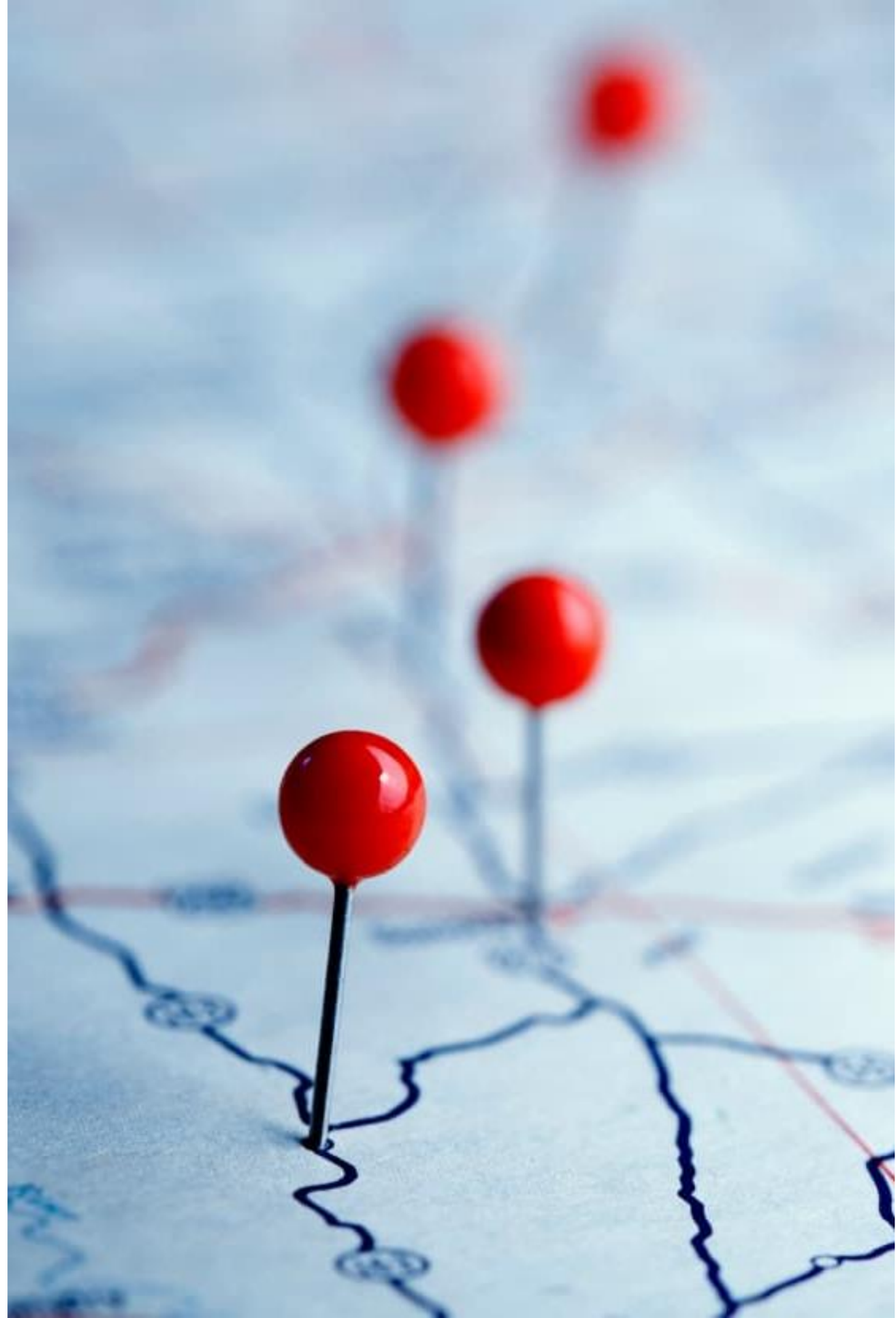
Facilitation Slides: Using Health Equity Indicators to Guide Community Health Improvement in the U.S. Territories and Freely Associated States

Purpose of Guide

Are you a public health agency staff member or partner from an island area seeking to achieve health equity using data?

