>> And I started to think, probably because I've got kids
and I watch a lot of animated movies, I started thinking
about it as-- as a-- as a little bit of a cartoon.
Well what happened in the frames before those images?
And then what happens in the frames after those images?
And the reality is that in the frames before a group
of people got together and built that fence

and they created a barrier.
And a group of people got together
and they built those boxes.

And then right before the frame for health equity somebody came
in and said, you know what,
we need to build some different boxes because some
of these folks are not getting well served by the boxes we have
in place, so we either need to dismantle those boxes
and build new ones or we need to build some extra boxes upon
which those folks can stand.
And the thing that it says to me is that the fence
and the barriers and the boxes, which are the enablers,
those are conscious decisions that we make as a society,
that's why we call them social determinants of health;
they're social and they are determined,
they don't happen by accident.
And we've been making these choices
for however long we've been around, 250 years.
We create these things with conscious,
population based consensus decisions,
and just as these fences and barriers
and boxes can be built they can be unbuilt and rebuilt.

So whether it's Success By 6 or the Brain Trust for Babies,
whatever box you want to build, you've got to look seriously
at the systems that build those boxes and the people
that we work with to build them together
because we've either got to bring that fence down or get rid
of it so that everybody can participate in what's going
on on the other side or we've got to build more and different
and targeted boxes so that we can get folks up so they can see
over that fence, right; it's one of the two,
either build some boxes or get rid of that fence.
And the important thing--
and the reason why I think it's an exciting time to be
in public health is we get to have this conversation
and we get to think about consciously taking down barriers
and consciously building enablers
that will improve our health.
And the thing is for public health, especially now
as we've seen our progression
into public health three point zero,
is that we can't do it alone; the fence is too big,
the boxes are too complex.
We've heard about reading, right;
public health isn't going to do that alone.
We can facilitate, we can build consensus,
we can collaborate, we can convene.

So, my question to the panelists is what are the potential
stakeholders and the sectors that public health can--
can work with to build kind of this health
and all policies approach to help bring those fences down
and build those boxes.

>> So I would recommend first, as you suggested,
is that we take this
as a conversation beyond public health,
beyond just our traditional partners in HHS.
With several of our demonstration programs
in OMH we've actually partnered with the Department
of Education, with the department with housing,
partnered with-- with justice,
because there are several demonstrations
when we're looking at,
and I know CDC has a national center on--
on injury prevention, so I recognize that.
But two years ago when we were examining a way
to address actually decreasing school absenteeism rates,
addressing the rates of out of school suspensions
because we know primarily by the time when we look at urban areas
and public schools and we look at the disparity rate
of suspensions with African American
and Latino males what we see is in some cases a two-fold,
a three-fold, rate in terms of disparity.
And so with designing or developing the demonstration
or the funding opportunity announcement we partnered
with the different agencies that traditionally
when we build these demonstrations we generally talk
to each other, and that can be great,
but this problem has grown bigger and we really need
to work with some of the other policy experts in the area
and evaluators to identify what's currently being funded
out there; where are some of the other challenges and be able
to build those partnerships so that we have joint announcements
and we can actually build much stronger programs
and we can assist the projects, the communities, that we fund
to actually have a more robust and program or intervention,
but also to ensure that when the funding ends for the project
that one, the communities, one on the data;
that's very important.
Secondly, that the projects are structured
so that they can continue, maybe not the entire project
in its entirety but perhaps what the essential elements are
and that we leave the community in a better place
than when we started, so that's--
>> I'll just-- I'll add to that with what we've always done
under leadership of Dr. Fitzgerald at the Department
of Public Health was look at our approach always
as a public private partnership,
because we know we can't do a lot of this work alone.
So we started that with our Georgia Shape initiative,
which is the governor's childhood obesity initiative,
and then that continued into work like the Brain Trust
for Babies and looking at, kind of, untrad--
traditional partners, but then also untraditional partners

