Dialogue4Health
Build Power for Health Equity: Strategic Practices for Local Health Departments
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>> Dave Clark: Greetings and welcome to today's Dialogue4Health web forum on Build Power for Health Equity, brought to you by The California Endowment, Human Impact Partners, CA4Health and the California Academy for the Public's Health. I'm Dave Clark, host for today's event. Before we get started there are a couple of things I would like you to know about. First of all, realtime captioning is available for the web forum provided by Home Team Captions. The captioning panel is located on the right side of your screen. It can be toggled on and off by clicking the Media Viewer icon on the top right of your screen. On a Mac you'll see the icon on the bottom right of your screen. If you would like to use captioning today you'll see a link in the panel that says show/hide header and another link that says show/hide chat. If you click both links you will be able to see the captioning easily. If that window disappears, click the Media Viewer icon I mentioned to bring it right back again.
Concerning the audio, today's web forum is listen only. That means that you can hear us but we can't hear you. But that doesn't mean that today's event won't be interactive. How will that work? We'll have a Q&A session at the end of the web forum. You will be typing your questions at any time into the Q&A panel. The Q&A panel is also located on the right side of your screen, toggled on and off by clicking the Q&A icon that you'll see on the top right of your screen. Again on a Mac you'll see that icon on the bottom right of the screen.
In the Q&A panel it is important that all panelists is selected from the dropdown menu. If it doesn't say that, choose that option. That will guarantee that your question gets sent to the right place. By the way you can also use the Q&A panel to communicate with me and my colleague, Laura Burr. We will be behind the scenes. If you have technical problems or other issues, let us know about it. Just type your issue into the Q&A panel.
We are interested today in your thoughts and your questions on this topic. So be sure to get all of your questions and all of your feedback into the Q&A panel and our panelists will make sure to answer as many of them today as they can.
In fact, why don't we bring your voice into the conversation right now. Let's get interactive right now. We thought that you might be interested in seeing who you are attending today's event with. We will bring up a quick interactive poll on the right side of your screen. You can select from one of the four choices. Let us know, are you attending today's web forum individually all by yourself? Attending in a small group of 2 to 5 people? Maybe in a larger group of say 6 to 10 people? Or maybe you're in a big conference room today with all of your colleagues, more than 10 people. Let us know who are you attending today's web forum with? We will have a

few more polls later on during the web forum. This is a good practice poll as well so you get used to using this interactive polling technology.

Let us know who are you attending today's web forum with? All alone? Are you in a group? Let's take a look at the results, get those results up on the screen. Who are you attending today's Dialogue4Health web forum with?

If you are not seeing the results appear right away, do give them a few minutes to tabulate. Sometimes it takes a few moments to analyze all of that polling data.

And if you did make a choice and didn't click the submit button, you will see an option right about now to do that. Click the submit button to ensure that your answer gets submitted.

As usual, a high percentage of you, no surprise are, are attending alone. About woo percent of you. Another 11 percent are attending in a relatively small group of two to five people and there's perhaps a scattering of you attending in larger groups. If you are in a group today you may want to a sign a single person the responsibility of submitting questions on behalf of the entire group or on behalf of individual group members. That might make things go easier for you when we get to the Q&A session.

On the other hand if you are alone, all by yourself, like I said, we want this to be a very interactive engaging event today. We don't want you to feel you're there all by yourself. Make sure you get all of your feedback into the Q&A panel and join in on the conversation today.

All right. Well, let's get started with today's presentation on Build Power for Health Equity. To kick things off today we'll hear first from Dr. Carmen Nevarez, Vice-President of Public Health Institute. Really, there is no better person to get us started today. Carmen, over to you.

>> Carmen Nevarez: Thank you so much for that. Good morning, everybody. On behalf of the Public Health Institute and Dialogue4Health I welcome you to join us in this conversation. There has been tremendous national interest in the this panel and the topic that they are going to tackle. I want to start out by telling you that this is actually the highest number of people who have ever registered, over 2,000. So you are in a great group of people who are fascinated by the topic and really interested in trying to see how do we move health departments and what are the opportunities for thinking in new ways around health equity. Jonathan Heller is going to be the moderator for this conversation. He is cofounder of Health Impact Partners back in 2006 and a nationally noted authority in health impact assessments. He will be taking this experience and wisdom and bringing this stellar panel into discussion. Renee, Sarah, and Jacques will be helping you to expand your vision, increase the intent and develop strategies around the role for local health departments in moving the needle towards health equity.

Jonathan, I would like you to go ahead and begin. Thank you so much.

>> Jonathan Heller: Great. Thank you so much, Carmen, to you and to the rest of folks at the Dialogue4Health. Let me also thank The California Endowment for both supporting Dialogue4Health and much of the work that I'm going to tell you about today as well.

And thanks to everybody who is joining. Got a huge audience and we really appreciate all the excitement and interest in figuring out how we really do a better job within public health focusing on equity.

All right. So all of you, we've got a huge turnout. We have people from all 50 states and outside the U.S. as well. You can see here that we've got about 285 people from California, but then huge numbers from many other states showing here. People from states where 30 or more people are attending.

So thanks.

Then more about you all. Very high turnout this round around from people who are in government. 46 percent in city or county government. Another 20 percent in state government and a couple percent in federal government as well. That's about two-thirds of the audience, which is great because a lot of what we talk about is focused on what public health departments can do to advance equity. There will be stuff for everybody in here as well. Thanks again for making the time for this.

So for those of you who don't know us, we are a national nonprofit based in Oakland. And we work to transform the policies and places people need to lead healthy lives by increasing equity in decision making. We do research, advocacy, and capacity building and we bring the power of public health to campaigns and movements for a just society.

So I want to start off with background. I will go through some basics, underlying ideas behind the work that we are doing that you'll hear about from Sarah, Jacques and Renee.

But I want to get us all on the same page in terms of some of the background. So first I want to make sure we are all on the same page about what equity means and what inequities are. And we use disparities and inequities differently. We think of disparities as differences in health outcomes for different groups. Sometimes those can be expected. For example, folks who are older will have cancer more at higher rates than children. That's a disparity.

It becomes an inequity when those differences are systemic, avoidable, unfair and unjust. A quote from Margaret Whitehead.

When we think about breast cancer mortality for black women versus white women. Black women have higher mortality rates, for no reason. It's systemic, avoidable, unfair and unjust. So it's an inequity.

When we think about what causes health outcomes, health inequities, we know that health inequities are largely caused by inequities in the social determinants of health. You see many factors starting in the middle with individual behaviors and branching out to public services and infrastructure like transportation and parks and to living and working conditions like wages and benefits and air, soil, water quality, housing. Finally out to social, economic, and political factors like power which we will be talking a lot of about, sexism and racism that we will be talking about today.

