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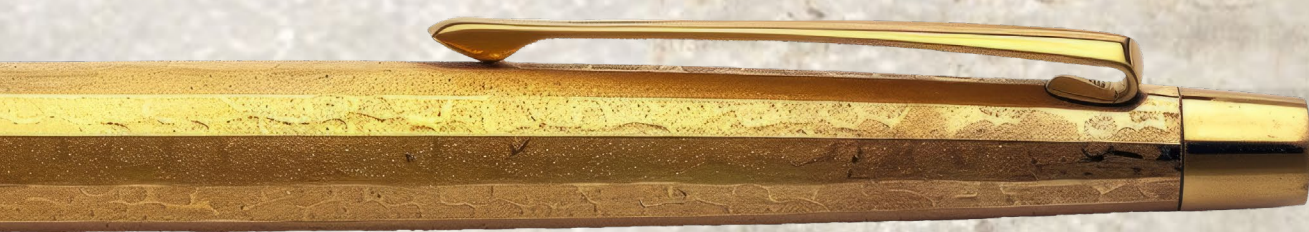
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Medicaid Expansion Benefits Rural and Urban Communities, Near-Retirees, Veterans, Essential Workers, and the Working Poor – 230,000 Missourians

Published in July 2020



A yes vote for Amendment 2 on August 4, 2020 would extend benefits to more than 230,000 hardworking Missourians, many of whom make up the state’s essential workforce. Missouri Medicaid expansion will deliver health care coverage to individuals earning up to \$18,000 per year, and \$30,000 for a family of three.

This access is critical to Black Missourians, who have been disproportionately impacted by the coronavirus. Nationally, Black people are infected at a rate 2.4 times higher than Whites and 2.2 times higher than Latinxs and Asians. To date, more than 26,000 Black people have died from COVID-19. This number is expected to increase as new cases continue to surge. According to Healthcare for Missouri, an expanded version of Medicaid would cover 36,000 more Black Missourians.

Even after COVID-19 ripped the veil off health care disparities among people of color, the current administration remains motivated to repeal the Affordable Care Act (ACA), which included 203,000 Missouri enrollees in 2020. If successful, this could mean many more uninsured Missourians with no access to health care.

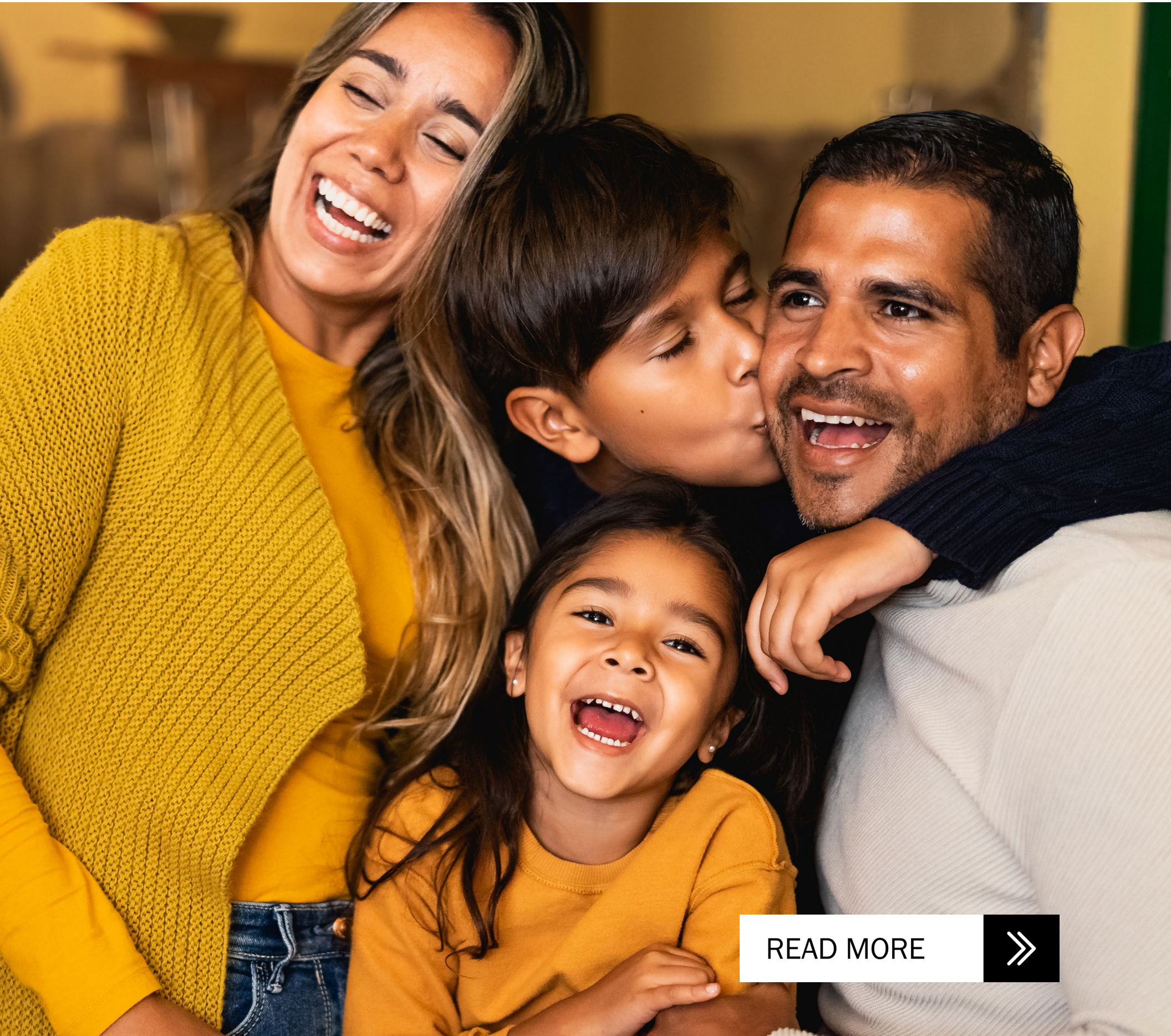
This makes a yes vote on Amendment 2 even more imperative. Additionally, a yes vote on Amendment 2 will provide health care to [working] Missourians whose employers do not offer health care, or who have lost their jobs and face economic uncertainty. Prior to the pandemic, Missouri’s uninsured rate was 9.4%. With pandemic-related job losses, The Urban Institute estimates the uninsured rolls will increase by more than 40% in non-expansion states, compared with less than a quarter in expansion states. If a bright red state like Oklahoma can pass Medicaid expansion, certainly Missouri can become the 38th state to deliver health care to individuals who need it the most.

