

BETTER HEALTH THROUGH EQUITY



Case Studies in Reframing Public Health Work

MARCH 2015

Healthy People 2020, the nation’s health objectives for the current decade, defines health equity as the “attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.” Such goals aren’t unfamiliar to public health practitioners—the field has a long and storied tradition of serving the most vulnerable and bringing life-saving care to communities that would have otherwise gone without. And while the nation has come a long way in identifying, acknowledging and addressing disparities¹ in health and health care access, it is clear that eliminating disparities cannot be accomplished without seriously addressing the underlying social determinants of health², many of which are shaped and perpetuated by bias, injustice and inequality. Across the country, state and local public health agencies are taking up this call to action in earnest, integrating a health equity framework at an organizational level and using equity values to drive community health work. The following are five case studies exploring the experience of public health departments as they make a concentrated shift toward achieving health equity.

1. What’s the difference between health disparities and health inequities? According to Paula Braveman in an article published in *Public Health Reports*, “Health equity means social justice in health (i.e., no one is denied the possibility to be healthy for belonging to a group that has historically been economically/socially disadvantaged). Health disparities are the metrics we use to measure progress toward achieving health equity. A reduction in health disparities (in absolute and relative terms) is evidence that we are moving toward greater health equity.” (Source: www.publichealthreports.org/issueopen.cfm?articleID=3074)
2. The social determinants of health are the conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at the global, national, and local levels. Examples of resources include employment, housing, education, health care, public safety, and food access. (Source: www.who.int/social_determinants/sdh_definition/en/index.html)

THE VALUE OF INVESTING IN HEALTH EQUITY

The efforts chronicled in this series of case studies are not only designed to improve health outcomes, they are also poised to save the country billions in health care spending. According to one study published in 2009, more than 30 percent of direct medical costs faced by African Americans, Hispanics and Asian Americans can be tied to health inequities. Because of inequitable access to care, these populations are sicker when they do find a source of care and incur higher medical costs. That 30 percent translates to more than \$230 billion over a four-year period. If health disparities among minorities had not existed between 2003 and 2006, direct medical care spending would have been reduced by a whopping \$229.4 billion.

ACKNOWLEDGEMENTS

With support through CDC Cooperative Agreement#5U38HM000459-05, the American Public Health Association (APHA) contracted with Kim Krisberg to conduct a series of 5 case studies of state, local and tribal health agency efforts to create health equity. We would like to acknowledge the staff at the health agencies that provided the information essential to this report. We are grateful for their participation and willingness to share their stories. The contents of this report are solely the responsibility of the authors and do not represent any official views or endorsement by CDC. CDC funds were not used to fund the work described in the report. This report is not designed to support or defeat enactment of any legislation, pending before Congress or any state or local legislature. Federal, state, tribal and local jurisdictions apply differing rules regarding engagement with legislative bodies and other policy-related activities. Jurisdictions considering legal or other policy initiatives should seek the assistance of state or local legal counsel. Additional guidance for CDC funded recipients may be found at www.cdc.gov/od/pgo/funding/grants/foamain.shtm.

About APHA

APHA champions the health of all people and all communities. We strengthen the public health profession. We speak out for public health issues and policies backed by science. We are the only organization that influences federal policy, has a 140-plus year perspective and brings together members from all fields of public health.

TABLE OF CONTENTS

ACHIEVING HEALTH EQUITY: LESSONS LEARNED	Page IV
SHIFTING THE DISCUSSION, APPLYING A NEW LENS (MULTNOMAH COUNTY, OREGON)	Page 1
EQUITY IN ACTION: Multnomah County	Page 5
HARNESSING THE POWER OF CROSS-SECTOR COLLABORATION (MENOMINEE INDIAN TRIBE, WISCONSIN)	Page 9
EQUITY IN ACTION: Menominee Indian Tribe	Page 13
MAKING HEALTH EQUITY A COMMUNITY AFFAIR (VIRGINIA)	Page 16
EQUITY IN ACTION: Virginia Department of Health	Page 21
INTEGRATE AND OPERATIONALIZE: RECOGNIZING EQUITY EVERY DAY (COLORADO)	Page 24
EQUITY IN ACTION: Colorado Department of Public Health and Environment	Page 30
TRANSFORMING THE WORK OF COMMUNITY HEALTH (TEXAS)	Page 32
EQUITY IN ACTION: Texas Department of State Health Services	Page 36

A number of lessons learned identified as essential to successfully implementing a health equity framework were gathered during APHA's Better Health Through Equity project. The following are the most salient.

WITHIN YOUR ORGANIZATION: Achieving health equity first begins with building knowledge, understanding and capacity within your organization or agency.

1 ACKNOWLEDGE THAT EQUITY IS MORE THAN ANY ONE, SINGLE INTERVENTION: Health equity truly is a state of mind. It's a framework within which public health practitioners from all disciplines can work. Making a purposeful shift toward achieving health equity forces us to consistently view health status within the larger context of society and history and will ultimately bring public health farther upstream than it's ever been before.

2 HAVE AN OPEN AND HONEST DIALOGUE: Start a conversation in your health agency—and ideally across fellow public agencies—about racism, bias and inequality and how they contribute to disparate health outcomes. Use an icebreaker such as the documentary “Unnatural Causes: Is Inequality Making Us Sick?” and make sure you tailor the event to fit your audience and create a respectful environment. Talking about inequity is not always a comfortable exercise—in fact, it can put some people on the defensive—but it is vital to gaining buy-in and shifting the focus from traditional disease prevention to tackling the social determinants of health.

3 PARTNER, PARTNER, PARTNER: Moving toward health equity means zeroing in on the social determinants of health, which also means that the public health sector can't achieve health equity on its own. Transportation, housing, health care, employment, environmental quality, working conditions, education, child care, law enforcement—all of these sectors and many more have a role in creating the conditions that enable all people and communities to attain and sustain good health. Public health workers are uniquely skilled at convening players across sectors, and this skill will be invaluable in achieving health equity.

4 WITHIN YOUR COMMUNITY: Achieving health equity requires an empathetic approach that acknowledges a community's history, respects its traditions, listens to its stories and actively engages its members as leaders in any health equity intervention.

5 BE MINDFUL OF HISTORY: Government and public policy played enormous roles in perpetuating the very biases, injustices and inequalities that created the health disparities and inequities we seek to address today. Be mindful that many communities are still very much experiencing and facing the effects of historical trauma. As a public official, coming into such a community with a predetermined plan and top-down approach only perpetuates that trauma.

6 LET GO OF YOUR AGENDA: Avoid going into a community that has a long history of experiencing health and social inequities with a predetermined agenda. Instead, go in with an open mind and simply

listen and learn about the lives of the people you serve. This may throw a wrench into all of your preconceived plans and force you to go back to the drawing board. But that's okay—achieving health equity may mean taking as many steps backward as we do forward.

7 BUILD TRUST: Trust is the foundation of all health equity work. In fact, it may be the only starting point that will lead to sustainable progress. Building trust requires having an open mind, being flexible, listening to people's stories, respecting and integrating traditional ways, engaging community leaders and empowering people with the means to seek change for themselves and their communities.

8 WITHIN YOUR PRACTICE: Achieving health equity means allowing community values and priorities to shape and inform interventions. Science-based evidence is always important to measuring needs and progress, but gaining community buy-in is critical to sustainability.

9 FOLLOW THE DATA, BUT...: Data are essential to the work of public health. We need data to pinpoint problems, deploy resources, track progress, evaluate effectiveness and justify continued support. But in the work toward health equity, data can't be the only driver. For example, worrisome data on prenatal care may lead you to initiate contact with a community. However, residents might have more pressing concerns, such as few employment opportunities, difficulties affording enough food and unsafe housing conditions. These are the issues you have to tackle first if you want to positively impact infant health in the long term.

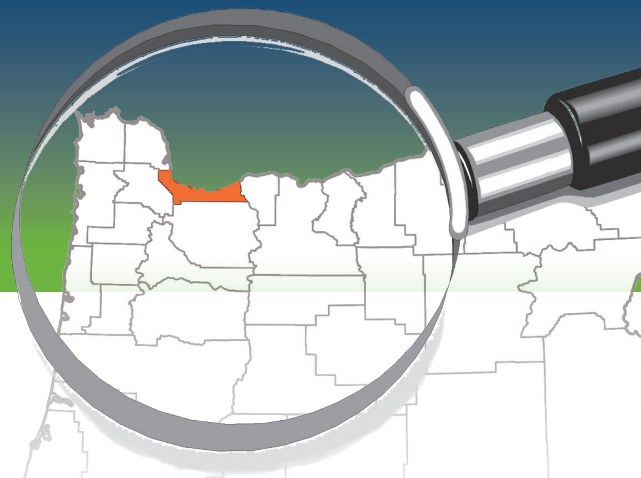
10 COMMUNITY OWNERSHIP IS PARAMOUNT: Community participation is intrinsic to health equity work. This is probably a no-brainer for most practitioners, as community engagement is a fundamental component of public health work. However, ensuring that the community is involved in every aspect of health equity work—from data gathering to implementation to evaluation—is key.

11 PAY ATTENTION TO PROCESS: The process of developing strategies to create health equity is as important as—and sometimes even more important than—the actual initiatives. If you can create a process for developing interventions that is truly community-driven and founded on trust, you have a better chance of sustaining momentum on the long journey toward health equity.

12 KNOW WHEN TO STEP ASIDE: Despite your skills, experience, education and competencies as a public health practitioner, you might not be the best person to implement a strategy to create health equity on the ground. Many successful health equity efforts recruit and train workers from the community who have the same lived experience as the residents you are hoping to reach. Keeping this in mind will help build trust, community ownership and sustainability.

SHIFTING THE DISCUSSION, APPLYING A NEW LENS

Multnomah County Health Department, Oregon



“When we talked about disparities it was simply reflecting the data. We weren’t telling the whole story, we weren’t talking about the structural pieces. ...Until we started looking through a lens of race, power and poverty, we really weren’t moving upstream. Now we’re focusing on the conditions that lead to the outcomes we see.”

— BEN DUNCAN

FORMER PROGRAM MANAGER OF THE MULTNOMAH COUNTY HEALTH DEPARTMENT HEALTH EQUITY INITIATIVE
AND CURRENT DIRECTOR OF THE COUNTYWIDE OFFICE OF DIVERSITY AND EQUITY

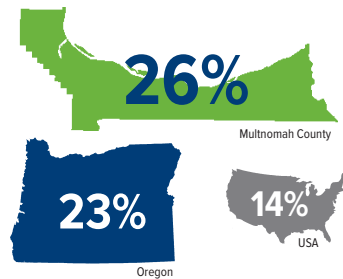
In 2008 and in the wake of a report on racial and ethnic health disparities in Multnomah County, Ore., local officials launched the Health Equity Initiative, a countywide effort to raise community awareness of the root causes of health inequities and put forth real solutions. The effort—led by the Multnomah County Health Department with strong support and participation from county leadership—began with the seemingly simple but critical step of encouraging honest, reflective and often challenging conversations about the connections between racism, injustice and health disparities. Those community conversations eventually led to the creation of the Equity and Empowerment Lens: Racial Justice Focus, a health equity tool that is slowly transforming the everyday work of public health in Multnomah County.

Health Inequity by the Numbers

Out of 33 counties in Oregon, Multnomah ranks 15 in health outcomes.