When we think about inequities, the two orangish rings, public service and infrastructure and living and working conditions rings are the ones we focus on when we go upstream. Those are the social determinants of health we are thinking of and trying to work on. What we are also go to say today, it is important that we focus on the outer most ring. That the power and various forms of oppression are a huge part of what we want to do if we want to move the dial on advancing equity within public health work.

So why is that? Again when we think about inequities we think about then moving up to inequities and social determinants of health like housing or education. But those inequities in education and social determinants of health are most often caused by power imbalances. We have an unequal distribution of power in our society. Those in power benefit from inequities and benefit from the status quo. They push back against policy change that would address the inequities and really probably most often hurt them financially. Those inequities are faced by disenfranchisement and lack of power. That power imbalance is really important.

Power is a relatively complicated concept. There are many forms of it. Power can take the form of having enough votes to pass or to block a particular piece of legislation or to elect a particular person. It could also mean having the networks and relationships to actually influence what is on the political agenda. And the third piece of power is having the ability to

influence people's world view, which is the narrative that is being told out there about the world. That form of power shapes what is power, what we can even discuss in legislative discussions today. We also know that power imbalances are partially a result, significant result of various forms of oppression, based on race, religion, class, gender, sexual orientation, and others. Those who use oppression to maintain their power can manifest as structural oppression, structural racism, for example, institutional, interpersonal or internalized. Overt or coded. The various forms of oppression morph as times change and people find and need new ways of keeping their power.

Currently we are in a moment where the attacks are certainly overt and very dangerous for many, many people in the country.

So from our perspective this all means that in order to address equity and inequity in a lasting way we need to confront oppression directly.

So a lot of what we are going to focus on today is this document shown on this slide which we call build power for health equity, what we did was looked at what people had written about how to advance equity at health departments. People these various organizations, NACCHO and others, had sets of practices. They often shared that underlying analysis that I just talked about with power and oppression. They had various practices of public health departments could implement to advance equity. What we did in the document we grouped and gathered all of that information and wrote it up into essentially 15 practices that crossed all of those different documents that we reviewed.

You should have gotten the document from Laura in advance. We'll send it out after the webinar again. You can also download it from this website. It is not totally ready yet. It is not actually launched yet, but the document is on it and we will be launching it at the NACCHO Annual Conference in July.

In reviewing all of what people had written, it became clear that in order for us to confront power imbalances and oppression we need to take an inside/outside approach to change. Health departments can work internally to prioritize work on the social determinants of health, for example, but they have limited power. We know that a lot of the decisions lie outside of public health domain. And so they can really only have a limited impact. So we know that they need to go further than working internally. They need to build relationships with others outside of public health in other parts of government, whether they are elected officials or other agencies who have more control over the social determinants of health.

That's one thing that they need to do, internal work and across government and then go in further and work with community groups who are what we would say are on the outside. In the inside/outside framework. Public health departments need to build partnerships and share data with those groups. Outside groups can then for example take that data and make their case to elected officials via advocacy in ways public health departments are not allowed to do. They can also ask elected officials to ask the departments of health to do more work and put pressure on the public health department, hopefully welcome pressure to do work to advance equity.

Another key component of the outside strategy is to be part of building alliances that include others advancing equity. We need to recognize in public health that outside of our field most people call this work social justice. We need to be partnering with other social justice organizations especially given the recent election and its aftermath. We know that we need to build stronger, more powerful alliances and public health can be part of that.

We've taken what we've seen others writing and from our own experience and put together this

document. It is not intended to be a step-by-step guide to how one advances equity. Really, you need to customize the ideas in here and make them your own and figure out how to do it locally. Every situation is different. We know that equity needs to be a central part of public health work. It can't be something on the side lines. So it needs to be a core part of what your agencies are doing.

These strategic practices, these 15 things aren't independent. They build off of one another. They work together. When you make progress on one, you'll likely be making progress on another. You might get to a point where you realize you are lagging on one and that will get in the way of doing of some the other work that you need to do. You will oh he need to ping that up. This he are intertwined. We want to recognize that public health departments are in very, very different places. Some just started, some made progress on different pieces of it. Few have really done all of it. And have it all going in the right direction. And it is important to recognize that and know that everybody needs to get on the sale page about how they are doing this and start working together to figure it out and moving it forward no matter where you're starting.

So this framework, next few slides take you through the framework. The first piece of this, there are four buckets of strategies. The first is building internal infrastructure. We need to build organizational capacity, allocate resources, change internal process practices and policies, prioritize on the social determinants of health and mobilize data, research and evaluation to do this work. We will be going into each of these in more depth and the other panelists will be giving you examples of how they have done this.

The second bucket is working across government. We need to build government alliances, develop a shared analysis and change the regulatory scope of what public health practice means.

And then we also need to reach out to the community, foster strategic community partnerships by sharing power with communities, decision making, support-building alliances I mentioned and engaging in social justice movements.

Across that whole body of work are some transformative practices that need to be implemented that are super difficult. We need to focus on confronting the root causes. We need to be talking and acting on power and oppression. Those need to be an explicit part of our work. We need to develop leadership that is willing to and cultivate leadership that is willing to could innovative things and that is willing to take risks. We need to be able to change the conversation about what public health is and what causes public health, change the public narrative which we'll talk about more later on as well.

Last, the more we do this together, the more we build a movement across many public health departments and others in public health who are trying to do this. The stronger we will be and the more freedom we will have to do the work and more change we can bring about. Building a stronger community is an important part of this as well.

That is the framework. As I said this will be up on a new website in July that is a health equity guide.org. We will be releasing it at NACCHO.

With that I'm going to introduce the panelists. These are friends of mine that I've known for now a number of years. We all were part of a leadership development cohort. Renee was a mentor in that and Sarah and Jacques were fellows and Health Impact Partners led that program.

So they are amazing, all doing great work locally. We thought it would be interesting for you to hear how they are implementing all these strategies.

So Renee Canady serves as CEO of the Michigan Public Health Institute. Prior to moving there a couple years ago Renee served as health officer for Ingham County in Michigan. Jacques is the coordinator for the Tacoma-Pierce County Health Department in Washington. Prior to taking that position, Jacques led some of the health equity work at NACCHO. Sarah Hernandez is with the Colorado Department Public Health and Environment. She recently took a new role there was policy analyst in the Office of health equity.

So I would like to say welcome to them and thank them for being part of this.

