Today’s Webinar Moderator

Ernest J. Grant PhD, RN, FAAN
President, American Nurses Association

Dr. Grant has more than 30 years of nursing experience and is an internationally recognized burn-care and fire-safety expert. Grant serves as adjunct faculty for the UNC-Chapel Hill School of Nursing.

In 2002, President George W. Bush presented Grant with a Nurse of the Year Award for his work treating burn victims from the World Trade Center site. He holds membership in Sigma Theta Tau and Chi Eta Phi.

Grant holds a BSN degree from North Carolina Central University and MSN and PhD degrees from the University of North Carolina at Greensboro. He was inducted as a fellow into the American Academy of Nursing in 2014. He is the first man to be elected to the office of president of the American Nurses Association.
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Impact of Race on COVID-19 Mortality

Mortality Rates per 1,000 Population

- Black Americans: 50
- Asian Americans: 23
- Latino Americans: 23
- White Americans: 21

Mortality Rates per 1,000 Population
Impact of Race on COVID-19 Mortality

• Black Americans represent 13% of the population in all areas in the U.S. releasing COVID mortality data, but they have suffered 25% of deaths.

<table>
<thead>
<tr>
<th>Location</th>
<th>Blacks as % COVID-19 Deaths</th>
<th>Blacks as Percent of Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chicago</td>
<td>70%</td>
<td>30%</td>
</tr>
<tr>
<td>Louisiana</td>
<td>71%</td>
<td>31%</td>
</tr>
<tr>
<td>Michigan</td>
<td>40%</td>
<td>14%</td>
</tr>
</tbody>
</table>

• Whites represent 62% of the population, but have experienced 49% of deaths in America where race and ethnicity is known.

• COVID-19 mortality rates could not be calculated Nationally for Indigenous Americans due to limited and uneven data.
  • In Arizona, the Indigenous mortality rate is 5 times the rate for other groups.
  • In New Mexico, the rate is 7 times all other groups.
Today’s Topics

• tbd
Today’s Webinar Speakers

Tanya R. Sorrell PhD, PMHNP-BC

Associate Professor of Psychiatric Nursing at the University of Colorado, Anschutz Medical Campus. Program Director of a $5 million state-wide Colorado Legislative funded Medication Assisted Treatment (MAT) Services Program.

Served on national SAMHSA committees for Cultural Competence in Nursing Care and increasing Minority representation in graduate nursing programs. Her doctoral training is in rural and urban underserved Mental Health and Substance use services research.

Bridgette M. Brawner, PhD, MDiv, APRN

Associate Professor of Nursing and Senior Fellow in the Center for Public Health Initiatives at the University of Pennsylvania. Chair of the National Advisory Committee for the Minority Fellowship Program at the American Nurses Association/ Substance Abuse and Mental Health Services Administration.

Dr. Brawner is passionate about eliminating health disparities and works toward health equity promotion in disenfranchised communities.
Presenter: Tanya R. Sorrell, PhD, PMHNP-BC
COVID-19 Overview

- Severe Acute Respiratory Syndrome- Coronavirus-2
- SARS-CoV-2 is a new virus.
- The first cases were identified in people with pneumonia in Wuhan, China, in late December 2019, hence COVID-19.
- It probably started in animals (pangolin) then spread between people.
- As this virus is new, we are learning more all the time, and what we know now may change.
US COVID Cases with Racial Densities

**Confirmed COVID-19 Cases in the U.S.**

Number of confirmed COVID-19 cases, by U.S. state*

- 0-4,999
- 5,000-9,999
- 10,000-49,999
- 50,000+

* as of May 25, 2020, 2:30 AM EDT
Sources: Johns Hopkins University, CDC

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COVID-19 Effects on African Americans

<table>
<thead>
<tr>
<th>Location</th>
<th>% of Population</th>
<th>% of Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Washington, DC</td>
<td>45%</td>
<td>75%</td>
</tr>
<tr>
<td>New York</td>
<td>9%</td>
<td>19%</td>
</tr>
<tr>
<td>Louisiana</td>
<td>33%</td>
<td>65%</td>
</tr>
<tr>
<td>Michigan</td>
<td>14%</td>
<td>46%</td>
</tr>
<tr>
<td>Missouri</td>
<td>12%</td>
<td>44%</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>7%</td>
<td>39%</td>
</tr>
<tr>
<td>South Carolina</td>
<td>27%</td>
<td>55%</td>
</tr>
</tbody>
</table>

