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RESEARCH ARTICLE

Consideration of racism experiences in the implementation of trauma-focused therapy in primary care

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Abstract

Objective: To understand providers' perceptions of how a patient's experience of racism may impact the successful implementation of a brief posttraumatic stress disorder (PTSD) treatment in the safety net integrated primary care setting. To conduct a developmental formative evaluation prior to a hybrid type I effectiveness-implementation trial.

Data Sources and Study Setting: From October 2020 to January 2021, in-depth qualitative interviews were conducted with integrated primary care stakeholders ($N = 27$) at the largest safety net hospital in New England, where 82% of patients identify as racial or ethnic minorities.

Study Design: Interviews with clinical stakeholders were used to (a) contextualize current patient and provider experiences and responses to racism, (b) consider how racism may impact PTSD treatment implementation, (c) gather recommendations for potential augmentation to the proposed PTSD treatment (e.g., culturally responsive delivery, cultural adaptation), and (d) gather recommendations for how to shift the integrated primary care practice to an antiracist framework.

Data Collection/Extraction Methods: Interview data were gathered using remote data collection methods (video conferencing). Participants were hospital employees, including psychologists, social workers, primary care physicians, community health workers, administrators, and operations managers. We used conventional content analysis.

Principal Findings: Clinical stakeholders acknowledged the impact of racism, including racial stress and trauma, on patient engagement and noted the potential need to adapt PTSD treatments to enhance engagement. Clinical stakeholders also characterized the harms of racism on patients and providers and provided recommendations such as changes to staff training and hiring practices, examination of racist policies, and increases in support for providers of color.

Conclusions: This study contextualizes providers' perceptions of racism in the integrated primary care practice and provides some suggestions for shifting to an antiracist framework. Our findings also highlight how racism in health care may be a PTSD treatment implementation barrier.

KEYWORDS

primary health care, PTSD, racism, therapy

What is known on this topic

- Following heightened media attention to the murder of several Black people by the police in 2020, structural racism became a topic of national concern.
- The impact of racism, discrimination, and health care disparities is evident within the health care system, including in the treatment of PTSD, where racial/ethnic differences exist in treatment completion and outcomes.
- Although models of antiracist health care are emerging, less is known about how to implement antiracist approaches for improving patient engagement and outcomes in behavioral health within integrated primary care settings.

What this study adds

- The current study presents qualitative findings from interviews with clinical stakeholders in primary care regarding how racism impacts patients and providers and identifies recommendations for the consideration of racism-based trauma in PTSD treatment.
- Providers described perceptions of patients' experiences with racism, identified the importance of consistent information gathering, and highlighted the burden that racially/ethnically minoritized providers face due to racism.
- Clinical stakeholders highlighted the importance of considering experiences of racism and discrimination in case conceptualization and treatment planning for PTSD, as well as in selecting implementation strategies.

1 | INTRODUCTION

Following years of fatal police shootings of Black people (Eric Garner, Tamir Rice, Alton Sterling), the murders of Ahmaud Arbery, Breonna Taylor, and George Floyd in 2020 heightened public attention to the presence of structural racism within our society. As a result of these murders, “Black Lives Matter” protests erupted across the United States, and national discourse increased regarding how race is associated with increased experiences of structural inequities and individual discrimination. Additionally, the COVID-19 pandemic further highlighted the impact of these inequities and discrimination within numerous contexts, including the health care system.

Racism has been identified as a public health crisis¹ and contributes to disparities in morbidity and mortality experienced by racially or ethnically minoritized (REM) people.²⁻⁴ Extensive literature demonstrates that health care providers exhibit implicit biases against REMs,⁵⁻⁷ which can result in this population feeling stereotyped or even suffering overt racism.⁸ These implicit biases, in turn, can affect clinical care by influencing diagnoses and treatment decisions⁵ or by impacting patient-provider rapport.⁸ Health care providers who are REMs also suffer from experiences of racism directed at them by their patients, coworkers, or the health care institution broadly.⁹ Racism within the health care system is also apparent at a systemic level. A history of mistreatment of Black people within medical science (e.g., the Tuskegee syphilis experiment and the theft of biological samples from Henrietta Lacks) has resulted in a medical system that assumes provider authority, normalizes discrimination, and promotes differential treatment of REMs.¹⁰

Interpersonal and systemic racism within the health care system contributes to intergenerational trauma and medical mistrust that negatively impacts the patient-provider relationship and can contribute to poor health outcomes.¹¹ One area where this is evident is in the treatment of posttraumatic stress disorder (PTSD). Racial differences have been observed in PTSD treatment completion, where Black people are 28% less likely to complete treatment than White people, even when controlling for income, education, trauma history, and treatment expectation.¹² This suggests there may be racially specific factors [e.g., structural racism (including poorer quality of care) or internalized stigma] that should be considered when providing PTSD treatment for Black communities.¹³ Previous studies indicate that racism is associated with poor engagement and retention in PTSD care, thus driving disparities in access and quality; however, the impact of racism on PTSD treatment outcomes from evidence-based treatments has been under-studied. Existing studies suggest that minoritized groups can equally benefit from these treatments.¹²

One of the most salient factors that may contribute to racial differences in PTSD treatment outcomes is race-based trauma. Bryant-Davis¹⁴ defines race-based trauma as a set of clinical features, such as emotional injury or stressors that are experienced because of racism. We will use the term “racism-based trauma” within this manuscript to indicate that racism is the context for this harm, not race. As such, racism-based trauma may increase the burden of traumatic stress within REM populations.¹⁵ Although similar to PTSD, racism-based trauma produces a more expansive set of clinical features than currently captured by the PTSD diagnosis, and the nature of the trauma

is often repetitive and ongoing (i.e., lifetime experiences of systemic and individual level racism).¹⁵ Due to a more expansive clinical presentation, PTSD treatments may be insufficient in addressing additional features of racism-based trauma. More research is needed to support the conceptualization of racism-based trauma within PTSD clinical care. Further, there is a need to establish empirical support for the cultural adaptation of existing therapies and/or the need to develop new therapies to address the unique sequelae of racism-based trauma.¹⁶

Following the national response to the numerous murders of Black people in 2020, several manuscripts have emerged exploring how to recognize and address racism within health care in an effort to mitigate the role racism plays on the health and well-being of REMs. These manuscripts propose antiracist approaches to health care, that is, approaches that oppose overt or subtle acts of racism. Focusing on the patient-provider interaction, Legha and Miranda¹⁷ advocate for an antiracist approach to mental health care that includes encouraging clinicians to acknowledge racial biases, taking pauses in order to heighten mindful awareness of biases, naming racism when noticed, understanding historical origins of racism, and preventing exposure to racism during the clinical encounter. Hassen and colleagues¹⁸ systematically reviewed 37 manuscripts that outlined antiracist interventions in outpatient health care settings. The authors found that interventions often occur at five levels: (1) individual (e.g., providing cultural competence training), (2) interpersonal (e.g., developing guidelines for how to address racist comments), (3) community (e.g., ongoing partnerships with REM community members), (4) organizational (e.g., developing leadership committees charged with monitoring practices and prioritizing antiracist approaches), and (5) policy (e.g., mandating targets and actions).¹⁸ Many interventions included multilevel approaches; however, only 14% of the interventions included in this review outlined antiracist interventions for primary care settings, and only 11% outlined interventions for mental health care providers.¹⁸ Despite these advances in the literature, more information is needed to implement multilevel antiracist approaches across other clinical care settings, including integrated primary care.

