
Report from the National Leadership Academy on Health Equity

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ATLANTA, GEORGIA*

**RECOMMENDATIONS FOR STRENGTHENING THE
CAPACITY OF PUBLIC HEALTH DEPARTMENTS TO
ADVANCE HEALTH EQUITY AND OPERATIONALIZE THE
CDC HEALTH EQUITY FRAMEWORK**

JUNE 30, 2016

The views and recommendations in this report do not represent the official position of the Centers for Disease Control and Prevention.

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Introduction

Leadership is a key component in supporting initiatives in any setting. Addressing health inequities and advancing health equity takes commitment, perseverance and courage beginning with public health department leadership followed by dedicated champions who implement the programs, practices and policies that move the needle forward on eliminating health disparities and addressing the root causes of health inequities.

In April 2016, the Centers for Disease Control and Prevention (CDC) in collaboration with the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (NACCHO), and the National Association of State Offices of Minority Health (NASOMH) convened the ***National Leadership Academy on Health Equity: Strengthening the Capacity of Public Health Departments to Advance Health Equity*** to provide recommendations on the CDC Draft Health Equity Framework and to develop strategies for implementation of the Framework in governmental public health. The goals of this conference were:

- To align national, state, and local priorities and goals.
- To share best practices in reducing health disparities and promoting health equity.
- To strengthen partnerships among federal, state, and local offices.

This report captures key takeaways from both the plenary panel sessions and breakout sessions where nationally recognized experts convened to provide feedback to the CDC Draft Health Equity Framework as well as provide recommendations to CDC and other national partners about how health equity activities at the local, state, tribal and national levels can be supported and operationalized.

The World Health Organization (WHO) defines health equity as “the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically”¹. *Health inequities* therefore involve more than access to physical health care and more with respect to access to resources needed to improve and maintain health or health outcomes. They also entail a failure to avoid or overcome inequalities that infringe on fairness and human rights norms. Advancing health equity and optimal health for all has to take into account the importance of understanding the role of the Social Determinants of Health (SDOH). Healthy People 2020 defines Social Determinants of Health as “conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks”². These conditions can be social or physical; examples include quality of education and job training, public safety, social norms and attitudes (e.g., discrimination, racism, and distrust of government), housing and community design, exposure to toxic substances and other physical hazards, and aesthetic elements (e.g., good lighting, trees, and benches).

¹ “Equity.” World Health Organization. Last Updated June 2016.

<http://www.who.int/healthsystems/topics/equity/en/>

² “Social Determinants of Health.” Office of Disease Prevention and Health Promotion. Last Updated June 21, 2016. (<https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>)

Setting the Context

Discrimination and bias are pervasive components of American culture. People may be discriminated against for a variety of reasons including but not limited to: disabilities, sexual orientation, religious background, racial and ethnic background, inability to speak English, age, and income level. Some individuals or groups may face discrimination as a result of several overlapping and intersecting identities, and the discrimination resulting from those overlapping identities may be different as a result of the overlap; sociological theory calls this *intersectionality*³. For instance, a woman of color may experience sexism and racism in ways that a white woman or a man of color would not experience in the same situation.

The results of this discrimination are often visible in the social determinants of health. For example, in 2008, 33 percent of White American adults ages 25 and older had at least a bachelor's degree, compared to 20 percent of African American adults, 13 percent of Hispanic adults and 15 percent of American Indian/Alaska Native adults⁴. As noted earlier, the quality of education an individual receives affects their health. In 2011, nearly 77 percent of adults with disabilities reported that physical or program barriers had limited or entirely prevented them from using available local health and wellness programs⁵. In 2010, only 59 percent of Hispanic people, 66 percent of American Indian/Alaskan Native people, and 74 percent of Black non-Hispanic people reported having health insurance, compared to 83 percent of Asian/Pacific Islander people and 84 percent of White non-Hispanic people⁶. A 2007 report on Transgender Virginians found that 46 percent of respondents had to educate their regular doctors about their health care needs as a transgender person, and 24 percent had experienced discrimination from a doctor or other health care provider as a result of their gender identity or expression⁷. The poorest quarter of the adult population are hospitalized for potentially preventable conditions—health problems that might not have required hospitalization had the patients had better primary or outpatient care options—at nearly twice the rate of the richest quarter of the adult population. The CDC estimated that, had those poorer adults been hospitalized at the same rate as their rich peers, in 2009 they would have had approximately 500,000 fewer hospitalizations and saved \$3.6 billion in hospitalization costs⁸. Discrimination and bias affect the lives of all Americans in some way, and for many, those acts of discrimination and bias, intentional or otherwise, have very measurable effects on their health. The

³ "Race/Gender/Class'Intersectionality.'" The University of California Center for New Racial Studies. 2006. <http://www.uccnrs.ucsb.edu/intersectionality>

⁴ "Status and Trends in the Education of Racial and Ethnic Groups." U.S. Department of Education. 2010. <http://nces.ed.gov/pubs2010/2010015.pdf>

⁵ "Disability and Health." Office of Disease Promotion and Prevention (ODPHP). 2016. <https://www.healthypeople.gov/2020/data-search/Search-the-Data?nid=4156>

⁶ "CDC Health Disparities and Inequalities Report – United States, 2013." Center for Disease Control and Prevention. November 2013. <http://www.cdc.gov/mmwr/pdf/other/su6203.pdf>

⁷ "The Health, Health-Related Needs, and Lifecourse Experiences of Transgender Virginians." Community Health Research Initiative, Center for Public Policy, Virginia Commonwealth University. January 2007. <http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/documents/pdf/THISFINALREPORTVol1.pdf>

⁸ "CDC Health Disparities and Inequalities Report – United States, 2013." Center for Disease Control and Prevention. November 2013. <http://www.cdc.gov/mmwr/pdf/other/su6203.pdf>

Individual, and importantly, institutional bias and discrimination represent one of several key sets of factors involved in the inequitable distribution of social determinants of health. The National Leadership Academy on Health Equity meeting in April 2016 provided an opportunity for state health officials and public health experts to explore ways to advance health equity in their own states and operationalize the CDC Health Equity Framework.

*Strengthening the Capacity of Public Health Departments to Achieve Health Equity:
National Leadership Academy*

To provide feedback and guidance on the CDC's Draft Health Equity framework, CDC convened the First *National Leadership Academy on Health Equity: Strengthening the Capacity of Public Health Departments to Achieve Health Equity* meeting in collaboration with the Association of State and Territorial Health Officials (ASTHO), the National Association of State Offices of Minority Health (NASOMH) and the National Association of County and City Health Officials (NACCHO). The core planning team consisted of CDC, ASTHO, NACCHO and NASOMH staff.

An internal team at CDC developed draft objectives for the meeting, receiving input from the entire planning team on the final objectives. ASTHO led the planning and logistics of the meeting while working closely with CDC, NACCHO, and NASOMH to plan the agenda and develop the list of invited presenters. Financial support for the meeting was provided through CDC.

The National Leadership Academy on Health Equity took place in Atlanta at the Global Communications Center on April 11-12, 2016. More than 120, federal, state, local, and tribal partners convened for two days to present on state and local activities around health equity and brainstorm ways CDC can operationalize the health equity framework.

Health Equity Framework for Action - Draft

Operating principles on data measurement, program implementation, policy initiatives, and organizational infrastructure should guide state and local health departments as they work toward achieving health equity. CDC has developed the following as a framework for national action:

Monitoring

Five recommended practices for monitoring health equity in United States include:

1. Identify characteristics of groups of people that are associated with more/less power and privilege or with higher/lower social position. Measure differences in health and its determinants (including social determinants) associated with these characteristics and assess change over time.
2. Groups to be compared should be simultaneously classified by multiple social statuses. It is not enough to look at one dimension of power/privilege or social position in isolation.
3. Social and structural determinants of health should be assessed, and multiple levels of measurement (e.g., individual, family, census block or tract, county, state) should be considered.
4. Those who design data systems to monitor health equity indicators should make it clear why they made their methodological choices and selected certain measures.
5. Although rigor always comes first, it is sometimes possible to consider stakeholders' communication needs when selecting analytic methods.

