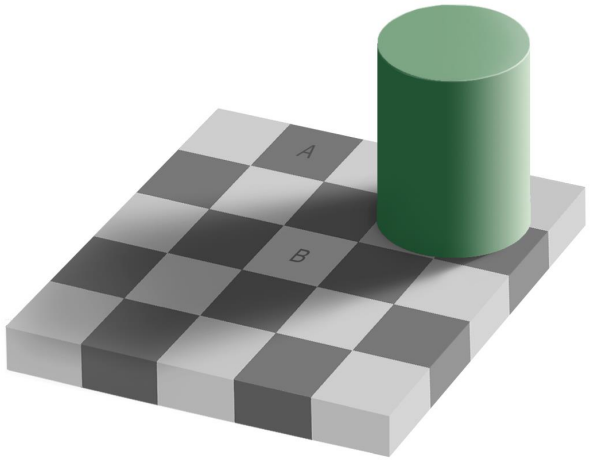
- Reduce Cognitive Fatigue
  - Sleep, De-stress, Snacking

- Practice “Constructive Uncertainty”
  - ask yourself why

- Check in BEFORE and AFTER
  - Explore awkwardness and discomfort



What can we do?



- Perspective Taking
  - Empathy
- Important? Slow down
  - Don’t make quick decisions
- Make assumptions explicit
  - Identify what they are and articulate them
- Humility
  - It’s apart of who we are. We are not bad. We are going to have bias, let’s be humble enough to address

Take Action!

Read

Listen

Watch

Notice

Connect

Engage

Act

Reflect

Stay Inspired

https://www.eddiemoorejr.com/21daychallenge

References and Resources

- Abrams, L. & Moio, J. (2009). Critical race theory and the cultural competence dilemma in social work education. *Journal of Social Work Education, 45*(2), 245-261.
- Bailey ZD, Feldman, JM, Bassett, MT. How structural racism works — racist policies as a root cause of U.S. racial health inequities. *N Engl J Med.* 2021; 384(8):768-773. doi.org/10.1056/NEJMms2025396
- Braveman, P. (2006). Health disparities and health equity: Concepts and measurement. *Annual Review of Public Health, 27,* 167-194.
- Cooper, L., Hill, M., & Powe, N. (2002). Designing and evaluating interventions to eliminate racial and ethnic disparities in health care. *Journal of General Internal Medicine, 17*, 477-486.
- Cultural Awareness Quiz: https://edge.sagepub.com/sites/default/files/9.3_cultural_diversity_awareness_questionnaire.pdf
- Edgoose, J, Quiogue, M, Sidhar, K. (2019). How to Identify, Understand, and Unlearn Implicit Bias in Patient Care. Family Practice Management. https://www.aafp.org/fpm/2019/0700/p29.html
- Healthy People 2030. https://health.gov/healthypeople
- Key Facts: Race, Ethnicity and Medical Care http://kff.org/disparities-policy/report/key-facts-race-ethnicity-and-medical-care/
- Smedley, B.D. , Stith, A.Y. & Nelson, A.R. (2003). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* Washington, D.C.: The National Academies Press.
- Whitley, B. E., & Kite, M.E. (2010). The psychology of prejudice and discrimination. Belmont, CA: Wadsworth.
- Wilson, T. D. (2002). Strangers to ourselves: discovering the adaptive unconscious. Cambridge, MA: Belknap Press of Harvard university press.
- Kirwan Institute for the Study of Race and Ethnicity. Implicit Bias Module Series. http://kirwaninstitute.osu.edu/implicit-bias-training/
- Moore-Bembry N. Cultural Humility: A Life-Long Transformation. *Reflections: Narratives of Professional Helping*. 2020;26(2):4-12. Accessed June 12, 2021. http://search.ebscohost.com.proxy-hs.researchport.umd.edu/login.aspx?direct=true&db=sih&AN=144842952&site=eds-live
- National Academies of Sciences, Engineering, and Medicine. The root causes of health inequity. In: Communities in Action*: Pathways to Health Equity*. Baciu A, Negussie Y, Geller A, et al., eds. Washington (DC): National Academies Press (US); January 11, 2017.
- Nelson A. Unequal treatment: confronting racial and ethnic disparities in health care. *J Natl Med Assoc.* 2002;94(8):666-668.
- Northouse, P. 2017. Introduction to Leadership: Concepts and Practice. Cultural Diversity Awareness Questionnaire https://edge.sagepub.com/sites/default/files/9.3_cultural_diversity_awareness_questionnaire.pdf
- Paul Kivel. *Uprooting Racism : How White People Can Work for Racial Justice*. Vol 4th revised & updated edition. New Society Publishers; 2017. Accessed June 12, 2021. http://search.ebscohost.com.proxy-hs.researchport.umd.edu/login.aspx?direct=true&db=e025xna&AN=1700732&site=eds-live
- Kamalapathy, Pramod N. BA; Dunne, Patrick J. BAS; Yarboro, Seth MD. National Evaluation of Social Determinants of Health in Orthopedic Fracture Care: Decreased Social Determinants of Health Is Associated With Increased Adverse Complications After Surgery. Journal of Orthopaedic Trauma 36(7):p e278-e282, July 2022.

