SLM Consulting, LLC
Data Driven Public Health Solutions

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

Health Disparities	Poverty	Unequal Access to Healthcare	Poor Environmental Conditions	Education Inequalities	Language Barriers	Other
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.						
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.						
LGBTQ youth are more likely to be overweight than non-LGBTQ youth.						


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

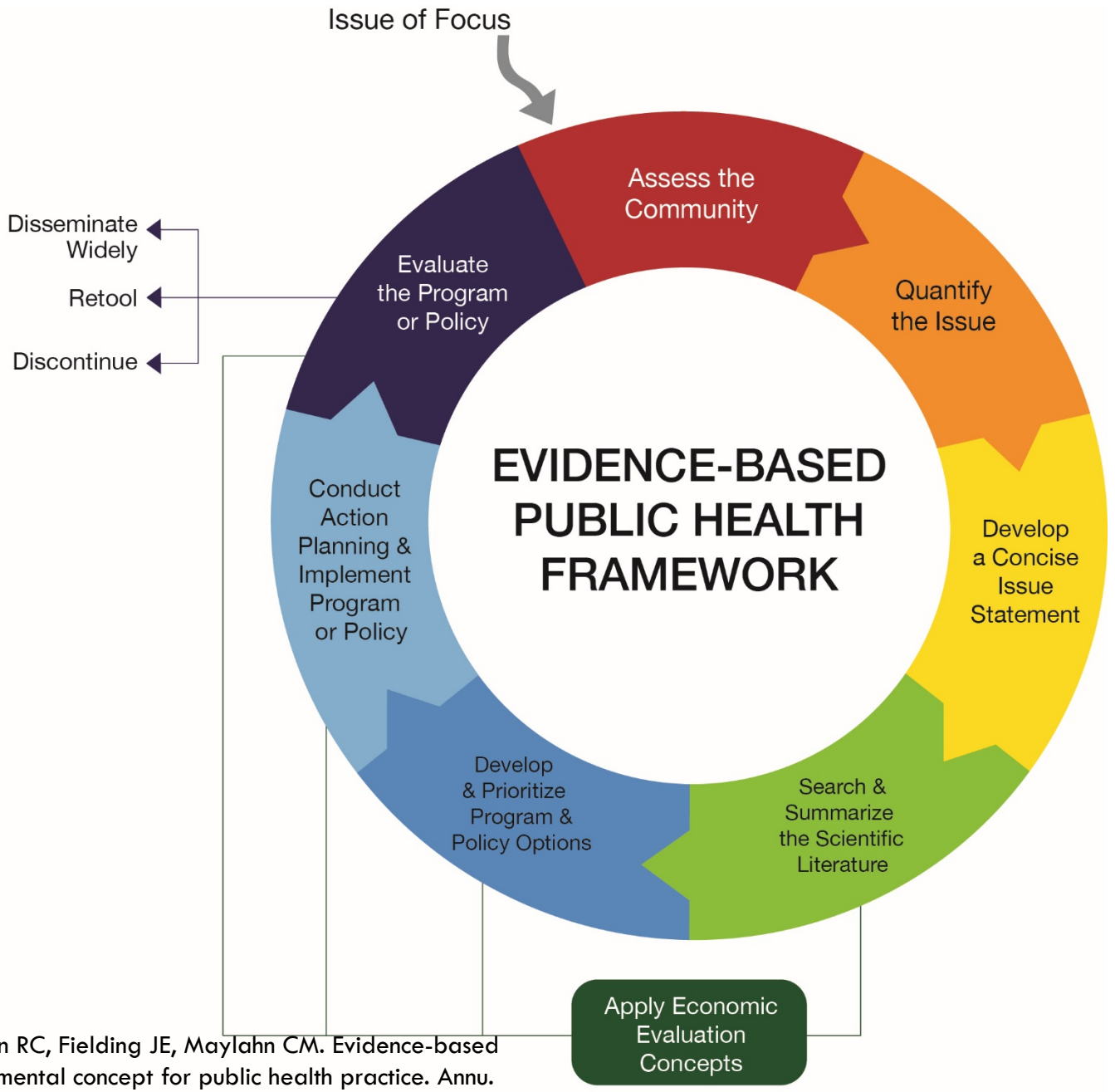
Evidence-Based Public Health

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

Source: Kohatsu, et al. Am J Prev Med 2004.

