



Transformative Change

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

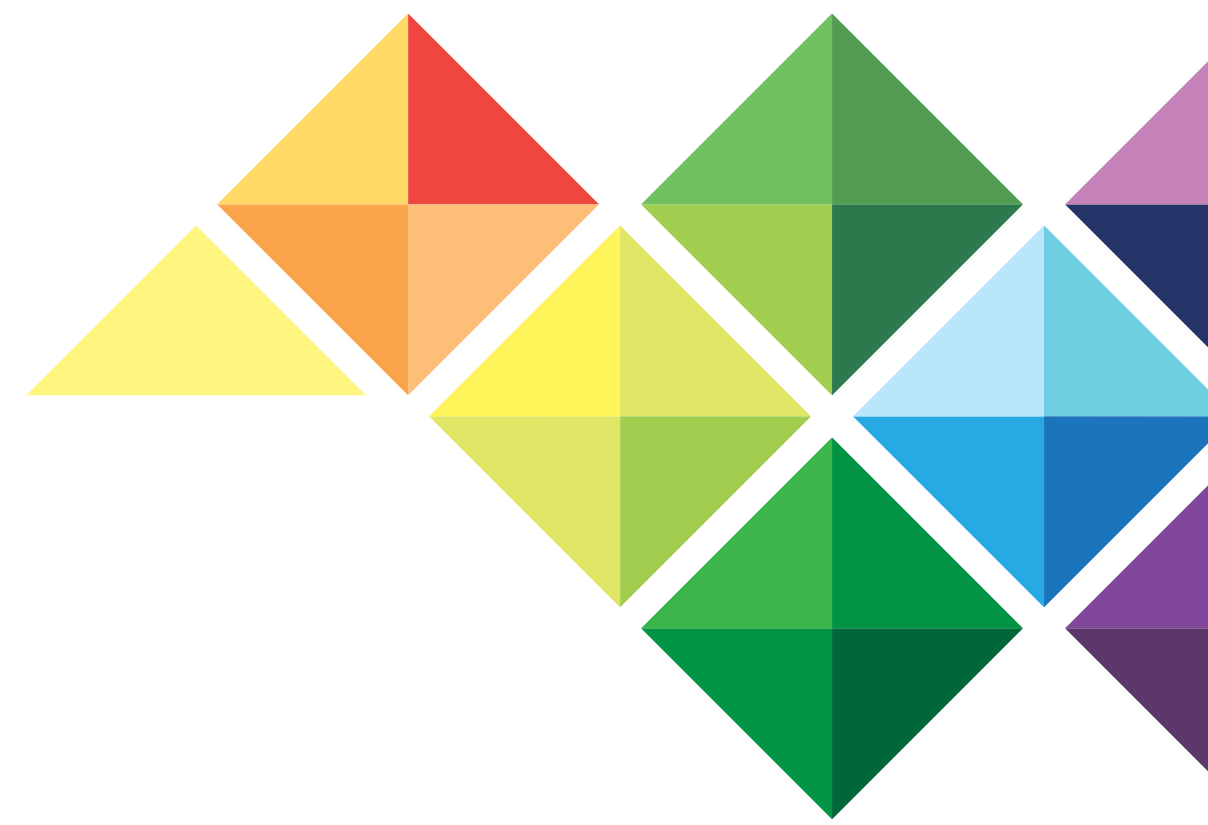


PRINCE GEORGE'S
HEALTHCARE
ACTION COALITION
COMMUNITY-POWERED



Forum Report
November 29, 2018





Collaborating Partners & Sponsors



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Introduction – Health Equity in Prince George's County

Pamela B. Creekmur
Former Prince George's County Health Officer

On Thursday, November 29, 2018, the Prince George's Healthcare Action Coalition (PGHAC) and the Prince George's County Health Department (PGCHD) hosted a one-day health equity forum, Transformative Change – Our Role in Achieving Health Equity in Prince George's County. The second of its kind, this forum engaged stakeholders from different sectors in the county in conversation about the intersections of health equity through presentations, facilitated panel discussions, and an interactive group activity.

PGHAC is a collaboration of over 300 members representing 200 agencies, organizations, and communities that conducts the Community Health Needs Assessment (CHNA) and develops and implements the Community Health Improvement Plan (CHIP). The CHNA collected and analyzed data about health needs from a variety of sources across the county. The four health priorities that emerged were behavioral health, cancer, metabolic conditions, and cancer. The CHIP uses a policy, systems, and environments framework to address health needs. In order to address long-term change

within this framework, the PGHAC formed work groups that focus on population health improvement and health equity. The coalition envisions a county that elevates and invests in the health and well-being of all residents and engages community members to share in the responsibility of creating the conditions that foster a healthier county.

Former Prince George's County Health Officer Pamela B. Creekmur highlighted there is a difference of 16 years in life expectancy across Prince George's County. This difference is unacceptable – all residents must have the chance to live long, healthy, and productive lives. Outcomes such as life expectancy cannot be equal where resources are unevenly distributed. Differences in resources have resulted in disparities impacting prosperity, health, and length of life. In some areas of the county, 75 percent of the population has not graduated high school or obtained GEDs and unemployment in the County ranges from 9 percent to 25 percent. These life circumstances impact where someone lives, how they live, and how long they can expect to live. 🌈

National Update on Health in All Policies (HiAP)

Katherine Robb, MS
Senior Program Manager, Center for Public Health Policy, APHA

Katherine Robb provided a national perspective on Health in All Policies (HiAP) initiatives in the United States. She explained that HiAP began with the World Health Organization Declaration of Alma-Ata in 1978, which identified primary health care as the key to attaining health for all people.¹ HiAP can be formal or informal, situational or systematic, and can involve policy, programs, or overall strategies. When promoting health equity, Robb said that one must be intentional and explicit, as well as consider both social determinants of health and social determinants of equity. Understanding social determinants of equity requires identifying and addressing historic and current systems that are inequitable, and current policies and practices that widen disparities. These must be replaced by systems, policies, and practices that promote fairness and inclusion and affected groups must be included in this process.

Most recently, HiAP has emerged in many states across the nation. The Centers for Disease Control and Prevention (CDC) became involved with HiAP initiatives nationwide in 2011. In 2010, California created a HiAP task force, the first of its kind in the country. This task force provides a venue for convening 22 state agencies to address health policy, enabling California to advance health equity through statewide action plans. Robb also highlighted the state's Government Alliance on Race and Equity, which consists of 12 teams of 15 state employees who receive 50 hours of racial equity training and experiential learning. Their goal is to develop a customized racial equity action plan to be operationalized in 2019.

According to Robb, Minnesota is an example of a more informal HiAP effort. The Minnesota Department of Health convened a Healthy Minnesota Partnership in 2010, the Minnesota Health Impact Assessment Coalition formed in 2013, and a memorandum of understanding was established in 2015. Minnesota released Minnesota

Walks in 2016 and became the first state to adopt a pedestrian plan. Stakeholders were very intentional in efforts to ensure statewide representation and conducted six months of community engagement activities.

At the county level, Robb described the HiAP work of King County in Washington, Multnomah County in Oregon, and Genesee County in Michigan.

- ❖ King County, Washington developed a 2016-2022 Equity and Social Justice Strategic Plan to examine social determinants of equity. This effort engaged more than 600 county employees and 100 local organizations to develop specific county goals.
- ❖ In 2012, Multnomah County, Oregon, launched the Equity and Empowerment Lens which takes steps to mend the relationship between native communities and the government by involving them directly in the process of applying the equity lens.
- ❖ The Board of Health in Genesee County, Michigan proposed and received approval for a Health Equity in All Policies Resolution in 2016.

