MOVING EVIDENCE INTO ACTION TO ADDRESS HEALTH EQUITY: RECOMMENDATIONS, STRATEGIES, AND APPROACHES TO UTILIZE EVIDENCE-BASED DECISION MAKING TO IMPROVE PUBLIC HEALTH PRACTICE IN SOUTH DAKOTA

Sandra Melstad, MPH, SLM Consulting, LLC
Learning Objectives

- Understand what evidence-based decision making and evidence-based public health is
- Understand what is evidence
- Identify what health equity is and how it affects health
- Understand evidence-based strategies to address health inequities and how to apply to practice
- Identify resources to support addressing health equity
<table>
<thead>
<tr>
<th>Health Disparities</th>
<th>Poverty</th>
<th>Unequal Access to Healthcare</th>
<th>Poor Environmental Conditions</th>
<th>Education Inequalities</th>
<th>Language Barriers</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>A baby born to African-American mother has more than twice the risk of dying during the first year of life than a white American baby.</td>
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<tr>
<td>Suicide rates among American Indians/Alaska Natives aged 15-35 years are more than two times higher than the national average for that age group.</td>
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<tr>
<td>LGBTQ youth are more likely to be overweight than non-LGBTQ youth.</td>
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</tbody>
</table>
CHECK YOUR BLIND SPOTS
Evidence-Based Decision Making
Evidence-Based Decision Making

“A process for making decisions about a program, practice, or policy that is grounded in the best available research evidence.”

Source: Prevention Research Center in St. Louis, Washington University in St. Louis
Evidence-Based Public Health

“Evidence-based public health is the process of integrating science-based interventions with community preferences to improve the health of populations.”

Key Characteristics of EBPH

- Making decisions based on the best available peer-reviewed evidence
- Using data and information systems systematically
- Applying program planning frameworks
- Engaging the community in assessment and decision making
- Conducting sound evaluation
- Disseminating what is learned
What is “Evidence”?
What is “Evidence”?

**OBJECTIVE**

- Scientific literature in systematic reviews
- Scientific literature in one or more journal articles
- Public health surveillance data
- Program
- Qualitative evaluation data
- Media/marketing data
- Word of mouth

**SUBJECTIVE**
Domains that Influence Evidence-Based Decision Making

## Think Broadly: Evidence Typology

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Sources</th>
<th>Examples</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective</td>
<td>Authoritative, rigorous systematic reviews (2+ studies)</td>
<td>Published reviews by an independent review group</td>
<td>Community Guide Cochrane reviews</td>
<td>Reach Effectiveness Design Execution</td>
</tr>
<tr>
<td>(1st Tier)</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effective</td>
<td>High quality studies with peer review (1+ studies)</td>
<td>Published articles Technical reports Books or chapters</td>
<td>Journal articles Government reports</td>
<td>Reach Effectiveness Design Execution</td>
</tr>
<tr>
<td>(2nd Tier)</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promising</td>
<td>Intervention evaluations and descriptive studies</td>
<td>Unpublished dissertations/theses Reports</td>
<td>Case studies Health impact assessments</td>
<td>Reach Effectiveness Design Execution</td>
</tr>
<tr>
<td>Emerging</td>
<td>Practice-based summaries or evaluation works in progress</td>
<td>Websites Demonstration projects</td>
<td>Policy briefs Professional standards of practice</td>
<td>Reach Effectiveness</td>
</tr>
</tbody>
</table>

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SLM Consulting, LLC
Data Driven Public Health Solutions
Health Equity in Practice
What Is Health Equity?

And What Difference Does a Definition Make?
Health Equity

“the attainment of the highest level of health for all people...Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historic and contemporary injustices, and the elimination of health and healthcare disparities.”

U.S. Department of Health and Human Services
Health Equity ≠ Health Equality
Root Cause of Health Inequity

“Racism, class oppression, gender discrimination and exploitation, and other similar systems for disadvantaging one group and advantaging another, which have direct and indirect impacts on population health.”

