PARTICIPANT HANDOUTS

Health Equity is Social Justice: Health Centers in the Context of Racial and Social Justice

Thank you for attending today's training. By doing so you are strengthening the ability of your community-based and patient-directed health center to deliver comprehensive, culturally competent, high-quality primary health care services.

Presented by:
Rachel Gonzales-Hanson, National Association of Community Health Centers (NACHC) and Ross Brooks, Mountain Family Health Centers

Live Broadcast Date/Time:
Tuesday, August 11, 2020
12:00–1:15PM Mountain Time / 1:00–2:15PM Central Time

Target Audience:
The presentations in the series are intended for health center and PCA staff from various positions including clinical and non-clinical. Please see the registration information sent out prior to each training for more information about learning objectives and other details.

Event Overview:
The Community Health Center Movement has a deep and rich history in social justice. This webinar will offer a historical perspective for the Community Health Center Movement nationally and in Region VIII as well as ideas for how health centers can continue to play a role in pursuing racial justice and health equity.

Learning Objectives:
Though this session, participants will:

- Come away with an overview of the history of the Community Health Center Movement and its roots in the racial and social justice movements.
- Have context for how health centers today continue to play a role in the fight for health equity.
- Understand how health centers as organizations are integral to the work of social justice.

CONTENTS

CCHN/CHAMPS ARCHIVES

This event will be archived online. This online version will be posted within two weeks of the live event and will be available for at least one year from the live presentation date.

For information about all CCHN archives, please visit: www.CCHN.org/webinar-archive.

For information about all CHAMPS archives, please visit www.CHAMPSonline.org/events-trainings/distance-learning.

DESCRIPTION OF CCHN

The Colorado Community Health Network (CCHN) represents the 20 Colorado Community Health Centers that together are the backbone of the primary health care safety-net in Colorado. For more information about CCHN, please visit www.CCHN.org.

DESCRIPTION OF CHAMPS

Community Health Association of Mountain/Plains States (CHAMPS) is a non-profit organization dedicated to supporting all Region VIII (CO, MT, ND, SD, UT, and WY) federally funded Community, Migrant, and Homeless Health Centers they can better serve our patients and communities. Currently, CHAMPS programs and services focus on education and training, collaboration and networking, workforce development, and the collection and dissemination of regional data. For more information about CHAMPS, and the benefits of CHAMPS Organizational Membership, please visit www.CHAMPSonline.org.

SPEAKER BIOGRAPHIES

A life-long resident of Uvalde, Texas, **Rachel A. Gonzales-Hanson** joined the National Association of Community Health Centers (NACHC) as the Senior Vice-President for Western Operations in January 2020. Prior to joining NACHC, she served the CEO of Community Health Development, Inc. (CHDI). Rachel's involvement with CHDI began while serving as a board member of its original Board of Directors in 1983. In 1984, she accepted the position of Executive Secretary and in 1986, she was appointed the CEO.

In addition to overseeing CHDI, Rachel has focused on improving access to affordable, quality health care for people from all walks of life, including those from rural areas, agricultural workers, and veterans. Rachel remains committed to the advancement of the "Community Health Center" primary care delivery model. This model espouses the philosophy that every patient is treated respectfully, in a wholistic approach, and where the patient is a partner with the health care team in determining their treatment plan.

As CEO of Mountain Family Health Centers, **Ross Brooks** is chief curator and leader of Mountain Family's values, vision, and mission, which includes overseeing the strategic plan, workforce, operations, and more. He is driven by the simple principle that access to affordable health care is a human right, not a privilege. Ross joined Mountain Family in July 2012, after serving as Chief Operating Officer at Colorado Community Health Network and previously the Health Care Advisory Board Company in Washington DC. He earned his Bachelor of Arts and Sciences in International Business and Economics at Washington University. Ross also serves on various local, state and national boards and committees, including NACHC, Colorado Community Health Network, Colorado Community Managed Care Network, Mountain Valley Developmental Services and Reunion Health, LLC. He enjoys hiking, eating a good meal and spending time with his wife Lindsey, and their two children.

CCHN/CHAMPS
2020 Health Equity Learning Series

Health Equity is Social Justice: Health Centers in the Context of Racial and Social Justice

Tuesday, August 11, 2020
12:00-1:15PM MT/1:00-2:15PM CT

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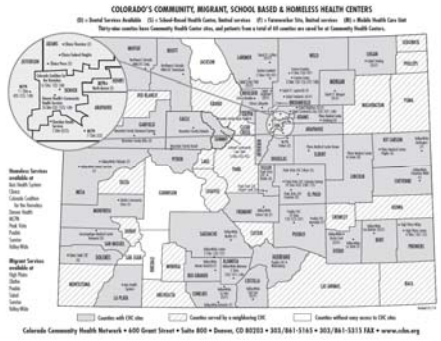
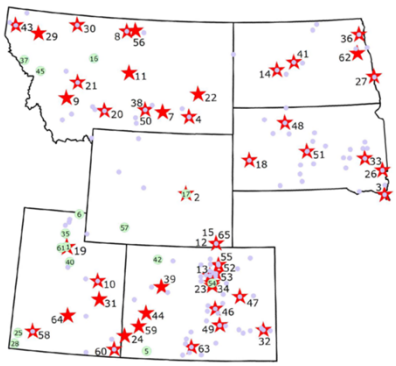
COLORADO
COMMUNITYHEALTHNETWORK
Access for All Colorado



COLORADO COMMUNITY HEALTH NETWORK (CCHN)

www.CCHN.org

2



COMMUNITY HEALTH ASSOCIATION OF MOUNTAIN/PLAINS STATES (CHAMPS)

www.CHAMPSonline.org

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PRESENTED BY

RACHEL GONZALES-HANSON

Senior Vice President for Western Operations

National Association of Community Health Centers (NACHC)

ROSS BROOKS

Chief Executive Officer

Mountain Family Health Centers

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HOW MANY PEOPLE ARE WATCHING THE EVENT AT YOUR COMPUTER, INCLUDING YOURSELF?

