HEALTH CARE FOR THE HOMELESS TESTIMONY
FAVORABLE
HB 783 – Health Occupations - Structural Racism Training

House Health and Government Operations Committee
February 19, 2025

Health Care for the Homeless supports HB 783, which would expand the scope of required training for individuals licensed or certified by a health occupations board to include implicit bias *and* structural racism. Health Care for the Homeless was proud to support the 2021 legislation, HB 28 - Public Health – Implicit Bias Training and the Office of Minority Health and Health Disparities, which, among other things, required applicants for the renewal of a license or certificate issued by a health occupations board to attest to completion of an approved implicit bias training program the first time they renew their license or certificate after April 1, 2022. Adding the structural racism component to this training is vital to ensuring that health care providers have the full knowledge and tools to address the racial health disparities that their jobs require.

Health Care for the Homeless is deeply committed to deliberately addressing racial inequities, racial disparities and system racism. Our society is rife with both interpersonal and institutional racism, and our workplace is no different. The challenge now is to acknowledge this and then to address it in a deliberate and transparent manner. It is critical that our approach be grounded in data collection and analyses, policies and practices that replace systemic racialization with systemic equity. Recognizing that understanding implicit biases and structural racism are necessary to tackling racial inequities is essential. Addressing racial equity and inclusion (REI) is a formidable, yet necessary task within the health care setting, where health disparities are highest among communities of color. Below, Health Care for the Homeless REI staff discuss why this bill is necessary.

Testimony of Arie Hayre-Somuah, LMSW, MPH
REI Health Equity Specialist, Health Care for the Homeless

We need to be explicit about race. While there is a recognition that various levels of oppression exist, the experience of racism compounds and exacerbates all of those systems of oppression. And yet, structural racism is oftentimes the most difficult to address and easiest to leave out of our conversations about oppression. Therefore, it is important to call out structural racism explicitly so that we don't shy away from those tough conversations and difficult realities.

The importance of being explicit about structural racism is imperative in health occupations. We need to examine the ways in which we interact with the world and other groups of people so that we are not perpetuating these systems of oppression.

There is an overwhelming need for anti-racism training in health professions because health profession, like social work, have largely been occupied by white individuals and serving populations of ethnic or racial minorities. For instance, social workers that don't look like the people they are serving must understand the racial dynamics in which they work so that they are not doing harm, advertently or inadvertently. This harm can manifest in a number of ways. For example, a white social worker without training in structural racism might have one white patient and one black patient with the same symptoms, yet diagnose the white patient with bipolar and the black patient with schizophrenia. Without explicit training, a provider might, inaccurately and unnecessarily, pathologize a person with the same features. Black men, in particular, are over diagnosed with schizophrenia and that disorder, as a misdiagnosis, can have a negative effect on that person's life, from treatment options to social stigmatization.

What structural racism training does is, in the least, allow that provider to pause and think about a patient's lived experience, presenting symptoms, differential diagnoses, and treatment plans.

With health occupations, we see the effects of racism in terms of disparities and health outcomes. We can see this with our clients at Health Care for the Homeless. For instance, black women have higher rates of uncontrolled hypertension compared to all other racial/ethnic and gender groups. Black women experience a disproportionate level of stress, racial stress in particular, and that could be contributing factor to higher levels of hypertension.

Myths and assumptions about black people's bodies fuel health inequities and the only way to counter is to make sure people know that these falsities exist.

One alarming example of these myths is how health professionals use Estimated Glomerular Filtration Rate (eGFR). This is a lab that assesses kidney function and kidney failure and, among other things, it is used to be evaluated for a kidney transplant and be placed on the kidney transplant list. However, this assessment wrongly adjusts for race. The calculation used to determine a patient's value includes and adjustment for race only if that person is African American/Black. This is due to the racist and inaccurate assumption that black people have an inherently higher muscle mass and thus their Kidneys function differently. When this adjustment is made, a Black person's eGFR value is higher and inaccurately shows better kidney function which has serious implications such as underdiagnosis, misdiagnosis, and inequitable access to Kidney transplants.

