# Pathways to Population Health Equity Compass: A Guide for Public Health Change Agents

PATHWAYS TO POPULATION HEALTH EQUITY

**What is Pathways to Population Health Equity?** Pathways to Population Health Equity (P2PHE) is a framework and set of tools designed to support public health leaders to strategically advance population health, well-being, and equity. P2PHE helps public health leaders to:

- Build their health equity team, including groups experiencing inequities
- Understand and get in relationship with groups of people and places (environments) that might be at risk for not thriving, based on historical, structural, and systemic factors
- Co-design a balanced set of strategies to improve health and well-being over the life course, upstream community conditions, and assess root causes with an equity lens
- Take strategic action to advance equity
- Learn, improve, and sustain change.

P2PHE helps public health leaders to advance health equity in three dimensions:

1) **Thriving people (individuals and groups)** – Build health and well-being throughout life with groups that might be at risk of not thriving based on historic and systemic factors
2) **Thriving places (environments)** – Build vital community conditions (social determinants) that everyone needs to thrive in places that have been marginalized. This includes access to basic needs, meaningful work and wealth, and a sense of belonging and civic muscle. This needs to be addressed in rural as well as urban and suburban areas
3) **Systems driving inequities** – Address root causes that lead whole groups of people and places to experience hardship. This can be done through acknowledgement of how inequities have developed and become rooted. Improvement can be achieved by eliminating policies that create harm and building ones that promote health and well-being. It can also come from changing how public health departments and their partners buy goods and hire people from groups and places that have experienced historic harm.

**What is the Pathways to Population Health Equity (P2PHE) Compass?**
The P2PHE Compass is a tool to help public health change agents see where they are in their health equity journey. Like any good compass, it can be used to enable individuals to look ahead and chart a path forward. This should ultimately be done in collaboration with communities that are not thriving. In the early stages of implementation, a health department might use it to prepare for a more comprehensive equity journey.

**How was the P2PHE Compass developed?**
The P2PHE Compass is a tool adapted for public health leaders in partnership with public health by leaders, multisector leaders, and community residents. This adaptation was developed by Well-being and Equity (WE) in the World, together with the Association of State and

Territorial Health Officials (ASTHO), and with support from the Centers for Disease Control and Prevention (CDC). It is part of a suite of well-being and equity tools adapted by WE in the World for different sectors. P2PHE builds on the Pathways to Population Health Framework (P2PH), originally developed for 100 Million Healthier Lives. P2PH has been used by hundreds of organizations in health care, public health, business and within faith communities for shared strategic planning for population health and equity. This framework can help public health leaders to partner with other sectors and facilitate multisector collaboration around health equity.

## How the Compass is structured

The Compass is structured around these key concepts.

| Core Transformation Skills | Physical and/or Mental Health of People | Social and/or Spiritual Well-being of People | Community Conditions | Root Causes |
|---|---|---|---|---|
| • Equity<br>• Stewardship<br>• Communication<br>• Partnerships with people with lived experience<br>• Understanding our populations through an equity lens<br>• Community collaboration<br>• Budgeting and payment | • Data for physical and/or mental health<br>• Advance population health strategies<br>• Direct care services<br>  ○ Integrated care<br>  ○ Care management | • Data for social and/or spiritual well-being<br>• Planning around social needs<br>• Direct care services:<br>  ○ Screen for and address social needs | • Common vision<br>• Concrete aims<br>• Shared theory of change/community strategy<br>• Set measures with the community<br>• Community access to data | • Power sharing<br>• Growing community leadership and voice<br>• Institutional/health department policy<br>• Public policy and context<br>• Directing fiscal and human resources<br>• Aligning and leveraging assets |

## Who should complete the Compass? Who is a public health change agent?

A public health change agent is anyone working to improve the health and well-being of the public!
The P2PHE Compass can be used by:

1) A health department or public health change agent taking this assessment as an individual
2) A health equity team working within a health department or division
3) A community or state collaboration. This might include community residents experiencing inequities, health department leaders, and other multisector partners/agency leaders.

If you are using the Compass as an individual, go ahead and get started!
If you are taking this as part of a health equity team or community collaboration, see below for additional instructions.

## How to use the Compass as a public health department facilitating a health equity collaboration

1) [1]***Identify who in your health equity team or collaboration will take the Compass***. This might include all members of your collaboration (if you have one), members of your health department division, community partners, and/or community members, including those most affected by health inequities who have some familiarity with your health department. Ask each person to think about whether they are comfortable rating for the health department, the community collaboration, or both. They should hold this perspective throughout the Compass.

***Invite each person to take the Compass individually and come up with their own scores.***

An item will look like the below example and will give words that relate to the stage you are at. Answer the question just from your perspective.

| | | **Not yet started** | **Starting: "We're in the early stages and are still figuring things out"** | | | **Gaining skill: "We're getting the hang of this!"** | | | **Sustaining: "This is who we are and how we do our work"** | | | **Present progress:** | **Future goals:** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **2. There is a shared commitment to health equity** | | People don't yet have a shared sense of commitment to health equity in our community | A few people (<10%) have begun to develop a shared commitment to health equity | | | A significant number of people (11-40%) have a shared commitment to health equity | | | A significant number of people (>40%) across our health department have a shared commitment to health, equity | | | | |
| In our health department | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |
| In our community collaboration | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |

There is no right answer – we are trying to understand everyone's perspective.

**If you don't know an answer or feel a question is not relevant, just mark "not sure" or NA for "not applicable".**

[1] image: Freepik.com

**A few instructions to go over with those taking the Compass:**

*This process should be tailored to your needs.* For example, if the P2PHE Compass is being used by a health department team where the agency is not involved in the provision of clinical services, you should mark N/A.

Since community change is often not linear, consider, when scoring, which stage your team or collaboration has inhabited most often in the past 3-6 months. The indicators for each item and stage should help guide you in thinking about how to score your community effort.

Remember, we are assessing ourselves to learn and improve, so the goal isn't to get the best possible grade. It is to identify strengths and opportunities to grow. Try to record your best estimation.

2) ***Talk it through.*** Compare answers with other members of your collaboration. Where members of your community collaboration have a score difference of 4 or more points, discuss why you might have such different answers. This could be because people have access to different pieces of information or resources within your collaboration or might arise from gaps in improvement opportunities. The greatest value of this tool is to foster a dialogue within your team or collaboration to help identify strategies to improve. Come up with a final answer as a community based on your conversation.

