Health Equity Guide for Public Health Practitioners and Partners

November 2019

Second Edition

Prepared for the Delaware Division of Public Health

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

UNIVERSITY OF DELAWARE
BIDEN SCHOOL OF PUBLIC POLICY & ADMINISTRATION

Health Equity Guide for Public Health Practitioners and Partners, Second Edition

Delaware Department of Health and Social Services
Division of Public Health, Community Health

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FOREWORD by Dr. Rattay

When I started as Director of the Delaware Division of Public Health (DPH) in 2009, I identified several priorities for DPH. Among those priorities was achieving health equity in Delaware. Over the past several years, DPH staff have worked with many of you — community leaders, representatives from non-profit organizations, other state agencies and community stakeholders — to develop and implement a strategy to reach our vision of “health equity for all Delawareans where everyone will achieve their full health potential.”

In 2015, we produced the Health Equity Guide for Public Health Practitioners and Partners to support this strategy and our work around the social determinants of health. We have heard from many of you that this guide has been a valuable resource to enhance our collective work to move upstream to improve the conditions that create not only health, but also the inequities related to health. I believe we have made progress working together to create healthier communities, but there is much more to be done. We present this updated guide (2nd edition) to further support our efforts to advance health equity, which is as important as ever.

I am happy to report many positive changes in the state’s health profile since our first edition of the guide was published in 2015. For instance, the percentage of adults who smoke in our state continues to drop; our air quality, as measured by the level of air pollution, has improved in recent years; and the percentage of young people who graduate from high school has increased. Death rates from cancer have been declining, and we have seen an improvement in all-site cancer mortality among black men, in particular, leading to a reduction in racial disparities in cancer-related deaths. We have also made (and continue to make) improvements in the delivery of health care and public health services in our state. For instance, we have increased the number of mental health providers and are working to better integrate behavioral health care with primary care. Along with many community partners, we are also making lasting investments in the social determinants of health at the local level through the Healthy Communities Delaware initiative.

Yet even as our overall health profile improves, we still have persistent health inequities in our state. Black babies still die at a rate that is more than two and half times that of white babies, and that gap is getting worse, not better. The gap in life expectancy between blacks and whites in our state also increased slightly since 2015. We still see differences in many health indicators according to “place,” with Kent County experiencing the highest rates of adult obesity, for instance. Differences in community conditions and resources still lead to dramatic differences in health, such that life expectancy varies by as much as 16 years across Wilmington neighborhoods.

I believe these inequities are unacceptable and they will persist unless we are purposeful in our efforts to close the gaps. Our mission at the Division of Public Health is to protect and promote the health of all people in Delaware. I continue to be concerned that many of our residents are not achieving their potential for health because of their skin color, language, immigration status, disability status, gender, or other characteristics, putting them at a disadvantage compared with the majority of Delawareans.

Health inequities may be partially blamed on our economic environment and are certainly not unique to Delaware. However, as our political climate appears increasingly divided, I feel a sense of urgency to address the differences we see in health, particularly those differences that arise from social inequities. To that end, we have added a chapter to specifically call attention to health inequities arising from racism. Despite what we would like to believe, racism is NOT just a historical phenomenon. Whether intentional or unconscious, racism persists at the individual and the institutional levels and is harmful to the health of mothers and babies, men and women, and your neighbors as well as mine, across our state. As a field grounded in social justice, it is incumbent upon public health workers to confront racism in all of its forms more directly. As a human being and a member of one human family, this is a moral imperative for me. For those who might not share my values, or a social justice orientation that is characteristic of public health practitioners, addressing racism makes practical sense; because the existing system undermines the well-being of entire communities and other investments we make in health care, education, and social services. In public health, it is often the case that “a rising tide lifts all boats” because creating healthy communities is good for all of us.

This work is not for the fainthearted. I am grateful to my staff and our community partners who do the work of social justice for public health every day. Your energy, expertise, and commitment make me optimistic that we will indeed achieve our vision of health equity for all Delawareans and that everyone will achieve their full health potential. This new version of the Health Equity Guide has been refreshed with more recent data, new ideas and approaches, and a renewed commitment social justice and equity. I challenge all of us to keep advancing our efforts, and look forward to working with you.

Karyl T. Rattay, MD, MS

Dr. Karyl Rattay, Director of Delaware Division of Public Health

SECTION 1: Introduction

Imagine a roaring river in the mountains. You and a friend are observing the peaceful scene when a person appears in the middle of the rapids calling for help. You have to save him!
You jump into the river and pull him safely to the bank. Not long after, a few more people appear in the water, calling for help. Then a whole crowd is in the rapids, calling desperately for help. They are going to drown if you and your frienddo not save them.

Your intuition tells you to run upstream and see why so many people are falling into the river. Your friend, frustrated, confused, and concerned about the people that urgently need to be saved, can't seem to understand why you would do such a thing. But you know that you cannot keep up

with the throngs of near-drowning people.
When you reach the top of the rapids,you clearly see why so many people are falling in. There is an old, decrepit bridge that people are trying to cross, not realizing that it is unsafe. They will continue to fall in by the dozens and drown downstream if you do not fix the bridge or put up a fence to prevent them from trying to cross.

* * *

The stream parable, which is frequently recited in relation to prevention, illustrates a major contributor to the current health crisis in our country. For too long, too much attention and effort has focused downstream, treating the results (or symptoms) of the upstream problems, leading to excessive health care spending and relatively poor health outcomes. Since public health has traditionally been a field grounded in prevention, public health professionals generally appreciate the need for moving upstream to improve the public's health, even as they encounter barriers and resistance to upstream health interventions. Public health professionals promote healthy behaviors; ensure access to prenatal care; advocate for clean air; and ensure safe water and food, among many other upstream preventive health strategies. In a sense, they build fences and mend bridges. However, there is more to the story…

• • •

As you look farther upstream, you notice bridges in various states of repair along the river. Some are strong, made of sturdy components. Others are weak and debilitated, with missing boards or flimsy railings. It doesn't surprise you that most of the people falling in the river are crossing the poorly made bridges, while those individuals that live near or travel across the strong bridges are protected. Of course, all of the bridges could use more reinforcement, but it's easy to see which bridges need the most attention.

• • •

The health profile of the United States reflects persistent inequities in health. It is becoming increasingly evident that we must look farther upstream to identify and address the underlying conditions that create such inequities if we expect meaningful changes in health outcomes. These underlying conditions are often referred to as social determinants of health, and include things like education, early childhood conditions, income, housing and neighborhood conditions, and workplace characteristics (Marmot & Wilkinson, 2005). The conditions in which we live, learn, work, and play are the primary determinants of health; investments in these areas will help to improve health outcomes for everyone (Marmot & Wilkinson, 2005). Importantly, however, differences in these underlying conditions are the root causes of inequities in health (Graham, 2004).

In the stream parable, certain groups of people are more likely to fall into the river than others. They do not fall in because of individual weakness or intrinsic flaws. Rather, some people are privileged to live in communities with strong bridges, usually made of high-quality materials that protect them from falling into the river and promote their safe passage across. Members of other groups, often characterized by gender, race, socioeconomic status, sexual orientation, gender identity, age, or disability status, are more likely to live in communities with poorer quality bridges. So while we need to move upstream to prevent people from falling in, instead of directing the majority of our efforts to pulling people out, we also need to ensure that all of our communities have strong bridges.

Purpose

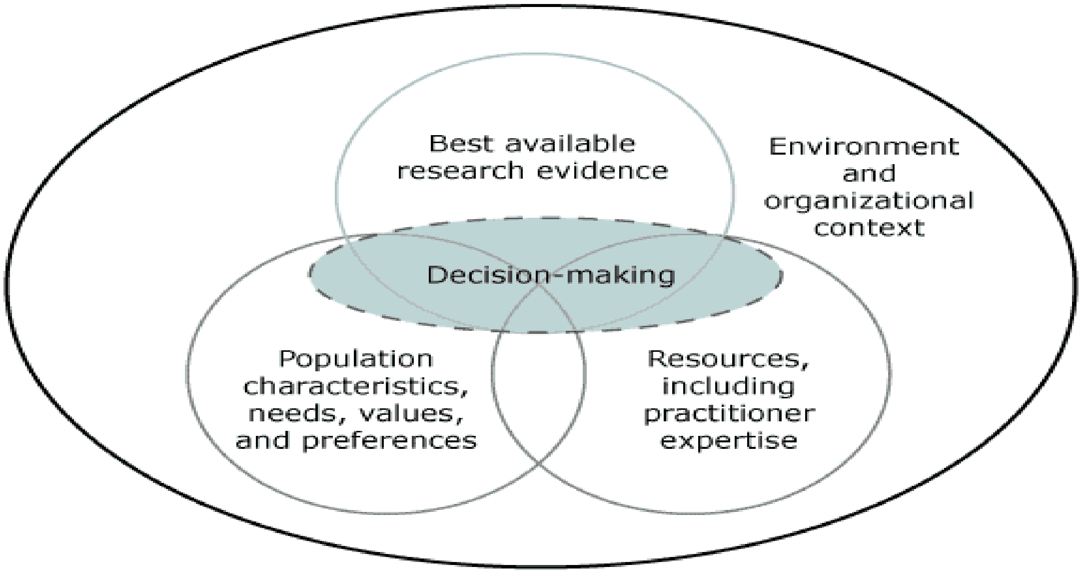
The purpose of this updated guide is to provide the most current evidence and strategies to assist the Delaware Department of Health and Social Services (DHSS), Division of Public Health (DPH) and its partners in moving farther upstream to address the underlying causes of health inequities in Delaware's communities. Based on recent advances in our understanding of the root causes of health inequities, the guide now incorporates a racial justice framework in order to better understand and address the ways in which structural racism creates and perpetuates health inequities. By raising awareness of the social and structural determinants of health and sharing strategies and lessons learned, the goal is to enhance our collective capacity to foster optimal health for all Delawareans.

The original guide was created to support DPH in the implementation of its health equity strategy. This continues to be a major driver of this effort; progress has been made but challenges remain and the work of advancing health equity in Delaware is ongoing. The guide's early development was influenced by several national efforts to promote population health and achieve equity in health including the U.S. Department of Health and Human Services' (DHHS) Action Plan to Reduce Racial and Ethnic Health Disparities, the National Partnership for Action's National Stakeholder Strategy for Achieving Health Equity (http://minorityhealth.hhs.gov/npa/) and Healthy People 2020 (http://www.healthypeople.gov/2020/default.aspx). The guide is also aligned with the Patient Protection and Affordable Care Act and related efforts to transform the health care system in Delaware (http://dhss.delaware.gov/dhss/dhcc/cmmi/). This updated version of the guide relies more heavily on scholarly literature, particularly in the new section on structural racism, but includes evidence from technical reports, websites, and other practical tools and resources. Much of the material provided in the guide is publicly available and/or reproduced with permission. References and web links for additional information are provided as appropriate.

It is important to note that efforts to achieve health equity through community change and improvements in the social determinants of health are emergent in the scholarly literature. Terms like "best practices" and "evidence-based practices" are difficult to interpret and apply when working with communities. This is because community-based and community-oriented work is, by definition, unique to each community. Public health practice must embrace the preferences of the targeted population or community in addition to considering the needs, assets, and resources of that community.

Figure 1 is a model of evidence-based practice developed by Satterfield and colleagues (2009). It illustrates the complexity of research translation in public health practice by putting decision-making at the intersection of research, community characteristics, and available resources. This model is particularly relevant to efforts to promote health equity, given the heightened attention to community empowerment and social context in a health equity approach, which is described in greater detail later in this guide. Because of the complexity involved in making informed decisions to achieve health equity, this guide is a compilation of promising approaches, informed by the literature, that are meant to be adapted for community needs, assets, preferences, and available resources. It reflects the dynamic nature of the social and environmental context that can vary by place and by time.

Figure 1: Domains that influence evidence-based decision making in public health



Source: Satterfield JM, et al., 2009. Retrieved from https://www.cdc.gov/pcd/issues/2012/11_0324.htm.

The contents of this guide are based on priority professional development needs that were identified when DPH developed its health equity strategy. Revisions and additions in this updated version are based upon feedback received on the first edition, as well as our understanding of the evolving nature of health equity work and public health practice. This updated version also includes the most recent data available at the national and state levels, including new maps and data on infant mortality across Delaware communities.

Although the guide is not comprehensive, it provides a foundational understanding of important concepts related to health equity. It also includes links to supplemental resources and tools where appropriate. Each section includes a glossary of terms, which serves to promote a common language. Feedback on the guide, including updates or areas needing greater attention or detail, should be addressed to:

Division of Public Health
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417 Federal St.
Dover, DE 19901
http://www.dhss.delaware.gov/dhss/dph/mh/healthequity.html

References and Additional Resources

Graham, H. (2004). Social determinants and their unequal distribution: Clarifying policy understandings. The Milbank Quarterly, 82(1), 101-124.

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SECTION 2: Background

This section provides information regarding the population health profile of the United States, including statistics that highlight the various types of health inequities (and their magnitude) seen across the country. It defines key terms and summarizes select national efforts to advance health equity through a “social determinants of health” lens. Included is a brief summary of DPH’s efforts underway over the past several years – efforts that created the need and opportunity for this document. It concludes with a set of suggested principles and values to guide our future work in Delaware.

Health Profile of the United States

Despite being one of the wealthiest countries in the world with an abundance of health-related resources, the U.S. has poor health compared to other countries. In an analysis of health outcomes, the U.S. showed a “strikingly consistent and pervasive pattern” of higher mortality and poorer health beginning at birth when compared to 16 high-income nations, including: Australia, Austria, Canada, Denmark, Finland, France, Germany, Italy, Japan, Norway, Portugal, Spain, Sweden, Switzerland, the Netherlands, and the United Kingdom (National Research Council and Institute of Medicine [NRC & IOM], 2013). Specifically, the U.S. fared worse in nine domains when compared with the average for peer countries, including: adverse birth outcomes, injuries and homicides, adolescent pregnancy and sexually transmitted infections, HIV and AIDS, drug-related mortality, obesity and diabetes, heart disease, chronic lung disease, and disability (NRC & IOM, 2013).

Life expectancy is often used as an indicator of the overall health of a community or population. In the U.S., average life expectancy peaked in 2014 at 78.9 years, but has decreased since then to 78.6 years in 2017 (Murphy, Xu, Kochanek, & Arias, 2018). According to Dr. Robert Redfield, Director of the CDC,

> “The latest CDC data show that the U.S. life expectancy has declined over the past few years. Tragically, this troubling trend is largely driven by deaths from drug overdose and suicide. Life expectancy gives us a snapshot of the Nation’s overall health and these sobering statistics are a wakeup call that we are losing too many Americans, too early and too often, to conditions that are preventable.” (CDC, 2018a)

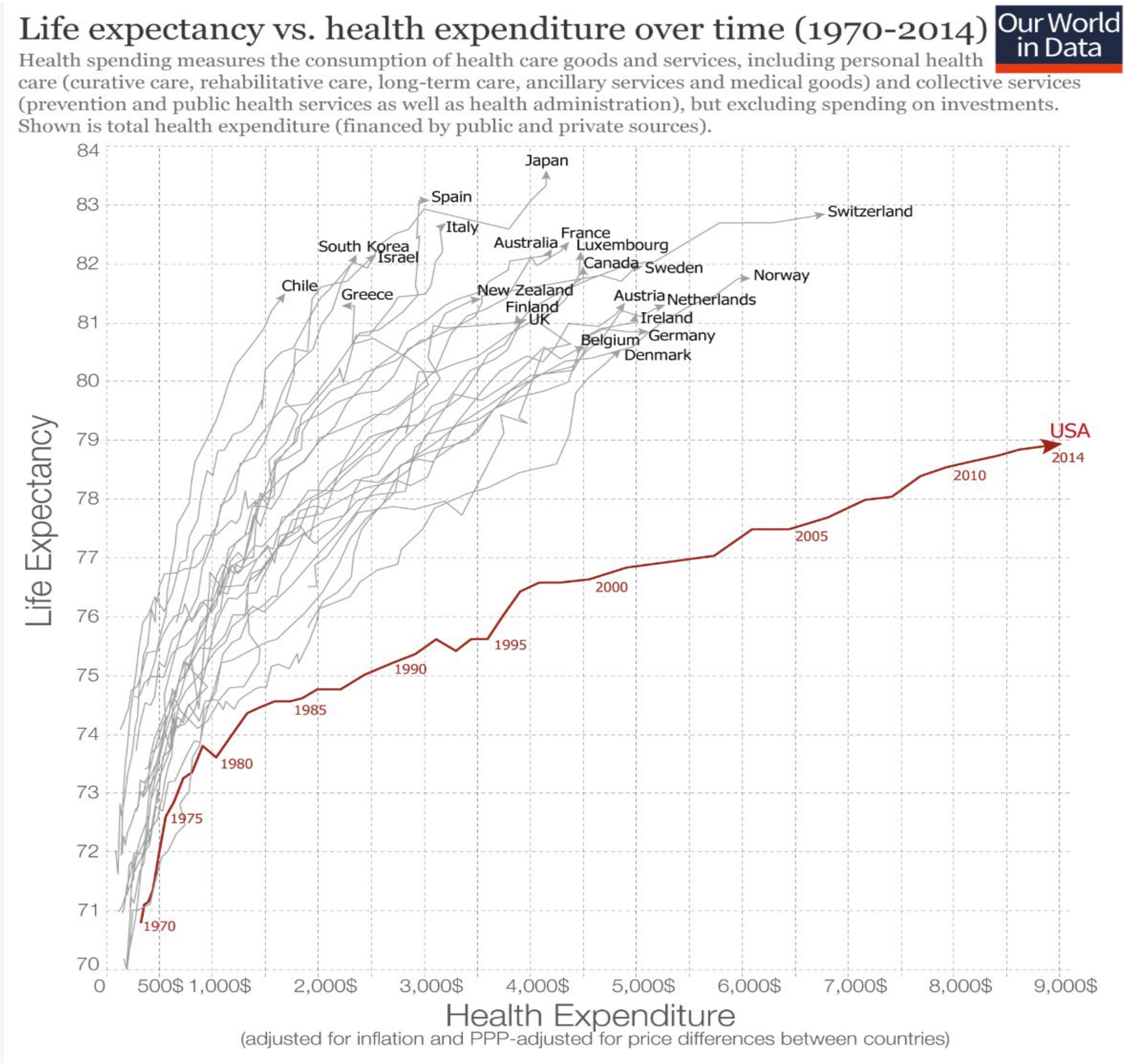
The U.S. also ranks near the bottom among wealthy developed countries (and some developing countries) in infant mortality, which is another indicator frequently used to describe the overall health of a population. Specifically, the U.S. ranks 170th in the world, with an infant mortality rate of approximately 5.80 per 1,000 (Central Intelligence Agency, 2019).

Of particular concern is that these indicators are moving in the wrong direction, with the U.S. falling in the rankings in recent years and with some indicators getting worse. For instance, the premature death rate, which is the number of years of potential life lost before age 75, has increased across the U.S. for the fourth consecutive year (UFH, 2018). Contributing factors in this increase include drug-related deaths which have increased 25% since 2015; suicide deaths which have increased 16% since 2012; and occupational fatalities which have increased significantly since 2015 (UHF, 2018).

In addition, more than 30% of U.S. adults are obese, and deaths from cardiovascular disease have increased since 2015 (UHF, 2018).

As we consider the immense resources the U.S. allocates towards health care compared to other wealthy developed nations, it is also clear that we are not receiving a good return on our investment (Figure 2). As this graph indicates, life expectancy generally increases with expenditures; however, the U.S. is a clear outlier in terms of high expenditures and lower life expectancy. The flatter curve for the U.S. indicates that increasing investments do not equate with improved life expectancy as may be true in other higher income countries.

Figure 2: Life expectancy versus health expenditure over time, by country, 1970-2014.



Source: Ortiz-Ospina & Roser, 2019; Health expenditure data from the OECD, Life expectancy data from the World Bank; Reproduced from OurWorldInData.org. Retrieved from [https://ourworldindata.org/financing-healthcare.](https://ourworldindata.org/financing-healthcare)

Healthy People 2020, the national strategic plan for improving the health of all Americans, provides a comprehensive set of 10-year goals and objectives with targets for health improvement (see www.healthypeople.gov). A Mid-course Review produced by the U.S Department of Health and Human Services (DHHS) in 2017 shows progress on many indicators. For instance, fewer adults are smoking cigarettes and fewer adolescents are starting to smoke. Similarly, deaths from motor vehicle crashes are down, as is the number of high school students who report driving with someone who had been drinking alcohol. However, most indicators of mental health have gotten worse, including an increase in the age-adjusted rate of suicide and in the percent of adolescents with major depressive episodes. Other indicators show mixed results (U.S. DHHS, 2017).

Health Differences

Differences in health among different groups of people, often referred to as health disparities, are well documented, persistent, and increasing in many areas across the United States. These differences in health among groups may be viewed in the context of race, gender, income, education level, or geographic location, among others. Examples of such differences are highlighted below:

Health varies by race:

- Infant mortality rates are highest for non-Hispanic black women (11.4), and American Indian/Alaska Native women (9.4). Non-Hispanic black women experience a rate 2.3 times that for non-Hispanic white women (4.9) and over three times that for Asian women (3.6) (CDC, 2019a).

- Non-Hispanic blacks can expect to live approximately 77.9 years, while non-Hispanic whites have a life expectancy of 81 years and Hispanic or Latino individuals have the longest life expectancy at 84.2 years (CDC, 2018b).

- Blacks account for a higher proportion of new HIV diagnoses and people living with HIV, compared to other races/ethnicities. In 2017, black Americans accounted for 13% of the U.S. population but 43% of new HIV diagnoses (CDC, 2019b).

- Blacks experience preventable hospitalizations at a rate that is approximately double that of whites (CDC, 2013).

- Self-reported health status also varies across racial and ethnic groups, with 29% of American Indian/Alaska Natives reporting being in poor or fair health compared to just 11% of Asians and 14% of Non-Hispanic whites (Figure 3).

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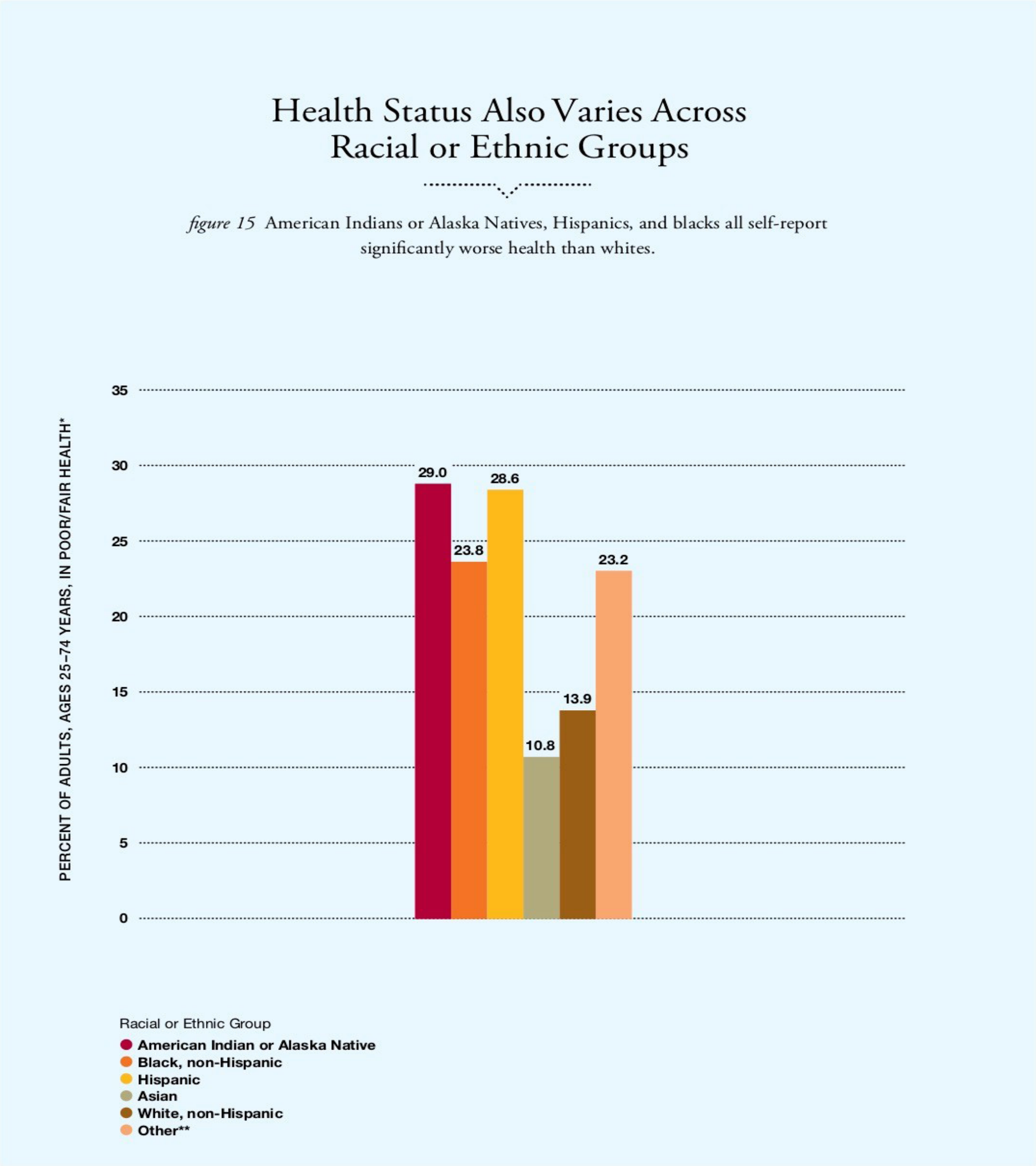
1 The authors of this guide are sensitive to the use of labels to describe people. However, when making comparisons it is useful to categorize individuals (e.g. by race or ethnicity, sexual orientation, income, etc.). According to the American Psychological Association, both the terms “Black” and “African American” are widely accepted. For consistency, we use the term “black” (except where citing a source that uses a different term).

Figure 3: Health status varies across racial or ethnic groups, United States, 2008-2010



Source: Robert Wood Johnson Foundation Commission to Build a Healthier America, 2013.

Health varies by gender:

- Men are two to three times more likely to die in a motor vehicle crash than are women (CDC, 2013).

- Rates of firearm-related deaths are six times as high for men as women (CDC, 2018b).

- Asthma is more prevalent among women than men (CDC, 2013).

- Although men and women report poor or fair health at similar rates, women are more likely to report having a medical condition that requires ongoing care (Kaiser Family Foundation, 2013).

Health varies by income:

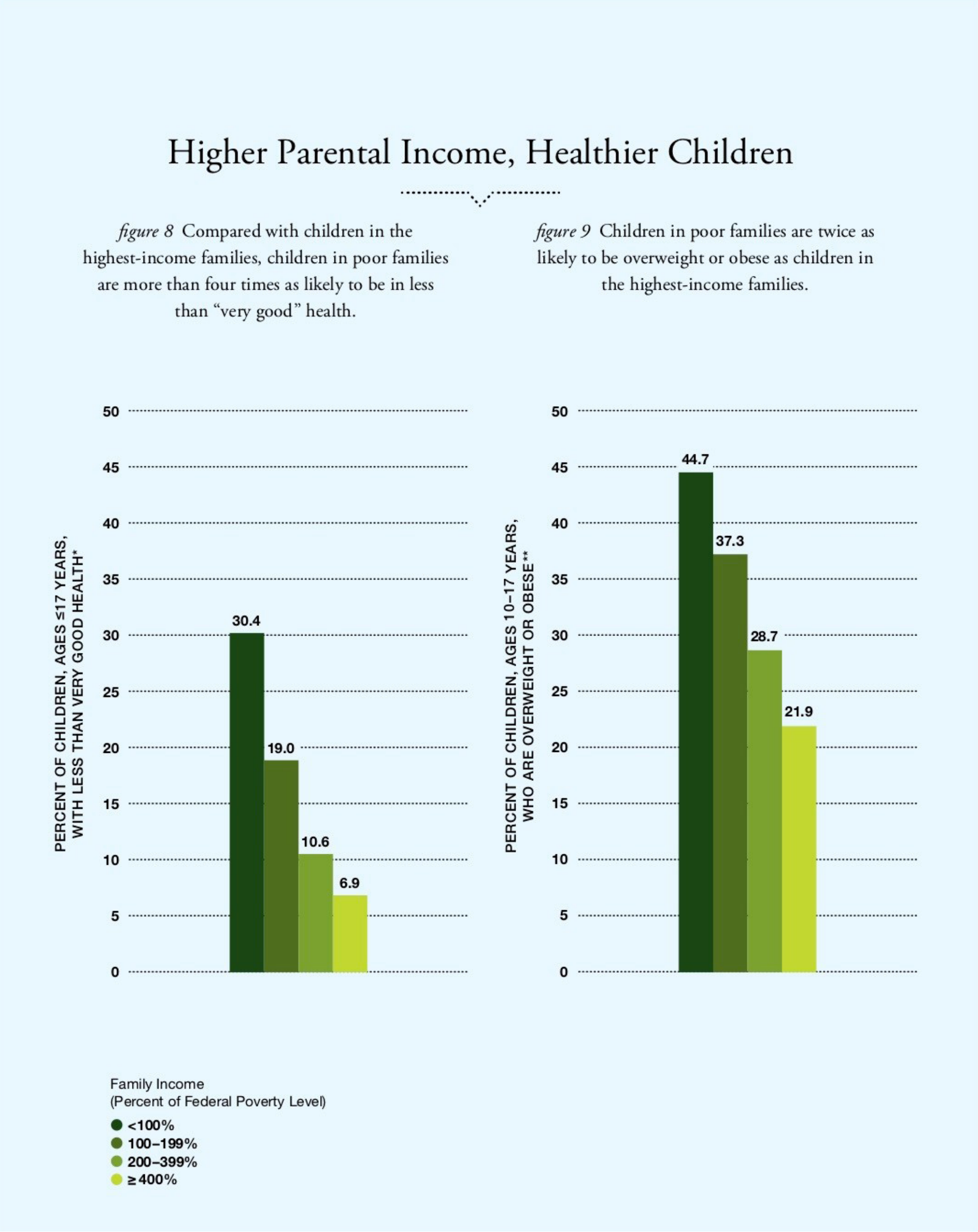
- Higher income is associated with longer life across the income distribution. The difference in life expectancy between the richest 1% and poorest 1% is nearly 15 years for men and 10 years for women (Chetty, et al., 2016).

- Rates of preventable hospitalizations increase as income decreases (CDC, 2013).

- Compared to children in highest-income families, children from poor families are more than four times as likely to be in less than “very good health.” (Figure 4; RWJF, 2013).

- Children in poor families are twice as likely to be overweight or obese as children in higher income families (Figure 4, RWJF, 2013).

Figure 4: Higher parental income, healthier children, United States, 2011/2012



Higher Parental Income, Healthier Children

figure 8 Compared with children in the highest-income families, children in poor families are more than four times as likely to be in less than "very good" health.

figure 9 Children in poor families are twice as likely to be overweight or obese as children in the highest-income families.

Source: Robert Wood Johnson Foundation Commission to Build a Healthier America, 2013.

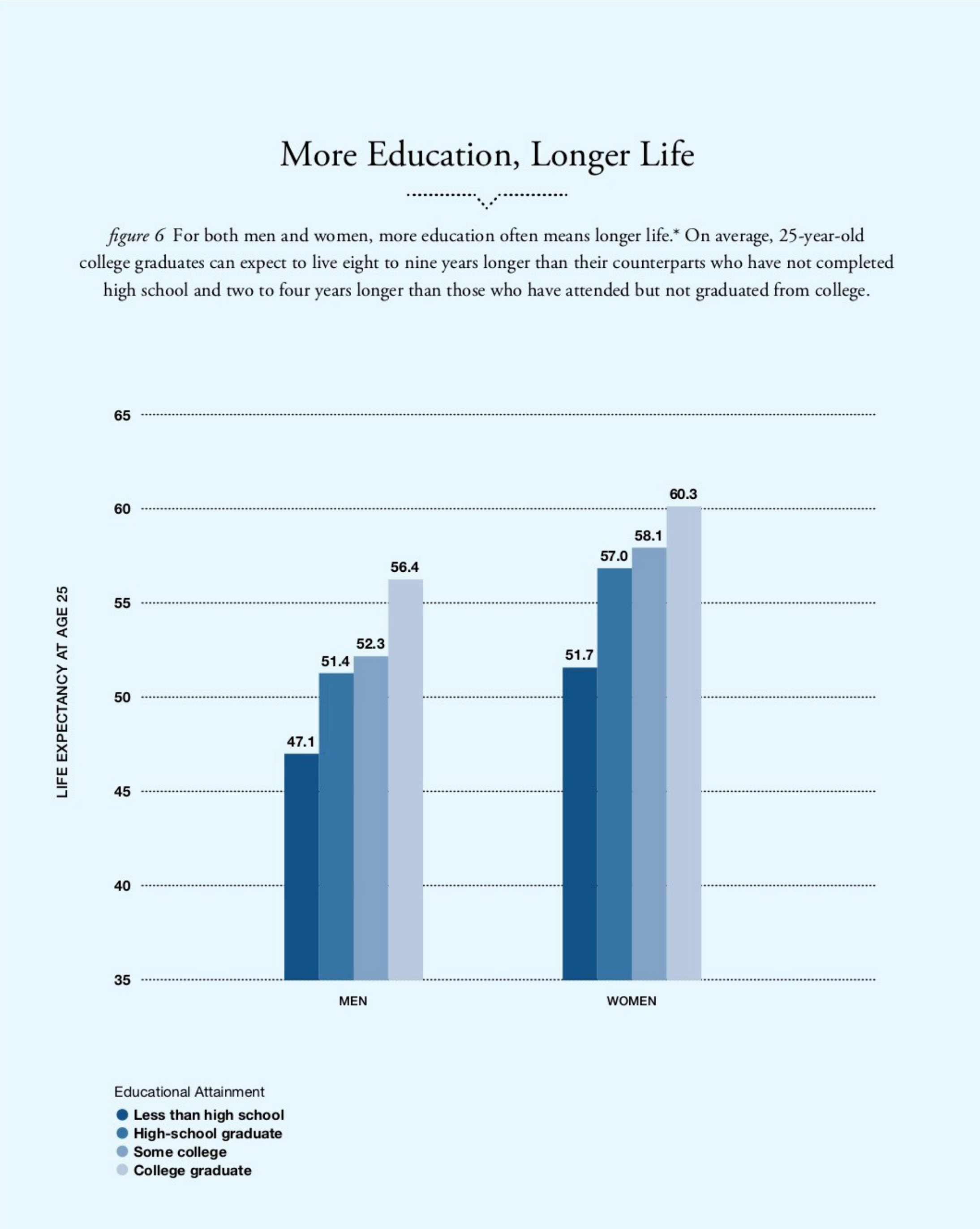
Health varies by education level:

- On average, 25-year-old college graduates can expect to live eight to nine years longer than those who have not graduated from college (Figure 5; RWJF, 2013).
- Obesity — which is a major cause of cardiovascular disease and cancer — varies by educational attainment, such that adults with less than a high school degree have the highest prevalence (37.4%), followed by high school graduates (36.1%), and followed by adults with some college (34.8%). Adults with a college degree have the lowest prevalence (23.3%) (UHF, 2018).
- Frequent mental distress, which is defined as the percentage of adults who reported their mental health was not good 14 or more days in the past 30 days, decreases as education level increases. Adults with less than a high school degree have the highest prevalence (17.2%), followed by high school graduates (13.2%), and followed by adults with some college (12.8%). Adults with a college degree have the lowest prevalence (7.1%) (UHF, 2018).

Health varies by place:

- Infant mortality rates vary significantly by state. In 2017, Massachusetts had the lowest infant mortality rate at 3.7 per 1,000 live births, whereas Mississippi has the highest rate at 8.6 per 1,000 live births (Figure 6; CDC, 2019c).
- Health even varies by neighborhood. For example, in cities like New Orleans, there is as much as a 25-year life expectancy for babies born in neighborhoods only miles apart (Figure 7; RWJF, 2013).

Figure 5: Life expectancy by education attainment, United States, 2006

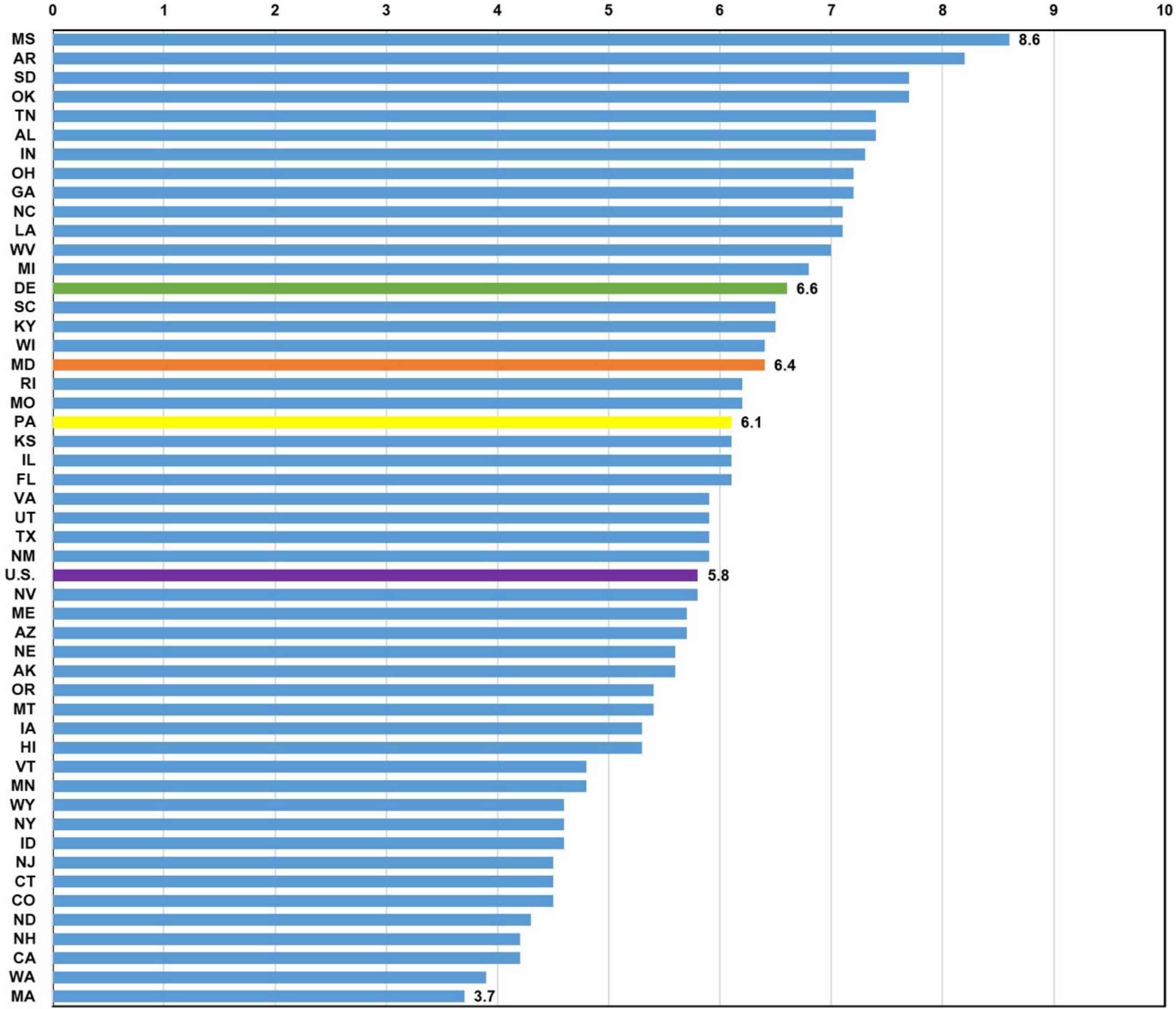


More Education, Longer Life

figure 6 For both men and women, more education often means longer life.* On average, 25-year-old college graduates can expect to live eight to nine years longer than their counterparts who have not completed high school and two to four years longer than those who have attended but not graduated from college.

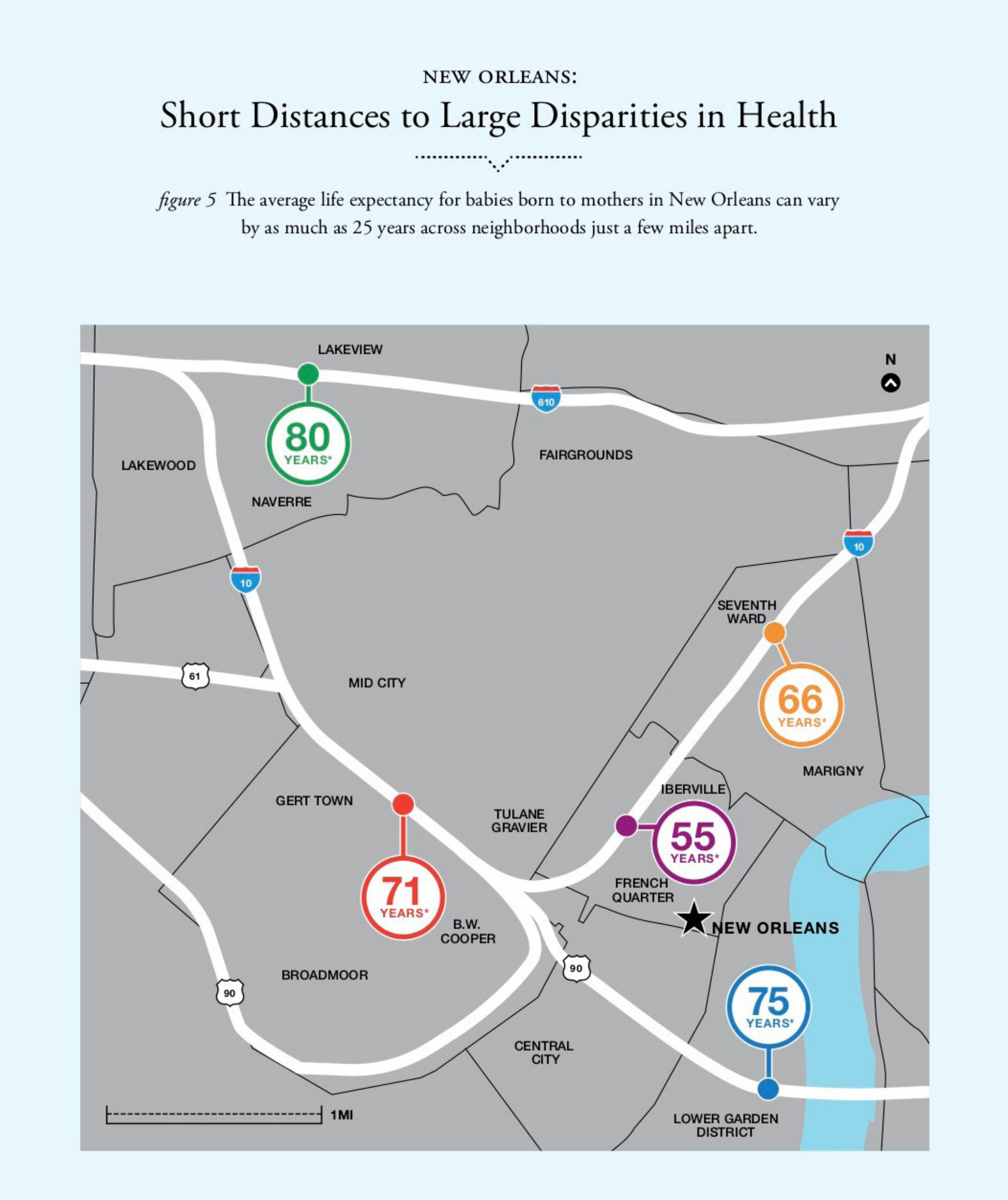
Source: Robert Wood Johnson Foundation Commission to Build a Healthier America, 2013.

Figure 6: Infant Mortality Rate per 1,000 live births, by state, U.S., 2017.



Source: CDC Wide-ranging Online Data for Epidemiological Research (WONDER). (2019c).

Figure 7: Short distance to large disparities in health, New Orleans, LA, 2012



Source: Robert Wood Johnson Foundation Commission to Build a Healthier America, 2013.

Differences in health also exist according to things like sexual orientation and disability status. For example, sexual minorities tend to have poorer physical and mental health than heterosexual men and women (Gonzales & Henning-Smith, 2017) and individuals with disabilities are likely to have higher rates of chronic diseases, unrelated to their disability, compared to individuals without disabilities (Krahn, Walker, & Correa-De-Araujo, 2015).

Further, when it comes to health, people are often disadvantaged by more than one type of oppression based on their identity or class (e.g., “black” and “gay”). This concept of intersectionality, originally described by Crenshaw (1989), is important for understanding how groups of people with overlapping identities and experiences may be discriminated against in many ways that can translate into poor health. Because these are socially constructed categories related to social hierarchy, and related differences in health do not derive from biology or genetics, experts consider such health differences to be socially produced. As such, we can conclude that "health inequities are not only unnecessary and avoidable, but in addition, are considered unfair and unjust" (Whitehead, 1992). Trends in Delaware generally reflect those of the U.S. and are discussed in greater detail in the next section.

Clarifying Terms: Health Disparities, Inequalities, and Inequities

We hear these terms often within community health; sometimes used interchangeably and sometimes with implied differences in meaning. Until recently in the United States, the phrase health disparity was commonly used to denote a difference between two or more groups, leaving the causes and nature of the difference open to interpretation. The phrase has generally been used in relation to differences in health between racial and ethnic groups, implying some sort of social disadvantage. This is in contrast to differences in the rate of breast cancer between men and women, for instance, which has not generally been referred to as a disparity.

The phrase health inequalities has sometimes been used interchangeably with health disparities, most frequently in the scientific and economic literature or in reference to socioeconomic differences among broadly defined groups. Internationally, differences in health between those in distinct positions on the social hierarchy have been more frequently referred to as inequities. Health inequities are often defined as "differences in health which are not only unnecessary and avoidable but, in addition, are considered unfair and unjust" (Whitehead, 1992). The World Health Organization further notes that health inequities are "health differences which are socially produced."

There is a great deal of attention in the literature and among advocates about the appropriate use of these terms that is only touched upon above. While we appreciate the significance of this discussion and the importance of language and meaning, we also recognize that different terms may be used in practice depending on the audience and purpose (e.g. policy makers may be most familiar with disparities). However, for the sake of clarity and because of the need to draw attention to issues of fairness and justice, this guide will henceforth use the term inequity to refer to socially produced health differences (except where citing a source that uses a different term).

Health Equity Framework

Although the terms "disparity," "inequality," or "inequity" may be used somewhat interchangeably (see text box), a shift to a health equity framework is particularly meaningful and an important foundation of this guide. Healthy People 2020 defines health equity as "attainment of the highest level of health for all people." Additionally, according to Healthy People 2020, achieving health equity "requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities."

This shift is more than semantics and is distinguished from a disparities-driven approach in several important ways. First, an equity framework draws attention to the concepts of fairness and justice in the distribution of resources. Furthermore, it highlights the idea that social inequities in health are avoidable through collective action and that inaction is unacceptable. In addition, a health equity framework provides a positive vision to work towards — it is inclusive, affirming, and empowering.

Importantly, achieving health equity does not necessarily mean seeing equal outcomes across the population. DPH envisions "health equity for all Delawareans, where everyone will achieve their full health potential." This is important as the full health potential for one individual may be different than that of another due to genetic or biological factors, for instance. Thus, a health equity framework draws attention to the need for equity in access to and quality of the resources needed for health and moves away from a disease-specific or individual risk factor orientation. Some experts have referred to this as needing to "create a level playing field" (Knight, 2014). Achieving health equity requires a greater focus on improving underlying social and economic conditions, such as income and education. These conditions are structural and systemic in nature, much like the strong bridges and fences of the stream parable. In essence, a health equity lens moves us farther upstream to address the social determinants of health and health equity.

"Health equity is about fairness and justice, and is indistinguishable from equity generally" (Knight, 2014).

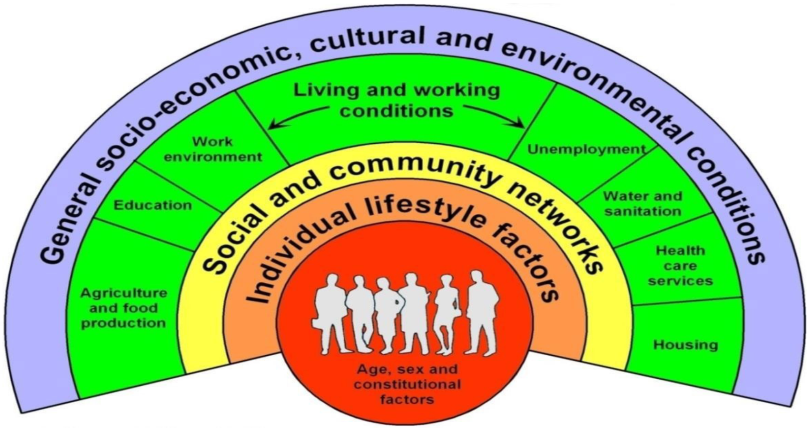
Social Determinants of Health (SDOH)

The social determinants of health (SDOH) are often defined as the circumstances in which people are born, grow up, live, work, and age. The World Health Organization (WHO) explains that these circumstances are, in turn, shaped by a wider set of forces: economics, social policies (such as education, social security and welfare), and politics (including power and decision-making). This understanding of the SDOH is important in relation to health equity, as it recognizes that economic, social, and political conditions are not naturally occurring. Instead, these conditions are the result of public policy and other community or collective actions. Therefore, the SDOH are rooted in long-term structures and traditions that may be resistant to change and require concerted and sustained effort.

Efforts to define, understand, and address the SDOH have been growing since the 1990s. Many research organizations and public health institutions have sought to identify the various social influences on health and explain their relations with population health and the health of specific population groups. Conceptual frameworks have been developed to help explain levels of influence and identify opportunities for intervention. One such model, developed by Dahlgren and Whitehead at the forefront of the field (Figure 8), is frequently used to describe the various determinants of health. The model highlights levels of influence, with the most distal factor -- the prevailing socioeconomic and cultural conditions -- as the very structure of society in which each of the other levels function.

The model puts living and working conditions, such as housing and education, within the context of these societal structures, suggesting that they are not naturally occurring conditions. Rather, living and working conditions come about as a result of overall societal structure, culture, and both historic and current public policies. Another way of thinking about this is that living and working conditions are not inevitable; they are amenable to change. The model also highlights the fact that individual behavior and lifestyle choices are made within the context of one’s social and community networks as well as the broader environment.

Figure 8: Social determinants of health and levels of influence



Source: Dahlgren & Whitehead, 1991

Attention to addressing the SDOH to improve population health has grown substantially in the United States in recent years. A major goal within Healthy People 2020 is to “create social and physical environments that promote good health for all.” Healthy People 2020 distinguishes between social and physical determinants in the environment but recognizes their interrelated nature in contributing to the places where people are born, live, learn, work, play, worship, and age.

Many lists of determinants and variations on the rainbow model originally presented by Dahlgren and Whitehead (1991) were created in recent years and used for different purposes. Experts continue to learn more about the ways in which social conditions impact health; models are improving to reflect this enhanced understanding. Notwithstanding such scientific advances and differences in purpose among varied approaches, it is important to recognize that all of the lists, frameworks, and models describing the SDOH in recent years share key elements that are critical for health promotion:

- Health is a result of a complex web of influences, including social, economic, political, physical, behavioral, and biological factors.
- Individual level influences, such as behavior, occur in the context of the broader social and physical environment, and a focus on individual level influences without appropriate attention to other contextual factors is likely to be inadequate for achieving meaningful health improvements.
- Social and physical environmental factors are shaped by societal structures and public policy.
- Health care services are less important than traditionally thought.
- Biological and genetic factors can mediate the effects of other influences but are not the primary determinants of health.
- The determinants of health affect individuals over the course of their lifetime, often varying in importance and degree of influence.

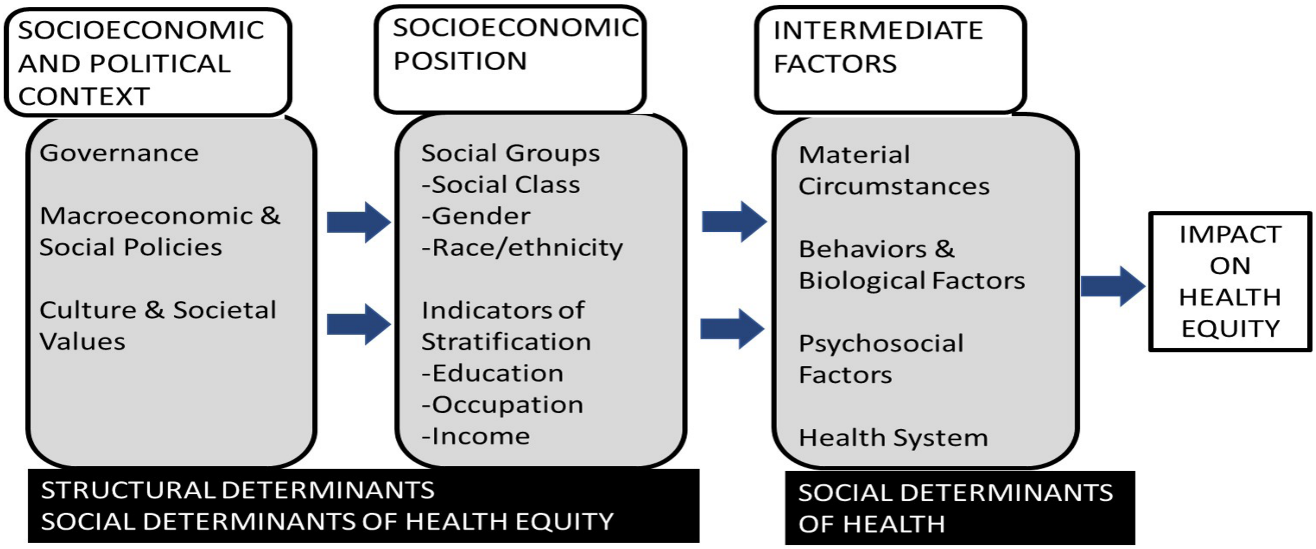
Social Determinants of Health Equity (SDOHE)

In 2008, the WHO Commission on the Social Determinants of Health published a ground-breaking report on health inequities, which summarized decades of research from around the world. The report explained that differences in SDOH are mostly responsible for health inequities. The relation between the SDOH and health inequities can be seen very clearly in Figures 4 and 5, which were shared from the Robert Wood Johnson Foundation (RWJF). The staircase pattern in both figures illustrates what is often referred to as the social gradient in health. The data indicate that social advantages and disadvantages are relative. For example, individuals who experience extreme poverty are more likely to experience poor health than those with slightly more resources, while those at the highest socioeconomic level are generally the healthiest. The same pattern holds for education level and other indicators of social status. Furthermore, the effects of these factors can be cumulative. For example, individuals who are poor, black, and have low levels of education are more likely to be in poor health than someone who has just one or two of those characteristics.

Importantly, the WHO report (and numerous related publications) point out that differences in the SDOH that underlie health inequities are themselves socially determined. In other words, the working and living conditions that determine health and health inequities are not naturally occurring. Instead, they are determined by policy decisions and other social structures and actions (e.g. media, business, etc.) that affect communities and societies at large.

Figure 9, reproduced from the 2008 WHO report, illustrates this understanding regarding the structural determinants of the social determinants of health. This figure is useful for highlighting the need to move even farther upstream. Living and working conditions, described as SDOH, are viewed as more proximate to health and equity, whereas macroeconomic policies and other social policies — housing, education, and social security — are further upstream. These policies — along with culture, societal values, and governance — are related to socioeconomic position and result in inequities between groups of people categorized by gender, race, and class (Figure 9). Meaningful, long-term changes that promote health equity are needed farther upstream at that structural level — identified in Figure 9 as being within the socioeconomic and political context — in a health equity framework.

Figure 9: Conceptual Framework for the Determinants of Health Equity



Source: World Health Organization, 2010.

