

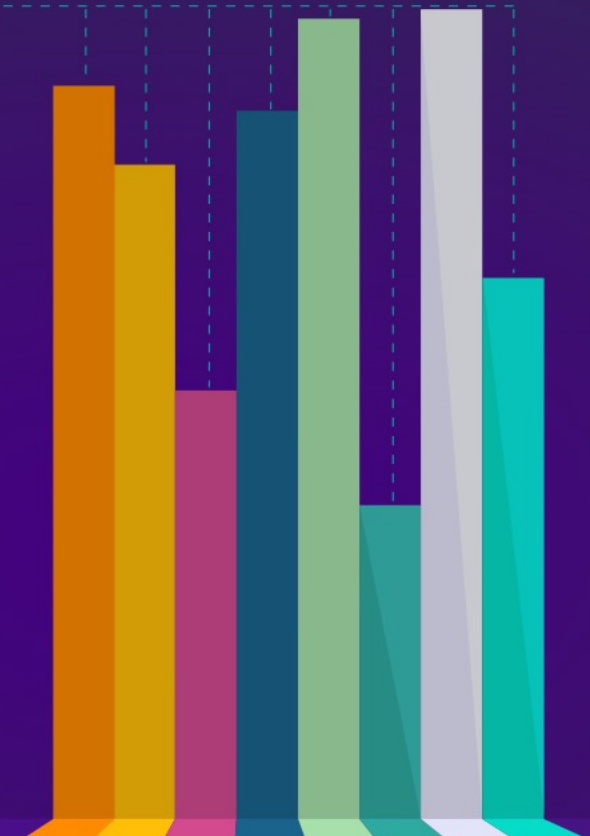
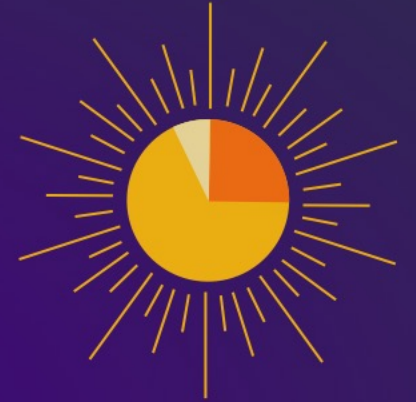
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Social Interventions Research & Evaluation Network

RACIAL HEALTH EQUITY IN SOCIAL CARE

2022 National Research Meeting

How do we put anti-racism into practice in tech-forward SDOH interventions, and what does it mean for the field?



Day 3: How do we put anti-racism into practice in tech-forward SDOH interventions, and what does it mean for the field?



Artair Rogers



Sonia Sarkar



Lisa Richardson



**Jen Lewis-
Walden**

Agreements for a safe and brave meeting

Practice active, judgement-free, and empathetic listening

Respect each other's differences and backgrounds

Agree to disagree – but seek understanding. We are here to learn!

Honor the difference between unsafe and uncomfortable

Be curious about intentions but recognize that impact is more important than intentions

Welcome being called in as a gift and an invitation to learn

Be mindful of positionality and power dynamics

Acknowledge judgments and assumptions (including our own – we all have biases)

Use inclusive language and avoid using derogatory or stigmatizing language

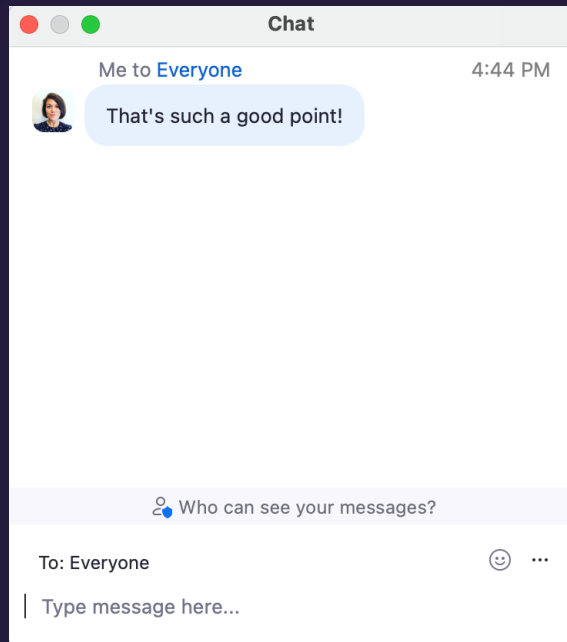
Release control, privilege, and notions of being right

