Centering Health Equity in Diabetes

Prepared by the Diabetes Council Leadership Group

Summer 2023

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MESSAGE FROM THE DIABETES COUNCIL LEADERSHIP GROUP EXECUTIVE TEAM

The Diabetes Council Leadership Group engaged in a multi-part health equity opportunity led by the National Association of Chronic Disease Directors (NACDD) Center for Justice in Public Health in 2022-2023. We learned more about ourselves as individuals, reflected on working with our communities and partners to amplify health equity, and discussed possible ways to work on upstream factors and address system-level changes while remaining focused on diabetes interventions. We share key learnings in this resource to support our purpose of "inspiring strategic direction for diabetes prevention and management in all states." We also share brief descriptions from our leadership group members about how they are working to address health equity in their states. We hope you feel inspired to share your work and reach out to your peers and colleagues in other states as you pursue health equity.

This resource lays out ways to promote health equity in your states at the individual, organizational, and systems-change levels. It shares key resources to help you move forward in this work. This resource aims to deepen your ability to pursue health equity in your states and communities actively.

We hope this document helps you to continue this journey to make lasting changes at all levels.

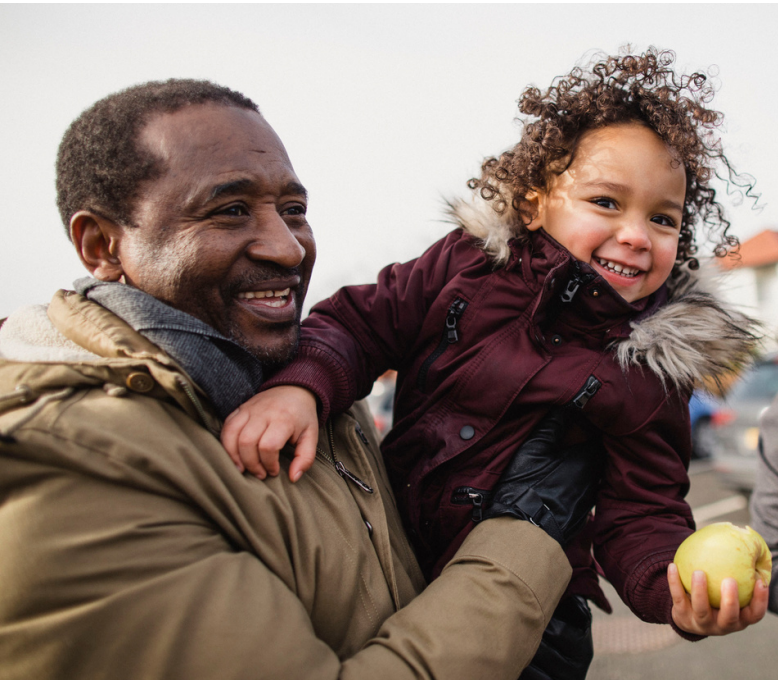
Sincerely,

Edward Clark, II	Liz Curry	Rebecca O'Reilly
Chair	Chair Elect	Past Chair
Florida	Ohio	Vermont

> The goal of this resource is to deepen your ability to actively pursue health equity.

WHAT IS HEALTH EQUITY?

Health equity refers to an environment where everyone can attain their highest level of health (NACDD, 2022). Achieving this requires removing barriers to health, including poverty and discrimination and their consequences (Braveman et al., 2018). Promoting health equity extends beyond health care and includes addressing social determinants of health, including access to healthy food, high-quality education, and fair employment opportunities.



Health inequities are outcomes in health that are avoidable, unfair, and unjust (NACDD, 2022). "Long-standing systemic social and health inequities have put some populations at risk of getting sick, having overall poor health, and having worse outcomes when they do get sick" (CDC, 2021). Health equity can both refer to the process of removing barriers to health and the outcome of achieving fair and just opportunities to be healthy for everyone (Braveman et al., 2018).

Ways to Get Started

Review definitions of health equity and related terms with state partners and seek consensus on how these terms are being defined. Consider why coming to a consensus on what health equity is matters and how definitions guide actions. Refer to "What is health equity? And what difference does a definition make?" for guidance on how to shape these discussions.

ASSESSING INDIVIDUAL EXPERIENCES AND BIASES

Everyone can actively work towards health equity. Self-awareness and reflection are vital to moving forward. Identify your own experiences and biases. Assess what you are doing to move health equity forward and use accountability mechanisms to ensure you're not perpetuating the problem.