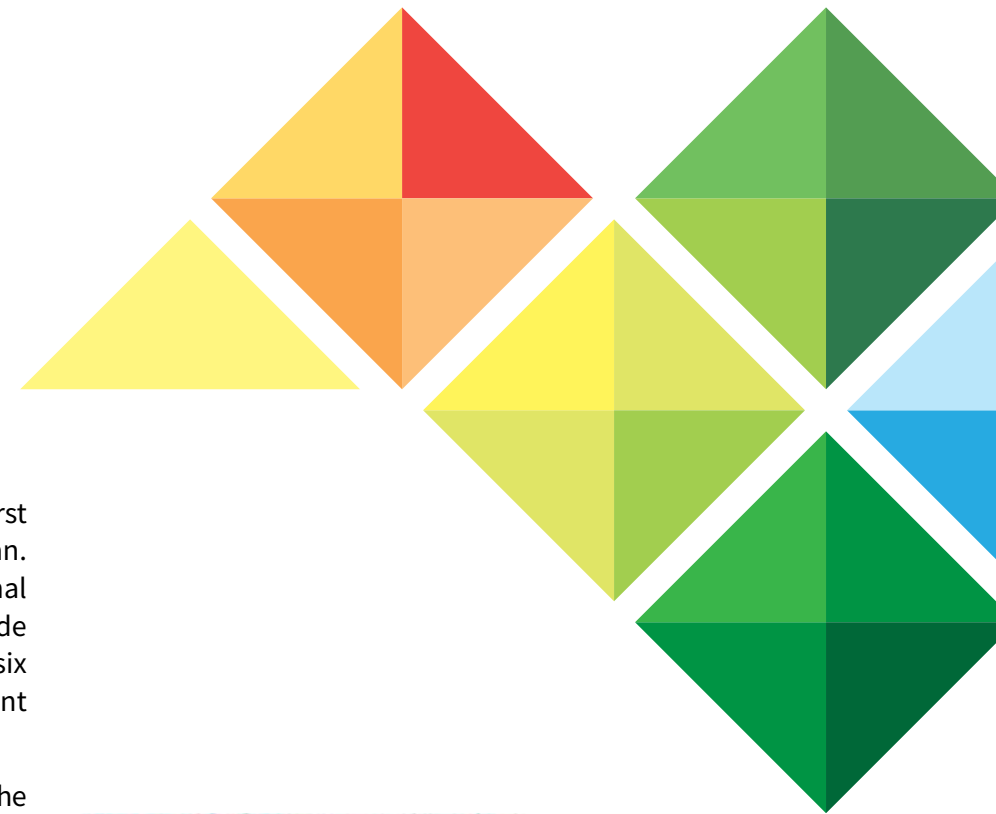


TABLE 1. Examples of HiAP Initiatives across the United States

TYPE OF INSTITUTION	HIAP INITIATIVE	TYPE OF INITIATIVE
FEDERAL		
Multiple federal agencies	National Prevention, Health Promotion, and Public Health Council (2010)	Interagency Taskforce
STATE		
Vermont	Vermont Health in All Policies Task Force (2015)	Executive Order/Legislation
California	California Health in All Policies Task Force (2012)	Executive Order/Legislation
Washington, DC	Office of Equity (2015); Sustainable DC Transformation Order	Government Office; Executive Order
Massachusetts	Adoption of Health Impact Assessment Requirements for major transportation projects (2009)	Legislation
Washington	Governor's Interagency Council on Health Disparities (2006); Board of Health - Health Impact Reviews (2014)	Legislation
COUNTY		
Multnomah County, OR	Health Equity Initiative (2007)	Policy/Agenda
Prince George's County, MD	Passed an ordinance requiring all new planning projects to have a Health Impact Assessment (2011)	Policy/Legislation
King County, WA	King County Equity and Social Justice Initiative (2006); Inter-Branch Teams/Chairs/16948 (2016)	Policy/Legislation
CITY		
Denver, CO	Community Health Improvement Plan's objective includes health considerations and analysis in city policy, processes, and planning	Strategy
Baltimore, MD	Healthy Baltimore (2015)	Policy/Agenda
Richmond, CA	HiAP strategy and ordinance adoption	Legislation
Fairfax, VA	Partnership for a Healthier Fairfax (2010)	Strategy/Interagency Community Taskforce
Louisville, KY	Mayor Healthy Hometown Movement Leadership Team (2012)	Interagency Taskforce
New Orleans, LA	White Paper on Health in All Policies (2013)	Framework Publication

¹Declaration of Alma Ata International Conference on Primary Health Care, Alma Ata, USSR, 6-12 September 1978. https://www.who.int/publications/almaata_declaration.en.pdf?ua=1



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

Ms. Natalie S. Burke, CommonHealth ACTION

Ms. Natalie S. Burke is a nationally known speaker, strategist, master facilitator, and public health leader and resident of Prince George's County. She utilizes her skills to orchestrate constructive discomfort, a temporary phenomenon that is necessary for change.

Raised in an intergenerational household with beneficially aligned social determinants of health, she saw that her grandparents still faced challenges accessing health care. This motivated her to learn how health happens.

Burke's move from Silver Spring in Montgomery County to Bowie in Prince George's County illuminated the difference between disparities and inequities in health. Montgomery County ranks first or near the top for several categories in health. In contrast, Prince George's County ranks much lower in most categories. Similarly, there are wide gaps in median income and high school graduation rates between these two contiguous counties. The way these disparities play out relative to each other exemplifies how

underlying conditions contribute to health inequity.

Burke explained that disparities are differences in health status and outcomes and should not be conflated with inequities, which are disparities that are pervasive, preventable and unjust. She explained that health is a production of society, with 40 to 50 percent of health attributed to systems and institutions that create the constructs we live by. She defined "healthiest life expectancy" as the number of years one can expect to live without illness or disability. Maryland's healthy life expectancy, assessed at 68 years, was not very far from that of the top five states. Full life expectancy in Prince George's County is around 81 years, which means that 13 years of potentially healthy life are lost.

In examining why Prince George's County residents lose 13 healthy years, Burke said that several factors play a role: housing and residential segregation, education, employment, transportation, healthcare, public safety, structural

racism, identity-based inequity and culture. Burke illustrated how major incidents over the past few years have shaped our international dynamic. The response of communities to the rallies in Charlottesville, the racist incident at Starbucks in Philadelphia, and the shootings at the Tree of Life Synagogue in Pittsburgh, has been to call out the injustice and continuously show support. This provides hope that change is possible. However, we are a nation that has struggled with identity, so getting to a place of continued support did not happen suddenly. In 1968, even Prince George's County experienced racially charged riots in Annapolis when county residents opposed desegregating schools. The courts intervened by mandating that the county integrate public schools in the early 1970s, which precipitated "white flight". Many of the challenges we see today are a manifestation of how events played out through history. This is evident in Prince George's County.

When it comes to cultural competence, Burke discussed that diversity and inclusion have become part of a checklist, as it is easy to be inclusive if you are not very diverse, and it is harmful to fail to be inclusive when you are diverse. Furthermore, Burke emphasized that making the case for health equity necessitates knowing your audience. Baby boomers are more likely to argue that health equity is a moral

imperative (about fairness and justice), whereas millennials are more likely to present health equity as a business imperative (what we can do to be successful).

According to Healthy People 2020, health equity is defined as the attainment of the highest level of health for all people, which will vary from person to person. Health equity requires that everyone achieves their optimal level of health and is provided with fair opportunities to reach their potential. Burke explained that human beings are hardwired for fairness because of our interdependence throughout history. However, in the present day, human beings are experiencing an unbundling of interdependence such that our brains do not respond to fairness in the same way anymore. The following human traits impact fairness:

- ❖ **Unconscious or Implicit Bias** – No one is immune to the background noise in our minds that we don't even realize we are hearing, yet are sometimes acting upon.
- ❖ **In-Group Bias** – People congregate, seek out, and bond with people like themselves.
- ❖ **Prejudice** – In the absence of data or information, we pre-judge others based on assumptions which may or may not be accurate.

2016 County Health Rankings	Prince George's County	Montgomery County
Health Outcomes	14	1
Length of Life	12	1
Quality of Life	14	1
Clinical Care	22	2
Social/Economic Factors	16	4
Physical Environment	7	11
Median Household Income (2017)	\$81,240	\$103,235
High School Graduation (2013)	83%	90%

Data Sources: 2018 County Health Rankings; 2017 American Community Survey 1-year-estimates; 2018 Maryland Report Card (for class of 2017)

Power, Privilege, and Racism

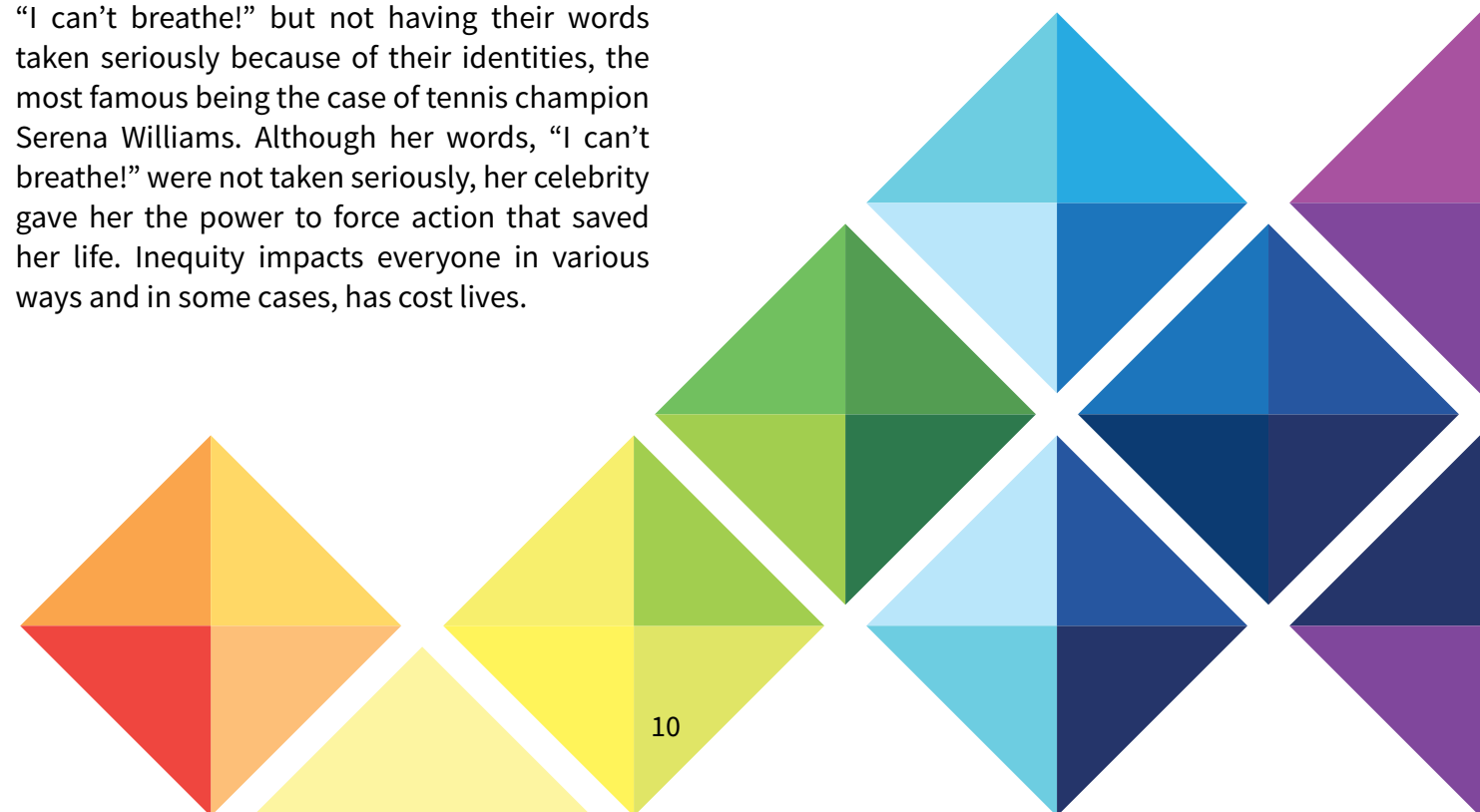
Power is the ability to define reality for yourself and others. When our power is used in a way that incorporates our biases, it distorts reality and impacts our ability to be fair and equitable. Burke defined privilege, the value that society places on you based on your identity, as an escalator that carries people up, and oppression as an escalator that carries people down, operating with a force beyond the control of those on it. What is in our collective control is how we choose to value identities.

