Guidance for Applying a Health Equity Lens to HIV-related Disparities

How to Use this Guide: This guide outlines a twelve-step process for adopting a health equity lens in the work of an organization with responsibilities for addressing HIV. Under each step, a series of questions are posed. An agency seeking to apply a health equity lens would bring together a team of individuals from various levels of the organization and the community served to explore these questions and take purposeful action. Prior to beginning this process, it is important to familiarize the team with each step and then proceed roughly in accordance with the order of the steps, circling back to address previous steps as needed. The process of applying a health equity lens is one that should be understood as ongoing, as is stated clearly in Step 12.

As an agency undertakes this process, they should take steps to communicate with funders regarding health equity goals, potential impact on services delivered, how funds might be used or redirected, and to ensure all activities remain in line with the funder's intent and permitted services.

Use the WORKSHEET at the end of the document to record:

1. responses to key questions;
2. relevant data elements;
3. other important information;
4. action steps.

I. Assess Organizational Representativeness, Capacity Building and Staff Training Needs and Resources.

Every organization can work towards applying a health equity lens in its work. Reflecting on the organization - its leadership, policies, staff composition, relationship to communities served, work culture, access to resources, and other factors - is an important first step in the process.

REPRESENTATIVENESS

KEY POINT: When seeking to apply a health equity lens, it is important to ensure that representatives from the communities you are trying to serve are included in the process of program development, implementation and evaluation.

Assessing your organization's level of representativeness is a preliminary step to developing a plan. It is the most basic element to be explored and should be the first item addressed.

KEY QUESTIONS FOR THE TEAM TO ADDRESS:

1. To what extent are the following reflective of the communities and subcommunities served:
    - Agency board of directors
    - Agency senior leadership
    - Agency staff
    - Community Advisory Boards

2. What steps have, or could be taken, to increase representativeness of the board, leaders, staff and CABs?
3. To what extent does representativeness reach into all subpopulations, for example young, Black gay men of color, trans women, trans women of color, etc.
4. What steps can you take to ensure that people who are representative of communities and subcommunities served have an opportunity to participate in health equity program planning, implementation and evaluation?
5. To what extent has the agency reached out to community leaders/ members of the communities they serve?
6. To what extent has your agency taken steps to become an anti-racist organization?
   Resources:
   - Becoming an Antiracist Organization
   - What You Can Do to Create an Anti-Racist Organization - Recruiting - Harvard Business School (hbs.edu)
7. To what extent are there agency policies that might hamper the agency's ability to engage in health equity work?

CAPACITY BUILDING AND TRAINING:

As your agency begins work applying a health equity lens, it is important to gather resources, trainings and other sources of information about health equity in order to establish a clear understanding of the issues and a common language for moving forward.

Some important resources include:

- Health Equity Resource List
- Health Equity Competencies for Health Care Providers
- Health Care Organization Considerations for Health Equity
- Health Equity 101 Training
- Training on Population-Specific Evidence Based Interventions:
  - www.hivtrainingny.org; https://www.cdc.gov/hiv/effective-interventions/index.html
- Access to funds (for training, consultants, community engagement) to support this organizational change work

KEY POINT:
An important element of this process is normalizing discussion about health equity within the organization and between the organization and the community.

KEY QUESTIONS FOR THE TEAM TO ADDRESS:

1. What steps can the agency take to ensure the agency board, leadership, and staff are trained in the areas of health equity, cultural competency, anti-racism and providing affirming services specific to the populations served?
2. Do staff have opportunities to provide input into the types of training they feel they need?
3. Does training provide staff with an opportunity for values clarification in a supportive manner?

4. To what extent do you provide training to all levels of staff at the agency; including reception, security, etc.
5. What efforts are made to ensure implementation and supervision of what is learned in training?
6. To what extent do you evaluate the impact of the training?

II. Become familiar with Community-Wide and Agency-Specific Data related to Health Equity.

Community-wide data related to your work.

