



MODERATOR:

Welcome to today's Coffee Break presented by the Applied Research and Evaluation Branch in the Division for Heart Disease and Stroke Prevention at the Centers for Disease Control and Prevention.

We are fortunate to have Ashley Marshall and Jasmin Minaya-Junca as today's presenters. They are Evaluators **on the Evaluation and Program Effectiveness Team** in **the Applied Research and Evaluation Branch**.

My name is Nicole Dickerman and I am today's moderator. I am an ORISE Fellow on the Evaluation and Program Effectiveness Team.

Before we begin...

**All phones have been placed
in SILENT mode.**

Issues or questions:

- Q & A box on your screen**
- AREBheartinfo@cdc.gov**



MODERATOR:

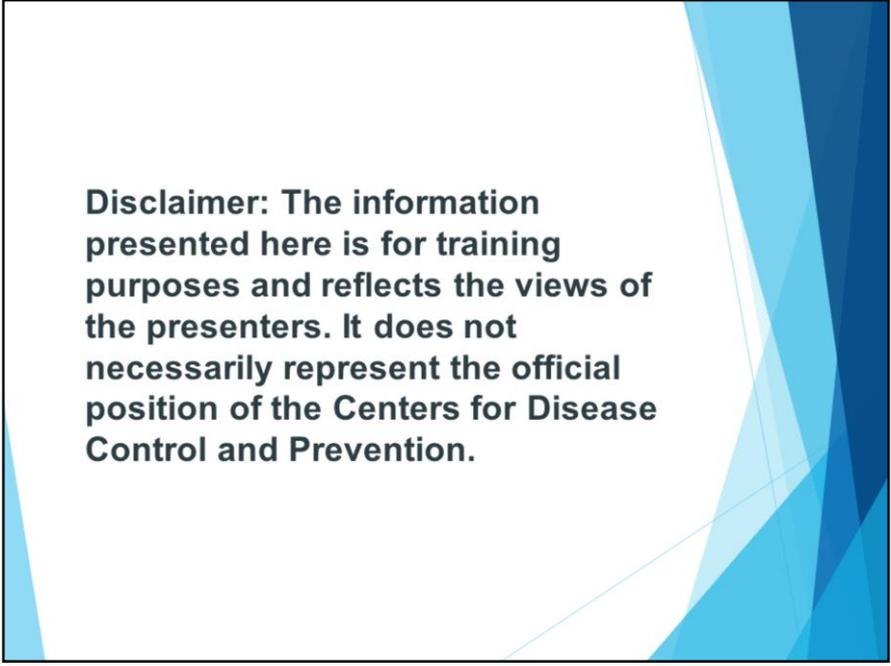
Before we begin we have a few housekeeping items.

All participants have been muted. However, to improve audio quality please mute your phones and microphones.

If you are having issues with audio or seeing the presentation, please message us using the chat box or send us an email at AREBheartinfo@cdc.gov

If you have questions during the presentation, please enter it on the chat box on your screen. We will address your questions at the end of the session.

Since this is a training series on applied research and evaluation, we do hope you will complete the poll and provide us with your feedback.



Disclaimer: The information presented here is for training purposes and reflects the views of the presenters. It does not necessarily represent the official position of the Centers for Disease Control and Prevention.

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So, without further delay. Let's get started. **Ashley** the floor is yours.

Presentation Overview

- ❑ **Overview of Health Equity**
- ❑ **CDC Evaluation Framework and Health Equity**
- ❑ **Applying a Health Equity Lens**
- ❑ **Additional Resources**
- ❑ **Questions & Answers**

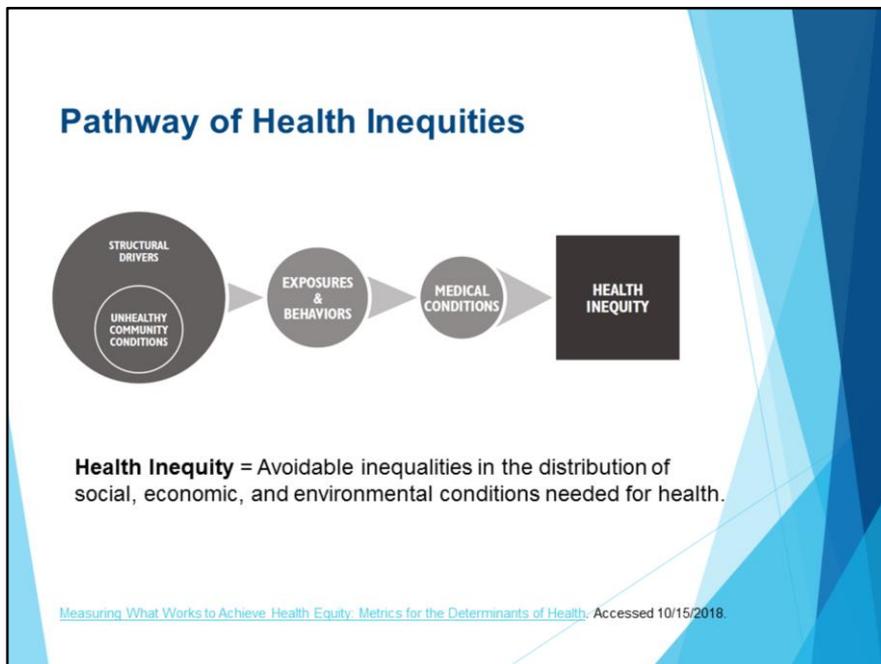
- Thanks, Nicole.
- In today's presentation we will review definitions of health equity and related terms, provide an overview of how health equity can be incorporated into the CDC Evaluation framework, and give an example of how we applied a health equity lens to a recent evaluation project.
- At the end, we will provide a list of resources, and have time for questions and answers.

