



# Incorporating Social Determinants of Health into our Work



**HE & EJ Collaborative**

Health Equity & Environmental Justice

Incorporating  
**Social Determinants of Health**  
into our Work

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## Acknowledgements

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This planning tool was created in accordance with the Colorado Department of Public Health and Environment Policy 2.4 - Incorporation of Health Equity and Environmental Justice Principles. The purpose of this tool is to help the health divisions develop strategies to reduce health inequities by addressing the social determinants of health. This tool parallels the efforts being conducted by the environmental divisions, which have also developed guidance to implement Policy 2.4.

## What we need to do

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### Goals

To integrate the social determinants of health into our work, the department has established the following goals:

1. **Develop understanding among staff members and community**  
on how the social determinants of health influence public health.
2. **Incorporate people with lived experience**  
into decision-making.
3. **Allocate resources**  
using social determinants of health principles.
4. **Work with partners**  
to develop a multisectoral approach (across sectors such as transportation, housing, higher education) for community initiatives.
5. **Develop policies and plans**  
using a social determinants of health lens.

## Transforming goals into action

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To meet the requirements of the department Policy 2.4 - Incorporation of Health Equity and Environmental Justice Principles, please review the background sections below if you need more context and then follow the steps provided in this planning tool.

# Why the social determinants matter

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Social determinants are the structural conditions in which people live, work and play. Traditionally, efforts to improve health outcomes have focused on the health care delivery system. However, research shows that to effectively address health disparities, health care policy must also address the social, economic and environmental factors that affect community health. Social determinants associated with negative health outcomes include:

- Economic instability
- Inadequate local infrastructure and physical environment
- Barriers to education or access to information
- Lack of food and healthy food options
- Insufficient social integration
- Inadequate access to the health care system

Scientists estimate that at least 40 percent of health outcomes are the result of social and economic factors, which means that focusing solely on treating disease will not improve population health.<sup>1</sup>

Under-resourced individuals and communities experience disproportionately negative health outcomes due to social determinants of health factors.

- A meta-analysis of nearly 50 studies found that social factors, including education, racial segregation, social supports and poverty accounted for more than a third of total deaths in a year.
- Poor members of racial and ethnic minority communities are more likely to live in neighborhoods with concentrated poverty than their poor white counterparts.
  - Lower education levels are directly correlated with lower income, higher likelihood of smoking and shorter life expectancy. Children born to parents who have not completed high school are more likely to live in an environment that poses barriers to health. Their neighborhoods are more likely to be unsafe, have exposed garbage or litter, and have poor or dilapidated housing and vandalism. They also are less likely to have sidewalks, parks or playgrounds, recreation centers or a library.
  - There is growing evidence demonstrating stress negatively affects health for children and adults across the lifespan. Recent research shows where a child grows up affects his or her future economic opportunities as an adult and also suggests that the environment in which an individual lives may have multigenerational impacts.<sup>2</sup>

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<sup>1</sup> Achieving Health Equity: How Academic Medicine is Addressing the Social Determinants of Health. Association of American Medical Colleges. . 2016, page 4. <https://www.aamc.org/download/460392/data/sdoharticles.pdf>

<sup>2</sup> Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. November 4, 2015. Harry J Heiman and Samantha Artiga. Kaiser Family Foundation Issue Brief. Accessed 05/23/17. <http://kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>

## Connecting determinants to public health

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To help understand how the five goals in this planning tool are connected to public health, each goal has been correlated with:

- The 10 essential public health services.
- The additional requirement established by the Public Health Accreditation Board standards version 1.5 regarding a competent workforce and administration and management capacity.

The essential public health services and Public Health Accreditation Board requirements are listed below.

1. **Monitor** health status to identify and solve community health problems.
2. **Diagnose** and investigate health problems and health hazards in the community.
3. **Inform, educate and empower** people about health issues.
4. **Mobilize** community partnerships and action to identify and solve health problems.
5. **Develop policies and plans** that support individual and community health efforts.
6. **Enforce laws and regulations** that protect health and ensure safety.
7. **Link** people to needed personal health services and ensure the provision of health care otherwise unavailable.
8. **Ensure a competent public and personal health care workforce.**
9. **Evaluate** effectiveness, accessibility and quality of personal and population-based health services.
10. **Research** for new insights and innovative solutions to health problems.
11. **Public Health Accreditation Board - Ensure competent public health workforce. (Standard 8.2) Provide a policy and procedure that demonstrates how health equity is incorporated as a goal into the development of policies, processes and programs. (Standard 11.1.4).**<sup>3</sup>