Essential Program Elements

Programs that are likely to lead to achievement of health equity share these qualities:

- Consideration of socio-demographic characteristics.
- Understanding the evidence base for health disparities and inequities.
- Leveraging multi-sectoral collaboration.
- Engendering meaningful community participation by mobilizing community engagement.
- Using clustered interventions, engagement with communities.
- Rigorous planning and evaluation.

Policy

Policy levers that support health equity include:

- Maximizing existing national policy strategies (such as the National Action Plan to Improve Health Literacy, improving access for Limited English Proficiency individuals and communities, executive orders, etc.).
- Using a SDOH framework to analyze problems and generate policy options.
- Using an intentional health equity lens to develop a Health in All Policies (HiAP) framework for policymaking.
- Using health equity impact assessment as a tool to get to HiAP.

Infrastructure

Infrastructure needed to support achieving health equity includes:

- Developing and maintaining a culturally- and linguistically-competent public health workforce.
- Developing appropriate data systems that collect data useful for health equity and SDOH.
- Ensuring accountability (by sharing results, maintaining key partnerships, including health equity/SDOH in strategic plans, etc.) at high levels of the organization.
- Effective and consistent leadership and accountability at high levels of the organization.

Both days were a mix of plenary panel sessions and breakout sessions. After each plenary panel session, a breakout session discussed the topic and dove deeper into the content area, hearing from multiple voices and perspectives. In each of the breakout sessions, facilitators/scribes facilitated the conversations and captured high-level dialogue.

Plenary Presentations: Day One

Panel One: Federal Strategies to Address Health Equity

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Director, National Center for Chronic Disease Prevention and Health Promotion

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The first presenter on the panel for Federal Policies to Address Health Equity was **John Auerbach**, Associate Director, Office for State, Tribal, Local and Territorial Health Support (OSTLTS), who set the stage by providing an overview of the roles and responsibilities of the Office for State Tribal, Local and Territorial Support (OSTLTS) in his presentation “Strengthening the Capacity of Public Health Departments to Advance Health Equity.” Auerbach’s presentation emphasized OSTLTS’ role in accessing data on health status indicators, providing examples of Motor vehicle-related deaths by race/ethnicity, drug induced deaths by race/ethnicity, and suicide by urbanization. OSTLTS also provides data for the Community Health Status Indicators (CHSI 2015), the Health in All Policies Resource Center, and the Social Determinants of Health Resource Center. OSTLTS plays an important role in funding key organizations and partners like the American Public Health Association (APHA), the Association of State and Territorial Health Officials (ASTHO), and the National Association of County and City Health Officials (NACCHO) to work on state and community efforts to support health equity. OSTLTS also provides support to tribes and tribal governments through the Agency for Toxic Substance Disease Registry (ATSDR) and tribal governments.

In addition to the funding role, OSTLTS promotes policies that support equity. These policies include:

- Recommendations proposed by the Social Determinants of Health Think Tank, in coordination with Health Equity Think Tank. They explore the available non-health data sources from other domains and sectors and explore ways state, territorial and local health agencies can collect and incorporate such data in their planning.
- Advancing health equity practice within Ten Essential Public Health Services and through the public health accreditation process.
- Informing changes to internal organizational policy and practice that impact ways to address SDOH within CDC. Providing optional modifiable language in funding announcements under cost sharing section and within Public Health Accreditation standards.

Auerbach also touched on the CDC Prevention Status Reports. The Prevention Status Reports (PSRs) highlight the status of public health policies and practices designed to address 10 important public

health problems and concerns for all 50 states and the District of Columbia. The reports cover topics such as excessive alcohol use, food safety and prescription drug overdose as well as three areas of prevention: traditional clinical prevention, innovative clinical prevention, and community-wide prevention.

In the near future, the Population Health Initiative will be available to the public. The initiative includes a core set of 24 evidence-based community population health interventions that aim to improve the health of the larger community (as contrasted with approaches that are clinical and patient-oriented), demonstrate health and cost impact, and address social, economic, or environmental conditions.

The panel's second presenter, **Ursula Bauer**, Director, National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), led a discussion around "Advancing Health Equity Using the Four Domains Framework." She shared that NCCDPHP provides leadership and technical assistance; monitors chronic disease, conditions, and risk factors; conducts and translates research and evaluation to enhance prevention; engages in health communication; develops sound policies; and implements prevention strategies. The four domains within its purview and some of its associated projects are:

- Data (epidemiology and surveillance).
 - Nicotine and tobacco research.
- Policies (health systems strategies).
 - Colorectal cancer: Screening Saves Lives.
- Partnerships (state, tribal, territorial, and local governments, national, state, and local nongovernmental organizations).
 - Safe Routes to Schools National Partnership, a nonprofit organization that coordinates between public and private organizations at many levels to support children and communities and promote healthy living, safe infrastructure, and physical activity, starting with bicycling and walking to school.⁹
 - Breathe Easy smoke-free gaming, a multi-sectoral partnership between CDC, the American Nonsmokers' Rights Foundation, and members of the gaming industry, including several federally-recognized Native American Tribes. The partnership produced the Breathe Easy with Smoke-Free Casinos Model Policy and Implementation Toolkit¹⁰.
- Community-clinical links (ensuring that people with or at high-risk of chronic diseases have access to quality community resources to manage their conditions).
 - Healthy foods.
 - Medical care.
 - Physical activity.

The third presenter, **Johnathan Mermin**, Director of the National Center for HIV, Viral Hepatitis, STD, and TB Prevention, spoke on "Addressing Health Disparities in HIV, Viral Hepatitis, STDs, and

⁹ For more information, go to <http://www.saferoutespartnership.org/>

¹⁰ This toolkit may be found at <http://smokefreecasinos.org/wp-content/uploads/2013/10/MainSection.pdf>

Tuberculosis.” Mermin divided his presentation into four areas: Data, Policy, Partnerships and Workforce. Mermin talked about A Future Free of HIV, Viral Hepatitis, STDs, and TB. The guiding principle is of high impact prevention to maximize impact through efficient implementation of cost-effective and feasible interventions, policy and research. Mermin emphasized that a reduction in disparities requires careful modeling, targeted distribution of resources, and thoughtful individual, community, and societal level interventions. Strong multi-sector partnerships and a trained workforce are critical factors in implementing programs and addressing policies to support this work.

Leandris Liburd, Associate Director for Minority Health and Health Equity, closed the panel with an “Overview of the Office of Minority Health and Health Equity activities.” Liburd divided her overview of the Office of Minority Health and Health Equity activities to support these initiatives into four areas:

- Data: A framework for action to advance health equity: measurement, essential program elements, policy and infrastructure.
- Policy & Practice: Health equity matters newsletter. Conversations in equity blog. MMWR supplements on strategies for reducing health disparities. Support for CDC’s Health Literacy Council, Language Access Plan, Workforce Diversity and Inclusion.
- Partnerships: ASTHO, national and global partners to promote the reduction and health inequalities.
- Education and Information Dissemination: Undergraduate summer public health scholars program (CUPS), Forum on the state of health equity at CDC, Journal of Public Health Management and Practice (JPHMP) supplement on health equity, Health disparities subcommittee and Hispanic health vital signs.

Panel Two: Best Practices for Measuring Health Disparities and Social Determinants of Health

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Marissa Levine opened the second panel with her presentation, “Enhancing Health Opportunity for All: Virginia’s Plan for Well-Being” and provided the audience with an overview of current initiatives underway in Virginia that support health equity. The VA DOH presented five factors that influence health to the Joint Commission on Health Care in September 2014. These were:

- genetic pre-disposition
- social circumstances

- environmental exposures
- behavioral patterns
- health care

Levine also provided a high level view of the Virginia Health Opportunity Index (HOI) a tool created by the VA DOH¹¹. This state of the art online mapping tool using community health data and influences that allows advocates, citizens and providers to view the many factors that affect health across the Commonwealth. Levine highlighted two maps, a Richmond City Map showing various levels of health opportunity and a Richmond City Map using the HOI to show gaps in health depending on zip code.