The New York State Ending the Epidemic (ETE) Dashboard includes the latest data related to ETE metrics. Assessing disparities in health requires a meaningful review of data by race, ethnicity and other factors. Metrics for which there is data available by race and ethnicity include:

1. New HIV Diagnoses
2. New HIV Diagnoses Among PWID
3. Concurrent AIDS Diagnosis
4. Linkage to Care withing 30 days of diagnosis
5. Receiving HIV medical care
6. Viral Suppression – diagnosed with HIV within 3 months of diagnosis
7. Viral suppression living with diagnosed HIV
8. Viral suppression living with diagnosed HIV and receiving HIV medical care
9. Sustained viral load suppression
10. Newly diagnosed with HIV who progress to AIDS within 2 years
11. HIV-related deaths
12. PrEP utilization
13. PrEP utilization for Medicaid recipients

Remember that a person's neighborhood and zip code are very predictive with regards to health outcomes and health equity. Explore the data at the level of availability that is closest to your agency's specific service delivery area. In many cases, you can access data at the Ryan White region level or county level.

Other important sources of information/ data:

- Medicaid Data; Opioid Overdose Data; HCV surveillance system; STI surveillance Data; BRFSS; County Health Ranking; Prevention Agenda Tracking Indicators (ny.gov)

KEY STEP: Examine agency-level data to identify disparities related to ETE metrics.

A critical step in applying a health equity lens is to carefully examine health outcomes for the clients you are serving. This will involve reviewing data from AIDS Institute Data Application (AIDA) and possibly other agency-specific data sources. Examine the data to define where health disparities exist. Prepare graphs or tables that highlight the data in a way that will be easy for staff and community members to understand.

Be sure to reflect on the extent to which certain communities, zip codes and neighborhoods might require specific focus and allocation of additional resources for health equity efforts.

III. Establish an inclusive process to identify health equity priorities that your agency will seek to address, based on the data.

KEY QUESTIONS FOR THE TEAM TO ADDRESS:

About the Process:

- Who will participate in the process of priority setting?
- As outlined in Step 1, how will you ensure representativeness related to all levels of your organization?
    - Agency board of directors
    - Agency senior leadership
    - Agency staff
    - Community Advisory Boards
- How can you ensure participation of the communities served in the decision-making process?
- As priorities are selected, how can the agency identify specific data collection sources and processes to monitor the impact of health equity work on specific measures selected?

About the Data:

- Where do agency and community-level data indicate disparities?
- Which disparities are most significant in terms of health of the individual and community?
- For the disparities identified, are there certain items that are central to your agency's mission and services that should be prioritized?
- Which disparities do you think you would best be able to impact?
- To what extent will you be able to access ongoing real time data to monitor the impact of your health equity work related to the data elements under consideration?

IV. Explore the reasons for the identified disparities.

KEY QUESTIONS FOR THE TEAM TO ADDRESS:

- What are the larger structural factors that are behind the disparity that is being focused upon?
- Is the disparity, in fact, an inequity (unfair, avoidable, and unjust)?
- Is there information from the professional literature that can help answer questions about the reasons for the disparity or inequity?
- How do social determinants of health play a role in creating or mitigating against the disparity or inequity?
- How will you engage and educate consumers, community leaders and staff in understanding why the disparity exists and what can be done about it?

V. Take steps to develop or enhance partnerships to address community-level and client level unmet Social Determinants of Health (SDOH) needs.

Engage in a process to assess the extent to which your agency has the capacity to meet the SDOH needs of clients, with a focus on assessing partnerships your organization has with other public and non-profit agencies to meet SDOH needs, including those related to each of the following domains:

SDOH	Existing Partnerships	Potential New Partners
Safe Housing		
Income/ Employment		
Nutrition		
Transportation		
Health Care		
Education		
Social Support		
Personal Safety		
Stigma and discrimination		
Racism		

KEY QUESTIONS FOR THE TEAM TO ADDRESS:

- What partnerships do your agency currently have?
- Do the existing partnerships help you to address the SDOH needs that have been identified during screening and/or treatment?
- If not, where are the gaps?
- What do you need to do to identify the non-traditional partners that may be needed to adequately address the gaps?