As another example, health professionals have historically made wrong assumptions that black people have higher pain tolerances and have not trusted black patients with regard to their self-report of pain levels. There was even a study of medical students and white lay persons that showed that they believe black people experience less pain compared to white people. If a black patient rates their pain as an "8," a medical professional without anti-racism training might give a less powerful painkiller such as Tylenol because of inaccurate assumptions that they are lying about their pain and/or that they are drug-seeking. These wrong assumptions also fuel the disparities with maternal mortality – black women are not believed about their health and they are not regarded as experts of their own bodies, and therefore are more likely to have their self-report of symptoms disregarded resulting in withheld treatment.

We have also found, anecdotally, that medical mistrust is oftentimes reason for health disparities. Historically, Black and Brown people in this country have been wronged by health systems that allege to be providing care. One of the most well-known examples is that of the Tuskeegee experiment. This is an often-cited reason why ethnic and racial minorities do not trust doctors, health professionals, and health systems. We saw this during COVID when black people were reluctant to get the vaccine. This is a symptom of the structural racism pervasive in this country. It is critically important for health professionals to have this context. People are not necessarily non-compliant with medications, and treatment they are mistrusting—and rightfully so. It is the job of health providers to prove their trustworthiness and one way to exemplify this is by having a foundational understanding of the systemic barriers to health their patients may experience.

Further, combatting medical misinformation is now of more urgency than ever given that the recently-confirmed U.S. Department of Health and Human Services, Robert F. Kennedy, explicitly stated that he believes black people have better immune systems and, therefore, should have different vaccine schedules. There are real world and direct consequences of structural racism. – take COVID, for example. Racial minorities, and black people specifically, suffered disproportionately from COVID death and injury; the COVID vaccine is responsible for saving the lives of millions of Americans, but especially the most historically oppressed and disenfranchised among us. To have the highest health official in our country espouse these lies is extremely dangerous. Now more than ever, at this point in our political climate, it is critically important for our state to set standards and resist federal influence and the dangerous spread of misinformation.

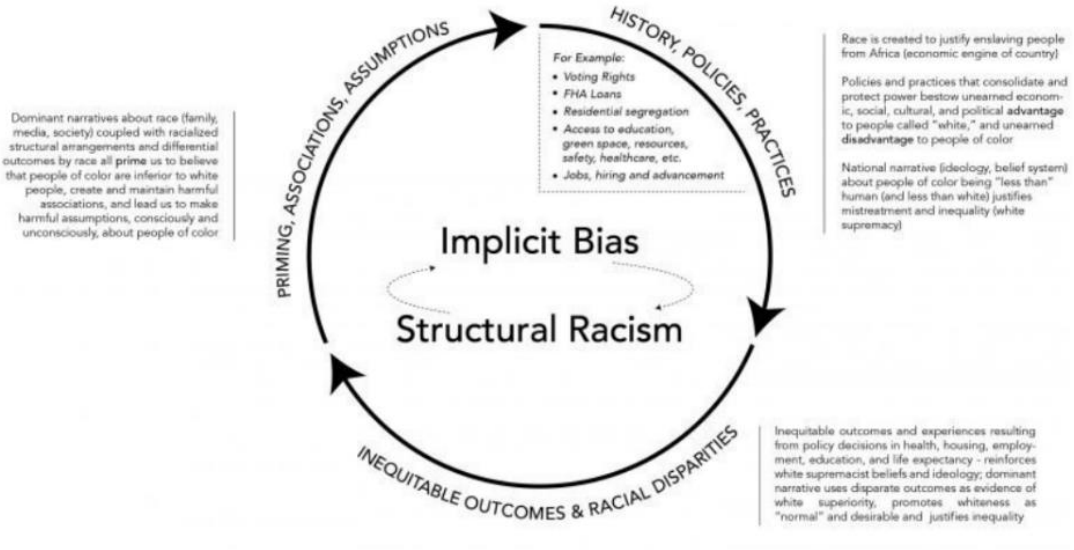
Health providers must be given the tools to question things, such as the assumptions they make about other people. We must give people the context to be able to understand the systems in which they are working and living. And for health providers in particular, they must understand the realities of how their patients are living. Without this anti-racism training, health providers might not even understand their patients' willingness to come to the doctor in the first place. This training is critical to something as fundamental as providing an accurate diagnosis for their patients.

