




Institutional procedural discrimination, institutional racism, and other institutional discrimination: A nursing research example

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Funding information

John and Marguerite Walker Corbally Professorship in Public Service at the University of Washington, and private donations from the authors; Public Health - Seattle King County, Grant/Award Number: Best Start for Kids

Abstract

Institutional discrimination matters. The purpose of this longitudinal community-based participatory research study was to examine institutional procedural discrimination, institutional racism, and other institutional discrimination, and their relationships with participants' health during a maternal and child health program in a municipal initiative. Twenty participants from nine multilingual, multicultural community-based organizations were included. Overall reported incidences of institutional procedural discrimination decreased from April 2019 (18.6%) to November 2019 (11.8%) although changes were not statistically significant and participants reporting incidences remained high ($n = 15$ in April and $n = 14$ in November). Participants reported experiencing significantly less "[when] different cultural ways of doing things were shared, the project did not support my way" from April 2019 (23.5%, $n = 4$) to November 2019 (0%, $n = 0$), Wilcoxon signed-rank test $Z = -2.00$, $p < 0.05$. Some participants reported experiencing institutional racism (29.4%, $n = 5$) and other institutional discrimination (5.9%, $n = 1$). Participants experiencing institutional racism, compared to those who did not, reported a higher impact of the Initiative's program on their quality of life ($t = 3.62$, $p < 0.01$). Participatory survey designs enable nurse researchers to identify hidden pathways of institutional procedural discrimination, describe the impacts experienced, and examine types of institutional discrimination in health systems.

KEYWORDS

community-based organizations, community-based participatory research, institutional discrimination, institutional procedural discrimination, institutional racism, mixed method, multicultural health, public health initiatives

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1 | INTRODUCTION

There is an urgent need for nursing to advance the study of discrimination and health to remedy systematic health inequalities (Krieger, 2012, 2020). Despite a growing interest in studying institutional discrimination and health by nurse researchers (Iheduru-Anderson et al., 2021), most inquiry focuses on interpersonal discrimination, or unequal treatment behaviors (Thurman et al., 2019). Institutional discrimination can appear so normalized that it is almost invisible although the effects are not. Such discrimination occurs in various forms such as institutional procedural discrimination or institutional racism. Studies are needed to explore institutional discrimination as a determinant of population health with an emphasis on the procedures, policies, and rules that create unequal systems and outcomes (Williams et al., 2019). Although efforts have been made to study and quantify institutional racism and its associations with physical and mental health outcomes (Groos et al., 2018), more nursing research is warranted. The need is to understand the various types of institutional discrimination from the point of views of those experiencing such discrimination.

This article focuses on an aspect of a larger longitudinal community-based participatory research (CBPR) study. This study examines institutional procedural discrimination, institutional racism, and other institutional discrimination, and their relationships with participants' health during a maternal and child health program in a municipal initiative (hereafter called the "Initiative"). The aims are to (1) describe 7-month changes in experiences of institutional procedural discrimination; (2) compare the health of participants between participants who experienced those types of institutional discrimination and those participants who did not; and (3) describe institutional racism and other institutional discrimination as reported by multicultural and multilingual participants in the Initiative.

To our knowledge, this is one of the first empirical studies in nursing that examines institutional procedural discrimination, institutional racism, and other institutional discrimination simultaneously. In the text below we briefly review the literature on institutional discrimination with definitions. We provide a background to the study in the context of the CBPR inquiry and summarize the results. We discuss these results and their implications for innovating nursing research.

1.1 | Literature review

The research team searched the Cumulative Index of Nursing and Allied Health Literature (CINAHL) database to obtain current article abstracts published in academic journals between January 2017 and June 2021. English language abstracts were retrieved if the following search terms were in both the title and article abstract: structural racism ($n = 58$), institutional racism ($n = 11$), institutional discrimination ($n = 5$), structural discrimination ($n = 3$), or institutional procedural discrimination ($n = 0$). Of the abstracts found, specific articles focusing on nursing and defining or measuring the aforementioned terms were retrieved.

Most article abstracts were reviews, opinions, calls to action, commentaries, or conceptual articles. No articles were found with the search term of institutional procedural discrimination. Nurses from various specialties offered insights on structural racism. These specialties included public health (de Valpine & Lewis, 2021; Waite & Nardi, 2019), perinatal and neonatal (Scott et al., 2019), geriatric (Medina-Walpole, 2021), and academic nursing (Murray & Loyd, 2020; Nardi et al., 2020). Addressing bias in institutions was highlighted as an area of importance, especially institutional racism (Agyepong, 2021; Santos Ferreira et al., 2020; Thurman et al., 2019).

Few researchers completed data-based research. As an example of such, Randolph et al. (2020) described historical distrust of health services as a finding. Bower et al. (2020) identified perceptions of systems that perpetuated biased maternal health services, such as retail, justice, and school systems. More studies are needed that explore the actual health impacts of types of institutionalized discrimination, such as institutional procedural discrimination, institutional racism, and other institutional discrimination.

Two nurse-led research teams conducted systematic literature reviews. Thurman et al. (2019) found that researchers mostly focused on interpersonal experiences of discrimination and racism. They noted a lack of consistency in defining institutional racism. Nardi et al. (2020) also observed this and applied an ecological model of overlapping systems and suggested that institutional racism operates through organized "practices and policies" (p. 697).

After finding no article abstracts about institutional procedural discrimination in CINAHL, additional searches were conducted using social work, public health, and law databases. In the field of law, institutional procedural discrimination is based on procedural justice theory (Tyler, 1988), that suggests "that one's satisfaction with legal or clinical interactions is primarily influenced by the quality of the procedural experience rather than the outcome of the interaction" (Kopelovich et al., 2013, p. 114). Institutional procedural discrimination operates in organizational policies and practices, such as in the ways decisions are made. Institutional procedural discrimination focuses on institutional agreements concerning the types of decisions, timing of discussions, conditions, and deadlines to privilege one group over another in the process. The institutional procedural experience is shaped by the visible and invisible norms, rules, customs, and power relations embedded in how organizational policies are decided and administered. Institutional procedures can result in selecting, crediting, and awarding the time orientation, language, thinking processes, and value systems of the group in power in making these decisions (Kopelovich et al., 2013 & Tyler, 1988).

