



Integrating Health Equity Into Overdose Prevention and Response: An Environmental Scan

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Integrating Health Equity Into Overdose Prevention and Response: An Environmental Scan

**National Association of City and County Health Officials
(NACCHO)**

Jasmine Akuffo
Laura Bosco
Julia Mandeville
Jasmyn Rudd



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INTRODUCTION

In 2020, the National Association of City and County Officials (NACCHO) in collaboration with the Centers for Disease Control (CDC) National Center for Injury Prevention and Control (NCIPC) set out to conduct an environmental scan and literature review for the purposes of designing a training to support state and local jurisdictions in their integration of health equity into drug overdose prevention and response work. Through high-level key informant interviews with state and local health departments, we sought to identify current activities, gaps and innovative strategies currently in use to address health equity and the social determinants of health (SDOH) within drug overdose prevention and response.

Current Gaps

Since 1999, there have been approximately 520,000 fatal drug overdoses in the United States (Hedegaard, Holly., Miniño, Arialdi M., Warner, 2020), with over 70,000 of these occurring in 2019 (Mattson CL., Tanz LJ., Quinn K., Kariisa M., Patel P., 2021). In recognizing this as a public health issue with widespread implications, there have been increased efforts to improve the quality of and access to related substance use disorder (SUD) treatment and service resources.

However, in a recently conducted review of the literature, the Division of Overdose Prevention (DOP) in NCIPC and NACCHO identified many unaddressed health inequities in the planning, design and implementation of SUD treatment and service programming (National Association of County and City Health Officials, 2021).

Using the Bay Area Regional Health Inequities Initiative (BARHII) framework (BARHII, 2015) as a guide, categories of social inequities (class, race, ethnicity, immigration status, sex, gender, LGBTQIA+ status), institutional structures and systems (law and regulation, organizations, media), living conditions (physical economic, work, social and service environments) and individual level factors (overdose, polysubstance use, co-morbidities, mortality) were used to analyze the literature.

Findings showed that higher overall rates of opioid-related deaths were associated with neighborhoods or communities facing higher poverty rates or economic hardship. Relatedly, the literature showed the most frequently identified impacts of physical environment on drug overdose health inequities are attributed to differences in urban versus rural settings and issues of housing and homelessness. Additionally, an examination of health inequities by race, highlighted an underrepresentation of literature focusing on drug overdose impacts on populations of color and a lack of acknowledgment of historically racist responses to overdose, such as the criminalization of drug use. There are also gaps in the literature as there was no literature identified examining an association with drug overdose health inequities and immigration status. Such knowledge gaps prevent an understanding of the full scope of drug overdose in the United States (National Association of County and City Health Officials, 2021).

The review's findings demonstrate that:

1. Most literature focused on inequities along racial or ethnic lines
2. Many demographic factors are being researched in silos without consideration for intersectional impacts on drug overdoses, and
3. Policy was identified as a tool to change institutional-level factors that drive inequities in drug overdoses.

Recommendations that emerged from the review to address these health inequities were to place more attention on health inequities within and across populations, including but not limited to LGBTQIA+, adolescent, aging, sex and gender-based, and immigrant populations. As supported by the BARHII framework, the review, also, suggests that more attention to upstream factors, such as social and institutional inequalities and living conditions, increases potential for more positive effects on downstream factors, including mitigating the causes of drug overdose. Thus, consideration of the intersectional effects of SDOH, social and institutional health inequities, and drug overdose, which previously have been researched in silo, is strongly recommended when developing related SUD policies, programs and interventions.



Methods

This report is based on key informant interviews with health equity, drug overdose prevention, and leadership staff from local and state health departments to elucidate the ways in which health equity strategies are being integrated into overdose prevention, including barriers and facilitators and, potentially, addressing gaps identified in the literature review. A purposive sample of nine local and state health departments were invited to participate in the study. The sample was selected to reflect diversity in the current level of health equity integration in drug overdose prevention and mitigation programming. Interviewed departments also represented a mix of location type (rural, suburban and urban), population size, and department size.

Initially, four local health departments (LHDs) and five state health departments (SHDs) were invited to participate in interviews that would inform our environmental scan. Due to scheduling, an additional local department was interviewed in the place of a fifth state department. Structured interviews were conducted from March to May 2021, via video conference calls with each health department. Each interview lasted one hour and included one to three representatives of the health departments who worked in drug overdose prevention and/or health equity programming. In one case, the participants present at the interview were staff at an academic institution employed by the state health department of interest to provide support on their Overdose Data to Action (OD2A) cooperative agreement, as well as to those of local health departments within the state.

Interviews focused on capturing departments' awareness and approach to health equity; current health equity actions; understanding the types of resources and partners available; gaining additional context on challenges and facilitators; and gathering promising practices. **The interviews and this report were intended to inform planned trainings and workshops to support better integration of a health equity approach to drug overdose prevention and response programming.**

All interviews were audio recorded with the verbal consent of respondents. Audio recordings were transcribed and then coded for key themes. Three researchers coded the interviews. To ensure understanding of and consistency across coding, two of the interviews were each coded by all three researchers and reviewed together before the final seven were divided amongst the team.

II. HEALTH EQUITY AWARENESS AND APPROACH

Health equity, according to the CDC is “...when everyone has the opportunity to be as healthy as possible.” (Centers for Disease Control and Prevention: Office of Minority Health & Health Equity, 2021) The World Health Organization extends this to “...the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically” (World Health Organization, 2021).

When asked to provide the definition of health equity used, most interviewed health departments (n= 7, 78%) reported utilizing a variation of these outlined by the CDC and the WHO. For example, one department defines health equity as:

“...everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health, such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and healthcare.”

Another described health equity as:

“...when all people have a fair and just opportunity to be healthy, especially those who have experienced socioeconomic disadvantage, historical injustice, and other avoidable systemic inequalities that are often associated with social categories of race, gender, ethnicity, social position, sexual orientation and disability.”

All departments interviewed were at least aware of the concept of health equity with 89% (n=8) stating that a health equity lens was either formally or informally applied to the work done by the health department. Specifically, two departments reported that health equity is one of the leading priorities in the work done by their organization with equity work intentionally integrated into their drug overdose response and prevention programming. The one department that was noted to not have a specific definition of health equity incorporated into the work, outlined that there is an existing framework allowing the department to reframe how they view health in order to better incorporate social determinants of health into their work. However, health equity was not clearly articulated in their overdose prevention and response programming.

Health equity deeply incorporated: Three LHDs and 1 SHD shared that health equity is formally incorporated into their work as a core value and is a part of staff's formal work responsibilities. One respondent elaborated that it was one of three leading priorities of the department which are:

“One, achieving health equity and the elimination of racial and ethnic disparities; two, addressing SDOH in all department’s programming; and, three, quality and access to care and services for most vulnerable members of the population.”

Others shared that health equity and a racial justice lens are purposefully integrated into their violence and overdose prevention work and, in so doing, invited those with lived experiences to participate in overdose fatality review (OFR) sessions:

“Yes, so health equity, I believe, is a part of every single staff person at public health’s job description. It’s actually set aside time specifically, to whatever their role is, to incorporate health equity within that. We have two full time health equity coordinators at public health who provide a variety of things, so they coordinate trainings and opportunities for that. In addition to – well, we’re a city and a county agency – so we both have the city equity team and the county equity team and are able to engage in those as well, so we really have a lot of, like, structural training support in that space and then those two equity coordinators are, also, available for programs like Overdose Prevention.”