Burke iterated that even privilege is killing the privileged. For example, white people are suffering from greater mortality rates than minority groups due to opioid addiction. Black people were protected from this crisis because doctors allowed their racial bias to influence their perception of black patients' pain tolerance and offered them fewer opioid prescriptions for pain management. Another case of health inequity fueled by racism is the rising maternal mortality rate among Native American and black women in the U.S. These women often die during or within a year of giving birth because their health concerns are not addressed. Burke provided example after example of women exclaiming, "I can't breathe!" but not having their words taken seriously because of their identities, the most famous being the case of tennis champion Serena Williams. Although her words, "I can't breathe!" were not taken seriously, her celebrity gave her the power to force action that saved her life. Inequity impacts everyone in various ways and in some cases, has cost lives.

Perspective Transformation

Although the deep divisions that exist in our country and region impact health outcomes, Burke suggested that culture can be changed through perspective transformation, the process of becoming critically aware of how and why our assumptions have come to constrain the way we perceive the world around us so that we are compelled to change. She contends that Prince George's County must undergo a perspective transformation to achieve health equity.

Burke asserted that leading with an equity lens – how we view conditions, circumstances, and processes to understand who experiences the benefits and burdens of any given program, policy, or practice – is a way to reach community. Since equity, diversity, and inclusion all require change that starts within, Burke encouraged attendees to take the implicit association test: <https://implicit.harvard.edu/implicit/>.



The Power of Words

Additionally, Burke spoke about the ability of language to trigger physical, mental, and emotional responses. For example, negative words can trigger illness and disease whereas positive words can help navigate stress. Words have power, therefore, Burke encouraged attendees to evaluate their use of the following words to have more productive and positive health equity discussions:

- ❖ **Vulnerable** – Rather than use a word which is equated with “weakness”, refer to people as experiencing vulnerability.
- ❖ **Empower** –The best we can do is help communities identify, harness, and use their power, but thinking we can empower them sounds condescending and paternalistic.
- ❖ **Underserved** – Overusing this technical term that refers to services is cultivating a mindset that services are all that communities need and if provided, all problems will be solved. The real issue is that communities and people are under-resourced – a misnamed problem that cannot be readily solved by services alone.
- ❖ **Non-White** – This term presumes a standard within which “whiteness” is the norm.
- ❖ **“The” Community** – Aim to get to a point in your work where you can say “our community” so that we can avoid an “us” versus “them” dynamic.

In closing, Burke expressed that courage is responding to a threat in real time, while bravery is when a person is willing to take a risk, not because they have to, but because they are compelled to. Burke recommends that we cultivate and nurture bravery so that more people are willing to take risks to stop Prince George's County residents from unnecessarily losing years of healthy life. For that to happen, we need to embrace constructive discomfort. 🌈



Facilitated Panel Discussion I

Natalie S. Burke, President & CEO, CommonHealth ACTION (Facilitator)

Andrew Fellows, MA, Community Outreach Manager, UMD College of Information Studies

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

Tonia Wellons, MA, VP Community Investment, Greater Washington Community Foundation

Wendy Wolff, MPH, Director of Consulting and Strategic Engagement, Maryland Nonprofits



Question 1 - Why is equity important to you as a personal value? What is the value of doing equity work?

Andrew Fellows described his upbringing in this area, viewing the essential issue of fairness through the lens of the 1960's Civil Rights Movement. After learning more about the history of inequity, he became committed to change. Fellows studied culture and politics in graduate school believing that culture had more impact on equity and fairness than political ideology. He opines that most people agree with the concept of fairness, but not everyone understands equity. Through his work on energy and toxic waste nationally and his local work on diversity in College Park, Fellows is convinced that equity requires deliberate work. He believes that since we live so close to the nation's capital, making a difference in this county can have a national impact.

The notions of justice, equality, and freedom have been part and parcel of Tonia Wellons' life because of her upbringing in Southampton County in southern Virginia, the place where Nat Turner led a slave rebellion in 1831. She described the population, 50% black and 50% white, as one that shares two histories; one of the confederacy and the other of rebellion. She has worked in international development, restoring the natural rights and privileges of people who have lost them over time. Wellons sees many opportunities in the county and region to demonstrate equity.

"We are all connected," said Wendy Wolff. Wolff has a Master's degree in Public Health and pursued work in HIV/AIDS education in Denver, Colorado. She learned about the importance of equity through the hardships endured by her adopted children in schools, as well as the harm that results when structures and rules are valued more than children.

David Harrington grew up in New York City and attended Howard University. He is driven by and engages with equity by learning how to become uncomfortable. Since Chambers of Commerce are known as more conservative institutions, he was surprised when asked to lead the Prince George's County Chamber. He accepted the position because he felt a different conversation about wealth was needed in the county. Conversations around change, he realized, were not going to begin in government so he wanted to push for these conversations through business and other interests so that wealth can extend to all. He describes his life's pursuit as enabling everyone to live their optimal life.

Question 2 - Given the movement towards greater equity in systems and institutions, what is the cost/risk to residents of NOT using an equity lens in institutional and public policies?

Andrew Fellows said Prince George's County can use the equity lens because they are under-resourced compared to other parts of the region, such as Montgomery County. He reflected on how a partnership between government and community creates a lens that allows them to address problems of equity. Politically, the risk is that the state may challenge the county. Financially, the risk is that developers may feel that their investments are being threatened.

According to Tonia Wellons, conversations on equity in communities where people of color are in the majority, create the perception that equity already exists so that the equity lens is unnecessary. However, looking deeper data shows that there are still differences in civic participation and outcomes, so the lens is necessary. She mentioned that risks may include the notion of overplaying the "race or poverty card," or creating advantages for some that disadvantage others. Without using the lens, Wellons said wealth, health, and education outcomes will not change. In Prince George's County, she argued that the flaws lie not with the leadership, but with systems that need to be changed.

Wendy Wolff emphasized that the risk and cost are very high because applying the lens takes money, time, and education. However, the benefit is also very high. She argued that we need to show people currently benefiting from inequity that others are suffering as a result. We must move forward even if that means the distribution of power will change.

David Harrington explained that without accepting the risks of using the lens, we will not establish policies to address the changes we are working towards. He continued, "We need to begin with truth-telling in the county." We may be known as the richest African-American county in the country, however, there are pockets of wealth that are not transferable to the community. For example, the profits from National Harbor, if sold one day, will go to property owners rather than the county residents who contributed to the project's success. He asserts that we should apply the equity lens when pursuing new projects even if it results in a power shift that will appear threatening to some.

Question 3: If you had one minute to make a case for the application of the equity lens, what would you say to those who are reluctant to accept that this is something we must do in Prince George's County?

Wendy Wolff wants people to ask, "Am I perpetuating the problem?" She stressed the importance of telling the truth about funds spent on solutions that miss the mark so that we can stop wasting money and do something different.

Harrington emphasized listening to beneficiaries of privilege and their concerns as the agenda shifts. He suggested using "transactionalism" to demonstrate how everyone benefits from the equity lens as all residents are elevated.


Tonia Wellons believes in shared prosperity, both in faith and economics, because there is enough for all to share and one group's gain does not necessarily lead to a deficit for another. She pointed out that insanity is doing the same thing again and again and expecting different results. Wellons opined that it will take comprehensive actions to reverse our failures.

Wrapping up, Andrew Fellows asserted that now is the time for sustained change. The next few years should be used to define what it means to have health equity in the county and how it looks. Fellows highlighted the value of engaging the University of Maryland Medical System and the UMD School of Public Health in the county's efforts to achieve equity.

Questions and Discussion

David Harrington was asked whether it was too late to do a study that shows how National Harbor has impacted health in the county, and whether there are any funds available to address negative impacts. Harrington replied that it is not too late, and a study would be beneficial. He also highlighted potential opportunities, with projects worth over \$6 billion slated for the next six years. When asked about HiAP involvement in the Chamber for new large development projects, he cited that a zoning rewrite includes HiAP.

