AMCHP Leadership Lab Webinar
November 16, 2020

(Re)Framing and (Un)Doing:

Practicing Racially Just and Equitable MCH Leadership

Learning objectives

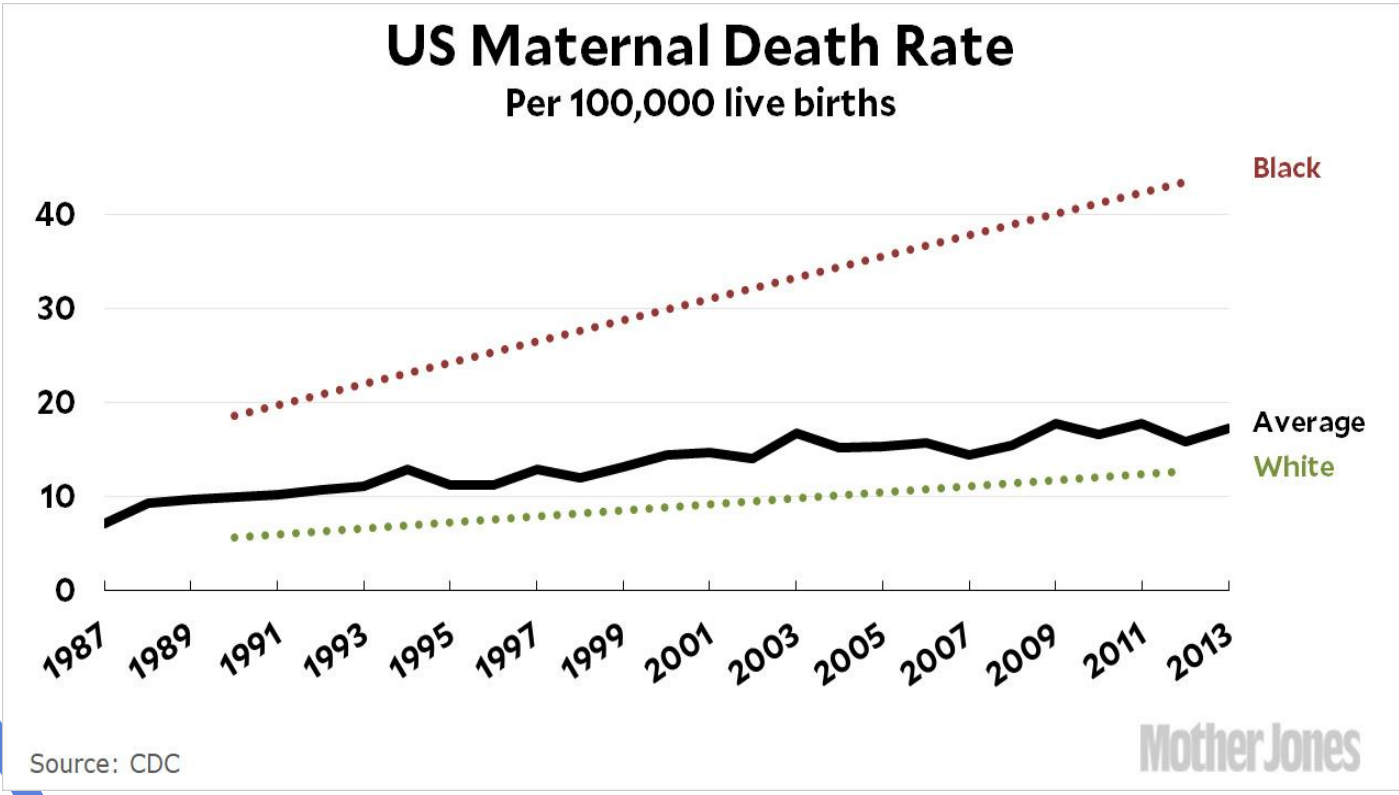
- **Identify, distinguish, and deconstruct:**

frameworks, cultural competency, health equity, and racial justice

- **Identify ways in which MCH leaders can leverage the prioritization of health equity and cultural competency to advance racial justice within and across systems**

The Problem of racial Inequities is exemplified by extreme disparities in health.

Source: CDC*Pregnancy Associated Mortality Rates*



The hard truth:

Equity is an outcome and a process

Maternal and child health equity *is an outcome where personal demographics do not predict differences in morbidity/mortality.*

Maternal and child health equity exists when:

- *No one is denied the resources they need to achieve a good health outcome*
- *No population group in need is physically, economically, socially or psychologically disadvantaged or mistreated*
- *Outcomes cannot be predicted by race/ethnicity, age, education, income level, or geographic location*

What does it mean to "achieve equity"? Equity signals the need for a specific PROCESS

In addition to being an outcome, equity is also a specific ***process*** *that leads to the achievement of that outcome. The process of achieving health equity includes:*

- *Providing treatment and resources, as needed, to ensure different population groups experience no more than population-proportionate rates of adverse maternal health outcomes.*
- *Eliminating inequitable policies, practices, attitudes, and cultural messages that measurably disadvantage some population groups relative to others*
- *Correcting the damage that various population groups have experienced as a result of past or present inequitable policies, practices, attitudes, and cultural messages.*
- *Rooting out underlying causes, such as racism, leading to inequities in maternal and child health*
- *Advocating for social justice in maternal health*

Words matter:

Framework? Strategy? Approach? Tool? Skill? State of Being? Outcome?

- Difference
- Disparity
- Health Equity
- Equity
- Racial Equity

- Targeting
- Evidence based practice
- Cultural Competence
- Undoing Racism
- Implicit Bias
- Social Determinants

- Racial Justice

- Equity Lens/Equity Framework

- Equity Capacity

OUTCOMES

STRATEGIES

APPROACHES

FRAMEWORKS

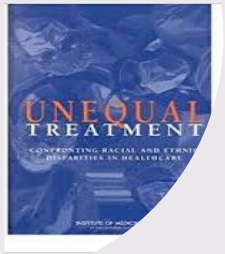
ABILITY TO IMPLEMENT EQUITY FRAMEWORK, APPROACHES AND STRATEGIES

Frameworks	Strategies	Approaches	Tools	Skills
Causal Change Operational	Regular vs Equity-framed	Regular vs Equity-framed	Regular vs Equity-framed	Regular vs Equity-framed

“Contributaries” to inequity

- We make claims about eliminating disparities and inequities that are not grounded in reality

Very Brief History: Evolution of Health Equity

ERA	APPROACH
Era of Differences	Surveillance, Reporting, Consciousness-raising
Era of Disparities -in Healthcare -in Outcomes 	Focus on characteristics of populations experiencing disparities Evidence based practice targeting POC Cultural Competence
Era of Health Equity	Diversity and inclusion Recognition of/Addressing multiple populations in need (Rural, Low income, People with disability, immigrants, etc..) Recognition of systemic contributors, social determinants Research into causes of inequities (vs causes of disease)
Era of Racial Equity/Social Justice	Racism, History, Social and Structural contributors recognized; change outcomes by changing structural conditions governing behavior; Implicit bias, SJ, anti-racism training, QI; focus on populations, providers & systems, structures, communities

Where are we now?

