

Vital Voices, a podcast from the Josiah Macy Jr. Foundation

Episode 1 Transcript

Holly Humphrey:

Welcome to our first episode of Vital Voices, a podcast from the Josiah Macy Jr. Foundation. I am Dr. Holly Humphrey, President of the Macy Foundation. On today's episode, we are going to provide an overview of harmful bias and discrimination in health professions learning environments, and present some practical suggestions and steps on how to address and mitigate what are unfortunately longstanding problems in the history, norms, and practices of the health professions and their learning environments.

To help us with this discussion, I am joined by Dr. Camila Mateo, Associate Director of Anti-racism Curriculum and Faculty Development at the Harvard Medical School, Faculty Advisor in the Office of Recruitment and Multicultural Affairs, and a primary care pediatrician at Martha Eliot and at Boston Children's Hospital where her work focuses on care for underserved children. Camilla is an expert on the issue of discrimination and bias in medicine, and is co-author of [More than Words: A Vision to Address Bias and Reduce Discrimination in the Health Professions Learning Environment](#), a paper that she presented at the 2020 Macy Conference and published in a special supplement in *Academic Medicine* in December, 2020.

This conversation is a follow-up to our webinar series, discussing the Macy Conference recommendations to address harmful bias and discrimination. If you haven't already done so, I encourage you to watch the recording of the webinar featuring Camilla, as well as our other webinars in this same series. You can find all of the webinars, the conference recommendations and other resources on our website at macyfoundation.org. And now here's my conversation with Camila.

Holly Humphrey:

Camila, thank you so much for being with us today. I'd like to begin with your paper, the one that you co-authored with Dr. David Williams. In that paper, the two of you examine some of the many ways that harmful bias and discrimination are embedded in health professions learning environments. Can you speak a little bit about how pervasive this problem is and what impact such bias and discrimination in health professions education actually has on health outcomes for our patients?

Camila Mateo:

Absolutely. Thank you so much for having me. It's really great to be here. In general, studies really indicate that bias and discrimination are prevalent in the general population. They follow a certain pattern. So for example, one study that was looking at the implicit association test over about a decade shows that there were general patterns of bias demonstrating that folks tend to prefer socially advantaged groups over marginalized ones. And so despite our best intentions as health professionals, it's not surprising that the literature that does exist on provider bias matches those patterns that we see in the general population.

Discrimination, similarly, is common in the general population and also in the health care space. There was one meta-analysis of the medical trainee literature that showed that over 50% of respondents reported gender discrimination, and one out of four reported racial discrimination. So, while unsettling, these patterns really aren't surprising for a lot of us because they really reflect these broader systems of inequity, like racism, ableism, sexism, and the like. So in terms of impact, you mentioned impact on

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patients. Bias and discrimination has been implicated in the large healthcare inequities that we see that treat social groups.

So, experiencing discrimination alone, there's a large literature that has shown these experiences to be associated with negative health outcomes, but also since the patterns of bias tend to skew towards a preference for socially advantaged groups, like I mentioned before, it's not surprising that when provider bias is activated, it's more likely to lead to negative health outcomes for members of marginalized communities, right? And whether that's through direct impact on clinical judgment, through effects on patient-provider relationship building, like negative impacts on the way we communicate, the way we can build trust with our patients or our ability to provide high quality care.

All of these things contribute to the health inequities that we see more broadly in healthcare. I think it's also important to mention, even though we didn't talk about it earlier, that it really has negative impacts on our trainees and our faculty and our colleagues. So, in our communities within the health professions organization, there's literature that really shows that trainees who experience bias or discrimination, but also who witness it, can have feelings of isolation, feelings of burnout, and even feelings of suicidal ideation. I think it's important to understand that for these and many other reasons, it's really critical for the health professions community to prioritize addressing these issues.

Holly Humphrey:

Thank you so much for actually bringing in some of the untoward and very, very negative effects that bias and discrimination can have on our trainees. I think that's a very real set of problems. I think that in your paper, you went on to not only create a vision for what the future could look like, but you gave some really specific recommendations. I'm wondering if you could share just a little bit about that vision. I want to encourage all of our listeners to read the paper for themselves because, as I mentioned, those recommendations, I think, are spot on and could be very helpful in transforming our learning environments.