Panelists were also asked to advise nonprofits on collaborating, soliciting funds, and presenting ideas. Wendy Wolff stated that the use of the equity lens is new to philanthropy so more awareness of its application is needed. She suggested that as a first step, organizations can implement self-assessments. Tonia Wellons indicated that many nonprofits submit grant applications based on what they want to do rather than what the community needs. She indicated that more philanthropy is needed in the county, but that nonprofits need to evolve and present projects that reflect community needs. Wolff added that there are around 30,000 nonprofits in Maryland, many with budgets of \$25,000 or less.

When asked how to influence policy changes at the government level, Harrington responded that government is not the place to initiate the equity conversation because legislators need more guidance. He recommended that conversation begin in the community and at events like the forum so that well-developed concepts are then taken to government. Tonia Wellons added that the county needs a stronger advocacy voice offering critical analyses on key issues. Harrington agreed that moving from program to policy may require a think tank approach to create a link for policymakers. 

Facilitated Panel Discussion II

Natalie S. Burke, President & CEO, CommonHealth ACTION (Facilitator)

Suyanna Barker, DrPH, MA, Senior Director of Health Equity and Community Action, La Clinica del Pueblo

Michelle Howell, RN, BSN, Director of Nursing, Arc of Prince George's County

Anna Ricklin, MHS, Health in All Policies Manager, Fairfax County Health Department

Tiffany Sullivan, MPH, Senior Vice President, Clinical Integration & Ambulatory Services, UMD Capital Region Health

Stephanie Slowly, MSW, LCSW-C Director, Clinical Support Systems for Serious Mental Illness (CSS-SMI), American Psychiatric Association

Question 1 – Why is equity important to you as a personal value?

While attending public health school in Baltimore, Anna Ricklin said experiencing limited access to resources, such as public transportation, helped her understand how disenfranchised people experience injustice and inequity. After realizing that educating people on healthy eating and exercise alone would not improve health if people couldn't even travel from place to place easily, she headed towards a career in policy.

When Michelle Howell joined the Arc, she saw that healthcare was not equitable for those with varying disabilities and needs. Seeing how change can happen for people when she assisted them with housing, jobs, support services, and advocacy elevated her nursing career to the next level.

As an Afro-Caribbean woman from the south, Stephanie Slowly said she was very aware of the differences, diversity, and inequities present in her life. Her upbringing and current role as a clinical therapist have framed her experiences such that she feels it is her responsibility to fight injustice for those who have not yet made it to where she is today.

Tiffany Sullivan spoke about growing up in South Carolina and her unwillingness to concede to injustice. Equity is important to her because she believes it is not enough to say there are diverse people in a specific place without also promoting their interests.

Speaking about her journey as an immigrant from Brazil, Dr. Suyanna Barker said that while she has faced discrimination, she also understood that her white complexion put her in a position of privilege that enabled her to benefit in a country where most of the population was black or brown. Therefore, she felt she needed to use that privilege to make a difference in immigrant communities.

Question 2 - Given the movement towards greater equity in organizations and communities, what is one opportunity you had or a challenge you have faced in using an equity lens and how did you respond or overcome it?

Barker explained that La Clinica del Pueblo primarily serves immigrant communities with the goal of reducing inequities for those who lack access to health care and other services because of language barriers. Expanding from the District of Columbia to Prince George's County was enlightening for her because there are no programs supporting primary and preventive health care for the uninsured and many residents do not understand how to obtain needed services. She stressed that recognizing the value of community-based primary health care as the first point of access is critical for prevention and health promotion. Community providers know what is needed, but they need long-term investment and resources to provide affordable, accessible, and culturally appropriate care.

Sullivan spoke about her experience using the disparity lens over the equity lens. She helped organize an event on foot care in a South

Carolina community where many diabetics had amputations. Only three people attended because the community did not need any more programs on foot care. Sullivan indicated that using the equity lens would have led her to engage the community to ask what they need or want.

In Slowly's view, community health workers are the most credible advocates. Professionals may begin with good intentions, but over time their actions may perpetuate the very things they are working against. It is critical to offer education and tools to assist people with being their own best advocates.

Howell spoke about the importance of educating providers to increase their understanding of how to care for people with varying abilities and recognize barriers and limitations that prevent them from obtaining care. She suggested that colleges and universities should provide this training and partner with community representatives to authenticate their efforts.

Ricklin said that Fairfax County focused internally on how they could change their strategies to include equity. She said it took time for departments to shift their mindsets and recognize that equity should be fully integrated with strategic plans so that the county, as a whole, could apply a health equity lens across all programs and services. She added that although Fairfax has a health equity policy, county officials have not yet figured out how to fully operationalize that policy.

Question 3 – How would you operationalize or institutionalize the health equity lens to ensure it is held firmly in place, and how would you hold people accountable?

Slowly shared that she had previously tried to create health equity champions but realized there were not enough people who shared her perspective to lead the initiative to operation. She emphasized that equity is neither an afterthought nor insurmountable. We need to be persistent and intentional about explaining its importance and benefits. . Slowly distinguished the difference between intention and impact to promote accountability. Our intention may be to do better, but the impact is how the work resonates with the people for whom we are working.

Sullivan agreed that we tend to be insular and are often reluctant to bring community voices to the table. However, equity is not just the work of organizations, but the work of those impacted as well. Therefore, communities need to be included because they will be honest and challenge us. This can be accomplished by creating ambassadors who can vet the work of your organization or agency.

Barker said that La Clinica del Pueblo created an advocacy strategy that incorporates staff so they can represent the community they serve. She urged us to develop strategies to impact public policies and to be mindful of partnerships that can be used to strengthen advocacy positions.

Ricklin indicated that we need to institutionalize procedures that integrate health equity into existing and future policies. For example, triggers should be built into processes indicating when and how health impact assessments must be conducted. . Due to the cross-sectoral nature of achieving equity, stakeholders from different fields must be involved because they collectively shape the environments in which people live. She shared that Fairfax is



currently integrating its data systems, so they can determine how many people benefit from their agencies' services. This establishes accountability and helps identify systemic inefficiencies.

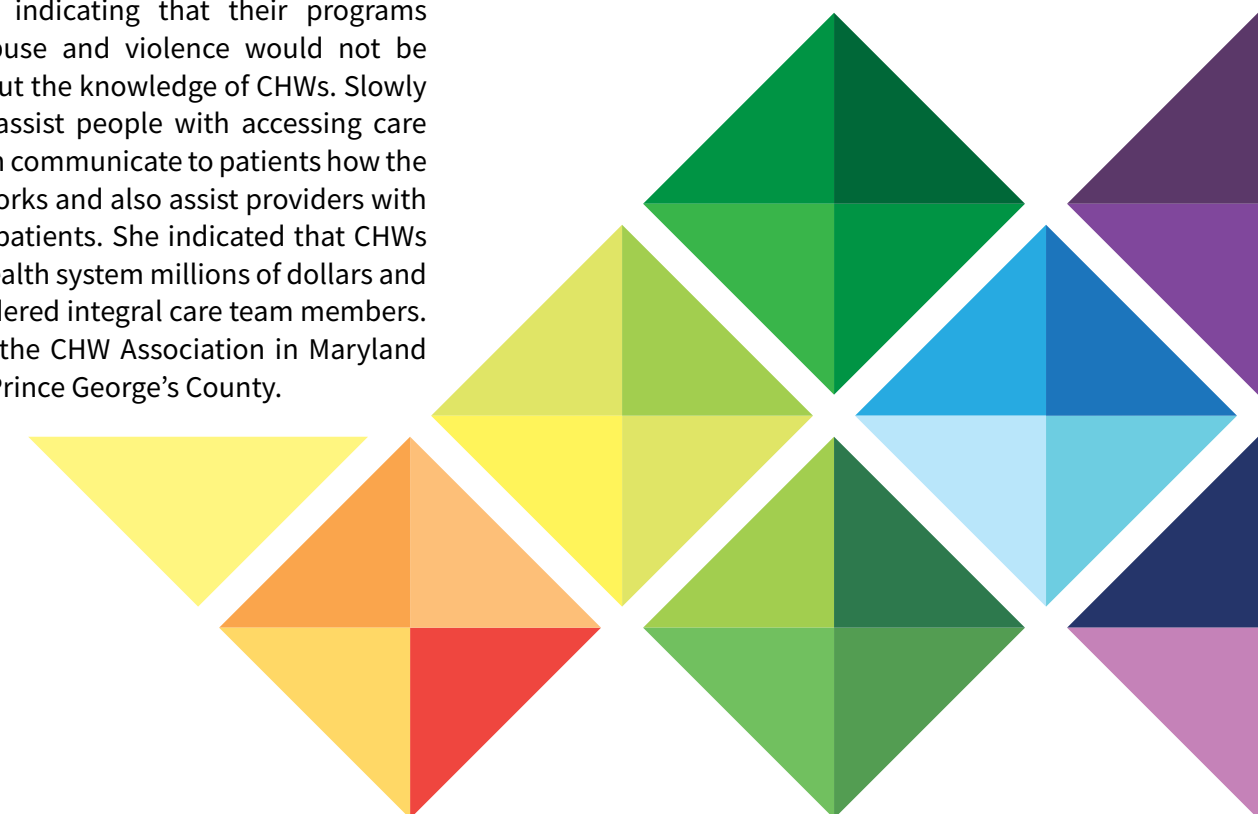
Natalie Burke added that accountability is essential when we set the expectation that we are promoting equity and claim our efforts publicly. Stephanie Slowly added that we should not be discouraged if equity involves a long process because equity is the foundation upon which everything else is built.

