

Health Equity Guide for Public Health Practitioners and Partners



June 2015

**Prepared for the Delaware Division
of Public Health**



DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health



School of Public Policy
& Administration



AUTHORS

Erin K. Knight, PhD, MPH
Health Policy Fellow
Center for Community Research and Service
School of Public Policy and Administration
University of Delaware
298E Graham Hall
Newark, DE 19716
302-831-3264
Email: eknight@udel.edu

Gabrielle Ransford, Public Health Associate
Community Health
Delaware Division of Public Health
417 Federal Street
Dover, DE 19901

Paige Gugerty, Undergraduate Public Policy Fellow
Center for Community Research and Service
School of Public Policy and Administration
University of Delaware

Erin Dugan, Undergraduate Research Assistant
Center for Community Research and Service
School of Public Policy and Administration
University of Delaware

Cassandra Codes-Johnson, MPA*
Director of Community Health
Delaware Division of Public Health
Jesse Cooper Building
417 Federal Street
Dover, DE 19901
Phone: 302-744-4741
Fax: 302-739-3313
Email: cassandra.codes-johnson@state.de.us
*Corresponding author

ACKNOWLEDGEMENTS

We thank members of the following agencies and organizations for their time and dedication to the success of the *Health Equity Guide for Public Health Practitioners and Partners*. Your thoughtful input and strategic direction transformed our ideas into a meaningful product that will make lasting change toward health equity.

Christiana Care Health System, Learning Institute

Christiana Care Health System, Pastoral Services

Christiana Care Health System, Department of Family and Community Medicine

Christiana Care Health System, Cultural Competence and Language Services

Delaware Division of Public Health, Data and Informatics

Delaware Division of Public Health, Office of Health Equity

Delaware Division of Public Health, Office of Health Risk Communication

Delaware Greenways

Medical Society of Delaware

National Association of County and City Health Officials (NACCHO)

Nemours Children's Health System

University of Delaware, Center for Community Research and Service (CCRS)

University of Delaware, Institute for Public Administration (IPA)

TABLE OF CONTENTS

FOREWORD by Karyl T. Rattay, MD, MS.....	7
SECTION 1: Introduction.....	9
Purpose.....	11
References and Additional Resources.....	13
SECTION 2: Background.....	14
Health Profile of the United States.....	14
Health Differences.....	16
Health Equity Framework.....	21
Social Determinants of Health (SDOH).....	22
Social Determinants of Health Equity (SDOHE).....	24
National Efforts to Advance Health Equity.....	26
Healthy People 2020.....	26
National Stakeholder Strategy for Achieving Health Equity (NSS).....	30
Source.....	32
The HHS Action Plan to Reduce Racial and Ethnic Health Disparities.....	32
Delaware Division of Public Health’s Health Equity Strategy.....	32
Underlying Values and Assumptions.....	35
Glossary – Section 2.....	38
References and Additional Resources.....	38
SECTION 3: The Case for Change.....	41
The Delaware Context.....	42
Social Determinants of Health in Delaware.....	42
Inequities in Health Status in Delaware.....	45
The Economic Case for Change.....	54
Health care Spending in Delaware.....	55
Health System Reform and Incentives for Investing in Community Health.....	57
Health System Reform in Delaware.....	59
Addressing the Health Equity Continuum.....	61
Glossary – Section 3.....	64
References and Additional Resources.....	65

SECTION 4: Upstream Strategies for Community Health	68
Place-Based Initiatives (PBIs).....	71
Dimensions of PBIs for Health Equity	72
Implementing PBIs for Health Equity	80
Recommendations and Lessons Learned	83
Glossary – Section 4.....	94
References and Additional Resources.....	95
SECTION 5: Upstream Strategies for Health Care Providers	97
Addressing the Social Needs of Patients	97
Screening Tools.....	98
Community Health Workers.....	98
Medical-Legal Partnerships	101
Health Leads	102
Care Coordination	103
Health System Integration.....	103
Medical Homes.....	106
Improving Quality and Access to Culturally Competent Care	108
Conclusion	111
Glossary – Section 5.....	113
References and Additional Resources.....	114
SECTION 6: Policy-Oriented Strategies	117
Health in All Policies	118
Identifying Root Causes	119
Fostering Partnerships.....	120
Engaging Community Stakeholders.....	122
HiAP in Practice	122
Economic Policies	122
Housing Policies.....	123
Transportation Policies.....	123
Food and Nutrition Policies	124
Partnering to Achieve HiAP	125

Health Impact Assessment—A Tool for HiAP	128
Fundamental aspects of HIA.....	129
HIA and Health Equity.....	130
HIA in Delaware	133
Recommendations and Toolkits for HIA.....	134
Communicating for Healthy Public Policy	135
Glossary – Section 6.....	138
References and Additional Resources	138
SECTION 7: Data, Research, and Evaluation for Health Equity.....	141
Data to Identify and Understand Health Inequities	141
Innovative Types of Data	142
Strengthening Existing Data Capacity.....	145
Selected Data Tools for Health Equity: GIS, HIA, CHA	147
Limitations of Data Collection and Analysis for Health Equity	148
Principles for Successful Use of Data for Health Equity	150
Evaluation for Health Equity.....	153
Evaluating Complex Community Initiatives.....	158
Evaluation Challenges.....	159
Research Priorities to Advance Health Equity.....	161
Glossary – Section 7.....	164
References and Additional Resources	165
SECTION 8: Leadership for Health Equity	167
Public Health Practitioners and Organizations as Leaders	169
Other Kinds of Organizations as Leaders.....	171
Individuals as Leaders.....	172
Conclusion	176
Glossary – Section 8.....	178
References and Additional Resources	178

FOREWORD by Karyl T. Rattay, MD, MS

When I started as Director of the Delaware Division of Public Health (DPH) in 2009, I identified several priorities for the Division. Among those priorities was, and still is, achieving health equity in Delaware. Over the course of the past several years, my staff has worked with many community leaders, non-profit organizations, other state agencies and stakeholders to develop a strategy to reach our vision of *health equity for all Delawareans where everyone will achieve their full health potential*. I am pleased to present this guide as a resource to support that strategy, which can be summarized as moving upstream to improve the conditions that create health and inequities in health.

Our mission at the Division of Public Health is to protect and promote the health of all people in Delaware. I believe we are making progress and we can see our population health statistics improving in many areas. Yet even as our overall health improves, we have persistent health inequities in our state. In some cases, the gaps we see in health between different population groups or communities are getting worse, not better. Persistent and growing inequities may be partially blamed on the current economic environment, and are certainly not unique to Delaware. However, it is time for a more concerted upstream effort to address those inequities. On the following pages you will read about the evidence that supports this perspective, particularly the need to focus more of our attention and resources on underlying social conditions in our communities. Research has made it increasingly clear that efforts to address the social and environmental determinants of health— the conditions in which we live, work, and play—are critical to improving health and achieving health equity.

But while there is a practical imperative for change that is difficult to ignore, there is also a moral imperative. It is simply not acceptable that Black infants in Delaware die at a rate that is more than twice that of White infants. It is unacceptable that we can predict how long someone will live based upon their ZIP code or income level. These are not naturally occurring or random phenomena related to individual weaknesses. Rather, they are systemic, structural, and predictable. At the same time they are not insurmountable. In fact, many efforts to improve social conditions are making a difference in the health of communities across the country. Many important initiatives are already making a difference in our state, and I am grateful for the efforts of my staff and our community partners for the work they are doing.

I acknowledge that the concepts outlined in this guide represent a new way of doing business for DPH (and many of our partners). Change is not always easy. However, I ask

that we keep an open mind and consider that we will not be able to make substantial changes to difficult problems unless we are willing to make fundamental shifts. I also ask that we realize that these changes are not those of a single person or group or section to make, but for our entire Division, partners in other state agencies, community-based organizations, and residents. We know we cannot achieve health equity alone and we know it will not happen overnight.

As you will read, many of the factors that influence health are grounded in historical inequities, often beyond the reach of traditional public health efforts and beyond the reach of state government. Health inequities result from a complex web of factors that span multiple sectors and disciplines. We all have a role to play, and this guide is meant to be a resource to promote and support a sustained, coordinated approach for moving upstream. It was originally developed for public health practitioners and community partners, but I believe it may be used by many different groups working in various ways to fulfill our common vision. Many individuals working outside of the health sector may not even realize the impact their work has on health and health equity. I hope this guide helps them to better understand their role in promoting health and health equity. By raising awareness of the social determinants of health and sharing strategies and lessons learned for promoting healthier living and working conditions, we can mobilize our collective capacity to foster optimal health for all Delawareans.

I look forward to working with you.

Karyl T. Rattay, MD, MS



SECTION 1: Introduction

Imagine a roaring river in the mountains. You and a friend are observing the peaceful scene when a person appears in the middle of the rapids calling for help. You have to save him!

You jump into the river and pull him safely to the bank. Not long after, a few more people appear in the water calling for help. Then a whole crowd is in the rapids, calling desperately for help. They are going to drown if you and your friend do not save them.

Your intuition tells you to run upstream and see why so many people are falling into the river. Your friend, frustrated, confused, and concerned about the people that urgently need to be saved, can't seem to understand why you would do such a thing. But you know that you cannot keep up with the throngs of near-drowning people.

When you reach the top of the rapids, you clearly see why so many people are falling in. There is an old, decrepit bridge that people are trying to cross, not realizing that it is unsafe. They will continue to fall in by the dozens and drown downstream if you do not fix the bridge or put up a fence to prevent them from trying to cross.

The stream parable, which is frequently recited in relation to prevention, illustrates a major contributor to the current health crisis in our country. For too long, too much attention and effort has focused downstream, leading to excessive health care spending and relatively poor health outcomes. Since public health is traditionally a field grounded in prevention, public health professionals generally appreciate the need for moving upstream to improve the public's health, even as they encounter barriers and resistance to upstream health interventions. Public health professionals promote healthy behaviors; ensure

access to prenatal care; advocate for clean air; and ensure safe water and food, among many other upstream preventive health strategies. In a sense, they build fences and mend bridges. However, there is more to the story...

● ● ●

As you look farther upstream, you notice bridges in various states of repair along the river. Some are strong, made of sturdy components. Others are weak and debilitated, with missing boards or flimsy railings. It doesn't surprise you that most of the people falling in the river are crossing the poorly made bridges, while those individuals that live near or travel across the strong bridges are protected. Of course, all of the bridges could use more reinforcement, but it's easy to see which bridges need the most attention.

● ● ●

The health profile of the United States reflects persistent inequities in health. It is becoming increasingly evident that we must look *farther* upstream to identify and address the underlying conditions that create such inequities if we expect meaningful changes in health outcomes. These underlying conditions are often referred to as *social determinants of health*, and include things like education, early childhood conditions, income, housing and neighborhood conditions, and workplace characteristics (Marmot & Wilkinson, 2005). The conditions in which we live and work are the primary determinants of health; investments in these areas will help to improve health outcomes for everyone (Marmot & Wilkinson, 2005). Importantly, however, differences in these underlying conditions are the root causes of inequities in health (Graham, 2004).

In the stream parable, certain groups of people are more likely to fall into the river than others. They do not fall in because of individual weakness or intrinsic flaws. Rather, some people are privileged to live in communities with strong bridges, usually made of high quality materials that protect them from falling into the river and promote their safe passage across. Members of other groups, often characterized by gender, race, socioeconomic status, sexual orientation, gender identity, age, or disability status, are

more likely to live in communities with poorer quality bridges. So while we need to move upstream to prevent people from falling in, instead of directing the majority of our efforts to pulling people out, we also need to ensure that *all* of our communities have strong bridges.

Purpose

The purpose of this guide is to provide a resource to assist the Delaware Division of Public Health (DPH) and its partners in moving farther upstream to address the underlying causes of health inequities in Delaware’s communities. By raising awareness of the social determinants of health and sharing strategies and lessons learned, the goal is to enhance our collective capacity to foster optimal health for all Delawareans.

Specifically, this guide was created to support DPH in the implementation of its health equity strategy. The guide’s development was influenced by several national efforts to promote population health and achieve equity in health, including the U.S. Department of Health and Human Services’ (DHHS) *Action Plan to Reduce Racial and Ethnic Health Disparities*, the National Partnership for Action’s *National Stakeholder Strategy for Achieving Health Equity* (<http://minorityhealth.hhs.gov/npa/>) and *Healthy People 2020* (<http://www.healthypeople.gov/2020/default.aspx>). The guide is also aligned with the Patient Protection and Affordable Care Act and related efforts to transform the health care system in Delaware (<http://dhss.delaware.gov/dhss/dhcc/cmami/>).

While informed by scholarly literature, this guide relies heavily on technical reports, websites, and other practical tools and resources. Much of the material provided in the guide is publicly available and/or reproduced with permission. References and web links for additional information are provided as appropriate.

It is important to note that efforts to achieve health equity through community change and improvements in social determinants are emergent in the scholarly literature. Terms like “best practices” and “evidence-based practices” are difficult to interpret and apply when working with communities. This is because community-based and community-oriented work is, by definition, unique to each community. Public health practice must embrace the preferences of the targeted population or community in addition to taking into account the needs, assets, and resources of that community.

Figure 1 is a model of evidence-based practice developed by Satterfield and colleagues (2009). It illustrates the complexity of research translation in public health practice by putting decision-making at the intersection of research, community characteristics, and available resources. This model is particularly relevant to efforts to promote health equity, given the heightened attention to community empowerment

and social context in a health equity approach, which is described in greater detail later in this guide. Because of the complexity involved in making informed decisions to achieve health equity, this guide is a compilation of promising approaches, informed by the literature, that are meant to be adapted for community needs, assets, preferences, and available resources. It reflects the dynamic nature of the social and environmental context that can vary by place and by time.

Figure 1. Domains that influence evidence-based decision making in publichealth



Source: Satterfield JM, et al., 2009. Retrieved from http://www.cdc.gov/pcd/issues/2012/11_0324.htm.

The contents of this guide are based on priority professional development needs that were identified when DPH developed its health equity strategy. Although the guide is not comprehensive, it provides a foundational understanding of important concepts related to health equity. It also includes links to supplemental resources and tools where appropriate. Each section includes a glossary of terms, which serves to promote a common language. Feedback on the guide, including updates or areas needing greater attention or detail, should be addressed to:

Delaware Division of Public Health
Office of Health Equity
417 Federal St.
Dover, DE 19901
<http://www.dhss.delaware.gov/dhss/dph/mh/healthequity.html>

References and Additional Resources

Graham, H. Social determinants and their unequal distribution: Clarifying policy understandings. *The Milbank Quarterly*, 2004, 82(1), 101-124.

Jacobs, J.A., Jones, E., Gabella, B.A., Spring, B. & Brownson, R.C. (2012). Tools for implementing an evidence-based approach in public health practice. *Prev Chronic Dis*, 9, 110324. Retrieved from http://www.cdc.gov/pcd/issues/2012/11_0324.htm

Marmot, M. & Wilkinson, R. (Eds.). (2005). *Social Determinants of Health* (2nd ed.). Oxford: Oxford University Press.

Satterfield JM, Spring B, Brownson RC, Mullen EJ, Newhouse RP, Walker BB, et al. Toward a transdisciplinary model of evidence-based practice. *Milbank Q* 2009, 87(2), 368-90.

SECTION 2: Background

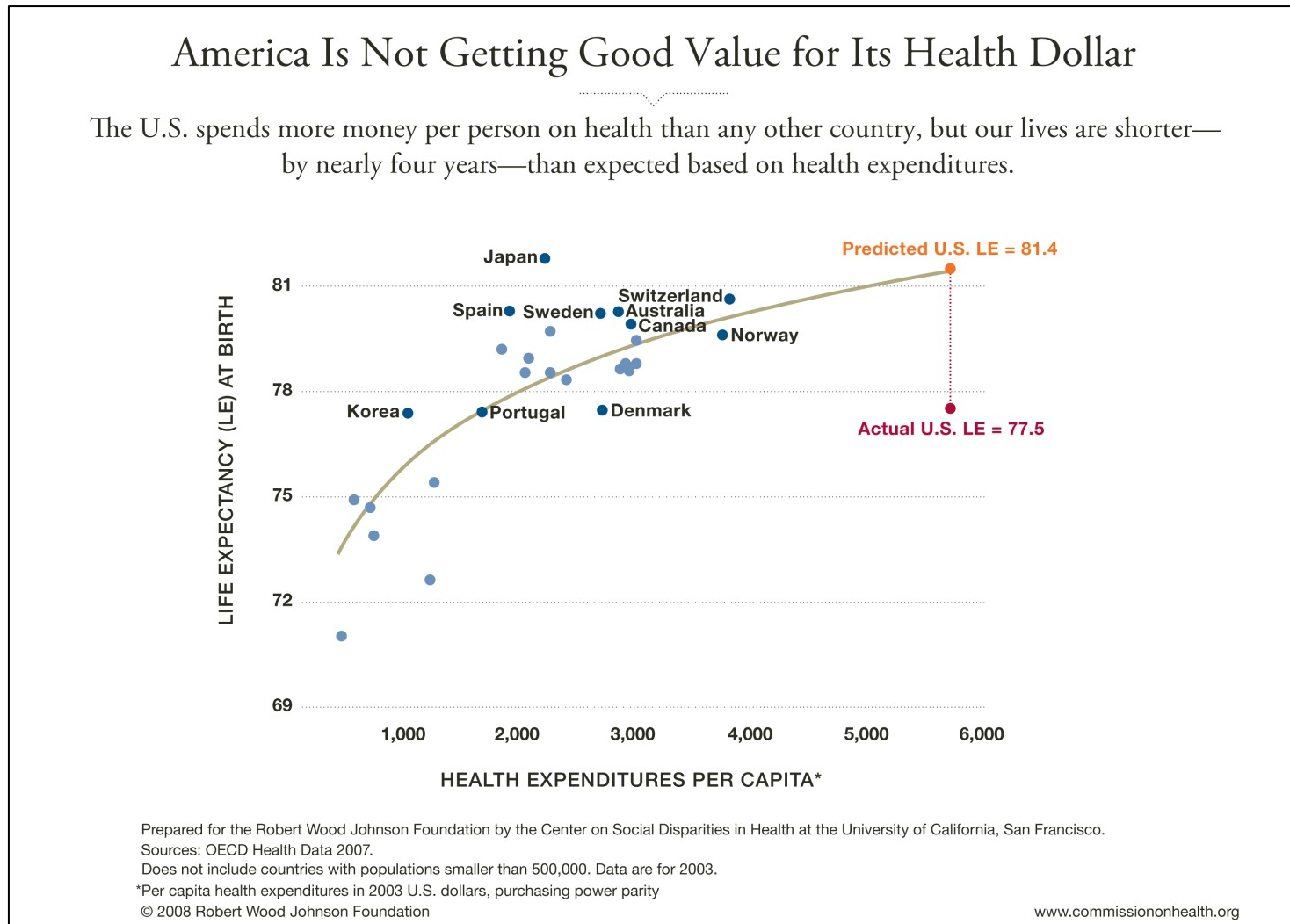
This section provides information regarding the population health profile of the United States, including statistics that highlight the various types of health inequities (and their magnitude) seen across the country. It defines key terms and summarizes select national efforts to advance health equity through a “social determinants of health” lens. Included is a brief summary of DPH’s efforts underway over the past three years – efforts that created the need and opportunity for this document. It concludes with a set of suggested principles and values to guide our future work in Delaware.

Health Profile of the United States

The average life expectancy in the United States has increased substantially over the past century to an estimated 79.6 years in 2014 (Central Intelligence Agency, 2013). However, this places the U.S. 42nd in the world, despite being one of the wealthiest developed countries (Central Intelligence Agency, 2013).

The U.S. also ranks near the bottom among wealthy developed countries (and some developing countries) in infant mortality, which is another indicator frequently used to describe the overall health of a population. The U.S. ranks 169th in the world, with an infant mortality rate of approximately six per 1,000, which equates to approximately 25,000 infant deaths per year (Central Intelligence Agency, 2013). Of particular concern is that these indicators are moving in the wrong direction, with the U.S. falling in the rankings in recent years. It is also clear that the U.S. is not receiving a good return on its investment in terms of health care expenditures, as seen in Figure 2, reproduced courtesy of the Robert Wood Johnson Commission to Build a Healthier America (RWJF, 2008). The graph indicates that in 2003 the projected life expectancy in the U.S. based on the amount of money spent on health care should be 81.4 years; however, the actual life expectancy was substantially lower at 77.5 years.

Figure 2. Life expectancy at birth by per capita health expenditures in 2003



Source: Robert Wood Johnson Commission to Build a Healthier America (RWJF, 2008).

Healthy People 2020, the national strategic plan for improving the health of all Americans, provides a comprehensive set of 10-year goals and objectives with targets for health improvement (see www.healthypeople.gov). A progress report produced by the U.S. Department of Health and Human Services in March of 2014 shows progress on many indicators. For instance, fewer adults are smoking cigarettes and fewer children are being exposed to secondhand smoke. Similarly, the percent of children receiving recommended vaccines increased and adolescent alcohol and drug use is down slightly. Yet the overall suicide rate increased and the percent of adolescents with major depressive episodes rose. Other indicators show mixed results (U.S. DHHS, 2014).

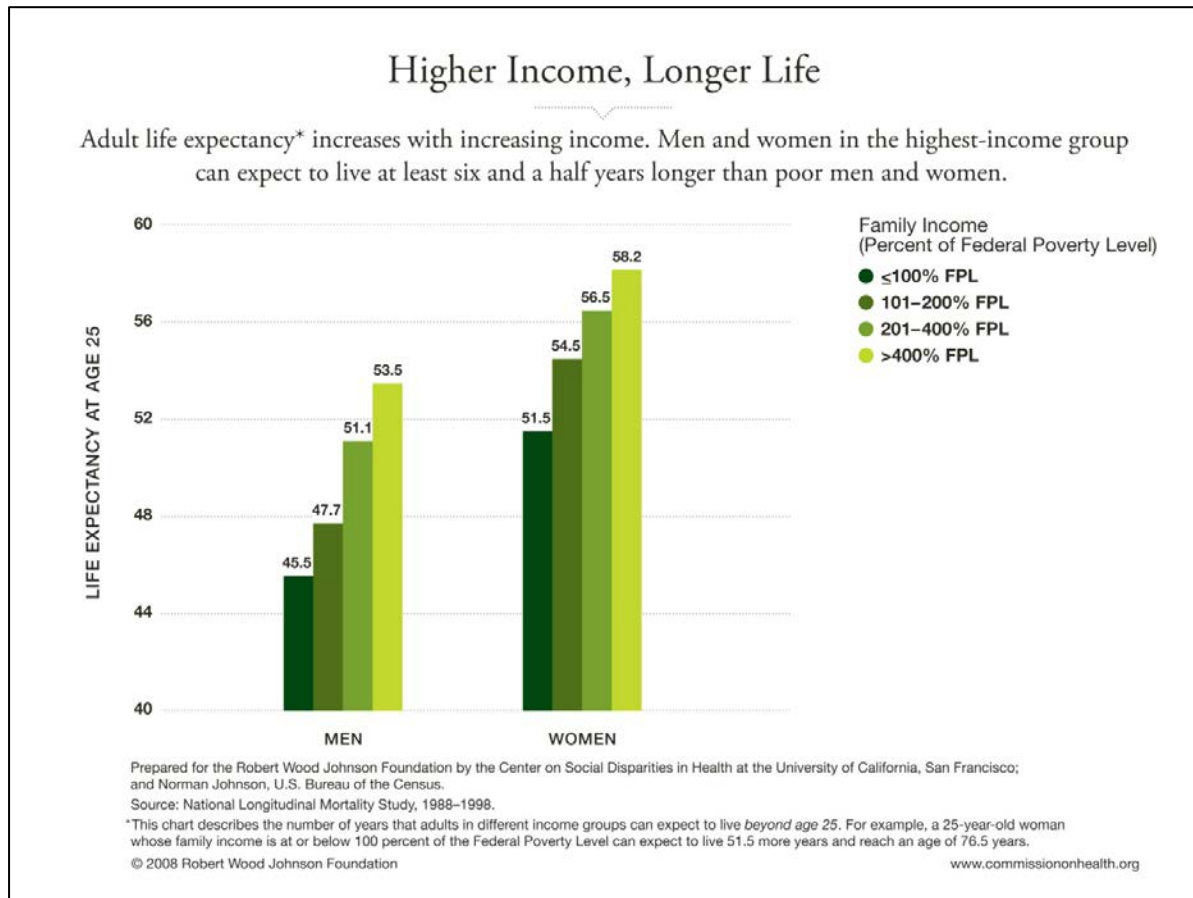
Health Differences

Differences in health among different groups of people, often referred to as health disparities, are well documented, persistent, and increasing in many areas across the United States. These differences in health among groups may be viewed in the context of race, gender, income, education level, or geographic location, among others. Examples of such differences are highlighted below:

- ❖ Infant mortality rates by race/ethnicity are highest for non-Hispanic Black¹ women (12.7), with a rate 2.4 times that for non-Hispanic White women (5.5) and 2.8 times that for Asian or Pacific Islander women (4.5) (Mathews & MacDorman, 2012).
- ❖ Poor Americans live, on average, 6 ½ years less than wealthy Americans (Figure 3; RWJF, 2008).

¹The authors of this guide are sensitive to the use of labels to describe people. However, when making comparisons it is useful to categorize individuals (e.g. by race or ethnicity, sexual orientation, income, etc.). According to the American Psychological Association, both the terms "Black" and "African American" are widely accepted. For consistency, we use the term "Black" (except where citing a source that uses a different term).

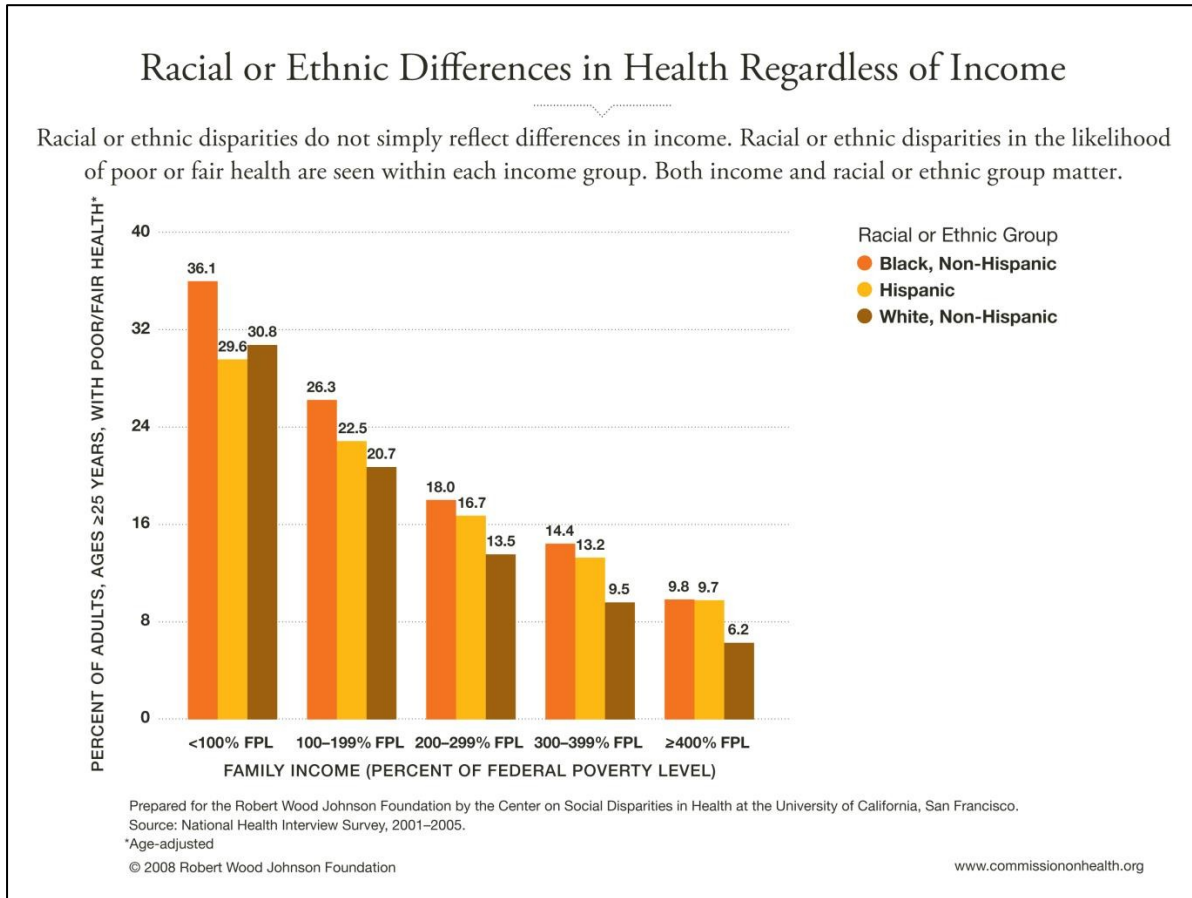
Figure 3. Life expectancy at age 25 years by family come level



Source: Robert Wood Johnson Foundation Commission to Build a Healthier America, 2008.

- ❖ Life expectancy can differ dramatically by neighborhood. There is as much as a nine-year difference across the Washington, D.C. metro area and as much as a 6 ½ year difference across the greater Philadelphia area (RWJF, 2008).
- ❖ Rates of preventable hospitalizations increase as income decreases, and Blacks experience preventable hospitalizations at a rate that is more than double that of Whites (CDC, 2011).
- ❖ Men are two to three times more likely to die in a motor vehicle crash than are women (CDC, 2011).
- ❖ Asthma is more prevalent among women than men (CDC, 2011).
- ❖ Although race/ethnicity and income are often interrelated, racial or ethnic differences in health exist independent of income level (Figure 4; RWJF, 2008).

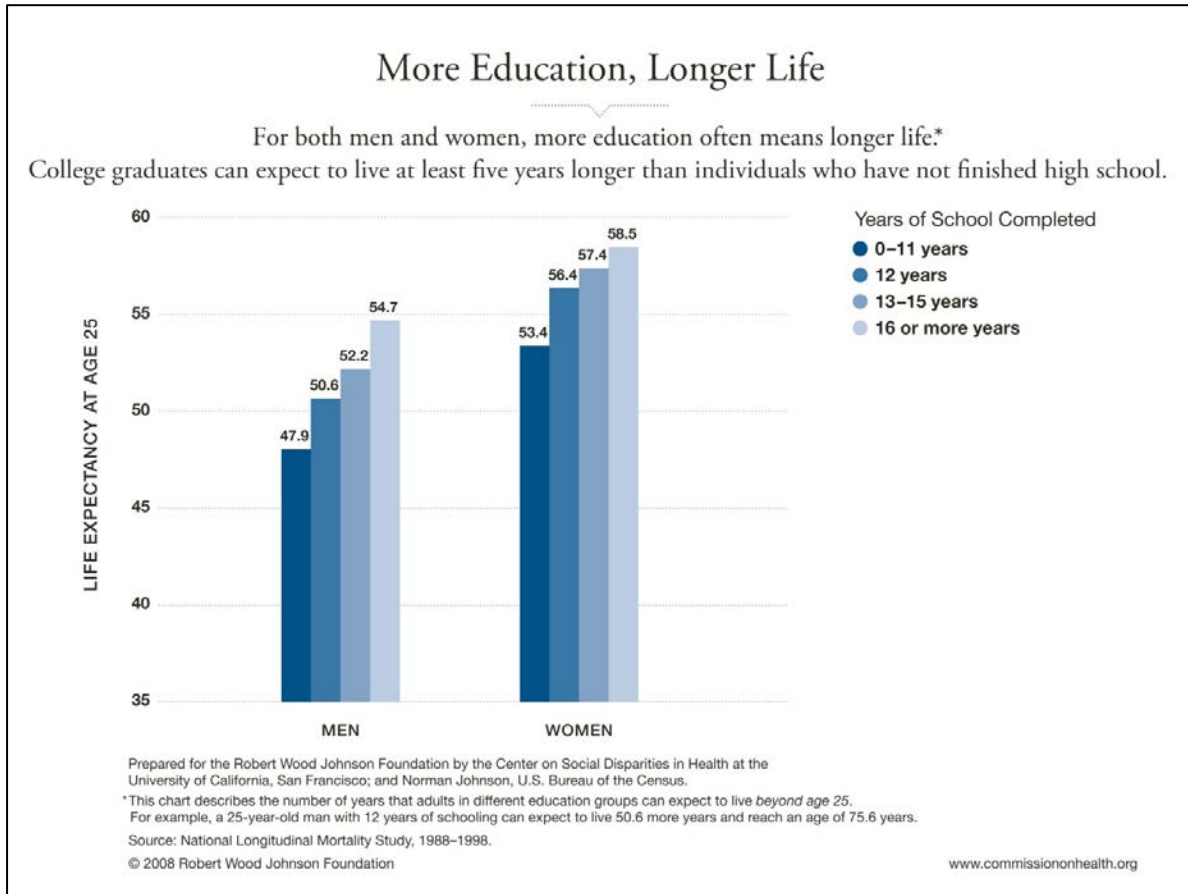
Figure 4. Percent of adults in poor or fair health according to race/ethnicity and income



Source: Robert Wood Johnson Foundation Commission to Build a Healthier America, 2008.

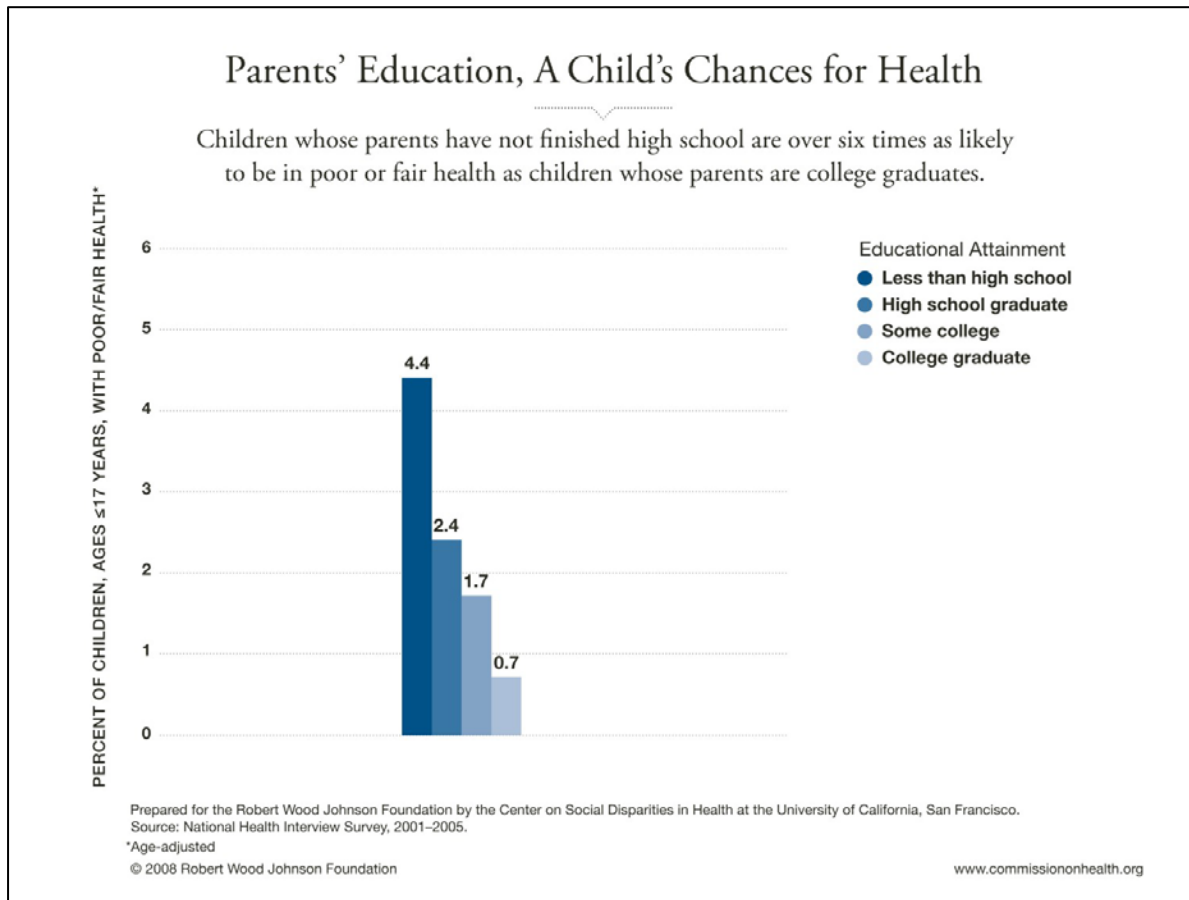
- ❖ Compared with college graduates, adults who have not finished high school are more than four times as likely to be in poor or fair health. The relation between education and health persists through generations, and children whose parents have not finished high school are over six times as likely to be in poor or fair health as children whose parents are college graduates (Figures 5 and 6; RWJF, 2008).

Figure 5. Life expectancy at age 25 years according to education level



Source: Robert Wood Johnson Foundation Commission to Build a Healthier America, 2008.

Figure 6. Percent of children in poor or fair health according to parents' education level



Source: Robert Wood Johnson Foundation Commission to Build a Healthier America, 2008.

Differences in health also exist according to disability status and sexual orientation, though better data collection is needed to understand these gaps. Trends in Delaware generally reflect those of the U.S. and are discussed in greater detail in the next section.

Clarifying Terms: Health Disparities, Inequalities, and Inequities

We hear these terms often within community health; sometimes used interchangeably and sometimes with implied differences in meaning. Until recently in the United States, the phrase *health disparity* was commonly used to denote a difference between two or more groups, leaving the causes and nature of the difference open to interpretation. The phrase has generally been used in relation to differences in health between racial and ethnic groups, implying some sort of social disadvantage. This is in contrast to differences in the rate of breast cancer between men and women, for instance, which has not generally been referred to as a *disparity*.

The phrase *health inequalities* has sometimes been used interchangeably with health disparities, most frequently in the scientific and economic literature or in reference to socioeconomic differences among broadly defined groups. Internationally, differences in health between those in distinct positions on the social hierarchy have been more frequently referred to as *inequities*. *Health inequities* are often defined as “differences in health which are not only unnecessary and avoidable but, in addition, are considered unfair and unjust” (Whitehead, 1992). The World Health Organization further notes that health *inequities* are “health differences which are socially produced.”

There is a great deal of attention in the literature and among advocates about the appropriate use of these terms that is only touched upon above. While we appreciate the significance of this discussion and the importance of language and meaning, we also recognize that different terms may be used in practice depending on the audience and purpose (e.g. policy makers may be most familiar with *disparities*). However, for the sake of clarity and because of the need to draw attention to issues of fairness and justice, this guide will henceforth use the term *inequity* to refer to socially produced health differences (except where citing a source that uses a different term).

Health Equity Framework

Although the terms “disparity,” “inequality,” or “inequity” may be used somewhat interchangeably (see text box), a shift to a health equity framework is particularly meaningful and an important foundation of this guide. *Healthy People 2020* defines health equity as “attainment of the highest level of health for all people.” Additionally, according to *Healthy People 2020*, 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.”

This shift is more than semantics and is distinguished from a disparities-driven approach in several important ways. First, an equity framework draws attention to the concepts of fairness and justice in the distribution of resources. Furthermore, it highlights the idea that social inequities in health are avoidable through collective action and that inaction is unacceptable. In addition, a health equity framework provides a positive vision to work towards—it is inclusive, affirming, and empowering.

Importantly, achieving health equity does not necessarily mean seeing equal outcomes across the population. DPH envisions “health equity for all Delawareans, where everyone will achieve their full health potential.” This is important as the full health potential for one individual may be different than that of another due to genetic or biological factors, for instance. Thus, a health equity framework draws attention to the need for equity in access to and quality of the resources needed for health and moves away from a disease-specific or individual risk factor orientation. Some experts have referred to this as needing to “create a level playing field” (Knight, 2014). Achieving health equity requires a greater focus on improving underlying social and economic conditions, such as income and education. These conditions are structural and systemic in nature, much like the strong bridges and fences of the stream parable. In essence, a health equity lens moves us farther upstream to address the social determinants of health and health equity.

“Health equity is about fairness and justice, and is indistinguishable from equity generally” (Knight, 2014).

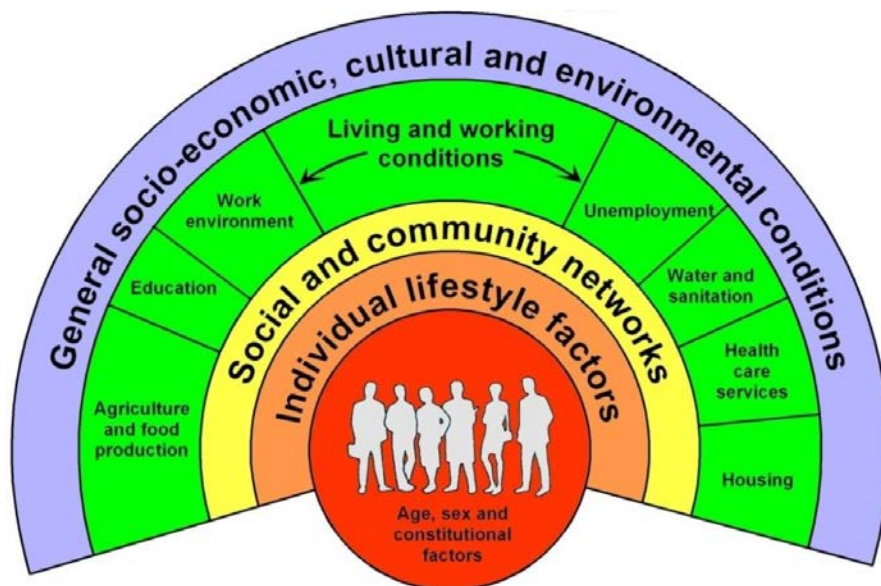
Social Determinants of Health (SDOH)

The social determinants of health (SDOH) are often defined as the circumstances in which people are born, grow up, live, work, and age. The World Health Organization (WHO) explains that these circumstances are in turn shaped by a wider set of forces: economics, social policies (such as education, social security and welfare), and politics (including power and decision-making). This understanding of the SDOH is important in relation to health equity, as it recognizes that economic, social and political conditions are not naturally occurring. Instead, these conditions are the result of public policy and other community or collective actions. Therefore, the SDOH are rooted in long-term structures and traditions that may be resistant to change.

Efforts to define, understand, and address the SDOH have been growing since the 1990s. Various research organizations and public health institutions have sought to identify the various social influences on health and explain their relations with population health and the health of specific population groups. Conceptual frameworks were developed to help explain levels of

influence and identify opportunities for intervention. One such model, developed by Dahlgren and Whitehead at the forefront of the field (see Figure 7), is frequently used to describe the various determinants of health. The model highlights levels of influence, with the most distal factor, the prevailing socioeconomic and cultural conditions, as the very structure of society in which each of the other levels function. The model puts living and working conditions, such as housing and education, within the context of these societal structures, suggesting that they are not naturally occurring conditions. Rather, living and working conditions come about as a result of overall societal structure, culture, and both historic and current public policies. Another way of thinking about this is that living and working conditions are not inevitable; they are amenable to change. The model also highlights the fact that individual behavior and lifestyle choices are made within the context of one’s social and community networks as well as the broader environment.

Figure 7. Social determinants of health and levels of influence (Dahlgren & Whitehead, 1991)



Source: Dahlgren & Whitehead, 1991.

Attention to the SDOH has grown substantially in the United States in recent years. A major goal within *Healthy People 2020* is to “create social and physical environments that promote good health for all.” *Healthy People 2020* distinguishes between social and physical determinants in the environment but recognizes their interrelated nature in contributing to the places where people are born, live, learn, work, play, worship, and age.

Many lists of determinants and variations on the rainbow model originally presented by Dahlgren and Whitehead (1991) have been created in recent years and used for different purposes.

Experts continue to learn more about the ways in which social conditions impact health; models are improving to reflect this enhanced understanding. Notwithstanding such scientific advances and differences in purpose among varied approaches, it is important to recognize that all of the lists, frameworks, and models describing the SDOH in recent years share key elements that are critical for health promotion:

- Health is a result of a complex web of influences, including social, economic, political, physical, behavioral, and biological factors.
- Individual level influences, such as behavior, occur in the context of the broader social and physical environment, and a focus on individual level influences without appropriate attention to other contextual factors is likely to be inadequate for achieving meaningful health improvements.
- Social and physical environmental factors are shaped by societal structures and public policy.
- Health care services are less important than traditionally thought.
- Biological and genetic factors can mediate the effects of other influences, but are not the primary determinants of health.
- The determinants of health affect individuals over the course of their lifetime, often varying in importance and degree of influence.

