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SCIENCES • ENGINEERING • MEDICINE

Framing Race and Ethnicity to Advance Health Equity: A Workshop
Roundtable on Population Health Improvement
February 4, 2016
Draft Resource List

Readings for the workshop are listed in order of speaker (see agenda). Pages 3-13 are additional background readings. This is not meant to be an exhaustive list, but rather illustrative of themes covered at this workshop.

Keynote: Gilbert Gee, Health equity and racism

Gee, G. C., and D. C. Payne-Sturges. 2004. Environmental health disparities: A framework integrating psychosocial and environmental concepts. *Environ Health Perspect* 112(17):1645-1653. "Although it is often acknowledged that social and environmental factors interact to produce racial and ethnic environmental health disparities, it is still unclear how this occurs. Despite continued controversy, the environmental justice movement has provided some insight by suggesting that disadvantaged communities face greater likelihood of exposure to ambient hazards. The exposure–disease paradigm has long suggested that differential "vulnerability" may modify the effects of toxicants on biological systems. However, relatively little work has been done to specify whether racial and ethnic minorities may have greater vulnerability than do majority populations and, further, what these vulnerabilities may be. We suggest that psychosocial stress may be the vulnerability factor that links social conditions with environmental hazards. Psychosocial stress can lead to acute and chronic changes in the functioning of body systems (e.g., immune) and also lead directly to illness. In this article we present a multidisciplinary framework integrating these ideas. We also argue that residential segregation leads to differential experiences of community stress, exposure to pollutants, and access to community resources. When not counterbalanced by resources, stressors may lead to heightened vulnerability to environmental hazards." http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1253653/

Gee, G. C., K. M. Walsemann, and E. Brondolo. 2012. A life course perspective on how racism may be related to health inequities. *Am J Public Health* 102(5):967-974. "Recent studies show that racism may influence health inequities. As individuals grow from infancy into old age, they encounter social institutions that may create new exposures to racial bias. Yet, few studies have considered this idea fully. We suggest a framework that shows how racism and health inequities may be viewed from a life course perspective. It applies the ideas of age-patterned exposures, sensitive periods, linked lives, latency period, stress proliferation, historic period, and cohorts. It suggests an overarching idea that racism can structure one's time in asset-building contexts (e.g., education) or disadvantaged contexts (e.g., prison). This variation in time and exposure can contribute to racial inequities in life expectancy and other health outcomes across the life course and over generations." http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2012.300666

Natalie Burke, Developing an equity lens within and across sectors…

Cuyahoga Health Improvement Partnership. 2015. *Cuyahoga county community health improvement plan.* Cuyahoga County: Cuyahoga Health Improvement Partnership. http://projects.cgeniuses.com/hipc/wp-content/uploads/2015/07/HIPC_CHIP_report_F_060215_new1.pdf

ROUNDTABLE ON POPULATION HEALTH IMPROVEMENT

Mindy Fullilove, The evidence for the historical policy production of racialized…

Fullilove, M. T., and R. Wallace. 2011. Serial forced displacement in American cities, 1916–2010. *Journal of Urban Health : Bulletin of the New York Academy of Medicine* 88(3):381-389. "Serial forced displacement has been defined as the repetitive, coercive upheaval of groups. In this essay, we examine the history of serial forced displacement in American cities due to federal, state, and local government policies. We propose that serial forced displacement sets up a dynamic process that includes an increase in interpersonal and structural violence, an inability to react in a timely fashion to patterns of threat or opportunity, and a cycle of fragmentation as a result of the first two. We present the history of the policies as they affected one urban neighborhood, Pittsburgh's Hill District. We conclude by examining ways in which this problematic process might be addressed." http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3126925/

Julie Sweetland, Framing messages to policy makers about racial and ethnic…

FrameWorks Institute. *The storytelling power of numbers.* This short article explores how the data we use can either reinforce, or disrupt, inequalities - depending on the framing. http://www.frameworksinstitute.org/assets/files/eZines/Storytelling_power_of_numbers.pdf

Framing Wellness. This interactive online course explores the communications aspects of advancing a holistic wellness agenda by translating the social determinants of health perspective for the public. The course includes quizzes, exercises, and videos of on-the-streets interviews revealing patterns of public thinking and the effects of recommended reframing strategies. Sponsored by the Alberta Health Ministry. Free, but requires registration. http://frameworksacademy.org/products/framing-wellness-in-alberta

Simon, A. F., and F. Gilliam Jr. 2013. *Framing and facts: Necessary synergies in communicating about public safety and criminal justice.* Washington, DC: FrameWorks Institute. This study, sponsored by the Ford Foundation, reports on an experiment demonstrating that when and how race is introduced into an advocacy/outreach conversation can make all the difference in public thinking about racial disparities.http://www.frameworksinstitute.org/assets/files/pscj_values_and_facts.pdf