Camila Mateo:

Absolutely. Dr. Williams and I really tried to focus on what we felt were the most important themes and steps that health professions learning environment institutions could really take based on the literature and our experience in this space. And so in general, our first recommendation really focused on creating systems to identify and address bias and discrimination in our local environments. Because really before being able to address a problem, we have to understand it. We have to also understand the extent of it and that might be different in different spaces.

These forces can manifest very differently in different institutions while they have similar patterns. We may have different populations as a part of our local communities. And so, it's really important for us to do that hyper-local work and look at our institutions specifically and better understand the experiences that are going on for our colleagues throughout the organization, but also for our patients in seeking care at our institutions. And so, in this particular recommendation, we included a few approaches that focused really on being able to capture those experiences, whether it be through surveys related to the experiences for members of our community or our patient community, but also in thinking about the ways in which our health profession learning institutions recruit folks into our organizations, really looking at those recruitment processes with a critical eye to be able to ensure that we are doing our recruitment in an equitable way. This could include things like anti-bias training for folks who are actively involved in recruitment. It could also include the review of things like technical standards for

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admission and graduation, and review different steps in recruitment for equity, looking at metrics like who gets invited to interview? What ends up being the rank position of different folks if we are using a match type of rank system for recruitment? Who ends up accepting an offer to come and matriculate? Who is graduating and moving on to different specialties or different parts of their career? I think that that attention is really important.

The other piece in here is really paying attention to parity as well between members of our faculty and staff, ensuring things like compensation and promotion are not exacerbating inequities that we already see further down in the training process or pathway. And so, the second recommendation we made is really to make the reduction of bias and discrimination an institutional priority. How do we do that? One of the big ways to do that is to invest in people in the organization. And what I mean by that is aligning institutional excellence and understanding institutional excellence as the reduction of bias and discrimination and creating a space where folks feel like they belong regardless of where they're from or what they look like.

That investment requires resource allocation. Allocating appropriate resources for initiatives that seek those goals out is really important, as is supporting the professional development of folks from different groups. Examples that exist in higher education include the Michigan Mandate where the University of Michigan made improving the diversity of the institution a strategic priority by coupling academic excellence to improving social diversity of the university overall. Instead of having diversity be this separate endeavor, it was very much central and core to achieving excellence for the institution.

That kind of prioritization really has significant effects on how folks view diversity as not something extracurricular or external to the excellence of our institution and our professional responsibility, but instead as core to achieving our professional responsibilities. We can learn a lot from thinking about how are we allocating resources and how are we creating systems of accountability to be able to meet time-sensitive goals related to reducing bias and discrimination in our institutions.

The third recommendation focused on ensuring comprehensive curricula to reduce bias and discrimination, making sure that it was accessible to all levels of the organization and thinking about what kind of skills and knowledge are necessary to actively dismantle these forces in our workspaces and learning spaces. And then the fourth recommendation was really, in my opinion, the most important in reducing bias and discrimination, which is focusing on achieving equity and representation of all backgrounds within our learning environments.

I think that this is particularly important because not only is improved representation associated with reduced bias in our training programs and leading to better science and teams that are more efficient and effective, but it also creates a space where we are able to reflect our community, reflect our patients, reflect the excellence and the genius that exists in all different facets of our environment or population. When we think about that, it's easy to say there's a lot of rhetoric around improving representation and diversity and inclusion, but these initiatives are often decoupled from concrete, meaningful initiatives that show change in the direction we are aiming for.

I think it's really important that when we're thinking about our diversity and inclusion initiatives, that we are again, using a critical eye to say, "Are we really allocating appropriate resources to these initiatives? Are we prioritizing them in the way that we should be? Are we being able to link these initiatives to improvements on the institutional level that we're really aiming for? Is representation improving? Are we focusing on parity? Do our colleagues feel heard and respected and a part of this institution and supported by this institution?" I think that this kind of critical diversity is a really important focus for a

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lot of institutions. And again, we'll really need to take collaborative and collective action on the part of the organization to figure out what the best ways to do that will be.

Then the final recommendation focused on creating an institutional culture of respect and inclusion and equity -- ensuring that people who are a part of our organizations feel like they belong. Part of that has to do with making sure that we're creating a space where folks can trust that if they bring up issues of bias and discrimination that they will be dealt with accordingly and that they don't have to fear retribution if they are bringing up these issues and trying to improve the environment overall for everyone.