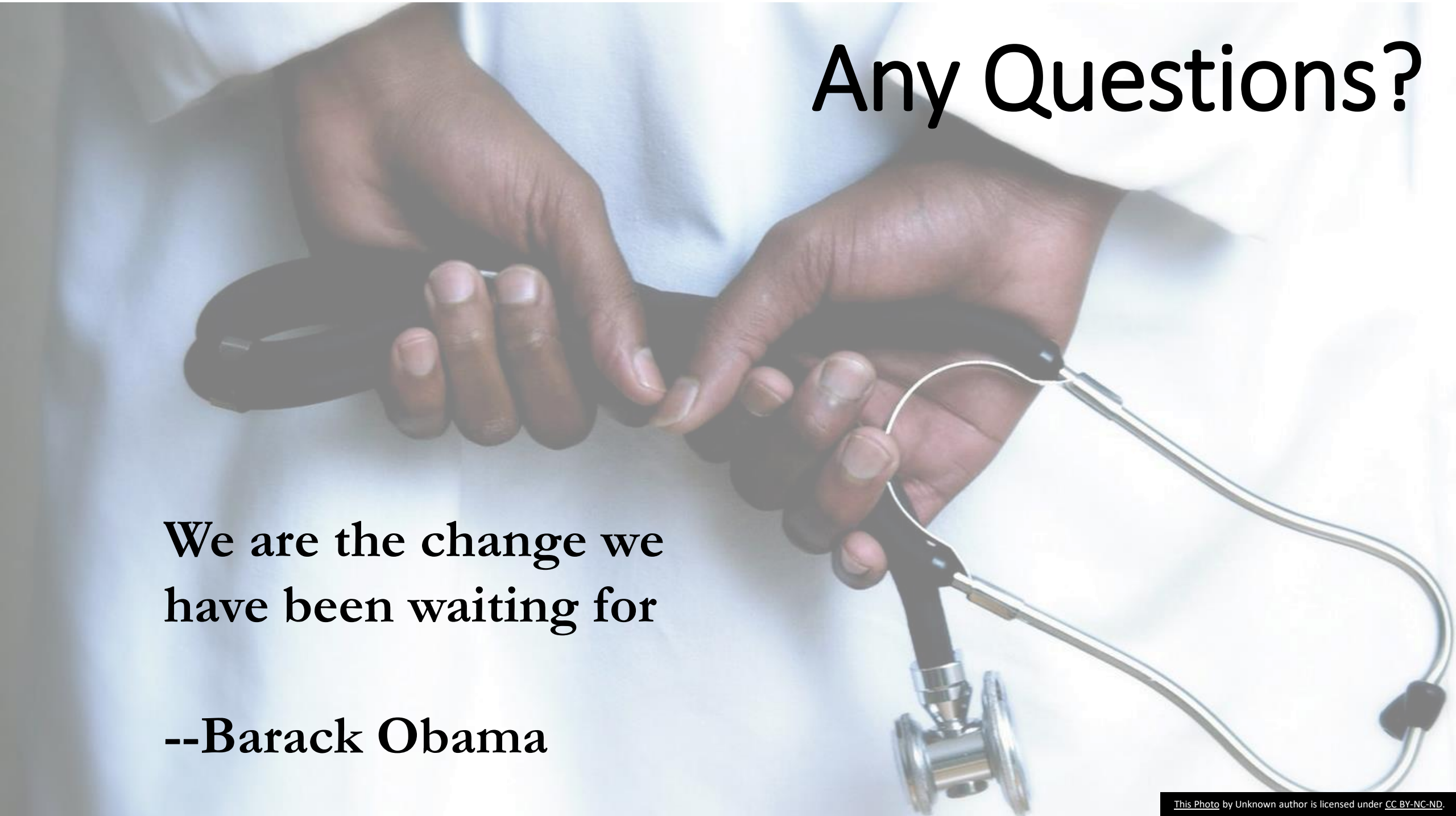
References and Resources

- Physician Assistant History Society. https://pahx.org/
- Healthy People 2030. https://health.gov/healthypeople
- Zelle, B.A., Morton-Gonzaba, N.A., Adcock, C.F. *et al.* Healthcare disparities among orthopedic trauma patients in the USA: socio-demographic factors influence the management of calcaneus fractures. *J Orthop Surg Res* **14,** 359 (2019). https://doi.org/10.1186/s13018-019-1402-8
- White AA III, Hill JA, Mackel AM, et al. The relevance of culturally competent care in orthopaedics to outcomes and health care disparities. *Journal of Bone & Joint Surgery, American Volume*. 2007;89(6):1379-1384. http://search.ebscohost.com.proxy-hs.researchport.umd.edu/login.aspx?direct=true&db=rzh&AN=106007028&site=eds-live
- Levinson W, Hudak PL, Feldman JJ, et al. 'It's not what you say ': Racial disparities in communication between orthopedic surgeons and patients. *Medical Care*. 2008;46(4):410-416. doi:10.1097/MLR.0b013e31815f5392
- Nayar SK, Marrache M, Ali I, et al. Racial Disparity in Time to Surgery and Complications for Hip Fracture Patients. *Clinics in orthopedic surgery*. 2020;12(4):430-434. doi:10.4055/cios20019
- Schoenfeld AJ, Tipirneni R, Nelson JH, Carpenter JE, Iwashyna TJ. The influence of race and ethnicity on complications and mortality after orthopedic surgery: a systematic review of the literature. *Medical Care*. 2014;52(9):842-851. doi:10.1097/MLR.0000000000000177
- Pandya NK, Wustrack R, Metz L, Ward D. Current Concepts in Orthopaedic Care Disparities. *Journal of the American Academy of Orthopaedic Surgeons*. 2018;26(23):823-832. doi:10.5435/JAAOS-D-17-00410
- Nelson A. Unequal treatment: confronting racial and ethnic disparities in health care. *J Natl Med Assoc.* 2002;94(8):666-668.
- Northouse, P. 2017. Introduction to Leadership: Concepts and Practice. Cultural Diversity Awareness Questionnaire https://edge.sagepub.com/sites/default/files/9.3_cultural_diversity_awareness_questionnaire.pdf

References and Resources