Questions and Discussion

The panelists were asked to share how community health workers (CHWs) can best be used to assist patients and promote health equity. Barker said that making the healthcare system respect these workers is challenging. Their perspectives need to be incorporated in clinical teams and care planning. Sullivan agreed indicating that their programs for domestic abuse and violence would not be successful without the knowledge of CHWs. Slowly said CHWs can assist people with accessing care because they can communicate to patients how the health system works and also assist providers with reaching out to patients. She indicated that CHWs are saving the health system millions of dollars and should be considered integral care team members. She added that the CHW Association in Maryland has a branch in Prince George's County.

Burke asked panelists to share what they would like people to make their New Year's resolution to support health equity in Prince George's County.

- ❖ Barker would like to change the narrative around immigrants in the U.S. so our country can become a safe place for everyone.
- ❖ Sullivan said that she would like people to practice better listening skills.
- ❖ Slowly asserted that we cannot wait for others to make things better. She asked that we act fearlessly or embrace fear and do the work ourselves.
- ❖ Howell asked us to change one person's attitude about equity and watch how that shift grows and influences others.
- ❖ Ricklin asked everyone to become civically engaged where we live. 🌍





The Value of Equity: Policy/Procedures & Programs/Practices

During a group activity, forum participants explored the value and benefit of using an equity lens compared to the risk and cost of not using an equity lens. Each participant identified a policy or procedure and a program or practice to evaluate using a four-quadrant model. (See Appendix C).

Participants shared their evaluations in small groups and identified common themes in two of the quadrants: value/benefit of using the lens and cost/risk of not using the lens.

Although the policies and practices selected by individuals varied across sectors, such as housing, health and the environment, common themes emerged within and across groups.

The themes for the value and benefit of using the equity lens included:

- ❖ Greater and more timely access to care, and increased service availability;
- ❖ Elimination of barriers, more equitable treatment, and reduced trauma;
- ❖ Increased access to housing and less displacement;
- ❖ Increased social mobility and social connectedness;
- ❖ Residents become decision-makers in systems that impact their lives.

Participants also noted that even if costs increased initially, more money would be saved in the long-run. They agreed that applying the equity lens to existing and future policies and programs uplifts the humanity of county. Residents would become central decision makers in systems that impact the quality of their lives.

Reoccurring themes regarding the cost and risks of not applying the equity lens included:

- ❖ Limited access to services, poor quality care and treatment delays;
- ❖ Poor health outcomes and increased morbidity and mortality;
- ❖ Chronic stress, decreased mental health;
- ❖ Decreased safety and poor quality of life;
- ❖ Exclusion, isolation and humiliation;
- ❖ Disproportionate negative impact on certain populations.

Participants agreed that other risks included a lack of cohesiveness and a perpetuation of unaddressed and unmet needs that worsen over time, leading to unnecessary loss of life and wasted resources.

The break-out sessions promoted deeper and more personal exploration of the value, benefits, costs, and risks of incorporating health equity into the foundation of agencies, organizations, and businesses serving Prince George's County. Through this activity, groups uniformly concluded that the value and benefit of using a health equity lens is necessary to ensure that all residents have the opportunity to achieve optimal health and quality of life. Without rigorous fidelity to the equity lens and all that it entails, certain populations and communities will continue to be disproportionately disadvantaged. Applying the equity lens in our work should not be viewed as a burden or extra work, but as a necessary approach to achieving long-term goals that ultimately benefit the county. 🌈

Recommendations

Promote Perspective Transformation

- a. Engage in constructive discomfort. Evaluate yourself and your agency to identify implicit biases, prejudicial tendencies and inequity in structures, policies, and programs around you.
- b. Cultivate and nurture youth so that they can bravely act to address inequity. Bring community voices to the planning table and actively engage in respectful listening.
- c. Educate clinical providers on how implicit bias directly impacts how they provide health care. Provide training to clinical providers on how to care for people with varying experiences, abilities, and limitations.
- d. Value the insights of community health workers, recognize the critical role that they play in care teams, and acknowledge their contribution to improving patient care.

Institutionalize the Equity Lens

- a. Over time, restructure your organization so that equity is incorporated into its foundation.
- b. Integrate equity into existing and new policies and strategic planning processes rather than creating separate plans to address it.
- c. Consider successful initiatives in other states as models for next steps. This may include establishing an Office of Health Equity within the Department of Health, creating a Strategic Action Plan that addresses equity in the county, or establishing a cross-sector HiAP task force.
- d. Consider how to utilize Prince George's County's assets to support efforts to promote health equity and HiAP, such as increased engagement with the University of Maryland Medical System and School of Public Health.

Encourage Truth-Telling

- a. Provide guidance to legislators on how to proceed with conversations about equity. Facilitate a process for engaging stakeholders and policymakers in open dialogue through public forums and community events.
- b. Elevate the voices of community members and those affected by health inequities by including them in all planning and equity efforts.
- c. Consider potential risks and anticipate pushback to changes that create equity.
- d. Engage in transactional conversations that emphasize the long-term benefits and value of applying the equity lens.
- e. Publicly claim ownership of our work towards health equity to promote accountability.
- f. Raise awareness of the application of the equity lens in the nonprofit world.
- g. Encourage self-assessments to determine whether organizations are addressing what their communities need or want. 🌍



Forum Evaluation

The majority of respondents (93%) indicated a great deal of improvement concerning their knowledge of, and ways to achieve, health equity in Prince George's County. The components of the Forum that they enjoyed most are:

Great Speakers and Panels

"Great work by Natalie S. Burke."

"Excellent speakers and panels."

Diversified Event/Topics

"Excellent forum. Good combination of lecture, exercises, Q&A, and panel perspectives"

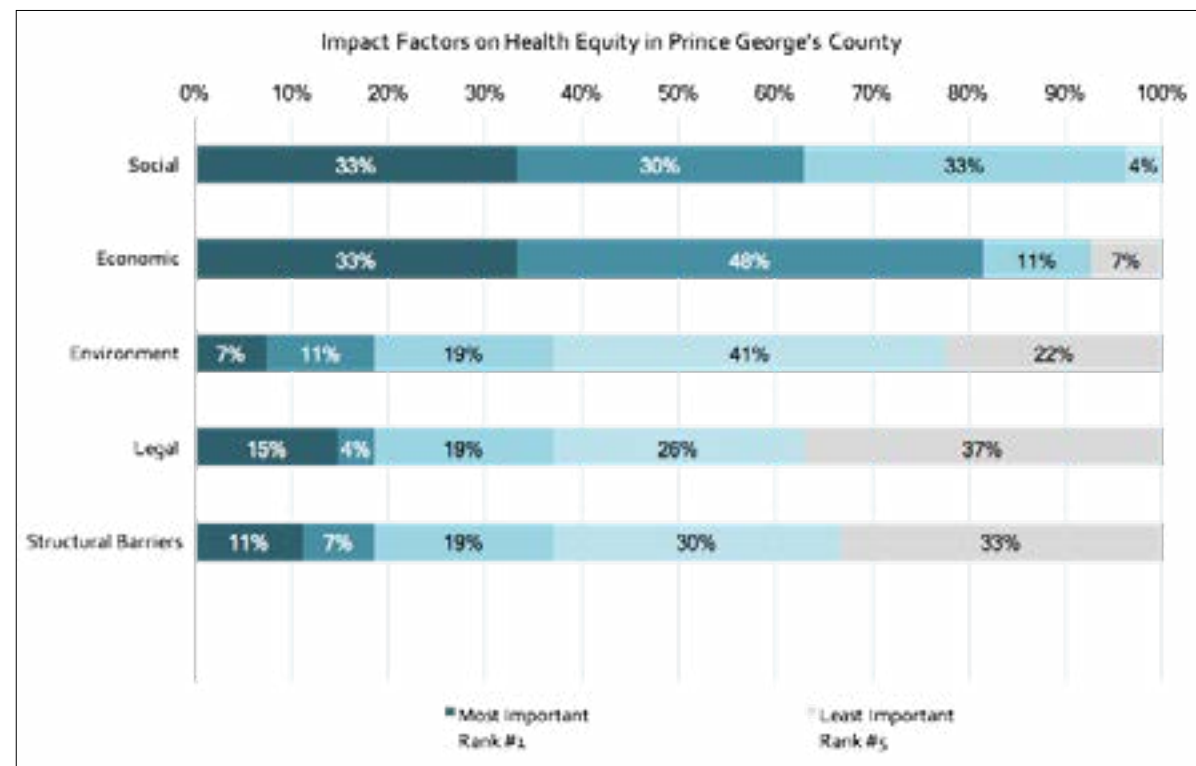
"I learned a great deal. Very informative, and I will definitely take this back to our department."

Engagement of Partners

"Love this opportunity, and thank you for invite, service and commitment. Keep up the great work!"

"Excellent session. Thank you for allowing me to participate."

Respondents were presented with a list of conditions and were asked to rank their impact on Health Equity in Prince George's County.



Most respondents (93%) said they were going to implement new approaches to advance health equity/HiAP in their agency/department. Here are some examples of how:

Applying or Strengthening the Health Equity Lens

"Fire/EMS is structured to work with end users everyday; therefore, we owe it to our community to use a HiAP approach to all decision making."

