Connecticut Department of Public Health Office of Health Equity Strategic Plan

Championing a Culture of Health Equity

DRAFT FOR REVIEW – JULY 2015

Message from the Commissioner

[TO BE INSERTED]

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Acknowledgments

This document was prepared by the **Connecticut Department of Public Health's Office of Health Equity.** The following organizations and agencies provided support:

- Specialized technical assistance (facilitation, strategy development, and analysis) was provided by **CommonHealth ACTION**, a national public health organization that aligns people, strategies and resources to generate solutions to health and policy challenges. Visit www.commonhealthaction.org for more information.

- General technical assistance and funding administration was provided by the **Association of State and Territorial Health Officials (ASTHO)**, the national nonprofit organization representing public health agencies in the United States, the U.S. Territories, and the District of Columbia, and over 100,000 public health professionals these agencies employ. Visit www.astho.org for more information.

- This project was funded by the **U.S. Department of Health and Human Services' Office of Minority Health (OMH)** within the Office of the Secretary as part of a **National Partnership for Action to End Health Disparities** capacity-building project with the Association of State and Territorial Health Officials. The project is designed to support state and territorial health departments with reducing health disparities and improving the health of minorities through their programs. Visit www.minorityhealth.hhs.gov/npa for more information.

In addition, many colleagues and leaders contributed their thought partnership to this effort. We wish to thank the following people for their contributions:

DPH staff who participated in the "Culture of Health Equity" planning meetings in May and June 2015:

- Federico Amadeo
- Chris Andresen
- Olga Armah
- Joan Ascheim
- Suzanne Blancaflor
- Carol Blanks
- Janet Brancifort
- Marianne Buchelli
- Marie Burlette
- Mike Carey
- Renee Coleman-Mitchell
- Juanita Estrada
- Wendy Furniss
- Bill Gerrish
- Nordia Grant
- Susan Hewes
- Tracy Hung
- Lisa Kessler
- Kevin Krusz
- Lori Mathieu
- Ava Nepaul
- Ramon Rodriguez-Santana
- Leslie Scoville
- Kristin Sullivan
- Danny White

DPH partners who participated in the "Culture of Health Equity" planning meetings in May and June 2015:

- Glenn Cassis, African American Affairs Commission/Commission on Health Equity.
- Marisol Feliciano, St. Francis Hospital.
- Anne Fountain, Stamford Health Department
- Mui Mui Hin-McCormick, Asian Pacific American Affairs Commission/Commission on Health Equity.
- Christi Staples, Connecticut Multicultural Health Partnership.
- Kathi Traugh, Yale University School of Public Health, Office of Public Health Practice.

Special thanks to:
Tiffany Cox, MPH, CPH, Directors of Health Promotion and Education Health Equity and Policy Fellow, 2013-2014.

Key Terms and Definitions

- **Community**: A group of people who share some or all of the following: socio-demographics, geographic boundaries, sense of membership, culture, language, common norms, and interests (CommonHealth ACTION, adapted from Centers for Disease Control and Prevention [CDC], n.d.).

- **Culture**: An integrated pattern of learned core values, beliefs, norms, behaviors and customs that are shared and transmitted by a specific group of people. Some aspects of culture, such as food, clothing, modes of production and behaviors, are visible. Major aspects of culture, such as values, gender role definitions, health beliefs and worldview, are not visible (The California Endowment, n.d.).

- **Culture of Health Equity**: A dynamic process that considers shared values, diverse beliefs and customs to ensure all individuals have fair and equitable opportunities to attain their highest potential for social, physical, and mental wellbeing (Connecticut Department of Public Health [DPH], 2015).

- **Disparity**: A noticeable and often unfair difference between people or things (Merriam-Webster, n.d.).

- **Disproportionality**: Over- or under-representation of a particular group or race in a public system (e.g. the child welfare or criminal justice systems) compared to their representation in the general population (CommonHealth ACTION, n.d.).

- **Equal**: 1) Of the same measure, quantity, amount, or number as another. 2) Regarding or affecting all objects in the same way (Merriam-Webster, n.d.).

- **Equality**: Equal treatment that may or may not result in equitable outcomes (Xavier University, n.d.).

- **Equity**: Providing all people with fair opportunities to attain their full potential to the extent possible (CommonHealth ACTION, adapted from Braveman and Gruskin, 2003).

- **Equity Lens**: The "lens" through which you view conditions and circumstances to understand who receives the benefits and who bears the burdens of any given program, policy, or practice (CommonHealth ACTION, n.d.).

- **Health:** Health is a state of complete physical, mental, and social well-being, not merely the absence of disease (World Health Organization [WHO], 1948).

- **Health Equity**: The highest level of health attainable for all people (CDC, 2015).

- **Health Disparities**: Preventable differences in the burden of disease, injury, violence, or opportunities to achieve optional health that are experienced by socially disadvantaged populations (CDC, 2008).

- **Inequity**: A difference or disparity between people or groups that is systematic, avoidable, and unjust (CommonHealth ACTION, adapted from CDC, n.d.).

- **Social determinants of health**: The complex social and economic circumstances, in which people are born, grow up, live, and work...These circumstances are in turn shaped by a wider set of forces: economics, policies, social and culture contexts, and politics (Connecticut DPH, adapted from WHO, n.d.).

- **Systems Change**: Change that impacts all elements, including social norms of an organization, institution, or system; may include a policy or environmental change strategy. Policies are often the driving force behind systems change (CDC, 2010).

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I. Introduction: Championing a Culture of Health Equity

The Connecticut Department of Public Health (DPH) believes that achieving our vision of healthy people in healthy Connecticut communities requires us to recognize health equity not only as a priority, but also as a human right. We define health equity as the attainment of the highest level of health for all people. No one should be disadvantaged from achieving their full health potential because of their social position or other socially determined circumstance. If we do not examine how our programs, policies, and practices disproportionately burden or benefit people in our state, then we run the risk of improving overall health while masking and even worsening health disparities between population groups. In order to achieve health equity, we must understand and address the root causes that create the unfair and avoidable differences in health status that exist within our state's population.

DPH's Health Equity Journey

DPH understands that health equity is a journey that requires continuous commitment. For nearly three decades, we have invested in creating equitable opportunities for all Connecticut residents to experience good health. By establishing Community Health Centers and School Based Health Centers, identifying Health Professional Shortage Areas, and supporting health districts, DPH has connected vulnerable Connecticut communities to essential public health services. Through the establishment of the Connecticut Office of Multicultural Health in 1998, DPH has been active in both internal and external efforts to ensure that all residents have access to public health and healthcare services. We have invested in developing partnerships to understand and address the needs of communities of color, people with limited English proficiency, and other populations who experience disparities in health. We have adopted and championed nondiscrimination and language access policies for our staff, vendors, and partnerships. In 2014, we updated the Office of Multicultural Health to its current name, the Office of Health Equity (OHE) and revamped its mission. OHE is charged with carrying out our Department-wide priority, championing a culture of health equity within DPH and throughout the state. See **Figure 1,** which illustrates major milestones on our health equity journey. The entire timeline of events, which provides historical context for DPH's equity-focused work, is located in **Appendix A**.

FIGURE 1 – DPH Health Equity Journey – TO BE INSERTED

Development of Office of Health Equity Strategic Plan

In February 2013, DPH identified "Championing Health Equity" as one of our original six priority areas in our five-year strategic plan. In October 2014, we updated our strategic map to reflect the recognition that adopting an equity lens is critical to achieving all of our goals, establishing "Championing a Culture of Health Equity" as a cross-cutting strategic priority. See **Appendix B** for an overview of the Department strategic planning process and **Figure 2** for the updated strategic map. The newly-created OHE was then charged with operationalizing this priority within the Department. This document outlines OHE's strategic plan to leverage assets and opportunities to advance this goal over the next three years.

In this strategic plan, we include an overview of the Office of Health Equity, describe our internal and external partners involved in the work, present an analysis of opportunities and challenges for this work, and identify tools we will use to measure progress. We present five strategic goals to advance the cross-cutting priority to champion a culture of health equity; each goal is paired with specific objectives that support these goals. We also discuss the ways in which a culture of health equity undergirds and advances the Department's five key priority areas. Finally, we developed a work plan to guide our activities over the next year; this work plan will be updated on an annual basis. Please see **Appendix C** for DPH health equity strategic planning activity details.

INSERT FIGURE 2 – DPH Strategic Map

II. Office of Health Equity Structure, Roles, and Responsibilities

The DPH OHE was created in 2014 though Connecticut General Assembly Public Act No. 08-171. It replaces the former Office of Multicultural Health. The change in the name and mission statement of the office followed a two-year re-consideration of DPH priorities vis à vis under-resourced populations in the state, and its subsequent decision to champion health equity in all of its programs, plans, and policies.

The Office is housed within the newly reorganized Community, Family and Health Equity Section, formerly the Community Health and Prevention Section and the Family Health Section (see **Figure 3** for the DPH organizational chart). It ensures that health equity is a central component of all Agency programs and planning efforts, supports the development of a workforce that applies an equity lens to their daily work, and aligns DPH initiatives so that they serve the public health needs of all Connecticut residents. OHE program activities focus on the underlying social determinants of health and federally-supported initiatives that promote the National Culturally and Linguistically Appropriate Services in Health and Healthcare ("CLAS Standards") within the Department as well as among DPH contractors, local offices of public health, and community-based organizations.

The following vision, mission, and guiding principle will guide OHE regardless of changes in Department goals, strategies, or leadership:

Vision: Healthy people in healthy, equitable Connecticut communities.

Mission: To improve the health of all Connecticut residents by working to eliminate differences in disease, disability and death rates among ethnic, racial and other population groups that are known to have adverse health status or outcomes. Such population groups may be based on race, ethnicity, age, gender, socioeconomic position, immigrant status, sexual minority status, language, disability, homelessness, mental illness or geographic area of residence.[1]

Guiding Principle: Equal enjoyment of the highest attainable standard of health is a human right and a priority of the state.[2]

[1] This mission statement was adopted by the Connecticut General Assembly as Section 5 of Public Act 14-231 "An Act Concerning the Department of Public Health's Recommendations Regarding Various Revisions to the Public Health Statutes," which was signed into law by Governor Malloy on June 13, 2014.

[2] CGA Public Act No. 08-171.

FIGURE 3 – DPH Organizational Chart – TO BE INSERTED

The Office of Health Equity responsibilities include:

- Assisting in the development of a DPH health equity plan and ongoing health equity implementation efforts; and
- Providing technical assistance, information, and resources to internal and external partners on topics of health disparities, health equity, and the social determinants of health.
- Providing leadership in the development of the CLAS Standards and health equity training materials and resources for both staff and partners;
- Providing technical assistance to DPH staff, vendors, and local health partners in implementing the CLAS Standards;
- Coordinating and monitoring CLAS Standards' implementation within the agency and its vendors;

OHE has also advocated for public policies that institutionalize equitable access to healthcare services for Connecticut's residents. For instance, OHE significantly contributed to passage of Connecticut Senate Bill No. 856, which requires acute care hospitals to provide foreign language interpretation services to patients, and Section 20-10b of the Connecticut General Statutes, which requires medical providers to receive training in cultural competency.

The Office is supported by three full-time state-funded staff. Currently, federal funds (U.S. Department of Health & Human Services OMH State Partnership Grant to Improve Minority Health, 2013 -2015; and the U.S. Preventive Health & Health Services Block Grant, 2013 - 2015) support the implementation of CLAS Standards within DPH, its contractors, local health departments, and other health organizations in Connecticut.

III. Defining the DPH Culture of Health Equity

Championing a culture of health equity requires a common language. It is vital to establish a common understanding of core health equity concepts and to use consistent language throughout DPH in order to institutionalize the work. Defining the term and a vision for the DPH “culture of health equity” that complements the Department vision, mission, and values is the first step in this process. In May 2015, the OHE convened staff representing DPH offices and committees as well as several key external partners to draft a collective definition and vision for the DPH culture of health equity. See **Appendix D** for details about the event and its proceedings.

The following statements define and guide the Office Health Equity as it leads DPH’s efforts to champion a culture of health equity:

Definition: DPH defines a culture of health equity as *a dynamic process that considers shared values, diverse beliefs and customs to ensure all individuals have fair and equitable opportunities to attain their highest potential for social, physical, and mental wellbeing.*

DPH believes in championing this culture of health equity in Connecticut communities by: 1) respecting the diverse values and beliefs of our state residents; 2) optimizing the equitable use of resources (human, financial, and programmatic); and 3) advocating for socially equitable policies and practices.

Vision: One Connecticut where all people enjoy shared resources, optimal health, well-being, and a sense of dignity.

Value Statements: The following value statements complement the Agency core values and serve as guiding principles for DPH as we engage in activities and relationships to champion a culture of health equity within the agency and in communities across the state.

Universal Value Statements

A. Health is a state of complete physical, mental, and social well-being, not merely the absence of disease (World Health Organization, 1948).

B. We honor the diversity of the individuals and communities that we serve and value their varying approaches to health and well-being.