It is well-documented that health care providers exhibit implicit biases toward REMs, which can influence clinical decision making and treatment outcomes, including within PTSD treatment. To implement antiracist policies into health care settings successfully, it is crucial that we understand health care providers' perceptions of the problem. Gaining a better understanding of the providers' perceptions of their patients' experiences with racism could, in turn, inform practice. To address this gap, we present a subset of findings from a developmental formative evaluation¹⁹ conducted in 2020 as part of a parent NIMH-funded study (K23MH117221). Our formative evaluation utilized qualitative interviews with clinical stakeholders in the parent trial to characterize the impact of the racialized national events of 2020 (i.e., the murder of George Floyd and the "Black Lives Matter" Movement) and racial disparities heightened by the COVID-19 pandemic on the safety net integrated primary care setting prior to a hybrid type 1 effectiveness-implementation trial²⁰ of a brief PTSD treatment. Through semi-structured interviews with clinical stakeholders, the current study aims to: (a) contextualize current patient and provider experiences of and responses to racism in the local context, (b) consider

how racism may impact PTSD treatment implementation, (c) gather recommendations for potential augmentation to the proposed PTSD treatment (e.g., culturally responsive delivery, cultural adaptation, and assessment for racial trauma), and (d) gather recommendations for how to shift the primary care practice to an antiracist framework. We also highlight antiracist initiatives underway in the local setting.

2 | METHODS

2.1 | Study design and setting

2.1.1 | Parent study

The parent clinical trial (NCT04937504) aims to inform the development of a stepped care approach for PTSD by testing the "step one" intervention in a primary care setting. Skills Training in Affective and Interpersonal Regulation for Primary Care (STAIR-PC) is an abbreviated, evidence-based treatment for PTSD²¹⁻²⁴ for primary care,²⁵ which has shown effectiveness in Veterans²⁵ and through peer delivery in a safety net setting.²⁶ To maximize implementation success, the intervention was further refined to the local setting from October 2018 to March 2020, prior to the clinical trial start, through a developmental formative evaluation¹⁹ that utilized clinical stakeholder interviews and collaboration with Community Advisory Boards (CABs) to characterize the setting and inform adaptations; however, the clinical trial was halted in March 2020 due to the COVID-19 pandemic. In response, we conducted an additional developmental formative evaluation¹⁹ to re-characterize the setting in light of the events of 2020. The first two themes of this evaluation (i.e., shift to telehealth and COVID-19-related provider burden/burnout) are published elsewhere.²⁷ In this report, we focus on the third theme, which includes the need to understand experiences of racism as potential PTSD treatment implementation barriers and as relevant to traumatic stress assessment and treatment, and to consider providers' perceptions of racism in the local context. While we collected preliminary suggestions from stakeholders for potential treatment augmentation, adaptations to the intervention will be guided by Lau's model of selected cultural adaptation.²⁸ Adaptations will be informed by a post-trial, mixed-methods summative evaluation involving both clinical stakeholders and trial participants (patients).

2.1.2 | Setting

The study took place at a safety net hospital in New England serving over 50,000 patients in primary care, where 82% of patients identify as REMs. Medicaid insures most patients (70%), over half of whom are in need of behavioral health services (56%). The hospital utilizes an integrated behavioral health (IBH) model to meet the high behavioral health needs of primary care patients. The IBH model involves interdisciplinary collaboration and coordination, and the care team consists of behavioral health specialists and primary care physicians (PCPs).

2.2 | Study participants and data collection

Study participants were clinical stakeholders within the integrated primary care setting, including PCPs, psychiatrists, nurse practitioners, clinical social workers, psychologists, administrative staff, and operations managers ($N = 27$). All IBH therapists (study interventionists) were recruited first for participation. We then used purposive sampling to identify additional key informants. These stakeholders were nominated by primary care and psychiatry leadership for their unique perspectives on the implementation of PTSD treatment in the local setting. All participants were recruited via staff email. We collected sample characteristics, including age, gender, race, ethnicity, and role in the hospital.

From October 2020 to January 2021, semi-structured interviews were conducted by the Principal Investigator, a White woman clinical psychologist with experience in the stakeholder-engaged cultural adaptation of manualized treatments for PTSD and implementation science.²⁹⁻³³ Participation was voluntary and consisted of a 30-min, semi-structured interview conducted remotely using video conferencing. Participants were remunerated \$20 for their time. All interviews were audio-recorded and transcribed verbatim. This study received an exempt determination from the institutional review board, as the data collected was anonymized.

The research team collaborated with the previously established primary care CAB (PC CAB) and patient CAB to develop the interview guide and contextualize the findings. Both CABs emphasized the need to utilize the present evaluation to consider experiences of racism as an important implementation factor in the setting. The PC CAB ($N = 9$) consists of an interdisciplinary group of primary care and hospital employees selected due to their relevant clinical expertise and decision making authority in the setting. The PC CAB ($N = 6$) includes primary care patients with a past or current PTSD diagnosis who have key insights on contextualizing patient experiences in the setting, including experiences of racism. Full detail on our CAB engagement is published elsewhere.³⁴

Interviews focused on understanding providers' perspectives of how racism is experienced by patients and providers in the local setting. Given the context of the upcoming trial, we also asked focused questions pertaining to the treatment of PTSD among patients who have experienced racism and report racial stress and trauma responses in care. We asked clinical stakeholders if they had recommendations for responding to experiences of racism in the care setting and clinical treatment needs related to combined experiences of racial stress, trauma, and PTSD symptoms. Clinical stakeholders were then asked if they had recommendations for promoting antiracist health care practices to reduce the harms of racism on patients and providers, for augmentation of the PTSD intervention and implementation plan, and for improving engagement and experiences. See Table 1 for the interview guide.

