

LEADERSHIP NORTH CAROLINA

Charlotte, North Carolina

February 9, 2023

Goldie S. Byrd PhD

Class XV





GOAL – Brian and Kelly

...share with the group your philosophy of leadership, how you have developed your own leadership skills, the role leadership plays in your professional and community interactions, your reflections on leading through uncertainty, and the multiple connections throughout your career to supporting and enhancing health and well-being across North Carolina.

The group will be interested in hearing about your personal and professional journey, what drives you, what challenges you have overcome along the way, and the role your LNC experience has played.



“Beneath the skin,
beyond the differing features
and into the
true heart of being,
fundamentally,
we are more alike,
my friend,
than we are unlike.”
-Maya Angelou

Racial and Ethnic Health Disparities

MATERNAL AND CHILD HEALTH

Maternal/Child Health Indicators	Total	White	African American		American Indian		Hispanic/Latinx		Other	
	%/Rate	%/Rate	%/Rate	Disparity Ratio	%/Rate	Disparity Ratio	%/Rate	Disparity Ratio	%/Rate	Disparity Ratio
Infant Death Rate (per 1,000 live births), 2012-16 ¹⁰	7.2	5.4	13.0	2.4	9.0	1.7	5.1	0.9	5.3	1.0
Low Birth Weight (<=2500 grams) Births (%), 2014-16 ¹¹	9.1	7.5	14.1	1.9	12.0	1.6	7.0	0.9	8.6	1.1
Late or No Prenatal Care (%), 2014-16 ¹¹	30.6%	23.9%	39.1%	1.6	35.9%	1.5	41.1%	1.7	32.6%	1.4
Maternal Smoking During Pregnancy (%), 2014-16 ¹¹	9.4%	11.9%	9.0%	0.8	23.1%	1.9	1.7%	0.1	1.6%	0.1

■ Green indicates a group is faring better than the referent group
■ Red indicates a group is faring worse than the referent group
□ White indicates there is no significant difference between the referent and comparison group

Racial and Ethnic Health Disparities

MORTALITY RATES

Mortality Rates, 2012-2016 ²⁰		Total	White	African American		American Indian		Hispanic/Latinx		Other	
		Rate	Rate	Rate	Disparity Ratio	Rate	Disparity Ratio	Rate	Disparity Ratio	Rate	Disparity Ratio
Heart Disease		161.3	159.0	187.1	1.2	182.0	1.1	56.6	0.4	76.0	0.5
Stroke		43.1	40.6	56.0	1.4	39.5	1.0	21.7	0.5	36.4	0.9
Diabetes		23.0	18.8	44.0	2.3	45.0	2.4	11.3	0.6	14.3	0.8
Chronic Lower Respiratory Disease		45.6	50.7	27.6	0.5	43.8	0.9	8.6	0.2	12.5	0.2
Kidney Disease		16.4	13.4	31.0	2.3	19.6	1.5	8.2	0.6	10.5	0.8
HIV Disease		2.2	0.8	7.5	9.4	1.6*	◆	1.1	1.4	◆	◆
Cancer	Total	166.5	165.0	190.7	1.2	158.7	1.0	72.9	0.4	104.4	0.6
	Colorectal	14.0	13.3	18.9	1.4	13.1	1.0	5.0	0.4	8.0	0.6
	Lung	47.5	49.1	46.3	0.9	51.2	1.0	13.1	0.3	23.5	0.5
	Breast	20.9	19.4	28.3	1.5	20.2	1.0	9.9	0.5	13.2	0.7
	Prostate	20.1	17.2	39.1	2.3	28.5	1.7	6.8	0.4	6.5	0.4

■ Green indicates a group is faring better than the referent group □ White indicates there is no significant difference between the referent and comparison group
■ Red indicates a group is faring worse than the referent group ◆ Symbol indicates reliable rates could not be calculated

* Rates based on fewer than 20 cases may be statistically unstable and should be interpreted with caution. Rates based on fewer than five cases are suppressed in this report.

SOCIAL AND ECONOMIC WELL-BEING





Subject	Subcategory	Total	White	African American		American Indian		Hispanic/Latinx		Other	
		%/Rate	%/Rate	%/Rate	Disparity Ratio	%/Rate	Disparity Ratio	%/Rate	Disparity Ratio	%/Rate	Disparity Ratio
Education	High School Graduation Rate, 2016-2017 ⁶	86.5	89.2	83.8	1.1	84.3	1.1	80.5	1.1	93.6	1.0
	Adults 25+ with High School Diploma or GED, 2016 ⁷	87.3	89.3	84.7	1.1	75.7	1.2	59.5	1.5	87.0	1.0
	Adults 25+ with Bachelor's Degree, 2016 ⁷	30.4	33.2	20.3	1.6	13.9	2.4	14.8	2.2	57.1	0.6
Employment	Unemployed, 2016 ⁷	3.8	3.0	6.1	2.0	5.4	1.8	4.4	1.5	3.7	1.2
Income	Median Household Income, 2016 ⁷	\$50,584	\$55,656	\$36,014	1.5	\$38,002	1.5	\$39,388	1.4	\$80,381	0.7
Poverty Rate	All Ages	15.4	12.0	23.5	2.0	25.5	2.1	27.3	2.3	11.9	1.0
	Children <18 Years, 2016 ⁷	21.7	15.8	33.8	2.1	33.4	2.1	35.8	2.3	10.9	0.7
	Elderly 65+ Years, 2016 ⁷	9.4	7.7	16.6	2.2	16.9	2.2	21.4	2.8	6.6	0.9
Housing	Living in a Home They Own, 2016 ⁷	64.2	71.2	43.9	1.6	63.5	1.1	43.0	1.7	61.1	1.2
Disability Status	Disability, 2016 ⁷	13.8	14.0	15.4	1.1	16.5	1.2	6.8	0.5	5.1	0.4

■ Green indicates a group is faring better than the referent group
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Black newborns more likely to die when looked after by White doctors



Physician–patient racial concordance and disparities in birthing mortality for newborns

Brad N. Greenwood^{a,1,2} , Rachel R. Hardeman^{b,1} , Laura Huang^{c,1} , and Aaron Sojourner^{d,1} 

^aSchool of Business, George Mason University, Fairfax, VA 22030; ^bSchool of Public Health, University of Minnesota–Twin Cities, Minneapolis, MN 55455
^cHarvard Business School, Harvard University, Boston, MA 02163; and ^dCarlson School of Management, University of Minnesota–Twin Cities, Minneapolis, MN 55455

Edited by Christopher W. Kuzawa, Northwestern University, Evanston, IL, and approved July 16, 2020 (received for review August 2, 2019)

Recent work has emphasized the benefits of patient–physician concordance on clinical care outcomes for underrepresented minorities, arguing it can ameliorate outgroup biases, boost communication, and increase trust. We explore concordance in a setting where racial disparities are particularly severe: childbirth. In the United States, Black newborns die at three times the rate of White newborns. Results examining 1.8 million hospital births in the state of Florida between 1992 and 2015 suggest that newborn–physician racial concordance is associated with a significant improvement in mortality for Black infants. Results further suggest that these benefits manifest during more challenging births and in hospitals that deliver more Black babies. We find no significant improvement in maternal mortality when birthing mothers share race with their physician.

approaches to address this pressing social issue. Furthermore, to the extent that newborns cannot verbally communicate with their physician, we are able to observe the effects of concordance without trust or communication issues affecting the patient–physician relationship. Inasmuch as prior research has struggled to disentangle the mechanisms behind concordance’s effect (10, 26), the setting allows us to explore concordance in the absence of one invoked mechanism: communication. Thus, if concordance effects manifest, we are able to rule out communication as the exclusive mechanism.

