



Ned: Hi, I'm Ned Calonge. I'm the President and CEO of The Colorado Trust. We believe that all Coloradans should have fair and equal opportunities to live healthy, productive lives regardless of race, ethnicity, income, where we live, or the other differences that affect opportunity.

I have to admit to you that I woke up this morning full of hope. It's my hope born of the belief that we're a people who are at our best in facing challenges when the challenges are the greatest. It's hope fueled by a heightened sense of urgency for us working in this vitally critical space of health equity. I know there have been tragic events over the past couple of years that have challenged and threatened us.



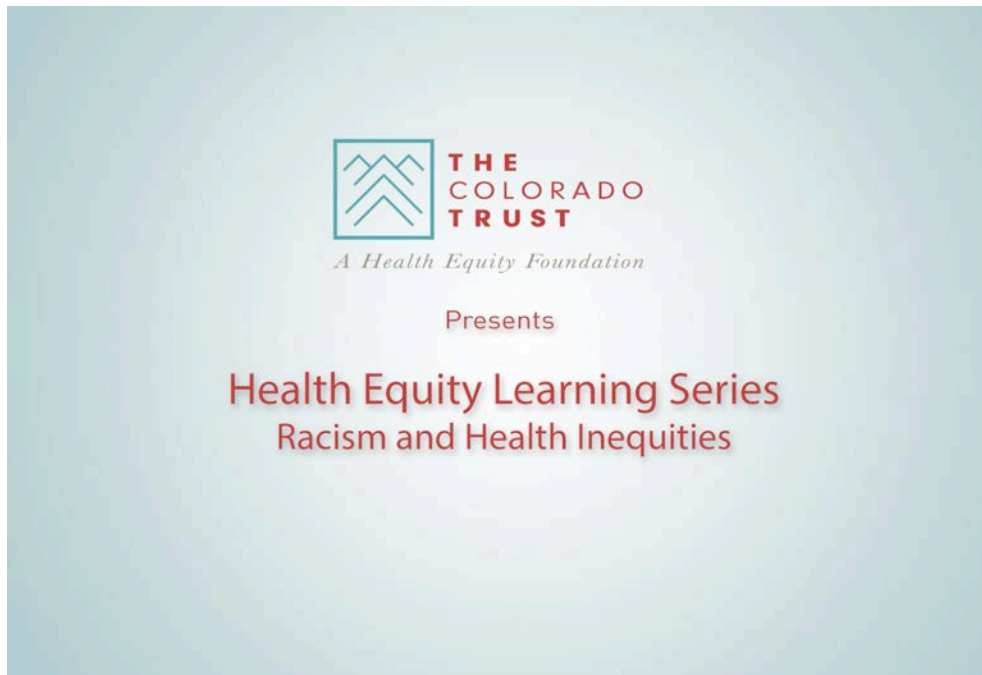
And now with the election, I know there's great uncertainty about the future. While I know that uncertainty brings new challenges and formidable obstacles, I also believe where there's uncertainty, there are opportunities. We must take opportunity to recommit and redouble our efforts to address the inequities in our communities. How we move forward from yesterday depends on how we show up, how we do our work. The Colorado Trust is undaunted, unwavering, adamant about pursuing our work in health equity. And I'm really turning to you, our colleagues and partners, to join us.

I'm inspired. How can you not sit in this room and not be inspired by the people around you? I'm inspired by those in other communities who will watch today's presentation and use it to dialogue in their communities about issues around health equity and race.



I believe our strength as a country is rooted in our diversity. I believe that our unity comes from our ability to embrace across difference. Today we have to accept the responsibility of helping our nation heal, helping our nation come together, and realizing the promise of equity in health for all.

I'm proud and I'm humbled to be here with such a strong ally in our work to advance health equity. A short time ago, Dr. Rachel Hardeman co-wrote a piece for the New England Medical Journal that linked police-related shootings to structural racism, which Dr. Hardeman called "the common denominator of the violence that is cutting lives short in the United States." This piece provides a remarkable overview of how structural racism impacts health, not just for communities of color, but for our entire society.



We'll post a link to the article on our Health Equity Learning Series website in the next day or two and I hope you'll take the advantage to read it. It gives me hope to know that people like Dr. Hardeman are actively working to address structural racism and other important issues and spreading the health equity message in the medical community and beyond. Before I turn things over to Dr. Hardeman, just a few notes. We'll email you an evaluation survey after today's presentation. Please keep an eye out for it and complete it. We honestly do read every evaluation and use it to plan our work going forward. Materials will be posted on the website after the presentation today, including the slide deck that Dr. Hardeman will use, the article I mentioned, and in another couple of weeks the complete video of today's event.

## HEALTH EQUITY LEARNING SERIES 2016-17 GRANTEES

- Aurora Mental Health Center
- Bright Futures
- Central Colorado Area Health Education Center
- Colorado Cross-Disability Coalition
- Colorado Latino Leadership, Advocacy and Research Organization
- Community Enterprise
- Eagle County Health and Human Services
- El Centro AMISTAD
- El Paso County Public Health
- Hispanic Affairs Project
- Northwest Colorado Health
- Poudre Valley Health System Foundation (Vida Sana)
- Pueblo Triple Aim Corporation
- Rural Communities Resource Center
- Southeast Mental Health Services
- The Civic Canopy
- The Gay, Lesbian, Bisexual, and Transgender Community Center of Colorado
- Tri-County Health Network
- Warm Cookies of the Revolution
- Western Colorado Area Health Education Center



*Dedicated to Achieving Health Equity for All Coloradans*

I also want to acknowledge the 20 grantees for the 2016-2017 Health Equity Learning Series who are listed on the screen. These organizations are hosting community viewings of today's event across Colorado. The viewings will be accompanied by professionally facilitated discussions and if you'd like to participate or find a viewing event near you please visit our Health Equity Learning Series webpage and you'll see links to all of our grantees' websites and their schedules. These will be taking place in the state in the next few weeks.

## HEALTH EQUITY LEARNING SERIES



**Rachel Hardeman, PhD, MPH**

Assistant Professor, Health  
Policy and Management

University of Minnesota School  
of Public Health

Minneapolis, Minnesota



*Dedicated to Achieving Health Equity for All Coloradans*

So now I'm pleased to introduce Dr. Rachel Hardeman. She is a health inequities researcher whose work focuses on the provider contribution to equity and quality of health care delivery and the ways in which race can impact health care. She is focused extensively on prenatal care delivery and persistent disparate birth outcomes for African American women. She's also a leading expert in medical education research focusing on the experiences of underrepresented minority physician trainees and how physicians can be trained and are trained to provide equitable and bias-free care. She holds her Doctorate in Health Services Research Policy and Administration and a Masters of Public Health, both from the University of Minnesota School of Public Health. Please help me in welcoming Dr. Hardeman.

# Racism and Health Inequities

Rachel R. Hardeman, PhD, MPH  
Assistant Professor  
UMN School of Public Health



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Dr. Hardeman: Good morning everyone. Almost good afternoon. I'm really, really happy to be here and have had a great experience learning more about The Colorado Trust and the work that is happening here in Denver and in Colorado around health inequities. I'm really excited to have a family member in the audience, my cousin Laura. And a colleague of mine, a former colleague from Minnesota, Megan. I certainly feel like I'm among family and that was apparent at dinner last night as well with folks from The Trust.

I want to start by acknowledging the new political climate that we have found ourselves in. As a Black mother, as a Black academic, as a Black woman, and a member of the Black community, I spent yesterday in mourning, as I'm sure many of you have as well.



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For me, the decisions our country made on Tuesday are not simply about who's going to run the country for the next four years but the fact that I walk among, work among, send my three-year-old to preschool among people who are willing to offer a racist, a sexist, and a misogynistic person the chance to make decisions about our communities, about my family, about my daughter, and our livelihood. While I wasn't necessarily the hugest supporter of Hillary Clinton, I knew she was our best chance. She was my best chance at being able to look my daughter in the eye and tell her that the work that I do when I get up in the morning and the work that I do when she goes to bed at night and I open my laptop and I keep writing and I keep researching, that it matters.