Institutional conditions create and sustain the policies and practices that constitute institutional racism. Williams et al. (2019) noted that institutional discriminatory practices and processes depend on groups within institutions creating and reinforcing discriminatory practices as norms. Institutional racism changes the institutional arrangements to limit the resources and services to those in the minority, and confer hidden privileges to majority members (Williams, 2018). Examples of resources might be funds or the time to complete work. Examples of services might be providing non-Western services and multilingual resources. Organizational

practices can create hidden pathways for sustaining institutional racism or other types of discrimination beyond individual racial bias.

Other types of institutional discrimination may include ageism, ableism, religious intolerance, language bias, cultural xenophobia, colonialism, and Western domination of ideas and ways of being (Sundstrom & Kim, 2014; Waite & Nardi, 2019). That is, other institutional discrimination can be viewed as organizational-level discrimination embedded in institutional ways of being and institutional guidelines. Those ways of being and guidelines are based upon language, country of origin, culture, relationship-based working, gender, income, ability, thinking styles, and religion that privilege some groups over others.

Institutional procedural discrimination, institutional racism, and other institutional discrimination are separate, yet related concepts. The focus on institutional discrimination is different from a focus on discrimination as those individual actions of unequal treatment, exclusion, and marginalization (Williams, 2018). Scholars have called for a shift in focus from examining self-reported individual and discriminatory bias towards the interrogation of institutional norms (Groos et al., 2018; Williams, 2018). The overall purpose of this longitudinal CBPR was to examine three types of institutional discrimination and their relationship with health. The next section defines the types of institutional discrimination.

1.2 | Definitions

1.2.1 | Institutional procedural discrimination

Institutional procedural discrimination as rooted in procedural justice theory (Kopelovich et al., 2013) is defined as the institutional agreements about the types of decisions, timing of discussions, conditions, and deadlines to privilege one group over another in institutional processes.

1.2.2 | Institutional racism

Institutional racism, within organizations in the United States, involves policies, practices, and procedures which privilege majority White racial groups (Carmichael & Hamilton, 1967; Dennis et al., 2021; Gee & Hicken, 2021). Thus, institutional racism is defined as the existence of systematic policies, laws, and practices that provide differential access to goods, services, and opportunities because of socially constructed racial identity.

1.2.3 | Other institutional discrimination

Other institutional discrimination is defined as the other types of institutional policies and practices that impact differently or harm non-dominant groups based on language, country of origin, culture, relationship-based working, gender, income, ability, thinking style, and religion, resulting in differential access to goods, services, and opportunities (Sundstrom & Kim, 2014; Waite & Nardi, 2019).

2 | METHODS

2.1 | Study design and sample

This longitudinal CBPR study (Holkup et al., 2004; Vaughn et al., 2017) used a triangulated mixed-method design (Halcomb & Hickman, 2015). The researchers were funded to examine the impact of the Initiative's public health program on developing home-based programs. The study sample included 20 participants from nine community-based organizations (CBOs), with 1–3 participants from each CBO. The inclusion criteria were: (1) involvement in developing a home-based program in participating CBOs; (2) completing workshops, focus groups, self-report surveys, or follow-up individual interviews; and (3) willingness to permit information used in research. There were no exclusion criteria. A power analysis indicated 63.0% power (Cohen's $d = 0.5$) to detect a pre- and postdifference between April 2019 ($n = 17$) and November 2019 ($n = 17$) survey data. Some scholars suggest that acceptable power should be 80% or greater (Cohen, 2013), thus this study indicates fair or moderate power.

2.2 | Overview of the program in the municipal public health initiative

The Initiative's program was to develop and implement home-based programs to promote healthier, more resilient families with children aged 0–5 years living in a Northwestern United States municipality. Home-based programs involving culturally congruent home visits are effective in providing support to families (Liu et al., 2019; Olds et al., 2014). The Initiative utilized the National Implementation Research Network (NIRN) model as an implementation science model (National Implementation Research Network, 2021), and funded NIRN consultants to teach this model to capacity building providers (CBPs). The NIRN model includes three components: (1) well-defined programs, (2) effective implementation, and (3) supportive environments to create improved outcomes. CBPs also focused on equity practices in their work with CBOs. The Initiative assigned CBP teams to address these three components: (1) a Well-Defined Program team; (2) a data support team together with an organizational capacity building team for the effective implementation component; and (3) a Supportive Environment team.

2.2.1 | Monthly workshops

Phase I of the Initiative's program focused on developing the Well-Defined Home-Based Programs in 6 months (December 2018–May 2019). The Well-Defined Program CBP team provided six monthly workshops for participants to (1) create the racial equity theory of change; (2) adapt the NIRN practice profile for cultural responsiveness; (3) engage community stakeholders; (4) develop an implementation plan; (5) identify components of 2-year budget; and (6) mobilize a CBO-based design team to apply equity practices in their programs. The CBP team delivered workshop topics in English

and presented topics in easily understandable ways for participant comprehension. CBO grantees were required to have at least two lead representatives who attended all capacity-building activities including monthly workshops. Biweekly meetings were held between the funding staff, CBP team, and a researcher. One author attended all workshops and wrote minutes. Phase II focused on home-based program implementation (started between June/July 2019 and November 2019). This study examined institutional procedural discrimination, institutional racism, and other institutional discrimination during Phase I and the beginning of Phase II.

