Conversation with Alexandra Quinn & Sue McCarron
Ashley Hopkinson
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Ashley Hopkinson: Hi Alexandra, tell me a little bit about yourself and what brought you to the work that you do today.

Alexandra Quinn: I'm Alexandra Quinn. I was born and raised in New York but I live in Oakland now. I'm the daughter of a clinical social worker and a small-time entrepreneur. That explains how I came together. Mom of two. I have a great partner and two huskies who you may hear during this.

I have been focused on equity issues since I can remember and can literally pinpoint the time in 7th grade when I had a great English teacher in New York City who was like — who is this little white girl that seems obsessed with all things race? That comes from my parents just having those dialogues around the table.

They assigned Langston Hughes for my first term paper in 7th grade, and I still can remember the moment where I was reading his poem "I, Too." There's this line at the very end that says, "They'll see how beautiful I am. And be ashamed." I can still feel the sense of white privilege starting to get in my head, and from that moment on, it's all I wanted to study. It's all I wanted to understand. Intersections of racial equity and health, intersections in education.

My career has just followed that. I worked in government for a little bit and then started my nonprofit career at a place called Peer Forward. It was a college summit around education access. In my heart of hearts, I'm a very off-track pre-med student and always wanted to do health. It gets funnier as I get older because I don't think it's going to happen. I ended up at Health Leads because a funder at the last nonprofit said "You seem a little obsessed about health." My story was coming to Health Leads because of health equity and just seeing – when I volunteered at the hospital – the difference that zip code made in people's health. I never expected to be CEO of Health Leads. I was very much on my way

out, helping organizations do their strategy and develop their senior teams, but I was asked if I was interested in the job; I interviewed and got it.

I really took this job for three reasons. One was, how do we put Health Leads squarely on a health equity journey? We did it well in pockets, but we didn't actually say that this is the thing that we're going to focus on. Doing that externally and internally are the first two reasons. The third was—and this is a little grandiose—how do you change the way revenue moves in the sector? How do you think about the inequities of philanthropy and earned revenue? If you're going to work on health equity, you have to understand how the money flows. That's me.

Ashley Hopkinson: Sue, can tell me about your background and what brings you to your work?

Sue McCarron: I'm from Rhode Island originally. I'm outside Boston now. My parents are public school teachers. My mom ended up as a principal in Providence, Rhode Island while I grew up a white kid in the suburbs. I'd always say, "Mom, why don't you come be a principal here where we live?" She was like, "No. I want to hear about those problems. What's going on in Providence is a lot more complicated."

I was one of those kids growing up in the '80s and early '90s with a bit of the white savior thing in my head, knowing I want to do good things and help people, but maybe a little blind to what I had going on with myself. I meandered through. I was always a writer. I was a reader. I was the editor-in-chief of my newspaper in college. Out of that, I started at PR firms, and got bit by the healthcare bug when I started working for one of the first electronic medical records organizations back in the day. I was like, this is wild. Then I sunk deeper and deeper in the communications agency side. I feel like people who touch healthcare in some way either dive in further or run away screaming. You're like, this is too complicated. Payers, providers, policy — I just loved all of it and I got a lot of education about the healthcare system through my clients over a really long time.

For 10 years I was working in a practice, in an agency. Somewhere along the way, I started chipping away at my master's in public health. I started to zoom out and really hate the narrative that there was a silver bullet, that a certain technology is going to be the thing that makes everybody healthy.

A lot of my clients were spinning that same story and I was like, I don't think this is it. I think we're missing some layers. As I dove more into public health, I found Health Leads at just the right time, and honestly I think my journey in equity was really just because of the investment Health Leads has made in me and the work that I'm doing to be able to see my own privilege differently.

I wanted to be a different kind of comms person. I wanted not only to do comms for Health Leads and to push our initiatives and our approach but also to show how comms could be different and push others. Because in everything we do, even in this conversation, we're always thinking about challenging the ways that words, data, and the care workforce show up in the world. What are we not seeing, and how do we hold ourselves accountable to doing it differently and having that conversation?

Ashley Hopkinson: How is Health Leads doing this work differently?

Alexandra Quinn: It's a great question. I'll talk a little bit about Health Leads and a little bit about the collaborative, too. I'm about to hit year seven as CEO, and about two years into this job, the thing that really struck me was how taking over from a founder isn't easy for anyone.