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Like Ned said, he's feeling more hopeful today. I'm still getting there. I'm working on it. And I think putting this presentation together and talking to you all today is helping me towards that point and I hope it will help you all as well. But I do have to say that prior to November 8<sup>th</sup>, I could see and envision a world where one day my daughter could be president, as she so confidently declared that she would be when we went to vote last week. She told me she was going to be both President and Princess Anna. She's obsessed with Frozen right now.

# Racism and Health Inequities

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So I say this to say that usually when I give talks like this around racism and health inequities, I do so with a lot of hope and a lot of belief in the greater good and the fact that we can make change, and that we're slowly making our way towards that.

So I just want to put it out there that I don't have as much of that today and I hope you all will bear with me. I think I'll get there again. I think we all will get there again. It's a long process and it's an important one and I think this conversation is an important piece of that. Now more than ever, we have so much work to do and I'm so happy that you all are here to continue the conversation and to continue that work.

“What old men know is that everything  
can change...”

*O, yes,  
I say it plain,  
America never was  
America to me,  
And yet I swear  
this oath —  
America will be!”*

— Langston Hughes, “Let  
America Be America Again”



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So I want to start... So I want to start by sharing with you an article that was published in the New York Times, actually before November 8th, and it was written by African American activist and actor Harry Belafonte. He started out by saying, “What old men know is that everything can change.” And it's a really, really kind of disturbing... He had some very important foresight around what might happen, and what could possibly happen, and what has now happened, and what we're faced with. But he also uses Langston Hughes' poem, “Let America Be America Again,” to describe our history and where we've been and where we are now and the potential pitfalls of where we can end up. And so I just want to share a little bit of what he wrote, kind of to set the stage for the conversation that I hope that we can have today.

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So he says, “It was an America where the life of a Black person didn't count for much. Where women were still second-class citizens, where Jews and other ethnic whites were looked on with suspicion, and immigrants were kept out almost completely unless they came from certain approved countries in Northern Europe. Where gay people dared not speak the name of their love, and where “passing” — as white, as a WASP, as a heterosexual, as something, anything else, that fit in with what America was supposed to be — was commonplace, with all of the self-abasement and the shame that it entailed.

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It was an America still ruled, at its base, by violence. Where lynchings, and especially the threat of lynchings, were used to keep minorities away from the ballot box and in their place. Where companies amassed arsenals of weapons for goons to use against their own employees and recruited the police and National Guardsmen to help them. These private corporate armies proved insufficient. Where destitute veterans of World War I were driven from the streets of Washington with tear gas and bayonets, after they went to our nation's capital to ask for the money they were owed.



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Much of that was how America had always been, and we changed it. Many of us, through some of the proudest struggles of our history. It wasn't easy, and sometimes it wasn't pretty, but we did it, together. We won voting rights for all. We ended Jim Crow, and we pushed open the Golden Door again to welcome immigrants. We achieved full rights for women, and fought to let people of all genders and sexual orientations stand in the light. And if we have not yet created the America that Langston Hughes swore will be – 'the land that never has been yet' – if there is still much to be done, at least we have advanced our standards of humanity, hope and decency to places where many people never thought we could reach.”

“What old men know, too, is  
that all that is gained can be  
lost...”

-Harry Belafonte



He goes on to say, “But what old men know, too, is that all that is gained can be lost...” This phrase hasn't stopped resonating in my head over the past couple of days, and I think that, in order to minimize our losses in the world of health inequities and in the world at large, there's a lot we need to understand and a lot of work we need to do. And so with that, I would like to start by talking about a subject that I don't often bring into my discussions around racism and health, but I think, given what's occurred over the past couple days, it's an important place to start. And that's with white supremacy.



# White Supremacy

- A historically based, institutionally perpetuated system of exploitation and oppression of continents, nations and peoples of color by white peoples and nations of the European continent; for the purpose of maintaining and defending a system of wealth, power and privilege.
- A political ideology that perpetuates and maintains the social, political, historical and/or industrial domination by white people (as evidenced by historical and contemporary sociopolitical structures such as the Atlantic slave trade, Jim Crow laws in the U.S. and apartheid in South Africa).

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White supremacy is what's changed our political climate overnight. And we need to understand what it is, what it looks like, and if we're going to have any more forward traction in eliminating health inequities and health disparities, we need to be able to define it, we need to be able to say the words, and we need to be able to accept it as part of what has created the inequities in our society. So white supremacy is a historically based, institutionally perpetuated system of exploitation and oppression of continents, nations and peoples of color by white peoples and nations of the European continent; for the purpose of maintaining and defending a system of wealth, power and privilege.

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It also can be described as a political ideology that perpetuates and maintains a social, political, historical and/or industrial domination by white people (as evidenced by the historical and contemporary sociopolitical structures such as the Atlantic slave trade, Jim Crow laws in the U.S. and apartheid in South Africa.)

White supremacy is at the root of structural racism and the persistent health inequities. But we don't often talk about that piece of it when we talk about health inequities and health disparities. And I really think that we need to move our conversation in that way to be able to really dismantle the systems that have created these persistent inequities that we're seeing in our communities.

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White supremacy is what has allowed Black men to be shot and killed by police officers with little or no recourse. And it's my hope that those of us that are doing this important work can begin to use that phrase and use that language and get comfortable with it. AS hard as that... As hard as that is, we have to get comfortable with the language that we're using, and really say what we mean and mean what we say.



**“America’s Race Problem”**

Race is deeply embedded in our society

**BLACK LIVES MATTER**



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Issues of race and white supremacy and structural racism have been at the forefront of our news and media, and certainly during this election cycle. But they're particularly highlighted in the media going back to when George Zimmerman shot and killed Trayvon Martin. We've seen headlines discussing America's race problem and we've really been forced to grapple with, or at least have been unable to turn away from the fact that race is deeply embedded in our society as Americans. And the Black Lives Matter movement in particular has highlighted the insidious impact of structural racism on the health and well-being of Black communities, as well as other marginalized communities.

# Race is a Social Construct

- **A folk Idea:**  
a culturally  
invented  
conception about  
human differences
- **Fluid:** racial  
classifications  
change over time  
and space
- **Social:** Shapes  
Interpersonal relations and patterns opportunity



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So I know it's a lot to process, it's a lot to handle and understand. And it's complex and it's disturbing. I do want to mention that when I talk about structural racism and white supremacy, I'm not talking about individual perpetrators. I'm not talking about individual racists. That's not what this discussion is about. It's about the systems. It's about the structures that are in place and the ideologies that have allocated privilege based on race for many, many years. And the fact that if we don't understand and recognize it, then we're playing a role in perpetuating it.

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So now I want to take a step back and talk about race as a social construct. I think it's an important piece of understanding why health inequities exist, and understanding what we can do to eliminate them. So the idea of race emerged as a justification for New World slavery in the 17th century, and legitimized a social hierarchy that privileged whites. At first, enslaved Africans received treatment only marginally different from that that was afforded other members of lower ranks. In the second half of the 17th century, slave laws were passed to secure the labor force for plantations and to prevent coalitions between Black slaves and white indentured servants.

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Status differentials between Blacks and whites solidified, and indentured servants from a variety of European nations began to see themselves as a white race for the first time. Racial beliefs have always been tied to social ideas and policy. After all, if differences between groups are natural, then nothing can or should be done to correct for unequal outcomes. The scientific literature in the late 19th and 20th centuries explicitly champion this view, and many prominent scientists devoted countless hours to documenting racial differences and promoting man's natural hierarchy.