2.3 | Study process, protocol, and data collection

A university institutional review board approved the study and participants' informed consent was obtained. Research consent forms were originally developed in English and then translated into Arabic, Spanish, and Somali to help participants read consent information in the commonly identified languages of participants. Researchers explained the study using the consent forms, answered questions, and invited participation in March 2019. Seventeen participants from nine CBO's consented in March 2019; three participants were recruited before November 2019. Participants chose to sign the consent forms using the English language version. Given that this study was a part of a funded public health program, persons were offered \$50 for each individual interview, focus group, survey, or survey session for program information regardless of their participation in research. This recognized participants' expertise and time. No in-person translators were provided during interviews, focus groups, or surveys because participants expressed confidence in listening (4.06 ± 0.90) and speaking (3.82 ± 0.8) in English. Also, no one requested in-person translation.

Researchers developed surveys by engaging participants for a 30-min to 1-hr interview to learn about their capacity-building experiences. Interviews with participants improved survey questions because keywords and phrases were offered for survey construction. This was done after researchers reviewed existing surveys for format and content. Surveys were first developed in English and translated into Arabic and Spanish by professional translators. The cross-cultural equivalence of the Arabic survey was checked by a second professional translator, and then pilot tested using cognitive interviewing techniques (DeMuro et al., 2012; Howlett et al., 2018) with a bilingual person. The cross-cultural equivalences of the Spanish and English surveys were checked by bilingual participants using cognitive interviewing techniques (DeMuro et al., 2012; Howlett et al., 2018). When asked, no one requested a Somali survey translation.

Surveys were in paper and online formats. Paper survey copies were completed during focus groups in April and November 2019 or by mail. Online surveys were also available via REDCap (Harris et al., 2009). Researchers were present at the April and November group sessions to answer survey questions. The surveys included both close-ended and open-ended questions as a result of participants' input. Participants asked for open comment boxes next to quantitative answers. Participants also added questions about

institutional racism because some had observed that interpersonal racism would not sufficiently measure equity. Participants wanted their suggestions for program improvement to be heard.

2.4 | Study instruments

2.4.1 | Demographics

Participants described their personal life, educational, and work conditions such as length of time working at their CBO in months. They also provided the number of years they had been working with diverse communities and the number of other Initiative grants obtained by their CBO. Regarding anticipated grant work, participants answered how many months they believed it would take for them to develop a meaningful program and how many months were needed for the meaningful modification. They rated their confidence on a 5-point Likert scale about some of the technical skills required for grant participation such as listening and speaking in meetings, reading materials, completing written deliverables, and other assignments. They reported how many workshops they attended and how much additional time they spent doing the Initiative's program work "on top of" regular paid or volunteer work.

2.4.2 | Institutional procedural discrimination

The research team applied CBPR processes (Holkup et al., 2004; Vaughn et al., 2017) to develop the institutional procedural discrimination survey. Researchers discussed with participants how the Initiative's program could help them and how well they understood the expected work. During these conversations, participants described being discriminated against. Researchers used this information to develop the institutional procedural discrimination survey. The first four survey items of the institutional procedural discrimination survey measured institutional procedural discrimination experiences during home-base program development such as procedures being changed without permission, words on documents being changed without explanation, cultural ways not being respected when they were known, and having meetings and materials based on Western culture. The last eight items of the institutional procedural discrimination survey measured being treated differently due to racial identity, nationality, English as a second language, gender, religious identity, age, sexual orientation, and income (e.g., "I was treated as not as well because of my age while doing this project"). Participants answered each item using "yes" or "no" replies in April and in November 2019.

2.4.3 | Patient-Reported Outcomes Measurement Information Systems-10

The Patient-Reported Outcomes Measurement Information Systems-10 (PROMIS-10) global health survey included self-rated health items

(Abma et al., 2021; Hays et al., 2009). The four-item global physical health portion of the PROMIS-10 global health survey measured physical health, physical functioning, pain intensity, and fatigue. The four-item global mental health portion of the PROMIS-10 global health survey measured overall quality of life, mental health, satisfaction with social activities and relationships, and emotional problems. PROMIS-10 also included items on general health and social roles. The question about general health was, "In general, would you say your health is..." The question about social roles was, "In general, please rate how well you carry out your usual social activities and roles." Participants answered items using a 5-point Likert Scale ranging from *poor* (1) to *very good* (5) in April and in November 2019. Mean scores were used, and higher scores indicated better health. Cronbach's α values were 0.45 for global physical health and 0.61 for global mental health for the current study. Cronbach's α of less than 0.50 can be interpreted as poor, \sim 0.60 as fair, \sim 0.70 as moderate, and 0.80–0.90 as strong (Panayides, 2013). This means that global physical health had a low degree of internal consistency and global mental health had a fairly acceptable degree of internal consistency (Field, 2009; Tavakol & Dennick, 2011) for this study.

2.4.4 | Initiative-related health

The research team co-developed the Initiative Program Related Health survey with participants to describe participants' perceptions about how their health was impacted through to November 2019. The 4-item survey measured the impact on participants' quality of life, physical health, mental health, and satisfaction. Participants answered each item using a 5-point Likert Scale ranging from *not at all* (1) to *very much* (5). Mean scores were used, and higher scores indicated more impact. Cronbach's α was 0.72 for the current study meaning that this was a moderate degree of internal consistency (Tavakol & Dennick, 2011). Two open-ended questions were added in November 2019 because researchers received comments from participants that the Initiative's program was impacting their health. The research team asked, if you want to share, please provide us an example of how this project impacted your health positively? And if you want to share, please provide us an example of how this project impacted your health negatively?

2.4.5 | Institutional racism and overall institutional discrimination

In November 2019, questions were added about institutional racism and other institutional discrimination because study participants told researchers that they were experiencing those types of discrimination. Institutional racism was measured with the question, "Did you experience institutional racism (the existence of systematic policies or laws and practices that provide differential access to goods, services, and opportunities of society by race) during the capacity-building process?" Other institutional discrimination was measured with the

question, "Did you experience any other institutional discrimination (language, country of origin, culture, relationship-based working, gender, income, ability, thinking style, religion) during the capacity-building process?" Possible responses for both questions were "yes", "no", "not sure", or no answer. Respondents also wrote their comments.