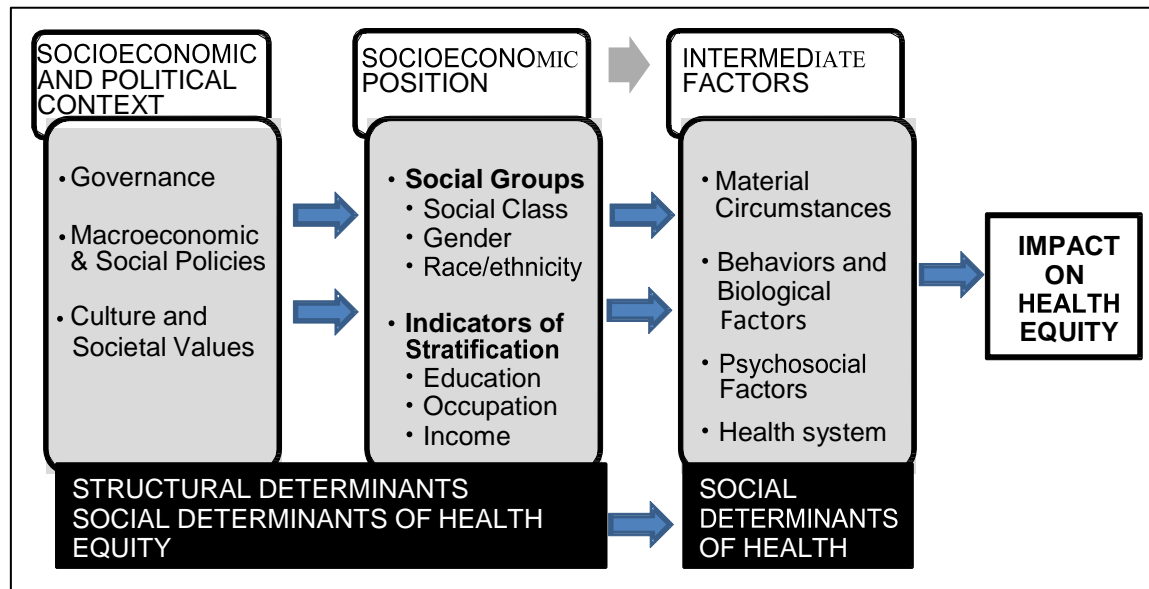
Social Determinants of Health Equity (SDOHE)

In 2008, the WHO Commission on the Social Determinants of Health published a groundbreaking report on health inequities, which summarized decades of research from around the world. The report explained that differences in SDOH are mostly responsible for health inequities. The relation between the SDOH and health inequities can be seen very clearly in Figures 3-6, which were shared from the Robert Wood Johnson Foundation (RWJF) on pages 18-21. The staircase pattern in each of the figures illustrates what is often referred to as the social gradient in health. The data indicate that social advantages and disadvantages are relative. For example, individuals who experience extreme poverty are more likely to experience poor health than those who have even slightly more resources, while those at the highest socioeconomic level are generally the healthiest. The same pattern holds for education level and other indicators of social status. Furthermore, the effects of these factors can be cumulative. For example, individuals who are poor, Black, and have low levels of education are more likely to be in poor health than someone who has just one or two of those characteristics.

Importantly, the WHO report (and numerous related publications) point out that differences in the SDOH that underlie health inequities are themselves socially determined. In other words, the working and living conditions that determine health and health inequities are not naturally occurring. Instead, they are determined by policy decisions and other social structures and actions (e.g. media, business, etc.) that affect communities and societies at large.

Figure 8, reproduced from the WHO report mentioned above, illustrates this understanding regarding the *structural* determinants of the *social* determinants of health. This figure is useful for highlighting the need to move even farther upstream. Living and working conditions, described as SDOH, are viewed as more proximate to health and equity, whereas macroeconomic policies and other social policies—housing, education, and social security—are further upstream. Figure 8 illustrates how these policies—along with culture, societal values, and governance—are related to socioeconomic position and result in inequities between groups of people categorized by gender, race, and class. Meaningful, long-term changes that promote health equity are needed farther upstream at that structural level—identified in Figure 8 as being within the socioeconomic and political context—in a health equity framework.

Figure 8. Conceptual Framework for the Determinants of Health Equity



Source: World Health Organization, 2010.

Many advocates and public health leaders now make a distinction between the SDOH and what are increasingly being referred to as the “social determinants of health equity” (SDOHE). This distinction is also based in part on the understanding that although medical advances and many public health interventions over the past century have improved population health, they

have moved the average and have not necessarily reduced differences between groups. Finally, this distinction is based on the recognition that inequities in health primarily result from an inequitable distribution in the quality of the SDOH. This reflects imbalances in political and economic power instead of “ad hoc events, individual failure, or the inevitable consequences of modern society” (Hofrichter, 2003, p. 1).

The inequitable distribution in health-related resources has tangible and measurable repercussions for the health of groups that experience social disadvantages. For instance, each year in the U.S. an estimated 83,570 Blacks die prematurely because of racial health disparities (Satcher et al., 2005); and, on average, 195,000 premature deaths result from disparities in education each year (Woolf, Johnson, Phillips, & Philipsen, 2007). Other health gaps exist in relation to such things as gender, gender identity, sexual orientation, and disability status, to name just a few. The current social, economic, and political context suggests that population health will continue to worsen, as will health inequities, if we do not move farther upstream with our health promotion efforts.

National Efforts to Advance Health Equity

Despite a research focus on health inequities since the 1970s and growing attention to SDOH in public health practice, health inequities remain a large, persistent problem that has garnered the attention of many state and federal agencies, foundations, and non-profit organizations. Over the past two decades, federal agencies have released numerous reports regarding health disparities, and have offered recommendations for addressing them. Those recommendations have become increasingly focused on the SDOH. The contents of three key reports: *Healthy People 2020*, the *National Stakeholder Strategy*, and the *Department of Health and Human Services’ Action Plan to Reduce Racial and Ethnic Health Disparities*, are particularly relevant to this guide and influenced its development.

Healthy People 2020

The *Healthy People* initiative provides science-based 10-year national objectives for improving the health of all Americans. Each 10-year plan is developed through a multi-year process that includes input from a wide range of experts and stakeholders. In its third iteration, *Healthy People 2020*, released in December of 2010, articulates a framework for achieving its national goals and objectives through a foundation in the determinants of health. As mentioned earlier, *Healthy People 2020* distinguishes between social and physical determinants in the environment, but recognizes their interrelated nature, as they both contribute to the places where people are born, live, learn, work, play, worship, and age. *Healthy People 2020* refers to

the social and physical determinants collectively as “societal determinants of health.” This phrase captures the interrelated and complex nature of the social and physical determinants².

Importantly, *Healthy People 2020* recognizes that the social environment is very broad and reflects things like culture, language, political and religious beliefs, and social norms and attitudes. The social environment also encompasses socioeconomic conditions (i.e. poverty) and community characteristics (i.e. exposure to crime and violence), as well as the degree and quality of social interactions. According to the Secretary’s Advisory Committee, mass media and emerging communication and information technologies, such as the Internet and cellular telephone technology, are ubiquitous elements of the social environment that can affect health and well-being. Furthermore, policies in settings such as schools, workplaces, businesses, places of worship, health care settings, and other public places are part of the social environment. Economic policy is highlighted as a critically important component of the social environment.

According to *Healthy People 2020*, the physical environment consists of the natural environment (i.e., plants, atmosphere, weather, and topography) and the built environment (i.e., buildings, spaces, transportation systems, and products that are created or modified by people). The physical environment affects health directly, such as through physical hazards like air pollution, and indirectly, such as the way in which the environment encourages or discourages physical activity. The Secretary’s Advisory Committee suggests that interventions should promote environmental justice by eliminating disparities in exposure to harmful environmental factors and improving access to beneficial ones.

Given the range of factors in the social and physical environment³ affecting health, *Healthy People 2020* calls for a multi-sector approach to address health equity. The Secretary’s Advisory Committee notes that the 10-year goals and objectives “can be achieved *only* if many sectors of our society—such as transportation, housing, agriculture, commerce, and education, in addition to medical care—become broadly and deeply engaged in promoting health.” The Committee acknowledges that many agencies do not have a mandate to address these cross-cutting issues, and recommends that the public health community provide leadership and encourage collaboration to promote health in the social and physical environment.

² For a more detailed explanation of the societal determinants of health, including why they are believed to be so important, and how they are related to the *Healthy People 2020* goals, see a companion report of the Secretary’s Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020: <http://www.healthypeople.gov/sites/default/files/SocietalDeterminantsHealth.pdf>.

³ Due to the interrelated nature of social and physical factors in the environment, the term “environment” is frequently used throughout this guide to refer to both. When a distinction is made, it is intended to draw attention to a particular aspect of the environment.

One recommendation for addressing societal determinants of health across sectors is for government to adopt a “Health in All Policies” (HiAP) approach. A HiAP approach requires intersectoral partnerships at all government levels and with non-traditional partners, with a focus on social and environmental justice, human rights, and equity. A HiAP approach has the potential to make meaningful impact in achieving health equity. An in-depth discussion of this approach, including related tools and strategies, is included in Section 6.

The Secretary’s Advisory Committee acknowledges that individual/disease-specific and population-based perspectives are both necessary to achieve optimal health for all. Rather than choose one or the other, they should be viewed (and used) as two components of an integrated solution. Table 1, excerpted from the *Report of the Secretary’s Advisory Committee*, provides examples of the two approaches and highlights their advantages and disadvantages from both a policy perspective and a practical perspective.

Table 1. Relative Advantages and Disadvantages of Disease Focus and Population Focus for Addressing Health Disparities

	Advantages		Disadvantages	
Focus	Policy Perspective	Practical Perspective	Policy Perspective	Practical Perspective
Individual/Disease Focus	<p>Provides convincing evidence that ethnic minority and low socioeconomic status (SES) populations are disadvantaged</p> <p>Keeps issues of health inequities on policy agenda</p> <p>Quantifies the problem</p>	<p>Matches NIH and other funding streams</p> <p>Matches organization of medical specialties</p> <p>Compatible with hi-tech medical solutions</p> <p>Conveys potential for dramatic success through focused effort on high-risk or already ill individuals</p>	<p>Sets lack of “excess deaths” as the standard</p> <p>Implies that health status of Whites or high SES represents optimal health</p> <p>Emphasizes relative risks more than absolute risks</p> <p>Frames issues in medical or health system terms; de-emphasizes structural variables or environmental circumstances</p> <p>Makes it difficult to identify where to focus attention</p>	<p>Inadvertently reinforces perception of minority group inferiority or inevitability of poor health among low SES populations</p> <p>Creates separate tracks for pursuing problems with many common determinants</p> <p>Leads to duplication, competing priorities, and fragmentation of efforts.</p> <p>Because of narrow focus, may not adequately identify unanticipated negative or positive consequences of policies or interventions in other areas</p>
Population Health Focus	<p>Facilitates focus on optimal health of the population in question</p> <p>Highlights relevant historical, cultural, and political contexts</p> <p>Draws attention to diversity within ethnic minority and low SES populations</p> <p>Integrates domains of knowledge and discourse</p> <p>Incorporates critical nonmedical health issues</p>	<p>Facilitates endogenous solutions</p> <p>Supports attention to assets and coping abilities</p> <p>By applying a more integrated approach, opportunities to identify unanticipated benefits or untoward consequences of interventions is increased</p>	<p>Links status on policy agenda to less popular issues</p> <p>Depends on actions in non-health sectors</p> <p>Poor match for National Institutes of Health (NIH) and other funding streams</p> <p>Is associated with slow, incremental progress versus quick fixes.</p>	<p>Is challenging to biomedical paradigm</p> <p>Generates less enthusiasm about hi-tech medical solutions</p> <p>Is often distal to disease outcomes</p> <p>More complex, multi-level solutions make it more difficult to identify key factors driving successful outcomes</p>

Source: Excerpt from Report of the Secretary’s Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020; Adapted from Kumanyika SK, Morssink CB. Bridging Domains in Efforts to Reduce Disparities in Health and Health Care. *Health Educ Behav* 2006; 33; 440.).

Finally, the Secretary’s Advisory Committee calls for more research regarding the societal determinants of health and efforts to address them. The Committee argues that the availability of high quality data for all communities should be a priority for public health departments and clinical preventive research. Furthermore, it acknowledges the need to build the evidence for community-based interventions and recommend that HHS place more attention on examining policies that impact the social and physical environment. Finally, the Committee stresses the importance of community-based participatory research. Elements of these recommendations are included in Sections 6 (Policy-Oriented Strategies) and 7 (Data, Research, and Evaluation for Health Equity).

National Stakeholder Strategy for Achieving Health Equity (NSS)

In response to persistent health inequities in the United States and a call to action for a national, comprehensive, and coordinated effort to eliminate disparities, the U.S. Department of Health and Human Services’ Office of Minority Health established The National Partnership for Action to End Health Disparities (NPA). The NPA was created with the support of nearly 2,000 attendees of the National Leadership Summit for Eliminating Racial and Ethnic Disparities in Health. Sponsored by the Office of Minority Health, the Summit provided a forum to strategize how to eliminate health disparities by increasing the effectiveness of programs that target health disparities and fostering effective coordination of partners, leaders, and other stakeholders.

In 2011, the NPA released the *National Stakeholder Strategy for Achieving Health Equity (NSS)*, which was developed through a very collaborative process, including contributions from thousands of individuals representing government, non-profit organizations, academia, business, and the general public. When the NPA released the initial draft for comment, thousands of community members responded. The resulting report is described as a “roadmap” for stakeholders at local, state, and regional levels to eliminate health disparities. The main values of the *NSS* are community engagement, community partnerships, cultural and linguistic literacy, and non-discrimination. The *NSS* report includes a set of five overarching goals and 20 community-driven strategies to help achieve them. Table 2, excerpted from the *NSS*, outlines these goals and strategies. For each of the 20 strategies, the report provides a menu of objectives, measures, and potential data sources as tools for stakeholders to use in implementing any given strategy. The strategies are intended to be translated and operationalized at different geographic levels (e.g. local, state, and regional) and across sectors. The NPA acknowledges many challenges in accomplishing these tasks and offers the report as a forum for lessons learned, best practices in the field, and tracking progress.

Table 2: Summary of National Stakeholder Strategy

Goal	Description	Strategies
1	AWARENESS Increase awareness of the significance of health disparities, their impact on the nation, and actions necessary to improve health outcomes for racial, ethnic, and underserved populations	1. Healthcare Agenda Ensure that ending health disparities is a priority on local, state, tribal, regional, and federal healthcare agendas
		2. Partnerships Develop and support partnerships among public, non-profit, and private entities to provide a comprehensive infrastructure to increase awareness, drive action, and ensure accountability in efforts to end health disparities and achieve health equity across the lifespan
		3. Media Leverage local, regional, and national media outlets using traditional and new media approaches as well as information technology to reach a multiter audience—including racial and ethnic minority communities, youth, young adults, older persons, persons with disabilities, LGBT groups, and geographically isolated individuals—to encourage action and accountability
		4. Communication Create messages and use communication mechanisms tailored for specific audiences across their lifespan, and present varied views of the consequences of health disparities that will encourage individuals and organizations to act and to reinvest in public health.
2	LEADERSHIP Strengthen and broaden leadership for addressing health disparities at all levels	5. Capacity Building Build capacity at all levels of decision-making to promote community solutions for ending health disparities
		6. Funding Priorities Improve coordination, collaboration, and opportunities for soliciting community input on funding priorities and involvement in research and services
		7. Youth Invest in young people to prepare them to be future leaders and practitioners by actively engaging and including them in the planning and execution of health, wellness, and safety initiatives
3	HEALTH SYSTEM & LIFE EXPERIENCE Improve health and healthcare outcomes for racial, ethnic, and underserved populations	8. Access to Care Ensure access to quality healthcare for all
		9. Children Ensure the provision of needed services (e.g., mental, oral, vision, hearing, and physical health; nutrition; and those related to the social and physical environments) for at-risk children, including children in out-of-home care
		10. Older Adults Enable the provision of needed services and programs to foster healthy aging
		11. Health Communication Enhance and improve health service experience through improved health literacy, communications, and interactions
		12. Education Substantially increase, with a goal of 100%, high school graduation rates by working with schools, early childhood programs, community organizations, public health agencies, health plan providers, and businesses to promote the connection between educational attainment and long-term health benefits
4	CULTURAL & LINGUISTIC COMPETENCY Improve cultural and linguistic competency and the diversity of the health-related workforce	13. Social and Economic Conditions Support and implement policies that create the social, environmental, and economic conditions required to realize healthy outcomes
		14. Workforce Develop and support the health workforce and related industry workforces to promote the availability of cultural and linguistic competency training that is sensitive to the cultural and language variations of diverse communities
		15. Diversity Increase diversity and competency of the health workforce and related industry workforces through recruitment, retention, and training of racially, ethnically, and culturally diverse individuals and through leadership action by healthcare organizations and systems
		16. Ethics and Standards, and Financing for Interpreting and Translation Services Encourage interpreters, translators, and bilingual staff providing services in languages other than English to follow codes of ethics and standards of practice for interpreting and translation. Encourage financing and reimbursement for health interpreting services
5	DATA, RESEARCH, & EVALUATION Improve data availability, coordination, utilization, and diffusion of research and evaluation outcomes	17. Data Ensure the availability of health data on all racial, ethnic, and underserved populations
		18. Community-Based Research and Action, and Community-Originated Intervention Strategies Invest in community-based participatory research and evaluation of community-originated intervention strategies in order to build capacity at the local level for ending health disparities
		19. Coordination of Research Support and improve coordination of research that enhances understanding about, and proposes methodology for, ending health and healthcare disparities
		20. Knowledge Transfer Expand and enhance transfer of knowledge generated by research and evaluation for decision-making about policies, programs, and grant-making related to health disparities and health equity

Source: *The National Partnership for Action to End Health Disparities, 2011.*

The HHS Action Plan to Reduce Racial and Ethnic Health Disparities

The U.S. Department of Health and Human Services' *Action Plan to Reduce Racial and Ethnic Health Disparities* was released simultaneously with the NSS. It represents the federal commitment to achieving health equity and the HHS response to the strategies recommended in the NSS. *The Action Plan* also builds on *Healthy People 2020* and leverages other federal initiatives (e.g. the National HIV/AIDS Strategy, the First Lady's *Let's Move* initiative, etc.) and many provisions of the Affordable Care Act. It outlines specific goals and related actions that HHS agencies will take to reduce health disparities among racial and ethnic minorities in the following five areas:

1. transforming health care by expanding insurance coverage, increasing access to care, and fostering quality initiatives;
2. strengthening the health workforce to promote better medical interpreting and translation services and increased use of community health workers;
3. advancing the health, safety, and well-being of Americans by promoting healthy behaviors and strengthening community-based programs to prevent disease and injury;
4. advancing knowledge and innovation through new data collection and research strategies; and
5. increasing the ability of HHS to address health disparities in an efficient, transparent, and accountable manner (U.S. DHHS, 2011).

Delaware Division of Public Health's Health Equity Strategy

As described in the *Delaware Division of Public Health [DPH] 2014-2017 Strategic Plan* (see <http://www.dhss.delaware.gov/dph/files/dphstrategicplan.pdf>), DPH identified health equity as one of its strategic priorities. Over the course of three years, DPH launched an organization-wide planning effort, where staff met to develop strategic, cross-cutting objectives, related activities, and performance measures that address health equity.

Consistent with a national effort to promote quality improvement in public health, DPH used a Balanced Scorecard strategy mapping process (Kaplan & Norton, 1992) to illustrate the Division-wide performance management system (see Figure 9), which integrates a health equity strategy throughout. This DPH Equity Strategy Map complements the Division's *2014-2017 Strategic Plan*. Noted in Figure 9, DPH's overall vision is "*health equity for all Delawareans where everyone will achieve their full health potential.*" Each objective is necessarily important

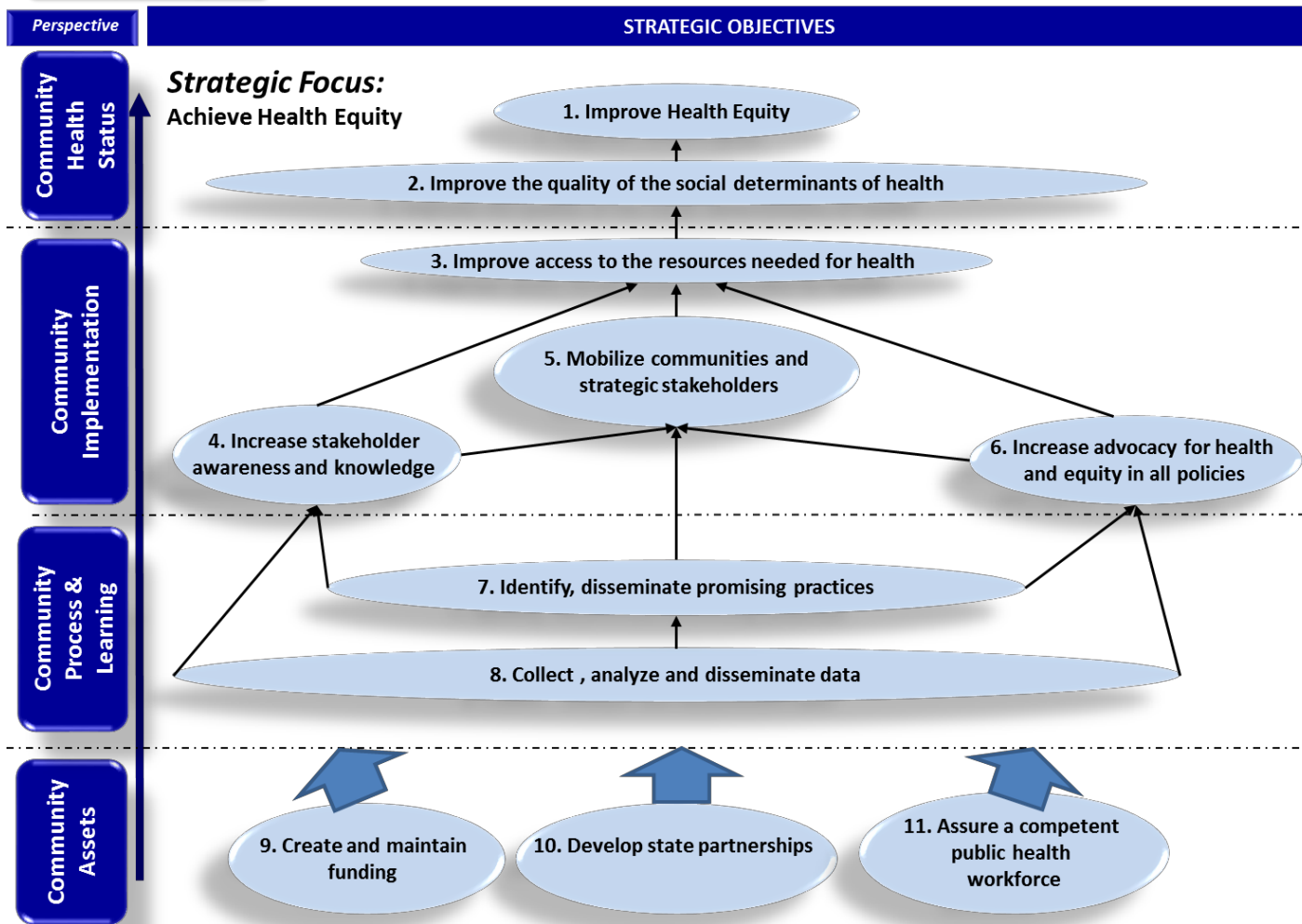
for achieving this vision. The objectives of the strategy map are interrelated and those on the bottom of the map provide a foundation for those on the top.

This guide is intended to support the Community Implementation Objectives outlined in the center of the strategy map, but is grounded in an appreciation for efforts underway at each level which support the overall vision. This strategy reflects a shift from a framework of health disparities that largely focused on individual risk factors and disease-specific approaches to one that focuses more on communities, systems, and the underlying conditions that determine health. Still, DPH recognizes the need to continue to enhance many of its efforts in reducing individual risk factors and improving access to quality services. DPH's approach parallels the integration of individual and population-based strategies recommended by the Secretary's Advisory Committee for *Healthy People 2020*. Drawing upon the direction of the national strategies, DPH will use the *Health Equity Guide for Public Health Practitioners and Partners* to promote collaborative efforts that address health equity in the unique context of Delaware's communities.

Figure 9. Delaware DPH Health Equity Strategy Map

Delaware Public Health
Health Equity Strategy Map

Vision: Health equity for all Delawareans where everyone will achieve their full health potential



Source: Delaware Division of Public Health, 2013.

Underlying Values and Assumptions

Before proceeding to the case for change and strategies for change, a discussion is warranted to clarify and summarize the underlying values and assumptions inherent in this guide. One of the major criticisms of the United States' health care system is that funds are being directed towards costly procedures and treatments of specific diseases rather than towards upstream preventive approaches like community-based interventions, population-based approaches, and policy changes that address the SDOH. Many have argued that the current emphasis on downstream treatment is generally not conducive to eliminating the major health inequities in the U.S., and contributes to excessive health care spending. The views expressed in this guide reflect the assumption that moving upstream to mend bridges and build fences is likely to be more effective in promoting health and reducing health inequities. Additionally, an upstream approach may be considered more ethical because it prevents pain and suffering for the population as a whole, while at the same time, reduces gaps in morbidity and mortality between groups. However, opportunities also exist within the health care system to make the delivery of care more equitable. Such changes can contribute to advancing health equity by ensuring access to quality health care for everyone. Reflecting again on the stream parable, this means that everyone has the opportunity to receive quality care, should they fall in the river and become ill. For this reason, the following sections prioritize activities in the social and physical environment, including within the health care system.

Several other important assumptions about the approach taken to develop this guide should be made explicit, including the ways in which this guide is limited. Our view is that effective action to eliminate health inequities must be grounded in principles of social justice, which includes attention to social and economic equality and a fair distribution of advantages, as well as a stronger democracy where individuals have greater control over decisions that affect SDOH. Achieving health equity will ultimately require us to confront deeply entrenched values and cultural norms. As one expert stated, "there has to be public recognition of the real sources of health inequities... we have to understand that class and class exploitation, racism, sexism, and imbalances in power that create those phenomena are the basic source of health inequities" (Knight, 2014). Referring to the stream parable, this means that we have to do even more than ensure everyone has the opportunity to cross the strong bridge or live near the quality fence. It means that all communities along the stream have the power to make decisions and have control over resources to build their bridges and fences the way they believe they should be built.

Changing the power dynamic in our communities means that some will have to relinquish power as others become more empowered. This complicated (and uncomfortable) conversation about class and power is beyond the scope of this guide, as it requires major

social and political changes. Still, it is easy for these important issues to be obscured by a focus on more intermediate kinds of change recommended in the following pages. Therefore, we encourage you to use this guide as it is intended—to support upstream strategies aimed at the social determinants of health—but do not lose sight of the broader social injustices even farther upstream that require ongoing attention and commitment. Over time, through our collective efforts to promote health equity in Delaware, we hope to draw greater attention to these underlying social issues and create positive social change.

In the meantime, there is much we can do. We hope this guide will support those efforts. To move forward together, we propose the following assumptions and values to guide our work.⁴ We recommend that collaborative community efforts aimed at advancing health equity begin with a discussion of these assumptions to ensure that participants understand their meaning and implications and are adopted as shared principles (or adapted accordingly):

1. Health is broadly defined as a positive state of physical, mental, and social well-being and not merely the absence of disease.
2. Everyone—regardless of race, religion, political belief, and economic or social condition—has the right to a standard of living adequate for health, including food, clothing, housing, medical care, and necessary social services.
3. Health is more than an end. It is also an asset or resource necessary for human development and well-functioning communities.
4. Health is socially and politically defined. Individual and medical definitions of health ignore important interactions between individual factors and social and environmental conditions.
5. Health is a collective public good, which is actively produced by institutions and social policies.
6. Equity in health benefits everyone because health is a public good necessary for a well-functioning society.
7. Inequities in population health outcomes are primarily the result of social and political injustice, not lifestyles, behaviors, or genes.

⁴Items 1 and 2 are adapted from the Constitution of the World Health Organization (1946) and the Universal Declaration of Human Rights (1948). Items 3-9 are adapted from Hofrichter, R. & Bhatia, R. (Eds.). (2011). *Tackling health inequities through public health practice: Theory to action* (2nd ed). New York: Oxford University Press, p. 6.

8. An accumulation of negative social conditions and a lack of fundamental resources contribute to health inequities, and include: economic and social insecurity; racial and gender inequality; lack of participation and influence in society; unfavorable housing; unhealthy conditions in the workplace and lack of control over the work process; toxic environments; and inequitable distribution of resources from public spending.
9. Tackling health inequities effectively will require an emphasis on root causes and social injustice, the latter concerning inequality and hierarchical divisions within the population.

Glossary – Section 2

Health disparity: A difference in health status between population groups.

Health inequity: A health disparity which is unnecessary, avoidable, unfair, and unjust; a socially-determined difference in health.

Health equity: Achieving the conditions in which all people have the opportunity to reach their health potential; the highest level of health for all people.

Infant mortality rate (IMR): The number of deaths of children less than one year of age per 1,000 live births. The rate for a given region is the number of children dying under one year of age, divided by the number of live births during the year, multiplied by 1,000. IMR is usually reported in relation to the race or ethnicity of the mother.

Life expectancy: The statistically predicted (average) number of years of life remaining at any given age. Life expectancy is usually reported and understood as “life expectancy at birth” unless otherwise noted.

Population health: The health status or health outcomes of a group of individuals, including the distribution of such outcomes within the group. Groups are often defined geographically (e.g. at the state or country level).

Social determinants of health: The circumstances in which people are born, grow, live, work, and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.

Social determinants of health equity: The underlying social, economic, and political structures that determine the quality and distribution of resources needed for health.

References and Additional Resources

- Asada Y. A summary measure of health inequalities for a pay-for-population health performance system. *Prev Chronic Dis* 2010;7(4):A72. Retrieved from http://www.cdc.gov/pcd/issues/2010/jul/09_0250.htm
- Carter-Pokras O, Baquet C. (2002). What is a "health disparity"? *Public Health Reports*; 117(5), 426-434.
- Centers for Disease Control and Prevention (CDC) (2011). CDC Health Disparities and Inequalities Report – United States, 2011. *MMWR*; 60(Supplement), 1-114. Retrieved from <http://www.cdc.gov/mmwr/pdf/other/su6001.pdf>
- Central Intelligence Agency. (2013). *The World Factbook 2013-2014*. Washington, DC: Central Intelligence Agency. Retrieved from <https://www.cia.gov/library/publications/the-world-factbook/index.html>
- Community Preventive Services Task Force (n.d.). *Guide to Community Preventive Services, Promoting Health Equity*. U.S. Department of Health and Human Services. Retrieved from <http://www.thecommunityguide.org/healthequity/index.html>
- Dahlgren G, Whitehead M. (1991). *Policies and Strategies to Promote Social Equity in Health*. Stockholm, Sweden: Institute for Futures Studies.
- Delaware Division of Public Health. (2014). *Delaware Division of Public Health 2014-2017 Strategic Plan*. Delaware Health and Social Services. Retrieved from <http://www.dhss.delaware.gov/dph/files/dphstrategicplan.pdf>
- Expert Panel, (2009). *Report of the national expert panel on social determinants of health equity: Recommendations for advancing efforts to achieve health equity*. Atlanta, GA. Retrieved from <http://unnaturalcauses.org>
- Graham, H. (2004). Social determinants and their unequal distribution: Clarifying policy understandings. *The Milbank Quarterly*, 82(1), 101-124.
- Hofrichter, R. & Bhatia, R. (Eds.). (2011). *Tackling health inequities through public health practice: Theory to action* (2nd ed). New York: Oxford University Press.
- Kaplan, R., S. & Norton, D., P. (1992). The Balanced Scorecard. Measures that drive performance, *Harvard Business Review*, January-February, 70-79.
- Knight, E. (2010). Health, equity and the social determinants. *Realities of Poverty in Delaware 2009-2010*, Wilmington, DE: Delaware Housing Coalition. Retrieved from http://www.housingforall.org/images/documents/ROP_110110.pdf
- Knight, E. (2014). Shifting public health practice to advance health equity: Recommendations from experts and community leaders, *Journal of Public Health Management and Practice*, 20(2), 188-196.

Malik, K., et al. (2013). *Human Development Report 2013*. United Nations Development Programme. New York, NY. 2013. Retrieved from http://hdr.undp.org/sites/default/files/reports/14/hdr2013_en_complete.pdf

Mathews, TJ & MacDorman, MF (2012). *Infant mortality statistics from the 2008 period linked birth/infant death data set*. National Vital Statistics Reports, National Center for Health Statistics, Volume 60, No. 5. Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_05.pdf

National Partnership for Action to End Health Disparities [NPA], (2011). *National stakeholder strategy for achieving health equity*. Rockville, MD: U.S. DHHS, Office of Minority Health. Retrieved from http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf

Robert Wood Johnson Foundation.(2008). *Overcoming obstacles to health: Report to the Commission to Build a Healthier America*. Princeton, NJ. Retrieved from <http://www.rwjf.org/content/dam/farm/reports/reports/2008/rwjf22441>

Satcher, D., Fryer, G. E., McCann, J., Troutman, A., Woolf, S. H., & Rust, G. (2005). What if we were equal? A comparison of the black-white mortality gap in 1960 and 2000. *Health Affairs (Project Hope)*, 24(2), 459-464.

Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. (2010). *Healthy People 2020: An opportunity to address the societal determinants of health in the U.S.* U.S. Department of Health and Human Services. Retrieved from <http://www.healthypeople.gov/sites/default/files/SocietalDeterminantsHealth.pdf>

Unnatural Causes: Is Inequality Making Us Sick? National Association of County & City Health Officials and California Newsreel. <http://unnaturalcauses.org/>

U.S. Department of Health and Human Services [US DHHS] (2011). *HHS Action Plan to Reduce Racial and Ethnic Disparities: A Nation Free of Disparities in Health and Health Care*. Washington, D.C.: U.S. Department of Health and Human Services. Retrieved from http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

U.S. Department of Health and Human Services [US DHHS]. (March 2014). *Healthy People 2020, Leading Health Indicators Progress Update*. Retrieved from http://www.healthypeople.gov/sites/default/files/LHI-ProgressReport-ExecSum_0.pdf

Whitehead M. (1992). The concepts and principles of equity in health. *International Journal of Health Services*; 76(3), 429-445.

Woolf, S. H., Johnson, R. E., Phillips, R. L., & Philipsen, M. (2007). Giving everyone the health of the educated: An examination of whether social change would save more lives than medical advances. *American Journal of Public Health*, 97(4), 679-683.

World Health Organization Commission on the Social Determinants of Health. (2007). *A conceptual framework for action on the social determinants of health*. Discussion paper for the Commission on Social Determinants of Health (CSDH). Geneva: World Health Organization. Retrieved from

http://www.who.int/social_determinants/resources/csdh_framework_action_05_07.pdf

World Health Organization. What are Social Determinants of Health?

http://www.who.int/social_determinants/sdh_definition/en/

World Health Statistics. World Health Organization, Global Health Observatory Data Repository.

Retrieved from <http://apps.who.int/gho/data/node.main>

SECTION 3: The Case for Change

There are many ways to try to convince the public, policymakers, and professionals that a new approach is needed to address health inequities. One can make an ethical case for change, as highlighted by the guiding principles and values outlined in the previous section. Or, one can make a practical case for change using health statistics to argue that the current approach is not working and offer a conceptual or evidence-based rationale for an alternative approach, as highlighted by the shift in focus of *Healthy People 2020* towards the social determinants of health. One can also make an economic case for change by pointing out that our current system is unsustainable and inefficient.

The ethical, practical, *and* economic perspectives are evident in the implications of a 2011 study which estimated the total number of deaths in the United States that could be attributable to social factors. Researchers (Galea et al., 2011) found that in the year 2000 alone:

- ❖ 245,000 deaths were attributable to low education;
- ❖ 176,000 deaths were attributable to racial segregation;
- ❖ 162,000 deaths were attributable to low social support;
- ❖ 133,000 deaths were attributable to individual-level poverty;
- ❖ 119,000 deaths were attributable to income inequality; and
- ❖ 39,000 deaths were attributable to area-level poverty.

These data illustrate the interconnectedness of the ethical, practical, and economic perspectives and reflect the context seen in Delaware. This section highlights examples of social inequities in health, which makes the practical case for change directly relevant to local stakeholders. It also summarizes the economic case for change broadly and in relation to health care spending in Delaware. Inherent in both of these perspectives is an ethical perspective that may be understood and appreciated differently by individual readers. Many potential users of this guide may not need convincing, but rather need tools to help foster change. For those individuals, we suggest that this section be used to help convince partners and colleagues to build the broad base of support required to make necessary kinds of change.

This section also provides a discussion of the need for a more holistic, prevention-oriented health system across the continuum of clinical and non-clinical services and approaches. It concludes with a brief discussion of the opportunities for reforming our health system provided through the Affordable Care Act and Delaware's *State Health Care Innovation Plan*.

The Delaware Context

As discussed in Section 2, the health profile of the United States is poor relative to the rest of the world. The health profile of Delaware generally follows similar trends and patterns to those of the nation. For instance, the average life expectancy in 2010 in Delaware is 78.4 years (compared with 78.9 years nationally). Delaware’s infant mortality rate of 8.7 per 1,000 live births in 2011 was high relative to the national average of 6.1 per 1,000 live births.

Social Determinants of Health in Delaware

According to the *State of Delaware Community Health Status Assessment (CHSA)* published in 2013, “Quality of life and health status are intrinsically linked to economic, income and educational attainment of Delaware residents” (DHSS, 2013, p. 7). Recent economic trends have contributed to poor social conditions among certain communities in the state and the resulting inequities in income, education, and other social factors are apparent in Delaware’s population. For instance, according to the *CHSA*:

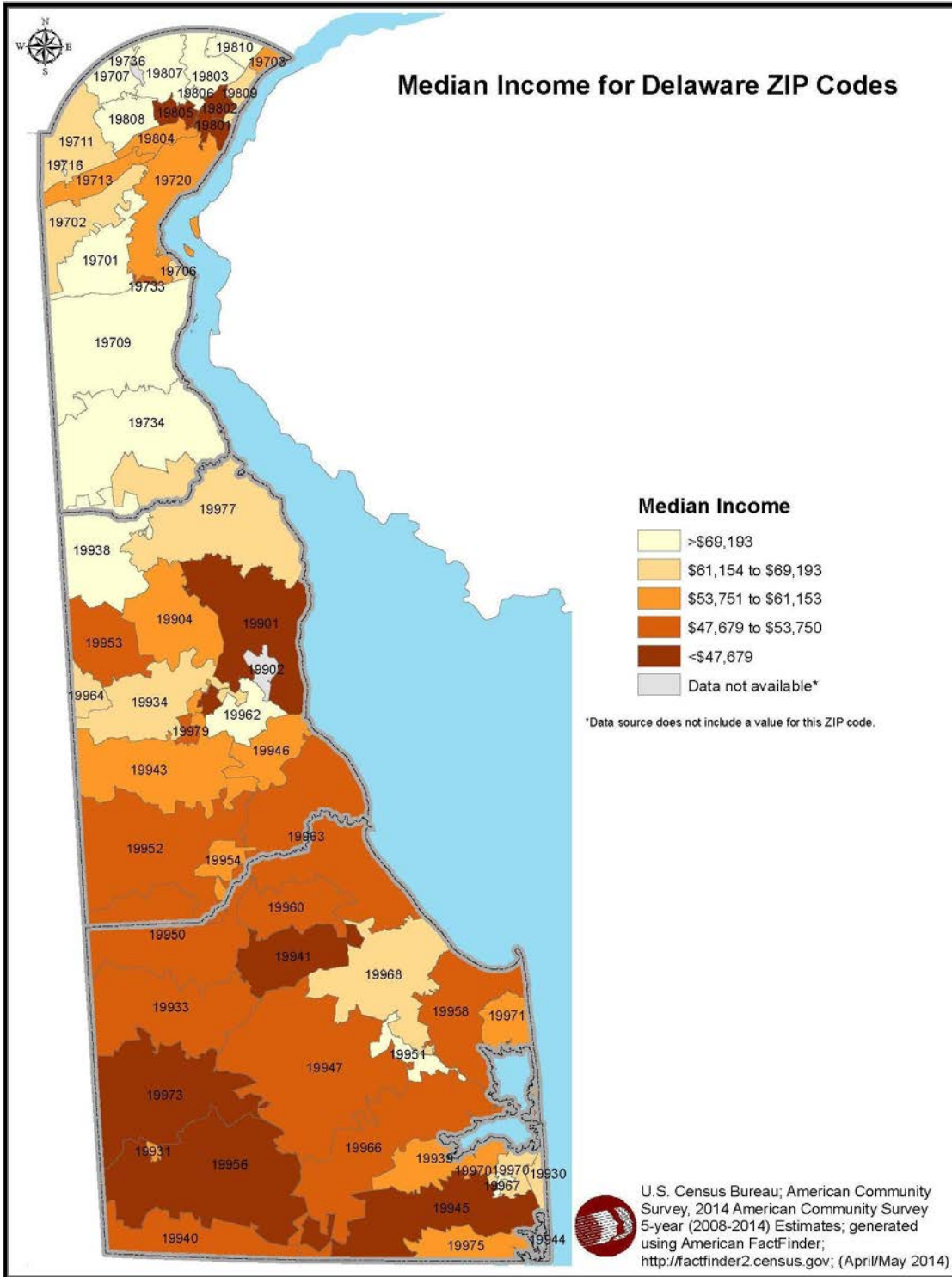
- ❖ Poverty levels increased by 20 percent between 2006 and 2012, contributing to a growing divide between the wealthy and the poor.
- ❖ In 2010, the percentage of children living in families at or below the poverty level was 18 percent. This was the highest child poverty rate in 10 years.
- ❖ The homeless population, the majority of whom are African American, has dramatically increased in Delaware.
- ❖ High school graduation rates have steadily increased, but Whites still have higher graduation rates than African Americans and Hispanics.

“Quality of life and health status are intrinsically linked to economic, income and educational attainment of Delaware residents” (DHSS, 2013).

It is particularly meaningful to consider such social determinants of health in the context of “place,” because the health of a community is directly linked to the physical and social conditions of that community. Healthy communities are characterized as those having an abundance of resources needed to create health, such as income, education, and quality housing.

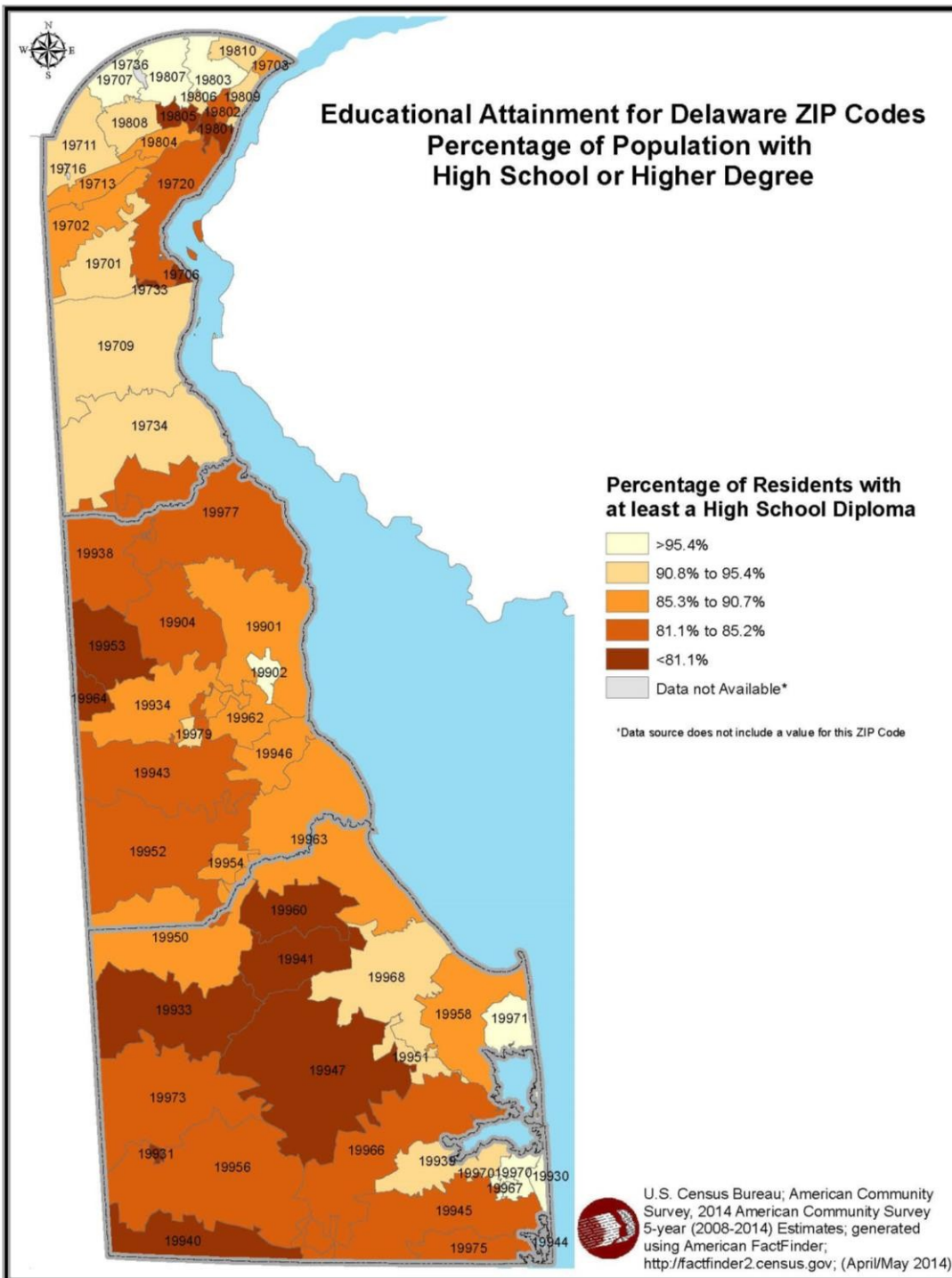
The maps in Figures 10 and 11, produced by the Delaware Division of Public Health (DPH) and the State Office of Planning Coordination (OSPC), illustrate how some of the resources needed for health are distributed. Figure 10 shows median income by ZIP code and indicates areas with large differences in income. In the northern part of Delaware, very high income communities border very low income communities. This is important given that emerging research suggests that income inequality is linked to poor health outcomes for everyone, not just those living in the poorer communities (Wilkinson & Pickett, 2006). Figure 11, which shows educational attainment by ZIP code, reveals similar patterns. Noticeably, many Delawareans who did not earn a high school diploma reside in low income communities. Although limitations in the statistical significance of Figures 10 and 11 prevent us from concluding definitively that there is a relation between these multiple risk factors, the concept of cumulative disadvantage is necessary to explore and understand. Explicitly, cumulative disadvantage is the increased likelihood of poor health outcomes with each additional risk factor. Each risk factor puts individuals increasingly in jeopardy of “falling into the river” of poor health outcomes.