Key Characteristics of EBPH

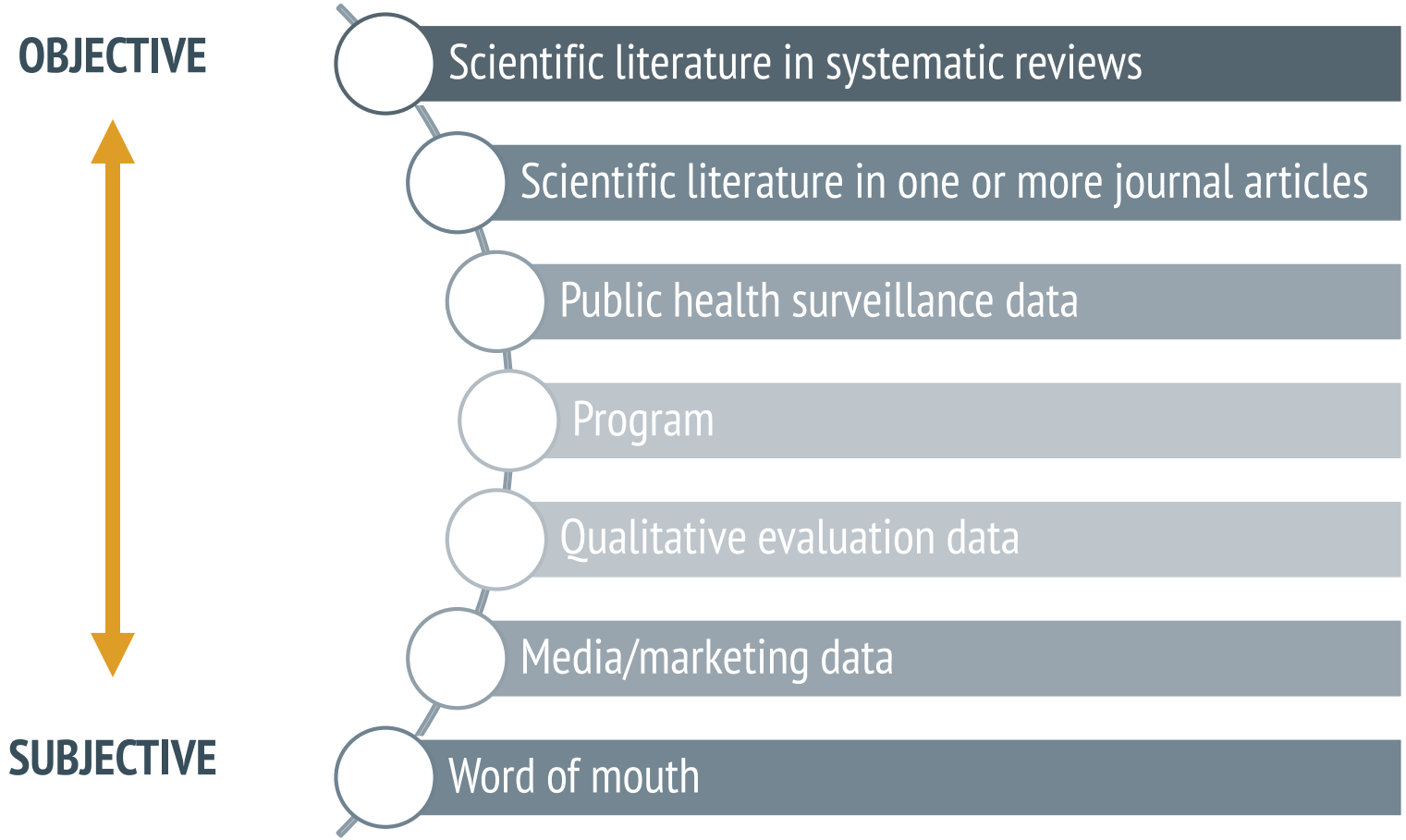
- Making decisions based on the best available peer-reviewed evidence
- Using data and information systems systematically
- Applying program planning frameworks
- Engaging the community in assessment and decision making
- Conducting sound evaluation
- Disseminating what is learned



Data Source: Brownson RC, Fielding JE, Maylahn CM. Evidence-based public health: a fundamental concept for public health practice. Annu. Rev. Public Health. 2009;30175–201.

What is “Evidence”?

What is "Evidence"?



Domains that Influence Evidence-Based Decision Making

Source: Jacobs J, Jones E, Gabella B, Spring B, & Brownson R. (2012). Tools for Implementing an Evidence-Based Approach in Public Health Practice. Preventing Chronic Disease 9, 1-9:110324. DOI: http://dx.doi.org/10.5888/pcd9.110324

Think Broadly: Evidence Typology

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

Health Equity in Practice

What Is Health Equity?

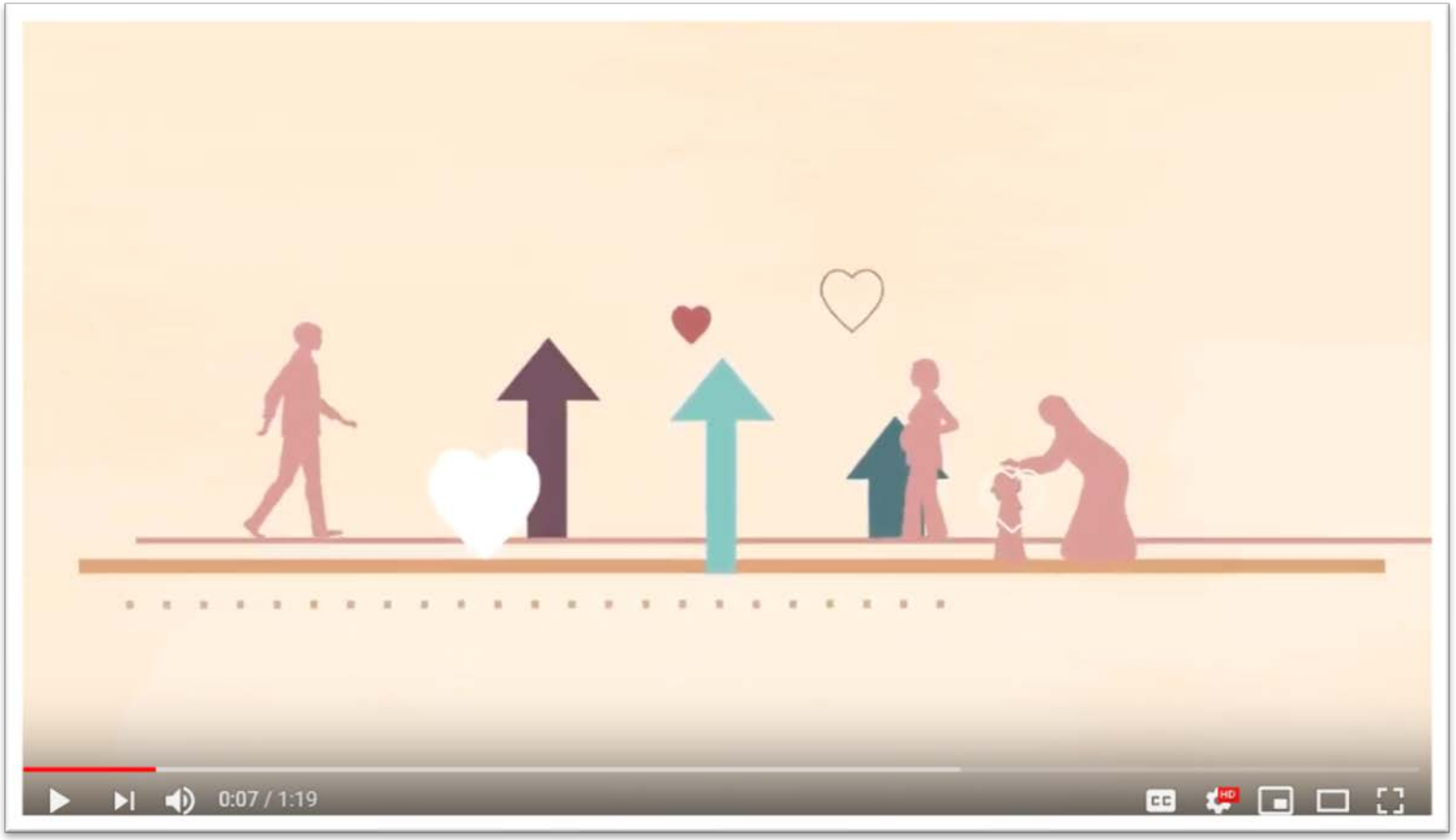
And What Difference Does a Definition Make?

