The Color of Health

The Devastating Toll of Racism on Black Lives

Common Ground Health

Racism is a public health crisis

Alvin Simmons was the first person in the Rochester area to die from COVID-19. He was a man who loved music, had a special affinity for karaoke, and reached out to others with texts and funny memes when they needed encouragement.

"When I first met Alvin, I was going through some personal things with a child," recalled his girlfriend Lisa Williams in a Democrat and Chronicle profile of Simmons after his death. "He used to send me things through Messenger, like uplifting songs. He'd send me messages like 'Hold your head up.'"

In his last days, when he was short of breath, he asked Williams to sing solo.

"He said, 'I want you to do karaoke,'" Williams remembered. "'I can't join. I want to hear your voice.'"

On March 17, 2020, Simmons, an African American, lost his battle with the mysterious new virus. He was 54 years old. [1]

In the months that followed, it became clear that Simmons' death was a harbinger of the toll that COVID-19 would extract on communities of color. Nationally, the COVID-19 death rate for the Black population was 2.2 times the rate for the White population.[2] In Monroe County, the disparity was even higher. African Americans were 2.9 times as likely to test positive for coronavirus as their White neighbors and 2.6 times as likely to die from the disease.[3]
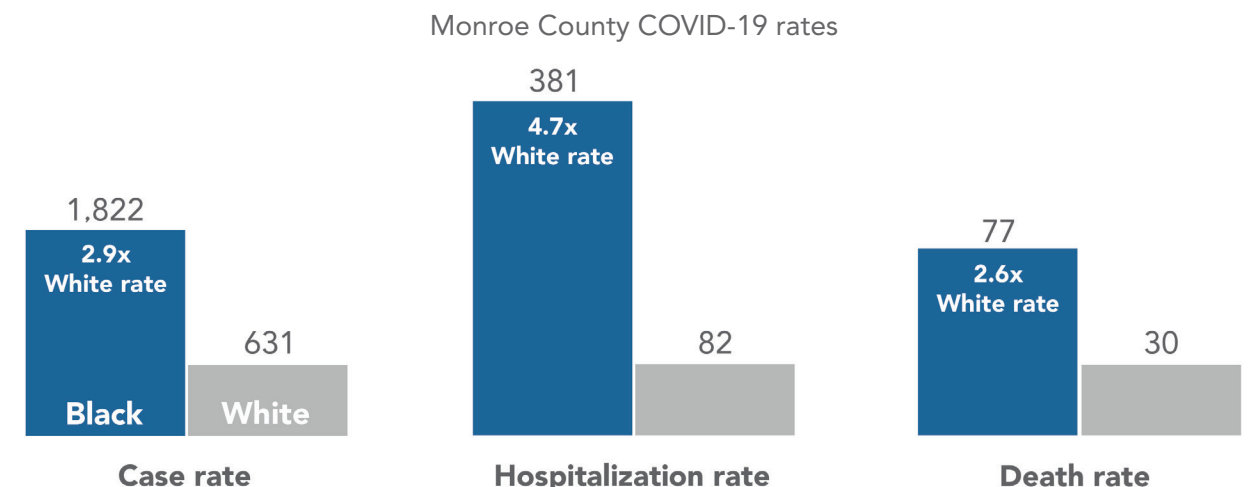
No one can say that Simmons died from the virus because he was Black. But what is beyond doubt is that the color of his skin subjected Simmons to layers of systemic disadvantage that put him, and his Black neighbors, at a much higher risk for exposure to, and complications from, the novel infectious illness. Racial bias in housing, education, employment and other social determinants of health meant that Black Americans were forced to the front lines of a global pandemic with fewer resources to protect themselves, including being less likely to have sick leave, health care and jobs that

Black Americans were forced to the front lines of a global pandemic with fewer resources to protect themselves.

allowed them to work from home.

Put simply: coronavirus does not discriminate on the basis of race, but our institutions and policies do. COVID-19 racial disparities are not a mystery. "What we're seeing here is the direct result of racism," says Dr. Camara Phyllis Jones, an epidemiologist and past president of the American Public Health Association. "That's the thing that is slapping

African Americans face much larger risk from COVID-19

Monroe County COVID-19 rates

Case rate
- 1,822 — Black — 2.9x White rate
- 631 — White

Hospitalization rate
- 381 — 4.7x White rate
- 82

Death rate
- 77 — 2.6x White rate
- 30

Rates are age-adjusted and shown per 100,000 residents.
Data is from 3/1/2020 to 10/21/2020 for White non-Hispanic and Black non-Hispanic populations.
This analysis excludes records with unknown race and ethnicity (5% of cases; 1% of hospitalizations; 1% of deaths).
Source: Rochester Emerging Infections Program, Center for Community Health & Prevention, University of Rochester Medical Center

us in the face. Actually, it's lashing us like whips."[4]

Over the past few years, overt racism has reemerged in the public sphere through White supremacist ideology on social media and nationally televised gatherings like the 2017 Unite the Right rally in Charlottesville, Va., that left one peaceful protester dead and 19 others injured.

However, explicit racism is only the tip of the iceberg. Most race-based discrimination in 21st century America is much harder to see because it does not require that individuals exhibit or embrace bigotry.

"Today, racial segregation and division often result from habits, policies and institutions that are not explicitly designed to discriminate," explains Dr. Eduardo Bonilla-Silva, author of Racism without Racists. "Contrary to popular belief, discrimination or segregation do not require animus. They thrive even in the absence of prejudice or ill will. It's common to have racism without racists."[5]

Systemic inequities are to blame. Centuries of discrimination, reinforced by exclusionary suburbanization, have perpetuated two vastly different life experiences in the United States — "two societies" as the Kerner Commission put it in 1968, "one black, one white — separate and unequal."[6]

While many well-intentioned people may believe that the country has moved beyond its racist past, economic and health outcomes of Black Americans tell a different story. By nearly every measure, the deck continues to be stacked against people of color.

The 2021 report by the Commission on Racial and Structural Equity (RASE) found that these inequities are persistent and widespread in Monroe County and the City of Rochester. "While we found hardly any laws in the City and County which created and sustained racist policies, we have found practices and conditions... where people of color are unable to fully participate and are implicitly or explicitly excluded from opportunities that could enhance their economic, social and mental health."[7]

Real estate and lending practices limit access to affordable, quality housing. Lower-quality schools and biased treatment in the classroom result in inequitable educational experiences. Implicit bias among health care providers leads to suboptimal treatment and lack of trust in the health care system. Consistent exposure to demeaning racist stereotypes prohibits individuals from fully believing in themselves and realizing their potential.

Each layer of racism, directly or indirectly, puts additional stressors on physical and mental health and makes it harder for people of color to access resources that support well-being.

The cumulative results are devastating. Despite our region's proud history of anti-slavery activism, today, policies and practices that lead to race-based inequities are killing Black residents in Rochester and the Finger Lakes region at a rate that is indefensible. Compared to White people, Black people in our region face dramatically higher rates of premature mortality from nearly every condition, including heart disease (133% higher), diabetes (146% higher), cancer (35% higher), and premature birth disorders (218% higher).[8] The breadth and depth of the disparities reflect the breadth and depth of racism's impact on the young and old alike. And this happens at tremendous cost to the region – human and financial.

In the midst of this pandemic, most of the world longs to return to normal. For Black residents of Rochester and the Finger Lakes region, normal is the last thing needed. Reducing illness and early death for communities of color is within our reach, but the science of health improvement is clear: community health is not determined primarily by biology or the medical system, but rather by the social constraints in which we live.

Health equity strategy for Black residents must look beyond the four walls of the medical clinic or hospital and include what happens in the classroom, on the way to school, on the job and in the home. Policies

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and practices that ensure African Americans equitable access to employment, education, housing and the other social determinants of health are not just good social policy, they are essential investments in public health.

All of us must find ways to drive such investments. Highlighted throughout this report are actions for increasing equity that each of us can take in our personal and professional lives. With collective action, we can build a region in which race-based health disparities are relics of a bygone era and wellness is a birthright for all.

About This Report

This report is the second in a series of health equity studies produced since 2019 by Common Ground Health, the health research and planning organization for the nine-county Rochester-Finger Lakes region. *The Color of Health* follows on the heels of *Overloaded*, an extensive analysis of the tragic toll that poverty takes on residents' health across our urban, rural and suburban communities.

The focus and recommendations in this report were guided by the African American Health Coalition. Convened by Common Ground, the long-standing advisory group brings together community leaders and health professionals to coordinate efforts to improve health for communities of color. This report builds on the coalition's proud history of providing community data and insight on African American health inequities to inform and mobilize meaningful change. A roster of coalition members is included at the end of this report.

Since 2003, coalition members have supported prior studies of health disparities experienced by Black communities in our region. Updated most recently in 2014, the *What's Goin' On* report documented higher rates of illness and premature mortality among Black residents and called for increased efforts to address social determinants of health as a central strategy for eliminating unfair and preventable health inequities. *The Color of Health* takes the next step to put a spotlight on the many ways that racism undermines the social determinants of health, and that dismantling systemic racism is the key to any significant and lasting improvement in African American health outcomes.

The health hazards of being Black

The racial health disparities put in the spotlight by COVID-19 are nothing new. Year after year, Black residents in the Finger Lakes region face significantly worse health outcomes than their fellow citizens who are White.

African American families struggle with reprehensible rates of chronic illness, mental distress and premature mortality. Even among those with high incomes and advanced education, Black people in our region face an unfair burden of disease and die earlier than their White neighbors.

Just how much earlier is captured by a measure called Years of Potential Life Lost (YPLL). This mortality metric places a larger weight on the deaths of younger people by estimating the additional years a person would have lived had they not died before the age of 75.* Black residents regionally have a 67% higher rate of YPLL than their White counterparts. Although this gap has decreased since 2000, the inequity remains large. Even at the highest socioeconomic

levels, the Black population has a 38% higher premature mortality rate.[9] †

Heart disease is the top cause of premature mortality within our region's Black population and is also one of the largest contributors to the racial disparity in years of life lost. Nearly one quarter of the total disparity is driven by the Black rate of premature mortality from heart disease, which is more than double the White rate.[10]

Homicide, the other leading cause of the premature mortality disparity, steals years of life from Black men at a rate that is 25 times higher than the rate faced by White men.[11] This shocking racial disparity is not inevitable. Decades of research shows that, similar to heart disease, diabetes and other

measures of public health, higher rates of violence in Black neighborhoods are the outgrowth of social and economic discrimination.

In short, violence is a symptom of poverty, explains Willie Lightfoot, Rochester city council member and founder of the Cut the Violence Initiative for teens. "At the end of the day, violence affects our entire community," he says. "It impacts everything and everyone."

Other major drivers of YPLL inequity include premature birth, diabetes and cancer (primarily lung and breast). The variety of these causes is a testament to how broadly health inequities are experienced across the entire Black community, including by babies, who should be the hope for the future, not victims of discrimination. In fact, the Black premature mortality rate is higher for nearly every cause of death, with the notable exceptions of suicide and drug overdose, which are higher for the White population.[12]

Racial health inequities not only shorten lives, they also diminish quality of life. Black residents of our region live with chronic illness more often than Whites and experience worse outcomes from these

diseases. High blood pressure is linked to heart disease and is 21% more common among Black adults.[13]
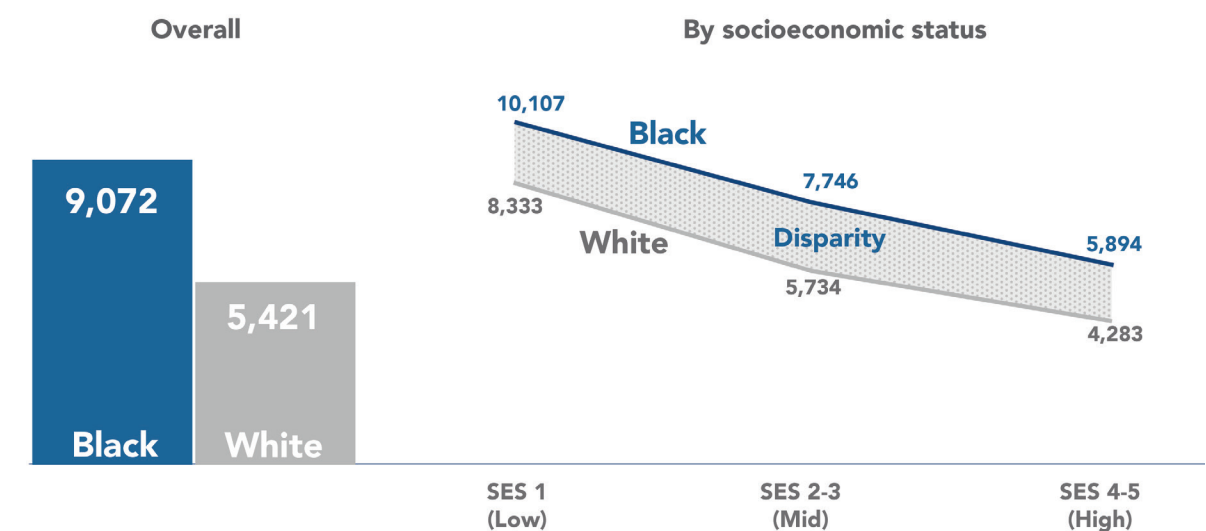
While blood pressure can be controlled and kept at safe levels through a combination of medication and lifestyle changes, Black patients have significantly lower control rates (69% vs. 81% for White patients), exposing them to greater health risks. This disparity persists across the socioeconomic spectrum. Black patients in high socioeconomic status areas have lower control rates (74%) than White patients in low SES areas (79%).[14]

The combination of higher prevalence, lower control rates and other risk factors leads to a Black rate of hypertension-driven preventable inpatient hospital stays that is nearly 6 times higher than the White rate. Unfortunately, asthma and diabetes show similar disparities.[15]

