

Health Equity at Work

Skills Assessment of Public Health Staff



September 2010
Health Equity Council

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OR

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<http://www.chronicdisease.org/nacdd-initiatives/health-equity>

Funded in part through a Cooperative Agreement (#32449) between the National Association of Chronic Disease Directors and the Centers for Disease Control and Prevention - Center for Chronic Disease Prevention and Health Promotion.
Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC.

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All quotations used in this report were made by survey participants

Executive Summary

The purpose of this report is to provide the Centers for Disease Control and Prevention (CDC) with training recommendations based on an assessment of health equity skills needed by the public health workforce.

The National Association of Chronic Disease Directors' Health Equity Council (NACDD-HEC) designed a survey instrument based on public health competencies and guided by suggestions from national health equity experts.

Chronic disease directors from thirteen states volunteered to be pilot sites. Over 450 individuals responded to the survey reflecting a 50% response rate. The survey was followed by a series of focus groups intended to gather information from survey respondents on ways to improve the survey instrument.

The NACDD-HEC members identified areas most in need of training and made recommendations for creating a series of "how to" skill building educational opportunities in the following areas:

- Communications
- Cultural competency
- Program planning and development
- Analytic assessment
- Community Practice
- Leadership and Systems

Based on the pilot assessment results, the following recommendations are proposed:

- Disseminate overall and individual pilot states results to state chronic disease directors.
- Conduct tri-annual nationwide assessments of all state chronic disease programs
- Host active discussions about the results at annual training conferences for state chronic disease directors & program officers and the CDC staff. Focus discussions on the training needs of public health staff; how competencies translate to work performance; and how improved competency skills lead to better programs, to achieve health equity.
- Identify and/or develop a series of trainings based on the results of the assessment using a three-tiered approach for staff with low, functional and high proficiency

"We know that there are a lot of factors that impact health but poverty, coupled with discrimination and education truly determine an individual's health outcome and that of a community..."

Introduction & Background

Public Health History

Public health has had a vital role in curbing or eradicating diseases and conditions that affect the public at large. Laws and practices have helped to stem the epidemics of everything from polio, typhoid and measles to tuberculosis and HIV infection. From the beginning, public health interventions were not limited to combating infectious and communicable diseases alone. Child labor laws were enacted to stop workplace exploitation and improve overall conditions for children. Housing laws gave people recourse if their homes were unsafe or unsanitary. We have laws that minimize exposure to secondhand smoke. We have regulations that limit the sodium in processed foods. The foundation of public health is to provide equal opportunities for people to live healthy lives. Therefore, public health practitioners must understand our history of responding to broadly defined needs of the public. We must not limit ourselves to providing only programs focused on specific diseases or conditions and their risk factors. While it is good science to have people with knowledge or expertise in a particular field it may limit our view of the many factors that contribute to diseases or risk factors.

“Much of this work is based upon courage, people know what to do, but they are afraid to do it and are afraid to say what needs to be done. We need ‘courage skills’ training”.

We are entering a new chapter that begins with a foundation in public health history. We have the science and the history that recognize chronic disease as more encompassing than just disease states. Preventing chronic disease is as important as treating chronic conditions and in both prevention and treatment there are social factors that help determine the ultimate outcome.

How do we as public health practitioners begin to incorporate these social factors into our ongoing efforts? Do we have the knowledge? Do we have the necessary skills?

Background to Assessment

The Health Equity Council was commissioned by the Centers for Disease Control and Prevention - Division of Adult and Community Health to complete a pilot assessment of health equity skills needed by public health staff. The purpose of the assessment is to inform the CDC of education and training needs as identified by the public health professionals who responded to the assessment. Following completion of the assessment, the NACDD-HEC was asked to make recommendations to the CDC for conducting a full assessment. The CDC will use the assessment results to plan and provide education and training opportunities for public health practitioners. Three criteria were addressed in developing the tool:

- The assessment should measure **skills** needed to address health equity.
- Survey participants must work in public health at the **state** level.
- Public health **competencies** must inform the elements of the assessment tool.