Health equity moderately or not incorporated: There were also 3 SHDs and 1 LHD that reported moderate incorporation of health equity in their approach. These indicated that health equity was recognized in theory, however, its integration into the department's work was quite informal.

A majority of the departments with health equity moderately incorporated shared that the events of 2020 – the COVID-19 pandemic, the exacerbation of poverty and social inequities along with the civil unrest associated with racial injustices – led to a reevaluation of their language and approach to health equity as it informs their work. This then caused greater discourse about including equity in the work in a more substantive way. For example, more substantive inclusion of health equity in the form of a dedicated health equity team, declarations of racism as a public health crisis and at least baseline SDOH focus. However, for one department, while the change has prompted greater verbal commitment to health equity, this has, admittedly, been with less than desired follow through in action. Only one department, an LHD, shared that health equity was not clearly incorporated into their programming:

“On one hand, all of that is happening. On the other hand, I realized that there are certain [...] values that we would articulate about how we do work within the Opiate Crisis Response Program but I don’t think that equity is explicitly articulated.”

III. HEALTH EQUITY ACTIONS

Actions Incorporated

Respondents were asked to describe health equity actions and activities relevant to drug overdose response work. Key actions that were considered are included in Table 1 below. All nine respondents described at least one way their health department addressed health inequities in drug overdose prevention and response work. One SHD and one LHD reported using all of the key health equity actions identified above while, for one LHD, the only action reported was the development or implementation of health equity trainings. Most departments interviewed reported using disaggregation of data, making it the most reported activity. Conversely only one SHD and two LHDs, shared that their work includes addressing structural drivers of health inequities via policy.

Table 1. Type of health equity actions reported by health departments

| Types of health equity actions | # of departments reporting | | | | | | | | |
|---|----------------------------|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| Including leadership of or formalized partnerships with directly impacted persons and populations | | | | | | | | | |
| Engaging policy to address structural drivers of inequity | | | | | | | | | |
| Utilization of health equity indicators | | | | | | | | | |
| Disaggregation of data | | | | | | | | | |
| Incorporation of community voice and storytelling | | | | | | | | | |
| Developing or implementing health equity trainings | | | | | | | | | |
| Changing or reclaiming the narrative | | | | | | | | | |

Formalized leadership and partnerships with directly impacted persons and populations:

Of the six respondents who listed this health equity action, three chose also to outline specific ways in which they engage directly impacted persons through formalized leadership positions and partnerships. These ranged from hiring of people with lived experiences as staff, engaging with grassroots organizations and the establishment of workgroups with community partners. One department shared that while staff may be aware of how critical these types of positions and partnerships may be to recognizing and addressing community needs, there is still difficulty in establishing them. This is attributed to the fact that the majority of persons working in the department do not have lived experience with the inequities being addressed and many are not from the community being served by the work. Thus, presenting a barrier to effectively address the needs of the community.

Engaging policy to address structural drivers of inequity: Engaging “little p” policy at the organizational level and “big p” policy at the local, state or federal levels were cited as health equity actions, but few health departments shared that this was a part of their strategy. Those that did use this approach outlined that, at the macro level, it was difficult. Thus, their policy advocacy work was iterative and incremental in nature, often focusing on “little p” policy, or changing policies within their own organization.

“A ‘little p’ policy is that infusion of equity analysis questions within our development of anything. A position statement, for example, has an equity component of the, you know, I’m going to propose this position statement [that] needs to get approved by our executive team, needs to get approved by our Board of health. It’s in that, embedded within that when we start a charter for a new project or program that we want to work on within public health, equity considerations are embedded within that document.”

Additionally, the inclusion of communities and community partners was highlighted as a crucial component to policy advocacy by those health departments that integrate this in their work formally. Specifically, the community partners provide feedback on ways to influence policy and in the process build capacity to advocate for change.

Utilization of health equity indicators: Indicators were collected and utilized by respondents in a variety of ways with the application of a health equity lens to ensure the demographic data of those most or disproportionately impacted are captured. For instance, whilst age, race and gender are collected by those departments that incorporate the use of health equity indicators, some departments also look at equity beyond these standard indicators to collect data on immigration status, ability and social vulnerability (housing & transportation, language, household composition & socioeconomic status). This type of data could then be used to identify overdose hotspots within a health department’s jurisdiction. Another respondent shared that they developed 15 core health equity indicators including number of naloxone kits distributed to number of overdose deaths, percentage of population who are food insecure and number of non-violent offenders under probation and parole (per 1,000 residents age 18 and older). These and other indicators are grouped into several domains including community trauma, integrated healthcare and community resilience. They are used to assess the effectiveness of the health equity interventions and to map and share progress.

Disaggregation of data: Departments reported that they work with local agencies and community partners in the collection, analysis and dissemination of drug overdose related data. These partners would typically, include the office of the medical examiner, prescription drug monitoring program personnel, correctional staff, law enforcement, the department of public safety, and hospitals. The level of disaggregation varied by jurisdiction with age and race/ethnicity being the most frequently reported variables. Some jurisdictions, with the application of a health equity lens in the evaluation of the data, take a more macro level approach to use the data to identify what populations or counties are disproportionately impacted by overdose and if medication assisted treatment (MAT) is available in these areas. One respondent provided more insight into their surveillance process:

"Another example that we use is actually from our surveillance strategies. We have a social autopsy report that we have created, and what that does is it actually brings together data sets from multiple different departments [...] and so what we do with that is we look at anyone that died due to a drug overdose in a given year [...] and we look at where they had touch points with the state with those various state entities prior to death and we try to determine, you know, what are the commonalities and so the vital statistics data that we get is one that really speaks to social determinants of health. All the contributors review it, it's reviewed at multiple levels and the final level of review is to send it to the Commissioners of all the departments that are involved and ask them for recommendations about what can be done. One thing that our Commissioner, the Commissioner of Health, recommended last year, which I think will come together is to have an overdose prevention panel where there's representation from all those contributing departments, so that they can review the data, where we're seeing trends in touch points prior to death and what sort of intervention and prevention, we can apply there."

When queried further about the provision of access to this data to the public, departments shared it is important for this information to not just be made available, but also have it presented in ways that the community would understand, both for situational awareness and to continue building community partnerships and support for intervention.

"Yeah, I mean, I think one of our biggest things is we have all of this really great data. It's our job to make it palatable for the Community so, yeah, we've definitely stepped up our like data visualization skills and have worked specifically with groups who are interested in making those sort of data driven-decisions."

Incorporation of community voice and storytelling: Many respondents were eager to share the ways in which they seek to include the community in the work they are doing. In addition to community-based projects, such as street outreach, health departments interviewed are making spaces for persons with lived experience to participate in focus groups to comment on proposed interventions, weigh in on existing policies, practices and priorities and co-design systems of care for persons who use drugs.

“If you don’t have any understanding of the communities [...] that are getting hit most by these public health issues, you’re going to be off base from the get-go when you’re trying to figure out how to.”

