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DIALOGUE4HEALTH WEBINAR

"Expanding the Boundaries":
Health Equity and Public Health Practice

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>> Joanna Hathaway: Hello, and welcome to "Expanding the Boundaries": Health Equity and Public Health Practice. My name is Joanna Hathaway, and I will be running today's web forum with my colleague Star Tiffany. Closed captioning will be available throughout today's web forum. Steve, with Home Team Captions, will be providing realtime captioning. The closed caption text will be available in the media viewer panel. The media viewer panel can be accessed by clicking on the small circle with a filmstrip running through it. On the PC, this is in the top right-hand corner of the screen. On the Mac, the bottom right-hand corner of your screen.

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We would like to invite you to connect with us via Twitter and Facebook. Both links are on screen now. We are encouraging you to ask questions throughout today's presentation. To do so, simply click the question mark icon. We will be addressing questions both throughout and at the end of the presentation.

We will be using the polling feature to get your feedback during the event. The first poll is on screen now. Please select your answer from the available choices and click the submit button: I am attending this web forum A. Individually, B. In a group of 2-5 people, C. In a group of 6-10 people, D. In a group of more than 10 people. Again, please click submit.

When you're done answering the poll, click on the media viewer icon to bring back the closed captioning if needed.

It is my pleasure to introduce Bob Prentice, who will be moderating our web forum. Bob is one of the lead authors on the book ""Expanding the Boundaries": Health Equity and Public Health Practice," which was recently published. A collaborative effort between Bob and several others, some of whom are on this call today, this book is the basis for the conversation we will be having.

Bob recently retired as director of the Bay Area Regional Health and Equities Initiative, BARHII, a collaboration of 11 local health departments in the San Francisco Bay area and beyond. He was also a senior associate for Public Health Policy and Practice at the Public Health Institute. He was previously director of the Public Health Division at the San Francisco Health Department where he worked for nearly two decades in a variety of roles. During the mayoral administration of Art Agnos, he had lead responsibility for the city homeless policy.

Bob is alumnus of the Public Health Leadership Institute, instructor at San Francisco State University and, obviously most importantly, one of our favorite moderators to work with here at Dialogue4Health.

Bob, please go ahead.

>> Bob Prentice: Thanks, Joanna. Thanks to everybody who is participating in this webinar. It's really heartening to see the level of interest. We had over 1,000 people register. I understand a portion of that will be on the webinar, but that certainly is a good measure of the interest.

As Joanna said, the focus of today's webinar is on the recent publication from the National Association of County and City Health Officials, which I will hereafter refer to as NACCHO, ""Expanding the Boundaries": Health Equity and Public Health Practice."

I need to show you how you can get ahold of this. It's available on the NACCHO website. You can purchase it as a book, or they've made it available as a PDF at no cost.

The purpose of this was to explore what it takes to more successfully advance health equity. I have to acknowledge something before we get into the presentations. This was written largely about health departments, urging health departments to think more broadly about what health equity work can consist of. We realize a lot of people on this webinar don't work in health departments. If you bear with us, the message is that part of the health equity principles of health equity practice is that health departments have to learn how to work more effectively with other organizations, agencies, different ways of working with communities, social justice organizations. So I hope that if you don't work in the health department you find interest from your perspective.

So among other things in the book, we profiled four health departments that have been made long-term commitments to work on health equity. We're fortunate to have representatives of three of those health departments on today's webinar, as presenters.

I'll mention them briefly now; I'll introduce them properly before their presentation. Jeanne Ayers is the assistant commissioner for health in the Minnesota Department of Health. Renee Canady is currently the CEO of the Michigan Public Health Institute, previously health officer for the Michigan Health Department. Kathy Schaff, health equity coordinator for Alameda County in California, Public Health Department.

I regret that Rajiv Bhatia couldn't join us on this webinar. He no longer works for the San Francisco Health Department. When there, he and his colleagues in the program at health equity and sustainability did pioneering work on health equity, especially using health impact assessments on minimum wage, living wage, paid sick leave, displacement, so on.

Finally, we'll be joined later by Richard Hofrichter who is senior director for health equity at NACCHO, and Marilyn Metzler, senior analyst for health equity in the Division of Violence Prevention in the Centers for Disease Control and Prevention.

As star mentioned -- there you go. A novice. Those are the people I mentioned. That is their pictures. I was supposed to flip there. Richard is a thuggish looking one in the dark glasses there.

We occasionally do polls. Let me introduce this poll briefly. It's been mentioned sometimes that we tend to profile same health departments when we talk about this work, wondering if that's because it's not more generalized. The only honest response is we profiled the four health departments we did in this publication because they were immediately accessible and we had no capacity to do a more broader survey. We don't intend to ignore the good work in other health departments around the country.

Out of curiosity, we wanted to get a sense of other health departments that might be exploring territory that's not typically thought about as the work of health departments. Please, using Joanna's instructions, proceed with poll number 2.

I want to provide a little bit of context for today's discussion as I introduce the presenters. First, "Expanding the Boundaries" was a group effort. It was a core team that consisted of Richard Hofrichter, Marilyn Metzler and Claire Reddy, who was Marilyn's colleague at CDC, who moved, no longer works there. It's a great loss for all of us, because she's really remarkable.

We had an advisory panel, a very impressive one, of people from public health around the country, and we spent a day and a half in Atlanta a year ago November reviewing and commenting on an early draft. I'd say the publication is very different, and it's largely because of the critical insights and guidance from them. Their names are all listed in the foreword to the publication. You can look at it there.

The central theme of "Expanding the Boundaries" is that health equity practice should focus on the underlying social inequalities that are at the root of health equities, not only on their consequences. That's rhetorical, so let me try to explain what is intended in that statement.

I think it's fair to say that a cutting edge of public health practice over the last decades, probably starting with tobacco, certainly including big changes in the way we think about work on nutrition, physical activity, particularly as it got into built environment, really did broaden our sense of what the whole scope of public health practice can be. It's been hugely important, and an example is the recent community transformation grants, supported environmental improvements to tobacco-free living, active living and healthy eating. Those are risk factors that account for 1/3 of deaths in the United States. That work is often carried out in low-income communities of color.