- ***Evolved to the point where we KNOW we need to be transformative, but unsure how to do it within the current context of our agencies and skills***
- ***Everybody is expected to be an expert, few have requisite expertise***
- ***"Applying an equity frame" has taken many different manifestations–few are complete***
- ***We complete equity-related "trainings" without a clear sense of where it fits in the grand conceptual schema, nor have a sense of how to translate into action; yet they give us a sense of being "woke"***
- ***Many trainings are not considerate of "where people are" in the conscientization/learning process***
- ***"Doing equity" without institutional change***
- ***Leadership not actively supportive of structural change or capacity development***
- ***Organizations claim equity capacity when its only one small group doing the work***
    - ***Many individual "units" or equity champions are left to fend for themselves within organizations***

What do MCH Leaders need to be able to promote/ensure/ practice racially just and equitable decision-making, planning, funding, practice ?

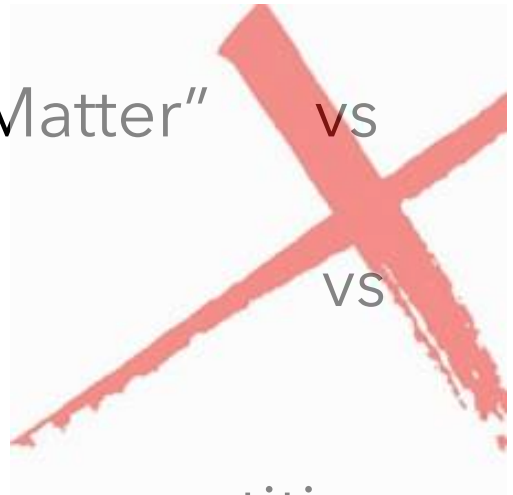
- *We need a **science-based framework** that holistically maps **all** of the conditions creating health inequities*
- *We need the causal framework **translated into an action framework** that maps to **all** causes and can be used in the field*
- *We need to gain **new knowledge** and **capacities** to change the paradigm of action and operationalize action framework:*
  - *Community engagement*
  - *Anti-racism*
  - *Structural change*
  - *Narrative change*
  - *Human centered design*
  - *Universal design*

  -Critical race theory

  -Social and racial justice

  -
- *We need to structure equity into the day-to-day operations of our teams, organizations, partnerships*
  - *Everyone needs to develop equity capacities*
- *We need to partner across orgs and sectors to change the structural conditions that impede racial equity, health and health equity*
- *We need new tools to help us implement these*

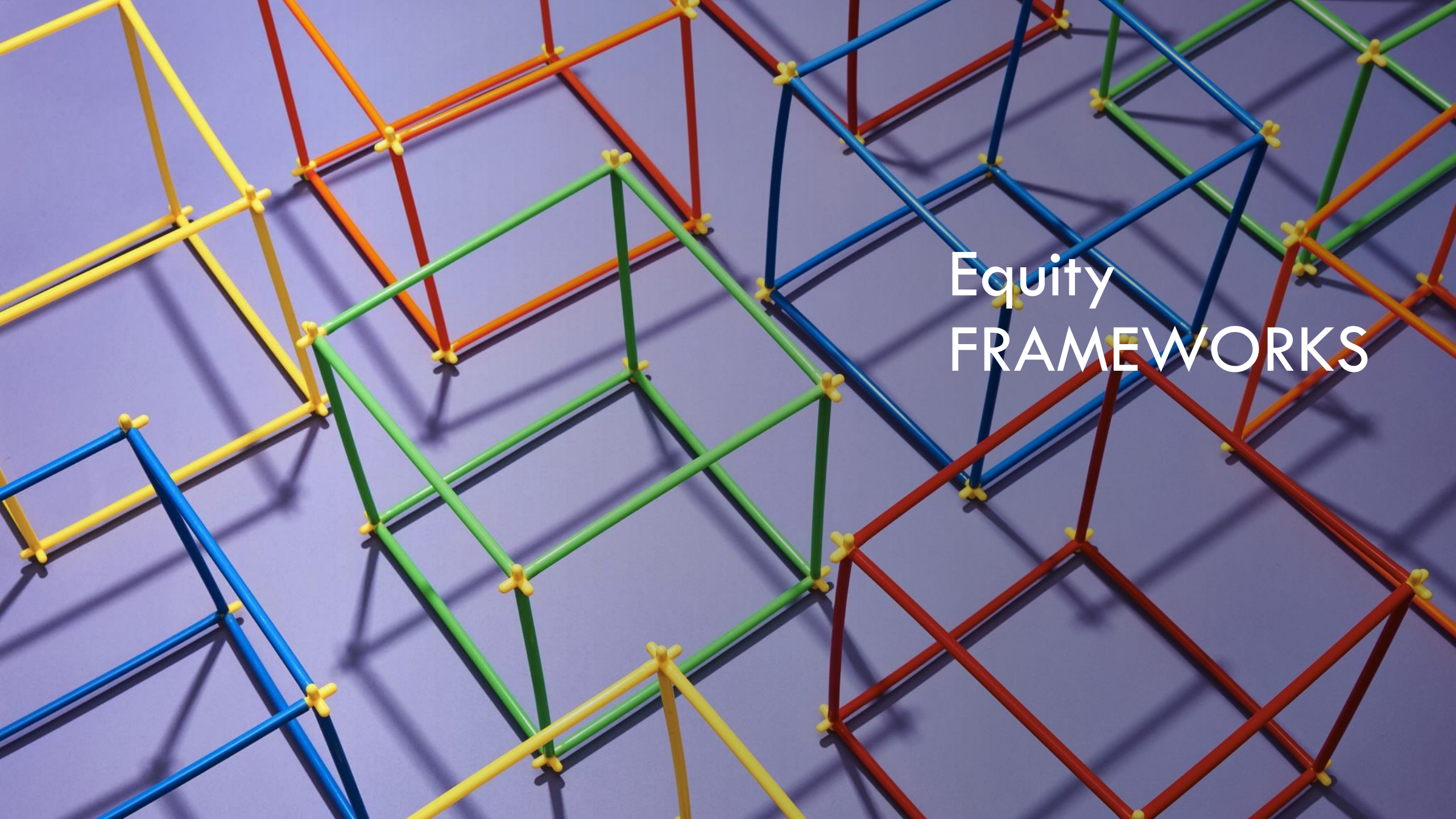
An aside….