"Intentional self-evaluation and care to my patients, clients and students."

Awareness

Encourage healthcare providers to attend health equity conferences – "We, physicians, need to be accountable as well."

Educate on unconscious bias and prejudice

Bringing the conversations to communities

Seek out population health data

Immediate Action

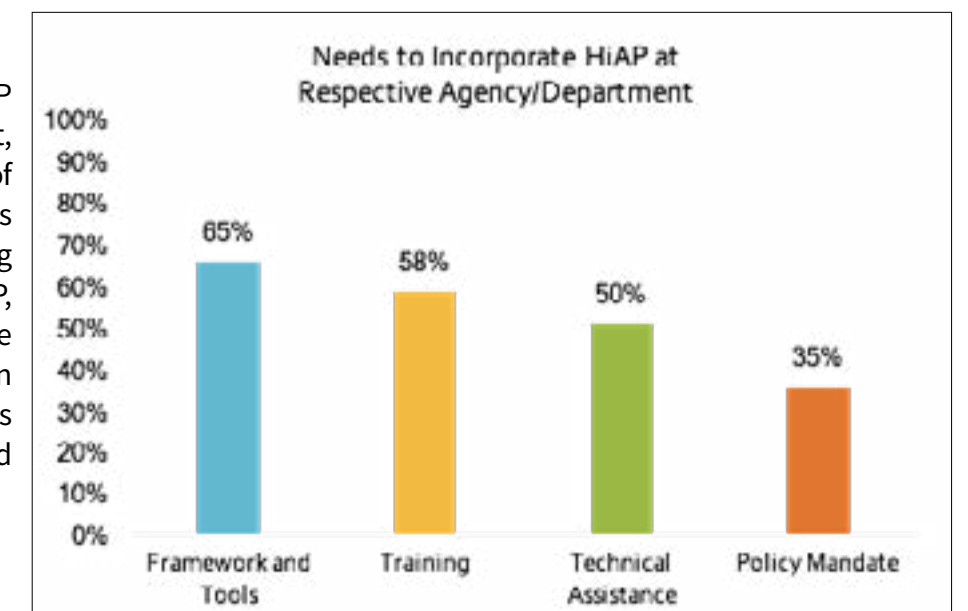
Language changes

Review homelessness access policies and facilities, including barriers to resources

Implicit Association Test will be implemented (staff and board to complete)

Using breakout session ideas and guidelines

In order to implement HiAP at their agency/department, respondents identified areas of need. In addition, respondents expressed interest in attending follow-up meetings on HiAP, and a willingness to encourage colleagues to participate in future meetings / trainings related to Health Equity and HiAP.



Appendix A Agenda



TRANSFORMATIVE CHANGE – OUR ROLE IN ACHIEVING HEALTH EQUITY IN PRINCE GEORGE’S COUNTY

AGENDA NOVEMBER 29, 2018

8:15a – 9:00a	Sign-in and Continental Breakfast	12:00p – 12:25p	Pick Up Lunch
9:00a – 9:15a	Welcome and Opening Remarks – Pamela B. Creekmur, Health Officer, Prince George's County Health Department	12:25p – 1:25p	Facilitated Panel Discussion II
9:15a – 9:25a	National Update – Katherine Robb Senior Program Manager, Center for Public Health Policy, APHA		Suyanna Barker , Senior Director of Health Equity and Community Action, La Clinica del Pueblo
9:25a – 10:25a	Health Equity Overview – Natalie S. Burke, President & CEO, CommonHealth ACTION (Facilitator)		Michelle Howell , Director of Nursing , ARC
10:25a – 10:40a	Q&A		Anna Ricklin , Health in All Policies Manager, Fairfax County Health Department
10:40a – 11:00a	BREAK		Tiffany Sullivan , Senior Vice President, UMD Regional Health
11:00a – 11:50a	Facilitated Panel Discussion I	1:10p – 1:20p	Stephanie Slowly , Director, Clinical Support Systems for Serious Mental Illness (CSS-SMI), American Psychiatric Association
	Andrew Fellows , Community Outreach Manager, UMD College of Information Studies	1:25p – 2:40p	Break Out Session: The Value of Equity: Policy/Procedures& Programs/Practices
	David Harrington , President & CEO, Prince George's Chamber of Commerce	2:40p – 3:00p	BREAK
	Tonia Wellons , VP Community Investment, Greater Washington Community Foundation	3:00p – 3:40p	Report Outs
	Wendy Wolff , Director of Maryland Non-Profits Consulting Group	3:40p – 3:55p	Reflection & Appreciations - Natalie S. Burke
11:40a – 11:50a	Q&A	3:55p – 4:00p	Next Steps/Closing Remarks – Shari L. Curtis
11:55a – 12:00p	Physical Activity, Natalie Burke	4:00p	Evaluations

Appendix B

Presenters & Panelists



Natalie S. Burke, Facilitator
President & CEO, CommonHealth ACTION

A nationally-known speaker, strategist, master facilitator, and public health leader, Natalie S. Burke leads CommonHealth ACTION—whose mission is to develop people and organizations to produce health through equitable policies, programs, and practices. Natalie believes that to alter our collective health destiny, we must change our language; challenge deeply held beliefs about equity in our society and accept the role we each play in the production of the public's health.



Suyanna Barker, DrPH, MA
Senior Director of Health Equity and Community Action, La Clinica del Pueblo Inc.

As the current Sr. Director of Health Equity and Community Action at La Clínica del Pueblo, Suyanna Linhales Barker, DrPH is responsible for developing and supervising the implementation of culturally relevant health education interventions and other strategies to reduce health disparities affecting the local Latino community. Dr. Barker has an extensive background in public health, and community-based research. Dr. Barker has worked to address health disparities for Latino sexual minorities for much of her career, focusing in adolescent and occupational health. Dr. Barker's work experience includes 15 years conducting research for the Primary Health Care Program of the State University of Rio de Janeiro's Center for Adolescent Health Studies and 9 years consulting for various national and international organizations, including the Pan-American Health Organization, the International Labor Organization and the Brazilian Ministry of Health.



Andrew Fellows, MA
Community Outreach Program Manager, UMD College of Information Studies

Andrew Fellows coordinates Campus Community Connection at the University of Maryland, as part of a joint appointment to the National Center for Smart Growth Research and Education/School for Architecture, Planning and Preservation and the College of Information Studies. He served as Mayor of College Park from 2009-2015, having served on the City Council from 2001-2007. He served on the U.S. Conference of Mayors' Water Council, the Metropolitan Washington Council of Government's Board of Directors and Chesapeake Bay and Water Resources Policy Committee. By appointment of the Governor on the Maryland, he also served on the Commission on Environmental Justice and Sustainable Communities from 2002-2015.

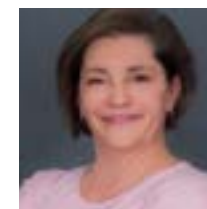
He worked as the Chesapeake Regional Director for Clean Water Action from 1999 through 2014. He earned an M.A. at the University of Maryland after serving for two terms as President of the Graduate Student Government, following a B.S. in Broadcasting and Film at Boston University.



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

David Harrington is president and CEO of the Prince George's County Chamber of Commerce. In this role, he is the primary advocate, policy advisor, and spokesperson for over 500 businesses, and led the Chamber to a "Top 15" regional ranking, as determined by the Washington Business Journal. Previously, Harrington was a Maryland State Senator (representing the 47th Legislative District), Mayor of the Town of Bladensburg, MD, and member of the Prince George's County Council. He was a faculty member at Harvard University's Summer Institute on Reading, Writing, and Civic Education, and associate director of the University of Maryland James MacGregor Burns Academy of Leadership.

Harrington holds a bachelor's degree in political science from Howard University, and completed graduate coursework at Miami University of Ohio.



Michelle Howell, RN, BSN
Director of Nursing, the ARC of Prince George's County

Michelle Howell, has been part of the Developmental Disabilities Nursing community since 2008. She started as a delegating nurse supporting individuals in the residential and vocational programs. In 2011, Michelle was promoted to Director of Nursing for The Arc of Prince Georges' County, and in 2012 Michelle became a founding member of DDNA, Developmental Disabilities Nursing Association. She currently assists a team of nurses that provide hands-on nursing case management, education, and healthcare consultation for The Arc of PGC. Michelle's responsibilities were broadened to include quality advancement. Her team's involvement and concern with people who live with disabilities and who try and navigate a complicated healthcare network has contributed to The Arc's mission "Achieve with us".



Anna Ricklin, MHS
Health in All Policies Manager, Fairfax County Health Department

Anna Ricklin, AICP is a passionate advocate for healthy communities. She joined the Fairfax County Health Department in March 2018 as the first Health in All Policies Manager, where she acts as a health ambassador across county agencies. In this role, Anna promotes the integration of public health objectives into county plans, policies, and building projects. Formerly, Anna led the American Planning Association's Planning and Community Health Center, where she oversaw applied research and place-based initiatives to advance healthy planning practice. She has a background in health impact assessment, active transportation planning, and cross-sector collaboration. Anna holds a Master of Health Sciences from the Johns Hopkins Bloomberg School of Public Health and lives in Falls Church, VA.