Figure 10. Median income levels according to ZIP code in Delaware



Source: Delaware Division of Public Health and Office of State Planning Coordination, 2014.

Figure 11. Percent of residents with at least a high school diploma according to ZIP code in Delaware



Source: Delaware Division of Public Health and Office of State Planning Coordination, 2014.

Inequities in Health Status in Delaware

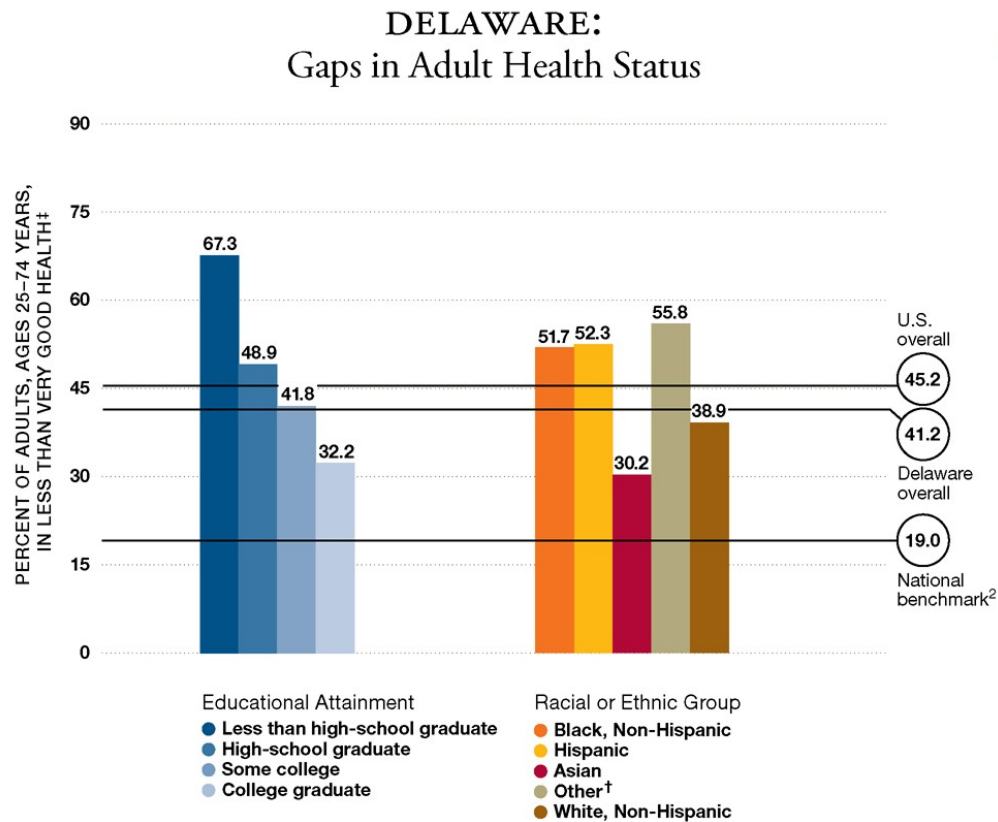
Health inequities may be understood as differences in health that are socially-determined. They are related to differences in the quality and distribution of the determinants of health, such as income and education, and are often most prominent across categories of race or ethnicity. The *CHSA* report highlights inequities in health outcomes by race and ethnicity (DHSS, 2013):

- ❖ African American infants have a significantly higher infant mortality rate than Caucasian infants, by as much as 2.8 times greater during some years. This gap is seen in all three of Delaware's counties.
- ❖ The homicide rate for African American men doubled between 1997 and 2009, and is four times higher than for Caucasian men.
- ❖ Sixty-six percent of the people living with HIV/AIDS in Delaware are African American, despite the fact that African Americans only account for 21 percent of the state's population. Hispanics account for 6 percent of the HIV/AIDS population and only 5 percent of the state's population.

Race/ethnicity, income, and education are related in complex ways and can interact to produce differences in health. Importantly, however, each is thought to contribute independently to health and health inequities. One should not be considered a proxy for another. Figures 12-14, reproduced courtesy of the Robert Wood Johnson Foundation Commission to Build a Healthier America, illustrate the patterns of health inequities in Delaware according to such social characteristics.

As seen in Figure 12, the average percentage of adults in less than very good health in Delaware is better than the national average, but is still far from the national benchmark. Furthermore, the Commission concludes "at every educational level and in every racial or ethnic group, adults in Delaware are not as healthy as they could be." Similar trends can be seen with infant mortality (Figure 13) and children's health status (Figure 14). With respect to the latter, the Commission concludes that there is "unrealized health potential among Delaware children in every income, education, and racial or ethnic group."

Figure 12. Percent of adults in less than very good health according to educational attainment and race/ethnicity in Delaware



In Delaware, adult health status¹ varies by level of educational attainment and by racial or ethnic group.

- Compared with college graduates, adults who have not graduated from high school are more than twice as likely—and those who have graduated from high school are 1.5 times as likely—to be in less than very good health.
- Hispanic and non-Hispanic black adults are approximately 30 percent more likely than non-Hispanic white adults to be in less than very good health.

Comparing Delaware’s experience against the national benchmark² for adult health status reveals that, at every education level and in every racial or ethnic group, adults in Delaware are not as healthy as they could be.

Prepared for the RWJF Commission to Build a Healthier America by the Center on Social Disparities in Health at the University of California, San Francisco. Source: 2005-2007 Behavioral Risk Factor Surveillance System Survey Data.

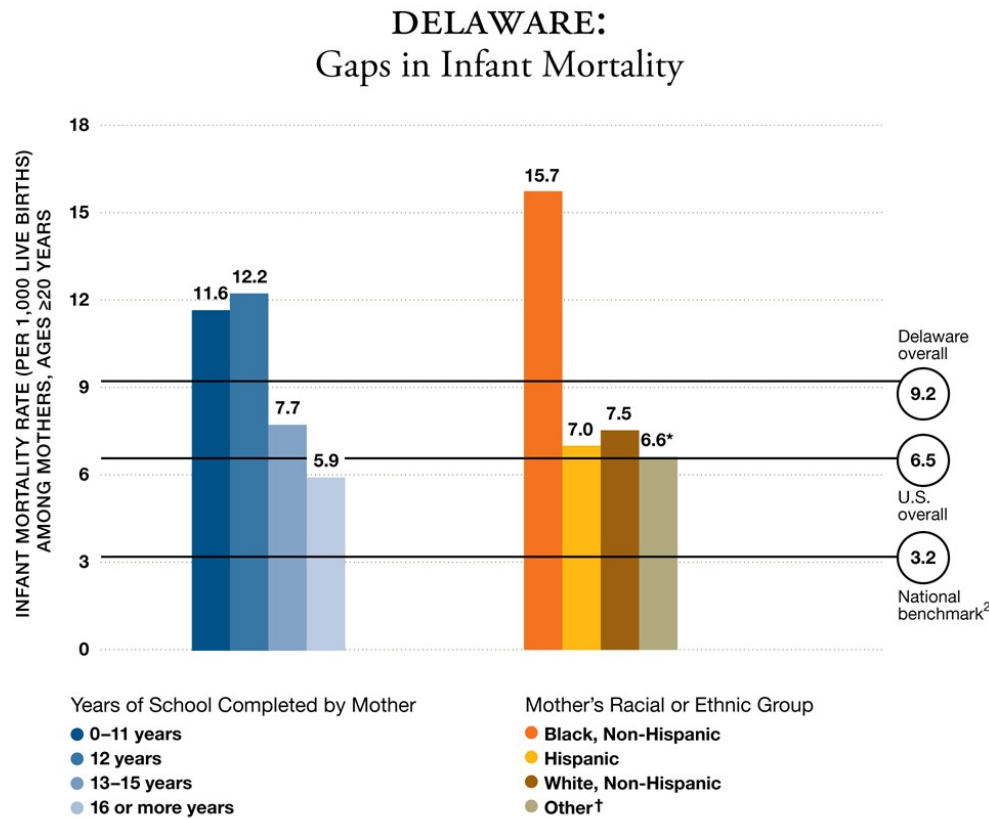
¹ Based on self-report and measured as poor, fair, good, very good or excellent.

² The national benchmark for adult health status represents the level of health that should be attainable for all adults in every state. The benchmark used here—19.0 percent of adults in less than very good health, seen in Vermont—is the lowest statistically reliable rate observed in any state among college graduates who were non-smokers with leisure-time physical exercise. Rates with relative standard errors of 30 percent or less were considered to be statistically reliable.

† Defined as any other or more than one racial or ethnic group, including any group with fewer than 3 percent of surveyed adults in the state in 2005-2007.

Source: Robert Wood Johnson Foundation, 2009.

Figure 13. Infant mortality rate according to educational attainment and race/ethnicity of mother in Delaware



Infant mortality rates¹—a key indicator of overall health—vary by mother’s education and racial or ethnic group in Delaware.

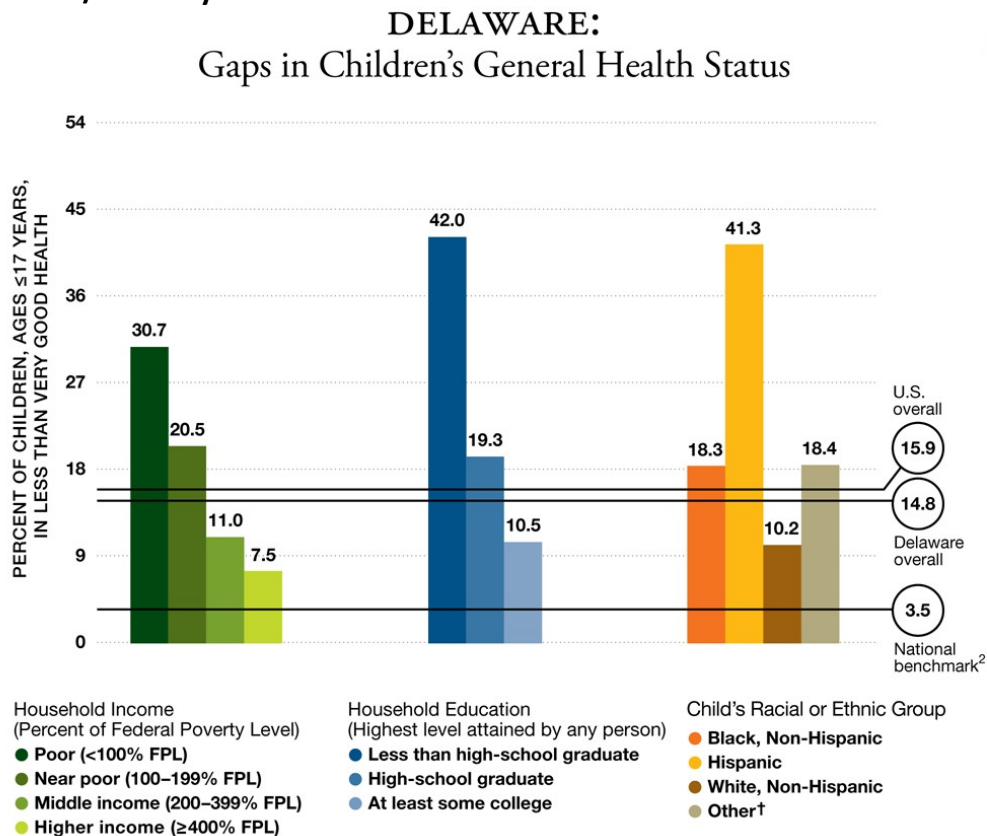
- Compared with babies born to the most-educated mothers, babies born to mothers with less education appear more likely to die before reaching their first birthdays. The infant mortality rates for babies born to mothers with 12 or fewer years of schooling are twice the rate for babies born to mothers with 16 or more years of schooling.
- The infant mortality rate among babies born to non-Hispanic black mothers is twice the rates seen among babies of non-Hispanic white or Hispanic mothers.

Comparing Delaware’s experience against the national benchmark² for infant mortality reveals unrealized health potential among Delaware babies across maternal education and racial or ethnic groups. Infants in every group could do better.

Prepared for the RWJF Commission to Build a Healthier America by the Center on Social Disparities in Health at the University of California, San Francisco.
 Source: 2000-2002 Period Linked Birth/Infant Death Data Set.
 1 The number of deaths in the first year of life per 1,000 live births.
 2 The national benchmark for infant mortality represents the level of mortality that should be attainable for all infants in every state. The benchmark used here—3.2 deaths per 1,000 live births, seen in New Jersey and Washington state—is the lowest statistically-reliable rate among babies born to the most-educated mothers in any state.
 * Rate based on fewer than 20 infant deaths and considered statistically unreliable.
 † Defined as any other or unknown racial or ethnic group, including any group representing fewer than 3 percent of all infants born in the state during 2000-2002.

Source: Robert Wood Johnson Foundation, 2008.

Figure 14. Percent of children in less than very good health according to household income, educational attainment and race/ethnicity in Delaware



Within Delaware, children's general health status¹ varies by family income and education and by racial or ethnic group. Children in the least-advantaged groups typically experience the worst health, but even children in middle-class families appear to be less healthy than those with greater advantages.

- Children in poor families are four times as likely and children in near-poor families are approximately 2.5 times as likely to be in less than optimal health as children in higher-income families.
- Children in households without a high-school graduate are four times as likely to be in less than optimal health as children living with someone who has completed some college.
- Hispanic children are four times as likely and non-Hispanic black children are nearly twice as likely to be in less than optimal health as non-Hispanic white children.

Comparing Delaware's experience against the national benchmark² reveals unrealized health potential among Delaware children in every income, education and racial or ethnic group.

© 2008 Robert Wood Johnson Foundation
www.commissiononhealth.org

Prepared for the RWJF Commission to Build a Healthier America by the Center on Social Disparities in Health at the University of California, San Francisco.

Source: 2003 National Survey of Children's Health.

¹ Based on parental assessment and measured as poor, fair, good, very good or excellent. Health reported as less than very good was considered to be less than optimal.

² The national benchmark for children's general health status represents the level of health that should be attainable for all children in every state. The benchmark used here—3.5 percent of children with health that was less than very good, seen in Colorado—is the lowest statistically-reliable rate observed in any state among children whose families were not only higher income but also practiced healthy behaviors (i.e., non-smokers and at least one person who exercised regularly).

† Defined as any other or more than one racial or ethnic group, including any group with fewer than 3 percent of children in the state in 2003.

Source: Robert Wood Johnson Foundation, 2008.

It is becoming increasingly evident that important differences in health indicators exist by geographic location, which is related to, but distinct from, other socioeconomic factors.

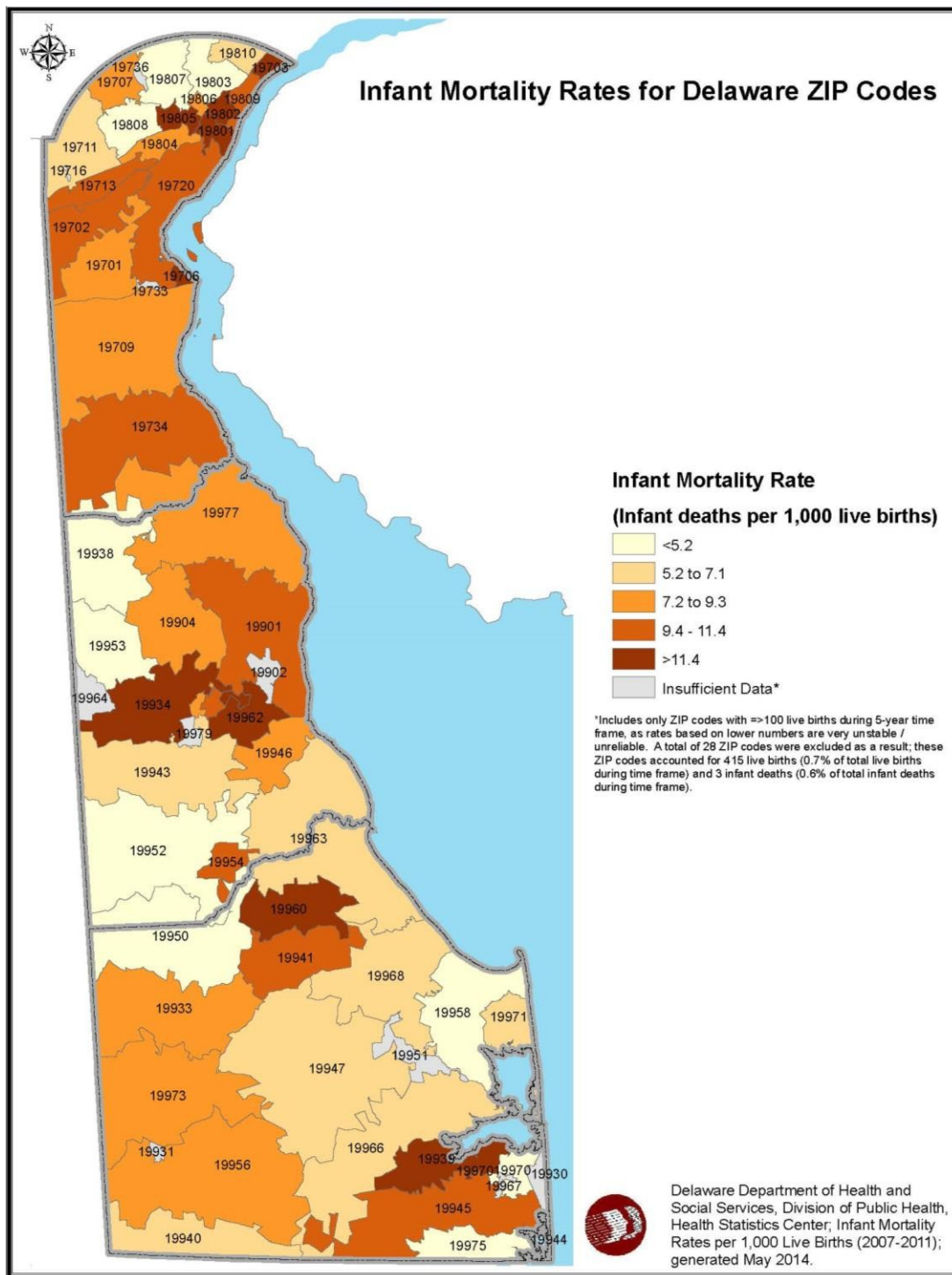
According to the *CHSA* (DHSS, 2013):

- ❖ HIV/AIDS rates are highest in New Castle County (with a rate of 44.4 percent in the City of Wilmington).
- ❖ Obesity has increased at faster rates in recent years in New Castle County than in Kent or Sussex County.
- ❖ Although cancer death rates are generally decreasing, Kent County has the highest rate and is decreasing at the slowest pace.
- ❖ Kent County sheltered 337 women and children victims of domestic violence in 2010, compared to 212 women and children victims in Sussex and New Castle County combined.
- ❖ In 2010, there were 18 days on which ozone levels surpassed the eight-hour safe limit; 14 days were in New Castle County, five were in Kent County, and nine were in Sussex County. (Note that of the 18 days, there were some days in which the ozone levels were high in more than one county, hence the overlap.)

Figures 15, 16, and 17 depict maps, produced by DPH and the Office of State Planning Coordination (OSPC), which illustrate geographic variations in infant mortality rates (Figure 15) and life expectancy (Figure 16). Figure 17 depicts how certain geographic areas have a preponderance of health-related risk factors and burdens compared with other parts of the state. This map was generated by calculating a cumulative measure of selected variables: infant mortality, life expectancy, median income, and high school graduation rates. It should not be interpreted as confirming direct causal linkages between social determinants of health (SDOH) and health outcomes; more analysis is needed to provide that level of understanding. Rather, it is meant to provide a visual representation of selected SDOH and related health indicators across the state, and to highlight areas of opportunity for improvement.

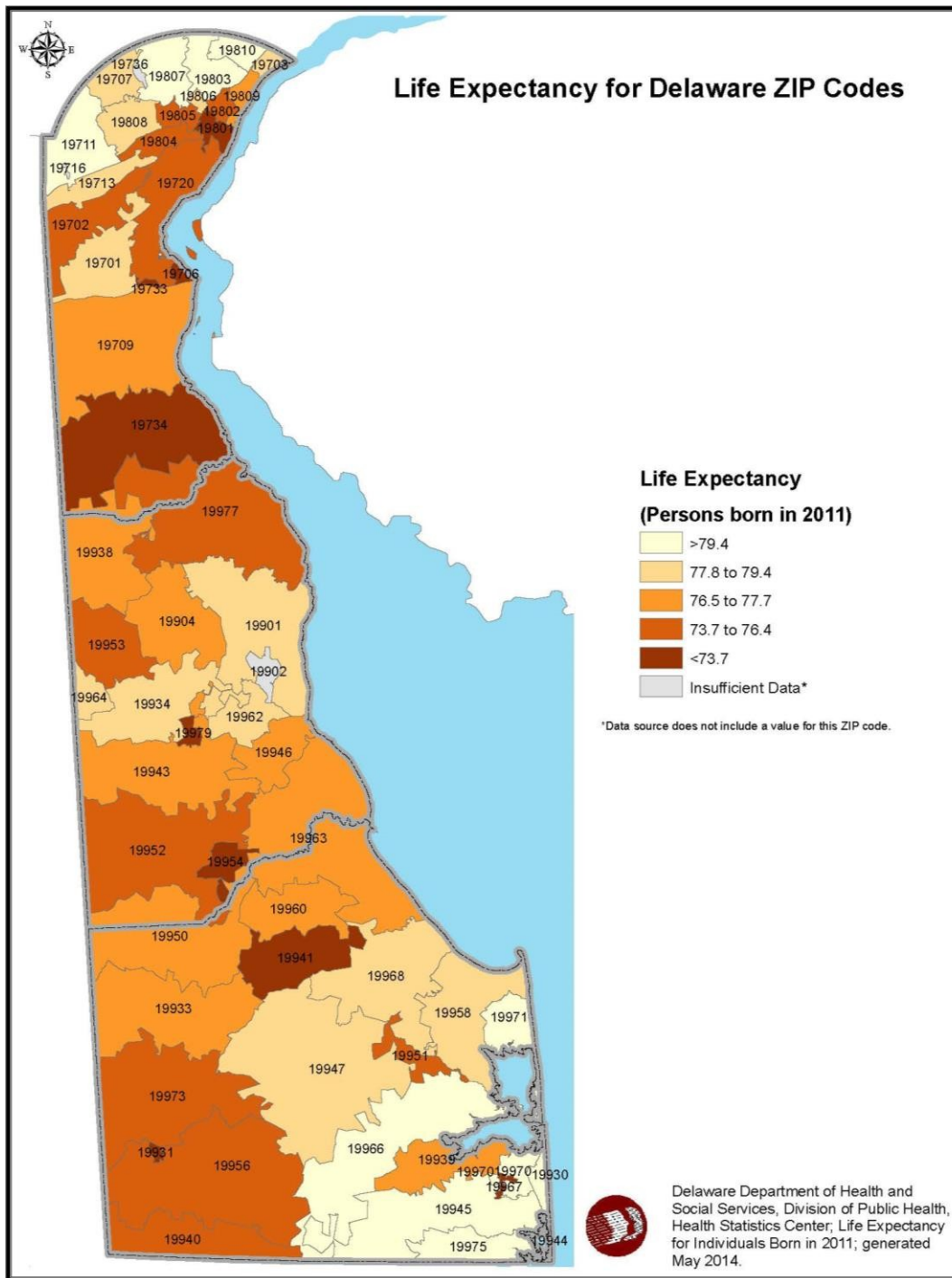
Importantly, these figures provide only snapshots of selected indicators of health status; they are not comprehensive nor do they reflect changes over time. Similarly, the data are aggregated at the ZIP code level, which may obscure differences that could emerge at smaller geographic levels (e.g. census tracts or block groups). Despite these limitations, and remembering the stream parable (Section 1), one can clearly see on these maps that the communities with the darkest shades are those with the weakest bridges and fences, and individuals living near them are more at risk of falling into the stream of poor health outcomes.

Figure 15. Infant mortality rates according to ZIP code in Delaware



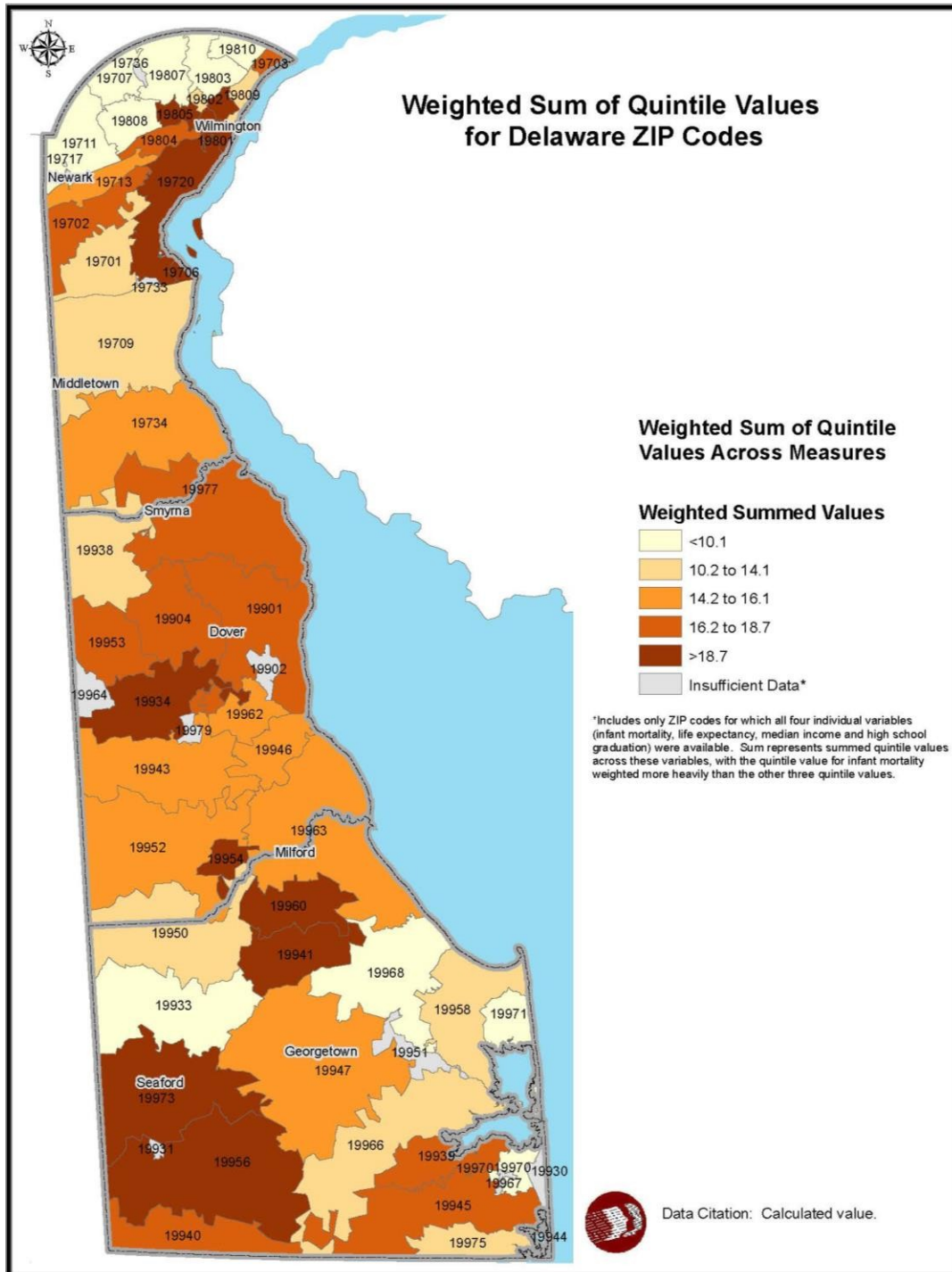
Source: Delaware Division of Public Health and Office of State Planning Coordination, 2014.

Figure 16. Life expectancy according to ZIP code in Delaware



Source: Delaware Division of Public Health and Office of State Planning Coordination, 2014.

Figure 17. Cumulative measure of selected health-related burdens according to ZIP code in Delaware



Source: Delaware Division of Public Health and Office of State Planning Coordination, 2014.

The Economic Case for Change

Health care spending in the United States has been described as excessive and unsustainable. The U.S. leads the world in per capita health care spending at almost twice the average of other wealthy developed countries. However, the health outcomes in the U.S. are relatively poor in comparison. Health care spending in the U.S. has generally grown faster than that in most other countries and, for several decades, has consumed a greater share of gross domestic product than other countries.

There is growing evidence that poor quality environments and unmet social needs have a negative impact on health care spending. This is not surprising, given the relation between social conditions and health. For instance, if poor quality housing contributes to increased rates of lead poisoning, asthma, and other respiratory conditions (Krieger & Higgins, 2002), it follows that spending to treat those conditions is higher in areas with poor housing than in areas with higher quality housing. While this makes sense intuitively, the tools to effectively measure the economic burden of social inequities in health have only recently become available.

In 2009, researchers LaVeist, Gaskin, and Richard conducted an analysis of the economic burden of racial inequalities in health. They estimated that

“Social justice can be cost effective” (LaVeist, Gaskin, & Richard, 2009).

eliminating health disparities would have reduced direct medical care expenditures by approximately \$230 billion between 2003 and 2006. Furthermore, indirect costs (such as lost productivity) associated with illness and premature death were estimated to be more than \$1 trillion for the same time period. Combined, this equates to \$309.3 billion lost annually from the United States’ economy due to health disparities. The authors of the study emphasize the ethical case for change, and offer this economic analysis as additional support for action. They conclude that “social justice can be cost effective” (LaVeist, Gaskin, and Richard, 2009, p. 235).

While aggregate health care spending hurts the overall economy and draws resources from other policy priorities, rising health care costs also burden private businesses. According to one report, businesses in the U.S. spent a staggering \$496 billion on health care services and supplies in 2006 alone. At the same time, employees who do not receive adequate health care have higher rates of absenteeism and lower rates of productivity, which negatively impacts the bottom line. One study found that indirect costs associated with unscheduled absences and productivity losses associated with family and personal health problems costs U.S. employers \$225.8 billion annually (Stewart, Ricci, Chee, & Morganstein, 2003).

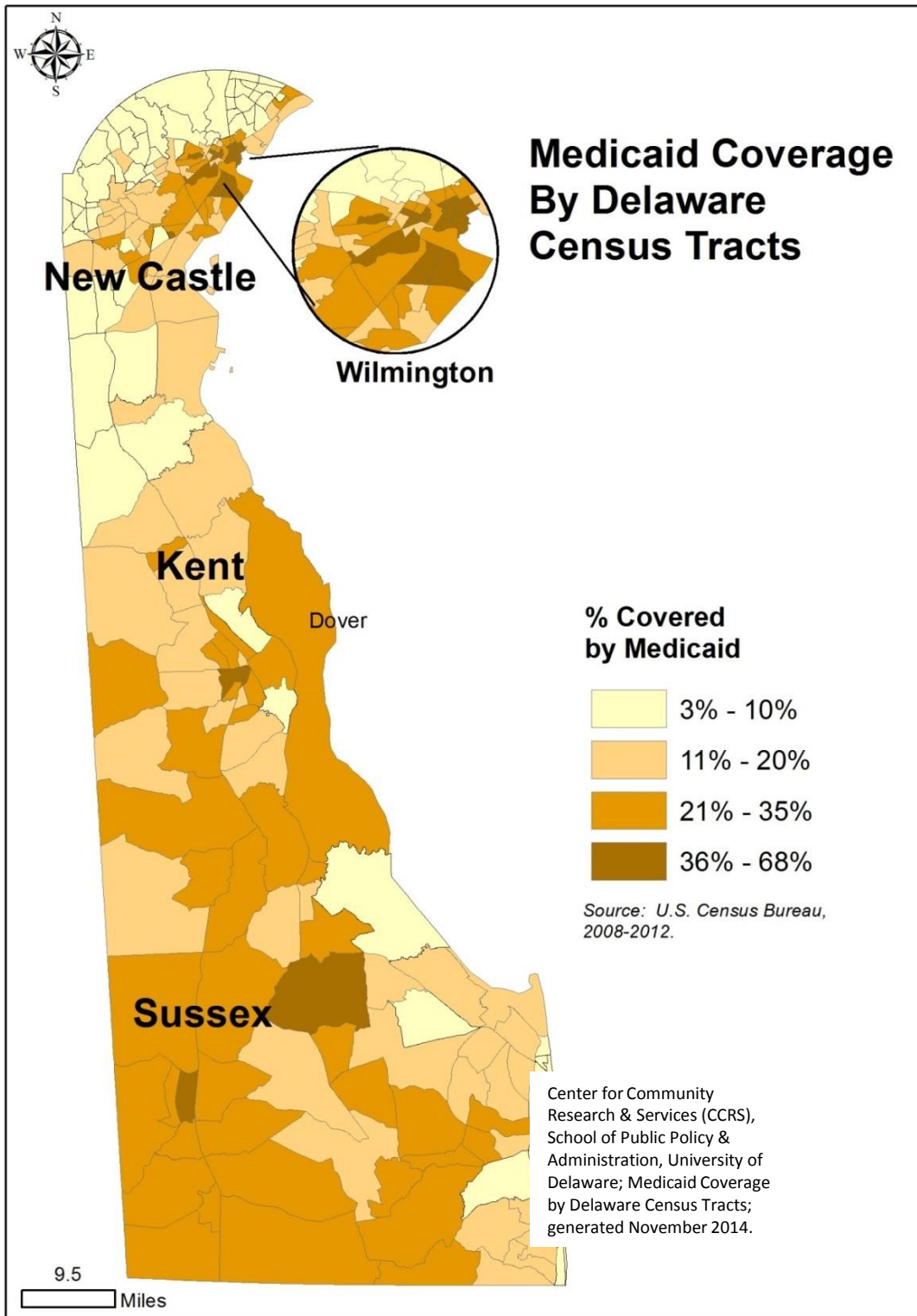
Health care Spending in Delaware

Health care expenditures in Delaware generally mirror national trends. In 2009, Delaware spent approximately \$8,480 per capita (including both public and private spending) for health care services. This places Delaware as one of the top five states in per capita health care spending (CMS, 2013).

Even prior to Medicaid expansion through the Affordable Care Act, Delaware's expenditures for Medicaid—the publicly funded insurance program for low income families, children, pregnant women, and people with disabilities—have increased steadily since 1996 and exceeded 17 percent of the state's 2013 budget (CMS, 2013). Approximately one-quarter of the state's population is enrolled in the Medicaid program and more than half of all births in the state were financed by Medicaid in 2009 (DPH, 2011). This is relevant to the economic case for change, considering that Medicaid is a resource available to low income persons and the amount of money spent due to income inequities exceeds what would be spent if those inequities were absent. Figure 18 illustrates the percent of Delaware's population covered by Medicaid. It is not surprising that the communities with the highest concentration of Medicaid enrollment mirror those communities with other social burdens and health needs. This further makes the case for investing in prevention in Delaware's low income communities.

Approximately 500,000 residents, or 55 percent of Delawareans, are covered by private insurance. The average family premium per enrolled employee in employer-based health insurance was approximately \$15,600 in 2012, slightly above the national average. This includes approximately \$4,100 paid by the employee and approximately \$11,500 paid by the employer.

Figure 18. Medicaid coverage by census tract in Delaware



Source: Center for Community Research & Services, 2014.

The rate of preventable hospitalization is an indicator often used to assess the quality of health care services in a particular area. According to the Agency for Healthcare Research and Quality (AHRQ), hospitalizations may be avoided if clinicians effectively diagnose, treat, and educate patients and if patients actively participate in their care and adopt healthy lifestyle behaviors. Higher rates of preventable hospitalizations may pinpoint areas in which improvements can be made in the quality of the health care system. Preventable hospitalizations may also be viewed as an indicator of efficiency within the system, based on the understanding that spending on preventable hospitalizations is unnecessary and less cost effective than prevention. For example, asthma is a condition that may result in preventable hospitalization because patients may be hospitalized if they do not receive adequate outpatient care or do not have access to appropriate medications. Asthma is also a condition that is directly influenced by environmental factors, such as air quality and housing conditions. Therefore, hospitalization may be avoided by increasing access to care and treatment and by improving air quality and housing conditions. Overall, Delaware ranks seventeenth in the country for its rate of preventable hospitalizations, according to America's Health Rankings, an annual report produced through a partnership between the United Health Foundation, the American Public Health Association, and the Partnership for Prevention.

Poor performance of the health care system—including excessive and potentially unnecessary spending, inadequate access to care, and poor or uneven quality of care—have driven reform efforts for decades. The Affordable Care Act (ACA), passed in 2010, aims to reduce costs, increase access, and improve quality of care. Embedded in many provisions of the ACA are opportunities to address social determinants of health and reduce health inequities, particularly through investments in community health.

Health System Reform and Incentives for Investing in Community Health

Increased awareness and understanding of how the social and physical environments impact health and health inequities is occurring at a time when the nation's health care system is undergoing immense change. The current health care landscape, including the passage of the ACA and promotion of the "Triple Aim," has created new opportunities and incentives for health care providers to pay more attention to the SDOH.

The Triple Aim is a framework originally developed by the Institute for Healthcare Improvement. It aims to optimize health system performance. The framework draws attention to three interrelated goals that are meant to be pursued simultaneously:

- Improving the patient experience of care (including quality and patient satisfaction)
- Improving the health of populations

➤ Reducing the per capita cost of health care

Many public and private health care providers have adopted this approach, which is supported and reinforced through various ACA provisions. The ACA's expansion of health insurance for low- and moderate-income individuals reduces the financial barrier to accessing primary care for millions of individuals. This also gives providers the opportunity to address patient care in a more holistic and prevention-oriented manner rather than the episodic or urgent care that is more typical among those without adequate health insurance. Additionally, new models of care have emerged which enhance patient care through improved care coordination, and allow real-time linkage of patients to local social service agencies and related services. One such model is the patient-centered medical home (PCMH).

The ACA's expansion of health insurance may also create new opportunities for hospital community benefit programs. According to a recent study, most non-profit hospitals, which are required to dedicate a portion of their revenue to provide community benefits, have done so in the form of discounted or uncompensated care for uninsured or underinsured individuals (Young et al., 2013). With fewer uninsured individuals, hospitals may now use their Community Benefit Programs for community-oriented prevention efforts. Similarly, the ACA now requires tax-exempt hospitals to regularly conduct community health needs assessments and to develop plans to address those needs (Young et al., 2013). This offers further incentive for hospitals to use community benefit programs to address upstream community needs and work to improve population health.

According to a recent report by the Commonwealth Fund (Bachrach et al., 2014), specific payment reform efforts, such as value-based purchasing and outcomes-based payment models, provide new economic incentives for providers to address patients' social needs. For instance, Medicare's Hospital Readmission and Reduction Program, created through the ACA, gives hospitals financial incentives to avoid readmissions by reducing payments to those hospitals where patients with certain medical conditions readmit within 30 days of their prior discharge. Although readmissions may be linked to health care quality, evidence also demonstrates a link between social factors and risk of readmissions. Other payment mechanisms that promote managing care, such as capitated, global, and bundled payments, also provide an incentive for providers to address patients' unmet social needs, which helps improve health outcomes. This is in contrast to traditional fee-for-service models that theoretically incentivize the quantity of services versus the quality of care.

The Commonwealth Fund report also highlights indirect economic benefits of health care providers investing in social interventions in the form of increased employee productivity, provider satisfaction, and patient satisfaction (Bachrach et al., 2014). Strategies that address patients' social needs free up physicians and other health care providers to address more

immediate physical needs and increase their time spent providing direct medical care to patients. Since providers can bill for the time spent with the patient, this increases provider income and promotes provider satisfaction, as they believe they are providing higher quality care. Higher quality care, in turn, translates into higher patient satisfaction.

Health System Reform in Delaware

The Affordable Care Act created a Center for Medicare and Medicaid Innovation (CMMI), housed within the Centers for Medicare and Medicaid Services (CMS), to test innovative payment and service delivery models to reduce expenditures, while preserving or enhancing quality of care. Delaware was awarded funding from the CMMI State Innovation Model (SIM) initiative to test a plan for transforming the State's health care system in ways that improve quality and reduce costs. Over \$622 million in Model Test awards will support 11 states that are ready to implement their State Health Care Innovation Plans.

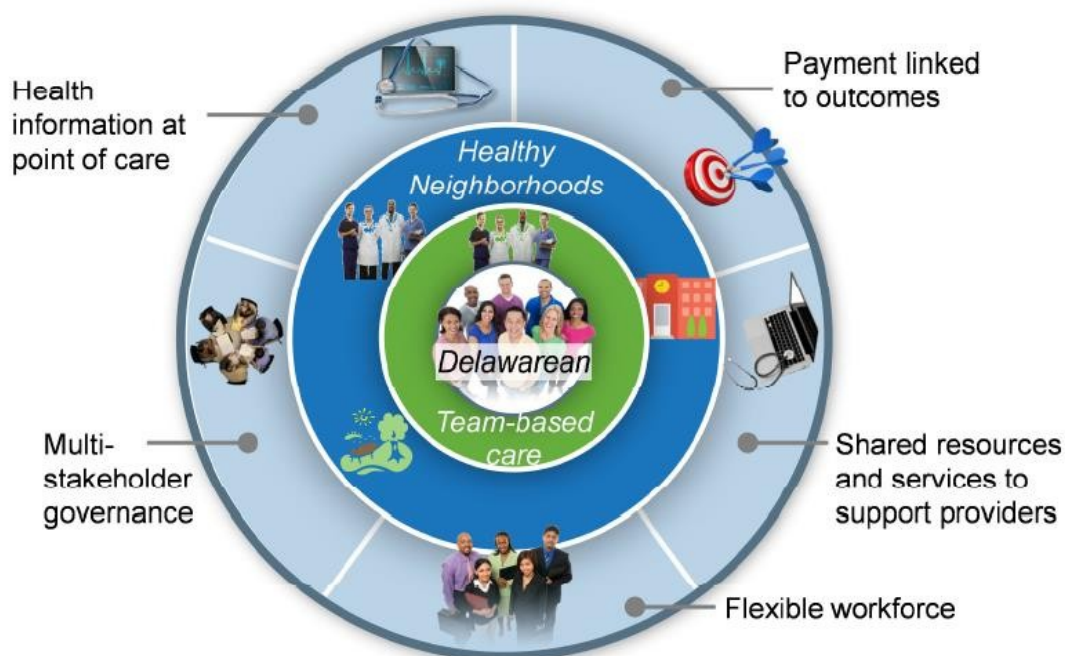
A State Health Care Innovation Plan is a fully developed proposal capable of creating statewide health transformation for the preponderance of care within a state. In addition, a State Health Care Innovation Plan describes a state's strategy to utilize available regulatory and policy levers to accelerate transformation, such as plans to align quality measures, leverage the adoption and implementation of health information technology and health information exchange, and evaluate innovative efforts. CMS will work with Model Test states for four years.

Delaware's State Healthcare Innovation Plan was developed through an extensive and collaborative planning process and provides the basis for a subsequent application to CMMI for funding to implement the plan. The Delaware SIM Plan is organized around six work-streams—delivery system, population health, payment model, data and analytics, workforce, and policy—that contribute to achieving the Triple Aim of improving the health of Delawareans, improving the patient experience of care, and reducing health care costs.

The Delaware SIM Plan is grounded in an understanding of three major structural barriers to an effective health system. The first barrier is that the prevailing payment model incentivizes volume or quantity, rather than quality of care provided. Secondly, the health system in Delaware is fragmented, and coordination of care is often lacking. Finally, Delaware's approach to population health does not integrate public health, health care delivery, and community resources in ways that promote health and an efficient use of resources. The framework illustrated in Figure 19 highlights the major components of Delaware's strategy to overcome these barriers.