2.3 | Data analytic approach

We used a team-based approach³⁵ in developing the codebook for qualitative data analysis. The coding team consisted of three bachelor's

TABLE 1 Interview guide

1. In what ways do you think racial identity or racism is related to PTSD in your patients?
2. What is the most common way in which you learn about your patient's racial identities? What about experiences of racism (e.g., ask the patient directly, self-report questionnaire, assumptions made by provider)? Does telehealth complicate this process (e.g., need for verbal disclosure, more direct asking, lack of safety cues for patients)?
3. How is racism commonly talked about with your patients? In your practice? What types of practices have been recommended to you?
 - a. What successes or challenges have you had in talking about the effects of racism on your patients' mental health and wellbeing?
 - b. Have you or are you planning to make any changes to your own practice in light of recent events?
4. How do you identify your own race? What differences do you notice in your approach or comfort in providing therapy to someone of your own race versus another race?
 - a. (for providers of color) How have your own lived experiences with racism influenced your practice?
5. How would you define antiracist clinical practice? What does antiracist clinical practice look like?
6. What suggestions do you have for integrating antiracist principles into therapy?
7. What suggestions do you have for applying an antiracist approach to PTSD treatment?

Abbreviation: PTSD, posttraumatic stress disorder.

level research assistants and one doctoral level psychologist (to provide clarification and resolve discrepancies). One team member was multiracial, and three were White. Two members of the team used a rapid coding procedure to generate initial themes from the interviews. Then, conventional content analysis³⁶ was applied to further refine the codebook. All members of the coding team met on a weekly basis to discuss and expand the codebook and enhance the intercoder agreement prior to coding. Once the codebook was finalized, transcripts were double-coded until reaching 80% intercoder agreement (20% of interviews were double-coded with 99% agreement). The remaining transcripts were coded independently, and the coding team continued to meet on a weekly basis to ensure consistency in the application of the codes. NVivo 12 software (QSR International) was used in assigning codes and calculating intercoder agreement.

We organized findings in terms of several themes, including racism-based trauma and PTSD treatment implications, provider perceptions of patient experiences of racism in health care, patient-provider interactions, and provider-institution interactions. We also have summarized recommendations for PTSD treatment adaptation.

3 | RESULTS

See Table 2 for sample characteristics. All clinical stakeholders agreed to participate ($N = 27$), yet demographic information was missing from one participant. Most respondents were White (62%), most were women (77%), and the average age was 37.23 years

TABLE 2 Sample characteristics (N = 26)

Age (years; M, SD)	37.23, 7.37
	n (%)
Gender	
Female/woman	20 (77)
Male/man	4 (15)
Nonbinary/third gender	1 (4)
Race ^a	
White	16 (62)
Black or African American	4 (15)
Haitian	2 (8)
Cape Verdean	1 (4)
Asian ^b	4 (15)
Hispanic, Latinx, Spanish origin ^c	2 (8)
Another race or more than one race	2 (8)
What is your role? ^a	
Primary care physician	9 (35)
Psychiatrist or nurse practitioner	2 (8)
Social worker, therapist, or psychologist	14 (54)
Administrative staff or operations manager	1 (4)
Leadership, supervisor, or director	4 (15)

^aIndicates that participants could select all responses that apply.

^bSpecified responses included: Chinese (n = 1), Korean (n = 2), Indian (n = 1).

^cSpecified responses included: Mexican (n = 1), South or Central American (n = 1).

(SD = 7.37). Key themes and exemplar quotes are presented in Table 3. A comprehensive summary of challenges and recommendations is presented in Table 4.

3.1 | Racism-based trauma and PTSD treatment implementation

Respondents (especially therapists) discussed the need to validate experiences of racism as trauma (adopting the patient's language) and consider the contribution of racism as a cumulative stressor that may lead to a higher risk of PTSD. They also noted that many experiences of trauma (based on the DSM-5 Criterion A for PTSD)³⁷ are racist events (e.g., discrimination or hate crimes) and that repeated media exposure to violence against Black men had caused elevated distress. Respondents proposed a nuanced response which included: (1) using cultural formulation and culturally responsive care principles to discuss how experiences of racism and trauma can lead to similar cognitive, behavioral, and affective responses and (2) being sure not to pathologize adaptive responses to racism (e.g., vigilance in the presence of realistic threat). IBH stakeholders provided detailed insight into strategies for validating racism-based interpersonal harms as part of traumatic stress and integrating these experiences into PTSD case conceptualization. They described the importance of culturally

responsive treatments³⁸ (which consider language, values, customs, traditions, distinctive stressors, and resources specific to certain cultural and racial groups) to ensure that interventions are delivered with the social-cultural context in mind.

3.2 | Patient level

Respondents described their perception of how historical maltreatment and individual experiences of racism in health care have led to their patients' medical mistrust. They noted how mistrust could make it difficult for patients to engage in treatment and establish rapport, especially when working with providers of a different racial or ethnic background. Respondents also perceived an increase in patients advocating for race-matched providers and raised questions about the presence of uniformed police officers in health care settings.

3.3 | Patient-provider interaction

Respondents provided the most detailed feedback on racism in the context of the patient-provider interactions (not specific to PTSD care). Generally, they described major concerns with the way that racial identity information is gathered and documented in the electronic medical record. Respondents were varied in whether they asked patients to self-identify their race and other aspects of cultural identity. There was consensus that many providers are not initiating conversations about racism with patients, which may be attributed to (a) perception by a small number of providers that racism is irrelevant to health, (b) discomfort with the topic/self-experienced biases, or (c) placing a lower priority on assessing the impacts of racism because of not having the tools or time to respond to/address race-related concerns. Respondents also noted how the lack of universal screening for some behavioral health problems might lead to providers using their own biases to guide screening and decision making. Some respondents reported feeling ill-equipped (and often not empowered) to confront racist attitudes expressed by patients and coworkers.

3.4 | Provider-institution interaction

Respondents drew attention to the cumulative burden of racism on minoritized providers, specifically, the added burdens of providing care while also coping with their own distress related to exposure to racism in the workplace and their personal lives, and to racialized national events. Respondents who identified as REM reported feeling further burdened by being asked to educate White colleagues and being pressured to help "fix" workplace issues without additional compensation. Some REM respondents expressed guilt about not being able to accommodate the increased demand for race-matched providers.