CENTER FOR HEALTH EQUITY PRACTICE, MICHIGAN PUBLIC HEALTH INSTITUTE
Root Cause Diagram: Obesity

Obesity

Physical Inactivity
- Lack of access to physical activity opportunities
- Unsafe neighborhood

Unhealthy nutrition intake
- Food Desert
- Poverty
Root Causes: Social Determinants of Health

- Depression
- Long-term Unemployment
- PTSD
- Homelessness
SOCIAL DETERMINANTS OF HEALTH

Health Outcomes
- Length of Life (50%)
- Quality of Life (50%)

Health Factors
- Health Behaviors (30%)
  - Tobacco Use
  - Diet & Exercise
  - Alcohol & Drug Use
  - Sexual Activity
- Clinical Care (20%)
  - Access to Care
  - Quality of Care
- Social & Economic Factors (40%)
- Physical Environment (10%)
  - Education
  - Employment
  - Income
  - Family & Social Support
  - Community Safety
  - Air & Water Quality
  - Housing & Transit

Policies & Programs

County Health Rankings and Roadmaps, a Robert Wood Johnson Foundation Program, www.countyhealthrankings.org/resources/county-health-rankings-model
Rural America & South Dakota

- Rural counties have had the highest rates of premature death for many years, lagging far behind other counties.
- Poverty rate: 17.4%, compared with 8.5% in urban areas of the state.
- 9.9% of the rural population has not completed high school (2012-2016 ACS data reported by ERS).
- Unemployment rate: 3.6%, while the urban rate is 3.0% (USDA-ERS, 2017).
Impacted Populations in South Dakota

- Because sexual orientation and gender identity are not included on death certificates, we do not actually know whether LGBTQ youth die by suicide more often than their peers. (South Dakota Suicide Prevention, 2019)

- 7.3% of South Dakota Seniors are Food Insecure (Feeding America, 2017)

- 19% of American Indian adults in South Dakota have been told they have diabetes (South Dakota Department of Health, 2013-2017)
ZIP CODE: 57623
Life Expectancy: 76.3

ZIP CODE: 57108
Life Expectancy: 80

Resource: Robert Wood Johnson Foundation, Practical Playbook Conference 2017
Social Determinants of Health & Levels of Influence

Address Social Determinants of Health

Address/Achieve Health Equity

Improve Population Health
<table>
<thead>
<tr>
<th>Current Approach</th>
<th>Health Equity Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vulnerable Population</strong></td>
<td><strong>Oppressed Populations</strong></td>
</tr>
<tr>
<td>Focuses on people rather than institutions or societal factors that generate risk</td>
<td>Addresses injustice in the everyday practices of institutions; systematic constraints resulting from traditions, laws, rules</td>
</tr>
<tr>
<td><strong>Factor/Social Problem</strong></td>
<td><strong>Social Injustice</strong></td>
</tr>
<tr>
<td>Reflects an individualistic approach; focuses on discrete facts or problems that mask the role of structures, systems, or social causes</td>
<td>By definition, this suggests a societal, and therefore, a health equity approach</td>
</tr>
<tr>
<td><strong>Lifestyle</strong></td>
<td><strong>Social Responsibility</strong></td>
</tr>
<tr>
<td>Assumes that individuals are responsible for change</td>
<td>Assumes that society must change</td>
</tr>
<tr>
<td><strong>Risky Behavior</strong></td>
<td><strong>Causes of Risky Conditions</strong></td>
</tr>
<tr>
<td>Assumes that individuals are responsible for poor health outcomes, overlooks societal factors that create harm</td>
<td>Examines the role that institutions play in shaping conditions, puts the focus on power and processes</td>
</tr>
<tr>
<td><strong>Risk Assessment</strong></td>
<td><strong>Alternatives Assessment</strong></td>
</tr>
<tr>
<td>Asking whether a chemical, for example, is safe or not avoids the broader question of whether that chemical is necessary at all</td>
<td>Starts with comparisons among alternatives to prevent exposure</td>
</tr>
<tr>
<td><strong>Find a Cure for Cancer</strong></td>
<td><strong>Find a Cause for Cancer</strong></td>
</tr>
<tr>
<td>Is targeted to individual people and does not address cause(s)</td>
<td>Not only addresses prevention, but opens the possibility that structures or environmental, rather than personal, changes are needed</td>
</tr>
<tr>
<td><strong>Intervention/Treatment</strong></td>
<td><strong>Systemic Change</strong></td>
</tr>
<tr>
<td>Is targeted to individual people and does not address cause(s)</td>
<td>Assumes that social, political, and economic structures play a role in health outcomes</td>
</tr>
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</table>
Evidence-Based Strategies

