Forum Report
June 7, 2018

Transformative Change

Our Role in Achieving Health Equity for Prince George's County

PRINCE GEORGE'S
HEALTHCARE
ACTION COALITION
COMMUNITY-POWERED

HEALTH EQUITY

This is an issue that many jurisdictions have been contending with for years nationwide. It is complicated, multi-prong, polarizing, but above all, attainable.

On Thursday, June 7th, 2018, the Prince George's Healthcare Action Coalition and the Prince George's County Health Department (PGCHD) hosted a one-day meeting, Transformative Change – Our Role in Achieving Health Equity for Prince George's County, to engage County elected officials, agency leadership, health provider organizations, and academic partners in a conversation about how policies and plans affect health equity. This meeting aimed to build a common language, shared framework, and policy agenda to identify changes needed to integrate Health in All Policies (HiAP) with an intentional focus on equity and inclusion.

Capturing the essence of the conversations that transpired on that day, this report documents the first steps to building a roadmap for the County and its stakeholders. Our vision is a Prince George's County where everyone has equitable access to achieve their full health and wellness potential, regardless of race, color, religion, country of origin, immigration status, class, age, disability, sexual orientation, gender or gender identity.

Health Equity Workgroup
Prince George's Healthcare Action Coalition

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The Prince George's Healthcare Action Coalition (PGHAC) would like to acknowledge the numerous stakeholders who contributed to the success of this forum. Thank you to the Consumer Health Foundation, Greater Washington Community Foundation, Kaiser Permanente of the Mid-Atlantic States, Prince George's County Health Department, Prince George's County Department of Parks and Recreation, PGHAC and the PGHAC Health Equity Workgroup. Members of the Prince George's Healthcare Action Coalition Health Equity Workgroup and the Transformative Change Planning Committee are listed below.

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Deanna Barath, University of Maryland School of Public Health

Suyanna Barker, La Clinica del Pueblo

Cynthia Baur, University of Maryland School of Public Health

Sharon Coker, Heart to Hand, Inc.

Ana Cortes, United Healthcare

Pamela Creekmur, Prince George's County Health Department (Coalition Chair)

Shari Curtis*, Department of Social Services, Prince George's County Health Connect (Workgroup Co-Chair)

Anthony DeSantis, City of Hyattsville

Jose Luis Diaz*, CCI Health & Wellness Services (Workgroup Co-Chair)

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Sara Glickman, City of Hyattsville

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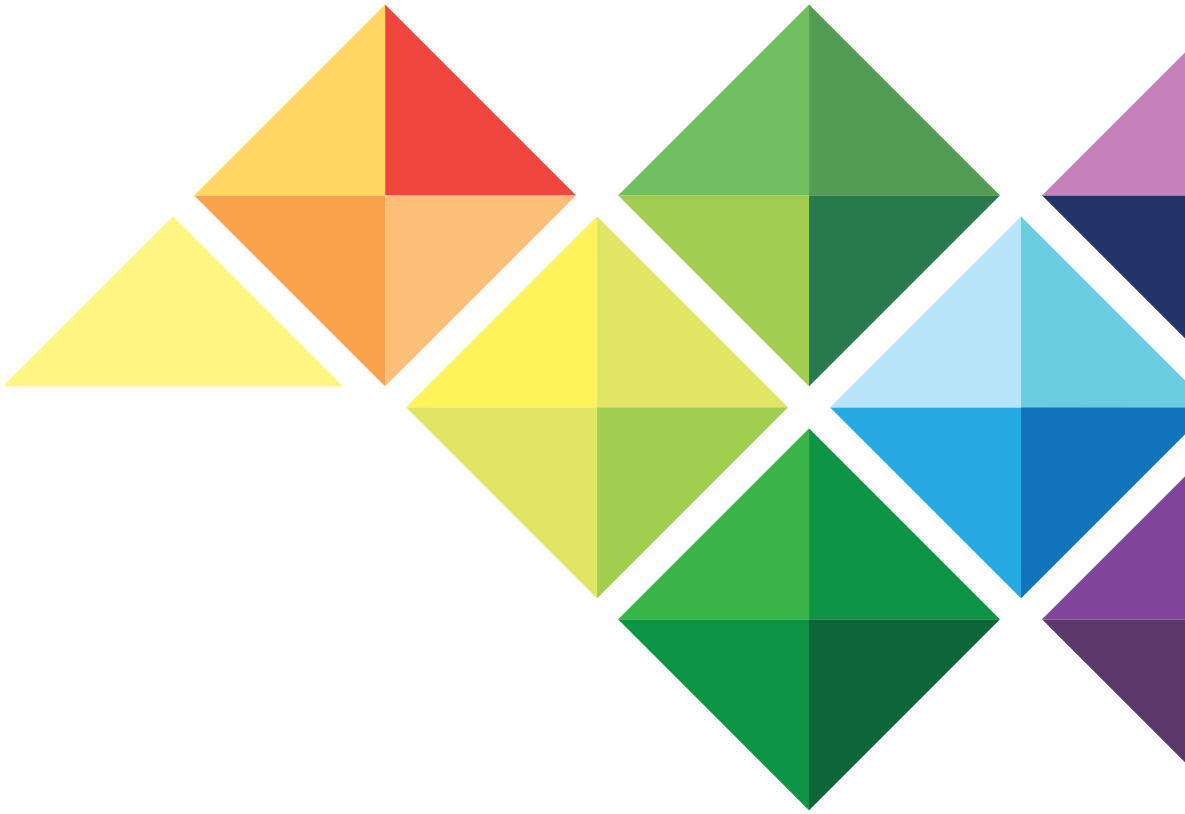
* Transformative Change Planning Committee