The Using Health Equity Indicators to Guide Community Health Improvement in the U.S. Territories and Freely Associated States serves as a roadmap for island areas public health agencies to establish a shared understanding of health equity, identify and develop health equity indicators and measures, and track progress on health equity efforts.



How to Use the Guide

1. Complement existing efforts of island areas public health agencies to collect data with the goal of understanding and addressing health inequities, health disparities, and social and structural determinants of health that impact communities and populations.

2. Use alongside community members and local partners.

3. Leverage expertise from collaborative efforts between island areas public health agencies and the communities and populations they serve.

4. Recognize that community members are experts on their needs and priorities.

[Using Health Equity Indicators to Guide Community Health Improvement in the U.S. Territories and Freely Associated States]

Overview

Monitoring progress toward health equity involves measuring health equity and inequities, health disparities, and social and structural determinants of health, as well as tools to facilitate the interpretation of these data.

Health equity metrics, including indicators and measures, play an integral role in helping to establish and sustain a culture of equity.

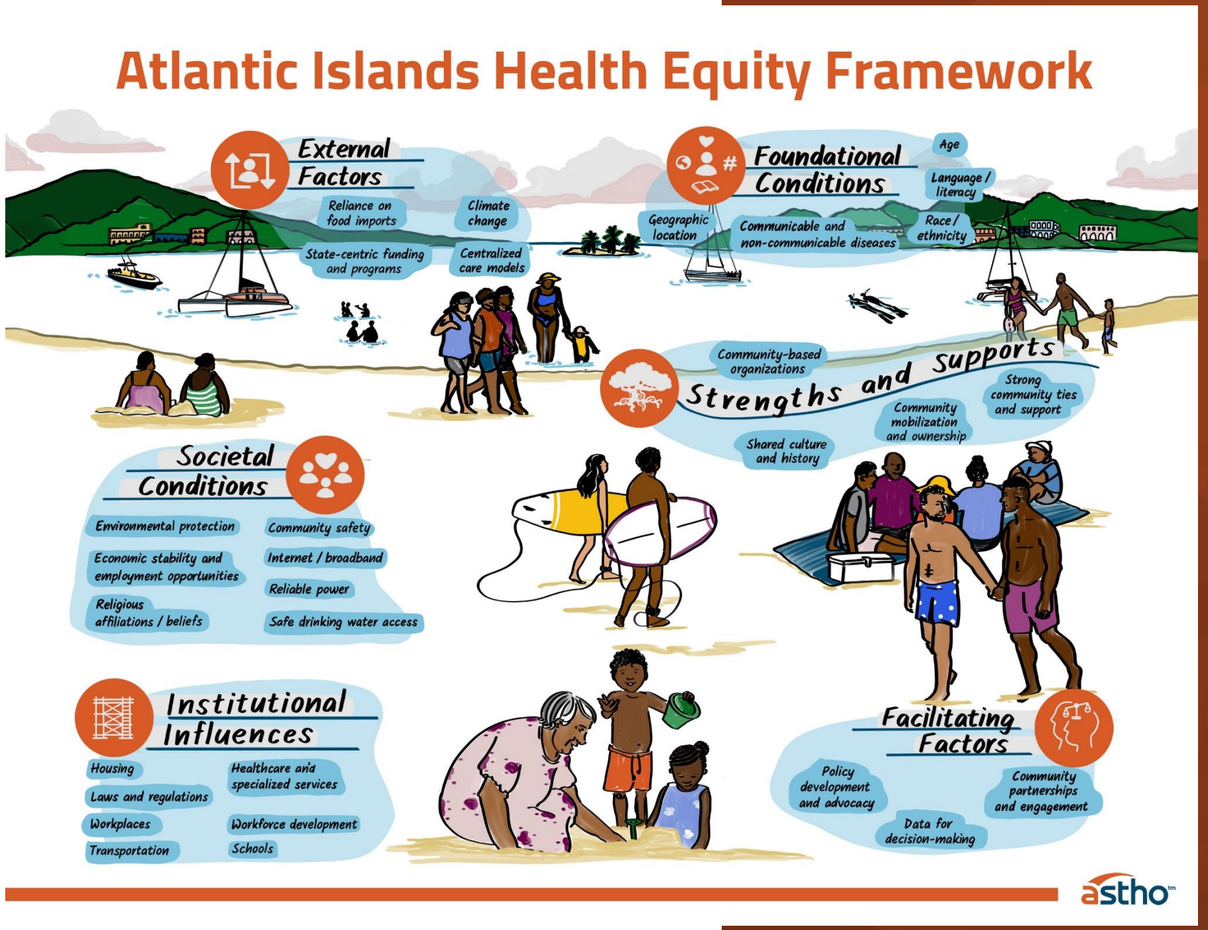
These slides align with the steps in the Guide and serve as a training to support conversations around measuring health equity in island areas. Slides may be adapted to reflect the local community and context. They may be especially helpful when working in collaboration with public health agencies, organizational partners, and the community.

