A Primer for Local Health Departments to Create a Culture of Health Equity

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Promoting Health Equity in All We Do

Kentucky Public Health Community,

I am excited to share with you the Primer for Local Health Departments to Create a Culture of Health Equity. This important tool outlines a health equity framework that recognizes and addresses root causes of health disparities and inequities. The framework outlined in the Primer provides a roadmap for fostering cultural humility, inclusivity, and embedding health equity principles into the work that we do to improve health outcomes and support for all Kentucky citizens. The Primer is also a valuable resource for building capacity, creating and expanding existing partnerships, and establishing accountability for achieving health equity.

Developed by state and local health department staff with guidance from nationally recognized health equity experts, the Primer provides a direction for recognizing social determinants of health and the impact on an individuals' health and well-being as well as steps to advance health equity initiatives.

Thank you for the work you do each and every day. I stand with you as public health champions striving for health equity. I support you in your endeavor to work strategically to use the Primer to implement health equity principles into the delivery of public health services within the Commonwealth.

Sincerely yours,

Steven J. Stack, MD, MBA, FACEP
Commissioner
Kentucky Department for Public Health

Introduction

The term health equity is not new. Since the 19th century, health and public leaders have denounced inequalities that lead to inequities in health. Equity is an ethical concept, defined as meaning social justice or fairness.[1] Healthy People (HP), which creates goals and objectives to help build a healthier nation, defines health equity as the attainment of the highest level of health for all people.[2] For this to be achieved, we must work together to address the root causes of health disparities and inequities. Unjust circumstances whether based on race, gender, income, ethnicity, and other social conditions, need to be eliminated. These unfair circumstances leave populations in danger of experiencing dire health outcomes.

To help combat these inequities, local health departments (LHDs) should adopt a health equity lens in which to view policies, programs, and services. An equity lens is an understanding of the social, political, and environmental contexts of a program, policy, or practice to evaluate and assess the unfair benefits and burdens within a population.[3] (A list of commonly used terms related to health equity can be found in **Appendix A**).

To truly adopt an equity lens at the local levels, the concepts of health equity, health disparities, and social determinants of health are moving to the forefront and impacting the day-to-day programs and services provided by these organizations. However, according to Umair Shah, MD, Executive Director of Harris County Public Health in Houston Texas: "The big thing [is] that we need to change the culture within our departments - to really move from a mindset of disparities to the language of equity."[4] To do this, all LHD employees must realize and understand the population they serve. The first step is to recognize the need for workforce development. This document, "***A Primer for Local Health Departments to Create a Culture of Health Equity***" was developed to assist with this effort.

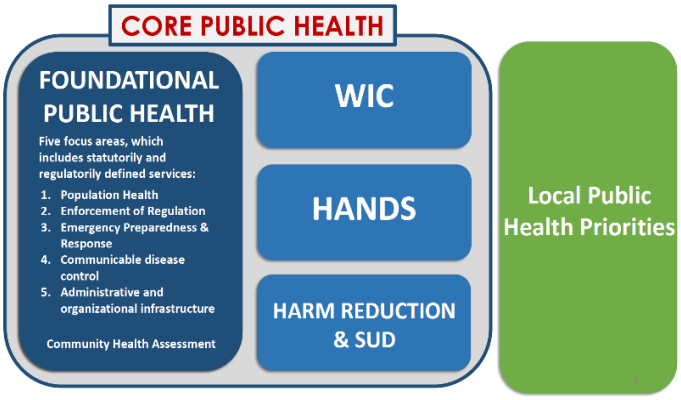
Equality ≠ Equity

Figure 1: Equality vs. Equity

Before one can tackle health equity, it is key to understand that equity is not the same as equality. As shown in **Figure 1**, equality means that each person or population is given the same opportunities, resources, and services. Equity recognizes that each person has different circumstances and allocates the exact resources and opportunities needed to reach fair and just outcomes.[5] All people should have the right to achieve an optimal level of health regardless of race, ethnicity, sex, sexual orientation, education level, or income, to name a few. In order to accomplish this, the focus should be on inequities faced by all groups within a community, especially those who experience socioeconomic burdens, historical injustices, and other forms of oppression. As many LHDs across the nation, including those in Kentucky, shift their emphasis towards Public Health Transformation (PHT), Public Health 3.0. (PH 3.0), and Public Health Accreditation, there is hope that most will begin to develop an agency approach to addressing health equity. Without a focus on health equity issues, some programs and services may instead unknowingly exacerbate inequities in vulnerable populations.

In Kentucky, PHT includes the following: (1) introducing a modern, simplified, and focused Public Health model with clearly defined priorities that are based on PH 3.0 priorities; (2) creating accountability at all levels of the system; and (3) supporting and emphasizing data driven decisions to best promote community health outcomes.[6] (**Figure 2)** A Health Equity Lens is essential to all aspects of the transformation process. During this transformation, it is important to address socioeconomic and environmental determinants of health embedded in our policies; eliminate health disparities; ensure access and quality of care; encourage innovative ways to address equity; build internal capacity and a will to act on the social determinants of health and health equity; and to develop relationships internally and externally in order to mobilize communities and government to address health inequities.[6] Everyone deserves the best health possible regardless of zip code. PHT is a great start in ensuring the optimal health of all Kentuckians.

Figure 2: Public Health Transformation



In addition, PH 3.0 is a renewed approach to public health. The goal of PH 3.0 is for local communities to take charge of moving public health to the next level and ensuring its continued success and relevance.[7] This shift centers around health equity with five essential pillars: Chief Health Strategist; Enhanced and Modified Funding; Actionable Data; Public Health Accreditation; and Cross Sector Collaboration. (**Figure 3**)

Figure 3: Public Health 3.0

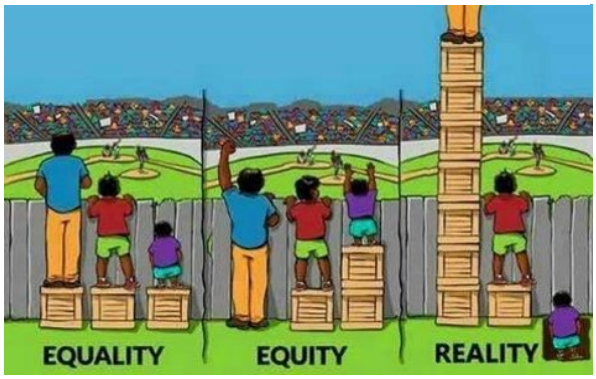
Finally, Public Health Accreditation is a national and voluntary program launched in 2011 and administered by the Public Health Accreditation Board (PHAB). The goal of the program is to "help public health departments access their current capacity and guide them to continuously improve the quality of their services, thus promoting a healthier population."[8] To qualify for accreditation, health departments must meet PHAB Standards and Measures which are grouped into domains designed to measure the ability of a health department to provide population-health programs and services in alignment with the 10 Essential Public Health Services (EPHS) Framework. "A health department that achieves initial accreditation through PHAB has demonstrated that it has the capacity to carry out the 10 Essential Public Health Services, as well as to administer and manage their health department and effectively engage with their governing entity."[9] The EPHS were initially released in 1994 and were last updated in 2020. In the Version 2022 update of the PHAB Standards and Measures, the revised 2020 EPHS will be utilized. The revised 2020 EPHS are listed below and also detailed in **Figure 9** on page 10**.**

Figure 4: PHAB Logo

- Assess and monitor population health status, factors that influence health, and community needs and assets
- Investigate, diagnose, and address health problems and hazards affecting the population
- Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it
- Strengthen, support, and mobilize communities and partnerships to improve health
- Create, champion, and implement policies, plans, and laws that impact health
- Utilize legal and regulatory actions designed to improve and protect the public's health
- Assure an effective system that enables equitable access to the individual services and care needed to be healthy
- Build and support a diverse and skilled public health workforce
- Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement
- Build and maintain a strong organizational infrastructure for public health

This swing in culture can provide a lens to enhance the way both internal and external services are delivered. Those in public health realize that everyone does not have access to the same resources and services. Disparities and inequities of all kinds occur in every community. No place is immune to injustices. However, local communities can identify the root causes and work diligently to deliver programs and services through an equity lens.

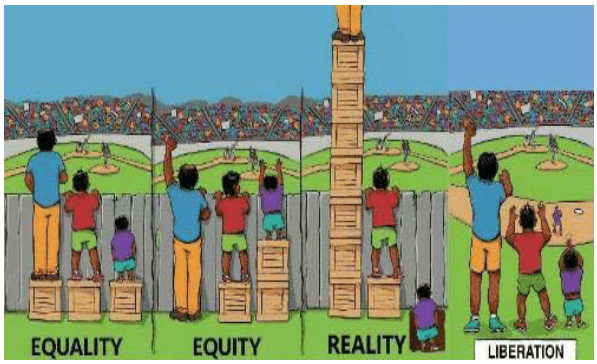
Figure 5



As previously stated, to attain health equity everyone should have the opportunity to utilize programs and services that can enable them to reach their highest level of health. Still, there is no one size fits all solution. **Figure 5** demonstrates Equality vs Equity vs Reality. In this baseball game example, an equal solution would be to provide everyone with the same size box despite their height to see over the fence. Yet, this does not come close to solving the problem. When an equity lens is applied to this situation, everyone would be provided enough boxes based on their height to see over the fence. However, in reality, one individual may receive all the resources needed to reach their potential, while another finds it extremely difficult to come out of the hole. Whether it is equality or equity, the reality of the situation will not be easily fixed. All over the world, people face all levels of advantages and disadvantages. This is why equity is important. Everyone has the right to achieve an optimal level of health. The only difference is how they get there.

