

Dialogue4Health Web Forum

Designing a System of Prevention to Advance Health, Safety, and Wellbeing for All

Wednesday, October 2, 2019

Communication Access Realtime Translation (CART) captioning is provided in order to facilitate communication accessibility and may not be a totally verbatim record of the proceedings.

This transcript is being provided in rough-draft format.



>> LAURA BURR: Welcome to "Designing a System of Prevention to Advance Health, Safety, and Wellbeing for All." My name is Laura Burr and I will be running this Dialogue4Health Web Forum with my colleague Tonya Hammond and we thank our funder for today's event, Prevention Institute.

Now it is my great pleasure to introduce La'Quana Williams, the moderator of this event. In her role as associate program manager at Prevention Institute, La'Quana utilizes a health equity framework working across many focus and project areas, including the California Approach, and health equity teams. Additionally La'Quana supports intakes and delivery of training and technical assistance. Welcome to Dialogue4Health, La'Quana.

>> LA'QUANA WILLIAMS: Thank you, Laura.

Welcome, everyone to the Dialogue4Health webinar. "Designing a System of Prevention to Advance Health, Safety, and Wellbeing for All." As mentioned, my name is La'Quana Williams and I'm excited to serve as your moderator for today's discussion. First, I would like to share a little about Prevention Institute. PI has offices in Oakland, south Los Angeles, Houston, and Washington, D.C. We are champions of prevention in health equity because we know health, safety and wellbeing are among the most important things for individuals, families and communities.

In everything we do, we are deeply committed to partnership and collaboration. Our ability to innovative, for example, immersion in our work alongside communities and organizations across the country that are surfacing problems and applying our methods to approach challenges in new ways. You will learn more about Prevention Institute by visiting our website at preventioninstitute.org.

Today we will hear from Juliet Sims, an associate director at Prevention Institute, who will discuss our System of Prevention framework. Juliet's presentation will be followed by a presentation from Gregory Brown and Dr. Heidi Gullett from Cuyahoga County in Ohio. They will share their efforts to advance health equity and racial justice and we will wrap up the session with questions for the panelists and end with a short Q&A from the questions posed by the audience. Please remember to send questions to us using the Chat box.

First up is Juliet. As an Associate Program Director at Prevention Institute, Juliet supports projects aimed at preventing chronic illness with emphasis on local state and federal initiatives that foster healthy and equitable communities. She directs the institute's policy efforts in California and collaborates with organizations to embed prevention? Governmental practices and advance health and safety policy across sectors. Juliet consults with government agencies, organizations in California and

across the country, providing training and technical assistance to incorporate community prevention approaches into their efforts.

Juliet...

>> JULIET SIMS: Well, thank you, La'Quana, for that introduction. And to everyone on the webinar, thank you for joining us. Today I would like to share with you a bit about how we at Prevention Institute have come to think about the role of systems in our work. And in broader collaborative efforts to advance health equity. As part of my presentation I will share our System of Prevention framework and talk about why we developed it and how it may prove useful to you and your community when it comes to advancing health equity.

So, La'Quana described Prevention Institute's focus on the practice of prevention, and I would like to underscore that when we talk about prevention, we're talking about the prevention of illness and injury before it occurs. And quality prevention efforts generally have several features in common. Rather than being aimed fully at the individual, they are aimed at the community environment and foster an environment supportive of healthy behaviors and outcomes. They are not focused on a single strategy but are instead comprehensive or multipronged. This means that a comprehensive prevention approach includes changes in policy and institutional practices alongside supportive community programs and education.

They generally shift norms making healthy and safe options the default, and finally, quality prevention efforts keep equity at the forefront of the work. That means that everyone has a fair and just opportunity to be healthy and safe because we know that when we don't intentionally focus on equity, we can unintentionally further inequity.

Centering our work around equity requires us to work towards the removal of obstacles to health such as poverty, discrimination and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments and even healthcare.

In fact, quality prevention practices really rooted in the strong evidence that place matters. And that the environments around us have the greatest influence on our health odds. This reality was well articulated in the National Academy of Medicine's 2001 report promoting health intervention strategies from social and behavioral research which stated, it is unreasonable to expect that people will change their behavior easily when so many forces in the social, cultural and physical environment conspire against such change.