***3) Set goals and chart a path forward.*** After discussing and comparing notes, create an improvement plan based on areas that you have prioritized. Meet with other members of your health equity team to strategize priorities. Identify up to five priorities to work on (these can be from any section) and develop a transformation plan. Decide on a goal for each of these items.

**Key terms**

- *Community:* In the P2PHE Compass, this refers specifically to the *geographic area served by your team*
- *Health equity team:* This is a team that collectively works on population health equity initiatives. This could just be within the health department, but can also include members of a broader multisector community collaboration and community residents
- *Multisector:* Collaboration that spans across sectors, such as business, community development, health care, faith communities, and community residents experiencing inequities
- *Population health:* The health of groups of people, including how health outcomes are distributed within the group (do some subgroups have poorer health than others?)
- *Equity: W*here everyone has the ability to participate, prosper and contribute, free from systems of injustice that limit one's potential and with the support they need to reach their potential
- *Health equity: W*here everyone has a fair chance to reach their full potential for health, with the support they need to get there and free from structures and systems that prevent them from doing so
- *Social determinants of health:* Factors such as income, job, education, etc, which contribute to a person's health and well-being. Often, these are linked to community conditions, sometimes called vital conditions. They include things like access to healthy and affordable food, humane housing, meaningful work and wealth, and a sense of belonging and civic muscle
- *Stewardship.* Stewardship is "the careful and responsible management of something entrusted to one's care. Stewards are people or organizations that are developing their abilities to:
    - Take responsibility for forming working relationships with others to transform well-being across a region.
    - Serve as natural boundary spanners because they are informed by place-based, interdisciplinary, multisector, and multicultural perspectives
    - Understand that purpose must be larger than oneself and one's organization; power must be built and distributed with others; and wealth must be invested to create long-term value as well as address short-term urgent needs.[2]

A full list of definitions can be found on the Pathways to Population Health Equity website at www.publichealthequity.org.

[2] https://niviachanta.com/articles/what-is-community-stewardship

# P2PHE: Compass Assessment

## About yourself:

1. I work with the public health system as a (*mark all that apply*):
   - □ State level public health department employee
   - □ City or county, tribal or territorial health department employee
   - □ Public health department contractor
   - □ Community resident
   - □ Community resident with lived experience of inequities
   - □ Community worker
   - □ Community organizational leader
   - □ A community leader in another sector (e.g., business, transportation, food and agriculture, etc). If this response, Name of sector: _____
   - □ Other (*As an optional element, please state*): _____

2. I work on public health (*mark all that apply*):
   - □ Within a territory
   - □ Within a tribe
   - □ Within a local health department (e.g., city or town)
   - □ Within the county level
   - □ Within the state level
   - □ At the national level
   - □ At the global level

3. We would describe our community as (*mark all that apply*):
   - □ Urban
   - □ Suburban
   - □ Rural
   - □ Frontier
   - □ Mixed urban/suburban
   - □ Mixed suburban/rural
   - □ Tribal

4. Do you personally identify as (*select all that apply*):
   - □ American Indian, Alaska Native, or Indigenous
   - □ Asian or Asian American
   - □ Black or African American
   - □ Hispanic, Latino/a/x, or Latin American
   - □ Middle Eastern
   - □ Multiracial or Multi-ethnic
   - □ Native Hawaiian or Pacific Islander
   - □ White
   - □ Race or ethnicity not included above (*As an optional element, please state*): _____
   - □ Prefer not to answer

# Core Transformation Skills

**EQUITY:** Consider how your health department and/or community collaboration works toward health equity. Select the description that best represents how your organization orients and operates. For this purpose, e*quity* is where everyone has the ability to participate, prosper and contribute, free from systems of injustice that limit one's potential and with the support they need to reach their potential.

| | | **Not yet started** | **Starting: "We're in the early stages and are still figuring things out"** | | | **Gaining skill: "We're getting the hang of this!"** | | | **Sustaining: "This is who we are and how we do our work"** | | | **Present progress:** | **Future goals:** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **1. Addressing health equity is a priority for our organization** | | We do not discuss health equity in our organization | We've had some discussions related to health equity but have not taken any action to address it | | | We advance health equity in several initiatives. It is not something we do across the board, however. We tend to focus on this at a programmatic level rather than a policy level | | | Advancing health equity is of strategic importance to us. We apply a health equity lens to all of our initiatives<br><br>We work with community partners to implement and improve programs and policies to address the root causes of inequities | | | | |
| In our health department | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |
| In our community collaboration | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |

| | | Not yet started | Starting: "We're in the early stages and are still figuring things out" | | | Gaining skill: "We're getting the hang of this!" | | | Sustaining: "This is who we are and how we do our work" | | | Present progress: | Future goals: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **2. There is a shared commitment to health equity** | | People don't yet have a shared sense of commitment to health equity in our community | A few people (<10%) have begun to develop a shared commitment to health equity | | | A significant number of people (11-40%) have a shared commitment to health equity | | | A significant number of people (>40%) across our health department have a shared commitment to health equity | | | | |
| In our health department | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |
| In our community collaboration | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |

| | | Not yet started | Starting: "We're in the early stages and are still figuring things out" | | | Gaining skill: "We're getting the hang of this!" | | | Sustaining: "This is who we are and how we do our work" | | | Present progress: | Future goals: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **3. We are able to have brave conversations about racial equity** | | Tackling issues of racial equity is difficult and causes tensions. We don't have good ways to resolve conflict. We tend not to go into these issues. | We understand that addressing racial inequities is a process. We know it is a difficult subject for many to discuss. We are working to build trust. We are having some conversations within similar racial groups | | | We have begun to put practices in place that help us to have honest and difficult conversations about racial equity. These help us work through the tension that can arise when addressing inequity | | | We have many social spaces where we have conversations about racial equity. We have formal processes to ensure we work through concerns together. We accept that tension is part of addressing racial inequity | | | | |
| In our health department | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |
| In our community collaboration | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |

**STEWARDSHIP:** Consider the organization that you work with. Select the description that best represents their attitudes, behaviors, or actions.

