Webinar Archive

Bridge to Health Equity Foundation

Recorded Expert Sessions on Health Equity
2025-2026 Webinar Series

Webinar 1: Understanding Health Disparities in Underserved Communities

Date: September 15, 2025 | Duration: 60 minutes

Session Overview

This session provided a comprehensive introduction to health disparities, grounding the content in both historical context and current data. It emphasized that health disparities are not natural or inevitable—they are the result of policy choices, systemic discrimination, and unequal distribution of resources. The session explored how factors like race, income, geography, and education create differential health outcomes and examined pathways through which these factors operate.

Key Concepts Covered

- Defining health disparities vs. health inequities: Disparities are differences; inequities are unjust differences
- Historical roots: Slavery, segregation, redlining, medical exploitation, and their lasting impacts
- Intersectionality: How multiple identities (race, class, gender, immigration status) interact to shape health
- Data deep-dive: Life expectancy gaps, maternal mortality, chronic disease prevalence by demographic groups

- Social determinants as pathways: How neighborhood, education, and income "get under the skin" to affect biology

- Community-based participatory research: Principles of partnering with communities as co-researchers, not subjects

Key Takeaways

- Health disparities cost the U.S. $451 billion annually—addressing them is both moral and economic imperative

- Black life expectancy is 5.8 years shorter than white life expectancy; this gap widened during COVID-19

- Zip code is a stronger predictor of health than genetic code

- Individual behavior change approaches fail without addressing systemic barriers

- Communities have assets and strengths; deficit-focused approaches are ineffective and disrespectful

Q&A Highlights

Q: How do we talk about race as a social construct while also collecting race data?

A: Race is not biological, but racism is real and measurable. We collect race data to document the impact of racism, not because race itself causes poor health. Always pair race data with analysis of racism and structural factors.

Q: What's the most important thing an individual healthcare provider can do?

A: Listen to and believe patients, especially Black, Indigenous, and Latino patients whose concerns are often dismissed. Advocate within your institution for policy changes. Screen for social determinants and connect patients to resources.

Discussion Questions for Teams

- What health disparities are most visible in our community? What are the root causes?

- How does our organization currently collect and use race, ethnicity, and language data?

- What assumptions or deficit-based language do we use when talking about underserved communities?

- How can we authentically partner with community organizations and residents?

Recommended Resources

- CDC Health Equity Tracker: healthequitytracker.org - Interactive data visualizations

- Book: "The Color of Law" by Richard Rothstein - History of residential segregation

- Report: "Unequal Treatment" by Institute of Medicine - Landmark report on healthcare disparities

- Website: County Health Rankings - countyhealthrankings.org - Community-level data

Webinar 2: Cultural Competency in Healthcare Delivery

Date: October 22, 2025 | Duration: 75 minutes

Session Overview

This webinar challenged traditional "cultural competency" training and introduced the framework of cultural humility—recognizing that we can never be fully "competent" in another culture, but can approach cross-cultural encounters with openness, curiosity, and humility. The session shared practical strategies for providing linguistically and culturally appropriate care, illustrated with real cases from community health centers serving immigrants and refugees from 40+ countries.

Key Concepts Covered

- Cultural humility: Lifelong learning, self-reflection, addressing power imbalances
- National CLAS Standards: Framework for culturally and linguistically appropriate services
- Health literacy: Only 12% of adults have proficient health literacy; communication must be accessible to all
- Professional interpretation: Why using family members (especially children) causes harm
- Building trust: Especially important with communities experiencing historical trauma and discrimination
- Decision-making styles: Recognizing individual vs. family/community-centered decision-making
- Traditional healing: How to respectfully inquire about and integrate traditional practices
- Implicit bias: How unconscious biases affect clinical decision-making and patient experience

Case Study: Somali Mother and Newborn Care

The presenters shared a case of a Somali mother who was labeled "non-compliant" for missing multiple well-baby visits. Through cultural humility and deep listening, staff learned she was avoiding the clinic because a male physician had examined her without a female chaperone present—violating her religious and cultural values. The clinic responded by: (1) apologizing, (2) ensuring female providers or chaperones for all Muslim women who request them, (3) training staff on Islamic practices around modesty, (4) hiring Somali interpreters and community health workers. The family returned and engaged fully in care.

