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TEACHING PUBLIC HEALTH: HEALTH EQUITY FOR ALL
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>> SANDRO GALEA: Can you hear me okay? You can hear me? Good. I see you nodding your head. Excellent. All right. Good morning, everybody. My name is Sandro Galea. I have the privilege of serving as Dean of the Boston University School of Public Health. And on behalf of our school, welcome to this Public Health Conversation.

This is really a hybrid conversation. Most of the speakers are in St. Louis, Missouri. There are more than 1,000 of us from around the country and all over the world. I'm actually calling in from California, where I am in another meeting. It is wonderful, however, to be able to connect virtually to welcome everybody to today's event. Thank you for joining us.

Thank you for our co-host, the Association of Schools and Programs of Public Health, and to the intellectual architects of these conversations, our Associate Dean for Education, Lisa Sullivan, and ASPPH's Director of Education, Elizabeth Weist. And thank you to the Dean's Office and Marketing and Communications team, without whose efforts these conversations would not take place.

This event is the fifth installment of our Teaching Public Health series, which began in 2018. At these conversations, we welcome speakers to discuss how public health pedagogy can evolve and adapt to help the next generation shape a healthier world. Today, we will discuss a topic that is ever more relevant

to the core mission of public health: How public health education models can more effectively advance health equity. In doing so, we will build on the themes raised by ASPPH's initiative, Framing the Future: Education for Public Health 2030.

The event will be divided into two panel discussions. The first will engage with the theme "Charting a New Course: A Transformative Agenda for Education in Public Health." After the break, we will reconvene for the second panel, "Leading the Change: Challenges and Opportunities in Academic Public Health." I look forward to learning from all of our speakers as the day unfolds. It is always a privilege and pleasure to do events and partnerships with ASPPH, and in particular, working with Laura Magana, President and CEO of ASPPH. Thank you for your partnership and leadership. I will turn it over to you now for remarks.

>> LAURA MAGANA: Thank you for joining this exciting conversation about Teaching Public Health. ASPPH is proud to co-host this meeting in collaboration with one of our members, the Boston University School of Public Health. As an association representing 143 accredited schools and programs of public health, training the public health workforce to protect population health and achieving health equity for all is at the center of what we do and is at the center of our Strategic Plan 2030.

We are living in historic moments where everything in our life has been redefined -- the way we work, the way we live, and of course, how and what we teach. The pandemic and the other social, economic and political forces have forced us to rethink education and practice. Higher education has been challenged to redefine its role in society. Health professionals' education has been challenged to focus more on the conditions that make people sick or healthy in the first place. And public health workforce has been on the spot in such a way that we have lost 50% of our governmental public health just in the recent years.

I can't think on a better time to come together as a community of educators to talk about these challenges and to opportunities we have to create a better future. Today's conversation will highlight some of the work of the ASPPH Framing the Future 2030 Task Force. Framing the Future envisions equitable, quality education in public health for achieving health equity and well-being for everyone everywhere.

The task force is exploring three key areas that will shape the future of education in public health: Number 1, inclusive excellence through an antiracist lens; Number 2, transformative education and pedagogy; and Number 3, expanding the reach, impact and visibility of academic public health.

I want to thank all of today's panelists for sharing your expertise with us, and I hope that all of you in the room and online will actively engage in all the conversations.

Now I'm pleased to introduce Lisa Sullivan, Associate Dean for Education at Boston University School of Public Health and Chair of the ASPPH Framing the Future Steering Committee, to lead our first panel. Lisa's co-moderator for the second panel is Elizabeth Weist, ASPPH Director of Education. So, let's welcome Lisa to introduce the first panel. Thank you.

>> LISA SULLIVAN: Thank you, Dr. Magana, for that introduction, and welcome, everyone. This program will be recorded, and the recording will be posted on the BUSPH website. If you'd like to take a picture of this QR code, we can show it in the room. I think it's showing online. You can access the recording. It will be available in one to two days. Can we see it in this room as well? There it is. Thank you. Also, here is a QR code for easy access to the Framing the Future effort, where we continue to post our work in progress and welcome your feedback on that initiative.

It is now my pleasure to be moderating the first panel, "Charting a New Course: A Transformative Agenda for Education in Public Health." This symposium is part of our regular series, and this year is an opportunity to share work in progress and to gather your feedback on our Framing the Future 2030 initiative. This work builds on the original Framing the Future initiative and the work of many ASPPH task forces and working groups.

I have the distinct pleasure to work with several of the panelists on the Framing the Future effort, as they are part of our three expert panels: Inclusive Excellence Through an Antiracism Lens, which we see as foundational and essential to all of our efforts; Transformative Educational Models and Pedagogy, an opportunity for us to rethink how we train future public health professionals; and Expanding the Reach, Visibility, and Impact of Academic Public Health, which is critical for us to ensure health equity for all. We are at a critical moment, and as you will hear, we have some tremendous opportunities ahead.

I'd like to now introduce our panel 1 speakers. Unfortunately, our friend and colleague, Tricia Penniecook, is unable to join us today. We thank her for her willingness and preparation for this panel, and we will certainly engage her in future endeavors.

I am on a different slide. Can you go ahead one? In the room? Sorry. We're just having to sync ourselves here. Bear with us for one moment. Back. Hang on. There we go! Okay. Thank you. Okay.

First, we will hear from Amy Fairchild. Dr. Fairchild

serves as Dean and Professor of The Ohio State University's College of Public Health. She also serves as Co-Director of the World Health Organization Collaborating Center for Bioethics at Columbia Center for the History and Ethics of Public Health. Dr. Fairchild is a historian who works at the intersection of history, public health ethics, and public health policy and politics, and is co-chair of the Framing the Future expert panel on Transformative Educational Models in Pedagogy.

Second, we will turn to Leah C. Neubauer, an Associate Professor of Preventive Medicine, Division of Public Health Practice at the Feinberg School of Medicine at Northwestern University. Dr. Neubauer also serves as Associate Director of the Program in Public Health and Director of Educational Advancement and Accreditation. As Associate Director, Dr. Neubauer works closely with the Institute for Public Health and Medicine leadership, the Program Director, Degree/Concentration Directors, and Professional Staff leaders to provide strategic vision, leadership, and oversight of all Educational Advancement and Accreditation-related initiatives across 13 degree variants. Dr. Neubauer is also a member of the Framing the Future expert panel on Transformative Educational Models and Pedagogy.

Then we will hear from Dr. Laura Linnan. Dr. Linnan is Senior Associate Dean of Academic and Student Affairs for the UNC Gillings School of Global Public Health and is a professor in the Department of Health Behavior and Director of the Carolina Center of Healthy Work Design and Worker Well-Being, one of ten NIOSH Centers of Excellence in Total Worker Health. She has more than 30 years of experience as a public health researcher and practitioner who works to eliminate chronic disease inequities with multilevel interventions designed and delivered in collaboration with the intended beneficiaries of these programs, policies, and/or environmental supports.

Finally, we will hear from Trinidad Jackson. Dr. Jackson is from St. Louis and currently resides in Louisville --

>> AUDIENCE: Yeah!

>> LISA SULLIVAN: And currently resides in Louisville, Kentucky. He is the Inaugural Assistant Dean for Culture and Liberation and is also an Assistant Professor at the University of Louisville School of Public Health and Information Sciences. Dr. Jackson is also a member of the Framing the Future expert panel on Inclusive Excellence through an Antiracism Lens.

For those of you joining virtually, please submit your questions via the Q&A at the bottom of your screens. For those of you in person, we will have you line up for questions at the end of our presentations.

It is now my pleasure to turn things over to Amy Fairchild.

>> AMY FAIRCHILD: Thank you, Lisa. Thank you, Laura. And

thank you, Sandro. And I, too, am really sad that Tricia's not here, but I'm glad to have the gift of one of her minutes.

So, I'm in the process of co-editing a book on public health ethics, and we're including a classic piece by Norm Daniels, Bruce Kennedy, and Ichiro Kawachi called "Why Justice is Good for Our Health," from 1999. It's nothing that I didn't know, but I'm struck as I'm working on this section that the serious discussions about social justice in this country really began in the early 1980s in the U.S. And by the 1990s, it was grounded in this really rich, powerful epidemiological evidence that was undeniable.

And here today, in 2023, it's not just that we are still arguing the case for addressing the social determinants of health; we are standing in a moment in which U.S. life expectancy is continuing to decline. We are unique among countries in not having bounced back from the COVID-19 pandemic. We're going in the wrong direction. And in part, that's a function of our current social political context, but a longer social political context -- we've been becoming polarized and fissured for decades, at least since the late 1970s. It's in part a function of increasing attacks on science, the attacks on public health, and the attacks on the legitimacy of government. And for public health, that's a double whammy, right, because public health lives in a lot of places, but we don't have public health without governmental public health. We depend on governmental public health. We depend on the state. So, that attack on public health and that attack on government has a double impact on us.

And public health is under attack in a lot of other ways, too. We have experienced, health officials in particular, but I know people in this room have experienced threats of violence, have experienced actual violence, and that's mirroring broader trends in our society.

2021 data from the Southern Poverty Law Center are sobering. Consequential percentages -- and depending on the question, it's anywhere from 20% to 50% of republicans and democrats, particularly young republicans and democrats, and particularly men, but also women -- are open to violence as a legitimate political tool; they're convinced that LGBTQ individuals are a threat to our youth; and they are hostile to feminism, among other things. Those are just some of the highlights. And state and local health officials are on track to having lost almost another half of their workforce by 2025, and that's on top of what Laura pointed out, that they've already lost 50% of their workforce.

But part of the reason for our sorry state of health and sorrier state when it comes to health disparities, is because we

as a field continue to focus downstream. We are stuck downstream. That's in part a function of compassion. People have suffered. They need help. They need assistance. We have populations in crisis. It's in part a function of NIH funding patterns that have begun to recognize the social determinants, begun to recognize racism as a crisis. But the vast majority of funding is still going into clinical areas.

But we're also stuck downstream because in the public and the policy conversation, our field has a long history of retreating into science. Think about our mantras of the past years. Facts, not fear. Follow the science. And that fear of undermining science, in doing so, we don't do a good job of talking about the values that help us navigate how we determine what counts as evidence, how we account for conflicting evidence, how we make decisions in the face of gaps in evidence.

And so, my group, in terms of Framing the Future, is making the fundamental argument that we need to pitch a teaching camp firmly upstream. We need to do a better job of accounting for the politics of public health, the levers that control policy and have students and faculty members who really understand this and are prepared to grapple with that.

We need to emphasize communications. I'm not talking about health behavior communications, where we have a rich history, and I'm not diminishing health behavior communications either. I'm talking about communicating in the public conversation, communicating to policymakers, and that's a different kind of communication skills. And we're also talking about the facility to talk about ethics and values.

We work in a space of democratic deliberation, and that's a space of values conflicts. So, to begin to wrap up, one of the things I want to note as we talk about -- and we have some specific ideas for how we pitch that camp upstream, how we move our faculty upstream, how we move our students upstream -- but I want to recognize, this is also a moment in which higher education is under attack.

As of this morning, there have been 37 bills introduced that would in some way limit the way we teach, that are a fundamental attack on our values as a field. 37 bills in 21 states. When I did this two weeks ago, it was 35 bills in 20 states. So, this total is only going to continue to mount. Ten of those have passed. And four have been signed by governors. And mine is a state that has a pretty scary bill sitting out there, some version of which will pass. So, that number is going to continue to ratchet up.

So, at this moment, we could do what we've historically done and strategically retreat into science, to talk about our neutrality, to talk about our objectivity; but while the

consequential debate of our era is informed by science, and we need our science out there -- we need to be excellent science stewards -- science is not the subject of the debate that we're engaged in as a field. We are engaged in a debate about social justice. And we will not be effective as a field -- this is really one of the foundational conclusions of my group -- if we are not prepared to recreate ourselves -- and by "ourselves," I also mean our faculty, because I think in some ways this is the choir -- recreate ourselves, recreate our faculty, and then graduate students prepared to engage in democratic deliberation, because we have to be in that space if we're going to make the structural changes, the policy changes, that are going to affect population health at scale.

We have to be able to recognize morally salient values and priorities that are different from our own. In other words, we can't see all values conflicts as coming from a place of ignorance or a place of immorality. And we have to be adroit at shaping persuasive, credible statements about these conflicts and be explicit about our values and the way we see the world and interpret evidence, and we have to be determined to stick it out and stay in those conversations and look at that. I did so good, right? Stopped right at the zero mark. Thank you so much.

>> LISA SULLIVAN: Thank you, Amy. Up next is Leah C. Neubauer, Associate Professor of Preventative Medicine, Division of Public Health Practice, in the Feinberg School of Medicine at Northwestern University.