The state also benefits. According to a study commissioned by the Missouri Foundation for Health (MFH) and conducted by Regional Economic Models, Inc., (REMI), it is projected Amendment 2 would bring more than 16,000 new jobs to the state per year, boost economic output by \$2.5 billion, and increase personal income in the state by \$1.1 billion, or more than \$500 per household. REMI also projects nine in 10 of the new jobs will pay more than \$15 per hour.

Missouri also benefits by bringing home its tax dollars, dollars that have bypassed this state and benefited expansion states. The federal government will pay 90% of the costs, leaving Missouri to cover the remaining 10%. To put this into perspective, Missouri covers 35% of MO HealthNet, the state’s current Medicaid program. Economists say tax revenues generated by economic growth and new job growth will help offset Missouri’s 10% contribution to Medicaid expansion, positioning the state to realize some of the same economic gains as other expansion states.

If Amendment 2 does not pass, Missouri’s tax dollars will benefit the other 37 states that expanded Medicaid. It could also foster more rural hospital closures. A recent report from the Chartis Center for Rural Health says that 2019 was the worst year for rural hospitals this decade, with 19 rural hospitals shutting their doors. The report, published in February 2020, also says nearly one in every four open rural hospitals is showing early warning signs that closure may be imminent soon. In Missouri, 15 hospitals have closed since 2014, and 10 were in rural communities.

We have the power to make life just a bit better for those who have been left behind. Quite frankly, some of these individuals are our family members.



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Health Care is a Human Right: Making a Case for Medicaid Expansion in Kansas

Published in January 2022

Earlier this year, Missouri became the 39th state to expand Medicaid coverage, providing access to affordable health care to more than 200,000 newly eligible adults. Kansas is now completely landlocked by states that have decided to adopt and implement Medicaid expansion. In neighboring states, expanded coverage and eligibility requirements have made better quality health care more accessible to more people. As for the majority of Kansans, they say – it’s our turn.

Barriers to health care, including high costs of insurance, have kept necessary care out of reach for many. Fear of high hospital bills keeps people from seeking care until it’s absolutely necessary, increasing not only emergency room visits but also preventable injuries, illnesses, and deaths. Affordable health insurance allows individuals to invest in their health, allowing patients and providers to develop a cost-effective, high-quality continuum of care.

Recently, more than 160 community leaders came together to discuss the need to expand Medicaid in Kansas. “Business, Faith, Health: Why Medicaid Expansion is Right for Kansas” explored the justifications for Medicaid expansion not only from a health and economic perspective, but from a place of faith and compassion as well.

The panel of speakers featured Joe Reardon, president and CEO of the Greater Kansas City Chamber of Commerce, Reverend Dr. Nanette Roberts, senior pastor of Grace United Methodist Church in Olathe, and Dr. Robert Simari, executive vice chancellor of the University of Kansas Medical Center.

Improving Public Health

Dr. Simari began by highlighting the effect that social determinants of health can have on a person’s wellbeing, regardless of the quality of care being given by their providers. The result is disproportionate health statuses across communities, with life expectancies changing just by crossing a block. To combat this, he believes the solution is a coordinated payer system that works to eliminate some of the barriers keeping people from accessing and investing in routine care.

“It’s estimated that Medicaid expansion in Kansas would cover about 165,000 Kansans, with two-thirds of those working full-time,” he said. “For those individuals who are uninsured or under-insured, they’re going to get sick at a higher rate than if they have preventative or maintenance care, and they’re going to receive care in emergency rooms or other health care settings that may be too late and too expensive.





“A God of generosity and hospitality asks all of us to look at those who are the weakest in our community and ask ourselves, ‘How do we in fact find a way to offer access to healthy lifestyles?’”

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Reproductive Rights: The Search For Common Ground

Published in October 2022



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I like to believe most people wish to make the world a better place. I like to believe most people would say that everyone has value. I like to believe most people want the best for humanity and the planet we call home, even if we disagree about exactly what that means. And I like to believe those shared goals make it possible, even in today's violently polarized world, to have real conversation about our beliefs.

Even as it becomes increasingly obvious how politics directly impact the health and safety of ourselves and our neighbors, our families and our friends, as more and more personal pain becomes attached to hotly-debated topics, I believe in the power of political discourse from a place of mutual desire to make the world a better place. Maybe that faith makes me an optimist, but believing common ground is impossible makes common ground impossible. Now, more than ever, we must at least try.

Let me propose this, then, as our starting point: All people have value.

We all matter just because we're human. That statement sounds straightforward, but what does it actually mean to say that everyone has value? The answer to that question, I believe, holds the key to the common ground that today so desperately needs.

The trolley problem is the most famous way to examine the question. It goes like this: a trolley is headed for five people who are stuck in its path.

The trolley problem is what's called a "thought experiment," in which you are faced with an imaginary problem in order to measure what you instinctively feel is the right thing to do. When polled, the vast majority of people (around 90%) consistently choose to divert the trolley so that one person dies and five others live.

Doing the most good for the most people seems obvious, but killing one to save five is not always the popular answer. In another thought experiment, a hospital admits six new patients: five in desperate need of organ transplants, and one perfectly healthy person. Should the surgeons kill the healthy patient and harvest those organs to save the lives of the five others? Here, very few people believe the right thing to do is kill the one to save the five — but if the math is the same, what's the difference?

Though it may seem complicated, the answer is simple: We tend to disagree with treating people as a means to an end, instead of as ends unto themselves.

