

Addressing health equity through state, regional partnerships

Partnerships elevate state, local work

Equity councils cross sectors to target roots of disparities

THIS OCTOBER IN WASHINGTON, D.C., representatives from historically black colleges and universities will gather to discuss attracting more students into nursing. More than just addressing projected provider shortages, the event is a strategic move to advance health equity in the region.

One of the main organizations behind the event is the Mid-Atlantic Regional Health Equity Council, one of 10 independent, cross-sector councils working to eliminate health disparities from the grassroots up. The volunteer councils, launched in 2011, correspond to the 10 U.S. Department of Health and Human Services regions and are charged with jump-starting action toward the goals of the National Partnership for Action to End Health Disparities, an initiative of the federal Office of Minority Health to address persistent and entrenched disparities. Among the partnership's top five action priorities is embedding health equity considerations in policies and programs across sectors "to impact health and the social determinants of health."

"Collective action to end health disparities is possible if individuals and organizations, those with a vested interest, are engaged in the work as equal partners," said Office of Minority Health officials in a 2011 article in APHA's *American Journal of Public Health*. "The (national partnership) offers a forum for sharing ideas and resources, an opportunity to partner and a collaborative approach to problem-solving."

Across the country, the regional health equity councils are charged with pushing the partnership's goals forward. Their process is similar across regions — councils identify shared problems and then leverage existing resources and expertise to move the needle on reducing disparities in a strategic and organized way. But their actions often vary to reflect

regional health needs, from expanding the reach of community health workers to helping providers connect with skilled translators and interpreters.

At the Mid-Atlantic equity council, for example, collaborating with HBCUs on workforce development is a top priority in support of national partnership goals to improve cultural competency and diversity in the health professions.

Steven Owens, MD, MPH, MA, co-chair of the Mid-Atlantic Regional Health Equity Council, said the October forum is sparked, in part, by data showing that HBCUs currently confer only a small percentage of nursing degrees. At the upcoming forum, discussions will focus on better understanding the challenges HBCUs face in attracting and graduating nursing students, with a short-term goal of connecting schools with workforce development practitioners already in the field and a much longer-term goal of increasing provider numbers in underserved communities.

"The (equity council) has really elevated the collaborations needed to address health equity from a variety of angles and brings together a diversity of thoughts, leadership and expertise to address a common issue," Owens, also vice president of programs and services at the Epilepsy Foundation, told *The Nation's Health*. "I think we're making some meaningful impacts."

Regional councils mobilize local work

The need for health equity work is clear in the data, with research consistently showing associations between adverse health outcomes and social determinants such



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A growing number of states are creating equity plans and reports to help ensure that all residents are given fair and adequate access to the tools they need to be healthy.

Social determinants of health key State plans bring health equity focus to community level

STATES THROUGHOUT THE U.S. are recognizing the importance of health equity, and are creating plans to improve it across their communities.

Sometimes called equity reports or assessments, state health equity plans can help health departments and communities ensure that their public health efforts are geared toward improving opportunities for all community members to live a healthy life — regardless of their ZIP code, race, ethnicity, sexual orientation, gender identity, insurance status, level of education or level of income, said Nicole Alexander-Scott, MD, MPH, president-elect of the Association of State and Territorial Health Officials and director of the Rhode Island Department of Health. Equity reports take each of those social determinants of health into account, as they can be barriers to achieving good health, or a free pass to good health for others.

"Employing a health equity lens in public health also helps ensure that communities consider the needs and health dis-

parities experienced by vulnerable populations," Alexander-Scott told *The Nation's Health*. "Without this lens, you run the risk of celebrating improvements in overall public health — for example, an overall reduction in infant mortality — without considering the disparities experienced by certain populations."

While each health equity report is different, and each state has many communities with different needs, all the plans chart where public health efforts are improving health and health equity for all residents. That means each resident is given fair and adequate access to the tools they need to be healthy. Such undertakings are often works in progress, but they can lead to greater movement in improving health outcomes, particularly in vulnerable populations.

One example is New



Photo by Annie Wells, courtesy Los Angeles Times/Getty Images

A mother breastfeeds her baby in Los Angeles in 2000. Regional Health Equity Councils are working to reduce disparities — including those for maternal and child health — and improve health equity in communities across the U.S.