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Although today many of those ideas are outmoded, it's still popular to believe in innate racial traits, rather than look elsewhere to explain group differences. We all know the myths and the stereotypes of natural Black athletic superiority, musical ability among Asians, but we really need to continue to ask ourselves, are these really true on a biological level? And if not, why do we believe them? There was an example that came out... A study that came out in 2015 from the University of Virginia that found that 50% – 50% – so half of medical students and residents at the school endorsed beliefs around race being biological. So these students would answer questions as true, such as Black people's blood coagulates more quickly, or Black people have a higher tolerance to pain.

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And one of the other findings from this work was that people who are more likely to endorse those types of beliefs were also more likely to hold implicit racial bias. So we have a lot of work to do to debunk a lot of the myths and understand that race is a social construct.

# This history has created Racism

- A system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call “race”).



Camara Jones, MD, PhD



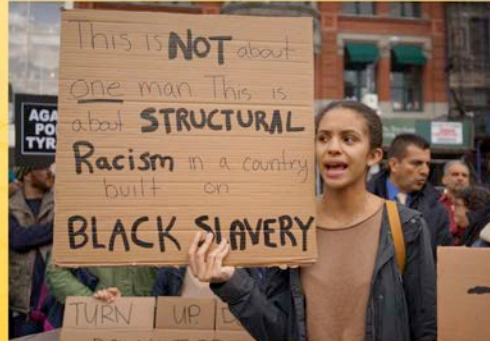
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And from this we've created what we call today “racism.” A system of structuring opportunity and assigning value based on the social interpretation of how one looks, which is what we call “race.”

# Structural Racism

- A confluence of institutions, culture, history, ideology, and codified practices that generate and perpetuate inequity among racial groups

Normative, sometimes legalized, and often manifests as inherited disadvantage.



So structural racism, then, is a confluence of institutions, culture, history, ideology, and codified practices that generate and perpetuate inequity among racial groups. Structural racism is often normative. It's sometimes legalized. And it often manifests as inherited disadvantage, and a lot of times it's very insidious. We don't even... We aren't always acutely aware that it's even operating.

So I think it's always important to have the discussion about health inequities and health disparities within this construct of structural racism, by distinguishing the difference between inequities and disparities.





I think for a long time in the field of public health we've talked about health disparities. Or we use the two, disparities and inequities, interchangeably. And it's important that we, again, are thoughtful about the language we use.

So a health inequity is a difference in health that's a result of systemic, avoidable, and unjust social and economic policies and practices, that create barriers to opportunity. So it's avoidable and unjust differences that are linked to systems and structures. Disparities, on the other hand, are the differences in incidents, prevalence, mortality, and burden of disease, and other adverse health conditions that exist among specific population groups in the U.S. And that's the definition that the National Institutes of Health uses.



So for years, researchers have asked: Is there a difference in health status rates between population groups based on a variety of different health outcomes? Failing to link that to the systems and structures that have created those differences. So again, the language we use is important.

## The *language* we use is important!

- We have been stuck on “disparities” for decades
- Failing to cultivate an understanding of *inequities*
- *Inequities* cause *disparities*
- *Disparities* are very real but they are also a very real distraction... Racism



As I said, we've been stuck on disparities for decades without cultivating our understanding of inequities. Inequities cause disparities. Structural racism causes inequities. While disparities are very real, those differences are very real and undeniable. But they're also a very real distraction in my mind from the issue at hand, which is structural racism.



# Structural Racism and Health

- Flint Michigan Water Crisis

“Flint residents, who are majority black or African-American and among the most impoverished of any metropolitan area in the United States, did not enjoy the same degree of protection from environmental and health hazards as that provided to other communities”



So, now I'd like to share with you a few examples of the link between structural racism and health inequities, just so we kind of understand how this is operating and the different ways that it can create those inequities in health. I'm sure you all have heard a ton about the Flint, Michigan water crisis. I think it's a casebook study of how structural racism has impacted health. Flint is a city that's almost 60% African American. It's incredibly poor. And since 2014, they've been drinking and bathing in water that contains enough lead to meet the Environmental Protection Agency's definition of toxic waste.

# Structural Racism and Health

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“Flint residents, who are majority black or African-American and among the most impoverished of any metropolitan area in the United States, did not enjoy the same degree of protection from environmental and health hazards as that provided to other communities”



And the most recent report on Flint found that – or stated – Flint residents, who are majority Black or African American, and among the most impoverished of any metropolitan area in the United States, did not enjoy the same degree of protection from environmental and health hazards as they provided to other communities. And this is a perfect example of where there is no single person to shoulder the blame for the situation, but thanks to widespread mismanagement of a largely Black and Brown community, they now face the disproportionate effects of systemic neglect.

# Structural Racism and Health

- Flint Michigan Water Crisis

“Flint residents, who are majority black or African-American and among the most impoverished of any metropolitan area in the United States, did not enjoy the same degree of protection from environmental and health hazards as that provided to other communities”



And to many, Flint's water crisis fits into a historical trend of environmental racism in the U.S., which for decades has allowed polluters to prey on communities of color and low income communities, and in part due to weak environmental regulations.

# Structural Racism and Health

- Food accessibility
- Residential segregation and seemingly neutral policy of financing public schools primarily through local private property taxes
  - Linked to poor health outcomes—cardiovascular health
- Housing policies and Redlining



Food accessibility is another important example that we need to consider. I'm sure many of you are doing work around— you know what, I think the phrase now is food deserts. So, decisions made on purely economic grounds can produce racial disparities. So, when grocery store chains decide not to locate a store in a poorer neighborhood... So, when was the last time you saw Whole Foods building a store in a low income or a Black or other marginalized community? This contributes to neighborhood and food environments that have very little access to healthy and fresh foods, or the foods they do have access to are very expensive. And there is a strong link between that and higher risks of obesity, cardiovascular disease, and diabetes.



# Structural Racism and Health

- Food accessibility
- Residential segregation and seemingly neutral policy of financing public schools primarily through local private property taxes
  - Linked to poor health outcomes—cardiovascular health
- Housing policies and Redlining



We also know that there's links between residential segregation and the seemingly neutral policies of financing public schools primarily through local private property taxes. So, this is linked to poor health outcomes in many ways. There are studies that have shown a link between cardiovascular health and just the idea that certain communities are building wealth and accumulating wealth in ways that a lot of other low income or Black communities are not able to do. And that's linked directly to housing policies and Redlining as well, and the use of race and ethnicity to determine mortgage eligibility in communities.

# Structural Racism and Health

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- Residential segregation and seemingly neutral policy of financing public schools primarily through local private property taxes
  - Linked to poor health outcomes—cardiovascular health
- Housing policies and Redlining



There's been studies that have looked at, for instance, elevated blood lead levels as a result of a higher likelihood of living in older housing that's contaminated with lead-based paint. And African American communities are disproportionately impacted in that way.

## Structural Racism; Prenatal Care & Birth Outcomes

- Persistent inequities and disparities—LWB; PTB; IMR; MM
  - *Joint Effects of Structural Racism and Income Inequality on Small-for-Gestational-Age Birth*
    - Structural racism indicators associated with higher odds of SGA birth
  - *Jim Crow Laws and Infant Mortality Rates*
    - A beneficial effect of the end of Jim Crow laws (i.e. legal discrimination) on the reduction of premature mortality for black babies



So now I'd like to share a few examples from the world that I work in, which is prenatal care and birth outcomes. So we know that birth outcomes – the inequities in birth outcomes – are persistent. We have not made much headway in closing that gap. Over the years, we've seen an improvement overall, if you look at the general population, in birth outcomes, but when you start to look at things by race and by socioeconomic status, those numbers haven't moved. Minnesota is a perfect example of the fact that – we're consistently ranked as one of the healthiest states in the nation, and we have some of the best birth outcomes in the nation – but when you start to look underneath the surface, African American and American Indian babies in particular are twice as likely to die in the first year of life, in comparison to white babies.



