FOUNDATIONAL PRACTICES for HEALTH EQUITY

A Learning and Action Tool for Public Health Organizations

2018

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EVOLUTION OF THE FOUNDATIONAL PRACTICES FOR HEALTH EQUITY LEARNING AND ACTION TOOL

The original version of this document – *Foundational Practices for Health Equity: A Learning and Action Tool for State Health Departments 2016* – was developed over a period from 2014 through 2016 as a part of the Social Determinants of Health Team for the Region V Collaborative Improvement and Innovation Network (COIIN) on Infant Mortality.

Subsequently, the *Foundational Practices for Health Equity: A Learning and Action Tool, for State Health Departments 2016 (Learning and Action Tool),* was piloted among a small group of state health departments and a formative evaluation was conducted by the Michigan Public Health Institute (MPHI) with input and funding from NICHQ and AMCHP. The goal of this evaluation was to inform improvements to the Learning and Action Tool and its instructions, as well as evaluate the document's usefulness in achieving better outcomes in advancing health equity. Three state health departments participated in the pilot by way of key informant interviews, a focus group, and through an online survey during March – August 2017.

Evaluation results showed that states decided to pilot the *Learning and Action Tool* because it complemented existing work already occurring in their organization to advance health equity. The pilot states reported that employing foundational practices in their equity efforts provided a clear and complete organizational structure for the work. States found it helpful to work through the critical capabilities by way of a set of questions and reported that this approach spurred valuable discussion.

While all of the states found it difficult to devote enough time to implementing the *Learning and Action Tool*, they all saw value in using the *Learning and Action Tool* and planned to continue its use beyond the time-period of the pilot.

The identified outcomes from this engagement included:

- Generating dialogue
- Learning challenging concepts
- Building competencies in advancing health equity
- Laying the groundwork for taking actionable steps to improve health equity

Suggestions from the pilot evaluation are incorporated within the current document: *Foundational Practices for Health Equity: A Learning and Action Tool for Public Health Organizations 2018* in order to improve the *Learning and Action Tool 2016*.

The evaluation findings demonstrate the promise of the *Learning and Action Tool* in advancing health equity in state public health departments. The contributors of the current, revised version also recommend use for a continuum of public health organizations – including local health departments and community-based public health organizations – as a means for improving practice and moving toward health equity.

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Introduction

Public health attention nationally and internationally is turning to the root causes of poor health: inequities in social and economic conditions. *The Foundational Practices for Health Equity: A Learning and Action Tool for Public Health Organizations 2018* (*Learning and Action Tool 2018*) is designed to build the capacity of public health organizations and their partners to advance health equity and create the conditions for better health across the life span.[1]

The *Learning and Action Tool 2018* applies a framework – developed by the Commission on Social Determinants of Health (CSDH) of the World Health Organization (WHO) – to collective efforts to improve health by focusing action on underlying policy, systems, and environmental, social and economic conditions, such as income and education, which are structural and systemic in nature.

A health equity perspective is one in which public health practitioners understand and act on the relationship between social determinants of health, health inequities, and resulting health disparities. Bringing a health equity perspective to our public health work is critical if we are going to achieve our goal to eliminate health inequities. Indeed, without an explicit focus on equity, some public health population-level interventions may actually increase inequities and result in increased health disparities for less advantaged groups.[2]

MOVING TOWARD PRACTICE

The *Learning and Action Tool 2018* can be useful for a continuum of health agency staff from executives to directors and managers as well as those planning continuous quality improvement efforts and community engagement strategies. Use of the foundational practices lays the groundwork for multiple plans and assessments including but not limited to:

- Statewide or local community health assessments
- Public health agency strategic plans
- Preparation for public health accreditation
- Development and incorporation of equity related data measures

Efforts to transform underlying systems using a health equity perspective will require new practices and may encounter resistance from entrenched political, economic, and cultural forces. The *Learning and Action Tool 2018* is intended to introduce a set of practices that will strengthen and support public health leaders and organizations in their efforts to advance health equity.

The *Learning and Action Tool 2018* will assist public health organizations to do the following:

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[1] The *Learning and Action Tool* 2016 was initially developed as part of the HRSA Collaborative Improvement & Innovation Network (CoIIN) to Reduce Infant Mortality. This partnership supports efforts to reduce infant mortality and improve birth and early childhood outcomes. Participants learn from one another and national experts, share best practices and lessons learned, and track progress toward shared benchmarks. While the CoIIN was focused specifically on improving birth outcomes, this *Learning and Action Tool 2016* focus was broader, including not only the ways in which public health organizations, working with diverse and committed partners, can help improve health outcomes for mothers and babies, but ways in which organizations can advance health equity broadly, thereby helping improve health outcomes for all, and reduce health inequities across a wide variety of health conditions and populations. This broad focus continues with the 2018 version as well.

[2] Lorenc T., Petticrew M., Welch, V., Tugwell P. (2013). What types of interventions generate inequalities? Evidence from systematic reviews. *J Epidemiology Community Health*. 67:190–193.

- Introduce a set of foundational practices to advance health equity within their organization and with partners
- Identify and document the organization's current capabilities and practices in the area of health equity and determine areas for development and action
- Track improvements and changes in capabilities and practices
- Transform public health practices to advance health equity

The *Learning and Action Tool 2018* assists public health organizations translate theory into action and is designed to support a dynamic process of learning and continuous improvement.

KEY CONCEPTS AND DEFINITIONS

The work of advancing health equity is guided by a set of important concepts and definitions.

Health, according to the WHO, "is a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity."[3] Good health is a result of multiple factors, including social, economic and physical environments, individual behaviors, genetics, and access to systems such as education and health care.[4] Better health offers greater quality of life, higher levels of function, and greater potential for productivity, with substantial benefits to individuals, families, communities and society as a whole. Health is a fundamental human right, recognized in the Universal Declaration of Human Rights (1948).[5] Health is also an essential component of development, vital to a nation's economic growth and internal stability."[6] *Full health potential* may be understood as the highest level of health an individual may reach without limits imposed by racial, social and economic inequities.

Health Disparities are population-based differences in health outcomes (e.g., breast cancer rates are higher among women than men). Although the term *disparities* is often interpreted to mean racial or ethnic disparities, many dimensions of disparity exist in the United States, particularly in health. If a health outcome is seen to a greater or lesser extent between populations, there is disparity. Discrimination based on race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual's ability to achieve good health [7] and may contribute to health disparities. Additionally, the term "disparities" does not address the underlying chain of factors driving most difference in health across populations.

Health inequities/health equity. *Health inequities* are "differences in health status between more socially advantaged and less socially advantaged groups, caused by systematic differences in social conditions and processes that effectively determine health;[8] health inequities are not only unnecessary

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[3] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

[4] Center for Urban Population Health. Retrieved from www.cuph.org

[5] UN General Assembly, *Universal Declaration of Human Rights*, 10 December 1948, 217 A (III), available at: http://www.refworld.org/docid/3ae6b3712c.html [accessed 1 February 2016]

[6] World Health Organization. Trade, Foreign Policy, Diplomacy and Health. Retrieved from: http://www.who.int/trade/glossary/story046/en/

[7] Healthy People 2020. Retrieved from: https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

[8] Braveman, P. (2003). Defining equity in health. *J Epidemiology and Community Health*, *57*, 254-258

and avoidable but are considered unfair and unjust."[9] The WHO defines health inequities as "health differences, which are socially produced."[10] According to Healthy People 2020, when we achieve *health equity*, every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances."[11] Moreover, 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 health care disparities."[12]

MOVING TOWARD PRACTICE

Language used to describe social determinants of health includes phrases such as, "the conditions for health," "the social and economic conditions in which people can be healthy," and other phrases that describe the contextual factors that shape health. Having multiple ways of speaking about and describing the social determinants of health helps to convey these important concepts to the many partners and audiences involved in advancing health equity.

Narrative. A narrative is a story or report of connected or thematically related events. Narratives are the way a group of people frame a shared understanding of an idea, an event, or a phenomenon. If the narrative is to have resonance, it must convey values and beliefs, as well as core ideas. Narratives influence and are influenced by data collection and analysis and action. A *public narrative* often becomes apparent in public discussions or policy-making. A *dominant public narrative* eclipses other public narratives and has the most power to shape what people believe is possible, and therefore what actions they take.

Social Determinants of Health. The circumstances in which people are born, grow, live, work, and age. Social determinants interact with individual behavior and shape the choices that are available. The WHO CSDH states that these "material circumstances" (living and working conditions) are in turn shaped by a wider set of forces: economic, social, and other public policies such as education, labor market, and housing. Governance and politics (including dynamics of power and decision-making) are forces that effectively enhance or impede access to life chances and opportunities for health based on socioeconomic position (i.e., socially-determined hierarchies of advantage and disadvantage such as race/ethnicity, class, and gender).[13]

Structural inequities. Structures or systems of society — such as finance, housing, transportation, education, health care, social opportunities, etc. — that are structured, typically through policies and

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[9] Eliminating Disparities in Child and Youth Success Collaborative (2014). *Tool for Organizational Self-Assessment Related to Racial Equity*. Retrieved from http://coalitioncommunitiescolor.org/wp-content/uploads/2014/06/Tool-for-Organizational-Self-Assessment-Related-to-Racial-Equity-2014.pdf

[10] CSDH (2008). *Closing the gap in a generation: health equity through action on the social determinants of health.* Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization Retrieved from http://apps.who.int/iris/bitstream/10665/43943/1/9789241563703_eng.pdf

[11] Whitehead M, Dahlgren G. Levelling Up (Part 1): A Discussion Paper on Concepts and Principles for Tackling Social Inequities in Health. World Health Organization. Retrieved from: http://www.euro.who.int/document/e89383.pdf.

[12] USDHHS, Office of Minority Health (2011). *The National Partnership for Action to End Health Disparities*. Available at http://minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=34

[13] CSDH (2008). *Closing the gap in a generation: health equity through action on the social determinants of health.* Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization Retrieved from http://apps.who.int/iris/bitstream/10665/43943/1/9789241563703_eng.pdf

systems, such that they unfairly benefit one population and unfairly disadvantage other populations (whether intended or not).