>> LEAH C. NEUBAUER: Good morning, everyone. I'm so delighted to be here to speak to and with, and invite you to consider what guides your decision-making about curriculum, teaching, and learning. I want to extend deep appreciation. Thank you, BU, and ASPPH, for the invitation. Special thanks to Victoria Wyant and Liz Weist for all of the support in getting ready for today.

I want to give a shout-out to my Northwestern colleagues. I get to do this work with you every day, and it's such a pleasure. I want to give a shout-out to Andrew and Adela, who are here in the audience, and several colleagues who are watching from afar. Last, my appreciation comes as an extension of my own legacy and a legacy of my own family.

I'm an alumni of Federal Trio programs, the Ronald E. McNair Scholars Program at the Pell Grant. You might think of this something like, she knows where she comes from; she carries it with her every day; and by extension, it honors the legacy of my first and forever teachers and mother. It's a legacy -- is my audio going in and out? Right? Okay. I should just keep talking, correct? Okay. I really worked on this one.

But it is, it honors a legacy of my grandmother and mother

and a story of migration from West Texas to Chicago and my own upbringing in rural Illinois.

For my brief slides today, I offer three points. A quick framing of context -- and my hope is for everyone here, I am doing justice to name what the last several years have been for us as educators and administrators. I'm going to briefly review a model and offer some definitions from my own home discipline. I am a critical adult educator, and I'll be sharing some of the thinking from that field today. And last, but certainly all the while, consider your own reactions and implications to what I'm talking about. This could be your own teaching, you know. What is she saying? Making me think about, and how might it inform my practice? And for those of you in the decision-making seat, although be it your own classroom, your own unit, your own department, or your own degree area or school, I invite you to consider the why and how of your own unit's practice, policies, and procedures.

Friday, March 13th of 2020, myself and colleagues received the note to head home and begin teaching remotely. In the weeks and months that followed, we all received and entangled and encountered similar messages. This piece at the top here came early in the spring of 2020, demanding our pedagogy be agile, demanding we be more responsive. Numerous documents, stories, letters, and opinions ensued in what we were taking on amidst teaching during the pandemic.

My longtime mentor, Ronald E. McNair Scholars mentor Gary Harper, circa '99, for Leah Neubauer, that relationship formed. And over time, we continued to talk a lot about teaching. We wrote "Teaching During the Pandemic" largely with two invites: One, to entail the need for trauma-informed response, but also as an invitation to examine why we were doing what we were doing, the how and why. Certainly, recognizing it came with a backdrop of emergency response. Specifically, it was the naming and the questioning of the pedagogical practices that we employ and also the consideration that what we do -- the social function of the university -- bears the power to potentially perpetuate inequities and bias already inherent in the way we're teaching, and also the opportunities or spaces that our students come from.

I recognize this model might not be showing up so well on the screen. What I'll call your attention to would be the three circles. We have students, instructors and professors, and academic administrators. While trauma-informed is centered in the model, in tandem with histories of racism and inequities, the three circles recognize the interrelationship, and sometimes disconnect, between our students, our faculty, and our academic administrators.

Who decides what and why? On the one hand, we recognize teaching and learning are often very much related to longstanding ideologies, missions, practices, or policies that long existed in the case of our paper and our thinking, long before COVID. Our paper quite specifically involved consideration for how you are developing the decisions that guide your teaching and learning.

I offer one framework and one way of thinking. You'll note potentially in the small print at the bottom that Silverman's work is 1970. This work that's now 53 years old lives on in many teacher training spaces and educational leader spaces with a simple set of questions: What guides what you do in your educational unit? How are the various elements of teaching and learning considered?

I also recognize that many of you may be using an educational philosophy or philosophies already. My intention in including it today, be it first consideration or reconsideration, is to name the role of institutions, educators, and administrators and thinking through both the thought of this work, but the action of this work.

In practice, what do you believe the purpose of your educational practice is? Why do you teach the way you do? Why are you using the textbook you're using? Who are the authors of the readings your course includes? Maybe the at a larger level, what do you believe the purpose of your concentration, degree, major, or unit to be? And how do you know? And also, what guides your educational decisions?

In closing, I offer these four points. There's no denying that the pandemic in many ways exacerbated what was already there. What was already there is a longstanding recognition that our teaching in public health is not static, nor should it be.

It invites consideration for what it means to be responsive to what's happening in the world and how it makes its way into our classroom or our community learning spaces. And at a deeper level, and potentially several other talks, it really invites us to consider how our choices influence effectiveness and sustainability.

I invite you and your own teams to consider the place and space, the reality of educational practice in your own teaching practice and your unit, and as a collective, the invitation and exploration to consider what our charge in academic public health is for the future. Thank you.

>> LISA SULLIVAN: Thank you, Leah. Now we'll hear from Laura Linnan, Senior Associate Dean for Academic and Student Affairs at the University of North Carolina Gillings School of Global Public Health.

>> LAURA LINNAN: Good morning, everyone. It's a pleasure to

be here. I'm honored to be part of this panel and part of the discussion that I know will follow today. My charge was to talk a little bit about education for life. What does that mean? And so, my plan for the day is to actually talk about what that means and then think about the transformations we might need to consider. Who are the learners we're talking about? Who are the teachers? And what should we be teaching with what kind of method?

So, you've heard some great ideas already to get us started. So, I'm going to just jump right in and talk about this notion of -- I had heard a lot about lifelong learning, but what is education for life? And Julio Frenk and others put together a really important paper -- two sets of papers on this topic. And they really picked out three components of education for life. One is learning throughout life, which is actually the idea that through our entire course, it's not just about we get our education, we do a job -- we, you know, work, have a job, and then retire, but really to move far beyond that and to think about all of the cycles that we're in as a continuous lifelong learning process.

But beyond that, there's also a second component, which is really the substantive information that we need to learn. And so, a second component of education for life is really what we study. What is our more traditional approaches to the kinds of curriculum that we might have, and so on, that we teach and that we learn from in order to be experts in a certain field.

And then, the third, which I think is a really important component, especially coming out of COVID, is that we think about education for life is individuals learning to live healthy lives. So, all of us have a purpose and a mission, and we know burnout is such an important part of what we're dealing with in our society and in our profession. So, thinking about how we actually think about education for life in that context as well. So, that's part of our education for life, these three components.

But there's been a lot of other work on lifelong learning that I think if we step back for a second and think about how it applies to public health, it could be very useful. So, thinking about long life learning thinks about this quote from Michelle Weise. So, we have to get about the business, we have to be the ones who will be affected, and so, we must get to the business of building the infrastructure. So, as you're sitting here today, think about the infrastructure. There's a lot of decision-makers in this room and online, I'm sure. So, thinking about, what is your role in building that infrastructure that's education for life?

There was also a really important report by UNESCO to talk

about the future of higher education. And they really found that while universities continue to prioritize academic programming, they are paying far less attention to this widening access. And when we talk about equity, we have to broaden access to education. And so, participation and broadening access is really important.

There's also a UN Sustainable Development Goal that recommends higher education institutions require a substantial transformation into a lifelong learning institution. And when they did this survey, they found out there were barriers to lifelong learning, things like finances, as you can suspect, but other things like no engagement with employers and many other factors that actually impact the ability of an institution to change and become more of a lifelong learning institution.

The idea of a 60-year curriculum is another idea that's been put forward that I think is really helpful for us to think about, is that the curriculum that we develop today is not just a curriculum for the little slice of education that our students are coming into, but really thinking about the life course and what are the different elements of curriculum we need to be thinking about in a 60-year curriculum.

So, why focus on education for life now? You've already heard our society is in a place where we need to be thinking differently about education. These demographic changes are coming where traditional students are no longer the age or the demographic that we are typically seeing in our institutions. We're going to have to broaden our focus. And work has experienced rapid changes. We need to adapt to what's happening in the work environment, as well as the technological advances that we're all experiencing.

Many of us started some of these in COVID, but it has expanded far beyond that. So, there's much more of a demand for this kind of a thinking as we move about putting our programs together.

So, what are the transformations we need to think about in terms of education? First of all, thinking differently about our students. We do have our traditional public health students that come to us, but we need to be thinking far beyond those students, the degree-seeking students, working public health professionals who want additional education, emerging public health leaders that we want to support and build up; community health workers who are out there on the front lines doing a lot of work -- how can we support them in our educational missions? Other health professionals who want a little bit of public health so they can be better in their own roles; and other non-health professionals, traditionally, like journalists and politicians and others. We need to think differently and

transform our thinking of what teachers are and their role. So, traditional public health faculty are committed to, we want those faculty to be committed to an education for life perspective. And that's not in existence in all of our institutions right now.

Recruiting new teachers by engaging with alumni, other practitioners, bringing them into our curriculum and getting them involved. And the role of teachers themselves is different, more of a coaching function, more of a facilitation function, establishing performance assessments differently, really thinking differently about the role of the teacher.

Transforming how we think about competency-based education. In public health, I think we've done a pretty good job of realizing we need foundational competencies. We also need specialized competencies, so we're really building our accreditation requirements and so on in that model. But then, these integrative competencies, which are ones we probably give less attention to that would be really helpful if we think about those -- emotional intelligence and thinking about how to talk about values, how to talk about the democracy issues that Amy was mentioning earlier.

So, what methods should we be considering as we're thinking about this transformation? Really using problem-solving, using case-based learning, real-world problems. I think we're all starting to bring those into our classroom. We can't avoid them anyway. But how we bring them in is so important.

Using the new, emerging technologies to be able to do a better job. How many of us are using simulations? How many of us are doing case studies, doing debates, doing modeling of any kind in our classroom of the kinds of issues that our students will be facing when they leave us? So, all different kinds of methods.

We need to think about our institution as well. So, working towards institutional changes that support education for life is going to be challenging. But again, as administrators and as decision-makers, we have a role to play in this. So, flexible learning pathways, this is a new word for me that I had not realized existed before, where we're really broadening the opportunity for people to come into our institutions in an open campus kind of format. So, we need -- this is an equity issue to bring people in who are part-timers, who are trying to figure out how to better themselves and their lives and do the work that they have a real passion for. But we need to provide these pathways, and there's many different ways we can do it. But only 66% of institutions had something of that nature in place.

And does your institution offer these kinds of digital learning, credentialing, other kinds of diplomas that are not

the traditional degrees? There's a few that are doing this. It's a growing field. It's probably the biggest growing field, actually. But we can do better and we can do more.

So, in summary, just a few points to take away and then I'm really looking forward to the discussion. So, using this education for life principles for transforming how we're thinking about our public health training opportunities and considering the three types of competency-based learning, rethinking how we think about students and learners, and integrating new technologies will really help us to build the kind of equitable approach to education that we all are striving for. So, thank you.

>> LISA SULLIVAN: Thank you, Laura. Our final presentation will be delivered by Trinidad Jackson, Assistant Dean for Culture and Liberation and Assistant Professor of Health Promotion and Behavioral Sciences at the University of Louisville School of Public Health and Information Sciences.

>> TRINIDAD JACKSON: Hello, everybody. That was weak. Hello, everybody!

>> AUDIENCE: Hello.

>> TRINIDAD JACKSON: Eight minutes. Does the consciousness of academic public health reign supreme, or is it dominated by supremacy? So, we live in an ideal, aspirational world that actually values humans and the sanctity of our existence. When we look at this image, it will resonate. We will see ourselves in this image, right? We would get it and feel the warmth of that sun. We will feel the support and the cultivation of those hands, saying, "Yes! Get thrive! Go be great! Enjoy your individual freedoms," also amongst your collective freedoms.

But this is the reality for many of us. Some of our identities, some of our communities are subjected to legacies of human rights violations, bondage, and murder. And so, how did we get here? Well, organized supremacy is how we got here. I have "white" in parentheses because I do want to acknowledge that supremacy has organized itself within societies historically, right? So, outside of whiteness, supremacy has existed. It's critical for us to note, though, that the current context of what we're contending with globally has been dominated by the culture of whiteness. And additionally, when people are primed to think about what the concept of white supremacy is, the default is potentially hate group, right? So, the KKK, for example, established in 1866 after the Emancipation Proclamation was ratified.

The issue is, right, when we think about Andrea Smith, who's added an additional conceptualization of what white supremacy is, it includes constructs such as slavery and capitalism, genocide, colonialism, or orientalism and war, so

"othering" people so that we have justification, quote/unquote, to remain at war.

And when people look to contend with some of these constructs, they do it from the perspective of distancing it in the context of time and geography, right? So, slavery, over 100 years ago. Get over it. We're past that. Colonialism. Good things came from colonialism, right? Europeans brought civilization and education and religion to societies who otherwise would still be living as savages, right? That's some of the revisionist history that the ruling class wants to maintain when we talk about learning critical aspects of critical consciousness, racial consciousness, et cetera. And so, when we consider constructs such as these, how do these constructs interface with academic and practice agendas for public health?

