Transcript: Why Health Equity Matters in Prevention

Presenter: Nicole Augustine
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ANN E. SCHENSKY: Good morning, everyone. Welcome We're going to give people a minute or so to get in from the waiting room. We're excited so many of you are attending.

All right. I think we will get started. We have a couple more people still logging in, but we will get started. Again, good morning and welcome. Our training today is why health equity matters in prevention, and our presenter today is Nicole Augustine.

This training is brought to you by the Great Lakes PTTC and SAMHSA. The Great Lakes ATTC and MHTTC and PTTC are funded by SAMHSA under the following cooperative agreements. The opinions expressed in this training are the views of the speaker and do not necessarily reflect the official position of DHHS or SAMHSA. The PTTC Network believes that language matters and uses affirming language that inspires hope in all of our activities.

We have some housekeeping details for you today. If you are having technical issues, please individually message Kristina Spannbauer or Stephanie Behlman in the chat section, and they'll be happy to assist you. The workbook for today will be in the chat. Please download it as we will be using it for the training today. We will also be using automated transcriptions for today's webinar.

The recording of this training and the workbook will be available on our website. It normally takes us about 7 to 10 days to get posted. You will also be sent a link at the end of this presentation to a very short survey. We would really appreciate it if you could fill that out. It takes about three minutes and it's how we report our activities back to SAMHSA. And certificates of attendance will be sent to all who attend the live session in full, and they can take up to two weeks to appear in your email.

If you'd like to see what else we're doing, please follow us on social media. And if you're on our mailing list, look for our weekly updates for events on Thursdays for the following week.

Again, I am very excited. Today our presenter is Nicole Augustine, founder and CEO of RIZE Consultants. Nicole is the founder and CEO of RIZE Consultants, a strategic consulting firm founded in January of 2015. Nicole is an entrepreneur, public health professional, and a social justice advocate. Her journey in public health began at Cornell University.

After graduating, she worked for three years as a basics course for Cornell's Campus Firm Reduction Initiative. From there, Nicole transitioned into the George Washington University School of Public Health before experiencing a rapid career progression from providing prevention education, to providing training and technical assistance to communities, professionals, and state agencies.

Nicole has served as the project coordinator for the Southwest PTTC, the project director of the North Carolina Behavioral Health Equity Initiative, and the prevention director for Addiction Professionals of North Carolina. Nicole currently serves as the advanced implementation specialist for the Opioid Response Network. This network is building trust across justice, corrections, and medical systems to address the opioid and stimulants crisis. And I'm happy to turn it over to you, Nicole.

Did we lose Nicole? I'm not hearing her voice.

NICOLE AUGUSTINE: Oh my gosh, I was on mute.

ANN E. SCHENSKY: There you are. I was like, I think you're there, but let's just make sure.

NICOLE AUGUSTINE: I've just been talking away. Well, good morning, everyone. The official challenges of technology. I have double mutes going on here. So it's an absolute pleasure to be here with you all. I thank you all in advance for your time and attention, and thank you for filling out the poll here, that way I get a sense of where folks are. Wonderful. Thank you.

So we've gotten most people replying to the poll. Great. Oh, good. Good. So we've got quite a mix. I guess we can go ahead and end it and show the results here. We got quite a few people saying you definitely know and understand why health equity matters. And I appreciate those folks in the room. Feel free to be adding to the chat. You'll have plenty of opportunity for conversation discussion. So be sure to share your expertise in this space.

We got some folks saying I get it, but I'm not really sure what to do and how to do it. And my hope is that our conversation today will really help it assist you in that, and essentially the whole series, that's the Great Lakes PTTC is doing.

So I'm excited to get started and to talk today about why health equity matters in prevention. I have been in the space of health disparities and health equity for a long time. So this is a topic of great understanding to me, but also great curiosity and a place I'm hoping for some change.

As we get started, there is something that I want to pause a minute to take note of. I am always learning. I'm always improving. I mean, we call it continuing education for a reason. And so back in December I attended a training that I felt for the first time really talked about land acknowledgment. And a part of this training that I had to do was to give my own commitment of action in the future, and something that I said that I would be doing in the future is to always moving forward include land acknowledgment and why it's important as a part of my conversations around equity, diversity, inclusion in this work.

So I want to share a quote with you from Northwestern University because something that's extremely important to me is making sure what we do isn't just a checkbox. And unfortunately in my history in this work, back to the days of cultural competence, a lot of it has felt like checkboxes, and I want to make sure that even when I'm doing this work that I'm not just checking a box too. So I didn't want to include land acknowledgment as my own personal checkbox, but really to kind of have a bit of a critical conversation as to why this should be something that we think about.

And so I want to share this quote and it says this. "It's important to understand the longstanding history that has brought you to reside on the land, and to seek to understand your place within that history.

Land acknowledgments do not exist in a past tense, or historical context. Colonialism is a current, ongoing process, and we need to build our own mindfulness of our present participation."

And when I found this quote, it really resonated with me the purpose and intention behind the land acknowledgment, the idea of understanding history. I'll just share with you all, I'm personally experiencing my own kind of changes in life. I lost my grandmother at the end of October, and she is someone who raised me. And in that process I've been discovering my own history, my own ancestry. And when I attended this training in December, just the idea and the

concept had such big alignment for me of recognizing when we're talking about health equity why even land acknowledgment matters because the history matters of the land that we're on.