Structural racism involves an array of structural and system inequities — historical, cultural, institutional and interpersonal — that routinely advantage white people while producing cumulative and chronic adverse outcomes for people of color and American Indians.

A FRAMEWORK FOR IMPROVING HEALTH OUTCOMES FOR CHILDREN AND ADULTS

Racism and other forms of discrimination; living in poverty; low educational attainment; poor access to public transit; little to no quality, affordable childcare; an incarcerated family member; or the inability to obtain affordable housing in a safe neighborhood are all examples of social conditions that increase stress levels in adults and children. However, because these are not one-time events, but actual living conditions, they lead to chronic stress (also referred to as "toxic stress").

The chronic elevation of stress hormones in the body, such as cortisol and adrenaline, lead to an increased risk of not meeting developmental milestones prenatally, in infancy and during childhood. Chronic stress also increases the risk of poor birth outcomes and many chronic diseases in all age groups, including diabetes, hypertension, heart disease, stroke, cancer, and immune system dysfunction, as well as premature mortality.[14] These stressors have a cumulative impact on population and individual health over the life-course. A woman who experiences these stressors during pregnancy (or even long prior to pregnancy) is less likely to have a healthy baby. A baby growing up in an environment where these stressors continually exist is unlikely to be as healthy as an infant who grows up surrounded by protective factors, which positively affect health and development. Without contextual changes in the environment, the impact of stressors continues to accumulate into adulthood.

The predominant understanding of health inequities continues to focus on receipt of health care services and the behavioral choices of individuals. This understanding prevails despite a growing body of research and clear evidence of the influences of systems and structures on population health,[15] all of which describe current and historical landscapes of policies, systems, and environments that create structural inequities and limit opportunities for health. The WHO CSDH Framework incorporates the social determinants of health and highlights many systemic influences on health and well-being.[16] This framework recognizes that economic, social (including racial and ethnic discrimination), and political conditions are not naturally occurring, but are instead the result of public policy and other community or collective actions. These conditions are rooted in long-term structures and traditions that will require new partnerships and new strategies to change them.

The WHO CSDH Framework *(see Figure 1)* synthesizes relevant evidence and theory in order to examine how health inequities arise and to support the development of effective actions to modify the differential distribution of health.[17]

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[14] Center on the Developing Child at Harvard University (2010). *The Foundations of Lifelong Health Are Built in Early Childhood*. Retrieved from: http://www.developingchild.harvard.edu

[15] Shonkoff, J.P., Garner, A.S., Siegel, B.S., Dobbins, M.I., Earls, M.F., McGuinn, L., … & Wood, D.L. (2012). The Lifelong Effects of Early Childhood Adversity and Toxic Stress. *Pediatrics*, *129* (1), 232-246. Retrieved from

[16] Solar, O. & Irwin A. (2010). *A conceptual framework for action on the social determinants of health*. Social Determinants of Health Discussion Paper 2 (Policy and Practice). Geneva, World Health Organization, 2010. Retrieved from http://www.who.int/social_determinants/corner/SDHDP2.pdf.

[17] Solar, O. & Irwin A. (2010)

The WHO CSDH Framework is best understood by focusing on the broad domains and how these domains connect to each other to influence health. Moving right to left, the framework describes how health outcomes are impacted by intermediary determinants, structural determinants, and cross-cutting determinants.

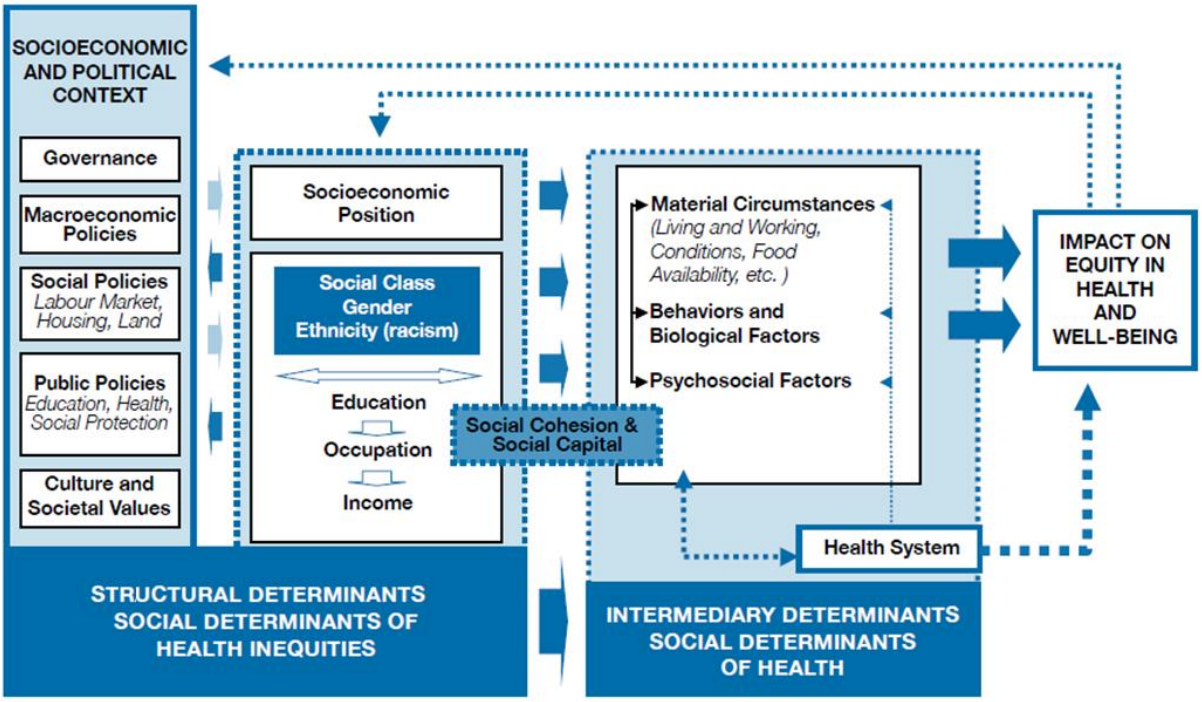

Figure 1. World Health Organization Commission on Social Determinants of Health Framework

Used with permission

The **intermediary determinants**, which most notably include individuals' material circumstances, are, as the WHO points out, the social determinants *of health*. These determine whether a given individual is more or less likely to be healthy than another individual. These determinants act through both instrumental mechanisms (e.g., available affordable healthy food, stable healthy housing, safe working conditions, etc.) and through chronic stress mechanisms (e.g., long-term effects of chronically elevated cortisol and adrenaline).

The **structural determinants** reflect how we as a society distribute power and privilege across groups by age, gender, race, income, education, etc. These are the social determinants *of health inequities*. These include the broad array of policies and systems that determine which large groups of people will be more likely to enjoy higher socioeconomic position (SEP), and therefore better material circumstances - and which other large groups of people will be more likely to have lower SEP, worse material circumstances, high chronic levels of cortisol and adrenaline and, therefore, worse health. The two parts of this domain are mutually reinforcing:

- Socioeconomic and political context determines which groups of people have higher or lower SEP
- Groups with higher SEP, in turn, often have more leverage in influencing the socioeconomic and political context - - and often act to preserve the policies and the inequitable distribution of power and SEP that benefit their groups.

MOVING TOWARD PRACTICE

The following example illustrates how the WHO CSDH Framework can be used to understand the risks for poor health and thus inform discussions about potential strategies to improve conditions for health, using the example of early childhood adversity, including poor birth outcomes.

While all children are at risk of early adversity, including poor birth outcomes, some are at greater risk than others. For example, children living in families with a parent who is currently unemployed are at greater risk of poor birth outcomes and other early adversities due to family stress. Making available education and services (e.g., evidence-based parenting programs, nurse home visits) are important approaches. However, the context – unemployment – is also an important "condition" contributing to differential risk for early childhood adversity. This raises the question: what places someone at risk of unemployment? Consider how employment is patterned in a given location: Are there differences by education or income levels, or between groups based on race/ethnicity? This information can then be used to explore how policies and societal processes may be contributing to these patterns with the overall goal of improving conditions for all families in order to reduce early childhood adversity. (See Appendix A for further example of using the WHO CSDH Framework).

Messer, L. C., Vinikoor, L. C., Laraia, B. A., Kaufman, J. S., Eyster, J., Holzman, C., . . . O'Campo, P. (2008). Socioeconomic domains and association with preterm birth. *J Social Science and Medicine*, 67(8) 1247-1257.

The **cross-cutting determinants** have to do with social cohesion, social support, and community civic capacity. These determinants interplay between the intermediary and the structural domains in at least two ways: building social cohesion and social support can help mitigate the chronic stress of poor material circumstances, while building community civic capacity brings with it increased power to influence the structural determinants of policy context and socioeconomic position setting.

In summary, the WHO CSDH Framework teaches us that health equity work is not only about identifying and attending to the social and economic stressors of individuals (i.e., material circumstances). Health equity work is also about getting at root causes and changing the structural determinants - - the policies and power structures that currently make it so much easier for some groups of people to be healthy, and so much more difficult for others.

Both the example below and *Appendix A* describe these domains in more detail, and provide specific policy examples related to each domain.[18]

The WHO CSDH Framework can be used:

- To increase awareness and expand the understanding of how social and economic conditions contribute to or detract from life-long health, from infancy to old age, as well as across generations

[18] Additionally, an interactive overview of the WHO CSDH Framework is available at: http://www.health.state.mn.us/divs/opi/healthequity/resources/docs/coiin-hrsa/story_flash.html.

- To identify where current health improvement efforts are situated (e.g., clinical care, individual material circumstance, social cohesion, and policy change), in order to set reasonable expectations for outcomes
- To organize specific data, including indicators, across multiple domains to provide a comprehensive yet accessible "snapshot" of social and economic conditions that may be contributing to current health inequities, such as poor birth outcomes and chronic disease
- To identify pathways and mechanisms that – if addressed – can reasonably be expected to improve conditions for populations at risk of inequitable health outcomes

Over time, the WHO CSDH Framework provides a means of monitoring indicators to see how changing conditions may decrease or increase the risk of inequitable health outcomes including, for example, early childhood adversity. The complex interplay of causative factors can be systematically understood and then specific strategies developed and resources directed to systematic interventions that advance health equity.

