DRAFT

FOUNDATIONAL PRACTICES FOR HEALTH EQUITY

A Learning and Action Tool for State Health Departments

Developed in partnership with the Region V Social Determinants of Health Team of the Infant Mortality Collaborative Improvement and Innovation Network (CoIIN) and the Health Resources and Services Administration

Acknowledgements

Foundational Practices for Health Equity: A Learning and Action Tool for State Health Departments has been developed through a partnership between the Health Resources and Services Administration (HRSA) and the Region V Collaborative Improvement and Innovation Network (COIIN) on Infant Mortality. The Contributors (listed below) would like to specially thank Dr. Ed Ehlinger, Dr. Art James – Co-Chairs of the Region V SDOH Team – and its members. As well, the Contributors would like to thank the many staff and consultants from HRSA and NICHQ for their support of this project.

Contributors:

Jeanne Ayers, RN, MPH	Assistant Commissioner	Minnesota Department of Health
Ann Batdorf-Barnes, DO, MPH	Consultant	Michigan Department of Health and Human Services
Dorothy Bliss, MA	Planner, Health Equity Core Team	Minnesota Department of Health
Jim Bloyd, MPH	Regional Health Officer	Cook County Department of Health
Susan Castellano	Maternal Child Health Director	Minnesota Department of Health
Brenda Fink, ACSW	Director Division of Family and Community Health	Michigan Department of Health and Human Services
Marilyn Metzler, RN, MPH	Project Consultant Senior Analyst, Health Equity Division of Violence Prevention	Centers for Disease Control and Prevention
Lilliann Paine, MPH	Regional Program Manager	Center for Urban Population Health – Milwaukee
Jeannette Raymond	Supervisor, Community Engagement Unit, Health Partnerships Division	Minnesota Department of Health
Angela Rohan, PhD	Senior Epidemiologist	Centers for Disease Control and Prevention – Assignee to WI Department of Health Services
Geoffrey Swain, MD, MPH	Medical Director and Chief Medical Officer; Professor of Family Medicine and Community Health	City of Milwaukee Health Dept. University of Wisconsin School of Medicine and Public Health
Paula Tran Inzeo, MPH	Health Promotion Specialist	University of Wisconsin Extension, Cooperative Extension
Megan Waltz, MSW	Prenatal to Three Policy and Systems Advisor	Minnesota Department of Health

Review and Comment

A NOTE FROM THE CONTRIBUTORS…

Developing and compiling the *Foundational Practices for Health Equity: A Learning and Action Tool for State Health Departments* has been and continues to be an iterative process. Continuous quality improvement is important to the evolution of the work to promote positive social determinants of health and advance health equity. We invite you to review the document in its entirety and contribute to the next stage of this work.

Please take the time to contribute to the learning process and improvement of this document by taking a short survey after you've reviewed the tool:

https://www.surveymonkey.com/r/6NVVF3Z

The survey will be open until November 30, 2016.

Table of Contents

FOUNDATIONAL PRACTICES FOR HEALTH EQUITY: A LEARNING AND ACTION TOOL FOR STATE HEALTH DEPARTMENTS

MAY 2016

Introduction

Public health attention nationally and internationally is turning to the root causes of poor health: inequities in social and economic conditions. The *Foundational Practices for Health Equity: Learning and Action Tool* (*Learning and Action Tool*) is designed to build the capacity of public health organizations and their partners to advance health equity and create the conditions for better health across the life span.[1]

The *Learning and Action Tool* applies a framework – developed by the Commission on Social Determinants of Health (CSDH) of the World Health Organization (WHO) – to collective efforts to improve health by focusing action on underlying policy, systems, and environmental social and economic conditions, such as income and education, which are structural and systemic in nature. Bringing a health equity perspective to our public health work is critical if we are going to achieve our goal to eliminate health inequities. Indeed, some public health population-level interventions may actually increase inequities and result in increased health disparities for less advantaged groups.[2] Recognizing that efforts to transform underlying systems will encounter resistance from entrenched political, economic, and cultural forces, the *Learning and Action Tool* is intended to strengthen and support public health leaders and organizations in their efforts to advance health equity.

The *Learning and Action Tool* will assist public health organizations to assess their capacity, translate theory into action, and transform their practices to address social determinants of health and advance health equity. It also offers a method for measuring progress as public health

---

[1] The *Learning and Action Tool* is a product of the Collaborative Improvement & Innovation Network (CoIIN) to Reduce Infant Mortality. CoIIN is a public-private partnership that supports efforts to reduce infant mortality and improve birth and early childhood outcomes. Participants learn from one another and national experts, share best practices and lessons learned, and track progress toward shared benchmarks. While the CoIIN was focused specifically on improving birth outcomes, this *Learning and Action Tool's* focus is broader, including not only the ways in which public health organizations, working with diverse and committed partners, can help improve health outcomes for mothers and babies, but ways in which organizations can advance health equity broadly, thereby helping improve health outcomes for all, and reduce health inequities across a wide variety of health conditions and populations.

[2] Lorenc T., Petticrew M., Welch, V., Tugwell P. (2013). What types of interventions generate inequalities? Evidence from systematic reviews. *J Epidemiology Community Health*. 67:190–193.

organizations transform practice to achieve health equity. It is intentionally designed to support a dynamic process of learning and continuous improvement.

The *Learning and Action Tool* will assist state public health organizations to do the following:

- Introduce a set of foundational practices to advance health equity within an organization and with partners;
- Identify and document the organization's current capabilities and practices in the area of health equity and determine areas for development and action;
- Track improvements and changes in capabilities and practices; and
- Transform public health practices to advance health equity.

KEY CONCEPTS AND DEFINITIONS

The work of advancing health equity is guided by a set of important concepts and definitions.

Health, according to the WHO, "health is a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity."[3] Good health is a result of multiple factors, including social, economic and physical environments, individual behaviors, genetics, and access to systems such as education and health care.[4] Better health offers greater quality of life, higher levels of function, and greater potential for productivity, with substantial benefits to individuals, families, communities and society as a whole. Health is a fundamental human right, recognized in the Universal Declaration of Human Rights (1948).[5] Health is also an essential component of development, vital to a nation's economic growth and internal stability."[6] *Full health potential* may be understood as the highest level of health an individual may reach without limits imposed by racial, social and economic inequities.

Health Disparities are population-based differences in health outcomes (e.g., women have more breast cancer than men). Although the term *disparities* is often interpreted to mean racial or ethnic disparities, many dimensions of disparity exist in the United States, particularly in health. If a health outcome is seen to a greater or lesser extent between populations, there is disparity.

---

[3] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.
[4] Center for Urban Population Health. Retrieved from www.cuph.org
[5]UN General Assembly, *Universal Declaration of Human Rights*, 10 December 1948, 217 A (III), available at: http://www.refworld.org/docid/3ae6b3712c.html [accessed 1 February 2016]
[6]World Health Organization. Trade, Foreign Policy, Diplomacy and Health. Retrieved from: http://www.who.int/trade/glossary/story046/en/

Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual's ability to achieve good health.[7]

Health inequities/health equity. *Health inequities* are "differences in health status between more socially advantaged and less socially advantaged groups, caused by systematic differences in social conditions and processes that effectively determine health;[8] health inequities are not only unnecessary and avoidable but, in addition, are considered unfair and unjust."[9] The WHO defines health inequities as "health differences, which are socially produced."[10] According to Healthy People 2020, when we achieve *health equity*, every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances."[11] Moreover, achieving health equity "requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities." [12]

Narrative. A narrative is a story or report of connected or thematically-related events. Narratives are the way a group of people frame a shared understanding of an idea, an event, or a phenomenon. If the narrative is to have resonance, it must convey values and beliefs, as well as core ideas. A *public narrative* often becomes apparent in public discussions or policy-making. A *dominant public narrative* trumps other public narratives and has the most power to shape what people believe is possible, and therefore what actions they take.

