Before we begin…

Put your name, health center/organization, and location in the chat!

AMERICAN CANCER SOCIETY

Health Equity Community Project ECHO
Medical Mistrust in Relation to Colorectal Cancer Screening

September 28, 2022

Welcome to the September Health Equity Community Project ECHO Session

Each ECHO session will be recorded and will be posted to echo.cancer.org

You will be muted with your video turned off when you join the call.
Use the buttons in the black menu bar to unmute your line and to turn on your video.
If you do not wish to have your image recorded, please turn OFF the video option.

Today's materials will be made available on echo.cancer.org

Type your name and organization in the chat box

This ECHO session takes place on the Zoom platform.
To review Zoom's privacy policy, please visit zoom.us/privacy

Remember: Do NOT share any personal information about any patient

Questions about Zoom? Type them in the chat box to: Allison Rosen

American Cancer Society®

Project ECHO®

Health Equity Community Project ECHO

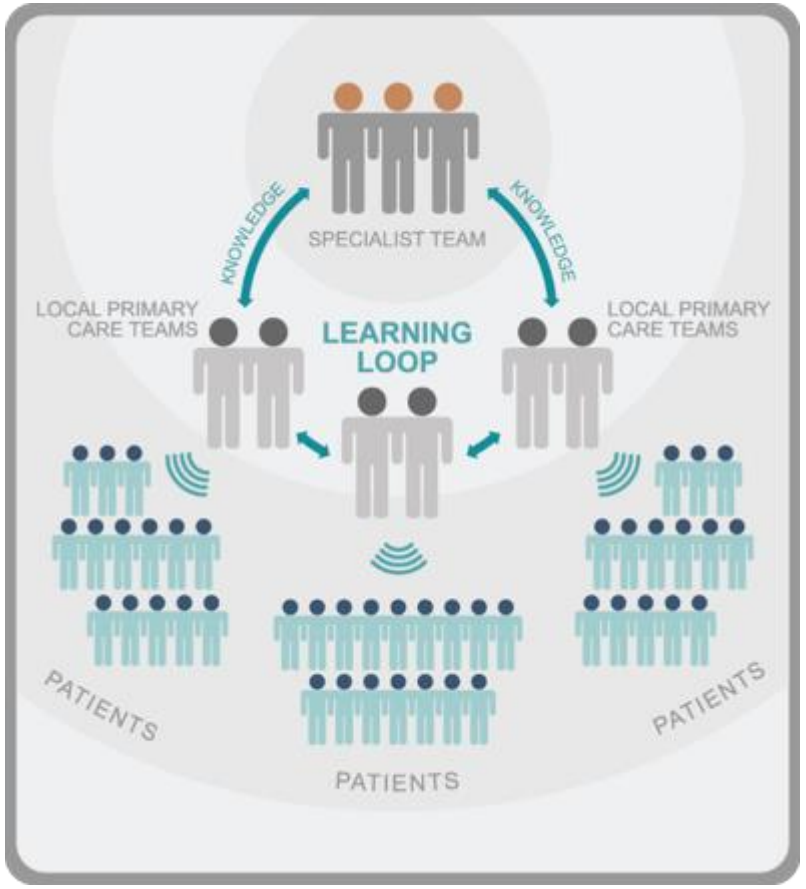
September Agenda

Welcome and ECHO Overview	5 minutes
Introductions and Ice Breaker	15 minutes
Didactic Presentation – Part 1 *Understanding and Addressing Medical Mistrust* *Hayley Thompson, PhD* *Wayne State University*	20 minutes
Didactic Q/A	5 minutes
Didactic Presentation – Part 2 *Introduction to the Group Based Medical Mistrust Scale* *Hayley Thompson, PhD* *Wayne State University*	20 minutes
Didactic Q/A	5 minutes
Case Study Overview and Sample Presentation	15 minutes
Wrap-up	5 minutes

ECHO

What does ECHO do?

- ECHO **effectively** and **efficiently** disseminates evidence-based strategies to improve cancer outcomes
- ECHO allows to **convene** for best practice sharing across health centers, institutions, and other silos
- ECHO is a proven **one-to-many** intervention
- For more information, please refer to your guidebook or visit www.echo.unm.edu



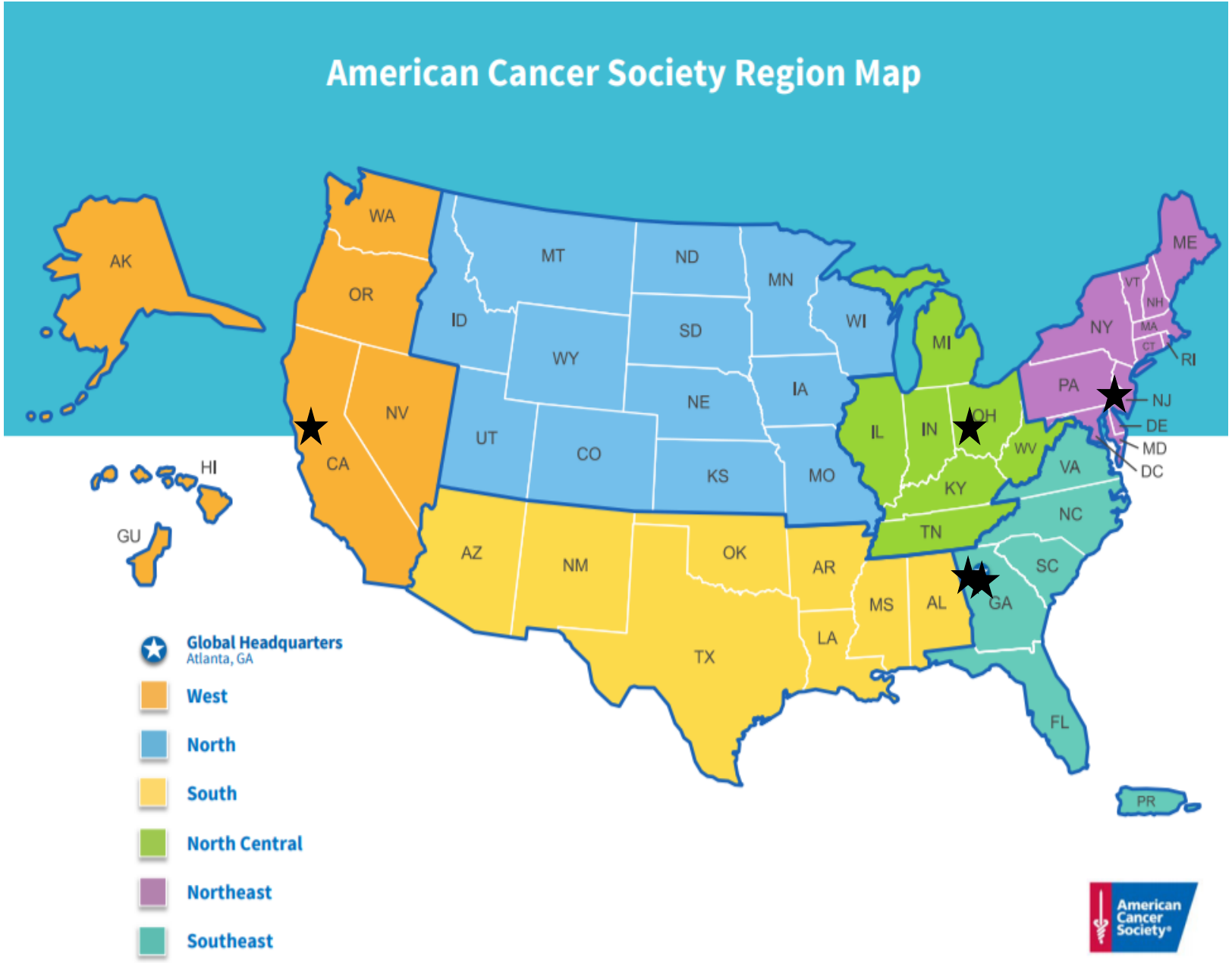
Health Equity Community Project ECHO Series