ORGANIZATION AND USE OF THE LEARNING AND ACTION TOOL 2018

The *Learning and Action Tool 2018* is designed for use by a continuum of public health organizations and is designed be used over time in ways that best fit each organization's specific context and needs. However, the concepts in the tool need to be understood in their entirety, as none of the components stand alone – all are intertwined and need to be addressed to improve outcomes.

The *Learning and Action Tool 2018* features seven practices. The foundational practices are not listed in any particular order – all seven interact with, cross-walk to, and support each other – and all are necessary to effectively advance health equity. The seven foundational practices are:

I. **Expand the understanding of health in words and action**
II. **Assess and influence the policy context**
III. **Lead with an equity focus**
IV. **Use data to advance health equity**
V. **Advance health equity through continuous learning**
VI. **Support successful partnerships and strengthen community capacity**
VII. **Assure strategic and targeted use of resources**

The *Learning and Action Tool 2018* provides operational definitions for each foundational practice. Following each of those definitions is a section titled, "Crosswalk to Other Foundational Practices." Each crosswalk describes how the current foundational practice interacts with the other foundational practices.

Next, each foundational practice is illustrated through a set of questions (critical capabilities). These questions are different for each practice and aim to increase an organization's current capacity to advance health equity practice and address the social determinants of health. Organizations should not consider the listed critical capabilities as exhaustive to all situations – rather as a tool to improve health equity practice.

Finally, public health organizations are urged to examine their own practices and activities against those in the *Learning and Action Tool 2018* and then to engage in dialogue to support continuous improvement and future strategic planning. For convenience, these questions are repeated within each foundational practice under the heading, "Remember to ask…":

- To what extent do we have these critical capabilities?
    - Not at all?
    - Isolated individuals, projects, or ad hoc efforts?
    - Some existing policies, procedures, and practices to support these capabilities?
    - Widespread organizational standards that support these capabilities exist and are measured?

- What are our supports/constraints in strengthening these critical capabilities? What else in our agency impacts our ability to achieve these critical capabilities?
- What unique challenges and opportunities are present in our organizational context?
- If we already have these capabilities, are we proficient? How could we improve?
- What are some specific examples of how we do this? How could we better or more extensively incorporate these capabilities in our work?
- How do our strengths and weaknesses in this foundational practice relate to the other six foundational practices?

Ideally, a team of individuals with significant knowledge of the organization's structures and functions should complete the *Learning and Action Tool 2018*. Each organization will have a unique experience with the *Learning and Action Tool 2018*.

MOVING TOWARD PRACTICE

In a formative evaluation of the *Learning and Action Tool 2016*, different states implemented the tool in different ways. The following are some suggestions for implementation from those states as well as the contributors:

"A small group could review the Learning and Action Tool 2016 to summarize or customize the tool for their organizational needs before using it with a large group or before attempting to write specific goals or strategic plans."

"Quick wins using the Learning and Action Tool 2016; Identify practices that intersect and plan to complete those together; and develop a plan for moving through the practices based on the determined agency leverage points (e.g., strategic planning, accreditation, etc.)"

"Develop a work plan that may include strategies for working through at least three of the [foundational] practices and how to connect those practices with agency leverage points."

"A small group could recruit participants from all levels of the agency (in order to promote sustainability of the process). Participants could also be recruited from those projects determined as agency leverage points or possible quick wins."

Foundational Practice I: Expand Understanding of Health in Words and Action

The organization is intentionally engaged in efforts to expand the understanding of what creates health both within the organization and with external partners in order to eliminate structural inequities and create opportunities for health.

The ability of an organization to align knowledge, action, and resources is critical to the actual advancement of health equity. Expanding the understanding of how social determinants of health influence population health requires knowledge of how health is created – or not – for differing populations, including differences by demographic factors such as race, ethnicity, language, geography, income, gender, disability, and sexual identification.

The dominant health narratives, as well as current health policies and resource allocation, generally focus on the behaviors of individuals and on providing health care services. But healthcare and individual behaviors are relatively minor drivers of health outcomes, and as such occupy only a small corner of the WHO Framework. Effectively advancing health equity requires an expanded narrative that builds shared understanding inclusive of the historical and current landscape of policies, systems, and environments that create structural inequities, and limit or support opportunities for health.

The organization must develop the practice of identifying and challenging the assumptions underlying the current dominant beliefs and narratives around health and wellness both within and beyond their organization and jurisdiction. The organization must be able to articulate and track relevant data that show the connections between health and the social determinants of health, as well as the policies, investments and actions that constrain or increase the opportunities for health.

Expanding the narrative of what creates health inequities related to discrimination at all levels (including class, gender, gender-identification, sexual orientation, and race/ethnicity) is necessary. However, particular attention must be paid to the structural and institutional policies and systems that result in poorer health outcomes by race and ethnicity. When outcomes related to other factors such as income, education, gender, sexual identification, and geography are analyzed by race/ethnicity, greater inequities are often evident for American Indians, African Americans, and persons of Hispanic/Latino and Asian descent. These racially-based patterns of health inequities are almost never genetic, and must be understood as evidence of structural racism. Race and racism are difficult to talk about, and it is not uncommon for these issues to get subsumed under broader conceptual terms, such as “injustice,” “discrimination” or even “equity.”

All structural determinants are important, and all forms of discrimination are important. Yet, a concerted effort to specifically address the issue of structural racism and to develop the language and tools to uncover and change the structures shaped by racism are invaluable in addressing direct negative health effects of experiencing racism, and effectively addressing other structurally and socially produced inequities.[19]

CROSSWALK TO OTHER FOUNDATIONAL PRACTICES

Strengthening the practice of expanding the understanding in words and action increases the organization’s capacity in all the foundational practices. When the organization works to expand the

[19]Minnesota Department of Health (2014). Advancing Health Equity Report to the Legislature. http://www.health.state.mn.us/divs/chs/healthequity/ahe_leg_report_020414.pdf

understanding of what creates health, the work acts as a foundation and a catalyst for policy change; strong equity-focused leadership; innovative approaches around data collection and analysis; workforce development and continuous improvement; new and stronger partnerships; and more effective ways to organize resources to address social determinants of health and advance health equity.

CRITICAL CAPABILITIES

To expand the understanding of health in word and action, the organization must:

A. Assure that the organization understands the structural and system-based issues that contribute to health inequities.

1. Does our organization utilize the WHO CSDH framework (or other health equity framework) to increase our understanding of structural and intermediary inequities?
2. Do clear messages around the key concepts of health equity permeate every area of work within our organization?
3. Does our organization use its mission, vision, and values statements to communicate and support understanding of the structural and system-based inequities that contribute to poor birth and health outcomes?
4. Does our organization encourage and support staff to apply knowledge of personal bias and structural racism in their own work at the program and policy levels?
5. Has our organization developed or adopted policies, practices, and tools that prioritize the history and context of different racial and cultural groups so that institutional and structural inequities are explicitly addressed?

B. Assure that the organizational partners understand the structural and system-based issues that contribute to health inequities.

1. Has our organization worked with communities experiencing inequities to develop, adopt, and promote a shared narrative around health equity – including around racism as well as other structural determinants?
2. Does our organization work with partner organizations in creating a shared narrative about what creates health?
3. Does our organization lead events, campaigns, and/or use social media to raise awareness of the conditions that create health and the impact of inequities on health outcomes?
4. Does our organization work to expand the understanding about conditions that lead to health health inequities with all staff, community stakeholders and with our public health system partners?
5. Does our organization then use this collective understanding to promote health equity in all policies?

C. Collect, analyze and share data to develop and contribute to an expanding understanding of health that links social determinants of health and health inequities and health outcomes.

1. Does our organization collect and analyze data to develop an understanding of the relationships between social and economic conditions and health outcomes?
2. Does our organization produce or contribute to reports that illustrate the relationships among the social determinants of health and health outcomes?
3. Has our organization conducted any analyses using tools such as health impact assessment or research studies to examine and demonstrate impact on health inequities across policy sectors?
4. Does our organization routinely include the broader context of health determinants and health and racial inequities in its reports?

D. Align actions including partnerships, policies, programs and investments to reinforce an expanded understanding of health.

1. Does our organization have working relationships with agencies or sectors such as housing, education, corrections, economic development, public safety, etc.?
2. Does our organization work with community partners and entities across sectors to analyze, develop and disseminate data and reports that build an expanded understanding of health?
3. Does our organization have the capacity to influence policy change efforts that address structural inequities under the auspices of other agencies such as housing, education, corrections, public safety, etc.?
4. Do the policies, programs and investments of our organization reflect the understanding of health and the structural and intermediary determinants of health and health inequities represented in the WHO CSDH Framework?

REMEMBER TO ASK...

- To what extent do we have these critical capabilities?
    - Not at all?
    - Isolated individuals, projects, or ad hoc efforts?
    - Some existing policies, procedures, and practices to support these capabilities?
    - Widespread organizational standards that support these capabilities exist and are measured?
- What are our supports/constraints in strengthening these critical capabilities? What else in our agency impacts our ability to achieve these critical capabilities?
- What unique challenges and opportunities are present in our organizational context?
- If we already have these capabilities, are we proficient? How could we improve?
- What are some specific examples of how we do this? How could we better or more extensively incorporate these capabilities in our work?
- How do our strengths and weaknesses in this foundational practice relate to the other six foundational practices?

Foundational Practice II: Assess and Influence the Policy Context

The organization actively assesses the policy context in which people live, and how various policies differentially support or inhibit the ability of different groups of people to achieve their full health potential. The organization is effective at leveraging policy change to address social determinants of health and advance health equity.

