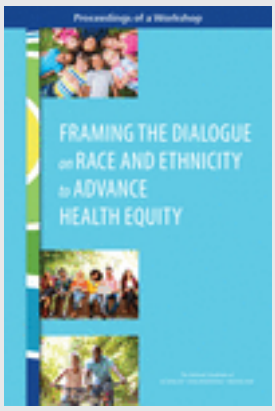

Framing the Dialogue on Race and Ethnicity to Advance Health Equity: Proceedings of a Workshop

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FRAMING THE DIALOGUE *on* RACE AND ETHNICITY *to* ADVANCE HEALTH EQUITY

Proceedings of a Workshop

Darla Thompson, *Rapporteur*

Roundtable on Population Health Improvement

Board on Population Health and Public Health Practice

Health and Medicine Division

The National Academies of
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This Proceedings of a Workshop has been reviewed in draft form by individuals chosen for their diverse perspectives and technical expertise. The purpose of this independent review is to provide candid and critical comments that will assist the institution in making its published Proceedings of a Workshop as sound as possible and to ensure that the publication meets institutional standards for objectivity, evidence, and responsiveness to the study charge. The review comments and draft manuscript remain confidential to protect the integrity of the process. We wish to thank the following individuals for their review of this Proceedings of a Workshop:

Judy Lubin, Public Square Communications
Xavier Morales, The Praxis Project
Wendy D. Puriefoy, Ford Foundation
Lydia Sermons, Department of Health and Human Services, Office of Minority Health

Although the reviewers listed above have provided many constructive comments and suggestions, they did not see the final draft of the Proceedings of a Workshop before its release. The review of this Proceedings of a Workshop was overseen by **Harold J. Fallon,** Medical University of South Carolina. He was responsible for making certain that an independent examination of this Proceedings of a Workshop was carried out in

accordance with institutional procedures and that all review comments were carefully considered. Responsibility for the final content of this Proceedings of a Workshop rests entirely with the rapporteur and the institution.

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BOXES

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Acronyms and Abbreviations

ACT	affirm, counter, transform
BMI	body mass index
CSI	Center for Social Inclusion
EDI	equity, diversity, and inclusion
GARE	Government Alliance on Race and Equity
IOM	Institute of Medicine
NACCHO	National Association of County and City Health Officials

1

Introduction[1]

The National Academies of Sciences, Engineering, and Medicine's Roundtable on Population Health Improvement convenes workshops for its members, its stakeholders, and the public to discuss matters of importance to improving the nation's health. On February 4, 2016, the roundtable held a workshop titled Framing the Dialogue on Race and Ethnicity to Advance Health Equity in which speakers shared strategies for individuals, organizations, and communities to advance racial and health equity. Topics included increasing awareness about the role of historical contexts and dominant narratives in interpreting data and information about different racial and ethnic groups; framing messages for different social and political outcomes; and readying people to institutionalize practices, policies, and partnerships that advance racial and health equity.

In her introductory comments, planning committee co-chair Phyllis Meadows of the University of Michigan and The Kresge Foundation said that although the characteristics of the populations served by the health sector may be different, the groups that most need interventions are

[1] This workshop was organized by an independent planning committee whose role was limited to identification of topics and speakers. This Proceedings of a Workshop was prepared by the rapporteur as a factual synopsis of the presentations and discussion that took place at the workshop. Statements, recommendations, and opinions expressed are those of the individual presenters and participants, and have not been endorsed or verified by the National Academies of Sciences, Engineering, and Medicine or the roundtable, and they should not be construed as reflecting any group consensus.

fundamentally the same. These are the groups that determine the extent to which health can be achieved. These beliefs, conditions, policies, and practices that have adversely influenced groups include people of color living in marginalized communities devoid of resources and voices, such as Flint, Michigan. Though resilient, these communities have historically been predisposed to social, economic, and environmental conditions that have resulted in persistently poor health outcomes over the decades, so much so that race, culture, ethnicity, and zip code have become proxies for poor health.

This workshop, Meadows said, sets the stage for an important dialogue about structural, institutional, and individual beliefs, conditions, policies, and practices that have adversely influenced health and limited the ability of this nation to achieve health equity. In 1988, in one of the most widely cited reports by the Institute of Medicine (IOM), public health was defined as "what we as a society do collectively to assure the conditions in which people can be healthy" (IOM, 1988, p. 1). This definition applies to all people all of the time—not to some people, not to all people some of the time, and not to some people more than others. This definition, Meadows said, implies that health is achieved through the actions we take as a society. This workshop, she said, is designed to raise awareness and inspire the audience to actively participate in finding solutions to persistent health inequities in the United States (see Box 1-1).

BOX 1-1
Statement of Task

An ad hoc committee will plan and conduct a 1-day public workshop featuring presentations on and discussion about different strategies to frame the dialogue about race and ethnicity to advance health equity. The workshop may highlight such topics as framing the evidence of racial and ethnic inequalities and health equity, the public understanding of the concepts of racial and ethnic equity and health equity, the supporting evidence for effective communication to and with policy makers and the public about racial and ethnic inequalities and health equity, and understanding equity as a desired outcome in efforts to apply a health lens to decision making in non-health sectors. The committee will identify specific topics to be addressed, develop the agenda, select and invite speakers and other participants, and moderate the discussions. A summary of the presentations and discussions at the workshop will be prepared by a designated rapporteur in accordance with institutional guidelines.

WORKSHOP OBJECTIVES

The title of this workshop was Framing the Dialogue on Race and Ethnicity to Achieve Health Equity. Some may ask, "Why this? Why now?" It has been nearly 30 years since the publication of the earlier IOM report, and many other reports on how to improve population health have appeared during that time, Meadows said, but the nation still has not moved the needle far enough. The nation has failed to meet this charge, Meadows said. It still has health disparities, and there are even growing disparities and growing inequities for some groups.

Meadows said that she and the other members of the planning committee charged with developing the workshop—co-chair Lourdes Rodríguez, Gillian Barclay, Marthe Gold, Sarah Linde, Sanne Magnan, and Vish Viswanath—believe that a part of changing the national narrative about health will be defining and elevating narratives that promote health equity. This workshop was intended as an early step in that direction with the goal of having a dialogue about race and ethnicity in a way that will prepare the roundtable and others in population health to "reframe our thinking, deepen our understanding, and build more grounded solutions," Meadows said.

This reframing will require, Meadows said, "that we not only look at race, but we look at racism, that we not only look at culture, but we must look at cultural elitism, and we cannot just describe problems based on ethnicity." It is necessary to look at racial and ethnic bias and the role these current realities play in shaping the resources, policies, and practices that limit the nation's capacity to achieve health equity for all.

This is the beginning of what will be a long and difficult journey, Meadows said. It is easy to talk about the facts. It is hard to talk about how these facts play out in reality. This workshop started with these objectives in mind: to explore and share a framework for applying the lens of race and ethnicity to promoting health equity; to explore some of the policies that affect the production of health inequalities; to explore best practices for communicating about racial and health equity; and, hopefully, to leave the audience with the capacity to be more conscious about applying a racial equity lens to the promotion of health equity for all population groups.

ORGANIZATION OF THE WORKSHOP AND PROCEEDINGS

The workshop consisted of a keynote presentation on racism and health inequities over the life course (see Chapter 2), followed by presentations on the policies of urban renewal and the production of inequities (see Chapter 3); building individual and institutional readiness for equity, diversity, and inclusion (see Chapter 4); framing messages to advance

racial and health equity (see Chapter 5); and a case study of institutionalizing racial equity in the New York City Department of Health and Mental Hygiene (see Chapter 6).

In accordance with the policies of the National Academies of Sciences, Engineering, and Medicine, the workshop did not attempt to establish any conclusions or recommendations about needs and future directions, focusing instead on issues identified by the speakers and workshop participants. In addition, the organizing committee's role was limited to planning the workshop. This Proceedings of a Workshop has been prepared by the workshop rapporteur Darla Thompson as a factual synopsis of what occurred at the workshop.

2

Racism and Health Inequities[1]

The keynote presentation was delivered by Gilbert C. Gee, a professor in the Fielding School of Public Health at the University of California, Los Angeles. Gee provided an overview of the role of racism in the production of racial and ethnic health inequities and discussed intersectionality as a lens for examining the impact of racism over the life course.

RACE IN THE UNITED STATES

As argued by Healthy People 2020, reducing racial health inequities will require attending to the "historical and contemporary injustices" that underlie race relations (National Partnership for Action to End Health Disparities, 2011; also see Braveman and Gruskin, 2003).[2] In the United States, a conversation about injustice and inequities has to include a discussion of the central role of race and ethnicity, Gee said. Race and ethnicity shape official reports, social policies, and many of our day-to-day interactions. Statistics from a variety of agencies, including the U.S.

[1] This synopsis by the rapporteur of the presentation by Gilbert Gee, a professor at the Fielding School of Public Health at the University of California, Los Angeles, and the statements therein have not been endorsed or verified by the National Academies of Sciences, Engineering, and Medicine.

[2] More on the definition of health equity cited by Healthy People 2020 is available at https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities#5 (accessed July 13, 2016).

TABLE 2-1 U.S. Census Categories

Race Alone or in Combination with One or More Other Races	
Total population	314,107,084
White	239,576,409
Black or African American	43,081,695
American Indian and Alaska Native	5,235,224
Asian	18,515,599
Native Hawaiian and Other Pacific Islander	1,234,990
Some other race	16,444,358

SOURCES: Gee Presentation, February 4, 2016, data available at http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_5YR_DP05&src=pt (accessed May 16, 2016).

Census Bureau, provide data on a variety of health indicators and population indicators. Despite their objective appearances, many of these reports carry implied messages and value judgements.

For example, consider this table (see Table 2-1) from the U.S. Census Bureau. The groups on the Census list are not in alphabetical order, they are not listed by population size, and they are not listed by who was on this land first, Gee said. Implied in this very simple ranking are some implicit notions of which groups are thought to be most deserving of conversation.

Racism

When people talk about race in the United States, Gee said, they need to confront the historical reality of racism. It is a historical and contemporary fact that racism has shaped the lives and meanings of people of color in the United States. In 1882, for example, President Chester A. Arthur signed the Chinese Exclusion Act of 1882 (see Figure 2-1). The act was the first to specifically prevent the immigration of an entire group of laborers based upon ethnicity. When people talk about discrimination, it is important to recognize the role not only of day-to-day individual experiences, but also the structures that perpetuate such inequality. Today, the United States may no longer have *de jure* segregation of things like water fountains or systems, but if people think about what has happened with lead in the drinking water in Flint, Michigan, or national discussions about closing United States borders to immigrants, it might be said that those days of overt blatant racism are not the distant past, but a contemporary reality (see Figure 2-2).

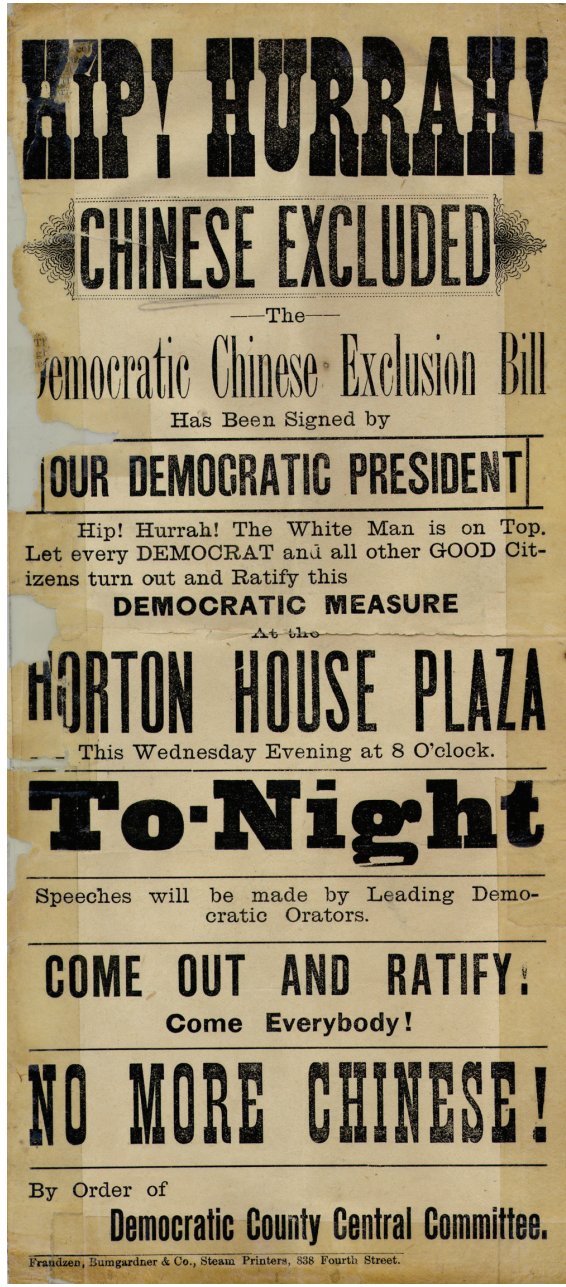

FIGURE 2-1 Image of Chinese Exclusion Act of 1882.
SOURCE: Courtesy of Royal British Columbia Museum and Archives.