Some examples of health inequities in Oregon and Multnomah County include:

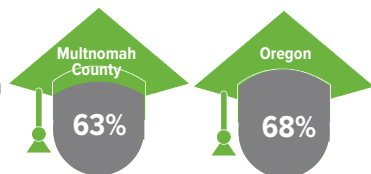
In 2011, 26 percent of Multnomah County children younger than 18 were living in **poverty**, as compared with a statewide rate of 23 percent and a national rate of 14 percent.



An estimated 108,000 of Oregon's children ages 0–6 are at risk of **not being ready for kindergarten** as a result of poverty, adverse childhood experiences, and other risk factors that are highly associated with or most often predicted by race and ethnicity.



In 2010–2011, only 63 percent of Multnomah County ninth-graders **graduated** from high school within four years, as compared with 68 percent statewide.



Source: www.countyhealthrankings.org

VISUALIZING INEQUITY

Tackling health equity in a meaningful way means confronting the social determinants at the root of poor health and engaging the officials and community stakeholders who are well positioned to drive change. But first, organizers in Multnomah County needed a way to jumpstart cross-sector collaborations, community conversations, and the slow, sustained drive toward systemic change. Taking on the social determinants of health would mean talking openly about oppression, racism and personal bias—topics that can make people uncomfortable or even defensive—and organizers needed an inclusive conversation starter.

To do that, staff from the Health Equity Initiative turned to film, specifically the four-hour PBS documentary *Unnatural Causes: Is Inequality Making Us Sick?*³ In 2008, they began hosting local screenings of the documentary, using the film to develop a shared understanding of the social determinants that contribute to poor and disparate health outcomes. In all, the initiative hosted 57 screenings open to both county officials and community members, eventually reaching more than 500 people. The screenings had three main goals: raising community awareness, building the capacity to address inequity, and advancing relevant policy solutions. During the screening events, trained volunteers from county agencies and the community facilitated open and honest discussions on the topic.

According to Ben Duncan, former program manager of the Multnomah County Health Department Health Equity Initiative and current director of the countywide Office of Diversity and Equity, *Unnatural Causes* “gave us new ways to talk about equity...the concepts and values weren’t new, but all of a sudden we had a language to talk about it.” “*Unnatural Causes* created a platform to shift the conversation from disparities to inequities—it was

3 <http://www.unnaturalcauses.org/>

a very intentional shift,” Duncan says. “We used the screenings as catalysts to start having conversations about what people were experiencing, but also to start thinking about the types of needed policies to address [health inequities] and the root causes that actually lead to lifelong negative health impacts. We went from a typical public health approach...and we created a vision for building partnerships, addressing issues like education, and getting engaged in activities that were traditionally out of the purview of public health.”

“FINDING OUR TRUE NORTH”: APPLYING A HEALTH EQUITY LENS

In the fall of 2012, the Multnomah County Office of Diversity and Equity launched the [Equity and Empowerment Lens](#) (E&E Lens, link on page 8) to address inequities in services, policies, practices, and procedures across the county. Based on the health department’s pilot equity framework, the E&E Lens was developed to help county agencies integrate key questions rooted in justice and inclusion into their decision making. The new movement was a priority—the county’s Office of Diversity and Equity had even created a new position dedicated to institutionalizing the lens countywide. In an introductory letter outlining the new equity lens, then health department Director Lillian Shirley wrote:

“This work takes stepping into an unknown space, a space that makes us vulnerable. Answering the Lens questions and institutionalizing clear, systemically-based recommendations based on equity and empowerment requires us to be brave, courageous, and persistent in our efforts. Focusing specifically on racial justice is essential for the health of all of our communities, because racial and ethnic inequities are the most prevalent and pronounced according to our data.”

The E&E Lens also benefits organizations by driving quality improvements, providing a more accurate assessment of client needs, and offering an enhanced ability to explain how the work and role of an agency contribute to the community. The E&E Lens leads agencies through nine questions that “seek to uncover patterns of inequities, separate symptoms from [the] actual causes of such inequities, and maintain the visibility of impacts on communities of color, immigrants, and refugees.”

For example, questions urge agency officials and staff to consider which particular group will be affected by a policy or decision or to think about how certain processes contribute to the exclusion of populations that disproportionately experience inequities. At the county health department, according to Duncan, an administrative policy dictates that all programs use the E&E Lens. “You’ll see the language of equity within almost every program within the agency,” he says.

The lens can help workers realize that regardless of their competencies and professional education, they might not be best positioned to effectively deliver public health services within every cultural context.



Now, because of the deeper understanding of social determinants brought about by the equity initiative, public health is regularly at the table with officials from transportation, criminal justice, education, and housing. All agencies better understand their role in improving people's health, and public health officials realize they can't do it alone.

"There is no doubt that if you asked what a core value of the health department was, all staff would talk about equity."

As of late 2013, the health department was still in the process of fully integrating the E&E Lens. The department has dedicated equity staff and administrative policies in support of the lens, and achieving equity is part of the health agency's strategic plan. "We've created the environment to move this work forward, and now it's just about doing it," Duncan says.

Now the question is: What does using an equity framework look like in everyday public health work? One example is that the lens can help workers realize that regardless of their competencies and professional education, they might not be best positioned to effectively deliver public health services within every cultural context. It can be a difficult realization to have—and one that can put people on the defensive—but it "helps hold us accountable when we're working with communities," Duncan says.

Five years after the Health Equity Initiative began, the health department released "[Five Year Reflection: The Policy Crosswalk](#)," (link on Page 8) a report that served as a showcase for an equity framework in action. Among the many outcomes of looking through a new lens, the health department has formed new partnerships to shore up addiction and mental health services, has applied for grant support to engage in chronic disease management for people transitioning from correctional institutions, and is using its own position as a contractor of services to promote economic development via micro-enterprise projects, which are typically carried out by small businesses and entrepreneurs.

The lens also makes it clear just how important policy is to both perpetuating and eliminating inequities. Now, because of the deeper understanding of social determinants brought about by the equity initiative, public health is regularly at the table with officials from transportation, criminal justice, education, and housing. All agencies better understand their role in improving people's health, and public health officials realize they can't do it alone. In fact, one of the health department's biggest equity-related successes, Duncan says, is building the internal capacity to effectively partner across agencies.

"There's been a shift in direction; we're finding our true north," Duncan says. "What the lens symbolizes to the community is a commitment to do our work better, a commitment to good government, a commitment to values and principles. This work is coming from the research...but it's the same thing communities have been demanding for years."

EQUITY IN ACTION: Multnomah County

The following are examples of what a health equity framework looks like when it's applied to traditional public health programs, which often involves a complete transformation in agenda setting, community engagement, collaboration and implementation.



Photo by eyecrave, courtesy iStockphoto

According to the Future Generations Collaborative, “historical and intergenerational traumas are emotional and psychological injuries that accumulate over time and across generations as a result of cultural genocide inflicted on Native peoples. ...Historically and today, public health planning and actions in Native communities are often implemented without regard to the effect of historical trauma in these communities.”

1. FUTURE GENERATIONS COLLABORATIVE

In Multnomah County, rates of poor birth outcomes, including preterm deliveries and infant mortality, are disproportionately high among women in Native communities, as is the prevalence of substance use before, during, and after pregnancy. Health department workers sought out a technical assistance grant to build the agency's capacity to address these disparities in both traditional and nontraditional health settings.

They took all of the steps typical to such work—collecting data, seeking buy-in from the local Indian Health Board, and initiating the process of finding community partners. But as public health staff began engaging with stakeholders in the Native American and Alaska Native communities, all of their preconceived ideas about how to develop and implement an effective public health intervention began to fall apart. While they had set out with the best of intentions, they had overlooked a key foundational starting point: **trust**.

“[The community] said we don't trust you, we have no working relationship with you,” says Heather Heater, MPH, health educator at the Multnomah County Health Department. “We had to take 10 steps back. ...Our organization had no institutional knowledge of how to partner effectively with Native communities.”

It was a huge wake-up call for Heater and her colleagues, who then approached leaders at two local Native American service organizations on how to move forward. They began to engage in critical discussions about the role of government in creating and perpetuating inequities within Native communities. They shifted their focus from getting a service model in place to forming collaboration with the community. While healthy pregnancies were still the ultimate goal, the health department's focus had dramatically shifted from programmatic to process. The outcome of that shift, the Future Generations Collaborative, was launched in 2011 with the aims of mending the relationships between Native communities and government entities and developing genuine community-driven solutions. As with most health equity efforts, however, it had to begin with open and honest dialogue.

To facilitate that dialogue and build the Future Generations Collaborative, health workers and community members engaged in a **trauma-informed collaborative process** that acknowledged the government’s role in the health and social inequities experienced by Native communities and was rooted in the traditional ways of knowing and doing within Native cultures. This collaborative strategy, developed in response to community demand, recognized that trauma is the root cause of health disparities among Native peoples. According to Heater, the process isn’t set in stone or even based on the literature—instead, it’s constantly evolving to meet the community’s needs.

“We’re still really struggling with managing and institutionalizing our learning,” says Heater, who serves as the collaborative’s project manager. “We realized that this is what needs to happen—they need us to listen. We’ve heard stories about grandmothers and mothers being removed from their homes, forced sterilization, tribes being stripped of their status...what’s important is for people to teach us through their stories so we can learn. They’re taking a huge leap of faith in us.”

If we really want to get to a place of health equity, we have to dismantle the systems that are preventing communities from reaching their full potential.

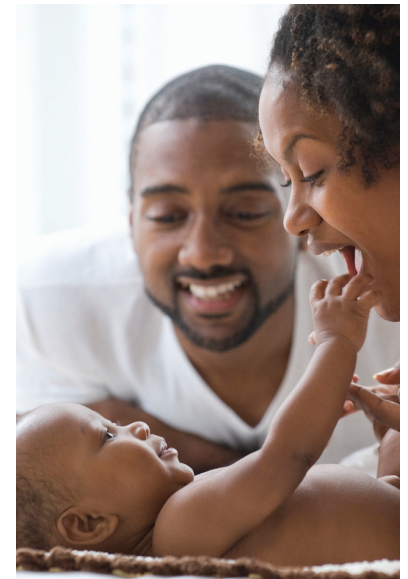
Consistent with the collaborative’s health equity framework, the community is involved every step of the way, from identifying possible interventions to overseeing how data can be used. The collaborative is now entrenched in the community engagement phase, working to mobilize community members to identify the root causes of poor pregnancy health, the impact of historical trauma on prenatal health, and the strengths and aspects of Native communities that support women and families. As of fall 2013, eight key organizations were involved—such as the county’s Native American Rehabilitation Association and Native American Youth and Family Center—and about 20 elders and natural helpers had been trained as community organizers and facilitators. And many more community members want to join the effort: “We’ve never seen this kind of engagement before,” Heater says.

“If we really want to get to a place of health equity, we have to dismantle the systems that are preventing communities from reaching their full potential,” Heater says. “That means examining how our systems perpetuate inequality.... The first day I was able to completely abandon my own agenda was the day I became a transformed professional.”

2. HEALTHY BIRTH INITIATIVE

In Multnomah County, where African Americans make up approximately 6 percent of the population, African American babies are more likely than white babies to be born prematurely and at low birth weights. In addition, they’re more than twice as likely to die before their first birthday. Such disparate birth outcomes were the impetus for the health department’s Healthy Birth Initiative, which began nearly two decades ago and is still going strong.

In conjunction with direct public health services, such as in-home visits, health education and support groups, the initiative is tackling the social determinants that often lay the groundwork for poor maternal and infant health outcomes, such as lower educational attainment, underemployment and poor housing conditions. To successfully address those factors, the initiative has grown into a genuine partnership among program participants, stakeholder organizations, social service agencies and health providers. Program participants, all of whom are African American, are screened to determine their health and social service needs and linked with appropriate agencies and resources. In particular, the initiative is governed by a client-driven consortium that provides programmatic direction and assists with evaluation. The initiative also uses a culturally specific approach that reflects the needs and experiences of African American women and families, notes Rachael Banks, MPA, program director of the Healthy Birth Initiative.