The comparison in **Figure 5** is a prime example of how we normally approach a situation. We commonly think that treating everyone the same is all it takes to do what is best for all members in a community. However, that is not the truth, as the same box given to all in this graphic still does not allow everyone to view the ballgame. Furthermore, the reality is that many of our populations, as depicted in **Figure 5**, have been impacted by systems, barriers, and challenges which have given them no solid ground to have a box to see the ballgame.

Figure 6



As we work to address the social determinants of health (SDOH) we must also recognize the systems and institutional barriers and hierarchy of power that has historically worked to disenfranchise one group over another. Using the baseball game, public health recognizes that by removing the fence all can see the game and liberation is achieved (**Figure 6**). But, we must not stop there. There are additional social injustices at play. Even though the fence has been removed liberation is not fully achieved. The spectators still aren't playing because the rules of the game have not changed; only then can true liberation be achieved.

Public Health, Health Equity, and Healthy People 2030

In 1988, the Institute of Medicine (IOM) defined public health as "what we as a society collectively do to ensure the condition for people to be healthy."[10] Since its inception, public health has evolved from a strict focus on disease prevention to include areas such as: disease assessment and screening; emergency preparedness; food regulation and safety; healthcare services; and child and maternal health services. As we move towards the year 2030, the field of public health continues to develop, expand, and shift priorities. These priority areas now include health equity and SDOH.

Healthy People 2030 (HP2030) sets "data-driven national objectives to improve health and well-being over the next decade" with a five-goal purpose.[11] HP2030 supports health improvements by setting 355 measurable and streamlined objectives for the nation to meet over the next decade on specific health issues, and tracking and sharing efforts that are most effective. The goals and objectives in HP2030 seek to promote health and well-being, prevent disease, eliminate health disparities, achieve health equity, and attain health literacy. Through the Plan of Action, upstream factors and interventions will be used to address health equity at local, state, and national levels.[11]

With a vision to "create a society in which all people can achieve their full potential for health and well-being across the lifespan,"[11] HP2030 objectives highlight upstream factors related to SDOH. SDOH are "conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning and quality of life outcomes."[11] SDOH are major influences on a person's life and overall health including but not limited to: education, housing, job opportunities, language, neighborhoods, safety, transportation, and violence.

Figure 7 shows the five SDOH domains as outlined in HP2030. Goals for each of the areas are briefly described below. [12]

- Economic Stability
  - Goal: Help people earn steady incomes that allow them to meet their health needs.
- Education Access and Quality
  - Goal: Increase educational opportunities and help children and adolescents do well in school.
- Healthcare Access and Quality
  - Goal: Increase access to comprehensive, high quality healthcare.
- Neighborhood and Built Environment
  - Goal: Create neighborhoods and environments that promote health and safety.
- Social and Community Context
  - Goal: Increase social and community support.

Figure 7: Healthy People 2030 Social Determinants of Health

By the year 2030, many LHDs will pursue the accreditation or reaccreditation process with updated PHAB standards and measures that promote health equity and address SDOH. At a local level, addressing SDOH and inequities now is essential to the future of LHD operations and community intervention.

Health Equity as an Essential Public Health Service

The 10 Essential Public Health Services (EPHS) Framework was originally developed in 1994. The EPHS framework serves as the description of activities that public health systems should undertake in all communities. A public health system is defined as "all public, private, and voluntary entities that contribute to the delivery of essential public health services within a jurisdiction."[13] **Figure 8** shows some examples of entities included in the public health system.

Figure 8: Public Health System

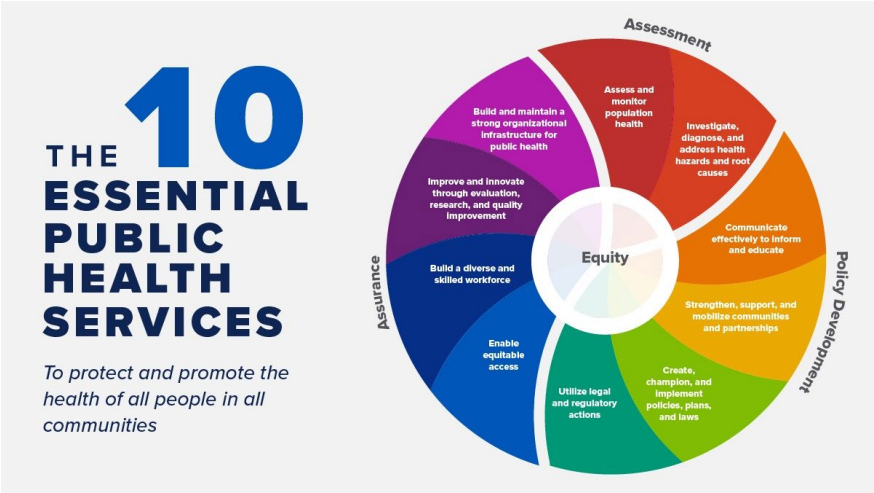
Public Health System Entities:

- State Public Health Agencies
- Local Public Health Agencies
- Community Partners
- Healthcare Providers
- Public Safety Agencies
- Education Organizations
- Youth Organizations
- Environmental Agencies

Centered around the three core functions of public health - assessment, policy development, and assurance - the EPHS Framework provides a roadmap of goals for carrying out the mission of public health in communities around the nation.

The EPHS Framework was revised in 2020 in order to be equity-driven, transparent, inclusive, data informed, evidence-based, and relevant. This updated framework centers around equity with a goal to protect and promote the health of all people in all communities. The EPHS Framework actively promotes policies, systems, and services that enable good health and seek to remove both systemic and structural barriers such as poverty, racism, and oppression that result in health inequities.[14]

Figure 9: 10 Essential Public Health Services



As shown in **Figure 9**, there is not a single essential service for which health equity is not a component. It is important for all members of a public health system to understand how the environment and conditions of a community affect a wide range of health issues and risks. "These social determinants of health (SDOH), and actions to address the resulting health inequities, can be incorporated throughout all aspects of public health work"[14]

The Importance of Data in Addressing Health Inequities

Data are essential to help us understand, investigate, and spread awareness about the root causes of health inequities and help us develop social and environmental interventions to improve health. Merriam-Webster Dictionary defines data as "factual information (such as measurements or statistics) used as a basis for reasoning, discussion, or calculation."[15] For public health professionals, data are vital in decision-making processes, strategic planning, productivity, and evaluation. Data collection pertaining to health behaviors and health outcomes are building blocks of any health equity analysis. For example, data shows that despite continuing health improvement interventions, the state of Kentucky has shown minimal progress over the past three decades. According to the annual America's Health Rankings, Kentucky continues to rank 40th or below in overall health ranking. However, Kentucky is also near the bottom in many specific measure areas such as drug deaths (46th); obesity (46th); physical inactivity (50th); smoking (49th); and children in poverty (43rd).[16] Changing the reactionary status quo to a more preventative health culture continues to be challenging. It is because of this challenge that Kentucky consistently ranks higher than the national average for many adverse health measures.

Data Resources and Databases

LHDs throughout the United States have access to various data resources and databases. Some of the most commonly used sites include: **American Community Survey (ACS); Kentucky Behavioral Risk Factor Surveillance System (KyBRFS); County Health Rankings and Roadmaps; and the Youth Risk Behavior Surveillance System (YRBSS).** In addition, **Community Commons** and the **Social Vulnerability Index (SVI)** are two common data sources used to look at inequities within communities.

- ***Community Commons*** is a resource designed to help create "healthy, equitable, and sustainable communities."[17] This site allows public health professionals to look at emerging trends, various community topics related to health equity, and community data. This information helps to "strengthen collaborative capacity to take action; better understand a community's unique assets and areas of the community; access proven strategies and innovative new approaches for driving community change; leverage data and lived experiences to make the case to policymakers and funders; and lead by sharing learnings, favoriting proven resources, or starting a dialogue."[17]
- ***Social Vulnerability Index (SVI)*** uses "census data to determine the social vulnerability of every census tract. The SVI ranks each track on 15 social factors and groups those factors into four related themes. These themes are: Socioeconomic Measures; Household Composition and Disability Measures; Minority Status and Language Measures; and Housing and Transportation Measures."[18] This index assists those in public health, as well as other policymakers, to better respond to emergency events within a community. "The SVI can help identify communities that may need more supplies, assistance or funding before, during, and after a disaster. It can be used to build overall wellness in a community by identifying local resources."[18]

Appendix B provides additional data tools that help LHDs identify inequities within communities. Data resources provide the information needed to develop interventions, policies, and programs that can benefit communities. Without these resources, there would be no reliable or verified information that would show the true picture of an area. The needs for every community are different; any and all data will help highlight the areas of most needed improvement and as well as beneficial programs and policies to address health outcomes.

To achieve health equity, we must reduce unfair and avoidable barriers in healthcare, resources, and services for all to reach an optimal level of health. The County Health Rankings, a popular data tool, provides examples on how to track health disparities as seen below.