Accept that things may remain unresolved; we might not feel a sense of closure

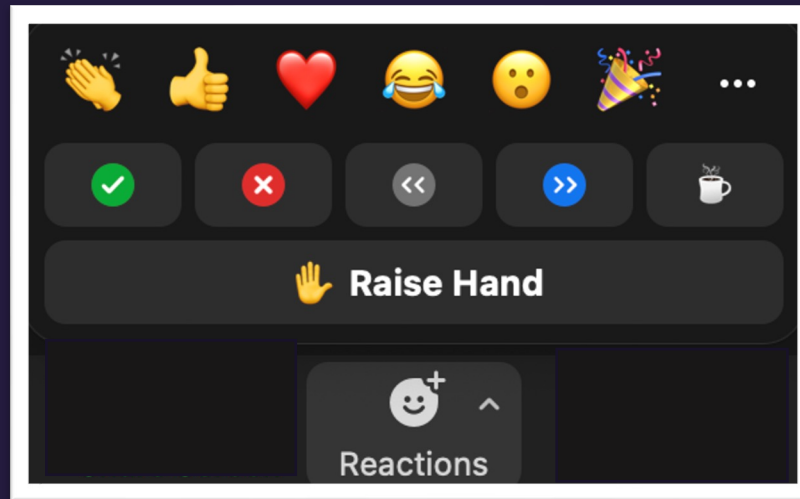
Reminder: This session is being recorded. Recordings and slides will be available after the meeting.

3 Ways to Engage in the Room

1. Chat Window

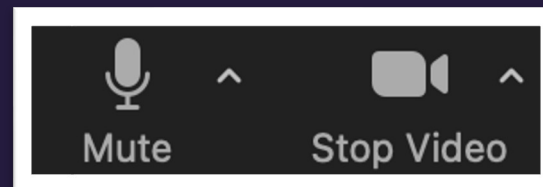


2. Emoji Reactions

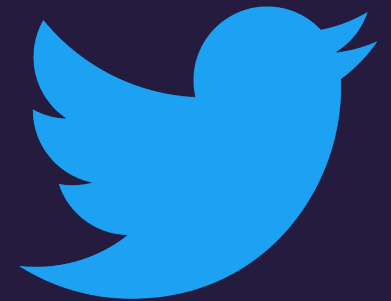


3. Audio and Video

(We encourage you to keep your camera on during the session)



