(Re)Framing and (Un)Doing:
Practicing Racially Just and Equitable MCH Leadership

AMCHP Leadership Lab Webinar
November 16, 2020
Learning objectives

• **Identify, distinguish, and deconstruct:** frameworks, cultural competency, health equity, and racial justice

• **Identify ways in which MCH leaders can leverage the prioritization of health equity and cultural competency to advance racial justice within and across systems**
The unacceptable outcomes we are getting are a reflection of the ineffectiveness of our approach.

Source: CDC

Pregnancy Associated Mortality Rates

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

Source: CDC

Pregnancy Associated Mortality Rates

US Maternal Death Rate
Per 100,000 live births

Source: CDC

The hard truth:
Equity is an outcome and a process

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

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

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

In addition to being an outcome, equity is also a specific process that leads to the achievement of that outcome. The process of achieving health equity includes:
- Providing treatment and resources, as needed, to ensure different population groups experience no more than population-proportionate rates of adverse maternal health outcomes.
- Eliminating inequitable policies, practices, attitudes, and cultural messages that measurably disadvantage some population groups relative to others
- Correcting the damage that various population groups have experienced as a result of past or present inequitable policies, practices, attitudes, and cultural messages.
- Rooting out underlying causes, such as racism, leading to inequities in maternal and child health
- Advocating for social justice in maternal health
Words matter:

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

• Difference
• Disparity
• Health Equity
• Equity
• Racial Equity

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

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• Racial Justice

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• Equity Lens/Equity Framework

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• Equity Capacity

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FRAMEWORKS

ABILITY TO IMPLEMENT
EQUITY FRAMEWORK,
APPROACHES
AND STRATEGIES

OUTCOMES

STRATEGIES

APPROACHES
<table>
<thead>
<tr>
<th>Frameworks</th>
<th>Strategies</th>
<th>Approaches</th>
<th>Tools</th>
<th>Skills</th>
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<tbody>
<tr>
<td>Causal Change</td>
<td>Regular vs</td>
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<tr>
<td>Operational</td>
<td>Equity-framed</td>
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“Contributaries” to inequity

• We make claims about eliminating disparities and inequities that are not grounded in reality
## Very Brief History: Evolution of Health Equity

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

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

- We need a **science-based framework** that holistically maps **all** of the conditions creating health inequities.
- We need the causal framework **translated into an action framework** that maps to **all** causes and can be used in the field.
- We need to gain **new knowledge** and **capacities** to change the paradigm of action and operationalize action framework:
  - Community engagement - Critical race theory
  - Anti-racism - Social and racial justice
  - Structural change
  - Narrative change
  - Human centered design
  - Universal design
- We need to structure equity into the day-to-day operations of our teams, organizations, partnerships
  - Everyone needs to develop equity capacities
- We need to partner across orgs and sectors to change the structural conditions that impede racial equity, health and health equity.
- We need new tools to help us implement these
An aside….

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

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

To design our systems, structures, our ways of doing things in ways that address the needs of the most vulnerable, and in the process, EVERYONE benefits, and no one is inconvenienced. To do otherwise is inequitable.
Equity FRAMEWORKS
Fig. 1 Final form of the CSDH conceptual framework brings together the key elements— including structural and intermediary determinants— of health inequities, and the processes and pathways that generate health inequities [29].
Figure 1. Conceptual Model of Historical Trauma
Policies on **stratification** to reduce inequalities, mitigate effects of stratification

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

Policies to reduce **vulnerabilities** of disadvantaged people

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

- Monitoring and follow-up of health equity and SDH
Group Processing

Chat box question: What is your biggest takeaway so far?
Things to Look out for...
1. What an equity action framework might look like:

• Introduction to “R4P” (Hogan and Rowley)
R4P

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

You need R4P to make an equity plan. Otherwise, it’s just “a plan”
<table>
<thead>
<tr>
<th>Unique Risk</th>
<th>Action req. to Reduce Risk</th>
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<tbody>
<tr>
<td>Racism</td>
<td><strong>REMOVE</strong></td>
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<tr>
<td>Historical/Intergenerational Risks</td>
<td><strong>REPAIR</strong></td>
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<tr>
<td>SDOH/Individ Risks</td>
<td><strong>REMEDIANTE</strong></td>
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<tr>
<td>Lifecourse, Structural</td>
<td><strong>RESTRUCTURE</strong></td>
</tr>
<tr>
<td>Attention to Implementation/Intersectionality</td>
<td><strong>PROVIDE</strong></td>
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PROVIDE

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

REPAIR

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

RESTRUCTURE

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

REMEDiate

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

REMOVE

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

• Stages of Equity Capacity

• Do capacity building in stages that match learner’s ability

• Structure as a permanent institutional structure/resource with accountability
Self-Assessed Measure of Racial Equity Capacity (SAMREC)

Determines how to target training for implementing equity

Versions being piloted in:
- AIM CCI/National Healthy Start Association
- Allegheny County Maternal Health Collaborative

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

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

Leadership training on implementing structural change and addressing upstream factors and racism
4. Statewide collaborative approach to racial equity in MCH

*Nurture New Jersey*

• Nurture NJ is a statewide campaign committed to elimination of racial disparities in birth outcomes and reducing maternal and infant mortality and morbidity.

• NJ is a public/private partnership led by the Office of the First Lady of New Jersey, Tammy Murphy, and funded by The Nicholson Foundation and the Community Health Acceleration Partnership.