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

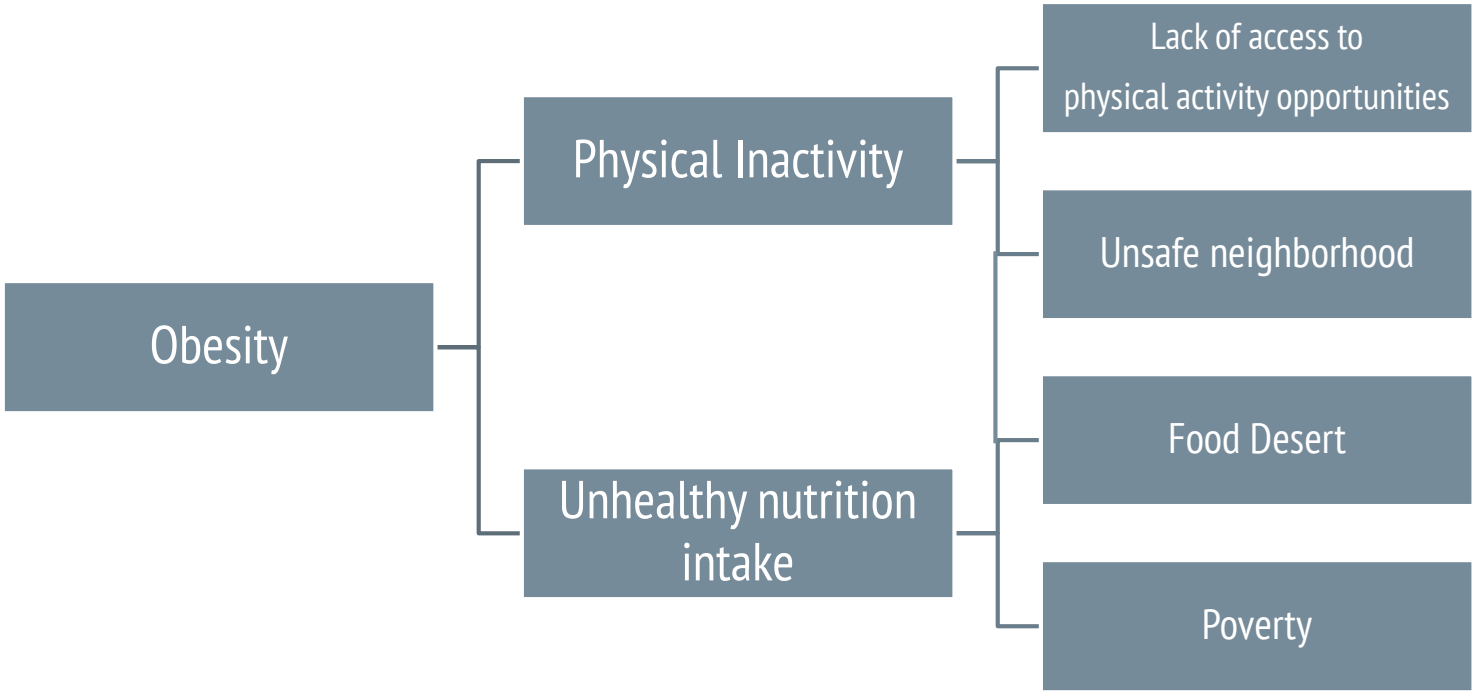


Root Cause of Health Inequity

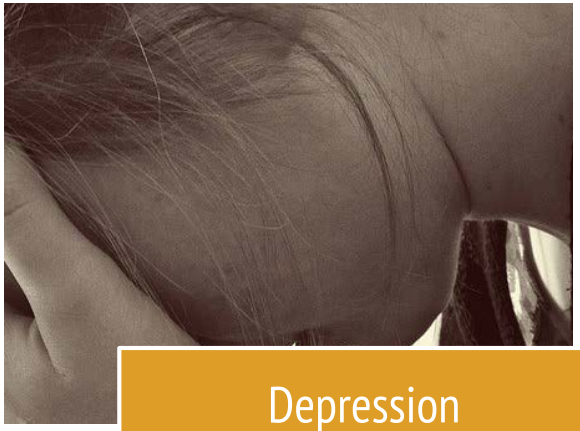
"Racism, class oppression, gender discrimination and exploitation, and other similar systems for disadvantaging one group and advantaging another, which have direct and indirect impacts on population health."