Submit your answers using the Q&A Box.

5

POLL QUESTION

How long have you been involved with health centers?

- 0-5 years
- 5-10 years
- More than 10 years

6

LEARNING OBJECTIVES

- Participants will come away with an overview of the history of the Community Health Center Movement and its roots in the racial and social justice movements.
- Participants will have context for how health centers today continue to play a role in the fight for health equity.
- Participants will understand how health centers as organizations are integral to the work of social justice.

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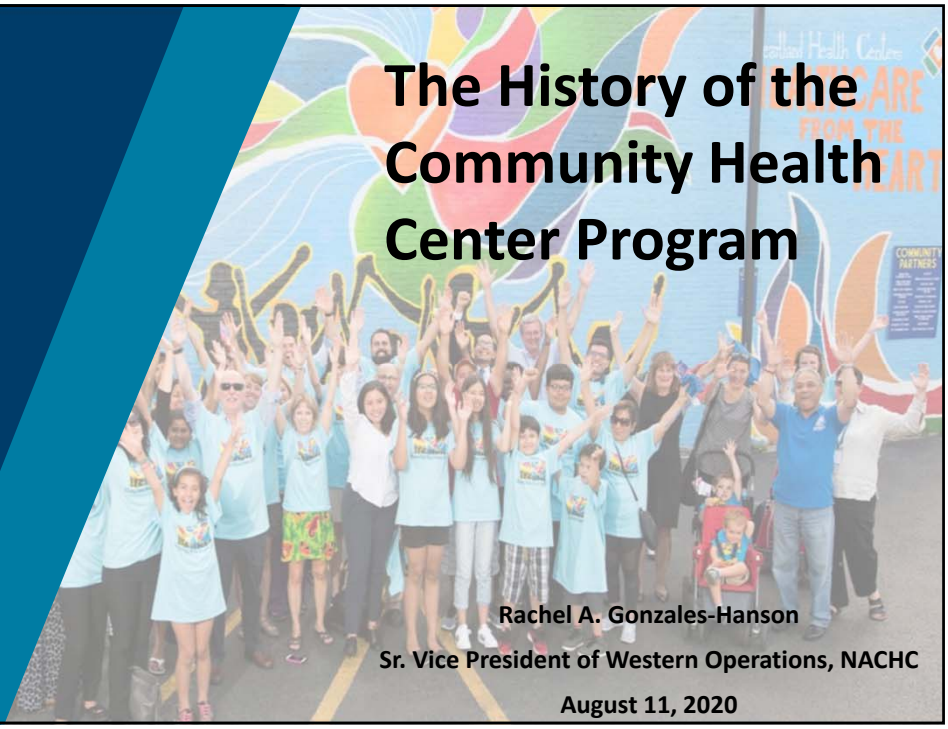
NATIONAL ASSOCIATION OF Community Health Centers®

The History of the Community Health Center Program



Rachel A. Gonzales-Hanson

Sr. Vice President of Western Operations, NACHC

August 11, 2020

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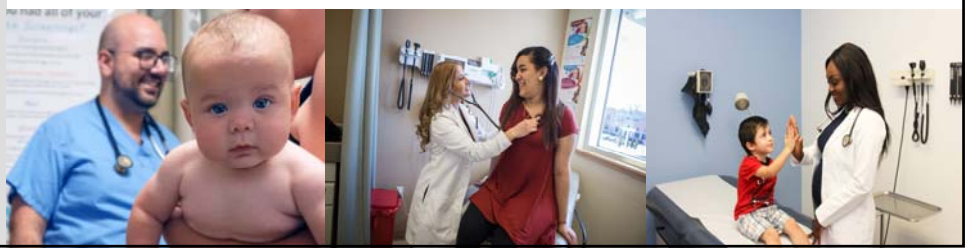
THE NACHC MISSION

America's Voice for Community Health Care

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.



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1850s - 1940s

1850s: Technological innovation in agriculture
Advances in crop production, machinery, transportation and refrigeration, increase the demand for a migratory seasonal labor force.

1930-1936: The Dust Bowl
Over-farming, poor soil management, and severe drought created vast dust storms in the lower Great Plains. Farmers in this area became the new migrants, traveling to California and other regions in search of work.

1942: The Bracero Program
The US and Mexico signed what came to be known as The Bracero Agreement. With the onset of WWII, Mexican citizens were recruited to alleviate the labor shortages in the agricultural fields. Hundreds of thousands of impoverished Mexicans migrated annually on temporary work visas to work as Braceros.

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1950s

1951: Extension of the Bracero Program

The Bracero Program is renewed.

1952: H-2 Program

An amendment is passed to the Immigration and Nationality Act that creates a new visa program for agricultural workers, known as the H-2 Program, which mirrored the Bracero Program.

