PROMISING PRACTICES[i] FOR ACHIEVING HEALTH EQUITY

THROUGH PUBLIC HEALTH PRACTICE

Prepared for the Delaware Division of Public Health

WORKFORCE DEVELOPMENT & INTERNAL CAPACITY

Promoting health equity requires public health agencies to have the internal capacity necessary for new models of practice that build on the foundation of traditional public health efforts. Internal capacity includes resources and infrastructure, organizational policies and practices, as well as workforce skills and competencies.

Organizational Self-Assessment: *The Organizational Self-Assessment for Addressing Health Inequities Toolkit* provides public health leaders with tools and guidelines that help identify the skills, organizational practices and infrastructure needed to address health equity and provide insights into steps health departments can take to ensure their organization can have an impact on this growing problem. This toolkit is aimed at local health departments but may be adapted for state health organizations. The toolkit and implementation guide was produced (and is available for download) from the Bay Area Regional Health Inequities Initiative (BARHI) at http://www.barhii.org/resources/toolkit.html

Facilitated Dialogue to Transform Practice: The Ingham County Health Department Social Justice Project was aimed at identifying ways in which the Department's policies and practices had an impact on the root causes of health inequities. The organization used a *facilitated dialogue process* that included a series of workshops over several months with employees and community residents to identify problems and solutions. It was grounded in a model of change created by Visions, Inc. (www.vision-inc.org) which identifies the need for change on four levels: personal (feelings, beliefs, values), interpersonal (actions, behaviors, language), institutional/systemic (rules, policies, procedures), and cultural (collective ideas about what is normal, right, true, beautiful). More information may be found in Hofrichter & Bhatia (2010), Ch. 13.

Staff Development: Various kinds of professional development may be useful in building knowledge, skills and competencies of health department staff. Specific professional development promising practices include:

Unnatural Causes: Is Inequality Making Us Sick? – Film screenings combined with facilitated discussions used to educate staff on the root causes of health inequities and encourage open dialogue about challenges and opportunities for practice changes: www.unnaturalcauses.org

The People's Institute for Survival and Beyond: Undoing Racism – Facilitated workshops use a systemic approach that emphasizes learning from history, developing leadership, maintaining accountability to communities, creating networks, undoing internalized racial oppression and understanding the role of organizational gate keeping as a mechanism for perpetuating racism: www.pisab.org

DATA

Promoting health equity requires innovation in data collection, analysis and dissemination. Different kinds of data are required than those that have been traditionally collected, and new strategies for communicating information about the social determinants of health is critical to making change and measuring progress. Specifically, health departments must obtain and maintain data that reveal inequities, their source and those most affected. Further, health departments must learn to place more value on qualitative data and 'stories' that move us beyond traditional 'risk factorology" to a more

holistic understanding and representation of health inequities, their causes and potential solutions. Finally, different kinds of data must be used for setting targets and accountability.
Health Equity Index – The Connecticut Association of Directors of Health developed a Health Equity Index to assess the social determinants of health, and their impact, at the community level. The Index is a community-based electronic tool that profiles and measures the social determinants of health and their correlations with specific health outcomes. The Index also generates community-specific scores and GIS maps. Moreover, the Index provides direction for collecting additional qualitative data—the narrative of those experiencing or witnessing health inequities. This narrative may be collected from interviews or recorded through media including photos, video, and audio-taping: http://www.cadh.org/health-equity/health-equity-index.html & Ch. 23 of Hofrichter & Bhatia (2010).

Reporting on Inequities vs. Disparities – The Virginia Department of Health, Office of Minority Health, produced a 2008 report titled, "Unequal Health Across the Commonwealth." The report made clear that health is tied to the distribution of resources highlighted data on the social determinants of health. It also provided a narrative to put the data into the context and included recommendations such as the need for policy change across sectors. The 2012 report is pending:
http://www.vdh.virginia.gov/OMHHE/2008report.htm

Community Mapping - Several organizations are using spatial data and mapping (e.g. GIS tools) to analyze and communicate about social determinants of health, community risks and assets. Community mapping has been found to be a particularly useful advocacy tool, as well as for engaging the community and working with nontraditional partners. Several case studies and research briefs on community mapping may be found at: www.opportunityagenda.org/mapping

Comprehensive Data Collection – Funded by the CDC, the Data Set Directory of Social Determinants of Health provides a comprehensive list of social determinants of health indicators in 12 dimensions, including economy, environmental, political, public health, and psychosocial:
http://www.cdc.gov/dhdsp/data_set_directory.htm

LEADERSHIP
While many of the strategies needed to address social determinants and promote health equity lie beyond the purview of health departments, leadership for such action resides within public health. Not only is it consistent with our mission, but there is no other discipline that owns the problem or has the comprehensive knowledge about the social determinants. Without the leadership of public health, social inequities in health will likely persist and even worsen over time. Importantly, leadership can take on many different forms—policy advocacy, community engagement, partnership building, raising awareness, etc. An important strategy for institutionalizing health equity as a public health priority is establishing an Office of Health Equity and investing significant resources aimed at health equity within health departments.