And so I leave this as a moment of reflection for all of you. I do want to share into the chat, there is a great website you can use that will help you identify your own personal land acknowledgment for the space that you live and the land that you occupy. I think it's important that everybody knows the history of the land that they occupy. And that's really the purpose and intention of why land acknowledgment exists. And you may be seeing it happen more and more into trainings and projects.

So as we are shifting into our content, I always like to start with creating an intention about the time that we have together. One of the things that I've seen interesting about this shift into virtual training, it is so easy to multitask. It's so easy to not truly be present in the virtual training experience. One, I can't see and touch you all, you all can't see and touch each other.

And so at the same time, I believe wholeheartedly in this work, in this content. And so I want to take a minute for us to ground ourselves in this space even though it's virtual. In the chat you all should have received a download to download the workbook for this training. This activity actually is inside of that workbook also. So feel free to open that up. You can also for this just grab a piece of paper and just draw a line to separate your piece of paper into four quadrants if you don't have the workbook.

And so I will need everyone to grab a piece of paper to do this, separate it into four quadrants, and what I'd like to do first is to clear our minds because I'm sure some of you came from another Zoom before this one. May even have a Zoom right after this one. You may even have overlaps and conflicts. But my hope is for the time that we have together that you're fully present.

And so what I'm going to ask is now that you've created that kind of cross section-- and if you're in the workbook, it's already there for you-- I'm going to have you all draw the tightest spiral that you can, right there at that cross section on your paper.

And I'm going to put a timer for just one minute. And, again, the purpose and intention of this is just to clear our minds from all the stuff that happened in the three or four minutes before you logged on to the Zoom meeting and to get us to be fully present in our time together so that we hopefully you all can leave you with some true concrete ideas on how we can actually build health equity

into our prevention practice because that's the essence and the truth of why we're here today.

So I'm setting my timer right now for just one minute, and if everyone can just draw the tightest spiral you can right there in the middle of your page as a way of clearing your mind and bringing your self present to today's session. Just 20 seconds remaining. Make sure you're breathing as you're doing this, not holding your breath.

OK, great. Now I'm going to ask you all a series of questions not to be shared with anyone else, but really to again help you be grounded into the space today. And I'm going to bring up the worksheet here just so you all can see the questions also.

So in your top left corner, if you can answer for me when you think about health equity and prevention, what comes to mind? When you think about health equity in prevention, what comes to mind?

In your top right corner, what fears do you have about racial equity? What fears do you have about racial equity?

The bottom left corner, what do you think is the greatest potential for improving equity in our prevention practice? What do you think is the biggest potential for improving equity in our prevention practice?

And then your final question of reflection is, what do you hope to get out of this training experience today?

We're together until 12:30 as long as you're able to be here the whole time. And I would be curious, what are you hoping to get out of this time together today?

All right. So wonderful. Hopefully everyone is here and present, and we are ready to get started on our content today. I have three primary goals that I want to accomplish. One, to build a bit of a foundation around some of our foundational terms; two, to really help draw the connection between equity and ethics. And this is something that's been coming up a lot for me personally; and then we'll spend most of our time really talking about, how do we do this in real time and action?

I'll provide three action steps that I believe we can all take, and we'll have opportunities for discussion. I want to give folks a heads up, we will be using breakout rooms. So the same rules apply. You can talk as much as you want or as little as you want, but we do want there to be great conversation amongst us as colleagues.

So let's get started on our first task, which is really setting the foundation for language and having a common understanding. And I want to preface this by saying I'm only going to be defining four terms for us today. The reality is there are whole courses on just terminology around equity and around disparities. And so we don't have time to do all of that. But I wanted to at least give the 40,000 foot view.

There's a quote here that says, "to attain knowledge, add things every day; and to attain wisdom, remove things every day." And just something to be thinking about as we are growing as professionals, what is the information we're adding, and in what ways are we using wisdom to remove thoughts, ideas, beliefs, and systems that no longer serve us, no longer serve the communities that we are attempting to help?

So the first definition I want to talk about is, what is a disparity? This term is used quite a bit. And so I think it's important that people understand what a disparity actually is. The best way that I like to think about a disparity is that this is a preventable difference in health outcomes. And the key word is that it's preventable, and when you really look at what's happening in a community, you'll notice that there will be demographic characteristics at play. And typically what happens is folks will look at data that's showing a disparity and they'll use that data to characterize a particular population. And unfortunately you can't do that that way.

A lot of times disparity data-- and I'll talk about this a little bit more when we get to equity issues because it's typically your inequities that create disparities, and folks don't always see that connection there. So the main thing to remember is that the disparity data is showing differences in health outcomes that are preventable.

And what I wanted to do was to look at some disparity data for the Great Lakes region. And so I specifically pulled data for HIV rates, new diagnosis rates, and I want to show you for the region what the disparity data is looking like and really begin to think about what disparities are.

I'll say one caveat, the fourth session of this series will focus more in depth on data. And so if these next slides of curiosity to you, I really want to encourage

you to come to the fourth session because we're really dive into data and understanding data more then.

Let's start with Minnesota. And how I've set up the data for all states is the same. What I want to show you first is looking at the population, the demographics of the state, and how that compares to the distribution of HIV diagnosis along race also. So for instance, in Minnesota, 77.8% of the population is white and 39% of the HIV diagnosis in 2019 were white.