01

Examine your actions

Intent is what we want to do, and impact is how it is received. Sometimes good intentions can lead to negative impacts. Take steps to understand the perspectives of others and how what you do or say could be harmful.

02

Elevate community voices

Assess power dynamics in decision-making. What voices are being heard and applied? Elevate and amplify the voices of those who are facing health inequity.

03

Seek to learn continually

Avoid thinking one class, book, or workshop is good enough or demonstrates expertise. Continually seek to learn and grow from others.

04

Listen to the experiences of others

Proximity to those who are oppressed does not equate full understanding of their perspective. Be open to listening to the experiences and perspectives of people who face health inequity.

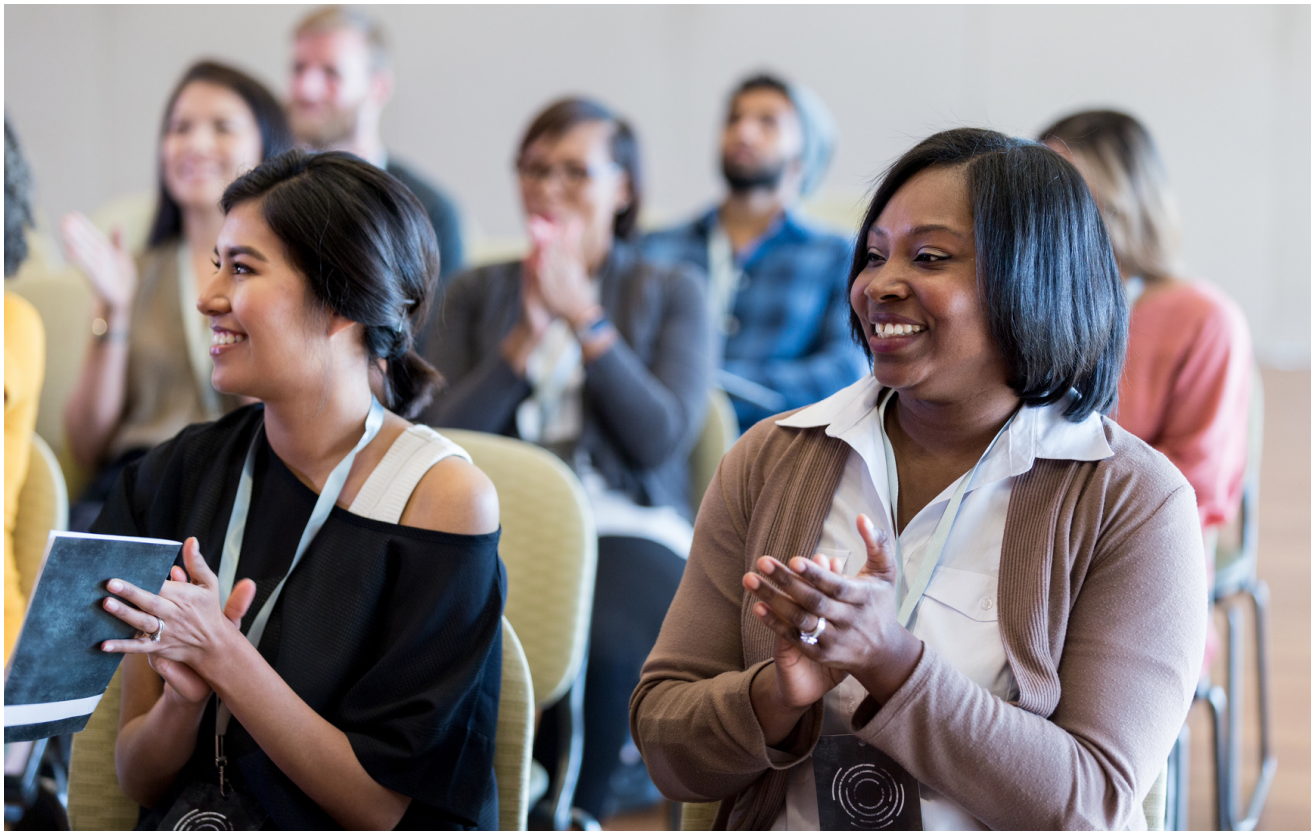
Ways to Get Started

Take an implicit bias test through Project Implicit. These tests may uncover unknown attitudes and beliefs. The tests provide an opportunity to assess one's implicit biases.

