HEIA

HEALTH EQUITY IMPACT ASSESSMENT

IMPLEMENTATION GUIDE

NOVEMBER 2021

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Introduction: An Overview of the Health Equity Impact Assessment

The **Health Equity Impact Assessment** (HEIA) is a step-by-step guide to help facilitate conversations about factors that support or weaken health, including the **root causes** of disparities and inequities, with your team. Information gathered throughout this process will provide community perspective and guide your team in strategic planning to improve an existing or proposed **public policy/program**. Feel free to adapt the steps in the guide to best fit your team's needs.

During the HEIA, your team will:

- **Analyze data** to determine potential impact of **policies/programs**.
- **Involve stakeholders and impacted populations.** Effective **health equity** assessments require early and continued involvement of members of impacted communities. It is important to have knowledge of the community and to gain their perspective on current policies and programs as well as understand the potential impacts on the community, both positive and negative.
- **Identify** ways to change current or proposed policies or programs to ensure they reduce **health disparities** and **inequities**, **NOT** make them worse.
- **Provide information** on uneven impacts on various populations or communities.
- **Recommend changes** to policies or programs that promote equity and ease negative impacts.

The HEIA tool consists of three pre-work steps, four action steps, a **Glossary**, and **Appendices**. There is also a companion Facilitator's Guide. Words that are underlined, bolded and in dark blue font are found in the **Glossary**.

HEIA PRE-WORK

A small **leadership team** will complete two of the Pre-Work activities prior to the implementation of the HEIA.

PRE-WORK A: IDENTIFY THE POLICY/ PROGRAM AND IMPLEMENTATION TEAM

During Pre-Work A, the leadership team will identify both the **policy/program** to be reviewed using the HEIA and the participants who are needed to implement the assessment (**implementation team**).

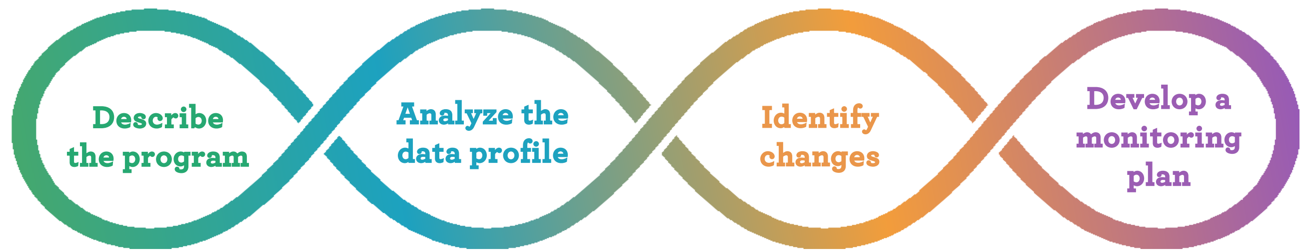
PRE-WORK B: SELF-ASSESSMENT/PREPARING YOUR TEAM

The purpose of Pre-Work B is to provide opportunities for team members to enhance their knowledge and skills associated with health equity, **health disparities**, and **implicit biases**. These resources are for both the **implementation team** and the leadership team members.

PRE-WORK C: PREPARE YOUR DATA PROFILE

The purpose of Pre-Work C is to engage the leadership team in collecting and analyzing data by race/ethnicity and other key demographic factors to identify **health disparities** and understand the complex factors that contribute to **health inequities** across groups of people.

The Action Steps of the HEIA on Implementation Day(s)



- Action Step 1: Describe the current policy or program
- Action Step 2: Analyze and interpret the data profile
- Action Step 3: Identify changes
- Action Step 4: Develop a monitoring plan

The four Action Steps of the HEIA will be completed jointly by the leadership team and the **implementation team** on the day of the assessment. It is strongly encouraged to implement Action Steps 1 – 4 of the HEIA at the **same time** with the **same group** of people, but if you need more time, the HEIA can also be broken down and implemented over a series of days. Based on experiences piloting the HEIA, it will take approximately five hours to implement all four Action Steps of the HEIA, including break time.

Prior to implementing the HEIA with your **implementation team**, the leadership team should develop a contingency plan for completing the HEIA and what they would suggest to the **implementation team** if they cannot get through Action Step 4.

In addition, if the leadership team decides to conduct the HEIA implementation on multiple days, make sure time is set aside each day to review and summarize material covered previously. It is advisable to complete a full step before ending an implementation day. Failure to complete a full step may lead to confusion at the next implementation day.

Pre-Work A: Identify the Policy/Program and Implementation Team

Purpose: Pre-Work A provides guiding questions to answer about the policy/program that will be assessed and information about recruiting the right people to be on the implementation team.

The success of a HEIA is highly dependent on knowing what the **policy/program** is you want to assess and having the right people at the table throughout the assessment process.

Many **policies/programs** are broad, containing a number of components that must be implemented in order to achieve the given outcome. It is recommended that instead of focusing on the larger, broader **policy/program**, the **leadership team** narrow the focus to one to two components of the **policy/program**.

EXAMPLE

The program to be assessed: Breastfeeding in X county.

The program has a number of components including increasing initiation and duration of breastfeeding, increasing the number of women who breastfeed for at least 6 months, and increasing the number of breastfeeding friendly businesses.

It is likely not feasible to focus on disparities among all these components, as each could involve different actors and may require different data. Instead choose one or two of these components to be the focus of the HEIA.

OVERVIEW OF POLICY OR PROGRAM TO BE ASSESSED

The leadership team should meet and answer the questions below in order to prepare an overview of the **policy** or **program** to be assessed. It is important to be able to provide a document that answers the "who-what-where-when-and-why" of the **policy/program** to be assessed. This information will be shared with the **implementation team** on the day of the assessment.

a. What is the name of the policy/program?
b. What is the goal? What outcomes are expected?
c. Who was involved in the creation of the policy/program?
d. Has this program/policy been attempted previously in this community? In other communities? What were the effects?

e. How is it funded?
f. Are there specific measures of success for the policy or program?
g. Currently, who is the **priority population** (i.e., race/ethnicity, SES, age, geographic location, individuals with disabilities etc.) affected by the policy or program?
h. What mechanisms are being utilized to achieve the goals and outcomes (i.e., outreach, education, counseling, media, etc.)?
i. Where do activities currently take place (i.e., health department, community, faith-based organization, worksites, etc.)?

IDENTIFYING THE APPROPRIATE PARTICIPANTS

After the overview is prepared, the leadership team will complete the **Participant Identification Table**. This will ensure the correct people can be engaged and be invited to the table. **The success of the HEIA is highly dependent on having the right people at the table during the implementation.**

Who: Think about what groups of people are already working on the **policy/program** to be assessed (e.g., faith-based organizations, civic groups, community leaders, community organizations, other public and private health care agencies, schools, etc.). Inviting people from these organizations to participate in the HEIA will reduce unnecessary replication of efforts.

