Session

Health Administration Roundtable: Health Equity & Public Health Administration

Nadine Nadal-Monforte, MPH, CPH, Community Impact, CHRISTUS Health, Irving, TX 76244

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Abstract

Advancing health equity through engaging with people with lived experience

Katya Seligman, MPH, PMP
Mathematica, Chicago, IL

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It is vital to equitably engage people with lived experience in developing and informing health and human services programs, policies, and research to ensure that they reflect the perspectives and needs of the communities we aim to serve. People with lived experience are those directly affected by social, health, public health, or other issues and by the strategies that aim to address those issues. This gives them insights that can inform and improve research, policies, practices, and programs.

This presentation will highlight guidance from three resources to build the capacity of health administrators and researchers to identify, recruit, and equitably engage with people with lived experience. Developed by the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) in partnership with Mathematica and experts with lived experience, the first resource, “What is Lived Experience?”, describes key elements of lived experience and why engaging people with lived experience is essential to advancing equity. The second resource, “Tips on Engaging Diverse Groups of External Partners”, provides guidance on identifying, recruiting, and building and sustaining productive relationships with people with lived experience. The third resource, “What Does it Look Like to Equitably Engage People with Lived Experience?” describes components of ideal engagements with people with lived experience and can be used to help identify strengths and opportunities for making engagements more equitable.

We will share key insights and tips from these resources as well as real-world examples on how the U.S. Department of Health and Human Services (HHS) Equity Technical Assistance Center is engaging partners with lived experience to help center equity in HHS policies, programs, and research.

Resource links:

https://aspe.hhs.gov/sites/default/files/documents/5840f2f3645ae485c268a2784e1132c5/What-Is-Lived-Experience.pdf

https://aspe.hhs.gov/sites/default/files/documents/934dada0240465383fb5bee435b57395/Tips-Engaging-Diverse-Partners.pdf

https://aspe.hhs.gov/sites/default/files/documents/e2fc155b542946f2bbde9233a33d504d/Equitable-Engagements.pdf

Administration, management, leadership Implementation of health education strategies, interventions and programs Planning of health education strategies, interventions, and programs Public health administration or related administration Public health or related public policy Public health or related research

Abstract

Addressing disparities in healthcare for limited english proficient individuals: Insights and best

practices

Cristina Essola, DPT, MPH
Rehabilitation Hospital of Wisconsin, Milwaukee, WI

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Millions of individuals in the United States self-identify as having limited confidence in English proficiency, posing a significant communication barrier in healthcare settings. Effective communication between patients and providers is crucial for quality care delivery and to avoid detrimental health effects due to miscommunications. While federal law mandates the provision of medical interpreters, challenges to effective communication persist. A review of literature investigates the disparities in care for limited English proficient individuals, identifies intervention barriers, and propose feasible solutions to enhance safety and cost-effectiveness. Interpretation services are commonly improvised or missing, leading to increased hospitalization lengths of stay, health complications, poor medication management, and greater rates of readmission. Furthermore, despite the common use of family members or bilingual staff and interpreter services through telecommunication, research suggests that language concordance among healthcare providers may be more beneficial to positively affect the noted disparities. This synthesis highlights the need for further research to optimize interpreter usage and ensure equitable care delivery.

Assessment of individual and community needs for health education Diversity and culture Public health or related organizational policy, standards, or other guidelines Systems thinking models (conceptual and theoretical models), applications related to public health

Abstract

What will it really take for transformative change? observations from practicing equity work with public health administrators

Benjamin Wood, MPH[1], Kate Holmes, MPH[2], Elena Bengochea[3], Erika Gaitan, MSW[4], Brittany Chen[5], Valerie Polletta[4], Kathleen McCabe, MPA[6] and Meghan Guptill, MPH[6]
(1)Health Resources in Action, Florence, MA, (2)Health Resources in Action, Baton Rouge, LA, (3)Atlanta, GA, (4)Boston, MA, (5)Health Resources in Action, Albany, CA, (6)Health Resources in Action, Boston, MA

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Background: The CDC’s COVID-19 Disparities grant (OT21-2103), a two-year $2.25 Billion initiative, provided public health agencies an opportunity to address critical capacity issues to advance health inequity. As a non-profit, public health institute tasked with providing technical assistance to 2103 recipients, Health Resources in Action (HRiA) had an insider’s view to the challenges health administrators face in implementing their equity focused goals and objectives. The challenges include formal policy constraints both within and outside agency control and engrained cultural norms and practices. Addressing both, from a full systems-change approach, is needed to build better approaches to health equity work that center community, build trust, and create more effective programs.

