Harris County
Public Health
Building a Healthy Community
WWW.HCPHTX.ORG

Health Equity Procedures:

Guidance for Implementing the HCPH Health Equity Policy (adopted July 21, 2015) Using Cross-Cutting Issues

Version 1.5

Last Updated: July 24, 2017
Adopted: April 7, 2016

TABLE OF CONTENTS

For more information or assistance with these procedures, contact:
Jennifer M. Hadayia, MPA | Health Equity Coordinator
(713) 439-6269 | jhadayia@hcphes.org

I. THINGS TO KNOW BEFORE YOU BEGIN

Introduction: *A procedure is a set of instructions for how to complete a task.* These procedures are instructions for implementing the HCPH Health Equity Policy. They use a cross-cutting issues approach, i.e., five issues cut-across the guidelines in the Policy; this document includes instructions for each of the five cross-cutting issues. Applying these procedures will satisfy implementation of the Policy.

Audience: These procedures are intended for use by all persons conducting business on behalf of HCPH, including contractors and interns/volunteers. However, each procedure may be more/less relevant to staff in certain positions or programs. Please read the audience statement included in each procedure.

Caveats: Each procedure is organized into sections, phases, and/or sub-topics (e.g., Assessment, Implementation, etc.). There is no requirement that every section, phase, or topic be applied if it is not applicable. *Emergency situations are excluded from the procedures.*

In some cases (and depending on the program's timeframe and resources), applying a procedure may not be feasible today, all at once, or by current staff. If the procedure inspires new thinking or awareness about how to incorporate health equity into daily practice, then that it successful application. Document these results and apply them when time, resources, and staff capacity allow.

There are numerous tools and examples for the procedures in the Appendix. These were vetted from a much larger sample of documents and are considered "best available" at this time. They are provided to assist with implementation, but are *not* required for use.

A Division or Office may be conducting regulatory or other mandated activities. Per above, there is no expectation that every component of a procedure is applied if is not applicable or, in this case, would result in deviation from federal or state laws, rules, and regulations.

Documentation: A Checklist has been provided for documenting implementation of the procedures. *Completing this Checklist at least annually for each Division and Office satisfies implementation of the HCPH Health Equity Policy.* The HCPH Health Equity Advisory Committee is responsible for overseeing this process.

II. DOCUMENTATION CHECKLIST

Name of Person Completing Checklist:_____

Division or Office:_____

Program (if applicable): _____Date: _____

Each of the key questions below corresponds to the key steps in each procedure.

CURRENT & NEW PROGRAM DEVELOPMENT

Has your Division, Office, or Program….

1) Assessed the impact of activities on the 4 Es in Harris County?

☐ Already applied ☐ In progress ☐ Will apply in the future ☐ N/A

Notes:

2) Brainstormed ways to incorporate additional activities or to adjust current activities to focus more upstream?

☐ Already applied ☐ In progress ☐ Will apply in the future ☐ N/A

Notes:

PROCEDURE FOR COMMUNITY ENGAGEMENT

Has your Division, Office, or Program….

1) Assessed the *current* level of participation among representatives of the target population in program design, implementation, or other decision-making?

☐ Already applied ☐ In progress ☐ Will apply in the future ☐ N/A

Notes:

2) Determined the level of engagement *needed* from the target population?

☐ Already applied ☐ In progress ☐ Will apply in the future ☐ N/A

Notes:

3) Determined specific strategies to initiate and/or improve engagement with representatives from the target population?

☐ Already applied ☐ In progress ☐ Will apply in the future ☐ N/A

Notes:

PROCEDURE FOR DATA COLLECTION, ANALYSIS, REPORTING, MONITORING & EVALUATION

Has your Division, Office, or Program….

1) Included data points on social determinants of health in current data collection efforts?

☐ Already applied ☐ In progress ☐ Will apply in the future ☐ N/A

Notes:

2) Disseminated data back to the community?

☐ Already applied ☐ In progress ☐ Will apply in the future ☐ N/A

Notes:

3) Included health equity considerations in program monitoring and evaluation activities?

☐ Already applied ☐ In progress ☐ Will apply in the future ☐ N/A

Notes:

PROCEDURE FOR COMMUNICATIONS

Has your Division, Office, or Program….

1) Solicited feedback from representatives of the target population during the development of communications message and/or products, including digital media?

☐ Already applied ☐ In progress ☐ Will apply in the future ☐ N/A

Notes:

2) Reviewed messages and products to ensure they are culturally and linguistically appropriate and in plain language, including digital media?

☐ Already applied ☐ In progress ☐ Will apply in the future ☐ N/A

Notes:

3) Made it known that language assistance is available when communicating verbally with community members?

☐ Already applied ☐ In progress ☐ Will apply in the future ☐ N/A

Notes:

PROCEDURE FOR COMMUNITY PARTNERSHIPS

Has your Division, Office, or Program….

1) Assessed the need for external partner engagement in order to achieve health equity goals?

☐ Already applied ☐ In progress ☐ Will apply in the future ☐ N/A

Notes:

2) Contacted potential partners to assess their interest in the activity?

☐ Already applied ☐ In progress ☐ Will apply in the future ☐ N/A

Notes:

3) Applied principles that help ensure an equitable partnership?

☐ Already applied ☐ In progress ☐ Will apply in the future ☐ N/A

Notes:

4) If it is determined that the program's mission is best achieved through a *coalition*, used an identified coalition-building model?

☐ Already applied ☐ In progress ☐ Will apply in the future ☐ N/A

Notes:

III. PROCEDURE FOR CURRENT & NEW PROGRAM DEVELOPMENT

POLICY: Apply a health equity lens to current and new programs, policies, services, and interventions to ensure they include public health actions that break the cycle of health inequity in the community and that they do not create or perpetuate health inequities.

DEFINITIONS:

4 Es: Economics, Education, Environment, and Engagement. According to national research, these four areas are responsible for 50% of all health outcomes compared to other causes of access to clinical care (20%) and health behaviors (30%) [Source: County Health Rankings Model, 2012 UWPHI]. As such, the 4 Es are also the HCPH framework for Upstream Solutions and Health Equity; by focusing on the 4 Es, the conditions for good health in Harris County can be improved in a sustainable and equitable manner. Local research has identified actual percentages for how much someone's health is affected by each of the 4 Es [See: Klineberg, SL et al, What Accounts for Health Disparities? Kinder Institute for Urban Research, 2014].

Disadvantaged Population. A population group that has limited access to opportunities and resources due to factors beyond their control; the groups of people whose lives we aim to improve by reversing health inequities. [Source: Adapted from Health in All Policies: A Guide for State and Local Governments. American Public Health Association and Public Health Institute, 2013]

Health Inequity: Differences in health between population groups related to unfair, unjust, and avoidable socioeconomic or environmental conditions, public policy, or other socially determined circumstances. [Source: Adapted from Bay Area Regional Health Inequities Initiative (BARHII), Local Health Department Organizational Self-Assessment for Addressing Health Inequities]

Social Determinants of Health (Root Causes): Conditions in the social and physical environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life risks and outcomes. The social environment refers to social, economic, and cultural norms, patterns, beliefs, processes, policies, and institutions that influence the life of an individual or community. The physical environment refers to both the natural and human-made environments and how they impact health. [Source: Healthy People 2020]

Upstream Solutions: "Upstream Solutions" are actions that address social determinants of health (root causes) such as socioeconomic or environmental conditions that contribute to poor health, whereas "downstream solutions" focus on changing health risk behaviors at the individual level. Upstream Solutions take into account the idea that individual behavior is strongly influenced by one's socioeconomic and environmental conditions. [Source: HCPHES Strategic Plan; see also Frieden, T., A Framework for Public Health Action: The Health Impact Pyramid, 2010]

AUDIENCE: Directors, Program Managers, Program Administrators, and relevant team members as determined

PROCEDURE:

1. *Assessment*: Assess the impact of the current or new program, policy, service, or intervention on the 4 Es in Harris County:
    a. Determine if the current or new program, policy, service, or intervention is already identified on the HCPH Health Equity Framework at the level of Living Conditions or Upstream Causes (See Appendix: HCPH Health Equity Framework). Alternatively, assess the following:
        i. Does the activity have an impact on social determinants of health:
            - Employment and income
            - Educational attainment (high school graduation, college degrees) and other skill building
            - Fostering community engagement (social supports, community connectedness, civic engagement)
            - Physical and built environments
        ii. Are the activity's impacts greater for disadvantaged populations?

2. *Response*: Brainstorm ways for the current or new program, policy, service, or intervention to incorporate additional activities or to adjust its current activities to focus on improving health inequities:
    a. Determine what the HCPH Health Equity Framework suggests for public health actions that would move the program toward the level of Living Conditions or Upstream Causes.
    b. Determine the industry standard or best practice for the program area using available evidence of effectiveness (e.g.,

research results, case studies, national reports or plans, etc.).

- ✓ Use of a credible source of vetted programs and policies that have a health equity lens include:
  - Health Resources and Services Administration (HRSA), Foundational Practices for Health Equity, Appendix A (See Appendix: ASTHO, Foundational Practices, Appendix A)
  - Centers for Disease Control and Prevention (CDC), Health Impact in 5 Years (HI-5)
  - DeBeaumont Foundation, CityHealth

c. Apply Voice of the Customer results (if available).
d. Target the activity to a population group or geographic area that is experiencing documented health inequities.
e. Tailor the activity to the needs of the target population (See Appendix: National CLAS Standards).
f. If sites are being selected for the program, use selection criteria that includes population groups or geographic areas with sub-optimal social determinants of health.

(See Appendix: CDC, Health Equity Checklist)

3. *Selection*: Apply selection criteria to the solution to ensure it will address health inequities. (See Appendix: WHO, Urban HEART Tool).

REFERENCES:

1. Centers for Disease Control and Prevention, A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease. Available at: http://www.cdc.gov/NCCDPHP/dch/pdf/HealthEquityGuide.pdf
2. County Health Rankings Model (2012). Available at: http://www.countyhealthrankings.org/our-approach
3. Health Resources and Services Administration (HRSA) and Region V Social Determinants of Health Team of the Infant Mortality Collaborative Improvement and Innovation Network (CoIIN), Foundational Practices for Health Equity. Available at: http://www.health.state.mn.us/divs/opi/healthequity/resources/docs/DRAFT-Health-Equity-Learning-and-Action-Tool_HRSA-COIIN.pdf
4. Sudbury and District Health Unit, Health Equity Mapping Checklist. Available at : http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/health_equity_checklist.pdf

5. Washington State Department of Health Division of Prevention and Community Health Office of Healthy Communities, Health Equity Review Planning Tool. Available at: http://here.doh.wa.gov/materials/equity-review-tool/13_HERtool_E14L.pdf
6. World Health Organization (WHO), Urban HEART: Urban Health Equity Assessment and Response Tool. Website: http://www.who.int/kobe_centre/measuring/urbanheart/en/
7. U.S. Office of Minority Health, National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care. Website: http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53

APPENDICES:

1. HCPH Health Equity Framework, p29
2. National CLAS Standards, p30
3. HRSA, Foundational Practices for Health Equity, Appendix A, p32
4. CDC, Health Equity Checklist, p36
5. WHO, Urban HEART, Step 6: Identify the Best Response, p37

IV. PROCEDURE FOR COMMUNITY ENGAGEMENT

POLICY: Provide institutional means for community-based organizations and individual community members to participate in decision-making for programs, policies, services, interventions, and communication materials.

DEFINITIONS:

Barrier: An obstacle to a desired outcome. In the context of health equity, societal factors have become barriers to the potential for good health for all. Policies and other systems directly influence the availability and distribution of the social and physical determinants of health (e.g., economics, education, environmental conditions, etc.) to certain populations and neighborhoods. When there is inequitable distribution of social determinants due to policies and systems, the result can be health inequities, whereas the equitable distribution of social determinants contributes in health equity. [Source: Adapted from CDC, Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health, 2008]

Community: A specific group of people, often living in a defined geographic area, who share a common culture, values, and norms and who are arranged in a social structure according to relationships the community has developed over a period of time. The term "community" encompasses worksites, schools, and health care sites. [Source: King County Healthy Places Terminology Guide]

AUDIENCE: Division Directors, Program Managers, Program Administrators and team members as determined

PROCEDURE:

1. *Assessment*: Assess the level of participation by community-based organizations and individual community members in decision-making for programs, policies, services, interventions, and communication materials.
    a. Define the target population for the program, policy, service, intervention, or communications.
    b. Assess organizational barriers to engaging community-based organizations and/or individual community members from this target population:
        i. What is HCPH's history of engagement?
        ii. What barriers exist for engagement by community?
        iii. What barriers exist for engagement by community-based organizations? Examples of barriers include: organizational capacity, staff, and communication.

iv. How can these barriers be addressed?

c. Assess the current level of engagement with community-based organizations and/or individual community members from this target population by determining:
    i. Has input been sought previously in the planning or implementation of the activity?
    ii. Is involvement encouraged on an ongoing basis?
    iii. Have other Division, Office, or programs engaged this population and how?

2. *Improvement*: Determine the level of engagement with community-based organizations and/or individual community members from the target population needed for each program, policy, service, intervention, and communication and the specific strategies to be used to initiate and/or improve engagement.
    a. Determine the purpose of engaging community-based organizations and/or individual community members. (See Appendix: Index Of Community Engagement Techniques)
    b. Determine the steps in the planning/decision-making process in which community representatives will be involved and how the target population will be involved in that process.
    c. Determine the logistical details that can be put into place in order to enhance participation (e.g., incentives, venue, accessibility, scheduling, etc.).(See Appendix: King County Community Engagement Worksheet)
    d. Apply the King County Community Engagement Continuum to determine the level of engagement to pursue and how (See Appendix: King County Community Engagement Continuum). Below are HCPH-specific examples of when each type of engagement on the Continuum may be indicated:
        - *County Informs Community*: During an emergency situation/response or risk communication.
        - *County Consults Community*: When developing written communication materials (non-emergent), planning health fairs or other events, and conducting client satisfaction surveys or needs assessments (See Appendix: Index of Community Engagement Techniques, for more ideas).
        - *County Engages Community in Dialogue*: During legislative session for purposes of bill evaluation or during strategic planning.

- *County Works Together with Community*: For initiatives that are seeking to change policies, systems and environments in communities (e.g., Healthy Living Matters, Healthy Dining, BUILD Health Partnership, etc.)
- *County is Directed by Community*: Programs that are legislatively or funder-mandated to have a Consumer/Community Advisory Board making service or allocation decisions (e.g., Ryan White HIV/AIDS program).

3. *Re-Assessment and Ongoing Improvement*: Engaging the community for the purpose of program improvement is a continuous process as both community and program needs evolve over time. The steps above should be repeated throughout program implementation as time, resource, and staff capacity allow.

REFERENCES:

1. King County Community Engagement Worksheet (May 2011). Available at http://www.kingcounty.gov/elected/executive/equity-social-justice/tools-resources.aspx (Accessed on 10/19/15)
2. King County Community Engagement Guide (May 2011). Available at http://www.kingcounty.gov/~/media/elected/executive/equity-social-justice/documents/CommunityEngagementGuideContinuum2011.ashx?la=en (Accessed on 10/19/15)
3. Meaningful Community Engagement for Health & Equity (CDC, 2014). Available at http://www.cdc.gov/nccdphp/dch/pdfs/health-equity-guide/health-equity-guide-sect-1-2.pdf (Accessed on 10/19/15)
4. Collective Impact Framework. Available at http://www.collaborationforimpact.com/collective-impact/ (Accessed on 10/19/15)
5. Index Of Community Engagement Techniques https://www.tamarackcommunity.ca/hubfs/.Resources/Index%20of%20Engagement%20Techniques.pdf?t=1499732120923

APPENDICES:

1. King County Community Engagement Worksheet (May 2011), p40
2. King County Community Engagement Continuum (May 2011), p43
3. Index Of Community Engagement Techniques (2017), p44

V. PROCEDURE FOR DATA COLLECTION, ANALYSIS, REPORTING, MONITORING & EVALUATION

POLICY: Include health equity and social determinants in community needs assessment, improvement planning, surveillance, and other monitoring efforts of community health status.

Identify opportunities to understand the social determinants of health for program participants (clients, users, customers, etc.).

DEFINITIONS:

Social determinants of health (Root Causes): Conditions in the social and physical environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life risks and outcomes. The social environment refers to social, economic, and cultural norms, patterns, beliefs, processes, policies, and institutions that influence the life of an individual or community. The physical environment refers to both the natural and human-made environments and how they impact health. [Source: Healthy People 2020]

Health Equity: Differences in health between population groups related to unfair, unjust, and avoidable socioeconomic or environmental conditions, public policy, or other socially determined circumstances. [Source: Adapted from Bay Area Regional Health Inequities Initiative (BARHII), Local Health Department Organizational Self-Assessment for Addressing Health Inequities]

Community-based participatory research: "Community-based participatory research (in health) is a collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to the community with the aim of combining knowledge and action for social change to improve community (health)..." [Source: Definitions, Goals and Principles of Participatory Action Research, UC Berkeley]

AUDIENCE: Directors, Program Managers, Program Administrators, and all staff engaged in data collection, analysis, reporting and monitoring

PROCEDURE:

1. Data Collection: HCPH conducts numerous types of data collection (including qualitative and quantitative data, clinical and community-based data, and data at the individual, animal, facility, and community-levels) for a variety of purposes (e.g., assessment, disease surveillance,

facility compliance, patient services, program evaluation/outcome measures, etc.). See Appendix for THRIVE Community Assessment Worksheet. For each type and purpose, the data collection should include data points on social determinants of health.

a. Determine social determinants of health data already being collected
b. Determine what other measures of social determinants of health need to be collected (See Appendix: HCPH health equity framework)
    i. Foundational data points that include: race, ethnicity, gender, age and language, must be collected.
    ii. Additional indicators of inequities such as income, education level, homeowner & housing status, social strengths, health beliefs and practices, perceptions of illness and health must be collected when it is deemed appropriate
    iii. See Appendices: Mobilizing for Action through Planning and Partnerships (MAPP): User's Handbook; Health Research and Educational Trust Disparities Toolkit & THRIVE Sample Indicators for examples of indicators of inequity.
c. For clinical services & programs, use the PRAPARE toolkit for responding to and assessing patient assets, risks and experiences, as a guide (See Appendices: PRAPARE toolkit and Accountable Health Communities Screening tool for responding to and assessing patient assets, risks and experiences). Data can be collected through standard tools (focus group discussions, surveys etc.) that are already in use in your programs, offices, divisions etc. Ensure the inclusion of key members of your circle of involvement in the data collection process.
d. Data on social determinants of health must be collected in the time frame as determined in a grant cycle or program evaluation plan.
e. Involve the community/target population in the data collection process. Discuss barriers to using a survey/data collection tool, the usefulness, clarity and ease of understanding of the tool. Talk to staff members, interns and volunteers who live in the target communities about the proposed data collection methodologies

2. *Data Analysis:* Apply health equity lens to analytical tools that are already being used in your program, divisions, offices etc.

a. Utilize tools such as GIS to visualize geographic areas of health inequities.
b. Cross tabulate or stratify data to identify differences in health status among different groups.
c. Understand the causes of missing data and improve future data collection.

3. *Data Reporting*: Findings must be disseminated in the community. To do this, work with the Office of Communication, Education and Engagement (OCEE). OCEE can provide guidance on plain language writing and culturally and linguistically appropriate platforms. The materials must be easy to read and understand. Care must be taken to follow HIPAA regulations. Meet with the community members after the release of findings to get their input on the findings, future services and programs based on their needs.

4. *Monitoring & Evaluation (M&E)*: There are two types of M&E activities within HCPH: (1) The HCPH Performance Management and Quality Improvement (PQI) Plan that includes Standards and Measures for monitoring performance and quality of HCPH services and its impact on community-level health status: and (2) Division, Office, and/or Program-level evaluations designed and conducted for purposes specific to the program, policy, intervention, or service. In both types, health equity should be included:
    a. The HCPH PQI Plan and dashboard should include measures of health equity of HCPH as an organization and of Harris County as a community:
        i. At a minimum, internal health equity performance standards and measures should address: staff and leadership diversity, staff training on health equity and cultural competence, community engagement, and collection of and stratification of data according to social determinants of health.
        ii. At a minimum, external health equity performance standards and measures should address: community-level social determinants monitoring (e.g., poverty, achievement gap, linguistic isolation, disability, insurance status, etc.); neighborhood conditions and other physical determinants of health, and community resilience.
        iii. A Demographic Profile of the Harris County jurisdiction including social determinants of health and any specific populations experiencing health inequities due to the 4Es should be produced every

two years (or when new open-source data are available).

iv. A Workforce Profile of HCPH employees including foundational data points listed above should be produced every two years.
See Appendix: Tacoma Pierce Health Department's Health Equity and Quality Framework.

b. M&E plans should include a goal to monitor the social determinants of health and health equity impacts of the intervention. The evaluation questions and methodologies in the plan should allow staff to address the following health equity concerns:
   i. Is there differential impact to populations from the program, policy, intervention, or service?
   ii. Have inequities among the target population of the program, policy, intervention, or service decreased, increased or remained the same?
   (See Appendix: Addressing Health Equity in Evaluation Efforts)

5. *Guiding Principles for Community-based participatory research:* Apply principles that help ensure equity goals (See Appendix: Definitions, Goals and Principles of Participatory Action Research). Some community-based research principles to apply include:
   - Recognize community as a unit of identity
   - Build on strengths and resources within the community
   - Facilitate collaborative partnerships across all research phases
   - Integrate knowledge and action for mutual benefit for all partners
   - Promote a co-learning and empowering process that addresses inequities
   - Involve a cyclical and iterative process
   - Disseminate findings to all partners

   Prior to involving community members in a research project, approvals must be obtained from HCPH Institutional Review Board (IRB).

REFERENCES:

1. Addressing Health Equity in Evaluation Efforts (CDC). Available at http://www.cdc.gov/nccdphp/dch/pdfs/health-equity-guide/health-equity-guide-sect-1-7.pdf (Accessed on 11/06/15)
2. Mobilizing for Action through Planning and Partnerships (MAPP): User's Handbook (NACCHO)
3. Tool for Health & Resilience In Vulnerable Environments (THRIVE), Prevention Institute, Available at

https://www.preventioninstitute.org/tools/thrive-tool-health-resilience-vulnerable-environments (Accessed on 7/12/17)
4. Hasnain-Wynia, R., Pierce, D., Haque, A., Hedges Greising, C., Prince, V., Reiter, J. (2007) *Health Research and Educational Trust Disparities Toolkit*. hretdisparities.org (Accessed on 11/06/15)
5. Billioux, A., K. Verlander, S. Anthony, and D. Alley. 2017. *Standardized screening for health-related social needs in clinical settings: The accountable health communities screening tool.* Discussion Paper, National Academy of Medicine, Washington, DC. https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf.
6. Definitions, Goals and Principles of Participatory Action Research. Available at https://nature.berkeley.edu/community_forestry/Fellowships/parinfo/PAR%20Definitions.pdf (Accessed on 11/06/15)

APPENDICES:

1. HCPH Health Equity Framework, p29
2. Prevention Institute, THRIVE Community Assessment Worksheet, p70
3. Mobilizing for Action through Planning and Partnerships (MAPP): User's Handbook (NACCHO), p72
4. Health Research and Educational Trust Disparities Toolkit, p83
5. PRAPARE (Toolkit for responding to and assessing patient assets, risks and experiences), p84
6. Accountable Health Communities Core Health-Related Social Needs Screening Questions, p90
7. Health Equity and QI Framework, p92
8. CDC Addressing Health Equity in Evaluation Efforts, p94
9. Definitions, Goals, and Principles of Participatory Action Research, p98

VI. PROCEDURE FOR COMMUNICATIONS

POLICY: Provide health education, health communications, and other public information about community health status and needs in the context of health equity.

DEFINITIONS:

Cultural Competence: The capacity of an organization and its personnel to understand and respond effectively to individuals' cultural needs. Cultural needs can stem from personal identification, origin, neighborhood, demographics, beliefs, values, customs, languages, and social institutions [Source: Adapted from NACCHO, Roots of Inequity].

Health Communications: The study and use of communication strategies to inform and influence individual decisions that enhance health [Source: CDC and National Cancer Institute, 2011].

Health Education and Promotion: Any combination of educational opportunities and community-based efforts designed to facilitate behavior change conducive to good health. This includes the provision of information on health risks, behaviors, disease prevention, or wellness to the community (including in response to disease and environmental hazards, acts, or outbreaks) as well as planned efforts to coordinate community, policy, and organizational supports for good health [Source: PHAB, 2014].

Linguistic Competence: The capacity of an organization and its personnel to communicate effectively and to convey information in a manner that is easily understood by diverse audiences, including persons of Limited English proficiency, those who have low literacy skills or are not literate, individuals with disabilities, and those who are deaf or hard of hearing [Source: National Center for Cultural Competence, 2009].

Plain Language: Communication that an audience can understand the first time they read or hear it (also called Plain English). Federal agencies are required to write in Plain Language per the federal Plain Writing Act of 2010.

AUDIENCE: Staff of Divisions, Offices, or programs that develop health communications messages or materials OR are points of contact with community members.

PROCEDURE:

Written Materials. Written materials (such as brochures, curricula, and flyers) used in health communications or health education and promotion

activities should be developed with the engagement of the community (PHAB, 2014) and be appropriate to the cultural and language characteristics of the target audience. Steps to achieving this are as follows:

1. *Community Input*. Solicit input, review, and feedback from the target audience during message and product development.
    a. Identify the target population for the message or product.
    b. Pretest the message or product with members of the target audience (or those that can represent target audience groups such as a partner organization that works with the target audience directly) using iterative design and testing methods such as: interviews, focus groups, surveys, and task analysis/card sorting. Questions to ask include:
        - Is the information clear and easy to understand?
        - Is it confusing in any way?
        - Are any parts/words hard to read or understand?
        - Does the content match how you and the people you know discuss the topic?
        - Do the images look like the people you know?
        - Is there anything offensive?
        - What is helpful and what isn't?

    (See Appendix: Brief Introduction to User-Centered Design;Design Easy-to-Read Material Tool 11; and Index of Community Engagment Techniques)
    b. Document the results of this process for use by others and in the future.

    ✓ Use of a coordinated communications model is advised for meeting public health accreditation requirements, such as CDCynergy Lite or social marketing theory (See CDC, http://www.cdc.gov/HealthCommunication/HealthBasics/WhatIsHC.html for an overview of such models)
    ✓ Communications for emergency situations are excluded from the above.

2. *Cultural & Linguistic Competence*. Assure messages and products are culturally and linguistically competent and use Plain Language. (See Appendix: Consider Culture, Customs and Beliefs Tool 10 for additional guidance)
    a. At a minimum, printed materials should be translated into English and Spanish. They should also be translated into the most commonly used languages by the target population of the message or product.

b. Include consideration of the cultural and linguistic characteristics of messages and products during pretesting (see above).
c. Apply federal Plain Language guidelines to messages and products (See tips and tools for Plain Language at: http://www.plainlanguage.gov/howto/quickreference/index.cfm; also reference the Plain Language dictionary for public health at: http://www.cdc.gov/other/pdf/everydaywordsforpublichealthcommunication_final_11-5-15.pdf).