Now, I did a little math because I like numbers and I'm always curious about numbers and I've always been fascinated by disparities. And when I do the numbers, it's even more fascinating to look at it this way; to think about the fact that the community and people of color in the state make up about 22% of the population, yet 61% of the new diagnosis. So for me because I'm curious about-- I always think of the first data point just gets you curious. What else do I need to know here?

I am going to show you the rest of the numbers just so you can see kind of what the distribution looks like across the state when it comes to diagnosis of HIV. But the main thing that I think is really fascinating is to see the difference in the population distribution in comparison to where people are.

So this is Minnesota, any of the Minnesotans on the call. For those who are from Wisconsin, Wisconsin's 81% white, 32% of the HIV diagnosis. So again, when you do your math, the burden of HIV diagnosis weighs heavily on the communities of color, even in Wisconsin.

And this is what I do. I like to always kind of look at this data that way I can see what's happening. As I look at data like this, I'd be wondering what's going on with some of the communities and populations in my state. And then because I'm in prevention and substance prevention specifically, I'm curious about what are the intersections between risk factors around HIV and risk factors around substance use? Because we know those things cross over.

For Michigan, it is 75% white, 32% of the HIV diagnosis were amongst whites, again, looking at these differences. And what's interesting is that so far all three of these states have basically looked about the same in terms of profile, again, just thinking about trends and things like that.

Now, the one state we begin to see where there starts to be a little bit of difference actually is when we look at Illinois. So I'll give you a minute to see

this here. I mean, just some of these numbers are striking how big a burden some communities are experiencing comparison to others.

So let's look at Illinois. Now, this is a state that is the most diverse amongst the states in the region. The white population is 61%, however, increase in diversity, I mean, the numbers are even larger. Most of the other states were in that 60% range. You're looking at 81% of the new HIV diagnoses. That burden on the populations of color is just consistent across the region.

All right. Let's look at Indiana. Indiana is looking more like the first three states we looked at, again, where you're seeing the people of color making up about 20% of the population, but 60% of the HIV diagnosis again. So these are just these trends.

I mean, and truly you all I have been in the work of disparities for a long time. I actually started in sexual health first, and these type of trends are like almost everywhere. And so I encourage people to really start looking at the data, and what is the burden of disease and really looking at the spaces in which we overlap with other social and health issues.

So Ohio, 77% white, 41%. So this is I think one of the highest rates of HIV amongst whites we've seen amongst all the states. So again, I'd be looking, what is happening? because something's happening across the whole region.

So hopefully this was helpful in thinking about and conceptualizing how you can see disparities within data. In our work and prevention, we are being really called to push out of just our lens like this.

I'll give you guys just a bit of a heads up, when we move into the second part of this series and we talk about the social determinants of health, we're really beginning to think about the power of collaborations, which we'll talk about more in the third part of the series. So I'm really looking forward for those of you who are here today to stay with us through this whole process because the goal is that this content will build on each other so we can really begin to re-imagine prevention and what we're doing to improve health outcomes for the communities that we care about.

So that's health disparity. Remember, it's a preventable difference. And so for me, if you think about the data I shared you and that burden, disparities are preventable. That's the main thing. So our data doesn't have to look the way it there are things we can do to create change, and that to me is the space of hope.

So the connected term with disparities is health inequity; and this is the term that really begins to look at the social parts, the environment, the access to health care, transportation resources, all the things to me that either perpetuate disparities in a particular community-- so what I've seen is that typically it's because a community has a lot of inequity that disparities in health begin to happen.

And so I did pull a data point that looks at inequity just so folks can see it. For this one I pulled the data point looking specifically at adults reporting not having a doctor. So this one I just did by state just to show us the trends here.

So again, same order, looking at Minnesota these are adults in 2020 reporting not having a doctor, and access to care, it's a proxy or an indicator for inequity issues. And so as you look across these numbers here, you can see some variance depending on how someone identifies in Minnesota with the greatest number of folks not reporting having a doctor being in the Latinx community.

And the trends are about the same all the way through you all. Same thing that we saw with HIV. The trends are about the same across the region where your communities of color are more likely to report not having a doctor.

So here's Wisconsin. Here is Michigan. And Michigan seems to be the numbers are a bit lower actually for folks reporting not having a doctor. Look at Illinois. Remember, Illinois was our most diverse state amongst the states in the region. Then we've got Indiana, and in the last one is Ohio.

And like I said, we're going to do a whole session on data. When I look at this chart, I look at these numbers, I feel like I have so many more questions. And that's the beautiful part about data. When you really start appreciating data, you recognize it's just asking more questions.

So why is this happening? What do I need to know? What specifically is occurring in these communities that they're reporting not having a doctor? What else is happening? What other inequities do I need to be looking at? And then how does this relate to health outcomes for that particular community?

So this is the purpose and intention of why we look at data this way because it helps us make some judgments and some decisions about how to intervene, and what are the places where community needs help and support.

The third term I want to think about are the social determinants of health. And I have mentioned this before. We are going to have a session specifically on the social determinants of health. It's actually part 2 of this series. But I did want to mention it because it's an important term I believe to be thinking about. Mainly because for me these last two terms I'll show you focus on what we can be doing to address equity issues.

So the idea of the social determinants of health is that there are five domains that cover all aspects of someone's life. And essentially the distribution of resources across these five domains is what determines quality of life and even length of life, you all. There's a lot of researchers going into this.

