[Health Equity and Communities of Color]

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>>> Good evening, everyone. Thank you so much for joining us here at our event this evening, at the University of Hartford. We're so happy to have you, and I did want to point out just a few things to help with the enjoyment of your event tonight. If you have any questions for our panelists throughout the evening, you can type them into the Q&A box, which is on the right side of your screen. Additionally, if you'd like captions, you can click on the multimedia viewer tab, which is on the right side of your screen and click continue, and the captions will then appear in the multimedia viewer. So with that, I'd like to turn things over to our host for the evening, Christine Grant.
>> CHRISTINE GRANT: Tonight is the third of a four-part series of discussion on race sponsored by the Rogow Distinguished Lecturer Program, and is a wide array of programming that University of Hartford offers for fulfilling a responsibility to the larger community which it's a part of. Thank you very much to the Rogow Family and the Distinguished Visiting Lecturer Program. The topic is Annual Diversity, Equity, and Inclusion Lecture Series. It's now my pleasure to introduce the moderator for tonight's program, Dean Cesarina Thompson, Dean of the University's College of Education, Nursing, and Health Professions. Again, we thank you for joining us. Dean Thompson, the floor is yours.
>> CESARINA THOMPSON: Thank you. It's so great to be here to host such an important program and topic and I'm glad to have three distinguished panelists with us and I'd like to take a few minutes to introduce them all to you. Dr. Reggie Eadie is Connecticut Chair of the COVID-19 vaccine advisory group appointed by the Governor, and became Trinity Health of New England's President and Chief Executive Officer in 2018. He is a Native of Detroit, Michigan, and a graduate of Wayne State University School of Medicine and he completed his emergency medicine residency at Wayne State residency Detroit receiving hospital. Welcome to the panel, Dr. Eadie. Next is Dr. Tekisha Dwan Everett, a member of the COVID-19 Vaccine Advisory Group appointed by Governor Lamont. She's the Executive Director of Health Equity Solutions, regulatory actions and ensuring that decision-makers are aware of key health priority inequities in our state. Prior to joining health equity solutions, she was the managing director of federal government affairs with the American Diabetes Association, and provided leadership and advocacy on initiatives with the White House, several federal agencies and Congress. Welcome, Dr. Everett. Next is Ms. Sarah Lewis, Vice President of Health Equity, Diversity, and Inclusion for Hartford Healthcare. Ms. Lewis oversees development and implementation of the system strategy to quantify and introduce interventions to reduce health disparities across the communities that Hartford healthcare serves. She also leads the healthcare systems diversity, inclusion, and belonging strategy blending training, education, and recruitment to make Hartford Healthcare an environment in which colleagues can contribute their best work. Welcome, Ms. Lewis. I am privileged to be the moderator of this program, and I know that many of our faculty

and students within our college are also joining us. So I'd like to begin this conversation and we have some questions for all of our panelists, but certainly it goes without saying that the pandemic has impacted all of us as a global public health crisis. However, the impact has not been equal among all of our citizens in our communities. Certainly we've all read about our disproportionately the pandemic has affected Communities of Color, and we are so pleased to have three experts on this topic that would help us to elucidate some of these reasons and factors and what we need to do as a community to improve health disparities, and as a University we'd like to be part of that in helping our communities. So I will begin with Dr. Eadie. One of the things that we read a lot in our media, we hear about it, is that Communities of Color are not receiving the vaccine, and we're talking a lot about the vaccine these days. At the same rates that whites are receiving it, and could you tell us a little bit about -- and you can give a background to that before you answer that question -- why is that? Why is there perhaps some mistrust or hesitancies and what can we do to improve that?
>> REGINALD EADIE: I want to say thank you for having the courage to bring forth such an important conversation. And we all appreciate that tremendously. I'm sure I speak on behalf of the panelists, as well. We take from historical perspectives, you know, it is -- although this happened many years ago, it's hard for one to forget, particularly Communities of Color, the misbehaviors, if you will, of the U.S. government. Oftentimes, in this conversation, the Tuskegee study of untreated syphilis in African-American men, and the U.S. government sort of engaged them by suggesting they could get free healthcare because, you know, healthcare and equity has been a problem for many, many years so from 1932, to I think '72, these greater than of hundred men were not treated. Penicillin was a standard treatment. And it's not a benign disease. For many years after that, 25 years later, they still were not treated, and so because they were intimate with their significant others, I mean, this did a number to the families in Tuskegee, and with great migration to the north, we think about that because of the negligence this government demonstrated, it's understandable why People of Color still don't trust the United States. Then, there are other things, like the microchip being present, that it causes or alters your DNA. It causes miscarriages or creates infertility. All these things coupled with the reality we still see although we can't point the finger at a particular study, such misbehaviors or to some degree, mistreatment for People of Color in the healthcare space, this is exactly why, and again, we completely understand why there's hesitancy around the vaccine. We have a lot to do and in a short time, and even after this pandemic, we cannot forget what illumination occurred because of the pandemic. It did not bring forth or lift up a new problem. It simply highlighted a problem that has existed the least since 1932.
>> CESARINA THOMPSON: Dr. Everett, as well, so now we're facing the pandemic and we have all this mistrust perhaps around the vaccine, but Ms. Lewis, tell us a little bit about in your work, what are some of the underlying factors that have led to health inequities for many problems, not just necessarily for the pandemic?
>> SARAH LEWIS: Thank you for that question, and thank you for having us this evening. It's great to be here with my esteemed colleagues, Dr. Eadie and Dr. Everett. So, the pandemic merely illuminates things that have existed for centuries and has sort of opportunistically made, where there were cracks, chasms, and in some instances, where there were chasms, really catastrophic failures, and death and disability for people who were sort of vulnerablized by the way our community and society is arranged. We have seen sort of historically, that African-

