Health Resources in Action

Advancing Public Health and Medical Research

POLICY AND PRACTICE REPORT

Embracing Equity in Community Health Improvement

May 2015

By Laurie Stillman, MM, and Steve Ridini, EdD

Health equity is 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 healthcare disparities.

Healthy People 2020

Health disparity is a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

Healthy People 2020
National Stakeholder Strategy
for Achieving Health

Across America, many public and private sector organizations are committed to generating greater opportunities and resources for the nation's most disadvantaged populations. These organizations are engaged in a wide range of strategies that are typically codified within their agencies' strategic plans. With similar overarching goals, they often work in uncoordinated silos. However, there is an increasing awareness among them that the fruits of their work impact community health status and their local health care systems. Conversely, medical institutions and public health agencies are realizing that community-building activities, which are outside of their traditional purview, are necessary to achieve improved population health status. This paper discusses the rationale and multi-sector approaches for intentionally promoting an *equity agenda* throughout the community health improvement (CHI) process, so that scarce resources are directed to addressing the underlying factors that have led to consistently poorer health outcomes for historically marginalized groups.

There are increasing examples of these various sectors partnering to collectively address the health of their communities by creating a unified Community Health Improvement Plan (CHIP) or Strategic Implementation Plan (SIP). Often led by public health departments, hospitals, or community health centers, these CHI processes tap the wisdom, desires, expertise, and political will of diverse community stakeholders. They accomplish this by collecting and analyzing data, identifying priorities, and developing coordinated and measurable approaches that leverage the resources of multiple partners to ultimately improve population health.

The Community Planning Imperative

Hospitals and public health departments across the nation are actively engaged in a more inclusive process of community health improvement (CHI) planning. The federal Patient Protection and Affordable Care Act (ACA) requires the nation's non-profit hospitals, through Internal Revenue Service guidelines, to engage in community health needs assessments (CHNA) and to develop strategic implementation plans (SIP) every three years to help guide community benefit expenditures. Additionally, because of their core missions, most state and local health departments are also engaged in CHI efforts. In 2011, the Public Health Accreditation Board (PHAB) officially launched its voluntary public health department accreditation program. PHAB encourages state, local, and tribal health departments to take part in a CHI process at least every five years.

On December 31, 2014, the Internal Revenue Service published final rules implementing the "Additional Requirements for Charitable Hospitals" section of the Affordable Care Act (ACA). These rules, among other things, relate to tax-exempt hospitals' community health needs assessments (CHNAs).

In summary, the final rules:

- *Impose a new requirement that a CHNA report include an evaluation—as opposed to a "plan to evaluate"—of the impact of any actions taken by a tax-exempt hospital to address significant health needs identified in the hospital's most recent CHNA. §1.501(r)-3*
- *Clarify that a tax exempt hospital may consider in its CHNA not only addressing financial and other barriers to care but also other community health factors such as preventing illness, ensuring adequate nutrition, or addressing social, behavioral, and environmental factors that influence community health status. §1.501(r)-3*

This process includes an expectation that diverse stakeholders will actively participate in the creation of a community health improvement plan (CHIP). The National Association of County and City Health Organization's (NACCHO) 2013 National Profile of Local Health Departments showed that a majority (53%) of local health departments were collaborating with hospitals on CHI efforts. However, little is known as to what extent these assessments or health improvement plans address the social determinants of health.[1]

The CHI cycle normally includes assessment, planning, implementation, evaluation, and monitoring. It begins with forming a Leadership Team to plan and monitor the process, and then convenes a larger multi-sector group of stakeholders to help devise and align priorities and strategies for greatest impact. At its best, the CHI process is a catalyst for place-based initiatives that bridges public health and health care, and includes efforts to improve other social determinants of health.

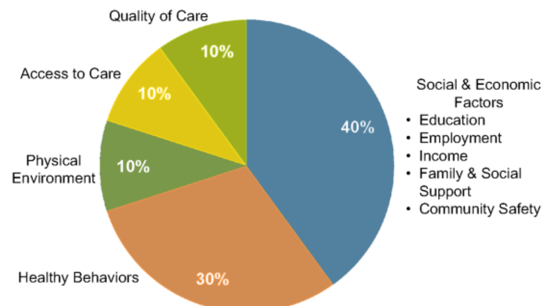
Social determinants of health are the conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels, which are themselves influenced by policy choices.

World Health Organization, May 2013

Drivers of Health

Population health is mostly influenced by the social opportunities and physical conditions found within our communities and workplaces – known as the Social Determinants of Health, or SDOH. (Figure 1) These factors can either positively or negatively influence the personal behaviors and the level of toxic substances and stress in our lives.[2] While some of the reasons for health disparities are due to inferior access to and quality of medical care[3], they can mostly be attributed to the variable and unfair distribution of economic resources, environmental exposures, pathways to success, and social experiences.

Figure 1: Factors that Influence Health Status

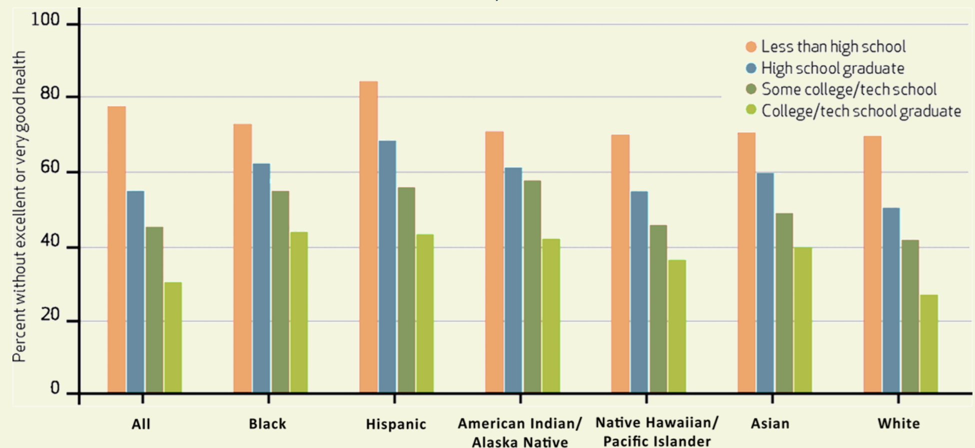


Source: Democracy Collaborative, adapted from *County Health Rankings*, University of Wisconsin Public Health Institute

Health Disparities by the Numbers

The burden of poor health, premature death, and disability in the U.S. is experienced most acutely by racial and ethnic minorities and those with lower socio-economic status.[4, 5] (Figure 2) In addition, certain other groups have been historically marginalized, discriminated against, or disempowered - putting them at higher risk of disease and mental illness. For example, Lesbian, Gay, Transgender, and Bisexual (LGBT) individuals have higher rates of smoking, HIV/AIDS, and substance abuse.[6] Women and those with a disability report higher rates of physically and mentally unhealthy days.[7] These health gaps are referred to as health inequities because they result from community conditions, social policies, and institutional practices that routinely expose disempowered groups to greater risks to their health.

