

The Health Equity Initiative at MCHD

Introduction

In July of 2007, the Multnomah County Health Department (MCHD) in Portland, Oregon, launched its Health Equity Initiative (HEI). The purpose of the HEI is to raise awareness about racial and ethnic health inequities and advance policy solutions to address their underlying causes. In many ways, the HEI represents a bold new departure for MCHD. In other ways, MCHD's HEI is rooted in philosophies and approaches that have guided MCHD's work for many years.

Previous Efforts to Address Health Inequities

Multnomah County is the largest and most diverse county in Oregon. While it does not possess the extremes of wealth and poverty or the racial/ethnic diversity characteristic of other metropolitan areas, Multnomah County does possess systematic health inequities that cut along racial/ethnic and socioeconomic lines. Historically, MCHD has sought to respond to these inequities in a variety of ways.

In 1998, in response to higher rates of infant mortality and low birth weight among African American women, MCHD launched its Healthy Birth Initiative (HBI). HBI's Community Health Workers (CHWs) and Community Health Nurses (CHNs) work with women and their families to increase the likelihood that African American women will have healthy births. A crucial aspect of HBI is its Community Consortium, which engages the community members most affected by this health inequity in identifying causes and developing solutions.

Responding to the fact that poor children in Multnomah County are at increased risk for asthma, in 2005 MCHD implemented its Healthy Homes Project. A multidisciplinary team composed of a CHN and CHWs works with families to identify and abate asthma triggers. This program has produced documented cost savings by reducing ER and hospital visits. Today this work is supplemented by policy analysis, contained in reports like the 2009 "Health Impacts of Housing in Multnomah County" (<http://www.co.multnomah.or.us/health/hra/reports.shtml>)

At the same time that MCHD was launching programs aimed at reducing particular health inequities, it was also focusing on developing community capacity to address and resolve health inequities. In the late 1990s, MCHD began to use strategies such as popular education, the Community Health Worker model, and community-based participatory research (CBPR) to foster the individual and community empowerment which is a prerequisite to communities becoming actively involved in policy development. Thus, when the HEI was launched in 2007, it was able to build on an existing foundation of knowledge and experience at MCHD.

Getting Equity on the Civic Agenda

A number of factors allowed MCHD staff to move health inequities onto the policy agenda in 2007. A series of reports produced by MCHD's Health Assessment and Evaluation Unit had raised awareness about health inequities across the community. Support from incoming County Chair Ted Wheeler was crucial. The documentary series, *Unnatural Causes: Is Inequality*

Making Us Sick? provided a tool to take the conversation to libraries, businesses, environmental organizations, local foundations, and academic settings. Approximately 500 people viewed screenings of *Unnatural Causes* and participated in community discussions. By identifying a clear and simple goal -- “Put Equity on the Civic Agenda” -- the department was able to shift resources to this issue, including staff who volunteered to facilitate and record these sessions. (The full report and appendices are accessible online at <http://www.mchealth.org/healthequity>.)

HEI Mission, Values, and Assumptions

The mission of the HEI is to eliminate the root causes of social injustice that lead to racial and ethnic health inequities. We aspire to change the way we do business and to work to decrease the gap in population health outcomes. Participating with partners in transportation, planning, and housing to frame policy and facilitate policy discussions is an essential part of the work. Equally vital is to create venues in which community members can hold discussions with decision-makers.

Guiding values include honesty, inclusion, integrity, and justice. Key assumptions include an acknowledgement of the connections between health inequities and economic and educational attainment, and the belief that to eliminate health inequities, it is necessary to identify and address institutionalized discrimination and establish trust in policy, planning, and practice.

Health Equity in Our Daily Work: Continuity and Change

How has the implementation of the HEI impacted day to day work at MCHD? In at least two areas, it has strengthened the rationale for efforts that were already underway. At the time the HEI began, MCHD was involved in a succession planning effort that emphasized increasing workforce diversity. For many years, particular programs within MCHD have sought to hire from the communities most affected by given health issues. The philosophy of health equity affirms the importance of these hiring practices, which improve the fit and quality of our services while increasing family-wage jobs in underserved communities.

