6/29/2020

**HEALTH EQUITY CHECKLIST**

## Introduction

COVID-19 has exposed the negative impact of the social determinants of health within communities of color where the rate of infections and deaths are the highest especially among racial and ethnic minorities. A growing body of evidence has shown that if we address unmet social determinants of health, we can improve health outcomes. Participating entities should pay special attention to community members who have historically been marginalized and develop intervention strategies designed to address health disparities and/or health inequities with the end result of furthering health equity.

## What is health equity?

> "A basic principle of public health is that all people have a **right to health**. Differences in the incidence and prevalence of health conditions and health status between groups are commonly referred to as **health disparities**…. Most health disparities affect **groups marginalized** because of socioeconomic status, race/ethnicity, sexual orientation, gender, disability status, geographic location, or some combination of these. People in such groups not only experience worse health but also tend to have less access to the **social determinants or conditions** (e.g., healthy food, good housing, good education, safe neighborhoods, freedom from racism and other forms of discrimination) that support health…. Health disparities are referred to as **health inequities** when they are the result of the systematic and unjust distribution of these critical conditions. **Health equity**, then, as understood in public health literature and practice, is when everyone has the opportunity to "attain their full health potential" and no one is "disadvantaged from achieving this potential because of their social position or other socially determined circumstance."[1]

## Why this Checklist is important.

Given that social disparities are rooted in institutional structuring, quality and controls of the underlying infrastructure and resource sectors that support the community members, it is imperative that participating entities engage in a structured inquiry that identifies unmet social determinants of health that communities of color are enmeshed within which have resulted in a population-based disparity of chronic medical conditions, such as obesity, diabetes, hypertension, asthma, lung disease, and cancer. This is especially true in the wake of the COVID-19 pandemic, where the recovery period for communities of color will be more prolonged and exceedingly difficult to resolve.

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[1] Brennan Ramirez LK, Baker EA, Metzler M. Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2008.

## Objectives

1. To encourage State, County, and Local participating entities to apply an efficacious health equity lens to any proposed intervention strategy designed to address health disparities and/or health inequities.
2. To use this Health Equity Checklist to think through determinants that may have unintended consequences on the health and well-being of community members disparately impacted by COVID-19.
3. To promote the development of a strategy to address the complex factors that influence health and equity, including educational attainment, housing, transportation, and neighborhood safety.[2]
4. To incorporate this checklist as an integral component of any participating entities' strategy development process.

## Health Equity Checklist designed to:

- Articulate how a proposed intervention strategy will improve overall health and advance health equity by reducing disparities and/or health inequities in disparately impacted communities.
- Proactively identify any barriers or undue burdens the proposed **intervention strategy** may impose upon **disparately impacted communities** that would limit the effectiveness of the intervention strategy.
- Ensure that members of disparately impacted communities are engaged and consulted in the planning and implementation of the intervention strategy.
- Assess the intervention strategy's impact on disparately impacted community members over time.

## Key Definitions:[3]

**Disparately impacted communities:** include, but are not limited to, racial and ethnic minorities, refugees, immigrants, seniors, low-income earners, uninsured individuals, undocumented individuals, individuals with limited English Proficiency, individuals with disabilities and the homeless.

**Health equity:** Health equity is attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.

**Health Disparities:** means differences in health outcomes and their determinants between segments of the population, as defined by social, demographic, environmental, and geographic attributes.

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[2] *See*, American Public Health Association, *Health in All Policies,* available at: https://www.apha.org/topics-and-issues/health-in-all-policies.

[3] Center for Disease Control and Prevention – Division of Community Health. *A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease.* Atlanta, GA: US Department of Health and Human Services; 2013.

**Health Inequalities:** a term sometimes used interchangeably with the term health disparities. It is more often used in the scientific and economic literature to refer to summary measures of population health associated with individual - or group – specific attributes (e.g., income, education, or race/ethnicity).

**Health Inequities:** a subset of health inequalities that are modifiable, associated with social disadvantage, and considered ethically unfair.