Practical Tools Shared

- LEARN framework: Listen, Explain, Acknowledge, Recommend, Negotiate - for cross-cultural encounters

- Teach-back method: "I want to make sure I explained clearly. Can you tell me in your own words...?"

- Questions to ask: "Where are you from originally? What languages do you speak? What do you call this condition in your language? What do you think caused this? What treatment have you tried? What are you most worried about?"

- Cultural brokers: Train bilingual staff or community health workers to bridge cultural gaps

- Environmental scan: Are clinic signs in multiple languages? Do images reflect community? Is food culturally appropriate?

Key Takeaways

- Cultural competence is impossible; cultural humility is the goal—always learning, always humble

- Professional interpretation is a patient safety and quality issue, not a luxury

- What we call "non-compliance" is often miscommunication, lack of trust, or structural barriers

- Diversifying the workforce is essential but insufficient; systems must change

- Small gestures matter: correct pronunciation of names, respectful curiosity, acknowledging holidays and traditions

Q&A Highlights

Q: How do I provide culturally appropriate care when I see patients from 20 different countries?

A: You can't know everything about every culture, and that's OK. Focus on the principles: ask, listen, don't assume, acknowledge power dynamics, partner with interpreters and cultural brokers. Each patient is an individual, not a representative of their culture.

Q: What if a patient's cultural practices conflict with medical recommendations?

A: Avoid binary thinking. Use the LEARN framework to negotiate. Can you honor both? If there's true conflict, explain your reasoning, acknowledge their values, explore creative solutions, document the conversation, and respect their autonomy.

Recommended Resources

- Think Cultural Health: Free online training - thinkculturalhealth.hhs.gov

- National CLAS Standards: minorityhealth.hhs.gov/clas

- EthnoMed: Contains cultural information on medical care for immigrant communities - ethnomed.org

- Book: "The Spirit Catches You and You Fall Down" by Anne Fadiman - Classic case study on cross-cultural medicine

Webinar 3: Policy Solutions for Health Equity

Date: November 10, 2025 | Duration: 90 minutes

Session Overview

This practical, action-oriented session equipped advocates with tools to influence policy at local, state, and federal levels. The session shared insider perspectives on how policy is made, what makes campaigns successful, and how to build power for health equity. It emphasized that policy advocacy is not just for "experts"—lived experience and authentic community voice are powerful and necessary.

Key Concepts Covered

- Policy landscape: Federal (Medicaid, ACA, Medicare), state (Medicaid expansion, insurance regulation, scope of practice), and local (housing, zoning, transportation, community benefits)

- Windows of opportunity: Budget cycles, legislative sessions, elections, crises

- Theory of change: How do we get from current state to desired policy change?

- Power analysis: Who are decision-makers? Who influences them? Where is public opinion?

- Coalition building: Diverse partners amplify impact and legitimacy

- Framing and messaging: Lead with values, tell stories, use data strategically

- Inside and outside strategies: Lobbying and relationship-building + grassroots pressure and public campaigns

- Persistence: Major policy wins take 5-10 years on average

Case Study: Medicaid Expansion Campaign

This 7-year campaign to pass Medicaid expansion demonstrated successful policy advocacy. Key elements: (1) Coalition of 150+ organizations (health, business, faith, labor). (2) Economic framing: jobs, hospital stability, federal dollars. (3) Stories: Real people in the coverage gap testifying. (4) Electoral strategy: Flipped 5 legislative seats in swing districts. (5) Inside game: Negotiated with hesitant legislators on implementation details. (6) Public campaign: Rallies, media, town halls building public pressure. Result: Expansion passed 2023; 200,000 people gained coverage.