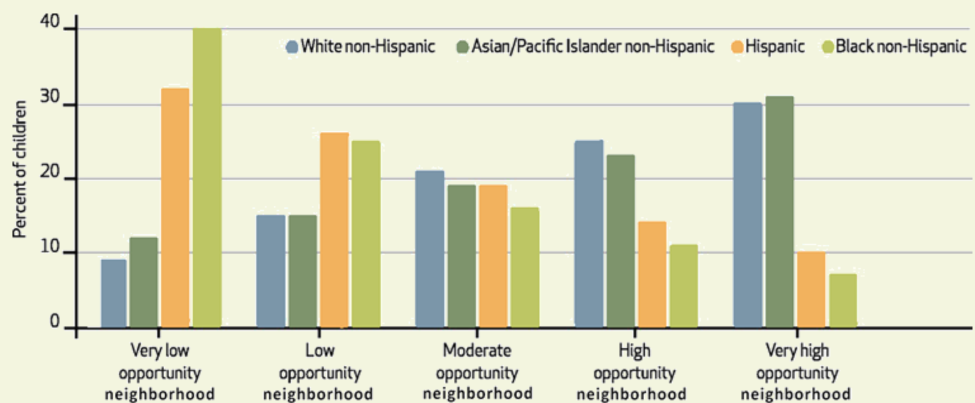
Figure 2: Disparities in Health Status of U.S. Adults Ages 25-74, by Educational Attainment and Race or Ethnicity



Source: *Health Affairs*, May 2011

The building blocks of adult health are established in childhood. Low household income and adverse life experiences are directly associated with less favorable childhood health and academic outcomes, yet nearly half of U.S. children now live in households that are financially struggling.[8] Low income and minority youth–especially males—are more likely to drop out of school, be unemployed, and end up in prison…all factors leading to poor life and health prospects.[9] Researchers at Brandeis University's diversitydatakids.org Project found that *across large metropolitan areas in the United States, 40 percent of black and 32 percent of Hispanic children live in very low-opportunity neighborhoods within their metropolitan area compared to 9 percent of white children.*[10] (Figure 3)

Figure 3: Health Equity Analysis of Children's Health Prospects, diversitydatakids.org (Brandeis University)



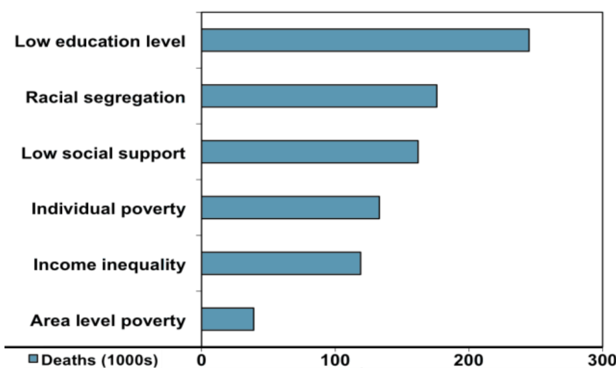
Source: *Health Affairs*, November 2014

> *"By the middle of this century, the Census Bureau tells us, the U.S. population will be majority minority. Our ability to compete in the global economy demands that we prepare students from every background for success in college and careers."*
>
> ***Gail Christopher, D.N.***
> ***W.K. Kellogg Foundation***

A key determinant of health, often not measured, is a lack of hope or power to control one's personal, neighborhood, or work environment. A growing body of evidence indicates that when people lack the ability to influence the context of their lives, it can affect their immune systems and vulnerability to disease.

Social isolation and discrimination are also underappreciated for their impact on health outcomes. Galea et al. estimated that the number of deaths attributable to social factors in the U.S. is comparable to the number of deaths attributable to physiological and behavioral causes. (Figure 4) "These findings," Galea writes, "argue for a broader public health conceptualization of the causes of mortality and an expansive policy approach that considers how social factors can be addressed to improve the health of populations".[11]

Figure 4: Estimated Deaths Attributable to Social Factors



Source: Eduardo Sanchez, MD, MPH, Sept. 2012, adapted from Galea et al.

Moving to an Equity Agenda

Society has tended to address the *symptoms*, rather than the *sources* of health disparities. Thus, our approaches tend to be expensive fixes to problems that may have been *prevented* in the first place.

If we are truly interested in improving the health status of all Americans, we need to confront the underlying societal inequities that fundamentally lead to poor health such as neighborhood poverty, racism, discrimination, and social and political isolation. This kind of transformation is harder to tackle, takes longer to achieve, and is more complicated to measure. But, addressing these factors will not only likely correct health disparities, they will also reduce unaffordable costs to our health care system.

Creating health equity is more prudent than treating avoidable and expensive hospitalizations, incarcerations, and disabilities. According to a 2009 study, eliminating health disparities for racial and ethnic minorities would have reduced direct medical care expenditures by $229 billion and reduced indirect costs associated with illness and premature death by approximately $1 trillion from 2003–2006.[12] In addition, a 2011 study estimated that giving all Americans the health status of college-educated adults would generate more than $1 trillion per year in health benefits.[13] It is not a question as to *whether* we have sufficient resources to tackle health inequities; it is a political decision about how we *choose* to spend them.

While tackling societal inequities may appear daunting as a health improvement strategy, research shows time and again that they are, indeed, the root causes of health disparities and a leading reason for our expensive medical care system.