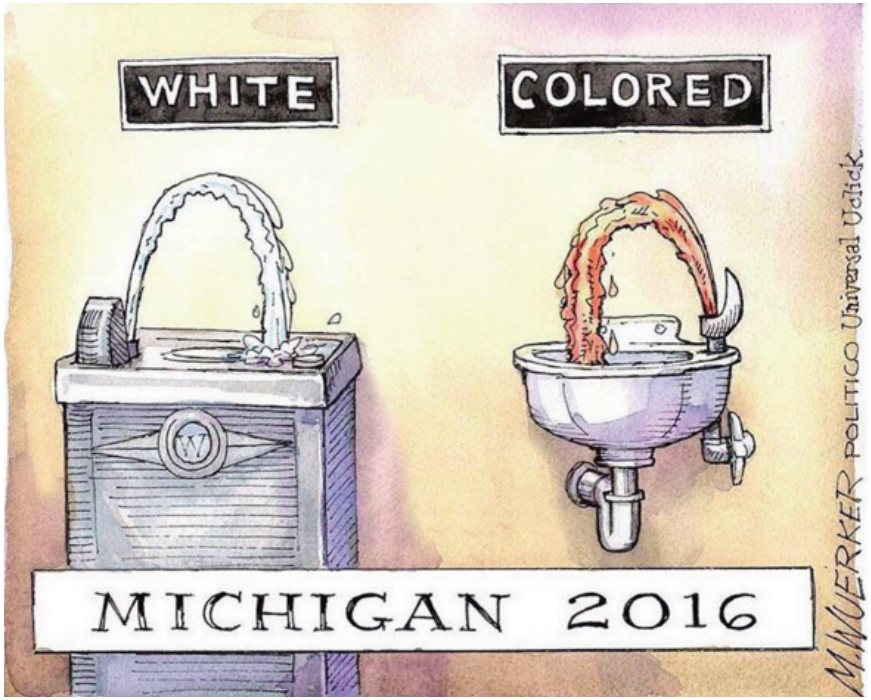

FIGURE 2-2 Michigan 2016.
SOURCE: Matt Wuerker, 2016.

Developing a Multilevel Understanding of Race and Health

Many scholars have talked about racism at multiple levels, including some of the early writings by Carmichael and Hamilton (1967) that talked about racism as stemming from both interpersonal and structural levels. More recent scholars such as Camara Jones (2000) have talked about a variety of these levels. In his own work, Gee uses a multilevel perspective on race and racism that incorporates an understanding of overt interpersonal racism and covert structural racism (Gee et al., 2009). Gee said that ignoring the significant contribution made by structural racism makes it much more difficult to reverse the trajectory of health inequities.

Importantly, this multilevel understanding of race and racism parallels a broader understanding of the multilevel production of well-being. Urie Bronfenbrenner and many others have talked about how the health and well-being of individual persons are not simply about their personal behaviors but, also, importantly, a function of who their peers are, what is going on with their families, where they live, where they work, where

they play, the laws of the land, economic conditions where they live, and where they are in a particular historical moment (Bronfenbrenner, 1994; Niederer et al., 2009).[3] Taken together, both health and racism are produced at multiple levels, and future research should account for such complexity, Gee said.

Discrimination and Health

Many meta-analyses and reviews have been published in recent years that have consistently shown that people's experiences with discrimination are associated with a variety of morbidity outcomes, not only in the United States but across the world (Paradies et al., 2015; Pascoe and Smart Richman, 2009; Schmitt et al., 2014; Williams and Mohammed, 2009).

Gee and colleagues documented the association between reports of discrimination and health outcomes with data from the 2002–2003 National Latino and Asian American Study. A greater frequency of reports of discrimination was associated with a higher predicted probability of having a variety of health problems such as clinical depression, respiratory problems, pain-related conditions, and cardiovascular conditions as well as with global markers of self-rated health (Gee et al., 2007b,c) (see Figure 2-3).

In another article Gee and his colleague Devon Payne-Sturges proposed an exposure-disease framework for environmental health disparities (Gee and Payne-Sturges, 2004) (see Figure 2-4). One of the key propositions of that framework is that not only does segregation concentrate social and environmental toxins as well as poverty and other social problems, but the two types of factors can potentially amplify each other. It is not just the independent effects of lead or the independent effects of concentrated poverty that affect individual and community stress; it is their combination that makes both of them more toxic. It is the synergy between these exposures to social and environmental toxins that amplifies or widens racial health inequities.

Intersectional Frameworks

The intersections between poverty and race and ethnicity can be approached through a broader body of research on intersectionality (e.g., Collins, 1991; Crenshaw, 1991). *Intersectionality* recognizes that our identities are not simply single social categories. Rather than treating race or

[3] An image of Bronfenbrenner's ecological model is available in Niederer et al. (2009); see http://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-9-94 (accessed May 4, 2016).

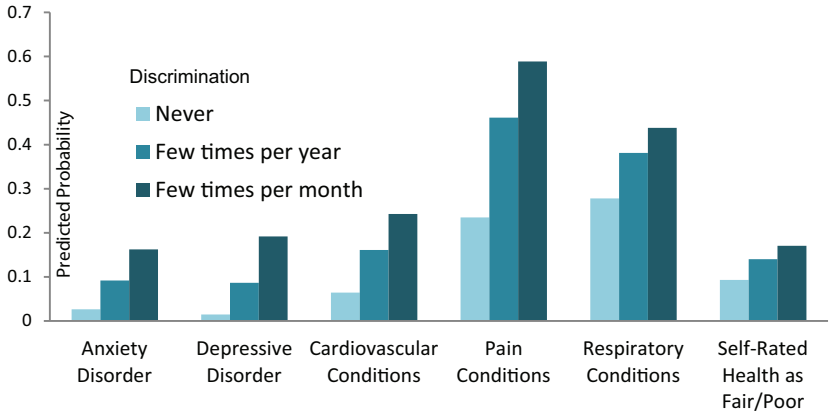

FIGURE 2-3 Association between reports of discrimination and health outcomes, according to the National Latino and Asian American Study, 2002–2003 (n = 2,095).
SOURCE: Gee and Ro, 2009.

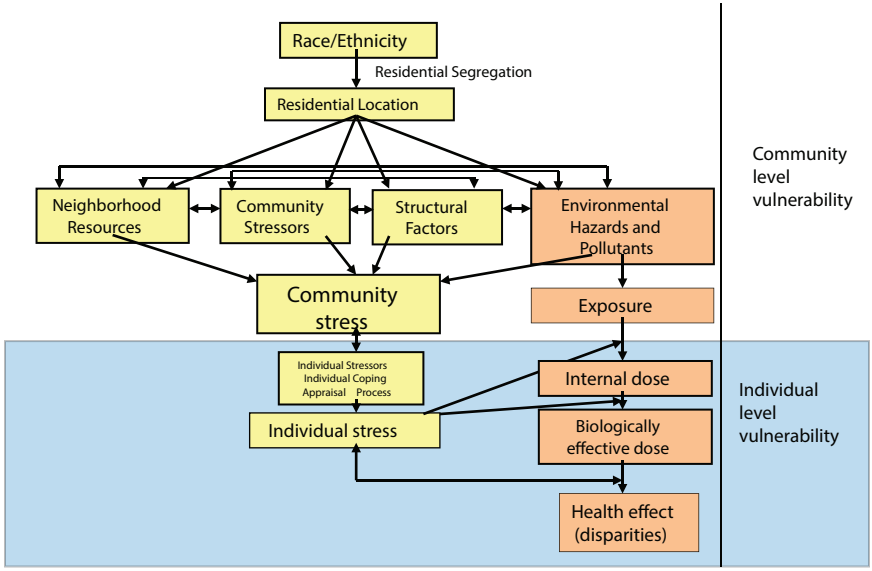

FIGURE 2-4 Exposure–disease–stress framework for environmental health disparities.
SOURCE: Gee and Payne-Sturges, 2004.

gender as separate categories, they need to be understood as interlocking systems of oppression that shape people's lives (Collins, 1991; Ford and Airhihenbuwa, 2010; Schulz and Mullings, 2005; Virnell-Fuentes et al., 2012).

An intersectional framework informed the work of Gee and colleagues when they did a national study of Latino and Asian American immigrants and the relationship between racial discrimination, body mass index (BMI), and years in the United States. What they found is that the longer immigrants were in the United States (the range was 1 to 45 years), the stronger the relationship between BMI and discrimination (Gee et al., 2008). Taken another way, this analysis suggests that duration in the United States is not simply a marker of "acculturation" to United States norms. Rather, duration could also be reconceptualized as a greater length of exposure to racial bias (see Figure 2-5).

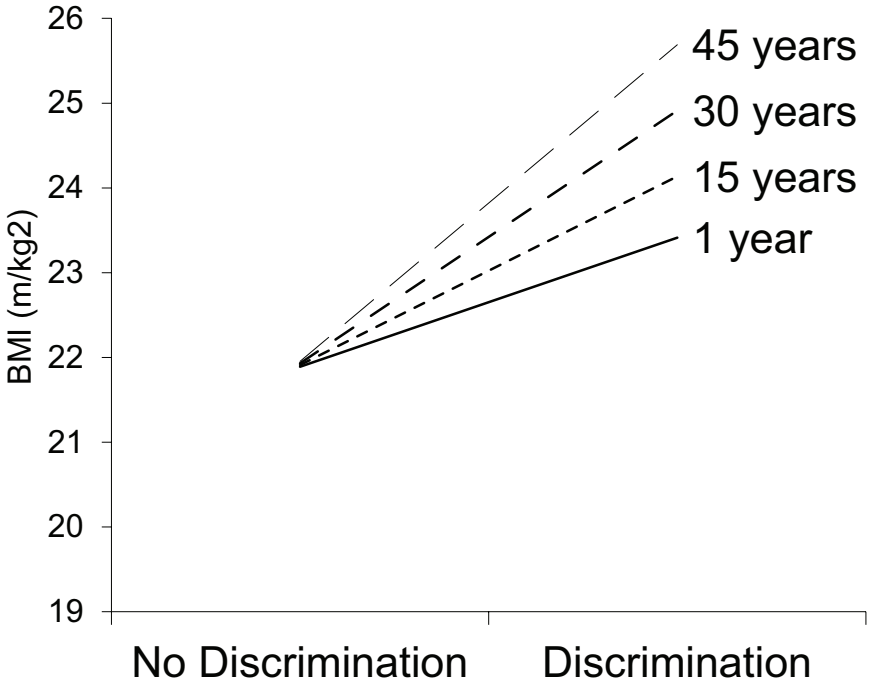

FIGURE 2-5 Interaction between racial discrimination and years in the United States, according to the National Latino and Asian American Study (n = 2,095).
SOURCE: Gee et al., 2008.

RACISM OVER THE LIFE COURSE

What is important about a life-course perspective, Gee said, is not simply viewing human aging as a function of biology, but also understanding that as people age, they encounter new social institutions. As people age into new social institutions, they age into new forms of racism (Gee et al., 2012).

What this suggests, Gee said, is that the nature of discrimination changes as people age, and researchers need to attend to these changes in their analyses. Gee presented evidence that reports of discrimination change with age, using data from the National Longitudinal Surveys of Young Women and Mature Women, a dataset produced by the Bureau of Labor Statistics. These surveys started in 1967 and have sampled more than 10,000 working women (2,815 black; 7,237 white; 134 other). To Gee's knowledge, these surveys include the longest running span of representative reports on self-reported race, gender, and age discrimination in the workplace (Gee et al., 2007a).

The analyses show that reports of age discrimination follow an S-shape. Reports of age discrimination in women are relatively high around age 20, drop around age 30, rise again in the 50s, and then decline in 60s and 70s when women retire or are at positions of power in the workplace (see Figure 2-6). The shape of gender discrimination is qualitatively different—almost the opposite pattern—with reports of discrimination being relatively low for women in their 20s, peaking in their 30s, and declining thereafter. The reporting of gender and age discrimination is similar between black and white women. However, reports of racial discrimination are low among white women and much higher among African American women throughout the life course. These data show the importance of considering how reports of discrimination vary by race, age, and gender over the life course.