1955: Social Security

Social Security coverage is extended to migrant farmworkers.

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Do you know…

- **The Migrant Health Center Program gave birth to the Community Health Center Movement**
- **Who are the individuals responsible for the creation of Migrant Health Centers?**

12

1960s

1962: The Migrant Health Act
The Migrant Health Act provides for financial and technical aid to public and private non-profit agencies that provide community health services to migrant farmworkers and their families.

1964: Bracero Program Ends

1965: Medicaid and Medicare programs are Enacted
Major expansion of federal responsibility for health care.

1960s (cont'd)

1965: Amendments to Economic Opportunity Act

- Senator Ted Kennedy works with House and Senate colleagues on legislation to extend the Migrant Health Program signed into law by his brother, President John F. Kennedy in 1962.
- Provided $50 million for the planning and operation of comprehensive health service program and the Migrant Health Program is reauthorized.
- Early grants provided to mainly local health depts., but also to local nonprofit health clinics in TX, WA, CO, and SC.

1965: The first Community Health Center established with two sites: Columbia Point, Boston and Mound Bayou, Mississippi

1970s

1970: Migrant Health Act is reauthorized.

The National Advisory Council on Migrant Health is mandated and seasonal farmworkers are added as eligible populations.

1970: The National Association of Neighborhood Health Centers (later to be called the National Association of Community Health Centers) is created.

A coalition of health center administrators, providers and consumers from across the country positions itself to be the leading advocacy organization for health centers.

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Community Health Development, Inc.
Uvalde, Texas

Do you know…

- **When was your health center established?**
- **When did YOU become part of the health center movement?**
- **Who was the first director of NACHC?**

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1970s (cont'd)

1971: Early Migrant Health Centers located in several communities: Toppenish, WA; Ft. Lupton, CO; Berrien Springs, MI; Beaufort, SC; and Harlingen and Laredo, TX

1970-73: Senator Kennedy co-authors the Emergency Health Personnel Act of 1970 (S 4106, P.L. 91-623).

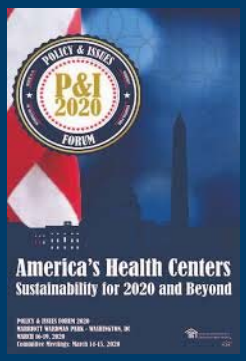
Establishes the new National Health Service Corps (NHSC) program to place trained health care providers in Health Professional Shortage Areas (HPSAs), then adds to the program by establishing the NHSC Scholarship program in 1972.

1970s (cont'd)

1975: Senator Kennedy authors S. 66, the Health Services Nurse Training Amendments of 1975 (P.L. 94-63)

- Establishes for the Community Health Centers Program in Section 330 of the PHS Act (after 10 years as an OEO demonstration project). The bill also reauthorizes the Migrant Health program in Section 329.
- And, sets minimum service and consumer-majority policy board requirements for both programs.

➢ By 1976, about 150 Health Center grantees serving approximately 3.5 million people.



Do you know…

- **When was the first NACHC P&I held? (Were you there?)**
- **How many people attended?**

1970s (cont'd)

1978: Senator Kennedy secures passage of S. 2474 (P.L. 95-626), the Health Services and Centers Amendments of 1978.

- Reauthorizes the Community Health Centers, Migrant Health, and NHSC programs
- Effort to eliminate governing boards is rebuffed, but new provision allows up to 5 percent of Section 330 funds to flow to public grantees
- Eligibility for Migrant Health care is extended to aged and disabled former farmworkers.

1980s

1980-1985: Pres. Ronald Reagan calls for major change in role of the federal government, including elimination of hundreds of federal programs and block granting others to the states - including the Community and Migrant Health Centers.

- NACHC's membership successfully fights for repeal of the optional block grant and the restoration of the program to direct federal-local partnership status.
- Triggers first new health center funding since 1981 and allows CHCs to develop special activities to reduce infant mortality in low-income and minority communities (P.L.s 99-117, 99-280, 99-660).

1980s (cont'd)

1980-1985 (cont'd):

- Decade started with 800 Health Centers serving 5.5 million people; growth largely due to Ed Martin's Rural Health Initiative started in 1978 with extra funding. Under Pres. Reagan, Health Center Program experienced it's first cut in funding – 25%, resulting in health centers being closed.

- NACHC leads successful efforts for funding the development of State and Regional PCAs.

1987: Enactment of the Steward McKinney Homeless Act –Leads to the establishment of the Health Care for the Homeless Program.

Do you know…

- **Why NACHC realized the importance of establishing**

  Primary Care Associations (PCAs)?

1990s

1990-91: Congress centralizes the Health Center Program administration and establishes Federally Qualified Health Centers (FQHCs) as a payment methodology for Medicaid/Medicare.

1993: Federal Tort Claims Act (FTCA) extends malpractice coverage to Health Centers, creating a savings of $200M/yr at that time.

- Health Center Program serving 6 million patients.

1995-1997: Under Republican leadership, Congress again considers block granting the Health Center Program and other programs (including Medicaid).

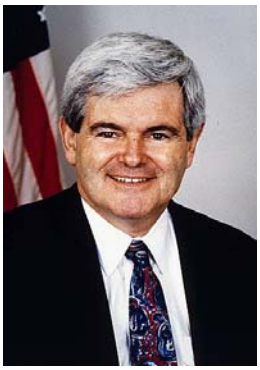
- NACHC leads successful effort to secure the 5-year authorization of the CHC Program and defeat the Medicaid block grant.