C. We recognize that the underlying social determinants of health (e.g., systems and institutions related to education, employment, transportation, built environment, healthcare, and others) are critical to health outcomes and consider this context when developing programs, policies, practices, and partnerships.

D. Timely and appropriate data on health, the social determinants of health, and indicators of disadvantage (e.g., socioeconomic status, race/ethnicity, geographic location, etc.) are critical to advancing health equity.

E. Collaborative leadership and effective listening are fundamental to improving the health of our communities.

Internal Value Statements

F. We are responsible stewards of the public trust and resources.

G. We value and encourage staff diversity; our staff are selected with care, treated with respect, held accountable for their performance, and encouraged in their personal growth.

H. We continuously improve the quality of our work.

I. We uphold DPH, state and federal law non-discrimination requirements, inclusive of the National Standards for Culturally and Linguistically Appropriate Services in Health and Healthcare (CLAS) Standards.

IV. Stakeholders and Partnerships

Engaging diverse stakeholders and developing and maintaining internal and external partnerships are critical to implementing the Health Equity Strategic Plan and achieving the vision of one Connecticut where all people enjoy shared resources, optimal health, well-being and a sense of dignity. This vision can only be achieved through the collaboration and input of stakeholders and partners from multiple sectors, which exist inside and outside of traditional public health practice.

Stakeholders

The Health Equity Strategic Plan affects individuals, organizations, and communities throughout the state of Connecticut that are directly involved or indirectly affected by the work. Such stakeholders include, but are not limited to all youth and adult Connecticut residents, businesses, local health departments, health providers and hospital systems, transportation agencies, schools, religious institutions, elected officials, social service agencies and community-based agencies, etc. OHE is committed to working with other DPH offices to ensure all stakeholders are taken into account in DPH policies and programs.

Internal Advising Teams, Committees, and Workgroups

Advising teams, committees, and workgroups have helped to guide the implementation of the Health Equity Strategic Plan by supporting OHE in its efforts to integrate an equity lens throughout all of the offices and programs within the Department. Key advising teams, committees, and workgroups have included the following:

- Health Equity CLAS Standards Workgroup (2012-2013)
- Health Equity Data Surveillance Workgroup (2012-2013)
- Health Equity Definitions Workgroup (2013-2013)
- Health Equity Partnerships Workgroup (2012-2013)
- Health Equity Staff Trainings Workgroup (2012-2013)
- Public Health Strategic Team (2013 – present)
- Public Health Systems Improvement (2011 – present)
- PROPOSED: Health Equity Staff Advisory

External Partnerships

Developing and maintaining relationships with partners that share similar equity-focused goals that have access to different communities and resources is an essential component of the Health Equity Strategic Plan. By partnering with organizations and agencies that share a common equity-focused perspective, OHE will conserve resources and have a broad and profound impact within Connecticut's diverse communities. A list of key partners can be found in **Appendix E**.

V. Strategic Challenges and Opportunities for Health Equity

We, like many public health departments across the country, face challenges with regard to improving the health and quality of life of our residents. Concurrently, DPH and OHE are presented with opportunities that will advance the Department towards championing a culture of health equity.

In August 2014, the OHE core team participated in a staff retreat in which they identified the internal strengths, weaknesses, opportunities, and threats (SWOT) that would impact the ability of DPH to champion health equity in their everyday work. As a result of the retreat, the core team generated the following summary of internal challenges and opportunities, which serve as a basis for the strategic objectives outlined within the OHE three-year work plan:

Challenges:

- Funding constraints
- Lack of a common language and coherent messaging regarding health equity
- Disjointed data management, surveillance system, and technological infrastructure
- Changes in staffing
- Partners that are resistant to change
- Inadequate internal communications strategy

Opportunities:

- Dedicated and talented core leadership
- Cross-departmental health equity champions
- Supportive DPH Administration
- Strong relationships with equity-focused external networks and partnering organizations
- Partners at regional, state, and federal levels
- Current political climate provides a window of opportunity for health equity

The full SWOT analysis list from this activity can be found in **Appendix F**.

In order to enhance the strategic position of OHE, the core team will reconvene and revisit the SWOT analysis exercise at a staff retreat in August 2015 to brainstorm collectively on a broader range of external as well as internal challenges and opportunities. In turn, the work plan may be revisited to reflect their analysis.

VI. Strategic Goals and Objectives to Champion a Culture of Health Equity

The following goals are drawn from the Agency Strategic Plan, the Health Equity Strategic Planning Workgroup Recommendations (see **Appendices G, H, I, J, and K** for summaries of workgroup recommendations), and the objectives from the U.S. Department of Health and Human Services OMH Strategic Framework for Improving Racial/Ethnic Minority Health and Eliminating Racial/Ethnic Health Disparities.[3] The objectives are aligned with the preliminary SWOT analysis conducted by OHE Staff in August 2014 and the DPH Culture of Health Equity definition created by DPH staff and external partners in May 2015. These goals and objectives are part of the one-year work plan, but are subject to change on an annual basis, upon completion of a second SWOT analysis, or as Departmental policies or practices are updated.

GOAL 1: Develop a common language that all DPH employees and partners can use to communicate about equity and apply an equity lens in their daily work. Establishing a common language demonstrates unity and support for the DPH culture of health equity and facilitates understanding and cooperation among internal and external partners.

- *Objective 1.1: Develop an institutional DPH–wide glossary.* The glossary will promote a Departmental-wide understanding of fundamental health equity-related terminology.

- *Objective 1.2: Develop a strategy to brand the culture of health equity at DPH.* The brand will serve as a representation of the Department as a champion of health equity.

DPH Office of Health Equity Goals to Champion a Culture of Health Equity:

1. Develop a common language that all DPH employees and partners can use to communicate about equity and apply an equity lens in their daily work.

2. Use data effectively to plan, monitor, and measure the equity impact of DPH policies and programs, with a specific focus on the determinants of health.

3. Leverage the effective implementation of the CLAS Standards to increase inclusion of under-resourced populations while raising awareness and support for health equity.

4. Engage in ongoing training and education to build institutional knowledge and skills among DPH staff and local partners to advance the application of an equity lens.

5. Develop and maintain internal and external partnerships to build individual and organizational capacity to engage in equity-focused work.

[3] U.S. Department of Health and Human Services Office of Minority Health. 2008. *Strategic Framework for Improving Racial/Ethnic Minority Health and Eliminating Racial/Ethnic Health Disparities.* Accessed 4/21/15: http://www.minorityhealth.hhs.gov/Assets/PDF/Checked/OMH%20Framework%20Final_508Compliant.pdf

GOAL 2: Use data effectively to plan, monitor performance, and measure the equity impact of DPH policies and programs, with a specific focus on the determinants of health. By continuously evaluating the effectiveness of DPH equity-focused initiatives, the Department will ensure that its policies and programs are consistently positioned to promote optimal health within all Connecticut communities.

- *Objective 2.1: Develop best-practices regarding data-collection, performance management, and reporting using an equity focus.* Collaborate with relevant DPH sections and programs to develop and promote best practices for applying an equity lens in the areas of data collection, policy, planning, and performance management.

- *Objective 2.2: Institute an agency-wide guidance document on equity impact to support using an equity lens in* data collection, policy, and performance management. The document will promote institutional knowledge of the value of integrating equity-centered practices into all relevant DPH processes.

- *Objective 2.3: Develop and implement training on DPH's data collection policy*. The web-based training module on the DPH Policy on Collecting Sociodemographic Data will be updated and promoted among DPH staff.

GOAL 3: Leverage the effective implementation of the CLAS Standards to increase inclusion of under-resourced populations while raising awareness and support for health equity. Through the implementation of the CLAS Standards, OHE will advance socially equitable policies and practices within DPH and its partners.

- *Objective 3.1: Develop a strategy with talking points about the connection between CLAS and health equity.* The plan and talking points will introduce stakeholders to the connection between the CLAS Standards and health equity.

- *Objective 3.2: Develop a language access policy.* The policy will identify key principles of language accessibility and provide guidance on the implementation of the CLAS Standards within DPH.

- *Objective 3.3: Develop a language access plan.* The plan will lay out action steps to support the implementation of the CLAS Standards within DPH.

GOAL 4: Engage in ongoing training and education to build institutional knowledge and skills among DPH staff and local partners to advance the application of an equity lens. Through the cultivation of institutional knowledge, OHE will develop and sustain a workforce that understands its role and responsibility in advancing health equity in Connecticut.

- *Objective 4.1: Work with DPH Human Resources and Workforce Development Committee to develop an orientation module for onboarding.* Introducing the culture of health equity at the staff on-boarding process will promote the development and application of an equity lens from the beginning stages of staff members' careers at DPH.

- *Objective 4.2: Train all DPH staff on the health equity toolkit and develop a plan for continuous learning.* Providing training on the availability and utility of the toolkit materials will help to sustain the DPH culture of health equity as staff transition within or from the Department.

- *Objective 4.3: Tailor and promote CLAS and health equity toolkits among relevant partners.* Customizing the toolkit to fit the needs of external partners will help to secure support for DPH equity-focused policies and initiatives across the state. See **Appendix J** for a full list of toolkit resources.

GOAL 5: Develop and maintain internal and external partnerships to build individual and organizational capacity to engage in equity-focused work. Through relationships with diverse partners, OHE will optimize the use of human, financial, and programmatic resources to advance health equity in Connecticut.

- *Objective 5.1: Create DPH awards/designations related to health equity for external partners (e.g., Connecticut Health Equity Champion designation).* The award will offer recognition and provide incentive for external partners that work towards a common equity focused goal.

- *Objective 5.2*: *Create internal DPH recognition/awards for staff that exemplify and champion the culture of health equity.* Champions would be awarded based on their demonstrated commitment to advancing health equity within the DPH work environment and for Connecticut communities.

VII. Alignment with Other DPH Strategic Priority Areas

As a cross-cutting priority within the DPH strategic plan, health equity is a fundamentally necessary component of all other DPH Strategic Priorities. None of the five key strategic priorities can be implemented unless they include an emphasis on health equity. The OHE Strategic Plan will guide DPH towards being a Champion of Health Equity and support the five priority areas in the following ways:

Strengthen Approaches and Capacity to Improve Population Health
Applying an equity lens to DPH policies and programs requires developing a workforce that embraces the responsibility of providing public health services that lead to fair, just, and equitable health outcomes for all Connecticut residents. With support from the Workforce Development Committee, DPH will use the Health Equity Strategic Plan to develop staff capacity to apply principles of health equity in its everyday work. Through ongoing health equity training, DPH staff will stand firm in their role to addressing health disparities and strengthen their approaches to public health programming by aiming to reach a broader and more diverse population.

Promote the Value and Contributions of Public Health
Developing staff capacity to effectively communicate about health equity is necessary for ensuring that all members of the public understand the value of public health services and the vital role that DPH plays in improving the health of Connecticut communities. Through the use of a common health equity language, equity-focused data collection and performance management, the Department will promote messages that resonate with internal and external stakeholders and speak to the realities of all Connecticut communities.

Build Strategic Partnerships to Improve the Public Health System
Developing and maintaining diverse partnerships is necessary for expanding the reach of DPH services to improve the health of all Connecticut residents. The Health Equity Strategic Plan will position the Department to form partnerships with organizations and agencies that represent and address needs of the state's most vulnerable populations. Furthermore, the relationships that OHE has developed and strengthened through the implementation of the CLAS Standards can be leveraged for future DPH initiatives.

Foster and Maintain a Competent, Healthy, Empowered Workforce
Developing a workforce that understands the vital role that the Department plays in addressing the many factors that lead to poor health outcomes is essential for improving the health and well-being of all Connecticut residents. Through the implementation of the Health Equity Strategic Plan training and workforce development activities, DPH will equip its staff with the necessary framework, knowledge, and skills to address the broad public health needs of Connecticut's diverse population.

Build a Sustainable, Customer-Oriented Organization
Departmental sustainability relies on having a skilled workforce that understands the complex needs of Connecticut communities and how to effectively communicate and plan

strategies to address those needs with stakeholders. The implementation of equity-focused workforce development and performance management practices will help to ensure customer-oriented policies and programs that result in transparent and equitable outcomes to support diverse partnerships and future strategic planning efforts.

VIII. Monitoring the Progress and Impact of the Health Equity Strategic Plan

OHE is responsible for implementing and monitoring the overall Health Equity Strategic Plan, work plan, and quality improvement activities related to health equity. OHE will work with the Public Health Systems Improvement (PHSI) unit, the Workforce Development Committee, the Public Health Strategic Team (PHST), and other relevant DPH sections to develop, document, and distribute data collection and evaluation protocols that are tailored to measure progress towards integrating an equity-focus into Departmental programs and practices. For details regarding the overall roles and responsibilities of PHSI and PHST, see **Appendix L**.