“The staff I work with reflect the communities we serve,” she says. “We’re very aware of the impact of racism on birth outcomes...and our success speaks to the value of hiring people who have a lived experience.”

The initiative’s primary goals are to prevent premature birth and low birth weight, and to ensure that every baby sees his or her first birthday. But a bigger question, according to Banks, is how to get there. Indeed, a 2013 study that examined the perspectives of African American women who were seeking pregnancy care showed that their experiences “fit within a definition of institutionalized racism—in which the system was designed in a way that worked against their attempts to get quality prenatal care.” For example, study participants felt they were treated differently based on whether they had public or private health insurance and that the stigma they faced affected the quality of available care. An earlier study published in the *American Journal of Public Health* determined that lifelong experiences of racism were an independent risk factor for preterm delivery.

Banks—who highlights the impact of racism by noting that college-educated African American women still tend to have poorer health outcomes than white women who have dropped out of high school—says that it’s essential for public health workers to address issues of systemic bias if they hope to improve health status.

“For us, health equity means working on social connections, addressing institutional racism in the health care system, paying attention to insurance discrimination, addressing educational and economic needs and making sure the environments families live in are supportive and healthy,” she says. “It’s really hard to talk about racism—it’s not as tangible as talking about the dangers of

In conjunction with direct public health services, such as in-home visits, health education and support groups, the initiative is tackling the social determinants that often lay the groundwork for poor maternal and infant health outcomes, such as lower educational attainment, underemployment and poor housing conditions.

88%

of participants initiate early prenatal care; a rate that's among the highest in the county.

smoking to birth outcomes...but the [health department's overall] Health Equity Initiative has made it a lot easier.”

Hand in hand with the communities it serves, the Healthy Birth Initiative has achieved some impressive outcomes, as follows.

Birth weight: In 2010, 4.3 percent of infants born to mothers participating in the Healthy Birth Initiative had a low birth weight, in comparison with 6.3 percent among African American women living in the initiative's service area but not enrolled in the initiative. The low birth weight rate among white women was 3.8 percent.

Prenatal care: Eighty-eight percent of the participants initiate early prenatal care—that's more than Multnomah County's white population and higher than the county's overall prenatal care entry rate. Also, about a third of Healthy Birth Initiative participants are self-referred, which is an indication of how well known the program is within the community.

Housing and employment: Between 2008 and 2012, the percentage of participants who were linked to housing resources rose from 75 percent to 85 percent, and the percentage initiating use of employment services increased from 67 percent to 80 percent. The initiative aims to have 95 percent of women who have identified housing, employment and education needs linked with the necessary resources to make a difference.

Banks says that while the Healthy Birth Initiative began many years before the Health Equity Initiative, the maternal and child health effort helped “lay the foundation and groundwork for the department really being intentional about addressing health equity.”

“I feel really optimistic,” Banks says. “I think we now have a better understanding of health equity, and now the challenge is to make sure it's an authentic understanding and not just a buzzword.”

RESOURCES

Equity & Empowerment Lens

<https://multco.us/diversity-equity/equity-and-empowerment-lens>

“Five Year Reflection: The Policy Crosswalk”

<https://multco.us/health/public-health-practice/health-equity-initiative>

Future Generations Collaborative

http://multnomah.granicus.com/MetaViewer.php?view_id=3&clip_id=616&meta_id=39353

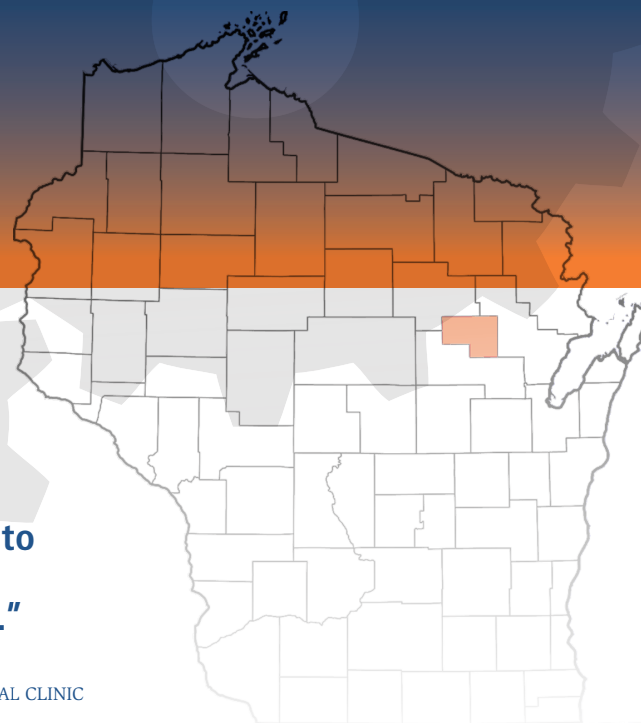
Healthy Birth Initiative

<https://multco.us/services/healthy-birth-initiative>

Cover photo children eating: Photo by Michael DeLeon, courtesy iStockphoto.

HARNESSING THE POWER OF CROSS-SECTOR COLLABORATION

Menominee Indian Tribe, Keshena, Wis.



“If we’re all trying to fight this battle, we should try to fight it together. I’m not getting anywhere by myself.”

— JERRY WAUKAU, HEALTH ADMINISTRATOR, MENOMINEE TRIBAL CLINIC

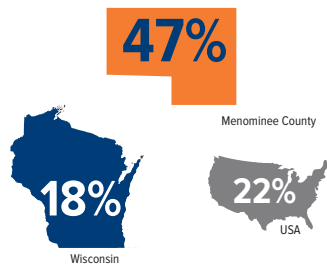
Menominee County, which is more than 85 percent American Indian, is the poorest county in Wisconsin and home to the state’s highest unemployment rate and worst health indicators. This is a recipe for adversity that even those with the best resources would have difficulty overcoming. For years, county and tribal officials witnessed and tackled the outcomes of social disadvantage and injustice within their own separate silos, addressing the same social determinants but from their different clinical, educational and social services perspectives. Then in 2003–2004, state education officials tapped the Menominee Indian School District as a “School Identified for Improvement.” At the same time, the Menominee Nation was struggling with significant health issues: the county scores higher than the state average on just about every negative health outcome for which there are available data. It was the proverbial “perfect storm” needed to jumpstart a community-wide transformation.

Health Inequity by the Numbers

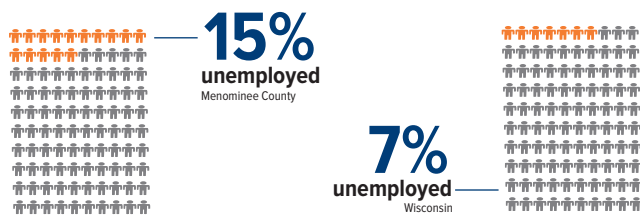
Out of 72 counties in Wisconsin, Menominee ranks 72 in health outcomes.

Some examples of health inequities in Wisconsin and Menominee County include:

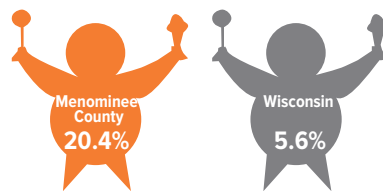
In 2012, 47 percent of Menominee County children younger than 18 were living in **poverty**, as compared with a statewide rate of 18 percent and a national rate of 22 percent.



More than 15 percent of Menominee County residents 16 years or older were **unemployed but seeking work** in 2012; the overall rate in Wisconsin was about 7 percent.



In 2009–2011, 20.4 percent of low-income preschoolers in Menominee County **were obese**; in contrast, Wisconsin’s best-performing county had a rate of 5.6 percent.



Sources: <http://www.countyhealthrankings.org>; <http://www.ers.usda.gov/data-products/food-environment-atlas/go-to-the-atlas.aspx>

AN EDUCATION IN COLLABORATION

When the state singled out the Menominee Indian School District for improvement, local officials began digging deeper into the reasons behind the district’s poor academic achievement and high dropout rates. What became clearer to officials was that students faced significant challenges in the larger community—challenges that stayed with them during the school day and handicapped their academic ability, says Wendell Waukau, superintendent of the school district. In other words, in addressing the state’s evaluation of the Menominee Indian School District, W. Waukau and his colleagues began to readjust their contextual frame to view students within a larger social context. And what they saw turned the usual way of doing business on its head.

“It was a paradigm shift of thinking about this as a dropout crisis to a public health crisis,” W. Waukau says. “Previously, we had thought the County Health Rankings were someone else’s report card, but we realized that those rankings apply to everybody. I don’t think anyone can hide from that.”

Poor health outcomes and risky health behaviors, such as teen pregnancy, obesity and alcohol use, were making it difficult for Menominee youth to excel and stay in school. On the flip side, not having a high school diploma dramatically increased tribal members’ chances of a lifetime of disease and disability as well as premature mortality. In fact, the scientific literature is increasingly pointing to educational attainment as a key factor in good health across the lifespan and one of the most promising levers available to public health professionals and their community partners (see textbox on page 11).

EDUCATION: A LIFELONG 'ELIXIR'

A 2013 study¹ of thousands of young people in Norway showed that high school dropout was linked to long-term illness and disability, even after adjustment for factors such as family income and health-related risk behaviors. In 2007, the Centers for Disease Control and Prevention published an article² calling on health professionals to reframe the dropout rate as a public health issue. The article's authors wrote that "if medical researchers were to discover an elixir that could increase life expectancy, reduce the burden of illness, delay the consequences of aging, decrease risky health behavior, and shrink disparities in health, we would celebrate such a remarkable discovery. Robust epidemiological evidence suggests that education is such an elixir."

To tackle the school dropout problem, Superintendent Waukau turned to the Bridges Out of Poverty³ framework, a strategy and training program designed to bring together leaders from different sectors to address sustainable solutions to social and economic issues. According to W. Waukau, Bridges Out of Poverty helped him and his colleagues view students' academic challenges within a larger, more holistic context and shifted the issue from a individual/family problem to a systemic/community problem. It also gave school and community officials a new way of understanding how historical trauma continues to shape the factors that lead to health and educational disparities. A trauma-informed framework recognizes the role that historical oppression and inequity play in shaping the social determinants that perpetuate poor health outcomes and low academic achievement. But perhaps most important, according to W. Waukau, the Bridges framework helped connect the dots between education and health and acted as a stepping stone for community-wide collaboration and engagement.

"You can't punish the behavior out of them," he says, referring to students who act out in school or who are repeatedly truant. "You have to look at what's going on in their lives so these kids can start to become resilient. ... We're out knocking on doors, we're listening and asking what it will take to get kids back to school and connecting families with resources and assistance."

Among the community collaborators who participated in Bridges Out of Poverty was the Menominee Tribal Clinic, which serves more than 8,000 local residents. At the time the Menominee Indian School District was facing a significant truancy problem, the clinic was trying to address the community's poor health rankings and outcomes, says Jerry Waukau, health administrator at the clinic. Clinic staff were beginning to realize that no matter how good the clinic was, no matter how many doctors it hired, patients would continue to face barriers to attaining and managing good health outside the clinic's walls. The Bridges Out of Poverty training was made available to all clinic staff and changed not only how

The Bridges Out of Poverty framework and training program educates participants on topics that include intergenerational poverty and effective client communication, and teaches stakeholders how to use that knowledge to redesign programs and policies toward building a sustainable path out of poverty.