Two departments also specifically shared that community voices were sought when determining how to allocate funding for programming using participatory budgeting. Participatory budgeting refers to “a democratic process in which community members decide how to spend part of a public budget. It gives people real power over real money” (Participatory Budget Project, 2021). Respondents made mention of some of the formalized ways with which they approach this particular strategy such as the development of community advisory boards or elevating community members as co-chairs of workgroups. One point of concern in incorporating community voice that was raised by multiple respondents was the difficulties they encounter in compensating community members for their time, experience and expertise due to regulatory guidelines. Where financial compensation is not possible, departments proposed compensating by addressing specific barriers to participation, like transportation or childcare.

“Instead of just talking about decedents in medical examiner reports and police reports and criminal justice reports. Having that voice has been huge. And, again, we can do best practices all we want but, if we don’t have the voice of the Community telling us what fits for this Community, it doesn’t, it’s not going to work. It’s not going to be as effective as it could be. And having the support behind that then to fund that, you know, to compensate folks for that experience and that expertise has been... It helps because then we’re not just using the Community but we’re actively partnering with the Community.”

Developing or implementing health equity trainings: There was a lot of variability in the ways in which trainings were facilitated and the models used by departments. Some trainings were mandatory for new employees and, although there was strong encouragement to attend others, these were voluntary. Departments may partner with community agencies, utilizing train the trainer models, hire a consultant or develop a web-based training. The time needed to participate in these sessions ranged from several hours each week to 2.5 months. Some departments also shared they have yearly summits focused on health equity. One department shared some of the training courses and modules that staff would study. These include: Transformative Public Health, Linguistic and Cultural Responsiveness and Authentic Community Engagement. Not all departments develop or implement regular health equity training, with one specifying that the last time a related training was done was five years ago.

Changing or reclaiming the narrative: During the interview process, the theme of “changing or reclaiming the narrative” was identified as several respondents shared about their work in health equity. Actions within this theme included embedding anti-stigma work in outreach activities, approaching addiction as a disease, using people-centered language, being transparent with the community, discussing the data in ways that would not further demonize or ostracize persons or populations in the community and onboarding bilingual providers who also translate materials. Departments shared that it was critical to constantly reevaluate “norms” that may be rooted historically in white supremacist structures and ideals and approach their work with a health equity lens to be more inclusive of the community – particularly under-resourced groups.

“Moving forward in overdose, first, we are in ensuring that our data are informed and get the message out that this epidemic specifically is affecting our Black and Hispanic communities. And so we’ve started on our [...] Website by including that specific data and addressing that this stems from racism. We have that on our website, and it is very explicit to that.”



IV. HEALTH EQUITY RESOURCES

Resources Available

Respondents reported the use of a diverse basket of resources, organizational policies and practices to support their work on health equity and drug overdose prevention and response. These resources are listed in Table 2. Access to trainings, data, and toolkits was nearly ubiquitous, though the scope, usefulness and quality differed. The following explores departments’ use of and diverse experiences with different health equity resources.

Table 2. List of resources utilized to support health equity reported by health departments

| Types of resources | # of departments reporting | | | | | | | | |
|--------------------------------|----------------------------|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| Trainings | | | | | | | | | |
| Toolkits; internally developed | | | | | | | | | |
| Toolkits; externally developed | | | | | | | | | |
| Dedicated health equity staff | | | | | | | | | |
| Consultants | | | | | | | | | |
| Funding | | | | | | | | | |
| Data | | | | | | | | | |
| Organizational Policies | | | | | | | | | |
| Structural Practices | | | | | | | | | |

Trainings: Almost all of the health departments interviewed responded that some type of training on health equity or social determinants of health (SDOH) was available to department staff. The scale and scope of trainings, however, differed substantially. One health department explained that health equity is a “fairly cursory” module within standard staff onboarding materials, while another spoke of training materials and learning opportunities that are made available to staff but only on a voluntary basis. At the other end of the spectrum, other health departments responded that health equity trainings were an extensive and mandatory part of department’s staff policies. The frequency differed by localities, ranging from weekly trainings to annual workshops to ad hoc mandatory sessions. Notably, the extent and/or mandatory nature of health equity trainings did not map perfectly onto the size or level of resources of the departments we interviewed. For example, highly resourced departments did not necessarily provide an abundance of trainings, nor did less resourced departments have comparatively less training options available.

Some interesting training practices included tailoring training topics and language to specific departments and/or geographic localities; providing incentives to staff encourage outside use of trainings by community partners; the creation of a centralized resource center to access extant trainings (at the state level); and incorporating outside expert knowledge either via the use of consultants or nationally provided resources.

Although none of the health departments listed the trainings as their most valuable resource, a handful did emphasize that their trainings were “solid” or “excellent.” A couple flagged some challenges with extant trainings, including excessive use of “academic words”, the absence of a shared health equity language across different levels of government, and, in one case, pushback from co-workers on the trainings. [Note: nature of pushback unclear but implied that there may have been some contention over the topic itself.] One health department specified that improved training opportunities were the most wanted resource that is currently absent. Ideal trainings, respondents elaborated, would be modularized for different audiences (e.g. local or state, rural or urban), would provide all a shared language and baseline knowledge, and would facilitate subsequent shared action to address health equity and SDOH. Finally, respondents acknowledged that such trainings might already exist but not be widely disseminated or broadly available. This suggests secondary opportunities including (1) to improve the archiving, accessibility and assisted tailoring of those training resources that already exist and (2) to facilitate learning across departments as at least one department interviewed had invested in building and supporting such a resource hub.

Demographic data: Access to data proved a valuable and near universal resource to inform programming and policy making among interviewed departments. In two interviews, respondents flagged access to demographic, usage, and/or surveillance data as the most valuable resource. Some localities reported the ability to collect their own primary data (e.g. community surveys, monitoring, and interviews), while others relied primarily on data collected by others including local medical examiner reports, hospital association overdose case data, treatment or alternative site data, prescription drug monitoring program histories, police arrest data, census data, and state equity reports, dashboards, and datasets. Two departments provided the caveat that reliance on external data sources can prove difficult, especially when data disaggregation differs across sources. Disaggregation by race, ethnicity and socio-economic metrics may not always be available.

Some best practices in data use included the creation of core health equity indicators, creating dedicated surveillance data teams and/or systems, and an emphasis on sharing data with partners via dashboards and visualizations. On the latter, departments have created standard visualizations and/or dashboards to facilitate better understanding, use and access to the data across partners. Other departments also made the connection of better data visualizations improving ability to share insights with – and, in turn, gather more data from – community partners.



The notable exception among them highlighted an important challenge that small localities have in collecting and using disaggregated data. Respect for patient confidentiality and anonymity means that localities with very small caseloads cannot collect, retain or report some demographic information for fear of identifying individuals. One respondent explained:

“This [disaggregated data] is something that we talked about pretty regularly but because we are a small place it’s trickier because there is a kind of tension between wanting to follow the general guideline of the threshold of cases that you have to have in order to not suppress the data and protect confidentiality and anonymity, but then also the risk of [...] erasing the demographic that they represented because you don’t have the numbers. In overdose fatality review report, we ended up disaggregating the data and the State health department questioned why we disaggregated the data.”

Another challenge is accessing extant data. One respondent specifically asked that federal level, CDC and NACCHO datasets be made available and more accessible for use at the local level. Finally, while this discussion focused mostly on availability of large-scale or quantitative data, it is important to remember and make space for other types of valuable data, especially qualitative data from community and non-traditional voices, which were repeatedly mentioned as departments’ most valued resource. See more under [Partnerships](#).

