Minnesota Medical Association

Best Practices for Communication about Health Equity

Haley Brickner
Health Equity Coordinator
Minnesota Medical Association
hbrickner@mnmed.org
www.mnmed.org/healthequity

MN Health Plans Collaborative

BlueCross BlueShield Minnesota

HealthPartners

Hennepin Health

United Healthcare

Medica

ucare

South Country HEALTH ALLIANCE

IMCare

Today's Presenter

Haley Brickner

- Haley Brickner (she/her) is the Health Equity Coordinator for the Minnesota Medical Association, where she works to advance equity and address disparities in our state. She has over 10 years of experience working in racial equity and inclusion spaces. Her work has emphasized strength- and resilience-based methods of change in marginalized communities, particularly in Indigenous communities. Haley has a Bachelor of Business Administration, a Master of Educational Leadership, a Master of Science in Health Promotion, and extensive experience facilitating topics related to racial justice, diversity, equity, and inclusion.

Minnesota Medical Association

Objectives:

- Identify best practices for using inclusive language to support health equity
- Describe how non-inclusive language contributes to health inequities
- Recognize stigmatizing terminology and non-stigmatizing alternatives

Minnesota Medical Association

Racism, not race, is the cause of maternal and infant health disparities.

- The maternal mortality rates for Black and Indigenous birthing people are 2 – 3x higher than their white counterparts.
- The infant mortality rates for Black and Indigenous babies are also more than double.

Source: CDC National Center for Health Statistics

Minnesota Medical Association

Minnesota is one of the heathiest states in the nation…

Our pregnancy-related mortality ratio (PRMR) was 8.8 deaths per 100,000 births, lower than the national average of 17.3 deaths per 100,000 births in 2017

…with some of the worst health disparities

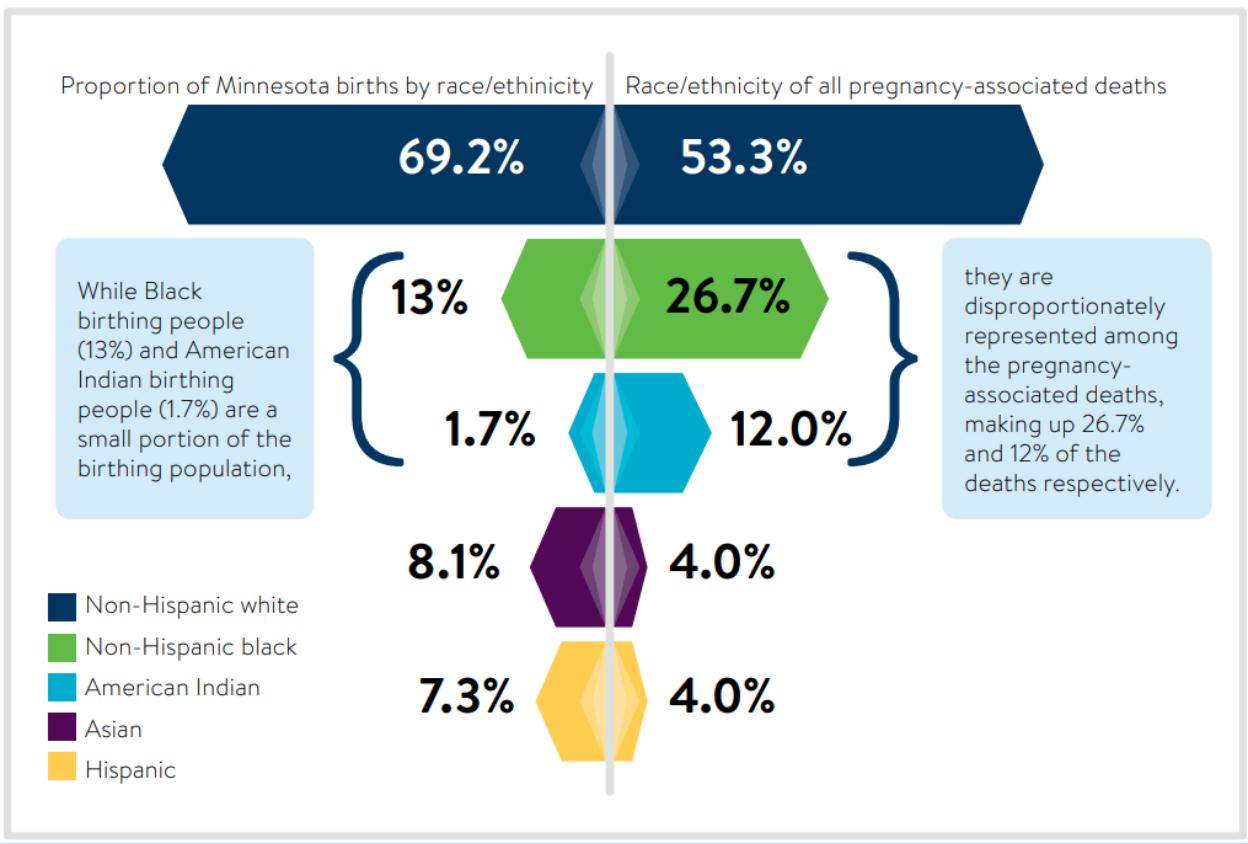
U.S. born Black/African American pregnant people die during pregnancy, delivery, or the year post-delivery 2.8 times higher than White pregnant people

