

## **Utilizing Health Equity Council (HEC) Tools to achieve HP 2020 Goals and assist with the federal Community Transformation Grant**

### **Health Equity Council**

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The Health Equity Council has developed a variety of tools to use for various purposes to address health inequities. The following table outlines some of the ways that these tools can be used to assist with achieving the CDC's Healthy People 2020 Goals, and capacity building or implementation with the federal government Affordable Care Act's Community Transformation Grant (CTG). The CTG states, "Recipients will engage populations that are facing health disparities in a variety of settings to make the healthy choice the easy choice and ensure opportunities to make healthy choices." The Council created this document containing tools to guide local efforts. The documents are available on the Health Equity Council website at <http://www.chronicdisease.org/nacdd-initiatives/health-equity> and have a direct link provided below. Please take advantage of these helpful resources

If you have questions about the tools or would like more information on the Council please contact Gail Brandt, [brandtconsulting@hotmail.com](mailto:brandtconsulting@hotmail.com) or [gbrandt@chronicdisease.org](mailto:gbrandt@chronicdisease.org)

<u>Tools</u>	<u>Purpose/use of document</u>	<u>HP 2020 Goals</u>	<u>Community Transformation Grant</u>
<p><b>Community Action Guide: Decreasing High School Dropout Rates (Coming Soon)</b></p>	<p>Provides communities and states statistics, research and general information on the importance of high school education and graduation on positive health outcomes for individuals and communities. The document contains examples of promising practices and successful programs that can be used to identify strategies for increasing graduation rates.</p>	<p>Priority focus areas:</p> <ol style="list-style-type: none"> <li>1. tobacco use</li> <li>2. nutrition and weight status</li> <li>3. physical activity and fitness</li> <li>4. health disease and stroke</li> </ol> <p><u>Topic area overlap:</u></p> <ol style="list-style-type: none"> <li>1. Social determinants of health</li> <li>2. Access to health services</li> <li>3. Health related quality of life and well being</li> <li>4. Occupational safety and health</li> </ol> <p><u>Focus area:</u></p> <ul style="list-style-type: none"> <li>• high quality education</li> <li>• health disease and stroke</li> <li>• nutrition and weight status</li> <li>• physical activity and fitness</li> </ul>	<p>5 strategic directions:</p> <ol style="list-style-type: none"> <li>1) Tobacco-free living</li> <li>2) Active living and healthy eating</li> <li>3) High impact evidence based clinical and other preventative services</li> <li>4) Social and emotional wellness</li> <li>5) Healthy and safe physical environment</li> </ol> <p>Capacity Building (A) OR Implementation (B)</p> <ul style="list-style-type: none"> <li>• Assist with identifying population subgroups with documented disparities</li> <li>• Address strategic direction 3, and 4. Provides sample strategies from other states and communities that address these required directions.</li> <li>• Assist with developing strategies to educate the public/stakeholders about evidence and practice based policy interventions related to high school dropout rate and health outcomes.</li> </ul>

[Community Action Guide: Changing Food Deserts into Food Oases](http://www.chronicdisease.org/nacdd-initiatives/health-equity/tools/food-deserts-to-food-oases/view)

Available at:

<http://www.chronicdisease.org/nacdd-initiatives/health-equity/tools/food-deserts-to-food-oases/view>

Changing Food Deserts to Food Oases outlines the background and history of food deserts, as well as providing steps to work toward available, affordable, and accessible healthy food choices for communities to positively impact health.

Topic area overlap:

1. Cancer
2. Diabetes
3. Food safety
4. Maternal, infant, child health
5. Heart disease and stroke
6. Nutrition and weight status
7. Social determinants of health

Focus areas:

- Health disease and Stroke
- Nutrition and weight status

- Assist with identifying population subgroups with disparities in a geographic area.
- Address strategic direction 2, and 5. Provides sample strategies from other states and communities that address these required directions.
- Assist with understanding how to summarize existing community health data related to access, affordability, etc of healthy foods and nutrition.
- Assist with identifying strategies for educating the public/stakeholders about evidence and practice based policy interventions.
- Use to address creating social and physical environments that support healthy living and ensure that healthy choices are the easy choice.
- Provides guidance on developing and diversifying community partnerships.
- Assist grantees in increasing the accessibility, affordability and availability (and identification) of healthful foods to improve nutrition among people with diabetes and to prevent diabetes
- Addressing food deserts will optimize maternal, infant and family nutrition

**Community Action Guide:  
Neighborhood and Residential  
Segregation and its Health Effects**

**Available at:**

This Community Action Guide provides information on neighborhood segregation and how this negatively affects the social and physical health of residents. Outlines steps for eliminating segregation through identifying geographic areas, bringing awareness to the issue, identifying resources and partners and possible action/policy changes for states and communities.

Topic area overlap:

1. Access to health services
2. Diabetes
3. Heart disease and stroke
4. Respiratory diseases
5. Social determinants of health
6. Educational and community based programs
7. Environmental health
8. Health related quality of life and well being
9. Violence and injury prevention
10. Maternal, infant and child health
11. Nutrition and weight status
12. Physical activity
13. Early and middle childhood

Focus areas:

- Decent and safe housing
- Affordable, reliable public transportation
- Clean water and Non-polluted air
- Nutrition and weight status
- Physical activity and fitness
- Health disease and stroke

- Assist with identifying population subgroups with documented disparities in a geographic area.
- Provides sample strategies from other states and communities and practical guidance to address required strategic directions 1, 2, 3, 4 and 5 by addressing neighborhood segregation.
  - Reducing barriers to accessing clinical and other preventative services
  - Creating affordable, safe and healthy housing
  - Strengthening the social environment to support and reinforce healthy choices
  - Increasing opportunities for regular physical activity (community design, safe/affordable locations for activity)
  - Create social and physical environments that support healthy living and ensure that healthy choices are the easy choice
- Assist with understanding how to summarize existing community health data related to segregation in the community.
- Assist with educating the public, and stakeholders about evidence and practice based policy interventions

<p><b>HEC Language/Policy Development Statements</b></p> <p><b>Available at:</b></p>	<p>Contains statements that drive action toward policies that result in real changes in the social determinants of health. These statements provide states and communities samples for determining by-laws, contracting, request for proposals, and hiring and membership policies, among others.</p>	<p>Topic area overlap:</p> <ol style="list-style-type: none"> <li>1. Social determinants of health</li> <li>2. Public health infrastructure</li> </ol>	<ul style="list-style-type: none"> <li>• Use to build capacity-- organizational infrastructure, and participation in policy.</li> <li>• Assist with educating the public/stakeholders about evidence and practice based policy interventions</li> <li>• Establish systems, procedures and protocols within communities, institutions and networks to support healthy behaviors.</li> <li>• Assist with developing a policy for hiring staff to manage the grant program, participate on the leadership team or coalitions with skills/understanding of health equity</li> <li>• Use tool to understand how to conduct a policy scan to identify gaps in existing policies, programs and infrastructure and learn opportunities to address these gaps</li> <li>• Sample policy statements related to membership policies address the requirement to diversify partnerships and establishing non-discrimination policies.</li> </ul>
<p><b><u><a href="#">Health Equity Skills Assessment</a></u></b></p> <p><b>Summary only available at:</b>  <u><a href="http://www.chronicdisease.org/nacdd-initiatives/health-equity/tools/health-equity-at-work/view">http://www.chronicdisease.org/nacdd-initiatives/health-equity/tools/health-equity-at-work/view</a></u></p> <p><b>Contact Gail Brandt for full assessment:</b>  <u><a href="mailto:brandtconsulting@hotmail.com">brandtconsulting@hotmail.com</a></u> or  <u><a href="mailto:gbrandt@chronicdisease.org">gbrandt@chronicdisease.org</a></u></p>	<p>A skills assessment for state level health department and organization staff that measures their skills competence in 6 key areas; communications, cultural competence, program planning and development, analytic assessment, community practice, and leadership and systems thinking. The purpose of the Assessment Tool is to identify training needs; including strengths and weaknesses of staff and those working in the field.</p>	<p>Topic area overlap:</p> <ol style="list-style-type: none"> <li>1. Social determinants of health</li> <li>2. Public health infrastructure</li> <li>3. Health related quality of life and well being</li> <li>4. Health communication and health information technology</li> </ol>	<ul style="list-style-type: none"> <li>• Tool can be used to assist with capacity building activities--developing human capital and skills, and programmatic/infrastructure training.</li> <li>• Assist with identifying staff with skills in health equity, in addition to others needed to manage the grant program.</li> <li>• Assist with health equity training development for grant management staff, leadership team, or coalition members.</li> </ul>

<p><a href="#"><u>Cultural Competency Definitions and Recommendations</u></a></p> <p><b>Available at:</b>  <a href="http://www.chronicdisease.org/nacdd-initiatives/health-equity/tools/cultural-competency-recommendations/view"><u>http://www.chronicdisease.org/nacdd-initiatives/health-equity/tools/cultural-competency-recommendations/view</u></a></p>	<p>A document that provides a detailed definition of cultural competency, health disparities and health equity. The second portion contains sample recommendations and action steps to work toward addressing cultural competency within an organization.</p>	<p>Topic area overlap:</p> <ol style="list-style-type: none"> <li>1. Access to health services</li> <li>2. Educational and community based programs</li> <li>3. Health communication and health information technology</li> <li>4. Health related quality of life and well-being</li> <li>5. Lesbian, gay, bisexual and transgender health</li> <li>6. Maternal and infant child health</li> <li>7. Public health infrastructure</li> <li>8. Social determinants of health</li> </ol>	<ul style="list-style-type: none"> <li>• Can assist with determining capacity building activities—building organizational infrastructure and developing programmatic training.</li> <li>• Provides examples of broad strategies that can be utilized to achieve population-wide health improvements, overarching all five strategic areas.</li> </ul>
<p><a href="#"><u>10 Promising Practices to Reduce Inequity</u></a></p> <p><b>Available at:</b>  <a href="http://www.chronicdisease.org/nacdd-initiatives/health-equity/tools/promising-practices-to-reduce-inequity/view"><u>http://www.chronicdisease.org/nacdd-initiatives/health-equity/tools/promising-practices-to-reduce-inequity/view</u></a></p>	<p>A document that outlines 10 crucial areas that demonstrate promise in reducing social inequities in public health. State level public health departments or community organizations can utilize this document to identify the most critical areas for reducing inequities. Examples of these areas include; targeting populations with universal approaches, social marketing, and community engagement.</p>	<p>Topic Area Overlap:</p> <ol style="list-style-type: none"> <li>1. Social determinants of health</li> <li>2. Public health infrastructure</li> <li>3. Health communication and health information technology</li> </ol>	<ul style="list-style-type: none"> <li>• Promising practices outline can assist with capacity building activities--building organizational infrastructure and human capital.</li> <li>• Assist with identifying systems, procedures and protocols within communities, institutions and networks to support healthy behaviors.</li> <li>• Provides examples of broad strategies that can be utilized to achieve population-wide health improvements.</li> </ul>