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<sup>3</sup>Public Health Accreditation Board. (2016) Standards and Measures Version 1.5.  
[http://www.phaboard.org/wp-content/uploads/PHABSM\\_WEB\\_LR1.pdf](http://www.phaboard.org/wp-content/uploads/PHABSM_WEB_LR1.pdf)

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## Select a strategy

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- Review goals 1 through 5. See Appendix A.
- Select a **strategy** associated with a goal. Although you may select multiple strategies, you are only required to select one strategy under one goal. The strategy can span multiple fiscal years as long as there are distinct milestones that must be implemented in the current fiscal year.

## Develop an implementation plan

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The implementation plan should include:

- The goal (i.e., 1 through 5) and the strategy.
- The **project lead** associated with the strategy. The project lead should have the authority to implement or coordinate the implementation of the strategy.
- A brief description of the **tasks and timelines** associated with the strategy.
- The **performance measure** for the strategy within the current fiscal year.
- If the strategy has direct impact on an under-resourced population, include the following elements, as **applicable**:
  - the under-resourced population that is being addressed (e.g., racial or ethnic minorities; low income; persons with disabilities; sexual orientation/gender identity; other)
  - the social determinant(s) of health that you are seeking to impact.
  - the partnerships with other divisions, state agencies, local government agencies, or the private sector who are **jointly** implementing the strategy. This includes entities that are delivering services to the same under resourced population or addressing the same type of inequity. It does not include advisory groups.
  - the type of community engagement that will be used to design or implement the strategy.
- If you are interested in addressing the social determinants of health **comprehensively**, please refer to Appendix B.

## Tracking progress

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- **Submit** information about your strategy using this [Google form](#) to the Office of Health Equity on or before **September 1, 2017**.
- The Health Equity and Environmental Justice Steering Committee will review the strategies submitted and make recommendations to the leads regarding opportunities for intra-department coordination of initiatives on or before **September 30, 2017**.
- The performance measure for the strategy shall be incorporated into the Division's performance management dashboard on or before **October 15, 2017**.
- The Division leads for the strategy **shall report to the steering committee quarterly** regarding the status of implementation.

## Goal 1

### Develop understanding among staff members and community on how the social determinants of health influence public health.

Categories	Strategies	Sample Activities	Relevant Essential public health services
<b>Data collection</b>	Develop datasets that allow programs to identify where the community is under- resourced in terms of social determinants of health.	<ul style="list-style-type: none"> <li>• Create maps that show social determinants of health assets and deficits at state, county, census tract and neighborhood levels.</li> <li>• Link CDPHE data sets to Melissa Data (a social determinants of health data set).</li> </ul>	1,2,3
	Use datasets holistically across programs rather than in silos.	<ul style="list-style-type: none"> <li>• Work with Data Users group to cross-link 200+ department databases and track info in Tableau.</li> </ul>	1,2,3
<b>Data formatting</b>	Format data so the underlying story about social determinants of health is easy to grasp. Frame data to avoid victim blaming.	<ul style="list-style-type: none"> <li>• Create visuals that allow the reader to determine the problem and associated social determinants of health concerns at a glance.<sup>1</sup> Ideally visuals assist with problem-solving.</li> <li>• Create dashboards that monitor health of specific sub-populations that serve as early warning systems.</li> <li>• Consider the following resources:               <ul style="list-style-type: none"> <li>○ <a href="#">7 Things Advocates Should Know When Communicating About Health Equity.</a></li> <li>○ <a href="#">Reframing Neighborhood Socioeconomic Diversity.</a></li> <li>○ <a href="#">Communicating About Equity: A Guide for Practitioners.</a></li> <li>○ <a href="#">Race and Social Justice Initiative - Imagine a City Where...</a></li> </ul> </li> </ul>	1,2,3
<b>Data use</b>	Systematically incorporate social determinants of health data into CDPHE initiatives (e.g., proposed legislation, regulation, decision items, grants)	<ul style="list-style-type: none"> <li>• Consider using the social determinants of health lens provided in this planning tool to determine data points.</li> </ul>	1,2,3,4, 5, 6

<sup>1</sup> - Consider using data to bring stakeholders together to develop a multisectoral approach. For example, a map that shows the correlation between children with high lead blood levels living in housing built on or before 1974 could be used to create consensus with housing agencies to consider low-cost loans for lead paint abatement.

