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(RE)FRAMING AND (UN)DOING: PRACTICING RACIALLY JUST AND EQUITABLE MCH LEADERSHIP

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>> I would like to introduce our presenter for today, Dr. Vijaya Hogan. Dr. Hogan is a nationally-known perinatal epidemiologist. She is a former member of the Department of Health and Human Services Secretary's Advisory Committee on Infant Mortality, has served as a program officer at the WK Kellogg Foundation, professor in the Department of Maternal and Child Health at the Gillings School of Public Health at the University of North Carolina, Chapel Hill, and lead epidemiologist on the Preterm Delivery Research Group at the Centers for Disease Control and Prevention.

In her career, she has worked at the community, state, and federal levels, in the public and private sectors, in academia, and has worked both domestically and globally. She conducted research and authored several papers relating to understanding and addressing health inequities in perinatal outcomes. She currently works as an independent consultant. She's utilizing her expertise to build the capacity of MCH and other public health organizations and their implementation of strategies to effectively address social determinants of health and to attain health equity. Thank you, Dr. Hogan, so much for being here today. We are looking forward to your presentation. With that, I will turn it over to you.

>> Thank you. Thank you. Good afternoon, everybody. I'm just going to share my screen here in a second. Can you see? Can you see the screen okay?

>> We can.

>> Okay, perfect. Okay. As Ben said, I'm Vijaya Hogan. It's great to be here and part of MCH Leadership Lab. Let's see. Okay, so I changed the punctuation a little bit in the objectives. I'll explain it a little bit later, but the objectives of this session are to identify, distinguish, and deconstruct some

of these terms, including frameworks, cultural competency, health equity, and racial justice, and identify ways in which MCH leaders can leverage the prioritization of health equity and cultural competency to advance racial justice within and across systems.

That's a big charge for the day. We're doing this session for a reason and this is one example of that reason. I'm sure you all are familiar with the data on maternal mortality. Not only does the US have the worst rate among comparable countries, but we also have an increasing rate and an unconscionable disparity between Black and White women in the rates of death.

For example, in New Jersey, that disparity is sevenfold, with Black women having seven times the rate of maternal mortality compared to White women. As I said, this disparity is increasing, not decreasing. It impacts young women, older women, low-income, well-off Black women. It affects women who did all the right things. A lot of the traditional projections and the traditional ways that we do business just hasn't been working.

The hard truth that we have to realize is that the systems that we have are designed perfectly to get the results that we're getting. If we want different results, we really do have to change the way our systems operate. For maternal and child health leaders, we really need to leverage our knowledge, power, positions to facilitate this team. The goal is to achieve equity and ensure that disparities that what we just saw are eliminated, but let's first define equity.

Equity is an outcome. It's something we're striving for. In maternal and child health, we achieve it when we cannot predict outcomes based on someone's personal demographics. Race, class, gender, income level, these things should not systematically predict what outcomes people have. When that's the case, we know we have inequities. Equity is not just an outcome, but it's also a process.

It defines a specific process that's needed to achieve equity and outcomes. That means providing the right treatment and resources as needed to ensure different population groups get what they need to achieve equity, eliminating inequitable policies, practices, et cetera, advocating for social justice, rooting out underlying causes, et cetera, but it's a specific process that's needed to get to that outcome.

I think it's important to understand that and maternal child health leaders need to leverage their power and positions and gain the knowledge and skills to operationalize and systematize the process for getting to these equitable outcomes. Okay, so back to the first slide. There were some words that I was asked to define and to clarify. I think that it's important to understand that these words are not interchangeable.

The top set of words, difference, disparity, health equity, equity, racial equity, these are outcomes. They are not the same even. Differences refer to exactly that rates and some particular outcomes are different. There's not necessarily any commentary about whether those differences are unjust or preventable. They're just different. That's one outcome you could look at, but disparity is a little bit different.

It's a difference that's preventable and it has the connotation of being both preventable and inequitable. It's a higher octave of difference. Health equity refers to disparity as it occurs in health outcomes and refers to all the demographic groups experiencing inequities. Health equity could refer to inequities among LGBQT people, racial ethnic groups, urban/rural, people with disabilities, et cetera. Health equity is specific to health and it's generic and it could cross any group.

Equity itself, again, refers to there being unjust differences. Again, it can refer to any group. Racial equity, however, it's different because it takes into consideration the unique history of racial

oppression, the existence of racism as a chronic instructor exposure to define a particularly egregious and deeply ingrained, often invisible exposure for African-American and Native Americans that has pretty deep impact on health. It is important to understand how those terms differ.

The next set of words are strategies. I'd like to stress that these are strategies. They're not frameworks. You might hear people say, "I'm using an equity lens. I'm doing implicit bias training, so I'm using an equity lens to address disparities in maternal and child health or whatever," and this is mixing of terms. When people talk about using an equity lens, what they're really doing is talking about a strategy.

When they say that they're using an equity lens, there's the expectation that they're doing everything that's needed to achieve equity. It's important to note that these strategies may be necessary, but they're insufficient by themselves to achieve racial equity in health. They're important, but they're not enough by themselves. The next set of-- or the next word, for example, "racial justice," can be considered a strategy.

I would say it's more appropriately called an approach because it provides guiding, overarching principles that you would use to guide your strategies and the choice of strategies. It's not necessarily an equity frame although it could potentially be an equity frame, but I would argue that there are other issues, other strategies that need to be included for it to be a true health equity frame.

We have frameworks. In general, frameworks are theories or maps that describe a causal pathway or an intervention pathway. The important thing about it is that its validity rests in its ability to map out all of the important contributing factors, leading to a particular outcome. [inaudible] only addresses one specific risk factor or one specific pathway out of the three or four or more that exist. It's not a good framework.