Health Equity and Related Terms

Term	Operational Definition
Health Equity	The opportunity for everyone to attain the highest level of their health potential. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities , historical and contemporary injustices , and the elimination of health and health care disparities .
Health Disparities	A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage .
Social Determinants of Health	Conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Healthy People 2020. <https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities>. Accessed 5/3/2017.
World Health Organization. http://www.who.int/social_determinants/en/. Accessed 5/3/2017.

- First, let's review a few definitions of terms that we will use throughout this presentation.
- There are many working definitions for health equity. Here are commonly used ones from Health People 2020 and the World Health Organization.
- Health equity is defined as **"The opportunity for everyone to attain the highest level of their health potential. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices and the elimination of disparities in health and healthcare."**
- Health disparities are a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage.
- Eliminating health disparities requires action on the social determinants of health, or the conditions in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.



- This diagram shows a potential pathway for how health inequities develop.
- Structural drivers, such as historical injustices and unequal distributions of resources, and unhealthy community conditions shape individual's behaviors and exposures which put them at risk for medical conditions.
- When community conditions are unhealthy, educational and economic opportunities are unequal, and healthcare access and quality are unequal, this leads to health inequity.
- In reverse, healthier neighborhoods, equal opportunities, and full access to quality healthcare advance health equity.

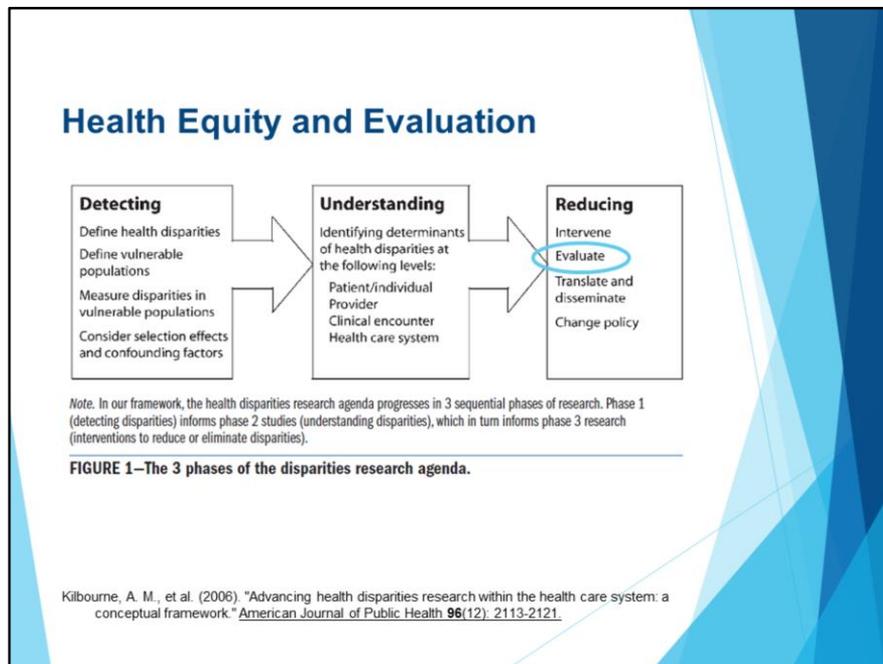
Health Equity and Cardiovascular Disease

“The most significant opportunities for reducing death and disability from CVD in the United States lie with addressing the social determinants of cardiovascular outcomes.”

- Socioeconomic status (e.g. income, education, employment)
- Race, ethnicity, and racism
- Social support
- Access to medical care
- Residential environments

American Heart Association. Social Determinants of Risk and Outcomes from Cardiovascular Disease: A scientific statement from the American Heart Association. Circulation. 2015; 132: 00-00.

- We know that disparities exist in cardiovascular disease morbidity and mortality, and hypertension and high cholesterol awareness, treatment, and control. The causes of these disparities go beyond the healthcare sector and individual knowledge, attitudes and behaviors.
- The American Heart Association released a scientific statement in 2015 that stated “...the most significant opportunities for reducing death and disability from cardiovascular disease in the United States lie with addressing the social determinants of cardiovascular outcomes”.
- The statement went on to catalogue the evidence on social determinants of health that affect cardiovascular disease including socioeconomic status; race, ethnicity, and racism; social support; access to medical care; and residential environments.



- Kilbourne and others discuss three phases for health disparities research. The first phase is detecting disparities, followed by understanding disparities, and finally, reducing disparities. It is in this third phase that evaluation appears.
- Public health program evaluation has an important contribution to make to advancing health equity. Through the systematic collection of data, evaluation can measure progress that programs are making to reduce disparities and advance health equity.
- DHDSP has funded several programs that aim to advance health equity, including cooperative agreements and evaluation research projects.
- Later in the presentation, Jasmin will provide an example of how we applied a health equity lens to one of these projects.
- Now, I will give an overview of how health equity can be incorporated into the first three steps of the CDC Evaluation Framework.