Purpose

- To share relevant medical mistrust and patient engagement related information with participants to enhance their community projects
- To provide participants with an opportunity to build their networks
- To offer an opportunity for participants to share project-related challenges or questions; seeking feedback from expert faculty and community project colleagues

Health Equity Community Project ECHO Series – Planned Topics

Session Date	Didactic Topics
September 28 2022	Understanding and Addressing Medical Mistrust: Introduction to the Group Based Medical Mistrust Scale
November 2022	Understanding Medical Mistrust Through the Colorectal Cancer Screening Lens
January 2023	Measuring Mistrust using the Group Based Medical Mistrust Scale: Best Practices from a Community
April 2023	Patient Engagement Series: Elevating Patient Voices to Reduce Medical Mistrust and Improve Colorectal Cancer Screening
June 2023	Patient Engagement Series: Implementing Patient Feedback to Improve Policies and Practices at FQHCs
August 2023	Patient Engagement Series: Sustaining a Highly Effective Patient Advisory Council/Governing Board
October 2023	Effective Strategies for Reducing Medical Mistrust: Support from Healthcare Providers
December 2023	Effective Strategies for Reducing Medical Mistrust: Patients Perspectives of Discrimination and Group Based Disparities
February 2024	Effective Strategies for Reducing Medical Mistrust: Patients Suspicion of Healthcare Providers



Health Equity Community Project Sites (Cohort 2)

- Northeast Region – Asbury Park, NJ
- North Central Region – Dayton, OH
- Southeast Region - Atlanta, GA
- Southeast Region – Stone Mountain, GA
- West Region – Fremont, CA

Introductions and Icebreaker

Introductions

ACS Hub Staff

Cecily Blackwater, MPH

Arielle Dance, PhD

Tracy Wiedt, MPH

Allison Rosen, MA

Faculty

Hayley Thompson, PhD

Laura Makaroff, DO

Bibiana Martinez (PhD Candidate)

For attendance purposes, please type your location, name, and organization in the chat box!

Asbury Park, New Jersey

Please come off mute and introduce yourself:

Name, Organization, Title

Atlanta, Georgia

Please come off mute and introduce yourself:

Name, Organization, Title

Dayton, Ohio

Please come off mute and introduce yourself:

Name, Organization, Title

Fremont, California

Please come off mute and introduce yourself:

Name, Organization, Title

Stone Mountain, Georgia

Please come off mute and introduce yourself:

Name, Organization, Title

About our Presenter

Hayley S. Thompson, PhD

Wayne State University

Karmanos Cancer Institute

Professor, Department of Oncology

Associate Center Director, Community Outreach & Engagement

BARBARA ANN Karmanos CANCER INSTITUTE
Wayne State University

Understanding and Addressing Medical Mistrust

Hayley S. Thompson, Ph.D.
Professor, Department of Oncology
Director, Center for Health Equity & Community Knowledge in Urban Populations (CHECK-UP)
Wayne State University School of Medicine
Associate Center Director, Community Outreach & Engagement
Barbara Ann Karmanos Cancer Institute

NCI Comprehensive Cancer Center
A Cancer Center Designated by the National Cancer Institute

Defining trust

- Hall et al. (2001): "The optimistic acceptance of a vulnerable situation in which the trustor believes the trustee will care for the trustor's interests."
  - Relational
  - Trust is a prediction about experience one will have in relationship to another
  - Vulnerability (being exposed, lacking security, weakness)
  - Tolerance of risk or uncertainty about the another's competence and intentions
  - Willingness to be vulnerable when confronted with risk
  - Optimism

Conceptualizing trust

- There is also a notion that trust can be constructed (Gilson, 2006)
- Trust develops over time as expectations are met
- Trust is also contextual
  - Institution may have rules, guidelines, laws that dictate behavior, thereby instilling trust.
- "...trust does not depend only on judgments one person makes about another, but also on assumptions that emerge from the context in which relationships take place, on expectations derived from previous relationships, and on criteria for making judgments that are deemed legitimate by the actors involved" (Wuthnow, 2004, p. 150).

Trust vs. mistrust

- Mistrust is not simply the absence of trust
- Mistrust is not part of a continuum ranging from low trust to high trust
- Mistrust/distrust may be defined as having anxious or pessimistic views of motivation and expected results.
- Mistrust implies that a trustor's negative beliefs are that the trustee will go against the trustor's best interest

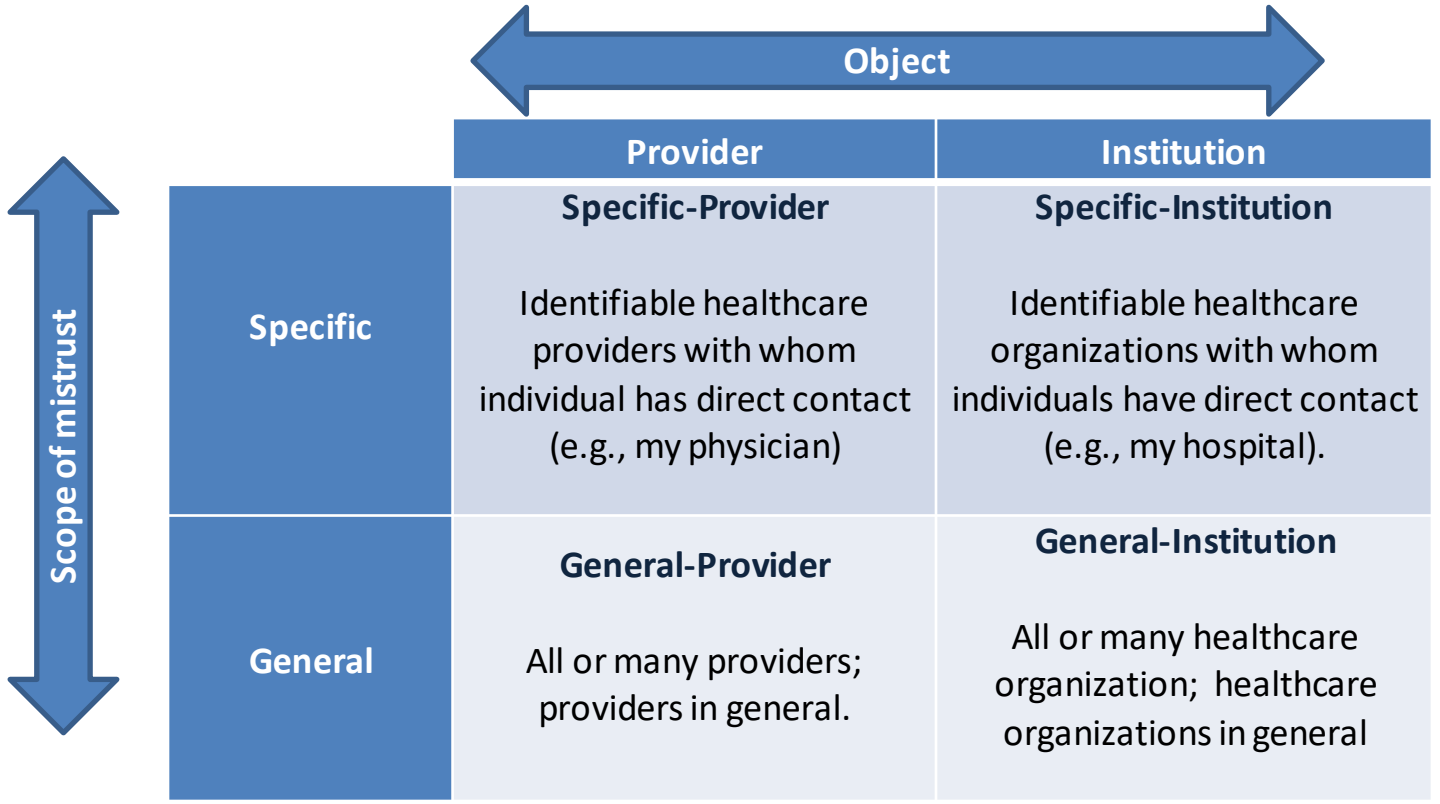
Edege et al., 2008; Benkert et al., 2019; Williamson et al., 2018