Foundational Skills
Community Assessment
Grant Applications
Data Collection & Analysis
Prioritize Program, Practice, or Policy
Action Planning
Evaluation
Partnership Engagement
Strategies to Achieve Health Equity

Robert Wood Johnson Foundation: For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups.

Healthy People 2020: Requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.

Measuring the gaps in health and in opportunities for optimal health is important not only to document progress but also to motivate action and indicate the kinds of actions needed to achieve greater equity.
Data Source: Bay Area Regional Health Inequities Initiative, Retrieved from http://barhii.org/
Incorporate Equity into Foundational Skills

- Build organizational capacity to advance health equity
  - Recruitment, retention, hiring practices
  - Staff knowledge and skills at all levels
- Community engagement for health equity
- Develop partnerships and coalitions to advance health equity
- Identify and understand health inequities: Data that ensures program, practices, and policies decrease inequities
- Health equity-oriented strategy selection, design, and implementation
- Make the case for health equity: Communication
- Address health equity in evaluation efforts: Measurement and evaluation that ensures program, practices, and policies decrease inequities
- Allocation of resources, budgets, and contracting that address health equity

Resource: National Center for Chronic Disease Prevention and Health Promotion, CDC
Community Assessment

Guided by Health Equity Model and Population Health Approach

Ongoing community engagement of diverse members, partners, & stakeholders

- Population affected by issues: Tribal communities, LGBTQ, low-income, rural, refugee, etc.
- Partners working to address issues

Collect comprehensive data (Qualitative, Quantitative, Primary and Secondary data)

- Social, Economic, and Environmental Factors (e.g. poverty, food desert, poor housing)
- Aggregate data by demographics
- Seek input from underserved and priority populations (e.g. tribal communities, LGBTQ, food insecure)
- Survey, Indicators, GIS Mapping, Focus Groups, Key Informant Interviews, Community Conversations

Identify priorities that address health equity and priority populations
COMMUNITY ENGAGEMENT

Working collaboratively with & through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting their well-being

Community Engagement Spectrum

**INFORM**
Provide residents with info and assist in understanding problems, alternatives, and solutions.

**CONSULT**
Obtain public feedback on analysis, alternatives, and decisions.

**INVOLVE**
Work directly with residents and consistently consider their concerns and aspirations.

**COLLABORATE**
Partner with residents in decision-making, including in identification of solutions.

**EMPOWER**
Residents are making decisions and leading solution-based efforts.

*Based on the IAP2 Public Participation Spectrum, developed by the International Association for Public Participation, 2014
http://c.ymcdn.com/sites/www.iap2.org/resource/resmgr/foundations_course/IAP2_P2_Spectrum_FINAL.pdf*
INVOLVE THE PEOPLE MOST AFFECTED BY THE PROBLEM
Partnership Engagement

"OUR PARTNERSHIPS WILL HAVE TO BE STRONGER IF WE ARE TO HAVE PRIVATE SECTOR, INDUSTRY, AND OTHER PARTS OF GOVERNMENT IN THE TRANSPORTATION, EDUCATION, AND JUSTICE SECTORS, FOR EXAMPLE"

- Engage partners from multiple fields and sectors that have a role in advancing health equity
- Include partners working with population groups experiencing health inequities
- Establish mechanisms to ensure new voices and perspectives are added
- Develop a common language among partners from different sectors and backgrounds
- Acknowledge and manage turf issues
- Recognize and address the power dynamics in a partnership

Dr. David Satcher, Director, Satcher Health Leadership Institute and the Center of Excellence on Health Disparities, Morehouse School of Medicine