Advocacy Tactics That Work

Direct Lobbying:

- In-district meetings: Meet legislators in their district, not just at the capitol

- Testify: Provide oral and written testimony at committee hearings

- Write letters and emails: Personalized, constituent letters matter more than form emails

- Phone calls: Brief, polite calls stating your position and asking for commitment

Grassroots Organizing:

- Town halls and community forums: Create space for legislators to hear from constituents

- Rallies and demonstrations: Show strength in numbers; generate media coverage

- Petition drives: Demonstrate breadth of support

- Voter education and mobilization: Register voters; create voter guides; turn out supporters

Media and Communications:

- Op-eds and letters to editor: Frame the issue; respond to opposition

- Social media campaigns: Hashtags, storytelling, rapid response

- Earned media: Press releases, press conferences, media interviews

- Paid media: Ads (if budget allows) to shift public opinion or pressure legislators

Key Takeaways

- Relationships matter: Know your legislators; they are more likely to listen to constituents they know

- Stories + data: Lead with human impact; reinforce with evidence

- Inside + outside: Combine relationship-building with public pressure

- Persistence wins: Keep showing up, session after session, year after year

- Electoral power: Sometimes you need to change who's in office, not just their mind

- You belong: Advocates with lived experience are powerful and necessary—policy is not just for "experts"

Q&A Highlights

Q: I've never done advocacy before. How do I start?

A: Start by identifying one issue you care about. Find an organization working on it and join them. Attend a lobby day or advocacy training. Meet with your local legislators. You don't need to be an expert—your story and your vote matter.

Recommended Resources

- Find your legislators: Find your representatives and their contact info - usa.gov/elected-officials

- Track legislation: See bill status and voting records - legiscan.com

- Policy analysis: KFF (kff.org), Center on Budget and Policy Priorities (cbpp.org), Health Affairs

- Training: Community Catalyst, Center for Community Change offer advocacy training

Webinar 4: Social Determinants of Health - From Theory to Practice

Date: December 5, 2025 | Duration: 60 minutes

Session Overview

This hands-on webinar moved beyond the concept of social determinants to practical implementation. The session shared a health center network's journey to systematically address SDOH, including workflow design, staff training, community partnerships, technology solutions, and outcome measurement. Downloadable tools and templates were provided for organizations to adapt.

Implementation Framework Presented

Phase 1: Foundation (Months 1-3)

- Leadership commitment and resource allocation
- Select screening tool (PRAPARE or AHC)
- Form implementation team (clinical, IT, operations, community health workers)
- Pilot in 1-2 clinics before scaling

Phase 2: Build Capacity (Months 3-6)

- Integrate screening into EHR workflow
- Train all staff on purpose, process, and trauma-informed approach
- Map community resources and build referral relationships
- Establish closed-loop referral system with community partners
- Hire and train community health workers for navigation

Phase 3: Scale and Sustain (Months 6-12)

- Scale screening to all clinics and visit types
- Refine workflows based on pilot learnings
- Develop dashboards to track screening rates, identified needs, and referral outcomes
- Engage in continuous quality improvement

- Pursue sustainable financing (value-based contracts, grants, Medicaid)

Phase 4: Intervene and Evaluate (Year 2+)

- Implement direct interventions (food programs, housing support, care coordination)

- Measure impact on health outcomes, utilization, and costs

- Share data to inform policy and secure additional funding

- Advocate for systemic change to address root causes

Results from Health Center Network Implementation

- Screening rate: 78% of adult patients screened in past year

- Needs identified: 42% food insecurity, 31% housing instability, 27% transportation barriers

- Resource connections: 68% of patients with identified needs successfully connected to resources

- Health outcomes: Patients receiving SDOH support had 0.4% greater A1C reduction than those declining services

- Utilization: 18% reduction in emergency department visits among high-risk patients receiving navigation

- ROI: $2.10 saved in healthcare costs for every $1 invested in screening and navigation

Challenges and Solutions

Challenge: Staff resistance - "This isn't our job"
Solution: Education on how social needs affect health; reframe as patient-centered care; demonstrate impact

Challenge: Lack of resources to offer
Solution: Start by mapping existing resources; build partnerships; advocate for new services; don't screen unless you can help