Now, the World Health Organization has described the structural drivers of poor health as an inequitable distribution of money, resources and power.

Inequitable distribution of these factors have resulted in community environments, including the social, cultural and physical -- and I would economic -- environments that generate different outcomes based on race, place, and income.

After seeing an inequities repeatedly in our work, we took an opportunity to take a look at how it got this way. With support from the Robert Wood Johnson foundation we looked at key determinants of health and conducted analysis of policies, practices and procedures related to each determinant of health that had inadvertently or by design contributed inequities in communities of color.

One that we looked into as part of the research was the built or some call physical environment. To illustrate this we've gotten into the habit of using gears to represent the production of inequity to represent how different policies and practices work together.

So, what is the built environment? The built environment refers to physical place, including human-made physical components, design and permitted use of space. That can include the look and feel of a neighborhood, access to affordable healthy food, parks and open space for physical activity, what sold and promoted, accessible transportation, and even the quality of air, water and soil. Which are all strong indicators of health and influence health outcomes.

And we know that root factors like racism have shaped each of these built environment-related policies and practices with negative health outcomes that persist over time. So like the gears of a machine, these policies and practices are interrelated and set one another in motion in ways that have created enduring and cumulative health impacts.

I'm touching on just a few examples of this today, but there are many others as well.

And, for example, it wasn't just investment in suburban infrastructure but also disinvestment of the urban core that intensified built environment inequities experienced by African American and Latino communities in particular in the second half of the last century.

And the slide includes a range of different policies and practices that together have really contributed to inequities in the built environment. And I'll just describe a few to give a sense of it, and they are described more fully in our production of health inequities paper available on our website.

You see here the Dawes Act authorized the president to survey Native American tribal land and fragment it into allotments for individual Native Americans. What that meant was one piece of land could have hundreds of owners, which consequently limited the ability for owners to make use of the land for agricultural or business development.

Policies such as the Federal Highway Act authorize construction of 41,000 miles of network of interstate highways across the nation. And the construction of these highways bisected neighborhoods and displaced people from homes and in some cases sliced communities in half, leading to abandonment and decay in communities and cities.

So these are just a few examples. I encourage those who would like to learn more to look at our paper and investigate some of the additional policy examples here.

In our production of inequities paper we identified eight determinants of health and looked at policies and practices just as I described related to the built environment for each of them. And what we know is that each of these determinants have strong evidence-based showing they connect to health and safety. And they also show how inequities play out in health and wellbeing outcomes. In fact, if we think about each of the determinants in terms of a system, we can see how the policies, practices and resource decisions of multiple sectors together produce systemic inequity.

When we look specifically at African Americans, for example, we see that they are two to seven times as likely to have bad outcomes across systems in comparison to people who are white. And this graph illustrates some of those disparities such as you can see on the bottom line health and differential impacts related to infant death and death from diabetes, and education we can see differential impacts related to proficiency in fourth grade and suspension.

In the legal, criminal justice system we see frequency of being searched at a traffic stop or incarcerated as an adult.

And in child welfare we see individuals identified as victims or in foster care.

And finally, finance we see individuals who are denied loans or don't own a home.

This research really got us thinking about systems. And we're including the definition of systems here, which is a set of things working together as parts of a mechanism or an interconnecting network. A complex whole. And Peter, who is a lecturer at MIT describes systems thinking as a discipline for seeing whole. It's a framework for seeing interrelationships, for seeing patterns of change rather than static snapshots.

So we got to thinking, you know, if we could look at key determinants of health, like the built environment, housing or education systems, and track the policies and practices that interrelate and produce inequities, how could we apply systems thinking to intentionally counter the production of these inequities?

And just as there are multiple systems in the human body that are distinct and reliant on one another, the systems that impact our daily lives connect with one another in ways that shape our communities and shape our daily experience. So we started to ask ourselves, how could we create a system of systems? In other words, a hub for collaboration across sectors to shared vision and approach to prevention and equity across all the systems that shape communities?

And this hub could facilitate different sectors rowing in the same direction to implement a social determinant of health approach.