Life Interrupted by Racism

Gee and his colleagues created a conceptual model (see Figure 2-7) to diagram what life interrupted by racism would look like (Gee et al., 2012). The top panel of this figure shows a "general" life trajectory that begins in utero. After a child is born, the child's experiences are largely shaped by family, but as the child ages, the child moves into new life stages shaped by education, work, and retirement. The blue bar in the figure represents undesirable times in one's life caused by such things as unemployment, incarceration, and illness. The bottom panel of this figure displays a life interrupted by racism. The blue bar is much larger, yet the total life expectancy is shorter (denoted by the red bracket). Thus, Gee said, racism can create a shorter life with greater strife.

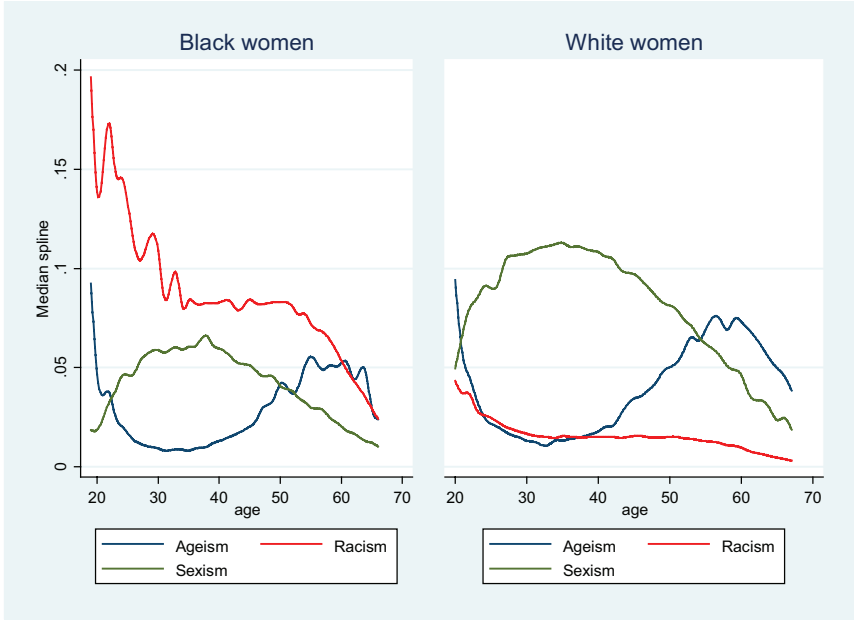

FIGURE 2-6 Reports of age, gender, and racial discrimination for black and white women.
SOURCES: Gee presentation, February 4, 2016, based on data from Gee et al., 2007a.

Gee said that the recent events highlighted by the Black Lives Matter movement and many other events such as the tragic death of Tamir Rice and other young people have encouraged him to rethink what the earlier framework published some years ago may look like in 2016 (see Figure 2-8).

In closing, Gee said that it is important to recognize the resistance and the resiliency that can be seen in communities in the form of individuals who are standing up for themselves and for their communities as well as coalitions and marches involving people agitating for improved living and working conditions. Historically, these acts of resistance have culminated in achievements like the Civil Rights Act of 1964. Gee suggested that the implementation of the Act can be linked to a decrease in infant mortality rates for African Americans in states like Indiana and Mississippi, as shown in research by Douglas Almond and colleagues (Almond et al., 2006). What the declines suggest is that social policies that

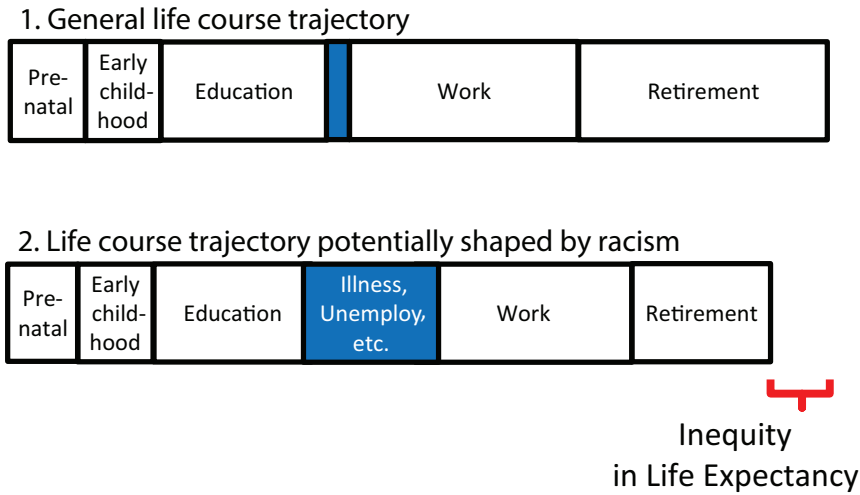

FIGURE 2-7 Conceptual model of how racism may shape time over the life course.
SOURCE: Gee et al., 2012.

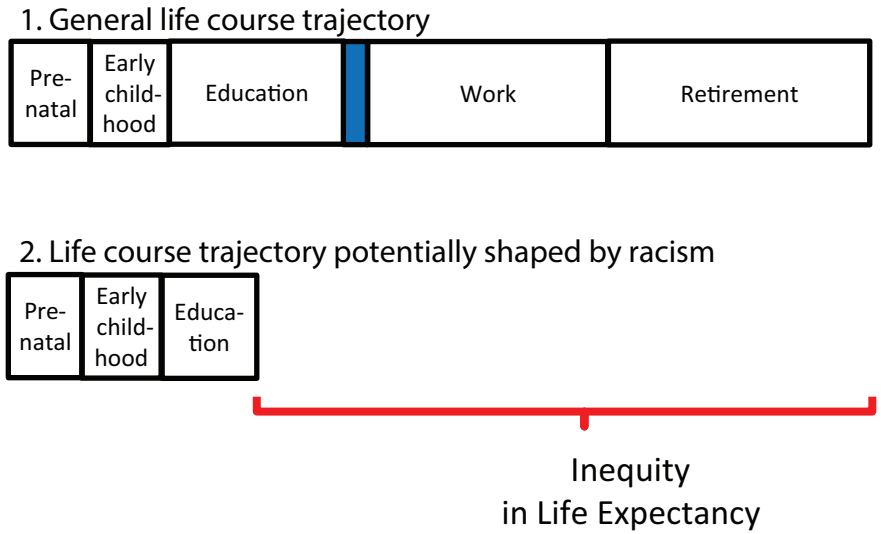

FIGURE 2-8 Conceptual model of how racism may shape time over the life course in 2016.
SOURCE: Gee presentation, February 6, 2016.

are designed to expand rights may also have important spillover effects in reducing things like infant mortality.[4]

Gee suggested that a framework for health equity should have four parts related to a multilevel perspective examining intersectionality that considers all these factors across the life course (e.g., race, class, gender, immigration, sexual orientation) and also considers the strength and resilience of communities. The study of racism and the interlocking systems of oppression across generations and individuals' life courses need to be studied directly, Gee said, in order to achieve health equity and social justice. What this suggests, ultimately, is that policies that are designed to improve civil rights not only buttress the foundations of a just and civil society but lead to a healthier one as well.

[4] The article focuses on Title VI of the 1964 Civil Rights Act, which mandated the desegregation of institutions receiving federal funds.

3

Urban Renewal and the Production of Inequalities[1]

Mindy Fullilove, a professor at the Columbia University Mailman School of Public Health, discussed the concepts, practices, policies, and power relationships that contributed to the historical production of community disintegration.

BEFORE DISINTEGRATION

Fullilove focused on one community, the Hill District of Pittsburgh, Pennsylvania, as a way to examine the impact of policies that promoted social disintegration and health inequities in the United States (Hughes, 1960). To put this process in context, Fullilove explained that as a result of African American struggles during the long civil rights era between the 1940s and the 1960s, a body of law emerged to protect voting rights.[2] However, at the same time there were also policies that led to devastated communities. The net result, Fullilove said, is that more people could vote in the United States, but their communities were destroyed.

[1] This chapter is the rapporteur's synopsis of the presentation by Mindy Fullilove, a professor at the Columbia University Mailman School of Public Health, and the statements therein have not been endorsed or verified by the National Academies of Sciences, Engineering, and Medicine.

[2] For more information, go to https://www.justice.gov/crt/introduction-federal-voting-rights-laws-1 (accessed June 21, 2016).

Dense Social Worlds

In Eva-Maria Simms's paper about childhood in Pittsburgh's Hill District, she described the experience of childhood in the 1930s to 1960 as a dense social world in which all adults were engaged in raising all of the children (Simms, 2008) (see Figure 3-1). This community had what Granovetter described as strong and weak ties, referring to both the strength of dyads and the weaker ties between groups that are part of the social structure of a community (Granovetter, 1973). This community is evident in the photos of the period, Fullilove said. For example, the Teenie Harris archival collection, in the words of poet, music, and cultural critic Stanley Crouch, "provides us with an epic sense of life, which is to say

FIGURE 3-1 Art class at the Irene Kaufman Settlement House in the Pittsburgh Hill District, 1950.
SOURCE: Esther Bubley, Pennsylvania Room, Carnegie Museum of Pittsburgh.

FIGURE 3-2 Checkers players in front of Babe's Place, Logan and Epiphany Streets, Hill District, June 1949.
SOURCE: Charles "Teenie" Harris, Carnegie Museum of Art, Pittsburgh, Heinz Family Fund.

that a civilization and how it worked is laid out before us" (see Figures 3-2 and 3-3).[3]

The Hill District was a dense, lively place, Fullilove said. This is important, "because in the rhetoric of urban renewal, this neighborhood was called a blighted slum that was a cancer on the city, and the only way to save the city was to destroy it, to literally wipe it off the face of the earth." To have this photographic evidence of this epic sense of life, of a sort of reciprocity, mutuality, people engaged with each other, and creating community, helps to create a sense of how wrong the policy was.

[3] See http://teenie.cmoa.org (accessed May 16, 2016).

FIGURE 3-3 View of Wylie Avenue with Crawford Grill No. I, Harry's, Joe's Money Loaned, and the Crystal Barber Shop, Hill District, 1942.
SOURCE: Charles "Teenie" Harris, Carnegie Museum of Art, Pittsburgh, Heinz Family Fund.

URBAN RENEWAL

The American Housing Act of 1949, Title V of Public Law 81-171, authorized urban renewal which was implemented over a 14-year period and carried out in 2,500 housing projects in 1,000 cities. Sixty-three percent of the people who were relocated were African American. Just by a simple ratio, that suggests that 1,600 urban renewal projects were directed at African American neighborhoods. Therefore, the black community called urban renewal "Negro removal," Fullilove said.

Pittsburgh's urban renewal plan was developed by white men (see Figure 3-4). Looking at the picture, one can see that there are no women and no black people, Fullilove said. These men represented the white power structure that labeled "this epic civilization that existed in the Hill District as a blighted slum that was a cancer on the city, and they wiped it out," she said. Fullilove identified this as an example of "white privilege thinking" and shared a description by Richard Rohr:

> White privilege is largely hidden from our eyes if we are white. Why? Because it is structural instead of psychological, and we tend to inter-

> pret most things in personal, individual, and psychological ways. Since we do not consciously have racist attitudes or overt racist behavior, we kindly judge ourselves to be open minded, egalitarian, "liberal," and therefore surely not racist. Because we have never been on the other side, we largely do not recognize the structural access, the trust we think we deserve, the assumption that we always belong and do not have to earn our belonging, the "we set the tone" mood that we white folks live inside of—and take totally for granted and even naturally deserved. Only the outsider can spot all these attitudes in us. It is especially hidden in countries and all groupings where white people are the majority. (Tune, 2016)

Fullilove described how Edgar Kaufman, the head of Kaufman Department Store, loved light opera and was looking for a site that the Pittsburgh Civic Light Opera could use. The Lower Hill District was identified as the prime area in which to build (see Figures 3-5 and 3-6). It came to be called the Civic Arena, and it was finished in 1961 after the African American community was forced to move. After the arena was built (see Figure 3-7), not only was an entire section of the Hill District wiped out, but highways and parking lots were erected between the remaining African American community and downtown Pittsburgh.

FIGURE 3-4 Executive committee of the Allegheny Conference.
SOURCE: Stefan Lorant, 1964, p. 433.

FIGURE 3-5 Segregation in Pittsburgh, 1930.
NOTE: The red oval identifies the Hill District neighborhood.
SOURCE: Darden, 1973.

Root Shock

The people who were forced to move (see Figure 3-8) experienced what Fullilove called root shock, which is a traumatic stress reaction to losing all or part of one's emotional ecosystem (Fullilove, 2009). People experience root shock when an entire neighborhood is uprooted and destroyed, similar to the root shock that plants experience when they are yanked out of the ground. These are profound experiences. People are losing their neighborhood. They are losing their neighbors. They are los-

FIGURE 3-6 Pittsburgh's proposed plan for urban renewal. Aerial photograph of the Lower Hill District, 1956.
SOURCE: Photographer unknown. Fullilove, 2009.

ing their businesses. They are losing their churches. They are losing their schools. They are having their whole lives upended. They have to make new lives and manage huge emotional costs, economic costs, social costs, and political costs.