"Stewards" in this context are people or organizations that are developing their abilities to:

- Take responsibility for forming working relationships with others to transform well-being across a region
- Serve as natural boundary spanners because they are informed by place-based, interdisciplinary, multisector, and multicultural perspectives
- Understand that purpose must be larger than oneself and one's organization; power must be built and distributed with others; and wealth must be invested to create long-term value as well as address short-term urgent needs.[3]

| | | **Not yet started** | **Starting: "We're in the early stages and are still figuring things out"** | | | **Gaining skill: "We're getting the hang of this!"** | | | **Sustaining: "This is who we are and how we do our work"** | | | **Present progress:** | **Future goals:** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **4. Population health and equity is a priority for our health department leadership** | | Our health department or state government leadership does not consider addressing population health and equity. We do not believe it is our organization's responsibility, or there are political constraints | Our health department leadership believe we should address population health and equity, but we don't yet have a clear strategy to do so | | | Our health department leadership believe population health and equity is a priority. We have dedicated time and effort to improve the health of individuals facing specific issues. Our board and senior leadership make sure we have resources to improve the lives of everyone in our community, whether or not we directly serve them | | | We are part of a group of organizations working to improve health, well-being, and equity in our communities. We have shared governance and dedicated resources to advance our work | | | | |
| In our health department | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |

[3] https://niviachanta.com/articles/what-is-community-stewardship

| | | Not yet started | Starting: "We're in the early stages and are still figuring things out" | | | Gaining skill: "We're getting the hang of this!" | | | Sustaining: "This is who we are and how we do our work" | | | Present progress: | Future goals: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **5. We have diverse collaboration with leadership representatives of the community** | | We want a diverse group of organizations and community residents in our collaboration but are not there yet. We tend to invite the same groups to the table that we have historically worked with, even though they don't bring us the diversity we need. We have not begun actively recruiting new organizations or individuals | We are recruiting community members from different backgrounds into our work. This includes people who have formal power. It also includes community members or organizations who speak for the community | | | We have both formal leaders and people from populations that are not thriving in our collaboration | | | Our collaboration is diverse and reflective of our community in most initiatives (>75%). There are many ways someone can be a leader in our work. We see this diversity as a source of strength<br><br>We have influential leaders from appropriate sectors. We also have influential leaders from populations who aren't thriving who are able to reach many others | | | | |
| In our community collaboration | **Not sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |

| | | Not yet started | Starting: "We're in the early stages and are still figuring things out" | | | Gaining skill: "We're getting the hang of this!" | | | Sustaining: "This is who we are and how we do our work" | | | Present progress: | Future goals: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **6. People in our community collaboration across groups and neighborhoods see themselves as stewards of the community's well-being** | | People don't generally see themselves as stewards of community health and well-being. They largely come to the table to represent their own interests | A few people (<10%) and organizations have begun to see themselves as community stewards. They advance their own interests but have begun to hold the needs of the community as a whole as a priority | | | A significant number of people and organizations (10-40%) have begun to see themselves as community stewards. They work together to help our community make progress, beyond matters related to their own interests | | | There is a widespread sense of stewardship and civic engagement across our community (>40%). People often offer and use their assets in nontraditional ways to advance what is needed in the community | | | | |
| In our community collaboration | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |

# COMMUNICATION

| | | Not yet started | Starting: "We're in the early stages and are still figuring things out" | | | Gaining skill: "We're getting the hang of this!" | | | Sustaining: "This is who we are and how we do our work" | | | Present progress: | Future goals: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **7. We have open lines of** communication | | Communication primarily happens between people who know each other. There is limited information-sharing across our community collaboration | There is at least one communication channel that everyone has access to (e.g., an email list or social media channel)<br><br>Communication usually flows in one direction (e.g., from a central source to partners) | | | We are developing processes for two-way communication within our collaboration. This usually goes through a central coordinating group<br><br>Communication channels and processes are accessible to everyone<br><br>We regularly communicate with the community at large. This helps us to get reliable and trustworthy information to people in our communities quickly | | | Our communication channels are multi-directional. People from a wide range of groups can offer concerns and solutions. They don't have to work closely together or know each other to do this<br><br>These channels help us to identify myths and misinformation quickly. People across our collaboration know what to do to address misinformation when they come across it | | | | |
| In our health department | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |
| In our community collaboration | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |

**PARTNERSHIPS WITH PEOPLE WITH LIVED EXPERIENCE:** Consider how your organization partners with people with lived experience of inequity in creating change. Select the description that best represents their attitudes, behaviors, or action.

| | | Not yet started | Starting: "We're in the early stages and are still figuring things out" | | | Gaining skill: "We're getting the hang of this!" | | | Sustaining: "This is who we are and how we do our work" | | | Present progress: | Future goals: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **8. We partner with people with lived experience of inequity to create change** | | We do not have formal mechanisms to engage the people we aim to serve in co-designing the services delivered or changes created by our organization | We have established advisory groups (like a patient and family advisory council (PFAC) or resident advisory council (RAC), but do not yet partner with them in a meaningful way | | | We routinely engage our people with lived experience of inequity (or whatever we are trying to improve) to help identify how to improve our services | | | All improvement projects are co-designed with people with lived experience, who remain active members of the improvement teams in developing the solutions. People with lived experience are active leaders of change initiatives in our organization and/or community | | | | |
| In our health department | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |
| In our community collaboration | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |

# UNDERSTANDING OUR POPULATION WITH AN EQUITY LENS

| | | Not yet started | Starting: "We're in the early stages and are still figuring things out" | | | Gaining skill: "We're getting the hang of this!" | | | Sustaining: "This is who we are and how we do our work" | | | Present progress: | Future goals: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **9. We have processes in place to stratify our data to identify communities that are not thriving** | | We usually do not stratify our data to identify communities who are not thriving. We sometimes do this for reporting to others, but do not use this for our own planning purposes | We have begun to stratify and use data to identify communities and parts of our population that are not thriving as part of our community needs assessment. For example, we regularly collect and disaggregate data findings by race, ethnicity, language, gender, age, sexual identification, disability status, income, educational attainment, Census tract, and other factors, such as a neighborhood deprivation index, as appropriate | | | We have stratified and used our data to identify communities who are not thriving as part of our community needs assessment and in many initiatives. We routinely use this in our outreach and planning to meet the needs of specific populations or communities. We currently have a number of health equity initiatives that use this data for planning and implementation in partnership with community residents experiencing inequities | | | We have ways of risk stratifying our data in an intersectional way that helps us to understand and proactively plan with populations and places that might be at greatest risk of not thriving over the life course and over generations. We have integrated this analysis into our population planning and surveillance systems<br><br>We use this information to proactively plan prevention and mitigation initiatives in partnership with community residents experiencing inequities to achieve strategic improvement in health equity. We allocate resources to proactively support groups of people and places at greatest and rising risk | | | | |
| In our health department | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |
| In our community collaboration | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |

| | | Not yet started | Starting: "We're in the early stages and are still figuring things out" | | | Gaining skill: "We're getting the hang of this!" | | | Sustaining: "This is who we are and how we do our work" | | | Present progress: | Future goals: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **10. Our health department** collects the data we need **to know whether we are reaching our goals for population health and equity** *Data can come from numbers and stories* | | We do not regularly collect data for population health and equity OR We largely collect data to report to others outside our collaboration for evaluation or required reporting | We are working to find a way to collect data in the community around health equity. This could be either from public data sources or from local collection efforts from community organizations | | | We have identified a way to collect data in the community. We are working to implement this | | | We have a space where we collect, pool and store data from the community for our community to access | | | | |
| In our health department | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |

## 11. Which of these practices about data and its collection does your health department or community collaboration engage in?

| | | Where are you currently? | Where would you like to be? |
|---|---|---|---|
| **What data we collect and how we collect it**<br>□ We regularly collect and disaggregate data findings by race, ethnicity, language, gender, age, sexual identification, disability status, income, educational attainment, census tract, and other factors, such as a neighborhood deprivation index, as appropriate. This is routinely integrated into our community needs assessment process<br>□ We evaluate different methods for categorizing race/ethnicity and make decisions about this with our community<br>□ We recognize where the dominant narratives about health shape our data systems and propose alternatives<br>□ We collect people-reported measures of health and well-being and value these as outcome measures<br>□ We identify missing data that would reveal health inequities, and act to obtain those data<br>□ We evaluate the ways our biases may determine how we analyze, report and use our data<br>□ Community leaders across sectors drive the collection and integration of community-level data to monitor <u>overall</u> trends in health, well-being, and equity<br>□ Local communities have access to actionable data to drive change<br>□ We have data-sharing agreements (e.g., Memoranda of Understanding, Data Sharing Agreements, Data Use Agreements, Interagency Agreements) in place to promote meaningful exchange of data across agencies, sectors and with community organizations<br>□ We have invested in data integration platforms to share data across agencies and sectors<br>□ We have a space where we collect, pool and store data from the community across sectors<br>□ Our data are accessible to community residents and make it easy for anyone to improve health, well-being, and equity. This includes translation and tools to help our residents understand | | | |
| **Our health department does this number of things** | **Not sure or NA** | | |
| **Our community collaboration does this number of things** | **Not sure or NA** | | |

| 12. Which of these data analysis and usage practices does your health department engage in? | | Where are you currently? | Where would you like to be? |
|---|---|---|---|
| **How we analyze and use the data**<br>□ Change leaders at the state level and community level come together to analyze our data to make improvements together<br>□ We use data related to equity factors, alongside other population health data, to proactively predict groups of people and places that might be at greatest and rising risk of not thriving (equity gaps)<br>□ Community residents who experience these inequities are part of our sensemaking and decision-making process around this data<br>□ We use tools like geotagging and geomapping to understand the relationship of place to <u>overall</u> health and well-being outcomes<br>□ We identify leading indicators (data that changes quickly) on major initiatives. We relate these to outcome measures that are important but might change over the long term (lagging indicators)<br>□ We regularly analyze and reflect on our data with a health equity lens together with partners across sectors and those who are most affected and use it to co-design short- and long-term improvement initiatives<br>□ We use our data for local planning around resources to address the social drivers of health and well-being<br>□ We relate our data on equity outcomes and drivers to cost so we can make better decisions about collaborations and investments that create value over the short, medium, and long term across sectors and in people's lives. We recognize that investing in equity yields greater results over a longer time period<br>□ We understand and draw links between our local outcomes and our statewide outcomes | | | |
| **Our health department does this number of things** | **Not sure or NA** | | |
| **Our community collaboration does this number of things** | **Not sure or NA** | | |

# COMMUNITY COLLABORATION

| | | Not yet started | Starting: "We're in the early stages and are still figuring things out" | | | Gaining skill: "We're getting the hang of this!" | | | Sustaining: "This is who we are and how we do our work" | | | Present progress: | Future goals: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **13. We partner across sectors and groups (public health, health care, social service, business, etc) to improve our community's health and well-being with an equity lens** | | We usually work alone | We have formed partnerships, largely within one sector. We have identified appropriate partners | | | About half of the appropriate sectors are engaged to address the priorities at hand | | | Most (>75%) appropriate sectors are working together to advance community health and equity | | | | |
| In our health department | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |
| In our community collaboration | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |

| | | Not yet started | Starting: "We're in the early stages and are still figuring things out" | | | Gaining skill: "We're getting the hang of this!" | | | Sustaining: \| "This is who we are and how we do our work" | | | Present progress: | Future goals: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **14. We form partnerships strategically to achieve our goals** | | Our partnerships are mostly based on existing relationships | We form partnerships largely to meet funding requirements. These aren't always the right partnerships to effectively address the problem we're trying to solve | | | We have begun to strategically map our partnerships to align to what we are trying to accomplish. We have expanded partnerships to include organizations who can address this | | | We routinely assess our partnerships to see whether they support what we are trying to accomplish. We expand and shrink partnerships to achieve our community's goals | | | | |
| In our health department | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |
| In our community collaboration | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |

| | | Not yet started | Starting: "We're in the early stages and are still figuring things out" | | | Gaining skill: "We're getting the hang of this!" | | | Sustaining: "This is who we are and how we do our work" | | | Present progress: | Future goals: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **15. Our collaboration has the relationships and trust needed to share resources and accountability** | | We don't know one another well in our collaboration or have experienced breaches in trust. This makes it difficult for us to have enough trust to share resources | We are building trust to get to know one another as a collaborator. We are in the process of understanding what each of us cares about in our work and the strengths we each bring to the table | | | We have developed trust among a key group of partners. This ability to share resources gives us a sense of hope and possibility. We frequently share resources and assets with one another | | | We routinely share data resources to get things done. This helps us create synergy and reduce duplication. This helps us to accomplish things that wouldn't have been possible otherwise. Our practice of sharing resources gives us a sense of abundance | | | | |
| In our community collaboration | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |

| | | Not yet started | Starting: "We're in the early stages and are still figuring things out" | | | Gaining skill: "We're getting the hang of this!" | | | Sustaining: "This is who we are and how we do our work" | | | Present progress: | Future goals: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **16. We have practices and processes that support open communication across our community collaboration** | | We don't have practices in place that support open, honest communication. We don't usually feel comfortable asking each other hard questions. We don't know how to implement practices/process to support open communication | We understand the importance of open honest communication to better understand one another. We are beginning to develop these as a practice in our collaboration | | | We have a practice of asking open questions of one another when something doesn't make sense or isn't going well in our collaboration | | | We have shared practices for people to ask open questions, to listen well, to express differences and work through conflicts | | | | |
| In our community collaboration | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |

## BUDGETING AND PAYMENT: Are you a health care or community health team leader? If not, skip to question 18.

| | | Not yet started | Starting: "We're in the early stages and are still figuring things out" | | | Gaining skill: "We're getting the hang of this!" | | | Sustaining: "This is who we are and how we do our work" | | | Present progress: | Future goals: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **17. Our health department engages in developing new payment models to advance prevention, improve health, and health equity** | | Our health care system partners are paid for each service provided. Our health care partners tend to focus on caring for people when they are sick, rather than keeping them well | We are having preliminary discussions with insurance providers to take on financial risk populations. Right now, less than 5% of people served in our health care system are currently covered under such arrangements | | | We are working with Medicaid (or another insurer) to implement payment models that support people to stay healthy<br><br>One or more of these are in operation in our community and cover 6 to 20% of people | | | We actively and regularly work with Medicaid and other insurers to develop payment models that support people who experience inequities to stay healthy and well and to better manage chronic illnesses. Some of these help to pay for social needs, public health, and support community-based prevention<br><br>These payment models cover 20% or more of people in the population | | | | |
| In our health department | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |

| | | Not yet started | Starting: "We're in the early stages and are still figuring things out" | | | Gaining skill: "We're getting the hang of this!" | | | Sustaining: "This is who we are and how we do our work" | | | Present progress: | Future goals: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **18. Our health department engages in shared budgeting processes across sectors to advance health equity** | | We do not engage in information sharing about budgets across public health and other health and social sector agencies | We are having preliminary discussions with partners in other agencies (e.g., housing, human services, education) to align budgets to support our common aims. We do not yet align our budgets | | | We align budgets together with agency and other partners across sectors (e.g., housing, human services, education). We have begun to coordinate budgets across sectors to advance strategic priorities around population health and equity | | | We regularly coordinate budgets and funding streams to advance strategic priorities around health and equity with agency and other partners across sectors (e.g., housing, human services, education, transportation). In some cases, we have integrated budgets or braided and blended funds to achieve our population health and equity aims | | | | |
| In our health department | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |

**The next several sections are about whether your public health department has a balanced public health strategy portfolio to advance population health and equity.**

Pathways to Public Health Equity describes four strategic portfolios that need to be balanced to impact health equity in the short, medium, and long term. These relate to addressing downstream, midstream, upstream, and ground-level root causes.

**Strategic Portfolio 1: Downstream – Addressing urgent medical (physical and mental health) and social needs**

**Strategic Portfolio 2: Midstream – Advancing preventative and primary care, addressing social and spiritual well-being**

**Strategic Portfolio 3: Upstream – Addressing vital community conditions in a focused way** (e.g., belonging and civic muscle, reliable transportation, humane housing, access to meaningful work and wealth, public safety, basic needs for health and safety, access to lifelong learning)

**Strategic Portfolio 4: Groundwater – Addressing *root causes* of health inequities** (e.g., changing the narrative about racism, classism, and structural inequities, building community power in those who experience inequities, changing policies and systems to address structural inequities)

# Strategic Portfolio 1. Physical and/or mental health of people

| 19. Consider the following statements about data. Choose the response that best describes your organization at this time. | Not Sure or NA | Present progress: | Future goals: |
|---|---|---|---|
| □ We collect data to proactively coordinate the system of prevention and management to improve physical health outcomes of specific populations<br>□ We collect data to proactively coordinate the system of prevention and management to improve mental health and addictions outcomes of specific populations<br>□ We look at our physical and mental health data through an equity lens<br>□ We analyze our physical and mental health data in an intersectional way, together with race, place, and other inequities<br>□ We use our data on physical health and mental health in an intersectional way, together with race, place, and other inequities, to develop our health equity strategy | | | |
| **Our health department does this number of things** | **Not sure or NA** | | |
| **Our community collaboration does this number of things** | **Not sure or NA** | | |

| | | Not yet started | Starting: "We're in the early stages and are still figuring things out" | | | Gaining skill: "We're getting the hang of this!" | | | Sustaining: "This is who we are and how we do our work" | | | Present progress: | Future goals: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **20. We advance population health equity strategies for physical and mental health** | | We do not engage in population health or equity strategies. We have not yet looked at our data with a population health lens | We have begun to segment our population to understand which groups are not thriving in terms of their mental and physical health. We are beginning to define or early in developing strategies to advance physical and mental health equity | | | We lead a multisector, population health strategy to advance the physical and mental health of our population with an equity lens. Many other sectors, such as education, business, and faith communities, contribute to advancing physical and mental health in our community | | | We advance evidence-based programs and policies, such as those outlined in 6\|18 across sectors to advance the health and well-being of our community, based on areas of population need. We apply an equity and racial justice lens to understand how trauma intersects with physical and mental health | | | | |
| In our health department | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |
| In our community collaboration | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |

**Answer questions 21-22 *only* if your public health department operates direct care services; otherwise, go to question 23. Choose the response that best describes your organization at this time.**

| | | Not yet started | Starting: "We're in the early stages and are still figuring things out" | | | Gaining skill: "We're getting the hang of this!" | | | Sustaining: "This is who we are and how we do our work" | | | Present progress: | Future goals: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **21. Our health department engages in the planning and implementation of integrated physical and mental health services** | | Planning for physical and mental health services largely happens outside of the public health department | The public health department is sometimes involved in the planning of physical and mental health services, but does not play a key decision-making role within this<br><br>Public health largely serves in a regulatory function for physical and mental health services | | | The public health department is an active partner in planning, implementation of physical and mental health services<br><br>In addition, our health department develops and implements initiatives, policies and regulations to create a healthy environment for everyone in partnership with other sectors in at least a few strategic areas | | | Our public health department plays a significant leadership role in coordinating, planning and implementation across physical and mental health service providers in the community. We advance a health in all policies approach with partners across sectors<br><br>In addition, we facilitate policy and regulation development to support physical and mental health with an equity lens. This includes, as an example, advancement of trauma-informed communities and racial healing initiatives in the community | | | | |
| In our health department | **Not sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |

| | | Not yet started | Starting: "We're in the early stages and are still figuring things out" | | | Gaining skill: "We're getting the hang of this!" | | | Sustaining: "This is who we are and how we do our work" | | | Present progress: | Future goals: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **22. We provide active care management for our population** | | Our organization does not have a dedicated staff for care management activities | We are developing ways to identify individuals who need care management based on who is likely to have the poorest outcomes. We direct these individuals to a dedicated person/team to support them with care management. We are exploring how to better conduct outreach to at-risk populations | | | We have ways to identify individuals who need care management and direct them to a dedicated person/team. We have begun to partner with community-based care management support initiatives or organizations, such as community health teams | | | Our care management teams actively identify and engage community partners to support patients and populations for social/spiritual needs. We regularly coordinate and plan with community-based care management supports, such as the community health team | | | | |
| In our health department | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |
| In our community collaboration | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |

# Strategic Portfolio 2: Social and spiritual well-being of people

**Social needs** include individuals need, like food, housing, education, transportation, income, and social connectedness to have good health. **Social determinants** are conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes. Sometimes people cause these vital community conditions.
**Spiritual drivers** include factors contributing to a sense of purpose, meaning, self-worth, hope, and resilience.