TABLE 3 Exemplar quotes by theme**Racism-based trauma and PTSD treatment considerations***Invalidation versus overpathologizing responses to racism*

1. "Sometimes 'symptoms' that patients present with appear to be pathological in nature and upon digging a little...you discover that these responses...are very healthy. [That is, 'symptoms' are actually] healthy responses to a(n)...unhealthy situation or...environment." – IBH; REM
2. "I've just thought about the relationship between trauma and behaviors and minority stress is something that we have not gotten enough practice wide training [in]. ... I often times...see providers [helping patients adapt to unhealthy situations that an] individual should not tolerate.... To me, this is a very rich area that we could do a lot of improvements on." – PCP; White Non-Latinx
3. "Trauma comes from racial injustice. It's really important for providers to understand that this is not just a physical or sexual assault or being in combat. There's other layers to trauma that impact the individual on a day-to-day basis and [impact] how they interact with others." – IBH; REM
4. "With discrimination it's not necessarily clear traumas. It could be, but it's also just the cumulative effect." – IBH; White Non-Latinx
5. "I think of it [racism] as being directly related to PTSD and trauma. And in so many instances, it's important to keep that in mind when applying evidence-based treatments, because you cannot really tell someone who has seen their family members be killed by police why it's in their head [referring to providers dismissing impact of witnessing trauma]...." – IBH; White Non-Latinx
6. "Are there any of those coping skills [in the proposed intervention] that could be adapted to deal with the kinds of chronic stress...that [is] coming up?... And this is true for other types of trauma as well, but the aspect of invalidation that happens with racism and discrimination, and with microaggressions in particular, where people are often doubting that that's happened or they are highly defensive about having made a microaggression. Like, maybe something to really deal with that pervasive invalidation and erasure of experience as it relates to ongoing stress." – IBH; White Non-Latinx

Some patients may not link stressors to racism (e.g., labeling experiences as microaggressions and systemic racism)

1. "As a Black person you are experiencing trauma every day in different forms. I think at some point it becomes complex and chronic, even if you do not recognize it. If our patients do not recognize it, it's still there and it's something that might show up later, as something more serious...like a...medical condition." – PCP; REM
2. "[I'll say] 'I gather it must be really hard for you to see some of these images and hear these stories over and over again throughout your lifespan, let us make some space to process and talk about that.' And talk about some of the PTSD symptoms that they may not even be recognizing.... the numbness, dissociation... [I'll ask] Where does your head go when you see these images? Do you feel present within your body?" – IBH; REM
3. "[I often provide psychoeducation to] younger patients, who may not have identified that something that happened at work, or school, or any environment, was actually a microaggression...They're seeing a lot of things on social media and the news as well, and I'm providing...more space for my patients, [by saying] things like 'the news has been heavy recently, is there anything you want to process about anything you have seen or experienced? Does it remind you of [a personal experience]?" – IBH; REM
4. "I've been doing a bit of psychoeducation about how this pervasive trauma throughout our lives can have impacts on us, you know? I have patients who have talked about their feelings of anger towards police, their feelings of...just anger towards people who do not understand what they are going through, and again just allowing them the space to process that." – IBH; White Non-Latinx

Patient experiences and responses related to discrimination in health care*Medical mistrust and its impact on engagement in care*

1. "...sometimes it can take a little bit longer to build a therapeutic relationship...because of... [medical] mistrust, which is only made worse by [trust issues related to] PTSD." – IBH; White Non-Latinx
2. "If you have been [subjected to] racism by White people, then there's definitely this mistrust...You've been abused by somebody and then suddenly they want to help you. That's...confusing...and it can sometimes be interpreted as paternalism or condescension, and not genuine. [These] are initial barriers that can be overcome if... [providers are] give[n]...a chance, but... prevent [patients] from [initially] accessing care." – PCP; REM
3. "I know we have all these conversations about engagement in care and I think we need to have more explicit conversations about race and racism...being part of that...feeling not welcome or safe." – IBH; REM
4. "We need to start an anti-racist... open dialogue within practitioners. I think we need...mental health staff, [primary care] providers, nurses, all the way down, [hosting] focus groups, having conversations on what anti-racism looks like." – IBH; REM

Advocating for race-matched providers

1. "I do have patients who look me up and choose me because I look like them, and some patients are resistant to see a provider who does not look like them because they do not trust providers who do not look like them, and I think what I'm saying is White providers. So I think that's an important feature to consider, you know. I think that folks... who have experienced racism [in healthcare] want to be able to identify with the person who's taking care of them." – PCP; REM
2. "I've had patients... ask me...about my racial identity...and... [state] that they would prefer to work with someone who has a similar racial identity to themselves, and [also] feeling that [having a race-matched provider is] a really big piece of the support that they need" – IBH; REM
3. "Patients and providers have voiced that they would like to see more diversity in the panel of clinicians" – IBH; REM
4. "You have to...look...at the racist structure that's still in the institution – who you hire, and how you hire, and the opportunities that you give to different people. We definitely need to do that [reflection]. And not just show the data [documenting disparities in hiring and promotion]...but actually do something about it." – PCP; REM

Presence of uniformed public safety and police officers at the hospital and in the care environment

1. "There's a lot of talk around public safety and whether having uniformed guards at our door is something that is helpful or triggering [for patients], or both" – PCP; White Non-Latinx

TABLE 3 (Continued)

Patient experiences and responses related to discrimination in health care

2. "When [discomfort with uniformed officers] come[s] up in my practice...it's like a patient in [outpatient substance use clinic] who is afraid of the police because they have a history of substance abuse. Police are [triggers] related to incarceration [and] violence in that setting..." – PCP; White Non-Latinx

Patient-provider interaction*Providers making assumptions of racial identity, lack of consistency in how providers as about race*

1. "There are some times where I feel like I may have not asked [about race identity], and I had two or three sessions with a patient, and I assume, and make lots of assumptions based on experiences, or how they sound, or their dialect that I'm assuming I know where they are from and that may not be the case." – IBH; REM
2. "It's just how someone appears to me. I do not usually ask. I do not ask 'how do you identify yourself racially?' I mean there probably have been times when I have, but it's definitely a minority of times." – PCP; White Non-Latinx
3. "If it's a language that they speak, that's definitely a big one. Another thing is probably name, I think a name can sort of suggest race pretty easily also. And then lastly if I'm seeing them in person. I do not typically ask [about racial identity], but I know that when patients get registered initially... they do get asked about their race, so if I wanted to I could go into the demographics and check, but I never do that." – PCP; White Non-Latinx
4. "I rely on the demographics tab...which is problematic...it just might be incorrect. I'm not asking them." – IBH; White Non-Latinx
5. "It has not been my practice to ask people what race they identify as because unless there was a conversation in which it was relevant for me to know that... I think some people, some would probably like to be asked and some would not and because I cannot tell which is which I just do not." – PCP; White Non-Latinx
6. "Race is a social construct. So, for me, it's important that I ask my patient, 'how do you identify?' ... it's very important that we do not microaggress our patients through these assumptions [about identity]. So, I ask because what I'm seeing is filtered through my own perceptions of the society in which I was conditioned, and I could be wrong. I ask because it's important to ask, we have to allow people to self-identify." – IBH; REM
7. "Including race and culture and ethnicity and all sorts of different social identities into case conceptualization is important. And I do think we do a fairly good job of doing that in IBH (the integrated behavioral health practice). But you are [not] prompted in [the EMR] to [consider racial identity], for example. When you open [the EMR] note all it will say is age, and female or male. ... I think there may even be some technological advances in the EMR... [to] help people to conceptualize...more fully." – IBH; White Non-Latinx