Growing understanding about the prerequisites for equity has reinforced our efforts at community engagement, which we see as a continuum of approaches to assure that those most affected by health inequities are meaningfully involved in their solution. At one school in Portland, staff from MCHD conducted a Photovoice project as a way of engaging low-income, Latino parents in the identification of health issues and the creation of policy recommendations. With seed funding from NACCHO, MCHD brought together leaders from the disability community with public health leaders to create an agenda for improving health in the disability community. Informed by popular education philosophy, our community engagement efforts seek to empower communities to analyze the root causes of health inequities and work together for change.

MCHD leaders have always been vocal advocates for the public’s health with local and state decision-makers. Addressing the social conditions that cause inequities has required MCHD

leaders to build strong relationships with elected officials so that they, too, become advocates. One example of the success of these efforts is a recent letter sent to all County employees by the County Chair. In that letter, the Chair stated that new programs will be required to assess their impact on equity. To facilitate this assessment, the Health Department is developing an *Equity and Empowerment Lens*. This tool will help internal and external partners identify the equity consequences of a program or policy. The Health Department will use the tool to inform the decision about where to site a new health clinic in an underserved area of the County.

While leadership support and organizational experience have facilitated the implementation of HEI, integrating equity into our daily work presents numerous challenges. Questions raised include: How do we maintain the focus on equity when organizational resources are stretched by emergencies like the H1N1 pandemic? It can be challenging for MCHD staff to see connections between their day to day work and the focus on health equity, leading to additional questions such as: “What does this equity training have to do with my work?” One solution to this challenge is to show how addressing health inequities ultimately benefits society as whole. Buy-in and support can be obtained by conducting conversations with program staff about how equity work can be tied to current efforts and how it relates to achieving key public health outcomes.

Tackling the Causes, Not Just the Consequences

According to Nina Wallerstein, PhD, Chair of the Public Health Program at the University of New Mexico, the unifying factor among all the adverse social conditions that produce health inequities is powerlessness. Groups that have less power relative to other groups in society are also likely to have poorer health. If lack of power is a risk factor for poor community health, then it stands to reason that by increasing individual and collective power, we can improve health. Teaching all MCHD staff to work in ways that empower our patients, our clients, our communities and one another is one strategy through which we are seeking to address the root causes of health inequities, rather than simply responding to the consequences.

Another way we are seeking to address root causes is by influencing decision-making by other organizations. Our Environmental Health Program has challenged organizations working on the issue of climate change to identify and address the potential health effects of climate change, especially on low-income communities and communities of color. Our city/county metrics for climate mitigation efforts include specific measures for health and equity. Key partners such as the City of Portland, local school districts, and local funders have requested leadership development and policy framing sessions from our HEI staff. Participants explore definitions and data related to health inequities and institutionalized racism and classism, as well as their organization’s role in influencing the social determinants of health. Creating common language and understandings promotes successful policy advocacy and change. To this end, we now produce a quarterly report on social determinants of health. (See a sample report, “The Economy,” at <http://www.co.multnomah.or.us/health/hra/reports.shtml>)

Future Directions and Lessons Learned

Our experience thus far with our HEI has produced a number of lessons. We have learned the importance of closely linking our health equity efforts with our efforts to implement an empowering model of health promotion since, in the words of one staff, **“Health equity is the why and health promotion is the how.”** We’ve realized how crucial it is for staff and managers throughout the Department to understand the purpose of our health equity efforts and how their actions can promote or hinder equity. We have come to appreciate the value of support from elected officials and leaders of business groups, community-based organizations and housing, transportation, and planning agencies. We have also learned that just because executive level leadership is present, we cannot make assumptions. We have to keep equity on the operations table or things can go back to the status quo pretty rapidly.

Concretely, future plans include continued application of the *Equity and Empowerment Lens* countywide and with interested local partners. We will continue to invest in policy advocacy and empowerment training for county employees and community members. We will continue to use our expertise and authority as a local public health department to move government and community partners towards a deeper understanding of the causes of health inequities and a stronger commitment to using their power in ways that promote equity. In this way, we will move closer to our goal of eliminating health inequities by creating a more just and equitable society.

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