Kate Robb, MS

Senior Program Manager, Environmental Health, APHA

Kate Robb leads the environmental health programs at APHA. APHA's environmental health portfolio is primarily comprised of healthy community design and natural environment initiatives, with a focus on improving environmental health systems and building partnerships. Through her work, Kate has partnered with a variety of stakeholders to raise awareness of the connection between transportation and health, climate change and the built environment, and the value of partnering across sectors to advance health equity. Prior to joining APHA, Kate worked on a local level to progress walking and walkability and chronic disease prevention initiatives. Kate received her Master of Science in Public Health from Johns Hopkins Bloomberg School of Public Health.



Stephanie C. Slowly, MSW, LCSW-C

Director, Clinical Support Systems for Serious Mental Illness (CSS-SMI) American Psychiatric Association

Stephanie Slowly is also CEO/ Founder of Slowly Behavioral Consulting Group. Established in 2015 it serves the DC, Maryland and Virginia metropolitan area doing lectures, trainings, motivational speeches and programing around Diversity, equity and inclusion. It also serves as counseling center providing Mental Health therapy to Adolescents, Adults, and Couples. Ms. Slowly currently services as the Director, Clinical Support System for Serious Mental Illness program at the American Psychiatric Association. She was previously the Deputy Director at the Maryland Department of Health, Office of Minority Health and Health Disparities. Prior to joining MHHD, Ms. Slowly served as the Deputy Chief of Programs and Training Capacity for the Maryland AIDS Drug Assistance Program with Maryland Department of Health. Ms. Slowly believes that the work of equity is one in which everyone must be an active participant

Stephanie received her bachelor's degree in Clinical Psychology from The Norfolk State University and she went on Master of Social Work from the Evelyn R. School of Social Work from Norfolk State University. She has gone on to become a Licensed Certified Social Worker-Clinical through the Maryland Board of Social Work Examiners.



Tiffany Sullivan, MPH

Senior Vice President, University of Maryland Regional Health

Tiffany Sullivan serves as the Senior Vice President, Clinical Integration and Ambulatory Services at the University of Maryland Regional Health. Prior to this position, she served as director of community outreach at Palmetto Health in Columbia, South Carolina. Sullivan earned a bachelor's degree in biology from Columbia College and a Master of Public Health in health care administration from the Arnold School of Public Health at the University of South Carolina. She has received several honors and awards to include the Foster G. McGaw Prize for Excellence in Community Service and the Congressman James E. Clyburn Public Health and Health Disparities Community Leadership Award.



Tonia Wellons, MA

Vice President Community Investment, Greater Washington Community Foundation

Tonia Wellons is a Vice President at the Greater Washington Community Foundation and leads the Community Investment function which includes investment strategy, grant-making, community engagement, and partnerships. She has over 20 years of experience spanning senior leadership in both locally-oriented and international organizations. Prior to joining the Foundation in July 2016, she served as a political appointee for the Obama Administration as head of global partnerships at the Peace Corps. Tonia previously served as fund manager a multi-donor initiative focused on financial access and inclusion at the World Bank Group; and a significant part of her career working on USAID-funded capacity development initiatives during the immediate post-apartheid era in South Africa and the broader sub-Saharan region. In 2010, Tonia founded The Prince George's County Social Innovation Fund (PGCSIF) in an effort to 'shift the narrative' and build social capital in the County. The Innovation Fund's flagship initiative, Forty Under 40 Prince George's, recognizes top talent in the County, and connects them to political, social, and economic opportunity; all the while sharing the important story of amazing people - under the age of 40 - who live and work in Prince George's. Tonia has a master's degree in Public Administration and International Development Policy from the University of Delaware, and a BA in Political Science from North Carolina A&T State University.



Wendy Wolff, MPH

Director, Maryland Non-Profits Consulting Group

Activating and coordinating community responses to the HIV/AIDS epidemic was how Wendy Wolff began her career in the nonprofit sector. Her early career helped her to build a strong understanding about the value and role of the community in program planning and policy development. She brings nearly 25 years of diverse consulting experiences to her role as Director of Consulting and Strategic Engagement for Maryland Nonprofits. Wendy has collaborated with government agencies; universities; non-profit organizations; and faith-based organizations to enhance the quality of life within many communities throughout the United States. Ms. Wolff holds a Master's Degree in Public Health from New York University. She has resided as an Adjunct Professor at the University of Denver and as an Associate Faculty Member at Indian River State College. Wendy is a licensed consultant with the Standards for Excellence® Institute. Her first book, *The Letter Writing Project* (Blooming Twig Books), was published in August 2014 and her second book is due to be released in Spring 2019.

Appendix C

Four Quadrant Model

IDENTIFYING THE VALUE OF EQUITY AND APPLYING AN EQUITY LENS

In the following activity you will identify the value/benefit of using an equity lens (taking an equity approach) in your work. You will work individually and then in a small group. Follow the instructions in each section. Times are provided to guide your individual work and group discussion. The facilitator will remind you when you need to move to the next section.

Definitions for the purpose of the activity:

- **Policies** are guiding/governing rules, strategies, principles, and/or plans within an organization or government.
- **Procedures** are steps to implement policies, particularly within an organization.
- **Programs** are how organizations, agencies, government, and companies operationalize their work through activities as they engage with clients, patients, customers, or constituents. "Program" often includes program design, planning, implementation, and measurement.
- **Practices** are the direct application of knowledge or skills and can be a part of program implementation or occur as stand-alone activities with clients, patients, customers, or constituents.
- **Equity Lens** is the lens through which you view conditions and circumstances to assess who experiences benefits and who experiences burdens as the result of policy, procedure, program, or practice.

INDIVIDUAL REFLECTIVE PRACTICE

1. POLICY/PROCEDURE (5 minutes)
 Think of a current policy and/or procedure within an organization, agency, or government that has implications for the health of residents in Prince George's County. This can include policies/procedures, not directly connected to healthcare but that have implications for health (e.g., housing, education, employment, transportation, leave policy, hiring, fiscal policy, etc.)

A. Write the Policy/Procedure you identified

B. Using the Policy/Procedure you identified above, complete the matrix below. List one or more idea(s) in each quadrant.

- (Quadrant 1) What is the value/benefit of using an equity lens?
- (Quadrant 2) What is the cost/risk of using an equity lens?
- (Quadrant 3) What is the value/benefit of not using an equity lens?
- (Quadrant 4) What is the cost/benefit of not using an equity lens?

Keep in mind that using an equity lens requires us to consider **who experiences the benefit** and **who experiences the burden** of a policy, procedure, program, or practice.

	VALUE/BENEFIT To/For Whom	COST/RISK To/For Whom
USE AN EQUITY LENS	1	2
NOT USE AN EQUITY LENS	3	4

INDIVIDUAL REFLECTIVE PRACTICE

2. PROGRAM/PRACTICE (5 minutes)
 Think of a current program and/or practice within an organization, agency, or government that has implications for the health of residents in Prince George's County. This can include programs/practices that are not directly connected to healthcare but have implications for health.

A. Write the Program/Practice you identified

B. Using the Program/Practice you identified above, complete the matrix below. List one or more idea(s) per quadrant.

- (Quadrant 1) What is the value/benefit of using an equity lens?
- (Quadrant 2) What is the cost/risk of using an equity lens?
- (Quadrant 3) What is the value/benefit of not using an equity lens?
- (Quadrant 4) What is the cost/benefit of not using an equity lens?

Keep in mind that using an equity lens requires us to consider **who experiences the benefit** and **who experiences the burden** of a policy, procedure, program, or practice.

	VALUE/BENEFIT To/For Whom	COST/RISK To/For Whom
USE AN EQUITY LENS	1	2
NOT USE AN EQUITY LENS	3	4

GROUP ACTIVITY POLICY/PROCEDURE

1. PLEASE READ ALL INSTRUCTIONS ON THIS PAGE BEFORE YOU PROCEED!

- 2. In your group, each person can take up to **two minutes** to share the policy/procedure they selected and up to two items they put in each quadrant and why. (TOTAL TIME:12 minutes)
- 3. Individually, as each person shares their ideas, pay special attention to ideas in **QUADRANT 1 and QUADRANT 4** and take notes.

A. What are the values and benefits of using an equity lens that people mentioned? What themes do you notice?

NOTES:

B. What are the costs and risks of not using an equity lens that people mentioned? What themes do you notice?

NOTES:

- 4. As a group, **use the flipchart provided to write the themes that emerged in QUADRANT 1 and QUADRANT 4** regarding value/benefit and cost/risk. (5 minutes)
- 5. As a group, **discuss how you might use this information to make a case for a more equitable approach to any policy/procedure you discussed.** (5 minutes)
- 6. During the report out period (After the break), your group should be prepared to **share themes** from **QUADRANT 1 and QUADRANT 4** and how you might use that information to make a case for more equitable approaches. Each report out will be limited to **3 minutes**. Identify someone who can report out for your group.

GROUP ACTIVITY PROGRAM/PRACTICE

1. PLEASE READ ALL INSTRUCTIONS ON THIS PAGE BEFORE YOU PROCEED!

- 2. In your group, each person can take up to **two minutes** to share the program/practice they selected and up to two items they put in each quadrant and why. (TOTAL TIME:12 minutes)
- 3. Individually, as each person shares their ideas, pay special attention to ideas in QUADRANT 1 and QUADRANT 4 and take notes.