Organizations are often set up by their CEOs and their funders as the answer. The sector is addicted to really simple theories of change to solve very complex problems. My point of view — and I think it's Health Lead's point of view — is that no one organization is going to do it on its own. It's just not going to happen. I don't care what a great organization it is. If we're talking about racial health equity or we're talking about educational inequities, you need a big tent.

We decided to get together fifteen of our closest friend organizations: other CEOs, someone from the Robert Wood Johnson Foundation, big organizations like Partners in Health, and basically got everybody around the table. All fifteen of us agreed, okay, let's figure out what we want to do together. Let's try this out.

If we were to do something together, can you imagine it being that much more powerful? It does mean divesting of ego and divesting of ground. The thing is, as much as foundations and others say they want you to collaborate, it's not really paid for in the sector. The idea of collaboration and sharing power is a more normalized concept now, but so much of inequity is in the guts of the small decisions and processes.

Long story short, COVID hit two folks from that group of fifteen, a guy named Dr. Darrell Brooks and then Tené Hamilton Franklin, who was on our team. We said if we want to do something together on a big health equity issue, we should focus on vaccines. We did our design principles. Everybody from the National Association of Community Health Workers to Partners in Health to Hopkins came up with a set of equity principles for vaccines and just put them out there. Forty of us wrote it together and then we suddenly got invited to the CBO meetings that the White House ran. We were on the Ad Council

campaign for vaccines, and Denise Octavia Smith, who's our co-backbone in the collaborative who runs the National Association of Community Health Workers, was also invited to all the meetings.

At the same time, I was working for one day a week at the San Francisco Department of Public Health as a community health worker. I wanted to do something more frontline. I worked at the vaccine call center in San Francisco just helping people schedule vaccines or get to other resources.

I'd be on the White House call earlier in the week with all the community-based organizations they're working with, and they'd announce, for example, that we have vaccines for kids over 15. Then, I would be at the call center that Friday, where it turns out that five different clinics interpreted parental consent in five different ways. One clinic said you had to have a parent or guardian there, another one said you could phone it in, another one said you could have a written letter.

The sector and the system dictates that there's going to be a hero and the hero is going to save the day. We said, what if we just got together and worked on vaccines and decided on three aims? How do we democratize data?

All of us, in our local and international work, are seeing this huge disconnect. That ended up enabling us to say – what if we just brought people together on a webinar and shared what it means to mask, or what it means to have access to vaccines? That was about democratizing information.

For example, one webinar was about community health workers and those leading community health worker groups. We're getting somewhere between 200 and 1,000 people to show up for the webinars. It was this really hard moment where there was a nurse from a state that was less vaccine-friendly, who came off mute, and basically said, "I don't even know how to talk about vaccines, because it's just a hostile environment." Then, the head of the NAACP from another state was like, "I've got a toolkit."

We took him off mute, and they were able to share learning across two states that were having a hard time. We said, how do we just enable this? How do we use Health Leads' privilege and power to get organizations and funders and community-based organizations to sit around the table, decide to collectively divest of power, share all the resources, and collectively go after policy wins?

And then we said, what if the collaborative went after some unsexy policy wins, like getting pediatricians reimbursed for COVID vaccines? So we went after that policy win. The collaborative really was born out of an information gap and a collaboration gap. We had a platform for anyone that wanted to use it, both to share their own work and to share resources. That's how the Health Equity Collaborative was born, which really is our big stake in the ground with our partners that we need to work differently.

Ashley Hopkinson: What do you think worked? What are some of the things that got people into the room and got them to stay in the room?

Alexandra Quinn: It's an ongoing experiment. All this could change in six months. We're learning. For the first phase, which the vaccine equity cooperative was born in, we had funders. One, we had a live crisis. At the same time, one of the core partners now, Rishi Manchanda, who runs HealthBegins, was creating a similar shared table around community-based workforce, and so we actually launched two collaboratives. We co-founded the Community-Based Workforce Alliance with Rishi, and then VEC [The Vaccine Equity Cooperative].

One of the values of VEC is being really clear about shared decision-making, which is hard to do. Health Leads does this kind of design work.

The way Health Leads has differentiated itself over the years is that we're not going to design any health equity intervention without community members, because that's who health equity actually impacts. We always co-design, and always have all the players around the table. Funders also have to sit at the same table. They can't just fund and be out. You need to have health care at the same table. Every initiative that we choose to do around access has to have all these elements. We took all the learning from that and said, can we do this at a bigger table?