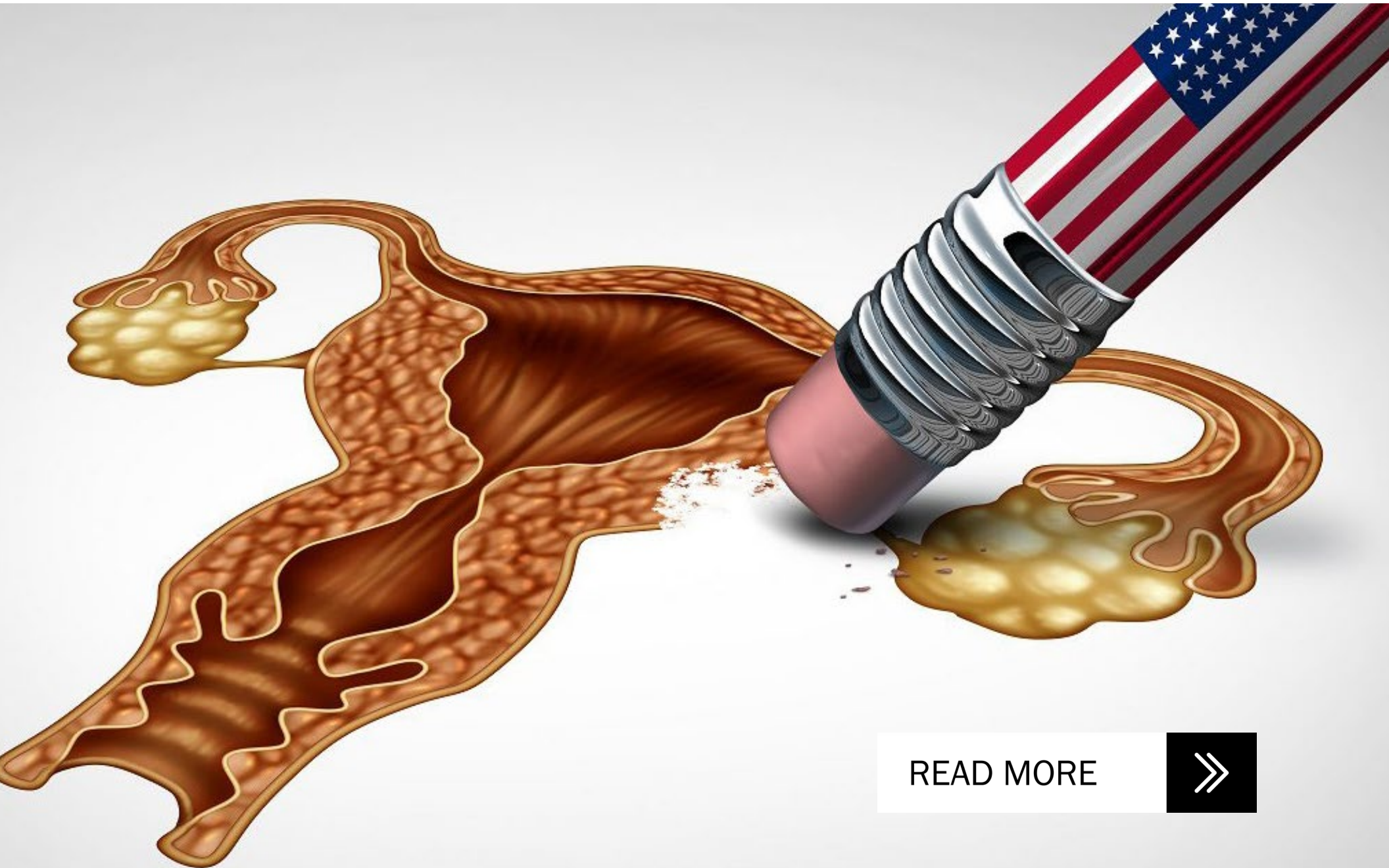
In the trolley problem, we find sacrificing one to save five morally acceptable because diverting the trolley is what would save the lives of the five others. The death of the one person is a consequence of diverting it, not the means by which the five could be saved. If, instead, you had pushed someone in the way of the trolley to stop it before it killed the five people, then the pushed person's death would be the means by which you saved the five.

By treating someone as a means to an end, we make them into a tool to accomplish our goals without allowing them a say in what happens to them. When surveyed about thought experiments, most people are, predictably, much less favorable of choices which use a person as a means to an end. At last, we seem to have an answer for our earlier question: What does it mean to say all people have value? No one should be treated as a means to an end. We are all ends unto ourselves; we are all worthwhile goals. Naturally, with our answer comes a hundred new questions. What does that mean for politics? For medicine? Surely, if health care is all about taking care of people, then it must never treat people as a means to an end.

Well, as a quick review of the infamous Tuskegee Experiments will tell you (among a thousand other cases of doctors and scientists using the bodies of people of color in appalling ways), that's unfortunately not the case. From policy to practice, medicine still fails to avoid treating people as a means. Now, reproductive health care is at the epicenter of this failure.

Facing red tape around many kinds of contraceptives, ignored in favor of the husband's wishes, and increasingly unable to easily access abortion care, anyone with a uterus is at constant risk of being reduced from a person to a means of birthing.

If we want to find common ground and work together to create change, to make the world a better place, we have to start with understanding why we believe what we believe. Everyone matters. Everyone deserves a better world, and that world starts with us working together to make it better.



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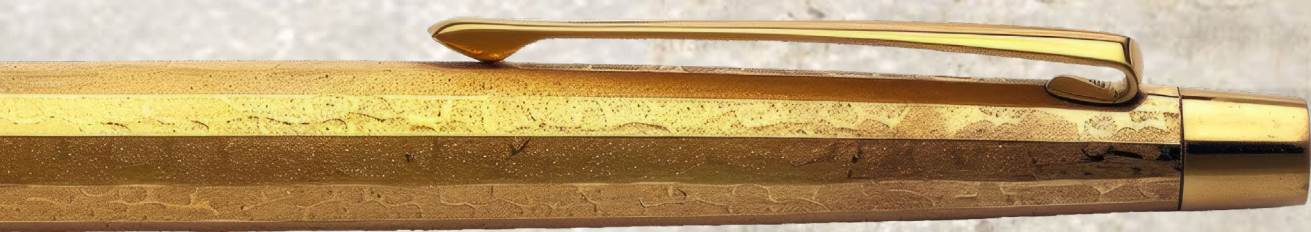


ake action for health equity.