So now what we are going to do, we are going to go back to the pieces of this framework starting with building internal infrastructure. I'm going to ask Renee and Sarah and Jacques to talk about their work. So the first piece of this is build organizational capacity. Building understanding and capacity to advance equity across the department and workforce. Health department staffs across the organization must develop, leadership needs to encourage continuous learning and experimentation within the department. Health departments must therefore implement organizational development strategies that build both the theoretical understanding of equity and oppression and power and really practical skills that help them apply that across all policies, programs and practices that the department is doing.

Renee, starting with you, I wonder if you can tell us a little bit about the training you did in Ingham County and the work you're doing throughout Michigan.

>> Renee Canady: Sure. Thank you very much, Jonathan. I will be concise and jump in in the interests of time. It has been about ten years now since we developed a model of, that we describe as using facilitated dialogue as a methodology. And we are very intentional about saying this is not a training. It really is a learning and growing process together. And so we created in Ingham County a workshop together with leadership, the workforce at the health department and the community to be driven by and set priorities for not only what we would talk about around health equity but also how we would talk about it. And so I want to emphasize the importance of taking time for the fundamentals. Often times you will hear people using the same words and meaning completely different things. So we have been pushed in advancing this work by our community, both at Ingham County but also in the work we are doing at MPHI who are doing the fundamentals and saying now what? How do we get into the nitty gritty of our work?

I want to emphasize there are lots of definitions out there. This idea of creating a shared vocabulary is really important. Jonathan shared Margaret Whitehead's definition. Many of us love that definition. There are some spaces where a different definition would advance the dialogue more effectively. You have to figure out what are the histories of your community, what are the kinks and relationships, and move there. We together with our community created a three-day workshop. Two days of fundamentals. We go away and see the world with our new lens and come back after three to four weeks and talk more about how do we apply this. It has been a really effective model for us.

I will say that initially when we started doing the work it was about the institution and policies and we just weren't able to get much traction in that space. So we figured we should back up and look at our workforce. What are the barriers to our effectively addressing policy and practices in our health department. We found that people were simply not comfortable with the concepts. I submit that is almost increasing because particularly in public health right now people feel like I should know this. Maybe I shouldn't say that I don't really understand.

So this assessment of what is the readiness of your organization has been really effective. We had the honor of managing a grant for Kellogg in five different sites across the nation where we

shared our facilitated dialogue methodology. It really was variable in terms of how people started. I always like to say it doesn't matter how you get in the pool, whether you go down the slide, jump off the diving board or just cannon ball in, as long as we all end up getting wet. Jonathan made that point that this looks very different in different communities.

>> Jonathan Heller: Great. Thank you, Renee. Jacques and Sarah, I know both of you have been doing training and building capacity within your organizations. I don't know if you want to add anything to what Renee said.

>> Sarah Hernandez: Sure, I'll jump in. This is Sarah. Thank you all for having us here today. I'll speak a little bit more about this as we get further into the framework. Here in Colorado, at the State Health Department we have implemented a Health Equity Environmental Justice 101. I can't say it's as comprehensive as what Renee has done in Michigan, and I really admire what you all have done, Renee, by the way.

Ours is really a foundational, about an hour and a half discussion. And all of our department staff are required to participate in that 101 this year. And what I can say is echo Renee's thoughts as far as getting everyone on the same page as far as definitions and narrative. We found that not everyone knows exactly what a social determinants of health is or how they impact health. It has driven the conversation forward in a positive way.

Jacques, I'll leave it to you if you have anything toed a.

>> Jacques Colon: Sure. Yeah, I'll just add that for us there were two things that I think really helped build our organizational capacity. The first is having a strategic plan that really calls out health equity in a very intentional way. I say that because resources aren't always available. If they do come up, having that strategic plan to always point us in the direction of what that work means and how much of a priority it is has been a very effective tool for us.

And the second is that we have done some discussions at the all-staff level. We really found if we want to change the way that programs have capacity to do this work, there has to be work at the smallest granular level you can get to with your staff to be able to work with them around what does health equity really mean specifically for the work in their area. What are the specific health inequities in their area. We did a health equity he assessment early on in our health equity work. That has been really another key tool that we have in our back pocket to help others in the organization understand what equity is and how it impacts their program area.

So I would just point to strategic planning and maybe some sort of health equity assessment, similar to what Renee mentioned.

>> Jonathan Heller: Great. Thank you all. All right. I'm going to keep us moving through. The audience can ask questions later on if they want to go into detail about any of these topics. Next I want to dive into this bucket of changing internal practices and aligning internal processes to advance equity.

There are huge variety of processes and policies that health departments do. It is difficult and we need to look at all of those policies and practices with an eye towards what is advancing equity or what might be impeding it. It could be things like increasing workforce diversity by changing hiring practices and through retention, promotion, and training. It can be building cultural competence and humility across the staff, especially those who are focused on service delivery. There are opportunities in accreditation and performance management and QI. Then there are administrative processes like contracting and RFPs that can be changed as well.

So Sarah, getting nuts and bolts for a few minutes. Do you want to talk a little bit about what

you have been able to do in Colorado to change internal policies and practices?

>> Sarah Hernandez: Yes, I would be happy to do that.

Here at the Colorado Department of Public Health and Environment. We have an environmental justice collaborative made up of staff across every single division on the environmental and health side, which has been really important for driving this work forward. A year ago through that collaborative we passed a health equity and environmental justice policy with incorporates principles and practices into the staff's work. Even when there is not a specific authority or regulation, specific authority and regulation or statute. That piece is really important for us because we heard from assessments and anecdotal data that not all staff felt they had support from their management to incorporate equity and justice into their work. Passing that policy was just the first step. That was actually the policy that called for all department staff to participate in the Health Equity Environmental Justice 101 discussion that I mentioned earlier as well.

So to build upon that policy, the collaborative members developed a set of accompanying guidance documents to operationalize the policy. For the environmental side we have a set of regulatory guidance documents that includes things like enforcement, permitting, and monitoring. For the health divisions, we have a list of suggested activities that staff can take to address the social determinants of health and tackle some of the upstream factors. It is mapped on to the ten essential health services. What we were hoping for is that it would be easier for folks to figure out precisely how to embed it into the core functions of their work. We are tracking those activities, asking each health division to identify at least one activity that will be monitored over the next several months on our department's performance monitoring dashboard. That is bringing in the QI perspective.

Another practice I wanted to mention is that we are now using a set of questions that is called checking assumptions. So we know that we all make important decisions in our day-to-day work, some big and some small, but we have certain unconscious biases. It's important to systematically consider how we make those decisions.