For Indigenous people, it is 8.1 times higher than White people.

Source: MN Department of Health

Minnesota Medical Association

Another look at inequity



Minnesota Medical Association

Language is powerful. Our words matter.

Cultural norms and societal belief systems are reflected in the language

This shapes our ways of thinking and seeing the world

These attitudes, beliefs, values, and biases are then reflected in the words we use

We can either perpetuate harmful narratives or promote inclusive ones

Minnesota Medical Association

Sticks and stones…

- Negative words activate the same regions in the brain associated with physical pain [1]
- Negative words can adversely affect mental and physical health [2]
- Positive words can contribute to overall well being [3]

Minnesota Medical Association

Communication is a Clinical Skill

- **Better communication leads to better outcomes.**
- **Patients of color receive:**
  - Less communication [4]
  - Less rapport-building statements [5]
  - Faster speech, shorter visits [6]
  - More verbally dominant language centered [7]

Minnesota Medical Association

Terminology impacts attitudes and actions

Elderly	Incompetent	Older Person	Competent
Substance Abuser	Culpable, needs punitive measures	Person with a substance use disorder	Needs therapeutic measures
"Sickler"	Seeking opioids	Person living with Sickle Cell Disease	Needs pain management

Key Principles:

- Use Person-Centered Language
- Use Strengths-Based Language
- Be Specific
- Highlight Causes, Not Outcomes

Minnesota Medical Association

Principle 1: Use Person-Centered Language

Language that avoids dehumanization and demonstrates respect for every person's humanity.

Person-first	Identity-first
Places the person *before* the disability, disease, condition, or circumstance.	Refers to individuals in a way that emphasizes hat they consider to a core part of their identity.
A person who is deaf	A Deaf person

Minnesota Medical Association

Person-Centered Language: Avoid dehumanizing terms, demonstrate respect for every person's humanity, and defer to the terminology preferred by individuals with lived experience.	
Instead of these terms…	**Use one of these terms…**
Handicapped	Person with a disability
Mentally ill	Person with a mental illness
Drug addict	Person with substance use disorder
Homeless	Person experiencing homelessness
Prostitute	Person who engages in sex work
Convict/Criminal/Prisoner	Person who is/has been incarcerated
Elderly/Senior citizens	Persons aged [specific numeric age group]
Obese/Morbidly obese	Person living with obesity.
Poor people	People with lower incomes
Illegal immigrant	Person with undocumented status

Minnesota Medical Association

Principle 2: Use Destigmatizing, Strengths-Based Language

Stigmatizing language assigns negative labels, stereotypes, judgement, or blame to people or groups of people.

Stigmatizing Language	Strengths-Based Language
Implies that a condition is inherent rather that the result of root causes.	Highlights inherent strengths and assets, focuses on causal factors.
Non-compliant	Unable to adhere because of (reason)

Minnesota Medical Association

Stigmatizing Language Impacts Equity

- Public opinion
- Research
- Policy

Stigmatizing language is correlated with lower support for evidence-based public health policies and shown to interfere with effective interventions [4] [5]

Minnesota Medical Association

Stigmatizing Language Impacts Equity

- Attitudes of clinicians
- Treatment decisions
- Quality of care

Providers are more likely to have a negative attitude towards the patient when their chart includes stigmatizing language, which directly impacts quality of care [6]