Goals of the Training

During this training, we will learn about the following:

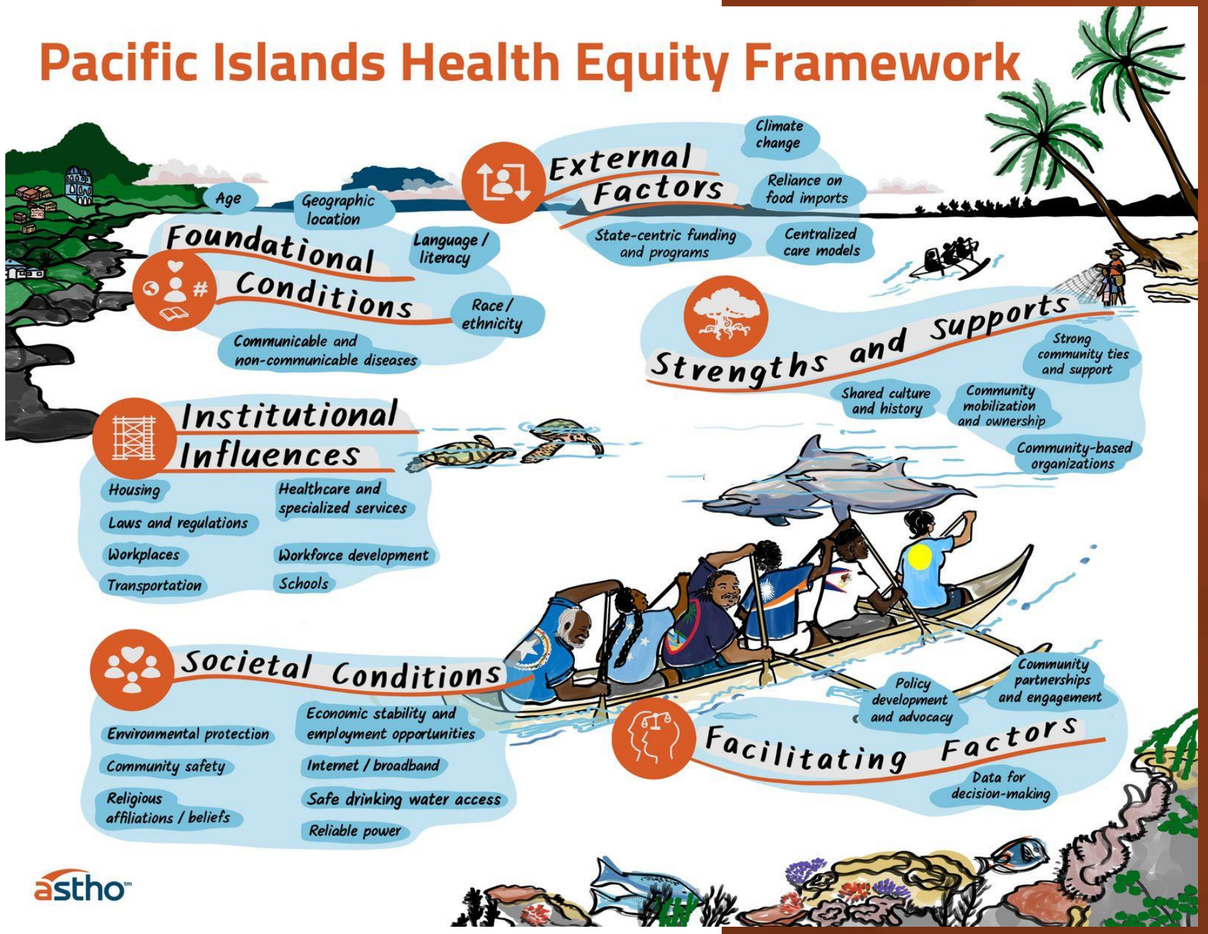
1. How to build shared understanding for health equity.
2. How to communicate health equity concepts to staff, partners, and community members.
3. How to identify and develop health equity indicators and measures.
4. How to monitor progress toward health equity and identify opportunities for improvement.