Figure 1: Virginia Healthy Connected Community Logic Model (source: Marissa Levine)

Some of the opportunities to continue using HOI include incorporating it into clinical practice, local decision-making, health impact assessments, government public health decision-making at the state and local levels, and planning for HOI data acquisition through other vehicles, such as electronic health records. HOI will continue to evolve as more is learned about factors impacting health and well-being.

Adrienne McFadden provided more information on the HOI through her presentation on “The Health Opportunity Index: Measuring Health Equity and the Social Determinants of Health.” According to America’s Health Ranking VA at is 21st in health (United Health Foundation Scorecard). Virginia uses several indicators in their assessment of health equity. The determinants include:

¹¹ Virginia Department of Health. (June 2016). <http://www.vdh.virginia.gov/OMHHE/policyanalysis/virginiahoi.htm>

- Affordable, safe, quality housing
- Access to parks and natural resources
- Equity in county practices
- Access to affordable, healthy local food
- Equitable law and justice system
- Community and public safety
- Access to safe and efficient transportation
- Strong, vibrant neighborhoods
- Economic development
- Early childhood development
- Family wage jobs and job training
- Quality education
- Healthy built and natural environments
- Access to health and human services.

The HOI has been used by VDOH to identify the impact of social determinants of health on a statewide health landscape, demonstrating that place matters when it comes to health. The HOI also points to those indicators that are most influential on local health. Using the tool helps communities to learn from each other on how to improve their own health status. The HOI is unique in that it conducts a multi-level spatial analysis of discrete geographic and demographic population segmentation.

- statewide by city/county
- census tract
- census block group
- social profiles

Within the segments HOI conducts an analysis of more than thirty variables that are then combined into thirteen indicators. The thirteen indicators are:

- Environmental Quality Index (EPA)
- Population Churning Index
- Population-Weighted Density Index
- Walkability Index*
- Affordability Index
- Education Index
- Townsend Deprivation Index
- Food Accessibility Index*
- Employment Access Index
- Income Inequality Index
- Job Participation Index
- Segregation Index*

The third presenter **Steve Huelatt** and his colleagues from Connecticut also developed an index tool which is described in his presentation “The Connecticut Health Equity Index-A Dynamic Tool for Promoting and Tracking Health Equity.” Huleatt began his presentation by providing a foundation for the importance of the public health system (health department, elected officials, mass transit, etc.) in addressing health equity.

- Local health departments
- Prevention : Affordable Care Act, National Partnership for Action
- Institute of Medicine
- CDC, Public Health Accreditation Board, NACCHO
- Essential Public Health Services
- Healthy People 2020.
- Eliminate disparities, SDOH, multi-sector.

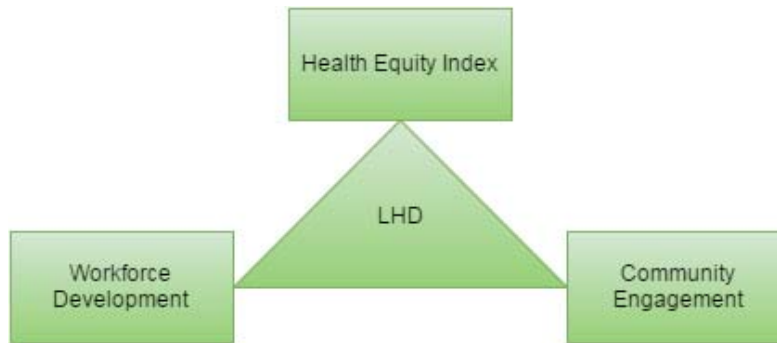


Figure 2: Connecticut Health Equity Model Approach (source: Steve Huelatt)

The objective for developing the CT Health Equity Index was to create a measurement tool that focuses on SDOH, builds on an analytic foundation, and expresses results as a single number per social determinant. Connecticut also wanted the index to permit more sophisticated disaggregation and analysis, provide comparability across a wide range of communities, depict the relationship between inequities and health outcomes at the local level, serve as a platform to encourage debate, dialogue, and action at the community level and be used for policy-making and changes in practices.

In addition to assessing community health needs the Health Index Tool has been extremely successful in assisting local health departments in writing grants and securing funding awards. The tool also assists with strategic planning and decision-making. Finally, the Health Index has also enhanced collaboration among community stakeholders to focus on issues impacting health. It emphasizes prevention as the most effective approach for improving community health and promotes evidence-based identification of the multiple factors impacting health, offering justification for a more comprehensive approach to community health.

Brandy Kelly Pryor, the final presenter for this panel, delivered a presentation titled “A Lens into Louisville’s Center for Health Equity.” Pryor provided background on the Center for Health Equity (CHE), an organization which works to eliminate social and economic barriers to good health, reshape the public health landscape, and serve as a catalyst for collaboration between communities, organizations, and government entities through capacity building, policy change, and evidence-based initiatives. CHE’s recent initiatives include community dialogues in five neighborhoods, visual narratives (photo-voice/digital storytelling workshops and presentations), and the Louisville Metro Health Equity Report.

CHE is planning future events that will build on the previous initiatives and include new ones, such as expanding its community-based participatory research and hosting community conversations using some of the visual narratives that it has collected. CHE is planning a multi-generational and multi-sectoral policy summit to focus on departmental and divisional reviews of process.

Panel Three: Best Practices for Implementing Effective Programs

Monica Bharel, MD, MPH

Commissioner, Massachusetts Department of Public Health

William Jahmal Miller

Deputy Director, Office of Health Equity, California Department of Health

Rex Archer, MD MPH

Director of Health, Kansas City, Missouri

Geoffrey Swain, MD, MPH

Professor, Department of Family Medicine and Community Health, University of Wisconsin School of Medicine and Public Health; Founding Director, Wisconsin Center for Health Equity; Center Scientist, Center for Urban Population Health; Medical Director and Chief Medical Officer, City of Milwaukee Health Department

MODERATOR: Katie Sellers, PhD, CPH, Chief of Science and Strategy, Association of State and Territorial Health Officials

Monica Bharel, Commissioner of the Massachusetts Department of Public Health, began the third panel with an overview of the “Massachusetts Department of Public Health Approach to Advancing Health Equity.” The VISION Optimal Health and Well-being for All People in Massachusetts is supported by a strong public health infrastructure and healthcare delivery system; the mission supports this vision. The mission of the Massachusetts Department of Public Health (MA DPH) is to prevent illness, injury, and premature death; to ensure access to high quality public health and health care services; and to promote wellness and health equity for all people in the Commonwealth.

Bharel discussed the three D’s of addressing health equity: Data, Determinants, and Disparities. The Massachusetts Department of Public Health (MA DPH) provides relevant, timely and easy access to data for researchers, the press and the general to assist with efforts to address the presence of disparities and impact outcomes. Using the social determinants of health as a guide, MA DPH consistently recognizes and strives to eliminate health disparities in Massachusetts, wherever they may exist.

Bharel deeply described MA DPH’s data collection activities around data collection. MA DPH plans to be a national leader in innovative, outcomes-focused public health based on a data-driven approach, with a focus on quality public health services and an emphasis on the social determinants and eradication of health disparities.



Figure 3: Massachusetts' Vision of Data Integration (source: Monica Bharel)

Bharel described MADPH's commitment to equity through promoting and integrating department-wide standards for Equity: Changing the Environment through Making CLAS (Culturally and Linguistically Appropriate Services) Happen. MADPH's CLAS initiative provides tools, guidance, training, and technical assistance to MADPH bureaus, programs, and vendors. MADPH has also provided targeted outreach through comprehensive health communications campaigns, identified needs for on-the-ground clinical partners, assisted in capacity building for partners targeting underserved populations, conducted need analyses and targeted location for treatment opportunities.

In addition to what has been outlined above, MA DPH is working with a Prevention and Wellness Trust Fund where they work with local health departments and partners on reaching specific populations to reduce disparities through community efforts - a boots on the ground approach.

MA DPH's approach to advancing health equity entails using big data to shape the future of public health. The challenge for MA DPH now is capitalizing on its work to ensure that it is focusing on the populations most in need of targeted outreach. Its next step is creating an Office of Population Health to work with the Office of Health Equity to bring data efforts together in a unified, cohesive, integrated manner.