American lives are just not as well valued and not just in the healthcare sector, but across institutions and across the various aspects of our lives, whether it's political, or financial. The history of redlining in our communities is just one example of how people's opportunities to take care of their families find the -- the homes and the school districts they want to be able to send their children to, all of those opportunities being limited and prescribed. And those affect cumulatively over time, can lead to core health, the fact there's discrimination in hiring, and the fact that that can lead to whether someone has a job that has access to healthcare. All of these things can vulnerablize a person and at the end of the day we saw that when COVID emerged, it just -- we were just able to see people were either vulnerablized because of these inequities that made them sicker, or because of their financial situation. People who are most likely to get sick with COVID, were the ones most likely to lose their jobs and working in service industry jobs that were cut and decimated by the economic downturn. And so then you've got someone who is already sort of, probably more likely to be sick, more financially insecure, and then living on a shoestring in the middle of a pandemic. So, these are all of the things we have to think about as healthcare providers, to make space for sort of that historical trauma that our patients and our communities may have lived through, and if someone has experience medical racism, we absolutely need to make space for that and validate that and also someone may just expect to experience medical racism because they experience institutional racism when they tried to get a loan, or when they try to buy a car, or do any number of things that African-Americans are often perceived as being less qualified to do. So, that's the onus on us as providers to make space for those realities.

>> CESARINA THOMPSON: Let me go on to Dr. Everett, make if you can pick on that, Dr. Everett, because I know we have some students with us. And give us some examples of what might be evidence or examples of medical racism? What are things for especially our healthcare students who are with us, there are things they need to consider, and what are some strategies that you yourself worked with or in collaboration with other colleagues to make sure that we promote and foster health equity among all People of Color?

>> TEKISHA EVERETTE: Thank you for the question, and my gratitude for being here this evening. When we talk about medical racism, historical and contemporary experiences that Black, African-American, Asian American, Latinx individuals are facing, the most concrete example we can give that has come over, and over again in the literature, is this belief, particularly for African-Americans because of the level of resilience, we have experienced in the United States, that we are somehow more -- more -- excuse me, less susceptible to pain. This has been repeatedly studied and repeatedly doctors have acknowledged that they think we have some sort of higher threshold for pain. And where you can narrow in on this specifically is when you look at individuals who have sickle cell, which is a chronic condition that is painful and definitely requires times when you need pain medication, where people are not being able to access the necessary pain medication to help them mitigate the pain that they're experiencing. And I'm going to give you a personal experience of my own. As an example of medical racism. It took a second to really even figure out what was going on, but -- and to -- for all the listeners to be clear, I have a Ph.D, not an M.D., so I don't pretend to play a doctor on television or Zoom, but I know enough about medicine and things that are related to my body and my family's experiences to really understand what necessarily needs to happen for healthcare provision. But here's my personal anecdote with medical racism. I went to the doctor. I was experiencing

some pain in the lower part of my back, it wasn't clear if it was my back or my hip. But about six years -- oh, no it's been about seven years now, I had a slipped disk and had to pretty much lay flat in order to correct it because the doctor stated that surgery was not the best option for the way that my desk had slipped, but that I would need to be mindful over time because it could happen again, or I could suffer another injury. So a few years ago I went into the doctor's office and I said something's really going on, on my lower back, and I'm in pain. It's not pain that's too extensive to walk, but I am noticing I get up a little bit differently and I move a little bit slower, and I need to take -- we need to take some further steps to figure out what this is. But in the meantime, I can't take Ibuprofen anymore, it's not helping. And we kept talking and talking and finally she would not give me medication and kept dismissing my pain and I realized and it clicked to me. I turned to her and I said, do you think I'm searching for opiates? She didn't know how to respond, but she thought I could there because she thought I had an opiate addiction and I was trying to get -- she had no belief in the fact that I had pain, no belief in the history of pre-existing pain here, and understanding that I knew distinctly my body, an expert of nothing else but the body that I live in, to really note that something different was going on here, and that these were the steps I wanted to take in the process of getting a specialist visit. So this is an experiment -- excuse me, not an experiment, but an experience that I personally had where I then actually sat with the doctor and talked her through why she thought -- and it was a painful conversation. I want everybody to be very clear. I applaud the physician, because she stuck with it. I would not leave her office until we had this conversation about how she basically profiled me, and profiled me in connection to my race and ethnicity. And so the challenge I have for you-all who are listening is, we have to acknowledge our biases when we are practicing -- when we're -- when we're in life, period. Practicing life, I will call it. When we're practicing medicine, we have to recognize the implicit and unconscious bias we may be bringing in with patients that impacts the delivery of care we give and the care experience that patient receives. And we have to understand the differences in culture and background. The example that I just gave you-all and how I would not leave the doctor's office. I was have -- what's the word? -- respectful about my entire not to leave and wanting to press the conversation, but [Intermittent Internet connection] would never do that. We're a southern race. That's not what you do. A person has a Ph.D, a doctorate, an M.D., they're a person of authority. You don't question that authority; you sit and take what happens. These are things we have understood how culture comes into play and the context of the execution of healthcare delivery.
>> CESARINA THOMPSON: Thank you.
>> TEKISHA EVERETTE: You might have asked me something more. I don't even know if I answered the question.
>> CESARINA THOMPSON: No, you did. That was terrific lead in, before we get into the vaccines because I know a lot of students are interested in that. So as a patient yourself and continuing consumer of healthcare -- and this could be any of the panelists answering -- you know, as a new provider, you know, the providers that we are, soon to graduate from the University. And I'm going to include our education students, because they are providers in a different setting, but also providing care in the broadest sense of the word. What might be some advice of, you know, some words of wisdom that you-all have for new beginners who may have very little, if any, insight that you just gave to us?