SOCIAL DISINTEGRATION

Simms reported that the people she interviewed talked about their social networks losing some of their density from 1960 to 1980, the period after urban renewal (Simms, 2008). One of her respondents mentioned that one of the changes was that previously all of the adult neighbors would discipline neighborhood children, Fullilove said. With urban renewal changing the density of social relationships, however, people did not know each other as well, and the dense networks started to "break apart." Not only were people heartsick for their lost neighborhood, Fullilove said, but without community monitoring of children, the children started to misbehave, and other things started to fall apart too.

FIGURE 3-7 The Lower Hill District after urban renewal. Aerial photograph of completed Civic Arena, 1961.
SOURCES: Photographer unknown. Courtesy of the Pennsylvania Room, Carnegie Library, Pittsburgh. Fullilove, 2009.

One of the things that happened in the aftermath of broader deindustrialization was that white workers had access to education that prepared them for work in scientific and technical fields, Fullilove said. Pittsburgh rebuilt its economy on education and medicine, but African Americans were not able to access the education necessary to get into those fields, and they have basically been left behind, not only in the economy of Pittsburgh but in economies all across the United States.

FIGURE 3-8 Moving Day, 1951.
SOURCE: Richard Saunders. Pittsburgh photographic project. Pittsburgh, Pennsylvania: Carnegie Library.

Petty-Mindedness

Petty-mindedness, a concept that the economist Paul Krugman has written about a great deal, is very useful for thinking about how Americans do not want to spend money for things that ought to be invested in, Fullilove said. An example of petty-mindedness is disinvestment in neighborhoods like Middle Hill in Pittsburgh (see Figure 3-9). Disinvestment led to the collapse and abandonment of buildings. Neighborhoods like Middle Hill illustrate the long-term ravages of bank redlining. These are neighborhoods that if not legally redlined were at least paradigmatically redlined. The narrative of disinvestment and petty-minded thinking, Fullilove suggested, is of not wanting to spend money "for those people" who were blamed for the conditions of slum neighborhoods. They were accused of not taking care of themselves, so why should the nation do it?

FIGURE 3-9 Middle Hill District, the ravages of disinvestment, 1999.
NOTE: Opposite end of Wiley Avenue, where Crawford Grill was located (see Figure 3-3).
SOURCE: Photographed by Fullilove, 2000.

Fragmentation

The result of disinvestment was the destruction of social bonds and the loosening of strong family ties, Fullilove said. Not only did families and churches fragment, but also the weak ties that carried across groups were disappearing. In the end, the social disintegration and fragmentation became universal. What is poorly understood about social disintegration is that not only were the so-called targeted neighborhoods destroyed, the functioning of the whole city was thrown into social disintegration, and

fragmented networks of connection become characteristic of the larger place.

The arc of the policies in the second half of the 20th century was the embodied habits of being in separate spaces, sorting people by race and class, Fullilove said. Individuals may work with people different from themselves, but they do not socialize outside of work. People go back to segregated neighborhoods and do not live together and do not know each other. Therefore, people do not experience someplace or something different, and this limits their capacity to think differently about the entire city.

A CITY IN MIND

One of the remedies for the ways in which division, apartness, and otherness are lodged in people's minds is to begin to see the big picture, the whole picture. The first principle of urban restoration is that people cannot just focus on neighborhoods or populations, but they must think more holistically and must have the whole city in mind (Kunstler, 2003).[4] Fullilove and her colleagues adopted a perspective of urbanism, a science of the ecology of cities. To them, urban restoration involves people finding common ground and talking to each other in new conversations. These conversations are a first step toward healing and recovery.

In order to understand the broader context of a city, Fullilove said, there is a need to learn the stories of an entire city, to learn about what architect and urban planner Michel Cantal Dupart calls the elephants, the wonderful things in unexpected places, and share them with others (Fullilove, 2013). Public housing, for example, has to be seen as a part of what is needed by a whole city. Public housing needs maintenance, and it does not get the maintenance it needs anywhere in the nation. The people that live in public housing are blamed for bad management and the conditions that lead to its disintegration into a distressed community. There is then a desire by officials to have it torn down. By adopting a broader perspective that considers the larger context, Fullilove said, it is obvious that the housing is part of a broader social disintegration where the bridges are not maintained, the electrical grid is not maintained, and the streets are not plowed when there is snow. When people get the big picture and shift their perspective to see the city in mind, they can see where the social disintegration has torn communities apart, where white privilege thinking has given people bad ideas, and where petty-mindedness is a dead end.

[4] See http://www.p2wny.org/uploads/2/5/4/2/25429918/periodic_table_of_elements_of_urban_restoration.pdf (accessed July 13, 2016).

4

Get Ready for Equity[1]

Natalie S. Burke, the president and chief executive officer of CommonHealth Action, discussed her organization's work with clients to create institutional readiness for equity. CommonHealth Action aligns people, strategies, and resources to generate solutions to health and policy challenges, Burke said.[2] CommonHealth Action approaches its work from the perspective of the social determinants of health and looks at health as a production of society. The staff of CommonHealth Action work with clients across sectors and disciplines in different communities, so they ensure that they approach projects in a language that is relevant and meaningful to the people they work with. The framework that CommonHealth Action has developed to most effectively do its work is called equity, diversity, and inclusion (EDI). EDI is used with the goal of helping others achieve equity competencies (see Box 4-1).

DEVELOP AN EQUITY LENS

A significant component of the work of CommonHealth Action is helping clients develop an equity lens (see Figure 4-1). Shifting to an

[1] This chapter is the rapporteur's synopsis of the presentation made by Natalie S. Burke, the president and chief executive officer of CommonHealth Action, and the statements have not been endorsed or verified by the National Academies of Sciences, Engineering, and Medicine.

[2] See http://www.commonhealthaction.org (accessed June 21, 2016).

BOX 4-1
Equity Competencies
Presented by Natalie Burke

Common language: Individuals are aware of and understand universally accepted words, phrases, and concepts. They are able to exchange knowledge and information based on shared meaning in ways that are easily understood to support collaboration and communication among colleagues, partners, and stakeholders.

Historical context: Knowledge, awareness, and understanding of U.S. history and the evolving policy environment that created past and current legal and social constructs for the privilege and oppression of certain populations. The module highlights the impact of those evolving policies on current social conditions (e.g., the impact of redlining on the inability to accumulate wealth from generation to generation and its relationship to health inequities in infant mortality).

Privilege and oppression: Knowledge, awareness, and understanding of the effect of privilege and oppression at a personal, community, and systemic level.

Equity lens: Understanding the social, political, and environmental contexts of a program, policy, or practice in order to evaluate and assess the unfair benefits and burdens within a society or population.

Policy: Knowledge and understanding of policy making, analysis, and implementation with a focus on equity impact.

Commitment to ongoing learning: Expansion of knowledge, skills, and understanding through engagement in a culture of inquiry and continuous learning.

equity lens is what CommonHealth Action calls a "perspective transformation," which is, to paraphrase Mezirow:

> the process of becoming critically aware of how and why our assumptions have come to constrain the way we perceive, understand, and feel about our world; changing these structures of habitual expectation to make possible a more inclusive and integrating perspective; and, finally, making choices or otherwise acting upon these new understandings. (Mezirow, 1978)

This perspective transformation, similar to Fullilove's city in mind (see Chapter 3), is aided in part by giving people a vocabulary to understand and articulate a vision of equity.

People default to equality, Burke said, when they are first introduced to the concept of equity. Burke and her team use analogies in order to explain the differences between equity and equality. One example of a

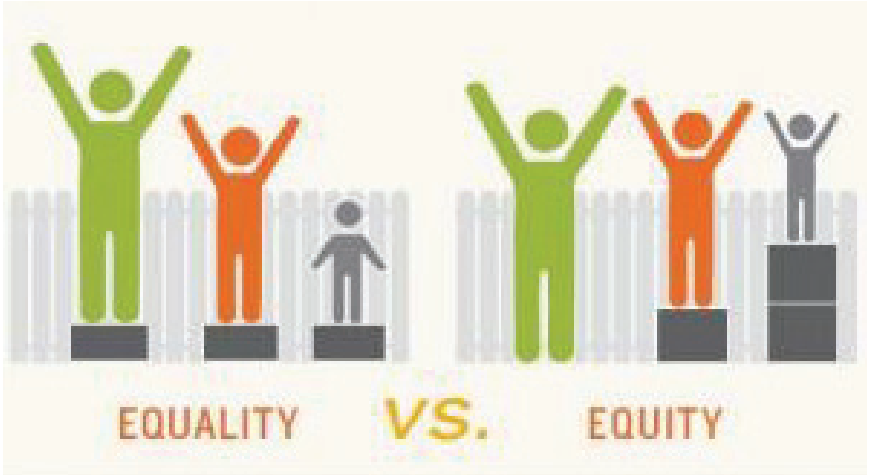

FIGURE 4-1 Equity lens: The lens through which people view conditions, circumstances, and processes to understand who experiences the benefits and burdens of a given program, policy, or practice (CommonHealth Action).
SOURCE: Burke presentation, February 6, 2016.

strategy that they use is to talk about runners competing in a 100-yard dash. It is a straight track. Everybody lines up shoulder to shoulder, so the start is even. It is equal, and there is no reason that one would want it to be any other way. But in the 400, there is a staggered start. The outside lane is longer; the inside lane is shorter. If runners line up shoulder to shoulder, there is an unfair advantage to the person in the inside lane. It does not matter how hard they trained or how hard they worked, it may not even matter how fast they run because the difference is so great that the runners in the outer lane can never catch up. This example, in addition to others, is used by CommonHealth Action to try to get people to understand what equity is. It is a real world example that tends to resonate with people, Burke said. Equality is equal treatment that may or may not result in equitable outcomes. Equity provides all people with fair opportunities to achieve their full potential, Burke said.

Privilege and Oppression

Burke emphasized the importance of considering how to frame equity when speaking to different audiences. One way to do this is to ask people to think of escalators. People who are privileged are on the up escalator for a lifetime. They do not necessarily have to take a step; they just have

to get on the escalator and it carries them to the top. But people who are oppressed are trying to go up a down escalator. If they pause even for a moment they end up back at the bottom. If they miss a step they end up back at the bottom. They have to work harder and faster. They have to be stronger.

The concepts of privilege and oppression can also be challenging for different audiences. Talking about privilege and oppression, Burke said, is a way to get people to relate to how others are experiencing differential power relationships in the society, as opposed to the term racism, which tends to make people feel like they are being judged. Burke explained that giving people terms like privilege can help them to understand the importance of membership in a group that has something of value that is denied to others simply because of the groups to which they belong rather than because of anything they have done or failed to do. She added that dominant group members may be unaware of their privilege or take it for granted. Defining oppression can also be helpful in training clients. Burke defined oppression as "the systematic targeting or marginalization of one group by a more powerful group for the social, economic, and political benefit of the more powerful group." Burke added that since privilege and oppression occur within the context of power, it is helpful to have a definition of power, such as "access to resources and to decision makers as well as the ability to influence others and to define reality for one's self and potentially for others."

By looking at issues of privilege and oppression and discussing the many ways that they operate in society, along with their associated intersectionality, people can begin to understand the challenges that other people face. Sexism and racism are systems of oppression that often manifest within institutions through processes and policies that exclude and marginalize women and people of color. These systems often interact simultaneously; therefore, an intersectional analysis of how racism, sexism, and other "isms" work together to affect health is needed. Race, class, and gender inequities undergird many of the social determinants of health. Understanding the root causes of health inequities and how to change them, Burke said, is critically important.

EQUITY, DIVERSITY, AND INCLUSION

CommonHealth Action training programs teach equity competencies through a process that involves equity, diversity, *and* inclusion. Burke explained that CommonHealth Action defines diversity as a collective mixture of differences and similarities that includes individual and organizational characteristics, values, beliefs, experiences, backgrounds, and behaviors. It encompasses personal and professional histories that frame

how people see the world, collaborate with colleagues and stakeholders, and serve communities. Inclusion, she said, is diversity in action. Inclusion is an active, intentional, and ongoing engagement with diversity, including intentional policies and practices that promote the full participation and sense of belonging of every employee, customer, or client. There can be diversity and inclusion without equity, but equity cannot be achieved without diversity and inclusion, hence CommonHealth Action's combination of equity, diversity, and inclusion as EDI.

Readiness and Awareness

CommonHealth Action connects EDI to the existing work and efforts of the organizations with which it is engaging. In some places EDI is approached through a value proposition and in others through a moral argument. Whether CommonHealth Action enters a community, a company, or an organization, issues of readiness, politics, and power have to be considered. Organizations have to be ready to assume a certain amount of risk, Burke said—the risk to be introspective. They have to assess who they are and prepare themselves by devoting a significant amount of support and resources. In order to fully institutionalize EDI into practice, an organization must possess a readiness and awareness of where it is at the start of training as well as make a long-term commitment to continue managing and measuring progress on the path to mastery.