CDC Framework for Program Evaluation in Public Health



Centers for Disease Control and Prevention. Framework for program evaluation in public health. MMWR 1999;48 (No. RR-11)

This is the CDC Framework for Program Evaluation in Public Health. The framework is a practical, nonprescriptive tool, designed to summarize and organize essential elements of program evaluation. It has six steps and four standards. Today we will focus only on the first three steps: engage stakeholders, describe the program, and focus the evaluation design.

Engage Stakeholders



- ▶ Questions to ask when engaging stakeholders
 - ▶ Who should be invited to participate in the evaluation?
 - ▶ Who will be involved in deciding what is to be evaluated?
 - ▶ Who will have the authority to make what kinds of decisions?
 - ▶ Whose values will determine what a good quality evaluation looks like?
 - ▶ What capacity may need to be strengthened to undertake or make use of evaluation?

Gujit, I. (2014). Participatory Approaches, Methodological Briefs: Impact Evaluation 5, UNICEF Office of Research, Florence. Retrieved from: http://devinfo.live.info/impact_evaluation/img/downloads/Participatory_Approaches_ENG.pdf

- The first step is to Engage Stakeholders. This involves fostering input, participation, and power-sharing among those who have an investment in the evaluation.
- Involving stakeholders during evaluation planning and implementation can make the evaluation more credible and increase the utilization of findings by building capacity and support for evaluation.
- For evaluation to address health equity, it is important to reflect upon whose values and beliefs are shaping the design of the evaluation and the interpretation and use of key findings to make decisions about the program. In order to distribute the capacity to do evaluation, the process should seek to engage diverse stakeholders with different perspectives on the program – including, if possible, beneficiaries of the program.
- By asking the questions on this slide, you can start to make stakeholder engagement in evaluation more inclusive and participatory.

Describe the Program

Determinants of Health	Behaviors and Exposures	Medical Conditions
Structural Drivers <ul style="list-style-type: none"> • Inequitable distribution of power, money, opportunity, and resources • Disempowered people 	Smoking Nutrition Physical Activity Air Pollution	Hypertension High Cholesterol Heart Disease Stroke
Community Determinants <ul style="list-style-type: none"> • Social-cultural environment (e.g. social networks, norms and culture) • Physical/built environment (e.g. safety, parks, air quality, transportation, housing) • Economic environment (e.g. education, living wages) 		
Quality Healthcare		

[Measuring What Works to Achieve Health Equity: Metrics for the Determinants of Health](#). Accessed 10/15/2018.

- The second step is to describe the program. This includes describing the features of the program being evaluated, including its purpose and place in a larger public health context. This step typically includes the development of a logic model.
- When developing your program logic model, consider including upstream determinants of health in your model. A framework that you can use to do this is featured on this slide.
- This model includes determinants of health in addition to behaviors and exposures and medical conditions. The determinants of health are divided into three clusters: structural drivers, community determinants, and quality healthcare.
- These factors affect the behaviors and exposures that lead to cardiovascular disease, such as smoking, nutrition, physical activity, and air pollution.
- When designing your logic model, consider using a framework that works for your program and think a few steps back to the upstream determinants of health that may be influencing health outcomes.

Focus Evaluation Design

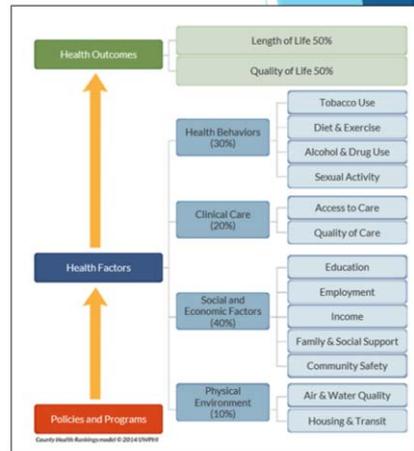
- Evaluation purpose
 - Example: To demonstrate that the program contributes to advancements in health equity through reduction of disparities in hypertension control among priority populations.
- Evaluation questions
 - Outcome Evaluation Example: To what extent is the program reducing disparities in hypertension control?
 - Process Evaluation Example: How is the program addressing social determinants of health that precipitate disparities in hypertension control?
- Evaluation methods
 - Example: Realist Evaluation – what works, for whom, under what circumstances?

Henry, G., M. Mark and G. Julnes (1998) "Realist Evaluation: An Emerging Theory in Support of Practices", *New Directions for Evaluation*. San Francisco: Josey-Bass.

- The third step is focusing the evaluation design. This step includes planning in advance where the evaluation is headed and what steps will be taken. Evaluators and stakeholders work together to develop evaluation questions with methods that are useful, feasible, ethical, and accurate.
- Simply put, one way to apply a health equity lens is to make clear from the outset that the purpose of the evaluation is to examine how and to what extent the program is contributing to greater health equity. That way, the evaluation questions and methods that cascade from the purpose will focus on health equity.
- Then, consider writing evaluation questions that answer how the intervention or program has improved health equity and tying indicators to those questions that can be used to monitor changes in community or social conditions that influence CVD outcomes.
- Finally, consider selecting participatory evaluation methods. This could include approaches such as empowerment evaluation, utilization-focused evaluation, or realist evaluation.