On the other hand, to get perspective, the differences in life expectancy in some of these communities are 10 years or more compared with more affluent neighborhoods in the same city or region. We've got data in places like Louisville, Minneapolis and St. Paul, Kansas City, San Francisco Bay area, Los Angeles. It's even 20 years or more in places like Baltimore and New Orleans and California's Central Valley. I think the point here is that in addition to the good work that goes on doing healthy eating, tobacco-free living, active living in these communities, it's not enough to just do that work without asking how those communities came to be the way they are in the first place. Not just the physical environment, but who lives there and why. And to explore how public health my be able to influence the forces that shape those communities now and in the future.

Now, the examples that you'll hear in the presentations will show how some health departments are really trying to take on that work. When they clear the book, this is not -- this publication is not a definitive statement about health equity practice. There is no catechism here. This is an exploration. We're trying to pose questions for people to consider over time. So that the next slide, this is my artistic skill, the aesthetics of the slide, it's a list.

Anyway, this is an attempt to distill from the examples of health equity practice some key elements that we think are part of what an expanded version of health equity practice would like like. I don't have the time to go through all of these in any depth. I'll go through them rather quickly, and some are explored in the presentations.

The first one is that health equity practice should be directed toward the causes of social inequalities, not just health consequences. You will hear Kathy talk about that when she describes Alameda County's work on disclosures, gentrification displacement.

It's important to develop alliances with other agencies and organizations to create openings to participate in policy decisions that affect social inequalities.

The territory, what produces the social inequality is not largely within the immediate purview of the local health department. You're going to explore other territory, there's got to be ways to enter that territory to have public health influence and health in all policies is one approach really gaining traction nationally to fill out public health to get involved in other policy decisions.

Another one is develop strategy relationships with communities based on mutual recognition of each other's strengths and leadership capabilities. Virtually all health departments work with communities, but this health equity work deserves a re-examination. Jeanne will explore that in her presentation.

Another element is that this work often requires participating in campaigns initiated by others that might not be primarily about health. One current example is the state and local initiatives on minimum wage. There's a role for public health to weigh in.

Another element, developing strategies to protect against political risk by building a base of support that can help create openings to participate in activities that would otherwise be politically constrained. It's fair to say this work can often be politically risky. How much risk it takes varies by jurisdiction. Some places you probably can't even say health equity. This requires thoughtful strategy to figure out how you can create room to move.

Another one is adopting organizational development strategies that incorporate principles of health equity into categorical programs as well as new and creative practice. The point is this isn't just a program area, it's a change in organizational culture. Renee will explore that in some depth.

Finally, it's important we develop a public narrative about health that is not circumscribed by diseases, risk factors or populations, but rather articulates the relationship between health equities and underlying social inequalities. It essentially means changing public understanding about what most influences health.

The presentations will amplify some of those elements. We don't have the time to do justice to all of them, but I hope people will at least touch on some of them.

Let me now introduce Kathy Schaff. Kathy's worked at the Alameda Public Health Department since 2006, worked on Place Matters, which promotes health equity through community center local policy agenda focused on criminal justice, housing, land use and transportation. Before moving to the Bay Area, she worked with local health departments, receiving her BA in international studies from University of Denver. Her master's in public health with a focus on health and social behavior from the University of California in Berkeley. She's now completing her doctor of public health program at UC-Berkeley and researching how local health departments can more effectively communicate to policymakers, media and public about health equity. Kathy, take it away.

>> Katherine Schaff: Thank you, Bob. I want to say I'm really looking forward to learning more about what's happening in Minnesota and Michigan, sharing some of our work, then hearing from those on the webinar about your work during the Q&A. I also want to echo, I think it's very powerful that so many people are on this webinar and I'm very glad to be part of this discussion and to connect to people across the country who are passionate about and committed to health equity.

I also want to acknowledge that this work I'll be talking about is really the work that a lot of our health department staff, partners and residents have led, and I'm highlighting the great work they've done.

I will be focusing on how health equity practice must focus on underlying social inequities, and although this is really connected to what the other presenters will speak about as well. So I'll talk about why we're focused on health equity, how we're doing this work, what it's taken to get here.

I wanted to start off with our mission at Alameda County Public Health Department. This has been our mission for many years. Yet we still have health equities along the lines, especially of place, race and class. So we know to achieve our mission we have to recognize and address the underlying issues that impact populations in Alameda County. At this time there's ample data and research and a lot of conversations with community members and partners that absolutely show that social inequities or inequities in access to things like transportation, good jobs, quality housing, quality education and, as we have seen so much recently, access to a fair criminal justice system absolutely affect health.

So we really believe that working on social inequities is a core part of our mission. In addition, the World Health Organization says that to improve conditions of daily life or to improve these social

factors we must tackle the inequitable distribution of power, money and resources that drive these social inequities. We also see addressing power and inequities in power as a core part of our mission.

I wanted to bring this up at the start, because one important aspect of our mission is that at the point a lot of government agencies and our partners expect us to be at the table and invite us to be at the table. This wasn't always the case. Leading with our mission, talking about how issues outside of what people traditionally think of as public health affect individual and community health, it's helped people understand our work as well as want to work with us.

In terms of how we are working to achieve our mission, this visual is a summary and provides a brief history. Our work began a long time ago with many people in the health department and partners in the community collaboration and partnership box. There was a conscious decision to really look at how we were working with community and to see community members as a true partner, rather than just as recipients of services and clients. This was about two decades ago. Quickly as the health department started this work, staff realized we also needed to change our institution, we weren't necessarily set up in a way to partner effectively with community. So this included a lot of internally focused work and we still continue this today.

In the policy and systems change circle, we had infrastructure around working on state and federal policy, but about nine years ago we realized that we were not really working on local policy, especially related to social factors that affect health. That's where Place Matters, the initiative I work on, comes in. I will speak more specifically about that.

With all of this work, we strive to connect to programs and services and utilize innovative data and research. Of course, we're continually trying to improve this. We have a lot of ways we want to grow and improve, but using this model has proven that we have had positive outcomes so far.

I will be focusing today on Place Matters, but I do want to acknowledge there's so much work going on in the health department from a lot of other folks and I'm hearing this today, but I want to acknowledge all of their work.