Atlantic Islands Health Equity Framework



ASTHO's Islands Health Equity Framework is visualized in this graphic:

- Creates a shared understanding of how to move toward health equity in an island context.
- Builds on current health equity frameworks to authentically reflect the culture, experiences, and strengths of island communities.
- To learn more, visit: https://www.astho.org/topic/territories-freely-associated-states/island-equity-framework/.



Pacific Islands Health Equity Framework

ASTHO's Islands Health Equity Framework is visualized in this graphic:

- Creates a shared understanding of how to move towards health equity in an island context
- Builds on and recontextualizes current health equity frameworks to authentically reflect the culture, experiences, and strengths of island communities.
- To learn more, visit: https://www.astho.org/topic/territories-freely-associated-states/island-equity-framework/.

Steps to Action

Six Steps

Six steps outline actions to identify and develop health equity indicators to find opportunities for improvement and track progress on efforts to achieve health equity.

Collaboration

Work through these steps in collaboration with island areas public health agency staff, practitioners, and community experts to advance local action.

Monitor Progress

Consider how each step stimulates monitoring and sustaining advancements in health equity.

Steps

1. Build Shared Understanding
2. Frame Health Equity
3. Identify and Develop Indicators Through a Health Equity Lens
4. Use Storytelling and Data to Achieve Health Equity
5. Embed Health Equity Indicators in Plans
6. Revisit and Scale Up Plan for Measuring Health Equity

Step One

Build Shared Understanding

Achieving health equity requires building a common understanding of concepts and language to help advance efforts and collaborative action to improve health and well-being for all.

Step One

Step One: Build Shared Understanding

1. **Build the concept of health equity within public health agencies.**
   - Consider the following questions:
     - *What is health equity?*
     - *What does an ideal state of health equity mean for the island areas public health agency and community?*
     - *Who are programs and services (e.g., schools, health systems, public health, housing, transportation) reaching versus not reaching?*
     - *How are interventions distributed across social factors of concern (e.g., income, geography, education)?*

Step One: Build Shared Understanding

2. **Engage island areas public health partners to help facilitate discussions.**
   - Identify island areas public health partners to engage and help facilitate discussions with public health agencies to build the foundation.

3. **Engage the community.**
   - Consider the following questions:
     - *Do they feel their knowledge of their community is important?*
     - *Has their voice been heard to identify their needs or thoughts?*
     - *Do they feel like a valued partner in the efforts to address health equity?*
     - *Has the community voice been part of the conversation to identify the needs of their community?*

Step Two

Frame Health Equity

Frame issues in a way that resonates with community members, partners, and other island areas collaborators.

Step Two

Step Two: Frame Health Equity

1. **Focus on health equity rather than health disparities.**
   - Reframe public health communication efforts that focus on health equity rather than health disparities.
     - *For example: Consider infant immunization rates. The percent of mothers with higher education by geography (outer islands versus main islands): Are the geographic differences in immunization rates attributable to education level? This reframing not only explores the differences in health status between population groups but also the differences in the distribution of resources between groups.*

2. **Frame health equity as achievable.**
   - Break down health equity into manageable concepts when solutions are offered across multiple levels.