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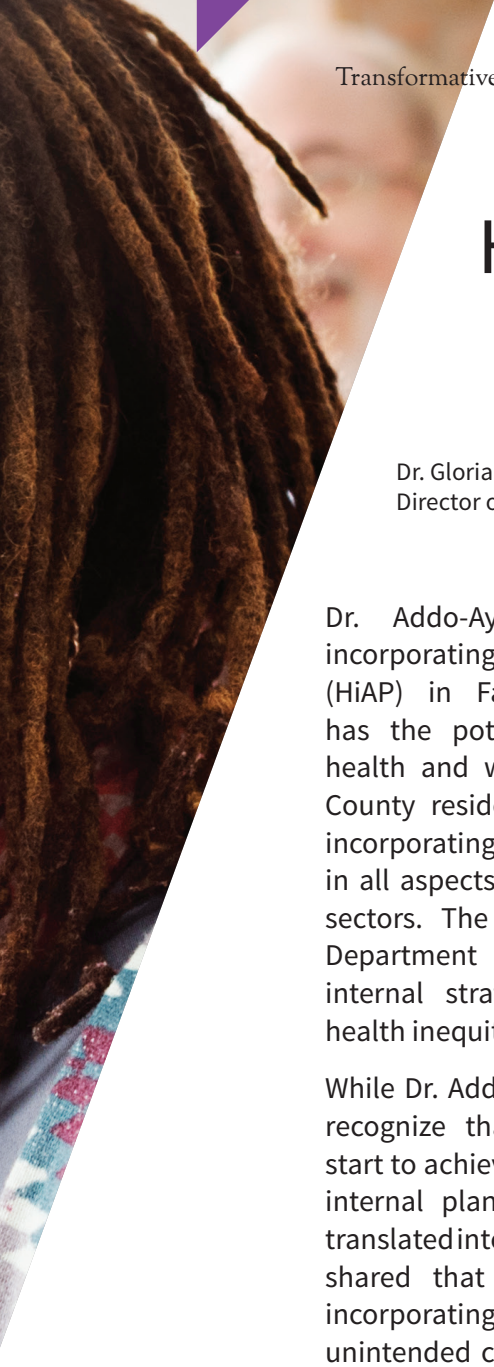


Health in All Policies in Fairfax County

Dr. Gloria Addo-Ayensu, MD, MPH,
Director of Fairfax County-Virginia Health Department

Dr. Addo-Ayensu explained that incorporating Health in All Policies (HiAP) in Fairfax County, Virginia has the potential to improve the health and well-being of all Fairfax County residents. HiAP is a way of incorporating health and health equity in all aspects of life and government sectors. The Fairfax County Health Department (FCHD) developed an internal strategic plan to address health inequities.

While Dr. Addo-Ayensu and the FCHD recognize that these efforts are a start to achieving health equity, these internal plans have not been fully translated into action. Dr. Addo-Ayensu shared that the challenge behind incorporating HiAP is identifying the unintended consequences. Moreover, "one's view of what constitutes a negative outcome is dependent upon the individual's professional training," says Dr. Addo-Ayensu.

Despite these challenges, one measurable action implemented by the FCHD was the creation of a HiAP managerial position in March 2018. The current HiAP Manager has a background in health and urban planning which is essential for translating the health department's HiAP plan. In this role, the HiAP Manager illustrates how health considerations can be incorporated into practices and policies in other government agencies. Recognizing that success in achieving health equity requires collaboration, the FCHD HiAP Manager participates in cross-sector meetings across the county. Dr. Addo-Ayensu anticipates that the HiAP Manager will be involved in housing development for older adults, among other Fairfax County initiatives.

Health Equity in the Age of Chaos, Privilege, and Bravery

Ms. Natalie Burke, CommonHealth ACTION

Ms. Burke is a nationally-known "equity evangelist," strategist, master facilitator, public health leader, and resident of Prince George's County. Prince George's County has the second largest population in Maryland with over 900,000 residents. A majority of residents are Black, non-Hispanic (62%), followed by Hispanic (19%), White, non-Hispanic (13%), Asian (4%), and two or more races (2%). In comparison, neighboring Montgomery County has over one million residents, with the majority being White, non-Hispanic (43%), Hispanic (20%), Black non-Hispanic (18%), and Asian (15%).

The difference in income between these two counties is striking: the median household income in Prince George's County in 2017 was $81,240, compared to $103,235 in Montgomery County. The 2016 County Health Rankings show similar disparities in health, with Prince George's County ranking 16th in overall health outcomes compared to Montgomery County's

2016 County Health Rankings	Prince George's County	Montgomery County
Health Outcomes	16	1
Length of Life	15	1
Quality of Life	18	3
Clinical Care	23	2
Social/Economic Factors	17	2
Physical Environment	8	5
Median Household Income (2017)	$81,240	$103,235
High School Graduation (2013)	74%	88%

Source: County Health Rankings & Roadmaps 2016, www.CountyHealthRankings.org

1st place ranking. Montgomery County also has a much higher high school graduation rate, at 88% compared to only 74% in Prince George's County. This disparity in wealth and health is not surprising since counties with higher household incomes tend to have better health outcomes.

Disparities between Prince George's County and Montgomery County also exist in life expectancy, quality of life, clinical care, social and economic factors, and physical environment. Montgomery County ranks significantly higher than Prince George's County in most health and economic indicators.

Common Language

The World Health Organization defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."

Given that health is not merely the absence of illness, Ms. Burke explained that health is multifaceted and not solely affected by individual behaviors. "One's health is a product of a variety of social determinants. Systems and social determinants that create the environment in which one makes health-related decisions impact 40 to 50% of our overall health. This is followed by 30 to 40% of our overall health being impacted by health behaviors, and 10 to 20% being impacted by genetics," said Burke.

According to Healthy People 2020, health equity is the attainment of the highest level of health for all people. "We are still struggling to achieve health equity because everyone does not feel connected with health and medicine. In fact, there is a lack of collaboration in education, housing, planning and health outcomes." Ms. Burke clarified that health inequity and health disparity are not synonymous terms. Inequities are caused by systemic and structural injustices, whereas disparities are differences in outcomes.

In an effort to ensure that attendees were equipped to have productive conversations around health equity, Ms. Burke provided the following health equity language toolkit:

Equity: Requires that all people are provided with fair opportunities to achieve their full potential.

Unconscious Bias: Stereotypes about certain groups of people that exist outside of our conscious awareness. Everyone holds unconscious beliefs about various social and identity groups.

In-Group Bias: The act of favoring members of one's own group that can lead to conflict with those who are not in the group.

Prejudice: A judgement or opinion, usually but not always negative, formed without sufficient data, before facts are known and/or in disregard of facts that contradict it.

Power: The ability to define reality for yourself and for others.

Privilege: When one group has something of value that is denied to others simply because of the groups to which they belong rather than because of anything they have done or failed to do.

Oppression: The systemic targeting or marginalization of one group by a more powerful group for a social, economic, and political benefit of the powerful group.

Culture: An integrated pattern of learned core values, beliefs, norms, behaviors, and customs that are shared and transmitted by a specific group of people. Some aspects of culture, such as food, clothing, modes of production, and behaviors, are visible. Major aspects of culture, such as values, gender role definitions, health beliefs and worldview, are not visible.

Perspective Transformation: The process of becoming critically aware of how our assumptions have come to constrain the way we perceive, understand, and feel about our world; changing these structures of habitual expectation to make possible a more inclusive and integrating perspective; and, finally, making choices or otherwise acting upon these new understandings.