Addressing health equity through state, regional partnerships



In this special section of *The Nation's Health*



Equity councils targeting roots of health disparities **Page S1**



States bringing health equity focus to community level **Page S1**



Utah tackling community oral health inequities **Page S3**

New England region using data to drive equity forward **Page S3**

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Regional councils partner on health equity

RHECS,
Continued from Page S1

as income, education, access to care and discrimination. Just last year, a study in *Health Affairs* found that the U.S. has some of the largest income-based health disparities in the world.

Knowing that no one sector can eliminate disparities and achieve health equity on its own, health officials created the National Partnership for Action in 2007 to mobilize collaborative and sustainable approaches. "It's a movement," said APHA member Oscar Espinosa, MA, a senior associate at Community Science, a research and development organization.

"(The partnership) could have just launched a bunch of national awareness campaigns around disparities, but they wanted to do something more than that — they wanted to create a groundswell," Espinosa, who recently co-authored a three-year retrospective on the partnership, told *The Nation's Health*. "The (equity councils) aren't just a collection of practitioners. They're bringing in other sectors so we're not just preaching to the choir...They turn the (partnership) into a megaphone for health disparities."

The retrospective study, published last year in the *Journal of Health Disparities Research and Practice*, reported that the partnership was making progress, with increasing levels of collaboration reported across stakeholders. The equity councils, in particular, had "solidified themselves as functioning regional collaboratives" focused on shared priorities. Researchers wrote that the "focus on equitable outcomes and the emphasis on the (social determinants of health) lens give the (partnership) unique standing among public efforts aimed at ending health disparities."

More than creating a foundation for the long term, the regional councils also mobilize direct action on eliminating disparities. For example, the study reported that in 2015,



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Partnerships are helping state and regional health workers address disparities and target health equity.

councils worked directly with local organizations to reach uninsured and underinsured residents with information about the Affordable Care Act. That year, the councils helped host 184 ACA outreach and education events attended by nearly 13,500 people.

"The solution to disparities lies in being equitable across the social determinants," said Espinosa, who will present on the study during session 3171 at APHA's 2018 Annual Meeting and Expo in San Diego in November.

To have the greatest chance for impact, regional councils focus on common barriers to better health. At the Region X Health Equity Council, which represents Alaska, Idaho, Oregon and Washington, members took a cue from data showing significant increases across the region in residents who speak languages other than English, according to Lambert Adjibogoun, MPA, co-chair of the Region X council and human services investigator at Oregon's Multnomah County Department of Human Services.

"Knowing that health literacy is a strong predictor of health outcomes and life expectancy, we decided to take on language access," Adjibogoun told *The Nation's Health*.

The results of that effort are expected to be released this fall in the council's new language equity guide. Lorena Sprager, chair of the council's Language Equity Committee and program manager for Nuestra Comunidad Sana, a community health program in Oregon, said the practical guide is designed to help

health and social service providers find appropriately trained interpreters and translators. Beyond its more

practical advice, Sprager said the guide also calls for strengthening national standards for language services.

"Translation is the first step, not the final step," she told *The Nation's Health*, noting that literacy-promoting language services should be adept at translating complicated health information into plain language and adapting messaging to make it culturally appropriate. "The guide is definitely for public health and health services, but it's also for other services that impact the social determinants of health, such as schools and housing programs and employment offices."

Promoting language equity is among the Region X council's top priorities, along with raising awareness of immigrant and refugee health, sup-

porting environmental justice activities and strengthening community health worker programs.

"The diversity in the regions and nationally means councils can really leverage resources to get things done," APHA member JamieLou Delavan, health equity program specialist at the Idaho Department of Health and Welfare and initial co-chair of the Region X council, told *The Nation's Health*. "I don't think any one of us had the resources to create a language equity guide on our own."

While the national partnership provides a "north star," the councils "give us the goal posts," said Connie Chan Robison, MPH, co-chair of the Pacific and Southwest Regional Health Equity Council and executive director of the Center for Collaborative Planning at the Public Health Institute. That council has a particularly daunting task in finding common problems and promising solutions, as its region runs from the continental U.S. West to territories in the Pacific, such as the Republic of Palau, the Marshall Islands and American Samoa.