Step Two: Frame Health Equity

3. **Communicate to address stigma.**
   - Consider how public health agency programs and services are engaging these communities.
     - *For example: Talk about health challenges as just another part of life that affects most people at some point, like many physical health issues.*

4. **Meet the community where they are.**
   - Engage community members and partners to discuss the impact of health inequities.
   - Discuss what health equity means to them and what it looks like in their community or context.
     - *For example: Consider external factors that are controlled or strongly influenced by institutions and governments outside of the Island Areas that affect the health of communities.*

Step Two: Frame Health Equity

5. **Communicate health equity as a "we" issue.**
   - Build on the island areas shared values, culture, traditions, and interconnectedness, and help the communities you serve see themselves as impacted by inequities.
     - *For example: Work with states and territories to help build CHW models.*

6. **Build public health agency staff capacity to understand health equity.**
   - Engage public health agency staff to help build capacity to understand and achieve health equity.
   - Use a health equity lens.
     - *For example: Consider, Who is affected/impacted? Who benefits, and who is harmed? What does the data tell us? What values underlie the decision-making process?*

Step Three

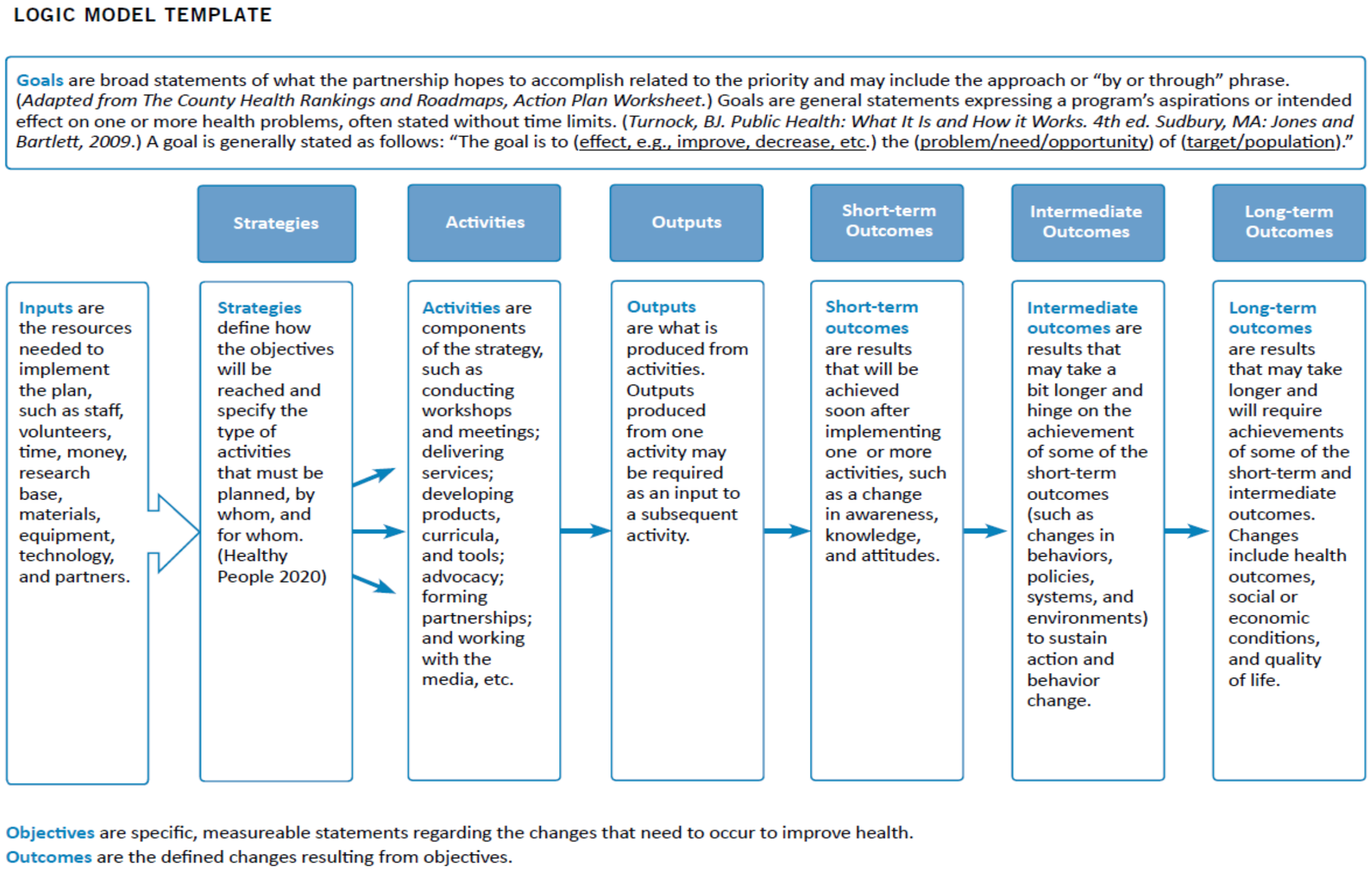
Identify and Develop Indicators Through a Health Equity Lens