Whenever CommonHealth Action goes to a place to do EDI work, it first does research on the historical context and works to understand the demographics and the shifts in the politics. The reason for this, Burke said, is that there is a potential to do harm. A group or organization cannot start this conversation if the work has not been done in advance to prepare for what emerges in an organization or a community. CommonHealth Action does research to understand as much as possible before getting started with the training process, while knowing that it is not possible to account for every situation that will come up. It does this extensive preparation in order to avoid leaving an organization or community in a worse condition than it was before the process of change started.

Burke shared an example of a training CommonHealth Action conducted in Azle, Texas. The place was nearly 100 percent white at that time, and Burke and the other trainers kept asking themselves how they would have a conversation about equity, diversity, and inclusion in a population and a community that was so homogenous. During the training, there was a woman who was rolling her eyes and using other expressive body language. Burke eventually asked her why she was behaving that way. The woman replied that she had been called a racist by a trainer during an antiracism training because of comments that

she made during a conversation about welfare. This woman went on to tell Burke that she had never met anyone other than white people who were on welfare. The only children that got into trouble that she knew were white children. The only people who had been incarcerated that she knew were white people. The only people who used drugs in their community were white people. Her frame of reference and her context were informed by being born, educated, and living her entire life in Azle.

What this story told Burke was not only that being called a racist was a very painful experience for this woman, but also that the people who had conducted the antiracist training with members of this community did not do their homework. They had their own implicit biases, even though they were the trainers—they were the people who were supposed to be coming to help folks to have this conversation in a way that was healthy and safe, and they did not do that.

Institutionalizing EDI

One of the sectors that CommonHealth Action has worked with is business. Business leaders know that diversity saves them money, makes them more money, makes them more competitive, and increases their value, Burke said. Citing data from a McKinsey analysis on "diversity's dividend" in the report *Why Diversity Matters*, she noted that

- Companies in the top quartile for racial and ethnic diversity are 35 percent more likely to have financial returns above their respective national industry medians.
- Companies in the top quartile for gender diversity are 15 percent more likely to have financial returns above their respective national industry medians.[3]

Burke described how CommonHealth Action advised a Fortune 150 company on global health and well-being. This company has an incredible reputation with regard to diversity, but it recognized that it was time to do more. Burke suggested that the Affordable Care Act is encouraging employers to begin to look at health as more than worksite wellness programs and to recognize that they need to invest in the 16 hours per day that their employees are spending outside of the office in their com-

[3] These data are based on an examination of 366 public companies in the United States, the United Kingdom, Latin America, and Canada. The data also suggested that in the United States "there is a linear relationship between racial and ethnic diversity and better financial performance: for every 10 percent increase in racial and ethnic diversity on the senior-executive team, earnings before interest and taxes (EBIT) rise 0.8 percent" (Hunt et al., 2016).

TABLE 4-1 EDI = Healthy Business

Current	Future
Provide health care benefits: FOCUS = physical health	Provide on-site wellness centers: FOCUS = determinants of health and well-being
Support workplace diversity and inclusion	Use influence to advocate for equitable public policies
Employee rewards = compensation + benefits	Employee rewards = compensation + benefits + health
Offer healthy worksite food	Support healthy community food environment

SOURCE: Burke presentation, February 6, 2016.

munities. Businesses are starting to look at health more broadly, as can be seen in the future column of Table 4-1, by focusing on factors that go beyond the worksite, such as promoting the conditions that improve overall health and well-being, supporting equitable public policies and a healthier food environment, and understanding that health is a form of compensation. For example, if employees are being encouraged to eat healthier, in order to do that throughout the day, they will need access to healthier foods within their community (IOM, 2015, 2016). Companies are starting to use their location in healthy communities as a recruitment tool, Burke said: come to work here and be healthier than if you do not.

Institutionalizing EDI work is a critical component of seeing any sustainable change in this society, in organizations, and even with regard to population health, Burke said. Institutionalizing EDI is not just about transforming the perspectives of individuals or organizations; it has to become a part of policy, program, and practice (see, for example, Chapter 6). And policy is only as good as the way that it is implemented. There are things that organizations and entities can do around employee orientation and recruitment to create an environment for equity, diversity, and inclusion. Every workplace and every community that is more equitable will result in more equitable health outcomes, she said.

5

Why Frames Matter[1]

Julie Sweetland, a sociolinguist and the vice president for strategy and innovation at the FrameWorks Institute, shared strategies to promote racial equity through strategic framing.[2] FrameWorks is a nonprofit think tank that conducts communications research about social issues.[3] Its staff consists primarily of multidisciplinary Ph.D.-level researchers.

Frames matter, Sweetland said. People's understandings of issues are frame-dependent and communicators need to be selective about what to say, what to leave unsaid, and what to emphasize. How issues are framed has a large impact on the way that people hear, interpret, and act on the different policy proposals that are put forth on racial equity in health outcomes or on any other issue.

METHODS AND MODELS FOR UNDERSTANDING RACE AND HEALTH

One method that FrameWorks researchers use to learn about how people understand social and policy issues is to talk to dozens of people

[1] This chapter is the rapporteur's synopsis of the presentation made by Julie Sweetland, a sociolinguist and the vice president for strategy and innovation at the FrameWorks Institute, and the statements have not been endorsed or verified by the National Academies of Sciences, Engineering, and Medicine.

[2] FrameWorks' definition of framing is available at http://www.frameworksinstitute.org/sfa-overview.html (accessed July 13, 2016).

[3] See http://www.frameworksinstitute.org (accessed June 21, 2016).

on the street and ask them about communication aspects of different topics such as criminal justice reform, human services, environmental health, climate change, child mental health, systems of care, the social determinants of health, immigration, and education. People talk on camera for 10 minutes, and researchers ask questions to get their "top-of-mind assumptions."[4] FrameWorks uses other methods as well, Sweetland said, but videos are a useful way to capture how people think and are more interesting to share than long transcripts, particularly when working with interviews from dozens of different people.

Sweetland shared video clips of responses to the question: "What are the factors or conditions that affect people's health?"[5] In the public mind, there are three determinants of health: diet, exercise, and smoking. This suggests two things, Sweetland said: The first is that members of the public are good learners. These three answers have been the emphasis of public health communications for the past 20 years. The second is that to get people to think about population-level outcomes, causes, and consequences, it will take careful framing of the issues. Individualism is the foundational cultural model used by most people in America. Therefore, people do not understand the mechanisms that create, maintain, or reproduce racial inequity. It is a black box for Americans, and they typically fill in that black box with individual-level explanations.

When the topic is race, Sweetland said, Americans appeal to a model of historical progress as represented by a narrative that Martin Luther King Jr.'s dream of racial equality has been fulfilled with the election of Barack Obama, an African American president. More broadly there is a deep narrative that racism was solved in the 1960s and that the policies that supported structural racism were taken care of during the years of the Civil Rights Movement. From an individualistic perspective, the discussion of health disparities can trigger deficit thinking[6] about communities of color instead of shifting people's perspectives.

The public also uses *separate-fates* thinking to understand social issues, Sweetland said. What this means is that different groups lead separate lives. Similar to what Mindy Fullilove discussed (see Chapter 3) concerning how many people in cities live separately from people with different backgrounds and experiences, Sweetland said that separate experiences lead to thinking that the consequences for one person are not shared

[4] Immediate and without much thought.

[5] The video of Sweetland's presentation is available at the roundtable's website, http://nationalacademies.org/hmd/Activities/PublicHealth/PopulationHealthImprovementRT/2016-FEB-04/Videos/5-Sweetland-Video.aspx (accessed May 18, 2016).

[6] Deficit thinking refers to blaming people of color (individually or collectively) rather than recognizing that structural factors contribute to health inequities.

consequences for all. If the problem is individuals, and the country has already "taken care of racism," then the problems are in the hearts and minds of a few outlier individuals with outdated views rather than in the ways that we structure our institutions. This assumption can lead to thinking that "the problems of other people are not my problem," Sweetland said. Separate-fates thinking leads to a sense of fatalism: "It is what it is. It cannot be affected. The poor will always be with us. You can't change genes." These opinions shape our policy climate, she said.

Simply telling people the scope of a problem without shifting their cognition, and without providing them with a framework in which to interpret data can backfire, Sweetland said. As an example, she shared the following disparities data: "In 2010, 35 out of every 100,000 white people were serving time in state prisons for drug-related crimes. By contrast, 280 out of every 100,000 African Americans were serving time in state prison for drug-related crimes, though the drug use of African Americans and whites in the United States is roughly equal."[7] If the meaning is not provided to them, the audience will provide the meaning. If the information is not reframed, the audience will accept the pre-frame. Stories that simply say who is affected and how much they are affected should be avoided and should be replaced with stories that are more explanatory, Sweetland said; otherwise, the shift in thinking will not occur. Statistics that are interpreted by a public health expert as indicators of an obvious systemic problem will not necessarily be interpreted the same way by the general American public. Members of the public will tend to rationalize them away in many different ways unless they are provided with some very powerful cues for how to interpret them.

The cultural models that people have available to understand health, such as health individualism, and the cultural models that people have to understand race, such as separate fates and historical progress, do not allow the public to really engage in the kinds of policy thinking that promote racial and social justice, Sweetland said.

REFRAMING COMMUNICATION TO ADVANCE RACIAL EQUITY

Sweetland discussed a range of examples and explanations of how to reframe communication in order to explain inequities in a manner that makes sense to a range of Americans.

[7] The video clip of a couple's response to this data is available at the roundtable's website, http://nationalacademies.org/hmd/Activities/PublicHealth/PopulationHealthImprovementRT/2016-FEB-04/Videos/5-Sweetland-Video.aspx (accessed May 18, 2016).

Reframing for Racial Equity Strategy #1: Lead with a Value That Counteracts Separate-Fates Thinking

Values are cherished cultural ideals. They orient thinking on a topic and have powerful priming effects. FrameWorks finds that from a framing point of view, the first problem is affirming that there are solutions available and that this is usually a more productive kind of way to engage people in the conversation. Rather than focusing on a problem, which can be overwhelming to an audience, a more effective way to frame is to state that there is a problem and that improvements are necessary, Sweetland said. Framing is not ignoring the problem; instead, it involves calibrating the level of "problemness" with the availability of solutions and focusing on the possibility of improvements having shared benefits. Sweetland offered advice on what to avoid and on the best strategies to advance a message:

Avoid

- Who is affected and how much.
- These data speak for themselves—look how bad this is for people of color!
- This is a problem that affects the vulnerable.
- This is a moral outrage!
- The system is broken and sweeping changes are needed NOW!!!

Advance

- What affects what, to what end.
- This is a problem with a system that should contribute to a functioning society.
- Here are the moving parts of the system. The data reveal problems.
- This is impractical and unsustainable.
- Improvements are necessary, possible, and will have shared benefits.

Sweetland suggested ways to make the transition from a pre-frame that should be avoided to a frame that advances equity. Leading with values often means not leading with equity. Equity is the mindset, the outcome of communication. The idea is to try to get people to endorse the cue that is put in front of them as to why this matters. Equity may already be a cherished ideal of a group of stakeholders, but, as Natalie Burke discussed (see Chapter 4), it means different things to different people. Instead, tap into values such as human potential and suggest that all people have potential that needs to be available to all communities. Additionally, tap into the value of pragmatism and people's can-do spirit.

Sweetland offered specific examples for how to shift thinking by promoting these values when using titles on slides, graphs, or annual reports. Instead of: "Latest data on early health indicators," consider "Maximizing potential: How are we doing?" Instead of: "Child poverty, homelessness on the rise," cue for pragmatism with "Challenges that call us to work harder and smarter." FrameWorks research studies recommend specific values for specific issues and they are available to the public on their website.[8]

Reframing for Racial Equity Strategy #2: Summarize Less, Explain More

Across several different studies FrameWorks has found that explanation beats description. Mere description presents the determinants and outcomes and does little to shift public thinking. A mechanistic explanation connects determinants to outcomes through a process. This can have up to twice the effect on people's support for policies. Framing effects literally shift the perspective, Sweetland said.

> **Description:** The primary factors that shape the health of Americans are not medical treatments but rather the living conditions they experience. These conditions have become known as the social determinants of health. Our health is shaped by how income and wealth is distributed, whether or not we are employed, and, if so, the working conditions we experience. Furthermore, our well-being is also determined by the health and social services we receive and our ability to obtain quality education, food, and housing, among other factors. Health and illness follow a social gradient: the lower the socioeconomic position, the worse the health.
>
> **Explanation:** Our physical, social, and economic environments shape our health. For example, when communities have areas with safe parks and sidewalks, exercise is easier. And when people live near quality grocery stores, it's easier to eat a healthy diet. Having social support also affects health and wellness by helping people avoid depression and other mental health problems. Poverty makes it difficult to afford good food and decent housing—which we know are basic requirements for health. And unemployment generates severe stress, contributing to mental health problems and placing strain on the body that makes it difficult to fight off illness. The conditions in the communities where we live shape our health and wellness.

