**NACCHO Performance Improvement Teleconference Webinar Series
May 10, 2012**

**Speaker: Mikhaila Richards, Senior Program Analyst-Health Equity and Social Justice, NACCHO**

**Moderator: Mary Kate Allee, Senior Program Analyst-MAPP, NACCHO**

**Introduction**
Mary Kate provided the following introduction to the call:

* This is NACCHO’s seventh performance improvement webinar. This has been a monthly webinar series aimed at responding to timely, common technical assistance (TA) requests of local health departments (LHDs) related to accreditation and quality improvement, community health assessment and improvement planning processes, Mobilizing for Action through Planning and Partnerships (MAPP), and more. Webinars are meant to be informal and interactive. We have piloted a variety of formats and based on your feedback make modifications. We thank those of you who have participated in previous calls for completing the evaluation. We are working to be responsive to your feedback.
* In the future, these webinars will be held on a bimonthly basis, with the next webinar occurring in July. We will continue to advertise these webinars in the same way, including to those who registered for this webinar.
* A recording of this call along with the PowerPoint slides are available at [www.naccho.org/piteleconference](http://www.naccho.org/piteleconference).
* As always, NACCHO staff are available to answer questions and provide timely and effective TA for all performance improvement needs.  NACCHO responds to submitted questions not addressed on the call individually via e-mail.
* This webinar was focused on a theme based on the types and number of questions staff received related to health equity in community health improvement planning.
* The presenter on this webinar was Mikhaila Richards from NACCHO.
* Mary Kate turned the webinar over to Mikhaila to introduce the topic.

**Content:**

The learning objectives for this webinar were to:

1. Define health inequity in a way that accounts for structures, processes and decision making.
2. Discuss types of information necessary for assessing and addressing health inequities in a community.
3. Identify tools for further understanding and measuring of health inequities as part of a community health improvement process.
4. Discuss experiences of local health departments with applying a social justice framework to community health improvement planning.

NACCHO’s work and this presentation are guided by several core assumptions about the definition of health and the role public health. These assumptions include:

1. Health is an asset or resource required for human development and well-functioning communities. Health is more than just an end; it is also an asset or resource.
2. Health is socially and politically defined. It is important to consider the relationship between cultural, social and environmental conditions and an individual’s health
3. An accumulation of negative social conditions and a lack of fundamental resources contribute to health inequities. This happens across generations and a person’s lifespan.

**Questions**

The following questions were posed and answered by Mikhaila during the webinar:

1. *What is social justice? Why is social justice important to consider in community health improvement planning work?*

There are many interpretations of social justice, but common themes include an emphasis on the dimensions of justice, the systemic character of injustice, and the cumulative affect on health and well being rather than on individual or legal rights. Social justice focuses on well-being, sustaining flourishing human existence, meeting fundamental needs, and minimizing oppression. There are four important social justice principles to consider when doing this work:

1. Social and Economic Equality: This is not referring to the redistributing of wealth and income. It refers to social hierarchies, power, influence, living conditions, and access to resources. These reinforce each other and produce a domino effect of disadvantages.
2. Political Equality and Democracy: Democratic decision-making ensures that no group has a disproportionate advantage of influence in shaping life conditions. Representation is essential in a well-functioning society as it provides an institutional means for people to participate in social and political life.
3. Liberation and Emancipation: This takes on many forms, including the freedom from having to conform to a dominant culture as well as freedom from social exclusion and marginalization. This is achieved through group representation in society, freedom of expression, and affirmation of and respect for group differences.
4. Autonomy: Groups have control over, or freedom from, oppressive conditions in their social, political and work lives.

We can see health inequities in many health outcomes: diabetes, HIV prevalence, infant mortality, etc. These inequities are increasing and research has documented a connection between the lived experience, social injustice and inequities in rates of illness and death in different populations.

1. *What is health inequity? How does it differ from health disparities and the social determinants of health?*

Several national initiatives make mention of health disparities and social determinants of health including Healthy People 2020 and the Public Health Accreditation Board standards. This presentation discusses health inequities, which focuses on a system of decision making and institutional and structural relationships. Health inequity refers to systemic differences in health status that are unnecessary, avoidable, unfair and unjust. They result from unequal structuring of life chances based on social and economic inequalities that are built and sustained over time and generations. These are growing rapidly and are beyond the control of individuals. They injure health by changing biology.