The purpose of this report is to provide recommendations to the CDC for assessing the health equity skills needed by the public health workforce based on this pilot assessment. In June

2010, the Health Equity Council completed an on-line survey of skills needed by chronic disease program staff working in state health departments. Thirteen state chronic disease directors volunteered to be pilot sites. Over 450 staff responded to the survey. This number represents a nearly 50% response rate based on the number of survey responses received compared with the number distributed by the pilot state chronic disease directors. The survey was followed by a series of 12 focus groups consisting of 3-4 members each. The focus groups were designed to gather information from survey respondents on ways to improve the survey instrument.

Recommendations by the focus groups for the instrument included:

1. Revise selective survey statements in response to focus group feedback
2. Modify the survey to eliminate the “Importance” scale after each question
3. Expand the definitions section
4. Provide examples for some skills statements

Following administration of the final survey, the CDC intends to use the results to identify areas for education and training opportunities to support state public health staff.

Health Equity Council (NACDD-HEC)

The Health Equity Council was established in July 2005 by NACDD to better address health equity issues within chronic disease programs throughout the U.S. The group has expanded from the initial five people to over 70 members representing thirty-nine states. Members bring experience working to address health equity at the local, state, national and international levels.

Since its inception, the NACDD-HEC has worked diligently to set up its infrastructure and develop a strategic map and profile to address disparities and inequities in populations disproportionately impacted by chronic diseases. The Council has organized itself into four workgroups: advocacy, cultural competency, promising practices, and social determinants of health. Collectively, NACDD-HEC members work to foster the National Association of Chronic Disease Directors’ agenda for the elimination of health inequities by providing, leadership and expertise, training, resources, and technical assistance. The Council strives to explain the social determinants of health more fully as well as identify actionable strategies, describe promising practices, and make recommendations to improve organizational cultural competency.

“...one challenge for PH professionals will be overcoming mistrust as a result of the history/experience of racial/ethnic minorities in accessing local health care systems...”

Methodology

Phase I

Examine public health competencies for those specific or relevant to health equity

The Health Equity Skills Assessment Team (Team) reviewed the document from National Association of Chronic Disease Directors that linked:

- (A) **Core Competencies for Public Health Professionals** (Public Health Foundation, 2009)
- (B) **NACDD Competencies for Chronic Disease Practice** (2009). The Team added competencies from the following sources:
- (C) Guidelines (#1-5, 8 & 10) based on the modification of the “Essential Services of Public Health” from the **National Association of City and County Health Officials (NACCHO) Guidelines for Achieving Health Equity in Public Health Practice** (2009),
- (D) The **Association of Schools of Public Health Competencies** for diversity and culture (10), and relevant competencies from environmental health (1), leadership (1) and systems thinking (2), which were part of the Association’s “Interdisciplinary/Cross-cutting Competencies” for master’s of public health students, and finally,
- (E) **Statements from the National Association of Social Workers (NASW) Code of Ethics** specific to health equity and social justice were added and modified. See Appendix B for references.

After reviewing all competencies the Team selected those relevant to health equity to guide the development of an assessment tool. As a result, a matrix of key health equity competencies was developed (Appendix C). These competencies were then used in developing key informant, survey, and focus group questions for Phase II of the project.

Phase II

Conduct key informant interviews for essential skills to include in the assessment

Next, the Team interviewed a sample of public health professionals with expertise in health equity. Thirteen one-hour individual interviews were conducted over the phone. Participants were asked a series of questions regarding their opinion on health equity skills as well as the assessment design. A transcription of the interviews was analyzed for common themes to use in developing the survey instrument. See Appendix A for list of participants, and Appendix D for key informant interview questions.

Phase III

Design an instrument to include essential health equity skills identified in Phases I & II

In early May 2010 the Team completed survey instrument draft and submitted it for review by the NACDD Science and Epidemiology workgroup. The workgroup examined the instrument for its strength measuring the health equity competency skills of public health employees, and the value of the competency. A draft of the survey was also sent to the Oklahoma Literacy Council for readability.