> *"Using the term inequities means there are health gaps brought about by policies and practices in communities. They can be undone, because they are policies and practices that human beings put into place. Human beings can undo them as well."*
>
> ***Brian Smedley, PhD, Health Policy Institute***
> ***Joint Center for Political and Economic Studies***

Steps toward Infusing Equity into the Community Health Improvement Process

Community health improvement efforts offer providers, planners, decision makers, policy makers, funders, and community leaders with an opportunity to intentionally infuse an equity frame into collective action and impact. Based on years of research and practice, Health Resources in Action (HRiA) has developed an approach to comprehensively integrate equity into the CHI process. These ideas are meant to complement many of the helpful resources that are available in the field.

Step 1: Form a Leadership Team and Create an Equity Vision

Key Questions:

- How do you define diversity?
- Does your Leadership Team reflect the diversity of your community?
- What values do you uphold as a Leadership Team to ensure equitable participation?
- What is your vision of an equitable community?

Since non-profit hospitals, health departments, and community health centers are charged with developing community assessments and health improvement plans, they often have responsibility for overseeing and underwriting this process. At the same time, each of these processes requires a high level of *authentic* community involvement and engagement from the start. Forming a Leadership Team provides an opportunity to engage diverse stakeholders including community residents in leadership roles to:

- develop a collective vision for success
- build and foster relationships and trust
- create common expectations
- understand current community resources and issues
- provide feedback on reports and other deliverables
- champion sustainable health improvement efforts

Figure 5:

GUIDING PRINCIPLES FOR WORKING ON HEALTH EQUITY:

- ACTIVE LISTENING
- ATTENTION TO POWER DYNAMICS
- COLLABORATION, NOT COMPETITION
- CRITICAL THINKING
- CULTURAL COMPETENCY
- LONG-TERM COMMITMENT
- OPEN / HONEST COMMUNICATION
- SHARED ACCOUNTABILITY
- TRANSPARENCY
- TRUST AND RESPECT

The Leadership Team has to identify its vision, values, and a set of *health equity principles* (Figure 5) from the onset, clearly communicate this commitment to planning participants, have buy-in from the highest organizational officials, and reflect these principles in organizational practices. If the participating individuals and institutions are not deeply committed to an equity agenda, then it will likely become relegated as an afterthought in the CHI effort.

In achieving a health equity agenda, establishing an inclusive community power-sharing process is a key successful outcome. An effective Leadership Team will:

- ***Carefully consider who will be at the planning table and continuously ask participants who is missing***. When it comes to addressing the SDOH in long-neglected communities, health care and public health agencies cannot possibly be successful on their own. This CHI effort will require a diverse, collective effort as well as sustained commitment and resources. Engaging a range of stakeholders and leaders who have a constituency that can influence key changes to the physical, social, environmental, and policy environments is critical. (Figure 6) The team should intentionally consider the question: *Who else do we need to actively engage in CHI efforts?*

Figure 6: Building a Multisector Partnership

Source: Health Resources in Action, Inc.

- ***Seek out diverse representation from within agencies***, including staff and consumers who are impacted by inequities. For a health department, members might be drawn from maternal and child health, environmental justice and occupational health, HIV/AIDS, health equity, etc. For a hospital, the team might include representatives from health care quality and disparities, primary care, behavioral health, union representatives, and government advocacy.

- ***Accommodate the needs of low-income people and community-based organizations***. Asking community members and organizations to take significant time for a prolonged planning effort is an expensive proposition in terms of both time and dollars. To the extent possible, offering incentives like childcare, evening meetings, meals, honoraria, and/or mini-grants can make it easier for participants to stay engaged.

- ***Create opportunities for all participants to develop and understand a Health Equity Framework***. Assigning readings and creating space for authentic discussions in meeting agendas will be useful. Providing participants with local health disparities data and collective impact resources will help participants focus on the need for an equity agenda. Engaging participants in a "Root Cause Analysis" exercise at an initial meeting could be very powerful way to spark conversation. (Figure 7) Refer to HRiA's website for CHI/Health Equity Resources: www.hria.org .

Figure 7: Root Cause Analysis

Source: Health Resources in Action, Inc.

- ***Utilize a neutral facilitator*** who is knowledgeable about advancing health equity conversations and who can foster trust and confidence in the group process. He or she will also need to attend to meeting power dynamics between community representatives and providers. Setting a tone that encourages everyone to try and relinquish his or her organizational best interests for the greater good will need to be reinforced.

Step 2: Conduct a Community Health Assessment

Key Questions:

- What key questions do you want to answer?
- What data exists? What data is missing?
- What are the assets and needs within your community?
- What indicators and methods are you using to understand health inequities?
- Does the data address issues across the lifespan?

Data is the basis for making effective change. A health equity agenda requires a different kind of analysis of health status than is traditionally undertaken. Equity data focuses on community gaps in opportunity, conditions, and resources. It is a less siloed approach to addressing health outcomes because each SDOH has the potential for impacting multiple health conditions at once. How you gather data, which indicators you use, and who interprets the information will influence the direction of your health improvement plan.

> *"Data is among the most powerful tools available in a democracy. Armed with data, communities can cut through ideological boundaries, focus on things that matter, and engage in conversations about challenges and opportunities."*
>
> ***Paul S. Grogan, President & CEO***
> ***The Boston Foundation***

For achieving collective impact, participants need to have useful data, and examples of effective strategies, in order to engage in priority setting as well as foster a cycle of continuous quality improvement. This part of the CHI cycle is called a Community Health Assessment (CHA). It takes into account the broad set of data indicators that impact community health, safety, and wellbeing.

Participants also need to consider the most practical indicators for measuring, evaluating, monitoring, and reporting on health inequalities, as well as the community assets that can address them. The good news is that there are an increasing number of data sources and analytic tools that can improve the ability of stakeholders to identify and attend to the array of health equity related concerns at the neighborhood level.

The act of collecting and analyzing data together and developing shared measurement approaches can be transformative. Data sharing has the ability to:

- Challenge long-held assumptions
- Identify community assets
- Illustrate problems and collective solutions
- Provide community members with a voice
- Offer credibility with funders and decision-makers

Collecting Data

In analyzing information on community desires, assets, and needs through an assessment, it is important to collect both quantitative (numbers) *and* qualitative (stories) data. Many of your partners are probably already collecting various types of community data as part of their own strategic planning processes or funding requirements. Below is a chart of organizations that are likely collecting community assessment data. (Table 1) They would be good candidates to invite to your CHI planning meetings.