Holly Humphrey:

Thank you. I love the specificity of those recommendations and it really would be a new world if we could consistently implement everything that you just outlined. I think those recommendations are a wonderful segue to some of the questions that actually came up during the webinar. In fact, I think it's fair to say that the most common question that came up during the webinar is that a number of people were interested to know, "how do we get started?" And specifically they acknowledged that the students and faculty at their institutions who had the lived experience of being part of a minoritized group, and who themselves have experienced bias and discrimination are often called upon to help the institution learn and do better.

How can institutions call on that lived experience without overburdening our student and faculty colleagues? In some instances, people worry about retraumatizing individuals, who've experienced trauma as a result of the bias and discrimination. Do you have some ideas for how to address that?

Camila Mateo:

This is a really great question. I have some thoughts on how best to approach it. So first I would say, these topics are emotionally charged, and they're difficult to discuss. Naming this is really important. You mentioned re-traumatization. I think it's important at the start of these types of discussions -- if it's a course, if it's a lecture, if it's something like this -- that we acknowledged that some of these topics or all of these topics that we're talking about can be very emotionally difficult to discuss. And I would emphasize the importance of creating spaces for learning and discussion that are trustworthy, where we are providing spaces for folks to discuss issues of bias, discrimination, and social justice, where individuals in that space feel seen, heard, and most of all, respected.

Approaches to creating this kind of "brave space" require facilitators to really show up authentically. I think that that can be facilitated by understanding a few different teaching approaches or learning about a few different teaching approaches like critical pedagogy and, in particular, paying attention to and trying to level the power dynamics and hierarchy that are often inherent to a teacher/facilitator space, especially in the health professions, because this will allow for more discussion. By creating that space, it invites folks to share their experience. It invites folks to understand that the space has been created for us to learn from one another, and that we are inviting folks to share a bit of themselves, but to trust us enough to hold that along with them. I think that by doing this, we encourage that sharing without having folks feel put on the spot or tokenized during these discussions.

That was talking about creating a space to have discussions, which I think is very important. We might also be able to get at some of these experiences and these very important perspectives through the types of surveys I mentioned before, where we might be able to assess some of these experiences of

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bias and discrimination in our community in a way that feels more anonymized and feels like you are less identifiable, but still able to share your perspective, which might feel a little bit safer for some of our trainees and faculty and staff to share their experience.

I think it's important that if we do elicit those experiences from folks in our community, that we are very clear about what we are using that information for: if it's a learning experience; if it's being able to find themes and trends and be able to address them, etc. Because I think something that can happen is, if these experiences are brought up and we don't know what happens to them -- we share something that happened to us, and it goes out into the ether and we're not sure what happens with that information -- it can almost feel like a double loss. It can feel like, "Okay, I put myself out there. That was already a hard experience. I shared that experience through this survey or in this space, and then nothing happens to address that." And it can feel almost like another loss in that space. Avoiding that is really important.

The other piece that I think about when I hear this question and something that comes up when we're trying to think about how to address these issues, we (and by "we" I mean, collectively health professionals and me as a medical professional wearing that medical professional hat or medical educator hat), I feel like my instinct is to look outward or externally -- focusing on where can I find evidence, whether that be learning from others or finding specific resources or literature. I think a lot of that is how I was trained. It's how a lot of us are trained. It's what we do. When we're confronted with a problem in clinical care, what do we do? We go to the literature. And with these issues, I think what's different, in my opinion, is that a lot of the most important work is personal self-work. We need to take time to identify and mitigate our own personal biases. As faculty, we need to understand our social identities and how they may be impacting our work and our teaching. This involves asking ourselves how these identities developed and unpacking the ways that they embody, both for some of us, privilege and the lack thereof, based on who we are. And it's that deep often uncomfortable personal work that I think can be the most helpful in approaching these issues, but I'm not certain that we're really trained to do that kind of work. It might be a blind spot for us that I just want to highlight and encourage folks to face, and that I've found very helpful in doing this work in different ways. It's not just learning about other people's stories. It's about learning our own stories -- privilege and marginalization, and really grappling with what might come up for us.

Holly Humphrey:

Wow. Thank you. You covered a lot of important points there and points that I think so many of us can relate to so easily from our own experiences with students, residents and faculty. Let me turn to another question that was posed during the webinar. And this one is really very specific, but I think it's also very important. And that is, one of our listeners is a faculty member for an undergraduate nursing school, and that individual was recently placed on a committee to review course syllabi to ensure that the curriculum that is being covered is inclusive and free from bias. So what are some of the foundational things that you would recommend be included in any course syllabi or be considered when reviewing course syllabi?