- A **health equity lens** can be used to explore equity within existing datasets and across indicators.
- This approach involves looking deeper at each indicator and examining differences in outcomes between populations or communities with different levels of access to resources, privilege, and power.

Step Three

Step Three: Identify and Develop Health Indicators Through a Health Equity Lens

Logic models are a helpful tool to anchor and organize indicators and measures in a larger framework.



Step Three: Identify and Develop Health Indicators Through a Health Equity Lens

Indicator	Existing Measure	Data Source	Applying a Health Equity Lens
Foundational Conditions			
Non-communicable disease	Diabetes prevalence in the population (based on either a self-report of having diabetes for which the patient is taking medication and/or an A1c measurement of 6.5% or higher)	NCD Hybrid Survey	Stratify rates of type 2 diabetes by geography (rural/urban, inner/outer islands), income level, social status, race/ethnicity, nationality, etc.
Societal Conditions			
Employment	Percentage of the population employed for wages	NCD Hybrid Survey	Stratify employment status by age, sex, gender, education nationality, geography, mental health, etc.

Step Three: Identify and Develop Health Indicators Through a Health Equity Lens

Examples of **new** health equity indicators that could be tailored to an island context.

Potential Indicator	Potential Measure
Foundational Conditions	
Language	Percentage of patients receiving language services supported by qualified language services providers, stratified by [insert factor(s) here]
Institutional Influences	
Healthcare and specialized services/ Public health services	Percentage of adolescents receiving depression screening, stratified by [insert factor(s) here]
	Number of [insert sectors, departments, community-based organizations, hospitals, clinics, etc. here] participating in health equity initiatives each year
	Public health-related social media reach, stratified by [insert subpopulations or priority populations here]

Step Three: Identify and Develop Health Indicators Through a Health Equity Lens

Action Steps

1. Identify what is important to measure.
2. Select existing indicators and measures.
3. Develop new indicators and measures to fill gaps and address new areas of health equity.

Step Four

Use Storytelling and Data to Achieve Health Equity

- There are multiple ways to pull together information, including infographics, brief data reports, and data profiles with selected indicators.
- Storytelling is a culturally responsive and powerful way to communicate public health information with communities in island areas.

Step Four

Step Four: Use Storytelling and Data to Achieve Health Equity

Consider how to engage the community within each of these steps:

1. Identify a public health issue or priority.
2. Review potential indicators and data sources to explore that issue.
3. Consider all the indicators you currently measure.
4. Stratify the data using a health equity lens.
5. Organize results in an infographic, brief data report, or data profiles.
6. Engage community partners in interpreting findings.
7. Use results to inform programs, practices, and policies within the public health agency, as well as the development of new health equity indicators.