>> TEKISHA EVERETTE: Dr. Eadie, do you want to go first as a practicing physician, or do you --
>> REGINALD EADIE: Sure. My advice could be sensitive to the teachings. I reflect on my days in medical school many, many years ago, but I have evidence that not much has changed. The conversation in the lecture hall would be one way for one race or ethnicity, and we'd have to turn to a different paragraph or page or chapter to talk about minorities. So it was very clear that there were different tracks of treatment. So we began to be morphed into a provider who would -- who would perpetuate, if you will, this systemic racism that exists in the healthcare space. So I advise that you, you know, go in with an open mind. Question and charge and challenge the research, at least the research they're providing, because there's always another story and two sides to every coin, especially in science. But don't just necessarily take what you are receiving, but instead charge and challenge yourself to think differently and do differently, and that's the only way we're going to sort of undo the system that has been put in place in healthcare and beyond many, many years ago.
>> CESARINA THOMPSON: Ms. Lewis, did you want to answer that?
>> SARAH LEWIS: I would love to add to that. I think that it's very important to be grounded in the truth, in the work that all caregivers are trained to do, and when they do provide it, if you're in education, obviously you know the importance of history, and you know the importance of lifting up narratives from all different sides of society, and those who are historically marginalized are, to Dr. Eadie's point, are treated second, last, or not at all. So make the extra effort to learn those stories, to learn the way that our history as a country has created very deep grooves in the road that have been hard for us to get ourselves out of, but that through your active work and your active attention to those sort of pre-existing societal conditions, you can right those historic wrongs. It takes the practice and the attention to it, and the humility to constantly learn, to write that ship.
>> CESARINA THOMPSON: Thank you. And so I want to pick up on something that you said even earlier, I believe. I want to make sure that we all understand the concept of the social determinants of health. I'm not sure that all of our students necessarily get that, and how does that impact the lives of all human beings, and their quality of health?
>> TEKISHA EVERETTE: I'll start on that and kick it over to either Sarah or Dr. Eadie. So I will say two things to this. First I will acknowledge I have a way of talking about the social determinants of health and acknowledging what it has allowed us to do in the better part of the last decade, to talk about systemic and institutional racism without really calling that out. For people who have been very uncomfortable of talking about racism, we've probably said it now about a dozen times thus far, which we're in a different time where it's a little bit easier to accept that word and understand that when it's used that people are not necessarily talking about interpersonal racism, but much more the insidious nature of institutional and systemic racism, but it has allowed us to acknowledge that people are living, growing -- they're being born, they're growing and living and working in environments that have much more impact and influence on in their health that's happening in the clinical setting and in order to get someone to the best and optimal health, which is what health equity is, making sure people with attain their health without barriers, we have to look in the environment where people are growing, and living and aging, and it's allowing us to look at the housing one lives in, the lack of income or employment, or challenges related to employment that one lives in, and helps us to understand

types of employments, the discrimination that is happening in the healthcare system and how all of that comes to play as a social determinants of one's health. Some people don't like the word determinant, because it feels there's going to be an end point or no other way around it, so you'll hear others say social influencers, or social drivers. At the end of the day, fundamentally, what we're talking about is Sarah mentioned redlining and we're talking about how communities are built and resourced based on policies that have been made before any of us were born or in fact, while we're continuing to make policies as we were -- we are here that reinforce prior policies that are built on systematically disadvantaged people. A lot of times when I say essential determinants, it allows us to talk about racism, and people are like what about me, or poor white individuals? Here's the catch. And you have to go all the way back to history. We fundamentally designed an unequal system of class in our society, and we did start off with indigent servants, and it was hard to divide and decide, wait a minute, you look like me and you can adapt and talk like me and I can't identify you necessarily as separately. So we continue to built our systems and policies in laws rooted in anti-Blackness. It's rooted in the desire to keep a class and an underclass in a certain particular place, and all of us kind of sail around it because we have this notion in our society we can pull ourselves up by our bootstraps and all be successful. When I talk about systemic racism, I'm including how we've included impoverished communities, or Apalasha, or the north end of Hartford, communities are under resourced and do not have what is necessary to get and gain optimal health. So this is my kind of -- however I've been talking -- ten minutes lecture on the social determinants and its connectivity to social racism. I understand the desire to not call it a determinants because it is a definite. The key part of the word, or the operative part of the word is social, and what I'm -- I'm a sociologist, so bear with me. This it was created by man, it was not biological, that it is not innate, it is something we cannot dismantle, thus these determinants can be changed if we work together in concert to make a different outcome possible. But we have to first acknowledge that they exist in order to make the change we want to see.