Camila Mateo:

That's a great question. I think that there are lots of folks at different institutions who are pursuing this type of work and working collaboratively to create checklists and the ability to go through and review different ways that courses and course syllabi can inadvertently perpetuate some of the biases that we've been talking about. I think, in general, if a course is going to be including information on

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healthcare disparities by social group, it's important to create ground rules or community agreements in order to, again, try to support a trustworthy space where if folks feel like something is coming up that is negatively impacting them, or something comes up that they would like to discuss further that there is a space that has been created where that can be brought up and discussed openly and honestly, and so I think that the creation of community agreements can be very helpful there.

Another piece that can be helpful, I believe is naming that discussions around social inequities can be incredibly difficult. And that process of just naming this can be an important part of, again, setting up that space where folks feel like they can participate. Where they feel like, if I'm sitting with this discomfort, it's not just me. Something that I like to mention, and I reflect on a lot, that I learned from Dr. Camara Jones is when discussing racism in particular (but I believe it can be extrapolated to many other systems of oppression) that the discomfort that we often feel when we're discussing these issues is really evidence that you're leading with your growing edge and challenging yourself, stretching yourself. You're growing in this space that feels uncomfortable and growth is uncomfortable. This has really helped me to frame those moments of tension that can come up during these discussions where I've often learned the most, if I'm being completely honest.

I think the other piece in reviewing course syllabi, again, is taking a step back before creating the syllabi and increasing the awareness of personal and structural bias among folks who are creating courses, participating in courses, and faculty in general. A focus on faculty development, I think, is something that we really must put effort and resources behind so that we can have these systems of review, so that folks who are creating them are made aware and provided the resources to create course syllabi that are hopefully free from bias. And that could include some strategies to try to review and think about your course syllabi. So for example, if you are mentioning a health inequity, or if you're mentioning a social group, have you defined the social group? For example, if you mentioned race in a course or in a slide, have you defined race? Have you defined racism? Because we should never talk about race without talking about racism. We should never talk about sexual and gender minority folks without also talking about heterosexism.

We need to understand that these pieces must be taught together and must be a part of the curricula so that there is that really important context around understanding social differences and the differences between social groups as a reflection of society, and the inequities that are a part of society, and not as a reflection of biology or inherent difference based on biology which is a very big teaching point that we should really, really, really be reviewing all of our work to ensure we are not perpetuating that myth of biological difference between social groups. Some of the foundational knowledge that we could put into our courses is being clear on the historical context that created the inequities that we see today. When we're talking about racial and ethnic differences, we should talk about the history of racism. If we are talking about social groups that have been marginalized, we must talk about the history, not just in general of marginalization, but also within the medical community so that we can contextualize these differences and think about how best to address them. I think it's really important that we include the science bias. How does implicit bias work? How do cognitive biases work? How might social groups and biases towards social groups be a part of that? So that we can understand and identify our own biases and think about ways to mitigate that through skills like individuation or perspective teaching.

We can think about frameworks like structural competency, so we can better understand how structures and systems can perpetuate inequity. I think that awareness of these different foundational principles can be embedded, not just in faculty development or used to review course syllabi, but also be included as core to the knowledge that we hope that our trainees are graduating with when they are

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becoming the health professionals they will become, so that when they are confronted with inequities, they read a paper that shows a difference between a social group and another, they're able to contextualize that and better think about how is it that I could address this gap, this health disparity with all that I know and all that I can learn about how it came to be.

Holly Humphrey:

Oh, Camila, that was a very rich answer about syllabi. I imagine that many of our listeners may feel that they are not up to the task, but the thing I want to just underline among the many important points you just made is you took the perspective of a fine pediatrician, and that is a growth and development perspective. I think if all of us authentically enter these conversations with that perspective, that we're all learning together and growing together, then hopefully those who might feel a little bit intimidated about tackling this may feel less intimidated. So thank you for not only the richness of that answer, but for the growth and development lens that you brought to it.