Perspective: It is important to think about the perspective each person brings on the day of the HEIA. Having more than one person with the same/similar perspective is important. Be intentional about whom you invite, particularly when thinking about members of the **impacted community**. Remember, one person from a certain impacted community does not represent the entire community. Be cautious not to generalize. **It is important that the table reflects the diversity (racial/ethnic, gender, socioeconomic, individuals with disabilities, etc.) of the community.** This group becomes your **implementation team**.

Hat: When recruiting people to participate, talk with them about their area of expertise and what role they believe they can fulfill. **Encourage each person to commit to wearing one "hat" during the implementation.** This can be difficult because many of the team members you invite could potentially represent more than one role, but for the purposes of the HEIA, identifying the "hat" each person will wear ensures broad participation and encourages team members to appreciate the expertise of the other team members.

EXAMPLE

The program to be assessed: the initiation and duration of breastfeeding in X county.

You invite an African American female pastor from a rural community in X county who happens to also be a new mother. Will her role be a pastor from the local church and a community leader, or is her role a currently breastfeeding or non-breastfeeding mother of an infant?

Either of these roles is perfectly acceptable, but the leadership team should know in advance of inviting her what role they think she could fill on the team. The leadership team and the potential participant can then work together to agree on the "hat" she will wear during implementation.

Below are definitions of the various roles that might be needed during the implementation, but this is not an exhaustive list. It is a good idea to define the role before reaching out to potential recruits.

- **Providers**: People who are on the frontlines carrying out the day-to-day work (e.g., teacher, health care provider, community health worker, public health program manager, etc.).
- **Community Member**: People who use the services your policy/program seeks to implement or change. They may be disproportionately impacted by the issue. There should be at least three to four people from this group at the table. Depending on their knowledge and experience working with groups made of up both professional and lay people, an orientation with someone from the leadership team should be conducted in advance of the implementation of the HEIA. An orientation may include background on the policy/program, the HEIA, **health equity**, acronyms used, who will be at the table, etc.
- **Key Decision Makers**: People who have the influence or power to create, change and set policies.
- **Community Experts**: Gatekeepers or people who have the trust and respect of the priority or impacted community and can mobilize action.
- **Advocates**: Individuals who support or oppose causes or policies in the interest of particular communities, groups, or issues.
- **Content Experts**: People who have a command of research, policy, and practice who can speak to the nuances of how each of those things work. Content experts are people who may know the issue best.
- **Convening Agency/Organization Staff**: The staff members at the agency or organization that initiate and execute the implementation of the HEIA.

PARTICIPANT IDENTIFICATION TABLE				
Role (Hat)	**Name of People to invite**	**Area of expertise**	**Who is extending the invitation?**	**Agreed to participate?**
Content Experts				
Providers				
Community Experts				
Key Decision Makers				
Community Members				
Advocates				
Convening Agency/ Organization Staff				

Pre-Work B: Self-Assessment/Preparing Your Team

Purpose: Provide opportunities for team members to enhance their knowledge and skills associated with health equity, health disparities, and implicit biases.

Discussing and working on **health disparities** and **health equity** can be challenging and messy. Both the leadership team and **implementation team** should be prepared for this work. Review the following resources to learn about **health equity** and **health disparities**. Additional resources can be found in Appendix A: Self-Assessment Resources for use as needed.

- **Dr. Camara Jones Explains the Cliff of Good Health.** *(2012).* This brief video examines the importance that everyone should have the opportunity to achieve good health. As a society, we need to address the **social determinants of health** (SDOH) by addressing the disparities and inequities in our systems. www.urban.org/policy-centers/cross-center-initiatives/social-determinants-health/projects/dr-camara-jones-explains-cliff-good-health
- **The Tale of Two Zip Codes** *(2016).* "What determines how long we live? The surprising thing to us was that adjacent communities can have a 15 year-difference in life expectancy. Your preconditioned brains might attribute this to dramatic factors like drugs and violence (ours did). But the causes are actually more sinister: heart disease, obesity, and diabetes, all of which can be linked to Chronic Stress and stem directly from economic inequality. So we are all implicated… and we hope you learn as much from this 4-minute video as we did in the 15 years it took us to make it." Video Link: https://vimeo.com/165205891
- **The Unequal Opportunity Race** *(2010).* Developed by the African American Policy Forum, this video shows metaphors for obstacles to equality which affirmative action tries to alleviate. Video Link: www.youtube.com/watch?v=vX_Vzl-r8NY
- **Implicit Bias** Implicit bias refers to the unconscious attitudes and associated stereotypes about categories of people [Godsil, Tropp, Goff, & Powell (2014)]. Becoming aware of one's own implicit associations and biases allows us to understand unconscious preferences for one race or identity group over another. This knowledge will allow us to make better-informed decisions as we proceed with this process. Follow this link to explore implicit biases related to race, gender, disability, and more: www.implicit.harvard.edu/implicit/takeatest.html.
- **Robert Wood Johnson Foundation** *What is Health Equity? And What Difference Does a Definition Make?* To read this article, visit: www.rwjf.org/en/library/research/2017/04/what-is-health-equity-.html

Pre-Work C: Compile Your Data Profile

Purpose: Collecting and analyzing data by race/ethnicity and other key demographic factors (such as literacy, language preference, place of birth, etc.) is critical in identifying health disparities and understanding the complex factors that contribute to health inequities across populations.

Pre-Work C is a three-part activity to compile and interpret data that will give the **implementation team** an overview of the **policy/program** they will assess. **Pre-Work C must be done prior to Action Step 1 of the HEIA process**. The process of identifying, analyzing, and interpreting data takes time. Make sure that sufficient time is given to complete this Pre-Work step. Enlist specialists to help if necessary. As you collect the data, consider the following:

- Gathering demographic data about the **priority population**s affected by an agency or program's policies is vital to recognizing **health disparities** and inequities.
- Information on the community and broader factors associated with the **priority population** should be gathered and analyzed as well.
- Identifying and interpreting the data allows for deeper thinking about whether the **policies/programs** that are in place are needed and/or if revisions are required.

The following types of information should be included in your Pre-Work C analysis:

- **Quantitative Data** are data that can be counted and measured, and are often expressed as numbers. Examples are surveillance data, administrative data, vital statistics, or survey statistics that capture dimensions that can be measured.
- **Qualitative Data** are descriptive data that can be categorized based on characteristics and identifiers. These data are often generated through focus groups, community conversations, listening sessions, surveys, and key informant interviews.

For more information on gathering **qualitative data**, see Chapter 3, Section 15. Qualitative Methods to Assess Community Issues in The Community Tool Box developed by the Kansas University Center for Community Health and Development: https://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources.

Part 1: Restate the policy/program. Include a brief description of what the policy/program is. The leadership team stated the policy/program in Pre-Work A. An example of a policy/program to address is below.

EXAMPLE

Problem: Breastfeeding

What we know: Early and exclusive breastfeeding can improve infant health and reduce infant death. There are disparities in breastfeeding rates. We know that infant mortality is higher in some populations than others.