Methods: HRiA developed three tools that were piloted with and implemented by health administrators and health department staff representing all regions of the country: *Health Equity Readiness Tool*; *Foundations of Community Engagement Toolkit*; *Legal Barriers to Equity Workbook*. These tools seek to 1. Provide systems-level analysis of existing agency practices related to equity, 2. Build capacity of staff to identify internal policies and cultural norms *and* formal external laws and regulations that restrict health equity practice, and 3. Identify actions that increase the ability of public health agencies to build more effective relationships with community to implement public health programs that address inequitable health outcomes.

Results: Public health administrators and HRiA collaboratively used these tools in live and asynchronous trainings and 1:1 coaching sessions to diagnose specific needs. Presenters will share examples of how these tools were used and how identified capacity building opportunities are being embedded in workplans and strategies of recipients of the CDCs Public Health Infrastructure Grant.

Conclusion: Systems change approaches that recognize the role of both internal and external factors are necessary to advance the ability of health administrators to effectively implement health equity initiatives.

Administration, management, leadership Diversity and culture Public health or related organizational policy, standards, or other guidelines Public health or related public policy Systems thinking models (conceptual and theoretical models), applications related to public health

Abstract

Factors associated with public health workforce competencies to advance health equity

Paula Kett, PhD, MPH, RN[1], Shahida Shahrir, PhD, MPH[1], Betty Bekemeier, PhD, MPH, RN, FAAN[2], Danielle Zemmel, MPH[3], Kay Schaffer, MPH[4] and Davis Patterson, PhD[1]
(1)University of Washington, Seattle, WA, (2)Northwest Center for Public Health Practice, Unive, Seattle, WA, (3)Southfield, MI, (4)de Beaumont Foundation, Washington, DC

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Background We examined individual staff and local health department (LHD) characteristics associated with health equity concepts.

Methods: Using the national 2021 Public Health Workforce Interest and Needs Survey (PH WINS) dataset (N=29751), we assessed associations between key factors and staff-reported “knowledge of” and “confidence in addressing” structural racism, health equity, social determinants of equity (SDoE), social determinants of health (SDOH), and environmental justice; also, agreement that addressing racism should be part of their work and whether they are involved in that work. Key factors included staff education, tenure, race/ethnicity, and skills (e.g. cross-sector collaboration, policy advocacy), LHD characteristics (e.g. clinician-led), and county demographics.

Results: Staff with a master’s degree or higher compared with less education reported greater odds of confidence in addressing structural racism (adjusted odds ratio [AOR]=1.23) and health equity (AOR=1.56), agreeing that addressing racism should be a part of their work (AOR=2.45) and being involved in such efforts (AOR=1.57). Black staff compared with White staff reported greater odds of confidence in addressing all concepts: structural racism (AOR=1.98), health equity (AOR=1.34), SDoE (AOR=1.53), SDOH (AOR=1.21), environmental justice (AOR=1.72), and agreeing that addressing racism should be a part of their work (AOR=2.11). Patterns were similar among other staff of color, however, Black (AOR=0.68) and Hispanic/Latino (AOR=0.83) staff reported lower odds of involvement in efforts to address racism. Staff skills like cross-sector collaboration and policy advocacy, as well as clinician-led LHDs, were positively associated with most outcomes.

Conclusions: Findings suggest the need for more targeted workforce development, including designing training which involves explicitly naming structural racism’s effects, application of health equity concepts, skill development in policy advocacy, and measurements to evaluate success. Future research should explore ways to effectively motivate white staff to accept responsibility as public health practitioners to address racism and support staff of color in health equity work.

Administration, management, leadership Public health or related organizational policy, standards, or other guidelines Public health or related research

Abstract

Health equity in practice: Hair care equity at the university of Vermont health network -

Vanessa Rose[1] and Kristin Fontaine, MPH[2]
(1)University of Vermont Medical Center, Burlington, VT, (2)University of Vermont Health Network, Burlington,

VT

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Hair care equity projects are not new, however implementing one at a medical center in a rural, predominately white state offered some unique challenges and opportunities. Building on a model from Nationwide Children's Hospital, this employee-led initiative navigated systemic racism, lack of funding supporting equity work, and the challenges of navigating a large, bureaucracy. Through a process of deep learning, and relationship building, the Hair Care Equity Project was launched at the University of Vermont Medical Center in Summer 2023.