We'll do a whole session on the social determinants of health. And in that session, we'll actually begin to talk about how do we as prevention specialists, how do we position ourselves to have some level of engagement and influence across all five domains? And for me that is strategically connected to the third session, which is focusing on how do we diversify our network because in order to be across all five of these domains, we have to have the right type of partnerships for something like that to happen. So I'm looking forward to those future conversations that we'll have together.

The fourth term that I want to share with you is health equity. Now, this is where we started. This is the definition of this session, which is why does health equity matter in prevention? And so I want to define and make sure we understand what the word health equity means. Essentially this is a conceptual term that is used to describe that everyone is treated fairly and justly.

We have looked at our inequity issues, we've looked at our disparities, and frankly we've looked at the various domains that affect health outcomes. And health equity is about taking a look at that picture and then adjusting the resources in a community to improve health outcomes. And that's really kind of the essence of what health equity is about. And if you think about what we do in prevention, our work is all about preventing unnecessary addiction because addiction is preventable.

And so if you think about it, equity is at the base of everything we do because when we're serving communities, a lot of the communities we serve are dealing with social issues around economics and poverty, geography and access to food and care, and all sorts of things. And so to me, equity is extremely important in the work we do.

I found a really great quick three minute video that I want to share with you all. It actually comes from California. California has made some really great initiatives focus on health equity. And so I wanted to share this because it does a great job of summing everything I've talked about so far and why health equity matters and how the fact that inequity affects us all.

And I want to share this with you all because one of the challenges that I've experienced as a trainer on this topic is so often people have limited the conversation of equity around just race. And it is an important issue to think about that, yes, there are definite specific racial inequities that are occurring.

And unfortunately what happens is that a lot of times I've noticed that white folks might pull out of the conversation or find it not as comfortable; or if you're in a community that's 98% white, sometimes folks won't realize that this conversation is important for them too.

And so I like this video because it really helps understand how inequity affects everybody. It's not just about race. It includes poverty. It includes technology. It includes education, access to health. It's a very, very broad topic that we all have work to do in. So I'm going to share this video with you all. And that was the one thing I did not do was make sure that I do the share for sound. So give me just a second. Sharing computer sound. Got it.

[VIDEO PLAYBACK]

[MUSIC PLAYING]

- What determines how long we'll live?

[MUSIC PLAYING]

Is it what we do? Is it who we are?

[MUSIC PLAYING]

Actually when it comes to predicting how long you'll live, your zip code is more important than your genetic code. Here's how this works.

Meet Deb and Maria. They both have jobs. They're around the same age. They're both married and they both have two kids. Deb lives in Atown while Maria lives in Bville less than one mile away. They're similar in so many ways. But here's the thing, on average residents of Bville will die more than 15 years sooner than the residents of Atown. Why? Because where you live is about more than just your address. It's about your opportunities.

For example, Deb and Maria's access to healthy options is really different. In Atown, Deb's family is surrounded by healthy food options, including farmers markets, specialty shops, and grocery stores. The air in Atown is cleaner and fresher, and there are lots of safe, clean parks where Deb can exercise and her children can play. Atown has good public schools for Deb's kids and easy access to emergency and preventive health care.

On the other hand, Bville has broken badly lit sidewalks and the parks are unsafe. The air is filled with truck exhaust from the nearby highway, and for food options, Maria's only choices are Bville's many liquor stores, fast food places, or convenience stores. The schools in Bville are overcrowded and unsupported. And even if Maria can get her kids into better schools far away, she needs to figure out how to get them there without access to a car.

So for Maria having to juggle so much to find healthy options can be an overwhelming source of chronic stress, which is a serious health risk factor. In fact, for all the residents of Bville, chronic stress drives health problems like obesity, diabetes, asthma, and heart disease.

How did Atown and Bville get so different? Well, in many cases in cities and towns across California, the root cause was racial and economic discrimination. Over the generations, poor white people and people of color were pushed to less desirable parts of town, where banks refused to lend money, businesses left, jobs too, schools declined and the neighborhood crumbled. Everyone who could move away did.

And what's more, when communities like Atown and Bville are so unequal, Bville isn't the only one that suffers because it turns out that not only is your zip code a predictor of how long you'll live. So is what country you live in. Countries with the greatest income inequality have the lowest life expectancy. So even Americans like Deb who are white, insured, college-educated, and upper-income die younger than their peers in other countries. In fact, our life expectancy is 43rd in the world, and that number is slipping.

In the end, our biggest health risk may actually be inequality, and extreme inequality hurts us all. So what do we do? Well, if we're all going to be

healthier, we don't just need to help the folks in Bville they'll beat the odds, we need to change the odds for everyone. And that's what we're doing.

There's a movement happening. We're Californians. We don't follow. We lead.

[END PLAYBACK]

NICOLE AUGUSTINE: Sorry, that's the video. They go into a little bit about what they're doing in California specifically. But that video I think does an amazing job of describing the complexity of the issue and how it affects influences all. The reality is you could literally do this video for just about any state in our country.

And like I said again, this one was specific to California, but everything they talked about, about location and zip code is so true. You could do a map of your own state to see the same sort of equity, disparity, inequality issues in your state. And a lot of times it lines up exactly with health outcomes and substance use issues too.

