Advancing Health Equity in Accountable Communities for Health

A Toolkit for Action

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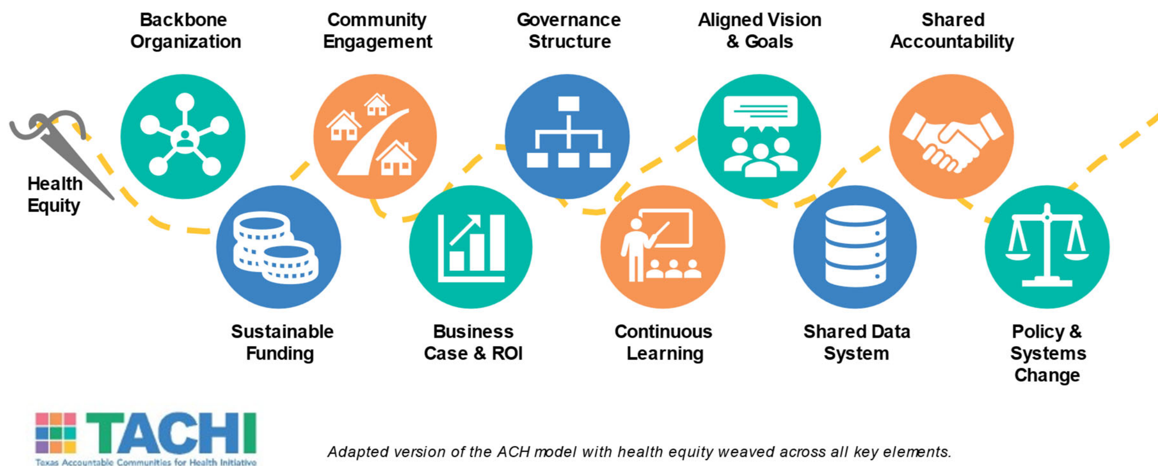
Introduction

The purpose of this toolkit is to provide evidence-informed resources, tools and strategies to guide Accountable Communities for Health (ACHs) in translating their health equity vision and commitment into action and impact. Developed for the Texas Accountable Communities for Health Initiative (TACHI) with support from the Episcopal Health Foundation, this toolkit provides a user-friendly inventory of actions and resources that align with the ten key elements of the ACH Model (Figure 1). The primary audience for this toolkit includes leaders, staff, philanthropy, payers, and other partners planning, implementing and/or evaluating ACHs.

ACHs are multi-sector partnerships that seek to improve health outcomes by addressing social determinants of health and health-related social needs such as food security, housing, and transportation, among others.[1] Growing evidence shows that centering health equity is critical to achieving the intended outcomes of multi-sector partnerships.[2] Building on this evidence, this toolkit is firmly grounded in the belief that to measurably and sustainably improve health outcomes in a community, an ACH must also strive to achieve health equity. Doing so necessitates explicitly embedding equity principles and actions throughout an ACH's strategic focus and work. In other words, the pursuit of health equity is both a process and an outcome. To achieve equitable health outcomes and improve population health, an ACH must center and weave health equity across all its elements and work (Figure 1).

Figure 1. Weaving Health Equity into the Accountable Community for Health Model



Adapted version of the ACH model with health equity weaved across all key elements.

TACHI defines health equity according to the Robert Wood Johnson Foundation's definition:

> *Health equity means everyone has a fair and just opportunity to be as healthy as possible. It requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.*
>
> *For purposes of measurement health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups.*[3]

This toolkit assumes a basic understanding of the ACH model and concepts of health equity and is not intended to serve as a comprehensive curriculum on either topics. However, it builds on and serves as an extension of two foundational health equity learning sessions hosted by TACHI and its partners through ACH planning and implementation phases: (1) A primer session on *what health equity means, why it matters, and understanding its root causes* hosted virtually in Spring 2021; and (2) a workshop focused on *putting health equity to practice to achieve equitable outcomes* hosted in-person in Summer 2022. Furthermore, this toolkit complements a *Health Equity Assessment Tool* developed for TACHI to help ACH sites obtain a baseline pulse of their commitment, progress, strengths and gaps for advancing health equity and developing an action plan.

Finally, the inventory of tools and strategies highlighted in this toolkit build on a growing body of research and practice from multisector collaborative and health equity champions, experts and practitioners in the field. This includes, but is not limited to:

- *Developing a Framework to Measure the Health Equity Impact of Accountable Communities for Health (2020)*, a summary of recommendations produced by the Funders Forum on Accountable Health

- *Powering Change: Building Healthy, Equitable Communities Together (2022)*, a comprehensive curriculum for multi-sector partnerships developed by the Population Health Innovation Lab

- *Centering Equity in Collective Impact (2022),* a research article by John Kania and colleagues in the *Stanford Social Innovation Review*

- *King County's Journey in Institutionalizing Equity and Social Justice (2017),* a research article by Matias Valenzuela in the *Public Administration Review*

- *A Practitioner's Guide for Advancing Health Equity (2013),* produced by the Centers for Disease Control and Prevention

This toolkit is organized into ten sections that align with the core elements of the TACHI model (Figure 1), providing evidence-informed guidance, strategies and tools to guide ACH sites on their journey to operationalize and achieve health equity:

- Section 1. Aligned Vision and Goals
- Section 2. Backbone Organization
- Section 3. Governance Structure
- Section 4. Community Engagement
- Section 5. Systems and Policy Change
- Section 6. Shared Data System
- Section 7. Shared Accountability
- Section 8. Business Case and ROI
- Section 9. Sustainable Financing
- Section 10. Continuous Learning

As ACHs may be at various levels of readiness and progress on their health equity journey, this toolkit can be used in any order and as needed to help fill gaps, make improvements and refine plans and actions for advancing health equity. The final sections provide a Glossary with key terms and concepts, and References.

Section 1. Aligned Vision and Goals

Establishing a shared vision and goals for community health among multisector and community partners represents a critical element for guiding the purpose and work of an ACH, as well as creating a framework for collective accountability. Making sustainable progress toward population health improvement rests upon progress toward health equity. In fact, an important reason why multisector collaborative initiatives fall short of achieving intended outcomes is a failure to center equity.[4] Centering health equity in an ACH's aligned vision and goals can be achieved through actions such as:

- **Create shared language and understanding of health equity** across all ACH partners. Consider building on or adapting existing definitions of health equity that embody principles of fairness and justice with respect to achieving optimal health for all people and communities. In doing so, create space during ACH team meetings to discuss, define and reach consensus on key terms and concepts for advancing health equity. This includes terms like health disparities, health inequities, root causes of health inequities, racism, implicit bias, cultural humility and others (see Glossary). Furthermore, engage community partners to learn more about the current and historical context of health inequities in the community to shape and ground the ACH's shared understanding of health equity in reality.

- **Explicitly mention health equity in the ACH's vision and goals.** Embedding health equity-focused language in the aligned vision and goals will help set shared expectations and foster accountability toward health equity objectives.

- **Provide all ACH partners and staff with resources on Health Equity 101**, in efforts to assure all partners have a shared understanding of health equity, its root causes, why it matters to their community and to society at large, and their role in advancing action.

Tools & Resources: Health Equity 101

- What is Health Equity? And What Difference Does a Definition Make? (2017) – a user-friendly guide produced by the Robert Wood Johnson Foundation on the basics of health equity

- TACHI Online Learning Session on Health Equity (2021) – a free 40-minute recording with basic concepts of health equity, its root causes, why it matters and how to take action

- Wisconsin Center for Public Health Education and Training Health Equity 101 Modules – a free 40-minute webinar with written transcripts providing an introduction to health equity, health and power, and how to operationalize health equity

- NACCHO's Politics of Health Inequity: Getting to the Roots – a 60-minute introductory webinar that takes a deep dive into the history and politics of health inequities in the U.S.

- NACCHO's Roots of Health Inequity (2011) – a free web-based course for the public health workforce outlining where to start; perspectives on framing; public health history; root causes of health inequities examining class, racism and gender; and principles of social justice

Section 2. Backbone Organization

Successful multisector collaboratives engage one well-anchored and trusted entity in the community as a "backbone" organization to facilitate, coordinate and align activities.[5] In an ACH, the backbone organization supports key activities such as guiding the vision, strategy and implementation, building public will, aligning interventions and activities across partners, sharing data and measurement, mobilizing funding, and advancing broader advocacy and policy.[6] The backbone organization plays a critical role in convening, communicating and ensuring continuity of work and progress with and across all partners. As the cornerstone for an ACH, centering equity in the structure and processes of a backbone organization is important to advancing equitable outcomes. Following are some key actions for advancing equity through the backbone role:

- **Build a backbone team that reflects the racial, ethnic and social diversity** of the community being served. This requires implementing institutional policies and practices that foster diversity, equity and inclusion in recruitment, hiring and retention of key staff.

- **Center health equity as a core value and competency** among members of the Backbone team and other ACH partners. Make training and resources available, as well as spaces for open dialogue and learning to help build core competencies for health equity.

- **Communicate with ACH and community partners** using language that is person-centered and accounts for health literacy as well as cultural and linguistic diversity of the community being served. Respectful, clear and inclusive communication is critical to fostering trust with partners.[7]

- **Meet community partners where they are and honor their time** by hosting meetings in trusted and accessible settings in the community, and providing adequate financial support to reimburse for parking, time as well as meals (e.g., providing the same benefits that would otherwise be afforded to paid and employed members of the ACH and backbone teams).

Tools & Resources: Health Equity-Centered Communication

CDC's Health Equity Guiding Principles for Unbiased, Inclusive Communication highlights five key principles that backbone and other partners should consider in communication:

- **Contextualize health disparities** in the community's circumstances, history and reality. Don't blame people for disparities that are systemically produced.
- **Use person-first language**, and not language that blames or dehumanizes people. For example, instead of labeling individuals as "homeless," reframe as "persons experiencing homelessness."
- **Avoid adjectives such as vulnerable and high-risk** to describe people and communities. These words imply that the condition is inherent to the group rather than the actual systemic factors that have produced them. Instead, use language such as "groups that have been marginalized."
- **Avoid terms such as combat, tackle and others with a violent connotation** when referring to people, groups or communities. Instead use terms such as "engage, prioritize and collaborate with" or "communities and populations of focus."
- **Acknowledge there are many types of subpopulation groups**, and work to disaggregate groups to the extent possible. Work with the community to identify how to name specific groups.

