Webinar Description

This webinar will focus broadly on integrating health equity into efforts to improve community health. Social Determinants of Health – the conditions in which people are born, grow, live, work and age – will be discussed to provide a context for community health improvement efforts. We will explore the “Twin Approach”, which occurs when both population-wide and culturally tailored interventions are applied concurrently. Awardee presentations will provide insight about how to identify health inequities, develop strategies to address these inequities, and evaluate interventions. Whether a focus on health equity is new or well-integrated in your community/organization, this webinar will provide practical strategies to improve your current efforts, as well as opportunities to learn from the challenges and successes of communities working to achieve health equity.
By the end of this webinar, participants are expected to be able to:

• Apply social determinants of health to better define the community context;

• Explain the benefits of simultaneously implementing public health programs in both general and priority populations; and

• Identify at least one foundational skill that can be (or is currently being) applied by your community or organization to achieve health equity.
LT. Shalon Irving has been at CDC since 2012 and currently serves as an Epidemiologist in the Division of Community Health, Office of Health Equity where her work focuses on the epidemiology of health disparities among racial and ethnic minorities as well as identifying indicators to better measure health equity. Increasingly, LT Irving is providing technical assistance to project officers and awardees to assist them in their efforts to work effectively across settings to implement their health improvement strategies. LT Irving has a PhD in Sociology and Gerontology from Purdue University and a Masters of Public Health from Johns Hopkins University Bloomberg School of Public Health. LT Irving is also a former W.K. Kellogg Health Scholar.
Dr. Sonya Shin
Executive Director, Community Outreach and Patient Empowerment (COPE) Project

Dr. Shin’s research and clinical experience has focused on health issues among underserved populations. She has worked for more than 20 years with the international social justice organization, Partners In Health, to develop and evaluate community-based programs to address chronic diseases in resource-poor settings.

She is the Executive Director and founder of a non-profit organization - Community Outreach and Patient Empowerment, COPE – which is dedicated to improving health outcomes in Native communities.

Dr. Shin received her B.A. at Yale University, and her M.D. and M.P.H. at Harvard. She is currently Assistant Professor at Harvard Medical School, Associate Physician at the Division of Global Health Equity at Brigham and Women’s Hospital, and Consulting Physician at Gallup Indian Medical Center.
Nineequa Blanding is the Director of the CDC-funded REACH Obesity and Hypertension Demonstration Project within the Chronic Disease Prevention and Control Division at the Boston Public Health Commission. Nineequa leads this collaborative effort of more than 40 organizational partners in the city. She holds a BA from Spelman College, a MPH from Long Island University and more than 11 years of research and program planning experience in academic, healthcare and local health department settings. Previously a NIMH Fellow with a focus on examining the underlying factors that contribute to Post-Traumatic Stress Disorder (PTSD), her experiences working with vulnerable populations ignited a strong interest to shift gears and establish a career in public health – with an explicit focus on advancing health equity and chronic disease prevention.
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Integrating Health Equity: Practical Strategies and Foundational Skills

From the Division of Community Health Webinar Series
Integrating Health Equity:
Practical Strategies and Foundational Skills

Shalon Irving, PhD, MPH, CHES, Epidemiologist
TACTIC Webinar
May 20, 2015
Acknowledgements

Pattie Tucker, DrPH, RN,
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Organization of Webinar

- Overview of Incorporating Health Equity into Foundational Skills of Public Health
- Awardee Presentations
  - Partners in Health, COPE Project
    - Identifying and Understanding Health Inequities
    - Health Equity-Oriented Strategy Selection, Design and Implementation
  - Boston Public Health Commission
    - Making the Case for Health Equity
    - Addressing Health Equity in Evaluation Efforts
Key Terms

Health Disparities
Key Terms

Health Inequalities

Percentage of Persons Aged ≥20 Years Diagnosed with Diabetes by County, CDC Behavioral Risk Factor Surveillance System and US Census Bureau’s Population Estimates Program, Texas, 2012

Key Terms

Health Inequities
Key Terms

Health Equity

Every person has an opportunity to achieve optimal health regardless of:

- Age
- Gender identity
- Level of education
- Neighborhood they live in
- Sexual orientation
- Skin color
- Income or the job
- Whether or not they have a disability
Equality vs. Equity

Equality doesn’t mean Equity
Focus is on Where We...