(See Appendices: Design Easy-to-Read Material Tool 11; and Developing Effective Communication Products Quick Check)

✓ Use of the CDC Clear Communication Index is advised: http://www.cdc.gov/ccindex/widget.html.

Clinical and Field Communications. HCPH Divisions, Offices, and programs that are points of contact with community members (including clinics, call enters, community-based behavior change interventions such as 115 Waiver projects, field staff, and inspectors) should adopt the National Standards for Culturally and Linguistically Appropriate Services (CLAS) related to Communications and Language Assistance:

1. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to services. (See Appendix: Address Language Difference Tool 9)
2. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing. (See Appendix: Clear Communications Tool 4)
3. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

(See Appendix: National CLAS Standards)

✓ Contact HCPH Operations & Finance receptionist to access the bilingual staff list.

Digital Communications. HCPH websites and social media pages should follow the procedures above for written materials. Application of federal usability guidance is advised (See: http://www.usability.gov/) with special attention to accessibility of electronic and information technology by people with disabilities or impairment. (See Appendix: Index of Community Engagement Techniques for additional guidance)

- ✓ Use of a tool for designing digital health information products is advised such as Health Literacy Online.

Messaging about Health Equity. Reference to how socioeconomic and environmental factors create poor health should be incorporated into HCPH messaging and products (both real and virtual). Some recommended phrases for describing health equity principles include the following (which have been user-tested by the Robert Wood Johnson Foundation for this purpose):

- Health starts – long before illness – in our homes, schools, and jobs.
- All Americans should have the opportunity to make the choices that allow them to live a long, healthy life, regardless of their income, education or ethnic background.
- Your neighborhood or job shouldn't be hazardous to your health.
- Your opportunity for health starts long before you need medical care.
- Health begins where we live, learn, work, worship, and play.
- The opportunity for health begins in our families, neighborhoods, schools and jobs.

(See Appendices: A New Way to Talk about Social Determinants, Chapter 2; and What is Health Equity? A Definition).

- ✓ Contact the HCPH Health Equity Coordinator for assistance with health equity messaging and products.

Note: All external communications materials should be reviewed by the Office of Communications (OCEE) before use. Relevant OCEE forms can be found here.

REFERENCES:

1. Agency for Healthcare Research and Quality (AHRQ), National Resource Center for Health IT, Accessible Health Information Technology (Health IT) for Populations with Limited Literacy: A Guide for Developers and Purchasers of Health IT. October 2007. Available at: https://healthit.ahrq.gov/health-it-tools-and-resources/health-it-literacy-guide
2. CDC, Division of Public Affairs, Office of the Associate Director for Communication, What is Health Communications? 2011. Available at: https://www.cdc.gov/healthcommunication/healthbasics/whatishc.html
3. CDC, Everyday Words for Public Health Communications (October 2015). Available at: http://www.cdc.gov/other/pdf/everydaywordsforpublichealthcommunication_final_11-5-15.pdf

4. Office of Disease Prevention and Health Promotion (ODPHP), Health Literacy Online (2nd Edition): A Guide for Simplifying the User Experience. Available at: http://health.gov/healthliteracyonline/.
5. Plain Language Action and Information Network (PLAIN), Federal Plain Language Guidelines, March 2011, Rev. 1, May 2011. Available at: http://www.plainlanguage.gov/howto/guidelines/FederalPLGuidelines/FederalPLGuidelines.pdf
6. Public Health Accreditation Board (PHAB) Standards and Measures (version 1.5). Domain 3. Available at: http://www.phaboard.org/wp-content/uploads/PHABSM_WEB_LR1.pdf
7. U.S. Office of Minority Health, National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. Available at: www.thinkculturalhealth.hhs.gov.
8. Robert Wood Johnson Foundation, A New Way to Talk about the Social Determinants of Health, 2010. Available at: http://www.rwjf.org/en/library/research/2010/01/a-new-way-to-talk-about-the-social-determinants-of-health.html
9. Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. *What Is Health Equity? And What Difference Does a Definition Make?* Princeton, NJ: Robert Wood Johnson Foundation, 2017.

APPENDICES:

1. Brief Introduction to User-Centered Design, p99
2. Design Easy-to-Read Material Tool 11, p103
3. Index of Community Engagement Techniques (Tamarack Institute), p44
4. Consider Culture, Customs and Beliefs Tool 10, p106
5. Address Language Difference Tool 9, p109
6. Clear Communications Tool 4, p112
7. CDC Clear Communication Index: Developing Effective Communication Products (Quick Check), p114
8. National CLAS Standards (U.S. Office of Minority Health), p30
9. A New Way to Talk about the Social Determinants of Health, Chapter 2: Choosing Words, Best Practices in the Language and Framing of Social Determinants of Health, p115
10. What is Health Equity? A Definition, p120

VII. PROCEDURE FOR COMMUNITY PARTNERSHIPS

POLICY: Engage the community, partners, and other local jurisdictions in strategic partnerships to develop public policies for the purposes of addressing and eliminating health inequities.

DEFINITIONS:

Partnership: A partnership is a purposive relationship between two or more parties (individuals, groups, or organizations) committed to pursuing an agenda or goal of mutual benefit. [Source: Adapted from CDC, Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health, 2008].

Coalition: A coalition is a group of organizations that come together for the purpose of gaining more influence and power than the individual organizations can achieve on their own. From a community organizing perspective, the reason to spend time and energy building a coalition is to amass the power necessary to do something you can't do alone. [Source: Western Organization of Resource Councils, How To Work In Coalitions]

AUDIENCE: Staff engaged in efforts to change policies and laws that are *not* specific to public health, such as policies focused on economic conditions or education access.

PROCEDURE:

1. *Assessment*: Assess the necessity and level of partnership engagement required in decision-making for programs, policies, services, interventions, and communication.
    a. Articulate the reason for seeking a partnership with a community stakeholder(s), such as such as shared vision, mission, goals, and objectives of the program
    b. Brainstorm potential stakeholders to engage as partners. (See Appendix: 2013-2018, HCPH Strategic Plan, Key Stakeholders)
    c. Assess the current level of partnership with potential stakeholders including the presence of any formal agreement. Review the list developed in 1.b with a supervisor.

2. *Establishing the partnership:* Contact potential partners to assess their interest in the activity. Share reasons for seeking a partnership as identified in 1(a). Convene a discussion with the partner(s) (in-person, by phone, by email, etc.). During this conversation:
    a. Discuss detailed activities and roles for each party.
    b. Determine other stakeholders to engage.

c. Identify each party's resources and needs in order to collaborate (See Appendices: Prevention Institute "Eight Steps to Coalition Building" and "Collaboration Multiplier").
d. Determine if there is a need for a formal agreement regarding the partnership. Review with a supervisor when there is a need for a formal agreement.

3. *Guiding Principles for an Equitable Partnership:* Apply principles that help ensure equity goals (See Appendices: CDC's Promoting Health Equity and Developing Partnerships and Coalitions to Advance Health Equity). Some principles to apply include:
    - Shared commitment to addressing social inequities that affect health, including those that constrain participation of affected individuals and communities in the decision-making process.
    - Commitment to shared decision-making among all members of the partnership.
    - Commitment to collective action by all members of the partnership.
    - Commitment to ongoing assessment of the partnership's structure and approaches.

4. *Coalition Building*: If it is determined that the program's mission is best achieved through a coalition, the following models of coalition building can be used:
    - Collective Impact model of coalition building (See Appendices: Collective Impact Framework & Collective Impact Principles of Practice).

REFERENCES:

1. Promoting Health Equity, A Resource to Help Communities Address Social Determinants of Health (2008) Sec1:38. Available at http://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/pdf/SDOH-workbook.pdf (Accessed on 10/19/15)
2. Developing Partnerships and Coalitions to Advance Health Equity (CDC). Available at http://www.cdc.gov/nccdphp/dch/pdfs/health-equity-guide/health-equity-guide-sect-1-3.pdf (Accessed on 10/19/15)
3. Prevention Institute "Eight Steps to Coalition Building". Available at http://www.preventioninstitute.org/index.php?option=com_jlibrary&view=article&id=104&Itemid=127 (Accessed on 10/19/15)
4. Prevention Institute "Collaboration Multiplier". Available at http://www.preventioninstitute.org/component/jlibrary/article/id-44/127.html (Accessed on 10/19/15)

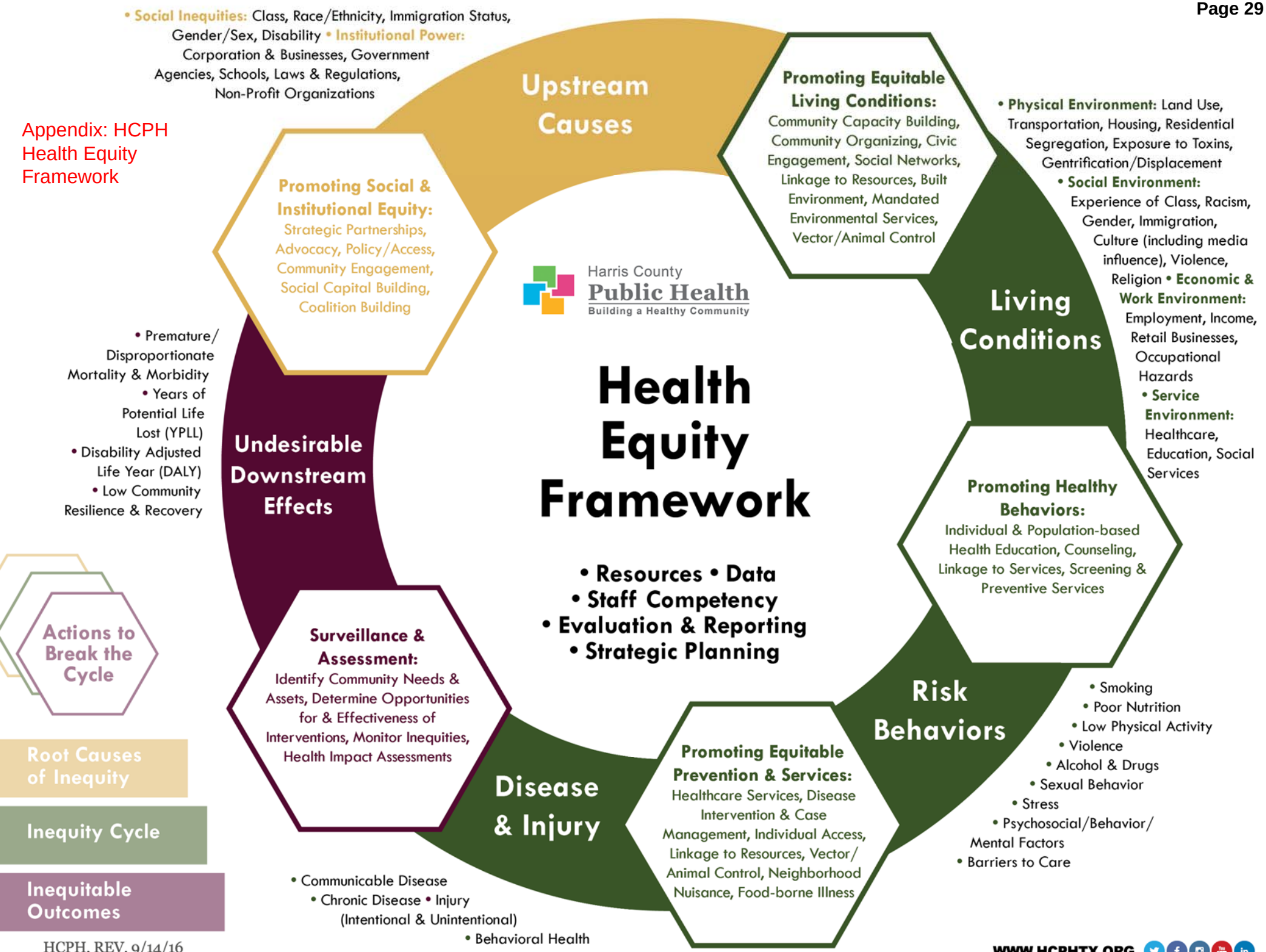
5. Collective Impact Framework. Available at http://www.collaborationforimpact.com/collective-impact/

APPENDICES:

1. 2013-2018, HCPH Strategic Plan, Key Stakeholders, p121
2. Prevention Institute "Eight Steps to Coalition Building," p126
3. Prevention Institute "Collaboration Multiplier,"p128
4. Promoting Health Equity, A Resource to Help Communities Address Social Determinants of Health, p132
5. Developing Partnerships and Coalitions to Advance Health Equity, p133
6. Collective Impact Framework, p137
7. Collective Impact Principles for Practice, p138

APPENDICES

Appendix: HCPH Health Equity Framework



HCPH, REV. 9/14/16

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

The Case for the Enhanced National CLAS Standards

Of all the forms of inequality, injustice in health care is the most shocking and inhumane.
— Dr. Martin Luther King, Jr.

Health equity is the attainment of the highest level of health for all people (U.S. Department of Health and Human Services [HHS] Office of Minority Health, 2011). Currently, individuals across the United States from various cultural backgrounds are unable to attain their highest level of health for several reasons, including the social determinants of health, or those conditions in which individuals are born, grow, live, work, and age (World Health Organization, 2012), such as socioeconomic status, education level, and the availability of health services (HHS Office of Disease Prevention and Health Promotion, 2010). Though health inequities are directly related to the existence of historical and current discrimination and social injustice, one of the most modifiable factors is the lack of culturally and linguistically appropriate services, broadly defined as care and services that are respectful of and responsive to the cultural and linguistic needs of all individuals.

Health inequities result in disparities that directly affect the quality of life for all individuals. Health disparities adversely affect neighborhoods, communities, and the broader society, thus making the issue not only an individual concern but also a public health concern. In the United States, it has been estimated that the combined cost of health disparities and subsequent deaths due to inadequate and/or inequitable care is $1.24 trillion (LaVeist, Gaskin, & Richard, 2009). Culturally and linguistically appropriate services are increasingly recognized as effective in improving the quality of care and services (Beach et al., 2004; Goode, Dunne, & Bronheim, 2006). By providing a structure to implement culturally and linguistically appropriate services, the enhanced National CLAS Standards will improve an organization's ability to address health care disparities.

The enhanced National CLAS Standards align with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities (HHS, 2011) and the National Stakeholder Strategy for Achieving Health Equity (HHS National Partnership for Action to End Health Disparities, 2011), which aim to promote health equity through providing clear plans and strategies to guide collaborative efforts that address racial and ethnic health disparities across the country. Similar to these initiatives, the enhanced National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. Adoption of these Standards will help advance better health and health care in the United States.

Bibliography:

Beach, M. C., Cooper, L. A., Robinson, K. A., Price, E. G., Gary, T. L., Jenckes, M. W., Powe, N.R. (2004). Strategies for improving minority healthcare quality. (AHRQ Publication No. 04-E008-02). Retrieved from the Agency of Healthcare Research and Quality website: http://www.ahrq.gov/downloads/pub/evidence/pdf/minqual/minqual.pdf

Goode, T. D., Dunne, M. C., & Bronheim, S. M. (2006). The evidence base for cultural and linguistic competency in health care. (Commonwealth Fund Publication No. 962). Retrieved from The Commonwealth Fund website: http://www.commonwealthfund.org/usr_doc/Goode_evidencebasecultlinguisticcomp_962.pdf

LaVeist, T. A., Gaskin, D. J., & Richard, P. (2009). The economic burden of health inequalities in the United States. Retrieved from the Joint Center for Political and Economic Studies website: http://www.jointcenter.org/sites/default/files/upload/research/files/The%20Economic%20Burden%20of%20Health%20Inequalities%20in%20the%20United%20States.pdf

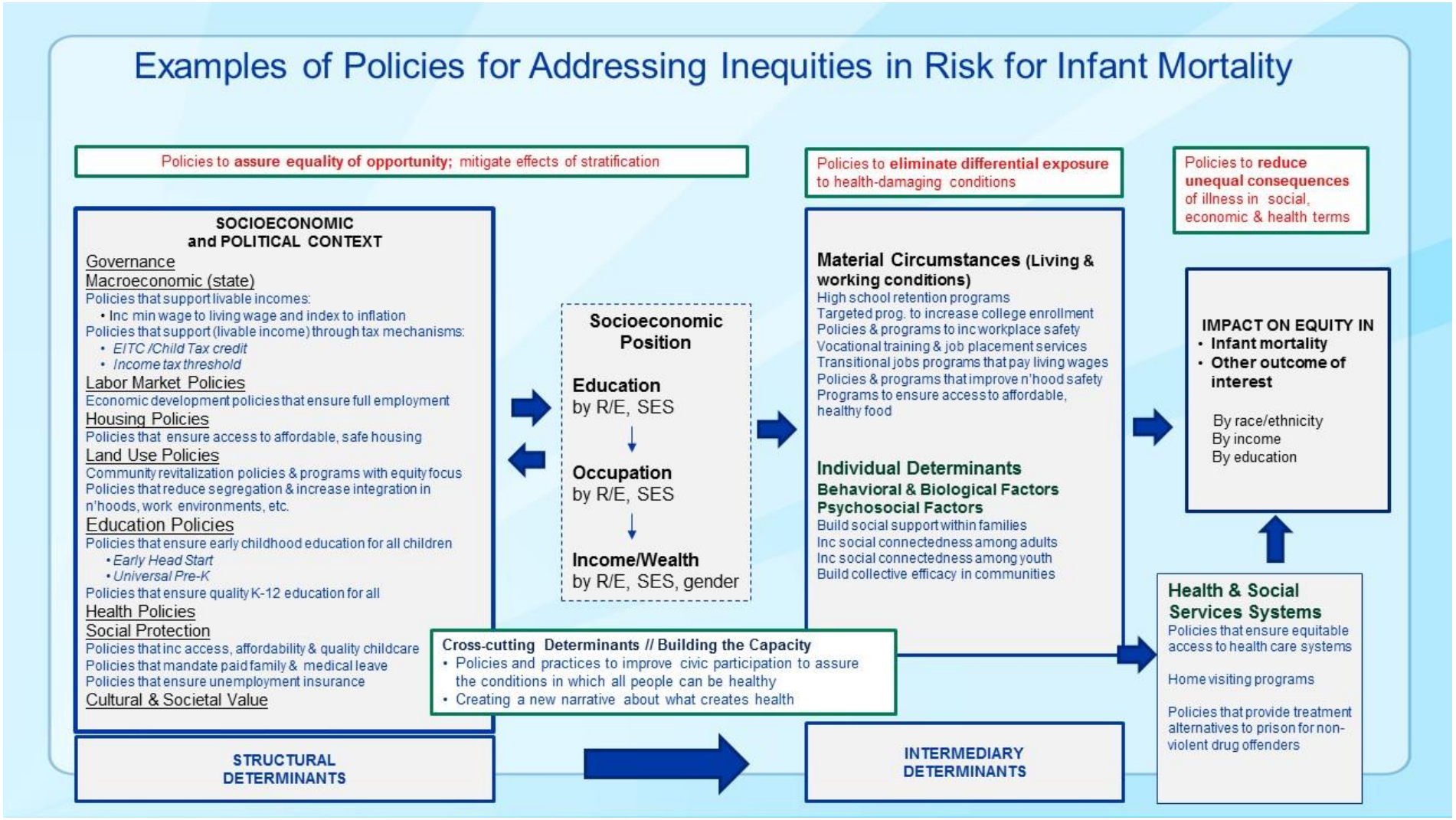
National Partnership for Action to End Health Disparities. (2011). National stakeholder strategy for achieving health equity. Retrieved from U.S. Department of Health and Human Services, Office of Minority Health website: http://www.minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286

U.S. Department of Health and Human Services. (2011). HHS action plan to reduce racial and ethnic health disparities: A nation free of disparities in health and health care. Retrieved from http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). Healthy people 2020: Social determinants of health. Retrieved from http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39

U.S. Department of Health and Human Services, Office of Minority Health (2011). National Partnership for Action to End Health Disparities. Retrieved from http://minorityhealth.hhs.gov/npa

World Health Organization. (2012). Social determinants of health. Retrieved from http://www.who.int/social_determinants/en/


Examples of Policies for Addressing Inequities in Risk for Infant Mortality
Policies to assure equality of opportunity; mitigate effects of stratification
Policies to eliminate differential exposure to health-damaging conditions
Policies to reduce unequal consequences of illness in social, economic & health terms
SOCIOECONOMIC and POLITICAL CONTEXT
Governance
Macroeconomic (state)
Policies that support livable incomes:
• Inc min wage to living wage and index to inflation
Policies that support (livable income) through tax mechanisms:
• EITC /Child Tax credit
• Income tax threshold
Labor Market Policies
Economic development policies that ensure full employment
Housing Policies
Policies that ensure access to affordable, safe housing
Land Use Policies
Community revitalization policies & programs with equity focus
Policies that reduce segregation & increase integration in n'hoods, work environments, etc.
Education Policies
Policies that ensure early childhood education for all children
• Early Head Start
• Universal Pre-K
Policies that ensure quality K-12 education for all
Health Policies
Social Protection
Policies that inc access, affordability & quality childcare
Policies that mandate paid family & medical leave
Policies that ensure unemployment insurance
Cultural & Societal Value
Socioeconomic Position
Education
by R/E, SES
Occupation
by R/E, SES
Income/Wealth
by R/E, SES, gender
Material Circumstances (Living & working conditions)
High school retention programs
Targeted prog. to increase college enrollment
Policies & programs to inc workplace safety
Vocational training & job placement services
Transitional jobs programs that pay living wages
Policies & programs that improve n'hood safety
Programs to ensure access to affordable, healthy food
Individual Determinants
Behavioral & Biological Factors
Psychosocial Factors
Build social support within families
Inc social connectedness among adults
Inc social connectedness among youth
Build collective efficacy in communities
IMPACT ON EQUITY IN
• Infant mortality
• Other outcome of interest
By race/ethnicity
By income
By education
Health & Social Services Systems
Policies that ensure equitable access to health care systems
Home visiting programs
Policies that provide treatment alternatives to prison for non-violent drug offenders
Cross-cutting Determinants // Building the Capacity
• Policies and practices to improve civic participation to assure the conditions in which all people can be healthy
• Creating a new narrative about what creates health
STRUCTURAL DETERMINANTS
INTERMEDIARY DETERMINANTS

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

Note: The Intermediary Determinants category includes Living and Working Conditions ("L&W"), Psychosocial ("PsySoc"), and Other (e.g., Health & Criminal Justice)
The following is a list of the kinds of policies that are considered to promote health and advance health equity and which are crucial to include in a comprehensive policy assessment. These are policies or policy areas that are evidence-based or evidence informed. Some have evidence for improving health outcomes in general, while others have specific evidence relating to improved birth outcomes (e.g., Earned Income Tax Credit).

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

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

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

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

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

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

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

APPENDIX D

HEALTH EQUITY CHECKLIST: CONSIDERING HEALTH EQUITY IN THE STRATEGY DEVELOPMENT PROCESS

The Health Equity Checklist provides questions for consideration when designing a strategy to ensure health equity remains central to all aspects of an initiative.

STEP 1: IDENTIFY

Clearly identify health inequities and protective factors in both health outcomes and community conditions across population groups and geographic areas through the use of existing data, community input, and environmental assessments.

STEP 2: ENGAGE

Include and meaningfully engage representatives of population(s)/area(s) defined in Step 1 in your partnerships, coalitions, or on leadership teams.

STEP 3: ANALYZE

Ensure the selection, design, and implementation of strategies are linked to the inequities identified in Step 1, and will work to advance health equity. Consider the following:

Is the strategy TARGETED to a population group(s)/area(s) experiencing health inequities?

- Is the outcome written in a way that allows you to measure the effect of efforts?
- Is it culturally tailored to the unique needs of population group(s)/area(s) experiencing health inequities, and are potential barriers addressed?

Does the strategy rely on SITE SELECTION (e.g., selecting X number of sites for smoke-free cessation services, creating X number of farmers' markets)?

- Do selection criteria for sites reflect populations/areas with the highest burden?
- If not, are selection criteria logical and justified?
- Are there additional supports provided for selected sites that might require them to be successful?

Is the strategy POPULATION-WIDE?

- Have population(s)/area(s) experiencing health inequities been engaged in efforts to identify possible barriers and unintended consequences of the proposed strategy?
- Are identified barriers regarding implementation and enforcement being addressed?
- Have potential unintended consequences been considered and accounted for in proposed activities?

STEP 4: REVIEW

Review evaluation and monitoring plans to ensure health equity-related efforts will be measured. Additionally, ensure appropriate data will be collected to conduct sub-analyses. These data will help in assessing the differential effects of each strategy across population group(s)/area(s), as well as the overall impact of strategies on reducing health inequities.

SUGGESTED CITATION: Centers for Disease Control and Prevention - Division of Community Health. Health Equity Checklist: Considering Health Equity in the Strategy Development Process. Atlanta, GA: US Dept of Health and Human Services; 2010.

STEP 6: IDENTIFY THE BEST RESPONSE

WHY DO IT?

The purpose of step 6 is to produce clear and strong recommendations about what governments and communities need to do to reduce the priority health inequities you have uncovered.

The merits of your Urban HEART recommendations will be threefold:

- You can show evidence that action is needed.
- You can demonstrate the relevance, effectiveness and feasibility of the proposed response.
- Your proposal has the support and backing of relevant sectors, communities and champions.

WHAT TO DO?

Link assessment to response. Once you have identified priority health equity issues, the next step is to identify the appropriate response(s). In this respect, step 6 flows naturally from step 5. Step 6 involves the same degree of intensive consultation and deliberation with stakeholders. A good strategy is to fold response planning into the priority-setting workshops you scheduled during step 5. Remember, as you assess the feasibility of different responses, you may want to revise your priority list, to focus on what is doable.

Brainstorm potential responses. Urban HEART provides an extensive menu of programme and policy interventions to reduce health inequities (see Annex VII). These interventions have been reviewed by experts and many have been tested in other cities. Use this resource to brainstorm with stakeholders about relevant responses. Affected communities should play a strong role in this process. Their health is at stake, and they may know best what needs to be done.

Use criteria to choose the best response. This can be done systematically (for example, by using a scoring system to weigh the value of different criteria) or less formally. There is no prescribed approach. The important point is to be comprehensive and to assess potential interventions carefully (see box below for recommended selection criteria). Above all, ensure that the interventions you prioritize are aimed to reduce equity gaps. This may mean delivering the intervention exclusively to vulnerable groups, or tailoring it for cultural relevance or doing extensive outreach. Use the expertise on the team, and consult other experts (including researchers, policy-makers and affected communities) for advice on selecting the best response or set of responses.

Write your response proposal. Your proposal should clearly describe why the response is needed, including your evidence about the health equity problem and its causes and consequences. Describe objectives of the response intervention, the criteria you used to select it, how it will work, how it will reduce health inequities, where and how it should be implemented, who needs to be involved, how much it could cost and how it aligns with government priorities. Use the information you collected during your various Urban HEART consultations. Describe your Urban HEART process to date, and include the MATRIX or MONITOR charts that demonstrate your city's priority equity gaps.

Develop an advocacy plan. Engage your champions and affected communities. They may be ideal spokespersons to present your response proposal to decision-makers, and to advocate its adoption in new planning and budgeting cycles.

WHO SHOULD BE INVOLVED?