Focus the Evaluation Design: A Conceptual Model

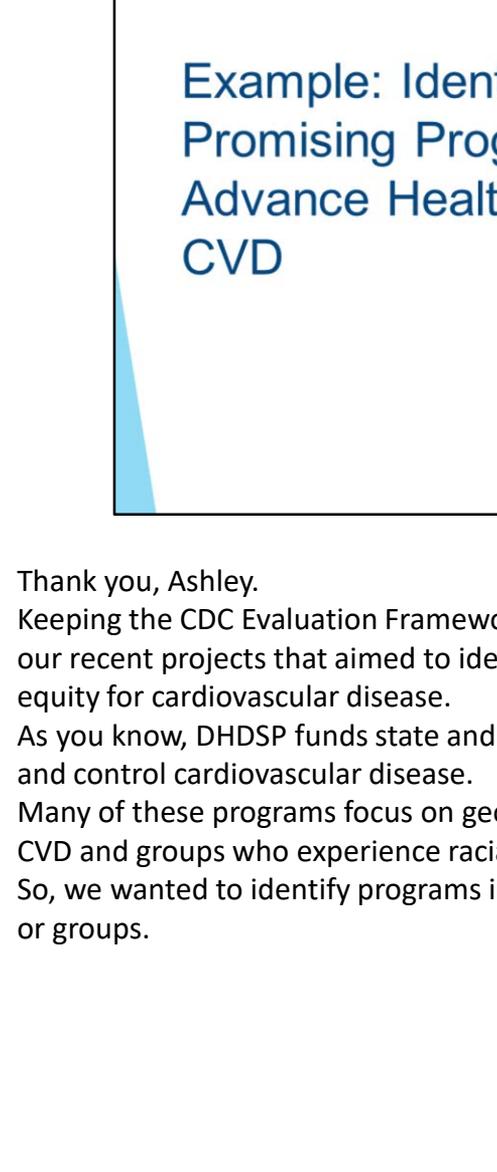
- ▶ Health Rankings Model of the Robert Wood Johnson Foundation
- ▶ A conceptual model of population health
- ▶ Four weighted health factors:
 - ▶ Social and economic factors
 - ▶ Health behaviors
 - ▶ Clinical care
 - ▶ Physical environment



Source: Health Rankings Model: Hood, Carlyn M., et al. "County Health Rankings: relationships between determinant factors and health outcomes." *American journal of preventive medicine* 50.2 (2016): 129-135.

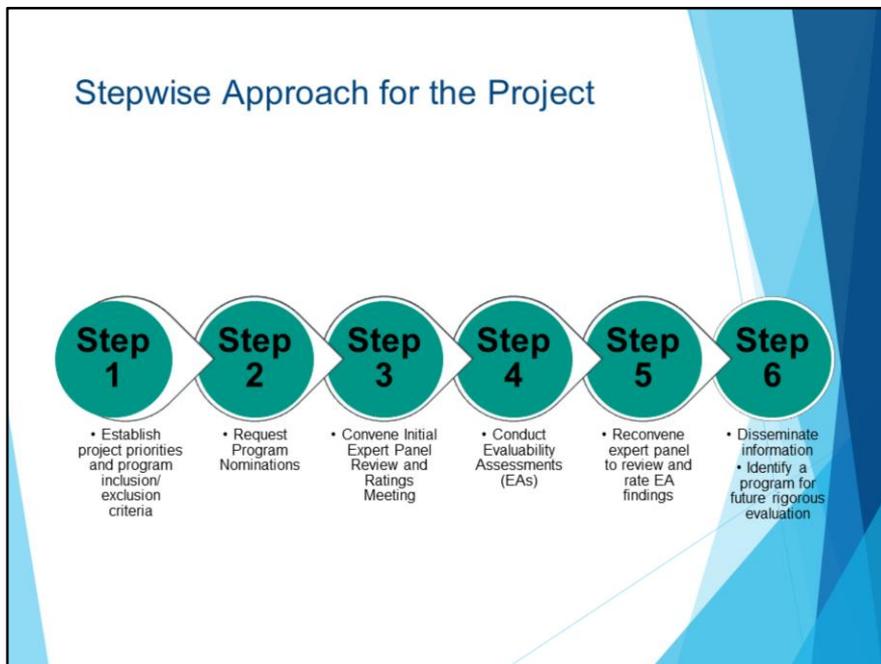
- An example of a conceptual framework that could be used for the evaluation design is the Health Rankings Model.
- This model recognizes four weighted health factors that influence length and quality of life – social and economic factors, health behaviors, clinical care, and physical environment. These factors and their relative weights are based on a review of the literature, expert opinion, and data analysis.
- You can use this model to determine what should be measured under each health factor. For example:
 - Under clinical care, you could collect data on the quality of care delivered and associated costs.
 - For physical environment, you could examine community resources, such as transportation infrastructure.

Now I will turn it over to Jasmin to walk us through an example from DHDSF that includes a health equity focus.