Categories	Strategies	Sample Activities	Relevant Essential public health services
<b>Data dissemination</b>	<p>Disseminate social determinants of health-formatted data (see row above) to other programs that may be able to partner on addressing social determinants of health, e.g.:</p> <ul style="list-style-type: none"> <li>• Other CDPHE programs/divisions.</li> <li>• Local public health agencies.</li> <li>• Other state agencies.</li> <li>• Policymakers, e.g.:               <ul style="list-style-type: none"> <li>○ Board of Health and other boards and commissions.</li> <li>○ Legislators.</li> <li>○ Local zoning boards.</li> </ul> </li> <li>• Community-based organizations.</li> <li>• Regulated entities.</li> <li>• Higher education.</li> <li>• K-12 schools.</li> </ul>	<ul style="list-style-type: none"> <li>• Incorporate social determinants of health-formatted data in the annual grant planning to local public health agencies.</li> <li>• Create data platforms that allow communities to access the data they care about.</li> <li>• Target the dissemination of data to organizations that serve under-resourced populations so that the data can be another tool to drive social change.</li> <li>• Consider the following resource from the Colorado Office of Health Equity:               <ul style="list-style-type: none"> <li>○ <a href="#">Framing Data to Advance Equity</a>.</li> </ul> </li> </ul>	1,3,4,5,6
	<p>Train end users on how to interpret and use data for problem solving.</p>	<ul style="list-style-type: none"> <li>• Provide training to:               <ul style="list-style-type: none"> <li>○ CDPHE staff.</li> <li>○ Grantees.</li> <li>○ Community members.</li> </ul> </li> <li>• Focus training on upstream rather than lower-level responses.</li> <li>• Include principles of self-advocacy in training for communities.</li> </ul>	
<b>Research social determinants of health data use</b>	<p>Explore how other states and organizations have collected, formatted and disseminated social determinants of health data. Determine how these innovations could be implemented in Colorado and disseminate findings to relevant CDPHE personnel.</p>	<ul style="list-style-type: none"> <li>• Explore the following indexes:               <ul style="list-style-type: none"> <li>○ <a href="#">Connecticut’s social determinants of health index</a>.</li> <li>○ <a href="#">Public Health Alliance of Southern California Health Disadvantage Index</a>.</li> </ul> </li> <li>• Consider the following resource(s):               <ul style="list-style-type: none"> <li>○ <a href="#">Using Data to Identify Health Inequities</a>.</li> <li>○ <a href="#">Using Social Determinants of Health Data to Improve Health Care and Health</a>.</li> </ul> </li> </ul>	10

## Goal 2

### Incorporate people with lived experience into decision-making.

Categories	Strategies	Sample Activities	Relevant Essential public health services
Workforce representation	Recruit and retain people with lived experience into CDPHE workforce.	<ul style="list-style-type: none"> <li>When CDPHE certifies professionals, such as radiology techs, ensure there is cultural inclusion.</li> <li>To ensure the workforce reflects populations being served, include management and rank-and-file with lived experience.</li> </ul>	6, 8
Stakeholder coalitions/groups representation	Recruit and retain people with lived experience onto stakeholder coalitions and groups.	<ul style="list-style-type: none"> <li>Existing coalitions often have a narrow focus. Consider expanding their focus so they become a resource for other projects that the department is also working on.</li> <li>Consider compensating people who serve on a coalition who are not paid by an agency.</li> </ul>	3, 5, 6
Boards and commissions membership	Recruit and retain people with lived experience onto regulatory boards and commissions.	<ul style="list-style-type: none"> <li>Identify the social determinants of health relevant to the matters that come before the board/commission. Incorporate a question in the solicitation application about the candidate's lived experience with one or more of these determinants. (This allows candidates to talk about experiences that are not captured in traditional resumes.) Discuss during interviews and on boarding possible appropriate ways of using the lived experience to inform the work of the board/commission.</li> </ul>	3, 6, 8