- Trinh N-H, Jahan AB, Chen JA. Moving from Cultural Competence to Cultural Humility in Psychiatric Education. *Psychiatric Clinics of North America*. 2021;44(2):149-157. doi:10.1016/j.psc.2020.12.002
- Moore-Bembry N. Cultural Humility: A Life-Long Transformation. *Reflections: Narratives of Professional Helping*. 2020;26(2):4-12. Accessed June 12, 2021. http://search.ebscohost.com.proxy-hs.researchport.umd.edu/login.aspx?direct=true&db=sih&AN=144842952&site=eds-live
- National Academies of Sciences, Engineering, and Medicine. The root causes of health inequity. In: Communities in Action*: Pathways to Health Equity*. Baciu A, Negussie Y, Geller A, et al., eds. Washington (DC): National Academies Press (US); January 11, 2017.
- Bailey ZD, Feldman, JM, Bassett, MT. How structural racism works — racist policies as a root cause of U.S. racial health inequities. *N Engl J Med.* 2021; 384(8):768-773. doi.org/10.1056/NEJMms2025396
- Paul Kivel. *Uprooting Racism : How White People Can Work for Racial Justice*. Vol 4th revised & updated edition. New Society Publishers; 2017. Accessed June 12, 2021. http://search.ebscohost.com.proxy-hs.researchport.umd.edu/login.aspx?direct=true&db=e025xna&AN=1700732&site=eds-live
- **Justice in June | https://justiceinjune.org/**
- **Scaffolded Anti-Racist Resources | Google Doc**
- Cultural Awareness Quiz: https://edge.sagepub.com/sites/default/files/9.3_cultural_diversity_awareness_questionnaire.pdf
- Edgoose, J, Quiogue, M, Sidhar, K. (2019). How to Identify, Understand, and Unlearn Implicit Bias in Patient Care. Family Practice Management. https://www.aafp.org/fpm/2019/0700/p29.html
- Kirwan Institute for the Study of Race and Ethnicity. Implicit Bias Module Series. http://kirwaninstitute.osu.edu/implicit-bias-training/
- Davis A. Hartnett, Peter G. Brodeur, Lindsay R. Kosinski, Aristides I. Cruz, Joseph A. Gil, Eric M. Cohen (2022) Socioeconomic Disparities in the Utilization of Total Hip Arthroplasty, The Journal of Arthroplasty, 37(2), 213-218.e1

Any Questions?



We are the change we have been waiting for

--Barack Obama