The framework can describe anything. For example, you can have a social determinants of health framework, but this is not necessarily an equity framework. An equity framework would map all of the factors contributing to inequities or all the factors that must be addressed to achieve equity. Again, the terms are not interchangeable. It really is important to be clear about this that using implicit bias is a good thing, but it's not an equity framework.

Addressing social determinants is a good thing, but it's not necessarily an equity framework. To summarize, an equity framework should guide the choice of strategies and approaches and tools and skills sought to achieve equity, but not all frameworks are equity frameworks. There are different kinds of frameworks. There are causal frameworks. There are change frameworks. There are operational frameworks.

The strategies, approaches, tools, and skills can either be equity framed or not. They don't automatically come that way. You have to apply an equity frame to make sure that they are equity-focused. For example, as a tool, community engagement is a very important tool, but it can be used without equity and use to learn about communities so that you can manipulate populations or it could be done in the equity frame when it's done correctly and be used as a way to strengthen communities.

Tools can be either equity-framed or not. Again, it's the role of maternal child health leaders to understand, communicate, and operationalize this level of clarity about these terms and the approaches to achieving equity. This might seem like a weird thing to include in this presentation, but it's the map of a river. I'm not sure what river it is or where it is. When I saw this image, my mind immediately interpreted it as a visual representation of the contributors to inequities.

This maps out all of the complexity that's involved with the creation of health inequities. Like a river, it has a lot of tributaries and inequities have a lot of contributors, hence the portmanteau of contributaries. All of these feed into the main outcome or the river that you could consider health disparities or health inequities, but all of these little side rivers feed into that bigger pathway and it really is just that complex.

As a leader in maternal and child health, you may have control over a small contributary. That's understood. As leaders, you also have to understand that you're part of a larger system and that you need to push some boundaries and do things differently with different partners often to be able to influence what happens upstream from where you are. None of us alone is going to fix this problem.

If we continue to act like lone rangers, we're equally unlikely to garner the collective impact that we need to have impact on that bigger river of health equities that exist. As leaders, maternal and child health has a role to work smarter, collaborate more widely, disrupt, and be transformative. Because if we don't, our efforts will never make a difference and these disparities will continue to exist and to grow. We need to map out how to have those upstream impacts.

I keep stating what MCH leaders in the field need to be doing, but what I didn't say yet is that those of us who work in research in the academic settings have really royally failed practitioners because we really haven't provided enough of a strong scientific framework for understanding or addressing racial inequities. We've essentially left everyone to fend for themselves and figure it out.

As a result, we're all over the map in terms of how people approach the elimination of inequities if they approach it at all. What I want to do is go through a really quick history of the evolution of thinking around action to address health equities so that we can pinpoint where people are. Because I think what happens is people have been socialized through different eras and they attached to the strategies of that era and bring it forward into the present.

Even though the science has developed considerably, I think we have people who get fossilized in time along the way. It's important to understand how our understanding of this issue has evolved over time. Again, this is a really simple overview history, high-level history. The initial age, if you think back to the mid to late '80s, early '90s, the initial age was one of discovery. I call that the era of differences.

If you were reviewing grants in that time period, many of them focused on uncovering yet another area or condition that exhibited disparities by race. The meme for that era would be, "Look, I found another one," because every single grant was focused on identifying new diseases or new conditions that exhibited disparities. This era really focused a lot on surveillance and documentation of these disparities and raising consciousness that they existed, which is really important, but they didn't really focus at all on action.

It was just making known that these disparities exist. The next phase, I call it the age of disparities. Now, by then, people became pretty exhausted with the continuous discovery, but no action to address the disparities. They started to really insist on research and intervention funds to be used towards doing something about it. Initially, the focus was pretty much centered on healthcare disparities.

In fact, at the time, whenever someone spoke about disparities, chances were they were talking about healthcare disparities, not health outcomes. The strategies to address this included things like cultural competence, evidence-based practice, targeting people of color, maybe language support, et cetera. Later in the next era, the focus turned to health outcomes.

Things like targeting populations with more culturally-focused care might have been a stronger intervention as opposed to just health care, but it still was focused mostly on access to care for populations and not necessarily upstream factors. This era didn't consider much about the underlying causes of disparate outcomes. It focused mostly on behaviors and equalizing care, not so much on upstream, environmental, political, economic, or other factors.

As I mentioned earlier, health equity meant any population where a disparity was documented. There was no notion of social inequities or social justice in that era. Also in this era, there was some beginning of consideration of social determinants and upstream factors, place-based factors, et cetera. These increased. That changed the direction of intervention to not just on behaviors of individuals or providers, but also on conditions and community.

The next phase, which is where, I think, we are now, is what I call the racial equity/social justice era. In this phase, there have been already a plethora of studies on racism and health and many people have been looking at the intersections of racism and all other potential contributaries. They find relationships to the excess rates of disease and death for African-American populations.

This really expanded the real estate of what needed to be considered in the approaches to eliminate racial-ethnic disparities. It also made it more complicated because many of those contributaries were in our own houses and embedded in the way that we do business on a day-to-day basis. We called them those factors racism or we called them social causes, but then we distance ourselves from them and acted as if they were too big to address because they were so big.

Somewhere out there, that gave us license to sweep them under the rug and wait for somebody else who had more power to do the work. As an MCH leader, it's our responsibility to lift that rug up and look at all of the things that have been swept underneath and begin to clean them up because they exist in our own houses. It's my contention that all of our organizations are a part of society.

We make up society. When we fix our part of society and influence our partners and our networks and our fields and our grantees, then we also influence and change society as well. That's how society changes. It's the role of maternal and child health leadership to clean up their own houses, make their work and that of their organizations such that every rule, decision, process, policy, action, and thought always promotes and never inhibits equity.