Many advocates and public health leaders now make a distinction between the SDOH and what are increasingly being referred to as the "social determinants of health equity" (SDOHE). This distinction is also based in part on the understanding that although medical advances and many public health interventions over the past century have improved population health, they have moved the average and have not necessarily reduced differences between groups. Finally, this distinction is based on the recognition that inequities in health primarily result from an inequitable distribution in the quality of the SDOH. This reflects imbalances in political and economic power instead of "ad hoc events, individual failure, or the inevitable consequences of modern society" (Hofrichter, 2003, p. 1).

The inequitable distribution in health-related resources has tangible and measurable repercussions for the health of groups that experience social disadvantages. For instance, each year in the U.S. an estimated 83,570 blacks die prematurely because of racial health disparities (Satcher et al., 2005); and, on average, 195,000 premature deaths result from disparities in education each year (Woolf, Johnson, Phillips, & Philipsen, 2007).

Other health gaps exist in relation to such things as gender, gender identity, sexual orientation, and disability status, to name just a few. A recent analysis of several indicators of health over the between 1993 and 2017 found “a clear lack of progress on health equity during the past 25 years in the U.S. (Zimmerman & Anderson, 2019, p1). The current social, economic, and political context suggests that population health will continue to worsen, as will health inequities, if we do not move our health promotion efforts farther upstream.

Structural Racism as a Determinant of Health

Informed by current research and persistent racial health inequities, the authors of this updated version of the Health Equity Guide found it essential to more explicitly recognize the poor health experienced by black communities in the U.S., and in the state of Delaware, as an issue of racial justice and equity (Bailey et al., 2017; Krieger & Bassett, 1986). In utilizing a racial justice lens, we aim to draw attention to racism as a root cause of racial health inequities, and structural racism as a determinant of population health (Bailey et al., 2017). Structural racism “…refers to the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice” (Bailey et al., 2017). Using Figure 9, one can see how racism that is expressed through the mechanisms in the first box (governance, macroeconomic and social policies, and culture and values) lead to differences in socioeconomic position along racial lines.

An example of “mutually reinforcing systems” can be seen in the causes and impacts of residential segregation. In the U.S., including in Delaware, people continue to live in racially and economically segregated communities, which were created in part as a result of historically discriminatory policies (Bailey et al., 2017; Ware, 2018). Rothstein (2017) debunks the notion that racial segregation in American cities was by chance or the sole result of individual racial discrimination by banks and landlords. Rather, it is clear that local, state, and federal policies such as the 1949 Housing Act[2] and unconstitutional racial zoning practices of city governments played important roles in creating racially segregated communities that are still largely intact today.

Residential segregation has a variety of direct and indirect effects on population health, which Bailey et al. (2017) identifies as: the high concentration of dilapidated housing in neighborhoods, the low quality of social and built environments, exposure to toxins, lack of access to high-quality education, and restricted access to quality health care (p. 1456). There is strong empirical support for the impact of racial residential segregation on poor health (Acevedo-Garcia, Lochner, Osypuk, & Subramanian, 2003; Williams & Collins, 2001). The role of segregation and other forms of racism in creating and perpetuating inequities in health among black communities in the U.S. is described in more detail in Section 3 of this guide.

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[2] For a detailed explanation of the 1949 Housing Act, including a discussion of its legacy, see von Hoffman (2000) at https://www.innovations.harvard.edu/sites/default/files/hpd_1102_hoffman.pdf.

National Efforts to Advance Health Equity

Despite a research focus on health inequities since the 1970s and growing attention to SDOH in public health practice, health inequities remain a large, persistent problem that has garnered the attention of many state and federal agencies, foundations, and non-profit organizations. Over the past two decades, federal agencies released numerous reports regarding health disparities, and offered recommendations for addressing them. Those recommendations have become increasingly focused on the SDOH. The contents of three key reports: Healthy People 2020: An Opportunity to Address Societal Determinants of Health in the U.S., the National Stakeholder Strategy for Achieving Health Equity (NSS), and the Department of Health and Human Services' Action Plan to Reduce Racial and Ethnic Health Disparities are particularly relevant to this guide and influenced its development.

Healthy People 2020

The Healthy People initiative provides science-based 10-year national objectives for improving the health of all Americans. Each 10-year plan is developed through a multi-year process that includes input from a wide range of experts and stakeholders. In its third iteration, Healthy People 2020, released in December of 2010, articulates a framework for achieving its national goals and objectives through a foundation rooted in the determinants of health. As mentioned earlier, Healthy People 2020 distinguishes between social and physical determinants in the environment but recognizes their interrelated nature, as they both contribute to the places where people are born, live, learn, work, play, worship, and age. Healthy People 2020 refers to the social and physical determinants collectively as "societal determinants of health." This phrase captures the interrelated and complex nature of the social and physical determinants[3].

Importantly, Healthy People 2020 recognizes that the social environment is very broad and reflects things like culture, language, political and religious beliefs, and social norms and attitudes. The social environment also encompasses socioeconomic conditions (i.e. poverty) and community characteristics (i.e. exposure to crime and violence), as well as the degree and quality of social interactions. According to the Secretary's Advisory Committee, mass media and emerging communication and information technologies, such as the Internet and cellular telephone technology, are ubiquitous elements of the social environment that can affect health and well-being. Furthermore, policies in settings such as schools, workplaces, businesses, places of worship, health care settings, and other public places are part of the social environment. Economic policy is highlighted as a critically important component of the social environment.

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[3] For a more detailed explanation of the societal determinants of health, including why they are believed to be so important, and how they are related to the Healthy People 2020 goals, see a companion report of the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020:

http://www.healthypeople.gov/sites/default/files/SocietalDeterminantsHealth.pdf

According to Healthy People 2020, the physical environment consists of the natural environment (i.e., plants, atmosphere, weather, and topography) and the built environment (i.e., buildings, spaces, transportation systems, and products that are created or modified by people). The physical environment affects health directly, such as through physical hazards like air pollution, and indirectly, such as the way in which the environment encourages or discourages physical activity. The Secretary's Advisory Committee suggests that interventions should promote environmental justice by eliminating disparities in exposure to harmful environmental factors and improving access to beneficial ones.

Given the range of factors in the social and physical environment affecting health, Healthy People 2020 calls for a multi-sector approach to address health equity. The Secretary's Advisory Committee notes that the 10-year goals and objectives "can be achieved only if many sectors of our society — such as transportation, housing, agriculture, commerce, and education, in addition to medical care — become broadly and deeply engaged in promoting health." The Committee acknowledges that many agencies do not have a mandate to address these cross-cutting issues, and recommends that the public health community provide leadership and encourage collaboration to promote health in the social and physical environment.

One recommendation for addressing societal determinants of health across sectors is for government to adopt a "Health in All Policies" (HiAP) approach. A HiAP approach requires intersectoral partnerships at all government levels and with non-traditional partners, with a focus on social and environmental justice, human rights, and equity. A HiAP approach has the potential to make meaningful impact in achieving health equity. An in-depth discussion of this approach, including related tools and strategies, is included in Section 7.

The Secretary's Advisory Committee acknowledges that individual/disease-specific and population-based perspectives are both necessary to achieve optimal health for all. Rather than choose one or the other, they should be viewed (and used) as two components of an integrated solution. Table 1, excerpted from the Report of the Secretary's Advisory Committee, provides examples of the two approaches and highlights their advantages and disadvantages from both a policy perspective and a practical perspective.

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[4] Due to the interrelated nature of social and physical factors in the environment, the term "environment" is frequently used throughout this guide to refer to both. When a distinction is made, it is intended to draw attention to a particular aspect of the environment.

Table 1. Relative Advantages and Disadvantages of Disease Focus and Population Focus for Addressing Health Disparities

	Advantages		**Disadvantages**	
Focus	**Policy Perspective**	**Practical Perspective**	**Policy Perspective**	**Practical Perspective**
Individual/Disease Focus	Provides convincing evidence that ethnic minority and low socioeconomic status (SES) populations are disadvantaged Keeps issues of health inequities on policy agenda Quantifies the problem	Matches NIH and other funding streams Matches organization of medical specialties Compatible with hi-tech medical solutions Conveys potential for dramatic success through focused effort on high-risk or already ill individuals	Sets lack of “excess deaths” as the standard Implies that health status of Whites or high SES represents optimal health Emphasizes relative risks more than absolute risks Frames issues in medical or health system terms; de- emphasizes structural variables or environmental circumstances Makes it difficult to identify where to focus attention	Inadvertently reinforces perception of minority group inferiority or inevitability of poor health among low SES populations Creates separate tracks for pursuing problems with many common determinants Leads to duplication, competing priorities, and fragmentation of efforts. Because of narrow focus, may not adequately identify unanticipated negative or positive consequences of policies or interventions in other areas
Population Health Focus	Facilitates focus on optimal health of the population in question Highlights relevant historical, cultural, and political contexts Draws attention to diversity within ethnic minority and low SES populations Integrates domains of knowledge and discourse Incorporates critical nonmedical health issues	Facilitates endogenous solutions Supports attention to assets and coping abilities By applying a more integrated approach, opportunities to identify unanticipated benefits or untoward consequences of interventions is increased	Links status on policy agenda to less popular issues Depends on actions in non-health sectors Poor match for National Institutes of Health (NIH) and other funding streams Is associated with slow, incremental progress versus quick fixes	Is challenging to biomedical paradigm Generates less enthusiasm about hi-tech medical solutions Is often distal to disease outcomes More complex, multi-level solutions make it more difficult to identify key factors driving successful outcomes

Source: Excerpt from Report of the Secretary’s Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020; Adapted from Kumanyika SK, Morssink CB. Bridging Domains in Efforts to Reduce Disparities in Health and Health Care. Health Educ Behav 2006; 33; 440.

Finally, the Secretary's Advisory Committee calls for more research regarding the societal determinants of health and efforts to address them. The Committee argues that the availability of high quality data for all communities should be a priority for public health departments and clinical preventive research. Furthermore, it acknowledges the need to build the evidence for community-based interventions and recommends that HHS place more attention on examining policies that impact the social and physical environment. Finally, the Committee stresses the importance of community-based participatory research. Elements of these recommendations are included in Sections 7 (Policy-Oriented Strategies) and 8 (Data, Research, and Evaluation for Health Equity).

As Healthy People 2030 is currently in development, the Subcommittee on Prioritization and Criteria for Objective Selection (2019) recommended that the next iteration of Healthy People continue to prioritize attention to health inequities and opportunities to reduce them. The committee recognized that health equity is directly related to social justice and essential to the Healthy People effort but acknowledged the difficulty in measuring progress. Therefore, they argued that health equity should remain an overarching goal and that Healthy People 2030 should include attention to the historical basis and context of health inequities, including acknowledging how structural issues affect health inequities in the U.S. Specifically, the subcommittee recommended describing how health inequities are related to determinants of health even further upstream than what are traditionally considered SDOH (e.g. poverty and housing) and how such determinants had far-reaching influence on health throughout our history. According to the subcommittee,

> "Racism, discrimination, and policy decisions have disadvantaged subpopulations over time and continue to have residual effects. Examples include: redlining decisions that led to consistent degradation in certain communities; policies limiting who can qualify for certain types of housing on bases other than their financial situation; and academic funding and policies that lead to differential opportunities for academic success."
> (Secretary's Advisory Committee, 2019, p14)

National Stakeholder Strategy for Achieving Health Equity (NSS)

In response to persistent health inequities in the United States and a call to action for a national, comprehensive, and coordinated effort to eliminate disparities, the U.S. DHHS' Office of Minority Health established The National Partnership for Action to End Health Disparities (NPA). The NPA was created with the support of nearly 2,000 attendees of the National Leadership Summit for Eliminating Racial and Ethnic Disparities in Health. Sponsored by the Office of Minority Health, the Summit provided a forum to strategize how to eliminate health disparities by increasing the effectiveness of programs that target health disparities through the coordination of partners, leaders, and stakeholders committed to action (NPA, 2018).

In 2011, the NPA released the National Stakeholder Strategy for Achieving Health Equity (NSS), which was developed through a collaborative process, including contributions from thousands of individuals representing government, non-profit organizations, academia, business, and the general public. When the NPA released the initial draft for comment, thousands of community members responded. The resulting report is described as a "road-map" for stakeholders at local, state, and regional levels to eliminate health disparities. The main values of the NSS are community engagement, community partnerships, cultural and linguistic literacy, and non-discrimination. The NSS report includes a set of five overarching goals and 20 community-driven strategies to help achieve them. Table 2, excerpted from the NSS, outlines these goals and strategies. For each of the 20 strategies, the report provides a menu of objectives, measures, and potential data sources as tools for stakeholders to use in implementing any given strategy. The strategies are intended to be translated and operationalized at different geographic levels (e.g. local, state, and regional) and across sectors. The NPA acknowledges many challenges in accomplishing these tasks and offers the report as a forum for lessons learned, best practices in the field, and tracking progress.

Table 2: Summary of National Stakeholder Strategy

Goal	Description	Strategies
1	AWARENESS Increase awareness of the significance of health disparities, their impact on the nation, and actions necessary to improve health outcomes for racial, ethnic, and underserved populations	1. **Healthcare Agenda** Ensure that ending health disparities is a priority on local, state, tribal, regional, and federal healthcare agendas.
		2. **Partnerships** Develop and support partnerships among public, non-profit, and private entities to provide a comprehensive infrastructure to increase awareness, drive action, and ensure accountability in efforts to end health disparities and achieve health equity across the lifespan.
		3. **Media** Leverage local, regional, and national media outlets using traditional and new media approaches as well as information technology to reach a multitier audience—including racial and ethnic minority communities, youth, young adults, older persons, persons with disabilities, LGBT groups, and geographically isolated individuals—to encourage action and accountability.
		4. **Communication** Create messages and use communication mechanisms tailored for specific audiences across their lifespan, and present varied views of the consequences of health disparities that will encourage individuals and organizations to act and to reinvest in public health.
2	LEADERSHIP Strengthen and broaden leadership for addressing health disparities at all levels	5. **Capacity Building** Build capacity at all levels of decision-making to promote community solutions for ending health disparities.
		6. Funding Priorities Improve coordination, collaboration, and opportunities for soliciting community input on funding priorities and involvement in research and services.
		7. **Youth** Invest in young people to prepare them to be future leaders and practitioners by actively engaging and including them in the planning and execution of health, wellness, and safety initiatives.
3	HEALTH SYSTEM & LIFE EXPERIENCE Improve health and healthcare outcomes for racial, ethnic, and underserved populations	8. **Access to Care** Ensure access to quality healthcare for all.
		9. **Children** Ensure the provision of needed services (e.g., mental, oral, vision, hearing, and physical health; nutrition; and those related to the social and physical environments) for at- risk children, including children in out-of-home care.
		10. **Older Adults** Enable the provision of needed services and programs to foster healthy aging.
		11. **Health Communication** Enhance and improve health service experience through improved health literacy, communications, and interactions.
		12. **Education** Substantially increase, with a goal of 100%, high school graduation rates by working with schools, early childhood programs, community organizations, public health agencies, health plan providers, and businesses to promote the connection between educational attainment and long-term health benefits.
		13. **Social and Economic Conditions** Support and implement policies that create the social, environmental, and economic conditions required to realize healthy outcomes.
4	CULTURAL & LINGUISTIC COMPETENCY Improve cultural and linguistic competency and the diversity of the health-related workforce	14. **Workforce** Develop and support the health workforce and related industry workforces to promote the availability of cultural and linguistic competency training that is sensitive to the cultural and language variations of diverse communities.
		15. **Diversity** Increase diversity and competency of the health workforce and related industry workforces through recruitment, retention, and training of racially, ethnically, and culturally diverse individuals and through leadership action by healthcare organizations and systems.
		16. **Ethics and Standards, and Financing for Interpreting and Translation Services** Encourage interpreters, translators, and bilingual staff providing services in languages other than English to follow codes of ethics and standards of practice for interpreting and translation. Encourage financing and reimbursement for health interpreting services.
5	DATA, RESEARCH, & EVALUATION Improve data availability, coordination, utilization, and diffusion of research and evaluation outcomes	17. **Data** Ensure the availability of health data on all racial, ethnic, and underserved populations.
		18. **Community-Based Research and Action, and Community-Originated Intervention Strategies** Invest in community-based participatory research and evaluation of community- originated intervention strategies in order to build capacity at the local level for ending health disparities.
		19. **Coordination of Research** Support and improve coordination of research that enhances understanding about, and proposes methodology for, ending health and healthcare disparities.
		20. **Knowledge Transfer** Expand and enhance transfer of knowledge generated by research and evaluation for decision-making about policies, programs, and grant-making related to health disparities and health equity.

Source: The National Partnership for Action to End Health Disparities, 2011.

Following the launch of the NSS, health equity coalitions (the Federal Interagency Health Equity Team and the Regional Health Equity Councils) were created to support its implementation. NPA (2018)[5] identified five top priorities for action:

(1) Strengthen access to quality health care: NPA works in partnership with community and faith-based organizations across the country to host community education events and health fairs in order to educate and inform individuals who are uninsured and underinsured about their health insurance options and available resources.

(2) Support the implementation of the National Standards for Culturally and Linguistically Appropriate Services in Health and Healthcare (National CLAS Standards): NPA supports the National CLAS Standards through various activities that create an effective foundation for communication between health care providers and their patients. The foundation is built through strategies on work force diversity, cultural competency training, and development of the field of practice.

(3) Educate youth and emerging leaders about health disparities and the social determinants of health so that they become champions for health equity. Increase the knowledge of young adults through practical learning opportunities, including internships at the regional and national level: The priority on youth was developed by the Regional Health Equity Council (Region VIII) to educate and engage young people on health equity. The University of Colorado at Boulder initiated a strategic engagement of youth leaders who have since created the Youth Health Equity Club, which works to address health disparities and support the work of the RHEC in their area.

(4) Strengthen the nation's network of community health workers, who play a key role in disease prevention and health promotion: Focused on the power of community-centered prevention to improve health and well-being, NPA works to strengthen the national network of Community Health Workers (CHW) by efforts to integrate CHW into the clinical and prevention care workforce, and advance leadership through capacity-building.

(5) Promote the integration of health equity in policies and programs: NPA promotes equity as a consideration in the development and implementation of all policies and programs of public and private organizations because of the impact on health and the social determinants of health.

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[5] Activities associated with the NPA priorities for action are updated periodically on their website: https://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=39&ID=348.

The HHS Action Plan to Reduce Racial and Ethnic Health Disparities

The U.S. Department of Health and Human Services' Action Plan to Reduce Racial and Ethnic Health Disparities was released simultaneously with the NSS. It represents the federal commitment to achieving health equity and the HHS response to the strategies recommended in the NSS. The Action Plan also builds on Healthy People 2020 and leverages other federal initiatives (e.g. the National HIV/AIDS Strategy, the First Lady's Let's Move initiative, etc.) and many provisions of the Affordable Care Act (ACA). It outlines specific goals and related actions that federal HHS agencies will take to reduce health disparities among racial and ethnic minorities in the following five areas:

1. transforming health care by expanding insurance coverage, increasing access to care, and fostering quality initiatives

2. strengthening the health workforce to promote better medical interpreting and translation services and increased use of community health workers

3. advancing the health, safety, and well-being of Americans by promoting healthy behaviors and strengthening community-based programs to prevent disease and injury

4. advancing knowledge and innovation through new data collection and research strategies

5. increasing the ability of HHS to address health disparities in an efficient, transparent, and accountable manner (U.S. DHHS, 2011).

Delaware Department of Health and Social Services (DHSS), Division of Public Health's (DPH) Health Equity Strategy

The DHSS DPH originally identified health equity as a strategic priority in its 2014-2017 Strategic Plan and has continued to prioritize efforts to achieve health equity since that time. DPH has:

- Engaged community groups in each county to champion SDOH at the community level and engaged partners through the Healthy Communities Delaware (HCD) initiative to invest in communities around health equity and SDOH.

- Provided health equity and SDOH learning events through the state, including hosting multiple health equity summits to raise awareness and facilitate partnerships.

- Created the My Healthy Community data portal (https://myhealthycommunity.dhss.delaware.gov/) with state and federal partners, to facilitate access to, and dissemination of, critical health indicators and data at the state, county and in some cases, neighborhood level.

- Developed an online training program for the state workforce outlining the importance of a “HiAP” approach.

- Supported a number of specific community efforts, such as the Wilmington Advisory Council, to help reduce firearm and youth violence.

DPH’s vision remains “health equity for all Delawareans where everyone will achieve their full health potential.” DPH’s most recent Strategic Plan (DPH, 2019) lists its five strategic priorities:

1. Achieving health equity

2. Promoting healthy lifestyles

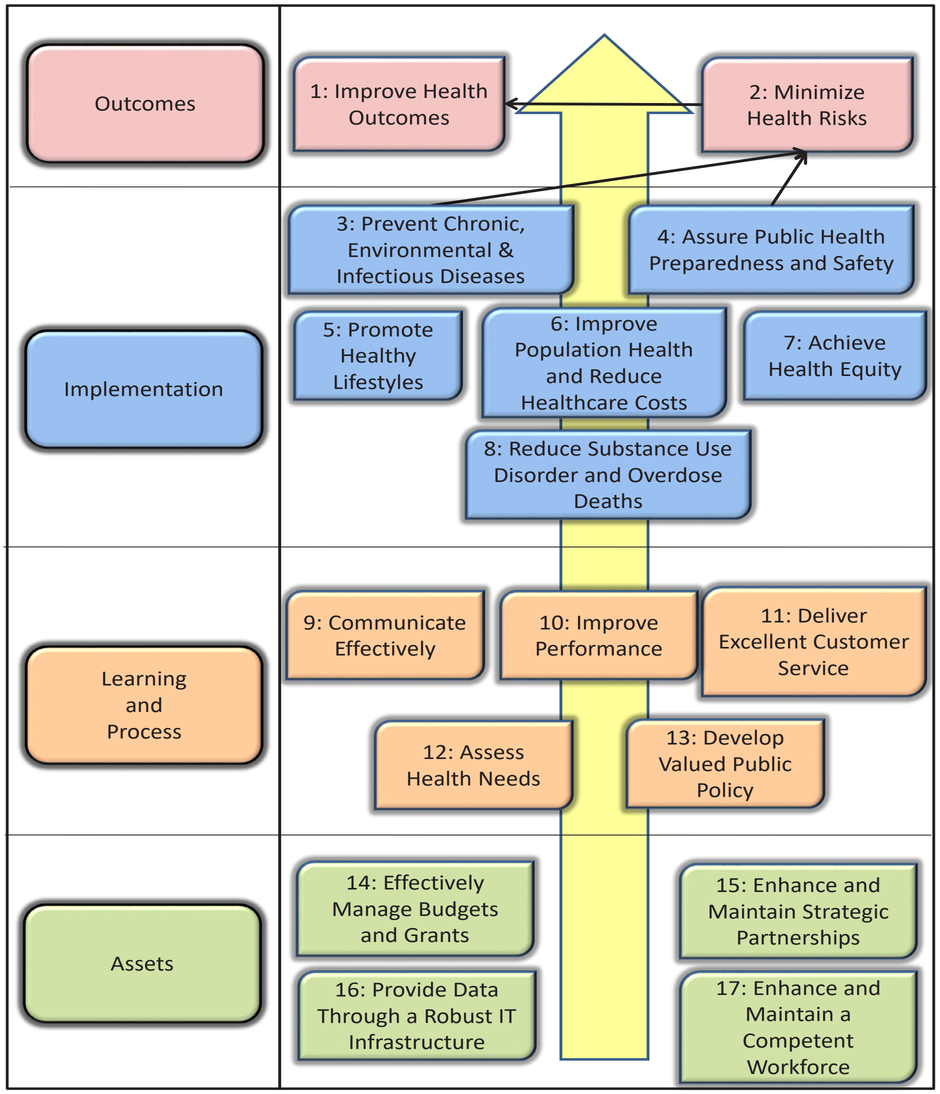
3. Improving population health

4. Reducing health care costs

5. Reducing substance use disorder and overdose deaths (DPH, 2019).

DPH’s “Top Level Strategy Map” is its framework for overall planning, including the development of measurable objectives (Figure 10). The Strategy Map includes objectives that form the basis for all of DPH’s work. The map also illustrates the ways in which resources and activities must be aligned in order to address the strategic priorities and ultimately achieve DPH’s overarching mission: to protect and promote the health of all people in Delaware (DPH, 2019).

Figure 10: Top Level Strategy Map, Division of Public Health, Delaware, 2019.



November 2011; Revised August 2012; Revised September 2013; Revised August 2014; Revised November 2015; Revised March 2018

Importantly, the Division's strategic planning process begins with a State Health Assessment and corresponding State Health Improvement Plan (both of which can be found on the DPH website: www.dhss.delaware.gov/dhss/dph. These reports reflect community health issues, needs and goals identified by public health system partners. As such, DPH aims to be responsive to community needs that form the basis of its strategic plan.

This guide is intended to support DPH and its community partners in achieving health equity. It is grounded in an appreciation for efforts already underway at the community and state level that support the overall vision. This strategy reflects a shift from a framework of health disparities that largely focused on individual risk factors and disease-specific approaches to one that focuses more on communities, systems, and the underlying conditions that determine health. Still, DPH recognizes the need to continue to enhance many of its efforts in reducing individual risk factors and improving access to quality services. DPH's approach parallels the integration of individual and population-based strategies recommended by the Secretary's Advisory Committee for Healthy People 2020. Drawing upon the direction of the national strategies, DPH will continue to use the Health Equity Guide for Public Health Practitioners and Partners, Second Edition to promote collaborative efforts that address health equity in the unique context of Delaware's communities.

Underlying Values and Assumptions

Before proceeding to the case for change and strategies for change, a discussion is warranted to clarify and summarize the underlying values and assumptions inherent in this guide. One of the major criticisms of the United States' health care system is that funds are being directed towards costly procedures and treatments of specific diseases rather than towards upstream preventive approaches like community-based interventions, population-based approaches, and policy changes that address the SDOH. Many have argued that the current emphasis on downstream treatment is generally not conducive to eliminating the major health inequities in the U.S., and contributes to excessive health care spending. The views expressed in this guide reflect the assumption that moving upstream to mend bridges and build fences is likely to be more effective in promoting health and reducing health inequities.

Additionally, an upstream approach may be considered more ethical because it prevents pain and suffering for the population as a whole, while at the same time, reduces gaps in morbidity and mortality between groups. However, opportunities also exist within the health care system to make the delivery of care more equitable. Such changes can contribute to advancing health equity by ensuring access to quality health care for everyone. Reflecting again on the stream parable, this means that everyone has the opportunity to receive quality care, should they fall in the river and become ill. For this reason, the following sections prioritize activities in the social and physical environment, including within the health care system.

Several other important assumptions about the approach taken to develop this guide should be made explicit, including the ways in which this guide is limited. Our view is that effective action to eliminate health inequities must be grounded in principles of racial and social justice, which includes attention to social and economic equality and a fair distribution of advantages, as well as a stronger democracy where individuals have greater control over decisions that affect SDOH. Achieving health equity will ultimately require us to confront deeply entrenched values and cultural norms. As one expert stated, "there has to be public recognition of the real sources of health inequities… we have to understand that class and class exploitation, racism, sexism, and imbalances in power that create those phenomena are the basic source of health inequities" (Knight, 2014).

In this updated edition of the guide, we draw attention to the need to confront historical and persistent forms of structural racism in order to advance health equity. Referring to the stream parable, this means that we have to do even more than ensure everyone has the opportunity to cross the strong bridge or live near the quality fence. It means that all communities along the stream have the power to make decisions and have control over resources to build their bridges and fences in the way they believe they should be built. Improving community conditions is insufficient if the underlying structures and processes that determine the distribution of resources are not fundamentally changed.

Changing the power dynamic in our communities means that some will have to relinquish power as others become more empowered. The original guide touched on this complicated (and uncomfortable) conversation about class, race, and power. This edition provides additional data and context to facilitate ongoing conversations and to ensure that these critical issues are not lost in favor of more immediate kinds of changes. However, specific, concrete strategies to address structural racism and reverse the impacts of historical injustices aimed at Delaware's black communities are still largely beyond the scope of this guide, as remediating such damage requires major social, political and cultural changes. Despite this limitation, we encourage you to use this guide as it is intended: to support upstream strategies aimed at the SDOH, and not to lose sight of the broader racial and social injustices even farther upstream that require ongoing attention and commitment. Over time, through our collective efforts to promote health equity in Delaware, we hope to draw greater attention to these underlying social issues and create positive social change.

There is much work to be done and we hope this guide will support those efforts. To move forward together, we propose the following assumptions and values to guide our work[6]. We recommend that collaborative community efforts aimed at advancing health equity begin with a discussion of these assumptions to ensure that participants understand their meaning and implications and are adopted as shared principles (or adapted accordingly):

1. Health is broadly defined as a positive state of physical, mental, and social well-being and not merely the absence of disease.

2. Everyone — regardless of race, religion, political belief, and economic or social condition — has the right to a standard of living adequate for health, including food, clothing, housing, medical care, and necessary social services.

3. Health is more than an end. It is also an asset or resource necessary for human development and well-functioning communities.

4. Health is socially and politically defined. Individual and medical definitions of health ignore important interactions between individual factors and social and environmental conditions.

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[6] Items 1 and 2 are adapted from the Constitution of the World Health Organization (1946) and the Universal Declaration of Human Rights (1948). Items 3-9 are adapted from Hofrichter, R. & Bhatia, R. (Eds.). (2011). Tackling health inequities through public health practice: Theory to action (2nd ed). New York: Oxford University Press, p. 6.

5. Health is a collective public good, which is actively produced by institutions and social policies.

6. Equity in health benefits everyone because health is a public good necessary for a well- functioning society.

7. Inequities in population health outcomes are primarily the result of social and political injustice, not lifestyles, behaviors, or genes.

8. An accumulation of negative social conditions and a lack of fundamental resources contribute to health inequities, and include: economic and social insecurity; racial and gender inequality; lack of participation and influence in society; poor quality housing; unhealthy conditions in the workplace and lack of control over the work process; toxic environments; and inequitable distribution of resources from public spending.

9. Tackling health inequities effectively will require emphasis on root causes and racial and social injustice, the latter concerning inequality and hierarchical divisions within the population.

Glossary – Section 2

Health disparity: A difference in health status between population groups.

Health inequity: A health disparity which is unnecessary, avoidable, unfair, and unjust; a socially-determined difference in health.

Health equity: Achieving the conditions in which all people have the opportunity to reach their health potential; the highest level of health for all people.

Infant mortality rate (IMR): The number of deaths of children less than one year of age per 1,000 live births. The rate for a given region is the number of children dying under one year of age, divided by the number of live births during the year, multiplied by 1,000. IMR is usually reported in relation to the race or ethnicity of the mother.

Intersectionality: A theory or framework for conceptualizing an individual or group as having overlapping identities and experiences that may be affected by different forms of discrimination and disadvantage. It is related to various forms of social stratification, such as race, class, gender, religion, and disability status, and recognizes that these identities do not exist independently (Crenshaw, 1989).

Life expectancy: The statistically predicted (average) number of years of life remaining at any given age. Life expectancy is usually reported and understood as “life expectancy at birth,” unless otherwise noted.

Population health: The health status or health outcomes of a group of individuals, including the distribution of such outcomes within the group. Groups are often defined geographically (e.g. at the state or country level).

Social determinants of health (SDOH): The circumstances in which people are born, grow, live, work, and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.

Social determinants of health equity (SDOHE): The underlying social, economic, and political structures that determine the quality and distribution of resources needed for health.

Structural racism: The totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, healthcare and criminal justice (Bailey et al., 2017).

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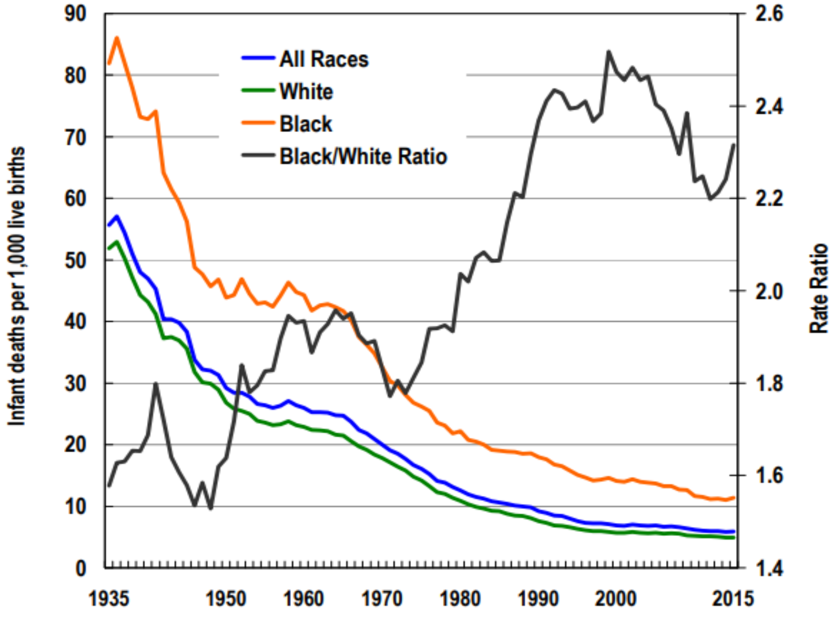
SECTION 3: Structural Racism as a Fundamental Cause of Health Inequities

As described in Section 2, health inequities may be viewed in the context of race, gender, sexual orientation, income, education level, disability status, or geographic location, among others. Further, when it comes to health, people are often disadvantaged by more than one type of oppression based on their identity or class (e.g., “female” and “immigrant”). However, people of color in the U.S. experience some of the most pervasive and persistent heath inequities in our country; and while we recognize the importance of health inequities that exist across various racial and ethnic groups, including Native people, Latinos, and others, we believe that the historical context of slavery and persistent oppression among black individuals in the U.S. warrants particular focus. For this reason, we added this section on structural racism with a particular emphasis on the black population. Much of its content is drawn from a policy brief (Knight, Codes-Johnson, Rendon, McDonough, 2019; UD, 2019) and related presentations featured at the April 17, 2019, “Reducing Inequities in Health & Well-Being by Addressing Structural Racism in the U.S.” spring Policy Academy. That event was hosted by the Partnership for Healthy Communities and the Partnership for Arts and Culture at the University of Delaware (UD), in collaboration with Delaware State University.

Using infant mortality as a snapshot, one can get a sense of the magnitude of health inequities experienced by black individuals in the U.S. As highlighted in the Section 2, the most recent infant mortality data reveal that the highest rates are among non-Hispanic black women (11.4 per 1,000 live births), compared to non-Hispanic white women (4.9 per 1,000 live births). Another way to look at the inequity in infant mortality is to examine the ratio of infant deaths across racial groups. This ratio (black infant mortality divided by white infant mortality) has changed over the past 80 years (Figure 11). The black-white infant mortality ratio reached a low of approximately 1.5 in 1948 and stayed below 2.0 prior to the mid-1980s, when it began to climb steadily until reaching a peak of over 2.5 in 2000. The ratio has remained well above 2.0 in recent years. The most recent data from the Centers for Disease Control and Prevention (CDC) indicate that the infant mortality rate for black mothers is 2.3 times that of white mothers in the U.S.

Figure 11: Infant mortality rate by race, United States, 1935-2015.



Source: Singh GK, van Dyck PC. Infant Mortality in the United States. A 75th Anniversary Title V Publication. HRSA. 2010 (updated data) and CDC/NCHS.

Health inequities experienced by black individuals in the U.S. can be seen across a range of other health indicators as well. Despite recent progress, especially among black males, the gap in life expectancy between blacks and whites was still 3.4 years in 2015 (Arias & Xu, 2018). Further, a recent analysis of health status and outcome measures across different racial and ethnic groups found that blacks fared worse than whites on 24 out of 29 indicators, including rates of asthma, diabetes, heart disease, HIV, and cancer (Artiga, Foutz, Cornachione, & Garfield, 2016). Among these findings is evidence that black children also have higher rates of asthma, teen pregnancy, and obesity.

Structural Racism

Racism is a complex social phenomenon that can be defined in many different ways and is expressed on different levels. It involves individual and collective attitudes, actions, processes and unequal power relations (Garner, 2017). On an individual level, racism can be expressed as intentional or unintentional acts of commission or omission, based on assumptions that one race is superior to another. For example, a restaurant owner who refuses to serve a black patron is committing an intentional act of racism, while a doctor who neglects to recommend the same surgery for a black patient that is recommended for a white patient with identical symptoms may be unintentionally committing an act of omission. On an individual level, racism may also be internalized, such that members of a stigmatized race accept negative messages about their own abilities and intrinsic worth (Jones, 2000). Internal racism may be expressed by black individuals dropping out of school or referring to themselves using negative stereotypes.

Institutional or systemic racism can be defined as differential access to the goods, services and opportunities of society by race, which is often codified in our institutions as customary practice or even law (Jones, 2000, p1212). The historic practice of redlining, such that blacks were systematically denied mortgages in certain neighborhoods, or charged higher insurance premiums, are expressions of institutional racism. A subtler, but potentially just as serious, form of institutional racism may be seen in the content of public school curricula, or images in the media, that are biased towards the culture and experiences of the majority population. Institutional racism in one area or sector may reinforce or interact with racism in another, such as the ways in which discrimination in housing perpetuates problems with underfunded schools and limited educational opportunities for black children living in segregated neighborhoods (Ware, 2018).

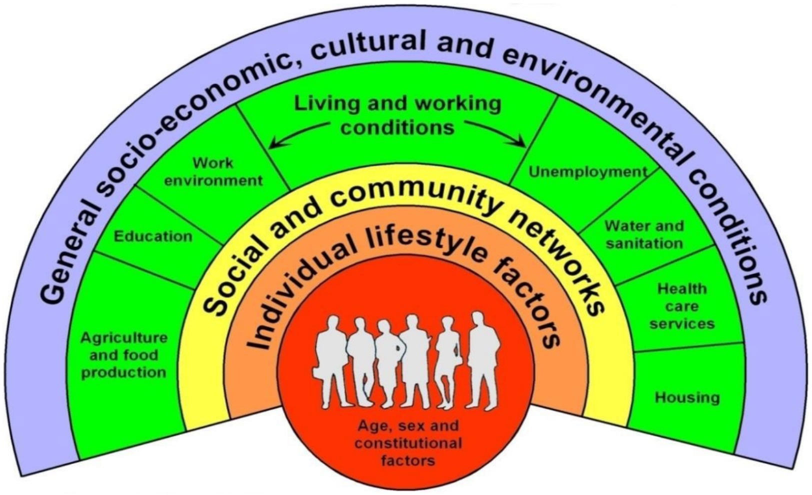
Institutional racism is interconnected with individual forms of racism and often serves to reinforce discriminatory beliefs and values. For this reason, the concept of structural racism has been suggested as a way to reflect the “totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, healthcare and criminal justice” (Bailey et al., 2017, p1454).

Another way to think about structural racism is as:

> “A system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity. It identifies dimensions of our history and culture that have allowed privileges associated with ‘whiteness’ and disadvantages associated with ‘color’ to endure and adapt over time.” (Aspen Institute, n.d.)

Conceptually, we can think about this definition of structural racism in the context of the determinants of health rainbow introduced in Section 2 and presented again as Figure 12. Specifically, we can see how negative aspects of living and working conditions in black communities are largely the result of structural racism, where historical and contemporary policies, practices, beliefs, and attitudes have resulted in an unequal distribution of resources across communities. More specifically, structural racism has led to many black neighborhoods being characterized by a lack of employment opportunities, underfunded public schools, substandard housing, inadequate access to health insurance and health care, and lack of greenspace and recreational opportunities, as well as high concentrations of poverty, pollution, and violence —all of which threaten health directly and indirectly (Paradies, 2016).

Figure 12: Social determinants of health and levels of influence



Source: Dahlgren & Whitehead, 1991

While social networks may be strong and promote health and well-being in communities of color, policies and practices in our criminal justice system disproportionately incarcerate black men, women and children, with direct health impacts on those who are incarcerated and potentially dismantling what would have otherwise been strong social support and community networks (Kramer & Hogue, 2009; Wildeman & Wang, 2017). In addition, the stress of racial discrimination is associated with coping behaviors that are detrimental to health, such as smoking, alcohol, and drug use (Paradies, 2016). Ongoing stress associated with racism can also have direct physiological impacts on the body (i.e. allostatic load) and is associated with mental health problems such as anxiety and depression (Paradies, 2016).

These negative influences and exposures can accumulate over time and across generations (Bailey et al., 2017). An understanding of how structural racism shapes the determinants of health for black communities leads us to conclude that structural racism is a fundamental cause of health inequities for these populations (Williams & Collins, 2001; Jones, 2002).

Residential Segregation

“Residential segregation is a foundation of structural racism” (Bailey et al., 2017, p1457). Residential segregation is the physical or spatial separation of two or more social groups within a geographic area. It is a fact of history in the U.S. and is long identified as the root of many social and racial inequities in American cities. While different racial and ethnic groups and immigrants, such as Native Americans, have experienced segregation in the U.S., blacks have been victims of an unparalleled level of deliberate segregation that is perpetuated through individual actions, institutional practices, and public policy (Massey & Denton, 1988). Patterns of segregation among blacks in the U.S. remain the highest across all racial/ethnic groups (Landrine & Corral, 2009). According to Dr. David Williams, a leading scholar on racism and health, "the single most important policy that continues to have pervasive adverse effects on the socioeconomic status and the health of African Americans is residential segregation" (Williams, 2006, p177). Further, residents of segregated neighborhoods continue to be politically alienated and lack power such that conditions often remain entrenched (Yang, Zhao, & Song, 2017).

Segregation is a contemporary problem that persists in the U.S., despite the myth of integration (Cashin, 2004). While the latter half of the 20th century saw an end to explicit policies aimed at keeping blacks from white neighborhoods (e.g. the Fair Housing Act of 1968), "such practices continue to be realized by purportedly color-blind policies that do not explicitly mention 'race' but bear racist intent" (Bailey et al., 2017, p1454). For a detailed historical analysis of segregation, including its roots in law, public policy, and public and private institutions, and its contemporary manifestations and enduring impacts see A Century of Segregation: Race, Class and Disadvantage by Leland Ware (2018). To listen to an overview of how public policy has contributed to residential segregation, visit National Public Radio's "Fresh Air" interview with Richard Rothstein who recently published a book on this topic (https://www.npr.org/2017/05/03/526655831/a-forgotten-history-of-how-the-u-s-government-segregated-america?utm_source=npr_newsletter&utm_medium=email&utm_content=20190430&utm_campaign=npr_email_a_friend&utm_term=storyshare).

"The single most important policy that continues to have pervasive adverse effects on the socioeconomic status and the health of African Americans is residential segregation" (Williams, 1999, p177).

An estimated 176,000 deaths were attributable to racial segregation in the U.S. in 2000 (Galea, Tracy, Hoggatt, DiMaggio, & Karpati, 2011), and there is a growing evidence base linking segregation to a range of indicators of poor health status of blacks living in segregated communities. Health inequities are "largely a function of the separate and unequal neighborhoods in which most Blacks and Whites reside" (Landrine & Corral, 2009, p179). Research demonstrates that racial health inequities grounded in segregation are more than a function of diminished socioeconomic status of individuals living in segregated communities, and that health inequities remain even after accounting for income and education levels. Rather, the places themselves and the nature of the social, political, built and physical environments affect health directly and indirectly in myriad ways (Bailey et al., 2017; Kramer & Hogue, 2009; Paradies, 2016; Williams & Mohammed, 2013). Figure 13 provides an overview of the pathways through which residential segregation impacts health outcomes with strong supporting evidence.

Figure 13: Pathways and outcomes through which residential segregation harms health.

Pathways through which segregation is believed to contribute to health inequities

- Poor quality housing, including dampness, inadequate heat, noise, overcrowding, and presence of environmental hazards and allergens (Bailey et al., 2017: Williams & Collins, 2001; Williams & Mohammed, 2013)
- Negative social environments, including exposure to violence, crime, and systematic differences in policing and incarceration (Landrine & Corral, 2009; Williams & Mohammed, 2013; Williams & Williams, 2000)
- Substandard built environment, including higher exposure to fast food outlets and alcohol retailers, reduced access to supermarkets with fresh fruits and vegetables, and lower access to recreational facilities (Diez-Roux & Mair, 2010; Landrine & Corral, 2009; Moore et al., 2008; Moore et al., 2009; Williams & Collins, 2001)
- Exposure to pollutants, toxins, and other environmental hazards (Bravo et al., 2016; Landrine & Corral, 2009; Landrine et al., 2017; Mohai et al., 2008)
- Limited educational and employment opportunities and earning potential (Kramer & Hogue, 2009; Williams & Collins, 2001; Williams & Mohammed, 2013)
- Limited access to quality health care (Hayanga et al., 2009; Landrine & Corral, 2009; White, Haas, & Williams, 2012; Williams & Collins, 2001)

Health Outcomes with Evidence linked to Segregation

- Adverse birth outcomes, including low birthweight, pre-term birth and infant mortality (Grady, 2006; Kramer & Hogue, 2009; Mehra, Boyd, & Ickovics, 2017; Salow et al., 2018)
- Decreased life expectancy and increased mortality (Nuru-Jeter & LaVeist, 2011; Popescu et al., 2018; Williams & Collins, 2001)
- Increased risk of chronic diseases including CVD, heart disease, cancer, hypertension, asthma, and mental health problems such as anxiety and depression (Alexander & Curie, 2017; Kershaw et al., 2011; Kershaw & Albrecht, 2015; Landrine & Corral, 2009; Landrine et al., 2017; Paradies, 2016)
- Increased risk of homicide and other forms of violence (Diehr & McDaniel, 2018; Krivo et al., 2015)
- Increased risk of infectious diseases, including tuberculosis and HIV (Acevedo-Garcia, 2000; Ibragimov et al., 2018)

Source: Knight, E., Codes-Johnson, C., Rendon, S., & McDonough, K.,2019.

Mass Incarceration

The rate of incarceration among blacks is higher than any other sub-population in the U.S. (Carson, 2015). Indeed, the incarceration rate among black men is 3.8 to 10.5 times greater than among white men, depending on the age group. The greatest gap occurs among 18-19 year olds; black males in this age group were more than 10 times more likely to be incarcerated than their white counterparts in 2014 (Carson, 2015). These rates translate into nearly one in three black men being imprisoned in their lifetime (Wildeman & Wang, 2017). Such high rates can be considered mass incarceration, which is defined as historically and comparatively extreme levels of imprisonment that are so heavily concentrated among some groups that incarceration has become a normal stage in the life course (Garland, 2001; Wildeman & Wang, 2017).

Mass incarceration obviously affects individuals who are imprisoned, but also has a ripple effect on families and entire communities; nearly half of black women have a family member who is imprisoned, and a black child is much more likely to have a father in prison compared with a white child (Wildeman & Wang, 2017).

The level of imprisonment is so heavily concentrated among Black men that incarceration has become a normal stage in the life course (Garland, 2001; Wildeman & Wang, 2017).

There is strong evidence that the disproportionate rates of incarceration among black communities are the result of discriminatory policies and practices in the criminal justice system, such as the "War on Drugs" era policies of the 1970s and 1980s (Bailey et al, 2017; Hinton, 2016). Further, upon release from jail or prison, existing policies, such as denial of voting rights among those convicted of a felony crime, create barriers for individuals to become fully integrated into society. Similar to the impacts of historical and persistent segregation, these "ostensibly color-blind policies have criminalized communities of color" and left a lasting legacy of cumulative disadvantage on individuals, families and communities with long-term impacts related to unemployment, low educational attainment, poverty, and violence (Bailey et al., 2017; Jensen, Gerber & Mosher, 2004; Wildeman & Wang, 2017).

Not surprisingly, the high rates of incarceration in black communities have negative health effects on incarcerated individuals, families, and entire communities. Given the magnitude of those affected by mass incarceration, it is believed to be a contributor to racial health inequities in the U.S. and may even help to explain inequities in health between the U.S. and other developed countries (Wildeman & Wang, 2017). Although there are a number of challenges in researching this topic and drawing conclusions about the nature of causality between incarceration and poor health, there is general consensus among experts that incarceration has strong negative effects on the health of inmates over their lifetime (Wildeman & Wang, 2017). In a comprehensive review of the literature, researchers Wildeman and Wang (2017) summarize the evidence:

- Ironically, imprisonment may be protective in the short-term, as it provides reduced exposure to some forms of violence, alcohol, and drugs, and improved access to health care; but physical and psychological well-being worsens over time.

- Incarcerated individuals have higher rates of many infectious diseases and chronic conditions compared with non-incarcerated individuals.

- Family members of incarcerated individuals are negatively affected by impacts of incarceration, including financial hardships (i.e. decreased family earnings), relationship challenges from separation, and reduced social support, stress, and behavioral and mental health problems in children.

- Neighborhoods with high levels of incarceration are associated with poor health indicators at the community level, including high rates of asthma, sexually transmitted diseases, and poor mental health.

Ultimately, mass incarceration is associated with a range of poor health indicators among those who are imprisoned as well as among their family and community members. The disproportionate incarceration of black individuals, coupled with the poor health outcomes associated with incarceration, likely contributes to racial health inequities at the community, state, and national levels. Wildeman and Wang (2017) conclude that "the criminal justice system has become an institution — like the education system — that both reflects systematic and institutionalized racism and exacerbates existing inequities" (p1470).

Racism in Health Care

In 1999, the U.S. Congress asked the Institute of Medicine (IOM)[7] to conduct an analysis of potential disparities in the types of care and quality of care received by racial and ethnic minorities within the U.S. health care system. Three years later, the IOM published their findings in the report, Unequal treatment: Confronting racial and ethnic disparities in health care (IOM, 2002), which was widely considered to be one of the most comprehensive analyses of the topic to date. Over the course of nearly 800 pages, the report documents strong evidence from over 100 studies of "remarkably consistent" patterns of racial and ethnic disparities in care for a range of health conditions and types of treatment, which remain even after socioeconomic factors are controlled (e.g. income and insurance status) and even when patients present with the same symptoms, diagnoses, and comorbidities.

The study authors highlighted the existence of "implicit" or "unconscious" stereotypes or biases among potentially well-meaning providers that can have significant influence on interactions with patients and contribute to negative outcomes. The report also documents discrimination across systemic or institutional factors, such as the ways in which care is organized and financed that negatively impact access to quality care among racial and ethnic minorities. The authors argued that disparities in care "occur in the context of broader historic and contemporary social and economic inequality, and evidence of persistent racial and ethnic discrimination in many sectors of American life" (p7). In effect, the report documented structural racism as it relates to the health care system.

Over the past 15 years, the federal government has continued to study and document trends in health care disparities in the National Healthcare Quality and Disparities Report that is mandated by Congress. The annual report is produced with the help of an inter-agency workgroup led by the Agency on Health Care Research and Quality (ARHQ) and can be found at https://www.ahrq.gov/research/findings/nhqrdr/nhqdr17/index.html. The most recent report (AHRQ, 2018) finds that blacks experience worse access to care compared with whites for more than half of the measures used in the analysis.

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[7] On March 15, 2016, the Institute of Medicine, which was part of the National Academies of Sciences, Engineering and Medicine, was renamed the Health and Medicine Division (HMD). For more information, see: http://www.nationalacademies.org/hmd/About-HMD.aspx.

While the report concludes that some progress has been made in relation to the quality of care provided to black patients, disparities remain for approximately 40% of the quality measures. For example, in 2015 the rate of adults with potentially avoidable hospital admissions for hypertension was 170.3 per 100,000 for blacks, a rate more than five times as high as the rate of 33.9 per 100,000 for whites. The report also reveals that approximately 20% of the quality measures show worsening disparities between blacks and whites, including children who visited the emergency department for asthma and a measure of exclusive breastfeeding through three months (AHRQ, 2018). Numerous studies in the academic literature also document inequities in access and quality of health care grounded in unconscious bias and other discriminatory practices. In a systematic review by Hall and colleagues (2015), the authors conclude that “Most health care providers appear to have implicit bias in terms of positive attitudes toward Whites and negative attitudes toward people of color” (p.60). Although the authors argued for more research to better understand the ways in which such bias contribute to poor outcomes, “there is widespread consensus that health care providers themselves contribute to racial health care inequalities” (Gollust et al., 2018; Hall et al., 2015).

White Privilege

One reason that unconscious or implicit bias may persist in even such a helping profession as health care is due to white privilege. White privilege is defined as “a system of benefits, advantages, and opportunities experienced by white persons in our society simply because of their skin color” (Donnelly et al. 2005). It involves greater access to power and resources among white people that are not earned, are unseen, and are often taken for granted. As Collins (2018) explains, subtle versions of white privilege can be seen as everyday conveniences that white people do not have to think about. For instance, it is difficult to find children’s books written by or about people of color; or when cashing a check, a person of color may worry that their financial credibility could be questioned[8]. Collins explains that these everyday conveniences are privileges associated with the “power of normal,” where white people are more likely to live their daily lives without thinking about their skin color.

While these everyday examples may seem benign to some, they reflect larger structural issues related to racism. Further, white privilege extends to other, potentially more impactful areas of everyday life, such as white people portrayed in positive roles on television and in movies; whereas black people are often portrayed using negative stereotypes (Wang Yuen, 2016). This contributes to things like racial profiling and its negative consequences. A sales associate may follow a black person around a store in suspicion of possible misdeeds, whereas white people do not have to worry that their skin color may influence others’ perceptions of their credibility, honesty, or innocence (Amico, 2017).

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[8] For a list of examples of white privilege, see https://neym.org/white-privilege-examples-unpacking-and-user-guide.

According to Collins (2018),

> "This privilege is invisible to many white people because it seems reasonable that a person should be extended compassion as they move through the world. It seems logical that a person should have the chance to prove themselves individually before they are judged. It's supposedly an American ideal. But it's a privilege often not granted to people of color."

The implications of white privilege are readily seen when it comes to our criminal justice system. For example, white people are less likely to be stopped by police because they looked suspicious, and people of color who are unarmed are still more likely to be killed by police (Bhopal, 2018).

White privilege can also help to explain why blacks are treated differently (with negative consequences) in our health care system. In his essay on "White Privilege in a White Coat", Dr. Max Romano (2018), explains many of the ways in which medical education privileges those with white skin, such as being taught from an early age that white people can become doctors; the ease with which he could find mentors and role models who shared his race; and learning about medical discoveries made by white people, without acknowledging how "many of those discoveries were made through inhumane and non-consensual experimentation on people of color." Such privileges have led to an entire system that is structured to favor white physicians and white patients. According to Romano (2018), "most white doctors do not think race affects them or their clinical decisions… however, multiple studies reinforce the existence of racial bias among physicians and its negative implications for patient care."

