



Connecticut Department of Public Health Office of Health Equity Strategic Plan 2015 – 2018

Championing a Culture of Health Equity

Funding for this plan was provided by the U.S. Department of Health and Human Services' Office of Minority Health (OMH) within the Office of the Secretary as part of a National Partnership for Action to End Health Disparities capacity-building project with the Association of State and Territorial Health Officials.

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STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner



Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

October 19, 2015

Dear Colleagues:

Health equity – the equal enjoyment of the highest attainable standard of health for all people – is a top priority of the Connecticut Department of Public Health (DPH). No one should be disadvantaged from achieving full health potential because of social position or other socially determined circumstance.

Since 2012, DPH has incorporated this principle of health equity into its planning efforts. The DPH Strategic Plan, 2013-2018 has identified health equity as a cross-cutting strategic priority. Healthy Connecticut 2020, the State Health Improvement Plan, has adopted health equity as a central tenet in its goals and objectives, and the social determinants of health – the circumstances in which we live, work, and play – as a focal point in improving services and addressing population health.

We are now pleased to present the DPH Office of Health Equity Strategic Plan, 2015 – 2018 as one more component of our agency's commitment to a policy, planning, and population-based approach to achieve health equity. This plan is closely aligned with all other DPH strategic priorities and planning efforts in promoting equitable and fair approaches to achieving optimum health for all Connecticut residents. Please join us in moving the principles, goals, and work of health equity forward in Connecticut.

Sincerely,

A handwritten signature in black ink that reads "Jewel Mullen" with a long horizontal line extending to the right.

Jewel Mullen, MD, MPH, MPA
Commissioner



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- General technical assistance and funding administration was provided by the **Association of State and Territorial Health Officials (ASTHO)**, the national nonprofit organization representing public health agencies in the United States, the U.S. Territories, and the District of Columbia, and over 100,000 public health professionals these agencies employ. Visit www.astho.org for more information.
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Table of Contents

Message from the Commissioner	<i>iii</i>
Office of Health Equity Core Leadership Team	<i>iv</i>
Acknowledgments	<i>v</i>
Table of Contents	<i>vii</i>
Preface	<i>viii</i>
Key Terms and Definitions	<i>ix</i>
I. Introduction: Championing a Culture of Health Equity	<i>1</i>
II. Office of Health Equity (OHE): Structure, Roles, and Responsibilities	<i>6</i>
III. Defining the DPH Culture of Health Equity	<i>8</i>
IV. Stakeholders and Partnerships	<i>10</i>
V. Strategic Challenges and Opportunities for Health Equity	<i>11</i>
VI. Strategic Goals and Objectives to Champion a Culture of Health Equity	<i>12</i>
VII. Alignment with Other DPH Strategic Priority Areas	<i>15</i>
VIII. Monitoring the Progress and Impact of the Health Equity Strategic Plan	<i>16</i>
IX. Three-Year Work Plan to Support Health Equity Goals	<i>17</i>
X. Detailed Annual Work Plan to Support Health Equity Goals (Year 1)	<i>23</i>
APPENDICES	<i>35</i>
Appendix A: DPH's Health Equity History and Process	<i>36</i>
Appendix B: DPH's Strategic Planning Process Summary	<i>41</i>
Appendix C: Overview of OHE's Health Equity Strategic Planning Activities	<i>43</i>
Appendix D: Health Equity Strategic Plan Activities	<i>45</i>
Appendix E: Partnership List by Organization Type	<i>46</i>
Appendix F: OHE's SWOT Analysis Results	<i>51</i>
Appendix G: Workgroup Recommendations — Health Equity Definitions.	<i>54</i>
Appendix H: Workgroup Recommendations — Health Equity Data and Surveillance	<i>58</i>
Appendix I: Workgroup Recommendations — CLAS Standards	<i>60</i>
Appendix J: Workgroup Recommendations — Health Equity Workforce Training	<i>65</i>
Appendix K: Workgroup Recommendations — Health Equity Partnerships	<i>70</i>
Appendix L: Public Health Systems Improvement Unit (PHSI) and the Public Health Strategic Team (PHST): Roles and Responsibilities	<i>72</i>
Appendix M: Turning Point Performance Management Framework Details	<i>74</i>
Appendix N1: Strategic Map Update – Implementation Planning Worksheet – Track of Work: Health Equity	<i>76</i>
Appendix N2: Strategic Map Update – Implementation Planning Worksheet – Track of Work: Data Quality and Reliability	<i>77</i>