Place Matters promotes health equity through community centered local policy and systems change focused on education, economics, criminal justice, housing land use and transportation. It started in Supervisor Keith Carson's office and is staffed by health department staff. We work in partnership with communities, nonprofits and government agencies on policy and systems change, and this is also connected to the National Collaborative for Health Equity at the national level, and there are different Place Matters teams across the country doing similar work tailored toward their area. We also connect to numerous internal health department programs and initiatives.

While we work on many different issues today to provide concrete examples what we've done around social inequities, I'll focus on housing. This allows me to talk about some of our lessons learned, and one of the things we learned about doing this policy work around social inequities, I want to refer to something Dr. Canady who will speak in the webinar said on the online course, that resonated with me and holds true for our work. She was talking about that health equity work isn't linear.

We might be standing around the sides of a swimming pool and our goal is to get to the middle. We may be unsure, debating how to get there. If we dive in, we can meet in the middle. Sometimes it doesn't matter exactly what we start on, as long as we dive in. This has held true for us. It was much easier to gain momentum and further this work when we were working on concrete things than when we were talking about it hypothetically and developing logic models or planning it. A lot of the questions we had about who you to do this work we couldn't answer until we were engaged in it.

In addition, it opened up a lot of opportunities to further the work we weren't aware of when we started and couldn't have anticipated, and a lot of opportunities too are develop and strengthen partnerships with people we weren't aware of. Really jumping in has helped us.

To tell you more about how this happened with our housing work, a staff member was watching the news, saw a news story on how landlords were being foreclosed on, tenants were still paying the rent to the banks, and the banks were not paying the utility bills, so there were water shut-offs, which was clearly a public health issue.

We partnered with Causa Justa, that builds community leadership to achieve justice for low income San Francisco and Oakland residents. They were already working on this. They were in the lead, not us. They had an organizational model that included building a strong base, and supporting resident leadership. They were well versed in housing, much more than we were. They were able to build our capacity.

So our approach with them was to, after working on the water shut-offs, to move on to working on a report on foreclosure and health. We learned we're much stronger together. An example is that in collecting primary data for this report we had a literature review, door-to-door surveys, interviews, then a lot of work releasing the report and garnering media attention. In collecting primary data, our health department staff developed a sampling plan that emphasized rigorous scientific standards, but aligned with Causa Justa's emphasis on community organizing that allowed them to connect with a lot of residents.

Around the report release, Causa Justa had a lot of experience with media events. They led that, the report release. It was in front of a home being foreclosed on. There were resident speakers, big poster boards of data, speakers from the health department. We got front page coverage in the "San Francisco Chronicle," "Oakland Tribune ,"and other outlets.

Here is one example of one of the media stories. If you want to see how the report release went, it's a great way to learn more. Some of the successes from this report is that the 11 policy areas, recommendations in the report really give us a foundation to move forward from and helped our Place Matters housing group work have a place to move from. There's been local and national focus on this. We know that the Health Resources and Services Administration and Housing and Urban Development offices at the national level used our frameworks and data. Causa Justa led efforts to stop the utility shut-offs at the local level, and worked on passing a bill at the state level that stopped them as well.

Causa Justa and other partners, as well as Place Matters housing group work, partnered on a vacant property ordinance in Oakland that mandates banks register foreclosed properties. This reduces plight and netted over $1.6 million for the city in the first 18 months. Our Place Matters economics workgroup and Causa Justa as well as partner collaborated with Oakland on a linked banking ordinance and other jurisdictions it might be more familiar under the term responsible banking ordinance. This mandates that banks disclose financial lending data including ties to predatory financial services, so that Oakland can use that in determining who they bank with.

As one more way to solidify this link between social inequities and health inequities, as our health officer wrote an op-ed about responsible banking and health for the Oakland Tribune. When we defense into the swimming pool in 2008, with this work on foreclosure, we didn't know it would lead to work on displacement. We had had multiple conversations, and it kept arising in our conversations internally as we were working on addressing these social inequities, if people were displaced they would not stand to benefit from increased access to opportunity and decreased exposure to risks. We hadn't known how to get involved. So this presented an opportunity.

Causa Justa led a report released in 2014 on displacement and health, and a key message of this report is that displacement is not inevitable and local government can play a role in preventing displacement and the negative health outcomes that come with in.

On this work in on gentrification, think back to the triangle, it included all areas. Strong partnership with the community partner, using innovative data and research to effect policy and systems change, it also necessitated that we look internally about how we were working and we had to really step up our game and do a lot of things differently. Then in the bottom right-hand corner one of our connections to programs and services is our healthcare for the homeless staff were able to testify. It was very compelling testimony to the Oakland City Council about the link between displacement and homelessness and the severe health consequences.

Again, by jumping into that swimming pool, we've been able to expand. One of the things we've learned is that we've been more successful when we've been able to tie our policy work on social inequities to both internal programs and services and externally to community partners. In this example, Causa Justa has brought people power, campaign knowledge, and a deep understanding of housing issues. They are engaging local residents to take collective action and they're freer from restrictions placed on government, so they can bring direct organizations capacity.

Our department has been able to bring data and policy analysis, a health lens and health equity lens, and offer objectivity, credibility and urgency by talking about these issues as life and death issues.

Some of the results we've had so far, we contributed key research to the report in an area that displacement hasn't been as talked about as a health issue. There were over 30 stories and blogs around this issue. Oakland City Council passed the first rental protections in 10 years based on this work. Then also passed tenant protection ordinance which prohibits 16 types of landlord harassment used to push people out and further displacement. We're going to continue this work as well.

I'm going to wrap up, but I wanted to put this slide up, and the slides will be available after so you can get a sense of some of what the other work groups are working on. I'd be happy to talk more about this.

Finally, in terms of what it takes to get here, I can talk more about any of this in the Q&A as well, but really engaging staff from across the health department, partnering with community organizations, leaders and government institutions, really pushing ourselves to be responsible to our community partners, fostering leadership across many levels. Working to understand and use our institutional power in multiple ways, contribute to building grassroots power, continuing to address root causes. Even though it can start without a lot of staff resources, delved dating some. Then continually looking at building staff and organizational capacity.

