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Diversity within diversity 00:49

Once again, on a Zoom call this week, I introduce myself as a two-legged, cisgender, old white man of privilege. I personally know several, not tens or hundreds, of people suffering or dying of COVID-19 - none in my immediate family. I know that racial and ethnic minority populations bear an outsized burden of COVID-19: higher infection rates, more severe illness, and higher death rates. Health disparities and inequities, and institutional racism play a role.

The science of measuring health equity and the effects of institutional racism intrigues me. I feel dissatisfied when I hear the conversation begin and end with slicing and dicing outcomes with race and ethnicity data – African American, Hispanic, Caucasian, Native American, etc. Any profound knowledge of race and ethnicity can only lead to an appreciation of more diversity and nuance. Diversity occurs within diversity. Consider, for example, the factor of whether someone is an immigrant or not (where they were born) Whatever race and ethnicity, is the person born outside the US, first-generation US, or 15th generation or more? If born outside the US, did they immigrate from poverty or wealth? Was a person labeled or self-labeled as Native American born on tribal lands or in a city, registered as Native American or not? Endless permutations and stories.

Diversity plus circumstances inform inequities 02:55

Genetics, nativity, and culture are still not enough. Individual circumstances – lived experience - likely play a role in COVID-19 infection rates - density of work and home, existing chronic conditions, essential worker, primary means of transportation. Indeed, community circumstances impact health equity as well: the time it takes to reach a store to buy fresh fruit and vegetables or reach a hospital with an emergency department; the number of primary care docs taking new patients in your neighborhood or region; maternal death rate; high-speed internet access; the amount spent per pupil in public schools; access to clean water and a functioning sewage system. These kinds of diversity impact health equity.

Community circumstances also reflect institutional racism. In 2018 Maya Groos, et al. wrote Measuring Inequity: A Systematic Review of Methods Used to Quantify Structural Racism. It described ways that

researchers measured structural racism. A few of the one included: residential neighborhood/housing, perceived racism in social institutions, socioeconomic status, criminal justice, immigration and border enforcement, political participation, and workplace environment. In 2020 Egede and Walker wrote Structural Racism, Social Risk Factors, and Covid-19 — A Dangerous Convergence for Black Americans. The article noted that social deprivation from reduced access to employment, housing, and education; increased environmental exposures; inadequate access to health care; physical injury and psychological trauma resulting from state-sanctioned violence, all affect health burden.

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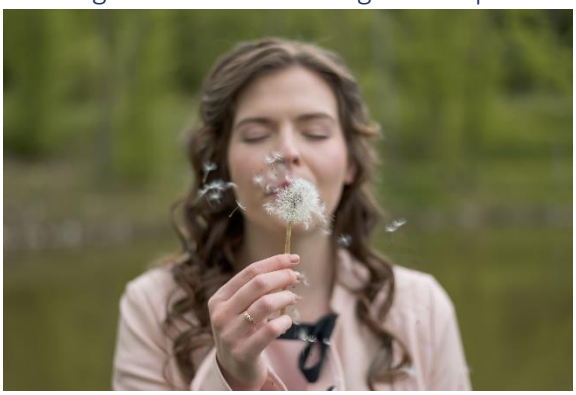
Research to inform action 06:25

OK, stop. I'm a bit overwhelmed. What do I try to accomplish with research? Research informs decision-making in the face of uncertainty, so I can act. A decision is an early action. Action, like circumstances, can be personal or community. Personal - making choices about habits, lifestyle, treatment, connections, spending, media choices. Community – policy development and implementation, funding and resource allocation, election choice, coalition building. My seasoning teaches me that action - behavioral, and cultural change - are way tougher than research.

Don't we already know that institutional racism, health inequities, and health outcomes go hand-in-glove? If someone doesn't already know that, will research influence them? Can measuring racism and inequity dent either? OMG, racism and inequities are so huge; I don't know where to start. Maybe if I knew the relative impact of various flavors of racism and inequities, I could choose the flavor with the most significant impact. Perhaps access to credit markets has more effect than social justice. It may or may not, but you get the idea. But who thinks like that? If we have circumstances, ability, passion, and opportunity to act, will research really inform the direction we take? Goodness, I've talked myself into a hole. Help, I'm lost and can't get out.

Planting seeds of co-learning and co-production 08:00

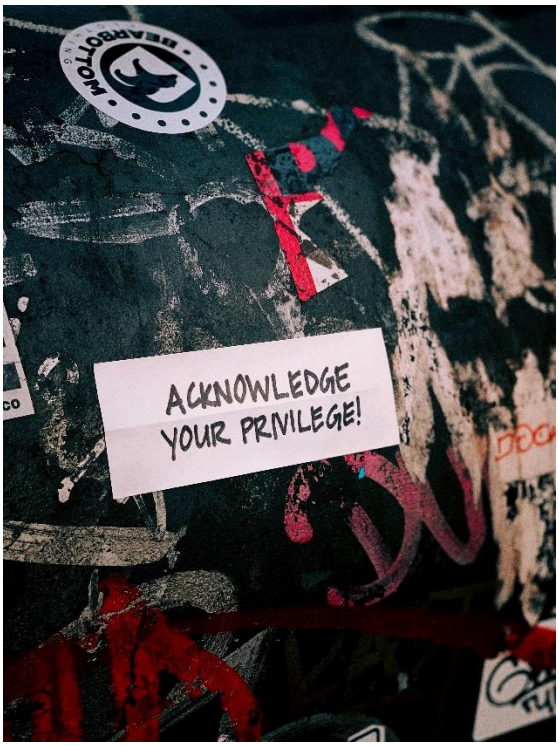


OK, deep breath. Addressing health inequities and institutional racism requires behavioral and cultural change. What do I know about behavioral and cultural change? I know that the most challenging yet fruitful connections in my life come from people with different brains, experiences, languages, cultures than me. Diversity coming together for a common purpose, no matter the size or cause, fertilizes seeds of action. I can look to my experiences as a boss, team member, podcaster, and working as a patient-caregiver stakeholder with PCORI, a technical expert with the National Academy of Medicine, National Quality Forum, CMS, and others. We did inspiring work during all these collaborations, and I met people I continue to work with and rely on regularly – weekly, monthly, ad hoc. I know their value and trust them. We can engage in moments and help each other take concrete, inspiring action. So, convening diverse stakeholders for research projects to better understand the impact of equity and racism and related research methods can create connections with culture of curiosity, respect, and trust. Connections plant seeds for co-learning that sprout into co-production of solutions and implementation. Co-learning and co-production are broad-spectrum antidotes to inequity and racism.

Health services research 10:02

Diverse co-production and co-learning can zoom out to a larger picture of the canopy (continuing the seeds to forest analogy). For example, if stakeholder-engaged research produces evidence that health inequity and institutional racism have a more significant impact on maternal and infant deaths than medical care, why fund more comparative studies of medical treatments? Instead, fund studies of community interventions, public policy, access to services, and provider behavior. See the more in the Center for American Progress article on Eliminating Racial Disparities in Maternal and Infant Mortality. Today, I listened to an episode of Casey Quinlan's Healthcare is Hilarious (full disclosure, I'm a sponsor of Casey's podcast). The episode, Lisa Simpson, Kristin Rosengren, Academy Health, and anti-racism in research opened my eyes to a wide range of health services research possibilities.

Doing my own work 11:12



Finally, let's remember that inequities and racism occur in communities - my communities, your communities. Town, county, state, workplace, home, clients, membership organizations, cronies are all communities. We impact inequities and racism in our communities with action and inaction. I need to do my own work. I'm on the PCORI (Patient-Centered Outcomes Research Institute) Board of Governors. What can I do as a privileged person in a privileged role in that privileged community? I could advocate for funding to develop more mature measurement methods of inequity and racism. I could advocate for mentorships of more diverse, younger investigators by seasoned investigators. I could back enhanced merit review criteria examining a funding request's impact on inequities and racism. I could support funding to increase under-represented community capacity to seek and obtain health services research. I could do more. I have tools in my toolbox to make a difference. I could use more tools. I better get to work. What are you going to do?