The Institute of Medicine defines public health as "fulfilling society's interest in assuring the conditions in which people can be healthy." Creating the conditions in which people can be healthy often requires policy solutions, and such policy solutions extend far beyond traditional, narrow conceptions of policy around health care.[20] In fact, health care accounts for only a small fraction of what determines health.[21] Even individual behavior, which plays a larger role than health care, is less influential than the social determinants of health in driving both health outcomes and health inequities. Further, both the individual behaviors and health care are directly influenced by the social determinants of health.

Not only do social and economic conditions either support or constrain individual behaviors but, through the action of stress hormones and epigenetic mechanisms, they also have a powerful direct effect on people's physiology and therefore their health. It is for these reasons that health policy must be thought of much more broadly than simply as health care policy. As Harvard researcher David Williams points out, "Housing policy is health policy. Neighborhood improvement policies are health policies. Everything that we can do to improve the quality of life for individuals in our society has an impact on their health and is a health policy."[22]

For example, the dominant narrative around infant mortality – which focuses on individual behavior and exhorts pregnant women to get early prenatal care and engage in healthy behaviors – is insufficient to achieve better health outcomes and reduce health inequities. Policy changes that create the context and conditions within which people can be healthy are essential in order to improve health and reduce health inequities. To be most effective, policy changes need to be inclusive of the following (listed in *increasing* order of importance):

- Improve access to quality health care, behavioral health, and human services
- Support healthy individual behaviors
- Create opportunities for access to health-promoting material circumstances, such as healthy food, safe housing, transportation, good jobs, and educational opportunities
- Attend to structural determinants in order to minimize the levels of chronic and toxic stress that large groups of people experience throughout their lifetimes, especially during pregnancy and early childhood.

The policies referred to in *Appendix B* span the entirety of the WHO CSDH Framework. Policies across the entire framework must be addressed in order to significantly improve health outcomes and eliminate health inequities.

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[20]Institute of Medicine (2003). *The Future of the Public's Health in the 21st Century*. Washington, DC: The National Academies Press.
[21] Tarlov A. R. (1999). Public policy frameworks for improving population health. *Ann N Y Acad Sci* 896: 281-93.
[22] Williams D. R. & Wyatt R. (2015). Racial bias in health care and health: Challenges and opportunities. *J American Medical Association.* 314(6):555-6.

CROSSWALK TO OTHER FOUNDATIONAL PRACTICES

Effectively assessing and influencing the policy context, like the other foundational practices, does not happen independently. Policy change will not occur without significant attention to broadening the understanding of policymakers, voters, and other influencers about what actually determines health - - far beyond healthcare and individual behaviors.

Effective leadership and expanded narrative and data are crucial for policy change, but so is workforce development, continuous improvement, and effective resource allocation. All of these factors are necessary to support successful partnerships and strengthen community capacity. Few policy changes can occur without significant support from affected individuals, key influencers, and the public.

Policy assessment and policy influence do not happen on their own, or as "other duties" tacked on to a job description. They require specific and targeted investments of money and other resources to support everything from the data systems to the organizational and community capacity building necessary for effective policy work.

CRITICAL CAPABILITIES

To effectively assess and influence the policy context, the organization must be able to:

A. Assess the policy context that creates underlying systems issues that perpetuate health inequities.

1. Does our organization have the knowledge, skills and resources needed to identify the policy context for health inequities?
2. Does our organization comprehensively assess our state and/or local policy context for the social and economic factors that contribute to or decrease health inequities?
3. Does our organization use the WHO CSDH Framework (or other health equity framework) to comprehensively assess our state and/or local policy context regarding the structural and intermediary determinants that contribute to health inequities or advance health equity?
4. Does our organization engage the community, especially communities of color, American Indians and other communities experiencing health inequities, to assure that these communities inform our assessment of the policy environment?
5. To what extent does our organization advance health equity by promoting a health equity in all policies approach?
6. Does our organization have a process for identifying timely strategic opportunities which may not be "high priority" or "hot-button" issues?

B. Implement policy changes that improve the social determinants of health and improve health equity.

1. Does our organization influence, develop and/or implement policies to improve social and economic conditions in our state and/or local jurisdiction, especially for populations of color, American Indians and others experiencing health inequities? (*See Appendix A and B for examples*)
2. To what extent can our organizational as well as governmental (state and/or local) policies be objectively considered to promote health and advance equity? *(See Appendix B)*
3. Do our employees have the capacity to ask critical questions to influence how policies and practices are developed within the organization? *(See Appendix B)*

4. Does our organization have the capacity to influence policy change efforts that address structural inequities under the auspices of other agencies in other sectors, such as housing, education, corrections, public safety, etc.?
5. Does our organization engage or support diverse community partners – including populations of color, American Indians and others experiencing health inequities – to advocate for, advance, and implement policies that support more equitable living and working conditions and address structural determinants of health equity?

C. Assess and improve our agency's internal policies, programs, and systems, using an equity lens *(See Appendix B).*

1. Does our organization apply a health and racial equity approach to our organizational processes and procedures, including:
   a. Grant making and grant reviewing processes and procedures?
   b. Hiring and human resources processes and procedures?
   c. Workforce development processes and procedures?
   d. Data acquisition and analysis processes and procedures?
   e. Budgeting and resource allocation processes and procedures?
   f. Other key organizational processes and procedures?

REMEMBER TO ASK...

- To what extent do we have these critical capabilities?
  - Not at all?
  - Isolated individuals, projects, or ad hoc efforts?
  - Some existing policies, procedures, and practices to support these capabilities?
  - Widespread organizational standards that support these capabilities exist and are measured?
- What are our supports/constraints in strengthening these critical capabilities? What else in our agency impacts our ability to achieve these critical capabilities?
- What unique challenges and opportunities are present in our organizational context?
- If we already have these capabilities, are we proficient? How could we improve?
- What are some specific examples of how we do this? How could we better or more extensively incorporate these capabilities in our work?
- How do our strengths and weaknesses in this foundational practice relate to the other six foundational practices?

Foundational Practice III: Lead with an Equity Focus

The organization fosters and supports a commitment to addressing social and economic conditions to advance health equity as a primary focus of its mission and supports its leaders in that effort.

Leadership occurs at many levels within organizations. Key leaders for health equity may not be in recognized positions of authority but have influence deep within the organization. Positional leaders committed to health equity also are critical for leveraging action inside and outside the organization.

Effective leaders for health equity are well-informed decision-makers with a shared understanding of the principles and practices of advancing health equity and have the skills and ability to inspire and motivate individuals and organizations to take action to improve health outcomes.

The framework for public health leadership elaborated by James Begun and Jan Malcolm includes "applying a social determinants perspective" as its definition of competence, and in doing so complements the WHO CSDH Framework adopted by the *Learning and Action Tool 2018*. Begun and Malcolm observe that "the evidence base for a social determinants framework for health policy and practice is strong and ever-accumulating" and "provides a foundation for stronger public health leadership." [23]

CROSSWALK TO OTHER FOUNDATIONAL PRACTICES

Leaders who are effective in advancing health equity are adept at creating, supporting, and advancing an expanded understanding of what determines health, in both words and actions.

Successful leaders work to eliminate power imbalances by creating new opportunities for groups who have been marginalized to influence policies that will have an impact on their lives and communities. Additionally, effective leaders assure that health equity is incorporated into all policies, including state, local, and/or organizational plans, budget assessments, and other key documents and efforts in advancing equity with the goal of alignment at the federal, state and local levels for achieving optimal health outcomes for all.

Effective leaders assure the development of equity-focused data systems and use relevant data for making decisions to assure equity in the conditions that create health and they maximize the effectiveness of their organization through workforce development and continuous learning.

Successful health equity leaders actively seek out and provide opportunities for the authentic involvement of populations that bear a disproportionate burden of poor health; and build sustained internal and external commitment to investing in, supporting, and building the necessary infrastructure, partners, and processes that systematically eliminate inequity.

CRITICAL CAPABILITIES

To lead with an equity focus, individuals in the organization must be able to:

A. Clearly articulate an equity framework and take action to advance health equity.

[23] Begun, J. W., & Malcolm, J. K. (2014). *Leading Public Health: A Competency Framework.* New York, NY: Springer.

1. Does our organization have health equity as a central focus of its mission/activities?
2. Does our organization have key senior staff who champion health equity and take action to address social determinants of health and promote health equity?
3. Do we have key staff throughout the organization who champion health equity and support action to address social determinants of health and promote health equity?
4. Are all leaders in our organization able to identify and analyze the power relations of institutions and organizations?
5. Does our organization incorporate health equity and the social and economic conditions necessary for health into state plans, budgets, assessments, and other strategic documents?[24]
6. Do leaders in our organization recognize the significance of social stratification and take action to advance equity along lines of race, gender, class and income, geography, sexual identification, physical ability, and other socially-defined categories that confer advantage and disadvantage?

B. Foster health equity leadership within the organization and community.

1. Does our organization foster and support the development of leaders at all levels of the organization?
2. Do leaders within our organization collaborate well with one another and with leaders outside of the organization to advance health equity?
3. Does our organization support and work collaboratively with community partners and individuals with lived experience and the organizations and advocates that support them?
4. Does our organization recognize and support existing and emerging leaders for health equity across the organization?
5. Does our organization assure that government leaders and policy makers are informed and prepared to set policy that advances health equity?
6. Do the leaders in our organization inspire and motivate staff and meaningfully engage all stakeholders – including communities of color, American Indians, and other communities experiencing inequities – toward a shared agenda and resources to advance health equity?

C. Develop leadership that is consistent around applying a racial equity lens and understanding of power and privilege

1. Is our leadership willing and able to speak clearly and effectively about racism at all levels (personal, interpersonal, institutional, and structural), and the effects of social exclusion?
2. Is our leadership willing and able to speak clearly and effectively about other aspects of power and privilege that maintain socially-determined advantages and disadvantages regarding health potential for individuals and groups?

REMEMBER TO ASK...

- To what extent do we have these critical capabilities?
    - Not at all?
    - Isolated individuals, projects, or ad hoc efforts?
    - Some existing policies, procedures, and practices to support these capabilities?
    - Widespread organizational standards that support these capabilities exist and are measured?