2.5 | Data analysis

The data were analyzed using IBM SPSS (Version 25). Data entry was verified by two research team members independently and then selectively checked by a third team member. To describe participants, descriptive statistics were used, including means, standard deviations, frequencies, and percentages.

The first aim, describing 7-month changes in experiences of institutional procedural discrimination, was analyzed by dichotomizing participants' responses into two groups, "yes" and "no." Then, the number of "yes" responses from the institutional procedural discrimination survey were calculated for the first four individual items in April and in November 2019, separately. To maintain confidentiality, responses were aggregated for the 8-items that asked about discrimination according to identity. A Wilcoxon signed-rank test was then used to analyze total "yes" responses in April 2019 and the total "yes" responses in November 2019 with a significance set at $p = 0.05$.

The second aim, comparing the health of participants between those who experienced types of institutional discrimination and those who did not, was analyzed by comparing participants' health according to "yes" and "no" responses about institutional procedural discrimination, institutional racism, and other institutional discrimination. Means and standard deviations of global physical health, global mental health, overall health, social roles, and Initiative program-related health items were calculated for each group. Similar data analysis was conducted for institutional racism and other institutional discrimination, using "yes" and "no" responses. Participants' open-ended responses to the positive and negative impacts of the Initiative's program on their health were also analyzed using inductive content analysis (Prior, 2020).

For the third aim, describing participants' experiences of institutional racism and other institutional discrimination, responses were analyzed using inductive content analysis (Prior, 2020) and by matching "yes" or "no" answers with participants' written comments. Three research team members: (1) identified units of analysis; (2) reviewed the data as a whole; (3) coded comments by categories; (4) grouped comments; and (5) finalized groups and selected exemplar quotes.

3 | RESULTS

3.1 | Demographics

Participants completed surveys as they felt comfortable. Seventeen out of twenty participants provided demographics including six directors, seven full-time staff, and four part-time staff and

TABLE 1 Demographics of participants from community-based organizations ($n = 17$)

Characteristics	<i>n</i>	%
Roles		
Director	6	35.3
Staff (full time)	7	41.2
Staff & volunteer (part-time)	4	23.5
Highest level of schooling		
Some college, technical school, or graduated college	7	41.2
Graduate school and beyond	9	52.9
No answer	1	5.9
Have you developed a program before?		
No	4	23.4
Yes	11	64.8
No answer	2	11.8
Birthplace		
United States	8	47.1
Outside of the United States	9	52.9
Social groups		
White	2	11.8
Immigrants, Black, Indigenous, Latinx, Asian, or People of Color	15	88.2
In general, would you say you (and your family living with you) have more money than you need, just enough for your needs, or not enough to meet your needs?		
More money than you need	3	17.6
Just enough for your needs	11	64.8
Not enough money for needs	3	17.6
Perceived net finances. How much money would you have left over if you turned all your assets (jewelry, car, house, etc.) into cash and paid off your bills?		
Be in serious debt	6	35.3
Break even	4	23.5
Have money left over	6	35.3
No answer	1	5.9
Work and initiative characteristics		
Months working at the organization ($n = 16$)	60.07	56.44
Years working with diverse communities ($n = 17$)	13.59	10.20
Total number of Initiative grants per CBO ($n = 12$)	4.25	1.14

TABLE 1 (Continued)

Work and initiative characteristics	Mean	SD
How many languages do you speak? ($n = 9$)	2.11	0.33
Total number of languages spoken by clients of the CBO	28 Different languages	
Characteristics related to grant work		
	<i>N</i>	%
Is the work related to capacity building added on top of your regular work that you are doing in the agency?		
No	1	5.9
Yes	14	82.3
Somewhat	1	5.9
No answer	1	5.9
Did you know you would have four capacity-building providers?		
No	15	88.2
Yes	1	5.9
No answer	1	5.9
Did you know the grant would have a 6-month Phase I to develop a new program or practice?		
No	3	17.6
Yes	14	82.4
Characteristics related to time, and ease of information		
	Mean	SD
Time in months to create a meaningful, new program ($n = 10$)	9.30	3.97
Time in months to create a meaningful, program modification ($n = 7$)	5.86	3.67
Ease of information: How easy was it for you to do the following? ($n = 17$)		
Read the materials	3.29	1.05
Listen at the workshop	4.06	0.90
Speak at the workshop	3.82	0.81
Write the deliverables/assignments	3.53	0.94

Abbreviation: CBO, community-based organization.

volunteers (Table 1). Overall, participants were well educated and experienced in multicultural, multilingual work. Most had graduate school education (52.9%, $n = 9$), or had some college, technical school, or graduated college (41.2%, $n = 7$). Nine spoke at least two languages. Sixteen participants had worked at the CBO for about 5 years and seventeen had worked with diverse communities for about 14 years. When asked about their confidence in fulfilling the technical skills required for grant participation, 17 participants were easily (4) or neutrally (3) able to listen (4.06 ± 0.90) and speak (3.82 ± 0.81) at the workshops, write assignments (3.53 ± 0.94), and read the

materials (3.29 ± 1.05). Twelve said they were involved with an average of 4.25 different Initiative grants. Overall, participants spent an average of 18.85 ± 11.26 h (range: 4.67–37.50) completing homework (outside of normal reimbursed hours) necessary for contract deliverables after the monthly workshops. Two out of seventeen identified as White only, others were from diverse immigrant, racial or cultural backgrounds. There were significant correlations between: (1) length of time working at the CBO in months and time spent doing homework after the monthly workshops ($r = 0.72$, $p < 0.05$); (2) years working with diverse communities, and number of Initiative grants ($r = -0.74$, $p < 0.01$); and (3) years working with diverse communities and time spent doing homework after the monthly workshops ($r = 0.70$, $p < 0.05$).

3.2 | Institutional procedural discrimination

As depicted in Table 2, the total number of “yes” responses of institutional procedural discrimination from April 2019 to November 2019 decreased from 38 (18.6%) to 24 (11.8%), although it was not statistically significant. Also, the number of participants who reported at least one out of 12 institutional procedural discrimination items in April (88.0%, $n = 15$) and November (82.0%, $n = 14$) did not decrease significantly.

