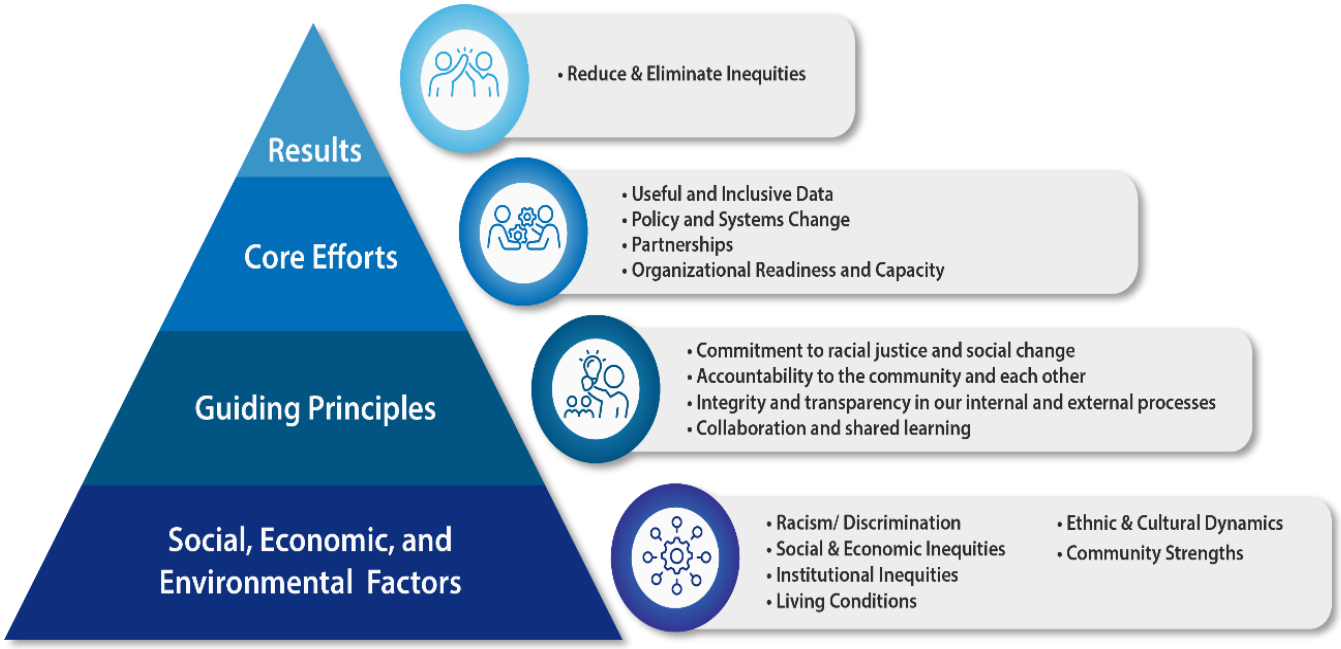
Los Angeles County Department of Public Health (DPH) Equity Framework

The following Equity Framework was developed based on Public Health's collective work addressing equity. It serves as a guide for designing or enhancing Public Health programs and administrative practices to achieve health equity, determine the best use of resources and investments, and ultimately achieve desired results. It identifies **social, economic, and environmental factors** to consider at every level of analysis and planning, **guiding principles** that serve as a foundation for actions and decision-making in our work, and a set of **core efforts** to help organize strategies for impact towards the desired results. There is also a set of questions for developing **performance measures** to assess strategies and make improvements**.**

Below is the framework with an explanation of each component in the following pages.



What is Health Equity

To ground the framework, it is important to remember that health is shaped by the community conditions in which we live, learn, work, play, and pray. They do this by affecting the things that can increase our chances of getting sick or being harmed. These conditions are categorized as the Social Determinants of Health (SDOH)[i]. They are non-medical factors that affect health outcomes and include the broader forces and systems that shape everyday life conditions (i.e. economic policies, developmental agenda, social norms, social policies, racism, climate change, and political structures.

> **Health Equity** is when everyone has a fair and just opportunity to reach their optimal health and well-being.

To achieve this, we must focus our efforts on those who are most impacted to close the gaps while improving outcomes for all. This is to ensure that all people have the goods, services, resources, and power they need to be healthy and well—especially people who have experienced socioeconomic disadvantage, historical injustice, and other avoidable and unjust systemic inequalities that are often associated with social categories of race, gender, ethnicity, social position, sexual orientation, and disability.

Achieving health equity across Los Angeles County asks that we all support and lead policy and systems changes within and outside of our department. This means examining how we use our current activities and resources to highlight and tackle the root causes of health inequities, such as economic, social, and racial injustices.

Equity Framework Components

Social, Economic, & Environmental Factors: Thinking about Causes and Reasons

Inequities don't arise from individual choices or behaviors alone, nor do they happen overnight. Instead, they result from a mix of factors that must be examined to understand their origins and to develop effective strategies for addressing them. The following factors are not meant to be exhaustive. Every community, population, or issue may have its unique considerations. Additionally, new factors may arise over time. These factors should be considered at every point of the framework: when determining the desired results, developing strategies, and assessing success.