So that's why we developed our framework called the System of Prevention. The System of Prevention framework applies systems thinking to an analysis of successful prevention initiatives that achieved population scale impact and outlines core common elements of their success.

So we define System of Prevention as an organized, purposeful set of interrelated strategies, laws, organizational practices and norms that catalyze, reward, incentivize, model and provide a regulatory basis for implementing and scaling up an array of prevention strategies.

Carried for by diverse sectors and community residents, all aimed at advancing community health and wellbeing.

The framework is guided by three overarching principles. First a System of Prevention should seek equitable outcomes by design. So we know that focusing on systems level change can facilitate inclusion and fairness and can open the door to addressing the less visible ways that systems produce inequities, such as bias and discrimination, diminished opportunities and community trauma.

Secondly, a System of Prevention needs to be community-driven. It should be accountable to and guided by community perspective and broad participation to achieve equitable health outcomes for people of color, people with low incomes or any marginalized groups.

And, finally, a System of Prevention needs leadership and collaboration, and the health sector in partnership with community leaders and decision makers can seize the opportunity to be champions of this approach and lay the groundwork for a shift away from systems that only respond to illness and injury after they occur and towards action to prevent inequities in illness and injury.

So by studying the core elements of past prevention and public health success, we identified eight key elements of a System of Prevention.

So this is really the core of the framework. So those elements are to develop a shared vision that recognizes the causes of health inequities and provides unified sense of direction. Engage in multilevel action that is comprehensive and includes policy and institutional practice change.

Elevate community voices and leadership as stewards of the system.

Facilitate community partnerships and multisector collaboration from a broad range of sectors whose policies, funding decisions and practices greatly influence health and safety outcomes.

Empower skilled prevention workforce grounded in social justice.

Make the case for prevention and equity through the data we share and the stories we tell about how inequities come to be in the first place. And gather and share data to support prevention efforts.

And, finally, generate stable sources of funding. Because those of us that are working to advance health equity know that the backbone infrastructure for this work takes resources. So these elements are interrelated and work synergistically to advance health, safety and wellbeing equitably. As a whole they create the backbone infrastructure that catalyze efforts to produce equitable health and safety outcomes.

Prevention Institute works with communities around the country to implement these types of approaches and we know for that communities interested in taking a systems approach, they will be in different places in terms of the groundwork or existing infrastructure they already have in place to build this out.

And the order in which the elements are put in place will differ. But the work of putting them in place can really build on existing community assets and strengths.

So we package the system of presentation framework into a graphic illustrated booklet. You have seen some of the images and the slides here today, and the reason we did that is because our goal was really to support those of you working in the health fields to really support you in your work with community partners, including residents, youth, and multiple sectors of disciplines you work with, so you can more easily communicate some of the core ideas and concepts that can be difficult to understand at times and often use quite a bit of public health jargon. So we really wanted to pull something together that was cohesive and makes sense to ease communication across partners.

Our book is available on our website. There is an e Version you can find and download, and we do offer print copies of the booklet for purchase as well.

So we already have seen the framework and the book have been helpful to governmental public health staff that are working with multisector collaboratives to implement health improvement plans as well as community collaboratives and coalitions seeking to align efforts across a host of health and safety issues.

And to wrap up my remarks, I was thinking about how, you know, sometimes thinking about this kind of work that really involves a C change in thinking from treatment and acute intervention to a System of Prevention. I thought it might be helpful to envision what change looks like.

So, you know, we feel like if we were to see this kind of system implemented, we would see, you know, defaults producing health, safety and equity. We would see social norms and attitudes shifting, policy and organizational practices changing, and we would see public and private dollars really flowing to prevention solutions. Not only to cure or treatment.

And we would see the conditions that make up our communities creating health. And finally we see rates of preventable illness and injury go down.