The survey consisted of 30 health equity skill statements, grouped into six categories: communications, cultural competency, program planning & development, analytic assessment, community practice, and leadership & systems thinking. Participants were asked to rate both the importance of the skill and their level of proficiency using a five-point Likert scale. June 1, 2010 was the target date for release of the assessment using *the “Survey Monkey”* software application. See Appendix E for a list of skill statements used in the survey and Appendix F for a sample of the survey.

Phase IV

Identify pilot states to participate in the survey

The Team chose a sample of thirteen states to participate in the pilot survey. Locations across a wide geographic distribution were selected, to include states with large and small populations as well as urban and rural states. Puerto Rico and the National Association of State Offices of Minority Health (NASOMH) were also included in the sample.

Phase V

Develop a process for obtaining survey feedback following administration of the pilot

Volunteers from among survey respondents participated in one-hour telephone focus groups. The purpose of the focus groups was to obtain information on ways to improve the survey content and formatting. Twenty-nine individuals representing 13 states participated in one of a series of focus groups. An analysis of the transcriptions of each session revealed recurring themes used to complete this report. See Appendix G for focus group questions and recommendations.

Phase VI

Analyze results to identify areas of need as well as ways to improve the survey tool

Data were obtained from the *Survey Monkey* software application and further analyzed using SPSS/PASW (Statistical Package for the Social Sciences). The results were summarized as simple frequency distributions (Appendix H.1.) and after consultation with the Team, cross-tabulation of survey responses by the number of years in public health was conducted (Appendix H.2.).

“...We need skills to radically reshape our cultural norms. The root causes of discrimination, poverty, and other social determinants of health are our society's collective unquestioned acceptance of individualism, consumerism, and unchecked capitalism. As long as these values remain dominant, there will be inequity in one form or another...”

Results of Survey Part 1.

Survey Sample Demographics and Frequencies of Responses

All tabular data on the sample demographics and response frequencies are presented in Appendix H.1. Although this survey was designed as a pilot assessment based on a sample of 13 States, the survey was forwarded widely by the state chronic disease directors. More than 450 people representing 20 states responded, including chronic disease directors who were not part of the pilot state sample. The majority of respondents (88.7%) work for state government. One-half of this pilot assessment sample was comprised of people working in public health for 6-20 years (51.9%), with another 18.4% working in public health for more than 21 years. Almost one-fourth (23.5%) has been working in public health for less than 5 years.

“...effective communications across cultural groups and building trusted partnerships...”

Communications

More than two-thirds of the respondents thought that at a functional, proficient or expert level, they were able to explain the difference between health equity, health inequities and health disparities (74.4%), describe the effects that the social determinants of health have on health equity for specific populations in their state (72.4%) and describe the effects that policies may have on health equity (73.1%). More than one-half also thought they could focus policy-makers attention on improving social and economic conditions instead of trying to change individual behaviors (58.9%) and less than one-half (43.1%) thought they could use television, radio and print media to describe the costs connected to the social determinants of health. More than 90% of the respondents rated these communication issues as important or very important/essential.

Cultural Competency

Three-fourths of the respondents (74.7%) thought that at a functional, proficient or expert level, they could identify the effects of cultural factors on public health services and describe the cultural differences among the populations they served (75.2%). Less than one-half (46.6%) thought they could provide cultural competency training to improve staff skills in working with diverse populations. And, while three-fourths of the respondents thought they could use their knowledge about cultural differences in public health planning (75.8%), two-thirds also thought they had the skills to recruit a diverse staff that reflects the populations they serve (66%). The vast majority of respondents (90-95%) rated these cultural competency issues as important or very important/essential.

Program Planning and Development

Just over one-half of the respondents thought that at a functional, proficient or expert level, they could include the use of health equity skills into job descriptions (54.3%) or implement on-going health equity and social determinants of health trainings for staff (50.9%). More than two thirds (71.3%) thought they could adapt public health programs to take into account the differences among populations, while 60.1% thought they could add the social determinants of health and health equity into public policies and actions, and 73.4% thought they could partner with other organizations to develop strategies to improve health equity. The vast majority of respondents

(90-95%) rated these program planning and development issues as important or very important/essential.

