Figure 1: A Group of People Standing in Front of the Ocean Waving

Using Health Equity Indicators to Guide Community Health Improvement in U.S. Territories and Freely Associated States

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astho™

Summary: This guide serves as a roadmap for territory and freely associated state health agencies to establish a shared understanding of health equity, identify and develop health equity indicators and measures, and track progress on health equity efforts. It aims to support island areas public health agencies by providing step-by-step guidance that leverages expertise from collaborative efforts between them and the communities and populations they serve. This guide complements existing efforts by island areas public health agencies to collect data to understand and address health inequities that impact communities and populations.

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Table of Contents

Figure 2: St. John, U.S. Virgin Islands

Introduction

The U.S. territories and freely associated states—collectively referred to as the island areas or island jurisdictions— face a unique and shared set of challenges and strengths, including the availability of resources, geographic isolation, cultural traditions, resilience, and emphasis on community well-being. The interplay of multiple factors shapes tracking advancements in health equity. Health equity metrics, including indicators and measures, play an integral role as the island areas define their mission, vision and achieve health equity efforts. Health equity metrics help to 1) understand issues impacting communities, 2) assess and monitor progress on efforts, and 3) identify opportunities for improvement. Health equity metrics also help to establish and sustain a culture of equity, guided by ongoing engagement of public health agencies, partners, and communities to help prevent, mitigate, and eliminate inequities among communities and populations. Differences in modernized data systems, workforce capacity, and public health infrastructure place different challenges on island areas public health agencies to collect, analyze, and monitor data to track improvements in health equity.

ASTHO developed this guide to help provide a new perspective aimed at expanding processes to track advancements in health equity. This guide serves as a roadmap for island areas public health agencies to establish a shared understanding of health equity, identify and develop health equity indicators and measures, and track progress on health equity efforts. For purposes of this guide, indicators are a summary of measures that capture relevant information on different attributes and dimensions of health status and performance of a health system. This guide aligns with ASTHO's Islands Health Equity Framework to help build the foundation for health equity and details how to move toward health equity in an island context. Specifically, examples of indicators that align with key areas of the ASTHO's Islands Health Equity Framework are included.

This guide was developed with input from island areas public health agency staff, partners, community members, ASTHO, and information from existing literature and resources relevant to the island areas. This guide aims to support island areas public health agencies by providing step-by-step guidance, leveraging expertise from collaborative efforts between them and the communities and populations they serve. This guide is designed to complement existing efforts conducted by island areas public health agencies to collect data to understand and address health inequities that impact communities and populations. It is critical to recognize that community members are experts on their needs and priorities. Thus, this guide should be used alongside community members.

Steps to Action

The following six steps outline actions to establish a shared foundation to achieve health equity and identify and develop health equity metrics using local and representative data. The metrics, including indicators and measures, can be used to explore opportunities for improvement and track progress on efforts to achieve health equity. Island areas public health agencies should work through these steps in collaboration with staff, practitioners, and community experts to advance local action. Consider how each one of these steps promotes achieving health equity. Consider how each one of these steps promotes monitoring and sustaining advancements in health equity. Refer to the Key Terms to inform utilization of this guide.

Step One: Build Shared Understanding

Health equity is achievable when everyone has a fair and just opportunity to be as healthy as possible in a society that values each member equally, through focused and ongoing efforts to address avoidable inequities, historical and contemporary injustices, and eliminate disparities in health and healthcare. Taking into account the variability of definitions and analysis of health equity in and between island areas, achieving health equity requires building a shared understanding of concepts and language. Island areas public health agencies will be better equipped to guide the measurement of health equity, and direct resources to the intended purposes, when a shared understanding of how health equity is defined is established in island area contexts. Learn more from a National Center for Health Statistics, Centers for Disease Control and Prevention presentation about defining and measuring disparities, inequities, and inequalities.[i]

Step One in Action

1. **Build the concept of health equity within island areas public health agencies.** Work with the island areas public health agency to discuss achieving health equity, including developing a clear definition. Lay out why it is important to pursue health equity in communities. Build understanding and capacity to achieve health equity through action, such as ongoing structured dialogue, agency-wide training, and peer learning. Assess and monitor current efforts and identify where health inequities can be further explored, including programs, services, organizational plans, and social and public policies. Consider the following:
    a. What is health equity?
    b. What does an ideal state of health equity mean for the island's public health agency and community? For example, the Puerto Rico Department of Health's Health Equity Program collaborated with the University of Puerto Rico Medical Sciences Campus to develop a definition of health equity, demonstrating the results of alliances between multi-sector partners for a joint purpose.