William Jahmal Miller, Deputy Director, Office of Health Equity (OHE), California Department of Public Health (CDPH), delivered the panel's second presentation, which was on the "Office of Health Equity's Mission." OHE's mission is to promote equitable, social, economic, and environmental conditions to achieve optimal health, mental health, and well-being for all. Miller provided the audience with a snapshot of OHE strategy, which involves:

- Assessment, communication, and infrastructure.
 - Capacity building for implementation.
 - Health field, health partners, and communities.
 - Eliminating health and mental health inequities.
- Cultural competence projects.
 - A sixty million dollar project funded by the California Mental Health Services Act to improve access and quality of care, increase positive outcomes for racial, ethnic, LGBTQ, and cultural communities in the public mental health system
 - Focusing on proven community defined practices.
- Strategies to reduce mental health disparities.
 - Phase 1: Community-based strategies and statewide education outreach and awareness.
 - Phase 2: Community-defined evidence programs or practices and local education, outreach, and analysis.
 - Outcomes: Increase in effective treatment, system change in mental health, and mental health equity.

- Moving toward a culture of health using a HiAP approach.

The overarching goal of the CDPH OHE is to eliminate the status quo by using an upstream focus with significant attention given to mental health, partnering beyond healthcare, and ensuring cultural and gender competence is baked in with an overall willingness to explore community defined practices and long-term goals with frequent measuring points.

The third presenter on this panel was **Rex Archer**, Director of Health, Kansas City, Missouri, who presented on “Public Health and Community Organizing: The Evolution of Public Health Practice in the 21st Century.” On December 4, 2015, the Kansas City Missouri Health Commission was awarded the Robert Wood Johnson Foundation’s Culture of Health Prize.

Archer emphasized using the WHO Root Causes/Health Inequities framework of “Why treat people, without changing what makes them sick?”). KCMO uses this framework as a foundation for advancing health equity and promotes the use of the Socio-Ecological Model to view public health as a social justice enterprise.

Initiatives that KCMO has been involved in recently to advance health equity include campaigns such as:

- Cap the Rate and Raise the Wage in 2012
- Ban the Box in 2013
- Low Wage Worker Actions/Living Wage from 2013-2014,
- Ban the Ban in 2014
- Raising of America Kansas City in 2014
- Advance KC Development Scoring in 2014
- Council Approved (12:1) Raise Living Wage in 2015
- Medicaid Expansion
- Early Voting
- Violence/Homicide Prevention.

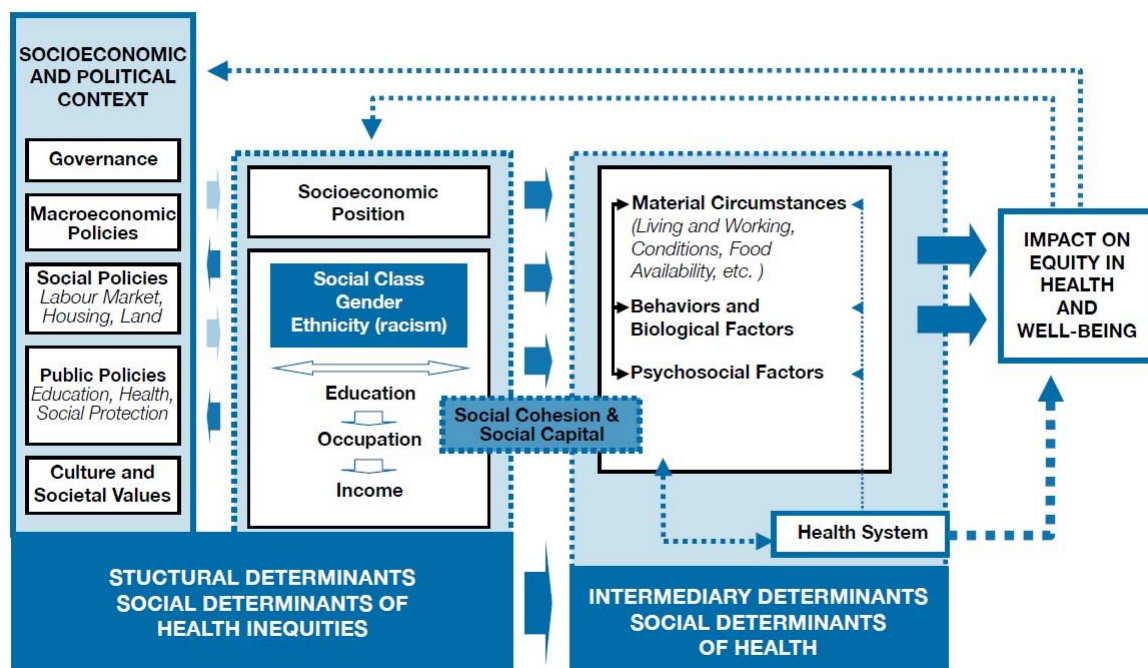
Archer ended his presentation with the following quote:

“Public health is what we, as a society, do collectively through organized actions to assure the conditions in which all people can be healthy.” - Institute of Medicine (1988), *Future of Public Health*

The final presentation for the third panel was delivered by **Geoffrey Swain**, Professor, Department of Family Medicine and Community Health, University of Wisconsin School of Medicine and Public Health and Chief Medical Officer, City of Milwaukee Health Department. Swain focused the majority of his presentation on the “Foundational Practices for Health Equity Tool,” which was developed by a team of health equity practitioners with unique experiences from across Region V and including CDC. This tool can be found online at: <http://www.health.state.mn.us/divs/opi/healthequity/resources/coiin-hrsa-foundational.html>.

The team conducted a literature review of the SDOH and health equity, and conducted an analysis of public health practitioners' approaches to continuous learning, refining and incorporating key conceptual health equity frameworks. Dr. Swain reviewed the mechanisms by which SDOH drive better or worse health, including by a) supporting or constraining access to quality medical care, b) supporting or constraining individual ability to practice healthy behaviors, and, most importantly, c) chronic stress mechanisms which drive chronic elevations of cortisol and adrenaline, which have significant adverse effects on blood pressure, glucose metabolism, immune system functioning, maternal-fetal physiology, and can even drive adverse health outcomes across generations through epigenetic mechanisms. He used the World Health Organization's Conceptual Framework for Health Equity to provide a context to understand the Foundational Practices for Health Equity Tool.

Figure A. Final form of the CSDH conceptual framework



Available at: www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf

The Foundational Practices, initially designed as a self-assessment tool for improving health and advancing health equity, features seven elements:

1. Expand the understanding of health.
2. Assess and influence the policy context.
3. Lead with an equity focus.
4. Use data to advance health equity.
5. Develop workforce via continuous learning.
6. Build partnerships and community capacity.
7. Use and target resources strategically.

These elements are similar to recommendations made by the National Expert Panel on Social Determinants of Health Equity, a group of experts that met in Atlanta in 2008. The similarities in the seven elements and the recommendations highlight a need for collective action to make real changes to advance health equity.

Panel Four: Advancing Health Equity for Tribes

Jay C. Butler, MD, CPE

Chief Medical Officer, Director of Public Health, Alaska Department of Health and Social Services

Phyllis Howard, MMT (Mandan, Hidatsa, Arikara)

Director, Health Equity Office, North Dakota Department of Health

LoVina Louie

Program Manager, Benewah Medical Wellness Center, Coeur d'Alene Tribe

MODERATOR: Yolanda Savage-Narva, MEd, Director of Health Equity, Association of State and Territorial Health Officials

Jay C. Butler, Chief Medical Officer, Director of Public Health, Alaska Department of Health and Social Services, started the final session of the day with his presentation on “Tribal-State Partnerships for Health in Alaska.” Butler opened his presentation illustrating the power of partnerships, stating how closely the department and Alaska Native Tribal Health Consortium worked together and shared a common vision and mutual goals in their respective programs, “Healthy Alaskans in Healthy Communities” and “Alaska Natives are the Healthiest People in the World.”