Defining terms

- Trust
  - Belief in healthcare provider or system competence to complete a certain task and act in one's best interest
- Distrust
  - Often preceded by personal or collective experience or reliable information
  - Based on a sense that one's trust has been diminished or violated.
  - Directed towards a specific provider or healthcare setting
- Mistrust
  - What or who is not trusted is not necessarily or explicitly named
  - Often a general sense of unease or suspicion
  - Mistrust may originate from distinct historical experiences linked to group identity, personal experience, vicarious experiences, and oral histories

Griffith et al., 2020

Dimensions of mistrust



- Also consider the specificity of the referent (individual vs. group experience)

Hall et al., 2001; Williamson et al., 2018

Mistrust measures

- Mistrust often asked as single item or a few items not part of a validated measure
- Most common mistrust measures
  - Medical Mistrust Index (MMI)
  - Revised Healthcare System Distrust Scale
  - Group-Based Medical Mistrust Scale (GBMMS)
- These 3 measures accounted for 49% of the medical mistrust measures in 185 studies

Williamson et al., 2018

Decision guide for choosing a medical mistrust scale

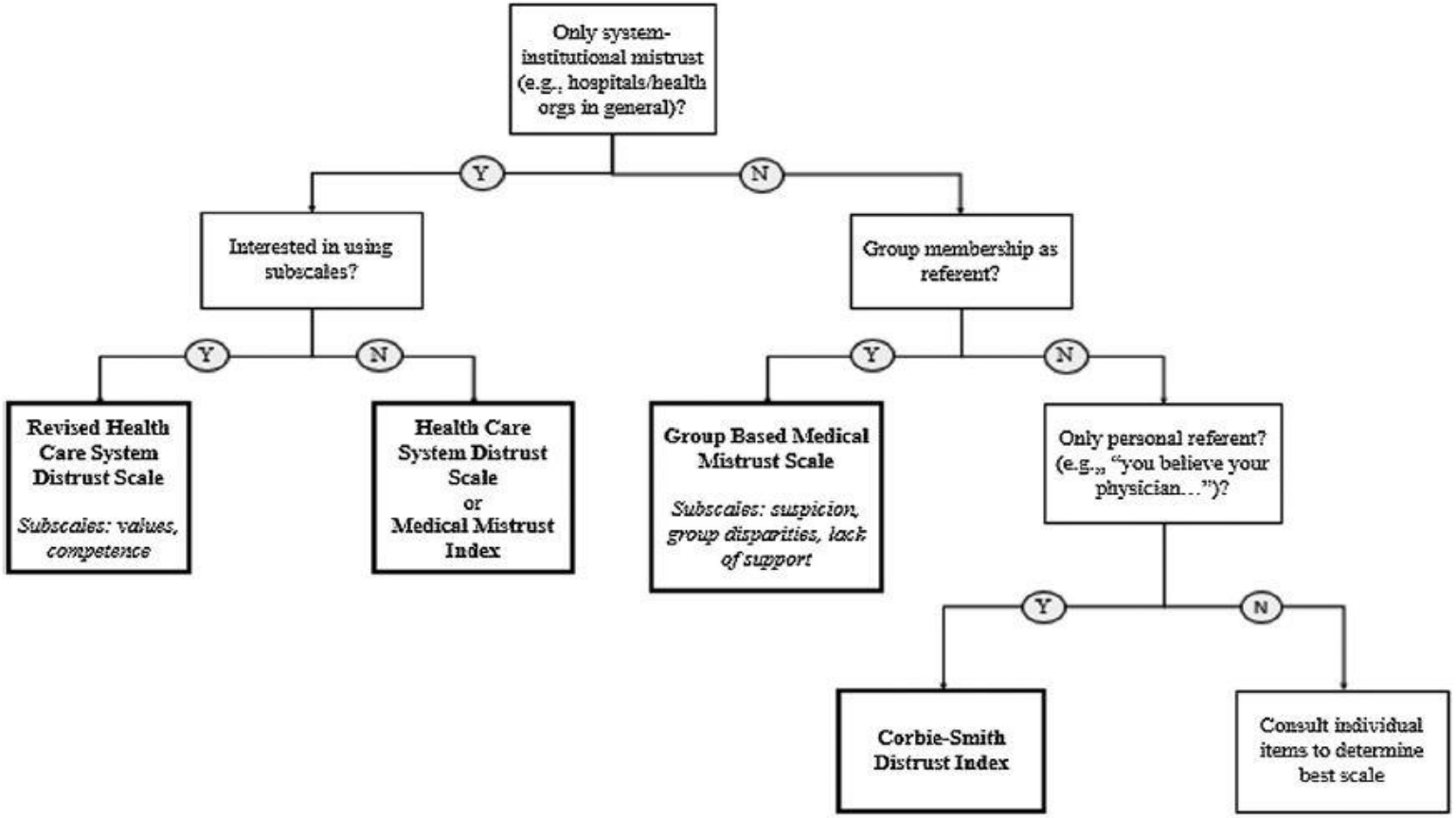


Fig. 2. Decision Guide for Choosing a Medical Mistrust Scale.

Williamson et al., 2018

Outcomes

- Mistrust is associated with a range of outcomes
  - Treatment nonadherence or diminished adherence
  - Delays/avoidance of cancer screening or care seeking
  - Low service utilization, low engagement in care

Benkert et al., 2019

Whose problem is it, anyway?

- Mistrust is often viewed as a characteristic of the individual that needs to be changed; the problem is the patient (or the patient's culture)
- Mistrust can also be viewed as protective
  - How much can this change this given ongoing systemic racism and unequal care? How much should it change?
- **Should we focus on reducing mistrust among patients or on making healthcare systems and providers more trustworthy?**

Mistrust interventions

- Several randomized controlled trials have been conducted to increase trust (rather than explicitly reduce mistrust)
- Three broad categories
  - Training providers
  - Educating patients
  - Increasing transparency

Training providers

Author, Year	Goal	Population	Intervention	Change in trust?
Thom et al. , 1999	Increase patient trust; increase pt satisfaction, continuity, adherence to tx	Family physicians; primary care pts	7-hour workshop on trust building behaviors, models of pt-physician relationship, listening to pt experiences	No difference between intervention and control group
Thom et al., 2006	Increase pt perception of physician cultural competence and pt satisfaction, trust, disease-specific outcomes	Primary care physicians; pts with diabetes or hypertension	A brief cross-cultural curriculum	No difference between intervention and control group
Tulksy et al., 2011	Change oncologist behaviors; pt perception of trust, empathy, therapeutic alliance, knowledge of pt	Medical, gynecologic, and radiation oncologists; pts with advanced disease	All oncologists received communication training; Oncologists in intervention group also received CD-ROM training program on communication skills that was tailored with exemplars from their own audio-recorded clinic visits	Pts in intervention group reported higher trust in oncologist compared to those in control group

Educating patients

BARBARA ANN Karmanos CANCER INSTITUTE
Wayne State University

Author, Year	Goal	Population	Intervention	Change in trust?
M Thompson et al., 2001	Engage new Kaiser Permanente enrollees and improve trust in health plan physicians, pt satisfaction, familiarity with their medical center, health plan loyalty, and prevention knowledge	Recent adult enrollees of Kaiser Permanente	Compared control group with 1) individual visit with a physician, 2) physician visit plus health educator, 3) a group visit of eight new members led by a physician and health educator	Only pts in group visit condition showed significant increase in trust
Clancy et al., 2003	Examine feasibility and acceptability of group visits and impact on perceived quality of care and trust in physician	Pts with Type 2 diabetes	Group visits with a PCP and diabetes nurse educator monthly for 6 months	Pts in group visits reported higher trust compared to those in usual care
Clancy et al., 2007	Examine feasibility and acceptability of group visits and impact on perceived quality of care, trust in physician, and diabetes-specific locus of control	Pts with Type 2 diabetes	Group visit scheduling allowed for 2 hours: 10 to 15 minutes for warm up and socialization, 30 to 45 minutes for an interactive discussion of a health-related topic, and 60 minutes for one-o-none consultations with the physician	No difference intervention group and usual care
Nannenga et al., 2009	Exploration of whether decision aid (DA) re: use of statins to manage cardiovascular risk among pts with diabetes increased trust in provider (secondary endpoint)	Pts with Type 2 diabetes	One-page tailored decision aid	Non-significant trend towards with pts exposed to DA; higher trust among those who reviewed DA with provider during visit (ns)