Challenge: Time constraints
Solution: Use tablets in waiting room; offer take-home option; integrate brief verbal screening; use CHWs for follow-up

Challenge: Sustainability
Solution: Document outcomes; negotiate value-based contracts; pursue grants; advocate for Medicaid coverage of SDOH services

Key Takeaways

- SDOH drive 80% of health outcomes; addressing them is core to health improvement

- Screening alone doesn't improve health; must connect people to resources and track outcomes

- Cross-sector partnerships are essential; health systems can't solve SDOH alone

- Community health workers are high-value investment for navigation and follow-up

- Start small, learn, iterate; don't wait for perfect system

- Advocate for policy change while addressing individual needs

Recommended Resources

- PRAPARE Toolkit: prapare.org - Free screening tool and implementation guide

- AHC Screening Tool: cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/hcia - CMS resource

- Aunt Bertha / findhelp.org - Resource database for referrals

- SIREN (Social Interventions Research & Evaluation Network): sirenetwork.ucsf.edu - Research and tools

Webinar 5: Addressing Maternal Health Disparities

Date: January 8, 2026 | Duration: 75 minutes

Session Overview

This powerful session confronted the U.S. maternal health crisis head-on, with particular focus on racial disparities. The session combined data, personal stories, and practical solutions. It shared experiences of Black mothers whose concerns were dismissed with tragic consequences, and detailed systemic changes that health systems have implemented to improve outcomes and reduce disparities. The session was both sobering and hopeful.

Key Concepts Covered

- U.S. maternal mortality crisis: 22.3 deaths per 100,000 births; highest among high-income nations; rate increasing

- Stark racial disparities: Black women 3-4x more likely to die than white women; disparities across all income/education levels

- Preventability: 60% of maternal deaths are preventable with quality care

- Leading causes: Cardiovascular conditions, infection, hemorrhage, hypertension, cardiomyopathy

- Postpartum period: 52% of deaths occur postpartum when coverage often lapses

- Role of racism: Implicit bias, discrimination, differential treatment explain disparities more than underlying health

- Evidence-based interventions: Doulas, midwives, quality improvement bundles, extended postpartum coverage

Personal Story: "They Didn't Believe Me"

"I was supporting a Black mother, Shanice, through her second pregnancy. At 34 weeks, she told her doctor she had a severe headache and swelling. He said it was normal, told her to rest. She called the advice nurse two days later—same symptoms plus blurred vision. Nurse said to come in if it got worse. The next day, Shanice had a seizure— eclampsia. Her baby was delivered by emergency C-section at 35 weeks. Both survived, but it was preventable. Her symptoms were textbook preeclampsia, but no one took her

> *seriously. When white women report those symptoms, they get immediate blood pressure checks and lab work. Shanice nearly died because she wasn't believed."*

System-Level Solutions for Maternal Health

1. Evidence-Based Safety Bundles (AIM Program):

- Obstetric hemorrhage bundle: Quantitative blood loss measurement, hemorrhage carts, rapid response protocols

- Severe hypertension bundle: Immediate treatment protocol for blood pressure >160/110; standing orders; education

- Opioid use disorder bundle: Screening, medication-assisted treatment, warm handoffs to treatment

- Obstetric care for women with obesity bundle: Protocols for safe care; respectful communication training

2. Anti-Racism and Implicit Bias Initiatives:

- Mandatory implicit bias training for all maternity care providers

- Patient advocacy: Doula support for all high-risk patients; patient advocates in labor and delivery

- Listen to Black women: Implemented "I Speak Up" campaign encouraging women to voice concerns; providers must document response

- Respectful maternity care training: Module on historical trauma, current discrimination, and respectful communication

- Accountability: Patient experience surveys specifically ask about respectful care; results included in provider evaluations

3. Workforce Diversity and Midwifery Integration:

- Recruitment: Pipeline programs, scholarships, mentorship for Black and Latino students entering midwifery and obstetrics

- Midwifery expansion: Integrated certified nurse-midwives for all low-risk births; collaborative care with physicians