Providers may not initiate discussions of racism with patients

1. "A lot of it is [my own] discomfort.... I'm a White woman with a theoretically more powerful role [than] a patient and it's weird and awkward to talk about." – PCP; White Non-Latinx
2. "It's a lot of my own discomforts [talking about racism]...with bringing up something that they [patients] have not brought up first...[I'm] still figuring out where that line is." – IBH; White Non-Latinx
3. "I try and talk about it [racism] by being very explicit and saying, 'I am a White woman, and I cannot speak to your experiences. I want to name that as well as making space for any issues, and if you have issues with how I'm phrasing anything, I want this to be a safe space for you, and you are the expert in your own experience. So if something I'm saying does not ring true for you, I know you may not feel comfortable, but I want [this] to be a space where you can bring that [power dynamics] up and that I'm here to listen and learn from you just as much as you are here to listen and learn from me.' I try to even that playing field based on practitioner-client dynamics so that we can then talk about racial power [and] privilege in the room." – IBH; White Non-Latinx
4. "I've been doing a lot more reading [about anti-racism] which I know is not enough, but just setting aside the unhelpful and unproductive feelings I might have as a White person and just opening up the space for the patient to communicate whatever they want to communicate in a safe, nonjudgmental space." – IBH; White Non-Latinx
5. "Systematically...identifying your own biases and having an awareness in your supervision or in your group around how those are playing out in the therapy room...needs to be an aspect [of clinical training]." – IBH; White Non-Latinx

Racism may not be prioritized or considered relevant to clinical care

1. "Plus it's hard [to bring up racism] because I cannot necessarily do anything about it. So it's my job to talk about your blood pressure." – PCP; White Non-Latinx
2. "Oftentimes it feels like we are so busy with the health issues, you know, the medication changes, the diabetes, the hypertension, that I feel like I think one of the reasons [racism] does not come up so much is I may blow over it because I feel like there's so much to get through in the next eighteen minutes and so, that could be a tangent that we cannot afford to make." – PCP; White Non-Latinx
3. "I'm providing a lot more space for my patients, I'm like 'the news has been heavy recently, is there anything you want to process about anything you have seen or experienced?'" – IBH; REM
4. "In the past, in the intake, I did not get to the race section or the more identity driven section, I think I've been more...I've moved that up in the intake so I'm less likely to not get to it or skip it." – IBH; White Non-Latinx
5. "I think...[providers] who identify as white, may be [having conversations about racism with patients] more...in the last couple of months, [when] they had not been before." – IBH; White Non-Latinx
6. "I have not really talked about racism with my clients. It's come up and...I validate them, mostly validate it and [show] I've understood. You know, as a black woman and most of my clients are black and brown, so they have been like, 'okay like you get it phew, thank God.'" – IBH; REM
7. "Whether this is 1800s or 2020, things have not changed and I think having a dialogue and some education from providers to then trickle down to how we can treat our patients in a different way or see our patients lives in a different way is probably where we should start." – IBH; REM
8. "There is a training gap. I think that if you are lucky, you have a [clinical training] program... that emphasizes racial justice, social justice, and how that affects clinical care. And if you are extra lucky, you have a practicum placement that...teaches you how to incorporate that into your treatment." – IBH; White Non-Latinx

(Continues)

TABLE 3 (Continued)

Patient-provider interaction

9. "The relationship between trauma and behaviors and minority stress is something that we have not gotten enough practice wide training." – PCP; White Non-Latinx
10. "All the research shows that you are living in these homes that produce high cortisol, you are always on high alert, and your neighborhoods aren't safe, and your role models are not CEOs or professors but they are doing their best to hold down a job in which they are not respected. Is it any wonder that there's...unbelievable hypertension? Disease? It's like the real word, 'dis-ease', lack of ease." – IBH; White Non-Latinx

Lack of universal screening may lead to providers using their own biases in screening practices

1. "[Patients] are perceiving racism in a way that I think that our decision-makers are not aware of. Some of the ways in which decisions about who to offer care to, and when, and how to screen, and who to screen. Those might all be leading to more racial inequity." – IBH; REM
2. "An example I'm thinking about is HIV screening because I get a prompt to screen everyone for HIV...and I do, but a lot of my patients think I assume that I'm asking them because of who they are, you know? And I always try to say, like, 'I ask everyone.' But they are never a hundred percent sure that that's true. [When assessing for trauma one-on-one, instead, printed screening forms could be used that ask] 'have you ever had a trauma? Have you ever had a trauma related to your race?' It's...you know...these kinds of things would feel a lot better because someone who it did not apply to would just be like 'no' and it would not bother them, and then someone who it did apply to it would be an easy way that they did not feel profiled." – PCP; White Non-Latinx

Confronting racist attitudes expressed by patients and coworkers

1. "I mean...it's [racist attitudes expressed by patients] a daily event. We know from all people across the practice...varying degrees of racial things that come out...inappropriate stuff. Sometimes they are egregious enough that we actually have to terminate patients, but it is a gray zone, right? Because if we terminated every patient who said something with a negative racial undertone, then we may have to terminate everybody." – PCP; White Non-Latinx
2. "I think there...there has to be policies in terms of how do we respond to racist comments, or racist attitudes from staff and from patients. It has to be clear. There's not a clear protocol in terms of how that should happen. I think it's very vague. It has to be very strong and it has to be something that they put out there saying, you know, 'This is a practice where we do not tolerate any racist or xenophobic or sexist comments.' The other thing is, I think at the individual level there needs to be more [staff] training in how do you respond to microaggressions, how do you become an ally, and what do you do when you see those things?" – PCP; REM
3. "I ask a patient, 'Where did you first learn that idea or that assumption? Or, where did you come up with that? Why do you think that black men are this way? And then I think I will use that as a point of...dissecting and dismantling kinds of social norms.'" – IBH; REM
4. "What actions are we really going to have the courage to take when we see that [provider]behavior is woefully inappropriate in terms of how they are treating their patients? And we know what those behaviors are because we are listening to our patients and we are finding that there's consistency with some of their complaints..." – IBH; REM
5. "I want my patients to feel safe...because if I'm ever feeling like my patient is not being heard, or they have experienced racism with a provider that I've worked with closely, I want to be able to feel empowered to say, 'I spoke with my patient and this occurred and I just want to share my thoughts and insight on how I think this was either poorly done or this could have been done differently.' And I just hope the provider or whoever I'm speaking with feels safe for me to approach them, because I'm advocating for my patients." – IBH; REM