Increasing transparency

Author, Year	Goal	Population	Intervention	Change in trust?
Hall et al., 2002	Investigation of disclosure of primary care payment methods, capitation payment fee-for-service (FFS) payment, mixed incentive bonus and impact on knowledge of and trust in physician	HMO members/patients	Members were told how the plan pays their primary care (gatekeeping) physician. The disclosure was made initially in a letter mailed from the HMO's medical director and then followed by a telephone call	Disclosure of incentives did not decrease trust in managed care physicians or health plans; Physician trust increased among the capitated plan members who received the disclosure, compared with those who did not
Hsu et al., 2003	Evaluate the impact of an intervention to help patients choose a new PCP compared to external assignment of PCP within an HMO	HMO members/patients whose PCP retired	Patients could choose PCP based on provider-specific info available on all PCPs gender, race/ethnicity, languages, training, personal interests/hobbies…also could obtains names of PCPs with similar beliefs re: medical decision making	No difference in trust in adjusted analyses
Pearson et al., 2006	Investigate impact of disclosure on patients' understanding of their physicians' financial incentives, and on pts' degree of trust in and loyalty toward their physician groups and personal primary care physicians	Patients of 2 multispecialty physician group practices	A mailed compensation disclosure letter written by the chief medical officer of their physician group	Disclosure intervention did not change trust in primary care physicians overall; trend towards increased trust

Thank you!

BARBARA ANN Karmanos CANCER INSTITUTE
Wayne State University

NCI Comprehensive Cancer Center
A Cancer Center Designated by the National Cancer Institute

Didactic Questions?

Please come off mute or type your questions into the chat

BARBARA ANN Karmanos CANCER INSTITUTE
Wayne State University

Introduction to the Group-Based Medical Mistrust Scale (GBMMS)

Hayley S. Thompson, Ph.D.
Professor, Department of Oncology
Director, Center for Health Equity & Community Knowledge in Urban Populations (CHECK-UP)
Wayne State University School of Medicine
Associate Center Director, Community Outreach & Engagement
Barbara Ann Karmanos Cancer Institute

NCI Comprehensive Cancer Center
A Cancer Center Designated by the National Cancer Institute

My experience

BARBARA ANN Karmanos CANCER INSTITUTE
Wayne State University

Kings County Hospital Center,
East Flatbush, Brooklyn, NY

NCI Comprehensive Cancer Center
A Cancer Center Designated by the National Cancer Institute

My experience

BARBARA ANN Karmanos CANCER INSTITUTE
Wayne State University

Detroit Free Press

COMMENTARY | Opinion *This piece expresses the views of its author(s), separate from those of this publication.*

Ralph Northam's yearbook shows how racism leads black patients to distrust doctors

Hayley S. Thompson
Published 4:50 p.m. ET Feb. 27, 2019

My mother worked as a registered nurse in the largest public hospital in New York City for most of her career. She would describe how the mostly black and immigrant patients would first consult with white doctors, who assumed that their directions would be followed, then debrief afterwards with nurses of color, like my mom, who looked like them — nurses they trusted more than the doctors.

A photo from Virginia Gov. Ralph Northam's medical school yearbook shows two men, one in blackface and one in a Ku Klux Klan robe and hood, on the same page as the governor. *Virginian Pilot/TNS*

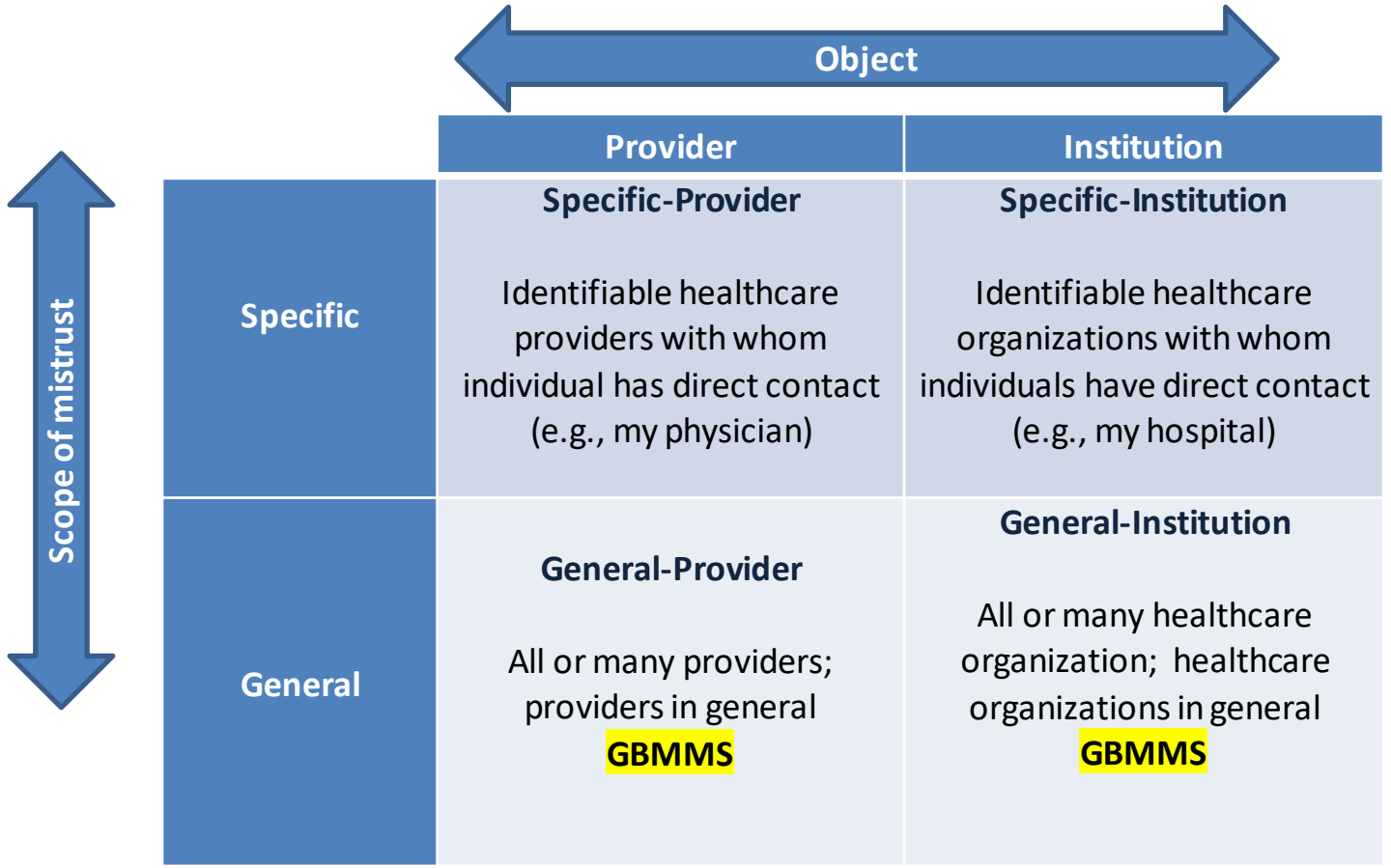
To be sure, Northam's past antics may be an extreme example of racial insensitivity on a continuum among physicians but that continuum exists all the same. Black folks' medical mistrust is not cultural paranoia. It is rooted in the realities of past and present racism.