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The March of Dimes actually just produced a report around preterm birth and graded all of the states. And there's a lot of states who got an A or B when it came to birth outcomes overall, generally speaking within their populations, and then those grades fell to a C or D when you started looking at the differences by race and by socioeconomic status.

So we know there's persistent inequities and disparities in birth outcomes: So low birth weight – babies that are less than 5 and a half pounds at birth; Preterm birth – so babies that are born before 37 weeks gestation; Infant mortality, and maternal mortality as well. So New York in particular has some of the highest – the worst – disparities in maternal mortality in the U.S.

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So some of the work that's been done around this... So, I should back up for a second to say that there's a lot of work that's shown that everyday discrimination, so women and families walking through life and experiencing the interpersonal encounters of discrimination, that that can impact birth outcomes because we know that stress is bad during pregnancy, and all of the physiological stuff that comes with that. But there's less that's looked at actually how structural racism and systems have impacted birth outcomes. And so that's where I'm spending a lot of the time with my work right now.

## Structural Racism; Prenatal Care & Birth Outcomes

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But a recent study did find that the joint effects of structural racism and income inequality on small-for-gestational-age birth is associated with – so, structural racism indicators are associated with – higher odds of small-for-gestational-age birth. And what they looked at were state-level indicators like employment, incarceration, education level, so having a bachelors degree or not, and then used state-level coefficients to assess income inequality as well.

## Structural Racism; Prenatal Care & Birth Outcomes

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  - *Jim Crow Laws and Infant Mortality Rates*
    - A beneficial effect of the end of Jim Crow laws (i.e. legal discrimination) on the reduction of premature mortality for black babies



And the second study I think is really fascinating. It was published, actually, in 2013 by social epidemiologist Nancy Krieger at Harvard. And she looked at Jim Crow laws. So actually looking at legal discrimination, a perfect example, right, of structural racism, and looked at the association with infant mortality rates and found that there was a beneficial effect at the end of Jim Crow laws on the reduction of premature mortality for Black infants.



## Interventions?

- The Effect of an Increased Minimum Wage on Infant Mortality and Birth Weight
  - If all states in 2014 had increased their minimum wage by ONE dollar, there would likely have been 2790 fewer LBW births and 518 fewer post neonatal deaths for the year
- Culturally-centered birth center care
  - Robert Wood Johnson Foundation
  - Roots Birth Center, Mpls, MN
  - Black owned—1 of 5



So, while there's little that's looked at structural racism in birth outcomes, there's even less that's actually measured or figured out interventions or thought about ways to disrupt this pathway between structural racism and adverse birth outcomes.

One study that was recently published, actually a couple months ago I think is really, really important work that needs to be explored further. And it was published in The American Journal of Public Health, if anyone's interested in taking a look. But what they found was, that the effect, that if all states in 2014 had increased their minimum wage by one dollar, so just one dollar increase, there would've likely been almost 3,000 fewer low birth weight births,



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and 518 fewer postneonatal deaths for the year. And I think that's a great example of the ways that policy can impact health, and we don't always see the direct impact there, but more work that area I think will start to help that unfold a little more.

I'm also really excited to share an intervention that I'm working on that's recently been funded by the Robert Wood Johnson Foundation. So, we are partnering – we, meaning the University Minnesota – are partnering with Roots Birth Center. It's a community birth center in North Minneapolis. North Minneapolis is a community in Minnesota that has some of the worst – well, the worst – inequities and birth outcomes in our state.

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It has a very high population of – African American population – and is also low income. And Roots Birth Center is one of five Black owned birth centers in the U.S. One of five, and the only one in Minnesota. And the midwife there, her name is Rebecca Polston, and she is providing what she calls “culturally centered” or “culturally focused care.” And she is seeing... They've been open for a year and she's seeing amazing outcomes. She's seeing less – actually she hasn't had any preterm births. She hasn't had any low birth weight babies. But she hasn't had a mechanism yet to be able to document the work that she's doing. And so that's what we're really excited to be able to do.

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And in some of the conversations that we've had with her and with her staff, she talks about how they are working to disrupt that pathway between structural racism and birth outcomes. How they're having conversations with the families. How they talk about the fact that it's painful for a Black woman to know that she is bringing a Black boy into this world, given that Jamar Clark was shot and killed less than a mile from where the birth center sits.

And so those are the types of interventions that I think are really important to consider as we're doing this work, and really important to be able to have those conversations around how racism is impacting the day-to-day lives of the people that we're helping and working with.

## Intersectionality

- An analytic sensibility, a way of thinking about identity and its relationship to power.
- Articulated on behalf of Black women highlighting their invisibility in the feminist movement
- Intersectionality has given many advocates a way to frame their circumstances and to fight for their visibility and inclusion.



Before I shift to talking about what we can do and what our role is in dismantling these systems, I wanted to bring up one more thing that I think is important for us to think about and to talk about a little bit, and that's intersectionality, which is a term that many of you have probably heard quite a bit throughout the election season. And it's a theoretical notion that originated by Kimberlé Crenshaw in the early 90s, I believe, and was revisited recently in her work. She actually wrote an essay that was published in The Washington Post entitled, “Why Intersectionality Can’t Wait.”



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In that essay she makes a case for using intersectionality as a framework for analyzing racial, sexual, and economic justice – the very issues that were at the forefront of the presidential election this year. And she also states that intersectionality was a lived reality before it became a term. So, in my mind it's this analytic sensibility, it's a way of thinking about identity and its relationship to power. So when I do work on prenatal care and birth outcomes, I'm thinking about the intersections of race and the intersections of gender, and what we sometimes refer to as “gendered racism.”



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It's also... It allows advocates a way to frame their circumstances and to fight for visibility and inclusion. I think it's really important to think about the fact that – so today I'm talking about structural racism and really focus my work on the Black community – but there's so many intersections there that we need to consider. So whether you're living in a rural area – and what does that mean for what your experience is as an African American person? Or girls of color in the fight against the school to prison pipeline? Women within the immigration movement? Trans women within feminist movements? People with disabilities fighting police abuse?

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So we all face about vulnerabilities that reflect these intersections of racism, of sexism, of class oppression, transphobia, ableism, and more. And if we're not thoughtful about those intersections, of all these identities, and how they are related to power and privilege, we're not doing our job fully.

# Collective Responsibility

Supporting Black Lives and Dismantling  
Racism



So, I want to switch gears before we wrap up and have a discussion, to talk a little bit about our collective responsibility for supporting Black lives and dismantling racism. So Ned mentioned the article that we published recently in the New England Journal of Medicine, called “Structural Racism in Supporting Black Lives: The Role of Health Professionals.”

And we wrote this... It was co-authored by, actually, my husband, who is a family medicine physician and my colleague, Katy Kozhimannil, who is a health policy researcher. We wrote this in July after Philando Castile was shot and killed by police about a mile and half from University of Minnesota where we work.

# Collective Responsibility

Supporting Black Lives and Dismantling  
Racism



And we were all feeling very helpless and feeling very sad, and needed to channel that in some way that could be useful and could facilitate a discussion among our colleagues who seemingly – didn't seem to be as affected by it as we were. I was sitting in my office and feeling like I had no one to cry with, and no one to talk to about these things, and so this is one way of being able to do that and to start this conversation.

And I will also say that I think what we wrote is not brand new information. We stand on the backs of many critical race theory scholars, W.E.B. Du Bois and others who have been talking about – and also people in the Black Lives Matter movement – who have been talking about this stuff for very, very long time.