More broadly, it is important we have anti-racism training because gives us context into the systems we are dealing with and the history of this country, which was founded on racism. In order to not perpetuate racism, we must be aware of it and actively take action to remediate those systems of racism. Structural racism training is just the first step creating an anti-racist health care workforce, but it's a start and sends an important message to all health professionals that an understanding of racism and its impact on health is critical to the provision of health care.

Testimony of Adedoyin Eisape, MPH
REI Program Manager II, Health Care for the Homeless

It is imperative that training for health professionals include both implicit bias and structural racism training in order to fully understand how systems of oppression show up in everyday practice. Implicit bias builds off of structural racism, while structural racism institutionalizes

implicit bias. We can visualize how implicit bias and structural racism play against each other with this graphic and associated descriptions from National Equity Project.



A key aspect of understanding how systems of oppression show up in everyday practice is recognizing that individuals hold specific viewpoints drive and are driven by biases and assumptions about groups of people. That assumption of sameness can obscure one's ability to cater to unique patient, peer, or community needs.

According to the National Equity Project,

We are not born with negative biases toward any particular group of people. The biases we have internalized, both consciously and unconsciously, have been "primed" through our experiences – images and messages we receive every day about who is "normal" or "desirable" and "belongs" and who is "different" or "undesirable" and "not one of us."

The concept of implicit bias is so deeply intertwined with structural racism in the system that we live in that separating the two would significantly hinder our understanding of how each of us is positioned within systems that influence us and that we replicate, which can create harm. Without getting a sense of the foundations and the root causes of implicit biases, a person's anti-racist training would necessarily be incomplete.

The negative associations we make about people of color then play out in everyday actions, but we don't have those associations without an acceptance of/reliance on the structural and institutional power structures that exist. The National Equity Project asserts that "[t]he negative associations and assumptions we make about people of color have been wired into our unconscious mind over hundreds of years and show up in all of our institutions today." We have been indoctrinated. Therefore, when we examine practices that lead to inequitable outcomes, we analyze actions rather than people's conscious beliefs about themselves, which requires orienting our understanding to look beyond what we assume to be true. As it relates to the bill, these associations and assumptions impact the practices health providers institute in the delivery of care as well as their interactions with peers and patients.

How intersections with systems impact one's practice can only be understood by examining one's unconscious beliefs and the historical and socioeconomic-political context that both created and fuels those beliefs. Implicit bias and structural racism are two sides of the same coin; you cannot effectively address one without understanding the other. If we don't understand where we came from and the systems of structural inequity in which we operate, it is impossible to transition from mere awareness of bias to achieving sustainable behavior change in care delivery and beyond.

This bill is a critical step to addressing these pervasive racial and ethnic disparities in our health care system. We urge a favorable report.

Health Care for the Homeless is Maryland's leading provider of integrated health services and supportive housing for individuals and families experiencing homelessness. We deliver medical care, mental health services, state-certified addiction treatment, dental care, social services, housing support services, and housing for over 11,000 Marylanders annually at sites in Baltimore City and Baltimore County.
Our Vision: Everyone is healthy and has a safe home in a just and respectful community.
Our Mission: We work to end homelessness through racially equitable health care, housing and advocacy in partnership with those of us who have experienced it.
For more information, visit www.hchmd.org.

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