LIVE
LEARN
WORK
PLAY
Social Determinants of Health

http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health
Evolving Terminology

Social Determinants of Health
Organize, Assess, Prioritize/Plan, Implement, Monitor/Evaluate

Select an Action Step or community member to learn more

- Evaluate Actions
- Work Together
- Assess Needs & Resources
- Focus on What's Important
- Choose Effective Policies & Programs
- Communicate
- Act on What's Important

Community Members

Public Health

- Healthcare
- Business
- Educators
- Philanthropy & Investors
- Nonprofits
- Community Development
- Government

National Center for Chronic Disease Prevention and Health Promotion
Division of Community Health
Division of Community Health
Target Intervention Area Tool

Step 1: Select Your Target Intervention Area

Why Use This Tool
Review and print the Target Area Tool overview

How to Use This Tool
Find step-by-step guides on how to use the Target Intervention Area Tool

Access Target Intervention Area Tool
Define your community

Tutorial Videos
Access training videos on selecting target intervention areas

www.communitycommons.org/chi-planning
Twin Approach to Health Equity

Population-wide interventions with health equity in mind + Targeted culturally tailored interventions to address the greatest chronic disease burden = Twin Approach
Poll

Our community is using the twin approach in our chronic disease prevention work.

• Yes

• No, but we are interested in learning more

• No, the twin approach is not applicable to our work
A Practitioner’s Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease

A resource for public health practitioners and others working to advance health equity through community health interventions. The guide focuses on policy, systems, and environmental changes designed to improve the places where people live, learn, work, and play.

[Link to guide](ww.cdc.gov/healthequityguide)
A Practitioner’s Guide for Advancing Health Equity: Foundational Skills

Organizations engage in many practices that can influence their impact on health equity. This section focuses on how to enhance your organization’s capacity to advance healthy equity through foundational skills and practices.

**Strategies include:**
- Building organizational capacity
- Engaging community members
- Developing partnerships and coalitions
- Identifying and analyzing health inequities
- Selecting, designing, and implementing strategies
- Developing effective communication efforts
- Conducting evaluations

[http://cdc.gov/healthequityguide](http://cdc.gov/healthequityguide)
Building Organizational Capacity

• Establish an institutional commitment to advance health equity
• Track and capture health equity efforts in training and performance plans
• Integrate health equity in services and resources
Engaging Community Members

Community-Based Participatory Approach

1. Recognizes the community as a unit
2. Builds on collective strengths and shared resources
3. Facilitates partnership and capacity building
4. Disseminates pertinent information
5. Involves a long-term process and commitment
6. Is action oriented
Partnerships

Multi-Sector Approach

- Education
- Urban Planning and the Built Environment
- Faith-Based
- Transportation
- Business Sector / Commerce
- Housing
Identifying and Analyzing Health Inequities

• Importance of understanding health inequities
  • Community context
  • Role of mapping

• Soliciting community involvement in all aspects of process
Selecting, Designing and Implementing Strategies

• Role of practice- and evidence-based
  • Culturally-tailored strategies
• Link to identified health inequities
• Take community context into consideration
• Barriers and unintended consequences
• Implementation challenges
  • Special considerations
  • Importance of process evaluation
Developing Effective Communication Efforts

• Messaging
  • Language Use
• Role of data in messaging
• Messaging should be action oriented / solution focused
• Dissemination
Conducting Evaluations

• Health equity considerations should be considered early in the evaluation planning process
  • Logic model
  • Development of evaluation questions and strategies (culturally-relevant)
  • Health Equity Indicators
• Employ varied strategies for evaluation
  • Process and outcome
  • Mixed methods
Thank You!