Materno



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Marijuana Use During Pregnancy Discouraged, Impact Remains Unknown

Published in June 2022

According to NIH's National Institute on Drug Abuse, animal research suggests that the body's neural system receptors play a role in controlling the brain's maturation, particularly in the development of emotional responses. Thus, THC (tetrahydrocannabinol – the main mind-altering ingredient found in marijuana) exposure very early in life may negatively affect brain development.

The medical community contends that more research is needed to know how marijuana use during pregnancy impacts the health and development of infants. With an increased use of recreational marijuana as new policies have made the drug legal in 19 U.S. states, and significant increases in pregnant women seeking treatment for substance use disorder, it's integral that funding is allocated to learn more about the effects of marijuana use during pregnancy.

One study found roughly 20% of pregnant women 24-years old and younger screened positive for marijuana. This revealed they are twice as likely to screen positive for marijuana use when drug tested as opposed to self-reporting. Research in rats, the NIH reports, reveals exposure to even low concentrations of THC late in pregnancy could have profound and long-lasting consequences for both brain and behavior in offspring.

NIH contends that school children prenatally exposed to marijuana are more likely to show gaps in problem-solving skills, memory and the ability to remain attentive.

Medical researchers agree that more research is needed to segment marijuana's specific effects from environmental factors and use of other substances by mothers.

Because roughly half of U.S. pregnancies are unplanned – with the rate considerably higher for teens and young adults – many women use marijuana without knowing they are pregnant.

A different school of thought

The American College of Obstetrics and Gynecology (ACOG) reports that somewhere between two percent and five percent of women say they used marijuana while pregnant. And since the drug crosses the placenta, harm to the fetus is plausible although the evidence is still unreliable. A review and analysis of 31 previously published studies have found no independent connection between marijuana use and adverse births.





One other study conclusion is that women who used only tobacco during pregnancy or only marijuana – and those who used both – were also four to seven times more likely than women who used neither to have depression or anxiety.

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Black Midwives and Doulas Are Central to Birth Justice

Published in July 2022



Black women in the United States continue to face maternal mortality rates nearly 3.5 times higher than their white counterparts, according to the latest data from the Centers for Disease Control and Prevention (CDC). While overall U.S. maternal mortality rates have declined since their peak in 2021, Black maternal mortality remains alarmingly high, with 50.3 deaths per 100,000 live births recorded in 2023—one of the highest rates among high-income nations..

The social determinants of health (SDOH)—such as access to care, economic stability, and racial bias in medical settings—continue to shape these disparities. Research shows that more than 80% of pregnancy-related deaths are preventable, yet racial inequities persist due to deeply embedded systemic factors.

Amid these disparities, Black midwives and doulas play an essential role in improving maternal outcomes. Community-centered birth workers, who have long provided holistic, culturally aligned care, are at the forefront of the birth justice movement—a framework that recognizes childbirth as a human rights issue and seeks to address the structural barriers leading to poor maternal health outcomes.

The Black Mamas Matter Alliance (BMMA), a national organization advocating for Black maternal health, convenes experts to discuss these pressing challenges.





Grand midwives—who traditionally served as healers, birth attendants, and abortion providers—were systematically removed from practice as medical institutions pushed for hospital births and physician-led care.

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Altruism, Inc. and The MalH Center Push Forward as Barriers Grow

Published in March 2025

More than a year after its launch, The Maternal and Infant Health (MalH) Center in Lexington, Missouri, continues to be a critical resource for expectant parents in Lafayette County and in urban areas in Missouri and Kansas. Established by Altruism, Inc., a 501 © (3) non-profit, to address maternal health disparities, the Center provides whole-person care—offering prenatal education, doula and midwifery support, postpartum services, and essential supplies such as diapers, car seats, and clothing.

Missouri has one of the highest maternal mortality rates in the U.S., and the crisis is especially severe in rural areas. According to the Missouri Department of Health and Senior Services, nine of the 10 Missouri counties with the highest infant mortality rates are rural, where the absence of adequate health care services puts expectant parents at greater risk. For many families in rural Lafayette County, the nearest OB-GYN is more than 45 minutes away, making consistent prenatal and postpartum care difficult to access.

The MalH Project launched in 2022 as a pilot project in the Kansas City area. A year later, The MalH Center, a pregnancy center, was established to provide relationship-based maternal care in Lafayette County. Now, more than a year later, staff members and partners reflect on its progress, ongoing challenges, and the work ahead.

Since opening in November 2023, The MalH Center has delivered comprehensive prenatal and postpartum care to families who otherwise might not have access. The center provides:

- Doula and midwifery services that support expectant parents through pregnancy, labor, and postpartum recovery, with a primary focus on rural families in Lafayette County and surrounding areas. To date, nearly 140 expectant parents have received doula support, and whole-person maternal care – reinforcing the Center's role as a trusted resource in the community.
- Educational programming to help families understand their birth options, create birth plans, and navigate pregnancy-related health concerns.
- Essential baby supplies, including diapers, clothing, and car seats, through partnerships such as Happy Bottoms. The Center has distributed more than 5,100 diapers to families in need.
- More recently, The MalH Center has partnered with a rural-based mental health care provider that offers counseling services on site for birthing people during prenatal and postpartum stages.





“We have such a dedicated team, our doula, midwifery, community health workers, and support staff put their hearts and souls into this work. Everyday, I see the work ethic and commitment they expend to serve the greater good.”