Social determinants of health. The circumstances in which people are born, grow, live, work, and age. These determinants interact with individual behavior and shape the choices that are available to them. The WHO CSDH states that these circumstances are in turn shaped by a wider set of forces: economics, social policies such as education, housing; and politics (including power and decision-making) that effectively enhance or impede access to life chances and opportunities for health based on social hierarchies of advantage and disadvantage (e.g., race/ethnicity, class,

---

[7] Healthy People 2020. Retrieved from: https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

[8] Braveman, P. (2003). Defining equity in health. *J Epidemiology and Community Health*, *57*, 254-258

[9] Eliminating Disparities in Child and Youth Success Collaborative (2014). *Tool for Organizational Self-Assessment Related to Racial Equity*. Retrieved from http://coalitioncommunitiescolor.org/wp-content/uploads/2014/06/Tool-for-Organizational-Self-Assessment-Related-to-Racial-Equity-2014.pdf

[10] CSDH (2008). *Closing the gap in a generation: health equity through action on the social determinants of health.* Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization Retrieved from http://apps.who.int/iris/bitstream/10665/43943/1/9789241563703_eng.pdf

[11] Whitehead M, Dahlgren G. Levelling Up (Part 1): A Discussion Paper on Concepts and Principles for Tackling Social Inequities in Health. World Health Organization. Retrieved from: http://www.euro.who.int/document/ e89383.pdf.

[12] USDHHS, Office of Minority Health (2011). *The National Partnership for Action to End Health Disparities*. Available at http://minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=34

gender).[13] Language used to describe social determinants of health includes phrases such as, "the conditions for health," "the social and economic conditions in which people can be healthy," and other phrases that describe the contextual factors that shape health. Having multiple ways of speaking about and describing the social determinants of health helps to convey these important concepts to the many partners and audiences involved in advancing health equity.

Structural inequities. Structures or systems of society — such as finance, housing, transportation, education, health care, social opportunities, etc. — that are structured (through policies and systems) such that they unfairly benefit one population and unfairly disadvantage other populations (whether intended or not).

Structural racism involves an array of structural and system inequities — historical, cultural, institutional and interpersonal — that routinely advantage white people while producing cumulative and chronic adverse outcomes for people of color and American Indians.

A FRAMEWORK FOR IMPROVING HEALTH OUTCOMES FOR CHILDREN AND ADULTS

Racism and other forms of discrimination, living in poverty, low educational attainment, poor access to public transit or quality affordable childcare, and the inability to obtain affordable housing in a safe neighborhood are all examples of social conditions that increase stress levels in adults and children. However, these are not one-time events but actual living conditions, therefore leading to chronic stress (also referred to as "toxic stress"). The chronic elevation of stress hormones in the body, such as cortisol and adrenaline, lead to an increased risk of not meeting developmental milestones prenatally and in [early] childhood as well as many chronic diseases in people of all ages, including diabetes, hypertension, heart disease, stroke, and immune system dysfunction, as well as premature mortality.[14]

Despite a growing body of research and clear evidence of the influences of systems and structures on population health,[15] the dominant understanding of health inequities (supported by the dominant public narrative about what creates health) continues to be focused on receipt of health care services and on the behavioral choices of individuals, rather than on the current and historical landscape of policies, systems, and environments that create structural inequities and

---

[13] CSDH (2008). *Closing the gap in a generation: health equity through action on the social determinants of health.* Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization Retrieved from http://apps.who.int/iris/bitstream/10665/43943/1/9789241563703_eng.pdf

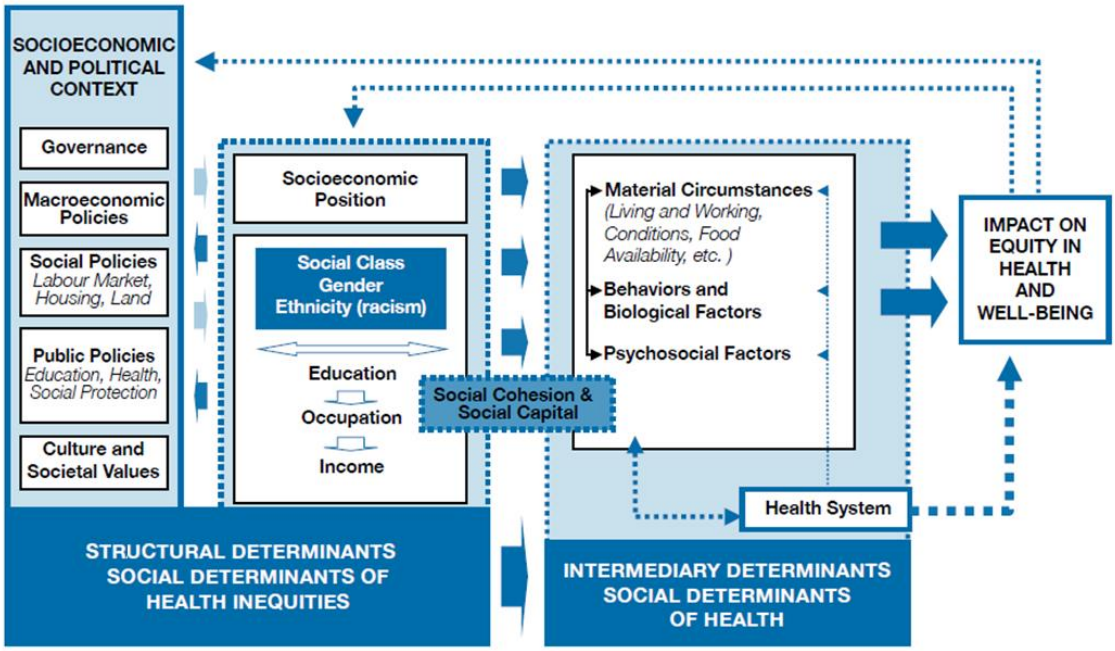
[14] Center on the Developing Child at Harvard University (2010). *The Foundations of Lifelong Health Are Built in Early Childhood*. Retrieved from: http://www.developingchild.harvard.edu

[15] Shonkoff, J.P., Garner, A.S., Siegel, B.S., Dobbins, M.I., Earls, M.F., McGuinn, L., … & Wood, D.L. (2012). The Lifelong Effects of Early Childhood Adversity and Toxic Stress. *Pediatrics*, *129* (1), 232-246. Retrieved from

limit opportunities for health. The WHO CSDH has developed a framework that incorporates the social determinants of health and thus highlights the many systemic influences on health and well-being.[16] This framework recognizes that economic, social, and political conditions are not naturally occurring, but are instead the result of public policy and other community or collective actions which, in turn, are rooted in long-term structures and traditions that will require new partnerships and new strategies to change them.

The WHO CSDH Framework *(see Figure 1)* synthesizes relevant evidence and theory in order to examine how health inequities arise and to support the development of effective actions to modify the differential distribution of health.[17]

Figure 1. World Health Organization Commission on Social Determinants of Health Framework



Used with Permission

The WHO CSDH Framework can be more clearly understood by focusing on the broad domains and how these domains connect to each other to influence health. Moving from left to right in Figure 1, the primary domains of the framework include the following:

---

[16] Solar, O. & Irwin A. (2010). *A conceptual framework for action on the social determinants of health*. Social Determinants of Health Discussion Paper 2 (Policy and Practice). Geneva, World Health Organization, 2010. Retrieved from http://www.who.int/social_determinants/corner/SDHDP2.pdf.
[17] Solar, O. & Irwin A. (2010)

- ***Structural Determinants: Socioeconomic and Political Context*.**
  This domain includes the broad array of structural, cultural, and functional aspects related to how societies are organized—governance structures, macroeconomic policies, social policies (e.g., labor market and housing), public policies (e.g., education, health and social protection), and cultural and societal values (e.g., about children or the roles of men and women in families and society). These aspects cannot be measured at the individual level. Policies and processes at this level would seek to maximize health and life opportunities through the fair distribution of society's resources to all members of a society.

- ***Structural Determinants: Socioeconomic Position*.**
  This domain seeks to describe how socioeconomic and political policies and processes interact to effectively assign socioeconomic position based on interacting social characteristics (e.g., social class, race/ethnicity, *and* gender) through greater or lesser access to essential resources including education, occupation, and income. Policies at this level would seek to minimize the systematic assignment of socioeconomic position based on social characteristics, as well as limit the inequitable burden of macro policies on members of society based on hierarchies spanning continuums of advantage-disadvantage.

- ***Intermediary Determinants*.**
  This domain includes material circumstances and psychosocial, behavioral and biological characteristics. Broadly encompassing living and working conditions, access to food, etc., this domain also includes the health care system, which has an independent and interacting effect on health. Policies at this level would seek to limit the effects of excess vulnerability and exposure to existing conditions that disproportionately impact groups disadvantaged by social status and/or socioeconomic position.

- ***Cross-Cutting Determinants*** *(collective efficacy, including social capital and social cohesion)*.
  This domain takes into consideration the ability to impact intended change – acknowledging the role of people in the shaping of policies and processes that effectively determine how societies are organized. The WHO emphasizes the need to include groups historically and currently excluded from decision-making processes that impact their health and life opportunities, and places special emphasis on theories of power and models where collective action is informed by a human rights and social justice approach.