Toolkits: Many departments reported using a toolkit to support health equity work as part of drug overdose prevention and mitigation. Some localities adopted and adapted external toolkits while other created their own internal toolkits. The context of internally created toolkits varied. One state health department used a health equity tool created by the Overdose Prevention Network, another adapted peer recovery toolkits for use in partnership with faith-based organizations, and a final county health department adopted and used an analysis tool developed by one of its cities. At the other end of the spectrum, one state health department spoke of an extensive toolkit created and rolled out as part of the state’s broader health equity strategy. Somewhere in between, another state department built a toolkit that collated programs and best practices from other departments for easier use by local jurisdictions. The respondent explained:

“We just put together a toolkit that has evidence-based programs in it. [O]ur health departments don’t have [the] time to go out and look for a lot of good programs that they could implement in their communities... [or] to analyze the programs that might work. So, in some cases, it’s just let’s do it...We’ve expected it takes the brunt off.”

The interviews suggest an opportunity for national or outside bodies to similarly ease the burden of searching for and adapting extant toolkits (and other resources) for stretched health departments.

Funding: Health equity funding was inconsistently available across interviewed departments. Braided funding (bringing together funding from multiple sources) was a frequently cited work around with one state department flagging its “braided funding model” as its most valuable resource. Two other states flagged reliance on funding opportunities provided by the CDC for health equity work, including the Overdose Data to Action (OD2A) program. One SHD shared that, as a requirement of their (OD2A) cooperative agreement, 20% of their received funds must be dedicated to community level interventions. As such, this SHD allocated this percentage to the four most burdened counties in their state as it relates to number of overdoses. At the local level, three responses illustrate a breadth of funding structures – (1) no formal funding available but health equity mindfully considered in spending decisions (e.g., by using participatory budgeting to ensure community priorities areas are well funded), (2) explicit health equity funding available but with challenging caveats, and (3) health equity items (e.g. professional development, full time staff) included as an explicit department budget line, supplemented by grants. In regard to funding disbursed directly to LHDs from SHDs, some SHDs ensure that health equity and SDOH are written into the funding they disburse so that grant applicants can incorporate this into the work – essentially making it a required element to receive funding.

Funding was also the most common response given when key informants were asked what resource was currently absent, but most wanted. Specifically, respondents emphasized the need for more flexible funding structures, even in the case of departments where explicit health equity funding structures already exist. Respondents provided a number of possible innovations to funding structures and opportunities for support around funding, including:

- Allowing grant funding to be used to compensate community members for their time and expertise sharing lived experience, as a way to formalize and sustain the incorporation of important voices. (A need flagged by two departments.)
- More funding opportunities for upstream work with young people, including creating spaces and opportunities for kids.
- Incorporating health equity and SDOH considerations as a funding requirement for federal level pipeline opportunities.
- Easing request for applications (RFA) requirements and policies that downstream the work or prevent overdose assistance funding from funding local organizations that are necessary to addressing SDOH and health inequities
- Allowing for community participation in the review of RFAs to ensure inclusivity
- Providing technical assistance or expert support to LHDs specifically on how to navigate extant funding mechanisms and opportunities

Staff and consultants: Ensuring sufficient, consistent and quality staff for health equity and drug overdose prevention and response initiatives proved an important resource. Four health departments reported that they employed up to two dedicated staff to run trainings, provide programmatic support, review policy proposals and more. At the local level, several departments reported up to two FTE staff equivalents working on health equity, while at the state level, two departments reported funding divisions that focused on community health and equity. Other departments reported a more diffused approach, either including health equity as a stated part of all department job descriptions and/or creating cross-cutting topical working groups. These approaches appear more effective when expectations are clear, health equity work is incorporated into standard staff reporting and performance reviews, and when staff are supported by subject matter experts (see "[Promising Practices](#)"). Five interviewed departments also reported hiring health equity consultants to supplement staff time. Most frequently, consultants were employed to design and implement health equity trainings and, in one case, support the roll out of health equity strategic plans.

Improving the staffing of health equity efforts – and health departments writ large – was frequently listed as the most desired resource by interviewed departments. Beyond advocating simply for more staff, respondents emphasized the importance of recruiting diverse staff that were representative of (and/or from) the served communities, ensuring retention of trained staff, and supplementing staff skills with access to technical assistance and subject matter experts among national partners.

Policies and practices: Health equity resources also include the policies and practices of health departments. Below lists several efforts described during the interviews. Notably the policies and practices span a wide range in terms of the resources required and upfront cost and effort to institute:

- Infusion of a standard set of equity analysis questions during the development stage of all programs
- Participatory policy development with persons who have lived experience
- Participatory budgeting for all programming
- Inclusion of health equity in all contracts, even fiscal requirements
- Access to full-time department experts on health equity
- Regular required time for all staff to spend on health equity and accountability in all staffs' performance reviews
- Inclusion of health equity into every public health official's job description
- Explicit and consistent communication from state officials that health equity is a stated priority
- Documented standards for the collection of demographic data

V. PARTNERSHIPS & HEALTH EQUITY CHAMPIONS

When asked what resource was most valuable to their health equity work on drug overdose prevention and response, respondents most frequently reported the importance of partners and champions. Table 3 presents common types of partners as well as examples of the specific partners and partner initiatives mentioned in the interviews. The most commonly mentioned partners across the interviews were community groups, law enforcement, health care providers and government agencies.

Table 3. Key partnerships for health equity and drug overdose work reported by health departments

| Types of partners | # of departments reporting | | | | | | | | | |
|---|----------------------------|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |
| Community groups | | | | | | | | | | Housing groups; regional, ethnic and cultural groups; topical advocacy groups |
| People with lived experience | | | | | | | | | | Hiring peer support specialists or recovery coaches; forming advisory groups and health equity communities |
| Law enforcement/ First responders | | | | | | | | | | State and local police departments, police academies; diversion programs, anti-stigma and harm reduction education; correctional facilities; the criminal justice system, AG office, prosecutor offices; firefighters |
| Health care providers, including harm reduction | | | | | | | | | | Hospitals and clinics; syringe and recovery service providers; physician professional groups |
| Government and elected officials | | | | | | | | | | Mayoral and governor offices, jurisdictional task forces, and social service departments |
| Internal partnerships, within HDs | | | | | | | | | | Other topical programs areas (e.g., HIV, harm reduction, health equity); cross-cutting working groups |
| Private sector | | | | | | | | | | Grants to work with higher risk student populations; coalitions that work with youth in schools |
| Religious partners | | | | | | | | | | Faith-based organizations |

Other noted partners included:

- One department’s work with a **theatre group** that used drama to educate persons about stigma, overdose, resources, and which encouraged persons affected to seek assistance;
- Another department’s participation in a state-wide association of **local health departments**, emphasizing that other health departments are a powerful partnership resource

The Importance of Community Voices & Champions

When asked what resource was most important to their department's health equity work on drug overdose prevention and response, respondents most frequently emphasized the great value of diverse voices and champions. Several departments emphasized the importance of consulting with people with lived experience, those who are actively using, family members, and others of diverse backgrounds – one even stating that this was their most valuable resource. As indicated in "Health Equity Actions", strategies included inviting participation on health equity committees and/or advisory groups; hiring those with lived experience as peer support specialists or recovery coaches; and, ensuring that those with lived experience were in some leadership positions. One department emphasized that community voices were especially important in conversations around stigma and development of stigma response. Another respondent stated:

"[T]he understanding and support of including the voices of lived experience has been the biggest help for us. We've got the data, we already know what that says that's, [but]it's nothing without the story that goes behind it. People are much more than numbers and check boxes and narratives and police reports... [W]e can do best practices all we want but, if we don't have the voice of the Community telling us what fits for this Community, ...it's not going to work. It's not going to be as effective as it could be."