Where are we now as a field as far as equity is concerned? Well, we've evolved to the point where we know we need to be transformative, but most people are unsure how to do it. Within the current context of our agency and funding and skills, everybody's expected to be an expert, but few have the requisite expertise. We say we're applying an equity frame. If you ask a hundred people what that means, you might get 99 different explanations of what that looks like.

We complete lots of trainings related to equity often without a clear sense of where it fits in the ground, conceptual schema. Sometimes we don't have the sense of how to translate those trainings into action, but they give us a feeling of being woke and consciousness-raised, et cetera. We feel good and we think we're done, but there's plenty more left to do. Another place where we are now is that many trainings don't consider where people are in that learning process.

We might throw people who are very not ready for undoing racism or anti-racism training into that type of training. It raises their threat response and may do more harm than good, so we have to take consideration of where people are and target specific training and capacity building to those levels. We also try to do equity without institutional change. What happens generally is there's a small team within a larger organization or champions within a larger organization who show the other way of doing the equity work.

The organization around them is not necessarily spending to support them and make it easier for them to do that work. Often with those champions, you have an organization that claims their equity work to be work of the organization when, in fact, it's only the work of that small group of people. Those units or equity champions are left to fend for themselves within the organizations and often feel isolated, stressed out because they tend to do more than what they're expected to do in their regular jobs and they get burned out.

I wonder how many of these characteristics apply to you all. Where do we need to go? What do we need to be able to do to promote, ensure, and practice racially-just and equitable decision-making planning, funding, and practice? First, we need a science-based equity framework that holistically maps all of the conditions that contribute to the creation of inequities. Some of them, not parts of them, but all of them.

We need a causal framework that's translated into an action framework that maps not only all the causes but also, what do we do to reverse the effects of those causes? We need to gain new knowledge and new capacities to be able to change how we act and how we operationalize any framework that might include community engagement, anti-racism, structural change, human-centered design, et cetera.

We shouldn't assume that we all start out with that knowledge. With the capacity to do this work, we have to learn new capacities and new knowledge to be able to do that. You have to actively engage in training. We also need to structure equity into the day-to-day operations of our teams, our organizations, our partnerships because everyone needs to develop equity capacity.

From the person at the front desk in a clinic setting to the CEO of an organization, everything and everybody in between needs to develop the capacity to promote equity. [coughs] Excuse me. We also need to partner across organizations and across sectors to change the structural conditions that impede equity, all kinds of equity. We need new tools to help us implement these.

Just for a little aside, many people express a concern that if they focus on racial equity that it precludes or siphons resources away from other disadvantaged populations. When you think of targeting populations as opposed to structural changes that meet the needs of the most vulnerable, then you might come to that conclusion. In fact, it's not a competition. It's more of a both/and approach when you focus on racial equity.

I just put the Black Lives Matter versus All Lives Matter because I think a lot of us have heard that sort of controversy about that. It's not a competition, but the analogy that I want to compare this to and that I think most of us are familiar with this, the concept of universal design. Because when we talk about racial equity, essentially, what we're doing is applying the principle of universal design.

What that is, basically, you're probably familiar with it as an architectural concept. If you go into a building and you see ramps or, on the street, you see curb cuts that allow for wheelchairs, [clears throat] excuse me, to maneuver around the building or around the city, these are principles of universal design. You design access to buildings to accommodate the people who are least able to use the traditional ways of access.

The suggestion and the approach to racial equity is essentially applying the principle of universal design. We design our public health systems in our approaches to accommodate those who are the most disadvantaged. In the process, what you're building is something that's robust enough that everybody else benefits. I think we all recognize that a civil rights movement, for example, didn't just benefit people of color.

It benefited women and it benefited people with disabilities. It benefited all other groups of people in different ways. It's just a matter of building to the needs of the most vulnerable. I mentioned earlier about frameworks. As for the frameworks we need for equity, there are some out there. Unfortunately, they're not all that good because most of them don't really map all of the factors that actually contribute to health outcomes.

They don't tend to get updated very often, but there are some out there that you can use that aren't bad. This is one of them. This is probably the most used conceptual framework for health equity. It includes most of the relevant factors. They put racism in parentheses, which it should be the bigger factor, but it does capture pretty much a lot of the forces that contribute to health inequities.

This is from the World Health Organization committee on social determinants of health. I use this sometimes, but it's not entirely accurate. It doesn't model things like time or history, which I think are important contributors to disparity, but I don't feel like you have to study it right now. I just wanted to present it so that you could see the level of complexity that goes into these frameworks.

They're not unidirectional. They're not just one factor, systems, but you get the sense, [clears throat] excuse me, of the complexity and all the contributaries that go into creating health inequities. This is another one. Again, I know it's hard to see it. The point is just to see the level of complexity, but this one is another conceptual model or a framework for health equity that does factor in the notion of time and historical disadvantage.

Again, it's pretty complex. Part of the reason why I'm showing these graphs, these frameworks, is because they are complex and they don't translate very well into intervention or action in the real world. They're great to get a sense of all the factors that contribute to inequities, but they don't really inform action very well. The World Health Organization, again, the CSDH, tried to remedy that by creating this framework, which is supposed to be an equity intervention framework.

It was supposed to serve as an action framework. I personally don't find it very useful. Some people do, though. They do exist. At least this one exists. There aren't very many intervention frameworks. I'm going to take a break for a second right now and ask you if you could put into the chatbox your thoughts about what the biggest takeaways you've had so far from this session.

While I continue and wrap up my session and before I introduce the panel of speakers, we'd like for you to put your comments in the chatbox. Before I end, I want to give you some illustrations of where I think the science of health equity needs to go and is trending to and some promising directions for you to look out for and to seek out to improve your ability to address health equity.