The WHO CSDH Framework can be used:

- To increase awareness and expand the understanding about how social and economic conditions contribute to or detract from life-long health, including infant mortality;
- To identify where current health improvement efforts (e.g., prenatal care, policy change) are situated, in order to set reasonable expectations for outcomes;

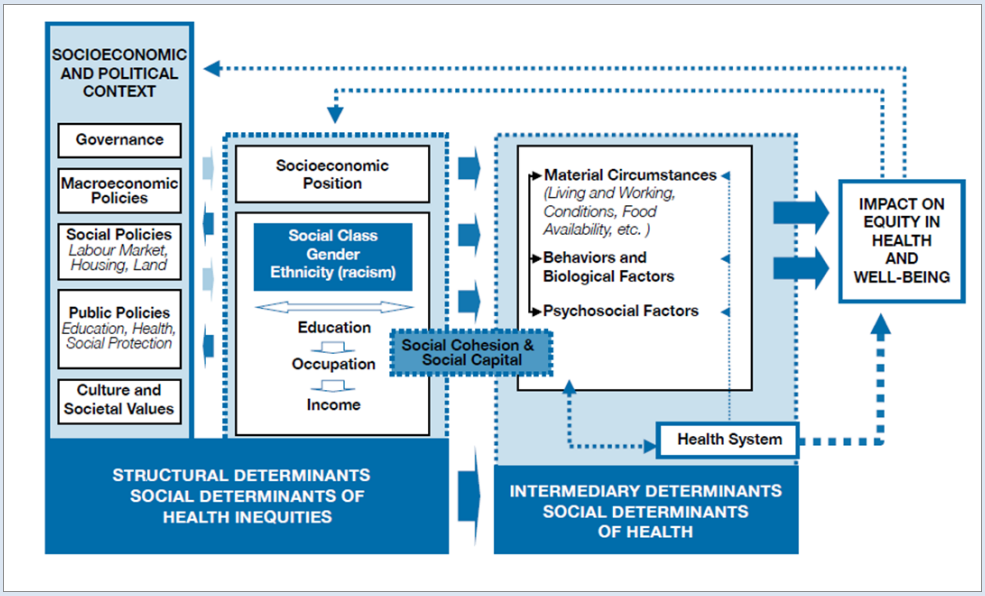
- To organize specific data, including indicators, across multiple domains to provide a complex yet accessible "snapshot" of social and economic conditions that may be contributing to current health inequities, such as infant mortality and low birth weight rates, including their differential distribution among populations in a given community or state; and
- To identify pathways and mechanisms that – if addressed – can reasonably be expected to improve conditions for populations at risk of inequitable health outcomes.

Figure 2. Using the WHO CSCH Framework[18]

The following example illustrates how the WHO CSDH framework can be used to understand the risks for poor health and thus inform discussions about potential strategies to improve conditions for health, using the example of early childhood adversity, including poor birth outcomes. Since many public health approaches begin by looking at surveillance or other health outcome data, the example starts on the right side of the framework and moves toward the left to develop a hypothesis about potential pathways that may be influencing this outcome.

All children are at risk of early adversity, including poor birth outcomes (health outcome); some children are at greater risk than others (differential burden/health inequity). For example, children living in families with a parent who is currently unemployed are at greater risk of poor birth outcomes and other early adversities due to family stress. Making available education and services (e.g., evidence-based parenting programs, nurse home visits) are important approaches. But the context – unemployment – is also an important "condition" (intermediary determinant) contributing to differential risk for early childhood adversity. This raises the question: what places someone at risk of unemployment? To more fully understand this, consider how employment is patterned in a given location: For example, are there differences by education or income levels, or between groups based on race/ethnicity? (Socioeconomic Position). This information can then be used to explore how policies and societal processes may be contributing to these patterns (Socioeconomic and Political Context), with the overall goal of improving conditions for all families in order to reduce early childhood adversity. *(See Appendix A for further example of using the WHO CSDH Framework).*

Used with permission



[18] Messer, L. C., Vinikoor, L. C., Laraia, B. A., Kaufman, J. S., Eyster, J., Holzman, C., . . . O'Campo, P. (2008). Socioeconomic domains and association with preterm birth. *J Social Science and Medicine*, 67(8) 1247-1257.

Over time, the WHO model provides a means of monitoring indicators to see how changing conditions may decrease or increase the risk of inequitable health outcomes including – for example – early childhood adversity.

ORGANIZATION OF THE *LEARNING AND ACTION TOOL*

This first iteration of the *Learning and Action Tool* is designed specifically for state health departments. It is expected that the tool will be employed at specific intervals defined by the organization.

The *Learning and Action Tool* is organized by seven *foundational practices* that, when taken together as a whole, provide a solid foundation for public health practice to advance health equity:

I. **Expand the understanding of health in words and action**
II. **Assess and influence the policy context**
III. **Lead with an equity focus**
IV. **Use data to advance health equity**
V. **Advance health equity through continuous learning**
VI. **Support successful partnerships and strengthen community capacity**
VII. **Assure strategic and targeted use of resources**

All seven foundational practices interact with and support each other. The *Learning and Action Tool* provides operational definitions for each foundational practice, followed by a critical capabilities section to assess the organization's capacity to advance health equity.

USING THE *LEARNING AND ACTION TOOL*

The *Learning and Action Tool* is a tool that seeks to evaluate an organization's current capacity to advance health equity by expanding practice to address the social determinants of health. Ideally, the *Learning and Action Tool* should be completed by a team of individuals with significant knowledge of the organization's structures and functions. Assessing the capabilities of the organization should be done in such a way that it allows the results to be monitored for improvements over time – recognizing that capacities will differ from organization to organization as each develops competence in addressing social determinants of health and

advancing health equity.[19] Each organization will have a unique experience with the *Learning and Action Tool*.

Each Foundational Practice is introduced then illustrated through a set of Critical Capabilities. Each critical capability has a list of questions meant to act as examples of specific activities that support the critical capabilities and foundational practices. Organizations may support critical capabilities with activities not listed; those activities should be included when completing the *Learning and Action Tool*.

Prior to each critical capability section is a set of questions, which allow the organization to begin to think critically about the practice:

- To what extent do we have these critical capabilities? E.g.:
    - Not at all?
    - Isolated individuals, projects, or ad hoc efforts?
    - Some existing policies, procedures, and practices to support these capabilities?
    - Widespread organizational standards that support these capabilities exist and are measured?
- What are our supports/constraints in strengthening these critical capabilities?
- What are some specific examples of how we do this? How could we better or more extensively incorporate these capabilities in our work?
- If we already have these capabilities, are we proficient? How could we improve?

Public Health organizations are urged to examine their own practices and activities against those in the *Learning and Action Tool* and then to engage in dialogue to support continuous improvement and future strategic planning.

[19] A specific scoring methodology has not been developed at this time, but the intent is to develop a means for each organization to track progress along a continuum.

Foundational Practice I: Expand Understanding of Health in Words and Action

The organization is intentionally engaged in efforts to expand the understanding of what creates health both within the organization and with external partners in order to eliminate structural inequities and create opportunities for health.

The ability of an organization to align knowledge, action, and resources is critical to the actual advancement of health equity. Expanding the understanding of how social determinants of health influence population health requires knowledge around how health is created – or not – for differing populations. Additional knowledge around the differences in health among different populations by demographic factors such as race, ethnicity, language, geography, income, gender, disability, and sexual identification. The organization must develop the practice of being able to identify and challenge the assumptions underlying the current dominant beliefs and narratives around health and wellness in their state. The organization must be able to articulate the connections between health and the social determinants of health and the policies, investments and actions that constrain or increase the opportunities for health.

The dominant health narratives and current health policies and resource allocation generally focus on the behaviors of individuals and on providing health care services. Instead, narratives could focus on the historical and current landscape of policies, systems, and environments that create structural inequities which limit or support opportunities for health. When the organization works to expand the understanding of what creates health, the work acts as a catalyst for strong leadership, new partnerships, innovative approaches around data collection and analysis, and more effective ways to organize resources to address social determinants of health and advance health equity.