NCI Comprehensive Cancer Center
A Cancer Center Designated by the National Cancer Institute

Capturing the intersection of racism and mistrust in the healthcare context

- As a postdoctoral research fellow in East Harlem, I worked with colleagues to develop the scale circa 2001 (East Harlem Partnership for Cancer Awareness)
- Part of community needs assessment
- Prior to early 2000s, such a scale didn't really exist
  - Medical Mistrust Inventory (MMI) addressed this in part (Laveist et al., 2000)

Dimensions of mistrust



Group-Based Medical Mistrust Scale - GBMMS (2004)

- Measures the tendency to distrust medical systems and personnel believed to represent the dominant culture

- Group-based in that it assesses the tendency to distrust…
  - Those who do not belong to one's ethnic group
  - Systems that do not represent one's ethnic group
  - Based upon a legacy of racism or unfair treatment

GBMMS subscales

- Subscale 1: Suspicion
  - 3. People of my ethnic group should not confide in doctors and health care workers because it will be used against them.
  - 4. People of my ethnic group should be suspicious of information from doctors and health care workers.
  - 5. People of my ethnic group cannot trust doctors and health care workers.
  - 6. People of my ethnic group should be suspicious of modern medicine.
  - 7. Doctors and health care workers treat people of my ethnic group like “guinea pigs”.
  - 9. Doctors and health care workers do not take the medical complaints of people of my ethnic group seriously.

GBMMS subscales (cont.)

- Subscale 2: Group disparities in healthcare
  - 8. People of my ethnic group receive the same medical care from doctors and health care workers as people from other groups *(Reverse-scored)*
  - 10. People of my ethnic group are treated the same as people of other groups by doctors and health care workers. *(Reverse-scored)*
  - 11. In most hospitals, people of different ethnic groups receive the same kind of care. *(Reverse-scored)*

GBMMS subscales (cont.)

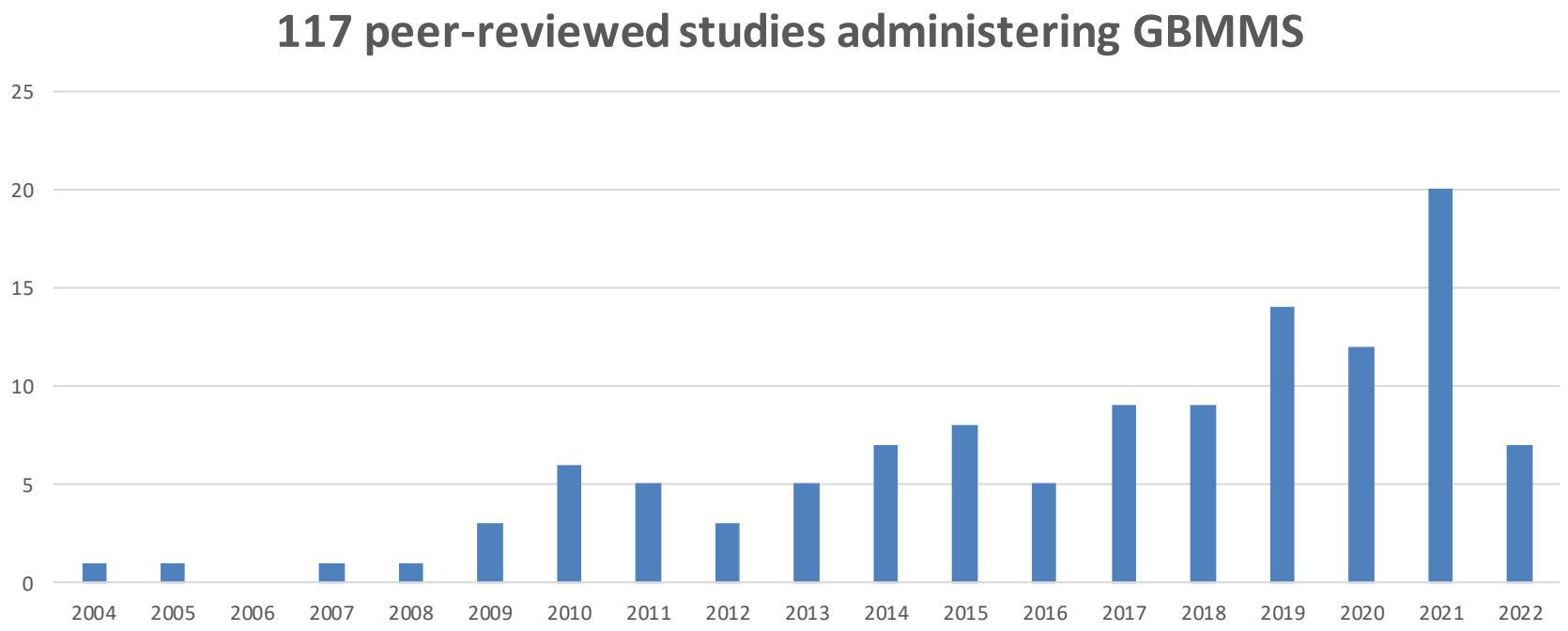
- Subscale 3: Lack of support from healthcare providers
  - 1. Doctors and health care workers sometimes hide information from patients who belong to my ethnic group.
  - 2. Doctors have the best interests of people of my ethnic group in mind. *(Reverse-scored)*
  - 12. I have personally been treated poorly or unfairly by doctors or health care workers because of my ethnicity. *(Only question with a personal referent)*

Instructions and response options

- These questions ask about your beliefs about the care you and other people of your racial and ethnic group receive from doctors, nurses, and other staff in the health care system. Please indicate how much you agree or disagree with the following statements.

		Strongly Disagree	Disagree	Neither agree or disagree	Agree	Strongly Agree	Prefer not to answer
1.	Doctors and health care workers sometimes hide information from patients who belong to my ethnic group.	1	2	3	4	5	999

