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AN EVALUATION OF PNLV'S HEALTH EQUITY FELLOWSHIP AND HEALTH DISPARITIES WEBINAR SERIES

Summary

In the summer of 2020, Promise Neighborhoods of the Lehigh Valley (PNLV) conducted eight webinars – the Health Disparities Webinar Series, and hosted six students who participated in the Health Equity Fellowship. These programs are part of the Health Equity Activation and Research Team (HEART)'s efforts to implement strategies to prepare students in health professional schools, as well as healthcare and social service providers to address the social determinants of health and to dismantle structural racism during and beyond the COVID-19 pandemic. This report assesses participants' perspectives of two of these strategies: The Health Disparities Impact Webinar Series and the Health Equity Fellowship.

Those who participated in at least one of the eight webinars were less likely than those who did not participate in any of the webinars to believe that persons impacted by structural inequities were responsible for addressing health disparities. Those who attended webinars were also more likely to report that they feel prepared to address racial inequities in health. Students were more likely than others (health care and social services providers, public health practitioners, and community members) to believe that as a society, we can address racial inequities in health.

The Health Equity Fellowship provided a unique opportunity for students to engage with and learn from the community. All the students we interviewed highlighted their interactions with community members and the opportunity to learn from context experts as the most valuable aspects the fellowship. The fellowship expanded their understanding of the nature and causes of health disparities and motivated them to be involved in dismantling systems of oppression.

As HEART continues to develop strategies for health equity, community resilience, and the elimination of systematic racism during and beyond the COVID-19 pandemic, it is important to continue to foster radical inclusion of people historically marginalized. Creating more opportunities in which healthcare providers interact with and learn from the expertise of community members is critical. HEART should examine unique issues faced by providers who have marginalized identities, for example, providers who are women, or Black, or Transgender, or first-generation college students. Finally, engaging with the framework of structural competency might increase the visibility, comparability and applicability of HEART strategies.

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AN EVALUATION OF PNLV'S HEALTH EQUITY FELOWSHIP AND HEALTH DISPARITIES WEBINAR SERIES

BACKGROUND

Promise Neighborhoods of the Lehigh Valley (PNLV) received a grant from the Dorothy Rider Pool foundation to help address health inequities during this time of covid-19 and beyond. The grant supports the development of a Health Equity Activation and Research Team (HEART), that seeks to develop partnerships for health equity, community Resilience, and the elimination of systematic racism during and beyond the ongoing COVID-19 pandemic. The grant funded four HEART deliverables - the Health Disparities Webinar Series, the Health Equity Fellowship, building a Community Resilience Fund, and starting a Radical Welcome Inclusion Health Workgroup. This report focusses on the impact of the Health Disparities Webinar Series, and the Health Equity Fellowship on improving our understanding of the causes of and potential solutions to health inequities, and on preparing participants to address these inequities.

Health and the resources that matter for health are not equally distributed because of structural racism. The society is organized in ways that advantage people who are White and disadvantage people who are not White, especially Black, Latinx and Native American persons. For example, Latinx populations in Allentown are more likely to live below the poverty line compared to their White counterparts, and Black, Latinx and Native American residents are significantly less likely than Whites to have a college degree. These social determinants of health – the conditions within which people are born, live, age and work that shape their wellbeing, access to health care and their use of health services – confer health benefits to some and health disadvantages to others. Examples of social determinants of health include income, education, housing, food, transportation, and violence; including police brutality. Residents with access to good quality housing, healthy food, transportation, and who are not exposed to violence are more likely to have better health compared to residents with limited access to quality food or who disproportionately experience police brutality. Social determinants of health are the reasons why health inequities are widened by social inequalities. Health risks increase among populations that are more likely to face barriers to healthy food choices, who lack access to reliable transportation, or are exposed to environmental risks such as poor quality housing. Therefore, one of the key priorities of the Community Health Needs Assessment in the Lehigh Valley is to decrease the burden of the social determinants of health in the community.