Minnesota Medical Association

Black people are 2.5x more likely to have negative descriptors and stigmatizing language in their medical records [7]

- Questioning patient credibility
- Expressing disapproval of reason or self-care
- Stereotyping by race or social class
- Portraying patient as difficult
- Using dehumanizing terms

Minnesota Medical Association

Strengths-Based Language

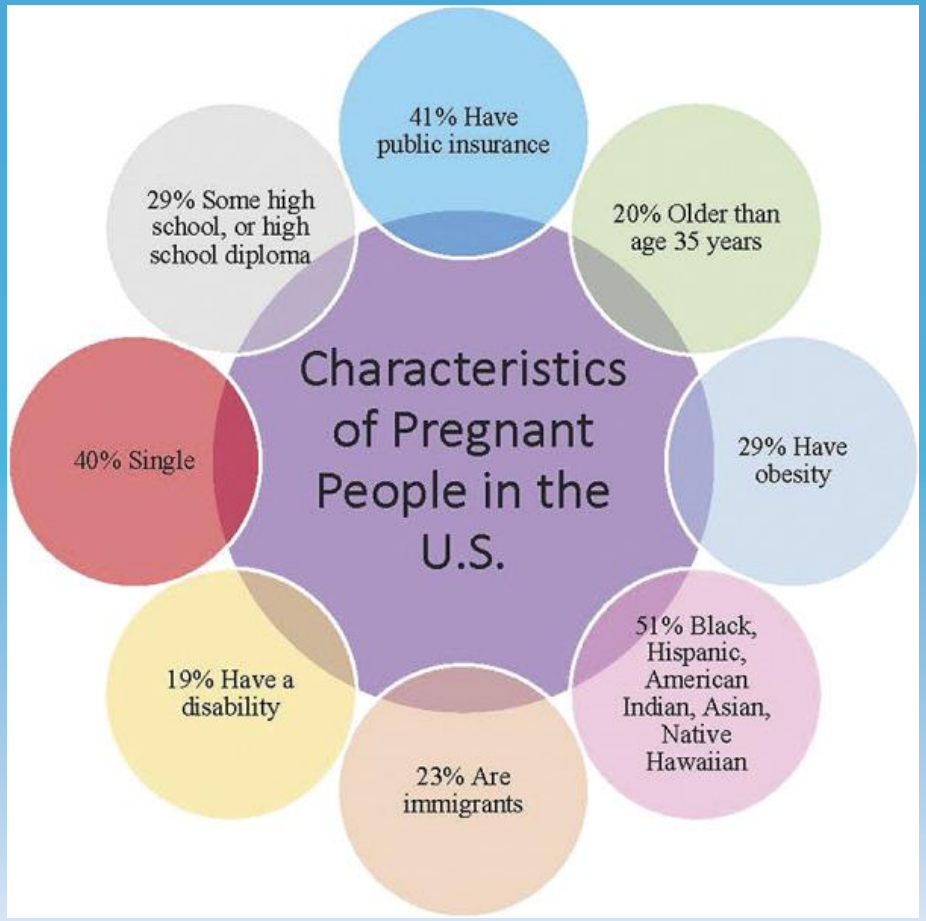
- Compliments
- Approval
- Minimizing blame
- Person Centered

Minnesota Medical Association

Destigmatizing Language: Avoid language that assigns negative labels, stereotypes, judgement, blame, and violent connotation.	
Instead of these terms…	**Use one of these terms…**
Disadvantaged	Experiencing disadvantage because of (reason)
Underserved	Intentionally excluded
Under-resourced	Disinvested
Vulnerable	Made vulnerable*
Needy	Struggling against economic marginalization
At-risk, high-risk	Put at increased risk of (outcome)
Non-complaint	Unable to adhere because of (reason)
Failed treatment	Did not respond to treatment
Target (communities)	Engage, collaborate
Tackle (issue in community)	Prioritize

Minnesota Medical Association

Pregnant people are diverse



The mother is a diabetic, noncompliant with insulin, uninsured

How could they say it better?

The childbearing parent is living with diabetes. She doesn't have insurance to cover insulin, so she has difficulty adhering to the recommended treatment.

Minnesota Medical Association

Mom is morbidly obese, claims to have too much pain to exercise and refuses to change her diet.

How could they say it better?