- Health Center Program serving 9 million people.

1990s (cont'd)

1996: Health Centers Consolidation Act

- The Act consolidates migrant health centers, healthcare for the homeless, health services for residents of public housing, and community health centers into a single Section 330 authority.
- Language ensures the continued funding of programs serving farmworkers, homeless individuals and Public Housing residents at the same proportional level as had been the case under the previous four separate programs.



1997: Relationships Matter…

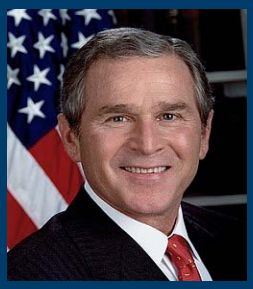
2000s

2000: Health center supporters in Congress block a phase-out of Medicaid FQHC payments and begin efforts to achieve the REACH initiative that doubles health center funding over 5 years.

- Over 1,000 Community, Migrant and Health Care for the Homeless Centers serve 11 million people at over 3,200 delivery sites.

2001: Presidential Initiative
President George W. Bush introduces his Initiative to Expand Health Centers, which seeks to double the number of people served by health centers over the next eight years.

2002: Health Care Safety Net Amendments
President Bush signs into law the Health Care Safety Net Amendments. It reauthorizes the Health Centers Program through 2006, seeks to expand services to rural communities, and authorizes the Community Access Program.



Do you know…

- During the Bush (W) Presidency, it was a "good" perfect storm of additional funding, FTCA savings & cost-based reimbursement for Health Centers.
- So, how much growth did Health Centers experience as a result of those good ol' days?

2000s (cont'd)

2007: Congress reauthorizes and fully funds the CHIP program.

2000s (cont'd)

2008: With strong bipartisan support, the Congress reauthorizes the Consolidated Community Health Center Program through 2012 and preserves its core elements.

2009: American Recovery and Reinvestment Act of 2009 (ARRA)

- President Obama's economic stimulus legislation provides for $2 Billion for the CHC Program.
  - $500 million is dedicated for increased demand for primary care, dental/oral health, pharmacy, mental health and substance abuse services.
  - $1.5 Billion is allocated for construction and renovation of health center facilities and HIT acquisition.

- ARRA provided $500 million for PHS workforce programs. Of this amount, $300 million is allocated to the NHSC.

2010s

2010: The Patient Protection and Affordable Care Act is enacted and signed into law by President Barak Obama on March 23, 2010. The ACA is the single greatest advance in health care policy in 50 years.

- As part of major health care reform, the Act provides for a major expansion of Health Centers dedicating $9.5 Billion to serve 20 million new patients by 2015 and provides $1.5 Billion for capital needs for health centers.
- The ACA also provides $1.5 Billion to expand the National Health Service Corps over 5 years
- Expands coverage under Medicaid to 133% of FPL w/o categorical eligibility and provides for health insurance premium subsidies for low and modest income Americans through State Health Insurance Exchanges beginning in 2014.

2010s (cont'd)

2011: Results of 2010 elections results in a shift of political control in the House and narrowing of majority control in Senate, ushering in a very different political climate focused on repealing health reform and reducing the federal budget deficit.

- With a $14 Trillion federal budget deficit, House proposals call for unprecedented cuts in domestic spending, block granting Medicaid to the states and deep reductions and elimination of many domestic programs.
- 2011-12 budget eliminates $600 million in funding from the CHC program and $125 million from the NHSC, resulting in a slowing down of health center expansion.

2015: Congress extends Health Center, NHSC & THCGME Funds for 2 years

Continues funding for CHCs at $3.6 billion through FY 2017, funds NHSC and THCGME programs

2017: Congress again extends Health Center, NHSC & THCGME Funds for 2 years, through FY 2019

Increases funding for CHCs to $4 billion by FY 2019, and extends level funding ($310 Million) for NHSC through FY2019.

What Did Health Centers Do in 2018?

(2019 Data will be available soon, shortly)

- Almost 1,400 Community, Migrant, Public Housing and Health Care for the Homeless Centers
- Over 12,000 delivery sites.
- Serving over 29 million people, including nearly 850,000 agricultural workers, 1.4 million homeless persons and more than 385,000 veterans.
- Reduce health care costs and produce savings – on average, health centers save 24% per Medicaid patient when compared to other providers
- Integrate critical medical and social services such as oral health, mental health, substance abuse, case management, and translation under one roof
- Employ over 236,000 people
- Generate at least $54.6 Billion in total economic activity in some of the nation's most distressed communities

Data is good, but –

It's not a job,

this is a

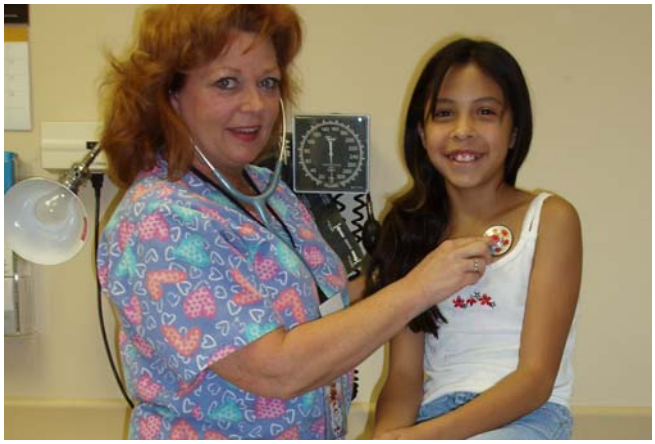
MISSION

HEALTH CARE

CON

CORAZÓN

HEALTHY COMMUNITIES



QUALITY HEALTH CARE FOR ALL

Why We Succeeded (Then)