Research posits that racial concordance between a newborn and their physician may mitigate disparities for at least two reasons. First, research suggests concordance is not only salient for adults. Indeed, a growing body of literature explores the

Greenwood et al. *PNAS* 1913405117

OVER HALF OF BLACKS LIVE IN 27101, 27105 AND 27107 JUST EAST OF HWY 52 (ONCE THE INDUSTRIAL HUB OF WINSTON SALEM)

Segregationists trends: grocery stores hospitals, libraries, parks and recreation centers were built closer to white neighbor and disinvestment in Black neighborhoods

Results:

Lower median household income

Lower education

Greater poverty than the county and state

Inadequate access to essential goods and services such as childcare, grocery stores, schools and jobs

2 of 20 grocery stores

2 of 11 public libraries

1 fully functioning medical clinic

2 of 43 elementary schools

2 of 17 highest schools

1 of 6 Colleges city-wide

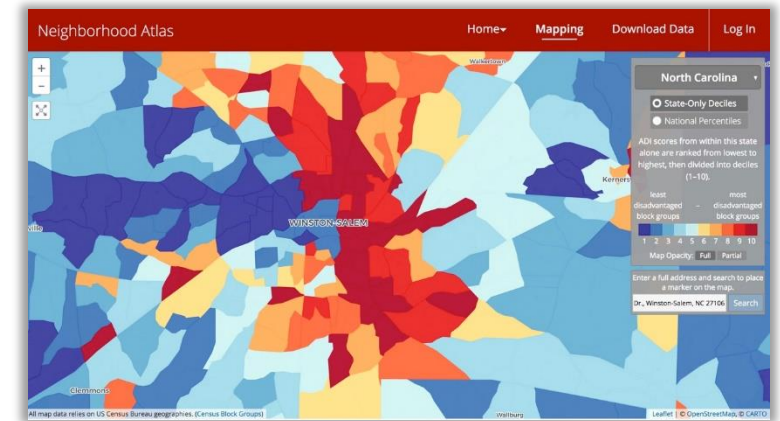
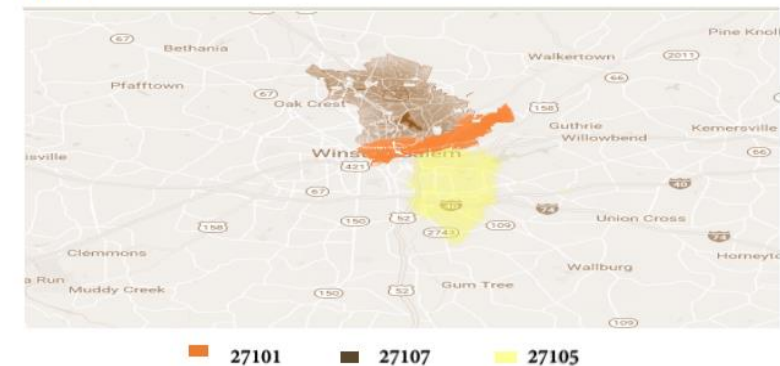


Figure 2. Predominantly Black Zip Codes in Forsyth County, NC



Black Philanthropy Initiative of the Winston-Salem Foundation. Rethinking Philanthropy: An Exploration of Black Communities in Forsyth County. 2015

Neighborhood Disadvantage is a Social Determinant of Health

- Alzheimer's disease and other chronic diseases disproportionately impact racial/ethnic minorities and the socioeconomically disadvantaged populations – populations often exposed to neighborhood disadvantage

Link and Phelan. *J. Health Soc Behav*, 1995.

- Neighborhood disadvantage influences many factors including health behaviors, access to food, toxic exposures and personal safety
- Living in a disadvantaged US neighborhood is strongly linked to increased mortality and disease

2/13/2023

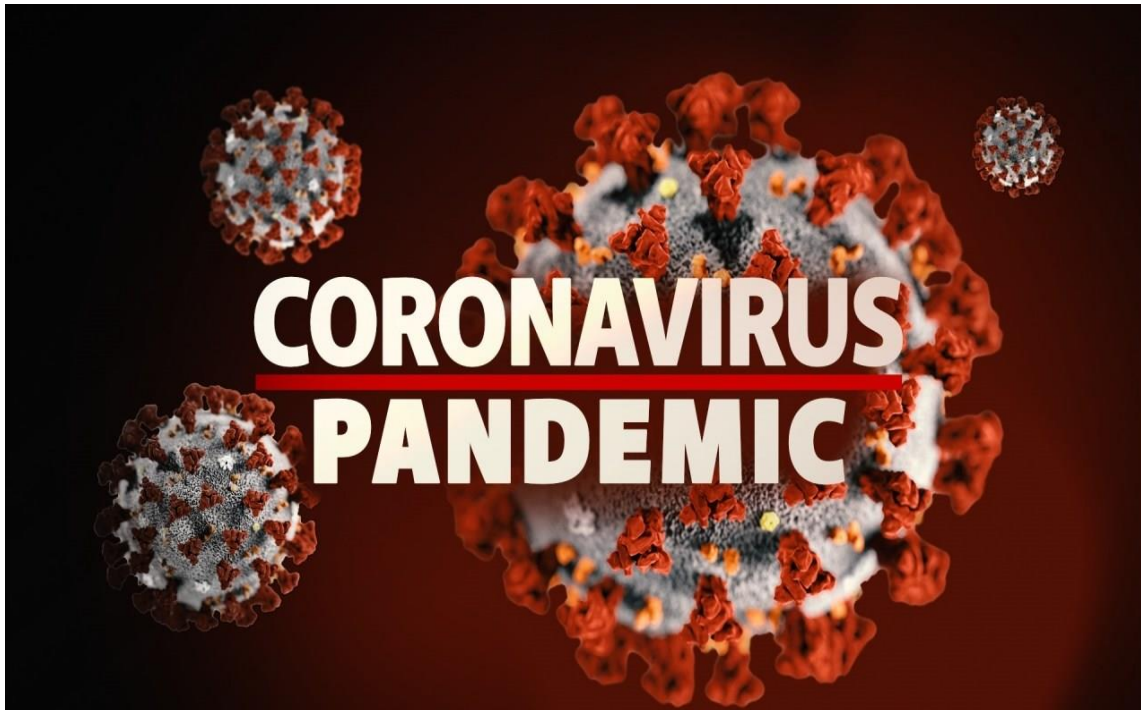
Kind et al, *Annals of Int Med*, 2014

Confidential information



10

The Covid-19 Pandemic Illuminated Longstanding Disparities and Inequities in Communities of Color.