There are great tools out there on assessments, the racial equity tool from King County, Washington. We heard from staff that they appreciate the tools and they were appropriate in certain circumstances but they wanted something that they could use in the smaller every day decisions right on the spot. This set of questions is not intended to be an ending practice but is really something that can be a start to routinely examine daily decisions with an equity lens. I should also mention we were inspired by a particular set of questions from the Minnesota Department of Health and what they are using, tweaked with feedback from staff here in Colorado.

The last things I will mention, we are examining our grant making practices and procedures, including barriers to applying for funding. We want to make sure that everyone has the opportunity to apply for state funding and have heard that the process can be onerous for smaller grassroots organizations. So one step we have taken, we've shrunk our request for application template from 60 pages down to seven. We eliminated unnecessary legalese and the remaining pages are written in plain language. We are looking to further guidance such as sample scoring metric as well as examining other processes and procedures trying to set up our grantees for success, looking at fiscal audits, what does state statute require, that sort of thing as well as looking at the programs we are funding. Some of our programs are shifting from funding direct services to funding local initiatives centered on policies and system change that address the social determinants of health. Thanks.

>> Jonathan Heller: Great, Sarah. That's a huge variety of things. We are hearing more things about taking down barriers to applying for grants from other health departments as well. Jacques or Renee, I don't know if one of you has something you want to add.

>> Renee Canady: I do want to add, I'm thinking about sort of the steps needed before you get to this internal practice and policy change. One of the unanticipated consequences of doing workshops and sort of educating and increasing the knowledge of your workforce, if they do come back with a different internal lens. Two unanticipated pushbacks that we got was staff coming from workshop and saying then to their supervisors or whatever: This is a social justice issue in terms of the culture of how they were being engaged with as an employee of a local health department.

The other push back we got was people began to recognize things and so those that were uncomfortable with the outing of these poor practices would say things like you know, we didn't have these problems until Renee made us do these workshops. Which was something we would always chuckle about with our health equity team, but figuring out that what is the readiness of your organization and these assessments that Sarah mentioned and the work that Jacques mentioned. You really need leadership and management prepared to deal with the pushback. What we found was management would be more inclined to just shut it down and let's go back to business as usual because this is too hard.

>> Jonathan Heller: Yeah, super important lessons learned there.

And as I said at the beginning, all of these strategic practices need to build together, right? They are all intertwined. That's a great example of that. Thanks for sharing that, Renee. Let's keep going and move on to the next one of these, which is prioritizing, improving the social determinants of health through upstream policy change. Most of the folks on the phone know the importance of upstream policy change and we talked about how social determinants are one of the largest causes of health inequities.

There are many ways that health departments can engage, many tactics to use including building awareness of the connection between these, conducting research on the connections and reporting that research publicly, doing direct and indirect advocacy in decision making contexts and strengthening staff capacity to identify and focus on upstream issues like these. So Jacques, I was wondering if you would talk a little bit about what you are doing in Tacoma-Pierce County around social determinants and moving upstream.

>> Jacques Colon: Absolutely. So one of the first things that I would start this conversation out with is you really have to begin with why when you are talking about upstream policy change and prioritizing that. The reason I say that, when we talk about direct service, even though at a population level we are not getting to a lot of people the fact that we can look at those people, we can see the change that we are creating at an individual level, that is a powerful thing. And so shifting to more upstream policy changes even though we know at a population level it is going to be more effective, that's something that can create some pushback internally and externally.

We always start with: Why? The why for us is if you look at what creates health, what makes us healthy, the majority lies in the social, economic, and environmental conditions that folks live in. So we base that work on CDC, WRJF's rankings. There are data show that social, economic and environmental conditions are the most influential pieces of what makes us healthy. So with that in mind, we can start talking about results. And actual health. Most of you probably know we are in the first generation now that is expected to have a shorter life expectancy than their parents. So what we are doing is not necessarily working. And

continuing to double down on the same strategies is not necessarily going to give our community what they need to be healthy.

We are also operating in an environment where budgets are being scaled back. We are being asked to do more with less. If we want to create efficiency through our public health depositions, then that efficiency means that we have to start taking an increased prioritization on that 55 percent. And the upstream policy changes that we know are going to have the largest impact on the population level.

When we talk about this with staff that may not be receptive or with our Board of Health or policymakers, return on investment is something that we talk about. If we are looking at the work that we are doing and the health results that we are seeing, and that's ultimately what we are delivering is support for health, it doesn't add up right now. So upstream policy change is necessary.

So getting into the how we make that happen, I'm a big advocate of health in all policies as the main driver, the main vehicle forgetting that done. I say that because the health in all policies umbrella offers enough flexibility that all the different agencies, the jurisdictions, governments, organizations that you may work with, there is a menu item underneath that health in all policies umbrella that can potentially meet those needs. For example, if there's a large scale environmental siting concern, maybe a large scale health impact assessment is the right move. There's money or regulatory need to do such a thing, but in a lot of cases there isn't.

Health in all policies allows us to do work with shorter, more manageable tools. And so health in all policies, whether it's a resolution that gets you started, whether it's doing a fact sheet to provide data on an issue that is hot in your community right now, that can be a great way to sort of get your foot into the door of perhaps taking a role in these upstream policy issues where you may have not had that policy in the past.

The last piece of advice I'll give on this particular point, be clear about what your role is. As we go further upstream into these policy worlds that we may not have been involved in before, it is important to be clear about what our role is and what our role is not. As you get involved in issues like paid sick leave or minimum wage or housing, and vouchers for economic development, these are areas where perhaps public health hasn't always been involved, may not be welcome in all forms because of the message that we are sending in terms of health impacts and equitable development, things of that nature. But being clear about our role in terms of providing data in some cases can be very, very useful and prevent some of the headaches that some health departments may have experienced from diving too quickly into this without being clear about what their role is.

>> Jonathan Heller: Great. Thanks, Jacques. We'll come back to a little bit about health in all policies in a bit. Sarah, Renee, anything you want to add?

>> Renee Canady: I would like to underscore that and maybe even push a little bit on Jacques' comment that although modern public health feels like this is not our lane, I think we want to emphasize the points that NACCHO is making about trying to transform public health back to our root causes.

So abolition of child labor laws, adequate housing laws, reduction in the scale of poverty, minimum wage. All of those were public health. We lost our identity in that work. So instead of thinking about this as new space for us, it really is returning to our original space. And I would encourage people to look up Richard Hofrichter and Rob Bhatia's book that they authored together and there is a chapter on historically why we existed as a field.

>> Jonathan Heller: Richard also wrote a book with Bob Prentice called "Expanding The

Boundaries," which is a great read as well. Thanks for bringing that up, Renee.