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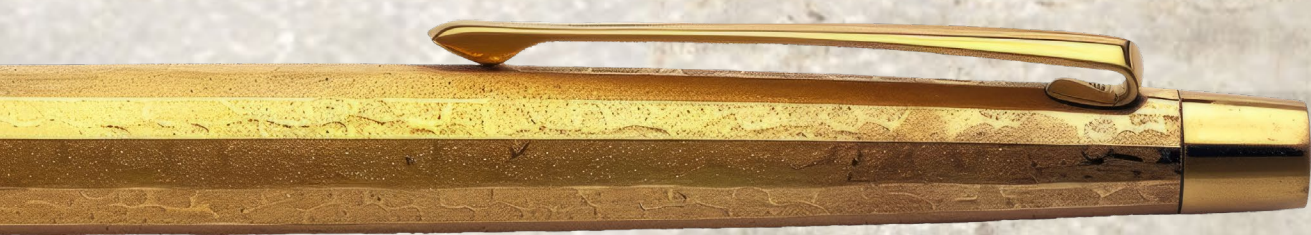
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The ‘Weathering’ Of Black Women And Its Implications on Health And Mortality

Published in August 2020

If you are fatigued from the hate-filled vitriol televised or posted daily, you are in good company... so is former First Lady Michelle Obama. In the second episode of her new podcast, The Michelle Obama Podcast, she spoke with friend Michele Norris and former longtime host of NPR’s All Things Considered. “I know that I am dealing with some form of low-grade depression,” Mrs. Obama said. “Not just because of quarantine, but because of the racial strife, and just seeing this administration, watching the daily hypocrisy of it all, day in and day out, is dispiriting.”

Racism, discrimination, and marginalization are the prerequisites for depression, anxiety, PTSD, and other disorders that fuel racial health care disparities. Arline Geronimus, Sc.D., Professor of Public Health at the University of Michigan, calls this “weathering, the cumulative effect of stress resulting from racial discrimination, long-term exposure to environmental toxins, redlining that limits essential services, disproportionate victimization by crime...” and the proverbial list for people of color continues. Geronimus likens weathering to the body’s way of eroding due to constant stress and marginalization.

In ScienceDirect’s published abstract on Racial Differences in Weathering and its Associations with Psychosocial Stress: The CARDIA Study, biological age (BA) is defined as a “construct that captures accelerated biological age attributed to wear and tear from various exposures.” The weathering hypothesis, which Geronimus coined, is now recognized by scholars and researchers as the measured distance from BA and chronological age, and how that dichotomy correlates with race and psychosocial factors.

According to the authors, experiences of racism that lead to stress and anxiety can manifest for some black people in three harmful ways: perceptions of lack of control over one’s environment; internalized racism and negative self-evaluation; and avoiding distressing emotions.

The article states that one in four black Americans will experience an anxiety disorder at some point in life and is more likely to suffer from social anxiety disorder. According to the article, symptoms associated with anxiety persist longer for black Americans compared with the general population.



The CARDIA (Coronary Artery Risk in Young Adults) study backs this up. It used a middle-aged, bi-racial cohort in four U.S. cities from 1985-2016 to examine weathering for adults aged 48-60 years.

Using selected biomarkers (measurable factors that indicate disease, infection, environmental exposure, etc.), the study assessed overall race-specific associations between weathering and psychosocial measures.

For the 2,694 participants, blacks had a BA 11.8 years older than their chronological age, compared with whites, who had an average BA 10.0 years younger than their chronological age.

Some of these conclusions were bizarre and far-fetched, like the “hypertension gene” that followed slaves from Africa onto slave ships and through the Middle Passage, infusing surviving slaves with a propensity for salt retention, thus making them more susceptible to hypertension. Geronimus said that notion was easily debunked as American blacks and blacks from the Caribbean both went through the Middle Passage, yet American blacks have a far higher rate of hypertension.

In more recent years, research and genetic science dispelled the DNA myth and embraced Geronimus’ weathering theory. In an NPR story, Making the Case that Discrimination is Bad for Your Health, Geronimus explains weathering as chronic stressors that afflict people of color as [lifetime] stressors, often occurring in young adulthood through middle age as opposed to earlier in life.

Social injustice and health inequity run in the same circle. Solutions to counteract the physio-psychological weathering of black people is more than complex.



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Mental Health Equity Requires a Reckoning with Medical Racism

Published in August 2021

In a recent installment of a webinar series titled “Racial Equity and Mental Health,” panelists examined the importance of providers contextualizing medical racism when helping patients of color. “The Big Picture: The History of Mental Health and Race” explored the history of race and epidemics in the U.S. and a timeline of global health care advancements. Together they painted a broader picture: There is a well-documented history of providers aligning themselves with the oppressive side of systemic racism. Racial equity in health care is not achievable without first acknowledging this history and actively working to provide a safe, comfortable, and trusting experience for patients of color.

Race and Epidemics in the U.S.

Throughout the COVID-19 pandemic and national vaccination efforts, examples of racism in medical history were brought to light as reasons for caution. Black Americans hesitant to receive a vaccine pointed to the Tuskegee experiments as one example of many to be wary of trusting providers. While the intention to achieve herd immunity is positive, some vaccine campaigns may have alienated Black people by failing to recognize or validate their concerns. Lacking the historical context of racism in health care both weakens patients’ trust in medical professionals and allows for more risk of malpractice.

According to panelist Kirby Randolph, Ph.D., observing and tracking what happened to slaves and newly freed Black Americans throughout health epidemics was not a priority. Because of this, the medical research we have on these health crises lacks countless experiences. Dr. Randolph pointed to the 1792 Yellow Fever epidemic in Philadelphia where Black people were believed to be immune and were therefore excluded from treatment and data collection. Similar mishandling of Black experiences occurred throughout the smallpox and HIV epidemics.

Slavery created the furthest-reaching loss of Black lives. Possessing the want for freedom, considered a mental illness in slaves at the time, was one of many reasons a slave could be killed or sold. “If you had serious mental illness – depression, delusions, mania, hallucinations – and you were property of someone else, that person could dispose of you in any way they see fit,” said Dr. Randolph. Slave owners sometimes chose to disguise disabilities and frailties in slaves to sell them for a profit. Aggressive slaves were sedated with alcohol, morose slaves were given cocaine to look lively or dance, and hair and faces were often painted to look more youthful.

Physicians attended auctions along with slave owners to vouch for the soundness of slaves. “You see how the physicians had the interests of slave owners in mind,” said Dr. Randolph.



Providers especially need to educate themselves and their teams on implicit biases, the historical context of racism in medicine and how these combine to create health disparities.



Today, health providers may alienate Black patients by refusing to consistently bring this historical context into their practices, according to Dr. Randolph. “If your mental health center didn’t say anything about Trayvon Martin, Mike Brown, police brutality, or the deaths of people in police custody, but suddenly decided last summer that Black lives do matter, and now are saying ‘trust us, get the vaccine, you’re ignorant if you don’t – we don’t have to go back to Tuskegee,’” she said.