Table 1: Opportunities for Alignment – Organizations Conducting Community Health Improvement Efforts

ENTITY	NUMBERS	DESCRIPTION
Public Health Departments	2,800	State and local government health departments often conduct CHAs and CHIPs as part of their missions. They are required to be updated every five years, if nationally accredited.
Tax-Exempt Hospitals	2,900	IRS regulations stipulate that non-profit hospitals conduct CHNAs and Strategic Implementation Plans every three years and post them for public review.
Federally Qualified Community Health Centers (FQHC)	1,000	FQHCs engage in planning for federal Health Resources and Services Administration (HRSA) designation and must address community and patient health. This includes examination of medical, dental, and mental health services as well as specific health outcomes.
Community Action Agencies	1,100	Private and public anti-poverty agencies are required to perform a needs assessment every three years and develop a community strategic plan every five years to be eligible for Community Development Block Grant (CDBG) funds.
Community Development Finance Institutions (CDFI)	800	The Federal Deposit Insurance Corporation (FDIC) evaluates certified CDFIs. Regulations allow these financial institutions to develop a three-year strategic plan, with community input and data, as a pathway for their evaluation. It must be available for public comment. Evaluation criteria includes the extent of community development lending.
United Way Affiliates	1,300	Most United Way affiliates are guided by local community assessment and strategic plans, with focus areas and giving that address education, income, and health.
Public Housing Agencies (PHA)	3,330	PHAs have to develop five-year plans. Larger PHAs have to update them annually. New regulations will likely require the collection of housing and neighborhood data useful for promoting healthier communities, such as on neighborhood segregation, income, and affordable housing.
Area Agencies on Aging (AAA)	655	The Administration on Aging (AoA) awards funds for nutrition and supportive home and community-based services to the 56 State Units on Aging (SUAs), 655 Area Agencies on Aging (AAAs), 244 Tribal organizations, and two Native Hawaiian organizations. Each of the SUAs, AAAs, Tribal organizations and Hawaiian organizations are required to complete a plan every four years, compiling both qualitative (including the voice of older adults) and quantitative data for their target area and developing a plan. These data are useful for understanding the needs of older adults in a community and for promoting healthier communities.
Aligning needs assessments, plans, resources, and implementation strategies amongst these players can improve efficiency, effectiveness, and impact.		

Source: Health Resources in Action, Inc., adapted from Kevin Barnett, Public Health Institute

Quantitative Data: The utility of national and statewide data is quite limited when attempting to characterize neighborhood conditions – unless they are used for comparison purposes. County-level data is better, but still has limitations since it coalesces information about many neighborhoods with varying socioeconomic status, risk factors, and health outcomes. Sub-county-level information, therefore, such as U.S. Census tract-level data, which typically consists of local areas of about 4,000 people, is more useful for identifying concentrations of unmet need. Unfortunately, the more granular the data, the more difficult to find.

Hospital discharge data and "211" lines can be rich sources of information at the neighborhood level that are typically untapped. Agreeing to "oversample" vulnerable neighborhoods via public health surveys such as the Behavioral Risk Factor Surveillance Survey (BRFSS) can improve the statistical validity of data from specific neighborhoods.

Non-health sector CHI participants may be collecting survey or other useful data, as well. However, sometimes participants may feel proprietary about their data. Engaging in an exercise at an assessment meeting that encourages everyone to share the types of data they are collecting and identifying opportunities for alignment and critical gaps can help foster a willingness to work together, share results, and participate in future data collection. All of this will help to more effectively target health inequities in an ongoing manner.

Rural communities have particular advantages and challenges in this regard. While small rural hospitals and underfunded health departments generally lack the capacity or statistical power to collect place-based data, leaders in these communities tend to have an accurate pulse on the life circumstances of residents and places in most need within their towns.

Qualitative Data: Gathering information and stories from the voices of disenfranchised residents is an essential part of formulating a CHI equity agenda. It is important to engage with and hear from community members, to understand their hopes/dreams, their values, and concerns. This can be accomplished by collecting primary data through in-person key informant interviews, focus groups, and/or discussion groups arranged through local agencies, community health centers, PTAs, cultural centers, faith organizations, community-based organizations (CBO), labor organizations, etc.[14] Polls and self-reporting surveys, while expensive, can be a valuable source of information, as well. These methods are good ways to assess the important health determinant of hope – *the ability of people to influence events that influence their lives.* A validated instrument worth considering is the Experiences of Discrimination survey, for measuring the effects of discrimination on feelings of distress and high risk behaviors.[15]

Analyzing Gaps

Once you have selected your indicators, you can begin analyzing your quantitative and qualitative data to help inform the planning and implementation processes. Using a place-based lens, you can identify the most disadvantaged neighborhoods and vulnerable populations. Overlaying data using GIS maps that describe risk factors, opportunities for accessing the SDOH, as well as health outcome data will be instructive for identifying target neighborhoods. Additionally, examining neighborhood assets, systems, needs, desires, and relationships will help narrow priority populations and neighborhoods and identify the actions it will take to address the issues of social inequalities, resource allocation, and power within them.

Digging deep into the data is critical. Asking questions about what you are seeing and most importantly, *why*, and then perhaps collecting more information to answer these questions is important to understanding how to best develop effective and sustainable interventions. This is an iterative, but critical process.

"Asking the 'why' questions in a community health needs assessment is essential to identify upstream causes of health disparities in any community given its unique social and political context. Recognizing systemic barriers to health and well-being have the propensity to highlight new areas of investment and, more importantly, ways in which existing resources, programs, and policies can be tailored and coordinated for greater impact."

Onyemaechi C. Nweke, DrPH, MPH
Lead, National Partnership for Action to End Health Disparities

DATA THAT COUNTS

Table 2 illustrates five different approaches to analyzing key gaps between populations and neighborhoods. The first is a more traditional look at population health indicators such as morbidity, mortality, and risk prevalence; the others focus on community factors including pathways to opportunity for children, community wellbeing, and socioeconomic indicators. The five approaches could be combined for purposes of prioritizing vulnerable populations and places, strategies and policies for change, as well as for monitoring progress. The full list of indicators can be accessed online through the U.S. Department of Health and Human Services Key Disparities Measures, Brandeis University's diversitydatakids.org, the Prevention Institute's THRIVE tool, the National Association of County and City Health Organization's MAPP Health Equity Supplement, and U.S. Housing and Urban Development's Affirmatively Furthering Fair Housing.