Preface

The Connecticut Department of Public Health Office of Health Equity Strategic Plan, 2015 – 2018 is a three-year blueprint for integrating the principles of health equity into the everyday practices, policies, and services of the agency. The three-year work plan will be reviewed and updated as needed on an annual basis.

DPH health equity strategic planning efforts began in 2012 as one part of the DPH Strategic Plan, 2013 – 2018. Since then, DPH staff and partners have engaged in a series of working group meetings and self-assessments to further develop: 1) our understanding of interrelated concepts of health equity and the social determinants of health (SDOH); and 2) our approach to integrate a health equity perspective and SDOH framework into ongoing program and planning efforts of the agency.

The plan is divided into the following sections: 1) Introduction: Championing a Culture of Health Equity; 2) Office of Health Equity (OHE): Structure, Roles, and Responsibilities; 3) Defining the DPH Culture of Health Equity; 4) Stakeholders and Partnerships; 5) Strategic Challenges and Opportunities for Health Equity; 6) Strategic Goals and Objectives to Champion a Culture of Health Equity; 7) Alignment with Other DPH Strategic Priority Areas; 8) Monitoring the Progress and Impact of the Health Equity Strategic Plan; 9) Three-Year Work Plan to Support Health Equity Goals; and 10) Detailed Annual Work Plan. A series of Appendices follow, which provide documentation on the extensive efforts to develop strategic priorities for promoting health equity in the everyday practices, policies, and services of DPH.

Key terms and definitions used in this plan are described in the next section. Concepts such as health equity, health disparities, and the social determinants of health help to characterize the underlying social structures and relationships that influence population health. Such concepts provide a common language for public health; they help to clarify meanings; and they unite us in achieving a common understanding, vision, and purpose – that is, to focus our efforts on social structural and institutional change to improve public health.

With the passage of the federal [Affordable Care Act](#), signed into law by President Obama on March 23, 2010, there has been a renewed focus at the federal and state levels on health outcomes – that is, achieving health equity – rather than on health problems or health disparities per se. There is also a recognition that: “From the health equity perspective, improving the health of minority communities is a social and moral imperative because it is socially just and will benefit society as a whole.”¹

¹ Grantmakers in Health (2010) What’s in a Name: Untangling Health Disparities, the Social Determinants of Health, and Health Equity. Available at: http://www.gih.org/files/usrdoc/Issue_Focus_Whats_In_a_Name_3-22-10.pdf

Key Terms and Definitions

- **Community:** A group of people who share some or all of the following characteristics: sociodemographics, geographic boundaries, sense of membership, culture, language, common norms, and interests (CommonHealth ACTION, adapted from the Centers for Disease Control and Prevention [CDC], n.d.).
- **Culture:** A dynamic pattern of learned values, beliefs, norms, behaviors and customs that are shared and transmitted by a specific group of people. Some aspects of culture, such as food, clothing, modes of production and behaviors, are visible. Major aspects of culture, such as values, gender role definitions, health beliefs and worldview, are not visible (Adapted from The California Endowment, n.d.).
- **Culture of Health Equity:** A dynamic process that considers shared values, and diverse beliefs, customs, and behaviors, to ensure that all individuals have fair and equitable opportunities to attain their highest potential for social, physical, and mental well-being (Connecticut Department of Public Health [DPH], 2015).
- **Disparity:** A noticeable and often unfair difference between people or things (Merriam-Webster, n.d.).
- **Equal:** 1) Of the same measure, quantity, amount, or number as another. 2) Regarding or affecting all objects in the same way (Merriam-Webster, n.d.).
- **Equality:** Equal treatment that may or may not result in equitable outcomes (Xavier University, n.d.).
- **Equity:** Providing all people with fair opportunities to attain their full potential to the extent possible (CommonHealth ACTION, adapted from Braveman and Gruskin, 2003).
- **Equity Lens:** The perspective through which one views conditions and circumstances to understand who receives the benefits and who bears the burdens of any given program, policy, or practice (adapted from CommonHealth ACTION, n.d.).
- **Health:** A state of complete physical, mental, and social well-being, not merely the absence of disease (World Health Organization [WHO], 1948).