Additionally, the Alaska Department of Social Services Healthy Alaskans 2020 team organized a governance structure of community-based teams to address health disparities. They chose the following health priorities as the foundation for their outreach:

- Cancer deaths
- Tobacco use - Youth
- Tobacco use - Adults
- Overweight or obesity - Adults
- Overweight or obesity - Youth and children
- Physical activity - Adults and youth
- Suicide deaths
- Mental health - Youth
- Mental health - Adults
- Social support - Youth
- Child abuse and neglect
- Rape
- Dating violence - Youth
- Alcohol-induced deaths
- Binge drinking - Adults and youth
- Unintentional injury deaths
- Childhood vaccinations
- Chlamydia (STD) Rate
- Home water and wastewater services
- Fluoridated community drinking water
- Early prenatal care
- Preventable hospitalizations
- Cost as a barrier to healthcare
- Poverty
- High school graduation

Butler also provided the audience with success stories from the department's efforts and these and other partnerships with other public health entities. For instance, in 2005, 90 percent of Alaska Native women chose to breastfeed their babies at birth, and as a result more mothers are breastfeeding now than 10 years ago. The number of Alaska Native mothers who report exercising every day is almost three times higher than non-Native mothers (2004) and the number of Alaska Native teens who smoke has gone down 30 percent since 1995. There has been a 68 percent decrease in deaths by drowning since 1995 and a 71 percent decrease in the number of people who have died in a fire since 1995.

Phyllis Howard, Director, Health Equity Office, North Dakota Department of Health, was the second presenter on the panel. Howard provided an overview of the work of the "North Dakota Department of Health Support to Advance Health Equity," and offered a snapshot of its challenges, success, and recommendations. The North Dakota Department of Health service area includes six reservations in North Dakota.

Howard elaborated on the challenges, successes, and recommendations for advancing health for tribal members in North Dakota. The department's successes include above average resources, a strong advocacy system, the opportunity to provide education and training, and strong and coordinated partnerships. Challenges faced include:

- Limited access to quality healthcare and providers.
- Lack of health insurance or access to the Indian Health Service.
- Lack of transportation to major health facilities.
- Change systemic health systems.
- Rural versus urban priorities.
- Lack of awareness regarding benefits of healthcare and screenings for certain diseases.
- Cultural disparities preventing quality healthcare.

In closing, Howard provided recommendations on how to work with tribes effectively. She recommended building meaningful relationships and mutually beneficial relationships with tribes to build trust. She also emphasized that in order to create linkages that are lasting and sustainable, it is critical to learn and understand the history of American Indians, the significance of tribal health policies and government to government relationships developed, and what exists today.

LoVina Louie, Program Manager, Benewah Medical Wellness Center, Coeur d'Alene Tribe, opened her presentation with a powerful musical tribute to her ancestors. Her "Quest Life" program focused on three components: Eat, do, and Honor.

- *Eat*: Health is tied to how the Coeur D'Alene people fuel their bodies. Whole, non-processed foods are the basis of a healthy diet. Along with fruits, vegetables, and lean proteins, incorporating foods from their own cultural heritage honors their bodies and who they are. These include traditional foods like camas, huckleberries, water potatoes, and lean meats like salmon, trout, elk, moose, and deer.

- *Do*: Activity and movement are everyday parts of life for the Coeur d'Alene people. Hunting, gathering, and migration were daily physical activities for their ancestors. Today, the honor is paid to them by getting 30 minutes of physical activity through walking, running, swimming, gym workouts, and traditional games and activities, such as the Powwow Sweat videos.
- *Honor*: By tapping into the core of who the Coeur d'Alene Tribe is, future generations can fuel success. These activities include: Respect and Honor for elders, preservation of their language, education and empowerment of their youth, and continuation of traditional community activities such as gardening, ceremonials, and storytelling.

Plenary Presentations: Day Two

Panel One: Best Practices for Developing Policies to Address Social Determinants of Health

Jerome Adams, MD, MPH

State Health Commissioner, Indiana State Department of Health

Angela Dawson

Executive Director, Ohio Commission on Minority Health

Esther L. Muña, MHA

Chief Executive Officer, Commonwealth of the Northern Mariana Islands

Jim Bloyd, MPH

Regional Health Officer, Cook County Department of Public Health

MODERATOR: Leandris Liburd, PhD, MPH, MA, Associate Director for Minority Health and Health Equity

Jerome Adams, State Health Commissioner, Indiana State Department of Health (ISDH), began the first panel of the day by discussing "Health Equity Policy for a State Health Officer Perspectives from Middle America." Adams started by sharing the lessons he wanted the audience to glean from the presentation:

- Views of health equity and potential policy look very different to different groups.
- The Public Health Community must do a better job of speaking to our audience versus ourselves.
- Leadership matters: Set the tone and inject an equity discussion into everything.
- Know your data.
- Workforce development and retention are underappreciated aspects of health equity initiatives.

Adams provided examples of how important it is to speak to the audience you are trying to influence. When talking about health equity, Adams suggested to remember it is not simply a racial or ethnic issue. Health equity also includes acknowledgement of preferred language and gender, and respecting the LGBTQ community. Adams also advised to keep in mind that a focus on socio-economic, military, disability, urban vs. rural, may be more relatable for some communities where there is less diversity. He also cited the importance of providing your audience with the right definitions, examples and data, making it possible to make informed decisions.

Adams said that leadership plays a vital role in advancing policy; leaders must walk the walk and talk to successfully bring light to health disparities. He emphasized the importance and relevance of talking about health disparities in every opportunity to speak and modeling that behavior for his staff.

The Indiana Office of Minority Health (OMH) currently offers ISDH employees cultural competency training twice a year and works with external partners to provide culturally-appropriate trainings and presentations for healthcare professionals, public health students, community organizations, and local affiliates. The Indiana OMH also incorporates the National CLAS Standards and cultural competency into its trainings across the department (e.g., immunization, long-term care, WIC, etc.).

Angela Dawson, Executive Director, Ohio Commission on Minority Health, was the second presenter, and reminded the audience that “We all have a Role in Advancing Health Equity.” In her introduction, she quoted Rev. Martin Luther King Jr.: “Of all the forms of inequality, injustice in healthcare is the most shocking and inhumane.”

Dawson drew upon multiple models for improving health equity. She highlighted ASTHO’s Triple Aim of Health Equity, the WHO’s Conceptual Framework for Action on the Social Determinants of Health, the Institute for Healthcare Improvement (IHI) Triple Aim for Healthcare, and the goals of the National Partnership for Action (NPA). Dawson then described an adaptation of the National Partnership for Action Model now used by the Ohio Commission of Minority Health used, which focuses on:

- Leadership
 - Pay for performance based on health outcomes.
 - Infant Mortality Legislative Package SB 276-280.
 - Pathways Community HUB Model Replication.
- Cultural Competency
 - Ohio Department of Mental Health and Addiction Services, Diversity and Cultural Competence Advisory Council.
 - NPA Framework Ohio Behavioral Health System.
- Awareness
 - Ohio Commission on Minority Health/Ohio Department of Health-Health Equity Survey.
- Data
 - Medicaid integrated eligibility system with HHS data standards.
 - Medicaid managed care health equity contract language.
- Health System
 - ACA Passage and Medicaid Expansion.
 - Patient centered medical home expansion targeting minorities.

In conclusion, Dawson’s presentation emphasized the importance of data collection, research, and evaluation of health data to drive sound policy and program implementation.

Esther Muña, Chief Executive Officer, Commonwealth of the Northern Mariana Islands (CNMI), was the third presenter. She spoke on “Best Practices for Developing Policies to Address Social Determinants of Health.” Muña provided the audience with an overview of life in the Commonwealth. From an economic standpoint, tourism is the main industry. The government is the largest employer on the island. The Chamorros and the Carolinians, members of ethnic groups indigenous to the islands, own or homestead small parcels of land and only native residents of the CNMI may own property.

Access to health services is difficult on the islands; 34 percent of the population is uninsured, 60 percent is on Medicaid, one percent receives Medicare, and five percent have private insurance. There is a high prevalence of diabetes on the island, and the leading causes of death are cardiovascular disease and cancer. CNMI has one hospital located on the island of Saipan, while the islands of Rota and Tinian have health centers that accommodate primary, emergency, and observation care. The closest access to tertiary care is in Guam.