"Black Lives Matter"	vs	"All Lives Matter"
Racial Equity	vs	Equity for other disadvantaged Population groups

This is a false competition, and the first terms are not exclusionary. Instead, the focus on racial equity is a function of **Universal Design**.

To design our systems, structures, our ways of doing things in ways that address the needs of the most vulnerable, and in the process, EVERYONE benefits, and no one is inconvenienced. To do otherwise is inequitable.


Equity
FRAMEWORKS

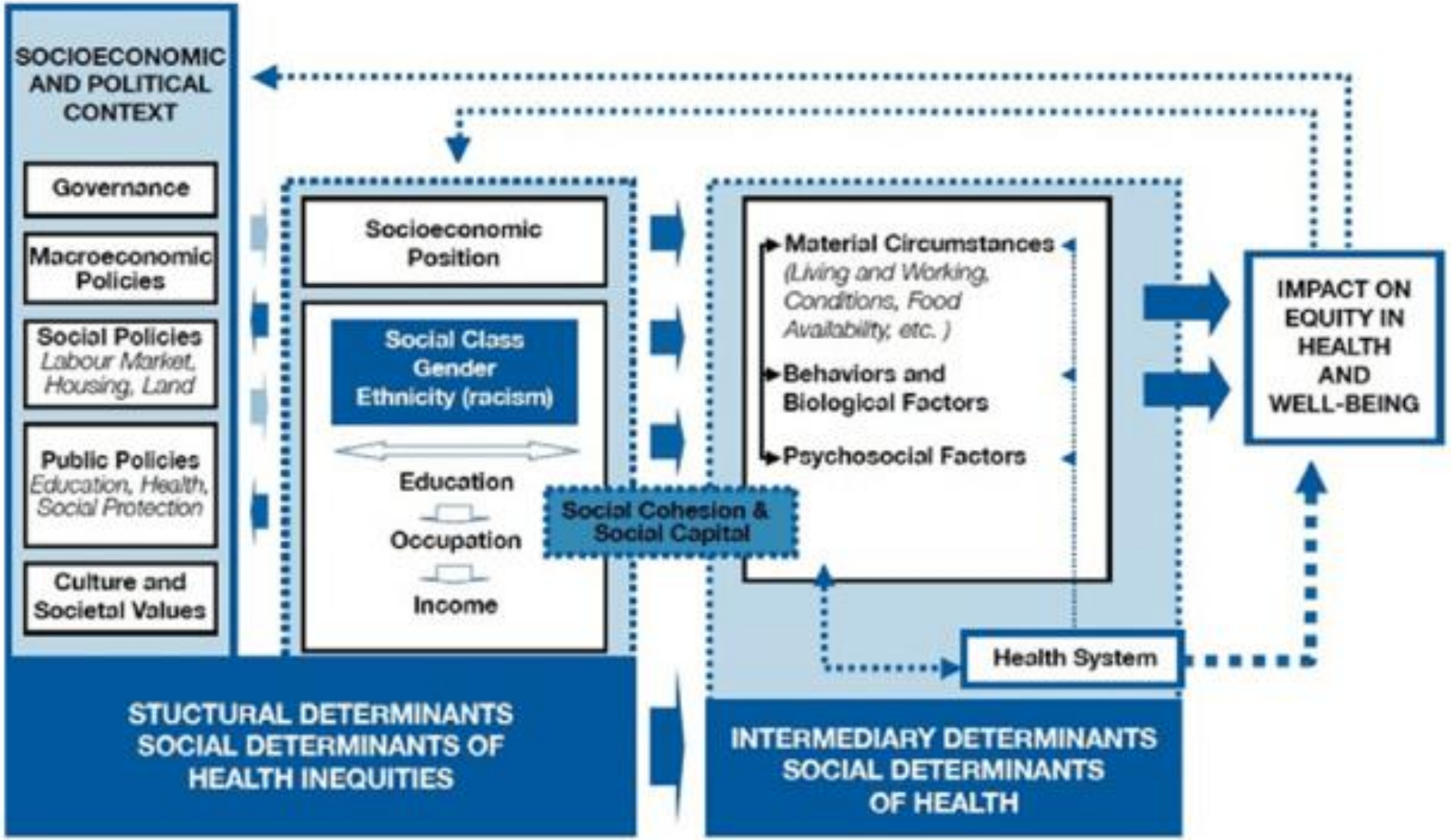


Fig. 1 Final form of the CSDH conceptual framework brings together the key elements -including structural and intermediary det the processes and pathways that generate health inequities [29]

Sotero et al.