First, I mentioned that causal frameworks are necessary but don't necessarily translate well into action. My colleagues and I, when I was at UNC, attempted to address this by developing an action framework that we call R4P. R4P is more like a heuristic, but you could consider it a framework or an equity bundle if you will. What it does is it outlines five areas of action.

It is an action framework, an equity action framework that's needed to address and transform something from just a plan or just a strategy into an action plan or action strategy or an intervention. If you're planning any kind of intervention or strategy, these are the five things you have to think through carefully to ensure that it becomes an equity plan. The way we've developed it was to look at the literature and look for the truly unique contributors to racial equities and maternal and child health.

We added to that some of the general contributors to inequities and then defined specific actions that needed to be thought through in all the programmatic and planning efforts to address these.

These again are the four Rs: remove, repair, remediate, restructure, and the P is provide. The risks that go along with them are racism. The action is to remove racism from policies and procedures.

Historical and intergenerational factors, the action is to repair those and create a level playing field because this is probably the biggest contributor to inequities that we keep accumulating and we don't do anything to level that playing field. It just gets bigger and bigger. Remediate, these are the individual risks that we generally do very well in public health and we tend to focus on these the most.

The fourth R is restructure and this include life course and structural factors. The difference between these two, sometimes people have a hard time understanding, is that if you were sitting in a room and there were holes in the ceiling and the rain was pouring down and coming through and dripping on you while you're sitting in the seminar, you would probably get an umbrella or a tarp or something to cover yourself, to protect yourself. That's called remediation.

You're protecting yourself from the immediate harm, but that's not a long-term solution. If you want to stop the production of risk, then you have to restructure. Call in a repair person to fix that roof and cover up those holes so you don't have the water coming in. Remediation is generally a structured action that's temporary while you're waiting for restructuring to occur, but we tended to stall in the remediation.

It's necessary but insufficient by itself. The fifth action is provide, which is related to the ability to implement any intervention or any strategy in ways that do not cause more stress on the populations that we're working with. That means to provide care and services in ways that are matched to the needs, the abilities, the resources that occludes time, money, et cetera, of the populations in question.

Because many of the populations that we're talking about live at the intersection of multiple risk factors, multiple areas of oppression, that forms a totally different set of risks that need to be addressed in a certain way and so our implementation strategies really do need to take those into consideration. This is basically R4P. I kind of walked through it, but there are more details to it.

Again, repair the damage of the past to create level playing fields. Change structures so that you stop the production of risk. Remediate the immediate danger so you could protect people in the short term while you wait for the restructuring to happen. Remove is related specifically to racism, making sure that it's removed from every policy and procedure, and then providing culturally, economically-feasible health education, medical, or whatever other services that are required to meet the needs of populations.

Again, that's an example of an equity framework and it's just one. There are probably more that will emerge in the literature, so you should look out for them and look for ones that are specifically translated into an action framework. A second thing that you should look out for and seek guidance on is how to build capacity for you and your staff to do equity. Most of us were not trained in the science and we've essentially been winging it, but we do need some support and capacity building to know how to become equity-proficient.

Now, most of you are probably familiar with baby-friendly hospitals. Now, these have been very successful in increasing rates of breastfeeding initiation and reducing inequities and at least breastfeeding initiation for Black women. They work because structural changes happen, because staff were re-educated into new methods of delivery because they use bundles of care and specific protocols and quality assurance.

Most of the hospitals that became baby-friendly designated had some sort of technical assistance to help them navigate the process. Programs like best-fit beginnings or the chance program from Boston University. There was another project at Boston University that provided technical support, but the point is that when we're talking about these structural changes that require people to learn new ways of doing things, technical support is often necessary to get to that point.

People should not be afraid to admit that they need additional training to have the skills to be proficient in promoting equity. There are also some challenges because I think I mentioned this before. There are a million different trainings out there, a million different approaches who do some sort of equity training. How do you know what's the right one for you and your staff?

There are some trainings that are really important that don't have the word "equity" anywhere near it, but they're really critical for achieving equity in public health. How do you navigate that and how do you know that stuff? This is a big problem in our field right now. Organizations have required staff to participate in undoing racism or social justice training. For some people, it might be transformative. For others, it may have elicited a really strong threat response. The reason is because they weren't ready for it.

They didn't have the basis for where to put that, anything to build that knowledge on. We hypothesize that equity capacity is like Prochaska's stages of change. People are at different levels of readiness and they need to start their training at the level that they're at, not something much higher. Somebody who's at the pre-contemplation stage, for example, you wouldn't put in an action training, something like anti-racism training, because they don't have anything to build it on because they haven't developed those lower levels of readiness.

Our hypothesis is that we need to identify within our own staff where people are along this continuum and target the training for them to where they are and let them traverse the process at their own speed and in their own direction. With this hypothesis, it's being tested right now through the National Healthy Start Association, the AIM CCI program. The group in Allegheny County in Pennsylvania is also using it, so stay tuned as we talk about how effective that is.

The instrument is called the SAMREC, self-assessed measure of racial equity capacity. Another example of capacity development focused on maternal and child health leadership is the Michigan Public Health Association, ABEST project, which is going on right now. It's designed to develop skills and capacities of maternal and child health leaders and teams and communities to lead structural systems change and address the racism that's embedded in systems.

Again, that's, [coughs] excuse me, another resource to look for. Lastly, what you should look for are models of cross-sector collaboration that are unified and coordinated action with surveillance of the coverage and action, not just surveillance of the risk factors, but watching when things are done, where they're done, how they're done at a statewide level to be sure that all of the pieces are in place that are needed to address equity at the same time.

Nurture New Jersey is an example of this. It's basically a statewide campaign that developed a strategic plan committed to eliminating racial disparities and birth outcomes, including every sector. Education is involved, public works is involved, transportation is involved, criminal justice communities are involved, et cetera. Basically, what they're doing is, again, expanding the real state of impact that they can have because they're working collectively and so they will have collective impact.