Mental illness mirrors the disparities seen in physical illness. Black adults across the Finger Lakes are over 50% more likely to report poor/fair mental health than White adults (22% vs. 14%). Black residents also identified mental health as their number-one priority when asked broadly about concerns for their health and well-being.[16]
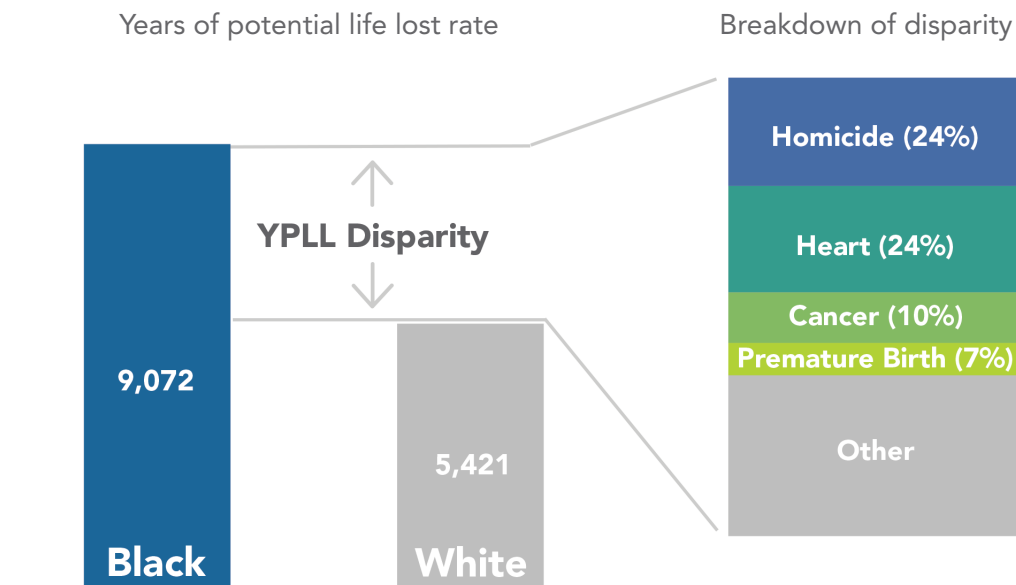
Black people die earlier regardless of socioeconomic status

Years of potential life lost rate

Overall

9,072	5,421
Black	White

By socioeconomic status

Black: 10,107 (SES 1), 7,746 (SES 2-3), 5,894 (SES 4-5)
White: 8,333 (SES 1), 5,734 (SES 2-3), 4,283 (SES 4-5)

Disparity

| SES 1 (Low) | SES 2-3 (Mid) | SES 4-5 (High) |

All rates are age/sex-adjusted and shown per 100,000 residents
Source: NYSDOH Vital Statistics for Finger Lakes nine county region 2015-2017; Analysis by Common Ground Health

Homicide and heart disease drive higher rates of premature mortality for Black residents
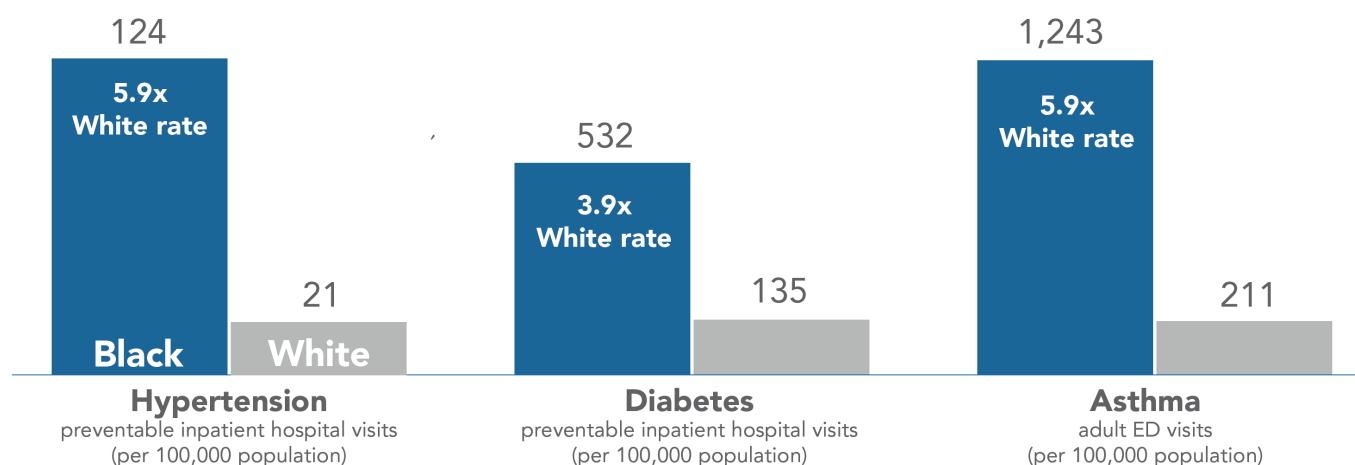
Years of potential life lost rate

Breakdown of disparity

YPLL Disparity

9,072

Black

5,421

White

Homicide (24%)

Heart (24%)

Cancer (10%)

Premature Birth (7%)

Other

All rates are age/sex-adjusted and shown per 100,000 residents
Source: NYSDOH Vital Statistics for Finger Lakes nine county region 2015-2017; Analysis by Common Ground Health

The breadth and depth of these inequities is striking – nearly every health metric is significantly worse for our region's Black population. And while health outcomes are particularly poor for low-income Black people, the disparities persist across the socioeconomic spectrum.

The results are devastating for so many individuals, their families and our region's entire Black community. As Martin Luther King Jr declared: "Of all the forms of inequality, injustice in health is the most shocking and the most inhuman because it often results in physical death."[17]

Black communities face much higher rates of hospital visits for chronic conditions

124

5.9x White rate

Black

21

White

Hypertension
preventable inpatient hospital visits
(per 100,000 population)

532

3.9x White rate

135

Diabetes
preventable inpatient hospital visits
(per 100,000 population)

1,243

5.9x White rate

211

Asthma
adult ED visits
(per 100,000 population)

Source (hypertension and diabetes): NYSDOH SPARCS Inpatient Data; Finger Lakes 9 county region (2011-2015)
Source (asthma): NYSDOH SPARCS Outpatient Data; Finger Lakes 9 county region (2013-2015)
Age/sex-adjusted analysis analysis by Common Ground Health
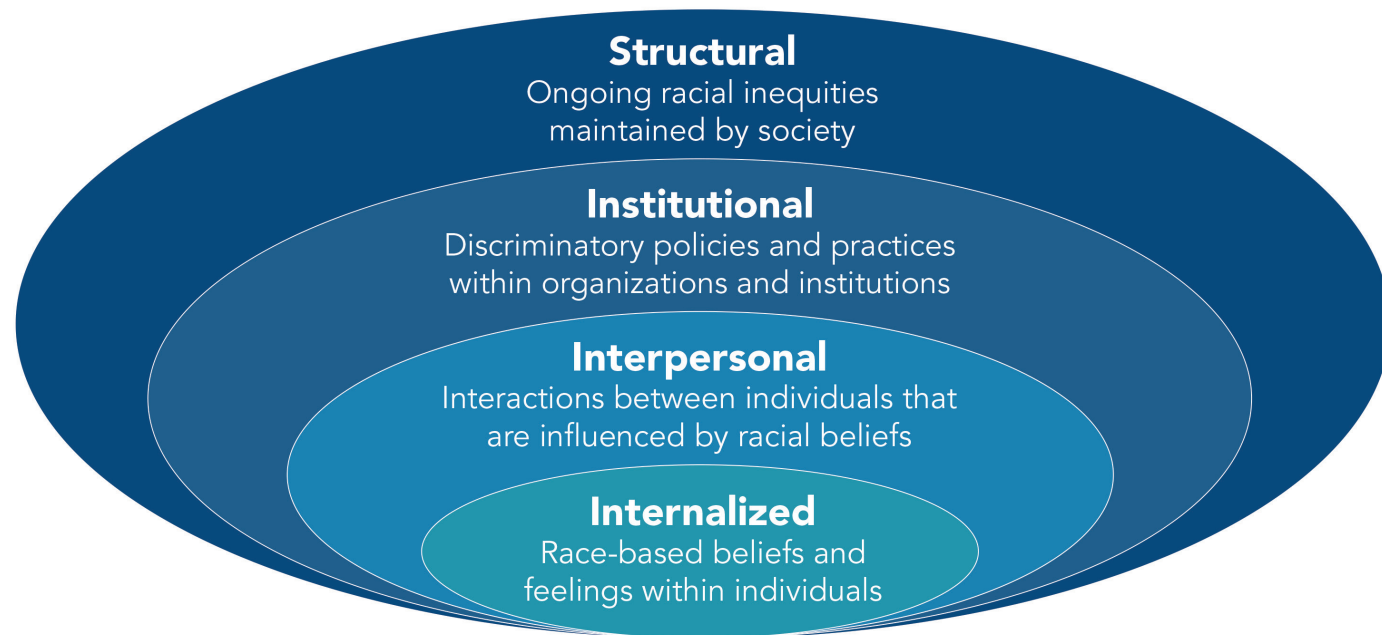
Racism, not race, is the problem

In his groundbreaking research more than a century ago, sociologist and civil rights leader W.E.B. Du Bois declared that racial health disparities were driven by social inequality – not biology.[16]

Scientists have since proven that no genetic or inherent biological condition explains the broad and extreme health disparities associated with race in the United States. Race is a social construct without biological significance. Genetic studies show that far more genetic variation occurs between individuals within a population, than between populations.[19]

While race does not explain outsized health disparities, racism does.[20] [21] A growing body of medical and sociological research provides clear evidence that how people are perceived, treated and able to access resources because of their race has a real – and dangerous –

The Four Levels of Racism

Structural
Ongoing racial inequities maintained by society

Institutional
Discriminatory policies and practices within organizations and institutions

Interpersonal
Interactions between individuals that are influenced by racial beliefs

Internalized
Race-based beliefs and feelings within individuals

impact on health. Hundreds of studies show a relationship between racial discrimination and poor physical and mental health, and researchers are illuminating many of the pathways by which racism degrades health.[22] [23]

> **"What is the high cost of being black? Even in 2020, I have to run faster, further, carry a heavier burden and do it with a smile on my face."**
>
> — WADE NORWOOD, CEO, COMMON GROUND HEALTH

Americans may be tempted to believe that racism is no longer an oppressive force. Although "Whites Only" signs and other forms of in-your-face discrimination are now illegal, racism remains embedded in American culture and institutions. The reality is that the broadest-reaching effects of racism are not from hurtful words or the actions of bigoted individuals, but rather from public policies and business practices that lead to racially

disparate outcomes – whether intentional or not. In his book, Racism without Racists, Eduardo Bonilla-Silva explains: "Whereas for most whites racism is prejudice, for most people of color racism is systemic or institutionalized."

Racism is a complex force that is experienced on four levels: structural, institutional, interpersonal and internalized.[24] Each of these layers creates obstacles that make it much harder for the Black community to live long, healthy lives. Discrimination limits access to employment, housing, nutritious food, health care and other social determinants of health. Additionally, exposure to racism is a chronic, toxic stress that has a weathering effect on the mind and body.[25] Through these varied and reinforcing mechanisms, racial discrimination is the driving force behind large physical- and mental-health inequities.
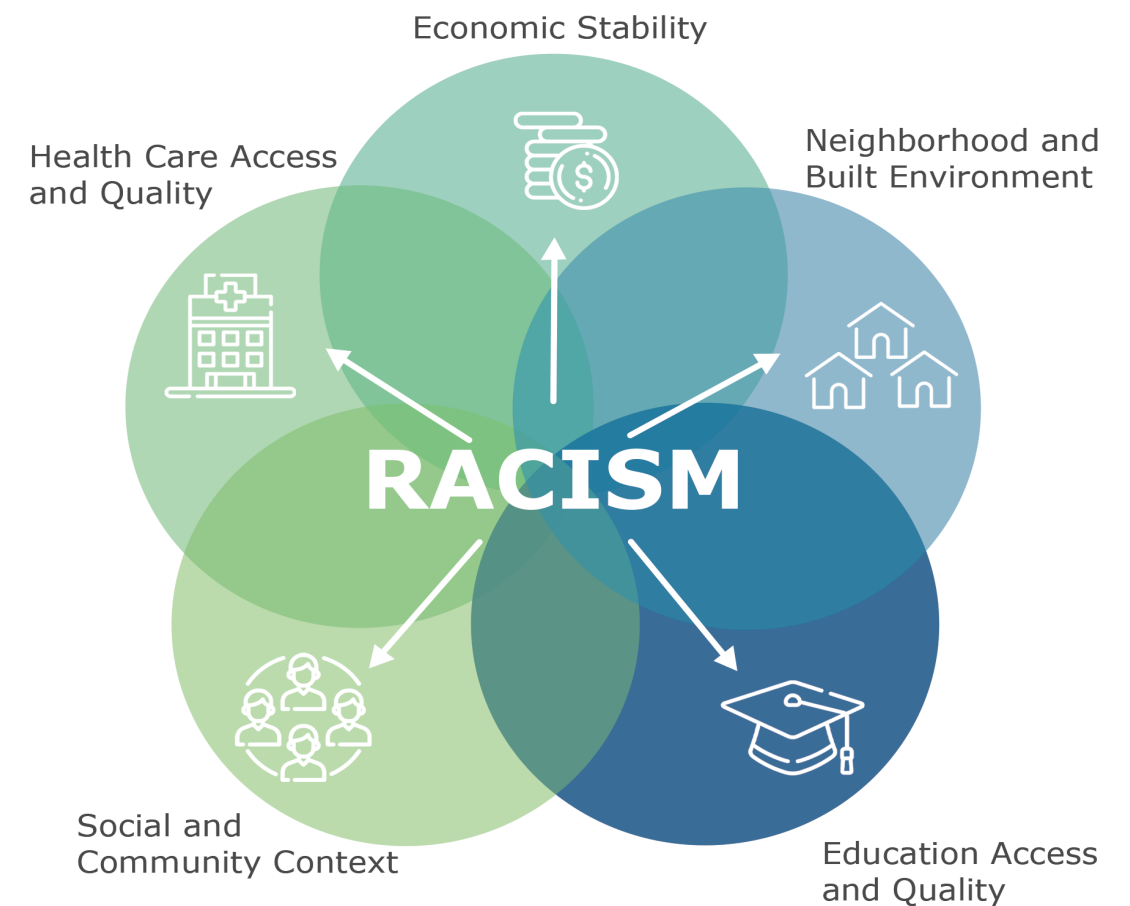
The overarching problem is that racism, in its

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many forms and whether intentional or not, creates a gauntlet of barriers that makes it very difficult for the Black community to thrive. As Wade Norwood, CEO of Common Ground Health, puts it, "What is the high cost of being Black? Even in 2020, I have to run faster, further, carry a heavier burden and do it with a smile on my face."