- Racism
- Discrimination
- Social and Economic Inequities
- Living Conditions
- Ethnic and Cultural Dynamics
- Community Strengths

Guiding Principles: Having a Foundation

The following principles serve as a foundation for actions and decision-making in our work toward achieving health equity:

Commitment to racial justice and social change

Accountability to the community and each other

Integrity and transparency in our internal and external processes

Collaboration and shared learning

Results: Begin With the End in Mind

When thinking about the specific inequities or disparities that need to be addressed, it is crucial to start by identifying the Result, i.e., the condition(s) of well-being/quality of life condition(s), we want to achieve for the population, geographic area, or clients served. This can happen at a population, program, or client level.

What is the difference between population well-being (population accountability) and client well-being (performance accountability)?

- One program, Division, Bureau, or even a department alone cannot solely be accountable for the well-being of a whole population in a geographic area or population-level conditions. It is bigger than any one program or agency or one level of government. It requires the whole community, public and private partners, to make a difference. ("It takes a village to turn a curve.")

- Organizations and programs are accountable for the performance and results of the strategies and services they provide for their clients (i.e., those who receive service or otherwise directly benefit from the program). They do, however, contribute to the well-being of the population within the geographic area served. Additionally, they should contribute to a deeper understanding of both the root causes of the issues affecting their clients and what's needed to address those issues.

Core Efforts: Structuring the Work

Public Health identified four key core efforts that will guide our collective work to advance equity:

- **Useful and Inclusive Data**
- **Policy and Systems Change**
- **Partnerships**
- **Organizational Readiness and Capacity**

These efforts help the organization structure its work to strengthen efforts and tackle the root causes of inequities. To maximize impact, initiatives should be designed toward achieving the result and include strategies that positively turn the curve in all four core efforts. Please note that some strategies can fit under multiple areas. When developing strategies, keep the following in mind (these are not exhaustive):

1) Communicate in ways that **amplify community voices, lived experiences, and authentic narratives*** to drive action.

2) S**upport/build community and DPH collective capacity and ability** to enhance, promote, and sustain efforts that result in equitable health outcomes.
3) **Align resources** toward work that eliminates inequities.

The following are provided to guide planning and strategy development. For each Core Effort, a broad spectrum of potential considerations, questions, and examples is provided. Exploration beyond these initial suggestions is encouraged.

Core Effort #1: Gather and share **Useful and Inclusive Health Equity Data** to identify health gaps and direct resources where needed to improve health and well-being.

Useful and inclusive health equity data means collecting and analyzing data in a way that is fair, inclusive, and without bias. This helps identify health gaps and guides decision-making that ensures everyone has equitable access to fair and just resources and opportunities, regardless of their background.

Core Effort #2: Support **Policy and Systems Change** to advance the conditions needed to ensure that everyone has a fair and just opportunity to achieve their optimal health and well-being.

Focusing on policy and systems change actively addresses institutional practices and structural barriers that promote or hinder opportunities for well-being. This ensures that everyone has equal access to the conditions needed to live a healthy life, regardless of their social background or circumstances.

> Policy refers to both "Big P" and "Little p" policies. *What's the difference?*
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> **"Big P"** policies are broad, formal laws or regulations passed by government bodies through official legislative processes, that have a significant and systemic impact on society.
>
> **"Little p"** policies are informal, day-to-day practices or decisions within organizations or communities that influence behavior, interactions, and the management of specific issues. They may also be written as an organizational policy.

Core Effort #3: Build and Maintain Partnerships that truly share power and respect community perspective and autonomy

Building partnerships that share power and respect community input helps create better, more lasting solutions to health issues by ensuring everyone's voice and perspectives are integrated. Partnerships should be inclusive of organizations and

individuals from the community who have a role to play in understanding and addressing the issue at hand, improving program performance, or achieving population results. These partnerships can be longstanding or formed to address a specific need. They can be formal, with memorandums of agreement, or informal, based on shared values and commitments.

Core Effort #4: Strengthen Organizational Readiness and Capacity to adopt a just culture and advance health equity

Strengthening organizational readiness and capacity to adopt a just culture and advance health equity is essential because it ensures that the organization is equipped to implement policies and practices that are fair, inclusive, and equitable, resulting in an environment where everyone—employees, clients, and communities—can thrive.

> Organizational readiness: typically time-bound and situation-specific (e.g., preparing for a new strategy), refers to an organization's preparedness and willingness to implement a specific change, including leadership support, employee engagement, resource availability, and cultural alignment.
>
> Organizational capacity: is the overall ability of an organization to effectively use its resources, structures, and skills to achieve its goals and handle ongoing operations and challenges.

Performance Measures: Ensuring There Is Success

Systematically evaluating and improving the quality and performance of programs, processes, and services is critical for creating the conditions that lead to healthy outcomes for all. Doing so leads to efficiency, effectiveness, and customer satisfaction.

Public Health utilizes the Results-Based Accountability™ (RBA) framework to measure and improve the effectiveness of programs, services, and initiatives. The principles and practices of implementing RBA have been integrated into the DPH's Equity Framework.

