15.1 Purpose:

The purpose of this policy is to embed health equity values throughout Metro Health and provide high level guidance for health equity procedures and practices. Following the Department Health Equity policy guidelines, each division will collaborate both within Metro Health and with community partners to develop plans to operationalize the policy and advance health equity goals in their respective areas.

This policy and the Bay Area Regional Health Inequities Initiative’s Framework for Health Equity, and the Human Impact Partners Health Equity Guide will serve as guidance to help institutionalize health equity goals into Metro Health programs, policies, services, and interventions.

Overview of Health Equity:

A basic principle in public health is that all people have a right to good health (Mann, J, et. al, 1999). Metro Health recognizes the pervasive and deep disparities that affect groups marginalized because of income level, race/ethnicity, sexual orientation, gender, age, immigration status, geographic location, or some combination of these (Braverman, P., 2006). However, Metro Health leads explicitly, though not exclusively, with race because racial inequities persist in every system across the country, without exception. There are no examples of a system where there are no racial disparities in health outcomes: Health, Education, Criminal Justice, Employment and so on. We also lead with race because across other dimensions of identity, including income, gender, sexuality, education, ability, age, citizenship, and geography, there are inequities based on race (https://healthequityguide.org/about/why-lead-with-race/).

People of color not only experience worse health but also tend to have less access to life-enhancing resources, such as: healthy food; safe, affordable and adequate housing; high quality education; safe neighborhoods; transportation; and social relationships that support health. Advancing health equity requires addressing all areas of marginalization and understanding the interconnected nature of oppression. However, there is a benefit to starting with race as we can harness tools, frameworks, and resources to address these inequities.
Background:

Metro Health strives to integrate an understanding of health equity across all programs and services and thus established an Office of Health Equity (OHE) in early 2017. The OHE seeks to address the root causes of health inequities, beyond healthcare and health behaviors. OHE will achieve this by supporting projects and policies that enable residents to achieve their optimal level of health where they live, learn, work, worship, and play. Using the tenet of social determinants of health, OHE will achieve its mission by informing, educating, and empowering people about health issues and facilitating multi-sector and community driven partnerships to identify and solve community health problems. Metro Health will use a common set of terms to describe its work (see Appendix B), and staff will use an equity and empowerment lens (see Appendix C) to analyze programs and policies and identify and eliminate the root causes of racial and ethnic inequalities.

In 2009 NACCHO released guidelines to assist local health departments in moving from an “improvisational” approach to addressing upstream factors to one that is systematic and institutionalized by infusing a health equity lens throughout the department. The Public Health Accreditation Board (PHAB) included a health equity standard in Version 1.5 of their Standards and Measures for local health department accreditation. The standard notes that excellence in local public health practice includes health equity incorporated in policies, processes, and programs. Other national benchmarking, assessment, and health improvement systems also include a social determinants and a health equity focus (e.g. Healthy People 2020, MAPP, Health in All Policies).

15.1.1 **Values for a Health Equity Policy:**

1. Commitment to the full elimination of health inequities in San Antonio and Bexar County to improve health outcomes for vulnerable populations, including communities of color, people living in poverty, immigrants and refugees, and people with mental and/or physical disabilities.
2. Fairness in access to socioeconomic and environmental resources (“level the playing field”).
3. Sound stewardship of fiscal resources and the use of resources for greatest impact.
4. Accountability through measurement, process improvement and quality management.

15.1.2 **Departmental Health Equity Policy Guidelines:**

The following are high-level guidelines for specific health equity procedures and practices:
1. Apply a health equity lens to current and new programs, policies, services, and interventions to ensure they include public health actions that break the cycle of health inequity in the community.

2. Apply a health equity lens to current and new programs, policies, services, and interventions to ensure they do not create or perpetuate health inequities in the community.

3. Engage individuals, families, and community in identifying and planning culturally relevant strategies related to advancing health equity work.

4. Develop and maintain a demographic profile of Bexar County using community-level data disaggregated by income level, race/ethnicity, sexual orientation, gender, age, immigration status, geographic location, or some combination of these.

5. Include health equity and social determinants in community needs assessment, improvement planning, surveillance, and other monitoring efforts of community health status.

6. Provide health education, health communications, and other public information about community health status and needs in the context of health equity (e.g., focused on determinants vs. focusing solely on individuals’ health behaviors).

7. Identify opportunities to understand the social determinants of health for program participants (clients, users, customers, etc.).

8. Maintain an assessment of workforce diversity and apply strategies for recruiting and hiring a workforce that reflects the demographic, cultural, and linguistic characteristics of the populations it serves.

9. Provide staff with a safe and respectful space to engage in health equity learning opportunities with their teams and/or supervisors on an annual basis to learn how to advance health equity.

10. Monitor the delivery of services and budget allocations to ensure equitable distribution as well as cultural, social and linguistic competence.