Figure 19. Delaware’s framework for health system reform

EXHIBIT 1: FRAMEWORK FOR DELAWARE’S HEALTH TRANSFORMATION



Source: Delaware Health Care Commission, 2013.

The Delaware SIM Plan’s focus on *Healthy Neighborhoods* as a way to transform Delaware’s approach to population health is viewed as a critical element to achieving the Triple Aim and leveraging resources for health equity. More specifically, Delaware’s *Healthy Neighborhood* program will provide resources for individual communities to identify and address community-specific health needs through targeted interventions. The program’s intent is to integrate public health and health care delivery on the local level, match existing community assets and resources with community-defined needs, and prioritize investments accordingly. In this way, *Healthy Neighborhoods* is consistent with the integrated approach recommended by the Secretary’s Advisory Committee for *Healthy People 2020* and is supported by the Delaware Division of Public Health’s health equity strategy, both of which are described in (Section 2).

Combined, increased focus on the SDOH and shifting toward more prevention-oriented and integrated systems of care create an important window of opportunity to advance health equity. Delaware appears poised to create a more effective, inclusive, and comprehensive health system that better addresses the entire continuum of health determinants, from the upstream social conditions to the downstream delivery of care. The potential benefits of such a system—for individuals, communities, businesses, and the state—are immense.

Addressing the Health Equity Continuum

Addressing health equity requires a multi-pronged approach. Figure 20, reproduced courtesy of the Bay Area Regional Health Inequity Initiative (BARHII), highlights the continuum of strategies needed for advancing health equity. This framework illustrates the need for public health activities to refocus upstream, while simultaneously shifting the way that critical downstream services are provided. To refer to the river parable, we need to build stronger bridges and fences *and* we need to do a better job ensuring everyone who falls into the river of poor health/health outcomes gets rescued with high quality care. This continuum also reflects the multi-sector and integrated approach taken by *Healthy People 2020*, which is described on page 27.

Importantly, to address all components of the continuum, the public health workforce, health care workforce, and partners need to provide culturally competent care. The National Center for Cultural Competence acknowledges that there are multiple definitions of cultural competence. Of particular relevance to the themes of this guide, the Office of Minority Health within the U.S. DHHS defines cultural competence as “having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors and needs presented by consumers and their communities” (OMH, 2001). Due to the breadth of services that public health agencies, health care systems, and community-based organizations provide, and the range of populations that these services target, it is imperative that the workforces of these agencies are culturally competent. Workforces should represent the diversity of the populations that they serve, including the ability to communicate with non-English speaking populations. For more information regarding cultural competence, the National Center for Cultural Competence provides numerous resources and tools (see <http://nccc.georgetown.edu/>).

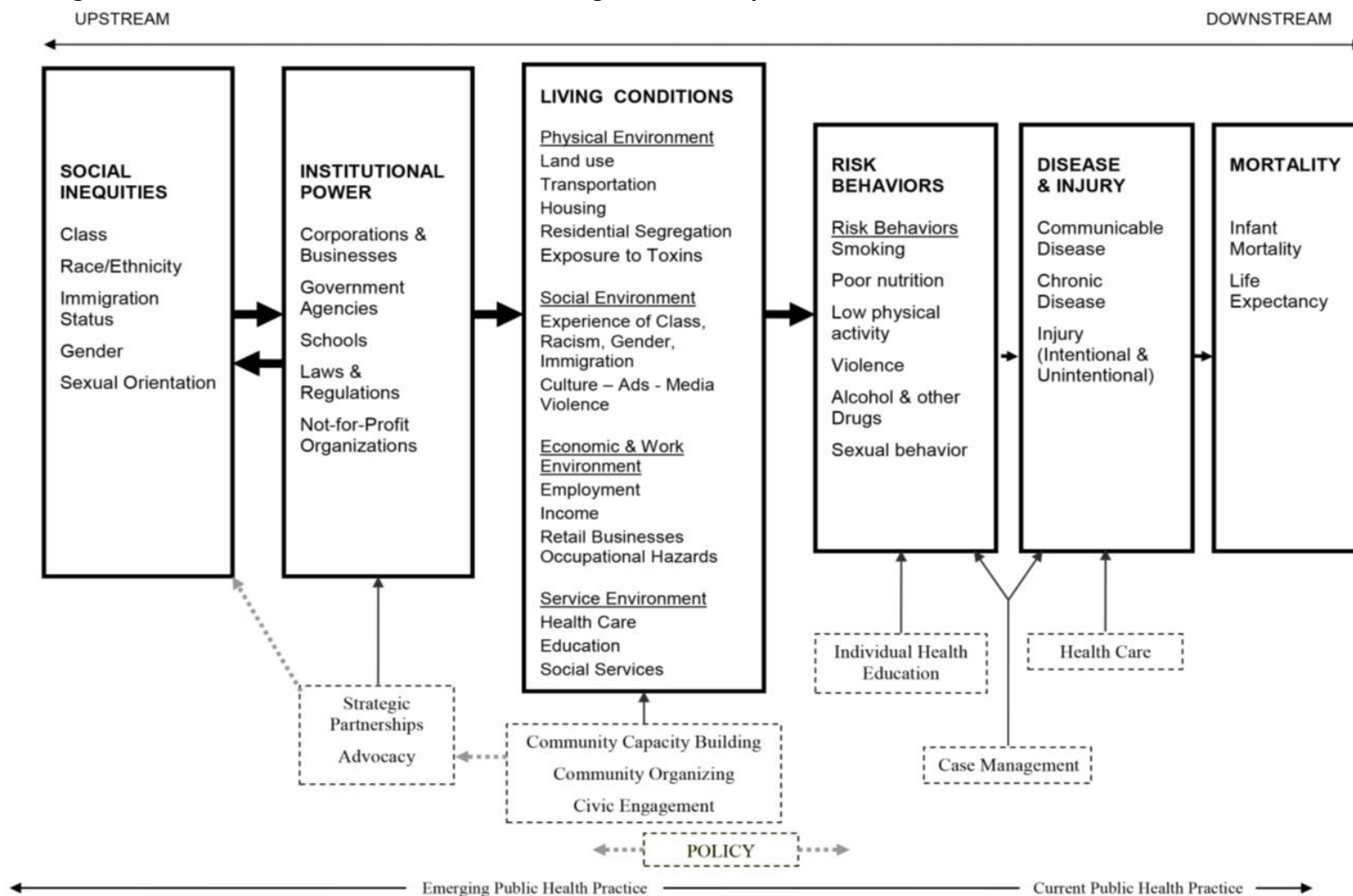
The following three sections provide examples of strategies and resources for public health professionals, health care providers, and others to improve the conditions that create health and those that reduce health inequities. Section 4 describes upstream strategies for community health, including place-based and community-oriented strategies to address living and working conditions. Consistent with the framework below, Section 4 includes a discussion of community capacity-building, partnerships, and civic engagement.

Section 5 describes upstream strategies for health care providers, including ways in which providers can incorporate upstream approaches in their service delivery and/or provide care that is more equity-oriented. Section 5 highlights opportunities within the health care system to address the psychosocial needs of patients and provide more coordinated care that can connect patients to resources in the community. Section 6 highlights policy-oriented

approaches that can support or facilitate the changes described in the previous two sections and address underlying social inequities in a more direct and systemic way.

Together, the information and examples provided in the following sections represent a comprehensive effort to address health equity. Although it may not be feasible to address all of the factors identified in the framework in every community in our state, a comprehensive approach is ideal for achieving meaningful and sustainable change.

Figure 20. Public Health Framework for Reducing Health Inequities



Source: Bay Area Regional Health Inequity Initiative, 2013.

Glossary – Section 3

Community Benefit Program: Most hospitals and health systems in the United States are incorporated as not-for-profit entities. To maintain tax exemption status, not-for-profit hospitals must dedicate a portion of their revenue to providing community benefits. Activities often include improving access to care for uninsured or under-insured individuals, health education efforts, and other strategies to promote community health.

Cultural Competence: “Having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities” (OMH, 2001).

Medicaid: A publicly funded insurance program for low-income families and other eligible aged, blind, and/or disabled people whose income is insufficient to meet the cost of necessary medical services. Medicaid pays for: doctor visits, hospital care, labs, prescription drugs, transportation, routine shots for children, and mental health and substance abuse services.

Preventable hospitalizations: Hospitalizations that may be avoided with high quality primary and preventive care, including living a healthy lifestyle; also referred to as “potentially preventable hospitalizations” or “ambulatory care sensitive conditions.”

Primary Care Medical Home: A team-based health care delivery model led by a physician that provides comprehensive and coordinated medical care to patients with the goal of obtaining maximized health outcomes. Care coordination, which may require additional resources such as health information technology and payment incentives, is an essential component of the PCMH. PCMHs are also referred to as “patient-centered medical homes” or simply “medical homes.”

Triple Aim: A framework developed by the Institute for Health care Improvement to optimize health system performance by simultaneously pursuing three dimensions: improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of health care.

References and Additional Resources

Association of State and Territorial Health Officials. *The Economic Case for Health Equity Issue Brief*. Retrieved from <http://www.astho.org/Programs/Health-Equity/Economic-Case-Issue-Brief/>

Bachrach, D., Pfister, H., Wallis, K. & Lipson, M. (2014). *Addressing patients' social needs: An emerging business case for provider investment*. Retrieved from http://www.commonwealthfund.org/~media/files/publications/fund-report/2014/may/1749_bachrach_addressing_patients_social_needs_v2.pdf

Bay Area Regional Health Inequalities Initiative. (2013) *Health Equity and Community Engagement Report*. Retrieved from <http://barhii.org/resources/health-equity-community-engagement-reports/>

Centers for Medicare and Medicaid Services [CMS]. (2013). National Health Expenditure Data. Retrieved from <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html>

Choose Health Delaware. December 2013. *Delaware's State Health Care Innovation Plan*. Retrieved from <http://dhss.delaware.gov/dhss/dhcc/cmmi/files/choosehealthplan.pdf>

Delaware Health and Social Services. Delaware Health Care Commission. <http://dhss.delaware.gov/dhcc/>

Delaware Health and Social Services, Division of Public Health [DE DPH]. (2011). *Delaware vital statistics annual report, 2009*. Delaware Health Statistics Center. Retrieved from <http://www.dhss.delaware.gov/dph/hp/files/lb09.pdf>

Delaware Health and Social Services, Division of Public Health [DHSS]. (2013). *Community Health Status Assessment 2013*. Retrieved from <http://www.dhss.delaware.gov/dhss/dph/files/shachsa.pdf>

Delaware Division of Public Health. (2008). *Delaware racial and ethnic health disparities health status report card*. Retrieved from <http://www.dhss.delaware.gov/dhss/dph/mh/files/2008dredreportcard.pdf>

Galea, S., Tracy, M., Hoggatt, K., Dimaggio, C., Karpati, A., et al. (2011). Estimated deaths attributed to social factors in the United States. *American Journal of Public Health, 101*(8), 1456-1465.

Georgetown University. (n.d.). National Center for Cultural Competence. Retrieved from <http://nccc.georgetown.edu/>.

Georgetown University. (n.d.). *Definitions of Cultural Competence*. Retrieved from <http://www.ncccurrecula.info/culturalcompetence.html>

The Henry J. Kaiser Family Foundation. (2014). State Health Facts. Retrieved from www.kff.org/statedata

Himmelstein, D., Warren, E., Thorne, D., Woolhandler, S. MarketWatch: Illness and injury as contributors to bankruptcy. *Health Affairs, Web Exclusive*. Retrieved from <http://content.healthaffairs.org/content/suppl/2005/01/28/hlthaff.w5.63.DC1>

Institute for Healthcare Improvement. *IHI Triple Aim Initiative*. Retrieved from <http://www.ihl.org/engage/initiatives/TripleAim/Pages/default.aspx>

Kabel, C. What is the future of hospital community benefit programs? *Stanford Social Innovation Review*. Retrieved from http://www.ssireview.org/blog/entry/what_is_the_future_of_hospital_community_benefit_programs

Kids Count. (2015). Infant Mortality. Retrieved from <http://datacenter.kidscount.org/data/tables/6051-infant-mortality#detailed/2/9/true/867,133,38,35,18/any/12718,12719>

Krieger, J., & Higgins, D. L. (2002). *Housing and Health: Time Again for Public Health Action*. *American Journal of Public Health*, 92(5), 758–768.

LaVeist, Gaskin, & Richard. (2009). *The Economic Burden of Health Inequalities in the United States*. Washington, D.C.: Joint Center for Political and Economic Studies. Retrieved from http://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1224&context=sphhs_policy_facpubs

Methodist Healthcare. (2013). Health Systems Learning Group (HSLG) Executive Summary. Retrieved from <http://www.methodisthealth.org/about-us/faith-and-health/research/learning-collaborative/>

National Business Group on Health. (February 2009). *Eliminating racial and ethnic health disparities; a business case update for employers*. Retrieved from http://www.minorityhealth.hhs.gov/Assets/pdf/checked/1/Eliminating_Racial_Ethnic_Health_Disparities_A_Business_Case_Update_for_Employers.pdf

Robert Wood Johnson Foundation Commission to Build a Healthier America. (2009). Adult health status: Snapshot of Delaware. Retrieved from <http://www.commissiononhealth.org/PDF/DelawareSnap.pdf>

Robert Wood Johnson Foundation Commission to Build a Healthier America. (2009). A snapshot of Delaware's children. Retrieved from http://www.commissiononhealth.org/PDF/RWJ039_StateSnaps_Delaware.pdf

State of Delaware, Division of Public Health & Office of State Planning Coordination [DPH/OSPC]. (2014).

Stewart, W., Ricci, J., Chee, E., Morganstein, D. (2003). Lost productive work time costs from health conditions in the United States: results from the American Productivity Audit. *Journal of Occupational and Environmental Medicine*, 45(12), 1234-46

United Health Foundation. (2014). America's Health Rankings. Retrieved from <http://www.americashealthrankings.org/>

U.S. Department of Health and Human Services, Office of Minority Health [OMH]. (2001). *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report*. Retrieved from <http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf>

Wilkinson, R. G., & Pickett, K. E. (2006). Income inequality and population health: A review and explanation of the evidence. *Social Science & Medicine*, 62(7), 1768-1784.

Young, G., Chou, C., Alexander, J. Lee, S.D., & Raver (2013). Provision of community benefits by tax-exempt U.S. hospitals. *NEJM*, 368, 1519-1527.

SECTION 4: Upstream Strategies for Community Health

This section focuses on the upstream strategies necessary to improve living conditions. As outlined in the Public Health Framework for Reducing Health Inequities (Figure 21), these strategies target the physical, social, economic and work, and service environment through community capacity building, community organizing, and civic engagement. Related strategies include building strategic partnerships and engaging in advocacy to change the underlying structures that determine living conditions.

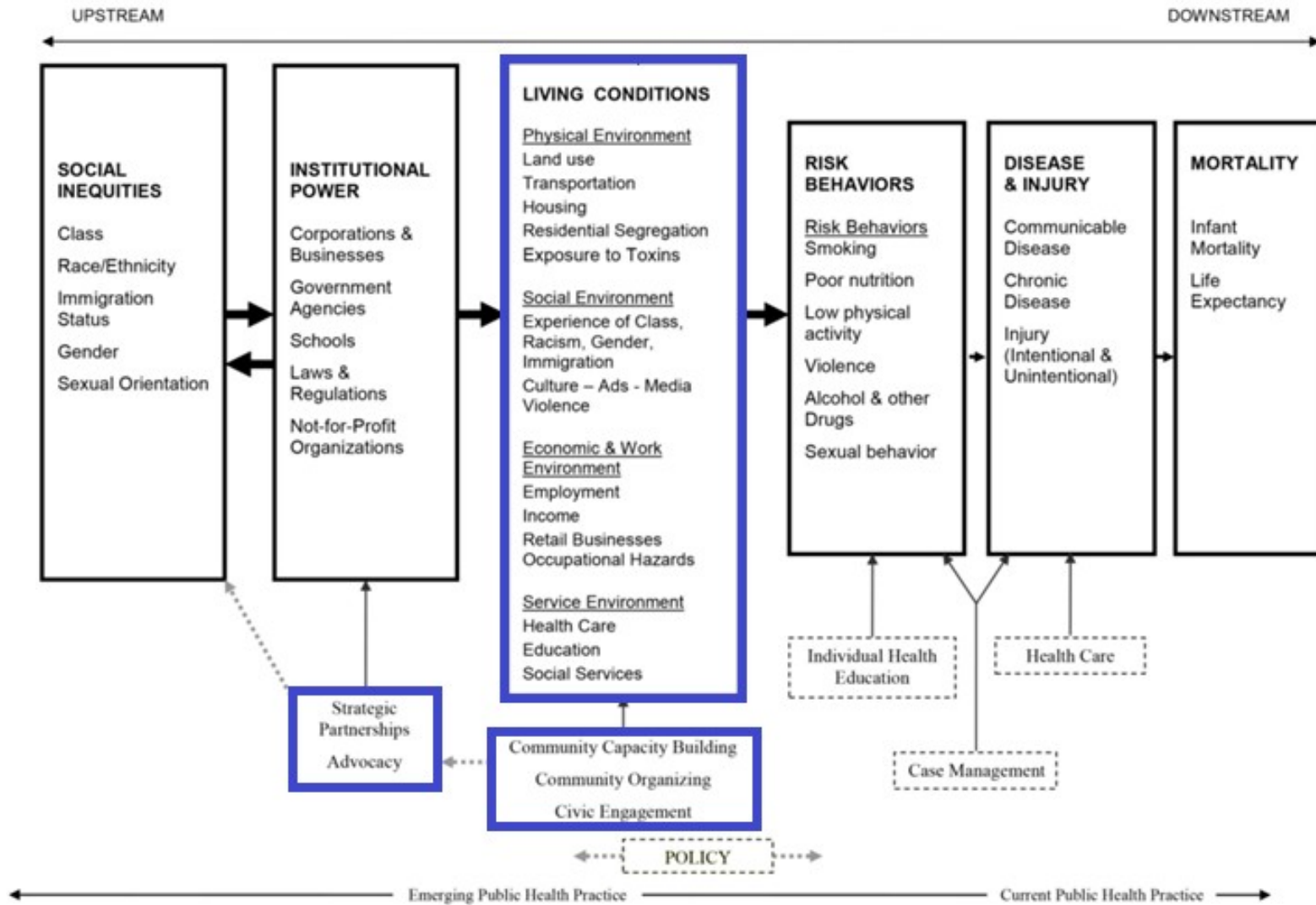
By improving living conditions, we will create healthy communities and, ultimately, improve health equity. According to *Healthy People 2020*, a healthy community is one that continuously improves its physical and social environments, thereby helping people to support one another to develop to their fullest potential. In other words, a healthy community is one in which all of its residents have the resources needed to thrive: clean air and water, parks and green space, healthy food, affordable housing, jobs and income, transit, and positive social interactions. It is easy to envision a healthy community because it is one in which each of us would like to live, raise our children, and grow old.

“Healthy places are those designed to improve the quality of life for all people who live, work, worship, learn, and play within their borders” (CDC).

For everyone to thrive, a healthy community must also include social justice, equity, and sustainable resources. A healthy community must be free of all forms of discrimination and allow everyone an opportunity to participate in its governance. According to the Work Group for Community Health and Development at the University of Kansas:

“Like a truly healthy human body, a truly healthy community is one in which all systems function as they should, and work together to make the community function well. In an individual, health is, to a large extent, a result of all the body’s billions of cells getting what they need. For a community, health is, to a large extent, the result of all citizens getting what they need, not only to survive, but to flourish” (Community Tool Box, Chapter 2).

Figure 21. Public Health Framework for Reducing Health Inequities



Source: Bay Area Regional Health Inequity Initiative, 2013.

Regardless of whether a community is healthy or less healthy, opportunities for improvement exist across the continuum. As discussed in the Introduction, *all* communities need strong bridges and fences, and maintaining a healthy community takes continuous effort. Furthermore, given what we know about the social gradient in health and the social determinants of health (SDOH), everyone can be healthier. Therefore, every community holds the potential to be a healthier place to live.

Understandably, some health professionals become overwhelmed by the complex web of challenges and apparent disadvantages in less healthy communities. But those communities simply have more areas for improvement. A seemingly modest change can build upon itself or be leveraged to promote greater changes and impact. An investment in one area can stimulate investments in other areas. A new playground that brings families together can inspire an adjacent community garden. Removing graffiti and improving the lighting along a sidewalk invites people outside, simultaneously discouraging vandals and other criminal activity. And a new corner store can encourage additional commercial activity and investment.

Communities can be defined in many different ways. Traditionally, communities are conceptualized as geographic areas. In terms of healthy equity, communities are often defined broadly and can also refer to groups of people that share certain characteristics, values, or a common social identity. Furthermore, a community is often best defined by the members of that community. While we appreciate the importance of various definitions of community, for the purposes of this guide, we draw attention to the geographic definition of community and the idea that communities are physical places. Growing evidence suggests that there are healthy places to live and less healthy places to live. Furthermore, the differences between healthy and less healthy places cannot be explained by the characteristics of the people living in those places, such as income or race.⁵ According to the Centers for Disease Control and Prevention (CDC), healthy places are those designed and built to improve the quality of life for all people who live, work, worship, learn, and play within their borders—where every person is free to make choices amid a variety of healthy, available, accessible, and affordable options (<http://www.cdc.gov/healthyplaces/about.htm>). The concepts of healthy communities and healthy places from *Health People 2020* and the CDC, respectively led to the development of place-based initiatives for improving health.

⁵ For a more technical discussion of the contextual effects of the environment on health, see Macintyre, Ellaway and Cummins, 2002.

Place-Based Initiatives (PBIs)

Health-oriented strategies that are focused on living conditions in specific communities are often described as “place-based initiatives” (PBIs) because the target of the interventions is the place itself (or characteristics of the place), rather than the people living in that place. For instance, place-based strategies to address obesity may include working with fast-food establishments to offer healthy food options as opposed to more traditional people- or population-based approaches, such as health education to change eating habits. Comprehensive approaches recognize that both place-based and people-based strategies are important, and this is reflected in Figure 21. However, PBIs are generally considered to be more effective at addressing underlying root (upstream) causes of unhealthy behaviors. PBIs are the focus of this section because they address the health inequities we currently see in the distribution of resources and hazards across communities.

PBIs are not exclusive to health. A 2009 memo from the Office of the White House addressed to the leaders of all executive departments and agencies called for greater attention to place-based efforts to increase the impact of government dollars (see http://www.whitehouse.gov/sites/default/files/omb/assets/memoranda_fy2009/m09-28.pdf). The memo highlights the interconnected nature of the economy, environment, and health at the local level and urges stakeholders to embrace place-based approaches to promote the prosperity, equity, sustainability and livability of places. The Department of Education’s *Promise Neighborhoods* initiative exemplifies the Obama Administration’s attention to PBIs, by focusing resources on a comprehensive range of factors in the community that lead to better educational outcomes. Similarly, the Department of Housing and Urban Development’s *Choice Neighborhoods* initiative is aimed at transforming poor neighborhoods into places with sustainable, mixed-income housing. Importantly, both of these initiatives support locally-driven, collaborative strategies for improving community conditions to address complex social problems. Place-based initiatives for health and health equity are similarly characterized by:

- a concentration of resources and interventions in a defined geographic area;
- integrated and holistic approaches to addressing the determinants of health;
- an investment in early intervention and prevention;
- multi-sector participation and collaboration;
- community engagement, participation, ownership, and leadership;
- a good understanding of the community (needs, resources, priorities, etc.);

- a focus on long-term and sustainable changes; and
- advocacy and policy change.

Dimensions of PBIs for Health Equity

As highlighted in Figure 21, four main dimensions of the environment fall under the heading of “living conditions”: physical environment, social environment, economic and work environment, and service environment. These may be viewed as dimensions of PBIs for health equity because they account for the most critical levers of meaningful change at the local level. Here we describe the relations between each dimension and health equity, along with strategies for improving conditions in each dimension. Note that much of the content for these descriptions comes from the publication *Why Place Matters: Building a Movement for Healthy Communities*, produced by PolicyLink in 2007. Additional details and case studies highlighting activities to promote community health along each dimension can be found at http://www.policylink.org/sites/default/files/WHYPLACEMATTERS_FINAL.PDF.

Physical Environment. The physical environment includes both the natural environment (i.e. parks and green space) and the built environment (i.e. roads and sidewalks). The physical environment can influence health directly. For instance, the quality of the air we breathe can be directly linked to asthma rates, such that people living in poorer air quality areas (such as near highways) experience higher rates of asthma. The physical environment also impacts health indirectly by influencing health-related behaviors. For instance, the existence of sidewalks and bike lanes can promote physical activity, while poor lighting or graffiti can discourage people from being outside.

Healthy places have an abundance of health protective, or health promoting, factors such as safe parks and green space, walkable neighborhoods, quality mixed-income and racially diverse housing, healthy food outlets, public transportation, and access to other kinds of community resources that encourage residents to gather together socially. In contrast, unhealthy places tend to be characterized by risk, or health damaging, factors such as substandard housing and residential segregation, abandoned buildings and lots, run-down or non-existent sidewalks and parks, toxic environmental exposures (i.e. lead or air pollution), physical barriers for people with disabilities, and a high concentration of tobacco, alcohol, and fast food retailers.

The quality of the physical environment—natural and built—varies from place to place, which contributes to health inequities along geographic lines. For this reason, *Healthy People 2020* emphasizes improving neighborhood living conditions to promote health equity.

Sample Strategy

Asthma disproportionately affects low-income children due to the poor air quality in their homes, schools, and neighborhoods. Indoor and outdoor triggers and pollutants cause trips to the emergency room and school absences. In urban areas, diesel particles from ports and heavy traffic have been linked to worsening asthma. Across the country, communities are addressing this issue by improving public transportation and holding industries and governments more accountable for environmental impacts, particularly concerning air quality. Indoor air quality is being improved by enhancing ventilation in older school buildings and enforcing housing codes in low-income housing residences.

In June 2014, the Delaware Division of Public Health (DPH) launched the Healthy Homes initiative in partnership with Nemours Health and Prevention Services and four housing authorities. The initiative aims to reduce asthma triggers while promoting healthier and safer home environments in targeted communities. The program educates families and provides tools to create and maintain home environments free of common contaminants. Pilot programs are also underway in each of Delaware's three counties to provide training and technical assistance to local housing authorities. Representatives from the Wilmington Housing Authority, the Delaware State Housing Authority, the Dover Housing Authority, and a privately owned and managed housing agency in Laurel receive several hours of training and technical assistance. The pilot programs support the development of integrated pest management plans at the building level, which expands upon the training and resources offered to individual families. In this way, the Healthy Homes initiative contributes to a healthier physical environment.

For more information and examples of efforts to address childhood asthma, as well as other strategies for improving the physical environment, visit <http://www.policylink.org/sites/default/files/asthma.pdf>. For more about Delaware's Healthy Homes initiative, visit <http://www.dhss.delaware.gov/dhss/dph/hsp/healthyhomes.html>.

Social Environment. The social environment refers to the relationships between community members and the factors that affect those relationships. Places where residents work together, welcome diversity, and have a strong sense of community are places with social capital. Social capital is the strength of relationships among community residents, and is a protective factor. Strong social ties, community cohesion, and civic participation promote health and equity. A well-known study about the 1995 heat wave in Chicago that resulted in hundreds of deaths, particularly among the elderly, revealed that residents of neighborhoods with low levels of

social capital were much more likely to die than residents of neighborhoods with high levels of social capital (Klinenber, 2002). Elderly survivors had neighbors and friends to check on them and provide assistance, whereas the deceased were often isolated and lived in areas that lacked social cohesion.

Social capital may also be viewed in terms of the collective identity of a neighborhood and the sense of solidarity that such a collective identity can promote. This is important from the standpoint of health equity because it supports and enhances community empowerment and collective action. The presence of social capital in this regard may be directly associated with community residents' control over the decisions that affect their living conditions because it strengthens their positions with businesses or institutions that may put the community at risk. For example, when a landlord threatens to displace tenants by increasing rent beyond what is affordable for residents, members of tenant associations can organize to resist such a change that would harm their community. Similarly, strong social capital is appealing to businesses and others considering investments in the community. Like neighborhood beautification projects, social capital is attractive.

Conversely, social segregation, lack of community cohesion, and weak ties put communities at risk for disinvestment and threaten community well-being. Communities with limited social capital are less likely to organize and advocate for themselves. They may also experience more crime and may be viewed negatively by those outside of the community. All of these contribute to disinvestment, lack of resources, and discrimination. According to Bell and Rubin (2007):

“The impacts of a community’s social environment on health run the gamut from psychological to political, with consequences for the physical and economic environments. A community with strong social networks is better able to advocate for itself, its residents better able to control their individual and collective futures” (p. 31).

Sample Strategy

Urban agriculture and urban farms not only improve economic and health outcomes among low-income families but also foster a sense of community. Community gardens have recently gained popularity through First Lady Michelle Obama’s “Let’s Move!” campaign. Community gardens are believed to reduce obesity and other chronic diseases by improving diets among low-income residents. Community gardens provide a unique opportunity to engage vulnerable individuals—including youth, people who are homeless, and those who are incarcerated—in valuable job training. Residents involved with urban farms can generate supplemental income

by selling produce through farm stands, Community-Supported Agriculture (CSA) programs, and at farmers' markets. Community gardens transform vacant urban spaces into safe green spaces and link different sectors of the community to achieve common goals.

In Delaware, beginning in 2014, Kent Gardens brings together businesses, non-profit organizations, and individuals to build community gardens in Kent County. Partners include: the City of Dover, Delaware Electric Cooperative, Delaware State University, Dover High School, Dover Housing Authority, 4-H, Kent Kids Coalition, Greater Kent Committee, Lowes, Nemours Health and Prevention Services, and many others. The initiative brings the community together to provide healthy food for local residents. In addition, the gardens serve as an avenue to teach children where their food comes from and the importance of agriculture. Community gardens are located in Simon Circle, Kirkwood, Manchester Square, Owens Manor, and Dover High School. These efforts represent community assets that improve the social environment and promote health equity. More information about Kent Gardens can be found at <http://www.greaterkentcommittee.org/kent-community-gardens.html>. For examples of other kinds of community garden projects, as well as other strategies for improving the social environment, visit <http://www.policylink.org/sites/default/files/urban-agriculture.pdf>.

Economic and Work Environment. The economic and work environment is closely linked with physical and social environments, considering that businesses are necessary to provide jobs and support parks, healthy foods, and other retail establishments. Having a strong business sector is a protective factor in that it promotes financial security among residents through living wage jobs, it encourages homeownership, and it attracts other kinds of community investments. A vibrant retail sector, including a full service grocery store, also promotes healthy behaviors and contributes to increased social capital.

Hazardous working conditions and low wage jobs, on the other hand, can threaten the health of community residents in many ways. Poverty is among the strongest determinants of poor health and is closely tied with low educational attainment and other threats to personal and community well-being. Concentrated poverty (geographical areas with high levels poverty) is associated with high levels of stress and risky coping behaviors, such as tobacco use and substance abuse. Communities without a strong economy and financial and job security are at risk of a host of poor health outcomes.

Sample Strategy

A living wage is defined as the minimum income needed to meet basic needs. It is generally thought to be higher than the minimum wage set by the federal government, which since the 1970s has been considered inadequate for workers to live at a safe and sufficient standard of living. Living wage ordinances have emerged in response to the declining “real value” of the minimum wage. The basic philosophy behind the living wage movement is that someone working full-time should not be poor (PolicyLink, 2002).

The first living wage provision in the U.S. was passed in Baltimore, Maryland in 1994. By 2007, there were at least 140 living wage ordinances in U.S. cities and more than 100 living wage campaigns underway in other cities. Living wage policies typically require that local governments pay, and can only contract with companies that pay, a living wage. Therefore, living wage provisions apply to companies that provide municipal services and those receiving any government subsidies or financial assistance. There are several advantages to living wage provisions, including:

- improving living standards;
- encouraging governments to employ local workers on public projects, instead of sub-contracting to the lowest bidder;
- alleviating poverty;
- reducing the strain on government welfare programs; and
- stimulating the economy.

Researchers have estimated the wage needed to meet basic needs for individuals and families living in Delaware. As seen in Table 3, the state’s minimum wage is far below the living wage in each of its three counties. This has serious consequences, considering that families living on Delaware’s minimum wage are likely to experience poor health outcomes and struggle with competing financial priorities, such as shelter, food, and health care.

Table 3. Hourly Rate that an individual must earn to support their family, if they are the sole provider and are working full-time, in Delaware, in 2013

	1 Adult	1 Adult and 2 Children
New Castle County		
Living Wage	\$10.80	\$26.47
Minimum Wage	\$7.25	\$7.25
Kent County		
Living Wage	\$10.01	\$24.56
Minimum Wage	\$7.25	\$7.25
Sussex County		
Living Wage	\$9.59	\$24.08
Minimum Wage	\$7.25	\$7.25

Source: Glasmeier, 2014.

Unfortunately, in 2015, a living wage campaign is not high on Delaware’s legislative agenda. However, other efforts are underway to improve the economic environment, which may alleviate some of the disadvantages of living on minimum wage. For example, the Blueprint Communities Program is helping to build economically, physically, and socially vibrant neighborhoods in several communities by developing the capacity of community stakeholders to plan and implement comprehensive revitalization plans. Blueprint Communities throughout Delaware include: Edgemoor Gardens, Simonds Gardens, Historic Overlook Colony and Vicinity in New Castle County; Wilmington’s Browntown, Eastside, 2nd District, Westside/Little Italy and Riverside communities; Dover; and the Town of Georgetown.

“Blueprint Communities” is an initiative of the Federal Home Loan Bank (FHLB) of Pittsburgh, which selected the University of Delaware’s Center for Community Research and Service (CCRS) as its partner to develop and lead the comprehensive training, coaching, and capacity-building program in Delaware. CCRS provides training, technical assistance, and coaching to self-developed teams comprised of community leaders, bankers, public officials, developers, and health and social service providers. The training aims to help them learn how to develop community revitalization plans that include implementable projects. The CCRS trainings enable the teams to obtain new knowledge and skill sets while engaging them in leadership development. Teams produce well-developed written plans with feasible projects that will improve their communities economically, physically, and socially.

Launched in 2008, the Blueprint Communities Program realized many positive impacts within its first two years. That success includes the development of nine plans which triggered more than \$27 million in community development programs; the construction or rehabilitation of 118 housing units; 10 infrastructure improvements; and the launch of six other community projects. As a result of these changes, the FHLB of Pittsburgh committed \$250,000 toward the

affordable housing initiatives and \$215,000 in business loans. The Delaware Community Investment Corporation, the Delaware Community Foundation, several local banks, and the Jessie Ball du Pont Fund provided another \$325,000 in grants (FHLB, 2011). An important focus of the Blueprint Community planning teams is to include employment opportunities for members of their various communities in the projects and programs designed in their revitalization plans. Since 2010, several full and part-time jobs, with salaries above minimum wage, were created and sustained through Blueprint Community project or program implementation. Additionally, in three of the Blueprint Communities, access to fresh, healthy produce is another strategic focus resulting in the establishment of community gardens and small businesses.

Ultimately, however, an increase in the minimum wage is necessary to improve the state's economic conditions for Delawareans to thrive and achieve optimal health. This can be accomplished through living wage campaigns and ordinances. For examples of living wage efforts, as well as guidance for ways to develop a living wage campaign, visit:

<http://www.policylink.org/sites/default/files/living-wage-provisions.pdf>.

Service Environment. It is not surprising that high quality, accessible, and affordable health care services contribute to the health of a community. However, other kinds of services such as high performing schools, strong public safety, efficient public transportation, good sanitation services, churches, clubs, and recreational services also contribute to a community's health. For instance, after-school programs and recreation centers provide space for social interaction and positive youth development. Senior centers offer similar opportunities for older residents to interact socially and promote physical activity. Sanitation services affect health directly by reducing environmental hazards and indirectly by promoting a clean and more appealing place to live and work. Good schools contribute to good health in many ways, including short-term effects on literacy and long-term impacts on employment and wealth. Similarly, efficient and accessible public transportation services can reduce reliance on fossil fuels, ease traffic congestion, and reduce air pollution while lowering residents' transportation costs, promoting physical activity, and improving access to jobs and other community services. Additionally, public transit can simultaneously improve the social environment by promoting social ties.

A lack of any of these services can put communities at higher risk for poor health and often discourages investment, which inhibits other services from existing locally. For example, lack of adequate public safety services and sanitation can be linked to higher crime rates. Inaccessible and/or poor quality health care, or care that is not culturally appropriate, can contribute to poor outcomes because residents are unable to get appropriate treatment when they are ill.

Communities without recreational services or community centers may lack opportunities for social interaction. Finally, communities that lack dependable public transportation cannot link residents with jobs or other community services. Overall, deficiencies in the availability and quality of services prevent communities from attaining optimal health.

Sample Strategy

Transit-oriented development has been described as “a planning and design trend that seeks to create compact, mixed-use, pedestrian-oriented communities located around new or existing public transit stations” (Policylink, 2008). Transit-oriented development has grown tremendously over the past several years, and the approach is highly regarded because it contributes to healthy communities. However, transit-oriented development without adequate attention to equity can lead to gentrification and displacement of lower-income residents. Community engagement in the transit-oriented development planning process is critical. Many Community Development Corporations are now facilitating this approach and empowering communities to take the lead. For examples of community-led transit-oriented development that promote health equity, including strategies, challenges, and recommendations, visit http://policylink.org/sites/default/files/transit-oriented-development_0.pdf.

Delawareans have paid considerable attention to transit-oriented development in recent years, even including it in a broad effort to promote “Complete Communities.” Complete communities are livable, sustainable, and meet the needs of people of all ages, abilities, ethnicities, and income levels (<http://completecommunitiesde.org/introduction/>). According to Scott and colleagues (2010) from the University of Delaware’s Institute for Public Administration (IPA):

“A new vision for transportation policy and planning has emerged that includes a focus on community livability, transportation accessibility, and transportation equity. Livable communities integrate transportation and land-use planning to achieve more sustainable growth, development, and accessibility of residents. The new vision for transportation policy and planning also stresses the need to invest in transportation accessibility—or multi-modal transportation systems that serve people of all ages, abilities, ethnicities, and incomes. Transportation and land-use planning need to be assimilated to manage growth, focus on infill development, preserve community character, and provide equitable and accessible transportation options” (p. 1).

Such a comprehensive and integrated approach requires intersectoral collaboration and strong community engagement, similar to other health equity approaches described

throughout this guide. In partnership with the Delaware Office of State Planning Coordination, the Delaware Department of Transportation, and the Delaware Association of Realtors, experts from IPA developed a “Complete Communities Planning Toolbox.” The Toolbox helps build local capacity to develop “complete communities” planning approaches, community design tools, and public engagement strategies. The Toolbox and related resources (including a review of best practices for complete communities) may be accessed at <http://completecommunitiesde.org/getting-started/>.

Four dimensions of healthy communities—the physical, social, economic and work, and service environments—are interrelated and interdependent. Many of the risk and protective factors described could fit within multiple dimensions (e.g. parks could be described within the physical environment as well as the service environment). Similarly, the strategies highlighted for each dimension are likely to have positive impacts across other dimensions. For instance, the complete communities approach is described in relation to its impact on the service environment, but the effect on other aspects of community well-being may be viewed in the context of the physical, social, and economic and work environments and the connections between each. It is unnecessary to specify or prioritize a dimension when promoting place-based initiatives. Rather, the distinctions among the four dimensions are intended to organize the discussion and can be useful in identifying areas for intervention.

Implementing PBIs for Health Equity

Recommended strategies for implementing PBIs for health equity are consistent with evidence-based strategies for building healthy communities in general. Through its work as a designated World Health Organization (WHO) Collaborating Centre for Community Health and Development, the Kansas University Work Group for Community Health and Development created “The Community Tool Box” (CTB). This tool box is a comprehensive, online, and publicly available resource for people working collaboratively to build healthier communities. According to the Kansas University Work Group for Community Health and Development:

“Building healthier cities and communities involves local people working together to transform the conditions and outcomes that matter to them. That civic work demands an array of core competencies, such as community assessment, planning, community mobilization, intervention, advocacy, evaluation, and marketing successful efforts. Supporting this local and global work requires widespread and easy access to these community-building skills.

However, these skills are not always learned, nor are they commonly taught either in formal or informal education.”

To ensure access to the necessary knowledge and skills needed to build healthy communities, the Kansas University Work Group for Community Health and Development made their community tool box widely available. The contents are exhaustive and include 46 chapters through which users can obtain practical, step-by-step guidance in community-building skills. The Table of Contents, including the major sections of the tool box, is reproduced as Figure 22. Importantly, some sections are more relevant than others to specific communities and individual place-based efforts. However, it is valuable to see the extent of topics covered in the Community Tool Box, as this reflects the complexity of working with communities and the need for a different approach than what was traditionally used in health promotion and disease prevention.

Figure 22. Kansas University Community Tool Box Table of Contents

Overview: An overview of the Community Tool Box and frameworks for guiding, supporting and evaluating the work of community and system change		Chapter 22: Youth Mentoring Programs	11. Influencing Policy Development	
Chapter 1: Our Model for Community Change and Improvement		Chapter 23: Modifying Access, Barriers and Opportunities		
Chapter 2: Other Models for Promoting Community Health and Development		Chapter 24: Improving Services		
		Chapter 25: Changing Policies		
		Chapter 26: Changing the Physical and Social Environment		
Community Assessment: Information about how to assess community needs and resources, get issues on the public agenda, and choose relevant strategies		Cultural Competence and Building Inclusive Communities: Information on understanding culture and diversity, how to strengthen multicultural collaboration, and building inclusive communities		
Chapter 3: Assessing Community Needs and Resources	<i>Related Toolkits:</i> 2. Assessing Community Needs and Resources	Chapter 27: Cultural Competence in a Multicultural World	9. Enhancing Cultural Competence	
Chapter 4: Getting Issues on the Public Agenda		Chapter 28: Spirituality and Community Building		
Chapter 5: Choosing Strategies to Promote Community Health and Development		Chapter 29: The Arts and Community Building – Celebrating, Preserving, and Transforming Community Life		
Promoting Interest and Participation in Initiatives: Information about how to promote interest in an issue (e.g. press releases) and how to encourage involvement among diverse stakeholders		Organizing for Effective Advocacy: Information on advocacy principles, advocacy research, providing education, direct action campaigns, media advocacy, and responding to opposition		
Chapter 6: Promoting Interest in Community Issues	<i>Related Toolkits:</i> 1. Creating and Maintaining Partnerships 8. Increasing Participation and Membership	Chapter 30: Principles of Advocacy	10. Advocating for Change	
Chapter 7: Encouraging Involvement in Community Work		Chapter 31: Conducting Advocacy Research		
		Chapter 32: Providing Encouragement and Education		
		Chapter 33: Conducting a Direct Action Campaign		
		Chapter 34: Media Advocacy		
Developing a Strategic Plan and Organizational Structure: Information about developing a strategic plan and organizational structure, recruiting and training staff and volunteers, and providing technical assistance		Chapter 35: Responding to Counterattacks		
		Evaluating Community Programs and Initiatives: Information on developing a plan for evaluation, evaluation methods, and using evaluation to understand and improve the initiative		
Chapter 8: Developing a Strategic Plan	<i>Related Toolkits:</i> 5. Developing Strategic and Action Plans 15. Improving Organizational Management and Development	Chapter 36: Introduction to Evaluation	12. Evaluating the Initiative	
Chapter 9: Developing an Organizational Structure		Chapter 37: Operations in Evaluating Community Interventions		
Chapter 10: Hiring and Training Key Staff of Community Organizations		Chapter 38: Some Methods for Evaluating Comprehensive Community Initiatives		
Chapter 11: Recruiting and Training Volunteers		Chapter 39: Evaluation to Understand & Improve the Initiatives		
Chapter 12: Providing Training and Technical Assistance		Maintaining Quality & Rewarding Accomplishments: Information on achieving & maintaining quality performance, public reporting, providing incentives, & honoring colleagues & community champions		
Leadership and Management: Information about the core functions of leadership, management, and group facilitation		Chapter 40: Maintaining Quality Performance		
Chapter 13: Orienting Ideas in Leadership	<i>Related Toolkits:</i> 6. Building Leadership	Chapter 41: Rewarding Accomplishments		
Chapter 14: Core Functions in Leadership		Generating, Managing, and Sustaining Financial Resources: Information on writing grants, preparing an annual budget, and planning for financial sustainability		
Chapter 15: Becoming an Effective Manager		Chapter 42: Getting Grants and Financial Resources	14. Writing a Grant Application for Funding	
Chapter 16: Group Facilitation and Problem-Solving		Chapter 43: Managing Finances		
		Chapter 44: Investing in Community Resources		
Analyzing Community Problems and Designing and Adapting Community Interventions: Information about analyzing community problems to design, choose, and adapt interventions for different cultures and communities		Social Marketing and Institutionalization of the Initiative: Information on conducting a social marketing effort (promoting awareness, interest, and behavior change), and planning for long-term sustainability.		
Chapter 17: Analyzing Community Problems and Solutions	<i>Related Toolkits:</i> 3. Analyzing Problems & Goals 7. Developing an Intervention	Chapter 45: Social Marketing of Successful Components of the Initiative	13. Implementing a Social Marketing Effort 14. Sustaining the Work or Initiative	
Chapter 18: Deciding Where to Start		Chapter 46: Planning for Long-Term Institutionalization		
Chapter 19: Choosing and Adapting Community Interventions				
Implementing Promising Community Interventions: Information on illustrative interventions using various strategies for change				
Chapter 20: Providing Information and Enhancing Skills	<i>Related Toolkits:</i> 7. Developing and Intervention			
Chapter 21: Enhancing Support, Incentives, and Resources				

Source: Kansas University, 2014. Retrieved from <http://ctb.ku.edu/en/table-of-contents>.