When outcomes related to other factors such as income, gender, sexual identification, and geography are analyzed by race/ethnicity, greater inequities are often evident for American Indians, African Americans, and persons of Hispanic/Latino and Asian descent. Race and racism are difficult to talk about, and it is not uncommon for these issues to get subsumed under broader conceptual terms, such as "injustice," "discrimination" or even "equity." A concerted effort to specifically address the issue of structural racism and to develop the language and tools to uncover and change the structures shaped by racism are invaluable in addressing other structure-based inequities.[20]

[20] Minnesota Department of Health (2014). Advancing Health Equity Report to the Legislature. http://www.health.state.mn.us/divs/chs/healthequity/ahe_leg_report_020414.pdf

CRITICAL CAPABILITIES

In reviewing the critical capabilities listed below, the following questions should be kept in mind:

- To what extent do we have these critical capabilities? E.g.:
  - Not at all?
  - Isolated individuals, projects, or ad hoc efforts?
  - Some existing policies, procedures, and practices to support these capabilities?
  - Widespread organizational standards that support these capabilities exist and are measured?
- What are our supports/constraints in strengthening these critical capabilities?
- What are some specific examples of how we do this? How could we better or more extensively incorporate these capabilities in our work?
- If we already have these capabilities, are we proficient? How could we improve?

♦

To expand the understanding of health in word and action, the organization must be able to:

A. Assure that both the organization and its partners understand the structural and system-based issues that contribute to health inequities.

1. Does our organization utilize the WHO CSDH framework to increase our understanding of structural and intermediary inequities?
2. Has our organization worked with communities experiencing inequities to develop, adopt, and promote a shared narrative around health equity?
3. Do clear messages around the key concepts of health equity permeate every area of work within our organization?
4. Does our organization use its mission, vision, and values statements to communicate and support understanding of the structural and system-based inequities that contribute to poor birth and health outcomes?
5. Does our organization lead events, campaigns, and/or use social media to raise awareness of the conditions that create health and the impact of inequities on health outcomes?
6. Does our organization work with partner organizations in creating a shared narrative about what creates health?

B. Use data to demonstrate the connections among social and economic conditions and health outcomes *(See Foundational Practice IV)*.

1. Does our organization analyze data to develop an understanding of the relationships among the social determinants of health and health outcomes?

2. Does our organization request the same types of data collection and analysis *(see Foundational Practice IV)*[21] from its partners/grantees and other cross sector agencies, so that comparable data can be used to develop a shared understanding?
3. Has our organization conducted any analyses using tools such as health impact assessment or research studies to examine and demonstrate impact on health inequities across policy sectors?

C. Develop leadership that is consistent around applying a racial equity lens and understanding of power and privilege

1. Is our leadership willing and able to speak clearly about racism, structural racism, and the effects of social exclusion?
2. Does our organization invite and support staff in applying knowledge of personal bias and structural racism in their own work at the program and policy levels?
3. Has our organization developed or adopted policies, practices, and tools that prioritize racial equity so that racial equity and racial and ethnic impacts are addressed explicitly?

D. Align actions and investments to reinforce an expanded understanding of health *(See Foundational Practice VII)***.**

1. Does our organization have working relationships with agencies or sectors such as housing, education, corrections, economic development, public safety, etc.?
2. Do our employees have the capacity to ask critical questions to influence how policies, practices and investments are developed within the organization? *(See Appendix B)*
3. Does our organization have the capacity to influence policy change efforts that address structural inequities under the auspices of other agencies such as housing, education, corrections, public safety, etc.?
4. Do the actions and investments of our organization follow the WHO CSDH Framework and messaging around health equity?

[21] Data reporting by race, ethnicity, language, gender, age, sexual identification, disability status, income, educational attainment, zip code, and other conditions as necessary.

Foundational Practice II: Assess and Influence the Policy Context

The organization actively assesses the policy context in which people live, and how policies differentially support or inhibit the ability of different groups of people to achieve their full health potential. The organization is effective at leveraging policy change to address social determinants of health and advance health equity.

The Institute of Medicine defines public health as "fulfilling society's interest in assuring the conditions in which people can be healthy." Creating the conditions in which people can be healthy often requires policy solutions, and such policy solutions extend far beyond traditional, narrow conceptions of policy around health care.[22] In fact, health care accounts for only a small fraction of what determines health.[23] Even individual behavior, which plays a larger role than health care, is less influential than the social determinants of health in driving both health outcomes and health inequities. Additionally, both the individual behaviors and health care are directly influenced by the social determinants of health.

Not only do social and economic conditions either support or constrain individual behaviors but, through the action of stress hormones and epigenetic mechanisms, they also have a powerful direct effect on people's physiology and therefore their health. It is for these reasons that health policy must be thought of much more broadly than simply as health care policy. As Harvard researcher David Williams points out, "Housing policy is health policy. Neighborhood improvement policies are health policies. Everything that we can do to improve the quality of life for individuals in our society has an impact on their health and is a health policy."[24] In this light, for example, the dominant narrative around infant mortality – which focuses on individual behavior and exhorts pregnant women to get early prenatal care and engage in healthy behaviors – is insufficient to achieve better health outcomes and reduce health inequities.

Policy changes that create the context and conditions within which people can be healthy are essential in order to improve health and reduce health inequities. To be most effective, policy changes need to be inclusive of the following (listed in increasing order of importance):

- Improve access to quality health care, behavioral health, and human services;
- Support healthy individual behaviors;

---

[22]Institute of Medicine (2003). *The Future of the Public's Health in the 21st Century*. Washington, DC: The National Academies Press.
[23] Tarlov A. R. (1999). Public policy frameworks for improving population health. *Ann N Y Acad Sci* 896: 281-93.
[24] Williams D. R. & Wyatt R. (2015). Racial bias in health care and health: Challenges and opportunities. *J American Medical Association.* 314(6):555-6.

- Create opportunities for access to healthy food, safe housing, transportation, good jobs, and educational opportunities; and
- Attend to structural determinants in order to minimize the levels of chronic and toxic stress that people experience throughout their lifetimes especially during pregnancy and early childhood.

The policies referred to in *Appendix A* span the entirety of the WHO CSDH Framework. Policies across the entire framework must be addressed in order to significantly improve health outcomes and eliminate health inequities.

CRITICAL CAPABILITIES

In reviewing the below listed critical capabilities, the following questions should be kept in mind:

- To what extent do we have these critical capabilities? E.g.:
  - Not at all?
  - Isolated individuals, projects, or ad hoc efforts?
  - Some existing policies, procedures, and practices to support these capabilities?
  - Widespread organizational standards that support these capabilities exist and are measured?
- What are our supports/constraints in strengthening these critical capabilities?
- What are some specific examples of how we do this? How could we better or more extensively incorporate these capabilities in our work?
- If we already have these capabilities, are we proficient? How could we improve?

♦

To effectively assess and influence the policy context, the organization must be able to:

A. Assess the policy context that creates underlying systems issues that perpetuate health inequities.

1. Does our organization have the knowledge and skills to identify the policy context for health inequities?
2. Does our organization comprehensively assess our state and local policy context for the social and economic factors that contribute to or decrease health inequities?
3. Does our organization use the WHO CSDH Framework (or other health equity framework) to comprehensively assess our state and local policy context regarding the structural and intermediary determinants that contribute to health inequities or advance health equity?
4. Does our organization engage the community, especially communities of color, American Indians and other communities experiencing health inequities, to assure that these

communities inform our assessment of the policy environment? (*See Foundational Practice VI*)

5. To what extent does our organization advance health equity by promoting a health equity in all policies approach? (*See Appendix B*)

B. Implement policy changes that improve the social determinants of health and improve health equity.

1. Does our organization influence, develop and/or implement policies to improve social and economic conditions in our state, especially for populations of color, American Indians and others experiencing health inequities? (*See Appendix A and B for examples*)
2. To what extent can our organizational and state policies be objectively considered to promote health and advance equity? *(See Appendix B)*
3. Does our organization have a process for identifying timely strategic opportunities which may not be "high priority" or "hot-button" issues?

C. Assess and improve our agency's internal policies, programs, and systems, using an equity lens *(See Appendix B).*

1. Does our organization apply a health and racial equity approach to our organizational processes and procedures, including:
   a. Grant making and grant reviewing processes and procedures?
   b. Hiring and human resources processes and procedures?
   c. Workforce development processes and procedures?
   d. Data acquisition and analysis processes and procedures?
   e. Budgeting and resource allocation processes and procedures?
   f. Other key organizational processes and procedures?

Foundational Practice III: Lead with an Equity Focus

The organization fosters and supports a commitment to addressing social and economic conditions to advance health equity as a primary focus of its mission and supports its leaders in that effort.