Well, according to Public Health's Code of Ethics, it is our duty, right? We are ethically responsible for using our knowledge, our skills, our experience, and our influence to promote equitable distribution of burdens, benefits, and opportunities for health. And we are also ethically responsible for engaging, disrupting, dismantling institutions, structures, that facilitate inequities related to voice, power, and wealth, right? This is in our Code of Ethics. And so, what does that mean, then, as one of my co-panelists mentioned, about the consciousness of public health? Where are we? How have we been practicing?

And so, this framework, right, it illustrates the consciousness of public health, what we have done and what we must do, right? So, we have done too much of attending to the risk behaviors, the disease and injury, the mortality, and putting the onus on people who are suffering from those at the most disparaging rates. Ignoring the ruling class, right, those that are creating the social and institutional inequities, and also the poor living conditions that we must contend with.

And so, if you look in that left category, social inequities, and we assess that for, well, who's the ruling class in each of these categories? Well, we know it's higher socioeconomic status. When we look at race and ethnicity, we're talking white dominance, again, white supremacy. When we're thinking about gender, we're thinking about patriarchy. And so, to what extent has the consciousness of public health contended with that disparity of who's the -- even within us, right? We're in this room and we're saying, we down for public health, right? We are the arbiters of what public health is, and its grounding in social justice. To what extent are we assessing and interrogating ourselves and getting out of the way?

This is a tool that I use in my spaces, especially

leadership spaces, where people are making decision. And it demands for us to interrogate our individual selves, but also the collective, right? So, what does this constellation look like? Who in these decision-making spaces lie on the domination axis? Who in these spaces lie below the domination axis? So, who's in domination? Who's being oppressed? Who's present? Who's absent? Who should be centered? And who should be relinquishing power? This should be consistent practice for us every day.

And so, to touch on a couple of examples that many of us might be familiar with and tie this back to some of those constructs of supremacy, many of you are familiar with Stop Cop City. A little genocide for you, a little capitalism for you, throw in a little colonialism and war as well. So, the process of defending a force that sits on sacred, indigenous land, but also in a Black community, the citizens of Atlanta have uprised and said, "Hey, we don't want this training center to exist within our community," and we see what happened. An activist was murdered in the process, and (?) gave hours upon hours of testimony and said we don't want it. Council voted against the people's interests anyway, right? That's public health for you. (Microphone cutting out.)

Additionally in Louisville, Kentucky, for example, we don't have zoning laws as it relates to alcohol sales. And so, it's part one of our research initiatives, hired young people (?) as communities engaged in social justice development so they can understand, violence isn't just about direct violence, we also have to explore, contend with, and fight structural and cultural violence. And so, when (?) Family Dollar wanted to put the dollar over the family and the (?) to sell liquor, in West and south Louisville, the areas with the most black and brown people in the city, I worked with the young people to mobilize, energize, educate their peers about alcohol, alcoholic substance use being one of the risk factors for violence in our communities, right? That doesn't make sense, we don't have zoning laws for it. We allot licenses for that, but we're saying, you know, we want to be antiviolent. And so, alcohol (?) said no, due to community protest, right? So, critical social action.

Additionally, we, fresh off the heels of our Department of Justice report dealt with the murder of Breonna Taylor and the investigation into our police department, we're sitting in St. Louis who had their own process of a DOJ report and consent decrees. We are now at the table with activists who are demanding the people's consent decree. We are saying we are not fully trustworthy of our government to deliver the demands that we want through the negotiation process with the Department of Justice and our city government.

Additionally, moving for black lives, right? So, again, what I'm getting at is there are a number of agenda that people in community who are directly impacted have said, "Hey, we are prioritizing these things." If we ask ourselves in this room, to what (?) do our research agenda look at ending the war on Black people, investing and divesting -- thank you -- reparations, community control, political power, how many of these are priorities on our research agenda?

This pyramid here is the Quality Institute created the Pyramid of White Supremacy. What I want us to attend to here is the bottom level, which is indifference, because that sets the foundation for all of the other structural, cultural, and direct ways that white supremacy and its violence cascades across our society. And so, how do we contend? How do we intervene with indifference? And I'm at zero time, y'all, so I'm about to fly through the rest of this. But, right? So, we know that it's through philosophy of education, ideology. So, look at how we're being educated. Look at how we're being conditioned in society.

And so, what I do with my students is I expose them to the different philosophies of education so that we're understanding, who created this philosophy, this way of learning? How are we engaging in practices? What's the role of the student, the role of the teacher, and how does that impact our conditioning? How does that empower us? How does that facility critical inquiry of what we think we know?

And so, right? We know that that is one of the interventions, that is one of the most effective interventions, and that's why we see so much banning of quote/unquote CRT curriculum or DEI initiatives at universities. And so, this, for example, is in Kentucky. This was a bill request filed in 2021. We fought against it in 2022. But, right? It states, "Outlawing of designated concepts related to race, sex, and religion." So, this just isn't about race, this is about ensuring that we're not understanding that the dominance of Christianity and the oppression that has occurred within that religion is kept secret. This is ensuring that the patriarchy isn't overthrown. This is to ensure that white supremacy isn't dismantled. And so -- oh, there we go. The bill request.

Here we have some preliminary findings from some of my research, using the color-blind racial attitude scale with high school students. This is essentially saying that they want this information. Racism is not a problem. It's one of the questions on this survey. They believe it is, overwhelming majority of the students. Racial problems are rare and isolated in the U.S. They don't believe that. Racist history should be taught in school. They want it.

And so, for us, if we are to educate and facilitate

critical consciousness and sociopolitical action to break us from these bonds of oppression, it is critical that we understand that we are at war; we are in fights against systems of oppression. And if not, we will continue -- I want to let that chill before I get emotional. We will continue to contend with this, right? I will continue to have to contend with my young people dying that I employ, or living in two cities, St. Louis and Louisville, living through uprisings and the trauma that manifests because of that.

So, for me, I think it's critical that we all reorient ourselves to the liberation frames, right? It's not something that we can passively do. We have to actively engage in the practice of liberation, if we want to be able to envision ourselves in imagery that says, "Hey, we're breaking bonds, we're free." Thank you.

>> LISA SULLIVAN: Thank you. Thank you, Trinidad. And thank you all for your presentations. We are now going to move to a discussion with the full panel. I'll kick things off with one question --

>> 9:51 a.m.

>> LISA SULLIVAN: It's 9:51. For those of you joining virtually, again, please submit your questions through the Q&A function at the bottom of your screen. For those of you here in person, we ask that you line up at the microphones that are placed around the room for questions, and we'll take them in turn.

So, thank you all for your presentations. I'd like to start with one question, and anybody can jump in. I was struck by Dr. Magana kicked things off saying "everything has changed." But listening to the presentations, not a lot has changed, and there's so much more work for us to do.

I know we have lots of faculty and administrators, both in this room and with us online, and I wonder if you could give us, as faculty members, any advice on how we manage these transformations, putting at the forefront our values, our duty, our purpose? What words of encouragement and support might you have for faculty and administrators at a time that we're all feeling tired and burnt out, yet, excited about and feeling responsible for all of the changes that have to happen?

>> AMY FAIRCHILD: I'll do a quick response first. I can just tell you from a personal perspective, I was feeling all of those things. And the thing that energized me and excited me was finding a research project that really invited me to dig into the backlash against public health, really understand violent extremism, really understand -- we'll be talking about this some later, so I won't talk too much -- but having an intellectual agenda and coming at that as a person who is committed not just

to having my voice sound in the pages of journals, but being part of the public conversation. And it does require being willing to lose something in the face of doing this, being willing to be censured, being willing to be fired. And I know we have examples of that out there, but I think that's part of what we have to do.

And I think when we throw ourselves into this work and make it a priority, and as leaders, create an environment where you protect as much as you can faculty who do this work and then faculty who are the spokespeople, who are the stewards of evidence, who are the stewards of our values, that's what we do. And I know it's hard in states that have passed laws, in states that are cracking down, but -- and I think, too, we can think about what kind of safety net do we create as a community? If we have political academic refugees, how do we begin to support people in place, but how do we begin to create safe havens in the institutions where we are?

>> LISA SULLIVAN: Others? Go on.

>> LAURA LINNAN: It's such a great question. I think each of us are in different places in our careers. And I think what gives me hope is that the students that are coming into our programs now have lived through a lot, and they are not willing to sit back and have this same old same old stuff happening in our classrooms. So, they give me hope.

They also challenge me and challenge us as a faculty to really move beyond where we are right now. And I think we all can think of faculty who are not -- I had that one line in my talk about, we have to have the teachers who are able to have these discussions, to have -- to really get into it in a classroom with students and to have projects that challenge them to move beyond the status quo, to look at our readings, to look at who's benefitting from getting certain publications out. Who are we lifting up in our syllabi? And you know, I think that gives me hope, because I think our students are challenging us.

And then, I think we've just got to be, you know, willing to take on -- as I think what Amy is saying -- the recognition that we can help elevate faculty in our institutions who are doing this work in ways that will lift the rest. I mean, it's not going to happen overnight. But to me, we do have to have an environment where our faculty who are doing this work -- I think of Trinidad. We were talking earlier about the work he's doing, which is -- so thankful for folks who are doing this kind of research and projects -- engage more with our community. Because if we do it on our own, we're not going to be successful, either. We have to do it with community. And we have some experiences in Chapel Hill where our capstone experience is now, we start with community. What would they like to work on? And

then we are doing projects with community that they want to work on, not the reverse. So, just as simply as asking community, what is needed? How can we help as public health folks? And how can we engage with you to help build capacity to do the work you want to see happen in your community? So, those are the kinds of things that give me hope, a couple of examples, so.

>> TRINIDAD JACKSON: As to what Laura's mentioned, she just stated, what is community's focus, and start from there, you know. So, that's central as I just mentioned. There are a number of agenda that have been standing for decades.

But additionally, to the central question, I think about to what extent have people in positions of power in public health had to contend with, oppression being central to their identity and the way that they navigate society every day? And then, so, how equipped are you to fight, right? How prepared and how equipped are you to understand what a conceptual model -- right? Everybody loves models. What does it look like to understand power, power leverage, organize and mobilize in ways that we need to, right? Because again, we're talking about, Dr. Magana mentioned the social, political, and economic landscape.

These are all facets that we have to navigate, not just as public health professionals, but as individuals. Everyone in here, we are global citizens. And so, how does that -- does it translate? Does our individual experience as a human being, does that translate into the classroom, into our professional spaces? And so, I think we have to wrestle with that. Are we prepared to organize? Are we prepared to look to the civil rights movements or movements prior to that to understand how those who were targeted by different supremacist actions, how they organized for their liberation. Are we doing that? The answer is no. So, that's what we have to do.

>> LISA SULLIVAN: If you have something you'd like to share, please.

>> LEAH C. NEUBAUER: Thank you for the question. Two quick responses. The first being a question. You know, I'd wonder, what are the truths and the realities for how you are compensating and retaining your teaching faculty? And also, what does it mean, right, to have folks who teach in your unit? Are they clinical lines? Are they teaching lines? Are they tenure track? I think, regardless, if you're in a teaching or research-intensive university, I think we need to be very real about some spaces seeing teaching as less than and less than research or less than other things. So, I think really naming that, in tandem with how are we compensating folks to revamp their courses?

And I know some units have formulas, and it's really interesting to think about, you know, what do we expect for a

course to be updated? And when are we in spaces where we're asking more of our faculty, and their time should be compensated.

The second and related piece is just to acknowledge, you know, one of the things -- I think we are learning to continue to do well at Northwestern -- I'm looking at our MPH Director, Director of Community Partnerships, and saying this -- which is, our community partners are teaching in our program. They have adjunct appointments. And you know, when that works for them, it works well. The other option is consistent guest speakers and compensated guest speaking time in our courses. So, I think we are still thinking and learning what it means to have real-world public health in our curriculum. But if you're sensing a theme, you know, from my comments, it comes with attention to time, dollars, and cents.

>> LISA SULLIVAN: Thank you. Thank you. Let me take some questions from the audience. Please.

>> KIM RAMSEY-WHITE: Hi, I'm Kim Ramsey-White from the University of North Carolina Chapel Hill. And really, I'm standing here even though the panelist answered most of what I was going to ask as far as a question is concerned. But I stayed standing here because I think it's important for us to reiterate and understand, you know, what Trinidad presented is really the foundation of what it is that we have to do. And people got to get comfortable with that conversation. People have to get comfortable with being uncomfortable. That's the cliche at this point, but that's exactly what it comes down to, because everything that Laura and Leah and Amy put forth, if it doesn't start foundationally with the work that Trinidad presented, it's just kind of like us talking about it.