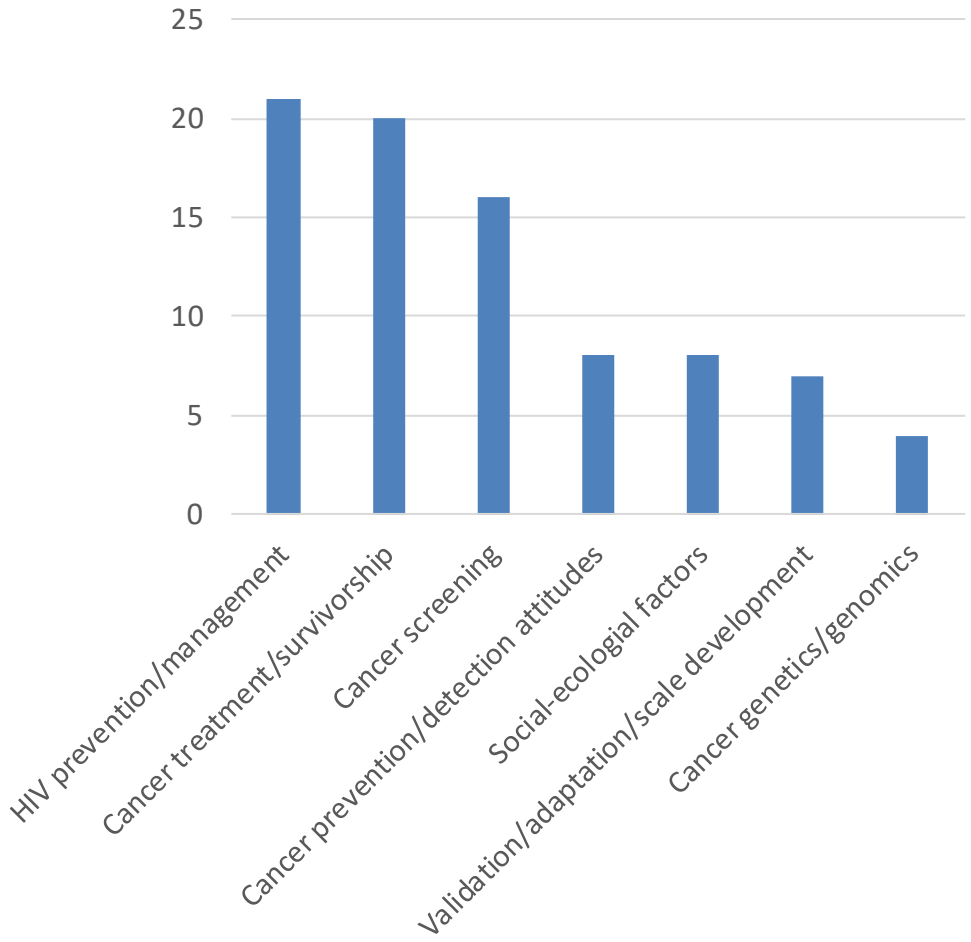
GBMMS use over time



53% published since 2017

Reference groups and topics

- Selected groups/study samples
  - African Americans
  - Latinx groups
  - South Asians
  - Arab Americans
  - Aboriginal groups
  - Rural populations
  - LGBTQ/MSM
  - Recently incarcerated adults
- Reference group within items can be changed to match population



GBMMS studies across the cancer care continuum

- Cancer screening
  - 5 of 12 studies: GBMMS associated with non-adherence to cancer screening guidelines (Hall. et al., 2018; Menon et al., 2014; Cronan et al., 2008; Thompson et al., 2004; Thelemaque et al., 2014)
  - GBMMS associated with perceived benefits, barriers, and other attitudes (Jaffee et al., 2020; Manning et al., 2019; Purnell, 2010; Kue et al.,2020)
  - GBMMS moderated response to screening interventions (Thompson et al. 2010, McQueen et al., 2010)

GBMMS studies across the cancer care continuum (cont.)

- HPV vaccination
  - Women with higher GBMMS scores less likely to be vaccinated against HPV and preferred an HPV vaccine recommendation from a same race/ethnicity provider (Kolar et al., 2015; Hernandez et al., 2019)
  - Associated with greater parental HPV vaccine hesitancy (Tsui et al., 2022)
- Clinical genetics/genomics
  - Associated with perceived benefits/barriers and concerns about abuses of genetic testing for breast/ovarian cancer risk (Sussner et al., 2009)
  - Associated with greater concern about tumor genomic profiling (Hoadley et al., 2022)

GBMMS studies across the cancer care continuum (cont.)

- Cancer treatment
  - GBMMS partially mediated association between race and late-stage lung cancer presentation as well as lower receipt of stage-appropriate treatment (Bergamo et al., 2013; Lin et al, 2014)
  - Associated with patients' treatment attitudes, perceptions of physician patient-centeredness, past medical adherence, decisional preferences (Sutton et al., 2019; Penner et al., 2017; Penner et al., 2016)

GBMMS studies across the cancer care continuum (cont.)

- Cancer survivorship
  - Black cancer survivors (prostate, liver, breast) have higher GBMMS scores compared to survivors of other groups (Halbert et al. 2009; Sheppard et al., 2013; Sheppard et al., 2018; Schoenberger et al., 2021)
  - GBMMS associated with greater symptom burden, persistent symptoms, worse health-related quality of life (Graves et al., 2012; Barsevick et al., 2016; Bustillo et al., 2017)
- Cancer clinical trials
  - Suspicion was associated with lower willingness to discuss clinical trials among Black prostate cancer patients (Senft et al., 2020)

Measurement matters

- Group-based medical mistrust can yield different results from other types of trust/mistrust
- Among 200 Black and white men with prostate cancer, group-based medical mistrust (not general trust in medical profession) was associated with lower willingness to discuss clinical trials (Senft et al., 2020)
- Among Black cancer patients, group-based mistrust (not general mistrust of physicians) was directly associated with
  - Lower patient ratings of their physician's patient centeredness
  - Lower levels of patient confidence in treatments
  - Lower physician perceptions of patients' personal attributes associated with successful treatment outcomes (e.g., intelligence, healthy lifestyle) (Penner et al., 2017)

Group-based medical mistrust and COVID-19 vaccines

BARBARA ANN Karmanos CANCER INSTITUTE
Wayne State University

JAMA Network | Open

Original Investigation | Public Health

Factors Associated With Racial/Ethnic Group–Based Medical Mistrust and Perspectives on COVID-19 Vaccine Trial Participation and Vaccine Uptake in the US

Hayley S. Thompson, PhD; Mark Manning, PhD; Jamie Mitchell, PhD; Seongho Kim, PhD; Felicity W. K. Harper, PhD; Sheena Cresswell, MPH; Kristopher Johns, MPH; Shoma Pal, MPH; Brittany Dowe, MPH; Madiha Tariq, MPH; Nadia Sayed, MPH; Lisa M. Saigh, BSN; Lisa Rutledge, BA; Curtis Lipscomb, BFA; Jametta Y. Lilly, BA; Heidi Gustine, MPA; Annie Sanders, MSA; Megan Landry, BS; Bertram Marks, JD, DMin

- N=1835 Michigan residents, age 18 and older
- Mean age = 49.4 years
- 21% identified as Black/African American

NCI Comprehensive Cancer Center
A Cancer Center Designated by the National Cancer Institute

Findings

Racial/ethnic group	Medical mistrust score, mean (SD)[a]
All	1.83 (0.91)
White	1.52 (0.71)
Black	2.35 (0.96)
MENA	1.77 (0.90)
Hispanic	2.22 (0.95)
Asian	2.10 (1.01)
Other[b]	2.11 (1.01)

Abbreviation: MENA, Arab, Chaldean, Middle Eastern, or North African.

[a] $P < .001$ for all based on 1-way analysis of variance.

Findings

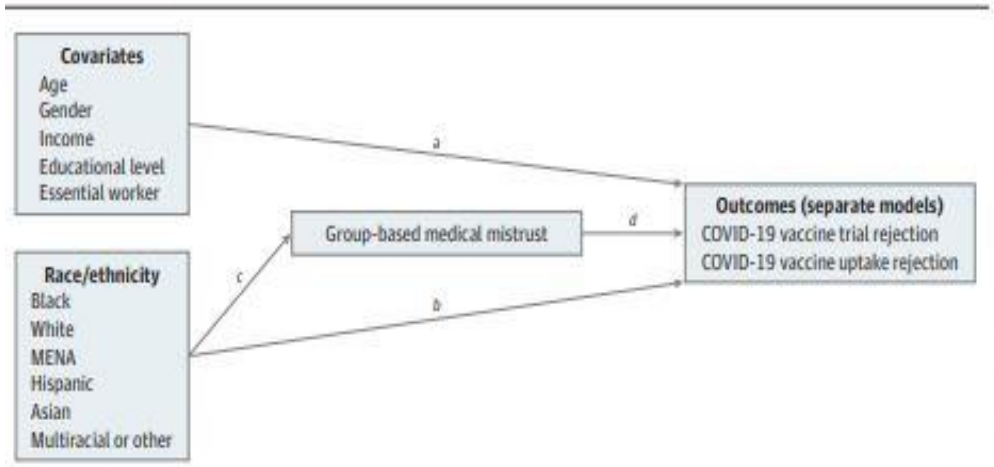
- If you were asked today to participate in a research study to test a COVID-19 vaccine, would you agree to participate?
- If you were offered a coronavirus vaccine that had been approved by the U.S. FDA today, would you agree to be vaccinated?