1 Source: <http://www.biomedcentral.com/1471-2458/13/941>

2 Source: http://www.cdc.gov/pcd/issues/2007/oct/07_0063.htm

3 Source: <http://www.ahaprocess.com/solutions/community/>



The Bridges training put the problem in better perspective and led to cross-sector collaborations between the clinic and education system that brought dental hygienists and oral health services into the schools. Health officials also integrated preventive dental care into local Head Start efforts and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

clinic providers worked with patients, but also how they delivered services. And the focus on community collaboration remained key.

“You don’t always see where a patient who lives in poverty is coming from,” J. Waukau says. “You think you have this great clinic, but if people aren’t accessing it then something is wrong.”

Here’s just one example: If a patient misses three dental appointments, he or she is at risk of losing access to the clinic’s dental services; to maintain access, the patient has to appeal to the clinic’s Health Committee. This process meant both the clinic and patients were spending a great deal of time and resources reinstating people’s access to dental care without addressing the behaviors that led to missed appointments in the first place.

According to J. Waukau, the Bridges training put the problem in better perspective and led to cross-sector collaborations between the clinic and education system that brought dental hygienists and oral health services into the schools. Health officials also integrated preventive dental care into local Head Start efforts and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Instead of waiting for residents to access care, the Menominee Tribal dental clinic brought care to the community. Because of such efforts, active tooth decay among Menominee children declined by 22 percent between 2001 and 2008. Also, the percentage of children with no history of tooth decay increased from 12 percent to 41 percent over that period. Bridges Out of Poverty not only compelled health workers to view patients in a more holistic sense but also pushed them to optimize existing community resources toward better health outcomes and, thus, better educational outcomes.

“We’ve become more outcome focused and patient focused,” J. Waukau says. “First we have to create healthy individuals, then healthy families and then your community can heal.”

EQUITY IN ACTION: Menominee Indian Tribe

The following is an example of what a health equity framework looks like when it's applied to traditional public health programs, which often involves a complete transformation in agenda setting, community engagement, collaboration and implementation.



Students pick up their diplomas during the 2012 graduation ceremony at Menominee Indian High School. That year, the school achieved a 94 percent on-time graduation rate. (Photo courtesy Menominee Indian School District)

According to 2005–2006 data, only 68 percent of Menominee County ninth-graders graduated within four years, as compared with the statewide rate of 88 percent. In a testament to the community's collaborative success as detailed in this case study, that rate rose to 93 percent in 2010–2011, surpassing the statewide rate of 87 percent.

Source: www.countyhealthrankings.org

COMMUNITY ENGAGEMENT WORKGROUP

Building on the momentum and lessons learned from the Bridges Out of Poverty training, the Menominee school district and tribal clinic formally partnered to address the intersections among academic performance, health outcomes and social determinants, eventually launching the Community Engagement Workgroup in 2010 and quickly attracting the attention, support and participation of fellow community agencies. The importance of child and adolescent health and well-being was a closely held value throughout the community, J. Waukau says, and became a rallying point for gathering support, as was aligning the workgroup's goals with existing local efforts and the tribe's strategic plans. Led by the Menominee Indian School District and Menominee Tribal Clinic, the workgroup is dedicated to developing partnerships to improve community health, with an initial focus on increasing graduation rates and decreasing childhood obesity rates.

Ron Corn, who served as administrative coordinator for Menominee County until 2014 and participated in the workgroup, says that obesity was chosen as a target because good data were already available and having reliable baseline data meant stakeholders could measure their progress and hold each other accountable. (Menominee County has the state's highest obesity rate.) In addition, nearly every community organization and agency has a role to play in reducing childhood obesity, whether directly (serving healthier foods or providing nutrition education) or indirectly (modeling healthy behaviors). Obesity is also an issue with substantial social contributors, such as the affordability of healthy foods or the availability of safe places to be physically active, and so a purely medical model is insufficient. On the school front, the positive health outcomes that come with declining child obesity could tip the scales toward better academic achievement.

To move the collaborative effort forward and promote accountability, the workgroup developed a "grid" that matches existing community resources and initiatives to health indicators listed in the County Health Rankings report. The local school district and tribal clinic were among the first organi-



Schoolchildren at the Menominee Indian School District Keshena Primary School take part in the Smart Sack Program, which sends healthy foods home with young students every week. (Photo courtesy Menominee Indian School District)

Other short-term achievements include a new apple orchard next to the primary school, healthier school snacks, more fresh fruits and vegetables at local groceries and new guidelines for providing healthy food and beverage choices at Menominee Nation events and seminars.

zations to place themselves on the grid, with many more quickly following their lead. The workgroup also adopted a framework for creating 90-day implementation plans, which J. Waukau says helped jumpstart community action and boost accountability.

The workgroup’s efforts are based on seven principles: promoting patient- and client-centered care, self-management of health conditions or health behaviors, linking community resources, breaking down barriers to support and use of resources, improving access to community resources, promoting traditional beliefs and values, and integrating trauma-informed principles.

“People were operating in their own silos; everyone was just doing their own thing,” Corn says. “We got to a point where we realized we’re all in this together, and when we started seeing things from that perspective we started gaining our successes.”

While the workgroup initiative is still quite young, success has been achieved in a number of areas. As of 2013, more than 40 local and external agencies and departments were involved in the community engagement effort, including Menominee County, the local Head Start program and the Shawano/Menominee County Health Department. In fact, enabling organizations and agencies that don’t directly focus on health and education to see their work as supportive of children’s health and academic achievement was a success in itself, says J. Waukau.

Other short-term achievements include a new apple orchard next to the primary school, healthier school snacks, more fresh fruits and vegetables at local groceries and new guidelines for providing healthy food and beverage choices at Menominee Nation events and seminars. W. Waukau says that since the Bridges Out of Poverty training, more of the district’s students are taking college entrance exams and more are going on to pursue a college degree. In fact, the percentage of Menominee County ninth-graders who graduate within four years rose from 68 percent in 2005–2006 to 93 percent in 2010–2011. The workgroup was also able to secure funding to support a population health fellow whose responsibilities include collecting and analyzing relevant data and creating new monitoring and evaluation methodologies. Among its latest efforts, the group is participating in the state-led Fostering Futures project, which supports the Menominee Indian Tribe in examining the consequences of adverse childhood experiences and in using trauma-informed care to reach at-risk children and families.

At the end of the day, support among community leaders and members has been absolutely key, J. Waukau says.

“Ten years ago, the community wasn’t ready for discussions about poverty, it was just too painful,” W. Waukau adds. “But now when we sit at the table as

agencies, as families, as educators, as leaders and to have those conversations without judgment, without blame or shame...we can help create the conditions that allow people to make changes.”

RESOURCES

Menominee Nation Community Collaboration

<http://uwphi.pophealth.wisc.edu/programs/match/healthiest-state/find-the-bright-spots/menominee-nation-community-collaboration.pdf>

Menominee Tribal Clinic

www.mtclinic.net

County Health Rankings

www.countyhealthrankings.org

Bridges Out of Poverty

www.ahaprocess.com/solutions/community

MAKING HEALTH EQUITY A COMMUNITY AFFAIR

Virginia Department of Health



“People are not opposed to the idea of [health equity] if it’s presented in a way that they can receive it—in general, people are open to fairness. The key is to know your audience, so they can understand it and relate to it and be open to receiving your message.”

— KAREN REED, MA, DIRECTOR OF THE DIVISION OF MULTICULTURAL HEALTH AND COMMUNITY ENGAGEMENT, VIRGINIA DEPARTMENT OF HEALTH

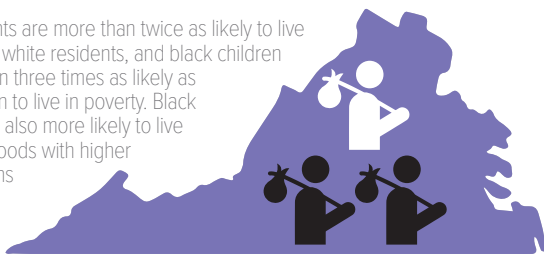
When Michael Royster, MD, MPH, arrived at the Virginia Department of Health in 2007, he brought a passion for health equity along with him. While narrowing health disparity gaps was already a priority focus at the state public health department, his arrival coincided with what may seem on the surface to be a minor philosophical shift, but, in reality, radically transformed how the agency works toward better health and community engagement. Instead of primarily focusing on typical health disparity data, public health practitioners would begin to equally examine the characteristics of inequities—in other words, what were the social determinants that shaped a person’s opportunities to attain optimal health? The department’s newly named Office of Minority Health and Health Equity (formerly the Office of Minority Health and Health Policy), with Royster at its helm, had reset its course to head far upstream to uncover the very roots of poor health and disproportionate disease burden.

Health Inequity by the Numbers

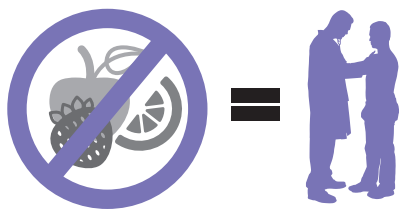
According to the 2013 America's Health Rankings, Virginia ranks 26th in the nation.

Some examples of the social and health disparities that lead to health inequity in Virginia include:

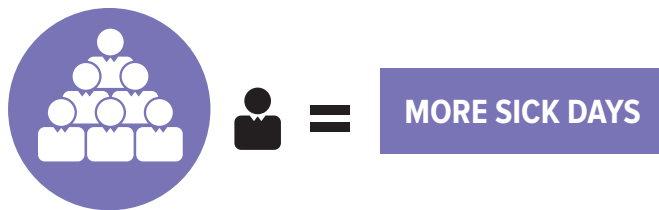
Black residents are more than twice as likely to live in poverty as white residents, and black children are more than three times as likely as white children to live in poverty. Black residents are also more likely to live in neighborhoods with higher concentrations of poverty.



Adult residents who report worrying about having enough access to healthy and affordable food are twice as likely to report being unhealthy as adults who do not have such worries to report.



Virginia residents who report experiencing racial discrimination are more than twice as likely to report being in fair or poor health. They are also more likely to report higher frequencies of mentally unhealthy days.



Sources: www.americashealthrankings.org/VA and www.vdh.virginia.gov/OMHHE/2012report.htm

TRAINING THE TRAINERS

Implementing a health equity perspective within the state health department—what Royster described as seeing health challenges through a health equity lens—didn't happen overnight. First, staff within the Office of Minority Health and Health Equity, which Royster directed from 2007 to 2013 and which houses the state's Primary Care Office and Office of Rural Health, began educating themselves on equity using resources such as the documentary, "Unnatural Causes: Is Inequality Making Us Sick?" In fact, Karen Reed, MA, director of the office's Division of Multicultural Health and Community Engagement, says that "we were reading whatever we could get our hands on." Despite a long-standing focus on disparities and cultural competency, understanding health equity and how to apply its principles to traditional public health work required new skills and knowledge, Reed says. Royster adds that while work within the minority health office had been somewhat sectioned off into silos, the new health equity focus allowed the staff to unite across different projects with different grant-mandated requirements.

"You really have to start internally with your staff and within your organization," says Royster, who now serves as vice president at the Institute for Public Health Innovation. "There's always going to be a learning and growth curve, and it takes a long time for change to become integrated and sustainable. This is long-term work."