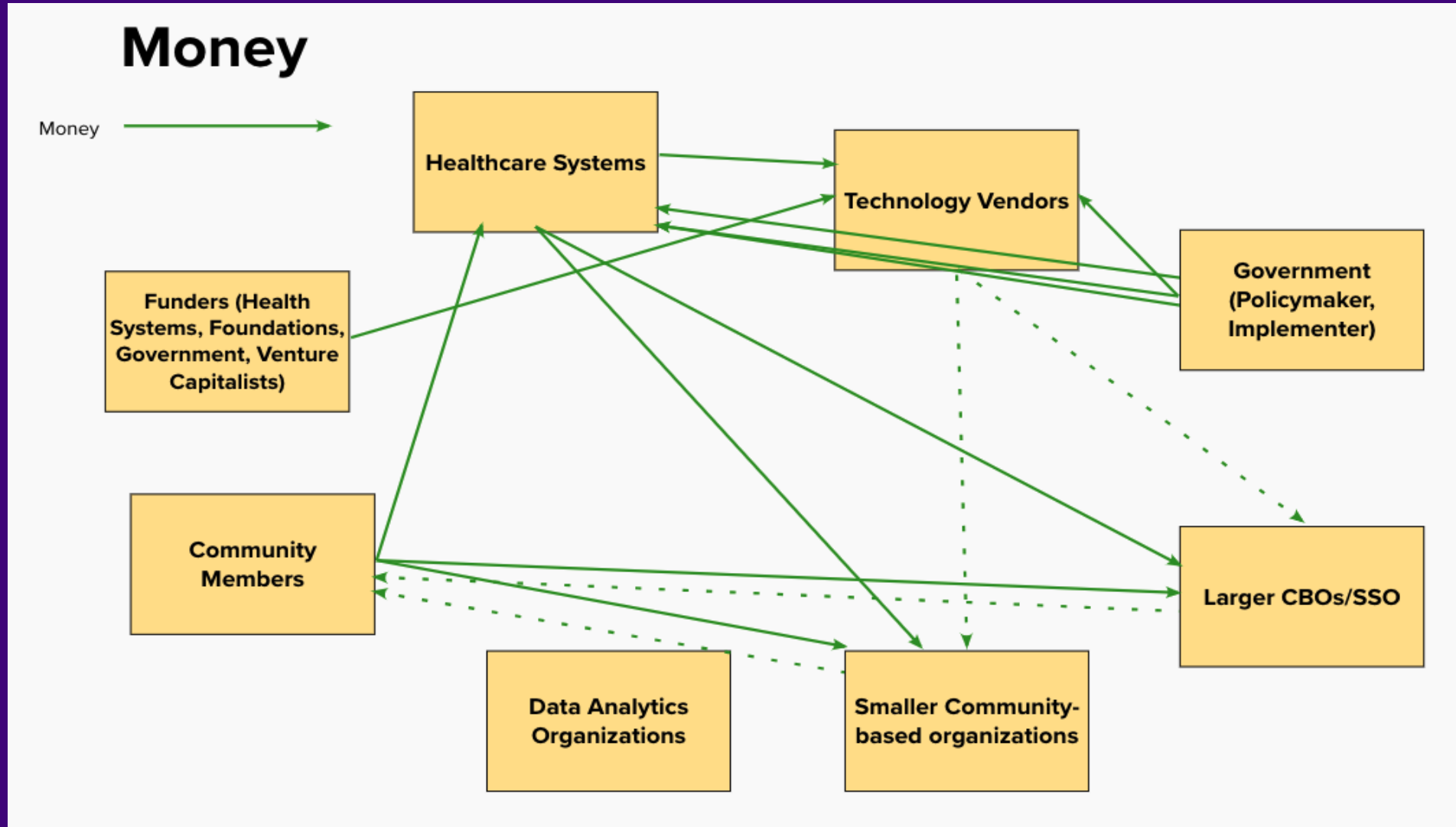
...and on Twitter!