“If Black lives did not matter until last year, you can trust that your staff and patients remember that.” Dr. Randolph said openly recognizing and acknowledging patients’ real-world stressors, such as police brutality and racism, as well as their strengths and ambitions, builds trust. “This is 400 years of disparate health outcomes and it’s not going to be fixed immediately, but having these acknowledgments is a good first step.”

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There Is A Mental Health Crisis Among Black Youth in the United States

Published in July 2024

The mental health crisis among Black youth in the United States is a pressing issue that requires immediate attention. The intersection of systemic racism, socioeconomic disparities, and cultural stigma has created an environment where Black youth are particularly vulnerable to mental health challenges. This essay explores the multifaceted nature of this crisis, examines the contributing factors, and highlights the need for comprehensive solutions to address the mental health needs of Black youth.

Federal data reveals that in 2022, the suicide rate among Black youth aged 10 to 19 exceeded that of their white peers for the first time, marking a 54% increase since 2018. In contrast, the suicide rate for white youth decreased by 17%. The suicide rate among Black adolescents is rising faster than in other racial and ethnic groups, with a 144% increase observed from 2007 to 2020 among Black individuals aged 10 to 17. Despite a general decline in the overall youth suicide rate, this data highlights the urgent need to enhance and address mental health care for Black communities.

Black youth face significant mental health challenges that are often exacerbated by their social and economic conditions. According to a report by the Congressional Black Caucus, Black youth are more likely to experience severe psychological distress, yet they are less likely to receive mental health treatment compared to their white counterparts.

The National Institute of Mental Health (NIMH) indicates that suicide rates among Black youth have increased dramatically over the past decade, making suicide the second leading cause of death for Black children ages 10 to 14, and third for those ages 15 to 19. These alarming statistics underscore the severity of the mental health crisis facing Black youth.

Contributing Factors to the Mental Health Crisis

Systemic Racism and Discrimination: Black youth are often subjected to systemic racism and discrimination, leading to chronic stress, anxiety, and depression. Experiences of racism in schools, communities, and through the media can negatively impact their mental health. A study published in the Journal of Clinical Child and Adolescent Psychology found that perceived racial discrimination is associated with increased depressive symptoms in Black adolescents. Systemic racism also plays out within the medical field and results in inadequate access to mental health services. Black youth often face barriers to accessing quality mental health care, including a lack of culturally competent providers, financial constraints, and limited availability of services in their communities. The Health and Human Services Office of Minority Health reports that Black Americans are less likely to have access to mental health services and are more likely to receive poor-quality care when they do seek help.





The mental health crisis among Black youth is a complex issue that demands urgent and comprehensive action. Addressing this crisis requires a concerted effort from policymakers, mental health professionals, educators, and community leaders to create an environment where Black youth can thrive.

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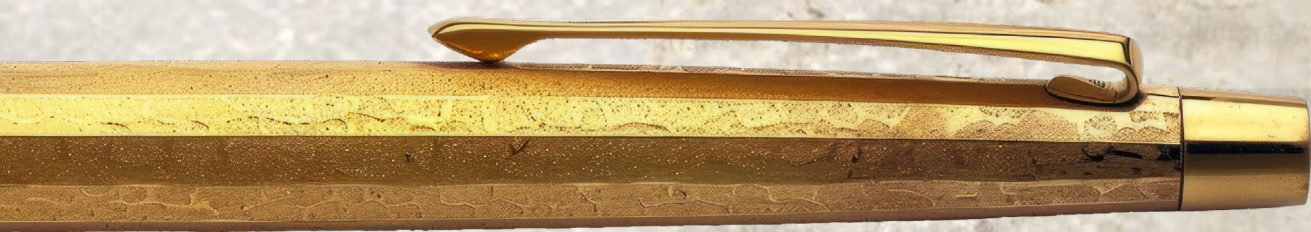


tion tips and resources.

Racial



Equity



Countering Racism Requires Understanding and the Will to Activate Privilege and Influence

Published in July 2020



The recent killing of George Floyd has intensified the hurt and anger from years of targeted violence, oppression, and racism that many Black Americans have endured. With days of social unrest, there is a sense of sheer devastation about the role race plays in American culture.

Parents of black children pray their sons and daughters are never listed among the litany of black people who have been unmercifully killed by police. They pray the younger generation will accomplish what their generation couldn't – demanding parity among all people, the kind of parity that evens the scales, and levels the playing field.

As this country experiences a reckoning with centuries of racist acts, practices, and brutality, there is a shift in the atmosphere. The veil has lifted. Now, the putrid stench of an American way of life, dressed up in the guise of democracy, is exposed for the world to see.

Many parents of black boys made it a point to have “the talk” with their sons before they reached middle school. These boys received explicit lessons about how to respond if ever approached by a police officer. These lessons were reinforced as they grew older. In the last few years, it has become apparent that this talk should be extended to their daughters, too.

Many white Americans are having the talk, as well. This one is not about the dos and don'ts when approached by the police. Instead it's about white privilege – defined by Oxford as inherent advantages possessed by a white person based on race in a society characterized by racial inequality and injustice.

The truth is, so-called white privilege will continue to lace American culture as long as white people leverage this false sense of superiority to maintain the higher rung within the power dynamic – at the expense of people of color.

Oxford defines racism as prejudice, discrimination, or antagonism directed against a person or people based on their membership of a particular racial ethnic group, typically one that is a minority or marginalized. Merriam-Webster defines racism more simply as belief that certain races of people are by birth and nature superior to others; or, discrimination or hatred based on race.

Racism is also referred to as a variety of practices, beliefs, social relations, and phenomena that work to produce a racial hierarchy and social structure that yield superiority, power, and privilege for some, and discrimination and oppression for others. Racism typically manifests in seven different forms: representational, ideological, discursive, interactional, institutional, systemic, and structural.

It is important to know the faces of racism, so that when it shows up, it is recognized and confronted.