Along with the new perspective, the office changed its vision and mission statement to pointedly include health equity as well: its current mission is "to identify health inequities and their root causes and promote equitable opportunities to be healthy," and its vision describes the office as a "policy change agent." The office also expanded its strategic plan to make room for health equity and a greater focus on the social determinants of health.

After educating themselves, staff decided to grow the conversation statewide, developing a train-the-trainer toolkit that teaches interested residents, stakeholders and organizations how to facilitate community discussions about health equity. During a two-year period, the equity office led approximately 100 training sessions with diverse audiences such as churches, colleges and volunteer organizations, Reed says. The training curriculum educates participants on health equity as well as how to host and facilitate screenings of “Unnatural Causes” on their own and integrate health equity into organizational missions. Of particular note, the training explains how anyone can play a role in promoting better health for all Virginians and creating health opportunities. For example, according to Reed, a church or scouting group may feel compelled to reach out to homebound residents after learning about the negative health effects of social isolation.

“They can take this knowledge and work it into their [missions] because the puzzle is big when it comes to the social determinants of health,” Reed says. “I think ‘Unnatural Causes’ is having an impact. People are looking for real solutions to health problems, and in order to do that you have to do something different.”

Instead of presenting health equity to audiences from an academic perspective, consider simply talking to residents about their priorities for the community and what they believe most affects their health and their ability to stay healthy.

So how does health equity manifest itself at a programmatic level?

One way is through a stronger commitment to community engagement, Royster says. The office uses a strategy known as the community-based participatory approach, in which community members are involved throughout a health promotion project or intervention and share in decision-making authority. Tenets of the approach include recognizing the community as a unit of identity, distributing relevant information and findings to all participants and building on a community’s existing strengths. The approach also requires going into a community with an open mind rather than a predetermined agenda. For instance, Royster says, instead of presenting health equity to audiences from an academic perspective, consider simply talking to residents about their priorities for the community and what they believe most affects their health and their ability to stay healthy. (To read about more about this approach, see the Equity in Action section on page 21.)

To drive momentum, office staff and community stakeholders need to track their progress. One way to do so is to include equity and social determinants language in state health plans. For example, in the most recent version of the Virginia State Rural Health Plan, released in 2013, the authors call for increasing “awareness, engagement, and coordination among an expanded base of stakeholders to address the social determinants of health and promote healthy and equitable communities.” The plan also calls on local, regional and state policymakers to consider health equity in their day-to-day decision making. And instead of simply envisioning a future in which all rural residents have access

to quality health care, the plan envisions a future in which geographic distance, language and culture are no longer barriers to quality care. In other words, the plan directs energy toward leveling the playing field of health opportunities and targeting the conditions that make better health possible.

MAPPING VULNERABILITY: THE HEALTH OPPORTUNITY INDEX

The Virginia Department of Health’s “2012 Virginia Health Equity Report” served as a call to action on health inequities. The report introduced the new Health Opportunity Index (HOI), a tool designed to identify and analyze the social and economic factors associated with life expectancy and pinpoint policy levers that can be instrumental in expanding health opportunities and moving toward health equity. Royster says the idea for the HOI tool came from the department’s geographic information systems (GIS) staff, who assist public health practitioners in using the technology to map and predict disease trends. In essence, the HOI applies GIS technology to social and economic variables, using data at the census-tract level to map the distribution of determinants such as housing affordability, transportation availability and economic opportunity. When these geographic data are then viewed in conjunction with life expectancy data, the resulting maps make it easy to see that health-promoting opportunities are strongly correlated with how long people live, according to Royster, who notes that life expectancy in Virginia can vary by more than 25 years depending on where a person lives. At the end of the day, the tool underscores the notion that “place matters” when it comes to achieving health equity.

“It really does show the extent of inequity in Virginia,” he says. “Our goal is to raise awareness, to change the discussion around health and really broaden the strategies we use to promote equity.”

The HOI consists of 10 indicators: education, environmental hazards (as designated by the U.S. Environmental Protection Agency), affordability of transportation and housing, household income diversity, job participation, population density, racial diversity, population churning (people moving in and out of a community), material deprivation, and local commuting patterns. The indicators are used to generate statewide color-coded maps that show the geographic distribution of communities with high health opportunities and those with low health opportunities. For instance, black residents are most likely to live in areas with a low HOI score and least likely to live in areas with a high score—in fact, black residents are nearly four times as likely as white residents to live in census tracts with a low HOI score. The color-coded maps make it easy to quickly pinpoint communities with low life expectancy—such as Richmond City, Danville, Pe-



Black residents are most likely to live in areas with a low HOI score and least likely to live in areas with a high score—in fact, black residents are nearly four times as likely as white residents to live in census tracts with a low HOI score. The color-coded maps make it easy to quickly pinpoint communities with low life expectancy—such as Richmond City, Danville, Petersburg, Roanoke and Hampton Roads.

tersburg, Roanoke and Hampton Roads—and see that they are also home to low HOI scores. The report concludes:

“While race and poverty explain over 70% of the variation in life expectancy across Virginia, the HOI explains 87% of the variation in life expectancy at the state level. The HOI includes key socioeconomic, demographic and environmental processes that explain how race and class (and geography) influence health outcomes. In effect, the HOI helps answer the question ‘how do race and poverty (and geography) act to influence life expectancy?’”

In addressing that question, the HOI succinctly illustrates the role policy can play in achieving health equity, and the tool can help guide effective policy development. It can also help communities and nontraditional public health partners, such as transportation and education officials, better understand their roles in improving people’s health, Royster says. He adds that public health staff throughout the health department are also using the HOI tool to prioritize their work and outreach.

“It’s a powerful way to learn about equity,” he says.

EQUITY IN ACTION: Virginia Department of Health

The following is an example of what a health equity framework looks like when it's applied to traditional public health programs, which often involves a complete transformation in agenda setting, community engagement, collaboration and implementation.



Photo by monkeybusinessimages, courtesy iStockphoto.

Using the community-based participatory approach, the Connection first organized an asset mapping activity to identify community strengths as well as a “visioning” session to help residents “get excited about what Mosby could be and to help those who felt hopeless realize there was still hope for the community.”

MOSBY COMMUNITY HEALTH CONNECTION

What does the community want? It's a seemingly obvious question but one that, despite the best of intentions, even public health practitioners may neglect to ask. However, when it is posed to residents, it can have a powerful impact.

A few years ago, that very question came up in a meeting at Virginia Commonwealth University's Center on Health Disparities, which was working to improve birth outcomes in Richmond. In response, staff decided to go into the community and find out.

“We had been data driven and we decided it was time to see what would happen if we were community driven instead,” says Nannette Bailey, EdM, who at the time served as a program administrator at the disparities center.

So in 2008, in partnership with the Office of Minority Health and Health Equity, Bailey and her colleagues reached out to nearby Mosby Court, a public housing complex east of downtown. They approached the Mosby Tenant Council to ask whether the community would be interested in forming a partnership aimed at improving residents' health. According to Bailey, the council responded with serious hesitation. They were interested but noted that the university had come into Mosby Court before with promises of opportunity and improvement that had never materialized. Fortunately, Bailey and partners found a champion in Cynthia Newbille, a local city councilwoman who herself had grown up in public housing and spoke in support of the health project. And so the Mosby Community Health Connection was born.

“It was really hard to hear, but we needed to be open to residents telling us why they had trust issues,” Bailey says. “We needed to listen to their stories to be able to address them.”

Using the community-based participatory approach, the Connection first organized an asset mapping activity to identify community strengths as well

as a “visioning” session to help residents “get excited about what Mosby could be and to help those who felt hopeless realize there was still hope for the community,” Bailey says. Soon after, work began on developing a survey to gather information on what residents believed to be the community’s priority health issues. Bailey notes that residents were initially concerned about who would have access to the survey data, “but we reassured them that this was their information and they would own it.” The survey was conducted in the fall of 2008 during a Mosby Court community day, and approximately 100 people took part. Interestingly, respondents tapped a number of social determinants as top issues. For instance, many residents said they wanted a medical facility in the Mosby community, as it was often difficult to obtain transportation to nearby health clinics or the hospital. They also called for a safe place for their children to play and be outdoors as well as coordinated children’s activities. Birth outcomes—the original health topic the Center on Health Disparities had wanted to address—were a low priority for residents.

“Residents talked about diabetes, asthma, violence, access to healthy foods, housing issues, transportation, general barriers to economic opportunity—their lived experience naturally leaned toward the social determinants of health,” Royster says. “We, as public health professionals, oftentimes think of health out of context...but someone living day to day in this environment can see these connections on a daily basis.”

The Mosby Community Health Connection launched a “photovoice” project to address the issue of youth engagement. During the project, local middle school students took photos of what they believed to be barriers to good health. Their photos captured images such as a rundown house, a convenience store where the only healthy foods were canned vegetables and a recreational facility for young children that had little to offer to adolescents. The photovoice project was a success and eventually led to the launch of the Youth Health Equity Leadership Institute, which engages youth in developing leadership skills and in creating or improving health opportunities in Mosby Court. Its curriculum covers not only health equity and social determinants but racism, conflict resolution, advocacy, community organizing and assessment, critical thinking and much more.

“The institute was an opportunity to really demonstrate the importance of community-based participatory work in which residents are involved as equal partners to help create change in the community,” Royster says.

Around the time of the survey, the city was beginning to build health facilities back into public housing communities, but Mosby Court wasn’t being consid-

ered, Bailey says. With the help of the new Connection partnership and the support of Councilwoman Newbille, city officials put Mosby on the list. In 2011, the new Mosby Resource Center, a partnership among the university's School of Nursing, the Mosby Tenant Council, the Richmond City Health District and the Richmond Redevelopment & Housing Authority, opened its doors to offer residents a range of health and social services.

Bailey says that among the lessons learned from the experience is developing steps for action and keeping active, "as people will get discouraged with you if you do more talking and less moving." She also notes that it was critical for residents to believe that better health was, indeed, within reach. The Mosby Community Health Connection continues to hold meetings every month.

"Some residents had discounted themselves and their ability to achieve a level of health," Bailey says. "It helped them to see that good health belongs to everybody, that we deserve good health just like everybody else and we have the ability to ask for it and go out and get it."

RESOURCES

Virginia Office of Minority Health and Health Equity
www.vdh.virginia.gov/OMHHE

Health Equity Training of the Trainer Resources
www.vdh.virginia.gov/OMHHE/healthequity/unnaturalcauses/resources.htm

2012 Virginia Health Equity Report
www.vdh.virginia.gov/OMHHE/2012report.htm

Mosby Community Health Connection
www.slideshare.net/vahealthequity/community-connections-for-health-vcus-center-on-health-disparities-community-engagement-initiative-with-mosby-court

Youth Health Equity Leadership Institute
www.facebook.com/pages/Youth-Health-Equity-Leadership-Institute-YHELI/183074925201961?ref=stream

www.institutephi.org/our-work-in-action/research-evaluation/youth-health-equity-leadership-institute/

INTEGRATE AND OPERATIONALIZE: RECOGNIZING EQUITY EVERY DAY

Colorado Department of Public Health and Environment



“The Health Equity and Environmental Justice Collaborative’s mission is to build an organizational culture that empowers and supports staff in addressing equity and environmental justice.”