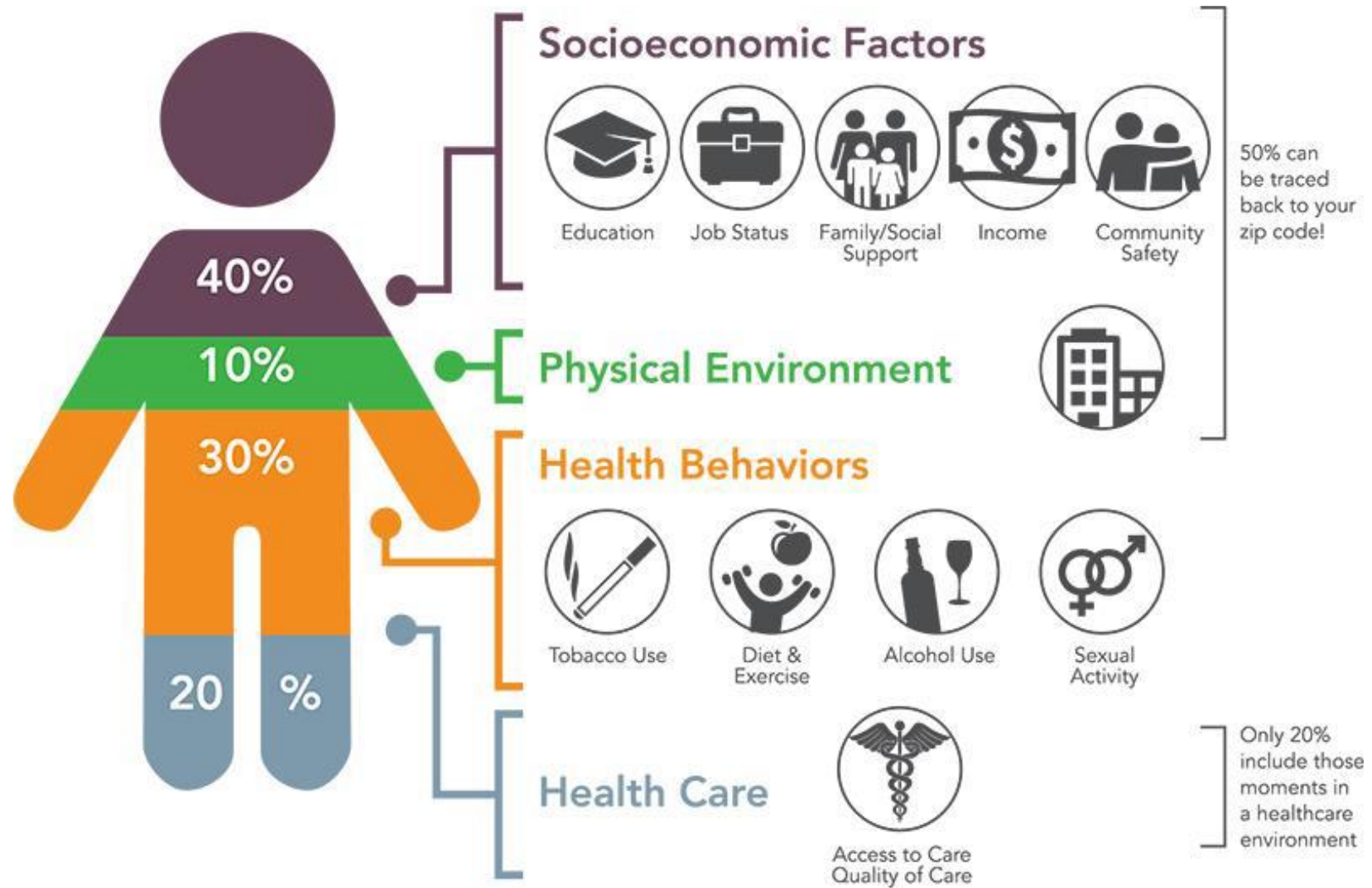


Very Difficult for Alzheimer's Patients and Families

Covid-19 illuminated disparities and inequities

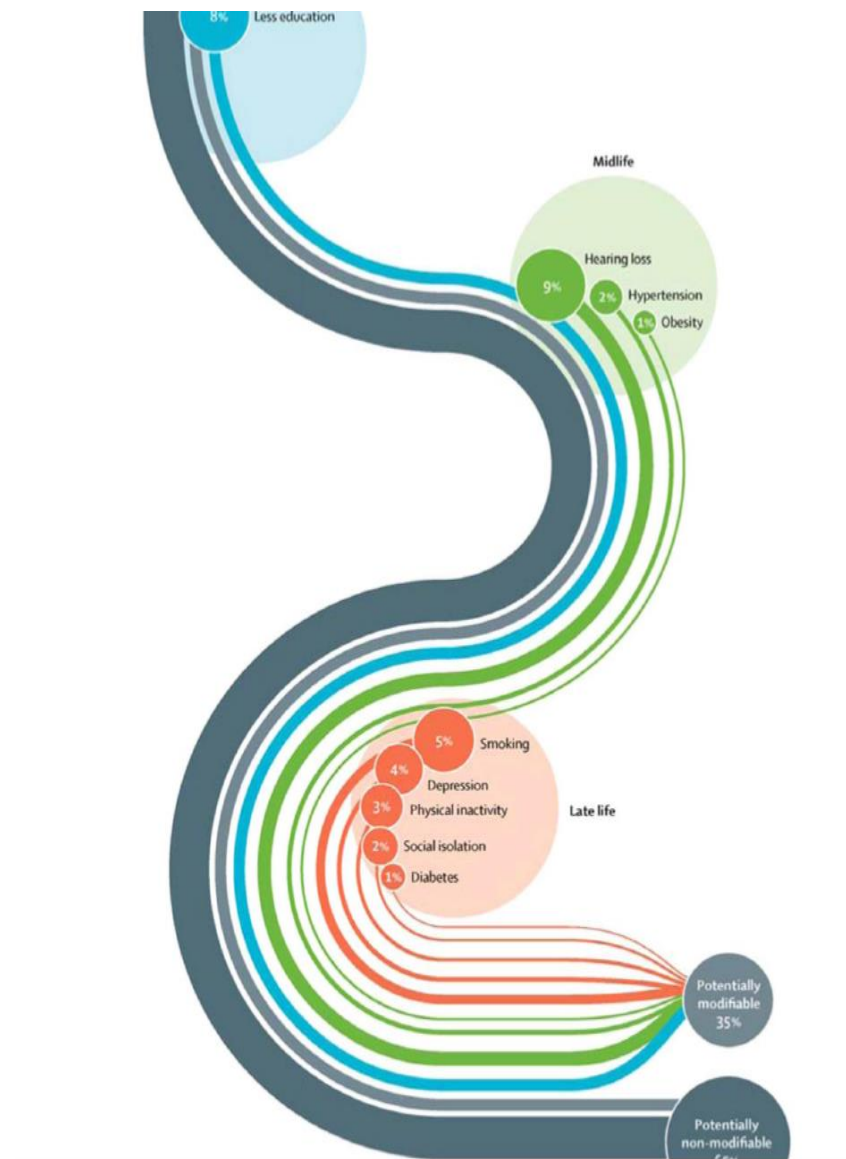
- Infections
- Hospitalizations
- Deaths
- Literacy
- Vaccinations
- Hesitancy/Access





Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

There is Good Potential for Dementia Prevention!



Slide Credit: Amy Kind

Life-course model of contribution of modifiable risk factors to dementia.
Orgeta et al. 2019 *The Lancet Commission on Dementia Prevention, Intervention,
and Care: A Call for Action. Irish J of Psych. Medicine.* 36: 85-88

Alzheimer disease in African American individuals: increased incidence or not enough data?

Lisa L. Barnes

Abstract | Research on racial differences in Alzheimer disease (AD) dementia has increased in recent years. Older African American individuals bear a disproportionate burden of AD and cognitive impairment compared with non-Latino white individuals. Tremendous progress has been made over the past two decades in our understanding of the neurobiological substrates of AD. However, owing to well-documented challenges of study participant recruitment and a persistent lack of biological data in the African American population, knowledge of the drivers of these racial disparities has lagged behind. Therapeutic targets and effective interventions for AD are increasingly sought, but without a better understanding of the disease in African American individuals, any identified treatments and/or cures will evade this rapidly growing at-risk population. In this Perspective, I introduce three key obstacles to progress in understanding racial differences in AD: uncertainty about diagnostic criteria, disparate cross-sectional and longitudinal findings; and a dearth of neuropathological data. I also highlight evidence-informed strategies to move the field forward.

and use the term African American to refer to individuals who would be grouped by the US Census into the Black or African American category.

The ageing and dementia research community has identified a number of genetic, medical, and lifestyle factors that are associated with the risk of dementia. Although this knowledge, largely gathered from study cohorts that are overwhelmingly white, is generally assumed to characterize risk in all populations, we know very little about the drivers of disease in African American individuals. The preponderance of data from one population can lead to the false and potentially dangerous conclusion that that group represents some type of scientific norm that all other groups should be compared to. However, research on the drivers of AD in minoritized populations — that is, populations that have been systematically marginalized in society — is as important as research of drivers in the majority population, and should be the focus of studies, even if it does not explicitly inform us about racial differences.

The current evidence for higher rates

Table 2 | Studies of Alzheimer disease biomarkers in Black or African American individuals and white individuals

Study	Biomarker(s)	Number of Black or African American participants	Number of white participants	Biomarker levels in Black or African American participants compared with white participants
Gottesman et al. (2016) ⁶⁹	Aβ PET	141	188	Higher
Howell et al. (2017) ⁶²	CSF p-tau ₁₈₁ and t-tau	65	70	Lower
Garrett et al. (2019) ⁶³	CSF p-tau ₁₈₁ and t-tau	152	210	Lower
Morris et al. (2019) ⁶⁴	CSF p-tau ₁₈₁ and t-tau	97	816	Lower
Kumar et al. (2020) ⁶⁵	CSF p-tau ₁₈₁ and t-tau	30	50	Lower
Meeker et al. (2020) ⁶⁶	Aβ PET, tau PET and structural and functional MRI	70	434	No difference in tau PET, Aβ PET, or functional MRI; lower brain volume
Brickman et al. (2021) ⁶⁷	Plasma Aβ ₁₋₄₀ , Aβ ₁₋₄₂ , t-tau, p-tau ₁₈₁ , p-tau ₂₁₇ and NfL; Aβ PET ^a	98	99	No difference in any biomarker
Rajan et al. (2021) ⁶⁸	Serum t-tau, NfL and GFAP	811	516	No difference in any biomarker

Aβ, amyloid-β, t-tau, total tau; p-tau, phosphorylated tau; NfL, neurofilament light chain; GFAP, glial fibrillary acidic protein. ^aIncluded 100 Hispanic participants.

www.nature.com/nrneuro1

Changing the narrative by increasing the number of studies that include AA participants, integrating risk factors that reflect the lived experience and acquiring the biological data that allows us to comprehensively examine the underlying mechanisms of disease, we will continue to have an incomplete of racial differences in AD. We will come nowhere near developing therapeutics, at best a cure, that will be effective in this population.