OK. So I want to move now into our second objective of the day, which is really to think about the connection between ethics and equity. And I love this quote from Helen Keller that says, "until a great mass of people shall be filled with the sense of responsibility for each other's welfare, social justice can never be attained." And I really love that because to me that is the essence of why we do what we do, why we care, because we want to see the health and welfare of the communities we serve. and prove.

So I always like to tailor things back to the Prevention Code of Ethics. I am someone who decided to get certified as a prevention specialist. That's a whole another topic of the professionalism of our field. Not every state even has it as a mandate. But that is the history that I come from. So I always like to think about, what is the Prevention Code of Ethics? because to me even if you're someone who doesn't get certified, you should be very knowledgeable about our Code of Ethics.

And one of the very first principle in our Code of Ethics is non-discrimination. For those of you who do have the packet, the full information around non-discrimination is provided there for you inside that packet. But essentially if you understand what non-discrimination is, you can see why it is connected with ethics and why it's connected to equity.

The other main foundational concept for us in prevention that I think really solidifies why we should be talking about this work is our strategic prevention framework. Now, I do want to say there are many prevention planning models that exist in the world. For us, the one that's predominantly used is the strategic prevention framework. So that's why I mentioned this one.

But right in the middle of the strategic prevention framework has always been sustainability and cultural competence. And truly for me if we remember what competence and cultural competence means and the error and time that brought that about, the essence of it was to address some of the disparity issues that were occurring.

So for me this conversation about equity and ethics technically we should have always been having even under the umbrella of cultural competence. And if you are following spiff as the acronym we use for it, that means you are actually thinking about the ways in which you are culturally sensitive. You have culture humility, awareness, intelligence, cultural responsiveness, all the words that we use in every single component of your planning process.

And if we're truly doing that work you all, we can't help but to be thinking about equity. It's a part of what happens. And if you are doing your community needs assessment, think about it, and you're gathering all the data on the needs, the resources, the gaps, you're going to see the inequality in your community, whether that's based on income, whether that's based on geography or race, or whatever. You're going to be able to see that information if you truly do a comprehensive assessment.

So for me this is why it's important. And I think sometimes in this work we get into checking boxes, and cultural competence have become a concept of a box that we check to make sure. And I'm like, we've got to get back to our roots, which is truly looking at how we build equity into every aspect of the planning process.

So that is where we are shifting to now. And now is the time for us all to participate. I think I've talked enough in this session today. And we want to really begin to move into the action portion of this content. How do we do the work of embedding equity into prevention? There's this quote that I want to share by Napoleon Hill that I love. It says "knowledge has no value except that which can be gained from its application towards some worthy end."

And my personal call of action to each of you today is, how do we take this knowledge of what equity is and apply it to the worthy end of changing the

communities we serve, of reducing the burden of disparities in the communities we serve? That's the essence of what we're called to do.

And look, the years are a little fuzzy also. It might actually be the end of 2020, I did a partnership work with a few folks and the Region 9 PTTC. There were actually three of us that helped create this document, and created a document about structural racism and how us as a field can be of help and support to communities of color in a real true tangible way.

And so there are three action items that I want to share with you all that I think all of us can be engaged in, can have conversations around for action steps to really embed equity into the work that we do as first initial steps.

And so there's three things, the first is mandating and measuring health outcomes in the right way; the other is around strategically divesting, thinking about our money and our funds; and the third is about civic engagement. So what we're going to do is I will share each one of these action steps, provide a little bit of background on what I'm talking about when I'm talking about the action step, and then what we'll do-- let me go back to here a second-- then what we'll do, everyone you'll have an opportunity.

People will be randomly moved into breakout rooms. I'll give you just 10 minutes to talk amongst your breakout room about the particular action step that we're looking at; and then you'll have an opportunity to have a worksheet that we'll give you when we get there for you to put in for you in the next 30 days, what is your commitment to action on that particular topic? So that's kind of where we're going for the rest of the session today.

So our first action step is really looking at health outcomes. And this one connects back to data, and this is recognizing that racism really has had a fundamental cause of health outcomes in our country. If you remember the video and they talked about how your location of where you live matters, we live in a particular country in space where in addition to location affecting things like economics, you have an added layer of race. And so a lot of the times you'll find that in addition to seeing things health outcomes based upon income, you'll also see disparities that are based on race and racism too.

And so that's why I have here the definition of what structural racism is, that way folks can understand that it's a system in which our public policies, our institutions, our practices and other types of norms often perpetuate and keep going the inequity issues. And I think that sometimes is what makes structural racism difficult to see because there is a bigger system happening that's kind of, if you will, turning out these results; that we have now assumed are just the

characteristics of a community and not that they are a response to structural issues.

The last part of this quote says, "it is come about as a result of the way that historically accumulated white privilege, values, contemporary culture have interacted to preserve gaps." That's what happens, is the gaps get preserved between white Americans and Americans of color. And so this is a topic that honestly is often sensitive for us to talk about as a people and as a country, but truly unfortunately is the root of a lot of our disparity and equity issues. And so we've got to get to a place where we're uncomfortable and are comfortable being uncomfortable until we get past and through these sorts of conversations.

So now we will have our first opportunity to have a breakout room discussion. And what I'd like for you all to do is as we move into these breakout rooms, you'll have just 10 minutes, which is not a lot of time, just 10 minutes to talk about what your thoughts are around how we look at our data in a way that helps us actually find the health equity issues, find the disparity issues. Feel free if you have experience already having looked at your community data in a way that helps you see disparities, to talk about that and to share with your colleagues on how you made that first step.