In addition, PHST and PHSI will support OHE with the implementation of the Turning Point Performance Management Framework. The framework, originally created in 2004 and then updated in 2013, is organized around each of the four components of a performance management system including: 1) Performance Standards, 2) Performance Measurement, 3) Reporting of Progress, and 4) Quality Improvement. The framework will steer OHE towards achieving work plan goals and objectives and making strategic decisions regarding quality improvement of equity-focused initiatives. See **Appendix M** for more details regarding the framework.

OHE has added CLAS-related and data collection -- quality improvement project performance measures -- to its performance management system and is currently tracking CLAS Standards training data through a project inventory and quality assurance database so that progress can be documented. Other health equity performance measures will be considered and developed over time.

IX. Three-Year Work Plan to Support Health Equity Goals

OHE has mapped out the general activities that it will undertake to accomplish the goals and objectives outlined in this strategic plan over the course of three years (2015-2018), which are aligned with the DPH strategic plan timeline.

In recognition that resources are finite and these activities build upon one another, OHE has prioritized specific goals and objectives for Year 1: Goal 1 (all objectives), Goal 3 (all objectives), Goal 4 (Objective 4.3), and Goal 5 (Objective 5.2). For greater details about the Year 1 work plan, please see Section X of this strategic plan.

Office of Health Equity Strategic Plan Three-Year Work Plan			
Goals and Objectives	**Major Activities: Year 1 (2015-2016)**	**Major Activities: Year 2 (2016-2017)**	**Major Activities: Year 3 (2017-2018)**
Goal 1: Develop a common language that all DPH employees and partners can use to communicate about equity and apply an equity lens during their daily work.			
Objective 1.1: Develop an institutional DPH-wide glossary. Lead 1. M. Mitchell 2. M. Hynes	• Revise, circulate, and finalize glossary of terms. • Promote glossary.	• Promote glossary & key concepts.	• Promote glossary & key concepts.
Objective 1.2: Develop strategy to brand the *culture* of health equity at DPH. Lead 1. TBD 2. A. Jimenez and M. Hynes	• Develop and finalize brand strategy. • Develop and finalize OHE/culture of health equity elevator pitch. • Train key staff.	• Develop and implement plan to train all staff on brand strategy and talking points.	• Roll out plan to train and support all staff.

Office of Health Equity Strategic Plan Three-Year Work Plan			
Goals and Objectives	**Major Activities: Year 1 (2015-2016)**	**Major Activities: Year 2 (2016-2017)**	**Major Activities: Year 3 (2017-2018)**
Goal 2: Use data effectively to plan and monitor performance on the equity impact of DPH policies and programs, with a specific focus on the determinants of health.			
Objective 2.1: Develop best practices regarding data collection and performance management with an equity focus. Leads: 1. M. Hynes 2. K. Sullivan, other key staff	• Convene key staff. • Develop work plan. • Standardize performance measures.	• Develop, vet, and finalize guidance. • Monitor performance measures.	• Release guidance and promote among staff. • Monitor performance measures.
Objective 2.2: Institute an agency-wide guidance document on equity impact to support using an equity lens in data collection, policy, and performance management. Leads: 1. M. Hynes 2. K. Sullivan, other key staff	• Convene key staff. • Develop work plan.	• Develop, vet, and finalize guidance. • Develop internal launch plan.	• Release guidance and promote among staff.
Objective 2.3: Update and implement trainings on DPH's data collection policy. Leads: 1. M. Hynes 2. Data Collection QI Committee	• Convene key staff. • Update and finalize first training module. • Promote online training. • Launch first training cohort.	• Develop plan to transition from voluntary to mandatory training. • Develop plan to roll out in phases and support continuous learning.	• Roll out plan to train all staff and engage in continuous learning.
Goal 3: Leverage the effective implementation of the CLAS Standards to increase inclusion of under-resourced populations while raising awareness and support for health equity.			

Office of Health Equity Strategic Plan Three-Year Work Plan			
Goals and Objectives	**Major Activities: Year 1 (2015-2016)**	**Major Activities: Year 2 (2016-2017)**	**Major Activities: Year 3 (2017-2018)**
Objective 3.1: Develop a strategy and promote talking points about the connection between CLAS and health equity. Leads: 1. A. Jimenez 2. A. Stratton, M. Hynes, M.J. Mitchell	• Develop elevator pitch and key talking points. • Promote talking points.	• Develop and implement plan to train all staff. • Develop and implement plan to train partners.	• Roll out plan to train and support staff and partners.
Objective 3.2: Finalize language access policy. Leads: 1. M. Hynes 2. A. Stratton	• Convene key staff. • Finalize and approve policy.		
Objective 3.3: Develop language access plan. Leads: 1. A. Stratton 2. M. Hynes	• Convene key staff. • Develop and finalize a plan to implement policy (completed in Objective 3.2).	• Develop and implement plan among staff, contractors, partners, and other stakeholders.	• Implement plan among staff, contractors, partners, and other stakeholders.

Goal 4: Engage in ongoing training and education to build institutional knowledge and skills among DPH staff and local partners to advance the application of an equity lens.			
Objective 4.1: Work with DPH Human Resources and Workforce Development Committee to develop an orientation module for onboarding. Leads: 1. M. Mitchell 2. A. Jimenez	• Develop list of training opportunities. • Convene key staff. • Develop and finalize orientation training module.	• Implement module. • Evaluate module.	• Revise and update module. • Continue module implementation.
Objective 4.2: Train all DPH staff on the health equity toolkit and develop a plan for continuous learning. Leads: 1. M. Mitchell 2. Workforce Development Committee	• Develop detailed work plan for training and continuous learning.	• Develop and finalize continuous learning plan. • Roll out voluntary training to all staff – cohort 1.	• Roll out voluntary training, open to all staff – cohort 2. • Roll out continuous learning – cohort 1. • Update master plan for additional cohorts. • Recruit additional trainers.
Objective 4.3: Tailor and promote CLAS and health equity toolkits among relevant partners. Leads: 1. A. Stratton 2. A. Jimenez	• Update CLAS Standards toolkit. • Promote and send updated toolkit.	• Promote CLAS toolkit with partners. • Hold train-the-trainer trainings.	• Promote CLAS toolkit with partners. • Hold train-the-trainer trainings.

Goal 5: Develop and maintain internal and external partnerships to build individual and organizational capacity to engage in equity-focused work.			
Objective 5.1: Create DPH award/designation related to health equity for external partners (e.g., Connecticut Health Equity Champion designation). Leads: 1. A. Jimenez 2. M. Hynes	• Convene key staff. • Complete draft of concept.	• Implement plan to develop designation. • Promote designation among partners. • Award first designations.	• Promote designation among partners. • Award designations. • Leverage designation partners to promote other key activities (trainings, etc.).
Objective 5.2: Create internal DPH award/designation for staff that exemplify and champion the culture of health equity. Leads: 1. M. Hynes 2. A. Jimenez, M. Mitchell, A. Stratton	• Convene key staff. • Complete draft of concept • Implement plan to develop designation. • Award first designation.	• Promote and continue internal awards.	• Promote and continue internal awards.

X. Detailed Annual Work Plan to Support Health Equity Goals (Year 1)

The timespan Year 1 is **October 1, 2015–September 30, 2016**. Please note: in order to plan a successful launch for this strategic plan, some of these activities will be performed in the summer of 2015. Many of these activities will continue over the course of the official planning year. As noted in our three-year work plan (Section IX), we have prioritized specific goals and objectives for Year 1: Goal 1 (all objectives), Goal 3 (all objectives), Goal 4 (Objective 4.3), and Goal 5 (Objective 5.2). Jump to specific goal activities here: Goal 1 | Goal 2 | Goal 3 | Goal 4 | Goal 5

Office of Health Equity Strategic Plan Year 1 Detailed Work Plan | Goal 1			
Goal 1: Develop a common language that all DPH employees and partners can use to communicate about equity and apply an equity lens during their daily work.			
Objective 1.1: Develop an institutional CTDPH –wide glossary.			
Measurable Activity	Person(s) Responsible	Time Frame	Resources/Capacity Notes
Revise glossary of terms.	Lead: M. Mitchell Support: M. Hynes, A. Jimenez Consulted: Definitions Committee	July 2015	• Existing definitions from the committee. • Definitions from OHE. strategic planning process.
Circulate draft for DPH agency comment.	Lead: M. Mitchell Support: M. Hynes, A. Jimenez Consulted: B. Gerrish	August 2015	• Email or SurveyMonkey link. • Feedback at PHST.
Finalize glossary.	Lead: M. Mitchell Support: M. Hynes, A. Jimenez Consulted: Deputy Commissioner	September 2015	
Promote glossary through activities – town hall forums, meetings with section	Lead: M. Mitchell Support: M. Hynes, A. Jimenez	September 2015-September 2016	• Intranet.

Office of Health Equity Strategic Plan Year 1 Detailed Work Plan | Goal 1			
chiefs, one-on-one meetings, etc.	Consulted: B. Gerrish; Section chiefs; Human resources		• Present at section meetings and town hall forums.
Objective 1.2: Develop strategy to brand the *culture* of health equity at DPH.			
Measurable Activity	Person(s) Responsible	Time Frame	Resources/Capacity Notes
Meet with internal staff to brainstorm the look and feel of brand strategy.	Lead: M. Hynes Support: OHE staff, DPH Health Equity Team	August 2015	• Communications brand guidelines.
Finalize brand guidelines.	Lead: Support: OHE staff, DPH Health Equity Team, B. Gerrish	September 2015	
Share brand guidelines with the Department.	Lead: Support: OHE staff, B. Gerrish	October 2015	
Develop elevator pitch and top 3-5 messages or talking points about the culture of health equity.	Lead: M. Hynes Support: OHE staff, DPH Health Equity Team, B. Gerrish	August 2015	
Convene and train key DPH and OHE staff to deliver talking points and messaging.	Lead: M. Hynes Support: A. Jimenez, M. Mitchell Consulted: B. Gerrish	September 2015	

Office of Health Equity Strategic Plan Year 1 Detailed Work Plan | Goal 2			
Goal 2: Use data effectively to plan and monitor performance on the equity impact of DPH policies and programs, with a specific focus on the social determinants of health.			
Objective 2.1: Develop best practices regarding data collection, evaluation, and reporting for continuous quality improvement using an equity focus.			
Measurable Activity	Person(s) Responsible	Time Frame	Resources/Capacity Notes
Convene meeting of key staff to facilitate buy-in to institutionalize best practices for data collection and performance management which reflect health equity.	Lead: M. Hynes Support: A. Jimenez, M. Mitchell Workgroup members Consulted: K. Sullivan, Joan Ascheim, Diane Aye, Mehul Dalal-	Fall 2015	• Aligned with Connecticut State Health Improvement Plan (SHIP). • Workgroup expertise. • DPH Performance Dashboard
Develop work plan to institute data collection and performance management best practices which reflect health equity.	Lead: M. Hynes Support: A. Jimenez, M. Mitchell Workgroup members Consulted: K. Sullivan, Joan Ascheim, Diane Aye, Mehul Dalal	Winter/Spring 2016	• Aligned with Connecticut State Health Improvement Plan (SHIP). • Workgroup expertise. • DPH Performance Dashboard
Collect and organize repository of online resources related to data collection and performance management best practices which reflect health equity.	Lead: Intern/Fellow Support: M. Hynes, A. Jimenez, M. Mitchell Workgroup members	Winter/Spring 2016	• Recruit intern.

Objective 2.2: Institute agency-wide guidance document on equity impact to support using an equity lens in data collection, policy, and performance management.			
Measurable Activity	Person(s) Responsible	Time Frame	Resources/Capacity Notes
Convene meeting of key staff to facilitate buy-in to create and institute agency-wide guidance document.	Lead: M. Hynes Support: A. Jimenez, M. Mitchell Consulted: K. Sullivan, Diane Aye, Mehul Dalal.	Spring 2016	• Workgroup meetings.
Develop work plan to create and institute guidance document.	Lead: M. Hynes Support: A. Jimenez, M. Mitchell Consulted: K. Sullivan, Diane Aye, Mehul Dalal	Summer 2016	• Workgroup meetings.

Objective 2.3: Develop and implement training on DPH's data collection policy.			
Measurable Activity	Person(s) Responsible	Time Frame	Resources/Capacity Notes
Convene key staff and update data collection policy training modules.	Lead: M. Hynes. M. Mitchell Support: A. Jimenez	Winter 2016	• Data collection policy. • Web-based training module
Finalize updated data collection policy training module.	Lead: Data Collection Quality Improvement Committee Support: M. Hynes, M. Mitchell, Communications. Consulted: Workforce Development workgroup; K. Sullivan	Spring 2016	
Promote online data collection training.	Lead: Data Collection Quality Improvement Committee Support: M. Hynes, M. Mitchell Communications. Consulted: Workforce Development workgroup; K. Sullivan	Spring 2016	• Intranet, division meetings, town hall forums.
Make Updated online data collection policy training available to DPH staff.	Lead: Data Collection Quality Improvement Workgroup Support: M. Hynes, M. Mitchell Communications Consulted: Workforce Development workgroup; K. Sullivan	Summer 2016	• Online training capacity.