That's something that I think we need to think about how we can get better at doing them. I'm going to stop here and bring in our illustrious panel into the dialogue and I'll introduce some of our panel

members. First, we have Stephanie Campbell. Stephanie is a public health practitioner, facilitator, educator, and entrepreneur. She spent her career working on initiatives to improve the reproductive health of adolescents and women of color in Massachusetts.

Stephanie is as director of the Office of Sexual Health and Youth Development at the Massachusetts Department of Health. Second, we have Ayanna Eggleston, who is a parent consultant with the Family Center for Children and Youth with Special Health Care Needs. This is based in Michigan's Children's Special Health Care Services Division. Ayanna coordinates the Parent-to-Parent Support Network.

Last but not least, we have Amy Zapata, who's director of the Bureau of Family Health at Louisiana Department of Health, Office of Public Health. She's originally from Massachusetts. She's currently pursuing her doctorate in public health leadership and is the Title V Block Grant Director for Louisiana.

I want to introduce first, Stephanie.

>> Thank you so much. Good afternoon, everybody. It's nice to know you're out there, although I can't see some of your faces. If you go to the next slide, please. I wanted to take a moment to introduce myself. My name is Stephanie Campbell. I identify as Black. I use the she series pronouns. Professionally, I'm the director of the Office of Sexual Health and Youth Development at the Massachusetts Department of Public Health, as well as adjunct faculty at Boston university school of public health, where I teach one of my favorite courses there on adolescent health.

In addition, I serve as our national state adolescent health coordinator, and I'm also president of the National Network of State Adolescent Health Coordinators as well. Adolescent health is my field. In addition, as I was thinking about preparing for this panel, we had some quite wimpy questions, so feel free. I just want to put it out there after this, if you have additional questions for me. I wanted to introduce myself as the daughter of Stephanie, the daughter of Dr. Dorothy, the daughter of Maddie, the daughter of Ida. Those identities are really critical to how I lead and how I show up. I come from a strong lineage of women, Black women in particular.

My intersectional identities and leadership are intrinsically connected. I think part of what helps me to be able to keep this approach is growing up in Dorchester in the city of Boston, my love of the Celtics and most importantly, my love of Howard University. Part of what I believe is super important even as I sit here today, this afternoon, that my mere existence as a story of love and survival and resilience. As I embark upon equity, I'm really centered and grounded in those things.

In addition, I feel like it's my duty to do public health. As a public health student, I was always looking at data similar to how we currently are of the impact on Black and Brown communities in particular. That for me, was a justice issue. We weren't talking about all races and ethnicities suffering from different outcomes, regardless of what you're looking at. As was discussed earlier, this is systematic. You could pick the system and the outcomes are the same.

That in itself, I feel like there's a moral obligation to lead with justice. I want to share this quote with you all, because I do believe it is a risk professionally that I take as a Black woman speaking out and as a state institution. One of my favorite quotes that I keep near and dear to me is, "When we speak, we are afraid our words will not be heard nor welcomed, but when we are silent, we're still afraid. It's better to speak." Next slide, please.

Part of what I wanted to share is that there are many frameworks, and I love the outline earlier language and how it shows up in what we used to know that for me, racial equity work is freedom

work. We are trying to really redesign systems, as we just discussed to ensure that they are more equitable for all folks. If we design them correctly, like I love the curb cut example, it's the best one out there. If we design them, redesign them and re-imagine them correctly, we will see the outcomes that we're looking to see.

With that being said, I'm sharing one of my favorite tools with you all. If you haven't picked up this book, I highly recommend it. It's called *Emergent Strategy.* This has been a crucial part of how I've really helped my team to start to apply an equity lens. *Emergent Strategy* for me personally, has been a guide on my journey on how to keep it inside and outside of approach and an institution. Many of the principles I think is what is helpful as a public health leader to help re-imagine. Our skills of public health will get us thus far and I do believe that we run the risk of recreating the same systems unintentionally because we have the same training.

Some of the principles of *Emergent Strategy* that are helpful is to remember that change is constant, to be like water. Whatever container water is in, it redefines itself. There's always enough time to do the right work. We know time is always against us. Equity work is time. If we're going to get centered and do this right, we have to make time for it. Trust the people. If you trust the people, they become trustworthy.

Ben opened up with a slide to talk about how our systems haven't showed us that we should be able to trust them, particularly for BiPAP folks.>> The last one that I think is important before I move on to the next slide is less prep and more presence. What we actually pay attention to, girls, and I highly encourage you all to pick this up. I just pulled out these three nuggets because I do believe in order for us to start to see the outcomes that we want to see across systems, we have to take a deep look at the current systems that we sit in.

Next slide, please. How have I applied equity across different levels of leadership? Those principles I've just shared with you, I use them at staff meetings before I even say we're going to jump in to talk about racial equity because they will land with folks differently. The first bullet is relationships. You have to foster the relationships. The way I introduced myself here today, I often in my team encourage us to introduce ourselves to be on the roles.

If we continue to engage with each other in the same relationships on how we've met in the systems, we're just contributing to the system giving us those same results. I have to know that you're beyond the finance director. That is where we begin to see each other and have a shift. Relationships, accountability. I know these arrows are all going from left to right, I wish I could make them go back and forth and all around because it's not a linear process.

Accountability can only be really held when there is a relationship. I have to trust it because we're in relationship, your place of a calling me in or calling me out is really founded in love and that's important in any team. The other piece that I think has really helped foster equity across leadership in my team particularly is, in our bureau, there is a wider effort around racial equity. We're at a unique moment in the Massachusetts department of public health.