In April 2019, the most common “yes” reply was for the statement, “I was told things would happen one way and then it changed without my permission to another way” (70.6%, $n = 12$). In November 2019, the most common “yes” reply was for the statement, “All meetings and materials presented were based on Western culture so I had difficulty understanding the work” (64.8%, $n = 11$). The only significant change in

“yes” replies from April 2019 (23.5%, $n = 4$) to November 2019 (0%, $n = 0$) was for the statement, “When my different cultural ways of doing things were shared, the project did not support my way,” Wilcoxon signed-rank test, $Z = -2.00$, $p < 0.05$. There was a trend of decrease in the eight aggregated items, “I was treated not as well because of... my racial identity/nationality/use of English/gender/religious identity/age/sexual orientation/income/economy, etc.” from 8.8% (total “yes” replies = 12) in April to 0.7% (total “yes” replies = 1) in November using Wilcoxon signed-rank test, $Z = -1.89$, $p = 0.06$.

3.3 | Relationships between institutional procedural discrimination, institutional racism, other institutional discrimination, and health

As depicted in Table 3, participants who experienced institutional racism reported a greater impact of the Initiative's program on their quality of life than those who reported no institutional racism ($t = 3.62$, $p < 0.01$). There were no significant mean differences in participants' global physical health, global mental health, general health, social roles nor in Initiative program-related health between those who reported at least one “yes” and those who reported all “no” in institutional procedural discrimination, institutional racism, or other institutional discrimination.

The same seven out of seventeen participants (41%) wrote about positive and negative Initiative program health impacts (there was one quote of “N/A”). There were two categories of positive comments: (1) Meeting a community need and (2) Working when it's not easy. Meeting a community need was noted as a category with a quote like, “Providing a critical service and filling a gap in the community

TABLE 2 Changes of “Yes” replies for institutional procedural discrimination ($N = 20$)

Statements	Institutional procedural discrimination	
	April 2019 ($n = 17$)	November 2019 ($n = 17$)
	Number of total yes replies (% of participants)	Number of total yes replies (% of participants)
Institutional procedural discrimination total of yes replies	38 (18.6%)	24 (11.8%)
I was told things would happen one way and then it changed without my permission to another way	12 (70.6%)	10 (58.8%)
All meetings and materials presented were based on Western culture so I had difficulty understanding the work ^a	8 (47.1%)	11 (64.8%)
Words on my documents were changed and I do not know why	2 (11.8%)	2 (11.8%)
When my different cultural ways of doing things were shared, the project did not support my way	4 (23.5%) ^b	0 (0.0%) ^b
I was treated not as well because of... my racial identity, nationality, use of English, gender, religious identity, age, sexual orientation, income/economy, or so forth ^c	12 (8.8%) ^d	1 (0.7%) ^d

^aAll meetings and materials refer to the workshops using the National Implementation Research Network model from December 2018 to May 2019.

^bWilcoxon signed-rank test showed a significant difference between April 2019 and November 2019. $Z = -2.00$, $p < 0.05$.

^cParticipants could check multiple items about not being treated as well because of racial identity, nationality, use of English, gender, or other characteristics. Replies are combined for confidentiality.

^dWilcoxon signed-rank test showed trend of decrease between April 2019 and November 2019. $Z = -1.89$, $p = 0.06$.

TABLE 3 Comparison of health by institutional procedural discrimination, institutional racism, and other institutional discrimination

	Institutional procedural discrimination				Institutional racism				Other institutional discrimination			
	April 2019 ^a		November 2019 ^a		November 2019		November 2019		November 2019		November 2019	
	Yes M (SD)	No M (SD)	Yes M (SD)	No M (SD)	Yes M (SD)	No M (SD)	Yes M (SD)	No M (SD)	Yes M (SD)	No M (SD)	Yes M (SD)	No M (SD)
Global physical health	3.70 (0.64) (n = 11)	3.88 (0.53) (n = 2)	2.96 (0.46) (n = 12)	2.75 (0.00) (n = 3)	2.92 (0.38) (n = 3)	2.86 (0.42) (n = 11)	2.50 (0.00) (n = 1)	2.88 (0.41) (n = 12)	2.50 (0.00) (n = 1)	2.86 (0.42) (n = 11)	2.50 (0.00) (n = 1)	2.88 (0.41) (n = 12)
Global mental health	3.68 (0.52) (n = 14)	3.75 (1.41) (n = 2)	3.75 (0.00) (n = 14)	3.30 (0.75) (n = 2)	3.20 (0.76) (n = 5)	3.30 (0.75) (n = 10)	2.25 (0.00) (n = 1)	3.44 (0.63) (n = 13)	2.25 (0.00) (n = 1)	3.30 (0.75) (n = 10)	2.25 (0.00) (n = 1)	3.44 (0.63) (n = 13)
PROMIS-10 general health	3.60 (0.63) (n = 15)	4.00 (1.41) (n = 2)	3.57 (1.02) (n = 14)	3.67 (0.58) (n = 3)	3.40 (1.14) (n = 5)	3.73 (0.91) (n = 11)	2.00 (0.00) (n = 1)	3.64 (0.84) (n = 14)	2.00 (0.00) (n = 1)	3.73 (0.91) (n = 11)	2.00 (0.00) (n = 1)	3.64 (0.84) (n = 14)
PROMIS-10 social roles	4.00 (0.93) (n = 15)	3.50 (2.12) (n = 2)	3.57 (1.02) (n = 14)	4.33 (0.58) (n = 3)	3.40 (1.14) (n = 5)	3.91 (0.94) (n = 11)	2.00 (0.00) (n = 1)	3.79 (0.89) (n = 14)	2.00 (0.00) (n = 1)	3.91 (0.94) (n = 11)	2.00 (0.00) (n = 1)	3.79 (0.89) (n = 14)
In general, how did working on this project ^b impact your quality of life?	-	-	3.36 (1.34) (n = 14)	2.00 (0.00) (n = 3)	4.40 ^c (0.89) (n = 5)	2.45 ^c (1.04) (n = 11)	3.00 (0.00) (n = 1)	2.93 (1.33) (n = 14)	3.00 (0.00) (n = 1)	2.45 ^c (1.04) (n = 11)	3.00 (0.00) (n = 1)	2.93 (1.33) (n = 14)
In general, how did working on this project ^b impact your physical health?	-	-	2.29 (1.20) (n = 14)	1.33 (0.58) (n = 3)	2.60 (1.14) (n = 5)	1.73 (1.01) (n = 11)	3.00 (0.00) (n = 1)	1.86 (1.10) (n = 14)	3.00 (0.00) (n = 1)	1.73 (1.01) (n = 11)	3.00 (0.00) (n = 1)	1.86 (1.10) (n = 14)
In general, how did working on this project ^b impact your mental health, including your mood and your ability to think?	-	-	2.36 (1.15) (n = 14)	2.00 (0.00) (n = 3)	2.80 (1.10) (n = 5)	2.00 (1.00) (n = 11)	3.00 (0.00) (n = 1)	2.14 (1.10) (n = 14)	3.00 (0.00) (n = 1)	2.00 (1.00) (n = 11)	3.00 (0.00) (n = 1)	2.14 (1.10) (n = 14)
In general, how much are you satisfied with working in this project? ^b	-	-	4.50 (0.86) (n = 14)	4.67 (0.58) (n = 3)	4.60 (0.89) (n = 5)	4.45 (0.82) (n = 11)	3.00 (0.00) (n = 1)	4.57 (0.76) (n = 14)	3.00 (0.00) (n = 1)	4.45 (0.82) (n = 11)	3.00 (0.00) (n = 1)	4.57 (0.76) (n = 14)