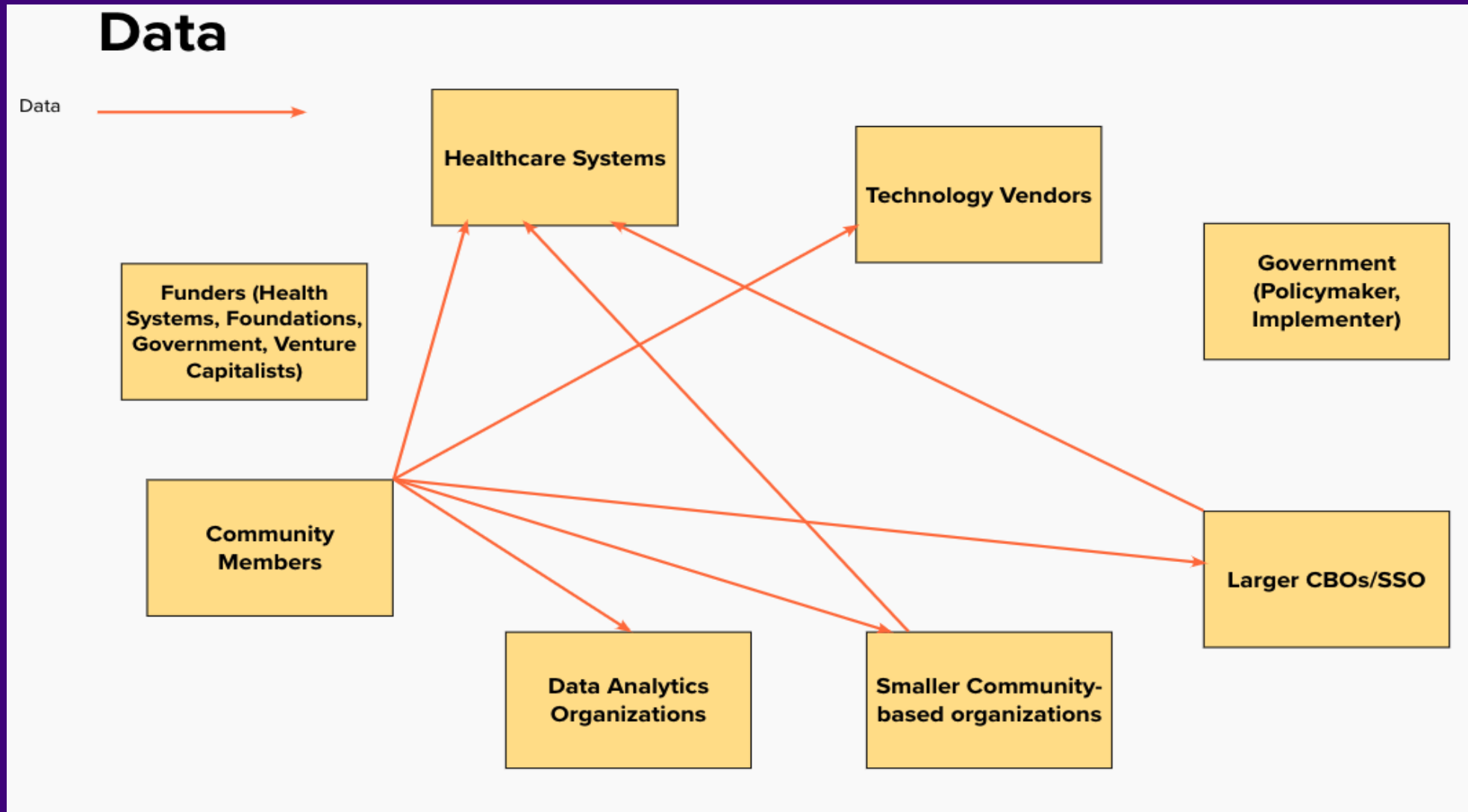
#SIRENRacialEquity

@SIREN_UCSF

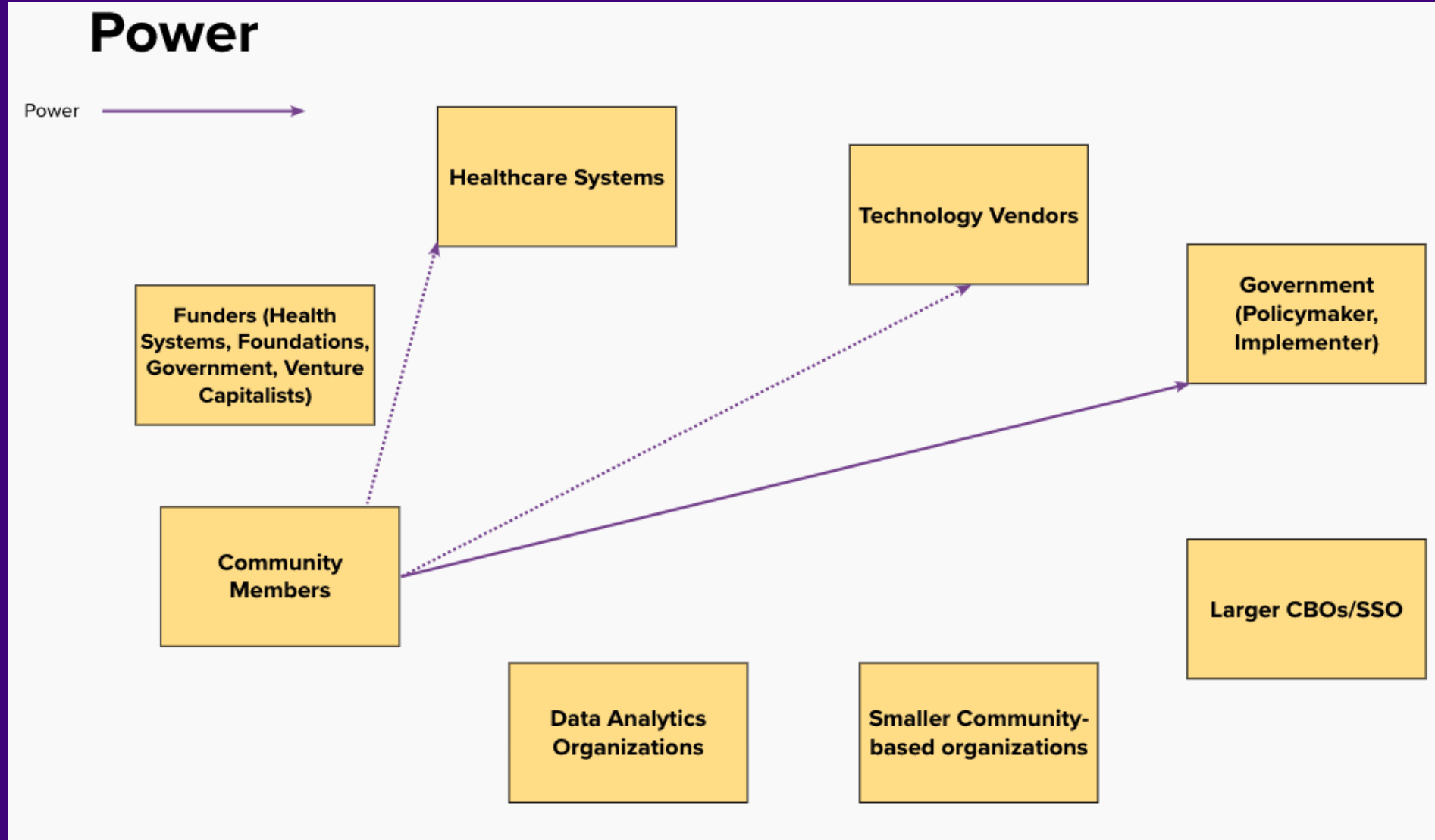