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Lessons Learned:
Understanding, Addressing & Evaluating Health Disparities in Navajo Nation

Sonya Shin
Executive Director, COPE/PIH
May 20, 2015
Agenda

• Navajo Nation Setting
• COPE Background
• Understanding Health Inequities
• Finding Solutions
  – Strategy Design & Implementation
Setting: Navajo Nation

- Roughly 250,000 Navajo live on reservation of 27,000 sq mi\(^1\)
- Unemployment rate is 52\(^2\)
- Individual income\(^2\)
  - 57% earn less than $10,000/yr
  - 2% earn more than $100,000/yr
- Utilities\(^2\)
  - 56% of homes have running water
  - 83% of homes have electricity
  - 50% of homes lack complete plumbing facilities
- Health
  - 40% of Navajo adults over age 45 have diabetes\(^2\)
  - Heart disease is the second leading cause of death\(^3\)

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2-Phase II housing needs assessment and demographic analysis: Prepared for Navajo Housing Authority. (2011).

Inset: [Untitled map of Navajo Nation, USA.](http://www.nnrecovery.navajo-nsn.gov)
COPE’s Sister Organization: Partners In Health

- Our mission is to provide a preferential option for the poor in health care.
- We believe that health is a human right.
- Ill health is a symptom of poverty and structural inequality.
- We address the root causes of disease by providing clean water, housing, food, medicine—whatever it takes.
To eliminate health disparities and improve the wellbeing of American Indians and Alaska Natives.

To promote healthy, prosperous, & empowered Native communities.

In order to achieve these aims, COPE focuses on three approaches:
• Robust community-based outreach
• Increased access to healthy foods; and
• Local capacity and system-level partnerships
COPE: Three Areas of Focus

- Comprehensive Approach to Health Equity
- Socio-ecological model
- Multi-level intervention ➔ Synergistic impact

STRENGTHENING COMMUNITY-BASED OUTREACH

INCREASING ACCESS TO HEALTHY FOODS

BUILDING LOCAL CAPACITY & PARTNERSHIPS
COPE: Partnership and capacity building
Broad Coalition across Navajo Nation, including national partners.

Goals:

• To increase access to healthy foods among individuals living in Navajo Nation;

• To increase access to chronic disease services through clinic-community outreach
Poll

Our community has used mixed methods to understand health inequities in our community.

• Yes
• No
Don’t rely on assumptions about what health inequities exist in your community:

- Burden of disease among children in Eastern Navajo seems to be much higher than what had been supposed
- Clear need for intervention early in the life cycle

SOURCE: Understanding the Food System in Navajo Nation: A summary of research and interventions to date Joan VanWassenhove—Paetzold MIA MPH; Shruthi Rajashekara, MD, MMSc; Sonya Shin MD MPH
Learn from community members: Economic & physical environment

- Navajo Nation classified as a food desert by USDA
- Average distance to grocery store is over an hour

Historical and cultural context

- U.S foreign policy x 200 years → current Navajo food system
- Food sovereignty movement
- Cultural traditions and connection to food
Understanding Health Inequities: Utilizing Mixed Methods
Finding Solutions: Shifting to a Strengths-based Approach

Identify resources within the community as a starting point

- Navajo Stores CDC Epi-AID report 2013
- Tax-exemption for healthy foods & “Junk Food Tax” recently passed
Finding Solutions: Applying a Strengths-based Approach

Small stores on Navajo Nation: Partners rather than “the problem”

Healthy Navajo Stores Initiative!
Finding Solutions:
Common Ground and Shared Objectives

Navajo Fruits & Vegetable Prescription (FVRx) Program

Local Community Members

FVRx Team

FVRx Family

FVRx Retailer
Finding Solutions: “The Devil is in the Details…”

Predict barriers to success, then…

Design the program up front to deal with those barriers

- Clinic & CHW staff limitations & turnover
- Transportation & distance for families to get to access food and chronic disease services
- Distribution & produce handling for small stores
Ahéhee’! Thank you!
To all COPE’s partners who make this work possible!