>> REGINALD EADIE: If I can just add one point to that. Not that I can undo anything she so eloquently said, but just to add to it, so in medical school, I was taught that one -- you can -- one's life expectancy is determined by things like the past history, whether or not you have high blood pressure or diabetes, or if cancer runs in your family, or your social history, if you smoke, exercise, and things of that nature. And to Dr. Everett's point, today, the truth is being told in medical school, and that is that the number one determining factor of one's life expectancy is something as simple as five digits. It's your zip code. So to her point, and truth be told, when your zip code determines how long you will live it speaks to the resources that are provided to that community. You know, Sarah also talked about redlining. You can also look at -- I encourage the students to look up the Highway Act of the '50s. This is how we got the north end of Hartford and things of that nature. This is the truth. It's an uncomfortable conversation, but until we shine a light on reality, we're never going to be able to undo the misbehaviors the policymakers and leaders of this country have put in place. I'm proud to be an American, I would not want to live anywhere else, but we have some opportunities to improve. Because one thing that this pandemic reminded us of is, we may have all come here on different ships, but we're now on the same boat, and you can't afford to leave one community behind if we expect to get through this pandemic as safely, quickly as possible. Thanks.

>> CESARINA THOMPSON: Ms. Lewis, did you want to add anything to that?

>> SARAH LEWIS: I think they did a beautiful job. I would be foolish to try to add.
>> CESARINA THOMPSON: You know, one thing that I -- I don't know if our students listening necessarily are familiar with -- perhaps they are, but I just want to make sure that everybody understands. You've all used, I believe, the word "Redlining," and I don't know if all of our students understand what that means. Would one of you explain?
>> TEKISHA EVERETTE: Sarah, do you want to take it, because we've been talking a lot but I'm happy to if I'm putting you on the spot.
>> SARAH LEWIS: You're the Ph.D in sociology so I want you to give us the real deal.
>> TEKISHA EVERETTE: Once I find it I'm going to pop into the chat. I'd like to share -- I'm a big fan of popular culture and using desensitizing the conversations that we have to have that are very sensitive around issues like this. I'm going to pop in the chat once I have an opportunity to, this short video called "Adam ruins everything: The suburbs edition" and it helps you understand redlining neighborhoods and the impacts of them. Redlining was a systematic process that denied various services and goods that was sanctioned by the federal government, as well as in concert to local governments to housing and created a system where individuals of color were relegated to particular neighborhoods and were not afforded mortgages or loans or the opportunity to live in other neighborhoods. It started with Levittown, in New York, if you want to look historically, there was a question in the chat. And I'm not going to address it completely now. But the spirit of the question was about, well, how is -- how is historical things that have happened before any of us who are here now were born really impacting what's happening right now? And redlining is a wonderful example of this, and wonderful in a bad way. But it's a wonderful example of this because it's happened in Levittown in the 1940s, I believe it was. It might have been the '50s. But here's the outcome of where we're going so Levittown was -- Levittown had racial covenants that stated only white people could live there. Redlining forced the continuation of keeping it majority white by not allowing loans and mortgages for People of Color to live there. And if you look at Levittown, it remains to have the same percentages almost of how many white citizens live there. So this is the connection. We don't have quote/unquote redlining practices anymore, and I'm saying quote/unquote because it's not legal to do it, but you find ways in which there are subtleties, on how these are still happening. When I say subtleties, it's the way you may be able to find out, but if you look in the back-end research of the data, a person of color is given a higher loan rate for the same comparable mortgage as another person in the same neighborhood, but because they're a person of color they have a higher rate for their mortgage, or it might be difficult for the same people who look similarly on paper, but because either a last name, meaning their surname, or first name indicates that they're a person of color or if we look at their buying history, or economic behavioral practices, because these are things you can look up when you're kind of looking at credit card usage and things of that nature. There are ways in which we've now embedded the opportunity to continue to discriminate against people in the process of buying a home, but fundamentally redlining, the connection is, we created communities and said Black people can live here, or People of Color or minoritized individuals can live here, and I also want to highlight a fun historical fact. Not fun, but most people don't know this, the ghettos in the United States were designed for Jewish individuals and we moved forward to creating a different kind of -- project housing, if you will, in different kinds of populations have moved into them. But then the impact directly about not only having individuals relegated to certain areas they could live in is the under resourcing of those