Section 3. Governance

A clear and defined governance structure is critical to assuring accountability in an ACH. Based on its experience, the California Accountable Communities for Health Initiative (CACHI) identified the following as important conditions for establishing a sound governance structure: "effective decision-making; accountability to the community; representation of stakeholders' interest; proper fiduciary, fiscal, and social responsibilities; and control over funding and staff."[8] Centering health equity in the ACH's governance is foundational to creating systems and activities that are inclusive and equitable by design, and ultimately yield equitable outcomes. Following are some ways to embed health equity explicitly within the ACH's governance structure:

- **Build a Governing Body that is reflective of the diversity of the community.** The Governing Body should look like and reflect the diversity and interests of the community being served.[9] This includes diversity by race, ethnicity, age, gender and other sociodemographic factors. While an ACH's Governing Body will include influential and powerful health, social service and other cross-sector leaders (who are needed to champion and lead the ACH), balancing their perspectives and voices with those of diverse community leaders and lived experience experts is critical to grounding the ACH's efforts in the community's reality.

- **Assess and balance power dynamics** among Governing Body, Backbone, ACH partners and community partners. Advancing health equity requires attention to power (as a fundamental upstream determinant of health and health inequities); and empowerment or building power (as an essential process).[10] Those who lack power experience some of the deepest health inequities in this country.[11] Understanding this reality and working to redistribute and share power so that those most-impacted can contribute to decisions is important to driving equitable and lasting change (Figure 2). Power comes from different sources such as money, influence and position, and manifests in three critical ways:[12]

    - **Visible power** shapes decisions and refers to power that can be seen, such as who is at the decision-making table, who gets to speak and what are consensus-building and decision-making dynamics.

    - **Hidden power** shapes politics and influences the decisions that are made at an upstream level. While it is often not easily seen, it decides who is at the decision-making table, what is the agenda and what are/are not the priorities.

    - **Invisible power** shapes mindsets, narratives and ideologies. It is perhaps the most insidious kind of power as it is not known or seen by many people yet drives and shapes issues that ultimately get addressed.

    The Population Health Innovation Lab provides further guidance in their *Powering Change: Building Healthy, Equitable Communities Together* toolkit on addressing power dynamics. They suggest that "[i]n relationships where there is an imbalance of power, such as those with community partners, it is important to be aware of your power and how you can use your understanding of recurring power dynamics to support personal growth, team dynamics and your ability to authentically engage with community leadership. Addressing power dynamics is critical to achieving equity."[13]

- **Establish shared leadership with diverse community leaders and members** who have lived experience expertise and deep connections in the community. This may involve adding seats to the Steering Committee that include a representative group of community members to share in decision-making and guide the ACH's work. It could also take the shape of a separate Community Advisory Board, that functions in parallel with the Steering Committee, having equal say and votes in driving decisions as the Steering Committee.

Figure 2. A Tool for Assessing and Sharing Power

	CURRENT POWER DYNAMICS	ACTIONS TO DISTRIBUTE POWER MORE EQUITABLY
VISIBLE POWER : Who is at the decision-making table? Who is not? How inclusive is decision-making?		
HIDDEN POWER: Who decides who is at the table? Who decides the agenda?		
INVISIBLE POWER: What are the narratives that define the issues & what can be on the agenda? Who holds this power?		

Adapted from Abby Charles with Institute for Public Health Innovation.

Tools & Resources: Health Equity & Power

- Wisconsin Center for Public Health Education & Training: Health Equity Module 2 on Health & Power and Power Map Activity in Module 3 on Operationalizing Health Equity
- See Power Dynamics presentation by Abby Charles in County Health Rankings & Roadmaps Webinar on Building Equity into Your Network of Partners (starts at 26 minutes)
- Health Equity Guide: Share Power with Communities
- See Equity & Power section on page 19 of the Population Health Innovation Lab's ACH Start Up Guide

Section 4. Community Engagement

According to CDC, community engagement is "the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people. In general, the goals of community engagement are to build trust, enlist new resources and allies, create better communication, and improve overall health outcomes as successful projects evolve into lasting collaborations."[14] Authentic and meaningful engagement with community leaders, organizations and members with lived experience from the beginning of an ACH initiative is paramount to success.[15] Following are ways in which an ACH can take explicit steps to assure principles of health equity guide effective community engagement:

- **Participate in deep listening and learning** with "curiosity, humility, commitment and an open heart, open mind and open will" to understand and address longstanding health inequities facing the community.[16] Create space to learn openly about the histories, legacies and root causes of health inequities. Some realities may make ACH partners uncomfortable—such as discussions of racism—especially for those who have not been on the receiving end of it.[17] Such discomfort is to be expected, and in fact, avoiding it only maintains the status quo of inequities around us. Therefore, work from a place of empathy, compassion and understanding to embrace the discomfort and seek to learn and grow to be an ally and champion for health equity.

- **Strive to move along CDC's Community Engagement Continuum**, shifting from simply consulting communities for input as a token or check-in-the-box activity to fostering authentic, meaningful and long-term collaboration and shared leadership. Trusting, lasting and bi-directional community partnerships take time to develop and outlive one-time grants, projects and activities. Such partnerships value the expertise and assets of community partners and engage them in decision-making from the outset from designing and planning initiatives to implementation, evaluation and continuous improvement.

Figure 3. CDC's Community Engagement Continuum

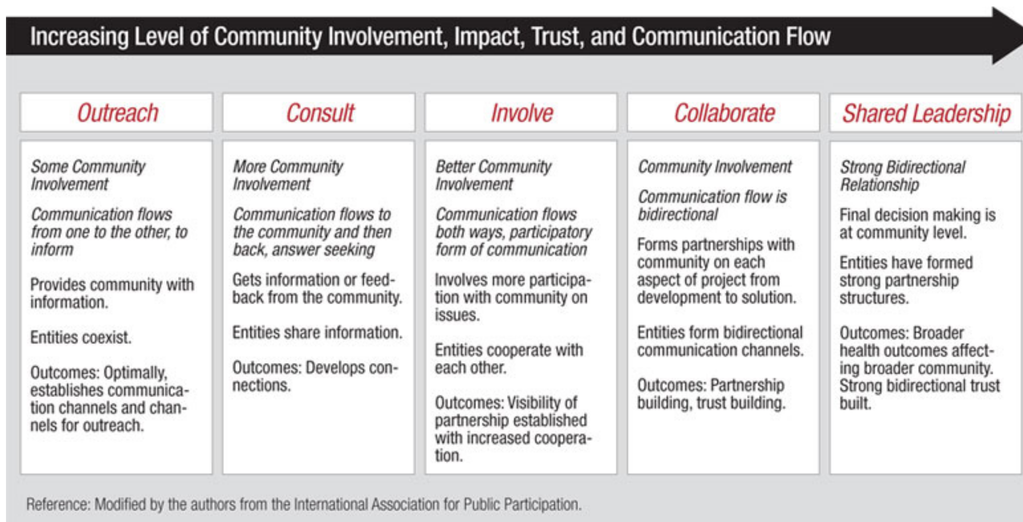


Figure 1.1. Community Engagement Continuum

- **Work *with* your community.** Sustainable and transformative change happens by recognizing and building on the strengths, assets and skills of communities, rather than viewing them as "problems to be solved."[18] This approach "recognizes the talent and commitment of residents, the importance of local relationships, and the value of institutions run by community members as building blocks of change."[19] It asks community members to define: What problems they want to solve, what power and assets they already have, and what solutions they are already creating that can be supported by the ACH.

- **Support community members to meaningfully engage.** Fairly compensate community members for their time to participate in the ACH, and provide other supports such as transportation and child care. Use interpreters and provide translated materials to bridge gaps in language access among those with limited English proficiency. Consider hosting ACH events within the community in sites accessible to community partners and members. Furthermore, coach, mentor and help transition community members involved in the ACH and with an interest into leadership and staff positions to foster long-term sustainability.

- **Develop inclusive facilitation processes** that value the voice, perspective and contributions of community members who bring lived experience expertise equally with other multisector leaders and experts. Three key strategies for facilitation include: practicing inclusive listening and prioritizing learning; practicing multi-partiality giving equal attention to participants of all backgrounds, identities and experiences; and fostering shared meaning by acknowledging differences, reflecting, and arriving at a shared understanding.[20]