See more on how this department importantly also compensates community members for sharing their expertise and experiences in "[Promising Practices](#)."

Several departments emphasized the importance of identifying and empowering champions among their various partners. Champions, respondents explained, help to keep health equity work present on the agenda, lend commitment and their voice to relevant issues, provide health equity and SDOH expertise and language, help maintain momentum and, in the end, are often the ones to get the work done. One department explained that identifying champions within partner organizations was a key part of their strategy for engaging partners:

"When we're working with some of our partners it's helpful to get champions within those agencies - [for example,] for diversion programming for the police department. Again, great people, want to do great things, let's go, let's hit the street and make some changes. Finding the right person internally to share the benefit of what an equity analysis would do for the project, and then having them... internally advocate for making the space and the time for those sorts of things, has been easier than trying to change a whole department, for example. [S]tart with that internal champion. They've got more of a voice and they're more respected by their peers than public health coming in and telling [them] what to be doing. [F]inding those internal champions has been invaluable to us in getting some agency buy-in... and putting the time into some of that work."

The diversity in the types of champions identified is instructive, with departments finding health equity champions across their own department leadership, government leadership (e.g. mayor, county commissioners), funders, grassroots organizations and advocacy groups, policy planners, administrative support staff, recovery center directors, equity commissioners, working groups, police, and judges.

Engaging With Partners

Respondents shared diverse strategies for engaging with partners in health equity and drug overdose prevention and response work. Strategies include:

- Compensating community expertise and experience via stipend gift cards, providing for transportation and childcare, and/or sharing desired trainings or capacity building efforts.
- Identifying champions within partner organizations to advance shared efforts.
- Committing to creating a safe space where people with lived experience can feel comfortable engaging.
- Ensuring data is shared back with partners and concerted “street outreach” with partners to both share data and gather information.
- Committing to meeting regularly with community affinity groups.
- Supporting voluntary workgroups across partnerships.
- Concerted efforts to build coalitions across partners in geographic locations or campaigns.

Partnership Challenges

Partnerships can also present challenges. While law enforcement was a common partner across interviewed departments, one department cautioned that partnering with the police can also be “polarizing.” In their experience, such partnerships have complicated community working groups, especially where there is a “lack of trust” or general skepticism concerning the police. Another department described the coordination challenge posed by serving tribal areas, which have separate government entities. Coordination and communication with partners are also more difficult in places that lack internet and other infrastructure not commonly considered in intervention planning. A third department emphasized the challenge of ensuring common understanding of health equity language across partners. On this point, a best practice mentioned by another department – creation and use of a health equity glossary – suggests a solution. (See “[Promising Practices](#)” below.) This feeds into the final challenge highlighted by respondents – one department flagged wanting to partner more with other LHDs but described the difficulty of creating, accessing, or fully leveraging these partnerships. The respondent described their experience as too often one of working “in a fishbowl,” especially as the magnitude and proportion of the opioid epidemic in their community overburdens staff and leaves them without “the time to get creative”.

VI. CHALLENGES

Main Challenges

During the course of the interview, respondents were asked to share some of the challenges they encounter when integrating health equity into drug overdose prevention and response work. Additionally, they were encouraged to provide any ways these challenges have been navigated. Table 4 outlines the challenges departments identified in the interviews with the most prominent and underlying themes given explanation below.

Table 4. Type of challenges met when incorporating health equity into drug overdose work reported by health departments

| Types of challenge | # of departments reporting | | | | | | | | |
|---|----------------------------|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| Lack of resources | | | | | | | | | |
| Time constraints | | | | | | | | | |
| Staffing challenges | | | | | | | | | |
| Lack of shared/consistent language | | | | | | | | | |
| Lack of skills/knowledge to address health equity | | | | | | | | | |
| Working in silos | | | | | | | | | |
| Apathy | | | | | | | | | |
| Stated opposition | | | | | | | | | |
| Lack of funding | | | | | | | | | |
| Data gaps | | | | | | | | | |
| Partnering with law enforcement | | | | | | | | | |

Additional challenges are noted as such:

- One respondent spoke to how narratives inconsistent with existing data framed drug overdose as “a white man’s problem,” thus, diverting attention away from the particular needs and harms faced by communities of color due to stigma
- Another challenge reported was difficulty partnering with “tribal agencies” as they have a separate government entity.

Structural Barriers

A recurring theme throughout the challenges listed were structural barriers seeded in white supremacist culture and structural racism, overarching root causes of health inequity. One of the ways this was seen to manifest was through inaction, or apathy, from (often, predominantly white) leadership and community members when it comes to (often, predominantly Black, Indigenous, or people of color (BIPOC)) communities and populations that are disproportionately impacted by health inequities. Pervasive structural and social norms and practices drive inequity, even in the face of no clear opposition. One respondent spoke of the ease with which people and departments will default to norms and practices that are racist and white supremacist in nature, rather than challenging these norms which do harm to and create the inequities faced by communities experiencing drug overdose. Another respondent expressed how frustrating the bureaucracy of programming and funding was as they characterized the systems and structures as ones that support “pro-social people with resources who are most often white” but fail to adequately address the needs of the people who are most vulnerable.

These sentiments are further enabled by hierarchical bureaucratic structures of power, wherein inaction or opposition from the top spirals down to all below. Throughout the interviews, respondents frequently spoke of the importance of receiving timely guidance and support from leadership in order to be able to truly advance health equity in their jurisdictions. One participant in particular spoke to how delayed support from leadership or elected officials at the top, can have a trickle down effect on how states are able to address health inequity and, subsequently, local jurisdictions:

“I think that the more open, the more honest that the state health department can be on issues of equity, I think that has kind of a trickle effect. Because, you know, like I told you, the state health department was kind of waiting for CDC to say, ‘Hey, this is an issue’ before they moved. The local health departments do the same thing with the state health department, you know. So, they’re waiting to see is the state going to say anything? And we’re going to wait until they say something because we don’t want to, you know, upset anyone or step on any toes or risk our funding or any of that kind of stuff. So [...] everyone’s kind of waiting, you know, to see what happens and what the reaction will be, rather than just kind of like just being more bold and just, you know, stating what’s painfully obvious to a lot of people.”

These power dynamics, also, trickle down and manifest among community members in their willingness to take on or support efforts to address health inequity. For example, having less racially/ethnically diverse populations or lower numbers of overdoses, to some, indicates that large media campaigns or other actions to address inequity are unnecessary. This belief that the numbers need to reach a certain threshold in order to warrant action or provision of targeted resources to disproportionately impacted populations serves as a barrier to health equity, particularly in predominantly white communities where apathetic racism (racism through passive tolerance, benign ignorance or neglect) (American Heart Association, 2021), may be prevalent. One department further explained:

“[There are] [s]uch longstanding issues within the community that are sometimes even missed as issues or accepted as just a part of the culture -- but slowly but surely more are becoming more aware. People hear health equity and think communities of color, so language does not resonate in areas that are majority white even though it is applicable and rural whites may be dealing with the same issues.”