The COVID-19 pandemic has significantly affected Allentown. It laid bare long-standing structural inequities that affect many racially and economically marginalized populations, and has now put them at risk for contracting the coronavirus and dying from COVID-19. In Allentown, the case rate per capita is one of the highest in the state of Pennsylvania. The city wards with the most cases are those with limited resources and those in which the racial composition is predominantly Black and Latinx. In fact, a study published by the Georgetown Public Policy Review concluded that: "The neighborhoods in Allentown that have higher percentages of Black and Latinx residents are the ones that have been particularly impacted" and that resource allocation should prioritize these communities.

Communities impacted the most by COVID-19 in Allentown are the same communities that have been excluded in decision-making about their own wellbeing. Decision-makers, as well as healthcare and social services providers know very little about the reality of facing the brunt of two intersecting pandemics: COVID-19 and police brutality – both sustained and exacerbated by structural racism. The Health Equity Activation and Research Team (HEART) sought to implement strategies to prepare students in health professional schools, healthcare and social service providers to address the social determinants of health and to dismantle structural racism during and beyond the COVID-19 pandemic. This report assesses participants' perspectives of two of these strategies: The Health Disparities Impact Webinar Series and the Health Equity Fellowship.

METHODS

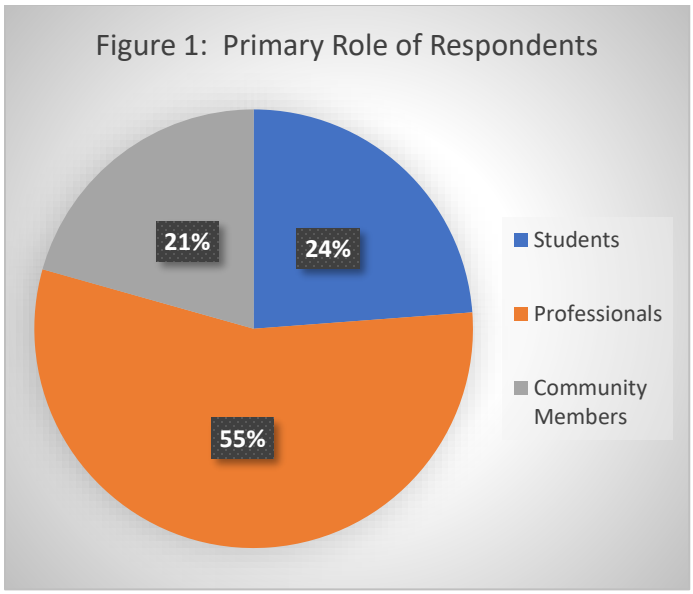
To assess the impact of the Health Disparities Webinar Series, a retrospective case control design was used. All persons (cases) who attended at least one of the Health Disparities Impact Webinar Series received a short online survey administered via the Qualtrics platform to complete anonymously. A list of the webinars is presented in Appendix A. Each webinar was facilitated by a content expert: a person with formal training on the issue to be addressed, and a context expert: a community member with lived experiences. The survey (Appendix B), assessed their understanding of health disparities, how to best address them, and their level of preparation to take on the social determinants of health. The same survey was sent to out to PNLV's listserv of community members, health and social service professionals, some of who are students who did not attend the Health Disparities Webinar Series. These are controls. The survey assessed their understanding of health disparities, how to best address them, and their level of preparation to take on the social determinants of health.

A total of 63 persons completed the survey, 25 attended at least one of the health disparities webinars while 38 did not attend any. We analyzed the survey to understand perspectives of health disparities. We compared the results between cases and controls to determine the impact of the webinars.