Racism negatively impacts all of the social determinants of health for the Black community

Economic Stability

Health Care Access and Quality

Neighborhood and Built Environment

RACISM

Social and Community Context

Education Access and Quality

Structural racism

What is structural racism?

Structural racism is the cumulative and compounded effects of many forces – historical, cultural, institutional and interpersonal – that routinely disadvantage people of color. While the specific mechanisms evolve over time and may not have racist intent, they consistently lead to power inequalities, unequal access to opportunities and differing policy outcomes by race.[25]

How does it damage health?

Structural racism ensures the persistence of many barriers to improving living conditions and accessing resources that are foundational to health.

Structural racism is so persistent and devastating because it is not something that individuals and institutions choose to do, rather it is embedded in our social, economic and political systems.[26]

Although the civil rights movement brought an end to certain explicit forms of discrimination, systems and policies continue to produce racially disparate outcomes, even when they aren't overtly or intentionally racist.

Constantly reinforcing and far-reaching, structural racism confronts Black citizens with new barriers at every turn, often transforming the American dream of working one's way up the economic ladder into an unattainable fantasy. A recent study by researchers at Harvard University, Stanford University and the U.S. Census Bureau found that Black children are less likely to reap the benefits of upward mobility and more likely to slip down the rungs of prosperity.[28] White children born into the lowest income group are nearly twice as likely as their Black peers to climb their way to the middle-income group, 46% vs. 25%. And while 41% of White children with parents in the highest income group stay at that level, only 18% of highest income Black children maintain their affluent standing. Such inequity in economic opportunity reduces access to resources such as healthy food, health care and social determinants of health more broadly. Structural racism also reduces political power for the Black community through:

Wealth inequity: Given that money facilitates access and influence in the political realm, the large economic inequities described above translate to large inequities in political power.[29]

Segregation: Black voters tend to be geographically isolated from White voters, limiting opportunities to build alliances around shared interests in neighborhood priorities.[30] Black communities in cities like Rochester have limited success pushing through county or state legislation and

policies to make investments in their neighborhoods and community resources because White suburban voters often have different and sometimes competing priorities for limited resources.

Inequity in economic opportunity reduces access to resources such as healthy food, health care and social determinants of health more broadly.

Obstacles to voting: Across the nation, Black citizens typically face more and larger barriers that suppress voter turnout. In recent years, half of the states have imposed new burdens on the voting process that effectively disenfranchise people of color. Strict voter-ID laws are an example of policy which may seem race-neutral on the surface, but disproportionately impact Black Americans who are much more likely to not have a current government-issued photo ID. Additionally, because of inequities in the distribution of electoral resources, Black voters wait an average of 46% longer in line than White voters, according to a recent study by the Brennan Center for Justice.[31] Beyond these obstacles, there are an estimated 1.8 million Black citizens who have been stripped of their right to vote because of state laws that disenfranchise – sometimes permanently – those with felony convictions. Those laws also disproportionately affect people of color because of inequities in the criminal justice system. While New York State does currently allow people to vote post-sentence and during parole, research suggests that confusion about the policy has prevented many eligible voters from actually voting.[32]

Taken together, systemic discrimination robs Black residents of the political power to drive large-scale change. Without policy and

Structural racism confronts Black citizens with new barriers at every turn, often transforming the American dream of working one's way up the economic ladder into an unattainable fantasy.

Only 25% of Black Americans are able to rise from poor households to the middle class

46%

25%
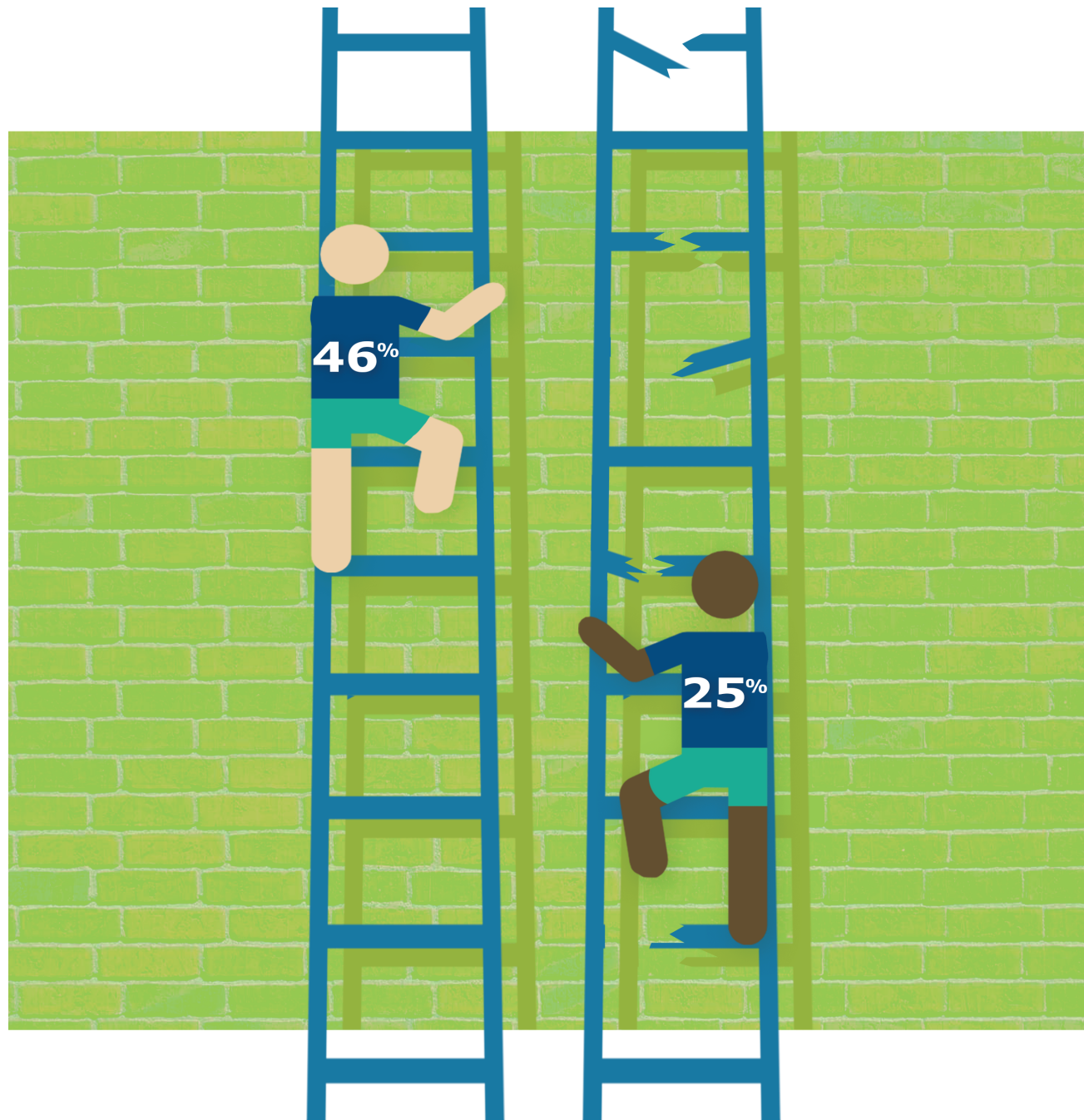
The percentage of children raised in households with income in the lowest quintile who grow up to earn household income in third quintile or higher.[32]

Source: Race and Economic Opportunity in the United States: An Intergenerational Perspective. Raj Chetty, et.al. NBER Working Paper No. 24441. December 2019.

systems reform, Black communities will continue to have less access to well-paying jobs, quality housing, healthy food, safe neighborhoods and other resources that are critical for health and well-being.

Institutional racism

What is institutional racism?

Policies and practices within and across institutions (including government, business, schools and media) that produce racially disparate outcomes, regardless of the intentions of the people working within those institutions.[32]

How does it damage health?

Institutional racism profoundly shapes living conditions (including employment, housing and neighborhood environment) which are foundational to health. It also limits access to key health resources such as nutritious food and quality clinical care.

For many Americans, the term racism brings up the image of an individual, such as "Bull" Connor, Birmingham, Alabama's commissioner of public safety who directed the use of police attack dogs against civil rights protestors, including children, in 1963.

Or, more recently, Derek Chauvin, the officer who pressed his knee against George Floyd's neck for nearly nine long minutes until he died.

By contrast, institutional racism is not tied to a specific event or individual. Cloaked in seemingly colorblind language or hidden behind plausible denial, biased policies and practices often exist below the radar of public attention or understanding. Though not necessarily intentional, these policies and practices remain entrenched in industries and arenas decades after race-based discrimination was outlawed, often ferreted out only through research and undercover investigations.

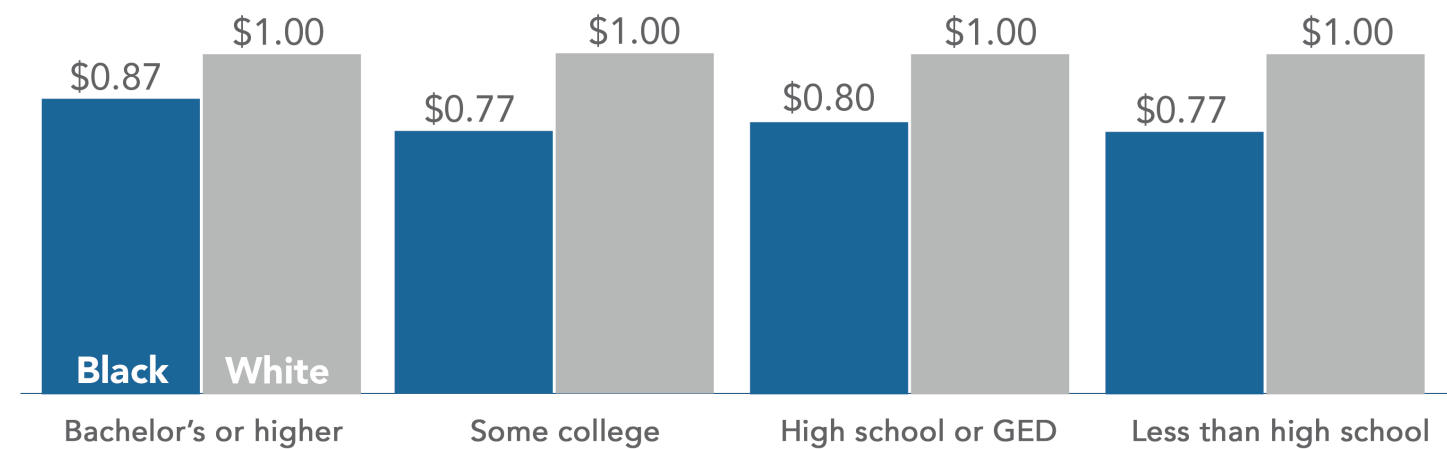But the appalling consequences of institutional racism are anything but hidden. Faced with biased treatment and constrained opportunities, Black Americans experience worse outcomes than other groups at almost every turn, from employment and housing to education and the courts. The degradation of these social determinants of health ultimately leads to the most tragic outcome of all for Black residents of Rochester and the Finger Lakes region: sicker and shorter lives.

Racism in the workplace
Employment plays a major role in access to resources and well-being, so discrimination in hiring and wages fundamentally undercuts the ability to lead a healthy life. A landmark study by Devah Pager at Northwestern University found clear racial discrimination in the hiring process for a wide variety of entry-level positions. Black candidates with the same qualifications as White candidates were less than half as likely to get a callback for a follow-up interview.[34]

Black employees are paid less regardless of educational level
Monroe County racial wage gap

	Bachelor's or higher	Some college	High school or GED	Less than high school
Black	$0.87	$0.77	$0.80	$0.77
White	$1.00	$1.00	$1.00	$1.00

Data compares the median earnings of White non-Hispanic and Black non-Hispanic populations.
For example, among people with bachelor's degrees, Black workers are paid 87 cents for every dollar paid to White workers.
Source: Doucette, Luticha, and Henry Fitts. Wage Disparities in Monroe County by Race and Gender. City of Rochester Mayor's Office of Innovation and Strategic Initiatives. July 2017.

What can we do?

Support existing community initiatives to dismantle structural and institutional racism

✓ Eliminate the upstream root causes of racial health disparities by replacing policies and practices that lead to inequities in housing, employment, education and other social determinants of health.