Office of Health Equity Strategic Plan Year 1 Detailed Work Plan | Goal 3			
Goal 3: Leverage the effective implementation of the CLAS Standards to increase inclusion of under-resourced populations while raising awareness and support for health equity.			
Objective 3.1: Develop a strategy and talking points about the connection between CLAS and health equity.			
Measurable Activity	Person(s) Responsible	Time Frame	Resources/Capacity Notes
Develop elevator pitch and 3-5 key talking points about the role of CLAS in the culture of health equity.	Lead: A. Jimenez Support: M. Hynes, M. Mitchell, A. Stratton Consulted: B. Gerrish, K.Sullivan, J. Ascheim	August 2015	• DPH QI Pitch
Promote and circulate elevator pitch and talking points to key staff.	Lead: A. Jimenez Support: M. Hynes, M. Mitchell, A. Stratton Consulted: B. Gerrish, K.Sullivan, J. Ascheim	September 2015	
Objective 3.2: Develop language access policy.			
Measurable Activity	Person(s) Responsible	Time Frame	Resources/Capacity Notes
Convene staff to finalize language access policy.	Lead: M. Hynes Support: Communications, Administration M. Mitchell, A. Stratton Consulted: Commissioner's Office	July - September 2015	• Aligned with SHIP.
Finalize language access policy with Commissioner's sign-off.	Lead: M. Hynes Support: Communications, Administration, A. Stratton Consulted: Commissioner's Office	September 2015	• Aligned with SHIP.

Office of Health Equity Strategic Plan Year 1 Detailed Work Plan | Goal 3			
Objective 3.3: Develop language access plan.			
Measurable Activity	Person(s) Responsible	Time Frame	Resources/Capacity Notes
Convene staff to develop language access plan.	Lead: A. Stratton Support: A. Jimenez, M. Hynes Communications, Administration	Winter 2016	• Approved language access policy.
Finalize language access plan.	Lead: A. Stratton Support: A. Jimenez, M. Hynes Bill Gerrish, Administration	Summer 2016	

Office of Health Equity Strategic Plan Year 1 Detailed Work Plan | Goal 4			
Goal 4: Engage in ongoing training and education to build institutional knowledge and skills among DPH staff and local partners to advance the application of an equity lens.			
Objective 4.1: Work with DPH Human Resources to develop an orientation module for onboarding.			
Measurable Activity	Person(s) Responsible	Time Frame	Resources/Capacity Notes
Develop list of potential onboarding health equity training opportunities/options to present to HR.	Lead: M. Mitchell, A. Jimenez Support: M. Hynes, Workforce Development Committee Consulted: HR Staff	Winter 2016	• Health Equity toolkit. • Workgroup recommendations.
Meet with HR and Workforce Development Committee to discuss opportunities to integrate health equity training into onboarding process and present list of potential.	Lead: M. Mitchell, A. Jimenez Support: M. Hynes, Workforce Development Committee Consulted: HR Staff	Winter 2016	
Develop and finalize training module with HR input.	Lead: M. Mitchell, A. Jimenez Support: M. Hynes, Workforce Development Committee Consulted: HR Staff	Spring 2016	
Objective 4.2: Train all DPH staff on the health equity toolkit and develop a plan for continuous learning.			
Measurable Activity	Person(s) Responsible	Time Frame	Resources/Capacity
Develop detailed training and continuous learning work plan to roll out over 2 years and eventually train all staff.	Lead: M. Mitchell Consulted: M. Hynes, A. Jimenez	Spring 2016	• Health Equity toolkit. • Workgroup recommendations.
Meet with relevant leadership staff to	Lead: M. Mitchell	Spring 2016	

Office of Health Equity Strategic Plan Year 1 Detailed Work Plan | Goal 4			
approve and promote first training cohort.	Consulted: M. Hynes, A. Jimenez		
Objective 4.3: Tailor and promote CLAS and health equity toolkits among relevant partners.			
Measurable Activity	Person(s) Responsible	Time Frame	Resources/Capacity
Review and update CLAS Standards toolkit.	Lead: A. Stratton, A. Jimenez Support: M. Hynes	Fall 2015	• CLAS Standards toolkit. • Webinars (existing systems) with local health departments.
Update partner list to include newly formed relationships with providers and local health department staff.	Lead: A. Jimenez Support: A. Stratton, M. Hynes	Fall 2015	• Existing partnership list.
Promote toolkit to partners.	Lead: A. Stratton, A. Jimenez Support: M. Hynes	Winter/Spring 2016	• Website; partnership list-serve; in-person meetings with partners.

Office of Health Equity Strategic Plan Year 1 Detailed Work Plan | Goal 5			
Goal 5: Develop and maintain internal and external partnerships to build individual and organizational capacity to engage in equity-focused work.			
Objective 5.1: Create DPH award/designation related to health equity for external partners (e.g., Connecticut Health Equity Champion designation).			
Measurable Activity	Person(s) Responsible	Time Frame	Resources/Capacity
Meet with internal staff to brainstorm ideas for external award or designation program.	Lead: A. Jimenez, M. Hynes	Winter 2016	
Complete first draft of award/designation concept.	Lead: A. Jimenez, M. Hynes Consulted: B. Gerrish, Branch chiefs	Spring 2016	
Finalize plan to promote and implement award/designation program in Fall 2016.	Lead: A. Jimenez, M. Hynes	Summer 2016	
Objective 5.2: Create internal DPH award/designation for staff that exemplify and champion the culture of health equity.			
Measurable Activity	Person(s) Responsible	Time Frame	Resources/Capacity
Meet with internal staff to brainstorm ideas for internal awards program.	Lead: M. Hynes, A. Jimenez, M. Mitchell, A. Stratton	July 2015	
Develop plan for yearly awards program.	Lead: M. Hynes, A. Jimenez, M. Mitchell, A. Stratton	September 2015	
Launch first awards program in concert with strategic plan launch.	Lead: M. Hynes, A. Jimenez, M. Mitchell, A. Stratton	October 2015	

APPENDICES

- Appendix A: DPH Health Equity Journey
- Appendix B: DPH Strategic Planning Process Summary
- Appendix C: Overview of OHE Health Equity Strategic Planning Activities
- Appendix D: Health Equity Strategic Plan Activities
- Appendix E: Complete Partnership List
- Appendix F: OHE SWOT Analysis Results
- Appendix G: Workgroup Recommendations—Health Equity Definitions
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- Appendix K: Workgroup Recommendations—Health Equity Partnerships
- Appendix L: Public Health Systems Improvement Unit (PHSI) and the Public Health Strategic Team (PHST) Roles and Responsibilities
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Appendix A: DPH Health Equity Journey

The Department of Public Health is proud of how far we have come on our health equity journey. With the launch of our strategic plan, we look forward to adding new milestones in realizing our vision: *One Connecticut where all people enjoy shared resources, optimal health, well-being, and a sense of dignity.*

1998

- **July:** DPH Office of Multicultural Health was created and established within DPH by state statute CGA 19a-4j.

1999

- **June:** The first Connecticut DPH health disparities report, *Multicultural Health: The Health Status of Minority Groups in Connecticut,* published.

2001

- **October:** *Connecticut Women's Health* published.

2005

- **November:** *Mortality and Its Risk Factors in Connecticut, 1989-1998* published.

2006

- **June:** The Connecticut Health Disparities Project established through a grant from the Connecticut Health Foundation – Purpose: To improve the statewide infrastructure for documenting, reporting, and addressing health disparities among racial and ethnic minority residents of our state.

2007

- **August:** *Issue Brief: Defining Health Disparities* published

- **October**
    - *The Collection of Race, Ethnicity, and Other Sociodemographic Data in Connecticut Department of Public Health Databases* published.
    - *Issue Brief: Race and Ethnicity Matters: Concepts and Challenges of Racial and Ethnic Classifications in Public Health* published.
    - First Statewide Meeting on Health Disparities –*Monitoring Health Disparities: Concepts and Challenges in State Health Data Collection* held at the CT Legislative Office Building, Hartford on October 19, 2007.

2008

- **July:** CT Multicultural Health Partnership Launched - Established to draw together expertise, resources, and programming to eliminate health disparities in Connecticut.

- **September**
  - *CT DPH Policy on Collecting Sociodemographic Data* published.
  - *The Spatial Context of Health Disparities: A Literature Review* published.

- **October:** Second Statewide Meeting on Health Disparities – *Monitoring Health Disparities: Creating Data Collection Policies that Work* held at the CT Legislative Office Building, Hartford on September 19, 2008.

- **December**
  - Third Statewide Meeting on Health Disparities –The Spatial Context of Health Disparities held at The Lyceum, Hartford on December 10, 2008
  - The Connecticut Health Disparities Project concluded.

2009

- **January:** *The 2009 Connecticut Health Disparities Report* published.
- **June thru December:** Film and Discussion Series – 1) *Unnatural Causes: Is Inequality Making Us Sick*; and 2) *Race: The Power of An Illusion.*

2010

- **March:** *Connecticut Health Database Compendium* published.
- **June thru December:** Film and Discussion Series – 1) *Unnatural Causes: Is Inequality Making Us Sick*; and 2) *Race: The Power of An Illusion.*

2011

- **March:** DPH Health Equity Policy Statement developed.

- **April:** DPH Strategic Map finalized on April 11, 2012.

- **May:** DPH Health Equity Policy Statement approved and signed by DPH Commissioner Jewel Mullen on May 11, 2012.

- **July:** Non-Discrimination in the Provision of the Department of Public Health Programs and Services Policy finalized and signed by Commissioner Mullen on July 15, 2011.

- **September:** Two-day strategic planning session

2012

- **March**
  - DPH Data Collection Quality Improvement Initiative established through a grant from the National Network of Public Health Institutes. Purpose: Establish a long-range plan to achieve DPH databases compliance with the DPH data policy through a continuous quality improvement process.
  - *Connecticut Health Database Compendium* published.

- **May:**
  - DPH Health Policy Statement finalized and signed by Commissioner Mullen on May 11, 2012.

- **June**
  - DPH Health Equity Research, Evaluation & Policy Initiative established to integrate health equity as a cross-cutting principle in all agency programs and planning efforts. DPH mission statement revised to include the principle of health equity.

- **August**
  - One-day strategic plan development session.
  - DPH mission statement updated to include the principle of health equity.
  - Connecticut Department of Public Health's five year strategic plan for 2013-2018 finalized and published, which identified "champion of health equity" as one of six agency goals.

- **September**
  - DPH Staff Health Equity Workgroups formed as part of the DPH Strategic Planning Initiative in the areas of: Definitions, Data and Surveillance, CLAS Standards, Staff Training Needs, and Partnerships.
  - Health Equity Quality Improvement Training – focus on Health Equity – with the Public Health Foundation.
  - Two-day strategic planning process with TSI, Inc.

- **November:** DPH Data Collection Quality Improvement Initiative concluded; final report with recommendations issued.

- **December**
  - DPH Health Equity Self-Assessment completed.
  - Draft Health Equity Definitions Workgroup Report issued.
  - Draft Health Equity Data and Surveillance Workgroup Report issued.

- Draft CLAS Standards Workgroup Report issued.
- Draft Health Equity Staff Training Needs Workgroup Report issued.
- Draft Health Equity Partnerships Workgroup Report issued.

2013

- **February:** DPH Agency Strategic Plan 2013-2018 published – Reaffirmed the vision and mission; identified organizational values for the agency; and built consensus around priorities with an additional focus on worksite wellness and the importance of partnerships

- **September:** DPH receives federal Office of Minority Health State Partnership Grant to Improve Minority Health (SPG) to promote and implement equity-focused national standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards).

- **October:** DPH Data Collection Quality Improvement staff committee formed in response to the recommendation of the DPH Data Collection Quality Improvement Initiative – Charge is to ensure adherence to DPH Data Collection Policy and recommend any revisions to the current policy; Standing Committee meets on a quarterly basis.

2014

- **January:** Connecticut Department of Public Health Quality Plan finalized.

- **March**
  - *Champion Health Equity* established as a cross-cutting priority within CTDPH's Agency Strategic Plan (2013-2018).
  - Connecticut State Health Assessment and State Health Improvement (SHIP) Plan published with health equity and the social determinants of health as cross-cutting priorities with 39 SHIP health equity-focused objectives included.

- **June:** DPH Office of Multicultural Health was renamed "Office of Health Equity" and the mission statement was revised; name and mission statement adopted and signed into law by CT Governor Malloy on June 13, 2014.

- **August:** DPH health equity retreat on August 20, 2014.

- **September:** One-day planning session.

- **October**
  - DPH "Office of Health Equity" established on October 1, 2014.

- CLAS Standards Baseline Assessment Report published.
  - DPH Strategic Plan updated.
  - *Champion a Culture of Health Equity* is the revised cross-cutting priority within CTDPH's Agency Strategic Plan (2013-2018).

2015

- **April:** Health Equity Staff Advisory proposed – Would provide guidance, insight, and feedback on health equity initiatives of the Office and within the agency. It meets twice per year (bi-annually).

- **May:** DPH staff and partners established the DPH definition and vision of the Culture of Health Equity.

