I'm Ned Calonge. I'm President and CEO of the Colorado Trust.

Thank you for joining us today. This is our first health equity learning series event for the 2016 - 2017 season. And we're really pleased with those of you who've turned out.

You know in 1990 the share of Colorado's population that were immigrants was 4.3% and when we last looked in 2013
it had risen to nearly 10%.

6
00:00:32,465 --> 00:00:39,906
We’re home now to more than
half a million immigrants

7
00:00:40,373 --> 00:00:44,744
which is about the same population
as the entire state of Wyoming

8
00:00:44,744 --> 00:00:48,415
and would fill many
of our major cities in the US.

9
00:00:49,349 --> 00:00:54,587
How immigrants are integrated into
communities in Colorado and in other settings
and how they can do that in a safe, healthy and equitable manner is at the heart of today’s session.

In addition to the presentation and the discussion, there written materials at your places that can help you continue the conversation as you leave today to your other organizations.

We’re also going to send each of you an evaluation via email.

We hope you’ll take the time to fill it out. We listen to you, we respond to you
both the topics and the speakers that we consider for the health equity learning series

come from our audience as well as our grantees.

The materials will be posted on our website after the presentation.

Our presenter slide deck will be there and in about a of couple weeks
a complete video of the presentation
will also be available for viewing.

I need to acknowledge that even though
we have lots of people in the room

...there are lots of other folks. These are
our 2016 - 2017 HELS grantees.

They're scattered across the state and the difference
in this year is that after today's presentation

...and when the video is available, these grantees
will have events where they view
and look at the presentation followed by professionally facilitated discussions about what they've heard today and how to make it come alive in their communities.

So we're looking forward to really continuing this work throughout Colorado.

Now I want to introduce our speaker today.

Deliana Garcia or "Del" is Director of the International Projects Research and Development
at the Migrant Clinicians Network in Austin, Texas.

Del has dedicated more than 25 years of her life and career to the health and wellness needs of migrant and other underserved populations.

She's responsible for the development and expansion of Health Network and international bridge case management.
and patient navigation system

00:03:04,884 --> 00:03:07,720
to make available
across international borders

00:03:07,720 --> 00:03:12,125
the health records of migrants diagnosed
with infections and chronic diseases.

00:03:12,125 --> 00:03:15,461
She's performed research
and written on topics such as

00:03:15,461 --> 00:03:20,833
sexual and intimate partner violence prevention
among Latino migrant and immigrant families
trauma in transit for migrants crossing international borders

and emotionally charged dialogues between patients and healthcare providers.

I hope you'll all join me in welcoming Del to our stage and to Colorado.

So I can recall the days when I would be able to do this without my reading glasses, but those are long gone now.

So please forgive me if I stop every now and again to pull my glasses up
to make sure that I haven’t missed a point on my notes.

When I was invited to come, and I’m so thrilled and so grateful for the opportunity to be with you.

and I was trying to think about what was the critical issue that I wanted to raise with you.

it was that I feel like we find ourselves needing to identify
that point in that sphere of health equity where we want to be doing our work.

Because it's just such an enormous idea to just wrap your head around.

And so what I want to speak to is the intersection of poverty, migration, and health.

Because when you think about migration, it is huge the world over.

But it can happen for people who are doing so under wonderful economic circumstances.
and where their healthcare is really seen to
by their employer or by nationalized medicine, whatever.

So what I really want to do is focus
down then on those populations

who migrate for purposes of employment
where there's poverty that is really pushing them

and keeping them from being
able to access what they need

and then the effect of that migration on health.
But when I reflect, and I really need to upgrade my bio because it’s been 30 years.

I was trying to think about what best exemplified my own work and where I saw myself and while I was sitting there reviewing my slides, this passage came to mind:

"Would you tell me please, which way to go from here?"
"That depends a good deal on where you want to get to," said the Cat.

"I don't much care where," said Alice.
"So long as I get somewhere."

"Oh, you're sure to do that," said the Cat.
"If you only walk long enough."

And I think what's really true for so many of us, and I have a dear friend who uses this expression,

"We've been laboring in the vineyards of peace for so long, that very often we realize
that we walk back around and see our footsteps
again someplace where we've been before."

And so I think it's always very important
for us to position ourselves
to cite where we're going and to see that point
on the horizon that we're trying to get to.

So for me right now then it is to really talk about
the impact of migration on health.
And as I was preparing for this presentation...
How do we determine that we've gotten there?

And the more I read, the more that I could see in people's language that they were conflating equality with equity.

And equality is treating everyone the same. So we have performance measures that everybody needs to meet.
And goals for entry into care.

And measures for their diabetes that we want to make sure everybody achieves.

And so we look at how people should be dealt with and we want to make sure that it is happening for everyone.

But when we talk about equity it's really looking at what the individual needs to be successful.

And very often that's different, one person from another.
So one of the definitions of health equity that I came upon as I was reviewing everything was this:

"Absence of avoidable or remediable differences."

And the more I pondered it, while there are truly very few things that are unavoidable perhaps nature, a flood, whatever those things may not be avoidable.

There really isn't any reason that our recovery from that is irremediable.
There wasn't anything that I could think of at that moment where we really could not have come to a way of remediating the effects of what had occurred.

And so when I think about health equity then,

I was trying to look at all of the elements that come into play.
And when we think about what affects health and we look at things like employment,

which is one of the pieces that I focus on because it is for employment that so many of the people with whom I work leave their home and move on to the next place.

But then I think about racism and I think about how difficult it is for us to truly have a conversation about race, the effects of racism,
and the long term effect in this country on poverty that is based on the racism that has existed for decades.

And that same effect then can be seen in education, both in terms of access and quality.

And that it is individual decisions that get made about whether or not my child should have the education
that they merit and that they need

00:08:53,900 --> 00:08:57,970

versus what I see is going to be

important for my entire community.

And I had the good fortune of being at dinner

with members of the Trust board last night

and some of the staff and some of the grantees,

and this has raised a particularly important issue for me.

I have a son who is now 27

and he has Asperger's.
and I was so firmly committed to public education
that I absolutely required that he attend public school
from kindergarten all the way up to high school,
through his senior year in high school.

And on evaluation
I have moments, quietly at night
when I believe that I sacrificed
my son on the altar of public education.

Because when I look at what he needed
and what might have better served him
Would he have thrived more in a private setting?

and I don’t truly know that. And so I do have moments of extreme quiet where I wonder if I would redo the same thing. And yet, if asked about education my commitment to public education, to the demand of the citizenry to support education for all children is still true.
And so it is at this point that I really understand
what is a challenge for so many people

when they try and look at it in the global or the universal
or the large-scale versus the individual and the personal.

And I think we see some
of those same things in healthcare.

When we say, "Don't you believe people
should have access to quality healthcare?"

In general people will say, "Absolutely." And when you say
that it might have some effect on your particular access
I think some people stop and they stumble
and they're unable to embrace it completely.

And we see it now in
issues of public safety

and in terms of, do we see the police force
as an ally? Or do we see them as a challenge.

And the experience that so many
communities are having now

to try and figure out what the relationship
is going to be around issues of public safety.