Equity Lens: The lens through which you view conditions, circumstances, and processes to understand who experiences the benefits and burdens of a given program, policy, or practice.

Diversity: Differences and similarities that include individual and organizational characteristics and behaviors. It encompasses our personal and professional histories that frame how we see the world, collaborate with colleagues and stakeholders, and work with communities.

Inclusion: Active and ongoing engagement with diversity, including intentional policies and practices that promote the full participation and sense of belonging of every employee, customer, or client.

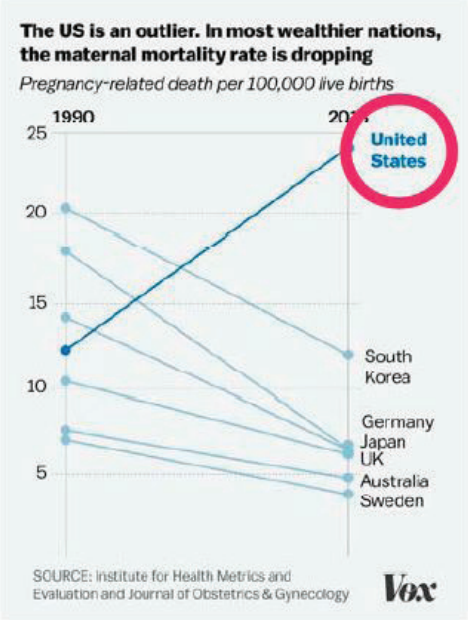
Cultural Competence: The ability to interact effectively with people of different cultures. Cultural competence means to be respectful and responsive to the health beliefs and practices, and cultural and linguistic needs of diverse population groups (Ms. Burke credited the Substance Abuse and Mental Health Services Administration for this definition).

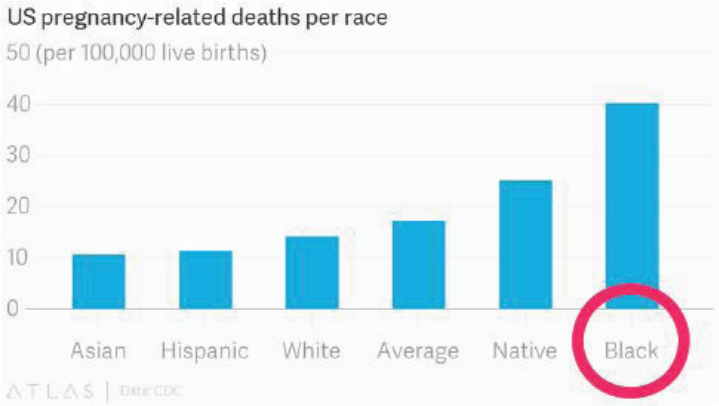
Gender Identity: The psychological sense of self.

Gender Expression: The way one presents their gender, through actions, clothing, and demeanor.

Biological Sex: Comprised of things like genitals, chromosomes, hormones, body hair, and more.

"Privilege is killing the privileged and oppression is killing the oppressed."





Regarding racial privilege, Ms. Burke explained that white middle class Americans are dying at faster rates than minorities. Most recently, White Americans are most affected by the opioid epidemic. In this instance, racism has been a "protective factor" for people of color in America. On the other hand, the oppressed experience chronic stress caused by trauma and a consistent feeling of hopelessness.

Ms. Burke presented evidence of racial disparities in maternal mortality. Black women have the highest rate of pregnancy-related deaths compared to other racial and ethnic groups, regardless of their socioeconomic position or educational attainment. In fact, research shows that Black women with advanced degrees are less likely to carry pregnancies to term than White women without high school diplomas. According to Ms. Burke, this phenomenon can be attributed to the "weathering effect" that racism has on Black women (Villarosa, 2018).

As leaders in Prince George's County, we need to "Get Uncomfortable" and consider our role in the continuing inequities in our community. Ms. Burke urged attendees to take the first step by applying an equity lens at their organizations, to consider who benefits and who is burdened by policies, plans, and programs.

Health in All Policies Panel

David Harrington, President and CEO, Prince George's Chamber of Commerce

Celeste A. James, Executive Director, Community Health and Benefit, Kaiser Permanente of the Mid-Atlantic States

Abel Nuñez, Executive Director, Central American Resource Center (CARECEN)

Stephanie Slowly, MSW, Deputy Director, Maryland Office of Minority Health and Health Disparities

Sacoby Wilson, PhD, Associate Professor, Director of the Community Engagement, Environmental Justice, and Health, University of Maryland College Park

Question 1 - Define health. Why is it important to you as an individual? Explain why your organization has a vested interest in the health of Prince George's County residents.

Mr. David Harrington defined health as full access to reach optimization, the ability to have access to healthy environments, and reach opportunities without hindrances. He said that the Prince George's Chamber of Commerce wants all residents to be able to have access and achieve their aspirations.

Working in communities for more than 10 years, Ms. Celeste A. James said she believes that health is driven by the ecosystem of opportunity, education, access to transportation, food, family, and community. She stated that health includes the opportunity to live a high-quality life that is passed on from generation to generation.

Similarly, Mr. Abel Nuñez stated that the health of he and his family are indicative of the health of everyone. "Essentially, we are all better if everyone is healthy," said Nuñez.

Ms. Stephanie Slowly affirmed that health is where you live and that mental health as well as access to quality foods and resources are very important. Ms. Slowly said that one cannot be healthy if one's health does not holistically involve the mind, body, and spirit.

Dr. Sacoby Wilson defined health as well-being, quality of life, and how health is incorporated in all aspects of the environment.

Question 2 - Thinking of the social determinants of health, based on what you know about Prince George's County, which determinant should be the highest priority?

Dr. Wilson said that zoning should be the highest priority because it impacts housing, access to quality foods, resources and education. In agreement, Mr. Harrington shared that zoning laws are currently being rewritten. He added that education and how we treat youth also need to be considered. "The conversation around education needs to be powerful and show students that they can do whatever they want, pursue an education at any institution, and guarantee that they are able to access power," said Harrington.

Mr. Nuñez shared that it is important to understand intersectionality, which is the interaction of social determinants of health. "There is a need to understand the specific intersections that are causing health inequities that keep us down," said Nuñez.

Ms. Slowly said she does not believe it is a specific social determinant of health but rather a collection of circumstances that interact. According to Ms. Slowly, as it stands, resources are in silos, which causes chaos for individuals who need to utilize multiple agencies. "This puts a lot of responsibility on the individual to navigate social services for assistance. There is a need for those who are governing these agencies to remove these barriers," said Slowly.