Perception of Tech Forward SDOH Solutions



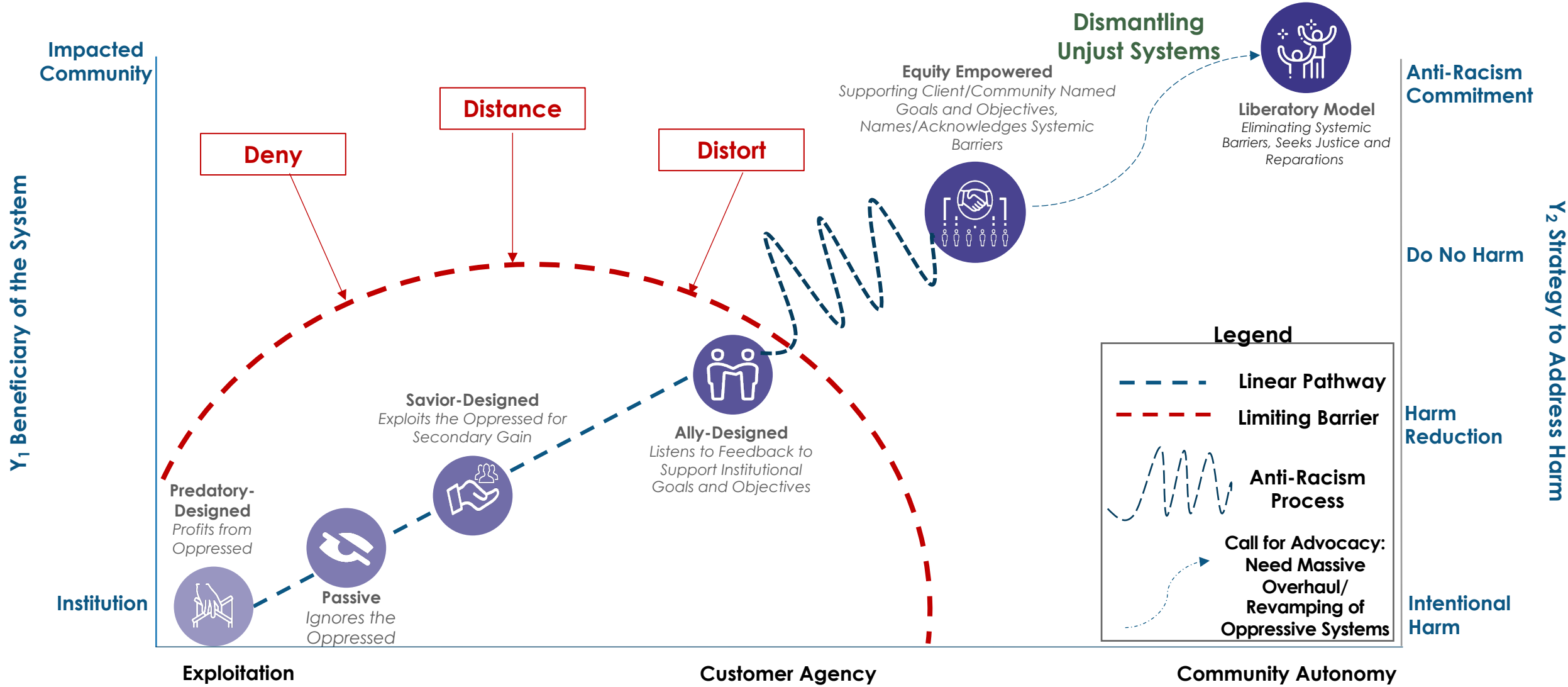
Perception of Tech-Forward SDOH Solutions