With community-based organizations, national NGOs, and funders, who can't just fund—you're literally going to make decisions with us as health care partners. There isn't any decision in the governance model that doesn't have a mix of those people, both for the overall governance of the collaborative and for our working group.

We have a kids health working group that has four funders, four NGOs; that's the group that had the expertise and power to help get pediatricians reimbursed for COVID vaccines.

The other thing you do is offer pay to everybody. Assume funders will say no, but every single NGO and expert partner gets paid well to be in the collaborative. You have to buy their time. So many times you hear that you're lucky to be able to input, and we're like, no, these are professionals. Whether it be a community health worker on the ground or an academic, their time has to be bought for every hour they're spending co-creating and co-governing with us.

The other piece is, where do we take our direction from? Right now, the core partners are an interesting mix of leaders, but we don't design anything without community health worker input and focus groups. For example, we don't take any webinar without it coming from the community. Right now, we have 9,000 community members, essentially.

Honestly, I didn't want to do a webinar around the election, but we kept hearing from our community partners: can you actually do something around the issue areas that are important for the election? We're a 501(c)(3). We can't endorse candidates. We said, yes, if this is what our community wants, let's do a webinar around better understanding the health equity issues on the election, and it was wildly popular.

To us, it's also like, who do we take cues from? Then how does the shared governance reinforce taking those cues? Because at every moment, the system wants us to listen to the funder first or listen to the more powerful national NGO. How do we understand that no, that's actually not what it means to be community driven. How do you go against the grain constantly?

Health Leads has its own power and privilege. We're using that to create the collaborative. I have to remind my colleagues all the time that we don't want to eat your young.

You should run that webinar because it's your issue, we're just going to support you. I think that's not the message they're getting, because that's how they compete or stay sustained. At all times, there's managing of the partners that has to happen.

Sue McCarron: I think a lot about that, especially as we have passed the real spike of the vaccine work. Think of all the vaccine-specific groups that popped up to vaccinate your family. That's been around forever. I think a lot about the way we were able to join forces, and we're not taking anything away.

This is an additive thing. How do we work together differently? Then how do we carry that vibe, which was felt absolutely necessary in a pandemic, and say that this is how we could work all the time? We all came together in such a beautiful way. We wove a little bit of a fabric during that time out of necessity and fear, but that worked great. Why aren't we doing that more often moving forward?

Part of the reason why this group gelled so quickly was that it was a pressure-filled time. But after you move past the pressure of the pandemic, there's no lack of really stressful equity challenges. They continue.

The mental health fallout was the next wave that came after COVID. Community-based organizations were now left trying to pick up the pieces in their communities of stress for kids and adults, loneliness. All that stuff that came out, and they were right there.

It's a place to come back to where everyone's dealing with these same things. We're on our webinars, that's the vibe in the room. You're surrounded by people that are touching the same challenges you're touching, whether you're touching it from a public health or CBO or healthcare or food security

perspective, whatever part of the piece you're in, you're seen here. You're part of this. You're working on your piece of it. There's a place to go with the things you're grappling with because it continues. Pick any issue in equity. That is something I think we've done a good job cultivating in the room when people are together.

Ashley Hopkinson: How do you manage competing priorities in a room of people?

Alexandra Quinn: It's a great question. I had this great conversation with our chief medical officer about this.

We decided to put our stake not in information but in belonging. We've had multiple retreats where we've got our core partners together and said, what's our vision? You have some of the most influential folks in health within the larger collaborative, and the vision for us was belonging. If that's your aim, no matter what your issue area is, no matter what you fall asleep with, you have a place here.Today we may not focus on your part of health, but we're going to introduce you to folks. We do this all the time. We're going to introduce you to the folks who will be able to work on your area.

Like, this webinar is going to be about kids going back to school, or this is the toolkit we're going to put out or the set of resources. We're going to ask all the folks who are most expert in that, because that's what's timely and what's needed. The core partners have a way to make decisions around the timely things we're going to respond to. The idea is not only giving the resources and access support around the issue but also that anybody who joins that conversation feels like they belong.

That is the stage that we set at every webinar that we could. How do we see everybody? If you ever watch the webinars, I will make sure that everybody who drops something in the chat gets liked or seen. They are very tactical things you do. Very clear communications of what we're focused on now and what we're not focused on.