Question 3: What is in the way of reaching health equity in Prince George's County?

Ms. Slowly said a key barrier is "the lack of acknowledgment of Prince George's County's reality." Ms. Slowly shared that at the national level, Prince George's County does not appear to be in trouble because of the wealth of a portion of its population. "Even from working at the state level, it is difficult to pinpoint what is needed at the county level," said Slowly. Ms. James highlighted that there is damage and inhibition caused by the lack of acknowledgement. Ms. James suggested that at the core of this issue is a need for community organizing and community engagement.

Question 4: At what point are people in Prince George's County in enough pain to compel its residents to organize?

Mr. Harrington started the conversation by explaining that Prince George's County is not the richest county in the state, and that there is a wealth disparity in the county. "Elected officials are not telling the truth and until they do and begin understanding the urgency of the situation, we will not get the empowerment of the residents," said Harrington.

Additionally, according to Mr. Harrington, there is no public education on what the county needs in order to elect a proper leader. He reiterated that there is a need for more truth-telling and enlightenment. He stated that "we have the power to choose destiny without it being obstructed by the system." Mr. Harrington argued that it is time to make room for the next generation of leaders and it is our responsibility to mentor and train them to make their lives as elected officials more impactful than the recent generation of leaders.

Dr. Wilson said there is a structural problem. For example, there is no joint planning amongst Prince George's County and Montgomery County. Dr. Wilson explained that the lack of joint planning prevents Prince George's County residents from being civically engaged. He continued, saying "we need to work on community engagement and developing an interagency workgroup to alleviate agencies from working independently from one another." Mr. Nuñez added that newcomers from other countries are excluded and are often lost in the Black and White dynamic. "There is no space for immigrants to understand the struggle before they migrated to the United States. As it stands now, Blacks and Latinos appear to be fighting to have their needs met divergently," said Nuñez.

Question 5: What role do you see race and racism playing in health outcomes for people in Prince George's County? What can be done to alleviate this?

In regards to environmental slavery and environmental racism, Dr. Wilson shared that we need to change the culture around having people of color in office, otherwise, the problems around race and racism will not be known. Ms. Slowly added that racism is a social construct that operates beneath classism. She said it is important for community leaders to be representative of the community and for their views on economics to align with the views of their constituents. Ms. Slowly stressed the need for humility and honesty. She said that the community could benefit from allowing a community member to have a seat at the decision-making table.

Ms. James said that some who have a seat at the table have spent years to obtain their position, which could make it challenging to give up and allow room for others. She explained that we need to have "keep it real" conversations and the ability to be introspective in order to move the needle and shift towards racial equity.

Mr. Harrington agreed that racism exists in Prince George's County, and reminded the audience that minorities in power are not exempt from the effects of racism. To alleviate the impact of race and racism on health outcomes, Mr. Harrington said we need be mindful of institutions that were built on racism. He believes we also need to create structures for individuals to be brave in a safe place, such as think tanks and nonprofits that are able to translate their work into policy change.

Question 6: What are needed shared values that are necessary for Prince George's County to get to the point where we have health equity? Think about values and give a call to action for the attendees.

The panelists urged the audience to be as concerned about someone else as they are about themselves because it will better the community and the community's health, saying "remember you are your brother's keeper and be intentional with your actions."

The panelists encouraged the audience to use their voices to keep their "territory," stressing the importance of continuing to preserve current assets, resources and influence for the next generation.

Ms. James suggested that the audience continually think about what health means and to be reminded that it is not a medical model. She urged the audience to think about health holistically including transportation, jobs, schools, small businesses, and nonprofits.

Mr. Harrington said he values power, truth and love, and urged attendees to shape their institutions around these values in order to attain shared aspirations.

HiAP Initiatives Panel

Annetta Arno, PhD, MPH, Director, Office of Health Equity, District of Columbia Department of Health
Jennifer Martin, JD, MA, Deputy Commissioner Population Health and Disease Prevention, Baltimore City Health Department

Dr. Annetta Arno provided a brief organizational overview. The District of Columbia Department of Health (DC Health) established an Office of Health Equity in 2015, which aims to work collaboratively with community partners and government agencies to identify and address social determinants of health.

Dr. Arno and the Office of Health Equity aim to address health disparities by supporting research, policies, and projects that allow all residents to achieve their optimal level of health. Their strategies include: (1) building multi-sector partnerships; (2) promoting health in all policies; (3) leveraging community-based participatory processes; and (4) demonstrating health equity practice change.

Current Office of Health Equity initiatives include:

Safer, Stronger Advisory Committee 2016,

Buzzard Point CHASS 2016,

Healing Futures Fellowship (HFF-DC) 2016 – 2018,

DC Comprehensive Plan Amendment 2017,

Commission on Health Equity, and

Health Equity Report 2018.

Dr. Arno shared her prior experience at the Louisville Metro Department of Public Health and Wellness. She produced a baseline health equity report and delivered it to all elected officials, local government leaders, and nonprofits to get everyone on the same page. Prior to this, entities were competing for grants and presenting conflicting data. Working together allowed for transparency and collaboration which is essential for health in all policies.

Ms. Jennifer Martin presented population health and health in all policies efforts in Baltimore City targeting youth, patients with behavioral health conditions, the homeless and those with unstable housing, HIV positive residents, and men who have sex with men. Current Baltimore City Health Department initiatives include:

Accountable Health Communities,

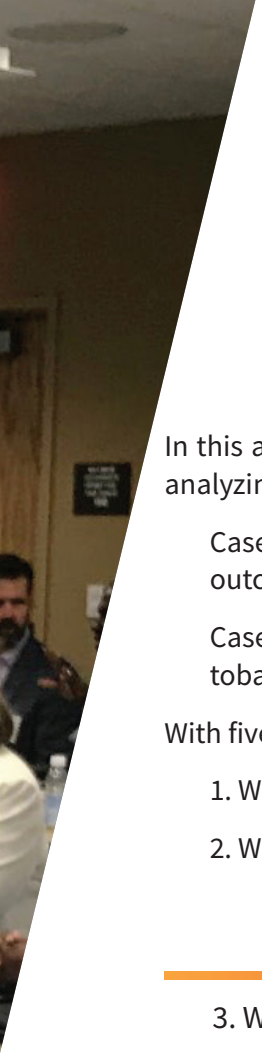
High Utilizer Task Force,

Business Advisory Group,

Transforming Engineering for Civic Health (TECHealth), and

A city-wide wellness challenge.

When asked how best to engage with elected officials, Ms. Martin shared that they have invited respective Councilmembers to engage in conversations with the Baltimore City Health Department. In addition, they have ongoing meetings with individuals in the city council regarding the health department's initiatives and they are fortunate to have Council members who understand how health impacts all aspects of city life.