That leadership support not at the commissioners' level but at the bureau level also reinforces what we're fostering in our team and in our division. We're not quite the long ranges, I would say we're the lone bureaus. Not every Bureau has committed but it's still an amazing thing to be able to witness, to see how something can grow from something small to larger. I was like, "Yes, thank you for saying that lone ranger a piece because it's so important." I believe if we didn't have this bureau-wide effort between my bureau and our sister bureau, we would all be exhausted.

We would have tapped out a long time ago because it's important as it is for us to start internal, that is the hardest work. Many of you on this call work in government, you understand the number of processes that we have to do to get to X contracting. Once you get your grantees, all of those steps are opportunities for equity. The last piece and again, I'm going to really go back to this bureau-wide initial is that integration allows us to look at all of these processes like procurement, professional development, having continuous lunch and learns.

There's a bureau-wide one each month. We host them inside our team that continuous learning is really fostering our relationships for accountability. Have we seen some results? absolutely. They're small, they're language shifts. If we could just start there, we're celebrating those small wins and I leave that to you. We want the big ones but celebrate the small ones that you get. If you can get folks to stop saying at-risk youth and be explicit and name the populations that you're talking about, that is a win too. think I might be at my four minutes, so I'm going to stop right there.

>> Thank you.

>> You're welcome.

>> Ayana.

>> Hello, I'm Ayanna Eggleston. I work within the family center. Just to give you a little bit about me and my family and the roles that I have within the family center, within children's special healthcare services. I am a parent of two children with special needs. I have a daughter who had medical challenges and this adult son with different types of challenges. Now that he's an adult, I'm really careful about what I tell his challenges are. He gets funny about when they become adults, you can't tell their business. As a parent, I witnessed firsthand the disparities that affected my community and my children, my son, in particular, I saw a lot of bias that was geared towards him.

It's funny growing up, I saw different things that happened within my community. I grew up in Detroit and so when I saw things, I didn't understand until I began to work with health equity, how so many things were tied in to what I was seeing growing up and how it was not-- For one thing you think the whole world understands what you see and you think that everybody sees it and sees what people face, and you get into the world and you realize that people just do not see everything that their families face, that parents face.

As a professional, I've worked in various areas with families, from community organizations. I've worked with prevention services and now working with families with special needs, and I haven't seen one area that I've worked in ever that disparities and inequities were not apparent. I've seen injustice, inequities, and bias in every single area, no matter where I am in those in those spheres of influence in those workplaces. I've learned that unconscious bias left unchecked can affect a whole trajectory of a family or a child's life. Next slide, please.

>> Sorry, so that will come on.

>> To me, I play two roles as a parent and as a professional, because I'll be a parent forever. As a parent, my focus is to listen to what people are saying about their communities, because people live in communities and they're speaking, but people are not hearing, people are hearing what they want to hear, or they're not hearing what's being said. They're hearing what they think should be done, and so making sure that parents feel empowered to use their voice starts with actually hearing what is happening.

When COVID-19 happened, there was a lot of bias. Like I said, I mentioned before I came from and I saw a lot of bias in regards to what people in Detroit were saying, and people were giving opinions,

but they weren't listening to what people were saying. Then understanding the historical context about why problems exist is crucial. When a parent speaks of bias in education, knowing the historical context of how black and brown children have been discriminated against helps you listen and encourage with different eyes and ears.

Hearing your education helps identify potential areas of engagement. It doesn't mean you jump on everything, but your senses are heightened. I work with families who have rare diseases and then I work with families who have more common diseases. Sickle cell is a disease that is well-known. However, the resources for it are scarce in a lot of areas, even though it's a well-known disease. It's handled as though it's a rare disease and that shouldn't be so.

We're working with community leaders now to address those barriers and also address some other barriers such as transition. It comes to being intentional. You're looking to see if parents are being provided opportunities to receive support or give support. In those, in my equity with parent leadership, I'm always making sure that parents are given an opportunity to receive support, but also be givers of support. We do the parents to parent match support. Just making sure that parents are given opportunities to be a support.

If I see a pool of parents and I'm looking at my pool of parents, and I'm not seeing people of color, that means that people are not being given that access to be able to have their voice be heard. Next slide. That brings me to professional leadership. Just taking the opportunity to take concerns being heard within the community and voice them to leadership. That affects policy, that affects procedure. It puts in place service evaluations, it puts in place services such as language translation services when language barriers are brought to the forefront. Just take in what the community is saying and relaying it to the proper channels.

Then becoming an advocate for those families who I have the privilege of serving but are not in the room at that moment. Always making sure that even though they are not in the room, they are with me when they come in the room because I'm speaking what they have spoken. Just understanding that you have the charge of cultivating environments and providing education. Like I mentioned earlier, providing historical context is important to give insight that things are not just surface issues, especially as a parent of a child with special needs.

Not only am I speaking to racial contexts but also parental contexts. All plays into building an environment of anti-racism where allyship is built and we work for equitable practices. How we do that at my job is we have a health equity group. We have a health equity group that focuses on personal development. You're developing yourself and you're also looking at team development and community development. I see I have gone past my time. I am going to share just a little later.

>> Thank you so much, Ayanna. I'm sorry to interrupt>> I just want to make sure we get everybody in. I wanted to just remind people to continue to put your comments in the Q&A box, any take-home messages that you might be picking up from today that you want to raise up. I want to bring up Amy Zapata.

>> Hey there. Can you hear me?

>> Yes.

>> Okay, great. Yes, my name is Amy Zapata. I am the director of the Bureau of Family Health within the Office of Public Health. My pronouns are she and her. I think what motivated me around this work is really what we'll look at next, which is from the Undoing Racism Workshop, and I could see how we all lose our humanity in systems that are unfair and unjust. When you can see the

structures, you can't then unsee them. When I was in that workshop, I felt that we were at the rear wheel and it just resonated with me so deeply.