- **Health Disparities:** The avoidable differences in health that result from cumulative social disadvantage. Specifically, "...the differences in disease risk, incidence, prevalence, morbidity, and mortality and other adverse conditions, such as unequal access to quality health care that exist among specific population groups in Connecticut. Population groups may be based on race, ethnicity, age, gender, socioeconomic position, immigrant status, sexual minority status, language, disability, homelessness, mental illness, and geographical area of residence." (Adapted from Stratton A, Hynes MM, and Nepaul A, 2007).
- **Health Equity:** Equity in health refers to how uniformly services, opportunities and access are distributed across groups and places, according to the population group. Equity in health implies that ideally everyone could attain their full health potential and that no one should be disadvantaged from achieving this potential because of their social position or other socially determined circumstance. Efforts to promote equity in health are therefore aimed at creating opportunities and removing barriers to achieving the health potential of all people. It involves the fair distribution of resources needed for health, fair access to the opportunities available, and fairness in the support offered to people when ill. (Adapted from the World Health Organization Concept Paper as cited by the American Medical Student Association, n.d.).
- **Healthy Connecticut 2020:** The State Health Improvement Plan, which sets measurable health objectives with targets and strategies for Connecticut. Objectives are organized within seven broad focus areas: maternal, infant, & child health; environmental risk factors & health; chronic disease prevention & control; infectious disease prevention & control; injury & violence prevention; mental health, alcohol, & substance abuse; and health systems.
- **Health Inequity:** An unfair and avoidable difference in health status seen within and between communities. (Adapted from the WHO Commission on Social Determinants of Health).
- **Inequity:** A difference or disparity between people or groups that is systematic, avoidable, and unjust (CommonHealth ACTION, adapted from CDC, n.d.).
- **Public Health Accreditation Board (PHAB) Standards:** A set of national benchmarks for public health agencies, which are recognized, practice-focused and evidenced-based. Health department performance is measured against these standards, and national accreditation is granted to those meeting standards within a specified time frame. PHAB's goal is to improve and protect the health of the public by advancing the quality and performance of public health departments.
- **PHAB Standard 11.1:** "Develop and Maintain an Operational Infrastructure to Support the Performance of Public Health Functions." Measure 11.1.4A refers

to: health department “Policies, processes, programs, and interventions provided that are socially, culturally, and linguistically appropriate to specific populations with higher health risks and poorer health outcomes.”

- **Social determinants of health:** The conditions in which people are born, grow, live, work, age and die, including the health system. These circumstances are shaped by the distribution of money, power, and other resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between communities. (Adapted from the WHO Commission on Social Determinants of Health).
- **Socially disadvantaged:** Those populations “who have persistently experienced social disadvantage or discrimination...and systematically experience worse health or greater health risks than more advantaged social groups...” conversely, socially advantaged refers to a group’s relatively high “...position in a social hierarchy determined by wealth, power, and/or prestige” (Braveman, 2006).
- **Turning Point Performance Management Framework:** A set of resource materials to help public health systems manage performance, which were first developed in 2003 by the Public Health Foundation (PHF). These materials were developed and revised over time, and in 2013, PHF released an updated Public Health Performance Management System Framework, which includes four key components: 1) Performance Standards, 2) Performance Measurement, 3) Reporting of Progress, and 4) Quality Improvement.
- **Under-resourced:** Those populations that have insufficient capital or assets (e.g. economic, human or social), in part due to historical policies and systemic exclusion. (Adapted from CommonHealth ACTION, n.d.).
- **Vulnerable:** Those populations that are “not well integrated into the health care system because of cultural, economic, geographic, or health characteristics...This isolation puts members of these groups at risk for not obtaining necessary medical care, and thus constitutes a potential threat to their health.” (Urban Institute Health Policy Center 2010).