Rebekah Gowler and Jessica Kang, Framing racial and ethnic disparities…

Bassett, M. T. 2015. #BlackLivesMatter — Challenge to the medical and public health communities. *The New England Journal of Medicine* 372:1085-1087. http://www.nejm.org/doi/full/10.1056/NEJMp1500529?viewType=Print&viewClass=Print

CSI (Center for Social Inclusion). *Talking about race toolkit.* New York, NY: Center for Social Inclusion. http://www.centerforsocialinclusion.org/communications/talking-about-race-toolkit/

Kang, J. 2015. *Let's talk about race: How racially explicit messaging can advance equity.* New York, NY: Center for Social Inclusion. http://www.centerforsocialinclusion.org/lets-talk-about-race-how-racially-explicit-messaging-can-advance-equity/

ADDITIONAL READINGS

VISIONS, Inc. (CLOSED SESSION READINGS)

Batts, V. 2005. *Is reconciliation possible? Lessons from combating 'modern racism'*. Boston, MA: VISIONS, Inc. http://visions-inc.org/wp-content/uploads/Is-Reconciliation-Possible.pdf

DiAngelo, R. 2011. White fragility. *International Journal of Critical Pedagogy* 3(3):54-70. http://libjournal.uncg.edu/ijcp/article/view/249

Drexler, M. 2007. How racism hurts — literally. *The Boston Globe*. http://www.boston.com/news/globe/ideas/articles/2007/07/15/how_racism_hurts___literally/?page=full

CONCEPTUAL TOOLS

Braveman, P. 2014. What are health disparities and health equity? We need to be clear. *Public Health Reports* 129(Suppl 2):5-8. "Health disparities" and "health equity" have become increasingly familiar terms in public health, but rarely are they defined explicitly. Ambiguity in the definitions of these terms could lead to misdirection of resources. This article discusses the need for greater clarity about the concepts of health disparities and health equity, proposes definitions, and explains the rationale based on principles from the fields of ethics and human rights. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3863701/

Braveman, P. A., S. Kumanyika, J. Fielding, T. LaVeist, L. N. Borrell, R. Manderscheid, and A. Troutman. 2011. Health disparities and health equity: The issue is justice. *American Journal of Public Health* 101(Suppl 1):S149-S155. "Eliminating health disparities is a Healthy People goal. Given the diverse and sometimes broad definitions of health disparities commonly used, a subcommittee convened by the Secretary's Advisory Committee for Healthy People 2020 proposed an operational definition for use in developing objectives and targets, determining resource allocation priorities, and assessing progress. Based on that subcommittee's work, we propose that health disparities are systematic, plausibly avoidable health differences adversely affecting socially disadvantaged groups; they may reflect social disadvantage, but causality need not be established. This definition, grounded in ethical and human rights principles, focuses on the subset of health differences reflecting social injustice, distinguishing health disparities from other health differences also warranting concerted attention, and from health differences in general. We explain the definition, its underlying concepts, the challenges it addresses, and the rationale for applying it to United States public health policy." http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3222512/

Ford, C. L., and C. O. Airhihenbuwa. 2010. Critical race theory, race equity, and public health: Toward antiracism praxis. *American Journal of Public Health* 100(Suppl 1):S30-S35. "Racial scholars argue that racism produces rates of morbidity, mortality, and overall well-being that vary depending on socially assigned race. Eliminating racism is therefore central to achieving health equity, but this requires new paradigms that are responsive to structural racism's contemporary influence on health, health inequities, and research. Critical Race Theory is an emerging transdisciplinary, race-equity methodology that originated in legal studies and is grounded in social justice. Critical Race Theory's tools for conducting research and practice are intended to elucidate contemporary racial phenomena, expand the vocabulary with which to discuss complex racial concepts, and challenge racial hierarchies. We introduce Critical Race Theory to the public health community, highlight key Critical Race Theory characteristics (race consciousness, emphases on contemporary societal dynamics and socially marginalized groups, and praxis between research and practice) and describe Critical Race Theory's

contribution to a study on racism and HIV testing among African Americans." http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2837428/pdf/S30.pdf

Ford, C. L., and C. O. Airhihenbuwa. 2010. The public health critical race methodology: Praxis for antiracism research. *Soc Sci Med* 71(8):1390-1398. "The number of studies targeting racial health inequities and the capabilities for measuring racism effects have grown substantially in recent years. Still, the need remains for a public health framework that moves beyond merely documenting disparities toward eliminating them. Critical Race Theory (CRT) has been the dominant influence on racial scholarship since the 1980s; however, its jurisprudential origins have, until now, limited its application to public health research. To improve the ease and fidelity with which health equity research applies CRT, this paper introduces the Public Health Critical Race praxis (PHCR). PHCR aids the study of contemporary racial phenomena, illuminates disciplinary conventions that may inadvertently reinforce social hierarchies and offers tools for racial equity approaches to knowledge production." http://www.ncbi.nlm.nih.gov/pubmed/20822840