We were founded outside of the mainstream

- Roots in civil rights, farmworker justice, and War on Poverty movement; away from mainstream medicine and public health
- At the core, health centers were driven by: Community, Equality, Diversity

We focused on forgotten people and places

- Few in power saw threat in our model, as we served people & communities that no one else wanted to compete for; Health Centers were addressing Social Determinants of Health before there was "SDOH"

We grew slowly over the first 25 years

- Stayed below the radar of power centers that could have decimated us
- Allowed us to build from a solid foundation, even as we reached out to new underserved communities in every state

Strong in Community – Strength in Unity

Why We Continue to Succeed – Today

We are firmly grounded in our communities

- Patient-majority Boards ensure strongest possible support for our continuation

We occupy the most opportune place in health care

- The entry point, where quality preventive and primary health care, and committed management of chronic conditions, yield both better care and enormous system savings

We are open to all, regardless of ability to pay

- This removes barriers that cause too many to delay necessary care or to use costly alternatives (i.e.; emergency rooms)

We have stayed true to our successful original model of care

- Multi-disciplinary teams ensure better health care outcomes and patient experience, with full care team committed to highest quality care and enabling staff able to wrap around clinical care with vital support services

We nurtured partnerships for the betterment of our patients and communities

- Strategic partnerships result in additional resources for health centers, patients, and the communities served

2019 - 2020

2019 - 2020: Health Center Fund programs again face a potential funding 'cliff', seek extended funding for at least 5 years

2019 – Several bills introduced to provide 5-year extension of funding for CHCs, NHSC, THCs

- **September 2019 –** Funding extended on a short-term basis to avoid cliff
- **December 2019 –** Senate HELP/ House E&C Committee leaders' agreement to provide 5-year extension of programs at level funding ($4 billion/year for CHCs, $310 million/year for NHSC, $126.5 million/ year for THCs) fully paid for by reforms to Surprise Billing
  - No broad agreement in Congress around surprise billing, so agreement does not move forward
  - Funding again extended on a short-term basis until May 2020

March 2020 – CARES Act extends funding to Nov 30, 2020

Our Stories are the Voices of Our Patients

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What Will Secure Our Success in the Future

ONE VOICE – UNITED, STRONG & LOUD

↑

OUR MISSION

↑

OUR ROOTS

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For further information about NACHC and America's Health Centers

Visit us at www.nachc.com

Thank you!

Health Equity is Social Justice

Health Centers in the Context of Racial and Social Justice

Ross Brooks, MFHC Patient, Son of a Preacher Man, Father, Husband, CEO, 18-Year CHC Veteran, Privileged White Guy

Mountain Family HEALTH CENTERS

Our Goals Today

1. Participants will come away with an overview of the history of the Community Health Center Movement and its roots in the racial and social justice movements.

2. Participants will understand how health centers as organizations are integral to the work of social justice.

3. Participants will have context for how community health centers today continue to play a role in the fight for health equity.

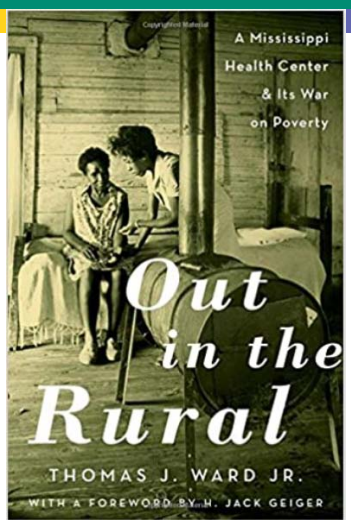
About Me: I Scored 75 out of 100!

How Privileged Are You?

https://www.buzzfeed.com/regajha/how-privileged-are-you

You're among the most privileged people in the world. We don't live in an ideal world, but you happened to be born into an ideal lot. This is not a bad thing, nor is it something to be ashamed of. It just means a lot of other people in the world don't live life with the advantages you have, and that's something you should always be aware of. Hey, the fact that you took the time and effort to check your privilege means that you're already trying.

Our Global Community Health Center and Social Justice Roots



Out in the Rural: Health Equity and the Social Justice with Dr. Jack Geiger and "Miss Pearlie"

Reflections on a Sabbatical and the International Community Health Center Movement: www.mountainfamily.org/a-letter-from-our-ceo-reflections-on-a-sabbatical-and-the-international-community-health-center-movement/

CHC Chronicles: www.chcchronicles.org/

Health Equity, Social and Racial Justice in 2020

1. COVID-19 Exposes Deep Health Disparities for People of Color in the United States.

2. Killings of George Floyd, Breonna Taylor, Ahmaud Arbery, Elijah McClain and others ignite racial justice reckoning in America.

3. CHCs Answer the Call: *Bending the Arc of Social Justice:* https://www.mountainfamily.org/bending-the-arc-of-social-justice/

Less Talking, More Listening

In response to ongoing racial injustices and protests nationwide, we decided we needed to ask questions and listen to others:

A). **Hold space:** to solicit roses/thorns in staff meetings, Board meetings, one-on-ones, zoom rooms, and (remote) community gatherings. Listen and empathize.