She is living with obesity, and has difficulty maintaining an exercise regimen due to severe pain. She lives in an area without access to healthy food, and struggles to maintain a nutritious diet.

Minnesota Medical Association

Principle 3: Be Specific

When describing groups of people, avoid:

- Terms that lump multiple communities together
- Erasing important differences between groups
- Center whiteness as the norm

Try to:

- Use the terminology preferred by the individual or group
- Err on the side of inclusivity
- Understand what the term means and use it in the correct context

Minnesota Medical Association

Principle 4: Highlight causes, Not Outcomes

Use data strategically. Share data points that emphasize the need to fix systems, not people.

Leading with data

May unintentionally trigger biases, reinforce stereotypes, and perpetuate harmful narratives

Leading with root causes

Highlights the need to fix systems, not people.

Minnesota Medical Association

American Values

Equality

Fairness

Individualism

Meritocracy

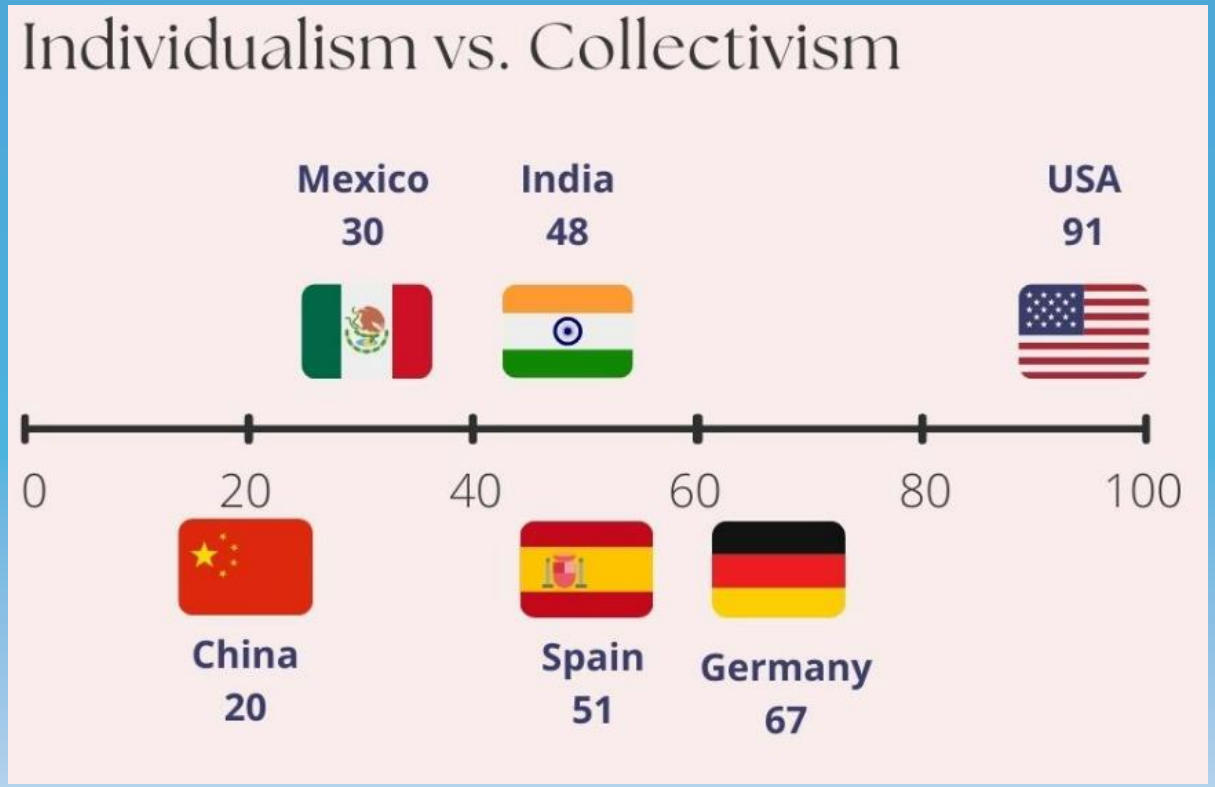
Work Ethic

Achievement

Determination

Health comes down to individual choices

We're Number 1



Source: Hofstede's Model is generally accepted as the most comprehensive framework of national cultures' values

Minnesota Medical Association

Health Individualism

Source: FrameWorks Institute National Culture Tracking Survey

Minnesota Medical Association

Principle 4: Highlight causes, not outcomes

Use data strategically. Share data points that emphasize the need to fix systems, not people.