Note: Total sample size was 20.

Abbreviation: PROMIS-10, Patient-Reported Outcomes Measurement Information Systems-10.

^aYes includes those who marked at least one "yes" on the 12-item institutional procedural discrimination scale.

^bParticipants called the Initiative's program a project; it was called a program by the Initiative's staff.

^ct-Test showed a significant difference between yes and no, $t = 3.62$, $p < 0.01$.

improves my mental health.” Working when it's not easy was represented with a quote like, “*This work is not easy but knowing we have a method to address the institutional racism that impacts our families during birth brings me peace.*”

Negative health impacts were categorized in three areas: (1) Self-health compromises, (2) Stress, strain, and working additional workload hours, and (3) Concerns about maintaining funding. Related to stress, strain, and working additional workload hours, two quotes are, “*I was stressed out and had little time to relax or meditate, exercise, yoga, etc.*” and

Mental health: This [Initiative] workload was in addition to my existing org. work and it strained my relationships and perspective of my org/other colleagues and impacted my wellbeing/quality of life/work life/investment and commitment to org. Physical health: I did [the Initiative] work in the evenings, weekend, and holiday (whenever I wasn't in my typical workday), so it impacted the amount and quality of sleep, which directly and indirectly impacted health in different ways. (Note: The name of the funder was replaced with [the Initiative] or [Initiative]).

Concerns about maintaining funding was expressed as, “*Self-doubt can sometimes creep in and feeling unsure if we will be able to maintain funding to continue this work.*”

3.4 | Institutional racism and other institutional discrimination

Table 4 contains participants' survey responses and exemplar quotes related to institutional racism and other institutional discrimination. Quotes were matched with participants' “yes” or “no” responses. Five participants out of 17 (29.4%, $n = 5$) said “yes” to experiencing institutional racism. Those who noted institutional racism reporting a greater impact of the Initiative's program on their quality of life compared to those who did not report experiencing institutional racism (see Table 3, $t = 3.62, p < 0.01$). In terms of other institutional discrimination, one (5.9%, $n = 1$) said “yes” and commented about using Western materials. One participant did not mark “yes” or “no” and instead wrote about being “punished” for doing Initiative work.

It was also noted by a participant that they were not compensated for the Initiative's program work. This information helped explain the finding that fourteen participants (82.3%) out of seventeen said “yes” the work was on “top of their regular work.” Researchers used this information to contextualize the discussion.

4 | DISCUSSION

Types of institutional discrimination reinforced the praxis of privilege and power in the Initiative's program design as well as in the research design and writing. Naming privilege and power pathways must occur

for future nursing research and practice to advance. This CBPR study mattered in six important ways to name what was present and absent.

First, participants codesigned the surveys to name how they wanted their data presented. Participants were present and wanted to be heard, possibly by those who may not share, understand—or in the worst case may get offended by—their experiences. The scientific field ranks data-based research publications, usually populated with numerical tables, higher than commentaries or editorials. It was thusly reasonable that participants wanted aggregate data shown for a “numbers” reading audience. The research team wrote this article with the intent to honor how participants wanted to present to those in power and recognize the scholarly nursing readership.

Second, researchers learned that the design of procedures often mirrors the privileges of those in power (such as Western, English only, scientific models, etc.), without naming it as such. This study offers to nursing research a way to name embedded privilege and power in the procedures that institutions employ that discriminate against those with less power. Participant reports of their experiences of institutional procedural discrimination persisted, and the number of participants reporting at least 1 out of 12 institutional procedural discrimination items did not decrease significantly. While institutional procedural discrimination decreased between April and November 2019, this was not statistically significant. The most reported institutional procedural discrimination item was, “I was told things would happen one way and then it changed without my permission to another way” (see Table 2, 70.6% in April 2019 and 58.8% in November 2019). This type of exclusionary procedure is perhaps closely related to the conditions identified by Kapelovitch et al. (2013). They noted that programs administered by institutions privilege one group over another through organizational values and decision-making practices. Exclusionary procedures are difficult to discern, yet important to document. Not knowing why procedures change without their permission may increase confusion among participants and may result in distrust.