During our research into the production of inequities, one of the things that really became clear was that a lot more has been written about how inequities are created than about the solutions to countering their production. And in a recent commentary we wrote about the System of Prevention in health promotion practice. We acknowledge that the truth is there is a lot we learned about how to create community conditions and norms that can reduce the risk of poor outcomes. And we implemented some of what we learned, but there's even more we've learned and have yet to implement. And that is really what we want to do or want to accomplish or help catalyze with System of Prevention. So I hope that the framework can be supportive to each of you in your efforts to build community leadership and power, to forge partnerships and to align those efforts in order to achieve health equity. I'll go ahead and wrap there. Thank you, I'll turn it back to you, La'Quana.

Now we will have a presentation from Gregory and Heidi.

Gregory L. Brown is the executive director of PolicyBridge, which is a nonprofit nonpartisan public policy research and advocacy think and action tank in northeast Ohio. He is also the president of Brown & Associates Consulting Services which provides services and philanthropic, public and nonprofit organizations.

Mr. Brown has more than 40 years of public nonprofit and private sector organizational and leadership experience. His expertise includes strategic planning, project and program development, organizational development and leadership, community building and organizing, meeting facilitation, public policy and advocacy issue and survey research as well as data analysis.

And Mr. Brown is going to be co-presenting with Dr. Heidi Gullett, a family and public health presenter at the Center for Community Health Integration at Case Western Reserve University School of Medicine.

There she teaches health professional students and residents. Her research focuses on helping people move out of poverty, especially in the context of primary care. She has served in community health centers most of her career, including currently practicing at a practice where she provide family medical care, including inpatient medicine with emphasis on prevention and women's health services.

Most importantly Dr. Gullett is a wife and mother of two.

Greg and Heidi...

>> GREG BROWN: Thank you, La'Quana. On behalf of Heidi and me, I would like to thank the Prevention Institute for this opportunity. And it certainly would like to thank all you participants out there who are on this webinar for your interest and your time and energy today. Today we're going to share

Cuyahoga's consortium journey to improve health outcomes for everyone and advance health equity and racial justice in Cuyahoga County.

For those of you who may not know, Cuyahoga County is located in northeast Ohio. The city of Cleveland is the largest municipality in Cuyahoga County.

The health improvement partnership Cuyahoga, commonly known as HIP-Cuyahoga is a cross-sector consortium of diverse people who care about racial equity and health.

HIP-Cuyahoga currently has more than 100 members from various sectors of our community. Our consortium is led by a Steering Committee composed of representatives from the public sector, the nonprofit sector, faith based sector and community residents.

Together we are building opportunities for everyone in Cuyahoga County to be healthy, and we also believe everyone should have a fair chance to reach his, her or their fullest potential.

HIP-Cuyahoga was formed in 2009 by our three local health departments. The city of Cleveland, the city of Shaker Heights, and the Cuyahoga County Board of Health.

These health departments and other concerned community stakeholders came together to confront growing health disparities in the county, especially in communities of color. Health inequities in our community are the direct result of historical and contemporary injustices related to social, political, economic place-based factors and particularly structural racism.

We adopted the social determinants of health as a new way of understanding and addressing structural racism and the social political place-based and economic factors that impact the health of people in our community. We now know that the circumstances in which people are born, grow up, live, work, and age impacts their ability to have a great quality of life and their health status.

These circumstances are shared by a wider set of forces. Research shows that improving the economic, social place-based and political conditions where people live, work, learn and play will improve their health status. Healthy people need healthy places. So place matters.

We also know that race, ethnicity, and social economic status impact health status and quality of life. So race matters.

Ethnicity matters.

And certainly socioeconomic status matters.

HIP-Cuyahoga works from the premise that unequal opportunities plus poor health equals shorter lives. Research has demonstrated that in Cuyahoga County, where you live impacts life expectancy. A person with a City of Cleveland zip code does not live as long as a person living in the suburbs just ten miles away. The difference in life expectancy can be as great as 20 years.

So why does it matter?

Why should we be concerned about health disparities and health inequities? Well, it matters because differences in opportunities and in health outcomes are unjust and unfair and it significantly impacts everyone in the community.

Economically, there are major opportunity costs for poor health across the county due to disability and lost years of productive work.

In Cuyahoga County, people of color are needlessly suffering and dying before their time. In the U.S. it is estimated more than \$1 trillion is a combined cost for health inequities. So it really matters socially. It really matters politically. It really matters when it comes to place. And it certainly matters economically.