— MAURICIO PALACIO, MS, DIRECTOR, OFFICE OF HEALTH EQUITY, COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

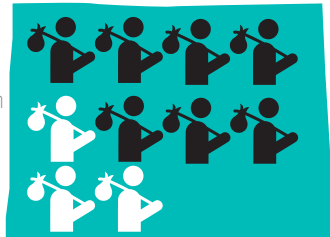
Like most health departments, the Colorado Department of Public Health and Environment has long been working to address community disparities in health status, disease rates and access to care. Still, a few years ago, a group of public health practitioners within the agency began to ask: Why aren’t we making more profound progress in closing disparity gaps? What are the social determinants of health that we need to address more comprehensively to truly make the elimination of health disparities a reality? The answer was shifting from a framework of disparities to one of health equity. With roots in the department’s Prevention Services Division, achieving health equity is now a cross-cutting priority goal for the state public health and environment department, which has cultivated support for equity not only in the department’s ranks but also among state policymakers. Today, at the Colorado Department of Public Health and Environment, health equity is much more than a goal—it’s a standard of everyday public health practice and the driving idea behind a new workplace culture.

Health Inequity by the Numbers

According to the 2013 America's Health Rankings, Colorado ranks 8th in the nation.

Some examples of the social and health disparities that lead to health inequity in Colorado include:

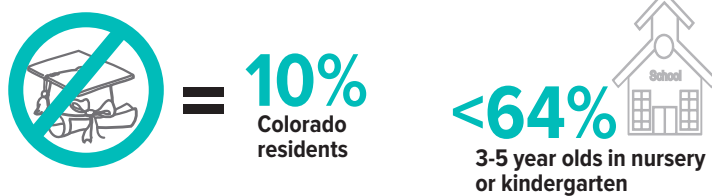
The percentage of Colorado residents living below the poverty line increased from 12.6 percent in 2009 to 13.4 percent in 2011. In addition, the percentage of Colorado children younger than 18 living in poverty rose from 14.4 percent in 2008 to 17.7 percent in 2011. Overall, three in 10 Colorado residents live at or below 200 percent of the poverty level.



Nine in 10 white Coloradans report that they can easily buy healthy food in their neighborhoods, as compared with eight in 10 Hispanic adults and seven in 10 black adults.



In Colorado, the school dropout rate among American Indian, Alaska Native, Hispanic and black students is two to three times higher than the rate among white and Asian students. Overall, one in 10 Colorado residents do not have a high school diploma or equivalent diploma, and less than 64 percent of children 3 to 5 years old are enrolled in nursery school or kindergarten.



Sources: www.americashealthrankings.org/CO; www.colorado.gov/pacific/sites/default/files/OPP_2013-Colorado-Health-and-Environmental-Assessment_0.pdf

1 <http://mchb.hrsa.gov/lifecourse>.

ROOTS OF CHANGE

The shift toward health equity at the Colorado state health department began in the late 2000s within the department's tobacco use prevention unit. At the time, tobacco prevention staff were taking a deeper look into why the state's progress in narrowing tobacco-related disparities seemed to be at a standstill. During their research to find the answer, health equity issues related to the social determinants of health, such as the greater visibility of tobacco marketing and retailers in certain communities as well as the need to better engage and value the insights of those directly affected by tobacco disparities, rose to the top. In response, staff members Lorena Zimmer, MA, and Indira Gujral, PhD, MS, pulled together a small group of fellow public health practitioners—those working in the areas of chronic disease prevention, maternal and child health (MCH), health disparities, and injury, suicide and violence prevention—to form the Social Determinants of Health Workgroup and to study and pull from successful equity models already in action, with the eventual goal of building an equity model of their own. The result of the workgroup's efforts is the Colorado Health Equity Model: An Explanatory Model for Conceptualizing the Social Determinants of Health, which is now being used to guide the agency's overall health equity work. A key component of the model is the MCH-inspired life course perspective,¹ which maintains that during critical periods of a person's life, such as infancy, childhood, adolescence, the childbearing period and the elderly years, specific determinants, experiences or exposures can have long-term implications. According to this perspective, it is during these particular times that intervening with education, support and resources can be especially pivotal and can set a course toward a healthier lifelong trajectory.



The model compels practitioners to not only examine disparate health behaviors and risk factors but to ask why certain populations are more vulnerable to those behaviors and factors in the first place.

“We started to recognize the importance of this model, as it brought key concepts together and provided a common language for everyone to use,” says Gujral, who previously served as senior epidemiologist with the department’s Prevention Services Division and now serves as the division manager for Communicable Disease and Emergency Management at Boulder County Public Health. “Traditionally, we’d been more concerned with health outcomes and [conventional] risk factors, but we realized that to impact health disparities we needed to go upstream and address the social determinants of health.”

The conceptual model, designed to better illustrate the connection between the social determinants of health and health disparities, comprises five interconnected components: national influences, such as government policies and cultural norms; the life course perspective, which spans the period from pregnancy to older age; the social determinants of health, such as income, education, air quality, political influence and racism; health factors, such as nutrition, tobacco use, substance abuse and insurance coverage; and population outcomes, such as quality of life, mortality and life expectancy. The model is designed to help public health practitioners broaden their perspective—regardless of their programmatic area—from conventional health risk factors to the more encompassing social and economic conditions of communities. In other words, the model compels practitioners to not only examine disparate health behaviors and risk factors but to ask why certain populations are more vulnerable to those behaviors and factors in the first place.

After developing the model, Gujral and Zimmer, who at the time was the department’s health equity coordinator, took it to their division director, who agreed to train the entire Prevention Services Division staff on its principles and how to integrate it into all of the division’s prevention planning (eventually, all agency staff would be trained on the new model as well). In addition to informing effective upstream interventions, the model can help practitioners effectively deploy resources by designating counties in greatest need as those with four or more social indicators in the bottom quartile. To ensure that the equity model was correctly tapping counties in need, Colorado staff compared the counties as identified by the new model with the Robert Wood Johnson Foundation’s County Health Rankings.² The match was nearly perfect. In other words, following social indicators successfully led health workers to counties already documented to be among the least healthy in the state, illustrating the fundamental connections between poor health outcomes and poor social and economic conditions.

The model would also become a key tool in helping staff operationalize health equity. For example, Gujral says, one of the biggest barriers to implementing health equity as an agency-wide priority is that programmatic public health funding is often tied to specific health conditions and outcomes as opposed to

² www.countyhealthrankings.org.

social determinants. Thus, a program may be funded to reduce tobacco use and related disease but not to reduce poverty and unemployment, which are risk factors in whether a person uses tobacco. However, the equity model creates a path for that practitioner or agency to reach out and collaborate with nontraditional public health partners, such as criminal justice and education officials, who may have a better chance at affecting relevant social determinants and reaching residents at risk for tobacco use at critical points in their lives (i.e., the life course perspective). Similarly, a program funded to address worrisome obesity rates could use the equity model to identify potential policies and activities that target obesity at its roots, such as creating built environments that automatically integrate safe spaces for physical activity and organizing farmers markets in neighborhoods with little access to fresh produce.

With the new model in place, the philosophy of health equity took a firm foothold within the state health agency and jumpstarted an agency-wide transformation. In 2013, the model was used by the Association of State and Territorial Health Officials to support the implementation of strategies for promoting health equity across state and territorial health organizations.



The collaborative is charged with promoting methods for addressing health equity and environmental justice through the agency, and its mission is “to build an organizational culture that empowers and supports staff at every level in addressing the root causes of health inequity and environmental injustice in their work.”

“We were looking at so many different things—there were disparities not only racially and ethnically, but also relating to gender, literacy level, sexual orientation, disability status and geography,” says Mauricio Palacio, MS, director of the health department’s Office of Health Equity, which officially transitioned from the Office of Health Disparities to the Office of Health Equity in summer 2013. “Health equity is a big, lofty goal, but it’s more positive and more encompassing than only focusing on health disparities.”

BUILDING THE CAPACITY TO ACHIEVE EQUITY

Following the success of the new equity model, the first step in building agency-wide support for equity and applying it to everyday public health work was building a new organizational culture: “We decided we needed to take care of internal business first,” Palacio says. That process began in earnest in 2011, when the agency developed a new strategic map that tapped the promotion of health equity and environmental justice³ as a cross-cutting priority. The agency also convened the Health Equity and Environmental Justice Collaborative, which included representatives from every division within the health department. The collaborative is charged with promoting methods for addressing health equity and environmental justice through the agency, and its mission is “to build an organizational culture that empowers and supports staff at every level in addressing the root causes of health inequity and environmental injustice in their work.” Palacio notes that one of the tools collaborative leaders used to make

³ Environmental justice is the fair treatment and meaningful involvement of all people, regardless of race, color, national origin or income, in the development, implementation and enforcement of environmental laws, regulations and policies (see www.epa.gov/environmentaljustice). According to the Natural Resources Defense Council, “Communities of color, which are often poor, are routinely targeted to host facilities that have negative environmental impacts. Environmental justice is an important part of the struggle to improve and maintain a clean and healthful environment, especially for those who have traditionally lived, worked and played closest to the sources of pollution” (see www.nrdc.org/ej).

sure all members were on the same page was the documentary “Unnatural Causes: Is Inequality Making Us Sick?”

“[The film] really brought the issue home in simple language,” he says.

Among its accomplishments, the collaborative has provided intensive internal education and training on health equity, conducted a baseline knowledge survey among the agency’s staff and developed a dynamic electronic library of equity training tools, webinars and resources that are accessible to all agency staff members. The collaborative includes six priority-area workgroups focusing on data, workforce development and training, meaningful community involvement, resource alignment, policy development and communications. For example, within the area focusing on data, the goal is to use high-quality data in policy development, resource allocation and program development; within the area addressing meaningful community involvement, the goal is to ensure that all voices are heard when identifying and implementing possible interventions; and within the policy area, one of the goals is to review proposed legislation using a health equity and environmental justice framework.

Most of the workgroups meet monthly and have created a number of new resources and opportunities for learning, Palacio says. For instance, the Professional Workforce Development and Training Workgroup is creating a set of core competencies related to health equity work; the Meaningful Community Involvement Workgroup organized a series of lunch lectures for staff members on issues such as health literacy and environmental health; the Policy Development Workgroup created a tool that the staff can use to review policies for their impact on equity issues; and the Data Workgroup created a map illustrating the inequity-related burden throughout the state. In late 2014, the collaborative launched a new pilot project in partnership with a local health agency, Eagle County Public Health. Designed to facilitate the sharing of equity tools and information between the two public health agencies, the project will also focus on better aligning existing resources toward long-term equity goals.

“Eagle County Public Health aims to be a model of health equity,” Palacio says. Also among the Colorado health department’s new equity tools is its Equity and Empowerment Lens, which is used for measuring internal inequities in services, policies, practices and procedures. The lens is a modified version of one developed by the Multnomah County Health Department in Oregon in 2010 (for more, see the Multnomah case study on Page 1). The Colorado health department tailored the Multnomah County lens to its specific needs, developed its own set of equity and empowerment assessment questions and began using the new lens in 2012 to evaluate decision making and service provision within the agency. Like the Multnomah County lens, the Colorado lens is based on principles of social justice and helps expose how histories of racism, oppression and institutional



Like the Multnomah County lens, the Colorado lens is based on principles of social justice and helps expose how histories of racism, oppression and institutional bias contribute to poor health; it also assists in determining whether public health activities will negatively or positively impact communities already struggling with health inequities.

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STATE LAWMAKERS TAKE NOTICE

After years of building the foundations needed to effectively tackle health inequity, the Colorado public health and environment department received a welcome boost to its efforts with the passage of state legislation that codified the department's new focus into law. In 2013, the state's governor signed a bill⁴ modifying the department's existing charge of addressing health disparities to include health equity as well, and the department's Office of Health Disparities was renamed the Office of Health Equity. In fact, the bill's language expressly acknowledged the role of health equity in eliminating health disparities:

“The General Assembly finds that modifying the duties and structure of the Office of Health Disparities to become the Office of Health Equity reflects the recent advancements in the field of health by broadening the scope of the office to include the economic, physical and social environment, and offers a more inclusive approach to eliminating health disparities for all Coloradans.”