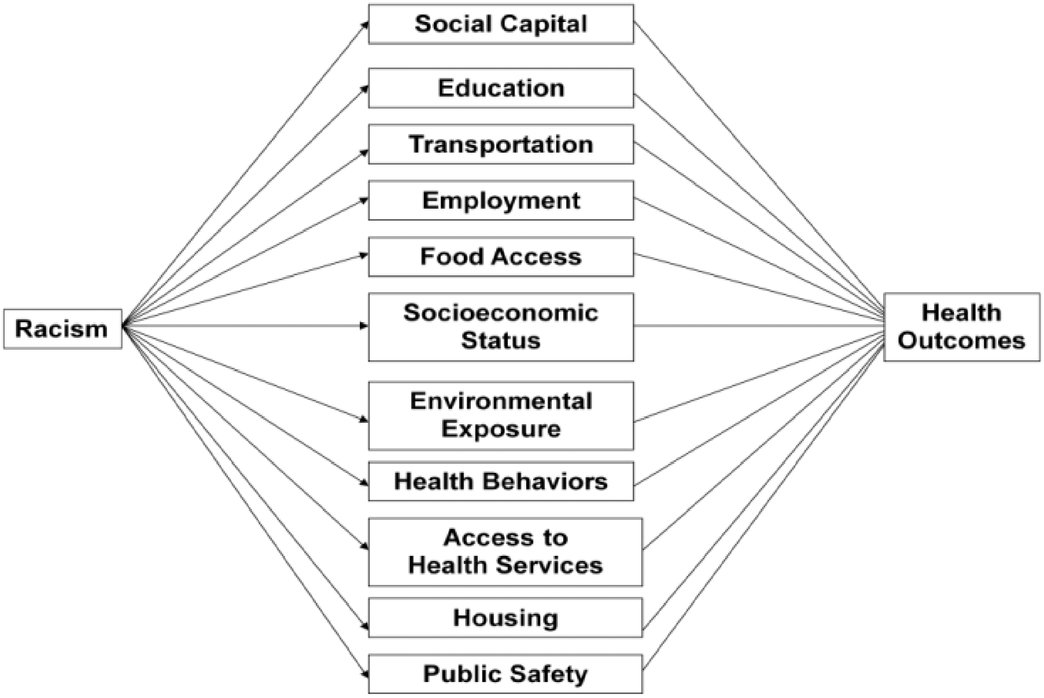
Whether it is in relation to everyday conveniences, housing and education, criminal justice, or health care, these myriad privileges are ubiquitous and yet largely unseen. McIntosh (1988) likens white privilege to "an invisible weightless knapsack of special provisions, assurances, tools, maps, guides, codebooks, passports, visas, clothes, compass, emergency gear and blank checks." These privileges accumulate over time and space contributing to the large and persistent gaps in resources and status across racial and ethnic groups in the U.S. And while white privilege is not the same as racism, it exists because of historic and enduring racism. As McIntosh (1988) further explains, "white privilege is an invisible package of unearned assets that I can count on cashing in each day, but about which I was 'meant' to remain oblivious." Collins (2018) also argues that white privilege is unconsciously enjoyed but consciously perpetuated. Acknowledging white privilege does not devalue or ignore individual accomplishments or hard work; but rather draws attention to unearned privileges simply granted due to the color of one's skin. Acknowledging white privilege calls on public health practitioners, health care providers, and policymakers to be more explicit and purposeful in addressing racism in order to advance health equity.

Racial Justice Framework for Advancing Health Equity

One way to be more explicit and purposeful in advancing health equity is to adopt a racial justice framework. Racial justice is "the systematic fair treatment of people of all races, resulting in equitable opportunities and outcomes for all…it is not just the absence of discrimination and inequities, but also the presence of deliberate systems and supports to achieve and sustain racial equity through proactive and preventive measures" (NEA, n.d., p34-35).

The Boston Public Health Commission (BPHC) adopted a racial justice framework in their approach to improving public health and advancing health equity. According to the BPHC (2015), their "Racial Justice and Health Equity Initiative is a broad organizational transformation process, which aims to integrate health equity and racial justice principles and practices into all of the health department's work, both internal and external, to measurably reduce inequities in Boston." The BPHC initiative is not a single, defined project, but rather an approach woven throughout the entire organization, which requires a different way of doing business. While many public health organizations are increasingly adopting a SDOH approach, the BPHC goes further in identifying racism as the root cause of differences in those determinants of health and works to promote health equity through a racial justice lens (Figure 14).

Figure 14. Boston Public Health Commission Racial Justice Health Equity Framework, 2015.



Source: Boston Public Health Commission (2015). The racial justice and health equity initiative.

Activities that support the integration of a racial justice approach to health equity at the BPHC include an Anti-Racism Advisory Committee, which builds organizational capacity by reviewing internal polices, practices, structures and systems and making recommendations for the organization to more effectively incorporate a racial justice lens. The BPHC also adopted a professional development series to provide staff with the knowledge, skills, and motivation to create and sustain organizational and programmatic change. Importantly, this training (which consists of 22 hours of workshops) is considered mandatory for all staff; and additional opportunities and resources for independent learning are provided and encouraged. These and other activities adopted by the BPHC are described in more detail in The Racial Justice and Health Equity Initiative 2015 Overview (found at http://www.bphc.org/whatwedo/health-equity-social-justice/racial-justice-health-equity-initiative/Documents/RJHEI%202015%20Overview%20FINAL.pdf).

Others have similarly begun to be more explicit in acknowledging the role of structural racism in creating and perpetuating health inequities, and are developing and testing interventions to dismantle racism and its effects on health. Examples will be included in subsequent sections of the guide, which focus on strategies to advance health equity. Many of the strategies we highlight in subsequent sections are aimed at promoting health equity generally, however, we have integrated a racial justice orientation where possible given the focus of this edition of the guide. Importantly, as explained earlier, this focus is not meant to diminish the challenges of other groups that experience social inequities in health (e.g. other racial/ethnic groups, individuals with disabilities, sexual minorities, etc.). Rather, we felt it was important to emphasize racial justice with a focus on black individuals in the US, and in DE, due to the pervasive and persistent health inequities experienced by blacks compared to whites.

Glossary – Section 3

Mass incarceration: Historically and comparatively extreme levels of imprisonment that are so heavily concentrated among some groups — namely African American men — that incarceration has become a normal stage in the life course.

Racial Justice: The systematic fair treatment of people of all races, resulting in equitable opportunities and outcomes for all…it is not just the absence of discrimination and inequities, but also the presence of deliberate systems and supports to achieve and sustain racial equity through proactive and preventive measures (NEA, n.d., p34-35).

Residential segregation: The physical or spatial separation of two or more social groups within a geographic area; a foundation of structural racism (Bailey et al., 2017).

Structural racism: The totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care and criminal justice (Bailey, et al. 2017). Alternately, may be defined as a system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity. It identifies dimensions of our history and culture that have allowed privileges associated with 'whiteness' and disadvantages associated with 'color' to endure and adapt over time" (Aspen Institute, 2004). Structural racism includes both individual racism and institutional racism:

- **Individual racism:** Intentional or unintentional acts of commission or omission based on assumptions that one race is superior to another; can include internalized racism such that members of a stigmatized race accept negative messages about their own abilities and intrinsic worth (Jones, 2000).
- **Institutional racism:** Differential access to the goods, services, and opportunities of society by race, which is often codified in our institutions as customary practice or even law (Jones, 2000); may referred to as "systemic" racism.

White Privilege: A system of benefits, advantages, and opportunities experienced by white persons in our society simply because of their skin color (Donnelly et al., 2005). As described by McIntosh (1989), white privilege may also be conceived as "an invisible package of unearned assets that [a white person] can count on cashing in each day, but about which [they] were 'meant' to remain oblivious. White privilege is like an invisible weightless knapsack of special provisions, assurances, tools, maps, guides, codebooks, passports, visas, clothes, compass, emergency gear, and blank checks."

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SECTION 4: The Case for Change

There are many ways to try to convince the public, policymakers, and professionals that a new approach is needed to address health inequities. One can make an ethical case for change, as highlighted by the guiding principles and values outlined in the previous section. Or, one can make a practical case for change using health statistics to argue that the current approach is not working and offer a conceptual or evidence-based rational for an alternative approach, as highlighted by the shift in focus of Healthy People 2020 towards the SDOH. One can also make an economic case for change by pointing out that our current system is unsustainable and inefficient.

The ethical, practical, and economic perspectives are evident in the implications of a landmark study which estimated the total number of deaths in the United States that could be attributable to social factors. Researchers (Galea et al., 2011) found that in the year 2000 alone:

- 245,000 deaths were attributable to low education.
-
- 176,000 deaths were attributable to racial segregation.
-
- 162,000 deaths were attributable to low social support.
-
- 133,000 deaths were attributable to individual-level poverty.
-
- 119,000 deaths were attributable to income inequality.
-
- 39,000 deaths were attributable to area-level poverty.

These data illustrate the interconnectedness of the ethical, practical, and economic perspectives and reflect the context seen in Delaware. This section highlights examples of social inequities in health, which makes the practical case for change directly relevant to local stakeholders. It also summarizes the economic case for change broadly and in relation to health care spending in Delaware. Inherent in both of these perspectives is an ethical perspective that may be understood and appreciated differently by individual readers. Many potential users of this guide may not need convincing, but rather need tools to help foster change. For those individuals, we suggest that this section be used to help convince partners and colleagues to build the broad base of support required to make necessary kinds of change. In addition to more recent data where possible, this updated version of the guide includes several maps intended to illustrate the magnitude of health inequities across Delaware neighborhoods.

This section also provides a discussion of the need for a more holistic, prevention-oriented health system across the continuum of clinical and non-clinical services and approaches. It concludes with a brief discussion of the opportunities for transforming our health system provided through Delaware’s State Health Care Innovation Plan and the HCD initiative.

The Delaware Context

As discussed in Section 2, the health profile of the United States is poor relative to the rest of the world. The health profile of Delaware generally follows similar trends and patterns to those of the nation. For instance, the average life expectancy between 2011 and 2015 in Delaware was 78.7 years (similar to the national average) (Arias, et al., 2018). Delaware's infant mortality rate of 6.6 per 1,000 live births in 2017 was high, compared to the national average of 5.80 per 1,000 live births (CDC, 2018). Infant mortality rates in Delaware also vary significantly by race. In Delaware, the infant mortality rate in 2017 was 4.5 per 1,000 live births for non-Hispanic white mothers, and 12.1 per 1,000 live births for non-Hispanic black mothers (see Figure 18) (DHSS, 2018).

Social Determinants of Health in Delaware

According to the State of Delaware Community Health Status Assessment (CHSA) published in 2013, "Quality of life and health status are intrinsically linked to economic, income and educational attainment of Delaware residents" (DHSS, 2013, p. 7). Recent economic trends have contributed to poor social conditions among certain communities in the state and the resulting inequities in income, education, and other social factors are apparent in Delaware's population. For instance:

- Poverty levels for the state increased from 11.1% to 13.6% between 2006 and 2017, contributing to a growing divide between the wealthy and the poor (U.S. Census Bureau, 2017).

- In 2017, the percentage of children living in families at or below the poverty level was 17.4% percent as compared to 15.8% in 2006 (U.S. Census Bureau, 2017).

- The number of homeless children and youth enrolled in Delaware public schools dropped to 3,018 in school year 2016-2017, from 3,227 in the previous school year; however, that translates to 2.4% of Delaware students who are homeless (NCHE, 2019).

- High school graduation rates have steadily increased, but whites still have higher graduation rates than blacks and Hispanics (DE DOE, 2019).

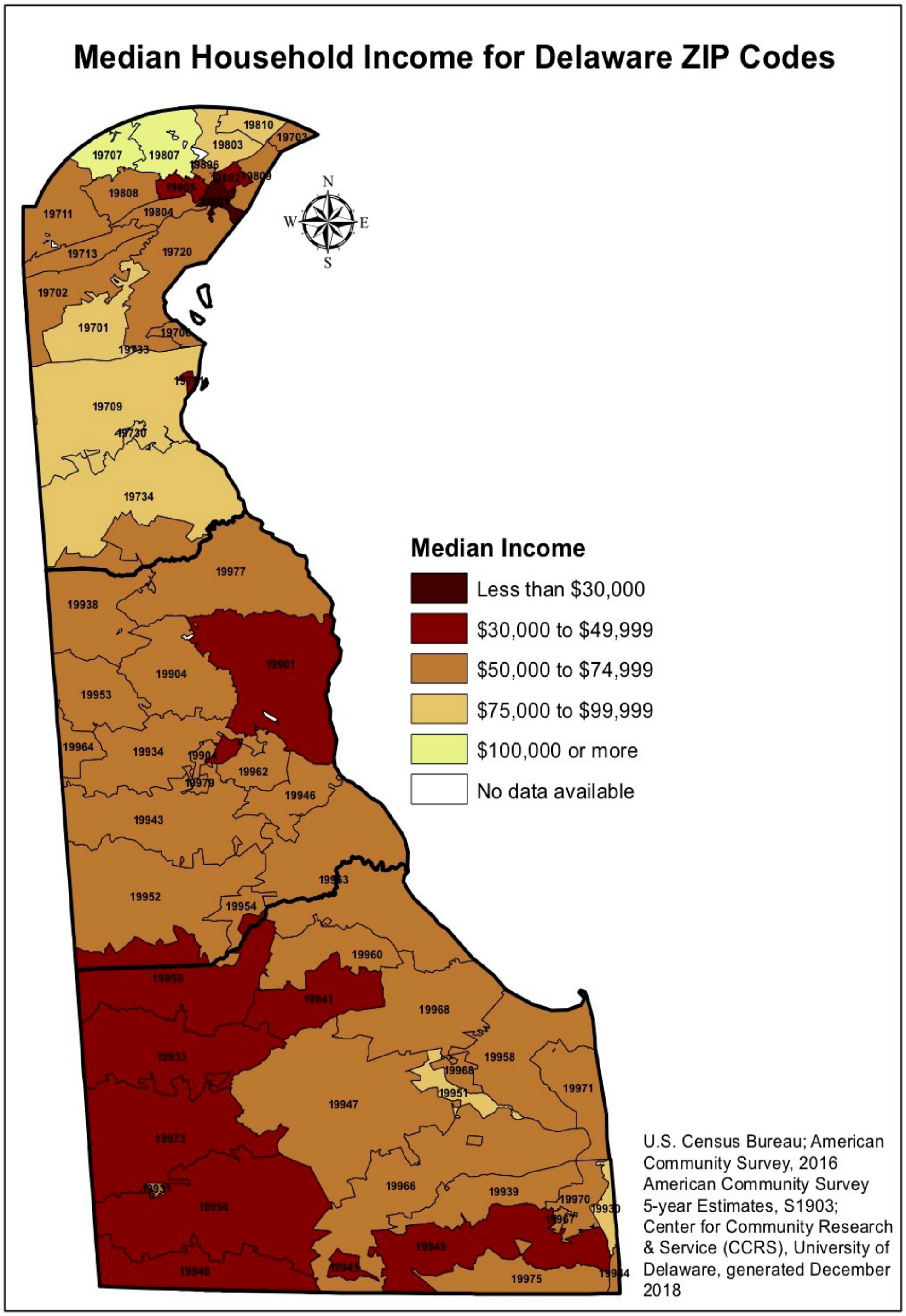
> **"Quality of life and health status are intrinsically linked to economic, income and educational attainment of Delaware residents" (DHHS, 2013).**

It is particularly meaningful to consider such SDOH in the context of “place,” because the health of a community is directly linked to the physical and social conditions of that community. Healthy communities are characterized as those having an abundance of resources needed to create health, such as income, education, and quality housing.

Resources needed for health, such as income, are not distributed equitably in Delaware. Certain areas have large differences in median income, such as in the northern part of Delaware, where very high income communities border very low-income communities (Figure 15). This is important, given that research suggests that income inequality is linked to poor health outcomes for everyone, not just those living in the poorer communities (Wilkinson & Pickett, 2006). There are similar geographic patterns regarding educational attainment. Noticeably, many Delawareans who did not earn a high school diploma reside in low income communities (Figure 16).

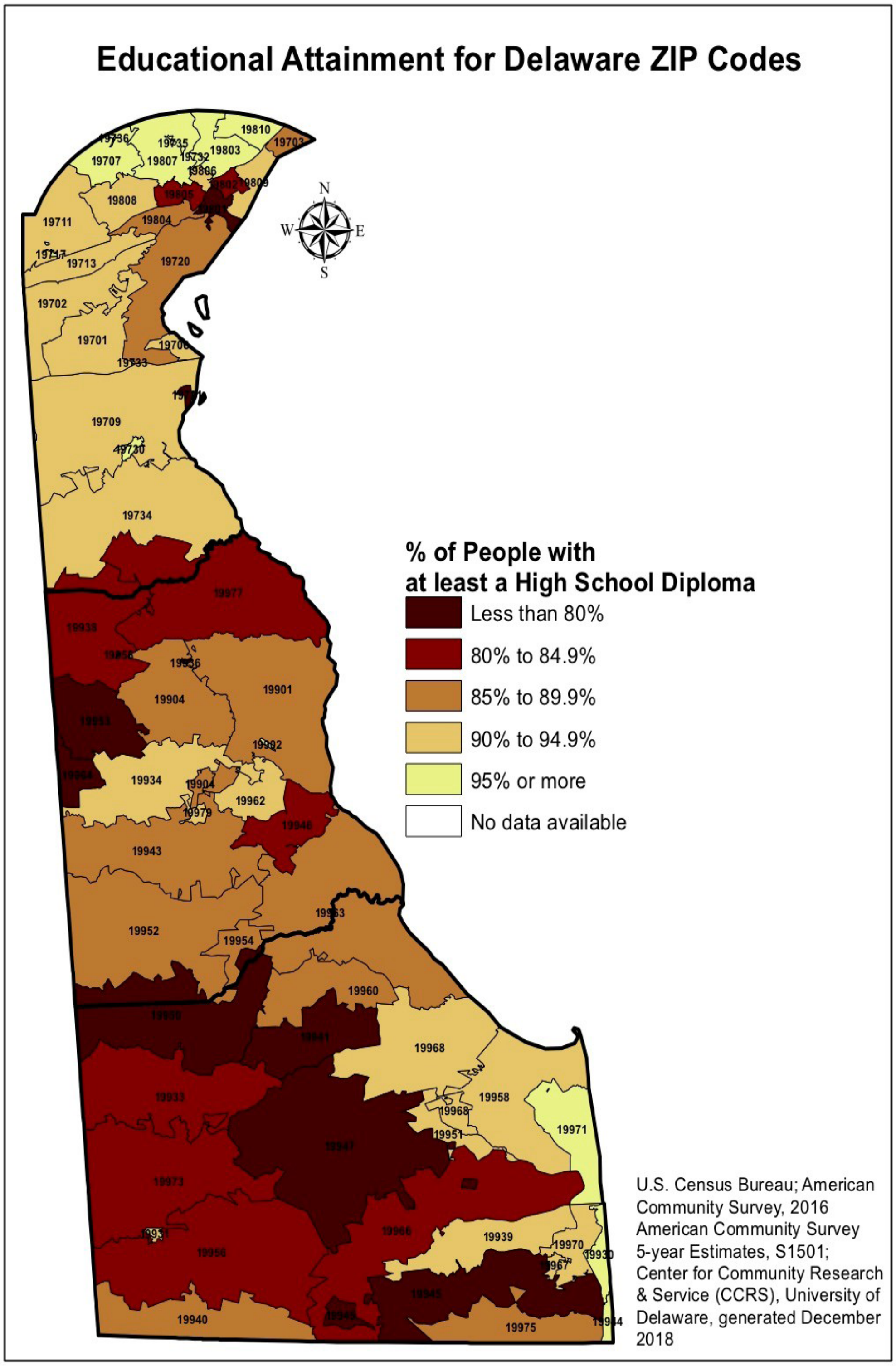
The “dissimilarity index” is used to estimate residential segregation across the state (Figure 17). The dissimilarity index is a commonly used measure of the separation or integration of two groups across a geographic area — in this case, black residents and white residents. Values of the index between 0 and 30 are considered low segregation; 30-60 are considered moderate; and above 60 are considered highly segregated (Massey & Denton, 1988). In Delaware, the highest levels of segregation are seen in the northern part of the state, specifically in the City of Wilmington (Figure 17). Although it is difficult to make any definitive conclusions regarding the nature of the relation between income, education, and segregation, it is important to explore the concept of cumulative disadvantage. Explicitly, cumulative disadvantage is the increased likelihood of poor health outcomes with each additional risk factor. Said differently, each risk factor puts individuals increasingly in jeopardy of “falling into the river” of poor health outcomes.

Figure 15: Median incomes by ZIP Code, Delaware, 2018.



Source: Center for Community Research and Service, 2018.

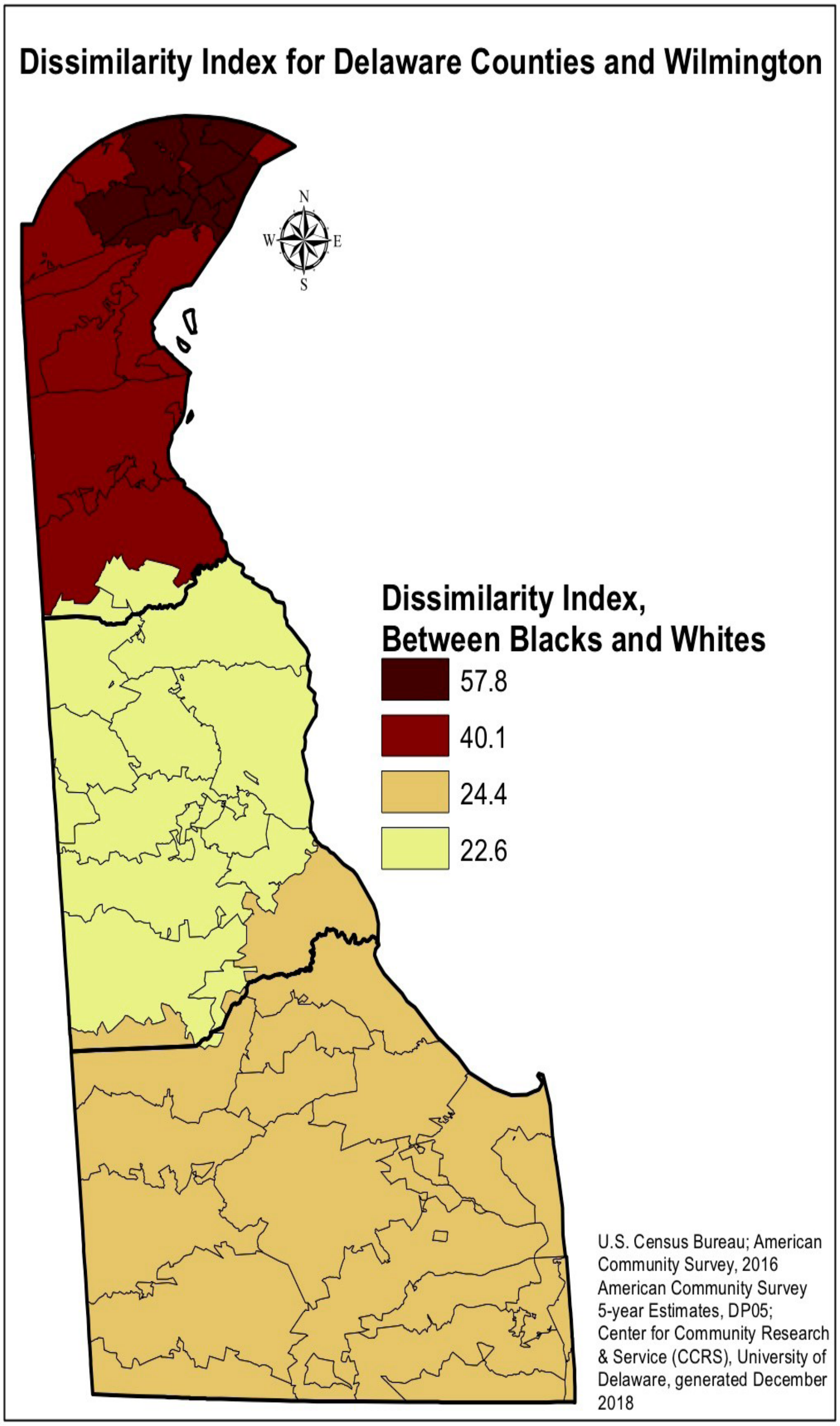
Figure 16: Percentage of residents with at least a High School Diploma, by ZIP Code, Delaware, 2016



U.S. Census Bureau; American Community Survey, 2016 American Community Survey 5-year Estimates, S1501; Center for Community Research & Service (CCRS), University of Delaware, generated December 2018

Source: Center for Community Research and Service, 2018.

Figure 17: Dissimilarity Index by ZIP Code in the counties and Wilmington, Delaware, 2016.



Source: Center for Community Research and Service, 2018.

Inequities in Health Status in Delaware

As described in earlier sections, health inequities may be understood as differences in health that are socially determined. They are related to differences in the quality and distribution of the determinants of health, such as income and education, and are often most prominent across categories of race or ethnicity. Examples of health inequities in Delaware include:

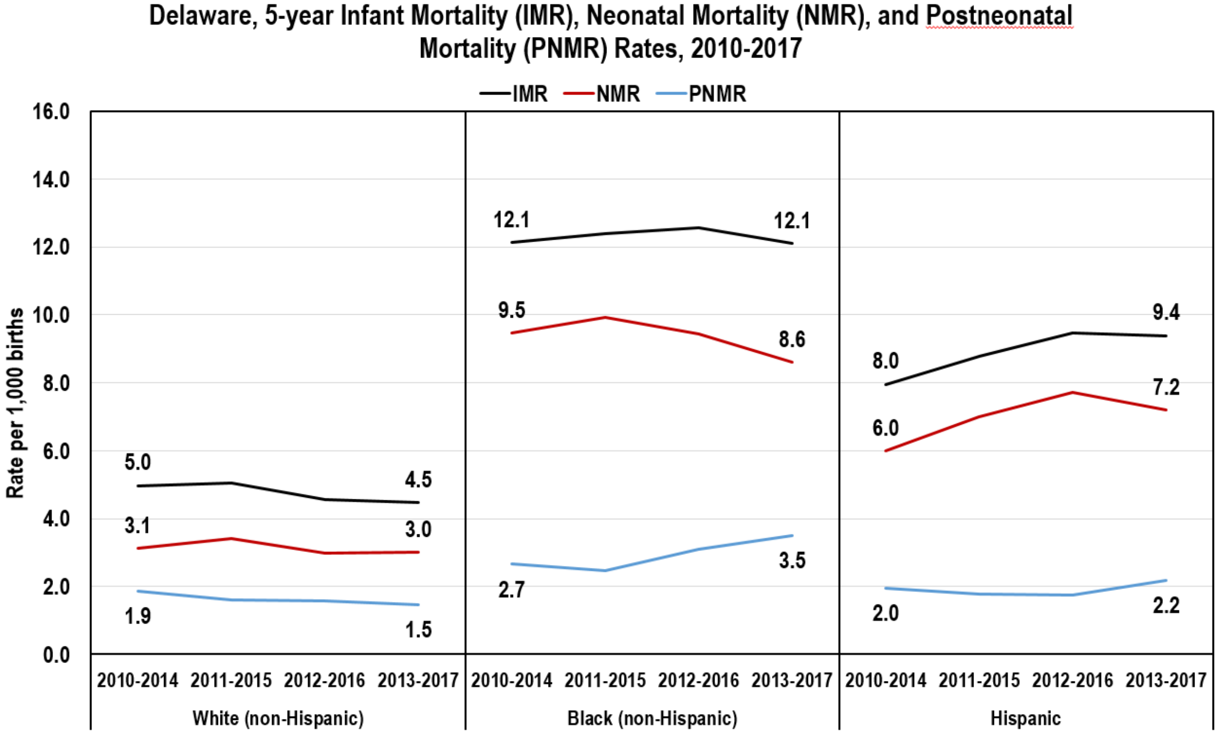
- Black women have an infant mortality rate of 12.5 per 1,000 live births, which is approximately 2.5 times that of white women in Delaware (DHSS, 2016); the pattern holds for both neonatal mortality and postnatal mortality (Figure 18).

- The homicide rate for black men increased 116% between 2012 and 2016, and is seven times higher than for white men (DHSS, 2016).

- Forty-six percent (46%) of the people living with HIV/AIDS in Delaware are black, despite the fact that blacks only account for 21% of the state's population. Hispanics account for 12% of the HIV/AIDS population and only 9% of the state's population (Kaiser, 2017).

- On average, life expectancy for black people in Delaware is three years less than life expectancy for whites in Delaware (DHSS, 2016).

Figure 18: Five-year infant mortality rates of neonatal mortality and postnatal mortality, by race/ethnicity, Delaware, 2010-2017.

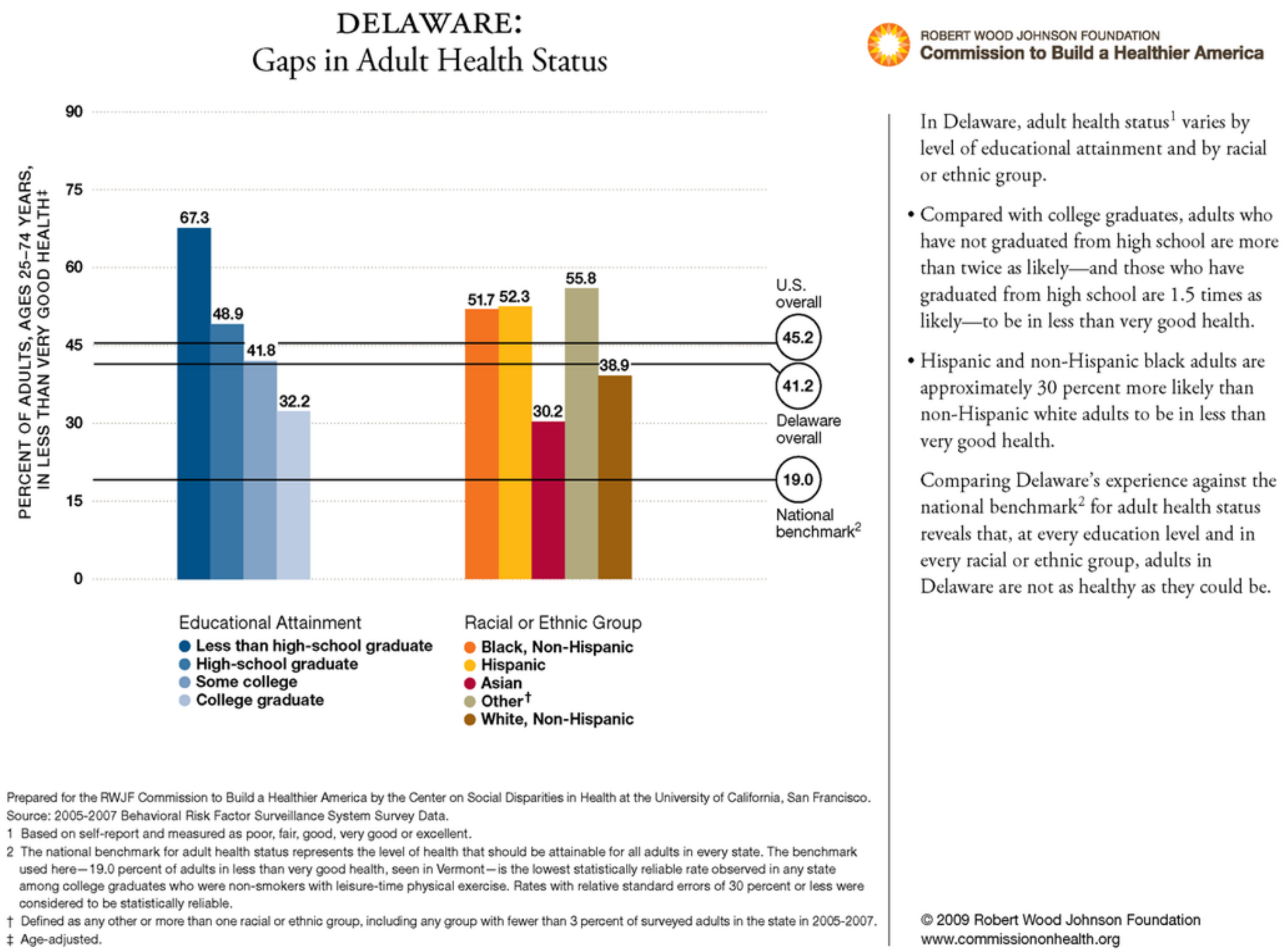


Source: Delaware Department of Health and Social Services, Division on Public Health, Delaware Health Statistics Center, 2010-2017.

Race and ethnicity, income, and education are related in complex ways and can interact to produce differences in health. Importantly, however, each is thought to contribute independently to health and health inequities. One should not be considered a proxy for another. Figures 19-21, reproduced courtesy of the RWJF Commission to Build a Healthier America, illustrate the patterns of health inequities in Delaware according to such social characteristics.

The average percentage of adults in less than very good health in Delaware is better than the national average, but is still far from the national benchmark (Figure 19). Furthermore, the Commission concludes: “at every educational level and in every racial or ethnic group, adults in Delaware are not as healthy as they could be.” Similar trends can be seen with infant mortality (Figure 20) and children’s health status (Figure 21). With respect to the latter, the Commission concludes that there is “unrealized health potential among Delaware children in every income, education, and racial or ethnic group.”

Figure 19: Percent of adults in less than very good health according to educational attainment and race/ethnicity, Delaware, 2005-2007.



In Delaware, adult health status[1] varies by level of educational attainment and by racial or ethnic group.

- Compared with college graduates, adults who have not graduated from high school are more than twice as likely—and those who have graduated from high school are 1.5 times as likely—to be in less than very good health.
- Hispanic and non-Hispanic black adults are approximately 30 percent more likely than non-Hispanic white adults to be in less than very good health.

Comparing Delaware's experience against the national benchmark[2] for adult health status reveals that, at every education level and in every racial or ethnic group, adults in Delaware are not as healthy as they could be.

Prepared for the RWJF Commission to Build a Healthier America by the Center on Social Disparities in Health at the University of California, San Francisco.
Source: 2005-2007 Behavioral Risk Factor Surveillance System Survey Data.

[1] Based on self-report and measured as poor, fair, good, very good or excellent.

[2] The national benchmark for adult health status represents the level of health that should be attainable for all adults in every state. The benchmark used here—19.0 percent of adults in less than very good health, seen in Vermont—is the lowest statistically reliable rate observed in any state among college graduates who were non-smokers with leisure-time physical exercise. Rates with relative standard errors of 30 percent or less were considered to be statistically reliable.

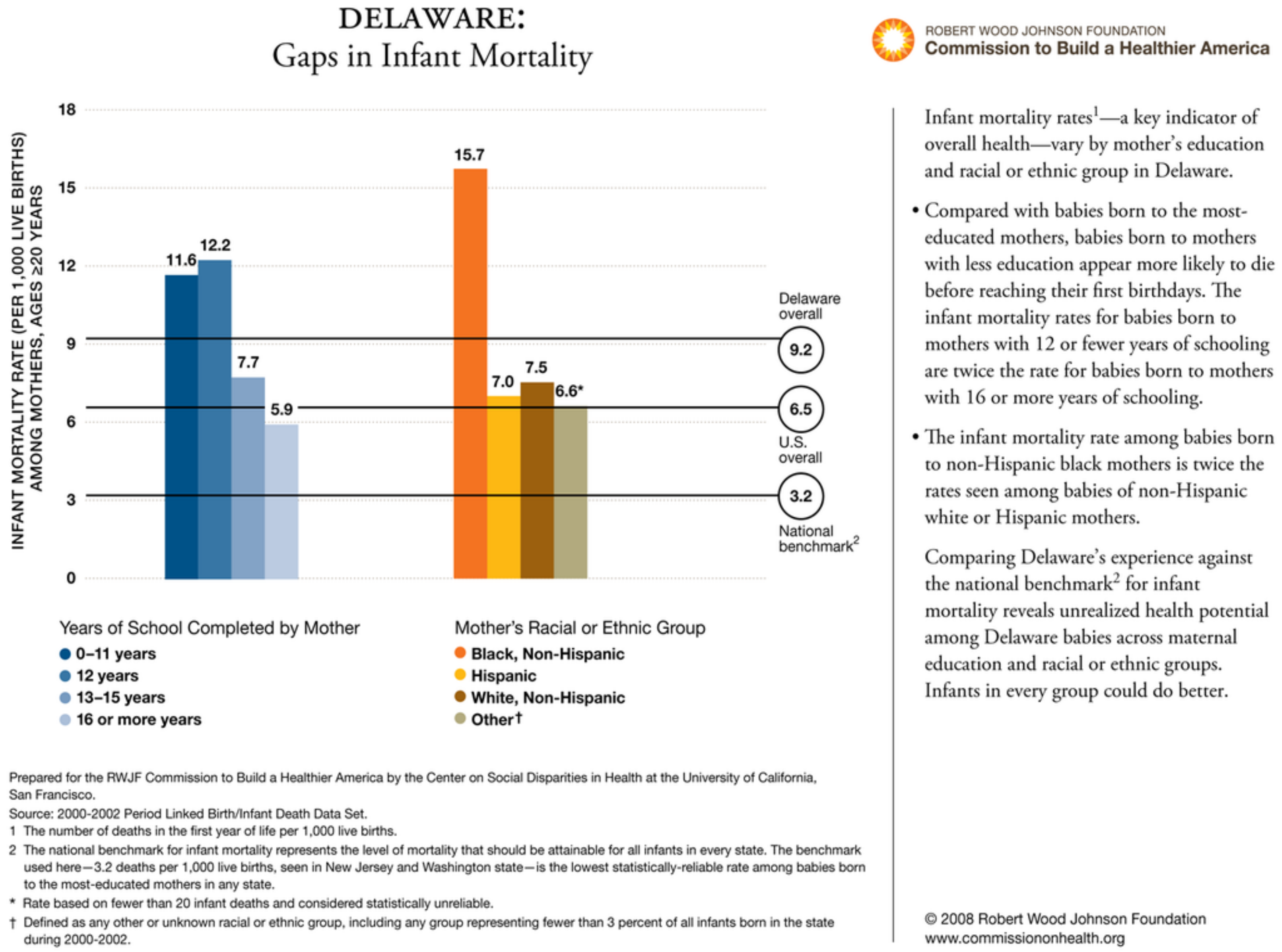
† Defined as any other or more than one racial or ethnic group, including any group with fewer than 3 percent of surveyed adults in the state in 2005-2007.

‡ Age-adjusted.

www.commissiononhealth.org

Source: Robert Wood Johnson Foundation, 2009.

Figure 20: Infant mortality rate according to educational attainment and race/ethnicity of mother, Delaware, 2000-2002



Infant mortality rates[1]—a key indicator of overall health—vary by mother's education and racial or ethnic group in Delaware.

- Compared with babies born to the most-educated mothers, babies born to mothers with less education appear more likely to die before reaching their first birthdays. The infant mortality rates for babies born to mothers with 12 or fewer years of schooling are twice the rate for babies born to mothers with 16 or more years of schooling.
- The infant mortality rate among babies born to non-Hispanic black mothers is twice the rates seen among babies of non-Hispanic white or Hispanic mothers.

Comparing Delaware's experience against the national benchmark[2] for infant mortality reveals unrealized health potential among Delaware babies across maternal education and racial or ethnic groups. Infants in every group could do better.

Prepared for the RWJF Commission to Build a Healthier America by the Center on Social Disparities in Health at the University of California, San Francisco.

Source: 2000-2002 Period Linked Birth/Infant Death Data Set.

1 The number of deaths in the first year of life per 1,000 live births.

2 The national benchmark for infant mortality represents the level of mortality that should be attainable for all infants in every state. The benchmark used here—3.2 deaths per 1,000 live births, seen in New Jersey and Washington state—is the lowest statistically-reliable rate among babies born to the most-educated mothers in any state.

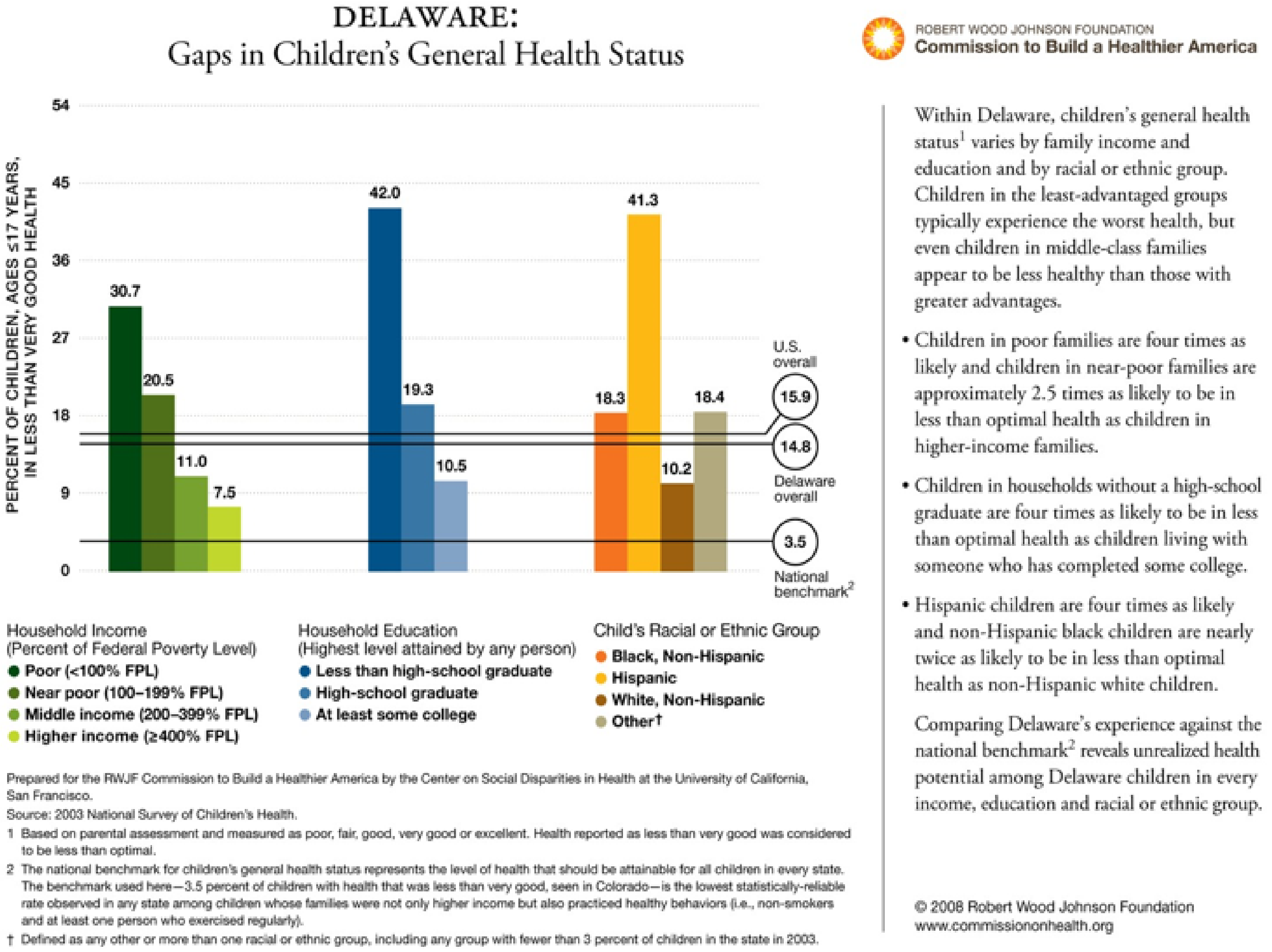
* Rate based on fewer than 20 infant deaths and considered statistically unreliable.

† Defined as any other or unknown racial or ethnic group, including any group representing fewer than 3 percent of all infants born in the state during 2000-2002.

www.commissiononhealth.org

Source: Robert Wood Johnson Foundation, 2009.

Figure 21: Percent of children in less than very good health according to household income, educational attainment, and race/ethnicity, Delaware, 2003.



Within Delaware, children's general health status[1] varies by family income and education and by racial or ethnic group. Children in the least-advantaged groups typically experience the worst health, but even children in middle-class families appear to be less healthy than those with greater advantages.

- Children in poor families are four times as likely and children in near-poor families are approximately 2.5 times as likely to be in less than optimal health as children in higher-income families.
- Children in households without a high-school graduate are four times as likely to be in less than optimal health as children living with someone who has completed some college.
- Hispanic children are four times as likely and non-Hispanic black children are nearly twice as likely to be in less than optimal health as non-Hispanic white children.

Comparing Delaware's experience against the national benchmark[2] reveals unrealized health potential among Delaware children in every income, education and racial or ethnic group.

Prepared for the RWJF Commission to Build a Healthier America by the Center on Social Disparities in Health at the University of California, San Francisco.

Source: 2003 National Survey of Children's Health.

[1] Based on parental assessment and measured as poor, fair, good, very good or excellent. Health reported as less than very good was considered to be less than optimal.

[2] The national benchmark for children's general health status represents the level of health that should be attainable for all children in every state. The benchmark used here—3.5 percent of children with health that was less than very good, seen in Colorado—is the lowest statistically-reliable rate observed in any state among children whose families were not only higher income but also practiced healthy behaviors (i.e., non-smokers and at least one person who exercised regularly).

† Defined as any other or more than one racial or ethnic group, including any group with fewer than 3 percent of children in the state in 2003.

Source: Robert Wood Johnson Foundation, 2009.

It is becoming increasingly evident that important differences in health indicators exist in Delaware by geographic location, which is related to, but distinct from, other socioeconomic factors. For instance:

- There is as much as a 16-year difference in life expectancy across neighborhoods in inner city Wilmington and the surrounding suburbs, and an 8.7-year life expectancy difference for neighborhoods in inner city Dover and the surrounding suburbs (NCHS, 2018).

- Children in Kent County reported significantly higher rates of Adverse Childhood Experiences (ACEs) when compared to the other two counties. ACEs are a measure of childhood trauma and have a lifelong impact on health (CCHD, 2015).

- The prevalence rate of existing cases of HIV/AIDS is highest in New Castle County (with ~37% of Delaware residents with HIV residing in the City of Wilmington), but Kent County has the highest incidence rate of new cases of HIV (DHSS, 2017).

- Adult obesity rates are highest in Kent County, but Sussex County has the highest percentage of children who are overweight or obese (DHSS, 2017).

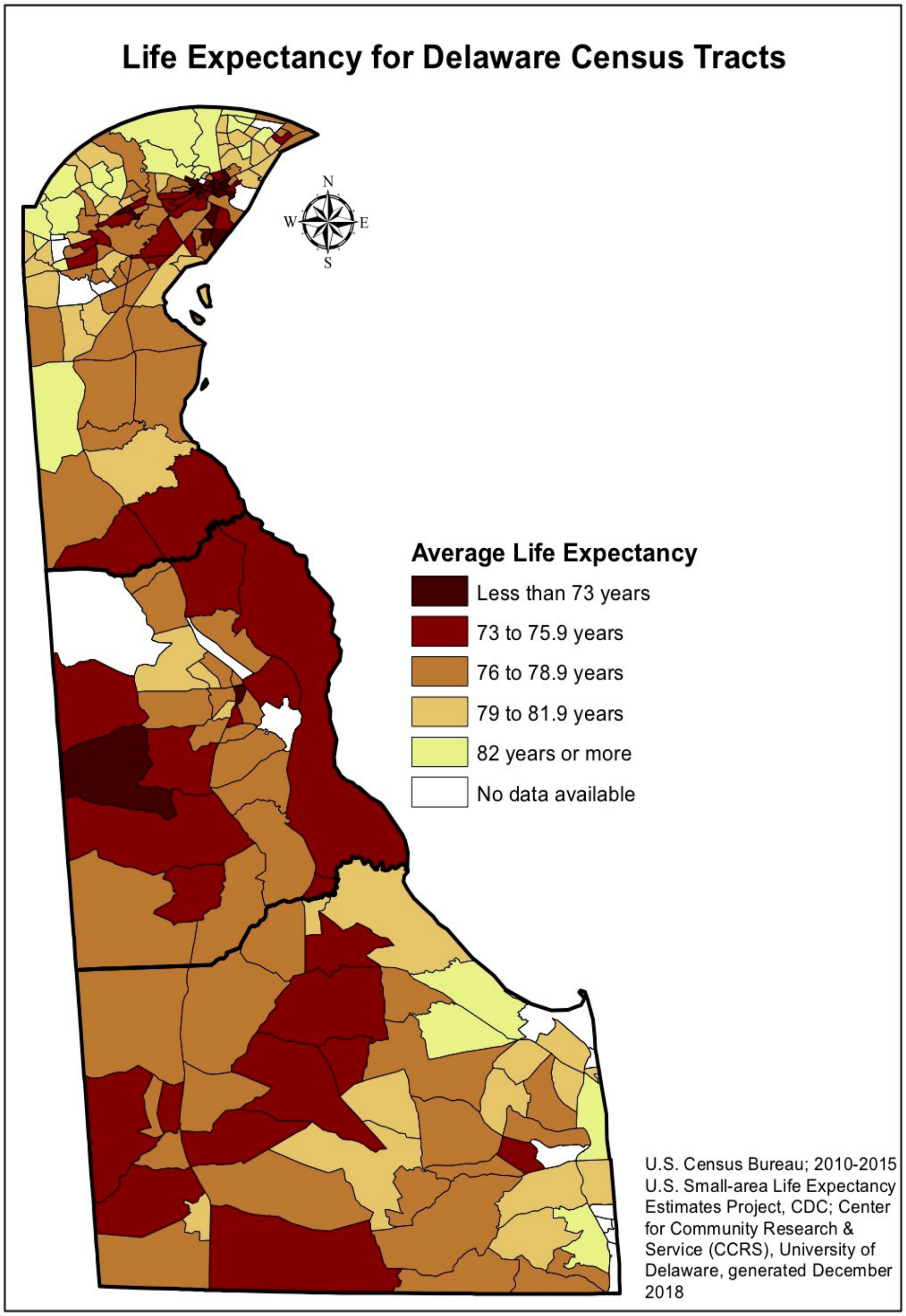
- Although cancer death rates are generally decreasing, the rate of new cases of cancers varies significantly across certain census tracts in Delaware (DHSS, 2019).

- Kent County sheltered 337 women and children victims of domestic violence in 2010, compared to 212 women and children victims in Sussex and New Castle counties combined (DHSS, 2012).

- Air quality is generally improving in Delaware, but in 2017, the number of days with unhealthy air quality was higher in New Castle County than in Sussex and Kent counties (DNREC, 2017).

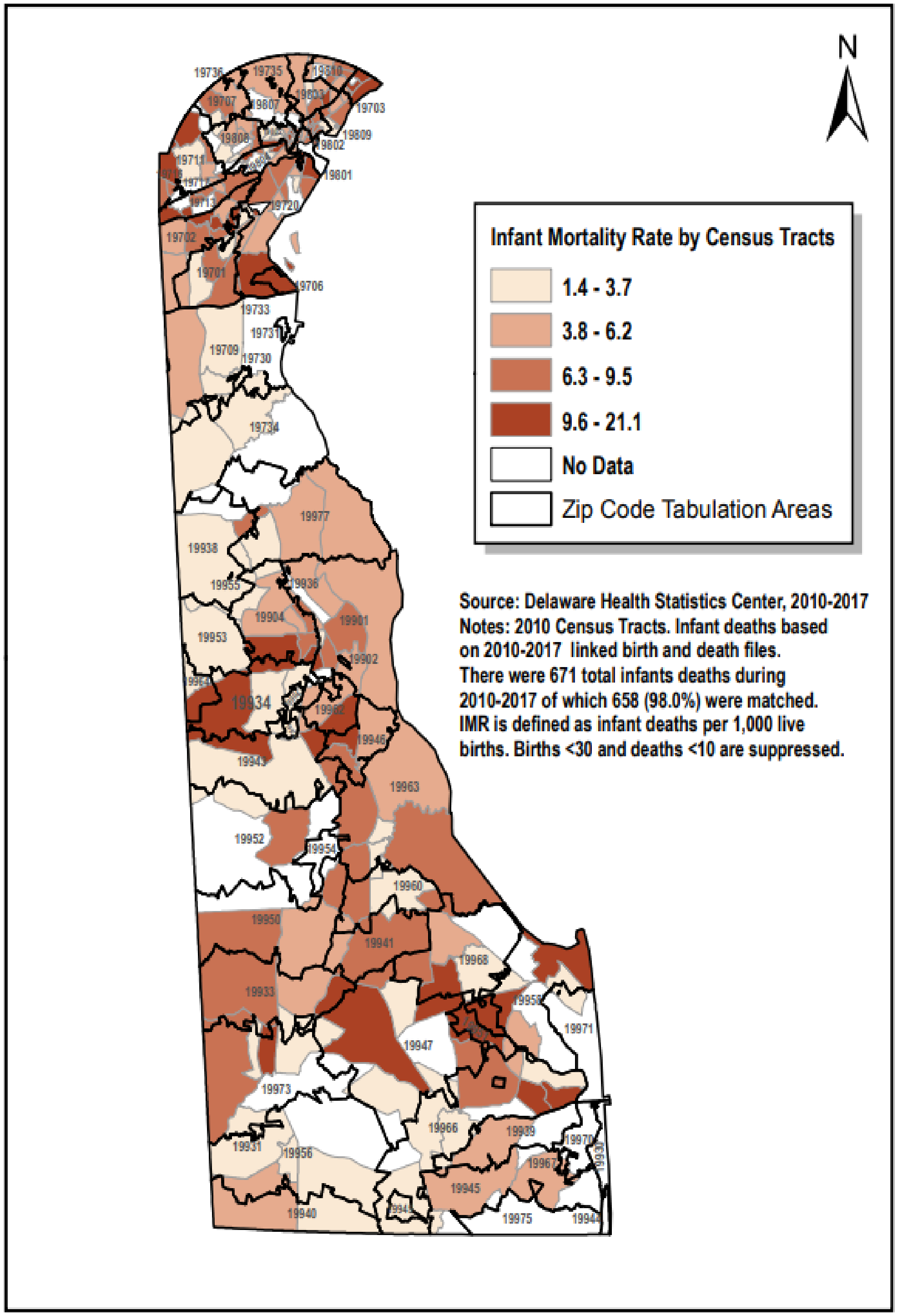
Geographic variations in life expectancy rates (Figure 22) and infant mortality rates (Figure 23) exist across Delaware. Although both life expectancy and infant mortality are important indicators often used to describe the overall health of a population or community, they provide only snapshots and do not reflect changes over time. Similarly, it is important to remember that health is determined by a complex array of factors and it is not possible to pinpoint a specific cause of these variations. Despite these limitations, and remembering the stream parable (Section 1), one can clearly see on these maps that the communities with the darkest shades are those with the weakest bridges and fences, and that individuals living near them are more at risk of falling into the stream of poor health outcomes.

Figure 22: Life expectancy by census tract, Delaware, 2010-2015.



Source: Center for Community Research and Service, 2018.

Figure 23: Infant mortality rate by census tract, Delaware, 2010-2017.



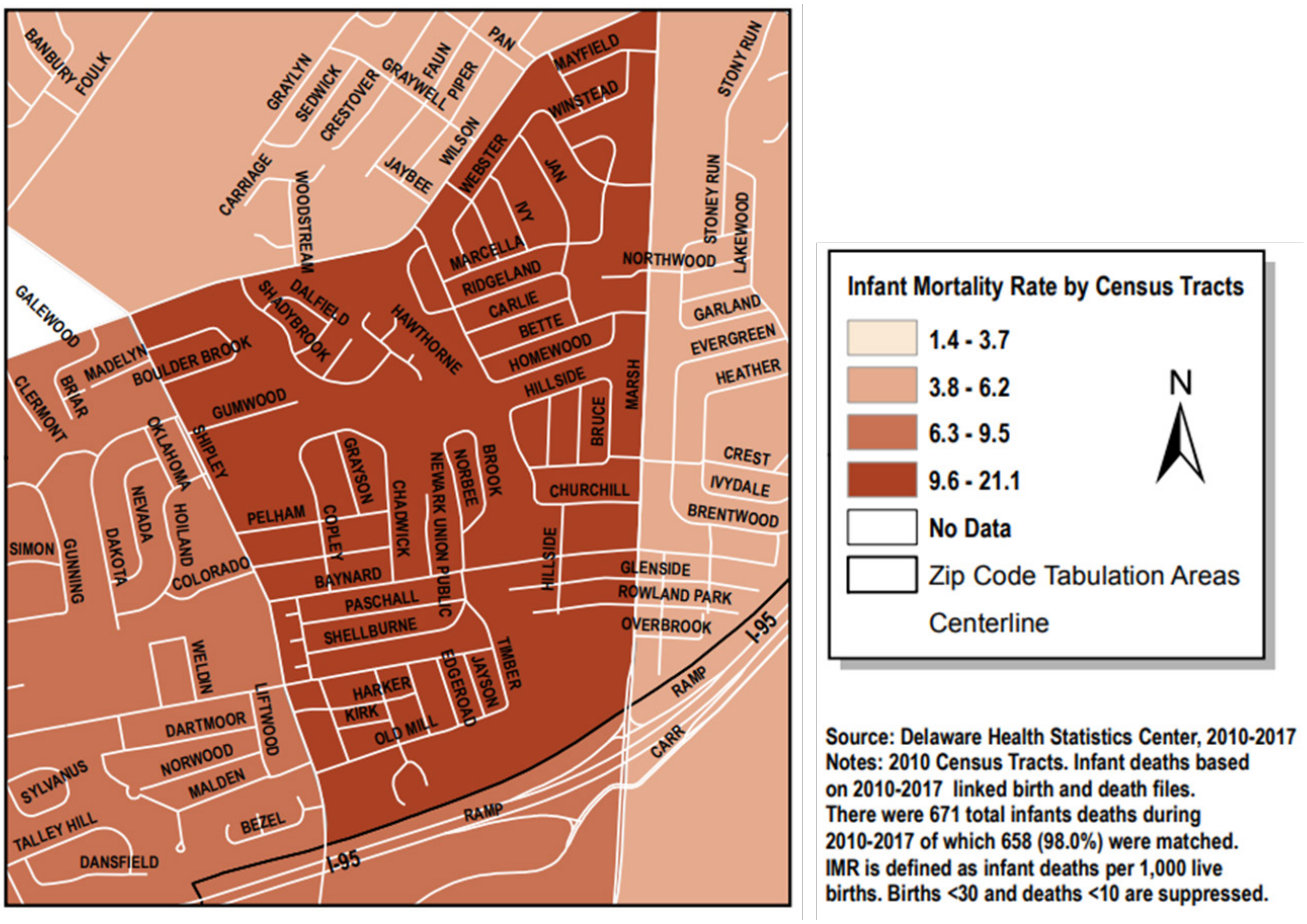
Source: Delaware Health Statistics Center, 2010-2017
Notes: 2010 Census Tracts. Infant deaths based on 2010-2017 linked birth and death files. There were 671 total infants deaths during 2010-2017 of which 658 (98.0%) were matched. IMR is defined as infant deaths per 1,000 live births. Births <30 and deaths <10 are suppressed.