Acknowledgements:

Our dedicated Navajo Nation CHRs
The community members that we all serve
Navajo Area Indian Health Services
Navajo Nation Department of Health
Diné Food Sovereignty Alliance
Diné Policy Institute
All IHS and 638 facilities in Navajo Nation

Sonya Shin
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Advancing Health Equity through Communication, Program Planning and Evaluation

Nineequa Blanding, MPH
Director, REACH Obesity & Hypertension Demonstration Project
Boston Public Health Commission
Learning Objective

- Develop shared understanding of 2 Foundational Skills:
  1. **Making the Case for Health Equity**
     - Guiding Principles:
       1. Framing: Naming the Issue
       2. Assessing the Community Context
       3. Engaging Stakeholders
       4. Targeting Resources
       5. Tailoring Communications/Messaging
  2. **Addressing Health Equity in Program Planning & Evaluation Efforts**
     - Guiding Principles:
       1. Integrating program planning & implementation with evaluation
       2. Incorporating health equity in evaluation questions
       3. Using process and outcome evaluations to understand the effect on health inequities
Making the Case for Health Equity

1. Framing: Naming the Issue
2. Assessing the Community Context
3. Engaging Stakeholders
4. Targeting Resources
5. Tailoring Communications/Messaging
1. Framing: Naming the Issue

*Frames are mental structures that shape the way we see the world. As a result, they shape the goals we seek, the plans we make, the way we act, and what counts as a good or bad outcome of our actions…frames shape our social policies and the institutions we form to carry out policies.*

George Lakoff (Professor of Linguistics at UC Berkeley)
1. Framing: Naming the Issue

Boston Public Health Commission

Mission Statement
- To protect, preserve, and promote the health and well-being of all Boston residents, particularly the most vulnerable.

Vision Statement
- The Boston Public Health Commission envisions a thriving Boston where all residents live healthy, fulfilling lives free of racism, poverty, violence, and other systems of oppression. All residents will have equitable opportunities and resources, leading to optimal health and well-being.
Social Determinants of Health: BPHC’s Health Equity Framework

Racism

- Social Capital
- Education
- Transportation
- Employment
- Food Access
- Socioeconomic Status
- Environmental Exposure
- Health Behaviors
- Access to Health Services
- Housing
- Public Safety

Health Outcomes

Source: Boston Public Health Commission
Factors that Affect Health

Socioeconomic Factors
*And Racial Justice

Long-lasting
Protective Interventions

Changing the Context

to make individuals’ default decisions healthy

Clinical Interventions

Counseling & Education

Examples

- Eat healthy, be physically active
- Rx for high blood pressure, high cholesterol, diabetes
- Immunizations, brief intervention, cessation treatment, colonoscopy
- Fluoridation, 0g trans fat, iodization, smoke-free laws, tobacco tax
- Poverty, education, housing, inequality

Smallest Impact

Largest Impact
2. Assess the Community Context
Hypertension Among Adults by Selected Indicators, 2013

DATA SOURCE: Boston Behavioral Risk Factor Survey (2013), Boston Public Health Commission
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office
Obesity Among Adults by Selected Indicators, 2013

DATA SOURCE: Boston Behavioral Risk Factor Survey (2013), Boston Public Health Commission
DATA ANALYSIS: Boston Public Health Commission Research and Evaluation Office
3. Engaging Stakeholders is Key

- Stakeholder involvement is **critical** in the planning & evaluation of interventions to address health inequities. This process includes:
  1. Identifying Stakeholders
  2. Engaging Stakeholders
  3. Identifying and Documenting Racial Inequities
  4. Examining the Causes
  5. Clarifying the Purpose
4. Targeting Resources

- Achieving health equity involves focusing resources in areas with the greatest burden of disease.
- Example: 2014 Boston Partnership to Improve Community Health (PICH) Strategy
City-wide Rethink Your Drink Efforts

- **2004:** Policy restricting sale of unhealthy beverages in Boston Public Schools
- **2011:** Mayor’s Executive Order for all City Property
- **2011 – 2012:** 10 Boston area hospitals supported the educational campaign through a variety of interventions
- **2013 -2014:** 3 major supermarket chains supported the educational campaign through signage and product placement interventions
5. Tailor Messaging: Youth-focused & driven media campaigns

2011: Fat Smack Educational Campaign
• Youth Media Council (primarily comprised of youth of color) formed to develop the campaign.