But using a health equity model, the council was able to identify cross-cutting priorities, such as improving behavioral health outcomes and expanding pipelines into health professions, as well as promising tools that communities across the wide region could adapt, such as models of successful community health worker integration.

"I think (these councils) are really important to moving the needle on this big ticket item of health equity," Robison told *The Nation's Health*. "It opens up and really elevates the work in a different space to think about how we scale up and leverage what we've done and help other communities do the same...If we can begin to make the connections and then connect the dots, that's where there's great opportunity and advantage."

To learn more about the Regional Health Equity Councils and national partnership, visit www.minorityhealth.hhs.gov/npa. ■

— Kim Krisberg

Free dental service days address social determinants of health Utah workers tackle community oral health inequities

IN 2015, Utah public health workers set out to tackle dental disparities with a specific focus on achieving oral health equity. Three years later, the work has helped hundreds of residents and is building new, community-driven partnerships that organizers hope will sustain its progress.

The effort stands out for its attention to the social determinants that shape oral health access and outcomes, such as income, employment status, language barriers and where a person lives. In particular, organizers used a framework based on goals of the National Partnership for Action to End Health Disparities, an initiative of the federal Office of Minority Health designed to mobilize action toward eliminating health disparities. To date, the Utah oral health project, which began providing access to free dental care in 2016, has served more than 500 residents across 23 languages.

In 2016, according to state health officials, 30 percent of Utah adults had not seen a dentist in the year prior, with the rate even higher among people without dental insurance.

“Using the pillars of the (national partnership) framework, we’re much more likely to reach populations that experience disparities,” Brittney Okada, MPH, CHES, program coordinator in the Utah Department of Health’s Office of Health Disparities, which oversees the dental effort, told *The Nation’s Health*. “Without that strategic approach, this would be considered Band-Aid care. With this approach, we can jump-start a long-term structure even though we’re only providing short-term care.”

The effort zeroes in on two of Utah’s most underserved urban communities — the Salt Lake City neighborhood of Glendale and the city of South Salt Lake — and leverages an existing outreach program known as Bridging Communities and Clinics, a partnership-driven strategy that the Utah Office of Health Disparities created to widen access to culturally compe-

tent health services. The first of the “free dental day” clinics opened in 2016, providing one day of no-cost dental care to residents who live in the two communities. Seven free dental days have followed since, according to APHA member Christine Madrid Espinel, health program specialist in the Utah Office of Health Disparities. The goal, she said, is to host four free dental clinics each year through 2020, which marks the end of the five-year grant that supports the equity effort.

“Our goal is to demonstrate its value in creating a sustainable approach to disparities,” said Espinel, who also serves as co-chair of the Mountain States Regional Health Equity Council, one of 10 such councils through the country that help advance national partnership goals.

The ultimate aim is to jump-start and demonstrate the partnerships and structural components needed to sustain access gains long after the five-year grant ends, Espinel told *The Nation’s Health*. For example, during the free dental days, practicing dentists and dental hygienists work alongside students from local dental schools to care for patients. The dental days are also staffed with interpretation services and held in a local brick-and-mortar clinic.

All those components, Okada said, were specifically picked to boost sustainability. The staffing, for instance, facilitates academic-practice linkages that widen oral health access and educate the future

workforce. Working with interpreters builds cultural competency among providers and health literacy among residents. And setting up in a building, rather than a mobile unit, creates a sense of connection to the community.

“So many times, these efforts are mobile,” Okada said. “But this one is building the capacity and health literacy to go to a clinic that will always be there.”

To impact the social barriers to good oral health, Espinel said organizers looked to the five goals of the National Partnership for Action: awareness, leadership, health system and life experience, cultural and linguistic competency, and data research evaluation. For example, the clinics were held in locations close to public transit options and residents were offered tokens to cover travel expenses. Also, the availability of interpreters is giving people who may have never visited a dentist before an entry point into the oral health care system.

“When we can’t rely on big policy changes, we rely on strategies like the (national partnership) to find ways to make our strategies sustainable in the long term,” Okada said.

In January, the Utah Office of Health Disparities issued the first of three reports on its oral health equity effort. For information on “Addressing Oral Health Disparities in Urban Settings: A Strategic Approach to Advance Access to Oral Health Care,” visit www.health.utah.gov/disparities. ■

— Kim Krisberg



Photo by DragonImages, courtesy iStockphoto

Public health workers are tackling oral health disparities in Utah by offering free dental clinic days.