Equity Lens
Health Policy Activity

In this activity, attendees were separated into groups of three to four individuals and were tasked with analyzing one of two case studies (see Appendix D):

Case Study #1 focused on prescription drug abuse among pregnant women and negative birth outcomes in Tennessee.

Case Study #2 focused on hospitals imposing smoking bans and no longer employing people who use tobacco products.

With five minutes to read the case studies, participants were asked the following questions:

1. Which stakeholder did you identify for your equitable solution?

2. What benefits and burdens did they experience due to the policy?

3. What is your solution?

Case Study #1: The groups identified doctors, pregnant women, friends of pregnant women, prescription drug users, and pharmaceutical companies as stakeholders for an equitable solution. The groups also identified criminal punishment as a burden of this policy and incentives (such as diapers) as a benefit of this policy.

Proposed solutions included providing guidelines for doctors around prescribing drugs and encouraging other methods of relieving pain, encouraging social support from family as women go through treatment, and funding a sustainable network.

Case Study #2: The groups identified the smoker/employee, children of employees, and the employer as stakeholders for an equitable solution. They identified maintaining employment, finding a new job, and children having the resources to earn high school diplomas as major burdens faced by the employees due to the smoking ban policy. The groups suggested having a probationary period for employees and having the employer invest in helping them quit using tobacco products. The case study identified high-risk groups who would be most impacted by this policy: lower-income, less educated, disabled, unemployed, American Indians/Alaska Natives, lesbian, gay, and bisexual groups. The groups suggested that policy-makers study the data to identify groups who are at high risk of smoking and using tobacco-products and implement targeted prevention strategies.

Recommendations

Improve Interagency Collaboration

a. Positive results were shared from leadership representing Fairfax County Health Department, Baltimore City Health Department, and the District of Columbia Department of Health. Prince George's County Health Department should consider prioritizing collaboration with the Department of Social Services as a large portion of discussion centered on how difficult it is for constituents to navigate health and social services in order to get what they need to improve their overall quality of life.

b. Streamline the social services application or form a one-stop shop for all needs between the Health Department and the Department of Social Services.

Create Health in All Policies Positions

a. Mirror Fairfax County Health Department's Health in All Policies Manager and Coordinators by seeking individuals with backgrounds and experience in health and urban planning. Such individuals can translate HiAP into planning, practice and policy and participate in cross-sector meetings throughout Prince George's County.

Encourage Truth-Telling

a. Appropriately disseminate data and research findings to elected officials and constituents.

b. Engage policy-makers in meetings around current and upcoming health equity initiatives.

c. Include community members impacted by inequity in policy discussions and decision-making.

Strengthen Prince George's County's Non-Profit Sector

a. Bolster non-profit organizations based in the county. They have been seen to do impactful work that can be translated into practice and policy intervention.

b. Financially support non-profits, strengthen organizations and provide training for staff and volunteers to improve effectiveness.

c. Encourage volunteerism to empower constituents who want to be involved in change.

Invest in the Future

a. Educate youth and promote civic engagement.

b. Recruit and mentor future leaders so that they are prepared to serve.

c. Develop a long-term change strategy that engages multiple agencies, organizations and community stakeholders.

Appendix A
Agenda

8:15 am - 9:00	Sign in and continental breakfast
9:00 - 9:20	Welcome Pamela B. Creekmur, Prince George's County Health Department
9:20-9:30	Health in All Policies (HiAP) Overview Dr. Gloria Addo-Ayensu, Fairfax County Health Department
9:30 -10:10	Health Equity Overview Natalie S. Burke, CommonHealth Action
10:10 -10:25	Break
10:25 - 12:15 pm	Panel Discussion David Harrington, Prince George's County Chamber of Commerce Celeste A. James, Kaiser Permanente Mid-Atlantic States Abel Nuñez, CARECEN Stephanie Slowly, MD Office of Minority Health & Health Disparities Dr. Sacoby Wilson, School of Public Health, University of Maryland
12:15 - 12:30	Pick Up Lunch - Return to tables
12:30 - 1:15	Health in All Policies (HiAP) Panel Dr. Anneta Arno, Office of Health Equity, DC Health Jennifer Martin, Population Health & Disease Prevention, Baltimore City
1:15 - 1:30	Policy Activity Instructions
1:30 - 2:15	Policy Activity (Break into Groups)
2:15 - 2:30	Break
2:30 - 2:45	Groups Report Out
2:45 - 3:30	Organizational Assessment Tool Overview Next Steps Adjourn

Appendix B
Presenters & Panelists

Pamela B. Creekmur

Pamela B. Creekmur's professional health care management career spans over 25 years in healthcare administration, clinical operations and public health. As the Health Officer for Prince George's County, she is responsible for a local Health Department that serves over 900,000 residents with 600 employees.

Prior to this role she was the Medical Center Administrator for the Kaiser Permanente Largo Medical Center, she was accountable for the overall management of a large multi-specialty medical center with over 350 employees and physicians. During her tenure with Kaiser Permanente, she gained experience with process improvement, policy setting, fiscal management, program development, and leadership development. Creekmur is known as a dynamic group motivator and performance coach with proven accomplishments in the areas of organizational management, leadership assessment, recruitment and retention, and performance improvement.

Natalie S. Burke

A nationally-known speaker, "equity evangelist," strategist, master facilitator, and public health leader, Natalie S. Burke is President and CEO of CommonHealth ACTION whose mission is to develop people and organizations to produce health through equitable policies, programs, and practices. Since the mid-90s, Natalie has focused on creating opportunities for health through community, institutional, systemic, and policy change. Since 2016, Natalie has served as co-Director for the Culture of Health Leaders National Program Center, funded by the Robert Wood Johnson Foundation; she directs the Kaiser Permanente Institute for Equitable Leadership in Baltimore; and she is a member of the Institute for Healthcare Improvement's Equity Advisory Group. Throughout her career, Natalie has sought to understand the interaction among genetics, personal health behaviors, and the systems and institutions that provide the contexts within which we live our lives and make our decisions. That understanding guides her work to create positive change that produces the best possible health for all people.