communities that follow and we don't have enough time to talk about this tonight, but the relationship between tax bases and how you tax and how things are resourced that continue to reinforce redlining. So I went on a little bit too long there, Dean Thompson, I apologize.
>> CESARINA THOMPSON: Wonderful lesson for us all. That's wonderful.
>> SARAH LEWIS: I can just add one thing to Tekisha's excellent elucidation of redlining from the past to the present, if we overlay in certain communities -- you can do this in Connecticut -- redline maps, it's actually drawn in red the areas where you could -- where it's preferential for whites to get loans for homes and it's exclusionary for People of Color, and maybe white ethnic or religious minorities. If you overlay that map with current information about demographic health disparities, it's thought someone was predicting the future when those redlining maps were created. Again those under resourced communities lead to that factor that Dr. Eadie mentioned of your zip code determining how long you will live. This is about telling the truth about our history will set us free to build equity into the health and well-being of our society in the longer term. I wish I had that map to show you right now. I'll have to look for it.
>> CESARINA THOMPSON: Thank you. That's another program then we could do on that, of course. But thank you. I'd like to move in the remaining time that we have until the Q&A to talking specifically about the vaccine, because I know that that's on -- I know that's on everybody's mind. Before that, we've been talking about how there is some hesitancies, there is some mistrust, having to do with the fact a lot of healthcare providers look like me. They don't look like the people that we really serve. And so in your work, all of you out in the communities, what might be -- what are some ways that you've used to really bring that message home to the communities that we need to get vaccinated? So share your experiences with us. .
>> REGINALD EADIE: I'll be happy to jump on that one. I call it education through explanation, and that is having the ability to have a conversation regardless of the audience, right? So if we have an audience of let's say I'm speaking to an audience of physicians. My way of describing or explaining a topic is going to be different from non-medical -- a non-medical audience, and so you know there's something to being able to explain something at whatever level possible. The reality of it all is that regardless of the audience, we have to explain it the way the audience wants to receive it. Oftentimes we aren't familiar or sensitive to the audience, their beliefs, their experiences, the lack of trust or whatever may be the case, we give it to them the way we want it -- we want to give it to them or we think the way they want to receive it. And so that's really been a challenge here. I happen to think though and we may get to this, that the hesitancy is less of a problem and I say that because we've had multiple conversations. I'm seemingly doing these every Monday through Friday night, and that's not the problem. And to the extent where it is, our conversion rate is rather high, so the problem just isn't that. It goes back to the fundamental challenges, the mistrust and why as to why those numbers are so low. There are other things we can do as a state, as a DPH, as an advisory group. I get that, but the reality of it all is that even if we had an abundance of vaccines in this example, getting people to actually come to the vaccine versus us taking the vaccine to the community are two different conversations and the latter is the one we need to have a lot more of, in my opinion.
>> CESARINA THOMPSON: In the education space, and because we have students that are with us, too, and I know we've concentrated a lot about healthcare, but certainly children are in the school most of -- most -- they spend lots of time there, and so they are getting information through their teachers, through their friends, through staff members. How could teachers -- and I

don't know if you've had interactions in that space -- but how could teachers or educational professionals help us, you know, as healthcare providers to really bring that message home to Communities of Color to make sure that they receive the correct information?
>> TEKISHA EVERETTE: One thing I'd like to offer. Health Equity Solutions, the nonprofit I run, we've launched an educational effort to dispel myths and to create agency in the process of the vaccine, and when I say agency, making sure people have the right information to make the right choice to get the vaccine or not for their family and themselves. We welcome the invitation for anyone who wants to participate in the dispelling of those myths. We're looking for speakers who can talk to the community, who reflect the community, Dr. Eadie is in our speaker's bureau, so he's somebody we refer to often. But I also know the State of Connecticut is doing a train the trainer program, where they're looking for people to come in, get quickly trained on the myths and facts related to coronavirus and related to COVID-19, and related to the vaccine and be able to give that information out. I encourage you, if you're an educator, to participate in the train the trainer, to share that information and dispel myths when you listen -- I mean when you hear them. And the last I would say is all of us have a responsibility, and I'm going to just be Frank and say I'm stealing Dr. Eadie's words here. When you learn about what's happening and about the vaccine, you can become the ambassador and speak yourself. You don't have to be a Dr. Eadie. You don't have to be a Sarah Lewis. You don't have to be a Tekisha Everett. When you know the facts, it is your duty to dispel that myth and quash it quickly, because misinformation travels faster than truth and we need many more truth tellers out there to make sure we're building and gaining the trust in the community that we need in order for us to be successful in fighting this virus.
>> CESARINA THOMPSON: You know all about this. I know you've been vaccinated already, so you can tell us, first of all what vaccines are out there, what the differences are, and what has been your experience receiving the vaccine?
>> REGINALD EADIE: Is that directed towards me? I missed it.
>> CESARINA THOMPSON: Yes.
>> REGINALD EADIE: We have on the ground, in the field now, as of mid-December, I think it was the Pfizer vaccine. Second, a few weeks later came the Moderna, and now of recent, the Johnson & Johnson company has applied for emergency use authorization, so we hope to have that in the State of Connecticut within the next few weeks. So the difference -- all of them have one thing in common and that is besides the fact their efficacy is ideal, they use the so-called messenger RNA technology, which essentially is, and off all seen the picture or the illustration of the coronavirus. It's a circular molecule or virus that has protrusions, which we refer to spike proteins. They opened it up, and removed the RNA. Remember DNA, RNA. You know the basics. The DNA is the instruction manual. It's the genetic code. RNA reads the genetic code and does what the genetic code tells it what to do, which is why our color is, and we get half of our genes from the mother and half from the parents. The entire RNA can produce whatever the DNA tells it to produce. The entire coronavirus RNA can produce an entire coronavirus. So you go from two cells, to 16, et cetera. And this is not new technology, despite the evidence that's out there. It was focused on the vaccine and a cure for cancer. In the midst of a pandemic, scientists went to the lab and isolated the portion of the RNA that's responsible only for producing spike protein. That is what Pfizer and Moderna injects into one's muscle. The RNA that's responsible for producing the spike protein. Once it hijacks your cell, it produces in your