## 23. Consider the following statements about data around social and/or spiritual well-being:

| | | Present progress: | Future goals: |
|---|---|---|---|
| □ We collect data to proactively understand the social well-being of specific populations<br>□ We collect data to proactively understand the spiritual well-being of our specific populations<br>□ We apply an equity lens to our data on social needs and/or spiritual well-being<br>□ We include social and spiritual risk factors when we consider how we develop and manage care plans for individuals.<br>□ We use data in improvement initiatives for social and/or spiritual well-being in our community<br>□ We use data on social needs and/or spiritual well-being to partner across sectors to create improvement in social determinants of health<br>□ We use data on social needs and social determinants to support other sectors (e.g., housing, human services) in their strategies on policy and regulatory change<br>□ We use data on social needs and/or social determinants in budgetary planning within the public health department<br>□ We use data on social needs and/or social determinants in budgetary planning with other sectors | | | |
| **Our health department does this number of things** | **Not sure or NA** | | |
| **Our community collaboration does this number of things** | **Not sure or NA** | | |

| | | Not yet started | Starting: "We're in the early stages and are still figuring things out" | | | Gaining skill: "We're getting the hang of this!" | | | Sustaining: "This is who we are and how we do our work" | | | Present progress: | Future goals: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **24. Public health is engaged in planning around and addressing social needs and determinants of health** | | Planning for social needs services largely happens outside of the public health department. Some organizations in our community address individual social needs | The public health department is sometimes at the table in the planning of social services but largely serves in a regulatory function. We understand that social determinants like housing are important but have not developed a strategy or formed the partnerships needed with leaders in other sectors or agencies to address these | | | The public health department is at the table and is an active partner in a few initiatives in partnership with leaders in those sectors. We do this in partnership with those in housing, education, food, etc | | | Our public health department plays a significant role in addressing social determinants as part of our health equity strategy in partnership with leaders across transportation, housing, business, etc<br><br>We advance a health equity in all policies approach in those sectors and stand with leaders in those sectors to advance their policy and funding priorities by helping them to make the case | | | | |
| In our health department | **Not sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |
| In our community collaboration | **Not sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |

## Answer the following question only if your health department is involved in direct care services.

| | | Not yet started | Starting: "We're in the early stages and are still figuring things out" | | | Gaining skill: "We're getting the hang of this!" | | | Sustaining: "This is who we are and how we do our work" | | | Present progress: | Future goals: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **25. We address people's social needs (e.g., food or housing insecurity, social isolation) and/or spiritual needs (e.g., sense of purpose and meaning)** | | We do not plan to meet the social needs and/or spiritual needs of people | We screen for social needs and/or spiritual needs and assets, but don't always connect individuals with the appropriate services | | | We reliably direct people to the appropriate home- and community-based services for their social and/or spiritual needs. We develop policies to support payment and integration of these services | | | We follow-up to ensure the individual's social and/or spiritual needs were met. We work collaboratively with community-based service partners and payers to demonstrate impact related to cost, quality, and experience | | | | |
| In our health department | **Not sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |
| In our community collaboration | **Not sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |

# Strategic Portfolio 3: Addressing community conditions

| | | Not yet started | Starting: "We're in the early stages and are still figuring things out" | | | Gaining skill: "We're getting the hang of this!" | | | Sustaining: "This is who we are and how we do our work" | | | Present progress: | Future goals: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **26. We have a common vision for health equity in our community that is shared with community residents who experience inequities** | | We have not begun to develop a vision for our community | A number of different groups have visions for their work, but we have not come together yet to create a common vision | | | Our community has begun to develop a common vision. We are doing this in partnership with multiple groups and residents of our community | | | Our community shares a clear, overarching vision of health equity that feels concrete and motivating. We develop and align programs and policies to achieve our common vision | | | | |
| In our health department | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |
| In our community collaboration | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |

| | | Not yet started | Starting: "We're in the early stages and are still figuring things out" | | | Gaining skill: "We're getting the hang of this!" | | | Sustaining: "This is who we are and how we do our work" | | | Present progress: | Future goals: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **27. We have developed concrete aims for our population health and equity work**<br>*An aim is a concrete, audacious goal that describes what will be accomplished by when (how much, by when?)* | | We have not yet created a concrete aim to guide change in our community | Community partners have come together to better understand where we are and to set goals about where we wish to be in a given period of time in at least one initiative. Most groups in our community do not have a habit of setting concrete aims | | | We have developed concrete aims in some (<50%) of the initiatives in our community | | | We regularly set concrete aims for what we will accomplish by when in most (>50%) of our initiatives. We regularly assess our progress and refine or set new aims based on our progress | | | | |
| In our health department | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |
| In our community collaboration | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |

| | | Not yet started | Starting: "We're in the early stages and are still figuring things out" | | | Gaining skill: "We're getting the hang of this!" | | | Sustaining: "This is who we are and how we do our work" | | | Present progress: | Future goals: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **28. Key partners have come together to create a** theory of change/strategy<br><br>*A theory of change is a community's belief about the set of programs, policies and investments that will help us achieve our goals* | | We have many projects in our community. These projects are not guided by an overall design based on what we think will create impact in our community on health equity (theory of change) | We are holding community meetings to develop our ideas about how we will achieve our aims for health equity. We are actively developing our ideas about programs, policies, and investments that could help us to achieve our aims in at least one initiative (theory of change) | | | We actively develop our ideas about what programs, policies, and investments will help us to achieve our aims in some (<50%) of our initiatives (theory of change) | | | We have a theory of change to help us to achieve our aims for most population health equity initiatives (>50%) in our community<br><br>We coordinate our efforts around a set of initiatives based on this theory of change<br><br>We regularly track our progress and update our theory of change as needed | | | | |
| In our health department | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |
| In our community collaboration | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |

| | | Not yet started | Starting: "We're in the early stages and are still figuring things out" | | | Gaining skill: "We're getting the hang of this!" | | | Sustaining: "This is who we are and how we do our work" | | | Present progress: | Future goals: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **29. Our collaboration values measurement for improvement. We have developed a set of measures related to what we believe needs to change**<br><br>*Measures include types of data and the ways to collect that data* | | We have not yet made measurement of improvement in health equity a priority | We have prioritized measurement and have some measures. However, our measures do not align well with the things we believe will need to change to create improvement in health equity | | | We have chosen measures, with community input, which relate to the things we are trying to improve health equity in some (<50%) of our initiatives | | | We have an overall strategy for measurement that aligns measures with what we need to improve health equity in most (>50%) of our initiatives<br><br>We regularly assess and change measures based on what we are learning as a community | | | | |
| In our health department | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |
| In our community collaboration | **Not Sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |

| | | Not yet started | Starting: "We're in the early stages and are still figuring things out" | | | Gaining skill: "We're getting the hang of this!" | | | Sustaining: "This is who we are and how we do our work" | | | Present progress: | Future goals: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **30. Community members have access to the community's data and use it to help us reflect and improve**<br><br>*Data can come from numbers and stories* | | Members of our community do not have access to our community's data | We are working to display our data for all community members to see in a couple of initiatives | | | Members of our community know where to access and view data for several major initiatives. The data is easy to understand and reflect on | | | Members of our community know where to access and view data on our impact. We regularly use these data to reflect as a community<br><br>The community feels a sense of ownership over the data. Community members contextualize the numbers with stories to create greater insight | | | | |
| In our community collaboration | **Not sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |

# Strategic Portfolio 4: Addressing root causes

| | | Not yet started | Starting: "We're in the early stages and are still figuring things out" | | | Gaining skill: "We're getting the hang of this!" | | | Sustaining: "This is who we are and how we do our work" | | | Present progress: | Future goals: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **31. Power is distributed and shared.** | | A few people and organizations hold much of the power to create change in our community | We are beginning to do our work so we share power within our collaboration<br><br>We develop processes to share power with community members | | | Many groups and many community residents take leadership and share power<br><br>We have processes to share power effectively with our community members | | | We have moved beyond our collaboration to create broader social change<br><br>Local residents have substantial power to transform the community. This is true regardless of their involvement in our collaboration | | | | |
| In our community collaboration | **Not sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |

| | | Not yet started | Starting: "We're in the early stages and are still figuring things out" | | | Gaining skill: "We're getting the hang of this!" | | | Sustaining: "This is who we are and how we do our work" | | | Present progress: | Future goals: |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **32. We seek to grow the leadership and voice of those who have less power** | | We need to build the power of individuals in our community. We do not yet have a method for fostering opportunities to do this | We are figuring out how to grow the leadership of people who have less power. We see every person as someone who has gifts to offer and has potential to be a leader | | | We use community organizing or other similar methods to build the leadership and voice of those who have less power. We see this as a way of unlocking our community's potential | | | We use several methods to empower more leaders in the broader community, including potential leaders among those most affected by an issue. We often see evidence that our methods are working | | | | |
| Our community collaboration | **Not sure or NA** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | | |

## 33. Consider the following statements about institutional policy.

| | | Present progress: | Future goals: |
|---|---|---|---|
| □ We have organizational policies and practices around diversity, equity and inclusion<br>□ We use fair hiring practices to assure that those who would be marginalized are able to be hired and are supported in being retained<br>□ We have institutional policies to improve working conditions for staff and contractors who experience racial, economic and other inequities (e.g., livable wages)<br>□ We have institutional policies to increase contracting and purchasing with local vendors to enhance local economic development<br>□ We have institutional policies and investments to reduce our negative environmental impacts (e.g., waste disposal, energy utilization) at the local, regional, and/or national level<br>□ We measure our organization's impact on the health and well-being of our employees and have set goals to improve this<br>□ We measure our organization's impact on equity and have set goals to improve this | | | |
| **Our health department does this number of things** | **Not sure or NA** | | |

## 34. Consider the following statements about public policy.

| | | Present progress: | Future goals: |
|---|---|---|---|
| □ We join community residents and organizations to advance equity and racial justice<br>□ We partner to eliminate policies that exclude certain groups<br>□ We partner to advocate for policies and practices that include everyone<br>□ We partner with others to advocate at the local level to address social drivers of health. This includes things like better schools, housing, food access, transportation, youth development<br>□ We advocate for public policies at the national level to address social drivers like food, housing, etc<br>□ We partner with multisector partners and community residents to advocate for elimination of exclusionary policies<br>□ We partner with multisector partners and community residents to advocate for inclusionary policies and practices<br>□ We partner with multisector partners to advocate at the local level to address social drivers of health (e.g., improved schools, housing, food access, transportation, youth development)<br>□ We advocate for public policies at the national level to increase attention and funding to address population health issues and the social determinants that drive them<br>□ We join in solidarity with community residents and organizations across our community who are seeking to advance equity and racial justice | | | |
| **Our community collaboration does this number of things** | **Not sure or NA** | | |

| **35. Consider the following statements about <u>assessing the policy context</u> that creates underlying systems issues that perpetuate health inequities.** | | **Present progress:** | **Future goals:** |
|---|---|---|---|
| □ We have the knowledge and skills to identify the policy context for health inequities<br>□ We comprehensively assess our state and local policy context for the social and economic factors that contribute to decrease health inequities<br>□ We use a health equity framework to comprehensively assess our state and local policy context regarding the structural and intermediary determinants that contribute to health inequities or advance health equity<br>□ We engage the community, especially communities of color, Native Americans and other communities experiencing health inequities, to assure that these communities inform our assessment of the policy environment<br>□ We engage the community, especially communities of color, Native Americans and other communities experiencing health inequities, in developing policies<br>□ We promote a health equity in all policies approach | | | |
| **Our health department does this number of things** | **Not sure or NA** | | |
| **Our community collaboration does this number of things** | **Not sure or NA** | | |

## 36. Consider the following statements about strategically directing <u>fiscal and human resources</u> to advance health equity.