Let me turn to another question that came up during the webinar, which I also heard very frequently during our previous discussions on this topic. And that is that several faculty members commented that they feel like they have a very good programming at the home institution related to mitigating against harmful bias and discrimination in their clinical learning environments. But it's when their trainees go and rotate to their clinical affiliates, where there are often reports of harmful bias and discrimination occurring in interactions with clinical position faculty members and staff at the affiliated institutions. Do you have any thoughts on how to effectively address that?

Camila Mateo:

I think that that's a really difficult situation, and I have some thoughts. I think a lot of it has to do with again, creating environments where this is less likely to happen. And so for our clinical affiliates, as compared to folks who are maybe on a main campus where medical school is located. I think there is a responsibility for us to provide the training and the resources and the awareness necessary to our clinical affiliates of what initiatives are happening and what is expected of folks who are trainee-facing, whether they're at affiliates or not. That information is readily available and understood to be core to their role as a clinical site, including staff, as well as all the healthcare providers. Understanding what the medical school and the main campus are up to and how to create that collaboration, I think again, is going to be very unique for every medical school and affiliate situation. But I think creating a structure where that collaboration and communication can occur is out of the utmost importance. I think the other piece that can be thought about is going back to some of the recommendations on how do we incentivize some of this work? This is a really important part of the healthcare learning environment, being able to create spaces where our trainees can learn, and, as such, I believe this work, whether it's completing training, demonstrating competency, etc., should be considered as a part of the requirement to be affiliated with the school.

How do we create systems where this is a part of being able to maintain that affiliation for our clinical sites that are perhaps a little bit more distanced from our main campuses? How do we tie it to eligibility for promotion, tying it for eligibility for institutional grants, for example, or other important incentives? How do we incentivize this? Because I think that we can look to some of the ways that we ensure other initiatives make it to our clinical affiliates and see how it is that we can parallel that with ensuring that our students and our trainees are in a space that is structured to the best of our ability to prevent bias and discrimination from happening. I think there's another place where reporting systems are really

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important. So it sounds like is this coming up because reporting systems are in place, and we're seeing this disparity. This sounds like a reporting system that is doing exactly what it's supposed to do. You've demonstrated, "Oh, here is a hotspot, if you will, how is it that we can work collaboratively with the stakeholders -- folks at the main campus, folks in educational leadership, students, folks at the clinical affiliates site, whether it be provider staff, et cetera, to get together and really brainstorm how to reduce this?"

How do we think about accountability systems so that there's a transparency about what happens when someone reports an episode of bias or discrimination or so that there's transparency about what's being done if there seems to be a disproportionate amount of reporting happening at a clinical affiliate. And so I think that these are different strategies that I'm sure folks are already using that I think would be at the core of trying to figure out how to best address these findings.

Holly Humphrey:

Thank you for mentioning the reporting systems, because I strongly agree with you. You're right that the reporting system is in fact doing exactly what it should be doing. And that is a perfect segue to another group of questions that came up during the webinar, and that is people were asking whether or not we had any recommendations for assessment and collecting data about the different forms that harmful bias and discrimination in the clinical learning environment can take. I'm wondering if you have any recommendations about any specific tools that might be validated that institutions can use.

Camila Mateo:

Such a great question. I think in general, there are many different ways that folks have been using surveys to try to glean what is going on in their diversity and inclusion climate, and many of these will include information on bias and discrimination. I think that there are many examples and in general, I would say extrapolating from the discrimination literature and in healthcare, I believe important parts and collecting this type of data include understanding the details of the source of bias or discrimination, whether it be patient, provider, colleague, peer, lecture material, whatever it might be. What the exposure type might be. Was it witnessed? Was it experienced? Was it bullying that was noted? And then also thinking about the attribution of that exposure. So why do folks feel like that episode of bias or discrimination happened? Would they attribute it to an identity or several identities? I think that all of those pieces can better help us understand the exposure.

I think frequency is also a really important consideration. How often is this happening for folks? And that could help us understand, is there a disproportionality of who it's happening to and how can we better address that or understand that so it can help us focus in on areas where we might need to focus a bit more among our population to ensure equity? I think it's also important to pair this information with demographic data so we can understand who is being affected and when.

And having again, those reporting structures so that when we do have that information, let's say through a survey of our organization, that we try to capture a response rate that is meaningful, which I know can be quite the challenge, especially at our very large institutions. But I do think it's worth thinking about what can we do to get that response rate up.