So, ultimately, what I wanted to ask, and everybody brought it up, it's how do we get our faculty to do it? We've had this conversation a million times. We're not really saying anything that we haven't said before. And I don't know that we'll get it answered here today, but my question is, what's the path forward? Not just talking about it anymore. That's the one thing I've learned is that we all know good buzz words to say to make it seem like we're moving the work forward, but there's really no substance behind it. How do we do that?

>> LISA SULLIVAN: Thank you.

>> TRINIDAD JACKSON: Still want us to comment on that, doctor? So, I'll actually mention that, right? So, this is being recorded. And we're in here talking about what we need to do to fight the powers that be. I've actually been fired twice in my state. Won't get into it. But because of this, because of doing this work in the state from which I come -- Kentucky, its legislative makeup, et cetera.

And so, I think while we're having this very public conversation and uplifting what the overarching issues are, I think, you know, when these cameras go off, that's when some of that real connection about what we should actually be doing, to get to your point, should happen, right? We shouldn't be leaving here without structured plans about how we move forward, because laws are being passed; bills are being filed daily. And so, we have to understand that this, again, to your point, this ain't just a feel-good conversation, where we come up, make talking points and leave on Friday. What are we actually doing in this space over the next 2 1/2 days?

>> LISA SULLIVAN: Thank you.

>> AMY FAIRCHILD: Let me add one thing because I've been at three institutions now, you know, tried to crack this problem a number of ways. It's sort of mandates, strong incentives. And I think the thing I see happening at OSU now was a really powerful call by students. I mean, like, students have to wake up the faculty. It's going to feel forced. Students have to wake up the faculty. And you know, frankly, students have to scare the faculty a little bit and make them understand, you are in these spaces, you are in hard spaces, you are in tough learning spaces, and students are expecting you to be able to have these hard conversations. They're expecting you to have this foundation.

And what I've seen at OSU is a faculty member who has really stepped up and is galvanizing faculty from below. And if you can support that person. And that's what we've been doing at OSU is, how do we support that person? How do we get that person into the spaces where faculty can really hear, talk, begin to build that faculty coalition. And then it's going to be peer pressure, which is going to be far more powerful than Dean pressure, I think, to do this work.

>> LAURA LINNAN: Since Kim is my partner in crime, I just want to say, there is no easy answer here. But I love Trinidad's, like, yeah, let's get about the work of putting some real action plans together. But I think in our institution, I will say that we are coming at it from a bunch of different angles. And you know, we have inclusive excellence, which Kim leads, and academic affairs, and we partner on some things and training opportunities. But we all know, who comes to the trainings, if they're voluntary? It's the folks who are doing the great work already. So, it will take time.

I do think that if you can elevate the stars, which we all have stars. We have folks who get it, who are teaching it, who are engaging with their students. And then, you know, through a whole host of steps -- it doesn't happen overnight -- sometimes it does, if it's a problem -- but you know, you're moving people

into different spaces than in the classroom. And I think there's a way to do that. It's not easy. We have 300-some faculty. So, not all of them are great teachers. Not all of us are great researchers. And I'm speaking myself, too. I mean, we all have strengths, but not everybody belongs in the classroom. And so, there are times when we have to take real action to move people.

And we were talking just the other day about putting development plans together for folks who they're getting bad course evaluations; the students are complaining. You know, we know who they are, and we don't base it just on course evaluations because we know those are biased as they are. But the idea of really taking action and holding people accountable is the only way we're going to be able to get this turned around.

And then, I guess the last thing is just providing learning opportunities for people who are really eager to sort of turn the corner on some of this work. And we don't have, necessarily, the right learning opportunities always available to us. So, that's where partnering with community to come in and actually be part of those conversations, I think, is a really good place to start.

>> LEAH C. NEUBAUER: I'll just respond to say thank you so much for the prompting and the foundational grounding. I would extend Amy's comments to say it should be or could be top-down, bottom-up, side by side, and all in between.

Trinidad's slide on philosophy, you know, offered the "B" word, and the "B" word being behaviorism. And for folks familiar with Ed Philosophy, behaviorism has manifested in academic public health. We are a competency-based field, competency-based education is core to behaviorism. And I think, you know, really understanding some of those roots.

I asked someone once, "How did we get here?" And they said, "It's behaviorism. I blame the psychologists." And I thought, "Wait, what?" But we heard this from our students at Northwestern, which is, why are there so many health behavior change theories with no acknowledgement of social and critical theories, or rather, those courses -- that talk exists, but outside of the core theory class. And this was several years ago. And we really listened on the student voices, and it matches very much what Dr. Jackson's slide is inviting us to consider, which is, we have to do more, to be frank, than what I hear a lot, which is, "Well, why are you doing this?" Well, we're doing it because SEF required it. And related, we understand this is foundational and entry-level guidance and standards for our field, but that's the floor. And count me in for a ceiling that is way more than behaviorism and is much more to collective solutions.

>> AMY FAIRCHILD: Can I add one thing here, too? And we've talked about this. So, I agree absolutely with what Leah just said. But we can still take those same SEF guidelines and center something very different and meet the guidelines. So, that's why I say, you know, we're stuck in a lot of ways and we need to shake ourselves up and need to shake our thinking up.

>> LISA SULLIVAN: Thank you. Thank you. Next?

>> AUDIENCE: Good morning, I'm Alina Zami from University of Miami. I want to say, you have invigorated me from the beginning of the conference, and I have learned a lot.

I want to start with a question that was raised about who decides and why for teaching and learning. And I started thinking about design teams. Who are the people who need to be participants on, what is it we teach? Probably not me only as the faculty. And I connected it to the lifelong learning of strategies -- who do we teach? And then I thought about, there is a special moment right now in discussion of this learning and teaching about public health belongs at all levels. The discussion started with the curriculum about high school, before high school.

So, the question I have here is that, how do we create that spice of urge and interest in learning that's lifelong, and it's connected to our field of public health? Because while we have wonderful students, part of the structure is that, as faculty, how many times you've heard, "Is this going to be on the test? Is this going to be on the exam?" How do we capture the young generation, not only in college, but before that, that says, learning is part of living? It's like breathing. And public health is not a discipline out there that we seek out when there is a pandemic. It is part of healthy living long life. And discussion of social justice is just part of our lives. Thank you.

>> LISA SULLIVAN: Thank you.

>> LAURA LINNAN: Can we have that on record? Because that's really a comment of what we need to do. So, I think when I was doing preparation for this and I was really getting into sort of the lifelong learning and education for life literature, you know, it was clear to me that we need to start earlier. And you know, thinking about how our education system is right now, getting anything else on the curriculum, it's just -- if there was a way to sort of wave the magic wand, there would be an opportunity to sit down with the existing curriculum in the younger ages and bring public health into it, right? So, not adding new, but adding public health examples and so on into it so that people could see public health for where it is.

I don't know how many of us probably grew up not knowing what public health is and, all of a sudden, we found ourselves

in public health. So, the idea of what it is earlier, at an earlier stage, because it is part of life.

And then, I think the other thing that I heard in your comment, which I really resonated with, is the notion of critical thinking, you know, just really opening your eyes and just saying, you know, "Why is this the way it is?" You know? And digging in. And I think it gets at some of the ethics, it gets at some of the values that we need to start a lot earlier. And I think in our schools right now, unfortunately, what's happening is people are X'ing it out, you know? They're taking out anything that could be even, you know -- like my sister is a seventh grade teacher. Just unbelievable what constraints are being put on at the younger ages, and now in our universities.

So, I guess my answer is long-winded -- I apologize -- but just the idea of starting early with examples of public health would be great, and then thinking about, you know, all of us embracing the idea that, I mean, we are all learning. This world is changing really rapidly, and if there's a way for us to plug in, it's not opening up the university, this open access institution where people are coming and going as opposed to it's just a destination and then you leave, you know. Think about our institutions. We all may have lifelong learning institutes, but how are they being utilized and by whom and when? We just, we really need a different mind-set about that. Maybe employers will force us to do this because they're demanding workers have more training, so they're forcing us to respond to that in some cases, or they're just moving outside higher ed altogether and doing their own thing. So, maybe there's an opportunity there to also get this notion of lifelong learning really mobilized. Because right now, it's just limping along. I don't think we're there yet.

>> LISA SULLIVAN: Thank you. Next question?

>> LEAH ALEXANDER: Hi, good morning. I work at Meharry Medical College. We're historically Black academic medical health center of some type. So, Dr. Jackson, when you said we were recording, I thought I should maybe go back to my seat, but I'm here now, so I'm going to ask my questions.

So, at Meharry, you know, we have an unspoken hierarchy, really, of schools and programs with a focus on the medical school and the dental school. And my students feel like step children sometimes. I mean, you know, they just feel like they're not a priority as much as we try. And even though, you know, we know that public health really is the foundation for everything that's happening at Meharry, there's leadership that believes that. So, we're trying to be transformative and trying to, of course, collaborate, you know, with the bigger schools. But I'm just wondering if others are facing those types of

challenges? And what are some thoughts about solutions?

And then my other question is specifically for Dr. Jackson. I want to know about your title, because that is transformative. It doesn't fit our usual, you know, academic models of how we call Deans and Assistant Deans and things. So, I just want to know how you are able to manage that and what you do in your role. Thank you.

>> LISA SULLIVAN: Thank you.

>> TRINIDAD JACKSON: So, the title. Again, we're being recorded. I won't answer your question comprehensively, but --

>> LEAH ALEXANDER: Lunch, lunch, lunch.

>> TRINIDAD JACKSON: Let's go back to 2020, right? Some of my co-panelists mentioned this new awareness that people had about racism, right, as we looked at non-traditional instruction for kids who are, you know, structurally marginalized. We also had Ahmaud Arbery, Breonna Taylor, et cetera, who had been murdered, right? So, we had banks, cities, states, you name it people were coming out with antiracism declarations and also declaring racism as a public health crisis. University of Louisville was no different. Our then president at the time made this bold statement that we were going to be a premier antiracist, you know, metro institution. And she challenged a number of units, departments, et cetera, across the university to formalize chief Diversity Officers. So, School of Public Health was not exempt, right? We did not have -- we had a Diversity Committee Chair, but there was nothing from a structural and institutionalized perspective that existed within the school. And so, our Dean, Craig Blakely, he formalized that role. And so, they interviewed people. I got the position. And so, when I got the call for the offer, I asked, you know, let's have a follow-up conversation, because I'm not operating under the language of DEI, right? That has served us -- at this time, it can serve us a very minimal purpose, right?

When I go into spaces and I'm talking about white supremacy, cultural violence, structural violence, but it's under a title of DEI, people look at me and falter to, "Hold on, that's not DEI! That's not what we're here to talk about!" Right? But when I go into a space talking about such constructs and I'm doing it from a cultural and liberation perspective, that's everything. And so for me, that was a nonnegotiable for me. Either I'm changing title or you can offer the position to someone else. And there was a little back-and-forth, right, "Liberation, what does that mean?" Right? Black man coming into the space talking about liberation. And I'm like, you work in education, liberation, theology, look it up and do your homework. But that's my stance, and we can, you know, we can take it or leave it.

And so, the response thereafter was, a couple of days later, you know, it's time for us to, you know, chart a new territory, et cetera, right? So, long story short, that was my nonnegotiable, and I navigated that with our Dean, and here we are. And you mentioned what I do in the role. We can have a conversation, but I'll definitely say it's organizational --

>> LEAH ALEXANDER: I'll find you at lunch.

>> TRINIDAD JACKSON: Organizational transformational work in Kentucky.

>> AMY FAIRCHILD: Thank you, Trinidad. I'll pick up on that theme because it's liberation from medicine. I'm a historian in public health, so I'm a bit of an odd duck and this is something I've been interested in my whole life. And so, I think the first step is to, as much as you can, get out of medicine, though you still might be in a health sciences center where all the research ties you there. So, I think a strategy that's really helpful is to align yourself with the university as much as you can, align yourself with -- make those connections, inroads to sociology, to anthropology, to history. And then that's kind of how you get out of that behaviorist mind-set and form those connections, create interdisciplinary programs. I can tell you at OSU, there's just such an appetite for that. And I'd be happy to talk to you about how we've navigated that at different places, but that would be, you know -- cast your lot in with the greater university.

>> LEAH ALEXANDER: Thanks.

>> LISA SULLIVAN: Let's try to get a couple more questions in.

>> I have a question from the Zoom. In the 60-year length education model, is there a place to continue to educate alumni who are practicing public health and did not have such an up-to-date education, especially around socioeconomic and racial equity issues?

>> LAURA LINNAN: Beautiful question. Thank you for the question on the 60-year curriculum. Yes, there is a place. Are we doing it? I would love to hear from some organizations that are. We have done some training for our alumni, but not nearly enough, and that's a great example of opening up the institution to more and better. So, thank you for that question. Absolutely.