[i]The National Center for Health Statistics, Center for Disease Control and Prevention presentation developed by Klein and Huang is focused on Defining and measuring disparities, inequities, and inequalities in the Healthy People initiative.

c. Who are programs and services (e.g., schools, health systems, public health, housing, transportation) reaching versus not reaching? For example, populations with or without health insurance or inner islands versus outer islands. Explore where healthcare is delivered. Is it delivered only in clinics, or are there other health systems outside of public health that have thrived when access is an issue?

d. How are interventions distributed across social factors of concern (e.g., income, geography, education)?

2. **Engage island areas public health partners to help facilitate discussions.** Identify island areas public health partners to engage and help facilitate conversations with the public health agency to build the foundation. Use discussions to explore what creates health from a disease/outcome focus to include "what's needed to be healthy." Consider other programs and services outside the health system that also impact the health outcomes of individuals, communities, and populations (e.g., Pacific/Atlantic public health associations/organizations, the Centers for Disease Control and Prevention, or community health centers).

3. **Engage the community.** Gather a wide range of perspectives to ensure that a shared definition of health equity will resonate with diverse community members, recognizing they are the true experts in their communities. Work with communities to explore the ideal picture of health equity. Developing a shared vision for health equity may help partners reflect on the structural and systemic factors contributing to health inequities. Communities may find common ground in defining health equity regarding core values and opportunity. Engage the community to include them in identifying the problems and solutions to achieving health equity. Consider the following questions:
   - Do they feel their knowledge of their community is essential?
   - Has their voice been heard to identify their needs or thoughts?
   - Do they feel like a valued partner in the efforts to address health equity?
   - Has the community voice been part of the conversation to identify the needs of their community?

Tools and Resources

HealthEquityGuide.org *Human Impact Partners*

Rural Health Equity Toolkit *Rural Health Information Hub*

Health Equity Resources *Minnesota Department of Health*

Roots of Health Inequity *National Association of County and City Health Officials*

Foundations of Health Equity Self-Guided Training Plan *Centers for Disease Control and Prevention*

A Conversation Guide for Health Equity *Health Equity Lab*

The Spectrum of Community Engagement to Ownership *Rosa Gonzalez, Facilitating Power*

Step Two: Frame Health Equity

Addressing health equity requires reframing the conversation to resonate with community members, partners, and other island areas collaborators. Island areas public health agencies must actively work with community members, partners, and decision-makers to change the narrative around what factors limit progress on health equity. Leverage data to change the narrative of what creates health and well-being. Reframing helps focus communication on the underlying drivers of inequities and deepen understanding of the factors that impact health outcomes. As you develop health equity indicators, reframing will help you identify the most important indicators to measure health equity in your community

Figure 3: Graffiti Art Promoting Diabetes Awareness

> *"Communicating what health equity is…would deserve making the point that it'll [health equity] be different depending on the social fabric and the communities…we're talking about."*
>
> *Island Areas Partners*

Step Two in Action

1. **Focus on health equity rather than health disparities.** Reframe public health communication efforts to focus on health equity rather than health disparities. This reframing outlines a pathway to address health disparities in a meaningful, non-stigmatizing, and sustainable way and how to examine data meaningfully. Reframing equity is essential when you clearly understand disparities, have data to describe them, and can frame them in terms of equity. Health equity can measure endpoints rather than focus on the starting points when the data is available. Reframing focuses on assets and not just deficits, which traditionally are used as the foundation to measure health disparities.

For example, consider infant immunization rates: the percentage of mothers with health insurance, by geography (outer versus inner island). Are the geographic differences in immunization rates attributable to health insurance differences? If so, a geography of health approach might be needed. This reframing not only explores the differences in health status between population groups but also the differences in the distribution of resources between groups.

2. **Frame health equity as achievable.** Break down health equity into manageable concepts when solutions are offered across multiple levels, including individual, population, local, and island. Consider using action terms to highlight that achieving health equity is feasible. Avoid language that speaks to a false belief that nothing can be done to change health outcomes.