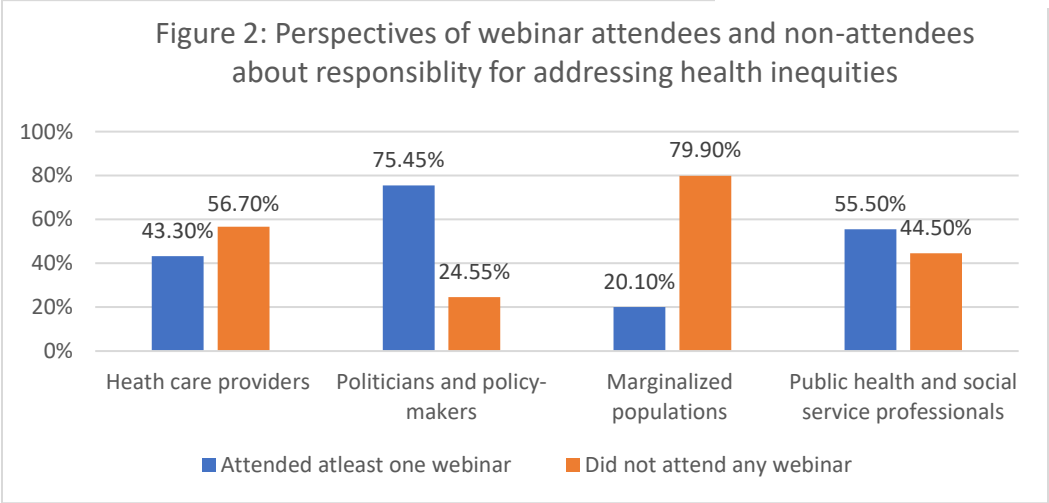
Three of six students who participated in the Health Equity Fellowship agreed to be interviewed. The interviews assessed the extent to which the fellowship met its objectives of providing basic understanding of social determinants of health and health equity, having fellows able to incorporate self-reflective practices, deep listening and a collective impact framework into their studies and professional work, being able to value the expertise of the community, and participating in dismantling systems of oppression that cause health inequities. The interviews lasted an average of 30 minutes and were recorded and transcribed. The results are described with themes consistent with the interview questions. The interview guide is included in Appendix C.

FINDINGS

Majority of survey respondents were professionals such as clinicians, public health, social work practitioners, other social service providers, and teachers and professors. As shown on Figure 1, only about one in four were students, and two in ten were community members.



Survey respondents were asked to assign a percentage of responsibility they believe each one of four select entities had towards addressing health inequities. These entities are i) healthcare professionals, ii) politicians and policymakers, iii) marginalized populations impacted by health inequities, and iv) public health and social service providers. These assignments are summarized on Figure 2. Responses of persons who attended at least one webinar are contrasted against the responses of those who did not attend any of the webinars. Among persons who said healthcare providers should take some responsibility (≥26% responsibility) 43.3% attended at least one webinar (cases) while 56.7% did not attend any webinars (controls).

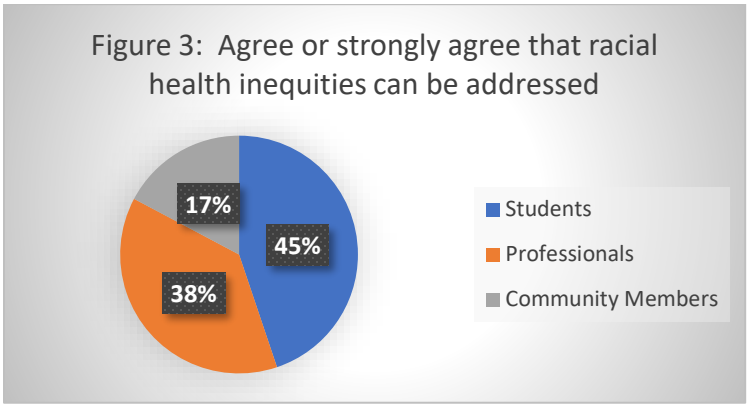


44.5% of persons who believed that public health practitioners and social service providers should take some responsibility for addressing health inequities did not attended the webinar, and this proportion was not significantly different from the proportion of persons who believed similarly. Therefore, the webinars are unlikely to make a difference in perceptions of the role of healthcare providers, public health practitioners, and social service providers in addressing health inequities.