Table 2: Types of Indicators to Identify Disparities

U.S. DHHS ACTION PLAN TO REDUCE RACIAL AND ETHNIC HEALTH DISPARITIES http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf	
Approach 1	Percent of infants born at low birth weight Percent of people receiving influenza vaccination in the last 12 months Percent of adults and adolescents who smoke cigarettes Percent of adults and children with healthy weight
INDICATORS IN THE CHILD OPPORTUNITY INDEX http://www.diversitydatakids.org/files/CHILDOI/DDK_KIRWAN_CHILDOI_METHODS.pdf	
Approach 2	School poverty rate (eligibility for free or reduced-price lunch) Student math and reading proficiency level Proximity to licensed early childhood education centers Retail healthy food environment index
PREVENTION INSTITUTE'S TOOL FOR HEALTH AND RESILIANCE IN VULNERABLE ENVIRONMENTS (THRIVE) http://www.preventioninstitute.org/component/jlibrary/article/id-96/127.html	
Approach 3	Clean and safe parks, recreation and open space Norms and customs Jobs and local ownership Social networks and trust
NACCHO'S MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIP (MAPP) HEALTH EQUITY SUPPLEMENT http://mappnetwork.naccho.org/page/mapp-publications	
Approach 4	Percent of children under 18 in poverty Neighborhood segregation Percent of renters Political participation by race, income, gender, and neighborhood
U.S HUD AFFIRMATIVELY FURTHERING FAIR HOUSING http://www.huduser.org/portal/affht_pt.html	
Approach 5	**Health hazards exposure index**: Distance to facilities in EPA's Toxic Release Inventory database, volume of releases, toxicity of released chemicals **Transit access index**: Distance to nearest fixed-rail or bus rapid transit station **Labor market engagement/Human capital index:** Neighborhood unemployment rate, neighborhood labor force participation, percent of population over 25 with a bachelor's degree or higher **Poverty index:** Percent of families living below poverty line and percent of households receiving public assistance

Source: Health Resources in Action, Inc., 2015

Table 3 provides other sources for obtaining health equity data.

Table 3: Other Sources for Obtaining Customized Health Equity Data

- American Opportunity Index: www.opportunityindex.org/about
- CDC Community Health Status Indicators: http://wwwn.cdc.gov/CommunityHealth/home
- Community Common Core Health Indicators: www.chna.org
- County Health Rankings: www.countyhealthrankings.org
- diversitydatakids.org Child Opportunity Map: http://www.diversitydatakids.org/data/childopportunitymap
- Environmental Public Health Tracking Network: http://ephtracking.cdc.gov/showHome.action
- EPA's Toxics Release Inventory for Communities: http://www2.epa.gov/toxics-release-inventory-tri-program/tri-for-communities
- Health indicators Warehouse: www.healthindicators.gov
- Urban Institute's Strengthening Communities with Neighborhood Data: www.urban.org/strengtheningcommunities/

Step 3: Develop a Community Health Improvement Plan

Key Questions:

- Who are you engaging to prioritize your data?
- Is health equity a key criterion for prioritizing your goals, objectives, and strategies?
- What decision-making processes are you utilizing?
- What equity issues are you addressing through the proposed strategy/approach? Who is intended to benefit? How?
- What strategies/policies support healthy choices? What strategies/policies are barriers to healthy choices?

Now that the quantitative and qualitative data have been gathered and analyzed, the planning process of priority-setting, action planning, and identifying evaluation metrics can begin. Re-engaging in conversations about what success would look like for achieving health equity and revisiting your equity-informed Vision Statement engenders mutual understanding and group buy-in, as well as ensuring the alignment of each element of the health improvement plan. (Figure 8)

Figure 8: Elements of a Health Improvement Plan

Source: Health Resources in Action, Inc.

The planning process is another opportunity to engage community stakeholders with lived experiences. Based on the findings from the assessment, Leadership Team members and community stakeholders can utilize criteria (Figure 9) to identify priorities, develop data-driven goals, measurable objectives, actionable strategies, and metrics. Conversations often arise as to whether there should be a specific equity goal with its own objectives and strategies, or whether equity strategies should be infused within all of the goals and objectives contained in the CHIP. Our belief is that you can do both!

Figure 9: Criteria to Identify Priorities

- Equity
- Impact
- Need
- Political Will
- Readiness
- Resources

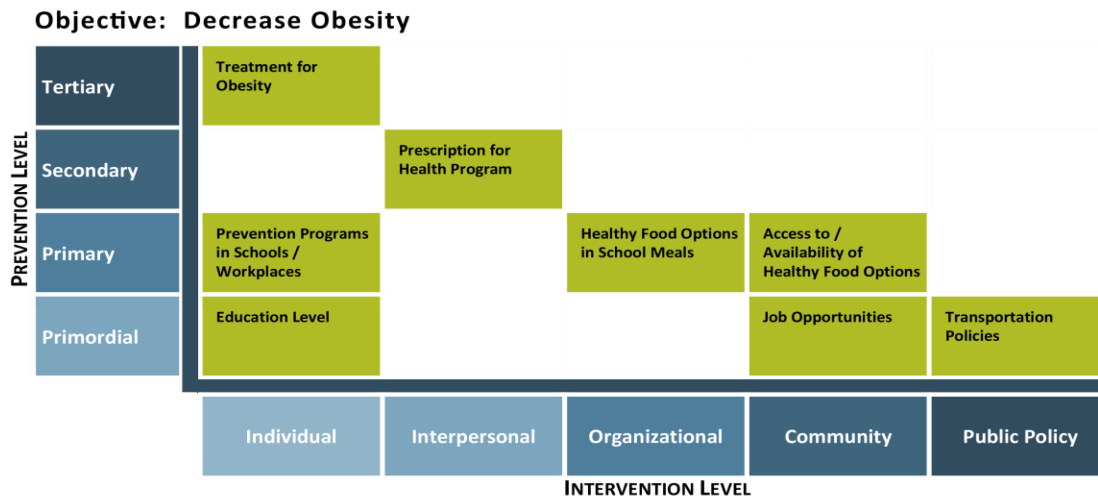
Source: Health Resources in Action, Inc.