# Collective Responsibility

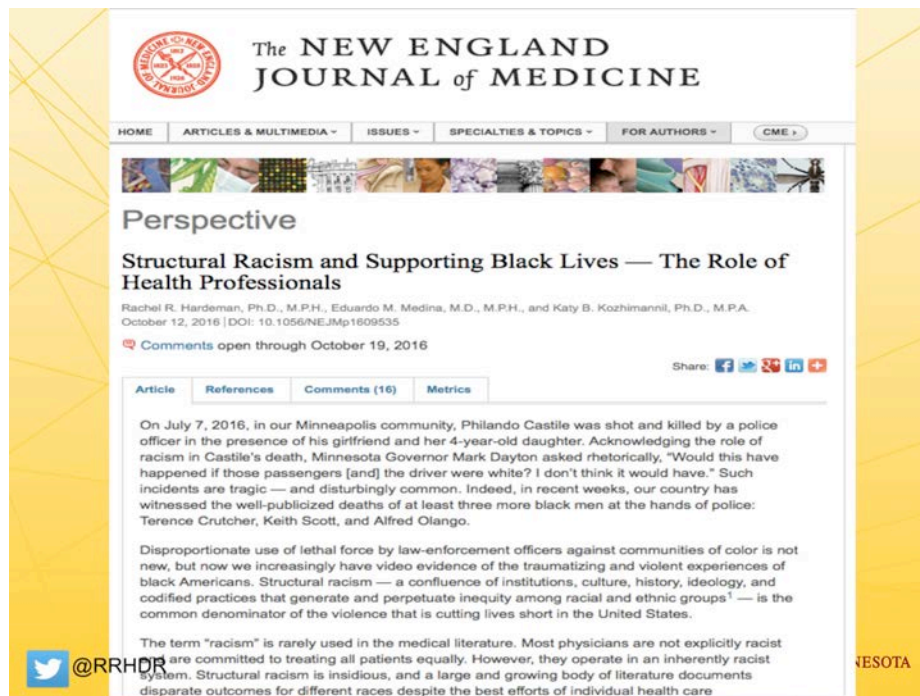
Supporting Black Lives and Dismantling  
Racism



Our goal was really to package it for health care professionals, so clinicians and researchers, in a way that they were able to understand it and to really take it to heart and to put it into practice.

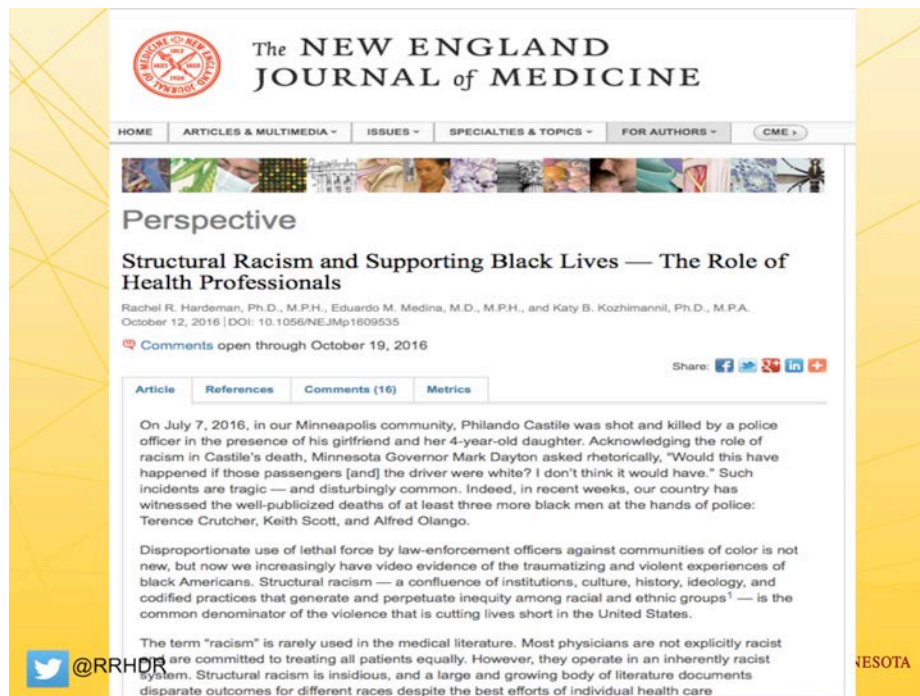
And so I'm going to share with you the five things that we talk about in this piece. And, while I recognize that not everyone in the room is a health care professional, I think that it's relevant for all of us – especially now more than ever as we move through this world and we encounter people who may not have the same belief system and values as us. It's an important way and an important tool to be able to facilitate discussions and hopefully to come to some kind of understanding. See, I'm already becoming more optimistic.





So the first thing we say is that we need to learn about, understand, and accept the United States' racist roots. And that's why I started by talking about white supremacy, and the social construction of race, and what that means. If we don't understand that, then we can't understand why the structures and systems are in place that have created health inequities.

“Structural racism is born of a doctrine of white supremacy that was developed to justify mass oppression, involving economic and political exploitation.” So that's a direct quote from the article, and we were really excited to see that the New England Journal of Medicine published the phrase ‘white supremacy.’ I don't think they've ever done that before, and again, I think it's an important part of moving this conversation forward.



So part of that is understanding the history of experimentation on Black communities, understanding segregation of care based on race, and that history, and why there's mistrust among a lot of Black communities when accessing the health care system.

Disparate health outcomes and systematic inequalities in terms of wealth, well-being, and quality of life must be seen as extensions of the historical context in which Black lives have been devalued. We also – oops, sorry about that.

## Our Role... Understand how racism has shaped our narrative about disparities

- Implicit biases and false beliefs are common
- We all hold them and we all must challenge them
  - Ex: Race as biologic



So, we also talk about the fact that we need to understand how racism has shaped our narrative about disparities, and that's why I always try to make the link between structural racism in health inequities and health disparities.

We need to understand why disparities exist and not talk about just those differences. We also need to recognize that implicit biases and false beliefs are common, we all have them. But if we can't... And while that's our reality, we have to be able to recognize that. And we have to be able to challenge them within ourselves and also within one another.

## Our Role...Define and name racism

- Consistent definitions and accurate vocabulary for measuring, studying, and discussing race and racism and their relationships to health
- If we acknowledge and name racism in our work, writing, research, and interactions, we can advance understanding of the distinction between racial categorization and racism and clear the way for efforts to combat the latter



We also need to define and name racism. So consistent definitions and accurate vocabulary for measuring, for studying, and discussing race and racism, and their relationships to health, particularly as a health services researcher. We put race in models – in our regression models and analytical models – all the time, without giving any thought to what it means, and without giving any thought to the fact that there's a processes, there's racism that is behind what race means in those findings.

And the same happens in clinical medicine as well, when medical students are taught to present the case by saying, so-and-so is a 60-year-old African American male. So what does that mean, why is that relevant for how you're presenting the case?



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So if we acknowledge and name racism in our work, our writing, our research, and interactions we can advance understanding of the distinction between racial categorization and racism, and clear the way for efforts to combat the latter.

I also would say, you know as I started out this talk by saying, this requires all of us to name racism, to name structural racism, to name white supremacy, and also ask the question in all of our interactions and all of what we're – you know even if we're sitting in our workplaces looking at our strategic plan – asking, “How is racism operating here?” Because I think we would be surprised at the answer in a lot of those cases.



## Our Role...Recognize racism, not just race

- Black Americans, on average, have more poorly controlled diabetes and higher rates of diabetes complications than white Americans
- Successful treatment requires attention to structural factors and social determinants of health
- Antiracism strategies are rarely recommended for improving diabetes control.



Recognize racism not just race. Black Americans on average have more poorly controlled diabetes and higher rates of diabetes complications than white Americans. So going back to my example of the link between structural racism in food accessibility, being able to recognize that the reason that poorly controlled and higher prevalence of diabetes may be linked to policies around food accessibility and the decisions of different grocery store chains as to where they're going to open up their businesses. Successful treatment is going to require attention to those structural factors, attention to the social determinants of health, and using antiracism strategies as part of, kind of, the broader way that we think about health inequities, particularly around these chronic diseases.