Lack of Resources

Another common theme throughout the challenges noted was related to lack of resources. Specifically, lack of time, dedicated staff, adequate health equity skills or trainings, and working in silos were reported as barriers to effectively developing programming to address drug overdose and health inequity. In addition to being a challenge in itself, lack of resources, of course, then leads to additional challenges. In some ways, this can be attributed to the fact that the operationalization of health equity is still somewhat new to many health departments, though the concept may have been around for some time. One respondent elaborated:

“In doing a lot of searching and talking to other communities and even talking to some of our grant managers I don’t get a sense that there’s, you know, a long list of places that have had a lot of success around health equity or have had really promising pilots and so that’s challenging.”



Additional detail is provided below on the ways that a lack of different types of resources have impacted health departments:

- **Lack of time:** The process of integrating health equity into workloads can be time intensive as it requires intention and “buy-in” from others, particularly leadership. This dependency on buy-in from external stakeholders or those in leadership lends itself to additional time constraints as the responses from stakeholders may be delayed due to bureaucratic reasons. Some respondents, additionally, shared that not everyone wants or is able to dedicate time to health equity projects or related activities as delays and disruptions are commonly experienced in this work. They provided examples such as the pandemic, civil unrest and staff turnover as more recent contributors to this barrier.
- **Lack of staff & associated skills:** The inability of some departments to acquire or retain trained staff was shared as a challenge in addition to the fact that some health departments are understaffed (e.g. some were reported as having as little as four people) and, thus, have limitations on the types and numbers of programs they can implement in their jurisdiction. This challenge of staffing acts as a barrier for health departments, not only in the administration of regular projects and programming, but also in obtaining new foundational programming that can address health inequity or insights that could improve upon current programming using some of the health equity actions previously mentioned. For example, engaging effectively with communities requires building trust which, in turn, requires consistency. High turnover in, or overburdened, staff can make navigating these relationships difficult, creating missed opportunities to engage communities and capture community voice.

“There is the ability to have some staying power and some institutional memory over time, and so you’re able to work with communities. If we keep starving public health, and health in general, people can’t. The staff turnover, there’s no institutional memory and you can’t, you go back to what [I] said before. You’re running one program, and so you’ll only work on something for three years and staff dissolves and goes away. So, you’re not retaining the people that you’re training and that’s a problem.”

- **Lack of health equity skills or training:** In addition to lacking adequate or less burdened staff, lack of existing or regular trainings around health equity can serve as a challenge to health equity and drug overdose work. This becomes especially challenging when trying to keep up with recent funding specifically intended to address health equity. One department reported that while funding is provided to “do the work,” they are still ill-equipped to do the work efficiently as the staff does not possess the adequate skills needed and has not received the training that would support them in this work.

- **Working in silos and lack of shared/consistent language:** With lack of staff and lack of health equity trainings representing significant challenges within organizations, the challenge of departments working in silos further restricts opportunities to address these challenges. As indicated above, partnerships within jurisdictions serve as a significant resource for pooling information, data and other resources across different organizations that can improve health equity and drug overdose prevention and response efforts. Not only does working in silos miss these opportunities, it leads to inconsistencies in both language and actions utilized to address the same or similar work. This is further impacted by top-down inconsistencies, for example, between the local and state level as one respondent reported. For some, terms like “health equity” and other concepts might feel academic in nature and have yet to find resonance at the community level. For others, health equity and associated terms are equated with race and communities of color, thus predominantly white communities may feel the term does not apply to them. On the whole, this challenge serves to weaken the possibilities for partnerships and collective action around health equity and drug overdose within and across jurisdictions.

“I think a big thing that we talked about earlier is training, specific training modules or opportunities or events [that] state health department representatives and all the way down to local community representatives would have the ability and the opportunity to attend because I think a big thing is getting everybody on the same page and seeing health equity and social determinants of health in the same way because, I think, there’s some variation in that, too. So, once everybody’s on the same page, getting people to come up with concrete plans of how to address health equity and social determinants of health in their communities.”

Lack of Funding

Undergirding many of the challenges mentioned above is funding. Although majority of respondents did not report a lack of funding, it still was cited as a significant challenge in more than one regard. Public health on the whole is poorly funded, especially when compared to other public sectors, making it far beyond the means of health departments alone to address (McKillop & Lieberman, 2021). Where available, existing funding and grants often fluctuate, making them difficult for departments to depend on for specific programmatic areas. One department shared that they’d recently lost a lot of funding and were currently in the process of acquiring more. Another spoke of a governor’s attempt to put forth a proposal to privatize public health that would have effectively bankrupted 50% of LHDs within the state in 3 years. Of further note, a lack of flexible and sustainable funding was the most highlighted barrier under this theme.

“[G]oing back to the funding mechanism, the way the health departments and the state health department are funded, most of the funds, 90%, -- 90 to 95% -- of the funding is designated. It has to be used in this way, it has to be used in this certain field. So, there’s no money, there’s almost no monies to shift over to be able to do things in a different way [...] And so, I won’t say money is necessarily the problem, but it is certainly a barrier.”

With restrictions on how funding can be used, this becomes a particularly significant barrier to departments that wish to engage their communities in more equitable ways. Throughout the interviews, respondents voiced frustrations as to how the lack of mechanisms to engage underserved communities tangibly (e.g., with financial or other compensation) and effectively hampers work or undermines progress made:

“CDC funding does not preclude us from using the funds for reimbursement or incentives for people to be at the table. NACCHO has gone out on its own and put extra barriers and precluded us from providing incentives for people to be at the table. I mean you want to talk about like a bureaucratic limit and engaging communities in authentic ways [...]. That’s a prime example of like how we as systems put bureaucratic barriers that don’t work in the community for community.”

Thus, while there may be funding provided to departments, restrictions on how and when funds can be used can serve as obstacles to sustaining traditional programming, let alone incorporating health equity into the work. With more adequate and consistent funding, many of the challenges identified above could be addressed and more tangible efforts to advance health equity could be sustained.

A Case Study: Written Commitment vs. Practice in Action

A well-resourced health department recognizes health equity in theory and has stated verbal commitments to the same, but the actions and practices of the department demonstrate otherwise. There was criticism on the approach leadership took in recognizing racism and white supremacy as a public health issue, attributed to the fact that persons in positions of power benefit from the current systems and structures and do not fully understand the community they serve and its needs. Retention of diverse staff is low and thus the staff population is quite homogeneous and not reflective of the community. This situation has created additional barriers preventing tangible integration of health equity into the work, most notably, a lack of trust for the health department and its leadership. Additionally, there is heavy reliance on secondary data which is not disaggregated by race, ethnicity or socio-economic status and, therefore, prevents the design and implementation of tailored interventions.

“We need to do more peer education. We need to be able to trust community members to be able to do the actual work – and people with lived experience, not just, you know, City Council person or somebody like that [who’s] talking about some of the best books that I know that do overdose.”

VII. PROMISING PRACTICES

Throughout the interviews, respondents shared their success stories, lessons learned and most valuable resources, all of which might be replicable, adapted, and/or provide inspiration for other departments. The following is an abbreviated list of promising practices, ranging from low-cost policies to large interventions.

Please note that these best practices are shared via direct quotes from key informants. Where possible, respondents were quoted at length to allow for additional information about the context, motivations, facilitators, challenges, and/or outcomes. One valuable path for future research would be to dive deeper into these recommendations to provide the additional context, identify opportunities for adaptation and replication, and determine relative impact. As is, these best practices are shared simply as inspiration.