While Vermont is the third whitest state in the US, there is growing racial and ethnic diversity. Although race or ethnicity alone do not determine hair type, straight hair is more dominate among white populations. With the majority of our providers identifying as white, BIPOC patients have gone without appropriate hair care, often causing harm. The launch of new products and staff training have been led by black and brown staff. Products have been procured with a focus on BIPOC and women owned businesses and hundreds of staff have been trained. A local salon owner consulted to create a hands-on curriculum, video and supplies products which has allowed her to expand her distribution business.

There were many lessons learned including compensating employees for work outside the scope of their jobs; how to navigate rupture and repair processes as employees navigate systems issues while taking on health equity work; and the joy of bringing a project to completion that had been identified an area of inequity for many years.

Administer health education strategies, interventions and programs Provision of health care to the public

Abstract

Continuing the equitable delivery of vaccine services in the post-pandemic era: The Los Angeles department of public health mobile vaccine team

Janina Morrison, MD, MPH[1], Samentha Han, BSBA[2], Christa Davison, DNP, RN, PHN, FNP-C[1], Angela Austin, RN, MSN/MPH[3], Emy Murakami, PHN[1], Eiko Williams, RN, BSN, PHN[3], Heidi Lopez, PHNS[3], Daniel Newell, MA[1], Cindy Lam[3], Patrick So[1], Gema Morales-Meyer, DNP, RN, MPH, CNS[1] and Jadwiga Czachor, MPH[1]
(1)Los Angeles Department of Public Health, Los Angeles, CA, (2)Los Angeles Department of Public Health, Alhambra, CA, (3)Los Angeles County Department of Public Health, Los Angeles, CA

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The COVID-19 pandemic resulted in 37,540 deaths in Los Angeles County as of 2/2/2024, with the death rate correlating closely with demographic factors such as age, race/ethnicity, and area poverty level. These disparities highlight the need for innovative delivery models that maximize equitable access to vaccines. In response, the Los Angeles County Department of Public Health (LACDPH) established a Mobile Vaccine Team (MVT) to bring vaccines directly to vulnerable individuals. The MVT facilitates vaccine events through its own team of nurses and partnerships with community-based vaccinators. Since the end of the COVID-19 pandemic, MVT has conducted two fall respiratory virus vaccine campaigns, including COVID-19 and influenza vaccinations. The locations of the events were chosen through a health equity lens. Utilizing the California Healthy Places Index (HPI) indicators, sites in low-resource areas were prioritized for events offering no-cost vaccines. When the updated COVID-19 vaccines were released in 2022 and 2023, MVT utilized a database of 30,000 facilities to guide outreach, beginning with seniors in HPI priority communities. From 9/1/22 to 2/28/24, MVT facilitated 35,723 clinics, administering 161,315 COVID-19 and 39,393 flu vaccine doses. 58% of doses were administered at locations in the most vulnerable communities, as defined by the HPI. The ability to provide patient-centered vaccine services in accessible locations has bolstered vaccine uptake, especially for high-risk individuals living in low-resource communities. The work of the MVT is now an integral part of LACDPH's ongoing efforts to curb the spread of vaccine-preventable diseases.

Provision of health care to the public Public health administration or related administration Public health or related nursing

Abstract

Enabling effective health administration by identifying leadership training needs on the job.

Emmanuel Jadhav, DrPH, MHM, MSc
Ferris State University, Big Rapids, MI

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Research objective: In the context of the COVID pandemic that exacerbated already strained resources. Turnover of tenured leadership could make an already strained situation complex. One potential approach to address the turnover is to complement the training needs of the leadership early in their leadership trajectory. This we hypothesize because leaders with lower level of educational attainment tend to accumulate human capital on the job. Subsequently taking longer to demonstrate their potential for effective leadership. This study's research objective is to identify the nature of relationship between leadership tenure and their highest level of educational attainment.

Methodology: secondary data from the 2019 NACCHO Profile study will be used for the analysis. The variables of interest will be highest level of educational attainment, controlling for having a specialized degree in public health or medicine, age, gender, and race, the workforce composition, and change in budget over time. Descriptive analysis will be used to characterize the study sample. For the relationship between tenure and educational attainment logistic regression analysis will be used controlling for the variables of interest.

Results: transfer of 2019 NACCHO data is pending review. The analysis of the data will be completed in advance of the conference presentation.

Conclusion: descriptive data of the local health department leadership are available in the NACCHO profile, and we do not anticipate any different findings for leadership demographic profile. For our research objective we anticipate that findings of the study will support our hypothesis that leadership tenure is directly related to the education attainment level. Longer tenure being associated with low level of educational attainment, independent of age, gender, race, and workforce composition.