Example: Identifying Promising Programs to Advance Health Equity for CVD

- Thank you, Ashley.
- Keeping the CDC Evaluation Framework in mind, I will provide an example of one of our recent projects that aimed to identify promising programs to advance health equity for cardiovascular disease.
- As you know, DHDSP funds state and local health departments and tribes to prevent and control cardiovascular disease.
- Many of these programs focus on geographic areas with a disproportionate risk of CVD and groups who experience racial/ethnic or socioeconomic disparities.
- So, we wanted to identify programs in the field that may be beneficial to these areas or groups.



- This project used a pre-evaluation methodology known as a systematic screening and assessment and evaluability assessment (SSA/EA).
- The goal of this methodology is to identify promising programs in the field that may be ready for rigorous evaluation to determine their effectiveness.
- In this way we can find what is working in the field, build the evidence-base, and disseminate our findings so that the program can be replicated by other organizations.
- This methodology has six steps, that starts with setting priorities and requesting nominations, then screening them against criteria, conducting sites visits to determine their evaluation readiness, and finally, screening them again to determine which is most ready for a rigorous evaluation.

Programs Eligible to Participate in the Project

- ▶ Eligible programs have strategies that:
 - ▶ focus on advancing health equity, reducing health disparities and/or addressing the social determinants of health.
 - ▶ focus on reducing/preventing heart disease, stroke and other cardiovascular disease conditions or preventing risk factors related to heart disease and stroke.
 - ▶ have been delivered in the United States for at least 6 months.

- **The first step in an SSA/EA approach is to** establish project priorities and program inclusion/exclusion criteria.
- In this project eligible programs had to focus on advancing health equity, reducing health disparities, and addressing the social determinants of health.
- We were also interested in programs that focused on reducing or preventing CVD or related risk factors.
- Lastly, the program had to be in the United States and in operation for at least 6 months.

Health Equity: Project Definition and Criteria

“Advancing health equity requires eliminating health inequities and health disparities through action on the social determinants of health.”

A program had to have one or more of the following components to be considered as advancing health equity:

- Modify health systems to provide more culturally and linguistically appropriate services
- Address social determinants of health for an individual
- Engage community to raise public awareness of disparities or conditions; and/or help identify community needs and provide input on appropriate and effective care
- Involve partners from multiple sectors
- Implement strategies beyond the health sector

Baker E, Metzler M, Galea S. Addressing social determinants of health inequities: learning from doing. American Journal of Public Health 2005; 95(4):553-555.
Brennan Ramirez LK, Baker EA, Metzler M. Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2008.
Centers for Disease Control and Prevention – Division of Community Health. A Practitioner’s Guide for Advancing Health Equity. Community Strategies for Preventing Chronic Disease. Atlanta, GA: US Department of Health and Human Services; 2013.
Braveman P. Health disparities and health equity: concepts and measurement. Annu Rev Public Health 2006; 27:167-194.

- To apply a health equity lens to the nominated programs, it was important to develop an operational definition that we could use to help us identify programs that were most likely to advance health equity.
- This lens for health equity was guided by research that indicates that advancing health equity requires eliminating health inequities and health disparities through action on the social determinants of health.

We considered a program to be advancing health equity if it had the following components:

- Modified health systems to provide more culturally and linguistically appropriate services;
- Addressed social determinants of health for an individual;
- Engaged community to raise public awareness of disparities or conditions; and/or help identify community needs and provide input on appropriate and effective care;
- Involved partners from multiple sectors; and
- Implemented strategies beyond the health sector.

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Three Programs Selected to Assess Readiness for Evaluation

San Francisco Health Network Hypertension Health Equity Project

- **Setting:** Public health department clinics
- **Priority Population:** Blacks/African Americans with hypertension
- **Health Equity Approach:**
 - Chronic Care Visits with RNs
 - Food Pharmacy
 - Data Monitoring

North West Ohio Pathways HUB

- **Setting:** Community-based health center/clinic
- **Priority population:** Residents of 6 low-income, low education zip codes
- **Health Equity Strategies:**
 - Community Health Workers
 - Care Coordination

Grady Hospital Heart Failure Program in Atlanta, GA

- **Setting:** Hospital
- **Priority population:** African-Americans, patients with low socioeconomic status
- **Health Equity Strategies:**
 - Specialized Transportation
 - Mobile Integrated Health
 - Medication Access

- After we screened the nominations and reviewed them with a panel of experts, three programs were selected for an evaluability assessment.
- The three programs selected represented a range of settings. The programs were delivered in public health department clinics, a community-based health center, and a hospital.
- For programs in San Francisco and Atlanta, the priority populations included Blacks/African Americans. The priority population for the NW Ohio program was residents in six zip codes.
- The San Francisco Program focuses on three areas to advance health equity:
 - To improve quality of care for African American patients, the project offers chronic care visits with registered nurses. In these visits materials are tailored to the unique needs of the patients.
 - In partnership with local food banks, the project offers a food pharmacy in its clinic to promote consumption of healthy foods, increase nutrition knowledge, and increase access to healthy food.
 - Lastly, the project collects, tracks, and shares with clinic staff the blood pressure control rate for African American patients and set goals for improving in blood pressure control.
- The North West Ohio Pathways HUB uses community health workers (CHWs) who

- are familiar with or live in the local community to support and help clients meet their health and social needs. The program also employs care coordination to address unmet health and social needs. CHWs match clients with resources that address needs such as enrollment in health insurance plans or transportation resources.
- The Grady Heart Failure Program utilizes three approaches to address health disparities and advance health equity in its priority population:
 - In partnership with a ride service company, the program provides specialized transportation for heart failure patients who may otherwise be limited or confined to their homes due to poor health. These patients receive transportation to and from their appointments.
 - For Mobile Integrated Health, the program partners with the hospital's Emergency Medical Services and pairs a paramedic and Program nurse together to provide CVD care and deliver medication to a person's home in order to provide access to care.
 - Finally, the program provides access to medication by partnering with pharmaceutical companies. The medication assistance allows patients to receive medication for free or at a significantly reduced price.
 - These programs rose to the top because they had specific components addressing health disparities in vulnerable populations through action on SDH.