Part 2: **Decide what data are needed and available. Decide how data will be collected**. Information about the community, county, state can be included in the data profile. Data should be specific to what you are trying to learn about the current state of the policy/program and should be stratified by demographic factors as much as possible.

The **Key Factors Checklist** found below can be used as a guide to make sure you are thinking about a broad range of disparities that might be associated with the problem. Data for all of these factors will probably not be available, but look through the checklist to determine which factors are the most important to consider with regard to the policy/program. Be as specific as possible when providing information on the key factors.

KEY FACTORS CHECKLIST			
Individual/Demographic Factors (Describe population by a breakdown of these factors)			
	Race		Marital Status
	Ethnicity		Home Ownership
	Gender		Education Level
	Age		Parenting (single or co-parenting)
	Household income (for a family of four)		Employment
	Medical Insurance		Geographical Location (rural, urban)
	Parity (pregnancies reaching viable gestational age – includes live birth and still births)		Individuals with Disabilities (access and utilization)
Community/Structural Factors			
	Neighborhood and Community Supports (safe and quality indoor and outdoor public areas, community-based recreation, proximity to communities of support services, accessible transportation, clean air and water, accessible public libraries, access to healthy foods)		
	Cultural (regulations presented in language(s) most commonly spoken, honor cultural holidays and traditions, wear traditional clothing without repercussion)		
	Educational (quality, accessible, affordable early childhood education, elementary and secondary public education, advanced training or college)		
	Jobs and Economic Security (available jobs, access to work, training, transportation, livable wages, affordable basic needs, ability to save money)		
	Health/Healthcare (accessible, affordable, attainable)		
	Housing (affordable, safe, clean living environments, residential integration)		
	Public Services and Supports (law enforcement, emergency medical services (EMS), fire stations, code enforcement)		
	Tax Incentives (credits, subsidies, exemptions, abatements)		
	Zoning and Planning (voting districts, sidewalks, infrastructure planning)		

Now that you have identified individual/demographic and community/structural factors, it is time to think about the specific data you need to better understand the **policy/program**. The following are questions to be considered:

1. What data do we need to learn more about the policy/program?
2. How will this data help us learn more about the policy/program?
3. Where could we find this data?
4. Who will coordinate gathering and analyzing the data?

The example below highlights one method of streamlining the data collection using the Streamlining the Data Collection Process Table. See Appendix B for a list of North Carolina data sources.

EXAMPLE

Problem: Breastfeeding

STREAMLINING THE DATA COLLECTION PROCESS TABLE			
What data do we need to learn more about the policy/program?	**How would this data help us learn more about the policy/program?**	**Where could we find this data?**	**Who will coordinate gathering and analyzing the data?**
Initiation and duration status by race/ethnicity, SES. Age.	Identify populations with lowest and highest rates	County WIC agency; NC State Center for Health Statistics	Ms. Smith – WIC Coordinator
# of trained lactation consultants in X county and where they work	Identifies resources available to women in county	County WIC agency; NC DPH /WCHS/Nutrition Services Branch	Ms. Smith – WIC Coordinator Ms. Jones – Regional Breastfeeding Coordinator
Reasons cited by women of various demographic groups for not breastfeeding, etc.	Identify barriers to breastfeeding	LHD or WIC Agency surveys or results from focus groups; journal articles; Carolina Global Breastfeeding Institute	Ms. Smith – WIC Coordinator; Nutrition student intern with LHD

STREAMLINING THE DATA COLLECTION PROCESS TABLE			
What data do we need to learn more about the policy/program?	How would this data help us learn more about the policy/program?	Where could we find this data?	Who will coordinate gathering and analyzing the data?

Important considerations when collecting data:

- **Just because you have the data does not mean you have to present it all.** Remember that even though we can get the data, understand the data, and provide the data to the **implementation team** members – we should only present the data that helps us answer the questions around the policy/program we are assessing.
- **Use trend data.** Data should be for more than just one-time period when possible. Looking at 5- or 10-year trend data may be important to understand the scope of the issue.
- **Stratify data.** Stratifying data means breaking it down into subpopulations. Data should be presented at the state level, county level, zip code, or census tract level whenever possible, as well as by race/ethnicity, age, gender, education, insurance status, employment, home ownership, disability status, and other **social determinants** that affect the subject.
- **Compare data.** State data can be compared to national data; county data to state data; and zip code (or census tract) to other zip code (or census tract) data. It will be difficult to know if one population is different if we do not compare it to another. Be sure to use consistent data sources for comparison data (compare "apples to apples").
- **Present the data in an easy to understand format.** It is important to remember that everyone around the implementation table may not be well versed in data.
  - Summarize the data into simple tables and graphs that tell a story.
  - Interpret the data using everyday language.
  - Find examples that are easy for the average person to understand.
  - Make comparisons of one group to another

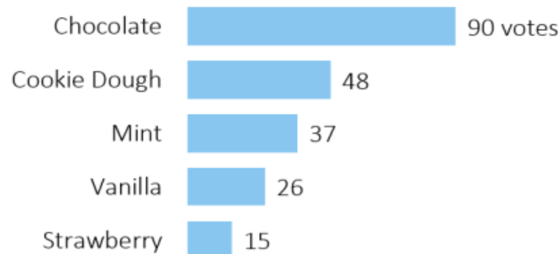
Step 3: **Construct the data profile**. Use charts, tables, or graphs in the data profile to explain the policy/program as simply as possible. You will use this profile in Action Step 2 of the assessment.

Remember the data should tell the story of the policy/program and how it impacts the affected community. The data profile should include both positive and negative findings. Here are a few examples of compelling ways to display data from Ann K. Emery with graphs that present the data as-is on the left and her improved graphs which help interpret the data on the right. She uses several techniques including descriptive titles and subtitles, annotations, and saturation to help tell a story. For more information about data visualization from Ann Emery, check out this website: https://depictdatastudio.com/data-visualization-design-process-step-by-step-guide-for-beginners/.

TIP!

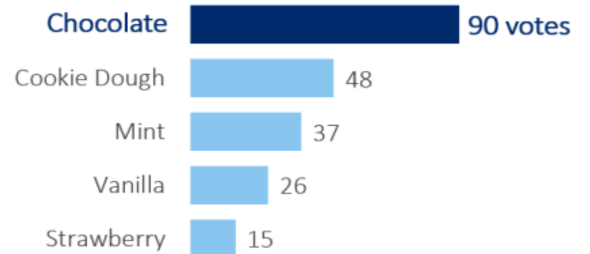
Consider providing copies of the data profile to the implementation team in advance of the meeting!