Leadership occurs at many levels within organizations. Key leaders for health equity may not be in recognized positions of authority but have influence deep within the organization. Positional leaders committed to health equity also are critical for leveraging action inside and outside the organization.

The framework for public health leadership elaborated by James Begun and Janet Malcolm includes "applying a social determinants perspective" as its definition of competence, and in doing so complements the WHO CSDH Framework adopted by this *Learning and Action Tool*. Begun and Malcolm observe that "the evidence base for a social determinants framework for health policy and practice is strong and ever-accumulating" and "provides a foundation for stronger public health leadership." [25]

Leaders are well-informed decision-makers with a shared understanding of the principles and practices of advancing health equity and have the skills and ability to inspire and motivate individuals and organizations to take action to improve health outcomes. Leaders use relevant data for making decisions to assure equity in the conditions that create health. They actively seek out and provide opportunities for the expression of the voice of populations that bear a disproportionate burden of poor health. Leaders work to eliminate power imbalances by creating new opportunities for groups who have been marginalized to influence policies that will have an impact on their lives and communities. In addition, leaders assure that health equity is incorporated into all policies, including state plans, budgets, assessment, and other key documents and that efforts in advancing equity with the goal of alignment at the federal, state and local levels for achieving optimal health outcomes for all. Leaders build sustained commitment to investing in, supporting, and building the necessary infrastructure and processes that systematically eliminate inequity.

CRITICAL CAPABILITIES

In reviewing the below listed critical capabilities, the following questions should be kept in mind:

[25] Begun, J. W., & Malcolm, J. K. (2014). *Leading Public Health: A Competency Framework.* New York, NY: Springer.

- To what extent do we have these critical capabilities? E.g.:
    - Not at all?
    - Isolated individuals, projects, or ad hoc efforts?
    - Some existing policies, procedures, and practices to support these capabilities?
    - Widespread organizational standards that support these capabilities exist and are measured?
- What are our supports/constraints in strengthening these critical capabilities?
- What are some specific examples of how we do this? How could we better or more extensively incorporate these capabilities in our work?
- If we already have these capabilities, are we proficient? How could we improve?

♦

To lead with an equity focus, individuals in the organization must be able to:

A. Clearly articulate an equity framework and take action to advance health equity.

1. Does our organization have health equity as a central focus of its mission/activities?
2. Does our organization have key senior staff who champion health equity and take action to address social determinants of health and promote health equity?
3. Does our organization have key staff who champion health equity and support action to address social determinants of health and promote health equity?
4. Are all leaders in our organization able to identify and analyze the power relations of institutions and organizations?
5. Does our organization incorporate health equity and the social and economic conditions necessary for health into state plans, budgets, assessments, and other strategic documents?[26]
6. Do leaders in our organization recognize the significance of social stratification and take action to advance equity along lines of race, gender, class and income, geography, sexual identification, physical ability, and other socially-defined categories that confer advantage and disadvantage?

B. Engage stakeholders and commit resources to achieve health equity.

1. Do leaders in our organization encourage and champion individuals and populations that experience inequities to influence the department's program/policy efforts?

[26] For example: Budgets, Infant Mortality Plans, Title V Needs Assessment, State Health Assessment, State Health Improvement Plan, Strategic Plan, Quality Improvement Plan, etc.

2. Do our organizational leaders engage with people and organizations to create and carry out strategies to advocate for and advance policy change for health equity? *(See Foundational Practice VI)*
3. Do the leaders in our organization inspire and motivate staff and meaningfully engage all stakeholders – including communities of color, American Indians and other communities experiencing inequities – toward a shared agenda and resources to advance health equity?

C. Foster health equity leadership within the organization and community.

1. Does our organization foster and support the development of leaders at all levels of the organization?
2. Do leaders within our organization collaborate well with one another and with leaders outside of the organization to advance health equity?
3. Does our organization support and work collaboratively with leadership from grassroots and civic organizations whose activities and campaigns advance health equity?
4. Does our organization recognize and support existing and emerging leaders for health equity across the organization?
5. Does our organization assure that government leaders and policy makers are informed and prepared to set policy that advances health equity?

Foundational Practice IV: Use Data to Advance Health Equity

The organization has data and performance systems that provide actionable data for improvement which holds itself and stakeholders accountable to advancing health equity.

Data have a unique role in both building and affirming the narrative of what creates health. "What gets measured gets done" is a familiar maxim about data, meaning that what an organization chooses to measure, such as health outcomes, creates the basis for action to improve those outcomes. Using data to advance health equity requires bringing together multiple sources of data, including those that focus on intermediary and structural determinants of health which impact social and economic conditions. These data are fundamental to expanding the understanding of the factors that contribute to health and health equity and can contribute to healthy public policy making.

Data collection, analysis, and reporting should occur in coordination and collaboration with cross sector agencies, relevant organizations – including the business community and other community partners. These partners not only have the capacity to contribute to a new health narrative inclusive of health equity, but are also essential for forming authentic relationships with communities of color, American Indians, and other communities experiencing inequities (*See Foundational Practice VI)* and for influencing policy change *(See Foundational Practice II).*

CRITICAL CAPABILITIES

In reviewing the below listed critical capabilities, the following questions should be kept in mind:

- To what extent do we have these critical capabilities? E.g.:
  - Not at all?
  - Isolated individuals, projects, or ad hoc efforts?
  - Some existing policies, procedures, and practices to support these capabilities?
  - Widespread organizational standards that support these capabilities exist and are measured?
- What are our supports/constraints in strengthening these critical capabilities?
- What are some specific examples of how we do this? How could we better or more extensively incorporate these capabilities in our work?
- If we already have these capabilities, are we proficient? How could we improve?

♦

To use data to advance health equity, the organization must be able to:

A. Develop and maintain data systems with an expanded understanding of structural and intermediary determinants.

1. Does our organization regularly and systematically collect data on a range of measures across the WHO CSDH Framework?
2. Has our organization identified, with community stakeholders, a core set of measures to identify and track correlations between key structural determinants and intermediary determinants and their contributions to measures of health outcomes and health inequities?
3. Does our organization ensure that surveillance systems, forms, surveys, and other data collection methods gather information that allow us to accurately and effectively analyze the interrelationships among structural and intermediary determinants of health and health outcomes?
4. Does our organization identify gaps in data collection, i.e., additional measures that are needed to better understand the impacts social and economic conditions have on health outcomes?
5. Does our organization acknowledge the limitations and challenges of collecting and reporting data by race/ethnicity and other population subgroups, and do we have strategies in place to address these?

B. Analyze data effectively in order to monitor trends and impacts of social determinants of health and health inequities.

1. Does our organization regularly collect and disaggregate data findings by race, ethnicity, language, gender, age, sexual identification, disability status, income, educational attainment, zip code, and other factors, such as a neighborhood deprivation index, as appropriate?
2. Does our organization evaluate different methods for categorizing race/ethnicity?
3. Can our organization recognize where the dominant narratives about health are shaping our data systems and propose alternatives?
4. Can our organization identify missing data that would reveal health inequities, and act to obtain those data?
5. Does our organization evaluate the ways in which biases may determine how we analyze, report and use our data?

C. Report data to stakeholders and the public in order to promote action to advance health equity.

1. Does our organization format and communicate data findings so that they are useful for action by all sectors, community stakeholders, and at all levels of government?
2. Does our organization leverage findings from data collection and analysis in order to help change the narrative of what creates health? *(See Foundational Practice I)*

3. Does our organization leverage findings from data collection and analysis in order to inform and inspire policy change? *(See Foundational Practice II)*
4. Does our organization leverage findings from data collection and analysis in order to support partnerships and engagement? *(See Foundational Practice VI)*

Foundational Practice V: Advance Equity through Continuous Learning

The organization assures optimal workforce development and builds a culture of learning that incorporates improvement processes at all levels of the organization.

Continuous learning allows organizations to rapidly incorporate new understandings developed through research and approaches that emerge from evolving evidence and best practices in accelerating improvement processes (i.e., innovations in practice). When an organization and its leadership encourage learning, progress can be made through both the successes and failures of all partners working together toward a shared goal of health equity.

Research demonstrates that success in achieving sustained systems change requires a well-designed learning and improvement system, with a robust evaluation process.[27] Initiatives that are successful in spreading large-scale systems transformation are characterized by three critical success factors:

1. *Leadership capacity*: Successful organizations have champions at every level that have the capacity and motivation to improve the system to achieve shared goals.
2. *Vibrant relationships and functional networks*: Successful organizations incorporate coaches and peer-to-peer support and sharing of lessons learned.
3. *Structured method to make improvement and spread good ideas*: Successful organizations incorporate a facilitated, rigorous process of measurement with small-scale rapid-cycle testing for ongoing improvement, and are able to spread what works.