## Our Role... Center at the margins

- Shift viewpoint from a majority group's perspective to that of the marginalized group or groups
- Diversifying the workforce;
- Develop community driven programs and research
- Ensure that under-resourced people and communities gain positions of power
- Recognize whose narratives receive attention and voice



And finally we talk about – we use the phrase ‘center at the margins’ – which has been used in critical race theory quite a bit. And really what we mean is that we need to shift our viewpoint from a majority group's perspective to that of the marginalized group or groups. And I think... I think on the surface a lot of us who are committed to this cause are doing that in many ways, but I think we need to do more.

So that means diversifying our workforce. Making sure that the people we're serving, that they can see people in positions of power that look like them and represent them.

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Developing community driven programs and research... That's why I'm so excited about this work with the birth center. That work is driven directly from that birth center and the work that they're doing. It was their idea. These ideas don't need to come from the Academy. We've created enough of that knowledge but we need to be able to trust that the knowledge that communities possess is what the real evidence is.

Ensure that under-resourced people and communities gain positions of power... So we need to be able to look around the room and see... I would love to – I'm the only African American faculty member in my department and one of two in the School of Public Health.

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I need to see more people that look like me in positions of power in the Dean's office and in other roles. We have a lot of work to do in that respect.

And then recognize whose narratives receive attention and voice, and that's something we're talking about a lot, at least in academia. And understanding that, just because you have a PhD and can write a paper and get it published, that doesn't mean that what you say is the full narrative and the full truth. We need to really start to consider other narratives and give those narratives voice.



## Right Now...

- Create fully inclusive, equitable & safe organizations, groups, and any other spaces we can
- Work to make our communities & places of work a safe haven where all feel empowered to show up fully as themselves-
- Space where everyone can rest in the knowledge that their importance, dignity and value as human beings is unquestioned



And then, right now I think more than ever, given the events of November 8<sup>th</sup>, we need to really focus on creating fully inclusive, equitable, and safe organizations, groups, and other spaces. We need to work to make our communities and places of work a safe haven where we feel empowered to show up as ourselves, as our true authentic selves, within the work that we're doing. And we need spaces where everyone can rest in the knowledge that their importance, that their dignity, and their value as human beings is not questioned.



“We changed it, many of us, through some of the proudest struggles of our history. It wasn’t easy, and sometimes it wasn’t pretty, but we did it, together.”

-Harry Belafonte



So, I would like to close by just saying that while these U.S. election results, they are what they are, they were terrible, they’re devastating, they’re frightening on many levels, but Harry Belafonte in his New York Times article also says: “We changed it, many of us, through some of the proudest struggles of our history. It wasn’t easy, and sometimes it wasn’t pretty, but we did it, together.”

So, I’m reminding myself that fight after fight, from one generation to the next, this work is our work and it will go on. Because we will go on, we have to find ways to collectively create a world in which we can all benefit from good health and well-being. And so while I don’t feel like I have the answers right now, and I’m sure many of you are feeling the same way.

“We changed it, many of us, through some of the proudest struggles of our history. It wasn’t easy, and sometimes it wasn’t pretty, but we did it, together.”

-Harry Belafonte



And, you know, our strategies may change moving forward. I don't know. I don't know what I might be talking about in the next three months. It might shift considerably given the new climate that we're facing.

But I think Harry Belafonte's words remind us that we've done it before, and we will do it again. Thank you.



Ned: So, I get the privilege of having the first question. I did want to point out that it is a diverse group of folks in the room and for those who don't know, the New England Journal of Medicine is one of the two premiere medical journals in the entire country, and for NEMJ to be paying attention to this issue bringing those words forward, it really has a landmark feel to it. So I congratulate you.

One of the phrases you used in there was, “addressing violence against Black communities can start with antiracist practices in clinical care and research.” And I wonder if you have any examples of successes in that area, where doing something with the intervention that’s antiracist in one of those two settings made a big difference?



Dr. Hardeman: Yeah, I think I don't have any specific examples because I think we still, we haven't done that. I think it's what we need to be doing, and I draw a lot in my work from critical race theory, which really focuses on dismantling the power and privilege and the structures that have allocated privilege to certain groups and certain communities. And so part of the discussions that we have with health care professionals and researchers are around, are on just that, is setting that stage, helping people to understand those ideas and that that's very real.

And then being able to ask, even ask a patient... I have a colleague who is a general internal medicine physician and she is working to figure out ways to ask her patients how, for instance, Philando Castile being shot on July 7th by police in their community is impacting their health and well-being on that day as they walked into



the clinic. And so even practicing a level of empathy that I think is beyond what we've traditionally done within health care settings at least, is really important... a really important piece of that.

Ned: Thanks. Maggie Frasure at the front here actually has a microphone and if you hold up your hand... As does Julian at the back. If you hold up your hand, we'll get you the microphone. There's one there.

Audience: Dr. Hardeman, I think I just want to start by saying thank you. I think that you spoke words in ways that aren't often spoken and it was courageous, especially given the climate of the time, thank you. My question is... When you think about health care organizations, whether they're delivering medical or primary care or behavioral health... What do you think? Would you talk to us about





what policies you think are critical to be part of the fabric of organizations in such a way that they support the kinds of delivery of equitable care that you talked about.

Dr. Hardeman: Yeah, so thank you. It's a really great question. Can you all hear me? Oh, there we go. So... I sit on the mission effectiveness board for our county hospital in the Twin Cities area, and that serves probably the largest, has the largest percentage of patients of color and low-income patients in the state. And one of the things that we discuss a lot and have focused a lot of efforts on is one of the things I mentioned in one of my last slides around diversifying the workforce.



So, recruiting physicians from marginalized communities has been a value and a strategy that they have committed to quite a bit, and it's a long process because really if you want to do that well, you have to start way before people are in medical school. We need to start at Pre-K and kindergarten and start there to really do that effectively. And so they're trying to figure out their role as a county hospital in doing that, which is not easy and some would argue is outside of the scope of what a hospital should be doing. But I think the more health care systems, the more organizations that are thinking in that way and thinking beyond health care to the social factors and the social determinants that we hear so much about, is a really important part of that.



I also think that... Looking at policy, so policy with – “little “p” policy – right, within a health care system, within a public health organization, whatever it may be, is something that's really important. So to understand kind of – I think there's ways that we don't realize that the policies or the language we've used are not promoting what we think they are. I know that's something that the Department of Health is doing in Minnesota, and there are a lot of places using health equity scorecards right now to help them measure some of that. So those are the two things that I feel like are good places to start.



Audience: I really appreciate your research and the things you shared today, but I have a question. Is there any research that can help those in the communities with these disparities and inequities to have a voice and to be able to articulate what they are feeling and be able to understand some of the things that you shared today?

Dr. Hardeman: Yeah, I think that's a huge, huge part of it, and when I think about those... Listening to people's narratives and considering or reconsidering what evidence we decide is real is a huge part of what you just mentioned. And off the top of my head, I don't know. I think it's – right now it's individual people who are doing that work in creating those spaces.



And I haven't seen any organizations or systems that are specifically promoting that, but I know, at least in academia, there's people like Chandra Ford at UCLA, and Camara Jones, who's the current President of the APHA, the American Public Health Association, who are really committed to that. I hope it's a movement and that's what we're working towards.

Laura: Thank you very much for your remark. I'm Laura Gabbay. I had question because you're at the forefront of this, has there been any research done on the impact on health outcomes for people who then, not only have access to food and so forth, but what you're talking about is a lot about racial justice and social justice. So Carol Gilligan does some work around women from low income backgrounds who get involved in community service or social justice, and it actually impacts their mental health outcomes, on a very





measurable basis. Have you seen this elsewhere in the country? Because we're looking at this – I work for the Colorado Cross-Disability Coalition and we work with many people who have very fragile health, and yet when they get involved as social advocates or social justice advocates, we think that it's impacting not just their mental health but perhaps their attention to preventative care, and so forth.