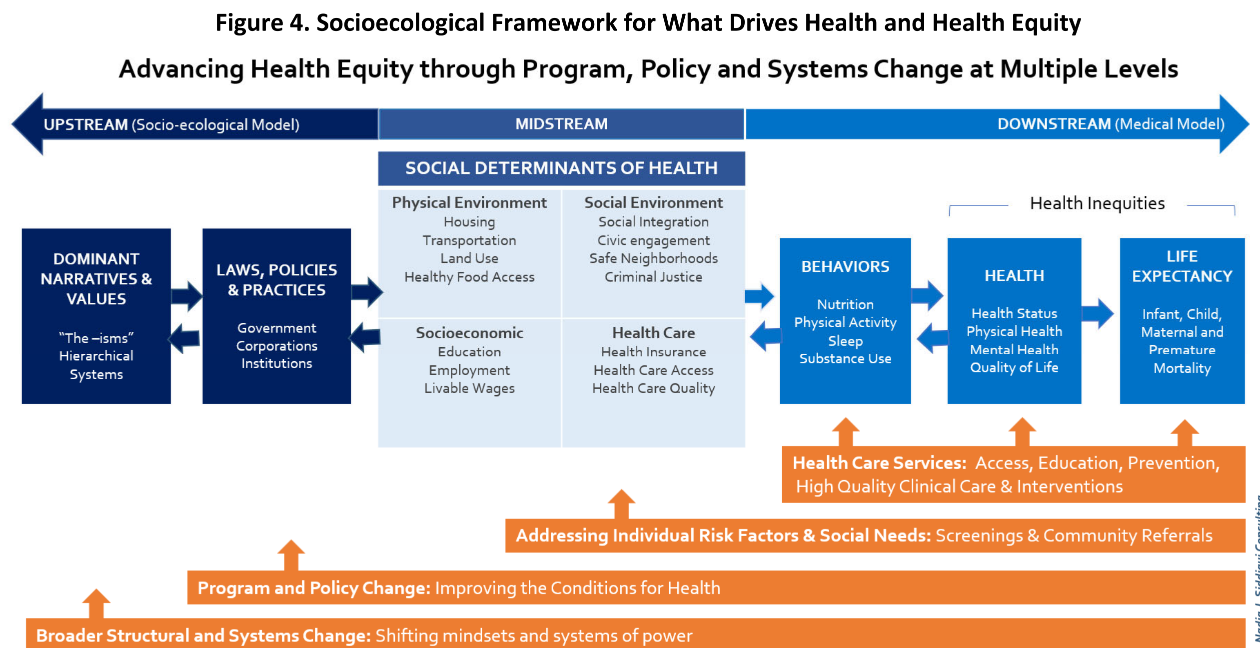
Tools & Resources: Community Engagement

- CDC's Principles of Community Engagement – 2nd Edition (2015)
- Meaningful Community Engagement for Health and Equity – featured in the CDC Practitioner's Guide for Advancing Health Equity
- Community Resident Leadership & Communications Training (2019) – to help support and build community leadership capacity in health and ACH-like work
- Assessing Meaningful Community Engagement: A Conceptual Model to Advance Health Equity through Transformed Systems for Health (2022) – a National Academy of Medicine Commentary
- Centering Equity in Community Health Partnerships (2022) – a research article highlighting key lessons from the BUILD Health Challenge

Section 5. Systems and Policy Change

By design, ACHs seek to drive transformational systems and policy change to improve community health. The ACH model recognizes that health and health inequities are shaped by multilevel socio-ecological influences.[21] These influences include midstream social, economic, environmental and health care determinants, which are influenced by upstream structural drivers such as laws, policies and practices. Structural drivers in turn are shaped by dominant narratives and systems of power and oppression in society (such as racism, sexism, classism, ablism and other "-isms"). [22] The upstream structural and systemic forces that shape health and health inequities are complex and interrelated and thus, warrant action that is likewise systemic and multidimensional (Figure 4). [23]

Figure 4. Socioecological Framework for What Drives Health and Health Equity



Adapted from frameworks developed by Bay Area Regional Health Inequities Initiative (BARHII), Alameda County Public Health Department, and Greater Houston's Health Equity Collective.

Below are actions an ACH can take to design and implement a portfolio of interventions that centers health equity in driving systems and policy change.

- **Identify the root causes of poor health and health inequities** in your community by conducting a root cause analysis in collaboration with ACH partners, key stakeholders, and community leaders and members to help understand the context, histories and legacies that have contributed to gaps in health. A root cause analysis is a process for understanding why a particular disparity exists utilizing a systems perspective. In other words, what systemic factors contribute to differences in health outcomes? It could be related to underlying social needs in the community at a downstream level to gaps in the social determinants of health and to historic legacies of discriminatory policies and actions at an upstream level. There are many types of root cause analysis tools, all with the same intent of uncovering "why" inequities exist until all answers are exhausted.

Tools & Resources: Root Cause Analysis

- A webinar on How to Conduct a Root Cause Analysis for Diabetes Prevention (2021)
- Root Cause Mapping Exercise on pages 28-29 in Health in All Policies: A Guide for State & Local Governments (2013)
- Health Quality Innovation Network (2021) provides a suite of templates to conduct root cause analyses and prioritize causes for action. This includes:
  - Root Cause Fishbone Diagram
  - Five Whys Worksheet
  - Root Cause Priority Matrix

Figure 5. Simple Root Cause Map[24]

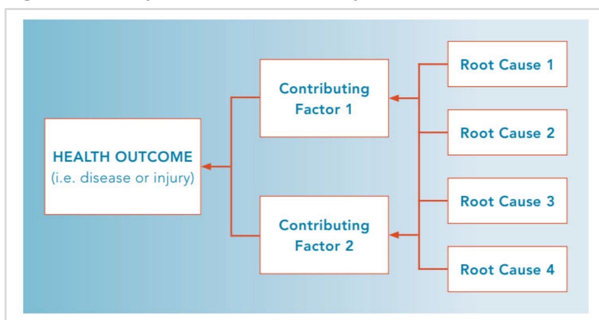
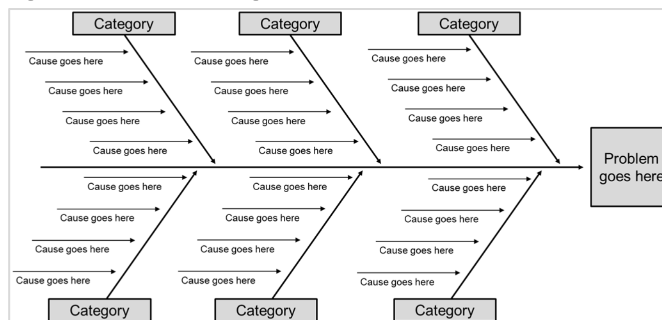


Figure 6. Fishbone Diagram[25]



- **Explore the role of racism as a root cause in your community.** Research documents that racism is a fundamental root cause of health inequities in the U.S.[26] And as such, achieving health equity requires working to dismantle the forces and impacts of racism that exist to present day.[27] To address racism, you need to "name it, frame it and explain it."[28] Work with community and ACH partners to learn about and reflect on the historical and current context of racism and the role of discriminatory policies in shaping health inequities in the U.S. and in your community.

- **Prioritize the root cause(s) for action** by weighing the importance and feasibility of addressing each identified cause. A Priority Matrix can be helpful in sorting which root cause(s) to prioritize first for action.[29] See resources above to access the Priority Matrix template.

- **Consider Targeted Universalism When Designing Equity-Centered ACH Interventions.** Targeted Universalism is a concept founded by john a. powell, director of UC Berkeley's Othering & Belonging Institute. Targeted universalism means setting universal goals that are pursued through targeted interventions. "Within a targeted universalism framework, universal goals are established for all groups concerned. The strategies developed to achieve those goals are targeted, based upon how different groups are situated within structures, culture, and across geographies to obtain the universal goal." [30]

- **Implement interventions at multiple levels**, such as those that seek to:
  - Meet health-related social needs of individuals (e.g., food insecurity or homelessness)
  - Address the social determinants of health in the community (e.g., food deserts and housing)
  - Address broader structural drivers of health through advocacy and policy change (e.g., national, state and local policies that shape food and housing systems and opportunities)

Section 6. Shared Data Systems

Building and utilizing shared data systems is an essential component of an ACH to identify community-wide needs and priorities, inform and tailor interventions, monitor and measure progress and outcomes and ultimately hold the ACH accountable. Centering health equity across the spectrum of shared data activities is critical to both advancing equitable processes and making progress toward achieving health equity in outcomes. Following are actions that ACHs can take to ensure an equity-centered approach to shared data:

- **Identify health inequities** defining who is most affected and where and how to target interventions to close gaps. Combine both quantitative and qualitative data to understand the full scope, scale and context of health inequities in your community.
  - Build on existing Community Health Needs Assessments, Community Health Improvement plans, and other community reports to generate a basic understanding of health inequities
  - Utilize administrative, local, state and national data to generate a more complete portrait of health inequities, who is impacted and trends over time (Quantitative Data)
  - Engage community members and cross-sector partners to help understand the stories behind the data, particularly current and historical context of health inequities (Qualitative Data)
  - Identify the root causes of health inequities to better focus interventions (see Section 5)

- **Define SMARTIE goals for interventions.** Building on the root cause analysis and priority matrix exercise from Section 5 can help ACHs focus their portfolio of interventions on upstream priorities that are important to the community and feasible to implement. Consider developing not just “SMART Goals”, but “SMARTIE Goals” for interventions to help focus their intent, provide a tool to measure progress, and ground them in principles of equity and inclusion. SMARTIE Goals are:[31] [32]
  - **S**pecific – It is focused on a particular priority.
  - **M**easurable – It includes a benchmark to be met.
  - **A**chievable – It is aspirational, yet attainable.
  - **R**ealistic – It is relevant and practical based on capacity and resources.
  - **T**imebound – It includes a clear deadline.
  - **I**nclusive – It includes groups facing inequities or traditionally excluded as part of the solution.
  - **E**quitable – It intends to advance equity by addressing systemic inequities and bridging gaps.