>> LISA SULLIVAN: Okay. Yes.

>> CRAIG ANDRADE: Hi, I'm Associate Dean of Practice at BU School of Public Health. I stand here hopeful and anxious. I also stand here at a university where we have leadership like Lisa and Dean Galea, where we are able to find ways to navigate the less-navigated territories in all kinds of ways, and having in all of my career in nursing and health promotion and late to public health, have never been in front of a professor of color.

And I feel the urgency of broad spectrums of people that don't feel under threat, otherwise in all kinds of ways. And our students are in the center of that. And we've been talking about behavioral change and things like this.

Truthfully, this is a structural change. I was on an antiracism work group for the university, focused on antiracism and climate change, and trustees were saying that we can't talk to community in a liberal state that tries to consider themselves progressive. So, there's bastions of looking for change while we're also in this transition point where we're trying broad spectrums of institutions are trying to hold on to power. And academia is the most hierarchal institution that we have.

I'm waiting for us to rip the roof off and pull the walls aside and bring community in. And we're still having challenges about, is advocacy a core competency? So, I guess part of my question is, how do we find ways to organize amongst ourselves? Because it's not -- the students aren't going to be the main levers of making this change. It's not going to come from the top. And I feel the urgency of now, that 60 years in a life course learning, I sometimes lose that hope that it's just going to take attrition for this change to happen. We're going to have to wait for the old people to die and new people to come in. I don't think that that has to be that way, but I also can't -- I'm having difficulty seeing the revolution coming from the inside. So, I wonder what people think.

> LISA SULLIVAN: Response?

> TRINIDAD JACKSON: We've got to talk.

> LAURA LINNAN: It can't come from only inside. I think we have to bring employers, we have to bring the community, we have to bring others into these conversations. And that is challenging. I get it. But when that happens, beautiful things can happen. And it won't happen overnight, but we've got to start. I mean, that's the whole point. We've got to start.

>> LISA SULLIVAN: One last question. Sorry! Sorry.

>> KATHERINE MASYN: Hi, I'm from Georgia State University. Thanks, Carlos. So, I was wondering about the panel's thoughts. I agree with my colleague here in terms of, I really want to kind of blow things up a bit. I'm a bio statistician by training and also do a lot of measurement work, so my sort of safe and happy place is thinking about units and metrics and what not. And I think that in terms of faculty incentives -- Leah mentioned this little bit, too -- the way that we measure faculty workload is absolutely critical, and the way that we measure it signals what we value. The way that we pay our faculty signals what we value. Who we give tenure to or not signals. And that feels very intractable, some of that.

What we require of our faculty; the way we actually sort of dictate workload. We're practitioners when it comes to -- most of us aren't scholars of teaching and learning, we're practitioners on the teaching side of things, but we require no teaching continuing education. You know, we talk about lifelong learning or education for life, but we don't require that of ourselves. And a lot of us weren't taught any of this when we were coming up. So, that's my sort of one thought on the metrics side.

The other thing, thinking about the transformation requirement and sort of, really, one of the things that I felt very constrained by is the Carnegie metrics, right? We measure learning by time in the classroom. We've shifted to competency-based learning, but we're still trying to fit it into an entire system that only measures progress by credit hours. And how do we open up access and think about microcredentialing and thinking about this education for life if we can't get away from this sort of industrial measure of learning and outcomes?

>> LISA SULLIVAN: Yeah.

>> AMY FAIRCHILD: One of the things I would point out is what's unique about the work of this group is that we are looking at recommendations across a number of dimensions, not only what needs to happen with students, but also what needs to happen with faculty. And that includes the training. And then what needs to happen at the institutional level to address precisely this. Because if we don't hit recommendations at the institutional level and begin to do precisely what you said, you're right, it's not going to happen, if it's all forced into the classroom without addressing all three of these, all three of these levels. Go ahead.

>> LEAH C. NEUBAUER: Thank you, Katherine, for both the comment and the prompting. I wanted to share one example from our debriefings as a panel, which is around dosage. 56 credit hours. Well, that's the quarter speak for an MPH degree. And I had said, wait, so, what's the story behind the 56? How did we get here? Who determined what was enough? Very classic adult educator question. No one knew.

And then, eventually we heard, and it was someone from CEPH that said it was 2006 when the minimum credit hours was put forward in this context for MPH. And for me, right, in my own training and thinking, that was just a moment of, okay, but why? And who was there? And who decided this? And I know several of you, we've discussed, our degree looks a little thicker, right, or a few more courses than other degrees. All this to say I think -- I appreciate the comment and the consideration to dosage. And you know, this example from our panel, it was focused on, who decided the MPH degree needed to be these number

of hours? Thank you for raising that very much.

>> LISA SULLIVAN: Yeah, thank you so much. I'm sorry to cut this off, but we are at time. And I want to thank the panel. And if you could please join me in a round of applause for our panelists.

(Applause)

For those of us here in St. Louis, we will certainly continue these conversations. We welcome all of you to join us for a brief coffee break ahead of Panel 2, which will be moderated by Elizabeth Weist, Director of Education at ASPPH. Thank you very much.

(Break taken at 10:30 a.m. CT)

>> ELIZABETH WEIST: Welcome back from the break. We are going to get started. I hope you got your coffee and your drinks. We heard from five distinguished speakers in the first panel guiding us along transformative avenues for education in public health. Our second panel of this program is leading the change, challenges and opportunities in academic public health.

I'm your moderator, Elizabeth Weist. Each upcoming speaker will take us farther along in framing our future to help ensure health equity for all. Our panel of speakers follow, first, we will hear from Diane St. George, Dr. Saint George serves as Associate Professor and director of the MPH program at the University of Maryland School of Medicine public health programs. Dr. Saint George chairs the association of schools and programs of public health, diversity and inclusion Advisory Committee. And she is a member of the associations framing the future expert panel on inclusive excellence through an antiracism lens.

Second, we will hear from Marc Kiviniemi. Dr. Marc Kiviniemi is it the development dimensions international endowed professor of health, behavior and society at the University of Kentucky college of public health. Dr. Marc Kiviniemi is a social health psychologist whose work focuses on understanding how people make decisions about engaging in health-related behaviors, how individuals process and respond to information about their health, and how to communicate that information most effectively.

Dr. Marc Kiviniemi also is cochair of the framing the future expert panel on expanding the reach, visibility and impact of academic public health. He also chaired the association of schools and program of public health teaching work group within the scholarship of teaching and learning task force. Then we will turn to Heather Hagerman and CJ Walker who

will copresent. Ms. Heather Hagerman is the inaugural director of the Center for Interprofessional Practice and Education at Washington University in St. Louis, medical campus.

Her background is in strategic planning, program and outcomes assessment, accreditation, and project management. Ms. Walker serves as President and CEO of the St. Louis community health worker coalition. Ms. Walker received her master's in public health with a concentration in prevention science from Emory University's executive mph program. CJ Walker is a doctoral student in the public health leadership program at the University of Illinois, Chicago where she will earn a DRPH taking a keen focus in social epidemiology. Her research explores the business of public health. Illustrating community-based innovation and non-traditional partnerships as levers for sustainability.

Finally, we will hear from Paul Halverson. Dr. Paul Halverson is the founding Dean of the Indiana University Richard M. Fairbanks School of Public Health in Indianapolis. He came to Indiana University from the Arkansas Department of Health where he served as state health officer and director. Prior to his appointment as state officer Dr. Paul Halverson served in senior management roles at the U.S. Centers for Disease Control and Prevention and as the Senior Health Policy Advisor for the North Carolina Department of Environment, Health, and Natural Resources.

Now, please join me in welcoming Diane St. George, Associate Professor and director of MPH program at the University of Maryland School of Medicine public health programs to the stage.

>> DIANE MARIE ST. GEORGE: So good morning, everyone. Let me thank the symposium organizers for inviting me this morning. They asked me to speak on holding ourselves accountable for moving academic public health forward with respect to issues related to diversity, equity, inclusion and justice.

As we parse that out though we are really thinking about a tripartite mission. The first part of the mission is ensuring staff, students and faculty represent the communities we strive to serve. Despite some efforts to address lack of diversity, as a whole, our institutions still do not fully reflect our communities.

There is indeed been progress, but we are not there yet. The second part of our mission is ensuring that the environments in this we teach and learn uphold the highest ideals for inclusivity, justice and respect. Climate surveys tell a story of institutions that do not feel the same for all of us.

Some may feel comfortable feeling they fit in and belong but others do not. The third part of the mission is to move us

all toward health equity. We do that through our scholarship when we produce the evidence that uncovers the systems, structures and practices that create and perpetuate the disparities we observe. And then, more important, when we produce the evidence on which to base interventions that effectively address the problems that we find.

We also move us toward health equity when our public health practice drive for authentic mutually beneficial partnerships that identify and meet the needs of communities. And, of course, we are training the next generation of leaders with the skills they will in turn use to engage effectively as culturally humble scholars and practitioners into the future.

With that in mind, I would like to share some of the ways that the ASPPH has focused on the pressing issues we are facing. In 2019 ASPPH paneled a group to develop a statement on zero tolerance of discrimination and harassment. Putting a stake in the ground, they envisioned academic hub institutions that were free of micro and macro aggressions that make our teaching and learning spaces toxic environments.

The statement called for preventive measures, antiharassment and antidiscrimination policies, not just ones created and sat on the shelf, but living ones that evolved as we, the world, evolved.

It called for training of students, staff and faculty to change behavior and challenge biased world views. It also called for creation of a culture of accountability in which everyone recognized their responsibility to ensure that bad actors were identified and reported and victims were protected.

The statement also called for clear and consistent communication and transparency about how perpetrators are held accountable. And finally, shifting the cultural from one in which facilitates harassment and to one in which institutional norms demand equity and respect.

Only one year later in 2020 as our world changed in front of our eyes and the calls for action grew stronger and clearer, ASPPH commissioned a task force to go further, think broader, killing deeper, and develop a framework for dismantling structural racism in academic public health. This framework challenges us to tackle policies and practices that enable and sustain racism in our institutions.

With input from our sections and Committees, the framework offered recommendations for actions to impact our five constituencies, the public health workforce, the communities and populations we serve, the staff, the students and alumnae, and the faculty. For each of these constituencies we recognized that we needed to consider strategies that related to our three domains of influence, education, pedagogy and training is one,

practice is another, and research is a third.

Across these five populations and domains there are multiple strategies that have the potential to affect immediate change. Efforts such as holding listening sessions with our students, our staff, and faculty to understand their lived experiences. Or creating teaching practice and research awards that recognize staff and faculty excellence in addressing barriers to equity. Or involving students in community engaged research. Or ensuring that student practice placements include not only a diverse away of communities, but that the students benefit from mentoring by a diverse array of community preceptors.

Strategies that take a little more time to implement but may go further include actions such as developing university mechanisms for adequately and fairly compensating community members for service they provide, or tackling outdated appointment, promotion and tenure guidelines that fail to recognize the value of DEI work, participatory research and the time that it takes to do all of this well. Or creating alternative faculty lines with flexibility to appoint community-based practitioners whose expertise are so sorely needed in our classrooms.

And, of course, there are those actions which will take more time but are so critically important as well, such as advocacy at state and federal levels for creative and sustained funding to support work that seeds our pipeline with the future public health leaders and health equity change agents.

The ASPPH work in this area continues with the framing the future panel on inclusive excellence through an antiracism lens. As the panel tries to envision a diverse, equitable, inclusive academic hub of the future, we are channeling the collective wisdom of the previous work groups and sharing experiences from our respective institutions.

One such effort was our preliminary environmental scan which sought to answer five key questions. First, we asked our key informants what is happening out there, what are schools and programs doing to achieve inclusive excellence? What are those systems, structures, policies, et cetera? Second, we wanted to understand the implementation, how are they making these things happen at their institutions?

Thirdly, what are the results of those initiatives? Where have they seen impact? Fourth, what has helped or hindered their progress? And lastly, how do they plan to keep this growing? What are the mechanisms in place to sustain progress? Data collection on this environmental scan is now complete and over the next few months findings will be released and we can all look forward to learning what has been found to be

successful, what is not worked well and what contextual factors are important in contributing to success.

So to conclude, it is easy for us to throw our hands up and say the system took centuries to create and cannot be easily disrupted. However, none of us signed up because it was easy. We signed up because we are passionate about leaving the place better than we found it and creating brighter future for generations to come. Deep inside, we knew it was going to be tough, and, of course, we know that for some of us the job is even tougher.