Use a health equity lens when communicating about health. Equity-centered health communication provides guidance on effectively reaching people in your audience of focus, using non-stigmatizing language. Use the CDC's "Health equity guiding principles for inclusive practice" and Communicate Health's "A framework for equity-centered health communication" to guide messaging.

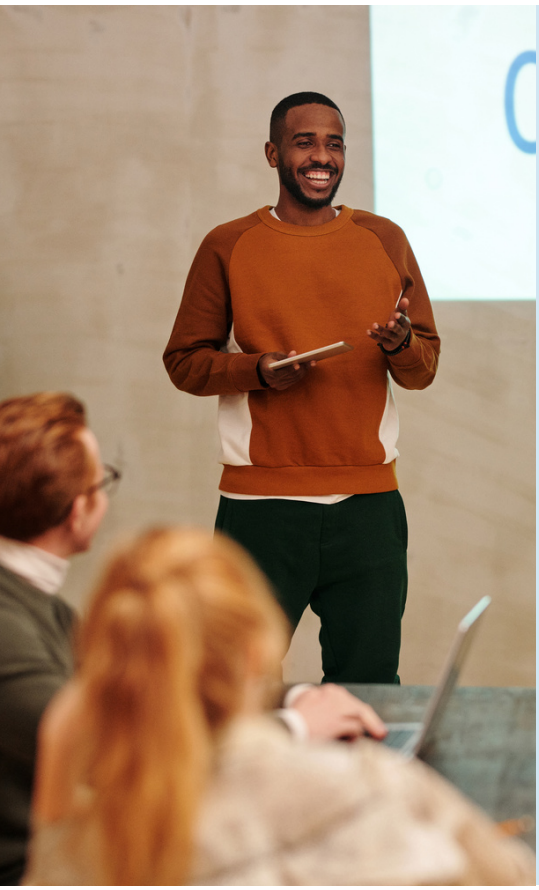
EXAMINING WORK WITH PARTNERS AND NETWORKS

Identify and implement program changes through local and national partnerships and elevate the health of groups who are disproportionately affected by diabetes. Support community-led health initiatives. Attend and take part in these initiatives. Provide technical and educational opportunities to community members through conferences and events.



Shift Power in Collaborative Work

Health is a shared responsibility. Assess who is and who is not at the table in collaborative work. Consider the power dynamics in collaborative work, including whom you have power over, whether due to your position, education, access to resources, or some other factor. Identify whose voices are being heard and reflected in the decisions being made. Elevate the voices of those affected by health inequity/disparities as they have the agency and power to create and implement their own solutions (Robert Wood Johnson Foundation, 2023). Work towards transformative change by adopting a “power with” approach, which “shifts the concept to one of building coalitions and collective strength. 'Power with' is an advocacy-oriented concept based on building allies to transform power relations collectively” (Harris, et al., 2020, p. 551).



Fully Engaging Community Leaders

The Michigan Department of Health and Human Services, along with Michigan Public Health Institute Center for Health Equity Practice, developed a "community champion" model to address diabetes prevention in southeast Michigan/metro Detroit. Through this model, four community champions have been onboarded to engage community members who are disproportionally affected by type 2 diabetes. Lifestyle Coaches and health care providers provide feedback and make recommendations on how to better meet the needs of Black adults at risk for type 2 diabetes. The partnership itself contributed to the success of this work as power was shifted to leaders in the Center for Health Equity Practice to actively participate in meetings with the funder, serve as the primary spokesperson(s) for the project, and provide a direct avenue to elevate community voices. The partnership was truly collaborative rather than in name only.

Build Equity, Leadership, and Accountability

Consider the ever-evolving context and continue to center health equity and engage the community in the work. Public health leaders often don't have formal training in developing strategies that meaningfully address areas outside of public health. Create opportunities to expand the capacity of leaders in equity work. Incorporate meaningful evaluation methods to hold individuals, leaders, organizations, and communities accountable for this work.