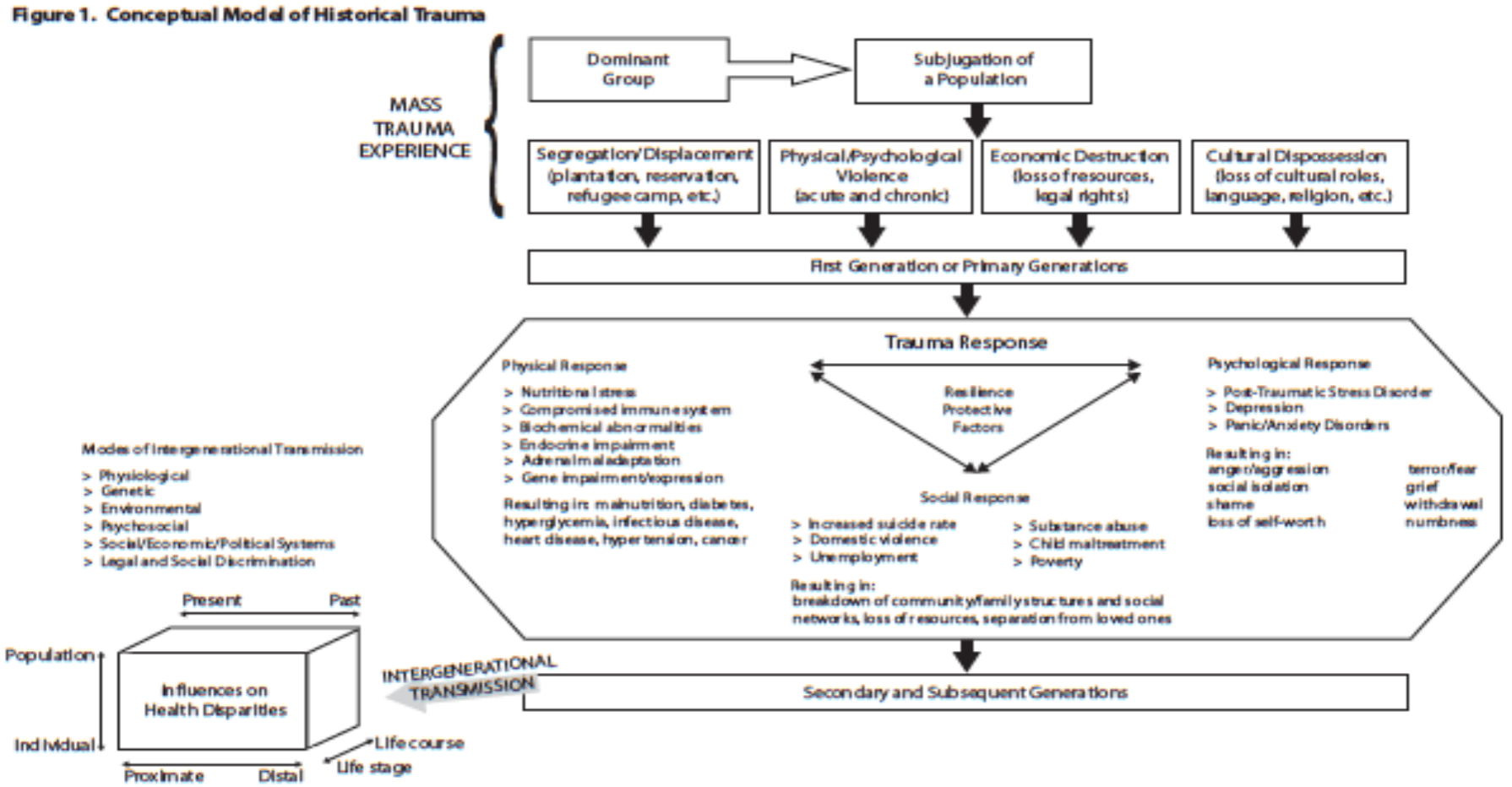
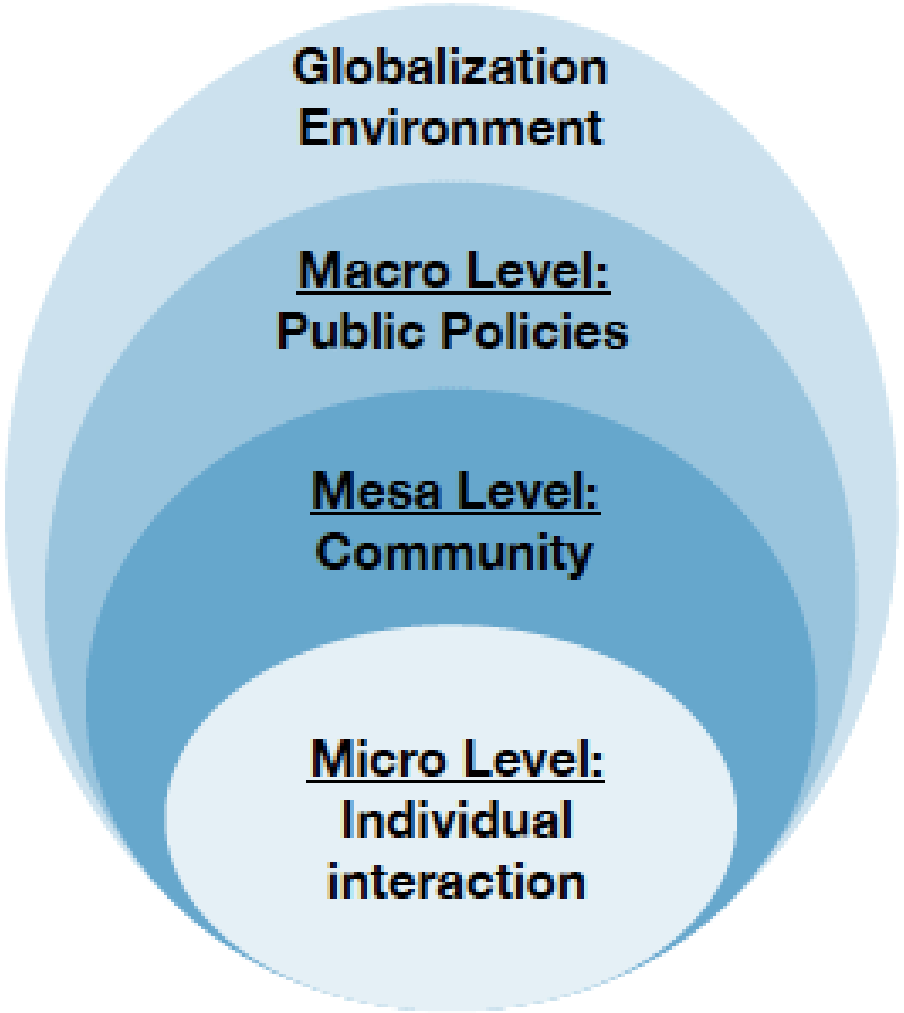