✓ Learn more about ways to support and leverage the work of groups that are targeting systemic racism. Great local initiatives include:

- Commission on Racial and Structural Equity (RASE)
- Interrupt Racism
- Black Agenda Group

Even when Black workers find employment, they are likely to face a major wage/benefits gap. A 2017 report focused on Monroe County found that Black full-time employees were paid roughly 15-20% lower wages than their White peers at every educational level.[35]

Racial discrimination in the workplace results in large financial disparities for the Black community. Compared to the White population in the Finger Lakes region, Black residents face nearly triple the unemployment rate (14% vs 5%), lower median income by half ($30,151 vs $60,919) and more than triple the poverty rate (34% vs. 11%).[36] These economic inequities compromise health in many ways: limiting access to health-related resources like nutritious food and medical care because of cost or transportation barriers; causing chronic toxic stress rooted in the uncertainty and overwhelming challenges of financial insecurity; and creating day-to-day complexities and obstacles to taking care of one's self and family.[37]
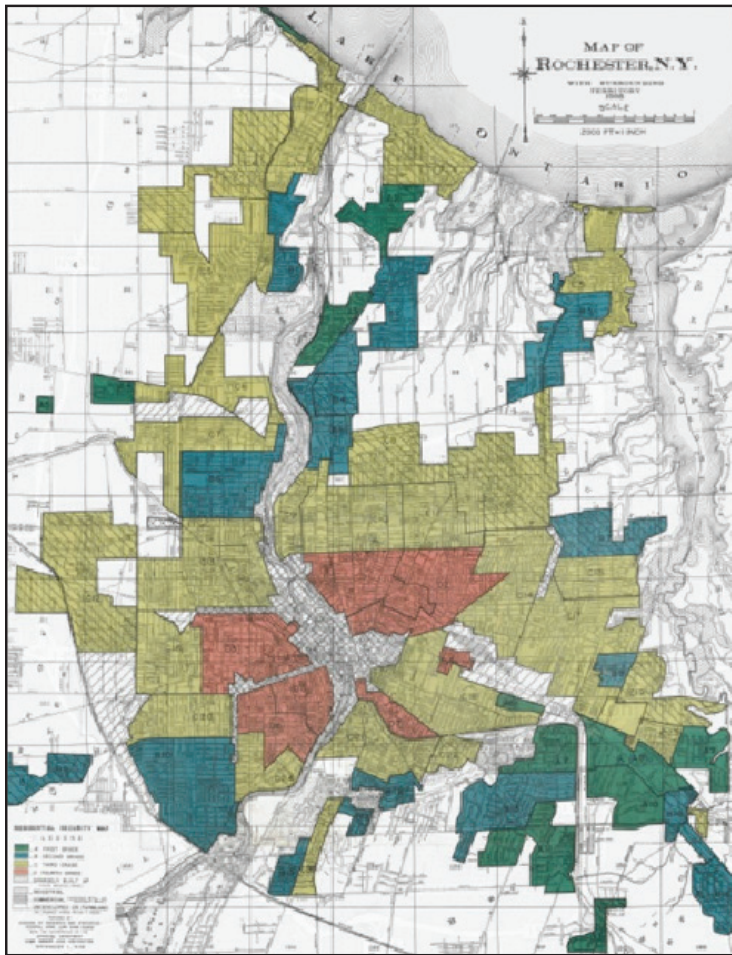
Unfair housing
Housing is much more than just a roof over one's head. As Douglas Massey and Nancy Denton explain in American Apartheid: Segregation and the Making of the Underclass, where a family lives determines "a variety of resources that shape and largely determine one's life chances. Along with housing, residential markets also allocate schooling, peer groups, safety, jobs, insurance cost, public services, home equity and, ultimately, wealth."[38]

The neighborhoods we live in were shaped by housing policies that typically favored White homebuyers. New Deal programs like the GI Bill and Federal Housing Administration loans explicitly or effectively excluded Black participation, essentially subsidizing White flight to the suburbs. Additionally, racially restrictive covenants kept some neighborhoods exclusively White for decades, further limiting housing options for Black residents.[39]

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Government policies enforced segregation and disinvestment that persist today

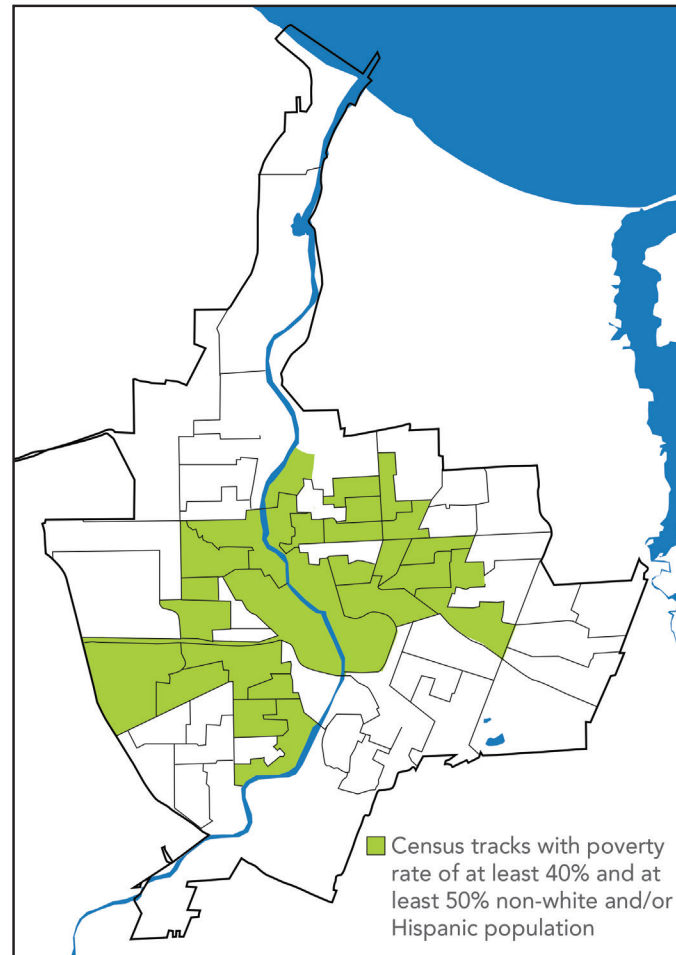1935 map with neighborhoods redlined by Federal Home Loan Bank Board

Source: Robert K. Nelson, et al. Mapping Inequality: Redlining in New Deal America

2017 map with racially and ethnically concentrated areas of poverty

Census tracks with poverty rate of at least 40% and at least 50% non-white and/or Hispanic population

Source: Analysis of Impediments to Fair Housing Choice. The City of Rochester. 2020.

In their new report, Confronting Racial Covenants, the City Roots Community Land Trust and the Yale Environmental Protection Clinic detail the history and lasting impact of racial covenants in Monroe County. The researchers found many examples of deeds and development agreements from the 1920s to 1940s that explicitly prohibited Black people from property ownership in the newly developing suburbs. For example, in 1939, when Monroe County sold a group of foreclosed properties near Irondequoit High School to a developer, the agreement required that all homes "be occupied by persons of the Caucasian race only."[40]

These covenants were consistent with national policies. For example, one of the guidelines in the 1938 Federal Housing Administration's Underwriting Manual effectively mandated keeping neighborhoods segregated: "Areas surrounding a location are investigated to determine whether incompatible racial and social groups are present, for the purpose of making a prediction regarding the probability of the location being invaded by such groups. If a neighborhood is to retain stability, it is necessary that properties shall continue to be occupied by the same social and racial classes."[41]

A recent report in the Rochester Democrat and Chronicle described the tragic results: "As tens of thousands of black people arrived in Rochester from the South in the 1950s and 1960s, they were met with a sophisticated, far-reaching, government-sponsored infrastructure dedicated solely to keeping them out of 'respectable' white neighborhoods, both in the city and the suburbs."[42] Acknowledging this history of racial discrimination is critical, because such policies created and reinforced patterns of segregation that endure in Rochester and most other cities.

Indeed, a comparison of historical and current maps of the city of Rochester shows that the neighborhoods that were labeled as high risk ("redlined") by the federal Home Owner's Loan Corporation in the 1930s are generally the same which are now considered to be Racially and Ethnically Concentrated Areas of Poverty.[43] This segregation is particularly pervasive in Rochester, which has a higher degree of racial concentration than 94% of cities around the country, according to the Racial/Ethnic Segregation Score developed by the City Health Dashboard.[44]

Although explicitly racist policies and practices have not been legal since the passage of the Fair Housing Act in 1968, research shows clearly that racial discrimination persists in housing markets. A three-year undercover investigation of real-estate agents published by Newsday in 2019 found that Black house hunters were denied the same treatment as White clients 49% of the time.[45] Realtors steered Black clients to particular neighborhoods, provided fewer house listings, and/or imposed more stringent scrutiny of their finances. While this study was conducted on Long Island, the findings are consistent with a 2017 national survey that found almost half (45%) of Black adults have experienced discrimination when seeking a new apartment or buying a home.[46]

In the Finger Lakes region, a 2015 study by the Empire Justice Center found that Black homebuyers continue to be turned down for mortgages at more than double the rate of White applicants. Even within upper-income groups, the Black denial rate is nearly double.[47]

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>
> — JUSTIN MURPHY, DEMOCRAT AND CHRONICLE

One result of historic and persistent discrimination is that Black families are less likely to own a home. Across the Finger Lakes region, 32% of Black households own their home, compared to 74% of White households.[48] As home ownership is the primary pathway to wealth accumulation for poorer and middle-class families, this inequity has huge implications that are both immediate and intergenerational.

Additionally, the cumulative effect of decades of housing discrimination has led to high levels of segregation, with Black people heavily concentrated in disadvantaged neighborhoods. Seventy-seven percent of our region's low-income Black households live in areas with high poverty levels, low educational attainment, high percentages of single-parent households, and other markers of deprivation. By contrast, only 25% of low-income White households are located in the region's most distressed areas. And racial segregation transcends income; nearly half (46%) of high-income Black households live in under-resourced neighborhoods.[49]

Black homebuyers continue to be turned down for mortgages at more than double the rate of White applicants.

The underinvestment in these neighborhoods creates a variety of health risks and barriers. For example, poorly maintained apartments and houses in distressed neighborhoods can expose residents to lead, mold, dust and other contaminants and allergens. Such environmental toxins lead to higher incidence of diseases including lead poisoning and asthma among Black families, and especially

Black households are heavily concentrated in disadvantaged neighborhoods

Percent of households in census tracts with high deprivation (ADI 9/10)
Finger Lakes region
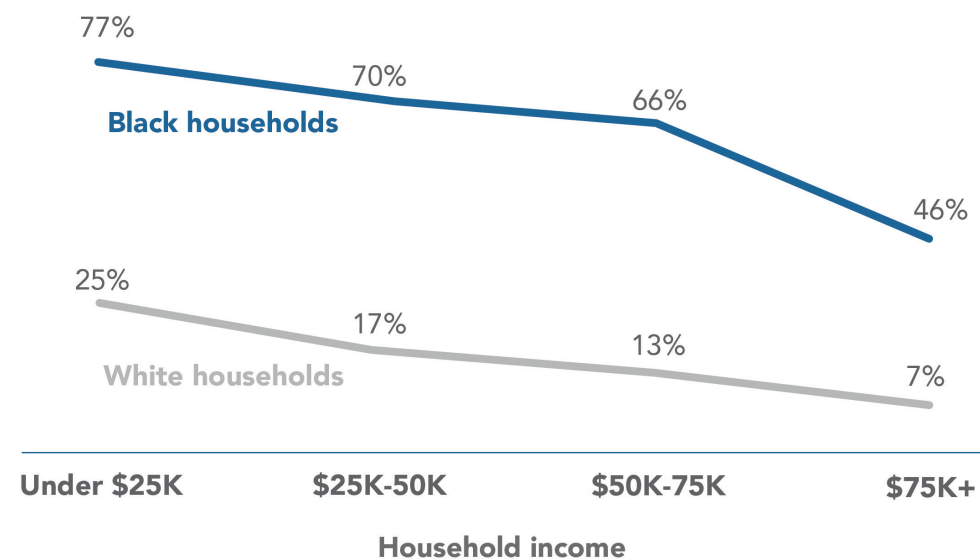
Source: Household counts by income and race/ethnicity of head of household from ACS 2017 5-year estimates (table B19001); Area Deprivation Index data from University of Wisconsin School of Medicine Public Health 2015 Area Deprivation Index V2.0. Age/sex-adjusted analysis by Common Ground Health

children, who live in these areas. The authors of one study on lead toxicity called it "a source of ecological inequity by race and a pathway through which racial inequality literally gets into the body."[50]

Another stumbling block to living a healthy life in resource-deprived neighborhoods is the lack of healthy foods. Many of these areas are considered 'food swamps' because they tend to be densely packed with corner stores and fast-food restaurants but have no or limited convenient options for accessing fruits, vegetables, and other nutritious food at affordable prices.

No equality in education
Discrimination in housing is the driving force behind entrenched racial and economic segregation across Monroe County's public schools, depriving students of color of equal access to a more robust learning environment. Despite the historic strides of the Civil Rights movement, segregation in schools persists. Though explicit segregation has been illegal since the Brown v. Board of Education Supreme Court decision in 1954, schooling for Black children remains largely separate and unequal.

The 2020 national Fault Lines study by EdBuild found that the "single most segregating school district border in the country divides New York's Rochester City School District, which has a poverty rate of 47%, from Penfield, whose poverty rate is just 5%."[51] The high poverty rate creates two challenges for the Rochester schools: a large proportion of high-needs students and relatively low levels of funding available from the local tax base. These disparities result in a very large performance gap. RCSD had a graduation rate of only 63% in 2019, compared to 93% in Penfield. And because of racial segregation, the vast majority of RCSD students are non-White (90%), whereas the vast majority of Penfield students are White (86%).