2013: #Hydration Nation Social Media Campaign
• 6 youth organizations (primarily serving youth of color) contracted to support youth to develop and promote the educational campaign via social media platforms (Facebook, Twitter, YouTube, etc.).
2011 “Sugar Smarts”: Parent Focused Unhealthy Beverage Educational Campaign

You do so much to protect them.

But, maybe you never realized how much these could hurt them.

After all, your kids are sweet enough already. Visit www.sugarsmarts.com

Made possible by funding from the US Department of Health and Human Services through Communities Putting Prevention to Work.
2014 “Sugar Smarts”: After Resident Feedback through Focus Group Testing

YOU DO SO MUCH TO PROTECT THEM.

BUT, MAYBE YOU NEVER REALIZED HOW MUCH SUGARY DRINKS COULD HURT THEM.

After all, your kids are sweet enough already. For more information on healthy beverages, visit www.sugarsmarts.com

TÚ HACES TANTO PARA PROTEGERLOS.

PERO TAL VES NUNCA TE DISTE CUENTA DEL DAÑO QUE LAS BEBIDAS DULCES PUEDEN CAUSAR.

Después de todo, tus niños ya son tan dulces. Para más información de bebidas saludables, visita a www.bphc.org/AzucarSabia.

Not a model by authoring and support busca el Cuidar de las Enfermedades Mental, Páginas de la Educación de los Niños.
Poll

» Our community has tailored our messaging to priority populations.
  » Yes
  » No, our efforts to tailor messaging have not yet succeeded
  » No, we have not yet tried to tailor our messaging
  » No, tailoring messaging is not applicable in our community
Considerations for Developing Awareness Campaigns with a Health Equity Lens

- Know your audience and engage stakeholders
  - Example: 2014 Sugar Smarts campaign
    - Through a Request for Proposal (RFP) process, a communications consultant was contracted to conduct focus groups with Black & Latino residents, primarily from the priority areas of interest (5 neighborhoods: Mattapan, Roxbury, Hyde Park, Dorchester, East Boston)

- Ensure media placements saturate priority areas
  - Example: 2014 Sugar Smarts ads were placed in all 5 priority neighborhoods

- Ensure materials are appropriately translated
  - All translated materials were vetted by stakeholders to ensure the fidelity of the messages were retained in a way that resonates with community members
Addressing Health Equity in Program Planning & Evaluation Efforts

1. Integrating program planning & implementation with evaluation
2. Incorporating health equity in evaluation questions
3. Using process and outcome evaluations to understand the effect on health inequities
1. Integrating Program Planning & Implementation with Evaluation

- Without a focus on health equity in both programmatic and evaluation efforts, it would be difficult to assess the impact of an intervention.

- Boston Public Health Commission frequently uses data to inform intervention planning and to monitor the impact of an intervention to make improvements mid-course.

- Let’s walk through a few examples of this work…
Program Examples

Active Transportation
Communities Putting Prevention to Work

Healthy Beverage Policies
Communities Putting Prevention to Work
REACH Obesity & Hypertension Demonstration Project

Out-of-School Time Nutrition and Physical Activity (OSNAP)
REACH Obesity & Hypertension Demonstration Project
Example: Program Planning & Evaluation with a Health Equity Lens

Program activities: Designed to address health inequities in obesity and hypertension health outcomes

Determine to what extent these activities affect pre-existing health inequities among Boston residents

Health outcomes: Short / intermediate term
△ Healthy beverage consumption, △ Physical activity

Health impact: Longer term
↓ Hypertension prevalence
↓ Obesity prevalence
Example: General Evaluation Questions

1. What was the reach of these programs?
   - Did the reach include the desired neighborhoods and/or populations of interest?