3. **Communicate to address stigma.** When communicating with, about, or for communities who are disproportionately impacted by health inequities, such as LGBTQ+, migrant, older adults and outer island populations, consider the unique needs and barriers these communities face, including language, discrimination, stigma, and rejection. Consider how public health agency programs and services are engaging these communities, including the currently available data to help understand the inequities they may be facing. Develop communication messages and tools to help reduce perceptions of stigma. For example, refer to Tips for Stigma-Free Communication about Mental Health for information to help craft communication messages and tools.

4. **Meet the community where they are.** Identify populations or groups who are not showing up to receive public health services (e.g., immunizations, screenings). Engage community members and partners who represent these populations to discuss the impact of health inequities and understand what supports the community needs to address inequities, including data. Discuss what health equity means to them and what it looks like in their community or context, helping the community to adopt a different perspective to influence their actions and views. Leverage the ASTHO Islands Health Equity Framework to inform discussions and examine determinants of health. Engage community members who are showing up to learn why and how they are able to come.

5. **Communicate health equity as a "we" issue.** Build on the island areas shared values, culture, traditions, and interconnectedness, and help the communities you serve see themselves disproportionately impacted by inequities. Share examples of how equitable approaches can benefit all, such as using the Community Health Worker (CHW) model to bridge the gap between public health agencies and communities served to address access to services. For example, the National Association of Community Health Workers works with U.S. states and territories to help build CHW models.[ii]

6. **Build island areas public health agency staff capacity to understand health equity.** Engage public health agency staff, such as those not trained in health equity and data science, to help build capacity to understand and achieve health equity. Build capacity through staff orientation and training to help set the stage for a shared understanding. Outline the main concepts of health equity and how it applies to agency programs and services, including how data plays a role in community health improvement. Consider what you can do to advance health equity – learn more about practice through a health equity lens.

Tools and Resources

Health Equity Guiding Principles for Inclusive Communication *Centers for Disease Control and Prevention*
Three Principles to Communicate about Health Equity Concepts *Centers for Disease Control and Prevention, Office of Health Equity*
Framing Health Equity *Rural Health Information Hub*

Step Three: Identify and Develop Indicators Through a Health Equity Lens

Indicators are used to measure health equity and reflect various factors that promote or harm health and well-being in populations and communities. Although there are common definitions of health equity across public health systems, there are fewer resources on how to measure health equity, beyond describing disparities and inequities. Given this gap, local knowledge and context are essential to both the definition and measurement of health equity, especially in the island areas with diverse geographies, cultures, economies, and resources.

Health equity can be measured in multiple ways, including measures of health disparities, inequities, and social and structural determinants of health.[iii] Measures of health disparities can highlight differences in outcomes or determinants. Measures of equity are also helpful to gauge the absence of inequities or efforts that aim to advance health equity, such as the number of local sectors involved in equity initiatives.

To measure health equity, you can start by exploring existing health indicators **and** by developing new indicators. Before developing new indicators, a health equity lens can be used to explore equity within existing datasets and across indicators of health status and outcomes, social determinants of health, and other community-level factors that influence health and well-being. Using existing sources is an excellent way to minimize the burden of reporting new

[ii] The National Association of Community Health Workers is a nonprofit membership-driven organization with a mission to unify CHWs across geography, ethnicity, sector, and experiences to support communities to achieve health, equity, and social justice.
[iii] RAND Health Care developed a report, Developing Health Equity Measures, for the Office of Assistant Secretary for Planning and Evaluation at the U.S. Department of Health & Human Services.

indicators. In addition, this approach aligns with key recommendations from the World Health Organization's Commission on Social Determinants of Health and involves looking deeper at each indicator and examining differences in outcomes between populations or communities with different levels of access to resources, privilege, and power. Consider if data are being reviewed through a health equity lens or if there are alternative ways to collect data to understand community strengths, priorities, and needs. Using a health equity lens not only deepens understanding of key drivers of health inequities but also informs the distribution of resources and efforts where the need is greatest. Logic models are helpful for anchoring and organizing indicators and measures in a larger framework to measure short-, medium--, and long-term outcomes. By connecting resources, activities, and outcomes, island areas can begin prioritizing indicators and data that help tell the equity story.

The ASTHO Islands Health Equity Framework highlights existing and new health equity indicators within an island context, which can be used alone or combined to measure equity. Within each area of the framework are examples of indicators that reflect health, socioeconomic, environmental, cultural, and structural factors (see Appendix, Table 1).