Institutionalizing Health Equity – The Ohio Department of Health includes Equity and Social Justice as one of its 10 core principles in its strategic plan. The Department has outlined its commitment to identify and address the root causes of health inequities; actively seek out and promote decisions and policies aimed at equity; empower communities; and make equity and social justice visible and aim for sustained, permanent change: http://www.odh.ohio.gov/features/odhfeatures/HealthyEquityFeature.aspx

Multifaceted Approach – The Boston Public Health Commission (BPHC) has been recognized nationally for its efforts to address institutional racism and other forms of oppression which perpetuate heath inequities. The Commission supports an anti-racism framework throughout its organization and refocuses its

external activities to center on racial/ethnic health disparities and racism. Other social determinants of health addressed by the BPHC are economic opportunity, education, housing, residential segregation, safe neighborhoods, and food access in addition to healthcare access and quality. BPHC has also established a New England Partnership for Health Equity that works to create institutional and community changes in policies, programs, and practices that help to sustain health equity work. The Partnership for Health Equity also provides technical assistance, training and resources for health equity initiatives, and it fosters a learning collaborative of local and regional partners engaged in health equity work. The Commission also established a data collection regulation which required all hospitals and community health centers in Boston to collect demographic information on race, ethnicity, preferred language, and education for all patients. This information will help to identify and reduce disparities in clinical practice and outcomes: http://www.bphc.org/Pages/Home.aspx

Other health departments that have been identified as health equity leaders include the following:

San Francisco Department of Public Health, Occupational & Environmental Health - Hofrichter & Bhatia (2010), Ch. 16 and http://www.sfphes.org/

Metro Louisville Health Department, Center for Health Equity –Hofrichter & Bhatia (2010), Ch. 14 and http://www.louisvilleky.gov/health/equity/

Seattle & King County Health Department, Equity & Social Justice Initiative – Hofrichter & Bhatia (2010), Ch. 21 and http://www.kingcounty.gov/healthservices/health/ehs/healthyplaces/health.aspx

Oregon Department of Human Services, Office of Equity & Inclusion - http://www.oregon.gov/OHA/oei/about_us.shtml

POLICY

Health departments should develop policy strategies that improve the physical, social and economic conditions that affect the public's health, paying special attention to the idea that 'social policy is health policy.' This means health departments need to advocate for policy changes in domains seemingly unrelated to health, but affect health and health equity (e.g. housing, transportation, education, etc.). Health departments may also use their regulatory powers to promote health equity.

Health Impact Assessment - Health impact assessment (HIA) is a data-driven approach used to identify the potential health consequences of a proposed policy or program that may not appear to be directly related to health. It is intended to be a decision-making tool to contribute to policy in that it can provide information and practical strategies to enhance the potential health benefits and/or minimize adverse effects of a proposal. It makes health effects an explicit part of the policy discussion. It is usually a community-driven effort that has the added benefit of encouraging participation and a more democratic process. The Health Impact Project, which is a collaboration of the Robert Wood Johnson Foundation and The Pew Charitable Trusts, is a national initiative designed to promote the use of HIAs as a decision-making tool for policymakers. http://www.healthimpactproject.org/ Examples of HIAs may also be found in Hofrichter & Bhatia (2010), Ch. 17 & 18, and at http://www.ph.ucla.edu/hs/health-impact/

Health in All Policies – Health in All Policies (HiAP) is a related approach to healthy public policy used more commonly abroad. Similar to HIA, this strategy recognizes the social determinants of health and the idea that policymaking outside of the traditional health arena is likely to impact health and health equity. Therefore, it encourages governments to view all policies and policy proposals through a health lens. It requires strong partnerships and coordination among various state agencies whose policies influence health. The California-based Prevention Institute advocates for consideration of health in all policies and

shares examples of ballot initiatives that they endorse based on their connection to health and equity: http://www.preventioninstitute.org/about-us/lp/497-building-health-in-all-policies.html Similarly, the State of CA recently established an HiAP Task Force, comprised of 19 state agencies: http://sgc.ca.gov/hiap/publications.html