Categories	Strategies	Sample Activities	Relevant Essential public health services
Community voice	Develop a community engagement strategy to ensure interventions honor community voice.	<ul style="list-style-type: none"> <li>• Consider partnering with a community thought leader such that CDPHE provides the data/research and the thought leader develops and delivers the public health message and intervention.</li> <li>• Consider the following resources:               <ul style="list-style-type: none"> <li>◦ <a href="#">Colorado's Community Engagement Continuum</a>.</li> <li>◦ <a href="#">Colorado Community Engagement Indicators</a>.</li> <li>◦ <a href="#">Impacts of Community Engagement</a>.</li> <li>◦ <a href="#">Evaluation and Community Engagement</a>.</li> </ul> </li> <li>• For further technical assistance, contact <a href="#">Vaishnavi Hariprasad</a> in the Office of Health Equity.</li> </ul>	3, 4, 5, 6

## Goal 3

### Allocate resources

based on social determinant of health principles.

Categories	Strategies	Sample Activities	Relevant Essential public health services
RFA grant criteria	Incorporate one or more of the strategies in this planning tool into the grant criteria.	<ul style="list-style-type: none"> <li>• Require grantees to:                             <ul style="list-style-type: none"> <li>○ Collect and use of data on social determinants of health concerns. (See Goal 1.)</li> <li>○ Conduct meaningful community engagement and developing culturally responsive services. (See Goal 2.)</li> <li>○ Establish multisectoral partnerships, since social determinants of health concerns cannot typically be addressed in silos.</li> <li>○ Allocate resources within the community to directly address social determinants of health issues, with emphasis on evidence-based interventions.</li> <li>○ Evaluate process and outcomes using measures associated with increasing equity.</li> <li>○ Incorporate one or more strategies in the social determinant of health lens in this planning tool. (See Appendix C.)</li> </ul> </li> </ul>	1, 7, 9
Technical assistance to grantees	Include funding to educate grantees regarding the incorporation of social determinants of health in their work.	<ul style="list-style-type: none"> <li>• Consider the following resource(s):                             <ul style="list-style-type: none"> <li>○ <a href="#">Community Tool Box - Addressing Social Determinants of Health in Your Community.</a></li> </ul> </li> </ul>	
RFAs - grant scoring	Create guidance for scoring that incorporates social determinants of health.	<ul style="list-style-type: none"> <li>• Provide higher scoring for applicants who meet certain social determinants of health criteria, such as those in the sample activities under the “RFA grant criteria” category above.<sup>1</sup></li> </ul>	

<sup>1</sup> For example, higher scores could be provided to grantees that assist low-income populations in maximizing benefits that help alleviate social determinants of health concerns. When providing services to low-income populations, such as WIC services and services for pregnant women, grantees could be required to also provide information about how to access other low-income programs for which they may be eligible, such as the Earned Income Tax Credit.

Categories	Strategies	Sample Activities	Relevant Essential public health services
Local public health agency grant planning	Incorporate social determinants of health requirements into scopes of work. Contact the <a href="#">Office of Planning, Partnerships and Improvement</a> to ensure consistent messaging to local public health agencies regarding social determinants of health requirements, resources and support.	<ul style="list-style-type: none"> <li>• Provide technical assistance to increase capacity of local public health agencies to address social determinants of health.</li> <li>• Consider using the following resource(s):               <ul style="list-style-type: none"> <li>○ <a href="#">New Approaches for Moving Upstream: How State and Local Health Departments Can Transform Practice to Reduce Health Inequalities.</a></li> </ul> </li> </ul>	4,5



## Goal 4

### Work with partners

to develop a multisectoral approach (across sectors such as transportation, housing, higher education) for community initiatives.

Categories	Strategies	Sample Activities	Relevant Essential public health services
Local public health departments	Partner with local public health agencies.	<ul style="list-style-type: none"> <li>• Create criteria for determining the lead agency<sup>1</sup>.</li> <li>• Connect with the <a href="#">Office of Planning, Partnerships and Improvement</a> staff and resources to learn about other ways of engaging local public health agencies and/or regional partnerships. Resources include:                             <ul style="list-style-type: none"> <li>◦ Local public health agencies assessment and planning status <a href="#">map</a> that includes links to community health assessments and public health improvement plans per agency or region.</li> <li>◦ Colorado Public Health Structure <a href="#">Map</a>.</li> <li>◦ Find your local public health agency <a href="#">contact list</a>.</li> </ul> </li> </ul>	4
Other state agencies	Partner with other state agencies.	<ul style="list-style-type: none"> <li>• Use a Health in All Policies Framework. For more info, <a href="#">access this guide for state and local governments</a> or contact <a href="#">Sarah Hernandez</a> in the Office of Health Equity.</li> </ul>	4
Community-based organizations/private sector	Partner with community-based organizations and the private sector, including regulated entities.	<ul style="list-style-type: none"> <li>• Consider using a collective action approach.</li> <li>• Consider the following resource(s):                             <ul style="list-style-type: none"> <li>◦ <a href="#">Environmental Scan of Initiatives Incorporating Social Determinants in Public Health</a>, 2016.</li> </ul> </li> <li>• Disseminate data about the impact of social determinants to regulated entities and solicit and jointly implement solutions.<sup>2</sup></li> </ul>	4