Governance that enables a stake in the ground, a vision that goes way beyond solving health equity issues. Governance that enables you to pick the most urgent issues — all of that sounds easier than it actually is, but it's all by design. Even If it's not your issue, we're going to capture what you need by a belonging survey in a webinar. We're going to want to hear what's pressing for anyone so that it helps us to know what the next collective force should be focused on.

Ashley Hopkinson: How do you measure progress in the cooperative?

Alexandra Quinn: The Vaccine Equity Cooperative was a good experiment because it's contained. The metric was how many people are joining the larger collaborative? How many people are downloading

our resources or showing up to webinars? How many people are answering surveys? Then, we had some policy things we wanted to get through.

For example, we wanted to do a TA session. There was a big grant that came down from HRSA [Health Resources and Services Administration]. We said, let's do a one-and-done TA session for any community-based organization that wanted to apply for it. We had 700 people show up for that. We did a one day of TA and then we could track who was able to access the money or not, and then did a pretty cool analysis on how inequitable the money distribution was, to be perfectly honest. There's the one-and-done infusion of democratizing information and data, providing a little bit of TA, and then enabling folks to maybe reach for something they might not have reached for.

Then, there's the policy wins. One of them was making sure that there was a strategy for getting the children's vaccine out in the United States. That's a much more complicated story, but we got together the head of the American Academy of Pediatrics, some funders, and the head of the School-Based Health Alliance, Dr. Rhea Boyd, and said, how can we set up the government to have a great kids' vaccine strategy knowing how strapped everybody is? We wrote this set of principles and handed it off to the White House and they used them.

We don't need to be out front, we don't even need credit. What's the foundational support we can give so that any member of the collaborative can actually further their issue? We have measurements around that. As you can imagine, because it's all shared governance, things take twice as long as you think they will.

We have lots of support. We launch with a set of aims with our belonging survey, and then do listening. The other part is how we measure ourselves on listening to the community and then responding to the community's needs.

Sue McCarron: As we grew and we were able to really support the folks on the ground, we were getting asked by folks to help make sure there was awareness around access to test kits. We were a big part of the push to get test kits to CBOs to that community. We also got asked to run a webinar on antivirals, realizing that the government didn’t have a channel to get to the folks that really need to know about them. We were getting asked to participate as an arm on some of the bigger pushes.

As we grew and were in more and more of those rooms, we were being asked to reach the community with those messages because we had built a container, people were coming to it. I don't know that there were hard measures, but there were certainly indicators that we were becoming an arm to reach that group at really critical moments. That kept happening throughout the pandemic. I think now

we're in a different place where we're going to be more proactive in playing that role. We've got one thing built. Now we want to see where else we want to lean in on. Obviously, this election's going to determine a lot about what those things are and how we're going to approach it.

Alexandra Quinn: We're trying to make a proof point around an approach. That you can get organizations who traditionally may not be seen as good collaborative players playing together to move the mark on several policy and process issues. That's the ongoing experiment, especially in a world where you have really busy leaders and really busy staff that have to actually do the thing that they were hired to do and are supported to do while also sharing power with others. That's extremely hard to do.

We try not to take on any issue that's supersaturated. For example, housing is a supersaturated issue with a lot of organizations. Recently, someone argued to me that that's exactly why we should take on housing and figure out if there is something we can do together. But I think we don't want to compete for dollars. We don't want to take dollars away from other places where they should go.

Ashley Hopkinson: How do you balance that? Is that a challenge in your work?

Alexandra Quinn: I would differentiate between Health Equity Community Collaborative and Health Leads in that. I think about the collaborative as a vehicle that at all times is trying to create belonging, data democratization, and moving on some collective policy and process wins. That's the group that should always think within the shared governance model, because that's a powerful approach. Health Leads, on the other hand, which is the backbone along with NACCHO [The National Association of County and City Health Officials], we'll take on any issue if it makes sense.

We have four aims. One's around power sharing, one's around sustainable care and sustainable caregiving, another one's around data equity, and then investment. Half the things we do are initiatives that we believe are important to actually change the way things are done. For example, we're doing food work in Boston that came out of COVID, and it is about home-based food pantries. That came out of listening to community members say, “I want to deliver food. I want people to come to my house to get their food, to create a different kind of environment." That initiative has been going for three years, and we've fed 20,000 people. We're doing SNAP enrollment.