[8] See http://www.frameworksinstitute.org (accessed May 18, 2016).

The slight change in text is what frame effects are: they are the small differences in what is emphasized and how messages are framed that can lead to large differences in how people understand the kind of narrative that is being elevated. Explaining that the physical, social, and economic environments shape our health is different from what people are expecting to hear when they hear the term health. Connecting poverty to access to food and housing and connecting unemployment to stress and mental health problems explains what is affected and to what end. Sweetland said that this sort of explanation can lead people to be up to twice as supportive of public-minded, progressive kinds of policies than other messages.

Reframing for Racial Equity Strategy #3: Cue Structural Interpretations of Disparity Data

"Naked numbers" will be interpreted through unproductive interpretive models such as "health individualism," Sweetland said. Order matters. Start with meaning, then numbers, in order to bring the public along: Values first, then disparities data = more powerful frame. When values are used together with data on disparities, it is one of the most powerful ways of making the case for equity, Sweetland said.

FrameWorks has tested three types of messages: (1) just racial, which involves just presenting facts on the disproportionate impact of a problem on people of color; (2) just the value, which refers to presenting a pragmatic, commonsense approach to tackling a problem; and (3) combining pragmatism and racial impact data. Together, pragmatism and data are a powerful way to give people the tools to understand that there is a problem and that there is something people can do together to solve it.

As an example, Sweetland discussed two different narratives regarding data on tooth decay. The first was framed using "evidence of systemic inequality":

> Blacks, Latinos, and Mexican Americans experience nearly twice the amount of untreated tooth decay as their white, non-Latino counterparts. There are stark racial and ethnic inequities that characterize almost every area of life—from education and housing to development and health. Bostonians face very different opportunities and futures depending on their skin color, language proficiency, country of origin, and neighborhood of residence due to structural and institutional racism. (DentaQuest Foundation, 2014, p. 25)

The frame effects of this "disparities drop," as Sweetland termed it, are that the audience is likely to interpret this as a "You made your own bed" flavor of fairness. Poor outcomes are the result of people making

poor choices. Trends by race reveal cultural deficits, not structural deficits. A reframing of this public health information with "fairness across places and pragmatism" leads to this:

> When public health officials in Boston realized that some communities were experiencing up to twice as much untreated tooth decay than others, they looked for underlying reasons for the patterns of this chronic disease. It was more common in neighborhoods where employment opportunities were few and access to health care and oral health care was spotty. The Southern Jamaica Plain Health Center took a practical approach to building community awareness of the troubling data among Blacks, Latinos, and Mexican Americans by engaging a team of young men of color to serve as "oral health ambassadors.

The frame effects of this "fairness across places" approach is that it cues a contextual flavor of fairness that the circumstances beyond individuals' control should be taken into account.

> By bringing this issue to light and pointing out ways to get involved with groups working for change, this *common-sense approach* to a campaign has started an uncommon conversation.

The frame effects of such a pragmatic approach are to reduce fatalistic thinking about racial inequities and tap into an American sense of "can do." Sweetland emphasized that the point is not to hide race, but rather to make sure that the message is framed in a manner that explains how inequities are more an issue of access and structures before the concept of race is introduced. Discussing equities through a lens of place-based fairness provides people with a context to think more structurally and to take into account the impact of circumstances beyond individuals' control. The frame effects of using this pragmantic lens are to reduce fatalism and the sense that "it is what it is" and instead to prompt people to think that together "we can take matters into our own hands, roll up our sleeves," and solve these problems, Sweetland said.

In the research studies conducted by FrameWorks, Sweetland said, the public have some very deeply engrained and well-rehearsed narratives that make it difficult to move a health equity agenda. However, Sweetland said, those preferences are not fixed, but rather they are frame-dependent. The way that people talk about these social issues can open up the "barn raiser" tradition—the collective tradition in American culture—and it is really up to people to shift their communications in order to advance that kind of agenda.

In summary, Sweetland said that there is an untapped or underutilized source of power that people have as change agents, which is intentional framing, conscious framing, and looking at data when framing. At FrameWorks, the focus is on science translation. FrameWorks invites the

public into expert modeling through the use of good communications and helps them become more informed decision makers, advocates, and citizens. Substance absolutely matters, Sweetland said, but substance is framed for good or for ill. Leading with an equity message may not be the way to bring the most people into this kind of movement, but they absolutely can get there. People will support equity. It is a matter of the invitation that they get.

6

Institutionalizing Racial Equity[1]

Jessica Kang, a senior research scientist at the Center for Social Inclusion (CSI), and Rebekah Gowler, the director of health equity capacity development at the Center for Health Equity in the New York City Department of Health and Mental Hygiene (health department), discussed how the health department under the leadership of Commissioner Mary Bassett is transforming culture and practices to promote racial equity through its own work, as well as through its networks and partnerships.

CENTER FOR HEALTH EQUITY

The Center for Health Equity was established at the health department in 2014, Gowler said, and its purpose is to strengthen and amplify the health department's work to eliminate health inequities and to ensure that all residents of New York City have equitable access to the resources and opportunities they need to reach their full health potential.

[1] This chapter is the rapporteur's synopsis of the presentation made by Jessica Kang, a senior research scientist at the Center for Social Inclusion, and Rebekah Gowler, the director of health equity capacity development at the Center for Health Equity in the New York City Department of Health and Mental Hygiene, and the statements have not been endorsed or verified by the National Academies of Sciences, Engineering, and Medicine.

The center takes four different key approaches to health equity:

1. Focus on building and strengthening partnerships with other city agencies and community advocates in order to advance policy and systems change across the city.
2. Work to make injustice visible through the use of data and storytelling and promoting critical research.
3. Invest in key neighborhoods through place-based initiatives that the center manages in East and Central Harlem, the South Bronx, and North and Central Brooklyn.
4. Support internal reform across the agency, with the aim of building the health department's capacity to advance racial equity and social justice in all of its programs' policies and practices.

All of the center's work rests on a set of core values: racial and social justice, community power, accountability, diversity and inclusion, and data- and community-informed practice.

CENTER FOR SOCIAL INCLUSION

CSI is a national nonprofit organization whose mission is to catalyze local communities, government, and other public and private institutions to dismantle structural racial inequity, Kang said. CSI does this through five different types of strategies: policy development and evaluation, organizational change strategies, partnerships in coalitions, communication strategies, and leadership development.

For the past 5 years CSI has conducted research, including the use of focus groups, interviews, and testing, to answer such questions as: How can people talk about race to effectively change policies? and, How can people talk about race more explicitly? What CSI has found is that the first consideration is the dominant racial narratives. Similar to what FrameWorks researchers have found (see Sweetland's discussion in Chapter 5), some people believe that the context of race today in the United States is post-racial. A version of this narrative is that there are people of color in positions of power, and a black man is president. Some people may even say that now some whites are discriminated against, Kang said. Now, more than ever, there are organizations, there are movements, such as Black Lives Matter, that have pushed the topic of race and racism into the forefront, particularly in terms of policing.

Understanding Racism

The work of CSI, Kang said, is informed by an understanding of what is called "dog whistle racism." It combines implicit bias, which is defined by the Kirwan Institute for the Study of Race and Ethnicity as attitudes and stereotypes that affect our understanding, actions, and decisions (Kirwan Institute for the Study of Race and Ethnicity, 2014), with the current understanding of symbolic racism, in which there is a use of images, code words, and metaphors that implicitly signal race (Sears and Henry, 2003). Dog whistle racism—or the race wedge, as it is also called—is the combination of implicit bias and symbolic racism, and it involves the use of symbols or words. There is no need to mention race at all in order to trigger unconscious racism and push people toward policies that support and facilitate inequity.

Working from research done by Eduardo Bonilla-Silva involving white Americans born between 1940 and 1980 (Bonilla-Silva, 2013), CSI found that there are four dominant race frames, Kang said. These frames are (1) racism and inequality are things of the past, (2) disparities are caused by culture/behavior, (3) disparities are inevitable and/or natural, and (4) programs helping people of color are unfair to whites.

Affirm, Counter, Transform

CSI's research-informed approach to counteracting dominant race frames is focused on speaking inclusively about race in a way that can move people on policy, Kang said. CSI developed a model based on research called ACT, which stands for affirm, counter, transform. CSI uses this model to train people on how to communicate about race in a way that can move people toward better outcomes. "Affirm" means to start with the heart and engage the audience with emotional appeals and explain how people are in this together. "Counter" means to explain the problem and take on race directly. "Transform" involves reframing winners and losers, and it ends with a message that binds the heart and a transformative solution that people want to support.

Gowler said that the health department has learned the importance of using effective and strategic communication to advance racial equity. They found the ACT framework developed by CSI to be essential to internal reform and public advocacy. She added that the health department also found it useful for appealing to shared values; talking explicitly about race, racism, and racial justice; countering dominant race frames; and offering practical solutions and action steps for people to be able to move and advance work that hopefully will continue to mobilize and garner additional support in the public health field and beyond in order to advance racial equity and social justice across cities.

NORMALIZE, OPERATIONALIZE, AND ORGANIZE FOR RACIAL EQUITY

In February 2014, Bassett, the newly appointed New York City Health Commissioner, introduced herself to all agency staff in an e-mail in which she described her priorities for the agency. In that e-mail she called health inequities unfair, unnecessary, and avoidable. New York City, Gowler said, is one of the most unequal and most segregated cities in the United States, so it is unsurprising that there are also health inequities. This communication set the stage for an ongoing cultural shift at the health department involving agency leadership and staff engaging in more open and honest conversations about inequities in terms of what they are, what is at their root, and what can be done to address them.

In 2015, Bassett published a perspective piece in the *New England Journal of Medicine* titled "#BlackLivesMatter: A Challenge to the Medical and Public Health Communities." In this piece, Gowler said, Bassett addressed her call to action against racism directly to the medical and public health communities and health professionals. Bassett identified key actions that practitioners of the field could take to advance racial equity: critical research, internal reform, and public advocacy.

Critical Research

Gowler explained that taking action through *critical research* involves professionals conducting critical studies that examine racism alone and at the intersection of other systems of inequity that harm health. Critical research is intended to spur conversations about systemic health, responsibility, and accountability for poor health outcomes. Critical research can also provide tools that are used in the public health and medical fields for community advocates and policy makers to make changes in their own communities.

The health department looked for opportunities to use its data and information to advance critical research, Gowler said. The department relaunched its Community Health Profiles with the purpose of increasing its utility for advocacy and decision making across the city.[2] The Community Health Profiles are newly aligned with the 59 community districts, which are the local level of government in New York City. The Community Heath Profiles include not only health outcomes, but also data on new neighborhood level measures that were not previously provided, such as air quality, school absenteeism, and housing. The profiles

[2] See https://www1.nyc.gov/site/doh/data/data-publications/profiles.page (accessed June 22, 2016).

also provide disaggregated data by place, making it possible to make comparisons across communities and also with the citywide data, as well as providing more robust demographic data for each of the communities.

Internal Reform

Internal reform, Gowler said, should include looking for inequities in institutions, systems, infrastructures, policies, and practices and identifying ways that change can be implemented. Bassett called for internal reform in the health department with the goal of strengthening and aligning internal institutional practices with the department's mission and goals to advance health equity externally. Without attention to the reform of the health department's own policies and practices, Bassett was concerned that its actions might make unintended contributions to the inequities that it sought to eliminate. Internal reform is focused on building the capacity of the agency to advance racial equity and social justice in all things that it does. To do this, the health department's work is being supported by CSI and the Government Alliance on Race and Equity (GARE).[3]

Developed by CSI and GARE, the National Best Practice Framework has three components, Gowler said. The first component is normalizing conversations about race, racism, and racial justice within an organization. The second component is operationalizing racial equity by providing staff and leadership with the tools that they need to make conscious choices that will advance equity. The third component is organizing staff and partnering with others to mobilize and engage people to get the critical feedback and support they need to grow and continuously advance the work through an iterative and cyclical process.

Coupled with this framework, Gowler said, is a set of six core strategies developed by CSI and GARE for jurisdictions and public agencies to support their internal reform process. These are:

- First, operate with urgency and build collective will. Strong leadership combined with strategic and effective communication is important.
- Second, build and use a shared analysis across the agency. This strategy involves staff training to build a common language and shared understanding for how to build the strategies and activities necessary to create and advance their own equity lens.
- Third, build internal capacity to create a focused and organized infrastructure within the organization that moves equity work forward.

[3] See http://racialequityalliance.org (accessed July 19, 2016).