Implications for policy or practice: local health departments could potentially develop agency level policy that requires leadership to undertake leadership specific training. Creating a measurable metric for job performance review.

Administration, management, leadership Planning of health education strategies, interventions, and programs Public health administration or related administration Public health or related organizational policy, standards, or other guidelines

Abstract

How oncology practices are considering quality and equity when sustaining virtual visit programs: A qualitative study

Jennifer Elston Lafata, PhD[1], Lauren CJ Barrow, MHA[2], Amy Barrett, MSPH, MA[2], Ilona Fridman, PhD[2], Regina Jones, AAS[2], Chris Neslund Dudas, PhD[3], Samantha Tam, MD[4] and Tiffany Yeh[2]
(1)UNC Chapel Hill, Chapel Hill, NC, (2)Chapel Hill, NC, (3)Henry Ford Health, Detroit, MI, (4)Detroit, MI

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Background. We evaluated how, in the context of heightened awareness regarding structural racism and disparities, oncology practices considered equity and quality when providing virtual visits post pandemic.

Methods. We created a sampling universe of academic and community-based oncology practices from publicly available National Cancer Institute and Association of Community Cancer Centers information, and conducted semi-structured, in-depth interviews with key informants knowledgeable about an organization's oncology telehealth program. One research team member with a background in hospital planning conducted interviews between 10/21 and 1/23. The interview guide explored characteristics of the practices' inner and outer settings per the Consolidated Framework of Implementation Research, and efforts to identify and address telehealth care disparities and quality. All interviews were conducted via voice conferencing software and transcribed verbatim. Transcripts were organized topically in Atlas.ti. In this study, we focused on data categorized as "diversity, equity, or inclusion (DEI)" or "care quality." Nine research team members, including two patient and family advisory board members, independently reviewed reports before group meetings to identify themes through a series of iterative and interpretive immersion/crystallization cycles.

Results. A total of 39 individuals from 16 oncology practices were interviewed. Those interviewed primarily represented middle management, including administrators and clinicians. Four overarching themes emerged (1) general awareness regarding DEI and organization's DEI-related priorities; (2) care equity and quality overlooked within oncology telehealth, (3) reactionary support services within oncology telehealth, and (4) telehealth processes supported patient and provider concerns.

Conclusions. Oncology practices were housed within organizations in the early stages of DEI maturity (i.e., those developing awareness and communicating importance via centralized/top-down strategies). General DEI awareness did not transfer to oncology telehealth services. Oncology telehealth practices did not proactively address either equity or quality. Findings underscore the need for concrete implementation strategies that integrate organizational DEI efforts into equitable service provision.

Administration, management, leadership Program planning Provision of health care to the public

Abstract

Resilience catalysts in public health

Tahlia Gousse and **Alexandra Halprin**
Washington, DC

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Resilience Catalysts (RC) in Public Health is a national collaborative and network of 13 local health departments (LHDs) across the country seeking to identify structural drivers of place and race-based inequity rooted in structural racism.

The RC program is a Centers for Disease Control and Prevention (CDC) sponsored project convened by the National Association of County and City Health Officials (NACCHO) in partnership with the Center for Community Resilience (CCR) at George Washington University and the American Public Health Association (APHA). Collectively, these partners offer extensive public health experience and program administration to facilitate implementation of the RC process.

The RC process supports communities' ability to prepare, withstand, and grow despite acute and chronic adversity such as structural racism. Using the Community Resilience (CR) framework and capacity building Technical Assistance (TA), RC sites address the Pair of ACEs—adverse childhood experiences in the context of adverse community environments.

This presentation will provide an overview of RC, a standardized process that facilitates customized solutions for each public health organization and their local community. Participants will learn how public health organizations can use the RC process to translate PH 3.0 from theory into practice. The presentation will highlight the essential elements of the RC process – root cause analysis, Pair of ACEs tree, key informant interviews, and coalition building – as identified through the 2023 RC evaluation.

After this presentation, participants will learn how the RC process provides tools to address many PH 3.0 implementation challenges such as identifying gaps in data, centering equity in their work (meaningfully), effective cross-sector collaboration, and improved capacity to apply systems thinking.

Administration, management, leadership Conduct evaluation related to programs, research, and other areas of practice Public health or related education Public health or related public policy Public health or related research Systems thinking models (conceptual and theoretical models), applications related to public health