March 11, 2009

Health Equity Readiness: 1) Competencies and 2) Summary: the Wisconsin Division of Public Health Assessment

Health Equity Readiness Competencies

Four domains of competencies (see attached PowerPoint slides) support the concept of health equity readiness (HER). The domains of knowledge include:

1. The social determinants of health (SDOH): defined as both an ideology and a fact based concept with supporting scientific evidence;
2. Public Policy and Political Efficacy;
3. Multi-sectored collaboration; and,
4. The social change ethos

In early 2008 when the Wisconsin Division of Public Health HER assessment was undertaken, only two of these domains formed the underpinnings for the assessment. The Wisconsin project aimed to gauge the division's knowledge on the SDOH as a research based concept as well as an ideological, values-laden concept. Conclusions were also drawn about the Division's views on its role as an agent of social change and the quality of its interactions with the community.

The Wisconsin assessment failed to evaluate the Division's political efficacy and understanding about the public policy process as connected to the SDOH as a mechanism to both improve measurable health outcomes in marginalized groups while at the same time expanding the policy agenda.

Not included in this model but examined as part of the Wisconsin project are notions of equitable access to services for all groups plus cultural and linguistic competency. The Canadian model of health equity typically frames the concept as a person-based strategy requiring service providers to consider groups, their needs and whether services, programs and policies have been formulated to meet those needs. While these issues and strategies have been examined and refined in the U.S. health care sector as health disparities initiatives, public health has not placed them very high on the health equity strategies agenda.

In any future work to assess HER or develop training modules consideration should be given to these areas of competency.

Summary: the Wisconsin Division of Public Health Assessment of Health Equity Readiness

This 2008 health equity readiness assessment of the Wisconsin Division of Health was a comprehensive effort that included: development and piloting of several questionnaires plus qualitative methods of assessment; analysis of the data and findings; and recommendations.

Charting new territory, this health equity readiness assessment relied primarily on qualitative research methods using structured interviews[1] and questionnaires. The underlying foundation for this choice of methodology rests on a constructivist concept and the philosophy of post-positivism.

Table 1 depicts the groups from whom evidence was gathered and the methods used. The questionnaire (see Appendix A) given to grant recipients of the Minority Health Program utilized a narrative on vulnerable populations as defined in Canada.[2] The questionnaire provided a definition of vulnerable populations based on social position.

The intent behind the questionnaire for the grant recipients was to gauge the ability of the service providers to think more expansively about the underlying causes of social and health inequities in response to an explanatory model[3] using vulnerable populations and social position.

Table 1

Method-Tool	**Respondents**	**Distribution Method**
Discussion questionnaire	Grant recipients, Minority Health Program	Mail
Follow-up Interviews	Grant recipients, Minority Health Program	Telephone
Questionnaire	Managers & Supervisors	Online
Group Interviews plus discussion questions	Bureau Directors & Managers	Face-to-face
Group Interview with questionnaire	Minority Health Leadership Council	Teleconference

Thirty-one grant recipients received the questionnaire via mail. Twelve questionnaires were returned and nine follow-up telephone interviews were conducted.

Group interviews with managers and supervisors were conducted in a single day with the Division's five bureaus and six regional office directors (RODs). Each session lasted approximately 45 minutes and included the Bureau's director and the chief medical officer. In some cases bureau interviews also involved a program manager such as the

[1] Kvale, S. (1996). Inter Views: An introduction to qualitative research interviewing. Thousand Oaks, CA: Sage. Kvale defines qualitative research interviews as an effort to understand a phenomena (project, program, policy) from the subjects' point of view. The format helps to unfurl the meaning of peoples' experiences before scientific explanations might exist.

[2] Frohlich, K.L. and Potvin, L. "Transcending the Known in Public Health Practice: The Inequality Paradox: The Population Approach and Vulnerable Populations." *American Journal of Public Health*, February 2008, Vol. 98: No. 2.

[3] Explanatory models (a term developed by Cultural Logic) are expressions that include specific language and images to help an individual grasp an issue. The expressions are based on theories gleaned from previous research analyzing language/images that are helpful and language that causes respondents to revert to an unhelpful pattern of thinking. More details provided below.

manager for the HIV/AIDS program. The interviews with the RODs took place with some directors in the room and others phoning in to participate.

The original methodology called for the program managers in each bureau to complete a paper questionnaire so that during face-to-face interviews with bureau directors the responses from the program managers could be discussed. This did not occur due to timing errors.

Subsequently, the plan was revised so that bureau directors received a questionnaire (see Appendix B). They were instructed to review the questions for discussion purposes during the interviews. The contents of the questionnaire were structured to provide nominal explanatory models for health equity. The intent was to: 1) gauge the participant's current level of knowledge; 2) measure resistance/willingness to change; 3) determine common practices; and 4) uncover the shared understandings established by the Division with regard to health equity.