Remember, the poll that I took at the beginning said there are some of you who are like, I absolutely understand and know this work, but there are some of you who said I get it, but I'm not sure how. And sometimes the very first place people get stuck is looking at the data that shows that the disparities exist in your community. So we want to first think about that.

So we're going to have folks go into your breakout rooms here in just a minute. And what we have too, which I'm trying to think if we should put this in once people get into the breakout rooms, we made a Google worksheet for this, to give everybody an opportunity here to make a statement about what you think you could commit to do. What's, let me ask you, are we putting the link in the chat after people go into the room?

PRESENTER: We actually need to put it in now because once we go in, you can't see it. They just put it in.

NICOLE AUGUSTINE: OK, perfect.

KRIS GABRIELSEN: There you go.

NICOLE AUGUSTINE: Perfect. So that link you all, that will take you to a Google Sheet that everyone can see. Have your conversation, talk first, and then you'll get a warning sign about one minute before the room closes, and just take a minute to think about, what would I do in the next 30 days on this particular topic?

So if we can get moving into the breakout rooms. And before we go there, I just want to say, I think someone mentioned it, the break room panic. So we already know we're going to lose some of you all, and that's OK, but for those of you who stay I look forward to coming back together after we have our short breakout.

PRESENTER 1: So a couple of things to mention, if some of your other group members don't have the workbook handy where the prompts are and things like that, one of the team members could share their screen if they're able to bring it up if that helps your conversation; and also if anyone has any questions or issues while you're in the breakout room, there is a call host button. It's typically located in the bottom left. Click that and one of us can pop into your room and check in and help out. So we'll see you back here in about 10 minutes.

PRESENTER 2: Being recorded.

NICOLE AUGUSTINE: OK, y'all. So look. We try to use technology. Now, who's going to admit to deleting column one?

[LAUGHTER]

It looks like column one accidentally got deleted on our sheet here. We'll figure out how to get it back because I think Google does save versions. So hold on one second.

PRESENTER 3: Try clicking Undo and see if that just doesn't pop it right up.

NICOLE AUGUSTINE: Yeah. I was thinking about that. I think one of the tech folks is going to work on that for us. We lost our column one.

I did notice some folks had responded and had some things put in there. So let's just do this since folks have come back into the space. Feel free to use the chat to write any thoughts or comments you'd just kind of like to share

thinking about data differently and how your personal plan to look at data and evaluate a little bit differently moving forward from here. Just send them a view here. I'm checking out the chat.

Yes, I know. I've thought about Google Docs and the whole space. And when you lose stuff, you lose stuff. But at the same time, Google does do a great job of saving versions of it. So I think we can find the version right before we lost everything on there.

KRIS GABRIELSEN: Nicole, I wonder if we could have people just put it in the chat box what they entered in as their action item, so we can see a few of those at least.

NICOLE AUGUSTINE: Yeah, let's do that. Thank you, guys. We appreciate y'all working with our technology.

KRISTINA SPANNBAUER: I just want to say I am stepping back through the versions right now. So I just have to find the one that was where it got deleted. So I think I have got it fixed. It'll just take me one more minute.

NICOLE AUGUSTINE: Perfect. Thank you so much. OK, great. Thank you all for the comments here.

Yeah. I'm just really hopeful y'all are reading some of them too. These are great. Yeah. And like I said, we're going to dive deeper into data on the fourth session because I think data is one of our biggest challenges as a field, yet it's instrumental for us having the information we need to create the changes we need to create. And I think that's the biggest challenge that we're experiencing around data.

So let's move on to task number two that we can be a part of. And this one I will admit to you all, this one is more challenging. This one requires not just us, but having conversations with the powers that be organizationally, and number two is really focused on money and this recognition that money is an important concept of us getting work done too.

And so really what this is, is looking at taking a minute to evaluate some of your partnerships, your collaborations, and really thinking about, do the values, policies, and practices of your community partners align with your organization? Ideally if you are prioritizing equity, it should be evident in your work, in your approach, in your organizational documents, and it should also

be apparent in the work and documents of your community partners. And so really taking a critical look at our collaborations, and then thinking about, do the financial practices of our organization show that we support equity? And I don't know if we look at our finances from that particular perspective, but truly if we're going to be prioritizing equity, I think this work calls us to look at things a bit differently.

And the third question is saying, are we willing to end collaborations with toxic organizations? I think of our collaboration work the same as relationships. Some of them are healthy, but some of them are unhealthy. And sometimes when it comes to organization relationships, we are in unhealthy connections that are there because of the money you all. Everyone has seen things like that in situations like that. And so sometimes the work of equity does require us to really think about, are we willing to end collaborations that are not helpful or beneficial, or people who are not showing that they really truly care about prioritizing equity in action?

And so what we're going to do, we're going to talk a little bit about this one. How do we look at the money and the finances around equity? Are we truly evaluating our partnerships, our values, and our practices of our collaborating partners? And really to have a bit of a conversation discussion on what you all think we can do in this space.

For this one, just for my tech folks, we'll move the time to eight minutes on this one if we can do that. And then, again, our document I believe it's back in working now. So feel free to use the document. We're on column two now of looking at finances and money.

And I always preface this, a lot of times this is the conversation people have the hardest time with because a lot of times in our role, we know nothing about the money except that maybe a grant is providing our support for this. And so I do want to preface that we might find this conversation a little bit harder to have. But I do think we should be knowledgeable about the money stuff and start having more conversations with our leadership around money and equity issues.