- Fourth, develop and implement tools that can be used to operationalize the advancement of equity. Many people support the advancement of health equity across communities but are unsure how to do it.
- Fifth, partner with others. Partnering is not only outside the organization, but also inside. The health department for example, has more than 6,000 employees and 13 different divisions, so organizing staff internally is critical for the success of the effort to advance racial equity and social justice.
- Sixth, use data and metrics. There is a need to evaluate and track the progress and success of the internal reform efforts and also to ensure that the organization is tracking its racial equity goals and really measuring its success in reducing inequities in health outcomes across the city.

Public Advocacy

In Bassett's article in the *New England Journal of Medicine* she identified public advocacy as a key strategy for health professionals to use in various forms, such as working with policy makers to direct policy change, writing editorials and opinion pieces, and sharing a new narrative and framework, Gowler said. Partnering with community advocates can be accomplished by offering the department's expertise in supporting advocates' work to address health inequity.

An example that Gowler provided of the health department's own advocacy work was its participation in the New York City Coalition to Dismantle Racism in the Health System, which was convened by Doctors for America. This coalition of institutions and advocates includes members from area medical, public health, and social work schools; hospitals, health centers, and other service providers; unions; community-based organizations; and others.

Institutionalizing Equity

Gowler connected the internal reform efforts of the health department to the concepts of equity, diversity, and inclusion, as Burke had discussed earlier (see Chapter 4). What they have found in the health department, Gowler said, is that encouraging equity requires focusing on diversity and inclusion within the department's workforce and that equity is important to implementing internal reform. The chief diversity officer leads the effort to create a more diverse and inclusive workforce. The health department is making an effort, Gowler said, to implement reform efforts that will

link the workforce to the demographics of the city, which would mean a workforce that reflects the city. It will also mean maintaining awareness of how implicit bias and the persistence of dominant race frames are perpetuated. If the health department's workforce does not reflect the diversity of the broader community and does not make an effort to challenge dominant race frames, then it could potentially be a place where, as Fullilove discussed (see Chapter 3), there is prevalent white privilege thinking, Gowler said.

Internal reform is really about transforming the way that the staff and the institution practice equity in all of the work that they do, which includes administrative services, hiring practices, procurement, and contracting, Gowler said. Organizational change takes a lot of time and patience, balanced by an impatience and persistence to continually move forward. Internally, there has been some pushback to see early outcomes in a short time frame, but this is a long process. Inequities have been created over centuries, so to expect them to be resolved in 5 years or less is unrealistic.

Talking explicitly about race, racism, and racial justice is not typically normalized in institutions, Gowler said. Within public health, many people are comfortable talking about social determinants—how environmental factors, housing, and education affect health—but people are not yet comfortable in really naming the systems that drive not only the determinants of health but the determinants of inequity, like racism. There is a need, Gowler said, to move the conversation in that direction through training, through the critical analysis of data, and through engaging with communities and residents of neighborhoods and cities to hear their experiences and move beyond the traditional quantitative data analysis by using more storytelling to connect to peoples' hearts and minds.

DISCUSSION

During the discussion, Gowler suggested that there is a role for the federal government to use its national platform to amplify and support racial and health equity work happening at the local level in health departments and across communities in the United States.

Mary Kate Allee of the National Association of County and City Health Officials (NACCHO) said that she was looking forward to discussing with her federal partners how NACCHO can help health departments to do more and do better. Lydia Sermons, the communications director for the U.S. Department of Health and Human Services' Office of Minority Health, emphasized that she and her staff want to be a part of the dialogue moving forward. As representatives of a federal agency,

they are positioned to have impact through their engagement with so many communities and partners across the nation. She added that they are thinking about how to reframe messages because of the demographic shifts across the nation and about the need to address a range of inequities that the nation is confronting.

Appendix A

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Appendix B

Workshop Agenda

Roundtable on Population Health Improvement[1]
Framing the Dialogue on Race and Ethnicity to Advance Health Equity:
A Workshop
February 4, 2016

AGENDA

Location: Lecture Hall, National Academy of Sciences Building, 2101 Constitution Avenue NW, Washington, DC

WORKSHOP OBJECTIVES:

1. Explore the development of a shared framework for applying a race/ethnicity equity lens and health equity lens to the discourse on population health.
2. Advance the population health field's understanding of how policies and their implementation foster or perpetuate ethnic and racialized health inequities.
3. Explore current best practices in the communication, advocacy, and messaging of ethnic and racialized health inequalities.
4. Increase the capacity of participants to effectively foster a professional agenda that integrates the application of racial/ethnic equity and health equity lenses across multiple sectors and health systems.

[1] In coordination with staff and members of the Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities.

8:15 a.m. **Welcome and overview of the day**

Sanne Magnan, former president and chief executive officer, Institute for Clinical Health Systems; member, workshop planning committee; co-chair, Roundtable on Population Health Improvement

Phyllis D. Meadows, associate dean and director of the Office of Public Health Practice, and clinical professor of health management and policy, School of Public Health, University of Michigan; senior fellow, The Kresge Foundation; co-chair, workshop planning committee; member, Roundtable on Population Health Improvement; member, Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities

8:30 a.m. **Keynote—Health equity and racism**

Gilbert C. Gee, professor, Department of Community Health Sciences, Fielding School of Public Health, University of California, Los Angeles

9:00 a.m. **Q&A/Discussion**

9:20 a.m. **Developing an equity lens within and across sectors to improve population health**

Moderator: Terry Allan, health commissioner, Cuyahoga County (Ohio) Board of Health; member, Roundtable on Population Health Improvement

Speaker: Natalie S. Burke, president and CEO, CommonHealth Action

9:45 a.m. **Q&A/Discussion**

10:10 a.m. **Break**

10:25 a.m. **The evidence for the historical policy production of racialized health inequities and their continuing impact on population health**

Moderator: Lourdes J. Rodríguez, program officer, New York State Health Foundation; co-chair, workshop planning committee

Speaker: Mindy Fullilove, professor, clinical psychiatry, Mailman School of Public Health, Columbia University

10:50 a.m. **Q&A/Discussion**

11:15 a.m. **Framing messages to policy makers about racial and ethnic disparities and the promotion of health equity**

Moderator: Thomas LaVeist, William C. and Nancy F. Richardson professor in health policy, and director, Hopkins Center for Health Disparities Solutions, Johns Hopkins Bloomberg School of Public Health; member, Roundtable on Population Health Improvement

Speaker: Julie Sweetland, vice president for strategy and innovation, FrameWorks Institute

11:40 a.m. **Q&A/Discussion**

12:00 p.m. **Lunch**

12:30 p.m. **Framing racial and ethnic disparities to increase public support for policies that promote health equity**

Moderator: Sarah R. Linde, RADM U.S. Public Health Service, chief public health officer, Health Resources and Services Administration; member, workshop planning committee; member, Roundtable on Population Health Improvement

Speaker: Rebekah Gowler, director of health equity capacity development, Center for Health Equity, New York City Department of Health and Mental Hygiene

Speaker: Jessica Kang, senior research scientist, Center for Social Inclusion

12:55 p.m. **Q&A/Discussion**

1:15 p.m. **Closing remarks and reflections on the day**

George Isham, senior advisor, HealthPartners; senior fellow, HealthPartners Institute for Education and Research; co-chair, Roundtable on Population Health Improvement

2:00 p.m. **Adjourn open session**

Appendix C

Speaker and Moderator Biographical Sketches

Terry Allan, R.S., M.P.H., has been the health commissioner at the Cuyahoga County (Ohio) Board of Health since 2004, which serves as the local public health authority for 855,000 citizens in 57 Greater Cleveland communities. He received his bachelor of science degree in biology from Bowling Green State University and a master of public health from the University of Hawaii. Mr. Allan is an adjunct faculty member at Case Western Reserve University's School of Medicine and was a Year 13 Scholar of the Centers for Disease Control and Prevention's National Public Health Leadership Institute. Mr. Allan is a past president of the Association of Ohio Health Commissioners and a past president of the National Association of County and City Health Officials. He has been a member of the Ohio Department of Health/Local Health Department Emergency Preparedness Workgroup since 2004. He has served on range advisory boards in Cuyahoga County, including the Invest in Children Executive Committee, the Case Comprehensive Cancer Center's Community Advisory Board, Case Western's Clinical Translational Science Collaborative, and the Prevention Research Center for Healthy Neighborhoods. Mr. Allan was a member of the Standards Development Workgroup for the National Public Health Accreditation Board and currently serves as a member of the Accreditation Improvement Committee. He is a member of the State, Local, Territorial, and Tribal Workgroup supporting the Advisory Committee to the Director of the Centers for Disease Control and Prevention and is a member of the National Academies of Sciences, Engineering, and Medicine's Roundtable on Population Health Improvement.

Natalie S. Burke is president and chief executive officer of CommonHealth Action (CHA). She provides visionary leadership for CHA's business development and business model, capacity building, and programs. A relationship specialist, she is known for building and sustaining successful, long-term interactions with leaders and innovators across sectors. As an advisor to corporate leaders, communities aspiring to change, and everyone in between, Ms. Burke guides people and organizations to the solutions, plans, and common language necessary to succeed and make the world a better and more healthy place. As a strategist, she focuses on the connective tissue that forms organizations (people and entities in relationship) and on how to strengthen it, and as a facilitator she cultivates spaces to exchange ideas that create change. Since the mid-1990s, she has held leadership positions focused on creating opportunities for health through community, organizational, institutional, and systemic change. Her public health and health care experience includes technical assistance (problem solving) and capacity building for national entities including Kaiser Permanente; Cummins, Inc.; and the W.K. Kellogg Foundation as well as federal, state, and local governments. Prior to co-founding CHA in 2004, Ms. Burke was in executive leadership at the National Association of County and City Health Officials (NACCHO) in Washington, DC. While at NACCHO, she served as co-supervising producer for the documentary *The Edge of America: Struggling for Health and Justice*, which focused on people living in three rural communities and the challenges they face to their health, well-being, and quality of life. A graduate of the University of Maryland with a degree in government and politics, Ms. Burke conducted federal health policy analysis at the National Health Policy Forum and was on staff at the National Institutes of Health. She has been selected for numerous national fellowships including the Emerging Leaders in Public Health Fellowship (jointly hosted by the University of North Carolina's Schools of Business and Public Health) and New York University's Robert F. Wagner School of Public Service Lead the Way Fellowship for visionary and entrepreneurial leaders in the nonprofit sector. In 2012, Ms. Burke was selected to the Council of Innovation Advisors for ConvergeUS, a national initiative focused on technology-based social innovation between the technology sector and the nation's nonprofit organizations. Committed to the health and well-being of all people, Ms. Burke views health as the product of complex interactions among systems and factors such as education, employment, environmental conditions, access to technology, housing, transportation, and health care. Throughout her career, she has sought to understand the root causes of ill health, including the delicate balance among genetics, personal health behaviors, and the systems and institutions that provide the contexts within which we live our lives

and make our decisions. That understanding guides her work with local and national leaders whose decisions play critical roles in the production of the public's health.

Mindy Thompson Fullilove, M.D., is a research psychiatrist at New York State Psychiatric Institute and a professor of clinical psychiatry and public health at Columbia University. She is a board-certified psychiatrist who is interested in the links between the environment and mental health. She started her research career in 1986 with a focus on the AIDS epidemic and became aware of the close link between AIDS and place of residence. Under the rubric of the psychology of place, Dr. Fullilove began to examine the mental health effects of such environmental processes as violence, rebuilding, segregation, urban renewal, and mismanaged toxins. She has published numerous articles and six books, including *Urban Alchemy: Restoring Joy in America's Sorted-Out Cities*, *Root Shock: How Tearing Up City Neighborhoods Hurts America and What We Can Do About It*, and *House of Joshua: Meditations on Family and Place*.

Gilbert C. Gee, Ph.D., is a professor in the Department of Community Health Sciences at the Fielding School of Public Health at the University of California, Los Angeles (UCLA). He received his bachelor's degree in neuroscience from Oberlin College, his doctorate in health policy and management from the Johns Hopkins University, and postdoctoral training in sociology from Indiana University. Prior to coming to UCLA, he was on the faculty at the University of Michigan and the University of Michigan–Flint. His research focuses on the social determinants of health inequities of racial, ethnic, and immigrant minority populations using a multi-level and life-course perspective. A primary line of his research focuses on conceptualizing and measuring racial discrimination and on understanding how discrimination may be related to illness. He has also published more broadly on the topics of stress, neighborhoods, environmental exposures, occupational health, and Asian American populations. His research has been honored with a group merit award from the National Institutes of Health for the development of multicultural measures of discrimination for health surveys. In addition, he has received two scientific and technical achievement awards from the Environmental Protection Agency for development of the stress–exposure–disease framework (in collaboration with Devon Payne-Sturges). He has also been a guest editor for *Child Development*, *Asian American and Pacific Islander Nexus Journal*, and the *Asian American Journal of Psychology*. Dr. Gee is currently the editor of the *Journal of Health and Social Behavior*.