Elements of continuous learning include:[28]

- Develop leadership capacity for improvement
- Create peer-to-peer relationships for learning
- Conduct rapid-cycle improvement processes
- Use relevant data and measurement systems
- Incorporate learnings into processes and systems in all levels of the organization

---

[27] Research include: Hester, J., Auerbach, J., Chang, D., Magnan, S., & Monroe, J. (2015). Opportunity Knocks Again for Population Health: Round Two in State Innovation Models. *Institute of Medicine Roundtable on Population Health*. Foster-Fishman, P. & Watson, E. (2014). The ABLe Change Framework: A Conceptual and Methodological Tool for Promoting Systems Change," *Am J Community Psychology*. Institute for Health Care Improvement (2015). *Spreading Community Adopters through Learning and Evaluation (SCALE), Theory of Change.* Retrieved from: http://www.ihi.org/Engage/Initiatives/100MillionHealthierLives/Pages/default.aspx

[28] The information, enumerated above and below is from a PPT that was presented at the *Spreading Community Accelerators through Learning and Evaluation, Community Health Improvement Leadership Academy, 2015.*

- Create systems for spread and sustainability
- Assure a workforce that is trained in addressing social determinants of health and health equity

CRITICAL CAPABILITIES

In reviewing the below listed critical capabilities, the following questions should be kept in mind:

- To what extent do we have these critical capabilities? E.g.:
  - Not at all?
  - Isolated individuals, projects, or ad hoc efforts?
  - Some existing policies, procedures, and practices to support these capabilities?
  - Widespread organizational standards that support these capabilities exist and are measured?
- What are our supports/constraints in strengthening these critical capabilities?
- What are some specific examples of how we do this? How could we better or more extensively incorporate these capabilities in our work?
- If we already have these capabilities, are we proficient? How could we improve?

♦

To advance health equity through continuous learning, an organization must be able to:

A. Provide education and communication on health equity to all parts/sectors of the organization

1. Does our organization work to expand the understanding about what creates health and health equity with all staff, community stakeholders and with our public health system partners?
2. Does our organization educate public health leaders in effective public health practices to advance health equity?

B. Develop and maintain a highly qualified, well-trained and diverse workforce.

1. Does our organization work with educational institutions to assure the availability of a highly qualified, well-trained, and diverse workforce with the knowledge and skills to advance health equity?
2. Is our organization committed to developing a professional workforce that reflects the demographics of the populations we serve?
3. Does our organization build the skills and competencies of public health practitioners to identify the role of structural and intermediary determinants on health?

4. Does our organization systematically build internal capacity related to health equity through training and other means of professional development?

C. Use continuous quality improvement strategies for ongoing learning, innovation, and improvement of the organization.

1. Does our organization develop leadership capacity for building a culture of health equity, ongoing learning, and incorporating continuous quality improvement into daily work to advance health equity?
2. Does our organization use performance management and quality improvement principles, such as rapid-cycle improvement, to continuously improve our policies, processes, and programs to advance health equity?
3. Does our organization have a plan for spreading successes in advancing health equity?
4. Does our organization provide peer-to-peer learning opportunities to advance practice around health equity?

Foundational Practice VI: Support Successful Partnerships and Strengthen Community Capacity

The organization engages multiple partners – explicitly including communities of color, American Indians, and others experiencing health inequities – in strategic and powerful partnerships to transform public health practice in order to collectively address social determinants of health and advance health equity.

Advancing health equity and promoting a health-in-all-policies approach with health equity as the goal requires two distinct but interrelated areas of engagement and partnership working across sectors and supporting communities in creating opportunities for health. If intentional, both these strategies can be leveraged to address institutional and structural inequities and institutional and structural racism.

Working across sectors can take many forms, ranging from simply sharing information all the way to collaborating on new projects or adopting shared goals, measures, and resources that are integrated through each other's work. These types of interagency relationships require a foundation of trust, mutuality, and reciprocity. This is a particularly important strategy when taking a health-in-all- policies approach with health equity as the goal.[29]

Supporting communities in creating opportunities for health requires an organization to be committed to developing authentic partnerships and shared decision-making. This requires that organizations go beyond forming intermittent relationships for the purposes of gaining feedback and move into the realm of building and sustaining relationships. The WHO CSDH in its final report stated that it is the role of governments to create opportunities for communities experiencing the greatest health inequities to become involved in societal decision-making processes that effectively determine their access to the conditions needed for health.[30]

CRITICAL CAPABILITIES

In reviewing the below listed critical capabilities, the following questions should be kept in mind:

---

[29]Research Includes: Institute of Medicine. *For the Public's Health: Investing in a Healthier Future.* Retrieved from: http://iom.nationalacademies.org/Reports/2012/For-the-Publics-Health-Investing-in-a-Healthier-Future.aspx Public Health Accreditation Board. PHAB Standards and Measures Version 1.0 – see Standard 5.2. Page 118.

[30] World Health Organization, Commission on Social Determinants of Health. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health.* Geneva: World Health Organization.

- To what extent do we have these critical capabilities? E.g.:
    - Not at all?
    - Isolated individuals, projects, or ad hoc efforts?
    - Some existing policies, procedures, and practices to support these capabilities?
    - Widespread organizational standards that support these capabilities exist and are measured?
- What are our supports/constraints in strengthening these critical capabilities?
- What are some specific examples of how we do this? How could we better or more extensively incorporate these capabilities in our work?
- If we already have these capabilities, are we proficient? How could we improve?

♦

To support successful partnerships and engagement, the organization must be able to:

A. Develop and deepen cross-sector and interagency relationships.

1. Do our organization's leaders reach out and engage their interagency counterparts to add health considerations to policies in areas outside of traditional public health concerns such as transportation, housing, employment, economic development, etc.?
2. Does our organization use the WHO definition of health to support our efforts to engage other entities in improvements in the social and economic conditions for health? [31]
3. Does our organization work to ensure an understanding of a health equity in all policies approach?
4. Does our organization use cross-sector data to support our collaborations with other cross sector agencies? *(See Foundational Practice IV)*
5. Does our organization work with entities across all sectors to improve social and economic conditions that advance health equity?
6. Has our organization developed partnerships with communications experts and the media to assure understanding in the community and expand opportunities for health?

B. Form and maintain community partnerships with multiple stakeholders, including communities of color, American Indians, and others experiencing health inequities.

1. Does our organization partner in a way that intentionally shares power and decision making?
2. Does our organization partner with a diverse group of individuals and organizations/agencies, including but not limited to: individuals and groups experiencing

[31]Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

inequities: people of color; local and Tribal health departments; cross sector agencies; universities/colleges; the executive branch; community organizations and coalitions?

3. Does our organization designates enough time and create avenues for meaningful participation of communities of color, American Indians and others experiencing health inequities in project governance and oversight, assuring that the people who are affected by various decisions are involved in the decision-making process?
4. Are decisions in our organization made in collaboration with community partners – especially communities of color, American Indians and others experiencing health inequities?
5. Does our organization practice transparency with communities around agency needs and priorities?
6. Does our organization prepare and support staff to respectfully and thoughtfully engage with communities of color, American Indians and others experiencing health inequities?
7. Has our organization, completed, participated in, or planned a community health needs assessment in collaboration with community partners including people of color, American Indians and others experiencing health inequities?
8. Does our organization utilize the WHO CSDH Framework with partners in conducting community health needs assessments?

C. Strengthen community capacity to build collective efficacy to foster institutional and structural change that advances health equity.

1. Does our organization build the leadership capacity of community members to advocate on issues affecting the environmental, social and economic conditions that impact health?
2. Does our organization intentionally foster strong relationships between cross-sectoral partners and populations of color, American Indians and others experiencing health inequities?
3. Have community partnerships led to changes in our own institutional policies, processes, and practices?
4. Does our organization work to engage (connect) or support populations of color, American Indians and others experiencing health inequities in creating more equitable, local living and working conditions?
5. Does our organization actively work to reduce the marginalization of specific racial, socio-economic or newcomer groups and build inclusive communities and decision making processes?
6. Does our organization have an evaluation plan of our community engagement efforts to ensure continuous learning and impact of partnering with communities?
7. Does our organization share the evaluation results of our community engagement efforts with community partners?