These educational disparities lead to longer-term health disparities. Without access to

> **Despite the historic strides of the Civil Rights movement, segregation in schools persists — though illegal since 1954, schools remain largely separate and unequal.**

high quality, academically motivating schools, students are less likely to find the path toward jobs that provide health insurance and a living wage. People without adequate financial means face a variety of obstacles to staying healthy: the cost and accessibility of healthy food; affordability of health care; and the chronic stress of living month-to-month while worried about housing, transportation and other bills.

Segregation in public schooling is a particularly grievous side effect of housing discrimination, because it undermines academic opportunities that are foundational to each child's future wealth and health.

Criminal (in)justice
Over the last half century, our nation has implemented policies leading to mass incarceration at a scale beyond all other countries. The United States has the most people in prison and the highest percentage of its population in prison.[52] This indiscriminate "tough-on-crime" approach has devastated the Black community because of racial inequities at every level of the criminal justice system, from misdemeanor arrests made by law enforcement to life sentences issued by the courts.

In the Finger Lakes region, not only are Black people more than 5 times as likely to be arrested as White people, but when arrested, they are more than twice as likely to be given a prison sentence.[53] To blame are a host of policies that unfairly target people of color, from racial profiling to harsher sentencing. For example, possession of crack cocaine for many years carried penalties 100 times higher than possession of an equal amount of the powdered form, which was more commonly used by White people.

Beyond the physical and mental stress of incarceration, serving time complicates and damages family and community relationships. Once released, a prison record makes it much harder to find employment. A recent report by the Brennan Center for Justice found that people who spent time in prison saw their annual earnings reduced by more than 50%.[54] Through these social and economic pathways, a conviction can have long-lasting impacts on health.

The damage to health extends beyond the imprisoned individual, explains Precious Bedell, a community health worker at the University of Rochester and founder of Turning Points, a program to support family members of incarcerated individuals. Tearing

What can we do?

Engage the leaders of your organization and community in dialogue about racism and its impact on health

✓ Leverage the findings and data from this report and material from other racial-equity initiatives to educate others on the health impacts of racism. Resources available at **urbanleagueroc.org/irall**

✓ Push for racial equity to be a strategic priority at boards of directors and leadership levels within organizations.

✓ Focus on racial discrimination and racial privilege as problems at a systemic level to help break through potential defensiveness from White individuals who believe they are not personally racist. It is critical for leaders to understand that even well-intentioned individuals and organizations often create racially inequitable outcomes.

families apart can lead to emotional health problems and trigger risky coping behaviors, she says. When a family's breadwinner is

Cloaked in seemingly colorblind language or hidden behind plausible denial, biased policies and practices often exist below the radar of public attention or understanding.

behind bars, dependents are also deprived of financial support. Says Bedell, "Incarceration locks individuals and families out of the American Dream."

Entire Black communities are locked out as well. Eroded trust in law enforcement leads to constant concern about being stopped by the police without cause or being falsely accused of a crime. This persistent undercurrent of fear and anxiety within the Black community, like other toxic stressors, has been shown to undermine physical and mental health.

Communities of color are confronted with excess policing — and police brutality — and not enough psychiatrists and social workers to help heal the wounds of historical trauma, says Bedell.

"George Floyd's death was a lynching on the cement instead of a lynching on a tree," she says. "Imagine what we don't know that's not caught on camera. Now that people are coming out in droves, so angry, there is a note of hope. But we still have a long way to go."

Interpersonal racism

What is interpersonal racism?

Interpersonal racism occurs between individuals due to conscious or unconscious racial bias, and takes the form of discriminating attitudes and actions including social exclusion, unfair treatment and threats or harassment.[54][55]

How does it damage health?

Interpersonal racism can occur in any setting and can therefore undermine health in a variety of direct ways (e.g., implicit bias by medical providers can lead to suboptimal clinical care) and indirect ways (e.g., disparate treatment by teachers can undermine school achievement, which is foundational to long-term health, well-being and socioeconomic status).

Interpersonal racism can be intentional and vicious, unintentional and subtle, or anywhere in between.

"We wake up each day with these challenges," says Jackie Dozier, program manager of community health and well-being at Common Ground Health. "It is our life's journey to walk through the microaggressions and the macroaggressions every day."

Microaggressions are brief yet common verbal or behavioral snubs that communicate hostile or negative messages, often targeting someone who is culturally marginalized. Macroaggressions are more explicit and represent a larger-scale form of oppression.

A 2015 Monroe County survey by the Rochester Area Community Foundation and Democrat and Chronicle found that 37% of Black residents recalled being treated unfairly in the previous few months because of their race, ethnicity or some other personal characteristic. The most common situations for this discrimination were: shopping at a store (51%); working (50%); being at a restaurant or bar (37%); and dealing with police (36%).[57]

Whether inadvertent or premeditated, blatant or covert, discrimination — in all its forms — can be toxic to physical and mental health.

The daily indignities start young. Black adolescents average more than five racial discrimination experiences per day.[58] They might come across a racist image online, hear a joke about the negative treatment of Black people, observe a store clerk giving preferential treatment to a White customer, get looked at suspiciously, or be teased because of their skin tone. This is just a sampling of typical exposures to racism which have been associated with depressive symptoms and poor mental health in general.[59]

These persistent experiences of discrimination can also degrade physical health. Research has found that coping with the stress of everyday racism triggers physiological responses that have a "wear and tear" effect on the body and mind. Over time, this eroding process disrupts the regulation of several systems in the body— including the cardiovascular, metabolic and immune systems. Called "weathering," the physiological process is associated with a decline in cognitive and physical functioning, and an increase in all-cause mortality.[60] [61]

Notably, researchers have specifically linked the anticipation and stress of everyday interpersonal racism to high blood pressure[62] – which is a significant risk factor for heart disease, the number-one cause of premature mortality among our region's Black population.[63]

Dr. Sharitta Gross, an African American educator at a local college, explained how microaggression at work led to health problems. Following the death of her grandmother, Dr. Gross was wracked with sadness that the woman who raised her was going to miss her wedding and she took two weeks leave from work to recover. When she returned, her supervisor reprimanded her for taking the time off and demanded that she apologize to coworkers, who were also judgmental.

Coping with the stress of everyday racism triggers physiological responses that have a "wear and tear" effect on the body and mind.

"I felt humiliated," recalls Dr. Gross, who was diagnosed with high blood pressure during this upsetting period. "All of it was culturally insensitive, because I was raised by my maternal grandmother and as a Black woman, that's not unusual. My grandmother was my mother."

One of the challenges in understanding the extent of racism is that it can be hard to see when you're not the person who experiences it repeatedly. "Racism is really hard to assess until you feel it at the personal level and even then you're not always sure if the bad treatment you're receiving is actually the result of racism," explains Lisa Goff, a retired registered nurse and active community health advocate. "You just know you're being treated as an other. And you've been treated as an other throughout your life."

Health care
The medical mistreatment of Black people has historical roots, most notoriously in the Tuskegee Study of Untreated Syphilis in the Negro Male, a 40-year government-run experiment which withheld information and treatment from a group of poor Black men who had the disease. Scholars today see a strong link between the public revelation of the study in 1972 and poor health outcomes for Black men today.[64]

"People are fearful because of some of the stigma attached to history," says Jackie Dozier. "They begin not to trust the health care system. It becomes a 'Why bother? I know how they're going to treat me.' So they have a tendency not to go to the doctor. They don't feel it would matter."

National statistics show that 22% of Black adults avoid seeking health care for themselves or family members due to anticipated discrimination.[65]

Common Ground Health CEO Wade Norwood knows firsthand the pain and danger of experiencing racism in a clinical setting. "My wife's second pregnancy resulted in the death of one of our daughters and our surviving twin was born with cerebral palsy. She required a great deal of medical intervention in the early weeks of life... I have the profound memory of being at a regional clinic; we were there doing exams for our daughter. We knew they looked at my wife as if she were a drug user, that they assumed we'd created a [disabled] baby. I remember my wife just started crying... I told her I would never have her come back there again. The reality is that no matter how high I get up on the ladder, I will always be Black."

Norwood isn't alone. A University of Rochester survey of more than 700 Black patients revealed that 31% reported experiencing discrimination while receiving medical care.[66]

Black adolescents average more than five racial discrimination experiences per day.

That discrimination can be unintentional, coming from well-meaning physicians who may come to faulty conclusions about the needs and preferences of people from backgrounds and living situations very different from their own.

Regardless, racial biases in the doctor's office can result in suboptimal care, which is another contributor to health inequities.

Implicit bias – often driven by unconscious assumptions about patients – combined with a lack of cultural understanding and empathy, can undermine any type of therapeutic intervention. A 2003 study from the National

What can we do?

Develop and assess all health improvement interventions through a racial-equity lens

✓ Evaluate policies and programs to ensure accessability, adoption and effectiveness for the Black community.

✓ Use Racial Equity Impact Assessments and other tools to identify the potential for disparate outcomes.

✓ Engage the experts — Black patients, caregivers and health professionals — when designing interventions.

✓ Teach all health care professionals to properly diagnose non-White patients and to deliver culturally appropriate care.

✓ Build processes and metrics to ensure programs and results are measured by race.

Academy of Sciences found that Black patients received fewer procedures and lower-quality clinical care than White patients, and this was true of procedures ranging from complex surgeries to basic diagnostics.[67]

Strikingly, these differences persisted even after adjusting for variations in health insurance, socioeconomic status, stage and severity of disease, and other factors.

Since that comprehensive study was published, additional research has continued to document the role of racial bias and misconceptions in health care disparities, including the 2016 research article "Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites."[68]

To counteract implicit bias, health care providers must be more aware of assumptions they may make, according to Dr. Candice Lucas, Chief Community Engagement Officer, Monroe County and Lead Staff for the Commission on Racial and Structural Equity. "This can range from assuming they know if a patient can afford a medication to whether the patient has support at home. The best practice is to ask and provide care from there."

Schools
Racial bias from teachers and administrators, even when unintentional, can undermine educational achievement of Black children. Given the importance of education to long-term socioeconomic status and access to resources, these school experiences can reduce the likelihood of long-term good health and well-being.

Underestimated potential, reduced encouragement and support, and harsher disciplinary actions are some of the consequences of racism in the school system. A Rutgers University study found that White teachers were three times more negative with Black students than with White students when responding to behavior, emotions and contributions. For example, teacher responses to behavioral issues were more likely to be intense back-and-forth exchanges that tended to escalate rather than solve problems.[69]

Racial disparities in school discipline

outcomes are a well-studied issue, and has been linked to implicit bias on the part of teachers and staff. A 2018 United States Government Accountability Office report studied these disparities and found they surfaced as early as pre-school.[70] In the Rochester City School District, out-of-school suspension rates for Black students are more than double those for White students. That disparity is even greater in Monroe County's suburban districts, where Black students are suspended at nearly 4 times the rate of White students.[71]

The undermining effects of biased treatment in the classroom are compounded for many Black children by the disadvantage of attending under-resourced schools. Black students are more likely to attend schools with fewer resources and poorer outcomes because of housing segregation and school-funding policies which disfavor lower-income districts. The result of these layered burdens is large and persistent disparities in academic achievement. In our region, the high-school graduation rate for Black students is 71%, compared to 90% for White students.[72]

It is very sad, but not surprising, that a survey by the United Negro College Fund found that Black students "are all too clear about the barriers that imperil their educational aspirations."[73] Beyond the widespread concern about the affordability of college, more than a third of the Black youth were specifically concerned that their opportunities were limited by their race. Given the foundational role of education in determining one's life path, the undermining effects of racism in the school environment have a particularly devastating and long-lasting impact on the ability to live a fulfilling, healthy and long life.

Internalized racism

What is internalized racism?

Internalized racism is an individual's conscious and unconscious acceptance of negative attitudes, beliefs, ideologies and stereotypes about themselves, their racial group and other groups based on a racial hierarchy.[73]

How does it damage health?

Internalized racism is a chronic toxic stress, reinforced in everyday life, that erodes mental and physical health. It can also generate feelings of low self-esteem and hopelessness, which increase the likelihood of unhealthy coping mechanisms in both the near term and far into the future.

Racism underlies so many parts of our society that it soon begins to inform the self. The result is internalized racism — a form of personal oppression.

From W.E.B. Du Bois' seminal book The Souls of Black Folks: "It is a peculiar sensation, this double-consciousness, this sense of always looking at one's self through the eyes of others, of measuring one's soul by the tape of a world that looks on in amused contempt and pity."

> **"When I'm the only Black person in all-White spaces, I begin to question myself: Am I articulating properly? Do they understand me?"**
>
> — CHIARA SMITH, ASSOCIATE PROGRAM OFFICER, GREATER ROCHESTER HEALTH FOUNDATION

This double-consciousness is the powerful phenomenon triggered by internalized racism – eroding self-perception and creating toxic stress.

Dr. Linda Clark, practicing physician, adjunct assistant professor at the University of Rochester and chief medical officer at Common Ground Health, recalls of her high-school days: "I remember having an

argument with one girl who said, 'You think you're so smart. What's the matter — you think you're White?' People would call me 'ugly' or 'spook.' Those things wear on you, and early on you start to doubt whether you're pretty or likeable or smart. That's something that's always with me."

Internalized negative stereotypes can engender lower self-esteem and perceived potential, resulting in reduced academic and vocational achievement, both foundational to long-term health and well-being.[75]

And the combination of self-doubt and stress undermine mental health, which can lead to depression[76] and anxiety.[77] These forces are also associated with a higher risk of alcohol[78] and substance use.[79]

"It's a very real thing that racism makes people of color sick," says Chiara Smith, associate program officer at Greater Rochester Health Foundation. "When I'm the only Black person in all-White spaces, I begin to question myself: Am I articulating

properly? Do they understand me? So you try to find your grounding. You try to find your tribe within some of those spaces to reassure you and help validate what it is you already know."