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Data Driven Public Health Solutions
Collect & Frame Data to Advance Equity

Quantitative & Qualitative

Demographic Context

Include data on other systemic determinants

Identify trends & sub-population specific data

Incorporate the voice of people facing inequities

Make data understandable and know your audience

Figure 1: Table by the Joint Center, *Segregated Spaces, Risky Places: The Effects of Racial Segregation on health Inequalities*


Resource: Colorado Department of Public Health & Environment
Development & Implementation of Program, Practice, or Policy

- Evidence-Based
- Community Engagement
- Strong Partnerships
- Evaluation Support
- Identify and Target Community Challenges and Assets
“there is nothing inherently superior about any intervention method or any method of social change...It always depends on the appropriate fit of the intervention with the person or population and their circumstances and the delivery setting”

## Integrate Health Equity into Grant Applications

- Justify the extent to which specific health disparities are priority areas within the health focus of the funding program and how addressing these will advance health equity.

- Proposing evidence-based solutions to the health disparities identified in the RFP.

- Demonstrate how proposed activities address specific health inequities.

- Identify relevant social and environmental factors that impact the social determinants of health and propose evidence-based solutions.

- Include culturally diverse communities, tribal populations, and other groups into emergency preparedness and response activities, including incorporating community engagement into planning and ensuring that response efforts are culturally appropriate for communities served, including language assistance during emergency response.

- Assess the effects of a disease or natural disaster in diverse populations.

- Develop RFP scoring processes that encourage greater specificity on how the proposal addresses health inequalities within stated objectives, activities, and evaluation strategies.
Example of Health Equity RFP: Hawaii

- The Hawaii Department of Health’s Office of Health Equity provides sample contract language for funding applicants to include in RFPs.

- The language suggests that the applicant collect demographic data, including on race, ethnicity, disability, sex, and geographic area.

- Suggests that applicants use this data to submit an annual report on a quality improvement activity determined by the applicant.

Action Planning

Balance community input with best available evidence

Ensure strategies are linked to inequities and evidence-based

Recognize everyone is not starting at the same place

Comprehensive set of approaches

Account for diversity within communities

Use a tool to ensure health equity is part of strategy selection and design
Health Equity Assessment Tool (HEAT)

The HEAT helps users to tackle health inequities when making health decisions.

1. What inequalities exist in relation to the health issue under consideration?
2. Who is most advantaged and how?
3. How did the inequalities occur? What are the mechanisms by which the inequalities were created, maintained or increased?
4. Where/how will you intervene to tackle this issue?
5. How will you improve Ma¯ori health outcomes and reduce health inequalities experienced by Ma¯ori?
6. How could this intervention affect health inequalities?
7. Who will benefit most?
8. What might the unintended consequences be?
9. What will you do to make sure the intervention does reduce inequalities?
10. How will you know if inequalities have been reduced?

Help guide practitioners grow in understanding of community engagement and be thoughtful about our own practice of engagement techniques.

### Community Engagement Assessment Tool

**Q: What kind of relationship do you have with community members?**

<table>
<thead>
<tr>
<th>OUTREACH</th>
<th>INITIATORS</th>
<th>DOING MAINLY OUTREACH</th>
<th>BEGWINING TO TALK ABOUT MOVING TO CE</th>
<th>WORKING TOWARD CE</th>
<th>DOING CE</th>
<th>COMMUNITY ENGAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>RELATIONSHIPS ARE INTERPERSONAL</td>
<td>TRANSACTIONAL FOR THE PURPOSE OF COMPLETING A PROJECT</td>
<td>RELATIONSHIPS ARE OFTEN NOT INCLUSIVE OF ALL RACIAL OR ETHNIC GROUPS IN THE COMMUNITY</td>
<td>RELATIONSHIPS CAN BE LIMITED TO A FEW COMMUNITY MEMBERS, OFTEN GIVING INFLUENCE TO THOSE WITH THE LOUDEST VOICES</td>
<td>RELATIONSHIPS ARE SHORT-TERM, SO STAFF HAVE TO REBUILD THEM AS OTHER PROJECTS OR ISSUES COME UP</td>
<td>RELATIONSHIPS ARE AN IMPORTANT VENUE TO BRIDGE THE RACIAL OR ETHNIC GAP</td>
<td>RELATIONSHIPS ARE BUILD ON THE FOUNDATIO AND ARE NOT NEEDED TO END, BUT ARE WITH PEOPLE WHO ARE INTERESTED AND OPTED TO BE LEADERS</td>
</tr>
</tbody>
</table>