Figure 7. From SMART to SMARTIE Goal Example

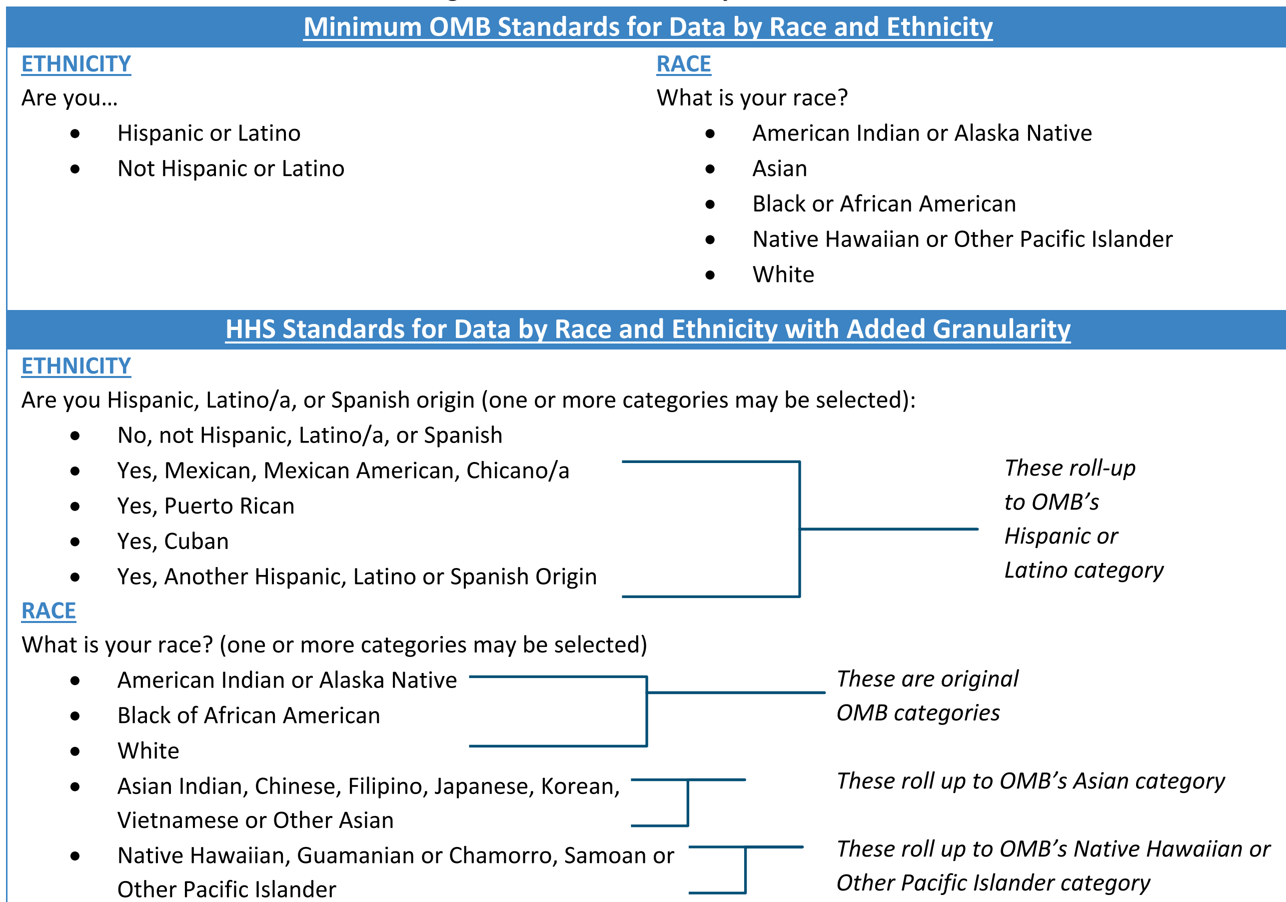
SMART Goal	SMARTIE Goal
Increase the rate of social needs screening and community referral by 10% by the end of Year 1	Increase the rate of social needs screening and community referral by 10% by the end of Year 1, ***by focusing outreach efforts to increase screening and referral among Hispanic and Black patients by 20% each to close wide gaps by race and ethnicity.***

Tools & Resources: SMARTIE Goals

- Resources and 8-minute video provided by The Alford Group on what are SMARTIE Goals and examples of how to establish them (2020).
- CDC's two-pager: From SMART to SMARTIE Objectives (2022).
- The Management Center's SMARTIE Goals Worksheet (2021).

- **Collect Data by Race, Ethnicity, Language and other demographic measures**. An ACH's shared data system should collect self-reported demographic information such as age, sex, race, ethnicity, language and disability status.[33] Data for race, ethnicity and language (REAL) should be self-reported using the minimum standards developed by the Office of Management and Budget (OMB).[34] Where possible, ACHs should also strive to collect more granular data to reflect the racial, ethnic and linguistic diversity of the community, while also including other measures such as for sexual orientation and gender identity (SOGI). The HHS Office of Minority Health provides some additional granular categories that rollup to the OMB minimum standard (see Figure 8). Finally, data systems should also document data by small geographic areas such as Zip Code, Census Tract or Neighborhood to illuminate place-based concerns and inequities. In addition to creating the infrastructure to collect such data, ACHs should assess and improve their completeness and quality.[35]

Figure 8. Race and Ethnicity Data Standards



Minimum OMB Standards for Data by Race and Ethnicity

ETHNICITY

Are you…

- Hispanic or Latino
- Not Hispanic or Latino

RACE

What is your race?

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

HHS Standards for Data by Race and Ethnicity with Added Granularity

ETHNICITY

Are you Hispanic, Latino/a, or Spanish origin (one or more categories may be selected):

- No, not Hispanic, Latino/a, or Spanish
- Yes, Mexican, Mexican American, Chicano/a
- Yes, Puerto Rican
- Yes, Cuban
- Yes, Another Hispanic, Latino or Spanish Origin

These roll-up to OMB's Hispanic or Latino category

RACE

What is your race? (one or more categories may be selected)

- American Indian or Alaska Native
- Black of African American
- White

These are original OMB categories

- Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese or Other Asian

These roll up to OMB's Asian category

- Native Hawaiian, Guamanian or Chamorro, Samoan or Other Pacific Islander

These roll up to OMB's Native Hawaiian or Other Pacific Islander category

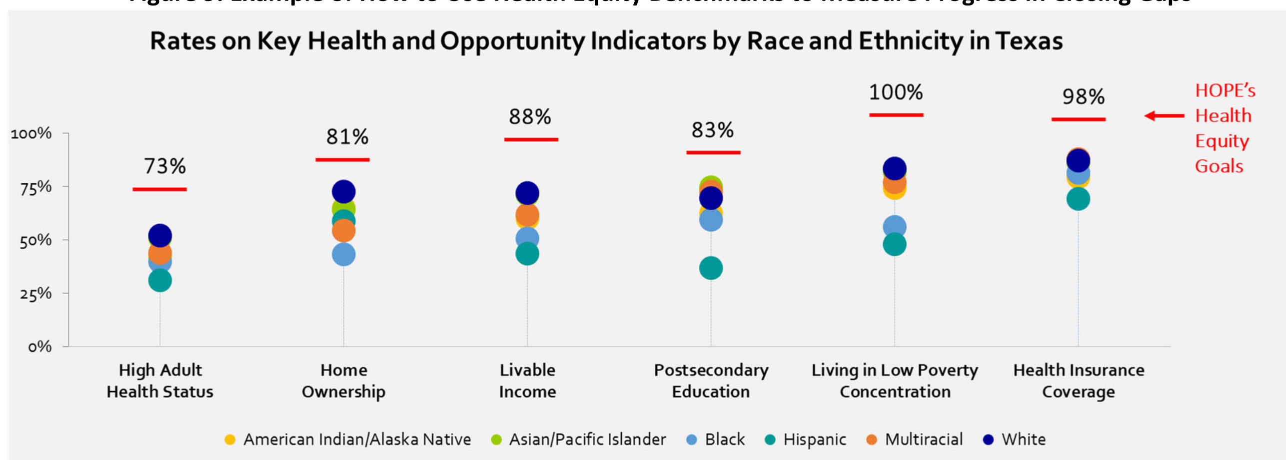
- **Identify key performance indicators to stratify by subpopulation.** The most common method for measuring progress toward health equity—i.e., the elimination of disparities—is to stratify selected health outcome, health care, social and economic performance indicators by subpopulation group such as sex, race and ethnicity.[36] For each indicator, consider:
    - What are overall baseline rates?
    - What are rates by subpopulation group?
    - How wide are gaps between subpopulation groups?
    - Which groups are disproportionately affected?

  Such questions can help inform where interventions need to be targeted, while also providing a baseline for measuring progress and impact over time. For other types of health equity measures, methods for measuring health equity, and health equity-focused data sources see the next page.

- **Set aspirational, yet achievable benchmarks to measure progress** on key performance indicators using the best outcomes possible instead of average rates.[37] Such an approach aligns with the concept of Targeted Universalism described in Section 5—i.e., setting universal goals, and monitoring interventions and progress needed for each group to attain the goal. This approach also builds on the work of the Health Opportunity and Equity (HOPE) initiative (see example in Figure 9). Consider the following when applying such an approach:
    - What is the best outcome possible for a given indicator that can serve as the benchmark?
    - How far is each group from achieving this benchmark?
    - What is the "Distance to Go" for each group to achieve the benchmark?

- **Share data and progress with all ACH and community partners transparently.** Democratizing data—that is sharing data and its ownership with all partners and the community—is an important step in centering equity in shared data systems. "Democratizing data changes the power dynamic with residents. Owning data and shaping the narrative about data's past, present and future means that communities are not described as subjects of study, but rather as empowered storytellers who are demonstrating models for liberation." [38] In doing so, ACHs should work to meaningfully engage communities across all data phases and help build data literacy to guide informed decisions.[39]

Figure 9. Example of How to Use Health Equity Benchmarks to Measure Progress in Closing Gaps



Source: 2020 Health Opportunity and Equity (HOPE) Initiative Data for Texas available at www.hopeinitiative.org #HOPEData

Tools & Resources: Types of Health Equity Measures

- A Typology for Health Equity Measures (2022) summarizes four kinds of measures:
  - **Measures to assess the completeness of health equity indicators** within shared data systems (e.g., percentage of patients with complete race and ethnicity data)
  - **Process and outcome measures stratified by subpopulation groups** (e.g., colorectal cancer screening rates by race and ethnicity)
  - **Process and outcome measures targeted at specific subpopulation groups** (e.g., emergency department utilization rate among Hispanic patients)
  - **Process and outcome measures targeted at strategies intended to reduce inequities** (e.g., percentage of patients with timely and appropriate access to translator services)

Tools & Resources: Research Articles on Measuring Health Equity

- Measurement of Health Disparities, Health Inequities, and Social Determinants of Health to Support the Advancement of Health Equity (Penman-Aguilar et al., 2016)
- A Three-Stage Approach to Measuring Health Inequalities and Inequities (Asada et al., 2014)
- Health Disparities and Health Equity: Concepts and Measurement (Braveman, 2006)
- A Framework for Measuring Health Inequity (Asada, 2005)

Tools & Resources: Select Health Equity-Focused Data Platforms

National

- 500 Cities Project & PLACES Data
- America's Health Rankings Health Disparities Report & Data Platform
- CDC/ATSDR Social Vulnerability Index
- County Health Rankings & Roadmaps
- Health Opportunity and Equity Initiative
- National Equity Atlas
- Well-Being in the Nation (WIN) Measures