[24] For example: Budgets, Infant Mortality Plans, Title V Needs Assessment, State Health Assessment, State Health Improvement Plan, Strategic Plan, Quality Improvement Plan, etc.

- What are our supports/constraints in strengthening these critical capabilities? What else in our agency impacts our ability to achieve these critical capabilities?
- What unique challenges and opportunities are present in our organizational context?
- If we already have these capabilities, are we proficient? How could we improve?
- What are some specific examples of how we do this? How could we better or more extensively incorporate these capabilities in our work?
- How do our strengths and weaknesses in this foundational practice relate to the other six foundational practices?

Foundational Practice IV: Use Data to Advance Health Equity

The organization has performance improvement systems and infrastructure that provide actionable data for improvement and accountability advancing health equity.

Data have a unique role in both building and affirming the narrative of what creates health. "What gets measured gets done" is a familiar maxim about data, meaning that what an organization chooses to measure, such as health outcomes or health determinants, creates the basis for action to improve those outcomes.

Using data to advance health equity requires bringing together multiple sources of data, including data on health outcomes as well as data that focuses on intermediary and structural determinants of health, which influence social and economic conditions. These data are fundamental to expanding the understanding of the factors that equip leaders to advance health and health equity and can contribute to healthy public policy making.

CROSSWALK TO OTHER FOUNDATIONAL PRACTICES

Methods of data collection and analysis must align with, as well as inform, the organization's expanded narrative and understanding of what determines health. Likewise, there is a two-way relationship between data informing policy change, and existing policies which themselves provide data for the purpose of policy analysis, which then comes full circle to inform policy influence.

There is a similar two-way relationship between data collection/analysis and leadership. Leadership must support the organization's equity-focused data collection and data analysis, and leadership activities must be data-driven and data informed. Data must also be used to support advancing equity through workforce development and continuous improvement.

Data collection, analysis, and reporting should occur in coordination and collaboration with cross sector agencies, and relevant organizations – including the health care delivery system, business community and other community partners. These partners not only have the capacity to contribute to a new health narrative inclusive of health equity, but are also essential for forming authentic relationships with communities of color, American Indians, and other communities experiencing inequities.

Finally, strategic and targeted investments must be made to support data systems and data analysis; in turn, data analysis should be used to inform equity-related resource allocation.

CRITICAL CAPABILITIES

To use data to advance health equity, the organization must be able to:

A. Develop and maintain data systems – including data collection and analysis - with an expanded understanding of structural and intermediary determinants.

1. Does our organization regularly and systematically collect data on a range of measures across the WHO CSDH Framework?
2. Has our organization worked with community stakeholders to identify a core set of measures to identify and track correlations between key structural determinants and intermediary determinants and their contributions to measures of health outcomes and health inequities?
3. Does our organization ensure that surveillance systems, forms, surveys, and other data collection methods gather information that allow us to accurately and effectively analyze the

interrelationships among structural and intermediary determinants of health and health outcomes?

4. Does our organization identify gaps in data collection, i.e., additional measures needed to better understand the impacts social and economic conditions have on health outcomes?
5. Does our organization acknowledge the limitations and challenges of collecting and reporting data by race/ethnicity and other population subgroups, and do we have strategies in place to address these?
6. Does our organization evaluate different methods for categorizing race/ethnicity?
7. Does our organization regularly collect and disaggregate data findings by race, ethnicity, language, gender, age, sexual identification, disability status, income, educational attainment, zip code, and other factors (such as a neighborhood deprivation index), as appropriate?

B. Analyze data effectively in order to monitor trends and impacts of social determinants of health and health inequities.

1. Does our organization analyze data to develop an understanding of the relationships among the social determinants of health and health outcomes?
2. Can our organization recognize where the dominant narratives about health are shaping our data systems, and do we explore *and implement* alternatives?
3. Does our organization request a standard approach to data collection and analysis from its partners/grantees and other cross-sector agencies, so that comparable data can be used to develop a shared understanding?
4. Can our organization identify missing data that would reveal health inequities, and act to obtain those data?
5. Does our organization evaluate the ways in which biases may determine how we analyze, report and use our data?
6. Has our organization conducted any analyses using tools such as health impact assessment or research studies to examine and demonstrate impact on health inequities across policy sectors?
7. Do we seek out and use and/or develop the most effective analytical constructs for gathering and evaluating data related to structural and intermediary determinants of health?

C. Report data to stakeholders and the public in order to promote action to advance health equity.

1. Does our organization format and communicate data findings so that they are useful for action by all sectors, community stakeholders, and at all levels of government?
2. Does our organization leverage findings from data collection and analysis in order to help change the narrative of what creates health?
3. Does our organization leverage findings from data collection and analysis in order to inform and inspire policy change?
4. Does our organization leverage findings from data collection and analysis in order to support partnerships and engagement?
5. Does our organization use cross-sector data to support our collaborations with other cross sector agencies?
6. Does our organization leverage findings from data collection to understand how best to allocate and align resources?
7. Does our organizations leverage findings from data collection to develop a value proposition securing resources?

REMEMBER TO ASK...

- To what extent do we have these critical capabilities?
    - Not at all?
    - Isolated individuals, projects, or ad hoc efforts?
    - Some existing policies, procedures, and practices to support these capabilities?
    - Widespread organizational standards that support these capabilities exist and are measured?
- What are our supports/constraints in strengthening these critical capabilities? What else in our agency impacts our ability to achieve these critical capabilities?
- What unique challenges and opportunities are present in our organizational context?
- If we already have these capabilities, are we proficient? How could we improve?
- What are some specific examples of how we do this? How could we better or more extensively incorporate these capabilities in our work?
- How do our strengths and weaknesses in this foundational practice relate to the other six foundational practices?

Foundational Practice V: Advance Equity through Continuous Learning

The organization assures optimal workforce development and builds a culture of learning that incorporates improvement processes at all levels of the organization.

Continuous learning and workforce development allow organizations to rapidly incorporate:

- New understandings developed through research
- Approaches that emerge from evolving evidence and best practices in accelerating improvement processes (i.e., innovations in practice).

When an organization and its leadership encourage learning, progress can be made through both the successes and failures of all partners working together toward a shared goal of health equity. Research shows that success in achieving sustained systems change requires a well-designed learning and improvement system with a robust evaluation process.[25] Successful initiatives to spread large-scale systems transformation are characterized by three critical success factors:

1. *Leadership capacity*: Successful organizations have continuous-learning champions at every level with the capacity and motivation to improve system performance.
2. *Vibrant relationships and functional networks*: Successful organizations incorporate coaches and peer-to-peer support and sharing of lessons learned.
3. *Structured method to make improvement and spread good ideas*: Successful organizations incorporate a facilitated, rigorous process of measurement with small-scale rapid-cycle testing for ongoing improvement and are able to spread what works.

The following are elements of a learning health system for continuous learning and improvement.[26]

- Develop leadership capacity for improvement
- Create peer-to-peer relationships for learning
- Conduct rapid-cycle improvement processes
- Use relevant data and measurement systems
- Incorporate learnings into processes and systems in all levels of the organization
- Create systems for spread and sustainability
- Assure a workforce that is trained and kept up-to-date in best practices for addressing social determinants of health and health equity

[25] Research include: Hester, J., Auerbach, J., Chang, D., Magnan, S., & Monroe, J. (2015). Opportunity Knocks Again for Population Health: Round Two in State Innovation Models. *Institute of Medicine Roundtable on Population Health*. Foster-Fishman, P. & Watson, E. (2014). The ABLe Change Framework: A Conceptual and Methodological Tool for Promoting Systems Change," *Am J Community Psychology*. Institute for Health Care Improvement (2015). *Spreading Community Adopters through Learning and Evaluation (SCALE), Theory of Change.* Retrieved from: http://www.ihi.org/Engage/Initiatives/100MillionHealthierLives/Pages/default.aspx

[26] The information is from a powerpoint that was presented at the *Spreading Community Accelerators through Learning and Evaluation, Community Health Improvement Leadership Academy, 2015.*

CROSSWALK TO OTHER FOUNDATIONAL PRACTICES

Continuous learning, process improvement, and workforce development are essential for developing and honing an expanded understanding – and skills for framing an expanded understanding of health – as well as for optimal effectiveness in policy analysis and policy influence.

Leaders at all levels are crucial, and must take an active role in developing and sustaining a culture of ongoing improvement and a structured method to make improvements and spread good ideas. Learning is also a fundamental element of successful partnerships; and the approach to learning must include engagement of those most affected by inequity in testing new ideas and co-designing systems change.

Continuous learning and improving are essential in the ongoing effort to assure optimal investments of strategic and targeted resources in the advancement of health equity.

CRITICAL CAPABILITIES

To advance health equity through continuous learning, an organization must be able to:

A. Develop and maintain a highly qualified, well-trained and diverse workforce in all parts / sections of the organization.

1. Does our organization work with both internal trainers and external facilitators (e.g., educational institutions) to assure the availability of a highly qualified, well-trained, and diverse workforce with the knowledge and skills to advance health equity?
2. Is our organization committed to developing a professional workforce that reflects the demographics of the populations we serve?
3. Does our organization build the skills and competencies of public health practitioners to identify the roles of structural and intermediary determinants on health?
4. Does our organization systematically build internal capacity related to health equity through training and other means of professional development?
5. Does our organization support staff in applying knowledge of the effects of implicit bias in their own program or policy work, as well as at the broader population level?
6. Does our organization educate public health leaders in effective public health practices to advance health equity?
7. Does our organization provide peer-to-peer learning opportunities to advance practice around health equity?
8. How can our organization advocate for, support and provide training guidance for other organizations, including health care and educational institutions?

B. Use continuous quality improvement strategies for ongoing learning, innovation, and improvement of the organization.

1. Does our organization build a culture of ongoing learning, and incorporating continuous quality improvement into daily work to advance health equity?
2. Does our organization use performance management and quality improvement principles, such as rapid-cycle improvement, to continuously improve our policies, processes, and programs to advance health equity?
3. Does our organization engage broad stakeholders, including those experiencing health inequity in iterative testing and co-design?
4. Does our organization have a plan for spreading successes in advancing health equity?