Source: Hussaini, SK. (2018). Delaware Infant Mortality by Race/Ethnicity 2010-2017, Delaware Department of Health and Social Services, Division of Public Health.

Although it is often difficult to collect and analyze health outcomes at the census tract or neighborhood level, such efforts are important for understanding and addressing health inequities in the community. Delaware's infant mortality rates vary dramatically across short distances within many of our communities (Figures 24-30). Again, such health inequities likely reflect unequal access to resources and services, inequitable social conditions, and disparities in physical environments.

In May of 2019, DPH recently launched a new web portal to provide community-level data on a range of health and related factors known to influence health. DHSS is hopeful that My Healthy Community site (https://myhealthycommunity.dhss.delaware.gov/) encourages place-based approaches to improve and support community-level decision-making. Indicators available in the portal include those related to substance use disorder, air quality, asthma, and drinking water. More data are being added as they become available and as resources allow. Importantly, data are shared at the smallest geographic level possible, and can be used for comparisons across time and place.

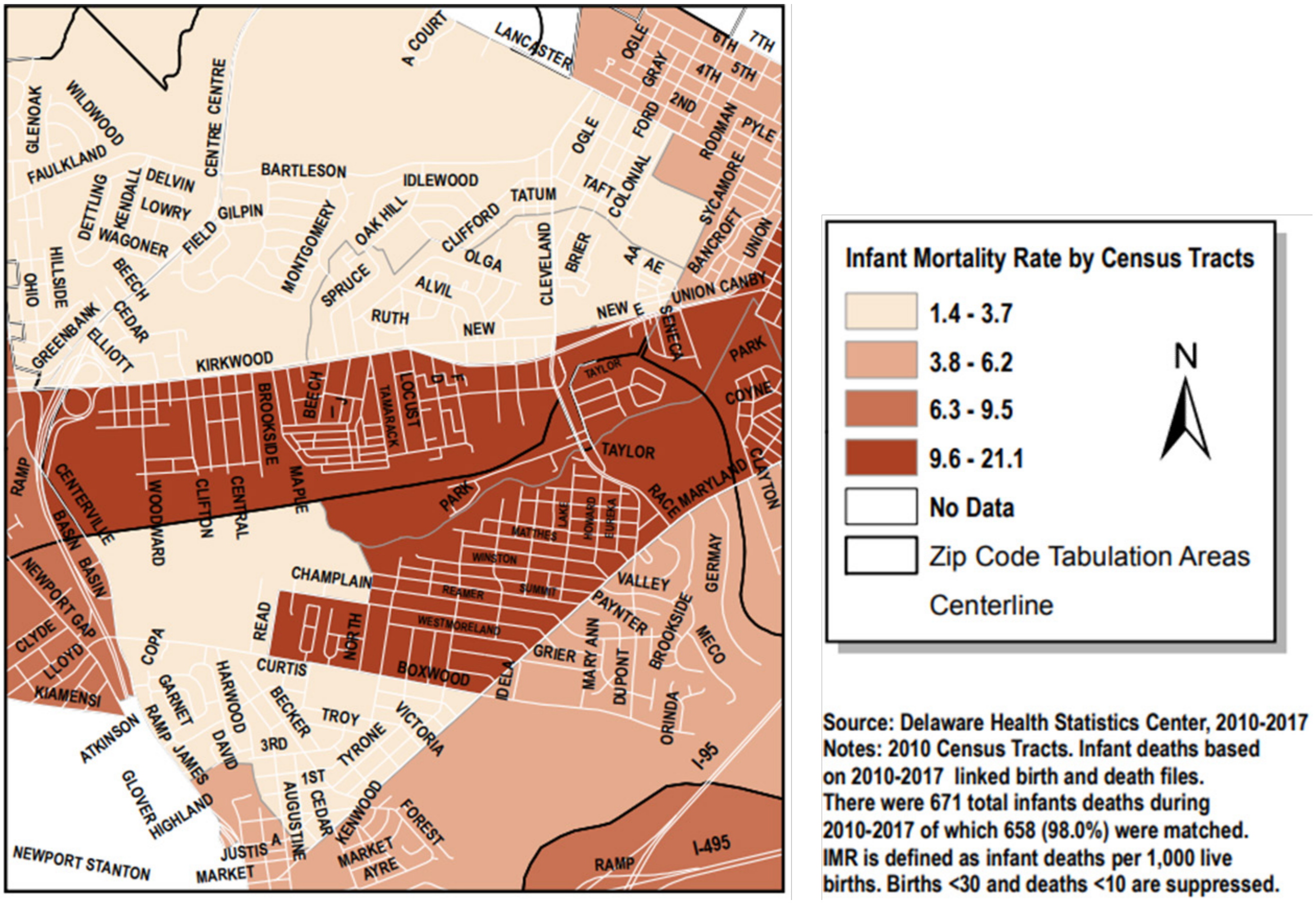
Figure 24: Infant mortality rate by census tract, Northeast Wilmington area, New Castle County, Delaware, 2010-2017.



Source: Delaware Health Statistics Center, 2010-2017
Notes: 2010 Census Tracts. Infant deaths based on 2010-2017 linked birth and death files. There were 671 total infants deaths during 2010-2017 of which 658 (98.0%) were matched. IMR is defined as infant deaths per 1,000 live births. Births <30 and deaths <10 are suppressed.

Source: Hussaini, SK. (2018). Delaware Infant Mortality by Race/Ethnicity 2010-2017, Delaware Department of Health and Social Services, Division of Public Health.

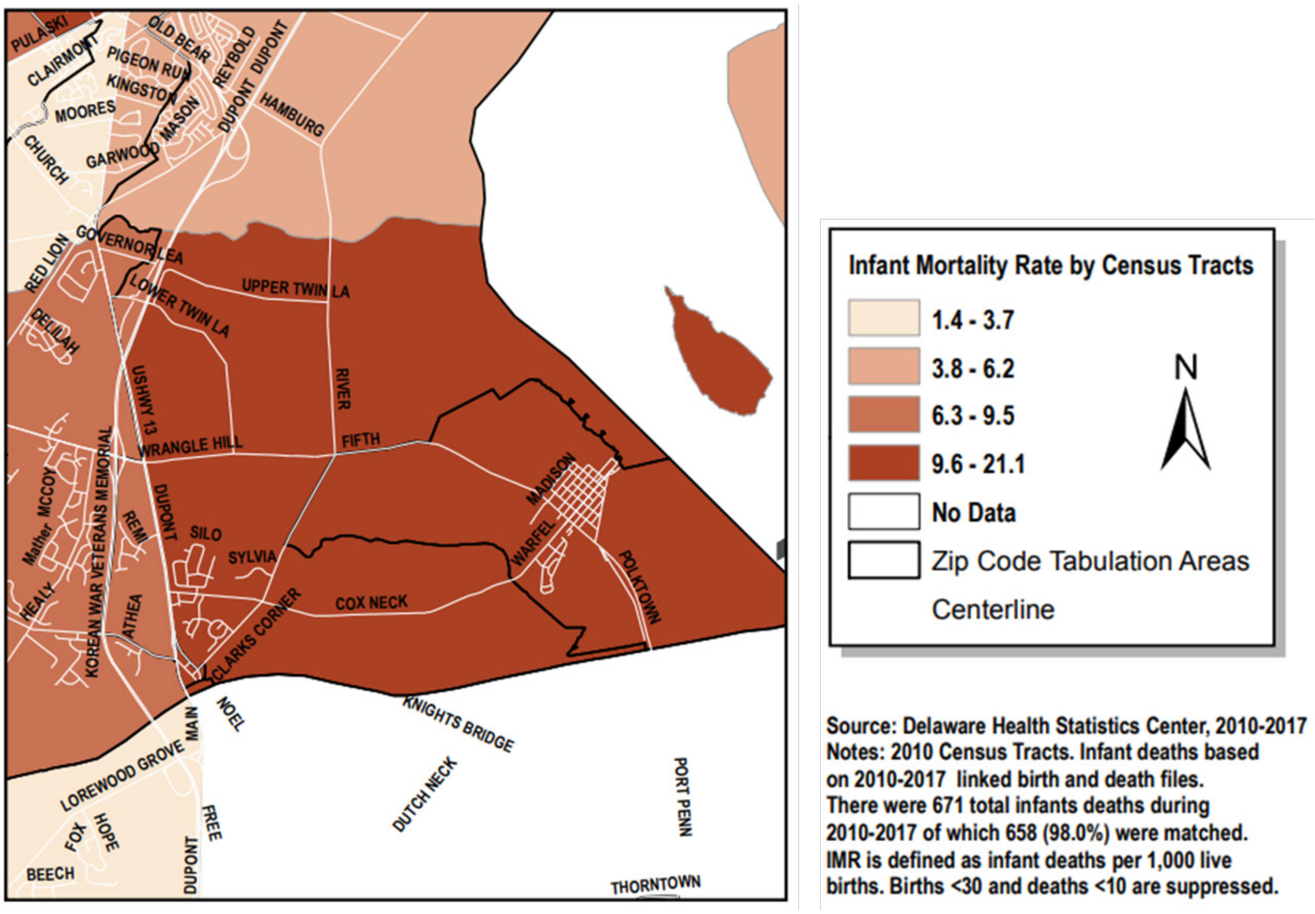
Figure 25: Infant mortality rate by census tract, Southwest Wilmington including Hedgeville, Bayard Square, and St. Elizabeth's areas, New Castle County, Delaware, 2010-2017.



Source: Delaware Health Statistics Center, 2010-2017
Notes: 2010 Census Tracts. Infant deaths based on 2010-2017 linked birth and death files. There were 671 total infants deaths during 2010-2017 of which 658 (98.0%) were matched. IMR is defined as infant deaths per 1,000 live births. Births <30 and deaths <10 are suppressed.

Source: Hussaini, SK. (2018). Delaware Infant Mortality by Race/Ethnicity 2010-2017, Delaware Department of Health and Social Services, Division of Public Health.

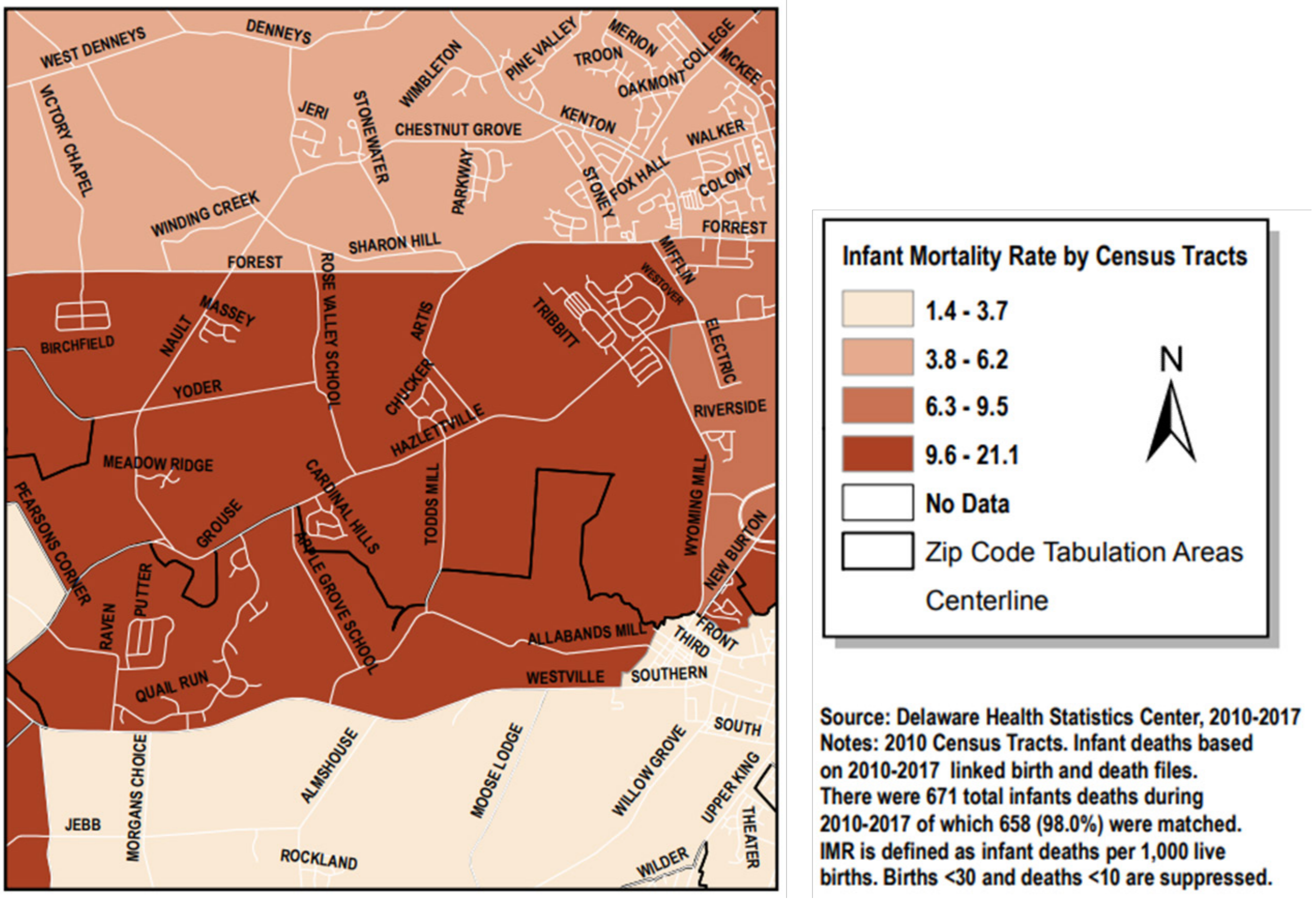
Figure 26: Infant mortality rate by census tract, Delaware City area to the west of the Delaware River and north of St. Georges, New Castle County, 2010-2017.



Source: Delaware Health Statistics Center, 2010-2017
Notes: 2010 Census Tracts. Infant deaths based on 2010-2017 linked birth and death files. There were 671 total infants deaths during 2010-2017 of which 658 (98.0%) were matched. IMR is defined as infant deaths per 1,000 live births. Births <30 and deaths <10 are suppressed.

Source: Hussaini, SK. (2018). Delaware Infant Mortality by Race/Ethnicity 2010-2017, Delaware Department of Health and Social Services, Division of Public Health.

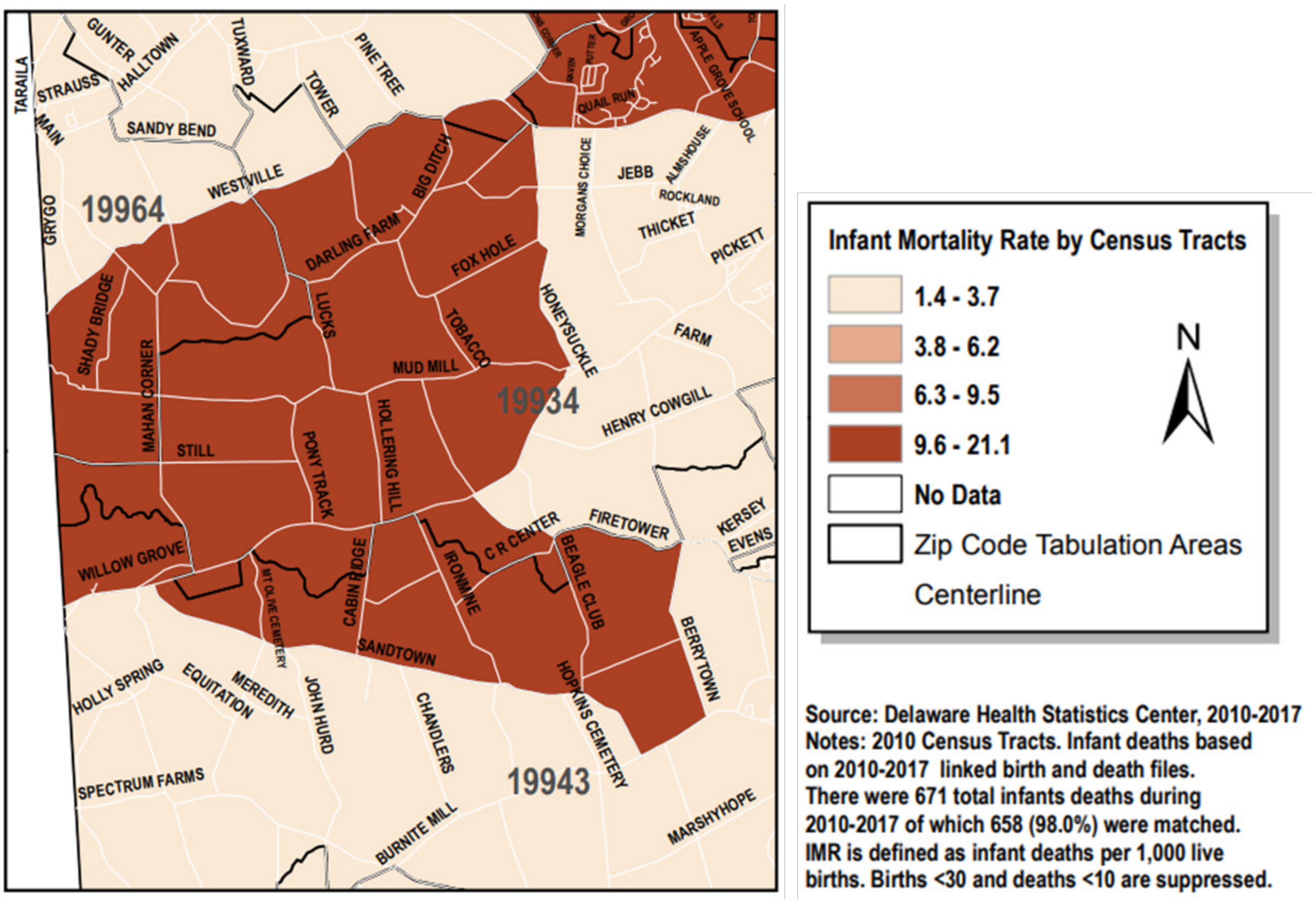
Figure 27: Infant mortality rate by census tract, west of Dover in the area of Sharon Hill and Todds Mill, Kent County, Delaware, 2010-2017.



Source: Delaware Health Statistics Center, 2010-2017
Notes: 2010 Census Tracts. Infant deaths based on 2010-2017 linked birth and death files. There were 671 total infants deaths during 2010-2017 of which 658 (98.0%) were matched. IMR is defined as infant deaths per 1,000 live births. Births <30 and deaths <10 are suppressed.

Source: Hussaini, SK. (2018). Delaware Infant Mortality by Race/Ethnicity 2010-2017, Delaware Department of Health and Social Services, Division of Public Health.

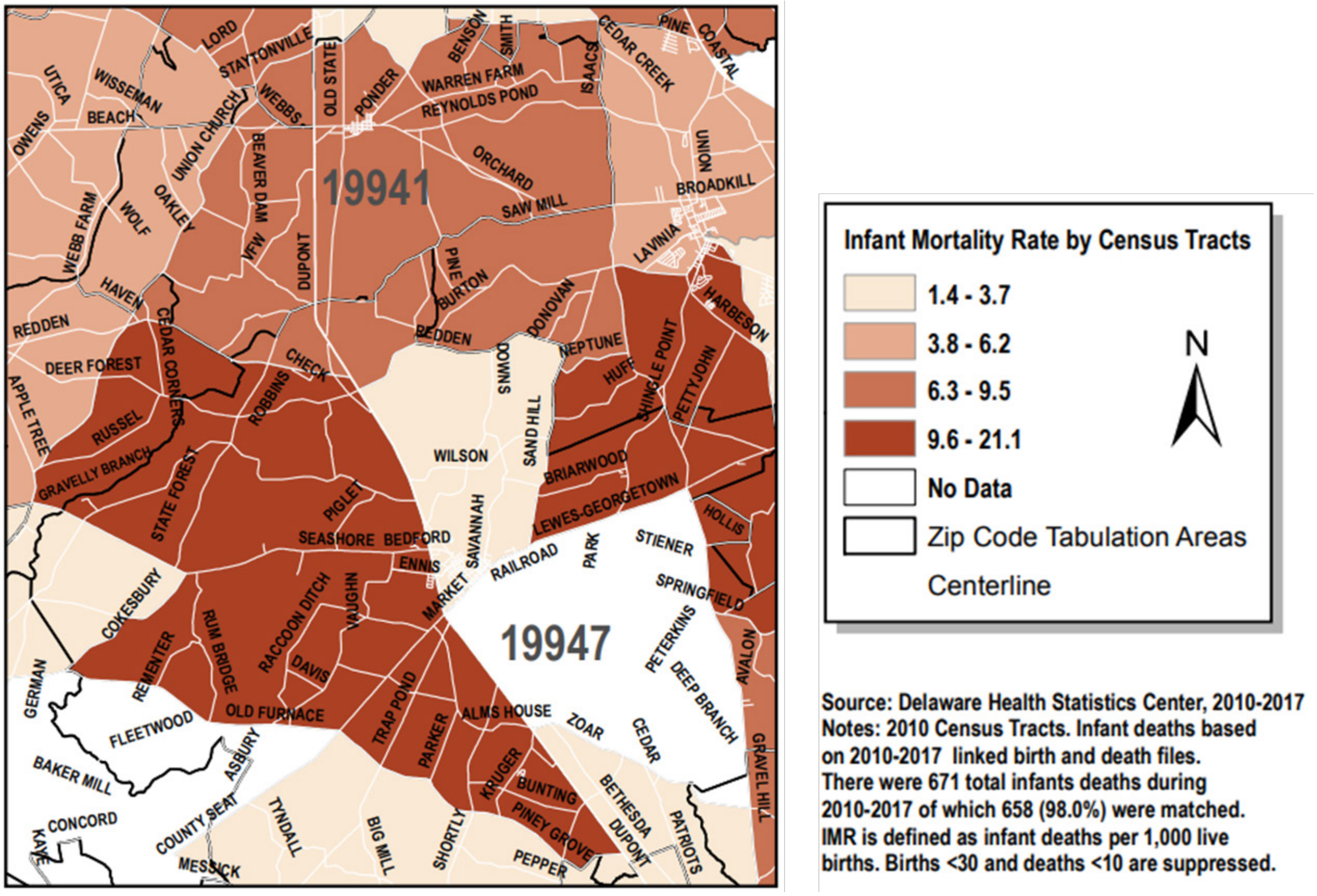
Figure 28: Infant mortality rate by census tract, area southwest of Camden and west of Route 13, Kent County, Delaware, 2010-2017.



Source: Delaware Health Statistics Center, 2010-2017
Notes: 2010 Census Tracts. Infant deaths based on 2010-2017 linked birth and death files. There were 671 total infants deaths during 2010-2017 of which 658 (98.0%) were matched. IMR is defined as infant deaths per 1,000 live births. Births <30 and deaths <10 are suppressed.

Source: Hussaini, SK. (2018). Delaware Infant Mortality by Race/Ethnicity 2010-2017, Delaware Department of Health and Social Services, Division of Public Health.

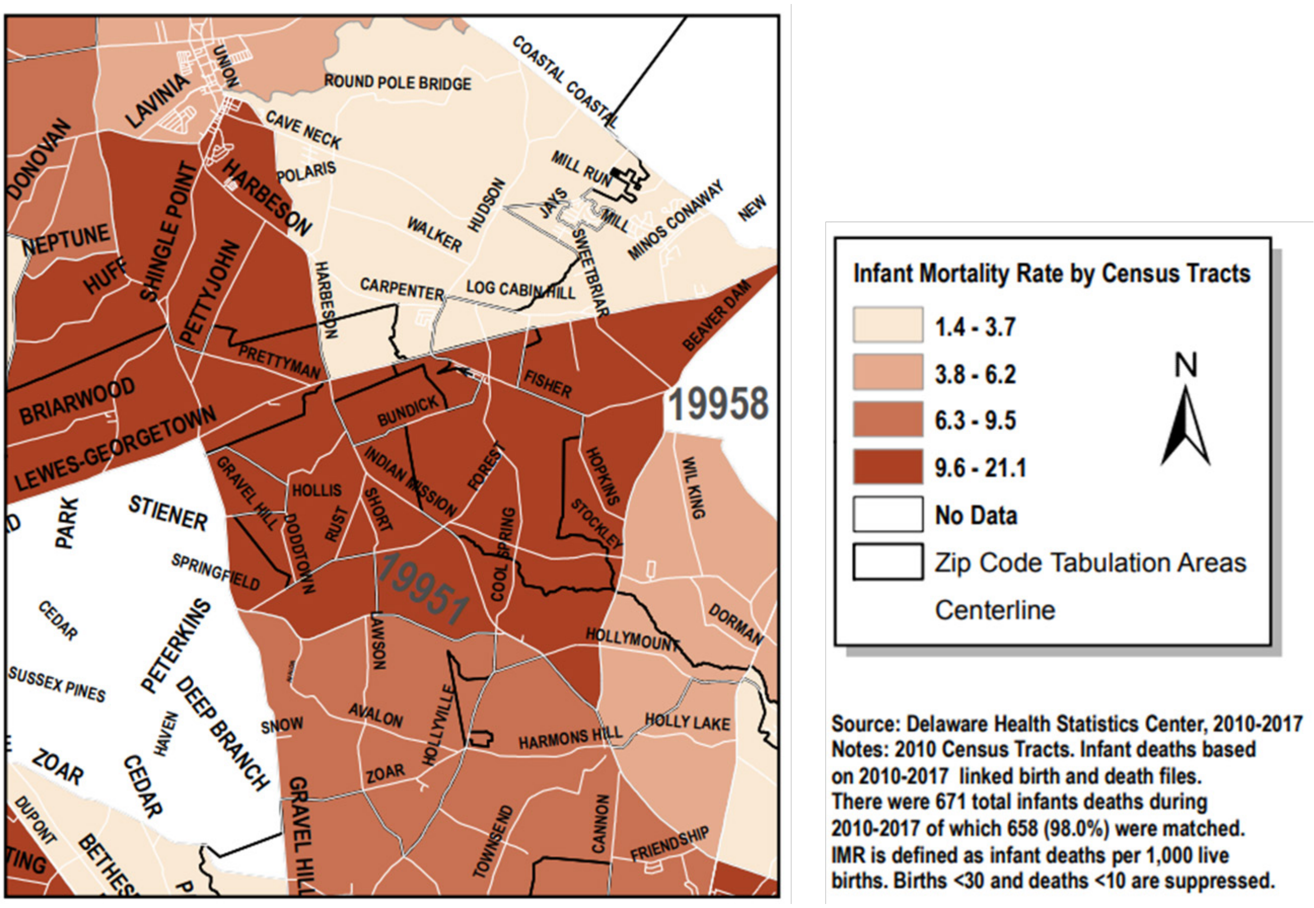
Figure 29: Infant mortality rate by census tract, area surrounding Georgetown and Ellendale, Sussex County, Delaware, 2010-2017.



Source: Delaware Health Statistics Center, 2010-2017
Notes: 2010 Census Tracts. Infant deaths based on 2010-2017 linked birth and death files. There were 671 total infants deaths during 2010-2017 of which 658 (98.0%) were matched. IMR is defined as infant deaths per 1,000 live births. Births <30 and deaths <10 are suppressed.

Source: Hussaini, SK. (2018). Delaware Infant Mortality by Race/Ethnicity 2010-2017, Delaware Department of Health and Social Services, Division of Public Health.

Figure 30: Infant mortality rate by census tract, area east of Georgetown to Lewes, Sussex County, Delaware, 2010-2017.

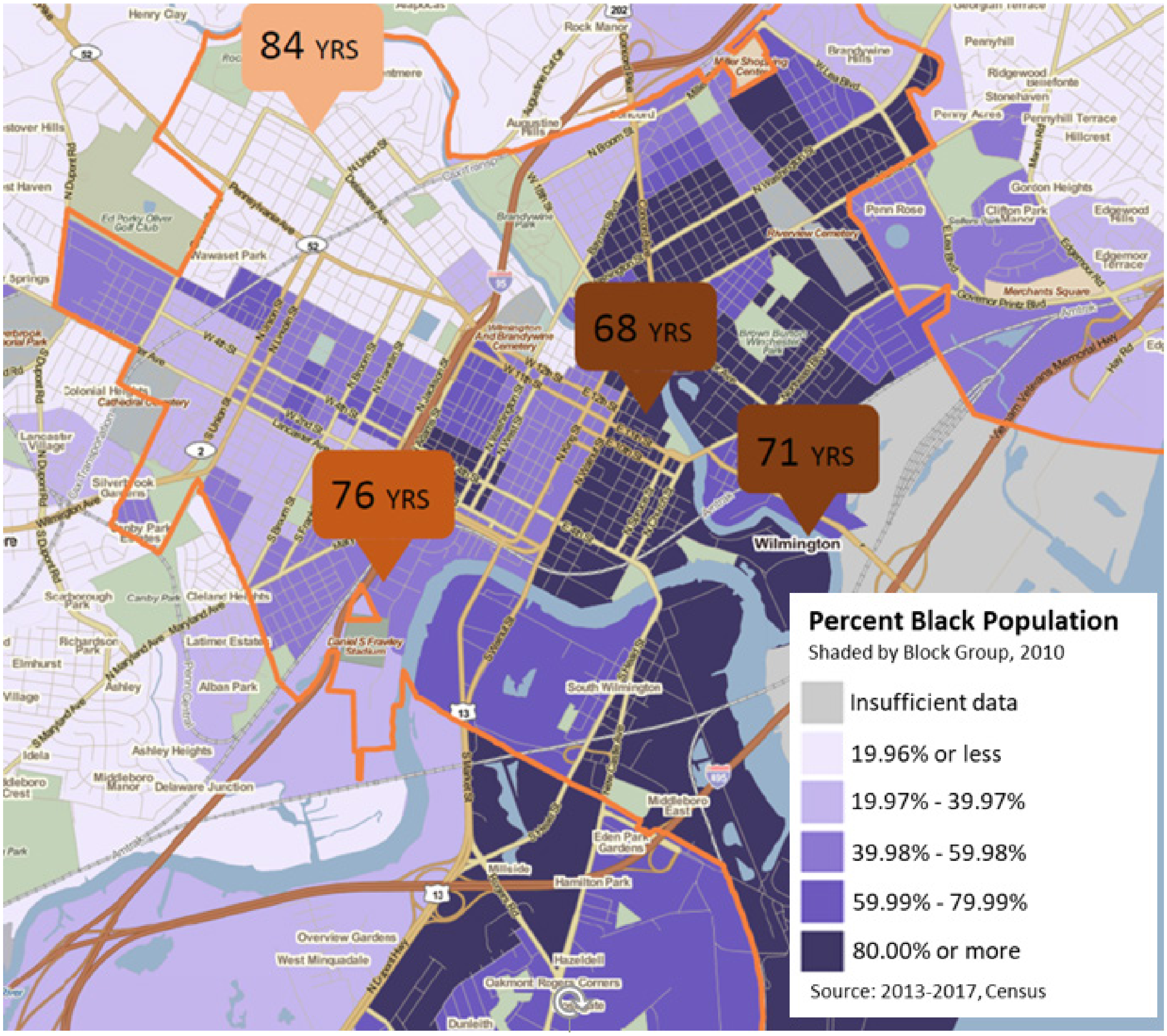


Source: Delaware Health Statistics Center, 2010-2017
Notes: 2010 Census Tracts. Infant deaths based on 2010-2017 linked birth and death files. There were 671 total infants deaths during 2010-2017 of which 658 (98.0%) were matched. IMR is defined as infant deaths per 1,000 live births. Births <30 and deaths <10 are suppressed.

Source: Hussaini, SK. (2018). Delaware Infant Mortality by Race/Ethnicity 2010-2017, Delaware Department of Health and Social Services, Division of Public Health.

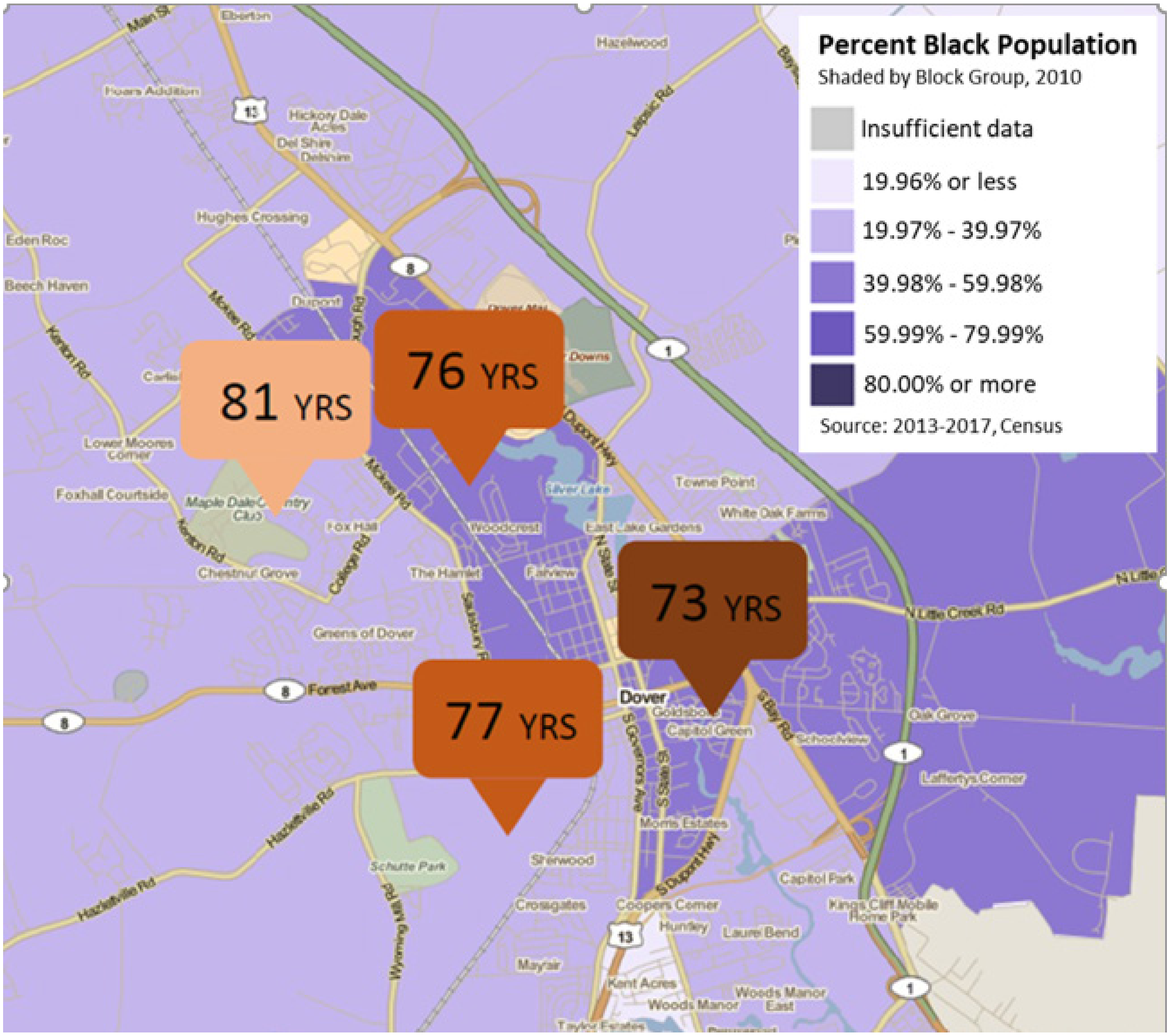
It is also useful to explore relationships between social factors that may be related to health and health inequities. Life expectancy patterns in Delaware vary across place and according to race (Figures 31 and 32). Specifically, there is as much as a 16-year difference in life expectancy between neighborhoods in inner city Wilmington, that are characterized by high percentages of black residents, and the surrounding suburbs that are home to more white residents (Figure 31). Similarly, in the City of Dover, there is an approximately eight-year gap in life expectancy across neighborhoods characterized by large percentages of black residents (Figure 32).

Figure 31: Estimated life expectancy by percentage of black residents in Wilmington, Delaware neighborhoods, 2018.



Source: Produced by the Center for Community Research and Service, Biden School of Public Policy & Administration, University of Delaware, with data from the National Center for Health Statistics, 2018.

Figure 32: Estimated life expectancy of black residents in Dover, Delaware neighborhoods, 2018.



Source: Produced by the Center for Community Research and Service, Biden School of Public Policy & Administration, University of Delaware, with data from the National Center for Health Statistics, 2018.

The Economic Case for Change

Health care spending in the United States has been described as excessive and unsustainable. The U.S. leads the world in per capita health care spending at almost twice the average of other wealthy developed countries. However, the health outcomes in the U.S. are relatively poor in comparison. Health care spending in the U.S. has generally grown faster than in most other countries, referenced in Section 2,Figure 2, and, for several decades, has consumed a greater share of gross domestic product than other countries.

There is growing evidence that poor quality environments and unmet social needs have a negative impact on health care spending. This is not surprising, given the relation between social conditions and health. For instance, if poor quality housing contributes to increased rates of lead poisoning, asthma, and other respiratory conditions (Krieger & Higgins, 2002), it follows that spending to treat those conditions is higher in areas with poor housing than in areas with higher quality housing. While this makes sense intuitively, the tools to effectively measure the economic burden of social inequities in health have only recently become available.

In 2009, researchers LaVeist, Gaskin, and Richard conducted an analysis of the economic burden of racial inequalities in health. They estimated that eliminating health disparities would have reduced direct medical care expenditures by approximately $230 billion between 2003 and 2006. Furthermore, indirect costs (such as lost productivity) associated with illness and premature death were estimated to be more than $1 trillion for the same period. Combined, this equates to $309.3 billion lost annually from the United States' economy due to health disparities. The authors of the study emphasize the ethical case for change, and offer this economic analysis as additional support for action. They conclude that “social justice can be cost effective” (LaVeist, Gaskin, and Richard, 2009, p. 235).

While aggregate health care spending hurts the overall economy and draws resources from other policy priorities, rising health care costs also burden private businesses. According to one report, businesses in the U.S. spent a staggering $496 billion on health care services and supplies in 2006 alone. At the same time, employees who do not receive adequate health care have higher rates of absenteeism and lower rates of productivity, which negatively impact the bottom line. One study found that indirect costs associated with unscheduled absences and productivity losses associated with family and personal health problems costs U.S. employers $225.8 billion annually (Stewart, Ricci, Chee, & Morganstein, 2003).

Health care spending in Delaware

Health care expenditures in Delaware have consistently been higher than the national average, and are currently the third highest in the nation (CMS, 2017; Choose Health Delaware, 2018) despite the state's ranking of 31st in overall health (UHF, 2018). Delaware ranks in the bottom half of states for overdose deaths, infant mortality, cancer deaths, diabetes, physical inactivity, smoking, and cardiovascular deaths (Choose Health Delaware, 2018). Health care spending consumes 30% of the state's budget, and is projected to double between 2009 and 2020 (Choose Health Delaware, 2018).

In 2014, Delaware spent approximately $9.5 billion for health care services, which equates to over $10,000 per capita (Choose Health Delaware, 2018).

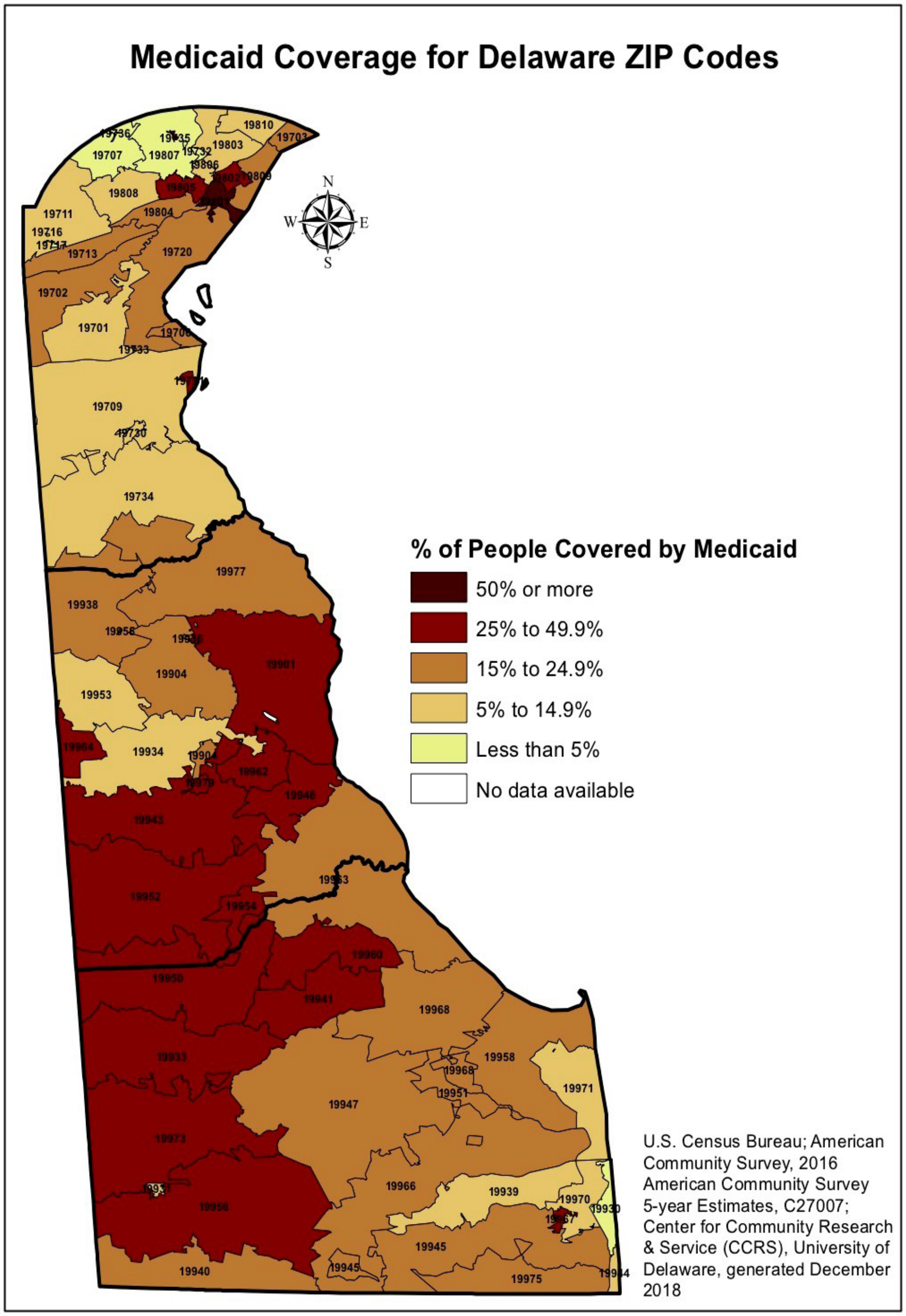
Even prior to Medicaid expansion through the ACA, Delaware's expenditures for Medicaid — the publicly funded insurance program for low income families, children, pregnant women, and people with disabilities — had been increasing steadily since 1996 and exceeded 17 percent of the state's 2013 budget (CMS, 2013). Approximately one-quarter of the state's population is enrolled in the Medicaid program and a little less than half of all births in the state were financed by Medicaid in 2016 (DHSS, 2016). This is relevant to the economic case for change, considering that Medicaid is a resource available to low income persons and the amount of money spent due to income inequities exceeds what would be spent if those inequities were absent. It is not surprising that Delaware communities with the highest concentration of Medicaid enrollment mirror those communities with other social burdens and health needs (Figure 33). This further makes the case for investing in prevention, particularly in Delaware's low income communities.

Approximately 495,000 residents, or 53% of Delawareans, are covered by private insurance provided through their employers. In 2017, the average annual family premium per enrolled employee for employer-based health insurance in Delaware was $19,407, including approximately $6,533 paid by the employee and $12, 874 paid by the employer. This is higher than the national average of $18,687, and employees pay a higher proportion of the total premium in Delaware compared with the national average (34% compared with 28%) (Kaiser, 2017).

The rate of preventable hospitalization is an indicator often used to assess the quality of health care services in a particular area. According to AHRQ, hospitalizations may be avoided if clinicians effectively diagnose, treat, and educate patients and if patients actively participate in their care and adopt healthy lifestyle behaviors. Higher rates of preventable hospitalizations may pinpoint areas in which improvements can be made in the quality of the health care system. Preventable hospitalizations may also be viewed as an indicator of efficiency within the system, based on the understanding that spending on preventable hospitalizations is unnecessary and less cost effective than prevention. For example, asthma is a condition that may result in preventable hospitalization because patients may be hospitalized if they do not receive adequate outpatient care or do not have access to appropriate medications. Asthma is also a condition that is directly influenced by environmental factors, such as air quality and housing conditions.

Therefore, hospitalization may be avoided by increasing access to care and treatment and by improving air quality and housing conditions. Overall, Delaware ranks 23rd in the country for its rate of preventable hospitalizations, according to America's Health Rankings (2018), an annual report produced through a partnership between the United Health Foundation, the American Public Health Association, and the Partnership for Prevention.

Figure 33: Medicaid coverage by ZIP Code, Delaware, 2016.



Medicaid Coverage for Delaware ZIP Codes

U.S. Census Bureau; American Community Survey, 2016 American Community Survey 5-year Estimates, C27007; Center for Community Research & Service (CCRS), University of Delaware, generated December 2018

Source: Center for Community Research and Service, 2018.

Poor performance of the health care system — including excessive and potentially unnecessary spending, inadequate access to care, and poor or uneven quality of care — have driven reform efforts for decades. The ACA, passed in 2010, aims to reduce costs, increase access, and improve quality of care. Embedded in many provisions of the ACA are opportunities to address the social determinants of healthand reduce health inequities, particularly through investments in community health.

Health System Reform and Incentives for Investing in Community Health

Increased awareness and understanding of how the social and physical environments impact health and health inequities is occurring at a time when the nation's health care system is undergoing immense change. The current health care landscape, including the passage of the ACA and promotion of the "Triple Aim," has created new opportunities and incentives for health care providers to pay more attention to the SDOH.

The Triple Aim is a framework originally developed by the Institute for Healthcare Improvement. It aims to optimize health system performance. The framework draws attention to three interrelated goals that are meant to be pursued simultaneously:

- Improving the patient experience of care (including quality and patient satisfaction)
- Improving the health of populations
- Reducing the per capita cost of health care.

Many public and private health care providers have adopted this approach, which is supported and reinforced through various ACA provisions. The ACA's expansion of health insurance for low- and moderate-income individuals reduces the financial barrier to accessing primary care for millions of individuals. This also gives providers the opportunity to address patient care in a more holistic and prevention-oriented manner rather than the episodic or urgent care that is more typical among those without adequate health insurance. Additionally, new models of care have emerged which enhance patient care through improved care coordination, and allow real-time linkage of patients to local social service agencies and related services. One such model is the patient-centered medical home.

The ACA's expansion of health insurance may also create new opportunities for hospital community benefit programs. According to a recent study, most non-profit hospitals, which are required to dedicate a portion of their revenue to provide community benefits, have done so in the form of discounted or uncompensated care for uninsured or underinsured individuals (Young et al., 2013). With fewer uninsured individuals, hospitals may now use their Community Benefit Programs for community-oriented prevention efforts. Similarly, the ACA now requires tax-exempt hospitals to regularly conduct community health needs assessments and to develop plans to address those needs (Young et al., 2013). This offers further incentive for hospitals to use community benefit programs to address upstream community needs and work to improve population health.

According to a recent report by the Commonwealth Fund (Bachrach et al., 2014), specific payment reform efforts, such as value-based purchasing and outcomes-based payment models, provide new economic incentives for providers to address patients' social needs. For instance, Medicare's Hospital Readmission and Reduction Program, created through the ACA, gives hospitals financial incentives to avoid readmissions by reducing payments to those hospitals where patients with certain medical conditions readmit within 30 days of their prior discharge. Although readmissions may be linked to health care quality, evidence also demonstrates a link between social factors (such as income level or insurance status) and risk of readmissions. Other payment mechanisms that promote care management, such as capitated, global, and bundled payments, also provide an incentive for providers to address patients' unmet social needs (like inability to afford prescription drugs), which helps to improve health outcomes. This is in contrast to traditional fee-for-service models that theoretically incentivize the quantity of services versus the quality of care.

The Commonwealth Fund report also highlights indirect economic benefits of health care providers investing in social interventions in the form of increased employee productivity, provider satisfaction, and patient satisfaction (Bachrach et al., 2014). Strategies that address patients' social needs free up physicians and other health care providers to address more immediate physical needs and increase their time spent providing direct medical care to patients. Since providers can bill for the time spent with the patient, this increases provider income and promotes provider satisfaction, as they believe they are providing higher quality care. Higher quality care, in turn, translates into higher patient satisfaction.

Health System Reform in Delaware

The ACA created a Center for Medicare and Medicaid Innovation (CMMI), housed within the Centers for Medicare and Medicaid Services (CMS), to test innovative payment and service delivery models to reduce expenditures, while preserving or enhancing quality of care. In 2016, Delaware was awarded funding from the CMMI State Innovation Model (SIM) initiative to test a plan for transforming the State's health care system in ways that improve quality and reduce costs. Over $622 million in Model Test awards were distributed to support 11 states in implementing their State Health Care Innovation Plans.

Delaware's State Healthcare Innovation Plan was developed through an extensive and collaborative planning process that spanned several years. The final plan was organized around six work-streams: delivery system, population health, payment model, data and analytics, workforce, and policy. These work-streams were believed to be critical for achieving the Triple Aim: improving the health of Delawareans, improving the patient experience of care, and reducing health care costs.

The Delaware SIM Plan (DE SIM) was grounded in an understanding of three major structural barriers to an effective health system. The first barrier was that the prevailing payment model incentivized volume or quantity, rather than quality of care provided. Secondly, the health system in Delaware was fragmented, and coordination of care was often lacking. Finally, Delaware's approach to population health did not integrate public health, health care delivery, and community resources in ways that promote health and an efficient use of resources. Activities in the plan were meant to address these and other related issues in order to achieve meaningful and sustainable healthcare transformation across the state.

Funding from CMMI for DE SIM ended in January 2019, but efforts around system transformation continue. Specifically, the work of system transformation has evolved and is now framed under the umbrella of the Road to Value. The Road to Value aims to improve the quality of care in Delaware while reducing costs, and includes seven goals meant to provide a path for continuing to move forward. These goals include: accelerating payment reform, establishing cost and quality benchmarks, strengthening primary care, advancing behavioral health integration, establishing a health care claims database, advancing the work of healthy neighborhoods, and engaging patients and consumers (see https://www.choosehealthde.com/Road-to-Value).

The Delaware Center for Health Innovation (DCHI), which was established as a non-profit organization meant to guide the implementation of the DE SIM plan in conjunction with multiple stakeholders committed to achieving the plan's goals, remains committed to transformation work. DCHI did not receive direct funding from CMMI for SIM, but rather operated with funding from local health care institutions and insurance companies, as well as generous in-kind contributions (e.g., volunteer time) from a variety of stakeholders. DCHI continues to play a leadership role in health care reform in Delaware, aligning itself with the Road to Value. An independent evaluation of the CMMI-funded SIM initiative found that stakeholder engagement, as evidenced by the work of DCHI, was an important outcome of the SIM funding, as it supports the ongoing sustainability of Delaware's health care transformation efforts.

Another major initiative related to system transformation has evolved from the healthy neighborhoods work originally included in the DE SIM plan (and is included in the seven goals of the Road to Value). Specifically, HCD was established in 2018 to advance population health outcomes by aligning investments at the local level to address the SDOH. HCD is a partnership between the State of Delaware (DHSS, DPH), the UD Partnership for Healthy Communities and the Delaware Community Foundation; all three entities are working together to provide operational support to the effort. A leadership council, with representatives from organizations and communities across the state, provides guidance; ensures alignment with existing efforts; and advocates for investments on behalf of community health needs. Finally, a community investment council was established to contribute funding towards community-based projects based on identified needs and proposals for addressing the SDOH. Funding from the State of Delaware Health Fundo fund was allocated in fiscal year 2020 to support HCD.

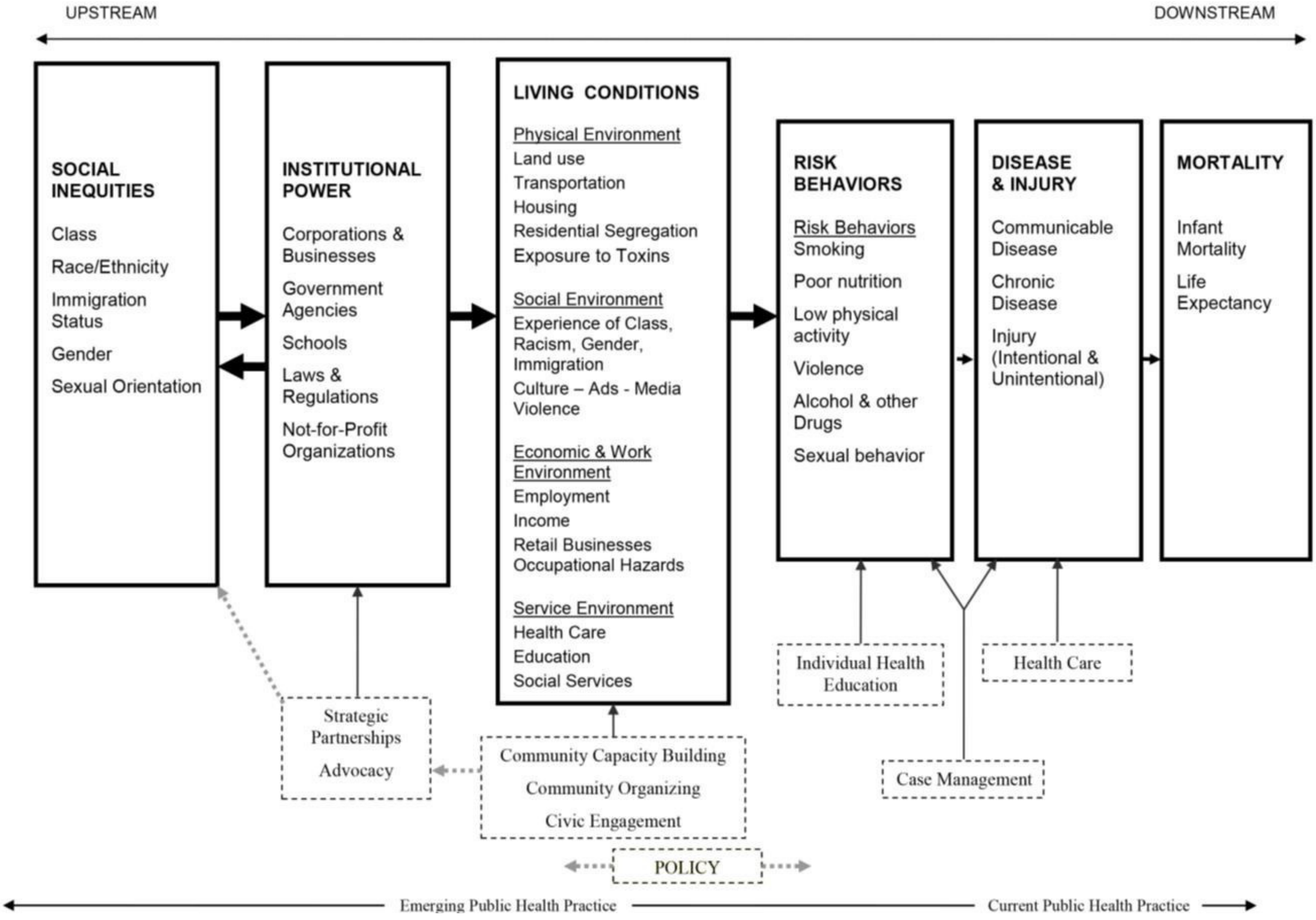
Finally, DPH's launch of its My Healthy Community data portal (https://myhealthycommunity.dhss.delaware.gov/) was developed with support from DE SIM. As mentioned earlier, this data portal provides community-level statistics and data that can be used to understand and explore health and related factors that influence health. DHSS hopes communities will use the data to educate their communities about their community's health and the environment in which they live. With the data, they can describe and define population health priorities to support and facilitate data-informed discussions, thus transforming population health.