<sup>1</sup> For example, when the health threat crosses multiple local public health agency jurisdictions, CDPHE might be the best entity to lead a regional intervention. If the threat is evenly distributed throughout the local agency's population, the local public health agency may be the most appropriate entity to take the lead. Determine responsibilities of each agency - whether they are taking the active or supportive role. If it is appropriate for local agencies to take the lead, CDPHE should provide requisite resources, to include flexibility in grants.

<sup>2</sup> For example, the University of New Mexico piloted a questionnaire to screen patients for social determinants that helped health care providers make better informed decisions about effective interventions. See: [Addressing Social Determinants of Health in a Clinic Setting: The WellRx Pilot in Albuquerque, New Mexico](#). Reeves et al. Journal of American Board of Family Medicine. May-June 2017.

## Goal 5

### Develop policies and plans using a social determinants of health lens.

Categories	Strategies	Sample Activities	Relevant Essential public health services
Strategic plans - state	Embed health equity and environmental justice in the CDPHE strategic plan.	<ul style="list-style-type: none"> <li>• Select specific health disparities that the department would like to reduce/eliminate.</li> <li>• Require divisions to use of the health equity and environmental justice guidance and planning documents</li> <li>• Consider the following resource(s):                             <ul style="list-style-type: none"> <li>◦ Minnesota Department of Health <a href="#">Strategic Plan</a> Annual Report (2016) &amp; Work Plan (2017)</li> </ul> </li> </ul>	5, 11
Strategic plans - local	Encourage health equity and environmental justice principles to be used in local planning.	<ul style="list-style-type: none"> <li>• Develop a health in all policies approach. Consider the following resource(s) and/or contact <a href="#">Sarah Hernandez</a> in the Office of Health Equity:                             <ul style="list-style-type: none"> <li>◦ <a href="#">Health in All Polices: A Framework for State Health Leadership</a>, ASTHO.</li> <li>◦ <a href="#">Minnesota Public Health Association Resources</a>.</li> </ul> </li> <li>• Consider the following resource(s):                             <ul style="list-style-type: none"> <li>◦ <a href="#">Saint Paul --Ramsey County Public Health, Health Equity Plan</a>, 2016-2018</li> </ul> </li> </ul>	5, 11
Accreditation	Meet the Public Health Accreditation Board standards concerning health equity	<ul style="list-style-type: none"> <li>• Consider the following resources:                             <ul style="list-style-type: none"> <li>◦ <a href="#">PHAB Standards and Measure Version 1.5</a>.</li> <li>◦ Tri-County Health Department Health Equity <a href="#">Crosswalk</a> for Health Departments.</li> </ul> </li> <li>• Connect with <a href="#">Office of Planning, Partnerships and Improvement</a> staff for guidance.</li> </ul>	5, 11
Decision items	Develop a systematic process for considering the relevance of the determinants	<ul style="list-style-type: none"> <li>• Consider developing a menu of possible strategies using the strategies under Goals 1 through 4 as well as the strategies in the social determinants of health lens in Appendix C.</li> </ul>	5,6
Competent workforce	Ensure workforce is competent re: social determinants of health.	<ul style="list-style-type: none"> <li>• Develop competencies related to implicit bias and social determinants of health barriers associated with poverty and discrimination.</li> <li>• Establish competency requirements in your work unit.</li> </ul>	8