The following are examples of how to apply a health equity lens to existing health indicators. Keep in mind that data may be presented as proportions on socioeconomic characteristics (e.g., poverty, unemployment, income levels), proportions and rates of health or social conditions (e.g., prevalence, incidence), and the relationship between proportions and rates of health or social conditions (e.g., odds ratios, risk ratios). Explore the Health Indicators, Conceptual and operational considerations to learn more about how health equity indicators are measure and presented.

Table 1: Example of Health Equity Indicators

Indicator	Existing Measure	Data Source	Application of a Health Equity Lens
Foundational Conditions			
Non-communicable disease	Diabetes prevalence in the population (based on either a self-report of having diabetes for which the patient is taking medication and/or an A1c measurement of 6.5% or higher)	NCD Hybrid Survey	Stratify rates of type 2 diabetes by geography (rural/urban, inner/outer islands), or consider disease complications vs. diagnosis, income level, social status, race/ethnicity, nationality, etc.
Social Conditions			
Employment	Percentage of the population employed for wages	NCD Hybrid Survey	Stratify employment status by age, sex, gender, education, nationality, geography, mental health, or consider wages vs. employment status

Note: Hybrid Survey's approach to non-communicable disease surveillance in the US-Affiliated Pacific Islands - PMC (nih.gov)

When there are gaps, developing new health equity indicators can be helpful. Below are examples of health equity indicators that could be tailored to an island context. Although these examples are not tied to any existing data sources, they could be adapted to highlight specific populations or communities and/or stratified by multiple factors (e.g., gender, geography, employment status, economic status).

Table 2: Example of Health Equity Indicators

Potential Indicator	Potential Measure
Foundational Conditions	
Language	Percentage of patients receiving language services supported by qualified language services providers, stratified by [insert factor(s) here (e.g., wait time for care)]
Institutional Influences	
Healthcare and specialized services/ public health services	Percentage of adolescents receiving depression screening, stratified by [insert factor(s) here]
	Number of [insert sectors, departments, community-based organizations, hospitals, clinics, etc. here] participating in health equity initiatives each year
	Public health-related social media reach, stratified by [insert subpopulations or priority populations here]

Step Three in Action

Developing new indicators and measures of health equity is complex and requires time, resources, and expertise in measurement. When determining health equity indicators and measures, consider the following steps in collaboration with public health agency staff, partners, and community members:

1. **Identify what is essential to measure.** Determine which characteristics of programs and services are important to track to understand and achieve health equity. Consider what you learned through community engagement in Steps One and Two. It may be helpful to review available literature, assessment data, and other available data to understand what currently exists and where data gaps may be.

2. **Select existing indicators and measures.** Consider working with your jurisdiction's epidemiologist to assess program, surveillance, and national data sets for existing indicators and measures that align with your goals. Identify various data sources, including disparities in health status, health services coverage and quality, risk factor prevalence, and social determinants of health. This has the dual purpose of providing a clearer baseline picture of suspected inequities and helping to identify existing data sources that can be applied in the future. Consider using a logic model to help organize existing indicators in a larger framework and identify gaps where new indicators are needed.

3. **Develop new indicators and measures.** Use the SMARTIE (Specific, Measurable, Actionable, Realistic, Timely, Inclusion, Equity) criteria to help develop new indicators and measures. Consider the following when developing indicators and measures: definition, criteria to rate, quality of data, and comparability. Remember that new indicators and measures should be validated to ensure reliability and validity. For example, to better understand access to care for LGBTQ+ community members, an outcome indicator may read as follows: Percentage of LGBTQ+ adults in [community/island areas] who have had an annual exam in the past year.

Below is an example of a logic model to illustrate the connection between inputs, resources, activities, and measures to assess short-, intermediate-, and long-term outcomes related to health equity initiatives led by an island areas public health agency. It builds on Steps One (Define health equity) and Two (Frame health equity) and can be a tool for organizing and tracking priorities, assumptions, and external factors related to health equity.

When using a logic model, completing it from right to left can be helpful. Consider starting with what is desired (e.g., long-term outcomes) and moving to what is needed (e.g., inputs and activities).