cell additional spike proteins. Not the entire coronavirus, which means you can't get coronavirus from the vaccine. You only produce inside of your body spike proteins. Your body in response then produces antibodies to the spike protein. You get your second injection of Pfizer Moderna two weeks after that, you have the 95 in Pfizer, and 95.4% efficacy with Moderna and now you're ready so in the event you are exposed to the actual virus, when the spike protein of the coronavirus tries to attach to your cell and deposits its entire RNA, your antibody will prevent that from happening and that's how we get immunity. Johnson & Johnson and AstraZeneca contain it with the adenovirus. Plus, it's the virus that produces the cold, and inject that into a man and then man just goes to the same process of producing only spike proteins and it renders the immunity, as well. So they're all very similar. They're not much similar than something we've already been exposed to. So I'll conclude with this reminder. Remember the influenza virus, it is an actual virus that's infected inside of you that has been attenuated. Measles, mumps, and rubella, it's a regimen that uses a virus, that's injected, as well. The RNA that's used and the efficacies we have coming from these immunizations, it's hard to not advocate one at least strongly considering or have me be willing to share the facts around why they should or should not become vaccinated. I was vaccinated twice. I had Pfizer. Side effects were very minimal. I'm past the 14-day mark after my second injection, and I gotta tell you, I'm proud of myself, and I'm proud to speak on behalf of Pfizer, and Moderna and soon to be Johnson & Johnson because this is the only way we're going to reach herd immunity, which is some 75% to 85% of the globe or the United States of America, or your community, or the State of Connecticut.

>> CESARINA THOMPSON: Thank you so much. I'm going to ask one more question of you, Dr. Eadie, then we're going to move to the Q&A. So with more and more people being eligible and getting vaccinated, tell us should that change our social distancing practices or any of the other CDC guidelines that have been recommended?

>> REGINALD EADIE: That's a good question. The CDC just came out a day or two ago with some quarantine recommendations assuming you've been vaccinated and waited those couple of weeks. But the moment we can remove our masks -- we should always practice adequate hygiene and stop social distancing. It is the time when someone like a Dr. Fauci says the United States or the globe has reached herd immunity. The primary goal is to mitigate morbidity and mortality. Until we get there in the face of these variants, it's hard to predict when that's going to be reality. We must continue to wear our masks and social distance. In fact, if you can compare the efficacy of masking and social distancing with the vaccine, if the students really want to know what to do, especially those that Dr. Everett alluded to who aren't quite sure or comfortable as to whether or not they'll get the vaccine, it's more effective to social distance and wear a mask. So the narrative that came out of Washington, D.C. that said you do not need to wear a mask is the antithesis of the truth. So you as students of education, absorb the facts, make the right decisions based on the science and intelligence, and free your mind as opposed to listening to people giving their humble opinions and redirecting us down a path of danger is where we're in the path we're in now.

>> CESARINA THOMPSON: Thank you so much. We've got to the portion of Q&A, but I want to thank you-all for a wonderful conversation and I'd love to do this again sometime soon. Thank you so much for being with us.

>> PAIGE BRAY: I'm happy to see some people putting things in the Q&A already. We had an initial question from Mark Boxer thanking us for shining light on a spotlight on these very concerning health equity issues. The question is as follows: What should CMS be doing around the emerging definitions of healthcare with regard to the growing social determinants of health challenges? Especially as amplified by the pandemic?
>> REGINALD EADIE: Sarah, or Tekisha, do you guys want to take those?
>> SARAH LEWIS: I can take a stab at it. It sounds like there may be a more specific question underneath this, but I can just say that on a general level, the CMS should always work diligently to incorporate a health equity lens in the policies they promulgate and some think holistically about how they support healthcare providers, health systems, and the communities that they serve, and look at social determinants of health, not just things that need to be managed in the physician's office or in the hospital, but as something that is a whole community responsibility and the CMS has a lot of funds at their disposal. They should figure out ways to help those -- to help mitigate those upstream effects that we've been talking about those social, again, determinants of health that we can't just rely on our physicians to mitigate in a person-to-person interaction. Tekisha, would you add anything to that?
>> TEKISHA EVERETTE: Probably just a little bit of a rephrase, or restate of what you said. I would just extract one key point. CMS currently is the funder of Medicaid, Medicare, and the SCHIP programs. I think there needs to be a little bit less focus on how to we innovate -- how do we innovate where we already know things work and start paying for things that actually work, so I think we should -- what I think CMS could do is make sure that we have funding for community health workers and patient navigators that make it easier -- making it easier for states to employ those individuals to help during this really difficult time and making sure that we can navigate people through the healthcare -- the complicated systems of health and social services. I think we could also redirect funds and making sure that we're able to use Medicaid dollars to pay for things such as housing, transportation, food access, et cetera, the things we know if we correct those issues, we can actually help people become healthier. These are the things I think are the innovations we should be looking to and needing for CMS further. They are also doing some interesting innovative projects, but these are basic innovations we already know work and we should implement them.
>> REGINALD EADIE: And I would add, to underscore the points they both made, the number one cause of bankruptcy in America is healthcare, right? So the fact that, to CMS and the question, CMS should loosen up the criteria for those eligible for every single American. We live in the most prosperous -- the most wealthy, the most powerful country on the planet, but the fact we have people who are still underinsured or uninsured is the tragedy, I believe. We have the capability to provide it all. Other countries have already mastered this many, many years ago, but to see that someone cannot afford to purchase a home, which is the first step to any wealth in this country because they have -- they filed for bankruptcy, why? Because they need their gallbladder removed, and this is not because of bad habits because oftentimes we like to point the finger at that, but because they could not afford the healthcare -- it's a right in my opinion, and that success denied, it leads to bankruptcy, and it disrupts that family and the generations to come because of the policy that has been put in place. If they really want to make a difference, all adults and children should have access to equal healthcare and it should not be based on the income that you make, but instead, it should be considered a right.