And then food access. And food access is one of the pieces that I think is such an enormous challenge both urban and rural. It isn't just, is there the grocery store, but do they have what you need? Is it affordable? What does it take to get there and get back?

An advancement of ideas like community action for agriculture
and everything that has the ability to affect food access is really fairly enormous.

And one of the pieces that I like to review regularly because he is such a wonderful speaker and he makes me think so differently about food access is the Ted Talk done by Ron Finley.

He's the guerilla gardener. Yes, the guerilla gardener from LA.

And he went out and he evaluated how much public land there was in LA that was unused
and tried to talk about the amount of gardening that could be done on these public lands and the food that would then be available.

He started by using the easements in front of his house and his front yard and areas in his neighborhood that were between lanes.
and he planted food that he made available to everybody

and then the city of Los Angeles decided that they would ticket him because he was using the land for purposes that were not subscribed to by the city of Los Angeles.

It was only through public outcry and Lopez, I can't remember what his first name is who is the writer for the LA Times, that they were finally able to turn the corner on that.
And so you have people who create wonderful solutions:

it really doesn't require an enormous dollar investment:

they can bring people in to learn, to give them access. And then there are:

political challenges and legal challenges that can get raised that don't make any difference:
that then draw away time and attention that could be devoted elsewhere to try and fight that good fight.

And so I really commend to you Ron Finley. I just think he's a wonderful speaker and a wonderful community advocate.

And so when we think about equity then

in looking at the unequal distribution to and access to these resources.

And where I stop and I have to think about my own work
is in the second piece of this, which is failure to avoid or overcome the inequalities that infringe on fairness.

And that, once again, puts the onus on the individual who is challenged by those barriers, by those inequalities.

As if somehow they had the opportunity to supersede these barriers and were electing not to.

So I looked at this more as my inability to help
someone avoid or overcome those infringements.

And I see that as my challenge going forward. That where I see an infringement
do I have the ability to aid someone as an ally

so that they no longer have to look at trying to get past that infringement to fairness.

And the unfortunate reality is this is where most of us get stuck in our arguments.
If we work with small not-for-profit organizations or if we work in state government, if we work anywhere.

How many of you have been engaged in a conversation of we need to do more with less?

Or we need to make sure we get the biggest bang for our buck.

Or we need to understand that this is three years and in three years, the whole project is going to go away.

so everyone who started needs to think about the fact that they're likely going to lose their job in three years
but for the next three years they’re going to
give it a go, hit the gas and do incredible work.

And what does that require for someone mentally
to understand that this is the quadrant

in which most of the decisions are being made
around their work and their action.

I always wonder how people
are able to move forward
and I have an example from my youth.
I grew up in El Paso, Texas.

There's a convent there and I was sent to school there
by my mother for reasons that we won't go into now

but it was a really beautiful place
and I received a wonderful education.

And when it was built
at the turn of the last century,

the woman who was the head
of the convent was named Mother Praxities.
And she wanted to have a convent, a chapel, a theater, and a full school.

And they kept trying to say, "Mother Praxities, there isn't enough money."

And her response then was, "God will provide."

And so they built the school and they built the convent.
and then they ran out of money
and so she built half of the chapel.

And said, "Well the city hasn't
provided us with what we need."

And the embarrassment to the community was such
that the money was immediately raised.

And then Mother Praxities
was able to say, "God provided."

How we choose to raise what we need
and take the action that we do
at times may be uncomfortable and certainly make people feel that they've been highlighted and marginalized and narrowed for their position but very often it does take a willingness to step forward in the spotlight in a way that makes a lot of people uncomfortable.
And so that's the case. Is that in rare instances, can we go it alone?

That it really does require that we look to our allies, that we look to our partners to really be successful in what we're doing.

But it also means that we need to be clear about our own work because very often we're moving so hard and so fast and we're so grateful for any recognition.
or we're so grateful for any kind of funding
and we really feel like we're on the road

and then suddenly we get to that block
where we have a funder who says

"I absolutely want to support what you're doing
but I'd like for you to double the numbers of people

that you're going to reach and I need for you
to split the money with these six other groups."

And then you have to stop.
And so I think many people have had that experience.

I think of a wonderful group that I work with out of Oakland, where they've been looking at incarceration and kids and they wanted, 10 years ago, to be thought leaders. And they really push the work and they really got into community and they did some great stuff.
And then they started to receive recognition
and then they started to receive funding

00:17:32,751 --> 00:17:36,355

and then they were being invited
to all of those conversations

00:17:36,355 --> 00:17:40,325

where they had not been invited before
to be able to set the agenda.

00:17:40,325 --> 00:17:45,230

And then when they got there
they realized that the money was tied

to working with individuals and organizations
that did not share their commitment to community
that didn’t hold the same vision
and that felt a good outcome was

a series of meetings
to discuss our issues.

And that left them stopped and having to come back in
and reconsider how they wanted to work organizationally.

So I think that that’s one of the pieces is that we need
to understand what our position is going to be

We have to come back
and reevaluate it.

We really do need to look across the horizon to individuals that are going to be allies.

It needs to be okay to say, "This is not someone with whom I can ally."

because we do not share the same decisions of how we want to move forward in community.

It doesn't mean that we need to tear one another down, but it doesn't mean that we need to tie ourselves
into an ungraceful three-legged race
with a group that really does not support our work,

merely because we feel like somehow we lose potency
for our position when we say, "No, thank you."

I would encourage you all to look at a group
out of Florida. It’s the Immokalee’s workers

and they’re the individuals that pushed
for the penny-a-pound extra for tomatoes.

They held out against farmers in Florida
and they were able eventually
to successfully rally
for an extra penny a pound.

And what that really meant for the pay of the farmworkers
that they represented was really enormous.

But what the Immokalee workers have decided
is that they will not take any money

from a foundation or an organization.
They don't take it from the federal government
because they feel that they are an organization of the workers
and the workers need to decide the work to be done.

00:19:34,173 --> 00:19:39,211
And that if they take money then it comes
with a requirement that you see through

00:19:39,211 --> 00:19:41,980
to the end whatever the donor
would like for you to do.

00:19:41,980 --> 00:19:47,519
And I think that's a really interesting challenge
because they've been incredibly successful in Florida

00:19:47,519 --> 00:19:53,859
without the kind of support that we often believe is essential.
So I would recommend that you give them a look.
And I think the other piece that’s also really critical when we look at the areas that we engage in because they somehow advance equity like law reform or economic capacity or social relationships. When we are really steeped in trying to look at those reforms or trying to push the advancement
of someone's economic capacity

236
00:20:19,318 --> 00:20:24,289
or develop those strong relationships,
that what can also happen

237
00:20:24,289 --> 00:20:31,230
is that we get seduced by that work. And then
the law reform really becomes position power.

238
00:20:31,230 --> 00:20:35,601
And economic capacity really becomes
the wealth of the organization

239
00:20:35,601 --> 00:20:40,606
or the organizations with whom we've worked.
And their ability to stay the course
to be true to the mission gets challenged, because who wants to have their funding threatened?

And then when you start to have connections with individuals it is no longer that you have this wonderful frame for allies but that then you have prestige. And how do you turn loose of that prestige?

And so each element can have two sides to that same coin
and it's very difficult not to be drawn,
and this is my expression, to the dark side

when you're really trying to advance
all of your good work.