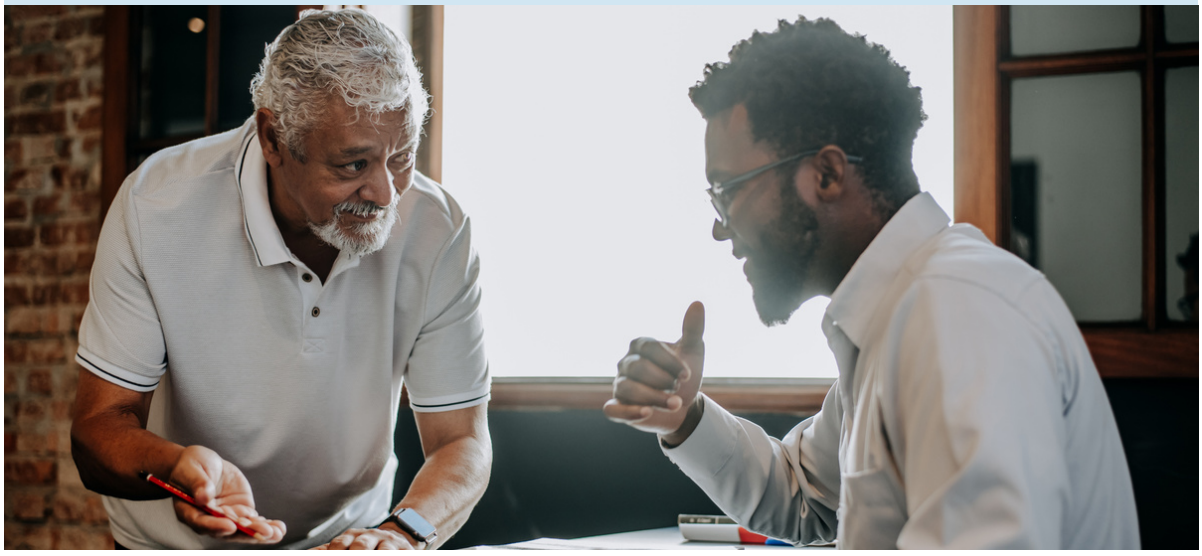
Listen To and Act With Communities

Establish relationships within communities and support community-led health initiatives. For example, work collaboratively with local ethnic committees, tribal entities, faith communities, health councils, and community-based organizations. Actively listen to the needs of the community and work with communities to address those needs. Establish relationships with local ethnic committees, tribal entities, and health councils.

Gathering Data to Guide Programming Using a Community-Based Participatory Approach

The Utah Department of Health and Human Services Healthy Environments Active Living (HEAL) program contracted with four community-based organizations (CBOs) to develop and administer a survey to identify the effects of discrimination in healthcare access among Black/African American and Indigenous and/or Native American populations in Utah. Organizations included Best of Africa, International Rescue Committee – Salt Lake City, Utah Muslim Civic League, and Utah State University – Blanding. The survey asked about demographics, social determinants of health, healthcare access, discrimination, and chronic diseases.

The survey findings were used to develop calls to action, inform diabetes grant activities, and guide ongoing work with the CBOs. The findings were translated into Arabic, Kinwaryanda, and Swahili so more community members could easily access the information. Review the "Healthcare, discrimination, and media use among underserved Utahns: Healthcare Access Survey results."



Work Towards Solutions

Ground solutions in both an understanding of the data and of the context. Use the information to shape the work and solutions rather than simply identifying those who are affected by health equity or their needs.