- Doula program: Hospital employs community doulas; Medicaid reimbursement; prioritize Black and Latino women

4. Extended Postpartum Care:

- Extended coverage: Advocate for Medicaid 12-month postpartum coverage; ensure private insurance covers comprehensive postpartum visits

- Enhanced postpartum visit: Blood pressure check, depression screening, contraception counseling, chronic disease management

- Outreach: Phone calls at 3, 7, and 14 days postpartum; home visits for high-risk patients

- Telehealth: Virtual postpartum visits increase attendance

Results After 3 Years

- Severe maternal morbidity decreased by 21% overall; 28% among Black women

- Cesarean section rate decreased from 32% to 26%

- Postpartum visit attendance increased from 58% to 79%

- Patient satisfaction with respectful care increased from 71% to 89%

- Racial gap in severe morbidity narrowed by 35% (not eliminated but improving)

Key Takeaways

- The maternal health crisis is a human rights issue, not an inevitability

- Racism—not race—drives disparities; implicit bias and discrimination are real and measurable

- Black women deserve to be believed, respected, and given high-quality care

- Doulas and midwives improve outcomes, especially for women of color

- Quality improvement works: Safety bundles and protocols save lives

- Postpartum period is high-risk; extended coverage and follow-up are essential

- We can't train our way out of racism; must pair education with accountability and system change

Q&A Highlights

Q: How can I support a pregnant friend or family member who's experiencing discrimination?

A: Believe her. Validate her experience. Offer to attend appointments as a support person. Help her document concerns. If needed, help her find a new provider who will respect her. Connect her to a doula.

Q: What's the single most important thing hospitals can do?

A: Implement the AIM safety bundles, particularly for hemorrhage and hypertension. These are evidence-based, proven to save lives, and free to access. No hospital should delay.

Recommended Resources

- AIM Program: saferbirth.org - Free safety bundles and implementation toolkits
- Black Mamas Matter Alliance: blackmamasmatter.org - Advocacy and resources
- National Birth Equity Collaborative: birthequity.org - Training and technical assistance
- March of Dimes: marchofdimes.org - Data and advocacy on maternal and infant health
- Find a doula: DONA International (dona.org) or local doula collectives

Access and Continuing Education Information

How to Access Webinar Recordings

All webinar recordings, presentation slides, transcripts, and supplementary materials are available free of charge on our website.

Website: bridgetohealthequity.org/webinars
Email: education@bridgetohealthequity.org
Phone: (555) 123-4567

Accommodations Available:

- Closed captions on all video recordings

- Full transcripts in PDF and Word formats

- Spanish language interpretation and materials (contact us 1 week in advance for live webinars)

- Accessible presentation slides (screen reader compatible)

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- Nurses: Contact hours available through our accredited provider

- Physicians: AMA PRA Category 1 Credits (application pending for future webinars)

- Social Workers: Approved for NASW continuing education credits

- Community Health Workers: CHW continuing education certificates available

To claim CE credits, you must watch the full recording and complete a brief evaluation and quiz. Credits are issued within 2 weeks.

Upcoming Webinars (Spring 2026)

- February 12: Climate Change and Health Equity

- March 19: Addressing Health Equity in Rural Communities

- April 23: Youth Mental Health and Trauma-Informed Schools

- May 14: Food as Medicine: Implementing Produce Prescriptions

- June 11: Racism as a Public Health Crisis: Moving from Declaration to Action

Register at bridgetohealthequity.org/webinars. All webinars are free and recorded.

Custom Training for Your Organization

We offer customized training and technical assistance for healthcare organizations, community-based organizations, government agencies, and coalitions. Topics include:

- Health equity 101 and foundational concepts
- Implicit bias and structural racism in healthcare
- Implementing social determinants screening and referral
- Building community partnerships
- Cultural humility and trauma-informed care
- Policy advocacy skills

Training formats: Half-day or full-day workshops, multi-session series, train-the-trainer, ongoing consultation.

Contact: training@bridgetohealthequity.org to discuss your needs and request a proposal.

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