The rubber meets the road in developing strategies, metrics, and roles for holding each other accountable. While upstream approaches will likely offer the greatest impacts and health care savings, it can take decades before health improvements will be realized. Short-term healthcare and social service interventions, aimed at closing gaps in quality and access to care are also important for creating momentum and reaping potential health care savings for later reinvestments. Health care initiatives should strive to improve on access to primary care and behavioral health, care coordination, increasing rates of community screenings and immunizations, home visiting programs, and addressing hospital quality metrics[16] such as ambulatory care sensitive conditions[17]. Preventable hospitalizations are higher for black, Hispanic, and low-income populations[18] and are a reasonable priority to work on.

Recognizing that health inequities are interconnected and complex, strategies must be addressed through multi-sector approaches. Focusing on upstream interventions by identifying *actionable* policy, systems, and environmental change strategies will be the keys to success.

A useful community asset planning exercise is to first map out all known existing organizations and strategies for tackling the SDOH in your targeted neighborhood(s), and then locating them on a chart to strategize how to move existing interventions upstream. NACCHO's Community Health Improvement Matrix (Figure 10) is a valuable tool for accomplishing this task. The matrix's prevention levels include the three traditional public health categories: *primary (reduce susceptibility or exposure to health threats); secondary (detect and treat disease in early stages); and tertiary (alleviate the effects of disease and injury)*. Additionally, NACCHO added a relatively new category: *primordial (preventing the*

Figure 10: Sample Community Health Improvement Matrix



Source: Health Resources in Action, Inc., adapted from NAACHO

emergence of predisposing social and environmental conditions that can lead to causation of disease). The two variables, prevention level and intervention level, provide a beginning point for ensuring that CHI planning efforts include the SDOH.[19]

Repeat the exercise with your newly developed CHI implementation strategies and compare their placement. Hopefully, you will observe movement toward the primordial and primary prevention levels, along with the community and public policy intervention strategies.

Equity Strategies

To address the root causes of inequities, we need to expand our notion of what is considered legitimate practice in health improvement planning. A comprehensive approach will be needed, which includes addressing the SDOH. To accomplish this, six key elements should be considered for inclusion in your health improvement plan:

- **Empowering People and Communities:** The National Prevention Strategy calls for engaging and empowering people and communities to plan and implement prevention policies and programs. Thus, building power through lifting up community organizing and advocacy initiatives is critical.
- **Community Building:** Effective strategies will build community and human capital, such as neighborhood revitalization and safety, childhood development, social engagement and support systems, transportation and shelter, education, criminal justice, and the environment.
- **Promoting Youth Development:** Providing adolescents with the skills to change their environments and opportunities to lead meaningful lives.
- **Shared Data:** Creating a data platform that is populated with local data on agreed-upon equity indicators from a variety of partners will help promote collective impact, transparency, and shared responsibility.
- **Confronting Oppression:** Everyone's health, safety, and wellbeing is affected by how fairly we organize society. Racism, sexism, homophobia, and stigma based on mental and physical disabilities must be recognized where it occurs and addressed through dialogue and social policies.
- **Changing the Public Narrative:** Achieving health equity means helping everyone understand what factors produce health and why health disparities hurt us all. Creating opportunities for authentic dialogue, communications, and messaging are necessary components of an equity agenda.

"We need to change the biased beliefs driving policies and practices that create neglected communities. These problems are not about bad people behaving badly."

Anthony Iton, MD, JD, MPH
The California Endowment

Step 4: Develop, Implement, and Evaluate Approaches

Key Questions:

- How are you engaging the community in implementation and evaluation efforts?
- Who is holding individuals/agencies accountable?
- What training, technical assistance, and funding may be needed for effective implementation?
- What institutional/community barriers may support or create barriers to achieving your equity goals?
- What metrics/outcomes have you established? Has equity been considered?

Implementation

It will be important that the health improvement plan contain an *Action Plan* that contains negotiated and articulated tactics, timeframes, partnerships, as well as assigned member roles/responsibilities, and metrics. The more precisely these are all laid out, the more transparent and the more accountable partners will be to the plan.

Be aware that there are challenges to keeping planning efforts going over the long-term: committed leaders and community members who initially participated in the CHI process often move on; ongoing financing is needed to implement your equity strategies; the external environment may change and strategies may need updating; and evaluation is necessary to monitor whether you're making a difference. For all these reasons, developing a formalized organizational structure to oversee your community building and equity strategies is advisable.

For neutrality, we suggest a dedicated entity within a backbone organization[20] or anchor institution[21] be established, and we will call it the *Community Systems Integrator* (CSI). The CSI can be part of a new organization, or with consensus from the CHI partners, it can become a sponsored initiative within an existing community-based organization. The CSI will serve as the keeper of the community building and equity pursuits contained in the CHIP's Action Plan and will work closely with the key stakeholders for coordination with other CHI efforts. The CSI will be given primary responsibility for leading, communicating, and evaluating identified elements of the Action Plan. The CSI will pursue 501(c)3 status or seek out fiscal sponsorship with a host organization so that funding and other resources can be secured. Staff will demonstrate skills such as being trustworthy and democratic conveners/facilitators, community organizing and advocacy, policy development, quality improvement, and ability to marshal resources.

Evaluation and Measurement

As Peter Drucker, management guru, famously said, "What gets measured gets done!"

Documenting reductions in health gaps, and the conditions that influence them, are important to monitor. Additionally, measuring financial returns on investment is important to policymakers, business, and health payers.

Using logic models as a basis for documenting inputs and outputs, as well as medium- and long-term health outcomes is helpful for understanding the direction of your work and holding the process, and each other, accountable. Because there is a limited set of data on neighborhood characteristics, and it is more challenging to measure changes in equity, evaluation tends to be given less prominence and is frequently relegated to an afterthought in CHI efforts. This is why it is so important to identify metrics early on in the CHI process, and then agree to standardize data collection across organizations so progress can be monitored. In the end, a key equity outcome is the extent to which power is engendered in the community so that members can ultimately decide and advocate for how resources for health are deployed. Better long-term health outcomes will likely follow.

Once your draft health improvement plan has been developed, it is advisable to take it back to a larger number of community residents for comment and feedback. Getting new ideas, and buy-in, before the plan is finalized will be critical to broader ownership and sustainability.

Using data for ongoing quality improvement is critical. Achieving health equity is a new field that will require continual learning and adjustments. Some of the interventions will consist of promising practices that have not been sufficiently studied. Tracking progress and updating logic models will be necessary components of a successful equity building process.