While that tribe can include individuals from any race, a research paper by the Ackerman Institute for the Family concludes that a group of people exclusively of African descent can provide an optimally safe space for initial stages of healing from internalized racism.[80]

Dr. Clark's parents — her father was a physicist, her mother an educator — provided her a safe space while ceaselessly encouraging her and advocating for her rightful opportunities at school.

"They could not overcome the world, but they kept me going, pushed me to achievement, and [though deceased] continue to guide and undergird me today," Dr. Clark explains of her parents. "Whereas self-doubts can still pop

up, what they poured into me has kept me afloat… I am happy and whole."

Internalized racism is exhausting. Even those who don't self-doubt can have persistent sensitivity to the way they're being perceived in a race-conscious society.

You can use replacement thoughts to

Internalized negative stereotypes can engender lower self-esteem and perceived potential, resulting in reduced academic and vocational achievement.

counteract the influence of racism that surrounds you, says Smith, but replacement thoughts only go so far. "If the things happening outside you aren't changing, then it's like you're continuously riding a carousel, hoping you're going to see something different. You're just going around and around and around."

What can we do?

Advocate for racial equity in your everyday actions and conversations

✓ Learn and self-reflect about implicit bias, racial privilege and antiracism.

✓ Broaden your knowledge with the suggested readings and community forums at *urbanleagueroc.org/irall*

✓ Demonstrate public allyship in the office, and with family and friends: If you see something, say something.

✓ Support Black-owned businesses and cultural events.

✓ Build relationships with people who don't look like you.

✓ Be a model for racial tolerance in *all* that you do, whether at work, socially, in your faith practice or elsewhere.

Spotlight Issue:
Mental health

I n the snowy early morning hours of March 23, 2020, Daniel Prude, unarmed and in the throes of a psychotic episode, was handcuffed by Rochester police and forcibly held face down until he stopped breathing.

"I can only imagine Daniel's sense of confusion and helplessness during his last moments," Dr. David Paul, a Black neurosurgeon at the University of Rochester and Prude's cousin, wrote in a personal essay in the New England Journal of Medicine.

"Naked, hooded, vomiting, breathless, he lay with his head pinned to the pavement under a police officer's weight. My cousin was someone's brother, son, and nephew. He was known as a comedian who could light up a room with his jokes. And there he lay, suffocating on Jefferson Avenue." [81]

Six months later, when video of the fatal arrest was released by his grieving family, Prude become a national symbol of racial injustice and his treatment provoked months of protests on the streets of Rochester.

Prude's preventable death exemplifies the lack of culturally appropriate mental-health responses for people of color and the tragic consequences of such neglect. His 41 years of life were marred by a series of personal tragedies, including the premature deaths of two brothers and his mother, and the suicide of a nephew with whom he shared a home.

Without support to manage his anguish, Prude's behavior became increasingly erratic and he struggled with drug addiction. The night of his arrest, his brother worried he was hallucinating and a danger to himself and had him hospitalized for a psychiatric evaluation, only to be released hours later.

Prude's story illustrates why, when asked in 2018 to identify the biggest concern for their own health and well-being, Black residents in our region were clear: mental health tops all other worries. More than access to health care, more than aging or weight, psychological wellness ranks as the number-one health concern for African Americans in Rochester and the Finger Lakes. [82]

That focus on mental health is well founded. Research shows strong connections between racial discrimination and poor mental health, including higher rates of depression, anxiety and psychological stress, and lower levels of self-esteem and well-being. [83]

Structural and institutional racism limits access to food, housing and other essentials for many lower-income African Americans, creating an environment of constant stress that can be emotionally exhausting and mentally debilitating. In our region, nearly 1 in 3 Black residents making less than $25,000 annually reported poor or fair mental health. [84]

> **"My cousin was someone's brother, son, and nephew. He was known as a comedian who could light up a room with his jokes. And there he lay, suffocating on Jefferson Avenue."**
>
> — DR. DAVID PAUL, NEUROSURGEON, UNIVERSITY OF ROCHESTER MEDICAL CENTER

Segregation and poverty also increase the likelihood that Black individuals will face Adverse Childhood Experiences (ACEs), potentially traumatic events that occur between birth and age 17. Examples of ACEs include: experiencing violence, abuse or neglect; exposure to mental-health issues or substance abuse within the household; or separation from a parent. The 2017 Monroe County Youth Risk Behavior Survey found that 29% of Black high-school students reported three or more ACEs, almost double the 16% rate of White students. For children who experience ACEs, studies have shown a link to long-term mental health, substance use and chronic health problems.

Coping with the dual stresses of racism and poverty can have a particularly toxic effect on mental health. However, the psychological impacts of racism are not restricted to Black families of limited means or those living in under-resourced neighborhoods.

Regardless of income, education or professional standing, Black residents regularly experience interpersonal racism in

the form of outright discrimination and micro-aggressions, including everyday slights, indignities and invalidations that express a prejudicial attitude, whether intentional or not.[85] Together, these subtle and not-so-subtle forms of unfair treatment can create feelings of anxiety, depression, fear and hopelessness.

As Dr. Clark put it: "Every day I wake up Black, I'm tired."

Steeped in a racist culture, many Black individuals internalize racist attitudes, absorbing negative cultural stereotypes, which can erode self-esteem and discourage a person from seeking help. Researchers have found that internalized racism is associated with depressive symptoms, psychological distress, substance use and chronic physical-health problems.[86]

> **Regardless of income, education or professional standing, Black residents regularly experience interpersonal racism in the form of outright discrimination and micro-aggressions.**

The cumulative toll of racism leads to significantly higher rates of poor or fair mental health among Black residents in Rochester and the Finger Lakes region than their White counterparts, 22% vs 14%.[87] Depression and anxiety are the most commonly cited mental- and emotional-health concerns. While less common, anger

and grief were reported at significantly higher rates by Black respondents than by White respondents.

This increased psychological burden is reflected in hospitalizations related to behavioral health, including depression, anxiety and substance-use disorders. For Black residents in our region, the rate for behavioral health inpatient visits has nearly doubled in the last 15 years, and the disparity between Black people and White people has grown.[88]

Despite the higher prevalence and self-reported concerns about mental health, Black residents are less likely to get needed professional help. Among the Black population that reported they received the needed help for their mental- or emotional-health issues, 65% said their support came from professionals, compared to 80% of Whites.[89]

Melanie Funchess, CEO and President of Ubuntu Village Works, said the reasons for not seeking professional help are complex. In addition to the stigma surrounding mental illness within the Black community, she pointed to the community's widespread mistrust of the medical system. This

The rate of behavioral health-related hospitalizations for Black people has nearly doubled since 2000

Behavioral health-related inpatient visit rate
Finger Lakes region
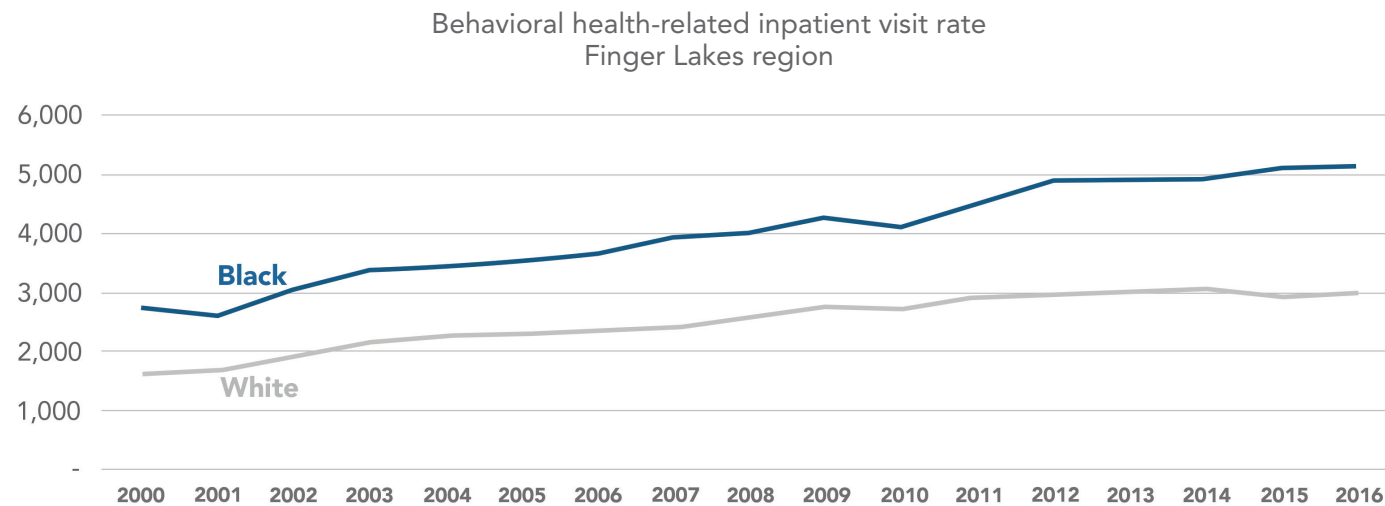
Rates are age/sex adjusted and shown per 1000,000 residents. Includes visits with primary or secondary behavioral health diagnosis.
Source: NYSDOH SPARCS Inpatient Data; Analysis by Common Ground Health

wariness, she noted, is rooted in the well-documented history of substandard care and unethical experimentation on communities of color, as well as present-day disparities in access to quality care. Unfortunately, unequal care is not a relic of a bygone era: research has found that Black patients with depression or anxiety are less likely than White patients to receive the best available treatments.[90]

When Black residents do seek mental-health treatment, they may be stymied by a lack of culturally relevant support and may have to rely on White mental-health providers. Nationally, only 3% of health-service psychologists identify as Black or African American for a population that is 12% Black.[91]

Funchess points out that the racial mismatch can be frustrating because gaps in cultural empathy create barriers to building trust.

> **"Fixing how we solve these issues is just part of the problem. As long as we have people living in the conditions they do, treated the way they are, Black people will continue to see their mental health undermined."**
>
> — MELANIE FUNCHESS, CEO & PRESIDENT, UBUNTU VILLAGE WORKS

With therapists from dissimilar backgrounds, patients may need to spend extra time explaining culturally recognizable relationship dynamics, reactions and language, which can undermine both the genuine re-telling of these events and the overall relationship, Funchess explained. For example, a patient may be afraid to discuss an argument because of fear that a Black male partner could be inappropriately criminalized due to bias. Having to provide these explanations to create understanding is exhausting and an unfair burden on the people seeking help. "When you have providers who don't have the same background, it can make it more difficult because sometimes the critical connection that needs to happen with a therapist doesn't exist," she said.

A lack of trusted, professional mental-health providers forces many Black people to seek aid elsewhere, from those they do trust – including friends, family and the church. More than a quarter of Black adults who got help for mental health-issues turned to faith leaders, highlighting an opportunity to bolster faith- and service-based organizations in their effort to provide better opportunities for psychological treatment.[92] Ministers, barbers, stylists and other community-based leaders

have built long-term trusting relationships with congregation members and clients, but may need more training and resources to provide appropriate guidance.

In addition, Emotional Emancipation Circles and other grassroots healing methods can improve mental health and well-being, says Funchess. Such community-driven support groups can help Black people understand their experiences in the context of historical and community forces and develop the skills needed to counter these pressures and nurture wellness.

Without trusted and effective mental health support, Black people like Daniel Prude face increased risk of developing unhealthy coping mechanisms. For example, 28% of Black residents identify as smokers, which is significantly higher than the 16% rate for White residents.[93] Substance use is a particular problem, as measured by Black rates of emergency department visits for alcohol and drug use, which are more than three times higher than White rates.[94]

Increasing Black representation among mental health professionals, implementing training in culturally-responsive practice across the behavioral health system, and building new channels for support are important steps to getting people the help they need. But they don't address the root causes of mental health inequities: the many ways that racism undermines mental health for so many people.

"Fixing how we solve these issues is just part of the problem," said Funchess. "As long as we have people living in the conditions they do, treated the way they are, Black people will continue to see their mental health undermined."

Spotlight Issue:

Maternal/infant health

Tennis pro Serena Williams may hold 23 Grand Slam titles, but her harrowing experience after giving birth to her daughter in 2017 showed she went unheard by medical professionals — and prompted questions of racial bias.