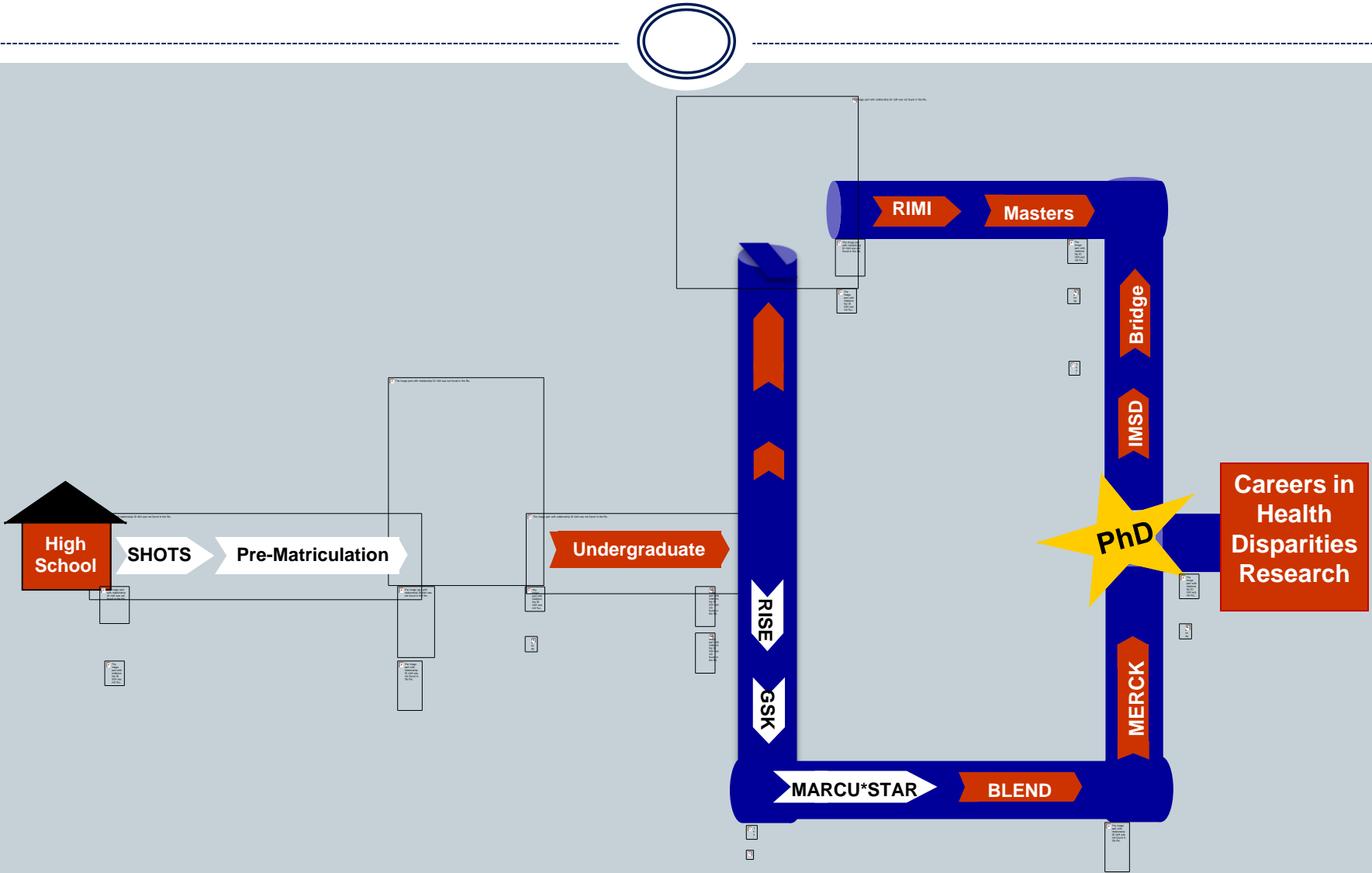
Hope and Sparking
the Change



Integrating Special Populations

MAYA ANGELOU CENTER FOR HEALTH EQUITY

Student Pipeline at NC A&T SU in STEM



In Spite of 1993 NIH Revitalization Act

- Denied 'life-extending opportunities': Black patients are being left out of clinical trials amid wave of new therapies
- African Americans make up less than 5% Clinical Trials



A black and white photograph of a person with short, curly hair, seen from the back and side, looking out a window. The window shows a view of a building and bare trees. The person's hand is near their face. The overall mood is contemplative.

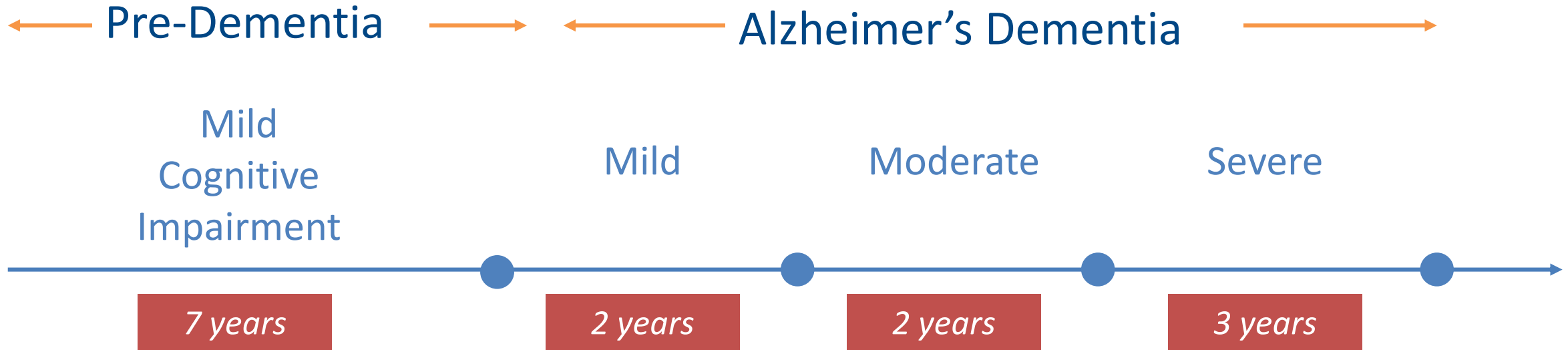
6.2 Million Americans over 65 have AD
Expected to be 12.7 million by 2050

Most common form of dementia
Alzheimer's is a health disparity

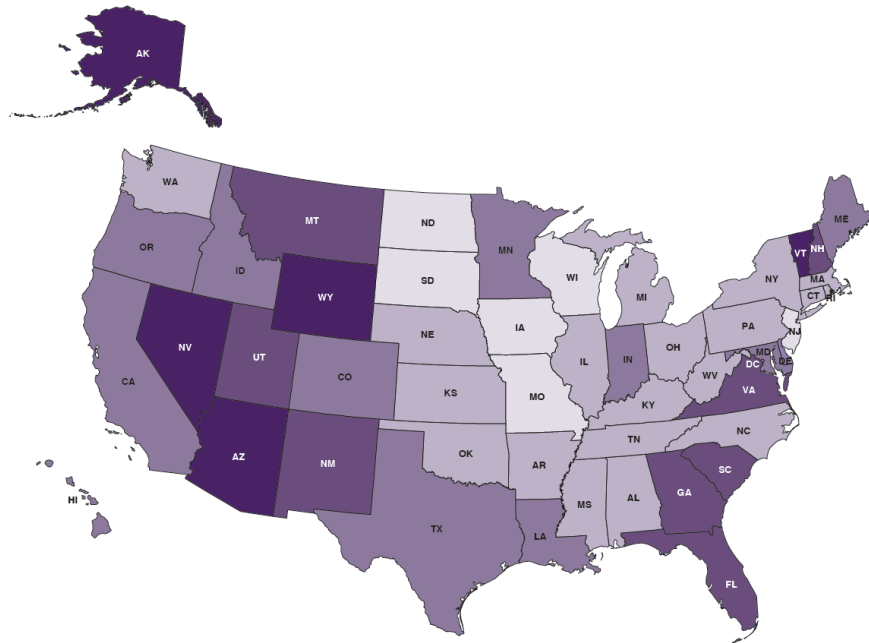
Primary risk factor: age

*No cure

*No Drug to Slow Progression



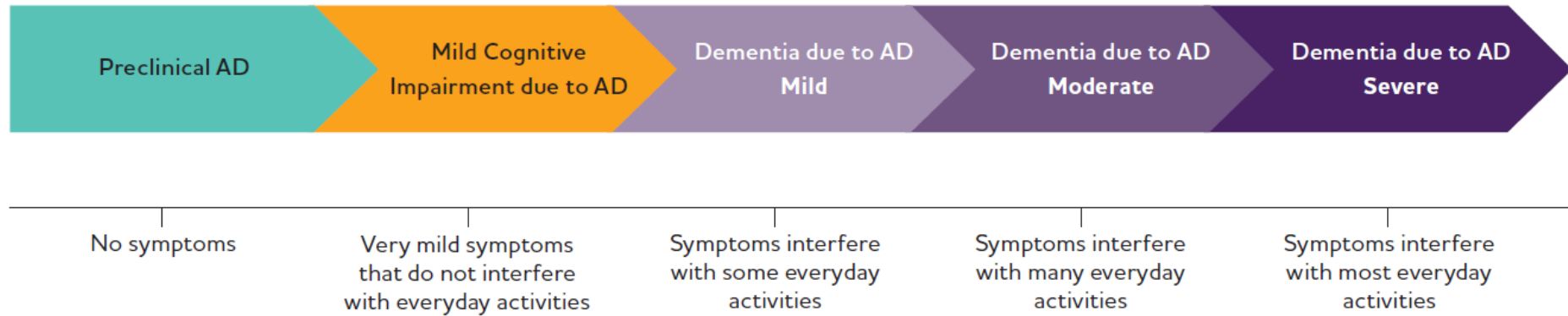
Projected Increases Between 2020 and 2025 in AD Prevalence by State