CENTER FOR HEALTH EQUITY PRACTICE,
MICHIGAN PUBLIC HEALTH INSTITUTE

Root Cause Diagram: Obesity

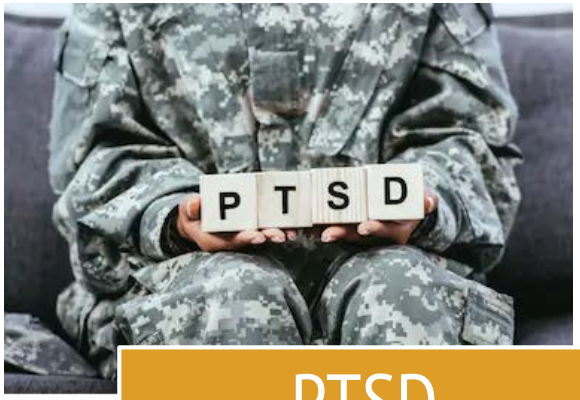


Root Causes: Social Determinants of Health



Depression

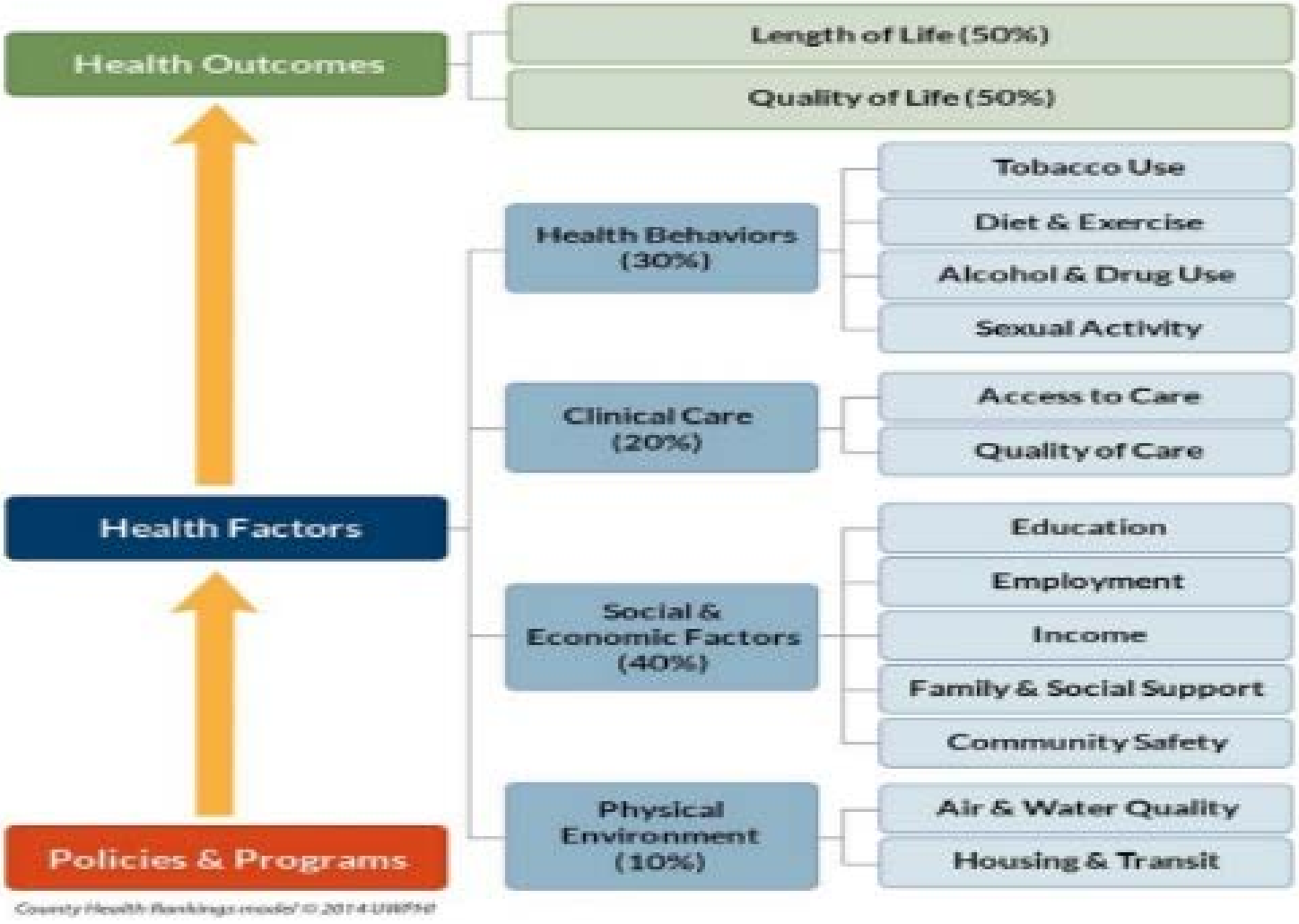
Long-term Unemployment



PTSD

Homelessness

SOCIAL DETERMINANTS OF HEALTH



County Health Rankings and Roadmaps; a Robert Wood Johnson Foundation Program, www.countyhealthrankings.org/resources/countyhealth-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