Health disparities refer to a disproportionate burden of illness across the population. This does not address the fundamental social justices that cause inequities

The social determinants of health refer to the economic and social conditions that influence the health of individuals, communities, and jurisdictions as a whole. This includes food systems, transportation systems, employment, etc.

There are several models or frameworks that can be used to look at health inequities. This can be helpful in community health improvement planning, as it can influence the visioning and planning processes that follow.

1. The first model is the Determinants for Population Health framework. This can guide data collection in a way that helps to assess and monitor based on theories of population health. This model focuses on communities and context and delineates major influences on health, all of which can help to define an assessment or research agenda.
2. The second model—is the Bay Area Regional Health Inequities Initiative (BARHII) framework. Please note this framework may soon be updated to stack the first two boxes on the left (Institutional Power and Social Inequalities), as these two concepts are linked. This framework was developed in 2006 in an effort to promote greater understanding of the social determinants of health and the link to health inequities. It shows the path of the risk of mortality and morbidity and risk factors and challenges health departments to shift their attention to upstream factors. While individuals are responsible for behavior change, an individual’s behavior is connected and determined by the social environment.

1. *How can public health affect change?*

Local public health representatives can affect change in a number of ways including:

* Acting as facilitators and mediators;
* Being present at meetings and hearings to discuss decisions being made regarding urban planning;
* Having access to data;
* Influencing decisions by inclusion and;
* Supporting communities, especially those historically excluded from participating.
* Community health assessments are a way to do this and expose social injustices
1. *How do I conduct a community health improvement process within a social justice framework?*

It is important to note that there is no step-by-step process to conduct a community health improvement process within a social justice framework. Rather, using a social just framework is based on a set of actions that build capacity among staff, hire the correct people, build alliances and ask the right questions. It is important to recognize the differences that exist between the traditional and social justice frameworks that look at health issues. Specifically, questions asked are never neutral—they are formed within social, political, historical and cultural contexts and driven by agendas, values and priorities that may not address community needs and wants.

There are actions that can be taken throughout the community health improvement process that can help the community move towards addressing health inequities.

* Prepare and plan:
	+ Choose a model that accounts for decision-making processes and institutional power.
	+ Assess workforce competencies and organizational standards for eliminating health inequities as a part of an overall assessment of competencies and organizational standards. There is an [Organizational Self-Assessment for Addressing Health Inequities Toolkit](http://www.naccho.org/toolbox/tool.cfm?id=2216&program_id=22) that provides public health leaders with tools and guidelines that identify skills, organizational practices and infrastructure needed to address health inequities.
* Engage community:
	+ Adopt a social justice framework for community engagement that integrates social justice principles. This includes support for participation the autonomy of communities being served.
	+ Define the community honestly and clearly. This can be complicated as a particular definition of community is not always relevant to everyone. Be sure to define community in a way that is not a euphemism, or that refers to a historically marginalized group.
	+ Refer to Contra Costa Health Services’ [Ladder of Community Engagement](http://www.barhii.org/resources/ladder.html)  and aim for comprehensive community consultation, bridging, and power-sharing.
* Developing vision
	+ Create a vision for what the health assessment will include as well as how health issues will be prioritized and how the community will develop and implement the health improvement plan. This also includes the vision for a healthy community. It is important to work with the community and stakeholders to advocate for a vision that emphasizes eliminating health inequity. This will establish the framework for future work.
* Conduct the health assessment
	+ Utilize indicators that account for inequality, social conditions and institutional decision-making
* Prioritize health issues:
	+ Solicit community input as part of comprehensive community consultation
* Develop the health improvement plan:
	+ Advocate for strategies that address inequality in social conditions, and institutional decision making, keeping in mind the principles and historically legacy of social justice.
	+ Refer to past and ongoing health improvement initiatives in jurisdictions that have used a social justice framework. NACCHO can connect local health departments to facilitate this.
* Implement
	+ Implement the community health improvement plan with the community and the local public health system partners.
	+ Support community initiated and directed actions.
* Evaluate and Monitor
	+ Constantly refer to the vision that emphasizes eliminating health inequities.
1. *What data are necessary for assessing and addressing health inequities in a community?*

There are many options or sample domains/areas that can be used and within each domain are a number of indicators that can be used. One example is economic security and financial resources. To measure this, you could look at wealth and access, owner-occupy homes, assessed value of land, average number of vehicles, or average mortgage amount. This data can be obtained from the US Census, local tax assessors, the local office on housing, or the office on planning and zoning.

