A New Health Disparities Toolkit for Public Health Agencies to Improve Their Practices

Inventory of public health practices and structures to eliminate and reduce health disparities

SUMMARY

Racial and ethnic minorities receive less and lower-quality health care and have higher rates of preventable sickness and death than non-minorities according to numerous studies. Elimination of these disparities has long been a goal of public health agencies at all levels of government. Little progress has been made in closing those gaps, however.

From August 2007 to March 2010, researchers at the University of Washington School of Nursing in Seattle developed an inventory of practices and strategies being used by public health agencies to address the problem of disparities. They also established an electronic database of the most promising initiatives that serves as a tool for agencies striving to improve their efforts to reduce disparities.

Bobbie Berkowitz, Ph.D., professor emerita and Alumni Endowed Professor of Nursing at the University of Washington School of Nursing served as project director. (She is now dean of the Columbia University School of Nursing and a senior vice president of the Columbia University Medical Center.) Berkowitz was the director of *Turning Point: Collaborating for a New Century in Public Health*, a national program of the Robert Wood Johnson Foundation (RWJF) that helped 22 states and 41 communities strengthen their public health systems; see Program Results.

Berkowitz and her colleagues gathered data for the inventory by:

- Conducting literature searches. These included a review of the National Association of County and City Health Officials (NAACHO) 2008 survey that provided a profile of local health departments.

- Distributing an online survey about disparity efforts to 619 local public health agency leaders who had indicated in the 2008 NAACHO profile that they had engaged in activities to address disparities; 100 officials from 31 states responded.

- Interviewing officials from 38 local health departments. This enabled the researchers to learn more about their programs to address health disparities.

The project team had originally planned to create its own website about the most promising initiatives it had identified. Rather than create a stand-alone site, however, the nursing school subcontracted with NAACHO to post the database as part of its larger toolkit of resources for public health agencies.

Key Results

Project Director Berkowitz reported the following results to RWJF:

- The research team created a Health Disparities Toolkit, a searchable database of summaries of 27 programs and tools to address health disparities from local health departments. The toolkit was designed to provide policy-makers, public health systems researchers, and public health leaders with inspiration and ideas for implementing programs to address health disparities and inequities.

  Examples of featured programs and tools are:

  — *Building Social & Health Equity*, Alameda County, Calif. The Alameda County Public Health Department employs institutional and policy change and community capacity building to change the way it conducts public health and integrates more equitable systems, policies, procedures and practices into its daily activities.

  — *Preparedness through Linking All Neighbors (P.L.A.N.),* Madison and Dane County, Wis. This is a 10-step approach to emergency preparedness and all-disaster planning through building social capital, partnerships and collaboration. P.L.A.N. conducts community outreach to raise awareness and spark discussion about racial and economic inequities. It provides support and resources for organizing communities around effective emergency response.

  The 27 summaries are part of NAACHO's larger toolkit of resources for public health agencies. A complete list of the 27 programs and tools is available online.

Key Findings

Researchers reported the following findings from the online survey of 100 public health agencies:

- Nearly all of the health disparities programs identified fell into these categories:

  — Access to care

  — Chronic disease

  — Environmental health

  — HIV/sexually transmitted diseases

  — Infectious diseases

- — Maternal and child health

- — Obesity

- — Oral health

- — Systemic initiatives

- — Tobacco

- Some 83 percent of health disparities programs targeted risk factors such as personal behaviors (e.g., smoking, nutrition and physical activity), socioeconomic status or the built environment.

Researchers reported the following findings from their interviews with public health officials:

- Agencies rarely conduct scientifically rigorous evaluations of their programs. The main reasons for not conducting evaluations were:

  - — Time constraints

  - — Lack of human resources

  - — Insufficient technical expertise

- The most promising programs have strong investment from local health department and government leaders and are often developed from leadership priorities. They employ multiple strategies to address health disparities, including:

  - — External policy advocacy

  - — Community capacity-building partnerships

  - — Health promotion education

  - — Internal professional development

See the Appendix for additional findings from the surveys and interviews.

Conclusions

"There is a limited evidence base for the programs that are being used for intervening in health disparities and health inequities," according to Berkowitz. As her team characterized the 27 programs included in the toolkit:

- Some 19 were "emerging" in terms of the level of evidence used in program development and evaluation.

- Six were "promising."

- Two were "effective."

- None were "evidence-based."

Communications

Researchers presented the project toolkit and results at the 2009 annual meetings of the American Public Health Association and the National Association of County and City Health Officials.

Funding

RWJF funded this work through a grant of $460,229.

Afterward

The Health Disparities Toolkit remains available as part of the toolkit on the NACCHO website. Project Director Berkowitz and her colleagues are working on an article about the project.

APPENDIX

Additional Survey and Interview Findings

More Findings from the Online Survey

- Some 61 percent of respondents said their health disparities programs targeted chronic diseases such as obesity, cardiovascular disease or diabetes.

- Some 55 percent of respondents said their health disparities programs addressed societal and social inequities by improving things like community safety, social capital or health policy.

- Some 67 percent of respondents said their health disparities programs addressed health services (i.e., facilitating access to and use of services that prevent disease).

- Some 31 percent of respondents said their health disparity programs targeted all of these areas:

  — Chronic disease

  — Social inequities

  — Risk factors

  — Health services

- Most respondents cited many influences guiding program development; some 70 percent were influenced by at least three factors. The most common factors were:

  — Local health department data

  — The scientific literature

  — Advisory group input

  — The interests of community-based agencies

  — Funding or legislative mandates

More Findings from the Interviews

- Health officials' definitions of "health disparities" typically fell into two categories: health inequities and health disparities:

  — Health inequities were defined as differences in health status resulting from the unequal and unjust distribution of power, income, goods and services.

  — Health disparities were defined as differences in health outcomes among different populations.

- Differences in definitions often reflected differences in approaches to addressing health disparities.

  — Health departments that used the phrase health disparities more often reported targeted, downstream programs to reduce the burden of particular diseases or improve service for particular populations. These programs generally focused on integrating culturally-relevant activities into existing systems and facilitating health promotion through individual behavior change.

  — Local health departments that had adopted the phrase health inequities typically reported on broad, upstream interventions or initiatives targeting the social determinants of health through policy advocacy and community capacity building.

    These health departments also often reported conducting internal review of policies and procedures, as well as staff training on the social determinants of health. The goal was to ensure that community outreach and engagement, as well as program development and implementation, was conducted in a manner that builds power and capacity within the community rather than reinforcing existing systems of oppression and exacerbating disparate health outcomes

- The majority of interviewees reported that their health departments conducted a community assessment to inform program development and implementation. However, community assessments were not always translated into plans of action for addressing health disparities.

BIBLIOGRAPHY

(Current as of date of the report; as provided by the grantee organization; not verified by RWJF; items not available from RWJF.)

Education & Instruction

Health Disparities Toolkit, an online database maintained by the National Association of County and City Health Officials. Seattle: University of Washington School of Nursing, 2010. The link takes you to a page where different state and county results can be accessed.