You can go backwards. Oftentimes within public health, when asked a question of why are people poor, something that happened in that workshop, why are people poor, we have a lot of esoteric answers, academic answers of poverty, of discrimination, of substance use, of whatever might come to mind there. Then when we pose a scenario of someone is in the supermarket and are whipping through a lot of coupons and just taking a long time in the supermarket and we're asked the same question of why people are poor, the narrative is really a lot different.

The very central comes to mind, "Well, people are lazy, or they're--" What do we think that other people are saying with this. "People are lazy or they're not working or they're not trying hard or--" All the narratives that are deep in our society. Next slide, please. In the Undoing Racism Workshop really contrasting that "Academic and professional narrative" to then really one question deeper of what do you think somebody else is thinking in this situation in the supermarket led to a discussion of what are the systems and identifying the foot.

You can go to the next slide. Of what is the foot in anyone's rear end of how our systems, our education systems, our banking systems, and our media, all might be stepping on people and impeding full recognition of humanity and of success. That really led me to think-- You can go to the next slide. -of how is it that we, within our own four walls are doing that, within our own systems that we touch. Of course, Title V provides services but we also are assessing how those services are working for people, and from one of our Title V assessments can look in our data and see people are feeling like they keep you in poverty in order for you to get the services and then if you're above that, you don't get it.

So it's an incentive to stay below that and perceptions of the system not being set up for anyone to succeed. Next one. My approach the way that I felt it inside of me was lighting a match and lighting a spark and a spark of curiosity and that's been my approach so far. Next slide. The question was after leaving Undoing Racism Workshop was just okay, now what do I do? How do I do this? Next slide, please. The way that I've been working on it is commitment to three things. Commitment to individual and organizational learning, re-envisioning the organization and how we do public health, and then work to ignite the spark externally.

Next slide. On the individual and organizational learning, I will say this probably started about seven years ago. It was definitely a lonelier time to do that than I think it is. Now I still think it's quite hard and quite important, but I think definitely felt much more out on our own there at that time. Literally just tried to start with developing a common language and develop for ourselves the toolkit of what is race, what is racism, what is reverse racism, is that even a thing, and a lot of different concepts that are much more now, I would say used, I won't say that they're used well or used correctly as you were talking about, Dr. Hogan.

Also with individual and shared experiential learning through workshops, documentaries, and discussion, and just really integrated into the work that we're doing. We also did an examination of our own state history and policies. There's always a temptation to go try to fix somebody else, but my deep commitment was to fixing ourselves individually or examining ourselves individually. Then we also created a Health Equity Action Team made of people inside of our organization, externally, to create both a little bit of inside and outside perspective and pressure for ourselves to continue to move forward.

Next slide. A big A-ha for me in there was realizing what's the effect of something versus the intent, whether it's of language or beyond. One example of that was us re-learning some of our history, and

did a deep dive into Louisiana history of educational and medical policies and vital records and public health and really saw plenty of history and fodder for what needed to be addressed within our own system. Next slide.

The second action has been re-envisioning the organization and how we do public health. That all of the work in number one really was catalyze that slow burn, which ultimately led to a new vision for who we are and how we do our work of envisioning Louisiana as a state where all people are valued to reach their full potential from birth through the next generation.

Our mission to elevate the strengths and voices of individuals, families, organizations, and communities to catalyze transformational change. I would say that's still a vision. We're now starting to operationalize what does that look like. I won't say we're there, I think we now have more of a North Star. Next. Part of that has been then thinking about, what is our big opportunity through public health services if we reach hundreds and thousands through our services? Next slide. Really then shifting to how is it that we reach tens of thousands and millions or hundreds of thousands and that's through policy and systems change. Next slide.

Then the third is then brings us to a systems change and trying to make the spark in others. That spark of curiosity of using data system change. Using data, external pressure, supports to mobilize change in others, and policy change really capitalizing on the learning interest to mobilize others. Next slide. Part of that then has been as a, for example, with our Louisiana Perinatal Quality Collaborative, when we started that we use that as a catalyst for support and learning and change, we used our pregnancy-associated mortality review data to really highlight that in the media attention.

Next slide. We included a very explicit equity aim at that point, at that point, we didn't have the data. Hospitals didn't have the data or they weren't looking at the data, but we included that equity aim right from the beginning so that it would then prompt both the pressure and the release of looking at it, understanding it, and potentially beginning to address it and change it. Next slide.

What that then lead to our Perinatal Quality Collaborative and action around policy was more relationship and trust and more curiosity. Then catalyzing more learning and action. For example, a legislator who worked on one of our committees with us related to the Perinatal Quality Collaborative, then became interested in implicit bias, not somebody who I was expecting, who would become interested in that.

Then she sponsored the legislation, which I helped her then craft to then point back to the department of creating a mandate for ourselves for producing curriculum around implicit bias. I would say those are different levels. Next slide, please. The levels of where I've thought to try to change is mostly in creating advantage of that spark inside to prompt individual organizational learning reenvision and then spark it externally. I feel like now, after this work now we're at the beginning of being able to really do the deepest work and the best work. Thank you.

>> Thank you. I have some questions, but I think at this point it might make sense to bring the audience in. I want to turn it over to Ben, to go through the questions that we got from the audience or the comments.

>> This has been thanks, Dr. Hogan. There are a few that came in and I think I'll start with the one that actually addresses something from the training you provided but also something that Amy just referenced. One attendee asked here, "Evolution of health equity is very helpful. In my state, policymakers are focusing on implicit bias training as the panacea for health inequities. Yet, there doesn't seem to be much evidence for individual or institutional change after such trainings. Do you

see implicit bias training as a distractor or a tool that should be explored?" I think that's a question for you and probably for the panelists as well.