Readers are highly encouraged to visit www.ctb.ku.edu to access the CTB and related materials. Each chapter has detailed sections describing key elements of the strategy along with related checklists, examples, and PowerPoint presentations. Associated toolkits include detailed instructions and examples. In addition to these resources, the CTB website includes a troubleshooting guide for identifying and addressing common problems in community health work as well as a database of best practices. There is an online course for community health promotion as well as an “Ask an Advisor” feature, which links users with community leaders and experts in the field. Furthermore, because health equity raises specific issues that warrant additional attention, some of the topics included in the CTB are discussed in greater detail in Section 6 (policy-oriented strategies) and Section 7 (data needs and evaluation approaches for health equity).

*“Improving health through a focus on place is not primarily a scientific or technical enterprise. It is in large part a process of community change and development, and the participation of residents and community leaders is critical”
(Bell & Rubin, 2007, p.54).*

Recommendations and Lessons Learned

Many of the “how to” strategies included in the CTB are not specific to health equity. Therefore, it is valuable to consider them within the context of recommendations and broad lessons learned from recent efforts to address health inequities for improving living conditions at the local level. The following list of recommendations and lessons learned is drawn from case study research conducted by PolicyLink (2007) and the Bay Area Regional Health Inequities Initiative (2013), as well as interviews with experts in the field (Knight, 2014). Some recommendations are reminders of important principles to keep in mind when promoting health at the community level using an equity lens. These are directly tied with the values and assumptions underlying health equity work described in the Background section of this guide and include:

1. Identify priorities in collaboration with the community
2. Embrace a broad definition of health and promote a comprehensive approach
3. Maintain a focus on equity
4. Build community and multi-sector partnerships
5. Build awareness and appreciation for the social determinants of health
6. Leverage successful PBIs for regional and state level changes
7. Build skills and capacities of health professionals
8. Be flexible and plan ahead for new ways of working

9. Document and disseminate success stories
10. Be patient and persistent, and be willing to take risks

Each of these recommendations and lessons learned is expanded on below.

1. **Identify priorities in collaboration with the community.** Professionals must remember that residents themselves understand, better than anyone else, what their needs and assets are, and what will work in their community. Traditional public health surveillance, assessment strategies, and data sources provide valuable information, but cannot replace local knowledge and the “lived experience” of residents. Often many interrelated problems exist simultaneously and quantitative, data-driven assessments can help inform prioritization. However, community members’ perceptions and understanding of problems are equally important and communities often know best what is needed to address those problems. Therefore, when providing technical assistance or other kinds of support to community groups, public health agencies and other professionals should work in true partnership with community members.

Sample Strategy

Community members in Alameda County, California led a community assessment process to assess and identify priorities. According to the BARHII Health Equity and Community Engagement Report (2013), local agencies involved in promoting health equity consistently engaged community members in assessments, program planning, and implementation of strategies. Community concerns regarding a lack of educational support and activities for youth led three agencies to create after-school, summer, and evening programs, including community leadership training. Similarly, community concerns about neighborhood violence led to the organization of violence prevention workshops that include dialogue between the local police department and community members. For more information about Alameda County’s health equity efforts, including lessons learned and ongoing challenges, visit:

http://barhii.org/download/publications/hecer_alameda.pdf.

2. **Embrace a broad definition of health and promote a comprehensive approach.** Health is more than the absence of disease. A healthy community is one that promotes physical, mental, and social vitality. It is important to view health holistically, and consider the various factors that impact the health of the community. This may mean

that health professionals need to support efforts that are not defined by health or may appear to be outside the scope of traditional health-related efforts.

Sample Strategy

It is often useful to educate partners about the health impact of their work, but it is not necessary to make everything explicitly about health in order to create positive change. An example of this approach is the role of the Boston Public Health Commission (BPHC) in advocating for the “Jobs not Jails” program in Massachusetts. “Jobs not Jails” is a campaign to reform the state’s criminal justice system by focusing more attention on prevention, treatment, and rehabilitation. The BPHC recognizes that by addressing problems related to incarceration and recidivism, “Jobs not Jails” will indirectly have major implications for health equity. Notably, the BPHC acknowledges that the health equity-oriented impacts that may result from the program may not be the main drivers of the reform effort. Instead, the BPHC supports the effort on the principle that health equity will be an indirect result of the program, in addition to the intended outcomes of reducing the numbers of people being incarcerated and increasing the number of people who are employed (B. Ferrer, personal communication, June 1, 2009). For more information regarding “Jobs not Jails” see <http://jobsnotjails.org/jni/>.

3. **Maintain a focus on equity.** Healthy communities benefit everyone. However, without attention to equity and the factors that create inequity, we are likely to improve the average health of different population groups without closing the gaps between them. The resources needed for health are not equally distributed across communities, and health professionals and other local leaders must focus on creating a level playing field for all communities. This becomes particularly important when identifying priority communities for interventions and investments. As mentioned earlier, all communities could benefit from healthier living conditions and more attention to the SDOH. However, state agencies and community-based organizations considering PBIs should look first to those communities with the greatest needs and the greatest opportunities for improvement. Similarly, leaders should recognize that not all communities will be affected in the same way by standardized or statewide policies and programs, and to close the gaps, they must consider the impact on the most vulnerable communities rather than the average or typical community.

Sample Strategy

In Delaware, the *IM40*[®] initiative exemplifies an approach to targeting communities using an equity lens. *IM40*[®] is a partnership between AstraZeneca, the United Way of Delaware, and several community-based organizations. It is a comprehensive approach to positive youth development designed to improve academic performance and overall well-being of Delaware's youth aged 12 through 15. As of April 2015, the initiative had been launched in three target regions: Eastside Wilmington, North Dover, and Seaford/Bridgeville/Laurel. These communities were identified through a comprehensive assessment of the needs in those communities, resources available to address those needs, and the recognition that youth living in these areas face a disproportionate number of challenges to healthy development relative to those living in other communities. Similarly, community-based organizations were identified in each of the target areas to implement the initiative, which reflects an appreciation for the unique nature of communities, the importance of relationships in those communities, and the fact that a "one size fits all" approach is less likely to work.

- 4. Build community and multi-sector partnerships.** Partnerships are necessary to identify and prioritize concerns and to actualize solutions for remedying them. A network of partnerships should mirror the complexity of the community and the priorities identified by the community. Therefore, the network will likely need to include stakeholders from multiple and diverse sectors: health care, public health, government, law enforcement, education, faith-based organizations, non-profits, transportation, agriculture, etc. It is important to create buy-in with partners so they understand how their organization and assistance are keys to achieving the overall goal and how their organization might benefit from participating. Once stakeholders identify mutual areas of interest, those interests can be leveraged to create healthier communities. Specific projects or mechanisms for collaboration can facilitate partnership development, often leading to long-term relationships. Multi-sector partnerships and collaborations across community agencies can generate collective impact, such that the whole is greater than the sum of the parts. Such collaboration is necessary to address complex social problems such as health inequities. The CTB includes several tools to support partnership development, such as the National Association of County and City Health Officials' "Mobilizing Action through Planning and Partnerships" (MAPP) process. MAPP is an effective way to garner stakeholder and community engagement to improve community health. More information about MAPP can be found in the CTB and at:

<http://www.naccho.org/topics/infrastructure/MAPP/index.cfm>.

Sample Strategy

An example of a strong network of partnerships can be seen in a local advocacy project in San Mateo County, California. According to the Bay Area Regional Health Inequities Initiative (BARHII) *Health Equity and Community Engagement Report* (2013), a local health partnership, with training and support from the San Mateo County Health System, organized mobile home park residents to advocate for and establish a rent control ordinance. The partnership persuaded an affordable housing management company to purchase their mobile home park. Where residents were previously subject to an owner who constantly raised rents beyond what was affordable, ignored resident input, and neglected the grounds, they were now empowered as local leaders. According to BARHII (2013), “This community-driven project was sustained over time, led to increasing community pride, and resulted in environmental changes such as a renovated playground, pool, and community center.” For more information about San Mateo County’s health equity efforts, visit:

http://barhii.org/download/publications/hecer_sanmateo.pdf

5. **Build awareness and appreciation for the social determinants of health.** Residents from low income or disempowered communities inherently understand the social determinants of health because they regularly experience the impacts of poverty, discrimination, poor quality schools, and inadequate access to other resources needed for health. Policy-makers and the general public, on the other hand, generally view health through a medical or behavioral lens without appreciating the social and environmental context for health and health inequities. It is important to raise awareness of the SDOH and the role of public policy in determining the distribution of the resources needed for health.

Sample Strategy

The *Unnatural Causes* campaign is a national effort, launched in 2008, explicitly to enlighten the public about social inequities in health. The campaign includes a website (www.unnaturalcauses.org) with a large collection of resources and a seven-part documentary film series, titled “Unnatural Causes: Is Inequality Making Us Sick?” Originally broadcast on public television in the fall of 2009, the film series has since been

used in thousands of community events across the country. The *Unnatural Causes* film series is an effective tool for increasing awareness of the SDOH and equity and can be used to facilitate a community dialogue about change. California Newsreel, the producer of the film series and leader in the broader *Unnatural Causes* campaign, is currently developing a follow-up campaign and film series focused on the role of early childhood development in health and equity (www.raisingofamerica.org).

- 6. Leverage successful PBIs for regional and state level changes.** Communities are unique in their needs, assets, resources, and culture. Nonetheless, regional and state level initiatives can support local efforts and help bring successful efforts to scale. Similarly, state level policy changes can often address community needs that are beyond the reach of community stakeholders and/or can address health inequities more systematically.
-

Sample Strategy

Delaware's *Help Me Grow (HMG)* program is a partnership of many statewide organizations that promotes healthy early childhood development. Launched in Delaware in 2012, *HMG* began as a pilot program in a single community in Hartford, Connecticut in 1998. The initial pilot yielded such promising results that the Connecticut legislature funded a statewide replication of the Hartford program in 2002. In 2010, the W. K. Kellogg Foundation funded the establishment of the *HMG* National Center to promote widespread implementation and impact.

Currently in Delaware, *HMG* offers a comprehensive, upstream approach to promote maternal and child health. It is a result of strong partnerships and support from many components of Delaware's early childhood community including the Delaware Early Childhood Council, the Division of Public Health's Maternal and Child Health Program, the Race to the Top Early Learning Challenge grant, the United Way of Delaware, Nemours Health and Prevention Services, American Academy of Pediatrics, and many others. Each partner is working to promote strong-parent child relationships, safety, child development and overall family health and well-being. With technical assistance from the National Center, Delaware's *HMG* program is supported at the state level and reaches across every community statewide. Additional information about the *HMG* National Center can be found at <http://www.helpmegrownational.org/index.php>.

Information specific to *HMG* in Delaware is available at <http://dethrives.com/help-me-grow>.

- 7. Build skills and capacities of health professionals.** Workforce development is important to creating healthy communities because new and different kinds of work are required of health professionals. Similar to community residents, many health professionals inherently appreciate the SDOH, often because the needs of their patients or target population are beyond the scope of their professional practice. In a recent survey, four out of five physicians in America and 95 percent of physicians serving low-income urban communities say that patients' social needs are as important to address as their medical conditions; however, only one in five are confident in their ability to address these needs (Robert Wood Johnson Foundation, 2011). For instance, clinicians often recognize that their asthma patients suffer due to poor housing conditions. They prescribe effective medications to treat asthma symptoms, and can do much to alleviate pain and suffering. However, many clinicians are frustrated by their limited ability to help their patients avoid unhealthy living conditions that trigger asthma symptoms. In another example, health educators and other public health professionals recognize that nutrition education is inadequate if their audience does not have access to affordable fruits and vegetables.

The skills needed to build multi-sector partnerships or to advocate for environmental and other policy changes are often not taught in medical schools or schools of public health. Professionals need additional training to build the knowledge and capacity for new approaches to promoting community health. These new skills and capacities should be institutionalized in public health and medical education programs and professional development.

- 8. Be flexible and plan ahead for new ways of working.** The kinds of changes needed to promote healthy communities rarely happen quickly. Managers should explore ways in which staff may have more flexibility and consider different kinds of performance expectations. Similarly, traditional approaches to funding health-related projects (e.g. disease-specific efforts) may not be conducive for a place-based approach. Flexible funding streams can facilitate efforts to target living conditions underlying many interrelated health problems. Finally, funders should consider investing for the long-term, instead of funding short-term projects.

Sample Strategy

Many national grant-making organizations are embracing upstream approaches to community health which recognize the importance of social determinants and community engagement. The Annie E. Casey Foundation's *Making Connections* initiative was a 10-year, \$500 million investment to strengthen families and communities through place-based initiatives. Although the program recently concluded, an evaluation of the effort showed improvements in the capacity for community change. However, evidence of widespread impact on population outcomes was limited (Annie E. Casey Foundation, 2013). Many important lessons were learned from *Making Connections* that can be applied to funding strategies in Delaware. For instance, evaluation findings revealed an even greater need for sustained, sufficient investments. Similarly, it is important for funders (and those working in communities) to do a better job of defining success for place-based community change, and identifying the models and strategies that will produce measurable impacts. Additional information about these and other lessons learned from *Making Connections* may be found at

<http://www.aecf.org/m/blogdoc/aecf-CommunityChangeLessonsLearnedFromMakingConnections-2013.pdf#page=6>.

Examples of other upstream funding initiatives include those of the California Wellness Foundation (<http://www.calwellness.org/>) and the Kresge Foundation (<http://kresge.org/programs/health>).

9. **Document and disseminate success stories.** Evaluating community health efforts is important for continuous improvement and expansion. Unfortunately, evaluation is particularly difficult due to the complex nature of PBIs and collaborative upstream strategies, coupled with the long timeframe that is often needed to see the health impacts of changes in the SDOH. Therefore, success stories become important as do other kinds of qualitative and innovative approaches to evaluation (more about evaluation is found in Section 7). Champions should be celebrated to raise awareness about successful approaches.

Sample Strategy

In Delaware, the Delaware Healthy Mother and Infant Consortium (DHMIC) recently began honoring local Health Equity Champions at its annual summit. Recognizing these champions is an important avenue for sharing success stories and building momentum. For more information about the DHMIC Health Equity Awards, see <http://dethrives.com/thriving-communities/health-equity-awards>.

The media can be a particularly valuable partner in recognizing champions and helping to reframe health and health inequities using a SDOH lens. Professionals must work with the media⁶ to share positive stories about community change and help to reframe health equity in a positive way, as opposed to the more negative and potentially divisive frame of “health disparities.”

Several research and advocacy organizations are working to reframe poor health and health disparities from being viewed as individual, biomedical problems to being viewed as social problems grounded in collective responsibility. These communication efforts are aimed at building public will for change, and shifting the conversation from a “deficits model” to one which emphasizes what works and what is needed to foster optimal health for all. Berkeley Media Studies Group produced a webinar in 2014 to educate professionals on how to make their case for health equity (see <http://www.bmsg.org/resources/publications/health-equity-communication-framing>). Similarly, the Frameworks Institute has a number of recommendations for communicating about various issues related to communities and SDOH (<http://www.frameworksinstitute.org/>). Finally, the Robert Wood Johnson Foundation conducted research on message development for SDOH and produced a series of recommendations. To view them, visit <http://www.rwjf.org/content/dam/farm/reports/reports/2010/rwjf63023>.

⁶ For a detailed discussion of the importance of media advocacy in public health and strategies for developing effective messages see Dorfman, L. & Daffner Krasnow, I. (2014). Public health and media advocacy. *Annual Review of Public Health*, 35, 293-306.

Sample Strategy

In Delaware, KIDS COUNT works closely with the media to share information about the well-being of children and families. One of 53 projects across the country funded by the Annie E. Casey Foundation, the mission of KIDS COUNT in Delaware is to provide up-to-date, accurate, objective, and comprehensive data on the well-being of children, youth, and their families to raise awareness and inform both policy and programmatic decisions.

KIDS COUNT in Delaware produces multiple publications, but is best known for its annual *Fact Book*, the singular account of every child under 18 in Delaware. Disseminating this information is critical to promoting positive change and is accomplished through a well-developed media strategy that includes a schedule of planned releases and the promotion of consistent messages. The use of press releases, email blasts, and social media support consistent messaging and allows KIDS COUNT in Delaware to frame information for the media in ways that support its advocacy efforts. This has become increasingly important as the state's news outlets decreased their budgets and laid off reporters. Similarly, while it is important to share data about the challenges faced by children and families in Delaware, it is critical to offer solutions and strategies for positive change. Therefore, KIDS COUNT in Delaware annually highlights "causes for concern" as well as "causes for applause." Finally, KIDS COUNT in Delaware uses its communication channels to leverage its partners and stakeholders by referring reporters to additional community resources and providing contacts in other agencies. This strategy should be replicated, given the importance of partnerships and the role of a wide range of community organizations in advancing health equity in Delaware.

10. **Be patient and persistent, and be willing to take risks.** A long-term commitment to community change is vital. Building trust and authentic partnerships takes time. Changing conditions and policies that affect those conditions also takes time. Seeing a difference in health outcomes can take even longer. Therefore, recognizing the need for a long-term commitment at the outset is important to preventing unrealistic expectations.

Lessons learned from Marin County, California reveal the importance of health department staff having a sustained physical presence in the community. According to the Bay Area Regional Health Inequities Initiative (BARHII) Health Equity and Community Engagement Report (2013):

“Physical presence in the communities served was among the keys to success discussed by both community representatives and LHD [Local Health Department] staff alike. One community representative stated that it is important when the LHD is “Being present, accountable, and genuine when ‘showing up’ and actually doing what is said that will be done.” Another community member shared that, the LHD “Showing up consistently on ‘non-health’ events, makes a lot of difference.” Some of these non-health events include food banks, PTA meetings, and school registration nights.”

For more information about Marin County’s experience promoting health equity at the community level, visit: http://barhii.org/download/publications/hecer_marin.pdf.

When projects appear to be stalled or losing momentum, community champions and health professionals need to demonstrate leadership in the form of persistence and ongoing commitment. Part of that commitment is to advance social justice and equity, which is not always a popular or easy topic. Public health, as a field grounded in social justice, can play an important leadership role in this endeavor. Furthermore, partnerships can protect individuals and/or individual agencies or organizations from standing alone on difficult issues.

Glossary – Section 4

Built environment: Elements of the physical environment made by humans, such as sidewalks, roadways, and buildings. The term can refer to infrastructure as well as spatial and cultural aspects of places and is often used in relation to urban design or in relation to natural environments modified by people.

Collective impact: Collaboration across disciplines and sectors to solve complex social problems. It is grounded in the premise that no single organization can create large-scale, lasting social change alone.

Community: Traditionally defined as a physical location such as a ZIP code. It can also refer to a group of individuals that share common characteristics, identity, experiences, or values. For the purposes of this guide, “community” refers to a physical location and the stakeholders and institutions within it.

Community capacity: The ability of community members to work together, solve problems, set goals, and achieve sustainable change.

Healthy community: A community in which every member has access to the resources they need to live a healthy life, including housing, education, food, income, a safe environment, and positive social interactions. It includes social justice, equity, and sustainable resources and is free of all forms of discrimination. Furthermore, by viewing communities geographically, one can envision healthy *places* as those that are designed or built to improve the quality of life for all people who live, work, worship, learn, and play within their borders.

Place-based initiative (PBI): A social change effort that is concentrated in a specific geographic area. Health equity strategies focused on living conditions in a specific geographic community are often referred to as PBIs because the target of the interventions is the place itself (or characteristics of the place), rather than the people living there.

Stakeholder: Anyone who has an interest – directly or indirectly – in the health and well-being of a community.

References and Additional Resources

- Annie E. Casey Foundation. (2013). *Community Change: Lessons from Making Connections*. Baltimore MD: Annie E. Casey Foundation. Retrieved from <http://www.aecf.org/m/blogdoc/aecf-CommunityChangeLessonsLearnedFromMakingConnections-2013.pdf#page=6>
- Bay Area Regional Health Inequities Initiative. (2013). *Health Equity & Community Engagement Reports*. Retrieved from <http://barhii.org/resources/health-equity-community-engagement-reports/>
- Bell, J. & Rubin, V. (2007). *Why place matters: Building a movement for healthy communities*. A report of Policy Link & The California Endowment. Retrieved from http://www.policylink.org/sites/default/files/WHYPLACEMATTERS_FINAL.PDF
- Berkeley Media Studies Group. (2014). *Communicating about health equity: Showing the bigger picture to build healthier communities (webinar)*. Retrieved from <http://www.bmsg.org/resources/publications/health-equity-communication-framing>
- California Newsreel (2009). *Unnatural Causes: Is Inequality Making Us Sick?* Retrieved from www.unnaturalcauses.org
- California Newsreel (2014). *The Raising of America*. Retrieved from www.raisingofamerica.org
- Centers for Disease Control and Prevention. (n.d.). *Healthy Places Fact Sheets*. Atlanta, GA: U.S. Department of Health and Human Services. Retrieved from <http://www.cdc.gov/healthyplaces/factsheets.htm>
- Centers for Disease Control and Prevention, Division of Community Health. (2015). *A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease*. Retrieved from <http://www.cdc.gov/NCCDPHP/dch/health-equity-guide/index.htm>
- Federal Home Loan Bank of Pittsburgh [FHLB], (2011). *Blueprint Communities: A Report to the State of Delaware*. Retrieved from <http://www.blueprintcommunities.com/de/pdfs/Del-2011-summary.pdf>
- Glasmeier (2014). *Living Wage Calculator*. The Living Wage Project. Retrieved from <http://livingwage.mit.edu/>
- Institute for Public Administration. (n.d.). *Delaware Complete Communities Planning Toolbox*. Retrieved from <http://www.ipa.udel.edu/healthyDEtoolkit/index.html>
- Kania, J. & Kramer, M. (2011). *Collective Impact*. *Stanford Social Innovation Review*, Winter, 84. Retrieved from http://www.ssireview.org/articles/entry/collective_impact/
- Kansas University Work Group for Community Health and Development. (2014). *Community Toolbox*. Retrieved from <http://ctb.ku.edu/en>
- Klinenberg, Eric (2002). *Heat Wave: A Social Autopsy of Disaster in Chicago*. Chicago, IL: Chicago University Press.

Larson, K. (2007). *Health impacts of place-based interventions in areas of concentrated disadvantage: A review of the literature*. Liverpool, NSW: Sydney South West Area Health Services: Retrieved from http://www.sswahs.nsw.gov.au/populationhealth/content/pdf/population_health/KLarsenLiteratureReviewSept07.pdf

Macintyre, Ellaway & Cummins (2002). Place effects on health: How can we conceptualize, operationalize and measure them? *Social Science & Medicine*, 55, 125-139.

Manuel, T., & Gilliam, F. (2008). *Framing healthy communities: Strategic communications and the social determinants of health* (A Frameworks Research Report). Washington, DC: Frameworks Institute. Retrieved from http://www.frameworksinstitute.org/assets/files/food_and_fitness/social_determinants_of_health.pdf

National Association of County and City Health Officials. (2015). *Mobilizing for Action through Planning and Partnership (MAPP)*. Retrieved from <http://www.naccho.org/topics/infrastructure/MAPP/index.cfm>

Policy Link. (2014). *Equity Tools*. Retrieved from <http://www.policylink.org/equity-tools/equitable-development-toolkit/about-toolkit>

Preskill, H., Parkhurst, M., & Splansky-Juster, J. (2014). *Guide to Evaluating Collective Impact*. Collective Impact Forum, retrieved from <http://www.fsg.org/tabid/191/ArticleId/1098/Default.aspx?srpush=true>.

Prevention Institute. (n.d.) *Health Equity & Prevention Primer*. Retrieved from <http://www.preventioninstitute.org/tools/focus-area-tools/health-equity-toolkit.html>

Robert Wood Johnson Foundation [RWJF]. (2010). *A new way to talk about the social determinants of health*. Retrieved from <http://www.rwjf.org/en/research-publications/find-rwjf-research/2010/01/a-new-way-to-talk-about-the-social-determinants-of-health.html>

Robert Wood Johnson Foundation [RWJF]. (2011). *Healthcare's blind side: The overlooked connection between social needs and good health*. Summary of Findings from a Survey of America's Physicians. Retrieved from http://www.rwjf.org/content/dam/farm/reports/surveys_and_polls/2011/rwjf71795

Scott, M., Calkins, A., & Coons, R. (2010). *Enhancing mobility to improve quality of life for Delawareans*. Institute for Public Administration, University of Delaware, retrieved from http://www.ipa.udel.edu/publications/enhancing_mobility.pdf

U.S. Department of Education. (November 2014). *Promise Neighborhoods*. Retrieved from <http://www2.ed.gov/programs/promiseneighborhoods/index.html>

SECTION 5: Upstream Strategies for Health Care Providers

As discussed in Section 4, the social determinants of health and health equity are generally outside the scope of what is typically considered part of the health care system. Health care providers are usually trained to address their patients' immediate needs based on individual symptoms, risk factors, and biological or genetic characteristics. Medical education and health care models in the U.S. typically reflect a biomedical and individualistic concept of health. Similarly, the United States' health care system is biased toward treatment rather than prevention and health promotion, as well as toward specialization instead of a more holistic and comprehensive approach to health and well-being. Finally, payment systems and incentives tend to prioritize innovation and high end technology, which creates additional barriers for providers to attend to their patients' social needs. These characteristics of the health care system, which are at odds with efforts to advance health equity, are driven by long-standing cultural barriers, numerous regulatory barriers, and financial challenges related to payment mechanisms and our insurance system (Manchanda, 2013).

Fortunately, passage of the Affordable Care Act and increasing attention to the Triple Aim (see Section 3), have created opportunities for reforming the health care system in ways that can better address the social determinants of health and promote equity. Providers are positioned to better address their patients' social needs by creating stronger linkages with other community resources; coordinating care more effectively; and ultimately ensuring high quality, accessible care to a diverse patient population. Strategies in each of these three areas can contribute to a more equity-oriented health care system, which is part of the broader continuum of strategies needed to advance health equity overall. This is important because, while health care is only one determinant of health, it is an important lever of change and can open the door to other changes in the broader community context.

Addressing the Social Needs of Patients

Providers inherently understand the social needs of their patients. They recognize that prescribed treatments may be of limited value when patients leave the clinic, only to return to the conditions that caused their illnesses in the first place.

Providers are frequently frustrated by an apparent lack of ability to address the challenges their patients face with respect to poverty, poor housing, and other environmental factors. However, there is much that providers can do to address the social needs of their patients and several resources exist to help them do so:

1. Screening Tools

First, to support a paradigm shift from addressing symptoms to addressing causes, providers can systematically screen and assess their patients for social needs. Various assessment tools have been developed to identify patients' social needs as the first step to connecting them to community supports and resources. Some screening mechanisms are administered by clinicians and others are self-administered (e.g. in the clinic waiting room before an appointment). A variety of screening tools focused on a variety of social needs—such as food insecurity, housing insecurity, financial stability, stress, and social isolation—are available to clinicians on the HealthBegins websites (<http://www.healthbegins.org/> and <http://healthbegins.ning.com/>). Dr. Rishi Manchanda and other “Upstream Doctors”⁷ created this site to help improve the health care system by sharing information and resources among clinicians. The site includes more comprehensive instruments that address a multitude of social needs in single surveys of varying lengths and with different purposes. Recently, the founders of HealthBegins developed a composite questionnaire for clinical settings, based on a compilation of available, evidence-based instruments. Health care providers may visit the website for more information or contact Dr. Manchanda directly for a copy of this composite questionnaire (<http://healthbegins.ning.com/page/social-screening-tools>).

2. Community Health Workers

Community Health Workers (CHWs)—also referred to as community health advocates, lay health educators, health navigators, or promotores de salud—are uniquely qualified to create linkages between patients, providers, and community resources. CHWs serve in a variety of roles, including:

- cultural mediation between communities and the health care system;
- providing culturally appropriate and accessible health education and information;
- assuring that people get the services they need;

⁷ *The Upstream Doctors* by Rishi Manchanda is a TED Book available for download as an e-book. Dr. Manchanda is the founder of HealthBegins, a social network where clinicians can learn and share upstream strategies. For more information, visit: <http://healthbegins.ning.com/>.

- providing informal counseling and social support;
- advocating for individuals and communities within the health and social service systems;
- providing direct services (such as basic first aid) and administering health screening tests; and
- building individual and community capacity (Wiggins & Borbon, 1998).

CHWs' unique qualifications include understanding the communities they serve. They typically reside in the community, speak the language, and share the community's culture. This allows them to connect individuals with needed services and to educate providers about community needs and important cultural considerations in the delivery of care. Growing evidence documents the value of CHWs in improved health outcomes and reduced health care costs (e.g., see <http://www.cdc.gov/diabetes/projects/pdfs/comm.pdf>). The Institute of Medicine recommends increased using CHWs to help address racial and ethnic disparities in health care (Smedley et al., 2002).

Massachusetts was one of the first states to create a supportive, statewide infrastructure for expanding and institutionalizing the role of CHWs. After considerable research and collaborative planning, the state Executive Office of Health and Human Services formally recognized CHWs as a vital component of the health care system because they play an important role in reducing health inequities among vulnerable communities. Massachusetts instituted several initiatives to promote CHWs. The state's experience led to the development of several recommendations within four domains aimed at institutionalizing CHWs (Anthony, Gowler, Hirsch, & Wilkinson, 2009):

1. Infrastructure

- Establish a CHW advisory body to assist with the development and implementation of a sustainable program.

2. Professional Identity

- Encourage the adoption of the term "community health worker," a unified definition of CHW core competencies, and a common scope of practice.
- Incorporate information about the role of CHWs into training for health care providers.

3. Workforce Development

- Develop statewide infrastructure for CHW training and education.
- Develop a CHW certification process and training curriculum, including defined core competencies and skills.
- Require continuing education and recertification.

4. Financing

- Include CHW services in Medicaid administrative cost claims.
- Integrate CHWs into managed or team-based care models.
- Increase and sustain grant funding for outreach.
- Provide incentives for private insurers to use CHWs.

CHWs can be particularly effective in connecting with hard-to-reach community members, especially those who are socially isolated and/or have multiple and complex social needs. However, CHWs have yet to become fully integrated members of the health care delivery system in most parts of the country due to cultural, financial, and regulatory barriers. Because they perform a wide range of services and activities, they lack a unified professional identity with a defined scope of practice and educational credentials. Minnesota has led efforts to remedy some of these barriers and promote the integration of CHWs. A coalition of educational institutions, health care systems, government agencies, foundations, businesses, and non-profits created a statewide, standardized training program called the Minnesota Community Health Worker Alliance. The coalition is also working to develop a sustainable funding stream to support CHWs. Additional information and lessons learned can be found at:

http://www.rwjf.org/content/dam/farm/reports/program_results_reports/2012/rwif403543.

Sample Strategy

Several programs that incorporate the use of CHWs exist in Delaware. The Health Ambassador Program is a joint initiative between the Delaware Department of Health and Social Services and the Christiana Care Health System. The program promotes the health of pregnant women, fathers, and young families through outreach and education on reproductive health and pregnancy, parenting, and healthy infant and early childhood development. Health Ambassadors working at the Claymont Community Center, the

Henrietta Johnson Medical Center, Westside Family Health, and the Wilmington Hospital Health Center connect people to needed health care and social services.

Using a similar approach, the Promotoras Program at Christiana Care Health System teaches Hispanic volunteers about various health issues, such as breast cancer screening and overall wellness. The volunteers, or Promotoras, then teach others in the community about the importance of screening and other ways to be healthy. The Promotoras provide health education and help people navigate the health care system, improving access to care. This approach facilitates outreach to community members who may otherwise be difficult to reach, while simultaneously encouraging community cohesion.

These and similar CHW programs in Delaware are making a positive impact on the individuals and families that they serve and can provide a foundation for a more comprehensive and supportive infrastructure across the state. Additional attention is needed to implement the recommendations emerging from Massachusetts's experience and the lessons from Minnesota to ensure the systematic integration of high quality CHWs into health care delivery in Delaware.

3. Medical-Legal Partnerships

Another promising strategy for addressing patients' social needs is through a Medical-Legal Partnership. As the name implies, the approach includes collaboration between health care providers and legal institutions to improve the health care system's response to social determinants of health. The approach is grounded in the idea that poor living conditions and the unequal distribution of resources needed for health can be traced to laws that are unfairly applied or under-enforced, which has often led to denial of services and benefits that are designed to help vulnerable people (<http://medical-legalpartnership.org/>). One might view the MLP strategy as increasing access to justice, which is synonymous with equity. According to the National Center for Medical-Legal Partnerships, there are five main domains where complicated bureaucracies, wrongfully denied benefits, and unenforced laws commonly impact health and require legal intervention: income support and insurance; housing and utilities; education and employment; legal status or citizenship; and personal and family stability. In response to these legal challenges to health, Medical-Legal Partnerships:

- Train health care, public health, and legal teams to work collaboratively and identify needs upstream;

- Address individual patients' health-harming social and legal needs with interventions ranging from triage and consultations to legal representation;
- Transform clinical practice and institutional policies to better respond to patients' health-harming social and legal needs; and
- Prevent health-harming legal needs broadly by detecting patterns and improving policies and regulations that have an impact on population health.

The number of MLPs has grown tremendously in recent years due to evidence of their effectiveness in addressing the social needs of patients. According to the National Center, Medical-Legal Partnerships exist in 262 health care institutions in 36 states. In an assessment of their impact, researchers found that these partnerships positively impact patient health, and offer a significant return on investment, justifying the expansion of the model (Beeson, McAllister & Regenstein, 2013).

Medical-Legal Partnerships are usually financed at the local level through hospitals' operating budgets, community benefit programs, and/or private grants. However, state and federal grants for addressing health inequities and social determinants of health (SDOH) are becoming increasingly supportive of Medical-Legal Partnerships (Bachrach, Pfister, Wallis, & Lipson, 2014). Both the American Medical Association and the American Bar Association currently endorse them.

Support for developing a Medical-Legal Partnership can be found on the National Center for Medical-Legal Partnerships' website (<http://medical-legalpartnership.org/>). The website includes a toolkit to help partners assess a community's needs and the feasibility of implementing a partnership. Following the initial assessment phase, the National Center provides more in-depth consultation and support to local partnerships in relation to building the infrastructure for Medical-Legal Partnerships, and to plan for growth and sustainability.

4. Health Leads

Other promising initiatives to create linkages between health care and community resources include programs such as Health Leads (<https://healthleadsusa.org/>). Health Leads allows health care providers to prescribe basic resources like food and heat just as they do medication. Patients are referred to a Health Leads advocate to fill these prescriptions and help connect patients to basic resources they need to be healthy. The program is unique in that college students are trained to serve as volunteer Health Leads advocates and are, therefore, contributing to community needs as they are gaining

important knowledge and skills to become future health care leaders. Health Leads programs currently operate in seven U.S. cities. Early findings about the impact of the Health Leads model can be found on the Health Leads website.

Sample Strategy

In Delaware, a telephone hotline called Delaware 2-1-1 and its companion website (www.delaware211.org) are available to individuals seeking help with a wide range of health and social service needs. Delaware 2-1-1 is a free and confidential service for residents that provides a central access point for information about services related to basic needs (e.g. food, housing, transportation, etc.), criminal justice and legal services, health care, individual and family support, substance abuse, education, and employment services. Individuals can access the hotline directly, but professionals may also use it to link patients or clients with support services in the community. In addition, community organizations can contact Delaware 2-1-1 to be included in its inventory of resources. The 2-1-1 service is offered by Delaware Helpline with support from United Way of Delaware and the State of Delaware. Staff is bilingual and can help callers in English or Spanish.

Care Coordination

Advancing health equity through the health care system requires the delivery of high quality, accessible care that is comprehensive, patient-centered, and coordinated for individual patients. At the same time, the provision of health care must be better integrated with population and behavioral health strategies. Changes to the health care delivery landscape, including new regulations and funding streams provided through the Affordable Care Act (ACA), have created opportunities for improved coordination between providers and patients, as well as between providers. (For a general overview of the ACA, visit <http://kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/>. For a recent analysis of grant opportunities available as a result of the ACA, visit <http://www.chrt.org/publications/price-of-care/affordable-care-act-funding-an-analysis-of-grant-programs-under-health-care-reform/>).

The following are examples of interventions, tools, and options to improve care coordination:

A. Health System Integration

Although health care and public health institutions share the goal of the improving health of the populations that they serve, they have traditionally practiced independently of each other. Better integration and alignment of resources can improve population health and reduce health inequities. Recognizing that lack of integration was a barrier to health improvement, the Institute of Medicine recently convened a committee of experts to develop recommendations for enhanced integration, particularly between primary care and public health. The committee defined integration as “the linkage of programs and activities to promote overall efficiency and effectiveness and achieve gains in population health” (IOM, 2012, p. 3). They found that the unique needs of communities, differences in local resources, and the varied nature of health delivery systems made it difficult for the committee to recommend specific models of integration. Rather, their research led to the development of a set of principles thought to be essential for successful integration of primary care and public health:

1. a shared goal of population health improvement;
2. community engagement in defining and addressing population health needs;
3. aligned leadership that:
 - a. bridges disciplines, programs, and jurisdictions to reduce fragmentation and foster continuity,
 - b. clarifies roles and ensures accountability,
 - c. develops and supports appropriate incentives, and
 - d. has the capacity to manage change;
4. sustainability, the key to which is the establishment of a shared infrastructure and foundation for enduring value and impact; and
5. the sharing and collaborative use of data and analysis (IOM, 2012, pp.5-6).

“The status quo of siloed enterprises is not good enough. Moving along a path of integration will promote better health and wellbeing for all Americans” (IOM, 2012).

Sample Strategy

Delaware's Healthy Weight Collaborative is an example of integration between primary care and public health. The collaborative includes a range of partners: the Delaware Division of Public Health, La Red Health Center, Henrietta Johnson Medical Center, Delaware State University Health Center, Christiana Care Health System, the Governor's Council on Health Promotion and Disease Prevention, the Healthy Eating and Active Living Coalition, the Medical Society of Delaware, Nemours Health and Preventive Services, the University of Delaware, Health Sciences Alliance, Westside Family Health, United Way of Delaware, and the YMCA of Delaware. Supported by funding through the Affordable Care Act, the initiative's goal is to address obesity among targeted populations. The leadership is particularly focused on creating a permanent capacity for system-wide integration to promote health and prevent illness.

Community Health Centers offer an important avenue for health system integration. According to the U.S. Department of Health and Human Services (HHS), Community Health Centers are community-based and patient-directed organizations that serve populations who otherwise experience limited access to health care (<http://www.bphc.hrsa.gov/about/>). They are located in communities with great needs; are governed by a community board that must be comprised of at least 51 percent patients; provide comprehensive services (often including dental care, mental health and other supportive services); and do not turn anyone away from receiving services. Community Health Centers are a critical component of the health care safety net and an increasingly important provider of primary care services to newly insured patients under the ACA. Typically, Community Health Centers provide high quality primary care services based upon a keen understanding of community needs and prioritizing services in response to those needs. By their very nature, Community Health Centers are models of primary care and public health integration that promote the health of communities and help to advance health equity.

In Delaware, Community Health Centers exist in the form of Federally Qualified Health Centers and are located in each county. They include: Henrietta Johnson Medical Center, Westside Family Health, and La Red Health Center. (View a map of the Delaware's FQHCs at <http://www.dhss.delaware.gov/dph/hp/files/fqhcs.pdf>.) Future efforts to integrate primary care and public health may benefit from ensuring one of our Community Health Centers is included in the initiative. For additional information on the role of Community Health Centers in addressing the SDOH, read a 2012 report by the Institute for Alternative Futures at <http://www.altfutures.org/pubs/leveragingSDH/IAF-CHCsLeveragingSDH.pdf>.

B. Medical Homes

The health care system can be strengthened by addressing the organization and delivery of primary care so that more attention is focused on access, coordination, and prevention. The medical home model, also referred to as the patient-centered medical home, delivers primary care that is comprehensive, patient-centered, coordinated, accessible, and of high quality. The Agency for Healthcare Research and Quality (AHRQ) Patient-Centered Medical Home Resource Center describes five functions or attributes of medical homes:

1. **Comprehensive Care.** Patient-centered medical homes are accountable for meeting the large majority of each patient’s physical and mental health care needs, including prevention, wellness, acute care, and chronic care. Providing comprehensive care requires a team of providers that may include physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, social workers, educators, and care coordinators. As an alternative to having in-person access to a wide range of care providers, many medical homes, including smaller practices, build virtual teams that link their patients to providers and services in their communities.
2. **Patient-Centered Care.** Patient-centered medical homes provide primary care that is personalized for each patient. Patient-centered care relies on partnerships between providers and patients (and their families) so that providers can gain an understanding and respect for each patient’s unique needs, culture, values, and preferences. Medical home practices actively support patients in learning to manage and organize their own care at the level the patient chooses. Recognizing that patients and families are core members of the care team, medical home practices ensure that these individuals are fully informed partners in establishing care plans.
3. **Coordinated Care.** Patient-centered medical homes coordinate care across all elements of the health care system, including specialty care, hospitals, home health care, and community services and supports. Coordination is particularly critical during transitions between sites of care, such as when patients are being discharged from the hospital. Medical home practices also excel at building clear and open communication among patients and families, their medical homes, and members of the care team, which facilitates coordination of care.
4. **Accessible Services.** Patient-centered medical homes deliver accessible services with shorter waiting times for urgent needs, enhanced in-person hours, around-the-clock telephone or electronic access to a member of the care team, and alternative

methods of communication, such as email and telephone care. Medical home practices are responsive to patients' preferences regarding access.

5. **Quality and Safety.** Patient-centered medical homes demonstrate a commitment to quality assurance and quality improvement. This is done through ongoing engagement in activities such as using evidence-based medicine and clinical decision-support tools to guide collaborative decision-making with patients and families. Similarly, patient-centered medical homes engage in performance measurement and improvement, evaluating and responding to patient experiences and patient satisfaction, and practicing population health management. Medical homes exhibit a systems-level commitment to quality and safety by sharing robust data and improvement activities publicly.

More about each of these attributes, including academic papers, research briefs, and other resources that support the patient-centered medical home model can be found on AHRQ's PCMH Resource Center website: <http://www.pcmh.ahrq.gov/>. Additionally, the *Joint Principles of the Patient Centered Medical Home* (2007) provide guidelines for primary care organizations. In 2008, the Medical Society of Delaware adopted the guidelines, which have guided the development of 37 patient-centered medical homes across the state (AAFP, 2007).

Implementing the patient-centered medical home model supports health equity in a number of ways. For instance, there is evidence that racial and ethnic disparities in access to health care are reduced through medical homes (Hernandez, Doty, Shea, Davis & Beal, 2007). In addition, medical homes have been found to improve the quality of care for vulnerable patients by, for example, promoting higher rates of routine preventive screening (Hernandez, Doty, Shea, Davis & Beal, 2007). Medical home initiatives can also promote linkages to social supports. Blue Cross Blue Shield of Michigan supports a patient-centered medical home program in which providers use a systematic approach to assess patients' social needs. Providers maintain a database of community resources and refer patients to those resources as appropriate. Providers then track referrals for high-risk patients to ensure follow-up (Bachrach, Pfister, Wallis & Lipson, 2014).

Although the concept of medical homes has been in practice for some time, implementing the patient-centered medical home model is just recently spreading across the U.S. due in part to new incentives created through the ACA. Furthermore, according to a recent review by the National Academy for State Health Policy, state and federal governments are increasingly looking to primary care as a foundation for broader system reform and patient-centered medical homes offer an important mechanism for achieving

many of the reform goals (Kinsler & Worth, 2014, p. 7). Although not listed in the review, Delaware is piloting patient-centered medical home PCMHs through a partnership between the Medical Society of Delaware and Highmark Delaware. An overview of the pilot can be found at

<http://www.medicalsocietyofdelaware.org/Portals/1/PCMH/PCMH%20Report%204-9-13.pdf>. Additionally, care coordination, including efforts to support patient-centered medical homes, is an integral part of Delaware’s health care system transformation plan (i.e. the State Innovation Model plan) referenced in the “Health System Reform in Delaware” sub-section (beginning on page 60).