SOURCE: AP News
COVID Fatalities v. Percentage of Population

[Charts showing fatalities in the Black and Latinx communities due to COVID-19, with data collected from state websites as of April 13, 2020.]
Comorbidities and COVID-19 Rates/Deaths

Underlying conditions among adults hospitalized with COVID-19

Leading comorbidities among COVID-19 deaths in New York

Source: MMWR. 2020 Apr 8:69(early release):1-7

Note: Data reported on a daily basis by hospitals, nursing homes, and other health care facilities.
Source: New York State Department of Health

As of midnight on April 6, 86.2% of the state’s 5,489 COVID-19 deaths involved at least one comorbidity.
## COVID Recovery: Minority Job Loss and PPP Funding

### Share of Adults Ages 18 to 64 Whose Families Lost Jobs, Work Hours, or Work-Related Income during the Pandemic, by Race and Ethnicity, March and April 2020

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>PPP funded</th>
<th>Percent Accepted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>42%</td>
<td>0%</td>
</tr>
<tr>
<td>Latino</td>
<td>38%</td>
<td>0%</td>
</tr>
<tr>
<td>White</td>
<td>41%</td>
<td>20%</td>
</tr>
<tr>
<td>Other</td>
<td>57%***</td>
<td>40%</td>
</tr>
</tbody>
</table>

### Notes:
- "Other" includes non-Hispanic adults who are not Black or white or who are more than one race.
- 
- "Estimate differs significantly from reference group (*) at the 0.10/0.05/0.01 level, using two-tailed tests.

### Source:
The Health Reform Monitoring Survey for the first quarter of 2020. The survey was conducted between March 25 and April 10, and 74.5 percent of respondents completed the survey by March 31.
Native Americans and COVID: Navajo Nation

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White, non-Hispanic</td>
<td>49%</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>14%</td>
</tr>
<tr>
<td>Native American</td>
<td>20%</td>
</tr>
<tr>
<td>Black, non-Hispanic</td>
<td>3%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>1%</td>
</tr>
<tr>
<td>Other, non-Hispanic</td>
<td>1%</td>
</tr>
<tr>
<td>Unknown</td>
<td>12%</td>
</tr>
</tbody>
</table>

**New Data Sheds Light on Distribution of New Mexico COVID-19 Cases**

- **Statewide age breakdown**
  - 0-9: 3.06%
  - 10-19: 4.83%
  - 20-29: 13.03%
  - 30-39: 16.51%
  - 40-49: 16.51%
  - 50-59: 15.39%
  - 60-69: 15.99%
  - 70-79: 8.10%
  - 80-89: 4.01%
  - 90+: 1.76%

- **Positive COVID-19 cases in NM by race/ethnicity**
  - Native American: 30.68%
  - Asian: 1.70%
  - Black: 3.10%
  - Hispanic: 25.76%
  - White: 23.47%
  - Unknown: 8.27%

- **Positive cases by gender**
  - Female: 51.82%
  - Male: 48.18%

*Source: NM Department of Health*
The likely COVID-19 patient characteristics

- African-American
- Male
- 40-64 years old
- Urban-suburban
- Middle income worker
- 1 or more chronic illnesses
- Average health risk factors
COVID Morbidity-Mortality Factors and Race/Ethnicity
COVID-19 Factors Affecting Minority Risk: An Ecological Approach
COVID-19: Individual-Level Factors

• Genetic Factors do not appear to be an indicator
  • African nations have fewer cases/deaths than US
  • Rates of Children’s COVID cases are similar

• Health Behavior Choices- Rates of smoking, substance use are equivalent to whites
COVID-19 Data Across the World

• UK—Office of National Statistics
  • Blacks 4.1 times more likely to die of COVID than whites
  • Bangladeshi/Pakistani/Indian 1.8 times more likely to die than whites
  • 90% of NHS worker deaths to COVID-19 were among these groups—SES controlled

• France sees similar disparities in Saint Denis and areas surrounding Paris

• Only country in Africa with similar disparity rates is South Africa

US Blacks 6x more likely to die of COVID than whites
COVID-19: Social Factors Affecting Comorbidities

- Food Deserts/Cost of Healthy Foods → Obesity
- Lack of Safe Exercise Opportunities
- Discrimination/Resultant Cortisol/HPA → HTN
- Environmental/Air Quality
- Unsafe/High-Density Living → Respiratory Dx
- Lack of Safe Exercise Opportunities
- Food Deserts/Cost of Healthy Foods → DMII
- Access to Preventive Health Services
- Environmental/Air-Water Quality
- Unsafe/High-Density Living → Cancer
- Access to Preventive Health Services
## COVID-19: Social Factors Affecting Comorbidities