B). **Model vulnerability:** in sharing personal and professional roses and thorns re gender, racial and social equity. Soft heart, thick skin.

C). **Follow up:** celebrate the roses, acknowledge the thorns, work towards addressing the challenges, provide transparent feedback and data on progress.

D). **As CEO, ask myself regularly:**

- How does my privilege impact the way I show up?
- What privileges do I have that others in this (zoom) room don't enjoy?
- Who has power and voice at this table? How can I help distribute that power and voice more equitably?

Equity Vs. Equality
Ask Specific Questions of Staff

How Equity and Equality Are Different: www.premiertalentpartners.com/how-equality-and-equity-are-different/.

Train: Supervisors, Providers, and Leaders (ideally All Staff) in racial, gender, economic, and health equity. Harvard University Implicit Bias Tests: https://implicit.harvard.edu/implicit/takeatest.html

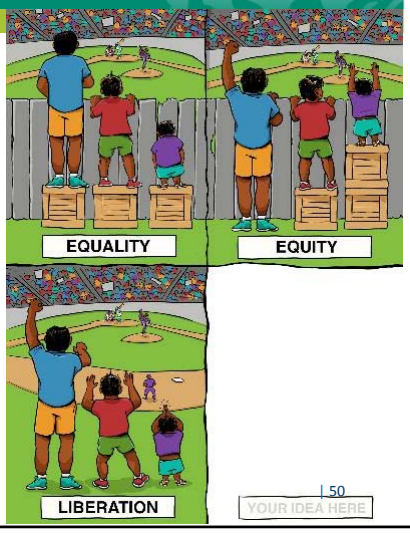
Ask Staff to Provide Specific Feedback:

A). As an employer, MFHC is committed to the pursuit of racial/ethnic, gender, and socio-economic equity.

B). As a healthcare provider, MFHC is committed to improving health outcomes and disparities that exist in our communities based on race/ethnicity, gender, and/or socio-economic status.

C). What are you most proud of re: MFHC's pursuit of gender/ethnic, racial, and/or socio-economic equity?

D). What is the biggest challenge you see re MFHC's pursuit of gender, racial/ethnic, and/or socio-economic equity and what is your recommendation for how we can best address this challenge?



Mountain Family Roses and Thorns

Governance: MFHC Board is 50% Hispanic/ 50% Non-Hispanic reflecting our communities and patients; first Latina Board Chair.

Equitable Compensation Philosophy: Ben and Jerry's 5:1 principle drives MFHC pay equity practices.

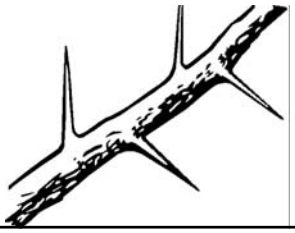
Culture of Care: Bilingual/bi-cultural staff, positive movement on health disparities (maternal, behavioral, HgA1c), SDoH awareness.

Innovation: *Mountain Family Health Solutions*, providing care for chronically underinsured, uninsured, and small businesses.

Racial Equity in Leadership Positions: Executive, Medical and Dental providers are predominantly white, non-Hispanic. MAs, DAs, Front Desk, O&E, Call Center staff are predominantly Hispanic.

Health and Economic Disparities Run Deep: Despite gains, Hispanic patients have higher rates of diabetes, infant mortality, mental health issues, and higher rates of un-insurance.

COVID-19: Higher rates of positive COVID-19 amongst MFHC Hispanic patients. Free parking in Aspen and rent relief locally?



New England Journal of Medicine Perspective:

Stolen Breaths. July 2020

www.nejm.org/doi/full/10.1056/NEJMp2021072

1. *Divest from racial health inequities.* The U.S. health insurance market enables a tiered and sometimes racially segregated health care delivery structure to provide different quality of care to different patient populations. Universal single-payer health care holds the promise of removing insurance as a barrier to equitable care.

2. *Desegregate the health care workforce.* The health care workforce is predominantly white at essentially every level, from student and staff to CEO. Extending employment opportunities to those communities can extend the employer-based insurance pool, raise the median wage, support the local tax base, and counter the gentrification and residential segregation that often surrounds major medical centers.

New England Journal of Medicine Perspective:

Stolen Breaths. July 2020 (continued)

3. Make "mastering the health effects of structural racism" a professional medical competency. In 2020, it is clear that clinicians need to master learning the ways in which structural racism affects health. We believe that medical schools and training programs should equip every clinician, in every role, to address racism. And licensing, accreditation, and qualifying procedures should test this knowledge as an essential professional competency.

4. Mandate and measure equitable outcomes. Just as health care systems are required to meet rigorous safety and quality performance standards for accreditation, they should be required to meet rigorous standards for addressing structural racism and achieving equity in outcomes.

5. *Protect and serve.* Health care systems must play a role in protecting and advocating for their patients. Victims of state-sanctioned brutality are also patients, who may present with injuries or disabilities or mental health impairments, and their interests must be defended.

National CHC Points of Light and ?s

- How do CHCs today play a role in the fight for health equity, social, and racial justice?

Addressing health disparities in local communities, leading on SDoH, governed by patient-majority Boards, leading the charge for access to affordable care for all, strong social justice roots.