Provider-institution interaction

Cumulative burden on REM providers

1. "I was working with a new patient...who had expressed that they would prefer to work with a therapist who is Black. Some patients I've had to explore that with them, and if it feels like something that needs to be addressed where I could work with them, I've tried to do that. Other patients I've tried to say, 'Okay we'll try to make it work,' but at the same time we all have such large caseloads, and my colleagues who are Black also have large caseloads who are also then dealing with their [our] own experiences." – IBH; REM
2. "How do we motivate people to even want to engage with, look within, and really address and confront their own implicit biases?" – IBH; REM
3. "What I've found is when I've attended diversity trainings, the people there...I do not say they do not need to be there, but they are the ones who are always showing up. It's the ones who really need [the training] who may be apprehensive about showing up in these types of spaces." – IBH; REM
4. "I want to make sure...we do not stop having [these] conversation(s). It's easy to want to sort of hide from the topic. We're in it, then we tend to sort of go back to the bystander approach once things calm down - the news, media stuff. So, anything we [can] do to encourage to keep it going for everybody. And I think it's different conversations with, you know, myself as a White clinician versus people of color, really balancing my role with patients...challenging others who identify as White and engaging in those conversations... and I'm not perfect at it. Just thinking about my role as a person of...power and privilege in this...not putting it [the burden] on [those] who identify(y) as a person (people) of color." – IBH; White Non-Latinx
5. "The team I'm a part of...they really do a good job of everything...in terms of being inclusive and diverse. Also, having our director...every time we have a meeting...she holds that space. We vent for like 5-10 minutes. She acknowledges what's been going on in the community. She's just amazing and...a perfect example of working towards anti-racist, supportive, validating, comforting, all of that." – IBH; REM

Diversity of staff decreases as position of power within the department/hospital increases

1. "Within the teams there is a [racial] disparity between the docs and NPs and the medical assistants." – PCP; White Non-Latinx
2. "The culture of medicine is a White supremacy culture...I do not even think that I can even articulate how much unlearning we have to do in that way." – PCP; White Non-Latinx
3. "I do not think that there's any sort of training that's going to make a difference. I think we need to have more diversity in every single level in terms of our leadership, and that will trickle down into how we work with our patients." – PCP; White Non-Latinx

TABLE 3 (Continued)

Provider-institution interaction

4. "Anti-racist work is also ensuring that the people with the power, with the most power making these decisions, reflect the people they are making these decisions about." – IBH; REM
5. "To be truly anti-racist you have to truly be about fighting for equity. For not only your patients, but also your staff. Some organizations focus a lot on the people they serve but they do not necessarily put as much a priority on the people who are serving those people. So, I think it's about equity. It's about justice and it's about liberation." – IBH; REM
6. "The practice needs to advocate outside in the community to make sure that these communities that are affected the most because of their racist policies have the support and they actually have things change." – PCP; REM

Note: We have included the role (PCP vs. IBH team member) and race/ethnicity (REM vs. White Non-Latinx) of the clinical stakeholder for each exemplar quote.

Abbreviations: EMR, electronic medical record; IBH, integrated behavioral health; NP, nurse practitioner; PCP, primary care physician; PTSD, posttraumatic stress disorder; REM, racially or ethnically minoritized.

3.5 | Recommendations

Respondents noted that PTSD treatment might need cultural adaption to respond to the sequelae of racism (e.g., adding psychoeducation on the psychological impacts of racism and attending to culture and race as important factors within therapeutic interactions). Respondents also advised that many of the cognitive behavioral skills in the intervention could be applied to help clients resist the harms of racism and discrimination (e.g., mindfulness and cognitive restructuring). IBH stakeholders mentioned that there might be a need to adapt aspects of the intervention, for example, eliminating language that may be experienced as pathologizing or adding relevant case examples and strategies that reflect the culture of the patient.³⁹ To address stigma and mistrust among patients, recommendations included increasing the diversity of providers to accommodate race-matching (when possible), encouraging assessment of patients' past experiences of racism within health care settings, and setting the expectation that providers understand and feel comfortable discussing both racial power dynamics in the clinical interaction and the impact of racism on health. Respondents emphasized the importance of training across all staff, extending to hospital police officers, and the need for applied clinical training in examining biases and integrating topics related to racism into clinical practice. At the provider-institution level, recommendations focused on increasing workforce diversity across the hierarchy, with an emphasis on re-examining the promotion process. Respondents called for an institutional commitment to antiracist health care that could provide *paid* support to REM providers leading these improvement efforts.

4 | DISCUSSION

The current study aimed to understand and begin to address the harms of racism on primary care patients, including considerations of the patient-provider encounter and of the treatment of traumatic stress. Clinical stakeholders described the challenges of addressing the deleterious effects of racism, stress, and trauma in brief clinical encounters. Racism was noted as a potential barrier to PTSD treatment engagement and addressing racism-related mistrust was central to

successful treatment implementation. Responses drew attention to the cumulative burden of racism on REM providers, who must provide care while simultaneously coping with their own exposures to the psychological destructiveness of racism. This may lead to higher burnout among REM providers, which is a key issue that may impact implementation success.

Respondents also described their understanding of how experiences of racism may contribute to clinical distress broader than PTSD and may also contribute to higher severity of PTSD. This is consistent with scientific findings that experiences of racism often serve as cumulative stressors, which contribute to disparities in PTSD prevalence and severity.⁴⁰ Like trauma, racism is often seen as difficult to discuss with patients, especially when providers lack training on how to effectively respond. This may lead some providers to deprioritize or avoid discussing racism and trauma. Providers reported feeling ill-equipped to discuss racism or confront racist attitudes expressed by patients and coworkers. They emphasized the importance of increasing diversity among the provider workforce, training providers to discuss experiences of racism with patients, setting the expectation that providers attend to their own biases related to clinical decision making, as well as the need for institutional commitment to antiracism.

To preserve confidentiality, we did not report findings by race or specialization. However, we observed broad thematic differences of note. PCP stakeholders described competing priorities during clinical visits that seemingly prohibited in-depth conversations regarding racism and racism-based trauma, while IBH stakeholders (likely due to their role within the clinic) described an ability to explore racism and racism-based trauma more deeply with patients. The IBH team utilizes a supervision model that directly invites conversations around identity, cultural formulation, and the impact of racism, which may have contributed to differences in comfort discussing racism across specialties. IBH stakeholder were also more racially diverse compared to PCP stakeholders (54% v. 38% identifying as REM).