### Black and Latino Workers Overrepresented in Most Essential Industries

<table>
<thead>
<tr>
<th>Industry</th>
<th>Share of industry workers who identify as Black</th>
<th>Share of industry workers who identify as Latino</th>
</tr>
</thead>
<tbody>
<tr>
<td>Share across all industries</td>
<td>12.3</td>
<td>17.6</td>
</tr>
<tr>
<td>Grocery stores</td>
<td>12.6</td>
<td>20.5</td>
</tr>
<tr>
<td>Hospitals</td>
<td>16.0</td>
<td>10.8</td>
</tr>
<tr>
<td>Nursing care facilities</td>
<td>27.6</td>
<td>12.6</td>
</tr>
<tr>
<td>Residential care facilities</td>
<td>23.9</td>
<td>12.6</td>
</tr>
<tr>
<td>Bus service and urban transit</td>
<td>31.4</td>
<td>18.7</td>
</tr>
<tr>
<td>Postal Service</td>
<td>27.2</td>
<td>11.3</td>
</tr>
<tr>
<td>Couriers and messengers</td>
<td>25.1</td>
<td>19.5</td>
</tr>
<tr>
<td>Warehousing and storage</td>
<td>23.8</td>
<td>32.2</td>
</tr>
<tr>
<td>Waste management and remediation</td>
<td>14.6</td>
<td>21.9</td>
</tr>
<tr>
<td>Construction</td>
<td>6.4</td>
<td>30.4</td>
</tr>
</tbody>
</table>


**Notes:** Bolded percentages represent industries where workers are overrepresented. This is not an exhaustive list of industries, but it represents some of the most high-contact and therefore high-risk industries being affected by the pandemic.
COVID-19: Social Factors Affecting Comorbidities

Rates of physical proximity, disease exposure, and face-to-face interactions, 15 representative occupations, 2018

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Employment</th>
<th>Median hourly wage</th>
<th>Share frequently in close proximity to others</th>
<th>Share frequently exposed to disease</th>
<th>Share with frequent face-to-face interactions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Nurses</td>
<td>2,951,960</td>
<td>$34.49</td>
<td>89.1%</td>
<td>93.1%</td>
<td>96.4%</td>
</tr>
<tr>
<td>Cashiers (grocery stores only)</td>
<td>910,400</td>
<td>$10.93</td>
<td>86.3%</td>
<td>27.6%</td>
<td>79.1%</td>
</tr>
<tr>
<td>Home Health Aides</td>
<td>797,670</td>
<td>$11.63</td>
<td>85.2%</td>
<td>64.3%</td>
<td>73.6%</td>
</tr>
<tr>
<td>Packagers, Hand</td>
<td>663,970</td>
<td>$11.62</td>
<td>72.0%</td>
<td>4.5%</td>
<td>84.6%</td>
</tr>
<tr>
<td>Police and Sheriffs</td>
<td>661,330</td>
<td>$29.51</td>
<td>77.5%</td>
<td>58.8%</td>
<td>93.3%</td>
</tr>
<tr>
<td>Plumbers, Pipefitters, and Steamfitters</td>
<td>438,070</td>
<td>$25.92</td>
<td>74.3%</td>
<td>27.4%</td>
<td>86.2%</td>
</tr>
<tr>
<td>Postal Service Mail Carriers</td>
<td>342,410</td>
<td>$26.54</td>
<td>34.9%</td>
<td>5.3%</td>
<td>86.3%</td>
</tr>
<tr>
<td>Firefighters</td>
<td>321,570</td>
<td>$23.66</td>
<td>85.2%</td>
<td>57.4%</td>
<td>95.6%</td>
</tr>
<tr>
<td>Bus Drivers, Transit and Intercity Refuse and Recycling Material Collectors</td>
<td>174,110</td>
<td>$20.23</td>
<td>86.5%</td>
<td>41.2%</td>
<td>65.3%</td>
</tr>
<tr>
<td>Telecommunications Equipment Installers and Repairers</td>
<td>118,520</td>
<td>$17.91</td>
<td>25.7%</td>
<td>62.7%</td>
<td>67.6%</td>
</tr>
<tr>
<td>Physician Assistants</td>
<td>114,710</td>
<td>$32.22</td>
<td>88.8%</td>
<td>97.5%</td>
<td>98.6%</td>
</tr>
<tr>
<td>Transportation Security Screeners</td>
<td>45,250</td>
<td>$19.95</td>
<td>85.2%</td>
<td>55.6%</td>
<td>85.2%</td>
</tr>
<tr>
<td>Pharmacy Aides</td>
<td>36,970</td>
<td>$12.72</td>
<td>99.6%</td>
<td>81.3%</td>
<td>83.3%</td>
</tr>
<tr>
<td>Power Plant Operators</td>
<td>33,020</td>
<td>$38.27</td>
<td>44.1%</td>
<td>3.9%</td>
<td>93.1%</td>
</tr>
<tr>
<td>All Occupations</td>
<td>144,733,270</td>
<td>$18.58</td>
<td>55.3%</td>
<td>19.9%</td>
<td>85.3%</td>
</tr>
</tbody>
</table>