COMMUNICATIONS

Creating the kinds of changes needed to achieve health equity requires a new way to talk about health, health disparities and social determinants. Many organizations are currently involved in creating media and public awareness campaigns and trying to figure out how best to communicate with different kinds of audiences. Experts recommend a comprehensive communication plan with a wide range of strategies aimed at different audiences for different purposes. Regardless of the purpose, however, health equity should be integrated into health departments' core messages. The Unnatural Causes Campaign described above for professional development is also being used in communities across the country to raise public and policymaker awareness and build the will for change. Other promising practices include the following:

Robert Wood Johnson Commission to Build a Healthier America – The Commission was convened by RWJF in 2008 to explore issues related to the social determinants and health disparities. Because part of their purpose was to raise awareness, they consulted with communications experts to develop a communications strategy for their work: www.commissionhealth.org

Berkeley Media Studies Group – BMSG works with organizations to develop communications strategies to influence policies related to the social determinants of health: http://www.bmsg.org/our-commitment-to-public-health/health-equity

PARTNERSHIPS

Given that many social determinants lie outside of traditional public health, intersectoral partnerships are critical to achieving health equity. Health departments must work closely with professionals in the areas of education, local/urban planning, transportation, agriculture, etc. We also need to work more effectively with other kinds of public health organizations to strengthen the support and resources for community and state level changes.

Comprehensive planning – Local governments prepare a variety of plans that address social, economic and environmental issues in their areas. The 'comprehensive plan' is generally updated every 10-15 years and offers a long-term guidance for local level policymaking on issues related to the build environment. Sustainability and public health considerations are beginning to emerge as part of the comprehensive planning process and are being integrated in such plans. The American Planning Association is conducting research on how best to integrate public health in this process: http://www.planning.org/research/publichealth/ Examples of existing comprehensive planning approaches that involve public health include the Healthy Portland Plan (http://www.orphi.org/healthy-community-planning/healthy-portland-plan) and the Amherst, Massachusetts Master Plan (http://www.amherstma.gov/index.aspx?NID=526).

Regional Collaboration - The Bay Area Regional Health Initiative (BARHI) is a regional partnership of local health leaders working to "transform public health practice for the purpose of eliminating health inequities…" Among its various strengths is the support it provides its members for the risk-taking that is often involved in health equity work. The partnership also offers a platform for sharing resources and competing for grants: www.barhii.org/about

COMMUNITY ENGAGEMENT

Working with the communities that are most affected by health inequities is critical to achieving health equity and is considered a core principle of this work. This may involve building local capacity for research, advocacy and program implementation. It involves building trust and ensuring transparency within health department policies, procedures, programs and services. Health departments should actively seek community participation in planning and evaluation and support existing leaders in the community.

Building Community Capacity – The Almeda County Public Health Department is using an "explicit community power-building strategy to achieve social and health equity through institutional change, community capacity-building and strategic policy interventions." The approach involves identifying community assets, and specifically community leaders, and helping to build their local infrastructure to create change. For more information, see Hofrichter & Bhatia (2010) Ch. 20.

Empowering Communities to Identify Priorities – State health departments are beginning to create innovations in their funding mechanisms that allow communities to identify their own priorities and strategies for addressing social determinants. See Health Equity Michigan Planning Grants http://www.healthequitymi.com/index.html and Washington State's Fostering Health Equity Partnership grants: http://healthequity.wa.gov/Grant/index.htm

Building Community Resilience – The Prevention Institute's *Toolkit for Health and Resilience in Vulnerable Communities (THRIVE)* provides guidance for community assessment and interventions that take a community resilience approach to improving health outcomes. It is intended to help communities prioritize the factors within their community that can be addressed to improve health: http://thrive.preventioninstitute.org/thrive/index.php

Facilitating Dialogue – Referenced several times above, the *Unnatural Causes* documentary series is being used in town hall-like meetings across the country to facilitate community engagement. The website has an extensive list of resources that can be used to promote dialogue and action around social and health inequities: http://www.unnaturalcauses.org

Community-Based Participatory Research - Community-based participatory research (CBPR) has been recognized as a critical strategy in addressing health inequities among socially disadvantaged and marginalized communities. CBPR is being used by health departments, non-profits and academic institutions across the country. Case studies and other resources may be found at http://depts.washington.edu/ccph/commbas.html

Additional References:

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[i] For our purposes, "promising practices" are defined as strategies or actions for which there exists at least preliminary evidence of effectiveness based on small-scale interventions, or for which the underlying approach is consistent with health equity principles. Importantly, scholars and practitioners recognize there is no 'one-size-fits all' strategy for achieving health equity, particularly as an underlying principle of health equity work is that it must be community-driven and grounded in community specific needs and resources.