Third, being multilingual and multicultural enabled participants to navigate the Western-based procedures and name the privileges that Western English-only speakers do not readily observe. As an example of this, the second most experienced institutional procedural discrimination item was “Meetings and materials presented were based on Western culture, so I had difficulty understanding the work.” These experiences increased over the research period from April (47.1%, $n = 8$) to November (64.7%, $n = 11$), although it was not statistically significant. Participants might have felt discriminated by the colonial and White practices of convening meetings and majoritarian (e.g., nonconsensus) styles of decision-making (Came, 2014). In order words, the cultural tailoring of the Initiative to multilingual and multicultural groups was not working. This was based on the finding that multicultural and multilingual participants “had difficulty understanding the work.” This also might have impacted home-based program development as there was no significant increase in program development between May and November 2019 (Kim et al., 2021).

Not engaging participants and providing materials consistent with participants' cultures and languages is another example of the hegemony of Western culture. The participants' engagement, for

TABLE 4 Institutional racism and other institutional discrimination

Yes or no answer choices	Number commenting about answer choice	Exemplar quotes
Institutional racism (<i>n</i> = 17)		
Yes ^a (<i>n</i> = 5)	3 Out of 5 selected yes and commented	"At soo many levels. The entire process was top down. I was excited to learn [the Initiative ^b] was having a planning phase and assumed this process would help strengthen my program. But on top of preparing for our program we had homework from [the Initiative] (tools). We should have been asked what we needed. [The Initiative] should work with the organization to identify the capacity support they need." "I had enjoyed the work my team has done, we work very hard." "Styles of communication were not culturally sensitive at all times. At one meeting most people were white & the consultant of color was on a laptop screen. However, when we had a consultant who spoke [identifying information removed] things went smoothly & the idea flow was high."
No (<i>n</i> = 11)	2 Out of 11 selected no and commented	"We found the mainstream model used during [identifying information removed] capacity building to be difficult to use. Our [identifying information removed] capacity building assistance is much easier and more supportive." "I don't think that I experienced direct racial/ethnic/linguistic bias, but the process is definitely based on dominant culture. It is a mainstream, western, college educated model. There is a disconnect between those serving communities directly and how relevant some of these models are for them and those who are creating/deciding which models and how they are used."
No answer (<i>n</i> = 1)	1 Out of 1 selected no choice and commented	"I'm not sure. I think the intent of [the Initiative] was different than the reality in programs/back within organizations. For example, I think [the Initiative] hoped and assumed that grantees participating in [the Initiative] work would be acknowledged for their time (like getting another staff to help maintain programming/work or [the Initiative] work being a part of a grantee's existing work hours), but that was not the case for me. I worked my 40 hours as a full-time staff/continued all work tasks, so [the Initiative] work was in addition and not allows understood by my organization - like my org. being annoyed that I missed a staff meeting, etc. because I was at a [Initiative] workshop."
Other institutional discrimination (<i>n</i> = 17)		
Yes (<i>n</i> = 1)	1 Out of 1 selected yes and commented	"The material/concept/tools are very western. The research and materials shared were all English and in many times not in lay language."
No (<i>n</i> = 14)	0 Out of 14 selected no and commented	No comments.
No answer (<i>n</i> = 2)	1 Out of 2 selected no choice and commented	"I'm not sure. Because I hold a lot of 'dominant' identities, like as an English speaker, much of the experience aligned with my preferences during [the Initiative] process, but not within my organization experience doing the [Initiative] work. For example, being 'punished' for [the Initiative] work like this situation [arrow to the question above] with my organization/leadership getting annoyed or not really understanding when I (or others on my [Initiative] team) missed org. happenings, like staff meetings, because of attending [the Initiative] workshops. Another punishment was doing [the Initiative] work outside of my existing work (and work time) - like evenings and holidays."

^aCross-referenced with Table 3, participants who experienced institutional racism reported greater impact of the project on their quality of life than those who reported no institutional racism ($t = 3.62, p < 0.01$).

^bThe name of the funder was replaced with [the Initiative] or [Initiative].

example, in survey design allowed the researchers to detect signals of institutional procedural discrimination. Researchers were able to capture significant decreases in participants' reports that their "cultural ways of doing" were not acknowledged in the 7-month period (23.5%, $n = 4$ in April 2019, 0%, $n = 0$ in November 2019, see Table 2). This possibly happened because there were changes after June 2019 resulting in fewer prescribed contracted deliverables and participants had more time and space to exercise their "cultural ways of doing."

Excluding cultural ways can be a form of institutional procedural discrimination. This has often been addressed in prior research using the conceptual practice of "tailoring" interventions with community members (Kreuter et al., 2003). This tailoring can reduce discrimination as a barrier to cultural competency and cultural safety (Berg et al., 2019). There was also a trend of decrease in reports of "not treated as well" because of different social identities, including race, immigration, English as a second language, sex, religion, age, gender,

and other social identifiers. This finding may also be related to participants working more within their CBOs.

Fourth, the research team learned that the relationship between institutional discrimination, health, and quality of life is nuanced. There were no associations among institutional procedural discrimination, other institutional discrimination, and health. This finding is not consistent with previous findings that discrimination is related to health (Berg et al., 2019; Cobbinah & Lewis, 2018). Finding no significant relationships may be related to Cronbach's alpha of the PROMIS-10 survey (0.45 for global physical health and 0.61 for global mental health). Also, prior research primarily focused on the health effects of individual discrimination (Williams, 2018; Williams et al., 2019), rather than institutional discrimination (Burt et al., 2012). However, participants who experienced institutional racism reported a statistically significant impact of institutional racism on Initiative program-related quality of life compared to those who did not (Table 3). Quality of life may be an early indicator of how experiences of institutional racism become embodied through the life course (Krieger, 2020). Thus, a focus on specific health indicators, including quality of life, may be important in future studies of institutional racism in public health programming.