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Generations of Activism: What One Woman Can Do

Published in March 2021

Shedding light on injustice was a way of life for activist Ida B. Wells. As an investigative journalist, she wrote of the horror of lynchings, indignities, and violence she witnessed against Black people. As cofounder of the National Association for the Advancement of Colored People (NAACP), she spoke out against the atrocities of systemic racism. As a suffragist, she marched and protested for a woman’s right to vote, refusing to walk behind white women leading the cause.

“She was on a rampage to tell the whole world of the atrocities being committed,” says Michelle Duster, who is Ida B. Wells’s great-granddaughter and author of the newly released *Ida B. the Queen: The Extraordinary Life and Legacy of Ida B. Wells*. “She clearly knew she was facing danger and continued writing and speaking out against injustice. By her actions, she felt the fight was worth potentially dying for.”

Wells was born in 1862 in Mississippi and died in Chicago in 1931. She blazed trails along the way. In the book, Caitlin Dickerson of *The New York Times* states, “Wells is considered by historians to have been the most famous Black woman in the United States during her lifetime.”

Today, generations later, there are women—activists—who have taken up her cause and carry on her legacy, trying to shed light on the truth.

Carrying the Torch

People had big expectations for Duster and her siblings to be like Wells, but her parents encouraged them to find their own paths. Duster came full circle, connecting to activism in college for different reasons than Wells.

“I became more aware of how powerful media images are in shaping attitudes, which can affect policies, so I wanted to get involved in helping to shape those images to more closely reflect the reality of Black people’s lives and experiences.”

And Duster was on her own way, on her own social justice journey.

Reclaiming Our Own Narrative

For Black History Month, Duster was interviewed at Charis Books, a feminist bookstore, by Dr. Catherine Meeks, the retired Clara Carter Acree Distinguished Professor of Socio-Cultural Studies at Wesleyan College and the Executive Director of the Absalom Jones Episcopal Center for Racial Healing.



“Live with your antennae up. Any time anyone marginalizes you or a group—with encroachments, bad jokes, denigrating slurs—say something.”



The Center for Racial Healing where Meeks is executive director, speaks to dismantling racism while addressing the toll that can take on activists—physically, mentally, and emotionally. Its mission is to provide tools and experiences that allow faith communities – and the larger community of individuals – to engage in dismantling racism through education, prayer, dialogue, pilgrimage, consulting, curriculum design, webinars, and spiritual formation and other resources.

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Community Health Workers Help Heal Communities from Systemic Inequities

Published in May 2023

Throughout history, community health workers (CHWs) have been integral to helping communities heal with regard to both physical well-being and healing from trauma as a result of oppression. To honor the first National Day of Racial Healing earlier this year, the National Association of Community Health Workers (NACHW) held an inaugural annual webinar to highlight the newly endorsed American Public Health Association (APHA) policy recognizing CHWs’ role as racial health advocates and the historical role of CHWs as healers.

Though the policy itself is within the APHA’s CHW section, Rumana Rabbani, MHA, CHW-VPP, and Abdul Bin Abdullah, CHW-VPP – the policy’s principal authors who presented the webinar along with NACHW – are from Community Healing through Activism and Strategic Mobilization (CHASM). Rabbani is CHASM’s director of strategic improvement and policy, and Abdullah serves as the director of programs and community mobilization.

CHASM is a community-led organization of strategic learning that aims to build capacity for CHWs and community-based organizations (CBOs) within historically oppressed communities, neutralize systemic inequities, and enhance harmony within the social ecology. The organization recognizes the deep “chasm” between health care and social determinants of health interventions resulting in the perpetuation and inequities within systems.

CHASM recognizes Historically Oppressed and Other Peoples Experiencing Inequities (HOPEIs) as people who were brought from Africa and enslaved in America, and Indigenous First Nations (including descendants of those groups who trace their genealogy back to Indigenous Mexicans, Aztecs, Mayans, Incas, etc.) whose land was colonized by Europeans. HOPEIs also include other populations experiencing inequities, such as women, Muslims, immigrants, LGBTQ+ people, people with disabilities, and others. However, due to the imbalance caused by the transgenerational and systemic nature of racism, historically oppressed people are prioritized in this specific work.

Addressing Racism as a Public Health Emergency

There is no clear universal strategy to address and dismantle systemic racism, especially with regard to public health. The policy authored in part by Rabbani and Abdullah is one potential approach that recognizes the value of CHWs in helping communities heal in a culturally appropriate and responsive way.

The policy, A Strategy to Address Systemic Racism and Violence as Public Health Priorities: Training and Supporting Community Health Workers to Advance Equity and Violence Prevention, addresses three main points.





The roots of CHWs run deep in both global and American history because humans have naturally stepped up to fill in gaps when their communities are being harmed.

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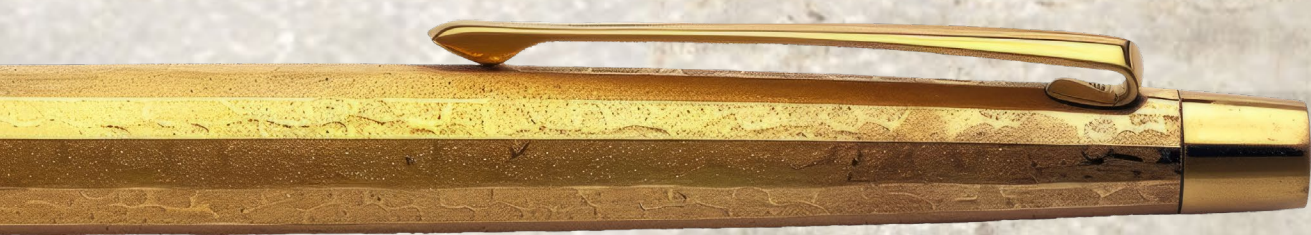
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Medicaid Work Requirement Could Pose Challenges in Rural Communities

Published in May 20218



Last November, intentions to shake up safety net programs, like Medicaid, were communicated in plain English. “I know people that work three jobs and they live next to somebody who doesn’t work at all,” Mr. Donald Trump declared. “And the person who is not working at all and has no intention of working at all is making more money and doing better than the person working his or her *** off..