- Questions for CHCs as a movement:

Do we lead our organizations in the pursuit of health, racial, gender, and social equity? Are our pay scales equitable? Do our leadership teams and providers look like/come from our communities? Do I, as CEO, understand the stressors of medical assistants, call center, and front desk staff? Who is the highest paid person of color in my organization? Are women and men compensated equitably for the same work in my organization? How much progress have we made on racial/ethnic health disparities in our community? Do I consistently speak out on behalf of undocumented immigrants? Am I most committed to universal healthcare access for all or defending the Community Health Center way?

U.S. Representative John Lewis, The Conscience of the People's House

"Do not get lost in a sea of despair. Be hopeful, be optimistic. Our struggle is not the struggle of a day, a week, a month, or a year, it is the struggle of a lifetime. Never, ever be afraid to make some noise and get in good trouble, necessary trouble."

Questions for You

1. What are you most proud of re: your organization's pursuit of gender, ethnic, racial, health and/or socio-economic equity?

2. What is the biggest challenge you see re; your organization's pursuit of gender, racial/ethnic, and/or socio-economic equity and what is your recommendation for how you can best address this challenge?

Resources and References

Harvard University Implicit Bias Tests: https://implicit.harvard.edu/implicit/takeatest.html

How Equity and Equality Are Different: www.premiertalentpartners.com/how-equality-and-equity-are-different/

How Privileged Are You? https://www.buzzfeed.com/regajha/how-privileged-are-you

***NEJM*: Stolen Breaths:** www.nejm.org/doi/full/10.1056/NEJMp2021072

International Community Health Center Movement: https://www.ifchc.org/wp-content/uploads/2019/05/Community-Health-Centres-Operationalizing-the-Declaration-of-Astana-on-Primary-Health-Care.pdf

Industrial Areas Foundation (IAF): Connecting with faith-based communities, schools, small business, and other institutions via broad-based community organizing: www.industrialareasfoundation.org/

Reflections on a Sabbatical and the International Community Health Center Movement: www.mountainfamily.org/a-letter-from-our-ceo-reflections-on-a-sabbatical-and-the-international-community-health-center-movement/

CHC Chronicles: www.chcchronicles.org/

QUESTIONS?

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at the bottom of the screen.

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www.surveymonkey.com/r/HE2020-Event1

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Perspective

JULY 16, 2020

Stolen Breaths

Rachel R. Hardeman, Ph.D., M.P.H., Eduardo M. Medina, M.D., M.P.H., and Rhea W. Boyd, M.D., M.P.H.

In Minnesota, where black Americans account for 6% of the population but 14% of Covid-19 cases and 33% of Covid-19 deaths, George Floyd died at the hands of police.

"Please — I can't *breathe*."

He was a black man detained on suspicion of forgery, an alleged offense that was never litigated or even charged, but for which he received an extrajudicial death sentence.

"Please — I can't *breathe*."

He was only 46 years old.

"Please — I can't *breathe*."

And he was loved.

But despite onlookers' pleas and his own calls of distress, with his face against the pavement, three officers on his back, and a knee in his neck, he was murdered.

"Please — I can't *breathe*."

While trained officers and paramedics stood by, and a horrified community witnessed, Floyd was denied the basic rights of due process and the basic dignity of life support.

"Please — I can't *breathe*."

In the wake of his public execution, uprisings have ignited in cities throughout the United States and the world, many of them led by young black people. Despite potential risks of exposure to Covid-19, demonstrators are laying bare the deep pain that persists for black people fighting to live under the crushing weight of injustice that has long been at our necks. The words "I can't breathe" hang heavy in the air. But they are so much more than a rallying cry. They are indictments.

"Please — I can't *breathe*."

The truth is black people cannot breathe because police violence is a major cause of premature death, of stolen lives and stolen breaths in America. And it is a particularly deadly exposure for black Americans.

"Please — I can't *breathe*."

The truth is black people cannot breathe because as many mourn George Floyd, we also mourn Breonna Taylor and Tony McDade, and the nearly 1000 people who are killed by police each year, an outsized proportion of whom are black.

"Please — I can't *breathe*."

The truth is black people cannot breathe because we are preemptively grieving the 1 in 1000 black men and boys who will be killed by police.[1]

"Please — I can't *breathe*."

We are holding our children closer and tighter because we know black girls will be presumed to be older, less innocent, and less in need of protection than white girls as early as 5 years old,[2] and black boys by 10 years old. We know the risks that may meet them when they leave our sides, and we hide our silent devastation when we prepare them for those risks — risks that no amount of guidance may deter.

"Please — I can't *breathe*."

The truth is black people can-

not breathe because the legacies of segregation and white flight, practices of gentrification and environmental racism, and local zoning ordinances combine to confine us in residential areas where we are disproportionately exposed to toxins and pollutants. As a result, black populations have higher rates of asthma and cancer. And recent data suggest that chronic exposures to particulate matter in the air may contribute to a risk of death from Covid-19 as much as 15% higher for black Americans than that faced by white Americans.[3]

"Please — I can't *breathe*."

The truth is black people cannot breathe because we are currently battling at least two public health emergencies, and that is a conservative estimate. One of every 1850 black Americans have lost their lives in this global fight against a novel virus that could have harmed anyone (https://apmresearchlab.org). And yet — because of racism and the ways humans use it to hoard resources and power for some, while depriving others — it has killed an enormous number of black people.