We have heard references to that already today. Let us recognize that there are those among us right now who are being forced to engage with this work under very difficult conditions. Their environments are less receptive to this change and enormous barriers stand in their way. So we stand by that, those colleagues. Supporting them, applauding them for their valor, and honoring their commitment by realizing that those of us who can do more must do more, digging in more deeply and expanding the evidence base so that there can be no doubt in anyone's mind of the necessity for and value of this work. Thank you. (Applause).

> ELIZABETH WEIST: Thank you, Dr. St. George, we will hear now from Marc Kiviniemi, Development Dimensions International Endowed Professor in the Department of Health, Behavior and Society at the University of Kentucky College of Public Health.

>> MARC KIVINIEMI: Thank you, Liz, and thank you everybody, those of you in the room and people in the camera lens in the back. It's great to have so many people interested in improving teaching and learning for equity. We have heard a lot of calls to action about changing what we do in classrooms and other learning spaces to rebuild trust in public health, to create lifelong learners, to start to work towards liberation, to dismantle racist structures, and the question is how do we do that more effectively and to make sure that what we are doing is making a difference? I want to start that question with an observation.

For those of us in public health, in practice we have been an evidence-based or evidence-informed discipline basically as long as we have been a discipline. We have long collected data to understand what kinds of problems we need to address. Figuring out which interventions we need to do, and after we have gotten the scanner and taken the handle off the pump collecting data to make sure that interventions were effective.

We are good at it and we have developed sophisticated tools to help us use evidence and collect evidence specifically that we were taught by somebody who was taught the way they were

taught and taught the way they were taught all the way back to a case where our classrooms today often don't look that different from times of yore. And my favorite part about the picture is the dude in the bottom right corner who is the first documented student to fall asleep during class.

So as we think about this route towards transformation and all of the ways we have talked about today, the question is how can we leverage our work in public health practice to think about doing this transformational work in a way that truly improved student learning. Often when you start to have this conversation with our faculty, the response is, well, I was never trained to do that, nobody taught me how to teach, by the way, I have a day job.

And every single bit of that is true. But if we think about where we are as a field, the truth is that we are remarkably well equipped to engage in the scholarship of teaching and learning if we stop using that word and use the word evidence-based teaching and learning.

Because we are quite good at answering the question does it improve public health. And the question of does it improve teaching and learning is actually not that different. So what I would like to do with the rest of the time is to show you some ways in which evidence-based teaching and learning or scholarship of teaching and learning can leverage what we already know about evidence-based public health to reduce the barriers to entry. If you are an instructor, a faculty member, I hope you will see ways in which you can incorporate scholarship of teaching and learning in your practice using things you already know.

If you are someone who works with faculty on improving teaching and creating environments for student learning, I hope you will see lenses through which you can work with faculty to have this conversation. So how do we do this?

I from time to time teach evidence-based public health, and what I tell my students when I do that is that the very best intervention is the one that you don't have to create. If you can find an existing intervention that someone has created and shown to be effective, and it works in your context, run with it. So an important evidence-based point for teaching and learning is you don't have to reinvent the wheel in the same way that we talk about using things like community guide to preventive services to find interventions for public health practice, there is a wealth of scholarship and knowledge about evidence-based teaching and learning already out there.

These are a few of my favorites if you are looking for a place to start. I want to talk a moment and put in a plug for the resource in the bottom corner. ASPPH created a teaching and

learning resource hub. It is a place you can go and find evidence-based teaching solutions that your colleagues have put forward as exemplars of good practice.

If you are someone who is already doing this work, you can submit your work. You can have it peer reviewed so there is some cachet towards this being a form of scholarship. If you are in the room, there will be a table to find out more about the hub. If you are joining us online it is available at the ASPPH member resource site.

You don't have to reinvent the wheel. A second thing we are good at doing in public health is leveraging existing data sources. So oftentimes we don't have the energy, the person power, the money power, whatever it is to collect original data for everything we do.

And the same can be true for the scholarship of teaching and learning. We have a wealth of data we are collecting and can bring to bear to think about ways to improve our assessment of student learning. I will show you one example of this. A few years ago I got interested in flipped classroom or blended learning approaches to education. I took a course that I had taught a number of times in traditional doing lecturing and trying to fit in activities where you can format. I switched to blended learning. I wanted to see if that was effective because you want to make sure you are improving and not making things worse when you make a change in your educational practice.

All I did was keep the exams the aim from one semester to another and with data that already existed I was able to look at the change that took place in student learning without doing anything that I wasn't already collecting as part of the assessment portion of teaching. It's even already in an Excel file that's formatted perfectly for analyzing data. You can think about other sources of existing data.

So looking at comments in student evaluations, doing content analysis to see if it's working, and in this case about 75% of students' comments about what was working well in the course after the transformation had something to do with the blended learning format. So without collecting data, you already have the ability to go in and ask whether teaching and learning is working and finding out what is working well and what needs to be improved in your classroom environment.

The last point in terms of connections to evidence-based public health, is that not everything has to be a randomized clinical trial. When we see the words scholarship of teaching and learning in all capital letters and it sounds very imposing, we tend to think about very involved, hard to do, and again with the day job, research designs.

There are a number of valid ways of knowing in the

scholarship of teaching and learning doing quasi experimental work as I demonstrated earlier, doing case studies, pre/post designs, there are ways that do work in a context of a busy faculty member to do this work.

So by leveraging those kinds of knowledge and skills that we already have, we can lower the barrier to entry for doing truly evidence-based teaching as we are doing this work of transforming our classrooms to meet the needs of public health in the future.

One final point related to that. Is that if we think about the essential public health services, we go through a framework of assessing what needs to be done, creating interventions to do it, and then making sure that the interventions work, and that same work and weave works for teaching and learning.

What do our students not know coming into our classrooms that they need to know? Policy development is essentially how do we create the interventions and teaching and learning is an intervention like any other in order to do that effectively, and then how do we make sure that those interventions work.

So in closing, where do we go from here? Hopefully you will see you have a new set of tools in your tool box for doing this kind of work. So I would ask you to reflect on two questions. How will your teaching and learning practice change based on what you have learned here today either from this talk or from others in the session?

More importantly, what will you do to evangelize and talk to a colleague about what you have learned today? The last thing to say is if you are in academic leadership in a school or program of public health, I spent eight minutes trying to make this seem easy and simple and anybody can do that.

Forgot that for a second because if you are in academic leadership, my challenge for you is to see the parallels to evidence-based public health practice and to research practice, and think about what will you do to recognize that high quality teaching and learning and evidence-based teaching and learning requires the same rigor and the same specialization as the other parts of the faculty role and create mechanisms for honoring and rewarding it in the same way we do others.

Regardless of the way that we do that, go out, explore, investigate, and I look forward to the rest of the talks. Thank you.

>> ELIZABETH WEIST: Thank you, Marc. Up next is a joint presentation by Heather Hagerman, director, center for interprofessional practice in education at Washington University Medical Center, and CJ Walker, President and CEO of the St. Louis Community Health Worker Coalition.

(Applause).

>> HEATHER HAGERMAN: Thank you for the invitation to share about our center, as director of the Center for Interprofessional Practice and Education on the Washington University medical campus, a collaboration of three free standing schools on that campus, I as well as the national interprofessional education community and anxiously awaiting the soon to be released updates to the interprofessional education collaboratives competencies known as IPEC. In particular, the strengthening of the princes of public health, structural and social determinants of health and just culture, I am hopeful that these changes will further flatten the medical hierarchy alluded to earlier so that everyone is able to fully show up with all of their identities on teams.

The journey we want to share today started in 2018 when this incredible leader and I met copresenting on a panel similar to this one. Listening to her presentation about the emerging St. Louis Community Health Worker Coalition, I knew I had found the community voice that we needed to follow and partner with to best train our health profession students to work in teams with community toward our vision of improving the health of the St. Louis region. I will let CJ tell you the story.

> CIEARRA "CJ" WALKER: Good morning, everyone. So while I come to you outside of university representation and rather in partnership, I hope that you can understand my place in this conversation today. The hope is that we will have the chance to really demonstrate a lot of what's been discussed and show that a path forward is truly possible. So what Heather and I have done, before I get into it I will give you space to read the blurb on the screen.

We want to say thank you to BU and ASPPH and thank you to Heather for your demonstrable leadership. We are in St. Louis so I must thank St. Louis for the way in which they have leaned in this work over five years.

I will also take a moment to thank the entire workforce in St. Louis. We have over 180 trained CHWs who are on their way to being credentials at the state, and he is going to be upset I have done this, but I want to thank a member of my team, Mr. Ryann Smith which serves as Director of Leadership and Development. He is the first in the region to hold the title as we are actively building a career ladder.

In that allow me the chance to center us in this space around definition. Most often we will combine these two words and let them be synonymous. We will talk about collaboration and partnership as if they are the same. I want to challenge that, and I know I'm speaking to the choir, so lean in a bit. What if I told you that process was really collaboration, and the product of collaboration is partnership?

So we hear this famous mantra of form follows function. So what if I told you that the form of how we do our partnership is actually how we yield more effective collaboration? Let's make this a little bit more real. I'm a storyteller by nature, so bear with me. Inside of a city, we expect that there will be cultivation, we expect that things will come and grow from it. There are several similarities inside of a village as well. Let's talk about the differences., maybe the pace, maybe the centrality, maybe the unisense that happens in a village versus that in a City where there might be individualism or streets that separate the way in which you get places.

Heather and I are representing a village inside of the city. The way we do that is through an evidence-based practice from the Teagle Foundation known as the collaboration continuum. What I'm challenging is that collaboration is not a linear process, nor is it a one time achievement.

So our first meeting or our third meeting may not actually yield true collaboration. You will notice that the formality of the relationship increases along with trust. So we are all practitioners here, and what I want to do is make this real. So in order to get to a space of collaboration, we had to take it slow.

We started in silo working, then we started to network and you will notice the information sheet that actually the Center for Interprofessional Practice and Education took ownership to create to see if they were understanding what we were communicating correctly. Going forward they invited us to do professional development sessions to their faculty and students and you will notice that in 2021 we signed a formal contract. But that wasn't a normal contract. Not only were we resourced for our time, but they fully agreed to all of our partnership values.

What most people call MOU, my organization called a collaboration covenant. If we decide we are going to move into collaboration with you because recognizing there are several other ways we can interact. We can network, get to know each other, but we don't have to collaborate because our reputation and the responsibility we hold to our communities, our members and those which we serve will always be of utmost importance.

So we walk our partners through a very smooth but also respectful process using this continuum, and we will constantly say thank you to the Center for Interprofessional Practice and Education for their humility and reciprocal learning we engaged in.

In 2021 you will notice Ryan Smith is listed as a member of the Curriculum Assessment Committee. That's big talk. Essentially what we are saying is he is actively involved in the

way in which curriculum is evolving in that space. For anyone who knows CHWs, this is not a degree accredited program. This was a risk taken in the university and a journey that was embraced as we think about how do we take this possible, and a lot of what has been talked about today, we find comfort in frameworks, we find comfort in objective, in steps. So our suggestion is to lean into the collaboration continuum and be real with yourself.

There are three calls to action. The first is to assess where you really are. Where are you on that continuum and what capacity and interinstitutional supports might be needed? Is there is a full white paper on that continuum that we are happy to share if you want to dig into it.

Additionally, we are all familiar with positionality. We must assess bias and assumptions because the way in which you interact with others is solely contingent on that. The second might make us a little uncomfortable because we are known to be experts in the space, but I encourage you to ask. Ask for the supports that you ask. Ask for accountability and don't be afraid to ask for grace.

This is a new process for all of us. When neighbors come to the stage in this institution, it's scary for them too. Similar to when we step into their territory. So let's be transparent and ask for grace which will yields natural accountability.

As I started this presentation, it's clear we have clear definitions because that's when we start to miscommunicate. Let's talk about what success means to us. Let's coniform that we understand the spirit of reciprocity, and let's really explain what a partnership could be if we get collaboration right.

And then my final comment what I will say is you must act, and you have heard that throughout this entire time. You must find a way to position yourself in a place of power that is both respectful, that is both humility and that both allows you to really lean into a posture of yes. So with integrity and with shared ownership, we will get there. So I just want to close this by, again, we are all champions in this space, but it is very important that you champion not only a side of your institution, but you continue to do just what you are doing today and spread this word outside of those walls as well.

So as the previous speaker has said, we have truncated this into an abbreviated time but we have a ton of lessons learned and we would love to share them with you. My organization provides asset mapping, think tanks and deep workshopping where we will take you from your current place and move you to your desired position. Thank you, Heather for your demonstrable

leadership and thank you all for your time.

>> ELIZABETH WEIST: Thank you Ms. Heather Hagerman and Ms. CJ Walker. We will hear from Paul Halverson, founding Dean of the Indiana Richard Fairbanks schooling of public health.