The idea is Health Leads doesn't need to create a new food pantry. Health Leads doesn't need to add to the credit food space, but there are spaces that need a little bit of disruption if it's on a community member's terms. For us, it's how do we deeply listen to the community and then do a little bit of systems disruption while also having one foot in practice? Similarly in New York, we were doing some

work with women and doulas, and playing backbone to this doula collective. What was important to them was getting reimbursed. We did some advocacy work with them to get them reimbursed in the State of New York, but that was with doulas in the driver's seat.

The other half of Health Leads' work is just consulting. Whoever wants to learn how to do community co-design, how to get the players around the table to redesign everything, from community health workers in California to a Medicaid equity tool with the state health agencies. We ask ourselves across the four aims, is there a place where we can have one foot in addressing immediate needs and one foot in changing the system? Then we'll give it the Health Leads treatment to push it ahead.

The other part of our work is that, ideally, we're only in for two to five years to create a proof point of how the system needs to change and then get out. We're not great at doing this; it's hard to say goodbye to programs. But we're not running programs in perpetuity. We're doing it to serve immediate needs and change systems.

We'll take on any issue, but it has to be at the community's behest. It's not Health Leads deciding this is important. It is getting brought in by a community partner and a funder and others to say they need our help in redesigning.

With Health Equity Collaborative, we backbone it, so there's some reflection on how we operate, but it's also how NACCHO operates and it's how HealthBegin operates. How do we take what we're all best-in-class at, put it together in a collaborative, and move some policy and process faster? That's the way we think about it. How do we spread all the good work that everyone in the collaborative is doing? We're still going to do our day jobs, and for Health Leads it is this intersection of healthcare systems and communities and public health around access, food, housing, mental health, healthcare.

Sue McCarron: With the consulting work we do, we're taking that same approach and applying it to the challenge that we might get from a partner. In the last year, we've been working on a Medicaid equity tool. We were brought in to run the process of getting to community members, getting them in the room, and shifting the power to get the information that would potentially inform Medicaid. That's an example.

We did something similar on a different scale with California Health Care Foundation in training CHWs, offering a lot of support to promotoras [community health workers] in California over the course of several months. Whatever it is, the partner's aware this is our approach. Every part of what we do is run in a community-led way. That's the difference-maker for partners wanting to work with us.

Ashley Hopkinson: What have been the biggest challenges that you've faced coming out of the pandemic? How have you managed the challenges that have come up?

Alexandra Quinn: I think there are three challenges. One is just the cumulative exhaustion of working through COVID to the point of recognizing that journalists probably have some PTSD from being frontline journalists. There's the Health Leads team and then there's our community health workers, partnered with others who for the last four years have just not had a break. How do you care about the health and wellbeing of your team and your partners and others when there's been no respite? Honestly, I think things have gotten worse in some ways, because you do have folks who are burnt out. Healthcare aside, that's one.

Suddenly people think they understand what health equity is. Eradicating health inequities or racism, this is the work of generations. This is not something that's going to get solved in our lifetime.

You may get some wins; doulas being reimbursed in New York was a huge win. Even understanding that doulas are important to women's health, particularly Black women's mental health. Great—let's all pat ourselves on the back that the doula collective is being reimbursed. But how are the doulas actually accessing those dollars? What's the next ten steps that need to happen to support them? Do you have to be attached to a healthcare system? Do you need to be at a community-based organization? It is a long game to try to undo inequities, and doulas are a bandaid for deep racial inequities.

Unfortunately, revenue and how these things are actually solved are not always aligned. Often a philanthropy or a for-profit wants to show a return or that they've had a big impact. But there's going to be incremental progress on changing any one of these underlying inequitable policies or processes.

I think we've all seen a real decline in interest and resources going to that long-game work. I know at least fifteen organizations, ourselves included, who had to go through layoffs or some kind of financial instability over the past year and a half in particular.

How do you have the ongoing resources for all of us? I think it has to be us, our community partners, our sisters and brothers, and their organizations to do not only the big win that feels good but the ten steps that enable that win to take root. There's a real wane in interest, particularly with the election right now. Yes, the election is important, and we should invest in it, but so are the livelihoods of our community health workers, doulas, and mom partners. It is cumulative exhaustion. This is all a long game, and who's going to fund the long game?