However, attending at least one webinar was associated with significant differences in perceptions of the role of marginalized populations and policymakers in eliminating health inequities. The majority of persons (79.9%) who believed that marginalized populations should bear more than one fourth of the responsibility of addressing health inequities were those who did not attend any webinar, and the majority of those who see this responsibility resting on the shoulders of policy-makers attended at least one of the webinars (75.4%).

The other significant findings are in relation to preparedness for addressing health inequities. **A greater proportion of survey respondents who attended at least one webinar reported that they felt comfortable working with persons who belong to a racial group other than theirs, compared to those who did not attended any webinars (69.5% versus 30.5%). And, 61% of webinar participants strongly agreed that they felt comfortable working with persons whose background and experiences are different from theirs compared to 39 % of persons who did not attend any of the webinars.**

Responses to whether as a society, we can address racial inequities in health did not vary by webinar attendance but varied by participant roles. **As shown in figure 3, a larger proportion of students compared to professionals (healthcare and social services providers, public health practitioners) and community members believed that as a society, we can address racial inequities in health.**



Interviews with three students who participated in Health Equity Fellowship provide additional information. We present the information under themes that are consistent with the objectives of this report.

<u>Valuing the expertise of the community context</u>

When asked what resonated with them the most about their participation in the fellowship, including the webinars, all participants talked about the relevance of community expertise. Listening to and learning from community members was something they knew was important, but had not had a chance to experience how meaningful it would be in terms of their ability to continue to reflect on their interactions with and role in the community. One fellow stated:

> "*The extent to which community members straight from Allentown were involved and telling their stories of lived experiences made it different from me. I asked questions and participated in dialogue. I was also able to investigate my own feelings about these issues, not just read about them. To me, it made the reflections more impactful and the discussions went further than the webinar."*

One of the reasons why communities marginalized by structural inequalities continue to experience health inequities is because they are systematically excluded from decisions that impact them the most. Listening to and learning from marginalized communities is often

talked about but not done. One of the things this fellowship accomplished was showing fellows how to engage communities:

> *"Listening to the community. This is a big one. It seems obvious in hindsight and it is something that is taught but not really put into practice. What they want and need and acting on that. That was the biggest takeaway for me, seeing it done."*

> *"The community, the people with the lived experiences, those who have the clout to show that these are the needs and why stuff needs to be changed are the most important component. The data and statistics need to go hand-in- hand with the stories and lived experiences of community members."*

The involvement and expertise of context experts also provided a guide for fellows entering the healthcare profession, and in a lot of ways, context experts shaped what fellows expect of themselves. Here is an excerpt from a fellow that underscores this:

> *"One speaker's story about how she was treated really stood out to me. She was treated so badly after making a request to the nurse that she wanted her beddings changed. I had read and learned about cultural competency but hearing her story was very shocking to me. Reading something is very different than hearing an actual account. One of things she said that stood out to me was that when I become a healthcare provider, my 15 minutes is another person's three or four months. I will keep this in mind when I and give people the best care possible."*

<u>Understanding social determinants of health</u>

Prior to the fellowship, all interns had learned about social determinants of health – they could name several. But what seemed less understood are the reasons why the social determinants of health were unequally distributed. For example, they understood that education, for example, is a social determinant of health but did not understand exactly why some populations were likely to have more education than others. The fellowship helped clarified that. Here are some comments:

> *"I really wasn't sure about causes of health inequities and reasons for social determinants of health, I didn't know why. After this internship, it is so clear to me that it is just a faulty system. That it is just how America was born. It has always been shaped in a way to destroy Black and Brown people. All the webinars took us back from housing to farming, all the laws like redlining and how even your zip code can tell you how long you are expected to live. How people in Allentown have to take two busses to their providers, who may not even have anyone who speaks the same language as them. With all that is happening in the Allentown community, how do we even expect people to have good health?"*

> *"This summer, I really understood the components of structural racism. This internship has helped me see how racism is embedded in every aspect of society and how it has an effect on healthcare and quality of care. There needs to be more education for healthcare professionals about structural racism"*

"The social determinants of health for me now is about polices and bias. Laws put in place that can be used as a tool to keep others down. I have never had the social determinants of health laid out for me in such a concise way, that it is about policies whether they are intentional or not or explicit or not."