VI. Assessing client needs related to SDOH.

IMPORTANT RESOURCE:
Several different very good standardized SDOH screening tools are available, including:

- PRAPARE - Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)
- Accountable Health Communities Health Related Social Needs Screening Tool
- AIDS Institute SDOH Screening Tool (integrated into AIRS, the AIDS Institute Data Application)

KEY QUESTIONS FOR THE TEAM TO ADDRESS:

- Does the program screen for SDOH? If so, what tool is used?
- How often does screening take place?
- Is there a method to close the loop with regards to meeting client SDOH needs?
- Does the agency monitor agency-wide data to identify trends and unique community needs regarding unmet SDOH?
- What steps would be needed to initiate and make this screening routine?
- Does the agency have the capacity to integrate the screening in EHR or other accessible data system?
- What steps can be taken to ensure that all staff in the "need to know circle" have access to results of the screening in order to best meet client needs?

VII. Take steps to evaluate the extent to which your service delivery model is effective for reaching communities of color.

KEY QUESTIONS FOR THE TEAM TO ADDRESS:

- To what extent does the agency environment (buildings, artwork, etc.) reflect communities of color served?
- Are there elements related to accessing services that present barriers to community members?
- What are the assumptions built into your service delivery model and how do these assumptions line up with, or conflict with, community assumptions or perceptions of the agency?
- What steps can be taken to ensure staff diversity such that clients will "see themselves" in the providers offering services?
- How can agency services be provided in a manner that is more accessible to communities of color, for example, days and times of services?
- To what extent is the organizational culture reflective of community values?
- To what extent does the agency create a safe, stigma-free and affirming place for clients served?
- How can the agency use consumer and community surveys, stakeholder interviews and focus groups to explore how to fine-tune its service delivery model to better serve communities of color?

Developing a Specific Plan to Promote Health Equity

VIII. Setting Specific, Measurable, Achievable, Relevant, Time-bound (SMART) Goals and Objectives

Key Points:

- The team should set specific, data-driven goal(s) with SMART objectives.
    - Resources for SMART Goals and Objectives
- It is important to establish goals and objectives that are both reasonable to accomplish and would represent a significant advancement in health or prevention outcomes.
- Set a time interval that allows enough time to make a difference but also includes a reasonable endpoint for evaluation in order to provide timely feedback on effectiveness of the efforts.
- For transparency and buy-in, the goal should be shared with agency staff and the community.
- Data tracking systems should be in place to monitor both process and outcome data related to the goal and objectives.

CRITICAL POINT: Agencies should take steps to communicate with funders regarding health equity goals as they are developed, including potential impact on services delivered, how funds might be used or redirected, and to ensure all activities remain in line with the funder's intent and permitted scope of services.

IX. Explore Innovative Service Delivery Models

Once clear goal(s) and objectives are established, it is essential to explore how to modify agency operations in a manner that will result in the desired outcomes.

KEY QUESTIONS FOR THE TEAM TO ADDRESS:

- How can agency operations and services be revised to achieve the health equity goals and objectives?
- What was learned in steps 1-8 that should inform the agency service delivery model?
- What health equity policies and practices should be adopted or updated?
- What are the elements of organizational transformation that are needed?
- To what extent is there a need for change in agency staffing patterns to more effectively promote health equity?
    - increased reliance on peer workers
    - change in staff job descriptions or workload
    - change in staff qualifications
    - enhanced supervision
    - changing some other aspect of staffing/ human resources
- How can the agency develop a training plan as well as staff supervision practices to ensure that staff are prepared to implement all innovations to be adopted?
- How will the program address efforts to screen for and meet client SDOH needs?
- Are there opportunities to explore utilizing innovative partnerships to achieve the goal?

X. Use QI approaches to test creative ideas on a small scale and track the data.

Agencies should become familiar with quality improvement / organizational change models such as the Plan - Do - Study - Act process, to test creative ideas on a small scale before going to full scale implementation.

KEY QUESTIONS FOR THE TEAM TO ADDRESS:

- What QI model will the team use to test new ideas?
- How will organizational change related to health equity be integrated into the agency's overall quality improvement program?
- Who should lead QI efforts related to health equity?