- **June:** Draft OHE Strategic Plan finalized.

- **October:** Final OHE Strategic Plan launched.

Appendix B: DPH Strategic Planning Process Summary

A strategic plan serves as a road map for all employees and partners to make decisions that further the goals of the organization. To ensure that the plan meets the needs of the people of Connecticut, the Department is engaged in a comprehensive, participatory strategic planning process that includes staff, partners, and the public in identifying needs and setting priorities.

The Connecticut Department of Public Health published its first draft of a five-year Agency Strategic Plan for 2013-2018 in February 2013.

The following six Strategic Priorities were established within the Strategic Plan:

1. **Ensuring Programmatic Excellence** by creating a culture of continuous quality improvement that aligns the health needs of the public with the actions of the health department.
2. **Promoting the Value and Contributions of Public Health** by educating the public about the role public health plays in increasing the number of Americans who are healthy at every stage in life.
3. **Building Strategic Partnerships to Improve the Public Health Systems** by seeking input and increasing collaborative efforts.
4. **Fostering and Maintaining a Competent Empowered Workforce** by providing opportunities for continuous skill building in a safe and healthy environment.
5. **Establishing a Sustainable, Customer-Oriented Organization** by increasing access to our services, personal, and information.
6. **Championing Health Equity** by making a concerted effort to address the many social determinants that impact one's ability to be healthy.

In March 2014, health data were analyzed and the community provided input to the *Connecticut State Health Assessment* through key informant interviews, advisory groups, Coalition meetings, and public forums. The assessment documented health risks and factors contributing to poor health.

Findings from the health assessment were used to set priorities for health improvement. The *State Health Improvement Plan* aligned the activities of the health department and its partners with the health improvement goals. The Department asked its partners from the public, private, and non-profit sectors across Connecticut to identify successful strategies for promoting health. These partners include State, Tribal, and local agencies; hospitals and other providers of medical, dental, and behavioral health care; community and professional organizations and coalitions businesses, community services providers and representatives of vulnerable populations; academic institutions; and complementary service providers.

The *Connecticut State Health Assessment* and the *State Health Improvement Plan* identified the need to update the DPH Strategic Plan, including establishing health equity as an essential component of all DPH programs and policies. In 2015, DPH updated our Agency Strategic Plan to include **Champion a Culture of Health Equity** as one of four Cross-Cutting Priorities.

Updated DPH Strategic Priorities and Cross-Cutting Priorities (2015-2018):

Strategic Priorities:

A – Strengthen Approaches and Capacity to Improve Population Health

B – Promote the Value and Contributions of Public Health

C – Build Strategic Partnerships to Improve the Public Health System

D – Foster and Maintain a Competent, Healthy, Empowered Workforce

E – Build a Sustainable, Customer-Oriented Organization

Cross Cutting Priorities:

F – Ensure Quality and Reliability of and Access to Data Statewide

G – Foster a Culture of Performance Management & Quality Improvement

H – Champion a Culture of Health Equity

I – Secure Sustainable, Diversified Funding

Appendix C: Overview of OHE Health Equity Strategic Planning Activities

Creation of the DPH Health Equity Policy Statement

In the spring of 2011, a DPH Health Equity Policy Statement was developed in consultation with approximately 20 key staff throughout the agency. This statement identifies health disparities priority population groups; a health equity policy based on the ten essential services of public health; and a process to guide the policy. It was approved and signed by DPH Commissioner Jewel Mullen in May 2011, and publicly disseminated.

Strategic Plan Priorities

The Agency Strategic Plan (2013-2018), updated one of its cross-cutting priorities to: *Champion a Culture of Health Equity*, which was established in 2014 as a revision to the previous strategic priority: *Champion Health Equity*. Two other quality related priorities in the Strategic Plan are: *Ensure Programmatic Excellence and Build a Sustainable, Customer- Oriented Organization.* Each of these priorities has or is being addressed by a workgroup or council, established through the strategic planning process that has developed objectives to realize these priorities.

State Health Improvement Plan

A State Health Assessment and State Health Improvement Plan (SHIP) were completed in the spring of 2014. Health equity and the social determinants of health are cross-cutting priorities in the SHIP. An Advisory Council, comprised of key state partners, oversees the SHIP Implementation Plan, and the Plan is organized into seven focus areas. Progress in meeting these objectives are being monitored by the Public Health Strategic Team using a performance management IT system.

Health Equity Quality Improvement Workshop

As part of DPH Quality Improvement staff training initiative funded through the National Network of Public Health Institutes, DPH held a one-day workshop on September 11, 2012 with Dr. Jack Moran of the Public Health Foundation. Approximately 30 DPH staff participated in this workshop to learn QI tools and through examining two questions:

- What are the issues of incorporating health equity into our everyday work?
- What are the issues faced by DPH in implementing its Health Equity Policy Statement?

Staff participants were assembled into four equivalent groups, and each of two groups developed responses to the two questions. Responses generated have provided important information for the development of strategies and activities for a health equity plan.

Strategic Planning Workgroups

As part of the 2012 – 2013 staff-led DPH Strategic Mapping process, five Health Equity Strategic Mapping Workgroups were formed in the areas of promoting: health equity definitions, health equity data and surveillance, CLAS Standards, health equity staff training, and health equity partnerships. Summary reports and recommendations of these staff workgroups were published in December 2012, and a subset of these recommendations have provided the basis for the Office of Health Equity's work plan from 2013 through the present.

Health Equity Assessment

In response to the state Commission on Health Equity's request for an agency self-assessment in relation to health equity, approximately 32 DPH staff met in small groups and/or corresponded from November 8 through December 21, 2012.

Health Equity Staff Retreat

In August 2014, the OHE held a half-day retreat with five project staff. Five other "DPH Health Equity Champions" were invited to participate in a one-hour discussion session. A SWOT Analysis was completed to identify strengths, weaknesses, opportunities, and threats to project progress.

CLAS Standards Baseline Assessment

From September 2013 through September 2014, the OHE conducted an assessment of the agency's promotion and implementation of the CLAS Standards. A CLAS Standards Baseline Assessment, published in October 2014 summarized DPH efforts to date, and also laid out a set of eight distinct recommendations for implementation of the CLAS Standards. Since October 2014, OHE staff persons have been engaged in implementation of these recommendations in consultation with the Commissioner's Office and agency partners, especially those in the offices of Communications, Equal Employment Opportunity, Strategic Planning, and Administration.

Appendix D: Health Equity Strategic Plan Activities

May 12, 2015 Culture of Health Equity Working Meeting

On May 12, 2015, the OHE Core Team, DPH staff, and external partners attended a half-day meeting facilitated by CommonHealth ACTION, a national public-health non-profit organization that aligns people, strategies, and resources to generate solutions to health and policy challenges. The meeting consisted of three group activities in which participants collectively defined the DPH Culture of Health Equity, established the Culture of Health Equity Vision Statement, and revised the Culture of Health Equity Value Statements. The results of that meeting are published in the Health Equity Strategic Plan narrative.

In the afternoon of May 12, 2015, The OHE Core Team met with CommonHealth ACTION staff to discuss strategies to revise the Health Equity Plan created in April 2015. CommonHealth ACTION presented and received feedback on a revised Health Equity Strategic Plan outline, and together the two teams established an updated one-year work plan. Based on the compiled results of both the morning and afternoon meetings, CommonHealth ACTION and the OHE Core Team produced the first draft of the Health Equity Strategic Plan in May 2015.

June 10, 2015 Health Equity Strategic Plan Communication Strategy Meeting

In a morning session on June 10, 2015, CommonHealth ACTION and ASTHO facilitated a second meeting with fourteen members of the DPH staff. At the meeting, participants engaged in two brainstorming activities in which they collectively generated strategies for communicating about their health equity-focused work to internal and external audiences. CommonHealth ACTION used the information produced at the meeting to create the OHE communication plan, which was finalized at the end of June 2015.

In the afternoon of June 10, 2015, CommonHealth ACTION, ASTHO, and OHE reviewed and made revisions to the first draft of the Health Equity Strategic Plan narrative and work plan. CommonHealth ACTION then finalized the full Health Equity Strategic Plan on June 30, 2015.

Appendix E: Complete Partnership List

2-1-1 United Way of CT

91 Holiday Hill

A Different Perspective, Inc.

AARP CT

Abdul-Majid Karim Hasan Health Awareness Advisory Council.

Action for Equity/JZ Consulting Services

Advocacy Unlimited, Inc.

AETNA Foundation

Aetna Foundation Children's Center

Aetna, Inc.

African Community Services

American Cancer Society

American Health, Stroke Association, State Health Alliances

American Health, Stroke Association, State Health Alliances

American Heart Association

American Lung Association of New England

AmeriCares Free Clinics

Asian Family Services, Community Renew Team

Asian Pacific American Coalition of CT

Association of Physicians of Indian Origin (CAPI)

Beulah Heights Social Integration

Birth to Three State of CT

Blok Group LLC

Bridgeport Hospital

Capital Workforce Development

Catholic Charities

Center for Health Equity, Curtis D. Robinson Men's Health Institute, Saint Francis Hospital

Center for Medicare Advocacy Inc.

Central Area Health Education Center (AHEC), Inc.

Charter Oak Health Care

Children's Trust Fund

CIGNA

Citizens for Quality, Sickle Cell Care, Inc.

City of Hartford Court of Common Council

City of Hartford Department of Families, Children, Youth and Recreation

City of Hartford Department of Health and Human Services

Commission on Health Equity

Community Based Education, Dept. of Community Medicine, UCONN Health Center

Community Enterprises Inc.

Community Health Center

Community Health Center Assoc. of CT

Community Health Center of Meriden, UCONN School of Medicine

Community Health Center, Inc.

Community Health Corps Inc.

Community Health Corps with CHCACT

Community Health Network of CT, Inc.

Community Health Services

Community Mental Health

Community Resources LLC

Conference of Churches

Connecticut Cancer Partnership

Connecticut Children's Medical Center

Connecticut Children's Medical Center, Special Kids Support, North Central Medical Home Initiative

Connecticut League for Nursing (CLN)

Connecticut Public Health Association

CPHA Mentoring Organization Registry

CT Academy of Family Physicians

CT AIDS Resource Coalition (CARC)

CT Assoc. for Home Care and Hospice, Inc.

CT Association for United Spanish Action

CT Association of Directors of Health, Inc.

CT Birth to Three System, DDS

CT Center for a New Economy

CT Center for Economic Analysis, UCONN

CT Coalition of Mutual Assistance Association

CT Coalition to End Homelessness

CT Council on Problem Gambling

CT Department of Public Health, Office of Health Equity Health

CT Department of Public Health, Public Health Initiatives

CT Dept of Public Health, Children with Special Healthcare Needs

CT Dept of Public Health, Maternal and Child Health

CT DPH, Office of Oral Health

CT General Assembly's Latino and Puerto Rican Affairs Commission

CT Health Foundation

CT Hospital Association

CT Legislature

University of CT Health Center

CT Nurses Association

CT Oral Health Initiative

CT Parent Power

CT State Conference of NAACP Branches

CT State Dept. of Education

CT State Medical Society

CT VNA Hospice

Daughters of Eve

Department of Health & Physical Education, Eastern CT State University

Department of Mental Health and Addiction Services

Department of Social Services

Dept. of Developmental Services

Dept. of English, Fairfield University

Dept. of Health and Human Services

Diabetes Support Group of CT

Diamond Research Consulting, LLC

Donate Life CT

CT Dept of Public Health-Tumor Registry

Drinking Water Section, DPH

E2 Consulting Services Educational Advocacy

East Shore District Health Department

Eastern AHEC, Inc.

Eastern Highlands Health District

Enharmonic Solutions

Essay Writers

Family Life Education, Inc.

Fellowship Place

Ficklin Media Group

Fluency, Inc.

FoodNet, Yale School of Public Health, Emerging Infections Program

Galaxy

General Clinic Research Center, UCONN Health Center

Generations Family Health Center, Inc.

Gettysburg College

Graduate School of Education and Allied Professions, Fairfield University

Greene Law, PC

Hartford Childhood Wellness Alliance/ CT Children Medical Center

Hartford City Hall

Hartford Dispensary

Hartford Food System

Hartford Foundation for Public Giving

Hartford Healthcare

Hartford Hospital

Health and Wellness Division

Health Justice CT

Health Matters Community Services Administration

Hispanic Health Council

Hospital of Central CT

HRANB Head Start

Human Resource Agency

Immunization Plan

Insight Unlimited, LLC

Institute for Community Research

Internal Medicine, Yale Physician Assistant Program, Yale New Haven

Interpreters and Translators, Inc.

IRIS - Integrated Refugee & Immigrant Services

ISI Translation Services

Johnson Memorial Hospital

Khmer Health Advocates, Inc.

Kingian Nonviolence, Conflict Reconciliation

La Vida Latina Inc., Northwest Caring Connection

Lao Association of CT

Latino Community Health Services, Inc.