Our findings support the recommendation that patients' past and current experiences of racism should be assessed and considered during the clinical interaction to reduce the chances of repeating these harms.¹⁷ The current study also highlights that patient-provider race-matching may be an important patient preference to consider when implementing antiracist approaches in care. Although research

TABLE 4 Summary of key findings

Level of interaction	Challenges/current problems	Stakeholder recommendations
Racism-based trauma and PTSD treatment considerations	<p>Risk of pathologizing adaptive responses to racism (e.g., vigilance)</p> <p>Some patients may not link stressors to racism and may internalize (e.g., labeling experiences as microaggressions and systemic racism)</p> <p>Current PTSD treatments may not sufficiently address the clinical presentation of racism-based trauma</p>	<p>Validate patient experiences of racism and discrimination as “trauma” and provide psychoeducation to patients around racial stress, trauma, and PTSD (overlap and distinctions)</p> <p>Provide psychoeducation on minority stress experiences (microaggressions, systemic exclusion/rejection) to help clients understand and externalize the problem</p> <p>Validate shared responses to discrimination and trauma events; Discuss the application of coping skills to experiences of racism</p> <p>Consider the potential need to adapt PTSD treatments to address unique features of racism-based trauma</p>
Patient experiences and responses related to discrimination in health care	<p>Presence of uniformed public safety and police officers at the hospital and in the care environment</p> <p>Perception of lower quality care due to race</p> <p>Medical mistrust (due to previous experiences of discrimination in health care) may impact engagement in care</p> <p>Demand from patients for race-matched providers</p>	<p>Ask patients about previous experiences in medical/mental health care to dismantle power dynamics</p> <p>Targeted training/s for <i>all</i> staff who interact in the care setting (including front desk staff, public safety, etc.)</p> <p>Setting standards for <i>all</i> providers regarding discussions of racism and health</p> <p>Diversity and inclusion efforts in hiring practices to ensure that the staff reflect the identities of the patient population being served</p>
Patient-provider interaction	<p>Providers making assumptions of racial identity (e.g., relying on the EMR), lack of consistency in how providers ask about race</p> <p>Lack of universal screening for some behavioral health conditions (PTSD) may lead to providers using their own biases in screening practices</p> <p>Discussions of racism may not be prioritized by providers (providers may wait for patients to initiate these conversations or avoid them due to personal discomfort in discussing racism with patients)</p> <p>“White Guilt”</p> <p>Providers may not perceive racism as relevant to clinical care</p> <p>How to confront racist attitudes expressed by patients</p>	<p>Directly ask patients how they self-identify</p> <p>Include patient identities in case conceptualization</p> <p>Integrate cultural considerations as requirements in clinical training (making these mandatory)</p> <p>Initiate conversations with patients about experiences with racism and responses to racialized events</p> <p>Cultivate an awareness of personal discomfort/biases and develop concrete strategies for acknowledging and moving past these in the practice</p> <p>Acknowledge systemic racism in medical care and practice selective self-disclosure to create safety in the clinical environment</p> <p>Acknowledge that racial consciousness may be new for White providers but has always been there for REM providers and patients (not “new”)</p> <p>Educate providers on racial stress and trauma and its connection to negative health outcomes in patients (“racism is relevant to health”)</p> <p>Need for hospital-wide policies on how to respond and confront racist attitudes expressed by patients</p>
Provider-institution interaction	<p>Cumulative burden on REM providers (coping with their own exposures to racism in the workplace and responses to racialized national events, facing newly imposed responsibility of educating their colleagues, stress of not being able to accommodate patient demands for race-matched therapists/not “doing enough” for the cause [guilt])</p> <p>Diversity of staff decreases as position of power within the department/hospital increases</p>	<p>Promote engagement (especially of White providers) in conversations of racism, antiracist clinical practice, and how to support REM providers</p> <p>Promote platforms for REM providers to openly share their needs and experiences (e.g., supervision, structured support from outside entities) in order to reduce burnout and secondary traumatic stress</p> <p>Diversity and inclusion efforts in hiring practices with a particular focus on retention, promotion, and diversity at the leadership level</p> <p>Institutional commitment/mission to support antiracist health care (including within patient care <i>and</i> the work environment)</p> <p>Utilize hospital-wide collaboration and community input to inform institutional policy changes/decisions</p>

Abbreviations: EMR, electronic medical record; PTSD, posttraumatic stress disorder; REM, racially or ethnically minoritized.

suggests limited evidence on the effectiveness of race-matching as a preventative health care measure,⁴⁰ there is evidence that it may be important in behavioral health settings.⁴¹ Results from the current study move beyond the patient-provider level, highlighting several

interpersonal, organizational, and policy level recommendations for an antiracist approach to integrated primary care. As noted by Hassen and colleagues,¹⁸ many antiracist approaches to health care utilize a multilevel approach. Our study extends this research forward by

providing suggestions for implementing a multilevel approach within integrated primary care. Additionally, our study explores the experience of REM providers, offering recommendations for the implementation of antiracist approaches that benefit not only REM patients but also the REM providers who care for them.

The importance of culturally responsive PTSD treatment highlighted in these interviews is similar to clinical approaches that have been studied in the literature. A systematic review of the effectiveness of interventions designed to improve therapeutic communications between REM patients and providers in behavioral health services identified commonly used strategies such as ethnic-matching, cultural adaptations of therapies, and interventions that included social community systems to help with communication and engagement.⁴² None of the reviewed studies focused on the direct assessment or communication of issues related to racism or PTSD; however, Williams et al.⁴³ published on the effectiveness of a culturally adapted, manualized prolonged exposure therapy for PTSD with African American patients that included initial therapy sessions designed to better establish rapport, asking directly about race-related themes during the assessment process, and confronting racism-related experiences in treatment when indicated. These adaptations echo many of the recommendations we found in our study.

4.1 | Application of findings

4.1.1 | Clinical practice applications

Our findings have important immediate practice implications. Antiracism workgroups have been formed across levels within the institution, including the antiracism workgroup in general internal medicine (GIM) primary care, which consists of hospital employees in the department. Our interview data were being collected concurrently with workgroup initiatives aimed at responding to experiences of racism in practice. Although our data did not directly inform initial practice responses, we have since relayed findings from our study to leaders of the antiracism workgroup and IBH leadership. Using Hassen and colleagues' levels of antiracist interventions,¹⁸ in Table 5, we highlight current and future goals and initiatives within primary care, IBH, and hospital-wide. Notably, our findings and recommendations align with new initiatives and have provided suggestions for future efforts that focus on system change.