Modifying Curriculum for Inclusivity

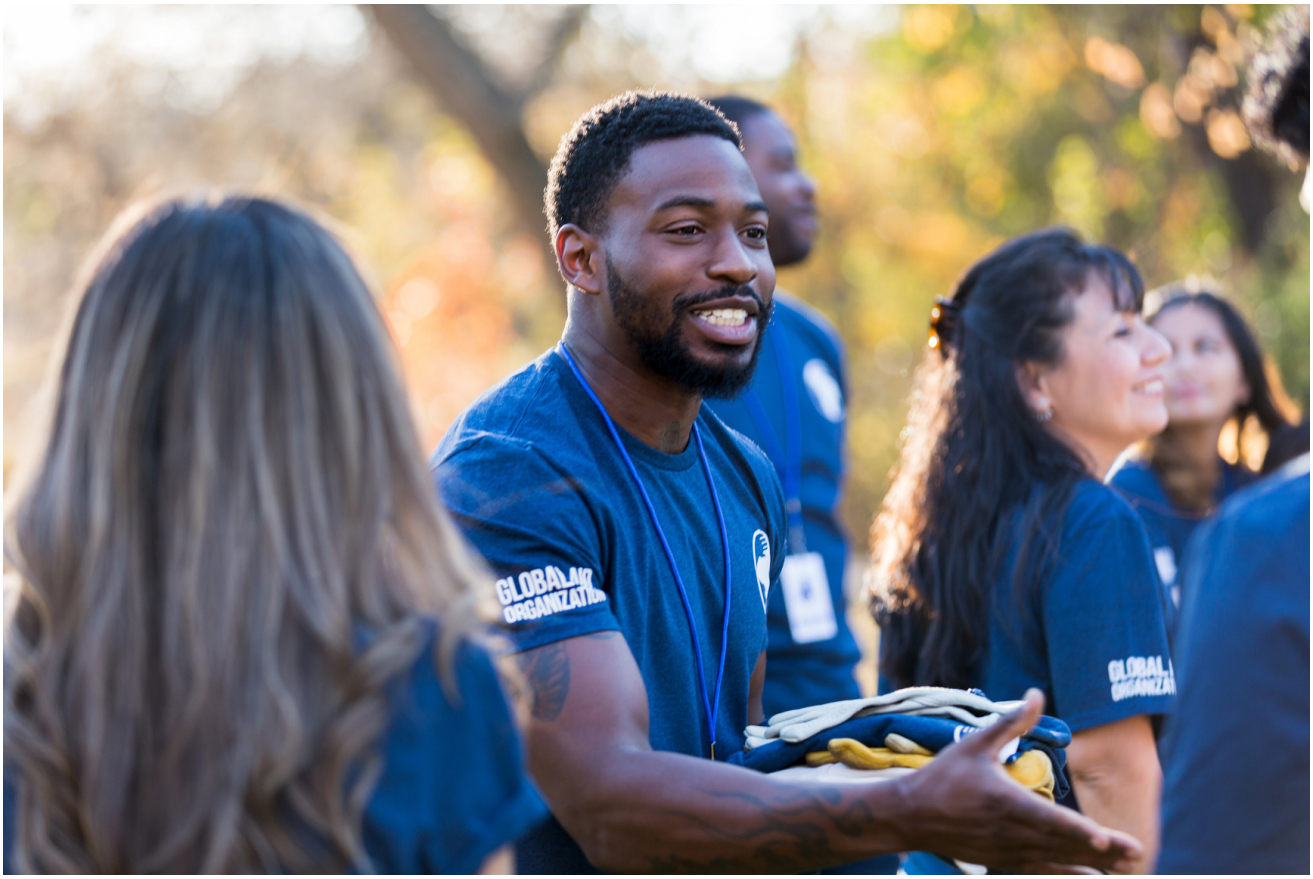
The Florida Department of Health, Diabetes program utilized the "Prevent T2 for All" curriculum adapted by the National Center on Health, Physical Activity and Disability (NCHPAD) and NACDD to implement a CDC-recognized diabetes prevention lifestyle change program which incorporates universal design to include both people with disabilities and their caregivers as change agents to encourage healthy eating and continuous engagement in physical activity.