Lawrence and Memorial Hospital

Ledge Light Health District

Legislative Offices

Leukemia & Lymphoma Society

Love Makes a Family

Lupus Foundation

Mansfield Public Schools

March of Dimes

Mashantucket Pequot Tribal Nation

MATRIX Public Health Solutions, Inc.

Metaphrasis Language and Cultural Solutions, Inc.

Middlesex Hospital

Mijoba Communications

Muhammad Islamic Center Health

Multicultural Affairs Department of Children and Families

Multicultural Education, Title IX, Sexual Harassment, Civil Rights

and Bullying, Department of Education

Muslim Journal Enterprises, Inc.

My Fit Style

NAMI-CT (National Alliance on Mental Illness-CT-Hartford

Nami-CT (National Alliance on Mental Illness-CT- Farmington Valley

National Association for the Advancement of Colored People (NAACP), Bridgeport Branch

National Association of Hispanic Nurses

National Association of Social Workers, CT Chapter

National Kidney Foundation

New Britain Health Dept.

New Horizons Domestic Violence Services

New Opportunities, Inc.

Newington Board of Education

NIH Center for Eliminating Health Disparities Among Latinos, Hispanic Health Council

NIH EXPORT Center for Eliminating Health Disparities among Latinos (CEHDL)

Consumer

North Central Regional Mental Health Board, Inc.

Northwestern CT AHEC

Northwestern CT Community College

Nursing and Community Health Education Dept., William W Backus Hospital

NYSL

Office of the President, Pace University

Patient Care Regulations, CT Hospital Association

Patient Performance Institute

Pediatric Care Center, LLC

Pequot Health Care/PRXN

Performance Edge

Planned Parenthood Southern New England

Prudence Crandall Center

Qualidigm

RED Evaluation and Training/ FLECHAS, Inc.

Rose Ego Center for Health Informatics

Saint Francis Hospital and Medical Center

Saint Joseph College

Saint Joseph College School of Pharmacy

Saint Joseph College, School of Nursing

Saint Savior

Say Hi Translate and Owner Latino Expo

Self-Injury Awareness Network, Inc. (SIAN/CT) c/o APAAC

Sickle Cell Association of American, Southern CT

Social Security Administration

Southeastern Mental Health Authority

Southern CT State University

Southwestern AHEC, Inc.

St. Vincent's Medical Center

Stamford Community Health Center (Optimus Health Care)

SW Area Health Education Center

The Community Foundation for Greater New Haven

The Conference of Churches

The Hispanic Health Council

The Leukemia and Lymphoma Society

The Multicultural Leadership, Inc.

The Parent Academy

The Salvation Army

The William Caspar Graustein Memorial Fund

Three Rivers College

Town of Putnam

Town of Somers Health Department

Transcreating LLC

Trinity Episcopal Church

Truven Health Analytics

Tulane University, New Orleans LA

United Community and Family Services

UCONN Health Center, Dept. of Community Medicine

UCONN Health Center, Graduate Programs in Public Health

UCONN School of Nursing

UCONN School of Pharmacy

UCONN School of Social Work

UCONN School of Social Work, & Chair of the Black Studies Project

UCONN Stamford, Sociology and Women's Studies

UCONN, Storrs

Uncas Health District

United Community and Family Services

Universal Health Care Foundation

University of CT Public Health Program

University of Hartford

VITAS Innovative Hospice Care

Waterbury School System

Wellpath

Wesleyan University, Career Center

William W Backus Hospital

Willimantic Housing Authority

Windham Hospital

Witness Project of CT

Women's Center for Breast Health

Language Link

Yale New Haven Hospital

Yale School of Public Health

Yale School of Medicine

Yale University

Yale University, Program for Recovery and Community Health

Youth Care After Crisis & SBFSP- Negril

Appendix F: OHE SWOT Analysis Results

Connecticut Department of Public Health
Health Equity Staff Retreat
Wednesday, August 20, 2014, 8:30 – 11:30 a.m.

In Attendance: Tiffany Cox, Margaret Hynes, Angela Jimenez, Marijane Mitchell, Alison Stratton

SWOT Analysis (9:30 – 10:30 a.m.)

Question: ***In thinking about our group objective "Championing Health Equity in every day work at DPH," what would you say are our strengths, weaknesses, opportunities, and threats?***

1. **Strengths**
   - ✓ Dedicated, committed staff with a variety of experiences, skill sets, and talents
   - ✓ Expert leadership
   - ✓ State- funded positions to support work
   - ✓ Partial (0.2 FTE) federally funded position to support work
   - ✓ One free DHPE Fellow working (~ 0.5 FTE)
   - ✓ Knowledge re: how to "work" a state agency, overcome bureaucratic hurdles
   - ✓ Agency climate focused on Public Health Accreditation
   - ✓ Strong, supportive internal group networks across the agency
   - ✓ Individual health equity champions across DPH
   - ✓ DPH Administration that is supportive

2. **Weaknesses**
   - ✓ Insufficient funding (and staff) to accomplish large goals
   - ✓ Bureaucracy (various systems, e.g., contracts process can be an impediment to our work)
   - ✓ Internal groups that create obstacles (e.g., in implementing CLAS language access standards)
   - ✓ Lack of coordinated agency messaging and communications with the public
   - ✓ Data and surveillance of health disparities are fragmented and not integrated throughout the agency
   - ✓ Technology does not always work as needed
   - ✓ Inadequate communication, (e.g., failure to share important information across the agency)
   - ✓ Failure to keep up with larger trends in Public Health (e.g., use of social media to communicate message)

3. Opportunities

- ✓ Current political climate (governor, legislature) provides a window of opportunity for health equity
- ✓ Networks and partner organizations, especially CT Multicultural Health Partnership
- ✓ State partner agencies
- ✓ State commissions
- ✓ Regional partners, e.g., Regional Health Equity Council
- ✓ Federal partners (technical assistance, resources, and funding through HHS OMH)

4. Threats

- ✓ Political environment, and consequent agency infrastructure and funding changes
- ✓ Negative public perceptions of state agency workers
- ✓ Federal partners may not always be helpful
- ✓ State agencies that are resistant to CLAS Standards directives and data standardization
- ✓ Lack of data sharing among state agencies
- ✓ Impending staff retirements and no succession plan
- ✓ Inadequate state technology infrastructure to support our work

Appendix G: Workgroup Recommendations—Health Equity Definitions

Workgroup Purpose and Members:

The Health Equity Definitions Workgroup was tasked with defining key concepts describing the relationship between public health and the social environment.

The Health Equity Definitions work group was comprised of the following DPH staff: Federico Amadeo, Suzanne Blancaflor, Nordia Grant, Susan Hewes, Margaret Hynes, Marijane Mitchell, and Alison Stratton. Five meetings were held from September to November 2012 at which key concepts were discussed, relevant readings were exchanged, and definitions were reviewed, revised, and or developed. A series of recommendations were also generated.

The workgroup proposed the following definitions:

Health Disparities

"…the differences in disease risk, incidence, prevalence, morbidity, and mortality and other adverse conditions, such as unequal access to quality health care, that exist among specific population groups in Connecticut. Population groups may be based on race, ethnicity, age, gender, socioeconomic position, immigrant status, sexual minority status, language, disability, homelessness, mental illness, and geographical area of residence. Specifically, health disparities refer to those avoidable differences in health that result from cumulative social disadvantage."[§] (Adapted from Stratton A, Hynes MM, and Nepaul A (2007) ***Defining Health Disparities.*** Hartford, CT: Connecticut Department of Public Health).

Health Equity

"Equity in health refers to how uniformly services, opportunities and access are distributed across groups and places, according to the population group. Equity in health implies that ideally everyone could attain their full health potential and that no one should be disadvantaged from achieving this potential because of their social position or other socially determined circumstance. Efforts to promote social equity in health are therefore aimed at creating opportunities and removing barriers to achieving the health potential of all people. It involves the fair distribution of resources needed for health, fair access to the opportunities available, and fairness in the support offered to people when ill" (Adapted from the WHO).

Social Determinants of Health

[§] Connecticut Department of Public Health (2012) *Health Equity Policy Statement*. Hartford, CT: Connecticut Department of Public Health. Available at: http://www.ct.gov/dph/lib/dph/hisr/pdf/Health_Equity_Policy_Statement.pdf

“The social determinants of health are the conditions in which people are born, grow, live, work, age and die, including the health system. These circumstances are shaped by the distribution of money, power, and other resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between communities.” (Adapted from the WHO Commission on Social Determinants of Health).[**]

Health Disparities Populations

Various terms are used in the public health literature to describe populations that experience “health disparities”, such as: “socially disadvantaged,” “vulnerable,” “at risk,” “priority,” and “target.” These terms convey slightly different meanings and one term may be more appropriate than others in any given context. No one term is recommended for use by this work group.

- *Socially disadvantaged* groups are described as those “who have persistently experienced social disadvantage or discrimination…and systematically experience worse health or greater health risks than more advantaged social groups…” while *socially advantaged* refers to a group’s relatively high “…position in a social hierarchy determined by wealth, power, and/or prestige” (Braveman, 2006).

  The terms “socially disadvantaged” and “socially advantaged” appear to communicate important, nuanced information vis à vis health and relative position in the social hierarchy. Our group agrees that these are two terms that well describe societal underpinnings/structures leading to unequal health outcomes, and are appropriate for use in surveillance reports and other documents that contextualize health disparities within a given social environment.

- *Vulnerable populations* have been described by the Urban Institute Health Policy Center as those that are “not well integrated into the health care system because of cultural, economic, geographic, or health characteristics.” UIHPC furthermore notes that “This isolation puts members of these groups at risk for not obtaining necessary medical care, and thus constitutes a potential threat to their health. Commonly cited examples of vulnerable populations include racial and ethnic minorities, the rural and urban poor, undocumented immigrants, and people with disabilities or multiple chronic conditions” (Urban Institute Health Policy Center 2010).

  Some advocates have suggested that the term “vulnerable” populations, may connote levels of disempowerment, frailty, and/or “not being well,” and as such may not be an appropriate way to characterize all health disparities populations. While this work group recognizes the sensitivity of and nuances surrounding this issue, we agreed that there may be some instances in which “vulnerable population” is an

[**] WHO Commission on Social Determinants of Health. Available at: http://www.who.int/social_determinants/en/

appropriate term – for example, in discussing the frail elderly, youth under 18, rural communities, or undocumented persons without access to care. This is an important consideration when determining the content and the audience for a particular DPH communication and should be used carefully.

The terms “at-risk,” “priority,” and “target” population have been used by federal agencies and funders, and as such, DPH programs may choose to use these terms for purposes of consistency.

- *At risk* is a commonly used term in public health to describe the high probability of an unfavorable health outcome due to an identified exposure. Similarly “risk group” is a term that is used very frequently in the environmental health arena and in epidemiological investigations. It has also been incorporated into the chronic disease literature.

- *Priority* refers to preceding others in terms of rank or need; and this may be an appropriate term for DPH plans (and reports) that set health priorities for the agency (e.g., Healthy Connecticut, which will be the state health improvement plan).

- *Target* population refers to a population of interest, and is commonly used in the field of marketing. The term does not have any other additional “health-related” connotations about the population.

References

Braveman, P. 2006. Health Disparities and Health Equity: Concepts and Measurement. Annual Review of Public Health 27:167-94. Available at: http://www.ops.org.bo/textocompleto/riarph270004.pdf

Urban Institute, Health Policy Center. 2010. Vulnerable Populations. Washington, DC: Urban Institute, Health Policy Center. Available at: http://www.urban.org/center/hpc/index.cfm

Recommendations

Following are recommendations to DPH Leadership from the Health Equity Definitions Workgroup:

1. **Include these definitions in all plans and surveillance reports published by DPH.** The DPH definitions of health equity, health disparities, the social determinants of health, and disparities populations should be included in DPH plans and reports in either the narrative section or else as part of a glossary section. This will promote consistency in usage of important concepts across the agency.

2. **Create issue briefs on cross-cutting topics, such as homelessness and health, which emphasize an integrated approach to pressing public health concerns.** The leadership for this activity, initially at least, should come from the Health Equity Research, Evaluation and Policy Initiative, in consultation with other DPH programs as appropriate.

3. **Coordinate cross-cutting issues (e.g., housing) that impact health across programs through the DPH webpage/webmaster**.
   The leadership for this activity, initially at least, should come from the Health Equity Research, Evaluation and Policy Initiative, in consultation with other DPH programs as appropriate.

4. **Reconsider the name and mission statement of the DPH Office of Multicultural Health so that it is aligned with current agency strategic planning efforts regarding health equity.**
   The concept of multiculturalism has been used in both Europe and the United States to describe the increased recognition and appreciation of cultural diversity and ethnic heterogeneity as a societal good. A long-standing criticism of this concept is that it does not recognize or acknowledge the underlying social and economic structures in place that are the basis of widespread inequality, which lead to health disparities. A fuller appreciation of cultural diversity alone will not sufficiently address structures and institutions responsible for social and economic inequality and subsequently health disparities. “Health equity” embodies the principle of health as a human right and social good, and it is consistent with DPH strategic planning efforts as well as other statewide initiatives.