Example Logic Model

Inputs	Activities	Short-term Outcome	Intermediate-term Outcome	Long-term Outcome
Resources to health equity department staff Organizational support to increase health equity initiatives Existing relationships with community-based organizations (CBOs)	Staff training in health equity Organizational and community involvement in defining health equity and embedding in organizational plan Developing health equity-related communication materials Planning health equity-related initiatives and events	Example Measure: Increase in health equity-related outreach and educational activities to CBOs in past 6 months	Example Measure: Increase in CBOs participating in health equity initiatives each year	Example Measure: Increase in CBOs embedding health equity into their organizational structure, policies, and services in past 5 years

Tools and Resources

Developing Health Equity Measures *U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation*
Logic Model *Centers for Disease Control and Prevention*
Using Data to Reduce Health Disparities and Improve Health Equity *American Hospital Association*
About Disparities Data *Healthy People 2030*
From SMART to SMARTIE Objectives *Centers for Disease Control and Prevention*

Step Four: Use Storytelling and Data to Achieve Health Equity

This step provides ideas for using storytelling and data to explore a public health issue or priority, building on a shared understanding of health equity and applying a health equity lens to existing and new indicators. There are multiple ways to assemble information, including health equity-related infographics, brief data reports, and data profiles with selected indicators (such as this interactive example of U.S. Census Bureau's Community Resilience Estimates For Equity: Puerto Rico Profiles and these examples from the Kaiser Family Foundation for the U.S. Virgin Islands: Fast Facts and Puerto Rico: Fast Facts,[iv,v] and Statistical Profile of the Population with Functional Diversity in Puerto Rico and Statistical Profile of the Population of Minors and Older Adults in Puerto Rico.) Measuring health equity often involves combining multiple indicators and stratifying data by groups and characteristics. Having a simple way to organize indicators and data is an important step in using results to inform public health decisions. It also provides a tool to engage community partners in helping

Storytelling is a culturally responsive and powerful way to communicate public health information with communities in island areas. Stories help connect people and share information or lessons learned. Stories are also helpful tools when communicating public health data to diverse audiences. For example, using clear language such as "four out of five people" can feel more personal and less analytical than "80% of people." Learn other tips from Storytelling 101.

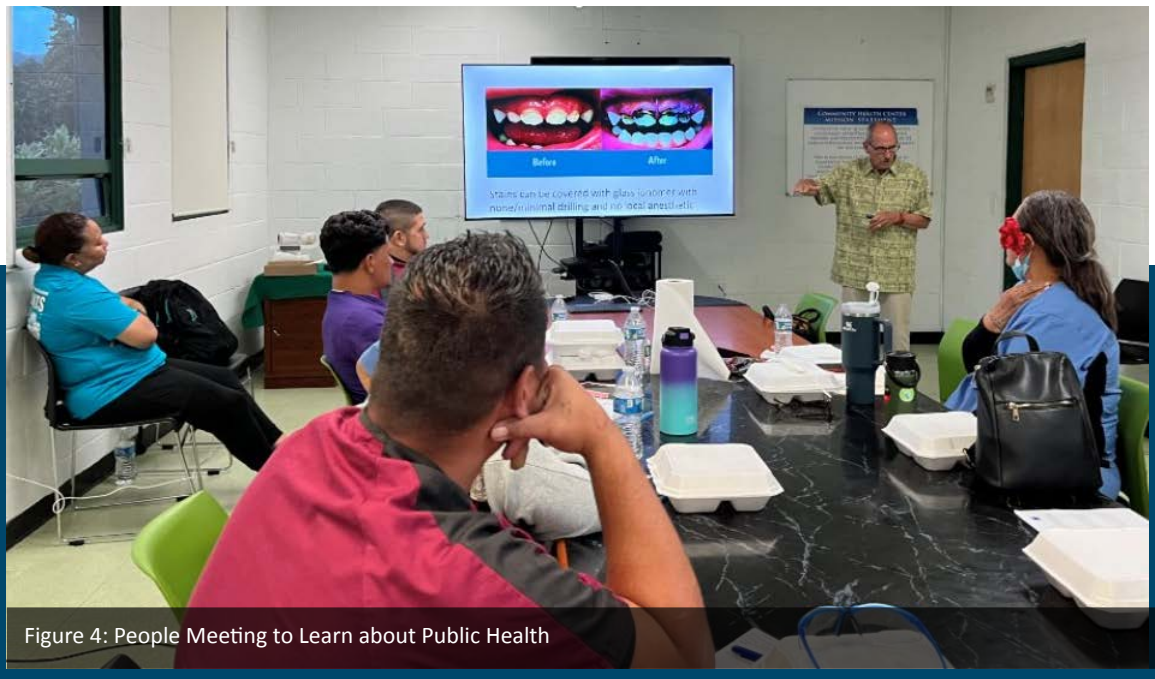

Figure 4: People Meeting to Learn about Public Health

[iv] The United States Census Bureau is a provider of quality data about the United States people and economy.
[v] Kaiser Family Foundation is a leading health policy organization in the United States that brings together policy research, polling, and journalism into one organization.