Fifth, the nexus of privilege and power was also observed in participants' health. Their own health and wealth were compromised because they used the privilege of their roles and assets to work to promote the health of clients over their own quality of life. For positive health impacts, participants did not mention personal benefits but instead identified organizational benefits of improving service capacity by meeting community needs. When asked about positive health impacts, participants referred to organizational contexts or improvements; whereas, when asked about negative impacts, participants reported personal health experiences. Their work was emotionally challenging because they addressed the institutional racism that their client families were facing. Meanwhile, when asked about health-related negative impacts, participants wrote examples about self-health compromises; stress, strain, and working additional hours; and concerns about maintaining funding. They were working additional hours to their normal workload, and some reported that these were uncompensated hours. Participating in the Initiative's program may have achieved intended results (e.g., deliverable completion, filling a gap in the community) but with personal health and wealth costs as noted in the findings.

Sixth, simply asking about other institutional discrimination allowed two participants to name what other conditions impacted them. This carved a new pathway for naming what mattered. For example, the focus on Western ways and technical language was a concern (Parker et al., 2021). Different thinking styles among participants were noted as a possible reason for not making significant progress in home-based program development with multicultural, multilingual participants from CBOs (Kim et al., 2021). Participants also reported "yes" they were doing the work of the Initiative's program on top of their regular paid or volunteer work, with 82.3% reporting it in the demographic survey. Public health programs can prevent this by setting expectations on the equitable use of budgets and allowing reasonable timelines. Participants, for example, reported that it would take 9 months to develop a new program but the

Initiative decided to only allot them 6 months. More time, resources, and funds were needed for equitable home-based program development.

4.1 | Nursing research and practice implications

Study results contribute to robust inquiry about types of institutional discrimination that is rare in discourses of nursing research and practice in health care (American Association of Colleges of Nursing, 2021). Nurses researching community-based interventions need to receive training in ways to identify, mitigate, and transform types of institutional discrimination within their inquiry. The employment of participants' own words and explanations, for example, enabled the researchers to understand contexts for institutional procedural discrimination, institutional racism, and other institutional discrimination such as Western English-based language discrimination. Nurse researchers working in public health programs can be aware of the possible institutional discrimination and the consequences of revealing such discrimination to funders and supporting institutions. Our results indicate that consent to procedures is an ongoing process that must be navigated at each step to avoid the imposition of institutional procedural discrimination through procedures being changed "without my permission." Multicultural and multilingual participants considering involvement in population health programs may not be fully aware of the impacts on their quality of life before contracting. Therefore, ongoing consent for participation would also entail continued contract monitoring and adjustments by the Initiative's program staff to ensure socially-just procedures throughout the process.

4.2 | Limitations

A few study limitations are notable. The sample size was small, and it became smaller when data were analyzed based on "yes" or "no" replies. However, when considering that the study participants represented nine CBOs serving linguistically diverse families (28 languages served), the sample size is not small. Not many empirical studies are available that examine multicultural and multilingual populations developing home-based programs. Researchers developed the measures of types of institutional discrimination and Initiative program-related health because of indications from participants that they were experiencing institutional discrimination and health risks. However follow-up interviews might have provided important details on these same experiences.

5 | CONCLUSION

This is a historical moment when nurse researchers are discerning how best to study institutional discrimination related to research and career impacts. The research team learned about the multiple realities

of participants' lives, and the Western boundaries of the current field. Participants courageously shared their experiences to not recreate a similar history of institutional discrimination for others.

That is, participants were addressing institutional discrimination for families served while also naming their institutional discrimination experiences in the Initiative's program design. This double-work along with working "on top of" their regular workload without additional compensation was the context of the negative health reports. The positive health reports were anchored in what they were developing for families and children. Participants courageously shared their knowledge to improve the Initiative's program at a cost to their own quality of life.

"History despite its wrenching pain cannot be unlived, but if faced with courage, need not be lived again" (Angelou, 2014, p. 68). Participants shared experiences so that others would not relive their history and learn from their multicultural, multilingual vision. It takes courage to recognize when one's vision for equity is limited via one's own power and privilege. It takes courage to learn from others who are positioned as recipients. It takes courage to accept the knowledge that the design of a well-intended public health program could hurt those it was meant to help. Nurses invested in research and careers studying types of institutional discrimination can consider ways to advance relevant inquiry into institutional discrimination and health beyond the current Western, English-privileged research. Nurses can consider the intended and unintended consequences for participants and the careers of nurse researchers after findings are revealed. Future courageous inquiry is needed to respond to these challenges in advancing nursing research.

ACKNOWLEDGEMENTS

The authors would like to thank the participants, the community-based organizations, capacity-building providers, Public Health—Seattle & King County, and the University of Washington. This study was funded provided by Public Health—Seattle & King County, Best Starts for Kids, the John and Marguerite Walker Corbally Professorship in Public Service at the University of Washington, and private donations from the authors.

CONFLICTS OF INTEREST

The authors declare that there are no conflicts of interest.

AUTHOR CONTRIBUTIONS

Authors provided equal contributions. Sungwon Lim co-led methods, including data collection, verification, and analysis; and provided substantive research knowledge. Dr. Doris M. Boutain designed the study, co-led the literature review, and provided substantive research knowledge. Dr. Eunjung Kim designed the study, led methods and data analysis, and provided substantive research knowledge. Dr. Robin A. Evans-Agnew co-led the literature review, co-led the discussion, and provided substantive research knowledge. Mrs. Sanithia Parker co-led data collection, led the literature review, and provided substantive research knowledge. Dr. Rebekah Maldonado-

Nofziger led community-based engagement, data collection, verification, archiving, and provided substantive research knowledge.

DATA AVAILABILITY STATEMENT

The data are not publicly available due to privacy and ethical restrictions.

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How to cite this article: Lim, S., Boutain, D. M., Kim, E., Evans-Agnew, R. A., Parker, S., & Maldonado Nofziger, R. (2022). Institutional procedural discrimination, institutional racism, and other institutional discrimination: A nursing research example. *Nursing Inquiry, 29*, e12474. <https://doi.org/10.1111/nin.12474>