Evaluability Assessment Criteria

Category	Criteria
Program Design	Is the program aligned with primary priority areas , specifically the reduction or prevention of heart disease, stroke, or other cardiovascular disease conditions?
Potential Impact	The intervention appears to have potential for impact on the social or physical environment pertinent to heart disease, stroke, or other cardiovascular disease conditions.
Evaluation Capacity	Does the program have the capacity to provide data for evaluation (i.e., staff have the capacity to participate fully in an evaluation)? Does it seem that an external rigorous evaluation is feasible given the description of the strategy, the existing data collection activities and targeted population(s)?
Sustainability	What is the likelihood that the program can continue over time without special resources or extraordinary leadership support? What is the likelihood that the program's intended health effect will endure over time?
Replicability	To what degree is the strategy able to be replicated in a similar setting and target population?
Transferability	To what degree is the strategy able to be replicated in a different setting and target population?

- Experts were asked to review and score the programs based on criteria in six categories: program design, potential for impact, evaluation capacity, sustainability, replicability and transferability. I want to highlight three of the categories in which health equity was incorporated.

First, the program had to be aligned with the primary priority areas, and that included a focus on advancing health equity, reducing health disparities and/or addressing the social determinants of health.

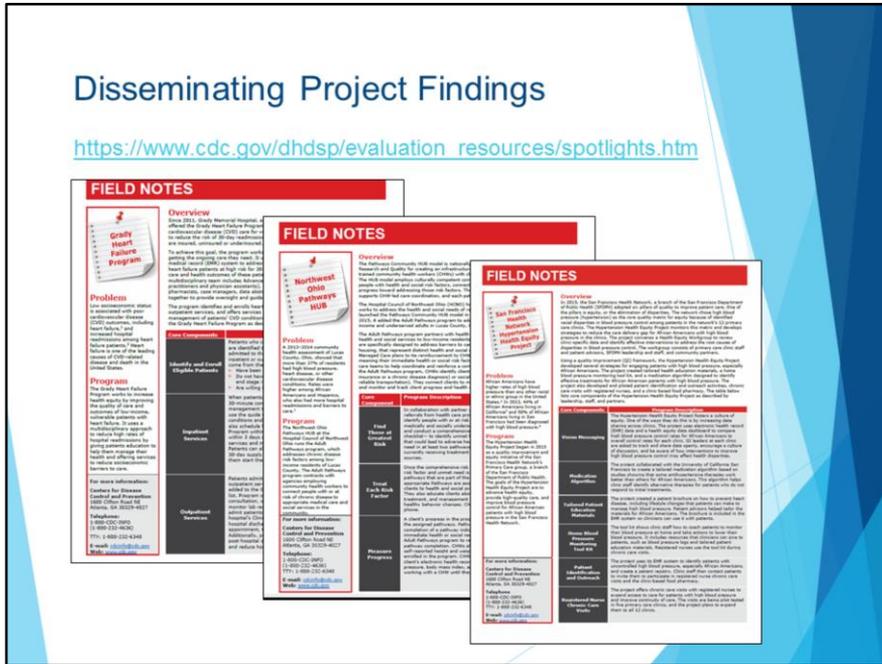
Second, the invention had to impact the social or physical environmental conditions related to heart disease, not just individual behaviors.

Finally, the program had to have data for evaluation, including data related to health equity, such as disaggregated data or data on the social determinants of health.

By applying these criteria, we determined that only one program was mature enough and had the necessary data for a rigorous evaluation.

Disseminating Project Findings

https://www.cdc.gov/dhdsp/evaluation_resources/spotlights.htm



- Experts were asked to review and score the programs based on criteria.
- By applying these criteria, we determined that only one program was mature enough and had the necessary data for a rigorous evaluation.
- The final program selected focused on CVD outcome data. In the future we will spend more time collecting data on SDH and/or structural drivers.
- We disseminated the findings of this project through field notes. These are short, two-page documents that highlight the program components, progress toward implementation, and reach and impact, among other things. For these particular field notes, we added a section on how the program is addressing health disparities.
- You can find the field notes on our webpage.

Considerations

- Consider ways to build capacity for health equity in your organization
 - Can start with reflection and education/training
- Can start small - Consider ways you can incorporate health equity in evaluation projects
 - Adapt different models
 - Establish a shared understanding of health equity
 - Include diverse stakeholder perspectives

- In conclusion, we want to acknowledge that doing this work is important but challenging to put into practice.
- One place to start could be by building capacity within your organization to talk about health equity. This can include reflection and education or training to build capacity.
- In terms of incorporating health equity into evaluation, it may be best to start small. We provided examples in this presentation of ways that you can incorporate different models of health to develop your program description, possible criteria and definitions that you can use for health equity, and ways to work with priority populations to advance health equity.