Sources:

Braveman P, and Gruskin S. (2003). Defining equity in health. *Journal of Epidemiology & Community Health*, 57, 254-8. doi:10.1136/jech.57.4.254.

Braveman, P. (2006). Health Disparities and Health Equity: Concepts and Measurement. *Annual Review of Public Health* 27:167-94. Available at: <http://www.ops.org.bo/textocompleto/riarph270004.pdf> (Accessed 10/26/15).

California Endowment. (n.d.). Principles and Recommended Standards for Cultural Competence Education of Health Care Professionals.

Centers for Disease Control and Prevention [CDC]. (n.d.). Community Engagement: Definitions and Organizing Concepts from the Literature.

CDC. (2008). Community Health and Program Services (CHAPS): Health Disparities Among Racial/Ethnic Populations. Atlanta: U.S. Department of Health and Human Services. <http://www.cdc.gov/healthyouth/disparities/> (Accessed 10/26/15).

CDC. (2010). Community Health Assessment and Group Evaluation (CHANGE) Action Guide: Building a Foundation of Knowledge to Prioritize Community Needs. Atlanta: U.S. Department of Health and Human Services.

CDC. (2015). Health Equity. <http://www.cdc.gov/chronicdisease/healthequity/index.htm> (Accessed 10/26/15).

CommonHealth ACTION Institutional Glossary. <http://commonhealthaction.org/> (Accessed 10/26/15).

Connecticut Department of Public Health (2015). Office of Health Equity Strategic Planning Meeting, May 12, 2015.

Disparity. (n.d.). Merriam-Webster Online. <http://www.learnersdictionary.com/definition/disparity>. (Accessed 10/26/15).

Equal. (n.d.). Merriam-Webster Online. <http://www.merriam-webster.com/dictionary/equal>. (Accessed 10/26/15).

Public Health Accreditation Board (PHAB) Standards. (n.d.) Available at: <http://www.phaboard.org/accreditation-process/public-health-department-standards-and-measures/> (Accessed 10/27/15).

Public Health Foundation. (2015). Turning Point: Performance Management Project and Publications. http://www.phf.org/resourcestools/pages/turning_point_project_publications.aspx (Accessed 10/26/15).

Stratton A, Hynes MM, and Nepaul A (2007). Defining Health Disparities. Hartford, CT: Connecticut Department of Public Health. Available at: <http://www.ct.gov/dph/cthealthdisparitiesproject> (Accessed 10/26/15).

Urban Institute, Health Policy Center. (2010). Vulnerable Populations. Washington, DC: Urban Institute, Health Policy Center. Available at: <http://www.urban.org/center/hpc/index.cfm> (Accessed 10/26/15).

World Health Organization [WHO]. (1948, April 7). Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

World Health Organization Concept Paper as cited by the American Medical Student Association. Available at: <http://www.amsa.org/> (Accessed 10/26/15).

WHO. (n.d.). Social Determinants of Health. http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/index.html. (Accessed 10/26/15).

Xavier University. (n.d.). Glossary of Terminology. <http://www.xavier.edu/diversity/Glossary-of-Diversity-Terminology.cfm>. (Accessed 10/26/15).