Increased focus on the SDOH and shifting toward more prevention-oriented and integrated systems of care create an important window of opportunity to advance health equity. Delaware appears poised to create a more effective, inclusive, and comprehensive health system that better addresses the entire continuum of health determinants, from the upstream social conditions to the downstream delivery of care. There are immense potential benefits of such a system for individuals, communities, businesses, and the State of Delaware.

Addressing the Health Equity Continuum

Addressing health equity requires a multi-pronged approach. A continuum of strategies is needed to advance health equity. A framework developed by the Bay Area Regional Health Inequity Initiative illustrates the need for public health activities to refocus upstream, while simultaneously shifting the way that critical downstream services are provided (Figure 34). To refer to the river parable, we need to build stronger bridges and fences and we need to do a better job ensuring everyone who falls into the river of poor health/health outcomes gets rescued with high quality care. This continuum also reflects the multi-sector and integrated approach taken by Healthy People 2020, which is described in section 2.

Figure 34: Public Health Framework for Reducing Health Inequities



Source: Bay Area Regional Health Inequity Initiative, 2013.

The following three sections provide examples of strategies and resources for public health professionals, health care providers, and others to improve the conditions that create health and those that reduce health inequities. Section 5 describes upstream strategies for community health, including place-based and community-oriented strategies to address living and working conditions. Consistent with the framework below, Section 5 includes a discussion of community capacity building, partnerships, and civic engagement. Section 6 describes upstream strategies for health care providers, including ways in which providers can incorporate upstream approaches in their service delivery and/or provide care that is more equity-oriented. Section 6 highlights opportunities within the health care system to address the psychosocial needs of patients and provide more coordinated care that can connect patients to resources in the community. Section 7 highlights policy-oriented approaches that can support or facilitate the changes described in the previous two sections and address underlying social inequities in a more direct and systemic way.

Together, the information and examples provided in the following sections represent a comprehensive effort to address health equity. Importantly, this updated version of this guide highlights the need to incorporate a more explicit focus on racial justice at the community level, within health care institutions, and in public policy. Although it may not be feasible to address all of the factors identified in the framework in every community in our state, a comprehensive and justice-oriented approach is ideal for achieving meaningful and sustainable change.

Glossary – Section 4

Community Benefit Program: Most hospitals and health systems in the United States are incorporated as not-for-profit entities. To maintain tax exemption status, not-for- profit hospitals must dedicate a portion of their revenue to providing community benefits. Activities often include improving access to care for uninsured or under- insured individuals, health education efforts, and other strategies to promote community health.

Medicaid: A publicly funded insurance program for low-income families and other eligible aged, blind, and/or disabled people whose income is insufficient to meet the cost of necessary medical services. Medicaid pays for: doctor visits, hospital care, labs, prescription drugs, transportation, routine shots for children, and mental health and substance abuse services.

Preventable hospitalizations: Hospitalizations that may be avoided with high quality primary and preventive care, including living a healthy lifestyle; also referred to as “potentially preventable hospitalizations” or “ambulatory care sensitive conditions.”

Primary Care Medical Home: A team-based health care delivery model led by a physician that provides comprehensive and coordinated medical care to patients with the goal of obtaining maximized health outcomes. Care coordination, which may require additional resources such as health information technology and payment incentives, is an essential component of the PCMH. PCMHs are also referred to as “patient-centered medical homes” or simply “medical homes.”

Triple Aim: A framework developed by the Institute for Healthcare Improvement to optimize health system performance by simultaneously pursuing three dimensions: improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of health care.

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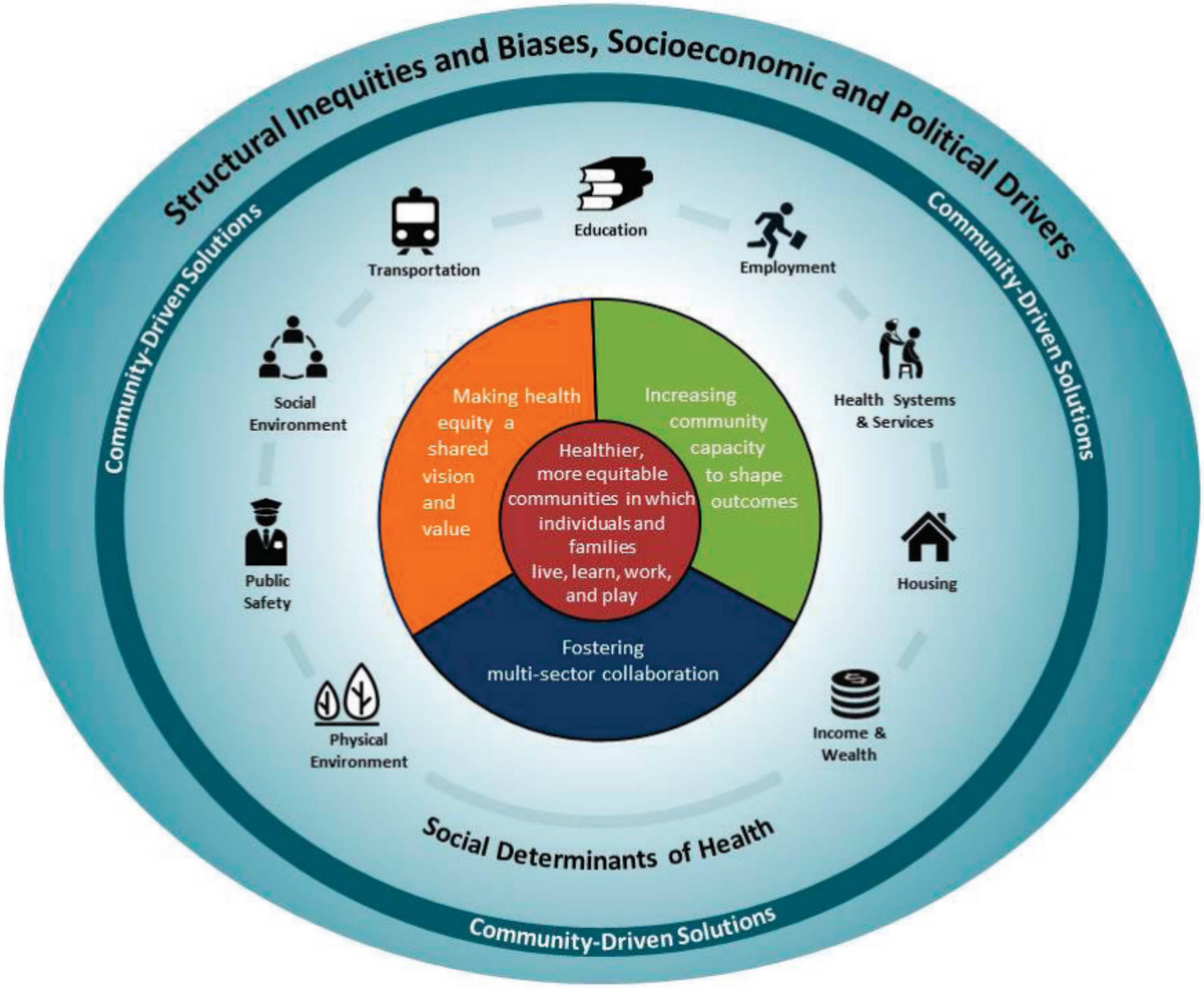
SECTION 5: Upstream Strategies for Community Health

This section focuses on community-based strategies to promote health equity. In the original version of this guide, this section was organized around key elements of the physical, social, economic and work and service environment highlighted in Figure 34 (in the previous section), and included attention to community capacity building, community organizing, and civic engagement. We included a discussion of related strategies for building strategic partnerships and engaging in advocacy to change the underlying structures that determine living conditions. The rationale was that by improving living conditions, we would create healthier communities and ultimately improve health equity. According to Healthy People 2020, a healthy community is one that continuously improves its physical and social environments, thereby helping people support one another to develop to their fullest potential. In other words, a healthy community is one in which all of its residents have the resources needed to thrive: clean air and water, parks and green space, healthy food, affordable housing, jobs and income, transit, and positive social interactions.

In the original guide, we acknowledged that for everyone to thrive, a healthy community must also include social justice, equity, and sustainable resources; that a healthy community must be free of all forms of discrimination and allow everyone an opportunity to participate in its governance. We also argued that opportunities for improvement exist across all communities and that maintaining a healthy community requires continuous attention. Furthermore, given what we know about the social gradient in health and the social determinants of health (SDOH), everyone can be healthier. Therefore, every community holds the potential to be a healthier place to live. Promoting health equity through a racial justice lens requires us to be more explicit about the underlying social and political structures — including the legacy of residential segregation and historical trauma experienced by black communities — and more deliberate in our efforts to address structural racism.

For this reason, we reorganized this section of the guide to be more consistent with a conceptual model developed by the Committee on Community-Based Solutions to Promote Health Equity in the United States (National Academies, 2017). With support from the Robert Wood Johnson Foundation (RWJF), this committee of the National Academies of Sciences, Engineering and Medicine, was charged with reviewing the state of health disparities in the U.S., including exploring underlying conditions and root causes, and identifying community-based solutions to advance health equity. The committee created a conceptual model (Figure 35) that builds on other existing frameworks, including the RWJF Culture of Health Action Framework and the Prevention Institute's Systems Framework to Achieve an Equitable Culture of Health (see https://www.rwjf.org/content/rwjf/en/cultureofhealth/taking-action.html). While this model includes many of the same elements as the Bay Area Regional Health Inequities Initiative (BARHII) model in the previous section, we decided to use this newer model for the updated guide because of the explicit reference to structural inequities and biases that form the context within which community-driven solutions reside. Further, as the committee acknowledged (National Academies, 2017, p6), the circular nature of this model reflects a level of complexity related to addressing health inequities that can be lost in more linear kinds of models.

Figure 35: A conceptual model for community-based solution to promote health equity



Source: National Academies of Sciences, Engineering, and Medicine (2017). Communities in action: Pathways to health equity. Washington, DC: The National Academies Press.

This section contains many of the same examples and strategies highlighted in the previous version but was reorganized to align with the conceptual model (Figure 35). Further, we added examples and strategies to reflect new elements of this model that were not addressed by the previous version. More specifically, this section now includes promising practices and recommendations for each of the following SDOH at the community level: physical environment, public safety, social environment, transportation, education, employment, health systems and services, housing, and income and wealth. We recognize that some health professionals may understandably become overwhelmed by the complex web of challenges and apparent disadvantages in less healthy communities, including the challenge of addressing structural racism. Fortunately, we included examples of programs and strategies that have shown promising results in other communities. We built on examples from the previous version of the guide with examples highlighted in the National Academies Committee Report (2017). We are confident that a seemingly modest change can build upon itself or be leveraged to promote greater changes and impact. An investment in one area can stimulate investments in other areas. A new playground that brings families together can inspire an adjacent community garden. Removing graffiti and improving the lighting along a sidewalk invites people outside, simultaneously discouraging vandals and other criminal activity. And a new corner store can encourage additional commercial activity and investment.

To be most effective in advancing health equity, these kinds of activities are implemented as a result of purposeful efforts to make health equity a shared vision and value, to foster multi-sector collaboration, and to increase the community's capacity to shape outcomes, as seen in the model. Further, given the context of structural inequities and biases, and socio-economic and political drivers, policy change at the state and federal level is often needed to facilitate or accelerate changes at the community level. A policy change discussion is in Section 7.

Defining Communities by Place

Communities can be defined in many different ways. Traditionally, communities are conceptualized as geographic areas. In terms of healthy equity, communities are often defined broadly and can also refer to groups of people that share certain characteristics, values, or a common social identity. Furthermore, a community is often best defined by the members of that community. While we appreciate the importance of various definitions of community, for the purposes of this guide, we draw attention to the geographic definition of community and the idea that communities are physical places. Growing evidence suggests that there are healthy places to live and less healthy places to live. Furthermore, the differences between healthy and less healthy places cannot be explained by the characteristics of the people living in those places, such as income or race[1]. According to the Centers for Disease Control and Prevention (CDC) (2009), a healthy community is a community that is continuously creating and improving those physical and social environments and expanding those community resources that enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential (https://www.cdc.gov/healthyplaces/terminology.htm). The concepts of healthy communities and healthy places from Health People 2020 and the CDC, respectively, led to the development of place-based initiatives for improving health.

Health-oriented strategies that are focused on living conditions in specific communities are often described as "place-based initiatives" (PBIs) because the target of the interventions is the place itself (or characteristics of the place), rather than the people living in that place. For instance, place-based strategies to address obesity may include working with fast-food establishments to offer healthy food options as opposed to more traditional people- or population-based approaches, such as health education to change eating habits. Comprehensive approaches recognize that both place-based and people-based strategies are important; however, PBIs are generally considered to be more effective at addressing underlying root (upstream) causes of unhealthy behaviors (which are often the target of people-based strategies). PBIs are the focus of this section because they address the health inequities we currently see in the distribution of resources and hazards across communities.

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[1] For a more technical discussion of the contextual effects of the environment on health, see Macintyre, Ellaway and Cummins, 2002.

PBIs are not exclusive to health. A 2010 memo from the Office of the White House addressed to the leaders of all executive departments and agencies called for greater attention to place-based efforts to increase the impact of government dollars (see https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/memoranda/2010/m10-21.pdf). The memo highlights the interconnected nature of the economy, environment, and health at the local level and urges stakeholders to embrace place-based approaches to promote the prosperity, equity, sustainability and livability of places. The Department of Education's Promise Neighborhoods initiative exemplifies the Obama Administration's attention to PBIs, by focusing resources on a comprehensive range of factors in the community that lead to better educational outcomes. Similarly, the Department of Housing and Urban Development's Choice Neighborhoods initiative is aimed at transforming poor neighborhoods into places with sustainable, mixed-income housing. Importantly, both initiatives support locally-driven, collaborative strategies for improving community conditions to address complex social problems. Place-based initiatives for health and health equity are similarly characterized by:

- a concentration of resources and interventions in a defined geographic area
- integrated and holistic approaches to addressing the determinants of health
- an investment in early intervention and prevention
- multi-sector participation and collaboration
- community engagement, participation, ownership, and leadership
- a good understanding of the community (needs, resources, priorities, etc.)
- a focus on long-term and sustainable changes; and
- advocacy and policy change.

Dimensions of Place-Based Initiatives for Health Equity

Nine broad categories of determinants of health are highlighted as action areas for advancing health equity: physical environment, public safety, social environment, transportation, education, employment, income and wealth, health systems and services, and housing (Figure 35). These may be viewed as dimensions of PBIs for health equity because they account for the most critical levers of meaningful change at the local level. Here we describe the relations between each dimension and health equity, along with strategies for improving conditions in each dimension. Note that much of the content for these descriptions comes from the publication Why Place Matters: Building a Movement for Healthy Communities, produced by PolicyLink (Bell & Rubin, 2007) and from the National Academies Committee Report Communities in Action: Pathways to Health Equity. Additional details and case studies highlighting activities to promote community health along each dimension can be found at:

http://www.policylink.org/sites/default/files/WHYPLACEMATTERS_FINAL.PDF and at https://www.nap.edu/catalog/24624/communities-in-action-pathways-to-health-equity.

Physical Environment. The physical environment includes both the natural environment (i.e. parks and green space) and the built environment (i.e. roads and sidewalks). The physical environment can influence health directly. For instance, the quality of the air we breathe can be directly linked to asthma rates, such that people living in poorer air quality areas (such as near highways) experience higher rates of asthma. The physical environment also impacts health indirectly by influencing health-related behaviors. For instance, the existence of sidewalks and bike lanes can promote physical activity, while poor lighting or graffiti can discourage people from being outside.

Healthy places have an abundance of health protective, or health promoting, factors such as safe parks and green space, walkable neighborhoods, quality mixed-income and racially diverse housing, healthy food outlets, public transportation, and access to other kinds of community resources that encourage residents to gather together socially. In contrast, unhealthy places tend to be characterized by risk, or health damaging, factors such as substandard housing and residential segregation, abandoned buildings and lots, run-down or non-existent sidewalks and parks, toxic environmental exposures (i.e. lead or air pollution), physical barriers for people with disabilities, and a high concentration of tobacco, alcohol, and fast food retailers. The quality of the physical environment — natural and built— varies from place to place, which contributes to health inequities along geographic lines. Research from across the country documents how negative environmental exposures — such as poor outdoor air quality — are heightened in segregated communities, thus contributing to higher rates of chronic diseases in black neighborhoods (Morello-Frosch, 2004).

Sample Strategy

Asthma disproportionately affects low-income children due to the poor air quality in their homes, schools, and neighborhoods. Indoor and outdoor triggers and pollutants cause trips to the emergency room and school absences. In urban areas, diesel particles from ports and heavy traffic have been linked to worsening asthma. Across the country, communities are addressing this issue by improving public transportation and holding industries and governments more accountable for environmental impacts, particularly concerning air quality. Indoor air quality is being improved by enhancing ventilation in older school buildings and enforcing housing codes in low-income housing residences.

Recognizing the disproportionately high number of emergency department visits and hospital admissions for black and Latino children with asthma, the Boston Children's Hospital Community Asthma Initiative (CAI) was launched in 2005 to address this health inequity. The CAI started with a pilot intervention focused on neighborhoods with the highest asthma rates among black and Latino children served by the hospital but has since expanded across the city. Case managers work with each family to design an intervention that fits the child and family's needs, including tailored asthma education, home visits to help identify triggers in the home and other environments, and connecting the family to necessary medical and community services, among others (CAI, 2019). Along with working with children and families, CAI partners with coalitions to influence local and state policy, such as improving housing and school environments, which often trigger children's asthma. Further, CAI is partnering with other asthma home visiting programs in the city to develop home visiting standards and to coordinate training. As of December 2016, CAI reported:

- An 80 percent reduction in the percentage of patients with asthma-related hospitalizations
- A 58 percent reduction in the percentage of patients with Emergency Department visits
- A 45 percent reduction in the percentage of patients with missed school days for children
- A 53 percent reduction in the percentage of patients with lost work days for parents.

More information about CAI, including a manual to support replication of their model, can be found at http://www.childrenshospital.org/centers-and-services/programs/a-_-e/community-asthma-initiative-program.

For more information about other ways in which the physical environment affects health and strategies for improving the physical environment, see the National Academies Committee report at https://www.nap.edu/catalog/24624/communities-in-action-pathways-to-health-equity.

Public Safety. Public safety and violence are interrelated at the community level, where public safety is thought of as the protection of the public and an absence of violence (Davis et al., 2016). The relationship between being a victim of violence, and physical injury and emotional or psychological trauma, is clear and easily understood. However, research now documents how exposure to violence (i.e. witnessing violence) is also linked to poor health outcomes, especially among children (Moffitt et al., 2013). This can happen directly and indirectly. For instance, perceiving one's neighborhood as dangerous or hearing about violence in the community can lead directly to psychosocial stress, which has negative repercussions for both physical and socio-emotional wellbeing (RWJF, 2011). According to RWJF (2011), "violence in the community can lead to widespread feelings of fear, distrust and isolation, which in turn can contribute to diminished levels of health-promoting social support and social cohesion. Residents of communities where violence frequently occurs may be less likely to exercise and to use community resources like parks and playgrounds that would otherwise promote both healthy behaviors and social interaction. Conversely, strong social networks and cohesion in communities may contribute to community norms that support healthier behaviors and discourage violence. Violence can also act as an obstacle to investments in health-promoting community resources and opportunities for residents. For example, companies may be less likely to operate full-service supermarkets in neighborhoods where violence is prevalent, contributing to the creation of "food deserts" where residents have few options for purchasing fresh foods" (page 6). In this way, violence is related to and contributes to the challenges associated with many other SDOH at the community level, including education, employment, and income and wealth.

Low-income communities are disproportionately impacted by violence and communities of color have among the highest rates of violent crime. Importantly, “criminologists attribute the disparities in neighborhood violence not to the kinds of people living in certain neighborhoods but to the vast differences in social and economic conditions that characterize communities in the United States” (National Academies, 2017, p156). Further, research shows that the higher rates of homicide in black communities, for instance, is directly related to residential segregation (Williams & Collins, 2001). As discussed in Section 3, the criminal justice system — an institution meant to protect the safety of communities — has exacerbated issues existing inequities in black communities through discriminatory policies and practices that disproportionately incarcerate black men.

Sample Strategy

Cure Violence is an internally recognized, evidence-based approach to addressing violence from a public health perspective (see http://cureviolence.org/). The Cure Violence model uses principles from infectious disease epidemiology to understand the spread of violence and intervene to prevent further “transmission.” The model focuses on three activities often used when addressing infectious disease outbreaks including: interrupting transmission of the disease, reducing the risk among those at highest risk, and changing community norms related to the disease. More specifically, in order to detect and interrupt violence, outreach workers are trained to identify and mediate potentially dangerous conflicts in the community. At the same time, outreach workers are identifying and intervening with individuals most likely to commit violence by “meeting them where they are at, talking to them about the costs of using violence, and helping them to obtain the social services they need, such as job training and drug treatment.” Finally, the outreach workers work to change norms around violence among community leaders, residents, local businesses, faith leaders and others, trying to convey the message that violence is not acceptable in the community. All of this work is supported by ongoing data collection and monitoring, training of outreach workers, and partnerships with local hospitals.

For more information about the Cure Violence model, including specific stories of success across U.S. cities, and information about replicating the model, see http://cvg.org/resources/. For more information on the relationships between public safety, violence, and health, see the RWJF issue brief (2011) on Violence, Social Disadvantage and Health: https://www.preventioninstitute.org/sites/default/files/publications/How%20Social%20Factors%20Shape%20Health.pdf.

Social Environment. The social environment refers to the relationships between community members and the factors that affect those relationships. Places where residents work together, welcome diversity, and have a strong sense of community are places with social capital. Social capital is the strength of relationships among community residents and is a protective factor. Strong social ties, community cohesion, and civic participation promote health and equity. A well-known study about the 1995 heat wave in Chicago that resulted in hundreds of deaths, particularly among the elderly, revealed that residents of neighborhoods with low levels of social capital were much more likely to die from heat-related complications, than residents of neighborhoods with high levels of social capital (Klinenberg, 2002).

Elderly survivors had neighbors and friends to check on them and provide assistance, whereas the deceased were often isolated and lived in areas lacking social cohesion.

Social capital may also be viewed in terms of the collective identity of a neighborhood and the sense of solidarity that such a collective identity can promote. This is important from the standpoint of health equity because it supports and enhances community empowerment and collective action. The presence of social capital in this regard may be directly associated with community residents' control over the decisions that affect their living conditions because it strengthens their positions with businesses or institutions that may put the community at risk. For example, when a landlord threatens to displace tenants by increasing rent beyond what is affordable for residents, members of tenant associations can organize to resist such a change that would harm their community. Similarly, strong social capital is appealing to businesses and others considering investments in the community. Like neighborhood beautification projects, social capital is attractive.

Conversely, social segregation, lack of community cohesion, and weak ties put communities at risk for disinvestment and threaten community well-being. Communities with limited social capital are less likely to organize and advocate for themselves. They may also experience more crime and may be viewed negatively by those outside of the community. All of these contribute to disinvestment, lack of resources, and discrimination. According to Bell and Rubin (2007):

> "The impacts of a community's social environment on health run the gamut from psychological to political, with consequences for the physical and economic environments. A community with strong social networks is better able to advocate for itself, its residents better able to control their individual and collective futures" (p. 31).

Sample Strategy

Urban agriculture and urban farms not only improve economic and health outcomes among low-income families but also foster a sense of community. Community gardens have recently gained popularity through First Lady Michelle Obama's "Let's Move!" campaign. Community gardens are believed to reduce obesity and other chronic diseases by improving diets among low-income residents. Community gardens provide a unique opportunity to engage vulnerable individuals — including youth, people who are homeless, and those who are incarcerated — in valuable job training. Research suggests that community gardens can also increase social cohesion, social support, and social connections (Kingsley & Townsend, 2006). Residents involved with urban farms can generate supplemental income by selling produce through farm stands, Community-Supported Agriculture (CSA) programs, and at farmers' markets. Community gardens transform vacant urban spaces into safe green spaces and link different sectors of the community to achieve common goals.

In Delaware, beginning in 2014, Kent Community Gardens built community gardens in Kent County with businesses, non-profit organizations, and individuals. Partners include: the City of Dover, Delaware Electric Cooperative, Delaware State University (DSU), Dover High School, Dover Housing Authority, 4-H, Kent Kids Coalition, Greater Kent Committee, Lowe's, Nemours Health and Prevention Services, and many others. The initiative brings the community together to provide healthy food for local residents. In addition, the gardens serve as an avenue to teach children about the origin of their food and the importance of agriculture. By 2016, more than 15 community gardens flourished in Kent County, providing fresh, free produce to local residents. These efforts represent community assets that improve the social environment and promote health equity. For examples of other kinds of community garden projects, as well as other strategies for improving the social environment, visit http://www.policylink.org/sites/default/files/urban-agriculture.pdf.

Transportation. The National Academies Committee Report Communities in Action: Pathways to Health Equity (2017) included transportation in its conceptual model as distinct from other aspects of the built environment "because of its multifaceted nature: pollution and greenhouse gas production; motor-vehicle related deaths and injuries; mobility and access to employment and vital goods and services; and active transportation" (pages 148-149). As this list highlights, characteristics of transportation can have both positive and negative community health impacts. Research indicates that many of the negative issues associated with transportation, such as pollution and motor vehicle-related injuries and deaths, take the greatest toll on poor communities and communities of color. There is even research to suggest that black pedestrians are at greater risk for their safety due to the effects of racism (whether conscious or unconscious) among drivers who are less likely to stop for black pedestrians in crosswalks, compared to white pedestrians (Sanchez, 2006); and poor communities are less likely to have sidewalks, crosswalks, and street lighting compared with higher income communities in the first place (Safe Routes to School, 2015).

An efficient transportation network is essential to ensure access to health promoting resources such as goods (including healthy food options) and services (including recreation and health services), as well as providing access to employment and education. Infrastructure investments that support active forms of transportation, including walking or bicycling, can also contribute to positive health outcomes. Researchers found that physical activity, in particular, is largely influenced by the built environment, including land use mix and overall community design (McCormack & Shiell, 2011). Not surprisingly, there are significant variations in active transportation features across communities and low-income neighborhoods, and black communities are less likely to have infrastructure that supports safe, healthy active transportation (Zimmerman et al., nd).

Sample Strategy

After decades of building car-oriented roadway networks, many streets lack connectivity and do not safety accommodate pedestrians or bicyclists. Mobility-constrained populations — including children, the elderly, persons with access and functional needs, zero-car households, and low-income and minority groups — face substantial challenges and transportation inequities in such a car-dominated culture. Research by Smart Growth America and others shows that "incomplete" streets — those without safe places to walk, bike, or take public transportation — disproportionately impact the health and safety of people residing in low-income communities, people of color, older adults, and children (Smart Growth America, 2013).

In recent years, there has been a growing recognition of the need for equitable transportation systems and complete streets. While definitions vary, the National Complete Streets Coalition describes complete streets as [transportation systems] that are planned, designed, operated, and maintained to be safe and comfortable for everyone, regardless of age, ability, ethnicity, income, or chosen travel mode (Smart Growth America, 2013). Complete streets became part of Delaware's policy agenda in 2009, with the issuance of an executive order by Governor Jack Markell.

Delawareans have paid considerable attention to advancing Complete Streets in recent years, even including it in a broad effort to promote "Complete Communities." Described as "attractive, inclusive, efficient, healthy and resilient," complete communities are more compact, provide a greater mix of land use, provide multimodal transportation and housing choices, offer activity-oriented destinations, foster sociability, and promote greater economic competitiveness. According to Scott and colleagues (2010) from the University of Delaware's (UD) Institute for Public Administration (IPA):

> "The integrated approach to transportation policy and planning also stresses the need to invest in transportation accessibility — or multi-modal transportation systems that serve people of all ages, abilities, ethnicities, and incomes. Transportation and land-use planning need to be assimilated to manage growth, focus on infill development, preserve community character, and provide equitable and accessible transportation options" (p. 1).

Complete Streets is identified as one of five elements to plan for complete communities in Delaware. One challenge with this approach is that land-use decisions in Delaware are made at the local government level while, unlike other states, the bulk of infrastructure and services are funded by the State.

To address the need for local governments to plan more prosperous and livable communities, the UD's IPA offers local government training, planning assistance, published guides, and online resources to assist local governments and community leaders. Such a comprehensive and integrated approach requires intersectoral collaboration and strong community engagement, similar to other health equity approaches described throughout this guide. In partnership with the Delaware Office of State Planning Coordination, the Delaware Department of Transportation (DelDOT), and the Delaware Department of Health and Social Services' (DHSS) Division of Public Health (DPH), experts from IPA developed an online "Delaware Complete Communities Planning Toolbox" (www.completecommunitiesde.org). The Toolbox helps build local capacity to develop "complete communities" planning approaches, community design tools, and public engagement strategies.

One way that DelDOT is instituting Complete Streets is through traffic-calming techniques such "road diets." This type of roadway reconfiguration involves narrowing or eliminating travel lanes to calm traffic and increase safety of all roadway users. Permanent, large-scale changes can be difficult to launch, costly, and gain public endorsement. In recent years, community-led approaches have gained popularity as a way to use short-term, low-cost, and scalable interventions to catalyze long-term changes. Often described as "tactical urbanism," pop-up demonstration and pilot projects are designed to provide low-cost, temporary built environment changes that can transform public spaces into vibrant, activity-oriented places that are more walkable, bikeable, and transit friendly.

Several community-driven initiatives, recently launched in Delaware and highlighted within the Delaware Complete Communities Planning Toolbox, have realized community pride, safer streets, calmer traffic, economic revitalization, and creative place-making benefits. The Toolbox features visual tools designed to help local government officials learn how pop-up demonstration and pilot projects can engage community members to temporarily transform and co-create high-value public spaces, including streets. Case studies showcase examples of ways Delaware communities transformed a street into a vibrant cultural corridor in Wilmington, calmed traffic with a temporary traffic circle in Newark, tested a pop-up protected bike lane in Newark, and converted on-street parking into a mobile parklet in Seaford. Complete streets planning tools may be accessed within the Toolbox at https://www.completecommunitiesde.org/planning/complete-streets/.

For more information on the relationship between transportation and health, see the National Academies Committee report at https://www.nap.edu/catalog/24624/communities-in-action-pathways-to-health-equity. For more information specific to active transportation and health equity, including examples of promising strategies, see http://saferoutespartnership.org/sites/default/files/pdf/At-the-Intersection-of-Active-Transportation-and-Equity.pdf.

Education. As described in Section 2, education is an important determinant of health and there is a large body of evidence describing the relationship between educational attainment and health status indicators, including life expectancy and infant mortality. Similar to income, the relationship between education and health is characterized by a gradient, whereby there is a not just a difference between the health of individuals at the low and high levels of the educational attainment, but rather we see improved health status as educational attainment increases across the full spectrum. Importantly, we also see intergenerational effects of education on health, where the education level of parents is correlated with the health of their children (Figure 5, Section 2). The major pathways between education and health are believed to be related to the ways in which educational attainment shapes employment opportunities and earnings; how education affects social status, self-efficacy and related social and psychological factors; and how education improves health-related knowledge and literacy, which influences health-related behaviors (National Academies, 2017).

According to researchers, educational attainment improved across all racial and ethnic groups between 1988 and 2015; however, there was virtually no progress in closing the achievement gap between blacks and whites during this time (Ryan & Bauman, 2016). Further, according to a report by the U.S. Government Accounting Office (GAO, 2016), the percent of K-12 public schools in the U.S. with high percentages of poor and minority students has increased since 2000 and students in these schools are typically characterized as having poor student outcomes. According to the report,

> "The percentage of K-12 public schools in the United States with students who are poor and are mostly Black or Hispanic is growing, and these schools share a number of challenging characteristics. From school years 2000-01 to 2013-14 (the most recent data available), the percentage of all K-12 public schools that had high percentages of poor and Black or Hispanic students grew from 9 to 16 percent, according to GAO's analysis of data from the Department of Education (Education). These schools were the most racially and economically concentrated: 75 to 100 percent of the students were Black or Hispanic and eligible for free or reduced-price lunch — a commonly used indicator of poverty. GAO's analysis of Education data also found that compared with other schools, these schools offered disproportionately fewer math, science, and college preparatory courses and had disproportionately higher rates of students who were held back in 9th grade, suspended, or expelled" (GAO, 2016).

There is also a large and growing evidence base linking early childhood education (ECE) and health outcomes. Access to high quality ECE is important to childhood development and is believed to promote adult health and well-being (CDC, 2016). Further, access to high quality ECE among low-income families has been linked with a range of positive social and economic outcomes for families including, for example, increases in maternal employment and income, reduced health care costs, savings related to reduced grade retention and remedial education, and earning gains associated with high school graduation (CDC, 2016). Despite strong evidence of the positive cost-benefit ratio associated with investments in ECE, especially for low income and minority children, many families struggle to afford high quality ECE for their children or it is simply not available in poor and racially segregated communities. Further, even when ECE is available and accessible, preschool suspensions and expulsions, which are more common among black children, can undermine these important educational opportunities. According to some research, racial stereotyping and bias among ECE teachers may be contributing to the disproportionately higher rates of disciplinary action in ECE settings (Gilliam et al., 2016).

Sample Strategy

Investments in ECE are one of the CDC's "HI-5" Interventions. According to CDC, HI-5 interventions are community-wide approaches that have strong evidence for positive health outcomes within five years and are shown to be cost effective and/or result in cost savings over time (see https://www.cdc.gov/policy/hst/hi5/). Among the list of promising programs highlighted by CDC is the Child-Parent Center (CPC) education program in Minnesota. The project, which is a partnership between the University of Minnesota and community partners, is funded by a grant from the U.S. Department of Education. The CPC program is described as one of the most comprehensive in the country with intensive and continuous educational and family support services for pre-kindergarten to third grade children in low-income families and high-poverty neighborhoods at 33 sites across Minnesota, Wisconsin, and Illinois. According to McCormick (2011), cost-benefit analyses indicate a return of $8 to $11 for each dollar invested in the program.

For more information on the relationship between education and health, see the National

Academies Committee report at https://www.nap.edu/catalog/24624/communities-in-action-pathways-to-health-equity.

Employment, Income and Wealth. The economic and work environment is closely linked with physical and social environments, considering that businesses are necessary to provide jobs and support parks, healthy foods, and other retail establishments. Having a strong business sector is a protective factor in that it promotes financial security among residents through living wage jobs, it encourages homeownership, and it attracts other kinds of community investments. A vibrant retail sector, including a full-service grocery store, also promotes healthy behaviors and contributes to increased social capital.

Hazardous working conditions and low wage jobs, on the other hand, can threaten the health of community residents in many ways. Poverty is among the strongest determinants of poor health and is closely tied with low educational attainment and other threats to personal and community well-being. Concentrated poverty (geographical areas with high levels poverty) is associated with high levels of stress and risk-coping behaviors, such as tobacco use and substance abuse. Concentrated poverty disproportionately affects black communities in the U.S. (National Academies, 2017). Further, research shows that blacks have the highest unemployment rate among all racial and ethnic groups, and despite overall progress in unemployment in recent years, disparities between blacks and whites have persisted for more than 40 years (National Academies, 2017). According to Buffie (2015), this disparity persists even after controlling for education levels.

Sample Strategy

A living wage is defined as the minimum income needed to meet basic needs. It is generally thought to be higher than the minimum wage set by the federal government, which since the 1970s has been considered inadequate for workers to live at a safe and sufficient standard of living. Living wage ordinances have emerged in response to the declining “real value” of the minimum wage. The basic philosophy behind the living wage movement is that someone working full-time should not be poor (PolicyLink, 2002).

The first living wage provision in the U.S. was passed in Baltimore, Maryland in 1994. By 2018, there were at least 46 living wage ordinances in U.S. cities and counties (UC Berkeley, 2019) and many more living wage campaigns underway in other cities. Living wage policies typically require that local governments pay, and can only contract with companies that pay, a living wage. Therefore, living wage provisions apply to companies that provide municipal services and those receiving any government subsidies or financial assistance. There are several advantages to living wage provisions, including:

- improving living standards

- encouraging governments to employ local workers on public projects, instead of sub- contracting to the lowest bidder

- alleviating poverty

- reducing the strain on government welfare programs; and
- stimulating the economy.

Researchers have estimated the wage needed to meet basic needs for individuals and families living in Delaware. As seen in Table 3, the state's minimum wage is far below the living wage in each of its three counties. This has serious consequences, considering that families living on Delaware's minimum wage are likely to experience poor health outcomes and struggle with competing financial priorities, such as shelter, food, and health care.

Table 3: Hourly Rate that an individual must earn to support their family, if they are the sole provider and are working full-time, in Delaware, in 2018.

	1 Adult	1 Adult and 2 Children
New Castle County		
Living Wage	$13.25	$30.79
Minimum Wage	$8.25	$8.25
Poverty Wage	$5.84	$9.99
Kent County		
Living Wage	$12.51	$28.61
Minimum Wage	$8.25	$8.25
Poverty Wage	$5.84	$9.99
Sussex County		
Living Wage	$11.36	$28.39
Minimum Wage	$8.25	$8.25
Poverty Wage	$5.84	$9.99

Source: Glasmeier, 2019.

Policymakers in the state of Delaware have recently focused efforts on addressing the minimum wage to improve the economic environment. In 2018, the state enacted a bill to which will initiate a two-step increase of the minimum wage. Starting January 1, 2019, Delaware's minimum wage will increase from $8.25 to $8.75, and will increase again on October 1, 2019 to $9.25 (NCSL, 2018). In addition, there are other efforts underway to alleviate some of the disadvantages of living on minimum wage. For example, the Blueprint Communities Program is helping to build economically, physically, and socially vibrant neighborhoods in several communities by developing the capacity of community stakeholders to plan and implement comprehensive revitalization plans. Active Blueprint Communities throughout Delaware include: Northeast Wilmington, Washington Heights, and the Town of Georgetown. Previous Blueprint communities included: Eastside, Edgemoor Gardens, Historic Overlook Colony, Simonds Gardens, Westside, Belvedere, Browntown, Dover, Riverside, and the 2nd District (in Wilmington).

"Blueprint Communities" is an initiative of the Federal Home Loan Bank (FHLBank) of Pittsburgh, which selected the University of Delaware's Center for Community Research and Service (CCRS) as its partner to develop and lead the comprehensive training, coaching, and capacity-building program in Delaware. CCRS provides training, technical assistance, and coaching to self-developed teams comprised of community leaders, bankers, public officials, developers, and health and social service providers. The training aims to help them learn how to develop community revitalization plans that include implementable projects. The CCRS trainings enable the teams to obtain new knowledge and skill sets while engaging them in leadership development. Teams produce well-developed written plans with feasible projects that will improve their communities economically, physically, and socially.

Launched in 2008, the Blueprint Communities Program has achieved measurable impacts in the community. For instance, research on the first phase of the initiative found that more than $27 million in community development funding was leveraged through the development of nine community revitalization plans. These investments led to the construction or rehabilitation of over 100 housing units, numerous infrastructure improvements and other community projects. Since 2016, communities in Wilmington have developed two revitalization plans. These recent initiatives have already leveraged $50,000 in grants from FHLBank to build their backbone capacity, including hiring staff, renovating community facilities, and establishing or re-establishing community-based organizations to coordinate local revitalization. While the original 2008 cohort of Blueprint Communities teams has aged out of their FHLBank designation, six of these previous Blueprint Communities maintain an active revitalization initiative after 10 years of activity. These mature revitalization initiatives continue to make large strides in affordable housing development (e.g., Westside created 408 new low-income units as part of the Flats multi-phase project), maintaining and renovating community parks and gardens, developing youth programming, creating opportunities for entrepreneurs and developing commercial corridors, and hosting hundreds of community events among many other activities and accomplishments. For more information on Blueprint Communities, visit https://www.bidenschool.udel.edu/ccrs/service/blueprint-communities-program.

Despite the passage of a new bill increasing the minimum wage, the living wage in Delaware continues to rise and presents a challenge to the economic conditions for Delawareans. For example, in New Castle County the minimum wage was 67% of the living wage in 2014, but decreased to 62% in 2018 despite wage increases. In order to reconcile this decrease, efforts such as living wage campaigns and ordinances can support the economic conditions for Delawareans to thrive and achieve optimal health. For examples of living wage efforts, as well as guidance for ways to develop a living wage campaign, visit: http://www.policylink.org/sites/default/files/living-wage-provisions.pdf. For more information on the relationships between employment, income, wealth and health, read the National Academies Committee report at https://www.nap.edu/catalog/24624/communities-in-action-pathways-to-health-equity.

Health systems and services. As discussed in previous sections, addressing SDOH and health inequities is generally outside the scope of what is typically considered part of the health care system. Further, when we think about interventions within the health care system, we are usually addressing more “downstream” factors that influence the health of individuals rather than communities. However, as indicated by the National Academies Report conceptual model (Figure 35), the health system and health-related services are themselves important determinants of health, and inequities in access and quality of care contribute to inequities in health outcomes. For this reason, and because the health care system is an integral part of the full continuum of services needed to advance health equity, we have included a discussion of “upstream” strategies for health care providers in section 6 of the guide. These strategies include approaches to better address the social needs of patients, and ways to improve access to, and quality of care, particularly for patient populations that face barriers to care and may experience discrimination within the health care system.

When we think about other services in the community that impact health, we can see how the service environment is related to other aspects of the social and physical environment. For instance, as referenced above, high quality and equitable access to schools, public safety, and public transportation are critical elements of a health community. In addition, healthy communities must have basic infrastructure and services such as clean and safe water, good sanitation services (including sewer and trash removal), and emergency response systems (such as fire and ambulance services). While many of these services are often taken for granted as basic infrastructure available to all residents, recent crises such as the Flint, MI, water crisis remind us that even these basic services are not equitably distributed and weaknesses in municipal infrastructure are likely to have the greatest negative impact on poor communities and communities of color.

While a lack of any of these basic services can be directly harmful to communities, weak public infrastructure can also discourage private investment, which inhibits other services from existing locally. This is important because thriving communities are also characterized by health-promoting resources and services such as public libraries, churches, clubs, and recreational services for residents to use across the lifespan. For instance, after-school programs and recreation centers provide space for social interaction and positive youth development. Senior centers offer similar opportunities for older residents to interact socially and promote physical activity. Communities without recreational services or community centers may lack opportunities for social interaction. Overall, deficiencies in the availability and quality of services prevent communities from attaining optimal health.

Sample Strategy

Bon Secours Mercy Health has operated an acute care hospital in West Baltimore, MD, since 1919 and has been working to improve the health and well-being of its community since its inception. In addition to provide high quality care, Bon Secours Hospital has partnered with the community to establish essential social services and revitalize the neighborhood. For instance, they have purchased and rehabilitated a number of vacant properties in the West Baltimore area to create affordable housing. In doing so, they have leveraged over $100M in capital investments for housing construction, resulting in more than 800 housing units in the area. Bon Secours operates a Family Support Center, serving pregnant mothers and families with young children, including through Early Head Start; and a separate Women’s Resource Center, which allows women to “drop-in” and access a range of education and other support such as mail and telephone service, washers and dryers, and a computer lab. Bon Secours also operates a Career Development program providing teens and adults training and support for job readiness. Further, they offer financial support services, including financial education, eviction prevention assistance, tax preparation, and screening for social services and benefits.

In February of 2019, Bon Secours entered into an agreement to become part of the LifeBridge Health Network, ensuring continuation and expansion of the range of services provided in the West Baltimore area. In describing the partnership, the CEO of Bon Secours Hospital, Dr. Samuel Ross, acknowledged the importance of social determinants of health in stating "Bon Secours and LifeBridge Health are committed to focusing on better access to quality health care services, wellness and prevention, addressing the root causes of health disparities, and transformational work to improve the health and wholeness of west Baltimore" (https://bonsecours.com/baltimore/about-us/newsroom/news/announcement). More about Bon Secours work in the community and accomplishments to date may be found at https://www.hilltopinstitute.org/wp-content/uploads/hilltop/Symposium16/ClarkSlides.pdf.

Housing. As described in previous sections, housing as a determinant of health is typically thought of in relation to the availability of stable, safe, affordable housing for community residents. At the extreme, homelessness is associated with other important determinants of health such as barriers to education, employment, and health care. People who are homeless have higher rates of a number of infectious and chronic diseases (National Academies, 2017). Low-income communities often experience poor quality housing, which threatens their health directly through increased exposures to health threats, such as lead or allergens. Old or poorly maintained housing can also increase residents' risk of injuries and other hazards. While well-constructed and well-maintained affordable housing can reduce the threats associated with substandard housing, housing investments can have a number of additional benefits that contribute to the health of a community. Researchers at the Center for Housing Policy conducted a comprehensive review of the ways in which affordable housing can promote health and identified the following themes:

- Affordable housing frees up family resources for nutritious food, health care and other needed services.
- Affordable housing reduces stress and related adverse health outcomes, including mental health problems in children that can be associated with housing instability.
- When affordable and sustainable, homeownership, in particular, can support mental health.
- Stable, affordable housing may support medical treatment for individuals with chronic illnesses, as having a stable address is critical for continuity of care, storage of medications, and maintaining healthy behaviors.
- Living in low-poverty, socially supportive areas can reduce stress, increase access to amenities, and improve health.
- Affordable housing can reduce stressors associated with overcrowding, including psychological distress and potential increases in exposure to infectious diseases.
- Affordable housing allows victims of domestic violence to escape abusive relationships, improving mental health and physical safety.
- Sustainable housing strategies, such as green building and location efficiency, can reduce exposure to pollution and improve air quality.
- Pairing housing with supportive services enables older adults and people with disabilities to avoid moving to assisted living facilities or nursing homes (Maqbool, Viveiros, & Ault, 2015).

As discussed in Section 3, residential or housing segregation (the physical or spatial separation of two or more social groups within a geographic area) is a fact of U.S. history and has long been identified as the root of many social and racial inequities in American cities. Research demonstrates that racial health inequities grounded in segregation are more than a function of diminished socioeconomic status of individuals living in segregated communities, and that health inequities experienced by black communities remain even after accounting for income and education levels. Therefore, strategies to promote access to high quality affordable housing must incorporate a racial justice lens to effectively reduce racial health inequities. This means identifying and ameliorating barriers to integration and confronting persistent forms of racism in policy and practice. For instance, resistance to investments in affordable housing projects are often based upon arguments related to school overcrowding, traffic, or density concerns, when these may, in fact, be veiled attempts to maintain racial segregation. Further, while it is important that investments in housing do not lead to gentrification and displacement of lower income residents, we must also consider the ways in which public policy and community development efforts reinforce existing segregation. For instance, an analysis of New York City's policy of giving preference to local residents for new affordable housing units found that the policy actually reinforces racial segregation (U.S. District Court, Southern District of New York, 2019). Finally, it is important to address housing integration in partnership with communities of color so that it is possible to "dismantle the racist system of policies that created and continue to sustain residential segregation without simultaneously destroying valuable cultural and economic institutions that black and brown communities have created in response to it" (Quick & Kahlenberg, 2019).

Sample Strategy

The Dudley Street Neighborhood Initiative (DSNI) is a community-driven initiative focused on the Roxbury and North Dorchester neighborhoods in Boston, Massachusetts. DSNI's mission is to "empower residents to organize, plan for, create and control a vibrant, diverse and high-quality neighborhood in collaboration with community partners" (https://www.dsni.org/). DSNI focuses on a range of interrelated community development issues, including neighborhoods revitalization and "development without displacement." Their approach includes the establishment of an urban community land trust, though which DSNI was able to purchase vacant lots and redevelop the land into affordable housing, urban gardens, community parks and playgrounds, and other spaces for economic development (National Academies, 2017). A distinguishing feature of DSNI is the structure of its 35-member board of directors, which is designed to reflect the demographic composition of the Dudley community, including black and Latino members, as well as youth representatives and representatives from small businesses and religious organizations. DSNI's efforts have led to a range of positive impacts in the community related to housing and the physical environment, education, employment, and public safety (National Academies, 2017).

For more information on the relationship between housing and health see research from the Healthy People Initiative, visit https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/quality-of-housing and the National Academies Committee report at https://www.nap.edu/catalog/24624/communities-in-action-pathways-to-health-equity. For more information about DSNI, visit www.dsni.org and the National Academies Committee report, which details DSNI's history, approach, outcomes, and lessons learned.

The various dimensions of healthy communities illustrated in the National Academies model (Figure 35) — the physical environment; public safety; the social environment; transportation; education; employment; health systems and services; housing; and income and wealth — are interrelated and interdependent. Many of the risk and protective factors described could fit within multiple dimensions (e.g. parks could be described within the physical environment as well as the service environment). Similarly, the strategies highlighted for each dimension are likely to have positive impacts across other dimensions. For instance, the "Complete Communities Planning" approach is described in relation to its impact on transportation, but the effect on other aspects of community well-being may be viewed in the context of the physical, social, and work environments, and the connections between each. It is unnecessary to specify or prioritize a dimension when promoting place-based initiatives. Rather, the distinctions among the dimensions are intended to organize the discussion and can be useful in identifying areas for intervention.

Implementing PBIs for Health Equity

Recommended strategies for implementing PBIs for health equity are consistent with evidence-based strategies for building healthy communities in general. Through its work as a designated World Health Organization (WHO) Collaborating Centre for Community Health and Development, the Kansas University Work Group for Community Health and Development (2014) created "The Community Tool Box" (CTB). This tool box is a comprehensive, online, and publicly available resource for people working collaboratively to build healthier communities. According to the Kansas University Work Group for Community Health and Development:

"Building healthier cities and communities involves local people working together to transform the conditions and outcomes that matter to them. That civic work demands an array of core competencies, such as community assessment, planning, community mobilization, intervention, advocacy, evaluation, and marketing successful efforts. Supporting this local and global work requires widespread and easy access to these community-building skills. However, these skills are not always learned, nor are they commonly taught either in formal or informal education."

To ensure access to the necessary knowledge and skills needed to build healthy communities, the Kansas University Work Group for Community Health and Development made their community tool box widely available. The contents are exhaustive and include 46 chapters through which users can obtain practical, step-by-step guidance in community-building skills.

The Table of Contents, including the major sections of the tool box, is reproduced as Figure 36. Importantly, some sections are more relevant than others to specific communities and individual place-based efforts. However, it is valuable to see the extent of topics covered in the CTB, as this reflects the complexity of working with communities and the need for a different approach than has been traditionally used in health promotion and disease prevention.

Figure 36: Kansas University Community Tool Box Table of Contents.

Overview: An overview of the Community Tool Box and frameworks for guiding, supporting and evaluating the work of community and system change	
Chapter 1: Our Model for Community Change and Improvement	Related Toolkits: 1. Creating and Maintaining Partnerships
Chapter 2: Other Models for Promoting Community Health and Development	
Community Assessment: Information about how to assess community needs and resources, get issues on the public agenda, and choose relevant strategies	
Chapter 3: Assessing Community Needs and Resources	Related Toolkits: 2. Assessing Community Needs and Resources
Chapter 4: Getting Issues on the Public Agenda	
Chapter 5: Choosing Strategies to Promote Community Health and Development	
Promoting Interest and Participation in Initiatives: Information about how to promote interest in an issue (e.g. press releases) and how to encourage involvement among diverse stakeholders	
Chapter 6: Promoting Interest in Community Issues	Related Toolkits: 1. Creating and Maintaining Partnerships 8. Increasing Participation and Membership
Chapter 7: Encouraging Involvement in Community Work	
Developing a Strategic Plan and Organizational Structure: Information about developing a strategic plan and organizational structure, recruiting and training staff and volunteers, and providing technical assistance	
Chapter 8: Developing a Strategic Plan	Related Toolkits: 5. Developing Strategic and Action Plans 15. Improving Organizational Management and Development
Chapter 9: Developing an Organizational Structure	
Chapter 10: Hiring and Training Key Staff of Community Organizations	
Chapter 11: Recruiting and Training Volunteers	
Chapter 12: Providing Training and Technical Assistance	
Leadership and Management: Information about the core functions of leadership, management, and group facilitation	
Chapter 13: Orienting Ideas in Leadership	Related Toolkits: 6. Building Leadership
Chapter 14: Core Functions in Leadership	
Chapter 15: Becoming an Effective Manager	
Chapter 16: Group Facilitation and Problem-Solving	
Analyzing Community Problems and Designing and Adapting Community Interventions: Information about analyzing community problems to design, choose, and adapt interventions for different cultures and communities	
Chapter 17: Analyzing Community Problems and Solutions	Related Toolkits: 3. Analyzing Problems & Goals 7 Developing an Intervention
Chapter 18: Deciding Where to Start	
Chapter 19: Choosing and Adapting Community Interventions	
Implementing Promising Community Interventions: Information on illustrative interventions using various strategies for change	
Chapter 20: Providing Information and Enhancing Skills	Related Toolkits: 7. Developing and Intervention
Chapter 21: Enhancing Support, Incentives, and Resources	

Chapter 22: Youth Mentoring Programs	11. Influencing Policy Development
Chapter 23: Modifying Access, Barriers and Opportunities	
Chapter 24: Improving Services	
Chapter 25: Changing Policies	
Chapter 26: Changing the Physical and Social Environment	
Cultural Competence and Building Inclusive Communities: Information on understanding culture and diversity, how to strengthen multicultural collaboration, and building inclusive communities	
Chapter 27: Cultural Competence in a Multicultural World	Related Toolkits: 9. Enhancing Cultural Competence
Chapter 28: Spirituality and Community Building	
Chapter 29: The Arts and Community Building – Celebrating, Preserving, and Transforming Community Life	
Organizing for Effective Advocacy: Information on advocacy principles, advocacy research, providing education, direct action campaigns, media advocacy, and responding to opposition	
Chapter 30: Principles of Advocacy	Related Toolkits: 10. Advocating for Change
Chapter 31: Conducting Advocacy Research	
Chapter 32: Providing Encouragement and Education	
Chapter 33: Conducting a Direct Action Campaign	
Chapter 34: Media Advocacy	
Chapter 35: Responding to Counterattacks	
Evaluating Community Programs and Initiatives: Information on developing a plan for evaluation, evaluation methods, and using evaluation to understand and improve the initiative	
Chapter 36: Introduction to Evaluation	Related Toolkits: 12. Evaluating the Initiative
Chapter 37: Operations in Evaluating Community Interventions	
Chapter 38: Some Methods for Evaluating Comprehensive Community Initiatives	
Chapter 39: Evaluation to Understand & Improve the Initiatives	
Maintaining Quality & Rewarding Accomplishments: Information on achieving & maintaining quality performance, public reporting, providing incentives, & honoring colleagues & community	
Chapter 40: Maintaining Quality Performance	
Chapter 41: Rewarding Accomplishments	
Generating, Managing, and Sustaining Financial Resources: Information on writing grants, preparing an annual budget, and planning for financial sustainability	
Chapter 42: Getting Grants and Financial Resources	Related Toolkits: 14. Writing a Grant Application for Funding
Chapter 43: Managing Finances	
Chapter 44: Investing in Community Resources	
Social Marketing and Institutionalization of the Initiative: Information on conducting a social marketing effort (promoting awareness, interest, and behavior change), and planning for long-term sustainability	
Chapter 45: Social Marketing of Successful Components of the Initiative	Related Toolkits: Implementing a Social Marketing Effort Sustaining the Work or Initiative
Chapter 46: Planning for Long-Term Institutionalization	

Source: Kansas University, 2014. Retrieved from http://ctb.ku.edu/en/table-of-contents.