Okay, I'll keep us moving. Let's talk about the last one of these internal infrastructure ones, which is mobilizing data, research an evaluation to make the case for assess and inform interventions for health equity. We pride ourselves on data and capacities in public health and we need to get those aligned towards working on health equity. There are many ways to do that. We can use inequities to develop priorities, highlight health inequities across program areas and partner with government agencies to help them understand those inequities in the data. We can give the data to community members and have them use it for advocacy as we mentioned earlier. We can make sure we are disaggregating things as much as possible. Lots of different things we can do.

Sarah, I wonder if you'll take this on and talk a little bit about how you have been able to mobilize research data and make the case for equity in Colorado.

>> Sarah Hernandez: Yes, happy to. So when we look at data, most people automatically don't do population based data such as data on health outcomes. So first and foremost I want to underscore that type of data should be sliced and died by different demographics so you have a good understanding of what is going on and you can arrive at an equitable solution.

I know that some of the participants on the webinar today asked which states had done an equity index. And more and more local and state jurisdictions are working on this. I wanted to actually give a shout-out to the Public Health Alliance of Southern California because they put together a health disadvantage index that is really great.

Also BARHI, the Bay Area Regional Health Inequities, has a good social determinants of health database.

There is a lot of buzz on the science of framing these days. We know that data are critical for digs making but they don't always tell the will whole story. People project their own biases on to the data which leads to victim blaming or perpetuating negative stereo types which most health departments are not intending to do. For example, individuals may believe that high rates of obesity exist in certain populations because those quote-unquote people don't drink -- they drink too much soda or eat too much junk food. We don't acknowledge that they don't have safe places for physical activity or live near grocery stores with healthy options.

We have realities also such as structural racism. We talked a lot about this in Colorado. Some of our staff at the state health department were concerned about what is the appropriate language to use. So we developed a statement on structural inequity which lives on our website. It is not, you know, perfect in every means but a starting place so that staff know that our executive leadership have approved this statement on structural inequity to be included on any kind of data that we put out for public conception. That can be fact sheets, reports, but even making its way into grant applications and various other forms. That has been exciting.

But the other thing I want to note, numbers only tell part of the story. It is important to include qualitative data and stories whenever possible. Jonathan mentioned giving the data to communities so that they can use it for advocacy, but making sure that their stories are integrated in that data as much as possible really helps frame and give the appropriate context.

And then I wanted to talk about one other piece of data. So my previous position I was a program evaluator and grappled with what it means to measure equity efforts and how to do it well through performance monitoring. And public health I think we are used to using widgets to measure our work. How many immunizations did we administer? Did that actually improve anything?

Where I think we need to go with performance metrics is measuring shifts in power. So how did our power or policy disrupt the status quo or even the playing field? How did we redistribute resources in an equitable way?

We know that inequity is rooted in systems. Sometimes this is looking at systemic change through systemic evaluation measures, but those can be hard to measure on a three or five-year grant cycle. Here is where progress measures are definitely our friend. And using them to look at how you are embedding equity into the core functions of the agency's work so you can engage if you're on the right path.

Since we love data so much in public health, I think using these types of process measures as a means of quality improvement can also help build internal buy-in. Jacques mentioned the department strategic plan. We also have health equity and environmental justice built into our strategic plan which means that there's measurement tied on to it. That's great to get momentum across the department.

That's it. Thanks.

>> Jonathan Heller: Yeah, that's similar again to what we have been hearing elsewhere, right, Sarah, where process measures are important to be tracking evaluation work. We know it's hard to move the dial on actual health outcomes. Those take longer to come to fruition. Just changing, we can measure power changes through process measures, for example. It's important to focus on.

Jacques or Renee, anything quick to add on here?

(There is no response.)

>> Jonathan Heller: I take that as a no.

We want to get you guys involved. Laura, if you can put up the first poll. We, the first question we want to ask you guys and we will have similar questions for the other areas. Where do you feel your health department is with respect to building internal infrastructure, the things we were just talking about? And focusing those on advancing equity. Feel like you are in infancy or preteen or you're an adult or a wise elder? Take a few seconds to answer that. We'll see where you guys all think you are.

Maybe two or three more seconds. Laura, do you want to go ahead and put up the results? I am told there's a little bit of a delay.

So I want to emphasize that, like I said at the beginning, every health department is at a different place when it comes to doing this work. It is important that we all just get on the train and start moving. So it looks like from the results, about a little less than half the folks feel like they are in their infancy. Another 40 percent feel like they are preteen. That is over 80 percent are at that level versus only 1 percent feels like they are a wise elder and 13 percent feel like they are an adult.

So clearly many of us have a long way to go and we are not alone in this, again learning from even other and figuring out how to move it forward together is an important piece of doing this work.

So I want to move on to the second bucket of these, working across government. And Jacques already started talking about health in all policies. That's where this comes into play. There are two components that Jacques will talk about in a second, about how he's built alliances with other government agencies to advance health equity and the other is sharing analysis with other agencies in the government's role in creating health equity.

Jacques and others talked about the importance of talking about the social determinants. It is important to remember that throughout the history of the U.S. the government played a role in

creating and mitigating inequities. Transportation, employment, our lack of protections for many disadvantaged groups, have all contributed to marginalization of people of color, Native-Americans, LGBTQ people, people with disabilities, women, than many other groups.
And, therefore, that discrimination has led to poor health outcomes for all these different groups. It is important that we co-learn that together and remember that in government an understand what our role has been and understand the role that we can play in changing that. So Jacques, I wonder if you would talk a little bit about your HIP work in more detail.
>> Jacques Colon: Yeah, I'm going to jump to the implementation side of things. If you are trying to build government alliances, the first thing, you have to come to the table with an understanding that many people will come to the health department as working with hospitals and doctors. You have to do some work on the front end, talking about that 55 percent of health, about social, economic and environmental conditions and how if we are going to be efficient in creating change in our community, we have to do that together.
And one of the key points that I would say you really need to focus your communications around, we want the same things. That economic development jobs, good education systems, liveable neighborhoods, all of these things are shared values and shared goals that we have across multiple government agencies. We just don't necessarily talk about them in the same way.
How do you build the alliances? You start with the question: What can you bring to the table? All the agencies are in the sames positives we are in terms of being over capacity, being asked to do more with less. Unless you are coming to the table with something you can offer to build value added into the situation, chances are it is not going to be effective long-term in terms of being an alliance.
So data is one of the first things that I think we can be effective at bringing to the table. We are good at using data to tell stories. GIS mapping is a huge tool that not everybody has access to. And so I just wanted to give you a couple of quick examples of government alliances that we are building right now. One is with the county auditor that we are working with the data around voting rates, to answer the question for them why are voting rates so low. We have some assumptions about why they might be low. Those are going to be related to the same root cause that is we will talk about in terms of health outcomes. We are excited about that partnership and what we can do to work with them around voting.
We are doing a similar project with the Pierce County Superior Court about jury summonses on to answer the question why is it so difficult to get a jury of peers within certain demographics in our county.
And working with people in the parks who may have money to redesign a park and we can offer advice on participatory budgets to move to a process that is more meaningful and empower powering than we would have been able to do without our support and partnership. What can you bring to the table and how can you make that a spring board for a more fruitful alliance over time.
>> Jonathan Heller: Great, Jacques. And unusual, right, to hear about public health departments getting involved in things like voting or participatory budgeting. That's super exciting. As Renee said it returns us to our roots about what public health really is. Renee or Sarah, I don't know if you want to add anything about building alliances across governments or sharing analyses?
>> Renee Canady: Well, I want to absolutely underscore the point that we have access to data that some of our partners and other sectors in the community doesn't have. I also want