11. Each division will collaborate with the Office of Health Equity to develop written work-plans that operationalizes the policy and advances health equity goals in their respective areas.

15.1.3 **Departmental Health Equity Practices:**

To advance health equity, Metro Health must transform how the department works internally, with community partners and stakeholders, and alongside other government agencies. This requires implementing key strategic practices drawn from the Health Equity Guide developed by Human Impact Partners ([https://healthequityguide.org стратегических практик](https://healthequityguide.org/strategic-practices)).

The Metro Health Policy Manual’s Health Equity chapter will be organized around the following practices. Additional policies and procedures will be developed for each one.
I. Build Infrastructure
   A. Mobilize data, research & evaluation
   B. Build organizational capacity
   C. Change internal practices and processes
   D. Prioritize upstream policy change
   E. Allocate resources

II. Work across Government
   A. Build government alliances
   B. Develop a shared analysis
   C. Broaden regulatory scope

III. Foster Community Partnerships
   A. Share power with communities
   B. Build community alliances
   C. Engage in movements

IV. Champion Transformative Change
   A. Confront root causes
   B. Develop leadership and support innovation
   C. Change the conversation
   D. Build a health equity movement
Sources:


Bay Area Regional Health Inequities Initiative (BARHII), Local Health Department Organizational Self-Assessment for Addressing Health Inequities.


Centers for Disease Control and Prevention (CDC), Promoting Health Equity, 2017.

Community Toolbox, Work Group for Community Health and Development at the University of Kansas, 2014.


Healthy People 2020, Social Determinants of Health.


National Association of County and City Health Officials (NACCHO), Guidelines for Achieving Health Equity in Public Health Practice, 2009.

Public Health Accreditation Board (PHAB), Standards and Measures, Version 1.5, See Measure 11.1.4.

Appendix A: Key Terms

Bias: prejudice toward one group and its members relative to another group. Can be implicit, at the subconscious level, or explicit, expressed directly.

Cultural humility: the ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the person.

Diversity: The inclusion of the variety of personal experiences, values and worldviews that arise from differences of culture and circumstance. These include: socioeconomic status, race, ethnicity, language, nationality, sex, gender identity/gender expression, sexual orientation, religion, geography, ability/disability, age and more.

Equity: promoting fairness within policies, processes, and the distribution of resources by accounting for the different histories, challenges, and needs of our population.

Health Disparities: A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion (HP 2020).

Health Equity: The attainment of the highest level of health possible for all people. Achieving health equity requires valuing everyone with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities (HP 2020).

Health Equity Lens: A tool used by an organization to identify and remove barriers and reinforce best practices in the planning, development, implementation and evaluation of policies, services and programs.

Health in All Policies (HiAP): a change in the systems that determine how decisions are made and implemented by local, state, and federal government to ensure that policy decisions have neutral or beneficial impacts on the determinants of health. HiAP emphasizes the need to collaborate across sectors to achieve common health goals, and is an innovative approach to the processes through which policies are created and implemented.

Health Inequity: Differences in health between population groups that are not only unnecessary and avoidable but, in addition, are considered unfair and unjust and are rooted in social injustice.

Inclusivity: The action or state of including or of being included within a group or structure. More than simply diversity and numerical representation, inclusion involves authentic and empowered participation and true sense of belonging.
Individual racism: pre-judgment, bias, or discrimination based on race by an individual.

Institutional racism: a pattern of social institutions (such as governmental organizations, schools, banks, and courts of law) giving negative treatment to a group of people based on their race, often unintentionally.

National CLAS standards: The National Standards for Culturally and Linguistically Appropriate Services in Health and Healthcare are a set of 15 action steps intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services. Outputs: details what an organization or program does. Tangible products or services created by your work. They are usually quantifiable.

Outcomes: defines changes that have taken place because of your organization or program. They are changes, benefits, learning or other effects that happen as a result of your work. Typically defined through short-term (shift in learning), mid-term (shift in actions), and long term (shift in conditions).

Race conscious vs. race neutral: taking a “color blind” approach to policy development simply perpetuates the status quo. When explicit bias morphs into implicit bias, race neutral polices replicate the same racially inequitable outcomes that have previously existed.

Social Determinants of Health (Root Causes): Conditions in the social and physical environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life risks and outcomes. The social environment refers to social, economic, and cultural norms, patterns, beliefs, processes, policies, and institutions that influence the life of an individual or community. The physical environment refers to both the natural and human-made environments and how they affect health. (HP 2020).

Social justice: a concept of fair and just relations between the individual and society. This is measured by the explicit and tacit terms for the distribution of wealth, opportunities for personal activity and social privileges.

Structural racism: a history and current reality of institutional racism across all institutions, combining to create a system that negatively impacts communities of color.