>> TEKISHA EVERETTE: Yeah, I'm a huge advocate, Medicaid for all. If you're born here, start off on Medicaid and if there's a way to go up, go up, but we should definitely have universal healthcare programs and if we're not willing to do that in a comprehensive way and we want to tie healthcare to employment, then let's start at birth you have some healthcare from the beginning regardless of you who are. I've said enough. Next question.
>> PAIGE BRAY: There's a few more questions coming in. Do you think the under funding and lasting effects of redlining in historically black areas will affect or already affect the reach of the vaccine to those communities that have been hit so hard by the pandemic?
>> TEKISHA EVERETTE: I'm going to try to be so brief here because I know the others want to say something, I'm going to say yes and the data shows it. There's a story that came out today from stat News that shows -- and the state had already produced this information, but a story came out from stat news today that our wealthier cities, towns, counties are getting the vaccine at higher rates than our more -- our poor or less resourced cities and urban centers. Said differently, you have towns that are 80% white, that have 80% vaccine rates, and then you have towns that are majority People of Color, or areas that are majority or close to majority People of Color having lower rates. The answer is yes, it definitely impacts and has a direct correlation to our vaccine rollout.
>> SARAH LEWIS: I would say ditto to what Dr. Everett said in that we're also -- when we look at the way eligibility is determined for vaccines in Connecticut, we have a majority -- our population tends to be older in this state than some other states around the country, and our older population is far whiter than other sort of age groups around the state, so we've had healthcare workers and people over 75 and just now recently over 65. It's very hard to vaccinate the folks who are African-American and Latinx and recent immigrants of the country if we're focusing on those older populations, and that -- those groups typically are on average much younger than our white populations, so the way that we even prioritize how vaccines are being distributed right now is affecting overall up take, and until we think about that through the equity lens, we're not going to hit a target when it comes to equitable distribution.
>> REGINALD EADIE: Just one quick comment. So, you know, this was really -- it was an emotional moment for me when we decided, which I think was the right thing to do from an infection prevention perspective to close the schools. But the heartbreak was that when we told kids that you had to E-learn, and we did not ask ourselves the question, at least publicly, we didn't, if they had the ability to have access to WiFi, Internet, et cetera, so they could not participate in learning. That was not asked. So what happens now? I don't know what's going to happen now. I do know we have thousands of kids who are -- have not been educated since March, and so when you apply that way of thinking to what we're seeing now, it's exactly why we got the results -- the results that were published yesterday, which we suspected. And so we have to rethink this thing. We have to make sure that we apply some intentionality around the decisions that we make to ensure that we don't leave one community behind. Because again, leaving one community behind means that we're going to be in this pandemic that much longer.
>> PAIGE BRAY: We have three related questions. One is about why are younger generations so reluctant to accept the vaccine and medical treatment when both the providers and the parents were not even alive during, like, the Tuskegee experiments, and related to what are the specific resources that can use to reassure People of Color and their communities about the COVID vaccine and protocol?