| | | Present progress: | Future goals: |
|---|---|---|---|
| □ We assure that resources are not reinforcing cultural bias, barriers or inequities<br>□ We assure strategic distribution of the fiscal and human resources that make possible optimal health and quality of life for all individuals<br>□ We have current data that inform where resources should be invested to address those with greatest need<br>□ We track resource allocation to assure that it is directed to those with greatest need in order to advance health equity<br>□ We allocate sufficient resources for policy development and implementation to advance health equity<br>□ We allocate sufficient resources for workforce development to advance health equity<br>□ We allocate sufficient resources for quality improvement and performance measurement of advances in health equity<br>□ We allocate funds to support the meaningful participation of communities of color, Native Americans, and others experiencing health inequities in societal decision-making and prioritization processes around resources<br>□ We hold our provider networks (hospitals/clinics), businesses and other public health system partners accountable for advancing health equity<br>□ We track and analyze whether public health allocations are spent in a manner that advances health equity and supports the reduction of health inequities<br>□ We put fiscal, programmatic and outcomes analysis, tracking, and improvement processes in place for all allocated expenditures<br>□ We rigorously follow and monitor fiscal principles and requirements of public/private stewardship and accountability to improve health equity | | | |
| **Our health department does this number of things** | **Not sure or NA** | | |
| **Our community collaboration does this number of things** | **Not sure or NA** | | |

**37. Consider the following statements about <u>aligning assets and funding streams</u> across all sectors and levels of government to maximize the impact of efforts to advance health equity.**

| | | **Present progress:** | **Future goals:** |
|---|---|---|---|
| □ We combine assets to achieve greater impact in our equity initiatives<br>□ We align funding streams to promote health equity and the elimination of health inequities<br>□ We braid and blend funding when possible to address health equity<br>□ We use payment methodologies and fiscal incentives aligned with performance on health equity measures<br>□ Our fiscal policy is aligned with equitable access to services, supports, assets, and opportunities | | | |
| **Our health department does this number of things** | **Not sure or NA** | | |
| **Our community collaboration does this number of things** | **Not sure or NA** | | |

## 38. Consider how your organization's different roles use yourpower and assets to improve health, well-being, and equity.

### Employer

- ☐ Develop career pipelines to public health in communities with poor equity outcomes
- ☐ Build a diverse public health workforce
- ☐ Expand cultural humility practices within the public health workforce
- ☐ Build the capacity of the public health workforce around legacies, racial and structural inequities and strategies to address these
- ☐ Remove application questions about criminal history
- ☐ Offer a living wage and good benefits that support health, wealth and well-being for all public health employees
- ☐ Invest in peer workforce from underserved communities, such as community health workers
- ☐ Incentivize employees to live in communities that have experienced racial or income segregation

### Purchaser

- ☐ Procure selectively from or preference women and/or minority-owned vendors in low-income communities
- ☐ Invest in growing the capacity of women and minority-led small businesses in the community to grow jobs and wealth

### Communicator/Narrative strategist

- ☐ Build practices to listen, amplify and create space for the voices of communities experiencing inequities
- ☐ Communicate using accessible language in modalities that communities experiencing inequities are using
- ☐ Tell the story of why we have inequitable outcomes and what creates health as part of regular health communication
- ☐ Shift the narrative of advancing equity from scarcity to abundance

### Food purchaser and server

- ☐ Purchase healthy food from local community sources, especially community gardens
- ☐ Support sustainable local food policies
- ☐ Assure schools and local businesses offer healthy options as part of contracting with us
- ☐ Connect to local sources of healthy food in food deserts to improve the market for healthy food

### Builder

- ☐ Choose to locate new facilities in communities with poorer health outcomes to support job promotion

### Funder

- ☐ Use sub-granting to advance health equity narratives and frameworks in the community

### Environmental steward

- ☐ Be responsible for your overall environmental footprint and work to reduce carbon emissions and health care waste

| Our health department does this number of things | Not sure or NA | Present progress: | Future goal: |
|---|---|---|---|

## Developing your transformation plan together

**2.** **Talk it through.** Compare answers with other members of your collaboration (you may find it helpful to print the map out for this conversation so it is in front of you). Where there is a score difference of ***4*** or more points, discuss why you might have such different answers. People have access to different sources of information or resources within your collaboration. It could also be from gaps that offer opportunities for improvement.

Remember that there is no one right way to transform. It depends on your context and what your team is willing and able to work on, and what you're ready to do. Some different options for choosing priorities might be:

1) Choose areas that are scored low
2) Choose areas where small changes could lead to big gains
3) Consider the highest scoring areas, and how these could be used as leverage points to move other areas forward
4) Think about which areas could move in the short term, and which to start planning for the medium and long term
5) Ask yourselves what you are ready and motivated to take action on and which matters most for the communities you want to partner with.

Feel free to use a mix of criteria for identifying priority areas. Be sure to include everyone's perspective and don't be afraid to set ambitious goals! This is your journey – and your path. The greatest value of this tool is to foster a dialogue within your collaboration to help identify strategies to advance. Once you've worked through these differences, come up with your team's final scores and put the totals of your self-rated scores for each section into the boxes below. Now start identifying some priority areas to work on!

**Collaboration or health department/division name:** _____ **Located in:** _____

| Section | Now (current self-score) | Goal in 6 months | Goal in 12 months (sum of goal scores) | Potential priority areas that would help us reach our goals (circle) |
|---|---|---|---|---|
| **Core transformation skills** | | | | 1. Equity<br>2. Stewardship<br>3. Communication<br>4. Partnerships with people with lived experience<br>5. Understanding our populations with an equity lens<br>6. Community collaboration<br>7. Budgeting and payment |
| **Portfolio 1. Physical and/or mental health** | | | | 1. Data for physical and/or mental health<br>2. Advance population health strategies<br>3. For health departments with direct outreach or care services:<br>a. Integrated care<br>b. Care management |
| **Portfolio 2: Social and spiritual well-being** | | | | 1. Data for social and/or spiritual well-being<br>2. Planning around social needs<br>3. For health departments with direct outreach or care services:<br>a. Screen for and address social needs |
| **Portfolio 3: Community health and well-being** | | | | 1. Common vision<br>2. Concrete aims<br>3. Shared theory of change/community strategy<br>4. Set measures with the community<br>5. Community access to data |
| **Portfolio 4: A community of solutions** | | | | 1. Power sharing<br>2. Growing community leadership and voice<br>3. Institutional/health department policy<br>4. Public policy and context<br>5. Directing fiscal and human resources<br>6. Aligning and leveraging assets |

# **Take Action**: Develop an action plan for advancing your transformation

What three priority areas will you work on over the next 6 months? Work with your coach and collaboration to develop this.

| Priority area | Strategy: What will you do? | Key partners who will need to be engaged | Resources and capacities needed | By when? | Who will action this? |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |