The link between Public Health and Medicine to improve health outcomes for Black and Brown Communities

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Combining public health initiatives with traditional medicine can significantly improve health outcomes for BIPOC (Black, Indigenous, and People of Color) communities.

Here are some ways this collaboration can be effective:

- Culturally Relevant Care: Integrating traditional medicine practices, such as herbal remedies, healing circles, and storytelling, into public health strategies can make healthcare more culturally relevant and acceptable.
- Building Trust: Historical and contemporary experiences of systemic racism and medical malfeasance have led to distrust in the healthcare system among BIPOC communities. Collaborating with the BIPOC community and its leaders can help to bridge this trust.
- Holistic Approaches: Traditional medicine often emphasizes holistic care, addressing physical, mental and spiritual health. This aligns well with public health goals of promoting overall well-being.

Here are some ways this collaboration can be effective:

- Community Engagement: Public health initiatives involve community members in the planning and implementation stages are more likely to succeed. Traditional medicine practitioners can play a key role in these efforts.
- Addressing Disparities: The COVID-19 pandemic highlighted and exacerbated health disparities in BIPOC Communities. Combining public health efforts with traditional practices can help address these disparities more effectively.

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By working together, public health professionals and traditional medicine practitioners can create more inclusive and effective health strategies for BIPOC communities.

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Social Determinant of Health

- Social determinants of health (SDoH) as defined by the US Centers for Disease Control and Prevention (CDC) are the conditions in which people live, learn, work, and play that are determined by the distribution of money, power, and resources and that affect a wide range of health and quality-of-life risks and outcomes.
- Economic disparities disproportionately place Black, indigenous, and people of color (BIPOC) within zones marked by substandard health promotion and excessive health risks.
- The compounding nature of adverse SDoH, such as housing instability, food insecurity, poor healthcare access, and hazardous exposures, has serious health implications.
- Health disparities are the profound downstream effect of the socioeconomic disadvantages that BIPOC endure under the moniker *structural racism*.

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Structural Racism

- Structural racism, *implicit bias*—defined as unconscious attitudes, positive or negative, toward a person, group, or idea—often leads to differential treatment based on perceived race.
- Implicit bias further restricts quality healthcare as a separate factor above and beyond inequities of structural racism.
- Emergency department (ED) data indicates that Black (vs White) patients have longer treatment wait times, longer lengths of stay, and lower triage acuity levels.
- Additionally, Black ED patients have a 10% lower likelihood of admission and 1.26 times higher odds of ED or hospital death than White patients.
- Research also suggests that physicians' own implicit racial biases may contribute to disparities in healthcare quality and delivery.

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- Across clinical pathology interests and in almost every area studied, BIPOC communities experience worse patient care and health outcomes.
- Contrary to historical medical teachings, there is no biological evidence for the concept of race as a genomic human subspecies to explain health disparities.
- Rather, it is the social interpretation of people in a race-conscious society that disparately impacts health.
- The system of structuring opportunity and assigning value, based on assumptions about groups of people with certain physical attributes, systematically privileges some while disadvantaging others and undergirds the deadly problem of structural racism.
- Physicians must acknowledge the insidious health threat that implicit biases and structural racism pose. Disproportionate levels of socioeconomic disadvantage, social vulnerability, and poor health outcomes are manifestations of long-established and deeply entrenched racial segregation and racial deprivation.

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In this critical to explore the complex effects of **race**, **implicit bias**, and **structural racism** on SDoH, healthcare quality and, ultimately, health outcomes.

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Condition Example: HIV/AIDS

- Racial and ethnic disparities in the incidence and prevalence of HIV infection and AIDS have been documented in the US since the 1980s.
- Despite prevention, identification, and treatment advances, Black-White and Hispanic-White disease incidence disparities have increased since 1984.
- In 2013, Blacks and Hispanics accounted for 46% and 21% of new HIV infections and 49% and 20% of new AIDS diagnoses despite representing 12% and 16% of the total US population, respectively.
- Although HIV incidence rates have improved in recent decades, Blacks and Hispanics have benefitted less from antiretroviral therapy advancements.
- Incidence rates (IR) have declined with the advent of pre-exposure prophylaxis (PrEP); however, PrEP usage remains disparately low among Black (5.9%) and Hispanic (10.9%) adults with an indication as compared to Whites (42.1%).

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What can Public Health and Traditional Medicine do to lower the incidence of HIV and AIDS among the Black and Brown Communities in Oklahoma?

- Increase access to HIV testing and referrals to PrEP and post-exposure prophylaxis.

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Condition Example: Type 2 Diabetes

- Type 2 diabetes prevalence rates among Black (13.2%) and Hispanic (12.8%) Americans are similar and higher than rates among Whites (7.6%).
- Well-controlled glycemia and hospitalization rates, quality indicators, are both worse among Black patients (37.6% and 26.5%, respectively) compared to Whites (44% and 16.1%, respectively).
- The marker of glycemic control, hemoglobin A_{1c} ($HgbA_{1c}$), is statistically worse among Black vs White patients ($HgbA_{1c}$ 9.1 ± 2.9% vs. 8.5 ± 2.2%, $P = 0.001$).
- Black and Hispanic patients have higher odds of diabetes-related ED visits (odds ratio [OR] 1.84, 95% confidence interval [CI] 1.7–2.0 and 1.60, 95% CI 1.4–1.8, respectively) than Whites.

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Public health departments and Traditional Medicine can help reduce the incidence of type 2 diabetes in the Black and Hispanic community by providing interventions for individuals and community groups at higher risk for the disease. These interventions can include:

1. Education:Teaching about diabetes prevention and lifestyle changes
2. Support: Providing informal counseling, coaching, and extended support for people with a higher risk for diabetes
3. Community resources: Identifying or developing resources to support healthy lifestyle

What can Public Health and Traditional Medicine do to improve health outcomes for Black and Brown Communities in Oklahoma?

- Participate in local, state, and federal government forums advocating for health through resources and advantages historically inaccessible to BIPOC Communities.
- Develop meaningful individual and organizational partnerships with antiracist stakeholders and communities (ie, Black Lives Matter, White Coats for Black Lives, etc).
- Engage medical leadership in changing organizational culture to one that consistently prioritizes equity, addresses inequities in clinical and professional spaces, and recognizes the systematic advantage of privilege.
- Create permanent positions accountable to equity, diversity, and inclusion initiatives and ensure core leadership articulates diversity as an institutional priority and dialogues constructively with all relevant stakeholders.
- Identify racial disparities and their sources within the system, conduct root cause analyses, and implement strategies to remedy inequities.

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What can Public Health and Traditional Medicine do to improve health outcomes for Black and Brown Communities in Oklahoma?

- Educate medical personnel through multimodal continuous medical education on trauma-informed care, anti-racism practice, and cultural humility.
- Increase BIPOC representation within the pipeline and across all organizational strata.
- Evaluate the impact of educational programs on patient care and health outcomes to curate efforts. Disseminate evidence-based best practices.
- Endeavor as an institution and specialty to eliminate racialized conceptions of disease susceptibility (eg, casting Blacks as innately diseased and dehumanizing their suffering).
- Describe, document, and proactively work to mitigate the health impact of racism
- Draft policies and enforce protocols for dealing with race-based aggression by patient and other staff.

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As Public Health Professionals and Traditional Medicine Practitioners, we must acknowledge that structural racism drives health inequities.

This issue is a matter of life and death…it is time for leaders who care enough, know enough, will do enough, and are persistent enough to eliminate health inequities in our community.

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