Analytic Assessment

More than three-fourths of the respondents thought that at a functional, proficient or expert level, they could use data to identify health disparities (77.7%), and 71.9% thought they could explain the social determinants of health and identify health equity issues. However, less than 40% thought they could evaluate an organization's readiness to work on the social determinants of health that effect health equity (38.8%). More than one-half of the respondents thought they could analyze the policies intended to improve the social determinants of health and health equity (56.2%) or identify the evidence linking discrimination and health outcomes (58.6%). The vast majority of respondents (90-95%) rated these analytic assessment issues as important or very important/essential.

Community Practice

More than one half of the respondents thought that at a functional, proficient or expert level, they could engage communities to work on the social determinants of health and health equity (59.6%), use community-based research to affect the social determinants of health and improve health equity (54.8%), yet less than one-half (40.6%) thought they could develop community leaders within populations negatively affected by the social determinants of health. More than two thirds of the respondents thought they could provide communities with data on health, the social determinants of health and health equity status, and more than one-half (51.8%) thought they would advocate for community investments that improve the social determinants of health and health equity. The vast majority of respondents (90-95%) rated these community practice issues as important or very important/essential.

...we MUST work side by side with [community] if we are to truly develop our health equity skills...

Leadership and Systems Thinking

Almost two-thirds of the respondents thought that at a functional, proficient or expert level, they could promote promising practices that would aid in fair service delivery (63.4%), yet less than one-half thought they could identify the policies and systems of institutionalized racism (43.1%), or identify the policies and systems of institutionalized discrimination (45.9%). Just about one-half thought they could develop policies that will affect the social determinants of health and improve health equity (49.9%) or convert policies into programs that improve fair service delivery (47.3%). The vast majority of respondents (90-95%) rated these leadership and systems thinking issues as important or very important/essential.

Results of Survey Part 2.

Cross Tabulation of Responses by Level of Public Health Proficiency and Experience

All tabular data on the cross-tabulation of all responses are presented in Appendix H.2. Cross tabulated results compare three tiers of proficiency and three levels of importance with public health experience/the number of years in public health (less than 5 years, 6-20 years and more than 21 years). Proficiency was grouped into three tiers from low (tier1=unaware or only aware), medium (tier 2=functional) and high (Tier 3=proficient/expert). Importance was also grouped into three levels from low (1-unimportant/slightly important), medium (2=important) to high (3=very important/essential). For this pilot assessment, we highlighted those areas which seem to be the most needed areas for training with respondents who report low levels of proficiency, not only among those who report having less public health experience, but in the areas where there was low reported levels of proficiency across all years of public health experience. These areas are suggestive of where additional training and information on health equity and the social determinants of health.

Communications

There was a statistically significant difference ($p < .01$)¹ between those with less public health experience and those with more experience, in their proficiency/ability to “explain the difference between health equity, health inequities and health disparities” (Q1)², suggesting a needed area of training for entry level public health workers. At least one-third of those with less public health experience reported being lower in proficiency in “describing the effects that the social determinants of health have on health equity for specific populations in their state” (Q2) and “describing the effects that policies may have on health equity” (Q3), suggesting additional areas for education/training. Across all categories of public health experience/number of years in public health, one-third to one-half of respondents reporting their proficiency as low for being able to “focus policy maker attention on improving social and economic conditions instead of trying to change individual behaviors” (Q4). There were even greater proportions of reported low proficiency across all levels of public health experience for “using television, radio and print media to describe the costs connected to the social determinants of health” (Q5). There was a general trend across all levels of public health experience to rate these communication issues as very important/essential (70-80%). This was slightly less for media utilization (60-70%).

Cultural Competency

At least one-third of those with less public health experience reported being lower in proficiency in “identifying the effects of cultural factors on public health services” (Q6), “describing the cultural difference among the populations they served” (Q7) and “using their knowledge about cultural differences in public health planning skills to recruit a diverse staff that reflects the

“...I may not be able to fully understand another person's experience with inequity and discrimination, but I can listen with compassion and empathy...”