Ashley Hopkinson: How do you demonstrate the value of this when we're running on grant cycles or four-year political terms?

Alexandra Quinn: Have a safe birthing where you feel respected. You can look to other countries, those who have invested in public health and social services. The meta issue is that we have deeply under-invested in public health and social services. We're one of the wealthiest countries that spends the most on healthcare with declining life expectancy and declining health and treatment. If you look at zip code, race, gender, those health outcomes are even worse.

The biggest issue is how to have a real investment in public health and social services in the United States. How do we really think about prevention? There are some niche things like ultra-processed food, for example. England, as much of a mess they may be right now, their public health system banned ultra-processed food everywhere years ago. They have accountability measures for companies. We don't have those in the United States because we're deeply entrenched in profit, both on the healthcare side and on the for-profit side. Those are the big meta issues we have to go after. Honestly, everything we're doing until then can feel like a bandaid.

As much as we want to blame philanthropy, they are asked time and again to step in for our lack of social services and investment in public health. They're exhausted too. That was never seen more than during the pandemic, how philanthropy stepped in to support the White House or to support government agencies. In the meantime, until we do have a very good prevention system, public health, and social services, we are going to have to step in: us, philanthropy, others.

We need to be honest about that as a sector. Let's stop pretending. Especially in the social impact sector, twenty-five years ago there was this premise that if we invest in nonprofits the same way we do venture philanthropy and for-profits, they'll make the case for education or whatever, and then the government or for-profits will take it over and everything will be solved. We're still living with that premise and it's not working. The hypothesis is deeply broken.

It's not to say that many organizations haven't done incredible work to make progress on issues, but if the hypothesis itself isn't going to work, the government is never going to take on some of the things we create, at least in our lifetime. So we're going to create some band-aids until we invest in public health and social services, and we have to work together around those band-aids.

Ashley Hopkinson: This meta paradigm shift has to happen at a large level.

Alexandra Quinn: Local too. Indiana actually increased their public health spending by I think 1000%. We will see returns on that. There will be better prevention. Can you imagine at a local level, state

level, national level, if we could see more of that? We actually would see some returns in terms of people's health.

Have you read the “Healing Systems” article? That was in the *Stanford Social Innovation Review*. It is one of my favorites. We want to get really deep in it. We've never done reparations. We've never actually healed and repaired from slavery and from atrocities against Native Americans. Until we do that, we're just going to be putting band-aids on there, too, which is a deeper, harder conversation to have. What I loved about that was, yes, our systems need healing, too. Not only the people within it but the systems themselves.

Even the hypothesis around venture philanthropy that comes from feeling guilty. Maybe you make a lot of money, you want to do some good, but if you haven't repaired the underlying systems, you're just going to be pouring money on top of unrepaired and unhealed systems. So what do you do? What you do in the day-to-day is face the daily challenges. You pick the initiatives or the programs that you feel like you can do smaller systems change with.

For example, let's make sure the doulas are reimbursed by the state, and make sure that they can actually get into hospitals, and make sure that moms and all birthing people have a doula if they want. That's the fight. That's the immediate kind of systems change that we do while we think about the bigger changes that need to happen with the system. That's where the advocacy comes in.

Ashley Hopkinson: What have you learned from the work that might be valuable to share?

Alexandra Quinn: The first lesson is that this is just a constant improvement. When we aim for perfection — particularly as a white leader on equity — you don't want to get it wrong. We need to go from fragility to vigilance. In order to be vigilant, that means visually listening to the community, visually understanding your own power and the space you take up. I'm going to make mistakes. We all are. So how do we improve and learn faster?

How can we be honest about when we've sat with a bunch of community health workers and they thought we got it totally wrong? How do you create the space and the container to get the feedback so you can improve? Then do the power analysis at all times, every time. Especially in the context of this country right now, there's never a situation where there isn't a way you can use your power for advocacy.

I want to use every part of Health Leads and my own privilege and power to change the underlying systems. Imagine what we could do together if we were all aware of that and did that kind of analysis.

That goes back to improvement. That means I'm going to overstep bounds sometimes. Sue's given me lots of good feedback like, "I didn't like this," and I'd do the same for her.

Then, I don't think you can ever collaborate enough. You can never listen enough. How do I divest of my confidence and ego a little bit to better listen to my partner? Maybe you can be confident in the skills and the competencies you bring, but every time you're open to a different way of doing something, even when you think you've nailed something.