- All team members, champions and stakeholders who are affected by or who have a direct interest in the priority equity gaps identified at step 5.
- Other experts who can provide advice about the effectiveness of interventions, and optimal ways to advocate the uptake of your recommendations.

WHAT RESOURCES ARE NEEDED?

- The Urban HEART response interventions menu. See Annex VII. You may want to make copies for distribution during consultations.
- Research reports, case studies and other evidence of intervention effectiveness. Many of these resources have been collected for use by Urban HEART teams and can be downloaded at http://www.who.or.jp/urbanheart.
- Additional resources to support workshops and consultations, as described for step 5.

WHAT KNOWLEDGE AND SKILLS ARE NEEDED?

- Knowledge of existing programmes and policies.
- Knowledge of the effectiveness of potential programmes.
- Skills in appraising the scientific evidence on interventions.
- Knowledge of community priorities and preferences.
- Excellent facilitation and negotiation skills, to encourage open and transparent discussion about potential interventions and their relative merits.
- Community engagement skills.
- Knowledge of government planning and budgeting cycles and strategic sense about how to encourage uptake of the response plan.
- Proposal writing skills.

HOW MUCH TIME WILL IT TAKE?

In total, you should estimate three to six months to finalize response planning.

Brainstorming response strategies may overlap with step 5. Additional time will be required to evaluate candidate responses and to make a final response selection. Allocate two to three months for these activities.

Developing your proposal will also take time. Although you should use the information you collected throughout the Urban HEART process, you will also want to do additional consultations. Allocate one to two months for this activity.

Preparing an advocacy plan and equipping stakeholders to do advocacy may take one to two months.

WHAT ARE THE OUTCOMES?

The Urban HEART team has developed an evidence-based, feasibility-tested and collaborative plan to respond to priority health inequities in your city.

An advocacy plan has been developed to champion the Urban HEART response proposal to decision-makers.

The team has completed the assessment and response phases of Urban HEART. You can move forward to next steps. Congratulations!

TIPS

Use a scoring system to choose the best response. Many pilot cities recommend using a weighting system to prioritize equity problems and to select the best response. This is a systematic approach for comparing and selecting candidate responses. This strategy was utilized in Parañaque City, Philippines, and it helped the team decide on three priorities: improving access to safe water in poor barangays (city subdistricts), increasing the rate of facility-based births and addressing the index crime rate. See Annex VIII for a sample scoring table for selecting the best response.

Define concrete objectives for the proposed Urban HEART response. Be clear about what the intervention(s) should accomplish. Objectives should be "SMART" – Specific, Measurable, Actionable, Realistic, and Time-bound. A quantifiable objective, linked to your problem indicator and to the numeric scores presented on the MATRIX or MONITOR, is optimal. This approach directly links your Urban HEART response plan to the assessment phase. The team in Ulaanbaatar, Mongolia, developed objectives using this framework to assess response performance.

Include a strong monitoring and programme evaluation component. Plan to measure the response in action. Evaluation evidence can help to improve the quality of the response and can guide interventions elsewhere. Evaluation should focus not only on if a programme works to reduce health inequities, but also how, why, when and for whom it works (or does not work). Work with experienced researchers to design an evaluation.

Propose legislative changes to improve health equity. Most actions resulting from Urban HEART have been tied to legislative changes in participating cities.

Build on existing programmes. Legislatively and logistically, it is easier to expand existing programmes than to launch new ones from scratch. Look for existing programmes that could incorporate or support your proposed intervention. This can minimize costs and prevent duplication, which will make your proposal more palatable to decision-makers. For example, in Nakuru, Kenya, the team is working to link water quality issues to national plans to address climate change. In Mexico City, the team is aligning its recommendations with Mexico's new health laws. In Jakarta, Indonesia, the team's recommendations are streamlined with the local WHO Healthy Cities strategy.

Help decision-makers to "own" the issue. You need their commitment to the Urban HEART response plan, so they will advocate it in parliament or at city council. Include them in (or regularly update them about) your activities. Ensure that they understand the equity problem clearly and why the recommended response makes sense. They can provide strategic advice about when and how to present the proposal to others.

Time workshops and advocacy efforts to harmonize with planning and budgeting cycles. This will increase opportunities for decision-makers to adopt your response proposal into government plans.

Participate in formal and also informal advocacy. To encourage uptake of Urban HEART across Kenya, the team made formal presentations to national government, and also worked behind the scenes promoting Urban HEART to sister municipalities.

One size does not fit all when it comes to health policy in a rapidly urbanizing environment. Some populations and some districts will face greater problems than others. With Urban HEART, the team can make an evidence-based case for policies and programmes that focus on small areas or districts inside cities.

CHECKLIST

- Have you considered the strengths, weaknesses, opportunities and threats associated with potential responses?
- Have you made sure your selected response plan will target your health equity priorities? Make sure that your intervention will not make inequities worse.
- Has the affected community helped design the response plan?
- Do you know the right time, format and audience for presenting your proposal?

BUILDING COMMUNITY CAPACITY: A SUCCESS STORY

Urban HEART generates evidence that can empower communities to advocate on their own behalf. For example, in Davao, Philippines, residents of the Sasa barangay learned through Urban HEART that they lived in the only neighbourhood marked "red" for unsafe water. With this evidence, the community was empowered to approach the mayor and successfully lobbied for clean water access. Popular education related to the social determinants of health, government process and human rights, as well as media training, can build community capacity to advocate health equity. Other resources may also be needed, such as transportation, child care, and translation support, to enable residents to participate fully.

HOW TO USE THE URBAN HEART RESPONSE MENU

1. Review your MATRIX to confirm the policy domain responsible for your problem indicator.
2. Turn to the appropriate section of the menu in Annex VII (it is organized by policy domain).
3. Review the five strategy packages for your policy domain. Choose the package that is most relevant to the equity problem you want to address.
4. Review the list of interventions in the strategy package.
5. Choose the best response using clear selection criteria, such as feasibility, cost-effectiveness and acceptability. See the checklist below for a full list of selection criteria.
6. Select the intervention that is most appropriate for your context.

CRITERIA FOR SELECTING THE BEST RESPONSE

REDUCES HEALTH INEQUITIES	• Will the intervention address the gaps in health determinants and outcomes? • Does it address the target as outlined in the strategic objective's expected outcomes?
AVAILABLE LOCAL RESOURCES	• Is there commitment from other sectors and stakeholders regarding resources? • Does the intervention require more than the current collected resources? • Has accountability been set for each party involved?
ACCEPTABLE BY AFFECTED COMMUNITIES / OTHER KEY PLAYERS	• Is the intervention culturally sensitive? • Have the community members shared their views on the priority of needs and appropriate interventions?
ACHIEVABLE WITHIN TIME FRAME	• Given available resources (financial, human, organizational), can the intervention be implemented within a time frame that will be socially, politically and economically acceptable?
LIKELY TO BE EFFECTIVE & EFFICIENT	• Is the intervention proven to be of minimal cost for the maximum effect on health inequities? • Is it proven to be cost-effective or is it shown through outcome evaluation studies to be of proven or promising effectiveness?
COMPLIES WITH LOCAL/ NATIONAL PRIORITIES	• Is the intervention's goal aligned with the local or national political agenda? • Is there political support from the local government?

King County

Community Engagement Worksheet

Project Title:

Project Lead:

Program Name:

Timeline: to

How to use this worksheet:

This worksheet will assist you in thinking about your process, purpose, primary audience, potential barriers, impacts and strategies to inform and involve your intended audience before you begin. Below are some key questions with prompts to guide and direct you before beginning and during your engagement process. You may reference the Community Engagement Continuum to determine the level and methods of engagement that best suit the type work you are doing.

What is the purpose of your engagement?

1. State briefly why you are doing the community engagement:

What do you hope to achieve? What is your main purpose for involving community members? Where does your engagement fit best on the continuum? Is there enough time to carry out the engagement properly?

Stakeholders and audiences

2. Who are the key stakeholders or partners? Who is affected by, involved in, or has a specific interest in the issue?

What steps will you take to ensure impacted communities that have not historically been included in the initial decision making phase be included? Are there specific communities that will impacted/affected by decisions or processes related to engagement? How will you utilize internal staff expertise to provide technical assistance or consultation to ensure inclusive stakeholder involvement? Are stakeholders groups defined (e.g., neighborhoods, topic area, ethnic or racial, language, gender, tribal, etc.)? Do you or others in the county have appropriate partnerships or contacts in place to initiate and support the adequate county level of engagement?

What strategies will you use to ensure you have information from and research about the relevant groups and communities?

3. Have you gathered adequate background information about the affected populations you intend to reach? (i.e., language or dialect spoken, customs, historical or geographic data, relevant data reports). For example, see Communities Count – Indicators for King County). What other research will you need to better know and understand your public? How will you identify community strengths and assets?

4. How will you make sure you are effectively reaching all of your audiences?

A. How do you plan to address language and literacy needs including translations, interpretations and reading levels? (See the Plain Language Style Guide and King County executive order on written language translation) and Guidelines for Accessible Printed Materials kcweb.metrokc.gov/dias/ocre/printguide.pdf

B. Have you taken into account that alternative and non-traditional approaches to consider before proceeding? Does your intended audience have their own engagement practices that should be considered? Alternatively, does your audience or community use new and social media (e.g., web videos, texting), and could this be an effective way of reaching them?

Barriers and risks

5. What do you perceive as barriers and risks to doing this work?

Are there trust issues among members of the public or a community that may prevent full engagement (i.e., social, political, tribal, gender specific)? How will you address the diverse cultural differences among affected communities? Is there adequate justification for proceeding with your project concept (i.e. time, cost, level of interest)? Is there community and public support for your project? What are some unintended consequences of the project if not done effectively? Are there strategies in place to address unintended consequences?

Decision-making process and communications

6A. If there are decisions to be made, how does the engagement fit into the overall decision-making process?

Are there processes in place to involve affected communities in decisions at different levels and phases? Do you have representation from affected communities in decisions? What decisions need to be made after the engagement and how will the community be involved in that process? How will the affected community be informed of final decisions? Do you have a standard point of contact for community members?

6B. What is in place to inform community of benchmarks or progress about your project?

How will you recognize the contributions of community members? Will there be opportunities for formal project/program updates and feedback (i.e. meetings, website updates, phone calls, e-mail)? Is there budget for printing and circulating a report on the outcomes? Who will inform the community on impacts of final decisions? What steps will be taken to maintain opportunities for future collaboration or engagement?

Evaluation and monitoring of success

7. How will you evaluate the success of your project both in terms of process and outcomes?

Were you able to successfully reach the intended audience? Did people receive the necessary information they needed to make a relevant response? Did you choose the right type or level of engagement to match the purpose? Was feedback received from the community positive or negative? Did the community feel like they received proper feedback on the results of the engagement? Did they indicate they want to be part of a similar process again? If not, why not? What would you do differently to make the process better, more inclusive, and more impactful?

Logistics and things to consider for planning community meetings:

The logistics of community engagement is critical for turnout and community interest. Paying attention to a number of logistical issues will enhance participation and improve the overall effort. Some things to consider:	
Venue	Making meetings geographically close to communities or stakeholders is critical to get a good turnout. Choosing a site that is community centered may more familiar and comfortable for attendees. Does the venue accommodate for public parking and transportation?
Host	If inviting public officials make sure you have followed appropriate channels before inviting them to participate. Clarify in advance the role for County Executive, Council members, Public Information Officer and community members prior to the engagement.
Staffing	Will you use program staff, other King County staff or partner staff to help with set up, welcoming, and meeting facilitation?
Budget	Is your budget adequate to provide resources for advertising, communication and promotion, rental space, refreshments/food, transportation, child care, translation/interpretation?
Accessibility	Is the location wheelchair accessible and code approved for people with disabilities?
Time	Do you have staff that can attended evening or weekend meetings? Can you accommodate community members to hold evening or weekend meetings?

If you have questions or need assistance contact:

Matias Valenzuela	206.205.3331; Matias Valenzuela@kingcounty.gov
June Beleford	206.263.8762; June.Beleford@kingcounty.gov

Appendix: King County Community Engagement Continuum (May 2011)

King County

Community Engagement Continuum

The continuum provides details, characteristics and strategies for five levels of community engagement. The continuum shows a range of actions from county-led information sharing that tends to be shorter-term to longer-term community-led activities. The continuum can be used for both simple and complex efforts. As a project develops, the level of community engagement may need to change to meet changing needs and objectives.

The level of engagement will depend on various factors, including program goals, time constraints, level of program and community readiness, and capacity and resources. There is no one right level of engagement, but considering the range of engagement and its implications on your work is a key step in promoting community participation and building community trust. Regardless of the level of engagement, the role of both King County and community partners as part of the engagement process should always be clearly defined.

Levels of Engagement

County Informs	County Consults	County engages in dialogue	County and community work together	Community directs action
King County initiates an effort, coordinates with departments and uses a variety of channels to inform community to take action	King County gathers information from the community to inform county-led interventions	King County engages community members to shape county priorities and plans	Community and King County share in decision-making to co-create solutions together	Community initiates and directs strategy and action with participation and technical assistance from King County
Characteristics of Engagement				
• Primarily one-way channel of communication • One interaction • Term-limited to event • Addresses immediate need of county and community	• Primarily one-way channel of communication • One to multiple interactions • Short to medium-term • Shapes and informs county programs	• Two-way channel of communication • Multiple interactions • Medium to long-term • Advancement of solutions to complex problems	• Two-way channel of communication • Multiple interactions • Medium to long-term • Advancement of solutions to complex problems	• Two-way channel of communication • Multiple interactions • Medium to long-term • Advancement of solutions to complex problems
Strategies				
Media releases, brochures, pamphlets, outreach to vulnerable populations, ethnic media contacts, translated information, staff outreach to residents, new and social media	Focus groups, interviews, community surveys	Forums, advisory boards, stakeholder involvement, coalitions, policy development and advocacy, including legislative briefings and testimony, workshops, community-wide events	Co-led community meetings, advisory boards, coalitions, and partnerships, policy development and advocacy, including legislative briefings and testimony	Community-led planning efforts, community-hosted forums, collaborative partnerships, coalitions, policy development and advocacy including legislative briefings and testimony

INDEX OF COMMUNITY ENGAGEMENT TECHNIQUES

Organized by engagement level:
Inform, Consult, Involve, Collaborate, Empower.

TAMARACK INSTITUTE

COMMUNITY ENGAGEMENT CONTINUUM

	INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
					
GOAL	**To provide stakeholders with balanced and objective information to assist them in understanding the problem, alternatives and solutions.**	**To obtain stakeholder feedback on analysis, alternatives and/or decisions.**	**To work directly with stakeholders throughout the process to ensure that their concerns and aspirations are consistently understood.**	**To partner with stakeholders in each aspect of the decision from development to solution.**	**Shared leadership of community-led projects with final decision-making at the community level.**
STYLE	"Here's what's happening."	"Here are some options, what do you think?"	"Here's a problem, what ideas do you have?"	"Let's work together to solve this problem."	"You care about this issue and are leading an initiative, how can we support you?"

Adapted from the IAP2 Public Participation Spectrum

INDEX OF COMMUNITY ENGAGEMENT TECHNIQUES

Technique	Description	Considerations
INFORM		
Website	• General information • Fact sheets • Downloadable resources, articles, papers, etc. • Photo galleries • Registration forms • Repository for meeting minutes, strategies, etc.	• Website address should always be clearly visible on all project materials • Ensure website is kept up to date regularly and at key project milestones – out of date content will deter people from visiting again • Highlight key milestone or project highlights clearly on homepage • Consider Accessibility – See: City of Peterborough Guide to Accessible Documents
General Information Channels	• Email • 1800 Phone Line • Voicemail commenting	• Contact your IT Department or telephone service provider to set up a dedicated 1800 project line and ensure a voicemail is available to collect missed calls. • Be clear on hours of operation of phone line and target response times for each method (i.e. all phone and email inquiries must be responded to within 48hours) • Include details of the information lines and hours of operation on all project collateral and other internal communication material • Ensure adequate staffing is in place, and a system is in place when staff are absent

Videos	• Digital video	• Digital video is one of the leading ways to drive online engagement
		  ○ Website pages with video content attract more users and increase length of time spent on page
		  ○ People are more likely to click on an email containing a video

		• Great tool to convey messages quickly and succinctly • Consider using a video to launch an engagement activity, encourage participation, update a community about a project's progress or inform community about a consultation's outcomes • Videos should be short (under 5 mins) and include a variety of presentation styles, images, intro/outros and most importantly, they should be entertaining! • Add closed captioning to ensure accessibility – as a bonus, this also helps with increased view times
Infographics Useful tool to create Infographics: https://piktochart.com/	• A visual image such as a chart or diagram used to represent information or data	• Infographics should be visually engaging and contain subject matter and data that is appealing to your target audience • Great tool to simplify complicated or complex information (40% of people respond better to visual information compared to text) • Fun and easy way to learn about a topic or issue without heavy reading (high quality infographics are 30 times more likely to be read than text articles) • Useful for documenting progress and reporting back during engagement process
Social Media Useful Resource: • The Value of Social Networking in Community Engagement (https://www.atsdr.cdc.gov/communityengagement/pdf/pce_report_c	• Facebook • Twitter • LinkedIn • Instagram • Snapchat • Pinterest	• Social media is a great way to communicate with participants who are not able to make it to an event or consultation in person • Social media meets people where they are and widens the net in terms of who you reach – a great tool to discover new audiences within the community. • Don't do it all. Choose relevant social media tools based on your target audience and capacity to maintain the channel. Quality over quantity is key. • Use the Rule of Thirds when posting – 1/3 of content promotes you/your project; 1/3 shares relevant content of others; 1/3 should be engaging and interacting with others.

hapter _6_shef.pdf)		• Use visuals to inspire higher interaction and engagement rates (images uploaded to Facebook get 5X the interaction and engagement rates than posted links and tweets with images see double the re-tweet rates)
Advertising and Media Coverage	• Advertisements – paid ads on radio, newspapers, TV or online • Earned media – free media through press releases, news conferences, media packages or letters to the editor	• Consider using a mix of paid advertising and unpaid earned media • Ensure your messaging is targeted to your audience and you're using suitable media outlets for your audience segment • Engaging visuals of your project will be beneficial. Ensure you have good photos available or arrange a photo opportunity for the media outlet's photographer • For radio, a short, engaging sound-bite is generally required • Decide who your media spokesperson will be and ensure that they are appropriately trained. • Releases have a better chance of being picked up if they contain a strong hook or element of excitement or risk
Printed Collateral Useful tool to create beautiful designs for free: Canva - https://www.canva.com/	• Newsletters • Letters • Posters • Fact Sheets • Brochures • Reports	• Key stages in the production of print collateral include drafting content, graphic design, printing and distribution • Within each stage build in time for internal and external approvals • Timelines and cost can vary depending on complexity of project • When drafting content, consider readers' level of project knowledge and understanding of overall scope and context of the project ○ Tip: Include a Project Background section that outlines the 5 W's and H as well as a project timeline. • Consider distribution – direct mail, letterbox drop, addressed or unaddressed mail, web, etc. • Print extra quantities to hand out in person at events or for requests • Consider Accessibility - See: City of Peterborough Guide to Accessible Documents

Presentations/Live Streaming
 	
Useful blog showcasing Top 5 Free Tools for Live Streaming events: http://blog.capterra.com/free-live-stream-tools-event/
	• Informational presentations within community that can be leveraged through live-streaming.	• Presentations can be an effective way to disseminate information to a large group of people
		• Some key tips when preparing a presentation:
		  ○ Set the tone right away - Do you want your presentations to be a 'one-way' or a 'two-way' street?
		  ○ Consider using nametags so that you can call people by name directly
		  ○ Don't use slides as a crutch – people have taken the time to come and hear you speak, so don't relay information in a way that would have been better suited for someone to read. Be engaging and use slides to portray key messages, include visuals and videos where possible.
		  ○ Be personable – don't speak down to people or in language they won't understand. Treat your audience as fellow citizens and show them that you value the time they've taken to engage with you.
		• Consider live-streaming or video recording your presentation so that it can be accessed without having to show up in person, or after the fact.

Expert Panel	• Expert panels are engaged when highly specialized input and opinion is required for a project. • Generally, a variety of experts are engaged based on various fields of expertise to debate and discuss various courses of action and make recommendations.	• Allow citizens to hear a variety of informed (expert) viewpoints from which to decide on recommendations or courses of action in relation to an issue or proposal. • Often used when an issue is highly complex and contentious and decisions are likely to have possible legal ramifications or where the best possible results (based on expertise) are required. • Useful where conflict exists to provide opinions which may have more credibility, and hence may assist in resolving the conflict.
Displays/Exhibits	• A community event intended to provide project information and raise awareness about particular issues.	• Bringing the project to public spaces is a good way of involving people who wouldn't normally engage or turn up to a public meeting. • Consider staffing these display locations during certain times.

	• Set up at relevant public locations (e.g. libraries, ward or electorate offices, shopping centres, community festivals, etc.)	• Consider whether the community will be able to provide feedback, get involved or find out more information at these displays. • Displays can be interactive, and can be used as part of a forum, workshop, exhibition, conference or other event. • An interactive display will encourage more interest (e.g. touchscreen kiosk, internet café, 3D model/s or digital fly-through). • Interactive displays can include 'post-it' ideas boards, maps for people to make their most and least favourite buildings or spaces, and flip charts or blank posters for comments and questions. • Displays and exhibits can include feedback opportunities such as blank sheets with one-line questions, and can include drawings, models, posters, or other visual and audio representations relevant to community issues and interests.
Site visits/Tours	• Opening up a project venue for the public to visit	• Works well for large infrastructure projects (e.g. a dam, busway, lightrail) that have a defined area. • Add fun! Consider combining it with an event like 'family day' or a 'BBQ' • Opportunity to link with other similar or local projects of interest to the community • Gives the community a chance to see the project 'in action' and feel involved. • Could be supported by a range of project material on display, and some promotional items to hand out to the public (e.g. pens, hats, water bottles, etc.) Ideally, the promotional items should link in with the project (i.e. water bottles for a clean water project). • Consider offering 'guided tours' of the site where attendees can ask questions • Can help to create a sense of openness and transparency around the project

Public Meetings	• A meeting is a coming together of people for a specific purpose. The meeting can involve a large number of people, or a smaller (under 10) number of people who focus on a specific problem or purpose. • Meetings generally have a facilitator who encourages two-way communication, and a recorder who records suggestions and issues that are revealed at the meeting.	• Public meetings should be used as part of a series of engagement events, rather than a stand-alone technique. When used in conjunction with other methods, they can be a valuable way of sharing information and demonstrating openness and transparency. • Provides an opportunity to relay information, explain processes and gather feedback with a large number of people. • Can be a good opportunity for people within the community to meet each other and network • Large groups and traditional formats may be intimidating for some people and can limit audience participation. Consider incorporating smaller group discussions. • Public meetings provide a good focal point for media interest in an event, and photos can provide a visual indicator or levels of interest and the range of people who attended. • Public meetings are often the springboard for a movement or for the establishment of a common-interest group which will continue to act on the issues raised and suggestions made. • Note that the audience is likely not representative and attendance levels can be low unless people feel deeply connected to the issue and/or make the time to attend. • Ensure the meeting place is accessible
CONSULT		
Polls Useful online polling tools:	• Online polls allows anonymous visitors to click on a choice from a list of options and track the responses. • Results are shared once the person has clicked on a choice, or they can be shown without having to vote.	• Online polls are a fast and easy way to take the pulse of the public about topics of interest. • Polling can be used to gauge support for a municipal initiative or for lighter topics like getting to know an audience or voting on meeting locations

• Doodle - https://doodle.com/polling-tool • Poll Everywhere – https://www.polleverywhere.com/		• Polling allows a certain level of anonymity which can help break down barriers for people who are weary of sharing their opinion openly or in front of a group • Polling can also be done in real time – during an open house or public meeting – or can be integrated into an email or featured on your website.
Voting	• Voting offers the community the opportunity to decide or have influence on a decision from a list of pre-determined choices.	• Be sure your voters are informed – provide a backgrounder with key facts, resources, project timeline and any other information that one would need to know to make an educated decision. • Voting can be done in person, by mail or online. • Be clear about the influence the vote will have on the outcome of the project.

Surveys
 	
Useful online survey tools:
• Survey Monkey
• Typeform
• Google Forms
	• A survey is a structured form or questionnaire distributed to a relevant population group within the community. Surveys are used to gather data, assess needs, gain feedback, and/or collect community opinions.
	• The five main types of surveys include:
	  ○ Web-based
	  ○ Telephone
	  ○ Mail out
	  ○ In person interviews
	  ○ Hand out surveys
		• Surveys are used to gauge the level of public information about an issue and provide a 'snapshot' of attitudes and ideas at a particular time.
		• They can be used to determine community attitudes or target a particular group.
		• Surveys may be carried out in a number of ways depending on the purpose, scope, and stakeholders involved.
		• Key tips:
		  ○ Keep it simple
		  ○ Avoid leading and ambiguous questions
		  ○ Balance open vs closed questions
		  ○ Give time - Allow enough time to gather a sufficient number and variety of responses
		  ○ Provide options to opt out or clarify - Proposed answers may not be relevant to all respondents. When using lists, offer the option to select and clarify "Other"

Interviews	• Interviews are usually defined as a conversation with a purpose.
	  • Face to face
	  • Telephone
	  • Focus Groups (See below)
		• Using an interview is one of the best ways to have an accurate and thorough communication of ideas between you and the person from whom you're gathering information.
		• Can be very helpful when you need information about assumptions and perceptions of activities in your community.
		• Consider suitability of approach before moving ahead, interviews may not make sense if:
		  o Your project is dealing with a large population and interviews would be time-consuming and expensive
		  o The type of information you are collecting is numerical
		  o Respondents are unwilling to cooperate
		• Carefully consider the questions you ask, avoid questions that:
		  o Put the interviewee in the defensive
		  o Look for two answers in the same question
		  o Are too long, too involved or too intricate
		• Record or take notes during the interview – Put quotation marks around the person's actual words, and don't embellish their quotes.

Focus Groups	• A focus group has a well framed topic and involves a small group of 6 to 10 people that fit a set of criteria. The goal is to learn about people's opinions on the topic that help the host plan future actions. It should be guided by a trained facilitator/leader.	• A good technique to find out what issues are of most concern for a community or group when little or no information is available. • Questions posed should be those that participants have, or should have, some knowledge about. • A smaller group allows you to dive deeper into a conversation than you could in a large group. It also allows you to see the conversation - body movements, facial expressions, interactions - providing context missed in other engagement techniques • Begin with open ended questions but also allows for iterative engagement (asking follow up questions based on responses). The following examples may be a helpful guide to phrasing your questions: o What do you think about…?