Leading with data

May unintentionally trigger biases, reinforce stereotypes, and perpetuate harmful narratives

Leading with root causes

Highlights the need to fix systems, not people.

Minnesota Medical Association

Individualism

Healthy Choices = Health

Solution = Awareness

Minnesota Medical Association

When using data:

- Order Matters
- Less is More
- Highlight causes, not outcomes

*Bonus points for solutions and strengths-based information.

Minnesota Medical Association

Intent vs. Impact

You Say:	What you hope they think:	What they actually think:
The prevalence of obesity is higher in Hispanic or Latino/Latina children than it is for white children.	Social drivers of health that negatively impact Latino/Latina and Hispanic people.	The parents don't care about their children's health, they let them eat whatever they want

Say it better:

The places where Hispanic and Latino/a children live are less likely to offer access to healthy foods and safe places to exercise. This helps explain why the prevalence of obesity is higher in Hispanic and Latino/a children that it is for white children

Minnesota Medical Association

"Minorities, such as Hispanic and black children, are disproportionately affected by obesity. Hispanic children have the highest rates of obesity at 25.8 percent nationwide in comparison to non-Hispanic black, non-Hispanic white, and non-Hispanic Asian children." [8]

Minnesota Medical Association

Intent vs. Impact

You Say:	What you hope they think:	What they actually think:
Native Americans have the highest prevalence of alcoholism and have lower utilization of treatment options.	Substance use as a symptom of historical trauma, systematic oppression, and forced assimilation	Native Americans are more susceptible to alcoholism, they don't want to help themselves

Say it better:

There is a lack of culturally appropriate substance use treatment programs for Indigenous peoples. Few programs have been funded, implemented, and evaluated. This helps explain why Native Americans have lower utilization of treatment programs.

Minnesota Medical Association

"The biggest death disparities, by far, are between members of different racial groups. In 2021 Minnesotans of Asian descent had the lowest rate (7.6 per 100,000) of alcohol-driven mortality. Black (14.0) and white (17.8) Minnesotans had the next-highest rates. But the rate among indigenous Minnesotans, by contrast, was a staggering 120.5 — 7 times higher than whites, and 16 times higher than Asians." [9]

Minnesota Medical Association

Intent vs. Impact

You Say:	What you hope they think:	What they actually think:
Compared to their straight peers, twice as many young people who are LGBTQ+ have smoked a cigarette before the age of 13.	Unfair and unjust practices harm LGBTQ+ people and drive health inequities.	That's probably because they are more rebellious, don't follow rules, want to feel liberated.

Say it better:

Young people who are LGBTQ+ report high levels of stress from discrimination. The link between stress and smoking helps to explain why, when compared to straight peers, twice as many LGBTQ+ youth have tried a cigarette before the age of 13.

Minnesota Medical Association

"Discrimination causes stress that harms physical and mental health

Compared to 14% of the general population, 25-31% of LGBTQ adult Minnesotans smoke; among LGBTQ youth, one in three use tobacco. In addition to being the target of advertising, another factor known to affect health disparities is discrimination; many LGBTQ people have to cope with discrimination and bullying from family, schoolmates, coworkers, and society as a whole, resulting in feelings of anxiety, marginalization, and fear." [10]

Minnesota Medical Association

Intent vs. Impact

You Say:

African American women are two to three times more likely to experience premature birth and three times more likely to give birth to a low-birth-weight infant, even after controlling for socioeconomic factors.

What you hope they think:

The impacts of racism in medicine on African American women

What they actually think:

They don't take as good care of themselves as they should while pregnant. They don't have a healthy lifestyle.

Say it better:

Racism serves as a source of chronic stress, negatively affecting the body's hormonal levels, which can increase the likelihood of premature birth and low birth weights. This helps explain why African American women are two to three times more likely to experience premature birth and three times more likely to give birth to a low birth weight infant.

Minnesota Medical Association

Racism, not race, is the cause of racial health inequities for Black birthing people and their babies. Structural racism involves interconnected institutions created by the historical and ongoing devaluation of Black lives. Because of structural racism:

Black and Indigenous birthing people die 2-3x as often as white their counterparts across the U.S.

Black and Indigenous babies die before reaching their first birthday 2x as often as white babies.