We may have nailed our doula collaborative in New York, but we're going to try it in a few different states and that same play may not work. It doesn't matter how well it went. Every community is different, every community member in CBO deserves to be listened to with open eyes and ears, and even though you have some confidence from your first thing. Then you move from there.

The last one I'll say is, we need joy in the work. We need to have fun, and you need a sense of belonging. We can all take ourselves very seriously. Because it's hard. How do you make time for that? How do you make space for that? Because it is a very heads-down white supremacy.

We have to get the stuff done, but it's leading with love. How do you be that bold and understand that my own healing is connected to joy and love and to your healing? That feels dangerous in some ways and vulnerable. Appreciating other people's work doesn't take anything away from ours.

Sue McCarron: Those four things—constant improvement, power analysis, collaboration, and joy and connection—sometimes when we enter into partnerships, we're in rooms where those are the things we're leading with. Sometimes, depending on where you are in your equity journey, you think the things you have to do are different. It really is very much in the fabric of Health Leads. Internally and externally, those are the things. Sometimes we will start on a project and the partner will say, this is how we do this. It's not a playbook. We have an approach. Bringing people into the work where they think, oh, I thought it was a list of items that I could check off.

Alexandra Quinn: I'm going to go with my policy. What's wrong with my policy?

Sue McCarron: Right. Evaluate this. Do I have enough people of color working here? You're like, wait. It's like a double click. It's a level deeper than what you think it is, and I think that's what Health Leads is always trying to say: this is not a stack of trainings, this is a way of life.

Alexandra Quinn: I really wish people could stay curious, because the other belief for us is that every answer that's needed is already within that community. Maybe we bring in a different approach or stack, but ask anybody what they need to make decisions about their living conditions, they'll tell you.

They'll tell you what they need. They'll tell you how they want to spend money. They'll tell you who they think they need to work with.

We could come into another doula collective. They may have already figured it out, and it's actually some random state actor that doesn't want them reimbursed. They may not need anything we bring. Then if you listen deeply, you might say, OK, it sounds like you need someone who's better at lobbying or someone who's got more political chops to talk to that person and make the case. You may not need what we do.

Often it is about facilitation versus solutions. Facilitation really has to be where you start, because you never know. So often people think they know the problem they're trying to solve. Our R&D team does a really good job of this, but let's actually just figure out what the problem is and create a hypothesis as opposed to saying, I know your problem and here's the solution.

Ashley Hopkinson: What do you think is missing from the public health conversation? What would you like the health community to be talking more about?

Alexandra Quinn: Let's take health equity. If we really think health equity is possible in our lifetimes, we have to go five deeper on why we have the health outcomes we do. Why do Black birthing people have so much worse outcomes, and could you get a collective group from multiple communities across to actually dig deep on all the root causes? A committed root cause analysis from multiple players, including those with resources.

Then on the other side, setting our vision and scope, way out there and working towards that. What if we actually had some kind of collective vision or movement that is about belonging or is about healing, and then we do the very intense design work to get to what it means? That, to me, is not soft. If we take healing systems, if that's the thing we want to plant the pole on, or belonging for anybody who enters any kind of health system, then we need to build the thousands of processes and policies that get to that.

Ashley Hopkinson: Given the right resources—the funding is there, the people are there—what would you like to see expand and grow and scale?

Alexandra Quinn: If we have all the resources, let's just alleviate poverty. How about that? It used to be said that if you give money to people who don't have money, they're not going to spend it well. We've disproven that. We all knew that, especially those of us that have roots in rural Texas like I do.

How do you make sure people have enough money to be able to make decisions about their living conditions? If we have also already fixed the healthcare system and invested in public health, and we've gotten a root cause, then you need enough resources to make decisions about your living conditions and thrive. That, to me, is what you do. I don't need to spend people's money for them. I need to help eradicate the inequities in the system.

We do as Health Leads, we do as HECC. How do we go after the systems and then let people spend their dollars how they want?

Ashley Hopkinson: Thank you.

Ashley Hopkinson is an award-winning journalist, newsroom entrepreneur and leader dedicated to excellent storytelling and mission-driven media. She currently manages the Solutions Insights Lab, an initiative of the Solutions Journalism Network. She is based in New Orleans, Louisiana.

** This conversation has been edited and condensed.*