Muña outlined recent initiatives that have taken place to support public health and eliminate health disparities:

- In 2008, in an effort to combat rising rates of diabetes, Bishop Tomas Camacho issued a notice advising the Catholic population to show some restraint in funeral arrangements, particularly ending the nightly “fiesta” feeding of those attending nightly rosaries.
- In May 2010, the Pacific Island Health Officers’ Association declared a regional state of health emergency due to an epidemic of non-communicable diseases in the United States-affiliated Pacific Islands, including CNMI.
- In October 2011, the newly established Commonwealth Healthcare Corporation replaced the health department to coordinate the delivery of healthcare to commonwealth residents in a financially responsible manner. The Commonwealth Healthcare Corporation is intended to be a professionally-managed, nationally-accredited public healthcare institution that is as financially self-sufficient and independent from the Government as possible.
- In March 2013, CNMI Gov. Eloy S. Inos issued an executive order¹² declaring a state of significant emergency for CNMI due to the imminent threat of disruption of critical medical care as a result of the poor financial state of the main healthcare corporation in the Commonwealth.
- On April 5, 2016, representatives passed HB 19-99, which would levy a tax on a tax on sugar-sweetened beverages.

Jim Bloyd, Regional Health Officer, Cook County Department of Public Health, gave the final presentation on “Policy Development to Tackle Structural Origins of Health Inequities: Thoughts on Best Practices.” Bloyd provided details of what has led to the state’s health inequities. Children in Cook County, IL, which encompasses a great percentage of the city of Chicago, grow up in neighborhoods with stark and unfair differences in opportunity for healthy development; forty percent of black and thirty-

¹² CNMI Exec. Order 2013-04.

two percent of Hispanic children live in very low-opportunity neighborhoods compared to nine percent of white children. Segregation policies enacted in the 1930s continue to affect Cook County today.

Boyd believes that public health values and ethics should guide policy development. He said social justice and health are human rights, and “humans have a right to the resources necessary for health.”¹³ Boyd also emphasized the importance of addressing fundamental and systemic causes of health inequities, and that in order to make lasting change in advancing health equity it is important to identify and confront systems of privilege and white dominance. He closed his presentation with the following quotation:

“Power, after all, is the heart of the matter—and the science of health inequities can no more shy away from this question than can physicists ignore gravity or physicians ignore pain.” - Jason Beckfield and Nancy Krieger

Panel Two: Sustaining an Organizational Infrastructure to Advance Health Equity

Jeanne Ayers, MPH, BSN

Assistant Commissioner, Minnesota Department of Health

Ngozi T. Oleru, PhD

Environmental Health Services Director, Public Health – Seattle and King County

Aletha Maybank, MD, MPH

Associate Commissioner, Center for Health Equity, NYC Dept. of Health and Mental Hygiene

Johnnie “Chip” Allen, MPH

Director of Health Equity, Ohio Department of Health

Moderator: George W. Roberts, PhD, Senior Advisor, Office of Minority Health and Health Equity

Jeanne Ayers, Assistant Commissioner, Minnesota Department of Health, began her presentation with a graphic of the Triple Aim of Health Equity for her talk on “Advancing Health Equity: Foundational Practices to Strengthen Capacity.” The Triple Aim of Health Equity was modeled after the Institute of Healthcare Improvement’s Triple Aim. The Triple Aim of Health Equity takes the IHI model one step further by highlighting the role of social cohesion in bringing together the three foundational goals of health equity:

- Expand our understanding of what creates health.
- Implement a HiAP approach with health equity as the end goal.
- Strengthen the capacity of communities to create their own healthy futures.

After introducing the Triple Aim, Ayers provided an overview of several initiatives in Minnesota: the Healthy Minnesota 2020 Statewide Health Assessment and Statewide Health Improvement Framework, the Minnesota Department of Health and the Healthy Minnesota partnership and the Advancing Health

¹³ “Principles of the Ethical Practice of Public Health (Version 2.2).” Public Health Leadership Society. 2002. https://www.apha.org/~media/files/pdf/membergroups/ethics_brochure.ashx

Equity in Minnesota Report to the Legislature. The Advancing Health Equity in Minnesota Report to the Legislature states: “The opportunity to be healthy is not equally available everywhere or for everyone in the state.” Things are the way they are because they were designed that way. The roots are deep in historical policies and structural racism. A new program isn’t needed; rather, what is needed is a new commitment to fundamental shifts in paradigms about what constitutes evidence, who is involved in decision-making, and what creates health.

Ayers shared overall lessons learned with the audience. An organic process must be interwoven with the recognition that health equity work is iterative and there must be an intentionality to the work. This work also requires commitment: commitment to building our organizational and community capacity and skills. Ayers noted that leadership is essential to anything moving forward and we must hold ourselves and each other accountable to bringing more people into decision-making. Finally, imperfect work is alright as long as the general course is towards health equity; course corrections are not only permissible, but sometimes necessary.

The panel’s second presenter, **Ngozi Oleru**, the Environmental Health Services Director for Public Health in Seattle King and County, touched on social justice in her presentation “King County Equity and Social Justice: Working toward Fairness and Opportunity for All.” In 2005 there was a proposal to change the namesake of King County from William de Vane King to Martin Luther King, Jr. Washington state legally changed the county’s namesake in 2007, and King County adopted a new logo in honor of Martin Luther King, Jr. Oleru walked the audience through a timeline of events that support health equity and social justice. In 2006, King County was chosen as one of 16 Place Matters teams¹⁴. The next year, King County adopted a framework for the health of the public. The guiding principles are:

- Driven by social justice.
- Based on science and evidence.
- Centered on community.
- Focused on prevention.

In 2008, King County launched the Equity and Social Justice Initiative¹⁵. In 2009, the county developed a strategic plan for equity and social justice, then passed an ordinance to establish definitions of equity and social justice and to implement certain steps of the strategic plan. Oleru left the audience with recommendations on how to gain traction with an equity and social justice approach:

- Build on your unique strengths using the “right” language.
- Remember that policy leads to action. Even small actions make a difference, if only in your organizational culture.
- Be both integrated and intentional. You don’t need money, but you do need focus.

¹⁴ Place Matters is a national initiative of the Joint Center for Political and Economic Studies, Health Policy Institute. The initiative is intended to improve the health of participating communities by addressing social conditions that lead to poor health. For more information see <http://jointcenter.org/content/our-purpose>

¹⁵ For more information, go to <http://www.kingcounty.gov/elected/executive/equity-social-justice.aspx>

- Be visionary, but also practical and cultivate leaders at all levels.
- Create a framework that relates your organization to the broader context.
- Accountability produces results.
- Maintain momentum and “Fail forward!”

The panel’s third presenter was **Aletha Maybank**, Associate Commissioner for the Center of Health Equity at the New York City Department of Health and Mental Services (DOHMH), who spoke on “A Commitment to Advance Health Equity.” The mission of NYC Health Department is “to protect and promote the health of ALL New Yorkers.” In 2014, NYC Health Commissioner Mary T. Bassett said: “Inequities in health are unfair, unnecessary, and avoidable. New York City is one of the most unequal cities in the United States and one of the most segregated. It is no surprise that these everyday realities are reflected in our health. A more deliberate effort to name and address these disparities will frame all that we do.”

Neighborhood disparities exist in New York City based on income, health outcomes, and life expectancy. The Center for Health Equity’s mission is to strengthen and amplify the health department’s work to eliminate health inequities rooted in historical and contemporary injustices and racial discrimination and are direct responses to neighborhood disparities.

Maybank shared DOHMHM’s inside strategy to support their external work. They found that it was important to name racism and social injustices (social determinants of inequities) by addressing them head-on and unpacking invisible biases. Another very important internal strategy was to build the internal capacity at neighborhood health departments by developing an understanding of equity, including all forms of oppression and changing the structures, policies, and practices that contribute to it. And lastly, changing the narrative on the real causes of inequities and what determines good health.