Figure 1. Conceptual Model of Historical Trauma
MASS TRAUMA EXPERIENCE
Dominant Group
Subjugation of a Population
Segregation/Displacement (plantation, reservation, refugee camp, etc.)
Physical/Psychological Violence (acute and chronic)
Economic Destruction (loss of resources, legal rights)
Cultural Dispossession (loss of cultural roles, language, religion, etc.)
First Generation or Primary Generations
Trauma Response
Physical Response
> Nutritional stress
> Compromised immune system
> Biochemical abnormalities
> Endocrine impairment
> Adrenal maladaptation
> Gene impairment/expression
Resulting in: malnutrition, diabetes, hyperglycemia, infectious disease, heart disease, hypertension, cancer
Resilience Protective Factors
Social Response
> Increased suicide rate
> Domestic violence
> Unemployment
> Substance abuse
> Child maltreatment
> Poverty
Resulting in: breakdown of community/family structures and social networks, loss of resources, separation from loved ones
Psychological Response
> Post-Traumatic Stress Disorder
> Depression
> Panic/Anxiety Disorders
Resulting in: anger/aggression, social isolation, shame, loss of self-worth, terror/fear, grief, withdrawal, numbness
Modes of Intergenerational Transmission
> Physiological
> Genetic
> Environmental
> Psychosocial
> Social/Economic/Political Systems
> Legal and Social Discrimination
Present
Past
Population
Individual
Influences on Health Disparities
Proximate
Distal
Life course
Life stage
INTERGENERATIONAL TRANSMISSION
Secondary and Subsequent Generations



Policies on **stratification** to reduce inequalities, mitigate effects of stratification

Policies to reduce **exposures** of disadvantaged people to health-damaging factors

Policies to reduce **vulnerabilities** of disadvantaged people

Policies to reduce **unequal consequences** of illness in social, economic and health terms

- **Monitoring and follow-up of health equity and SDH**

Group Processing

Chat box question: What is your biggest takeaway so far?

Things to Look out for…..

1. What an equity action framework might look like:

- Introduction to "R4P" *(Hogan and Rowley)*

Maternal and Child Health Journal (2018) 22:147–153
https://doi.org/10.1007/s10995-017-2411-z

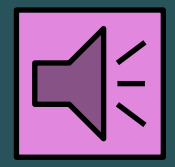
COMMENTARY

CrossMark

Dimensionality and R4P: A Health Equity Framework for Research Planning and Evaluation in African American Populations

Vijaya Hogan[1,2] · Diane L. Rowley[1] · Stephanie Baker White[3] · Yanica Faustin[1]

Published online: 1 February 2018



R4P

Outlines five domains of action you need to add on top of EBP to address inequity

Crosswalk Between Equity Contributors and R4P Equity Frame

Unique Risk		**Action req. to Reduce Risk**
Racism	→	**R**EMOVE
Historical/ Intergenerational	→	**R**EPAIR
SDOH/Individ risks	→	**R**EMEDIATE
Lifecourse, Structural	→	**R**ESTRUCTURE
Attention to Implementation/ Intersectionality	→	**P**ROVIDE

REPAIR

Repair the damage of the past. Historical risk is embedded in current physiologic, biologic, psychological, behavioral and social structures. Historical trauma sets a population group back in the present.

RESTRUCTURE

Societal structures *(where we live, work, play…..)* can function inequitably and continue to expose new populations and produce risk. Structural changes *(changes in social,economic, educational equity, rules, regulations, etc…)* are needed to stop new production of risk and permanently remove the stressors and toxic exposures.

• PROVIDE

- **Culturally and economically feasible health education and medical care are required, along with the required resources and environmental supports, so that it is the easiest option for people to choose and sustain health promoting actions**

Forces that are adverse to health, health maintenance and health seeking are embedded in most societal institutions. Such forces-- like Power imbalances, Racism, SES inequities-- must be directly acknowledged and removed.

REMOVE

While we wait for structural changes to be completed, the social context continues to be a source of adverse exposures. At-risk populations need to be buffered from these exposures to reduce their vulnerability until such time that the negative stressor is completely removed

REMEDIATE

2. Guidance on how to become EQUITY PROFICIENT

- Stages of Equity Capacity
- Do capacity building in stages that match learner's ability
- Structure as a permanent institutional structure/resource w accountability

Self-Assessed Measure of Racial Equity Capacity (SAMREC)

Determines how to target training for implementing equity

Versions being piloted in:

- AIM CCI/National Healthy Start Association
- Allegheny County Maternal Health Collaborative

Uses "stages of change" framework

- Based on Prochaska stages of change *(The Transtheoretical Model (Prochaska & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992))*
- *Change is not an event but a process*
- Equity capacity development matched to level of consciousness and current engagement with equity
  - e.g. do not put people through anti racism training (Action stage) until they have prior levels of understanding as context for it

3. Structural change support

- Michigan Public Health Association (MPHI)
  - Achieving Birth Equity through Systems Transformation **(ABEST)** project

Leadership training on implementing structural change and addressing upstream factors and racism

4. Statewide collaborative approach to racial equity in MCH

Nurture New Jersey

- Nurture NJ is a statewide campaign committed to elimination of racial disparities in birth outcomes and reducing maternal and infant mortality and morbidity.
- NJ is a public/private partnership led by the Office of the First Lady of New Jersey, Tammy Murphy, and funded by The Nicholson Foundation and the Community Health Acceleration Partnership.
- A statewide, multi sector, community partnered strategic plan is being implemented to achieve sustained equity in maternal and infant health across the lifecourse.