Perception of Tech-Forward SDOH Solutions



Landscape of System Design – Institutional Reflection



X Impact on Oppressed Community

The CIE Data Equity Framework." CIE San Diego, 16 March 2022, <https://ciesandiego.org/data-equity/>.

Chow, R.M. . Phillips, L. Lowery, B.S.. Unzueta, M.M.. *Fighting Backlash to Racial Equity Efforts: Understanding the Real Reasons Why Diversity Initiatives Provoke Opposition Can Help You Lead Employees Through Cultural Transformation* . MIT Sloan Management Review(Summer 2021)

System types partially adapted from the National Institute for Children's Health Quality. <https://www.nichq.org/insight/savior-designed-equity-empowered-systems>

Positivist View of Investment in Addressing Social Needs/Social Determinants of Health

Study Design

We ran multiple regressions on community benefit expenditures linked with the number of health professionals, food insecurity, and adherence to diabetes and hypertension medication for each county.

Data Collection

The three outcomes were chosen based on prior studies of community benefit and a recent survey sent to 12 health care executives across four regions of the U.S. Data on community benefit expenditures and health outcomes were aggregated at the county level.

Principal Findings

Average hospital community benefit spending in 2019 was \$63.6 million per county (\$255 per capita). Multivariable regression results did not demonstrate significant associations of total community benefit spending with food insecurity or medication adherence for diabetes. Statistically significant associations with the number of health professionals per 1000 (coefficient, 12.10; SE, 0.32; $p < 0.001$) and medication adherence for hypertension (marginal effect, 0.27; SE, 0.09; $p = 0.003$) were identified, but both would require very large increases in community benefit spending to meaningfully improve outcomes.

Findings found that community health investment in food security does not yield a statistically significant association with adherence to diabetes and hypertension.

Implications:

- Community benefit does not yield ROI desired within the time dictated by researchers/healthcare leadership.
- The investment in food insecurity is questioned due to lack of statistical association .

Other thoughts:

- Who set diabetes and hypertension medication as metric of success? Why?