UMN, School of Public Health Newsletter, April 2022 3

QUESTIONS?

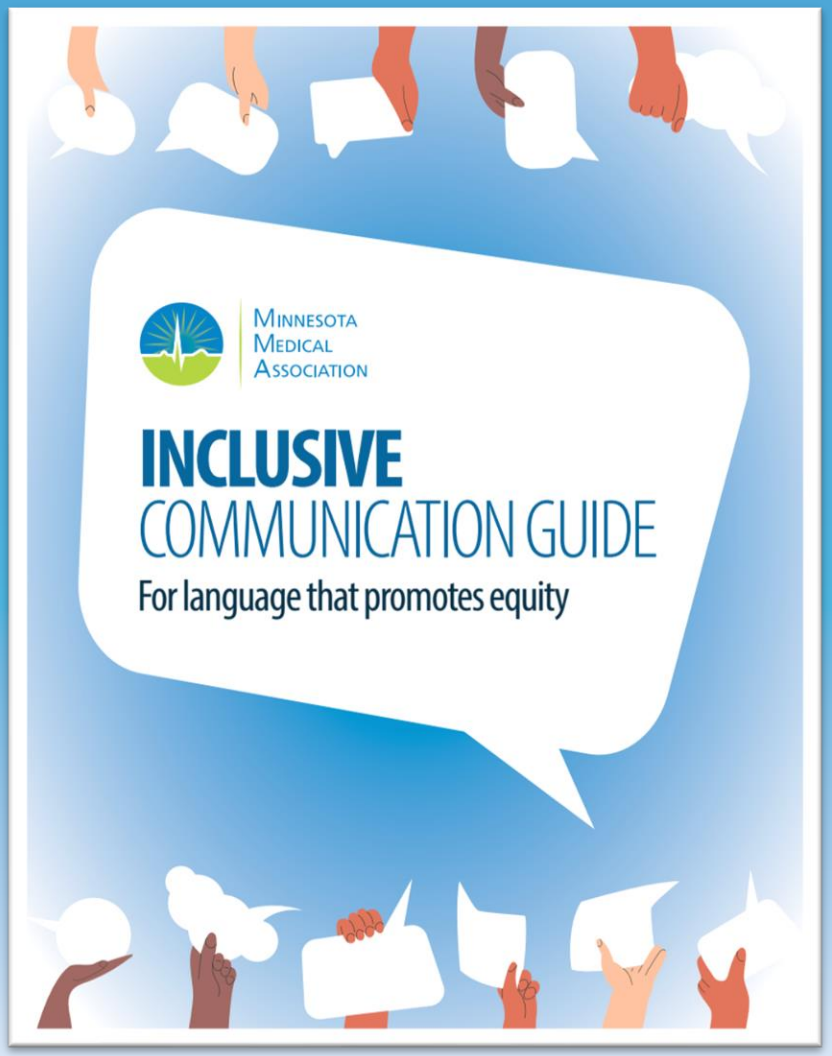


TABLE OF CONTENTS

INTRODUCTION

Language is powerful. Our words matter.

The Minnesota Medical Association (MMA) is committed to improving health equity and promoting an anti-racist culture in medicine, including within the MMA. Language has power, and words can either promote a culture of respect and inclusion or perpetuate harm. The purpose of this document is to enable more inclusive communication by providing suggested language, guidance, and explanatory context.

This document provides definitions for commonly used words in health equity discourse, identifies harmful words and offers equity-centered alternatives, clarifies subtle differences between seemingly synonymous terms, and explains how certain words perpetuate racist narratives while others promote racial justice. It aims to raise awareness and encourage users to think critically about the words they use, the meaning conveyed, and the potential impact.

The use of inclusive language means not only avoiding certain harmful phrases, but also centering the voices, perspectives, and lived experiences of those who are marginalized. This means valuing the lived experiences of the people most impacted by the issues at hand, paying attention to whose points of views are included and whose are absent, whose voices are amplified and whose perspectives are subdued or othered.

This guide is a living document that will be periodically reviewed and updated to reflect evolving terminology. This is not an exhaustive list of "correct terms" or the "right ways" of using inclusive language. Language and cultural norms change over time. Context matters and, in some cases, there is no consensus on one correct term. It is our responsibility to stay up to date on best practices for equity-centered communication.