Panelists

Gloria Addo-Ayensu, MD, MPH
Director of Health
Fairfax County

Jennifer Martin, JD, MA
Deputy Commissioner
Population Health and
Disease Prevention
Baltimore City

Anneta Arno, PhD, MPH
Director, Office of Health Equity
DC Health

Abel Nuñez
Exectuive Director
CARECEN

David Harrington
President and CEO
Prince George's
Chamber of Commerce

Stephanie Slowly, MSW
Deputy Director
Maryland Office of
Minority Health and
Health Disparities

Celeste A. James
Executive Director
Community Health & Benefit
Kaiser Permanente
of the Mid-Atlantic States

Sacoby Wilson, PhD, MS
Director, Community
Engagement, Environmental
Justice, and Health,
School of Public Health,
University of Maryland

Appendix C
Attendees

Makeitha Abdulbarr, LCPC
Metropolitan Behavioral Health Services

Gloria Addo-Ayensu, MD, MPH,
Fairfax County Health Department

Dr. C. Annetta Arno, District of Columbia Government

Barbara Banks-Wiggins, Healthcare Alliance

Suyanna Barker, La Clinica del Pueblo

Benjamin Barksdale,
Prince George's County Fire Department

Karen Bates, RN, MS, Office of School Health,
Prince George's County Public Schools

Cynthia Baur, PhD
University of Maryland School of Public Health

Gloria Brown Burnett,
Prince George's County Department of Social Services

Afryea Brown,
University of Maryland, Capital Region Health

Sonya Bruton, CCI Health & Wellness Services

Natalie Burke, CommonHealth Action

Elsa Canales, CCI Health & Wellness Services

Ernest Carter, MD, PhD
Prince George's County Health Department

Pamela Creekmur
Prince George's County Health Department

Karina Cruz
Town of Bladensburg Police Department

Curtis Cutler, Prince George's County Department of Family Services,
Office of Veteran's Affairs

Shari Curtis
Prince George's County Health Action Coalition

Anthony DeSantis
City of Hyattsville, Communications and Outreach

Jose Luis Diaz
Prince George's County Health Action Coalition

Michele Dickson, Prince George's Community College

Lane Dillion
Prince George's County Health Department

Kodjo Dodo, Prince George's County Health Department, WIC Program

Brittney Drakeford
M-NCPPC Cottage City Community Garden

Kristen Duncan, Regional Primary Care Coalition

Robert Elliot
University of Maryland Prince George's Hospital Center

Kristin Forrest
University of Maryland Capital Region Health

Benjamin Fulgencio-Turner, Primary Care Coalition

Dannielle M. Glaros, Prince George's County Council

Maria Gomez, Mary's Center

Paul Grenaldo, Doctors Community Hospital

Trudy Hall, MD, Lauren Regional Hospital Center

David Harrington,
Prince George's Chamber of Commerce

Collette Harris, Prince George's County
National Alliance on Mental Illness

Ta'Nae Harrod, Prince George's Health Department

Dawn Hawkins-Nixon, Prince George's County Department of Public Works and Transportation

Melvin High, Prince George's County Sheriff's Office

Evelyn Hoban,
Prince George's County Health Department

Lee Hopkins, CASA

Truly Hull
University of Maryland Capital Region Health

Shawnta Jackson, Cause Engagement Associates

Celeste James, Kaiser Permanente Mid-Atlantic States

Jere Jefferson, CCI Health & Wellness Services

Diane Jones
Family and Medical Counseling Services, Inc.

Emmett Jordan, Mayor, City of Greenbelt

Olivia Kachingwe
University of Maryland School of Public Health

Antony King
Prince George's Health Department

Andrea Lasker
Prince George's County Department of Works and Transportation

Sylvette LaTouche-Howard, PhD
Prince George's County Health Department

Leroy D. Maddox Jr.
County Council of Prince George's County, Maryland

Stacey Little, PhD, MPH, MSW
University of Maryland Capital Region Health

Colenthia Malloy, Greater Baden Medical Center

Robert Malone, The ARC

Jennifer Martin, Population Health & Disease Prevention, Baltimore City

George Lettis, Prince George's Health Department

Mary Lou McDonough
Prince George's County Department of Corrections

Tanya Morgan, Greater Baden Medical Services

Caitlin Murphy, Prince George's Health Department

LaShontae Norman, Maryland Health Connection

Adelline Ntatin, Aetna Better Health

Abel Nunez, CARECEN/Cottage City

Kristanna Peris
University of Maryland School of Public Health

Donna Perkins
Prince George's County Health Department

Sherry Perkins
University of Maryland Capital Region Health

Vanessa Purnell, MedStar

Wesley Queen, Director,
Legacy Leadership Institute on Public Policy

Michael Rhein
Institute of Public Health Innovation

Taylor B. Rogers
University of Maryland School of Public Health

Duane Rosenberg, City of New Carrolton

Darlene Saunders
Prince George's County Health Department

Phyllis Slade Martin, Slade & Associates, LLC

Jimmie Slade
Community Ministry of Prince George's County

Stephanie Slowly
Maryland Office of Health & Health Disparities

Samantha Smith
Prince George's County Health Department

Deirdre Spears-Johnson, Heart to Hand

Christine Stewart
Institute for Public Health Innovation

Tiffany Sullivan
University of Maryland Capital Region Health

Adrian Talley
Prince George's County Public Schools

Tonia Wellons, The Greater Washington Community Foundation, Prince George's County

Rhonda White-Yakob
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Alicia Wilson, La Clinica del Pueblo

Sabra Wilson
University of Maryland Capital Region Health

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Angela Wood
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Sharon Zalewski, Regional Primary Care Coalition

Appendix D
Case Study 1

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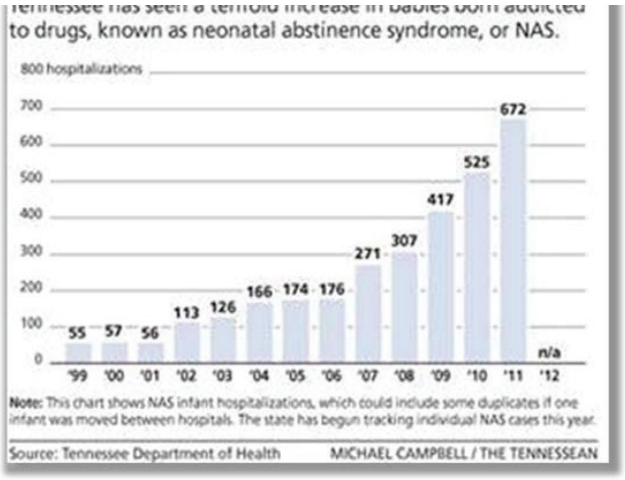
Step 1

As an individual, take the next 5 minutes to read the case study.