Influx of Investment focused on SDOH

Accountable Health
Communities
Introduction

SDOH is between **40%
to 50%**
Medicare/Medicaid
Cost Structure

2.5 billion dollars of
health systems funds
are invested in SDOH

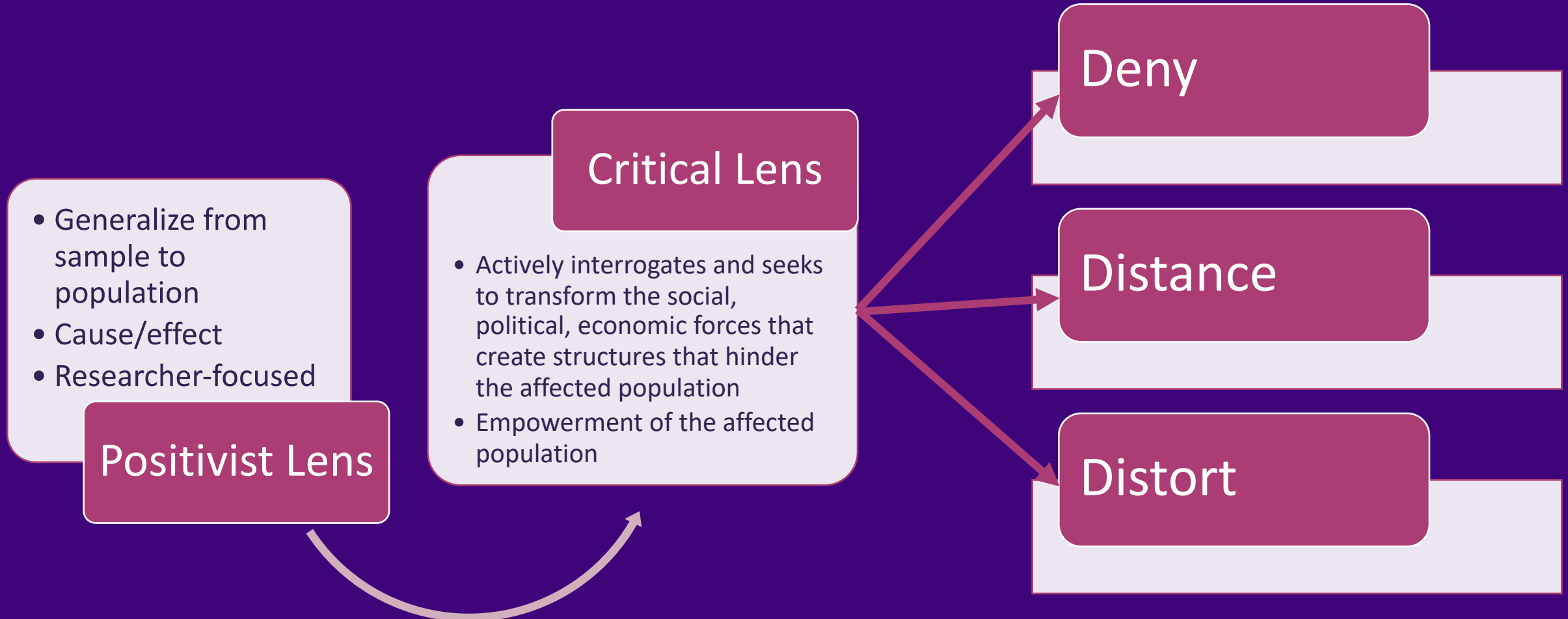
58 Companies
\$2.4 billion in funding
\$18.5 billion valuation
(mostly in CA, NY, MA, IL)

5 companies alone have
a **total valuation**
between **\$100 million**
and **\$1 billion**

**1 SDOH Technology
Company** alone has a
valuation of \$1 billion

- Why is funding concentrated in a few companies in a few places?
- What does the investment structure say about the SDOH sector landscape?
- How does this funding structure correspond with antiracism and equity?
- How would community respond to this investment structure?

Moving to a Critical (Antiracism) Lens



Institution and/or individual actively or inactively DENIES systemic racism is a significant oppressive force for marginalized communities in SDOH/social needs work.

Structural Racism is not interrogated in SDOH research

Research serves as a gatekeeper to establish the type of evaluation that is important.

Research serves as a gatekeeper determining what is an effective intervention.