COVID-19 Vaccine Trial and Uptake Willingness by Race/Ethnicity

Response	Participants, No. (%)						
	All	White	Black	MENA	Hispanic	Asian	Multiracial or other
Would participate in a vaccine trial							
Definitely no, probably no, or unsure	1376 (75)	669 (70)	345(88)	76 (82)	57 (68)	67 (70)	162 (80)
Definitely yes or probably yes	451 (25)	290 (30)	45 (12)	17 (18)	27 (32)	29 (30)	43 (21)
Would receive a vaccine							
Definitely no, probably no, or unsure	945 (52)	410 (43)	279 (72)	57 (62)	49 (58)	34 (36)	116 (57)
Definitely yes or probably yes	870 (48)	545 (57)	108 (28)	35 (38)	35 (42)	61 (64)	86 (43)

Abbreviation: MENA, Arab, Chaldean, Middle Eastern, or North African.

Findings



The product of paths from the racial/ethnic group to mistrust and mistrust to outcome ($c \times d$) indicates indirect associations. MENA indicates Arab, Chaldean, Middle Eastern, or North African.

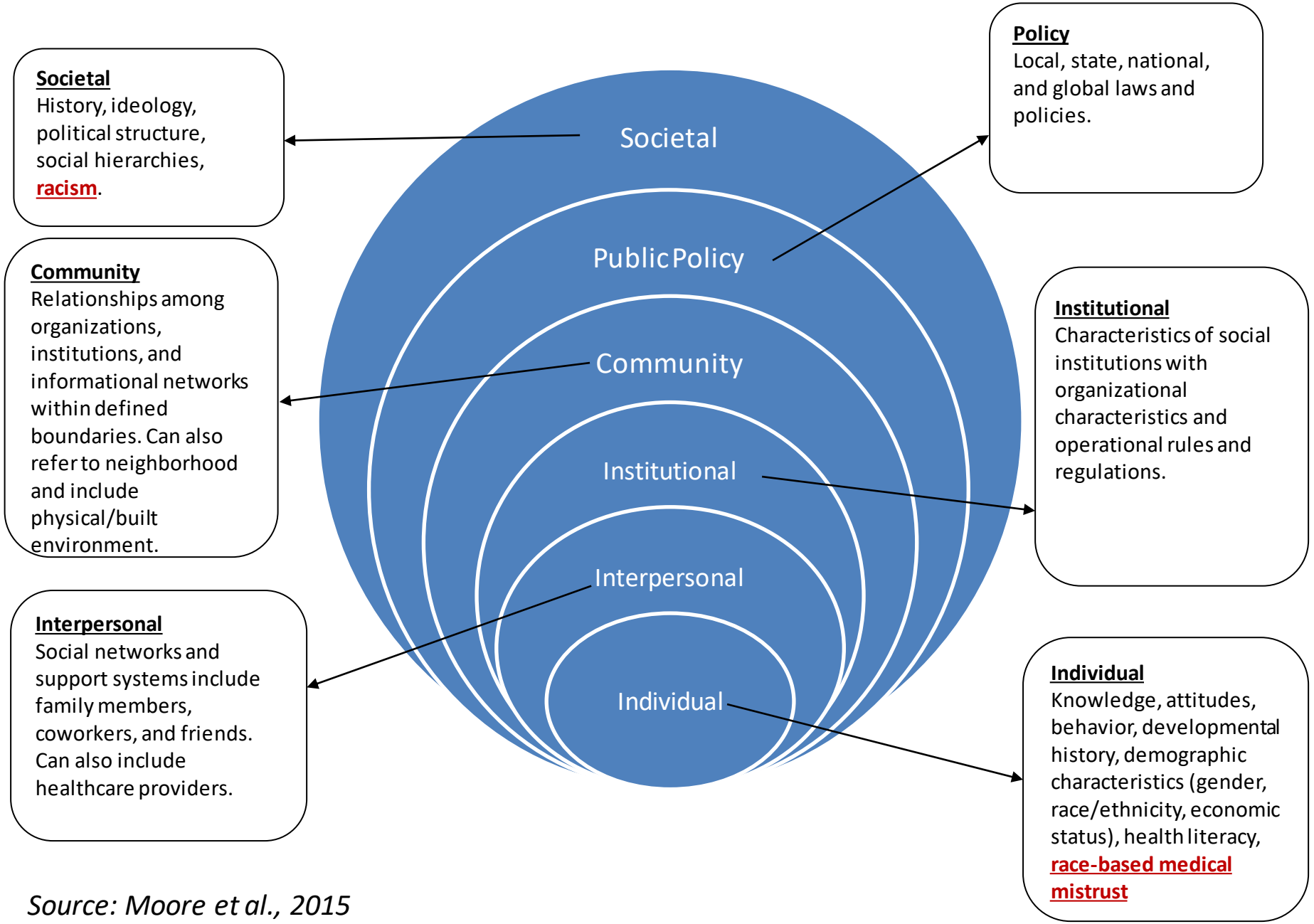
- Path analyses revealed significantly more rejection of participation in a vaccine trial among Black participants (*B* [SE], 0.51 [0.08]; P < .001) compared to overall/grand mean, partially mediated by mistrust (*B* [SE], 0.04 [0.01]; P = .003).
- There was greater vaccine uptake rejection among Black participants (*B* [SE], 0.51 [0.08]; P < .001) compared to overall/grand mean, partially mediated by mistrust (*B* [SE], 0.07 [0.02]; P < .001)

Race-based medical mistrust is informed by context

BARBARA ANN Karmanos CANCER INSTITUTE Wayne State University

- Findings suggest that rejection of vaccine trial participation and vaccine uptake is influenced by racial context
- Rejection is informed by…
  - Longstanding racial health disparities that are reflected in greater COVID-19 burden among African Americans and other marginalized groups
  - Documented implicit bias within healthcare systems and among providers that results in lower quality care among marginalized (partly fueling COVID-19 disparities)
  - Rapid development and promotion of a COVID-19 vaccine in a sociopolitical climate that African Americans and others perceive as hostile

Social-Ecological Model/Social Determinants of Health



Source: Moore et al., 2015

Emerging work on social-ecological context and GBMMS

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Are you better off? Perceptions of social mobility and satisfaction with care among Latina immigrants in the U.S.

Sonia Mendoza[a,*], Adria N. Armbrister[b], Ana F. Abraído-Lanza[c]

"Multiple regression analyses indicated that downward social mobility was associated with less satisfaction with care when controlling for demographic covariates, quality of care, and medical mistrust."

Journal of Health Communication, 24: 791–799, 2019

ISSN: 1081-0730 print/1087-0415 online
DOI: https://doi.org/10.1080/10810730.2019.1669742

Routledge
Taylor & Francis Group

Does Discrimination Breed Mistrust? Examining the Role of Mediated and Non-Mediated Discrimination Experiences in Medical Mistrust

LILLIE D. WILLIAMSON, MARISA A. SMITH, and CABRAL A. BIGMAN

"Results indicated prior personal and vicarious discrimination experiences were related to medical mistrust. Furthermore, exposure to mediated discrimination influenced medical mistrust in different ways for Black and White participants. Among Black participants, medical mistrust was significantly higher for those exposed to the implicit racial discrimination condition than the control condition."