Foundational Practice VII: Assure Strategic and Targeted Use of Resources

The organization optimizes the use of resources and directs investments to address social determinants of health and health inequities.

The strategic and targeted use of resources to advance equity assures that public and private efforts to address social determinants of health and achieve equity are aligned and as effective as possible. Optimal resource utilization is, at its most fundamental level, strategic distribution of the fiscal and human resources that make possible optimal quality of life for all individuals. To optimize resource utilization, fiscal policy and organizational decision-making must reflect the organization's commitment to the goal of advancing health equity.

State-level public health organizations have the responsibility to align funding streams across local and state-level systems to maximize the impact of targeted spending on shared strategic priorities that advance equity.[32] Fiscal analysis must be employed to determine whether expenditures are allocated in a manner that addresses the structural and intermediary determinants of health. State public health organizations should track progress in optimal use of resources through ongoing evaluation in order to demonstrate that the resource investments actually advance health equity.

CRITICAL CAPABILITIES

In reviewing the below listed critical capabilities, the following questions should be kept in mind:

- To what extent do we have these critical capabilities? E.g.:
  - Not at all?
  - Isolated individuals, projects, or ad hoc efforts?
  - Some existing policies, procedures, and practices to support these capabilities?
  - Widespread organizational standards that support these capabilities exist and are measured?
- What are our supports/constraints in strengthening these critical capabilities?
- What are some specific examples of how we do this? How could we better or more extensively incorporate these capabilities in our work?
- If we already have these capabilities, are we proficient? How could we improve?

[32] For example: transportation, education, agriculture, economic development, child welfare and human services, the state Medicaid agency, housing, licensing and insurance regulatory agencies, etc.

♦

To assure strategic and targeted use of resources, the organization must be able to:

A. Strategically direct fiscal and human resources to those with the greatest need to advance health equity.

1. Does our organization assure that resources are not reinforcing cultural bias, barriers or inequities?
2. Does our organization assure strategic distribution of the fiscal and human resources that make possible optimal health and quality of life for all individuals?
3. Does our organization have current data that inform where resources should be invested to address those with greatest need? *(See Foundational Practice IV)*
4. Does our organization track resource allocation to assure that it is directed to those with greatest need in order to advance health equity?

B. Invest in research and practice-based strategies and shared priorities for advancing health equity.

1. Does our organization invest in identifying practice-based evidence that is culturally responsive?
2. Does our organization have a planned approach to assure that resources to advance health equity are allocated based on research and practice-based evidence?
3. Does our organization prioritize funding in ways that emphasize the assets and opportunities needed across the life span?

C. Use resources to build system capacity to advance health equity.

1. Does our organization allocate sufficient resources for policy development and implementation to advance health equity? *(See Foundational Practice II)*
2. Does our organization allocate sufficient resources for workforce development to advance health equity? *(See Foundational Practice V)*
3. Does our organization allocate sufficient resources for quality improvement and performance measurement of advances in health equity? *(See Foundational Practice V)*
4. Does our organization allocate funds to support the meaningful participation of communities of color, American Indians, and others experiencing health inequities in societal decision-making and prioritization processes?

D. Align funding streams across all sectors and levels of government to maximize the impact of efforts to advance health equity.

1. Does our organization align funding streams to promote health equity and the elimination of health inequities?

2. Are our organization's payment methodologies and fiscal incentives aligned with performance on health equity measures?
3. Is our organization's fiscal policy aligned with equitable access to services, supports, assets, and opportunities?

E. Track progress to assure accountability for optimal resource use.

1. Do we hold our organization's provider networks (hospitals/clinics) and other public health system partners accountable for advancing health equity?
2. Does our organization track and analyze whether public health allocations are spent in a manner that advances health equity and supports the reduction of health inequities?
3. Are fiscal, programmatic and outcomes analysis, tracking, and improvement processes in place for all allocated expenditures?
4. Does our organization rigorously follow and monitor fiscal principles and requirements of public/private stewardship and accountability to improve health equity?

References

Begun, J. W., & Malcolm, J. K. (2014). *Leading Public Health: A Competency Framework.* New York, NY: Springer.

Center for Urban Population Health. Retrieved from www.cuph.org

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.html

Delaware Health and Social Services, Division of Public health. (2015). *Health Equity Guide for Public Health Practitioners and Partners*. Retrieved from http://www.ccrs.udel.edu/sites/ccrs.udel.edu/files/health%20equity%20guide.pdf

Eliminating Disparities in Child and Youth Success Collaborative (2014). *Tool for Organizational Self-Assessment Related to Racial Equity*. Retrieved from http://coalitioncommunitiescolor.org/wp-content/uploads/2014/06/Tool-for-Organizational-Self-Assessment-Related-to-Racial-Equity-2014.pdf

Minnesota Department of Health (2014). *Advancing Health Equity in Minnesota: Report to the Legislature.* Retrieved from: http://www.health.state.mn.us/divs/chs/healthequity/ahe_leg_report_020414.pdf

National Association of Chronic Disease Directors (2014). State Health Department Organizational Self-Assessment for Achieving Health Equity: Toolkit and Guide to Implementation. Retrieved from: http://barhii.org/download/toolkit/nacdd_he_toolkit.pdf

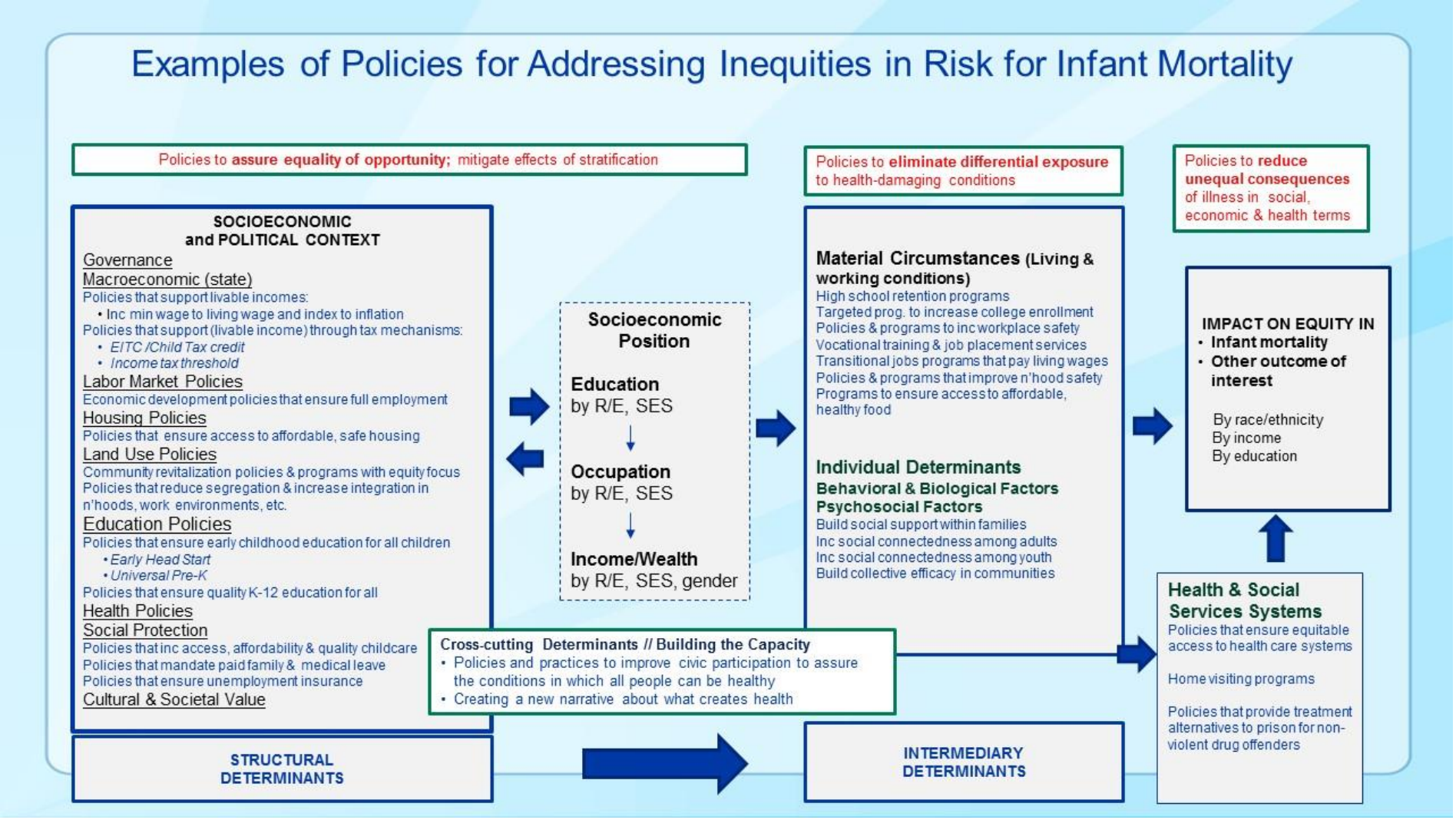
Solar, O. & Irwin A. (2010). *A conceptual framework for action on the social determinants of health*. Social Determinants of Health Discussion Paper 2 (Policy and Practice). Geneva, World Health Organization, 2010. Retrieved from: http://www.who.int/social_determinants/corner/SDHDP2.pdf.