Self-reflection and deep listening practices

One of the expectations of the fellowship was journaling. Fellows wrote about their experiences and interactions and had an opportunity to talk about it weekly. This provided the structure needed to engage in self-reflection:

"It made it possible for me to sit with uncomfortable topics and to express how uncomfortable I felt. I learned how to actively listen and hear things that aren't necessarily said."

"It helped me sit with my feelings. Writing down the things that were most impactful for me helped me sort through my own feelings and keep in mind the most important thing I learnt in each moment, how I felt in each moment.

The direct interrogation of perspectives also encouraged critical self-reflection:

"I appreciated the honesty of the all the PNLV staff when they were looking at our material and questioning where we were coming from, what our experiences are and more of demand for work to look outside of where we were coming from, to push people to look outside. It was a good thing."

"The staff challenged intern perspectives on racism. We were talking about our research and articles we had looked at and our community preceptor asked us how many of the articles were by Black people and we hadn't even thought about it , and how important it is to get these voices in research."

For one fellow, the intentional practice of refection was not new, but it reiterated its relevance in any field:

"I have been doing a lot of reflection in my placements before this, and regardless of the profession, taking a step back and thinking about your interactions and how you communicated with someone or how you didn't communicate is very important. For me, I have always been comfortable with the silences and just letting someone go on. When you let someone go through what they are thinking and feeling, it is when I feel like you can get the most out of the conversation."

Preparing fellows to dismantle systems of oppression

For most fellows, the fellowship motivated them and gave them the tools needed to be involved in structural change. Some identified specific roles for themselves and their work.

"To me, what I have learned boils down to one simple phrase: silence is violence. I will have RN next to my name soon and I will be working for and representing a system I am not proud

of. This was the perfect time for me to think about my core values about how I will make a difference. I know it will be hard, but I have to focus on advocating and sticking to my core values. I hope that I can be an example and encourage other health care professionals to do the same."

The health equity fellowship didn't only prepare students for the future, but it enabled them to reflect on their learning until this point, and how they would want to move forward:

The internship opened my eyes to how much I have been isolated in my own White society. In my high school and college, all my teachers are White, and most of the students are White. Going forward I will like to keep all these things in mind and really treat my patients in a trauma informed manner, realizing that my experiences where I grew up and went to school are different from their experiences. And when I develop their treatment plan to realize that some barriers might be present for them that were not present for me and form a plan that will work for them.

"For a while, I felt pressured to leave where I grew up, which is in Allentown. But after this internship, I feel more connected to my community and it will feel wrong for me to know all the challenges people are facing just 10 mins from me and it will feel wrong to leave. I feel like I can make a difference and my community needs me."

They also felt empowered to say something and do something, regardless of how hard it might be.

Wherever I end up, I hope to start small. I hope to call out or at least question policy or practice that is questionable, and that is not right or just. I don't know if I have had the opportunity to feel that I can do that in a setting yet. Regardless, it should be done. That is one thing I got out of this, that it doesn't matter whether you feel you have it or not, just do it.

Even with the desire, motivation, and tools to begin dismantling systems of oppressions, all the health equity fellows who were interviewed identified some potential barriers. For example, healthcare providers with marginalized identities might themselves worry about being ignored by the healthcare system:

"I know that by not being White and also by being a woman, I will face disrespect within a system where decision-makers are predominantly White."

White fellows also noted barriers in relation to race and ethnicity.

I as a white person speaking on behalf of or advocating for the Black and Latinx populations, other providers might think what I do know about these problems and that I have not personally experienced them. But I have witnessed them and listened to their experiences in this internship so I will like to help address these problems.

The lack of consistent training on these issues is also an important barrier

Ignorance of other providers might be the hardest thing. They may not realize how prevalent these problems are.

I really do not like the trope of pull yourself by the bootstraps. I will want to change some people's perspectives on that because I feel that people put others down by saying that they should be able to do it for themselves even though other individuals have so many other barriers.