Prescription drug abuse is a national public health problem, particularly among women. Women are more likely than men to receive prescriptions for chronic pain, anxiety, and depression. Differences in metabolism mean that women are more likely than men to become addicted or dependent on these substances. The National Council on Alcohol and Drug Dependence explains that prescription drug abuse has fueled rising rates of heroin use, particularly among white, suburban young people who are looking for a less expensive alternative. Many states are grappling with how to reduce prescription drug abuse, particularly among women who are pregnant and may have poor birth outcomes as a result.

Tennessee has prioritized reducing the number of babies born addicted to narcotics, often painkillers or antianxiety medications as well as illicit drugs such as heroin or cocaine. According to the Tennessee Department of Health, the number of babies born with neonatal abstinence syndrome (NAS) increased nearly tenfold over the past decade (see graph). Mothers who use legally prescribed drugs are also at risk of giving birth to babies with NAS, though not all fetuses exposed to substances in the womb develop addiction. Newborns with NAS experience a range of withdrawal symptoms that last from one week to six months, depending on overall health and type of drug exposure. Most of these babies require two to four weeks of hospital treatment, and their average hospital costs are estimated at $40,000—compared to $4,300 for a typical birth. Many of these children are covered by TennCare, the state's managed Medicaid program; the Department of Health reports that in 2010 alone, NAS hospitalizations accounted for $22 million in TennCare costs. Babies born with NAS are 18 times



more likely than babies without NAS to be removed into state custody. The Department of Children's Services estimates that as many as one in five of these newborns are removed from the home.

In 2013, the Tennessee Health Commissioner added NAS to the list of Reportable Diseases and Events in order to track the number of babies born to mothers residing in the state. The state legislature also revived its debate regarding the best way to tackle this public health and social problem. In 2013, the Safe Harbor Act provided incentives for pregnant women who are illegally using prescription drugs to enter treatment programs, including assurance that mothers will not lose parental rights or custody to the state as long as they continue treatment. In 2014, Public Chapter 820 was signed into law mandating that women be prosecuted for misdemeanor assault for "illegal use of a narcotic drug…while pregnant, if her child is born addicted to or harmed by" the drug as a result of use during pregnancy. The law does not override or nullify the Safe Harbor Act. Public Chapter 820 allows women who enroll and successfully complete a treatment program before birth to plead an "affirmative defense" and thus avoid prosecution. Tennessee intends to continue data collection on NAS while Public Chapter 820 is in force; the law automatically expires in 2016.

Step 2

As an individual, consider: Who is experiencing the benefits in this scenario—and what are they? Who is experiencing the burdens in this scenario—and

what are they?

Benefit: A good or helpful result or effect.

Burden: A heavy load; an obstacle.

Use the matrix provided to record responses (5 minutes).

BENEFITS		BURDENS	
Who benefits? (stakeholder)	What are the benefits?	Who's burdened? (stakeholder)	What are the burdens?

Think about the different people, organizations, and institutions involved—including those not directly named.

Benefits and burdens can reinforce privilege or oppression by providing or denying access to resources, opportunities, time, or information. Some people or groups may experience both.

The implications of benefits and burdens may be social, economic, political, physical, or psychological.

Step 3

As a group, discuss what you entered into the benefits/burdens worksheet on page two.

INTRODUCTIONS: Name, Department, Gender Pronoun (2 minutes)

DISCUSSION: (13 minutes)

Step 4

Discussion & Solution

A. Discuss stakeholders for whom you could develop a more equitable strategy or solution. Ideally, the stakeholders you identify in this step will have a direct relationship to the scenario. (15 minutes)

REMEMBER...

Equity requires that each person has a fair opportunity to achieve their full potential or to reach their best possible outcome.

Fair is whatever is necessary to get a person, population, or community to the best possible outcome.

B. What solution would you offer to make the situation more equitable for this stakeholder and possibly others in the scenario. (i.e., a situation in which benefits and burdens are experienced more fairly)?

C. Select a spokesperson for your table. Be prepared to share your solution in 2-3 key points. (5 minutes)

Case Study 2

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Step 1

As an individual, take the next 5 minutes to read the case study.

Thanks to decades of policy change, public education campaigns, and programmatic investments, cigarette smoking in the U.S. has reached an all-time low. About one in six adults (17%) smokes cigarettes today, compared to nearly one in two (45%) in 1965. Policies that make smoking less accessible and attractive, such as smoke-free workplaces, have played an important role in this reduction. Public and private employers first began adopting policies to ban indoor smoking to protect workers and customers from toxic environmental tobacco smoke beginning in the 1970s. Today, 28 states have comprehensive smoke-free workplace laws. Citing health and environmental concerns, many jurisdictions have also limited smoking near building entrances and outdoor spaces such as public parks. Yet tobacco use continues to exact enormous social and economic costs. Each year, approximately 480,000 people in the U.S. die due to smoking-related illnesses, and for every smoker who dies, 30 more live with chronic diseases linked to tobacco use such as emphysema and chronic bronchitis. Smoking is disproportionately high among American Indians/Alaska Natives; people who are lesbian, gay, or bisexual; people with lower income and education levels; people with disabilities; and people who are unemployed.

The Role of Healthcare Organizations

To protect the public's health, healthcare organizations and hospital systems have long embraced smoking bans on their campuses. Smoke-free policies are aligned with healthcare organizations' missions to improve health by creating environments where everyone on site—employees, contractors, patients, families, and visitors—is protected from tobacco smoke exposure. Secondhand smoke is especially a concern in a place of healing; chemicals in smoke that linger on staff or visitor clothing could exacerbate patients' conditions. Discouraging smoking also makes business sense; economists estimate that each employee who smokes costs his or her employer $2,885 to $10,125 annually in sick days and lost productivity. Nationally, moking costs the U.S. nearly $300 billion each year. This amount includes $170 billion in healthcare costs and more than $156 billion in lost productivity—$5.6 billion of which is due to secondhand smoke exposure.

Some hospitals are taking smoking bans a step further by imposing smoker bans. In 2007, Cleveland Clinic announced that it would no longer employ people who use tobacco, citing its mission to heal the sick and cultivate community health. Other hospitals—though not all—have followed suit. While some accept self-attestation from job candidates and current staff, many hospitals screen for tobacco using a urine test, essentially treating it like any other illicit substance in a drug screen. Under this no-hire policy for smokers, job candidates must pass the screen as a condition of employment. If the candidate tests positive for nicotine, then the offer is rescinded. in the case of the Cleveland Clinic, the smoker candidate is also offered a free tobacco cessation program and invited to reapply in three months. If existing employees test positive, then they may be required to enroll in a cessation program and see their share of health insurance premiums increase. At least one healthcare system in Kansas City has investigated and terminated employees who have been found to violate the policy.