University of Wisconsin Population Health Institute (2012). *What Works? Policies and Programs to Improve Wisconsin's Health*. Retrieved from: http://uwphi.pophealth.wisc.edu/programs/match/healthiest-state/what-works-policies-and-programs-to-improve-wi-health.pdf (and on-line database at http://whatworksforhealth.wisc.edu/).

World Health Organization: *A Conceptual Framework for Action on the Social Determinants of Health*: *Social Determinants of health Discussion Paper 2* (2010). Retrieved from: http://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf

World Health Organization, *Social Determinants of Health*. 2015. Retrieved from: http://www.who.int/social_determinants/en/

Appendix A: Health Equity in All Policies Approach with Health Equity as the Goal



NOTE: The policies and programs referred to below must be *effective* (evidence based and/or rigorously evaluated)	
Conceptual Category	**Policy/Program**
Structural	Policies that ensure early childhood education for all children (e.g., Early HeadStart, Universal Pre-K)
Structural	Policies that increase access to, affordability of, and quality of childcare
Structural	Policies that ensure quality K-12 education for all (e.g., funding, teacher quality)
Structural	Community revitalization policies and programs with equity focus
Structural	Economic development programs and policies that ensure full employment
Structural	Support livable income through tax policies
Structural	Support livable income by Increasing minimum wage to living wage and indexing to inflation
Structural	Policies that mandate paid family & medical leave
Structural	Expand and ensure unemployment insurance
Structural	Policies that ensure access to affordable, safe housing (e.g., Moving to Opportunity, Housing First)
Structural	Policies that reduce segregation and increase integration in neighborhoods, work environments, etc.
Intermediary PsySoc	Evidence-based programs to build social support within families
Intermediary PsySoc	Policies that build social capital and social cohesion within communities
Intermediary PsySoc	Policies and programs that increase social connectedness among adults
Intermediary PsySoc	Policies and programs that increase social connectedness among youth
Intermediary L&W	Policies that create safe school environments to support learning
Intermediary L&W	Targeted programs to increase college enrollment
Intermediary L&W	High school dropout-prevention programs
Intermediary L&W	Policies and programs to increase workplace safety
Intermediary L&W	Programs that provide vocational training and job placement services
Intermediary L&W	Massive expansion of living-wage-paying transitional jobs programs
Intermediary L&W	Policies & Programs that improve Neighborhood Safety
Intermediary Health & Crim Just	Policies that provide treatment alternatives to prison for non-violent drug offenders
Cross-Cutting	Policies and practices to improve civic participation to assure the conditions in which all people can be healthy
Cross-Cutting	Creating a new narrative about what creates health

Note: The Intermediary Determinants category includes Living and Working Conditions ("L&W"), Psychosocial ("PsySoc"), and Other (e.g., Health & Criminal Justice)
The following is a list of the kinds of policies that are considered to promote health and advance health equity and which are crucial to include in a comprehensive policy assessment. These are policies or policy areas that are evidence-based or evidence informed. Some have evidence for improving health outcomes in general, while others have specific evidence relating to improved birth outcomes (e.g., Earned Income Tax Credit).

When completing this *Learning and Action Tool*, policies should be assessed in multiple areas across the WHO structural, intermediary, and crosscutting areas (see Appendix II and III). To assist your organization, these policies areas are grouped by conceptual category according to the WHO conceptual framework.

Our state has effective policies in the WHO conceptual framework area of "Structural Determinants," including policies that effectively (check all that apply):

- ❒ Ensure early childhood education for all children (e.g., early HeadStart, universal pre-k)
- ❒ Increase access to, affordability of, and quality of childcare
- ❒ Ensure quality K-12 education for all (e.g., funding, teacher quality)
- ❒ Support community revitalization interventions that focus on increasing equity
- ❒ Support economic development initiatives that ensure full employment
- ❒ Support livable income through tax policies
- ❒ Support livable income by increasing minimum wage to living wage and indexing to inflation
- ❒ Mandate paid family & medical leave
- ❒ Expand and ensure unemployment insurance
- ❒ Ensure access to affordable, safe housing (e.g., Moving to Opportunity, Housing First)
- ❒ Reduce segregation and increase integration in neighborhoods, work environments, etc.

Our state has effective policies in the WHO conceptual framework area of "Intermediary Determinants," including policies that effectively (check all that apply):

- ❒ Support programs to build social support within families
- ❒ Build social capital and social cohesion within communities
- ❒ Increase social connectedness among adults
- ❒ Increase social connectedness among youth
- ❒ Create safe school environments to support learning
- ❒ Increase college enrollment
- ❒ Support high school completion programs
- ❒ Increase workplace safety
- ❒ Provide vocational training and job placement services
- ❒ Support expansion of living-wage-paying transitional jobs programs
- ❒ Improve neighborhood safety
- ❒ Provide treatment alternatives to prison for non-violent drug offenders

Our state has effective policies in the WHO conceptual framework area of "Cross-cutting Determinants," including policies that effectively (check all that apply):

- ❒ Support substantially improved civic participation among all segments of society
- ❒ Support a broader narrative about what creates health (e.g., a health-in-all-policies)

Appendix B: Advancing Health Equity – Asking the Right Questions Is a Path to Action

1. The central questions when looking at **existing policies** are:
   - What are the outcomes?
   - Who benefits?
   - Who is left out?

2. The central questions to help design **new policies** are:
   - What outcomes do we want?
   - Who should benefit?

3. The central questions to examining **processes** are:
   - Who is at the decision-making table, and who is not?
   - Who has the power at the table?
   - Who is being held accountable and to whom or what are they accountable?

4. The central questions to help develop **new processes** are:
   - How should the decision-making table be set, and who should set it?
   - Who should hold decision-makers accountable, and where should this accountability take place?

5. The central questions to identify **assumptions** are:
   - What values underlie the decision-making process?
   - What is assumed to be true about the world and the role of the institution in the world?
   - What standards of success are being applied at different decision points, and by whom?

6. The central questions to define **new assumptions** that will create the opportunity for health and healthy communities for all are:
   - What are our values?
   - What would it look like if equity was the starting point for decision-making?

Appendix C: Five Competency Sets for Public Health Leadership[33]

Invigorate Bold(er) Pursuit of Population Health

1. Critically assess the current state of your program or organization
2. Articulate a more compelling agenda
3. Enlist others in the vision and invigorate them to drive toward it
4. Pursue the vision with rigor *and* flexibility
5. Marshal the needed resources

Engage Diverse Others in Public Health Initiatives

1 Assess local conditions, in ways relevant and credible to the local stakeholders
2 Search widely for the right partners
3 Apply a social determinants perspective to planning
4 Take time to build relationships, teamwork, and common understanding
5 Clarify roles and governance

Effectively wield power to increase the influence and impact of public health

1. Understand and strategically use both positional authority and informal influence
2. Analyze a given public health problem and proposed solution in "campaign" terms
3. Build coalitions of core supporters, new partners, and issue-specific allies
4. Deal effectively with opponents
5. Be strategically agile

Prepare for Surprise in Public Health Work

1. Promote resilience in individuals and communities
2. Develop and critique an emergency response plan
3. Communicate effectively during surprises
4. Execute an emergency response plan with flexibility and learning
5. Learn and improve after surprises

Drive for Execution and Continuous Improvement in Public Health Programs and Organizations

1. Build accountability into public health teams, programs, and organizations
2. Establish metrics, set targets, monitor progress, and take action
3. Proactively demonstrate financial stewardship of public health funds
4. Employ the methods and tools of quality improvement
5. Encourage innovation and risk-taking

---

[33] Begun, J. W., & Malcolm, J. K. (2014). *Leading Public Health: A Competency Framework.* New York, NY: Springer.