		○ What are the pros and cons of…? ○ What would you change about…? ○ What would make you want to…? ○ What bothers you most about…? ○ Would you prefer this or that… How come? • The issues that emerge from the focus group may be developed into a questionnaire or other form of survey to verify the findings • Relatively inexpensive, focus groups can provide fairly dependable data within a short time frame.
Online Forums	• An online forum is part of a website where expression of viewpoints and discussion can take place in the form of electronic postings. • Online forums are open to postings for a set period of time: hours, days, weeks, months or indefinitely. • An administrator has the ability to add, edit or remove content. • The administrator can create the topic of the online forum or can allow individual users to create it.	• An online forum is useful for generating interest and feedback from the public over a period of time and does not require the same amount of physical investment as a public forum. • An online forum is accessible at any time of the day and therefore may appeal to regular Internet users because it does not require planning to participate. • The forum can be open to anyone and can be anonymous, or only to members who sign up with a special username. • Make it easy to participate - Use multiple entry points. (email, newsletters, intranet, posters) • Welcome and encourage new users by making them feel comfortable and ensure they know how to use the technology • Ask questions that matter - Asking questions using actionable language is recognized as a good way of generating discussion.
Online Commenting	• Offering the opportunity to comment on online • This could be integrated into the release of information, stories, materials, blogs, announcements, etc.	• Ensure you have the ability to approve comments before they are published to avoid any spam or offensive language. • While filtering out inappropriate comments is important, remain open to a diversity of perspectives reflected in comments and do not filter based on which ideas you might agree more with than others – remain as objective as possible.

		• Engage with the comments – when a new comment is received, respond to it in a timely manner so people feel that they've been heard.
Social Media Listening Useful tools for social monitoring: - TweetChat - Hootsuite	• Social media listening, also known as social media monitoring, is the process of identifying and assessing what is being said about a particular company/organization, individual, topic, product or brand on the Internet.	• Find out where your potential and current audience carry out conversations or share their opinions • Define what the goals and scope (topic area, organization name, particular issue) are for your social media listening will be o Wanting to identify influencers? o Looking for opportunities to delight or assist your community? o Watching a specific hashtag or phrase? • Offers a great insight into the natural conversation that is surrounding the topic you are interested in and provides opportunity to get involved • Where monitoring looks at social mentions and/or actions, the act of 'listening' requires analysis and reflection - watch for patterns, track sentiment and draw conclusions based on where and when conversations happen.
Social Media Discussion/Town halls	• Convening a group online using social media platforms to engage around questions, ideas and/or solutions related to a particular issue. Conversations are typically posted and followed through a hashtag (#) in order to keep the dialogue specific to that event.	• Town hall's are unique from regular messaging and posting since specific issues and topics are addressed by the main parties involved. • The concerned public can directly delve on related issues and get straight answers from the group or individual. • Good tool to show citizens that you aim to connect with them in places outside the walls of your government building. • Some tips: o Prepare some tweets in advance – make it easy to share and link to relevant resources or websites o Don't be too wordy – leave room for re-tweets

		○ Have both government and non-government participants hosting ○ Use a social monitoring tool to stay on top of the tweets coming in (e.g. TweetChat) ○ Have an offline alternative for people who are not on Twitter ○ Store the conversation online where it is accessible for others to read or reference
Workshops	• A workshop involves a group of people who meet to work through an issue and/or develop solutions. Workshops may be formally or informally structured to disseminate information about a particular topic and provide a forum for group discussion. • To make workshops more interactive, they typically involve larger, as well as smaller group exercises. • Workshops may take place over a two hour period or last an entire day and are usually facilitated by one or more trained facilitators	• Workshops generate discussion and broader thinking regarding an issue or topic. They also provide a forum through which participants can genuinely be involved in identifying and solving particular issues. • Workshops may involve a small number of people (e.g., 10-12) or a larger number of people (e.g., 30-40). • Workshops that have more than forty participants may be difficult to manage and may create challenges for participants to actively engage in workshop activities and exercises. • If the workshop is intended as a community event focusing on a community issue, the selection of participants should be determined by knowledge, expertise or by selecting a cross-section of views. Alternatively, workshops can be organized to target particular groups (e.g. young people, or women).
Door-to-door	• In person outreach whereby individuals are engaged at their doorstep	• Can be used as a 'check in' with residents to gain a better understanding of their needs, priorities or thoughts on a particular issue or initiative. • A nice way to re-establish, create or strengthen social connection within the community. • Removes barriers for people who would normally not go out of their way to participate in the conversation • Schedule door knocking shifts in 2-3 hour blocks

		• Consider the timing – visit households at different times throughout the day to increase chances of reaching them • Have dedicated resources and partners in place to respond to cultural and language needs of individuals/families
Kitchen table talks	• A kitchen table talk is a small, informal meeting that takes place in someone's home or a local cafe. Kitchen table discussion groups are often used in conjunction with other methods as part of a wider community engagement process.	• During the meeting, participants discuss issues related to a broader project or topic. They may be provided with a guide or set of questions from interest groups or local governments, but there is no formal agenda for the meeting. • The aim of kitchen table talks are to enable dialogue within the community, that is informal and relaxed. • Kitchen table discussions aim to build and deepen a sense of community and explore the range of opinions on an issue. It fosters community organizing and can stimulate and nurture public debate.
Open houses/pop ups	• Open houses or Pop up engagement is a style of engagement in which organizers simply pop-up a booth or table in a busy public location, perhaps in conjunction with another event, and offer simple and fun ways for people to learn about the project and have their say. • Open houses provide information, a forum for understanding people's concerns and discussing issues, as well as opportunities for follow up or feedback.	• Bringing the project to public spaces is a good way of involving people who wouldn't normally engage or turn up to a public meeting and allows people to contribute or obtain information at their own convenience. • Host pop ups at different times throughout the week to ensure a variety of people can participate • There is typically project staff on hand to chat with people, project materials, fun activities for visitors to do, refreshments, and other inexpensive ways to slow people down and draw them in.
Comment boxes	• Comment boxes can be placed in strategic locations within a community, or leveraged online.	• Use clear, concise and simple language to outline what types of comments you are hoping to receive • If using a comment box online, think about the location of your comment box – for general comments, make it easy to find (e.g.

	• They provide opportunities for community members to voice their opinion around a particular topic or provide more general feedback.	homepage, or pop up) if your comment box is specific to a certain issue place it in a relevant location relevant to the individual's interest (e.g. specific page about the issue; adding it to the bottom of a related article or post)
INVOLVE		
Crowdsourcing ideas/ideation Useful resource: Crowdsourcing for Dummies Cheat Sheet http://www.dummies.com/business/start-a-business/crowdsourcing-for-dummies-cheat-sheet/	• Crowdsourcing is a type of participative online activity in which an individual, an institution, a nonprofit organization, or company with varying skills, experiences and perspectives utilizes a group of people for the voluntary undertaking of a task.	• Allows you to obtain ideas or services from a large group of people quickly. • Great way to engage your community and provide the opportunity to network, hear fresh ideas and problem-solve together. • Managing a large group of expectations and ideas all at once can be difficult so be clear and specific in outlining your purpose, timeline and the outcome you're hoping to achieve. • Build a relationship with the crowd to identify those who are invested. Get to know the people who actually care about your issue or initiative.
Community Mapping	• Community Mapping is a participatory process that enables citizens to map the social, ecological and economic assets, along with historical events of their community. It is a useful way for initiating dialogue and planning in a community. • Mapping is an accessible and graphic way to learn about people's perceptions of a place and can be useful in the visioning process.	• The method can be used to document certain aspects, strengths or weaknesses, or locations of services within a community, neighbourhood or municipality. • It is useful to break a large group into smaller circles of 3-6 people. • With the use of a blown-up map of the municipality, or large blank pieces of paper, participants can use different coloured markers to locate various things on the map. • The small group maps can eventually be integrated into a larger, collaborative map. • This method is interactive and fun, and can also be used successfully with children and youth.

Digital Storytelling	• Digital storytelling is a relatively new term which describes the practice of everyday people who use digital tools to tell their 'story'. Digital stories are multimedia movies that combine photographs, video, sound, music, text, and often a narrative voice.	• Digital Storytelling has been used by community change organizations to empower community members, educate stakeholders and the public, and as a way to evaluate change • The process of creating a digital story is usually interactive. Community members are invited to a workshop-like setting and a facilitator takes them through the process of creating their digital story. • Participants are invited to bring photographs, clips and/or music to help tell their story. • The facilitator guides participants through the principles of a story, such as setting the context, building to a climax, sharing lessons learned, etc. • The process from the participants' experience can be very empowering. They have the opportunity to work with people who have similar experiences, are provided a process to work through emotions, and are given a voice and a platform for sharing.
Design Charrette Useful resources: - Effective Engagement: Design Charrettes - http://www.dse.vic.gov.au/effective-engagement/toolkit/tool-design-charrettes	• A charrette is an intensive planning session where citizens, designers and others collaborate on a vision for development. It provides a forum for ideas and offers the unique advantage of giving immediate feedback to the designers. More importantly, it allows everyone who participates to be a mutual author of the plan.	• Charrettes are organized to encourage the participation of all. That includes everyone who is interested in the making of a development: the developer, business interests, government officials, interested residents, and activists. • The charrette is located near the project site. The team of design experts and consultants sets up a full working office, complete with drafting equipment, supplies, computers, copy machines, fax machines, and telephones. Formal and informal meetings are held throughout the event and updates to the plan are presented periodically. • Through brainstorming and design activity, many goals are accomplished during the charrette. ○ First, everyone who has a stake in the project develops a vested interest in the ultimate vision.

- Engage; Don't Rage: Use a Design Charrette to Negotiate Your Next Development Proposal - https://www.planetizen.com/node/68464		○ Second, the design team works together to produce a set of finished documents that address all aspects of design. ○ Third, since the input of all the players is gathered at one event, it is possible to avoid the prolonged discussions that typically delay conventional planning projects. ○ Finally, the finished result is produced more efficiently and cost-effectively because the process is collaborative. • Ultimately, the purpose of the charrette is to give all the participants enough information to make good decisions during the planning process.
Mind Mapping Useful resource: wikiHow to Make a Mind Map http://www.wikihow.com/Make-a-Mind-Map	• A mind map is a diagram used to visually organize information. A mind map is hierarchical and shows relationships among pieces of the whole. It is often created around a single concept, drawn as an image in the center of a blank page, to which associated representations of ideas such as images, words and parts of words are added. Major ideas are connected directly to the central concept, and other ideas branch out from those.	• Mind maps can be a useful tool to: ○ Create things and devise approaches for handling issues ○ Capture information that's directly relevant to a topic so you can compress large amounts of information ○ Help you easily consume information and then use it ○ Communicate ideas • Mind maps can use words, symbols and pictures and should include be done with at least three different colours
Most Significant Change (MSC)	• The most significant change (MSC) technique is a form of participatory monitoring and evaluation. It is participatory because many project stakeholders are involved both in deciding the sorts of change to be	• MSC is not just about collecting and reporting stories but about having processes to learn from these stories – in particular, to learn about the similarities and differences in what different groups and individuals value. • Provides some information about impact and unintended impact but is primarily about clarifying the values held by different stakeholders.

	recorded and in analyzing the data. It is a form of monitoring because it occurs throughout the program cycle and provides information to help people manage the program. It contributes to evaluation because it provides data on impact and outcomes that can be used to help assess the performance of the program as a whole. • Essentially, the process involves the collection of significant change stories emanating from the field level, and the systematic selection of the most significant of these stories by panels of designated stakeholders or staff. The designated staff and stakeholders are initially involved by 'searching' for project impact. Once changes have been captured, various people sit down together, read the stories aloud and have regular and often in-depth discussions about the value of these reported changes. • When the technique is implemented successfully, whole teams of people begin to focus their attention on program impact.	• By itself it is not sufficient, as it does not provide information about the usual experience but about the extremes. • MSC can be very helpful in explaining HOW change comes about (processes and causal mechanisms) and WHEN (in what situations and contexts). • Best used in initiatives that are complex and produce diverse and emergent outcomes.
Visioning	• Visioning is a participatory tool that brings citizens and stakeholders	• Visioning is typically done at the beginning step of any planning process at all levels.

	together and is used to assist a group of stakeholders in developing a shared vision of the future. By asking the group where they are now and where they can realistically expect to be in the future, you can develop a vision together.
	• The goal of visioning is to develop written and visualized statements of a community's long term goals and strategic objectives.
		• Visioning can be used in:
		  ○ Activity planning - What will be the end result of the activity?
		  ○ Organizational change - What kind of organization do we want? How will it be structured? How will effectiveness be improved?
		  ○ Formulating an overarching development vision or strategy
		• The outcome of a visioning exercise is a long term plan, generally with a 20-30 year horizon.
		• Visioning exercises also provide a frame for a strategy for the achievement of the vision.
		• Alternatively, some visioning tools may be used to promote thought and encourage discussion of future land use and planning options, without the need to create a future orientated document.

Scenario Testing	• Scenario testing is a way of developing alternative futures based on different combinations of assumptions, facts and trends, and areas where more understanding is needed for your particular scenario project.
	• They are called 'scenarios' because they are like 'scenes' in the theatre – a series of differing views or presentations of the same general topic. Once you see several scenarios at the same time, you better understand your options or possibilities.
		• 'Scenario testing's greatest use is in developing an understanding of the situation, rather than trying to predict the future' (Caldwell, 2001).
		• Generally, scenario testing would deliver three scenarios: a positive (or optimistic), negative (or pessimistic), and neutral (or middle-of-the-road) scenario. By actively using 'scenarios', several concerns and outcomes can be addressed at the same time.
		• Participants are able to:
		  ○ Identify general, broad, driving forces, which are applicable to all scenarios.
		  ○ Identify a variety of plausible trends within each issue or trend (trends that vary depending on your assumptions so you get positive and negative perspectives).
		  ○ Combine the trends so you get a series of scenarios (for example, mostly positive trends identified in relation to an issue would give a positive scenario).

		• Once you see several scenarios at the same time, you can better understand your options or possibilities
Citizens' panels	• A Citizens' Panel involves ongoing panels of around 1,000 to 2,000 people who are representative of the local community. The participants of the panel are surveyed several times a year by mail, telephone or online.	• A Citizens' Panel aims to be a representative, consultative body of local residents. • Participants are usually recruited through random sampling as well as other means to ensure recruitment includes socially excluded and hard to reach groups. • It is important to be clear at the recruitment stage about what is expected of each Panel member, and what their membership is likely to consist of in terms of type of contact and time commitment to the process. • This method offers a more inclusive approach to engaging with individuals who may not typically take part in such efforts. • When scaled own, it can be effective and attract those who traditionally avoid going to meetings. • Those who cannot attend regular meetings due to physical, social or psychological issues may be encouraged to take part in this process.
Hackathons	• Hackathons originated in the tech industry as design sprint-like intensive events (usually 1-2 days) where computer programmers and tech developers get together to collaborate and work on topics of interest that may or may not be related to their regular work. • The tool has now expanded outside of just the tech industry and is used to bring together diverse individuals into one space to collaborate on	• Consider bringing in speakers to guide the thought leadership throughout the event • Include participants from different fields and experiences • Typically, participants will form groups (4-6 people) and are challenged to work together to come up with solutions to the issue or topic being focused on ○ Solutions will later be presented, refined and prototyped • Don't expect to have actually solved a problem by the end of the hackathon. Real life problems are hard! Think of the hackathon as a pit-stop on a long journey to solve problems or as a training session to prepare participants for solving problems.

	finding innovative solutions to a particular issue.	
Participatory budgeting	• Participatory Budgeting programs are innovative policymaking processes. • Citizens are directly involved in making policy decisions. Forums are held throughout the year so that citizens have the opportunity to allocate resources, prioritize broad social policies, and monitor public spending.	• Participatory Budgeting works best where there are already high levels of community activism. • The power attributed to citizens in the decision process can vary, from providing decision-makers with richer information about citizen preferences to processes that assign parts of the budget to direct citizen control. • Has the ability to be a very public process and can therefore convey legitimacy beyond the immediate participants. • Isn't as successful where central targets and restricted budgets limit the amount of power that can be given to citizens. • If managed poorly, can create unrealistic expectations amongst participants.
COLLABORATE		
Large group meetings	• Convening a large group around a particular issue or initiative	• Consider inviting a diverse group of people who will offer different perspectives • Be sure that all participants have a chance to be heard • Don't jump straight into the issue – warm up the room by including an ice breaker to offer opportunities for people to meet each other and get to know one another • Consider breaking the group into smaller groups throughout the meeting in order to allow more opportunities for people to share their perspective. • Include food and fun where possible. • Consider accessibility and offer stipends or supports where needed in order to allow all those who are interested in participating the option to get involved.

Document co-creation	• Ability to co-own a document whereby a number of people can view and/or have the ability, to edit and contribute.	• Allows individuals to collaborate on a project in real time from different locations. • Provides the opportunity to contribute and build upon a document at a time that works for you – always having access to the most up to date version of your file. • Most co-creation documents offer the ability to chat and add comments while building a document together. • Be mindful of who has access to the document and whether or not they have the ability to 'view' or 'edit'
Online communities	• An online community is a group of people with common interests who use the Internet (web sites, email, instant messaging, etc.) to communicate, work together and pursue their interests over time.	• Be a leader – step in and encourage users to interact with one another. Make comments in Forums and frequent interactions with Group creators. • Make it easy to participate - Use multiple entry points. (email, newsletters, intranet, posters) • Welcome and encourage new users - Ensure that new members are welcomed and feel acclimated to the new community. • Thank your members for performing actions, suggest content they might like or point them towards new activities in order to build long-term engagement. • Create a "water cooler" environment in new communities - Make your online community a place where people can go to engage in light-hearted conversation with their peers in a non-threatening way. • Post inspiring content and ask questions that matter to the community • Identify and nurture power users • Be clear on the purpose and desired response to posted content and conversations – it will help members know what is appropriate and feel comfortable contributing. Clarity of purpose will also help you track and measure results effectively.

Open space	• In Open Space meetings, events and organizations, participants create and manage their own agenda of parallel working sessions around a central theme of strategic importance
	• Participants sit in a large circle and devote their first hour towards creating their own meeting. All participants are teachers and learners.
	• When a topic is brought up, everyone provides their views and opinions on the topic. There is no limit to the number of participants.
	• The conference usually lasts as long as necessary and concludes when participants decide that their work is done.
		• The theory behind open space is that people will take ownership of issues they wish to address.
		• Open Space works best when the work to be done is complex, the people and ideas involved are diverse, the passion for resolution (and potential for conflict) are high, and the time to get it done was yesterday.
		• This is a useful method where large groups of participants are involved and where the program or agenda needs to be flexible or capable of being shaped by the participants themselves.
		• The weaknesses of this approach include:
		  ○ Only likely to get small percentage of the 'whole system' to attend
		  ○ Unlikely to attract people who traditionally avoid open meetings
		• Operates on four key principles:
		  ○ Whoever comes are the right people
		  ○ Whatever happens is the only thing that could have
		  ○ Whenever it starts is the right time
		  ○ When it's over, it's over

Working groups/study circles	• A committee or group comprised of 10-15 people who meet regularly over a period of weeks or months to address a critical public issue in a democratic and collaborative way and make recommendations based on its findings. • Facilitated by a person/facilitator who is there not to act as an expert on the issue, but to serve the group by keeping the discussion focused,	• Groups should be formed in order to maximize diversity, balance, and complementary skills. • Each team member should add something unique to the team, such as subject matter expertise, a specific perspective, or a specialized skillset. • It is essential that tasks are assigned appropriately in cross-functional groups. In order to reduce confusion, each member of the team needs to know who is responsible for what. When responsibilities are unclear, efficiently completing an assignment or process is near impossible.

	helping the group consider a variety of views, and process difficult questions.	
EMPOWER		
Decision-making platform	• A computer algorithm that allows large numbers of people to express their preferences, and the software calculates "millions" of possible decisions to find the most agreeable one for the most people.	• The online software enables public engagement and voting in which hundreds or even many thousands of people explore background information on a decision that needs to be made, learn what the constraints are on it — for instance, its maximum budget, or a deadline, or legal limits — and offer their ideal solution. • Great way to unite stakeholders and maximize their support
Citizen committees	• Also known as public advisory committees and public liaison committees, citizen committees consist of a group of representatives from a particular community or set of interests appointed to provide comments and advice on an issue. • Generally, relevant community groups and agencies are invited to nominate as members of the committee, although people with specific skills may also be asked. • Members meet regularly to provide ongoing input and advice over the duration of the project. These generally have an agreed life span and are normally organized at the local level to address a specific issue.	• Citizen committees should be formed based on diverse representation of the community, expertise/interest in an issue or topic area, and in regard to each advisory committee's terms of reference. • Great opportunity for community members to share ideas, have a voice in decision-making and learn about what other community members think about particular issues or opportunities • Two major benefits to creating a citizen committee: o 1. The committee can offer specialized, practical expertise that may not be available from the city council or city staff. Such citizens often can help guide city leaders on important issues, usually at little or no cost to the city. o 2. The committee can lend legitimacy and credibility to the ultimate decision made by city government. Properly advised by the committee, the city council's decisions are more likely to be seen as fair and considerate of all people having a stake in the outcome. Ideally, the committee can even help "sell" the council's decision to the public.
Citizen juries	• A Citizen Jury is comprised of a group of citizens who are representative of	• As a Citizen Jury, Jurors can 'cross examine' expert 'witnesses' who will provide differing perspectives on the issue or subject matter

	the general public (usually selected in a random or stratified manner) who are briefed in detail on the background and current thinking relating to a particular issue, and asked to discuss possible approaches. • The issue they are asked to consider will be one that has an effect across the community and where a representative and democratic decision-making process is required.	before reaching agreement or producing a short report of recommendations and action items. • Citizen juries are intended to complement other forms of consultation rather than replace them. • Typically, an advisory panel, with expertise in the particular area, considers the jury's findings and determines what, if any, recommendations should be taken forward. • Citizen Juries require both time and a high level of skill as participants are asked to analyze complex issues. • Be aware that the sponsoring body has to be committed to accepting the results, otherwise the process loses credibility. • It is a useful technique to combat potential power struggles or conflict between the organizing body (e.g. Municipal government) and citizens or even between citizens. • Consider live streaming citizen jury sessions or have them open to the public for transparency.
Community indicator projects	• Community indicator projects are those where communities have a vision for a sustainable future and have established ways of tracking their progress through the use of indicators. The list of indicators varies and is generally developed by the community itself. • In this approach, indicators are selected either across topical domains or with a focus (like children) to collectively track trends in community well-being and quality of life.	• A community indicators project offers the opportunity to discuss what is important, to systematically review whether things have been getting better or worse, and to establish priorities for policy response. • Indicators measure what the community cares about and track whether the community is moving in the right direction. Without indicators, it is difficult to know whether progress is being made on important issues. • Those metrics provide essential guidance for action and key tools for appropriate engagement of the public. • Most successful projects have three characteristics in common: o The community created a vision of its future that balanced economic, environmental, and social needs. This future is

		long-term – not in the order of years, but for decades or generations. ○ The vision incorporated the views of a wide cross-section of the community. ○ The community decided how to keep track of its progress in reaching that vision.
Asset-based Community Development (ABCD)	• A methodology for the sustainable development of communities based on their strengths and potentials. It involves assessing the resources, skills, and experience available in a community; organizing the community around issues that move its members into action; and then determining and taking appropriate action. • This method uses the community's own assets and resources as the bases for development; it empowers the people of the community by encouraging them to utilize what they already possess.	• Key principles: ○ Everyone has gifts and something to contribute ○ Relationships build a community – people must be connected in order for sustainable community development to take place ○ Citizens at the centre – citizens are actors, not recipients ○ Leaders involve others – broad base of community action ○ People care – challenge notions of 'apathy' by listening to people's interests ○ Listen – decisions should come from conversations where people are heard ○ Ask – asking for ideas is more sustainable than giving solutions

THRIVE (Tool for Health & Resilience in Vulnerable Environments) Community Assessment Worksheet

This assessment helps to identify and prioritize the THRIVE factors that can be the basis for a local action plan to improve health equity. The goal of health equity is the reduction of disparate health outcomes that are unnecessary, avoidable, and unjust and that typically are the result of social and historical bias. As a determinant of health and safety, each factor in this assessment can help to ensure that all communities have access to the same opportunities for good health and a fulfilling and productive life.

WORKSHEET INSTRUCTIONS:
Complete steps 1-3 to identify the opportunities to improve health and safety and decrease health inequities in your community. The tool enables you to rate factors in the social-cultural environment (people), physical environment (place), and economic environment (equitable opportunity).

Step 1: COMMUNITY EFFECTIVENESS SCORE (A – F): How well is your community doing on this factor? Using a scale of A (excellent) to F (failing), rate how well this factor is currently being addressed in your community. Please bubble in your response.

Step 2: PRIORITY RATING: What are your priorities for increasing health and safety? Given what you know about the effectiveness of current efforts to address each of the factors, how would you rate the priority of future efforts to increase health and decrease inequity for each factor? Please bubble in your choices.

Step 3: TOP THREE PRIORITIES: What should your community focus on first? Based on your effectiveness and priority ratings, bubble in the three areas across all twelve factors that you feel are most important to address in your community with the goal of increasing health and safety and reducing health inequities.

Demographic Information (Optional):

Age:	**Sex:**	**Race/Ethnicity:**
☐ 0 - 17 ☐ 18 – 35 ☐ 36 - 64 ☐ 64+	☐ Male ☐ Female	☐ Non-Hispanic White ☐ Asian ☐ American Indian or Alaska Native ☐ Non-Hispanic Black/African American ☐ Native Hawaiian or Other Pacific Islander ☐ Hispanic/Latino/a ☐ Other: _____

THRIVE, a collaborative project between Prevention Institute and the National Network of Public Health Institutes, is funded through a cooperative agreement with the Department of Health and Human Services' Office of Minority Health.

Prevention Institute
Prevention and equity at the center of community well-being

Racial and Social Justice

Cluster	THRIVE Factor	Community Effectiveness Score A B C D E F	Priority Rating Low – Med - High	Top 3 Picks
People	1. **Social Networks & Trust:** Trusting relationships among community members built upon a shared history, mutual obligations, opportunities to exchange information, and that foster the formation of new, and strengthen existing, connections.	A	Low	☐
	2. **Participation & Willingness to Act for the Common Good:** Individual capacity, desire, and ability to participate, communicate, and work to improve the community; meaningful participation by local/indigenous leadership; involvement in the community such as through local community and social organizations and participation in the political process.	A	Low	☐
	3. **Norms & Culture:** Broadly accepted behaviors to which people generally conform that promote health, wellness and safety among all community residents; discourage behaviors that inflict emotional or physical distress on others; and reward behaviors that positively affect others; Norms include values and practices stemming from belief systems that are often linked to those core personal characteristics from which identity derives.	A	Low	☐
	Write-in at the People Level:	A	Low	☐
Place	4. **What's Sold & How It's Promoted:** availability and promotion of safe, healthy, affordable, culturally appropriate products and services (e.g. food, pharmacies, books and school supplies, sports equipment, arts and crafts supplies, and other recreational items); and the limited promotion, availability, and concentration of potentially harmful products and services (e.g. tobacco, firearms, alcohol, and other drugs).	A	Low	☐
	5. **Look, Feel & Safety:** Surroundings that are well-maintained, appealing, perceived to be safe and culturally inviting for all residents.	A	Low	☐
	6. **Parks & Open Space:** Availability and access to safe, clean parks, green space and open areas that appeal to interests and activities across the generations.	A	Low	☐
	7. **Getting Around:** Availability of safe, reliable, accessible and affordable ways for people to move around, including public transit, walking, biking and using devices that aid mobility.	A	Low	☐
	8. **Housing:** High-quality, safe and affordable housing that is accessible for residents with mixed income levels.	A	Low	☐
	9. **Air, Water & Soil:** Safe and non-toxic water, soil, indoor and outdoor air.	A	Low	☐
	10. **Arts & Cultural Expression:** Abundant opportunities exist within the community for cultural and artistic expression and participation, and for positive cultural values to be expressed through the arts; and arts and culture positively reflect and value the backgrounds of all community residents.	A	Low	☐
	Write-in at the Place Level:	A	Low	☐
Equitable Opportunity	11. **Living Wages and Local Wealth:** Local ownership of assets; accessible local employment that pays living wages and salaries; and access to investment opportunities.	A	Low	☐
	12. **Education:** High quality, accessible education and literacy development for all ages that effectively serves all learners.	A	Low	☐
	Write-in at the Equitable Opportunity Level:	A	Low	☐
Write-in at the Community Level:		A	Low	☐

THRIVE, a collaborative project between Prevention Institute and the National Network of Public Health Institutes, is funded through a cooperative agreement with the Department of Health and Human Services' Office of Minority Health.

WORKSHEET: Circles of Involvement

Developing Key Relationships for Implementation

Health Equity

Revisit Your Circle of Involvement

To identify, communicate, and develop strategies to achieve health equity, you need to mobilize and organize the right people. Reference the individuals, groups, and organizations you have included in your Circle of Involvement worksheet.

Ask members of the MAPP Core Group whether your Circle of Involvement includes the following:

- Population groups that are affected by decisions, policies, investments, rules, and laws that have compromised their abilities to live healthy lives. These groups include people who are the subject of racism, gender inequity, and class exploitation;
- People who have knowledge about the structure of power and patterns of decisions, policies, investments, rules, and laws that have caused health inequity;
- Groups that can influence processes that can combat, reverse, and prevent decisions, policies, investments, rules, and laws that have caused health inequity;
- People who know how to measure social, economic, and health inequities;
- Groups that can communicate the causes of health inequities in a way that inspires people to work on achieving health equity; and
- People who can facilitate productive discussions about health inequities that result in strategies and collaborative action.

Engage individuals and groups that are committed to achieving social justice and health equity, have power and influence in the community, and can be allies in an equitable partnership. Examples of groups that could have representation in your Circle of Involvement include the following:

- Civil rights organizations;
- Labor organizations;
- Organizations representing minority groups, including religious minorities, immigrant populations, and English as a foreign language groups;
- Housing authorities and service providers for the homeless;
- Community development organizations;
- Community organizing groups;
- Women's rights organizations;
- Gay, lesbian, bisexual, transgender organizations;
- Child advocacy groups;
- Developmental and physical disability rights organizations;
- Mental health advocacy organizations; and
- Organizations dedicated to transparency, accountability, representation, participation, and inclusiveness in democracy.

Community Health Status Assessment: Measuring Health Inequity

Several approaches exist for exploring and documenting areas of health inequity as part of the Community Health Status Assessment. All three of the following strategies should be used to identify patterns of health inequity in a community.

1. Cross-Tabulations that Measure Health Disparities

Health disparities are differences in health status. The term "health disparities" is not the same as "health equity." "Health disparities" describes simply differences in health outcomes among groups and does not describe the reasons why differences in health status exist. Still, information about health disparities can provide insight on health inequities depending on how the data are analyzed and discussed.

Cross-tabulations can be used to identify differences in health status among different groups. For instance, you can collect data on cardiovascular disease prevalence. You can also collect data on race and gender. You can then use cross-tabulations to see if there are differences in the prevalence of cardiovascular disease based on race and gender.

	White		Black		Hispanic/Latino		Asian-Pacific Islander		Native Indian/ Alaska Native	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Prevalence of diabetes in the county										
Infant mortality rate										
Prevalence of youth violence										

	Unemployed		Employed, part-time		Employed, full-time	
	Male	Female	Male	Female	Male	Female
Prevalence of heart disease						

Examples of data that should be collected and used in cross-tabulations to identify health disparities include the following:

- Income;
- Race;
- Ethnicity;
- Immigration status;
- Gender;
- Sexual identity;
- Education;
- Age;
- Employment status; and
- Homeownership and housing status.

These categories represent segments of your population that may experience different health outcomes. Comparing the health status of subgroups to those with the worst, the best, or the average or median health status can give you insight into groups affected by inequity. You can also compare subgroup health status with targets such as Healthy People 2020 objectives.

Health Equity

Community Health Status Assessment: Measuring Health Inequity continued

2. Indicators of Inequity

In addition to measuring health disparities, you should include measures of social and economic inequity. As with health outcomes, many indicators of socioeconomic status can be stratified by demographic category to show how different groups are affected by inequity.

	White		Black		Hispanic/Latino		Asian-Pacific Islander		Native Indian/ Alaska Native	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
High school graduation rate										
Percent living in poverty										

Example indicators of inequity that can be included in a Community Health Status Assessment include the following:

- Median household income;
- Percent of people living in poverty;
- Median value of owner-occupied homes;
- Percent of households below poverty;
- Percent of children under 18 in poverty;
- Unemployment;
- Percent of people without car ownership;
- Percent of renters;
- Civic engagement[1];
- High school graduation rate;
- Income inequality[2];
- Wealth inequality;
- Segregation[3];
- Bank loans by race, income, gender, and neighborhood;
- Political participation by race, income, and gender;
- Allocation of city or county budget by neighborhood;
- Level of housing inspections by neighborhood;
- Home foreclosure rates by neighborhood; and
- Disinvestments in community (e.g., outsourcing jobs to other countries).

Visit the Connecticut Association of Directors of Health's Health Equity Index (https://www.sdoh.org/) for examples of maps and health equity data. Hear the association discuss how it developed and used the Health Equity Index through NACCHO University's eLearning module, "Health Equity, Data Collection, and Analysis," available at http://www.naccho.org/university.cfm.

Alameda County analyzed data by neighborhood and found that in 2003, nearly 41% of African Americans and 26% of Latinos resided in higher-poverty neighborhoods, compared to 4% of Whites.

3. Geographic Mapping to Uncover Patterns on Health Inequity

Communities can use geographic mapping of data on health disparities and inequity to uncover patterns of health inequity. Geographic mapping provides pictures of where people are most affected by poor health status and areas where people experience relative good health. To map health status, you will need to have geographic data indicators such as zip code, census tract, or county residence. You can map health status by where people live. You can also overlay different measures of health status, race, ethnicity, age, income, immigration status, gender, and education to see patterns of inequity. Creating maps that show changes over time provides information on how inequities accumulate and concentrate over time.

[1] Examples of measures of civic engagement can be found at http://www.civicyouth.org/tools-for-practice/survey-measures-of-civic-engagement/

[2] Examples of measures of income inequality can be found in De Maio, F. (2007). Income inequality measures. *Journal of Epidemiology and Community Health*, 61(10):849–852.

[3] Examples of measures of segregation can be found at https://www.census.gov/hhes/www/housing/housing_patterns/pdf/app_b.pdf

Reflecting on Health Disparities and Health Inequity Data

The Community Themes and Strengths Assessment can be used to collect information about how community members experience the effects of health inequities. You can design this assessment to investigate what in your community currently and historically has contributed to health inequities identified in the Community Health Status Assessment. You can use the following questions to engage your community members in a conversation about the root causes of health inequities. Be sure to include individuals affected by inequity in your conversations.

1. What patterns do you see in the health inequity data?
2. Think about the groups that experience relatively good health and those that experience poor health. Why do you think there is a difference?
3. If you have identified individual behavioral reasons for differences in health status among different groups, what are some reasons why it is easier for some to make healthy choices than others?
4. What assets exist in our community? Where are these assets located, and who has access to them? How do these assets support health?
5. Who is in charge at local agencies, retail stores, healthcare providers, schools, and other institutions in our community? How do these institutions support or inhibit health?
6. What conditions (excluding individual behavior) in a community support some groups' abilities to experience better health than others? What conditions in a community inhibit some groups' abilities to experience good health? Who makes decisions that influence these conditions? What motivates the decisions they make that results in differences in health status? Where does power to make these decisions come from?
7. What public and corporate policies support healthy living? What policies inhibit healthy living? Which groups are affected by these policies? Who has the power to make and implement those policies? What motivates them to develop policies that favor some over others?

Conditions that Support Health Equity

The Connecticut Association of Directors of Health has identified nine social determinant domains. The following domains can be used to structure a Community Themes and Strengths Assessment that focuses on health inequity.

1. Economic security and financial resources;
2. Livelihood security and employment opportunity;
3. School readiness and educational attainment;
4. Environmental quality;
5. Availability and utilization of quality medical care;
6. Adequate, affordable, and safe housing;
7. Community safety and security;
8. Civic involvement; and
9. Transportation.

Measure the Effects of Discrimination on Health

Consider using **Experiences of Discrimination** survey questions in your Community Health Themes and Strengths Assessment. This survey is a reliable and valid instrument for measuring the experiences of discrimination. The results can be used to understand the extent to which your community experiences discrimination. When analyzed together with Community Health Status Assessment data, your community can get a picture of how discrimination is associated with poor health outcomes.

Local Public Health System Assessment continued

System Contributions to Assuring Health Equity

When completing the Local Public Health System (LPHS) Assessment using the National Public Health Performance Standards (NPHPS) Instrument, your group can reframe questions about essential service delivery to identify how well the LPHS acknowledges and addresses health inequities. The following questions provide examples of how the instrument can be revised to focus on health equity.

Essential Public Health Service 1: Monitoring Health Status

At what level does the LPHS…

- Conduct a community health assessment that includes indicators intended to monitor differences in health and wellness across populations, according to race, ethnicity, age, income, immigration status, sexual identify, education, gender, and neighborhood?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Monitor social and economic conditions that affect health in the community, as well as institutional practices and policies that generate those conditions?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

Essential Public Health Service 2: Diagnosing and Investigating Health Problems

At what level does the LPHS…

- Operate or participate in surveillance systems designed to monitor health inequities and identify the social determinants of health inequities specific to the jurisdiction and across several of its communities?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Collect reportable disease information from community health professionals about health inequities?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Have the necessary resources to collect information about specific health inequities and investigate the social determinants of health inequities?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

Essential Public Health Service 3: Inform, Educate, and Empower People about Health Issues

At what level does the LPHS…

- Provide the general public, policymakers, and public and private stakeholders with information about health inequities and the impact of government and private sector decision-making on historically marginalized communities?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Provide information about community health status (e.g., heart disease rates, cancer rates, and environmental risks) and community health needs in the context of health equity and social justice?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

Health Equity

Local Public Health System Assessment continued

System Contributions to Assuring Health Equity

- Plan and conduct health promotion and education campaigns that are appropriate to culture, age, language, gender, socioeconomic status, race/ethnicity, and sexual orientation?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Plan campaigns that identify the structural determinants of health inequities and the social determinants of health inequities (rather than focusing solely on individuals' health behaviors and decision-making)?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

Essential Public Health Service 4: Mobilizing Community Partnerships to Identify and Solve Health Problems

At what level does the LPHS…

- Have a process for identifying and engaging key constituents and participants that recognizes and supports differences among groups?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Provide institutional means for community-based organizations and individual community members to participate fully in decision-making?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Provide community members with access to community health data?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

Essential Public Health Service 5: Developing Policies and Plans that Support Individual Community Health Efforts

At what level does the LPHS…

- Ensure that community-based organizations and individual community members have a substantive role in deciding what policies, procedures, rules, and practices govern community heath efforts?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

Essential Public Health Service 6: Enforce Laws and Regulations that Protect Health and Ensure Safety

At what level does the LPHS…

- Identify local public health issues that have a disproportionate impact on historically marginalized communities (that are not adequately addressed through existing laws, regulations, and ordinances)?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

Local Public Health System Assessment continued

System Contributions to Assuring Health Equity

Essential Public Health Service 7: Link People to Needed Personal Health Services

At what level does the LPHS…

- Identify any populations that may experience barriers to personal health services based on factors such as on age, education level, income, language barriers, race or ethnicity, disability, mental illness, access to insurance, sexual orientation and gender identity, and additional identities outlined in Model Standard 7.1?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Identify the means through which historical social injustices specific to the jurisdiction (e.g., the inequitable distribution health services and transportation resources) may influence access to personal health services?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Work to influence laws, policies, and practices that maintain inequitable distributions of resources that may influence access to personal health services?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

Essential Public Health Service 8: Assure a Competent and Personal Health Care Workforce

At what level does the LPHS…

- Conduct assessments related to developing staff capacity and improving organizational functioning to support health equity initiatives?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Identify staff perspectives on the facilitators and barriers to addressing health equity initiatives?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Include staff members that are often excluded from planning and organizational decision-making processes in workforce assessments?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Recruit and train staff members from multidisciplinary backgrounds that are committed to achieving health equity?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

- Recruit and train staff members that reflect the communities they serve?

No Activity ☐ Minimal ☐ Moderate ☐ Significant ☐ Optimal ☐

Health Equity

Local Public Health System Assessment continued

System Contributions to Assuring Health Equity

Essential Public Health Service 9: Evaluate the Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services

At what level does the LPHS…

- Identify community organizations or entities that contribute to the delivery of the Essential Public Health Services to historically marginalized communities?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☐	☐	☐

- Monitor the delivery of the Essential Public Health Services to ensure that they are equitably distributed?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☐	☐	☐

Essential Public Health Service 10: Research for New Insights and Innovative Solutions to Health Problems

At what level does the LPHS…

- Encourage staff, research organizations, and community members to explore the root causes of health inequity, including solutions based on research identifying the health impact of structural racism, gender and class inequity, social exclusion, and power differentials?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☐	☐	☐

- Share information and strategize with other organizations invested in eliminating health inequity?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☐	☐	☐

- Use Health Equity Impact Assessments to analyze the potential impact of local policies, practices, and policy changes on historically marginalized communities?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☐	☐	☐

- Facilitate substantive community participation in the development and implementation of research about the relationships between structural social injustices and health status?

No Activity	Minimal	Moderate	Significant	Optimal
☐	☐	☐	☐	☐

Forces of Change Brainstorming

Forces of Change Assessment: Identify Forces that Affect Health Equity

Questions to Identify Forces

Powerful organized interests develop structures and support policies and practices that can either contribute to health equity or cause health inequities. The following questions can be answered during the Forces of Change Assessment to identify these forces, opportunities, and threats.

- What patterns of decisions, policies, investments, rules, and laws affect the health of our community?
- Who benefits from these decisions, policies, investments, rules, and laws?
- Whom do these decisions, policies, investments, rules, and laws harm?
- Who or what institutions have the power to create, enforce, implement, and change these decisions, policies, investments, rules, and laws?
- What interests support or oppose actions that contribute to health inequity?
- What opportunities exist to influence decisions, policies, investments, rules, and laws to benefit all groups?
- What forces now and in the future can reinforce health inequity in our community? How can we mitigate or prevent these forces?
- What forces now and in the future can reinforce health equity in our community? How can we take advantage of these forces?

When posing these questions, be sure to include people that are affected by health inequity.

Identifying Strategic Issues to Address Health Equity

As you develop strategic issues, remember that questions are never neutral. Rather, people apply frames that influence the questions they ask. They are posed within specific social, political, historical, and cultural contexts. Questions are often driven by institutional agendas, values, and priorities that may or may not address community members' needs and wants.

The following table contrasts conventional and health equity questions that can be used to understand public health problems and identify potential solutions. When analyzing data from the MAPP Assessments to identify strategic issues, use a health equity frame to ask your community these questions.

CONVENTIONAL APPROACH	HEALTH EQUITY APPROACH
Why are people unhealthy in our community?	What social conditions and economic policies make some people more likely to be unhealthy?
Why can't vulnerable populations access services?	What institutional policies and practices prevent people from accessing services?
What types of services and resources do we need to improve health?	What fundamental policy changes do we need?
How do we reduce disparities in health outcomes?	How do we eliminate the social injustices that produce inequities in health outcomes?
What programs and services do we need to address health disparities?	What kind of collective action and structural social changes do we need to tackle health inequities?
What unhealthy behaviors should we discourage among vulnerable populations?	What interests and power structures affect people's health and wellness?
Which government officials, expert researchers, or media personalities best understand the issue?	Which community members and grassroots organizations can best define the issue?
Which public officials and research institutions will decide on appropriate courses of action?	How can we work within our communities to define and prioritize public health concerns?
How can we make people more responsible for their own health?	How can we create social responsibility and public accountability to protect the public good?

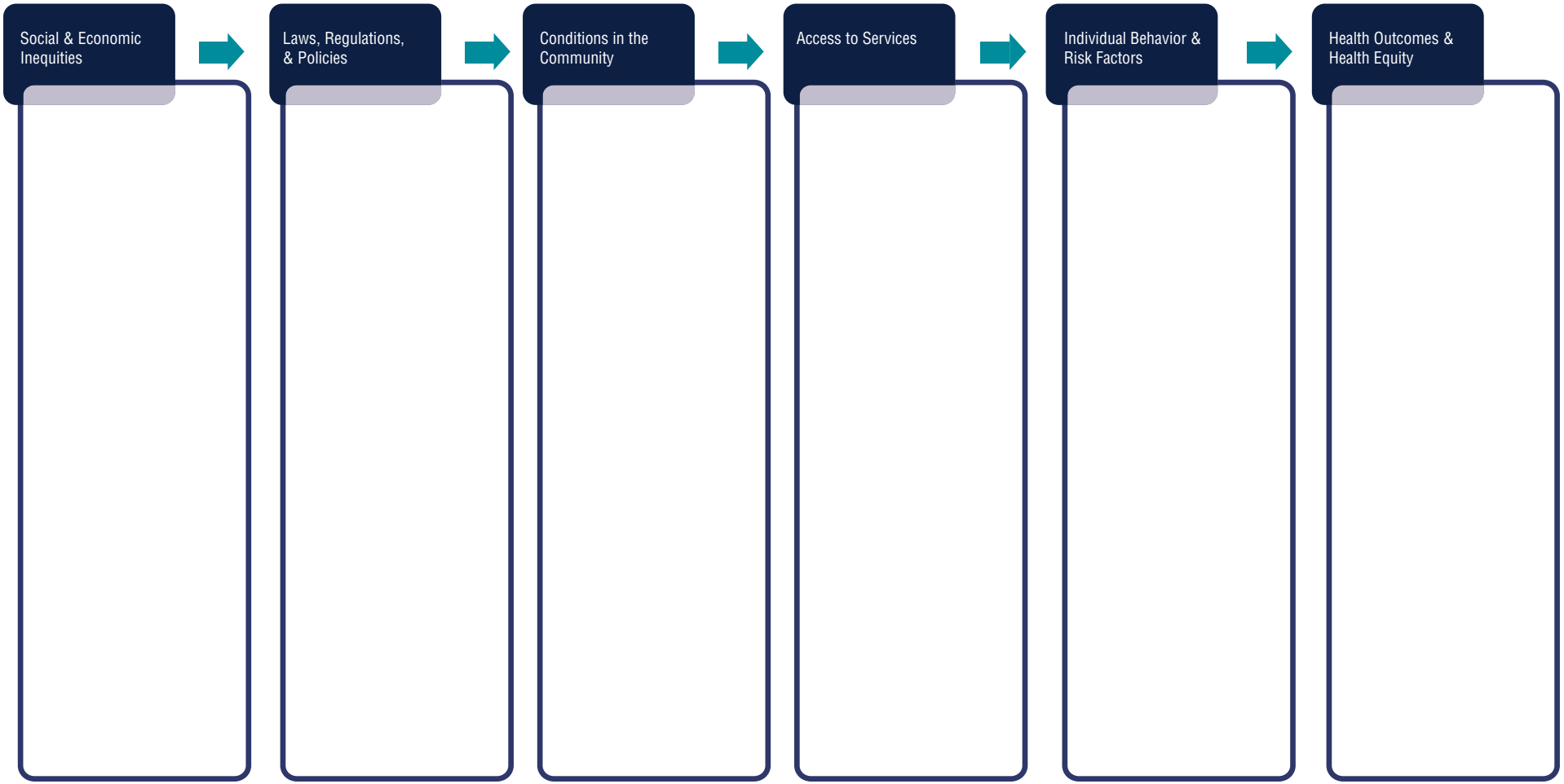
Health Equity

Identifying Root Causes of Health Inequity

Ask community members to review data from the four MAPP Assessments. Ask them to map the data to show what they learned about relationships among the following:

- Health outcomes and health equity (from Community Health Status Assessment);
- Individual behavior and risk factors (from Community Health Status Assessment);
- Access to services (from Local Public Health System Assessment);
- Conditions in the community (from Community Themes and Strengths Assessment);
- Law, regulations, and policies (from Local Public Health System Assessment and Community Themes and Strengths Assessment); and
- Social and economic inequities (from Community Health Status Assessment and Community Themes Assessment).

Ask your community members to share how social and economic inequities affect how laws, regulations, and policies decisions are made and how those decisions shape the conditions in the community that affect how people can access services, engage in healthy living, and maximize their health outcomes.



A PROCESS FOR COLLECTING DATA

WHEN?	Ask for data early — ideally, during admission or registration.
WHO?	Properly trained admissions or reception staff could collect data.
WHAT WILL YOU TELL INDIVIDUALS?	Before obtaining information, develop a script to communicate that: • This information is important. • It will be used to improve care and services and to prevent discrimination. • This information will be kept confidential. In addition, address any concerns up front and clearly.
HOW?	Individual self-report — select their own race, ethnicity, language, etc.
WHAT INFORMATION WILL YOU COLLECT? (INDIVIDUAL DATA)	• Race • Ethnicity • Nationality • Nativity • Ability to speak English • Language(s) other than English spoken • Preferred spoken/written languages or other mode of communication • Age • Gender • Sexual orientation • Gender identity • Disability status • Income • Education • Informed of right to interpreter services • Request for, and/or use of, interpreter services • Treatment history • Medical history • Outcome data (service type, utilization, length of stay) • Patient satisfaction
WHAT INFORMATION WILL YOU COLLECT? (STAFF DATA)	• Race • Ethnicity • Nationality • Nativity • Primary/preferred language • Gender • Records of cultural and linguistic competency training participation and evaluations
TOOLS TO COLLECT AND STORE DATA	Use standard collection instruments. Store data in a standard electronic format.
TRAINING	Provide ongoing data training and evaluation to staff.

Adapted from the Health Research and Evaluation Trust Health Disparities Toolkit (Hasnin-Wynia et al., 2007)

PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Paper Version of PRAPARE for Implementation in 2015

As of April 15, 2015

NOTE: THIS IS A WORKING DOCUMENT RESULTING FROM AN ITERATIVE PROCESS. PLEASE CHECK FOR UPDATES AND CONTACT MICHELLE JESTER AT MJESTER@NACHC.ORG FOR MORE INFORMATION AND TO JOIN THE MAILING LIST TO RECEIVE NOTIFICATIONS OF CHANGES.

Personal Characteristics

1. Are you Hispanic or Latino?

	Yes		No		I choose not to answer this question.

OPTIONAL feature: Additional/alternative more granular response choices that roll-up.

See Appendix E of the IOM's 2009 report Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement (available at: http://www.iom.edu/Reports/2009/RaceEthnicity Data.aspx) for a list of potential response choices.

2. Which race(s) are you? Check all that apply.

	Asian		Native Hawaiian
	Pacific Islander		Black/African American
	American Indian/Alaskan Native		White
	Other (please write)_____		I choose not to answer this question.

OPTIONAL feature: Additional/alternative more granular response choices that roll-up.

See Appendix E of the IOM's 2009 report Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement (available at: http://www.iom.edu/Reports/2009/RaceEthnicity Data.aspx) for a list of potential response choices.

3. At any point in the past 2 years, has seasonal or migrant farm work been your or your family's main source of income?

	Yes		No		I choose not to answer this question.

4. Have you been discharged from the armed forces of the United States?

	Yes		No		I choose not to answer this question.

5. What language are you most comfortable speaking? _____

	English		Language other than English (please write) _____		I choose not to answer this question.

Family & Home

6. How many family members, including yourself, do you currently live with?_____

	I choose not to answer this question.

7. What is your housing situation today?

	I have housing
	I do not have housing (staying with others, in a hotel, on the street, in a shelter)
	I choose not to answer this question.

8. What address do you live at? (include street and zipcode)

_____

_____

Money & Resources

9. What is the highest level of school that you have finished?

	Less than a high school degree		High school diploma or GED
	More than high school		I choose not to answer this question.

10. What is your current work situation? Check all that apply.

	Unemployed and seeking work		Part time work
	Full time work		Otherwise unemployed but not seeking work (ex. student, retired, disabled, unpaid primary care giver) Please write_____
	I choose not to answer this question.		

OPTIONAL Feature: Additional response choices

Work less than 20 hours a week		Work 20-34 hours a week
Work 35-59 hours a week		Work 60 hours or more a week

OPTIONAL Feature: Additional question

How many jobs do you work?

	1 job		3 or more jobs
	2 jobs		I choose not to answer this question.

11. What is your main insurance?[1]

	None/uninsured		Medicaid
	CHIP Medicaid		Medicare
	Other public insurance (Not CHIP)		Other Public Insurance (CHIP)
	Private insurance		

[1] If patient is unable to answer, health center staff fill out by pulling the information from the EHR or PMS.

OPTIONAL Feature: Additional question

Do you have insurance through your job?

	Yes		No		I choose not to answer this question.

12. During the past year, what was the total combined income for you and the family members you live with?_____

	I choose not to answer this question.

13. In the past year, have you or any family members you live with been **unable** to get any of the following when it was **really needed**? Check all that apply.

Yes	No	Food	Yes	No	Clothing
Yes	No	Utilities	Yes	No	Rent/Mortgage payment
Yes	No	Transportation	Yes	No	Child care
Yes	No	Medicine or medical care	Yes	No	Phone
Yes	No	Health insurance	Yes	No	Other (please write) _____
		I choose not to answer this question			

Social and Emotional Health

14. How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

	Less than once a week
	1 or 2 times a week

	3 to 5 times a week
	More than 5 times a week
	I choose not to answer this question.

15. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

	Not at all
	A little bit
	Somewhat
	Quite a bit
	Very much
	I choose not to answer this question.

OPTIONAL Feature: Additional question

Ask the open-ended follow-up question "Who are the people or groups you usually see or talk to at these times?"

Optional Questions

16. In the past year have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

	Yes		No		I choose not to answer this question.

OPTIONAL: What was your release date? _____

17. Has lack of transportation kept you from medical appointments or from getting your medications?

	Yes		No		I choose not to answer this question.

18. Are you a refugee?

	Yes		No		I choose not to answer this question.

19. What country are you from?

	United States		Country other than the United States (please write) _____		I choose not to answer this question.

20. Do you feel physically and emotionally safe where you currently live?

	Yes
	No
	Unsure
	I choose not to answer this question.

21. In the past year, have you been afraid of your partner or ex-partner?

	Yes
	No
	Unsure
	I have not had a partner in the past year
	I choose not to answer this question.

Box 1 | Accountable Health Communities
Core Health-Related Social Needs Screening Questions

Underlined answer options indicate positive responses for the associated health-related social need. A value greater than 10 when the numerical values for answers to questions 7-10 are summed indicates a positive screen for interpersonal safety.