I want to end, again it's been important not just to talk about the problems, not just data on health inequities, but to use our power as a health department to talk about a vision of health equity and talk about where we can go together to make people excited and to engage with us and really believe we can change what we see and achieve health equity.

Finally, I wanted to leave you with resources to stay connected with us via social media. There's a few more resources, videos and an article that can give you much more background on our work, and also my contact information.

I look forward to the Q&A and hearing a lot more about the other work happening. Thank you.
>> Bob Prentice: Thank you, Kathy. I see why the Alameda County Public Health Department has a reputation for doing a lot of advanced work in health equity.

Before I turn this over to Jeanne Ayers, this is the third polling question, as you can see. This is a question about how health departments and communities work together.

The questions are health department's working relationship with community include, and there are different ways in which health departments typically work with communities and maybe not so typically. This would be an interesting way to learn about the extent to which health departments and communities have figured out how they can work together.

There we go. So next I want to introduce Jeanne Ayers. Jeanne is the assistant commissioner for the Minnesota Department of Health. She earned her master's in public health from the University of Minnesota and bachelor's in nursing with a minor in psychology from Marquette in Milwaukee. She served as director of nursing at University of Minnesota Boynton Health Service.

Jeanne brings extensive experience in community organizations, launched the Healthy HeartLand Initiative, sponsored by Isiah, faith-based organization dedicated to social, racial and economic justice. Jeanne will say more about that. The initiative is a partnership of six community organizations in Missouri, Wisconsin, Michigan, Ohio and Minnesota dedicated to building capacity and leadership to effect public policy to assure health equity and healthy communities. She was selected as a 2010 University of Minnesota human rights and social justice award winner for her work on health and racial equity. Let me turn this over to Jeanne. I need to say this, the work she's describing is in a state health department. That seems to be remarkable. Maybe there were some jurisdictions that can get away with things others can't, but a state health department is a different environment to work in. It makes it even more impressive.

Jeanne, please.

>> Jeanne Ayers: Thank you, Bob. I want to thank Kathy for sharing the inspiring work from Alameda County. We've been watching from Minnesota and copying whatever we can from the learning you've been doing. Thank you. Very inspiring.

There were a couple points you were making, many, but one was the iterative, sort of the constant learning and reflecting and learning and how by acting our way into this work, as you used and Renee has used the journeying into the swimming pool, we actually create more opportunities. So I just want to say that what I'm sharing is really a work in progress.

The first thing I want to start with is that in Minnesota we have significant health disparities. The disparities, though we've been working in this area with the specific targeted grants for 13 or more years, we -- these disparities are persistent, they're unacceptable and they're often rooted in inequities in the actual opportunities for health between populations of color and the white population. And we believe that public health has a role in creating the urgency and the public understanding and political will to tackle the root causes of these disparities. And that we recognize that in order to do that, we're going to have to expand the boundaries as the title of the book is actually of traditional public health practice. This doesn't mean we have to leave what we're doing, but we do have to expand, or we're challenging ourselves to expand our boundaries.

With the time I'm going to have today, I'm going to focus on one key aspect of our work, which is the broadening and building of strategic relationships with the community, and I think that I'll give a little bit of overall grounding in our philosophy, because when we're trying to do work in a lot of different places having clarity about a philosophy actually helps guide us.

The first thing is that we take the -- we really embrace the IOM vision of public health. Public health is what we as a society do collectively to assure the conditions in which all people can be healthy. So there's a few really key concepts here. One is what we do collectively. That doesn't mean it has to be from the walls of our department or even our professional field. It's what we as a society do collectively, to assure the conditions, that aspect of the vision really means you have to be clear about what are those conditions, and what is our responsibility and sort of step up to our responsibility of assuring that those conditions are present.

So that all people can be healthy means basically we have to be clear about what is health, and added when we talk about it, we added "all" because in 1988 IOM didn't have that word in there.

So we start basically with the World Health Organization definition of health, which is a broad definition and helps us move the conversation away from a disease or healthcare. Wherever we are, whenever we're talking, we make sure we begin in that place, and we often will share the information about how much of our health is actually created in the clinical care sector and from behaviors. I'm sure many of you know that data and it's available in many places.

Fundamentally, our health is related to or completely dependent upon the prerequisite conditions for health, shelter and education and our stable income and ecosystem and peace. This isn't new information for most -- first, what I find it's not only not new information for public health people, but when you get further away from the professional training, people just know this. If you give them a chance to connect around it, and we broaden the understanding -- or we broaden the opportunity to connect the data and the pathways to health, it really makes things very much more clear, and people are -- it's a very natural connection.

So basically, this little model helps us to say our health is almost completely connected to our living conditions. In fact, we have in public health a word for that, that connection or the living conditions, and that is the social determinants of health. We say the definition of the social determinants of health, which also bears actually clear reading is the conditions and circumstances in which people are born, grow, live, work, and age. Sometimes we just end there, but this next part is so important, these circumstances are shaped by a set of forces beyond the control of the individual: Economics and the distribution of money, power, social policies, and politics at the global, national, state and local level.

It's all in context. It all gets nested. That's really important, because if you've embraced the first part of the -- you've embraced the IOM vision of public health and it's our role to ensure the conditions, and we've now named those conditions, there's an aspect that I think we are just beginning to invite ourselves into, which is our health isn't just completely interconnected with our living conditions; it's actually even more connected to our ability or capacity to impact those conditions.

This one model, this thinking about this this way, for me, has changed how we enter any space in terms of doing our work. It's not just naming the condition or measuring our health or trying to do an intervention on a particular condition, but how are we doing our work in a way that strengthens the capacity of the community and our partners or what we can do collectively to impact those conditions in a way that it helps achieve equity for all.

So that capacity to act, often when I'm in a space and talking about this, I will say, What's another word for that? It's basically -- you know, clearly it relates back to it's about power.

If part of our work, or maybe the most fundamental part of our work, needs to begin to take or expand our boundaries to be intentional about how we're going to transform the distribution of money, power, social policies and politics at all these levels, we have to have a sense of, a theory of, how we're going to incorporate that understanding of power into our work.

What we've done, or what I guess reflects our work, actually when you look at this model we see this is just a model about three arenas of power. If you look at the things, the elements of expanding practice that Bob outlined in the beginning of this webinar, they're all represented there. When you look at the work that Alameda County has just described, these elements or arenas of power are represented there.