NOTE: Shares of workers with “frequent” physical proximity, disease exposure, and face-to-face interactions are based on underlying worker survey data. Workers rate whether they experienced these relevant work contexts all the time or most of the time.

*NOTE: Since cashiers are employed in many different industries, we have focused on those in grocery stores and related establishments only.


Economic Policy Institute


White  37.0%  Asian  19.7%  Hispanic or Latino  16.2%  Non-Hispanic or Latino  30.4%

Less than one in five black workers and roughly one in six Hispanic workers are able to work from home.

Share of workers who can telework, by race and ethnicity, 2017–2018

Source: American Nurses Association

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COVID-19: Social Factors Affecting Comorbidities

- Social Determinants
- Risk Factors for Chronic Dx
- Essential Worker Exposure
- Interface with Health Services
- ↑ risk for COVID Contraction
- ↑ risk for COVID Mortality
# COVID-19: Societal-Level Factors

## Exposure to Racial Discrimination

**Exposure at the microsystem (individual) level:**
- Childhood experiences of racial discrimination (e.g., teasing, bullying, isolation)
- Observation of parent, family member, and peer experiences of racial discrimination
- Quality of parenting and racial socialization

**Exposure at the macrosystem (structural) level:**
- Media
- Schools (e.g., teachers)
- Social, political, and economic policies
- Police and other adults

## Psychological and Biological Responses

**Psychological distress:**
- Decreased self-efficacy
- Depression
- Hopelessness
- Anxiety
- Anger/aggression
- Perceptions of injustice/lower levels of empathy

**Changes in allostatic load:**
- Decreased immune function
- Increased cortisol levels
- Increased blood pressure
- Increased heart rate

## Child Health Outcomes and Disparities

**Health outcomes and disparities related to:**
- Increased likelihood of low birth weight or premature birth
- Increased risk behaviors such as drug use and/or sexual risk-taking
- Increased aggression/violent behaviors
- Increased risk of chronic illness such as cardiovascular disease
- Increased susceptibility to infectious diseases such as HIV/AIDS

## Health Care Interactions

- Access Coverage
- Implicit Bias

## Poor Health Outcomes
COVID-19: Societal-Level Factors

• Developed distrust in medical system
  • Past minority health care issues and ongoing negative health care encounters
  • Objective data from hospital outcomes/interaction studies
    • A-A women 3x more likely to have higher maternal/fetal mortality controlling for income

• Health care disparities in access to primary and acute care

• Discrimination on entering the health care encounter
  • Primary Care/Triage/Access in entry to care
  • Hospital Care

• Implicit Bias
Implicit Bias

- Attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. Form from ages 2-5.
- Thinking influences clinical decision making in the health encounter based on patient’s group
- Systemic power and comparative privilege drives narratives in seeing patients as separate than group characteristics, affecting attitudes
Implicit Bias

**IS**
- Pervasive
- Predictive of behavior in the real world
- Distinct from conscious stereotyping or prejudice
- Expressed indirectly
- Related but distinct from each other (some reinforce each other)
- Malleable – can be unlearned
- Hard to teach
- Something we need to understand, acknowledge, and work to overcome

**IS NOT**
- Always negative
- Activated voluntarily or intentionally
- Accessible through introspection
- Always consistent or aligned with our declared beliefs
- Always consistent with our own ingroups
- Mutually exclusive
- Something we should feel guilty about
How Does Implicit Bias Operate in Health Care?