I. Introduction: Championing a Culture of Health Equity

The Connecticut Department of Public Health (DPH) recognizes that achieving its vision of healthy people in healthy Connecticut communities requires that we emphasize the principle of health as a human right and a social good for all people. Thus, “health equity” is now a top priority of DPH. We define health equity as the attainment of the highest level of health for all people. No one should be disadvantaged from achieving full health potential because of social position or other socially determined circumstance. We deliberately focus on health disparities as part of our commitment to a policy and population-based approach to achieve equity. Current DPH efforts and initiatives are consistent with this effort, specifically:

- The [DPH Mission Statement](#), which was revised in 2012, to include the principle of health equity;
- The [DPH Strategic Plan, 2013-2018](#), which has identified "champion a culture of health equity" as one of its nine strategic priorities; and
- The [State Health Improvement Plan \(SHIP\), 2014-2020](#), “Healthy Connecticut 2020,” which includes health equity and the social determinants of health as overarching themes for the entire plan. A total of 39 SHIP objectives address health equity issues.

If we do not examine how our programs, policies, and practices disproportionately burden or benefit people in our state, then we run the risk of improving overall health while masking and even worsening health disparities between population groups. In order to achieve health equity, we must consider and address the root causes that create the unfair and avoidable differences in health status that exist within our state’s population.

National and State Context

Our DPH planning efforts are aligned with other similar national and state efforts. For example, the [National Partnership for Action to End Health Disparities \(NPA\)](#) was established under the guidance of the U.S. Department of Health & Human Services (HHS), Office of Minority Health to mobilize a community-driven, comprehensive approach to combating health disparities and to move the nation toward achieving health equity. This effort developed into the [National Stakeholder Strategy for Achieving Health Equity \(National Stakeholder Strategy\)](#), which was released in April, 2011. It is a roadmap for eliminating health disparities through cooperative and strategic actions.

The [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#), which was released together with the National Stakeholder Strategy, identifies goals and actions HHS will take to reduce health disparities among racial and ethnic minorities. It builds on provisions of the federal [Affordable Care Act](#), signed by President Obama in 2010, and is aligned with programs and initiatives such as the national [Healthy People 2020](#) initiative.

With implementation of the federal [Affordable Care Act](#), federal funds also supported the State Innovation Model (SIM) Design, which aims to improve health care quality and community health and reduce the rate of growth in health care spending. In 2014, Connecticut was one of 16 states awarded federal funds to develop its State Health Care Innovation Plan. The [Connecticut SIM](#) vision is to “Establish a whole-person-centered health care system that improves community health and eliminates health inequities; ensures superior access, quality, and care experience; empowers individuals to actively participate in their health and healthcare; and improves affordability by reducing healthcare costs.”¹

DPH Health Equity History and Process

Health equity is a process that requires continuous commitment. For four decades, DPH has invested in creating equitable opportunities for all Connecticut residents to experience good health. By establishing Community and School-Based Health Centers, identifying Health Professional Shortage Areas, and supporting local health districts, DPH has connected vulnerable Connecticut communities to essential public health services.

Beginning with the establishment of the Office of Multicultural Health in 1998, DPH has been active in both internal and external efforts to promote diversity and multicultural approaches in its efforts to ensure that all residents have access to public health and health care services. We have invested in developing partnerships to understand and address the needs of communities of color, of people with limited English proficiency, and of other populations that experience disparities in health. We have adopted and championed non-discrimination and language access policies for our staff, vendors, and partnerships. In 2014, we reconsidered the goals and mission of the Office of Multicultural Health, and re-named it the Office of Health Equity (OHE). OHE is charged with carrying out one of our agency-wide priorities: championing a culture of health equity within DPH and throughout the state.

The major milestones in the DPH health equity history or “journey” are illustrated in [Figure 1](#). The entire timeline of events, which provides historical context for DPH’s equity-focused work, is located in [Appendix A](#).