Projected Number with AD			% Increase
North Carolina	180,000	210,000	16.7%

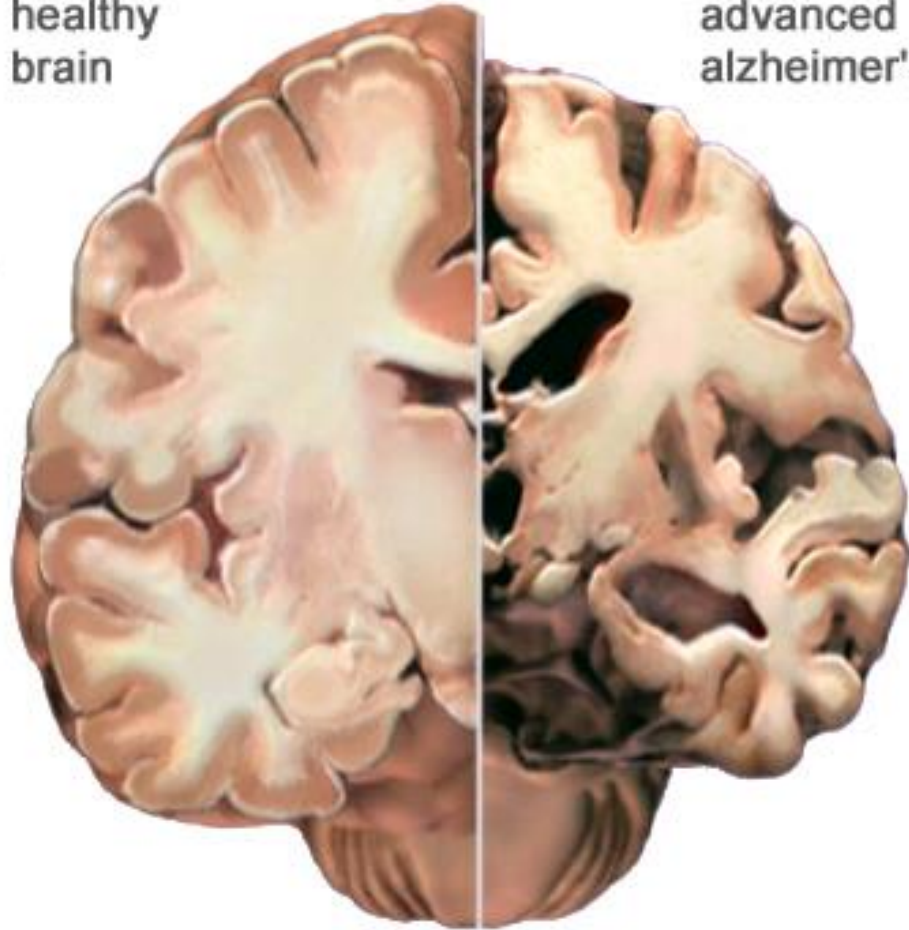
Stages of Alzheimer's Disease

Alzheimer's Disease (AD) Continuum*



*Although these arrows are of equal size, the components of the AD continuum are not equal in duration.

healthy
brain



advanced
alzheimer's

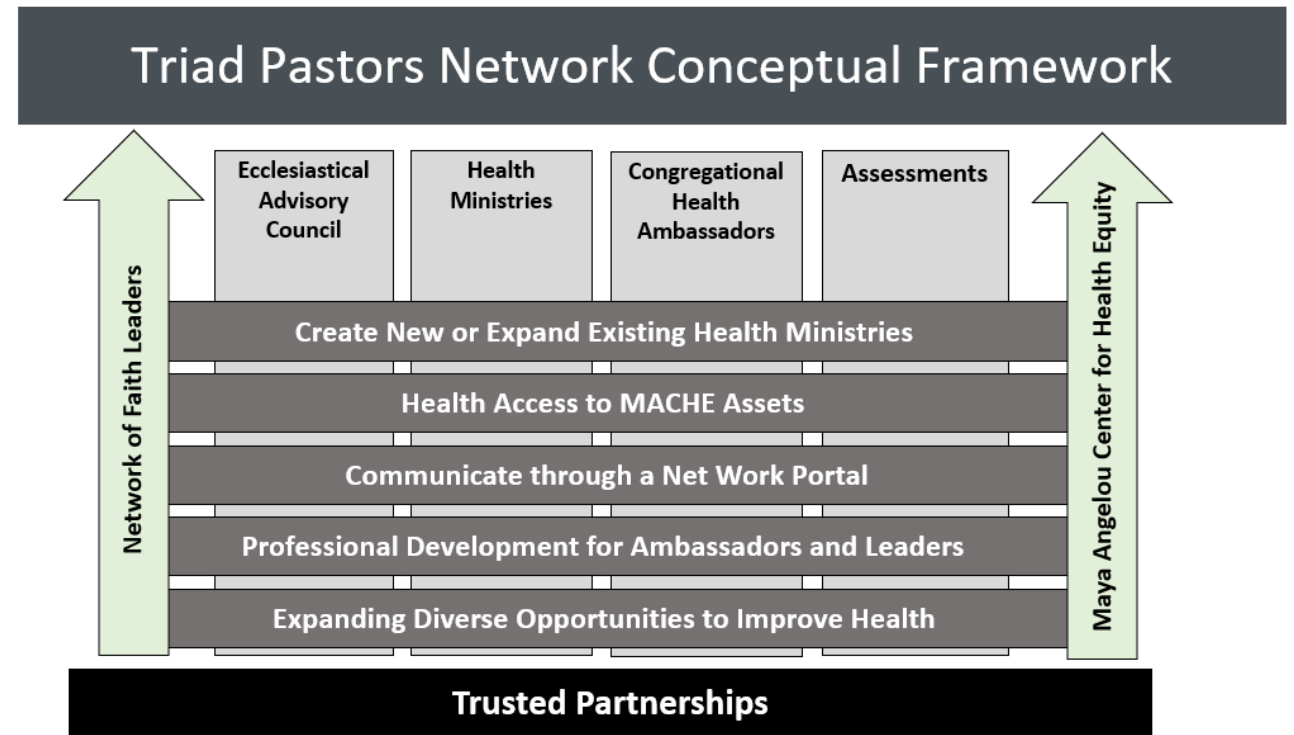
Addressing a Social Determinant of Health and Study Participation

- 5 Food Giveaways (> 6,000 persons)
- Bags with Study/Vaccine Information
- 300 Interest Sheets
- Pastor-led (average 6-10/event)



Enhancing Trustworthiness with Communities and Community Influencers

Triad Pastors Network



TPN LEADERS-LEADING-LEADERS 92,725 ATTENDEES

HOW CAN I TRUST THE COVID-19 VACCINE?