>> REGINALD EADIE: I mean, you know, I'm not a young person so this is just my opinion and I've spoken to a number of them. You know, the death rate, morbidity and mortality in younger groups just hasn't been there. So while it's true that the elderly were dying at a faster rate, I think 40% of the deaths in the country were people who were residents in long-term care facilities which is why they were in Phase 1A. But the reality of it all, when you look at the gross number, the overall number of deaths in the country, it's Caucasian people, so I submit to the students or whoever placed that question into the chat box to reconsidering this is because there's nothing that's done in the dark that won't come to the light and there's nothing that's done in your neighborhood and another neighborhood that won't impact yours eventually. So that's just the truth in the matter. Today is a new day. I happen to think the silver lining is God reminding us of the unjust we have moved forward in the country. And the chickens are coming home to roost. It's reality. We should have no deaths secondary to a pandemic. We just had the Spanish flu of 1918, and it wiped out a large number of Americans. Now, this pandemic is -- we -- this is the deadliest year, 2020, we've ever experienced in the history of America, and January was the deadliest month. We have to look and say although it may have been a friend or relative eventually it's going to hit us, so what do we do what do we do as a human race God expects us to do that will be fair and equal for all and we need to do that from in the other policy perspectives.
>> I'll add on to that. I'm not sure how young I am. I'm a professor and I work with a number of people who are younger than me, so I'll say a couple of things. One, what I appreciate and applaud and love about Generation Z, the level of natural skepticism and critical thinking they bring to everything, I think, has some relationship to do with hesitancy there. Above and beyond that, I want to address the Tuskegee movement, the Eugenic movement that paralyzed Black men and women in North Carolina, I want to talk about the timeline. It started in the '30s and '40s and ended in the 1970s. What that means is that you still have people that are still alive. People and are descendents of people who are directly related to those movements. I need you to hear me. This isn't 30,000 years ago, or 400 years ago. I'm 44 years old. I was born four years after the end of the Tuskegee institute, at the end of what happened with the Eugenics movement, and my mother was born right in the time frame of Henrietta Luck. So it doesn't matter how young you are. People who are critical thinkers and are questioning everything and trying to find the truth have a natural skepticism and he's -- hesitancy with the government and with the healthcare system.
>> PAIGE BRAY: As our final question, there's two questions related to equity. One is how can we support students of color in schools at any page, start to be critical consumers and advocates for their own access to health, and it is paired with given the inequities, what are specific steps Connecticut can do to begin to close that -- those gaps?
>> SARAH LEWIS: Did you want to add anything else with your experience as professor?
>> TEKISHA EVERETTE: We're a very polite group, the three of us. What I'll ask, is I ask my students constantly to question, and you've heard all three of us say this before. It is to understand your place and space in history, to understand history and question that which doesn't align with your -- with historical knowledge and your current knowledge. That's always what I -- it's how I teach and how I come into the space. I think additionally, when we're talking about what we can do from an equity standpoint is first to understand the difference between equity and equality, and because I know I'm speaking to healthcare providing -- students who

anticipate being healthcare providers or are currently healthcare providers, it's necessary to really echo understanding that equity is important, first and foremost. Equality didn't allow us to right the wrongs of the past and of the current and that's really important and if we're talking from the perspective of COVID-19 and the current vaccine, I think it's very important for us to, in the context of that and my life, just because we started something doesn't mean we have to finish it that same way. It is never too late to realize we have an inequity process. We don't need to cry or money about -- moan about it, we need to redirect our space of energy and equity. I don't know if Sarah, or Dr. Eadie, you want to add anything.
>> SARAH LEWIS: I think that was great and I would pick up there and talk about the need to tell the truth and be honest and go into the other question around what Connecticut can do to begin to close these inequities and close these gaps. We as a state need to be very clear about where we have and have not valued the lives of Black, and Indigenous People of Color across the state. And talking about the history of redlining, and our public officials, our leaders, anybody in any role or institution of power needs to think about what they can do to dismantle those structures. We can use our creative reimagination to think about a future that is more equitable and fundamentally in order for everybody in society, but in order do that we have to see everything around us and make the invisible, visible, and for those of privilege, it is very uncomfortable to see those marginalizations of same privileges. Sometimes I refer to our Department as the Department of discomfort, because in order to make radical change that leads to equity and doesn't leave anyone behind, we have to get a little bit uncomfortable in our seats and understand that promise land is one in come everybody thrives and is healthy. I would love some radical talk about where we have been. It's all over the state. You look at the history of our shoreline and who has had access to beaches and just access to public recreation in the summertime. It's in every corner of this state, and just because we're in the northern part of the country doesn't mean that structural or institutional racism doesn't exist here. It's part of the fabric of this country and it's what we've been built upon. It doesn't have to look like that. But if that's the lesson from COVID-19, which has just rendered so much pain and loss, it's that those historical truths got us to where we are right now, and it doesn't have to look this way the next time we have a crisis like this. It can look much better and we don't have to suffer because of our past sins. So I'm excited about the future if we're willing to take this step and step into our radical imagination. Thank you.
>> PAIGE BRAY: Thank you so much for those responses. I'm going to pass it back to Chris Grant to finish out the evening and thank you for the questions everyone provided.
>> CHRISTINE GRANT: I think we can agree the discussion on health equity and Communities of Color, along with the importance of the vaccine was both timely and informative. Thank you again to Dr. Reginald Eadie. Thank you to Dr. Everett, and Ms. Sarah Lewis for taking the time out. You were great, and thank you again for taking the time out to be with us. I also want to say that we want to be partners with you. I heard that extended to us, and so we are here waiting and we'll be in touch to be partners with you. Also want to say that we're at the beginning of these conversations. We need to continue here at the University, and across the country, so again thank you. Real quickly, I just want to share with you what's on tap and coming up for us here at the University. So on February 22nd, please join us as we continue the conversation with Leslie Torres-Rodriguez, superintendent of Hartford Public Schools. I heard Dr. Eadie touch upon a very important point and she will be here to discuss with us, role of community in

prioritizing education and health for children and families of color. So again, look -- you'll see that in our announcements here on campus. On the fourth of our lecture series that will be offered here by the Rogow series is police and campuses and Communities of Color on March 25th. So again, please be on the lookout, join us if you can. We have some very distinguished panel members again. Last but certainly not least, I wanted to take the opportunity for our campus to see the number of faculty members and other staff members that have helped to assemble the series that we've put together for this academic term and I want to say on behalf of the office of diversity and community Engagement. Thank you for joining us tonight and we look forward to seeing you back on campus. Good night.
[End of event]