Housing Instability

1. What is your housing situation today?

- ☐ I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
- ☐ I have housing today, but I am worried about losing housing in the future.
- ☐ I have housing

2. Think about the place you live. Do you have problems with any of the following? (check all that apply)

- ☐ Bug infestation
- ☐ Mold
- ☐ Lead paint or pipes
- ☐ Inadequate heat
- ☐ Oven or stove not working
- ☐ No or not working smoke detectors
- ☐ Water leaks
- ☐ None of the above

Food Insecurity

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.

- ☐ Often true
- ☐ Sometimes true
- ☐ Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

- ☐ Often true
- ☐ Sometimes true
- ☐ Never true

Transportation Needs

5. In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? (Check all that apply)

- ☐ Yes, it has kept me from medical appointments or getting medications
- ☐ Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need
- ☐ No

Utility Needs

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

- ☐ Yes
- ☐ No
- ☐ Already shut off

Interpersonal Safety

7. How often does anyone, including family, physically hurt you?

- ☐ Never (1)
- ☐ Rarely (2)
- ☐ Sometimes (3)
- ☐ Fairly often (4)
- ☐ Frequently (5)

8. How often does anyone, including family, insult or talk down to you?

- Never (1)
- Rarely (2)
- Sometimes (3)
- Fairly often (4)
- Frequently (5)

9. How often does anyone, including family, threaten you with harm?

- Never (1)
- Rarely (2)
- Sometimes (3)
- Fairly often (4)
- Frequently (5)

10. How often does anyone, including family, scream or curse at you?

- Never (1)
- Rarely (2)
- Sometimes (3)
- Fairly often (4)
- Frequently (5)

SOURCE: The above-noted health-related social need screening items are used with permission from their respective owners.

ed during referral and navigation. The AHC screening tool will include one question to identify any unmet transportation needs among community-dwelling Medicare and Medicaid beneficiaries in the AHC Model *(Box 1).* This question was adapted from the PRAPARE assessment tool. Selecting any answer option other than "no" indicates that a beneficiary has a transportation need for the purposes of the AHC Model.

Utility Needs

When screening for a beneficiary's difficulty paying utility bills, the TEP recommended listing specific utilities for clarity and adding furnace oil as an example to address regional variation in utilities. After reviewing validated and common questions on utility needs, the TEP recommended one question for inclusion in the AHC HRSN screening tool. This question is adapted from the validated Children's Sentinel Nutrition Assessment Program (C-SNAP) survey [21]. Selecting any answer option other than "no" would indicate that the beneficiary has a utility need for the purposes of the AHC Model.

Interpersonal Safety

The AHC HRSN screening tool includes four questions related to interpersonal safety, including exposure to intimate partner violence, elder abuse, and child abuse. CMS adapted these questions from the Hurt, Insult, Threaten, and Scream (HITS) instrument, which has been validated in multiple settings around the world for use as a self-report or clinician-administered tool to identify intimate partner violence among women and men [22, 23, 24]. In order to broaden the scope of these questions beyond intimate partner violence, the TEP recommended editing the question stems to say "anyone, including family" instead of "your partner." The HITS instrument is scored as a whole. Each answer option is numbered sequentially from 1 to 5 points, where "never" is 1 point and "frequently" is 5 points. Thus, scores for this domain range from 4-20. A score of greater than 10 would indicate that the beneficiary is experiencing or at risk of interpersonal violence for the purposes of the AHC Model.

The TEP made special recommendations regarding the framing and placement of the interpersonal safety questions because of the sensitive nature of this topic. For example, the TEP recommended introducing these questions with the following normalizing language: "Because violence and abuse happens to a lot of people and affects their health, we are asking the following questions." The TEP also recommended that the screening tool ask the questions on interpersonal safety later in the screening to give an opportunity for staff to first build rapport with beneficiaries when they deliver the tool face-to-face.

Appendix: TPCHD Health Equity & Quality Framework

Health Equity & Quality Framework

Tacoma-Pierce County Health Department
Healthy People in Healthy Communities

How does health equity work fit into division quality circles? Health equity is a quality issue because if we are not achieving equity, our work is not of the highest quality. We have an opportunity to create sustainable change by embedding equity into our divisions and organization through the Department's quality structure. This framework is a tool for quality circles to use a health equity lens when developing performance measures and initiating QI projects.

Quality Principles

- Customer Focus
- Quality Focus
- Process Focus
- Data-Driven Decisions
- Continuous Improvement

Quality Process Steps (equity lens in parentheses)

1. **Define** (What are the inequities in this area?)
2. **Measure** (Where are the inequities? Among whom? How significant are they?)
3. **Analyze** (What could affect these inequities? Who can help?)
4. **Improve** (Shift programs to address existing inequities)
5. **Control** (Evaluate results and re-assess approach)

Quality Structure

- Quality Steering Team
    - This is where the vision and strategic direction is set.
- Quality Coordinating Team
    - This is where oversight, guides, knowledge, tools, and leadership happens.
- Divisional Quality Circles
    - This is where the bulk of the work resides (performance measures, QI projects, and quality culture).
- Health Equity Implementation Team

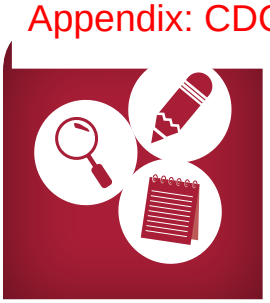
Implementation of Health Equity Considerations in Divisional Quality Circles

There are two main ways that quality circles can use an equity lens to help drive the work of divisional staff.

- Performance Measures
    - Have we looked at inequities when defining the problem?
    - Have we measured those inequities?
    - Process measures: Who are we involving?
    - Outcome measures: Are we addressing/reducing inequities or disparities? Why or why not?

- Quality Improvement Projects
    - Process: How do our current structures and processes create barriers for:
        - Addressing inequities;
        - Sharing power and knowledge with staff and community
        - Community to address inequities;
        - Results to be achieved, etc.
    - Customer focus: Are those most affected involved in the design and delivery of programs and services?
        - Are our products and services designed for the actual customer?
        - Is money used to the greatest benefit of the customer?
        - Are there priority customers? (geographic, racial, ethnic, etc.)

    - Data: Are we looking at the *right* data to affect inequities?



ADDRESSING HEALTH EQUITY IN EVALUATION EFFORTS

WITHOUT A FOCUS ON HEALTH EQUITY IN EVALUATION EFFORTS, THE EFFECTS OF AN INTERVENTION ON ADDRESSING HEALTH DISPARITIES AND INEQUITIES CAN GO UNNOTICED. FOR EXAMPLE, AN EVALUATION MAY REVEAL OVERALL IMPROVEMENTS IN HEALTH, BUT OVERLOOK THE FACT THAT HEALTH DISPARITIES OR INEQUITIES ARE WIDENING. HEALTH EQUITY-ORIENTED EVALUATIONS CAN BE DESIGNED TO UNDERSTAND WHAT WORKS, FOR WHOM, UNDER WHAT CONDITIONS, AND REVEAL WHETHER HEALTH INEQUITIES HAVE DECREASED, INCREASED, OR REMAINED THE SAME. INTEGRATE HEALTH EQUITY CONSIDERATIONS THROUGHOUT EACH STEP OF AN EVALUATION TO MORE ACCURATELY INTERPRET FINDINGS AND EFFECTIVELY FOCUS INTERVENTIONS. CONSIDER THESE IDEAS TO INTEGRATE HEALTH EQUITY GOALS INTO YOUR EVALUATION EFFORTS.

Develop a Logic Model That Includes Health Equity Activities and Goals

Guide implementation and evaluation efforts by documenting your health equity-related process activities and outcome goals in your logic model. Include these goals and activities to provide clarity on your intended effects on health equity. Secure buy-in and participation by engaging diverse stakeholders, including community members experiencing health inequities, in the development of the logic model. Also include them in every other step of the evaluation process.

Incorporate Health Equity into Evaluation Questions and Design

Since evaluation questions guide the evaluation process, it is critical that your health equity goals are reflected in them. Such questions may help you determine what has worked for whom and under what conditions. Additionally, consider indicators of success at all stages of the logic model to assess whether an intervention reached the intended population, was implemented correctly, and had the intended outcome(s).

Identify Appropriate Variables to Track Populations Experiencing Inequities

Appropriate variables and strategic sampling plans are needed to assess differential effects of interventions across population groups or settings. Choose relevant variables (e.g., income, race, zip code) early in the process to ensure sufficient data on populations experiencing inequities will be gathered, tracked, and analyzed. In addition, carefully select sites/settings or participants that are to be included in the sampling frame.

Use Culturally Appropriate Tools and Methodologies

Evaluations may be planned and carried out by individuals with different educational backgrounds, primary languages, and cultural identities than the populations experiencing health inequities. Therefore, gather the best possible data by using culturally appropriate tools and methodologies that consider factors such as the population's language needs, literacy levels, and facilitator preferences.

Use Multiple Approaches to Understand an Intervention's Effect on Health Inequities

One approach may not sufficiently account for the complexities of health inequities or reflect issues and successes identified as important by the community. Consider multiple approaches (e.g., GIS analysis, focus groups, assessment of environmental improvements) to understanding an intervention's effect to broaden the range of credible evidence, create new measurement models, and integrate new voices into the understanding of a strategy's effects. Additionally, consider a long-term plan for data collection, as it takes time to change the underlying factors that contribute to health inequities.

Include Health Equity Indicators Into Performance Monitoring Systems

Performance monitoring systems may be revised or developed to track whether changes occur in places where they are most needed, as well as other efforts to advance equity. Such tracking provides an opportunity to monitor progress, identify necessary mid-course corrections in underserved communities, and answer questions that may emerge as the evaluation proceeds.

Use Process and Outcome Evaluations to Understand the Effect on Health Inequities

Use process evaluation to gather information about the planning, engagement, and implementation of a strategy. These data may later help explain successful (or unsuccessful) outcomes as they relate to health inequities. Outcome evaluations can be used to understand the effect of an initiative across different populations and indicate whether health inequities have decreased, increased, or remained the same. Incorporating health equity implications in both process and outcome components of an evaluation can help explain an intervention's effect on health inequities.

Widely Disseminate the Results of Equity-Oriented Evaluations

Knowing what works, what does not work, and what may have promise is essential to expand the type of interventions being used to advance health equity. Contribute to the evidence-base by sharing findings, particularly if results identified disparate effects, such as an increase in health inequities. Additionally, build capacity and increase awareness among community members and stakeholders by sharing findings and providing the data they need to decide on next steps.

> "UNLESS THERE IS A DELIBERATE INTENTION TO ADDRESS HEALTH INEQUALITIES AND TO BUILD UP EVALUATIONS THAT PURPOSEFULLY USE EQUITY AS A VALUE CRITERION, THE FIELD OF HEALTH PROMOTION MAY GO ASTRAY REGARDING ITS UNDERLYING COMMITMENTS TO EQUITY IN HEALTH."[29]
>
> *— Louise Potvin, Université de Montréal*

Setting Up Systems to Understand Who Was Affected—Boston, MA

Boston Public Health Commission (BPHC)

The Boston Public Health Commission (BPHC) worked to ensure their *Communities Putting Prevention to Work* (CPPW) efforts were effective in reaching the populations experiencing obesity and tobacco-related health inequities. BPHC implemented the following steps in developing their evaluation plan:

- Developed evaluation questions to gauge their impact on health inequities.
- Required partners to routinely collect data on race/ethnicity, age, gender, and zip code for all of their initiatives. The data documented how activities benefitted the community in general, as well as population groups/areas experiencing health inequities.
- Increased sample size for the *CPPW* Behavioral Risk Factor Surveillance System in order to ensure sufficient power to assess neighborhood-level changes over time.
- Designed an analysis plan to assess the overall effect of the selected strategies, as well as the effect(s) across population groups.
- Set up their performance monitoring to identify areas where additional efforts may be needed to enhance intervention effects in underserved communities.

This strategic evaluation design enabled BPHC to make mid-course adjustments and enhanced their ability to contribute to the evidence-base regarding the influence of their initiative on advancing health equity.

QUESTIONS FOR REFLECTION: Addressing Health Equity in Evaluation Efforts

1. Where are we now?

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

2. How do we start the evaluation process with health equity in mind?

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

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

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

4. How can we integrate health equity principles in the data gathering process?

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

5. How can we understand our effect on health equity through our analysis plan?

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

6. How can we share our evaluation efforts with diverse stakeholders?

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

7. What are our next steps?

- [ ] What can we do differently to improve or enhance our ability to conduct health equity-oriented evaluations?
- [ ] What is our plan of action to implement improvements in our evaluation efforts?

Definitions, Goals and Principles of Participatory Action Research

Definitions

There is a dizzying array of definitions of participatory research, just as there is an array of terms to describe this "family" of research approaches. The following definitions come from the most recent body of work on community-based participatory research (CBPR) in the public health field, but applies similarly to any field utilizing a participatory approach to research:

"Community-based participatory research (in health) is a collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to the community with the aim of combining knowledge and action for social change to improve community (health)…"

W.K. Kellog Foundation, Community Health Scholars Program, 2001 quoted in Minkler and Wallerstein (2003: 4) [1]

"Participatory research is defined as systematic inquiry, with the collaboration of those affected by the issue being studied, for purposes of education and taking action or effecting change."
Green et al (2003:419) [2]

Goals

In Voices of Change: Participatory Research in the United States and Canada (1993) [3], Budd Hall provides several quotes by well-respected scholars and practitioners of the participatory research approach that help encapsulate its overall goals:

"Participatory research attempts to present people as researchers themselves in pursuit of answers to the questions of their daily struggle and survival" (*Tandon 1988: 7).*

"Participatory research attempts to break down the distinction between the researchers and the researched, the subjects and objects of knowledge production by the participation of the people-for-themselves in the process of gaining and creating knowledge. In the process, research is seen not only as a process of creating knowledge, but simultaneously, as education and development of consciousness, and of mobilization for action *(Gaventa 1988: 19)*

"…to enable the oppressed groups and classes to acquire sufficient creative and transforming leverage as expressed in specific projects, acts and struggles…(Fals borda and Rahman 1991: 4).

Principles

In an extensive synthesis of community-based and participatory research literature, Israel et al (1998)[4] propose the following key principles of community-based research widely accepted in the field of public health. These can be taken as a starting point but are by no means definitive:

1. **Recognizes community as a unit of identity.** This research should work explicitly with communities, which may be defined by a geographic area, or defined as a community of identity that is geographically dispersed but members hold a sense of common identity and shared fate.

A Brief Introduction to User-Centered Design

Question: How do I know whether my Web site meets the needs of users with limited literacy skills?

Answer: By involving users with limited literacy skills throughout all stages of Web site development. This is called user-centered design.

User-centered design is accomplished through an iterative process. The iterative process can be summed up in three words: Test. Revise. Repeat.

Imagine spending money and time designing a Web site from start to finish, only to discover that your users are unhappy with the site or unable to find what they are looking for (or both).

Instead, involve users as codesigners. Have users try out your Web site early on, and continue to test different sections of your site as you develop them. Fine-tune as you go to avoid a major overhaul. This is iterative design.[22]

> *The key to iterative design is to continually apply what you learn from users to improve your site.*[8]

Summary of Iterative Design and Testing Methods

Common iterative design methods are briefly described here. At the end of each chapter, we suggest specific methods and tips you can use to test and improve your Web site.

Individual Interviews

Individual interviews involve talking to users one on one, either in person or over the phone. Unlike a usability test, you aren't watching the participant work. You are finding out background information about their information preferences, habits, and experiences.[8,23]

Focus Groups

Focus groups are similar to individual interviews, except that you are interviewing several participants (typically 5 to 10) at once. A moderator facilitates the focus group and uses a script to lead the discussion. Focus groups are used to learn about users' beliefs, attitudes, or reactions to a design or prototype.[8]

Task Analysis

Conduct a task analysis to find out what users are trying to accomplish on your Web site and how they currently accomplish those tasks.[8,13,23,24] What steps do they take? What tools do they use? A task analysis can be done through observation or interviews.

A task analysis can help you "unpack" the requirements or demands put on users to accomplish a task on your site. Often we make false assumptions about Web users' knowledge or skills. For example, we may assume users know what BMI (body mass index) stands for or that users will correctly interpret the meaning of an icon or symbol.

Personas and Scenarios

A persona is a made-up individual who embodies the characteristics of the real users you may have interviewed and the data you gathered. When creating a persona, include demographics, values, access to technology, and quotes.[7,8,13,25–27]

It helps to give your persona a name and a picture. Keep your personas in mind as you design your site. Ask yourself: Would Susan use this? How would Joe approach this task?

Once you've developed personas for your site users, you are ready to develop scenarios. Scenarios are short stories that describe the goals and tasks of your users.[7,8,24] They can help paint a realistic picture of how personas use your Web site.

Card Sorting

Card sorting can help you group or organize information on your Web site. Many people use card sorting to help with information architecture. The topics and information featured on your site are listed on index cards. Participants are asked to sort or organize the cards into categories that make sense to them. You also can use card sorting to prioritize information by importance.[23]

Prototypes

A prototype is a mockup of your Web site, similar to a rough draft. Start with a paper prototype or wireframe. (A wireframe is an illustration of the layout of a Web page.) Each piece of paper represents a page of your Web site. Users tell you which information or link they would click on, and you show them the new piece of paper (or "screen").[8,22,24,28,29]

As you get further along in the development process, consider building a clickable prototype. This HTML (hypertext markup language) "shell" lets users click through several screens of content.

Usability Testing

In usability testing, a moderator observes a user performing tasks on your Web site. Have participants "think out loud" as they use the site to help you understand their approach and process. Note where users have problems or get lost.[22,30,31]

Six Strategies for Writing and Designing Easy-to-Use Health Web Sites

In the six chapters that follow, this guide presents specific strategies with examples for writing and designing health Web sites that are accessible to users with limited literacy skills.

1. Learn about your users and their goals.
2. Write actionable content.
3. Display content clearly on the page.
4. Organize content and simplify navigation.
5. Engage users with interactive content.
6. Evaluate and revise your site.

Each strategy includes:

- Actions
- Examples
- Iterative design methods and tips

Assess, Select, and Create Easy-to-Understand Materials — Tool 11

Overview

Practices often ask patients to fill out forms or provide them with written materials to read. With 36% of the U.S. adult population having limited health literacy skills, it is likely that many of your patients don't understand all of the written materials they receive. Assessing, selecting, and creating easy-to-understand forms and educational materials can help you improve patient comprehension.

Action

Train a staff member to evaluate the quality of materials you give to patients.

- Have at least one person in your practice learn to assess the materials you distribute. Focus first on important and frequently used materials, such as your lab results letter, after-visit-summary, appointment reminder, or fact sheets about managing chronic conditions. Be sure to review materials developed by your practice as well as materials obtained from outside sources.

Assess whether patient materials are easy to read and understand.

- There are numerous methods for assessing patient materials. Some approaches focus on how readable materials are. Others examine a broad array of features that can make materials easy to understand. You should use both types of methods in assessing your materials.
- **Readability Formulas:**
  - Readability formulas focus on the length of the words and sentences in a document and provide an estimate of how difficult text is to read. Several Web sites are available for conducting readability assessments using commonly used formulas, including the Fry formula, SMOG, and Flesch Reading Ease. Search the Internet for "readability formulas" to find free online resources.
  - In most cases, these sites indicate the grade level at which a patient would have to read to understand the material. The average adult reads at the 8th or 9th grade level, and 20% read at the 5th grade level or below. Therefore, to ensure wide understanding, it is best for materials to be written at the 5th or 6th grade level.
- **Understandability Assessments:**

Several methods are available to examine features of patient materials, other than readability, that affect understanding (e.g., word choice, organization of information, formatting).

- AHRQ's Patient Education Materials Assessment Tool (PEMAT) can help you assess written and audiovisual patient education materials. It provides separate measures of how easy materials are to understand and to act on.

- CDC's Clear Communication Index assesses the clarity and ease of use of written materials, particularly those with behavioral recommendations or those that communicate information about risk.
- The Suitability Assessment of Materials (SAM) assesses the suitability of health information materials, including how well materials stimulate learning and how culturally appropriate they are.

- **Ask patients to evaluate your forms and other written materials** that you hand out or are available on your patient portal. Include both materials that you developed and those you obtained from external sources. See Tool 17: Get Patient Feedback for suggestions.

- **Watch out for numbers. Ensure that your materials follow recommendations for improving communication of health-related numbers:**
  - Provide only the information patients must have to make informed decisions.
  - Provide patients with numbers, not just verbal descriptors (e.g., "low risk").
  - Use simple graphics to express numbers.
  - Provide absolute risk (e.g., a decrease from 4% to 2%) rather than relative risk (e.g. a reduction of 50%), especially when risk reductions are small.
  - Express risk/benefit in whole numbers, not fractions, decimals or percentages (e.g., "1 in 10,000" rather than ".01 %").
  - Provide both the positive and the negative (e.g., "5 in 100 people are expected to get the outcome, meaning that 95 out of 100 will not get the outcome").
  - Use consistent denominators to facilitate comparisons and prevent confusion (e.g., 1 in 1,000 versus 30 in 1,000).
  - Present risk in terms of a time span that is meaningful for patients, such as a 10-year period rather than lifetime.

Choose or make materials that are easy to understand.

- **Identify poor-quality materials.** Identify materials that performed poorly on your assessment. Working with your Health Literacy Team, consider whether these materials can be modified or whether they will need to be replaced.
- **Select better materials.** When you identify deficient materials that cannot be revised, search for new ones.
- **Consider alternatives to written materials.** As one-fifth of adults read below the 5th grade level, it is best not to rely too heavily on the written word. Audio and video resources as well as talking in plain language may be better for many patients. Videos are particularly useful for demonstrating self-care activities such as injecting insulin, using an inhaler, or exercising. Make sure that patients have the equipment, bandwidth, and know-how needed to view audiovisual materials before distributing them.

- **Use the Internet.** There are many free health educational resources available on the Web, such as the MedlinePlus "easy to read" collection, which contains interactive tutorials. Assess all new materials using the tools mentioned above. When directing patients to a Web site, be sure it has simple navigation and is easy to read and understand. See the Department of Health and Human Services' Health Literacy Online for guidance on easy-to-use Web sites.
- **Provide materials in languages your patients speak.** Making easy-to-understand materials available to your non-English speaking patients can be helpful. Keep in mind that some patients with limited English proficiency may also have limited literacy in their native language; make sure you consider alternatives to written materials. See Tool 9: Address Language Differences.
- **Create new materials to fill gaps, and revise homegrown materials that need improvement.** Sometimes you just can't find easy-to-understand instructions or information you want to share with your patients. Or you realize that the materials your office has created are not as easy to understand as you'd like.
  - **Use guides.** The Department of Health and Human Service's health literacy site has a number of guides to help you design or revise materials and Web sites so they are easy to understand. The Harvard School of Public Health also has a set of short Guidelines for Creating, Assessing, and Rewriting Materials.
  - **Streamline forms.** Make sure forms ask only for information that you absolutely have to have, and ask for it only once.
  - **Involve patients.** Invite patients to contribute to the development of new materials. They're the experts on what information is important to them and what makes sense.
  - **Consult on legal issues.** When using a form for a legally binding purpose, consult a lawyer for legal advice. Having patients sign something they don't understand isn't legally binding, however. So, be sure to advocate for plain language.
  - **Obtain approvals.** Some practices (e.g., those affiliated with large health systems) may need administrative approval to revise or replace written materials. Changes to materials accessed through the EHR or patient portal also may require administrative approval and technical support. Consult with your administration for guidance on how to obtain approval for revised materials and to garner their support for your efforts.

Track Your Progress

Every 4 months, tally the number of materials that have been assessed and the percentage of those that were rated poor that have replaced or revised. Are you making the progress you planned to make?

Before you start using Tool 11, tally the percentage of questions that were not answered on forms filled out by patients in a given week. In 2, 6, and 12 months, do it again and see if the percentage of unanswered questions has gone down.

If you field questions from the Health Literacy Patient Survey, calculate what percentage of patients responded "Always" to question #29.

If you use the Patient Portal Feedback Form, check whether patients answered "Yes" to question #8.

Consider Culture, Customs, and Beliefs Tool 10

Overview

Religion, culture, beliefs, and ethnic customs can influence how patients understand health concepts, how they take care of their health, and how they make decisions related to their health. Without proper training, clinicians may deliver medical advice without understanding how health beliefs and cultural practices influence the way that advice is received. Asking about patients' religions, cultures, and ethnic customs can help clinicians engage patients so that, together, they can devise treatment plans that are consistent with the patients' values.

TIP

Here are some examples of how religion, culture, and ethnic customs can influence how your patients interact with you.

- **Health beliefs:** In some cultures, people believe that talking about a possible poor health outcome will cause that outcome to occur.
- **Health customs:** In some cultures, family members play a large role in health care decisionmaking.
- **Ethnic customs:** Differing roles of women and men in society may determine who makes decisions about accepting and following through with medical treatments.
- **Religious beliefs:** Religious faith and spiritual beliefs may affect health care-seeking behavior and people's willingness to accept specific treatments or behavior changes.
- **Dietary customs:** Disease-related dietary advice will be difficult to follow if it does not conform to the foods or cooking methods used by the patient.
- **Interpersonal customs:** Eye contact or physical touch will be expected in some cultures and inappropriate or offensive in others.

Learn from patients.

- **Respectfully ask patients** about their health beliefs and customs, and note their responses in their medical records. Address patients' cultural values specifically in the context of their health care. For example:
  - "Is there anything I should know about your culture, beliefs, or religious practices that would help me take better care of you?"

- "Do you have any dietary restrictions that we should consider as we develop a food plan to help you lose weight?"
- "Your condition is very serious. Some people like to know everything that is going on with their illness, whereas others may want to know what is most important but not necessarily all the details. How much do you want to know? Is there anyone else you would like me to talk to about your condition?"
- "What do you call your illness and what do you think caused it?"
- "Do any traditional healers advise you about your health?"

- **Avoid stereotyping** based on religious or cultural background. Understand that each person is an individual and may or may not adhere to certain cultural beliefs or practices common in his or her culture. Asking patients about their beliefs and way of life is the best way to be sure you know how their values may impact their care.

Learn from other sources.

- **High-quality online resources** provide education about cultural competence, both as a general topic and as related to specific groups.
  - **Courses**
    - "Think Cultural Health" offers several options for free continuing education credit.
  - **Videos**
    - American Association of Family Physicians Quality Care for Diverse Populations has seven 3- to 8-minute videos showing clinicians thoughtfully communicating with diverse populations.
  - **Web sites**
    - EthnoMed is a Web site containing information about cultural beliefs, medical issues, and other related issues pertinent to the health care of recent immigrants.
    - Culture Clues are one-page tip sheets that offer insight into the health care preferences and perceptions of patients from 10 different cultures and special needs groups (including the deaf and hard-of-hearing). The Web site also covers end-of-life issues.
    - The Culture, Language, and Health Literacy Web site provides an exhaustive list of resources regarding cultural competence issues for specific ethnicities, religions, and special populations.

- **Community organizations** such as religious institutions and cultural organizations can often provide information and support to help make your practice more "culture-friendly."
  - Invite a member of a relevant cultural group to attend a staff meeting and share observations about how cultural beliefs may impact health care.
  - Invite an expert to conduct an in-service training to educate staff about cultural competence.
- **Integrate cultural competence into orientation and other trainings.** Take advantage of opportunities to integrate cultural competence into all of your training activities.