>> PAUL HALVERSON: Thanks, Liz, and thanks for all of you being here. I know this is the sort of optional session to come to today, but I think it really is a great way to start this section's retreat. I want to also acknowledge and thank Dean Galea, Sandro has been a great leader and Boston University has been gracious in helping to move our field forward. So thanks to BU. But also thanks to ASPPH. I would say having been a Dean now for over ten years, this is the first time I have actually got to come, got to attend to be with you in the sections retreat.

I have always heard this is where the fun happens and where all of the hard work begins and the networking that you are able to do has really been important. I want to spend a few minutes talking about Zooming out a bit in terms of focusing on what we produce as schools and programs in terms of graduates who ultimately impact the health of our nation and our world in terms of bringing evidence-based public health systems to fruition, to impact the health of populations, and ultimately do what we have all really dedicated ourselves to, which is to improve the health equity, the equity overall, the ability for people to live and work in an environment where they can do their best.

That's our quest. I think that's why most of us came to this field. The other sort of title I would have for this work is standards systems and relevance, providing standards for effective practice. Another way of putting it would be to talk about it as our quest for a national public health system, competency and in particular to do it in a collection of largely boutique organizations both large and small public and private.

So, again, I think as we think about our world, we have seen enormous change, and, again, nothing could be more relevant for us as to just reflect on the changes that have occurred as a result of COVID. I wanted to say I started this work, I came to public health administration as the Dean, but before I did that, I spent over 25 years leaving large complex organizations both in the healthcare sector as well as in public health at the federal and state level, and it was really my honor and privilege to have worked with incredibly talented people.

But essentially, what I have done in that 25 years before coming to the Deanship was really having a chance to sample all of the graduates, and, again, in my experience in both Arkansas and at CDC, I had a chance to work with graduates from just hundreds of schools of, well, schools and programs of public

health, hundreds of great graduates, but the reality is they came from far and wide, from very famous and well regarded schools to regional programs that maybe had just got started.

I had a chance to work with students from a lot of different perspectives, and most of those students were incredibly talented with terrific training in terms of foundation. But what I found as someone that needed to get a lot of work done is that many of our students, in particular those that came from our schools and programs right from the very beginning, lacked the level of understanding of the context in which the work is done, and in fact, it is sort of the unspoken truth for those of us that are employers of our students that we get students that get a great background in a School of Public Health and then we spend the next two or three years helping them to be productive and to actually learn to do public health.

And I think that's one way in which to do our work, but I would submit that part of our responsibility as leaders within schools and programs in public health is to move our field further faster. And to really focus on having students that are job ready day one.

And I know many of our schools and programs are working to do just that, but we are doing it in many different ways, some of which are effective and some that aren't. Let me take a quick review to say that our accreditation requirements, our accreditation, I think you can love it or leave it, but the worst part of it would be not having great standards and CIF provides us with a roadmap. Those standards require that all of us are in touch with our employers, our, and our alumnae to make sure that our training is relevant and meets the requirements of day-to-day practice.

How many of us have actually taken that to heart and substantially changed the work that we do so that our work really is resulting in students that are relevant day one. And, again, many of the work, many of the things that we do relative to the internship opportunities, and all of the class work that actually is now done outside within organizations helped move us in that direction, but, again, the idea is what are we doing today to really advance and to require that our students are ready day one.

One of the things that I wanted to visit about is the national board of public health examiners and the certified in public health exam. A little disclosure, I'm on the board so you will probably take that for what it's worth. The reality is that the CPH exam creates for us the opportunity as Deans and program directors and leaders within public health to see how well we are doing compared to others.

Not just how do we feel about our, the success of our programs and schools, but how do we compare to other programs and schools and what are the opportunities for improvement and to do so in a way that allows us to do that serious evaluation of our criteria and our curriculum?

The other thing that I wanted to say is that there are a number of schools now that are moving towards actually requiring the CPH and we just agreed to do that, our faculty I think were quite committed to trying to move the ball towards relevance and in fact now required that all of our students, both our MPH and DRPH students pass the CPH exam prior to graduation.

I have taken it another step forward and I have actually offered for all of our faculty and our staff I will pay for the exam and I'll pay a thousand dollars a year to every person on our faculty and staff that actually gets certified. I believe that that particular credential moves us further faster and gives our students a particular edge. I crave the ability to know how we are doing compared to the rest of the world, and I think that's an important thing.

The last thing I would say is that the public health accreditation board, now, over half of the, our state and local health departments in this country are accredited, over half of the population in this country are served by a state or local health department that's accredited, but how many have looked at the accreditation standards from PMAB and helped include those in our curriculum. It is our graduates who are going to be leading state and local health departments that need to meet evidence-based criteria that will make a difference in terms of implementing change.

So I guess my message is that as we think about trying to move towards equity, we need to make sure that what we are doing is producing students, now graduates, who will lead our public health organizations and our health systems towards essentially an evidence-based strategy, an evidence-based public health that ultimately will make a difference. I think that ultimately takes us further faster toward our equity goals, and I think that we need to be able to pay attention to our progress and I think there are some ways in which we can do that effectively. So thanks.

>> ELIZABETH WEIST: Thank you, Dean Paul Halverson. Our panel 2 presenters were outstanding and gave us a lot to think about. We saw and heard some beautiful images from both sets of panelists. Here are some of my favorites starting with Dean Fairchild, "pitching the camp," Dr. Trinidad Jackson, the uplifting image of the free birds. Dr. St. George, "digging deep," Dr. Marc Kiviniemi, "lower the barrier to entry," Ms. Heather Hagerman and Ms. CJ Walker "things will come and

grow." Dean Paul Halverson, "zooming out." Through both sets of panels we have been encouraged to work upstream. This is a blue sky question and the only one I will give to the panel. After that we will take questions from our remote audience and from inside the room. Panelists, what is the most important right next step to take in academic public health to do better in working upstream? The first next right step to do better in working upstream?...And you can tell this was not a planted question.

And since these are big thinkers, we are going to give them time to think. We have time. We have time for this.

>> HEATHER HAGERMAN: We would say listen, actively listen to the community, you have heard our journey has not been linear and we spent a lot of time talking and clarifying and understanding each other and to truly actively listen to the community will change your entire approach. We teach this to our health profession students, basically improv skills of how to listen actively to patients or clients, and what we have learned through our discussions is how you then add also the community discussion to that.

>> MARC KIVINIEMI: I think trying to draw a connection between what I talked about and what is a much bigger and more important question, one of the steps is to think about who already knows how to do this work and how can we draw from their models to do it? So there are effective models for working upstream. There are affective models for agitating for social change. There are effective models for working towards liberation. You are probably not going to find them in a P textbook, but thinking about what we mean by evidence base and blowing that apart in a way that honors the fact that high quality work that's known to be effective is being done in a number of spheres to work towards changing systems and changing upstream practices and looking for those models and then thinking about how we incorporate them in our work.

>> PAUL HALVERSON: I would like to extend Marc's comments to say that as we want to move forward, one of the important next steps as we think about practice is to consider the fact that our graduates who will be working in public health organizations need to recognize and to exercise their leadership in extending their work beyond the governmental public health agency because we know that the most effective public health happens in a system context. And I was taken by the wonderful description of the work by community health workers, but the community health workers are just as much part of our public health system as our MPH graduates.

The reality is that the work done in schools and in education and in churches and all of the community organizations

that are part of what we call the public health system, so much of the success of public health is built on the relationships.

And, again, you might say those are the soft skills. Well, perhaps they are the most important soft skills because our students who are going to be leading public health organizations need to understand quickly how to work and develop relationships that can then leverage the work that needs to be done in the community. So I would start there.

>> DIANE MARIE ST. GEORGE: Thank you for the question. There are a couple of things that come to mind for me. One is we need to have a drastic shift, and many of us have gotten there are or at least are getting there in terms of the type of people we bring into our spaces. Those discussions need to happen at the admissions committee level. What are we looking for in the students that we admit? Are we looking for the ones who are ready and able to do this kind of work? When we are recruiting for staff and faculty, who are we hiring? Are we hiring the people who are going to be able and want to do this work?

When we bring the right people in, we have to give them the time. We talk a lot about this work, but then we say really right now we have to stop and talk about our odds ratio, or we need to talk about how to do on RCT. We don't give ourselves the time to have these discussions because these discussions take more than ten minutes on your first slide and your first PowerPoint on day one. And so we bring the right people in, and we give them the time.

I think that's starts us off on the right foot.

> CIEARRA "CJ" WALKER: I would add that -- so I will echo and layer on some of the things I have heard. In addition to active listening, I think one of the biggest things, and this was shared by Paul is around relationship. When we talk about relationship, public health is extremely rooted in the ability to do partnerships, the ability to connect in order to make sure that your impact actually reaches the audiences that you desire.

So it's really important to root yourself in relationships both with your students, with likeminded faculty outside of the institution because relationships are what move kind of everything. The second thing I would say is we have to put a new value on lived experience because a lot of us forget that we are also patients or we were once students. So no matter how many letters are behind our name it doesn't validate or invalidate our opinion.

So for me, I think it's important for us to really center and know how lived experience contributes to PSE or evidence-based decision making and then that value comes back to IP. A lot of times we have students in our classrooms who are

bleeding with information, and we will ask them to turn it into a project, and we might take it back to our company and we might do whatever we choose to do with it.

The important thing to think about that is we could be cultivating leadership within those leaders if we had true focus in our public health programs around leadership implications, agile leadership, adaptive leadership, active learning. So for me, I will center it in the way in which we teach our students and how we revalue their IP both in lived experience and in traditional academia.

>> ELIZABETH WEIST: Thank you, panel. We have 20 minutes for Q and A and for conversation. There is the mic in the back for those in the room. Our Zoom participants, we have questions from you that our colleague at BUSPH Meredith Brown is pulling.

>> MEREDITH BROWN: We have a question from Zoom, how can schools of public health respond to state and city health department looking to hire staff with lived experience of marginalization and community engagement rather than academic credentials?

> CIEARRA "CJ" WALKER: I'm happy to take that one. I think the first thing will be recognizing that there needs to be room for progression. So a lot of times we will bring in people with lived experience expecting them to stay in an entry level profession. One thing we know is that no workforce is sustainable if there is only one space.

So here in St. Louis we service the first and the only in the statement who as a dual service model where we are not only a membership based organization but we provide direct services. What this has allowed us to do is take on one of the identities of previous health professions. Let's take nursing, for example. When you come into the nursing workforce it started very communal and then we decided to professionalize it from multiple places of access. So we have BSN, we have CNAs, we have RNs, LPNs, team leads, BMPs. So a nurse can come into the nursing workforce and work their way up. We have the same desire for CHWs.

So we challenge healthcare institutions as well as public health institutions to think about the career ladder and nurture that. In addition to that, we ask them to think about how they handle risk mitigation similar to how our funders would. A lot of times we find there is less risk if you have letters behind your name but we haven't thought about everything said in the conversation today and the way in which we might be institutionalized through academic learning so are we really less risky? It's important to think about fit assessment it's, but how fit are you from that, because CHWs are not what they are, it's who they are. So it's important that we also assess

their readiness. A lot of times CHWs, for instance, might get a negative wrap because when we get ready to bring someone into the emergency room where they are centered, they come back to the emergency room because they love CHWs. That's not a problem of the workforce.

It's actually our institutional structure. So it's important before we say I want to do right and bring people into this institution, that our institution is prepared to receive them both equitably, respectfully and authentically.

>> PAUL HALVERSON: I was going to say also that a couple of examples, one is related to being willing to get messy a little bit, and to think a little bit outside of the box. We partner very closely with our state and local health departments and we are very big believers in the idea of an academic health department and we help partner to strengthen those capacities.

During COVID, for example, our Marion County Health Department, our largest Health Department in the inner city actually where our campus is at needed help in actually doing contract tracing. So I talked with our president and I said I want to do something that will help support the work of our city Health Department, but it's going to be really hard and it will be a lot of people that we are not necessarily used to hiring, but we hired 200 people to do contact tracing.

We hired a lot of community health workers. We hired people on the basis of their relationship in the community, and their ability to reach out to people that would be difficult to reach normally. And I think that model was successful for us and the county Health Department, and that partnership made us stronger and better, but it was hard.

And we have to be willing to fight the battles administratively to be able to be successful in in that and provide support for the people in our organization to be the interface.

The second thing we have done, again, taking a page out of CJ's book is to work in our communities. And we are working in a project called DIP In, which is Diabetes Impact Project for Indianapolis.

The focus is three neighborhoods in Indianapolis where the life expectancy is substantially less than the rest of Indianapolis and the diabetes prevalence substantially higher. We hired community health workers, but we did it within the context of working with partners in community health centers and our health system, but also in working in collaboratively engaging in the leadership of our neighborhoods.