So we'll go into breakout rooms one more time here, or our second time. And we'll move it to eight minutes, please.

KRISTINA SPANNBAUER: All right. Here we go.

NICOLE AUGUSTINE: OK, y'all. So apparently Google does not like us today. We're going to blame it on Google because column two disappeared again right near the end. So that's OK. We're going to blame Google for that one.

So hopefully that was-- of the few that I saw, I saw some people writing some interesting things in there. If we can like we did before, feel free to drop some of your comments that you remember saying into the chat here.

We are going to fix and repopulate this file because we want to share this with you all so folks can remember what you said would be a part of your commitment moving forward for the next 30 days. So again, unfortunate. I'm not sure what's happening with the Google Doc there and why it's not cooperating for us today.

But I want to shift you to thinking about our final action step, and we're going to talk about this one as a group. Essentially our last action step is focused on civic engagement, focused on advocacy. And if you're someone who is familiar with our Prevention Code of Ethics, this actually fits our domain six of the Code of Ethics, which I have here essentially saying that part of our work is to be proactive in public policy and legislative issues.

I don't know how many of you all are actively engaged or connected with any sort of professional association, an association that does advocacy work for our field and behavior health. And so a part of the actions and the ideas and the things that we can be doing as professionals is to get connected on this space.

I will say when I talk with professionals, when I've had conversations around advocacy, this is the area where people get the most nervous. And I think for two reasons. One, there's always this when you're in a 501(c)(3), a concern about lobbying because of the connection with funding; and I think sometimes in people's fear of not lobbying, they don't even advocate. And it's like even though we're not supposed to be lobbying, we definitely can engage in civic engagement and advocacy work.

And there are plenty of national organizations that do that. You're probably familiar with a lot of the national ones. And definitely take some time to find your local or state based advocacy group that is doing this work of looking at and understanding what's necessary for our field, but also conversations around equity.

I would say in general when it comes to advocacy, prevention probably-- I'll just say this. When I have seen advocacy groups and legislative work around the behavioral health field prevention, we happen to be the smallest and we typically are in terms of funding too when you compare in terms of our cousins in treatment, harm reduction recovery. So we've got to do way more work on the advocacy side, you all, so we get better funding to support our work and really we get better funding to support our work. That's the main thing. And if nothing else shows us that advocacy work, look at the big harm reduction grant that just came out. That's brand new from SAMHSA, a harm reduction grant. And that type of work we've been seeing it in the recovery spaces, the peer recovery spaces. And so us in prevention need to be doing the same thing.

And so I'm not sure, Kris, if we should even drop the link in the chat again for y'all to put something in column three. I would love for folks to, but maybe we just put it into the chat this time. I'm a little nervous about losing a column again. So maybe in the chat if you all can share some thoughts about advocacy, or if any one person wanted to even share their personal experience of being a part of advocacy and what that was like because I think not everyone does the advocacy part of our work. So feel free to use the chat, like I said, or if maybe one person wanted to say something I'd be totally open to another voice being heard today.

Just looking at the chat I heard a lot about-- yes, lobbying versus advocacy. That comes up all the time. Oh yeah, we got a hand raised. Awesome. Wonderful. I believe you can be unmuted.

KRIS GABRIELSEN: We should be able to unmute you. Yeah.

PRESENTER 4: Awesome. So when I first got into tobacco control, I used to kind of oversee a state program that was an advocacy program for youth. So we took middle schoolers and high schoolers and kind of gave them a little bit of training on what advocacy was and how best to do it. And then they would go and advocate to lawmakers, to other students, to their school, to younger students. So it was a really successful way to engage the young people, give them some leadership training skills. And it was kind of youth led. They chose what they wanted to do. So that's a really great way, is to use youth.

NICOLE AUGUSTINE: Listen, absolutely. They're a lot of times way more effective than we are. And some because when you really empower a group of youths to do this work and they're the ones doing the voice, they receive a different level of respect I believe, mostly because folks are fascinated by the fact that a group of youth are speaking up on things like this. So that's a really great example to share with us today. Thank you for that.

Wonderful. I see some folks writing some things in the chat around advocacy, their experience. I really appreciate you all sharing the ways in which you are doing this work. And I really encourage folks not to be afraid of that advocacy part. I do know there are folks-- and I think Vanessa mentioned her own limitations because of her employment, but finding other ways that she helps and contributes. So be thinking about that. National organizations you can be a part of who are able to advocate for the field specifically, which is always good to do.

Yes, I see another hand raised. And I'm sorry, I can't see the names. My thing is not showing names.

VICTORIA SILSBY: That's all right. This is Victoria, and I've been doing this work since 2009, and one of my fears was policy work, and then finding that because policy work usually involves talking with decision makers. Decision makers are usually elected officials, and then we go down that fine line of advocacy lobbying. And so one of the words and processes that helped me was to use the word educate instead of advocating or anything.

So there have been times when I might be in front of our town board and I use the word educate in three sentences 50 times, just to make absolutely sure that everyone at the table knows that I am not lobbying, but I'm not telling them to ban whatever, but that I'm here to educate on why smoke-free parks or why ordinances or whatever it is has a trickle down effect and improves the overall health of a community.