"Please — I can't *breathe*."

And black people are three times as likely to be killed by police as white people (https://mappingpoliceviolence.org). Both these realities are acutely threatening black lives right now. But prevailing gaps in maternal and infant mortality have long threatened our survival beginning before we are even born.

"Please — I can't *breathe*."

In the face of literal gasps, as black communities bear the physical burdens of centuries of injustice, toxic exposures, racism, and white supremacist violence, too many either do not know what our communities endure or are aware but choose not to act. Too many "leaders" wonder how we got here and what we can do to move forward, as if the answers have not been ever-present.

We got here, as the sociologist Ruha Benjamin expertly notes, because "Racism is productive" (https://belonging.berkeley.edu/video-ruha-benjamin). We got here because we live in a country established by indigenous dispossession and genocide. Because slavery and the racial ordering of humans and goods it established constructed a political economy predicated on devaluing black labor, demeaning black bodies, and denying black humanity. We got here because stolen lives and stolen breaths are profitable and we work in systems that continue to reap the gains.

"Please — I can't *breathe*."

Any solution to racial health inequities must be rooted in the material conditions in which those inequities thrive. Therefore, we must insist that for the health of the black community and, in turn, the health of the nation, we address the social, economic, political, legal, educational, and health care systems that maintain structural racism. Because as the Covid-19 pandemic so expeditiously illustrated, all policy is health policy.

We expect the deployment of these solutions to meet the urgency of this moment and the dire needs it has evidenced. We have confidence that these changes can be made rapidly, given the agility with which health care systems have reorganized in the face of Covid-19 — many establishing new practice patterns, payment models, and delivery mechanisms. The response to the pandemic has made at least one thing clear: systemic change can in fact happen overnight.

Although there is much to do, we recommend that health care systems engage, at the very least, in five practices to dismantle structural racism and improve the health and well-being of the black community and the country.

Divest from racial health inequities. Racial health inequities are not signs of a system malfunction: they are the by-product of health care systems functioning as intended. For example, the U.S. health insurance market enables a tiered and sometimes racially segregated health care delivery structure to provide different quality of care to different patient populations. This business model results in gaps in access to care between racial and ethnic groups and devastating disparities like those seen in maternal mortality. Universal single-payer health care holds the promise of removing insurance as a barrier to equitable care.

Desegregate the health care workforce. The health care workforce is predominantly white at essentially every level, from student and staff to CEO. This lack of diversity must be understood as a form of racial exclusion[4] that affects the economic mobility and thus the health of nonwhite groups. For example, health care systems are often the economic engines and largest employers in their communities. Extending employment opportunities to those communities can extend the employer-based insurance pool, raise the median wage, support the local tax base, and counter the gentrification and residential segregation that often surrounds major medical centers — each of which improves population health.

Make "mastering the health effects of structural racism" a professional medical competency. In 2016, we asked individual clinicians to "learn, un-

derstand and accept America's racist roots."[5] In 2020, it is clear that clinicians need to master learning the ways in which structural racism affects health. We believe that medical schools and training programs should equip every clinician, in every role, to address racism. And licensing, accreditation, and qualifying procedures should test this knowledge as an essential professional competency.

Mandate and measure equitable outcomes. Just as health care systems are required to meet rigorous safety and quality performance standards for accreditation, they should be required to meet rigorous standards for addressing structural racism and achieving equity in outcomes.

Protect and serve. Health care systems must play a role in protecting and advocating for their patients. Victims of state-sanctioned brutality are also patients, who may present with injuries or disabilities or mental health impairments, and their interests must be defended. Health care systems should also be on the forefront of advocating for an end to police brutality as a cause of preventable death in the United States. They should take a clear position that the disproportionate killing of black (and indigenous and Latinx) people at the hands of police runs counter to their commitment to ensuring the health, safety, and well-being of patients.

"Please — I can't *breathe*."

Police violence, racial inequities in Covid-19, and other forms of structural racism are concurrent and compounding public health crises in the United States.

"Please — I can't *breathe*."

Postmortem evidence indicates that George Floyd tested positive for Covid-19, underscoring this reality. The choice before the health care system now is to show, not tell, that Black Lives Matter.

Because, like George Floyd, black people are loved.

Disclosure forms provided by the authors are available at NEJM.org.

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Creating Real Change at Academic Medical Centers — How Social Movements Can Be Timely Catalysts

Michelle Morse, M.D., M.P.H., and Joseph Loscalzo, M.D., Ph.D.

The deaths of Alton Sterling and Philando Castile in July 2016 reverberated throughout the Brigham and Women's Hospital (BWH) Department of Medicine, destabilizing daily routines in the new academic year. Momentum for change had been building since the Black Lives Matter movement burst onto national headlines in 2013. Our internal medicine residents enjoined us as a department and an institution to reinvigorate the long but essential process of recognizing racism within our environment and acting to address it. They declared that the issues that the Black Lives Matter movement was making visible weren't external to or separate from our experiences at an academic medical center. Structural racism, discriminatory policing, and criminalization of black people affect health care. These long-standing issues reflect the living legacy of our country's history of racial discrimination and its many tragic consequences, including genocide of Native American people, slavery, Jim Crow laws, and eugenics. The question posed was simple: "What are we going to do?"[1]

Leading with action on issues of health justice has been a long-standing challenge for health professionals, who are often more comfortable with descriptive research as the main focus of intervention. In our department, the