- Health outcome and factor measures for all states and counties
- Measures that have data available to illuminate differences in opportunities for health in all states and counties
- Additional data resources for Kentucky (as well as other states) that provide information about health and opportunity among other subgroups, such as gender, age, or zip code.[19]

Both length of life and quality of life are not only influenced by where we live, but also by our ethnic and racial backgrounds. These differences are experienced nationwide as access to affordable housing, safe neighborhoods, quality education, and good jobs are often different based on the color of skin or other ethnic traits.[19]

Using the Data: Making the Case

Data analysis has revealed disparities seen in communities, so the question becomes "Now what"? Understanding and using the data is pivotal to equity work. The data should be translated, disseminated, and presented in a way that tells a story and paints a picture of what is happening in communities. Along with quantitative data, mapping, digital storytelling, and qualitative analysis can provide vivid examples of real experiences in communities affected by health inequities. The data provides a narrative of how factors such as insurance status, substandard education, and unsafe

neighborhoods can influence the health of the population. This is important when decisions related to funding, resource allocation, and staffing are made. The data can be a powerful driver in making decisions that impact populations and/or communities.

Many times, the data reveals multiple disparities (i.e. low-income levels, high asthma levels, incarceration rates, lack of childcare, etc.) across populations and the need to prioritize disparities becomes extremely important. Now is the time to refer back to the goals identified in both local and community strategic plans in determining where to prioritize:

- ✓ Begin with the goals identified in the strategic plan
- ✓ Find and present the relevant data to the goal(s)
- ✓ Draw conclusions from the data to drive decision making
- ✓ Determine what needs to be done (create an action plan)
- ✓ Measure success (evaluate your impact)

Evidence-Based Public Health

As previously mentioned, data are an integral part of public health. However, what does the data tell us? Data allows public health officials to make decisions based on the best available evidence. Evidence involves "the available body of facts or information indicating whether a belief or proposition is true or valid."[20] In public health, this includes epidemiologic data, program evaluations, and qualitative data. This information provides evidence that is essential to the success and sustainability of LHD practices, programs, and/or services. This process of data collection and evaluation is known as Evidence-Based Public Health (EBPH).

EBPH is "the process of integrating science-based interventions with community preferences to improve the health of populations."[20] There are many benefits to this approach because it allows for: (1) decision making based on the best available data and evidence; (2) engagement of stakeholders and community partners in both assessment and decision-making; and (3) conducting of good evaluation practices. EBPH helps LHDs make the best decisions based on the best available evidence and/or science. Through this, LHDs can decide where, why, when, and how a particular program works. Why does the community need a particular program? Who will benefit? Will this intervention be worth the time and effort? Answering these questions before beginning a program or intervention will assist in the development of appropriate, cost-saving, and successful measures.

For example, Barren River Initiative to Get Healthier Together (BRIGHT) Coalition, is an alliance of more than 50 community members working together cross-jurisdictionally to improve the quality of life for all residents of their 10-county region.[21] Their vision is to deliver essential public health services and solve problems not easily addressed by single organizations or jurisdictions. Their mission is to ensure a safe place to live. The coalition is looking at the root causes of local health issues, focusing on community factors like median income, unemployment, and high school graduation rates because of the long-term impacts such factors can have on the health of the population.

Health Equity at the Local Level

To truly adopt a health equity lens at the local level, there must be a shift in the infrastructure of local agencies to provide policies, programs, and services that meet the needs for all. The Association of State and Territorial Health Officials (ASTHO) states that "an infrastructure that advances health equity implements supporting organization policies, encourages cross-sector partnerships, and is responsive to emerging priorities."[22] At a local level it is important for LHDs to receive feedback and input from all staff members when developing internal policies as well as community members when developing external policies. This helps ensure a voice for all.

Where to Begin

Health Equity work must begin at the local level. To fully achieve equity, the process must start with each and every staff member. Leadership needs to be on board with the culture shift and integrate health equity into departmental and agency policies, procedures, programs, and services in order to set the tone for supporting a cultural shift. In addition, leadership has the responsibility to make sure health equity is integrated into the mission and vision statements of an organization.

As LHDs focus on Public Health Transformation and Public Health 3.0 principles, it will be important for staff to develop and implement public health programs, as well as evaluate the effectiveness of the programs.

Required Conversations

To foster this culture shift, the first step is to start a health equity conversation. This conversation needs to include leadership and all staff. It will not be easy and may lead to uncomfortable moments. Nonetheless, staff need to understand both health equity and how every decision made within an agency affects the community.

Implicit Bias and Cultural Humility

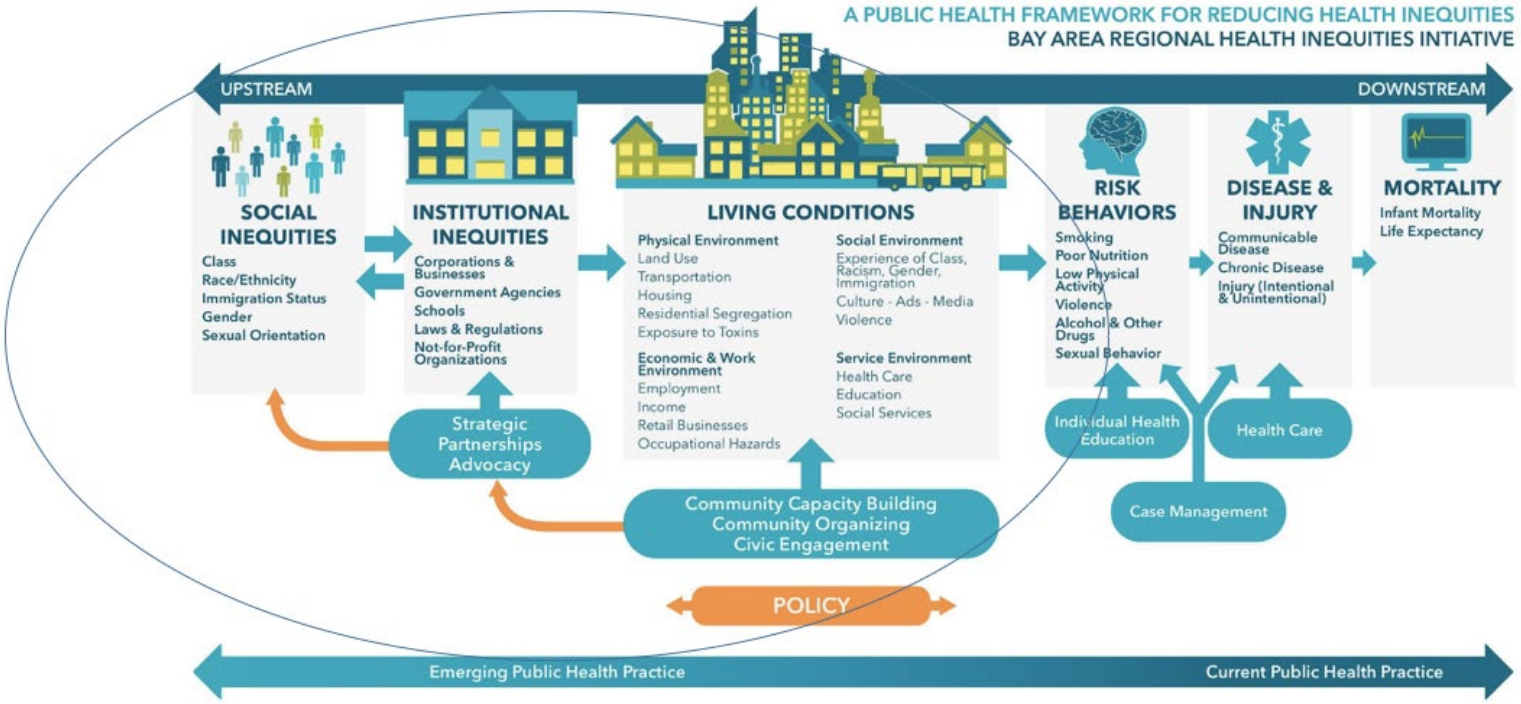
The discussions among staff will bring out implicit biases. We are born and raised within a certain group and often do not understand the trials and tribulations of those around us. The way we are raised shapes our culture, decisions, and values. These also lead to what is called implicit bias. Implicit bias is defined as the attitudes and stereotypes that affect our understanding, actions, and decisions in an unconscious manner. These are activated involuntarily and without an individual's awareness or intentional control.[23] Examining our implicit biases can be uncomfortable with tensions running high. However, this is only the first step in the discussions. Future conversations should focus on cultural humility as well as important 'isms' (genderism, racism, and sexism). Cultural humility is a "lifelong process of self-reflection and self-critique whereby the individual not only learns about another's culture, but one starts with an examination of her/his own beliefs and cultural identities".[24] To truly build an internal equity lens, staff will need to look deep inside themselves to address pre-existing cultural beliefs and views around racial equity and other 'isms'. These conversations will be difficult, but a LHD needs to be as culturally responsive as possible. A good resource to help assist in this process is the *Protocol for Culturally Responsive Organizations* (**Appendix C**). This tool provides organizations with advice to assist with the assessment and improvement process to advance culture responsiveness.

Staff Equity Health Assessment

While understanding the concepts is important, if all staff are not on board with change, it will not be a smooth or sustainable process. Implementing health equity into day-to-day operations is a complex issue, and one that will not occur overnight. Start the conversation by beginning with education and trainings, but also open the lines of communication between leadership and staff. Are staff ready to adhere to this change? Assess the readiness of staff by developing a staff readiness survey or by bringing in an outside neutral source to look at staff readiness and help develop the next steps to adopting a culture of health equity. There are many tools, such as the Bay Area Regional Health Inequities Initiative's (BARHII) **Local Health Departments Organizational Self-Assessment for Addressing Health Inequities**, available to assist LHDs in this process. BARHII is an organization that focuses its work on upstream efforts to address health equity through "a conceptual framework that illustrates the connection between social inequities and health, and focuses attention on measures which have not characteristically been within the scope of public health department epidemiology".[25] **(Figure 10 on page 15)** The BARHII framework, along with the readiness tool, have been used nationally by both local and state public health departments who are beginning to implement health equity work. The BARHII is a timely tool and is only one example of a staff readiness assessment. The link to the full BARHII tool can be found in **Appendix C**. Assessment tools serve many purposes, such as determining a LHD's capacity to address the root causes of health inequities from the perspectives of the staff. It also gives staff an opportunity to reflect on their own experiences in addressing health inequities through their work in the agency.[25] This process allows all staff to have their voices heard. How do staff view health inequities? How do staff view their own implicit biases? What is challenging for staff? What do staff need to make a change?

The assessment of readiness helps leadership to understand what needs to be completed in terms of continued trainings and education opportunities. This process could lead to the discovery of a true health equity champion within the organization. This champion will be essential in getting further buy-in from employees who may resist the change. A champion can also help an organization determine the pros and cons of adopting a health equity lens. While the pros should outweigh the cons, some employees may see this as only adding duties to an already packed workload. Since a health equity culture shift should not involve requests for additional funding or resources, a localized champion within a LHD can help motivate others to see past the initial constraints (time and resources) and encourage staff to get on board and remain engaged through the initial growing pains. All staff should celebrate the small wins as progress toward the big picture. The small wins may help motivate staff to continue and include such things as: a new community partner, establishing employee improvement goals related to health equity, and establishing the initial commitment for all staff to change the status quo.

Figure 10: BARHII Framework



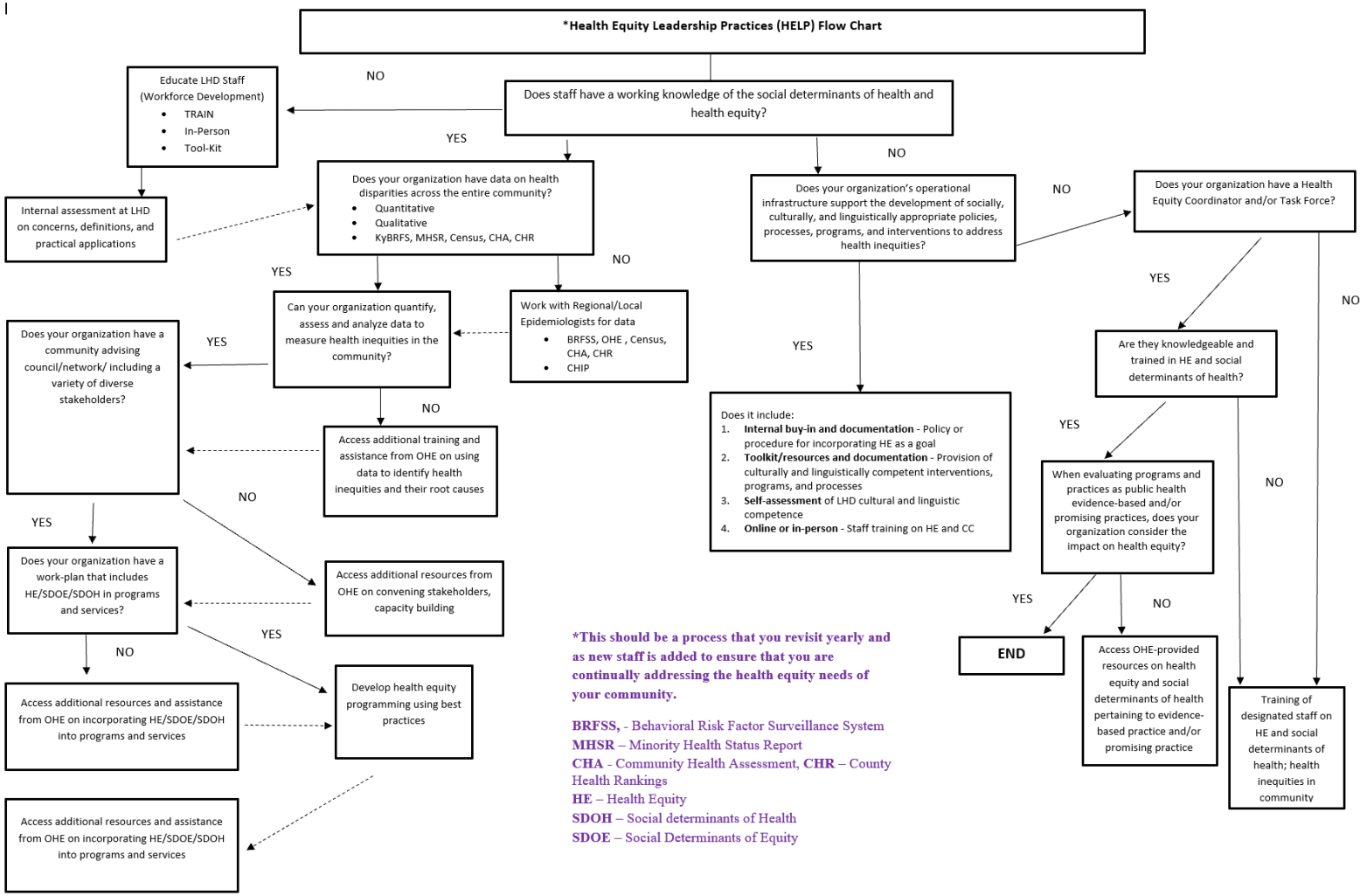
Staff Health Equity Training

To truly begin the conversation, staff must understand the meanings of equity, oppression, and power. In addition, staff should also understand health inequities and sources; the root causes of health inequities; how to address the root causes of health inequities; and how to identify health inequities present within a specific community. This knowledge can be developed through agency-wide education, in-person staff trainings, focus groups, leadership meetings, webinars, and annual employee competencies. For example, the Franklin County Health Department (FCHD) in Frankfort, Kentucky holds quarterly in-person meetings for all employees. During each of these meetings, all services are canceled for the day while staff participate in various training opportunities. Such trainings at FCHD have included: Adverse Childhood Experiences (ACEs), Bridges Out of Poverty, Implicit Bias, Raising of America, Resilience, and Unnatural Causes. A detailed list of possible trainings and tools can be found in Appendix B. It is a good idea to also include continuing education opportunities in the area of health equity for employee performance goals. This allows for continued growth and understanding on the subject of health equity.

Many times, it is helpful to use a flow chart to help map out a process to define, analyze, and build a step-by-step picture of how to make improvements in an organization's ability to improve population health. For example, the Health Equity Leadership Practices (HELP) Flow Chart **(Figure 11)** can be helpful in determining resources, processes, capacity, methodology and data needs. This flowchart can be a valuable asset as LHDs perform an environmental scan to assess and identify health inequities. It will enable the LHD to be more intentional and accurate in addressing the SDOH and other social indicators that are driving health disparities in communities. If interested in the HELP Flow Chart independent of this document, a printable copy can be found in **Appendix E.**

Environmental Scan

Figure 11: Health Equity Leadership Practices (HELP) Flow Chart



HELP Flow Chart Case Scenario

In the following case scenario, the HELP flow chart helps identify the SDOH and what additional actions are necessary to provide the best services and programs to meet the needs of the most vulnerable in local communities.

Joseph and his family live in a rural community with limited access to providers and no internet access. He is a teenager that regularly attends in-person church service where no one wears masks, social distancing is not practiced, and members sing openly and freely. He was unknowingly exposed to COVID-19. Days later, he goes to a sleepover at his best friend's house. He subsequently visited his grandfather who is homebound and has several chronic medical conditions. The next day Joseph begins to feel sick, but because he has no insurance and no medical home, he does not seek care. He later finds out that his best friend is also not feeling well. They find transportation to the LHD which is having a testing event. Soon they learn the whole family tested positive. All the positive cases are reported to the appropriate LHD in Kentucky. The LHD reached out to Joseph and his family to address their clinical and other unmet needs to improve their overall health as well as the health of other residents in the county.

Q: Does the LHD staff have a working knowledge of the social determinants of health (where we live, learn, work, pray, or play) and health equity?

If the answer is no, the LHD should educate staff utilizing existing resources, TRAIN, in-person trainings, and other tools that may be helpful in assessing the community's unmet needs.

Q: Does your organization have data on health disparities across the entire community?

Work with your local epidemiologist or data analyst to present both qualitative (focus groups, town halls, community conversations) and quantitative (KyBRFS, County Health Rankings, CHA, CHIP, Census, and the Minority Health Status Report) data that reflects health disparities in the community.

Q: Does your LHD have a work plan that includes health equity and the social determinants of health?

The Office of Health Equity (OHE) is ready to provide training on using data to identify health inequities and their root causes. This will enable the LHD to develop survey tools and methodologies to collect SDOH data and other social indicators that drive health disparities. All of which should be included in the work plan in delivery of programs and services.