Dr. Hardeman: Yeah, I haven't seen any research on that. It's actually something that's kind of been brewing in the back of my mind around, particularly around birth outcomes and the Black Lives Matter movement, so I will be starting a literature review on that soon, but I don't know of anything off the top of my head. I don't know if anyone in the audience does... I'm looking at Megan. Yeah, thank you.



Ned: There is some – I don't know how closely it's related and it's not necessarily in the disabled community, but a lot of the research going around the Gulf States after Deepwater Horizon, after Katrina, kind of repeated traumas to the community, have recognized that some communities bounce back quicker than others. Right? So they're all subsistence living based on seafood and fishing along the Gulf... And then trying to figure out those determinants that make one community bounce back and the other to define the world as the new normal. And what it seems to be is a sense of belonging, community and community cohesion that we think translates to resilience.

So trying to figure out how to measure those items of belonging and community support is where the research world is kind of trying to focus right now, and there's three different academic institutions along the Gulf who are taking the penalty money and trying to figure that out.



Dr. Hardeman: And I will add that there's some work around the idea of belonging and racial identity, and sociologists have done some work on that and found that it contributes to resiliency. So I actually, a couple years ago... I'm part of a research team that looks at the experiences of medical students. And so we've been tracking the same students, just under 5,000 students, since 2010, and they're now second year residents. And my particular interest has been in the experiences of underrepresented minority students in our sample, and one of the things that I've looked pretty closely at is the impact of racial identity. So having a strong self-concept and believing very strongly, that... Endorsing ideas around what it means to be African American or Black and what that means to them.



And we went in with the hypothesis that it would be protective, that be having a strong or a positive racial identity would result in better well-being, or mental well-being in particular, and found that that wasn't the case, that students who had a very strong self identity as African American were actually suffering more. And so we started looking at belonging, and how they describe feelings of inclusiveness and belonging within medical school, and it's directly related. And those spaces, I think – and we're hoping to do some qualitative work to dig into this a little more, but it seems that in these spaces that are so... Where they are very, very much part of the minority, both in the racial climate – so other work I've done is looked at the fact that a negative racial climate or diversity climate in these schools – it's 50 medical schools across the U.S. So a negative racial climate is impacting – is creating – poor well-being for everyone, for the underrepresented minorities students, but for everyone.



So we're hoping to do some qualitative work to dig into that more, and understand why racial identity isn't protective, and if it's related to this issue of belonging and inclusiveness.

Audience: Hi, thank you so much for being here. I appreciate your words and your comments. I too am one of the only, not one of, but the only faculty of color within my department, and so I get the isolation and the degree of invisibility, but the question that I have for you is that... I feel like it's a statement and a question all in one, because I think it's a double edged thing. So, there is this push for the Academy to diversify, and then when we show up, we're not really welcomed or received because there's this degree of perceived incompetence, right? So I'm constantly trying to prove that my research and my presence is just as valuable as my white colleagues. Yet, when we show up, it sort of lets people off the hook.





So, my question to you is how do you do both? And, how do you color up the workforce, but yet, have everyone still know that this is a collective responsibility, that just because I show up doesn't mean that no one else now is responsible for creating, you know, a diverse environment that fosters inclusion.

Dr. Hardeman: Yeah, I think that's a huge, huge issue and thank you for raising it. I do not have the answers to that. I think it's something that in my department... I would say, first, you know, we need allies. And creating a – I've been fortunate enough to create a strong group of allies and people who aren't going to let these issues drop, and let people off the hook, saying they checked the box because we have two faculty of color or whatever it may be.



And these allies can't be other people of color, right? They have to be white allies, or people who identify with the majority in some way. I think that's an important part of it. I would love to hear if anyone else has any thoughts, any strategies on that because I think retention is a huge piece of it. So if you don't feel like, they got you there but if you don't feel like you are welcome or included in some way, then there's no incentive to stay.

Audience: I don't have a question. I wanted to bear testimony and echo some of what you were saying, Dr. Hardeman. And I think these words are as much for me right now as they are for anyone else, but clearly it is very easy to lose hope right now, to lose heart, and you alluded to that. Ta-Nehisi Coates, he's a writer for the Atlantic and he wrote "Between the World and Me," which is a masterpiece on the experience of being Black in America. Many of you I'm sure are



familiar with this. But I listened to him speak once and he stated that the only charge he hears, or the only critique he has against his work, is not a refutation of any of the facts, because those are irrefutable. What he hears is, well, “That doesn't feel very good.” Or, “That's uncomfortable.” Or, “Where is the hope in that?”

And I heard him give a response and it stayed with me. And he said that if you were born in the early to mid 1700s, Black, in the South, you could look back a hundred-plus years to the life of your parents, the lives of your grandparents, and you would see nothing but slavery and bondage. And you could look forward a hundred-plus years into the lives of your children and your grandchildren, and see nothing but slavery and bondage. Where's the hope in that?



I think that hope is crucial, and it can serve as a catalyst for our work. But our work is bigger than hope, or even the desired outcomes that that hope is attached to. Those outcomes are often beyond our control. Ultimately we do this work because it is right, and because we must, to lay the foundation for those who will inevitably come after us, to continue our struggle at a higher elevation, and to serve and honor the legacy of those who came before us – 50 years ago, 100 years ago, two to 300 years ago – many of whom never lived to see the world that they were trying to construct and create, the world that we live in today. We have a long way to go, but we've come very, very far. And there's always been tyranny and oppression. But there've always been liberators, and here we are.

Dr. Hardeman: And here we are. Thank you.



Ned: I'm going to take this pause – Oh, go ahead.

Audience: I just have a quick question. Sorry, I couldn't see you back there. So I work for an organization that has an equity team, and I feel really thankful that we can have those conversations, but in light of recent events and the news got yesterday, I found that I'm pretty tired being like one of two people of color in the room, having the conversation of equity. So I'm wondering, what are some things you do for sustainability and how do you separate that, I don't know, in your personal life? Because I'm finding some of the struggles that I'm having are in my personal life as well with family members. So what are some things that you do outside of work and just on your own to kind of sustain that work?





Dr. Hardeman: So, I think that's a really good question for the whole audience, right? I mean we... I am certainly not the expert on that, because it's a struggle, right? It's a constant back and forth, and... You know, I personally have trouble separating the personal, the family life, and the work conversations because it's all intertwined, and part of me feels like you can't really separate it. But I would love to know if there is anyone that has any insight on that, who's sitting in this room... And it looks like there is.

Carol: I'll offer this. Hi, my name Carol. I'm from Global Minded and I have a husband who works for a technology company, and as you know, many of the technology companies have 2% minority and women. And one of their employees is this fabulous gentleman, who's originally from Africa, and does a great job. So my husband was on this leadership acceptance committee and rated him off the charts for



the fact that English is not his first language, he does a great job at work, all these reasons. But his boss's boss did not recommend him for this leadership class, so he did not have that buy-in. So, my husband went to bat for this individual and got him into the leadership class.

Part of what I think we need to put on the table here today is that we need people who are some of the Caucasian males, like my husband, who stand up and fight for, and open the door for, people of color. I think really being able to see that in a broad way. The second thing is, we were talking about this earlier, we have people on our board like Patty Lopez from Intel and she doesn't have a lot of other Latinos up at Intel in Fort Collins, so she has to build her network of support from a variety of other people – women and other folks – that support her through National Council for Women in Technology,



and through other networks. So, I think where, you know my case in my career – I was the first female assistant vice president – we have to build these coalitions of support from places sometimes other than where we're working. So, those are my two takeaways, is one, let's recruit some of the men who are willing to stand up to the people in power and fight for and open doors for diverse and LGBTQ and all kinds of other people who deserve access, and then let's ourselves realize that we can't always look to our place of work to be the place that inspires us and promotes us, but we have a number of amazing people in the communities around us and we can create those people, and be the amazing people of strength to be breaking trail where we need to be going and doing that.