HoSang, D. M. 2014. The structural racism concept and its impact on philanthropy. *Philanthropic Initiative for Racial Equity: Critical Issues Forum* 5. http://racialequity.org/docs/CIF5The%20Structural%20Racism%20Concept%20.pdf

powell, j. a. 2013. Deepening our understanding of structural marginalization. *Poverty & Race* 22(5):3-4, 13. http://www.prrac.org/pdf/SeptOct2013PRRAC_powell.pdf

powell, j. a., C. C. Heller, and F. Bundalli. 2011. *Systems thinking and race*. http://www.racialequitytools.org/resourcefiles/Powell_Systems_Thinking_Structural_Race_Overview.pdf

Viruell-Fuentes, E. A., P. Y. Miranda, and S. Abdulrahim. 2012. More than culture: Structural racism, intersectionality theory, and immigrant health. *Soc Sci Med* 75(12):2099-2106."Explanations for immigrant health outcomes often invoke culture through the use of the concept of acculturation. The over reliance on cultural explanations for immigrant health outcomes has been the topic of growing debate, with the critics' main concern being that such explanations obscure the impact of structural factors on immigrant health disparities. In this paper, we highlight the shortcomings of cultural explanations as currently employed in the health literature, and argue for a shift from individual culture-based frameworks, to perspectives that address how multiple dimensions of inequality intersect to impact health outcomes. Based on our review of the literature, we suggest specific lines of inquiry regarding immigrants' experiences with day-to-day discrimination, as well as on the roles that place and immigration policies play in shaping immigrant health outcomes. The paper concludes with suggestions for integrating intersectionality theory in future research on immigrant health." http://www.ncbi.nlm.nih.gov/pubmed/22386617

FRAMEWORKS AND GUIDES

American Public Health Association. 2015. *Better health through equity*. Washington, DC: American Public Health Association. https://www.apha.org/~/media/files/pdf/topics/equity/equity_stories.ashx

Annie E. Casey Foundation. 2014. *Race equity and inclusion action guide. Embracing equity: 7 steps to advance and embed race equity and inclusion within your organization.* Baltimore, MD: Annie E. Casey Foundation. http://www.aecf.org/resources/race-equity-and-inclusion-action-guide/

CDC. *A practitioner's guide for advancing health equity: Community strategies for preventing chronic disease.* Atlanta, GA: Centers for Disease Control and Prevention. http://www.cdc.gov/nccdphp/dch/health-equity-guide/

Davey, L. 2009. *Strategies for framing racial disparities: A frameworks institute message brief.* Washington, DC: FrameWorks Institute. http://www.frameworksinstitute.org/toolkits/race/mb.html

Davis, R. A., and L. Cohen. 2009. Toward health equity: A prevention framework for reducing health and safety disparities. In *The new world of health promotion: New program development, implementation, and evaluation*, edited by B. J. Healey and R. S. Zimmerman Jr. Burlington, MA: Jones & Bartlett Learning. Pp. 163-192. http://www.preventioninstitute.org/component/jlibrary/article/id-199/127.html

Frameworks Institute. Talking about disparities toolkit. http://www.frameworksinstitute.org/toolkits/race/index.html

FrameWorks Institute. 2009. *Talking about disparities toolkit: Message templates.* FrameWorks Institute. http://frameworksinstitute.org/toolkits/race/resources/pdf/disparitiesmessagetemplate.pdf

FrameWorks Institute. 2009. *You say/they think -- handling competing frames.* FrameWorks Institute. http://frameworksinstitute.org/toolkits/race/resources/pdf/disparitiesyousay.pdf

Gilliam Jr., F. 2008. *Effects of explicitness in the framing of race.* FrameWorks Institute. http://frameworksinstitute.org/assets/files/PDF_race/fwraceandimmig5july3bf.pdf

Gilliam Jr., F., and T. Manuel. 2009. *The illogic of literalness: Narrative lessons in the presentation of race policies.* Washington, DC: FrameWorks Institute http://frameworksinstitute.org/assets/files/PDF_race/illogic_literalness.pdf

Grantcraft. 2007. *Grantmaking with a racial equity lens.* Grantcraft in partnership with Philanthropic Initiative for Racial Equity. http://www.grantcraft.org/assets/content/resources/equity.pdf