¹ Chi-square=15.127

² Q1, Q2, Q3... refer to the numbered skill statements in the survey.

populations they serve” (Q9). Across all categories of public health experience, more than half of respondents reported their proficiency as low for being able to “provide cultural competency training to improve staff skills in working with diverse populations” (Q8). There was a statistically significant difference ($p < .01$)³ between those with less public health experience and those with the most experience who reported that they have the skills to recruit a diverse staff that reflects the populations they serve” (Q10). There was a general trend across all levels of public health experience to rate most of these cultural competency issues as very important/essential (70-80%), yet this was less so for providing cultural competency training (Q8) at 60-67%, and even less so for the ability to recruit a diverse staff (Q10).

Program Planning & Development

At least 40% of those with less public health experience reported being lower in proficiency in “adapting public health programs to take into account the differences among populations” (Q13), along with 30% with less public health experience who reported being low on “partnering with other organizations to develop strategies to improve health equity (Q15). These were statistically significant differences between lower and higher levels of public health experience ($p < .01$)⁴. Across all categories of public health experience, more than 40% of respondents

“You expect nothing less than everyone doing their part to make the workplace and practices civil and a place of honor for employees and the customers they serve.”

reported their proficiency as low for being able to “include the use of health equity skills into job descriptions” (Q11) or “implement on-going health equity and social determinants of health trainings for staff” (Q12). One-third to one-half of respondents reported they had low proficiency in “adding the social determinants of health and health equity into public policies and actions” (Q14). However, there were also statistically significant differences ($p < .01$)⁵ for (Q11) and (Q14) as well, whereby those with greater public health experience skewed into two groups: experts and those with

reported low proficiency in these two areas. In rating importance, across all categories of public health experience, 50-60% of respondents rated including the use of health equity skills into job descriptions as very important (Q11) and 60-70% who rated implementation of health equity and social determinants of health trainings as important (Q12). In contrast, across all categories of public health experience, 70-80% of respondents rated adapting public health programs to take into account differences among populations (Q13), adding social determinants of health and health equity into public health policies and actions (Q14) and partnering with other organizations to improve health equity as very important.

Analytic Assessment

Among those with less than 5 years of public health experience, 28.3% reported they had low proficiency “to use data to identify health disparities” (Q16) and this was a statistically significant difference compared to those with more public health experience ($p < .01$)⁶. There was also a

³ 15.595

⁴ Chi-square=14.096 (Q13) and 9.845 (Q15).

⁵ Chi-square=24.824 (Q11) and 18.392 (Q14).

⁶ Chi-square=9.845

statistically significant difference between those with lower versus greater public health experience, with 40.6% of those with lower number of years in public health reporting low proficiency in being able to “explain the social determinants of health and identify health equity issues” (Q17)($p < .01$)⁷. In contrast, across all categories of public health experience, there were 57%-65% who reported they had low proficiency in being able to “evaluate an organization’s readiness to work on the social determinants of health that effect health equity” (Q18), suggesting an across-the-board training need. Similarly, across all categories of public health experience, one-third of respondents with more than 21 years of experience, along with 42.9% of those with 6-20 years of experience and 53.3% with 0-5 years of experience, reported low levels of proficiency to “analyze the policies intended to improve the social determinants of health and health equity” (Q19). There was a similar reporting of low proficiency across all levels of public health experience (from 37-49%) on the ability to “identify the evidence linking discrimination and health outcomes” (Q20). The majority rated these analytic assessment issues were important, but using data to identify health inequities had the highest importance rating among all groups (82%), followed in importance by explaining the social determinants of health data and identifying health equity issues 74-79%. The other issues were rated very important by a majority, but in lesser proportions 58-72%).

“Go to the field, feel it, live it and then plan for the change...”

Community Practice

There was a statistically significant difference ($p < .01$)⁸ between those with less public health experience and those with more experience, in their reported proficiency/ability to “engage communities to work on the social determinants of health and health equity” (Q21); those with the least experience were less able to think they can do this. In contrast, across all levels of experience there were 41-56% of respondents who rated their proficiency as low for “using community-based research to affect the social determinants of health and improve health” (Q22), 55-68% for “developing community leaders within populations negatively affected by the social determinants of health” (Q23), and 44-60% for “advocating for community investments that improve the social determinants of health and health equity” (Q25). There was a statistically significant difference ($p < .01$)⁹ between those with less public health experience and those with more experience, in their reported proficiency/ability to “provide communities with data on health, the social determinants of health and health equity status” (Q24); those with more experience reporting more proficiency. Across all levels of experience/number of years in public

...Promote internal agency policies to redress institutional racism...

health, these community practice issues were generally rated very important by the majority of respondents (63-77%). This finding suggests a need for training in an area not traditionally associated with public health practice.