And then I think it's really important to be transparent about what we find. I think a lot of times these diversity and inclusion climate surveys go out, folks fill them out, and then it's unclear what the results are. They are likely being put somewhere. But I think that being very transparent back to the

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community, whether it be students, trainees, faculty, staff is such an important part of these types of surveys so that folks are aware that again, we're not just putting these experiences out into the ether and not fully understanding what the institution we're a part of is doing with that information. Because again, it can feel like that double work. And I think that that transparency and accountability are just so important for all that we do in this space. I think that a piece that could make that very, very stressful for institutions is that you might find, and you likely will find, bias and discrimination occurring at your institution. And it can feel very hard to then put that information back out and to broadcast that because it feels like we have failed at something. I think that that makes a lot of sense. I'm not an institutional leader in that way myself, but I could understand how that would feel very heavy.

I think I would frame it a little differently, which is that bias and discrimination exists in every single institution. If we are able to measure that thoughtfully, be able to show that to our community in a transparent way, and pair that with a plan on how we are going to collaborate with stakeholders in our community, including folks who are respondents to the survey and not just folks in leadership roles, we will then be able to mitigate this bias and discrimination and report in a regular fashion to hopefully see reductions. I think that is the kind of transparent leadership and approach that would really help. And having folks in the institution honestly feel like their voices matter. We are sharing these experiences and it's falling on deaf ears and folks aren't really paying attention to it. And so I feel like these are pieces that could contribute to folks being able to assess these issues, but then really importantly, tell us what's going to happen next.

And it's okay if what is going to happen next might change in two months or in three months or in four months. I think the other piece is all of the work that we're doing in this space, we need to understand that it's going to be work of improvement. We may not have a perfect answer to an issue that comes up, but hopefully we will be collecting information along the way to improve the ways that we respond to bias and discrimination in our learning environments over time. Again, bringing that growth mindset to it, that humility to it, I think is what's going to really help us move this work forward collectively in health professions education.

Holly Humphrey:

Oh, I really appreciate you emphasizing the need to close the feedback loop. Having spent a large number of years of my own career as an institutional leader, I saw firsthand that when the feedback loop is not closed, people understandably grow cynical and weary about change and about whether you're serious about your strategic priorities. But when the feedback loop is closed, I saw our response rates to our surveys increase because people bought in that we were really serious and wanted to make forward progress. So I thank you. You emphasized this point earlier in the podcast, and I'm glad you came back to it because I think it's so important in doing this kind of work. Listen, we are almost out of time, and in the final minutes, I am going to put you on the spot just a little bit. And that is to invite you to just take a look into the future. What is your outlook for the future? Is it possible for us to think about clinical learning environments that can be free from harmful bias and discrimination?

Camila Mateo:

Addressing bias and discrimination is daunting, no matter how much you read about it or talk about it, but I do believe that we can create learning environments that are deliberately structured to prevent and address bias and discrimination on all levels, thereby promoting the growth and the well-being of individuals and communities really on both sides of the stethoscope. I feel like I approach this work with

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cautious optimism and with hope, because hope really is active. It's a choice. And so, yes, I wake up every day and I choose to hope that that absolutely can happen.

I do have a lot of admiration for many colleagues, peers, trainees, mentors, who work in this space tirelessly and are really working to move the needle forward. So I think I have this really lovely window into some of this work that really keeps me feeling like, yes, I think we can really do a better job. I think in a lot of ways we already are, but there is a lot of work to do.

Holly Humphrey:

Oh boy, that is a wonderful note to end on -- the note of hope. I appreciate your optimism and your willingness to share your lived experience and all the things that you have learned so far in doing this work. So on that note of hope, I want to thank you for being with us today.

Camila Mateo:

Thank you so much for having me.

Holly Humphrey:

Thank you, Dr. Camilla Mateo, for taking the time to walk us through current issues related to bias and discrimination in clinical learning environments. Her expertise and thoughtful commentary will serve as a great starting point for our podcast series, as we take a deeper dive over the coming weeks on topics ranging from anti-Black racism to how to deal with racist patients. For more on this discussion, I encourage you to watch the webinar featuring Camila and to read the Macy Conference recommendations and our related resources.

You can find all of these on the Macy Foundation website at macyfoundation.org. Thank you for listening, and we hope you'll share this conversation with others. Be sure to subscribe wherever you get your podcasts so that you'll be notified when the next episode drops. And make sure you're signed up to receive email updates from the Macy Foundation.