**Q: Why are you engaging people?**

<table>
<thead>
<tr>
<th>OUTREACH</th>
<th>INITIATORS</th>
<th>DOING MAINLY OUTREACH</th>
<th>BEGINNING TO TALK ABOUT MOVING TO CE</th>
<th>WORKING TOWARD CE</th>
<th>DOING CE</th>
<th>COMMUNITY ENGAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>TO ACHIEVE A SPECIFIC GOAL DEFINED BY THE ORGANIZATION</td>
<td>TO CREATE SPACE FOR THE COMMUNITY TO ENGAGE IN THEIR OWN INTERESTS</td>
<td>TO SEEK BUY-IN FOR COMMUNITY</td>
<td>TO ENGAGE PEOPLE TO CONNECT, RAISE CONCERNS AND ACT IN THEIR OWN INTERESTS</td>
<td>TO ENGAGE PEOPLE TO CREATE SPACE FOR THE COMMUNITY</td>
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</tbody>
</table>

### Evaluation

- Develop a logic model that includes health equity activities and goals
- Incorporate health equity into evaluation questions and design
- Identify appropriate variable to track populations experiencing inequities
- Use culturally appropriate tools and methodologies
- Use multiple approaches to understand an intervention’s effect on health equities (e.g. GIS analysis, focus groups, photovoice)
- Include health equity indicators into performance monitoring systems
- Use process and outcome evaluations
- Disseminate the results of equity-oriented evaluations
Questions to Guide Evaluation

1. Where are we now?
2. How do we start the evaluation process with health equity in mind?
3. How can we consider health equity in evaluation questions and design?
4. How can we integrate health equity principles in the data gathering process?
5. How can we understand our effect on health equity through our analysis plan?
6. How can we share our evaluation efforts with diverse stakeholders?
Triple Aim of Health Equity

Implement Health in All Policies

Strengthen Community Capacity

Expand Understanding of Health

- Implement a Health in All Policies Approach With Health Equity as the Goal
- Expand Our Understanding of What Creates Health
- Strengthen the Capacity of Communities to Create Their Own Healthy Future
"UNLESS THERE IS A DELIBERATE INTENTION TO ADDRESS HEALTH INEQUITIES AND TO BUILD UP EVALUATIONS THAT PURPOSEFULLY USE EQUITY AS A VALUE CRITERION, THE FIELD OF HEALTH PROMOTION MAY GO ASTRAY REGARDING ITS UNDERLYING COMMITMENTS TO EQUITY IN HEALTH."

LOUISE POTVIN, UNIVERSITÉ DE MONTRÉAL
## Resources

<table>
<thead>
<tr>
<th>Resource</th>
<th>URL</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Public Health National Center for Innovations</td>
<td><a href="https://phnci.org/">https://phnci.org/</a></td>
</tr>
<tr>
<td>Sweet Tools to Advance Health Equity</td>
<td><a href="https://www.colorado.gov/pacific/cdphe/suite-of-tools">https://www.colorado.gov/pacific/cdphe/suite-of-tools</a></td>
</tr>
<tr>
<td>Community Health Equity Map</td>
<td><a href="http://www.cohealthmaps.dphe.state.co.us/cdphe_community_health_equity_map/">http://www.cohealthmaps.dphe.state.co.us/cdphe_community_health_equity_map/</a></td>
</tr>
<tr>
<td>Powering Health Equity Action with Online Data Tools</td>
<td><a href="https://nationalequityatlas.org/sites/default/files/10-Design-Principles-For-Online-Data-Tools.pdf">https://nationalequityatlas.org/sites/default/files/10-Design-Principles-For-Online-Data-Tools.pdf</a></td>
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Contact Information

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