⁷ Chi-square=14.760

⁸ Chi-square=12.176

⁹ Chi-square=10.585

Leadership & Systems Thinking

Across all levels of public health experience/number of years in public health, there were reported low proficiency levels among all groups for “promoting promising practices that would aid in fair service delivery (29-44%) (Q26), for “identifying the policies and systems of institutionalized racism” (50-60%) (Q27), low proficiencies for “identifying the policies and systems of institutionalized discrimination” (48-62%) (Q28), low proficiencies for the “development of policies that will affect the social determinants of health and improve health equity” (46-62%) (Q29) and low reported proficiencies for “converting policies into programs that improve fair service delivery” (49-63%) (Q30).

“IT’S A PHILOSOPHY AS WELL AS A SKILL.”

”...IT IS NOT SO MUCH A SKILL AS A WAY OF THINKING.”

“EMPHASIS NEEDS TO BE PUT ON EQUALITY OF OPPORTUNITY WHEN TALKING ABOUT HEALTH EQUITY.”

“I THINK IT IS ALSO IMPORTANT TO HAVE THE PERSONALITY, ENTHUSIASM AND RESPECT (IN THE COMMUNITY) TO GENERATE INTEREST AND EXCITEMENT AMONG COMMUNITY MEMBERS TO MOTIVATE CHANGE.”

“WE OPERATE ON A LOT OF ASSUMPTIONS AND OUR POLICIES AND PRACTICES JUST PAY LIP SERVICE TO THE TERMS HEALTH DISPARITIES AND SOCIAL DETERMINANTS...”

“... HAVE CRITICAL DISCUSSIONS ABOUT POVERTY AND DISCRIMINATION ISSUES ON A CONSISTENT BASIS.”

Results of Focus Groups

Enhancements to survey tool based on focus group results

Based on feedback from focus group respondents, the Team made **five** modifications to the health equity skills assessment survey tool.

We **revised the importance scale** to require respondents to prioritize the skills under each section of the assessment. That is, instead of rating the importance of each skill on a five-point Likert scale, respondents are asked to give the five skills in each section of the survey a 1 to 5 ranking *relative* to the other skills in that section. This change was made in response to focus group feedback that participants ranked all the skills either “very important” or “essential”. Because of this, the importance scale did not offer meaningful insight on which skills were most important. Analysis of survey responses supports this change. Respondents ranked most skills as “important” or “very important,” making it difficult to use these results to prioritize or sequence skills for training.

We **added sentences describing the content** of each section to the section headings in the survey. This will clarify the purpose of each section, and will help respondents recognize when they have moved into a new section of the tool. This change is in response to comments from focus group participants that some survey questions seemed redundant, but when they looked more closely they found that the context of the section that a question fell under provided more information on the question’s meaning. Focus group respondents suggested that it would clarify the meaning of the questions if we made it easier for respondents to understand the intention of the survey sections.

We **revised the description of the overall purpose** of the assessment to clarify what information the survey results provide and how respondents, agency heads or the CDC can use the assessment results. Focus group participants also suggested that we include a list of resources at the end of the assessment. This list should highlight the NACDD and the CDC technical resources, and encourage survey respondents to contact the Health Equity Council to learn more or take action.

We **added cultural competency** to the definitions section of the assessment. There was an interesting conversation in several focus group interviews about the questions in the cultural competency section. Participants struggled to respond to questions of general cultural competency, and felt that their proficiency in this area depended on the specific culture under discussion. This observation in itself provides information about the respondent’s comfort and proficiency in the area of cultural competency, and their understanding of the set of skills that compose cultural competency.