Readers are highly encouraged to visit www.ctb.ku.edu to access the CTB and related materials. Each chapter has detailed sections describing key elements of the strategy along with related checklists, examples, and PowerPoint presentations. Associated toolkits include detailed instructions and examples. In addition to these resources, the CTB website includes a troubleshooting guide for identifying and addressing common problems in community health work as well as a database of best practices. There is an online course for community health promotion as well as an "Ask an Advisor" feature, which links users with community leaders and experts in the field. Furthermore, because health equity raises specific issues that warrant additional attention, some of the topics included in the CTB are discussed in greater detail in Section 7 (policy-oriented strategies) and Section 8 (data needs and evaluation approaches for health equity).

Importantly, many of the "how to" strategies included in the CTB are not specific to health equity, nor do they incorporate a racial justice lens. Therefore, it is valuable to consider them within the context of recommendations and broad lessons learned from recent efforts to address health inequities by improving living conditions at the local level. The following list of recommendations and lessons learned is drawn from case study research conducted by PolicyLink (Bell & Rubin, 2007) and the BARII (2013), as well as interviews with experts in the field (Knight, 2014) and findings from the National Academies Committee Report (2017). Some recommendations are reminders of important principles to keep in mind when promoting health at the community level using an equity and racial justice lens. These are directly tied with the values and assumptions underlying health equity work described in the Background section and include:

- Identify priorities in collaboration with the community.
- Embrace a broad definition of health and promote a comprehensive approach.
- Maintain a focus on equity by making health equity a shared vision and value.
- Build community partnerships and foster multi-sector collaboration.
- Build awareness and appreciation for the social determinants of health and health inequities, including structural racism as a fundamental cause of racial health inequities.
- Leverage successful PBIs for regional and state level changes.
- Build skills and capacities of health professionals.
- Increase community capacity to shape outcomes.
- Be flexible and plan ahead for new ways of working.
- Document and disseminate success stories.
- Be patient and persistent and be willing to take risks.

Each of these recommendations and lessons learned is expanded below.

Identify priorities in collaboration with the community. Professionals must remember that residents themselves understand, better than anyone else, what their needs and assets are, and what will work in their community. Traditional public health surveillance, assessment strategies, and data sources provide valuable information, but cannot replace local knowledge and the "lived experience" of residents. Often many interrelated problems exist simultaneously, and quantitative, data-driven assessments can help inform prioritization.

However, community members' perceptions and understanding of problems are equally important and communities often know best what is needed to address those problems. Therefore, when providing technical assistance or other kinds of support to community groups, public health agencies, and other professionals should work in true partnership with community members.

Sample Strategy

Community members in Alameda County, California led a community assessment process to identify priorities. According to the BARHII Health Equity and Community Engagement Report (2013), local agencies involved in promoting health equity consistently engaged community members in assessments, program planning, and implementation of strategies. Community concerns regarding a lack of educational support and activities for youth led three agencies to create after-school, summer, and evening programs, including community leadership training. Similarly, community concerns about neighborhood violence led to the organization of violence prevention workshops that include dialogue between the local police department and community members. For more information about Alameda County's health equity efforts, including lessons learned and ongoing challenges, visit: http://barhii.org/download/publications/hecer_alameda.pdf.

Embrace a broad definition of health and promote a comprehensive approach. Health is more than the absence of disease. A healthy community is one that promotes physical, mental, and social vitality. It is important to view health holistically and consider the various factors that impact the health of the community. This may mean that health professionals need to support efforts that are not defined by health or may appear to be outside the scope of traditional health-related efforts.

Sample Strategy

It is often useful to educate partners about the health impact of their work, but it is not necessary to make everything explicitly about health in order to create positive change. An example of this approach is the role of the Boston Public Health Commission (BPHC) in advocating for the "Jobs not Jails" program in Massachusetts. "Jobs not Jails" is a campaign to reform the state's criminal justice system by focusing more attention on prevention, treatment, and rehabilitation. The BPHC recognizes that by addressing problems related to incarceration and recidivism, "Jobs not Jails" will indirectly have major implications for health equity. Notably, the BPHC acknowledges that the health equity-oriented impacts that may result from the program may not be the main drivers of the reform effort. Instead, the BPHC supports the effort on the principle that health equity will be an indirect result of the program, in addition to the intended outcomes of reducing the numbers of people being incarcerated and increasing the number of people who are employed (B. Ferrer, personal communication, June 1, 2009). For more information regarding "Jobs not Jails," visit https://nationinside.org/campaign/jobs-not-jails/about/.

Maintain a focus on equity by making health equity a shared vision and value. Healthy communities benefit everyone. However, without attention to equity and the factors that create inequity, we are likely to improve the average health of different population groups without closing the gaps between them. The resources needed for health are not equally distributed across communities, and health professionals and other local leaders must focus on creating a level playing field for all communities. This becomes particularly important when identifying priority communities for interventions and investments. As mentioned earlier, all communities could benefit from healthier living conditions and more attention to the SDOH. However, state agencies and community-based organizations considering PBIs should look first to those communities with the greatest needs and the greatest opportunities for improvement. Similarly, leaders should recognize that not all communities will be affected in the same way by standardized or statewide policies and programs, and to close the gaps, they must consider the impact on the most vulnerable communities rather than the average or typical community.

According to the National Academies Committee report (2017), maintaining a focus on equity requires a shared vision that is aligned with a clearly stated state purpose and values. The committee further argues that key ingredients of successful efforts include creating a sense of urgency and identifying a champion who can work across different stakeholder groups with varying perspectives. Often a shared vision is a result of a community-driven process that prioritizes the voice of the community; however, it is often necessary to facilitate a process by which a shared vision can emerge. Further, as demonstrated by the community-based efforts highlighted in the National Academies report, building public will for the kinds of changes that may be needed may require a distinct and purposeful communication strategy. For more about making equity a shared vision and building public will, read the National Academies Committee report at https://www.nap.edu/catalog/24624/communities-in-action-pathways-to-health-equity.

Build community partnerships and foster multi-sector collaboration. Partnerships are necessary to identify and prioritize concerns and to actualize solutions for remedying them. A network of partnerships should mirror the complexity of the community and the priorities identified by the community. Therefore, the network will likely need to include stakeholders from multiple and diverse sectors: health care, public health, government, law enforcement, education, faith-based organizations, non-profits, transportation, agriculture, etc. It is important to create buy-in with partners so they understand how their organization and assistance are keys to achieving the overall goal and how their organization might benefit from participating. Once stakeholders identify mutual areas of interest, those interests can be leveraged to create healthier communities. Specific projects or mechanisms for collaboration can facilitate partnership development, often leading to long-term relationships. Multi-sector partnerships and collaborations across community agencies can generate collective impact, such that the whole is greater than the sum of the parts. Such collaboration is necessary to address complex social problems such as health inequities. The CTB includes several tools to support partnership development, such as the National Association of County and City Health Officials' "Mobilizing Action through Planning and Partnerships" (MAPP) process. MAPP is an effective way to garner stakeholder and community engagement to improve community health. More information about MAPP can be found in the CTB and at: http://www.naccho.org/topics/infrastructure/MAPP/index.cfm.

Sample Strategy

An example of a strong network of partnerships can be seen in a local advocacy project in San Mateo County, California. According to the BARHII Health Equity and Community Engagement Report (2013), a local health partnership, with training and support from the San Mateo County Health System, organized mobile home park residents to advocate for and establish a rent control ordinance. The partnership persuaded an affordable housing management company to purchase their mobile home park. Where residents were previously subject to an owner who constantly raised rents beyond what was affordable, ignored resident input, and neglected the grounds, they were now empowered as local leaders. According to BARHII (2013), "this community-driven project was sustained over time, led to increasing community pride, and resulted in environmental changes such as a renovated playground, pool, and community center." For more information about San Mateo County's health equity efforts, visit: http://barhii.org/download/publications/hecer_sanmateo.pdf.

Build awareness and appreciation of the social determinants of health and health inequities, including structural racism as a fundamental cause of racial health inequities. Residents from low income or disempowered communities inherently understand the social determinants of health because they regularly experience the impacts of poverty, discrimination, poor quality schools, and inadequate access to other resources needed for health. Policymakers and the general public, on the other hand, generally view health through a medical or behavioral lens without appreciating the social and environmental context for health and health inequities. Further, there is a common misperception among the public and policymakers that we have achieved the promise of the Civil Rights era and problems such as racial segregation are a thing of the past. It is important to raise awareness of the SDOH and equity, and the role of public policy in determining the distribution of the resources needed for health, including the ways in which both historical and persistent structural racism underlie racial health inequities.

Sample Strategy

The Unnatural Causes campaign is a national effort, launched in 2008, explicitly to enlighten the public about social inequities in health. The campaign includes a website (www.unnaturalcauses.org) with a large collection of resources and a seven-part documentary film series, titled "Unnatural Causes: Is Inequality Making Us Sick?" Originally broadcast on public television in the fall of 2009, the film series has since been used in thousands of community events across the country (https://unnaturalcauses.org/assets/uploads/file/UC-Survey-Final.pdf). The Unnatural Causes film series is an effective tool for increasing awareness of the SDOH and equity and can be used to facilitate a community dialogue about change. California Newsreel, the producer of the film series and leader in the broader Unnatural Causes campaign, produced a follow-up campaign and film series focused on the role of early childhood development in health and equity (www.raisingofamerica.org).

While these campaigns raise awareness about SDOH, more explicit attention on structural racism as a fundamental cause of health inequities was the focus of a 2019 Policy Academy hosted by the Partnership for Healthy Communities and the Partnership for Arts and Culture at UD in collaboration with DSU.

The full-day event, titled "Reducing Inequities in Health and Well-Being by Addressing Structural Racism in the U.S.," convened cross sector representatives and community members to engage in discussions guided by research and lived experiences to direct future action in communities across Delaware. The Policy Academy used arts, culture, and other modalities to raise awareness and offer solutions about how policy and resource allocation often create or perpetuate racial injustice and health inequities. Participants explored the evidence linking structural racism with poor health, and the role of arts and culture in healing and promoting equity and social change. Finally, the event fostered a dialogue to advance policies and practices across a variety of sectors aimed at eliminating racism and promoting health equity. For more information about the Policy Academy at UD, including a report on the conference proceedings, visit: https://sites.udel.edu/healthycommunities/2019/03/15/inaugural-policy-academy-april-17-2019/.

Leverage successful PBIs for regional and state level changes. Communities are unique in their needs, assets, resources, and culture. Nonetheless, regional and state level initiatives can support local efforts and help bring successful efforts to scale. Similarly, state-level policy changes can often address community needs that are beyond the reach of community stakeholders and/or can address health inequities more systematically. (More information regarding policy-oriented strategies is included in Section 7.)

Sample Strategy

Delaware's Help Me Grow program is a partnership of many statewide organizations that promotes healthy early childhood development. Launched in Delaware in 2012, Help Me Grow began in Hartford, Connecticut in 1998, as a pilot program in a single community. The initial pilot yielded such promising results that the Connecticut legislature funded a statewide replication of the Hartford program in 2002. In 2010, the W. K. Kellogg Foundation funded the establishment of the Help Me Grow National Center to promote widespread implementation and impact.

Currently in Delaware, Help Me Grow offers a comprehensive, upstream approach to address the physical, social, emotional, cognitive, and behavioral aspects of development to promote the wellness of children 0-8 years of age. It is a result of strong partnerships and support from many components of Delaware's early childhood community including the Delaware Early Childhood Council, DPH's Maternal and Child Health Program, the Race to the Top Early Learning Challenge grant, the United Way of Delaware, Nemours Health and Prevention Services, American Academy of Pediatrics, and many others. Each partner is working to promote strong-parent child relationships, safety, child development and overall family health and well-being. Help Me Grow specialists in Delaware can be reached by dialing 2-1-1 to provide information on programs, services, and information on the healthy development of children. With technical assistance from the National Center, Delaware's Help Me Grow program is supported at the state level and reaches across every community statewide. Additional information about the Help Me Grow National Center is at http://www.helpmegrownational.org. Information specific to Help Me Grow in Delaware is available at https://dethrives.com/help-me-grow.

Build skills and capacities of health professionals. Workforce development is important to creating healthy communities because new and different kinds of work are required of health professionals. Similar to community residents, many health professionals inherently appreciate the SDOH, often because the needs of their patients or target population are beyond the scope of their professional practice. In a recent survey, four out of five physicians in America and 95 percent of physicians serving low-income urban communities say that patients' social needs are as important to address as their medical conditions; however, only one in five physicians are confident in their ability to address these needs (RWJF, 2011). For instance, clinicians often recognize that their asthma patients suffer due to poor housing conditions. They prescribe effective medications to treat asthma symptoms and can do much to alleviate pain and suffering. However, many clinicians are frustrated by their limited ability to help their patients avoid unhealthy living conditions that trigger asthma symptoms. In another example, health educators and other public health professionals recognize that nutrition education is inadequate if their audience does not have access to affordable fruits and vegetables.

> The skills needed to build multi-sector partnerships or to advocate for environmental and other policy changes are often not taught in medical schools or schools of public health. Professionals need additional training to build the knowledge and capacity for new approaches to promoting community health. These new skills and capacities should be institutionalized in public health and medical education programs and professional development.

Increase community capacity to shape outcomes. Increasing community capacity to shape outcomes is a key element of success identified in the National Academies Committee framework for community-based solutions to promote health equity (Figure 35). Recognizing that residents and grassroots organizations often have less power, experience and capacity in developing and implementing interventions (compared with larger or more established partners), it is important to increase this capacity to ensure true and sustainable partnerships. Capacity building helps critical community stakeholders to be more effective and promotes sustainability. According to the National Academies report (2017), skill building includes areas such as basic business planning and practices, communication tools and strategies, strategic planning, grant writing and fundraising (page 482). Further, the committee argues, capacity building depends on specific strategies related to leadership development, community organizing, and organizational development (including a focus on change processes). For more about increasing community capacity to shape outcomes, read the National Academies Committee report at https://www.nap.edu/catalog/24624/communities-in-action-pathways-to-health-equity.

Be flexible and plan ahead for new ways of working. The kinds of changes needed to promote healthy communities rarely happen quickly. Managers should explore ways in which staff may have more flexibility and consider different kinds of performance expectations. Similarly, traditional approaches to funding health-related projects (e.g. disease-specific efforts) may not be conducive for a place-based approach. Flexible funding streams can facilitate efforts to target living conditions underlying many interrelated health problems. Finally, funders should consider investing for the long- term, instead of funding short-term projects.

Sample Strategy

Many national grant-making organizations are embracing upstream approaches to community health that recognize the importance of social determinants and community engagement. The Annie E. Casey Foundation's Making Connections initiative was a 10-year, $500 million investment to strengthen families and communities through place-based initiatives. Although the program recently concluded, an evaluation of the effort showed improvements in the capacity for community change. However, evidence of widespread impact on population outcomes was limited (Annie E. Casey Foundation, 2013). Many important lessons were learned from Making Connections that can be applied to funding strategies in Delaware. For instance, evaluation findings revealed an even greater need for sustained, sufficient investments. Similarly, it is important for funders (and those working in communities) to do a better job of defining success for place-based community change and identifying the models and strategies that will produce measurable impacts. Additional information about these and other lessons learned from Making Connections may be found at https://www.aecf.org/resources/community-change-lessons-from-making-connections/. Examples of other upstream funding initiatives include those of the California Wellness Foundation (http://www.calwellness.org/) and the Kresge Foundation (http://kresge.org/programs/health).

Document and disseminate success stories. Evaluating community health efforts is important for continuous improvement and expansion. Unfortunately, evaluation is particularly difficult due to the complex nature of PBIs and collaborative upstream strategies, coupled with the long timeframe that is often needed to see the health impacts of changes in the SDOH. Therefore, success stories become important, as do other kinds of qualitative and innovative approaches to evaluation (Section 8). Champions should be celebrated to raise awareness about successful approaches.

Sample Strategy

In Delaware, the Delaware Healthy Mother and Infant Consortium (DHMIC) honors local Health Equity Champions at its annual summit. Recognizing these champions is an important avenue for sharing success stories and building momentum. For more information about the DHMIC Health Equity Awards, visit http://dethrives.com/thriving-communities/health-equity-awards.

The media can be a particularly valuable partner in recognizing champions and helping to reframe health and health inequities using a SDOH lens. Professionals must work with the media[2] to share positive stories about community change and help to reframe health equity in a positive way, as opposed to the more negative and potentially divisive frame of "health disparities."

Several research and advocacy organizations are working to reframe poor health and health disparities from being viewed as individual, biomedical problems to being viewed as social problems grounded in collective responsibility. These communication efforts are aimed at building public will for change and shifting the conversation from a "deficits model" to one which emphasizes what works, and what is needed, to foster optimal health for all.

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[2] For a detailed discussion of the importance of media advocacy in public health and strategies for developing effective messages see Dorfman, L. & Daffner Krasnow, I. (2014). Public health and media advocacy. Annual Review of Public Health, 35, 293-306.

Berkeley Media Studies Group has a number of resources aimed at helping professionals and advocates to frame health and racial equity (http://www.bmsg.org/?s=health+equity+-framing). Similarly, the Frameworks Institute has a number of recommendations for communicating about various issues related to communities and SDOH (http://www.frameworksinstitute.org). Finally, RWJF conducted research on message development for SDOH and produced a series of recommendations. To view them, visit https://www.rwjf.org/en/library/research/2010/01/a-new-way-to-talk-about-the-social-determinants-of-health.html.

Sample Strategy

In Delaware, KIDS COUNT (https://www.bidenschool.udel.edu/ccrs/research/kids-count-in-delaware) works closely with the media to share information about the well-being of children and families. One of 53 projects across the country funded by the Annie E. Casey Foundation, the mission of KIDS COUNT in Delaware is to provide up- to-date, accurate, objective, and comprehensive data on the well-being of children, youth, and their families to raise awareness and inform both policy and programmatic decisions.

KIDS COUNT in Delaware produces multiple publications, but is best known for its annual Fact Book, the singular account of every child under 18 in Delaware. Disseminating this information is critical to promoting positive change and is accomplished through a well-developed media strategy that includes a schedule of planned releases and the promotion of consistent messages. The use of press releases, email blasts, and social media support consistent messaging and allows KIDS COUNT in Delaware to frame information for the media in ways that support its advocacy efforts. This has become increasingly important as the state's news outlets decreased their budgets and laid off reporters. Similarly, while it is important to share data about the challenges faced by children and families in Delaware, it is critical to offer solutions and strategies for positive change. Therefore, KIDS COUNT in Delaware annually highlights "causes for concern" as well as "causes for applause." Finally, KIDS COUNT in Delaware uses its communication channels to leverage its partners and stakeholders by referring reporters to additional community resources and providing contacts in other agencies. This strategy should be replicated, given the importance of partnerships and the role of a wide range of community organizations in advancing health equity in Delaware.

Be patient and persistent and be willing to take risks. A long-term commitment to community change is vital. Building trust and authentic partnerships takes time. Changing conditions and policies that affect those conditions also takes time. Seeing a difference in health outcomes can take even longer. Therefore, recognizing the need for a long-term commitment at the outset is important to preventing unrealistic expectations.

> Lessons learned from Marin County, California reveal the importance of health department staff having a sustained physical presence in the community. According to the BARHII Health Equity and Community Engagement Report (2013):
>
>> "Physical presence in the communities served was among the keys to success discussed by both community representatives and LHD

> [Local Health Department] staff alike. One community representative stated that it is important when the LHD is "Being present, accountable, and genuine when 'showing up' and actually doing what is said that will be done." Another community member shared that, the LHD "Showing up consistently on 'non-health' events, makes a lot of difference." Some of these non-health events include food banks, PTA meetings, and school registration nights."

For more information about Marin County's experience promoting health equity at the community level, visit: http://barhii.org/download/publications/hecer_marin.pdf.

When projects appear to be stalled or losing momentum, community champions and health professionals need to demonstrate leadership in the form of persistence and ongoing commitment. Part of that commitment is to advance social justice and equity, which is not always a popular or easy topic. Public health, as a field grounded in social justice, can play an important leadership role in this endeavor. Furthermore, partnerships can protect individuals and/or individual agencies or organizations from standing alone on difficult issues.

Again, it is important to note that many of the examples highlighted above address a multitude of recommendations and promising practices. In fact, community-oriented strategies that promote health equity are likely to be most effective when they are multi-faceted and reflect the range of characteristics described above. One such effort that has the potential to advance health equity in Delaware is Healthy Communities Delaware (HCD). As described in previous sections, HCD was established to advance population health outcomes, including reducing health inequities, by aligning investments at the local level to address SDOH. The management of HCD is a partnership between the state of Delaware (DPH), the UD (Partnership for Healthy Communities) and the Delaware Community Foundation working together to provide operational support to the effort. However, the model aims to support and invest in community-driven initiatives across sectors and in collaboration with local organizations and residents. The approach includes capacity-building activities, along with strategic communications, advocacy, and evaluation. A leadership council, with representatives from organizations and communities across the state, provides guidance, ensures alignment with existing efforts, and advocates for investments on behalf of community health needs. Finally, a community investment council contributes funding towards community-based projects based on needs identified by the local communities and proposals for addressing SDOH. Funding from the state's tobacco fund has also been allocated to support HCD.

Finally, it is important to emphasize that to effectively address racial health inequities, community solutions to promote health equity may need to engage more directly with issues related to structural racism. As many of these structural issues are part of the policy arena, this is discussed in more detail in Section 7. However, there is still much work to be done within state agencies and community-based organizations. As described in section 3, the Boston Public Health Commission (BPHC), is an example of a health department that has identified structural racism as a barrier carrying out its mission and has incorporated a racial justice lens in its practice of public health. In launching the Racial Justice and Health Equity Initiative, BPHC has explicitly recognized that addressing racial health inequities requires a significant shift in the way they carry out their work.

According to the BPHC (www.bphc.org):

> "the Racial Justice and Health Equity Initiative is a broad organizational transformation process, which aims to integrate health equity and racial justice principles and practices into all Commission work, both internal and external, in order to measurably reduce inequities in Boston. The initiative encompasses a range of activities across the organization to achieve its goals: adopting a new organizational identity statement; assessing and adapting internal policies and procedures; providing professional development opportunities for all staff; addressing language justice and health literacy needs; quality improvement and performance management. BPHC is also developing processes by which budgets, programs, and measures are created with an equity lens. These components set a foundation for the Commission's ability to advance racial equity in health for the entire City of Boston."

For more information about BPHC's Racial Justice and Health Equity Initiative, visit: https://www.bphc.org/whatwedo/health-equity-social-justice/racial-justice-health-equity-initiative/Pages/racial-justice-health-equity-initiative.aspx.

Glossary – Section 5

Built environment: Elements of the physical environment made by humans, such as sidewalks, roadways, and buildings. The term can refer to infrastructure as well as spatial and cultural aspects of places and is often used in relation to urban design or in relation to natural environments modified by people.

Collective impact: Collaboration across disciplines and sectors to solve complex social problems. It is grounded in the premise that no single organization can create large-scale, lasting social change alone.

Community: Traditionally defined as a physical location such as a ZIP code. It can also refer to a group of individuals that share common characteristics, identity, experiences, or values. For the purposes of this guide, "community" refers to a physical location and the stakeholders and institutions within it.

Community capacity: The ability of community members to work together, solve problems, set goals, and achieve sustainable change.

Healthy community: A community in which every member has access to the resources they need to live a healthy life, including housing, education, food, income, a safe environment, and positive social interactions. It includes social justice, equity, and sustainable resources and is free of all forms of discrimination. Furthermore, by viewing communities geographically, one can envision healthy places as those that are designed or built to improve the quality of life for all people who live, work, worship, learn, and play within their borders.

Place-based initiative (PBI): A social change effort that is concentrated in a specific geographic area. Health equity strategies focused on living conditions in a specific geographic community are often referred to as PBIs because the target of the interventions is the place itself (or characteristics of the place), rather than the people living there.

Stakeholder: Anyone who has an interest – directly or indirectly – in the health and well-being of a community.

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SECTION 6: Upstream Strategies for Health Care Providers

As discussed in previous sections, addressing the SDOH and health equity is generally outside the scope of what is typically considered the responsibility of the health care system. Health care providers are usually trained to address their patients' immediate needs based on individual symptoms, risk factors, and biological or genetic characteristics. Medical education and health care models in the U.S. typically reflect a biomedical and individualistic concept of health. Similarly, the United States' health care system is biased toward treatment rather than prevention and health promotion, as well as toward specialization instead of a more holistic and comprehensive approach to health and well-being. Finally, payment systems and incentives tend to prioritize innovation and high-end technology, which creates additional barriers for providers to attend to their patients' social needs. These characteristics of the health care system, which are at odds with efforts to advance health equity, are driven by long-standing cultural barriers, numerous regulatory barriers, and financial challenges related to payment mechanisms and our insurance system (Manchanda, 2013).

Fortunately, passage of the Affordable Care Act (ACA) and increasing attention to the Triple Aim (Section 4), created opportunities for reforming the health care system in ways that can better address the SDOH and promote equity. Providers are positioning themselves to better address their patients' social needs by creating stronger linkages with other community resources; coordinating care more effectively; and ultimately ensuring high quality, accessible care to a diverse patient population. Strategies in each of these three areas can contribute to a more equity-oriented health care system, which is part of the broader continuum of strategies needed to advance health equity overall. This is important because, while health care is only one determinant of health, it is an important lever of change and can open the door to other changes in the broader community context. Further, while health care organizations and providers themselves may not have the power to address all of the various SDOH that impact their patients, they do have the power to address inequities in the delivery of care, including decreasing institutional racism and implicit bias that exists with the health care system (Wyatt et al., 2016).

Addressing the Social Needs of Patients

Providers inherently understand the social needs of their patients. They recognize that prescribed treatments may be of limited value when patients leave the clinic, only to return to the conditions that caused their illnesses in the first place.

Providers are frequently frustrated by an apparent lack of ability to address the challenges their patients face with respect to poverty, poor housing, and other environmental factors. However, there is much that providers can do to address the social needs of their patients and several resources exist to help them do so:

1. Screening Tools

First, to support a paradigm shift from addressing symptoms to addressing causes, providers can systematically screen and assess their patients for social needs. Various assessment tools help identify patients' social needs as the first step to connecting them to community supports and resources. Some screening mechanisms are administered by clinicians and others are self-administered (e.g. in the clinic waiting room before an appointment). A variety of screening tools focused on different social needs — such as food insecurity, housing insecurity, financial stability, stress, and social isolation — are available to clinicians on the HealthBegins website (http://www.healthbegins.org). Dr. Rishi Manchanda and other "Upstream Doctors"[3] created this site to help improve the health care system by sharing information and resources among clinicians. Similarly, Health Leads, a national organization that partners with communities and health systems to better address SDOH, released a Social Needs Screening Toolkit in 2018 to respond to the need for "field-tested, up-to-date tools and resources to help health systems launch and scale effective social needs screening initiatives" (https://healthleadsusa.org/resources/the-health-leads-screening-toolkit/). The toolkit and other related resources are available on the Health Leads website.

2. Community Health Workers

Community Health Workers (CHWs) — also referred to as community health advocates, lay health educators, health navigators, or promotores de salud — are uniquely qualified to create linkages between patients, providers, and community resources. CHWs serve in a variety of roles, including:

- cultural mediation between communities and the health care system
- providing culturally appropriate and accessible health education and information
- assuring that people get the services they need
- providing informal counseling and social support
- advocating for individuals and communities within the health and social service systems
- providing direct services (such as basic first aid) and administering health screening tests; and
- building individual and community capacity (Wiggins & Borbon, 1998).

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[3] *The Upstream Doctors* by Rishi Manchanda is a TED Book available for download as an e-book. Dr. Manchanda is the founder of HealthBegins, a social network where clinicians can learn and share upstream strategies.

CHWs' unique qualifications include understanding the communities they serve. They typically reside in the community, speak the language, and share the community's culture. This allows them to connect individuals with needed services and to educate providers about community needs and important cultural considerations in the delivery of care. Growing evidence documents the value of CHWs in improved health outcomes and reduced health care costs (e.g., see https://www.cdc.gov/diabetes/projects/pdfs/comm.pdf; Perry, Zulliger, & Rogers, 2014; Kim et al., 2016). The Institute of Medicine (IOM) recommends increased using CHWs to help address racial and ethnic disparities in health care (Smedley et al., 2002).

Massachusetts was one of the first states to create a supportive, statewide infrastructure for expanding and institutionalizing the role of CHWs. After considerable research and collaborative planning, the state Executive Office of Health and Human Services formally recognized CHWs as a vital component of the health care system because they play an important role in reducing health inequities among vulnerable communities. Massachusetts instituted several initiatives to promote CHWs. The state's experience led to the development of several recommendations within four domains aimed at institutionalizing CHWs (Anthony, Gowler, Hirsch, & Wilkinson, 2009):

1. Infrastructure: Establish a CHW advisory body to assist with the development and implementation of a sustainable program.

2. Professional Identity: a) Encourage the adoption of the term "community health worker," a unified definition of CHW core competencies, and a common scope of practice; and b) Incorporate information about the role of CHWs into training for health care providers.

3. Workforce Development: a) Develop statewide infrastructure for CHW training and education; b) Develop a CHW certification process and training curriculum, including defined core competencies and skills; and c) Require continuing education and recertification.

4. Financing: a) Include CHW services in Medicaid administrative cost claims; b) Integrate CHWs into managed or team-based care models; c) Increase and sustain grant funding for outreach; and d) Provide incentives for private insurers to use CHWs.

The Massachusetts Department of Public Health (2015) outlined the impact of CHWs in its report, "Achieving the Triple Aim: Success with Community Health Worker." Citing current research and experiences of provider organizations in Massachusetts, CHWs were credited with adding value to multidisciplinary care teams in the following ways (pages 1-2):

- Reducing Costs - Through the reduction of emergency department visits and decreased hospitalizations and readmissions for complex patients.

- Improving Health – By supporting patients to engage and adhere more fully in their care plans and by helping patients to control chronic conditions.
- Improving Quality of Care – By improving care utilization, reflected in performance measures and standards promoted by the National Committee on Quality Assurance (NCQA), such as Healthcare Effectiveness Data and Information Set (HEDIS), and other quality measures; by improving retention in care through outreach to reduce no- shows and assistance with insurance enrollment; and by improving patient satisfaction through the recognition and support in addressing social needs.
- Reducing Health Disparities - By strengthening communication with under-served patient populations and by diversifying the health care workforce.

CHWs can be particularly effective in connecting with hard-to-reach community members, especially those who are socially isolated and/or have multiple and complex social needs. However, CHWs have yet to become fully integrated members of the health care delivery system in most parts of the country due to cultural, financial, and regulatory barriers. Because they perform a wide range of services and activities, they lack a unified professional identity with a defined scope of practice and educational credentials. Minnesota has led efforts to remedy some of these barriers and promote the integration of CHWs. A coalition of educational institutions, health care systems, government agencies, foundations, businesses, and non-profits created a statewide, standardized training program called the Minnesota Community Health Worker Alliance. The coalition is also working to develop a sustainable funding stream to support CHWs. Additional information can be found at http://www.rwjf.org/content/dam/farm/reports/program_results_reports/2012/rwjf403543.

Sample Strategy

Several programs that incorporate the use of CHWs exist in Delaware. The Health Ambassador Program is a joint initiative between DHSS and the Christiana Care Health System (CCHS). The program promotes the health of pregnant women, fathers, and young families through outreach and education on reproductive health and pregnancy, parenting, and healthy infant and early childhood development. Health Ambassadors work in targeted high-risk ZIP codes to connect pregnant women and young families to health care, social services, home visiting, and educational programs. The health ambassadors work with community partners including Henrietta Johnson Medical Center, St. Francis Healthcare, Westside Family Healthcare, and the Wilmington Hospital Health Center. For more information, visit https://christianacare.org/services/communityhealth/healthambassadors/.

Using a similar approach, the Promotoras Program at CCHS teaches Hispanic volunteers about various health issues, such as breast cancer screening and overall wellness, and was recently expanded to include outreach on diabetes and mental health (Christiana Care News, 2017). The volunteers, or Promotoras, then teach others in the community about the importance of screening and other ways to be healthy. The Promotoras provide health education and help people navigate the health care system, improving access to care.

This approach facilitates outreach to community members who may otherwise be difficult to reach, while simultaneously encouraging community cohesion.

These and similar CHW programs in Delaware are making a positive impact on the individuals and families that they serve and can provide a foundation for a more comprehensive and supportive infrastructure across the state. Additional attention is needed to implement the recommendations emerging from Massachusetts's experience and the lessons from Minnesota to ensure the systematic integration of high quality CHWs into health care delivery in Delaware.

3. Medical-Legal Partnerships

Another promising strategy for addressing patients' social needs is through a Medical-Legal Partnership (MLP). As the name implies, the approach includes collaboration between health care providers and legal institutions to improve the health care system's response to SDOH. The approach is grounded in the idea that poor living conditions and the unequal distribution of resources needed for health can be traced to laws that are unfairly applied or under-enforced, which has often led to denial of services and benefits that are designed to help vulnerable people (http://medical-legalpartnership.org/). One might view the MLP strategy as increasing access to justice, which is synonymous with equity. According to the National Center for Medical-Legal Partnerships, there are five main domains where complicated bureaucracies, wrongfully denied benefits, and unenforced laws commonly impact health and require legal intervention. The domains are: 1) income support and insurance; 2) housing and utilities; 3) education and employment; 4) legal status or citizenship; 5) and personal and family stability. In response to these legal challenges to health, MLPs:

- Train health care, public health, and legal teams to work collaboratively and identify needs upstream

- Address individual patients' health-harming social and legal needs with interventions ranging from triage and consultations to legal representation

- Transform clinical practice and institutional policies to better respond to patients' health-harming social and legal needs; and

- Prevent health-harming legal needs broadly by detecting patterns and improving policies and regulations that have an impact on population health.

The number of MLPs grew tremendously in recent years due to evidence of their effectiveness in addressing the social needs of patients. According to the National Center, MLPs exist in 333 health care institutions in 46 states. Last year, MLPs helped more than 75,000 patients resolve legal issues that were inhibiting their health; and trained more than 11,000 health care providers to better understand and screen patients for health-related social needs (National Center, 2018). In an assessment of their impact, researchers found that these partnerships positively impact patient health and offer a significant return on investment, justifying the expansion of the model (Beeson, McAllister & Regenstein, 2013).

Medical-Legal Partnerships are usually financed at the local level through hospitals' operating budgets, community benefit programs, and/or private grants. However, state and federal grants for addressing health inequities and SDOH are becoming increasingly supportive of MLPs (Bachrach, Pfister, Wallis, & Lipson, 2014). Both the American Medical Association and the American Bar Association currently endorse them.

Support for developing an MLP can be found on the National Center for Medical-Legal Partnerships' website (http://medical-legalpartnership.org/). The website includes a toolkit to help partners assess a community's needs and the feasibility of implementing a partnership. Following the initial assessment phase, the National Center provides more in-depth consultation and support to local partnerships related to building an MLP infrastructure, and planning for growth and sustainability.

4. Clinical-Community Linkages

Other promising initiatives to address patients' social needs including create linkages between health care and community resources. This may require health care systems to invest in multisectoral partnerships or simply connect patients with resources already available in the community but may be unfamiliar to the patients. This approach may be particularly effective when providers have already screened for social needs and are developing care plans or health improvement strategies based upon specific health needs. For instance, to best support a patient with hypertension, the provider may need to consider the cost of hypertensive medications, access to transportation for appointments, access to healthy food, sidewalks, and public parks (Wyatt et al., 2016), and help the patient to identify and utilize resources to overcome potential barriers.

The U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality (ARHQ) describes the benefits of Clinical-Community Linkages. As patients get more help in changing unhealthy behaviors; clinicians get help in offering services to patients that they cannot provide themselves; and community programs get help in connecting with clients for whom their services were designed.

Sample Strategy

In Delaware, a telephone hotline called Delaware 2-1-1 and its companion website (www.delaware211.org) are available to individuals seeking help with a wide range of health and social service needs. Delaware 2-1-1 is a free and confidential service for residents that provides a central access point for information about services related to basic needs (e.g. food, housing, transportation, etc.), criminal justice and legal services, health care, individual and family support, substance use disorder, education, and employment services. Individuals can access the hotline directly, but professionals may also use it to link patients or clients with support services in the community. In addition, community organizations can contact Delaware 2-1-1 to be included in its inventory of resources. The 2-1-1 service is offered by the Delaware Helpline with support from United Way of Delaware and the State of Delaware. Staff is bilingual and can help English- and Spanish-speaking callers.

For more information on Delaware 211, visit https://www.delaware211.org/. For general information and resources on clinical-community linkages, visit: https://www.ahrq.gov/ncepcr/tools/community/index.html.

Care Coordination

Advancing health equity through the health care system requires the delivery of high quality, accessible care that is comprehensive, patient-centered, and coordinated for individual patients. At the same time, the provision of health care must be better integrated with population and behavioral health strategies. Changes to the health care delivery landscape, including new regulations and funding streams provided through the ACA, have created opportunities for improved coordination between providers and patients, as well as between providers. This section provides examples of interventions, tools, and options to improve care coordination:

A. Health System Integration

Although health care and public health institutions share the goal of the improving health of the populations that they serve, they have traditionally practiced independently of each other. Better integration and alignment of resources can improve population health and reduce health inequities. Recognizing that lack of integration was a barrier to health improvement, the Institute of Medicine (IOM) convened a committee of experts to develop recommendations for enhanced integration, particularly between primary care and public health. The committee defined integration as "the linkage of programs and activities to promote overall efficiency and effectiveness and achieve gains in population health" (IOM, 2012, p. 3). They found that the unique needs of communities, differences in local resources, and the varied nature of health delivery systems made it difficult for the committee to recommend specific models of integration. Rather, their research led to the development of a set of principles thought to be essential for successful integration of primary care and public health:

1. a shared goal of population health improvement
2. community engagement in defining and addressing population health needs
3. aligned leadership that:
    a) bridges disciplines, programs, and jurisdictions to reduce fragmentation and foster continuity
    b) clarifies roles and ensures accountability
    c) develops and supports appropriate incentives, and
    d) has the capacity to manage change.
4. sustainability, the key to which is the establishment of a shared infrastructure and foundation for enduring value and impact; and
5. the sharing and collaborative use of data and analysis (IOM, 2012, pp. 5-6).

Sample Strategy

Delaware's Healthy Weight Collaborative is an example of integration between primary care and public health. The collaborative includes a range of partners: the DHSS DPH, La Red Health Center, Henrietta Johnson Medical Center, the DSU Health Center, CCHS, the Governor's Council on Health Promotion and Disease Prevention, the Healthy Eating and Active Living Coalition, the Medical Society of Delaware, Nemours Health and Preventive Services, the UD, Health Sciences Alliance, Westside Family Health, United Way of Delaware, and the

YMCA of Delaware. Supported by funding through the ACA, the initiative's goal is to address obesity among targeted populations. The leadership is particularly focused on creating a permanent capacity for system-wide integration to promote health and prevent illness.

Community health centers offer an important avenue for health system integration. According to the U.S. Department of Health and Human Services (HHS), community health centers are community-based and patient-directed organizations that serve populations who otherwise experience limited access to health care (http://www.bphc.hrsa.gov/about/). They are located in communities with great needs; are governed by a community board that must be comprised of at least 51 percent patients; provide comprehensive services (often including dental care, mental health and other supportive services); and do not turn anyone away from receiving services. Community health centers are a critical component of the health care safety net and an increasingly important provider of primary care services to newly insured patients under the ACA. Typically, community health centers provide high quality primary care services based upon a keen understanding of community needs and prioritizing services in response to those needs. By their very nature, community health centers are models of primary care and public health integration that promote the health of communities and help to advance health equity.

In Delaware, community health centers exist in the form of Federally Qualified Health Centers and are located in each county. These centers provide a medical home for people in almost all income levels and provide care regardless of insurance status, with most centers billing their patients on a sliding fee scale, based on the household income. Future efforts to integrate primary care and public health may benefit from ensuring one of our community health centers is included in the initiative. For additional information on the role of community health centers in addressing the SDOH, read a 2012 report by the Institute for Alternative Futures at http://www.altfutures.org/pubs/leveragingSDH/IAF-CHCsLeveragingSDH.pdf; and for more information about community health centers in Delaware, see: https://dhss.delaware.gov/dhss/dph/chs/chsservicecenters.html.

B. Medical Homes

The health care system can be strengthened by addressing the organization and delivery of primary care so that more attention is focused on access, coordination, and prevention. The medical home model, also referred to as the patient-centered medical home (PCMH), delivers primary care that is comprehensive, patient-centered, coordinated, accessible, and of high quality. The AHRQ Patient-Centered Medical Home Resource Center describes five functions or attributes of medical homes:

1. **Comprehensive Care.** Patient-centered medical homes are accountable for meeting the large majority of each patient's physical and mental health care needs, including prevention, wellness, acute care, and chronic care. Providing comprehensive care requires a team of providers that may include physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, social workers, educators, and care coordinators. As an alternative to having in-person access to a wide range of care providers, many medical homes, including smaller practices, build virtual teams that link their patients to providers and services in their communities.

2. **Patient-Centered Care.** Patient-centered medical homes provide primary care that is personalized for each patient. Patient-centered care relies on partnerships between providers and patients (and their families) so that providers can gain an understanding and respect for each patient's unique needs, culture, values, and preferences. Medical home practices actively support patients in learning to manage and organize their own care at the level the patient chooses. Recognizing that patients and families are core members of the care team, medical home practices ensure that these individuals are fully informed partners in establishing care plans.

3. **Coordinated Care.** Patient-centered medical homes coordinate care across all elements of the health care system, including specialty care, hospitals, home health care, and community services and supports. Coordination is particularly critical during transitions between sites of care, such as when patients are being discharged from the hospital. Medical home practices also excel at building clear and open communication among patients and families, their medical homes, and members of the care team, which facilitates coordination of care.

4. **Accessible Services.** Patient-centered medical homes deliver accessible services with shorter waiting times for urgent needs, enhanced in-person hours, around-the-clock telephone or electronic access to a member of the care team, and alternative methods of communication, such as email and telephone care. Medical home practices are responsive to patients' preferences regarding access.

5. **Quality and Safety.** Patient-centered medical homes demonstrate a commitment to quality assurance and quality improvement. This is done through ongoing engagement in activities such as using evidence-based medicine and clinical decision-support tools to guide collaborative decision-making with patients and families. Similarly, patient-centered medical homes engage in performance measurement and improvement, evaluating and responding to patient experiences and patient satisfaction, and practicing population health management. Medical homes exhibit a systems-level commitment to quality and safety by sharing robust data and improvement activities publicly.

More about each of these attributes, including academic papers, research briefs, practice strategies, and other resources that support the patient-centered medical home model can be found on AHRQ's PCMH Resource Center website: https://pcmh.ahrq.gov. Additionally, the Joint Principles of the Patient Centered Medical Home (AAFP, 2007) provide guidelines for primary care organizations. In 2008, the Medical Society of Delaware adopted the guidelines, which have supported the development of 37 patient-centered medical homes across the state.

Implementing the patient-centered medical home model supports health equity in a number of ways. For instance, there is evidence that racial and ethnic disparities in access to health care are reduced through medical homes (Hernandez, Doty, Shea, Davis & Beal, 2007). In addition, medical homes were found to improve the quality of care for vulnerable patients by, for example, promoting higher rates of routine preventive screening (Hernandez, Doty, Shea, Davis & Beal, 2007).

Medical home initiatives can also promote linkages to social supports. Blue Cross Blue Shield of Michigan supports a patient-centered medical home program in which providers use a systematic approach to assess patients' social needs. Providers maintain a database of community resources and refer patients to those resources as appropriate. Providers then track referrals for high-risk patients to ensure follow-up (Bachrach, Pfister, Wallis & Lipson, 2014).

Although the concept of medical homes has been in practice for some time, implementing the patient-centered medical home model is just recently spreading across the U.S. due in part to new incentives created through the ACA. Furthermore, according to the National Academy for State Health Policy, state and federal governments are increasingly looking to primary care as a foundation for broader system reform and patient-centered medical homes offer an important mechanism for achieving many of the reform goals (https://nashp.org/category/primary-care-and-medical-homes/). Although not listed in the review, Delaware has been promoting PCMHs through a partnership between the Medical Society of Delaware and Highmark Delaware, since 2013. This statewide program was initially set up as a pilot with 20 practices, but quickly expanded. Additionally, care coordination and efforts to support patient-centered medical homes were integral to Delaware's health care system transformation plan (i.e. the State Innovation Model plan) referenced in earlier sections, and have led to state legislation in support of primary care (see https://www.pcpcc.org/initiatives/delaware).

Improving Access and Quality of Care

Although identified in section 3 as a contributor to health inequities, the health care system is an important lever of change for addressing patients' social needs and advancing health equity. As discussed in previous sections, the National Healthcare Disparities Report (AHRQ, 2018), produced annually since 2003, provides a summary of trends in health care disparities and reports on progress with efforts to reduce such disparities. 2018 report revealed that there was no significant improvement in disparities related to access to health care on most measures. The report finds that quality of health care continues to improve generally, but the "pace" of improvement varies by priority area. Further, quality varies by place, with wide variations across states, and by race, with blacks experiencing poorer quality on 40 percent of indicators compared with whites. Therefore, fundamental aspects of the health care system need to be addressed to reduce disparities in care while advancing health equity. Recommendations for remediating such disparities in care include the following: (see next page)

1. **Collect valid and reliable data on race, ethnicity, and language preference.** Although data collection alone is not sufficient for reducing disparities, it is a critical first step to identifying the health care needs of specific populations and gaps in care. National efforts, including requirements of the ACA and data standards produced by the HHS Office of Minority Health, are promoting better data systems. The IOM developed recommendations to identify of disparities in care, including: collecting standardized self-reported patient race, ethnicity, and language (REL) data and using those data to examine differences in quality of care between groups (Ulmer, McFadden, & Nerenz, 2009). In addition, the Institute for Healthcare Improvement (IHI) published a number of considerations and a series of guidelines to support the measurement of health care disparities (Wyatt et al., 2016). Ultimately, these data can be used to develop quality improvement interventions tailored to specific groups, and the IOM provides additional guidelines to this end. Lessons learned regarding efforts to collect and incorporate REL data into quality improvement initiatives are highlighted in an issue brief describing the RWJF's Aligning Forces for Quality (AF4Q) Initiative, found at https://www.rwjf.org/en/library/research/2014/04/using-data-to-reduce-disparities-and-improve-quality--a-guide-fo.html. Additional guidance from IHI on measuring health equity within health care systems can be found at http://www.ihi.org/resources/Pages/IHIWhitePapers/Achieving-Health-Equity.aspx.

2. **Diversify the workforce.** While strategies to address gaps in workforce diversity include expanding the use of interpreters to overcome language barriers and improving cultural competence education and professional development for health care providers, evidence suggests that the quality of care for racial and ethnic minorities improves when the workforce reflects the characteristics of the patient population (Smedley, Stith Butler, & Bristow, 2004; LaVeist & Pierre, 2014). Provider diversity is a key element of patient-centered care and may be achieved through the recruitment, retention, and training of racially, ethnically, and culturally diverse individuals. This requires a concerted effort, particularly by leadership within health care organizations and other state systems.

Sample Strategy

To address persistent racial inequities in infant mortality and growing inequities in maternal mortality, Roots Community Birth Center (see https://www.rootsbirthcenter.com/about) was established to address many of the reasons why black mothers and their babies are at greater risk for poor outcomes, including stress from racism and lower quality care (Proujansky, 2019). Located in Minneapolis, Roots is unique in that it is owned and staffed by black providers. University of Minnesota researchers are evaluating the model and are documenting positive outcomes.

Other similar health centers and models are growing in other parts of the country, including Mamatoto Village in Washington, DC (see https://www.mamatotovillage.org/about.html), and The Birth Place in Orlando, FL (see https://thebirthplace.org/about/). Importantly, these models move beyond cultural competence to care that is culturally focused or culturally based in order to mitigate health risks associated with structural racism (Cole, Rojas, & Joseph, 2018).

3. **Build community partnerships for research and action.** Similar to the principles underlying place-based strategies for promoting health equity, providers and researchers need to embrace community partnerships. The National Partnership for Action's National Stakeholder Strategy (2011) specifically calls for greater investments in community-based participatory research, which is research that involves community engagement throughout the entire research process, and evaluates community-oriented intervention strategies. Similarly, to promote health equity across the continuum of health-related services, the National Stakeholder Strategy recommends increased support for and improved coordination of research that enhances our understanding of strategies. Finally, more attention is needed to enhance the transfer of knowledge and translation of research at the program, community, system and policy levels.

Sample Strategy

In Delaware, the Delaware Clinical and Translational Research ACCEL Program (DE-CTR) offers a mechanism for community partnerships and research translation. The DE-CTR is a partnership between the UD, CCHS, Nemours Health and Prevention Services/Alfred I. duPont Hospital for Children, and the Medical University of South Carolina (MUSC). It aims to improve the state's infrastructure and capacity for conducting research that can be applied to effective interventions that lead to better clinical outcomes. The DE-CTR ACCEL program is supported by an Institutional Development Award (IDeA) from the National Institute of General Medical Sciences of the National Institutes of Health (under grant number U54-GM104941, PI: Binder-Macleod). Its strategic partnership with MUSC provides technical assistance and support. With an emphasis on community outreach and engagement, the DE-CTR is particularly well positioned to support community-based participatory research and research translation for health equity. For more information about the DE-CTR program and related funding and research opportunities, visit https://de-ctr.org/.

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4. **Implement evidence-based interventions and promising practices for advancing health equity.** Scholars and professionals alike are increasingly recognizing the potential impact of health care system changes and specific interventions for advancing health equity. Providers can find ideas, emerging practices, lessons learned, tools, and other resources through linkages with other providers. A RWJF program, County Health Rankings and Roadmaps, has a "What Works for Health tool" which provides evidence-based policies and programs that can be selected to fit a community's specific needs and priorities (http://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health).

   Similarly, the IHI highlights the opportunity to use the Community Health Needs Assessment (CHNA) required of non-for-profit hospitals as a mechanism for advancing health equity in partnership with other community stakeholders (Wyatt et al., 2016). While the ACA requires hospitals to undertake a CHNA every three years, the Public Health Accreditation Board calls for a similar assessment among health departments. Both assessments are meant to lead to the development of plans to improve community health by addressing identified needs. Both are also grounded in a community-driven approach and rely on community input in their development. Given the potential alignment of these processes, the IHI recommends coordination among health systems and with public health departments, in collaboration with community partners, to produce unified, comprehensive CHNAs and subsequent improvement plans to advance health equity in the community (Wyatt et al., 2016).

5. **Engage in the policy process.** Health and health equity are inherently political. The SDOH are determined by policy processes and decisions that tend to favor those with power and other resources. Policy changes are needed to facilitate the health care system changes that will help alleviate health inequities. Health care providers can be leaders in the policy arena by advocating for their patients' social needs. Similarly, providers can lend their expertise to policy discussions outside of the health care sector, but which have an impact on health. Because policy generally has such large implications on health, it is discussed in more detail in section 7.

Decreasing Institutional Racism within the Health Care System

Evidence regarding structural racism highlighted in Section 3 calls for a more explicit response at the institution or system level. Health systems, health care organizations, health insurers, and individual providers must acknowledge the ways in which they contribute to, or perpetuate, structural racism and implement remediation strategies (Wyatt et al., 2016). This includes considering the ways in which the physical space in health care can contribute to access barriers and other inequities (Wyatt et al., 2016). For instance, it is important to consider if the location of the organization is accessible through public transportation, or if the parking fees may be cost prohibitive for low-income patients. Further, one might consider whether the interior design and décor of the facility is welcoming to patients representing diverse cultures. Another potential contributor to structural racism may be reflected in the types of health insurance accepted by the organization. According to Wyatt and colleagues (2016), "When healthcare organizations refer to 'improving their patient [or payer] mix,' this may be coded language for denying care to Medicaid patients—who are often poor people and people of color" (p20).

Finally, Wyatt and colleagues (2016) recognize the growing literature about implicit bias in health care and offer a number of strategies for reducing such bias that may exist within organizational policies, structures, norms and among individual providers and clinicians. These include things like examining hiring and promotion policies and practices, and training staff to become more aware of their own biases and take actions to "redirect their responses." For more information on implicit bias in healthcare and recommendations from IHI, see http://www.ihi.org/resources/Pages/IHIWhitePapers/Achieving-Health-Equity.aspx.

Conclusion

As researchers have explained, re-orienting health care systems toward health equity is not for the faint-hearted (Baum, Bégin, Houweling & Taylor, 2009, p. 1967). It requires leadership within the health care sector and stewardship working with other sectors. Baum and colleagues (2009) describe the characteristics of a health equity-oriented health care sector:

1. Leadership to improve the equity performance of the health care system, including:
    - A focus on comprehensive primary care
    - Decision-making processes that involve local communities
    - Accessible and high-quality care for all
    - Planning, including allocation of resources, based on the needs of populations within a SDOH framework
    - Policy statements and strategies that are explicit about closing the health equity gap and the need for action on SDOH to achieve this goal; and
    - A shift in funding for community-based services and incentives that align with prevention.
2. Stewardship in working with other sectors to improve health and equity, including:
    - The presence of health sector advocacy in other sectors that influence SDOH and the importance of inter-sectoral action
    - Development of expertise to establish a health equity surveillance system and to conduct cross-sector impact assessments on health
    - Reform of medical and health professional education such that the importance of SDOH is reinforced in clinical training and an understanding of population health perspectives and related skills is promoted
    - Training and education of professionals in other sectors (including urban and transport planners, teachers, and others) on the SDOH; and
    - Increased funding for research on the impact of SDOH and evaluation of interventions designed to address them (Baum, Bégin, Houweling & Taylor, 2009, p. 1970).

Delaware’s health care system is undergoing intense changes due to the passage of the ACA and related reform initiatives. Many local providers are already engaging in leadership and stewardship to advance health equity by identifying and implementing specific upstream interventions. These efforts can be expanded and enhanced. New initiatives grounded in the recommendations from Baum and colleagues can be developed in an environment conducive to such changes. Section 7 describes policy strategies needed to support and reinforce the efforts of providers.

Glossary- Section 6

Community-Based Participatory Research (CBPR): An approach to research that involves an equitable partnership between and among community members and researchers in all aspects of the research process and in which all partners contribute expertise and share decision making and ownership. The aim of CBPR is to increase knowledge and understanding of a given phenomenon and integrate the knowledge gained with interventions, policy, and social change to improve the health and quality of life of community members.

Community Health Center (CHC): Clinics that generally serve people who are uninsured, underinsured, low income, or those living in areas where little access to primary health care is available. They are located in communities with great needs; are governed by a community board that must be comprised of at least 51 percent patients; provide comprehensive services (often including dental care, mental health, and other supportive services); and do not turn anyone away.

Community Health Workers (CHWs): Members of a community that provide basic, culturally appropriate, and accessible health information to hard–to-reach members of the community. CHWs can provide basic health services, counseling, and other support services or linkages to community resources. They can link health care providers and community members.

Implicit Bias: Also referred to as unconscious bias, refers to the attitudes or stereotypes that affect our understanding, decisions and behavior in an unconscious manner, or without our awareness or intent.

Medical Home: A model of primary care that provides whole-person, accessible, comprehensive, ongoing and coordinated, patient-centered care. It is also referred to as a patient-centered medical home (PCMH) or primary care medical home.