**Intervention Strategy:** any plan, guidance, proposal, policy, practice, communication, or directive, developed by statewide, regional and local level entities to treat, diagnose, study, provide awareness of, or otherwise address COVID-19 in Illinois residents, including in disparately impacted communities.

**Social determinants of health:** the conditions in the environments in which people are born, live, learn, work, play, worship, and age, that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

**Community Health Needs Assessment (CHNA)[4]:** assessment of a specific community being serviced and typically performed by a consortium of not-for-profit hospitals and community-based organizations. Although they vary by community, CHNAs "enable communities to identify issues of greatest concern and decide how to allocate resources to address those issues.[5]"

## Considerations for Assessing Health Equity:

Participating entities should use the below questions to assess both the short and long-term impacts to health equity, health inequalities and health inequities of a particular intervention strategy. Short-term initiatives might prioritize currently prevalent comorbidities for a disparately impacted community, whereas long-term initiatives might prioritize issues such as food insecurity, inadequate housing or limited access to health care that widen health disparities.

1. **What communities are most likely to benefit from this intervention strategy?** Which disparately impacted communities are most affected by this intervention strategy?
   For example, consider the use of the following resources to identify and inform where the most health needs are in your community.
   - Your Community Health Needs Assessment[6]
   - Community Health Rankings
   - The CMS AHC Screening Tool for the Social Determinants of Health

2. **How does this intervention strategy benefit disparately impacted communities?**
   - What specific health conditions (e.g., diabetes, asthma, hypertension, etc.) and inequities will be addressed with this intervention strategy?
   - What social determinants are targeted for intervention?
   - How will the members of each disparately impacted community be affected?

[4] Community Health Needs Assessment (CHNA) Retrieved from https://hpsa.us/services/chna/community-health-needs-assessment-chna/

[5] Community Health Needs Assessment & Strategic Implementation Plan – UChicago Medicine, Retrieved from https: www.uchicagomedicine.org/about-us/community/benefit/health-needs/chna

[6] O'Connor, W. Angela (2019, July 9) *New UChicago Medicine report outlines health priorities for South Side communities*. Retrieved from https://www.uchicagomedicine.org/forefront/community-articles/community-healht-nees-assessmment

3. **Will the proposed intervention strategy expand socio-economic opportunities for disparately impacted community members and their overall health?**
   - If yes, how?
   - If no, how can the proposed intervention strategy be revised to address that?

4. **Will the proposed intervention strategy promote inclusive collaboration and civic engagement of all disparately impacted communities?**
   - Is there community support for the intervention strategy?
   - If yes, who are your collaborating partners?
   - If no, which communities are in opposition, why does that opposition exist (i.e. what interests are in conflict with the intervention strategy), and how do you plan to address it?
   - Have you or do you plan to engage the disparately impacted community in a dialogue?
   - If there are unintended consequences or barriers to racial equity as a-result-of the proposed intervention strategy, what strategies are in place to mitigate any negative impacts? Are revised strategies needed to address those consequences?

5. **Will your intervention strategy ensure workforce equity and/or contracting equity?**
   - If yes, how?
   - What goals are contemplated for workforce equity and/or contracting equity?
   - If no, what modifications are needed to ensure the intervention strategy supports workforce equity and/or contracting equity?

6. **How will this intervention strategy achieve greater health equity for disparately impacted communities?**
   - Can you demonstrate how this intervention strategy improves health equity?
   - If not, why not, and what modifications are needed to ensure the plan meets the health equity goals?

7. **Are metrics in place to ensure health equity goals are met?**
   - If yes, what key performance indicators will be used to gauge the plan's performance over time?

**Additional Resources**

United States, U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. (2017, September 05). Accountable Health Communities Model. CMS AHC Screening Tool. Retrieved from https://innovation.cms.gov/initiatives/ahcm.

Entities in need of technical assistance utilizing this checklist should contact the IDPH COVID-19 Equity Team at DPH.COVID19Equity@Illinois.gov.