This infographic is a pictorial representation of the facts that I outlined and the equation that I previously discussed in this presentation. Once again you see at the top unequal opportunities plus poor health equals shorter lives.

You also see that when it comes to people of color, they do not fare as well as the majority population. In 2016, the Center for Achieving Equity, formerly known as the Cuyahoga County Place Matters Team, who are also members of HIP-Cuyahoga enlisted the assistance of the Kirwan Institute for the Study of Race and Ethnicity, and the city and regional planning program at the school of architecture at the Ohio State University to prepare History Matters: Understanding the role of policy, race and real estate in today's geography of health equity and opportunity in Cuyahoga County.

After reviewing this history and the circumstances, three specific things emerged that have guided HIP-Cuyahoga's thinking. The first is values influence policy. Values influence policies, shapes systems which help to produce prosperity for all or create barriers to opportunity for some.

The second thing we learned was that historical policies have long-term residual impacts that need to be taken into account when designing solutions for today. And last but not least, there is nothing natural about today's challenges that we see.

Nor are they unsolvable. But significant change can and only will begin through coordinated efforts focused on the principles of equity and inclusion.

I'd like to share with you for a moment a map of Cuyahoga County. And you see a population dispersion, and this is actually looking at the county in its full measure.

Thank you.

As you can see in the next slide, we have several maps on this slide and I want to have you focus your attention first on the one at the bottom left that is once again a representation of the county map. And then I want you to focus on the map above the county map which shows the county poverty rate. You see the darkened areas. If you look to the top right side map, you see the dispersion of the Hispanic population in Cuyahoga County, and if you look at the bottom map under the Hispanic map, you see the population of distribution for African Americans. If we were to overlay all of these maps and look at them in the context of poverty, what we would find is that the African American and Hispanic neighborhoods overlap where the greatest poverty exists.

The next map we have is a life expectancy, and once again you have the county map and then you have map of life expectancy. Once again, if we were to overlay where the African Americans and the Latinos live in neighborhoods, you would see the highest level of people who have the shortest life expectancy. If you think about it in the context of a historical policy such as red-lining, and if you think about it in terms of where disinvestment in urban renewal have happened, those are also correlating areas in Cleveland and Cuyahoga County.

The next slide provides us with a view of infant mortality. And once again, the local data shows us that where infant mortality is the greatest is in those areas where African American and Hispanics live. The question one could ask after looking at this data and the maps that have been represented is... why?

Well, Dr. Harry S. Green, a systems change theorist at the University of Chicago has stated that every system is exquisitely designed to produce the result it gets.

If we substitute the word "intentionally" for "exquisitely," we know the decisions we make contribute to health disparities and health inequities.

The next map is one we use when we try to talk about building the capacity for health equity in our community. And it's a critically important aspect of our work. We try to build the capacity of our members, our partners, stakeholders and friends, and we work to build their capacity to understand that equality and equity do not mean the same thing. If we only provide our community with equal opportunities, we continue to perpetuate the status quo.

Therefore those who have the ability to take advantage of systems and structures opportunities that occur, they will continue to do so. We must and are designing opportunities that meet people where they are, and these opportunities are designed to provide people with the supports they need to be fully able to take advantage of opportunities that occur.

>> HEIDI GULLETT: Thank you, Greg. We're grateful for the opportunity to share our work today. We're about ten years into this process. And at the second poll question, Greg and I looked at each other and said, we're working on all four of those. But the vast majority marked the first one, creating a shared agenda and shared priorities. We hope that the last few minutes here together will help you in understanding what our journey has looked like in that process. And about ten years in we are still building capacity around equity. We're still reminding people of the red-lining maps that you saw earlier and how that is impacting the current outcomes that we have today, how those historical policies have led to segregation that exists currently and inequities and health outcomes that exist currently.

So we realize throughout this process we had to create a shared value and commitment to equity and part of that is creating a narrative around equity and making sure we have a shared vocabulary and when talking to each other, we are talking about the same thing. Because there are a lot of different lenses and backgrounds people come to this work with.