Step Four in Action

Using storytelling and data to advance health equity involves:

- Conversations with multiple communities, organizations, and sectors.
- Access to quality and timely data.
- Resources and skills to manage and analyze data.

Consider starting small by using data to understand a key priority related to equity and then scaling over time by exploring other priorities. It is essential to collaborate with community members and partners when using storytelling and data to advance equity. The following list builds on Steps One through Three and is an outline of what could be shared during conversations with community partners:

1. **Identify a public health issue or priority.**
2. **Review potential indicators and data sources to explore that issue (see Appendix, Table One).**
3. **Consider all the indicators you currently measure.** From those indicators, identify a small set (two to four) to explore the issue (e.g., rates of depression among youth, geography, gender, age).
4. **Stratify the data using a health equity lens.**
5. **Organize results in an infographic, brief data report, or data profile**. When possible, use stories to describe what you found and when sharing the results with community partners, organizations, and other sectors.
6. **Engage community partners in the interpretation of findings.** Ask questions such as:
    a. What story does this information tell? And what story do you want it to tell?
    b. What data information is missing from the story?
    c. Whose stories are being told? Are there other populations who should be included in the future?
    d. Are new health equity indicators needed to measure this public health issue moving forward?
7. **Use the results to inform programs, practices, and policies within the public health agency and develop new health equity indicators.**

Tools and Resources

Infographics *National Institute of Health Care Management*
Data Report *Centers for Disease Control and Prevention*
Interactive Data Profile, *U.S. Census*
Static Data Profile Examples for the US Virgin Islands and Puerto Rico KFF
Public Health Storytelling *CDC Foundation*
Designing Data Dashboards Using a Health Equity Lens *ASTHO*

Step Five: Embed Health Equity Indicators into Plans

Achieving health equity requires a long-term approach. It is important to look beyond the project and program level and incorporate health equity indicators into organizational and community plans. Potential plans include, but are not limited to, strategic plans, community health improvement plans, and quality improvement plans. Plans designed to support health equity can bolster focus and accountability and encourage integration across divisions, departments, programs, and community partners. Applying a health equity lens to plans helps to institutionalize the efforts throughout the public health agency.

Figure 5: People Drumming in a Parade

> *"We have a health equity program that is housed within the Office of Planning and Development that is addressing how the department defines and institutionalizes health equity. It starts at the strategic plan level because it is one of the identified priorities in the current strategic plan, but also how we operationalize that and continue to develop it."*
>
> *Islands Areas Public Health Agency Staff*

Step Five in Action

1. **Establish long-term vision and commitment.** Long-term vision and commitment are necessary to develop intentional and systematic approaches to address health equity. Engage public health agency staff, partners, and communities to revisit a shared understanding of health equity and community needs and identify opportunities to expand plans to include health equity. For example, indicators and measures can be used to explore response and preparedness plans to meet communities' needs.

2. **Incorporate health equity within the quality improvement structure.** This promotes a systematic rather than episodic approach to advancing equity. Use this as an opportunity toidentify disparities and inequities in the context of quality improvement. Use indicators and measures to explore opportunities to tailor programs and services to meet the needs of the population of focus. Consider the focus of the public health agency plan and the degree of monitoring already underway at the program level.