Medical-Legal Partnership (MLP): A health care delivery model that combines the expertise of health and legal professionals to identify, address, and prevent health-harming legal needs for patients, clinics, and populations.

Care Coordination: Organization of patient care through communication between health care providers as well as the patient, mobilization of resources, and completion of patient care activities.

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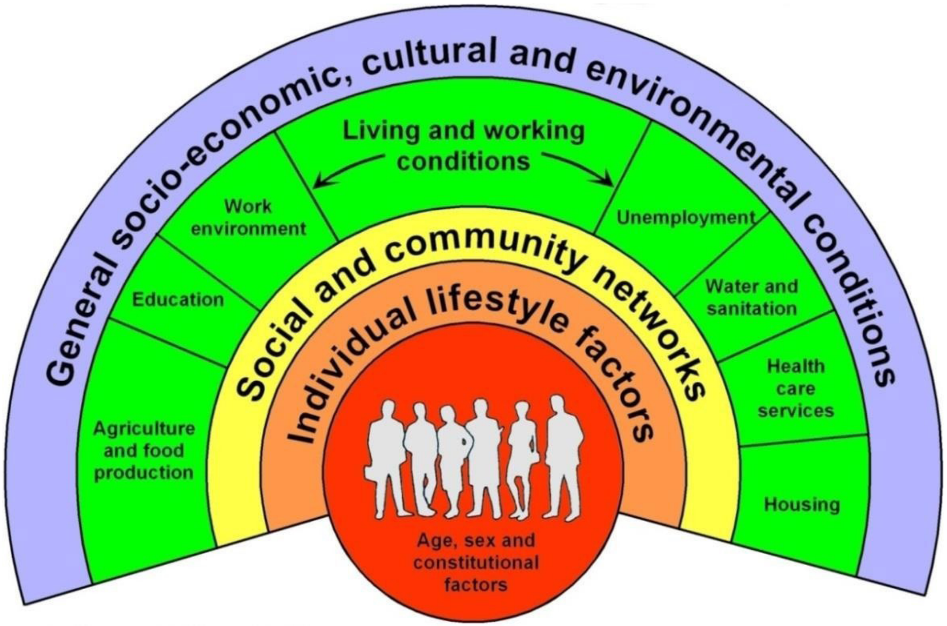
SECTION 7: Policy-Oriented Strategies

Policy-oriented strategies are generally thought to be among the most effective public health interventions because they have the potential to impact all of the residents in a given municipality, state, or nation. Furthermore, they often require the least individual effort in terms of behavior change due to broader changes in the environment. For instance, regulating the nutritional content of school lunches is believed to be more effective than educating students about the nutritional content of their lunch options. As former CDC Director Dr. Thomas Frieden explained, this type of strategy makes individuals' default choice the healthy choice (Frieden, 2010).

Policy-oriented strategies are particularly important for creating healthy communities because they can lead to safer and more health-promoting environments. Given our understanding of the determinants of health (Figure 37), it is clear that many policy domains such as employment, housing, transportation, and education have a major impact on health. One could argue that virtually all public policy impacts health and therefore all public policy should be "healthy public policy" (Kemm, 2001). According to the WHO (1988) , healthy public policy is characterized by an explicit concern for health in all areas of policy and accountability for health impacts. Furthermore, the primary aim of healthy public policy is to create a supportive environment to enable people to lead healthy lives. Healthy public policy may also be described in terms of "health in all policies," where health becomes an explicit goal across different sectors and policy domains.

Figure 37: Social determinants of health and levels of influence



Source: Dahlgren & Whitehead, 1991

As argued by the National Academies Committee on Community-Based Solutions to Promote Health Equity in the U.S. (2017), policy strategies at all levels are also critical for facilitating and leveraging other kinds of community-based action and place-based initiatives. For example, community economic development efforts may be facilitated by changing zoning laws that encourage different types of development in a given community. Finally, our understanding of the ways in which structural racism, as manifested in historical and contemporary public policies, have created and perpetuated health racial health inequities calls for a concerted policy response.

Importantly, creating healthy public policy and undoing or ameliorating racially unjust public policies requires stakeholders to accurately assess the health and equity impacts of public policy. The policy process itself must adapt in ways that reflect increased community participation and empowerment as well as a multi-sectoral approach. This section describes policy-oriented strategies for promoting health equity, including strategies for policy analysis, stakeholder engagement, and community empowerment. While the original version of this guide focused primarily on a “Health in All Policies” (HiAP) approach to improving SDOH, this version builds on HiAP and includes more attention to the drivers of health inequities and policy strategies to remove barriers to opportunity and health for those with the fewest resources and the greatest challenges (ChangeLab Solutions, 2019). It also includes a discussion of health impact assessments as a tool to promote healthy public policy, as well as racial equity impact assessments to prevent institutional racism and to identify new options to remedy long-standing inequities (Race Forward, 2009).

Health in All Policies (HiAP)

A HiAP approach addresses the complexity of health inequities and improves population health by systematically incorporating health considerations into decision- making processes across sectors and at all government levels. HiAP emphasizes intersectoral collaboration among government agencies and shared planning and assessment between government, community-based organizations, and often businesses. While its primary purpose is to identify and improve how decisions in multiple sectors affect health, it can also identify ways in which better health achieves goals in other sectors. For instance, a HiAP approach supports goals such as job creation and economic stability, transportation access, environmental sustainability, educational attainment, and community safety because these are good for health. By identifying and working towards common goals, a HiAP approach can improve the efficiency of government agencies.

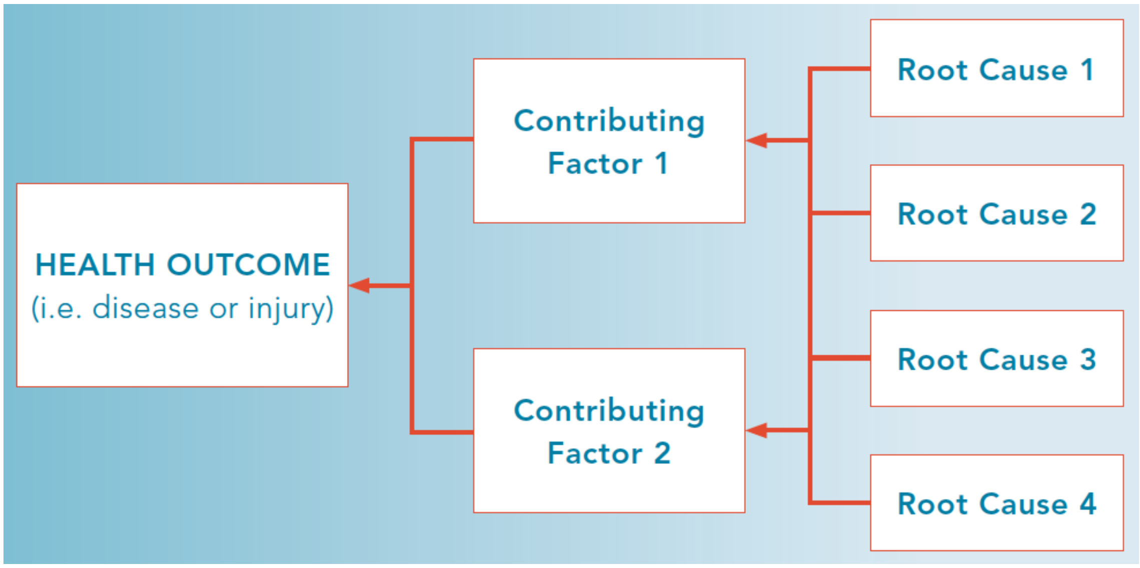
The HiAP approach and its underlying philosophy have taken hold in many parts of Western Europe, Australia, and New Zealand, but is relatively new in the United States. California was the first state to embrace an HiAP approach. The California Health in All Policies Task Force was formed from a strategic community initiative under the leadership of former California Governor Arnold Schwarzenegger, who recognized that many departments and agencies had similar agendas related to health, childhood obesity, and climate change. The task force, established through a 2010 executive order, consists of representatives from 22 state agencies, including the Department of Education, Department of Finance, Department of Food and Agriculture, Department of Parks and Recreation, and Environmental Protection Agency. For more information on the work of the task force and resources for a HiAP approach, visit http://sgc.ca.gov/programs/hiap/.

Details regarding the creation of the California Health in All Policies Task Force; the process used to identify priorities and build partnerships; and challenges, accomplishments, and future plans can be found in Section 8 of Health in All Policies: A Guide for State and Local Governments by Rudolph, Caplan, Ben- Moshe, and Dillon (2013), available at https://www.phi.org/uploads/files/Health_in_All_Policies-A_Guide_for_State_and_Local_Governments.pdf). Experts working closely with the task force developed this guide. It reflects a review of the literature, contributions from international cases, and lessons learned in California. The HiAP information presented in this guide draws heavily from the document and highlights some of the most important elements for Delaware stakeholders. Readers are encouraged to refer to the original document for more detailed information and tools.

Identifying Root Causes

The HiAP approach is centered on the belief that population health issues must be approached through a number of methods, beyond those that target individual behaviors and the provision of health care services. In effect, it is grounded in the upstream parable described in Section 1. More specifically, the HiAP approach recognizes that public policies outside of health care create upstream conditions that can either protect individuals from falling into the river or potentially elevate their risk of falling into it. Furthermore, the HiAP approach reflects the understanding that individual behavior is largely determined by environmental conditions. In this way, behavior is considered a proximate or downstream cause of poor health, whereas other environmental factors that influence behavior are thought to be upstream because they represent root causes. Creating a diagram of the root causes of public health issues may help to identify more indirect health policy correlations than initially imagined (Figure 38).

Figure 38: Root Cause Diagram.



Source: Reproduced from Rudolph, Caplan, Ben-Moshe, & Dillon, 2013.

In the context of this diagram, one can think of root causes as the focus of upstream interventions and contributing factors as the focus of more downstream interventions. Although a policy that attempts to combat a contributing factor may positively influence a given health outcome, it is likely that this improvement will be short-lived or less influential than a policy that seeks to resolve a problem that is farther upstream. This is because contributing factors are not independent factors; they are consequences of larger, more salient social problems.

Obesity is a useful example of a health outcome that can be discussed in the context of Figure 38. Two contributing factors to obesity are poor diet and lack of physical activity. However, poor diet and a lack of physical activity are not the root causes of obesity. In an urban setting, an unsafe built environment characterized by broken sidewalks, busy multi-lane streets, a lack of bike lanes, and high rates of violence and crime can negatively influence physical activity habits. Transportation, housing, and economic policies (all upstream approaches to addressing a health problem) might improve the built environment and create more opportunities for physical activity, thereby indirectly reducing the rates of obesity.

Fostering Partnerships

The goal of HiAP is to make health an explicit consideration in seemingly unrelated policy decisions. Incorporating health into new policy fields requires collaboration with many different sectors. Agencies focused on food, agriculture, building, transportation, social, economic, or crime-control policies may become partners. The public health field has a long history of collaboration with different sectors; to move forward with HiAP, those partnerships must continue and be further developed.

The most successful partnerships in HiAP are equally beneficial for all partners, which entails achieving specific goals for multiple organizations. This requires a great deal of negotiation and compromise and builds on the ideas of synergy, which were outlined in the community health strategies section (Section 5). Additional principles for establishing partnerships with other policy sectors to promote HiAP are:

- Build trust. This is a difficult, but essential, step in forming any successful partnership. Be humble and open to other partners' perspectives, goals, and values. Be sensitive to confidentiality between organizations by holding individual or sub-group meetings as well as larger group meetings. Hold your organization and your partners accountable for moving forward with the goals of the HiAP initiative.

- Model reciprocity. Partnerships involve a great deal of risk — most often requiring partners to risk two important assets, time, and resources — for the good of the partnership. Establish expectations and trust that partners will reciprocate. If possible, offer to help on a task that supports a partner's efforts. Ensure that credit is given where credit is due. Recognize that there will be misunderstandings with partners from different sectors and assume that your partners have good intentions towards advancing the HiAP initiative.

- Pursue mutuality. Ensure that partners have established shared values and are working towards mutually beneficial goals with no hidden agendas.

- Share information and ideas. Focus on highlighting ways for non-traditional partners to get involved in HiAP. Help others to understand how their work impacts health and how a healthy community can contribute to their efforts.

- Clarify language. Be extremely clear and make sure everyone understands one another. Avoid common public health jargon and abbreviations that partners from outside organizations may not understand.

These recommendations for building intersectoral partnerships were adapted from section 4 of the HiAP Guide for State and Local Governments (Rudolph, Caplan, Ben-Moshe, & Dillon, 2013). Additional information can be found on pages 50-58.

Given the strong relation between healthy neighborhoods and the built environment, experts have identified many areas where public health and planning agencies in particular, can collaborate to achieve common goals. As mentioned in previous sections, UD's IPA developed a Delaware Complete Communities Planning Toolbox that includes tools and strategies to address the five elements identified as creating a "complete community:" complete streets, efficient land use, healthy and livable, inclusive and active, and sustainable and resilient (IPA, n.d.). To access the toolkit, visit: https://www.completecommunitiesde.org/.

Engaging Community Stakeholders

Partnerships across government agencies are critical to HiAP but engaging other kinds of community stakeholders and residents is vital to ensure that efforts are aligned with community needs. Other kinds of stakeholders who may be important for promoting HiAP are civic groups, local coalitions, trade unions, faith-based organizations, school boards, and planning boards. One-on-one discussions, community meetings, forums, focus groups, and formal or informal advisory groups can foster community stakeholder engagement. The HiAP Guide for State and Local Governments highlights the importance of meeting people "where they are" to encourage public participation, such as regularly attending church group, parent group, and other existing meetings. Similarly, social marketing strategies may be used to communicate simple, concise key messages to create awareness, common language, and community engagement. Additional outreach and engagement strategies discussed in Section 4 are directly applicable to HiAP. Readers are referred to the Community Toolbox (http://ctb.ku.edu/en) for guidance in this area.

Policy-related Drivers of Inequity

While a HIAP approach has the potential to promote health equity, there is a growing consensus that reducing health inequities requires a more purposeful approach focused on policy actions related to the drivers of those inequities. According to a recent report, titled A Blueprint for Changemakers: Achieving Health Equity Through Law & Policy, from ChangeLabs Solutions (2019), supported by the RWJF, these drivers include:

- **Structural discrimination** – As described in Section 3, structural racism "refers to the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice" (Bailey et al., 2017). According to the Aspen Institute (n.d.), it is a characteristic of the social, economic and political systems in which we all exist. Therefore, it underlies the other drivers of health inequity (ChangeLabs Solutions, 2019).

- **Income inequality and poverty** – Also described in previous sections, wealth (or lack thereof) is one of the strongest determinants of health, as it determines access to many of the other determinants of health (e.g. housing, education, health care, etc.). Public policy, such as tax policy, can influence income in ways that contribute to wealth inequalities.

- **Disparities in opportunity** – Access to quality education and living wage jobs, which are critical to health, are not equitably distributed and are fundamentally influenced by policy decisions and resource allocation.

- **Disparities in political power** – Communities that lack political power have limited ability to influences decisions that affect them, or even to make their problems known to policymakers in the first place. Lack of power can be "exacerbated by voting laws that create barriers to democratic participation and support elected officials whose race and socioeconomic experiences are often not representative of the neighborhoods they serve" (page 10).

- **Governance that limits meaningful participation** -– Related to power are governance structures, which include decision-making processes that may exclude low-income communities or communities of color (ChangeLab Solutions, 2019).

According to ChangeLabs Solutions (2019), using a HiAP approach and focusing on these drivers of health inequities facilitates change at the local level that can advance health equity. Following are excerpts from the recommendations put forth by ChangeLabs Solutions[4]. Readers are encouraged to review the full report and list of recommendations and other important considerations at https://www.changelabsolutions.org/product/blueprint-changemakers.

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[4] ChangeLab Solutions allows content from this publication (ChangeLab Solutions, A Blueprint for Changemakers: Achieving Health Equity Through Law & Policy, 2019) to be reproduced without permission. Excerpted content includes additional citations that may be found in the original report.

Reducing structural discrimination requires taking actions to minimize bias at all levels of society by confronting historical oppressions; teaching people to be inclusive from an early age; and exposing people to a variety of cultures, experiences, and perspectives on characteristics such as gender, sexual orientation, social class, race, and immigration status. Potential policy strategies include:

- *Reduce racial and socioeconomic segregation*: 1.) Ensure racially and economically mixed neighborhoods through land-use planning, housing regulations, rental assistance programs, or school siting policies; and 2.) prevent housing and job displacement from driving racial and income segregation such as by enacting land-use or affordable housing finance regulations.

- *Teach equity*: Confront negative stereotypes and reduce racial prejudice and discrimination through school policies and curricula that educate children about the harms of historical oppression and the value of equality and inclusion.

- *Eliminate institutional discrimination*: 1.) Prevent biased policy decision-making and implementation through protocols that require equity analysis or through staff training on equity, bias, and cultural sensitivity; and 2.) ensure equal and unbiased law enforcement and criminal justice through policies on policing practices and through training, legal system protocols, and sentencing guidelines.

Reducing poverty and disparities in income and wealth accumulation requires strategically investing in neighborhoods and populations with the greatest need; providing support to individuals throughout their lives – as young children, in working life, and in old age; and providing financial protection against harmful or traumatic life events such as illness, disability, and loss of income or work. Potential policy strategies include the following:

- *Preserve, protect, and expand social protections*: 1.) Provide supplemental income to support healthy living through nutrition assistance, wage subsidies, Medicaid, or housing subsidies; 2.) limit health care costs to ensure that health care expenses don't lead to bankruptcy, poverty, or the need to choose between essential needs like medicine, food, and housing; and 3.) protect against loss of income caused by health events such as illness, accidents, and childbirth by strengthening the social safety net.

- *Ensure fair employment for all*: 1.) Make full and fair employment a goal for local government; 2.) improve working conditions by limiting exposure to material hazards in the workplace, encouraging healthy behaviors at work, and limiting work-related stress through worksite wellness policies; and 3.) provide workers, labor unions, and community-based organizations with tools and resources to implement effective and sustainable worksite wellness, worker training, and job creation programs.

- *Improve wages for poor and low-income individuals*: Increase the income of the poorest individuals through supplemental income, including Social Security, disability insurance, Temporary Assistance for Needy Families, and tax credits, as well as through increased wages, including an increased minimum wage.

- *Make place-based investments to improve neighborhood settings*: Improve neighborhood value through community development or neighborhood revitalization, including investment in housing, open space, transportation networks, food systems, and school facilities, while protecting priority populations from displacement.

- *Reduce the cost of housing, education, transportation, and health care*: 1.) Reduce housing instability by preserving, protecting, and expanding the supply of quality affordable housing through property tax incentives, rental subsidies, rent stabilization, good cause eviction policies, condominium conversion protections, inclusionary zoning, density bonuses, expedited permitting, or property acquisition; 2.) subsidize preschool for children from low-income families; 3.) provide financial aid to help low-income students get through college; 4.) Expand the coverage and frequency of public transportation, especially in poor areas; and 5.) provide universal or subsidized health insurance.

Reducing disparities in opportunity requires creating pipelines to success, increasing protective factors, and reducing exposure to adverse experiences for low-income people and people of color, across all ages. Early childhood development – including the physical, social-emotional, and language/cognitive domains – affects skill development, education, and occupational opportunities and has a determining influence on subsequent life chances and health. A comprehensive approach also requires recognizing that children are part of families and that effective supports must address family units.

- *Support healthy early childhood development:* 1.) Provide universal high-quality early childhood education focused on child development, in addition to primary and secondary education; and 2.) support parents, caregivers, and families by providing nurturing child care and protection so that young children can achieve their full developmental potential.

- *Improve the primary school learning experience in low-income neighborhoods:* 1.) Ensure that all children have the tools, resources, and support they need to learn, thrive, and lead healthier lives – for example, by enacting school funding and school wellness policies; 2.) identify and address barriers to enrolling and staying in school for poor children and children of color; and 3.) make schools safe, equitable places to learn, and avoid unfairly penalizing students who live in poor neighborhoods or who are experiencing health, learning, or psychosocial challenges – for example, by implementing trauma-informed school discipline or restorative justice policies.

- *Provide lifelong education and job training opportunities:* Ensure access to high-quality adult education and job training programs in underserved communities.

- *Improve access to quality jobs:* Increase access to safe, secure, work with fair wages and year-round work for low-income families through direct job creation, apprenticeship programs for those with barriers to employment, or fair-chance hiring for job seekers with criminal records.

- *Ensure access to medical care:* 1.) Prevent gender, education, occupation, income, ethnicity, and place of residence from limiting access to and experiences of health care; 2.) ensure access to health care and good nutrition, starting at conception; 3.) strengthen health care delivery systems while producing a more culturally relevant health care workforce through community health worker initiatives; and 4.) include mental health care in health care delivery.

Social inclusion and self-determination underpin health and well-being. **Reducing disparities in power** means that historically disenfranchised people are engaged as citizens and as professionals, working collectively to redistribute the power and resources that shape opportunities for health.

- *Lift up all residents' voices as part of inclusive, community-driven decision-making*: Involve underserved communities in the initiation, drafting, and implementation of policy solutions to local issues related to health equity, through community-based participatory research, inclusive and representative community engagement, participatory budgeting, or public deliberation.

- *Build a movement:* 1.) Use a "movement of movements" approach, bringing together changemakers across justice movements to work for fair and equitable access to the resources and conditions necessary for people to flourish; and 2.) build a broad coalition of changemakers and stakeholders to work for policy change that addresses the fundamental drivers of health inequity.

Undoing our nation's legacy of discrimination and segregation through law and policy requires new **governance structures**, including laws, policies, and government protocols that are written and implemented with the explicit goal of health equity.

- *Establish health equity as a goal of all local planning, budget, and government decision-making:* Formally commit to health equity through a resolution, health plan, or comprehensive plan or by stating it as a goal in all policies.

- *Formalize cross-governmental coordination, collaboration, and accountability:* 1.) Include the perspectives of all departments, agencies, and institutions in government decisions by taking a HiAP approach; 2.) If you are a health care leader, embrace your stewardship role of ensuring that policies and actions in other sectors improve health equity; and 3.) create structures for collaboration among local governments, community-based organizations, and health care institutions to act on the social determinants of health.

- *Strive for effective, responsive, and sustainable action:* 1.) Revise policies, protocols, and practices in ways that both respond to immediate community needs and use resources efficiently so that investments and assets are maintained for future generations; and 2.) use health data to identify policies that effectively achieve desired health outcomes through action on the SDOH.

- *Make government responsive, transparent, and accountable:* 1.) Make government protocols and decisions available to the community, and ensure that policies include clear roles, responsibilities, and evaluation processes to hold government responsible for successful implementation; and 2.) establish inclusive, participatory, community-based processes as the basis for planning and implementation of health equity initiatives.

Health Impact Assessment—A Tool for HiAP

Often the first step in undertaking a HiAP approach is to assess the potential health impacts of a given policy. This can be accomplished through the use of a Health Impact Assessment (HIA). As reported in a WHO Regional Office for Europe report, the most commonly cited definition explains that “HIA is a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population” (WHO, 2014; Diwan, 2000).

HIA often identifies methods to ensure positive health effects and can warn against practices that contribute to negative health impacts. Concisely, as defined by the National Research Council of the National Academies in their publication, Improving Health in the United States: The Role of Health Impact Assessment, “HIA is a systematic process that uses an array of data sources and analytic methods and considers input from stakeholders to determine the potential effects of a proposed policy, plan, program, or project on the health of a population and the distribution of those effects within the population. HIA provides recommendations on monitoring and managing those effects.” Therefore, HIA provides insight into the consequences that policies, programs, and projects have on health. Just as HiAP takes into account policies that are not directly related to health, HIA is used to assess policies, programs and projects that are not seemingly related to health.

This guide focuses on the use of HIA as a method to determine the effects of public policy on health and identify ways to improve the positive impacts of a given policy, while steering clear of adverse effects. However, HIA can also be used to evaluate programs, practices, and private policies. Because of the extensive impact that public policies have on communities and individuals, it is vital to ensure that policies maximize positive, and minimize any negative, health impacts. As discussed previously, policies based in all sectors (including housing, zoning, education, agriculture, and transportation) indirectly affects the health of individuals and communities. Therefore, by conducting HIA before policies of all types are developed and implemented, decision-makers and stakeholders can ensure the health of their constituents and those affected by policy decisions.

Fundamental aspects of HIA

HIA is a relatively new approach in the United States where it is frequently a voluntary process—only a few jurisdictions have mandated or institutionalized HIA or an equivalent. In other parts of the world, where HIA is more widely employed, countries have institutionalized HIA in the law-making process. Still, HIA has proven to be a valuable resource in the U.S. and many resources, toolkits, and guidelines can assist state and local governments, public health practitioners, and stakeholders in implementing this approach. As described by the CDC, the six major steps that occur in the HIA process are:

1. Screening – Identifying plans, projects, or policies for which an HIA would be useful.

2. Scoping – Identifying which health effects to consider.

3. Assessing risks and benefits – Identifying which people may be affected and how they may be affected.

4. Developing recommendations –Suggesting changes to proposals to promote positive health effects or to minimize adverse health effects.

5. Reporting – Presenting the results to decision-makers.

6. Monitoring and evaluating – Determining the effect of the HIA on the decision (CDC, 2014).

Pew Charitable Trusts and the RWJF offer several resources to encourage and support practitioners in using HIA through their partnership called the Health Impact Project. This joint project is leading the charge to promote HIA in the U.S. More information can be found at https://www.pewtrusts.org/en/projects/health-impact-project . These national leaders highlight several intrinsic characteristics of HIA, which:

- looks at health from a broad perspective that considers social, economic, and environmental influences

- brings community members, business interests, and other stakeholders together, which can help build consensus

- acknowledges the trade-offs of choices under consideration and offers decision-makers comprehensive information and practical recommendations to maximize health gains and minimize adverse effects

- puts health concerns in the context of other important factors when making a decision

- considers whether certain impacts may affect vulnerable groups of people in different ways

- increases transparency in the decision-making process; and

- supports community engagement and democratic decision-making (PEW Charitable Trusts, 2014).

HIA examines the health impacts of policies that may not be directly related to health, but are foundational in determining the health of a community. Therefore, HIA draws upon the collective knowledge of multiple sectors and disciplines, including urban planning, construction, transportation, agriculture, community development, environmental protection, etc. Additionally, HIA requires the involvement of community members and draws on their lived experience and desire for change. Together, the information generated by community members, stakeholders, and experts leads to a well-conducted HIA that will be used to inform decision-makers about the health impacts of a particular policy and identify ways to maximize positive health effects, while minimizing negative ones.

HIA and Health Equity

Often policies may seem to benefit the overall population but may actually hinder the well-being of vulnerable and marginalized sub-populations. For example, establishing fast-food chains may stimulate the economy and constructing a highway may ease traffic congestion, which both seemingly enhance public good. However, fast-food chains offer cheap meals that are high in calories, fat, and sodium, which often deters healthy eating among poor individuals. Highways are often constructed near impoverished areas, exposing residents to air pollutants. Therefore, with respect to health equity, HIA can be an effective tool in analyzing the health impacts of policies on marginalized groups and uncovering options to distribute positive effects in ways that level the playing field.

Due to its intrinsic qualities — namely, data analysis, community engagement, and advocacy for population health — HIA is believed to promote equity. By ensuring equity in policies regarding living conditions, policymakers promote health equity because these structural aspects of society influence the health of communities and individuals. To stress the importance of this concept, experts developed a guide titled, Promoting Equity through the Practice of Health Impact Assessment (2013), an excerpt of which is reproduced in Figure 39. The guide, which includes strategies for ensuring a health equity lens in HIA, can be accessed at https://hiasociety.org/resources/Documents/HIA-Promoting-Equity.pdf .

In a recent study aimed to evaluate the long-term impact of HIAs, researchers found that HIAs can “build trust and strengthen relationships between decision-makers and community residents, contribute to more equitable access to health-promoting resources such as healthy foods, safe places for physical activity, transit, and health care, and protect vulnerable communities from disproportionate exposure to environmental hazards” (Pew, 2019, p2).

Figure 39: Principles for Promoting Equity in HIA Practice.

Principles for Promoting Equity in HIA Practice

A. ***Ensure community leadership, ownership, oversight, and participation early and throughout an HIA*** from communities of color, low-income communities, and other vulnerable groups. These populations will likely be most impacted by policies under consideration and have valuable expertise and insights that can inform decision making. It is critical to develop partnerships with, and engage, community representatives.

B. Use the HIA as a process to ***support authentic participation of vulnerable populations in the decision-making process*** on which the HIA focuses. This is critical because vulnerable communities are often excluded from decision-making processes that stand to impact them. If needed, the HIA process should help build capacity for disadvantaged communities to fully participate in the decision-making process.

C. ***Target the practice*** of HIA towards proposals that are identified by, or relevant to, vulnerable populations. Resources and capacity should be focused on issues faced by the most vulnerable segments of any community.

D. Ensure that a central goal of the HIA is to ***identify and understand the health implications for populations most vulnerable*** or at risk for poor health. HIA goals should reflect a focus on expanding opportunities for good health outcomes in vulnerable populations.

E. Ensure the HIA ***assesses the distribution of health impacts*** across populations wherever data are available. Populations may be defined by geography, race/ethnicity, income, gender, age, immigration status, and other measures. Vulnerable groups should be involved in defining these populations and in developing measures of vulnerability. Where data are unavailable, surveys, focus groups, community oral histories and experiences and other methods can be used to understand the distribution of impacts.

F. ***Identify recommendations that yield an equitable distribution of health benefits*** and maximize the conditions necessary for positive health outcomes among the most vulnerable populations and those who stand to be most adversely impacted by the decision that is being assessed. Identification of the distribution of impacts should be accompanied by recommendations for actions that yield equitable health outcomes.

G. Ensure that ***findings and recommendations of the HIA are well communicated*** to vulnerable populations most likely to be impacted by the decision being assessed. Culturally appropriate materials with non-technical language and accessible summaries, distribution of findings via multiple mediums and platforms, and targeted outreach to sub-populations, such as vulnerable youth, are strategies that help ensure effective communication of findings and recommendations.

H. After the decision on which the HIA is focused is made, ***ensure that the actual impacts of the decision are monitored***, and that resources and mechanisms are in place to address any adverse impacts that may arise. If implemented with careful attention to these principles for promoting equity, HIAs can help transform how policy and other public decisions are made, who has a voice in those decisions, and how those decisions impact the health of vulnerable communities. Every day, policymakers and other public leaders make decisions that have implications for population health without acknowledgment or careful analysis of the potential impacts on our most vulnerable populations. To ensure these decisions reflect and address community health needs and aspirations, it is critical that vulnerable populations bring their knowledge and expertise to the decision-making process and have an active and affirmative voice in those decisions.

Source: Heller, Malekafzali, Todman & Wier, 2013.

HIA in Delaware

HIA is increasingly employed in communities across the nation. Leaders in HIA can take many forms, including community members, non-profit organizations, and government agencies. The diversity of how HIA is implemented reflects the variety of communities that may benefit from its outcome and the different types of policies that it may target.

For example, Delaware Greenways, a non-profit organization aiming to promote health through the use and preservation of green spaces, conducted a HIA regarding land use in 2013. In collaboration with the Delaware Coalition for Healthy Eating and Active Living's (DE HEAL) Environment and Policy Committee and the Governor's Council on Health Promotion and Disease Prevention, Delaware Greenways applied for and received one of three funding awards from the Association for State and Territorial Health Officials (ASTHO). The $15,000 award supported the formation of an HIA Advisory Committee, data collection and analysis, reporting, and various process tasks. The HIA, referred to as the Fort DuPont Master Planning and Feasibility Analysis, was intended to discern which scenario of the development of the 450-acre Fort DuPont site in Delaware City, Delaware promoted health and cost savings. Two development scenarios were analyzed with a primary focus on how Delaware City residents access goods, resources, services, and employment opportunities. A baseline analysis found that although certain features of the community promoted health, there was an absence of healthy food choices, public transportation options, and access to emergency or trauma care. The proposed development scenarios included the preservation of historic infrastructure while enhancing the built environment to support the growth of the local economy. The HIA uncovered that a key aspect of the development scenarios would be increased connectivity of non-motorized modes of transportation, such as sidewalks, multi-use paths, and other accommodations. This would be more likely to result in positive health outcomes, due to better access to recreational areas and the promotion of physical activity. More information about the effort is within the Fort DuPont Master Planning and Feasibility Analysis (https://www.pewtrusts.org/en/research-and-analysis/data-visualizations/2015/hia-map/state/delaware/fort-dupont-redevelopment-project).

More recently, Delaware officials and community leaders worked with the Environmental Protection Agency (EPA) to conduct a rapid HIA with the City of Dover and Kent County Levy Court to inform decisions related to the redevelopment of a downtown Dover property that was a former brownfield site. City and county officials were interested in using the property to produce food and help stimulate economic activity. The EPA worked with the City of Dover, Kent County Levy Court, the State of Delaware, the U.S. Department of Agriculture, and DSU to conduct the HIA and estimate the impacts the food production project might have on the health of the community, through increased food access, employment, urban revitalization, and household and community economics. The HIA revealed that the revitalization project may be effective in meeting market needs and providing food to community members. The final report included a series of recommendations that, if implemented, would make the positive health impacts of the project more likely to be achieved. More information on the Dover HIA can be found at https://www.epa.gov/healthresearch/health-impact-assessments.

Recommendations and Toolkits for HIA

The Fort DuPont Master Planning and Feasibility Analysis marked the first use of HIA in Delaware. Its HIA Advisory Committee developed recommendations for conducting HIAs. The following is a selection of those recommendations:

- Select a project/policy/program identified by a local stakeholder group, community leader, or elected official for assessment to help ensure effective stakeholder participation, local commitment, and open communication.

- Initiate stakeholder engagement before the HIA officially begins and maintain an effective stakeholder engagement strategy throughout.

- To the extent possible, select a subject project/policy/program that is well defined and about which there are sufficient data available.

- Select for assessment a project or health issues/impacts that have greatest potential for impacting population health.

- Work with subject project representatives to clearly define and agree upon how the subject project efforts and HIA efforts will interact, including reporting and communications strategies.

- Allocate sufficient resources (time, funding, and personnel) since subject projects often have fluctuating timelines; building in a cushion will help ensure a successful HIA. Effective HIAs also require commitment from a broad coalition of professionals.

- Be thorough in scoping phase brainstorming; plan for the scoping phase to be one of the longest phases of the HIA process and expect to adjust.

- Think beyond the strict definition of the HIA and the process for opportunities to bring health into the decision-making process; if the process is not going as planned, identify the opportunities that have arisen unexpectedly that offer possibilities for bringing health into the discussion.

- Select a project for which health, demographic, and other data are generally available, especially if new data collection is not possible. Also, use the most local data available so that the HIA can focus on the subject project population (Trabelsi, 2013).

As interest in HIA grows, many tools and resources are becoming available nationally. The website of Human Impact Partners at http://www.humanimpact.org/ provides links to many helpful sources. Similarly, the Community Tool Box (https://ctb.ku.edu/en/table-of-contents/overview/models-for-community-health-and-development/health-impact-assessment/main) presents valuable information about HIA and resources for its implementation. Many toolkits exist to assist state and local governments, public health practitioners, and stakeholders in implementing this approach. Within its website devoted to the concept of Healthy Places, the CDC provides several toolkits for conducting HIA with respect to parks and trails and transportation. (More information can be found at http://www.cdc.gov/healthyplaces/parks_trails/default.htm and http://www.cdc.gov/healthyplaces/transportation/hia_toolkit.htm). Additionally, the Society for Practitioners of Health Impact Assessment (SOPHIA) developed a series of metrics to ensure a focus on equity in HIAs. A worksheet to support the use of such metrics can be found at https://hiasociety.org/resources/Documents/EquityMetrics_FINAL.pdf.

Racial Equity Impact Assessment

Again, HIAs are inherently equity-oriented in that they are characterized by community-oriented processes, aim to address community priorities, and enhance transparency and democratic decision-making. However, the racial justice lens used to develop this revised guide led to the identification of additional tools and resources, ones that support a more explicit approach to assessing policy development for its likely impact on different racial or ethnic groups. More specifically, a Racial Equity Impact Assessment (REIA) is a systematic examination of how different racial and ethnic groups will likely be affected by a proposed action or decision (Race Forward, 2009). According to Race Forward (2009), "REIAs are used to minimize unanticipated adverse consequences in a variety of contexts, including the analysis of proposed policies, institutional practices, programs, plans and budgetary decisions. The REIA can be a vital tool for preventing institutional racism and for identifying new options to remedy long-standing inequities."

The City of Madison, Wisconsin is an example of a municipality that adopted an explicit approach to racial justice in its decision-making. The mission of Madison's Racial Equity and Social Justice Initiative is to "establish racial equity and social justice as core principles in all decisions, policies, and functions of the City of Madison" (https://www.cityofmadison.com/civil-rights/programs/racial-equity-social-justice-initiative/mission-vision). Representatives across all city departments make up a core team so that change happens across all aspects of the administration. Use of a REIA tool promotes "a comprehensive approach to challenging the perpetuation of institutional and structural racism."

In Delaware, the Wilmington Area Planning Council (WILMAPCO), the Metropolitan Planning Organization for New Castle County, Delaware, is working to incorporate environmental and racial justice into its planning efforts. The 2019 Transportation Justice Plan examines the experiences of various populations and communities that experience disadvantages within the transportation system and within public planning processes. While WILMAPCO uncovered transportation inequities for people with low incomes and Hispanics, the report indicates that blacks experienced the greatest inequities. These include more difficulty reaching activities, higher rates of bike and pedestrian accidents, more road traffic, and less community transportation project funding than expected based on population size. The Transportation Justice Plan makes several recommendations for how to begin to address the social inequities it uncovered. For example, the report recommends changing WILMAPCO's project prioritization process so that projects located in black neighborhoods and low-income neighborhoods receive higher priority for funding to help correct for chronic underfunding and transportation-related inequities. WILMAPCO also identified priorities related to community engagement in their planning processes, with particular emphasis on low-income communities and communities of color.

For more information about REIA, including tools and examples of states and municipalities that have used REIA in their decision-making processes, visit https://www.raceforward.org/practice/tools. For more information on the City of Madison's Racial Equity and Social Justice Initiative, including a long list of city projects that have used a REIA, visit https://www.cityofmadison.com/civil-rights/programs/racial-equity-social-justice-initiative. Read WILMAPCO's Transportation Justice Plan at http://www.wilmapco.org/EJ/WILMAPCO_2019_TJ_Plan.pdf.

Communicating for Healthy Public Policy

Creating the kinds of healthy public policies needed to advance health equity requires a significant shift in the way that most people understand health, health inequities, and the role of public policy in both. Building support for HiAP and for using HIAs requires that public health professionals, partners, and advocates reframe health from being something that is individual in nature and determined by personal choice, to something that is shaped by our environments and for which we have a collective responsibility to improve. These approaches to understanding health move from an individual and behavioral frame to an environmental frame. As discussed in the HiAP Guide for State and Local Governments (Rudolph, Caplan, Ben- Moshe, & Dillon, 2013), it is important to communicate this environmental frame early and often. A prevailing misconception is that the best way to improve health is through access to health care and healthier individual choices. Therefore, it is critical to communicate effectively how the places in which we live, learn, work, and play affect our health. Once this environmental frame is understood, it is easier to convince people about the need to improve their environment to improve health. This comprehension is necessary for a HiAP approach.

In addition to presenting an environmental frame, it is important to identify and then use commonly held values when communicating with stakeholders. This can be difficult for public health professionals or others who may be uncomfortable in moving away from statistics and research often used to make the case. However, values and emotion are what move people, and these need to be part of the conversation.

While there is generally consensus regarding the need to present an environmental frame when advocating for healthy public policy, recommendations for how to talk about racial justice in ways that build political will are somewhat more ambiguous. Some experts and advocates recommend talking explicitly about race; others recommend caution and suggest invoking a frame that is more generally related to things like "opportunity for all" and prevention broadly (Frameworks, 2008).

Whether one is promoting a shift to an environmental frame, HiAP, or racial justice, the consistency and credibility of the message is always important. Additionally, communication strategies are most effective when they are audience specific. Knowing the audience and their starting point can help craft tailored messages. Similarly, having a messenger who resembles or relates to the audience may influence the effectiveness of the messages because people tend to be more receptive to people like them. Some pay more attention to messages coming from persons whom they perceive are respected sources (Rudolph, Caplan, Ben-Moshe & Dillon, 2013).

Finally, it is critical that communication strategies include a focus on solutions. As explained by the authors of the HiAP Guide for State and Local Governments:

> "People are more inclined to act when they feel they can do something to solve a problem. But often public health professionals spend more time talking about the problem than the solution, leaving their audience feeling hopeless or overwhelmed. To more effectively inspire action we need to reverse that ratio and talk more about the solution than the problem. For example: "Increased access to healthy food will improve nutrition and contribute to reducing rates of childhood overweight and adult diabetes. Ensuring that everyone has access to healthy, affordable food can be complicated, but there are meaningful steps we can take right now. That's why we're asking [specific person/agency/ organization] to support the Healthy Food Financing Initiative to increase access to healthy food in our neighborhood." (Rudolph, Caplan, Ben-Moshe & Dillon, 2013, p. 105).

The HiAP Guide for State and Local Governments includes a detailed discussion of communication with several recommendations and sample messages. The authors include sample responses to commonly asked questions and offer a number of additional resources. The authors explain that the critical components to an effective message are as follows:

1. Make sure to present the environmental frame first.

2. State the values (e.g. health, equity, community, etc.).

3. State the solution clearly and be sure that the solution gets at least as much, if not more, attention than the problem.

Readers are encouraged to visit Section 7.1 of the HiAP guide for a detailed discussion on communication strategies to support HiAP. Similarly, the HiAP guide includes an annotated list of references related to communication for HiAP, which can be found beginning on page 155 (see https://www.phi.org/uploads/files/Health_in_All_Policies-A_Guide_for_State_and_Local_Governments.pdf).

Glossary - Section 7

Healthy Public Policy: A policy that is explicitly responsive to health needs. It may be a health policy, designed specifically to promote health. Alternately, it may be a policy outside of what is typically thought of as health policy, but promotes health or positively influences the determinants of health.

Health in All Policies (HiAP): A collaborative approach that makes health considerations explicit in decision-making across sectors and policy domains. A HiAP approach convenes diverse stakeholders to consider how their work influences health and how collaborative efforts can improve health while advancing other goals.

Health Impact Assessment (HIA): A systematic process that uses a variety of data sources and research methods, and considers input from a range of stakeholders to determine the potential effects of a proposed policy, plan, or action on the health of a population and the distribution of those effects within the population.

Racial Equity Impact Assessment (REIA): A systematic examination of how different racial and ethnic groups will likely be affected by a proposed action or decision.

Root Cause Mapping: A process for identifying the primary factors that contribute to community health problems to identify the most appropriate areas for intervention. This approach can be useful in in helping stakeholders identify links between health and risk factors in the community, including areas seemingly outside of public health.

Stakeholders: Any individual, group, or organization that has an interest in a project or policy. This can include residents, decision-makers, funders, community-based organizations, state agencies, advocacy groups, academic experts, and public health practitioners.

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SECTION 8: Data, Research, and Evaluation for Health Equity

As described earlier, research on the relations between health inequities and indicators of socioeconomic status, including income, race, ethnicity, and living and working conditions, is unequivocal. These social conditions have been described as "fundamental causes of disease" because they determine access to resources needed to avoid risks and can be linked to multiple diseases (Link & Phelan, 1995). This is an important rationale for place-based strategies that target living and working conditions and which are likely to have a positive, simultaneous impact on a range of health outcomes. However, the specific causal linkages between social conditions and health inequities are not always well understood and can vary by community. For this reason, even strong associations between social conditions and health inequities at the macro-level may not provide enough information to understand community-specific needs or to promote action at the community level. Furthermore, better data and concerted measurement strategies are needed to evaluate changes at the community level and to assess the impact of policy changes more broadly across the state of Delaware. For these reasons, the National Stakeholder Strategy for Achieving Health Equity (NPA, 2018), described in previous sections of this guide, identifies "improving data availability, coordination, utilization, and diffusion of research and evaluation outcomes" as one of its five over-arching goals.

This section describes the kinds of data and capacity needed to understand and monitor health inequities at the community and state levels. It includes a discussion of strategies for evaluating health equity initiatives and highlights ongoing challenges with respect to evaluation. Section 8 concludes with a summary of research priorities to advance health equity. Overall, it provides an overview of the challenges in collecting and analyzing data regarding the SDOH and health equity, but does not go into great detail on the complexity of the analyses (e.g. multi-level epidemiological approaches) necessary to draw conclusions using such data.

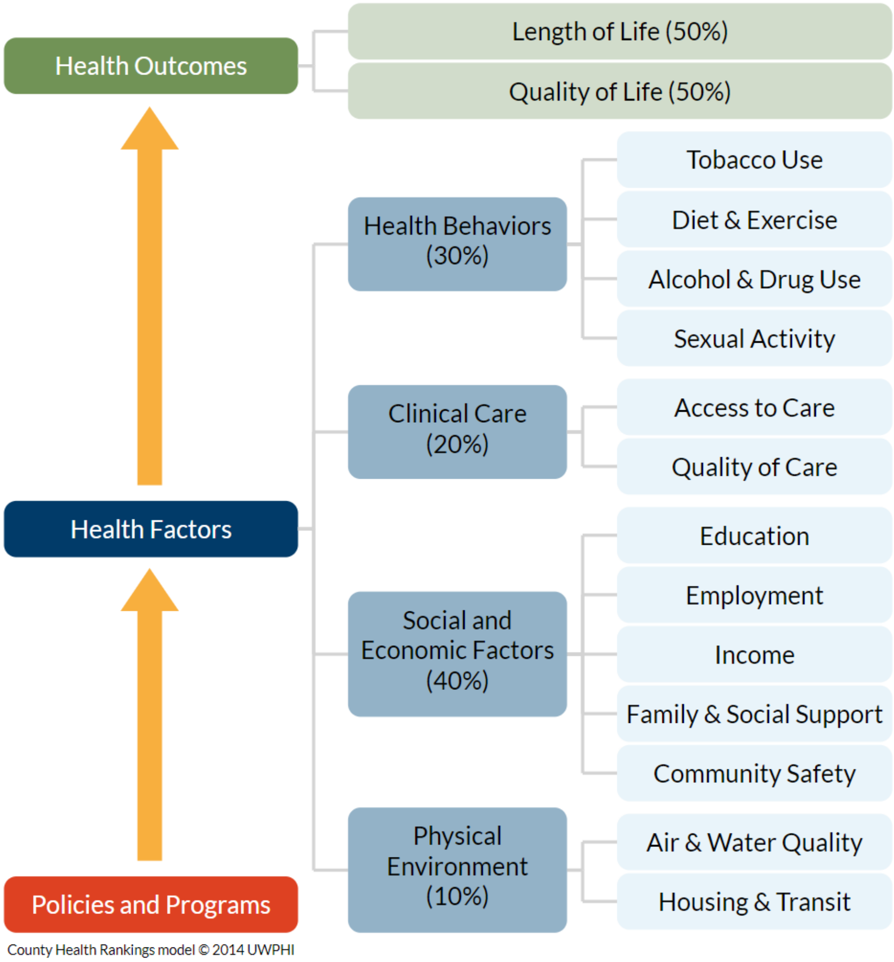
Data to Identify and Understand Health Inequities

It is critical to have a comprehensive understanding of population health status, including inequities in health across various characteristics, such as income level, race, ethnicity, sexual orientation, gender, gender identity, education level, and other indicators of socioeconomic status. It is important to note that health status data is not necessarily available for all population groups. For example, health status data is largely lacking for members of the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) population. A 2011 IOM report The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding, highlights the need for targeted data collection and research regarding the health status of this population (IOM, 2011).

Additionally, it is important to have a clear understanding of the underlying or upstream causes for health inequities, broadly defined as SDOH. Both types of data (health status and SDOH) are necessary to describe baseline status and to monitor changes over time as well as to make comparisons by place. Baseline data helps practitioners, policy makers, and community residents identify priorities and ensure that interventions reflect the community's needs and resources. Tracking changes over time helps to ensure that interventions remain focused on those priorities and accountable to stakeholders. Importantly, local-level data are needed to facilitate the identification of priorities and other kinds of decision-making. This can be challenging because many existing data sources do not allow for neighborhood-level analysis and/or would require substantial resources to do so.

Fortunately, models exist for linking determinants and outcomes. For example, the County Health Rankings model (Figure 40) is based on an understanding that community health is influenced by a range of factors in the physical and social environment, as well as clinical care and behavior. County Health Rankings is a collaboration between the RWJF and the University of Wisconsin Population Health Institute. Rankings are compiled using county level data on various determinants of health, as well as health status indicators. Researchers developed a weighting system for the various indicators based upon an extensive review of the literature (see https://www.countyhealthrankings.org/explore-health-rankings/our-methods). While the rankings are typically used to compare counties and track changes over time, some have used the rankings model for other kinds of research and evaluation purposes; visit https://www.enterprisecommunity.org/resources/on-the-path-to-health-equity.

Figure 40: County Health Rankings Model.



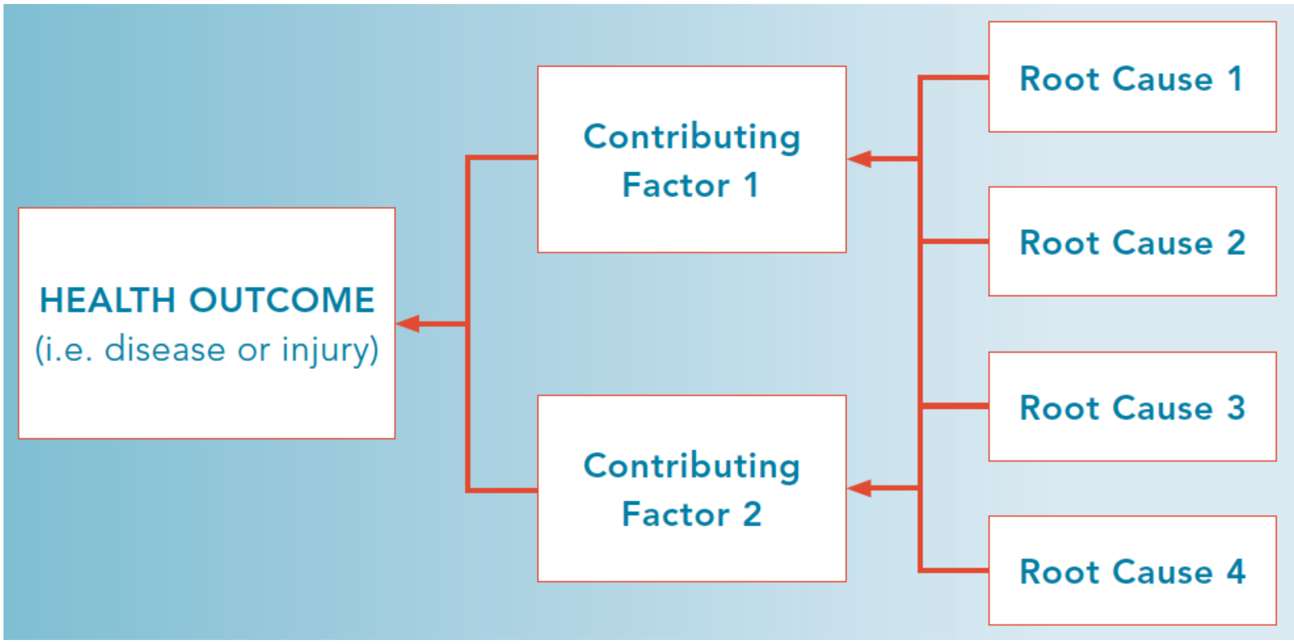
Source: RWJF and University of Wisconsin Population Health Institute. (2019). County Health Rankings & Roadmaps. Retrieved from https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources.

Innovative Types of Data

Data that describes SDOH are needed to highlight the ways in which unequal power and privilege influence the distribution of resources required for health (Knight, 2014). For instance, in addition to monitoring high school graduation rates, it is valuable to collect information and monitor changes in per capita spending on public education. Similarly, the availability of affordable housing is an important SDOH, but the level of racial segregation in a defined community is necessary to paint a more complete picture.

Many models analyze the underlying causes and factors of health outcomes. One model is the root cause mapping process described in the policy section, Section 7. It is useful for identifying important indicators of community health and inequities such as per capita spending and racial segregation. The root cause diagram, reproduced in Figure 41, highlights how data collection efforts also need to shift upstream. However, it should be noted that more exhaustive models, such as causal diagrams (see Pearl, 2000), depict the relations between causes and indicators and more accurately represent how root causes interplay to influence health outcomes. In either case, looking at the upstream causes of health inequities allows stakeholders to focus on the most meaningful indicators and helps shift the focus from individual risk factors and behaviors to community health and the structures that underlie inequities. Referring back to the obesity example discussed in Section 7, two contributing factors to obesity are poor diet and lack of physical activity. However, they are not the root causes of obesity. Rather, elements or structures within the built environment underlie these individual risk factors. Using this diagram to identify root causes of obesity might lead stakeholders to collect and track data on convenience and fast food retail locations, and/or the availability and safety of parks and playgrounds.

Figure 41: Root Cause Diagram.



Source: Reproduced from Rudolph, Caplan, Ben-Moshe, & Dillon, 2013.

Data on social and structural determinants are not readily collected, nor collected in systematic ways. This may require creativity and investments in novel approaches to data collection, such as community asset mapping; Photovoice, which utilizes photography as a means of communicating social issues; and walking audits. It likely involves partnering with other sectors that have existing data to support a broader understanding of SDOH and health inequities. Furthermore, community members should be engaged in identifying, collecting, and interpreting new kinds of data for health equity. As described by the CDC in their Practitioner Guide for Advancing Health Equity, “the perspectives of community members can bring static data to life by revealing the lived experience behind the data” (CDC, 2013, p. 19). The CDC’s guide also offers a systematic list of questions for practitioners in government and community-based organizations to reflect upon when building their capacity for identifying and understanding health inequities:

- Where are we now?
    - What are our organization’s current practices for identifying and understanding health inequities?
    - Can we clearly articulate health inequities related to the health issues we are trying to prevent and/or address? If so, list those health inequities.

- What types of information can we use to identify health inequities in our community?
    - What process can we set up to get a full understanding of health inequities in our community?
    - What type of information do we need to ensure we have a full understanding of health inequities in our community?
    - Have we looked beyond basic health risk behaviors and standard outcome data to examine social, economic, and physical indicators that may contribute to or maintain health inequities?
    - Have we examined community context and historical factors that may help our understanding of existing health inequities?

- What tools and resources can we use to identify and understand health inequities?
    - What combination of data sources do we need to better understand experiences of populations affected by health inequities?
    - What sources or partners may already have the data we need for assessing community environments or health behaviors?
    - Where can we go to understand the historical context of health inequities in the community?

- How can we engage community members in gathering and analyzing data?
    - How do we currently engage community members in our data collection and analysis process?
    - What process can we put in place to routinely engage populations affected by health inequities in collecting and analyzing data?

- What are our next steps?
    - What can we do differently to improve or enhance our ability to identify and understand health inequities?

"Without a clear understanding of existing health inequities, and the root-causes contributing to them, well-intentioned strategies may have no effect on or could even widen health inequities" (CDC, 2013).

Strengthening Existing Data Capacity

Understanding health inequities and their determinants can be improved by collaborating across sectors that may already collect the kinds of data that are needed. Similarly, it may be possible to make greater use of existing data within public health surveillance systems or within health and human service agencies. This involves linking data systems in ways that provide a more comprehensive view of community health. Adding data from one database to another can be resource intensive and may require addressing legal barriers in addition to overcoming technical barriers. It is critical to ensure the protection of privacy when working with individual-level data, particularly as the groups most affected by inequities may already experience disadvantages related to their identity.