Our evolving experience around this is these are very interrelated. They interact and feed and inform each other. So this is kind of the very helpful for us as we're thinking about are we actually operating in all those spaces when we're constructing our relationships or whatever.

So quickly, the arenas of power, these are quick descriptions. One is an aligning the narrative, how we help build the public understanding and public will. That's where we're bringing the data, white papers, reports, but it's also how we are talking about it. Then it becomes how we act. We have to also shift the resources and the infrastructure in a way that systems and processes are structured.

Those two elements are arenas of power. If you end up downloading these slides at some point, there's a little bit more on that, because I'm not going to spend time on what we've done in those areas today.

The third element or arena of power is directly impacting decision makers and developing relationships and aligning interests. When we say, well, it's about organizing people and organizing resources and organizing narrative, this is the organizing people part.

Bob mentioned at the beginning that we have been, over time, looking at how do we begin to explore this. For about four, five years or more, there's a set of partners who have been building a network for health equity, beginning with community organizations groups in these five states in the Midwest, called Healthy Heartland, which then begins to be very intentionally partnering with NACCHO and CDC and public health entities in those five states. And we call that effort building networks for health equity.

There's a number of examples that have gotten raised up as we've been exploring our work through those partnerships. But in 2011, we had a meeting, and Dr. Tony Eiton from The California Endowment, was part of that meeting. We were talking about what is it that we're really trying to do? This quote is what is represented in this book of "Expanding the Boundaries".

We need a new kind of public health practice where public health professionals understand that assuring health and racial equity requires deep relationships with people who understand and build power intentionally.

It isn't that we are going to be organizers from a state or local health department. It's that we need to be intentional about being in a relationship with people who understand and build power. One of the things is that we already are in a relationship with people who understand and build power. It just might not be always the whole -- we might need to expand that set of partners, because the power that is operating is maybe not -- well, it isn't in Minnesota anyway, hasn't helped us achieve health equity.

So when we're beginning this process, or when we start to kind of reflect on this here's a set of questions that I think are helpful. One is, who? What type of power? When we start to say we're going to change the foreclosure issue that Kathy just discussed, who do we need to be in relationship with? Or if it's a transportation issue? Or an issue about school discipline? Or minimum wage? Who? What kind of power would we really need to achieve the kinds of aims that will help assure health for the conditions for health for everyone?

Then look at that, say who are we in relationship with and where's the gap? What kind of interests do those folks represent?

We have -- we're evolving from kind of having a lot of familiarity with relating to the healthcare sector, and the health insurance sector, and we have much less familiarity with relating to groups, community groups working around incarceration justice or even other sectors like transportation or education or criminal justice.

So these are questions to begin to ask. Then when you start to think about who we're in relationship with, you have to ask the question do they have a base. This is a word that wasn't so familiar to me as a public health professional, but as a community organizer, as I did more work with faith-based group called Isiah, that's a central operating principle with community organizers, is do they have a base, and the base is basically a source of authority, a source of influence or support, people that they represent or they're accountable to.

So this is a really -- this helps us shift, because sometimes when we're looking for input from community that's one of the problems right there, we're saying we're looking for input from community versus partnering with the community. The other thing is that what we maybe don't have as sophisticated of a lens about what a base is and what power is.

I'll give you an example. It is usually not -- usually in an agency like our agency, if you are setting a process up, you would be assured to have the hospital association, our local public health as much, and we would -- there would be representatives from those sectors at the table. They have a base. They have a set of people that they're representing and are accountable to, and that's part of what they're bringing to the table, and that is the power.

We don't get confused in that situation with one president of one hospital from one part of the state and the representative from the hospital association. Those are two different kinds of levels of influence, and we're not really confused about that. But we often are confused when we invite an African-American from a community organization versus someone we haven't taken the time or haven't connected with a group that could actually bring a base or perhaps they're bringing their own knowledge of a clinical experience or an outreach effort.

All these things can be valuable, but we need to be clear. So different groups play different roles. They all -- sometimes you're looking for input about what will work best or how to do outreach best. Sometimes it's like informing us, but if you're looking to try to transform big conditions like minimum wage or foreclosure or where the light rail rail expansion gets located, those are not the same. So that's, I think, one of my key invitations in terms of considering expanding our boundaries.

Also as we begin to -- when we bring people together, don't assume we're the person or we're the organization that is in the position that can organize a base. And that is -- that's just really important. Find other organizations who have that as their role, work through intermediaries. Then recognize we do have power. We have a certain type of power, and sometimes it's expert, it's institutional, it's convening, there's a racial dynamic working, and be aware of that. So as we construct our spaces and do invitations into those opportunities or go to be in other people's opportunities, we're aware of that power and we're not underestimating that.

>> Bob Prentice: I apologize for the interruption. We're running pretty late.

>> Jeanne Ayers: That's fine. This ladder can help situate yourself into that work, and how you set that table is important both physically and through the propositions that you make. These are some examples of that.

Finally, just that there is a great -- there's just really good reasons for doing this in terms of strengthening the community's ability. I think it provides longer term sustainability and resilience and allows our partners and communities to respond to emerging challenges and threats.

Thank you.

>> Bob Prentice: Thank you, Jeanne. The work in Minnesota has been so impressive. I think people look to you for -- the way that you talked about Alameda County, I think Minnesota is developing that reputation where people are looking to you for much of the work you're doing.

I have one more -- how do I do this again? One more poll. There we go. This is a question about organizational development, that it's a theme that has run through both Kathy's and Jeanne's

presentations. This isn't just doing work off the cuff. This is often involving deep organizational development. I think that's one of the questions we're trying to get at here. Just trying to get a sense of how health departments around the country have tried to incorporate health equity into their organizational culture. And I think this poll will actually be a really good setup for the next presentation.

Renee Canady, who I've introduced. This says MPH. Didn't get your doctor stuff there, OK. Anyway, Renee is the chief executive officer of the Michigan Public Health Institute, but prior to that was the health officer for the county health department. I'll abbreviate the introduction to try to help manage the time a little bit. I think among the other things that they've done, the county developed a national reputation for their dialogue method and approach to organizational development. I think the question about how you approach organizational development as a culture change, not just as a program area, is really well reflected in the extensive work that has gone on. I don't mean to reduce the importance of all the other work they've done, but it highlights the work on health -- on the organizational development is really important.