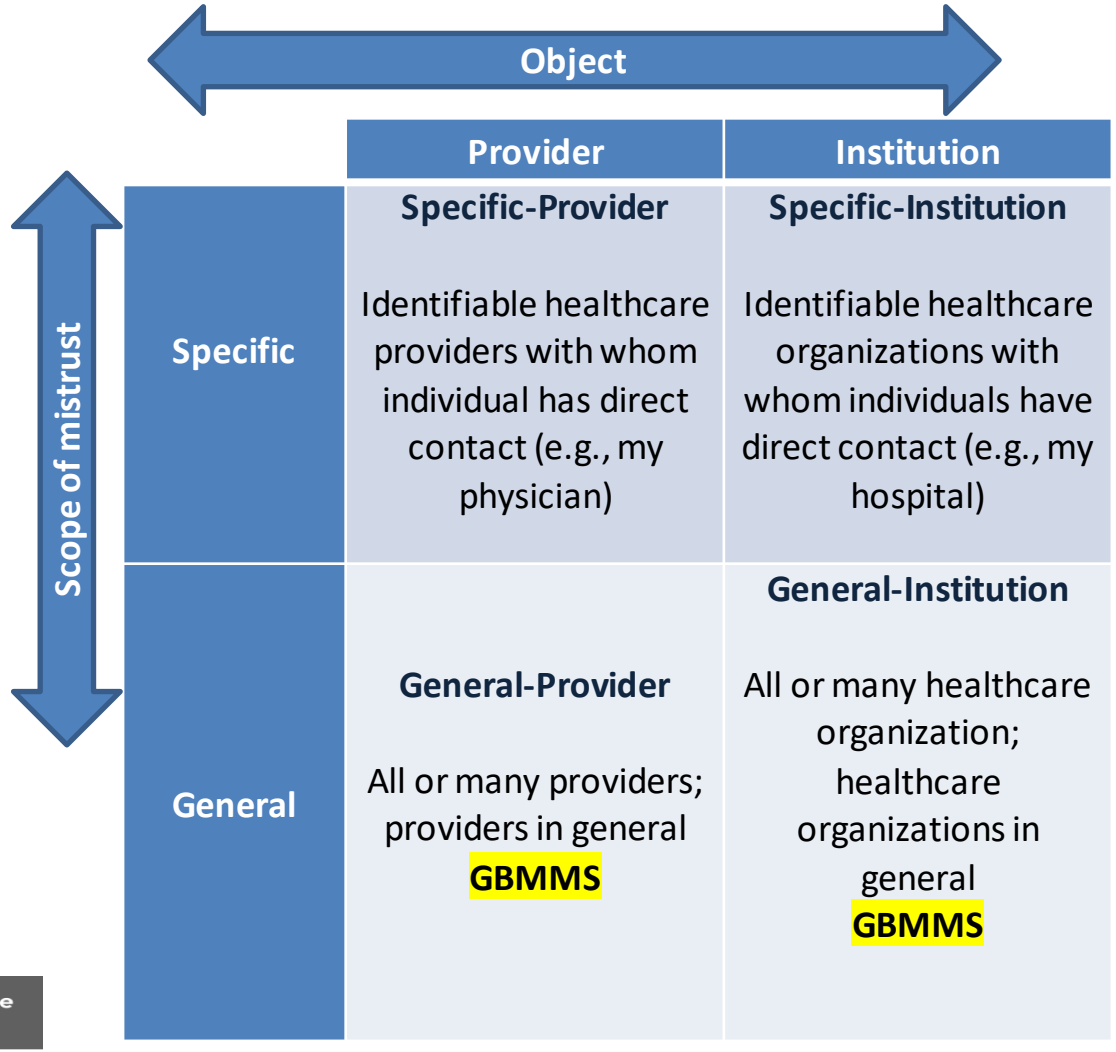
Journal of Racial and Ethnic Health Disparities (2020) 7:760–768
https://doi.org/10.1007/s40615-020-00706-w

Police Brutality and Mistrust in Medical Institutions

Sirry Alang[1] · Donna D. McAlpine[2] · Rachel Hardeman[2]

"Respondents who had negative encounters with the police, even if they perceived these encounters to be necessary, had higher levels of medical mistrust compared to those with no negative police encounters. Police brutality increased mistrust for all racial groups."

Can we disrupt group-based medical mistrust?



- A patient can simultaneously have high general (or group-based) mistrust and low mistrust (or high trust) in a specific provider or institution

Can we disrupt group-based medical mistrust?

BARBARA ANN Karmanos CANCER INSTITUTE
Wayne State University

- Group-based medical mistrust is influenced by longstanding systemic racism/oppression; activism and advocacy must continue
- In the meantime, can individual hospital systems do to disrupt the connection between racism/marginalization, mistrust, and healthcare and health outcomes?
  - Meaningful community engagement
  - Internal policies
  - Tracking healthcare and outcomes across racial groups through data to ensure equity
- What can individual doctors and other healthcare providers do to disrupt mistrust?
  - Communication training
  - Implicit-bias and anti-racism/oppression education

NCI Comprehensive Cancer Center
A Cancer Center Designated by the National Cancer Institute

Additional intervention approaches

- Merck for Mothers Initiative with Touro LCMC Health
  - Equity Action Labs: Black women described problems during delivery and with prenatal and postpartum care to perinatal professionals; helped design solutions
  - OB-GYNs and pregnant patients take part in a trust-building visit midway through pregnancy
    - What is most important to you about your birth? How is your care going so far? Do you have any fears or concerns…? What do you need to feel safe?

Additional intervention approaches

- Building relationships outside exam room; providers and patients share personal stories, facilitated conversations
- Use institutional data to identify and address disparities, inequities
- Signal commitment to improving patient experiences
  - Geisinger Health System offered refunds to patients reporting poor experiences
  - Emerging work in identity safety cues (e.g., representation cues, diversity philosophy cues and policies)

Thank you!

BARBARA ANN Karmanos CANCER INSTITUTE
Wayne State University

NCI Comprehensive Cancer Center
A Cancer Center Designated by the National Cancer Institute

Didactic Questions?

Please come off mute or type your questions into the chat

Case Study Presentation Overview

Health Equity Community Project Case Study Overview

Presenting a Case Study

- Submission of cases for presentation and discussion is a key component in the Project ECHO model.
- It is critically important for knowledge building and sharing for all ECHO participants and is therefore an expectation for Community Leadership Teams to present at least one case study **beginning November.**
- Community project sites are encouraged to present a case study involving information on their population of focus, efforts related to addressing medical mistrust within their community, and/or challenges involving project implementation.
- Community project sites will be notified a month in advance to present a Case Study for the next ECHO Session.
- Community Leadership teams will be provided with a Case Study presentation Power Point template, which will solicit demographic and relevant information pertaining to Community Project efforts. The Power Point will also include a section for listing questions Community Leadership Teams may have concerning their projects.

Presenters Name:
Role/Title:
FQHC Name:
Community-Based Organization Name:
Patient Advisory Council/Governing Board Info: *No Patient Identifiers!*

- Community Project Site:
- Rural, Suburban, Urban:
- Number of patients served:
- Population of focus:
- CRC Screening rate:
- Other information:

CASE STUDY TEMPLATE

Presenting Challenges

- List challenges you are experiencing and would like to discuss with the Faculty and your Community Project colleagues *(You are welcome to present more than one question)*

Mock Case Study Presentation

CASE STUDY TEMPLATE

EXAMPLE ONLY

Presenters Name: Cecily Blackwater
Role/Title: *Director of Nursing*
FQHC Name: *Rainbow Clinic*
Community-Based Organization Name: *Jolly Church (Faith Based Organization)*
Patient Advisory Council/Governing Board Info*: Using our PAC -10 members (Made up of Hispanic, White, Indigenous male/female patients)*

- **Community Project Site:** *Albuquerque, NM*
- **Rural, Suburban, Urban:** *Urban*
- **Number of patients served:** *4,023*
- **Population of focus:** *Hispanic men and women*
- **CRC Screening rate:** *2021 Baseline – 43%*
  Target – 50% or above

CASE STUDY TEMPLATE

Presenting Challenges

EXAMPLE ONLY

Data Collection for the Group Based Medical Mistrust Scale

- We are having trouble **recruiting community members** that identify as Hispanic to take our Group Based Medical Mistrust Scale survey.
  - *What are other community project sites doing for outreach?*

Colorectal Cancer Screening Efforts

- How are others ensuring under/uninsured patients have access to all colorectal cancer screening options?

Case Study Questions?

Session Survey

Next Steps

Project ECHO :

- ✓ Session 1: September 28, 2022 at 11am MT/1pm ET (90 min)
- Session 2: November 2022 at TBD (60 min)

Baseline Data:

- ✓ CRC Screening Questionnaire – Link has been released
  - FQHC leads please complete by October 21, 2022

Check-in Call:

- Budget and Action Plan call scheduled for October 19, 2022 at 12pm MT/2pm ET

Thank You and we will see you in November!