us to recognize that we have access to very powerful and influential relationships. If we are governmental public health we are tied to elected officials. Sometimes we see that more as an albatross than as an opportunity. And so being able to also come to the table, recognizing we bring important relationships and influenced in addition to data and knowledge and subject matter expertise is also really important. We can pick up the phone and call elected officials and have a different exchange with them than community members in some cases.

>> Jonathan Heller: Yes. Are we willing to recognize the power we do own and use it for this purpose? It's a really important point.

Sarah, anything you want to add?

(No response.)

>> Jonathan Heller: All right, I'll take that as a no.

I'll pull up the next poll. So similar to the previous poll, but now focused on working across government as opposed to what we talked about before in terms of building internal infrastructure. So where is your health department with respect to working across government to advance equity? Again four answers: Infancy, preteen, adult or wise elder? Take maybe ten seconds to answer that, and that would be great.

I know some folks were interested in some books and references that we have been mentions. I'll just say and the analysts can share their own. The last page of the PDF that was sent out in advance, the Build Power for Health Equity PDF has a list of some of the references we used to pull that together. There are great things to read. Laura, if you would pull up the poll results when you get a chance? That would be great.

I'll say that health impacts assessments was brought up. Jacques talked about it, something that we at Health Impact Partners have been doing a number of years now. It is a great fool for people to build into their health in all policies tool box. It has been effective in making change in jurisdictions around the country.

The results, even more people feel like they are in their infancy or preteen years when it comes to this work across government and implementing health in all policies. Here it's close to 90 percent of folks in those two categories, with only 6 percent feeling like they are in the adult phase when it comes to working across government. As I expected, as we move through this, I think people are going to feel like there is more and more work to be done. Like I said, we can get there.

Okay. Moving on to the third bucket, which is fostering strategic community relationships and partnerships. And in particular, folks in on the first strand practice of sharing power with communities, building strategic partnerships in ways intentionally allow for meaningful participation an share power and decision making. And we think that strong strategic long-term trusting relationships with community partners are vital to advancing health equity and improving health practice. There are many things to be done in this area. It requires being open to learning about community priorities. It requires allowing time and space to get to know community members and community organizations. Identifying strategic opportunities and avenues for communities to contribute their experience and knowledge, and sharing resources to develop the communities' skills and their partnership with the departments as well. Most importantly the health department has to have a willingness to be included in the communities' voices, those most impacted by the policies we are talking about.

Renee, you have been doing a lot of work around this in the Midwest with healthy heart lands and other groups, partnering with community partners. Would you talk a little bit about that work?

>> Renee Canady: Yes. This has really been, I think, a privileged opportunity for public health. We have across five states in the Midwest been bringing together public health practitioners with community organizers, two very powerful and influential disciplines to partner across the issues of social determinants of health. It has been interesting for public health to figure out what is our identity? Because community organizers have such strong identity. It has been a great sort of agitation of us as professionals.

But we've learned some transferable lessons from our community organizing colleagues. This technique of doing one-on-ones, or one to ones, which are almost kind of meet and greet things with a very strategic design and purpose. The idea of doing power analysis and really getting comfortable with where our power lies as a discipline and as individual professionals and getting comfortable with the idea, I think I used this term earlier, of agitation. In our workshop we have a core value of increasing comfort with discomfort. We've got to move a little bit past this culture of politeness to saying, you know, in order to get traction you've got to push through some uncomfortable things. And what we found was an engaging with community, it was all hands on deck. So I as the senior leader had access to relationships that others in the organization might not have. I was working with my peers while program directors were working with their peers or while sort of our boots on the ground, as we like to say, staff that were actually executing strategy and implementing projects were also building relationships across those.

We also had to not just share power but recognize the power of communities. That has been our pushback with this idea of empowering, which is to presume that we have power to give. No, they have power that we have to recognize and then we figure out where do our two power bases align to advance this shared interest of improving health and advancing health equity.

I think we have to also be very intentional again. I push this point about making sure that you're saying what you mean and you are meaning what you say because it is really easy for us to say, yup, we're just advancing health equity, but especially with community organizers, we were meaning sometimes completely different things.

So we would go back to the definition and say things like: Okay, where, like with the last question that Jonathan just used. Where is our health department with respect to working across governments to make sure there is a fair and just distribution of the social resources and the social opportunities needed to achieve wellbeing? We would push ourselves back to the definition again that we had identified as a community.

With this work in Ingham County we happened to identify two different priorities that were priorities that public health wasn't necessarily advancing as a priority. We had to come to this negotiation, again acknowledging power.

We focused on early childhood issues and mass incarceration as a public health threat. We've really gotten more traction with the mass incarceration work in terms of looking at certifications and licensures and there were some moral character clauses in our law that while people were incarcerated they could do the education to be eligible for certifications, say becoming a barber or some other profession that needed a license. But because of the good moral character clause in those policies, they would find themselves not eligible for licensure after obtaining the education while incarcerated. We were very effective in having a shift in the change in that policy.

So we have some very tangible outcomes where we found recognizing that community organizers were a thing, right? A lot of public health colleagues would say: Oh, yeah, we do community engagement. No, no, no. Not the same thing. Again, intentionality in words and

materials.

It has been very, very exciting project.

>> Jonathan Heller: Thanks, Renee. I want to keep us moving. As I do that I'll put up the next poll question. Laura, if you could put that up?

I do think it's an important thing to think about what is a community organizing group and how is that different from a community-based organization? I think the focus on intentionally building power an working with people to define the problems and address the problems that are affecting their lives is a really important component of being a community organizing group. So thanks for pointing that out, Renee.

So poll 4, where is your health department with respect to this stuff that Renee was talking about? Fostering strategic community partnerships to advance equity? Infancy? Preteen? Adult? Wise elder? Take a few moments again to respond to that.