Improving Quality and Access to Culturally Competent Care

Although the health care system is an important lever of change for addressing patients’ social needs and advancing health equity, it was identified as a contributor to existing health inequities. *The National Healthcare Disparities Report* (AHRQ, 2012), produced annually since 2003, provides a summary of trends in health care disparities and reports on progress with efforts to reduce such disparities. The most recent report highlights persistent challenges within the health care system and the need for urgent attention to issues related to access and quality of care, especially for minority and low-income groups. The report finds that quality is improving in some areas, but that access is worsening and disparities related to access are largely unchanged. Therefore, fundamental aspects of the health care system need to be addressed to reduce disparities in care while advancing health equity. Recommendations for remediating such disparities in care include the following:

1. **Collect valid and reliable data on race, ethnicity, and language preference.** Although data collection alone is not sufficient for reducing disparities, it is a critical first step to identifying the health care needs of specific populations and gaps in care. National efforts, including requirements of the ACA and data standards produced by the HHS Office of Minority Health, are promoting better data systems. In addition, the Institute of Medicine developed recommendations to identify of disparities in care, including: collecting standardized self-reported patient race, ethnicity, and language (REL) data and using those data to examine differences in quality of care between groups (Ulmer, McFadden, & Nerenz, 2009). Ultimately, these data can be used to develop quality improvement interventions tailored to specific groups, and the Institute of Medicine provides additional guidelines to this end. Lessons learned regarding efforts to collect and incorporate REL data into quality improvement initiatives are highlighted in an issue brief describing the Robert Wood Johnson Foundation’s (RWJF) *Aligning Forces for*

Quality (AF4Q) Initiative, which can be found at www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf412949. Related tools and additional resources to support REL data collection and standardization can be found in the *RWJF Equity Resource Guide*: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf412949/subassets/rwjf412949_3.

- 2. Diversify and ensure a culturally competent workforce.** There is evidence that the quality of care for racial and ethnic minorities improves when the workforce reflects the characteristics of the patient population (Smedley, Stith Butler, & Bristow, 2004). Provider diversity is a key element of patient-centered care and may be achieved through the recruitment, retention, and training of racially, ethnically, and culturally diverse individuals. This requires a concerted effort, particularly by leadership within health care organizations and other state systems. *The HHS Action Plan for Reducing Racial and Ethnic Health Disparities* (2011) specifically recommends creating an undergraduate pipeline program to increase the diversity of students entering health professions. Other strategies to address gaps in the diversity of the workforce include expanding the use of interpreters to overcome language barriers and improving cultural competence education and professional development for health care providers. The U.S. Department of Health Human Services (HHS) provides a web-based training opportunity for physicians regarding cultural competency, called *A Physician's Practical Guide to Culturally Competent Care*. Although the training focuses on physicians, all health care providers may benefit from the training, which can be found at <https://cccm.thinkculturalhealth.hhs.gov/>.
- 3. Build community partnerships for research and action.** Similar to the principles underlying place-based strategies for promoting health equity, providers and researchers need to embrace community partnerships. The National Partnership for Action's *National Stakeholder Strategy* (2011) specifically calls for greater investments in community-based participatory research, which is research that involves community engagement throughout the entire research process, and evaluates community-oriented intervention strategies. Similarly, to promote health equity across the continuum of health-related services, the *National Stakeholder Strategy* recommends increased support for and improved coordination of research that enhances our understanding of strategies. Finally, more attention is needed to enhance the transfer of

knowledge and translation of research at the program, community, system and policy levels.

Sample Strategy

In Delaware, the Delaware Clinical and Translational Research ACCEL Program (DE-CTR) offers a mechanism for community partnerships and research translation. The DE-CTR is a partnership between the University of Delaware, Christiana Care Health Services, Nemours Health and Prevention Services/Alfred I. duPont Hospital for Children, and the Medical University of South Carolina (MUSC). It aims to improve the state's infrastructure and capacity for conducting research that can be applied to effective interventions that lead to better clinical outcomes. The DE-CTR ACCEL program is supported by an Institutional Development Award (IDeA) from the National Institute of General Medical Sciences of the National Institutes of Health (under grant number U54-GM104941, PI: Binder-Macleod). The DE-CTR program includes a strategic partnership with the Medical University of South Carolina, which provides technical assistance and support. With an emphasis on community outreach and engagement, the DE-CTR is particularly well positioned to support community-based participatory research and research translation for health equity. For more information about the DE-CTR program and related funding and research opportunities, visit: <https://de-ctr.org/>.

- 4. Implement evidence-based interventions and promising practices for advancing health equity.** Scholars and professionals alike are increasingly recognizing the potential impact of health care system changes and specific interventions for advancing health equity. Providers can find ideas, emerging practices, lessons learned, tools, and other resources through linkages with other providers. As mentioned on page 99, HealthBegins is a social network where clinicians can learn and share upstream strategies. Examples of promising strategies shared by this network include the “Yelp for Help” pilot program in Los Angeles, where providers partnered with a charter school focused on preparing students for careers in the health field. Students learned about social determinants and then helped to map over 230 local “health-critical” community resources related to food insecurity, slum housing, adult education, job training, and other social determinants. The resources were uploaded to a searchable web-based platform with mapping capabilities. To learn more about “Yelp for Help,” visit:

<http://healthbegins.ning.com/page/hsa-resource-search>. For more information about the HealthBegins network and to access all of the shared resources, visit: <http://healthbegins.ning.com/> or <http://healthbegins.org>.

5. **Engage in the policy process.** Health and health equity are inherently political. The SDOH are determined by policy processes and decisions that tend to favor those with power and other resources. Policy changes are needed to facilitate the health care system changes that will help alleviate health inequities. Health care providers can be leaders in the policy arena by advocating for their patients' social needs. Similarly, providers can lend their expertise to policy discussions outside of the health care sector, but which have an impact on health. Because policy generally has such large implications on health, it is discussed in more detail in the next section.

Conclusion

As researchers have explained, re-orienting health care systems toward health equity through a social determinants of health lens is not for the faint-hearted (Baum, Bégin, Houweling & Taylor, 2009, p. 1967). It requires leadership within the health care sector and stewardship working with other sectors. More specifically, according to Baum and colleagues (2009), the characteristics of a health equity-oriented health care sector include the following:

1. Leadership to improve the equity performance of the health care system, including:
 - A focus on comprehensive primary care;
 - Decision-making processes that involve local communities;
 - Accessible and high quality care for all;
 - Planning, including allocation of resources, based on the needs of populations within a SDOH framework;
 - Policy statements and strategies that are explicit about closing the health equity gap and the need for action on SDOH to achieve this goal; and
 - A shift in funding for community-based services and incentives that align with prevention.
2. Stewardship in working with other sectors to improve health and equity, including:

- The presence of health sector advocacy in other sectors that influence SDOH and the importance of inter-sectoral action;
- Development of expertise to establish a health equity surveillance system and to conduct cross-sector impact assessments on health;
- Reform of medical and health professional education such that the importance of SDOH is reinforced in clinical training and an understanding of population health perspectives and related skills is promoted;
- Training and education of professionals in other sectors (including urban and transport planners, teachers, and others) on the SDOH; and
- Increased funding for research on the impact of SDOH and evaluation of interventions designed to address them (Baum, Bégin, Houweling & Taylor, 2009, p. 1970).

Delaware's health care system is undergoing intense changes due to the passage of the ACA and related reform initiatives. Many local providers are already engaging in leadership and stewardship to advance health equity by identifying and implementing specific upstream interventions. These efforts can be expanded and enhanced. New initiatives grounded in the recommendations highlighted above can be developed in an environment conducive to such changes. The next section describes policy strategies needed to support and reinforce the efforts of providers. It also includes policy strategies to promote healthier living conditions overall.

Glossary – Section 5

Community-Based Participatory Research (CBPR): An approach to research that involves an equitable partnership between and among community members and researchers in all aspects of the research process and in which all partners contribute expertise and share decision making and ownership. The aim of CBPR is to increase knowledge and understanding of a given phenomenon and integrate the knowledge gained with interventions, policy, and social change to improve the health and quality of life of community members.

Community Health Center (CHC): Clinics that generally serve people who are uninsured, underinsured, low-income, or those living in areas where little access to primary health care is available. They are located in communities with great needs; are governed by a community board that must be comprised of at least 51 percent patients; provide comprehensive services (often including dental care, mental health, and other supportive services); and do not turn anyone away.

Community Health Workers (CHWs): Members of a community that provide basic, culturally appropriate, and accessible health information to hard-to-reach members of the community. CHWs can provide basic health services, counseling, and other support services or linkages to community resources. They can be considered as a link between health care providers and community members.

Medical Home: A model of primary care that provides whole-person, accessible, comprehensive, ongoing and coordinated, patient-centered care. It is also referred to as a patient-centered medical home (PCMH) or primary care medical home.

Medical-Legal Partnership: A health care delivery model that combines the expertise of health and legal professionals to identify, address, and prevent health-harming legal needs for patients, clinics, and populations.

Care Coordination: Organization of patient care through communication between health care providers as well as the patient, mobilization of resources, and completion of patient care activities.

References and Additional Resources

Agency for Healthcare Research and Quality [AHRQ]. (2013). *2012 National healthcare disparities report: Highlights from the National Healthcare Quality and Disparities Reports*. U.S. Department of Health and Human Services. Retrieved from

<http://www.ahrq.gov/research/findings/nhqrd/nhdr12/highlights.html>

Agency for Healthcare Research and Quality [AHRQ]. (n.d.). Primary Care Medical Home Resource Center, U.S. Department of Health and Human Services. Retrieved from

<http://www.pcmh.ahrq.gov/>

American Academy of Family Physicians [AAFP], American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association. (2007). Point Principles of the Patient-Centered Medical Home. *Patient-Centered Primary Care Collaborative*. Retrieved from http://www.aafp.org/dam/AAFP/documents/practice_management/pcmh/initiatives/PCMHJoint.pdf

Anthony, S., Gowler, R., Hirsch, G., & Wilkinson, G. (2009). *Community health workers in Massachusetts: Improving health care and public health*. Boston, MA: Massachusetts Department of Public Health. Retrieved from <http://www.mass.gov/eohhs/docs/dph/com-health/com-health-workers/legislature-report.pdf>

Bacrach, D., Pfister, H., Wallis, K., & Lipson, M. (2014). *Addressing patients' social needs: An emerging business case for provider investment*. Manatt Health Solutions. Retrieved from <http://www.commonwealthfund.org/publications/fund-reports/2014/may/addressing-patients-social-needs>

Baum, F., Bégin, M., Houweling, T. & Taylor, S. (2009). Changes not for the fainthearted: Reorienting health care systems toward health equity through action on the social determinants of health. *American Journal of Public Health*, 99(11), 1967-1974.

Beeson, T., McAllister, B. D., & Regenstein, M. (2013). *Making the case for Medical-Legal Partnerships: A review of the evidence*. National Center for Medical-Legal Partnership, George Washington University. Retrieved from <http://medical-legalpartnership.org/wp-content/uploads/2014/03/Medical-Legal-Partnership-Literature-Review-February-2013.pdf>

Center for Healthcare Research and Transformation. (2012). *Affordable Care Act funding: An analysis of grant programs under health care reform*. Issue Brief. Retrieved from <http://www.chrt.org/publication/affordable-care-act-funding-analysis-grant-programs-health-care-reform/>

Centers for Disease Control and Prevention [CDC]. (n.d.). Community Health Workers/Promotores de Salud: Critical Connections in Communities. U.S. Department of Health and Human Services. Retrieved from <http://www.cdc.gov/diabetes/projects/pdfs/comm.pdf>

The College of Family Physicians of Canada. (2014). *Best advice guide: Social determinants of health*. Retrieved from <http://patientsmedicalhome.ca/resources/best-advice-guide-social-determinants-health/>

Gottlieb, M., Tirozzi, K., Manchanda, R., Burns, A., & Sandel, M. (in press). Moving Electronic Medical Records Upstream: Incorporating Social Determinants of Health. *American Journal of Preventive Medicine*, 48(2), 215-218.

Health Begins, LLC. (2014). Health Begins. Retrieved from <http://www.healthbegins.org/>

The Henry J. Kaiser Family Foundation. (2013). *Summary of the Affordable Care Act*. Retrieved from <http://kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/>

Hernandez, S., Doty, M., Shea, K., Davis, K., & Beal A. (2007). *Closing the divide: How medical homes promote equity in health care*. New York, NY: The Commonwealth Fund. Retrieved from: <http://www.commonwealthfund.org/Publications/Fund-Reports/2007/Jun/Closing-the-Divide--How-Medical-Homes-Promote-Equity-in-Health-Care--Results-From-The-Commonwealth-F.aspx>

Institute for Alternative Futures. (2012). *Community health centers Leveraging the social determinants of health*. Alexandria, VA: Institute for Alternative Futures. Retrieved from <http://www.altfutures.org/pubs/leveragingSDH/IAF-CHCsLeveragingSDH.pdf>

Institute of Medicine. (2012). *Primary care and public health: Exploring integration to improve population health*. Washington, D.C.: National Academies Press. Retrieved from http://www.iom.edu/~media/Files/Report%20Files/2012/Primary-Care-and-Public-Health/Primary%20Care%20and%20Public%20Health_Revised%20RB_FINAL.pdf

Kinsler, S. & Worth, B. (2014). *Sustaining multi-payer medical home programs: Seven recommendations for states*. Washington, D.C.: National Academy for State Health Policy. Retrieved from: <http://www.nashp.org/publication/sustaining-multi-payer-medical-home-programs-seven-recommendations-states>

Manchanda, R. (2013). *The Upstream Doctors*. New York: Ted Conferences, LLC.

Retrieved from

https://www.ted.com/talks/rishi_manchanda_what_makes_us_get_sick_look_upstream

McDonald KM, Sundaram V, Bravata DM, et al. (2007). *Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies (Vol. 7: Care Coordination)*. Rockville (MD): Agency for Healthcare Research and Quality (US). (Technical Reviews, No. 9.7.) 3, Definitions of Care Coordination and Related Terms. Retrieved from: <http://www.ncbi.nlm.nih.gov/books/NBK44012/>

National Partnership for Action to End Health Disparities, (2011). *National stakeholder strategy for achieving health equity*. Rockville, MD: U.S. Department of Health and Human Services, Office of Minority Health. Retrieved from http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf

Patient-Centered Primary Care Collaborative. (2014). *Defining the medical home*. Retrieved from <http://www.pcpcc.org/about/medical-home>

Robert Wood Johnson Foundation. (June 2014). *Equity resource guide*. Quality Field Notes, No. 4. Retrieved from http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf412949/subassets/rwjf412949_3

Smedley BD, Stith AY, Nelson AR eds. (2002). *Unequal treatment: confronting racial and ethnic disparities in healthcare*. Washington, D.C.: Institute of Medicine.

Smedley, B., Stith Butler, A. & Bristow, L. (2004). *In the nation's compelling interest: Ensuring diversity in the health-care workforce*. Washington, D.C.: Institute of Medicine.

Ulmer, C., McFadden, B., & Nerenz, D. (2009). *Race, ethnicity, and language data standardization for health care quality improvement*. Washington, D.C.: Institute of Medicine. Retrieved from <http://www.iom.edu/Reports/2009/RaceEthnicityData.aspx>

U.S. Department of Health and Human Services. (n.d.). Promotores de Salud Initiative. Retrieved from <http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=55>

U.S. Department of Health and Human Services. (n.d.). *A Physician's Practical Guide to Culturally Competent Care*. Retrieved from <https://cccm.thinkculturalhealth.hhs.gov/>

U.S. Department of Health and Human Services. (2011). *HHS action plan to reduce racial and ethnic disparities: A nation free of disparities in health and health care*. Washington, D.C.: U.S. Department of Health and Human Services. Retrieved from http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

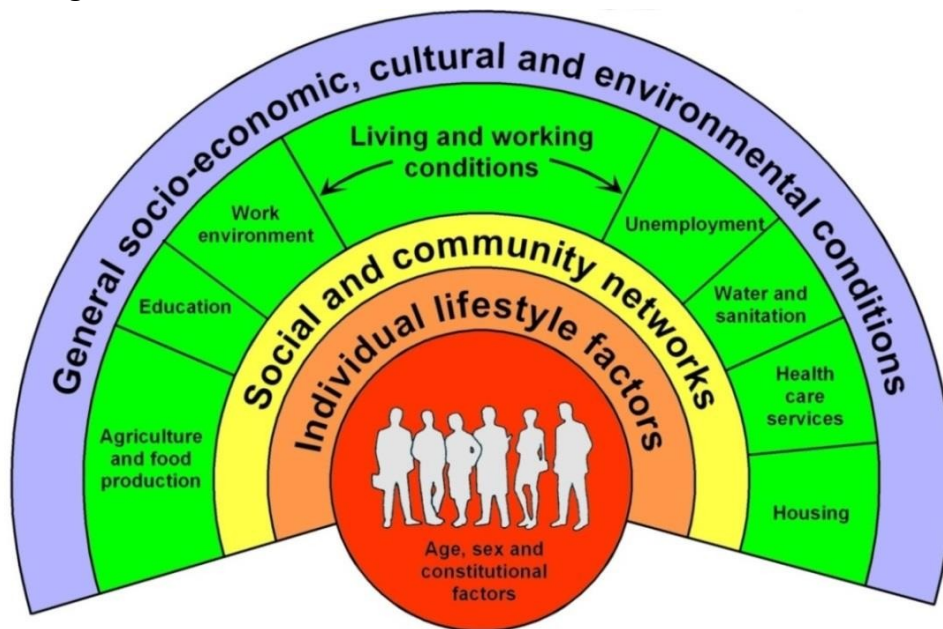
Wiggins N, Borbon A. 1998. *Core roles and competencies of community health advisors* (Chapter 3). The National Community Health Advisor Study: Weaving the Future. Tucson, Arizona: University of Arizona Press.

SECTION 6: Policy-Oriented Strategies

Policy-oriented strategies are generally thought to be among the most effective public health interventions because they have the potential to impact all of the residents in a given municipality, state, or nation. Furthermore, they often require the least individual effort in terms of behavior change due to broader changes in the environment. For instance, regulating the nutritional content of school lunches is more effective than simply educating students about the nutritional content of their lunch options. As Dr. Thomas Frieden, Director of the Centers for Disease Control and Prevention (CDC), explains, this type of strategy makes individuals' default choice the healthy choice (Frieden, 2010).

Policy-oriented strategies are particularly important in promoting health equity because they can create healthier living conditions and ameliorate inequities in the social determinants of health (e.g. housing conditions, educational attainment, etc.). It is apparent that many policy domains such as employment, housing, and education have an impact on health and health inequities. (See Figure 24.) One could argue that virtually all public policy impacts health and therefore all public policy should be “healthy public policy” (Kemmm, 2001).

Figure 24. Social determinants of health and levels of influence



Source: Dahlgren & Whitehead, 1991.

According to the World Health Organization (WHO, 1988), healthy public policy is characterized by an explicit concern for health and equity in all areas of policy and accountability for health impacts. Furthermore, the primary aim of healthy public policy is to

create a supportive environment to enable people to lead healthy lives. Healthy public policy may also be described in terms of “health in all policies,” where health becomes an explicit goal across different sectors and policy domains. Such policy approaches can facilitate place-based initiatives and support other efforts to promote community health, which were described in previous sections. Importantly, creating healthy public policy requires stakeholders to accurately predict and assess the health impacts of public policy. Finally, the policy process itself must adapt in ways that reflect increased community participation and empowerment as well as a multi-sectoral approach. This section describes policy-oriented strategies for promoting health equity. It focuses primarily on a “Health in All Policies” approach. It also includes a discussion of health impact assessments as a tool to promote healthy public policy.

Health in All Policies

The Health in All Policies (HiAP) approach addresses the complexity of health inequities and improves population health by systematically incorporating health considerations into decision-making processes across sectors and at all government levels. HiAP emphasizes intersectoral collaboration among government agencies and shared planning and assessment between government, community-based organizations, and often businesses. While its primary purpose is to identify and improve how decisions in multiple sectors affect health, it can also identify ways in which better health achieves goals in other sectors. For instance, a HiAP approach supports goals such as job creation and economic stability, transportation access, environmental sustainability, educational attainment, and community safety because these are good for health. By identifying and working towards common goals, a HiAP approach can improve the efficiency of government agencies.

The HiAP approach and its underlying philosophy have taken hold in many parts of Western Europe, Australia, and New Zealand, but is relatively new in the United States. California is breaking new ground in this area. The California Health in All Policies Task Force was formed from a strategic community initiative under the leadership of former California Governor Arnold Schwarzenegger, who recognized that many departments and agencies had similar agendas related to health, childhood obesity, and climate change. The Task Force, established through a 2010 executive order, consists of representatives from 22 state agencies, including the Department of Education, Department of Finance, Department of

“HiAP, at its core, is an approach to addressing the social determinants of health that are the key drivers of health outcomes and health inequities” (Rudolph, Caplan, Ben-Moshe, & Dillon 2013).

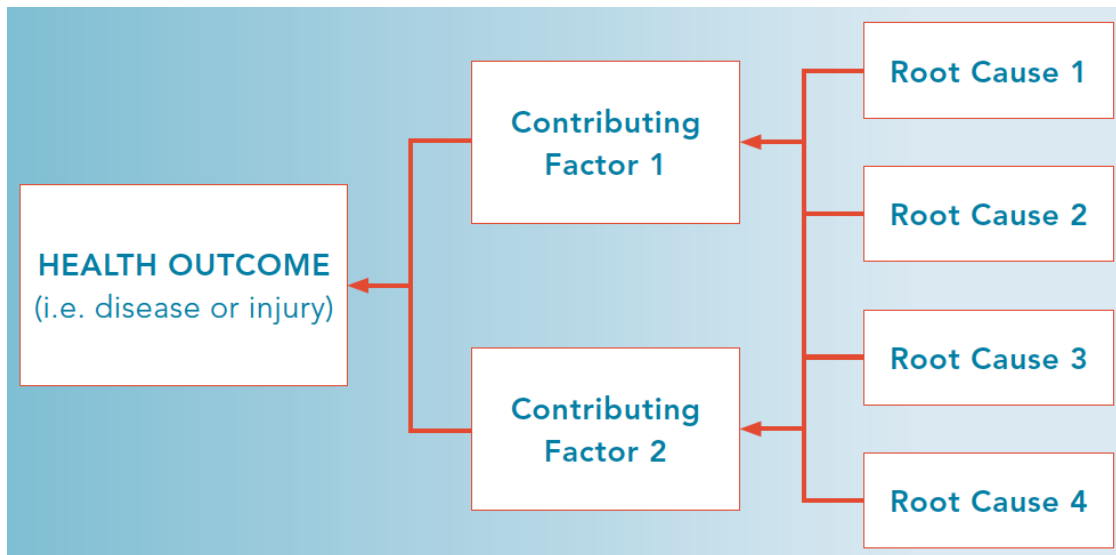
Food and Agriculture, Department of Parks and Recreation, and Environmental Protection Agency.

Details regarding the creation of the Task Force, the process used to identify priorities and build partnerships, and challenges, accomplishments and future plans can be found in Section 8 of *Health in All Policies: A Guide for State and Local Governments* by Rudolph, Caplan, Ben-Moshe, and Dillon (2013), available at [http://www.phi.org/uploads/files/Health in All Policies-A Guide for State and Local Governments.pdf](http://www.phi.org/uploads/files/Health_in_All_Policies-A_Guide_for_State_and_Local_Governments.pdf). This report was developed by experts working closely with the California Task Force. It reflects a review of the literature, contributions from international cases, and lessons learned in California.

The information presented in this guide about HiAP draws heavily from this report and highlights some of the most important elements for Delaware stakeholders. Readers are encouraged to refer to the original document for more detailed information and tools.

Identifying Root Causes

The HiAP approach is centered on the belief that population health issues must be approached through a number of methods, beyond those that target individual behaviors and the provision of health care services. In effect, it is grounded in the upstream parable described in Section 1. More specifically, the HiAP approach recognizes that public policies outside of health care create the conditions upstream that can either protect individuals from falling into the river or potentially put them at greater risk for falling in. Furthermore, the HiAP approach reflects the understanding that individual behavior is largely determined by environmental conditions. In this way, behavior is considered a proximate or downstream cause of poor health, whereas other factors in the environment which influence behavior are thought to be upstream because they represent root causes. Identifying root causes of public health issues by creating a diagram may help to identify more indirect health policy correlations than initially imagined. The following diagram (Figure 25) is useful for identifying the root causes of any public health issue.

Figure 25. Root Cause Diagram

Source: Reproduced from Rudolph, Caplan, Ben-Moshe, & Dillon, 2013.

In the context of this diagram, one can think of root causes as the focus of upstream interventions, and contributing factors as the focus of more downstream interventions. Although a policy that attempts to combat a contributing factor may positively influence a given health outcome, it is likely that this improvement will be short-lived or less influential than a policy that seeks to resolve a problem farther upstream. This is because contributing factors are not independent factors; they are consequences of larger, more salient social problems.

Obesity is a useful example of a health outcome that can be discussed in the context of Figure 25. Two contributing factors to obesity are poor diet and lack of physical activity. However, poor diet and a lack of physical activity are not the root causes of obesity. In an urban setting, physical activity habits may be negatively influenced by an unsafe built environment characterized by broken sidewalks, busy multi-lane streets, a lack of bike lanes, and high rates of violence and crime. Transportation, housing, and economic policies (all upstream approaches to addressing a health problem) might improve the built environment, creating more opportunities for physical activity and indirectly reducing the rates of obesity.

Fostering Partnerships

The goal of HiAP is to make health an explicit consideration in seemingly unrelated policy decisions. Incorporating health into new policy fields requires collaboration with many different sectors. Agencies focused on food, agriculture, building, transportation, social, economic, or crime-control policies may become partners. The public health field has a long history of

collaboration with different sectors, which must be continued and further developed to move forward with HiAP.

The most successful partnerships in HiAP are equally beneficial for all partners, which entails achieving specific goals for multiple organizations. This requires a great deal of negotiation and compromise and builds on the ideas of synergy, which were outlined in the community health strategies section (Section 4). The following are additional principles for establishing partnerships with other policy sectors:

- **Build trust.** This is a difficult, but essential, step in forming any successful partnership. Be humble and open to other partners' perspectives, goals, and values. Be sensitive to confidentiality between organizations by holding individual or sub-group meetings as well as larger group meetings. Hold your organization and your partners accountable for moving forward with the goals of the HiAP initiative.
- **Model reciprocity.** Partnerships involve a great deal of risk—most often requiring partners to risk two important assets, time, and resources—for the good of the partnership. Establish expectations and trust that partners will reciprocate. If possible, offer to help on a task that supports a partner's efforts. Ensure that credit is given where credit is due. Recognize that there will be misunderstandings with partners from different sectors and assume that your partners have good intentions towards advancing the HiAP initiative.
- **Pursue mutuality.** Ensure that partners have established shared values and are working towards mutually beneficial goals with no hidden agendas.
- **Share information and ideas.** Focus on highlighting ways for non-traditional partners to get involved in HiAP. Help others to understand how their work impacts health and how a healthy community can contribute to their efforts.
- **Clarify language.** Be extremely clear and make sure everyone understands one another. Avoid common public health jargon and abbreviations that may not be understood by partners from outside organizations.

These recommendations for building intersectoral partnerships were adapted from section 4.2 of the *HiAP Guide for State and Local Governments* (Rudolph, Caplan, Ben-Moshe, & Dillon, 2013). Additional information can be found on pages 50-58 of the *HiAP Guide for State and Local Governments* (Rudolph, Caplan, Ben-Moshe, & Dillon, 2013).

Engaging Community Stakeholders

Partnerships across government agencies are critical to HiAP, but engaging other kinds of community stakeholders and residents is vital to ensure that efforts are aligned with community needs. Other kinds of stakeholders that may be important for promoting HiAP include civic groups, local coalitions, trade unions, faith-based organizations, school boards, and planning boards, to name a few. Community stakeholder engagement can be fostered through one-on-one discussions, community meetings, forums, and focus groups, as well as formal or informal advisory groups. The HiAP Guide highlights the importance of meeting people “where they are” to encourage public participation, such as visiting regular meetings of church groups, parent groups, and other existing meetings. Similarly, social marketing strategies may be used to communicate simple, concise key messages to create awareness, common language, and community engagement. Additional outreach and engagement strategies discussed in Section 4 are directly applicable to HiAP. Readers are referred to the Community Toolbox (<http://ctb.ku.edu/en>) for guidance in this area.

HiAP in Practice

Economic Policies

Although economic policies are not typically viewed in terms of physical or mental health, when working from a HiAP perspective it is important to consider the impact that changes in wages, tax rates, or welfare benefits will have on certain populations. Income determines many of the resources available to individuals and communities and the choices that individuals make related to their health and well-being. Research consistently demonstrates the connection between income and health status: individuals with high incomes are more likely to live longer and healthier lives than individuals who occupy lower income brackets. Economic policies that consider health impacts exemplify the idea of HiAP.

Sample Strategy

In 1999, the City of San Francisco considered a proposal to require that all workers of city contractors and property leaseholders receive a wage increase from \$5.75 per hour to \$11.00 per hour (Bhati & Katz, 2001). The city commissioned researchers from San Francisco State University to examine the overall impact of the proposal, including the proposal’s impact on the health of workers who experienced the wage increase (Bhati & Katz, 2001). By conducting a “health impact assessment,” (described in more detail beginning on page 129), it was determined that a wage increase would reduce mortality risk and improve the overall health

status of both part-time and full-time workers (Bhati & Katz, 2001). The number of sick days, the risks of limitations in work or activities of daily living, and the occurrence of depressive symptoms were all predicted to decrease as well (Bhati & Katz, 2001). A new ordinance to raise the minimum wage was eventually passed. The extent to which the health impact assessment influenced the current ordinance is difficult to determine, but this case demonstrates the way in which health considerations can be made more explicit in economic policy discussions.

Housing Policies

According to the Joint Center for Housing Studies (2014), 35 percent of American households lived in unaffordable housing in 2012. For those who struggle to find housing, options may be limited to buildings with flawed construction or those located in unsafe neighborhoods. Policies that work to increase the number of affordable housing options and enhance the quality of low-income housing can have a meaningful impact on health and ought to be considered when working to advance health equity. For this reason, one of the six major goals of the California HiAP Taskforce is for “all residents [to] live in safe, healthy and affordable housing.”

Sample Strategy

In 2010, researchers from the Davis Institute of Health Economics and the RAND Corporation examined the impact of housing on the health of individuals in Philadelphia and four surrounding counties (Pollack, Griffin, & Lynch, 2010). The results indicated that housing has a major impact on overall health. Those who lived in unaffordable housing had increased odds of poor self-rated health, hypertension, and arthritis. They were more likely to reduce doctors’ appointments, ignore medical advice, or skip medications because of concerns about cost. Finally, renting instead of owning a home enhanced the likelihood of poor self-rated health and cost-related health care non-adherence (Pollack, Griffin, & Lynch, 2010).

Transportation Policies

Cities in the U.S. have constructed and maintained a variety of public transportation systems, from subways in New York to trolleys in Salt Lake City. Although these systems were originally designed to decrease traffic congestion and enable travel of large numbers of people,

transportation policies also have a health component. A public transportation policy using HiAP enhances the likelihood of exercise, contributes to weight loss, and reduces the possibility of becoming obese.

Sample Strategy

Following the completion of a light rail transit system in Charlotte, North Carolina in 2008, researchers from the University of Pennsylvania and Drexel University studied the health impact of such a policy (MacDonald, Stokes, & Ridgeway, 2010). The researchers focused on associations between objective and perceived measures of the built environment, obesity, and recommended physical activity levels (MacDonald, Stokes, & Ridgeway, 2010). They wanted to know what (if any) effect the use of a light rail transit system had on individuals' perceptions of their neighborhoods – and their health at large. The researchers found that there was a strong association between light rail transit system usage and health. In a 12-18 month time period, respondents who used the light rail transit system experienced an average weight loss of 6.45 pounds when compared with those who did not use the new public transportation system. In addition, light rail transit users were 81 percent less likely to become obese over time and were more likely to meet weekly recommended physical activity levels (MacDonald, Stokes, & Ridgeway, 2010). The development of a light rail transit system is an example of a collaborative approach taken with the goal of improving communities and thereby enhancing community health.

Food and Nutrition Policies

A healthy diet is often viewed as a key to longevity and well-being. However, many Americans do not have easy access to a source of nutrient-dense calories. People tend to make choices regarding their calorie intake based on accessibility, and many low-income, urban areas have a greater concentration of fast-food restaurants and convenience stores than higher income areas (Walker, Keane, & Burke, 2010). Diets supplied by fast-food and convenience stores are associated with high consumption of fat, sugar, and sodium, which are contributing factors to a number of chronic health problems.

Sample Strategy

One food access initiative taken in U.S. cities is the establishment of farmers' markets that accept Supplemental Nutritional Assistance Program (SNAP) benefits, formerly known as food stamps. In this way, SNAP shoppers can access fresh produce. In 2008, the City of Boston introduced the Boston Bounty Bucks program. The program was designed to address price barriers to purchasing fresh produce at farmers' markets and provided a dollar-for-dollar match each time a SNAP client shopped at a farmers' market. SNAP clients who used their benefits at a local farmers' market purchased fruits and vegetables more often, consumed more fruits and vegetables, and spent less on fresh produce than their peers who shopped elsewhere (Spiller & Obadia, 2012).

Policies that consider a community's access to quality foods take a HiAP approach and address issues of health equity by combatting not only issues of nutrition but issues of accessibility. Programs that lessen the barriers of cost and access for low-income residents enable citizens of all income levels to consume healthy foods. Cities, counties, and states should examine access to healthy food within their communities and formulate alternative policy solutions to address any issues. Incentive programs can be established, and new zoning laws can be implemented to prohibit the construction of fast food establishments or allow the creation of farmers' markets and community gardens.

Partnering to Achieve HiAP

Given the strong relation between healthy neighborhoods and the built environment, experts have identified many areas where public health and planning agencies can partner to achieve common goals. The University of Delaware's Institute for Public Administration developed a *Toolkit for a Healthy Delaware*. The toolkit offers information for local officials, public health practitioners, partners, and community leaders who want to develop policies and procedures with partners. Although the *Toolkit for a Healthy Delaware* has a specific focus for efforts that address the built environment, the strategies and tools within the toolkit can be generalized to begin important discussions regarding other policy issues. To access the toolkit, visit <http://www.ipa.udel.edu/healthyDEtoolkit/index.html>.

Additionally, the *Healthy Planning Guide* developed by the Bay Area Regional Health Inequities Initiative (BARHII) (n.d.), outlines policy recommendations, actions, and partners for community health risk factors, including alcohol and tobacco use, unsafe streets, polluted air, soil and water; and social isolation. A sample from the guide is included as Figure 26, and

readers are referred to the *Healthy Planning Guide* for additional examples and recommendations (see http://barhii.org/download/publications/healthy_planning_guide.pdf).

As Figure 26 depicts, partnerships are critical to the success of HiAP efforts at the local, state, and national levels. Public health practitioners have an important leadership role to play in assessment, outreach, and education, as well as lending their expertise to the planning process for new policy initiatives or policy changes. The BARHII guide identifies specific roles for public health practitioners in each of these key areas, depending on the nature of the issue being addressed. Engaging staff from other state agencies can be particularly important because of their ability to contribute expertise in areas that are outside of traditional public health knowledge: transportation, community development, law enforcement, and housing. Other kinds of community partners can also inform the process with local knowledge and experience, fulfilling an advocacy role that is uncomfortable (and often restricted) for government employees. For a HiAP approach to make the most meaningful long-term impact on health equity, partners from multiple sectors need to join together and leverage their expertise, fill unique roles, and collaborate effectively to influence change.

Figure 26. Healthy Planning Guide for “Unsafe Streets”

Negative Health Outcomes	Relation to Built Environment	Policy Recommendations	Action Steps for Public Health	Partners
<ul style="list-style-type: none"> • Injuries and Fatalities • Inactivity and associated outcomes, including obesity • Stress 	<p>STREET DESIGN</p> <ul style="list-style-type: none"> • Focus on auto use yields fewer lanes for bicycles, high traffic speed and congestion, noise pollution, and inadequate sidewalks <p>PEDESTRIAN & BICYCLIST FEATURES</p> <ul style="list-style-type: none"> • Lack of or poorly maintained pedestrian, wheelchair, and stroller amenities such as walkways, crosswalks, and islands • Lack of or poorly maintained bicycle lanes and bicycle parking • Absence of buffer separating cars from pedestrians, wheelchairs, strollers, and bicyclists 	<p>GENERAL & AREA PLANS</p> <ul style="list-style-type: none"> • Create a balanced transportation system that provides for the safety and mobility of pedestrians, bicyclists, strollers, and wheelchairs • Incorporate Pedestrian and Bicycle Master Plans into the circulation element of the general plan <p>ZONING</p> <ul style="list-style-type: none"> • Ensure zoning for bicycle and pedestrian routes • Use traffic-calming techniques to improve street safety and access • Require facilities for walkers, bicyclists, and people using wheelchairs in all new developments <p>REDEVELOPMENT</p> <ul style="list-style-type: none"> • Develop pedestrian and bicycling infrastructure in project area • Advocate for the inclusion of public health criteria, such as obesity, in state redevelopment law <p>ECONOMIC DEVELOPMENT</p> <ul style="list-style-type: none"> • Require developers receiving economic development incentives to build “complete streets” <p>TRANSPORTATION</p> <ul style="list-style-type: none"> • Adopt policies that require investment in public transportation, bicycle and pedestrian infrastructure • Coordinate bicycle and pedestrian routes with adjacent municipalities • Plan for and fund transit-oriented development and “complete streets” <p>SCHOOLS</p> <ul style="list-style-type: none"> • Implement Safe Routes to Schools programs <p>PARKS & RECREATION</p> <ul style="list-style-type: none"> • Ensure safe streets, walkways, and bike paths around parks or open spaces • Establish and fund a high “level-of-service” maintenance standard for parks 	<p>ASSESSMENT</p> <ul style="list-style-type: none"> • Map neighborhoods for connectivity to essential services • Conduct walkability and bikeability assessments • Review existing language in general plan for safe streets objectives • Compile evidence on link between safe streets and health <p>OUTREACH & EDUCATION</p> <ul style="list-style-type: none"> • Educate planners and decision makers on link between safe streets and health <p>PARTICIPATION IN PLANNING PROCESS</p> <ul style="list-style-type: none"> • Participate in Metropolitan Transportation Commission (MTC) regional planning processes • Develop and support Safe Routes to Schools programs • Support adoption and implementation of “complete streets” policies that accommodate all users of the road • Advocate for pedestrian and bike facilities 	<p>PUBLIC AGENCIES</p> <ul style="list-style-type: none"> • Planning department • Economic/community development department • Redevelopment agency • Local/regional transportation agency • Law enforcement • Parks and recreation <p>COMMUNITY PARTNERS</p> <ul style="list-style-type: none"> • Bicycle coalitions • Neighborhood groups • Disability rights groups

Source: Bay Area Regional Health Inequities Initiative (BARHII), n.d.

Health Impact Assessment—A Tool for HiAP

Often the first step in undertaking a HiAP approach is to assess the potential health impacts of a given policy. This can be accomplished through the use of a Health Impact Assessment (HIA). As reported in a WHO Regional Office for Europe report, the most commonly cited definition explains that “HIA is a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population” (WHO, 2014; Diwan, 2000).

Furthermore, HIA often identifies methods to ensure positive health effects and can warn against practices that contribute to negative health impacts. Concisely, as defined by the National Research Council of the National Academies in their publication *Improving Health in the United States: The Role of Health Impact Assessment*, “HIA is a systematic process that uses an array of data sources and analytic methods and considers input from stakeholders to determine the potential effects of a proposed policy, plan, program, or project on the health of a population and the distribution of those effects within the population. HIA provides recommendations on monitoring and managing those effects.”

Therefore, HIA provides insight into the consequences that policies, programs, and projects have on health. Just like HiAP takes into account policies that are not directly related to health, HIA is used to assess policies, programs and projects that are not seemingly related to health.

This guide focuses on the use of HIA as a method to determine the effects of policy on health and identify ways to improve the positive impacts of a given policy, while steering clear of adverse effects. However, HIA can also be used to evaluate programs, practices, and policies. Because of the extensive impact that policies have on communities and individuals, it is vital to ensure that policies maximize positive, and minimize any negative, health impacts. As discussed previously, policies based in all sectors (including housing, zoning, education, agriculture, and transportation) indirectly affect the health of individuals and communities. Therefore, by conducting HIA before policies of all types are developed and implemented, decision-makers and stakeholders can ensure the health of their constituents and those affected by policy decisions.

“HIA seeks to assess the impact of actions (mostly from non-health sectors) on population health using a comprehensive model of health which includes social and environmental determinants” (WHO Regional Office for Europe, 2014).

Fundamental aspects of HIA

HIA is a relatively new approach in the United States where it is frequently a voluntary process—only a few jurisdictions have mandated or institutionalized HIA or an equivalent. In other parts of the world, where HIA is more widely employed, countries have institutionalized HIA in the law-making process. Still, HIA has proven to be a valuable resource in the U.S. and many resources, toolkits, and guidelines can assist state and local governments, public health practitioners, and stakeholders in implementing this approach.

As described by the CDC, the six major steps that occur in the HIA process are:

1. *Screening* - Identifying plans, projects, or policies for which an HIA would be useful.
2. *Scoping* - Identifying which health effects to consider.
3. *Assessing risks and benefits* - Identifying which people may be affected and how they may be affected.
4. *Developing recommendations* - Suggesting changes to proposals to promote positive health effects or to minimize adverse health effects.
5. *Reporting* - Presenting the results to decision-makers.
6. *Monitoring and evaluating* - Determining the effect of the HIA on the decision (CDC, 2014).

Pew Charitable Trusts and the Robert Wood Johnson Foundation offer funding, training, and resources to encourage and support practitioners in using HIA through their partnership called the Health Impact Project. This joint project is leading the charge to promote HIA in the U.S. More information can be found at <http://www.pewtrusts.org/en/projects/health-impact-project>. These national leaders highlight several intrinsic characteristics of HIA. For instance, HIA:

- looks at health from a broad perspective that considers social, economic, and environmental influences;
- brings community members, business interests, and other stakeholders together, which can help build consensus;
- acknowledges the trade-offs of choices under consideration and offers decision makers comprehensive information and practical recommendations to maximize health gains and minimize adverse effects;

- puts health concerns in the context of other important factors when making a decision;
- considers whether certain impacts may affect vulnerable groups of people in different ways;
- increases transparency in the decision-making process; and
- supports community engagement and democratic decision-making (PEW Charitable Trusts, 2014).

HIA examines the health impacts of policies that may not be directly related to health, but are foundational in prescribing the health of a community. Therefore, HIA draws upon the collective knowledge of multiple sectors and disciplines, including urban planning, construction, transportation, agriculture, community development, environmental protection, etc. Additionally, HIA requires the involvement of community members and draws on their lived experience and desire for change. Together, the information generated by community members, stakeholders, and experts leads to a well conducted HIA that will be used to inform decision makers about the health impacts of a particular policy and identify ways to maximize positive health effects, while minimizing negative ones.

HIA and Health Equity

Often policies may seem to benefit the overall population, but may actually hinder the well-being of vulnerable and marginalized sub-populations. For example, establishing fast-food chains may stimulate the economy and constructing a highway may ease traffic congestion, which both seemingly enhance public good. However, fast-food chains offer cheap meals (that are high in calories, fat, and sodium), which often deters healthy eating among poor individuals. Highways are often constructed near impoverished areas, exposing residents to air pollutants. Therefore, with respect to health equity, HIA can be an effective tool in analyzing the health impacts of policies on marginalized groups and uncovering options to distribute positive effects in ways that level the playing field.

Due to its intrinsic qualities—namely, data analysis, community engagement, and advocacy for population health—HIA

promotes equity. By ensuring equity in policies regarding living conditions, policy-makers

“The HIA process provides opportunities for communities, especially those that endure health inequities, to ensure that decision-making processes reflect their health concerns and aspirations” (Heller, Malekafzali, Todman & Wier, 2013).

promote health equity because these structural aspects of society influence the health of communities and individuals. To stress the importance of this concept, experts developed a guide titled, *Promoting Equity through the Practice of Health Impact Assessment* (2013), an excerpt of which is reproduced in Figure 27. The guide, which includes strategies for ensuring a health equity lens in HIA, can be accessed at

http://www.pewtrusts.org/en/~media/Assets/External-Sites/Health-Impact-Project/PROMOTINGEQUITYHIA_FINAL.PDF.

Figure 27. Principles for Promoting Equity in HIA Practice

Principles for Promoting Equity in HIA Practice

A. Ensure community leadership, ownership, oversight, and participation early and throughout an HIA from communities of color, low-income communities, and other vulnerable groups. These populations will likely be most impacted by policies under consideration and have valuable expertise and insights that can inform decision making. It is critical to develop partnerships with, and engage, community representatives.

B. Use the HIA as a process to support authentic participation of vulnerable populations in the decision-making process on which the HIA focuses. This is critical because vulnerable communities are often excluded from decision-making processes that stand to impact them. If needed, the HIA process should help build capacity for disadvantaged communities to fully participate in the decision-making process.

C. Target the practice of HIA towards proposals that are identified by, or relevant to, vulnerable populations. Resources and capacity should be focused on issues faced by the most vulnerable segments of any community.

D. Ensure that a central goal of the HIA is to identify and understand the health implications for populations most vulnerable or at risk for poor health. HIA goals should reflect a focus on expanding opportunities for good health outcomes in vulnerable populations.