Among its many duties, the new Office of Health Equity leads the health department's equity efforts, provides awareness-raising education to the public and works with affected community stakeholders to set priorities, collect and distribute data, and align relevant resources both within the health department and across fellow state agencies. The recent legislation also consolidated existing minority health and disparities councils into the new Health Equity Commission, which advises the Office of Health Equity and reviews applications for the existing Health Disparities Grant Program,⁵ among many other duties. The 15-member commission meets monthly, and it counts among its members state legislators as well as a diverse range of public health professionals, including those with expertise in the health issues facing racial, ethnic and sexual minority communities.

In many ways, the health department's renewed focus on the social determinants of health that began in 2009 paved the way for the new law, Palacio says, noting that public health workers provided input throughout the legislative process.

“It expanded our horizons and made our office more inclusive,” he says. “It was a big deal and really provided the impetus to expand, modernize and broaden the reach of [the Office of Health Equity].”

⁴ [www.leg.state.co.us/clics/clics2013a/csl.nsf/fsbillcont2/D281C67DEF97558687257AEE0054BBB7/\\$FILE/1088_enr.pdf](http://www.leg.state.co.us/clics/clics2013a/csl.nsf/fsbillcont2/D281C67DEF97558687257AEE0054BBB7/$FILE/1088_enr.pdf).

⁵ The Colorado Health Disparities Grant Program provides financial support for statewide initiatives that address prevention, early detection and treatment of cancer, cardiovascular disease and pulmonary diseases in underrepresented minority populations. The program is supported with funding from the state's Tobacco Tax Initiative. For more information, see www.colorado.gov/pacific/cdphe/A35-health-equity.

EQUITY IN ACTION: Colorado Department of Public Health and Environment

The following is an example of what a health equity framework looks like when it's applied to traditional public health programs, which often involves a complete transformation in agenda setting, community engagement, collaboration and implementation.



Navigating the indicators system, users can view and compare data on a number of social and economic indicators such as poverty, education, housing, access to recreation and healthy food, political influence (as defined by the numbers of registered and active voters in a given community) and violence. (Users can also browse through information on more traditional health indicators such as tobacco use, physical activity, unintended pregnancy and injury rates.)

FACTORS INFLUENCING INEQUITY: THE COLORADO HEALTH INDICATORS

In 2008, state legislators enacted the Colorado Public Health Act, which among other measures called for a new state public health assessment and health plan and required the same of local public health jurisdictions as well. Typically, an assessment would focus on indicators such as mortality, morbidity and risk factor data. However, Colorado public health practitioners decided it was time for a radical change and used the opportunity to shift the idea of health improvement beyond the usual factors to include and elevate the social determinants of health. The result is the Colorado Health Indicators, a dynamic tool that organizes health indicators based on the Colorado Health Equity Model and considers a wide range of elements that influence residents' health.

“This is not just a data conversation, this is a values conversation,” says Alyson Shupe, PhD, MSW, chief of the Colorado Department of Public Health and Environment Health Statistics Section and a member of the department's Health Equity and Environmental Justice Collaborative. “It's not about blame, it's about history and circumstance and situation. What I always tell people is that this isn't typical work, this is transformative work.”

The Colorado Health Indicators tool offers a variety of information at the county, regional and state levels and is used in Colorado's Health Assessment and Planning System, in which a standardized process is used to help local public health agencies meet mandated assessment and planning requirements. Navigating the indicators system, users can view and compare data on a number of social and economic indicators such as poverty, education, housing, access to recreation and healthy food, political influence (as defined by the numbers of registered and active voters in a given community) and violence. (Users can also browse through information on more traditional health indicators such as tobacco use, physical activity, unintended pregnancy and injury rates.) For example, in the southern county of Costilla, one of the poorest

communities in the state, the indicators showed that as of 2012, more than 27 percent of residents lived below the poverty line, as compared with a statewide rate of 13.6 percent. The county is also home to a 12.7 percent unemployment rate, substantially higher than the state rate of 8 percent. In addition, more than 22 percent of Costilla County residents 25 years of age and older have never completed high school—a rate more than double the state average. Income, employment and education are key upstream determinants of health status, disease burden and the development of health risk behaviors.

While access to such data is not uncommon, making these factors a centerpiece of a statewide public health improvement tool specifically designed to facilitate standardized assessments across localities is a transformative step. In fact, state health officials encouraged their local counterparts to use the equity framework in their own assessments, and, according to Shupe, most have done so. The new indicators also assist health officials in their efforts to include health equity goals within their local public health improvement plans. In 2013, the state health department released its own “Colorado Health and Environmental Assessment,” in which the social determinants of health have a prominent role. According to Shupe, the 2013 report and the Colorado Health Indicators were significant steps in the long journey toward health equity.

“Before you have a model you can use and hold up and share with people, it’s really hard to do this kind of work,” says Shupe, referring to the Colorado Health Equity Model. “Most people are doing a piece of [equity work] somewhere, but if you have a model and measurements and a data system supporting you, we can really build momentum. ... We have to keep talking about these issues. You can’t wait—you just have to go, you have to move forward.”

RESOURCES

Office of Health Equity, Colorado Department of Public Health and Environment
www.colorado.gov/pacific/cdphe/ohe

Colorado Health Equity Commission
www.colorado.gov/pacific/cdphe/health-equity-commission

Colorado Health Equity Framework
www.colorado.gov/pacific/sites/default/files/HealthEquityModel.pdf

Colorado Health and Environmental Assessment, 2013
www.colorado.gov/pacific/sites/default/files/OPP_2013-Colorado-Health-and-Environmental-Assessment_0.pdf

Colorado Health Indicators
www.chd.dphe.state.co.us/healthindicators/Default.aspx

Role of the State and Territorial Health Official in Promoting Health Equity
www.astho.org/Programs/Health-Equity/Health-Equity-Orientation-for-SHOs

27%

of Costilla County residents lived below the poverty line, as compared with a statewide rate of 13.6 percent.

22%

of Costilla County residents 25 years of age and older have never completed high school.

TRANSFORMING THE WORK OF COMMUNITY HEALTH

Texas Department of State Health Services



“The first place to start in working toward health equity is having a courageous conversation about why disparities exist, and that really does open the door to understanding the work that we’re doing.”

— BRANDII MAYES, MPH,
COMMUNITY TRANSFORMATION GRANTS–
TRANSFORMING TEXAS GRANT
COORDINATOR, TEXAS DEPARTMENT OF
STATE HEALTH SERVICES

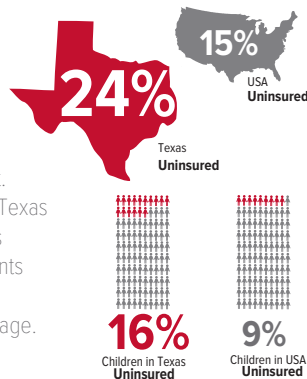
A key step in advancing health equity in every community is creating safe, nonjudgmental spaces where public health workers and their community partners can talk openly and honestly about the root causes of health disparities. This is no simple task. Health disparities are fundamentally linked to issues of racism, inequality and institutional bias, topics that are difficult to discuss in nearly every setting and every community. Making matters even more complicated is the lack of a common language with which to talk about health inequities. In Texas, finding this common language and tailoring it to fit local needs and cultures was the first step in uniting communities across the country’s second largest state in adopting a health equity framework. And today, in Texas communities both large and small, the language of health equity is slowly reshaping work toward creating healthy opportunities for all residents of the Lone Star State.

Health Inequity by the Numbers

According to the 2013 America's Health Rankings, Texas ranks 36th in the nation.

Some examples of social and health disparities that lead to health inequity in Texas include :

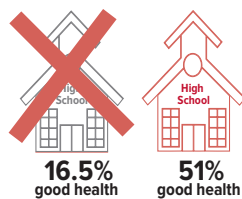
Texas leads the nation in the number of residents without health insurance. In 2012, 24 percent of the state's population was uninsured, as compared with a national rate of 15 percent. In that same year, 16 percent of children in Texas were uninsured, while the national rate was 9 percent. Black and Hispanic Texas residents are significantly more likely than their white counterparts to lack health insurance coverage.



The rate of childhood poverty in Texas grew by 47 percent between 2000 and 2011. In 2012, more than a quarter of Texas children were living in poverty.



Only 16.5 percent of the state's residents 25 years or older with less than a high school education report being in good or excellent health, as compared with more than 51 percent of residents with a high school education or more. Two-thirds of low-income children 3 and 4 years of age are not enrolled in preschool.



Sources: www.americashealthrankings.org/TX; www.texmed.org/Template.aspx?id=5519; http://forabettertexas.org/images/EO_2013_11_ECE_layout.pdf; http://forabettertexas.org/images/CPPP13_KC-databook-v27.pdf

EXERCISES IN EQUITY

In 2011, the Texas Department of State Health Services was awarded a five-year Community Transformation Grant (CTG)¹ from the Centers for Disease Control and Prevention, and the funds were distributed to 18 Transforming Texas subgrantees throughout the state. From the beginning, advancing healthy equity was a core principle and priority of the state's CTG work. However, Texas wasn't starting from scratch—in 1993, lawmakers created the Texas Office of Minority Health to focus on the needs of minority populations. Also, in 2011, legislators approved a bill creating the Center for Elimination of Disproportionality and Disparities, which is specifically tasked with finding systematic ways to narrow disparity gaps among children and families. While state public health workers had already begun laying some of the groundwork to advance equity, such as operationalizing equity as a standard of practice within the health department division responsible for overseeing Transforming Texas awardees, the CTG provided an opportunity to build a statewide movement and jumpstart dialogue at the local level.

"It's really about engaging communities so that they can take ownership of these interventions, and the Community Transformation Grant is the conduit that can provide the resources to help them do that," says Brandii Mayes, MPH, Community Transformation Grants—Transforming Texas grant coordinator at the Texas Department of State Health Services. "Texas is a large state and it's extremely diverse...so it was really important to us to create a level starting point for all [CTG] awardees. We didn't want to assume that everyone had the same understanding of disparities and equity. Getting everyone on the same page is really important, especially to sustain this work beyond the life of the grant."

¹ The Community Transformation Grant program supports awardees in designing and implementing community-based efforts focused on the prevention of chronic diseases such as heart disease, diabetes and cancer. More information is available at www.cdc.gov/nccdphp/dch/programs/communitytransformation.



More respondents agreed that the health care system treated patients unfairly based on their race, ethnicity, gender, education level or income, and prejudice and discrimination were the reasons most often cited for differences in life expectancy. The percentage of respondents who believed that a person's skin color affects the quality of the health care he or she receives rose from 47 percent pre-training to 74 percent post-training.

As with many equity initiatives, one of Texas' initial steps was to promote understanding and dialogue. But first, health officials wanted to pinpoint the proverbial starting line. In turn, the Center for Elimination of Disproportionality and Disparities collected baseline data on grantees' perceptions and knowledge of health inequities and disparities before and after a short, one-day equity workshop. The results would be used to aid Texas health officials in advancing a long-term equity strategy and would help shape the more formal equity curriculum showcased in the Equity in Action section on page 36. The exercise would also highlight the characteristics of effective equity education and awareness building. CTG grantees include public health officials as well as representatives from community and nonprofit organizations.