- **Use interpreters as cultural brokers.** Interpreters can eliminate language barriers as well as help you and your patients avoid misunderstandings due to cultural differences. See Tool 9: Address Language Differences for more information about interpreters.

Help staff learn from each other.

To raise awareness about cultural competence among your staff, you could:

- Hire staff that reflects the demographics of your patient population. These staff members can help contribute to a comfortable environment for patients and can share insights with other staff regarding the customs of their religious or ethnic groups.
- Encourage staff to complete online cultural competence trainings and share what they learned with each other during a staff meeting.

Track Your Progress

Before implementing this Tool, count the number of staff members who have completed a cultural competence training session. Repeat after 2, 6, and 12 months.

On a regular basis, randomly select some medical records and see what percentage have notes on the patient's culture, customs, or health beliefs.

Address Language Differences Tool 9

Overview

Patients who do not speak English very well, including those who speak American or other sign language, often do not get the health information they need. Addressing language and sensory differences is an important part of addressing health literacy and is required by law. Practices participating in Medicare or Medicaid can be legally required to provide language assistance for patients who do not speak or understand English well. Failing to use acceptable forms of language assistance can expose a practice to liability.

Actions

Assess language preferences and language assistance needs.

- Ask all new patients what language they prefer to speak and read, and if they would like an interpreter. Record patients' language assistance needs in the medical record.
- For patients who do not speak enough English to respond to questions about language preference, use "I Speak" cards to identify the language they speak.
- Match patients with qualified bilingual clinicians or staff members, or request an interpreter for patients who do not speak English very well or who appear to have difficulty understanding English.
- Display Interpreter Services Posters in your waiting and reception areas to make patients aware of the availability of free interpreter services.

Use acceptable language assistance services.

- Acceptable language assistance services include the following:
  - Bilingual clinicians or staff members whose proficiency has been confirmed can communicate directly with patients in their preferred language.
  - Staff who are trained as interpreters.
  - On-site trained medical interpreters.
  - Telephone or video medical interpreter services. Make sure you can access necessary equipment (e.g., dual handset phones) in all areas where patients interact with staff.
- All clinicians, staff, and interpreters should understand the importance of using plain language. See Tool 4: Communicate Clearly for guidance on communicating clearly.

Do NOT use unacceptable language assistance services.

- Individuals who are not trained to be an interpreter make more clinically significant mistakes. Unacceptable language assistance services include the following:
  - Clinicians or staff who are not trained and/or certified as medical interpreters.
  - The patient's family and friends. Using family or friends poses a problem with patient privacy. In addition, family or friends may provide you with their own views of what patients say or feel about their health problems. If a patient insists that a family member serve as interpreter, you should respect that request, but a qualified interpreter should also be present to assure that information is accurately relayed.
- Minor children should never be used as interpreters.

Plan for interpreter services in advance.

- Use data about patients' language preferences to determine how to best meet their language assistance needs (e.g., hiring bilingual staff, hiring professional interpreters, training staff as interpreters).
- For practices with small populations of non-English-speaking patients, consider scheduling appointments and having call-in hours on specific days or times when appropriate interpreter services are available (e.g., Spanish interpreters available Thursdays 1-5 p.m.).

Provide written materials in patients' preferred languages.

- Do not assume that non-English speakers, including speakers of American Sign Language, will understand notes or other materials written in English.
- Decide what to translate, such as signs, forms, and instructions.
- Obtain multilingual health education materials. See the List of Internet Resources at the end of this toolkit for links to easy-to-read materials in several languages.
- When you can't obtain materials in patients' preferred languages, enlist the help of interpreters trained in sight translation. Sight translation is reading a written document aloud in a different language from the one in which it is written.

Pursue sources of payment for language assistance services.

- Investigate whether insurers will pay for or have negotiated discounts with interpreters. Medicaid reimbursement is available in a number of States.
- Contact community organizations to see if they can provide volunteer trained medical interpreters.
- Develop contracts with language assistance services that can be shared among several practices.
- Consider sharing language services with local hospitals.
- Apply for grants to support interpreter services.

Track Your Progress

Within a month of beginning implementation, ask staff to record all of the language assistance needs they encountered during a specified week and how these needs were met. Collect these notes and discuss them at the next Health Literacy Team meeting. Explore new approaches to address any weaknesses and do another evaluation in 2, 6, and 12 months.

Routinely conduct a review of medical records of patients with recent visits to ensure that language assistance needs are being assessed and recorded. Check that qualified individuals are giving language assistance.

Compile a list of the most common languages spoken by your patients. Compare that list with the languages used in the written materials you distribute. Repeat after 2, 6, and 12 months to see whether more non-English materials are available.

Resources

The Guide to Providing Effective Communication and Language Assistance Services from the U.S. Department of Health and Human Services provides comprehensive guidance on addressing language assistance services in health care settings.

The Office Guide to Communicating with Limited English Proficient Patients is a booklet by the American Medical Association that offers practical advice for addressing communication barriers in health care settings.

Hablamos Juntos has a number of resources for language services, including a toolkit on improving the quality of health care translation.

LEP.gov provides federal guidance in providing language access.

The American Translators Association allows you to search for local translators (for written materials) and interpreters (for verbal communication).The Certification Commission for Healthcare Interpreters has a searchable registry of certified interpreters, as does the National Board of Certification for Medical Interpreters.

Sources of multilingual easy-to-read materials:

- MedlinePlus by the National Institutes of Health.
- Healthy Roads Media provides materials in handout form, audio, and video in several languages.
- Health Information Translations provides materials in 18 different languages, including American Sign Language video.

Communicate Clearly Tool 4

Overview

Using clear oral communication strategies can help your patients to better understand health information. Communicating clearly also helps patients to feel more involved in their health care and increases their likelihood of following through on their treatment plans.

Practice Experiences

Patients misunderstand health communications more often than clinicians might think. For example, one practice using Tool 4 shared a story of a clinician who told a patient that they could not use a local treatment to heal her wound. The patient thought she was going to have to travel to another city for care (instead of understanding that she could not use a topical treatment).

–Family practice facility

Actions

Use strategies for communicating clearly.

- **Greet patients warmly:** Receive everyone with a welcoming smile, and maintain a friendly attitude throughout the visit.
- **Make eye contact:** Make appropriate eye contact throughout the interaction. Refer to Tool 10: Consider Culture, Customs and Beliefs for further guidance on eye contact and culture.
- **Listen carefully:** Try not to interrupt patients when they are talking. Pay attention, and be responsive to the issues they raise and questions they ask.
- **Use plain, non-medical language:** Don't use medical words. Use common words that you would use to explain medical information to your friends or family, such as stomach or belly instead of abdomen.
- **Use the patient's words:** Take note of what words the patient uses to describe his or her illness and use them in your conversation.
- **Slow down:** Speak clearly and at a moderate pace.
- **Limit and repeat content:** Prioritize what needs to be discussed, and limit information to 3-5 key points and repeat them.
- **Be specific and concrete:** Don't use vague and subjective terms that can be interpreted in different ways.
- **Show graphics:** Draw pictures, use illustrations, or demonstrate with 3-D models. All pictures and models should be simple, designed to demonstrate only the important concepts, without detailed anatomy.

- **Demonstrate how it's done.** Whether doing exercises or taking medicine, a demonstration of how to do something may be clearer than a verbal explanation.
- **Invite patient participation:** Encourage patients to ask questions and be involved in the conversation during visits and to be proactive in their health care.
- **Encourage questions:** Refer to Tool 14: Encourage Questions for guidance on how to encourage your patients to ask questions.
- **Apply teach-back:** Confirm patients understand what they need to know and do by asking them to teach back important information, such as directions. Refer to Tool 5: Use the Teach-Back Method for more guidance on how to use the teach-back method.

Help staff remember these strategies.

- Review these strategies with staff during staff meetings, and hang the Key Communication Strategies poster in non-patient areas (e.g., kitchen or conference room) as a reminder.

Track Your Progress

Before implementing this Tool, ask all staff to complete the brief Communication Self-Assessment after a few patient encounters. Calculate the percentage of staff who completed the self-assessment. One month after beginning implementation, complete another round of self-assessments and look for changes.

Before and after Tool implementation, ask a respected individual to conduct observations of clinician/staff interactions with patients. Use the Communication Observation Form to assess communication quality. Provide feedback to staff. Repeat this process routinely. Calculate the percentage of staff who have been observed once, and the percentage who have been observed more than once.

Before implementing the tool, collect patient feedback using the Brief Patient Feedback Form or the more comprehensive Health Literacy Patient Survey in Tool 17: Get Patient Feedback. Administer the questions 2, 6, and 12 months later, to determine if there has been improvement.

Resources

Health Literacy and Patient Safety: Help Patients Understand, by the American Medical Association, offers suggestions for improving oral communication and alternatives to complex medical words (pages 29-34). Once you link to the Web site, look for the Manual for Clinicians. Access to the manual is free, once you have created an account.

Developing Effective Communication Products (Quick Check)

Are You on Track to Know Your Audience?

No matter how you use the Index, remember it's just one step in the process of developing effective communication products. It cannot take the place of formative research or pretesting with your intended audience. See Appendix B for an annotated version of this list and related resources.

1. **Did you identify your intended audience(s)?**
   Always consider the audience and what they need and want.

2. **Did you conduct audience research?**
   Get to know your audience – don't guess or assume. Review existing data or gather new data through formative research.

3. **Did you identify your behavioral objective(s) and key messages?**
   What do you want your intended audience to do? Define the behavioral objective(s) of the material based on behavioral and communication theory.

4. **Did you determine how your material will be formatted and distributed so that it reaches your audience?**
   Consider how your audience will find, receive and use the material. Choose the best format for your audience and the message (written, visual, audio, video). Identify dissemination channels, such as social media, community organizations, websites, and activities that match the audience.

5. **Did you build in time and resources to pretest the material with your intended audience and revise based on feedback?**
   This step can be done multiple times, if needed. Remember, even the most robust communication guidelines cannot substitute for pretesting with your intended audience.

CHAPTER
2

Choosing WORDS

Best Practices in the Language and Framing of Social Determinants of Health

There is no silver bullet, no single word or fact that will suddenly transform how people think about health. It is an intensely personal issue that carries with it complex beliefs, conflicted values and a deeply divided electorate about what leads to better health.

Instead, in this research, we studied numerous long-form messages and shorter statements that could offer a proxy for the phrase "social determinants of health." We uncovered a series of lessons, best practices, recommended language and watch-outs that can support better and more persuasive messages.

SEVEN LESSONS:

1

Traditional phrasing of social determinant language consistently tested poorly in every phase of research. Phrases like "social determinants of health" and "social factors" failed to engage the audience, even when we added more context. However, the concept behind social determinants of health does resonate with our audiences, as evidenced by our pre- and post-testing of people's attitudes after their exposure to our messages.

2

Priming audiences about the connection with messages they already believe makes the concept more credible. Messages that incorporate the importance of available quality health care with the need to address the social factors that affect health were more convincing than those that did not discuss medical care at all. **When messages are presented in colloquial, values-driven, emotionally compelling language, they are more effective.** Academic language, including "social determinants," did not resonate with audiences the way language like "health starts in our homes, schools and communities" did.

3

Use one strong and compelling fact—a surprising point that arouses interest, attention and emotion—for maximum impact. Loading messages down with more than one or two facts tends to depress responses to them.

4

Identify the problem, but offer potential solutions. Respondents, particularly opinion leaders, prefer messages that include some kind of direction—either an example of the kind of action that would address the problem or a set of principles that can guide us to where we need to be.

5

Incorporate the role of personal responsibility. The importance of all Americans having equal opportunity to make choices that lead to good health resonated with participants across the political spectrum. Incorporating this point made respondents more receptive to the idea that society also has a role to play in ensuring that healthy choices are universally available.

6

Mix traditionally conservative values with traditionally progressive values. Every phase of research showed that while some phrasing appealed to one political perspective over another, progressives had a tendency to be more open to conservative frames. Generally, however, we need to be aware of these different worldviews and communicate using language that puts us on common ground. For example, combining the notion of personal responsibility, which is wholly embraced by conservatives with a message about opportunities, language that also appeals to progressives, will appeal to a broader audience.

7

Focus broadly on how social determinants affect all Americans (versus a specific ethnic group or socioeconomic class). This research showed that Americans believe in equal opportunity to health, but describing actual disparities consistently evokes negative reactions. Messages that described disparities based on race or ethnicity fared poorly with every audience except Black respondents. Furthermore, some focus group participants expressed concern that focusing on one ethnic group reinforced negative racial stereotypes.

BREAKING IT DOWN:

Below you'll find one long-form message that was developed, revised, tested and revised again based on what the research showed us. It was consistently the most persuasive message among all groups, regardless of their political perspective. While we are not necessarily recommending that you use this in its entirety, it is helpful to understand why the phrase worked.

America leads the world in medical research and medical care, and for all we spend on health care, we should be the healthiest people on Earth. Yet on some of the most important indicators, like how long we live, we're not even in the top 25, behind countries like Bosnia and Jordan. It's time for America to lead again on health, and that means taking three steps. The first is to ensure that everyone can afford to see a doctor when they're sick. The second is to build preventive care like screening for cancer and heart disease into every health care plan and make it available to people who otherwise won't or can't go in for it, in malls and other public places, where it's easy to stop for a test. The third is to stop thinking of health as something we get at the doctor's office but instead as something that starts in our families, in our schools and workplaces, in our playgrounds and parks, and in the air we breathe and the water we drink. The more you see the problem of health this way, the more opportunities you have to improve it. Scientists have found that the conditions in which we live and work have an enormous impact on our health, long before we ever see a doctor. It's time we expand the way we think about health to include how to keep it, not just how to get it back.

WHY THIS WORKED:

- Audiences flat out didn't believe the statement, "America is not among the top 25 countries in life expectancy," and they responded negatively to any message that led with that statement. However, when we start off with something most Americans already believe, "Americans lead the world in medical research and medical care," they are more likely to believe everything that follows.
- Words like "insured or "uninsured" are politically loaded. But the phrase "ensure everyone can afford to see a doctor when they are sick" doesn't touch existing political hot buttons.
- Framing our message in the context of accepted beliefs like the importance of access to care or prevention helps our message fit into the broader thinking of what it takes to be healthy.
- The inclusion of specific solutions increased acceptance of the core message.
- Illustrating with examples like "playgrounds and parks" and "in the air we breathe and water we drink," makes the concept of social factors more tangible.
- In the statement, "Scientists have found," other options were tested with more specificity, such as "Scientists at the Centers for Disease Control and at universities around the country have shown that the conditions in which people live and work have more than five times the effect on our health than all the errors doctors and hospitals make combined." Presenting the fact in a more colloquial, relatable way, stripped of the academic support, is more effective than a longer statement.

SIX WAYS TO TALK ABOUT SOCIAL DETERMINANTS OF HEALTH:

Our hope in this research was to find a tidy proxy that could replace "the social determinants of health" as the leading descriptor for this area of work. While our testing showed that this phrase doesn't work for any of our audiences, we still don't have that neat replacement. But what you'll find here is a list of phrases that—in context—helped people understand the concept more clearly. These are the precise phrases that we tested and that scored well.

1	Health starts—long before illness—in our homes, schools and jobs.
2	All Americans should have the opportunity to make the choices that allow them to live a long, healthy life, regardless of their income, education or ethnic background.
3	Your neighborhood or job shouldn't be hazardous to your health.
4	Your opportunity for health starts long before you need medical care.
5	Health begins where we live, learn, work and play.
6	The opportunity for health begins in our families, neighborhoods, schools and jobs.

WHY THESE WORK:

- The proxy statements use colloquial, values-driven language and relatable lifestyle references that engage audiences.
- These statements all focus on the solution versus the problem.
- Some of the statements implicitly acknowledge the notion of personal responsibility.

A GLOSSARY OF "OTHER TERMS"

The terms that people often use to describe health disparities can get in the way of others accepting the idea of social determinants of health and who they are most likely to affect. One of the things we learned from OZA's research is that people with more conservative views tend to have negative reactions to the goal of equal levels of health for everyone. As such, below are some phrases we suggest avoiding.

- Any variation of equal, equality or equalizing
- Leveling the playing field
- Creating balance

People with a more liberal perspective on this issue often describe health disparities as an injustice, whereas more conservative people never use this phrase. Though it was never commented on directly in the OZA health disparities research, we suspect that the idea of health differences being unjust would not resonate with conservative audiences because it may activate the same response as inequality. This would include the following type of language, which you should also avoid:

- Unjust/injustice
- Outrage
- Immoral
- Unconscionable

A GLOSSARY OF "OTHER TERMS" (continued)

Below is an evolving list of terms that describe the groups most profoundly affected by this issue. These descriptions are not only technically accurate but more representative of how we relate to each other as human beings and fellow Americans. These phrases have not been tested, but are reflective of the insights we gained from the research.

Vulnerable Populations

- Too many Americans don't have the same opportunities to be as healthy as others
- Americans who face significant barriers to better health
- People whose circumstances have made them vulnerable to poor health
- All Americans should have the opportunity to make the choices that allow them to live a long, healthy life, regardless of their income, education, or ethnic background
- Our opportunities to better health begin where we live, learn, work and play
- People's health is significantly affected by their homes, jobs and schools

Health Disparities

- Raising the bar for everyone
- Setting a fair and adequate baseline of care for all
- Lifting everyone up
- Giving everyone a chance to live a healthy life
- Unfair
- Not right
- Disappointing (as in Americans should be able to do better, not let people fall through the cracks)
- It's time we made it possible for all Americans to afford to see a doctor, but it's also time we made it less likely that they need to

Poverty

- Families who can't afford the basics in life
- Americans who struggle financially
- Americans struggling to get by

Low-income workers and families

- People who work for a living and still can't pay their rent
- Hard-working Americans who have gotten squeezed out of the middle class in tough times
- Families whose dreams are being foreclosed

Violence in general, as well as gangs and intimate partner violence

- Unsafe streets
- The epidemic of violence
- Street violence
- Intergenerational cycle of violence and abuse
- Teen dating violence and abuse

The elderly population and their families, nursing homes and elder care

- Our aging parents and grandparents
- Our elders
- Elders
- Caring for people as they age

Refugees and immigrants including children

- People seeking a new home in America
- Children caught between two worlds
- From undocumented immigrants to productive, tax-paying American citizens

Youth and teens

- The years of opportunity and danger
- Teenagers: They aren't just young adults

Mental health or illness, including young people

- It's just as dangerous and debilitating as any other chronic disease

What Is Health Equity? A Definition

For general purposes, health equity can be defined as follows:

Health equity means that everyone has a fair and just opportunity to be healthy. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

The following should be added when the definition is used to guide measurement; without measurement, there is no accountability:

For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups.[2,3,4,5]

Many of the concepts in the definition are complex. A later section on "Terms That Often Arise in Discussions of Health Equity" may be useful to consult while reading this and subsequent sections.

Defining Health Equity for Different Audiences

A 30-second definition for general audiences: Health equity means that everyone has a fair and just opportunity to be healthy. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

A 15-second definition for technical audiences: For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups.

A 20-second definition for audiences who ask about the difference between equity and disparities: Health equity is the ethical and human rights principle that motivates us to eliminate health disparities; health disparities—worse health in excluded or marginalized groups—are how we measure progress toward health equity.

An 8-second version for general audiences (health equity as a goal or outcome): Health equity means that everyone has a fair and just opportunity to be healthy.

Another 8-second version for general audiences (health equity as a process): Health equity means removing economic and social obstacles to health such as poverty and discrimination.

Key HCPHES Stakeholders

Stakeholders are persons, groups or organizations that can place a claim on an organization's resources, attention or output, or are affected by its output.[3] In other words, stakeholders can affect or be affected by an organization's policies, objectives and actions. Recognizing and analyzing the needs, influence and resources of HCPHES' key stakeholders is crucial to the development and implementation of organizational goals and objectives. The stakeholders of HCPHES are many and varied, and include the following major categories.

- Harris County Residents/Public at Large

  The residents of Harris County are the key constituents of HCPHES. Because residents are the end-users of public health services, HCPHES requires their engagement, support, cooperation, collaboration and feedback in order to pursue our mission.

- Commissioners Court

  Harris County Commissioners Court is the stakeholder that most directly influences the funding policies of HCPHES. Commissioners Court consists of four Commissioners, each an administrator of a County Precinct, and the County Judge. As the body that approves the HCPHES budget, as well as administrative and programmatic requests, it is crucial that Commissioners Court has confidence in HCPHES as a responsive, effective, credible and relevant organization.

- Governmental Agencies

  - *Federal Agencies*

    Federal governmental agencies influence HCPHES by establishing national health and safety standards, publishing public health and clinical guidelines, setting environmental standards and setting priorities and goals that must be implemented at the local level. Examples of federal governmental agencies that influence the mission and activities of HCPHES include the Centers for Disease Control and Prevention, the Environmental Protection Agency and the Department of Homeland Security.

  - *State Agencies*

    State governmental agencies influence HCPHES by establishing health, safety and environmental rules and regulations; providing state and federal funding; administering legislatively mandated and other statewide programs; and collecting and disseminating statewide data. Examples of state governmental agencies that influence the mission and

[3] Bryson JM, Alston FK, Creating and Implementing Your Strategic Plan, 1996

activities of HCPHES include the Texas Department of State Health Services, the Texas Department of Agriculture and the Texas Animal Health Commission.

- *Local Agencies*

  Local governmental agencies influence HCPHES by collaborating and sharing resources on initiatives that benefit residents of Harris County and support the mission of HCPHES. Local governmental agencies include other County departments such as the Institute of Forensic Sciences, the County and District Attorney's Offices, the Public Infrastructure Department, the Fire Marshal's Office and the Office of Homeland Security and Emergency Management. HCPHES also works with agencies that are part of the many municipalities within Harris County such as the City of Houston Department of Health and Human Services, as well as local agencies in the region outside of Harris County.

- Medical Community

  Physicians and other health care providers, hospitals, health insurance plans and the veterinary community are crucial to the mission and activities of HCPHES. For example, HCPHES works with the medical community to coordinate public health emergency preparedness planning, and depends on their reports of notifiable conditions to conduct disease surveillance and shape population-based prevention efforts.

- Legislators

  The federal and state legislators who represent Texas and districts within Harris County impact the mandates and activities of HCPHES by shaping federal and state laws and responding to constituents' concerns. The federal legislative delegation representing Texas and Harris County includes two U.S. Senators and 32 U.S. Representatives. The State legislative delegation representing Harris County includes seven State Senators and 25 State Representatives. HCPHES works with the Harris County Office of Legislative Relations to inform legislators about public health issues and the impact of relevant legislation.

- Media

  As an important means by which the community obtains health-related information, the media – including print, television, internet and radio sources – are important HCPHES stakeholders. HCPHES depends on local, state and national media to deliver timely and accurate public health messages; therefore HCPHES must remain accessible, professional and knowledgeable when working with its media partners.

- Non-Governmental Organizations

- *Professional Organizations*

  Professional organizations enhance the mission and activities of HCPHES by providing guidance on mandates and policy, facilitating information exchange among partner agencies and coordinating opportunities for workforce development. Examples of national, state and local professional organizations with which HCPHES or its employees affiliate include American Public Health Association, National Association of County and City Health Officials, Texas Association of Local Health Officials, Texas Environmental Health Association, Texas Veterinary Medical Association and Harris County Medical Society.

- *Community-Based, Faith-Based and Philanthropic Organizations*

  Philanthropic, faith-based and community-based organizations can affect HCPHES by influencing public opinion, the media and policymakers as well as collaborating and sharing resources on initiatives that benefit the community. Examples include American Heart Association (local chapter), St. Luke's Episcopal Health Charities, Houston Endowment, Interfaith Ministries, YMCA of Greater Houston and Society for the Prevention of Cruelty to Animals.

- *Community Consortia*

  Community consortia and planning groups provide HCPHES with valuable information regarding the public health and environmental needs among Harris County populations, as well as strategies for addressing them. Examples of community consortia and planning groups include Houston-Galveston Area Council, Ryan White Planning Council, Harris County Healthcare Alliance and Gateway to Care.

- *Civic Organizations*

  Civic organizations and citizen groups influence HCPHES by identifying, communicating and working to address important public health-related issues at the community and neighborhood-level. Examples of civic organizations include neighborhood associations, community health watch groups and community preservation groups.

- Regulated Entities

  Following state and local laws, HCPHES conducts permitting, inspection, monitoring and enforcement activities for a variety of business and industrial entities. The cooperation of food establishments, public drinking water systems and businesses in complying with

applicable environmental, health and safety-related regulations directly impacts the public's health and well-being, as well as the activities and resources of HCPHES.

- Other Business Entities

  Business entities have a vested interest in the health and well-being of its workforce; a healthier workforce is associated with higher worker productivity, lower absenteeism and lower healthcare insurance costs. Furthermore, healthy community design features attract businesses and generate economic growth, which in turn benefits the health and well-being of community residents.

- Academic Institutions

  - *Institutions of Higher Learning*

    By conducting relevant research and training future professionals, institutions of higher learning influence how HCPHES puts into practice its mission and activities. Among the many area institutions that collaborate with HCPHES, some include University of Texas Health Science Center at Houston (UTHealth), Baylor College of Medicine, University of Texas Medical Branch, Texas Southern University, Rice University Kinder Institute for Urban Research and University of Houston.

  - *Independent School Districts*

    As influential local leaders with access to a majority of Harris County residents, educators and administrators of the 22 Independent School Districts (ISDs) within Harris County provide HCPHES with opportunities for disseminating public health information and resources to children, their families and communities at large.

  - *Pre-Kindergarten Facilities*

    Programs and facilities that provide pre-kindergarten education and care provide HCPHES with access to the County's youngest residents and their families, and therefore can play a cornerstone role in helping families set foundational healthy behaviors. Examples of pre-kindergarten facilities include Head Start programs and child day cares licensed by the Texas Department of Family and Protective Services.

- Emergency Response Community

  By providing information, resources, technical and logistical support, emergency response agencies and the community at-large influence HCPHES' ability to plan for, respond to and recover from public health emergencies, both manmade and naturally-occurring. HCPHES

collaborates with first responders such as police, fire and emergency management services; planning groups such as SouthEast Texas Regional Advisory Council, Local Emergency Planning Councils, and the Harris County Office of Homeland Security and Emergency Management; and state and federal partners such as Texas Department of Public Safety, Texas Department of State Health Services and the Centers for Disease Control and Prevention. Faith and other community based organizations, volunteer groups, the business community and the lay public also shape preparedness activities, and are activated to support response efforts.

- HCPHES Staff

  HCPHES employees are the backbone of the organization, executing the HCPHES mission on a daily basis. By providing public health assessment, assurance, policy development and education activities, HCPHES employees protect and promote the health and safety of Harris County communities.

  HCPHES Executive Staff, which includes the Executive Director, Deputy Director and Division and Office Directors, are the key decision-makers for HCPHES. By setting goals and objectives, allocating resources and guiding policy and procedure, HCPHES depends on their leadership to ensure that we follow our mission.