The MMA encourages all members, staff, and elected leaders to apply these guidelines across their internal and external communications, including when creating information or resources, giving presentations, developing promotional materials, and drafting and reviewing policies and procedures.

METHODOLOGY

This guide was drafted by the Minnesota Medical Association's health equity staff. A list of terms and topics was compiled based on the needs of the target audience. Each term was researched, consulting multiple sources representing a variety of perspectives, emphases, nuances, and considerations. With an understanding of each term from multiple perspectives, combined with prior and community knowledge, a definition was drafted using a health equity lens. Careful consideration was given to the words used, the meaning conveyed, and the potential impact. The guide was reviewed by a team of MMA leaders and physicians with experience and expertise in equity and endorsed by the Board of Trustees (Feb. 2024). While numerous resources provided inspiration for this document, some key sources include:

- The American Hospital Association Institute for Diversity and Health Equity (AHA, IFDHE)
- The American Heart Association (AHA)
- The Center for Disease Control and Prevention (CDC)
- The World Health Organization (WHO)
- Substance Abuse and Mental Health Services Administration (SAMHSA)

The guide will undergo an annual review process to ensure it is kept up to date.

Minnesota Medical Association

HEALTH EQUITY
AT THE MMA

Conversations on Race and Equity (CME Available)

The Conversations on Race and Equity (CORE) series is a virtual space for physicians to discuss topics that relate to health equity and inclusion in healthcare.

Each session is 1 hour and includes facilitated dialogue based on curated content. The topics include:

Session 1: Anti-racism
Session 2: Cultural Humility
Session 3: Implicit Bias & Microaggressions
Session 4: Racism in Medicine
Session 5: Allyship

There are two ways to bring CORE to your organization:

- MMA Facilitated: With this option, each session will take place via Zoom with an experienced CORE facilitator
- Self-Guided: The MMA has developed a CORE Toolkit for healthcare organizations to host a CORE series on their own.

To bring CORE to your organization, visit www.mnmed.org/CORE

The Minnesota Health Equity Community of Practice (CoP)

The CoP brings together health equity leaders and professionals from Minnesota medical practices to exchange expertise, resources, and ideas. It provides an opportunity for networking, cross-organizational communication, and collaboration. The CoP also guides the work of MMA by providing input on health equity priorities and identifying opportunities for collective action in support of health equity. The CoP meets quarterly and interested physicians may join at any time.

To attend a CoP meeting, contact Haley Brickner.

Racism in Medicine: Truths from MN Physicians (CME Available)

In this powerful video series, physicians of color share their stories of practicing medicine in Minnesota. Efforts toward making medicine more inclusive require an understanding of the experiences of these physicians. This project is a step toward addressing the harmful effects of racism, microaggressions, and implicit bias within the culture of medicine. Also available is a recording of the panel discussion with physicians featured in the videos.

View the videos and symposium at www.mnmed.org/racismtruths

Implicit Bias Training (CME available)

Research suggests that implicit biases contribute to health disparities by affecting patient relationships and care decisions.

The MMA offers health care providers several ways to learn about Implicit Bias:

- Public workshops: Our live, virtual 2-hour Understanding and Mitigating Implicit Bias in Healthcare Workshop is offered to the public twice a year.
- Private workshops: Bring workshop to your organization at a time and place that works for you.
- Recorded workshops: Our 4-part Implicit Bias Learning Series is available on demand

Explore Implicit Bias resources at www.mnmed.org/IB

Intercultural Development Inventory

The Intercultural Development Inventory (IDI) is a developmental assessment which provides in-depth insights on individuals' and groups' levels of intercultural competence. The IDI process empowers participants to increase their intercultural capability.

The IDI can be used by individuals to receive feedback and recommendations and by organizations for baseline assessments, organizational development, or as a pre-post assessment in program evaluation.

The MMA now offers this valuable resource, including:

- IDI Assessment
- Individual Profile Report
- Group Profile Report
- Customized Intercultural Development Plan
- 1:1 Debrief/Coaching sessions with a qualified IDI Administrator

Learn more at www.idiinventory.com and contact Haley Brickner to start your IDI process.

Questions and Open Discussion

Thank You!

Evaluation – https://survey.alchemer.com/s3/7955152/Maternal-Health-and-Inclusive-Communication

Certificate of Participation –upon completion of Evaluation

Recording - Performance Improvement Project (PIP): Healthy Start for Minnesota Children - Stratis Health