Fortunately, in the state of Delaware, the potential for such linkages can be facilitated by initiatives such as the Master Client Index (MCI). MCI tracks unique clients in each of the programs within the DHSS and the Department of Services for Children, Youth and their Families (DSCYF) (http://dhss.delaware.gov/dhss/dms/irm/files/mci_interfacing_requirements.pdf). Similarly, the Delaware Health Information Network (DHIN) is a statewide health information exchange among health care providers that facilitates an integrated data to improve patient outcomes and patient-provider relationships, while reducing service duplication and health care spending (http://dhin.org).

In May 2019, Delaware's DPH launched "My Healthy Community," a data portal which allows residents, advocates, practitioners, and policymakers to assess the overall health of communities in Delaware. The portal provides immediate access to community-level statistics and data that can be used to understand and explore health and related factors in the social and physical environment. Such data can facilitate community-based assessments and decision-making, and can help track changes over time. My Healthy Community is the result of a long-term planning process and partnership among several state agencies, including the DHSS Division of Substance Use and Mental Health (DSAMH), the Delaware Department of Natural Resources and Environmental Control (DNREC), the, and the Delaware Health Care Commission (HCC). For more information and access to the data portal, see https://myhealthycommunity.dhss.delaware.gov/. These and other data-sharing initiatives can provide the foundation for more concerted health equity-oriented efforts.

Several national databases can also be used to understand health inequities and their causes at the local level. The Data Set Directory of Social Determinants of Health at the Local Level contains an extensive list of existing data sources across 12 dimensions of the social environment: economy, employment, education, political, environmental, housing, medical, governmental, public health, psychosocial, behavioral, and transportation (Hillemeier, Lynch, Harper & Casper, 2004). Within each dimension, the directory includes several important indicators and data sources to describe those indicators. For instance, the political dimension identifies voter registration and voting rates as important indicators of civic participation and offers a specific data table within the U.S. Census Bureau dataset as a source for those indicators.

The behavioral dimension includes indicators commonly used in public health surveillance, such as smoking rates and levels of physical activity. However, it also includes indicators such as the average local price of cigarettes and physical education requirements in schools. These latter indicators speak to the social and structural characteristics of the environment, which allow public health practitioners and partners to better understand upstream root causes. For the full directory, visit: http://www.cdc.gov/dhdsp/docs/data_set_directory.pdf. Appendix C from the CDC Practitioner Guide for Advancing Health Equity (2013) (https://www.cdc.gov/nccdphp/dch/pdf/HealthEquityGuide.pdf) contains additional examples of resources for identifying and understanding health inequities.

More recently, the 100 Million Healthier Lives Initiative and the National Committee on Vital and Health Statistics facilitated the development of the Well-Being in the Nation (WIN) Measurement Framework. The WIN Measurement Framework was developed with input from experts around the country and was guided by the experiences of numerous communities working to promote health by working across sectors. The framework includes a set of common measures intended to assess and improve population and community health. It includes three elements:

- core measures – nine indicators used to describe the well-being of people, well-being of places, and equity
- leading indicators – a set of key measures within 12 domains (community vitality, economy, education, environment and infrastructure, equity, food and agriculture, health, housing, public safety, transportation, well-being, and demographics); and
- flexible measures – additional measures within the 12 domains identified as part of the leading indicators that communities may choose to incorporate based upon priority needs and access to data.

More information about the WIN Measurement Framework, including specific indicators, sources of data, and recommended strategies and tools, may be found at https://www.winmeasures.org/statistics/winmeasures.

Existing data collection and surveillance activities can also be strengthened with respect to the collection of race, ethnicity, and language data. Although race, ethnicity, and language data are captured in databases such as vital statistics and health care records, it is not collected consistently through other surveys, programs, or databases. Experts recommend that race, ethnicity, and language data be collected across sectors and collected by a variety of agencies including government, non-profit organizations, and academic institutions, among others. A race, ethnicity, and language workgroup of the Minnesota Department of Health and the Minnesota Department of Human Services specifically recommends the following:

- More detailed categories of race and ethnicity data should be used so that the data are more useful in understanding health issues and needs for particular groups.

- State agencies and organizations that collect and use health data should be regularly engaged with diverse communities to promote full understanding of how race, ethnicity, language, and culture affect the quality, access, and cost of health services.

- Data collected by state agencies and health care organizations should be as accessible to communities, as possible. The criteria and process for obtaining access to data should be provided to and discussed with the communities, and agencies should take steps to ensure that information about relevant datasets is easily available online.

- A workgroup (such as the one that developed these recommendations) should continue on an ongoing basis so communities, health care stakeholders, and government agencies can partner to improve data collection policies and practices and, using the data, eliminate health inequities.

- A uniform data "construct" should be developed so that all health data collected use the same categories for race, ethnicity, and language. The uniform construct should be used not just by state health agencies, but also by licensing boards, other governmental agencies, health plans, hospitals, clinics, non-profit agencies, quality and performance measurement programs, and others who collect, analyze, and report health data. In this way, disease burden, risk and protective factors, access to care, and quality of care can be measured and communicated for smaller populations within an overall population. To eliminate duplication of effort, the uniform construct should build on existing data collection frameworks. The data construct should be flexible so categories can be changed as needed. A process should be developed to assess changes in racial/ethnic populations in the state and determining when populations are of a sufficient size to be reported as a separate category.

- Programs that rely on survey data should consider over-sampling or mixed mode approaches to obtain larger numbers for communities of color (MDH/MDHS, 2011).

For more information about Minnesota's race, ethnicity, and language workgroup, its process for developing recommendations, and a more detailed discussion of the recommendations, visit https://www.health.state.mn.us/communities/equity/reports/racialethnicdata2011.pdf.

Selected Data Tools for Health Equity: GIS, HIA, REIA, CHA

Capacity to address health inequities at the community level can be strengthened by using various tools that help describe public health issues and available resources at the community level. One such tool involves the use of Geographic Information Systems (GIS) data. GIS data may be used in concert with health data to generate maps, which provide a powerful tool for visualizing health inequities at the community level. More specifically, maps can be used to analyze spatial patterns of health and illness in tandem with social inequities such as poverty and income, race/ethnicity, and environmental health hazards (MDH, 2014). For example, the maps presented in Section 4 reflect income level, educational attainment, life expectancy, and infant mortality by ZIP code. Ultimately, GIS maps can distill otherwise complex information into easily understood images. Importantly, they can be used to promote policy change, particularly because they can focus attention on areas defined by political boundaries (e.g. congressional districts).

The use of HIAs and Racial Equity Impact Assessments REIAs described in Section 7 require a different kind of analytical approach, research skills, and sources of data than traditionally used in public health. However, they also offer an important way of understanding existing health inequities and the changes (both positive and negative) that may result from proposed policy changes.

The methods for conducting HIAs and REIAs are consistent with the data and evaluation needs outlined in this section. Specifically, they call for community-based approaches to data collection and analysis; are grounded in the principles of equity, inclusion and democracy; often rely on mixed data collection methods (i.e. quantitative and qualitative approaches); and make connections between health and social and environmental conditions and structures. There is also a strong focus on dissemination and utilization of the results of the analysis. For these reasons, capacity for conducting HIAs and REIAs should be developed and/or enhanced to advance health equity in Delaware.

Another opportunity for addressing health equity data needs at the community level exists through community health assessments conducted by non-profit hospitals. The ACA now requires tax-exempt hospitals to conduct community health needs assessments at least every three years and develop plans to address those needs. The law strengthens the hospitals' obligation to work with public health agencies and others in this regard. Therefore, public health practitioners can partner with hospital administrators to support their data collection efforts and encourage them to implement action plans that focus on SDOH and equity.

Limitations of Data Collection and Analysis for Health Equity

The kinds of data needed to describe health inequities and their causes are not always available or accessible. Investments in new kinds of data collection may be needed to fill these gaps. Importantly, data collection systems need to be maintained to track changes over time and allow for the evaluation of interventions. Furthermore, investments may be needed to allow for easy access to the data once collected (e.g. interactive websites) and to effectively communicate the findings. Investments in data collection and analysis are wasted if the information is not shared in useful ways. Infographics, or images used to portray data, can be particularly effective in conveying information to the public and policymakers. Figure 42 shows how the average life expectancy for babies born to mothers in New Orleans can vary by as much as 25 years across neighborhoods just a few miles apart. Additional examples of infographics related to health equity are found here: https://healthequity.sfsu.edu/content/infographic. Each example demonstrates the power of images to convey this information and can be adapted to reflect the reality of health inequities in Delaware.

Figure 42: Metro Map: New Orleans, LA.

Source: Robert Wood Johnson Foundation, 2013. Retrieved from https://www.rwjf.org/en/library/infographics/new-orleans-map.html.

Another data challenge, inherent in working at the community level, is the limitation of small sample sizes. Ideally, data are analyzed by neighborhood to provide the most comprehensive understanding of local needs, assets, and priorities. However, the more granular the level of data collection, the greater the challenge in reporting rates and other statistical measures and interpreting changes over time. This is because small changes can appear large and be potentially misleading. For instance, if there are 10 cases of a disease one year and nine cases the following year, this could be interpreted as a 10 percent drop. A larger area might have 1,000 cases one year and 999 the following year, revealing a 0.1 percent drop. In both instances, there is one less person with the disease, but the reduction may or may not be relevant in the context of the population as a whole. When working with small numbers, it is difficult to know if a change is meaningful or the result of random chance or other anomaly.

Statisticians often aggregate data into larger geographic regions or over multiple years to address this challenge. However, such aggregation is less helpful when developing and evaluating place-based initiatives at the local level. Similarly, it is often difficult for practitioners to find, interpret, and use data from different sources aggregated at different level. Fortunately, in Delaware, the My Healthy Community data portal (https://myhealthycommunity.dhss.delaware.gov/) has used an innovative technological approach to this issue. More specially, the portal is designed to provide the user with data on the smallest geographic level that is feasible given the type of data and number of cases. This means that many indicators are available at the census block group level. When the nature of the data does not allow for reporting at that level, programming within the data portal automatically calculates and provides the user with the next level possible (e.g. ZIP code, city, or county level).

Another barrier that is somewhat easier to overcome than others is the lack of a skilled workforce. Surely, practitioners working in epidemiology and surveillance need strong analytical capabilities, including skills in statistics and quantitative analytics. However, it is also true that health equity work requires that practitioners be skilled in qualitative research methods. Similarly, there is a need for workers to think creatively about the kinds of data necessary to understand health inequities and describe them in ways that compel action. For example, storytelling approaches, such as Photovoice and media advocacy, are likely to leave a lasting impression on audience members.

Lastly, data collection, analysis, interpretation, and dissemination for health equity require meaningful community engagement and empowerment. It is often a challenge for public health practitioners and partners to dedicate the time and resources necessary to leverage and sustain community engagement. However, for data collection and analysis to impact change, the data must be easily understood and utilized by those most responsible for making change — community members, stakeholders, and policy makers. Therefore, it is in the best interest of public health practitioners and partners to engage and empower communities. By including community members, stakeholders, and policy makers in the data collection and analysis process, they are more likely to use the information to develop appropriate and effective interventions.

Principles for Successful Use of Data for Health Equity

In its report to the state legislature of Minnesota, the Minnesota Department of Health identified “four keys to the successful use of data for addressing health inequities” (MDH, 2014). These recommendations apply to the collection of new data, the improvement of existing data, and the use of tools such as GIS mapping and HIA (all described above). The four keys to the successful use of data include:

1. Make the data useful in terms of analysis, interpretation, and application. This suggests that many different kinds of techniques may be needed for the collection, analysis, and reporting of data related to health equity. The approaches that are used will depend on the purpose or intended use of the data.

2. Results must be disseminated effectively. Practitioners must consider their audience when deciding how to share their findings to achieve maximum impact. For example, data meant to inform policy change will be of little use unless policy makers can understand and appreciate the information. Different and creative channels for dissemination should be considered, such as interactive platforms and websites, newsletters, emails, and community forums. A public access web portal with interactive capabilities, such as allowing users to select indicators and geographic locations, can be particularly useful. At the same time, this approach may require substantial ongoing investment of staff to manage the portal's operation and financial support.

Sample Strategy

In Delaware, community dinners are a favorite tool to gather stakeholders and community members for share data and information. The community dinner model seeks to engage individuals in places within their community, such as a school or recreational center, and relies on partnerships. Often organizations contribute staff members' time, funds to order food, and space to house the event. CCHS and the Sussex County Health Promotion Coalition have set the tone for hosting community dinners, having achieved success in discussing health-related topics with local residents.

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3. It is essential to involve the community in data collection, analysis, and dissemination. The community should help to determine what data are needed and how the findings should be used. This may require practitioners to help build the capacity of community members, so they are equipped to engage in some of the more technical aspects of data collection and analysis. "Community involvement in monitoring health inequities will increase awareness, ensure health inequity data are responsive to the needs of communities, create a sense of ownership of the data, and facilitate a collaborative, equitable partnership in creating health equity policies, programs and practices" (MDH, 2014, p. 67).

Sample Strategy

In Delaware, CCHS employed Photovoice, which uses photography to communicate social issues, to engage black youth in an analysis of the issues that shape their lives. As participants in this community-based participatory research project, the youth were regarded as co-researchers assisted in developing the research question while holding autonomy in the research process. Results indicated that the youth saw violence and substance abuse/addiction as barriers to their personal success (Christiana Care Health System, 2014, p. 13). Photos representing safety, gun violence, teen pregnancy, and risky behaviors (such as gambling, tobacco use, and addiction to prescription and illicit drugs) were evidence of concerns for these youth (Christiana Care Health System, 2014, p. 13). By coupling these data with statistical reports and peer-reviewed research, the Photovoice approach provided validation of what is known in academia and represents a unique opportunity to view the SDOH through the lenses of those most vulnerable to their effects. The Photovoice approach exemplifies community engagement and quality data collection and analysis.

4. Effective collection and use of data for health equity requires a skilled workforce. This may involve recruiting new staff with research expertise, retraining existing staff, or simply supporting staff who possess the appropriate skills by providing the time, tools, and resources necessary to engage in surveillance, analysis, and dissemination of health equity data. Importantly, a workforce skilled in epidemiology is one that includes staff knowledgeable about health equity and SDOH, in addition to possessing analytical skills and research expertise. Mobilizing a skilled workforce toward an enhanced focus on qualitative methods and community-based participatory research is also warranted for a holistic description of the public health issue and potential interventions. Finally, a culture of continuous learning within state agencies and community-based organizations can support the successful use of health equity data (MDH, 2014, pp. 65- 67).

Evaluation for Health Equity

Evaluation is one of the Ten Essential Public Health Services outlined by the CDC. The Ten Essential Public Health Services describe the core public health functions that all communities should undertake, including “Evaluating the effectiveness, accessibility, and quality of personal and population-based heath services” (cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html). Ultimately, evaluation involves a value judgment about how well something worked and whether it should be continued. In the interim, evaluation is critical for sharing the ongoing work of any initiative and helps to ensure that stakeholders are focused on the most effective activities. Effective program evaluation is a systematic method of improving and accounting for public health actions (CDC, 1999). A framework for evaluating public health efforts, developed by public health leaders at the CDC, is widely used within the field. An illustration of the key elements of the framework is presented as Figure 43. A detailed discussion of the framework and how it is being used by CDC can be found at https://www.cdc.gov/mmwr/PDF/rr/rr4811.pdf and https://journals.sagepub.com/doi/10.1177/0033354918778034.

Figure 43: Framework for Evaluation in Public Health.

Source: Centers for Disease Control and Prevention, 1999.

The evaluation of health equity initiatives is particularly important, considering that it can reveal the effects of initiatives on different groups, ensure that stakeholders do not lose sight of the intention to reduce gaps in health status, and ensure equity in the distribution of resources needed for optimal health. The importance of understanding what works, for whom, under what conditions, and whether health inequities have decreased, increased, or remained the same requires a deliberate focus on equity in evaluation efforts (CDC, 2013). In their Practitioner Guide for Advancing Health Equity, the CDC offers several questions for practitioners in government and community-based organizations to reflect upon when working to incorporate health equity into evaluation efforts:

- Where are we now? How are we currently assessing the effect(s) of our efforts to address health equity?

- How do we start the evaluation process with health equity in mind?
    - Do we have the expertise to develop, implement, and assess an equity-oriented evaluation plan? What process can we establish to routinely engage community stakeholders, including those experiencing health inequities, in all aspects of our evaluation efforts? What are our current health equity strategies, activities, and goals? How can our logic model be modified to reflect our health equity activities and goals?

- How can we consider health equity in evaluation questions and design?

  - How can we reframe or create new evaluation questions to better understand our effect on health inequities? What are the key variables we should use to track the influence of our efforts on populations experiencing health inequities? How can our sampling plan be designed or modified to answer our health equity- oriented evaluation question(s)?

- How can we integrate health equity principles in the data gathering process?
  - What processes do we have in place to determine when culturally appropriate tools or methodologies are needed? If modifications are needed, how can we ensure that our evaluation tools meet the needs of populations experiencing health inequities (e.g., language and literacy needs)? Are the data we are collecting reflective of the real experience of the populations experiencing inequities? Are other approaches needed? Does our performance monitoring system allow us to track and identify needs that may arise when implementing efforts in underserved communities? How can we structure our evaluation processes to understand the long-term effects of our efforts on health inequities?

- How can we understand our effect on health equity through our analysis plan?
  - Does our analysis plan allow us to answer the following: What worked? For whom? Under what conditions? Is there any differential impact? Have inequities decreased, increased, or remained the same? If not, how can we modify the analysis plan to answer these questions? Does our outcome evaluation allow us to determine differential effects across population groups? Does our process evaluation allow us to understand the key factors that influenced the outcomes of our efforts in underserved communities? What actions do we need to take to improve or enhance our evaluation plan to understand our effects on health equity (e.g., have inequities decreased, increased, or remained the same)?

- How can we share our evaluation efforts with diverse stakeholders?
  - How and where do we typically disseminate our evaluation findings? What commitment can we develop to ensure we share findings, even if negative? How can we ensure we share our findings in plain and clear language that can be understood by stakeholders, partners, and community members? How can our findings be used to support more action in communities of greatest need? How can we revise the ways in which we share lessons learned to help others concerned with addressing health inequities?

- What are our next steps?
  - What can we do differently to improve or enhance our ability to conduct health equity-oriented evaluations? What is our plan of action to implement improvements in our evaluation efforts? (CDC, 2013, p. 33)

Evaluation efforts are most useful when considered during the planning phase of a health equity initiative and can contribute to the likelihood of its success. It encourages participants to think in depth about the goals of the initiative and what success looks like in the short-term as well as the long-term. This requires participants to clearly articulate their theory of change, or the rationale for their approach, and helps them communicate this effectively with other stakeholders. Similarly, incorporating evaluation at the outset of a program provides an opportunity to identify intermediate measures of progress towards the ultimate goal of achieving health equity, which is particularly important for place-based initiatives or community-based efforts that target upstream SDOH. In such cases, stakeholders must consider the relation between the targets of the intervention (e.g. affordable, quality housing) and longer-term outcomes related to health status and health equity (lower rates of asthma among low-income children). Finally, incorporating evaluation into early planning phases encourages stakeholders to consider important questions related to needed resources and the capacity available for evaluation.

Sample Strategy

An organization called the Children and Families Commission of Orange County (CFCOC) provides a good example of using evaluation during the planning stages of an intervention. CFCOC was created as a result of Proposition 10 in California, where funding from a tax on tobacco products is used to support early childhood development for children ages 0-5. CFCOC's vision is that all children in Orange County) are healthy and ready to learn. Through an extensive planning process, CFCOC identified the following four goals:

1. Healthy Children – Promote the overall physical, social, emotional, and intellectual health of young children.

2. Early Learning – Provide early learning opportunities for young children to maximize their potential to succeed in school.

3. Strong Families – Support and strengthen families to promote good parenting for the optimal development of young children.

4. Capacity Building – Promote an effective and quality delivery system for young children and their families.

The planning process helped to clarify for the organization and its community stakeholders the importance of individual-level parental support and systems support (or the capacity of community-based organizations) for promoting the health and education of young children. Attention to evaluation in the early stages of planning allowed CFCOC to identify indicators of success pertinent to each goal, ensuring that stakeholders considered data sources and the capacity for data collection and analysis. By incorporating evaluation into the planning phase, CFCOC connected upstream factors and its ultimate vision. For Fiscal Year 2017-2018, CFCOC reported the following indicators of success along the path to their vision (CFCOC, 2018):

- Commission-funded programs raised, leveraged, or generated over $76 million to support or sustain services for children ages 0-5 years in Orange County and their families.
- The percentage of children ready for kindergarten increased a full percentage point.
- 96.4% of children participating in Commission-funded programs received all age appropriate immunizations.
- 99.8% of children participating in Healthy Smiles had no cavities at the end of services.
- 50.3% of children ages 0-5 years and their families who exited homelessness prevention services left to permanent housing.
- 1,770 children were linked to a place for regular medical care (a “health home”).

More information about CFCOC is at http://www.occhildrenandfamilies.com/.

In Delaware, the Nurse-Family Partnership (NFP) provides a similar example of a coordinated strategy that incorporates evaluation from the outset for meeting multiple objectives. Implemented by Children and Families First, the NFP is an evidence-based community health program that links newly pregnant, first-time mothers with a registered nurse. The nurse provides home visits throughout the woman’s pregnancy and during the first two years of the baby’s life. NFP has three distinct, but complementary, goals:

1. Improve pregnancy outcomes by helping women engage in good preventive health practices, including thorough prenatal care from their health care providers, improving their diets, and reducing their use of cigarettes, alcohol, and illegal substances.

2. Improve child health and development by helping parents provide responsible and competent care.

3. Improve the economic self-sufficiency of the family by helping parents develop a vision for their own future, plan future pregnancies, continue their education, and find work (NFP, 2017).

The program was launched in Delaware in 2010. Evaluation data revealed early success in terms of positive health outcomes for babies. As of 2017, 89 percent of babies served by the program were born full-term; 95 percent of babies received recommended immunizations by 24 months, and 84 percent of mothers in the program initiated breastfeeding (NFP, 2017).

Evaluating Complex Community Initiatives

The evaluation of comprehensive place-based initiatives, described in Section 5, is particularly challenging due to the complexity of this type of initiative as well as the uniqueness of communities. Thomas Kelly from the Annie E. Casey Foundation describes the essence of this challenge:

"Most comprehensive place-based initiatives consist of multiple interventions over a number of years at individual, group, institutional, social and political levels. Any one of these interventions could be an evaluation in and of itself, but with [this approach] you want to capture what matters" (Kelly, 2010, p. 19).

Based on his experience working with the evaluation of the Casey Foundation's Making Connections initiative, Kelly developed Five Simple Rules for Evaluating Complex Community Initiatives:

1. Evaluations of complex, major initiatives are not experiments but part of the community change process.

2. Evaluations need a strong focus on the processes of community change.

3. Evaluations need to measure ongoing progress toward achieving outcomes and results to help a community guide its change process and hold itself accountable.

4. Evaluations need to understand, document, and explain the multiple theories of change at work over time.

5. Evaluations need to prioritize real-time learning and the community's capacity to understand and use data from evaluations (Kelly, 2010).

A more detailed description of each of these rules, and strategies for accommodating them, can be found at http://www.frbsf.org/community-development/files/T_Kelly.pdf. Additional tools and resources to support evaluation of community-based health equity initiatives can be found in the Community Toolbox referenced in previous sections of this guide (https://ctb.ku.edu/en/table-of-contents/evaluate/evaluate-community-initiatives). Finally, the CDC provides links to a number of valuable resources for evaluation at http://www.cdc.gov/eval/resources/index.htm.

Evaluation Challenges

The process of evaluation can be tedious and confusing and is not free of barriers. Because a successful evaluation relies on the use of data collection and analysis, the barriers inherent in those processes are also applicable to evaluation (see 'Limitations of Data Collection and Analysis for Health Equity,' p. 96). In addition, the evaluation process is subject to other barriers, which are more likely due to the substantial partnering that is necessary during the evaluation process. Regarding health equity efforts, this process is also subject to barriers that arise due to the complexities involved in assessing long-term outcomes related to SDOH.

Ideally, the evaluation process begins during the planning phase of developing an intervention. Because this phase is often highly collaborative and involves input from numerous stakeholders and community members, the evaluation process is often subject to much debate. Therefore, public health practitioners and partners will benefit from clearly defining their desired outcomes and deciding on the appropriate measures for assessing these outcomes early in the planning phase. Similarly, by garnering buy-in for the evaluation process early on, stakeholders will be more likely understand the importance of the evaluation, and then later make changes (such as resource allocation and alterations in program design) when the evaluation results indicate room for improvement.

Specifically, in regard to the evaluation of health equity-focused interventions, it is important to understand the limitations of assessing interventions that target SDOH. Typically, grants are awarded for short-term interventions (i.e. three to five years), which stunts the ability to assess impacts on the SDOH, such as income level and educational attainment. Therefore, the evaluation process for such interventions should include measures that can be used to indirectly assess the likely impact on SDOH.

To overcome the challenges described in this section, practitioners may need to build upon traditional evaluation methods and consider alternate approaches. For instance, when logic models are used to guide program implementation and evaluation, they must incorporate equity-related activities and outcomes. Because changes in living conditions (such as an increase in the number of affordable housing units or an increase in average wages) may be the target of the intervention, they should also be the focus of the evaluation. Evaluators must recognize that changes in health outcomes related to changes in the physical and social environment may take several years, if not generations, to manifest. Although tools like logic models can be useful in articulating the expected long-term changes, evaluators may need to consider intermediate outcomes and unique measures as indicators of impact. Case studies and other qualitative evaluation methods, for instance, can be used to help demonstrate impact. Similarly, other types of tools related to evaluation of systems change, such as group model building, may be more appropriate for representing the complexity of SDOH and community-based interventions (Rosas & Knight, 2018). Finally, since health equity-focused interventions typically target culturally diverse groups, culturally appropriate tools and methodologies are essential to effective evaluation of health equity interventions (CDC, 2014). Information regarding culturally appropriate evaluation approaches is at https://www.cdc.gov/dhdsp/docs/cultural_competence_guide.pdf.

Evaluation is a critical component to achieving health equity and should be as multi-faceted, responsive, and flexible as the initiatives themselves (Preskill, Parkhurst, & Splansky-Juster, 2014). Practitioners and other community stakeholders should explore resources available to support evaluation, such as partnerships with universities and other research organizations. Additionally, because of the growing attention to health equity nationally, and the limited availability of evidence-based strategies for achieving health equity, federal agencies and national funders may be a resource for financial support and/or technical assistance. The U.S. Department of Health and Human Services' Office of Minority Health offers support for identifying funding sources in response to specific organizational needs (visit https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=1&lvlid=5). Similarly, other organizations maintain lists of available funding opportunities that are regularly updated. For instance, the Association of American Medical Colleges posts weekly updates of funding opportunities to support research on health disparities and health equity (visit https://www.aamc.org/initiatives/research/healthequity/350530/fundin-gandtrainingopportunities.html). Readers are encouraged to subscribe to electronic mailing lists that provide this information and conduct regular scans.

Research Priorities to Advance Health Equity

Experts and community leaders have identified several research priorities to support efforts to advance health equity. Among the most important is that researchers need to shift from a disparities model to an equity model (Srinivasan & Williams, 2014). This means greater attention should be paid to social and structural determinants of health, rather than individual risk factors. Similarly, more attention should be placed on evaluating solutions to health inequities that are driven by social, economic, and environmental factors.
Given some of the challenges highlighted above, research must be multi-disciplinary. Additionally, it is important to improve our research capacity for multi-factorial and multi-level analyses, as well as to address challenges related to statistical power and small sample sizes (Srinivasan & Williams, 2014). These methods require highly skilled statisticians and epidemiologists and often take more time and effort than traditional research, so building such a capacity requires targeted investments.

Improved research for health equity also requires meaningful community engagement and participation. Research is needed that reflects community priorities, is meaningful to the community, and is better connected to the lived experiences of the people most affected by health inequities (Knight, 2014). To this end, the National Stakeholder Strategy for Achieving Health Equity calls for investments in community-based participatory research and the evaluation of community originated intervention strategies (NPA, 2011). The report identified several specific objectives in this area, including the following:

- Identify and work with community-based organizations and programs to determine and disseminate replicable best and evidence-based practices for ending health disparities.

- Work with researchers and evaluators to develop useful and practical models for evaluating community-originated intervention strategies, including new metrics from interventions that reflect communities' immediate needs.

- Engage community members and enhance their capacity to be equal partners in the conceptualization, planning, design, implementation, interpretation, evaluation, and dissemination of public health interventions, programs, and initiatives; and

- Strengthen community ownership of data and research and evaluation products by promoting the principles of community-based participatory research (NPA, 2011, p. 135.)

Similar to the need for collaboration to develop health equity strategies, research for health equity must also be better coordinated. This includes working across sectors and building partnerships between academic or research institutions, state agencies, and community-based organizations. Finally, research must be translated and applied to advance health equity. As explained by the NPA (2011):

> "Knowledge transfer is challenging but obligatory. Often, findings that may be valuable to communities are published in journals, reports, and other formats that are not widely distributed to them or easily accessible to non-research audiences. Nontraditional media should be used to disseminate data and information to improve accessibility. Improving the health outcomes of minority and underserved communities will take the combined efforts of medical scientists, statisticians, anthropologists, economists, sociologists, epidemiologists, policy analysts, psychologists, social workers, community developers, and others working in collaboration with community organizations" (p. 133).

Delaware is making strides to conduct and translate community-based research. As mentioned in Section 6, the National Institutes of Health awarded Delaware a multi-year grant to enhance the state's capacity for clinical and translational research. Specifically, the DE-CTR ACCEL is a partnership between UD, CCHS , Nemours Health and Prevention Services/Alfred I. duPont Hospital for Children, and MUSC. Its goal is to improve the state's infrastructure and capacity for conducting research that leads to better clinical outcomes and applying knowledge about effective interventions in the clinical setting. The DE-CTR is part of the ACCEL program, which represents a long-term research partnership that can be leveraged to enhance the research and evaluation capacity needed for health equity. More specifically, community engagement and outreach is a priority for the ACCEL program, and can be an important avenue for health equity-oriented research. For more information about the DE-CTR ACCEL program and related funding and research opportunities, visit https://de-ctr.org/.

Finally, from a translation and application perspective, research is needed that makes clearer linkages for the public and policymakers about the connection between policy decisions and health, including the ways in which public policy has contributed to racial health inequities. Powerful ideologies and preexisting assumptions about the role of behavior, health care, and individual responsibility must be overcome to promote the changes needed to advance health equity. HIAs and REIAs are valuable tools for addressing this challenge. Other approaches include providing training and technical assistance to professional associations, foundations, advocacy groups, and community organizations on how to interpret and use research and evaluation findings to inform their decisions and program designs (NPA, 2011, p. 137). As a standard of practice among researchers and evaluators and their sponsors, the NPA (2011) recommends promoting strategies to make findings accessible, easily understood, and used by policymakers and the public to inform programming and services (NPA, 2011, p. 137).

Finally, resources are emerging to help health departments in particular advance health equity. Healthequityguide.org is a web-based resource with a number of tools, case studies, and other information to support public health departments working to achieve health equity. Among the key strategies recommended by Human Impact Partners, the organization supporting this effort, is to "mobilize data, research and evaluation." Visit their website for case studies and tools supporting this strategy: https://healthequityguide.org/strategic-practices/mobilize-data-research-evaluation/.

Glossary - Section 8

Community-Based Participatory Research (CBPR): An approach to research that involves an equitable partnership between and among community members and researchers in all aspects of the research process and in which all partners contribute expertise and share decision-making and ownership. The aim of CBPR is to increase knowledge and understanding of a given phenomenon and integrate the knowledge gained with interventions, policy, and social change to improve the health and quality of life of community members.

Evaluation: A systematic way to improve and account for public health actions. It can be used to judge the impact of a particular intervention as well as describe and improve the process of implementation.

Geographic Information Systems (GIS): A computer system designed to capture, store, manipulate, analyze, manage, and present all types of spatial or geographical data. GIS may be used to develop maps that present health data according to place.

Health Impact Assessment (HIA): A systematic process that uses a variety of data sources and research methods, and considers input from a range of stakeholders to determine the potential effects of a proposed policy, plan, or action on the health of a population and the distribution of those effects within the population.

Place-based initiative (PBI): A social change effort that is concentrated in a specific geographic area. Health equity strategies focused on living conditions in a specific geographic community are often referred to as PBIs because the target of the interventions is the place itself (or characteristics of the place), rather than the people living there.

Racial Equity Impact Assessment (REIA): A systematic examination of how different racial and ethnic groups will likely be affected by a proposed action or decision.

Surveillance: The continuous, systematic collection, analysis, and interpretation of health-related data needed for the planning, implementation, and evaluation of public health efforts.

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SECTION 9: Leadership for Health Equity

This guide was originally developed with a specific audience in mind: professionals within DPH. However, the strategies needed for advancing health equity require partnerships across many different kinds of organizations and disciplines. Similarly, public health practitioners and advocates work in a variety of non-profit organizations, not solely within state agencies. For these reasons, the title, purpose, and contents were adapted accordingly, with the target audience broadly defined as public health practitioners and partners. These groups were identified, in part, because of their roles as leaders in advancing health equity.

Leadership can be defined in different ways. For the purposes of this guide, "leadership is a process whereby an individual influences a group of individuals to achieve a common goal" (Northouse, 2007, p. 3). This definition is important as it draws attention to leadership as an action instead of a trait possessed by an individual. This means that leadership is about interactions between people and implies that leadership is available to everyone and is not restricted to people with innate or special characteristics (Northouse, 2007, pp. 3-4).

Finally, this definition highlights the importance of influence since mobilizing others to reach a common goal is central to the concept of leadership.

With respect to this guide, the common goal is to promote health equity. More specifically, DPH's vision is for all Delawareans to achieve their full health potential. The various strategies and recommendations outlined in this guide are meant to move Delawareans closer to this common goal. However, as noted by Dr. Rattay in her foreword, these kinds of changes will not be easy. Achieving health equity is challenged, in part, by the fact that health inequities are caused by multiple factors such as access to resources, discrimination (include racism), and health-related behaviors operating on multiple levels (e.g. individual, neighborhood, state, etc.). There is not always agreement about who is responsible (e.g. individuals or societies/governments) or what should be done to address them. Further, when it comes to structural racism and white privilege, these conversations become even more challenging. These characteristics suggest that health inequities may be defined as a "wicked problem." A wicked problem is a social problem that is difficult[5] to solve for a number of reasons, including:

- Wicked problems are difficult to clearly define.
- Wicked problems have many interdependencies and are often multi-causal.
- Attempts to address wicked problems often lead to unforeseen consequences.
- Wicked problems are often not stable.
- Wicked problems usually have no clear solution.
- Wicked problems are socially complex.

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[5] Wicked problems are often described as impossible to solve, but we, the authors of this guide, believe that health equity is attainable

- Wicked problems hardly ever sit conveniently within the responsibility of any one organization.

- Wicked problems involve changing behavior.

- Some wicked problems are characterized by chronic policy failure (Australian Public Service Commission, 2007, pp. 3-5).

Creating meaningful change to address the wicked problem of health inequities and advance health equity requires leadership of public health practitioners and partners alike. In particular, collaborative leadership will be required to achieve health equity. Among other things, collaborative leaders build broad-based support, engage with coalitions, empower and catalyze systems change, work across boundaries, and demonstrate a sustained commitment to a collective vision. Collaborative leaders build upon the theory of "collective impact," which is the synergy that can result from organizations working together towards common goals (Kania & Kramer, 2011).

No single organization can create large-scale, lasting social change alone. Therefore, addressing the multiple determinants of health requires working across sectors. Organizations working across sectors and at the community level to tackle multiple determinants of health will likely engage in various activities, all of which may occur simultaneously. For more information about wicked problems and collaborative leadership, see materials from the Australian Public Service Commission (2007) and Beinecke (2009).

This section briefly highlights some of the important leadership roles needed by different kinds of organizations working across Delaware. Many of the organizations highlighted earlier (and others that were not) are demonstrating collaborative leadership, but more is needed to achieve health equity in Delaware. This concluding section is a discussion of the role that individuals, especially individuals with privilege, can play as leaders to advance health equity in Delaware and beyond.

Public Health Practitioners and Organizations as Leaders

Public health organizations — whether they are community-based organizations, health care providers, or governmental agencies — have an important leadership role to play in advancing health equity. As the experts on health, causes of poor health, and interventions to improve health, public health professionals have "legitimate power" which can be used to influence others (Northouse, 2007). This is particularly important when working across sectors, as their health-related knowledge and expertise are considered the most credible. Public health professionals can use this legitimate power to inform policy and implement practices that are likely to positively impact health and health equity. Medical doctors, for example, are often seen as credible sources of health-related information and can use their legitimate power to lend support for equity-oriented initiatives, while encouraging others to do the same.

Health professionals can also lead by making changes within their own organizations. According to the National Collaborating Centre for Determinants of Health (2013), health equity-oriented changes can be applied to every aspect of how a public health organization operates. At the program level, a health equity lens can be applied to how needs are assessed, and programs are planned, implemented, and evaluated (as discussed in previous sections). Practically, this includes reviewing whom the services are reaching and/or who is benefitting from the programs, and who is not being reached. This may include ensuring that individuals from communities that experience disadvantages are involved in the planning and evaluation of programs that affect them.

At the organizational level, a health equity lens can influence how priorities are set and how resources are allocated. State and local health departments can begin by undertaking an organizational self-assessment for addressing health inequities (Bay Area Regional Health Inequities Initiative, 2010; Bay Area Regional Health Inequities Initiative, 2014). Conducting such an assessment helps organizations identify internal areas for change. Examples of organizational level changes include things like changing hiring practices to recruit and retain more racial and ethnic minorities, incorporating more staff training on culturally competency, and adapting grant/contract funding mechanisms that require bidders to specifically address health inequities in their proposals. Additionally, hospitals can direct their community benefit resources to communities most in need and other health-related organizations can incorporate an equity lens into their strategic planning processes.

Leadership from public health agencies is particularly important in relation to policy change and advocacy. (For examples of health equity-oriented policy changes across many sectors, visit Section 6.) While these examples are based upon scientific evidence linking environmental and social conditions to health, policy change is rarely a rational process driven by science. Even the existence of a strong evidence base is often insufficient to change policy; therefore, policy change requires advocacy.

Advocacy is simply defined as the process through which an individual or group tries to influence policy. The term advocacy often takes on a negative connotation, and many public and non-profit health professionals shy away from engaging in the political process. In some instances, professionals are legally prohibited from engaging in certain forms of advocacy, but there are often opportunities for health professionals to play a role tangent to advocacy. Health professionals can consider their role in interpreting and communicating what has been learned through public health research with the public and policymakers as a form of research translation. It is common for public health practitioners to encourage people to prevent obesity and related conditions by becoming more physically active and eating more nutritious diets, which are behavioral changes based upon scientific evidence. Advocacy of this nature can similarly be applied to the SDOH. As one expert noted:

> “We really have to re-explore what are the limits of our advocacy…what are we willing to take a stand on and say it is good for the public health, like prenatal care and WIC [Women, Infants, Children]… Can we expand that kind of health advocacy to include housing and poverty?” (Knight, 2014, p. 192).

Raising awareness about the SDOH, and structural racism as a determinant of racial health inequities, is a form of education but it can also be a form of advocacy. Being proactive about such advocacy, including having a well-developed communications strategy, can be particularly effective when partnering with others who can engage in stronger forms of advocacy, such as the Delaware Public Health Association (see http://de-pha.org/).

Authentic partnerships with community-based organizations and other state agencies are critical for advancing health equity. This truth holds in regard to advocacy, as well. Representatives from state agencies must support both internal and external partners to advance shared goals. Public health leaders should accept that it is not always necessary to make stakeholders aware of the health implications of a given proposal or policy action. For instance, ensuring ongoing support at the state level for affordable, quality early care and education could be viewed through the lens of health equity. However, public health advocates can support early care and education initiatives without drawing attention to the health impacts. Sometimes raising awareness of the health impacts can broaden the base of support, but it can also unnecessarily complicate the debate. Unfortunately, there are no hard rules about when to raise health-related concerns and when to support partners' efforts from the sidelines. Involvement must be considered on a case-by-case basis.

Understandably, health equity-related work may require that the public health workforce develop new skills, knowledge, and competencies. In addition to this guide's many resources, several online training programs support public health organizations and individual practitioners in this regard, including:

- The Roots of Health Inequity: A web-based course for the public health workforce, (NACCHO, 2019) retrieved from http://www.rootsofhealthinequity.org/.

- PH101 Dialogue Series from the Alameda County Public Health Department (2009) retrieved from http://www.acphd.org/social-and-health-equity/organizational-transformation/trainings-and-dialogues/ph101.aspx

- Addressing Health Equity: A Public Health Essential from the Empire State Public Health Training Center (2012) retrieved from https://phtc-online.org/learning/?courseId=41. An updated version is expected in fall 2019.

Other Kinds of Organizations as Leaders

Leadership for health equity can reside within organizations not explicitly focused on health. This is largely due to health equity being about fairness and justice and indistinguishable from equity in general (Knight, 2014, p. 191). Therefore, the common goal or vision may be expanded to encompass social justice broadly. The need for collaborative leadership speaks to the value of having many kinds of community-oriented efforts working towards social justice. Furthermore, organizations that recognize the value of collective impact (described in Section 5), and help to facilitate collaborative, community-based efforts, can be leaders in advancing health equity. For more information about how to bring an equity lens to collective impact, visit https://ssir.org/articles/entry/the_equity_imperative_in_collective_impact#.

It is also important to recognize that not all changes need to be part of a large, coordinated strategy. Creating the kinds of social and cultural shifts that are necessary for health equity requires changes on all levels. Small changes matter, many different groups can play a part, and leadership comes in different shapes and sizes. Another way to view this is that effective leadership can be task-specific. For example, individuals working in organizations can consider ways to promote health equity as tasks or decisions arise. The UD educates many students who will secure jobs and remain in Delaware after graduation. Whether they work in a health-related organization or discipline or not, their understanding of SDOH and awareness of the magnitude and nature of health inequities in Delaware is important to advance health equity. For this reason, the Introduction to Public Health class at UD, which is open to the entire student body, incorporates a strong focus on these issues. This was a conscious decision on the part of the instructor (who is also the lead author of this guide).Other examples include when individual business owners choose to pay their employees a living wage, or when faith-based organizations work with each other to promote understanding and tolerance. Each of these decisions and actions can contribute to broader social and cultural changes, ultimately moving the state closer to the vision of health equity.

Individuals as Leaders

Leadership is generally ascribed to individuals or groups of individuals. Power is also a concept closely tied to leadership since it is related to the process of influencing others (Northouse, 2007). Because leadership is a process open to everyone, each person has the potential power to make change.

The idea that individuals possess power to influence change is important because the root causes of health inequities are often tied to differences in power and privilege among different groups of people. In the original version of this guide, we only made brief mention of issues related to class, race and power that underlie social inequities in favor of more tangible steps. We rationalized this with the assertion that the kinds of social and political changes needed to address issues such as structural racism do not lend themselves to a "how to" guide. However, in revising this guide, it became clear that neglecting such important topics such as power, privilege and racism was unacceptable. For if health equity — including the elimination of racial health inequities — is our vision, then these powerful issues must be confronted. As described by Human Impact Partners, "We must lead explicitly — though not exclusively — with race because racial inequities persist in every system across the country, without exception" (Human Impact Partners, n.d.).

We cannot lose sight of all of the various systems of oppression that are deeply embedded in our culture. For example, our culture tends to value males over females, whites over blacks, heterosexual individuals over gay men and lesbians, young over old, and able-bodied individuals over those with access and functional needs. Unfortunately, "built into the very fabric of our society are cultural values and habits which support the oppression of some persons and groups of people by other persons and groups. These systems take on many forms but they all have essentially the same structure" and are root causes of health inequity (Just Conflict, n.d.).

Although part of the broader, wicked problem of social injustice and inequity, there are practical daily steps that individuals can take to contribute to positive social change. Individuals can work toward social justice and promote health equity by being an “ally.” Social justice allies are “members of dominant social groups (e.g., men, whites, heterosexuals) who are working to end the system of oppression that gives them greater privilege and power based on their social- group membership” (Broido, 2000, p. 3). Allies work with those from the oppressed group in collaboration and partnership to end the system of oppression (Edwards, 2006, p. 51). Frances Kendall, an author and consultant for organizational change specializing in issues of diversity and white privilege (see www.franceskendall.com), explains this more simply:

> “Those of us who have been granted privileges based purely on who we are born (as white, as male, as straight, and so forth) often feel that either we want to give our privileges back, which we can’t really do, or we want to use them to improve the experience of those who don’t have our access to power and resources. One of the most effective ways to use our privilege is to become the ally of those on the other side of the privilege seesaw. This type of alliance requires a great deal of self-examination on our part as well as the willingness to go against the people who share our privilege status and with whom we are expected to group ourselves” (Kendall, 2003).

Being an ally is a unique form of collaborative leadership. Kendall offers a number of recommendations and examples for how to be an ally. These are reproduced as Figure 44, with permission from Kendall. Note that the examples provided focus largely on the oppression of black individuals and are geared towards individuals with the privilege of having white skin. However, the recommendations are applicable to many forms of social and economic privilege and systems of oppression.

Figure 44: How to be an Ally.

1. **Allies** work continuously to develop an understanding of the personal and institutional experiences of the person or people with whom they are aligning themselves. If the ally is a member of a privileged group, it is essential that she or he also strives for clarity about the impact of privileges on her or his life. What this might look like:
   - Consistently asking myself what it means to be white in this situation. How would I experience this if I were of color? Would I be listened to? Would I be getting the support I am getting now? How would my life be different if I were not white/ male/ heterosexual/ tenured/ a manager?
   - Closely observing the experiences of people of color in the organization: how they are listened to, talked about, promoted, and expected to do additional jobs.

2. **Allies** choose to align themselves publicly and privately with members of target groups and respond to their needs. This may mean breaking assumed allegiances with those who have the same privileges as you. It is important <u>not</u> to underestimate the consequences of breaking these agreements and to break them in ways that will be most useful to the person or group with whom you are aligning yourself. What this might look like:
   - Speaking out about a situation in which you don't appear to have any vested interest: "Jean, there are no women of color in this pool of candidates. How can we begin to get a broader perspective in our department if we continue to hire people who have similar backgrounds to ours or who look like us?"
   - Interrupting a comment or joke that is insensitive/stereotypic toward a target group, whether or not a member of that group is present. "Lu, that joke is anti-Semitic. I don't care if a Jewish person told it to you; it doesn't contribute to the kind of environment I want to work in."

3. **Allies** believe that it is in their interest to be allies and are able to talk about why this is the case. Talking clearly about having the privilege to be able to step in is an important educational tool for others with the same privileges. What this might look like:
   - Regularly prefacing what I am about to say with, "As a white person, I [think/ feel/ understand/ am not able to understand...]" By identifying one of my primary lenses on the world I let others know that I am clear that being white has an impact on how I perceive everything.

4. **Allies** are committed to the never-ending personal growth required to be genuinely supportive. If both people are without privilege it means coming to grips with the ways that internalized oppression affects you. If you are privileged, uprooting long-held beliefs about the way that the world works will probably be necessary. What this might look like:
   - Facing in an on-going way the difficult reality of the intentionality of white people's treatment of people of color, both historically and currently. In order to be an ally, I must hold in my consciousness what my racial group has done to keep us in positions of power and authority. This is not about blaming myself or feeling guilty. In fact, I think guilt is often self-serving; if I feel terribly guilty about something, I can get mired in those feelings and not take action to change the situation. Staying conscious of our behavior as a group moves me to take responsibility for making changes. It also gives me greater insight into the experiences of those with whom I align myself.

Figure 44: How to be an Ally (cont.)

5. **Allies** are able to articulate how various patterns of oppression have served to keep them in privileged positions or to withhold opportunities they might otherwise have. For many of us, this means exploring and owning our dual roles as oppressor and oppressed, as uncomfortable as that might be. What this might look like:
    - Seeing how my whiteness opened doors to institutions that most probably would not have opened so easily otherwise. Understanding that as white women we are given access to power and resources because of racial similarities and our relationships with white men, often at the expense of men and women of color. While we certainly experience systemic discrimination as women, our skin color makes us less threatening to the group which holds systemic power.

6. **Allies** expect to make some mistakes but do not use that as an excuse for inaction. As a person with privilege, it is important to study and to talk about how your privilege acts as both a shield and blinders for you. Of necessity, those without privileges in a certain area know more about the specific examples of privilege than those who are privileged. What this might look like:
    - Knowing that each of us, no matter how careful or conscious we are or how long we have been working on issues of social justice, is going to say or do something dumb or insensitive. It isn’t possible not to hurt or offend someone at some point. Our best bet is to acknowledge to others our mistakes and learn from them.
    - Keeping a filter in your mind through which you run your thoughts or comments. Remarks such as, "If I were you..." or "I know just how you feel..." are never very helpful in opening up communication, but, in conversations in which there is an imbalance of privilege, they take on an air of arrogance. People with privilege can never really know what it is like to be a member of the target group. While I can sympathize with those who are of color, it is not possible for me truly to understand the experience of a person of color because I am never going to be treated as they are. The goal is to show someone you are listening, you care, and you understand that being white causes you to be treated differently.

7. **Allies** know that those on each side of an alliance hold responsibility for their own change, whether or not persons on the other side choose to respond or to thank them. They are also clear that they are doing this work for themselves, not to "take care of" another. What this might look like:
    - Examining continually the institutional and personal benefits of hearing a wide diversity of perspectives, articulating those benefits, and building different points of view into the work we do.
    - Interrupting less-than-helpful comments and pushing for an inclusive environment. We do it because we, as well as others, will benefit. We do not step forward because we think we should or because the people without our privileges can’t speak for themselves or because we want to look good. We are allies because we know that it is in our interest.

8. **Allies** know that, in the most empowered and genuine ally relationships, the persons with privilege initiate the change toward personal, institutional, and societal justice and equality. What this might look like:
    - Assessing who is at least risk to step into a situation and initiate change, conferring with others who are at greater risk about the best strategies, and moving forward. Our moves should be carefully designed to have the greatest impact.
    - Understanding that this is not another opportunity to take charge. Ally relationships are just that: relationships. Together with the people who aren’t privileged, we choreograph who makes which moves and when they will be made.

Figure 44: How to be an Ally (cont.)

9. **Allies** promote a sense of inclusiveness and justice, helping create an environment hospitable for all. What this might look like:
   - Recognizing the expectation that people of color will address racism, women will take care of sexism, and gay men and lesbians will "fix" heterosexism in the organization and, in their stead, becoming the point person for organizational change on these issues. Clues that this assumption is operating include: the Diversity Committee is composed predominantly of people of color and white women, while those with greater decision-making power are on the "important" committees; or the majority of people pushing for domestic partner benefits are gay or lesbian.

10. **Allies** with privilege are responsible for sharing the lead with people of color in changing the organization and hold greater responsibility for seeing changes through to their conclusion. Sharing the lead is very different form taking the lead. What this might look like:
    - Working to build a strategic diversity plan for the organization, tying it to the organization’s business plan, and assuring that the plan is implemented.
    - Assessing current policies and procedures and changing them so that they don’t differentially impact groups of people.

11. **Allies** are able to laugh at themselves as they make mistakes and at the real, but absurd, systems of supremacy in which we all live. As many oppressed people know, humor is a method of survival. Those with privilege must be very careful not to assume that we can join in the humor of those in a target group with whom we are in alliance. What this might look like:
    - Appreciating that there are times when laughing together is the only thing we can do.
    - Paying attention to the boundaries of who-can-say-what-to-whom: While it may be OK for a person of color to call me his "white sister," it would be presumptuous for me to call him my "Latino brother.”

12. **Allies** understand that emotional safety is not a realistic expectation if we take our alliance seriously. For those with privilege, the goal is to "become comfortable with the uncomfortable and uncomfortable with the too- comfortable" and to act to alter the too-comfortable. What this might look like:
    - Being alert to our desire to create a "safe" environment for an interracial conversation. My experience is that when white people ask for safety they mean they don’t want to be held accountable for what they say, they want to be able to make mistakes and not have people of color take them personally, and they don’t want to be yelled at by people of color. Those of us who are white are almost always safer, freer from institutional retribution, than people of color. That knowledge should help us remain in uncomfortable situations as we work for change.

13. **Allies** know the consequences of not being clear about the Other’s experience, including lack of trust and lack of authentic relationships. For allies with privilege, the consequences of being unclear are even greater. Because our behaviors are rooted in privilege, those who are in our group give greater credence to our actions than they might if we were members of groups without privilege. Part of our task is to be models and educators for those like us. What this might look like:
    - Understanding that because we don’t see a colleague of color being mistreated doesn’t mean that daily race-related experiences aren’t occurring. I often hear white people make comments such as, "Well, my friend is Black but he’s beyond all this race stuff. He is never treated poorly." Comments such as these alert a person of color to the fact that we don’t have those experiences, we can’t imagine other people having them, and therefore put little credence in

the stories that people of color share. If we are to be genuine allies to people of color, we must constantly observe the subtleties and nuances of other white people's comments and behaviors just as we observe our own. And we must take the risk of asking, "What if I am wrong about how I think people of color are being treated in my institution? What can I do to seek out the reality of their experiences? How will I feel if I discover that people I know, love, and trust are among the worst offenders? And what will I do?"

Source: Kendall, 2003.

Conclusion

Leadership on multiple levels, across many different kinds of organizations and sectors, and even among interpersonal relationships, is necessary for the kinds of changes needed for achieving health equity. Armed with the knowledge and resources presented in this guide, public health practitioners and partners should:

1. Embrace a broad definition of health and the determinants of health and encourage others to do the same.

2. Make available continuous training and professional development opportunities around health equity.

3. Ensure a culturally competent, culturally focused, and linguistically diverse workforce.

4. Make equity a priority by regularly identifying opportunities to incorporate health equity strategies into their work.

5. Move efforts upstream, when appropriate, for the greatest impact, but recognize the value of the full continuum of strategies needed to achieve health equity.

6. Incorporate health equity strategies into grant applications and set aside funding specifically for health equity work.

7. Invite non-traditional partners to advance their health equity goals and support partners' efforts in-kind.

8. Build and maintain authentic partnerships with communities throughout all steps of a health equity effort.

9. Incorporate measures of health equity and the social determinants of health into their existing and future work and analyze data accordingly.

10. Evaluate their work and remain accountable for advancing health equity; hold others accountable, in turn.

11. Be willing to commit for the long term and find support among colleagues to maintain the effort; celebrate success along the way.

12. Be a collective leader and ally; participate in a network of support to advance equity.

A variety of changes on many different levels are required to advance health equity in Delaware. This guide presents a number of promising practices and resources to facilitate such changes. There is positive momentum at the national level, in communities across the country, and in Delaware specifically. Given the moral and ethical imperative that Dr. Rattay referenced in her foreword, each Delawarean has a responsibility to use our power and privilege to move towards this common goal. Over time and through our collective efforts, we will realize the vision that all Delawareans will achieve their full health potential.

Glossary - Section 9

Advocacy: The process through which an individual or group tries to influence policy and decision making.

Ally: A member of a dominant social group (e.g., men, whites, heterosexuals) who is working to end the system of oppression that gives him or her greater privilege and power based on membership in that social group

Collaborative leadership: A form of leadership that builds broad-based support, engages coalitions, empowers and catalyzes systems change, works across boundaries, and demonstrates a sustained commitment to a collective vision.

Collective impact: Collaboration across disciplines and sectors to solve complex social problems. It is grounded in the premise that no single organization can create large- scale, lasting social change alone.

Leadership: A process whereby an individual influences a group of individuals to achieve a common goal or vision.

Wicked problem: A social problem that is particularly difficult to solve because of its complexity, dynamic and contradictory nature, and interconnected relations with other problems.

White Privilege: A system of benefits, advantages, and opportunities experienced by White persons in our society simply because of their skin color (Donnelly et al., 2005). As described by McIntosh (1989), white privilege may also be conceived as “an invisible package of unearned assets that [a white person] can count on cashing in each day, but about which [they] were ‘meant’ to remain oblivious. White privilege is like an invisible weightless knapsack of special provisions, assurances, tools, maps, guides, codebooks, passports, visas, clothes, compass, emergency gear, and blank checks.”

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