2. What were the changes in . . .
   - Knowledge: awareness
   - Attitudes: support for systems change
   - Practices: unhealthy beverages / fruit / veggie intake, physical activity amount
   - Prevalence: Obesity
2. Incorporating Health Equity in Evaluation Questions

**Obesity Prevention**

1. Bike Share Initiative
2. OSNAP
3. Healthy Beverage Policies

1. **What were the reach of these programs? Did it include low-income populations of color?**

2. **Did Black and Latino residents participate in these activities?**

3. **What is the percentage of Black and Latino residents served by participating organizations that are undergoing policy change?**
3. Using process and outcome evaluations to understand the effect on health inequities
Example: Race/Ethnicity Data to Inform the OSNAP Intervention

Race/Ethnicity of Children Served by OST Programs that Completed OSNAP in 2013-2014 (N=24)

- Black: 43%
- Hispanic/Latino: 30%
- White: 16%
- Other: 11%
Example: Race/Ethnicity Data to Inform the OSNAP Intervention

Neighborhoods of OST Programs that Completed OSNAP in 2013-2014 (N=27)

- Roxbury: 33%
- Dorchester: 31%
- Mattapan: 16%
- Hyde Park: 13%
- East Boston: 5%
- Other: 2%
## REACH Out-of-school time Initiative
### 2013-2014 Results

<table>
<thead>
<tr>
<th>OSNAP Goal</th>
<th>Percent Meeting Goal at Baseline</th>
<th>Percent Meeting Goal at Follow Up</th>
<th>Change?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide all children with at least 30 minutes of moderate to vigorous physical activity every day</td>
<td>39%</td>
<td>68%</td>
<td>⭐️</td>
</tr>
<tr>
<td>Offer 20 minutes of vigorous physical activity (3 times per week)</td>
<td>37%</td>
<td>58%</td>
<td>⭐️</td>
</tr>
<tr>
<td>Do not allow sugary drinks to be brought in during program time</td>
<td>30%</td>
<td>63%</td>
<td>⭐️</td>
</tr>
<tr>
<td>Offer water as a drink at snack every day</td>
<td>73%</td>
<td>93%</td>
<td>⭐️</td>
</tr>
<tr>
<td>Limit computer and digital device time to homework or instructional only</td>
<td>77%</td>
<td>81%</td>
<td>🔄️</td>
</tr>
<tr>
<td>Offer a fruit or vegetable option every day at snack</td>
<td>76%</td>
<td>77%</td>
<td>✗️</td>
</tr>
<tr>
<td>Do not serve sugary drinks (100% juice larger than 4 oz. or SSBs)</td>
<td>62%</td>
<td>62%</td>
<td>✗️</td>
</tr>
<tr>
<td>No 100% juice was served</td>
<td>34%</td>
<td>42%</td>
<td>⭐️</td>
</tr>
</tbody>
</table>
Lessons Learned

- Understanding your audience is key – a “one-size fits all approach” cannot advance health equity
- Engaging stakeholders is an extremely powerful tool and should be utilized during every step of the process

Planning Implementation & Evaluation

- Data collected should be shared back with communities involved
- Addressing health equity involves ensuring appropriate data is collected to assess population priorities, plan interventions and assess the impact of these strategies
Thank You!

Nineequa Blanding, MPH
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Chronic Disease Prevention & Control Division
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Questions?
Resources


• Robert Wood Johnson Foundation (RWJF): A New Way to Talk About the Social Determinants Of Health http://www.rwjf.org/content/dam/farm/reports/reports/2010/rwjf63023

• DCH: Twin Approach (emailed prior to webinar)
• COPE Report: Understanding the Food System in Navajo Nation (emailed prior to webinar)