• A statewide, multi sector, community partnered strategic plan is being implemented to achieve sustained equity in maternal and infant health across the lifecourse.
## Introduction to the PANEL

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Stephanie Campbell</td>
<td>Director, Office of Sexual Health and Youth Development at Massachusetts Department of Health</td>
</tr>
<tr>
<td>Ayanna Eggleston</td>
<td>Parent Consultant and Parent-to-Parent Support Network Match Coordinator at Michigan Family Center for Children and Youth with Special Health Care Needs</td>
</tr>
<tr>
<td>Amy Zapata</td>
<td>Director, Bureau of Family Health at Louisiana Department of Health</td>
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</tbody>
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November 16, 2020

Panelist Remarks:

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

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

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

• Dedicated time at staff meetings to foster continued racial justice learnings
• Supporting staff to explore their own racial identity and involvement in Bureau Racial Equity Movement
• Integration into programs and services i.e. procurement and grantee meetings
AMCHP Leadership Lab Webinar
November 16, 2020

Panelist Remarks:

Ayanna Eggleston
Equity in Leadership

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

• Professional Leadership
  • Translating to leadership community needs
  • Advocating for equitable care and services
  • Cultivating environments for change
Motivation for Racial Justice

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

“OUR LIVES BEGIN TO END THE DAY WE BECOME SILENT ABOUT THINGS THAT MATTER.”

— MARTIN LUTHER KING JR
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November 16, 2020

Panelist Remarks:
Integrating Equity into the Organization and Cultivating Champions

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

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

-Louisiana Title V MCH Block Grant Focus Group Participants - 2015
HOW?
1. Individual and organizational learning

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

3. Ignite the spark externally
1. Individual and organizational learning

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

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

A-ha: Effect v. intent
Knowing Our History: Exploring Policies and Practices that have Contributed to Racial Disparities in Health Outcomes

Glenia Graeby, BA
Amy Zapota, MPH
Karin Saeboe, MPH

Background

- In Louisiana, racial disparities persist across a variety of health indicators, including birth outcomes.
- The Healthy People 2030 initiative highlights health disparities as an area of focus, emphasizing the need to reduce these disparities.
- Several factors contribute to these disparities, including socioeconomic status, access to healthcare, and institutional racism.

Study Question

- What are the historical, educational, economic, and health-related policies and practices of the colonial period that have contributed to racial disparities in health outcomes in Louisiana?

Methods

- Literature review of databases such as PubMed and the Cochrane Library, focusing on specific topics and relevant case studies.
- Analysis of state-level data from Louisiana's Department of Health and Hospitals.
- Interviews with local community leaders and healthcare providers.

Results

1800s:
- Slavery and Jim Crow laws established segregation and discrimination in all aspects of life.
- African Americans were denied equal access to education, employment, and healthcare.

1930s:
- The Louisiana State Board of Health conducted a survey that highlighted disparities in health outcomes between African Americans and white citizens.

1950s:
- The Brown v. Board of Education decision led to the desegregation of schools.

1970s:
- Legislation was enacted to address disparities in healthcare and education.

Conclusions

- While we did not answer "how" social, economic, and health policies or practices have led to health disparities, the research illustrates historical contributions.
- There have been systematic policies to limit civil liberties, voting, home ownership, education, and professional advancement, contributing to disparities in health and well-being.

Limitations

- Data on health outcomes and policies are historical, and newer data may not be available.
- The study was limited to Louisiana, and other states may have different experiences.

Public Health Implications

- Health outcomes are in part a product of historical factors.
- An estimated 40% of people born in Louisiana are still relevant to current medical conditions.
- Public health efforts should focus on the long-term effects of historical factors and work towards addressing these disparities in healthcare policies.
We envision Louisiana as a state where all people are valued to reach their full potential, from birth through the next generation.

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

hundreds and thousands

“Services”
THE BIG OPPORTUNITY!

hundreds and thousands

“Services”

Systems and Policy Change

tens-of-thousands and millions
3. Ignite the spark in others

- Systems change – use data, existing external pressures, and supports to mobilize change in others
- Policy change – capitalize on learning and interest mobilized in others
LaPQC as catalyst and support for learning and change (Pregnancy Associated Mortality Review process and report as triggering and reinforcing loops)

- Achieve a **20%** reduction in severe maternal morbidity among pregnant/postpartum women who experience hemorrhage or severe HTN in LaPQC participating facilities in **12** months and to narrow the Black-White disparity in this outcome in **12** months
- **Reliable Clinical Processes**
  - Assure readiness
  - Improve recognition and prevention
  - Understand & reduce variation in response
  - Eliminate waste
- **Respectful Patient Partnership**
  - Design for partnership
  - Invest in improvement
- **Effective Peer Teamwork**
  - Reduce variation in reporting
  - Change the work environment
  - Improve work flow
- **Engaged Perinatal Leadership**
  - Manage for quality & systems learning
  - Enhance patient and family relationships
  - Change the work environment
LaPQC

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

Reliable Clinical Processes
- Assure readiness
- Improve recognition and prevention
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Effective Peer Teamwork
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Engaged Perinatal Leadership
- Manage for quality & systems learning
- Enhance patient and family relationships
- Change the work environment
2020 First Extraordinary Session

HOUSE RESOLUTION NO. 33

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

A RESOLUTION

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

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

WHEREAS, Louisiana’s healthcare workers have performed heroically and made
1. Individual and organizational learning

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

3. Ignite the spark externally

Louisiana Department of Health – Office of Public Health Bureau of Family Health
Growing potential, from birth through the next generation

Amy.Zapata@la.gov
Audience
Questions