Categories	Strategies	Sample Activities	Relevant Essential public health services
Legislation	Develop a systematic process for incorporating the determinants.	<ul style="list-style-type: none"> <li>• Develop a health in all policies framework. Consider the following resource(s):               <ul style="list-style-type: none"> <li>◦ <a href="#">Health in All Polices: A Framework for State Health Leadership</a>, ASTHO.</li> <li>◦ <a href="#">Minnesota Public Health Association Resources</a>.</li> </ul> </li> <li>• Create process to weigh in on department legislative agenda and other proposed on issues such as:               <ul style="list-style-type: none"> <li>◦ Poverty (e.g., livable wage).</li> <li>◦ Violence (e.g., land use that creates neighborhood lighting and defensible spaces).</li> <li>◦ Food deserts.</li> <li>◦ Opportunity/achievement gap (e.g., school dropout, prevention initiatives).</li> <li>◦ Cumulative impact of pollution in low-income neighborhoods.</li> </ul> </li> </ul>	5,6
Regulations	Develop a systematic process for considering the relevance of the determinants.	<ul style="list-style-type: none"> <li>• Consider developing a menu of possible strategies using the strategies under Goals 1, 2, and 4 as well as the strategies in the determinants of health lens in Appendix C. For example, disseminate data about the impact of social determinants to regulated entities and solicit and jointly implement solutions.<sup>1</sup></li> </ul>	5,6
Performance management	Monitor incorporation of social determinants of health concerns into our work.	<ul style="list-style-type: none"> <li>• Develop performance measures that monitor the implementation of health equity-focused activities for department dashboard, division dashboards and/program dashboards.</li> </ul>	5,9
Program evaluation	Evaluate programs to determine whether social determinants of health are being addressed and/or inequities are decreasing.	<ul style="list-style-type: none"> <li>• Consider the following resources:               <ul style="list-style-type: none"> <li>◦ <a href="#">Addressing Health Equity in Evaluation Efforts</a>.</li> <li>◦ <a href="#">Considerations for Conducting Evaluation Using a Culturally Responsive and Racial Equity Lens</a>.</li> <li>◦ <a href="#">Office of Health Equity’s Measuring Process to Advance Equity &amp; Crafting Evaluation Questions and Outcome Measures to Advance Equity</a>.</li> </ul> </li> </ul>	9
Dept/division internal policies	Review internal policies with a health equity and environmental justice lens.	<ul style="list-style-type: none"> <li>• Develop and use a determinant policy lens.</li> <li>• Refer to the Office of Health Equity’s Checking Assumptions to Advance Equity.</li> <li>• Consider using <a href="#">King County’s Equity Impact Review Tool</a>.</li> </ul>	5

<sup>1</sup> For example, the University of New Mexico piloted a questionnaire to screen patients for social determinants that helped health care providers make better informed decisions about effective interventions. See: [Addressing Social Determinants of Health in a Clinic Setting: The WellRx Pilot in Albuquerque, New Mexico](#). Reeves et al. Journal of American Board of Family Medicine. May-June 2017.

## Strategies for **Comprehensively** Addressing Equity and Engagement

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### What does it mean to comprehensively integrate social determinants of health into your work?

It means engaging the community most adversely affected, and developing a multisectoral partnership to address the root causes of the issue (e.g., lack of education, poverty, racism), while ensuring equity is woven into programs, practices and policies that affect:

- Recruitment, retention, hiring practices.
- Staff knowledge and skills at all levels.
- Allocation of resources, budgets and contracting.
- Communication, including framing the issue in a culturally responsive way.
- Culturally responsive training and consultation with grantees or partners.
- Data, measurement and evaluation that ensures the agency's programs, practices and policies decrease inequities.

### Some strategies for consideration...

- Understand that comprehensively addressing equity may require systemic change. Resources to consider include:
  - [CDC Practitioners Guide for Advancing Health Equity.](#)
  - [Equity and Empowerment Lens.](#)
  - [Public Health Framework to Address Inequities.](#)
- Come to agreement on what "health equity" means to the group working on the initiative, and develop a statement or statements on how the group will prioritize and/or address equity. (For example, we will move forward only when the group represents the communities most affected by the issue.)
- Become aware of biases and know how to overcome/address them. This can be done through Harvard's implicit bias test (see first link below) with associated reflection questions. Ideally, someone skilled at having these conversations would facilitate a conversation with the group after everyone has completed the test. Resources to consider include:
  - [Project Implicit.](#)
  - [Intervention Level Strategies to Address Unconscious Bias.](#)
  - [Inclusion, Belonging and Excellence - Addressing Implicit Bias.](#)
  - [Proven Strategies for Addressing Unconscious Bias in the Workplace.](#)