Ice cream flavor preferences based on 2014 survey of elementary school students (n=216)



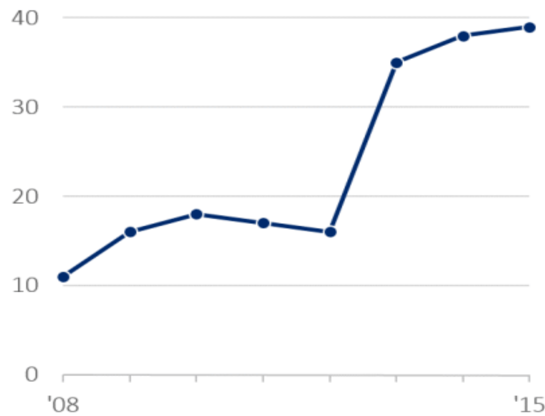
or

Chocolate was most popular flavor
among elementary students surveyed



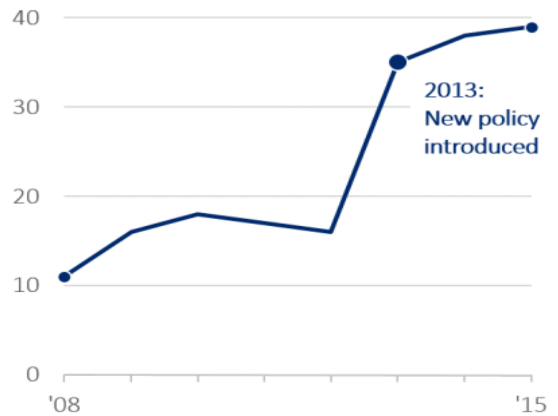
Source: 2014 survey of elementary school students (n=216)

Number of studies funded each year



or

We're funding more studies each year
Beginning in 2013, we set aside new funding to measure the effectiveness of our initiatives – and we evaluated 39 of our programs in 2015 alone.



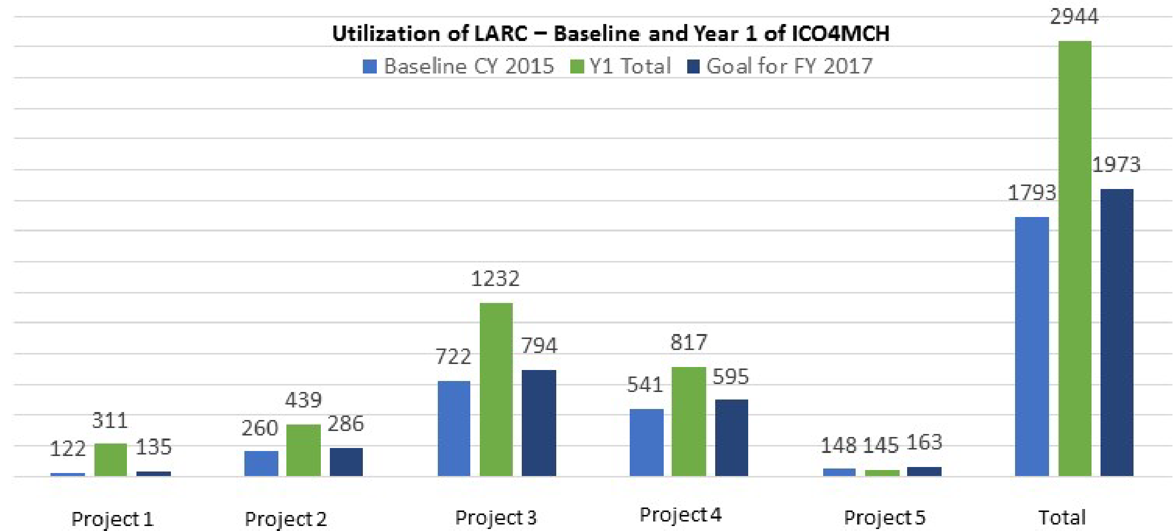
One way to display data is to use a data placemat. A data placemat is an activity that provides an opportunity to reflect on a set of data that is presented in a visually stimulating way. On the data placemat, specific questions are asked about the data, allowing participants to come to conclusions on their own that will determine implications for future decisions.

LARC

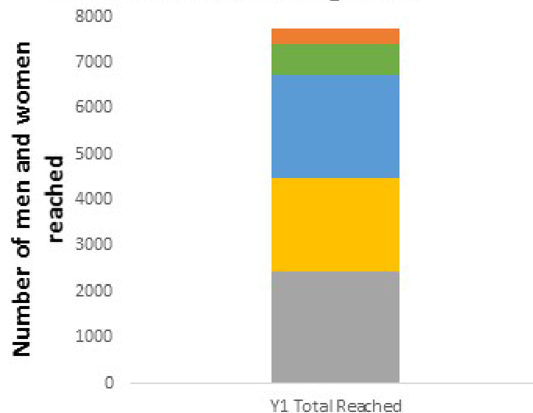
Answer the following questions for each performance measure:

1) What do the data tell you?
2) Was the performance measure met?
3) What questions do you have about the data? The performance measure?

Performance Measure 1: Increase the number of local health department clients who receive long-acting reversible contraception (LARC) by 10% by May 31, 2017.



Performance Measure 2: Increase the number of men and of women of childbearing age who are reached through education and outreach events by 15% by May 31, 2017.



Performance Measure 5: Increase the number of local health departments and community health care practices such as OB/GYN, pediatric offices, family medicine, FQHC/community/rural/migrant health centers/clinics who offer same day insertion of LARC by 15%. (*Baseline: Shown here, Year 1 of the Health Care Provider Survey*)

Action Step 1: Describe the Current Policy/Program

Purpose: Ensure that all implementation team members understand the policy/program that will be assessed using the Health Equity Impact Assessment (HEIA) tool.

Review the document prepared in Pre-Work A identifying the **policy/program**. Ask any clarifying questions to better understand the rationale for selecting the policy/program and details of the **policy/program**. Write down the **policy/program** in the space below.

POLICY/PROGRAM:

Action Step 2: Analyze and Interpret the Data Profile

Purpose: To develop a specific problem statement for the policy/program using the data profile completed in Pre-Work C.

By the end of Action Step 2, your team will have a clear understanding of what is contributing to any inequities of the **policy/program** being assessed. The problem statement will provide the foundation for Action Steps 3 and 4.

Below are examples of questions your team should be able to answer by the end of Action Step 2. This outline may not contain all the information needed to develop the specific problem statement. Add or delete questions as necessary.

1. What subgroups make up your priority population and/or community?
2. What would happen if the policy or program was successfully implemented?
3. Which population experiences the best related health outcomes that the policy/program is trying to address? Why?
4. Which population experiences the worst related health outcomes that the policy/program is trying to address? Why?
5. Are there geographic locations or clusters of disparities? If so, where and why?
6. What other relevant disparities do you observe in the data (e.g., differences by age, gender, nativity, etc.)?

2A. PRESENT THE DATA PROFILE

Share the data profile and discuss some of the following questions as a large group or in smaller discussion groups. Consider what other questions you have about the data profile.

1. What patterns did you see in the data?
2. What inequities are apparent or should be considered?
3. Is there anything about the data that does not line up with your perception of the issue?
4. What is the big takeaway from the data?
5. What was most surprising about the data?
6. What other data might help us better understand this issue?

2B. DEVELOP A PROBLEM STATEMENT THAT ADDRESSES THE INEQUITIES

Now that you have examined the data profile and had group discussion, the team is ready to develop the problem statement. Be sure to include the **quantitative** and **qualitative** information from the data profile, as well as answer the questions who, what, where, when, why, and how. Make the problem statement as concise and understandable as possible.

ORIGINAL PROBLEM STATEMENT:

2C. IDENTIFY ROOT CAUSES

A **root cause** is one of many factors that contributes to or creates an undesired outcome and, if eliminated, would have prevented the undesired outcome. In other words, **root causes** are the conditions in a community that determine whether people have access to the opportunities and resources they need to thrive.

One way to determine root causes is to use the **"But Why"** technique:

1. State the policy/program you are assessing. Summarize the existing problem statement.
2. Someone in the group takes the lead and begins the dialogue of "but why is **X** a problem?"
3. Repeat this back-and-forth process with the team until the potential responses are exhausted and the answers have sufficiently uncovered the multiple paths that could address getting to the underlying causes of the problem.
4. This technique will lead to multiple solutions and paths. You will utilize this information in the next steps to further identify which solution(s) will be a better fit.

More information about this technique can be found in this video: https://ctb.ku.edu/en/table-of-contents/analyze/analyze-community-problems-and-solutions/root-causes/main

EXAMPLE

Program to be assessed: Breastfeeding initiation.

Problem statement: Early and exclusive breastfeeding can improve infant health and reduce infant death. There are racial/ethnic disparities in breastfeeding initiation rates in our county as fewer non-Hispanic African American, and non-Hispanic American Indian mothers initiate breastfeeding compared to white mothers.

"But Why" Technique

Q: But why?

A: They do not get sufficient support in the hospitals.

Q. But why?

A: People think African American and American Indian women don't want to breastfeed.

Q. But why? …

2D. REVISE THE PROBLEM STATEMENT

Knowing more about the **root causes** after completing the **"But Why"** activity, it is time to look at the problem statement again to see if it should be revised. Be sure to include the **quantitative** and **qualitative** information from the data profile as well as answer the questions: who, what, where, when, how, and why. Make it as concise and understandable as possible. Ensure the problem statement is associated with the policy/program being assessed.

EXAMPLE

Program: Breastfeeding.

Original Problem Statement: Early and exclusive breastfeeding can improve infant health and reduce infant death. There are disparities in breastfeeding initiation rates in X county by race/ethnicity as fewer African American mothers initiate breastfeeding.

Revised Problem Statement: In the US and North Carolina (NC), minority-women, specifically African American (AA) and American Indian (AI) women, experience higher rates of infant mortality and lower rates of breastfeeding at initiation and one year. Breastfeeding is protective against infant mortality. The infant mortality rate among AA and AI in NC is 2.5 times higher compared to white infants (year). In X county, the same holds true. The infant mortality rate among AA is X per 100,000 and Y per 100,000 for AI compared to Z per 100,000 among white infants (year). In NC, the initiation and 6-month rates are X% and Y% for AA and AI women, compared to white women (Z%), respectively (year). The initiation and 6-month rates for AA and AI women are X and Y at initiation, compared to Z for white women. At six months, the rates are X and Y for AA and AI compared to Z for white women. Key factors such as ... affect breastfeeding rates among minority women.

REVISED PROBLEM STATEMENT:

Action Step 3: Identify Changes

Purpose: With the problem statement in hand, determine what changes need to be made to the policy/program to reduce the root causes that contribute to the health inequities.

3A. IDENTIFY THREE ASSETS OR STRENGTHS AVAILABLE AMONG YOUR PRIORITY POPULATION THAT CAN BE TAPPED INTO.

Prior to addressing the changes, it important to think about and document the assets or strengths within the **priority population**.

3B. IDENTIFY THREE CHALLENGES IMPACTING YOUR PRIORITY POPULATION.

Acknowledging the challenges prior to making changes will help the team examine changes that are realistic within the confines of the community/county.

3C. MAKE A LIST OF POTENTIAL CHANGES.

Brainstorm ideas about what needs to be changed in the **policy/program** to ensure more equitable outcomes. These changes will vary in significance, but no idea is too small or too large to think about.

3D. ASSESS THE FEASIBILITY OF THE PROPOSED CHANGES.

Thinking about the potential changes above, which changes are possible and in your control? Which changes are feasible, impactful, and manageable? Which of the changes are the most urgent?

Two methods of assessment are to create an **Impact Matrix** or conduct a **SWOT (Strengths, Weaknesses, Opportunities, Threats)** analysis. Information on both methods is in Appendix C: Tools to Complete Action Step 3, although other methods will work as well.

Impact Matrix		
	Hard (High Effort)	Easy (Low Effort)
High Impact		
Low Impact		

SWOT Analysis
Strengths
Weakness
Opportunities
Threats

3E. DETERMINE POSITIVE AND NEGATIVE IMPACTS.

Be sure to think about both intended and **unintended consequences** of the proposed changes. **Unintended consequences** are unforeseen positive and negative impacts that are not intended by a purposeful action. Use the following **Impact Category Table** as a guide to identify these impacts prior to deciding which changes to implement. You can use the information from the previous steps to help complete the **Proposed Changes Impact Table**. Not every impact category may need to be addressed but think through each category to determine if there are positive or negative impacts in that realm.

IMPACT CATEGORY TABLE
Cultural: Rules presented in language(s) most commonly spoken; honor cultural holidays and traditions; and wear traditional clothing without repercussion
Educational: Quality; culturally appropriate; close the education gap; accessible; affordable early care; public education; advanced training or college
Jobs and Economic Stability: Economic development; job training; livable wages; investment in community building; urban renewal; training; support working families; training; transportation
Health/Healthcare: Accessible; affordable; attainable
Housing: Affordable; safe; clean living environments; community supports; conditions surrounding homes
Neighborhoods and Community Supports: Safe, healthy, and quality indoor/outdoor public areas; community-based recreation; support services proximity to communities; strengthen father involvement; zoning and tax codes (voting districts, sidewalks, infrastructure planning); coordination and integration of family support services; promotion of health prevention; tax incentives (credits, subsidies, exemptions, abatements)
Public Services and Supports: Law enforcement that promotes equitable access and fair treatment; EMS; fire stations; code enforcement; transportation; organizational support that assesses and eliminates international and unintentional policies or practices that have negative impacts related to race/ethnicity; gender; national origin; disabilities; sexual orientation; gender identity

EXAMPLE

Problem: Disparities in breastfeeding rates among African American and American Indian Women

Proposed Changes Impact Table			
Proposed Change	**Impact Category**	**Positive Impact**	**Negative Impact**
Provide a peer educator from the local health department to visit the prioritized population's neighborhood every Saturday to provide support and information to breastfeeding or pregnant mothers.	Housing Healthcare	Increased access to breastfeeding information and built in support system with other new mothers	Cost/effort to hold trainings outside of WIC clinic hours and in different location

PROPOSED CHANGES IMPACT TABLE			
Proposed Change	**Impact Category**	**Positive Impact**	**Negative Impact**

3F. DESCRIBE THE AGREED UPON CHANGES AND DEVELOP AN ACTION PLAN.

Provide specific and detailed notes regarding your rationale for proposing the above changes to the policy/program. Complete the **Action Plan Table** or choose your own way of documenting this information. Keep in mind, one change may have multiple action steps, intended outcomes, timelines, and leads.

Consider:

- What are the action steps and intended outcomes?
- By when do you want to accomplish each action step, and who is the lead person driving the action?

Continue this process until there is an action plan for each change.

EXAMPLE

Problem: Disparities in breastfeeding rates among African American and American Indian Women

Action Plan Table				
Changes	**Action Steps**	**Intended Outcome**	**By When**	**Lead Person**
Provide a peer educator from the LHD to visit the prioritized population's neighborhood every Saturday to provide support and information to breastfeeding or pregnant mothers.	1. Identify the prioritized neighborhood and meeting location 2. Find local champion in priority neighborhood 3. Meet w/ WIC director to adjust peer educator's schedule	1. Neighborhood and meeting location identified 2. Champion identified 3. Meeting held, & permission granted	Within 30 days for all three action steps	1. LaDonna Smith (Community Outreach Worker) 2. LaDonna Smith 3. Jane Watson (Breast-feeding Coordinator)

ACTION PLAN TABLE				
Change	**Action Steps**	**Intended Outcome**	**By When**	**Lead Person**

3G. IDENTIFY POTENTIAL UNEQUAL IMPACTS.

Unequal impacts are negative effects on one group of people versus another in employment, housing, health, education, etc. It is possible that even with changes to a policy/program, unequal impacts may come up. How will you handle **unequal impacts** should they come up? Please write your ideas in the box below.

IDENTIFYING AND ADDRESSING POTENTIAL UNEQUAL IMPACTS:

Action Step 4: Develop a Monitoring Plan

Purpose: To develop an accountability plan to continue to monitor the impact of the revised policy/program, the changes, and ensure that unequal impacts and negative unintended consequences are assessed and remedied.

4A. DEVELOP A MONITORING PROCESS.

The monitoring process will help to determine if the changes had the intended outcomes and how any **unequal impacts** or negative **unintended consequences** were addressed. The development of an accountability plan is essential to ensure that the changes get made to the revised **policy/program** and that communication continues with the impacted communities, partners, and **stakeholders**. To ensure the documentation of the process and next steps, there are two tables below that might be useful.

Complete the **Monitoring Process Table** to identify who will lead this process, when the Action Plan completed in Action Step 3 will be reviewed and by whom, and how the outcomes of the changes will be shared with the impacted communities, partners, and **stakeholders**.

The **Monitoring Plan Table** is one tool that could be used in the process when reviewing the Action Plan Table. The Table provides a space to document each change, the intended outcome, whether the intended outcomes were achieved, and a description of any **unequal impacts** or **unintended consequences** and how they were addressed.

MONITORING PROCESS TABLE	
Who will lead this process?	
When will the Action Plan be reviewed?	
Who will review the Action Plan?	
How will the outcomes of the changes to the plan be shared?	

MONITORING PLAN TABLE			
Changes	**Intended Outcome**	**Outcome Achieved**	**Describe any unintended consequences or disparate impacts and what was done about them**
		☐ Yes ☐ No Why or why not?	
		☐ Yes ☐ No Why or why not?	
		☐ Yes ☐ No Why or why not?	
		☐ Yes ☐ No Why or why not?	

4B. DEVELOP A COMMUNICATION PLAN.

A communication plan is essential to ensure that feedback to the impacted community, partners, and stakeholders occurs. Determine how the information will be communicated regarding the revised policy/program, the changes, and the outcomes (e.g., list documents to be shared by what means – email, flyers, social media, etc.; dates and locations for meetings with impacted communities, partners, and stakeholders). Write your answers in the box below.

COMMUNICATION PLAN:

CONCLUSION

As you conclude, take a moment to reflect on the assessment and the process. Consider the following questions:

- What is one word that represents how you feel about our accomplishments today?
- What went well during this assessment process?
- What could be improved when we get back together next time?

Glossary

Advocates – Individuals who support or oppose causes or policies in the interest of specific communities or groups.

Community Experts – People who have the trust and respect of the community and can mobilize action. They can also be identified as consumers or people from the priority population/community that use available health and human services.

Content Experts – People who have a command of research, policy, and practice that can speak to how each of those things work. The person who knows the issue best.

Health Disparities – Differences in health outcomes and their causes among groups of people that are related to social or demographic factors such as race, gender, income or geographic region.

Health Equity – When everyone has the opportunity to be as healthy as possible.

Health Equity Impact Assessment – A tool that enables decision makers to intentionally focus and align strategies to reduce health inequities.

Health Inequities – Unfair health differences closely linked to social, environmental, or economic disadvantages that adversely affect specific groups of people.

Impact Matrix – A tool that will allow users to decide which of many suggested solutions to implement. It provides answers to the question of which solutions seem easiest to achieve with the most effects.

Implementation Team – A group of people brought together for the purpose of implementing the Health Equity Impact Assessment. The team consists of stakeholders, community experts, content experts, providers, etc. who are knowledgeable about the policy/program being assessed.

Implicit Biases – The attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. The biases can be favorable or unfavorable assessments that are involuntary and occur without an individual's awareness or internal control.

Key Decision Makers – People who have the influence or power to create change and set policies.

Leadership Team – A small group of people who come together to address a policy or program in their community (or service area) that may be negatively affecting impacted communities and resulting in negative unintended consequences. This group is responsible for recruiting and engaging stakeholders, community experts, content experts, providers, etc. who become the implementation team.

Priority Populations or Impacted Communities – A group of people or communities that are identified as the intended recipient of a policy or program.

Program – A defined set of activities implemented in response to needs within a community or target population.

Providers – People who are on the frontlines carrying out the day-to-day realities (e.g., teacher, health care provider, community health worker, public health program manager, social worker, etc.).

Public Policy – Rules, laws, or regulations that define government response to the needs of its citizens. Public policy may be legislative or administrative.

Qualitative Data – Descriptive data that can be categorized based on characteristics and identifiers. These data are often generated through focus groups, community conversations, listening sessions, surveys, and key informant interviews.

Quantitative Data – Data that can be counted, measured, and are expressed often as numbers. Examples are surveillance data, administrative data, vital statistics, or survey statistics that capture dimensions that can be measured.

Racial Equity – When social, economic, and political opportunities are not predicted based on a person's race.

Racial Inequity – When a person's race can predict their social, economic, and political opportunities and outcomes.

Root Causes – The underlying reasons that create the differences seen in health outcomes. Root cause(s) are the conditions in a community that determine whether people have access to the opportunities and resources they need to thrive (www.ncbi.nlm.nih.gov/books/NBK425845/).

Social Determinants of Health – The conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at national, state, and local levels. These are also known as the drivers of health.

Stakeholders – Those impacted by proposed policy, program, or intervention, who may have concerns or provide key information. Examples include: Specific racial/ethnic groups, housing authority, schools, community-based organizations, etc.

SWOT Analysis – Strengths, Weaknesses, Opportunities, and Threats analysis is a framework for identifying and analyzing the internal and external factors that can have an impact on the viability of a project, program, policy, etc.

Unequal Impacts – A negative effect of a practice or standard that is neutral and non-discriminatory in its intention, but disproportionately affects individuals, groups, communities, etc., based on race/ethnicity, sex, gender, age, etc.

Unintended Consequences – Unforeseen outcomes that are not intended by a purposeful action.

IMPLEMENTATION GUIDE

APPENDICES

Appendix A: Self-Assessment Resources

- **Public Health Nurses' Role in Promoting Health Equity: Opportunities for States** (December 13, 2016): The webinar highlighted the involvement of selected Public Health Nurse (PHN) leaders in promoting health equity in various initiatives and programs of national significance; illustrated the significant role of the public health nurse in identifying and improving social, economic, and environmental conditions that shape health and promote health behaviors; and demonstrated how state and local public health can utilize the experience, knowledge and skills of PHNs in promoting health equity and a Culture of Health. For more information, visit: http://www.astho.org/Programs/Health-Equity/Webinars/ **Colorado Department of Public Health and Environment:** The Colorado Department of Public Health and Environment's Office of Health Equity is "…committed to ensuring that every Coloradan has an equal opportunity to achieve their full health potential." For more information on the tools and resources developed by the Colorado Department of Public Health and Environment, visit: https://www.colorado.gov/pacific/cdphe/ohe

- **Community Tool Box:** A service of the Work Group for Community Health and Development at the University of Kansas. https://ctb.ku.edu/en Chapter 27, Section 1: Understanding Culture and Diversity in Building Communities was listed in the Pre-Work B.
    1. Chapter 27, Sections 1: Understanding Culture and Diversity in Building Communities https://ctb.ku.edu/en/table-of-contents/culture/cultural-competence/culture-and-diversity/main
    2. Chapter 27, Section 2: Building Relationships with People from Different Cultures https://ctb.ku.edu/en/table-of-contents/culture/cultural-competence/building-relationships/main
    3. Chapter 27, Section 4: Strategies and Activities for Reducing Racial Prejudice and Racism https://ctb.ku.edu/en/table-of-contents/culture/cultural-competence/reduce-prejudice-racism/main
    4. Chapter 27, Section 5: Learning to be an Ally for People from Diverse Groups and Backgrounds https://ctb.ku.edu/en/table-of-contents/culture/cultural-competence/be-an-ally/main
    5. Chapter 27, Section 7: Building Culturally Competent Organizations https://ctb.ku.edu/en/table-of-contents/culture/cultural-competence/culturally-competent-organizations/main
    6. Chapter 27, Section 11: Building Inclusive Communities https://ctb.ku.edu/en/table-of-contents/culture/cultural-competence/inclusive-communities/main
    7. Toolkit 9: Enhancing Cultural Competence https://ctb.ku.edu/en/enhancing-cultural-competence

- **Promoting Behavioral Health Equity through the California Reducing Disparities Project and Office of Health Equity** (*Sept. 15, 2014)* This webinar discusses the policy levers and partnerships that support the California Office of Health Equity and the California Reducing Disparities Project, as well as the strategies, resources, and tools that the California Reducing Disparities Project has used to promote health equity in the state. Webinar recording https://www.youtube.com/watch?v=hGLCjtVUIyQ

- **Just Health Action** Just Health Action (JHA) is an organization that "advocates for reducing health inequities that result from social, economic, or policies conditions." JHA offers interactive workshops to engage diverse groups of people to build skills. Check out their website for more information. We recommend Lesson Plan 3: How are Equity and Equality Different? as a group level activity that you can do with your team. For more information visit http://justhealthaction.org/resources/jha-curriculum-material/.

- N**ational Collaborative for Health Equity, George Washington University** The mission of the National Collaborative for Health Equity (NCHE) is to promote health equity by harnessing evidence, developing leaders, and catalyzing partnerships across the many different sectors that share responsibility for creating a more equitable and just society. Beyond Bias is a two-part webinar series sponsored by NCHE and the Within Our Lifetime Network (WOL), in partnership with The Perception Institute. www.nationalcollaborative.org/beyond-bias-webinar-series/

- **The MCH Navigator** MCH Navigator is a learning portal for maternal and child health professionals, **students, and others working to improve the health and well-being of women, children, and families.** For more information, visit: https://www.mchnavigator.org/

- **Unnatural Causes Video Series** "This video series is a seven-part documentary s exploring racial and socioeconomic inequalities in health. For more information, visit: https://unnaturalcauses.org/about_the_series.php

Appendix B: Online NC County-Level Data Sources

A. STATE CENTER FOR HEALTH STATISTICS (SCHS) WEBSITE
(www.schs.state.nc.us/data/county.cfm)

1. **Basic Automated Birth Yearbook (BABYBOOK)**
(https://schs.dph.ncdhhs.gov/data/vital/babybook/2019.htm)
Table 1 - By Age of Mother and Birth Order
Table 2 - By Age of Mother and Birth Order According to Marital Status
Table 3 - By Age of Mother and Birth Weight in Grams
Table 4 - By Education of Mother and Birth Weight in Grams
Table 5 - By Month Prenatal Care Began and Education of Mother
Table 6 - By Month Prenatal Care Began and Age of Mother
Table 7 - By Month Prenatal Care Began and Marital Status of Mother
Table 8 - By Month Prenatal Care Began and Birth Order
Table 9 - By Month Prenatal Care Began and Birth Weight in Grams
Table 10 - By Number of Prenatal Visits and Education of Mother
Table 11 - By Number of Prenatal Visits and Age of Mother
Table 12 - By Number of Prenatal Visits and Marital Status of Mother
Table 13 - By Number of Prenatal Visits and Birth Order
Table 14 - By Number of Prenatal Visits and Birth Weight in Grams
Table 15 - By Month Prenatal Care Began and Number of Prenatal Visits
Table 16 - By Medical History, This Pregnancy and Birth Weight in Grams
Table 17 - By Maternal Smoking, This Pregnancy, and Birth Weight in Grams
Table 18 - By Maternal Pre-Pregnancy BMI, This Pregnancy, and Birth Weight in Grams
Table 19 - By Characteristics of Labor and Delivery and Birth Weight in Grams
Table 20 - By Onset of Labor and Birth Weight in Grams
Table 21 - By Method of Delivery and Birth Weight in Grams
Table 22 - By Conditions of Newborn and Birth Weight in Grams

2. **BRFSS Survey Results** (www.schs.state.nc.us/data/brfss/survey.htm)
Not county specific, but state and regional data are available.

3. **Child Deaths in NC** (http://www.schs.state.nc.us/data/vital.cfm#vitalchild)
Data are grouped by cause and age group.

4. **County Health Data Book** (www.schs.state.nc.us/data/databook/)
Contains data on:
    - Population (estimates by age, race, and sex)
    - Pregnancy and Live Births (teen pregnancy rates, fertility rates, abortion rates, birth outcomes, etc.)
    - Birth Indicator Tables by State and County (including data on birthweight, gestational age, marital status, mother’s age and education, etc.)

- Life Expectancy
- Mortality
- Morbidity

5. **Detailed Mortality Statistics** (http://www.schs.state.nc.us/data/vital.cfm#vitaldms)

6. **Infant Mortality Statistics** (www.schs.state.nc.us/data/vital.cfm - vitalims)

7. **NC Health Statistics Pocket Guide 2017** (https://schs.dph.ncdhhs.gov/data/pocketguide/2017/)

8. **NC Reported Pregnancies** (www.schs.state.nc.us/data/vital.cfm - vitalpreg)

9. **NC Vital Statistics, Volume I** (www.schs.state.nc.us/data/vital.cfm - vitalvol1)

10. **NC Vital Statistics, Volume 2** (www.schs.state.nc.us/data/vital.cfm - vitalvol2)

11. **NC Statewide and County Trends in Key Health Indicators** (www.schs.state.nc.us/data/keyindicators/)

    For each county in NC, the SCHS has produced 24 graphs representing trends in key health indicators at both the county and state levels over approximately the past 15 years (latest data is for 2017). In order to ensure a fair degree of stability in rates and trends when annual numbers for a county may be relatively small, several years of data have been grouped together and averaged out for each indicator, resulting in three data points for each indicator. Example of a county data report can be found at here: https://schs.dph.ncdhhs.gov/data/keyindicators/reports/Alamance.pdf.

LIST OF INDICATORS

a. Percentage of Resident Live Births Classified as Low Birthweight
b. Percentage of Resident Live Births Classified as Very Low
c. Percentage of Resident Live Births that were Premature
d. Percentage of Resident Live Births Delivered by Cesarean Section
e. Teen Pregnancies (Ages 15-19) per 1,000 Female Residents
f. Percentage of Resident Teen Pregnancies (Ages 15-19) that Were Repeat
g. Infant Deaths per 1,000 Live Births
h. Child Deaths per 100,000 Residents Ages 0-17
i. Age-Adjusted Cardiovascular Disease Death Rates
j. Age-Adjusted Heart Disease Death Rates
k. Age-Adjusted Stoke Death Rates
l. Age-Adjusted Diabetes Death Rates
m. Age-adjusted Colorectal Cancer Death Rates
n. Age-Adjusted Trachea, Bronchus, & Lung Cancer Death Rates

o. Age-Adjusted Female Breast Cancer Incidence Rates
p. Age-Adjusted Prostate Cancer Incidence Rates
q. Age-Adjusted Unintentional Motor Vehicle Death Rates
r. Age-Adjusted Other Unintentional Injury (excluding MVA) Injury Death Rates
s. Age-Adjusted Homicide Rates
t. Age-Adjusted Suicide Death Rates
u. Number of Primary Care Physicians per 10,000 Residents
v. Number of Dentists per 10,000 Residents
w. Number of Registered Nurses per 10,000 Residents
x. Number of Physician Assistants per 10,000 Residents

12. **Life Expectancy - State & County Estimates** (www.schs.state.nc.us/data/lifexpectancy/)

B. DATA AVAILABLE ON NC CHILD WEBSITE/KIDS COUNT NC

1. **Child Health Report Card County Data Cards**
(https://ncchild.org/what-we-do/insights/data/2021county-data-cards/)
Data are provided on a variety of social, economic, and health outcomes for each county as a supplement to the NC Child Health Report Card 2021 which can also be found through this link.

2. **KIDS COUNT Data Center** (https://datacenter.kidscount.org/data#NC/2/0/char/0)
County, state, and national data for topics such as demographics, economic well-being, education, family and community, health, safety, and risk behaviors can be found on this website.

C. WOMEN'S AND CHILDREN'S HEALTH SECTION PROCESS OUTCOME OBJECTIVES (POOs) DATA

1. **Family Planning Outcome Objectives (OOs) by County 2021-2022**
(https://whb.ncpublichealth.com/provpart/docs/2021-2022-FPAAOutcomeObjectivesByCounty.pdf)

2. **Maternal Health Outcome Objectives (OOs) by County 2020-2021**
(https://whb.ncpublichealth.com/provpart/docs/MHAA-FY21-CoOutcomeObjs.pdf)

Appendix C: Tools to Complete Action Step 3

Impact Matrix* An impact matrix is a decision-making tool that will help people, teams, organizations, or groups understand more about the level of effort required for activities and the potential impacts the activity will have. The impact matrix is an easy way to:

- Identify the activities to focus on, as well as ones that should be ignored
- Optimize resources and time
- Provides opportunities to reflect on a range of strategies and find the most efficient path to achieve goals and reduce wasted time and effort.

An impact matrix is read from top to bottom. The higher the placement on the vertical axis, the greater the impact the process has on the perception of value.

IMPACT MATRIX*		
	Hard (High Effort)	Easy (Low Effort)
High Impact		
Low Impact		

- If you want **major** changes, consider the "hard or high effort and high impact" categories.
- If you want **quick wins**, consider the "hard or high effort and low impact" categories.
- **It may not be worth the time to make the change** if suggestions fall in the "easy or low effort and high impact.
- The "easy or low effort and low impact" categories **can be used to fill in the gaps or address gaps.**

**Source: Excerpted from Biorn Anderson, Tom Fagerhaug, and Marti Beltz, Root Cause Analysis and Improvement in the Healthcare Sector: A Step-by-Step Guide (Milwaukee, WI: ASQ Quality Press, 2010), pages 19, 146-147.*

SWOT: Strengths, Weakness, Opportunities, Threats Analysis.* A SWOT analysis is useful technique for understanding different problems, policies, or programs. In general, strengths and weaknesses are part of the internal structure, while opportunities and threats are external. Questions can be asked for each quadrant. These questions are only a guide. Additional questions can be asked as they are related to the specific subject being discussed.

STEP 3: SWOT (STRENGTHS, WEAKNESS, OPPORTUNITIES, THREATS) ANALYSIS*	
Strengths *What do you do well? What unique resources can you draw on? What do others see as the strengths?*	**Weaknesses** *What could be improved? Where do you have fewer resources than necessary? What are others likely to see as weaknesses?*
Opportunities *What opportunities are available? What trends could you take advantage of? How you can you turn strengths into opportunities?*	**Threats** *What threats could be harmful? What are other people doing? What threats do the weaknesses expose?*

*Source: Excerpt from *Essentials of Strategic Planning in Healthcare* by Jeffrey P. Harrison (Health Administration Press, 2010).