WHAT EVERY YOUNG ADULT NEEDS TO KNOW

TALKBACK PRESENTED BY MAYA ANGELOU CENTER FOR HEALTH EQUITY (MACHE)

PANEL

Allison Caban-Holt, PhD, PhD, MPH
Professor and Associate Director of Health, Behavior, and Society
Duke University School of Medicine

Guido Di Biase PhD Professor
Director of the Maya Angelou Center for Health Equity at Wake Forest School of Medicine

MAJ Timothy D. Peters, MSc, MBA
United States Army

Lorrian Taylor, BA, EdM, EdS
Senior Associate of the Maya Angelou Center for Health Equity at Wake Forest School of Medicine

Melissa Funderburk, MBA, MACH, BSCHA
Member, Total Operations Manager, Region 9
NC Credit Union

Orlynn Conroy, BS
Wake Forest College 2020 Graduate

Maya Angelou Center for Health Equity

COMMUNITY PARTNERS

Wake Forest School of Medicine, NC COUNTS COALITION, HUSTLE

JUNE 22
6 - 7:30 PM EST
STREAMING
YouTube
MAYA ANGELOU CENTER FOR HEALTH EQUITY

LEXINGTON COMMUNITY MINISTERS CONFERENCE PRESENTS COVID-19 VACCINE TOWNHALL

HELPING YOU UNDERSTAND THE FACTS AND MYTHS OF THE VACCINE

IN PARTNERSHIP WITH WAKE FOREST SCHOOL OF MEDICINE

OUR PANELIST OF EXPERTS

DR. LAMONTE WILLIAMS
Senior Pastor, Dignity Memorial UMC
Community Liaison
Maya Angelou Center for Health Equity
Wake Forest School of Medicine

DR. NANCY DENZARD THOMPSON
Associate Professor
General Internal Medicine
Wake Forest School of Medicine

MR. E. BENJAMIN MONEY, JR., MPH
Deputy Secretary for Health Service
North Carolina Department of Health & Human Services

MONDAY, MARCH 22, 2021
6:30PM EST

DR. GOLDIE BYRD
Professor and Center Director
Maya Angelou Center for Health Equity
Wake Forest School of Medicine

REV. KATHY WATFORD
Pastor, Lexington Community Conference

Live on Facebook, YouTube, and Zoom

The United Holy Church of America Presents A NATIONAL COVID VACCINE TOWN HALL

February 18, 2021
7:00 PM - EST

A COMMUNITY CONVERSATION

THE QUESTIONS AND THE ANSWERS
A FAITH-BASED COMMUNITY CONVERSATION

Hosted by Bishop Harry L. Cohen, Presiding Prelate

In partnership with WAKE FOREST School of Medicine and Maya Angelou Center for Health Equity

Panelists include: Rev. Dr. Lamonte Williams, Rev. Dr. Nancy Denzard Thompson, Rev. Dr. Goldie Byrd, Rev. Dr. Tony Ozart, Rev. Dr. E. Benjamin Money, Jr., and Rev. Dr. Ebonny Talley-Brame.

!!!SPREAD THE WORD!!!

United Shiloh Missionary Baptist Association Presents COVID-19 VACCINE TOWNHALL

HELPING YOU UNDERSTAND THE FACTS AND MYTHS OF THE VACCINE

IN PARTNERSHIP WITH WAKE FOREST SCHOOL OF MEDICINE

OUR PANELIST OF EXPERTS

DR. LAMONTE WILLIAMS
Senior Pastor, Dignity Memorial UMC
Community Liaison
Maya Angelou Center for Health Equity
Wake Forest School of Medicine

DR. NYREE K. THORNE
General Internal Medicine
Wake Forest School of Medicine

MR. E. BENJAMIN MONEY, JR., MPH
Deputy Secretary for Health Service
North Carolina Department of Health & Human Services

THURSDAY, APRIL 8, 2021
7:00PM EST

Rev. Ebonny Talley-Brame
Associate Director of the United Shiloh Missionary Baptist Association

DR. GOLDIE BYRD
Professor and Center Director
Maya Angelou Center for Health Equity
Wake Forest School of Medicine

DR. TONY OZART
Senior Pastor, Shiloh Missionary Baptist Association

TOWN HALL COVID-19 VACCINE

The Questions & The Answers
THURSDAY JANUARY 28, 2021 - 7:00PM

Panelists include: Dr. Goldie Byrd, Dr. Lamonte Williams, Dr. Nancy Denzard Thompson, Dr. E. Benjamin Money, Jr., and Pastor Shirley Caisa.

Host: Dr. Aaron McNaair, Sr. Pastor, Shiloh Baptist Church

GREAT CHURCH OF DELIVERANCE, INC. PRESENTS A NATIONAL TOWN HALL COVID-19 VACCINE AND THE VACCINE UNMASKED...NOT TOO FAST!

MONDAY, DECEMBER 21, 2020 - 7PM EST
LIVE STREAM

Host: Bishop Freddie B. Marshall, P.L.D., Presiding Prelate, Metro Politan

TOWN HALL Triad Communities Against COVID-19

In Partnership With Wake Forest School of Medicine
Saturday February 27, 2021 11AM-12:30PM EST

Panelists include: Dr. Goldie Byrd, Dr. Terrence P. Johns, Mr. Cornell P. Wright, Rev. Dr. Lamonte Williams, and Pastor Calvin Smith.

TRENT RIVER OAKLEY GROVE MB ASSOCIATION PRESENTS COVID-19 VACCINE TOWNHALL

Helping you understand the facts and myths of the vaccine
In Partnership with Wake Forest School of Medicine

MONDAY, MARCH 8, 2021
LIVE @ 7:00PM EST

GUEST PANELIST

DR. GOLDIE BYRD
Professor and Center Director
Maya Angelou Center for Health Equity
Wake Forest School of Medicine

KRISTEN GILL NIXON, MD
WAKE FOREST BAPTIST CHURCH

DR. LAMONTE WILLIAMS
Senior Pastor, Dignity Memorial UMC
Community Liaison
Maya Angelou Center for Health Equity
Wake Forest School of Medicine

MR. E. BENJAMIN MONEY, JR., MPH
Deputy Secretary for Health Service
North Carolina Department of Health & Human Services

¡Hablemos de las vacunas contra el COVID-19!

OPRECIAMOS UNA CONVERSACION CON EXPERTOS DE LA SALUD DE WAKE FOREST BAPTIST HEALTH

26 ENERO @ 5:30pm

Panel of Experts includes: Dr. Giselle Melendez, Dr. Julio Nolas, Dr. Ebonny Talley-Brame, Heriberto Beckles, M.S., and Pamela Daniel Sestalla, MDV.

Virtual ALZHEIMER'S, DEMENTIA & MEMORY LOSS PREVENTION STATEWIDE TOWN HALL

Hosted by North Carolina NAACP
Wake Forest School of Medicine

THURSDAY, APRIL 29, 2021
8:00-8:30 PM EDT

Panel of Experts includes: Dr. Lamonte Williams, Dr. Nancy Denzard Thompson, Dr. Goldie Byrd, Dr. E. Benjamin Money, Jr., and Dr. Ebonny Talley-Brame.

NATIONAL BAPTIST CONVENTION OF AMERICA INT'L, INC. President Tolbert and NBCA Hosts COVID-19 VACCINE TOWNHALL

Helping you understand the facts and myths of the vaccine
In Partnership with Wake Forest School of Medicine

MONDAY, FEBRUARY 1, 2021
7:30 PM CST (6:30 PM PST / 8:30 PM EST)

Panel of Experts includes: Dr. Kenneth R. Kemp, Dr. Michelle Long, Dr. Barbara Norman Hicks, and Dr. Lamonte Williams.