Prevention Institute
Putting prevention at the center of community well-being

THE EIGHT STEPS TO EFFECTIVE COALITION BUILDING

Increasingly, the problems that communities need to resolve are complex, requiring comprehensive solutions. Addressing issues such as health promotion and chronic disease prevention requires the inclusion of people from diverse backgrounds and disciplines. Work in partnerships, collaborations and coalitions can be challenging but a powerful tool for mobilizing individuals to action, bringing community issues to prominence and developing policies. These associations are also an effective means of integrating health services with other human services so that resources are not wasted and efforts are not needlessly duplicated. Coalitions are often best equipped to utilize the resources and findings of participants and apply them more effectively than any single group or organization.

The Eight Steps to Effective Coalition Building is a framework developed by Larry Cohen, et. al., for engaging individuals, organizations and governmental partners invested in addressing community concerns. The complete document (available at www.preventioninstitute.org) offers concrete steps towards building effective partnerships and provides tips for making collaborations and partnerships work. Rather than creating new projects or programs, effective coalitions can harness existing resources to develop a unique community approach and achieve results beyond the scope of one single institution or organization.

1. Discuss and analyze the group's objectives and determine coalition need(s)

A coalition is a prevention *tool*, so groups must be specific about what needs to be accomplished. After the needs have been determined, the group must consider if a coalition is the best approach to meet the identified needs. Groups must ask the following questions: What are we trying to accomplish? What are our community's strengths and needs? What are the pros and cons associated with the proposed collaboration? What are our objectives and what types of activities seem logical? Cohen suggests using the *Spectrum of Prevention* to help define a group's possible actions.

2. Recruit the right people

The group's objectives will prescribe the type of coalition developed. Some groups may choose to start small to accomplish specific tasks and then strategically expand. Depending on the needs of the coalition, either program directors or front-line staff should be encouraged to attend. In addition, invite community members, youth leaders, and politicians. The size of the group matters. It takes large groups longer to define and agree on common objectives and activities. Yet large groups may have access to greater resources that may be required for accomplishing certain tasks.

265 29th Street
Oakland, CA 94611
510.444.7738
fax 510.663.1280

www.preventioninstitute.org

Prevention Institute
Putting prevention at the center of community well-being

3. Adopt more detailed activities and objectives suiting the needs, interests, strengths, and diversity of the membership

A key to a successful coalition is the early identification of common goals and benefits of working together. The coalition must avoid competing with its members for funding. An important consideration for adopting specific coalition activities is to identify some short-term outcomes. For example, if a coalition's objective is to increase public knowledge about chronic disease as a preventable community problem, a short-term outcome could be the publication of two editorials in the local newspaper.

4. Convene coalition members

A coalition can be convened at a meeting, workshop, or conference. The lead agency should plan the first meeting using a time-specific prepared agenda, a comfortable and well-located meeting area, and adequate refreshments. It is appropriate to prepare a draft mission statement and proposal for coalition structure and membership. Anticipate that not all invited members will become coalition members.

5. Develop budgets and map agency resources and needs

Lead agencies usually provide staff time to keep the coalition up and running and to handle detail work. Though coalitions can usually run on a minimal budget, each member's time is a valuable contribution.

6. Devise the coalition's structure

Structural issues of the coalition include: how long the coalition will exist, meeting locations, meeting frequency and length, decision making processes, meeting agendas, membership rules, and participation between meetings by subcommittees or planning groups. Templates of different coalition structures should be collected prior to the meeting and presented for discussion to reduce the time needed to make management decisions.

7. Plan for ensuring the coalition's vitality

Methods for noting and addressing problems, sharing leadership, recruiting new members, providing training on identified needs, and celebrating success can help ensure a coalition's viability and success. It is very important to recognize both the individual and organizational contributions to a coalition each step of the way.

8. Evaluate programs and improve as necessary

Each coalition activity and event should include evaluations. This can be as simple as a satisfaction survey or it could be the more formal use of pre- and post-tests of specific subject knowledge.

265 29th Street
Oakland, CA 94611
510.444.7738
fax 510.663.1280

www.preventioninstitute.org

The full document, *Developing Effective Coalitions: An Eight-Step Guide*, written by Larry Cohen, Nancy Baer and Pam Satterwhite is available at: www.preventioninstitute.org

COLLABORATION MULTIPLIER

Enhancing the Effectiveness of Multi-Field Collaboration

Collaboration Multiplier is an interactive tool for strengthening collaborative efforts across diverse fields. A multi-field approach has proven vital for tackling today's complex social challenges. Whether the goal is promoting health equity, strengthening local economies, reducing greenhouse gas emissions, or enhancing community safety, improving our well-being requires community-wide changes that include strengthening government policies and the practices of key organizations. Multi-field collaboration expands available resources, strategies, and capabilities to achieve outcomes that could not be accomplished by one field alone.

Collaboration Multiplier provides a systematic approach to laying the groundwork for multi-field collaboration. The tool guides organizations through a collaborative discussion to identify activities that accomplish a common goal, delineate each partner's perspective and potential contributions, and leverage expertise and resources. *Collaboration Multiplier* is based on the understanding that different groups and sectors have different views of an issue and different reasons for engaging in a joint effort. For example, a collaborative formed to increase access to healthy food in underserved neighborhoods can more effectively engage partners by recognizing that each has their own goals. A grocery store operator might expand fresh food offerings to enhance sales and profits, a health department would support the effort to improve health, and the Mayor might see enhanced food retail as fundamental for a flourishing community. *Collaboration Multiplier* helps surface these perspectives and forge strategies that advance their objectives simultaneously.

Collaboration Multiplier can be used in different stages of collaboration. It can be used by a newly formed or established partnership that wants to strengthen its collective effort, or it can be used by an individual or small set of organizations that recognize the value of a diverse partnership and want to think strategically about whom to invite to the table.

The Collaboration Multiplier Process

Collaboration Multiplier occurs in two phases: 1) Information Gathering and 2) Collaboration Multiplier Analysis

In the first phase, the key sectors and fields that can contribute to a solution are identified. Then key information from the *perspective of each field* (or prospective field) is collected according to a common set of categories. Specific categories vary based on the particular collaboration, but typical examples include:

- **Importance:** Why is this issue important?
- **Organizational Goals:** What are the goals related to this issue?
- **Audience:** Who is the primary audience/ constituency?
- **Expertise:** What unique expertise does this field bring to the collaborative?

Partner	Importance	Organizational Goals	Expertise	Assets & Strengths	Key Strategies	Desired Outcomes	Partnership	Organizational Benefit

- **Assets/Strengths:** What resources (skills, staff, training capacity, funding) can be brought to the table?
- **Key Strategies:** What key strategies/ activities are currently implemented relevant to this issue?
- **Desired Outcomes:** What specific results/outcomes are desired as a result of this collaboration? What does success look like?
- **Data:** What data is collected, and how?
- **Partnership:** Which partners/participants can be brought to the table to enhance outcomes?
- **Organizational Benefit:** What is the benefit of participating in this collaborative?

Compiling this information can provide a "big picture" snapshot for partners and lays the groundwork for a collaborative discussion.

In the next phase, the collaborative engages in a "collaboration multiplier analysis" to discuss the implications based on the information collected. Some key areas of discussion can include:

- What partner strengths can the collaborative utilize? How do you leverage each partner's expertise?
- What results and outcomes can be achieved together?
- What strategies/activities can two or three partners work together on?

Collaboration Multiplier serves as a starting point for appreciating what different fields can bring to the table and for building effective interdisciplinary efforts through partnership. After completing the two-phase process, partners can begin developing a comprehensive strategy to achieve their shared vision. To support strategic efforts, *Collaboration Multiplier* is designed to complement and inform Prevention Institute's *Spectrum of Prevention,* a tool for developing multifaceted activities for effective prevention, and *The Eight Steps to Effective Coalition Building,* a step-by-step guide for coalition development and sustainability. Effective collaboration can be a powerful force for mobilizing individuals to action, bringing health and safety issues to prominence, forging joint solutions, and developing effective policies. By working through *Collaboration Multiplier*, partners will see the fruits of their efforts grow exponentially.

For more information, visit Prevention Institute's website at www.preventioninstitute.org or e-mail virginia@preventioninstitute.org.

Collaboration Multiplier Example: Traffic Safety Coalition

Goal: Decrease traffic-related crashes and fatalities
Phase I: Information Gathering

(This is a sample; expected levels of detail would be greater)

	Expertise	Desired Outcomes	Strategies
Public Health	Population-based prevention approaches and data collection of injury rates	Reduce unintentional injuries among all travelers, including drivers, pedestrians, bicyclists, disabled, elderly	Facilitate environmental and policy changes (i.e., pedestrian/ bicycle-friendly street design, car seats, seat belts, driving under the influence, bicycle helmets)
Law Enforcement	Expertise in legal requirements and crash investigations and has the authority to enforce traffic laws	Increase compliance to traffic safety laws	Enforce traffic laws, patrol neighborhoods, implement check points, cite reckless drives, and participate in educational campaigns
Transportation Engineering	Road and sidewalk design that provides safe travel for multiple modes of transportation	Prevent traffic crashes and reduce severity of injuries if a crash occurs	Promote safety regulations for occupants and vehicles n Implement street designs that promote safety
Optometry	Understanding of how people visualize traffic signs and signals	• Improve vehicle displays, traffic signals, and road signage • Better driver assessment for licensing purposes	Utilize color and design features to increase driver attention to traffic signals and signs

Phase II: Collaboration Multiplier Analysis

Public Health

Expertise:
Population-based prevention approaches and data collection of injury rates

Desired Outcomes:
Reduce unintentional injuries among all travelers, including drivers, pedestrians, bicyclists, people with disabilities, elderly

Key Strategies:
Facilitate environmental and policy changes (i.e., pedestrian/bicycle-friendly street design, car seats, seat belts, DUI, bicycle helmets)

Law Enforcement

Expertise:
Expertise in legal requirements and crash investigations and has the authority to enforce traffic laws

Desired Outcomes:
Increased compliance to traffic safety laws

Key Strategies:
Enforce traffic laws, patrol neighborhoods, implement check points, cite reckless drivers, and participate in educational campaigns

Shared Outcomes

- Improved transportation infrastructure and systems
- Ability for motorists, bicyclists, pedestrians, people with disabilities, and elderly to travel easily and safely
- Decrease in traffic-related injuries and deaths

Partner Strengths

- Subject matter expertise
- Authority and ability to implement policies and environmental changes
- Understanding of motor vehicle patterns and individual transportation behaviors
- Knowledge of street and vehicle design

Joint Strategies/Activities

- Incorporate health and safety elements into transportation planning
- Promote complete streets policies
- Connect roadways to complementary systems of trails and bike paths
- Implement smart growth strategies, including transit-oriented developments

Transportation Engineering

Expertise:
Road and sidewalk design that provides safe travel for multiple modes of transportation

Desired Outcomes:
Prevent traffic crashes and reduce severity of injuries if a crash does occur

Key Strategies:
- Promote safety regulations for occupants and vehicles
- Implement street designs that promote safety (e.g., traffic calming)

Optometry

Expertise:
Understanding of how people visualize traffic signs and signals

Desired Outcomes:
- Improved vehicle displays, traffic signals, and road signage
- Better driver assessment for licensing purposes

Key Strategies:
Utilize color and design features to increase driver attention to traffic signals and signs

MOVING FORWARD

Sample Partnership Principles

Convene a meeting with your partners to agree on a set of principles for all members to adhere to during meetings and other interactions. These principles are based on the premise that all members seek, as a partnership, to create initiatives that build on the unique strengths and assets of the local community. To do so, all partners agree to respect the beliefs and cultural norms of others and to build trust and mutual respect to ensure that programs will be maintained and enhanced over time. The following principles may help to start your discussion:

We are committed to equity, collective decisions, and collective action.

- Knowledge originates and resides in all members of a group.
- All partners are encouraged to participate in all phases of the process.
- Information is shared among all partners.
- Differences in interpretation are addressed with respect for all partners.
- Efforts are made to ensure that the language used is heard and understood by all partners.
- Partners will recognize and honor that each partner brings different assets and different needs to the partnership.

We are committed to high-quality, ethical initiatives.

- We are committed to ensuring that no harm, including emotional and physical harm, is done to anyone affected by the initiative.
- We are committed to full and total disclosure of all information related to risk.
- Informed consent protects the initiative partners and participants as well as the affected community.
- Confidentiality will be maintained.
- Partners agree to act in a manner that is respectful to other partners, to the community, and to the organizations they represent.
- Partners will obtain appropriate human subjects review or approval prior to the collection of qualitative or quantitative data.
- Partners will obtain approval from the partnership to use data or publish findings.

We are committed to addressing social inequities that affect health, including those that constrain the meaningful participation of individuals and communities in the decision-making process.

- We are committed to processes that foster inclusion and will work against all forms of exclusion, such as racism, sexism, or homophobia.
- We are committed to ensuring all partners have an opportunity to participate in local governance, such as membership on city councils or school boards.

We will maximize opportunities for learning within the local community and associated organizations.

- We encourage shared leadership (i.e., decision making, meeting facilitation, direction and management of the partnership).
- We encourage shared input into the development, implementation, evaluation, and dissemination of partnership initiatives.
- We will actively seek financial and other resources that can benefit the community. This includes working with local partners to develop applications for funding.

DEVELOPING PARTNERSHIPS AND COALITIONS TO ADVANCE HEALTH EQUITY

PARTNERSHIPS AND COALITIONS CAN HELP ORGANIZATIONS AMPLIFY THE OFTEN UNHEARD VOICES OF POPULATIONS MOST DIRECTLY AFFECTED BY HEALTH INEQUITIES. PARTNERSHIPS AND COALITIONS CAN ALSO WORK TO ACHIEVE EQUITABLE OUTCOMES BY LEVERAGING A DIVERSE SET OF SKILLS AND EXPERTISE. CONSIDER THE FOLLOWING IDEAS TO ENHANCE YOUR PARTNERSHIP AND COALITION EFFORTS AROUND ADVANCING HEALTH EQUITY.

Engage Partners from Multiple Fields and Sectors that Have a Role in Advancing Health Equity

Health inequities do not have a single cause, and public health alone cannot address such inequities. Partner with community, education, housing, media, planning and economic development, transportation, and business partners, and engage these sectors in your coalition. Such multi-sector partnerships can work to improve the underlying community conditions that make healthy living easier, particularly in underserved communities.

Include Partners Working with Population Groups Experiencing Health Inequities

Organizations dedicated to serving these various populations (e.g., people of color, the elderly, people with disabilities, LGBT individuals) may or may not have health-related expertise. However, such organizations often have substantial expertise on the norms, culture, and needs of the populations they serve and can contribute significantly to your efforts.

Establish Mechanisms to Ensure New Voices and Perspectives are Added

Groups that have been collaborating for a long time should be mindful not to exclude potential new partners. Periodically assess membership composition and participation, and evaluate decision-making processes. It may also be necessary to periodically adjust meeting times and locations to accommodate new partners. While important to ensure a diverse partnership, do not assume that individuals from a specific population group can speak for all members of that group. Additionally, be cautious of including community representatives as a symbolic gesture rather than as fully engaged partners.

Develop a Common Language Among Partners from Different Sectors and Backgrounds

Early in the process, establish a shared vision and understanding for the partnership. Plan discussions or trainings to build a common understanding about health equity and the strategies needed to address it. Additionally, establish guidelines for communication, such as spelling out acronyms and avoiding potentially confusing terminology or jargon.

Acknowledge and Manage Turf Issues

Turf struggles may arise over conflicts in ownership, recognition, or resources between organizations. Partners should acknowledge and commit to manage tensions that may arise by anticipating potential turf issues, cultivating trust and respect, and shaping a collective identity. If turf issues arise, a strong, established relationship can create a safe space for partners to address complex issues, competing agendas, and difficult decision making.

Recognize and Address the Power Dynamics in a Partnership

All partners should have an equal opportunity to define issues, create strategies, implement solutions, and make decisions. The different contributions, resources, and expertise each partner brings to the table could be a source of tension or could be leveraged to improve collaborative efforts and outcomes. For instance, without additional resources, some partners may not be able to participate on an ongoing basis due to limited staff and organizational resources. Finding ways to compensate partners (e.g., funding, continuing education credit, travel cost reimbursement, certificates of appreciation) may help provide opportunities for longer-term engagement for some partners. Additionally, partners may be able to cross train each other to build skills in unfamiliar areas, or they may have complementary resources that can be shared.

> "OUR PARTNERSHIPS WILL HAVE TO BE STRONGER IF WE ARE TO HAVE AN IMPACT. WE MUST REACH OUT TO NONTRADITIONAL PARTNERS IN THE PRIVATE SECTOR, INDUSTRY, AND OTHER PARTS OF GOVERNMENT IN THE TRANSPORTATION, EDUCATION, AND JUSTICE SECTORS, FOR EXAMPLE."[24]
>
> — *Dr. David Satcher, Director, Satcher Health Leadership Institute and the Center of Excellence on Health Disparities, Morehouse School of Medicine*

Diverse set of community partners who worked together to increase smoke-free protections for vulnerable populations by implementing a smoke-free campus at Women's Treatment Center in Chicago.

Intentional Recruitment of Partners Working with Underserved Populations—Chicago, IL

Respiratory Health Association of Metropolitan Chicago (RHAMC)

To address tobacco-related health inequities, the Respiratory Health Association of Metropolitan Chicago (RHAMC) and Chicago Department of Public Health have used various strategies to establish diverse partnerships. As part of the partnership process for CDC's *Communities Putting Prevention to Work* program, they took the following actions:

- Established a competitive request for proposals (RFP) process to identify and select appropriate partners. The RFP process was designed to select partners in diverse geographical areas that demonstrated experience in serving populations with disproportionate smoking rates.
- Promoted the RFP beyond traditional channels, including circulating it among current partners and coalitions serving the priority communities.
- Collaborated with city agencies like the Chicago Park District, Chicago Public Schools, and Chicago Housing Authority, as well as community-based social service organizations and community health clinics.
- Established a system to maintain strong partnerships, tracking efforts in underserved communities, and building capacity of community-based organizations through various trainings and technical assistance so they could address tobacco use in the future.

The diverse partnerships developed through this process helped the organization design appropriate strategies to address tobacco-related health inequities.

QUESTIONS FOR REFLECTION: Partnerships and Coalitions

1. Where are we now?

- How do our current partnerships/coalitions reflect the populations experiencing inequities in our community?
- What is the current commitment to advancing health equity among these partners/coalitions? How does this commitment translate into identifiable and measurable activities?

2. How can we build diverse and inclusive partnerships/coalitions?

- What partners are we missing in our network/coalition that should be included?
- What partners do we need to engage in order to address the major social determinants of health impacting our community (e.g., housing, transportation, education, urban planning, business)?
- What are the commonalities in the priorities of potential partners that can serve as levers for collaboration?
- What is each partner's role in addressing health equity?

3. How can we work to engage new partners in a meaningful way?

- What process can we develop to regularly assess our partnerships/coalitions to see who else should be invited to help advance our goals of achieving health equity?
- How can we improve efforts to engage new members in meaningful ways?
- How can we strengthen communication and understanding among partners?

4. How can we anticipate and address group dynamics that may arise?

- What are some of the challenges in collaborating with different partners? Once identified, what steps can be taken to address these challenges?
- What potential issues concern our partners? What issues can be anticipated?
- How can we ensure that all partners meaningfully participate and influence decision making?

5. What are our next steps?

- What can we do differently to improve or enhance our partnerships/coalitions?
- What is our plan of action to implement those changes?

The 5 Conditions of Collective Impact

1. **Common Agenda**
   - **Common understanding** of the problem
   - **Shared vision** for change

2. **Shared Measurement**
   - **Collecting data** and **measuring results**
   - Focus on **performance management**
   - **Shared accountability**

3. **Mutually Reinforcing Activities**
   - **Differentiated approaches**
   - **Coordination** through joint plan of action

4. **Continuous Communication**
   - **Consistent** and **open communication**
   - Focus on **building trust**

5. **Backbone Support**
   - Separate organization(s) with **staff**
   - Resources and skills to **convene** and **coordinate** participating organizations

Collective Impact Principles of Practice

We have been inspired watching the field of collective impact progress over the past five years, as thousands of practitioners, funders, and policymakers around the world employ the approach to help solve complex social problems at a large scale. The field's understanding of what it takes to put the collective impact approach into practice continues to evolve through the contributions of many who are undertaking the deep work of collaborative social change, and their successes build on decades of work around effective cross-sector collaboration. Accomplished practitioners of collective impact continue to affirm the critical importance of achieving population-level change in the five conditions of collective impact that John Kania and Mark Kramer originally identified in the *Stanford Social Innovation Review* in winter 2011. (For an explanation of the conditions, see the end of this document.) Many practitioners tell us that the framework developed in the original article has helped to provide the field with a shared definition and useful language to describe core elements of a rigorous and disciplined, yet flexible and organic, approach to addressing complex problems at scale.

Successful collective impact practitioners also observe, however, that while the five conditions Kania and Kramer initially identified are necessary, they are not sufficient to achieve impact at the population level. Informed by lessons shared among those who are implementing the approach in the field, **this document outlines additional principles of practice that we believe can guide practitioners about *how* to successfully put collective impact into action.** While many of these principles are not unique to collective impact, we have seen that the combination of the five conditions *and* these practices contributes to meaningful population-level change. We hope that these principles help funders, practitioners, and policymakers consider what it takes to apply the collective impact approach, and that they will bolster existing efforts to overcome challenges and roadblocks in their work. We also hope these principles can help guide those who aspire toward collective impact, but may not yet be implementing the approach fully, to identify possible changes that might increase their odds of success. As we continue to apply the conditions and principles of collective impact, we fully expect that, over time, our shared understanding of what constitutes good practice will evolve further.

1. **Design and implement the initiative with a priority placed on equity**. For collective impact initiatives to achieve sustainable improvements in communities, it is critical that these initiatives address the systemic structures and practices that create barriers to equitable outcomes for all populations, particularly along the lines of race and class. To that end, collective impact initiatives must be intentional in their design from the very outset to ensure that an equity lens is prominent throughout their governance, planning, implementation, and evaluation. In designing and implementing collective impact with a focus on equity, practitioners must disaggregate data and develop strategies that focus on improving outcomes for affected populations.

2. **Include community members in the collaborative**. Members of the community—those whose lives are most directly and deeply affected by the problem addressed by the initiative—must be meaningfully engaged in the initiative's governance, planning, implementation, and evaluation. Community members

can bring crucial (and sometimes overlooked) perspectives to governance bodies and decision-making tables, can contribute to refining the collective impact initiative's evolving goals, strategies, and indicators, can help co-create and implement solutions that are rooted in lived experience and have the potential for significant uptake, can participate in building communities' capacity to lead and sustain change, and can participate in data interpretation and continuous learning processes. Sometimes, decision-makers or other stakeholders may inadvertently face power dynamics or other structural barriers that can hinder particular partners from participating candidly and fully; true inclusion requires intentional examination of group needs and processes to ensure that all stakeholders have full opportunity to contribute to the process. Engaging community in these ways helps collective impact efforts address the issues most important to those most directly affected, builds capacity and enables community participation in and ownership of solutions, and helps embed the work in the community so that it will be more effective and sustainable.

3. **Recruit and co-create with cross-sector partners**. Collective impact collaboratives are created by and composed of actors from across sectors and parts of the community, including nonprofits, government, private sector, philanthropy, and residents. While not all initiatives will engage *all* sectors actively at the same time, collaboratives made up of only one or two types of actors (e.g., all nonprofits, all funders) do not have the diversity of actors required to create the systems-level view that contributes to a robust collective impact initiative. These cross-sector partners, who all have a role to play in the solution, share in co-creating the common agenda, identifying shared measures, and implementing the work required to achieve the effort's goals.

4. **Use data to continuously learn, adapt, and improve**. Collective impact is not a solution, but rather a collaborative problem-solving process. This process requires partners to remain aware of changes in context, to collect and learn from data, to openly share information and observations with others, and to adapt their strategies quickly in response to an evolving environment. To accomplish this, initiatives should have clear learning priorities, build strong structures and processes for learning, and create a learning culture that enables the group to use meaningful, credible, and useful qualitative and quantitative data for continuous learning and strategic refinement. Many initiatives find it valuable to use a disciplined and formalized process to guide their use of data.

5. **Cultivate leaders with unique system leadership skills**. For collective impact initiatives to achieve transformational change, leaders must possess strong facilitation, management, and convening skills. They must be able to create a holding space for people to come together and work out their disparate viewpoints, they must possess the capacity to foster shared meaning and shared aspirations among participants, they must be able to help participants understand the complexity and non-linearity of system-level change, they must be dedicated to the health of the whole and willing to change their own organizations in service of the group's agenda, and they must be adept at building relationships and trust among collaborators. These system leadership skills are essential for the backbone, and also other leaders in the collaborative such as steering committee members, community leaders, and action team leaders.

6. **Focus on program *and* system strategies**. The mutually reinforcing activities that the initiative takes on to achieve its goals should focus on collective program and system change strategies rather than individual programs or organizations. System strategies include strategies that increase communication and coordination across organizations, change the practices and behavior of professionals and beneficiaries, shift social and cultural norms, improve services system wide (by spreading techniques that already work within the community across organizations, or by bringing a new evidence-based practice into the community), and change policies.

7. **Build a culture that fosters relationships, trust, and respect across participants**. Collective impact partnerships require participants to come to a common understanding of the problem and shared goals, to work together and align work in new ways, and to learn from each other. Authentic interpersonal relationships, trust, respect, and inclusion are key elements of the culture that is required for this difficult work to occur. The backbone and other initiative leaders must be proactive in their efforts to create this culture.

8. **Customize for local context**. While the five conditions are consistent across collective impact initiatives, and initiatives benefit a great deal by learning from each other, customizing the initiative for the local context is essential. Initiatives can do their best work when they deeply understand the problem they are trying to solve locally—both from the data and input from the community and from understanding the existing work and coalitions that may be working on similar issues. Customizing the work to fit the local community context enables the coalition to honor, build on, and/or align with existing work and pursue system and program strategies that are most relevant to local needs.

These principles of practice were identified based on the work of the field of practitioners by the Collective Impact Forum in partnership with the Aspen Institute Forum for Community Solutions, FSG, the Forum for Youth Investment, Grantmakers for Effective Organizations, Living Cities, PolicyLink, the Tamarack Institute, and United Way Worldwide.

Five Conditions of Collective Impact

While our understanding of how to put collective impact into practice has deepened and expanded, the five conditions outlined in the original article *Collective Impact* remain the core of the approach.

- Common Agenda: All participants have a shared vision for change that includes a common understanding of the problem and a joint approach to solving the problem through agreed-upon actions.
- Shared Measurement: Agreement on the ways success will be measured and reported, with a short list of common indicators identified and used across all participating organizations for learning and improvement.
- Mutually Reinforcing Activities: Engagement of a diverse set of stakeholders, typically across sectors, coordinating a set of differentiated activities through a mutually reinforcing plan of action.

- Continuous Communication: Frequent and structured open communication across the many players to build trust, assure mutual objectives, and create common motivation.
- Backbone Support: Ongoing support by independent, funded staff dedicated to the initiative, including guiding the initiative's vision and strategy, supporting aligned activities, establishing shared measurement practices, building public will, advancing policy, and mobilizing funding. Backbone staff can all sit within a single organization, or they can have different roles housed in multiple organizations.