Clinician
Prior Experiences and Implicit Bias

Attitudes and Behaviors Brought into the Clinical Encounter

Differential Treatment and Adherence

Differential Outcomes

Patient
Prior Experiences and Implicit Bias

Implicit Bias Affects Health Care Outcomes

- Fewer prescriptions for pain medication
- 3x rate of maternal/fetal loss
- Fewer bypass surgeries
- Less likely to receive kidney dialysis or transplants
- More likely to undergo lower limb amputations for diabetes
- Already identified in COVID-19 treatment of blacks

Number and percentage of quality measures for which members of selected groups experienced better, same, or worse quality of care compared with reference group (White) in 2014-2015


http://www.ahrq.gov/research/findings/nhqrdr/nhqdr16/quality.html

- AI/AN = American Indian/Alaska Native
- NHOPI = Native Hawaiians and Other Pacific Islanders
COVID-19 Conspiracy Theories and Minorities

Social—Distrust in government, Historical and current distrust of health care interactions

Community—Reliance on community-disseminated knowledge, Social media tailored to minorities, Disinformation campaigns on social media

Individual—Attitudes/Beliefs
5G, “Plandemic”, HR6666

Conspiracy Theories

↑ Distrust, Delayed treatment, ↓ outcomes
The “Don’ts”

• Do not focus on “cultural competence”

• It is impossible to become “competent” in someone else’s culture

• The things we learn about culture cannot be blanketly applied across populations

Instead: Treat each person as an individual; find out from them what is important (e.g., spiritual beliefs, healthcare practices, perceptions of healthcare and providers)
The “Don’ts”

• Do not assume that the statistics reflect “poor” individual behavior and choices

  • Yes, some people are engaging in behaviors that increase their risk (i.e., not social distancing)

  • However, some of it is not by choice and/or driven by broader social and structural issues (e.g., living situation, work as an essential employee, care for loved ones)

Instead: Gain a better understanding of why people are doing what they are doing, to help mitigate their risk
The “Don’ts”

• Do not make assumptions about someone’s health, health behaviors or merit to be healthy/live based on their race or other attributes

• Every Black person does not have high blood pressure, every Black person with high blood pressure does not eat salty or fried foods, etc.

• Even if you have seen something 1,000 times, leave room for number 1,001 to be different

Instead: Engage each person with dignity and respect; ask relevant questions and be attentive to their responses
Acknowledge and Address the Roots of the Problem

• Implicit Bias
  • Unconscious (unlike explicit bias), but still affects our understanding, actions and decisions
  • Activated without awareness or intentional control
  • **Can** be changed through unlearning and debiasing of perceptions

• Racism
  • A system of oppression based on race; race itself, is a social construct devised to give and withhold power
  • Can operate through individual words and actions, as well as larger systems/structures (including the healthcare system)
  • Personal bigotry imposed onto others who are believed to be inferior

• Discrimination
  • Unjust or prejudiced treatment of people
  • Can relate to race, age, gender, disability, etc.
How does this translate into patient encounters? And when/how can nurses intervene?
Life-Threatening Effects of Implicit Bias: Case Study of Jonathan, a 45 Year Old African American Man
When/How Nurses Intervene: Point #1

• We should never assume someone’s health, dietary or other practices based on their race or any other factors

• We can ask relevant questions, instead of defaulting to harmful racial or other heuristics, to avoid such microaggressions and dehumanization

Note: This encounter, in addition to countless others before it, shaped Jonathan’s disposition toward the healthcare system and contribute to his delays in seeking care. This gives insight to help us be more gracious and understanding when people with experiences similar to Jonathan present for care with symptoms that are dire/more complex.
The Urgent Care Visit

• Through the night his fever fluctuated (100°-103° F)
• His wife convinced him to go to the urgent care center when his cough worsened and he had trouble breathing
• Upon arrival he noticed that the staff was overwhelmed by the volume of cases
• Jonathan requested to be tested for COVID-19 but was told that he did not meet the criteria and “wouldn’t be at risk anyway”
• He was diagnosed with bronchitis, given prescriptions for albuterol and azithromycin, and sent home
When/How Nurses Intervene: Point #2

• We should never assume that someone is or is not at risk for health issues based on their race or our other preconceived notions about them; we must challenge colleagues who do this as well

• We do not want to let what we think is going on with a patient cloud our judgment from doing/advocating for a complete and thorough workup

  • Frustrated because he wasn’t being listened to (similar to his prior healthcare encounter), Jonathan did not fully disclose his potential exposure
  • He hadn’t traveled, but his in-laws returned from Venice, Italy two weeks prior to his symptoms developing; they had slight colds but nothing as severe as what Jonathan was experiencing