New England region using data to drive health equity forward

MANY NEW England states regularly rank among the healthiest states in the nation. Just last year, Vermont, Massachusetts and Connecticut all ranked in the top five.

But a deeper dive into the data reveals even the healthiest states can be home to big health disparities.

“We know we have persistent and pervasive disparities,” said Rodrigo Monterrey, MPA, deputy director of the Massachusetts Department of Public Health’s Office of Health Equity and co-chair of the New England Regional Health Equity Council. “But we felt that just stating

that was not enough — we needed to document it.”

Monterrey is referring to a 2016 report from the council — “New England Regional Health Equity Profile and Call to Action” — that identified significant disparities across New England in both health outcomes and access to care.

But what made the report a first-of-its-kind was that it took a health equity approach, drilling down to identify differences in social determinants and opportunity that underlie disparities in poor health and disease burden.

Charles Drum, PhD, MD, MPA, lead author of the report and co-chair of the council’s Data, Research and Evaluation Committee, said the report is also unique for its inclusion of disability.

“Given limited resources for state and local health departments, the report provides New England states with comparisons to their geographic neighbors, examples of programs that can be replicated and calls for more regional partnerships,” Drum, a visiting scholar at the American Association on Health and Disability, told *The Nation’s Health*. “Equally important from my perspective, the report reveals the compounding disparity effect of

the presence of disability.”

The report, which council members disseminated in their home communities and that continues to guide regional equity work, found that racial and ethnic minorities and people with disabilities are twice — and in some cases, up to three times — more likely than whites and those without disabilities to delay needed care due to cost.

Among the report’s other findings: People with disabilities experience

higher rates of stroke, cancer and diabetes; significantly larger percentages of black, Hispanic and American Indian and Alaska Native households

live on less than \$25,000 a year; and considerably higher percentages of black, Hispanic, American Indian and Alaska Native and adults with disabilities did not graduate high school.

The report and call to action are based on data from the Behavioral Risk Factor Surveillance System and provides regional and state-based data for Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont.

Monterrey said the council hopes the report’s insights will continue shifting from a lens of disparities to one of equity.

“A lot of time, we think we’re talking about health equity, when in reality, we’re only presenting disparities data,” he told *The Nation’s Health*. “And if we base our responses only on disparities data as opposed to providing that data in the context of health equity, our responses won’t be as effective.”

The regional council’s next report will focus on mental health and addiction among minority youth and youth with disabilities. For more information or a copy of the 2016 report, visit <http://region1.npa-rhec.org>. ■

— Kim Krisberg

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North Carolina county advancing equity through collective impact tool

IN BUNCOMBE County, North Carolina, public health workers are going upstream to tackle health disparities between black and white residents.

To get there, local health workers are using the collective impact model, a health equity tool that helps leverage and create partnerships across sectors toward a common agenda. The tool is particularly apt at mobilizing action that is both sustainable and community-driven — two key factors when trying to impact social determinants that underlie health disparities.

According to Buncombe County's 2015 community health assessment, black residents experience significant disparities in nearly every leading cause of death. For example, they die from diabetes at a rate three times higher than whites and experience higher rates of death from cancer and heart disease.

"We've got lots to learn as we go...but one thing

that we are clear (on) is that keeping the voice of communities central to our planning, programming and interventions is key," said Zo Mpofo, community health assessment coordinator at Buncombe County Health and Human Services, during a May webinar from the National Partnership for Action to End Health Disparities.

Guided by the collective impact model, Mpofo said the health agency facilitates and engages with a variety of community-driven efforts that target social determinants of health, such as those working to expand access to healthy foods, educational attainment and trauma-informed services.

"The solutions are to come from communities," Mpofo said during the webinar.

To access the webinar and for more on the collective impact model, visit www.npa-rhec.org/in-the-spotlight. ■

— Kim Krisberg

Cultural competency tool to be offered in five languages

PUBLIC HEALTH PRACTITIONERS looking to better meet the needs of underserved communities have a new tool to draw on.