State

- California Healthy Places Index 3.0
- Virginia Health Opportunity Index
- Texas Health Maps – Life Expectancy Maps

Local

- Health of Houston Survey
- Nueces County Health Equity Report & Dashboard
- Healthy North Texas Disparities Dashboard
- Williamson County Health Equity Index

Section 7. Shared Accountability

Achieving shared accountability across partners for improving community health is central to the success of ACHs. Shared accountability occurs when multisector organizations and community partners develop the capacity to balance internal and external interests to achieve shared community health goals. [40] As health equity is central to achieving these goals, ACHs should also work to build shared accountability for health equity through the following actions:

- **Embrace a culture of equity** by treating health equity as a shared value and core competency for all individuals and organizations involved in the ACH.[41] Advancing health equity is not a separate activity or project, but a priority that must be a part of everyone's work in the ACH.[42] Embedding health equity directly within the ACH's shared vision and goals, developing a health equity action plan, advancing standards for diverse and inclusive community engagement toward shared leadership, and providing ongoing education, resources and training to support individual, organizational and collective health equity journeys can all help foster a culture of equity.[43]

- **Monitor ongoing progress on short, mid, and long-term process and outcome indicators for health equity.** While moving the needle on health equity takes time to see results, ACHs should monitor ongoing progress in advancing health equity in processes—including actions inventoried in the TACHI Health Equity Assessment Tool and highlighted in this toolkit. Equitable processes ultimately drive equitable outcomes, and without measurable progress in embedding health equity explicitly, an ACH could fall short of its efforts to achieve health equity in outcomes. Thus ongoing measurement, reflection and celebration of progress as well as quality improvement are critical to achieving health equity objectives. Transparency in sharing regular progress and outcomes data through scorecards or other visual data presentations can also help advance accountability.

- **Ensure community members have a meaningful role** in evaluating the ACH's health equity impact and holding ACH partners accountable. This requires meaningfully and continually engaging communities in all aspects of the ACH's work from planning and implementation to evaluation. It also requires building community capacity, data literacy and leadership skills through engagement and coaching so that community members can play a meaningful role in learning, evaluation and quality improvement.

- **Build accountability for broader systems change** that address root causes of health inequities. ACHs are not just about implementing projects, programs or interventions—they are designed for long-term transformational change that requires moving upstream to understand, confront and address complex drivers of health, including racism and other forms of oppression. Build strategic actions and plans and monitor progress for addressing broader systems and policy change in the long-run.

Section 8. Continuous Learning

ACHs must engage in continuous learning as work to improve the health of the community and health equity evolve over time.[44] There are number of actions ACHs—including organizations and individuals involved—can take to engage in continuous learning and improvement as it relates to advancing knowledge, skills, and capacity for building health equity into processes and ultimately achieving equitable health outcomes. These actions include:

- **Conduct a Health Equity Assessment of the ACH** working with the Backbone organization and ACH partners to identify baseline capacity for embedding health equity across the ACH's elements. The TACHI Health Equity Assessment Tool (HEAT), a 38-item inventory was designed to help ACHs engage in collaborative self-reflection, inventorying and dialogue on health equity strengths, gaps, aspirations and areas for improvement across the ten ACH elements. Findings from the assessment shed light on baseline capacity and can be used to create an explicit Health Equity Action Plan (HEAP) for implementing equity-focused actions across the ACH with greater purpose, clarity and intentionality. The HEAT can also serve as a learning and quality improvement tool to monitor progress and outcomes as well as make adjustments in operationalizing health equity over time.

Tools & Resources: Health Equity Assessment Tools (HEATs)

- **TACHI Health Equity Assessment Tool (2022)** – a 38-item tool designed to assess baseline health equity capacity and progress within the ACH model.
- BARHII Organizational Self-Assessment for Addressing Health Inequities **(2010)** – one of the very first comprehensive and foundational health equity assessment tools in the field
- Tool for Organizational Self-Assessment Related to Racial Equity **(2014)** – developed by Coalition of Communities of Color as an explicit tool to capture a snapshot of organizational practices and policies related to racial equity
- Organizational Race Equity Toolkit **(2018)** – developed by Washington Race Equity & Justice Initiative as an in-depth and comprehensive assessment and implementation tool
- Race Justice Assessment Tool **(2015)** – developed by Western States Center as a short instrument for measuring organizational commitment and progress toward racial justice

- **Identify and monitor the health equity impact** of your ACH and its interventions. The Health Equity Impact Assessment (HEIA) or Racial Equity Impact Assessment (REIA) are tools that provide an opportunity to systematically examine how different population groups will likely be affected (or are affected) by a proposed (or implemented) initiative, program or policy. These assessments are intended to minimize unintended adverse impacts, in particular the exacerbation of health inequities. Explore the tools listed on the next page.

Tools & Resources: Health Equity Impact Assessments (HEIAs)

- Race Forward's Racial Equity Impact Assessment (2013) – 10-item assessment to examine the racial and ethnic impact of proposed actions, policies and interventions
- Racial Equity Impact Assessment (2018) – an equity impact assessment tool developed by the Center for the Study of Social Policy and tailored to child welfare decision-making
- Health Equity Impact Assessment Template and Workbook (2013) – developed by Ontario Ministry of Health in Canada

- **Address implicit bias.** Advancing health equity is a journey at multiple levels, which starts with us as individuals to learn and grow our own knowledge, skills and capacities. A critical part of this individual journey is understanding and addressing our own biases—both conscious and unconscious. Implicit bias includes the unconscious attitudes or stereotypes individuals hold that affect actions and decisions.[45] Implicit biases, explicit biases and structural forces are often mutually reinforcing in maintaining the status quo on health inequities in society. Assessing, exposing and learning about our own implicit biases can help us move forward on the health equity journey with greater intentionality.

- **Provide peer and continuous learning opportunities** on health equity, systemic racism, anti-racism, implicit bias, narrative change, building cultural humility and other related topics for ACH and community partners involved at all levels. This can be done through formal offerings such as required learning modules or workshops for core competencies, as well as more informal avenues such as peer-learning and open discussions, brown bag lunches or book clubs.

Tools & Resources: Implicit Bias

- Kirwan Institute Implicit Bias Training (2018) – a free 1-hour interactive online training and reflective tool on defining implicit bias, real-world implications, understanding biases, and mitigation.
- Implicit Association Test (IAT) – a range of online tests to assess implicit bias with respect to diverse groups by race, ethnicity, age, religion, gender identity, sexuality, and disability, among others.

Tools & Resources: Continuous Learning

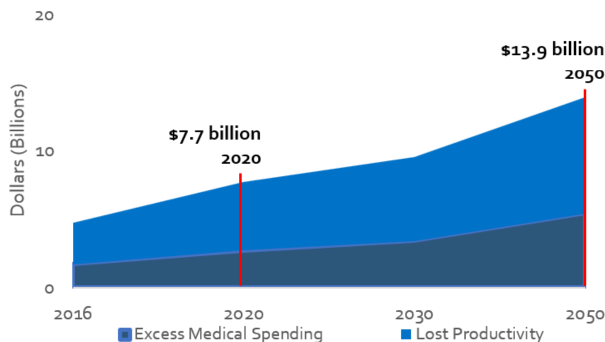
- AMA's Advancing Health Equity: A Guide to Language, Narrative and Concepts (2021)
- The Sum of Us: What Racism Costs Everyone and How We Can Prosper Together (2021)
- The Political Determinants of Health (2020)
- How to be an Anti-Racist (2019)
- NACCHO's Advancing Public Narrative for Health Equity & Social Justice (2018)
- White Fragility: Why It's So Hard for White People to Talk About Racism (2018)
- The Color of Law: A Forgotten History of How Our Government Segregated America (2017)
- Unnatural Causes: Is Inequality Making Us Sick? – A Seven-Part Documentary

Section 9. Business Case & ROI

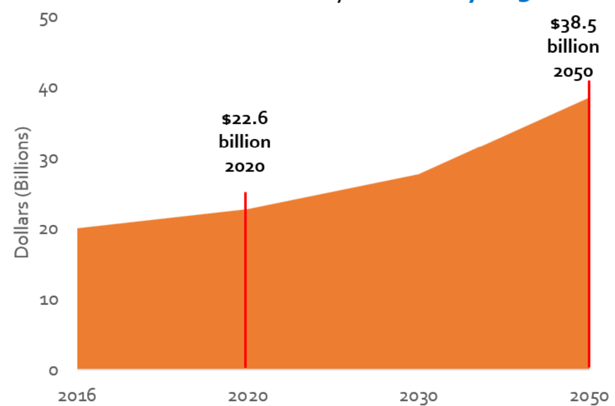
Health inequities contribute to our nation's poor rankings internationally on health outcomes, despite the U.S. spending more than any country on health care.[46] Health inequities cost us all. For example, in Texas in 2020, health inequities cost the government, health systems, health payers, businesses, and individuals nearly $8 billion in excess medical spending and lost productivity.[47] In addition, in the same year, premature deaths due to health inequities cost Texas nearly $23 billion for lost life years. Without action, the economic burden of health inequities will nearly double for the state by 2050. See Figure 10. As ACHs build their business case, they should highlight the economic imperative for improving *both* community health *and* health equity.

Figure 10. Economic Cost of Health Disparities in Texas, 2016-2050

In 2020, **health disparities cost Texas $7.7 billion** in excess medical spending and lost productivity. These costs will nearly **double by 2050.**



In 2020, **disparities in premature deaths cost Texas $22.6 billion** in lost life years. These costs will nearly **double by 2050.**



Source: Turner A, LaVeist TA, Richard P, and Gaskin DJ. Economic Impacts of Health Disparities in Texas 2020: An Update in the time of Covid-19. January 2021.Funded by Episcopal Health Foundation.