Step Five

Embed Health Equity Indicators into Plans

It is important to look beyond the project and program level and incorporate health equity indicators into organizational and community plans.

Step Five

Step Five: Embed Health Equity Indicators in Organizational Plans

1. **Establish long-term vision and commitment.**
   - Engage public health agency staff, partners, and communities to revisit a shared understanding of health equity and community needs to identify opportunities to expand the scope of plans to address health equity.
     - *For example: Indicators and measures can be used to explore response and preparedness plans so they meet the needs of communities.*
2. **Incorporating health equity within the quality improvement structure**.
   - Use this as an opportunity to identify disparities and inequities in the context of quality improvement.
   - Use indicators and measures to explore opportunities to tailor programs and services to meet the needs of the population of focus.
     - *Consider the following questions: What does the public health agency plan say? What monitoring is already being done at the program level?*

Step Five: Embed Health Equity Indicators in Organizational Plans

3. **Monitor the progress towards health equity indicators**.
   - Progress towards health equity indicators must be measured to improve outcomes and reduce inequities. Consider the following:
     - *Use health equity indicator data to demonstrate gaps in care by comparing a quality measure among two (or more) groups. For example: Colon cancer screening rates for migrant communities are compared with screening rates for community citizens.*
     - *Develop dashboards for monitoring progress and reporting. Use the dashboard to assign individual tasks to public health agency staff. Ask yourself: What are we trying to accomplish? What are the manageable bite-sized tasks involved in implementing a change?*
     - *Monitor progress on the health equity indicators and determine what actions will be taken to adjust to improve outcomes and reduce inequities. Ask yourself: Who is accountable for adjusting strategies to drive improvement as measured by indicators?*

Example

An island area's public health agency identified cancer as a leading cause of death through its vital statistics data. Based on this finding, the health agency included improving cervical cancer screening as part of its health improvement plan. When stratifying the screening data by age, the health department found that a lower percentage of women over the age of 30 received screening than those aged 30 and under, even though cervical cancer occurs most often in women over the age of 30. Therefore, the public health agency decided to focus its screening efforts on women over 30 years of age.

Example SMARTIE (**S**pecific, **M**easurable, **A**ttainable, **R**ealistic, **T**ime-Bound, **I**nclusive, and **E**quitable) Goal: Over the next five years, we will increase our cervical cancer screening rate for women over the age of 30 by 5% every year from 28% to 55%.

"We have a health equity program that is housed within the Office of Planning and Development that is addressing how the department defines and institutionalizes health equity. It starts at the strategic plan level because it is one of the identified priorities in the current strategic plan, but also how we operationalize that and continue to develop it."

Islands Areas Public Health Agency

Step Six

Revisit and Scale Up Plans for Measuring Health Equity

Revisiting and scaling up plans to measure health equity requires some flexibility as the issues will change over time.

Step Six

Step Six: Revisiting and Scaling Up Plans for Measuring Health Equity

1. **Consider challenges in measuring health equity.**
   - When revisiting and scaling up plans, it is important to consider the challenges identified in Measuring Health Equity: An assessment of equity metrics in performance management and planning – namely workforce capacity and data limitations.
     - **Increasing Workforce Capacity:** Seek out resources, tools, and training to enhance the skills of the workforce.
     - **Decreasing Data Limitations:** Identify data gaps in measuring health equity and including lacking data points on health assessments will inform subsequent health equity efforts.

Step Six: Revisiting and Scaling Up Plans for Measuring Health Equity

2. **Revisit and scale up health equity efforts. Consider the following:**
   - Continually engage with the community to identify additional priorities or public health issues.
   - Increase the workforce's skills to incorporate health equity into their work, from program planning, design, and implementation to monitoring and evaluation. Train staff on how to use data to measure progress on health equity.
   - Identify gaps and consider new data collection methods for identifying root causes and key drivers of inequities.
   - Utilize root cause and key driver data findings to inform public health practice.

Conclusion

By utilizing these steps, we can begin to understand and apply health equity metrics to help understand issues impacting communities, monitor progress on efforts, and identify opportunities for improvement.