The health equity readiness assessment questionnaire (see Appendix C), drafted in early February 2008, was originally meant to be a paper questionnaire. After reviewing the instrument and Division resources a decision was made to place the questionnaire on line. An email sent by Dr. Sheri Johnson on February 19th said, *"An electronic survey will be sent at the end of the week which should be completed by Bureau Director's, CMO's and Medical Advisors, RODS and Section Chiefs in each bureau."*

Finally, on February 26 a notice and questionnaire link was distributed via email. Due to an error, the questionnaire was placed on line with out the introductory paragraph displayed in the Appendix C. Further, the online version (in comparison to the pen and paper questionnaire) also modified the wording in some cases to fit the technology.

Twenty-four individuals received the following email message marked "high priority".

> *"Hello, please take a moment to complete the Access, Equity and Cultural Literacy Assessment, accessible at the attached link below. ……Please complete the assessment prior to March 4th."*

The invitation and link to the questionnaire was subsequently sent on to ten additional staff. It is estimated that the questionnaire was electronically accessed on fifty different occasions. It is not clear if these were first time attempts to complete the questionnaire, return visits to complete the questionnaire, or individuals curious to view the questionnaire.

The final responses did represent all of the Bureaus plus several programs and regional offices. The largest number of responses came from Community Health Promotion (6) and Local Health Support & Emergency Medical Services (5).This was followed by Communicable Disease (4); Health Information and Policy (2); and Environmental and Occupational Health (1).

The individuals occupied various positions in the bureaus:

- 8 program administrators
- 2 chief medical officers
- 4 regional office directors
- 4 bureau directors

The health equity readiness assessment instrument was divided into three sections.[4] Two of the sections asked about traditional areas of importance in the provision of equitable services: 1) Access and 2) Cultural competency. The last section titled "Equity". Questions included both open-ended and multiple choice questions. Definitions of some concepts were not provided. This was intentional so that respondents could apply the accepted and established ideas, definitions, and concepts that were in use in the Division.

The Equity section of the questionnaire was introduced with the following explanatory model.

> *Addressing health inequities requires that we reach beyond the categorical programs that focus on single diseases and risk factors to encompass the broad range of social and environmental conditions that affect community health. The origins of health inequities are in the structure of social inequalities. This means that efforts to eliminate health inequities are beyond what Public Health Departments can change on their own. However, it is within the ability of Health Departments to transform their practices in order to be more effective partners with communities and other allies.*

The questions in the Equity section of the online questionnaire focused on methods, practices, resources, community interaction, policy advocacy, collaborative partnerships, and other concepts used to define health equity.

The main objective of the Equity section was to assess the organization's underlying values and ideology, ideas, policies, and practices with regard to it's' vision and definition of health equity in comparison to the theories and fundamental frameworks of health equity readiness.

The interview with the Minority Health Program, Leadership Council took place via teleconference. The Council received at least two emails asking them to select the best time for a conference phone call from a list of dates. Subsequent emails from the Program provided more information on the purpose of the teleconference, which was to receive their "feedback and thoughts on efforts to address health inequities."

Initially, the plan was to send the Council an article to help inform the interview.

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[4] As stated earlier, sections on public policy, political efficacy (community organizing and agenda setting/social movements) should be added to the instrument.

The idea of sending an article was abandoned due to uncertainty on how the group understood health equity in relation to health disparities. To assess their understanding and mental models it seemed better to assume that they had an orientation similar to that of most Americans where the central focus is on health disparities for ethnic and racial groups.

In the end, the group was sent two explanatory models (see Appendix D). The Council's explanatory paragraphs described health inequities using language that has been developed and tested by Cultural Logic (CL).[5] CL[6] is exploring persistent patterns that currently characterize general thinking on topics related to health inequities. They are in the process of refining productive explanatory messages for health equity.

The group was instructed to read several short paragraphs, answer seven questions, and email their responses before the conference call. Council members were informed in the email that the information and questions in the attachment were meant to stimulate the discussion.

The written instructions asked the Council to explain what the paragraphs meant to them. They were also asked: 1) to describe the kinds of factors that make us ill based on their understanding of the information; 2) what they thought could be done about these kinds of problems; 3) who they might share the information with; and 4) if they agreed with the statements.

To begin the teleconference Council members were asked to give a brief history of their involvement with the Minority Health Program and then describe what the Program was doing well and what they could do better. They were also asked: 1) What health determinants does the Minority Health Program address primarily?; 2) What does it not address?; and, 3) Based on these statements can you think of any strategies for the Program that would get at improving the life odds of those experiencing health inequities?

****The full report and results are available by contacting Andress & Associates.*

[5] Cultural Logic, LLC. Website accessed April 30, 2008. http://www.culturallogic.com/index.php
[6] See "External Factors vs. Right Choices: Findings from Cognitive Elicitations and Media Analysis on Health Disparities and Inequities in Louisville, Kentucky," Cultural Logic, May 2007