Before the short workshop began, 106 participants were surveyed on their perspectives regarding racism and health disparities. Among the results, about half of the respondents said that racism and discrimination were major problems affecting people's health; however, less than half believed that racism and discrimination were major problems in other social determinants, including education, housing and the workplace. While most respondents agreed that factors such as health care coverage, the physical environment and neighborhood characteristics contributed to disparities, personal behaviors were most often tapped as the underlying reason for differences in life expectancy.

After the workshop, perceptions changed quite dramatically. Post-training, the number of respondents who agreed that racism and discrimination were major problems affecting a person's health rose by more than 10 percentage points. More respondents agreed that the health care system treated patients unfairly based on their race, ethnicity, gender, education level or income, and prejudice and discrimination were the reasons most often cited for differences in life expectancy. The percentage of respondents who believed that a person's skin color affects the quality of the health care he or she receives rose from 47 percent pre-training to 74 percent post-training.

Overall, while the survey showed that the equity workshop training made a positive difference in respondents' understanding of the origins of disparities, the facilitators also found that racism was a very difficult subject to broach and that participants had a hard time articulating the impact of racism on health and inequity. In a report (see link on page 39) that detailed the survey results and recommended continued health equity training throughout the CTG life cycle, the authors wrote:

“Racism is a complex phenomenon that manifests itself in a wide variety of forms, including direct and intentional prejudice, unconscious biases, and structural institutional policies and practices. Different manifestations of racism may have differential effects on health disparities, as is suggested by respondents’ varying responses on the role of racial discrimination (a direct, individual form of racism) and the role of limited access to health insurance (a structural, institutional form of racism). Respondents seemed to associate racism with its more direct manifestations, and therefore ascribed it a limited or nonexistent role in causing health disparities. However, their association of race and health disparities with income and insurance status suggests that they do, in fact, perceive racism, in its more indirect, institutional forms, as having a strong impact on health disparities. Their conceptualization seems close to that of ‘institutional racism,’ even if they do not explicitly use that term in their responses.”

With the baseline data in hand, Texas health officials set out to advance health equity as a public health priority. Part of that effort included building a more in-depth training course to help grantees shift their thinking from a sectoral approach to a systems approach and to provide the tools needed to operationalize an equity framework. To do that, the health department contracted with CommonHealth ACTION, a national nonprofit group working to increase communities’ capacity to address the economic and social determinants of health, to develop a comprehensive health equity curriculum and eventually conduct two-day workshops across the state.

“We can’t do our work effectively [as public health practitioners] without health equity being a part of it,” Mayes says. “There’s a shift in the way that we do our work in public health. Public health has traditionally worked in disease-based silos, but now we’re moving to coordinate our efforts, to focus on changing systems and infrastructures. The good thing about that is that it helps us take a step back and look at disparities in a different way and ask how do we change the community and system as a whole?”



There’s a shift in the way that we do our work in public health. Public health has traditionally worked in disease-based silos, but now we’re moving to coordinate our efforts, to focus on changing systems and infrastructures. The good thing about that is that it helps us take a step back and look at disparities in a different way and ask how do we change the community and system as a whole?

EQUITY IN ACTION: Texas Department of State Health Services

The following is an example of what a health equity framework looks like when it's applied to traditional public health programs, which often involves a complete transformation in agenda setting, community engagement, collaboration and implementation.



Another goal of the awareness-building conversation is to shift participants' perspectives from sector based to system based. For instance, participants are asked what community means to them and what values hold their communities together. Discussions also address how social and economic determinants, such as housing, transportation and poverty, both shape people's health and lead to systemic biases, as well as how those determinants affect the community's priority health problems.

TEXAS CTG EQUITY TRAINING: IMPLEMENTING AN EQUITY FRAMEWORK

With insights from the baseline data gathered during the previous equity workshop, CommonHealth ACTION developed a new health equity curriculum to lead two-day workshops for CTG grantees across Texas, eventually reaching about 250 public health officials and supporters in the summer of 2013. Realizing that many of the CTG grantees served rural communities and often had fewer resources at hand than metropolitan areas, curriculum developers knew they couldn't simply adopt and repurpose equity models from larger cities. Still, the meaning of health equity—that all people deserve an equal opportunity to achieve good health—remained the same. In Texas, the starting point for launching equity conversations may have been different from those in Seattle or Boston, but in no way did it mean that health workers on the ground didn't aspire to the same goals, says Mark Cervero, MPH, CPH, a program manager at CommonHealth ACTION who helped lead the workshops.

"We need to disavow ourselves of any expectation of what a rural community is or what they believe," Cervero says. "They were just as committed to the work [of equity], even though their solutions are going to look different. Everyone wants what's best for their community."

Day 1

Half of the two-day workshop focused on raising awareness and building knowledge regarding equity, disparities and racism. According to Cervero, this part of the process was critical: "If you start with just how to operationalize and use equity tools, you skip the heart of the work." In addition, this part of the workshop was designed to build a common equity language among attendees coming from a variety of organizational backgrounds. For example, at the two-day workshop in Lufkin, a town of about 30,000 north of Houston, at-

tendees included local public health workers as well as representatives from an anti-tobacco coalition, an American Cancer Society chapter and a local hospice.

In general, day 1 of the workshop proceeds as follows. Initially, basic concepts are defined and ground rules for discussion are set. The conversation builds slowly, with workshop facilitators discussing the data underpinning inequities and using icebreakers such as the film “Unnatural Causes: Is Inequality Making Us Sick?” Another beneficial tool is using journaling to help participants feel comfortable expressing their feelings; at no point do participants have to share their journal entries.

“It’s about creating a safe space in the room and allowing everyone to bring themselves into the conversation,” Cervero says. “One thing that would not work is bringing our own agenda into the room.”

Another goal of the awareness-building conversation is to shift participants’ perspectives from sector-based to system-based. For instance, participants are asked what community means to them and what values hold their communities together. Discussions also address how social and economic determinants, such as housing, transportation and poverty, both shape people’s health and lead to systemic biases, as well as how those determinants affect the community’s priority health problems. For example, these concepts were weaved into an interactive exercise called “What’s Your Issue?” The goal of the exercise, described below, is to help participants understand the extent to which local resources are aligned (or misaligned) to address priority community health issues.

First, facilitators post signs with different health problems—such as obesity, tobacco-related diseases, heart disease and cancer—on the classroom’s walls. Workshop participants are then asked to stand in front of the signs based on three different questions. The first is which health issue community residents would say is the biggest problem; the second is which issue receives the most focus, local action or funding; and the third is which issue the workshop participant believes is the biggest problem. Cervero says the exercise is a powerful way to help participants understand how their colleagues feel. Also, because the exercise doesn’t force anyone to verbalize their opinions, it ensures that everyone has a chance to be “heard” even if they’re not comfortable speaking up.

The next step in “What’s Your Issue?” begins to dig a little deeper into the root causes of poor health. It works as follows: after participants answer the third question—what they believe to be the community’s biggest health problem—the facilitators then flip over the sign to reveal a list of determinants and systems. For example, on the back of the obesity sign would be determinants such as poverty and access to nutritious food and safe spaces to be physically active. The goal is to help participants move from an individual behavior framework to one that considers the context in which people live and how it affects their op-

portunities for good health. After “What’s Your Issue?” workshop leaders facilitate a discussion about the partners, barriers and systems involved in addressing upstream determinants and ultimately preventing disease. According to Cervero, the interactive exercise is particularly effective because—in a very literal way—participants can visualize connections and opportunities for resource alignment they might not have otherwise considered by just sitting in a classroom.

Day 2

The second day focuses on operationalizing health equity goals and building the capacity to sustain equity work long after the CTG support ends. Two key ingredients in building capacity and sustainability are institutionalizing and applying an equity lens and building community coalitions around equitable health opportunities. As with the awareness-raising portion of the workshop, the second half is also tailored to meet the needs of smaller, often rural communities with limited resources.

“At every point, we ask ‘how does this apply to your work regardless of CTG?’ because that money will eventually go away,” Cervero says. “We know that having a knowledge and understanding that you’re not alone in this work is really important. So our ability to help [community stakeholders] connect with each other is a big element of the workshops as well.”

In the realm of coalition building, workshop facilitators encourage participants to think about current and future health coalitions—to specifically think about who’s missing and why they’re missing. For instance, what are the structural issues that may be impeding more comprehensive, more far-reaching coalitions and health-promoting activities? Collaboration is also positioned as a critical way to overcome the fluctuating resources, time and challenges that any given organization faces on its own. In other words, the odds of achieving health equity are always stronger when the process is viewed and actualized as a community affair. For example, Cervero says that one workshop participant expressed difficulty in reaching her community’s Hispanic population; however, the workshop gave her an opportunity to discuss the issue and best practices with fellow community stakeholders.

The second day of the workshop also focuses on how to apply an equity lens to public health work. Participants are encouraged to think about which populations are not able to access the potential benefits of health-promoting activities and why such barriers exist in the first place. For example, one of the workshop modules focuses on creating smoke-free environments and why smoke-free policies are effective in encouraging people to quit and reducing exposures to secondhand tobacco smoke. In applying an equity lens to the issue, participants are compelled to think about who is being exposed to tobacco and what mea-

asures are needed to reduce or prevent related disparities. The equity lens is key in helping participants shift their perspectives from sectors to systems.

At the end of each workshop, participants learn how to apply an equity lens to their CTG implementation plans and are asked to make personal, short-term action goals to guide and sustain equity-related activities. But, according to Cervero, perhaps one of the greatest strengths of the equity workshop is that participants leave with new and valuable partners for the long journey toward health equity.

“We don’t bring the answers,” he says. “Most of the answers are already in the room.”

RESOURCES

Center for Elimination of Disproportionality and Disparities, Texas Health and Human Services Commission
www.hhsc.state.tx.us/hhsc_projects/cedd/index.shtml

Health Equity: Perceptions, Knowledge, and Attitudes of Transforming Texas Sub-Grantees and Community Partners
http://web.unthsc.edu/download/downloads/id/5393/health_equity_final_report

CommonHealth ACTION
www.commonhealthaction.org

A PARTICIPANT’S PERSPECTIVE

Among the many CommonHealth ACTION workshop participants was Liz Johnson, MHA, executive director of the Community Health Coalition, which was established in 2004 to improve access to and coordination of medical care for uninsured and low-income residents of Caldwell County, Texas, where nearly half of the population lives at or below the federal poverty level. The coalition was formed to address the county’s high rate of chronic, preventable diseases and diabetes in particular. Initially, the coalition focused on disease self-management, helping residents access prescription drug assistance programs and bringing in primary care providers to alleviate gaps in health care access. Today, however, with the support of CTG funding, the coalition is shifting its focus from direct services to working on system, structural and environmental changes.

“In a lot of ways, we really viewed health and disparities in terms of the availability of medical services—we were very much focused on the medical side of this problem,” Johnson says. “But we wanted to get in on the preventive side.”

While Johnson and her colleagues were aware of the determinants that affected residents’ ability to manage their health—for example, the coalition addressed transportation barriers by arranging home care visits—they often tackled those barriers on an individual rather than systemic basis. During the two-day equity workshop, Johnson said the curriculum and exercises helped bring the root causes of poor health and disparities into clearer focus and offered her new tools for jumpstarting productive conversations about inequity in her community.

“The value for me was talking about the ‘why,’ about not just trying to respond to the needs of the person in front of me but thinking about the preventive efforts that can happen far upstream,” Johnson says. “I had thought about it before, but not really at that depth. ...We don’t really use the word ‘equity’ even though we’re doing that work. It’s prompted me to take what the [workshop facilitators] were saying and translate it into language that our community understands.”