I'm guessing that people may feel like they are even further behind when they listen to what Renee was talking about.

Laura, if you want to put the results up, that would be great.

All right, there we go. Not quite as bad. So in the first two categories, infancy and preteen, there's about 77 percent. And about 15 percent in the adult category and 1 percent in the wise elder category. That's better than some of the working across government pieces probably, but comparable to the building internal practices. That's actually good.

So now we are going to move on to the last group of these, which is making transformative change. And these are the most difficult. And take the most work. Making progress on these, though, opens up the space to do all of the other things we have been talking about. As you make progress on those other things it is going to increase your ain't to work on these transformative practices as well. The first is confronting power imbalances and racial and other imbalances used to maintain them. We talked a little bit about the importance of focusing on power and oppression. So we won't go into that again. Advancing health equity means balancing, forms of oppression, racism, homophobia, seeing a lot of xenophobia these days as well. We need to make sure we focus on those as well.

Jacques, you want to talk a little bit about how you confronted power and oppression in your work in Tacoma?

>> Jacques Colon: Sure. You cannot confront what you do not name. The first step was to call out race as the thing most difficult for us to talk about and go from there. We do a full day training with all of our staff based around the power of illusion series that ran on PBS several years ago. I would just say our objective for that full day is knowing that we are not going to leave than training about race the same way. Our objective is that all of our staff can leave that training able to have productive conversations about race. And we believe that if you can name it, if you can have productive conversations about it, even if you don't see things eye to eye, that at least positions you to be able to have productive work that is going to better reflect what the community actually needs.

The second phase of that is setting performance measures with your actual staff. So if the root cause of racism, for example, is playing out where you have staff that is disproportionately representative of one particular racial group and does not have another group, that is a key part of the community that you are trying to serve, talking to people about race, naming it, being able to have conversations about it is that first step. Being able to say with numbers and measurements, this is the level in terms of staff that we should set if we want to reflect our community. Or this is the number of documents that we should have translated to reflect our

community. Whatever the mechanism that makes sense, holding folks accountable to taking the next step after that conversation.

The next thing I'll say about confronting the root cause is a lot of times we like to think that bringing representatives of the communities to the table is going to get rid of those power dynamics. I'll say that any table is going to have power dynamics. Power dynamics play out every time in different ways. We focused in on participatory budgeting being a strategy to get us to true empowerment and confronting the root causes of oppression. The reason why is the participatory budgeting is the ultimate form of empowerment. And the community has direct control over the funds. Their vote is the actual controlling factor of where those funds go, et cetera. So in terms of what is going to confront the real root causes of oppression, those are some strategies that we feel comfortable that we are taking.

>> Jonathan Heller: Great. Thank you, Jacques. In the interests of time I'll keep us moving and go directly to the next one which is developing leadership and supporting innovation and rewarding strategic risk taking to advance equity. We are getting into controversial territory when we want to take on yet. There is no play book. So we need to innovate and take risks. Renee, I would love for you to talk about how you've done this both in Ingham and more broadly in Michigan.

>> Renee Canady: I candidly addressing health equity as part of the statutory responsibility that local health officials hold. If you are not attending to health equity, you are not, as C.E. Winslow said, assuring the conditions for good health. That's an obligation. Developmentally where we are as a field, it does require risk taking. It does require courage. We see a shift right now where we are getting new early career colleagues who are learning this in their academic settings, and they come into a local health department that has been doing work very differently than they. So it is not only about recognizing power of community, but it is also about recognizing power, knowledge, and influence of line staff who are bringing very different knowledge base in. I love a quote by Howard Coe who did research with public health leaders, who said there is something about public health leaders as a group that causes them to leave the comfort of the side lines and wade into controversy.

So I would say that right now our litmus test is if you are not feeling somewhat anxious, if you are not pushing and provoking some controversy, then we are not doing our work at the depth and legal that will address health equity and prompt change. It is what John Snow did. His work with the Broad Street Pump was not straightforward and simple. It's what Lillian Wald did in the maternal child health nursing in tenement housing of Harlem. It was all controversial. This is controversial work and I would encourage us to be em boldened by that to find a support group among your peers and say I'm feeling nervous about this, but what do you think? So we can keep pushing each other and indeed advance some changes that are ultimately going to improve the health and wellbeing of our society.

>> Jonathan Heller: That's great. Later maybe in the question and answer we'll have time. I want to if we have time later on to talk about risk taking a little bit who are as well because you're so eloquent about that. Let's come back to that. Sarah, I'll ask you to talk about changing the conversation about what causes health equity within public health and in government and in communities. Really we are talking about narrative change and moving from this disease and risk factor and biomedical model of public health to one that focuses on social determinants inequity. Can you talk about how you're doing that in Colorado?

>> Sarah Hernandez: Sure. I'll keep it brief because I know we're short on time.

I want to emphasize always talking about history in the conversation. In the health

environmental justice 101 that I mentioned earlier that has been a good starting place to talk about the historic events and inequities that have been created by government decision making. Some of us, especially those of us in the in health inequity, out doing presentations and talks, we try to remind everyone of the effects of red lining slavery, immigration policies, practices and that kind of things and the effects they have had throughout our history. How did we get here today? It's an important piece of driving the conversation.

Always cognizant of messaging. Frameworks Institute has a lot of great literature on that topic. And then being comfortable with the uncomfortable. I think Renee said that earlier. It's important to normalizing the conversation about where these inequities came from. Always tying it to your department mission, I found extremely helpful. We are all called to do this because this is our mission.

I'm going to leave it there.

>> Jonathan Heller: Great. Thank you, Sarah.

Dave, my screen looks like it's frozen again. If you would advance a slide for me? Take back control and advance the slides, if you would?

>> Dave Clark: That's slide 32. Is that the one you want, Jonathan?

>> Jonathan Heller: Yes, I guess I can't see the slides advancing either. So the last one of these transformative practices is joining with others to build a movement for health equity. Renee mentioned this when she was talking about leadership, that we need to be working together. That we need to get out of our comfort zone. That means that we need a support network to be doing that, especially in these times when there is such pushback against equity. We need to be learning from one another, point to the practices that others are implementing. And we can then say oh, they're doing this in such-and-such a county. Why can't we do take here? It gives you space to learn and find out what others are doing.

As part of that work, we at Health Impact Partners started a group called public health awakened, a group of public health professionals organizing for equity and justice formed in response to the Trump administration. We have done a lot of work with respect to Trump's budget and ACA and other things. If you want to help build this movement, we invite you to join and you can see that at publichealthawakened.com.