MAKE IT PLAIN COVID-19 VACCINE

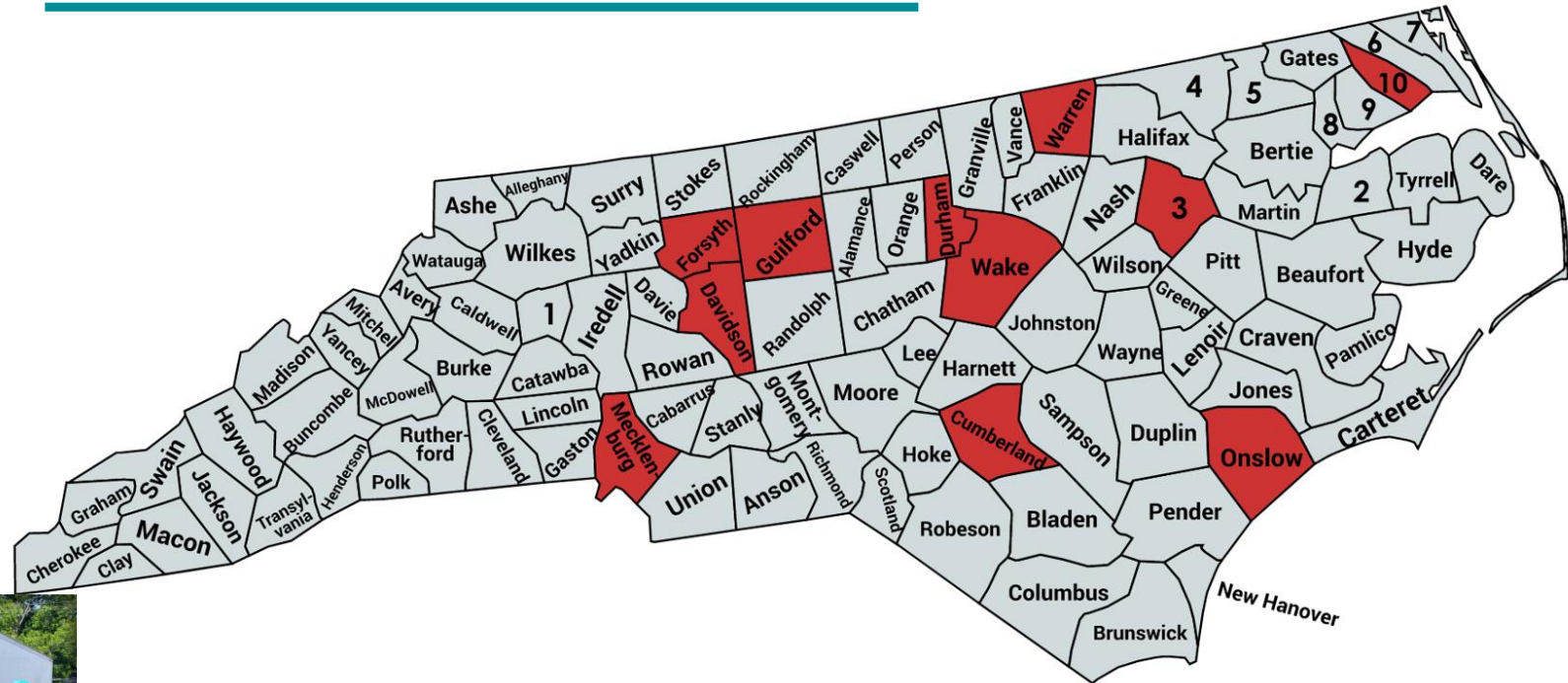
A CANONIC CONVERSATION TO ADDRESS CONCERNS ABOUT THE COVID-19 VACCINE

Panelists include: Dr. Goldie Byrd, Dr. Terrence P. Johns, Dr. Ebonny Talley-Brame, Dr. E. Benjamin Money, Jr., and Dr. Lamonte Williams.

North Carolina Statewide Farm-Px Food Distribution and Health Promotion Tour

County Distributions

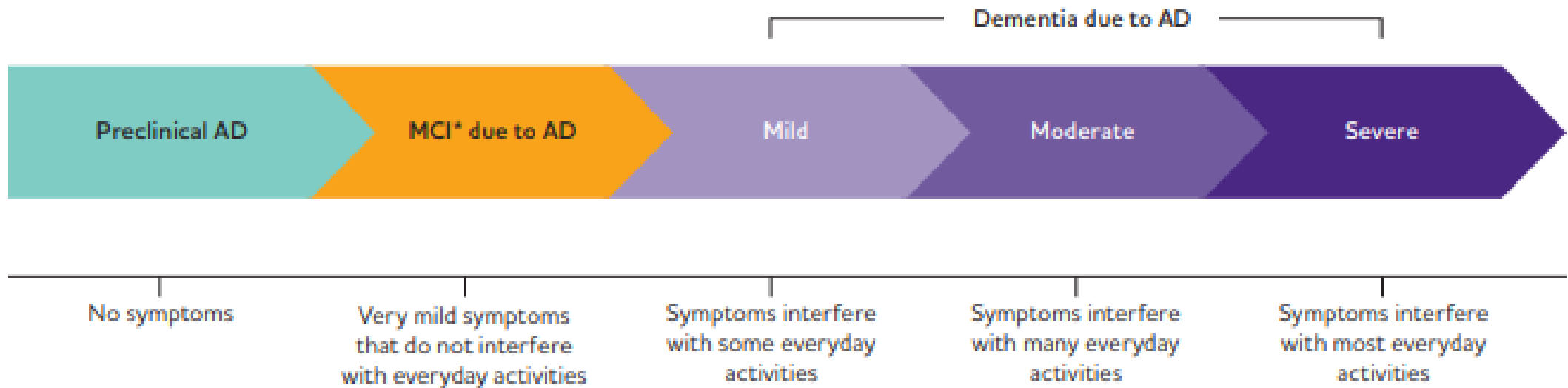
1. Alexander
2. Washington
3. Edgecombe
4. Northampton
5. Hertford
6. Camden
7. Currituck
8. Chowan
9. Perquimans
10. Pasquotank
11. Forsyth
12. Guilford



- 16 Distributions in 12 Counties
- 704,000 Pounds of Food (40-lb boxes)
- 1905 Participants Interested in COVID or AD
- Over 14,000 Recipients of Food
- 704,000 Pounds of Food (Value of \$880,000)

Alzheimer's Doesn't Just Begin with a Diagnosis

Alzheimer's Disease (AD) Continuum



Can See Brain Changes on PET

Have Biomarkers – abnormal levels Beta Amyloid – may revert to normal

The longest phase – may become Incontinent, personality changes

Need the most assistance because of damage to brain. Bed bound.

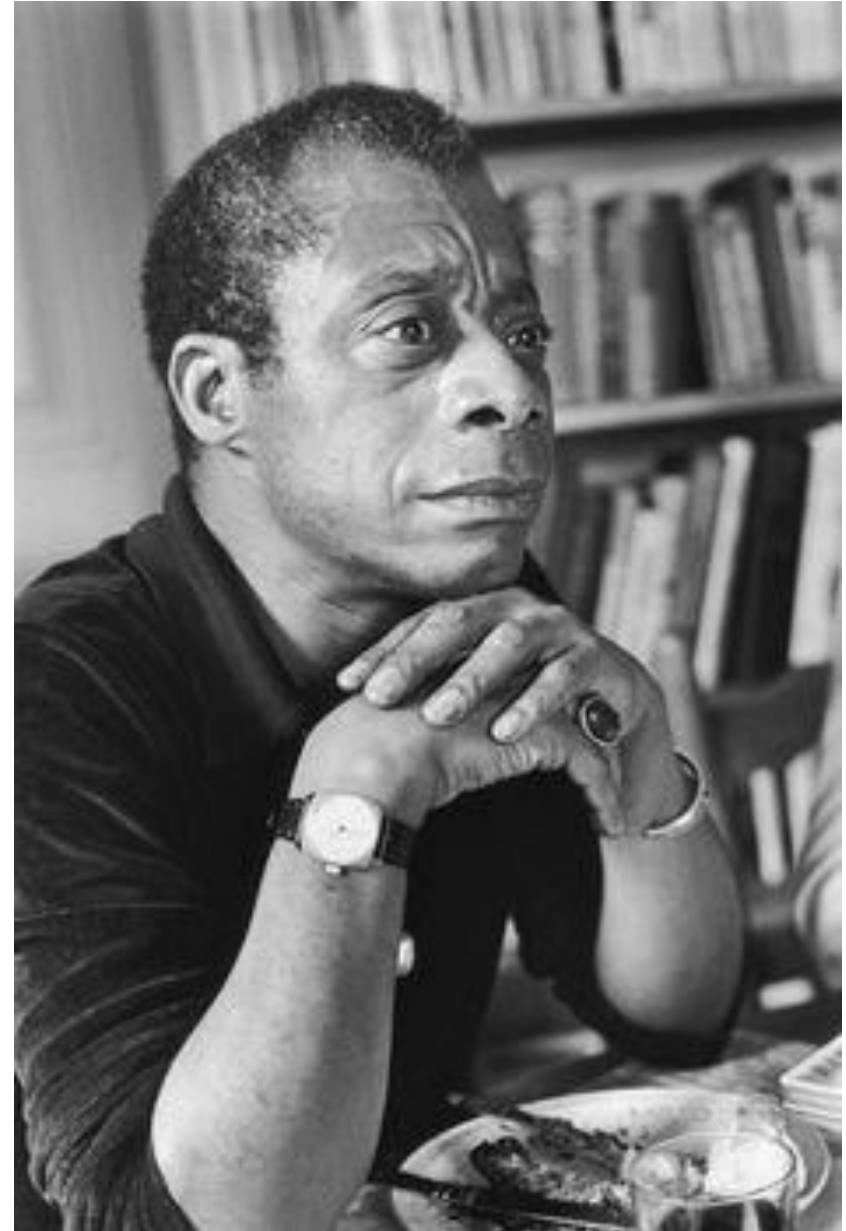
OBJECTIVES OF MACHE

- 1: Provide transformative and dignified partnerships with diverse communities to address equity health outcomes**
- 2: Increase diversity in science, medicine, and health professions**
- 3: Diversify participation in clinical trials and research studies**
- 4: Advance a culture of faculty and staff growth through professional development and perpetual learning**
- 5: Promote health equity advocacy and social policy changes**