I want to acknowledge that Renee has been active in the NACCHO and social justice committee, and she earned her bachelor's degree in public health nutrition from North Carolina Chapel Hill, a master's from Western Michigan University, and doctorate in medical sociology from Michigan State University, my alma mater, probably the reason I wanted to squeeze that in.

All yours, Renee. Thank you.

>> Renee Canady: Thank you, Bob. It's great to be a part of this conversation, and thank you to my colleagues Kathy and Jeanne for giving me such good setup. I think you're going to hear some recurring themes or patterns of the way we're sort of viewing this work, even though they may play out differently in your community.

I'm going to really highlight a few of the points and maybe enhance a couple of those points from the book, but we have been, I think, effective in "Expanding the Boundaries" in Ingham County by using facilitated dialogue specifically as a strategic methodology to shift within our department and within our community as an agent. We'll talk a little about that.

As I and my colleague have talked ad nauseam about this, we sort of frame this model that we're calling traction. It was like how did we get going? How did we keep going? How are we going to sustain the work into the future? You will see these little creative icons that I will attribute to Doak's creativity. I will talk you through these three models.

Getting started, where does the rubber meet the road? We really felt it was about leadership and policy or keeping us moving down the river in momentum, was about training, dialogue, then action. And the setting sail and kind of getting to that place of ease, where we're just sailing through the wind, was really about relationships and organizational culture. I'll give you detail on that.

In terms of how we got going, it really, there were so many components of this. But if you would think first about leadership and we really, and I really, argue, as a former senior leader of Ingham County, that there was some risk taking and opportunity ownership that required administrative buy-in. It would be very easy to be silent on some of these opportunities, but I had the privilege of following two consecutive health officers who just taught each other to do the work in this way.

It was really the leadership that facilitated a lot of our work. I would dare say, though, that that precipitating, facilitating leadership doesn't have to be in the senior leader. It might rest somewhere else in the organization.

We had such passion about this that our workforce was able to own health equity as a core organizational value, that being one of five core values. And then the other two, I think, important

components of getting our work going was being able to show the teeth in this work, that health equity was a measure of community well-being and contextualize it that way. Just as we often would talk about infant mortality not as a pregnancy outcome, but as a community measure, we talked about health equity in a very similar collective way.

We were very clear that we weren't just trying to increase people's knowledge and understanding, that we were trying to highlight the tension between what you know and what you do. So there was a commitment to train all of our staff, but that was not the outcome; the outcome was that ultimately the public health response would reflect health equity principles.

I was intrigued by Kathy's diagram. You will see that she and Jeanne and I have the holy trinities, the three weighty matters that had to be addressed. From a local perspective these are very, very similar to Alameda County. So where she was talking about policy and system changes, that's where our work, I would say, was represented around this leadership bubble. Was it endorsed by leadership? Was it mandated by leadership? We used to laugh and say was it mandatory training, it wasn't, but it was "volun-told" training.

We used change theories, and said let's let the critical early adopters choose to come onboard, then let's mandate this for the stragglers. So we used a lot of different, I would say, relationally driven decision making strategies.

The workforce, I think, parallels Kathy's institutional change. We really empowered our staff to correct, to challenge and to agitate us. That was encouraged, and it was welcomed.

Lastly, probably most importantly, as you saw with Kathy's triad, this embracing the community, seeing the community as the public in public health. In all of our decision making, we engaged the community, we had advocacy and support from the community, so that if we had commissioners that were a little uncomfortable, we could easily refer a community partner to talk to them, as opposed to our trying to set forth our own explanations.

Those three things really did, I believe, bring us into a cultural shift where we just do the work that way in Ingham County, if you would allow me to present it that way.

We got that traction, rubber met the road, we started moving forward, and it became the What shall we do, and what's the capacity to do anything? So we invested 12 days building a cadre of colleagues within the community and within the health department that could guide us through this very, as I said, methodological, strategically driven process of communicating around these very tough issues.

These 30 people have persisted, they've changed, they've continued to expand the work, and they continue to remain vitally important advancers of the work.

We did provide training to all of our staff, but it was not just about the learning but positioning them to go back and think differently about their work, and we have begun to see some consequences, tangible consequences of that.

We also offer this service to other organizations and groups in the community, because we are nested in the community. We see ourself as a community asset. We didn't want to develop a vocabulary and go around speaking a language that no one else in our family understood. So that was done free of charge, no fees associated with that, to community organizations. Then began to continue to hold onto facilitated dialogue as a process, when incidents came up. When you kind of open up people's eyes of understanding, they have these epiphanies, and we would hear a lot of people come back from workshops say, Oh, this is a social justice issue, some interaction with a client or family, or even amongst themselves as colleagues.

So we do some sort of smaller dialogue-based processes to unpack and problem solve some of the things that our colleagues would see.

This is the model that really has framed our world view, I guess I'll call it. It's from Valerie Batts, a very powerful article. Interestingly, we initially started our work at the institutional level. We were going to make Ingham County Health Department a better place, and didn't get much traction starting around our rules and policies. We figured out that you got to deal with the hearts and minds of folk. So we bounced back to being the personal, on the personal level, to begin shaping a different world view for our workforce, so they then could shape a different world view for our department.

Lastly, this sort of setting sail. You've heard this word repeatedly over the webinar time, but I quote Ron David in one of my favorite quotes, that says, "Relationships are primary; all else is derivative." Everything we've accomplished we've accomplished through a relationship. I would encourage you to do a bit of relationship assessment.

Some of the strongest relationships may not, as I said, start out at the health officer or senior leadership level. They may be at the grassroots level. They may be at the mid-level managerial level, but think about what those relationships are so that you can support each other. You sort of plan for the tough times. No one needs to go to bat when everything's comfortable, but when you need to pull together and say, No, this is together, this is worth wading through the discomfort to get to that end goal. And ultimately, as a department, I would dare say as a community, we've made repeatedly a commitment to authentic dialogue, to really talk about things from a sincere place. That helps us to make it as easy as possible to listen to and to hear the truth of racism, classism, gender discrimination.