Q: What best practices can be used to develop health equity programming?

Reaching out to non-traditional sources for feedback on programs and services including the community (active listening) and information from diverse and informed stakeholders that may have been partners currently or in the past. This feedback will help the LHD staff develop health equity programming related to testing and vaccination uptake, healthcare access, processes, policies, and other systems important in improving health and health outcomes using a health equity lens. The social vulnerability index and other data mapping tools can be useful in determining communities with the greatest unmet need and their accessibility to existing resources.

Implementation Process

Once a LHD has begun the culture shift through important conversations and trainings, what is the next step? Each of the previous sections have laid the groundwork for building capacity to address health equity agency-wide. To further advance, it is necessary to develop and implement an action plan with strategies to build on the knowledge of equity, oppression, and power. The action plan should be comprised of realistic SMART goals and objectives (**Figure 12**) and clear delineation of the roles and responsibilities of staff. This will help increase the understanding of health equity for ALL plans, policies, programs, and services. The action plan should be communicated clearly and often to all staff members, so everyone is aware of the expectations and intended outcomes in a health equity approach to addressing local health disparities.

Figure 12: SMART Goals

The Health Equity Guide's Strategic Practices and Actions to Achieve Health Equity in Local Health Departments is one of many tools that provide numerous strategies and actions to building a health equity culture both internally and externally. Some of the internal strategies to help build a culture of health equity include:[26]

- Using agency-wide trainings, workgroups, peer learning sessions, coaching, and other approaches that create safe spaces to reflect and discuss equity-related content.
- Building capacity around topics that normalize and operationalize health equity, such as:
  - Attending undoing racism or anti-racism trainings
  - Implementing policies, practices, and tools that explicitly address racial equity (links to same policies can be found in **Appendix C**)
  - Advancing an approach to include health equity in all policies
- Having an ongoing process of education, structured dialogue, and organizational development that engages all staff to:
  - Explain the evidence around health inequities and its source
  - Explore the root causes of health inequities such as oppression and power, and how to address them
  - Discuss the values and needs of the community
  - Build core competencies and capacities of staff to successfully achieve health equity
- Incorporating demographic characteristics and health equity metrics into ongoing department data collection and analysis efforts (e.g., disease surveillance, performance evaluation/Quality Improvement (QI), program evaluations, satisfaction surveys).
- Regularly collecting, analyzing, and reporting data on the social determinants of health (e.g., as indicators in the Community Health Assessment (CHA), Community Health Improvement Plan (CHIP), and policy development and evaluation).
- Committing to developing a professional workforce that reflects the demographics of the populations served and the communities facing health inequities.

- Using mission, vision, and values statements to communicate the priority of advancing health equity, as well as the health department's role in addressing health equity.
- Developing a strategic plan that outlines the health department's intentions to change and align internal practices and process to advance equity.
- Including health equity language and apply a health equity approach to organizational processes and procedures, including:
    - Hiring and human resources
    - Workforce development
    - Budgeting and resource allocation
    - Other key organizational processes and procedures
- Using performance management and quality improvement principles to continuously improve policies, processes, and programs that advance health equity.
- Examining public and organizational policies, rules, and regulations that facilitate or inhibit working upstream and ensure that sources are not reinforcing cultural bias, barriers, and inequities.

Additional strategies and actions can be found within the Implementation Tools resource page found in **Appendix C.** The action plan should also include:

- Organizational changes needed
- Policies and procedures
- Applicable workshops, trainings, and seminars
- Communication plan (internal)
- Distribution of staff and/or resources[25]

As LHDs address health inequities at the local level, it is important to maintain the momentum generated by the self-assessment. It is key that leadership assures ALL voices are valued and the information provided will help build an internal infrastructure, drawing from the diversity of perspectives and experiences that will create a more equitable and inclusive community in which to live, learn, work, pray, and play.

Community Health Assessment; Community Health Improvement Plan; and Strategic Plan

Community Health Assessment

Once a LHD has completed an internal environmental scan and has identified health equity as a strategic priority, the next step is to determine if it aligns with the issues and concerns of the community. How does the community view health equity issues? How can a LHD develop services that meet these issues? One way for staff to use and further develop health equity and SDOH knowledge is to identify the strengths and weaknesses of the local population. A key example of this would be completing a Community Health Assessment (CHA). The National Association of County and City Health Officials (NACCHO) defines a CHA as a process that uses quantitative and qualitative methods to systemically collect and understand health within a specific community. An ideal assessment includes information on risk factors, quality of life, mortality, morbidity,

community assets, forces of change, social determinants of health and health inequity, and information on how well the public health system provides essential services.[27] This information will be used to guide health issue prioritization, internal and external policy development, and strategic planning; as well as the development of a Community Health Improvement Plan (CHIP).

As part of Public Health Transformation, a local needs assessment is essential and required. A local needs assessment could be the same as a CHA or a subset. A local CHA helps guide the programs and services provided by a LHD as well as determine the amount of state funding allocated outside of core services offered by a LHD (See **Figure 2** on Page 6). The CHA results assist with development of any additional programs and services provided via each individual LHD based on the health outcomes of a community.

There are many ways to develop a CHA such as NACCHO's Mobilizing for Action through Planning and Partnerships (MAPP) process. For many LHDs across the nation, the MAPP method for CHA development is familiar and often used to help fulfill PHAB applications as well as Public Health 3.0 and Public Health Transformation recommendations and requirements. Currently, this method is being redesigned to better assist local MAPP communities address health inequities using a CHA and CHIP. "The MAPP evaluation revealed that while MAPP communities are successfully engaging in CHA/CHIP processes that resulted in effective action to improve health, overall, many of these communities did not make significant progress in acting on root causes of inequity through their CHA processes."[28]

Partner development, coalition building, and data collection are vital and lay the foundation for the entire CHA process. To get started, LHD staff need to form a new or convene an existing coalition of local residents, business owners, leaders, and other essential local figures. Both traditional and non-traditional partners should be invited to the table. Make sure to form a diverse coalition. Engage both individuals and groups that are committed to tackling health equity and racial justice issues.

After the initial partners come together, it is key to look at those assembled to see if anyone is missing. If the answer is yes to this question, re-evaluate who else needs to be involved and invite them to join the discussion. An example of a sound coalition building process is that of FCHD. When FCHD began their first iteration of the MAPP cycle in 2008, a wide range of community partners gathered around the table. The initial partners included representatives from city and county government, congregate shelters, detention centers, emergency management, faith-based organizations, healthcare, housing, parks and recreation, police, public health, and schools. FCHD has continued the MAPP cycle for over 12 years with many partners joining as coalitions, as priorities and strategies have been developed. With close to 100 community partners, this is only one example of a community-driven, community-owned, and inclusive process.

While LHD staff will serve a pivotal role throughout the CHA development and implementation, the journey and final product should be both community-driven and community-owned. It is crucial to have the right people at the table throughout the entirety of the process. To be successful, the CHA should promote inclusive, strong, and welcoming relationships. For many minimalized groups, this may be the first time they have been invited to the table and have had their voices heard, therefore, make sure to listen so they keep coming back.

As coalition partners begin to develop the CHA survey, the use of a health equity lens is essential. Surveys should address the SDOH impacting community as well as all health inequities that plague populations. When developing surveys, make sure to include questions related to education, food access, health access, safety, and transportation. Also, a community does not represent only one group of people; therefore, questions need to reflect the diversity of an area **(Figure 13).** Once the CHA has been developed and approved by the coalition as well as the Institutional Review Board (IRB), it is key to make it available in different languages and formats. To truly be successful, the CHA needs to be applicable, reachable, and understandable for all residents. This will require going to the people to help reduce potential transportation barriers that may arise as well as build relationships between LHD staff, community partners, and community members.

Figure 13: Inclusivity

Be Inclusive of the following groups:

- Civil Rights Organizations
- Elderly
- Ethnic and Racial Minority Groups
- Faith-Based Communities
- Homeless
- LGBTQ+ Populations
- Mental Health Groups
- Schools
- Special Needs Population
- Youth

The survey results will help coalition members identify important issues within the community. A community's strengths and weaknesses will be prioritized according to area, need, population, and resources. The issues outlined in the CHA are then used in the development of a community action plan known as the Community Health Improvement Plan (CHIP). A CHIP is developed in collaboration with community partners to set priorities and coordinate and target resources. The final stage of the CHA involves the planning, implementation, and evaluation of priority issues.