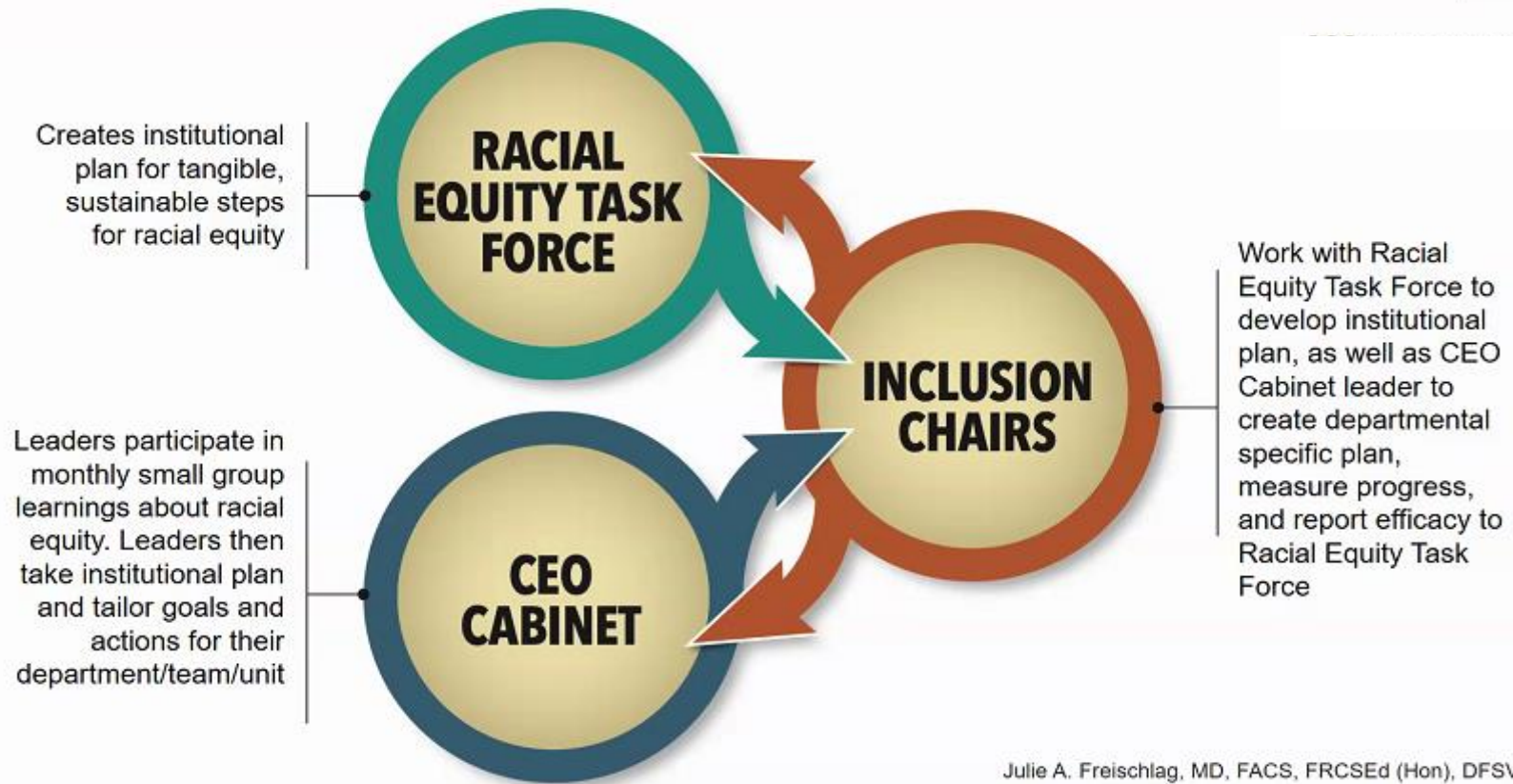
Face Reality

**“Not everything that is faced can be changed,
But nothing can be changed until it is faced.”**

James Baldwin



Racial Equity from the Top, Middle, and Grass Roots Level



Data Sets informed 9 Equity Issues and 27 Strategies

Domain	Data Sources
People	<ul style="list-style-type: none"> Peoplesoft Employee database HR Exit Survey
Education	<ul style="list-style-type: none"> Applicants, Acceptances, Matriculates for different programs Follow-up interviews and conversations AAMC data for application, acceptance, matriculation at U.S. medical schools
Patient Care	<ul style="list-style-type: none"> Press-Ganey Patient Experience Surveys Regional Quality & Safety Health Equity Data Sets
Culture	<ul style="list-style-type: none"> Press-Ganey Employee Experience Survey AAMC Standpoint Survey HR Exit Survey
Research	<ul style="list-style-type: none"> Wake Integrated Solution for Enterprise Research (WISER) data on study participants Research Participant Satisfaction Survey Key Informant perceptions
Community	<ul style="list-style-type: none"> Key informant perceptions Barriers to Health Justice in Winston-Salem & Forsyth County Study from Wake School of Law Forsyth Futures data sets



#	Results
9	Fundamental Equity Issues
76	Sub-Issues Across 6 Domains
27	Strategies



Framework for the Racial Equity Taskforce

Culture



Assure a just, equitable diverse, inclusive culture driven by policies and practice

People



Recruit, retain and advance diverse and skilled individuals at all levels

Patient Care



Provide all patients with inclusive equitable and quality care

Education



Train faculty students, staff providers, and community to address inclusion and racial equity

Research



Advance research to include health disparities, health equity and inclusion

Community

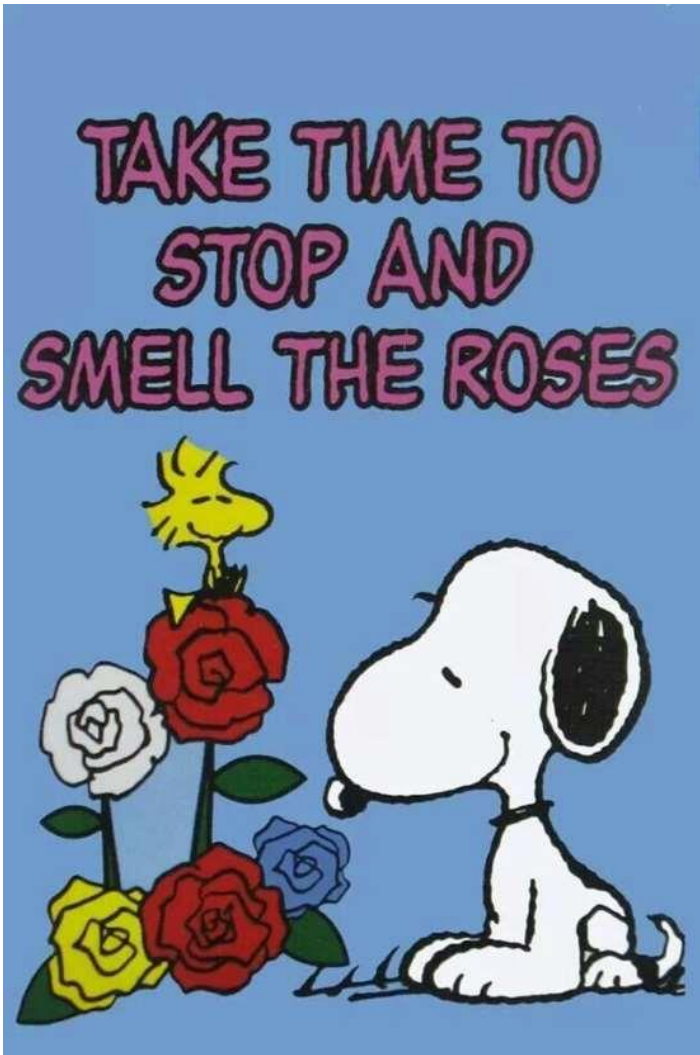


Engage and empower internal and external communities to create a just environment

Action for Cultural Transformation: Strategies to Ensure Equity, Mitigate Bias and Eliminate Racism at Wake Forest Baptist Health



“Beneath the skin,
beyond the differing features
and into the
true heart of being,
fundamentally,
we are more alike,
my friend,
than we are unlike.”
-Maya Angelou



Inclusion at all Levels

*Diversity makes for a rich tapestry,
and we must understand
that all the threads of the tapestry are*

EQUAL IN VALUE

no matter what their color.

- Maya Angelou





17,000+ Killed

Rescuers searching for survivors in the rubble of a collapsed building in Syria's opposition-held Idlib Province, on the border with Turkey, on Wednesday. Omar Haj Kadour/Agence France-Presse — Getty Images

JOURNAL: Do You Have A One-Word Thought?