Appendix H: Workgroup Recommendations—Health Equity Data and Surveillance

Workgroup Purpose and Members

The Health Equity Data Surveillance workgroup was responsible for providing recommendations for integrating an equity lens into DPH data collection and surveillance practices. Members included Federico Amadeo, Chris Andresen, Nordia Grant, Susan Hewes, Margaret Hynes, Cathryn Phillips, Robin Tousey-Ayers, and Susan Logan.

Recommendations

1. **Programs should develop a baseline description with a plan to reach compliance for data not currently in compliance indicating what resources are needed** so that all DPH databases comply with the *Connecticut Department of Public Health Policy on Collecting Sociodemographic Data, September 2008,* as well as federal standards.[††]

2. **DPH staff should keep in mind several key factors when reviewing data to collect and consider in planning programs.** These factors include: the social determinants of health and which socio-demographic variables have been reported in the literature as being most closely related to the program involved, training for data collectors, and current system limitations and expense.

3. **DPH should work towards linking DPH datasets such as birth and death, infectious, chronic diseases and environmental data to enhance understanding of our population and associations between variables.** As a first step the chronic disease epidemiology and surveillance group should explore what data sets are currently linked, where linkage of public health databases would likely benefit public health, and what are the impediments working against such linkages.

4. **The chronic disease epidemiology and surveillance group should encourage current efforts and consider additional ways to share knowledge within the department** such as a SAS book of common codes for epidemiologists to use, and reworked census data with social determinant focus which also considers the need for bridged data to reconcile changes in definitions between programs and over time.

[††] See DPH *Policy on Collecting Sociodemographic Data* http://www.ct.gov/dph/lib/dph/multicultural_health/collecting_sociodemographic_data.pdf. Federal standards that are applicable may a) vary somewhat between DPH programs, and b) be subject to change over time, so this is not a one-time exercise. Common standards include: *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity* (Office of Management and Budget [OMB] 1997 http://www.whitehouse.gov/omb/fedreg_1997standards/, and Section 4302 of the Affordable Care Act. See the Shared drive under "Health Equity" for more on these and other documents.

5. **Continued iterations of *The Connecticut Health Database Compendium* (2010, 2012) are encouraged.** *The Compendium* provides up-to-date descriptions of DPH databases, associated contacts, related publications and web pages. It has been a valuable reference tool for DPH staff and statewide partners; in fact, the "Improving Data" work groups of the Strategic Mapping Initiative spent considerable time reviewing the Compendium as a key DPH data resource.

Appendix I: Workgroup Recommendations—CLAS Standards

Workgroup Purpose and Members

The "CLAS Standards" workgroup, was responsible for reviewing and compiling information about the *National Standards for Culturally and Linguistically Appropriate Services in Health Care* (CLAS Standards) promulgated by the U.S. Department of Health and Human Services' (DHHS) Office of Minority Health in March 2001.

Work for the subcommittee took place from September 13, 2012 to December 7, 2012. The members of the subcommittee included: Alison Stratton (Chair), Salina Hargrove, JoAnn Ettienne-Modeste, Robin Tousey-Ayers, Marijane Mitchell, and Angela Jimenez.

This subcommittee agreed to focus work on: 1) Understanding, reviewing and compiling information about CLAS Standards 4-7, and 2) internal DPH CLAS initiatives and staff knowledge of CLAS Standards, as consistent with DPH Strategic Planning efforts. By integrating CLAS Standards into DPH's own systems, processes, actions, and policies, DPH will set an example of how it expects contractors, local health departments and providers to behave relative to the CLAS Standards, and health equity more generally.

Recommendations:

The subcommittee's recommendations for future DPH action to promote the CLAS Standards regarding linguistic access to health services may be grouped thematically. Issues regarding both *interpretation* (spoken or signed communication) and *translation* (written communication) are reflected below.

1. **Commissioner Statement Prioritizing CLAS Standards/Designation of a DPH CLAS Standards/LEP Issues Guru/ Establish LEP Issues Community Advisory Group:**
    a. Recommend that the DPH Commissioner issue a statement to all DPH employees emphasizing that awareness of and adherence to the CLAS Standards (especially regarding the mandated language access standards) are priorities for the agency.
    b. Designate and fund a CLAS/LEP Issues Guru, located in the DPH Office of Multicultural Health who would spearhead/coordinate DPH internal efforts as well as oversee the public face of DPH regarding linguistic access to DPH services.
    c. Require workforce development and training of all DPH staff about their own responsibilities regarding language access to health services. Send out reminder emails about internal DPH expertise and key people for language access issues.
    d. Create a Community Advisory Group that will assist DPH in its efforts to promote CLAS Standards and access for persons with LEP.

2. **Using the "four-factor analysis" tool promulgated by DHHS (Federal Register 2003), all DPH programs should conduct inventories of:**
    a. All service populations reached by the program.
    b. All languages spoken by the service population.
    c. Frequency of interaction with members of the service population, and their preferred languages.
    d. All materials written and distributed in oral, written, or electronic format, and the languages into which they are/have been translated.
    e. All DPH materials put into the public domain, with assessment of translation needs.
3. **Database Update: Federal law and DPH policy present opportunities to collect language data. Some DPH programs have already expanded possibilities of collecting complex language data.**
    a. At a minimum, all DPH databases should follow the federal OMB categories and the data collection parameters for primary language mentioned in Section 4302 of the Affordable Care Act.
    b. Further, all DPH databases should try to use the expanded/ideal parameters for language data collection as promulgated and approved in the *DPH Policy on Collecting Sociodemographic Data* (2008).
    c. All data collection instruments and databases should incorporate the option of "Other language, please specify".
4. **Public Face of DPH regarding Access to DPH services for persons with LEP:**
    a. Designate and fund a DPH Webmaster who would ensure consistency and cross-linkage of CLAS Standards efforts and websites, and translated materials nationwide and at DPH.
    b. DPH 8000 Line: Increase training for all operators or hire bilingual operators [currently contracted with Easter Seals – need more polished/CLAS – competent training].
    c. Revamp all entrance areas to DPH: include signage in those languages identified as the most-encountered languages at DPH.
    d. Review effects of the only bilingual signage being a warning about weapons.
    e. Train security guards as appropriate – Ensure that security personnel receive updated DPH staff directories.
    f. Ensure the completion of revisions to the DPH Office of Multicultural Health website.
    g. Investigate the possibility of partnering with the State Department of Higher Education in order to pursue proper educational and administrative structures by which to ensure professionally-trained and certified/ licensed medical interpreters.

h. Post the CLAS Standards and supporting documents on the main page of the DPH website.
i. All DPH programs should cross-link to the federal and state CLAS/ LEP web pages.
j. Encourage a public information campaign about CLAS Standards responsibilities and benefits.

5. **Translation of written documents:**
   a. Encourage a translation contractor to translate all DPH documents. Currently, individual programs at DPH must translate their own documents at their own expense (and often do not, for a variety of reasons). A DPH-wide undertaking would provide consistency and capacity.
   b. DPH programs should create documents in Plain English and/or incorporate picture language as basis for all documents. These can then be translated and back-translated to ensure clarity and consistency of messaging.
6. **Coordination of work among various DPH committees/initiatives already working on promoting health equity in everyday work.**
   a. Committees or staff involved in: Quality Improvement; Workforce Development; Workforce Training; Emergency Preparedness; Communications.
7. **Ensure Language Line (or other telephonic interpretation) contracts:**
   a. For all DPH programs that interact with persons with LEP, and train DPH staff how to use telephonic interpretation.

References and selected resources

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Appendix J: Workgroup Recommendations—Health Equity Workforce Training

Workgroup Purpose and Members

The Health Equity Workforce Training workgroup was created to develop recommendations for training staff on health equity concepts and their application in DPH policies and programs. The workgroup included: Errol Roberts (convener), Margaret Hynes, Marijane Mitchell, Suzanne Blancaflor, Marc Camardo, Nordia Grant, Kathryn Shuttleworth, Amanda Anduaga-Roberson, Angela Jimenez, and Kristen Day. The subcommittee convened on September 19 and came to a close in December after gathering enough information to be presented as recommendations. Areas of discussion included:

- Identifying staff training opportunities:
  - In house available staff training resources
  - Resources outside of DPH, National and local organizations that advocate cultural competency
  - Other recommended material resources
  - Human resource, certified trainers, a Speakers Bureau

- Training application and sustaining the process:
  - Facilitation, how to create interest amongst staff
  - Curriculum design, content, format
  - Conversation moving/discussions to fill in the gaps
  - Sustaining the training

In addition to the members of the staff training subcommittee contribution we had focused group meetings with the attendees from the film and discussion series on the social determinants of health – *Unnatural Causes: Is Inequality Making Us Sick?* as well as *Race: The Power of an Illusion*. A series of questions were asked about the film series/trainings and the responses were collected and added to the findings from the subcommittee.

Recommended Health Equity Resources

1. In-House Available Staff Training Resources

- *Race: The Power of an Illusion*, a 3-part film series that examines the historical and social construction of race in American society,describes the difference between social and biological views of race, and the origin and basis of the race construct in U.S. society. The film gives examples of how federal housing policies institutionalized segregation and wealth disparities.

- *Unnatural Causes: Is Inequality Making Us Sick*, a 7-part film and discussion series that address the root causes of socioeconomic and racial inequalities in U.S. health

through the following objectives:. 1. Increase awareness and understanding of the social and economic influences on health. 2. Promote an understanding of ways that disempowerment and race and class structures can 'get under the skin' and influence health status. 3. Move discussions of public health "upstream" beyond individual factors to underlying social conditions that influence health outcomes. 4. Illustrate and discuss the influence of social policies on public health.

- Multicultural Training curriculum through the Dept. of Mental Health and Addiction Services (DMHAS) cultural competence and training.

- Stir Fry Films, Lee Mun Wah, *Last Chance for Eden*, a three-part documentary on sexism and racism. *The Color of Fear* is a film about the state of race relations in America as seen through the eyes of eight North American men of Asian, European, Latino and African descent.

- A Class Divided Film & Study Guide, a PBS Video about an innovative teachers' (Jane Elliot) 1970 daring experiment in her elementary school classroom to evaluate how racial stereotypes effect young children. This program presents the long-term effects of racial stereotyping.

2. Resources Outside of the Department, National and Local Organization that Advocates Cultural Competency

- Peace Skills: Manual for Community Mediators, The National Conference for Community and Justice (NCCJ), Healing Racism-Facilitated Dialogue. NCCJ is a human relations organization dedicated to fighting bias, bigotry and racism in America. NCCJ promotes understanding and respect among all races, religions and cultures through advocacy, conflict resolution and education.

- The Connecticut Women's Consortium is an independent nonprofit agency in Hamden with a history of strong collaborations with many of Connecticut's community, academic and health care institutions on issues of women's mental health, substance use disorders, addiction, domestic violence and trauma. The Connecticut Women's Consortium provides trainings, advocacy and policy for caregivers and service providers in the behavioral health field.

- Fenway Health - The Network for LGBT Health Equity is community-driven network of advocates and professionals looking to enhance LGBT health by eliminating tobacco use, and enhancing diet and exercise. The Network is one of six CDC-funded tobacco disparity networks and a project of The Fenway Institute in Boston. It directly trains state health departments or other policymakers in LGBT cultural competency and forge bridges between them and local LGBT health specialists. It actively monitors national and state health policymakers and urge community action when there is an opportunity to enhance LGBT wellness.

- National Latino Tobacco Control Network is an open information and support system for tobacco control and health disparities advocates and experts who want to become more effective in changing policies and social norms around tobacco control through exchange of information and personal and institutional linkages. It is one of six CDC-funded tobacco disparity networks.

- CommuniCare Community Behavioral Health System (CCI) is a unique collaborative organization formed 15 years ago to promote high quality, cost effective, community based behavioral related services. A 501©(3) non-profit organization and its member agencies are licensed and accredited community based agencies established as Local Mental health Authorities (LMHAs), offering a comprehensive range of psychiatric and substance abuse services. Each agency provides community clinical, rehabilitative and support services for people with serious mental illnesses and substance abuse disorders in the towns they serve.

- The Multicultural Leadership Institute, Inc. (MLI Inc.) is a private, non-profit 501(c)(3) corporation that was established in 1997. Its mission is to provide leadership for positive change through implementing and coordinating multicultural and diversity awareness, education, advocacy and research programs.

- National African American Tobacco Prevention Network (NAATPN) is one of six CDC funded networks that engages national and statewide partners by providing technical assistance in tobacco control and prevention activities. In its role, NAATPN maintains and strengthens its national network by: educating and sharing information about tobacco's history, facts, and prevalence, assessing the impact of tobacco within disparate populations, and identifying gaps in data, interventions and/or research involving African Americans and tobacco use. NAATPN's National Network is open to any individual or organization that is willing to assist in decreasing the impact of tobacco in Black communities.