E. Ensure the HIA assesses the distribution of health impacts across populations wherever data are available. Populations may be defined by geography, race/ethnicity, income, gender, age, immigration status, and other measures. Vulnerable groups should be involved in defining these populations and in developing measures of vulnerability. Where data are unavailable, surveys, focus groups, community oral histories and experiences and other methods can be used to understand the distribution of impacts.

F. Identify recommendations that yield an equitable distribution of health benefits and maximize the conditions necessary for positive health outcomes among the most vulnerable populations and those who stand to be most adversely impacted by the decision that is being assessed. Identification of the distribution of impacts should be accompanied by recommendations for actions that yield equitable health outcomes.

G. Ensure that findings and recommendations of the HIA are well communicated to vulnerable populations most likely to be impacted by the decision being assessed. Culturally appropriate materials with non-technical language and accessible summaries, distribution of findings via multiple mediums and platforms, and targeted outreach to sub-populations, such as vulnerable youth, are strategies that help ensure effective communication of findings and recommendations.

H. After the decision on which the HIA is focused is made, ensure that the actual impacts of the decision are monitored, and that resources and mechanisms are in place to address any adverse impacts that may arise. If implemented with careful attention to these principles for promoting equity, HIAs can help transform how policy and other public decisions are made, who has a voice in those decisions, and how those decisions impact the health of vulnerable communities. Every day, policymakers and other public leaders make decisions that have implications for population health without acknowledgment or careful analysis of the potential impacts on our most vulnerable populations. To ensure these decisions reflect and address community health needs and aspirations, it is critical that vulnerable populations bring their knowledge and expertise to the decision-making process and have an active and affirmative voice in those decisions.

Source: Heller, Malekafzali, Todman & Wier, 2013.

HIA in Delaware

HIA is increasingly employed in communities across the nation. Leaders in HIA can take many forms, including community members, non-profit organizations, and government agencies. The diversity of how HIA is implemented reflects the variety of communities that may benefit from its outcome and the different types of policies that it may target.

For example, Delaware Greenways, a non-profit organization aiming to promote health through the use and preservation of green spaces, conducted a HIA regarding land use. In collaboration with the Delaware Coalition for Healthy Eating and Active Living's (DE HEAL) Environment and Policy Committee and the Governor's Council on Health Promotion and Disease Prevention, Delaware Greenways applied for and received one of three funding awards from the Association for State and Territorial Health Officials (ASTHO). The \$15,000 award supported the formation of an HIA Advisory Committee, data collection and analysis, reporting, and various process tasks.

The HIA, referred to as the Fort DuPont Master Planning and Feasibility Analysis, was intended to discern which scenario of the development of the 450-acre Fort DuPont site promoted health and cost savings. Two development scenarios were analyzed, with a primary focus on how residents of neighboring Delaware City access goods, resources, services, and employment opportunities.

*“Using HIA can ultimately lead to more cost-effective, health-enhancing decisions”
(Trabelsi, 2013).*

A baseline analysis found that although certain features of the community promoted health, there was an absence of healthy food choices, public transportation options, and access to emergency or trauma care. The proposed development scenarios included the preservation of historic infrastructure while enhancing the built environment to support the growth of the local economy. The HIA uncovered that a key aspect of the development scenarios would be increased connectivity of non-motorized modes of transportation, such as sidewalks, multi-use paths, and other accommodations. This would be more likely to result in positive health outcomes, due to better access to recreational areas and the promotion of physical activity. More information about the effort can be viewed at

http://www.delawaregreenways.org/media/HIA_Summary_Report_July_2013.pdf. A full report can be requested by emailing greenways@delawaregreenways.org.

With respect to health equity, the Fort DuPont Master Planning and Feasibility Analysis identified methods for improving access for low-mobility populations, including the elderly, children, and people with disabilities. Additionally, as identified in the baseline analysis, Delaware City experiences educational attainment and income averages that fall below state

and county levels. Therefore, by increasing access to services, resources, and goods and by stimulating the local economy, residents may benefit from improved living conditions and economic opportunity. Because of the link between the physical environment and health, the improvements in the built environment proposed by the Fort DuPont development scenarios have the potential to reduce health inequities.

Recommendations and Toolkits for HIA

The Fort DuPont Master Planning and Feasibility Analysis marked the first use of HIA in Delaware. Its HIA Advisory Committee developed recommendations for conducting HIAs. The following is a selection of those recommendations:

- Select a project/policy/program identified by a local stakeholder group, community leader, or elected official for assessment to help ensure effective stakeholder participation, local commitment, and open communication.
- Initiate stakeholder engagement before the HIA officially begins and maintains an effective stakeholder engagement strategy throughout.
- To the extent possible, select a subject project/policy/program that has been well defined and about which there are sufficient data available.
- Select for assessment a project or health issues/impacts that have greatest potential for impacting population health.
- Work with subject project representatives to clearly define and agree upon how the subject project efforts and HIA efforts will interact, including reporting and communications strategies.
- Allocate sufficient resources (time, funding, and personnel) since subject projects often have fluctuating timelines; building in a cushion will help ensure a successful HIA. Effective HIAs also require commitment from a broad coalition of professionals.
- Be thorough in scoping phase brainstorming; plan for the scoping phase to be one of the longest phases of the HIA process and expect to adjust.
- Think beyond the strict definition of the HIA and the process for opportunities to bring health into the decision-making process; if the process is not going as planned, identify the opportunities that have arisen unexpectedly that offer possibilities for bringing health into the discussion.

- Select a project for which health, demographic, and other data are generally available, especially if new data collection is not possible. Also, use the most local data available so that the HIA can focus on the subject project population (Trabelsi, 2013).

As interest in HIA grows, many tools and resources are becoming available nationally. The website of Human Impact Partners at <http://www.humanimpact.org/new-to-hia/tools-a-resources/#hiaguidesandsteps> provides links to many helpful sources. Similarly, the Community Tool Box (<http://ctb.ku.edu/en/table-of-contents/overview/models-for-community-health-and-development/health-impact-assessment/main>) presents valuable information about HIA and resources for its implementation. Many toolkits exist to assist state and local governments, public health practitioners, and stakeholders in implementing this approach. Within its website devoted to the concept of Healthy Places, the CDC provides several toolkits for conducting HIA with respect to parks and trails and transportation. (More information can be found at http://www.cdc.gov/healthyplaces/parks_trails/default.htm and http://www.cdc.gov/healthyplaces/transportation/hia_toolkit.htm). Additionally, the Society for Practitioners of Health Impact Assessment (SOPHIA) developed a series of metrics to ensure a focus on equity in HIAs. A worksheet to support the use of such metrics can be found at http://www.hiasociety.org/documents/EquityMetrics_FINAL.pdf.

Communicating for Healthy Public Policy

Creating the kinds of healthy public policies needed to advance health equity requires a significant shift in the way that most people understand health, health inequities, and the role of public policy in both. Building support for HiAP and for using HIAs requires that public health professionals, partners, and advocates reframe health from being something that is individual in nature and determined by personal choice, to something that is shaped by our environments and for which we have a collective responsibility to improve. These approaches to understanding health move from an individual and behavioral frame to an environmental frame. As discussed in the *HiAP Guide for State and Local Governments* (Rudolph, Caplan, Ben-Moshe, & Dillon, 2013), it is important to communicate this environmental frame early and often. A prevailing misconception is that the best way to improve health is through access to health care and healthier individual choices. Therefore, it is critical to communicate effectively how the places in which we live, learn, work, and play affect our health. Once this environmental frame is understood, it is easier to convince people about the need for improving their environment to improve health. And this comprehension is necessary for a HiAP approach.

In addition to presenting an environmental frame, it is important to identify and then use commonly held values when communicating with stakeholders. This can be difficult for public health professionals or others who may be uncomfortable in moving away from statistics and research often used to make the case. However, values and emotion are what move people, and these need to be part of the conversation.

In promoting a shift to an environmental frame and HiAP, the consistency and credibility of the message is also important. Additionally, communication strategies are most effective when they are audience-specific. Knowing the audience and their starting point can help craft tailored messages. Similarly, having a messenger who resembles or relates to the audience may influence the effectiveness of the messages because people tend to be more receptive to people like them. Some pay more attention to messages coming from persons whom they perceive are respected sources (Rudolph, Caplan, Ben-Moshe & Dillon, 2013).

“To make the case for healthy public policy most effectively, it is important to offer an alternative to the default frame of personal responsibility” (Rudolphe, Caplan, Ben-Moshe, & Dillon, 2013).

Finally, it is critical that communication strategies include a focus on solutions. As explained by the authors of the *HiAP Guide for State and Local Governments*:

“People are more inclined to act when they feel they can *do* something to solve a problem. But often public health professionals spend more time talking about the problem than the solution, leaving their audience feeling hopeless or overwhelmed. To more effectively inspire action we need to reverse that ratio and talk more about the solution than the problem. For example: “Increased access to healthy food will improve nutrition and contribute to reducing rates of childhood overweight and adult diabetes. Ensuring that everyone has access to healthy, affordable food can be complicated, but there are meaningful steps we can take right now. That’s why we’re asking [specific person/agency/ organization] to support the Healthy Food Financing Initiative to increase access to healthy food in our neighborhood.” (Rudolph, Caplan, Ben-Moshe & Dillon, 2013, p. 105).

The *HiAP Guide for State and Local Governments* includes a detailed discussion of communication with several recommendations and sample messages. The authors include sample responses to commonly asked questions and offer a number of additional resources. The authors explain that the critical components to an effective message are:

1. Make sure to present the environmental frame first.
2. State your values (e.g. health, equity, community, etc.).
3. State the solution clearly, and be sure that the solution gets at least as much, if not more, attention than the problem.

Readers are encouraged to visit Section 7.1 of the HiAP guide for a detailed discussion on communication strategies to support HiAP. Similarly, the HiAP guide includes an annotated list of references related to communication for HiAP, which can be found beginning on page 155 (see [http://www.phi.org/uploads/files/Health in All Policies- A Guide for State and Local Governments.pdf](http://www.phi.org/uploads/files/Health_in_All_Policies-A_Guide_for_State_and_Local_Governments.pdf)).

Glossary – Section 6

Healthy Public Policy: A policy that is explicitly responsive to health needs. It may be a health policy, designed specifically to promote health. Alternately, it may be a policy outside of what is typically thought of as health policy, but promotes health or positively influences the determinants of health.

Health in All Policies (HiAP): A collaborative approach that makes health considerations explicit in decision-making across sectors and policy domains. A HiAP approach convenes diverse stakeholders to consider how their work influences health and how collaborative efforts can improve health while advancing other goals.

Health Impact Assessment (HIA): A systematic process that uses a variety of data sources and research methods, and considers input from a range of stakeholders to determine the potential effects of a proposed policy, plan, or action on the health of a population and the distribution of those effects within the population.

Root Cause Mapping: A process for identifying the primary factors that contribute to community health problems to identify the most appropriate areas for intervention. This approach can be useful in helping stakeholders identify links between health and risk factors in the community, including areas seemingly outside of public health.

Stakeholders: Any individual, group, or organization that has an interest in a project or policy. This can include residents, decision-makers, funders, community-based organizations, state agencies, advocacy groups, academic experts, and public health practitioners.

References and Additional Resources

Bay Area Regional Health Inequities Initiative (n.d.), *Healthy planning guide*. Retrieved from <http://barhii.org/resources/healthy-planning-guide/>

Bhatia, R. & Katz, M. (2001, September). Estimation of health benefits from a local living wage ordinance. *American Journal of Public Health, 91(9)*. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446793/>

Centers for Disease Control and Prevention [CDC]. (2014). *Health impact assessment*. Retrieved from <http://www.cdc.gov/healthyplaces/hia.htm>

Centers for Disease Control and Prevention [CDC]. (2013). *Parks and trails health impact assessment toolkit*. Retrieved from http://www.cdc.gov/healthyplaces/parks_trails/default.htm

Centers for Disease Control and Prevention [CDC]. (2011). *Transportation Health Impact Assessment Toolkit*. Retrieved from http://www.cdc.gov/healthyplaces/transportation/hia_toolkit.htm

Changelab Solutions (n.d.), *Healthy planning resources*. Retrieved from <http://changelabsolutions.org/healthy-planning>

Diwan V., Douglas M., Karlberg I., Lehto J., Magnússon G., & Ritsatakis A. (2000). *Health impact assessment: From theory to practice*. Report on the Leo Kaprio Workshop, Gothenburg, 28-30 October 1999. Göteborg: Nordic School of Public Health.

Fehr R., Vilianni F., Nowacki J., Martuzzi M. (2014). *Health in impact assessments: Opportunities not to be missed*. Copenhagen: WHO Regional Office for Europe.

Frieden, T. (2010). A framework for public health action: The health impact pyramid. *American Journal of Public Health, 100(4)*, 590-595.

Human Impact Partners (n.d.). *Tools and Resources*. Retrieved from <http://www.humanimpact.org/new-to-hia/tools-a-resources/#hiaguidesandsteps>

Heller H., Malekafzali S., Todman L., Wier M. (2013). *Promoting equity through the practice of health impact assessment*. Retrieved from http://www.pewtrusts.org/en/~media/Assets/External-Sites/Health-Impact-Project/PROMOTINGEQUITYHIA_FINAL.PDF

Institute for Public Administration. (n.d.). *Delaware Complete Communities Planning Toolbox*. Retrieved from <http://www.ipa.udel.edu/healthyDEtoolkit/index.html>

Jacobson, E., DeCoursey, W.J., & Rosenberg, N. (2011) *Health impact assessment: A useful tool*. University of Delaware, Institute for Public Administration. Retrieved from <http://www.ipa.udel.edu/healthyDEtoolkit/hia/>

Jandu M., Bourcier E., Choi T., Gould S., Givens M., Heller J., Yuen T. Equity metrics for health impact assessment practice, Version 1. *The Society of Practitioners of Health Impact Assessment (SOPHIA)*. Retrieved from http://www.hiasociety.org/documents/EquityMetrics_FINAL.pdf

Joint Center for Housing Studies, (2014). *The state of the nation's housing, 2014*: Harvard University. Retrieved from http://www.ichs.harvard.edu/research/state_nations_housing

Kansas University Work Group for Community Health and Development. (2014). *Community Toolbox, Chapter 2, section 11 on Health Impact Assessment*, Retrieved from

<http://ctb.ku.edu/en/table-of-contents/overview/models-for-community-health-and-development/health-impact-assessment/main>

Kemm (2001). Health impact assessment: A tool for healthy public policy. *Health Promotion International*, 16(1), 79-85.

MacDonald, J. M., Stokes, R., & Ridgeway, G. K. (2010, August). The effect of light rail transit on body mass index and physical activity. *American Journal of Preventative Medicine*, 39(2).

National Research Council of the National Academies. (2011). *Improving health in the United States: The role of health impact assessment*. The National Academies Press. Retrieved from <http://www.nap.edu/catalog/13229/improving-health-in-the-united-states-the-role-of-health>

Pew Charitable Trusts. (2014). *Health Impact Project: Overview*. Retrieved from <http://www.pewtrusts.org/en/projects/health-impact-project>

Pew Charitable Trusts. (2014). *Health Impact Project: Health Impact Assessment*. Retrieved from <http://www.pewtrusts.org/en/projects/health-impact-project/health-impact-assessment>

Pollack, C. E., Griffin, B. A. & Lynch, J. (2010, December). Housing affordability and health among homeowners and renters. *American Journal of Preventative Medicine*, 39(6). Retrieved from [http://www.ajpmonline.org/article/S0749-3797\(10\)00455-1/pdf](http://www.ajpmonline.org/article/S0749-3797(10)00455-1/pdf)

Rudolph, L., Caplan, J., Ben-Moshe, K., & Dillon, L. (2013). *Health in all policies: A guide for state and local governments*. Washington, DC and Oakland, CA: American Public Health Association and Public Health Institute. Retrieved from [http://www.phi.org/uploads/files/Health in All Policies-A Guide for State and Local Governments.pdf](http://www.phi.org/uploads/files/Health_in_All_Policies-A_Guide_for_State_and_Local_Governments.pdf)

Spiller, K. & Obadia, J. (2012). Farmers markets: Impact on fruit and vegetable consumption of Supplemental Nutrition Assistance Program clients. *Boston Collaborative for Food and Fitness*. Retrieved from http://bostonfarmersmarkets.org/wp-content/uploads/2012/07/FarmersMarket-impact-on-FV_Website.pdf

Trabelsi A (2013). *Health impact assessment: Promoting health, cost-effective, sustainable and equitable decision making in Delaware*. Delaware Greenways & Delaware Coalition for Healthy Eating and Active Living. Retrieved from http://www.delawaregreenways.org/media/HIA_Summary_Report_July_2013.pdf

Walker, R.E., Keane, C.R., & Burke, J.G. (2010 September). Disparities and access to healthy food in the United States: A review of food deserts literature. *Health and Place*, 16(5).

World Health Organization [WHO], 1988. *The Adelaide recommendations: Healthy public policy*. WHO and the Commonwealth of Australia. Retrieved from <http://www.who.int/healthpromotion/conferences/previous/adelaide/en/index1.html>

SECTION 7: Data, Research, and Evaluation for Health Equity

As described in earlier sections of this guide, research on the relations between health inequities and indicators of socioeconomic status, including income, race, ethnicity, and living and working conditions, is unequivocal. These social conditions have been described as “fundamental causes of disease” because they determine access to resources needed to avoid risks and can be linked to multiple diseases (Link & Phelan, 1995). This is an important rationale for place-based strategies that target living and working conditions, which are likely to have a positive impact on a range of health outcomes simultaneously. However, the specific causal linkages between social conditions and health inequities are not always well understood and can vary by community. For this reason, even strong associations between social conditions and health inequities at the macro-level may not provide enough information to understand community-specific needs or to promote action at the community level. Furthermore, better data and concerted measurement strategies are needed to evaluate changes at the community level and to assess the impact of policy changes more broadly across the state of Delaware. For these reasons, the *National Stakeholder Strategy for Achieving Health Equity* (NPA, 2011), described in previous sections of this guide, identifies “improving data availability, coordination, utilization, and diffusion of research and evaluation outcomes” as one of its five over-arching goals.

Section 7 describes the kinds of data and capacity needed to understand and monitor health inequities at the community and state levels. It includes a discussion of strategies for evaluating health equity initiatives, and highlights ongoing challenges with respect to evaluation. This section concludes with a summary of research priorities to advance health equity. Overall, it provides an overview of the challenges in collecting and analyzing data regarding the social determinants of health (SDOH) and health equity, and does not describe the complexity of the analyses necessary to draw conclusions using such data.

Data to Identify and Understand Health Inequities

It is critical to have a comprehensive understanding of population health status, including inequities in health across various characteristics, such as income level, race/ethnicity, sexual orientation, gender, gender identity, education level, and other indicators of socioeconomic status. It is important to note that health status data is not necessarily available for all population groups. For example, health status data is largely lacking for members of the Lesbian, Gay, Transgender, Bisexual, and Questioning (LGTBQ) population. A 2011 report from the Institute of Medicine (IOM), titled *The Health of Lesbian, Gay, Bisexual, and Transgender*

People: Building a Foundation for Better Understanding, highlights the need for targeted data collection and research regarding the health status of this population (IOM, 2011).

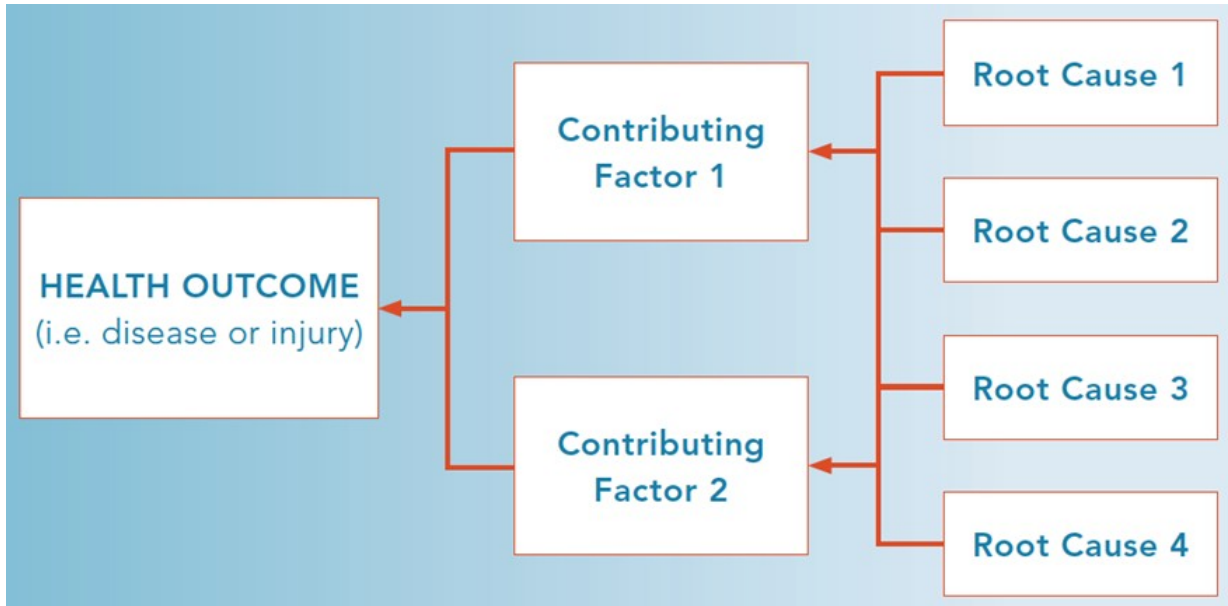
Additionally, it is important to have a clear understanding of the underlying or upstream causes for health inequities, broadly defined as social determinants of health (SDOH). Both types of data—health status and SDOH—are necessary to describe baseline status and to monitor changes over time as well as to make comparisons by place. Baseline data helps practitioners, policy makers, and community residents identify priorities and ensure that interventions reflect the community’s needs and resources. Tracking changes over time helps to ensure that interventions remain focused on those priorities and accountable to stakeholders. Importantly, neighborhood-level data are needed to facilitate the identification of priorities and other kinds of decision-making. This can be challenging because many existing data sources do not allow for neighborhood-level analysis and/or would require substantial resources to do so.

Innovative Types of Data

Data that describes SDOH are needed to highlight the ways in which unequal power and privilege influence the distribution of resources required for health (Knight, 2014). For instance, in addition to monitoring high school graduation rates, it is valuable to collect information and monitor changes in per capita spending on public education. Similarly, the availability of affordable housing is an important SDOH, but the level of racial segregation in a defined community is necessary to paint a more complete picture.

Many models analyze the underlying causes and factors of health outcomes. One model is the root cause mapping process described in the policy section, Section 6. It is useful for identifying important indicators of community health and inequities such as per capita spending and racial segregation. The root cause diagram, reproduced in Figure 28, highlights how data collection efforts also need to shift upstream. However, it should be noted that more exhaustive models, such as causal diagrams (see Pearl, 2000), depict the relations between causes and indicators and more accurately represent how root causes interplay to influence health outcomes. In either case, looking at the upstream causes of health inequities allows stakeholders to focus on the most meaningful indicators and helps shift the focus from individual risk factors and behaviors to community health and the structures that underlie inequities. Referring back to the obesity example discussed in Section 6, two contributing factors to obesity are poor diet and lack of physical activity. However, they are not the root causes of obesity. Rather, elements or structures within the built environment underlie these individual risk factors. Using this diagram to identify root causes of obesity might lead stakeholders to collect and track data on convenience and fast food retail locations, and/or the availability and safety of parks and playgrounds.

Figure 28. Root Cause Diagram



Source: Reproduced from Rudolph, Caplan, Ben-Moshe, & Dillon, 2013.

Data on social and structural determinants are not readily collected or collected in systematic ways. This may require creativity and investments in novel approaches to data collection, such as community asset mapping; Photovoice, which utilizes photography as a means of communicating social issues; and walking audits. It likely involves partnering with other sectors that have existing data to support a broader understanding of SDOH and health inequities. Furthermore, community members should be engaged in identifying, collecting, and interpreting new kinds of data for health equity. As described by the Centers for Disease Control and Prevention (CDC) in their *Practitioner Guide for Advancing Health Equity*, “the perspectives of community members can bring static data to life by revealing the lived experience behind the data” (CDC, 2013, p. 19). The CDC’s guide also offers a systematic list of questions for practitioners in government and community-based organizations to reflect upon when building their capacity for identifying and understanding health inequities:

- Where are we now?
 - What are our organization’s current practices for identifying and understanding health inequities?
 - Can we clearly articulate health inequities related to the health issues we are trying to prevent and/or address? If so, list those health inequities.
- What types of information can we use to identify health inequities in our community?

- What process can we set up to get a full understanding of health inequities in our community?
- What type of information do we need to ensure we have a full understanding of health inequities in our community?
- Have we looked beyond basic health risk behaviors and standard outcome data to examine social, economic, and physical indicators that may contribute to or maintain health inequities?
- Have we examined community context and historical factors that may help our understanding of existing health inequities?
- What tools and resources can we use to identify and understand health inequities?
 - What combination of data sources do we need to better understand experiences of populations affected by health inequities?
 - What sources or partners may already have the data we need for assessing community environments or health behaviors?
 - Where can we go to understand the historical context of health inequities in the community?
- How can we engage community members in gathering and analyzing data?
 - How do we currently engage community members in our data collection and analysis process?
 - What process can we put in place to routinely engage populations affected by health inequities in collecting and analyzing data?
- What are our next steps?
 - What can we do differently to improve or enhance our ability to identify and understand health inequities?
 - What is our plan of action to implement those changes? (CDC, 2013, p. 21).

*“Without a clear understanding of existing health inequities, and the root-causes contributing to them, well-intentioned strategies may have no effect on or could even widen health inequities”
(CDC, 2013).*

Strengthening Existing Data Capacity

Understanding health inequities and their determinants can be improved by collaborating across sectors that may already collect the kinds of data that are needed. Similarly, it may be possible to make greater use of existing data within public health surveillance systems or within health and human service agencies. This involves linking data systems in ways that provide a more comprehensive view of community health. Adding data from one database to another can be resource intensive, and may require addressing legal barriers in addition to overcoming technical barriers. It is critical to ensure the protection of privacy when working with individual-level data, particularly as the groups most affected by inequities may already experience disadvantages related to their identity.

Fortunately, in the state of Delaware, the potential for such linkages can be facilitated by initiatives such as the Master Client Index (MCI), which tracks unique clients in each of the programs within the Department of Health and Social Services (DHSS) and the Department of Services for Children, Youth and their Families (DSCYF) (see http://dhss.delaware.gov/dhss/dms/irm/files/mci_interfacing_requirements.pdf). Similarly, the Delaware Health Information Network (DHIN) is a statewide health information exchange among health care providers that facilitates an integrated data to improve patient outcomes and patient-provider relationships, while reducing service duplication and health care spending (see <http://dhin.org>). These, and other data-sharing initiatives, can provide the foundation for more concerted health equity oriented efforts.

Several national databases can be used to understand health inequities and their causes at the local level. The *Data Set Directory of Social Determinants of Health at the Local Level* contains an extensive list of existing data sources across 12 dimensions of the social environment, including: economy, employment, education, political, environmental, housing, medical, governmental, public health, psychosocial, behavioral, and transportation (Hillemeier, Lynch, Harper & Casper, 2004). Within each dimension, the directory includes several important indicators and data sources to describe those indicators. For instance, the political dimension identifies voter registration and voting rates as important indicators of civic participation and offers a specific data table within the Census Bureau dataset as a source for those indicators. The behavioral dimension includes indicators commonly used in public health surveillance, such as smoking rates and levels of physical activity. However, it also includes indicators such as the average local price of cigarettes and physical education requirements in schools. These latter indicators speak to the social and structural characteristics of the environment, which allow public health practitioners and partners to better understand upstream root causes. For the full directory, visit: http://www.cdc.gov/dhdsp/docs/data_set_directory.pdf. Appendix C from the *CDC Practitioner Guide for Advancing Health Equity* (2013) (see

<http://www.cdc.gov/nccdphp/dch/pdfs/health-equity-guide/foundationalskills.pdf>) contains additional examples of resources for identifying and understanding health inequities.

Existing data collection and surveillance activities can also be strengthened with respect to the collection of race, ethnicity, and language data. Although race, ethnicity, and language data is captured in databases such as vital statistics and health care records, it is not collected consistently through other surveys, programs, or databases. It is recommended that race, ethnicity, and language data be collected across sectors and collected by a variety of agencies including government, non-profit organizations, and academic institutions, among others. A race, ethnicity, and language workgroup of the Minnesota Department of Health and the Minnesota Department of Human Services specifically recommends the following:

- More detailed categories of race and ethnicity data should be used so that the data are more useful in understanding health issues and needs for particular groups.
- State agencies and organizations that collect and use health data should be regularly engaged with diverse communities to promote full understanding of how race, ethnicity, language, and culture affect quality, access, and cost of health services.
- Data collected by state agencies and health care organizations should be as accessible to communities, as possible. The criteria and process for obtaining access to data should be provided to and discussed with the communities, and agencies should take steps to ensure that information about relevant datasets is easily available online.
- A workgroup (such as the one that developed these recommendations) should continue on an ongoing basis so communities, health care stakeholders, and government agencies can partner to improve data collection policies and practices and, using the data, eliminate health inequities.
- A uniform data “construct” should be developed so that all health data collected use the same categories for race, ethnicity, and language. The uniform construct should be used not just by state health agencies, but also by licensing boards, other governmental agencies, health plans, hospitals, clinics, non-profit agencies, quality and performance measurement programs, and others who collect, analyze, and report health data. In this way, disease burden, risk and protective factors, access to care, and quality of care can be measured and communicated for smaller populations within an overall population. The uniform construct should build on existing frameworks for data collection, to eliminate duplication of effort. The data construct should be flexible so categories can be changed as needed. A process should be developed for assessing changes in

racial/ethnic populations in the state and determining when populations are of a sufficient size to be reported as a separate category.

- Programs that rely on survey data should consider over-sampling or mixed mode approaches to obtain larger numbers for communities of color (MDH/MDHS, 2011).

For more information about Minnesota's race, ethnicity, and language workgroup, its process for developing recommendations, and a more detailed discussion of the recommendations, visit:

<http://www.health.state.mn.us/ommh/publications/raciaethnicdata2011.pdf>.

Selected Data Tools for Health Equity: GIS, HIA, CHA

Capacity to address health inequities at the community level can be strengthened by using various tools that help describe public health issues and available resources at the community level. One such tool involves the use of Geographic Information Systems (GIS) data. GIS data may be used in concert with health data to generate maps, which provide a powerful tool for visualizing health inequities at the community level. More specifically, maps can be used to analyze spatial patterns of health and illness in tandem with social inequities such as poverty and income, race/ethnicity, and environmental health hazards (MDH, 2014). For example, the maps presented in Section 3 that reflect income level, educational attainment, infant mortality, and life expectancy by ZIP code are GIS maps that were developed by Delaware's Division of Public Health (DPH) and its Office of State Planning Coordination (OSPC). Ultimately, GIS maps can distill otherwise complex information into easily understood images. Importantly, they can be used to promote policy change, particularly because they can focus attention on areas defined by political boundaries (e.g. congressional districts).

The use of Health Impact Assessments (HIAs) described in Section 6 require a different kind of analytical approach, research skills, and sources of data than traditionally used in public health. However, they also offer an important way of understanding existing health inequities and the changes (both positive and negative) that may result from proposed policy changes. The methods for conducting HIAs described earlier are consistent with the data and evaluation needs outlined in this section. Specifically, they call for community-based approaches to data collection and analysis; are grounded in the principles of equity, inclusion and democracy; often rely on mixed data collection methods (i.e. quantitative and qualitative approaches); and make connections between health and social and environmental conditions and structures. There is also a strong focus on dissemination and utilization of the results of the analysis. For these reasons, capacity for conducting HIAs should be developed and/or enhanced to advance health equity in Delaware.

Another opportunity for addressing health equity data needs at the community level exists through the use of community health assessments conducted by non-profit hospitals. The Affordable Care Act (ACA) now requires tax-exempt hospitals to regularly (at least every three years) conduct community health needs assessments and develop plans to address those needs. The law strengthens the hospitals' obligation to work with public health agencies and others in this regard. Therefore, public health practitioners can partner with hospital administrators to support their data collection efforts and encourage them to implement action plans that focus on SDOH and equity.

Limitations of Data Collection and Analysis for Health Equity

The kinds of data needed to describe health inequities and their causes are not always available or accessible. Investments in new kinds of data collection may be needed to fill these gaps. Importantly, data collection systems need to be maintained to track changes over time and allow for the evaluation of interventions. Furthermore, investments may be needed to allow for easy access to the data once collected (e.g. interactive websites) and to effectively communicate the findings. Investments in data collection and analysis are wasted if the information is not shared in useful ways. Infographics, or images used to portray data, can be particularly effective in conveying information to the public and policymakers. Figure 30, shared courtesy of the Robert Wood Johnson Foundation to Build a Healthier America, shows how the average life expectancy for babies born to mothers in New Orleans can vary by as much as 25 years across neighborhoods just a few miles apart. Below are links to two additional examples of infographics oriented to health equity: http://www.hpoe.org/Reports-HPOE/EoC_Infographic_FINAL.pdf and http://healthequity.sfsu.edu/sites/sites7.sfsu.edu.healthequity/files/What%20are%20Health%20Inequities_1.pdf. Each of these examples demonstrates the power of images in conveying this type of information and can be adapted to reflect the reality of health inequities in Delaware.

Figure 30. Metro Map: New Orleans, LA



Source: Robert Wood Johnson Foundation, 2013. Retrieved from <http://www.rwjf.org/en/about-rwjf/newsroom/infographics/new-orleans-map.html>.

Another data challenge, inherent in working at the community level, is the limitation of small sample sizes. Ideally, data are analyzed by neighborhood to provide the most comprehensive understanding of local needs, assets, and priorities. However, the more granular the level of data collection, the greater the challenge in reporting rates and other statistical measures, and interpreting changes over time. This is because small changes can appear large and be potentially misleading. For instance, if there are 10 cases of a disease one year and nine cases the following year, this could be interpreted as a 10 percent drop. A larger area might have 1,000 cases one year and 999 the following year, revealing a 0.1 percent drop. In both instances, there is one less person with the disease, but the reduction may or may not be relevant in the context of the population as a whole. When working with small numbers, it is difficult to know if a change is meaningful, or the result of random chance or other anomaly.

Statisticians often aggregate data into larger geographic regions or over multiple years to address this challenge. However, such aggregation is less helpful when developing and evaluating place-based initiatives at the local level.

Another barrier, that is somewhat easier to overcome than others, is the lack of a skilled workforce. Surely, practitioners working in epidemiology and surveillance need strong analytical capabilities, including skills in statistics and quantitative analytics. However, it is also true that health equity work requires that practitioners be skilled in qualitative research methods. Similarly, there is a need for workers to think creatively about the kinds of data necessary to understand health inequities and describe them in ways that compel action. For example, storytelling approaches, such as Photovoice and media advocacy, are likely to leave a lasting impression on audience members.

Lastly, data collection, analysis, interpretation, and dissemination for health equity require meaningful community engagement and empowerment. It is often a challenge for public health practitioners and partners to dedicate the time and resources necessary to leverage and sustain community engagement. However, for data collection and analysis to impact change, the data must be easily understood and utilized by those most responsible for making change—community members, stakeholders, and policy makers. Therefore, it is in the best interest of public health practitioners and partners to engage and empower communities. By including community members, stakeholders, and policy makers in the data collection and analysis process, it is more likely that they will use the information to develop appropriate and effective interventions.

Principles for Successful Use of Data for Health Equity

In its report to the state legislature of Minnesota, the Minnesota Department of Health identified “four keys to the successful use of data for addressing health inequities” (MDH, 2014). These recommendations apply to the collection of new data, the improvement of existing data, and the use of tools such as GIS mapping and HIA (all described above). The four keys to success include:

1. **Make the data useful in terms of analysis, interpretation, and application.** This suggests that many different kinds of techniques may be needed for the collection, analysis, and reporting of data related to health equity. The approaches that are used will depend on the purpose or intended use of the data.
2. **Results must be disseminated effectively.** Practitioners must consider their audience when deciding how to share their findings to achieve maximum impact. For example, data meant to inform policy change will be of little use unless policy makers can

understand and appreciate the information. Different and creative channels for dissemination should be considered, such as interactive platforms and websites, newsletters, emails, and community forums. A public access web portal with interactive capabilities, such as allowing users to select indicators and geographic locations, can be particularly useful. At the same time, this approach may require substantial ongoing investment of staff to manage the portal's operation and financial support.

Sample Strategy

In Delaware, efforts to effectively disseminate data to community members have occurred through community dinners. The community dinner model seeks to engage individuals in places within their community, such as a school or recreational meeting area, to make data and information easily accessible. Resources required to successfully implement a community dinner rely on partnerships. Often organizations contribute staff members' time, funds to order food, and space to house the event. Community dinners are a favorite tool to gather stakeholders and community members together, and have been implemented across the state. Christiana Care Health System and the Sussex County Health Promotion Coalition have set the tone for hosting community dinners, having achieved success in discussing health-related topics with local residents.

- 3. It is essential to involve the community in data collection, analysis, and dissemination.** The community should help to determine what data are needed and how the findings should be used. This may require practitioners to help build the capacity of community members so they are equipped to engage in some of the more technical aspects of data collection and analysis. "Community involvement in monitoring health inequities will increase awareness, ensure health inequity data are responsive to the needs of communities, create a sense of ownership of the data, and facilitate a collaborative, equitable partnership in creating health equity policies, programs and practices" (MDH, 2014, p. 67).

Sample Strategy

In Delaware, Christiana Care Health System employed Photovoice, which uses photography to communicate social issues, to engage Black youth in an analysis of the

issues that shape their lives. As participants in this community-based participatory research project, the youth were regarded as co-researchers and assisted in developing the research question while holding autonomy in the research process. Results indicated that the youth saw violence and substance abuse/addiction as barriers to their personal success (Christiana Care Health System, 2014, p. 13). Photos representing safety, gun violence, teen pregnancy, and risky behaviors (such as gambling, tobacco use, and addiction to prescription and illicit drugs) were evidence of concerns for these youth (Christiana Care Health System, 2014, p. 13). By coupling these data with statistical reports and peer-reviewed research, the Photovoice approach provided validation of what is known in academia and represents a unique opportunity to view the social determinants of health through the lenses of those most vulnerable to their effects. The Photovoice approach exemplifies community engagement and quality data collection and analysis.

Sample Strategy

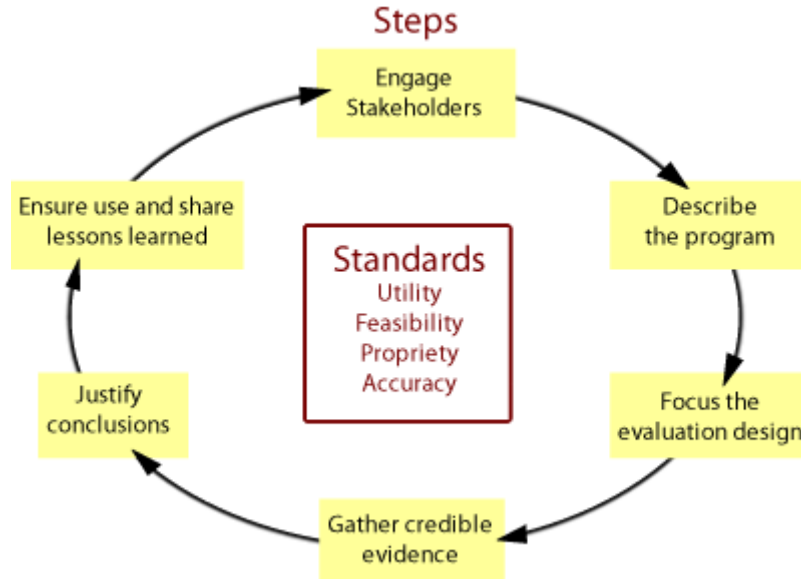
Another innovative example that involved community members in data collection is the *CommunityRx* system in the Chicago area. With funding from the Center for Medicare and Medicaid Innovation, a group of partners began developing a system comprised of a continuously updated electronic database of community health resources that will be linked to the Electronic Health Records of local safety net providers. In real time, the system will process patient data and print out a “HealthRx” for the patient, which includes referrals to community resources relevant to the patient’s health and social needs. To identify community resources for the database, new jobs were created for individuals residing in Chicago’s low-income communities. Many high school youth were employed to collect data on community health resources as part of the Urban Health Initiative’s MAPSCorps program. The *CommunityRX* project includes the creation of a new type of health worker, called Community Health Information Experts (CHIEs), who help patients use the system and engage community-based service providers in using its generated reports. For additional information, visit <http://www.uchospitals.edu/news/2012/20120508-communityrx.html>.

4. **Effective collection and use of data for health equity requires a skilled workforce.** This may involve recruiting new staff with research expertise, retraining existing staff, or simply supporting staff who possess the appropriate skills by providing the time, tools, and resources necessary to engage in surveillance, analysis, and dissemination of health equity data. Importantly, a workforce skilled in epidemiology is one that includes staff knowledgeable about health equity and SDOH, in addition to possessing analytical skills and research expertise. Mobilizing a skilled workforce toward an enhanced focus on qualitative methods and community-based participatory research is also warranted for a holistic description of the public health issue and potential interventions. Finally, a culture of continuous learning within state agencies and community-based organizations can support the successful use of health equity data (MDH, 2014, pp. 65-67).

Evaluation for Health Equity

Evaluation is one of the Ten Essential Public Health Services outlined by the CDC. Ultimately, evaluation involves a value judgment about how well something worked and whether it should be continued. In the interim, evaluation is critical for informing the ongoing work of any initiative and helps to ensure that stakeholders are focused on activities thought to be the most effective. Effective program evaluation is a systematic method of improving and accounting for public health actions (CDC, 1999). A framework for evaluating public health efforts, developed by public health leaders at the CDC, is widely used within the field. An illustration of the key elements of the framework is presented as Figure 29, and a detailed discussion of the framework can be found at <ftp://ftp.cdc.gov/pub/Publications/mmwr/rr/rr4811.pdf>.

Figure 29. Framework for Evaluation in Public Health



Source: Centers for Disease Control and Prevention, 1999.

The evaluation of health equity initiatives is particularly important, considering that it can reveal the effects of initiatives on different groups, ensure that stakeholders do not lose sight of the intention to reduce gaps in health status, and ensure equity in the distribution of resources needed for optimal health. The importance of understanding what works, for whom, under what conditions, and whether health inequities have decreased, increased, or remained the same requires a deliberate focus on equity in evaluation efforts (CDC, 2013). In their *Practitioner Guide for Advancing Health Equity*, the CDC offers a number of questions for practitioners in government and community-based organizations to reflect upon when working to incorporate health equity into evaluation efforts:

- Where are we now?
 - How are we currently assessing the effect(s) of our efforts to address health equity?
- How do we start the evaluation process with health equity in mind?
 - Do we have the expertise to develop, implement, and assess an equity-oriented evaluation plan?
 - What process can we establish to routinely engage community stakeholders, including those experiencing health inequities, in all aspects of our evaluation efforts?
 - What are our current health equity strategies, activities and goals?

- How can our logic model be modified to reflect our health equity activities and goals?
- How can we consider health equity in evaluation questions and design?
 - How can we reframe or create new evaluation questions to better understand our effect on health inequities?
 - What are the key variables we should use to track the influence of our efforts on populations experiencing health inequities?
 - How can our sampling plan be designed or modified to answer our health equity-oriented evaluation question(s)?
- How can we integrate health equity principles in the data gathering process?
 - What processes do we have in place to determine when culturally appropriate tools or methodologies are needed?
 - If modifications are needed, how can we ensure our evaluation tools meet the needs of populations experiencing health inequities (e.g., language and literacy needs)?
 - Are the data we are collecting reflective of the real experience of the populations experiencing inequities? Are other approaches needed?
 - Does our performance monitoring system allow us to track and identify needs that may arise when implementing efforts in underserved communities?
 - How can we structure our evaluation processes to understand the long-term effects of our efforts on health inequities?
- How can we understand our effect on health equity through our analysis plan?
 - Does our analysis plan allow us to answer the following: What worked? For whom? Under what conditions? Is there any differential impact? Have inequities decreased, increased, or remained the same?
 - If not, how can we modify the analysis plan to answer these questions?
 - Does our outcome evaluation allow us to determine differential effects across population groups?
 - Does our process evaluation allow us to understand the key factors that influenced the outcomes of our efforts in underserved communities?
 - What actions do we need to take to improve or enhance our evaluation plan to understand our effects on health equity (e.g., have inequities decreased, increased, or remained the same)?

- How can we share our evaluation efforts with diverse stakeholders?
 - How and where do we typically disseminate our evaluation findings?
 - What commitment can we develop to ensure we share findings, even if negative?
 - How can we ensure we share our findings in plain and clear language that can be understood by stakeholders, partners, and community members?
 - How can our findings be used to support more action in communities of greatest need?
 - How can we revise the ways in which we share lessons learned to help others concerned with addressing health inequities?