REMEMBER TO ASK...

- To what extent do we have these critical capabilities?
    - Not at all?
    - Isolated individuals, projects, or ad hoc efforts?
    - Some existing policies, procedures, and practices to support these capabilities?
    - Widespread organizational standards that support these capabilities exist and are measured?
- What are our supports/constraints in strengthening these critical capabilities? What else in our agency impacts our ability to achieve these critical capabilities?
- What unique challenges and opportunities are present in our organizational context?
- If we already have these capabilities, are we proficient? How could we improve?
- What are some specific examples of how we do this? How could we better or more extensively incorporate these capabilities in our work?
- How do our strengths and weaknesses in this foundational practice relate to the other six foundational practices?

Foundational Practice VI: Support Successful Partnerships and Strengthen Community Capacity

The organization engages multiple partners – explicitly including communities of color, American Indians, and others experiencing health inequities – in strategic and powerful partnerships to transform public health practice in order to collectively address social determinants of health and advance health equity.

Advancing health equity requires two distinct but interrelated areas of engagement and partnership: working across sectors; and supporting communities in creating opportunities for health. If intentional, both these strategies can be leveraged to address institutional and structural inequities and racism.

Working across sectors can take many forms, ranging from simply sharing information all the way to collaborating on new projects or adopting shared goals, measures, and resources with policymakers and agencies in other arenas. These types of interagency relationships require a foundation of trust, mutuality, and reciprocity. This is a particularly important strategy to successfully promote a health-in-all-policies approach with health equity as the goal.[27]

Supporting communities in creating opportunities for health requires an organization to be committed to developing authentic partnerships and shared decision-making. This requires that organizations go beyond forming intermittent relationships for the purposes of gaining feedback and move into the realm of building and sustaining relationships. The WHO CSDH, in its final report, stated "it is the role of governments to create opportunities for communities experiencing the greatest health inequities to become involved in societal decision-making processes that effectively determine their access to the conditions needed for health."[28] Organizations can leverage resources and use their influence to support communities, especially those most affected by inequity, to become change agents and to lead change efforts based on their values, needs, and priorities.

CROSSWALK TO OTHER FOUNDATIONAL PRACTICES

Successful partnerships are essential to each of the other foundational practices. Partners can inform and build expanded understanding of the factors, policies, and systems impacting health. Partnerships with affected communities, as well as with policymakers and other influencers, are essential in both understanding the current policy context as well as influencing policy change.

Likewise, effective leadership for health equity cannot be accomplished in a vacuum; it absolutely requires the development and maintenance of broad and deep community partnerships and is a key component of any efforts to strengthen community capacity.

Successful data systems and data analyses to advance health equity are informed by partnerships and are openly shared with partners to support those partnerships. Strong, meaningful, and lasting partnerships also require continuous learning and continuous improvement.

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[27]Research Includes: Institute of Medicine. *For the Public's Health: Investing in a Healthier Future.* Retrieved from: http://iom.nationalacademies.org/Reports/2012/For-the-Publics-Health-Investing-in-a-Healthier-Future.aspx

Public Health Accreditation Board. PHAB Standards and Measures Version 1.0 – see Standard 5.2. Page 118.

[28] World Health Organization, Commission on Social Determinants of Health. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health.* Geneva: World Health Organization.

The relationship between resource allocation and partnership/capacity building is both essential and bidirectional: When allocating strategic and targeted resources to support community capacity building, partners must be engaged to share decision-making around resource allocation decisions.

CRITICAL CAPABILITIES

For purposes of this section, community partners are described as communities of color, American Indians, immigrants, low SES groups, and others experiencing health inequities.

To support successful partnerships and engagement, the organization must be able to:

A. Develop and deepen cross-sector and interagency relationships.

1. Does our organization use the WHO definition of health and the expanded understanding of the determinants of health and health inequities to support our efforts to engage partners in improvements in the social and economic conditions for health
2. Does our organization reach out and engage its interagency counterparts in effective working relationships that add health considerations to policies in areas outside of traditional public health concerns such as health care, transportation, housing, employment, education, corrections, public safety, economic development, etc.?
3. Does our organization work with entities across all sectors to improve social and economic conditions that advance health equity?
4. Has our organization developed partnerships with communications experts and the media to assure understanding in the community and expand opportunities for health?

B. Form and maintain effective relationships with community partners at the organizational level as well as with coalitions of organizations (e.g., organizations and coalitions) - - *especially organizations representing communities of color, American Indians, immigrants, low SES groups, and others experiencing health inequities.*

1. Does our organization intentionally create strong relationships with a broad range of community partners (as described above)?
2. Does our organization partner in a way that intentionally shares power and decision-making?
3. Does our organization designates enough time and create avenues for meaningful participation of community partners?
4. Are decisions by our organization made in collaboration with community partners?
5. Does our organization practice transparency with community partners around agency needs and priorities?
6. Does our organization prepare and support staff to respectfully and thoughtfully engage with community partners (as described above)?
7. Has our organization, completed, participated in, or planned a community health needs assessment or planning process in collaboration with community partners (as described above)?
8. Does our organization actively work to reduce the marginalization of specific racial, socio-economic or newcomer groups and build inclusive communities and decision-making processes?

C. Strengthen the capacity of community partners at the organizational level as well as with coalitions of organizations - - *especially organizations representing communities of color, American Indians, immigrants, low SES groups, and others experiencing health inequities.*- - to build collective efficacy to foster institutional and structural change that advances health equity.

1. Does our organization build the leadership capacity of community members to advocate on issues affecting the environmental, social and economic conditions that impact health?

2. Have our organization's community partnerships led to changes in our own institutional policies, processes, and practices?
3. Do leaders in our organization encourage and champion community partners to influence the department's program/policy efforts?
4. Does our organization foster agency among community partners, especially those most affected by health inequities to lead their own change efforts?
5. Does our organization have an evaluation plan of our community engagement efforts to ensure continuous learning and impact of partnering with communities (as described above)?
6. Does our organization share the evaluation results of our community engagement efforts with community partners (as described above)?

D. Create effective partners with other individuals and organizations.

1. Does our organization partner effectively with other state, local and Tribal health departments; cross sector agencies; universities/colleges; the business community; the executive branch; and the legislative branch?
2. Does our organization partner effectively with other influencers, such as the media?

REMEMBER TO ASK...

- To what extent do we have these critical capabilities?
    - Not at all?
    - Isolated individuals, projects, or ad hoc efforts?
    - Some existing policies, procedures, and practices to support these capabilities?
    - Widespread organizational standards that support these capabilities exist and are measured?
- What are our supports/constraints in strengthening these critical capabilities? What else in our agency impacts our ability to achieve these critical capabilities?
- What unique challenges and opportunities are present in our organizational context?
- If we already have these capabilities, are we proficient? How could we improve?
- What are some specific examples of how we do this? How could we better or more extensively incorporate these capabilities in our work?
- How do our strengths and weaknesses in this foundational practice relate to the other six foundational practices?

Foundational Practice VII: Assure Strategic and Targeted Use of Resources

The organization optimizes the use of resources and directs investments to address social determinants of health and health inequities.

The strategic and targeted use of public and private resources are aligned to advance health equity by addressing inequities in the intermediate and structural determinants of health. In the context of health equity, optimal resource utilization is, at its most fundamental level, strategic distribution of the fiscal and human resources that make possible optimal quality of life for all individuals. To optimize resource utilization, fiscal policy and organizational decision-making must reflect the organization's commitment to the goal of advancing health equity. Public health organizations have the responsibility to align funding streams across local and state-level systems to maximize the impact of targeted spending on shared strategic priorities that advance equity.[29]

CROSSWALK TO OTHER FOUNDATIONAL PRACTICES

Part of the "action" component of expanding the understanding of health "in words and action" requires that organizations "walk the talk;" or, more precisely, "put their money where their mouth is." It is of little value to expand the narrative and expound on social determinants of health and health equity if the organization's resources aren't aligned with this expanded understanding of what creates health.

Assessing and influencing the policy context requires and demonstrates strategic investment of resources. More broadly, public policies drive public resource allocation. Moreover, many if not most strategic and resource allocation decisions at the organizational level are a function of organizational leadership and require support from community partners.

Determining whether expenditures are allocated in a manner that addresses the structural and intermediary determinants of health must be based upon a data analysis rooted in an expanded understanding of health and health inequities. Public health organizations, both governmental and non-governmental, should track progress in optimal resource allocation through ongoing evaluation in order to demonstrate that resource investments actually advance health equity

CRITICAL CAPABILITIES

To assure strategic and targeted use of resources, the organization must be able to:

A. Strategically direct fiscal and human resources to those with the greatest need to advance health equity.

1. Does our organization have current data that inform where resources should be invested to address those with greatest need?
2. Does our organization track resource allocation to assure that it is directed to those with greatest need in order to advance health equity
3. Do our employees have the capacity to ask critical questions to influence how investments are developed and deployed within the organization?

[29] For example: transportation, education, agriculture, economic development, child welfare and human services, the state Medicaid agency, housing, licensing and insurance regulatory agencies, etc.

4. Does our organization assure that resources are not reinforcing cultural biases, barriers or inequities?
5. Do the actions and investments of our organization follow the WHO CSDH Framework and messaging around health equity?
6. Does our organization assure strategic distribution of the fiscal and human resources that make possible optimal health and quality of life for all individuals?

B. Invest in research and practice-based strategies and shared priorities for advancing health equity.

1. Does our organization invest resources in identifying practice-based evidence that is culturally responsive?
2. Does our organization have a planned approach to assure that resources to advance health equity are allocated based on research, best practices and evolving evidence?
3. Does our organization prioritize funding in ways that emphasize the assets and opportunities needed across the life span?
4. Does our organization prioritize investments to support work addressing intermediary, cross-cutting, and structural determinants of health and health equity, as per the WHO CSDH framework?