The Southeastern Health Equity Council recently translated its Cultural Competency Resource Guide from English into four other languages: Chinese, Korean, Spanish and Vietnamese, and will release the new guides this year to curb disparities in Southern communities.

The Cultural Competency Resource Guide was released in English in 2014. It outlines available trainings on cultural competency — the ability of individuals and organizations to deliver services that successfully address the social, cultural and linguistic needs of individuals and communities — in both health care and general settings. The trainings included in the guide include those that address specific populations, such as Latin American immigrants.

The guide also highlights local and regional trainings that could be particularly useful for council members and others in the Southeastern U.S.

The Cultural Competency Resource Guide also includes suggested readings to improve users' cultural competency, and a glossary of key terms to expand users' understanding of culture competency, cultural humility and other critical elements of providing holistic, ethical and accessible care to underserved communities.

The council is a regional coalition of the National Partnership for Action to End Health Disparities.

To learn more or request the guide in any of its five languages, visit <http://region4.npa-rhec.org>. ■

— Lindsey Wahowiak

States mobilizing to address health equity

STATE PLANS,
Continued from Page S1

York. The New York State Department of Health has made its state and county level data on health disparities available to the public since 2007. But in 2017, the department's health equity report included data on health outcomes, demographics and other community characteristics for cities and towns with populations that were at least 40 percent non-white. Within the report, there were town- or city-specific reports with data that aligned with the New York State Health Improvement Plan and social determinants of health, such as housing, educational attainment and insurance coverage.

The New York State Department of Health noted that local health departments could use such data to understand and identify their own priorities, mobilize communities and promote health equity.

While individual communities will have their own needs, state-level data and support is critical, said Tia Taylor Williams, MPH, MS, director of APHA's Center for Public Health Policy and Center for School Health and Education.

"If you're applying an equity lens, there are clear gaps you can see and shore up by partnering across sectors, such as housing and transportation," Williams told *The Nation's Health*. "That has a trickle-down effect to the local level by serving as a model and also determining how funding is applied."

Eliminating disparities and achieving equity are some of the Rhode Island Department of Health's leading priorities, Alexander-Scott said. From the data the department collected on equity, it created its Health Equity Institute, which addresses systemic inequities so that all residents are able to achieve better health.

From the institute, the Rhode Island Department of Health has created a Health Equity Zone initia-



Photo by Steve Debenport, courtesy iStockphoto

In Washington state, health leaders have created and implemented a community engagement guide on equity. Communities across the country are coming together to address health equity, thanks in part to statewide plans.

tive, which Alexander-Scott described as a "community-led, place-based approach designed to build healthier, more resilient and more just communities across Rhode Island" through action plans for high-risk communities.

In Washington, there is no official statewide plan, but health leaders are using a work group to address health equity in communities. The Washington Department of Health's Health Equity Workgroup and Center for Public Affairs Community Relations and Equity staff collaborate to set priorities and lead activities to promote health equity. A 2017-2019 work

plan on health equity includes nine strategies to implement to enhance opportunity for at-risk communities. Some of the strategies have already been implemented, such as the creation and implementation of a community engagement guide on equity, said Katie Meehan, a health equity consultant at the department's Center for Public Affairs.

State and local health agencies can get help moving toward health equity from ASTHO's Center for Population Health Strategies, which supports public health agencies in addressing socio-economic and environmental determinants of health and health equity. Assistance through ASTHO includes technical help, leadership development and other educational and professional development

opportunities for state and territorial health officials and agency staff.

"ASTHO's organizational vision is to support state and territorial health agencies advancing health equity and optimal health for all," Alexander-Scott said.

APHA also highlights the work state and local leaders are doing to achieve health equity in their communities. The Association's "Better Health Through Equity: Case Studies in Reframing Public Health Work" report offers examples of successful efforts to address inequities. APHA also works upstream to eliminate the root causes of inequities. The Center for School, Health and Education works with schools and school-based health centers to address the factors that influence health and educational success.

"There's a lot of power and opportunity to really take action on what's most pressing for all state residents," Williams added. "It's important in times when there's not as much movement at the national level. The federal government can't dictate what states can do from an equity perspective. It has to be driven by where there's the most need. There's a lot of potential and power states have in creating equity."

For more information on health equity and resources from APHA, visit www.apha.org/health-equity. ■

— Lindsey Wahowiak