- Complete an organizational self-assessment (see links below) to understand where the group as a whole stands on addressing these issues. It's important not to make assumptions about how ready folks are. Resources regarding organizational assessments include:
  - [Wilder Research Brief about Health Equity Assessments June 2015.](#)
  - [Washington State Department of Health's Health Equity Review Planning Tool.](#)
  - [King County Equity Impact Review Tool.](#)
  - [Anne E. Casey Organizational Self-Assessment.](#)
  - [Bay Area Regional Health Inequities Initiative.](#)
  - [Western States Center Assessing Our Organizations - Racial Justice](#) and [LGBTQ Equity.](#)
- Look at the data and identify the populations most affected by the issue at hand. Then, not only engage them, but include them, in the process.
- Identify which social determinants of health and/or root causes are leading to the disparity. Then, select one to address and develop or incorporate it into an action plan.
- Ensure other relevant sectors (e.g. transportation, housing, higher education) are at the table and working to address the root causes.
- Improve systems, policies and practices whenever possible. Don't be afraid to tackle the hard stuff, such as racism. There are many policy assessment tools that will highlight how current policies are embedded with institutional "isms". Find them and work to change them.
- Use the framework provided below to determine whether your strategies to reduce health inequities are upstream or downstream. Incorporate activities that address upstream root causes to the extent possible.