57623
Life Expectancy
76.3

57108
Life Expectancy
80

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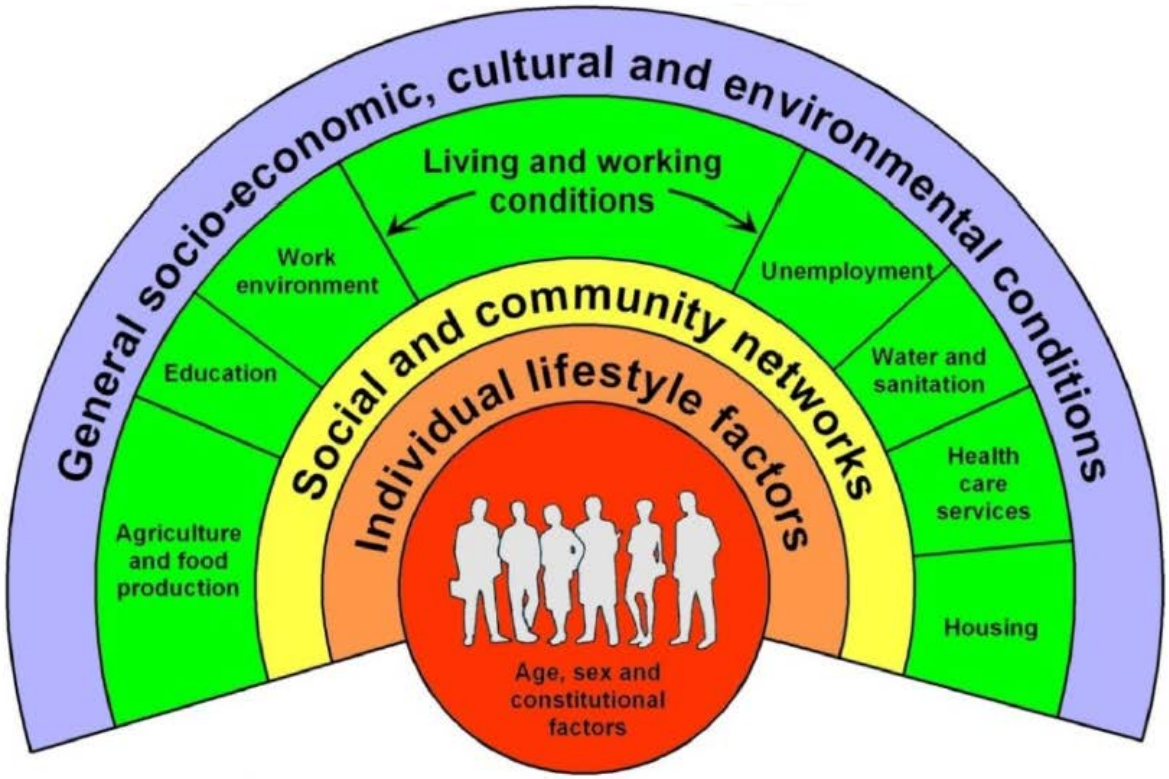
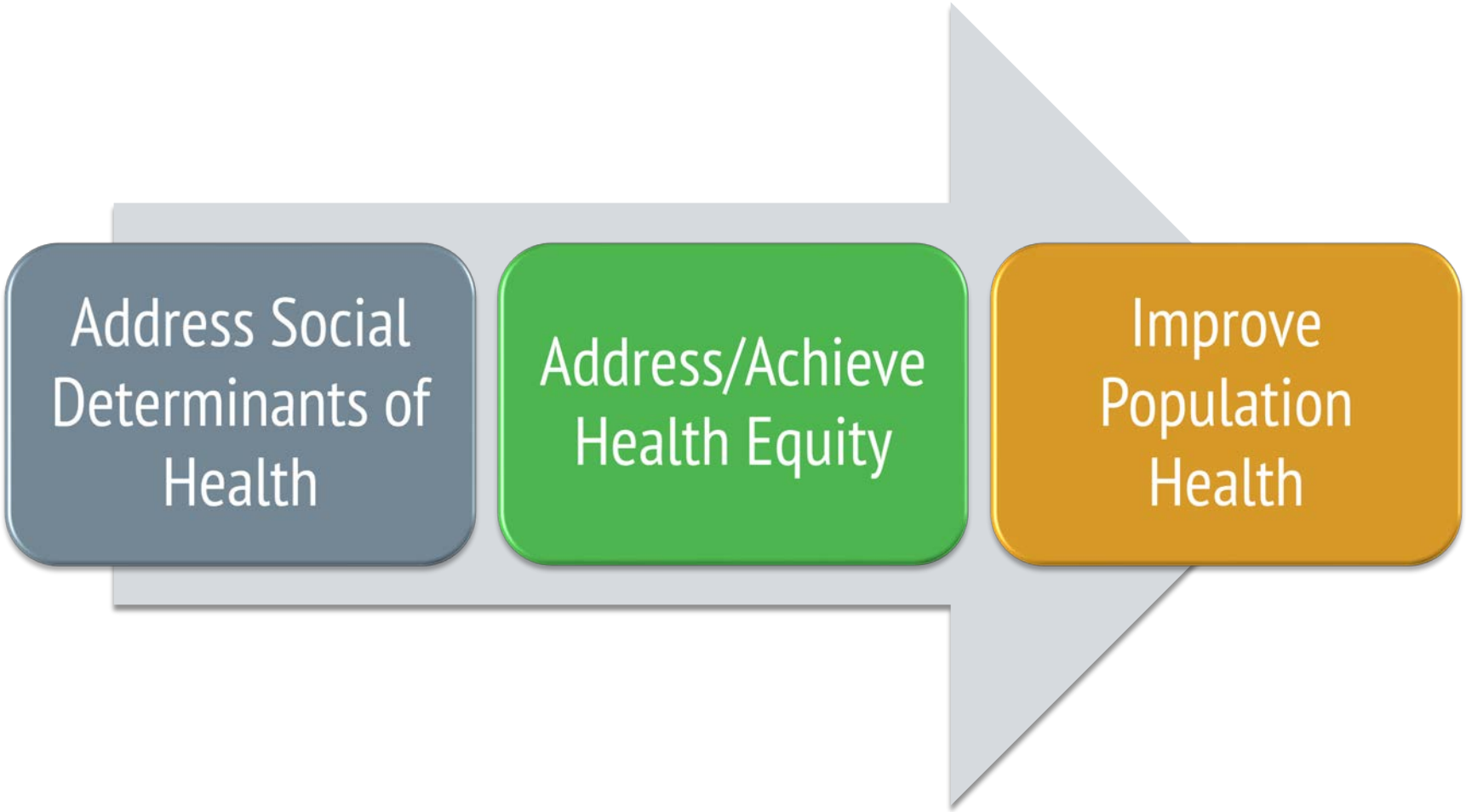
Resource: Robert Wood Johnson Foundation, Practical Playbook Conference 2017

Social Determinants of Health & Levels of Influence



Source: Dahlgren & Whitehead, 1991.


Address Social Determinants of Health
Address/Achieve Health Equity
Improve Population Health

CURRENT APPROACH	HEALTH EQUITY APPROACH
vulnerable population – focuses on people rather than institutions or societal factors that generate risk	**oppressed populations** – addresses injustice in the everyday practices of institutions; systematic constraints resulting from traditions, laws, rules
factor/social problem – reflects an individualistic approach; focuses on discrete facts or problems that mask the role of structures, systems, or social causes	**social injustice** – by definition, this suggests a societal, and therefore, a health equity approach
lifestyle – assumes that individuals are responsible for change	**social responsibility** – assumes that society must change
risky behavior – assumes that individuals are responsible for poor health outcomes, overlooks societal factors that create harm	**causes of risky conditions** – examines the role that institutions play in shaping conditions, puts the focus on power and processes
risk assessment – asking whether a chemical, for example, is safe or not avoids the broader question of whether that chemical is necessary at all	**alternatives assessment** – starts with comparisons among alternatives to prevent exposure
find a cure for cancer – is targeted to individual people and does not address cause(s)	**find a cause for cancer** – not only addresses prevention, but opens the possibility that structures or environmental, rather than personal, changes are needed
intervention / treatment – is targeted to individual people and does not address cause(s)	**systemic change** – assumes that social, political, and economic structures play a role in health outcomes