We also recognize that it's essential to have both the head and heart approach. We have to have data to help people understand this journey, to understand why we are where we are and understand the complex system as you heard Juliet talk about earlier, we're in a complex system and we need people to understand from a data perspective what that means.

But this work is about real people, real families, real lives. And so we also really know the impact of the heart approach. So we really tried to marry both together in the work that we do.

We continue to remind folks about the historical policies and practices that have shaped inequities, but that's not what we're going to continue to do. It's not about admiring a horrendous problem but figuring out collectively together alongside one another where voices are equally valued and supported to figure out how we tackle these upstream causes of inequities.

And part is building partnership and capacity. I'm going to share just a couple slides where we are in that process.

The other thing I'll share is that we began this work ten years ago and you heard about the beginning, and we're giving brief snippets in a short presentation we have, but part of what we determined was that with our community eliminating structural racism is a key thing we're going to work on long-term in our community health improvement planning process.

But a couple years in we realized that we actually didn't have the capacity to do that, and we needed to build an understanding within our own consortium and continue to do that as new members and new partners came along.

So we recognize this notion of perspective transformation was critical. It's thinking, acting, valuing, understanding things differently, and making sure that racial equity is an essential component of what we do both within our organizations and collectively.

So I share with you here our framework for action and I won't unpack it completely in the interest of time, but we started with key approaches two, three and four when we started this work, which were taking a collective impact approach, using community engagement as absolutely fundamental piece of what we do, and health inequity in all policies being a really important approach. But a couple years in we added perspective transformation as our first key approach. None of the rest of this work and none of the outcomes you see in the center can happen. Equity cannot be achieved if people don't have the capacity to think and understand things differently and make equity and racial inclusion shared values personally within their organizations and within their community.

So beyond key approaches our first improvement plan in 2015 identified key priority areas. I already spoke of eliminate structural racism, which has become our first key approach and also our long-term priority focus. But we also focused on healthy eating, active living, linking clinical and public health, which predominantly has been focused on bringing folks together for Community Health Assessments that have authentic voice of community in them to figure out what we should continue to be working on, and then chronic disease management, fully focused on hypertension to date, and we're happy to share more information if you're interested. Our emails are attached. But you can find more information on our website about some of the outcomes we have had with relation to each of these areas.

Our partnership has really grown. You see initially we started with 50 active individuals -- 200 active individuals, 50 active organizations. And now we're over 100 organizations. We're close to 1,000 folks. And they may engage in various ways, arm's length or very actively involved, but the reality is that we now have traction with a different group of people working together who share the notion that equity matters for our community long term.

And one of the examples of this, as you heard me talk about the priority area for public health and clinical medicine coming together, many heard Cleveland and you may have heard we're kind of rich in healthcare resources, but we don't have outcomes that necessarily reflect an abundance of health.

And so we were able to bring together in 2015 our three local health departments at the time and a bunch of other partners to create this Community Health Improvement Plan that generated the framework and the mission and vision you saw two slides ago, and the four key priority areas I just spoke about.

But in that improvement plan we decided to create an infrastructure to bring our hospital systems and our local health departments together with lots of other cross-sector partners to do another assessment ongoing, repeatedly, to figure out what matters to our community and how can we tackle those issues together rather than doing small downstream things in silos, let's come together in a collective impact way to actually make a difference and do things that matter to our community, what they feel are most important.

So in 2018 we released a Community Health Assessment with one hospital and two health departments, which is all that remains in our county, and we -- because Ohio requires us all to be aligned on timelines we back to back did another one this year and those priorities will be released actually in a couple weeks, so we would invite you to come back to our website in a couple weeks and hear about our new priorities, but what I can share with you is that in the center of the slide you see a lot of logos. And what that is is a visual representation of how important cross-sector work has become and how we are all committed to racial equity and that inequities in health will be tackled in our community and we will achieve population health improvement, individual health improvement and equity because we're working together and we're addressing these long-term historical issues that we can address. You heard Greg say that earlier. We can no longer say they're too big, we can't do this, it's not in our lane or wheelhouse. We have to work together in this way. We wanted to share a little of the narrative with you. We're happy about the partnerships we have, but we're continually growing and learning and we haven't figured out the playbook, but what we're trying to do is understand the complex systems in which we operate and figure out how we make opportunity for all maximize across our community.