While recovering after an emergency C-section, Williams had trouble breathing. Because of her history with pulmonary embolisms, she recognized the signs, alerted a nurse and asked for appropriate treatment. No one listened. Instead, Williams endured a different procedure before her medical team relented, tested and, as feared, found several dangerous blood clots in her lungs. Williams ended up with other life-threatening complications and spent her first six weeks of motherhood bedridden.[95]

Black women and their newborns face the highest rates of mortality and major birth complications, even after adjusting for socioeconomic status, highlighting the necessity and urgency of addressing racism and its undermining effects on health.
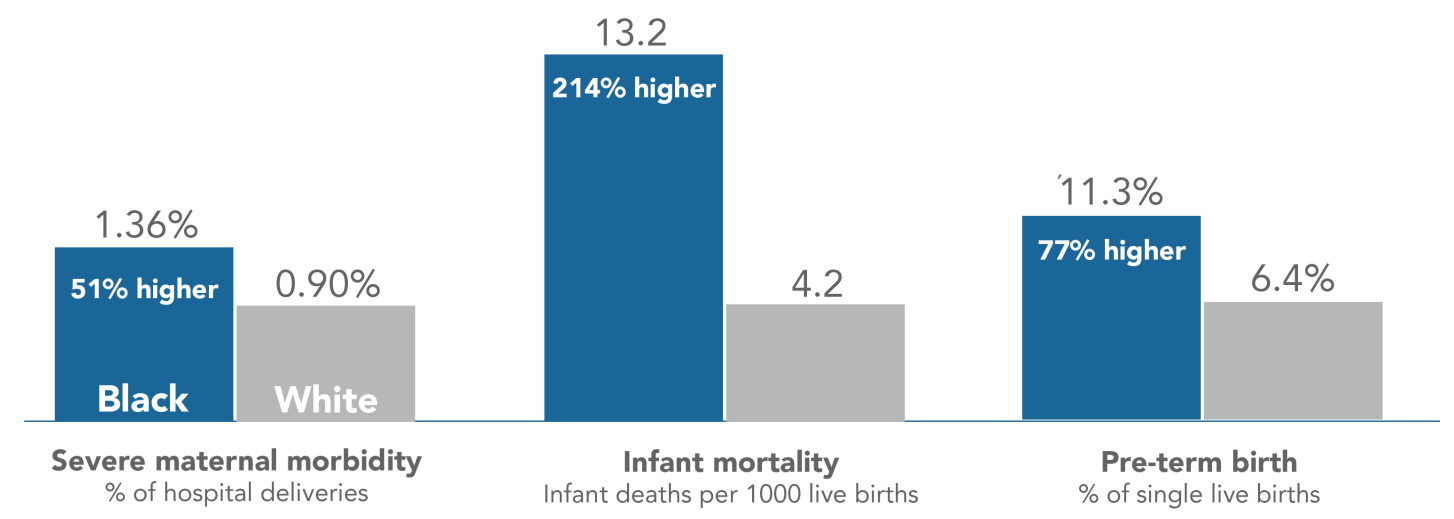
Nationally, Black women are more than 3 times as likely to die in childbirth as White women, a wider disparity today than a century ago.[96] [97]

Even when comparing mothers with the same pregnancy condition, Black women are 2 to 3 times more likely to die than White women.[98]

Beyond this large maternal mortality disparity, Black mothers also experience much higher rates of potentially life-threatening delivery complications, including hemorrhaging, sepsis and eclampsia. In the Finger Lakes region, these and other serious maternal illnesses are 50% more frequent among Black women compared to White women.[99]

Local data paints a similarly grim picture for newborn health. The Black infant mortality

Black women are more than 3 times as likely to die in childbirth as White women, a wider disparity today than a century ago.

rate in Monroe County is more than 3 times the rate for White infants (13.2 per 1,000 live births vs. 4.2 for White).[100] The largest cause of infant mortality is premature birth, when a baby is born before 37 weeks of pregnancy. Premature birth is associated with a variety of longer-term health problems that persist through adulthood, including chronic disease, disability and premature death.[101] In our region, the premature birth rate is 77% higher for Black mothers (11.3% vs 6.4% for

Childbirth is more dangerous for Black mothers and babies

	Severe maternal morbidity % of hospital deliveries	Infant mortality Infant deaths per 1000 live births	Pre-term birth % of single live births
Black	1.36% (51% higher)	13.2 (214% higher)	11.3% (77% higher)
White	0.90%	4.2	6.4%

White mothers).[102]

No genetic or biologically predetermined reason accounts for these large disparities; maternal health risk factors are the same for White women and Black women. However, Black mothers and their infants disproportionately suffer pregnancy and childbirth complications due to the layered effects of racism.

Hypertension, a major risk for pre-term birth, is much more common among Black women. A regional survey found that 48% of Black women report having hypertension, a rate 85% higher than the rate for White women (26%).[103] Such disparity is not surprising given the chronic toxic stress and physiological weathering that comes with racism.[104] Layers of racism undermine socioeconomic opportunities as well, creating additional stressors and limiting access to healthy food and other resources that help prevent and manage hypertension.

Poor mental health is another common pregnancy risk factor, with Black women being far more likely to rate their mental and emotional health as only fair or poor, compared to White women (24% vs. 14%).[105] A clear link exists between premature birth rates and maternal depression, anxiety and perceived stress.[106] A regional analysis conducted by Common Ground Health found that women diagnosed with depression or anxiety have a 41% higher likelihood of a pre-term delivery.[107]

While Black women are more likely to need clinical care and support, regional data show they are less likely to get the help they need to manage their risks and complications.

A historic lack of trust in the medical system poses one of the greatest barriers to prenatal care. Even when physicians have the best of intentions, implicit bias and a lack of deep sensitivity to the issues Black women face can interfere with a provider's ability to make meaningful connections with expectant mothers. Their assumptions are frequently rooted in cultural stereotypes, without an understanding that their patients' deep-seated skepticism should be taken seriously, particularly since that skepticism adds to stress — in itself a pregnancy risk factor.

Knowing that Black maternal-health inequity is a major problem, the New York State Department of Health set up listening sessions around the state to hear from Black women about their birth experiences. A subsequent state report included descriptions of being misheard or ignored in the clinical setting: "Nobody would answer you," "I was never told why I was high-risk," "Always see a different doctor that doesn't know me," and "Receptionist put single on the form, automatic assumption because you're Black."[108]

Medical providers should more consistently take the time to listen and respond to the

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As Serena Williams' experience illustrates, racism threatens maternal and infant health across the socioeconomic spectrum.

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concerns of their patients, which would help Black women advocate for themselves, says Sherita Bullock, executive director of Rochester's Healthy Baby Network. "People aren't just dealing with pregnancy, they also are dealing with multiple layers of health and other issues. When you have a fear of the medical world, you carry this emotional burden with you every time you go in," she says.

Frustrated with lack of access and the overall quality of care received, many new mothers simply elect out of necessary clinical care entirely, sometimes leading to catastrophic results for both mother and baby.

As Serena Williams' experience illustrates, racism threatens maternal and infant health across the socioeconomic spectrum, affecting both poor Black women and high-income Black women alike. The premature birth rate for Black mothers living in areas with the highest socioeconomic status (10.3%) is much higher than the rate for White mothers living in areas with the lowest socioeconomic status (7.6%).[109]

An additional toll of racism, which blends personal experience with chronic worry, may help explain why large disparities continue to exist at higher-income levels.[110] Black women at the higher socioeconomic levels may have more exposure to racism in educational, work and social environments that are

Black babies are more likely to be born prematurely regardless of socioeconomic level

Pre-term birth rates in Finger Lakes region
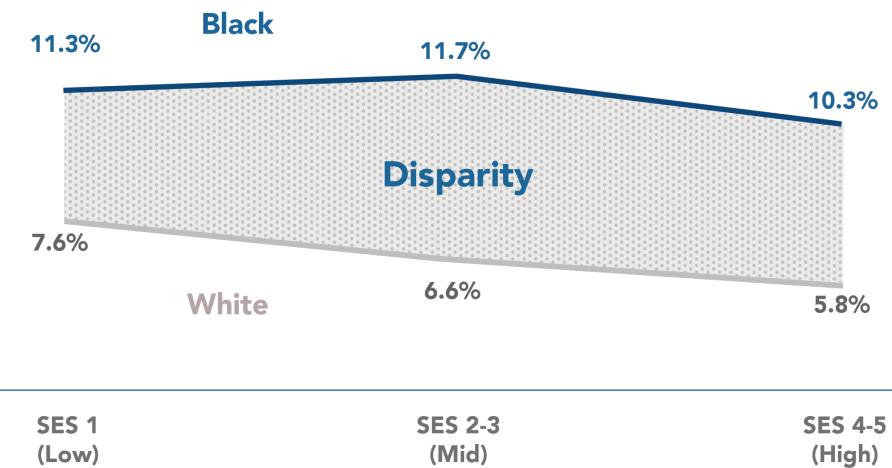
Pre-term birth rate calculated as % of single births delivered prior to 37 weeks gestation
Data is for single live births from Oct 2015 to Dec 2016 for Black non-Hispanic and White non-Hispanic mothers
Source: NYSDOH SPARCS Inpatient Data; Analysis by Common Ground Health

predominantly White, and exposure to these types of discrimination and stress can negatively affect birth outcomes.

As we take steps to illuminate and eliminate racism, it is critical to promote programs that help Black mothers manage the elevated risks they face while building trusting relationships to ensure they're connected to the right resources. Monroe County's Nurse-Family Partnership matches first-time

mothers with specially trained nurses who make at-home visits throughout the pregnancy and until the baby is 2 years of age. And the Healthy Baby Network's Black Doula Collaborative, comprised of Black women, provides mental, physical and spiritual support during and after pregnancy.

Says Bullock: "It's important that when women speak to us, we listen."

What can we do?

Promote business practices and policies to ensure there are more Black doctors and other health-care professionals

✓ Support the training, hiring and retention of Black health professionals at all levels and in all disciplines, including mental health and other specialties.

✓ Invest in workforce-development opportunities for Black health professionals such as college scholarships, internships, professional development programs, mentorships and clear opportunities for growth and advancement.

✓ Remove licensing barriers which unfairly limit entry for Black health practitioners.

Spotlight Issue:
Diet/nutrition

Leverett Copeland wants to provide healthy food for his family, but like many of his African American neighbors, he struggles to put fruits and vegetables on the table.

"To eat healthy, you have to go broke," concludes the northeast Rochester resident. "There's a lot of poverty in this neighborhood, and we can't afford it."

Copeland aims for good nutrition anyway. His entire family had no choice but to make dietary changes after his wife's heart attack several years ago. He explains: "We cut down the salts. We went from white bread to wheat bread. Even the crackers, everything wheat. From butter to margarine. We went to a more heart-healthy diet not only for her, but for all of us."

While beneficial, these dietary improvements have been extremely challenging to maintain. Aside from budgetary concerns, convenient access to nutritious food presents another hurdle. Because Copeland's family doesn't have a car, grocery store visits require hiring a taxi, making each trip more complicated, time-consuming and expensive.

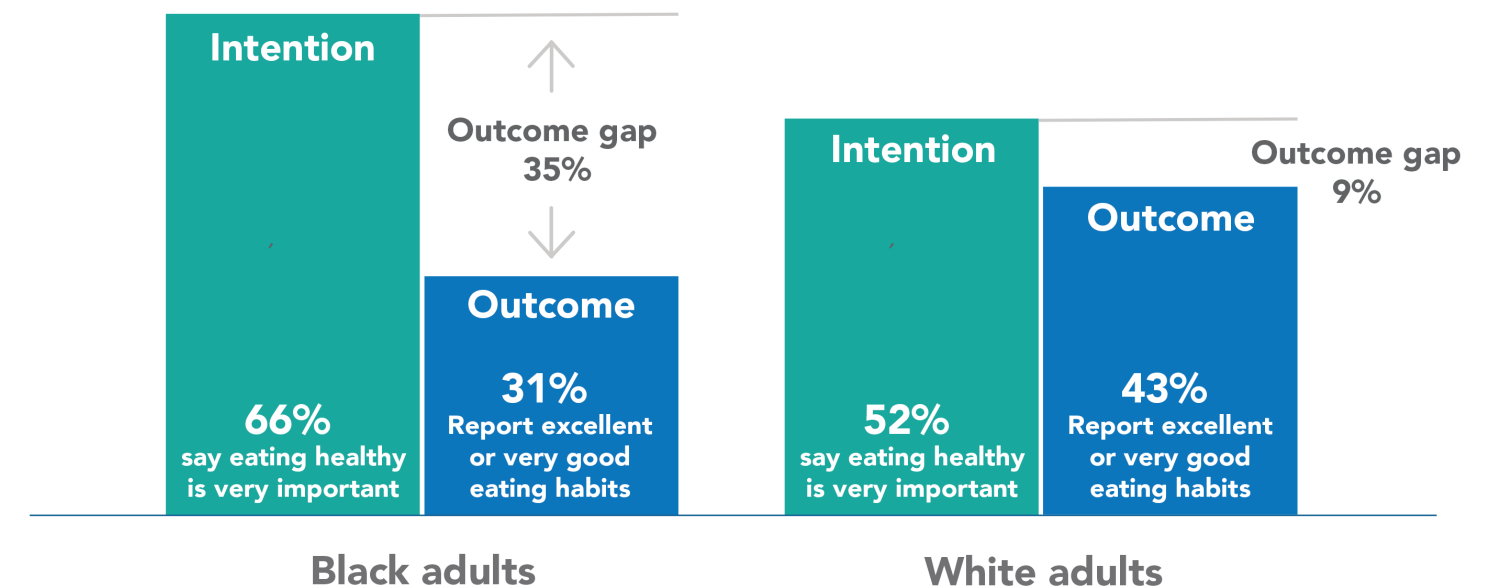Copeland's challenges are common. According to the 2018 My Health Story survey, Black adults in Rochester and the Finger Lakes region are significantly more likely to say that a healthy diet is very important to them — 66% vs. 52% for White adults. Despite this greater interest in eating well, Black people are less likely to be able to reach that goal. Only 31% report good or excellent eating habits, compared to 43% for White people.[111]

The large gap between the Black community's desire to eat healthy and the ability to eat healthy is due to several obstacles — with cost, as in Copeland's case, being the number-one complication, according to the survey. Other top challenges include lack of time, transportation and nearby grocery stores.

Food insecurity — being without reliable access to affordable, nutritious food — is a major public-health concern. The My Health Story survey showed that nearly 1 in 5 (19%) Black adults were "always stressed about having enough money to afford healthy food" compared to 11% of White adults. The

Barriers prevent many Black people from meeting their healthy eating goals

Self-reported survey responses Finger Lakes region

Black adults

Intention — 66% say eating healthy is very important

Outcome gap 35%

Outcome — 31% Report excellent or very good eating habits

White adults

Intention — 52% say eating healthy is very important

Outcome gap 9%

Outcome — 43% Report excellent or very good eating habits

Source: My Health Survey 2018. Analysis of Finger Lakes nine county region by Common Ground Health Age/Sex-adjusted

percentage is even higher, at 24%, among Black adults with children in the household.