>> Yes, I welcome any panelist who wants to also comment. Implicit bias training and any other training that probably you can find out there has a use. It's important to know what that use is, what its impact can potentially be, and accept it for what it is. It's implicit bias is not a panacea. It's not the thing that if you get trained in it, that you're going to be able to implement equity because it's not, it's an important piece. It's not the be-all-end-all.

You're right. The research right now is showing that even though it might have a lot of impact on people, it might bring them from one stage of development to another, it doesn't seem to get them to that action stage. Some of that might be how the trainings are implemented. There might be some out there that actually do bring people to a level of being able to create change, but for the most part, it's not. It is a little disturbing that people feel that implicit bias is the be all end all. Once they do that, they feel like they're done and there's so much more work to do than that. Panelists, any other comments?

>> My thought- this is Amy, is to use it as a door. If that's where there is some energy and some attention, I think it's in part, coming from wanting clarity of vocabulary and terminology and what does this mean? How does this apply? As long as it's not the only or even the primary focus, if that's where there is some energy, can you use it to create some propulsion and some curiosity, and by "it" I mean the interest in having training related to that?

>> Thank you, Stephen.

>> I was just going to say, I agree with you in terms of it could be a tool and I agree with Amy too, that it could be a starting place. I didn't have anything else to add.

>> Okay, Ben, next comment or question?

>> This has Ben, there was a question from another attendee that says, how do we encourage our stakeholders to share their lived experiences and what they are seeing in their own communities so we can better advocate for changes to address their needs.

>> Panelists?Stephanie, what do you think? Or, Ayana, it looks like you were about to say something.

>> I would say in regards to the community is letting them know that the biggest thing I hear is what I say won't make a difference and that has to be changed, there has to be a trust in a safety of community to be able to have that conversation. Too often I hear that, just in regular conversation, anybody if you're talking to someone and they're not listening, you don't feel safe enough to have that conversation. I think the first step is just simply acknowledging that what people say is happening within their communities really is happening.

>> Thank you. There's another aspect to that too and that is that whenever we, as professionals go to collaborate with somebody, we do our homework, we talk to our colleagues and our peers, we have discussions, we read, we prepare, but when we want to engage with community, we essentially walk up to them in the street with the microphone in their face, ask them a hard question that they've never had a chance to think about or talk to their peers about or to go through some critical thinking process.

When we talk about community engagement, it's not just getting them to the table, but it's also creating space and an opportunity for communities discuss these issues among themselves and to come to their own critical conclusions so that when they come to the table, they're not just swatting

down your ideas or rubber stamping your ideas, but they're bringing their own to the table as well. I think that's another way to get communities more engaged, it's by giving them the space to have those discussions in their own community, with their own peers.

>> Can I chime in with something too Dr. Hogan.

>> Sure.

>> Two other thoughts, one, this is Amy speaking, is I'm hoping that community engagement will be the next health equity and that we really, really get specific of what do we mean by that and how we do it. I really appreciated the AMCHP. One of the AMCHP plenary really excellent and with a focus on community-based participatory programming or research, what that says to me is that we really need to commit the resources to have engagement really meaningfully and purposely and not just the microphone in the face of a hard discussion, build it into the architecture of what we do.

I think another level for architecture that we already have is we have, probably a lot of us already have under our purview boards and commissions and councils or reports that we're publishing or PRAMS where we have comments that are in those and to use the platforms that we have that are the platforms of government agencies and use those officially recognized platforms to elevate voices and perspectives.

>> Thank you. Ben, next question.

>> Yes, this is Ben. Each of you in your own ways talked about processes and I think one of the questions that we got touches on that. "How do you determine where people are in their learning process?"

>> I think that's a really great question. I personally use the racial identity development tool. I'm not sure if you're familiar with it. I'll either send it to Ben so we could get it out, but it does a good job of describing the different stages of where people could be. I think that's a powerful tool, particularly if you're in a leadership role to be familiar with and think about what you see amongst your team. It's also helpful to share it with folks so they can think about where they are in their journey. That's what I use as a gauge or to figure out how to engage with folks.

>> Maybe another panel. I talked about that tool. We call the SAMREC, the Self-assess Measure of Racial Equity Capacity and again, this is something that's still under development and being tested, but it was designed specifically for that purpose to be able to gauge where people are in that developmental process so that they can self-select where they need to start out and you could start to build structures to accommodate people at each one of those levels. This is a weakness in the system that we have right now is we don't have a lot of good tools or people don't know about the tools for being able to assess someone's equity capacity, so we need more work in that area.

>> Next question, Ben.

>> I think we are about at time actually to wrap up, so I am going to just say thank you from me to each of you and then pass it off to Grace.

>> Hi, everyone, can you see my slide?

>> Yes.

>> Perfect. Oh my gosh. Thank you so so much Dr. Hogan, again, and Amy, Stephanie for such a powerful and much-needed conversation, some of the themes that really resonated with me and

then I'm sure it resonated with our audience was the idea that the process towards and the path towards equity is not linear, it is a lot of work and I also want to emphasize that even if we're talking about individual leadership development and leading for equity, this exists in the broader context of collective and transformational leadership development and impact because it shouldn't fall on one person, on the individual to change systems.

It's not until we are all in that we will see results and the outcomes that we want to achieve. I won't let you go until I pose a couple of questions to our audience, especially through the Leadership Lab full cert that are tuning in. I want you to think about how you will hold yourself and others accountable to advance equity, how you will use and expand your influence to build equity, and to think about and write an action plan for the next three months on what you commit to do to strengthen your leadership capacity and action on equity?

I encourage you to use your individualized leadership development plans to embed those action steps and monitor your commitment and progress towards those commitments.