Community Health Improvement Plan

The issues outlined in the CHA are used to develop a community action plan or a CHIP. A CHIP is developed in collaboration with community partners to set priorities in order to coordinate and target resources. This plan is a "long-term, systemic effort to address public health problems on the basis of the results from the CHA activities and health improvement process".[27] A CHIP is used by health and other governmental education and human services agencies, in collaboration with community partners, to set priorities and coordinate and target resources. A community health improvement plan is critical for developing policies and defining actions to target efforts that promote health. It should define the vision for the health of the community through a collaborative process and should address the strengths, weaknesses, challenges, and opportunities that exist in the community to improve the health status of the community.[26]

Figure 14: Franklin County MAPP themes of all four MAPP assessments

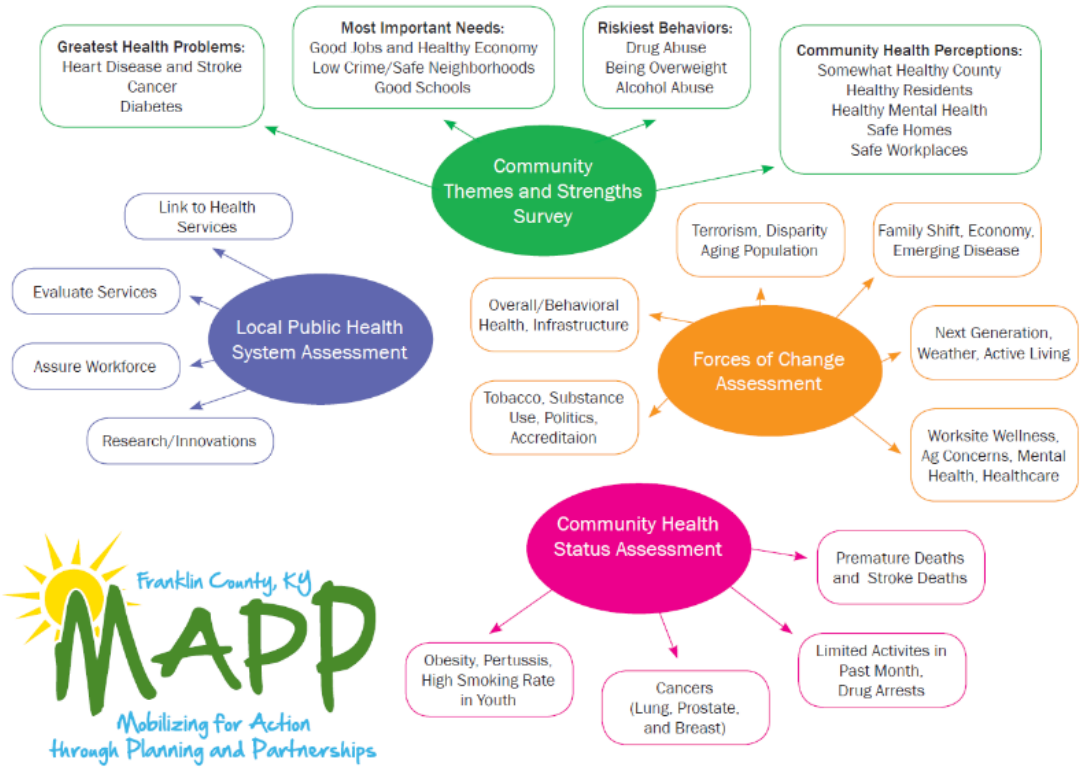


Figure 1: Franklin County MAPP themes of all four MAPP assessments.

One process for identifying the strategic issues is the MAPP framework. It begins by combining and comparing the four independent assessments (Community Health Status Assessment, Community Themes and Strengths Survey, Forces of Change Assessment, and Local Public Health System Assessment) which provide a wide range of data. As previously mentioned, these assessments are under revision. But ideally, this initial review is conducted by a steering committee where results can be summarized and grouped into broad categories or underlying themes. **Figure 14** demonstrates the underlying themes for all four MAPP assessments as used by the Franklin County Health Department in their 2017 CHA.

The following questions are posed during the initial planning process to begin the development of strategic issues. In addition, on page 113 of the *MAPP Users Handbook*[27], there is a great resource for using health equity to help identify strategic issues.

1. How will we present data for all assessments to coalition members?
2. Should language and the level of education of coalition members be considered as part of addressing health literacy?

3. How will we facilitate a process to coalition members to help identify strategic issues that are representative of the data from all assessments?
4. What process can be used for prioritization (i.e., Brainstorming Sessions, 5 Why's, Nominal Group Technique)?
5. Was ample opportunity provided for all coalition members to participate in development of strategic issues?
6. Were strategic issues biased by any one agency's agenda?
7. Do the identified strategic issues coincide with the community's need?

After you have cleared the hurdle of identifying strategic issues, it is time to begin the process of setting goals. The coalition is vital during this phase. The following should be considered when planning this portion:

1. What meeting format will be utilized?
2. Who should be present?
3. What agency will facilitate the meeting(s)?
    a. What techniques will be used by the facilitator for creation of goals and strategies?
    b. How will these be recorded?
    c. How will the goals and strategies be measured or evaluated?

These questions as well as others can be found on page 24 of the *MAPP User Handbook* resource (*Developing Health Equity Strategic Issues, Goals, and Strategies).*[27]

This is a community-owned and community-driven resource. As such, coalition members should feel a deep commitment to fulfilling their proposed action steps. As referenced earlier, when forming a coalition, it is essential for members to look around and observe who is missing from the table and critical to the success of the goal. **Figure 15** provides a real-life example of community-drive strategic issue as found in the 2017 version of the Franklin County MAPP CHIP.

Figure 15: Franklin County MAPP 2017 CHIP

Goal 4 – Create a one-stop-shop for community resources Frankfort Cares.

Objectives	Intervention	Responsibility	Progress
Advertise Frankfort Cares	Place signs, community presentations	Frankfort/Franklin County Emergency Management, DCBS, Fire Department, FCHD, VCPS, ARC, KSPW/KPRIC, Drug Court, Frankfort Transit	Completed (May 2017)
Launch the program/go live.		Frankfort/Franklin County Emergency Management, DCBS, FCHD, VCPS, ARC, KSPW/KIPRC, Drug Court, Frankfort Transit	Completed (September 2017)
Increase number of referrals to Frankfort Cares (BASELINE)	Social media posts, WOW show, begin tracking calls and number of referrals to each agency.	Frankfort/Franklin County Emergency Management, MAPP partners, DCBS, FCHD, VCPS, ARC, KSPW/KPRIC, Drug Court, Frankfort Transit	In Progress
Maintaining up-to-date resources	MAPP Partners	Frankfort/Franklin County Emergency Management, Adult Protective Services, Family Abuse Shelter, FCHD, VCPS, ARC, KSPW/KPRIC, Drug Court, Frankfort Transit	In Progress

All information gathered throughout this process can help the local public health system as well as community partners improve issues both efficiently, logically, and timely. A CHA allows for a deeper understanding of a community and the CHIP puts strategies in place to improve its overall health. For LHDs, a CHA provides fresh and local data that can then lead to policy and program development. What issues does the LHD need to focus on? Does the LHD have the resources to address the needed issues? How does staff need to be trained to address the concerns?

Strategic Plan

The third and final important piece to creating a culture of health equity is an agency-wide strategic plan which can also be helpful for PHAB accreditation. NACCHO defines a strategic plan as "a plan resulting from a deliberate decision-making process that defines where an organization is going. The plan sets the direction for the organization and, through a common understanding of the mission, vision, goals, and objectives, provides a template for all employees and stakeholders to make decisions that move the organization forward."[27] The LHD strategic plan indicates the journey needed to accomplish its goals. These plans are usually reevaluated and rewritten every 3 to 5 years and are therefore both flexible and continuous.

When looked at together; the CHA, CHIP, and strategic plan are integrated processes but should be linked together in some form. Since all three of these processes contain much of the same information entwined through all the documents, incorporating a health equity lens or framework will become infused throughout the programs, policies, and processes of the LHD. In most cases, the CHA is the first phase, followed by the CHIP and finally the strategic plan. "The results of the assessment serve as the foundation to inform the priorities to be addressed in the CHIP and strategic plan."[29]

Each of these documents can help be a driver for change…both within an organization and community wide. Change is hard. Change does not occur overnight. For LHDs, adopting a culture of health equity is a massive change to daily operations within both the organization and community. It changes the way programs and services are developed, funded, and implemented. All three of the previously mentioned documents are a way to identify inequities within a community and then use that knowledge to identify goals and objectives needed to address those issues. The CHA, CHIP, and strategic plan are ways to show that health equity is becoming a core foundation to all LHD operations.

Furthermore, healthcare systems have recognized the need for addressing health inequities and have made equity a core strategy in the realignment within their strategic plans. There are five actions to take to ensure that health equity is a core strategy and implemented at the local level:[32]

1. ***Make health equity a leader-driven priority.***
   This may sound simple, but leadership must be able to articulate the importance of these efforts while leading by example.
2. ***Develop structures and processes that support equity.***
   To advance equity, there must be dedicated financial and information resources as well as a governance structure that oversees and manages the work across the organization.
3. ***Take specific actions that address the social determinants of health.***
   Identify the health disparities that exist in communities, learn about the unmet needs and assets of the people who face the disparities, and use a health equity approach to develop an action plan aimed at closing those gaps.
4. ***Confront institutional racism and other 'isms within the organization.***
   Albeit uncomfortable and challenging when confronting racism or other 'isms (classism, sexism, ageism, ableism) whether it is implicit or overt, it can corrupt the population health work at both the state and local level. We must examine and dismantle structures, policies,

and norms that may perpetuate a particular group having an advantage based on personal biases or discriminatory practices.

5. ***Partner with community organizations.***
   Public Health and community organizations, coalitions, non-profits, and for-profits must all work together if they are serious about addressing health equity in the populations they serve.

Evaluation

Health equity-oriented evaluations help us to understand what works, for whom, under what conditions, and reveal whether health inequities have decreased, increased, or remained the same.[30] The evaluation plan must integrate health equity in determining what impact the program or initiative had on the intended population. The methodology for data collection and tools must be culturally appropriate and should be vetted with the intended population to ensure what was selected is the best way to gather information that will yield credible results. Both process and outcome evaluations are equally important, each giving valuable information regarding the initiative or program. It is also important to note that the results of the initiative or program may not yield positive results and may even have unintended consequences that could make inequities and disparities worse.