- **Create a reference glossary of health equity terms.** *"[N]ot only [do we have] a specific definition of health equity, we [also] have a series of definitions around health equity, around race, around how we talk about race, how we talk about equity that we use across the department and that we use with our partners because we wanted to make sure that we were all consistent in our definitions. [It helps for all to know...] That when I talk racism, this what I mean. That when I talk about white privilege, this is what I mean."*
- **Compensate community voice.** *"One of the things I haven't talked about is making sure that [our work to integrate community expertise] isn't... a token conversation. We – we, the system, the structural system – tend to talk about having the voice of lived experience at the table, and then not thinking through the back end of that of, [for example], how do we compensate people for their expertise? We would compensate a speaker at a conference for their expertise. We need to be doing the same thing when we're asking people to share their thoughts, their opinions, their experience, their stories with us... [T]hat looks a little bit different and something we don't [yet] have in a formalized way, but something we've incorporated within grant proposals when we're trying to design an overdose spike alert system. Who better to tell us how to do that than people who need that overdose spike alert? So [we have started] incorporating [for example] stipend gift cards. How do we manage transportation for those folks [or address] if childcare's an issue? How do we provide that so that there aren't barriers for folks to participate? And sometimes the feedback we've gotten is, 'I don't need any of those things, I'm good, but if you could send me to a training or build my capacity and understanding of how Robert's Rules work.' The request is different for different folks but the important thing is to mak[e] sure that that piece of things is also covered and it's not just us taking from community but us really truly partnering and valuing that community voice around the table."*

- **Integrate participatory budgeting into finance practices.** *“One of the things that we've evolved in our budgeting and finance is getting community voice on how to spend some of our budget dollars. What's the community's priority area and how do we implement those dollars to support those community areas? Participatory budgeting is a new process for us, but something – again we're trying to incorporate equity into all components of what it is that we do.”*
- **Include health equity in all staff job descriptions, with full-time experts available for staff to consult.** *“[H]ealth equity... is a part of every single staff person at the public health [department's] job description. [There is] actually set aside time specifically to whatever their role is to incorporate health equity within that. We have two full time health equity coordinators at public health who provide a variety of things, so they coordinate trainings and opportunities for that. In addition to – well, we're a city and a county agency – so we both have the city equity team and the county equity team and are able to engage in those as well. [S]o we have a lot of structural training support in that space and then those two equity coordinators are also available for programs like overdose prevention.”*
- **Incorporate health equity into grant requests.** *What is “starting to happen is that ...health equity and social determinants of health [are starting to be directly] written into [grant funding]... [W]hich is great because then it's requiring grant applicants to incorporate that work into the work that they're doing. I think, from like a state health perspective, ...when they're giving contracts to local communities or local health departments, they're starting to do the same thing where that's becoming a required elements to incorporate into the work that they're going to do into the community to receive the funding, if that makes sense.”*
- **Create and track health equity indicators.** *“First, within our department of health... we worked specifically to create 15 core health equity indicators that are on our website that we use and are working to continue to gather the data and bridge that gap to bring it to a local level of measurement, in addition to the state-wide work. And then, within our overdose prevention efforts, this is an area where we are continuing to bolster and increase the level of data that we are collecting on that with race and equity indicators, thinking about some of the overarching SDOH. Right now, we do look at the death rate by race and ethnicity. We are [also] looking at rates of MAT [Medication Assisted Treatment] within a race and equity lens, but we have more work to do in terms of some of those key indicators.”*
- **Create pathways to leadership for (directly impacted) community members.** *“Our workgroups diversify our workforce in terms of community voice and [even advance] leadership development... [O]ne of my favorite success stories from health equity zones is [about] an individual who decided to be a resident navigator or volunteer participant [in a work group] and [then] became a community health worker and then ran for a local council and got on the board and now has an equity voice, you know to change policies, systems and the environment. I think that that is just the most critical element of the work that we do.”*

- **Meet others where they are at, literally.** *"I think that we're very good at meeting people where they're at... in [both] a theoretical sense and a tangible physical sense. [Because of] the rural nature of our state, we work really hard to make sure that we're able to get out and provide services across the state. For example, with our syringe services programming and our harm reduction services, we've established several mobile units that go out and provide those services to ...our most rural areas, in addition to our most populous areas. So, I think that our dedication to doing that sort of meeting people where they're at and making sure that it also comes down to people being willing to engage in those services [without stigma] and understanding that it's that engagement that ebbs and flows."*
- **Make data accessible.** *"Another example that we use is actually from our surveillance strategies. We have a social autopsy report that we have created [that] brings together data sets from multiple different departments...[W]e look at anyone that died due to a drug overdose in a given year ... and we look at where they had touch points with ... state entities prior to death and we try to determine what are the commonalities. So the vital statistics data that we get is one that really speaks to social determinants of health. All the contributors review it - it's reviewed at multiple levels - and the final level of review is to send it to the Commissioners of all the departments that are involved and ask them for recommendations about what can be done. One thing that that our Commissioner, the Commissioner of Health recommended last year, which I think will come together, is to have an overdose prevention panel where there's representation from all those contributing departments, so that they can review the data, where we're seeing trends in touch points prior to death and what sort of intervention and prevention, we can apply there."*
- **Build coalitions of partners within geographic – or topical – zones to better leverage individual resources.** *In this case, the interviewed state health department served as a convener, implementing a concerted strategy to create connections and build coalitions at the local level: "health equity zones were built back in 2015, coming out of an almost 10 year journey of engaging with and trying to address racial and ethnic disparities from either a population perspective, meaning specific groups, or supporting organizations individually that work with those vulnerable groups. We decided to move from that approach to more of a place-based approach where we invested in a place, defined by a community collaborative [...] So, we funded the support of that collaborative, we used the Collective Impact Model, so identification of a backbone organization, and then we require a community-driven assessment – not a needs assessment, but an assessment – that identified needs, gaps, trends at the community-level. Through a community prioritization process, identification of priorities, develop a plan of action, and then we work with them to implement the plan of action and find additional funding. [...] Initially, we had 10 health equity zones, they were funded for four years and they continue to be. We continue to support the infrastructure and then they go out for funding, and they've grown tremendously in terms of implementation [...] We are in the second reiteration of health equity zones so, from that initial group of 10, we shoot another [request for proposals] RFP last year for a second cohort. We*

brought four more health equity zones. [...] We are expanding another four through support – we have a grant from [...] Foundation that is investing in places [...] Every one of them is funded for a period of four years for implementation, developing of the collaborative, development of the assessment, plan of action, and then implementation for two years and then, after that, we support the infrastructure. It's funded through a braided funding model.”