NICOLE AUGUSTINE: Yeah. Thank you so much for sharing that. I mean, that's extremely helpful. And I would agree focusing on the word educate does a lot. You know what I mean? So thank you for sharing that. It was great.

Good. Good. So that's our three action steps, you all, of what are some of the things we can be doing, how we look at our data, how we look at our finances and collaborations and our civic engagement.

These are three areas that we can be thinking about and working on. I love the different ideas folks have shared because I did see in the chat there are multiple people who say because of their job and because of where they were that there are restrictions.

And so I thank folks who've been sharing other ways you think about and getting connected and finding a way to support the space of policy action because policy action is one of the strategies that we use for creating environmental changes. So thank you all for that.

As we begin to come to a close today, we've talked about a lot of things. I want to share a closing thought with you all here because something that's become important to me that our training opportunities move beyond the hour and a half that we have together. And so there's a quote by Thurgood Marshall who says, "where you see wrong or inequality or injustice, speak out, because this is your country. This is your democracy. Make it. Protect it. Pass it on."

And so I want to kind of leave that with you all of making sure that what we talked about today doesn't end today. Shared with a colleague, shared with a friend, begin to have conversations about how we're thinking about our data, how are we thinking about our collaborations, what are we doing as an agency to promote prevention and wellness and educate policymakers, and really beginning to have those type of conversations as an agency.

I want to just share my information with you all. I'm always looking and excited about opportunities to connect with folks. If anybody is on LinkedIn, feel free to find me on LinkedIn. I did just drop my LinkedIn in there. I'm happy to connect with folks.

I think some of what we should be doing in the field is more just peer to peer talking and sharing and what's happening. Since the pandemic has happened, how we do prevention has changed. And I think the more and more we have conversations with each other and talk about how we're doing this work, the innovation we're doing, I think that's something that we can all benefit from. And so I truly appreciate you all's time today and having this discussion, and I hope you all will join us for the other sessions that are happening. What I want to do is pass it over to Kris to kind of do a few closing things before we end today.

KRIS GABRIELSEN: Great. Thank you so much, Nicole. Really appreciate all the information you pulled together for us and the excellent way that you delivered it and share the information. Thank you so much.

We have an exciting opportunity for you all. We are going to pilot a new kind of option for you to follow up on this information through what's called a Whisper Course. And the idea behind Whisper Course is that research shows that within an hour of finishing a training, of attending a training, we typically

forget 50% of what we have heard. So this wonderful information that you just heard from Nicole, on average, people are going to forget half of it within an hour. So we are looking for ways to help bring this information back to you to stir up those memories and also to apply it.

So the idea behind a Whisper Course is, hey, remember what Nicole said kind of thing. But really short emails, a couple of sentences, a reminder about some content, and then a couple of action items that you could take that day to apply that content.

So in the chat box is a link to register for this Whisper Course. You have to do it separately from this training. So it doesn't carry over. So if you would like to do this, go ahead and click on that link and fill that out. It's five emails over the next two and 1/2 weeks. So it's the time between now and part two of this health equity series.

So highly encourage you to sign up for that. At the end of it we are going to send an evaluation form, just a short questions to answer just to see how well it worked, and then we'll keep refining how we do the Whisper Course.

The other thing I wanted to share and encourage you to do is to continue this conversation on the Great Lakes PTTC Facebook page. Another way that we're trying to get people to continue to think about the information is to stimulate discussions on our Facebook page. So if you go to the Great Lakes PTTC MHTTC page, it will look like this. I encourage you to click following-- or it will say Follow, and If you click it, it changes to Following, and like it, and then if you use Facebook, then it will pop up on your feed our post over time.

I did create a post during this session, or it got posted during the session specifically for you all. So if you could go in and share your thoughts on that post, it would be fantastic to see what you share on there.

One other thing that is going on right now is on our Facebook page, if you are interested in attending the Ethics in Prevention moderated course, it's very hard to get into. It's the national course. Usually it fills up within an hour or two of it being posted. People have felt very frustrated trying to get in, which I understand. We were given for the course that we are going to be funding we're paying for it of Great Lakes, we were given six slots to fill. And we're like, well, how do we choose who gets those six slots? So we thought, well, let's just do a fun drawing. So if you're interested in attending that training and want to be included in the drawing, go to the Great Lakes PTTC Facebook page, just put your name and your state, and then we'll do the drawing the

week of January 17. So just something kind of fun, but also if you're interested, it could be a way to possibly get a spot in the course.

And the last piece of closing information is as usual, if you please, please please, please, please fill out the very short post-webinar or post-training feedback form, that would be great. Three questions real quick. And then if you do that, after you close that out, you will actually be redirected to the Great Lakes PTTC Facebook page, where you can go in and comment on that post. And if you wanted to enter for the ethics course drawing, you can get on there. So will just take you right through there.

Does anybody have any questions before we wrap this up? And I see a question. In terms of the drawing, Steven, if that's what you're asking about, the winners of the drawings do need to be in the Great Lakes region. So within our 6 to 8 Region.

Any other questions? Feel free to unmute yourself and just ask or you can ask in the chat if you'd like. I know we're a minute overtime. Hearing none, thank you again, Nicole, for the wonderful training you delivered today. Thank you also to Kristina, Ann and Stephanie who worked behind the scenes on this training. Really appreciate you all. And I hope to see you all again at part 2, which is January 24, as well as part 3 and part 4. Take care everyone.

NICOLE AUGUSTINE: Bye, everybody.