We **added promising practices** to the definitions section of the assessment. Focus group participants said that the phrase “promising practices” was not a commonly used or understood term and could use clarification. We added an example of “fair service delivery” to questions 26 and 30. This phrase was not immediately clear to respondents, and is an attempt to be straightforward in describing equitable service delivery.

We [revised the definition of institutional racism](#), clarifying the language and adding an example. It is important to note that focus group respondents struggled with this term; this in itself is telling. Interestingly, focus group respondents did not ask for clarification of the term “institutional discrimination,” which is less common and more newly developed term that is not yet widely understood.

In addition to the changes described above, the Team discussed two other substantive changes and agreed that the CDC needed to be involved in decisions about how to address them.

We asked focus group respondents which of the following questions was most appropriate for this assessment, given their job responsibilities:

“I can focus policy maker attention on improving social and economic conditions instead of trying to change individual behaviors.”

“I have the skills to move policy makers to action on the social determinants of health and health equity.”

During focus groups, respondents expressed feeling that both questions are important, and that they are very different. Because we know that policy shapes the social determinants of health, ultimately, it is critical that public health takes a role in moving policy makers to change policies that affect social determinants. However, we understand the complicated and sensitive nature of government funding being involved in lobbying, and feel that the CDC should select the final question they would like on the survey based on their expectations for state health departments.

The Team also discussed collecting race/ethnicity demographic data as part of the assessment. This could offer a better understanding of how personal experience mediates proficiency in health equity among public health workers. At the same time, it is critical that the entire public health workforce demonstrates proficiency in skills to achieve health equity; collecting race/ethnic information may inadvertently cloud achievement of this goal by suggesting that responsibility for achieving health equity rests with a sub-group of the nation’s public health workforce. See Appendix I for a summary of focus group responses and Appendix J for a revised survey based on the changes described in this section.

Recommendations

Based on results of the pilot assessment, these recommendations are proposed for continuous development of health equity skills among public health employees:

- A) **Conduct tri-annual nationwide assessments** of all state chronic disease programs using the survey instrument developed in this pilot study. The survey should be modified to include the recommendations of the focus group participants and the observations of the Team involved in this study.
- B) **Disseminate** overall and individual pilot states **results** to state chronic disease directors.
- C) **Host active discussions** about the results at annual training conferences for state chronic disease directors and program officers. Focus discussions on training needs of public health employees and how competencies translate to work performance as well as improved competency skills lead to better programs to achieve health equity.
- D) The Health Equity Council will simultaneously identify or work with CDC to develop a **series of trainings** based on the results of the assessment.
- E) **Develop a three-tier level** training approach with each of the six categories for health equity competencies at every level.
 - Tier 1: For employees self-identifying at a level of “Unaware or Only Aware” proficiency in health equities
 - Tier 2: For employees self-identifying at a level of “Functional” proficiency in health equities.
 - Tier 3: For employees self-identifying at a level of “Proficient/Expert” proficiency in health equities
- F) **Build on the previous level skills development** and advance knowledge in communications, cultural competency, program planning and development, analytic assessment, community practice, leadership, and systems thinking.

...we need to educate and empower the communities to make a difference, to demand better policies that impact health and well-being...

Comments and Questions on Demographics:

Demographic data collection in any study is essential to understanding the needs of specific segments within the population base as well as uncovering instrument biases. In this pilot assessment emphasis was placed on public health employees' years of service and job roles as key variables for assessing correlations with health equity skill levels. Upon review of the results and recommendations from the focus groups, the Team recommends that the CDC explore the value of including other demographic variables (race, ethnicity, gender, disability, and sexual orientation), in order to determine any national correlations and trends in health equity skills development. Such analysis could (1) reveal biases toward certain population groups based on race, ethnicity, gender, sexual orientation, and disability; and (2) provide valuable information about the diversity of advancement to higher levels of performance and careers within the public health sector. All recommendations would depend on the sample of respondents and cannot reflect proficiencies and importance of those who do not respond.

The National Association of Chronic Disease Directors Health Equity Council is optimistic that skills to address health equity will be included in the core competencies for public health professionals. These skills identified reflect the characteristics that staff of state health departments, as well as other public health organizations, may want to possess as they work to protect and promote health in our communities-at-large.



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