Finally, there were concerns about the gap between what the healthcare professions should be about and what they are about.

A lot of the medical field has moved towards being monetary and business orientated instead of do no harm, trying to help people. I know you can always play the role of 'this is a cost saving measure' but should it only be about cost savings instead of really for advocating for something like housing?

Despite these barriers, the resources provided during the fellowship and the health disparities prepared students to take on systems of oppression. The murder of George Floyd by four police officers renewed calls to address structural racism and other inequalities:

"I felt that I was at the right place at the right time. It's a shame that it took a police officer kneeling on the neck of a Black man for 8-9 minutes causing him to die for this passion to be awaken. The internship gave me a lot of context for what happened to George Floyd, and more of the history. It made me really frustrated and I was so angry wondering if anyone cared about ending health inequities, and then the internship showed me that I was not alone, and they are all these people doing this work who really care."

"Going into this internship was right after it happened and police brutality really opened my eyes to how not just police are the cause of racism and that racism is embedded in everything, even in healthcare. It has caused me to look more into racism in society, especially in healthcare."

CONCLUSION AND RECOMMENDATIONS

In general, the fellowship provided a unique opportunity for students to engage with and learn from the community. One of the things that stood out during the interviews is the extent to which fellows gained a new understanding the role of community members as context experts, people whose lived experiences can inform the delivery of health services.

The involvement of community members as experts underscores one of HEART's core principles of Radical Welcome – a practice of community engagement, capacity building and healing that mobilizes entire communities to support and amplify the voices of people who have historically been excluded, and to be intentional about creating welcoming environments where healing and recovery can occur.

Health equity fellows were also encouraged to recognize what perspectives and biases they hold and how these shape their understanding of issues within the community. The impact of this kind of critical self-reflection is likely to shape not only how students understand the

experiences of others, but how they would organize and deliver health services, and how they will advocate for and implement policies and programs.

HEART strives to address the structural inequities that have led to the disproportionate impact of COVID- 19 in Black and Brown communities. But these issues cannot be addressed without an understanding of what they are and their root causes. The Health Disparities Webinars and Health Equity Fellowship implicated the role of policies in creating inequities. **These programs helped future healthcare providers to understand the nature and origins of structural inequalities, specifically in Allentown.** For example, all of the students didn't know the extent to which the school-to-prison pipeline affected the well-being of Black men in Allentown or that "food scarcity was a modern problem." Being able to recognize what the local problems are, and how these problems exacerbate COVID- 19 is an important step towards addressing them. And, exposure to local resources and networks are important for capacity building of all participants, including context experts and students.

Recommendations: First, as HEART continues to develop strategies for health equity, community resilience, and the elimination of systematic racism during and beyond the COVID-19 pandemic, it is important to continue to foster radical inclusion of people historically marginalized. Second, creating more opportunities in which healthcare providers and other service providers interact with and learn from the expertise of community members is critical. This was by far the most relevant aspect of the fellowship for students. In addition, radical inclusion of communities most impacted will make health services better, improve population health, address the violence caused by exclusion, and will help build trust between health systems and populations who are negatively affected by structural inequalities

Third, recognizing the unique issues faced by providers who also have marginalized identities, for example, providers who are women, or Black, or Transgender, or first-generation college students. Building a strong support system for this group of healthcare and social services providers is important.

Fourth, building the capacity of healthcare providers to practice radical welcome is truly critical That students in health professional schools are more likely than others to be optimistic about addressing racial inequities in health presents an opportunity for programs such as the Health Equity Fellowship to harness this optimism and provide students with the tools they need. There is also the need to create and increase hope and optimism among community members, majority of whom disagreed with the statement that as a society, we can address racial inequities in health.

Finally, the Health Equity Fellowship and the Health Disparities Webinar Series align with the core issues of structural competency – a framework that has received significant attention in the development of curricular in medical, health, and other clinical professional schools. HEART should consider engaging with this framework to increase visibility and comparability of their work.