A healthy diet is a key ingredient for long-term health. Barriers to accessing nutritious food contribute to racial disparities in chronic conditions and premature mortality. Black residents in our region face higher rates of obesity (47% v 34% for White residents),[112] diabetes (18% vs. 12%)[113] and uncontrolled hypertension (12% vs. 6%).[114] Each of these chronic conditions is a risk factor for heart disease, which is the leading cause of early death in our Black community.[115] For children, food insecurity often leads to delays in cognitive, emotional and physical development.[116]

While socioeconomically related obstacles to eating healthy are not unique to the Black population, they are more common because of racism's impact on economic opportunity and the concentration of Black individuals at lower income levels. The challenges and constraints of living with limited means present more barriers to accessing and preparing nutritious meals, and makes it much harder to maintain the focus and energy necessary to consistently overcome those barriers.

Eating healthy is rarely seen as an urgent priority when more pressing challenges take center stage, says Calvin Eaton, a community educator and the founder of 540WMain, a Rochester-based nonprofit focused on antiracism and equity. Unpredictable work schedules, the demands of caregiving for children and other family members, and other everyday demands make it "tough to make anything a routine," says Eaton.

"When you don't have a car, you need to plan grocery trips, but then something else comes up that throws the whole thing off — and then you don't have healthy food for that week. But you still need to eat and it's easy to make a quick run down the street to McDonald's," he says.

Racial-dietary inequities are more than a matter of income, however. More than 1 in 4 Black residents with annual incomes above $50,000 report their eating habits to be "poor or fair," which is twice the rate of White residents in the same income range.[117]

One culprit is residential segregation, which limits housing and neighborhood choice for Black families, regardless of income. At every income level, Black families are more likely to live in disadvantaged neighborhoods that lack convenient access to healthy food. In the Finger Lakes region, nearly half of Black households with incomes of $75,000 or more live in resource-deprived ZIP codes.[118] Many of these neighborhoods are awash in fast-food restaurants and convenience stores but lack grocery stores and markets, making unhealthy eating the easy choice.

Not only are Black families more likely to be surrounded by food outlets with less nutritious offerings, they are also more likely to be bombarded with ads for fast-food restaurants, soft drinks, candy and other snacks. A systematic study of food-related advertising found that "companies almost exclusively target Hispanic and Black consumers with advertising for their least nutritious products, led by fast food, candy, sugary drinks and unhealthy snack brands." [119] Such pervasive marketing can set up young people for poor eating habits that can last a lifetime.

While our region's Black population likely will continue to face significant barriers to eating healthy as long as they face the socioeconomic impacts of racial discrimination, meaningful interventions can mitigate the problem.

Educational programming, for example, can help people learn how to prepare healthy meals that are affordable on a limited budget, well suited to dietary restrictions, and culturally appealing. 540W Main offers classes with a combination of budgeting, planning and cooking advice. "The education

> **"When you don't have a car, you need to plan grocery trips, but then something else comes up that throws the whole thing off — and then you don't have healthy food for that week. But you still need to eat and it's easy to make a quick run down the street to McDonald's."**
>
> — CALVIN EATON, FOUNDER, 540WMAIN

is about how to put this into practice for someone living in poverty," says Eaton.

Additionally, policies can make healthy food more accessible and affordable. The federal government directs less than 1% of farm subsidies toward research, production and marketing of fruits and vegetables — an amount that could be increased.[120] Opportunities also abound to encourage and facilitate the opening of grocery stores in underserved areas.

The right steps by local, state and federal policymakers can increase access to healthy food in poorer neighborhoods and schools.

The racial disparity in eating habits is larger at higher income levels

Percent of adults reporting poor/fair eating habits

	Black	White
under $25K	36%	34%
$25K-50K	33%	26%
$50K+	28%	14%
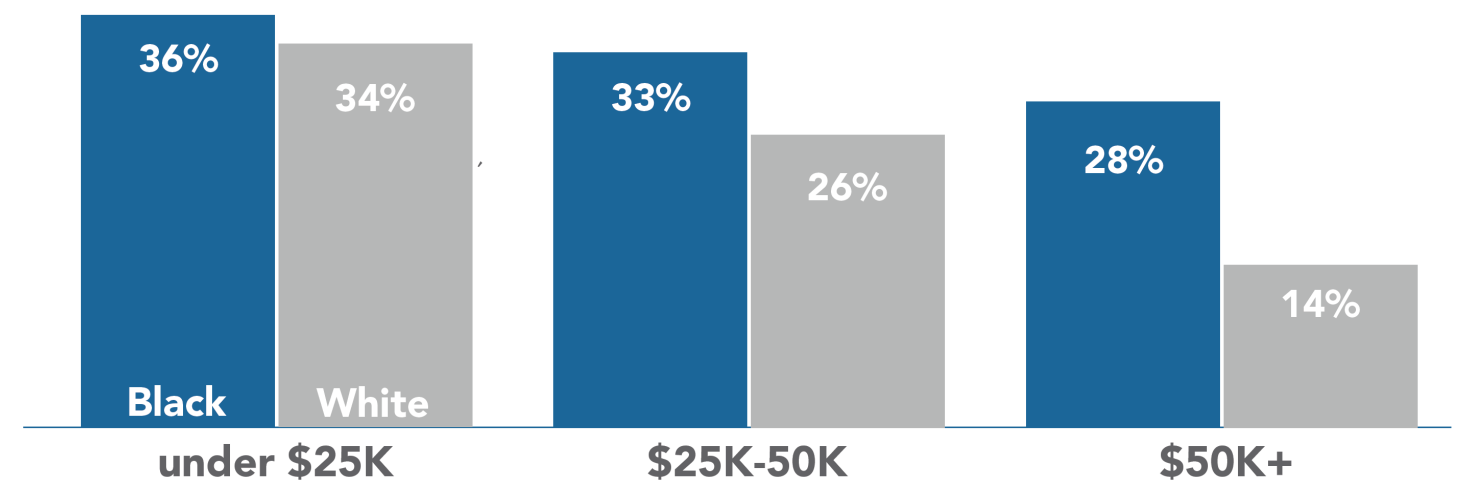
Source: My Health Story Survey 2018. Analysis of Finger Lakes nine county region by Common Ground Health

Designing more equitable and just systems

George Floyd's words have been a haunting refrain throughout this season of racial reckoning, a visceral reminder of the crushing weight of injustice that persists for Black people.

"Please — I can't breathe."

Those same words are an equally apt reminder of the COVID-19 pandemic that has stolen the breath from communities of color at an alarming rate and of the echo pandemic of unemployment, food insecurity, eviction threat and stress that has left little financial breathing room for families already living paycheck to paycheck, families that are disproportionately Black.

Woven into the fabric of American society, even if less explicit than in years past and sometimes unintentional, racism is thwarting the ability of Black people to lead long and healthy lives at almost every turn. As research has made clear, layers of discrimination undermine living conditions and resources that are foundational to health. Bias in housing, education, employment, criminal justice and other domains are behind higher rates for pre-term births, chronic disease and depression. Behind higher rates of homicide and substance abuse. And behind deplorably higher rates of infection and deaths from COVID-19.

Such tragic outcomes are unacceptable and are undeniable proof that our institutional norms, intentionally or not, create and perpetuate racist results. As Donald Berwick, one of the nation's foremost experts on health improvement put it, "Every system is perfectly designed to achieve the results it achieves."[121]

Working harder within broken systems or simply acknowledging racism on a personal level is a path to failure. Real and lasting improvement depends on a commitment to redesigning the institutions that structure our society to ensure that policies and programs produce fair and equitable outcomes regardless of race.

The calls to action within this report are wide-ranging and aimed at institutional change. As Ibram Kendi, author of *How to Be an Antiracist* reminds us, "Racial inequity is a problem of bad policy, not bad people." The same principle holds true for life experiences within the Black community. "Individual behaviors can shape the success of individuals. But policies determine the success of groups," Kendi writes.[122] Imagining and building better policies in housing, education, lending, criminal justice and other areas begins with the refusal to accept the status quo and a commitment to change.

Some of the important actions we can take are supporting the objectives and recommendations of local initiatives focused on eliminating systemic racism. In its final report, the Commission on Racial and Structural Equity (RASE) provides a deeper assessment of many of the inequities highlighted in this report. And the RASE Commission puts forth five broad solutions, each with numerous specific actionable recommendations that are critical steps to addressing the many ways that racism undermines the economic, socioemotional and physical well-being of Black people in our community.[123]

Additional efforts that specifically address inequities in the clinical care system are also needed. It is critical to apply an antiracist lens when developing and evaluating health-improvement interventions. And increasing the number of Black doctors and other health care professionals is essential to ensuring that the needs of Black patients are heard, understood and addressed.

Finally, we can all take steps to support racial equity in our everyday actions and conversations. Systemic change will be driven by individuals with the courage to speak up for, and act on behalf of, what is right.

> **"Individual behaviors can shape the success of individuals. But policies determine the success of groups."**
>
> — DR. IBRAM X. KENDI, DIRECTOR AND FOUNDER, BOSTON UNIVERSITY CENTER FOR ANTIRACIST RESEARCH

National and local conversations on racial injustice are gaining momentum, moving the focus from symptoms to solutions — especially at structural and institutional levels, where large-scale and lasting changes have the best chance of success.

"It'll be documented, who was doing what at this period…," reminds National Medical Association President Dr. Oliver Brooks. "This is a turning point."[124]

A crisis is a terrible thing to waste. We are being handed an opportunity to support equality like never before. We do not seek a return to normal; we aim to build something better. If we rise to this occasion, our region will enjoy a brighter, more just future.

What can we do?

Support existing community initiatives to dismantle structural and institutional racism

✓ Eliminate the upstream root causes of racial health disparities by replacing policies and practices that lead to inequities in housing, employment, education and other social determinants of health.

✓ Learn more about ways to support and leverage the work of groups that are targeting systemic racism. Great local initiatives include:

- ○ Commission on Racial and Structural Equity (RASE)
- ○ Interrupt Racism
- ○ Black Agenda Group

Engage the leaders of your organization and community in dialogue about racism and its impact on health

✓ Leverage the findings and data from this report and material from other racial-equity initiatives to educate others on the health impacts of racism. Resources available at **urbanleagueroc.org/irall**

✓ Push for racial equity to be a strategic priority at boards of directors and leadership levels within organizations.

✓ Focus on racial discrimination and racial privilege as problems at a systemic level to help break through potential defensiveness from White individuals who believe they are not personally racist. It is critical for leaders to understand that even well-intentioned individuals and organizations often create racially inequitable outcomes.

Promote business practices and policies to ensure there are more Black doctors and other health-care professionals

✓ Support the training, hiring and retention of Black health professionals at all levels and in all disciplines, including mental health and other specialties.

✓ Invest in workforce-development opportunities for Black health professionals such as college scholarships, internships, professional development programs, mentorships and clear opportunities for growth and advancement.

✓ Remove licensing barriers which unfairly limit entry for Black health practitioners.

Develop and assess all health improvement interventions through a racial-equity lens

✓ Evaluate policies and programs to ensure accessability, adoption and effectiveness for the Black community.

✓ Use Racial Equity Impact Assessments and other tools to identify the potential for disparate outcomes.

✓ Engage the experts — Black patients, caregivers and health professionals — when designing interventions.

✓ Teach all health care professionals to properly diagnose non-White patients and to deliver culturally appropriate care.

✓ Build processes and metrics to ensure programs and results are measured by race.

Advocate for racial equity in your everyday actions and conversations

✓ Learn and self-reflect about implicit bias, racial privilege and antiracism.

✓ Broaden your knowledge with the suggested readings and community forums at **urbanleagueroc.org/irall**

✓ Demonstrate public allyship in the office, and with family and friends: If you see something, say something.

✓ Support Black-owned businesses and cultural events.

✓ Build relationships with people who don't look like you.

✓ Be a model for racial tolerance in *all* that you do, whether at work, socially, in your faith practice or elsewhere.

Notes

* Years of Potential Life Lost (YPLL) is a widely used measure to assess the rate of premature mortality. YPLL places a larger weight on the deaths of younger people, in contrast with overall mortality statistics which are dominated by deaths of the elderly. The YPLL rates in Common Ground Health's analyses are derived using 75 years of age as the baseline. Therefore, a death at age 65 has a YPLL of 10, whereas a death at age 35 has a YPLL of 40. Rates are calculated per 100,000 population, and are age- and sex-adjusted to account for differences in population distribution.

† The Socioeconomic Status (SES) index ranking was developed by Common Ground Health and calculated using a variety of socioeconomic indicators from the American Community Survey, including average income, poverty rates, education levels, housing value and homeownership. Each ZIP code is assigned an SES index ranking from 1 to 5. The lower SES ZIP codes tend to have lower average income, higher poverty rates, lower prevalence of college degrees, etc.

‡ A Racial Equity Impact Assessment (REIA) is a systematic examination of how different racial and ethnic groups will likely be affected by a proposed action or decision. REIAs are used to minimize unanticipated adverse consequences in a variety of contexts, including the analysis of proposed policies, institutional practices, programs, plans and budgetary decisions. The REIA can be a vital tool for preventing institutional racism and for identifying new options to remedy long-standing inequities. For more information, go to: www.raceforward.org/practice/tools/racial-equity-impact-assessment-toolkit

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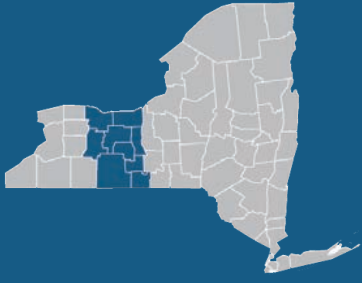
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About Common Ground Health

Founded in 1974, Common Ground Health is the health research and planning organization for the nine Finger Lakes counties of Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne and Yates. We bring together health care, education, business, government, residents and other partners to find common ground on health challenges. Learn more about our collaborative approach, our data analysis, and our efforts to improve health equity at www.CommonGroundHealth.org.