**RBN March 2021 Session -- Case Studies**

**CASE A**

Pediatric Clinic A is working to improve trauma- and resiliency-informed practices using an equity lens. They have been inviting practice members to bring concerns to a monthly ‘Equity Rounds.’ This month, a clinician raises the following concern based on reading a recent article in the New England Journal of Medicine (NEJM):

*Pulmonary function tests use spirometry to measure lung volume and the rate of flow through airways in order to diagnose and monitor pulmonary disease (asthma, reactive airway disease). In the United States spirometers use correction factors for persons identified as Black (10-15%) or Asian (4-6%). What does this ‘race correction’ mean for the accuracy of estimates of lung function* *and classification of disease severity among racial/ethnic minorities? How does this impact the quality of care for patients? How is this discussed with caregivers and patients?*

Use the Structural Integrity tool to describe how race-adjusted algorithms can contribute to inequities at systemic, institutional, and individual (interpersonal and intrapersonal) levels.

What process might Clinic A incorporate to develop strategies that honor dignity and improve equity?

Consider how this discussion relates to historical trauma, racial trauma, and medicine, research, ethics, and the definition of race. Consider conversations with patients and families.

**References:**

Vyas, Darshali A., Leo G. Eisenstein, and David S. Jones. "Hidden in plain sight—reconsidering the use of race correction in clinical algorithms." (2020): 874-882.

Braun L. Breathing race into the machine: The surprising career of the spirometer from planation to genetics. Minneapolis: University of Minnesota Press, 2014.

Kumar R, Seibold MA, Aldrich MC, et al. Genetic ancestry in lung-function predictions. N Engl J Med 2010;363:321-330.

**CASE B**

Adolescent Clinic B has used a substance use disorder (SUD) screening test for several years. The Clinic integrated a trauma- and resiliency-informed practice model in 2020 after several months of intentional planning. Through this process the clinical team has embraced a new framework for understanding the association between early life trauma and SUD risk: moving from “What’s wrong with you?” to “What happened to you?”

The patient navigator who administers the SUD screening test noted during a team meeting that the screening test does not include any items around racial trauma. The team committed to have a dedicated conversation about their trauma- and resiliency-informed model and their approach to patients with SUD.

Use the Structural Integrity tool to describe how racial trauma may be experienced at systemic, institutional, and individual (interpersonal and intrapersonal) levels by Adolescents receiving treatment for SUD.

How my Clinic B address the relation between racial trauma and SUD at each of these levels?

**References:**

Komaromy, Miriam, Elena Mendez-Escobar, and Erin Madden. "Addressing Racial Trauma in the Treatment of Substance Use Disorders." *Pediatrics* 147.Supplement 2 (2021): S268-S270.

**CASE C**

Pediatric Clinic C is an established trauma- and resiliency-informed practice. There is regular professional development and full support for this model. At Pediatric Clinic C security can be alerted and asked to come to the clinic for situations involving patients and families. During a recent incident when security was called to escort a family out of the clinic, one of the caregivers being removed stated “Why are they always calling security on the Black patients? Who is looking into this?” The caregiver went on to file a complaint with the clinic’s patient advocate and requested an investigation of not only the incident involving her family but the use of security in general.

The patient advocate has brought the reported concern to the clinic director for review. The current protocol is that each concern is reviewed and considered on its own and only in relation to the incident that happened to involved that family.

Use the Structural Integrity tool to explore inequities at systemic, institutional, and individual (interpersonal and intrapersonal) levels.

What process might clinic C incorporate to develop strategies that honor dignity and improve equity?

**References:**

Green CR, McCullough WR, Hawley JD. Visiting Black Patients: Racial Disparities in Security Standby Requests. J Natl Med Assoc. 2018 Feb;110(1):37-43.

Kim, Hyunil, et al. "Lifetime prevalence of investigating child maltreatment among US children." *American journal of public health* 107.2 (2017): 274-280.

**CASE D**

Pediatric Clinic D is working to incorporate equity into their newly established trauma- and resiliency-informed practice model. As a result, they are trying a model called “Courageous Conversations” that incorporates opportunities to transparently discuss issues of racism, ableism, classism, homophobia, and sexism.

One of the nurses, who has worked at Clinic D for 20 years, notes that she would prefer not to participate in these discussions because “I know too much, I’ve seen too much, and nothing ever changes. And I don’t want to get fired like others who spoke out before.” In past years Clinic D has had clinical staff that departed under different circumstances. There are sometimes non-disclosures so information was not shared about the reason for departure or termination by the staff member or by the administration.

Use the Structural Integrity tool to outline a way to explore inequities at systemic, institutional, and individual (interpersonal and intrapersonal) levels.

What process might clinic C incorporate to develop strategies that honor dignity and improve equity?

**Reference:**

Page KR, Castillo-Page L, Wright SM. Faculty diversity programs in U.S. medical schools and characteristics associated with higher faculty diversity. *Acad Med*. 2011;86(10):1221-1228. doi:10.1097/ACM.0b013e31822c066d

U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. 2017. Sex, Race, and Ethnic Diversity of U.S, Health Occupations (2011-2015), Rockville, Maryland.

<https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/diversity-us-health-occupations.pdf>

**CASE E**

On the website for Pediatric Clinic E they state the clinical care is provided in several languages and that they have a bilingual staff and access to language interpretation via phone as well. Providers at the clinic take pride in serving a culturally and linguistically diverse population and strive to provide equitable access to care. Providers routinely feel that they do not have adequate support to provide the same quality of care when engaging with a family that speaks a language other than English. Providers have noted time, broken equipment, inadequate access to translated materials. They also have concerns about the quality of the translation of screening tools and cross-cultural understanding of concepts such as “trauma.”

Use the Structural Integrity tool to outline how Clinic E can explore inequities at systemic, institutional, and individual (interpersonal and intrapersonal) levels.

What process might Clinic E incorporate to develop strategies that honor dignity and improve equity?

**Reference:**

Metzl, Jonathan M., and Helena Hansen. "Structural competency: theorizing a new medical engagement with stigma and inequality." *Social science & medicine* 103 (2014): 126-133.

**CASE F**

Pediatric Clinic F has a trauma-informed and healing-centered practice model. As part of their model there is a routine screening tool for ACEs and unmet basic needs. During a clinical team meeting to discuss the screening tools a provider asserts that they do not think that certain families, particularly families that have immigrated to the US, are responding to this screening tool honestly and there is underreporting of the needs. Another provider disagrees and states the responses are an honest reflection of what level of intervention is desired. Another provider states that the screening tools intimidate and raise concerns for families. The group is unsure how to move forward.

Use the Structural Integrity tool to outline the role of “citizenship” as a cause of disparities and xenophobia and anti-immigrant climate, and historical trauma in informing inequities at systemic, institutional, and individual (interpersonal and intrapersonal) levels.

What process might Clinic F incorporate to develop strategies that honor dignity and improve equity?

**References:**

Boynton-Jarrett, R. & Flacks, J. (2018). Strengths-based Approaches to Screening Families for Health-Related Social Needs in the Healthcare Setting. Washington, DC <https://cssp.org/wp-content/uploads/2018/08/Strengths-Based-Approaches-Screening-Families-FINAL.pdf>

Szaflarski M, Bauldry S. The Effects of Perceived Discrimination on Immigrant and Refugee Physical and Mental Health. *Adv Med Sociol*. 2019;19:173-204. doi:10.1108/S1057-629020190000019009