Supporting Enrollment and Retention Through Stipends

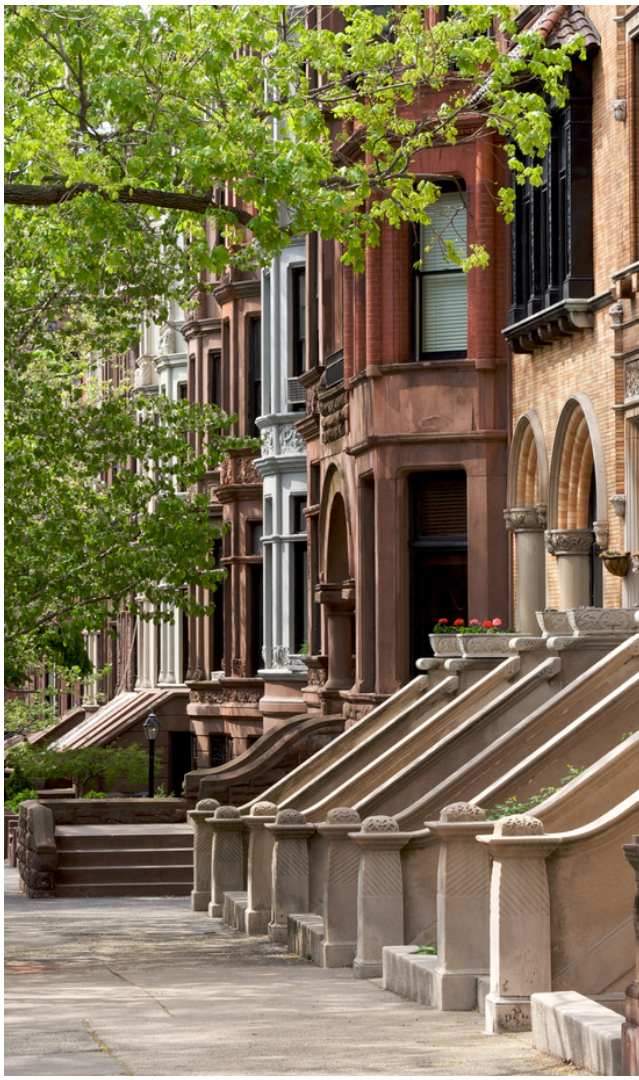
The Ohio Department of Health offered CDC-recognized organizations in Ohio funding to provide participant stipends to support the enrollment and retention of priority populations in the National Diabetes Prevention Program lifestyle change program. Organizations identified priority populations based on their community and context. Each organization collected and submitted de-identified participant-level data to determine if they reached their intended populations and to see if those participants met program outcomes.

ADVOCATING FOR BROADER SYSTEMS CHANGE

Advocate for policies and legislation that address upstream factors, including housing, land, air, and water. Address opportunities to deconstruct systems of racial bias and oppression.



Social Determinants of Health



Individual health is influenced by larger socioeconomic and environmental contexts, commonly called upstream factors or social determinants of health (SDOH). The CDC defines them as such:

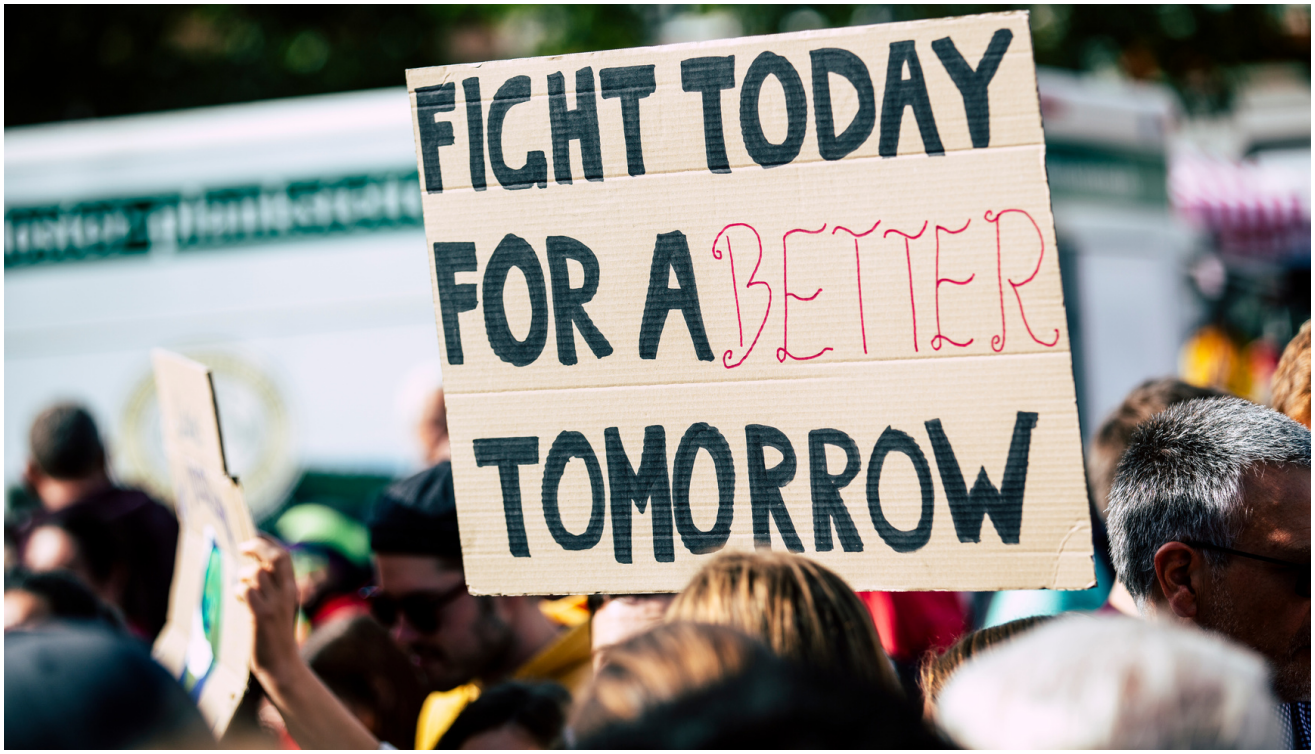
> SDOH are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems. (2022)