Another example is access to capital which shows access to resources. This can be measured by approval rates for home purchases, the number home purchases per mortgage application, or the average rate of mortgage approval. The [Home Mortgage Disclosure Act](http://www.ffiec.gov/hmda/) resources can provide these data points.

The following questions were posed by participants during the webinar:

* *Thinking about the BARHII Framework, there is some pushback on focusing only on race and ethnicity and other social inequities as some people feel that there should be a focus on mental illness and disabilities. How do these populations fit in this framework?*

It is important not to place oppression in any sort of hierarchy. NACCHO sees the core injustices (class, race/ethnicity, gender) as the root of all of the inequality that we see. For example, mental illness is linked to what is seen as a productive member of society within a specific framework about being a good worker. This is linked to issues of class and power and the distribution of resources. People with disabilities can be seen as not fitting in to a typical mold based on gender. These populations are not excluded from this model, because the root causes are still linked to these core injustices.

* *What suggestions do you have for smaller communities where numbers are too small for data analysis—particularly within smaller subgroups? What should be done if the N is too small to have statistically significant data?*

It is important to note that quantitative methods are not the only way to collect data as part of an assessment. Qualitative data collection methods are also important and are just as useful for assessing the health status of a community. Within the Mobilizing for Action through Planning and Partnerships (MAPP) framework, as part of Phase 3 (Collecting Assessment Data), communities collect both qualitative and quantitative data, and there is rich data that can be collected qualitatively to add to the assessment.

* *When prioritizing health issues, what are some different decision-making models that promote and prioritize health equity?*

There are not specific models to do this work, but one way to start it to structure the work to address social injustice. This may require reorienting staff to understand dimensions of power and privilege and how they work and interact in relation to partners and community members; developing leadership that will negotiate and push for an agenda that includes social justice and; thinking about how to assess structural issues in data collection. When prioritizing health issues, a community needs to think about what they are currently doing and how it can be changed to reflect community concerns and expertise to guide priority areas. This may result in not creating a new program or service that only focuses on individual behavior. Priority areas may involve looking at policies and practices that affect the health and wellness of a community. In the MAPP framework, as part of Phase 4 (Identifying Strategic Issues), there are techniques that can get at underlying or root causes of diseases or issues. For example, if people are passionate about a specific disease, you can use a [fishbone diagram](http://www.naccho.org/topics/infrastructure/mapp/framework/clearinghouse/loader.cfm?csModule=security/getfile&pageID=230521) to get at the root causes and policy implications of that disease and see the structural changes that need to occur.

* *Does NACCHO support avoiding words such as “class,” “injustice,” and “equity,” when speaking to popular audiences, especially in this political environment?*

NACCHO’s perspective is that part of the work of addressing social injustices is to name them clearly. However, popular audiences do need a way to understand this work and we need to find a way to discuss issues of privilege and power and enfranchise and include as many people as possible. There is discussion in the field about whether it is worth focusing on a sector of the population that is ideologically opposed to this frame of thinking, or if we should focus on building a coalition or alliance of people that are already poised to understand this work and need the support of others to be successful. It is difficult to fully confront these issues without naming them.

**Resources**

* *Tackling Health Inequities Through Public Health Practice: Theory to Action*, Richard Hofrichter and Rajiv Bhatia, eds.
* *Roots of Health Inequity: A Web-based Course for the Public Health Workforce* ([www.rootsofhealthinequity.org](http://www.rootsofhealthinequity.org))
* [NACCHO’s Community Health Assessments and Community Health Improvement Plans for Accreditation Preparation Demonstration Project Resources for Social Determinants of Health Indicators](http://naccho.org/topics/infrastructure/CHAIP/upload/Final-Resources-on-Social-Determinants-of-Health-112811.pdf)
* The Bay Area Regional Health Inequities Initiative ([www.barhii.org/](http://www.barhii.org/))
* The Alameda County Public Health Department ([www.acphd.org/](http://www.acphd.org/))
* Connecticut Association of Health Directors ([www.cadh.org/health-equity.html](http://www.cadh.org/health-equity.html))
* San Francisco Department of Public Health’s Healthy Development Measurement Tool ([www.thehdmt.org](http://www.thehdmt.org)*)*
* County Health Rankings and Roadmaps ([www.countyhealthrankings.org](http://www.countyhealthrankings.org))
* The Diversity Data project (<http://diversitydata.sph.harvard.edu/>)