In April, he issued an executive order that requires Medicaid beneficiaries to seek work in order to maintain insurance benefits. Most people would agree that moving individuals from poverty to work is in fact a win/win. However, in rural areas, finding work is not that simple.

“In 2017, the Federal Government spent more than \$700 billion on low-income assistance,” according to language in the executive order. “Since its inception, the [welfare] system has grown into a large bureaucracy that might be susceptible to measuring success by how many people are enrolled in a program rather than by how many have moved from poverty into financial independence.”

Historically, Medicaid excluded low-income adults without dependent children. Medicaid roles increased with passage of the Affordable Care Act (ACA), which allowed states to opt for or against expanding Medicaid programs to low-income, childless adults. This resulted in 12 million additional enrollees who no longer had to depend on ERs as their entry into the health care system.

Missouri opted out of Medicaid expansion. According to Robert Wood Johnson Foundation (RWJF) estimates, the state has lost and is losing \$17.8 billion in Medicaid funding and \$6.8 billion in hospital reimbursements between the years 2013 to 2022. RWJF estimates it would have cost Missouri \$1.6 billion to participate in Medicaid expansion. The Kaiser Family Foundation’s State of Health Facts reported that in 2016 Missouri ranked 49th in per capita expenditures on health care.

In states where Medicaid roles increased due to ACA, it is important to note that 60 percent of adults receiving this government-funded health insurance benefit are employed.

Consumer advocates contend that work requirements will lead to millions of people losing assistance and don't take into account barriers to finding employment. Rebecca Vallas, vice president of the Poverty to Prosperity Program, said, "So-called work requirements are premised on a set of myths about poverty. First, that the poor are some stagnant group of people who 'just don't want to work.' Second, that anyone who wants a well-paying job can just snap their fingers to make one appear. And third, that having a job is all it takes not to be poor."

As for rural West Central Missouri, here are just a few facts from the 2017 Missouri Economic Report that may pose challenges to meet the work requirement. The West Central Missouri region has a higher percentage of the population with a disability compared to the state and nation. Specifically, 16 percent of the population has a disability compared with 13 percent in Missouri and 10 percent in the United States. This poses a barrier to employment or may result in working in lower skilled and lower wage jobs.

Agencies like the Department of Agriculture, which administers SNAP, and the Department of Housing & Urban Development (HUD), which offers subsidized housing, have 90 days from April 2018 to submit a list of recommendations and policy changes to their work requirements per the executive order. HUD already has plans to increase rent on millions receiving federal housing assistance.



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Farmer Suicide Rate Continues To Rise in Rural Missouri

Published in March 2020



It's no secret that rural residents tend to be sicker, more cash-strapped, have less access to primary and mental health care, and are more susceptible to substance use disorders (SUDs). On top of that, rural communities often face transportation barriers and limited access to jobs that pay a living wage. The outcome is higher rates of depression and suicide.

A report, "Growing Stress on the Farm: The Expanding Economic and Mental Health Disparities in Rural Missouri," puts it this way: "Driven by what has come to be known as 'deaths of despair,' life expectancy for rural Americans is more than two years shorter than their urban counterparts, largely due to higher rates of drug overdoses, alcohol-related diseases, and suicide. As a leading cause of death in rural America, suicide has a particularly devastating effect on farm families."

Economic factors contribute to suicide rate

Missouri's rural suicide rate is growing 50% faster than nonrural suicide rates. The farm economy is a major driver. Slow recovery from the Great Recession, extreme weather, untenable commodity prices, tight lending conditions, and foreign trade policies have packed such a punch that today, there are 16,000 fewer Missouri farms than 20 years ago, according to the report.

A St. Louis Federal Reserve Bank's article, "A Tale of Two Economies: Farmers Struggle Despite Strong U.S. Economy," points to 2013 as the beginning of a downward pull on farming revenues. "At a time when the overall U.S. economy continues to boom, the U.S. agriculture sector has continued to struggle amid falling farm income and deteriorating agriculture credit conditions," the article states. "Over the past five years, U.S. economic growth has continued to strengthen. The growth in U.S. real gross domestic product (GDP) has averaged 2.04 percent per quarter since 2013. Down on the farm, though, conditions have been far from robust. From 2013 to 2017 net farm income – considered to be a broad measure of farm profitability – fell 39 percent, from \$123.8 billion to \$75.5 billion."





The report also states that data from the CDC signals the rate of rural suicide deaths in Missouri is 18% higher than the nonrural rate – and it's growing 50% faster.

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The Rural vs. Urban Safety Net: Two Sides of the Same Coin?

Published in October 2021

What is the state of rural health care in Missouri? Some might say fragmented, while others see hope. For rural America, the glass may be half full, or at least trending in that direction. During the Missouri Rural Health Association's 2021 Get Link'd Annual Conference, Brock Slabach, chief operating officer of the National Rural Health Association (NRHA), delivered the keynote address that talked about the state of rural health, as well as advocacy efforts underway to implement health policy changes that address some of Missouri's most flagrant health inequities.

This advocacy has gained momentum after the COVID-19 pandemic provided an impetus for policy makers to see, clear eyed, what's broken, and with pressure from advocates, how to fix it.

"We have unprecedented challenges that exist right now in the rural safety net," Slabach said. "We were already stretched to the limits before the pandemic with comorbidities and mortalities that challenged our rural communities. Then the pandemic hit.

Policy makers are now connecting the dots and understanding how social determinants of health and a lack of health equity moves downstream to manifest poor health outcomes in both rural and urban communities.

It's important to note that access to quality care contributes only 20% to one's overall health and wellness. Other social determinants of health, which are non-clinical, make up the highest predictors of health outcomes.

Socioeconomic factors make up 40% and include things like education, job status, family and social support, income, and community safety. One's physical environment makes up 10%. Health behaviors like tobacco and alcohol use, diet and exercise, and sexual activity make up the remaining 30%.

Two sides of the same coin

Although resilient, rural and urban communities share many of the same social determinants of health, like access barriers to care, poverty, food deserts, transportation, and broadband access.





By centering health equity, which allows everyone to reach their full health potential, value-based care is inherently achieved as it addresses the 80% of [non-health] related factors that determine one's overall health and wellness. This offers hope for both rural and urban safety nets.

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