Some examples of SDOH include access to quality healthcare, education, safe and affordable housing, and nutritious food. Pursuing upstream change involves policy and environmental approaches that can affect large populations through regulation, increased access, or economic incentives (NACDD, 2022).

Social determinants of health are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.

Addressing Upstream Factors Through SDOH Screening

The Missouri Department of Health and Senior Services integrated questions about SDOH into their National Diabetes Prevention Program (National DPP) platform, used to enroll and track participants' progress in the National DPP lifestyle change program. The SDOH questions help identify participant needs from the start that may hinder their ability to participate fully in the National DPP lifestyle change program. The program supplier can then follow up with the participant and their community resources platform to search for and refer participants to available resources to address their needs.



Focus on Systems Change

Work towards systems change in the design and provision of programs and services. Use understanding of the data and context to promote changes in larger structures or mechanisms, such as policies, power structures, resources, or service delivery systems (Foster-Fishman, Nowell, & Yang, 2007).

Expanding Coverage of the National DPP Lifestyle Change Program

The Wisconsin Department of Health Services is working with their Division of Medicaid Services to address policy and coverage around diabetes education and support. This includes preventing type 2 diabetes through coverage of the National DPP lifestyle change program and diabetes management through diabetes self-management education and support (DSMES), coverage of diabetes-related supplies, and self-managed blood pressure.

KEY RESOURCES

Health Equity and Social Determinants of Health Learning Series

Identify ways others are centering health equity in their type 2 diabetes prevention and diabetes management efforts by watching the CDC and Diabetes Council Professional Development workgroup's three-part series on health equity.

01

The Role of Multidirectional e-Referral Results in Health Equity, Part One and Part Two

Examines initiatives demonstrating efforts to advance national capabilities in leveraging data and information supporting electronic and community referrals in healthcare and community-based organizations across a state or jurisdiction.

02

The Role of Data-driven Processes in Centering Health Equity

Focuses on how data-driven processes are central to health equity. Data use can shape decisions such as identifying and selecting a population of focus, who to partner with, and how to tell the story of the collective work of public health and partners.

03

Working Upstream to Address Social Determinants of Health and Health Equity

Explores how working upstream can affect downstream participation in diabetes prevention and management education.

KEY RESOURCES

Helpful Articles, Guides, and Toolkits

Braveman, P., Arkin, E., Orleans, T., Proctor, D., Acker, J., & Plough, A. (2017, May). *What is health equity? And what difference does a definition make?* Robert Wood Johnson Foundation. https://www.rwjf.org/en/insights/our-research/2017/05/what-is-health-equity-.html

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Rural Health Information Hub. (2022, Oct.). *Rural health equity toolkit.* https://www.ruralhealthinfo.org/toolkits/health-equity

Samari, D. & Schmitz, P. (2023, February). *Racial equity toolkit: A reflection and resource guide for collective impact backbone staff and partners.* Collective Impact Forum. https://collectiveimpactforum.org/wp-content/uploads/2023/02/Racial-Equity-Toolkit.pdf

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Contact your Diabetes Council colleagues or email the NACDD Diabetes Team to learn more about the highlighted initiatives.

NATIONAL ASSOCIATION OF CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.

The National Association of Chronic Disease Directors (NACDD) and its more than 7,000 Members seek to strengthen state-based leadership and expertise for chronic disease prevention and control in states and nationally. Established in 1988, in partnership with the U.S. Centers for Disease Control and Prevention, NACDD is the only membership association of its kind to serve and represent every chronic disease division in all states and U.S. territories. For more information, visit chronicdisease.org.

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