Let's skip the next poll. And let me catch up to this. Okay. So I want to move to Q&A from the audience. And since my screen is frozen I can't see questions.

(Chuckles.)

>> Jonathan Heller: It makes it challenging. I did see one of the questions earlier that came up was funding for this kind of work. We hear a lot about how people in public health depositions have categorical funding. How do you get around the issues of having categorical funding and funding this kind of work that you guys have used in Colorado or Tacoma or Michigan, Renee?

>> Renee Canady: Yes, I push against the we don't have funding for this. Health equity work is not necessarily what we do. It is how we do everything that we do. It is shifting slightly everything that we do. So many health depositions -- I won't say most, but a lot of health departments hopefully have professional development dollars. So maybe instead of going to some more traditional training, you do work around health equity.

We happen in Ingham county to have a grant that got us started doing this when it was about access to care. But then we just held on to that and over the five years of the grant incrementally planned how are we going to keep this position? And so we were able to institutionalize the position working with Commissioners over five years, shifting and

prioritizing. It is about setting this as a priority.

So it doesn't always require a grant, but it does require an investment of workforce, gaining the knowledge and being willing to lead the work internally as well as externally.

>> Jonathan Heller: Great. Thanks, Renee.

Jacques or Sarah, any thoughts on that?

(There is no response.)

>> Jonathan Heller: No? Okay.

Dave, I don't know if you can -- oh, now I'm back maybe. Can you guys hear you?

>> Dave Clark: We can hear you.

>> Jonathan Heller: Great, all right. I now have the question panel open. All right. Sarah, can you share resources you discussed that has guidance documents for operational into daily practice?

>> Sarah Hernandez: Can you hear me? Yes, those are being finalized. And once they are, I will be happy to share those. We can look into putting them on our website. They are not in a shareable format today but within the next month or so should be shared.

I did see a few other questions about like the checking assumptions document. That is on our Office of health equities website, the Colorado website currently. That is already available.

>> Jonathan Heller: Great, okay. Jacques, a couple questions came in around health equity assessments. Are those available online? Tell us more about those.

>> Jacques Colon: Sure. So we kind of did two halves. There's internal health equity assessment. That's your staff. For that I recommend using the Bay Area Regional Health Inequities, BARHI organizational self-assessment. You can find that online very easily. That's what we used. We modified that and slimmed it down a little bit.

Externally if you go online and type in fairness across places, Tacoma, or Pierce County, the health equity assessment should pop up. That's what we share with the community. And we would be happy to talk to anybody about that more. It basically just looks at what creates health, what makes us healthy, and what are the inequities in the area broken down by different outcomes. That has been the springboard for a lot of my work with other government agencies is having them ask for a presentation on health inequities based on this assessment. That's one strategy you could use.

>> Jonathan Heller: Great, thanks. There are a couple questions that came in around working in particular places in the south and in rural areas that have more conservative environments or racial histories with regard to African Americans, for example.

Any suggestions for working in those more conservative regions like the south or in rural areas?

>> Renee Canady: You know, one of the things I would suggest there, although I did emphasize, right, having a shared vocabulary. If there is a phrase that shuts down dialogue, we suggest not using that phrase. The question was saying there was some denial and opposition to social determinants of health. Then don't use those terms. I think lead with stories. We are working on changing the narrative. The best way to change narrative is storytelling. What are the lived experiences of the constituents that elected officials are elected to serve? Find those stories. Tell them. Avoid the word, but use the concept to advance the work.

Some of the data and the stories just are so compelling, you really can't deny them. If they don't want to put that label, I would say take that resistance and just loop around another way.

>> Jonathan Heller: Great. Sarah or Jacques, anything to add?

(There is no response.)

>> Jonathan Heller: Okay.

>> Jacques Colon: I would say focus --

>> Jonathan Heller: Go ahead.

>> Jacques Colon: Sorry. I was going to mention with conservative politicians, what are their priorities? Because what we are talking about is expanding the scope of public health, chances are whatever their priority is in terms of economic development or whatever, is something that you can find common ground on and move forward together.

>> Jonathan Heller: Yes.

>> Renee Canady: What we learned from our community organizing colleagues, that is called identifying their self-interest -- everybody has a self-interest -- and tackle it from that frame.

>> Jonathan Heller: Great. Okay. I see questions about resources. What we will plan to do is gather some of those resources, like from Minnesota and other places, and send them out in a follow-up email. Any of the documents that we mentioned, we'll try to do that.

Another question: What are the best ways to build relationships with social justice and community organizers?

>> Renee Canady: The best way to build relationship is time. Time and listening, right? So attending their events, inviting them to your events. Having lunch. Doing one-on-ones. It's a very natural process.

I would also suggest that that can happen at varying levels of the organization. I think someone was asking should it be leadership? Should it be staff? It depends on who is best positioned and where the readiness lies. If you have a senior leader who is not as comfortable, it's better to not have them engaged, right? And lead up when you get the momentum.

So there is no secret trick to building relationships. It is the classic methods.

>> Jonathan Heller: Great. I'll also add that there are many national community organizing umbrella groups that have local partners. If you don't know who are the community organizers in your community, we may be able to help you identify some of them. You should feel free to reach out to us. We may be able to get you some names of organizations and potentially even some people in those organizations that would be interested in talking to you.

So weapon only have a couple minutes left. There are more questions but we'll try to answer these in follow-up as well.

So let me start closing out by thanking everyone for hanging in there. There are a ton of people who stayed on for the call for the entire time. Then once again thanking our panelists and my fabulous collaborators, Renee Canady, Jacques Colon and Sarah Hernandez. If you advance to the next slide I want to thank the partners, CA4Health, The California Endowment, and California Leadership Academy for the Public's Health, that partnered with us on so much of that. I pass it back to Dave.

>> Dave Clark: Thanks so much, Jonathan. I would like to thank our panelists today for their insights into Build Power for Health Equity. As Jonathan mentioned, thank you as well to the organizations who made today's web forums possible.

Many of you have asked about today's session and whether it was recorded. Yes, it was recorded. We will make that recording available to you as well as the presentation slides at Dialogue4Health.org within a few days.

We will also send you an email with a link to Dialogue4Health.org when the resources are available. Do check your inboxes for that.

That email you receive will also include a link to a brief survey we hope you will take. We would like to know your thoughts concerning today's web forum but also what topics you would be interested in for future Dialogue4Health web forums. Take a moment and complete that survey. We really read all of your comments and feedback. Like I said, take a couple of moments, complete that survey. We would like to hear from you.

Thanks so much for being with us today. That does conclude today's Dialogue4Health web forum. See you next time. Have a great day!

(The webinar concluded at 2:30 p.m. EDT.)

(CART provider signing off.)