Alece: I'm the Alece Montez-Griego. I work with the Orton Family Foundation and I love your question because I think we are all facing that in different networks that I belong in as well, and there's been a real conversation around self-care, because we can't always have our "equity warrior" hat on. There are times that we need to go home and be a "peace warrior" and "take-care-of-myself" warrior and, you know, some people have talked about whether you meditate or you just, you know, read a book like make sure you take time out to recharge, because it is hard work and we do go and hit our head against the brick wall every day, so...



Ned: Dr. Hardeman, I had a question about advice about “naming it” and using the word “racism.” So, there are a number of us in the room that have been here for every Health Equity Learning Series event. And, I love one of the comments that came out of our first convening of all the HELS – the Learning Series’ unfortunate acronym – the Learning Series grantees... And to paraphrase, it was, “Okay we get it, it’s racism. How do we talk about?” And what they were expressing is that in their communities – the Eastern Plains, the Western Slope – as we dribble farther out from the metro area and we leave the, I would say relative safety and comfort of audiences like this, there is a real fear and worry and a shutdown that happens with the word “racism.”





And so, I hear often, “How do we talk about it?” “How do we bring that up?” “How do we broach the word?” And then I'll tell you, I'm willing to be wrong, but I think Colorado is a little farther behind even Minnesota.

Dr. Hardeman: Yeah, I think that's the million-dollar question, right? Is, how do we have these conversations, and how do we talk about this? One of the things I, you know, try and start with a lot... Depending on the audience, is being clear that we're not talking about individual racist acts, you know. We're not talking about individual perpetrators. Because I think that's a lot of what, you know people shutdown like, “You're calling me racist,” and it has nothing, that's not it at all, in most cases.



That's not what we're talking about. So being clear about that from the outset I think it is so important. When people can start to see that we're talking about systems and we're talking about structures that, they may not have played an individual or specific role in creating, but are, by being silent, are part of that, I think that's the point I always hope to or try to get across. I think it's hard depending on where, you know we were talking about this a little bit last night at dinner, about kind of... I've been in classrooms with students where people are starting at a lot of different places in their understanding of this topic. So, starting at the beginning and starting with our history, and that's why in the New England Journal of Medicine piece, too, the first thing we say is we have to know our history. And unfortunately, that history is not being taught in our schools in the way that it always should be.



And so, I taught a... I had a four-day course – it was a Public Health Institute course where – students are around for four days, four to five hours a day. And so I had 16 hours to get from the history of white supremacy and structural racism to how it impacts health policy and health inequities. And it was really, really hard because there were some students who had no clue that it even was, that it existed in any way and just kind of had accepted that, they understood that there were disparities and had just accepted that, we've always known that, you know, Black folks, for instance, have worse health outcomes.

And actually Mary Bassett, who is the Commissioner of Health for New York City, 30 years ago – so, 30 years ago – wrote a piece called “The Health of Black Folks,” where she talked about the normalization of poor Black health and kind of how we've, as a society, accepted it as kind of the norm, and so that's part of the tools



that I use too – is to lay that out and say, you know – because people will say, “Yeah, we know that Black people are more likely to have heart disease.” Or, you know, whatever the disparity is. But then I ask question, “So why? What do you think is causing that?” And a lot of times that opens up a conversation and a door that wouldn't otherwise have been opened.

Paul: I'm Paul Aldretti with Mile High Connects. So we're doing a lot more work around health and equity. Health, specifically the social determinants of health around housing, access to food, good jobs, and the impacts of those. And... Becoming more increasingly involved with the health care industry and health care providers in communities of color and low-income communities.



I think that what's happening in Denver now in terms of displacement, in terms of gentrification, in terms of how transit is exacerbating those issues, in terms of forcing people into new communities. I've been doing a lot of thinking around segregation and how segregation exacerbates racism. Essentially, both overtly and covertly. And, as this gentrification and displacement occurs, what we're essentially doing is, I think, concentrating poverty and forcing people to live in more segregated communities than they actually lived in before.

And so, I think it's really challenging the health care providers and everyone who's in this room to think about how they engage in those conversations about racism as a byproduct of some of these things that are currently happening, like gentrification and displacement.





That health is not only an outcome of those, but it can be a driver in how we think about being better about, and more intentional about, addressing that on the front end. And so, my question – after all of that – is really, how can, how can... the health care industry or health care providers – I'm not sure exactly what you call yourselves – be more intentional about stepping up to the front on those issues?

Dr. Hardeman: Yeah, that's a really good question and one that a lot of health care systems are grappling with right now. There is a community clinic in the Twin Cities in Minneapolis that's linked to the hospital I mentioned previously that is – actually, I think is doing some really interesting work around this. So they've embedded, for instance, a lawyer in their clinic. So there's... On certain days of the week, you can go see your physician for whatever those health care needs are.



But then if the physician in that interaction realizes that... One of the examples that they use quite often is a patient who's dealing with housing issues and is going to be evicted for whatever reason. They're able to go down the hall and talk to someone who has the legal expertise to help them deal with that, because it is connected. All of those social factors are connected to our health in some way.

There's some folks at Yale who are doing some work around this, particularly with the homeless population, because they were dealing with – which a lot of cities and counties deal with – the homeless population being checked into the hospital or the ER for one reason or another, and then not having any place to send them once they are well.



And so, figuring out what the hospital or the health care system's role is in making sure that there is a link or a connection between a county hospital and transitional housing, or even a respite center that can provide some kind of temporary housing or care for patients.

So, I think we – meaning the health care system and health care professionals – are thinking about those things a lot more. And in some cases, are trying to get those structures and systems in to place to be able to more effectively serve the whole person, rather than just one component. But we have a long way to go in doing that. I think there are a lot of models outside of the U.S., too, that we can look to that are doing that quite well.



Ned: So, it's been a great dialogue and discussion today. I want to thank Dr. Hardeman again for joining us. I'm going to have to have us wrap up. I tried to start with a very positive message of hope. And it came – First of all, I really do believe that opportunities will be presented. We've now managed to open the whole wound, right? And so there's nothing hidden left. And that's an important part to start healing. I talked to my daughter last night. I reached out. So you'll know, probably, what side of the isle I might be on, but I felt the sense of that kind of natural disaster feel that makes you want to reach out to your family. I called her and she was in tears. And she works in health care and Medicare quality assurance. She's I think a little bit afraid for her job, certainly afraid for her clientele. And just so deeply saddened by the outcomes of the election. And it was hard to hear, and as you parents know, listening to a child in pain is just very, very hard.



And I realized that it really becomes my role in that setting to provide hope. I have to tell you something that she said that really got to me. She said, “It's okay, Dad. I need to wallow in this for about another day. And then I need to get to work.” And so, I'm telling you I understand the wallowing, and sharing, and the need to take care of ourselves. And I know that everyone is watching how we respond. So I hope you can respond with that sense of hope moving forward in healing that I think we're just going to have to have for this country to start moving back on the right track. And I think this is a room full of people that can do that.



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So I really appreciate you being here today. We'll post the slides from the presentation early next week at [coloradotrust.org](http://coloradotrust.org) and the video recording, probably week or two after that. You can sign up through our website to stay informed about future events via email.

The next learning series will be held on February 28th next year, featuring Lydia X Brown. Please check our website for where. I want you to help us. Make sure you take minutes to fill out the brief survey when it comes to you in an email. Share your thoughts and help us make this series better. And then finally, these are really a team effort. I have to thank the entire Colorado Trust staff for their assistance. I want to recognize Maggie Frasure for overseeing so much of the event today. And I want to thank the staff at Coffee at The Point. And of course, our friends at Open Media Foundation for everything they do to make this day possible. Thanks for being here.