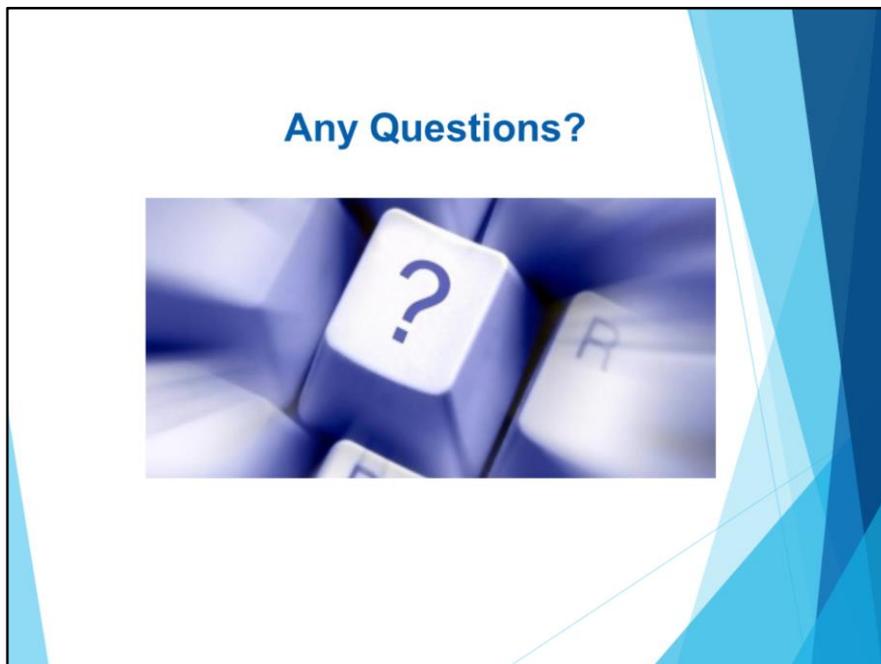
Resources

- ❑ CDC. *Integrating Cultural Competence into Evaluation*.
https://www.cdc.gov/dhdsp/docs/Cultural_Competence_Tip_Sheet.pdf
- ❑ CDC. *Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health*.
<https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/pdf/SDOH-workbook.pdf>
- ❑ CDC. *Field Note: Grady Heart Failure Program*.
<https://www.cdc.gov/dhdsp/docs/field-note-grady-heart-failure-program-508.pdf>
- ❑ CDC. *Field Note: Northwest Ohio Pathways HUB*.
https://www.cdc.gov/dhdsp/docs/field-note_nwOhio-pathways-508.pdf
- ❑ CDC. *Field Note: San Francisco Hypertension Health Equity Project*.
<https://www.cdc.gov/dhdsp/docs/field-note-sf-health-network-508.pdf>

- Here are a few more resources that you might find useful.

Resources, continued

- Prevention Institute. *Measuring What Works to Achieve Health Equity: Metrics for the Determinants of Health*.
https://www.preventioninstitute.org/sites/default/files/publications/Measuring%20What%20Works%20to%20Achieve%20Health%20Equity%20_Full_Report.pdf
- Institute for Healthcare Improvement. *Achieving Health Equity: A Guide for Healthcare Organizations*.
<http://www.ihl.org/resources/Pages/IHIWhitePapers/Achieving-Health-Equity.aspx>



MODERATOR:

At this time, we'll take an questions but first we'll check to see if any questions have come in through the Q&A box.

If we have questions ask the questions posed by the attendees to the presenter

If we do not have questions, proceed with the script below

Since it appears that we have no questions at this time from the audience, we have some questions that we wanted to ask that might be insightful to our participants.

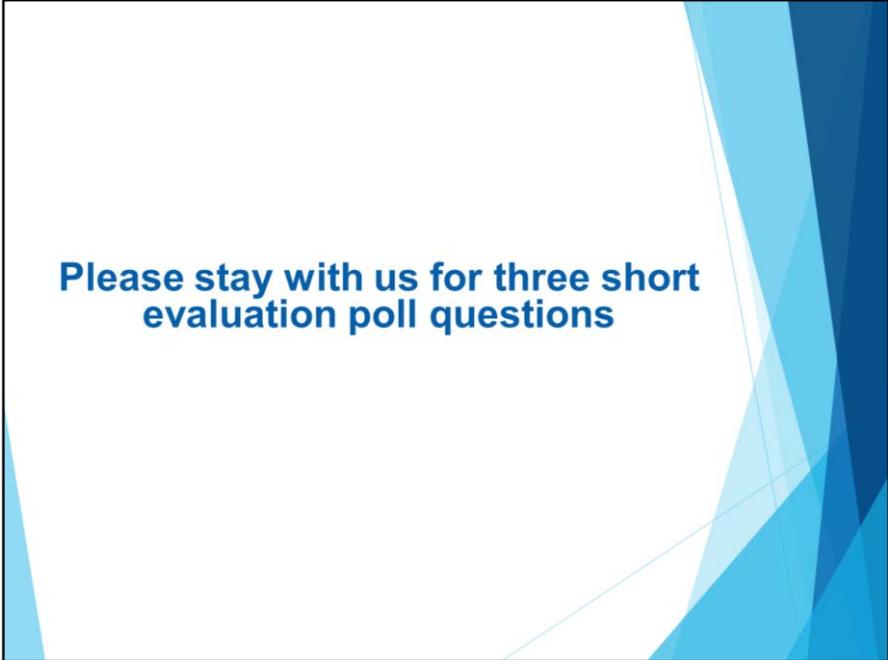
1. You mentioned that the example you gave is one of several DHDSP evaluation projects that incorporate a health equity lens. Can you share information about some of the other projects?
 1. Sure. As a result of the SSA/EA process we briefly described in today's presentation, we are closely examining the Grady Heart Failure Program's implementation processes to obtain conclusive results of its effectiveness in reducing or controlling cardiovascular disease and advancing health equity.