A. What are the values and benefits of using an equity lens that people mentioned? What themes do you notice?

NOTES:

B. What are the costs and risks of not using an equity lens that people mentioned? What themes do you notice?

NOTES:

- 4. As a group, **use the flipchart provided to write the themes that emerged in QUADRANT 1 and QUADRANT 4** regarding value/benefit and cost/risk. (5 minutes)
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Appendix D

Participant List

Adam Ortiz,
Prince George's County Department of Environment

Alison Mendoza-Walters, Public Health Impact

Amy Maguire, Mary's Center

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

Andrew Fellows, UMD College of Information Studies, Community Outreach Manager

Anea Jordan, Prince George's County Health Department

Angela Anderson, PGC Community College, Dean Health Business, and Public Service

Anna Ricklin, Fairfax County Health Department, Health in All Policies Manager

Anna Shao, UMD Horwitz Center for Health Literacy

Anta Jame, Kaiser Permanente

Anthony King, OHU

Anthony Sulartnen,
Prince George's County Police Department

Beth Ann Hancock, Maryland Coalition of Families

Bridget Kerner, National Association of County and City Health Officials

Candace Hollingsworth, Hyattsville

Carole Taliaferro, Prince George's County Department of Family Services, Aging

Chris Crabbs, Anne Arundel Medical Center

Christina Gray, Prince George's County Health Department

Christine Stewart, Institute for Public Health Innovation

Daisy Rickert, County Executive's Office

Dara Koppelman, Mary's Center

Darlene Saunders, Special Projects Manager, Health and Wellness Division

David Chernov, TLC-MD

David Harrington, PGC Chamber of Commerce

Dawn Hawkins-Nixon, Department of the Environment, Sustainability Division

Debora Whitehurst-Brown, Anne Arundel Medical Center

Dianna E. Abney, University of Maryland, School of Public Health

Donna Perkins, Prince George's County Health Department

Dorothy Glisson, Bowie State University

Duane Rosenberg, New Carrollton

Dushanka Kleinman, University of Maryland

Elana Belon-Butler, Prince George's County Department of Family Services

Griffin Davis, Ft. Washington Medical Center/Nexus

Henry Stawinski III, PGC Police Department

Howard Ainsley, Ft. Washington Medical Center/Nexus

Ify Nwabukwu, African Women's Cancer Awareness Association

Ignatius Iwuola, Prince George's County Department of Social Services

James Tisdale, Priority Partners of Johns Hopkins Healthcare

Janet Hadley, Hope Connections for Cancer Support

Jennifer Crawford, CCI Health & Wellness Services

Jose Leandro, La Clinica del Pueblo

Judith D'Ambrosi, Maryland National Capital Park and Planning Commission

Jullio Murillo, CASA

Kai Boggess-de Bruin, Prince George's County Department of Social Services

Katherine Robb, American Public Health Association

Kent Alford, UM Capital Region Health

Krystle Coldiron, PGHAC

Leah Paley, Laurel Advocacy and Referral Services (LAR)

Lee Alali, CCI Health & Wellness Services

Lynnette Appling, Lynnette Appling Ministries

Marcela Campoli, CCI Health & Wellness Services

Mercedes Lemos, Langely Park Multi-Service Center

Michael Jacobs, Esq, UM Capital Region Health

Michael Rhein, Institute for Public Health Innovation (IPHI)

Michelle Howell,
The ARC of Prince George's County, Director of Nursing

Michelle LaRue, CASA

Mindy Rubin, Kaiser Permanente

Nekia Neither, The ARC of Prince George's County

Norberto Martinez, Seventh Judicial Circuit of Maryland

Olivia Kachingwe,
Prince George's County Health Department

Pamela B. Creekmur,
Prince George's County Health Department

Phyllis Slade Martin, Slade & Associates, LLC

Renee Ensor-Pope,
Prince George's County Department of Social Services

Robin Jacobsen, Prince George's County Public Libraries

Roderick Wellington, The Bridge Center at Adam's House

Rodney Taylor, Office of Diversity and Inclusion

Rodrigo Stein, La Clinica del Pueblo

Rosa Goyes, Mary's Center

Ruby Stemmler, Eco Latinos Inc.

Salwa Ahmad, Regional Primary Care Coalition

Sanna Even, Prince George's County Fire Department, MIH

Shari Curtis,
Prince George's County Department of Social Services

Sharon Zalewski, Regional Primary Care Coalition

Shawnta Jackson, Cause Engagement Associates

Sinnons Leonard,
Prince George's County Fire Department, EMS

Stacey Little, UM Capital Region Health/
UM Prince George's Hospital Center

Stephanie Slowly, Minority Health & Health Disparities

Stephen Liggeh Creel, Prince George's County Department of Social Services

Stephen Thomas, UMD Center for Health Equity

Susanna Shapiro, Holy Cross Hospital

Suyanna Barker, La Clinica del Pueblo

Sydney Daigle, PGHAC HEAL Co-Chair

Sylvette LaTouche-Howard, University of Maryland, School of Public Health

Terry Lawlah, The Maryland Center at Bowie

Thompson Martin, Lillie, Fairmount Heights

Tiffany Sullivan, UMD Capital Region Health

Tiffany Williams-Jennings, PGHAC HEAL Co-Chair

Tollie Elliott, Mary's Center

Tonia Wellons, VP Community Investment, Greater Washinton Community Foundation

Tonya Kinlow, Children's National

V. Ursula Gnan, Aetna Better Health of Maryland, Community Outreach Coordinatort

Wanda Smith, Prince George's Healthcare Alliance

Wendy Wolff, Maryland Nonprofits Counseling Group

William F. Goddard, III, City Administrator, City of Laurel



The Prince George's Healthcare Action Coalition (PGHAC) would like to acknowledge the numerous stakeholders who contributed to the success of this forum. Members of the Prince George's Healthcare Action Coalition Health Equity Workgroup and the Transformative Change Planning Committee are listed below.

- | | |
|--|---|
| Adelline Ntatin, Aetna Better Health of Maryland | Lee Alali, CCI Health & Wellness Services |
| Andrea Lasker, Prince George's County Department of Works and Transportation | Lee Hopkins, CASA |
| Brittney Drakeford, M-NCPPC | Leroy Maddox, County Council for Prince George's County |
| Caitlin Murphy, Special Assistant to the Health Officer | Lynn Mejia, UnitedHealthcare, Community Development Specialist |
| Chantal Tuell, MedStar, Community Outreach Project Coordinator | Melissa Weir, Howard University, College of Nursing |
| Christina Gray, Prince George's County Health Department | Michael Rhein, Institute for Public Health Innovation |
| Christine Stewart, Institute for Public Health Innovation | Michele Burton, Amerigroup |
| Crystal Riley | Mindy Rubin, Kaiser Permanente, Safety Net Partnerships |
| Cynthia Baur, University of Maryland School of Public Health | Monica Spann, Prince George's County Health Department |
| Darlene Saunders, Prince George's County Health Department | Nancy Margai, University of Maryland, School of Public Health (MPH Student) |
| Dawn Hawkins-Nixon, Prince George's County Department of Public Works and Transportation | Nicole Cummings, National Center for Health Statistics, CDC |
| Deanna Barath, University of Maryland School of Public Health | Olivia Kachingwe, University of Maryland, School of Public Health |
| Deborah McGruder, Prince George's County Health Department - Health and Wellness | Patrice Tucker, UnitedHealth care |
| Diane Jones, Family & Medical Counseling Service, Inc. | Phyllis Slade Martin, Slade & Associates, LLC |
| Donna Perkins, Prince George's County Health Department – Office of Assessment and Planning | Sammar Butt, University of Maryland School of Public Health Intern (health literacy) |
| Emeobong Martin, Medstar Health, Regional Director, Community Health | Sara Glickman, City of Hyattsville |
| Ernest Carter, Prince George's County Health Department | Shari L. Curtis, Department of Social Services, Prince George's County Health Connect |
| Evelyn Hoban, Prince George's County Health Department | Sharon Coker, Heart to Hand, Inc. |
| Evelyn Kelly, Institute for Public Health Innovation | Sharon Zalewski, Regional Primary Care Coalition |
| Irwin Royster, East of the River Collaborative | Shawnta Jackson, Cause Engagement Associates |
| Jagdeep Singh, Prince George's Hospital Center/ Dimensions Healthcare | Stacey Little, Dimensions Healthcare |
| Jimmie Slade, Community Ministry of Prince George's County | Susanna Shapiro, Holy Cross Hospital |
| Kelley Ray, University of Maryland Medical System Health Plans, Manager of Community Development & outreach Medicare | Suyanna Barker, La Clinica del Pueblo |
| Lane Dillon, Prince George's County Health Department | Sylvette LaTouche-Howard, Prince George's County Health Department – Behavioral Health Services |
| LaShontae Norman, Maryland Health Connection | Theodosia Munford, National Coalition of 100 Black Women (PGC Chapter) |
| Leah Paley, Laurel Advocacy & Referral Services, Inc. | V. Ursula Gnan |
| | Aetna Better Health of Maryland, Community Outreach Coordinator |
| | Vanessa Purnell, MedStar |
| | Victoria Valcarcel |
| | Xerxeser Kayode, Georgetown University Medical Center |



We acknowledge the support and participation of the Consumer Health Foundation, Kaiser Permanente of the Mid-Atlantic States, the Greater Washington Community Foundation, and the Prince George's County Health Department. We are grateful to all participants who spent the day devoted to discussing health equity. The passion expressed at this event demonstrates the importance of equity and inclusion in Prince George's County, and will drive momentum towards achieving health equity for all residents.