4.1.2 | Research applications

The overarching goal of the parent study is the successful implementation of a brief trauma-focused therapy in the integrated primary care setting. As such, these data serve to better understand the potential of racism as an implementation barrier and as an area of therapeutic consideration. We have utilized key findings to take two approaches to address racism in the course of PTSD treatment implementation. First, we have adopted a group consultation model that

emphasizes the application of cultural formulation³⁷ and awareness of the provider's own positionality in PTSD case conceptualization, which encourages open discussion of the social context when teaching and applying various coping skills. For example, the therapy focuses on emotion regulation skills, and there may be a need to recognize that public expression of some emotions (such as anger) may result in backlash for Black patients. This consultation model aims to support the culturally responsive application of PTSD treatment. The clinical team working within the IBH practice had prioritized the need to support REM providers long before the present study and had already implemented a responsive supervision model where REM providers have a safe space to talk about their own experiences and responses to racism and to gain peer support. Cultural adaptations to the intervention will be made post-trial. We will use Dr. Anna Lau's model, which is based on evidence that an intervention needs to be tailored to a specific population and suggests that adaptations should be data-driven.²⁸ Our future evaluation will utilize feedback from both stakeholders and participants to inform augmentation in post-trial analyses. Ongoing engagement with our patient CAB will be essential in ensuring these adaptations are culturally responsive and appropriate.

4.2 | Limitations

The current study findings are not without limitations. As a formative evaluation for a clinical trial aimed to inform the development of a PTSD intervention, the current analysis focused heavily on individual-level racism; however, many respondents noted the impact of systemic racism as a multilevel concern, which required system-level changes. Additionally, the race of the coding team (three of whom identified as White, one identified as multiracial) should be considered when taking into account the interpretation of the findings. We took several steps to address biases and should note that the mentorship team for the NIMH-funded parent trial and manuscript co-authors are racially and ethnically diverse. The PI also applies participatory methods (clinical and patient stakeholders) in the parent study to ensure that the aims, procedures, and other research processes are relevant to the community. Finally, the current study took place at a time in United States history when the nation was ignited regarding issues of race and in the midst of a pandemic. Although these issues have been longstanding and persistent for centuries within U.S. society, social attention was heightened at the time of data collection. The temporal proximity to these events may have influenced the discourse and the degree of reflection on racism within health care institutions. Given the cross-sectional nature of this study and the importance of the historical moment in which these findings are anchored, we are unable to know what will be the long-term outcomes and sustainability of the implemented efforts described.

Participants in the study represent several different types of stakeholders. However, one of the most important voices, the voice of the patients themselves, is not included in this analysis. Moreover,

TABLE 5 Summary of current and future practice initiatives organized by Hassen's levels of antiracist interventions¹⁸

Level of antiracist intervention	Goal/focus	Current or future initiatives
Individual	Address implicit biases of providers and incorrect assumptions of racial identities	Hospital-wide effort to improve collection of self-reported racial identity in the EMR Emphasis within IBH on utilizing the medical record to advocate for patients and to contextualize their clinical presentation as relevant to their identity and background Equip residents and medical students at the affiliated medical school with tools to address racism in future practice
Interpersonal	Promote engagement of all staff in conversations around racism Develop policies and guidelines to respond to staff experiences of racism	Protected time in primary care and IBH for conversations around racism and space for REM providers to share their experiences and needs Optional book clubs in primary care on antiracist topics to facilitate conversations Weekly team case review in IBH to explore the impact of racism and incorporate it into case conceptualization Hospital-wide procedures have been developed for reporting racism as an issue of professionalism
Community	Strengthen community relationships and address mistrust among the patient population Invest in education and policies that respond to patient experiences and prevent future experiences of racism from occurring	Consider the impact of the presence of police/public safety in the health care setting on patients' experiences Directly engage patients and the community in institutional policy changes/decisions Research initiatives are underway in primary care and hospital-wide to examine patient experiences of racism and health outcomes
Organizational	Support the discussion of race and racism within the clinical interaction Utilize data reporting to identify racial disparities and better understand patient experiences of racism	Provide educational opportunities for staff around culturally competent care and racism within the clinical interaction (e.g., primary care has a secured commitment for quarterly Grand Rounds sessions that are dedicated to racism, racial stress, and trauma) The primary care workgroup has obtained hospital approval to use data gathering tools on patients' experiences with an explicit focus on racism Clinical outcomes by race/ethnicity have been pulled for individual providers in primary care; the need for additional guidance in utilizing this information
Policy	Promote staff diversity to reflect the patient population and meet the demand for race-matched providers (rather than placing an additional burden on REM providers) Investigate and provide transparent information on racial disparities in leadership positions Ensure that hiring practices and new hires reflect the hospital's commitment to antiracist care	Hospital-wide ongoing review of hiring practices to evaluate gaps in hiring and retention rates Commitment within primary care to collect self-reported demographic characteristics of faculty members and provide easily accessible and trackable data on disparities in hiring and retention rates, leadership positions, and pay During the hiring process for section chief in primary care, all interviews included standardized questions on racism, antiracist work, and the ability to support antiracist efforts

Abbreviations: EMR, electronic medical record; IBH, integrated behavioral health; REM, racially or ethnically minoritized.

the predominately (62%) White sample of clinical stakeholders likely have different perspectives about the experiences of racism and discrimination facing their REM patients than the patients themselves. Although the racial identities of our sample do not proportionally reflect the patient population, REM providers are more likely to practice in safety net settings, and our sample is more diverse than in typical primary care settings (i.e., 38% vs. 27% REM).⁴⁴ Patient interviews were beyond the scope of the present evaluation; however, the hospital has made a commitment to racial health justice and has utilized patient interviews to better understand the complexity of systemic racism in the setting.⁴⁵ Consistent with our provider perceptions, patients within these interviews reported experiences of

discrimination through protocols that are not inclusive of cultures, unconscious biases within health care that may impact their treatment, lack of diversity among their care team, and general mistrust of the medical system. Further data collection to better understand the patients' perspectives is an important direction for future research.

5 | CONCLUSION

Although thoughts and opinions may change over time, the impact of systematic racism within the health care system is longstanding. The adoption of antiracist health care practices and the consideration of

racism within clinical treatment are two ways to begin eradicating this issue. Findings from the current study suggest a multicomponent approach to antiracist health care is needed, and efforts by an antiracist work group at a large safety net hospital provide tangible examples of how to address this need. The current paper also highlights the need for the consideration of racism as a potential PTSD treatment barrier.

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CONFLICT OF INTEREST

The authors declare no conflicts of interest.

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