Step 5: Plan for Sustainability and Communication

Key Questions:

- Where will resources be sought?
- How will competition for limited resources be addressed between partners?
- What is your communication plan? Does the plan include an equity message?
- How will you communicate your findings and messages in a way that inspires change among diverse populations and policymakers?

Closing health gaps is a long-term process that will no doubt exceed the time horizon for your plan. Pursuing an equity agenda requires a collective vision, sustained effort, effective relationships, shared commitments, and political will. Thus, developing a *Sustainability Plan* is strongly advised. Refer to HRiA's website for CHI/ Health Equity Resources: www.hria.org .

Funding

There are a variety of ways to tap resources in your health ecosystem for supporting health equity initiatives. A growing number of large federal and state agencies and private foundations will only grant dollars to multisectoral partnerships. Community development financial institutions (CDFIs) are committed to providing loans and other forms of financial equity for initiatives dedicated to alleviating poverty and community disinvestments. Social investors are open to ideas that may reap financial returns. United Ways can be a source of funding for SDOH projects. Additionally, health departments and hospitals are working together to invest in community and human capital building activities.

The largest potential revenue stream within your community lies in savings to the medical care system by emphasizing prevention and quality improvement systems changes and policies.[22] Some of these health care strategies are being incentivized through payment reform and the creation of Accountable Care Organizations. Moreover, smaller hospitals are closing and converting their assets for various health activities. Making a business case to payers, providers, and business to have a proportion of these dollars reinvested in a *health savings account* or a *prevention and wellness fund* to fund your CHIP's equity goals is a worthwhile pursuit.[23] As you develop your health improvement plan, it will be important to engage health care leaders and legislative policymakers in conversations about what it would take for them to pay for addressing community health, safety, and wellbeing. Your ability to document returns on investment based on your CHIP interventions can make all the difference to your long-term viability.

Communicating and Reporting on the CHIP

Being transparent by communicating your process, methods, and results is paramount. Engage your CHI participants by requesting that they present the CHIP and your collective achievements to their respective constituents, partners, and funders.

Messaging is important, especially when communicating with legislators and other policy-makers. Have affected members of the community tell their stories. This includes priority populations, immigrants, youth workers, individuals struggling with preventable health conditions, providers, business people, labor, and academics. This context will make the data more real.

Keep in mind that reports, and their data, can be cumbersome and difficult to understand. If their purpose, though, is to help *everyone* understand the problems and get behind adopting transformative policies and practices, then the information has to be portrayed in ways that are inspiring and easily digestible. Take advantage of the visual tools available to you to help make your case. Infographics, GIS maps, charts and figures, pictures, videos, and PhotoVoice are all persuasive mechanisms for portraying data, reporting your results, and engendering collective action.

Develop a visually appealing downloadable report, with an Executive Summary, and get partners to post and link them to various websites. Create a PowerPoint presentation and/or video, in various languages, which can be presented by "community champions" at town meetings, faith communities, and other community settings. Your effectiveness in communications will be the key to whether the CHIP sits on a shelf or is actually being utilized!

Conclusion

The reasons for creating a culture of health equity go beyond mandates and regulations. As community health leaders, we have a *moral* and *ethical* obligation to direct our vast resources to eliminating the unnecessary, unfair, and expensive gaps in morbidity and mortality between peoples and neighborhoods. The health sector cannot make this happen alone. It will require multi-sector partners to move away from fragmented, piece-meal strategies and lean toward a more coordinated approach for making inclusion and opportunity part of their community's DNA.

Health Resources in Action, and many other public health institutes, are equipped and available to support your CHI efforts by making them as successful, productive, and sustainable as possible. The movement for health equity is gaining momentum; we are honored to be a part of it.

EQUITY RESOURCES

Sample free online reports, tools, maps, and resources:

- Association of State and Territorial Health Organizations (ASTHO) Equity Reports: http://www.astho.org/Programs/Health-Equity/Health-Equity-Reports-by-State-and-Territory/
- Brandeis University Heller Graduate School for Social Policy and Management's datadiversitykids.org child health and wellbeing indicators by race/ethnicity, Child Opportunity Index maps, and health policy equity analyses: www.diversitykids.org
- CDC Community Health Improvement Navigator: www.cdc.gov/CHInav
- Community Commons Community Health Needs Assessment Pages, Report Generator, and Vulnerable Populations Mapping Tool: www.chna.org
- Connecticut Association of Directors of Health Health Equity Index: www.cadh.org/health-equity/health-equity-index.html
- County Health Rankings, "What Works for Health": www.countyhealthrankings.org/roadmaps/what-works-for-health
- Democracy Collaborative - Organizing techniques for building community power and wealth: http://democracycollaborative.org
- Equity of Care - Toolkits for eliminating disparities in medical sector: http://www.equityofcare.org/
- National Association of County and City Health Organizations (NACCHO) - MAPP Equity Supplement and Community Health Improvement Index: www.naccho.org
- National Network of Public Health Institutes: www.nnphi.org
- National Partnership for Action - Toolkit for addressing health disparities: http://minorityhealth.hhs.gov/npa/files/Plans/Toolkit/NPA_Toolkit.pdf
- PolicyLink - Equitable Development Policy Toolkit, National Equity Atlas, and Getting Equity Advocacy Results (GEAR): www.policylink.org
- Prevention Institute - Tool for Health and Resilience in Vulnerable Environments (THRIVE): www.preventioninstitute.org
- StoryMaps- Free software creates spatial representations of data for nontechnical audiences: http://storymaps.arcgis.com/en/

For more information about Health Resources in Action's Community Health Improvement initiatives and tools, visit us online at www.hria.org .

References

[1] "Addressing the Social Determinants of Health through the Community Health Improvement Matrix," *NACCHO Research Brief*, Nov. 2014.

[2] Persistent stress can cause the brain to produce hormones such as cortisol and epinephrine at levels that may alter immune function or cause inflammation. Repeated or sustained exposure to these substances may produce "wear and tear" on organs and precipitate chronic diseases such as diabetes and heart disease. Woolf, S.H. and Braveman; P. "Where Health Disparities Begin: The Role of Social and Economic Determinants—And Why Current Policies May Make Matters Worse." *Health Affairs*, 30(10), 2011.