Note: He is not a healthcare professional. Jonathan assumed the provider knew best, so he started the bronchitis treatment. We are a trusted profession and the public looks to us to steer them in the right direction for their health; not for our biases to determine the course of action.
The Emergency Room
When/How Nurses Intervene: Point #3

• Both Jonathan and his wife’s concerns were ignored/dismissed after multiple points of contact with the healthcare system

• There are countless cases across health conditions where patients’ symptoms are ignored and/or minimized, and they don’t receive adequate diagnostic testing, treatment, etc. in time (e.g., inequitable maternal mortality)

• Nurses can (and should) be the advocates to make sure that our patient’s concerns are heard and taken seriously—whether we are in contact with them by phone, in person or other means
• Jonathan was admitted to the ICU and subsequently tested positive for COVID-19

• Over the course of a few days one of his nurses noticed that treatments weren’t being made available to Jonathan that other patients were receiving

• The nurse challenged the care team to consider all treatment options and provided comprehensive education for Jonathan’s wife to make an informed decision

• He was started on plasma therapy, his vent settings were weaned, and he was eventually extubated and switched to proning with high-flow nasal cannulas
When/How Nurses Intervene: Point #4

• The ICU nurse made it a point to stay up-to-date on everchanging guidelines for treatment and ask questions (this is especially important when you notice patterns in patients who are/are not receiving certain treatments)

• Take time to educate patients and their families, acknowledging potential fears or concerns they may have about different treatments and therapies (remember, medical mistrust)

• Advocate for patients when you see that clinical decisions aren’t rooted in evidence—implicit or explicit bias, racism and/or discrimination could be driving factors, which leads to poor health outcomes
Life or (Dignified) Death?
How does this apply to you?
Clinical Practice
- Ensure that all patients are treated equitably
- Provide comprehensive patient education

Research
- Ask research questions that don’t perpetuate disparities
- Analyze data to examine between and within group differences, factoring in social determinants of health

Education
- Acknowledge healthcare system mistrust in patient education
- Prepare future nurses to do the internal and external work of addressing racial disparities

Policy
- Create programs to address implicit bias, racism and discrimination in the nursing workforce
- Implement structural interventions to address social determinants of health
Remember Your “Why?”
COVID and Minority Disparity Resources

Project Implicit- learn your implicit biases
- [https://implicit.harvard.edu/implicit/takeatest.html](https://implicit.harvard.edu/implicit/takeatest.html)

Understand medical biases affect on outcomes
- [https://www.youtube.com/watch?v=tiiUlsq7qIo](https://www.youtube.com/watch?v=tiiUlsq7qIo)

Learn more to decrease Implicit biases affects on outcomes
- [https://www.tolerance.org/professional-development](https://www.tolerance.org/professional-development)
- [http://www.culturecareconnection.org/communication/implicit-bias.html](http://www.culturecareconnection.org/communication/implicit-bias.html)
ANA COVID-19 Resource Center

- Clinical Information Nurses Need to Know on COVID-19
- FAQ Document Answering over 40 COVID-19 Questions
- Legislative updates: 350,000 Letters to Congress Demanding PPE
- ANA Foundation: Coronavirus Response Fund for Nurses
- COVID-19 Workplace Survey Results from 32,000 nurses

www.nursingworld.org/coronovirus
ANA COVID-19 Webinar Series

Over 130,000 nurses registered for the ANA COVID-19 Webinar Series with more than 110,000 combined viewings!

- “Be Confident Protecting Yourself and Providing the Best Care to Your Patients during this COVID-19 Pandemic”
  - Recorded March 27, 2020

- “Ventilator Management: Essential Skills for Non-ICU Nurses”
  - Recorded April 8th, 2020

- “How to Respond to Ethical Challenges and Moral Distress during the COVID-19 Pandemic”
  - Recorded April 10th, 2020

- “How to Survive the Pandemic with An Unbroken Spirit -- Actions to Take Right Now to Stay Strong and Focused”
  - Recorded May 14th, 2020

- **Webinars Coming Soon:** The COVID-19 Disease Progression Explained; “COVID-19 Care on the Urgent/Primary Care Frontlines”; and “The Path to Recovery”
Thank You for Attending!

To help ANA continue to aggressively advocate for protections of nurses, monitor guidelines and advisories as they are released and educate and inform all nurses please consider joining ANA!

Go to www.joinANA.org