Introduction to the PANEL

Stephanie Campbell	Director, Office of Sexual Health and Youth Development at Massachusetts Department of Health
Ayanna Eggleston	Parent Consultant and Parent-to-Parent Support Network Match Coordinator at Michigan Family Center for Children and Youth with Special Health Care Needs
Amy Zapata	Director, Bureau of Family Health at Louisiana Department of Health

AMCHP Leadership Lab Webinar

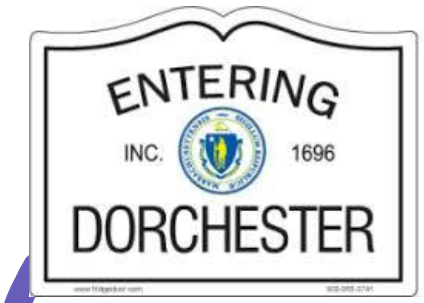
November 16, 2020

Panelist Remarks:

Stephanie Campbell, MPH

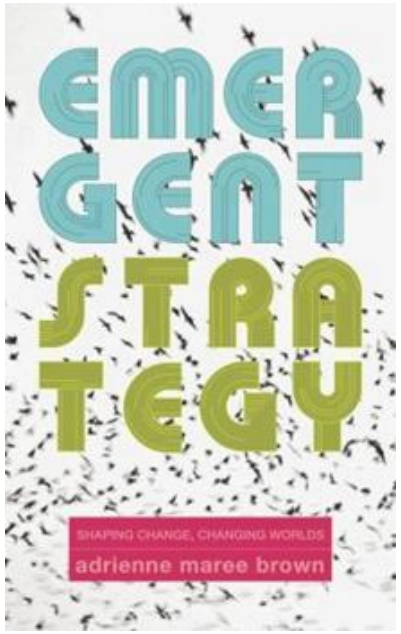
Stephanie Campbell, Director of the Office of Sexual Health and Youth Development

- #Daughter of Stephanie daughter of Dorothy daughter of Mattie daughter of Ida
- My Intersectional identities and leadership are intrinsically connected.
- “When we speak we are afraid our words will not be heard nor welcomed, but when we are silent we are still afraid, so it is better to speak” ~Audre Lorde



Emergent Strategy

- Change is Constant. (Be Like Water)
- There is always enough time for the right work.
- Never failure, always a lesson.
- Trust the people. (If you trust the people, they become trustworthy)
- Focus on critical connections more than critical mass- build the resilience by building the relationships.
- Less prep, more presence. What you pay attention to grows.



Applying and Equity Lens Across Levels Of Leadership

- Dedicated time at staff meetings to foster continued racial justice learnings
- Supporting staff to explore their own racial identity and involvement in Bureau Racial Equity Movement
- Integration into programs and services i.e. procurement and grantee meetings

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November 16, 2020

Panelist Remarks:

Ayanna Eggleston

Equity in Leadership

- Parent Leadership
  - Ensuring the parent voice is valued
  - Ensuring that attention is given to areas where resources are scarce *Sickle Cell
  - Ensuring diverse opportunities for support is given

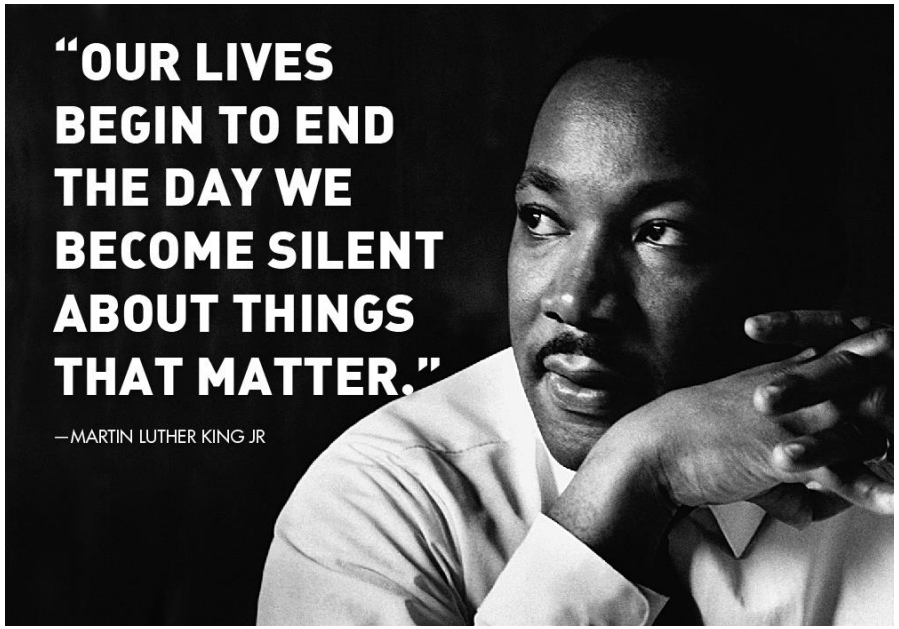
Equity in Leadership

- Professional Leadership
  - Translating to leadership community needs
  - Advocating for equitable care and services
  - Cultivating environments for change

Motivation for Racial Justice

- It is here where the world of being a professional and parent in leadership collide. My motivation for this work will always be the voices of families...the voice of children.

My Racial Identity



AMCHP Leadership Lab Webinar

November 16, 2020

Panelist Remarks:

Integrating Equity into the Organization and Cultivating Champions

Amy Zapata


FOOT IDENTIFICATION
Ghetto
The Rez
The Barrio
Chinatown
Hollywood Park
NON-PROFIT
SOCIAL SERVICES
EDUCATION
CRIMINAL JUSTICE
HEALTH
FOOD
TECH
SPORTS & ENTERTAINMENT
TRANSPORTATION
GOVERNMENT
RELIGION
MEDIA
HOUSING & REAL ESTATE
BANKING
PHARM
XXX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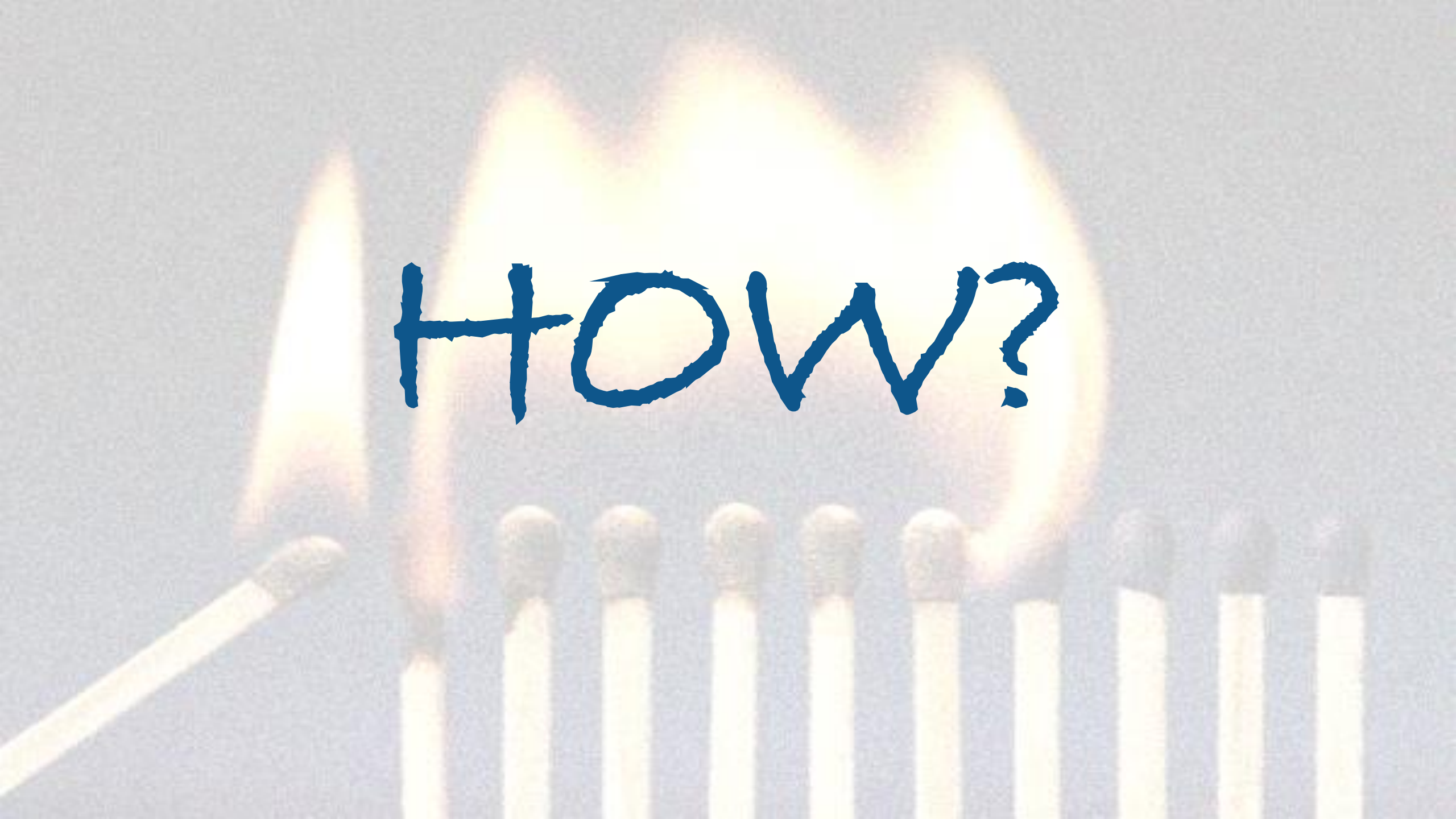
HOUSING & REAL ESTATE
BANKING
PHARM

"…They keep you in poverty in order [for you] to get the services . . . And if you're above that, you don't get it. So it's an incentive to stay below that."

"The system is not set up
for anybody to succeed, period."

-Louisiana Title V MCH Block Grant
Focus Group Participants - 2015


HOW?

1. Individual and organizational learning
2. Re-envision the organization and how we “do” public health
3. Ignite the spark externally

1. Individual and organizational learning

- Shared learning via common language (toolkit)
- Individual and shared experiential learning (workshops, documentaries, discussion)
- Examination of state history and policies
- HEAT (Health Equity Action Team)

1. Individual and organizational learning

- Shared learning via common language (toolkit)
- Individual and shared experiential learning (workshops, documentaries, discussion)
- Examination of state history and policies

A-ha: Effect v. intent

Re-learning history

(some)

Knowing Our History: Exploring Policies and Practices that Have Contributed to Racial Disparities in Health Outcomes

Gloria Grady, BA Amy Zapata, MPH Karis Schoellmann, MPH

Background

- In Louisiana, racial disparities persist across a variety of health indicators, including birth outcomes.
- The World Health Organization defines health inequities as systematic differences in health outcomes that are attributed to "the social conditions in which people are born, grow, live work, and age."
- The Bureau of Family Health has undertaken efforts to better understand racism and racial disparities through staff participation in the People's Institute for Survival and Beyond *Undoing Racism* workshops, educational videos on race and racism, and structured topical discussion groups.
- These discussions catalyzed staff interest in the historical social norms, policies, and laws may have contributed to race-based disparities in Louisiana.