C. Use resources to build system capacity to advance health equity.

1. Does our organization allocate sufficient resources for policy development and implementation to advance health equity?
2. Does our organization allocate sufficient resources for workforce development to advance health equity?
3. Does our organization allocate sufficient resources to support its employed and contractual workforce (e.g., living wage, paid family and medical leave, etc.)?
4. Does our organization allocate sufficient resources for quality improvement and performance measurement of advances in health equity?
5. Does our organization allocate funds to support the meaningful participation of community partners, including communities of color, American Indians, and others experiencing health inequities in societal decision-making and prioritization processes?

D. Align funding streams across all sectors and levels of government to maximize the impact of efforts to advance health equity.

1. Does our organization align funding streams to promote health equity and the elimination of health inequities?
2. Are our organization's payment methodologies and fiscal incentives aligned with performance on health equity measures?
3. Is our organization's fiscal policy aligned with equitable access to services, supports, assets, and opportunities?
4. Do our cross sector partnerships include a coordinated and integrative approach to allocating resources from each organization to maximize the effective alignment of funding across systems as they affect those most impacted by health inequities?

E. Assure accountability for optimal resource use.

1. Do we hold our organization's healthcare provider networks (hospitals/clinics) and other public health system partners accountable for advancing health equity?
2. Does our organization track and analyze whether public health allocations are spent in a manner that advances health equity and supports the reduction of health inequities?

3. Are fiscal, programmatic and outcomes analysis, tracking, and improvement processes in place for all allocated expenditures?
4. Does our organization rigorously follow and monitor fiscal principles and requirements of public/private stewardship and accountability to improve health equity?
5. Do we effectively inform and advocate with those who provide funding to our organization as to the importance of supporting the work of equity through the funding they provide us?

REMEMBER TO ASK...

- To what extent do we have these critical capabilities?
    - Not at all?
    - Isolated individuals, projects, or ad hoc efforts?
    - Some existing policies, procedures, and practices to support these capabilities?
    - Widespread organizational standards that support these capabilities exist and are measured?
- What are our supports/constraints in strengthening these critical capabilities? What else in our agency impacts our ability to achieve these critical capabilities?
- What unique challenges and opportunities are present in our organizational context?
- If we already have these capabilities, are we proficient? How could we improve?
- What are some specific examples of how we do this? How could we better or more extensively incorporate these capabilities in our work?
- How do our strengths and weaknesses in this foundational practice relate to the other six foundational practices?

Summary

Public health is focusing attention on the root causes of poor health by addressing inequities in social and economic conditions. The *Learning and Action Tool 2018* applies the WHO framework to collective efforts to improve health by focusing action on underlying social determinants of health – and the social determinants of health inequities – which are structural and systemic in nature.

Building upon the WHO Framework, the *Learning and Action Tool 2018* introduces seven foundational practices and their associated *critical* capabilities as a way to encourage deep reflection and dialogue about the capacity for public health organizations to address social determents of health and to build competencies to advance equity.

The foundational practices, which are not listed in any particular order – all seven interact with, cross-walk to, and support each other, and all are necessary to effectively advance health equity – include the following:

I. **Expand the understanding of health in words and action**
II. **Assess and influence the policy context**
III. **Lead with an equity focus**
IV. **Use data to advance health equity**
V. **Advance health equity through continuous learning**
VI. **Support successful partnerships and strengthen community capacity**
VII. **Assure strategic and targeted use of resources**

The *Learning and Action Tool 2018* is designed to build the capacity of public health organizations and their partners to advance health equity and create the conditions for better health across the life-course.

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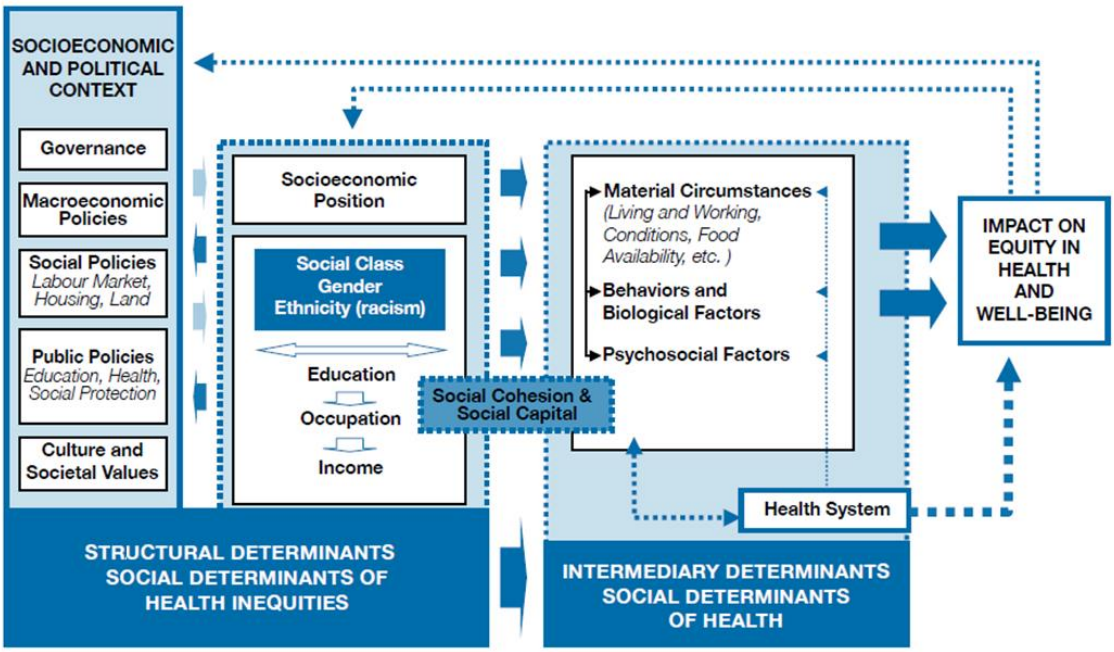
Appendix A: Understanding the WHO CSDH Framework

The WHO CSDH Framework *(see Figure 1)* synthesizes relevant evidence and theory in order to examine how health inequities arise and to support the development of effective actions to modify the differential distribution of health.[30]

Figure 1. World Health Organization Commission on Social Determinants of Health Framework



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The WHO CSDH Framework can be more clearly understood by focusing on the broad domains and how these domains connect to each other to influence health. Moving generally from right to left in Figure 1, the primary domains of the framework include the following:

- ***Intermediary Determinants*.**
  This domain includes material circumstances and psychosocial, behavioral and biological characteristics. Broadly encompassing living and working conditions, access to food, etc., this domain also includes the health care system, which has a relatively small but independent and interacting effect on health.

  Health-equity-supporting policies at this level would seek to limit the effects of excess vulnerability and exposure to existing conditions that disproportionately impact individuals and groups disadvantaged by social status and/or socioeconomic position, for example policies that support vocational training and job placement for those struggling to find family-supporting work.

  This domain is strongly influenced by the two large "structural determinants" domains to its left.

- ***Structural Determinants: Socioeconomic Position (SEP)*.**
  This domain describes how socioeconomic and political policies and processes interact to effectively assign socioeconomic position based on interacting social characteristics (e.g., social class,

[30] Solar, O. & Irwin A. (2010)

race/ethnicity, *and* gender) resulting in greater or lesser access to essential resources including education, occupation, and income.

Health-equity-supporting policies related to socioeconomic position would seek to minimize the systematic assignment of socioeconomic position (SEP) based on social characteristics, as well as limit the inequitable burden of macro policies on members of society based on hierarchies spanning continuums of advantage-disadvantage. Some examples include: policies prohibiting discrimination (racial, ethnic, gender, etc) in education, housing, employment, and other areas; policies that expand voting rights; and requirements to subject any new public policy proposal (in any sphere or sector) to an equity analysis before implementation.

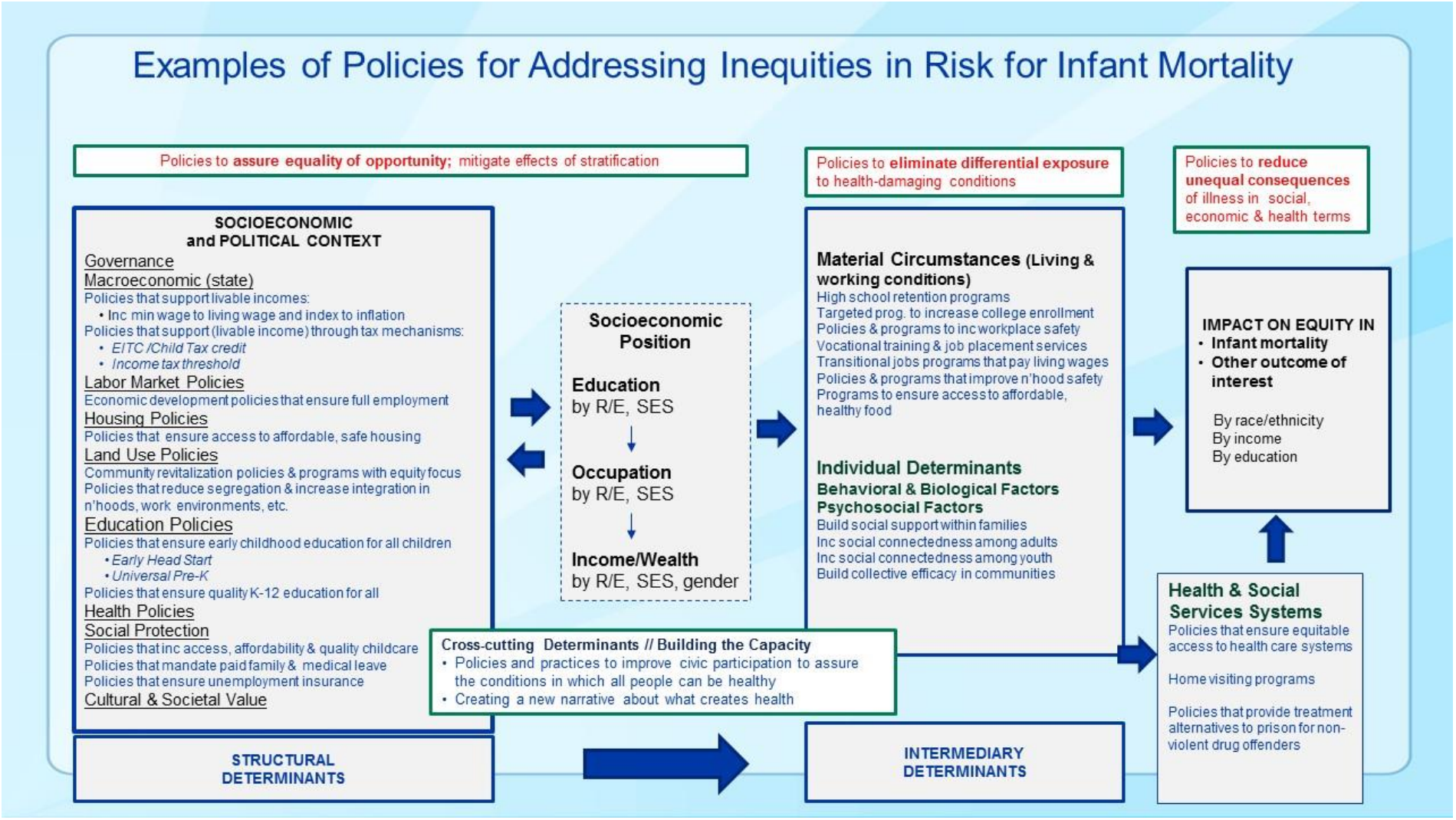
- ***Structural Determinants: Socioeconomic and Political Context*.**
  This domain includes the broad array of structural, cultural, and functional aspects related to how societies are organized, including governance structures, macroeconomic policies, social policies (e.g., labor market and housing), public policies (e.g., education, health and social protection), and cultural and societal values (e.g., the roles of men and women in families and society). These policies act to determine which groups of people have higher or lower SEP. Groups with higher SEP, in turn, have more leverage in influencing the socioeconomic and political context, and often act in such a way so as to preserve inequitable distribution of power and SEP.