Appendix A: Webinar Topics

1) Radical Welcome
2) Social Determinants of Health/Health Equity
3) Addiction, Recovery and Substance Abuse
4) Youth Violence as a Contagious Disease, Root Causes and Cures
5) Food Justice: Dismantling the Apartheid Food System
6) Managing Chronic Disease in Community
7) Countering the Conspiracy to Destroy Black Boys/Interrupting the School-to-Prison Pipeline
8) The House we Live In/The Need for Affordable Housing

Appendix B: Survey

1.What is your primary affiliation? Please select one that most describes you.

- Clinical professional student (medicine, nursing, physician assistant, etc)
- Public, community health, or social work student
- Another student
- Public health or social work practitioner, or a community-based service provider
- Teacher or Professor
- Medical professional (doctor, nurse, etc)
- Community member
- Other, please specify

2.Thinking about addressing health inequities, please select the level of responsibility you believe each of the flowing entities should have.

a. Healthcare providers
    - None
    - 1%-25% responsibility
    - 26% -50% responsibility
    - 51% -75% responsibility
    - 76% -100% percent of the responsibility

b. Politicians and policy makers
    - None
    - 1%-25% responsibility
    - 26% -50% responsibility
    - 51% -75% responsibility
    - 76% -100% percent of the responsibility

c. People who experience the negative effects of health inequities
    - None
    - 1%-25% responsibility
    - 26% -50% responsibility
    - 51% -75% responsibility
    - 76% -100% percent of the responsibility

d. Public health and social service professionals
    - None
    - 1%-25% responsibility
    - 26% -50% responsibility
    - 51% -75% responsibility
    - 76% -100% percent of the responsibility

3.How much do you agree or disagree with the following?

i.) Strongly disagree ii.) Disagree iii.) Agree iv.) Strongly agree

a) Social determinants of health such as education and food are less important than being able to receive healthcare
b) I feel comfortable working with persons who belong to a racial group other than mine
c) I feel comfortable working with persons whose background and experiences are different from mine
d) I am confident that as a society, we can address racial inequities in health
e) I am confident that as an individual, I can play a role in addressing racial iniquities in health

4.Have you ever participated in PNLV's Health Equity Fellowship, the Bridging the Gap Program in the Lehigh Valley, or any other workshop on Health Equity?

- Yes
- No

If no, skip to question 7

5.This summer 2020, PNLV organized a Health Equity Webinar Series. Which one (s) did you participate in? Select all that applies. Please select the webinar(s) you attended

- Radical Welcome
- Social Determinants of Health and Health Equity
- Addiction, Recovery and Substance Abuse
- Youth Violence as a Contagious Disease, Root Causes and Cures
- Food Justice: Dismantling the Apartheid Food System
- Managing Chronic Disease in Community
- Countering the Conspiracy to Destroy Black Boys/Interrupting the School to Prison Pipeline
- The House we Live In/The Need for Affordable Housing

6. Are you participating in the Health Equity Fellowship as a student in the Pre-Health Scholars Program or the Bridging the Gap Program?

- Yes
- No

7.Select your ethnicity

- Latinx or Hispanic
- Arab
- Non Latinx, non-Hispanic

8.Select your race

- White
- Black, African American, or African Descent
- Asian
- Indigenous, Native American, American Indian or Alaskan Native
- Native Hawaiian or Pacific Islander
- Other (Specify)

Appendix C: Interview Guide

1. Thinking about webinar (s) you attended, what are two things that resonated with you the most? –
2. Please describe what you think are the main causes of health disparities and inequities
3. Thinking about the self- reflection and deep listening, how has the Health Equity Fellowship shaped your understanding and engagement with these practices?
4. How do you see yourself working towards dismantling systems of oppression and their effects on health? What role have you identified for yourself and your work?
5. What do you think might be barriers for you applying this information to your current and future work to address health inequities? What kinds of support might you need?
6. Anything about the program that you particularly enjoyed?
7. Anything that you might change?
8. Anything you'd like to add?