Doak and I talk a lot about how you keep people at the table and why it's important to be very explicit about these root causes of the social determinants and the disparities across those determinants. One of our favorite things to say is to increase our comfort with discomfort. If something is uncomfortable, then we're making progress. But always doing that work in a way that honors the best in each of us, being mindful of love and fear. We're very clear in inviting values to the table.

We do have an agenda. We try to make it a common agenda. But this is not a consensus approach to this work. This is a collective approach, and we are trying to compel our audience of the importance of the work. It's not a throw it out there, take it or leave it. It is a throw it out there, take it. And through that, we've come to this place that I would say is our transition into action, and that is still beginning to blossom. We continually talk about what is the remediation that we need to do; what is the health equity, when you get past 101, how do you get to 201 or 301; how do you continue to make progress.

This continuing to move upstream, as I mentioned, requires intentionality and some explicitly focused conversation, and acknowledgment that, yes, it is difficult work. But unless we have a very deep understanding of right now the subtle forms of institutional discrimination, we challenge people all the time to think about the impact of their actions, not just the intent. We're sure you're a very good, well-meaning person, but if the consequences of your actions were negative and deleterious, you have to take ownership of that, and we'll support you in doing that as we begin to, hopefully quickly and expediently, erase the continuing legacy of institutional racism, class oppression and gender discrimination.

I just want to close with a quote from my colleague Doak. I had a completely different closing slide, and Doak and I met a couple days ago, and he landed with this quote in our conversation. "Institutions don't change institutions; people change institutions." I said, Ah! You've changed my presentation. That is what we're trying to do, impact the understanding of the people who comprise the departments, the communities and the society so that the outcomes ultimately can follow suit and improve.

Thank you.
>> Bob Prentice: Thank you, Renee. It's really heartening to see how you've embraced an approach that involves changing a whole organizational culture, that health equity is not just about a program area with a few people doing creative work, but it's getting all the existing programs and people who work there to rethink the approach they take.

We're running way behind here. I wanted to give an opportunity to Richard Hofrichter and Marilyn Metzler to say something about this work from the perspective of, on the one hand, NACCHO, and on the other hand the CDC. Richard Hofrichter, Marilyn, it's up to you. You can go one at a time or both join in and take turns. Actually, why don't I -- Richard, why don't you start off, then Marilyn.
>> Richard Hofrichter: OK. Well, again, I would like -- thank you very much. I would like to thank everybody, particularly Marilyn Metzler at the CDC, for supporting the work we've been doing in this publication that you've done. I've been working, obviously, for a number of years with our speakers, and this has been very, very critical to have colleagues who are willing to take the kinds of risks that we've all been talking about.

Let me say about the publication briefly that publications on public health practice and health equity are very rare. In fact, "Expanding the Boundaries" is, I believe, the first publication of its kind to describe systematically, with examples of insights, the requirements for advancing a practice, organized around the root causes of health and equity. That is beyond mitigating and equity.

Public health often focuses necessarily, necessarily, on the short term, but a long-term strategy is also required, that confronts directly the social and economic inequality that generates the inequities, and the nature of the organized powers Jeanne was talking about that supports it. And "Expanding the Boundaries," I think, also begins to explore the possibilities for social change, and not merely intervention and the effective role public health can play with committed allies. It does that by posing important questions, implicitly or explicitly, such as how do we collectively secure well-being and challenging us to recognize that achieving health equity is political and related to all aspects of social life. Public health has to pay attention then because of that to structures of inequality that arise and sustain themselves because of the actions of organized networks of power that limit us and what we can do.

Public health can avoid, therefore, attending to, as our speakers have talked about, things like land use, gentrification, climate change, investment in infrastructure, banking decisions and so on. "Expanding the Boundaries" is really about extending the range of what is considered legitimate practice.

I know I want leave time for questions. I had comments on all of the speakers, that I think are wonderful, but I'll save that to give time for the questions. I do want to say that, finally, these actions take courage and a willingness to take risks. We cannot simply rely on the traditional interventions or technical responses that we've tried in the past. I think it's critical also to be forthright and clear about the source of inequities, from social exclusion and unearned white privilege and domination, to marginalization and exploitation, and not focus on random, unfortunate events or personal failure.

So I will leave it there, because I see we're running very short on time. I want to thank everybody who has participated, certainly, in this very excellent set of presentations. Thank you.
>> Marilyn Metzler: Hello? Can you hear me?
>> We can hear you.
>> Marilyn Metzler: Oh, OK. I thought I got bumped out. This is Marilyn at CDC. I also want to thank everyone for participating in this webinar and organizing it. When we started on this project several years ago we really didn't know where we would end up, and it took a lot of different paths

until we got to this resource called "Expanding the Boundaries" that is really reflective of where the field is, and all these great examples what we're moving towards. That has just -- it's very heartening that we were able to do that.

In violence prevention we're increasingly shifting towards this understanding the context and addressing them, which give rise to increased risk for violence, and here in the division of violence there's probably just two quick examples to give of how we're trying to do that work. One is our work to prevent child maltreatment, which has historically focused on the relationships between parents and children, and that's important, but it wasn't enough. That whole body of work has now transitioned to a new strategic direction and umbrella called assuring safe, stable, nurturing relationships and environments for all children.

It's not just an academic exercise, even though it's cutting across all of our research on program and surveillance activities, but we're now funding state partnerships to participate in that endeavor with us, and even though the original funding announcement could only support five states, more than 30 states have convened these partnerships to start exploring a new way of approaching that. And that's just a whole new strategic direction. So this work is really helpful. In that regard.

Just a few weeks ago, we hosted a webinar on "Expanding the Boundaries" and discussion session for state and local coalitions addressing domestic violence that we work with, and it was just a fantastic discussion, and is really helping them to think about their work and moving beyond these boundaries of service provision, education, that that's all really important, but unless we really look at these dynamics of how race and class and gender inequalities influence and impact violence, that we're not going to really see the changes we want to see.

So this has just been a great success, and thank you to everyone who's participated in this.

>> Bob Prentice: Can you hear me?

>> Yes.

>> Bob Prentice: I apologize. My phone died. I had to reconnect. I'm out of breath, trying to get to another phone.