Grassroots Policy Project. n.d. *Race, power and policy: Dismantling structural racism.* Prepared for the National People's Action by the Grassroots Policy Project. http://www.strategicpractice.org/paper/race-power-and-policy-dismantling-structural-racism

Jones, C. A. 2009. Levels of racism: A theoretic framework and a gardener's tale. *American Journal of Public Health* 90(8):1212-1215."Jones presents a theoretic framework for understanding racism on 3 levels: institutionalized, personally mediated, and internalized. This framework is useful for raising new hypotheses about the basis of race-associated differences in health outcomes, as well as for designing effective interventions to eliminate those differences. She then presents an allegory about a gardener with 2 flower boxes, rich and poor soil, and red and pink flowers. This allegory illustrates the relationship between the 3 levels of racism and may guide our thinking about how to intervene to mitigate the impacts of racism on health. It may also serve as a tool for starting a national conversation on racism." http://www.cahealthadvocates.org/_pdf/news/2007/Levels-Of-Racism.pdf

Keleher, T. 2009. *Racial equity impact assessment toolkit.* Applied Research Center https://www.raceforward.org/sites/default/files/RacialJusticeImpactAssessment_v5.pdf

Keleher, T., S. Leiderman, D. Meehan, E. Perry, M. Potapchuk, j. a. powell, and H. Yu. 2010. *Leadership & race: How to develop and support leadership that contributes to racial justice.* Oakland, CA: Leadership Learning Community. http://leadershiplearning.org/system/files/Leadership%20and%20Race%20FINAL_Electronic_072010.pdf

Meehan, D., C. Reinelt, and E. Perry. 2009. *Developing a racial justice and leadership framework to promote racial equity, address structural racism, and health racial and ethnic divisions in communities.* Learning Leadership Community. http://leadershiplearning.org/system/files/Racial%20Equity%20and%20Leadership%20Scan.pdf

National Partnership for Action to End Health Disparities. 2011. *National stakeholder strategy for achieving health equity.* Rockville, MD: U.S. Department of Health & Human Services, Office of Minority Health. http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286

Nelson, J. 2015. *Racial equity toolkit: An opportunity to operationalize equity.* The Local & Regional Government Alliance on Race and Equity. http://racialequityalliance.org/newsite/wp-content/uploads/2015/10/GARE-Racial_Equity_Toolkit.pdf

Nelson, J., L. Spokane, L. Ross, and N. Deng. 2015. *Advancing racial equity and transforming government: A resource guide to put ideas into action.* The Local & Regional Government Alliance on Race and Equity. http://diversity.berkeley.edu/sites/default/files/gare-resource_guide.pdf

The Opportunity Agenda. *Vision, values, and voice: A social justice communications toolkit.* New York, NY: The Opportunity Agenda. http://toolkit.opportunityagenda.org/documents/oa_toolkit.pdf

The Opportunity Agenda. 2015. *The opportunity survey: Understanding the roots of attitudes on inequality.* New York, NY: The Opportunity Agenda http://opportunityagenda.org/files/field_file/2015-4-27_Color_of_Wealth_Opinion_Research.pdf

The Opportunity Agenda. 2015. *Public perceptions and attitudes relevant to the racial wealth gap.* New York, NY: The Opportunity Agenda. http://opportunityagenda.org/files/field_file/2015-4-27_Color_of_Wealth_Opinion_Research.pdf

Philanthropic Initiative for Racial Equity (PRE). 2014. *Moving forward on racial justice philanthropy.* Washington, D.C.: Philanthropic Initiative for Racial Equity http://racialequity.org/docs/CIF5.pdf

PRE. 2014. *Sustaining racial justice action in philanthropy: Ferguson & beyond.* Washington, DC: Philanthropic Initiative for Racial Equity. http://racialequity.org/docs/Sustaining%20Racial%20Justice%20Action%20inPhilanthropyFergusonBeyond.pdf

PolicyLink. *Equity tools.* https://www.policylink.org/equity-tools/equitable-development-toolkit/all-tools

PolicyLink. N.d.*Gear -- Getting Equity Advocacy Results*. https://www.policylink.org/equity-tools/gear/introduction

PolicyLink. 2013. Communicating about race, equity, and the economy. In *The 5th webinar in the All-In Nation Webinar Series*. https://www.youtube.com/watch?v=X12ADrFY7lQ

PolicyLink. n.d. *Health equity: Moving beyond 'health disparities'*. https://www.policylink.org/sites/default/files/Health%20Equity%20101%20Final%20May%202014%20AS%20pdf.pdf

Racial Equity Task Force. 2013. *Facing race: A renewed commitment to racial equity.* Minnesota Philanthropy Partners. http://www.corridorsofopportunity.org/sites/default/files/PRO-RECE-Toolbox-Lib-MNPPFacingRaceOct2013.pdf

Robert Wood Johnson Foundation. 2010. *A new way to talk about the social determinants of health.* Princeton, NJ: Robert Wood Johnson Foundation. http://www.rwjf.org/content/dam/farm/reports/reports/2010/rwjf63023

The Praxis Project Youth Media Council. *Communicating for health justice: A communications strategy curriculum for advancing health issues.* Oakland, CA: Youth Media

Council. http://www.thepraxisproject.org/sites/default/files/Miles/201204/Communicating%20for%20Health%20Justice.pdf

Race Forward. 2015. *Race reporting guide*. https://www.raceforward.org/sites/default/files/Race%20Reporting%20Guide%20by%20Race%20Forward_V1.1.pdf

W.K. Kellogg Foundation. *America healing. Racial equity resource guide*. East Battle Creek, MI: W.K. Kellogg Foundation. http://www.racialequityresourceguide.org/

HEALTH EQUITY BY DESIGN

Dicent Taillepierre, J. C., L. Liburd, A. O'Connor, J. Valentine, K. Bouye, D. H., McCree, T. Chapel, and R. Hahn. 2016. Toward achieving health equity: Emerging evidence and program practice. *Journal of Public Health Management & Practice January/February* 22(1):S43-S49. "Health equity, in the context of public health in the United States, can be characterized as action to ensure all population groups living within a targeted jurisdiction have access to the resources that promote and protect health. There appear to be several elements in program design that enhance health equity. These design elements include consideration of sociodemographic characteristics, understanding the evidence base for reducing health disparities, leveraging multisectoral collaboration, using clustered interventions, engaging communities, and conducting rigorous planning and evaluation. This article describes selected examples of public health programs the Centers for Disease Control and Prevention (CDC) has supported related to these design elements. In addition, it describes an initiative to ensure that CDC extramural grant programs incorporate program strategies to advance health equity, and examples of national reports published by the CDC related to health disparities, health equity, and social determinants of health."

Hall, M., C. D. Graffunder, and M.. Metzler. 2016. Policy approaches to advancing health equity. *Journal of Public Health Management & Practice January/February* 22(1):S50-S59. "Public health policy approaches have demonstrated measurable improvements in population health. Yet, "one-size-fits-all" approaches do not necessarily impact all populations equally and, in some cases, can widen existing disparities. It has been argued that interventions, including policy interventions, can have the greatest impact when they target the social determinants of health. The intent of this article was to describe how selected current policies and policy areas that have a health equity orientation are being used with the aim of reducing health disparities and to illustrate contemporary approaches that can be applied broadly to a variety of program areas to advance health equity. Applying a health equity lens to a Health in All Policies approach is described as a means to develop policies across sectors with the explicit goal of improving health for all while reducing health inequities. Health equity impact assessment is described as a tool that can be effective in prospectively building health equity into policy planning. The discussion suggests that eliminating health inequities will benefit from a deliberate focus on health equity by public health agencies working with other sectors that impact health outcomes."

Knight, E. 2014. Shifting public health practice to advance health equity: Recommendations from experts and community leaders. *Journal of Public Health Management & Practice March/April* 20(2):188-196. "Context: While the evidence base regarding the social determinants of health and their relationship to health inequities grows, the field of public health is challenged to translate this knowledge into practice changes that advance health equity., Objective: Drawing on the knowledge, beliefs, and experiences of public health experts and community leaders working to advance health equity, our objective was to develop and disseminate recommendations for changing public health practice to better address this problem., Design: We conducted semistructured, qualitative telephone interviews (n = 25) with key informants. Interviews were recorded and transcribed, and data were coded and analyzed using both inductive and deductive methods. Member checks were used to enhance quality., Setting and Participants: A purposeful sample of key

informants was selected from content experts and community leaders involved with the development of the Unnatural Causes public impact campaign. Participants represented state and local health departments, community-based organizations, national research/advocacy organizations, and academic institutions across the country., Results: Participants distinguished between social determinants of health and their structural precursors in social and political institutions. They believed that the field of public health has an obligation to address health inequities and shifts in practice are needed that focus more attention on societal factors that underlie such inequities. According to participants, specific practice changes are difficult to identify because actions should be community specific and community driven. Recommended approaches that may be adapted to community-based needs and assets include building nontraditional partnerships, engaging in political advocacy, promoting community leadership, collecting better data on social conditions and institutional factors, and enhancing communication for health equity., Conclusions: Recommended shifts in practice may be facilitated by revisiting our understanding of the 3 core functions of public health-assessment, assurance, and policy development."

Liburd, L. C. P., E. Ehlinger, Y. Liao, and M.. Lichtveld. 2016. Strengthening the science and practice of health equity in public health. *Journal of Public Health Management & Practice January/February* 22(1):S1-S4.

Penman-Aguilar, A. P. Talih, D. P.. Huang, R. P. Moonesinghe, K. P. Bouye, and G. Beckles. 2016. Measurement of health disparities, health inequities, and social determinants of health to support the advancement of health equity. *Journal of Public Health Management & Practice January/February* 22(1):S33-S42. "Reduction of health disparities and advancement of health equity in the United States require high-quality data indicative of where the nation stands vis-a-vis health equity, as well as proper analytic tools to facilitate accurate interpretation of these data. This article opens with an overview of health equity and social determinants of health. It then proposes a set of recommended practices in measurement of health disparities, health inequities, and social determinants of health at the national level to support the advancement of health equity, highlighting that (1) differences in health and its determinants that are associated with social position are important to assess; (2) social and structural determinants of health should be assessed and multiple levels of measurement should be considered; (3) the rationale for methodological choices made and measures chosen should be made explicit; (4) groups to be compared should be simultaneously classified by multiple social statuses; and (5) stakeholders and their communication needs can often be considered in the selection of analytic methods. Although much is understood about the role of social determinants of health in shaping the health of populations, researchers should continue to advance understanding of the pathways through which they operate on particular health outcomes. There is still much to learn and implement about how to measure health disparities, health inequities, and social determinants of health at the national level, and the challenges of health equity persist. We anticipate that the present discussion will contribute to the laying of a foundation for standard practice in the monitoring of national progress toward achievement of health equity."

Rust, G.. Levine, Y.. Fry-Johnson, P. P. Baltrus, J. P. Ye, and D. Mack. 2012. Paths to success: Optimal and equitable health outcomes for all. *Journal of Health Care for the Poor and Underserved* 23(2):7-19. "U.S. health disparities are real, pervasive, and persistent, despite dramatic improvements in civil rights and economic opportunity for racial and ethnic minority and lower socioeconomic groups in the United States. Change is possible, however. Disparities vary widely from one community to another, suggesting that they are not inevitable. Some communities even show paradoxically good outcomes and relative health equity despite significant social inequities. A few communities have even improved from high disparities to more equitable and optimal health outcomes. These positive-deviance communities show that disparities can be overcome and that health equity is achievable. Research must shift from defining the problem (including causes and risk factors) to testing effective interventions, informed by the natural experiments of what has worked in communities that are already moving toward health equity. At the local level, we need multi-dimensional interventions designed in partnership with communities and continuously improved by rapid-cycle surveillance feedback loops of community-level disparities metrics. Similarly coordinated strategies are

needed at state and national levels to take success to scale. We propose ten specific steps to follow on a health equity path toward optimal and equitable health outcomes for all Americans."

Stillman, L., and S. Ridini. 2015. *Embracing equity in community health improvement.* Boston, MA: Health Resources in Action. http://www.hria.org/uploads/catalogerfiles/embracing-equity/Embracing_Equity_Report.pdf

Wong, W. F., T. A. LaVeist, and J. M. Sharfstein. 2015. Achieving health equity by design. *JAMA* 313(14):1417-1418. "Disparities in health outcomes by race and ethnicity and by income status are persistent and difficult to reduce. For more than a decade, infant mortality rates have been 2 to 3 times higher among African American populations, rates of potentially preventable hospitalization have been substantially higher among African American and Latino populations, and the complications of diabetes have disproportionately afflicted African American and Latino populations.1 These and other disparities have persisted despite recognition that inequity costs the economy an estimated $300 billion per year.2 In addition, health disparities threaten the ability of health care organizations to compete fiscally as insurers increasingly base payments on quality and outcomes, such as reducing preventable admissions and readmissions." http://dx.doi.org/10.1001/jama.2015.2434

World Health Organization. 2008. *Closing the gap in a generation: Health equity through action on the social determinants of health. Final report of the commission on social determinants of health.* Geneva, Switzerland: World Health Organization. http://www.who.int/social_determinants/final_report/csdh_finalreport_2008.pdf

COMMUNICATION ABOUT HEALTH DISPARITIES IN THE MEDIA

Niederdeppe, J., C. A. Bigman, A. L. Gonzales, and S. E. Gollust. 2013. Communication about health disparities in the mass media. *Journal of Communication* 63(1):8-30. "A variety of scholars have explored the role of communication in reducing, maintaining, and even widening health disparities, but comparatively less attention has focused on the content and effects of communication about health disparities in the mass media. This article aims to summarize the current state of knowledge about these issues by identifying key outcomes and audiences for mass-mediated communication about health disparities, describing what is known about public opinion about health disparities, reviewing selected research on the content and effects of mass-mediated communication about health disparities, and identifying priorities for future research to better understand the role of communication in shaping public support and collective action to reduce health disparities." http://dx.doi.org/10.1111/jcom.12003

RACE AND PLACE

Badger, E. 2016. How Flint, Ferguson and Baltimore are all connected. *The Washington Post*, January 25. https://www.washingtonpost.com/news/wonk/wp/2016/01/25/how-flint-ferguson-and-baltimore-are-all-connected/

Bell, J., and M. M. Lee. 2011. *Why place & race matter: Impacting health through a focus on race and place*. PolicyLink. https://www.policylink.org/sites/default/files/WHY_PLACE_AND_RACE%20MATTER_FULL%20REPORT_WEB.PDF

Causa Justa :: Just Cause. 2014. *Development without displacement: Resisting gentrification in the Bay Area.* Oakland, CA: Causa Justa :: Just Cause. The Alameda County Public Health Department's Place Matters Team contributed health impact research, data and policy analysis. http://cjjc.org/images/development-without-displacement.pdf

Fullilove, M. T. 2001. Root shock: The consequences of African American dispossession. *J Urban Health* 78(1):72-80. "Urban renewal was one of several processes that contributed to deurbanization of American cities in the

second half of the 20th century. Urban renewal was an important federal policy that affected thousands of communities in hundreds of cities. Urban renewal was to achieve "clearance" of "blight" and "slum" areas so that they could be rebuit for new uses other than housing the poor. Urban renewal programs fell disproportionately on African American communities, leading to the slogan "Urban renewal is Negro removal." The short-term consequences were dire, including loss of money, loss of social organization, and psychological trauma. The long-term consequences flow from the social paralysis of dispossession, most important, a collapse of political action. This has important implications for the well-being of African Americans. It also raises important questions about the strength and quality of American democracy." http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3456198/

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Williams, D. R., and C. Collins. 2001. Racial residential segregation: A fundamental cause of racial disparities in health. *Public Health Reports* 116(5):404-416. "Racial residential segregation is a fundamental cause of racial disparities in health. The physical separation of the races by enforced residence in certain areas is an institutional mechanism of racism that was designed to protect whites from social interaction with blacks. Despite the absence of supportive legal statutes, the degree of residential segregation remains extremely high for most African Americans in the United States. The authors review evidence that suggests that segregation is a primary cause of racial differences in socioeconomic status (SES) by determining access to education and employment opportunities. SES in turn remains a fundamental cause of racial differences in health. Segregation also creates conditions inimical to health in the social and physical environment. The authors conclude that effective efforts to eliminate racial disparities in health must seriously confront segregation and its pervasive consequences." http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1497358/

RACE, RACISM, AND PUBLIC HEALTH

Garcia, J. A., G. R. Sanchez, S. Sanchez-Youngman, E. D. Vargas, and V. D. Ybarra. 2015. "Race as lived experience: The impact of multi-dimensional measures of race/ethnicity on the self-reported health status of Latinos. *Du Bois*

Review 12(2):349-373. "A growing body of social science research has sought to conceptualize race as a multidimensional concept in which context, societal relations, and institutional dynamics are key components. Utilizing a specially designed survey, we develop and use multiple measures of race (skin color, ascribed race, and discrimination experiences) to capture race as "lived experience" and assess their impact on Latinos' self-rated health status. We model these measures of race as a lived experience to test the explanatory power of race, both independently and as an integrated scale with categorical regression, scaling, and dimensional analyses. Our analyses show that our multiple measures of race have significant and negative effects on Latinos' self-reported health. Skin color is a dominant factor that impacts self-reported health both directly and indirectly. We then advocate for the utilization of multiple measures of race, adding to those used in our analysis, and their application to other health and social outcomes. Our analysis provides important contributions across a wide range of health, illness, social, and political outcomes for communities of color." http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4678876/

Gee, G. C., and C. L. Ford. 2011. Structural racism and health inequities: Old issues, new directions. *Du Bois Review: Social Science Research on Race* 8(1):115-132. "Racial minorities bear a disproportionate burden of morbidity and mortality. These inequities might be explained by racism, given the fact that racism has restricted the lives of racial minorities and immigrants throughout history. Recent studies have documented that individuals who report experiencing racism have greater rates of illnesses. While this body of research has been invaluable in advancing knowledge on health inequities, it still locates the experiences of racism at the individual level. Yet, the health of social groups is likely most strongly affected by structural, rather than individual, phenomena. The structural forms of racism and their relationship to health inequities remain under-studied. This article reviews several ways of conceptualizing structural racism, with a focus on social segregation, immigration policy, and intergenerational effects. Studies of disparities should more seriously consider the multiple dimensions of structural racism as fundamental causes of health disparities." http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4306458/