Evidence-Based Strategies

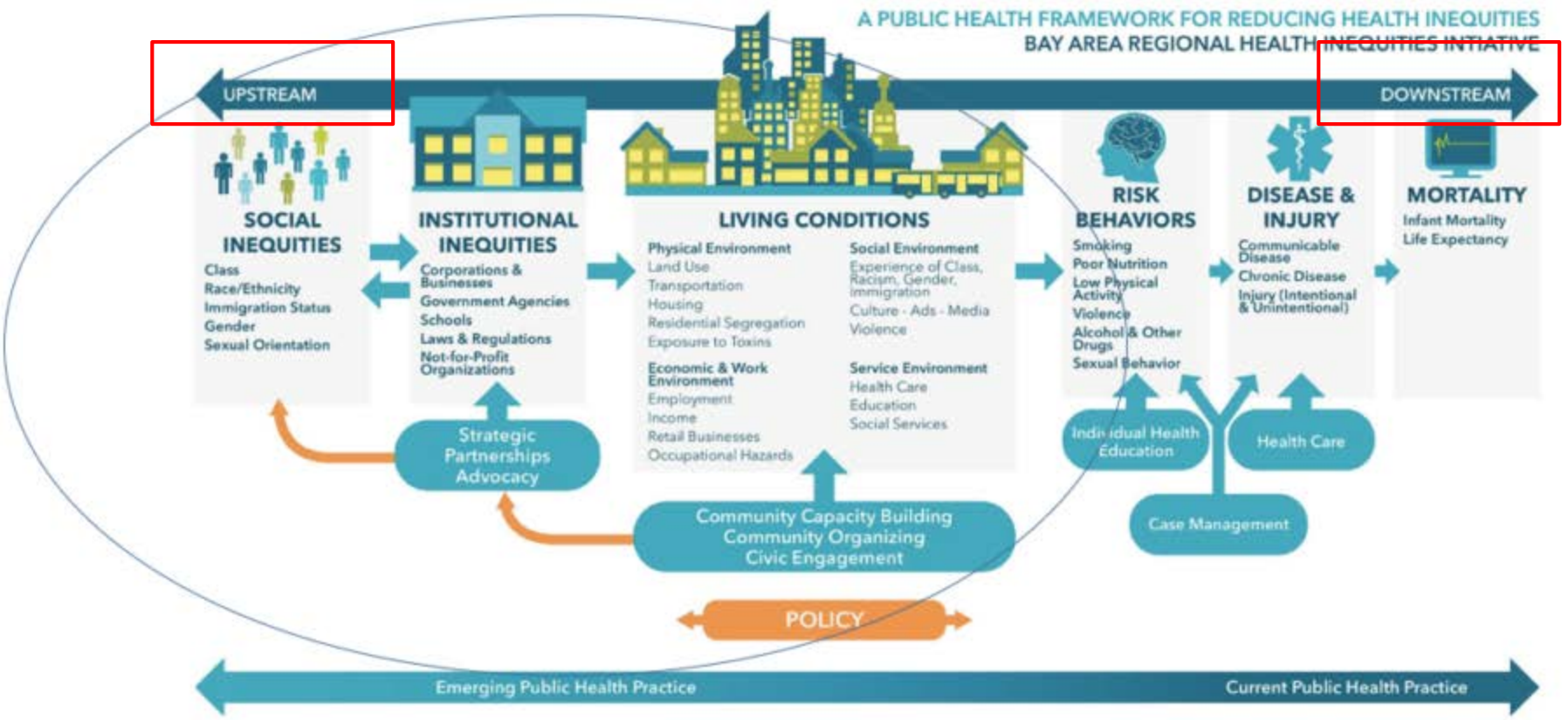
Foundational Skills
Community Assessment
Grant Applications
Data Collection & Analysis
Prioritize Program, Practice, or Policy
Action Planning
Evaluation
Partnership Engagement

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

Centers for Disease Control and Prevention (CDC). (1997), Principles of Community Engagement. Atlanta: Author.

Community Engagement Spectrum

INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
Provide residents with info and assist in understanding problems, alternatives, and solutions.	Obtain public feedback on analysis, alternatives, and decisions.	Work directly with residents and consistently consider their concerns and aspirations.	Partner with residents in decision-making, including in identification of solutions.	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"

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

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

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

Table 4. Segregation and Predicted Black-White and Hispanic-White Infant Mortality Rate Difference, 2010

Level of Segregation	Level of Black-White IMR Disparity	Level of Hispanic-White IMR Difference
0	4.68	-0.32
25%	5.90	0.36
34%	6.34	0.60
50%	7.12	1.04
67%	7.96	1.50
75%	8.35	1.72
100%	9.57	2.40

Source: Census data, 2000 and 2010 for Segregation; National Vital Statisics System, 2000 and 2007 for IMR Cities pop > 100,000

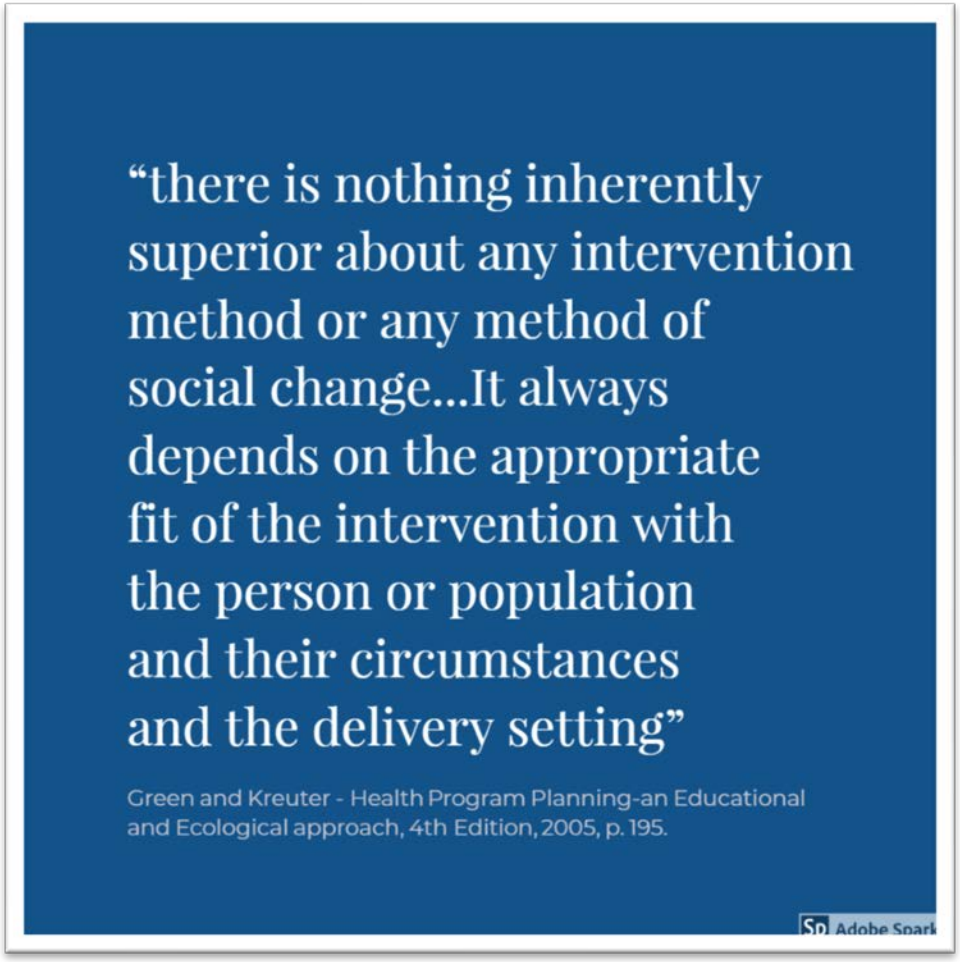
Figure 1: Table by the Joint Center, *Segregated Spaces, Risky Places: The Effects of Racial Segregation on health Inequalities*