Thank you all for your comments. We're way short of time that we had planned for the question and answer period. Let me at least get a start for all the presenters, certainly Marilyn and Richard feel free to join in.

The first question, just to -- I'm out of breath from chasing a decent phone. Was there something that you really didn't get the chance to say that is so extremely important that you want to take this opportunity now? Just because you got squeezed by time or you're asked to focus on a particular issue. Let me ask that to any of the presenters.

>> Jeanne Ayers: I just want to say, I was scanning through some of the questions, and there's a number of questions that relate to how do you know if you're having an impact. I guess, related to both your invitation, Bob, and that question, we have information to demonstrate that housing security and wages are related to health. It's a little different question to then say, Well, was this effort that we're just doing today, this week, making a difference?

Well, in Minnesota, for example, we've passed an increase in the minimum wage, which we helped contribute to in our Healthy Minnesota Partnership; our community partners used public health data to help do. It's very similar to the story Alameda County just told.

I guess I would encourage you to continue to go back to that understanding of the relationship between conditions so that actions we're taking that are actually changing conditions get to be counted as impact. Because sometimes we'll say, Well, yeah, but did our diabetes change yet? Then our time frame is too short. That's just a point I'd like to make.

>> Bob Prentice: Thank you. Any others? Comments?

>> Katherine Schaff: This is Kathy. Similar, I was looking through the questions, and there's one that I think is particularly relevant to our work and that I can speak to about power is frequently seen as a zero sum gain, as some gain power others lose. How have you worked with individuals, groups that may feel threatened by community empowerment activities?

Yes, as we've engaged in local policy, it's all about power. It is sometimes contentious, often contentious in some ways, or at least uncomfortable. So I have a few thoughts on this.

One, that we have great staff and we think critically staff come to work daily in uncomfortable conflict situations. Hiring staff with people who have the experience, maybe outside of public health but campaign experience, organizing experience, public policy experience, where they are OK being in uncomfortable positions for a long amount of time, because sometimes it take several weeks or months to work through things with government partners or others.

I think thinking critically about staffing and just being comfortable with being uncomfortable, knowing that's part of policy work. I also think focusing on the base. It can be really easy to want to placate the people who typically have had more traction. Another thing that I think we've dealt with is that as a Public Health Department, someone once called our health department the Switzerland of government agencies, that -- to try to reach I also think that using data, being data driven again showing the connections between housing and health or these issues, that people see it as credible, they see it as science-based, and it's important that we've maintained that, and that's helpful when people become threatened, we're able to fall back on that, see it's not a zero sum gain, and we have the equitable societies are healthier, that it benefits everyone.

So an example is we were working on a health impact assessment of a way in the Oakland Unified School District, which would change the funding to give schools that serve students who face barriers to educational outcomes more as going to make Oakland a better place for everyone. This means thinking critically and changing the way we work.

This group and the Hoss Institute for Inclusive Society, they've done a lot of work around language and epidemiologists, we came up with a model of the analysis that really brought some justification, particularly in Michigan, where our laws say that you cannot use race as a decision point in programmatic or admissions decisions for universities. So all of our work around infant mortality, around chronic disease, around smoking tobacco cessation have begun to think about where are the points of -- that are lacking justice? What is unfair in the way we distributed? If we have a pattern of disproportionate outcomes or burden of disease that have persisted over five years, how can we shift resources in order to reverse or avoid those trends? We have just been extending the dialogue to get people, again, the courage to make those policy decisions and programmatic decisions differently.

>> Bob Prentice: I think at this point I probably have to try to wind things up. We've only got a few minutes left. I want to pose an issue we can't possibly resolve. This whole webinar is putting 10 pounds in a five-pound sack. There's too much to be said, not enough time to say it. In that same spirit, I've had this conversation with Marilyn Metzler, the degree of interest in this webinar is really a strong indication that this has to go beyond webinars, that in fact I looked at one of the responses to the polling questions and I was actually pleasantly surprised, more health departments than I would have predicted are doing work on inequalities of income, wealth, racism, gender and such. Not just interest, but developing practice around the country that needs to maintain the momentum, a movement building strategy.

I think the challenge for us is to figure out how can that happen, and how maybe coming out of this webinar are -- I don't know how we have the conversations at this point, but we've got NACCHO, CDC, other possibilities that we need to sustain these discussions and have them being

done so there's more interaction, face to face maybe. Examples like the building networks for health equity where it's regional. But looking at sort of getting a sense of where all that activity is going, trying to help create some coherence. Obviously, I wouldn't be the one doing that. What I just said wasn't all that coherent, if anybody here has comments about next steps, where we can we go from here. Some quick thoughts? Everybody is on mute. Marilyn?
>> Marilyn Metzler: Not right off, but I think there's a discussion forum. Maybe at PHI or someplace, particularly from the participants in this webinar, it would be really good to hear what people would like to do next. I would definitely welcome hearing that.
>> Bob Prentice: That should have been a polling question. You're right.
>> Maybe we can do that afterwards. Can we poll participants?
>> Afterwards?
>> Through an e-mail perhaps.
>> Bob Prentice: Joanna would have to answer that question.
>> We do have a survey that we'll talk about, give us your thoughts and ideas. You can put your e-mail in there. And you can please put your comments to dialogue4health.org. We really look forward to hearing from you there. Thanks.
>> Bob Prentice: Well, it looks like it's just about time to wrap it up. I want to thank all the presenters, and to Jeanne Ayers, Renee Canady, Katherine Schaff, as well as Richard Hofrichter and Marilyn Metzler.

I've got to click these slides. Here's another shot of how you can purchase or download the book for no cost as a PDF. These are the pictures I was supposed to show you as I was thanking each person for participating.

The ones behind the scenes cannot be ignored. Star Tiffany and Joanna Hathaway are the ones who really make this thing work, and a total pleasure to work with. Thank you to them. And thank you to the sponsor, The California Endowment.

I think that just about is it for us. Joanna, do you have anything to say to formally wrap this up?
>> Joanna Hathaway: Thank you all so much for joining us, and have a wonderful afternoon.
>> Bob Prentice: All right.
[Webinar concluded at 1:00 p.m. PT, 4:00 p.m. ET]