  Health-equity-supporting policies and processes at this level would seek to maximize health and life opportunities through the fair distribution of society's resources to all members of a society.

- ***Cross-Cutting Determinants*** *(collective efficacy, including social capital and social cohesion)*.
  This domain takes into consideration the ability to impact intended change – acknowledging the role of people in the shaping of policies and processes that effectively determine how societies are organized. The WHO emphasizes the need to include groups historically and currently excluded from decision-making processes that impact their health and life opportunities, and places special emphasis on theories of power and models where collective action is informed by a human rights and social justice approach.

  Health-equity-supporting policies at this level would seek to support improved civic participation, to correct narratives and norms about what creates health, and to build social cohesion, social capital, and community capacity, power, and agency.

Appendix B: Health Equity in All Policies Approach with Health Equity as the Goal



(WHO CSDH Framework adapted by Geoff Swain and Marilyn Metzler)

NOTE: The policies and programs referred to below must be *effective* (evidence based and/or rigorously evaluated)	
Conceptual Category	**Policy/Program**
Structural	Policies that ensure early childhood education for all children (e.g., Early HeadStart, Universal Pre-K)
Structural	Policies that increase access to, affordability of, and quality of childcare
Structural	Policies that ensure quality K-12 education for all (e.g., funding, teacher quality)
Structural	Community revitalization policies and programs with equity focus
Structural	Economic development programs and policies that ensure full employment
Structural	Support livable income through tax policies
Structural	Support livable income by Increasing minimum wage to living wage and indexing to inflation
Structural	Policies that mandate paid family & medical leave
Structural	Expand and ensure unemployment insurance
Structural	Policies that ensure access to affordable, safe housing (e.g., Moving to Opportunity, Housing First)
Structural	Policies that reduce segregation and increase integration in neighborhoods, work environments, etc.
Intermediary PsySoc	Evidence-based programs to build social support within families
Intermediary PsySoc	Policies that build social capital and social cohesion within communities
Intermediary PsySoc	Policies and programs that increase social connectedness among adults
Intermediary PsySoc	Policies and programs that increase social connectedness among youth
Intermediary L&W	Policies that create safe school environments to support learning
Intermediary L&W	Targeted programs to increase college enrollment
Intermediary L&W	High school dropout-prevention programs
Intermediary L&W	Policies and programs to increase workplace safety
Intermediary L&W	Programs that provide vocational training and job placement services
Intermediary L&W	Massive expansion of living-wage-paying transitional jobs programs
Intermediary L&W	Policies & Programs that improve Neighborhood Safety
Intermediary Health & Crim Just	Policies that provide treatment alternatives to prison for non-violent drug offenders
Cross-Cutting	Policies and practices to improve civic participation to assure the conditions in which all people can be healthy
Cross-Cutting	Creating a new narrative about what creates health

Note: The Intermediary Determinants category includes Living and Working Conditions ("L&W"), Psychosocial ("PsySoc"), and Other (e.g., Health & Criminal Justice)

The following is a list of the kinds of policies that are considered to promote health and advance health equity and which are crucial to include in a comprehensive policy assessment. These are policies or policy areas that are evidence-based or evidence informed. Some have evidence for improving health outcomes in general, while others have specific evidence relating to improved birth outcomes (e.g., Earned Income Tax Credit).

When completing this *Learning and Action Tool*, policies should be assessed in multiple areas across the WHO structural, intermediary, and crosscutting areas (see Appendix II and III). To assist your organization, these policies areas are grouped by conceptual category according to the WHO conceptual framework.

Our state or local jurisdiction has effective policies in the WHO conceptual framework area of "Structural Determinants," including policies that effectively (check all that apply):

- ❒ Ensure early childhood education for all children (e.g., early HeadStart, universal pre-k)
- ❒ Increase access to, affordability of, and quality of childcare
- ❒ Ensure quality K-12 education for all (e.g., funding, teacher quality)
- ❒ Support community revitalization interventions that focus on increasing equity
- ❒ Support economic development initiatives that ensure full employment
- ❒ Support livable income through tax policies
- ❒ Support livable income by increasing minimum wage to living wage and indexing to inflation
- ❒ Mandate paid family & medical leave
- ❒ Expand and ensure unemployment insurance
- ❒ Ensure access to affordable, safe housing (e.g., Moving to Opportunity, Housing First)
- ❒ Reduce segregation and increase integration in neighborhoods, work environments, etc

Our state or local jurisdiction has effective policies in the WHO conceptual framework area of "Intermediary Determinants," including policies that effectively (check all that apply):

- ❒ Support programs to build social support within families
- ❒ Build social capital and social cohesion within communities
- ❒ Increase social connectedness among adults
- ❒ Increase social connectedness among youth
- ❒ Create safe school environments to support learning
- ❒ Increase college enrollment
- ❒ Support high school completion programs
- ❒ Increase workplace safety
- ❒ Provide vocational training and job placement services
- ❒ Support expansion of living-wage-paying transitional jobs programs
- ❒ Improve neighborhood safety
- ❒ Provide treatment alternatives to prison for non-violent drug offenders

Our state or local jurisdiction has effective policies in the WHO conceptual framework area of "Cross-cutting Determinants," including policies that effectively (check all that apply):

- ❒ Support substantially improved civic participation among all segments of society
- ❒ Support a broader narrative about what creates health (e.g., a health-in-all-policies)

Appendix C: Advancing Health Equity – Asking the Right Questions Is a Path to Action

(Adapted by the Minnesota Department of Health)

1. The central questions when looking at **existing policies** are:
   - What are the outcomes?
   - Who benefits?
   - Who is left out?

2. The central questions to help design **new policies** are:
   - What outcomes do we want?
   - Who should benefit?

3. The central questions to examining **processes** are:
   - Who is at the decision-making table, and who is not?
   - Who has the power at the table?
   - Who is being held accountable and to whom or what are they accountable?

4. The central questions to help develop **new processes** are:
   - How should the decision-making table be set, and who should set it?
   - Who should hold decision-makers accountable, and where should this accountability take place?

5. The central questions to identify **assumptions** are:
   - What values underlie the decision-making process?
   - What is assumed to be true about the world and the role of the institution in the world?
   - What standards of success are being applied at different decision points, and by whom?

6. The central questions to define **new assumptions** that will create the opportunity for health and healthy communities for all are:
   - What are our values?
   - What would it look like if equity was the starting point for decision-making?

Appendix D: Five Competency Sets for Public Health Leadership[31]

Invigorate Bold(er) Pursuit of Population Health

1. Critically assess the current state of your program or organization
2. Articulate a more compelling agenda
3. Enlist others in the vision and invigorate them to drive toward it
4. Pursue the vision with rigor *and* flexibility
5. Marshal the needed resources

Engage Diverse Others in Public Health Initiatives

1 Assess local conditions, in ways relevant and credible to the local stakeholders
2 Search widely for the right partners
3 Apply a social determinants perspective to planning
4 Take time to build relationships, teamwork, and common understanding
5 Clarify roles and governance

Effectively wield power to increase the influence and impact of public health

1. Understand and strategically use both positional authority and informal influence
2. Analyze a given public health problem and proposed solution in "campaign" terms
3. Build coalitions of core supporters, new partners, and issue-specific allies
4. Deal effectively with opponents
5. Be strategically agile

Prepare for Surprise in Public Health Work

1. Promote resilience in individuals and communities
2. Develop and critique an emergency response plan
3. Communicate effectively during surprises
4. Execute an emergency response plan with flexibility and learning
5. Learn and improve after surprises

Drive for Execution and Continuous Improvement in Public Health Programs and Organizations

1. Build accountability into public health teams, programs, and organizations
2. Establish metrics, set targets, monitor progress, and take action
3. Proactively demonstrate financial stewardship of public health funds
4. Employ the methods and tools of quality improvement
5. Encourage innovation and risk-taking

[31] Begun, J. W., & Malcolm, J. K. (2014). *Leading Public Health: A Competency Framework.* New York, NY: Springer.