Following are some ways to build a business case for advancing health equity in your ACH:

- **Center health equity in the ACH's value proposition**. Describe the issue from a health equity lens, highlighting how wide inequities are and who is disproportionately affected. Define solutions that integrate explicit health equity actions and seek to meet needs of groups facing the greatest inequities. Delineate benefits in terms of describing how the initiative will make measurable improvements to health outcomes and health equity (i.e., progress in reducing disparities).

- **Identify research data on the return on investment** for health equity-focused initiatives and leverage those data to make a business pitch for your ACH. For example, the Northwest Ohio Pathways Community Hub model founded in 2007 sought to address racial disparities in infant mortality. Over the years, the initiative has improved outcomes for Black infants and yielded a 236% return on investment (ROI).[48] The initiative continues to grow and serve as a model nationally.

- **Collect, measure and monitor health equity data** through shared data systems to generate evidence for your ACH's community impact and return on investment in the long-term.

Section 10. Sustainable Financing

ACHs require long-term funding to support not only the implementation of interventions but also the core backbone and infrastructure functions of community engagement, strategic planning, and program evaluation, among others.[49] As such, sustainable financing often depends on braiding and blending multiple public and private sources of funding. As ACHs work to build financial sustainability, making an explicit commitment to health equity is critical to supporting and sustaining equity-focused activities for meaningful impact. Following are actions ACHs can take to adequately support and sustain the important work of advancing health equity.

- **Make a financial commitment to health equity** in the ACH by dedicating financial resources and staffing. Allocating dedicated budget, staff time and resources to health equity-focused actions across all 10 ACH elements can help prioritize this work, provide adequate attention and support, and build accountability. For example, building equity-centered shared data systems require dedicated financial, technical and staff resources to build data infrastructure for equity-centered measures, collect quality disaggregated data, run stratified analyses and translate data for action.

- **Dedicate financial resources to support meaningful community engagement** that fosters shared leadership in the long-run. Population Health Innovation Lab's *Powering Change: Building Healthy, Equitable Communities* Curriculum outlines important strategies for achieving this:[50]
    - Budget for barriers to resident involvement (e.g., transportation, child care, translators)
    - Develop sustainable funding for paid positions for community members to support backbone activities or participate in the ACH's workgroups
    - Create coaching or mentoring programs to build community member capacity for leadership
    - Engage community leaders in participatory budgeting processes to allocate funds

- **Consider creating a Local Wellness Fund.** A Local Wellness Fund is "a locally controlled pool of funds created to support community well-being and clinical prevention efforts that improve population health outcomes and reduce health inequities. Sources of funding may be public and/or provide."[51] Such a dedicated fund can not only help an ACH establish financial sustainability but generate greater accountability toward investing funds for dedicated community health and health equity efforts. Many Local Wellness Funds started with seed government or philanthropic grants that was augmented by multiple sources of support such as small donor grants, fees assessed on health plans, community benefit dollars and other sources for blending and braiding funding.

Tools & Resources: Financial Models Supporting Health Equity

- Rhode Island Health Equity Zones: invested more than $30 million through braided funding to develop sustainable infrastructure to support health equity initiatives

- Establishing a Local Wellness Fund: Early Lessons from the California Accountable Communities for Health Initiative (2019)

- Local Wellness Funds: National learnings compiled by the Funders Forum on Accountable Health and the Georgia Health Policy Center (2019)

Glossary

The following glossary includes key terms for understanding and applying concepts of health equity in practice. These are intended to serve as a starting point to help ACHs dialogue and establish their own shared language for key terms. It is also intended to help ACHs move from a place of discomfort to comfort in discussing, understanding and embracing key concepts.

ALLY

Someone who makes the commitment and effort to recognize their privilege (based on gender, class, race, etc.) and work in solidarity with oppressed groups in the struggle for justice.

ACCOUNTABLE COMMUNITY FOR HEALTH

An Accountable Community for Health (ACH) is "a multi-sector partnership that seek to improve health outcomes by addressing social determinants of health and health-related social needs such as food security, housing, and transportation, among others."[52] ACHs serve as a local platform for bringing stakeholders and community residents together to transform systems to improve community health and achieve greater equity on a sustainable basis rather than provide "one-time" interventions based solely around a health care delivery system. [53] The process by which communities embrace a multi-sector approach to population health varies by community. As a result, standing up ACHs requires genuine community leadership, intentionality, resources, technical assistance, and opportunities to learn from each other.

ANTI-RACISM

"The active process of naming and confronting racism by changing systems, organizational structures, policies and practices, and attitudes, so that power is redistributed and shared equitably."[54]

According to Ibram X. Kendi: "The opposite of racist isn't 'not racist.' It is 'anti-racist.' What's the difference? One endorses either the idea of a racial hierarchy as a racist, or racial equality as an antiracist. One either believes problems are rooted in groups of people, as a racist, or locates the roots of problems in power and policies, as an antiracist. One either allows racial inequities to persevere, as a racist, or confronts racial inequities, as an antiracist. There is no in-between."[55]

COMMUNITY ENGAGEMENT

Community engagement is "the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people. In general, the goals of community engagement are to build trust, enlist new resources and allies, create better communication, and improve overall health outcomes as successful projects evolve into lasting collaborations."[56]

COMMUNITY POWER

Community power is the ability of communities most impacted by inequity to act together to voice their needs and hopes for the future and to collectively drive structural change, hold decision-makers accountable, and advance health equity.[57]

CULTURAL COMPETENCE

Cultural competence is "a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations."[58]

CULTURAL HUMILITY

A dynamic and lifelong process focusing on self-reflection and personal critique, acknowledging once's own biases. It involves understanding the complexity of identities – that even in sameness there is difference – and that individuals, organizations and systems will never be fully competent about the evolving and dynamic nature of understanding individual identity.

CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS)

CLAS is "services that are respectful of and responsive to each person's culture and communication needs." [59] They help organizations and individuals take cultural health beliefs, preferred languages, health literacy levels and communication needs into account when providing services. They help make services respectful, understandable, effective and equitable. In 2013, the Office of Minority Health developed National CLAS Standards to provide organizations with action steps and guidance on advancing CLAS through governance, leadership and workforce; communication and language assistance; and engagement, continuous improvement and accountability.

CRITICAL RACE THEORY

"Born out of both legal studies and education scholarship, this is a framework that centers experiential knowledge, challenges dominant ideology, and mobilizes interdisciplinary action and research in order to uncover inequalities related to race and racism and other intersectional identities and/or experiences."[60]

In simple terms, critical race theory is an academic concept that started in the 1960s and 1970s following the civil rights movement. It was designed to analyze laws and policies—and was centered on the idea that "race is a social construct, and that racism is not merely the product of individual bias and prejudice, but also something embedded in legal systems and policies."[61] The concept holds that racial inequality in education, income, wealth, housing, health care and across other systems are the result of current and historic policies including slavery, Jim Crow and other overt racist practices such as redlining. It compels leaders to confront the nation's history of racist policies and focus on systemic solutions to advance racial equity. In recent years, the term has become politically charged and falsely misrepresented as an ideology that is being indoctrinated in schools and society to frame all White people as racists and oppressors, and thus suggesting that Americans are being taught to hate or discriminate against White people. [62] This gross misrepresentation is being used to stall and undo important progress toward racial justice and health equity.

DIVERSITY

Refers to the different identities people embody based on race, gender, sexual orientation, class, age, country of origin, education, religion, geography, physical or cognitive abilities, or other characteristics. Valuing diversity means recognizing differences between people, acknowledging that these differences are a valued asset, and striving for diverse representation as a critical step towards equity.[63]

EQUITY
Equity is the state, quality or ideal of being just, impartial and fair. The concept is synonymous with fairness and justice.[64]

ETHNICITY
Social construct and category based on shared geography, language, ancestry, traditions or history.[65] The boundaries of authenticity (that is, who or what "counts" in recognizing members of an ethnic group) are often changeable and dependent on generational, social, political and historical situations.[66]

HEALTH
Health is "the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[67]

HEALTH DISPARITIES
Differences in health outcomes between segments of the population, as defined by social, demographic, environmental and geographic attributes. The use of the term disparities merely refers to *differences* and does not imply that differences are unfair or unjust. Whereas *health inequities* are health disparities that are systemic, avoidable, unfair and unjust.

HEALTH EQUITY
"Health equity means everyone has a fair and just opportunity to be as healthy as possible. It requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. For purposes of measurement health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups."[68]

HEALTH INEQUITIES
Differences in health status and outcomes that are systemic, avoidable, unfair and unjust.[69] They occur because of underlying inequalities in social, economic and environmental opportunities shaped by policies and other structural drivers. Inequities are sustained over time and generations, and require systems-level solutions, as opposed to individual-level.

IMPLICIT BIAS OR UNCONSCIOUS BIAS
The attitudes or stereotypes that affect our understanding, actions and decisions in an unconscious manner. These biases encompass both favorable and unfavorable assessments, and are activated involuntarily without an individuals' awareness. Residing deep in the subconscious, these biases are different from known biases that individuals may choose to conceal for the purpose of social and/or political correctness.[70]

INCLUSION

Inclusion refers to inviting in and making a space for all people, regardless of their race, ethnicity, gender, abilities, or other characteristics. Inclusion also requires authentically bringing traditionally excluded individuals and/or groups into processes, activities and decision-making in a way that shares power.[71]

INTERSECTIONALITY

"The acknowledgement that multiple power dynamics ("isms") are operating simultaneously—often in complex and compounding ways—and must be considered together in order to have a more complete understanding of oppression and ways to transform it. There are multiple forms of privilege and oppression based on race, gender, class, sexuality, age, ability, religion, citizenship or immigration status, and so on. These social hierarchies are products of our social, cultural, political, economic, and legal environment. They drive disparities and divisions that help those in power maintain and expand their power. There's a danger in falsely equating different dynamics (e.g. racism and sexism) or comparing different systems to each other (sometimes referred to as the "oppression Olympics"). It is important to give each dynamic distinct, specific and sufficient attention. Every person is privileged in some areas and disadvantaged in other areas."[72]

LGBTQ

Acronym for "lesbian, gay, bisexual, transgender and queer." Other forms of the term include LGBTQIA for "lesbian, gay, bisexual, transgender, queer or questioning, intersex, and asexual" and LGBTQ+ to recognize the growing understanding of sex and gender, and to include allies.[73]

OPPRESSION

Systemic devaluing, undermining, marginalizing and disadvantaging of certain social identities in contrast to the privileged norm; when some people are denied something of value, while others have ready access.