To support these efforts, the health department provided the 14 Deputy Commissioners with racism training and coaching sessions. It also provided Health and Equity in All Planning training with other city agencies such as the Center of Economic Opportunity, Department of Transportation, Parks, City Planning and Housing Preservation, and other. To move forward and change the narrative, Maybank offered the following recommendations:

- Conduct research and reach out to others who have engaged in similar work; engage consultants.
- Take a look at structure and resources, and change leadership and hiring practices while that window is open.
- Have a dedicated team of staff. Get creative on how to use staff time.
- Utilize the staff workforce development and skill building with a racial and social justice lens and community organizing
- Shift away from program and policy development in silos (within and among agencies, neighborhoods).
- Support expansion of those existing organizations already doing the work.

- Create reciprocal learning environments using a public health lens.
- Build a base with those already advocating and doing work on SDOH.

The closing presenter for this panel, **Johnnie “Chip” Allen**, health equity consultant from Ohio, presented “His Own Views and Thoughts about Advancing Health Equity.” Allen has worked with many states and understands the vital role the state office of minority health plays in advancing health equity. Currently, unstable organizational placement of health equity offices put these efforts in jeopardy.

The following questions are important in sustaining health equity initiatives in state health:

- What was the starting state budget for health equity?
- How much has it grown?
- How many staff are there to carry out initiatives?
- How has the staff grown?
- How many staff who were lost are health officials authorized to replace?
- What are the budget projections?
- Is health equity in the budget?

He noted that if public health cannot answer at least four of these questions in a positive manner, the jurisdiction will have challenges advancing health equity.

Allen also offered “Things to Remember about Health Equity Directors”:

- Never be afraid to speak truth to power.
- Find allies who can do the things you can’t.
- If you don’t have money, spend somebody else’s funds.
- Avoid the psychology of seduction.
- Understand we are here for a season.
- Keep the faith in what you are doing.
- Protect your health at all costs; this work can be hazardous to your mental and physical health.

Panel Three: Advancing Health Equity—The Role of State and Local Public Health Departments

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The Closing Plenary of the final day of the Strengthening Public Health Departments to Advance Health Equity: National Leadership Academy provided the audience with the inspiration and support needed to end an eventful two day convening with national experts and leaders in health equity. Each presenter provided an overview of the activities their organizations are involved in that support health equity as well as the commitment each organization has pledged to continue to collaborate and promote efforts such as this one to bring the public health enterprise together to develop a collective approach to advancing health equity and optimal health for all.

Breakout Sessions

Concurrent breakout sessions provided opportunities to hear directly from the more than 120 experts in the room about how they have addressed some of the challenges presented during the plenaries, how they would operationalize CDC Health Equity Framework, and what actions they would recommend for CDC and other national partners on how to support, promote, and provide technical assistance around health equity to local, tribal, and state initiatives.

Best Practices for Measuring Health Disparities and Social Determinants of Health

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How can health disparities be measured? A number of means by which health disparities might be measured were suggested, including as a ratio or difference between health indicator rates in communities and trends over time, such as differences in mortality rates in neighborhoods.

What are some of the best practices for measuring health disparities/inequities/injustices? Experts identified the need to establish a common language to discuss health equity and health disparities, inequities, and injustices, with training and clear models so that the health equity community can stand in agreement with a tangible set of terms and definitions. However, the terminology has to be flexible enough to accommodate several audiences. Healthy People 2020 and a Robert Wood Johnson study on developing common terminology and contexts were suggested starting points. The group also made the point that health equity is intimately related to social justice and that the values and meanings of health equity should be defined in social justice terms.

Several suggestions focused on using quantitative data, including socioeconomic status and heat maps/GIS, and qualitative data, including personal accounts collected from and by the community. The group discussed the importance of involving the community when performing needs assessments and sharing data with the community to assure their support, commitment, and buy-in.

The group noted the importance of strong partnerships across sectors and agencies with shared missions, as well as continually reassessing the need for additional partnerships and collaborations. They mentioned several case studies from state public health departments, including: the Health Disparities Report (NM), reports on racial/ethnic border regions (AL), identity indicators from community health status reports (OH), the Social Vulnerability Index (VT), a breakdown of populations by race/ethnicity (UT), a breakdown of populations by disability (RI), county and tribal health assessments (NM), and community partners for assessments (IN). Participants also made note of a report in the *New York Times* that looked at poor communities.

What are some best practices for measuring the Social Determinants of Health? SDOH are the context for measuring health inequities. These social determinants are the product of structural injustice, including structural racism, and the ongoing nature of these injustices can make it difficult but even more critical to find funding for health equity programs. Communities are familiar with systems of structural injustice, and it is important to involve them in the process of defining and identifying the health disparities that affect them. That evaluation needs to be continuous and transformative and can involve data sets that are not traditionally part of healthcare settings, including personal narratives. Cross-sector collaborations can provide access to datasets and measures that may yield useful data, and partners should understand the benefits of working collaboratively with the health sector.

What does “address SDOH” mean? It means addressing the root causes, as well as morbidity. A health department can't address and solve everything that has to do with health, so collaborations and partnerships are essential.

What are the best strategies when addressing SDOH? A good understanding of how communities work generally, as well as how specific communities work, is essential. The community should be involved in all aspects of decision-making, and it can be helpful to allow the framing and delivery to come from community leaders. Nontraditional venues and programs can be very useful, but should be used carefully, and in the case of nontraditional programs, there needs to be a sufficient evidence base to support their use.

The following are the combined recommendations/findings from the four breakout sessions on Best Practices for Measuring Health Disparities and SDOH:

- Invest time in developing a method for measuring health disparities and SDOH. Consider meaning of the words you use: “disparities” and “inequities” are not synonyms.
- Use plain language when describing disparities and inequities, especially when talking to partners in non-public health sector partners.
- Illustrate the economic impact of health equity measures.
- Develop intentional relationships, rather than only when the relationship is convenient.
- Look for common goals.
- Emphasize and support a shared vision and capacity.

- Work with nonprofit partners to develop messages that legislators will listen to (e.g., messages that emphasize fiscal impact).
- Accreditation leads to higher-level conversations, which leads to funding.
- Cultural competence training is a necessary tool for educating and creating a diverse workforce.
- Find local foundations to invest in work; they will provide long-term commitment.
- When using disparity ratios, choose indicators based on a strategic plan.
- Best practices will change based on results and population size.
- Build capacity to advance health equity.
- Policymakers may be a key missing piece.
- Use measurement as a tool to make the health equity argument.
- Build networks and community to use resources already there by bringing together community partners and finding federal funding to include minority health offices.

What are some useful capacity-building tools? Having key people present from the very beginning is important, and shows the community that the public health department values them. Funding is vital because it can assist with technical assistance and training, and should also focus on the system levels. It is, or should be, required to work with the offices of minority health, and it is useful to require a letter of support for grants of other departments.

What are some case studies of best practice?

- In Utah, disaggregating Asian American/Pacific Islander populations showed that there were important disparities between those populations than needed to be addressed carefully.
- In Rhode Island, community health workers were important to health equity efforts.
- Virginia saw a difference in the prevalence of diagnosis and mortality from breast cancer – while the former remained steady (2002-2011), the latter declined significantly (2003-2012); this prompted motivated action and an examination of the distances to birthing centers, where many women are diagnosed and/or treated.
- When the Virgin Islands Department of Health collaborated with other agencies, it saw a racial and financial divide that prompted careful monitoring of violence and some interventions.
- The New Mexico Department of Health used data to inform funding and campaigns and perform targeted interventions.

What are some case studies of action steps and challenges?

- Ohio leveraged the capacity and resources of its partners for data collecting and shared decision-making.
- Virginia experienced a pushback from teammates who worried that they would lose resources; the health department responded by requiring the areas with resources to participate from the beginning.
- Vermont brought partners to the table, appointed a HiAP Task Force, and worked to use relevant and data-driven framing with the help of the Department of Education.

- Wyoming’s economic analysis proved to be a challenge because the health department needed more tools.

Generally, the group preferred best practices around capacity building, emphasized adaptability and context as core practices, and preferred population health indicators over administrative process indicators. The breakout session participants also favored gathering data on health inequities to make a substantial case to policymakers, funders, and legislators.