We did something a little bit unconventional, and it, again, raised the ire of our administrative structure at the university, but we decided that people that were our advisory

panel for the community, that we were asking to take time and effort on this project to be actually compensated for their work as Advisory Council members.

And because of their impact, we actually believe that our project has been much more successful. The other thing that I have learned somewhat painfully because I'm a little bit impatient is the fact that this does take a lot of time, but we have seen over time that our hemoglobin A1C levels in diabetes patients is substantially lower now as a result of the implementation of the intervention that we had proposed and that we are working with.

And, again, I want to say in full disclosure, we are working with our colleagues at Eli Lilly and company who have been stalwart supporters of our community at large from electric lights by Colonel Lilly when he was developing the company to a lot of work that's done, hundreds of millions of dollars provided by the company for work in third world countries.

It was the fact that our relationship with lily suggested to them that they didn't have to go to a third world country to actually work on community issues that really mattered. That relationship then turned into our work in the communities which then will translate into improved health outcomes. So I think those are some examples.

>> MARC KIVINIEMI: I want to take a moment and ask everybody to think about the premise of the question. So the Health Department thinks they can hire somebody who has lived experience and experience in marginalized groups or someone with academic public health credentials.

The premise of the quo is there because by and large that's true. That's an indictment of us. So I think in the same way that we are using our critical thinking skills and our evidence-based abilities to investigate public health problems, doing this work and getting out of that dilemma involves thinking systematically and thinking in ways that are going to be painful about what it is about our admissions processes, what is it is about what we teach, what it is about who we attract and welcome at the table that leads that dichotomy to be the honest truth at this point in time.

And really, that systematic investigation is the only way that we are going to change that system. It's a downstream approach. It's a planting a tree approach, and it's not going to solve today's problem, but it's absolutely critical if we are not going to be sitting in the room 25 years from now asking the same question and having the same problem.

>> ELIZABETH WEIST: Very thoughtful responses for the other two panelists, I want to give you the moment if you have anything.

>> DIANE MARIE ST. GEORGE: Thank you. I would extend what you were just saying and recognizing. In my response I talked about who we are admitting to our programs. When we do a good job of admitting the right students into our programs, we have to make sure that we are not doing something to take away from them such that when they get out, they are seen as somebody with an academic public health credential as opposed to somebody with a lived experience that they can use, because there are some things that we do.

There is some part of that aculturation process that makes them move from us to them in the way that they talk, and that is a condemnation of us.

>> HEATHER HAGERMAN: I would like to ask Ciearra to share with you about a learning she taught me what community health workers from the St. Louis coalition's approach which is unique and not what I have encountered across the health systems that I have been educated what they call community health workers, and why I believe you are all saying very similar things that the community health worker effort in St. Louis is actually part of the workforce solution to some of the questions that you are asking. I have seen many of these community health workers go on to become other kinds of health professionals.

> CIEARRA "CJ" WALKER: Thanks Heather. Really quickly I will say that we lean into the model that agitation outside of relationship is irritation. And you don't get anything done through irritation. So when our CHWs are out in spaces not only do they root themselves in relationship, but they really leverage their lived experience as the way in which to have a point of commonality.

So many of our CHWs are dualy trained, we have some licensed clinical social workers, some who are trained as social workers, many addiction support specialists, a ton who are Doulas, but they do lean in the title of CHWs. CHWs are meant to be mobilizers so they are not meant to be case managers.

In our health system most often you see CHWs in, most often in health systems you will see CHWs only serve in that case management direct service provider space. Well, what Heather has allowed us to do and many other organizations throughout our region is show exactly how CHWs increased community capacity by increasing.

(Internet technical difficulties)

>> We start making small steps let's figure out where we are then, thank you all.

> CIEARRA "CJ" WALKER: That's my director. I would say to that point we include students own your Committees as we do the community and I'm sure many have that approach as well. It's hard to get them to come to such conferences, but having student

voices is very important.

> LEAH NEUBAUER: Regarding the question for Paul, a follow-up on the comments for the CPH exam, and a question extending from a quick story and reflection which is I just took and passed the CPH exam, I think as some of you are aware, there is a big push and I think we heard about this for faculty to take the CPH exam.

And so what I wanted to offer from that is my own reflection and a question really pushing on the utility and also the responsiveness. That's where I'm going. And the reflection is, of course, studying for and taking after I was done taking it, I thought, oh, gosh, would my student be able to answer this or this? Does our program cover this or that?

I would say the classic example for us is it and are the questions around program planning and evaluation. We actually know empirically there are two studies, one more recently out of Clairmount about the absence of program evaluation in CIFA accredited programs. So for me the kind of classic take away was oh, my gosh, could my students take this and pass this? And I have been talking with our program just about that, and so I wonder on the one hand, I could see it as a summative tool, for sure.

But I wonder, Paul, would you comment, you or the board offer your sense, what is the sense on the utility of the CPH exam as a tool for potentially informing curricula development or adaptation, and then the second piece is on the CPH side, how responsive, what are the cycles for where you might hear from us or others about what should be on the exam?

>> PAUL HALVERSON: Great questions, and you are exactly right. This year, there is an organized attempt to try to get as many faculty certified as possible. There is a special rate for all of the faculty, so if you are sitting here today, you ought to take the exam and I'm speaking to myself as well because I need to do it.

The reality is the biggest fear, the biggest impediment to pass the exam is our fear of taking an exam and not passing. Let me assure you we have gone to the extra attention to try to make sure your Dean will never find out if you took the exam and you can tell him if you passed, but the reality is that by and large our faculty do exceptionally well in taking the exam. This is an exam increasingly focused on a very scientific approach to asking people that are working in public health what is it that you do, so there is a job task analysis we are now just finishing the second job task analysis that's done approximately every five years, and painstakingly going through and asking people throughout your day what do you do, and what are the tasks, what are the functions, and then fashioning

questions going through the psychometrics related to developing good questions and answers and so forth to make sure it's reflecting the actual practice and not bias and so forth.

So all of that to say that we believe that the exam reflects the practice of public health, not what a bunch of faculty think is important, although I suppose that's also important, but it is really about what is it that people do and how can we begin to test on the basis of that. That leads me to the question you asked first so what value is it in terms of summative evaluation and that's what I alluded to in my presentation, I think it's probably one of the most important aspects of feedback related to our curriculum. We may think that we have the greatest epidemiology curriculum in the world but if we found out that frankly we are a little bit lower than average, then maybe we need to reassess what we are teaching.

Part of the point I would make is we are really at about the same point that most of the health systems were probably 20 years ago, enormous variation in what we do and not really a lot of accountability for the results we are getting.

So isn't it time we focus on trying to get better outcomes? I think the CPH exam gives us one measure that is a powerful measure we could use for comparison purposes as well as trying to trying to identify people that have demonstrated competence.

> ELIZABETH WEIST: A final question, if you are able to keep it to one minute that's what we have time for.

> CRAIG ANDRADE: I will do my best. I have taken multiple certification exams and licensing exams from nursing to athletic training to massage therapy, on and on, and have also spent a significant amount of time in state public health agencies almost, over ten years, and local public health and traveled visiting counting public health across the country and in the midst of everything we describe and the hope I gain from seeing community health workers partnering with institutions in ways that are truly collaborative, I also recognize that our systems were built not for those most marginalized. They were built for the majority population.

And we are only in the infancy when it comes to the equity conversation. We are shifted from racial equity to health equity and losing track of what that means for community. I wonder whether there is a need for CIF and public health accreditation to be re-evaluating. I sat at the table and looked at boards of these organizations and they still don't seem to look like multiculturally led organizes.

I wonder if they don't know what they don't know, and what that means in terms of the translation of how my nursing exam didn't reflect my community, my sports medicine degree licensing didn't reflect my community and whether they truly reflect what

communities are looking like and how their voice is seen or not seen, how people are seen, heard and valued in meaningful ways and whether there is room for reevaluating all of the systems before we encourage people to take these exams in a way that promised to bring the equity we are hoping for.

>> ELIZABETH WEIST: Thank you, those are excellent concluding remarks. We will need to move on as our time is up. I wish we had more time. Speaking of the certified in public health exam,I would like to note that we are providing for those of you who have stuck with us for the whole three hours, up to three hours of CPH credits for this time here today.

Now, we welcome Dean Perry Halkitis to the stage to wrap us up. Please help me in welcoming our board chair, Dr. Perry Halkitis.

>> PERRY HALKITIS: I was told I had two minutes to wrap up. I will take more. I know you are very hungry. First of all, thank you for this exceptional panel today. Happy Flag Day, everybody. Happy pride, are we allowed to say pride in this room? Thanks to my colleagues that support the sources. For those of you who don't know, education is central to my identity.

I started my trajectory to this path as a Dean by first coming to the sections meeting in 2013 as the academic Dean at another institution. Prior to that early in my career, I was an elementary science teacher. I could teach kindergarteners about science, and I was influenced in my thinking about education in a report published by ETS called perfect storm, where I think it was 2010 they published a report ahead of its time that talked about the need for education to change to a big shift country to older, more diverse population, to address new skills required for students in the 21st century, and the wide variability in numeracy and literacy skills in our country.

If you haven't seen the report, I recommend you read it. It was very Nostradamus in its efforts. My other learning took place in the first decades of AIDS on the front lines of learning about what public health is really all about. So I think we all agree that universities are places where we prepare the next generation of scholars with tools to do their work effectively, so we are obliged to provided excellent pedagogy. At my institution the Rutgers excellence in teaching sits alongside as an equal cohort to scholar and research, this is privileged in many places, and community engagement which is too often mismanaged and ignored. At this moment and with lessons of the last several years it is an important reflection for us, I think, and so we have heard my great things.

I will summarize some of the things I heard and leave you

with a thought. Here are some of my takeaways or calls to action. Revised curricula to develop the skills needed to confront the politics in public health, and then activism in curriculum, teach students how to embed activist perspectives by building relationships. Thank you for the beautiful conversation about relationships. Shift gears to documentation of health disparities to development of upstream health interventions. Confront inequities and bias in how we teach and a form of diversity we never talk about diversity in learning stuff. Not all students learn the same way. Advanced lifelong teachers, we must help those who are not us or our students learn how to work.

Call out supremacy that has dominated our field, the gate keepers who challenge change. Advocate for the funding of public health science, and teaching science that supports the health of those whose lives western seeking to improve. Challenge the health behavioral theories that seem people are rational operators.

These do not meet the basis of what we teach but let's not blame the poor psychologists for that. Incorporate public health in high schools and elementary schools. Consider dosage, maybe cover fewer more relevant skills but deeper, bolster classroom teaching, leverage the educational practices and the work of schools of education, share our practices widely and we know ASPPH is a great resource of.

And just something I didn't hear but I kind of heard it, but I will say it every time we speak push back on the biomedicalization of public health. If we are not keeping our eye on the ball here, other people are going to do what we are trying to do. Finally I want to leave you with a provocative thought so I will leave you with this. This is my thought. Should job analyses from employers really inform our curricula and our competencies and our exams? Should they? To what extent do these analyses really reflect the conditions of societies or communities we serve and the politics we discussed this morning. Do what extent do they attend to different learners who are not coming to a field in a manner that be upheld by the ivory tower.

To what extent do they represent the voices of the few. Are we simply perpetuating sameness? Is it the tail bagging the dog? We are the world's leading academic public health organization and we should lead with innovation and risk and we should be willing to take the punches by challenging the norms.

I ask you to look at or view or hear the last session at the annual meeting that was where I had the opportunity to talk to John Moore and Lori Garett who provide really nice and thoughtful insights into how we should train in public health.

So that's my thought for you. I know you are all super-duper hungry as am I. I do intermittent fasting so I'm starving now. I have the pleasure of passing the mic to my friend and colleague, the President and CEO of ASPPH Laura Magano.

(Applause).

> LAURA MAGANA: 30 seconds just to say thank you, thank you very much. This has been an incredible morning. Everything has been just perfect in the two sessions. Thank you to all of the panelists, insightful and thoughtful conversations. We have a lot to digest to keep on going. So thank you for all of the speakers, the moderators, thank you to the Boston School of Public Health, Dean Galea this morning and Lisa who is leading the effort. Thank you to all of the student Committees, members here present, all of the morning 100 people that actually are engage in our three expert panels. This is just starting.

I'm not saying it's starting because we have been having this conversation for years. I go back when be -- but I want to finalize saying that the future doesn't just happen. We are building it, and we are building it through the actions we take today. Thank you for being in this incredible building project that we are building together community, thank you for being here, thank you for being an attentive and participatory members here in St. Louis but also everyone online. Thank you for being here today, and have a wonderful afternoon!.

(Concluded at 1:05 ET)

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This text, document, or file was lightly corrected for accuracy by Liz Weist on June 28, 2023.