Identifying appropriate indicators and variables, such as income, race, gender, county (rural vs urban), etc., are helpful in examining the impacts of the program or initiative across various populations or settings. This should be considered early in the process to ensure sufficient data can be gathered, tracked, and analyzed. You will want to capture these variables using both quantitative and qualitative methods and ensure that multiple perspectives are gathered in preparation to have the data tell the full story of an impact because of the program, as it relates to health inequities. The goal of the evaluation is to make recommendations based on those findings having used an equity lens. It is equally important to engage community partners and stakeholders to ensure that the conclusions reflect the intended populations. Finally, the dissemination of the data will help build capacity and increase awareness among community members and stakeholders and give insight on what, if any, additional interventions, or programming efforts are needed.[31]

- *Develop a conceptual model that includes health equity activities, outcomes, and goals*
- *Integrate health equity into evaluation questions and focus the design*
- *Use culturally appropriate tools and methodologies*
- *Use process and outcome evaluation to understand the effect on health inequities*
- *Gather credible evidence and track health inequities*
- *Ensure health equity is reflected in conclusions*
- *Disseminate findings broadly from equity-oriented evaluations*

Sustainability and Next Steps

Once a CHA, CHIP, and strategic plan have been developed and implemented, what comes next? To get to this point, LHDs have begun the initial conversations, as well as competencies and trainings. In addition, health equity has also begun to become a foundational principle in agency plans, policies, programs, and services. However, more needs to be done. The work and culture shift now need to be sustainable. A key to this is through continuous quality improvement.

Quality Improvement (QI) is the use of a deliberate and defined improvement process, which is focused on activities that are responsive to community needs and optimizing population health. It refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality services or processes that achieve equity and improve the health of the community.[27] QI processes are key to the sustainability of public health programs and services. One such process is the Plan-Do-Study-Act (PDSA) cycle. The PDSA is a four-step four-stage problem-solving model used for improving a process or carrying out change.[33] (A more detailed description of the PDSA process can be found in **Appendix D**)

The information collected during continuous QI processes, such as the PDSA cycle, are essential for the future investment in organizational-wide competencies, meetings, and trainings related to health equity, SDOH, and racial justice. This will not look the same for every LHD or community. For example, knowledge and skill development will not look the same in Frankfort, Kentucky as it will look in Louisville, Kentucky. There is no one size fits all solution. LHDs should continue to increase health equity knowledge as it relates to a community's need, population, and resources.

As an agency-wide health equity culture shift continues, staff should also seek additional funding that will assist in programs and services that address both inequities and SDOH. Funding for LHDs is normally allocated for mandated services, as well as for specific purposes. Therefore, research for additional funding sources is needed and vital.

In addition to continued knowledge and funding, LHDs need to continue to prioritize health equity into strategic planning goals and objectives. This helps drive the culture shift in all departmental, individual, and organizational priorities. As mentioned earlier in this primer, a strategic plan is one of three prerequisites for PHAB applications and thus should have health equity as a central focus. As PHAB standards continue to change and develop towards more of a health equity lens, it is important for LHDs to begin to follow suit.

Other possible steps for LHD sustainability could include the following:

- Commit funding, staff, and time to a health equity culture shift
- Continue to evaluate local programs and policies to ensure equitable practices
- Continue to evaluate and update CHAs, CHIPs, and strategic plans to meet the changing community and public health landscape
- Continue to develop new and broadened partnership representation
- Implement health equity language and knowledge into the recruitment, retention, and training policies of all current and prospective employees

- Include health equity and SDOH language and knowledge in organizational procedures and processes
- Translate all data, educational materials, patient handouts, plans, and policies into multiple languages

At the beginning, approaching LHD operations with a health equity lens will seem like additional work. However, as time progresses, health equity should become a thought process. It should become the way an employee approaches their daily work. The programs and services will address the inequities of the community. The knowledge and skills acquired throughout this process will be a part of how staff will begin to interact with the public as well as coworkers and partners. There is no one size fits all answer, but with continued development of health equity process and training, an LHD will be able to successfully sustain a culture of health equity. The infrastructure and capacity needed to weave equity into all areas of population health at the local level is not easy. Local Health Departments must be intentional in making equity evident in all aspects of local public health work. It requires a thorough look at existing policies and practices and how they are currently being implemented to determine if changes need to be made to reflect an organization that is committed to equity.

Health Equity must be a strategic priority within the LHD in improving the outcomes of minority, marginalized and vulnerable populations. The focus should be not only addressing the SDOH but the root causes that drive those inequities widening the disparity gaps. As our communities become more diverse the need for a more comprehensive approach to health and healthcare using a health equity framework is critical. Eliminating inequities as we address the SDOH will require a long-term commitment. It is important that leadership and staff have a willingness to adapt as the needs of communities' change; different approaches and strategies may be needed to accomplish the goals. To keep the momentum, reiterating why the work is important, reiterating roles and responsibilities, and identifying activities that garner "small wins" while working to achieve a culture shift within the department.

In assuring these sustained efforts at the local level there are several ways to ensure health equity remains at the center of Public Health promotion and prevention efforts; funds may need to be redirected, staffing increased, allocation of additional resources and training of staff. Leadership must champion these efforts and recognize that equity must remain core to the local mission.

Appendix A: Terminology

Community Health Assessment (CHA): a process that uses quantitative and qualitative methods to systematically collect and understand health within a specific community.

Community Health Improvement Plan (CHIP): a long-term, systematic effort to address public health problems based on the results of the community assessment activities and the community health improvement process. A CHIP is critical for developing policies and defining actions to target efforts that promote health.

Cultural Humility: lifelong process of self-reflection and self-critique whereby the individual not only learns about another's culture, but one starts with an examination of her/his own beliefs and cultural identities.

Equity: the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically, or by other means of stratification.

Health Disparity: difference in health outcomes between groups within a population.

Health Equity: attainment of the highest level of health for all people.

Health Equity Lens: an understanding of the social, political, and environmental contexts of a program, policy, or practice to evaluate and assess the unfair benefits and burdens within a population.

Health Inequity: differences in health outcomes that are systematic, avoidable, and unjust.

Implicit Bias: the attitudes and stereotypes that affect our understanding, actions, and decisions in an unconscious manner.

Qualitative Data: data that approximates or characterizes but does not measure the attributes, characteristics, properties, etc., of a thing or phenomenon.

Quantitative Data: information about quantities: information that can be measured and written down with numbers.

Quality Improvement: use of a deliberate and defined improvement process, which is focused on activities that are responsive to community needs and improving population health.

Social Determinants of Health (SDOH): conditions in the environments in which people live, learn, work, play, pray, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Strategic Plan: results from a deliberate decision-making process and defines where an organization is going. The plan sets the direction for the organization and, through a common understanding of the mission, vision, goals, and objectives, provides a template for all employees and stakeholders to make decisions that move the organization forward.

Appendix B: Data Resources

- **America's Health Rankings**
  - www.americashealthrankings.org
- **American Community Survey (ACS)**
  - https://census.gov/acs
- **Behavioral Risk Factor Surveillance System (BRFSS)**
  - Behavioral Risk Factor Surveillance System - Cabinet for Health and Family Services (ky.gov)
- **CDC WISQARS**
  - www.cdc.gov/injury/wisqars/index.html
- **CDC WONDER**
  - https://wonder.cdc.gov
- **City Health Dashboard**
  - www.cityhealthdashboard.com
- **Community & Economic Development Initiative of Kentucky (CEDIK) County Data Profiles**
  - https://cedik.ca.uky.edu/CountyDataProfiles
- **County Health Rankings and Roadmaps**
  - www.countyhealthrankings.org
- **EnviroHealthLink: Kentucky's Environmental Public Health Tracking Network**
  - https://kyibis.mc.uky.edu/ehl/
- **Kaiser Family Foundation's State Health Facts**
  - www.kff.org/statedata/
- **Kentucky Cancer Registry (KCR)**
  - www.kcr.uky.edu
- **Kentucky Department for Public Health (KDPH) COVID 19 Dashboard**
  - https://kycovid19.ky.gov
- **Kentucky Health Facts**
  - www.kentuckyhealthfacts.org
- **Kentucky Incentives for Prevention (KIP) Survey**
  - www.kipsurvey.com
- **Kentucky Injury Prevention and Research Center (KIPRC)**
  - www.mc.uky.edu/kiprc/index.html
- **Kentucky Minority Health Status Report (2017)**
  - https://chfs.ky.gov/agencies/dph/Documents/2017minorityhealthstatusreport.pdf
- **Kids Count Data**
  - https://datacenter.kidscount.org
- **National Equity Atlas**
  - https://nationalequityatlas.org
- **Rural Health Information Hub (RHIhub)**
  - www.ruralhealthinfo.org
- **Social Vulnerability Index (SVI)**
  - https://kydph.maps.arcgis.com/apps/MapSeries/index.html?appid=b051448dfb4b4a69a39e8adf2e8ac44e
- **United States Census 2020**
  - https://2020census.gov