like the Department of Juvenile Justice.
We work a lot with Early Care and Learning, what you think
of traditionally as a daycare.
Face ba-- faith based communities
and advocacy organizations, which are I think critical,
especially when you're think of yourself;
if you're a government agency we can't always go
over to the Goal Dome and advocate for policies
that are good for babies and good for children.
We provide data, we can show that it's good, we can advocate.
So having those relationships with advocacy organizations,
the ones who can really go down there and get in front
of legislature-- legislators and help move stuff along,
move policies along I think are critical in this kind of work.
>> Yeah I-- I think it's interesting and just emblematic
of some of the changes happening out in the field
as we work closely-- have been working closely
with a major Midwest city on some of their policy initiatives
and the latest two priorities for the Health Department
and the city was, number one,
changing the enforcement mechanisms
for their housing code, and this is the policy he--
this is the head of policy for the Health Department
in the city; working
on the enforcement mechanisms for the housing code.
And once they worked on that the next one was payday lending;
that's coming out of the Health Department.
So working cross sector analysis there's-- there's research--
there's a really good paper that came out late last year,
some of you are probably familiar with a guy by the name
of Glen Mays, works with the University of Kentucky,
and he and a-- he and a team looked
at how jurisdictions were working cross sector and came
up with a metrics to determine the extent and the quality
with which that collaboration was taking place
and found statistically significant positive health
outcome effects by jurisdictions that work across sectors.
So this idea of collaboration and working
with non-traditional partners for public health, I think,
can have real world impacts
and hopefully bring a health equity to-- to the forefront.
So I know that-- I think we're right at time
so I don't know who's-- I think we're done.
[Applause]
>> Okay, I know we are kind of out of time but I do--
would like to ask quickly if our--
if our panel persons could come up to the--
to the-- to the table.
We know we haven't had time for any Q and A from the audience
but we would like to just have just a few minutes
for any final Q and A from our audience.
I would like to ask the-- our current panel,
our six panel members, yeah, to come back up.
Yes.

And you may have to-- you may have to share the mic.
So-- so the floor's now open for any questions

for our six panel members.

>> It doesn't matter where you sit.

>> Good afternoon.
My name is Fentrss Truxon and I'm with the Diversity
and Inclusion Management team here at CDC in the Office
of Minority Health and Health Equity.
I want to say way to go Dr. Liburd,
another great forum; I learned a lot here.
And my question I was looking at the mortality rates and I guess
about in 2008 when I was sitting in Arizona and Arizona started
to embrace diversity and inclusion one of the things
that came out that was a catalyst was the Public Health
Department talking about mortality rates, particularly
for not only adults but in hearing the morticians talking
about the death of babies.
My question to you, I heard you, I believe Dr. [inaudible],
talk about working with institutions, hospitals,
but I'm not hearing you all talk about anything
or what you're doing with the workforce that's
in these hospitals that are treating all kinds of patients
and if that possibly is something we need to focus more,
not only from a D and I perspective,
which I'm already clued in that we need to,
but are you seeing a studies or anybody talking about work
that needs to be done to help people deal with patients
that are coming in with cultural differences
and they dress different, they look different than you
and why they are treating those patients differently instead
of a gold standard for everybody.
>> It's a great question.
There is something called the CLAS standards,
cultural linguistically accessible services,
which comes out of HHS, and any institution
that accepts federal dollars is supposed
to have implemented these.
I don't think they're enforced at all, but they are getting
at what you're looking at in terms
of interactions with patients.
But overall, I think the first thing each of us needs
to do is look at our institutions
and are we diverse and inclusive.
Now that's something that we're starting to go--
undergo in the March of Dimes
because historically they have a history of promoting from within
and keeping people for 30 years
and therefore the workforce sometimes looks
like the workforce of 30 years ago, so very deliberate efforts
to become more diverse and more inclusive.
So we all have to do it; we have to make sure
that there are programs to move people from communities
into these roles so that they are culturally sensitive,
they know the community and I think-- I'm not an educator,
my wife's a health educator; there are a number
of programs supporting bringing underrepresented students in
and providing when necessary support services to them

to make it through, but we're not doing nearly enough
and I don't--
>> May I just add something to that?
You know, so we're in the Bronx and I'm the minority
as a white person in the Bronx
and our workforce reflects our patient population and some
of the worst interactions occur between Puerto Rican
and Dominican, right, and from our perspective they're both
Latina and they understand each other's cultures and--
and just having a diverse workforce it's a piece of it,
but I think what we're now be--
starting to call trauma informed care is a really critical
secondary piece of it; helping folks understand how critical
those interactions are and trying
to change the conversation from what's wrong with you
to what happened to you
and understanding vicarious traumatization
and all those things because we're seeing a lot
of really difficult interactions within cultures that goes deeper
than just getting-- you know, getting the right--
the right group in the room; it's also then training them
and giving them some self-care techniques
and some understanding of the impact of that relationship.
>> Thank you all for your serv-- leadership work.

>> My name is Tara Hurley; you'll have to excuse my voice,
but for Miss Cobb-Souza, you were talking
about the different programs that you all have in Alabama
and how prominent they were; what are the possibilities
with all the budget cuts of these programs being implemented
through Georgia in the rural areas?
How do we implement programs such as these in a rural area?
And I know Georgia's the banner,
but a lot of the rural area have gone satellite
and all the major, like, family and children programs their--
the major offices are in the largest city
in the parameters of the rural area.
So how do we get these promoted in rural areas
with all the budget cuts?
Where does this funding?
How do we find this funding?