Gee, G. C., and N. Ponce. 2010. Associations between racial discrimination, limited english proficiency, and health-related quality of life among 6 Asian ethnic groups in California. *Am J Public Health* 100(5):888-895. "OBJECTIVES: We examined the association of racial discrimination and limited English proficiency with health-related quality of life among Asian Americans in California. METHODS: We studied Chinese (n = 2576), Filipino (n = 1426), Japanese (n = 833), Korean (n = 1128), South Asian (n = 822), and Vietnamese (n = 938) respondents to the California Health Interview Survey in 2003 and 2005. We assessed health-related quality of life with the Centers for Disease Control and Prevention's measures of self-rated health, activity limitation days, and unhealthy days. RESULTS: Overall, Asians who reported racial discrimination or who had limited English proficiency were more likely to have poor quality of life, after adjustment for demographic characteristics. South Asian participants who reported discrimination had an estimated 14.4 more activity limitation days annually than South Asians who did not report discrimination. Results were similar among other groups. We observed similar but less consistent associations for limited English proficiency. CONCLUSIONS: Racial discrimination, and to a lesser extent limited English proficiency, appear to be key correlates of quality of life among Asian ethnic groups."

Jee-Lyn García, J., and M. Z. Sharif. 2015. Black lives matter: A commentary on racism and public health. *American Journal of Public Health* 105(8):e27-e30. "The recent nonindictments of police officers who killed unarmed Black men have incited popular and scholarly discussions on racial injustices in our legal system, racialized police violence, and police (mis)conduct. What is glaringly absent is a public health perspective in response to these events. We aim to fill this gap and expand the current dialogue beyond these isolated incidents to a broader discussion of racism in America and how it affects the health and well-being of people of color. Our goal is not only to reiterate how salient structural racism is in our society, but how critical antiracist work is to the core goals and values of public health." http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4504294/

Jones, C. 2002. Confronting institutionalized racism. *Phylon* 50(1/2):7-22. https://sph.umd.edu/sites/default/files/files/Jones-Confronting-Institutionalized-Racism_Phylon%202003.pdf

Jones, C. P., B. I. Truman, L. D. Elam-Evans, C. A. Jones, C. Y. Jones, R. Jiles, S. F. Rumisha, and G. S. Perry. 2008. Using "socially assigned race" to probe white advantages in health status. *Ethn Dis* 18(4):496-504. "OBJECTIVES: We explore the relationships between socially assigned race ("How do other people usually classify you in this country?"), self-identified race/ethnicity, and excellent or very good general health status. We then take advantage of subgroups which are discordant on self-identified race/ethnicity and socially assigned race to examine whether being classified by others as White conveys an advantage in health status, even for those who do not self-identify as White. METHODS: Analyses were conducted using pooled data from the eight states that used the Reactions to Race module of the 2004 Behavioral Risk Factor Surveillance System. RESULTS: The agreement of socially assigned race with self-identified race/ethnicity varied across the racial/ethnic groups currently defined by the United States government. Included among those usually classified by others as White were 26.8% of those who self-identified as Hispanic, 47.6% of those who self-identified as American Indian, and 59.5% of those who self-identified with More than one race. Among those who self-identified as Hispanic, the age-, education-, and language-adjusted proportion reporting excellent or very good health was 8.7 percentage points higher for those socially assigned as White than for those socially assigned as Hispanic (P=.04); among those who self-identified as American Indian, that proportion was 15.4 percentage points higher for those socially assigned as White than for those socially assigned as American Indian (P=.05); and among those who self-identified with More than one race, that proportion was 23.6 percentage points higher for those socially assigned as White than for those socially assigned as Black (P<.01). On the other hand, no significant differences were found between those socially assigned as White who self-identified as White and those socially assigned as White who self-identified as Hispanic, as American Indian, or with More than one race. CONCLUSIONS: Being classified by others as White is associated with large and statistically significant advantages in health status, no matter how one self-identifies." http://www.ncbi.nlm.nih.gov/pubmed/19157256

Williams, D. R. 2012. Miles to go before we sleep: Racial inequities in health. *J Health Soc Behav* 53(3):279-295.Large, pervasive, and persistent racial inequalities exist in the onset, courses, and outcomes of illness. A comprehensive understanding of the patterning of racial disparities indicates that racism in both its institutional and individual forms remains an important determinant. There is an urgent need to build the science base that would identify how to trigger the conditions that would facilitate needed societal change and to identify the optimal interventions that would confront and dismantle the societal conditions that create and sustain health inequalities.

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