3. **Monitor progress toward health equity indicators.** The organization must monitor the progress towards these indicators to improve outcomes and reduce inequities, not simply include health equity indicators into plans:
    a. Use health equity indicator data to demonstrate gaps in care by comparing a quality measure among two (or more) groups. For example, colon cancer screening rates for migrant communities are compared with screening rates for community citizens.
    b. Consider developing dashboards for monitoring progress and reporting. Use the dashboard to assign individual tasks to public health agency staff. Ask yourself: What are we trying to accomplish? What are the manageable, small tasks involved in implementing a change?
    c. Monitor progress on the health equity indicators and determine what adjustments will be made. Consider who is accountable for adjusting strategies to drive

Example: How to Embed Indicators into Plans

- An island areas public health agency identified cancer as a leading cause of death through its vital statistics data. Based on this finding, the island areas public health agency included improving cervical cancer screening as part of its health improvement. When stratifying the screening data by age, the island areas public health agency found that a lower percentage of women over the age of 30 received screening than those aged 30 and under, although cervical cancer occurs most often in women over the age of 30, with variation in rate by ethnicity and economic status. Therefore, the island areas public health agency focused its screening efforts on women over 30 and included the following SMARTIE goal in its Community Health Improvement Plan.
- Example SMARTIE (Specific, Measurable, Attainable, Relevant, Time-Bound, Inclusive and Equitable) Goal: Over the next five years, we will increase our cervical cancerscreening rate for women over the age of 30 by 5 percent every year from 28 percent to 55 percent.

Tools and Resources

Principles for Using Public Health Data to Drive Equity *CDC Foundation*
Advancing Health Equity in Health Department's Public Health Practice *Human Impact Partners*
Using Data to Reduce Disparities and Improve Quality *AHE*

Step Six: Revisit and Scale Up Plans for Measuring Health Equity

In this stage, the focus is on maintaining and building momentum. Revisiting and scaling up plans to measure health equity requires flexibility as the issues will change over time. How the issue was understood during the initial planning phases may no longer represent the reality in the community. Therefore, it is important to continually engage with the community. Ensure the initiatives remain relevant and responsive to the community by regularly reviewing goals and strategies with key partners. Include community groups or populations that have yet to previously participated in the discussions to solicit additional viewpoints from underrepresented populations. Island areas public health agencies should aim to review health equity indicators at least annually, if not more often.

Figure 6: A Yapese Faluw (Men's House) Near the Ocean with Palm Trees and Foliage Nearby.

Step Six in Action

1. **Consider challenges in measuring health equity.** When revisiting and scaling up plans, it is important to consider the challenges identified in ASTHO's Measuring Health Equity: An Assessment of Equity Metrics in Performance Management and Planning - namely workforce capacity and data limitations.[vi]

    a. Measuring health equity can be complex. Seek out resources, tools, and training to enhance the workforce's skills to bolster efforts to incorporate health equity into all aspects of grant-related work, from development to monitoring. Leverage workforce capacity strategies and practices to promote the integration of health equity, including understanding the workforce's current capacity, foster collaboration between performance improvement and health equity staff, and establish peer learning and tailored technical assistance for organizations seeking to continually improve their efforts.

[vi] The ASTHO Measuring Health Equity, An assessment of equity metrics in performance management and planning report summarizes challenges with developing health equity standards and measures, proposes incremental recommendations, and acknowledges the need for states and territories to apply both health equity and performance management strategies to develop health equity standards and measures.

b. Islands areas public health agencies might find data lacks information from subpopulations (e.g., race, ethnicity, sexual orientation, gender identity, socioeconomic status, geographic location, and residency status), inhibiting the ability to fully measure health equity. Identify these data gaps and include lacking data points on health assessments to inform subsequent health equity efforts. Collecting these data points allows for a more robust analysis of factors affecting health equity. Findings from the robust analysis should inform project planning and drive objectives and activities that directly respond to any inequities identified.

2. **Revisit and scale up health equity efforts.** Essential components of a monitoring plan include accountability (e.g., who will respond to feedback), mechanism for review (e.g., annual leadership retreat used to review progress on indicators), and generation of actions aimed at addressing findings. Consider the following:

   a. Continually engage with the community to identify additional priorities or public health issues.
   b. Increase the workforce's skills to incorporate health equity, from program planning, design, and implementation, to monitoring and evaluation. Train staff to use data to measure progress on health equity.
   c. Identify gaps and consider new data collection methods to identify root causes and key drivers of inequities.
   d. Utilize root cause and key driver data findings to inform public health practice.

Tools and Resources

Measuring Health Equity: An assessment of equity metrics in performance management and planning *ASTHO*

Conclusion

Monitoring progress toward health equity requires access to quality data that will measure health disparities, differences in health, and its determinants, including social determinants of health; it also requires tools to facilitate the interpretation of these data. By utilizing the steps in this guide, your island areas public health agency can apply health equity metrics to help understand issues impacting communities, assess and monitor progress on efforts, and identify opportunities for improvement. Island area public health agencies should start small to incorporate health equity indicators and measures into current work wherever possible. Monitoring and measuring these initial efforts lead to a greater understanding of the community and the impact the public health agencies can have on reducing disparities and achieving health equity. Over time, the public health agency should incorporate health equity indicators and measures into its long-term plans. Monitoring and measuring indicators are key to assessing the impact of these initiatives. Health equity will eventually become part of the everyday planning, actions, and values of the highly functioning public health and healthcare organizations. Thus, these efforts will help to create and sustain a culture of health equity.

Appendix A

Key Terms

The following key terms can be used to help understand the steps outlined in this guide.

- **Health Equity —** when everyone has a fair and just opportunity to be as healthy as possible in a society that values each member equally, through focused and ongoing efforts to address avoidable inequities, historical and contemporary injustices, and the elimination of disparities in health and healthcare. Achieving this requires ongoing societal efforts to 1) address historical and contemporary injustices, 2) overcome economic, social, and other obstacles to health and healthcare, and 3) eliminate preventable health disparities.

- **Health Equity Metrics** — a focus on evaluating health disparities and stratifying measures using social determinants of health (e.g., race, ethnicity, income, level of education).

- **Health Disparities** — preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations (Centers for Disease Control and Prevention, 2008).

- **Performance Improvement** — a way to help state and territorial health agencies and systems improve the quality and performance of their public health systems.

- **Social Determinants of Health** — the conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks (Healthy People 2030).

Appendix B

Potential Topic Areas and Data Sources for Indicators

Potential topic areas for indicators and data sources to explore health equity within and across island areas.

Key Areas of Health Equity Framework	Topic Areas for Indicators	Examples of Potential Data Sources
Foundational Conditions	Age	Program data, uniform data system (UDS) data, immunization registry, vital statistics registry, Non-Communicable Disease (NCD) Hybrid Survey, Pacific Syndromic Surveillance System (PSSS), WHO Global Health Estimates, WHO Global Health Observatory, WHO Mortality Database, CDC National Vital Statistics System, CDC National Program of Cancer Registries, CDC National Notifiable Disease Surveillance System, CDC COVID-19 Data Tracker, CDC Behavioral Risk Factor Surveillance System, CDC Youth Risk Behavior Surveillance System, U.S. Decennial Census (10 year), U.S. Census Bureau, American Community Survey, Maternal and Child Health Jurisdictional Survey, CDC Pregnancy Risk Assessment Monitoring System
	Communicable and non-communicable diseases	
	Geographic location (e.g., urban, rural, inner and outer islands)	
	Race/ethnicity	
	Nationality (e.g., migrant populations, foreign workers)	
	Language/literacy	
Strengths and Support	Community-based organizations	Program data, data from community-based organizations, WHO Global Health Observatory
	Community mobilization and ownership	
	Well-being	

Key Areas of Health Equity Framework	Topic Areas for Indicators	Examples of Potential Data Sources
Societal Conditions	Community safety	Program data, data from community-based organizations, CDC Behavioral Risk Factor Surveillance System, U.S. Decennial Census (10 year), U.S. Census Bureau, American Community Survey, WHO Global Health Estimates, WHO Global Health Observatory, UNICEF Pacific Islands Data Reports
	Economic stability and employment opportunities	
	Environmental protection	
	Internet/broadband access/cell phones	
	Reliable power	
	Safe drinking water access	
Institutional Influences	Healthcare and specialized services	Program data, data from community-based organizations (including schools), U.S. Decennial Census (10 year), U.S. Census Bureau, American Community Survey, WHO Global Health Estimates, WHO Global Health Observatory, UNICEF Pacific Islands Data Reports
	Public health services	
	Housing	
	Schools	
	Transportation	
External Factors	Climate change	Program data, data from community-based organizations, Pacific Food Trade Database (PFTD), WHO Global Health Observatory
	Reliance on food import	
Facilitating Factors	Data for decision-making	Program data, data from community-based organizations, Pacific Syndromic Surveillance System (PSSS), WHO Global Health Estimates, WHO Global Health Observatory, UNICEF Pacific Islands Data Reports *When databases are not available, most of the factors could be measured using qualitative methods, such as document review, interviews, and focus groups.
	Policy development and advocacy	
	Community partnerships and engagement	