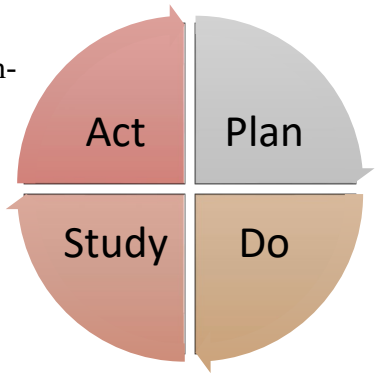
- **United States Department of Agriculture-Food Environment Atlas**
  - www.ers.usda.gov/data-products/food-environment-atlas.aspx
- **USAFacts**
  - https://usafacts.org

Appendix C: Implementation Tools and Resources

Implementation Tool/Resource Title	Description
A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease	A tool developed by the Centers for Disease Control and Prevention (CDC) for health professionals. https://www.cdc.gov/nccdphp/dch/pdf/healthequityguide.pdf
Advancing Health Equity in Health Department's Public Health Practice	A tool developed for health departments applying for PHAB accreditation for what is expected with respect to advancing health equity, and to offer concrete guidance and resources. https://www.phaboard.org/wp-content/uploads/HIP-Paper-Final.pdf
Applying SDOH Indicator Data for Advancing Health Equity	Developed by the Bay Area Regional Health Inequities Initiative, this step-by-step technical guide assists local health departments and community partners in the collection, analysis, and usage of SDOH indicators for local community health assessments, program/policy development, and health equity advocacy. https://www.barhii.org/sdoh-indicator-guide
Health Equity Guide	A resource with examples of how health departments have advanced health equity- both internally within their departments and externally with communities and other government agencies. www.healthequityguide.org
The Health Equity Guide's Strategic Practices and Actions to Achieve Health Equity in Local Health Departments	A tool to help local health departments develop health equity and strategic practices. https://healthequityguide.org/wp-content/uploads/2017/12/HealthEquityGuide_StrategicPractices_2017.11.pdf
Health Equity at Work: Skills Assessment of Public Health Staff	This survey instrument, developed by the National Association of Chronic Disease Directors, helps determine what skills public health staff need to advance health equity. https://chronicdisease.org/health-equity-at-work-skills-assessment-of-public-health-staff/
National Association for City and County Health Officials (NACCHO) Database of Model Priorities in Local Public Health Agencies	A database of model practices that were identified through the application of several key criteria. Included practices are considered to be exemplary and replicable. https://application.naccho.org/Public/Applications/Search
Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health	This workbook is for public health practitioners and partners interested in addressing social determinants of health to promote health and achieve health equity https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/pdf/SDOH-workbook.pdf
Protocol for Culturally Responsive Organizations	Developed by the Center to Advance Racial Equity, this research report provides mainstream organizations concrete advice to assist their assessment and improvement process to advance their cultural responsiveness. https://www.coalitioncommunitiescolor.org/research-and-publications/protocolfororgs
Public Health 2030: A Scenario Exploration	Scenarios of public health alternative paths that are parallel stories describing how the future may unfold (in ways both good and bad). They help us view the dynamic systems around us in more complex

	terms that accept uncertainty, and then clarify and challenge the assumptions about what we can do. https://kresge.org/sites/default/files/Institute-for-Alternative-Futures-Public-Health-2030.pdf
The Roots of Health Inequity: A Web-Based Course for the Public Health Workforce	As part of the Roots of Health Inequity Online Learning Collaborative, participants will be able to explore social processes that produce health inequities in the distribution of disease and illness, strategize more effective ways to act on the root causes of health inequity, and form relationships with other local health departments who are working to ensure health equity. http://www.rootsofhealthinequity.org/
Unnatural Causes: Is Inequality Making Us Sick?	This seven-part documentary series looks at how racism, immigration, oppression, place, globalization, and employment impact health outcomes and life opportunities, by uncovering ways in which the distribution of power, wealth, and resources shape opportunities for health. https://unnaturalcauses.org/

Appendix D: Plan. Do. Study. Act (PDSA)



The Plan-Do-Study-Act (PDSA) Cycle is a four-stage problem-solving model used for improving a process or carrying out change. PDSA is a quality improvement tool used by public health departments (local and state) when needed to change or improve an agency process or policy.

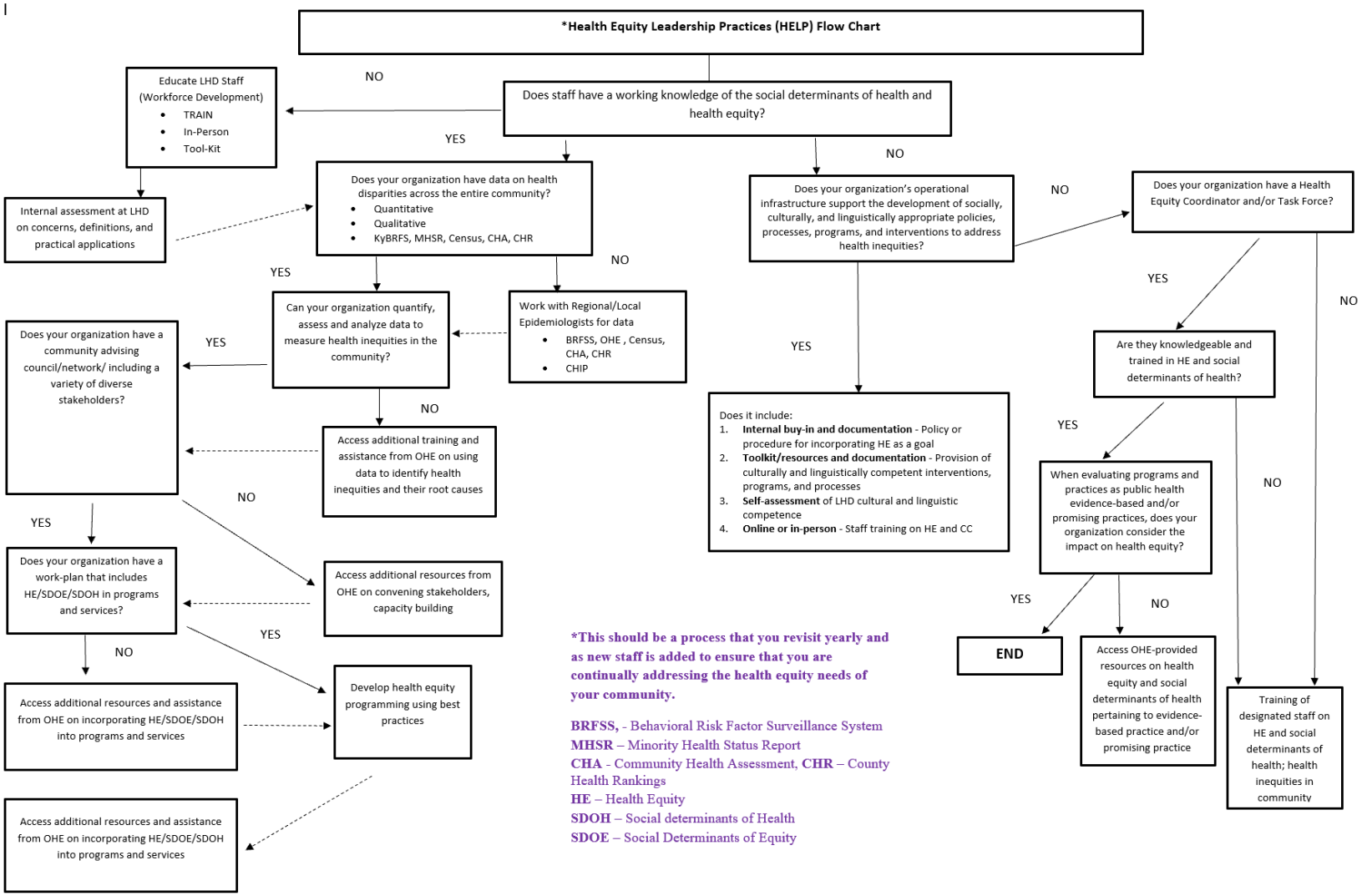
The four steps of the PDSA Cycle are described below.

1. Step 1: **Plan**
    a. Recruit a Team
        i. Make sure to assemble a team that is knowledgeable of the problem and areas for improvement
    b. Develop an AIM statement to answer three questions:
        i. What are you trying to accomplish?
        ii. How will you know that a change is an improvement?
        iii. What changes can you make that will result in an improvement?
    c. Examine the current program or service
        i. What are you doing now?
        ii. How do you do it?
    d. Develop a Problem Statement
        i. Clearly summarize the details of the problem
    e. Analyze Causes and Develop an Action Plan
        i. What are the root causes of the current problem?
        ii. How can the problem be solved?
        iii. What is the process to solve the problem?
2. Step 2: **Do**
    a. Implement Action Plan
    b. Collect Data
3. Step 3: **Study**
    a. Use the previously developed AIM statement and data collected to answer the following questions:
        i. Did your plan result in an improvement? By how much/little?
        ii. Was the action worth the investment?
        iii. Do you see trends?
        iv. Were there unintended side effects?
4. Step 4: **Act**
    a. Reflect on the plan and outcomes
        i. If the plan resulted in success, standardize the results/improvement, and begin to implement them.
        ii. If the plan was not successful, return to Stage 1 and develop a new and different plan that may result in a better approach

The PDSA is an ongoing cycle that can be used at any time.

Source: Minnesota Department of Health[3]

Appendix E: Health Equity Leadership Practices (HELP) Flow Chart



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