

Equity in All Policies Webinar

Rhode Island: Health Equity Zones

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Summarized by Jessica Gebhard

This webinar was jointly sponsored by the Federal Interagency Health Equity Team (itself a part of the National Partnership for Action to End Health Disparities [NPA]) and the Association of State and Territorial Health Officials (ASTHO).

The co-moderators of the webinar were

- Onyemaechi Nweke (NPA)
- Yolanda Savage-Narva (ASTHO)

The presenters were

- Ana Novais, Executive Director of Health at the Rhode Island Department of Health
- Angela Ankoma, Chief of the Office of Minority Health at the Rhode Island Department of Health,
- Carol Hall-Walker, Associate Director of the Division of Community Health at the Rhode Island Department of Health

The presenters discussed the place-based, community-orientated model that they implemented in Rhode Island. While the previous model had produced positive change in some key areas, including tobacco use, responsible sexual behavior, teen pregnancy, injury and violence, and environmental quality, in others, the data showed either a lack of change or a negative change. Further, the data also showed that minority and disadvantaged groups, including children, were experiencing disproportionately poor health, even in areas where the overall change had been positive.

In order to address these disparities, the Rhode Island DoH implemented a model based on Dr. Thomas Frieden's Equity Pyramid, which visualizes health initiatives as impact and individual effort; a large individual effort, such as counseling, will have a smaller impact on the overall health of the community than a community-wide effort, such as a change of socioeconomic factors, that requires little individual effort. The low-individual-effort, high-impact projects in particular provide an opportunity to engage multiple segments of the community, and it was here that the team focused most of its effort.

The first of the place-based programs were the Centers for Health Equity and Wellness (CHEW), which used existing funding from several resources to implement eight community-based

projects that focused on two components: (1) the understanding that a safe, healthy and sustainable community promotes health and wellness through prevention, and (2) a focus on chronic disease and a return to child health priorities through evidence-based approaches. Over three years CHEW grants were used to turn vacant lots into housing and community gardens, to revitalize a park, to assist with a diabetes self-management program, to reduce diet-related disparities, to reduce asthma rates in a community, and to increase school attendance rates.

After the successful CHEW program, the DoH decided to emphasize the community engagement and community-directed aspect of the program. With the help of local communities, the DoH defined several Health Equity Zones (HEZ): defined and continuous geographic locations of between 1,000 and 5,000 people that had measurable and documented health disparities, measurable and documented poor health outcomes, and identifiable social and environmental factors to be improved. The communities were asked to implement a project over a three- or four-year period; they are now in the second year. The presenters highlighted projects that addressed substance abuse, transportation, healthy diets, cultural barriers, cultural enrichment and many other community-identified health-disparity issues. The HEZ model is now being implemented statewide by other agencies and a curriculum is being developed for community health workers.

Funding was addressed as a problem; though there are few sources of funding that directly address health equity, many sources of funding do address health disparities, which allows those funds to be used for health equity programs. Prevention block grants, which can be used to address “emerging issues”, can also be leveraged for programs that address health disparities, which are an emerging issue. Both the CHEW and HEZ programs highlighted the need for intra-agency communication to prevent overlap and for strong clinical and community relationships. A legislatively mandated commission of representatives from all state agencies was charged with overseeing the DoH and providing guidance to the state on how to best address health equity and collaborate with the community. On the local level a collective impact framework kept all partners equal and emphasized consensus building and collaboration, though different HEZ implemented this framework differently.

There was some resistance from the community as well as internally within the agencies, both of which were accustomed to certain models of intervention and certain sets of priorities. Schools and private industry were also somewhat resistant to the changes, and all those concerns had to be addressed. Sustainability and flexibility also continue to be concerns. The DoH also developed a series of evidence-based chronic disease programs and a community health network to ensure the dissemination of chronic disease management programs throughout the health system.