>> So I'm going to provide some suggestions,
and I wouldn't be able to speak to the budget,
the current federal fiscal budget, but let me just say
that in terms of our funding opportunity announcements
when we actually develop them we take into consideration
that we're going to receive a huge response
from both urban areas and what we refer to as mix
and also those mic-- micropolitan, the smaller areas,
the rural areas, and we ensure that when we develop that set
of standards and the requirements for applicants
that we-- we develop them with specific indicators
and specific descriptions so that an applicant that's coming
in for a rural area will also have a chance to compete fairly
with that from an urban area.
The most recent example is that our office was asked

by the secretary to develop a funding opportunity announcement
for this past fiscal year, fiscal 2017, and we were tapped
in the spring, which I believe late April this year,
to develop this announcement to actually fund communities
to address the three focus areas, first being opioid abuse
or opioid overdose; second, to address childhood
and adolescent obesity; third, serious mental illness.
Now while we developed indicators for each population
and communities we knew some things and that is, you know,
with my tapping my colleagues from various centers at CDC
and from SAMHSA and also from HRSA that not all cities
and not all states report overdose rates, okay, first,
so that if we had designed the FOA, and I'm just using this
as an example, if we had designed the FOA
where an applicant would have
to actually report their overdose rates based
on x per population then the chances would have been greater
than only the urban areas would have been able to come
in because of the reporting and they could validate those rates.
For rural areas we provided them with examples of other sources
of data and the type of information
that they could submit so they also could compete.
Now we did that for opioids and also for childhood obesity.
And so out of the eight childhood obesity projects
that were funded, and they're for young children,
I would say that close to half, if not greater than half,
are serving a population that's more rural
and not your larger urban areas; so that's just one example.
I wouldn't be able to speak to the state decisions in terms
of their determination of which focus area
and which geographic population that they would like to select,
but what I can say for many
of the state partnership initiative grantees what they
did is actually identify urban area and also a rural area
because they understood the challenges of those rural areas.
And in many cases, a contract that they could engage
in with a local health department
or community health center
or federally qualified health center of an amount of $50,000
that investment in a rural area can go much further than it can
with an urban area where you're competing
with multiple priorities in that setting.
So I don't know if I've answered your question
but I can't speak specifically to, you know,
budget cuts whether at the--
>> You did answer with my question,
and with that being answered would that go
through our city counselor, our family children services,
what government intergo at the local level that I would reach
out to contact to see if any implementations can be taken?
>> So I would say as a federal staff person we first have
to be mindful of what restrictions we may have
when it comes for to advising, informing, advocating for
or encouraging non-governmental entities to compete
for competitive funds.
>> Yes ma'am.
>> So, in our office we have a resource center

and so we encourage-- that-- that last slide that I had up,
there is a link there and so we encourage members
of the community to sign up for newsletters
and for electronic updates because not only do we send
out e-blasts for federal funding opportunity announcements,
you know, there are also announcements for funding
from foundations and also they're--
they're combined announcements, so that information goes
out in terms of HHS funding forecasts for the fiscal year;
we send the electronic updates out to everyone that signed
up on the list, we include it in newsletters
and we also post it to our website.
So if there are persons in the community that you work
with I would strongly urge you to have them to sign
up for the e-blast, make them aware
of the HHS grants forecast,
and then from there I would say you'd want to consult, you know,
your-- your supervisor or those higher up in terms
of what are the next steps.
But we just have to be mindful of our role when we are advising
and informing the communities, whether or not it goes beyond
that sharing that information and directing them
to take some other advocacy type role.
>> Thank you so much.
>> Okay.

>> Do a final big round of applause
for all of our presenters.
[Applause]
>> So I want to ask for all of us who remain to stay
because you made it through [laughter] a lot.
You know we plan these forums we, you know, we're always--
we know we want to get a certain amount of things covered.
We know it's extremely difficult to hold CDC people
for like a whole day, especially when we're at home
because the temptation of going back to the office
or maintaining your regular schedule is-- is always there.
So I want to thank everyone who is here.
I see our dear colleagues, Dr. Richardson and Mildred Thompson
with Health Disparities; sub-committee we mentioned all
of you earlier today, welcome welcome.
But I just want to thank our-- our presenters.
We were able to pull in today the leaders in this--
in this field and they made a lot of adjustments
to their schedules to be here and I deeply appreciate that.
I always appreciate my colleagues from CDC
who come no matter-- we call, we say can you help,
the always say yes, and so I wanted to publicly thank them.
Thank Coleen Boyle for being here and for her participation.
Yes yes. And so, anyway, with that,
I just want to bid everybody farewell, stay well,
we'll see you again next year and I want
to thank all my colleagues in the Office of Minority Health
and Health Equity who rallied to bring today together
and a special thanks Captain Wilkins who has steered us
to this day from the beginning, so thank you so much.
Thank you everybody.

[Applause]