PEOPLE OF COLOR

Term used mostly, but not exclusively, in the U.S. to describe people not considered "white." The term emphasizes shared experiences of structural racism, and opposes reference to people as "non-white" or "minority." In recent years, the related term BIPOC (Black, Indigenous and People of Color) has been used. However, whenever possible it is important to identify people through their own racial/ethnic group, as each has its own distinct experience and meaning and may be more appropriate.[74]

POWER

Power is the capacity to act individually or collectively.[75] Power is also the ability to decide for others, including who has access to resources. In the context of health, power shapes the factors that determine social, economic and environmental opportunities people have to lead healthy lives. "Advancing equity requires attention to power (as a determinant) and empowerment, or building power (as a process)."[76]

RACE
Race is a social construct, and not a biological factor based on physical and genetic variation. It is a system of categorizing people that was borne out of a need to differentiate groups of people in hierarchies to advantage some and disadvantage others.[77] [78]
"Race as a category denoting skin color was first used to classify human bodies by Francois Bernier, a French physician. The notion of racial groupings was introduced in Carolus Linnaeus's Natural History in 1735 and subsequently advanced by many others. Both Linnaeus's concept of race and the subsequent racial groupings devalued and degraded those classified as non-European. Linnaeus's classification became the foundation on which many countries, including the United States, based their racial policies."[79]

RACIAL JUSTICE
The systematic fair treatment of people of all races, resulting in equitable opportunities and outcomes for all. Racial justice is not just the absence of discrimination and inequities, but also the presence of deliberate systems and supports to achieve and sustain racial equity through proactive and preventative measures.[80]

RACISM
"A system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call "race"), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources."[81]

There are four dimensions of racism:

- **Individual racism** includes private racial beliefs held by individuals such as stereotypes, bias and prejudice (both conscious and unconscious).
- **Interpersonal racism** is the expression of bias and discrimination between people. Examples include bigotry, hate speech and violence.
- **Institutional racism** occurs within institutions and organizations and includes unfair and discriminatory policies and practices.
- **Structural racism** exists broadly across institutions and society, in its history, ideology, structures, systems and laws.

ROOT CAUSES OF HEALTH INEQUITIES
Underlying systems and structures of social injustice that generate health inequities over time, including racism, patriarchy, and class oppression. They interact with each other to produce social exclusion, marginalization and exploitation.[82]

SOCIAL DETERMINANTS OF HEALTH
Social determinants of health are the non-medical factors that influence health outcomes. They are the conditions in which people are born grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agenda, social norms, social policies and political systems.[83]

SOCIAL EXCLUSION OR MARGINALIZATION

Social exclusion or marginalization refers to barring or deterring particular social groups—for example, based on skin color, national origin, religion, wealth, disability, sexual orientation, gender identify or gender—from full participation in society and from sharing the benefits of participation. Socially excluded or marginalized groups have less power and prestige and generally less wealth. Because of that, the places where they live often have health-damaging and/or non-health promoting conditions, such as pollution, lack of access to jobs and services, and inadequate schools.[84]

TARGETED UNIVERSALISM

"Targeted universalism means setting universal goals pursued by targeted processes to achieve those goals. Within a targeted universalism framework, universal goals are established for all groups concerned. The strategies developed to achieve those goals are targeted, based upon how different groups are situated within structures, culture, and across geographies to obtain the universal goal. Targeted universalism is goal oriented, and the processes are directed in service of the explicit, universal goal."[85]

References

[1] Hughes D, Levi J, Heinrich J and Mittmann H. *Developing a Framework to Measure the Health Equity Impact of Accountable Communities for Health, July 2020. Funders Forum on Accountable Health*. Available at https://tinyurl.com/2p86tz9b

[2] Kania J, Williams J, Schmitz P, Brady S, Kramer M & Juster JS. Centering Equity in Collective Impact. Stanford Social Innovation Review, Winter 2022. https://ssir.org/articles/entry/centering_equity_in_collective_impact

[3] Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. What Is Health Equity? And What Difference Does a Definition Make? Princeton, NJ: Robert Wood Johnson Foundation, 2017. https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html

[4] Kania J, Williams J, Schmitz P, Brady S, Kramer M & Juster JS. Centering Equity in Collective Impact. Stanford Social Innovation Review, Winter 2022. https://ssir.org/articles/entry/centering_equity_in_collective_impact

[5] Prybil L, Scutchfield FD, Killian R, Kelly A, Mays G, Carman A, Levey S, McGeorge A, and Fardo DW Improving community health through hospital–public health collaboration, 2014. Lexington, KY: Commonwealth Center for Governance Studies. https://uknowledge.uky.edu/hsm_book/2/

[6] Mongeon M, Levi J, and Heinrich J. Elements of Accountable Communities for Health: A Review of the Literature. November 6, 2017. NAM Perspectives. Discussion Paper, National Academy of Medicine, Washington, DC. https://nam.edu/elements-of-accountable-communities-for-health-a-review-of-the-literature/

[7] CDC. Health Equity Guiding Principles for Inclusive Communication, December 2021. https://www.cdc.gov/healthcommunication/Health_Equity.html

[8] ChangeLab Solutions. Accountable Communities for Health Legal & Practical Recommendations, 2015. Available at: http://cachi.org/uploads/resources/ChangeLab-Solutions_ACH-legal-recs.pdf

[9] Hughs D, Levi J, Heinrich J, and Mittmann H. Developing a Framework to Measure the Health Equity Impact of Accountable Communities for Health, July 2020. Funders Forum on Accountable Health. https://accountablehealth.gwu.edu/sites/accountablehealth.gwu.edu/files/Funders%20Forum%20ACH%20Health%20Equity%20Impact%20July%202020%20(1)_0.pdf

[10] Givens ML, Kindig D, Inzeo PT, and Faust V. Power: The Most Fundamental Cause of Health Inequity*? Health Affairs Forefront*, February 1, 2018. https://www.healthaffairs.org/do/10.1377/forefront.20180129.731387/full/

[11] Ibid.

[12] Charles A. Building Equity into Your Network of Partners. County Health Rankings & Roadmaps Webinar, October 20, 2020. https://www.countyhealthrankings.org/online-and-on-air/webinars/building-equity-into-your-network-of-partners

[13] Population Health Innovation Lab. Powering Change: Building Healthy, Equitable Communities Together, January 2021. https://pophealthinnovationlab.org/wp-content/uploads/2021/04/2021.04.29_PoweringChange_V1_Final.pdf

[14] CDC. Principles of Community Engagement, Second Edition, 2018. https://www.atsdr.cdc.gov/communityengagement/pdf/PCE_Report_508_FINAL.pdf

[15] Population Health Innovation Lab. Accountable Communities for Health Start Up Guide, 2019. https://docs.google.com/document/d/1DFlgSV9b2Kxv2kGx9WmQ4HHAXD_zxdYYG7c5PatlC5E/edit#

[16] Ibid.

[17] Washington Race Equity & Justice Initiative. REJI Organizational Race Equity Toolkit, 2nd Edition, 2020. https://justleadwa.org/wp-content/uploads/2020/11/REJI-Toolkit-v2-Final-2020-3.pdf

[18] Kania J, Williams J, Schmitz P, Brady S, Kramer M & Juster JS. Centering Equity in Collective Impact. Stanford Social Innovation Review, Winter 2022. https://ssir.org/articles/entry/centering_equity_in_collective_impact

[19] Ibid.

[20] Beldon C. Let's Get Practical: 3 Key Inclusive Facilitation Practices. The Inclusion Solution. June 13, 2019.

[21] World Health Organization. Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health, 2008. Commission on Social Determinants of Health. https://www.who.int/teams/social-determinants-of-health/equity-and-health/commission-on-social-determinants-of-health

[22] Iton T. Framework for Health Equity, 2008. Building Healthy Communities. https://www.buildinghealthycommunities.org/framework-for-health-equity/

[23] Woolf SH. Progress in Achieving Health Equity Requires Attention to Root Causes. Health Affairs, 2017: 36(6). https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2017.0197

[24] Rudolph L et al., Health in All Policies: A Guide for State & Local Governments, 2013. Public Health Institute & American Public Health Association. https://nam.edu/perspectives-2013-health-in-all-policies-improving-health-through-intersectoral-collaboration/
[25] University of Utah Health, 2021. https://accelerate.uofuhealth.utah.edu/improvement/fishbone-diagram-a-tool-to-organize-a-problem-s-cause-and-effect
[26] Williams DR & Collins C. Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health. Public Health Reports, 2001; 116 (September/October). https://scholar.harvard.edu/davidrwilliams/dwilliam/publications/racial-residential-segregation-fundamental-cause-racial-disparities-health
[27] Love B and Hayes-Greene D. The Groundwater Approach: Building a Practical Understanding of Structural Racism. 2018. Racial Equity Institute. https://www.groundwaterinstitute.com/groundwaterapproach
[28] The Annie E. Casey Foundation. Equity vs. Equality and Other Racial Justice Definitions, 2020. https://www.aecf.org/blog/racial-justice-definitions?gclid=Cj0KCQjw-af6BRC5ARIsAALPIlXMhccmwWTV5HJXPSXVSnV8KTtOrWn4iPL095ZL_4OziN6ZiBhEItMaAiZYEALw_wcB
[29] Health Equity Innovation Network. Root Cause Priority Matrix, 2021. https://hqin.org/wp-content/uploads/2021/10/Priority-Matrix_508.pdf
[30] powell ja, Menendian S and Ake W. Targeted Universalism: Policy & Practice, May 2019. Haas Institute for a Fair and Inclusive Society. https://belonging.berkeley.edu/targeted-universalism
[31] CDC. From SMART to SMARTIE Objectives, 2022. https://www.cdc.gov/cancer/dcpc/about/foa-dp22-2202/pdf/smartie-objectives-508.pdf
[32] Bibbs M. Be a SMARTIE: An Equity-Forward Approach to Goal Setting. January 5, 2021. The Alford Group. https://alford.com/be-a-smartie-an-equity-forward-approach-to-goal-setting/
[33] Center for Medicare and Medicaid Services (CMS). Inventory of Resources for Standardized Demographic and Language Data Collection, 2021. https://www.cms.gov/about-cms/agency-information/omh/downloads/data-collection-resources.pdf
[34] Manchanda R, Do R and Miles N. A Toolkit to Advance Racial Health Equity in Primary Care Improvement. California Improvement Network, California Health Care Foundation, Healthforce Center at UCSF, April 2022.
[35] Bailit M and Kanneganti D. A Typology for Health Equity Measures. Health Affairs Forefront, March 21, 2022. https://www.healthaffairs.org/do/10.1377/forefront.20220318.155498/
[36] Ibid.
[37] Health Opportunity and Equity (HOPE) Initiative, 2020. https://www.hopeinitiative.org/
[38] McKinlay SN and Sites E. Data Democratization: The Unsung Hero of Health Equity. Health Leads. June 2020. https://healthleadsusa.org/communications-center/blog/data-democratization-the-unsung-hero-of-health-equity/
[39] Robert Wood Johnson Foundation. Charting a Course for an Equity-Centered Data System: Recommendations from the National Commission to Transform Public Health Data Systems, October 2021. https://www.rwjf.org/en/library/research/2021/10/charting-a-course-for-an-equity-centered-data-system.html
[40] Standish M, et al. Chapter 18. Sustainability through Accountability: The Accountable Community for Health Model. The Practical Playbook II: Building Multisector Partnerships that Work, 2019. https://www.practicalplaybook.org/page/sustainability-through-accountability-accountable-community-health-model
[41] Population Health Innovation Lab. Powering Change: Building Healthy, Equitable Communities Together, January 2021. https://pophealthinnovationlab.org/wp-content/uploads/2021/04/2021.04.29_PoweringChange_V1_Final.pdf
[42] Public Health Institute. Advancing Equity: Adapting to Local Context and Confronting Power Dynamics: Lessons Learned from Accountable Communities of/for Health Equity. May 2022. https://pophealthinnovationlab.org/advancing-equity-download/
[43] Valenzuela M. King County's Journey in Institutionalizing Equity and Social Justice. Evidence in Public Administration, 2017. https://kingcounty.gov/~/media/elected/executive/equity-social-justice/2017/PAR2017ArticleValenzuela-KCJourneyInInstitutionalize.ashx?la=en
[44] Funders Forum on Accountable Health. Principles of Accountable Health. https://accountablehealth.gwu.edu/forum-analysis/principles-accountable-health
[45] Kirwan Institute for the Study of Race and Ethnicity. State of the Science: Implicit Bias Review, 2013. https://kirwaninstitute.osu.edu/article/understanding-implicit-bias

[46] Davis K, et al. Mirror, mirror on the wall, 2014 update: How the U.S. health care system compares internationally. The Commonwealth Fund. https://www.commonwealthfund.org/ publications/fund-reports/2014/jun/mirror-mirror-wall-2014update-how-us-health-care-system
[47] Turner A, LaVeist TA, Richard P, and Gaskin DJ. Economic Impacts of Health Disparities in Texas 2020: An Update in the time of Covid-19. January 2021.Funded by Episcopal Health Foundation.
[48] Northwest Ohio Pathways HUB. Five Year Report 2016-2020. http://www.hcno.org/wp-content/uploads/2021/04/Northwest-Ohio-Pathways-HUB-Five-Year-Report-2021-email-and-web.pdf
[49] Hughes DL and Mann C. Financing the Infrastructure of Accountable Communities for Health Is Key to Long-Term Sustainability. Health Affairs, April 2020; 39(4). https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01581
[50] Population Health Innovation Lab. Powering Change: Building Healthy, Equitable Communities Together, January 2021. https://pophealthinnovationlab.org/wp-content/uploads/2021/04/2021.04.29_PoweringChange_V1_Final.pdf
[51] Georgia Health Policy Center. Local Wellness Funds, September 2019. https://accountablehealth.gwu.edu/sites/accountablehealth.gwu.edu/files/Local%20Wellness%20Funds%20Brief.pdf
[52] Hughes D, Levi J, Heinrich J and Mittmann H. *Developing a Framework to Measure the Health Equity Impact of Accountable Communities for Health, July 2020. Funders Forum on Accountable Health*. Available at https://tinyurl.com/2p86tz9b
[53] Texas Accountable Communities for Health Initiative (TACHI). What are Accountable Communities for Health? https://www.txachi.org/about-tachi/
[54] AMA. Advancing Health Equity: A Guide to Language, Narrative and Concepts. https://www.ama-assn.org/about/ama-center-health-equity/advancing-health-equity-guide-language-narrative-and-concepts-0
[55] Kendi I. How to be an Antiracist. New York, NY: Random House, 2019.
[56] CDC. Principles of Community Engagement, Second Edition, 2018. https://www.atsdr.cdc.gov/communityengagement/pdf/PCE_Report_508_FINAL.pdf
[57] RWJF. Building Community Power to Advance Health Equity: How Do Local Community Power-Building Organizations Advance Health and Racial Equity. https://www.rwjf.org/en/library/collections/building-community-power-to-advance-health-equity.html
[58] Cross T, Bazron B, Dennis K and Isaacs M. Towards A Culturally Competent System of Care, 1989. Volume I. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center. https://nccc.georgetown.edu/curricula/culturalcompetence.html
[59] US Department of Health and Human Services. National CLAS Standards. https://thinkculturalhealth.hhs.gov/clas
[60] AMA. Advancing Health Equity: A Guide to Language, Narrative and Concepts. November 2021. https://www.ama-assn.org/system/files/ama-aamc-equity-guide.pdf
[61] Sawchuk S. What is Critical Race Theory, and Why Is It Under Attack? May 18, 2021. Education Week: Equity & Diversity. https://www.edweek.org/leadership/what-is-critical-race-theory-and-why-is-it-under-attack/2021/05
[62] Ray R and Gibbons A. Why are States Banning Critical Race Theory? Brookings Institution. November 201. https://www.brookings.edu/blog/fixgov/2021/07/02/why-are-states-banning-critical-race-theory/
[63] Race Forward. Race Reporting Guide, 2015. https://www.raceforward.org/reporting-guide
[64] The Annie E. Casey Foundation. Equity vs. Equality and Other Racial Justice Definitions, 2020. https://www.aecf.org/blog/racial-justice-definitions?gclid=Cj0KCQjw-af6BRC5ARIsAALPIlXMhccmwWTV5HJXPSXVSnV8KTtOrWn4iPL095ZL_4OziN6ZiBhEItMaAiZYEALw_wcB
[65] Ford CL, Harawa NT. A new conceptualization of ethnicity for social epidemiologic and health equity research. Soc Sci Med. 2010;71(2):251-258.
[66] AMA. Advancing Health Equity: A Guide to Language, Narrative and Concepts, 2021.
[67] World Health Organization. Constitution Adopted by the International Health Conference, 1946. https://www.who.int/about/governance/constitution
[68] Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. What Is Health Equity? And What Difference Does a Definition Make? Princeton, NJ: Robert Wood Johnson Foundation, 2017. https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html
[69] AMA. Advancing Health Equity: A Guide to Language, Narrative and Concepts, 2021.
[70] Ohio State University Kirwan Institute for the Study of Race and Ethnicity. Implicit Bias Module Series. https://kirwaninstitute.osu.edu/implicit-bias-training

[71] Racial Equity Tools. Glossary, October 2021. https://drive.google.com/file/d/1-h0EWxqHAZUfheFvuFRtVpEz5ODSxuI6/view
[72] Race Forward. Race Reporting Guide, 2015. https://www.raceforward.org/reporting-guide
[73] AMA. Advancing Health Equity: A Guide to Language, Narrative and Concepts, 2021
[74] AMA. Advancing Health Equity: A Guide to Language, Narrative and Concepts, 2021
[75] MATCH. Health Equity Training Module 2. Health & Power. https://uwphi.pophealth.wisc.edu/match/health-equity-training-modules/
[76] Givens et al., Power: The Most Fundamental Cause of Health Inequity*?* 2018.
[77] Jones CP. Levels of Racism: A Theoretic Framework and a Gardener's Tale. American Journal of Public Health, August 2000; 90(8). https://belonging.berkeley.edu/targeted-universalism
[78] Race Reporting Guide. New York: Race Forward; 2015. https://www.raceforward.org/sites/default/files/Race%20Reporting%20Guide%20by%20Race%20Forward_V1.1.pdf
[79] Ford CL and Airhihenbuwa CO. Critical Race Theory, Race Equity, and Public Health: Toward Antiracism Praxis. American Journal of Public Health, April 2010; 100(Suppl 1). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2837428/
[80] Race Reporting Guide. New York: Race Forward; 2015. https://www.raceforward.org/sites/default/files/Race%20Reporting%20Guide%20by%20Race%20Forward_V1.1.pdf
[81] Jones, CP. How Racism Makes People Sick: A Conversation with Camara Phyllis Jones. Kaiser Permanente Institute for Health Policy, 2016. https://www.kpihp.org/blog/how-racism-makes-people-sick-a-conversation-with-camara-phyllis-jones-md-mph-phd/
[82] AMA. Advancing Health Equity: A Guide to Language, Narrative and Concepts, 2021
[83] World Health Organization, Commission on Social Determinants of Health. the gap in a generation: health equity through action on the social determinants of health, 2008. Geneva: WHO.
[84] Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. What Is Health Equity? And What Difference Does a Definition Make? Princeton, NJ: Robert Wood Johnson Foundation, 2017. https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html
[85] powell ja, Menendian S and Ake W. Targeted Universalism: Policy & Practice, May 2019. Haas Institute for a Fair and Inclusive Society. https://belonging.berkeley.edu/targeted-universalism