To measure the quality, efficiency, and impact of programs, services, and initiatives, three types of performance measures must be selected, tracked, and analyzed over time:

1) How much work did we do?
2) How well did we do our work?
3) Was anybody better or worse off?

For more on RBA go to https://clearimpact.com/results-based-accountability/ or http://intranet.ph.lacounty.gov/ph/PHDirector/MedicalDirectorQualityAssurance/PerformanceImprovement.htm

Glossary

Community -Based Organization (CBO): A nonprofit organization that operates within a local community and provides services, support, and resources to address various social, economic, and health-related needs of individuals or groups. CBOs are typically grassroots and focus on improving the well-being of underserved populations in specific geographic areas or among a community of focus.

Disparity: Differences in health outcomes that we see when comparing groups of people or geographic areas

Discrimination: Treatment of an individual or group based on their actual or perceived membership in a social category, usually used to describe unjust or prejudicial treatment on the grounds of race, age, sex, gender, ability, socioeconomic class, immigration status, national origin, or religion.[ii]

Faith-Based Organization (FBO): A religiously affiliated organization that delivers services or provides support to the community, often in areas such as social services, education, health, and economic empowerment. FBOs operate under the principles of a particular faith tradition and may offer programs and assistance inspired by their religious mission.

Health Equity: When everyone has a fair and just opportunity to attain their optimal health and well-being. Ensures that all people have access to the goods, services, resources, and power they need to be healthy and well—especially people who have experienced socioeconomic disadvantage, historical injustice, and other avoidable and unjust systemic inequalities that are often associated with social categories of race, gender, ethnicity, social position, sexual orientation, and disability.

Inequity: When we understand that there is no biological or genetic reason for some of the alarming gaps we see between different social groups, we can see clearly that the root cause is systemic. In other words, these gaps are caused by systems that limit the availability and ability for certain groups to get resources, such as a good education, safe and supportive neighborhoods, and a job that pays a livable wage. These systemic, avoidable gaps are called health inequities.

Institutional Inequities: health disparities caused by the policies and practices of organizations or institutions, which can create or maintain disadvantages for certain groups or neighborhoods, exposing them to avoidable or unfair risks. These inequities influence how easily people can get essential goods and services, as well as the conditions and safety of their neighborhoods or workplaces.

Living Conditions: The physical environment that can be affected by land use planning, transportation, housing, residential segregation, and exposure to toxins. The economic and work environment, which include employment, income, financial institutions, retail businesses, and occupational hazards. The social environment, which includes culture, advertising, the media, violence, as well as the experience of class, racism, gender, or immigration. The service environment, which includes nutrition and food, education, health care, banking, and social services.

Narrative: stories or explanations that show up in our beliefs and actions, the way we think about other people, how we design and deliver services, how we allocate budgets and resources, and more.

Policy & Systems Change: Policies and systems shape the conditions that create and sustain disparities, often exposing certain groups and communities to greater risks and limiting access to resources necessary for optimal health. Policy and Systems change create long-lasting, equitable reforms that address the root causes of these disparities. By transforming policies and systems, we aim to improve the overall well-being of individuals and communities while closing the gaps in health outcomes.

Racial Equity: The condition that would be achieved if one's racial identity no longer predicted, in a statistical sense, how one fares. This includes elimination of policies, practices, attitudes and cultural messages that reinforce differential outcomes by race or fail to eliminate them. (Racial Equity Resource Guide/National Resource Defense Council)

Racial Justice: The systematic fair treatment of people of all races, resulting in equitable opportunities and outcomes for all. Racial justice — or racial equity — goes beyond "anti-racism." It is not just the absence of discrimination and inequities, but also the presence of deliberate systems and supports to achieve and sustain racial equity through proactive and preventative measures. (HCR National Education Association/Race Forward/National Resource Defense Council)

Racism: A historically rooted system of power hierarchies based on race infused in our institutions, policies, and culture that benefit White people and harm people of color. Racism isn't limited to individual acts of prejudice, either deliberate or unintentional. Rather, the most damaging racism is built into systems and institutions that shape our lives.[iii]

Root Cause: The root cause is the core issue that sets in motion the entire cause-and-effect reaction that ultimately leads to the problem(s).[iv]

Social and Economic Inequities are "systematic differences in health status between different social and economic groups that are socially produced (and therefore modifiable) and unfair".[v]

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[i] CDC Social Determinants website https://www.cdc.gov/public-health-gateway/php/about/social-determinants-of-health.html
[ii] Race Reporting Guide: A Race Forward Media Reference, Race Forward, 2015
http://www.raceforward.org/sites/default/files/Race%20Reporting%20Guide%20by%20Race%20Forward_V1.1.pdf
[iii] ibid
[iv] Adapted from American Society of Quality "What are Root Causes?" https://asq.org/quality-resources/root-cause-analysis
[v] Whitehead, M. & Dahlgren, G. Concepts and principles for tackling social inequities in health: Levelling up Part 1 World Health Organization 2006, reprinted 2007 https://www.enothe.eu/cop/docs/concepts_and_principles.pdf