Best Practices for Implementing Effective Programs

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How do we set in motion a culturally-conscious health equity culture? The group offered several suggestions for ways in which to begin to set a culturally-conscious health equity culture. These included making partnerships with culturally-conscious contractors and building a culturally-conscious leadership, with infrastructure that will sustain changes of leaders and will be able to be articulated by leadership and multiple levels of the system that support it.

It is also important to have data to be able to understand gaps, construct a plan, and make a case for change. In addition, it can be useful to look at past efforts to find and determine lessons learned and adapt to changing environments.

What are some examples of effective health equity programs? Tennessee’s infant mortality program addresses SDOH and has become increasingly comfortable discussing health equity. It built relationships with community partners, mandated that local officials convene for discussions of SDOH, gave federal funding to county health officials, talked about data, built a plan of action, and set up a health equity program council. As a result, the state’s overall infant mortality rate declined.

What is some advice for implementing an effective health equity program?

- Be careful not to miss opportunities to make laws from policies.
- Be sure to explain to legislatures and officials how strategies will benefit them and develop a good value proposition with them.
- Make sure the agency provides Culturally and Linguistically Appropriate Services (CLAS).
- Clearly demonstrate use of the CDC Health Equity Framework.

- Expand understanding of and investment in health equity throughout the agency, rather than only in the health equity office.
- Involve state and local administrators in the process.
- Understand clearly the funding of the Office of Minority Health.
- Look at models and current case studies of community organizing.

What are some ways to make health equity a priority? There were some questions about how to make health equity a priority. Suggestions included emphasizing that equity means health for all, leading by example, and using the 2016 ASTHO Presidential Challenge to Advance Health Equity and Optimal Health for All as a model.

Best Practices for Developing Policies to Address Social Determinants of Health

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What are some of the best practices for developing policies to address SDOH? There were several suggestions of actions that might be taken to develop policies to address SDOH. One suggestion was to mandate CLAS standards and patient compliance education for all employees; another was to track departments and policies through performance evaluations. The sustainability of policies could be addressed by making them departmental policy, possibly in addition to being made executive orders by the governor. A memorandum of understanding documenting policy and joint training could also be helpful. OMHHE could provide funds to assess health equity work.

HHS regulations for cultural competence may serve as a model. The Health Equity 101 Orientation Trainings implemented in 2010 can also serve as a model, and the group strongly encouraged retroactive participation. George Washington University has developed an implementation plan for the trainings that may be useful.

Other suggestions included setting up a health equity council (a membership of 18 health officers was suggested) that could lead workgroups for basic training and cultural competence and perform health equity evaluation. Alternately, or in addition, a health equity task force could monitor health equity efforts and orchestrate their review and maintenance; such a task force would also increase collaboration within health equity initiatives.

An equity FOA could also be useful. A well-written FOA could affect hiring practices for contractors, grants throughout the state, and add incentives for improving equity to zoning documents. A FOA facilitates compliance by implementing a clear set of standards, and OMHHE could assist by connecting to resources. There is a possibility that the funds would not be returned, but this has not been a problem in the areas where FOAs have been put in place.

How is performance evaluated? Policies are evaluated on the basis of pre- and post-tests and follow-ups. Evaluations of increased awareness can also be of use, as can the reach of sites' education pages. Equity evaluations, including increased life expectancy and decreases in health disparities, can also be used.

What metrics are used to evaluate success? There are several proxy measures to evaluate health outcomes, including high school education, poverty, and ambulatory care. Once super priorities are identified and programs are required to work together, metrics can be tracked more easily.

Who is responsible for implementing best practices? CDC, HHS Office of Minority Health, and state and local health departments are responsible for implementing best practices.

How can best practices be implemented? Advice for implementing best practices include building a base in the community to make legislators listen to the community, mobilizing the cause at the local level, advocacy outside of offices and partnerships, reacting to population demands from councils, and influencing the state (though this depends on the state in question).

What are some examples of best practice? One example of a best practice is that New Mexico requires all health employees to attend training about historical trauma and resiliency of tribal communities, and seven or eight states have centralized health systems.

What are some challenges to best practices? Representatives raised some questions about best practices and their implementation. These included the question of why equity was required when other agencies do not require it, whether population size can justify running pilot programs, how to operate on state funds, how to sustain programs without funding, and how to tie everything to health equity. The question of how to operate without the backing of political will was asked, and a number of suggestions were given, including operating with tenacity and faith, listening to younger people, and building a base.

Sustaining an Organizational Infrastructure to Advance Health Equity

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What are some of the challenges to sustaining an organizational infrastructure to advance health equity?

One of the challenges to health equity lies in its presentation to audiences in other sectors. The framing of health equity needs to be flexible and tailored to each audience for maximum effect. When effectively presented, those audiences may become part of a network of health equity champions who are invested in supporting health equity causes and the integration of health equity concepts into all sectors. If there is not adequate work or funds, resources might need to be redistributed or redirected from other programs in order to ensure that health equity work is completed. However, diverse networks provide a variety of resources that can help offset those issues. Clinical partners can provide unique resources, and government entities can expand an organization's funding base and provide additional tools, CDC can engage economic development tools for state and local organizations, and the federal or reserve bank can be a communication development resource and partner.

Health equity can also be supported by nonmonetary resources, including time and political will. For example, Indiana holds monthly partners meetings with key minority health stakeholders. Though there are advantages to the political ownership of health equity, there are also disadvantages that should not be ignored. There needs to be legislative support for the health equity offices, as there is in Illinois, where the Latina/Black caucus has a line item in the state agenda. Health equity policies should be embedded in accreditation standards because policies help sustain political momentum.

How should individual agencies and organizations support the infrastructure to advance health equity?

Within the organization, it becomes even more important to carefully plan action steps and make both work and results available. Although it can be tempting to work in metaphorical silos, that impulse should be avoided. Continued capacity building is vital. Consultants can provide health equity training on a regular basis, as well as new employee health equity orientations and introduction sessions that explicitly focus on health equity, including the root causes of health inequity. It is important to make the connection between cultural competence and health equity training explicit.

At the same time, the organization will always face challenges and unexpected crises, such as Ebola and Zika, as well as changes in leadership, changes in funding, and other shifts that can be hard for an organization to process. Some strategies to adapt to change and challenges include:

- Reaching out to collaborate across programs and with nontraditional partners.
- Resourcing infrastructure. New organizational orientations can mean working toward sustainable funding, rather than programmatic (and specific) funding.
- Looking for new or reallocated resources for equity.
- Promoting workplace diversity.
- Working together across sectors and at all levels.

- Using an organizational framework that promotes effective collaboration and funding.
- Using data.
- Educating leadership about the value of health equity and need to push equity.
- Using evidence to demonstrate programs' effectiveness; population-level interventions do this work well.
- Marketing your office for funding from other places in department.

Key Recommendations for CDC

There are a number of ways in which CDC can help with health equity efforts. CDC's Procurement and Grants Office has a financial risk protection agreement with regards to health equity, and requires a percentage of the base funding award to sustain state equity offices. CDC can also use its influence to help organize the effort to make health equity a priority.

There are a number of ways in which the federal government can assist in planning and implementing best practice policies. The federal government could consider rural and minority communities in funding, encourage transparency of federal and state finances, make health equity a requirement for grants, replicate federal partnerships for funds, and require joint projects to get state funds. The hospital program through CDC's Office of Public Health Preparedness and Response is an example of how the last two points might be implemented. It might also convene with states regularly and make health equity visits, possibly inviting the administration. It could also require collaboration with OMHHE.

Conclusion and Next Steps

The National Leadership Academy on Health Equity was successful in bringing key stakeholder and leaders in public health together to share best practices and the newest methods and tools to promote and advance state and community population health. Speakers shared valuable insights and lessons and were able to speak to specific case studies and examples when answering questions from the audience. The National Leadership Academy on Health Equity was well received by attendees and leadership, who appreciated the opportunities for further education and discussion. ASTHO remains committed to advancing health equity and continues to work with the CDC on efforts to reduce inequities in health and achieve optimal health for all people.