- **Challenge inequitable dominant organizational culture and default practices.** Often times "easy" solutions are rooted in colonialism, white supremacy and disadvantaging marginalized communities: “Our agency has a very long history of perpetuating racism and colonialism and white supremacy and often the default option or the easy option is not the most equitable one... [S]o I think the biggest challenge is that you just have to not get complacent...[and] you have to constantly be challenging norms and attitudes and defaults and just kind of probing... [Asking,] ‘Is that really the best way or the only way this is done? Is this the default because it's the best and most equitable way of doing it or is it that's just the way that we've always done it?’ And so I think. That is ...[a] skill set - constantly challenging things... not in an adversarial way, but in an inquisitive [and] curious kind of way - to raise questions and get folks to consider their methodology and their approach.” As a hypothetical example, consider the agency’s current overdose response program where folks that present to an emergency department are paired with a peer wellness advocate – someone with lived experience – who can connect them to resources. “That program is dependent on connections with hospitals, so it has to be connected with the hospital and the hospital has to learn... that we call this 24/7 number for relay and they'll send someone and what the protocol is.... A lot of times when new initiatives start [- not necessarily the case for this program, but hypothetically -], things will start in wherever it's easiest to do it. [In this example], we want to work with the hospital. [People naturally default to considering] what hospital do we know well, or do we have connections... Oftentimes that could lead to things rolling out in a way that seems easy and logical but may actually end up focusing resources in areas that do not have the highest need like. Perhaps the overdose rates are the lowest in [...], but because the [health department's] directors have connections with the hospital in [...], that's where the [pilot] program starts. That's wonderful for folks presenting to the hospital in [...], but if the greatest rate of overdoses are in [for example] [...], then the harder but more health equitable [place to pilot] would be that.... [You need to consider whether you are starting programs] in the area with like the highest need that would make the biggest difference and reduce disparity the most. Or is the program launching in the place where we have connections and connections [that are themselves] often historically rooted and perpetuate in inequity.”
- **Ensure careful and compassionate word usage within materials.** “[W]e've created a glossary that focuses on person-centered language as a standard for [training] new employees and [for use] when creating materials and sharing things with other sites. [The glossary provides] language that is compassionate [as well as] words that shouldn't be used, even if they are used by the community themselves... [The goal is to] utilize this compassionate language, while still respecting that people who use can say whatever they want and identify however they choose to do so.”

VII. RECOMMENDATIONS

In the course of the environmental scan, respondents provided several recommendations and requests of federal and national entities, such as NACCHO and the CDC, that could vastly improve their health equity efforts at the state and local levels. These focused on funding and accessibility of resources, so include:

Funding

- Explicitly incorporating health equity and SDOH considerations into funding requirements and contracts for federal-level pipeline opportunities
- Developing more flexible funding structures in order to better allow health departments to apply funds toward a variety of health equity actions. More flexible funding structures would allow jurisdictions to:
 - Compensate community members with lived experience for their time, experience, and expertise. This would, then, allow them to formalize and sustain the integration of community voices into health equity work, an essential need shared by more than one health department
 - Provide overdose assistance funding to local organizations and partners that play a significant role in responding to, mitigating, or preventing overdose within their jurisdictions
 - Shift more of their health equity work upstream. As is, current regulatory guidelines and RFA policies push organizations to work more downstream or create barriers to achieving health equity
- Providing technical assistance or expert support on how best to navigate funding mechanisms and opportunities, and
- Grantors can, additionally, provide guidance as to training or skills needed to do health equity work most effectively

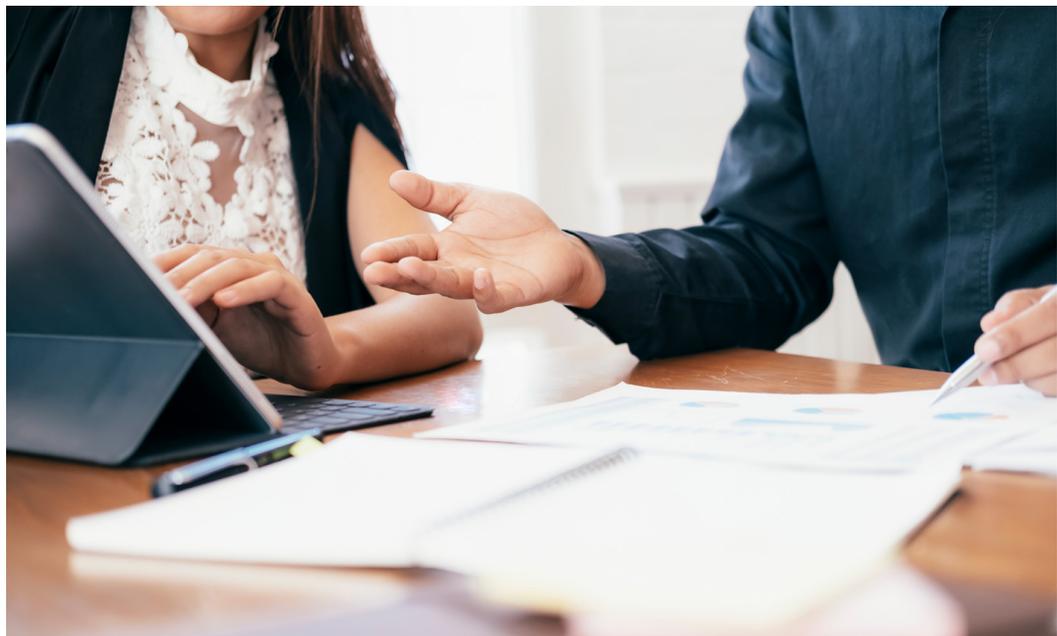
Trainings, Data, Toolkits and Other Resources

- Broadly, national and other external entities (i.e., NACCHO, CDC) working to address health equity can ease the burden of searching for and adapting health equity trainings, toolkits, large-scale datasets, and other resources for stretched health departments. In addition to curating, adapting, and archiving these resources, these organizations can ensure they are disseminated broadly and made accessible at the local level
- In developing or adapting trainings around health equity, national organizations can provide tailoring of trainings to different audiences. Considerations for tailoring trainings can include:
 - Geography, size and location, for example, local vs state or rural vs urban. Each type of jurisdiction might carry its own unique set of challenges or characteristics and be better suited to implement some health equity strategies over others
 - Providing a shared language and baseline knowledge around health equity that would facilitate subsequent collective action to address health equity and SDOH among partners
- In the use of datasets, departments also encouraged the use of documented standards for the collection of demographic data
- State and federal officials should provide clear, explicit, and consistent communication that health equity is a stated priority. The lack thereof was a recurring theme among the departments interviewed that served as a challenge to integrating health equity into their overdose practices.

Whilst more local jurisdictions are responsible for doing the on the groundwork of directly responding to and mitigating drug overdoses in their communities, leadership at the state and national level play a significant role in determining what is possible for these jurisdictions at the local level, and leadership at the national level for states. As indicated under Challenges and Recommendations, this role can either limit opportunities to advance health equity in drug overdose prevention and response or it can support efforts to take advantage of and expand the existing opportunities. Therefore, it is important that leadership at these state and national levels be bolder in our imaginings and actions to advance health equity by leveraging our roles to better respond to the needs expressed at the state and local levels.

IX. CONCLUSION

This environmental scan provided a host of insights into current activities, as well as existing barriers and facilitators, experienced by state and local jurisdictions in their efforts to advance and integrate health equity practices into drug overdose work. Future scans and research can dive deeper into the specifics of what creates these barriers and facilitators, and how best to create or navigate opportunities to address or utilize them. For example, further research and evaluation on how to prevent or overcome challenges, or on the promising practices shared in this report and the specific factors that might enable jurisdictions to adapt or implement them. These findings and recommendations serve to provide key insights on how we might continue to further efforts to advance health equity in drug overdose prevention and response, and inspiration for areas of further exploration.



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1201 I Street, NW, Fourth Floor • Washington, DC 20005

Phone: 202.783.5550 • Fax: 202.783.1583

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