So back to you La'Quana.

>> LA'QUANA WILLIAMS: Thank you so much Heidi and Greg. We really appreciate your presentation.

Greg and Heidi, this first question is for you.

You walked us through this journey, a trajectory that you and your partners in Cuyahoga County have been on and outlined key accomplishments and I'm curious, at this point in your journey, if you could reflect on any significant challenges you've encountered, both why they happened and how you are seeking to address them.

>> GREG BROWN: Well, La'Quana, I could be here until doom's day... (chuckling)

But to try to be brief, I think we have seen that there are, first of all, cultural issues, which means understanding different cultures when you try to bring people who are from different walks of life or organizational sectors together to sit them in the same room to try to get them to understand how to bring their lens of looking at the world into a bigger context so that it can be united with other folks trying to work on the same problem.

I think another thing is coming up with the common language that we all can understand and accept for a long time, structural racism and the word "racial equity" was taboo in our community. Now it is being kind of taken on. So when we started ten years ago, people were trying to dissuade us from using those words. Now people have embraced those words and starting to use those words in all those organizations that you see represented in our latest ability to try to develop community assessment.

And another thing that I would say is collecting data, not just the collection of data, but really putting an evaluation framework together that looks at not just the approach of what you're doing programmatically but looks at how you create systems change and measure that. That is a challenge. We've worked with many professionals to try to come up with that design. We're still working on it. It is a work in progress, but it is also very difficult because as many of you who have done evaluations such as myself know, we're effective in doing program evaluation. We're not as good at doing systems evaluation. And last but not least, I think this whole idea about funding has been a challenge, because most funding is siloed and it's specific to a program or a specific kind of project, we find it very difficult to get people who are in a philanthropic world or in government to think differently about how to use dollars to support not just a backbone but to how then to use the backbone as a catalyst to get others involved so that we can have resources to actually do work on the ground.

This work is complex and requires a long-term strategy and approach. How do you sustain momentum over the years with everything from maintaining stakeholder engagement to consistently focusing on racial equity? And that question is posed to anyone on the panel.

>> HEIDI GULLETT: I'll take that from our perspective here in HIP-Cuyahoga. This is a pivotal question and it's not easy, and it's very context dependent, but I do think there are lessons learned that translate across different contexts in different communities. One of our challenges has been that we have continually gained new partners, and that's a wonderful thing, a wonderful problem to have, but there's not always the same understanding and capacity around equity. So we continue to come back to the same narrative and the same understanding and ensure everybody along the way understands that, and sometimes that's frustrating for people on the journey for a while, but I think they realize the essence of collective impact, which is shared understanding and shared agenda is really important. So we try to stick really tightly to the notions of collective impact around grounding everyone in the same way, having a lot of communication and a lot of different ways. And really Greg and I do just practically, concretely, we do what we call our road show. Every year we go and meet with every single Steering Committee member for an extended period of time and we hear from them one-on-one, what is working and not working and where should we be heading. We have reorganized multiple times, but I think one of the challenges and one of the opportunities is that you need to be strategic enough to get work done to show that you're actually making progress, but you need to be nimble enough to respond to emerging opportunities that can only be seen when you work together differently, and those kind of changes and small wins are really important to point out, and they gave people renewed energy. So we really try to celebrate the small stuff. We really work hard on relationships with one another, relationships and trust are everything. And have taken us a long time to build. And we have setbacks interpersonally. We also have a set of partnership rules and we actually start every single meeting with those partnership rules, which we got from our great consultants and friends at common health action. So those are things that help us -- we know we're going to trip on each other and know we're going to

upset each other and know our organizations are competing for the same pots of money, but in the end this is the collective over the individual and the collective over the organization.

And so we're figuring it out but we have a few small wins and a few things that I think helped along the way. I'm happy to talk offline with more specifics if anybody is interested.

>> LAURA BURR: Thank you so much, La'Quana, Juliet, Greg and Heidi, for your presentation today. And many thanks to our funder The California Endowment and our great partner for today's event, Prevention Institute.