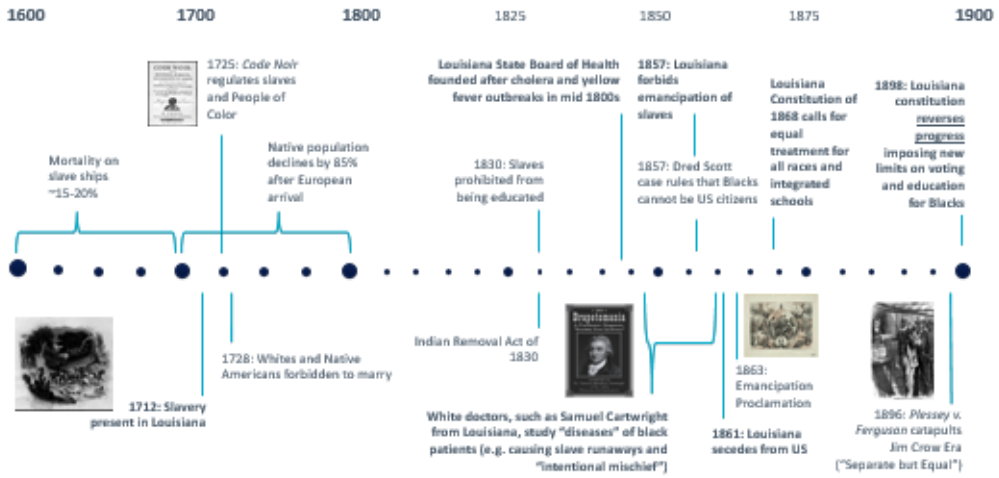
Study Question

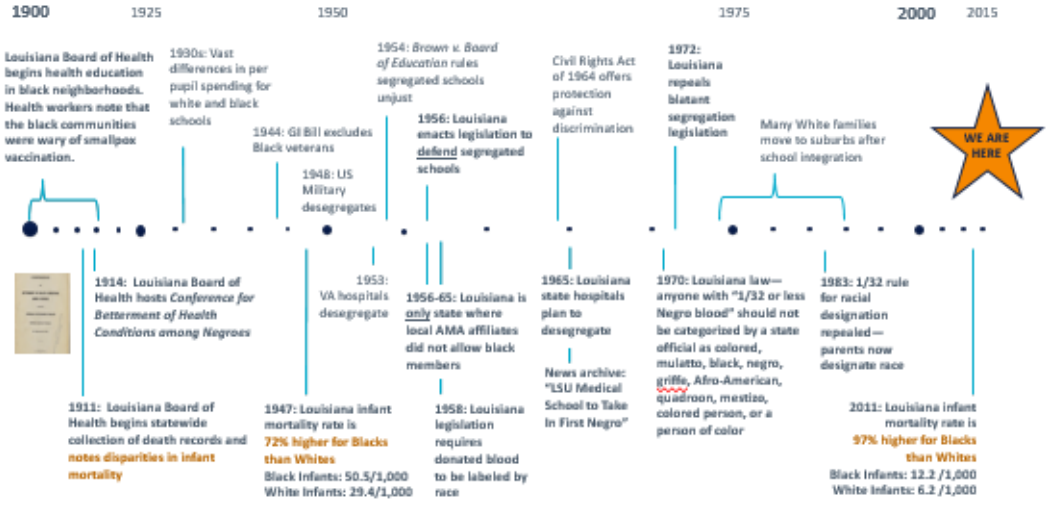
- How do social, educational, economic, and health-related policies and practices of the colonial period through the present contribute to racial disparities in health outcomes in Louisiana?

Methods

- Literature reviews of databases such as PUBMED and JSTOR, using key words specific to time periods and subject areas. Keywords included:
  - *Colonial Louisiana*
  - *race relations*
  - *segregation laws*
  - *segregated healthcare*
  - *school integration*
  - *Freedmen*
  - *Civil War*
  - *Reconstruction*
  - *Civil Rights Movement*
- Research of historical documents and books using the following libraries:
  - The Louisiana Research Collection
  - Rudolph Mates Library of the Health Sciences
  - Howard-Tilton Memorial Library
  - Amistad Research Center
  - Tulane Law Library
  - State Library of Louisiana

Results





.....Today's Great Grandparents....and Grandparents.....and Parents.....Today's Kids.....

Conclusions

- While we did not answer "how" social, economic, and health policies or practices have resulted in health disparities, the research illuminated historical contributors.
- There have been systematic policies to limit citizenship, voting, home ownership, education, and professional attainment—these are fundamental underpinnings of health and well-being.
- The state's social, economic, and education policies have mirrored the United States', but Louisiana as a state also has sought to preempt, delay, or actively resist changes.
- Medicine, healthcare and public health have not always been benevolent or neutral influences, but rather have reflected the historical context.
- Race is not rooted in biology but artificial definitions that have changed over time; as recently as 1983 in Louisiana.
- Racism is more than acts of discrimination or bias.

Limitations

- Because of time and resources, many historical documents may not have been found.
- Many documents from the colonial period were in French and therefore could not be analyzed.
- Information on the experience of Native Americans, Latinos, or Asian Americans was sparse and not thoroughly examined for this project.

Public Health Implications

- Health outcomes are in part a product of historical factors.
- An estimated 64% of people born in Louisiana stay in Louisiana. Generational history is still relevant to current residents.
- Public health touches the lives of all residents of a state—history shows that Vital Records, our interpretation of health and demographic data, and our policies and "services" have at times perpetuated inhumane and harmful practices. What are we fostering or perpetuating now?
- Public health should be informed by an understanding of the intrapersonal, interpersonal or institutional levels of racism; assistance, support, and tools may be needed for this work to be meaningful and impactful. Such a framework is also very valuable for considering the drivers of other health inequities.

This project was supported in part by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) Title V MCH Block Grant award. The information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

For a full list of resources, see hand out.

Presenter Information:
Gloria Grady, Tulane MPH Candidate
gloriajaygrady1@gmail.com

2. Re-envision the organization and how we “do” public health

We envision Louisiana as a state
where all people are valued to reach their full potential,
from birth through the next generation.

BFH’s mission is to elevate the **strengths and voices** of individuals, families, organizations, and communities **to catalyze transformational change** to improve population health and achieve equity.

THE BIG OPPORTUNITY!

hundreds
and thousands

"Services"

THE BIG OPPORTUNITY!

hundreds
and thousands

tens-of-thousands
and millions

"Services"

Systems and Policy Change

3. Ignite the spark in others

- Systems change – use data, existing external pressures, and supports to mobilize change in others
- Policy change – capitalize on learning and interest mobilized in others

LaPQC

as catalyst and support for learning and change (Pregnancy Associated Mortality Review process and report as triggering and reinforcing loops)

Achieve a 20% reduction in severe maternal morbidity among pregnant /postpartum women who experience hemorrhage or severe HTN in LaPQC participating facilities in 12 months and to narrow the Black-White disparity in this outcome in 12 months

Reliable Clinical Processes

- Assure readiness
- Improve recognition and prevention
- Understand & reduce variation in response
- Eliminate waste

Respectful Patient Partnership

- Design for partnership
- Invest in improvement

Effective Peer Teamwork

- Reduce variation in reporting
- Change the work environment
- Improve work flow

Engaged Perinatal Leadership

- Manage for quality & systems learning
- Enhance patient and family relationships
- Change the work environment

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relationship, trust, & curiosity

learning & action

2020 First Extraordinary Session

HOUSE RESOLUTION NO. 33

BY REPRESENTATIVES HILFERTY, DAVIS, DUPLESSIS, FREEMAN, GREEN, HUGHES, LANDRY, DUSTIN MILLER, NEWELL, STAGNI, WHITE, AND WILLARD

A RESOLUTION

To urge and request the Louisiana Department of Health to recommend and make publicly available standards and curricula on the subject of implicit bias in the delivery of health care for use by health professional education programs and health professional licensing boards.

WHEREAS, prior to and during the COVID-19 pandemic, healthcare professionals have been among the most valued and trusted workers in our state and nation; and

WHEREAS, Louisiana's healthcare workers have performed heroically and made

1. Individual and organizational learning
2. Re-envision the organization and how we “do” public health
3. Ignite the spark externally

Louisiana Department of Health – Office of Public Health Bureau of Family Health

Growing potential, from birth through the next generation

Amy.Zapata@la.gov

Audience Questions