The Grady Heart Failure Program (GHFP) serves a mainly lower income and African American population, with goals of advancing health equity, reducing hospital readmissions and length of stay, improving quality of care, improving health outcomes, and reducing mortality. The purpose is to determine whether the program can be recommended for replication.

2. In one project, we are evaluating the implementation of Kaiser Permanente Colorado's Hypertension Management Program and its core components in two healthcare systems with a high burden of uncontrolled hypertension. The evaluation will yield evidence of the replicability and transferability of an effective hypertension management program and create tools for health systems eager for strategies that effectively manage hypertension in lower resource settings.

2. How might recipients be able to use this information to inform their recipient-led evaluations that are part of the Division's cooperative agreements?

Good question. We focused on the first three steps to align with the planning phases of evaluation. Recipients can review how to incorporate health equity into these early steps. Recipients can also consider using a SSA/EA approach followed by an effectiveness evaluation using rigorous methods. In addition, you may want to investigate if your health department already has a framework for advancing health equity or reducing health disparities. As we are aware that there are many health departments that have such frameworks. If your department has a framework, you could align your evaluation with the framework's overarching goals and strategies.



Please stay with us for three short
evaluation poll questions

MODERATOR:

Next, please stay with us for three short poll questions.

Please allow a few seconds for the poll to pop up on your screen. We will pause for a few moments after the question is presented to give you time to answer. One moment everyone.

Moderator present poll question. Make sure to read the following after presenting each.

The **[first, second, or third]** question should be showing, it read **[read question and potential answers]**

Please respond with the appropriate answer at this time.

Please stay with us to answer a couple poll questions.

The level of information was...

Too basic
About right
Beyond my needs

The information presented was helpful to me.

Yes
Somewhat
Not at all

Reminders!

All sessions are archived and
the slides and script can be accessed at:

<https://www.cdc.gov/dhdsp/pubs/webcasts.htm>

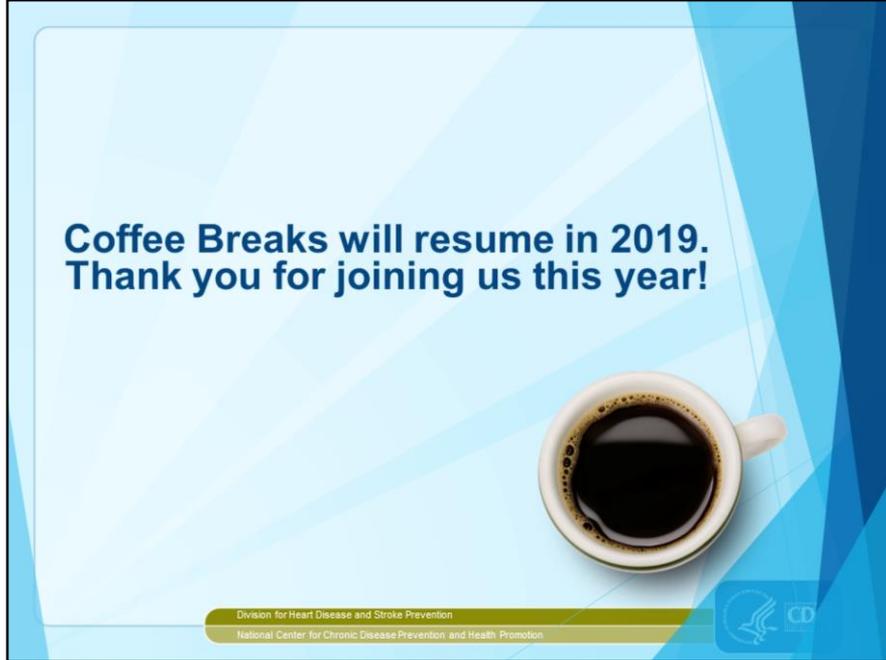
If you have any questions, comments, or topic
ideas send an email to:

AREBheartinfo@cdc.gov

Thank you for your participation!

As a reminder, all sessions are archived and the slides and script can be accessed at our Division website. Today's slides will be available in 2-3 weeks.

If you have any ideas for future topics or questions, please contact us at the listed email address on this slide.



Finally, this is our last coffee break for 2018. We will be sending out a summary of all the topics we have covered this year in the coming weeks and we will restart again in 2019. As such, please keep a watch on your emails for the next round of coffee breaks.

Thank you for joining us. Have a terrific day everyone. This conclude today's call.