[3] AHRQ Highlights from the 2011 National Health Care Quality and Disparities Report. http://www.ahrq.gov/research/findings/nhqrdr/nhdr11/key.html accessed 12/28/14

[4] A useful document that summarizes these disparities and the unequal living and working conditions that contribute to poor health outcomes in vulnerable populations is contained in the CDC's factsheet entitled, *CDC Health Disparities and Inequalities Report*, U.S., 2013. http://www.cdc.gov/disparitiesanalytics/Docs/CHDIR13_factsheet_nov_20_2013_final_508.pdf For more detailed information, see *MMWR: CDC Health Disparities and Inequalities Report, U.S. 2013* http://www.cdc.gov/mmwr/preview/mmwrhtml/su6203a2.htm?s_cid=su6203a2_w

[5] CDC Surveillance of Health Status in Minority Communities: Racial and Ethnic Approaches to Community Health Across the U.S., (REACH U.S.) Risk Factor Survey, United States, 2009. MMWR 2011; 60 (No. SS-6)

[6] Mayer, KH; Bradford; JB; Makadon, HJ; et al.; "Sexual and Gender Minority Health: What We Know and What Needs to Be Done"; *American Journal of Public Health*; 2008:98; 989-995.

[7] Zack, M. MMWR Health Related Quality of Life, US 2006, 2010;; Division of Population Health; National Center for Chronic Disease Prevention and Health Promotion, CDC. http://www.cdc.gov/mmwr/preview/mmwrhtml/su6203a18.htm?s_cid=su6203a18_w Accessed 12/19/14.

[8] Annie E. Casey Foundation http://www.aecf.org/blog/nearly-half-of-americas-families-with-young-children-struggle-to-make-ends/. Accessed 12/28/14.

[9] National Education Association www.nea.org/home/13579.htm Accessed 1/23/05.

[10] Acevedo-Garcia, D., et al., "The Child Opportunity Index: Improving Collaboration Between Community Development And Public Health", *Health Affairs*, November 2014, 33:11 1948-1957.

[11] Galea, et al, "Estimated Deaths Attributable to Social Factors in the U.S.", *American Journal of Public Health*, August 2011, Vol 101, No. 8.

[12] Joint Center for Political and Economic Studies. "The Economic Burden of Health Inequalities in the United States." 2009. Washington, DC. http://www.jointcenter.org/research/the-economic-burden-of-health-inequalities-in-the-united-states."

[13] Schoeni, RF; Dow, WH; Miller, WD; and Pamuk, ER. "The Economic Value of Improving the Health of Disadvantaged Americans." *American Journal of Preventive Medicine*. 2011; 40 (1 Suppl 1): S67–72.

[14] A useful resource for developing qualitative questions is *NACCHO's* "MAPP Health Equity Supplement." www.naccho.org

[15] Krieger N, et al. "Experiences of Discrimination: Validity and Reliability of a Self-Report Measure for Population Health Research on Racism and Health." *Social Science Medicine,* 2005 Oct; 61(7): 1576-96.

[16] Dartmouth Atlas of Healthcare can benchmark hospital quality indicators by hospital service area or communities. www.dartmouthatlas.org

[17] AHRQ quality measure defined as age-standardized acute care hospitalization rate for conditions where appropriate outpatient care prevents or reduces the need for admission to the hospital for younger than age 75 years.

[18] *CDC Health Disparities and Inequalities Report*, U.S 2013, MMWR Supplement, Nov 2013. http://go.usa.gov/Wp5C

[19] "Addressing the Social Determinants of Health through the Community Health Improvement Matrix," *NACCHO Research Brief*, November 2014.

[20] Backbone Support Organization: Creating and managing collective impact requires a separate organization and staff with a specific set of skills to serve as the backbone for a broad and comprehensive initiative. In Kania, J. and Kramer, M., "Collective impact," *Stanford Social Innovation Review*, Winter 2011, p.40.

[21] Anchor Institutions are place-based entities such as universities and hospitals that are tied to their surroundings by mission, invested capital, or relationships to customers, employees, and vendors. In *The Democracy Collaborative*, "The Anchor Dashboard: Aligning Institutional Practice to Meet Low-Income Community Needs," University of Maryland, August 2013.

[22] Institutes of Medicine. "The Healthcare Imperative: Lowering Costs and Improving Outcomes." Washington DC: National Academies Press, 2009.

[23] *JAMA* Forum. "Using Community Health Trusts to Address the Social Determinants of Health." April 2014

"Health equity is a common topic of discussion at health improvement tables, but a difficult one to integrate and measure. ***Embracing Equity in Community Health Improvement*** *is an excellent resource for health professionals and community laypersons alike who want to make a difference in their community's health. This comprehensive resource provides an integrated, easy to read presentation that assists communities to use health equity as a frame in their health planning process. It is logical and sequential in its five-step approach and helps the reader understand where to start what can otherwise be a very daunting task.*

Thank you, HRiA, for yet another powerful tool that communities can use to guide them in their efforts to improve community health."

Pilar Oates, Board Member
The Health Collaborative of Bexar County
San Antonio, Texas

Acknowledgements:

Special thanks to our expert reviewers:

David Aronstein – Boston Alliance for Community Health

Erin Hardy – Brandeis University, Diversity Data Kids Project

Stephen Blanchard – The Health Collaborative of Bexar County
Pilar Oates – The Health Collaborative of Bexar County

Harriet G. Tolpin – Chair, HRiA Board of Directors

Leslie Aldrich – Massachusetts General Hospital, Center for Community Health Improvement

Kelly Hughes – National Network of Public Health Institutes
Vincent Lafronza – National Network of Public Health Institutes
Jennifer McKeever – National Network of Public Health Institutes

Onyemaechi C. Nweke – National Partnership for Action to End Health Disparities

Ruth Palombo – Tufts Health Plan Foundation

Health Resources in Action (HRiA) is a nonprofit public health organization dedicated to promoting individual and community health through prevention, health promotion, policy, and support of medical research. HRiA is the parent organization of the Medical Foundation division for medical research grants programs and philanthropic advisory services.

Our Vision:

A world where social conditions and equitable resources foster healthy people in healthy communities.

Our Mission:

To help people live healthier lives and create healthy communities through prevention, health promotion, policy, and research.

Our Values:

- Commitment to social justice in our work
- Excellence and innovation in our approach
- Leadership where there is need
- Collaboration where there are opportunities
- Passion and thoughtfulness in our endeavors
- Diversity in our organizational practices
- Responsive, respectful, and flexible with our clients

Health Resources in Action
Advancing Public Health and Medical Research

www.hria.org