Health Equity
4 Essentials and Why Shared Platforms are Key

A paradigm shift

Health equity has become an increasingly important lens through which to view health, including how to approach public health and community health work. For the first time since its launch in 1994, the 10 Essential Public Health Services framework was recently revised to place equity at the center.

The framework is used as a roadmap for guiding public health work by health departments, community partners, and schools of public health and for setting standards by the Public Health Accreditation Board. The most notable update is the placement of equity at the center of these services. In the current edition, practitioners are called to protect and promote the health of all people in all communities by "actively promot[ing] policies, systems, and overall community conditions that enable optimal health for all."

The U.S. Dept. of Health and Human Services Office of Disease Prevention and Health Promotion took similar steps setting benchmarks for the next decade with Healthy People 2030 — outlining health equity as part of its foundational principles and overarching goals.

With bolstered support from these key frameworks, public and community health professionals are poised to play a critical role in addressing health equity. Below are four essentials for the path forward.

1. Start with credible data

Credible data is foundational to making inroads on health equity. It is key to identifying and defining areas of need as well as being able to confirm when there is improvement.

Health equity initiatives are most successful when there is cross-sector work between health, housing, business, transportation, and other relevant areas. Working from a **national framework** such as Healthy People 2030 offers stability, which facilitates collaboration across sectors. National frameworks also help communities track progress over time by setting standardized benchmarks for action.

Look for data that:
- Comes from reliable sources and uses validated methodology.
- Is regularly published, which helps to show change over time and differences in how various groups are trending.
- Is granular enough to reveal inequities at levels such as zip code, race/ethnicity, gender and age. Understanding disparities is key to informing local efforts and broader policy decisions.

2. Use data across the health equity spectrum

Data is often focused on downstream outcomes such as death rates, disease prevalence or risk behaviors like smoking. But **health begins where people live, learn, work, and play**, so when curating data, it's important to include data that reflects the full spectrum of people's lives.

Data points such as overcrowded housing, access to parks, or air quality can be pivotal to gaining insights about the living conditions that contribute to health inequities. Drawing from data across a full spectrum can also help identify institutional inequities such as differences in access to health care, unemployment and root causes of social inequities such as income disparities by gender or race/ethnicity.

Where possible, data points should show inequities by race/ethnicity, age, gender and neighborhood. This allows further exploration into the source of health inequities and how we can make systemic changes that have lasting impact on health.

3. Work from a unified platform to foster collaboration and link data to action

As public health practitioners, we're sometimes tempted to prolong the assessment and research process and get stalled on action. But action is essential to achieving positive change.

A community halth platform can be a critical differentiator in the ability to move past inaction toward collaborative, data-driven improvements that impact health equity.

Look for technology that:

• Provides a centralized online hub for curating and organizing data and activities. When data on health, education, and income are viewable in one location, it's much easier to collaborate across sectors and work together around a common data framework and language.

• Includes data visualization and analytic tools to help make data easy to understand and tell the stories behind figures and information.

• Links data to local initiatives. The best systems enable local partners to create or find reports and evidence-based practices alongside the data stories. For instance, local reports on maternal and infant health or an event to support a community health initiative on infant health can provide context about efforts addressing birth equity.

Building knowledge and expertise around health equity is equally important. Despite the growing interest in work to improve health equity, there remains a gap in expertise and skills. Facilitators, partners and experts can solidify your foundational framework by providing guidance related to stakeholder engagement, cross-sector collaborations and policy development.

4. Spotlight successes

When key elements fall into place, organizations and collaboratives can more easily identify priorities and implement effective policies and programs that positively impact health equity. And as they demonstrate success, they can build momentum.

Here are examples of two communities who have used their community health platform to do just that:

• United Way of South Hampton Roads identified a 23-year life expectancy gap in two adjacent census tracts and a host of other issues impacting health including housing, food insecurity, and mental illness. Using that data, the city secured a $30 million grant from U.S. Housing and Urban Development for a redevelopment project that involved the health department and hospitals, businesses, non-governmental organizations and others.

• In Orange County, California, data showing higher diabetes and obesity rates in specific neighborhoods led to community action to advocate for school policies supporting nutrition and physical activity in higher-risk school districts. This led to schools from the county being recognized nationally as a healthy school in 2018 for the first time ever. The next year, 25 of 40 schools in the state named "America's Healthiest Schools" were in the county and most were from these higher-risk communities.

Starting with credible data and using community dashboard tools that link data to action can help bring together a cross-sector of collaboratives working toward collective goals to improve health equity.

About Healthy Communities Institute

Conduent Healthy Communities Institute provides an end-to-end solution for community health that links health and social determinants of health with technology and expertise. The HCI platform brings stakeholders together with a centralized dashboard of more than 150 health, social, and economic indicators, high value analytics, and evidence-based practices at the user's fingertips.

HCI's Consulting Services team has completed more than 200 community health needs assessments and implementation strategies, providing expert guidance for assessing community needs, developing strategies, and implementing evaluation and monitoring processes. The HCI Strategy Tracking Solution combines the expertise of public health consultants with the leading strategy-tracking software to help communities plan for success and track progress and outcomes.

Contact Conduent Healthy Communities Institute at communityhealth@conduent.com.

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