And so, because I'm not
above dropping names

I want to say that my good fortune
has included working with folks like Paul Farmer.
And I was really fortunate to meet the people
at Partners In Health, including Paul

and Jim Kim, who is now
the president of the World Bank,

and Ophelia Dahl, who were the founders
at a time when they were really trying
to get Partners In Health
moving forward.

And their phrase in those early days
was "preferential options the poor."
that everything you did had
to be based in the clear knowledge

that when you were
deciding what action to take

the choice you made had to
make a preference for the poor.

And that was really quite remarkable because
we have many organizations that speak beautifully

about caring for the poor, but what is your
decision-making process? And that was wonderful to watch.

And so I had the opportunity to visit Haiti with them.

and at one point Paul was speaking to a woman who was receiving treatment for TB disease.

and he asked her, what I think is the universally important question that we ask patients,

"What do you think caused your illness?"

And her response to him was, "The evil eye."
And so he stopped and asked her, "Well if you believe it was the evil eye, then why do you take your medication so consistently?"

And she just looked at him and she patted him on the arm and she said, "Oh young man, you don't understand complexity."

And that's really the issue, is that what people are faced with is enormously complex.
And so really why don't we talk about complexity?

What is it that causes us to shy away from the conversations about complexity that could take us so far down the line.

And I'll offer you an example of something that you might recognize if you're engaged in healthcare.
We can say we have a young man, he comes to a clinic or he's been brought into care through the outreach because we're all trying to get out into community and bring people into care

and we realize that he would be eligible to services because we can classify him as homeless.

And so he comes in, he hasn't accessed care in the US. Great, this is a new user!

Another great category for health care very often.
And he has arrived from Honduras, although he says he came from Mexico.

So we're not quite sure the migration story because immigration holds a lot not an enormous amount actually, but a lot more perhaps acceptance for someone fleeing Honduras than someone who comes from Mexico. And so we see migrants making all sorts of choices to decide declaring
where they're coming from.

And the presumption we make is he is an economic migrant.

He's come to improve his lot in life, to work differently.

But this needed to be modified and I had modified it in my slides.

His concern is that he might have HIV.
But when you look at someone and you make the presumption that they're coming for economic reasons the place that you might not get to is that really he is a sexual migrant. And he has engaged in some experiences in his own country where then he's left with questions about whether or not he has put himself at risk and this might actually be an accurate diagnosis. But where did he come from? How is it that we pay
for our care to him? What does he qualify for?

291

00:24:53,725 --> 00:24:59,764

Where is he eligible? We don't have any medical records from before so this is all fresh.

292

00:24:59,764 --> 00:25:03,268

How deeply do we go in evaluating his health?

293

00:25:03,268 --> 00:25:10,108

And then if he is here as an economic migrant, can we charge the inevitable sliding fee scale?

294

00:25:10,108 --> 00:25:13,879

And so there's all of these pieces that come into play very often
with people of goodwill who are trying to provide healthcare.

But what happens is then it results in a number of missed opportunities.

Clinicians are not able to speak with one another because they're moving so fast.

We hear from health centers that clinicians have a panel so large that they have from seven to eleven minutes to speak to a patient in their exam room.
That they pass their colleague in the hall and there really is no opportunity to do a warm handoff

or to have spoken to someone from eligibility to say this was a question that was raised.

So do we ask all the right questions? Has this young man been evaluated for other STIs?

Have we contemplated hepatitis C which is actually so much more likely?
Are we doing a review of what is likeliest
to make this young man sick in the next five years

as opposed to our population calculations
of what it is that we're likely to see among Latinos.

And then, are we truly engaged
in a conversation with the patient

about what he needs, what his concerns include,
what it is that he would require from us that would really

maybe be much simpler than what we're going to put
him through when we do get him into the exam room
because in our seven minutes, how much do we want to try and do?

Because his eligibility means that he may not have a huge dollar amount to deal with

do we limit the care that we provide or do we go for the gold standard and then have to figure out later on

what to do when that pot of money runs out before the end of the fiscal year.

So there are so many missed opportunities
that people have to come up against

because of the challenges to the decisions that they make.

And it's everywhere. It's not just what we face day-to-day

in our work setting. It's what we are engaged in when we talk about funding.

It's what's going on in our own homes. It's what we hear on the radio.
It’s on a huge scale. There are so many points of intersection.

And really then, how do we tease them all out?

And I think that what you get is what many of us experience, which is that we lower our head and we hope that whatever tsunami is approaching will pass over us and flow away and leave us standing so we that we can go on marching through our work.
Because if we grapple with every single thing that comes our way then we are ineffective, the fatigue overtakes us and we have what my friend says, which is that you should get a job in an industry that pays a lot of money and give all your money away.
I think it's really very hard for
those of us who want to stay

and really want to work hard to see our way clear
through a path where we feel that we can be effective.

And I think that that's
really the critical piece.

And very often we don't because
it's challenging, what's going on out there.

And I think that we would also
have to be willing to look explicitly
at our own beliefs and experiences.

And what does that mean in how we interact with somebody?

And if it's an emotionally charged topic, are we going to be able to stand there and grapple with our own individual sense of discretion about whether or not you should talk to someone boldly and clearly about what's happening.
I hear the expression "conflict averse" and certainly

conflict at all its levels
makes people very uncomfortable

even small conflicts about office materials,
all the way up to larger conflicts

about pay equity in the same organization that is
trying to do the health equity work that we're describing.
And the choices that get made for how people are able to move up the ranks.

And the way evaluation is conducted very often requires that we look at our own personal beliefs and experiences and then be willing to grapple with it.

When you look at in healthcare, the piece that I always point to is I was doing an evaluation of clinicians in their engagement in emotionally charged conversations with their patients around STIs.
And I’m standing in an exam room partitioned off, I can see the clinician, I can’t see the young man directly

and she is looking down at her clipboard and she is ticking through everything that she needs to do

and she says to him, "Do you use condoms?"

"With every act of intercourse?" That’s how she phrases it. "Do you use condoms with every act of intercourse?"

And he says, "With women?" And she never looks up
and she says, "Yes." And he says, "Yes."

351

00:30:11,176 --> 00:30:16,781
And on we go to the next question.
I was a woman with her hair on fire.

352

00:30:16,781 --> 00:30:22,353
I didn't know what to do because at that point,
I couldn't intervene. That was not my role

353

00:30:22,353 --> 00:30:27,625
but we were going to let this man walk out
possibly from the only encounter

354

00:30:27,625 --> 00:30:32,096
he would have an STI clinic
and that answer was hanging in the air.
We would be confronted with trying to decide, do we intervene in a situation where we have not been explicitly included to try and course correct something that we see going on. That’s very hard to do.

As we look at out, we really need to understand that a lot of these values are unconscious.

We walk through our lives believing ourselves to be good people.
and I think that we truly are, by and large, good people

and want to do right by the folks that we purport to help and with whom we are engaged

but we also have at our core those unknown values, those unconscious values,

that can come out in very unexpected moments.
And what is it
that we do with that?

But as we look at the world and as
we understand that globalization

is going to increase the occasions when we need
to interact with somebody very different than ourselves

that we see we are no longer going to really
have the ability to set some of those things aside

and narrow our focus and channel our efforts
only in the area where we feel comfortable.
Really as the world becomes one place,

we're going to have to think about how we interact with people different than ourselves,

the other of us, and really grapple with the emotions that rise up,

our sentiment around what that means and then what it is that we might need to do for ourselves.

Because this is the reality.
244 million international migrants last year.

That's up from 2013 when it was 232 million.

So the world is just moving. And just in our own room, how many of you moved for school?

How many of you moved for a job?

How many of you moved in the military?
How many of you moved because your parents were in the military?

379

How many moved because economically where you were living was no longer viable and you needed to go elsewhere?

380

There are so many categories that move people away and yet, if we reflect on ourselves, we don't term ourselves migrants.

382

we want to categorize that as the other. But the causes of movement of humans
is millennial old and
at the core of health

is the migration of human beings and the movement
of those illnesses from one location to another.

So we need to stop seeing migration as an aberration,
as something that only happens elsewhere

and really understand that it is the casual or the extreme
movement of humans that we need to be concerned with
and that movement can really have a significant effect on health and the health of our communities.

388
00:33:30,908 --> 00:33:35,780
I think it’s really true as communities start to change.

389
00:33:35,780 --> 00:33:43,621
I know that in northern Colorado for decades Latino migrants engaged in agriculture was the huge reality.

390
00:33:43,621 --> 00:33:51,396
Yet as time has gone on, there’s been a challenge by the introduction of Somali migrants

391
00:33:51,396 --> 00:33:56,267
who then were able to engage in agriculture because they had come from a part of the world
where they had been involved in agriculture, but they came with a green card.

and they came with access to Medicaid and it made it much safer for many of those communities to then turn to that population for their workforce.

and eliminate the workforce that had been there historically for decades.

So when we start talking about culture
then we really need to think about the broader piece of how we articulate culture.

The culture of agriculture,

the culture of farmworkers,

the culture of migrants,

because we can hold one definition and have held it for decades and realize in a heartbeat that it's no longer true.

And yet we're not incorrect in believing that we need to focus there
but that how it needs to look
will really change.

When we talk about migration,
this is the place where I find myself
most focused and where I think
most of us can be putting our energy.

It is with the ability to drive down
vulnerabilities and increase opportunities.

It has to be
a measure of both.
If we can look at those places where the people for whom we are concerned are challenged with a vulnerability and also look at a place where there might be opportunities for them to better their position and feel stronger in their orientation of taking care of themselves, that we do a great deal.

This is one of the places that I think we struggle the most.
So much of our healthcare is provided through funding from governmental organizations.

If you look at the national level, the same government that's trying to encourage us to bring people into care and make sure that they utilize the services are the same government that has immigration policies that seeks to find people, incarcerate them, and return them to their country.
We find ourselves in a very difficult place of trying to speak to individuals and help them understand the nuance of what that might mean in their own lives.

We want them to step out of the shadows and take advantage of healthcare but we really know that by stepping out of that shadow they can put themselves at enormous risk.

So that’s a very difficult thing
for us to negotiate.

But as we were doing that, I want to offer you just a couple of examples so that you see also at the personal level and not just at the large level when we talk about the intersection of poverty and health.

This is the case of a man that we worked with in the Health Network project that Ned was talking about earlier.
He came from Guatemala
and was diagnosed with pulmonary TB.

Young man, but who knows
what the source case had been.

He now needs to move around
because there is no money without work.

If there's no work where he is,
he cannot stay.

But if we know that his treatment
is at least going to take six months
but if there's any kind of break it extends it,
then we need to follow him from place to place.

He kept calling and saying, "Nope, can't stay
in New Jersey. I need to go south."

So then we call Florida and he'd be like,
"I'm not going to stay in Florida any longer

because the work there really didn't pan out.
Now I'm gonna go to North Dakota."
Then we call North Dakota.

"I'm not going to stay there any longer."

00:37:19,737 --> 00:37:22,573

I'm going to go back and do
Christmas trees in North Carolina."

00:37:23,674 --> 00:37:28,779

Because what forces him is the need
to be able to provide for his family.

00:37:28,779 --> 00:37:32,350

That's economic and that's based
on the availability of work.

00:37:32,350 --> 00:37:36,921

But the only way we make sure
that he doesn't die from a fully treatable,
curable disease, is to make sure that we keep track of him.

That is where we through Migrant Clinicians Network have begun to see our work.

If we can reduce his vulnerability to illness, which is curable,

by providing him with the opportunity to access that care

regardless of where he goes,
then we know we've done a good job for him.

Another example would be
the young woman who's 18 years old.

It's always very interesting for me to talk about pregnancy
and the need for prenatal care in terms of healthcare

because by and large women who are pregnant
do not think they're sick. They're just pregnant.

So they're trying to move on with their lives
and get the kind of care that they need.
We worked with this young woman
and she had to move because she neither drove

nor was in charge of the housing,
nor had the money to take care of herself.

So if she didn’t leave with the group
that was going to provide her transportation

she was going to be stranded, there wasn’t work anywhere,
and she was going to lose her living circumstances.

So what we did was we allowed her to move
and make sure that she caught up.
We had an example of a woman who was going to leave Michigan for Florida at 39 weeks of pregnancy.

I had a moment and I must honestly admit where I said, "Can't you stay?"

I no sooner had those words out of my mouth then I thought, "Well of course she can't stay. If she could, she would."

But she wasn't going to have housing. There was no more work.
There was work waiting for her in Florida,
there were people who would let her live

and there was someone who was willing to
drive her and make her one of their passengers.

So at 39 weeks, we sent
her medical records to Florida

we found an OB that was willing to take her
at that point and she delivered a healthy baby.

But what it took to convince someone
that she was not a high-risk pregnancy
because we could document her care throughout the entire period of her pregnancy.

was really pretty remarkable and it took the good faith of a clinician that was willing to work with us.

So these are the cases that we see daily where it really is that intersection of the need to migrate to keep poverty at bay.

and the effect that it has on their health.
can really be quite enormous.

But the place where I find myself almost wholly unsuccessful

and I wish I understood better and this is something that I would love to learn from you and other colleagues

is truly how we can address stigma.

Stigma of individuals coming into communities to do important work,
to perhaps do work that no one else wants
to do that’s essential for what goes on

that keeps them from coming forward
and requesting services that are not unreasonable

and not even services
that they’re not going to pay for

that they are going to be willing to
step forward and pay what they can

and see that they are compliant
with what’s being requested of them.
But the stigma that's out in our communities now,

for me and in my perspective, is only increasing.

This is the one place where I find myself losing ground and I'm not quite sure what the answer is.

I would love during our discussion to hear more from you about what you see going on in your communities.
This is another example of a case where it was her own sense of feeling stigmatized and the stigma that she was experiencing as she sought care.

It was a woman who was enrolled in a southern site again for prenatal care.

Older than average, in her late 30s, for prenatal care.

She stated early on when we enrolled her that she really wasn't eating well,
that she wasn't taking very good care of herself, but that she needed to move.

We were able to get her into care further north. And when she showed up there, then we started getting calls:

"Your patient is missing her appointments. She is been noncompliant."

We really tried to engage with her and understand what was going on.

We have a wonderful caseworker
who was calling her regularly

and asking what was going on and
the woman declared feeling numb and sad

and being unable to continue. And finally
over time, even as she kept moving,

and our young worker
got her in to see a therapist,

what we finally discovered was this trauma
that’s referred to in the second panel.
She had left a 14-year-old daughter in a Central American country

and the young woman committed suicide by drinking pesticides.

So here's a woman, newly pregnant, bringing another life into the world, having to witness that a life she left behind ended when she was not there to attend to it and perhaps intervene.
So now we have someone who doesn't want to stay pregnant,

who doesn't even really, in many cases, want to stay alive.

But we brought her in, she was able to get some counseling, and eventually the woman declared that she really didn't see that the therapist was doing her any good anymore and so she didn't want to see her.
But how wonderful
that she stayed in care.

She was due in February. We did receive
word that she had a normal delivery.

But then we lost her
and we never heard from her again.

So we don't know what the end
result is for this particular woman.

But along the line, and I really want to credit
the young woman from our staff who worked with her
to really at least get her to a point of a normal healthy delivery.

Because I have to be honest and say my colleagues along the way wanted to find fault with her and her behavior without really truly understanding her motivation.

When we look at vulnerabilities for workers, it's so many things that we talk about.
It's language, culture, dangerous work,
immigration, lack of regulatory protections,

healthcare access. A number of items that keep
coming up over and over and over again.

I think that we really do need to pick the occasions
where we can try and have some effect.

I have colleagues that are looking at dangerous work.
They look at the lack of regulatory protections.

We make small inroads.
We've just now been very successful
in challenging the EPA to translate the labels on pesticides into Spanish.

You would not think that that would be such an enormous improvement or that it would take so much but that was a 10 year battle.

That one regulatory piece took a lot of energy.

We go through trying to see,
is there a way to do

521

00:44:53,457 --> 00:44:57,027

an intervention for

workers that are in danger.

522

00:44:57,027 --> 00:45:02,433

You'll call a state and they'll say, "For a state

of millions of people, there are three regulators."

523

00:45:02,433 --> 00:45:07,871

They might get to you once every two years.

And they might find fault with how

524

00:45:07,871 --> 00:45:11,875

a company is protecting their

workers and they might cite them

525
but the organization really doesn't pay the fine
and then you have to take them to court

to make that challenge stick.
It’s this sort of cyclical event

that very often anyone who is not
working to the best interest of workers
can challenge it by not moving and dragging
their feet long enough that very little goes on.

Immigration changes and it becomes a federal issue
that can have state and local implications
as well as access and use of funds. So these vulnerabilities, no matter how long we’ve been working on them, continue to remain in place and then continue to reemerge as the populations change.

What I ask individuals to do then is to think about examples where they might be experiencing some of this and reflect on what that experience is really saying to them.
If you’ve worked with someone and you start to feel impatience rise or you’re annoyed

You’re engaged with someone and at the moment it may be that they’re not just trying to be obstreperous

and not listen to what you’re saying. It’s that really, they’re feeling concerned or confused

and when you’re annoyance rises because you’re in a hurry, then perhaps it requires that we reflect on ourselves.

Or if personal questions get asked and it reflects to your perception
a cultural need that they're being a little bit offensive and a little bit invasive

and really what's being expressed is just a need to say, "I need to trust you."

Tell me a little bit more so that I feel confident about what you're saying to me."

Or if they repeat your instructions verbatim it could be that they really did not understand what you're saying and they're hoping that by just repeating the words
it will somehow make a little bit more sense.

So perhaps rephrasing.
And then hesitation.

And hesitation when you offer
a point and nothing comes back.

You may have hit a wall. I think we just need
to take a second look at those moments.

And this for me
is the new golden rule.
I'm not asking that you treat other people the way you want to be treated.

I'm asking you to take a moment to truly learn to treat people the way they want to be treated because it can be very, very different.

To highlight what many of you probably already know,

but is the motivation for my work and really reminds me why
is that every single day we need to realize
that two Latino workers die.

That one in four
construction workers are Latino

and that is one of the most
dangerous industries in the country.

Our representation both in that workforce
and in the mortality rate is enormous.
In every group then we can look at, agriculture is certainly very dangerous,
large penned animals, construction, being out in the field, gardening.

All of these elements really do require that we look around us and see where there is danger to workers that we might be able to respond to.

These are just examples from the newspaper in 2015 and early 2016.
of individuals. A man who was struck by a truck while he was mowing grass on a highway.

Or a young man that drowned in a waste pool at a location.

Or another young man who was working in construction and a marble slab fell on him.

The variety of dangers that workers confront are huge.

And the safety of those sites
really is not well monitored

because there are not enough inspectors
to go out there and look at that.

And so allying ourselves with individuals
who are trying to take a hard look

at worker safety I think is one of
the places where we can do a lot for health.

So this is a patient’s stroll
through a health center.
And I tried to do this from the perspective of what the patient sees.

The patient walks in and maybe the first person they see is at the front desk.

This was an amazing occurrence to me. I went to a health center in Georgia and I was doing some training on family planning for Latinas and how it is that we might reach out to them and really make it a more exceptional and acceptable service.
I had a woman raise her hand and say to me,
"I want you to know that in my memory

those services were not available
to me and my family.

And now you're asking me
to extend myself to someone else

who might not even be here legally. You need
to understand how difficult that is." And I stopped.
Because the person greeting you comes to their job with their own history and their own experience.

581
00:50:21,752 --> 00:50:25,088
The person arriving may not understand.

582
00:50:25,088 --> 00:50:29,559
And it’s certainly not that we can ask the patient to understand but we should work with our staff.

583
00:50:30,127 --> 00:50:34,231
Because we also have the experience, and this was at a different health center,

584
00:50:34,231 --> 00:50:38,702
where I spoke to some eligibility workers and what they said to me was,
"You know no one in my family ever took a benefit. My family didn't need to take a benefit."

As a point of pride, which I want to support, absolutely.

If you are proud of your family, you deserve to be proud of your family.

That you see the need and the use of benefits as a negative for the people that you are assessing.
that's a critical challenge.

And then we have members of our healthcare team who don't see themselves as a member of the healthcare team. They see themselves as a cog in the wheel often. They're just working along trying to get through the volume of work that's required of them in a day.
Yet they can be critically positioned in a place that can deeply affect our patients.

I was doing hepatitis C project and I was talking to a lot of lab workers and they were so fixated on making sure that the barcode matched the name, matched the barcode on the wrist, matched what they were trying to conclude from the tests. They were not looking at the patient in the eye and the patient was asked to be there
so that they could give blood

without any explanation of the process,

of what it meant, of any quelling of their fears.

That was a very interesting piece for me to observe.

Then something as simple as the medical

assistant speaking the same language

but idiomatically having some places where

they don’t match. Using some terms that are not good.
Truly not being fully competent in that language.

Then being tasked to report what the patient is saying to someone who's going then to be making healthcare decisions. So that was a difficult piece to look at as well.

Then finally we have the clinician who's going to try very hard.

I think if you ask the clinician, "Do you want to give your patient the best healthcare possible?"
The answer would be "Yes." And if you ask the patient, "Do you want to get the best healthcare you can?"

They would say, "Yes." Does it mean the same thing? Not always and really frequently, no. Not the same.

So it's that whole understanding of what is best for your patient and listening to the patient about what they feel is the problem and what it is that they could use.
and it's an old book now,

"The Spirit Catches You and You Fall Down,"
I really recommend that you go back to it.

Because in the face of trying to provide good care,

we're also looking at different care structures and pay structures and we're trying to do the systems part of it and the mechanics of it
as we're trying to do
the human engagement part of it

and the real addressing about
what our communities might need

and being receptive to changes
and understanding all of the elements.

I think it's at that juncture that we're
asking people to juggle a great deal.

How it is that you decide the right course
of action to take I think is really difficult.
Right now my particular irritation is that while I am certainly encouraged at the Affordable Care Act and that it has done so much to bring so many people into care who were not in care before, it explicitly excluded undocumented migrants.

So for me it was very difficult to do the great hallelujah and feel like we were moving forward
if what we want to do is guarantee advances
on the backs of people who deeply need that resource.

So what's our course of action?
I think the very practical piece of it is that we need to really think long and hard
about what we can do organizationally and individually.

And that we want to look
at both what's going on internally
and with our partners in the community. So it means
that we really need to have a defined set of values,
policies, and practices that we articulate with one another, and that we agree on and that we revisit.

Once stated is not solid. Once stated is just once stated and they must be reiterated.

We have to build that capacity to gain cultural knowledge and values, and understand the strength and the diversity.

I offer this as a simple example.

I been doing this a million years now.
says, "Latinos are fatalistic."

And I say, "Okay, well, if you are poor
and you live in rural Mexico

and you're diagnosed with stage IV cancer
and there's no money for transportation

and you don't live near enough to services
and you say out loud, 'I am going to die from my cancer.'"

Is that you being
fatalistic or pragmatic?
And it’s pragmatism. So, I ask us all to look at the values in the culture and really understand.

And trying to navigate those differences can be very difficult, absolutely.

So we need to challenge one another but we also need to support one another because it is a hard row.

Then we need to look at our own organizations and our own interactions for the biases that are propagated and remain in place.
Because we are an organization committed to doing good doesn't mean that everything we do internally is good.

So we need to take a hard and fast look at our organizations.

We're going to value diversity, look at some self assessment that is ongoing, and that we look at those dynamic differences and not try to quell them and make everybody the same
but that really the institution understands
that there are cultural differences

and that they're present in our organizations
and present in our communities

and we really want to address
the imbalance of power.

That means inside our own organizations,
as well as outside in our communities.

I see this in health centers right now that are putting
a lot of pressure on community health workers
to be out there and to be the voice of the health center and the messenger for health services

and the group that's recruiting patients into care.

Yet they have no power on the clinical team, no champion in the clinical setting,

and no way to change the culture and the environment of the health center.

So I really ask us to look at those pieces.
And then personally, I ask us all to be present and take risks and lower your defenses because if we can be flexible,

if we can look at alternative perspectives and really think that no matter how old we are,

and I have a friend who says to me, "You're as old as dirt." Okay. We're not too old to learn.

If we can just give ourselves those opportunities and welcome them
and know that it may be difficult
but we really can do a great job.

I always like to leave people with at least one instrument,
one tool that I think can make our work better.

This is specifically for healthcare.
We can do it also in other settings.

But where we take a long-standing practice,
the clinical history, the medical history,
and we look at deepening it and getting more
information that can give us a better understanding
of the person that's in front of us.

So that when we talk about

do you live in an apartment, a house,
a trailer, or with other people.

And we just get the answer of,

"Yes, I live in apartment."

But we don't follow it up with, "Is that really
where you sleep? Do you feel safe there?"
Are you sharing that space with
other people who are engaged in

using drugs, in selling drugs?"
So that you then feel like you are challenged.

And going all the way down to this area
at the bottom about presumed worthiness.

Ask the person if they consider themselves
to be someone who deserves good care

and who understands that
you want them to have that care
and that you all are
in alliance with one another.

It's one of the last slides in your packet. You have
some of the work that I've drawn from there as articles.

You have one of the very
early articles from Paul Farmer

when he talks about people like ourselves
who want to be out there championing good

are often the prophets and prophetic
voices are not always well received.

There’s an article there about deservingness and how people make decisions about who deserves what and who doesn’t.

I really recommend them all to you and hope that you and I can engage in conversation both here and further in time. Thank you so much.

NED: That was terrific, Deliana.

DELIANA: Thank you.
NED: I'm going to ask for questions from the group.

A couple of comments. The microphones, there's one here and one here. You'll have to move to the microphones.

I want to make sure that our Spanish speakers feel comfortable asking a question. Our interpreters will interpret it, for me anyway.

Everyone should have an opportunity.
I might get started with a question then. A lot of your work with the Migrant Clinicians Network looks at ending health disparities or providing healthcare.

I'm wondering if you can talk about an example in another state or different locale where you had a success in that area. What did it take? What where the elements that led to the success?

DELIANA: I offer the individual cases that we went through
in the presentations as some of our examples of success.

I think what it has really meant is that we've understood the systems that were in place,

we asked the patient specifically what it is that they wanted,

we sought those specific steps and replied in a way that then the person could say to us,

"This is what I want to see happen," versus, "This is what we believe you should see done."
01:01:16,939 --> 01:01:26,749

We've done this with tuberculosis. We now, through our system
which we've been doing for 20 years, have followed close to

701

01:01:26,749 --> 01:01:33,423

we had about 8000 patients come through the system
but we've followed about 500 cases of active TB.

702

01:01:34,057 --> 01:01:39,562

To 111 countries. From the US
to 111 other countries.

703

01:01:39,562 --> 01:01:46,235

And I can say to you that treatment completion
has been guaranteed for 84% of those cases.

704

01:01:47,403 --> 01:01:51,708

If you look at what the CDC
is able to do in the US,
it's about 87% for people who stay in their community and receive treatment.

And we're able to do that for people who are moving around the globe.

So it's understanding your systems, seeing good partners,
and engaging with the patient to make sure that they are getting what they want.

01:02:10,927 --> 01:02:16,432

NED: I was thinking about TB and HIV and a little bit about pregnancy.

01:02:23,372 --> 01:02:27,009

NED: This isn't supposed to be a cynical question.

Fair enough? DELIANA: Fair enough.

01:02:27,009 --> 01:02:32,749

NED: There's a little bit of an additional sense of urgency, especially around infectious diseases

01:02:32,749 --> 01:02:36,319

that I think helps garner interest and resources.
I wonder if there are examples around other conditions that don’t have that transmissibility, such as an abnormal pap smear. And taking the same person, who’s moving from state to state, who we, in our infinite knowledge, have provided a lifesaving screening. The actual condition is a more
of a risk to the person herself

01:03:05,581 --> 01:03:09,018

so there isn't that sense of,
we need to protect other people.

01:03:09,018 --> 01:03:17,693

Are there any differences in addressing chronic diseases
or diseases that don't have that sense of risk to others?

01:03:18,728 --> 01:03:25,468

DELIANA: There is and then there isn't.
I think that we started our work with TB

01:03:25,468 --> 01:03:31,440

because it was our position that mobility and migration
should never be an impediment to health.
The way we wanted to prove that was to show you that we could take someone with a condition that required treatment and see it through to the end successfully.

Now, we didn't have any money to do it. TB had a public mandate.

That treatment is free of charge and so that's why we started there.

But as soon as we did that somebody said, "That's because TB is a public health mandate."
So then we started working with cancer.

Because we wanted to say, here was someone with an urgent need of their own where healthcare is not guaranteed and the end result could be the same:

They could die, in the same way that someone dies from TB.
And so we did and we showed that you could do that.

Then they said, "Well, what if it's not as urgent as cancer?"

733
01:04:16,452 --> 01:04:23,025
So then we added diabetes to say we could show chronic disease that requires a lifetime of management.

734
01:04:23,025 --> 01:04:27,630
So yes, the urgency of something being communicable

735
01:04:27,630 --> 01:04:32,702
makes the community and the public health community a little bit more responsive

736
01:04:32,702 --> 01:04:37,673
but our work has always been to say, the endpoint is the same for us.
Migration should never impede health and we can show you that that can be the case.

You can move around and we can make sure that you can get into care and if we work in partnership, we can keep you as healthy as possible. So that's what we've been doing.

NED: Great. Thank you.

Question here?

ANNE: Rev. Dr. Anne Rice-Jones. Together Colorado
Greater Metro Denver Ministerial Alliance.

We here in Colorado have an initiative, a ballot issue, Colorado Care, that is one of the first single-payer universal health concepts.

Can you share with us the potential for us ever really getting that in place?

And are there other places looking at it? I know it has to have value
because the Koch brothers are fighting it and people are looking at the propaganda and accepting it.

Tell us a bit about universal and how that would help us all.

DELIANA: I think it’s a long way off in this country because payment for healthcare services is such a big business.

That makes it a real challenge. And I think because so many healthcare services, healthcare delivery systems,

are independent businesses,

that makes it a challenge as well.
But I think that as the world becomes more globalized and you have individuals coming to this country from other parts of the world where they do have nationalized health services and single-payer and they are able to see the stark differences between what they've come from and what they're experiencing here, that greater and greater momentum is built around it.
What it takes, as with so many things,
is a single state rising to the challenge,
willing to buy in,
demonstrating its effectiveness,

offering other states the template of how they
were able to make it work, that you then can build on it.

But I would really be remiss if I didn't say
that the challenge is fairly enormous.

The likelihood, and this is my pessimism,
of seeing it in my lifetime is really pretty bleak.
TRACY: I’m Tracy. I work with the Department of Health and Human Services and I specifically support the Title X family planning program here in the region.

I'm specifically interested in the imbalance of powers that you talked about towards the end because that's something that we very commonly see when we go out and we do a review at the health center level.

And the idea behind this patient centered approach
where we really want to understand the whole patient

and that empowerment at the level
of the providers that are seeing it

but the leadership level, whether they’re clinical or not within the health center,

not understanding why it may take more than 9 minutes or 11 minutes or 23 minutes to really understand why that's important.
So I didn't know if you have any talking points or any experiences that really would lend itself to folks who are seeing those patients and leading up.

Because ultimately we understand that it is a business and that there are financial repercussions for that extra four minutes that you're spending getting to know that patient.

But the other end of the equation being, if you take that four extra minutes, what that means
for providing additional services for the patient that you might not need to do there in that particular setting.

DELIANA: Thank you. I think it’s really interesting. Some of the places where I’ve seen it be successful,

they’ve been able to couch that internal evaluation, the reassessment and the realignment of time,

and responsibility under a performance improvement strategy.
And that's the kind of language that seems to make people happy.

So if you can couch you in terms of were going to look at the investment of time and energy at all levels and recalibrate that energy and our commitment to seeing that this is important here

and the effect to it is not going to be significant.
In the whole it may just bump it a little bit. You do have greater patient satisfaction,
greater patient adherence to the treatment protocols,
greater positive outcomes in your performance measures.
Then it seems to lead to a willingness to observe that.
So I would really ask you to read
some of the literature right now

788
01:08:59,802 --> 01:09:02,771
on some of the performance
improvement efforts that are under way.

789
01:09:02,771 --> 01:09:05,975
Because I think it does a lot
to advance the business part of it.

790
01:09:09,645 --> 01:09:14,984
AUDIENCE: Hi, I’m here with Voces Unidas
For Justice, based in Colorado Springs.

791
01:09:15,885 --> 01:09:21,624
You touched on it briefly.
I’m a holistic counselor for mental health.
You touched on it briefly with therapists counseling people who are mobile.

I, once upon a time, was a migrant farm worker myself for 15 years.

There's a lot of need for that as well. The other part of the question is with sexual abuse and domestic violence needing counseling and resources going forward, how much of that is tied into the counseling connection to the network?
DELIANA: It's enormous.
The connection is huge.

When you think about how sexual violence has been used to maintain power just starting right there.
So it's in the person's home,

it's in their migration process,
it's in their work environment,
it could be in their personal relationships.

And so then the cumulative experience of violence, the person really never gets to posttraumatic stress because it's traumatic stress ongoing.

And so the mechanism for coping is a strategy that is modified by the person all the way over the entire arc of their life.
What's needed is absolutely for us to look at violence and the use of sexual violence very deeply.

Those conversations need to be present at all levels.

You're starting to see it more now with efforts in farm labor to say we're going to hold managers, field supervisors, and farmers accountable.

We're starting to see some
wonderful being work being done

811
01:11:06,362 --> 01:11:10,232
for individuals who were cleaning
office buildings and who are alone.

812
01:11:10,232 --> 01:11:14,970
Those voices are coming forward.
So I think a couple things are happening.

813
01:11:14,970 --> 01:11:23,012
The magnitude of the issue is really starting to come to light
and those lights are remaining hard focused on it.

814
01:11:23,012 --> 01:11:26,715
The voices of those affected
are really coming forward

815
and they’re being amplified
and they’re being given a platform.

We’re really starting to see how general it is
across a lot of industries, particularly for women,

but I do not want to discount men
being affected by sexual violence as well.

I think the conversation
needs to start really

in terms of equity and relationships,
in person to person relationships.
Some of that education is now being done beautifully by groups that are doing men-to-boys,

where they're really trying to say the balance of power can be viewed very differently.

But it's all of a piece. So you have people experiencing it throughout their lives,

you have people trying to affect it in all of these different ways
by bringing legal assistance
to them and changing the law.

You have people trying to do education.
But in the end the piece that I see as really missing

is mental health, behavioral
health and access to it.

That’s one of the places where there’s
a stranglehold on what’s available to people.

I believe that that’s one of the places
where Telehealth could do a great deal,
particularly with non-English speakers.

But the ability to be able to provide mental health services across state lines is still a line in the sand that does not seem to budge.

So I think were doing a lot of great work but I think that that one piece in response is a place where
we're really falling short.

JULISSA: Hola, Deliana.
My name is Julissa Soto and I'm the Director of the American Diabetes Association Latino Initiatives.

I have been there for 11 years.

I started three years ago doing some work in the south area of Colorado. Colorado Springs, Pueblo.
This is a question for you. I have faced discrimination, Latinos against Latinos, right?

Specifically, when I visit the low-income clinics, or the federal qualified low-income clinics

I have noticed that Latinos have some resentment when there are Latinos but they don’t speak the language.

Therefore, they discriminate against new immigrants like myself.

They hear the accent right away and assume she’s a new immigrant.
She’s not a part of our community. Specifically, I’m talking about Pueblo, right?

When I was visiting the clinic, the way Latinos were treating the new immigrant community was very different than the way that they were approaching Latinos who have been here 5 or 6 generations, right?

And I faced them and said, "Hey guys, I really think you guys are discriminating here."
They looked at me and they're like, "No, we're all Latinos in here." And I said, "Come on. Come on."

How many years have you been in existence and you don't provide any programs in Spanish.

For the new immigrant community that you have on the east side of Pueblo. Right? Number one.

Number two, I just saw at the front desk a Latino speaking English to somebody that keeps saying, "No hablo Ingles. No hablo Ingles." How many times does that lady need to repeat the same phrase?
That hurt me and killed my heart because

Being in the United States, I know people hear my accent

but for me, when we're Latinos, we're all Latinos, you know?

It's like, if you see us and I don't speak you will put me with all the Latino community, right?

But if you get to know my story then
yes, I was born and raised in Michoacán, Mexico.

Yes, I will be with
the new immigrant community.

Talking to the Pueblo Community
Health Center and everyone else

me bringing programs to them
while my team operates here in Denver

but now I have migrated
to Colorado Springs and Pueblo.
That has been very challenging for me because then, I am labeled as the troublemaker just because I'm like, "Hey, the new immigrant community exists. Come on guys."

You're telling me that you don't have any programs in Spanish here?

How long have you been in existence here?

In Colorado Springs, 30% of the population is Latino.
In Pueblo, when they look at me and I say, "You don't have programs in Spanish?"

Specifically when it comes to CVD, cardiovascular disease, diabetes,

you have the highest rates of diabetes and therefore, you don't have a program in Spanish, right?

DELIANA: Let me stop you in that. Okay? Let's go there.
So you see it and you can view it.

And I think the challenge here is

is you can either challenge them

that they haven't done it or

you can step in and say, "You know what,

I see this as missing, and I'm going to help you bring it."

Because I think we can challenge and challenge and challenge and I tell you what,

I don't shy away from a good fight,

so please know that.
But on the other side, I want to have an effect.

and if I bring resources to the table, if I demonstrate that something can be brought to bear,

then some of the defenses come down.

But if it's always a challenge of, you're not doing it and you should be doing it, then the defenses really
have a very difficult time coming down.

So I offer it to you as perhaps an alternative.
I think you need to call people, always,

but then I think the next thing needs to be,
"But you know what, I can help you make that better."

Certainly and I'm starting
with the classes there.

And I'm speaking in here very differently
than the way I speak there.
In there I was a little bit more humble
because I really wanted to get into that clinic.

And I really want to work with low income clinics
and be part of their electronic medical records

so that when they think about diabetes,
they click that button and they refer to us. Yes.

But in here I’m speaking differently
because I feel we’re all professionals here

I’m in a different environment.
I’m not in Pueblo. So I’m like, "Yes."
DELIANA: Just know that people in Pueblo may see this video.

JULISSA: They'll be like, "We remember you!"

But hey, I'm like you. I'm not afraid to challenge but you know

I really would love to see the clinics working like you were saying in your presentation.
Understanding communities. And one of
the things that will stay with me from now on

01:17:36:184 --> 01:17:40,288
I will use your words in my presentations.
You know how everybody says,

01:17:40,288 --> 01:17:46,161
"Treat others like you wanted to be treated."
But you say, "Treat others like they want to be treated."

01:17:46,161 --> 01:17:50,399
So now, that's going to be my line.
I'm going to steal it from you. Thank you.

01:17:53,435 --> 01:17:55,737
NED: I think we have time
for one last question.
AUDIENCE: I kind of wanted to speak to what you talked about in the beginning of your presentation with having to answer to funders and donors and having your vision compromised versus the model of the Florida workers and how they were autonomous and saying that they wanted to maintain their vision and not necessarily accept federal dollars.

I guess my question is, with the Florida workers,
is this a new paradigm that we're finding, as a new means

by which we can operate autonomously
without having to answer to donors,

without running the risk of
not having as many resources?

Or is this something that each organization
will have to question for themselves?

What do you see as the pros and cons
of each side of that coin?
DELIANA: I think it’s the decision that each group is going to have to make for themselves, certainly.

I think if you look at worker groups now,

Immokalee workers in Florida or the Workers Defense Fund out of Austin and Dallas,

they have committed themselves to helping workers have a voice.

And the workers are then going to decide how those organizations will function,
and the decision-making authority about from whom they will accept money,

and how they will then disseminate the power internally to their organization.

I think every organization can have that conversation and that we do very often get into a place of we know we're doing good work
and so if we can just pursue some funding
we can keep doing the good work.

And I don’t mean to say
that that is bad at all.

I’m just saying that we need to do it
fully conscious of the choices that we’re making

and the effect that it can have
and that if there’s ever a moment

where we want to retrench and say,
"Really this inconsistent with our values and our goals."
that we take that position and understand, come what may, that it may not go the way we want it to.

But I'm not trying to make a hard and fast rule that it's one or the other

but only to say that there can be success

and that mostly I see there being success when people are truly evaluating what the group is interested in

where there is parity in the volume of the voices
in the room and in the decision-making authority.

01:20:10,038 --> 01:20:15,010
AUDIENCE: As a follow-up question,
is there a case study or

01:20:15,010 --> 01:20:19,881
similar literature in regards to how the farm workers
in Florida were able to accomplish what they did?

01:20:20,882 --> 01:20:25,754
To your knowledge, anything that you
would refer to the audience as a resource?

01:20:25,754 --> 01:20:29,324
DELIANA: I have not read
much about their work.
My information about their work is having visited with them and having their success put in popular press in terms of their legal challenges and the outcomes.

So, no. It doesn't mean that it's not out there, it just means that I'm not familiar with it. Sorry.

NED: So we need to wrap up but I hope you'll all join me in thanking Del for being with us today.

DELIANA: Thank you for having me.
NED: It's important to see a room full of people around these important topics.

We know that no foundation, including the Colorado Trust, has the ability or the resources to address health equity by itself.

We partner with communities and the residents in communities in working toward solutions.
to advance health equity in our state.

Your presence here is another part of that partnership.

We'll post the presentation, the slides, and then in a couple weeks the video of the presentation will be available.

I encourage you, if you found interesting things to think about today, that you sign up and go on our website to find out about our future health equity learning series events. The next one is November 10th.
And there will be additional information on the website soon.

Again please fill out the evaluation survey. We rely on it heavily in our planning for most parts of the event.

And then I can't stop without recognizing the team effort that these events are.

I want to thank my staff who are integrally involved in all steps.

And then especially Maggie Frasure, who took responsibility
for most of the things that happened today.

949
01:22:17,899 --> 01:22:22,203

It came off flawlessly,

Maggie. Thank you.

950

I hope you enjoy

the rest of the day. Thank you.