Ignore positionality of institution

Failure to understand and interrogate who profits/benefits from SDOH funding and investment

Ignore positionality of individuals who have power in the SDOH intervention/research

ACCOUNTABILITY QUESTIONS

Does work to examine racialized differences in health outcomes explicitly name structural racism as a driver?

Can qualitative data on the lived experience of people most impacted by racism and discrimination improve SDOH work?

How might we use SDOH solutions, including tech-forward ones, to create sound measures of structural racism?

How might we interrogate the positionality of the institution and the institution conducting the research on marginalized communities?

How might we create data narratives that actually highlight the need to invest in marginalized communities and individuals?

How do we ensure that we empower those without formal training who come from marginalized communities (especially folks with lived experience) to be seen and utilized as inquirers and researchers of their own lived experience?

The institution and/or individual DISTANCES itself/oneself from the power it has and avoids addressing the power imbalance between those in power and the most affected community.

Does not empower affected populations to set research agenda

Research deliverables are set by institutional powers---not affected community

Does not partner and invest in BIPOC-led tech, BIPOC community leaders, and research/evaluation with a critical approach

Community does not play an active role in data narrative

Research narratives characterizes community within a deficit frame if metrics of success are not met

ACCOUNTABILITY QUESTIONS

Can the perspectives of those most impacted by racism and inequities establish how success is defined and measured?

How might we fully invest in BIPOC-led solutions, including technology? How might technology be framed as a tool for BIPOC leaders to gather data meaningful to the community/community needs?

Is a power analysis incorporated into research and evaluation of SDOH initiatives?

How might the most marginalized shape the research/evaluation agenda and the deliverables of research and evaluation?

How might the community frame and verify the data narrative used in research deliverables, including research journals?

How might we move from framing the community from a deficit framing?

Are you using community based organizations as a proxy for community engagement? How are you reaching the most marginalized? How do you know?

Do institutions and vendors have mechanisms of communicating with, reporting to, and soliciting ideas for improvements from those that the SDOH intervention is intended to serve?

Research DISTORTS the value case of SDOH/social needs intervention by prioritizing institutional needs over the most marginalized community.

Implies investment to address impacts of structural racism is not worthwhile due to INSTITUTIONAL OBJECTIVES

Pushes heavily against known/assumed/ implied associations

Pushes heavily against or dismisses the knowledge of lived expertise of most affected communities

Prioritize data capture for statistical modeling or machine based learning only to characterize marginalized communities

No community verification of data narrative that is created and seeks to be published

Research is used for publication only. There are no research products developed for community use.

ACCOUNTABILITY QUESTIONS

Does the data collection process deepen existing harms caused by data surveillance and social service algorithms?

How does this process honor existing community definitions of success and data (oral histories, qualitative data, etc.)?

In what ways are community narratives centered in the design/evaluation of these programs, rather than dominant healthcare institution narratives?

When success defined by the institution is not met, how do we ensure that the evaluation is not used to unintentionally harm the community (i.e. not investing in solutions that address structural racism)?

Are the research products accessible for the community? How can the community, particularly the most marginalized, use the product of the research?

How does the SDOH intervention, evaluation, research facilitate agency for those being studied (the most marginalized)?

DISCUSSION QUESTIONS

- What narratives or tactics does your organization deploy in the context of SDOH evaluation and research that can be used to DISTORT research aims to institutional priorities over community priorities? What is your role/relationship to those tactics and narratives, and why are they effective?
- How are you individually interrogating your positionality and seeking to push back against those narratives and tactics? What are some of the shifts you are leading internally to ensure shared power with community re: evaluation and research?

Our Call To DISMANTLE Unjust, Structural Racist Systems

Learning Network

Rationale

- Feedback from community based leaders that current health equity frames do not enable actual power-sharing.

The Work

- This network seeks to develop actual standards around healthcare accountability by engaging in political education with healthcare leaders and centering community leader expertise, then executing on actual power-shifting projects

Want to Get Involved

- We would love to invite in this group and other institutions in the sector to investigating their own roles and co-developing accountability standards.
- Convening in early 2023
- Email Artair Rogers (arogers@g.harvard.edu) or Sonia Sarkar (sar.sonia@gmail.com) for more information.