Some smokers have said that the policy provided the motivation to help them quit. Yet critics argue that focusing on banning the smoker unfairly limits

personal choice outside of work hours and limits the candidate pool. Policies that encourage smoking cessation may also have unintended health consequences; evidence shows that body mass index increases shortly after quitting, with more pronounced increases among older women. There may also be systemic barriers that affect smoking rates among job applicants. One national study indicates that physicians were less likely to counsel Black and Latino patients than White patients to quit smoking. They were also less likely to advise patients with private health insurance to quit than they were to counsel patients with Medicaid or Medicare coverage. Finally, based on the demographics of smokers, the smoker ban is more likely to affect front-line positions than leadership. One New York Times article noted that after imposing a no-hire policy at El Paso, Texas' University Medical Center, most of the people rejected in the first three months were applying for support positions.

Regional Impacts

St. Luke's University Health Network is a nonprofit, regional health network providing care, primarily in Lehigh, Northampton, Carbon, Schuylkill, Bucks, Montgomery, Berks and Monroe counties in Pennsylvania and in Warren County, New Jersey. With more than 9,000 staff, it is the region's second-largest employer. In 2010, St. Luke's adopted the no-hire policy for its Pennsylvania locations. Staff who were currently employed were exempt from the ban but encouraged to quit smoking. St. Luke's was not allowed to impose the no-hire policy in its New Jersey sites due to a state law prohibiting employment discrimination for smokers. By 2013, sick time at the Pennsylvania sites dropped 12% to an average of 31 hours a year, while sick time at the New Jersey hospital has slightly increased to about 37 hours. In 2015, St. Luke's stated that it has had no hiring challenges due to the ban and that few applicants fail the nicotine screen. Yet few employers in the region have adopted a smoker ban, even competing hospital systems. Easton Hospital—the first in the community to adopt a smoke-free campus in 2005—has publicly stated that it discourages smoking on campus but does not want to limit the talent pool of candidates and employees.

Step 2

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Use the matrix provided to record responses (5 minutes).

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As a group, discuss what you entered into the benefits/burdens worksheet on page two.

INTRODUCTIONS: Name, Department, Gender Pronoun (2 minutes)

DISCUSSION: (13 minutes)

Step 4

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A. Discuss stakeholders for whom you could develop a more equitable strategy or solution. Ideally, the stakeholders you identify in this step will have a direct relationship to the scenario. (15 minutes)

   REMEMBER...

   Equity requires that each person has a fair opportunity to achieve their full potential or to reach their best possible outcome.

   Fair is whatever is necessary to get a person, population, or community to the best possible outcome.

B. What solution would you offer to make the situation more equitable for this stakeholder and possibly others in the scenario. (i.e., a situation in which benefits and burdens are experienced more fairly)?

C. Select a spokesperson for your table. Be prepared to share your solution in 2-3 key points. (5 minutes)

Appendix E
Forum Evaluation

At the conclusion of the one-day meeting, Transformative Change – Our Role in Achieving Health Equity for Prince George's County, attendees were asked to complete an online evaluation (see Appendix C). Of the 85 forum participants, 42 completed evaluations. The results are as follows:

- A majority of respondents felt that the forum improved their knowledge of health equity and ways to achieve health equity in the county a great deal (79%), followed by somewhat (17%) and little (5%).
- When respondents were asked of their opinion on the most important conditions impacting health equity in Prince George's County, a majority of respondents chose social factors, followed by economic, other, environmental, structural and legal factors.
- Thirty-three respondents (92%) said they would implement new activities or new approaches to advance health equity/Health in all Policies within their department or agency as a result of attending the forum.
- A majority of respondents (68%) would need a framework and tools in order to move forward with strategies to advance health equity and incorporate health in all policies of their agency or department.
- Over half (59%) of respondents expressed a need for training in order to implement health in all policies, 47% would need a policy mandate, and 41% would need technical assistance.
- More specifically, one attendee plans to, "re-examine policies and practices [and] share concepts and ideas with staff." Another plans to, "work with different county agencies at my level to effect change. Have more community input before regulatory change. Define who will benefit or be burdened by this new policy/law before committing or pursuing."
- In the future, 94% of respondents would participate in follow-up meetings and 97% of respondents would encourage colleagues from their agency or other agencies to participate in future meetings, training, or activities related to health equity and health in all policies.
- One respondent said, "this would be a great webinar so all could see. This is a great program to take to the schools and educate the next generation."
- Another respondent said, "this was an outstanding forum. I would love for it to be put on County Councils' agenda and the Planning Board agenda, so they can hear it first-hand."

In general, the PGHAC received very positive feedback from the forum. In an effort to keep attendees engaged in future efforts from the PGHAC Health Equity workgroup, the Health Equity Organizational Assessment Tool will be distributed to attendees .

Appendix F
Resources

FRAMING ARTICLES

These provide context for equity, diversity, inclusion; privilege and oppression; and the language of oppression.

How to Fix a Broken Tongue

https://medium.com/@natalie4health/how-to-fix-a-broken-tongue-cade93816add

The End of Non-Whites

https://medium.com/@natalie4health/the-end-of-non-whites-bcb702b0045e

8 Things You Should Do About Equity, Diversity, and Inclusion

https://medium.com/@natalie4health/8-things-you-should-do-about-equity-diversity-and-inclusion-ca39f684fe54

Why I Won't Give You Ten Tips to Manage Your Privilege

https://medium.com/@natalie4health/why-i-wont-give-you-ten-tips-to-manage-your-privilege-9ba16cf31671.

6 Steps to De-Weaponize Privilege

https://medium.com/@natalie4health/6-steps-to-de-weaponize-privilege-bab24972699d

GENDERBREAD PERSON

Genderbread Person

http://itspronouncedmetrosexual.com/2015/03/the-genderbread-person-v3/

IMPLICIT BIAS

Implicit Association Test

https://implicit.harvard.edu/implicit/takeatest.html

VIDEO RESOURCES

Unnatural Causes - Clips from When the Bough Breaks.

https://unnaturalcauses.org/video_clips.php?vid_filter=Episode%202%20-%20When%20the%20Bough%20Breaks

Verna Myers: On Bias

https://www.ted.com/talks/verna_myers_how_to_overcome_our_biases_walk_boldly_toward_them

Health Disparities vs Health Inequities

https://youtu.be/sigsrL8iivw

If Equity is Fairness, What's Fair?

https://youtu.be/lfFCYA_4NdQ

EQUITY RESOURCE (for organizations)

Equity Impact Review Tool

https://www.kingcounty.gov/elected/executive/equity-social-justice/tools-resources.aspx