Rebekah Gowler, M.S.W., M.P.H., is the director of health equity capacity development at the Center for Health Equity at the New York City Department of Health and Mental Hygiene. Ms. Gowler manages planning and activities to build the capacity of the Center for Health Equity and the health department to advance racial equity and social justice through its programs, policies, and practices. Ms. Gowler conducted similar work as a policy analyst at the Boston Public Health Commission, where she managed the development and implementation of a racial justice and health equity training series for all agency staff, which was part of a larger internal process to align the health department's work within an equity framework. Prior to that, Ms. Gowler worked in the Office of Community Health Workers at the Massachusetts Department of Public Health, assisting with the development of a legislative report on the Community Health Worker workforce in Massachusetts. More recently, she directed volunteerism and child nutrition work at the New York City Coalition Against Hunger. Ms. Gowler got her start in health equity and racial justice work more than 10 years ago as an AmeriCorps member in Sunset Park, Brooklyn, then received both an M.S.W. and an M.P.H. from Boston University.

George J. Isham, M.D., M.S., is a senior advisor to HealthPartners responsible for working with the board of directors and the senior management team on health and quality-of-care improvement for patients, members, and the community. Dr. Isham is also a senior fellow of the HealthPartners Research Foundation and facilitates forward progress at the intersection of population health research and public policy. Dr. Isham is active nationally and currently co-chairs the National Quality Forum–convened Measurement Application Partnership, chairs the National Committee for Quality Assurance's (NCQA's) clinical program committee, and is a member of NCQA's committee on performance measurement. He is a former member of the Centers for Disease Control and Prevention's (CDC's) Task Force on Community Preventive Services and the Agency for Healthcare Research Quality's U.S. Preventive Services Task Force and currently serves on the advisory committee to the director of CDC. His practice experience as a general internist was with the U.S. Navy; at the Freeport Clinic in Freeport, Illinois; and as a clinical assistant professor of medicine at the University of Wisconsin Hospitals and Clinics in Madison, Wisconsin. In 2014 Dr. Isham was elected to the National Academy of Medicine. Dr. Isham served as chair of the National Academies of Sciences, Engineering, and Medicine's Roundtable on Health Literacy from 2005 to 2014, and has chaired three studies in addition to serving on a number of studies related to health and quality of care. In 2003 Dr. Isham was appointed as a lifetime national associate

of the National Academy of Sciences in recognition of his contributions to the work of the Institute of Medicine.

Jessica Kang, M.A., is a senior research scientist at the Center for Social Inclusion (CSI). Ms. Kang engages in research strategies and initiatives on communications testing. Prior to joining CSI, Ms. Kang obtained her master's degree in social psychology from the University of Connecticut. As a graduate research assistant, Ms. Kang's research focused on people's identification with a social group such as race and gender and the effects of this identification on attitudes and stereotyping. Ms. Kang also researched the effects of the 2008 presidential election on different racial groups' identification with being American. During her undergraduate career, Ms. Kang studied how people react to racial minorities who are strongly identified with their racial group. Outside of research, Ms. Kang has actively participated in organizations that advocate for people of color and provide opportunities for underserved populations including One Heartland and the Pipeline Project. In addition to her master's degree, Ms. Kang holds bachelor's degrees in psychology (B.S.) and English (B.A.) from the University of Washington.

Thomas LaVeist, Ph.D., is the chairman of the Department of Health Policy and Management at the Milken Institute School of Public Health at the George Washington University (GWU). He joined GWU after 25 years on the faculty of the Johns Hopkins Bloomberg School of Public Health where he was the William C. and Nancy F. Richardson Professor in Health Policy and the director of the Hopkins Center for Health Disparities Solutions. He received his bachelor's degree from the University of Maryland Eastern Shore and his doctorate degree in medical sociology from the University of Michigan, and he had a postdoctoral fellowship in public health at the Michigan School of Public Health. Dr. LaVeist has published more than 100 articles in scientific journals. In addition to his scholarly writing, Dr. LaVeist has written articles for *Newsweek*, *Black Enterprise*, and the *Baltimore Sun*. He is a highly sought after lecturer at leading universities, corporations, professional conferences, and workshops. His research has been funded by the National Institutes of Health (NIH), the Centers for Disease Control and Prevention, the U.S. Department of Defense, The Commonwealth Fund, Sage Foundation, and the Agency for Healthcare Research and Quality. In 2012 he organized and hosted the International Conference on Health in the African Diaspora, which brought together health advocates from 24 countries in the Western Hemisphere. Dr. LaVeist has provided consultation services for numerous federal agencies and health care organizations on minority health and cultural competency issues and racial disparities in health. His dissertation

on racial disparities in infant mortality was awarded the 1989 Roberta G. Simmons Outstanding Dissertation Award by the American Sociological Association. He is the recipient of the Innovation Award from NIH and the Knowledge Award from the U.S. Department of Health and Human Services' Office of Minority Health. In 2013 he was elected to membership in the National Academy of Medicine. The second edition of his edited volume *Race, Ethnicity and Health: A Public Health Reader* (Jossey-Bass Publishers) was published in fall 2012. His textbook *Minority Populations and Health: An Introduction to Race, Ethnicity, and Health in the United States* (Jossey-Bass) was published in 2005. He is also the author of *The DayStar Guide to Colleges for African American Students* (Stanly Kaplan/Simon and Schuster) and co-author of *8 Steps to Help Black Families Pay for College* (Princeton Review/Random House). His most recent book project, *Legacy of the Crossing: Slavery, Race, and Contemporary Health in the African Diaspora*, is planned for publication in 2017.

RADM Sarah Linde, M.D., is a medical officer in the Commissioned Corps of the U.S. Public Health Service. She currently serves as the chief public health officer for the Health Resources and Services Administration (HRSA), which works to improve health and achieve health equity through access to quality services, a skilled health workforce, and innovative programs. Prior to working at HRSA, Dr. Linde was the deputy director of the Office of Disease Prevention and Health Promotion in the Office of Public Health and Science in the Office of the Secretary of Health and Human Services. There she helped oversee national disease prevention and health promotion activities, including Healthy People, the *Dietary Guidelines for Americans*, and the Physical Activity Guidelines. Her previous assignments included work at the Food and Drug Administration Office of Orphan Products Development, which helps in the development of drugs, biologics, and devices for rare diseases, and the National Health Service Corps in HRSA, where served as the director of the Shenandoah Valley Family Health Center, a community health center in Inwood, West Virginia. RADM Linde is board certified in family practice and is a graduate of the Uniformed Services University of the Health Sciences Medical School in Bethesda, Maryland.

Sanne Magnan, M.D., Ph.D., is the co-chair of the Roundtable on Population Health Improvement. Dr. Magnan served as president and chief executive officer of the Institute for Clinical Systems Improvement (ICSI) until January 4, 2016. Dr. Magnan was previously the president of ICSI, when she was appointed by former Minnesota Governor Tim Pawlenty to serve as Commissioner of Health for the Minnesota Department of Health. She served in that position from 2007 to 2010 and had significant responsibility

for implementation of Minnesota's 2008 health reform legislation, including the Statewide Health Improvement Program, standardized quality reporting, the development of provider peer grouping, the certification process for health care homes, and baskets of care. She returned as ICSI's president and chief executive officer in 2011. Dr. Magnan also currently serves as a staff physician at the Tuberculosis Clinic at the St. Paul-Ramsey County Department of Public Health and as a clinical assistant professor of medicine at the University of Minnesota. Her previous experience includes serving as vice president and medical director of consumer health at Blue Cross and Blue Shield of Minnesota, where she was responsible for case management, disease management, and consumer engagement. Dr. Magnan holds an M.D. and a Ph.D. in medicinal chemistry from the University of Minnesota and is a board-certified internist. She earned her bachelor's degree in pharmacy from the University of North Carolina. She currently serves on the National Academies of Sciences, Engineering, and Medicine's Roundtable on Population Health Improvement, and she has served on the board of Minnesota Community Measurement and the board of NorthPoint Health & Wellness Center, a federally qualified health center and part of Hennepin Health. She was named 1 of the 100 Influential Health Care Leaders by Minnesota Physician magazine in 2004, 2008, and 2012. Since 2012 she has participated in the Process Redesign Advisory Group for the National Center for Inter-Professional Practice and Education, coordinated through the University of Minnesota. Recently, she became a senior fellow at the HealthPartners Institute for Education and Research. She is participating in several technical expert panels for the Centers for Medicare & Medicaid Services on population health measures (2015–2016) and is a member of the Population-Based Payment Workgroup of the Healthcare Payment Learning and Action Network (2015–2016). She is also on the Interdisciplinary Application/Translation Committee of the Interdisciplinary Association for Population Health Sciences.

Phyllis D. Meadows, Ph.D., R.N., M.S.N., is a senior fellow in the Health Program at The Kresge Foundation, the associate dean for practice at the Office of Public Health Practice, and a clinical professor of health management and policy at the School of Public Health of the University of Michigan. As a senior fellow in the health program, Dr. Meadows engages in all levels of grant-making activity. Since joining The Kresge Foundation in 2009, she has advised the health team on the development of its overall strategic direction and provided leadership in the design and implementation of grant-making initiatives and projects. Dr. Meadows also has coached team members and created linkages to national organizations and experts in the health field. In addition, she regularly reviews grant

proposals, aids prospective grantees in preparing funding requests, and provides health-related expertise. Dr. Meadows's 30-year career spans the nursing, public health, academic, and philanthropic sectors. She is the associate dean for practice at the University of Michigan's School of Public Health and has lectured at Wayne State University's School of Nursing, Oakland University's School of Nursing, and Marygrove College. From 2004 to 2009, Dr. Meadows served as the deputy director, director, and public health officer at the Detroit Department of Health and Wellness Promotion. In the early 1990s she traveled abroad as a Kellogg International Leadership Fellow and subsequently joined the W.K. Kellogg Foundation as a program director. She also served as director of nursing for The Medical Team–Michigan.

Lourdes Rodríguez, Dr.P.H., is a program officer for the New York State Health Foundation (NYSHealth), where she works on projects related to building healthy communities. In this capacity she works toward supporting neighborhood-level interventions to increase healthy food options and improve the built environment; advancing public policies that promote healthy living; and increasing access to programs that help New Yorkers lead healthier lives. She also works to support the foundation's goals to advance primary care, especially on projects aimed at addressing the social determinants of health. Prior to joining NYSHealth, Dr. Rodríguez served as the associate director of community partnerships for the Healthy Neighborhoods initiative at City Harvest. In this position, she oversaw the implementation of the organization's community engagement activities to help address the epidemics of diabetes, cardiovascular disease, and other diet-related diseases in five low-income neighborhoods of New York City. From 2004 to 2012 she was on the faculty of the Columbia University Mailman School of Public Health. She currently holds an appointment as an adjunct associate professor at the New York University Global Institute of Public Health. In 2011 she co-edited a book examining community mobilization for health, and she has authored numerous publications on the subjects of violence prevention, the health of vulnerable populations, mental health, community mobilization, and active living. Dr. Rodríguez received a bachelor of science degree in industrial biotechnology from the Mayagüez Campus of the University of Puerto Rico, a master of public health degree from the University of Connecticut, and a doctorate in public health from Columbia University's Mailman School of Public Health. She serves on the board of Inwood Community Services, Inc., and on the consensus group of City Life Is Moving Bodies (CLIMB), a neighborhood-based initiative that plans Hike the Heights, an annual northern Manhattan community mobilization event.

Julie Sweetland, Ph.D., M.A., is a sociolinguist and the vice president for strategy and innovation at the FrameWorks Institute, where she leads efforts to diffuse the organization's cutting-edge, evidence-based reframing recommendations throughout the nonprofit sector. Since joining FrameWorks in 2012, she has led the development of powerful learning experiences for nonprofit leaders and has provided strategic communications guidance for advocates, policy makers, and scientists nationwide and internationally. Prior to joining the institute, Dr. Sweetland was actively involved in improving teaching and learning for more than a decade as a classroom teacher, instructional designer, and teacher educator. At the Center for Inspired Teaching, she served as the director of teaching and learning and helped to found a demonstration school with an embedded teacher residency. As the founding director of the Center for Urban Education, she launched a graduate teacher preparation program for the University of the District of Columbia. Dr. Sweetland's linguistic research has focused on the intersection of language and race, on the role of language variation and language attitudes on student learning, and on effective professional learning for teachers. Her work has appeared in publications such as the *Journal of Sociolinguistics*, *Educational Researcher*, and *Education Week*, and she is the co-author of *African American, Creole, and Other Vernacular Englishes in Education*. She is a graduate of Georgetown University and lectures regularly at her alma mater. She completed her M.A. and Ph.D. in linguistics at Stanford University.