3. Other Recommended Material Resources

- NACCHO Roots of Health Inequity, a web-based course for the public health workforce. It also serves as an online learning collaborative to address systemic differences in health and wellness that are, actionable, unfair, and unjust.

4. Human Resources, Certified Trainers and a Speakers Bureau

- State of Connecticut Train the Trainer Certificate Program provides our workforce with the necessary knowledge and skills to deliver effective training that transfers smoothly to the work environment. Since the start of the Train-the-Trainer Certificate Program there have been several DPH employees who have gone through the program and can be assets to in-house trainings. By forming a Speakers Bureau, DPH can create a list of speakers we can call on that lists each trainer skill set and availability. **Facilitation, How to Create Interest Amongst**

Staff

- A comprehensive agency plan for staff training in public health should be developed, and health equity should be incorporated into this overall plan. For example, DPH should offer courses such as Public Health 101 and Health Equity 101, and where possible offer continuing education credits for completion of these basic courses.

- Health Equity 101 training should be mandatory for the DPH workforce. Health inequity is at the root of many public health problems, and so principles of health equity are essential knowledge for all staff.

- Managers' support for Health Equity staff training is crucial and managers should participate and support their staffs' involvement in training by including staff training as part of their PARS.

5. Curriculum Design, Content, Format

- Many DPH employees do not know what health equity is, and may be confused by related concepts and terms such as health disparities. Before each discussion, defining health equity and discussing several different social determinants of health can help prepare the attendees for a clearer and more focused discourse.

- Developing two tracks, Health Equity 102 for those who have strong academic background /experience in public health and Health Equity 101 track for those with little to no public health experience/education, to better engage and challenge the attendees ensuring better participation.

- To help gauge a person's thinking before and after the training, a pre and posttest should be administered for the benefit of the attendee's awareness of their progress.

- Using multiple formats of delivery such as the DAS course offerings, Webinars, Guest lectures, CT-Train and On-line trainings, the scope of health equity trainings can serve employees both inside and outside of DPH. This training can reach our sister organizations, local health departments, hospitals and other health care institutions with an interest in culturally competent care. Building a curriculum to be used outside of DPH should ultimately be the goal.

6. Conversation Moving / Discussions that Fill in the Gaps

- The State of Connecticut Train-the-Trainer Certificate Program provides our workforce the necessary knowledge and skill sets to deliver effective training that transfers smoothly to the work environment. Certified facilitators are able to manage and bring out discussions especially in some of the more sensitive subject matters.

- We recommend a co-facilitator that can offer a different perspective. With that second facilitator attendees may share a perspective that may otherwise be overlooked and / or underrepresented and having this may broaden perspectives which can encourage further participation.

- We have found as with the film series / trainings that having small groups and a nice blend from different programs allows for better interaction between the attendees. Attendees can go back to their programs and share what they have learned to increase the effectiveness of the training.

7. Sustaining the Training

- To embed Health Equity principles in the Department's culture, these trainings should be an on-going year-to-year practice. Annual and follow up trainings assure that the new lessons/skills sets learned are being applied appropriately.

- •Using multiple means of sending Health Equity messages to the Department employees will preserve a greater awareness of the new practices learnt. Some creative ways of getting the message across may include: having payroll inserts and display banners for program events and posters for information boards throughout DPH. Using personal stories from staff that show how health equity has benefited them and the need for further trainings can increase fellow employees buy-in.

Appendix K: Workgroup Recommendations—Health Equity Partnerships

Workgroup Purpose and Members

As part of the DPH Strategic Mapping process, the Health Equity Partnerships Workgroup identified potential partners in relation to the DPH priority populations. These priority populations may be based on: race, ethnicity, age, gender, socioeconomic position, immigrant status, sexual minority status, language, disability, homelessness, mental illness, and geographical area of residence.[‡‡]

The Health Equity Partnerships work group was comprised of the following DPH staff: Kim Burkes, Salina Hargrove (convener), Margaret Hynes, and Angela Jimenez. Our work group reached out to other DPH "Partnership" working groups including the SHA/SHIP (Olga Armah and Suzanne Blancaflor), Connecticut Multicultural Health Partners (Angela Jimenez), and Coordinated Chronic Disease (Eileen Boulay) to coordinate our mutual efforts. Three meetings were held from September to November 2012 at which partnership lists, formats for these lists, and recommendations were discussed. A series of recommendations for DPH Leadership were also generated.

Recommendations

1. **The DPH Partnership Master List should be housed and maintained in one central office, possibly the DPH Office of Communications**. We also recommend that the Master List be put into an ACCESS database. An ad hoc DPH Partnership group should be convened to determine the details on maintaining this Master List.

2. **The Health Equity Partnership list should be maintained by the staff in the DPH Health Equity Initiative**. Updates will be sent to the Agency Partnership List as appropriate. The Health Equity Partnership list will be shared with other DPH staff and programs, for use when DPH advisory groups and committees are being formed. Health Equity staff will market the Health Equity Partnership list as a resource for DPH programs seeking diverse consumer representation.

3. **While DPH has active, engaged "Health Equity" partners, new partners representing our priority populations - race, ethnicity, age, gender, socioeconomic position, immigrant status, sexual minority status, language, disability, homelessness, mental illness, and geographic area of residence – should be engaged in the following ways**: a) Identify and develop expert staff within DPH with some knowledge of the community to help engage potential partners. A more personal approach can be helpful in engaging potential partners who may not be

[‡‡] Connecticut Department of Public Health (2012) Health Equity Policy Statement. Hartford, CT: Connecticut Department of Public Health. http://www.ct.gov/dph/lib/dph/hisr/pdf/Health_Equity_Policy_Statement.pdf

familiar with DPH mission and work; and b) DPH staff should communicate the benefits of partnership, and how can this help the community.

4. **DPH "Partnership" briefing documents should be developed and distributed in consultation with the Communications Office,** including: a) A Partnership Fact Sheet; b) Agency Guideline for building partnerships; and c) A press release.

Appendix L: Public Health Systems Improvement Unit (PHSI) and the Public Health Strategic Team (PHST) Roles and Responsibilities

Public Health Systems Improvement (PHSI)

The Public Health Systems Improvement (PHSI) unit is responsible for directing, managing, and coordinating all, strategic planning, public health improvement planning, quality improvement and performance management and public health accreditation efforts for the department. The unit is staffed by a full-time manager, full-time contracts administrator, full-time administrative assistant, full-time senior planning analyst, full-time performance improvement manager, and .75 FTE epidemiologist.

Responsibilities:

- Provide staff support to the Public Health Strategic Team (PHST) and the Quality Improvement (QI) Council.
- Provide technical assistance to QI Teams and DPH staff carrying out quality improvement initiatives.
- Coordinate and/or provide training on quality improvement tools and methods.
- Coordinate and monitor strategic planning and implementation.
- Coordinate and monitor State Health Improvement Planning and implementation.
- Coordinate all accreditation planning and activities.
- Develop and monitor the performance management system.
- Manage a performance management IT application.
- Assist DPH staff and programs in the development and monitoring of performance measures.
- Develop, monitor, implement, and update the agency quality plan.
- Develop and assist in the implementation of a systematic process to assess and improve internal and external customer satisfaction.
- Assist in the development of a workforce development plan.

Public Health Strategic Team (PHST)

The Public Health Strategic Team leads and assures the alignment of all major planning and strategic initiatives including: organizational Strategic Planning, State Health Assessment, State Health Improvement Planning, accreditation, and performance management to maintain and improve the health of the population of Connecticut. The PHST is comprised of senior leadership and strategic thinkers recruited and assigned to the team from across DPH. The inclusion of staff from across DPH promotes buy-in and diffusion of planning efforts throughout the organization. The team shall be comprised of 15-20 members.

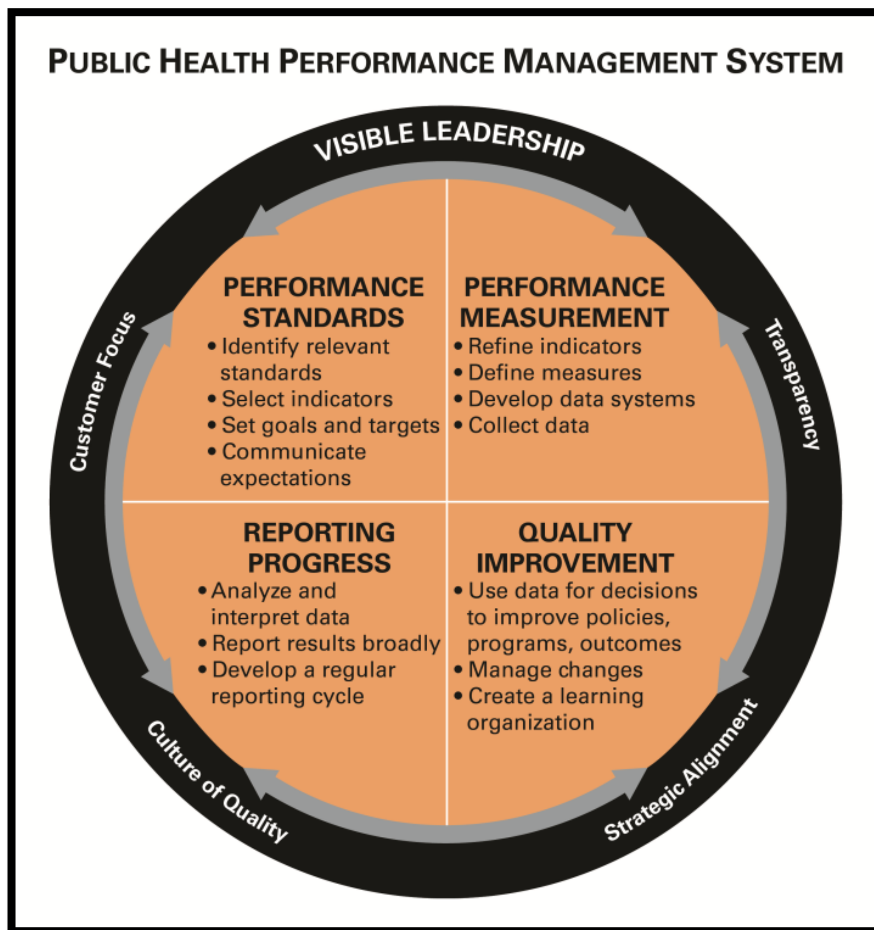
Responsibilities:

- Identify State Health Improvement Plan priorities to be addressed by DPH.
- Support implementation and monitor achievement of DPH priorities determined through the Strategic Plan and State Health Improvement Plan.
- Promote the use of data to drive decision-making and to plan and monitor programs
- Promote the use of evidenced based practices and/or promising practices across the department.
- Initiate and oversee quality improvement projects that address Department level priorities.
- Promote a culture of quality throughout the organization by serving as role models, creating and communicating performance expectations, encouraging training, and empowering staff to make necessary changes to improve quality.
- Consider strategic and health improvement priorities identified through strategic initiatives when making budgetary and policy decisions.
- Provide leadership and support DPH staff to carry out requirements to achieve accreditation.
- Monitor implementation of the Quality Plan and make recommendations for change.
- Advise the development of the Performance Management IT system and promote its use.
- Advise the development of future State Health Assessments and monitor data over time.

Appendix M: Turning Point Performance Management Framework Details

The DPH has adopted the Turning Point Performance Management framework as the underpinning for performance improvement work in the department. This framework was developed by the Turning Point Performance Management National Excellence Collaborative in 2004 and has been adopted widely by public health practitioners around the country. [§§] The framework, updated by the Public Health Foundation in 2013, is organized around each of the four components of a performance management system including: 1) Performance Standards, 2) Performance Measurement, 3) Reporting of Progress, and 4) Quality Improvement. See **Figure A**.

Figure A: Turning Point Performance Management System Framework, Updated by the Public Health Foundation, 2013



[§§] From Silos to Systems: *Using Performance Management to Improve the Public's Health*, prepared by the Public Health Foundation for the Turning Point Performance Management Excellence Collaborative, 2003.

This performance management framework also aligns with the Quality Trilogy approach to managing for quality created by JM Juran. [***] The trilogy consists of three processes: quality planning, quality control and quality improvement and was designed for business and manufacturing.

This trilogy can be easily adapted and applied to public health.

- **Quality planning** includes determining the customer or population's needs, developing programs or services that meet their needs, establishing goals to meet the needs, and using evidenced based or proven processes that can work under the existing conditions.
- **Quality control** essentially combines performance standards and measurement to assure that we are setting standards and measuring and monitoring performance to know when we are not meeting targets.
- **Quality improvement** is acting when we are not meeting targets by looking for causes, using quality improvement methods to make changes and assuring that the changes are making a difference. While this trilogy and the performance management model are consistent with sound public health practice, the field of public health has only recently begun to manage for quality consistently and deliberately.

[***] Juran, JM, The Quality Trilogy: A Universal Approach to Managing for Quality. Presented at the ASCQC 40th Annual Quality Congress in Anaheim, California, May 20, 1986. Available from: pages.stern.nyu.edu/~djuran/trilogy1.doc