Resources:

- Center for Quality Improvement and Innovation
- End Disparities ECHO Collaborative
- Institute for Healthcare Improvement

XI. Monitor data, analyze results and practice transparency.

KEY QUESTIONS FOR THE TEAM TO ADDRESS:

- How often should data be reviewed to monitor progress?
- Based on data, what progress is being made toward the agency's data-driven health equity goals?
- How will the results of health equity efforts be shared with staff, clients, and the larger community?
- Based on data, are there modifications in activities that would be advised?

XII. Recognize that change is an iterative process.

When your agency reaches the end of the designated period of time to evaluate impact, it is important to:

- Review data (qualitative and quantitative) to evaluate the extent of progress made
- Engage all stakeholders in interpreting the results
- Identify what worked and discontinue things that didn't work
- Begin the process of improving services again by refining goals, objectives and workplan.

In this way, the work continues until such time that there are no disparities present.

WORKSHEET: ACTION ITEMS

Use this worksheet to capture responses to key questions, data elements and important information and action items relative to each step in the process of applying a health equity lens.

I. Assess Organizational Representativeness, Capacity Building and Staff Training
Responses to Key Questions
To what extent are agency board of directors, leadership, staff and consumer advisory board (CBA) reflective of the communities and subcommunities served: *To what extent does representativeness reach into all subpopulations, for example: young, Black gay men of color; trans women: trans women of color, etc.* *What steps can the agency take to ensure staff are trained in the areas of health equity, cultural competency, anti-racism and providing affirming services specific to the populations served?* *What efforts are made to ensure implementation and supervision of what is learned in training?*
Action Items

II. Become familiar with Community-Wide and Agency-Specific Data related to Health Equity
Responses to Key Questions
What trends are seen in the ETE metrics and other data sources with regard to health equity and health disparities? *How will the agency examine local and agency-level data to identify disparities?*
Action

III. Establish an inclusive process to identify health equity priorities that your agency will seek to address, based on the data.
Responses to Key Questions
<u>About the process:</u> Who will participate in the priority setting process? How will the program illicit participation of communities-served in the process? *<u>About the Data:</u> Where do disparities exist? Which are most critical to focus upon?*
Action Items

IV. Explore the reasons for the identified disparities.
Responses to Key Questions
What are the reasons, structural factors or SDOH that play a role in creating or mitigating against the disparities? *Are the disparities inequities?*
Action Items

V. Take steps to develop or enhance partnerships to address community-level and client level unmet SDOH needs.
Responses to Key Questions
What steps will be taken to promote access to needed SDOH?
Action Items

VI. Assessing client needs related to SDOH
Responses to Key Questions
How will the agency assess for unmet client SDOH needs? *What steps will be taken to ensure identified needs are met?*
Action Items

VII. Take steps to evaluate the extent to which your service delivery model is effective for reaching communities of color
Responses to Key Questions
To what extent does the agency environment (buildings, artwork, etc.) reflect communities of color served? *How can agency services be provided in a manner that is more accessible to communities of color, for example, days and times of services?* *To what extent does the agency create a safe, stigma-free and affirming place for clients served?* *How can the agency use consumer and community surveys, stakeholder interviews and focus groups to explore how to fine-tune its service delivery model to better serve communities of color?*
Action Items

VIII. Setting Specific Time Bound Goals and Objectives
Responses to Key Questions
How will the team determine data-driven initiative-level and agency-level SMART goals and objectives? *How will the program ensure that data tracking systems are in place to track the impact of the program?*
Action Items

IX. Explore Innovative Service Delivery Models
Responses to Key Questions
What steps will be taken to support innovative service delivery models?
Action Items

X. Use QI approaches to test creative ideas on a small scale and track the data
Responses to Key Questions
What QI model will be used and how?
Action Items

XI. Monitor data, analyze results and practice transparency.
Responses to Key Questions
How often should data be reviewed? *How will the results be shared?*
Action Items

XII. Recognize that change is an iterative process.
Responses to Key Questions
How will what is learned be used to continue progress over time? *What steps will be built into the program to ensure continual refinements will be made to improve outcomes?*
Action Items