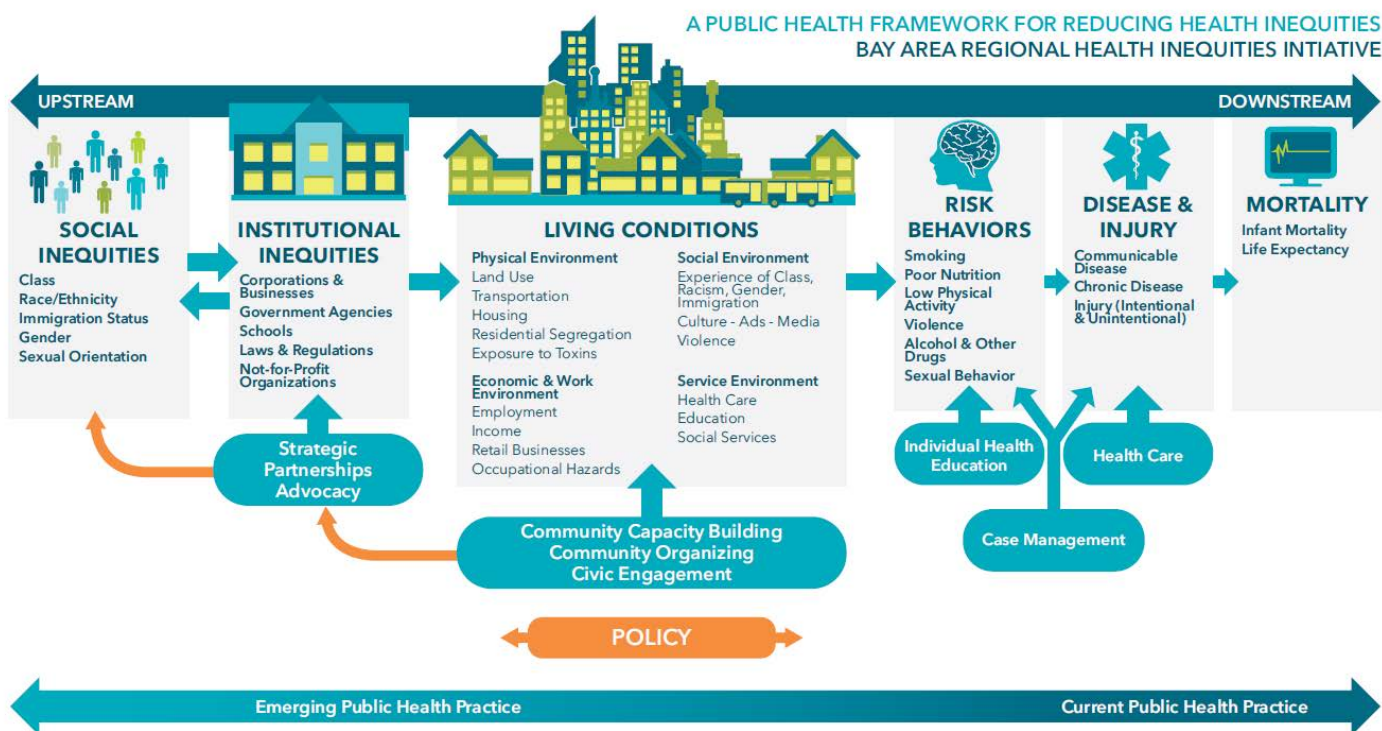


FIGURE 3: Bay Area Regional Health Inequities Initiative (BARHII) Conceptual Framework, 2006.

This lens lists the determinants as well as strategies additional to those listed under the five goals.

## Determinants and potential strategies

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### Economic instability

Factors	Example strategies that can help
<ul style="list-style-type: none"> <li>Income</li> </ul>	<ul style="list-style-type: none"> <li>Sliding fee scales.</li> <li>Client navigation through the social net continuum.</li> <li>Debt relief, e.g., forgiveness or payment plans of medical bills</li> <li>Improved employment opportunities</li> <li>Livable wage initiatives</li> </ul>

### Inadequate local infrastructure and physical environment

Factors	Example strategies that can help
<ul style="list-style-type: none"> <li>Housing</li> </ul>	<ul style="list-style-type: none"> <li>Mitigation of exposure to toxins in homes and/or communities.</li> </ul>
<ul style="list-style-type: none"> <li>Safety</li> </ul>	<ul style="list-style-type: none"> <li>Mitigation of violence: child abuse, domestic violence, crime.</li> </ul>
<ul style="list-style-type: none"> <li>Transportation</li> </ul>	<ul style="list-style-type: none"> <li>Transportation services to and from health care services.</li> <li>Delivery of health care services in their communities.</li> <li>Service delivery in their homes.</li> </ul>
<ul style="list-style-type: none"> <li>Access to healthy recreation</li> </ul>	<ul style="list-style-type: none"> <li>Promoting the development of safe parks, playgrounds, and sidewalks for walkability.</li> </ul>
<ul style="list-style-type: none"> <li>Environmental toxins</li> </ul>	<ul style="list-style-type: none"> <li>Determining the cumulative impact of pollution in low income neighborhoods</li> </ul>

### Barriers to education or access to information

Factors	Example strategies that can help
<ul style="list-style-type: none"> <li>Literacy</li> <li>Language</li> </ul>	<ul style="list-style-type: none"> <li>Promoting of health literacy and improving the readability of health information.</li> <li>Affordable quality early childhood education, higher education, and vocational training</li> <li>Drop-out prevention, particularly for drop out resulting from health related reasons.</li> <li>Language or communication assistance.</li> <li>Access to health equity and environmental data to the community.</li> </ul>

## Lack of food and healthy food options

Factors	Example strategies that can help
<ul style="list-style-type: none"> <li>• Hunger</li> <li>• Access to healthy options</li> </ul>	<ul style="list-style-type: none"> <li>• Income assistance</li> <li>• Access to affordable healthy options.</li> </ul>

## Insufficient social integration

Factors	Example strategies that can help
<ul style="list-style-type: none"> <li>• Support systems</li> <li>• Community engagement</li> <li>• Discrimination</li> </ul>	<p>Participation in decision-making</p> <ul style="list-style-type: none"> <li>• Forums on public health issues in locations and at times convenient to the community.</li> <li>• Participation in advisory committees.</li> <li>• Hiring practices that promote representation at all levels of CDPHE.</li> </ul>
	<p>Social supports and networks</p> <ul style="list-style-type: none"> <li>• Patient navigation through the health care system.</li> <li>• Self- or community advocacy training.</li> <li>• Advocacy for multisectoral approaches that address poverty, low educational attainment, structural discrimination.</li> </ul>

## Limited access to the health care system

Factors	Example strategies that can help
<ul style="list-style-type: none"> <li>• Health coverage</li> <li>• Provider availability</li> <li>• Provider linguistic and cultural competency</li> <li>• Quality of care</li> </ul>	<ul style="list-style-type: none"> <li>• Provider linguistic and cultural competency.</li> <li>• Enhanced health coverage.</li> <li>• Quality of care focused on the specific needs of the population.</li> </ul>