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

Program, Practice, & Policy Adaptation

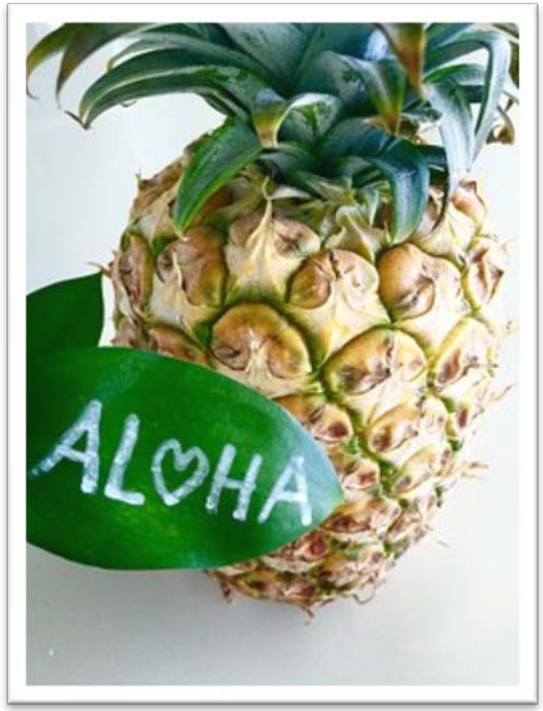


Integrate Health Equity into Grant Applications

- 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.



Source: State of Hawaii, http://health.hawaii.gov/healthequity/sample-contract-language-to-include-in-rfps/

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)

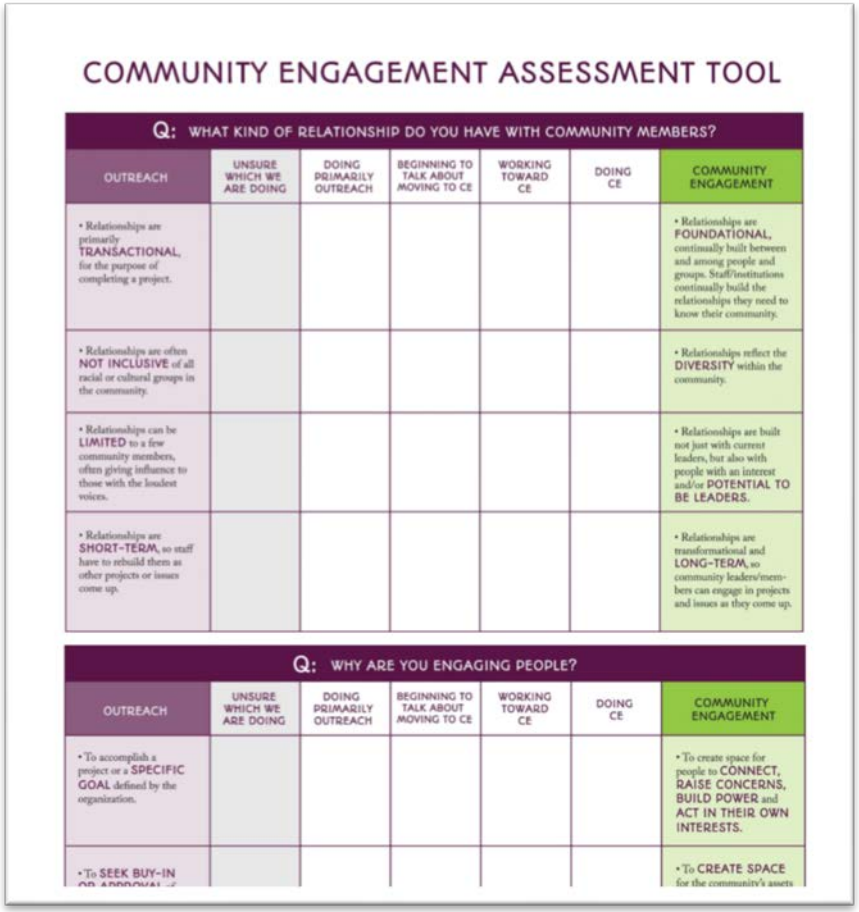
The HEAT helps users to tackle health inequities when making health decisions.

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?

Source: Ministry of Health, https://www.health.govt.nz/system/files/documents/publications/health-equity-assessment-tool-guide.pdf

Community Engagement Assessment Tool

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?

OUTREACH	UNSURE WHICH WE ARE DOING	DOING PRIMARILY OUTREACH	BEGINNING TO TALK ABOUT MOVING TO CE	WORKING TOWARD CE	DOING CE	COMMUNITY ENGAGEMENT
• Relationships are primarily **TRANSACTIONAL**, for the purpose of completing a project.						• Relationships are **FOUNDATIONAL**, continually built between and among people and groups. Staff/institutions continually build the relationships they need to know their community.
• Relationships are often **NOT INCLUSIVE** of all racial or cultural groups in the community.						• Relationships reflect the **DIVERSITY** within the community.
• Relationships can be **LIMITED** to a few community members, often giving influence to those with the loudest voices.						• Relationships are built not just with current leaders, but also with people with an interest and/or **POTENTIAL TO BE LEADERS.**
• Relationships are **SHORT-TERM**, so staff have to rebuild them as other projects or issues come up.						• Relationships are transformational and **LONG-TERM**, so community leaders/members can engage in projects and issues as they come up.

Q: WHY ARE YOU ENGAGING PEOPLE?

OUTREACH	UNSURE WHICH WE ARE DOING	DOING PRIMARILY OUTREACH	BEGINNING TO TALK ABOUT MOVING TO CE	WORKING TOWARD CE	DOING CE	COMMUNITY ENGAGEMENT
• To accomplish a project or a **SPECIFIC GOAL** defined by the organization.						• To create space for people to **CONNECT, RAISE CONCERNS, BUILD POWER** and **ACT IN THEIR OWN INTERESTS.**
• To **SEEK BUY-IN** OR APPROVAL of						• To **CREATE SPACE** for the community's assets

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Source: Nexus Community Partners, https://www.nexuscp.org/wp-content/uploads/2017/05/05-CE-Assessment-Tool.pdf

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

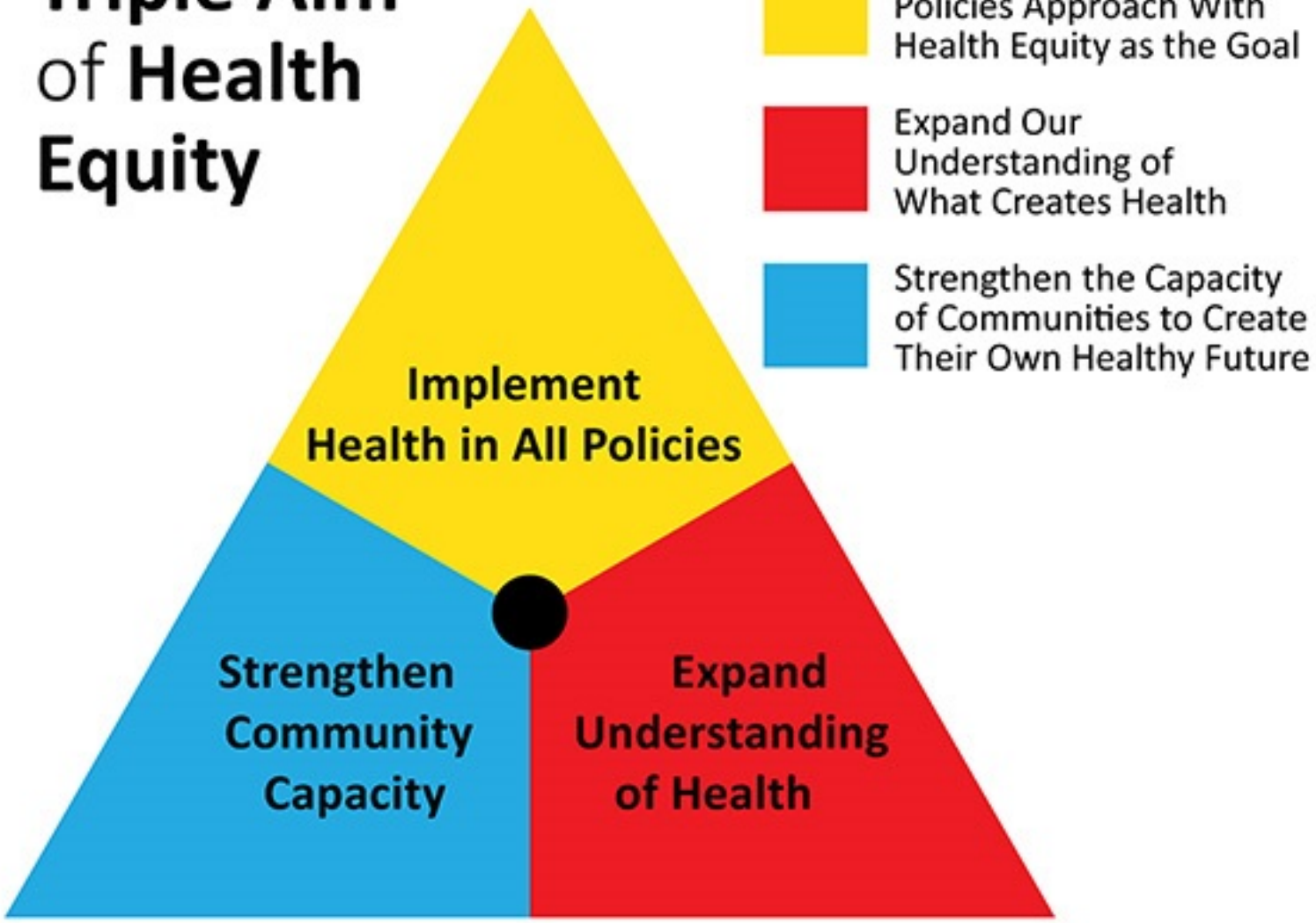
Questions to Guide Evaluation

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?

This Photo by Unknown Author is licensed under CC BY-SA

Source: Centers for Disease Control and Prevention, cdc.gov/healthequityguide

Triple Aim of Health Equity



"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

- The Public Health National Center for Innovations https://phnci.org/
- Sweet Tools to Advance Health Equity https://www.colorado.gov/pacific/cdphe/suite-of-tools
- Community Health Equity Map http://www.cohealthmaps.dphe.state.co.us/cdphe_community_health_equity_map/
- National Equity Atlas https://nationalequityatlas.org/data-in-action/local-equity-atlas-tools
- Powering Health Equity Action with Online Data Tools https://nationalequityatlas.org/sites/default/files/10-Design-Principles-For-Online-Data-Tools.pdf
- A Practitioner's Guide for Advancing Health Equity https://www.cdc.gov/NCCDPHP/dch/pdf/health-equity-guide/Practitioners-Guide-section1.pdf

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