- What are our next steps?
 - What can we do differently to improve or enhance our ability to conduct health equity-oriented evaluations?
 - What is our plan of action to implement improvements in our evaluation efforts? (CDC, 2013, p. 33).

Evaluation efforts are most useful when considered at the outset of the initiative. In fact, thinking about evaluation during the planning phase of a health equity initiative can contribute to the likelihood of its success. It encourages participants to think in depth about the goals of the initiative and what success looks like in the short-term as well as the long-term. This requires participants to clearly articulate their theory of change, or the rationale for their approach, and helps them communicate this effectively with other stakeholders. Similarly, incorporating evaluation at the outset of a program provides an opportunity to identify intermediate measures of progress towards the ultimate goal of achieving health equity, which is particularly important for place-based initiatives or community-based efforts that target upstream SDOH. In such cases, stakeholders must consider the relation between the targets of the intervention (e.g. affordable, quality housing) and longer-term outcomes related to health status and health equity (lower rates of asthma among low income children). Finally, incorporating evaluation into early planning phases encourages stakeholders to consider important questions related to needed resources and the capacity available for evaluation.

Sample Strategy

A good example of using evaluation during the planning stages of an intervention is provided by an organization called the Children and Families Commission of Orange County

(CFCOC). CFCOC was created as a result of Proposition 10 in California, where funding from a tax on tobacco products is used to support early childhood development for children ages 0-5. CFCOC's vision is that *all children (in the county) are healthy and ready to learn*. Through an extensive planning process, CFCOC identified the following goals to reach their vision:

1. Healthy Children – Promote the overall physical, social, emotional and intellectual health of young children.
2. Early Learning – Provide early learning opportunities for young children to maximize their potential to succeed in school.
3. Strong Families – Support and strengthen families to promote good parenting for the optimal development of young children.
4. Capacity Building – Promote an effective and quality delivery system for young children and their families.

The planning process helped to clarify for the organization and its community stakeholders the importance of individual-level parental support and systems support (or the capacity of community-based organizations) for promoting the health and education of young children. Attention to evaluation in the early stages of planning allowed CFCOC to identify indicators of success pertinent to each goal, ensuring that stakeholders considered data sources and the capacity for data collection and analysis. Finally, by incorporating evaluation into the planning phase, CFCOC connected upstream factors and its ultimate vision. For Fiscal Year 2012-2103, CFCOC reported the following indicators of success along the path to their vision:

- ❖ 142,296 shelter bed nights were provided to pregnant women, mothers, and young children.
- ❖ 40,654 children participated in a program to increase the frequency of reading at home.
- ❖ 18,728 children received dental services including restorative and emergency treatment and dental visits for children with special needs.
- ❖ 15,997 mothers received breastfeeding education, intervention, and support.
- ❖ 5,958 children were linked to a place for regular medical care (a "health home") (CFCOC, 2013).

More information about CFCOC may be found at <http://www.occhildrenandfamilies.com/>.

Sample Strategy

In Delaware, the Nurse-Family Partnership (NFP) provides a similar example of a coordinated strategy that incorporates evaluation from the outset for meeting multiple objectives. Implemented by Children and Families First, the NFP is an evidence-based community health program that links newly pregnant, first-time mothers with a registered nurse. The nurse provides home visits throughout the woman's pregnancy and during the first two years of the baby's life. NFP has three distinct, but complementary, goals:

1. Improve pregnancy outcomes by helping women engage in good preventive health practices, including thorough prenatal care from their health care providers, improving their diets, and reducing their use of cigarettes, alcohol, and illegal substances.
2. Improve child health and development by helping parents provide responsible and competent care.
3. Improve the economic self-sufficiency of the family by helping parents develop a vision for their own future, plan future pregnancies, continue their education, and find work (Nurse-Family Partnership, 2011).

The program was launched in Delaware in 2010. Evaluation data revealed early success in terms of positive health outcomes for babies. As of 2014, 90 percent of babies served by the program were born full-term; and 88 percent were born at a healthy weight. Furthermore, 82 percent of mothers in the program initiated breastfeeding, and 21 percent were still breastfeeding at their six month follow-up (Wallace, 2014). These evaluation data contributed to a recent increase of \$1.3 million in state appropriations, which doubles the number of women and babies served.

Evaluating Complex Community Initiatives

The evaluation of comprehensive place-based initiatives, "described in Section 4, is particularly challenging due to the complexity of this type of initiative as well as the uniqueness of communities. Thomas Kelly from the Annie E. Casey Foundation describes the essence of this challenge:

"Most comprehensive place-based initiatives consist of multiple interventions over a number of years at individual, group, institutional, social and political levels. Any one of

these interventions could be an evaluation in and of itself, but with [this approach] you want to capture what matters” (Kelly, 2010, p. 19).

Based on his experience working with the evaluation of the Casey Foundation’s *Making Connections* initiative, Kelly developed *Five Simple Rules for Evaluating Complex Community Initiatives*. These include the following:

1. Evaluations of complex, major initiatives are not experiments but part of the community change process.
2. Evaluations need a strong focus on the processes of community change.
3. Evaluations need to measure ongoing progress toward achieving outcomes and results to help a community guide its change process and hold itself accountable.
4. Evaluations need to understand, document, and explain the multiple theories of change at work over time.
5. Evaluations need to prioritize real-time learning and the community’s capacity to understand and use data from evaluations (Kelly, 2010).

A more detailed description of each of these rules, and strategies for accommodating them, can be found at http://www.frbsf.org/community-development/files/T_Kelly.pdf. Additional tools and resources to support evaluation of community-based health equity initiatives can also be found in the Community Toolbox referenced in previous sections of this guide (<http://ctb.ku.edu/en/table-of-contents/evaluate/evaluate-community-initiatives/measure-success/main>). Finally, the CDC provides links to a number of valuable resources for evaluation at <http://www.cdc.gov/eval/resources/index.htm>.

Evaluation Challenges

The process of evaluation can be tedious and confusing and is not free of barriers. Because a successful evaluation relies on the use of data collection and analysis, the barriers inherent in those processes are also applicable to evaluation (see *Limitations of Data Collection and Analysis for Health Equity* on page 149 of this guide). In addition, the evaluation process is subject to other barriers, which are more likely due to the substantial partnering that is necessary during the evaluation process. Regarding health equity efforts, this process is also subject to barriers that arise due to the complexities involved in assessing long-term outcomes related to SDOH.

Ideally, the evaluation process begins during the planning phase of developing an intervention. Because this phase is often highly collaborative and involves input from numerous

stakeholders and community members, the evaluation process is often subject to much debate. Therefore, public health practitioners and partners will benefit from clearly defining their desired outcomes and deciding on the appropriate measures for assessing these outcomes early in the planning phase. Similarly, by garnering buy-in for the evaluation process early on, stakeholders will be more likely understand the importance of the evaluation, and then later make changes (such as resource allocation and alterations in program design) when the evaluation results indicate room for improvement.

Specifically in regard to the evaluation of health equity-focused interventions, it is important to understand the limitations of assessing interventions that target SDOH. Typically, grants are awarded for short-term interventions (i.e. three to five years), which stunts the ability to assess impacts on the SDOH, such as income level and educational attainment. Therefore, the evaluation process for such interventions should include measures that can be used to indirectly assess the likely impact on SDOH.

“We must learn not only whether an intervention can work, but how, why and for whom, and how we can do better” (Schorr & Bryk, 2015).

To overcome the challenges described in this section, practitioners may need to build upon traditional evaluation methods and consider alternate approaches. For instance, when logic models are used to guide program implementation and evaluation, they must incorporate equity-related activities and outcomes. Because changes in living conditions (such as an increase in the number of affordable housing units or an increase in average wages) may be the target of the intervention, they should also be the focus of the evaluation. Evaluators must recognize that changes in health outcomes related to changes in the physical and social environment may take several years, if not generations, to manifest. Although tools like logic models can be useful in articulating the expected long-term changes, evaluators may need to consider intermediate outcomes and unique measures as indicators of impact. Case studies and other qualitative evaluation methods, for instance, can be used to help demonstrate impact. Finally, since health equity-focused interventions typically target culturally diverse groups, culturally appropriate tools and methodologies are essential to effective evaluation of health equity interventions. Information regarding culturally appropriate measures that can be incorporated into evaluation can be found at the San Diego Prevention Research Center’s website: <http://sdprc.net/lhn-cam.php>.

In summary, evaluation is a critical component to achieving health equity and should be as multi-faceted, responsive, and flexible as the initiatives themselves (Preskill, Parkhurst, & Splansky-Juster, 2014). Practitioners and other community stakeholders should explore resources available to support evaluation, such as partnerships with universities and other

research organizations. Additionally, because of the growing attention to health equity nationally, and the limited availability of evidence-based strategies for achieving health equity, federal agencies and national funders may be a resource for financial support and/or technical assistance. The U.S. Department of Health and Human Services' Office of Minority Health offers support for identifying funding sources in response to specific organizational needs (visit <http://minorityhealth.hhs.gov/omh/browse.aspx?vl=3&vlid=43>). Similarly, other organizations maintain lists of available funding opportunities that are regularly updated. For instance, the Association of American Medical Colleges posts weekly updates of funding opportunities to support research on health disparities and health equity (visit <https://www.aamc.org/initiatives/research/healthequity/350530/fundingandtrainingopportunities.html>). Readers are encouraged to subscribe to electronic mailing lists that provide this information and conduct regular scans.

Research Priorities to Advance Health Equity

Experts and community leaders have identified a number of research priorities to support efforts to advance health equity. Among the most important is that researchers need to shift from a disparities model to an equity model (Srinivasan & Williams, 2014). This means greater attention should be paid to social and structural determinants of health, rather than individual risk factors. Similarly, more attention should be placed on evaluating solutions to health inequities that are driven by social, economic, and environmental factors. Given some of the challenges highlighted above, research must be multi-disciplinary. Additionally, it is important to improve our research capacity for multi-factorial and multi-level analyses, as well as to address challenges related to statistical power and small sample sizes (Srinivasan & Williams, 2014). These methods require highly skilled statisticians and epidemiologists and often take more time and effort than traditional research, so building such a capacity requires targeted investments.

Improved research for health equity also requires meaningful community engagement and participation. Research is needed that reflects community priorities, is meaningful to the community, and is better connected to the lived experiences of the people most affected by health inequities (Knight, 2014). To this end, the *National Stakeholder Strategy for Achieving Health Equity* calls for investments in community-based participatory research and the evaluation of community originated intervention strategies (NPA, 2011). The report identified several specific objectives in this area, including the following:

- Identify and work with community-based organizations and programs to determine and disseminate replicable best and evidence-based practices for ending health disparities;

- Work with researchers and evaluators to develop useful and practical models for evaluating community-originated intervention strategies, including new metrics from interventions that reflect communities' immediate needs;
- Engage community members and enhance their capacity to be equal partners in the conceptualization, planning, design, implementation, interpretation, evaluation, and dissemination of public health interventions, programs, and initiatives; and
- Strengthen community ownership of data and research and evaluation products by promoting the principles of community-based participatory research (NPA, 2011, p. 135.)

Similar to the need for collaboration to develop health equity strategies, research for health equity must also be better coordinated. This includes working across sectors and building partnerships between academic or research institutions, state agencies, and community-based organizations. Finally, research must be translated and applied to advance health equity. As explained by the NPA (2011):

“Knowledge transfer is challenging but obligatory. Often, findings that may be valuable to communities are published in journals, reports, and other formats that are not widely distributed to them or easily accessible to non-research audiences. Nontraditional media should be used to disseminate data and information to improve accessibility. Improving the health outcomes of minority and underserved communities will take the combined efforts of medical scientists, statisticians, anthropologists, economists, sociologists, epidemiologists, policy analysts, psychologists, social workers, community developers, and others working in collaboration with community organizations” (NPA, 2011, p. 133).

Delaware is making strides to conduct and translate community-based research. As mentioned in Section 5, Delaware was recently awarded a multi-year grant from the National Institutes of Health to enhance the state's capacity for clinical and translational research. Specifically, the Delaware Clinical and Translational Research Program (DE-CTR ACCEL) is a partnership between the University of Delaware, Christiana Care Health System, Nemours Health and Prevention Services/Alfred I. duPont Hospital for Children, and the Medical University of South Carolina. Its goal is to improve the state's infrastructure and capacity for conducting research that leads to better clinical outcomes and applying knowledge about effective interventions in the clinical setting. The DE-CTR is part of the ACCEL program, which represents a long-term research partnership that can be leveraged to enhance the research and evaluation capacity needed for health equity. More specifically, community engagement and outreach is a priority for the ACCEL program, and can be an important avenue for health equity-

oriented research. For more information about the DE-CTR ACCEL program and related funding and research opportunities, visit: <https://de-ctr.org/>.

Finally, from a translation and application perspective, research is needed that makes clearer linkages for the public and policymakers about the connection between policy decisions and health. Powerful ideologies and preexisting assumptions about the role of behavior, health care, and individual responsibility must be overcome to promote the changes needed to advance health equity. Health impact assessments are one tool for addressing this challenge. Other approaches include providing training and technical assistance to professional associations, foundations, advocacy groups, and community organizations on how to interpret and use research and evaluation findings to inform their decisions and program designs (NPA, 2011, p. 137). As a standard of practice among researchers and evaluators and their sponsors, the NPA (2011) recommends promoting strategies to make findings accessible, easily understood, and used by policymakers and the public to inform programming and services (NPA, 2011, p. 137).

Glossary – Section 7

Community-Based Participatory Research (CBPR): An approach to research that involves an equitable partnership between and among community members and researchers in all aspects of the research process and in which all partners contribute expertise and share decision-making and ownership. The aim of CBPR is to increase knowledge and understanding of a given phenomenon and integrate the knowledge gained with interventions, policy, and social change to improve the health and quality of life of community members.

Evaluation: A systematic way to improve and account for public health actions. It can be used to judge the impact of a particular intervention as well as describe and improve the process of implementation.

Geographic Information Systems (GIS): A computer system designed to capture, store, manipulate, analyze, manage, and present all types of spatial or geographical data. GIS may be used to develop maps that present health data according to place.

Health Impact Assessment (HIA): A systematic process that uses a variety of data sources and research methods, and considers input from a range of stakeholders to determine the potential effects of a proposed policy, plan, or action on the health of a population and the distribution of those effects within the population.

Place-based initiative (PBI): A social change effort that is concentrated in a specific geographic area. Health equity strategies focused on living conditions in a specific geographic community are often referred to as PBIs because the target of the interventions is the place itself (or characteristics of the place), rather than the people living there.

Surveillance: The continuous, systematic collection, analysis, and interpretation of health-related data needed for the planning, implementation, and evaluation of public health efforts.

References and Additional Resources

Centers for Disease Control and Prevention, Program Performance and Evaluation Office. (n.d.). *Program evaluation resources*. Retrieved from <http://www.cdc.gov/eval/resources/index.htm>

Centers for Disease Control and Prevention [CDC]. (1999). Framework for program evaluation in public health. *MMWR*;48(No. RR-11), pp. 1-40. Retrieved from <ftp://ftp.cdc.gov/pub/Publications/mmwr/rr/rr4811.pdf>

Centers for Disease Control and Prevention – Division of Community Health. (2013). *A Practitioner’s Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease*. Atlanta, GA: US Department of Health and Human Services. Retrieved from <http://www.cdc.gov/nccdphp/dch/pdfs/health-equity-guide/foundationalskills.pdf>

Centers for Disease Control and Prevention, Division of Community Health. (2015). *A Practitioner’s Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease*. Retrieved from <http://www.cdc.gov/NCCDPHP/dch/health-equity-guide/index.htm>

Children and Families Commission of Orange County. (2013). *Annual Report*. Retrieved from <http://occhildrenandfamilies.com/about-us/annual-report/>

Christiana Care Health System (2014). *Using Photovoice to Engage and Empower Teens*.

Hillemeier M, Lynch J, Harper S, Casper M. (2004). *Data set directory of social determinants of health at the local level*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Retrieved from http://www.cdc.gov/dhdsp/docs/data_set_directory.pdf

Institute of Medicine. (2011). *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. Retrieved from <http://www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx>

Kansas University Work Group for Community Health and Development. (2014). *Community Toolbox. Chapter 38: Some Methods for Evaluating Comprehensive Community Initiatives*. Retrieved from <http://ctb.ku.edu/en/table-of-contents/evaluate/evaluate-community-initiatives>

Kelly, T. (2010). Five simple rules for evaluating complex community initiatives. *Community Investments, Special Focus on Place-Based Initiatives*, 22(1). Retrieved from http://www.frbsf.org/community-development/files/T_Kelly.pdf

Knight, E. (2014). Shifting public health practice to advance health equity: Recommendations from experts and community Leaders, *Journal of Public Health Management and Practice*, 20(2), 188-196.

Link, B. G., & Phelan, J. (1995). Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior*, 35(Extra Issue), 80-94.

Minnesota Department of Health & Minnesota Department of Human Services [MDH/MDHS]. (2011). *Collection of racial/ ethnic health data by the Minnesota Departments of Health and Human Services*, St. Paul, MN. Retrieved from <http://www.health.state.mn.us/omh/publications/racialethnicdata2011.pdf>

Minnesota Department of Health [MDH]. (2014). *Advancing health equity in Minnesota: Report to the legislature*. St. Paul, MN. Retrieved from http://www.health.state.mn.us/divs/chs/healthequity/ahe_leg_report_020114.pdf

National Partnership for Action to End Health Disparities [NPA]. (2011). *National stakeholder strategy for achieving health equity*. Rockville, MD: U.S. Department of Health and Human Services, Office of Minority Health. Retrieved from <http://minorityhealth.hhs.gov/npa/>

Nurse-Family Partnership. (2011). Nurse-Family Partnership: What We Do. Retrieved from <http://www.nursefamilypartnership.org/about/what-we-do>.

Pearl, J. (2000). *Causality: Models, Reasoning and Inference* (2nd ed.). New York, NY: Cambridge University Press.

Preskill, H., Parkhurst, M., & Splansky-Juster, J. (2014). *Guide to evaluating collective impact*. FSG Collective Impact Forum. Retrieved from <http://www.fsg.org/tabid/191/ArticleId/1098/Default.aspx?srpush=true>

Schorr, L. & Bryk, A. (2015). To achieve big results from social policy, add this: Continuous real-time learning to after-the fact program evaluations. *Huffington Post Blog*, posted 1/21/2015. Retrieved from http://www.huffingtonpost.com/lisbeth-lee-schorr/to-achieve-big-results-fr_b_6510262.html

Srinivasan, S., & Williams, S. D. (2014). Transitioning from Health Disparities to a Health Equity Research Agenda: The Time Is Now. *Public Health Reports*, 129(Suppl 2), 71-76.

Wallace, M. (2014). *Nurse-family partnership, Delaware state profile 2014*. NFP National Service Office. Retrieved from http://www.nursefamilypartnership.org/assets/PDF/Communities/State-profiles/DE_State_Profile.aspx

World Health Organization. (2015). *Health in all Policies Training Manual*. Retrieved from http://who.int/social_determinants/publications/health-policies-manual/en/

SECTION 8: Leadership for Health Equity

This guide was originally developed with a specific audience in mind: professionals within the Delaware Division of Public Health (DPH). However, the strategies needed for advancing health equity require partnerships across many different kinds of organizations and disciplines. Similarly, public health practitioners and advocates work in many different kinds of non-profit organizations, not solely within state agencies. For these reasons, the title, purpose, and contents were adapted accordingly, with the target audience broadly defined as public health practitioners and partners. These groups were identified, in part, because of their roles as leaders in advancing health equity.

Leadership can be defined in many different ways. For the purposes of this guide, “leadership is a process whereby an individual influences a group of individuals to achieve a common goal” (Northouse, 2007, p. 3). This definition is important as it draws attention to leadership as an action instead of a trait possessed by an individual. This means that leadership is about interactions between people and implies that leadership is available to everyone and is not restricted to people with innate or special characteristics (Northouse, 2007, pp.3-4). Finally, this definition highlights the importance of influence since mobilizing others to reach a common goal is central to the concept of leadership.

With respect to this guide, the common goal is to promote health equity. More specifically, DPH’s vision is for all Delawareans to achieve their full health potential. The various strategies and recommendations outlined in this guide are meant to move Delawareans closer to this common goal.

“Leadership is a process whereby an individual influences a group of individuals to achieve a common goal” (Northouse, 2007, p3).

However, as noted by Dr. Rattay in her foreword, these kinds of changes will not be easy. Achieving health equity is challenged, in part, by the fact that health inequities are caused by multiple factors such as access to resources, discrimination, and health-related behaviors operating on multiple levels (e.g. individual, neighborhood, state, etc.). There is not always agreement about who is responsible (e.g. individuals or societies/governments) or what should be done to address them. These characteristics suggest that health inequities may be defined

as a “wicked problem.” A wicked problem is a social problem that is difficult⁸ to solve for a number of reasons, including:

- Wicked problems are difficult to clearly define.
- Wicked problems have many interdependencies and are often multi-causal.
- Attempts to address wicked problems often lead to unforeseen consequences.
- Wicked problems are often not stable.
- Wicked problems usually have no clear solution.
- Wicked problems are socially complex.
- Wicked problems hardly ever sit conveniently within the responsibility of anyone organization.
- Wicked problems involve changing behavior.
- Some wicked problems are characterized by chronic policy failure (Australian Public Service Commission, 2007, pp. 3-5).

Creating meaningful change to address the wicked problem of health inequities and advance health equity requires leadership of public health practitioners and partners alike. In particular, collaborative leadership will be required to achieve health equity. Among other things, collaborative leaders build broad-based support, engage with coalitions, empower and catalyze systems change, work across boundaries, and demonstrate a sustained commitment to a collective vision. Collaborative leaders build upon the theory of “collective impact,” which is the synergy that can result from organizations working together towards common goals (Kania & Kramer, 2011).

No single organization can create large-scale, lasting social change alone. Therefore, addressing the multiple determinants of health requires working across sectors. Organizations working across sectors and at the community level to tackle multiple determinants of health will likely engage in various activities, all of which may occur simultaneously. For more information about wicked problems and collaborative leadership, see materials from the Australian Public Service Commission (2007) and Beinecke (2009).

⁸Wicked problems are often described as impossible to solve, but we, the authors of this guide, believe that health equity is attainable.

Section 8 briefly highlights some of the important leadership roles needed by different kinds of organizations working across Delaware. Many of the organizations highlighted earlier (and others that were not) are demonstrating collaborative leadership, but more is needed to achieve health equity in Delaware. This section concludes with a discussion of the role that individuals, especially individuals with privilege, can play as leaders to advance health equity in Delaware and beyond.

Public Health Practitioners and Organizations as Leaders

Public health organizations—whether they are community-based organizations, health care providers, or governmental agencies—have an important leadership role to play in advancing health equity. As the experts on health, causes of poor health, and interventions to improve health, public health professionals have “legitimate power” which can be used to influence others (Northouse, 2007). This is particularly important when working across sectors, as their health-related knowledge and expertise are considered the most credible. Public health professionals can use this legitimate power to inform policy and implement practices that are likely to positively impact health and health equity. Medical doctors, for example, are often seen as credible sources of health-related information and can use their legitimate power to lend support for equity-oriented initiatives, while encouraging others to do the same.

Health professionals can also lead by making changes within their own organizations. According to the National Collaborating Centre for Determinants of Health (2013), health equity-oriented changes can be applied to every aspect of how a public health organization operates. At the program level, a health equity lens can be applied to how needs are assessed and programs are planned, implemented, and evaluated (as discussed in Section 7). Practically, this includes reviewing whom the services are reaching and/or who is benefitting from the programs, and who is not being reached. This may include ensuring that individuals from communities that experience disadvantages are involved in the planning and evaluation of programs that affect them.

At the organizational level, a health equity lens can influence how priorities are set and how resources are allocated. State and local health departments can begin by undertaking an organizational self-assessment for addressing health inequities (Bay Area Regional Health Inequities Initiative, 2010; Bay Area Regional Health Inequities Initiative, 2014). Conducting such an assessment helps organizations identify internal areas for change. Examples of organizational level changes include things like changing hiring practices to recruit and retain more racial and ethnic minorities, incorporating more staff training on culturally competency, and adapting grant/contract funding mechanisms that require bidders to specifically address health inequities in their proposals. Additionally, hospitals can direct their community benefit

resources to communities most in need and other health-related organizations can incorporate an equity lens into their strategic planning processes.

Leadership from public health agencies is particularly important in relation to policy change and advocacy. (For examples of health equity-oriented policy changes across many sectors, visit Section 6.). While these examples are based upon scientific evidence linking environmental and social conditions to health, policy change is rarely a rational process driven by science. Even the existence of a strong evidence base is often insufficient to change policy; therefore, policy change requires advocacy.

Advocacy is simply defined as the process through which an individual or group tries to influence policy. The term advocacy often takes on a negative connotation, and many public and non-profit health professionals shy away from engaging in the political process. In some instances, professionals are legally prohibited from engaging in certain forms of advocacy, but there are often opportunities for health professionals to play a role tangent to advocacy. Health professionals can consider their role in interpreting and communicating what has been learned through public health research with the public and policymakers as a form of research translation. It is common for public health practitioners to encourage people to prevent obesity and related conditions by becoming more physically active and eating more nutritious diets, which are behavioral changes based upon scientific evidence. Advocacy of this nature can similarly be applied to the social determinants of health. As one expert noted:

“We really have to re-explore what are the limits of our advocacy...what are we willing to take a stand on and say it is good for the public health, like prenatal care and WIC[Women, Infants, Children]... Can we expand that kind of health advocacy to include housing and poverty?” (Knight, 2014, p. 192).

Raising awareness about the social determinants of health (SDOH) is a form of education, but it can also be a form of advocacy. Being proactive about such advocacy, including having a well-developed communications strategy, can be particularly effective when partnering with others who can engage in stronger forms of advocacy, such as the newly formed Delaware Public Health Association (see <http://de-pha.org/>).

Authentic partnerships with community-based organizations and other state agencies are critical for advancing health equity. This truth holds in regard to advocacy, as well. Representatives from state agencies must support both internal and external partners to advance shared goals. Public health leaders should accept that it is not always necessary to make stakeholders aware of the health implications of a given proposal or policy action. For instance, ensuring ongoing support at the state level for affordable, quality early care and education could be viewed through the lens of health equity. However, publichealth advocates

can support early care and education initiatives without drawing attention to the health impacts. Sometimes raising awareness of the health impacts can broaden the base of support, but it can also unnecessarily complicate the debate. Unfortunately, there are no hard rules about when to raise health-related concerns and when to support partners' efforts from the sidelines. Involvement must be considered on a case-by-case basis.

Understandably, health equity-related work may require that the public health workforce develop new skills, knowledge, and competencies. In addition to this guide's many resources, several online training programs support public health organizations and individual practitioners in this regard, including:

- The Roots of Health Inequity: A web-based course for the public health workforce, (NACCHO, 2011) retrieved from <http://www.rootsofhealthinequity.org/>.
- PH101 Dialogue Series from the Alameda County Public Health Department (2009) retrieved from <http://www.acphd.org/social-and-health-equity/organizational-transformation/trainings-and-dialogues/ph101.aspx>.
- Addressing Health Equity: A Public Health Essential from the Empire State Public Health Training Center (2012) retrieved from <http://www.phtc-online.org/learning/pages/catalog/equity/default.cfm>.

Other Kinds of Organizations as Leaders

Leadership for health equity can reside within organizations not explicitly focused on health. This is largely due to health equity being about fairness and justice and indistinguishable from equity in general (Knight, 2014, p. 191). Therefore, the common goal or vision may be expanded to encompass social justice broadly. The need for collaborative leadership speaks to the value of having many kinds of community-oriented efforts working towards social justice. Furthermore, organizations that recognize the value of collective impact (described in Section 4) and help to facilitate collaborative, community-based efforts, can be leaders in advancing health equity. For more information about how to bring an equity lens to collective impact, see Williams & Marxer, 2014.

It is also important to recognize that not all changes need to be part of a large, coordinated strategy. Creating the kinds of social and cultural shifts that are necessary for health equity requires changes on all levels. Small changes matter, many different groups can play a part, and leadership comes in different shapes and sizes. Another way to view this is that effective leadership can be task-specific. For example, individuals working in organizations can consider ways to promote health equity as tasks or decisions arise. The University of Delaware (UD) educates many students who will secure jobs and remain in Delaware after graduation.

Whether they work in a health-related organization or discipline or not, their understanding of SDOH and awareness of the magnitude and nature of health inequities in Delaware is important to advance health equity. For this reason, the *Introduction to Public Health* class at UD, which is open to the entire student body, incorporates a strong focus on these issues. This was a conscious decision on the part of the instructor (who is also the lead author of this guide). Other examples include when individual business owners choose to pay their employees a living wage, or when faith-based organizations partner with each other to promote understanding and tolerance. Each of these decisions and actions can contribute to broader social and cultural changes, ultimately moving the state closer to the vision of health equity.

Individuals as Leaders

Leadership is generally ascribed to individuals or groups of individuals. Power is also a concept closely tied to leadership since it is related to the process of influencing others (Northouse, 2007). Because leadership is a process open to everyone, each person has the potential power to make change.

The idea that individuals possess power to influence change is important because the root causes of health inequities are often tied to differences in power and privilege among different groups of people. As mentioned in Section 2 (page 37), the complicated and uncomfortable discussion about class and power that underlie social inequities and injustices is purposely omitted from this guide in favor of more tangible steps. The kinds of social and political changes needed to address issues such as institutional racism and other forms of structural discrimination do not lend themselves to a “how to” guide. However, it is important not to lose sight of the various systems of oppression that are deeply embedded in our culture. For example, our culture tends to value males over females, Whites over Blacks, heterosexual individuals over homosexual or bisexual individuals, young over old, and able-bodied individuals over those with disabilities. Unfortunately, “built into the very fabric of our society are cultural values and habits which support the oppression of some persons and groups of people by other persons and groups. These systems take on many forms but they all have essentially the same structure” and are root causes of health inequity (Just Conflict, n.d.).

Although part of the broader, wicked problem of social injustice and inequity, there are practical daily steps that individuals can take to contribute to positive social change. Individuals can work toward social justice and promote health equity by being an “ally.” Social justice allies are “members of dominant social groups (e.g., men, Whites, heterosexuals) who are working to end the system of oppression that gives them greater privilege and power based on their social-group membership” (Broido, 2000, p. 3). Allies work *with* those from the oppressed group in collaboration and partnership to end the system of oppression (Edwards, 2006, p. 51). Frances

Kendall, an author and consultant for organizational change specializing in issues of diversity and white privilege (see www.franceskendall.com), explains this more simply:

“Those of us who have been granted privileges based purely on who we are born (as white, as male, as straight, and so forth) often feel that either we want to give our privileges back, which we can’t really do, or we want to use them to improve the experience of those who don’t have our access to power and resources. One of the most effective ways to use our privilege is to become the ally of those on the other side of the privilege seesaw. This type of alliance requires a great deal of self-examination on our part as well as the willingness to go against the people who share our privilege status and with whom we are expected to group ourselves” (Kendall, 2003).

Being an ally is a unique form of collaborative leadership. Kendall offers a number of recommendations and examples for how to be an ally. These are reproduced as Figure 31, with permission from Kendall. Note that the examples provided focus largely on the oppression of Black individuals and are geared towards individuals with the privilege of having white skin. However, the recommendations are applicable to many forms of social and economic privilege and systems of oppression.

Figure 31: How to be an Ally

1. **Allies** work continuously to develop an understanding of the personal and institutional experiences of the person or people with whom they are aligning themselves. If the ally is a member of a privileged group, it is essential that she or he also strives for clarity about the impact of privileges on her or his life. What this might look like:
 - Consistently asking myself what it means to be white in this situation. How would I experience this if I were of color? Would I be listened to? Would I be getting the support I am getting now? How would my life be different if I were not white/ male/ heterosexual/ tenured/ a manager?
 - Closely observing the experiences of people of color in the organization: how they are listened to, talked about, promoted, and expected to do additional jobs.
2. **Allies** choose to align themselves publicly and privately with members of target groups and respond to their needs. This may mean breaking assumed allegiances with those who have the same privileges as you. It is important not to underestimate the consequences of breaking these agreements and to break them in ways that will be most useful to the person or group with whom you are aligning yourself. What this might look like:
 - Speaking out about a situation in which you don’t appear to have any vested interest: "Jean, there are no women of color in this pool of candidates. How can we begin to get a broader perspective in our department if we continue to hire people who have similar backgrounds to ours or who look like us?"
 - Interrupting a comment or joke that is insensitive or stereotypic toward a target group, whether or not a member of that group is present. "Lu, that joke is anti-Semitic. I don’t care if a Jewish person told it to you; it doesn’t contribute to the kind of environment I want to work in."
3. **Allies** believe that it is in their interest to be allies and are able to talk about why this is the case. Talking clearly about having the privilege to be able to step in is an important educational tool for others with the same privileges. What this might look like:

- Regularly prefacing what I am about to say with, "As a white person, I [think/ feel/ understand/ am not able to understand...]" By identifying one of my primary lenses on the world I let others know that I am clear that being white has an impact on how I perceive everything.
4. **Allies** are committed to the never-ending personal growth required to be genuinely supportive. If both people are without privilege it means coming to grips with the ways that internalized oppression affects you. If you are privileged, uprooting long-held beliefs about the way that the world works will probably be necessary. What this might look like:
- Facing in an on-going way the difficult reality of the intentionality of white people's treatment of people of color, both historically and currently. In order to be an ally, I must hold in my consciousness what my racial group has done to keep us in positions of power and authority. This is not about blaming myself or feeling guilty. In fact, I think guilt is often self-serving; if I feel terribly guilty about something, I can get mired in those feelings and not take action to change the situation. Staying conscious of our behavior as a group moves me to take responsibility for making changes. It also gives me greater insight into the experiences of those with whom I align myself.
5. **Allies** are able to articulate how various patterns of oppression have served to keep them in privileged positions or to withhold opportunities they might otherwise have. For many of us, this means exploring and owning our dual roles as oppressor and oppressed, as uncomfortable as that might be. What this might look like:
- Seeing how my whiteness opened doors to institutions that most probably would not have opened so easily otherwise. Understanding that as white women we are given access to power and resources because of racial similarities and our relationships with white men, often at the expense of men and women of color. While we certainly experience systemic discrimination as women, our skin color makes us less threatening to the group which holds systemic power.
6. **Allies** expect to make some mistakes but do not use that as an excuse for inaction. As a person with privilege, it is important to study and to talk about how your privilege acts as both a shield and blinders for you. Of necessity, those without privileges in a certain area know more about the specific examples of privilege than those who are privileged. What this might look like:
- Knowing that each of us, no matter how careful or conscious we are or how long we have been working on issues of social justice, is going to say or do something dumb or insensitive. It isn't possible not to hurt or offend someone at some point. Our best bet is to acknowledge to others our mistakes and learn from them.
 - Keeping a filter in your mind through which you run your thoughts or comments. Remarks such as, "If I were you..." or "I know just how you feel..." are never very helpful in opening up communication, but, in conversations in which there is an imbalance of privilege, they take on an air of arrogance. People with privilege can never really know what it is like to be a member of the target group. While I can sympathize with those who are of color, it is not possible for me truly to understand the experience of a person of color because I am never going to be treated as they are. The goal is to show someone you are listening, you care, and you understand that being white causes you to be treated differently.
7. **Allies** know that those on each side of an alliance hold responsibility for their own change, whether or not persons on the other side choose to respond or to thank them. They are also clear that they are doing this work for themselves, not to "take care of" another. What this might look like:
- Examining continually the institutional and personal benefits of hearing a wide diversity of perspectives, articulating those benefits, and building different points of view into the work we do.
 - Interrupting less-than-helpful comments and pushing for an inclusive environment. We do it because we, as well as others, will benefit. We do not step forward because we think we should or because the people without our privileges can't speak for themselves or because we want to look good. We are allies because we know that it is in our interest.
8. **Allies** know that, in the most empowered and genuine ally relationships, the persons with privilege initiate the

change toward personal, institutional, and societal justice and equality. What this might look like:

- Assessing who is at least risk to step into a situation and initiate change, conferring with others who are at greater risk about the best strategies, and moving forward. Our moves should be carefully designed to have the greatest impact.
- Understanding that this is not another opportunity to take charge. Ally relationships are just that: relationships. Together with the people who aren't privileged, we choreograph who makes which moves and when they will be made.

9. **Allies** promote a sense of inclusiveness and justice, helping create an environment hospitable for all. What this might look like:

- Recognizing the expectation that people of color will address racism, women will take care of sexism, and gay men and lesbians will "fix" heterosexism in the organization and, in their stead, becoming the point person for organizational change on these issues. Clues that this assumption is operating include: the Diversity Committee is composed predominantly of people of color and white women, while those with greater decision-making power are on the "important" committees; or the majority of people pushing for domestic partner benefits are gay or lesbian.

10. **Allies** with privilege are responsible for sharing the lead with people of color in changing the organization and hold greater responsibility for seeing changes through to their conclusion. *Sharing* the lead is very different from *taking* the lead. What this might look like:

- Working to build a strategic diversity plan for the organization, tying it to the organization's business plan, and assuring that the plan is implemented.
- Assessing current policies and procedures and changing them so that they don't differentially impact groups of people.

11. **Allies** are able to laugh at themselves as they make mistakes and at the real, but absurd, systems of supremacy in which we all live. As many oppressed people know, humor is a method of survival. Those with privilege must be very careful not to assume that we can join in the humor of those in a target group with whom we are in alliance. What this might look like:

- Appreciating that there are times when laughing together is the only thing we can do.
- Paying attention to the boundaries of who-can-say-what-to-whom: While it may be OK for a person of color to call me his "white sister," it would be presumptuous for me to call him my "Latino brother."

12. **Allies** understand that emotional safety is not a realistic expectation if we take our alliance seriously. For those with privilege, the goal is to "become comfortable with the uncomfortable and uncomfortable with the too-comfortable" and to act to alter the too-comfortable. What this might look like:

- Being alert to our desire to create a "safe" environment for an interracial conversation. My experience is that when white people ask for safety they mean they don't want to be held accountable for what they say, they want to be able to make mistakes and not have people of color take them personally, and they don't want to be yelled at by people of color. Those of us who are white are almost always safer, freer from institutional retribution, than people of color. That knowledge should help us remain in uncomfortable situations as we work for change.

13. **Allies** know the consequences of not being clear about the Other's experience, including lack of trust and lack of authentic relationships. For allies with privilege, the consequences of being unclear are even greater. Because our behaviors are rooted in privilege, those who are in our group give greater credence to our actions than they might if we were members of groups without privilege. Part of our task is to be models and educators for those like us. What this might look like:

- Understanding that because we don't see a colleague of color being mistreated doesn't mean that daily race-related experiences aren't occurring. I often hear white people make comments such as, "Well, my friend is Black but he's beyond all this race stuff. He is never treated poorly." Comments such as these alert a person of color to the fact that we don't have those experiences, we can't imagine other people

having them, and therefore put little credence in the stories that people of color share. If we are to be genuine allies to people of color, we must constantly observe the subtleties and nuances of other white people's comments and behaviors just as we observe our own. And we must take the risk of asking, "What if I am wrong about how I think people of color are being treated in my institution? What can I do to seek out the reality of their experiences? How will I feel if I discover that people I know, love, and trust are among the worst offenders? And what will I do?"

Source: Kendall, 2003.

Conclusion

Leadership on multiple levels, across many different kinds of organizations and sectors, and even among interpersonal relationships, is necessary for the kinds of changes needed for achieving health equity. Armed with the knowledge and resources presented in this guide, public health practitioners and partners should:

1. Embrace a broad definition of health and the determinants of health and encourage others to do the same.
2. Make available continuous training and professional development opportunities around health equity.
3. Ensure a culturally competent and linguistically diverse workforce.
4. Make equity a priority by regularly identifying opportunities to incorporate health equity strategies into their work.
5. Move efforts upstream, when appropriate, for the greatest impact, but recognize the value of the full continuum of strategies needed to achieve health equity.
6. Incorporate health equity strategies into grant applications and set aside funding specifically for health equity work.
7. Invite non-traditional partners to advance their health equity goals and support partners' efforts in-kind.
8. Build and maintain authentic partnerships with communities throughout all steps of a health equity effort.
9. Incorporate measures of health equity and the social determinants of health into their existing and future work and analyze data accordingly.

"Above all, it should be stressed that solving problems of inequity cannot be achieved by one level of organization or one sector but has to take place at all levels and involve everyone as partners in health to meet the challenges of the future." (Whitehead, 1992, pp. 217-228).

10. Evaluate their work and remain accountable for advancing health equity; hold others accountable, in turn.
11. Be willing to commit for the long term and find support among colleagues to maintain the effort; celebrate success along the way.
12. Be a collective leader and ally; participate in a network of support to advance equity.

Many different kinds of changes on many different levels are required to advance health equity in Delaware. This guide presents a number of promising practices and resources to facilitate such changes. There is positive momentum at the national level, in communities across the country, and in Delaware specifically. Given the moral and ethical imperative that Dr. Rattay referenced in her foreword, each Delawarean has a responsibility to use our power and privilege to move towards this common goal. Over time and through our collective efforts, we will realize the vision that all Delawareans will achieve their full health potential.

Glossary – Section 8

Advocacy: The process through which an individual or group tries to influence policy and decision making.

Ally: A member of a dominant social group (e.g., men, whites, heterosexuals) who is working to end the system of oppression that gives him or her greater privilege and power based on membership in that social group

Collaborative leadership: A form of leadership that builds broad-based support, engages coalitions, empowers and catalyzes systems change, works across boundaries, and demonstrates a sustained commitment to a collective vision.

Collective impact: Collaboration across disciplines and sectors to solve complex social problems. It is grounded in the premise that no single organization can create large-scale, lasting social change alone.

Leadership: A process whereby an individual influences a group of individuals to achieve a common goal or vision.

Wicked problem: A social problem that is particularly difficult to solve because of its complexity, dynamic and contradictory nature, and interconnected relations with other problems.

References and Additional Resources

Australian Public Service Commission. (2007). Tackling wicked problems: A public policy perspective. Commonwealth of Australia. Retrieved from http://www.apsc.gov.au/data/assets/pdf_file/0005/6386/wickedproblems.pdf

Bay Area Regional Health Inequities Initiative. (2010). *Local health department organizational self-assessment for addressing health inequities: Toolkit and guide to implementation*. Retrieved from <http://barhii.org/resources/barhii-toolkit/>

Bay Area Regional Health Inequities Initiative. (2014). *State health department organizational self-assessment for achieving health equity*. Retrieved from http://barhii.org/download/toolkit/nacdd_he_toolkit.pdf

Beinecke, R. (2009). Introduction: Leadership for wicked problems. *The Innovation Journal: The Public Sector Innovation Journal*, 14(1). Retrieved from <http://www.innovation.cc/scholarly-style/beinecke1.pdf>

- Broido, E. M. (2000). The development of social justice allies during college: A phenomenological investigation. *Journal of College Student Development*, 41, 3-17.
- Centers for Disease Control and Prevention, Division of Community Health. (2015). A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease. Retrieved from <http://www.cdc.gov/NCCDPHP/dch/health-equity-guide/index.htm>
- Edwards, K. (2006). Aspiring social justice ally identity development: A conceptual model. *NASPA Journal*, 43(4). Retrieved from <http://www.uwstout.edu/campuslife/getinvolved/ally/upload/AAIDNASPA.pdf>
- Just Conflict. (n.d.). Systems of Oppression. Just Conflict: Transformation through Resolution [Web log post]. Retrieved from <http://www.creativeconflictresolution.org/ic/maps-1/systems-of-oppression.html>
- Kania, J. & Kramer, M. (2011). Collective Impact. *Stanford Social Innovation Review*, Winter, 84. Retrieved from http://www.ssireview.org/articles/entry/collective_impact/
- Kendall, F. (2003). *How to be an ally if you are a person with privilege*. Retrieved from <http://www.scn.org/friends/ally.html>.
- Kendall, F. (2014). Frances E. Kendall, PhD. Retrieved from <http://www.franceskendall.com/>
- Knight, E. (2014). Shifting public health practice to advance health equity: Recommendations from experts and community leaders, *Journal of Public Health Management and Practice*, 20(2), 188-196.
- National Association of County and City Health Officials [NACCHO]. (2011). *The roots of health inequity: A web-based course for the public health workforce*. Retrieved from <http://www.rootsofhealthinequity.org/>
- Northouse, P. (2007). *Leadership theory and practice*. Thousand Oaks, CA: Sage Publications.
- National Collaborating Centre for Determinants of Health. (2013). *Let's talk: Public health roles for improving health equity*. Antigonish, NS: National Collaborating Centre for Determinants of Health, St. Francis Xavier University.
- San Diego Prevention Research Center. *Evaluation: Guidelines for Culturally Appropriate Measures*. Retrieved from <http://sdprc.net/lhn-cam.php>
- Whitehead, M. (1992). The concepts and principles of equity and health. *Health Promotion International*, 6(3), 217-228.
- Williams, J. & Marxer, S. (2014). Bringing an equity lens to collective impact. *Collective Impact Forum*, blog post September 4, 2014. Retrieved from <http://www.collectiveimpactforum.org/blogs/34176/bringing-equity-lens-collective-impact>