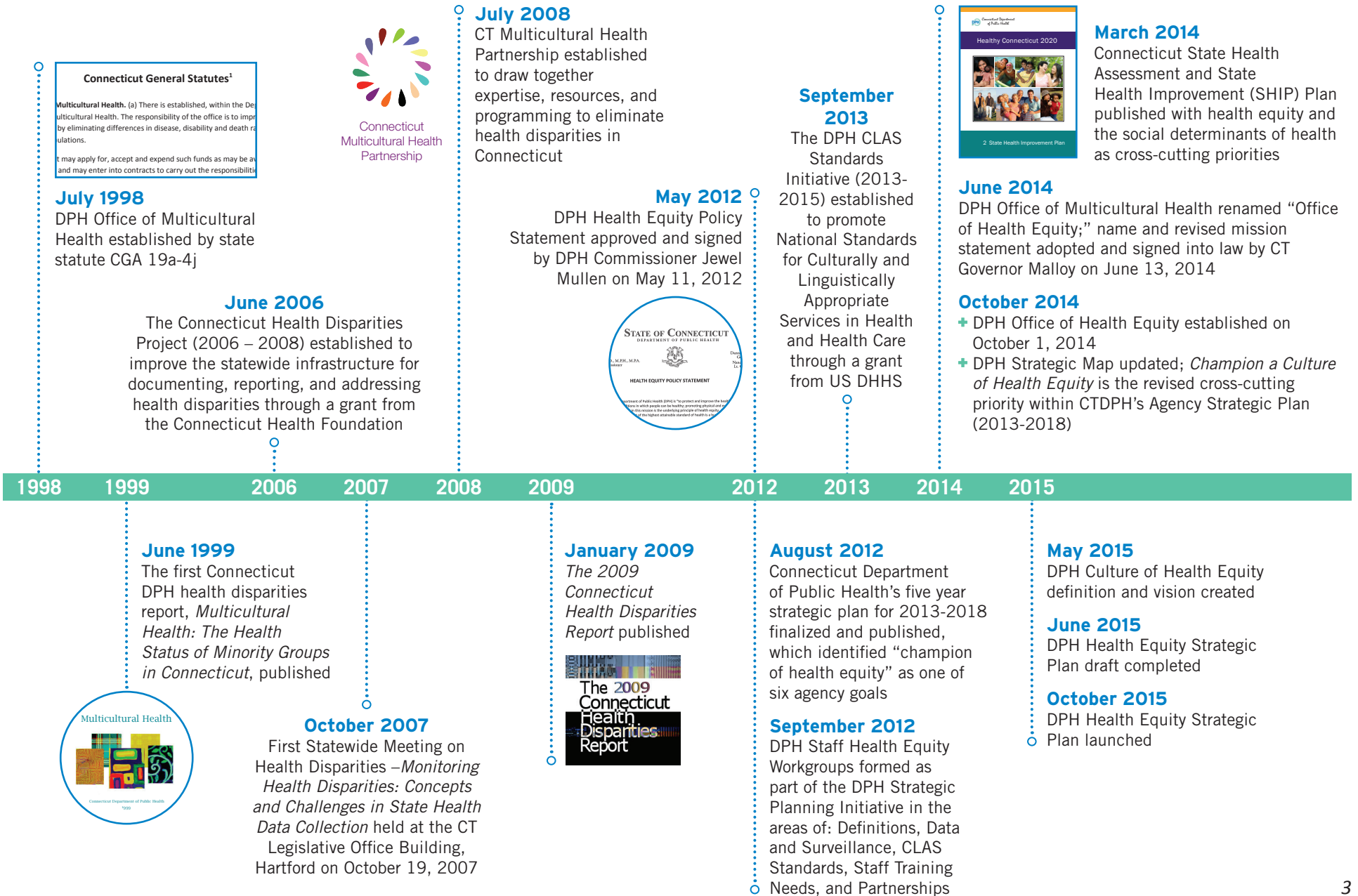
¹ Connecticut SIM: <http://www.healthreform.ct.gov/ohri/site/default.asp> (Accessed 10/27/15).



FIGURE 1

HEALTH EQUITY JOURNEY

+ Culture of Health Equity Vision: One Connecticut where all people enjoy shared resources, optimal health, well-being and a sense of dignity.

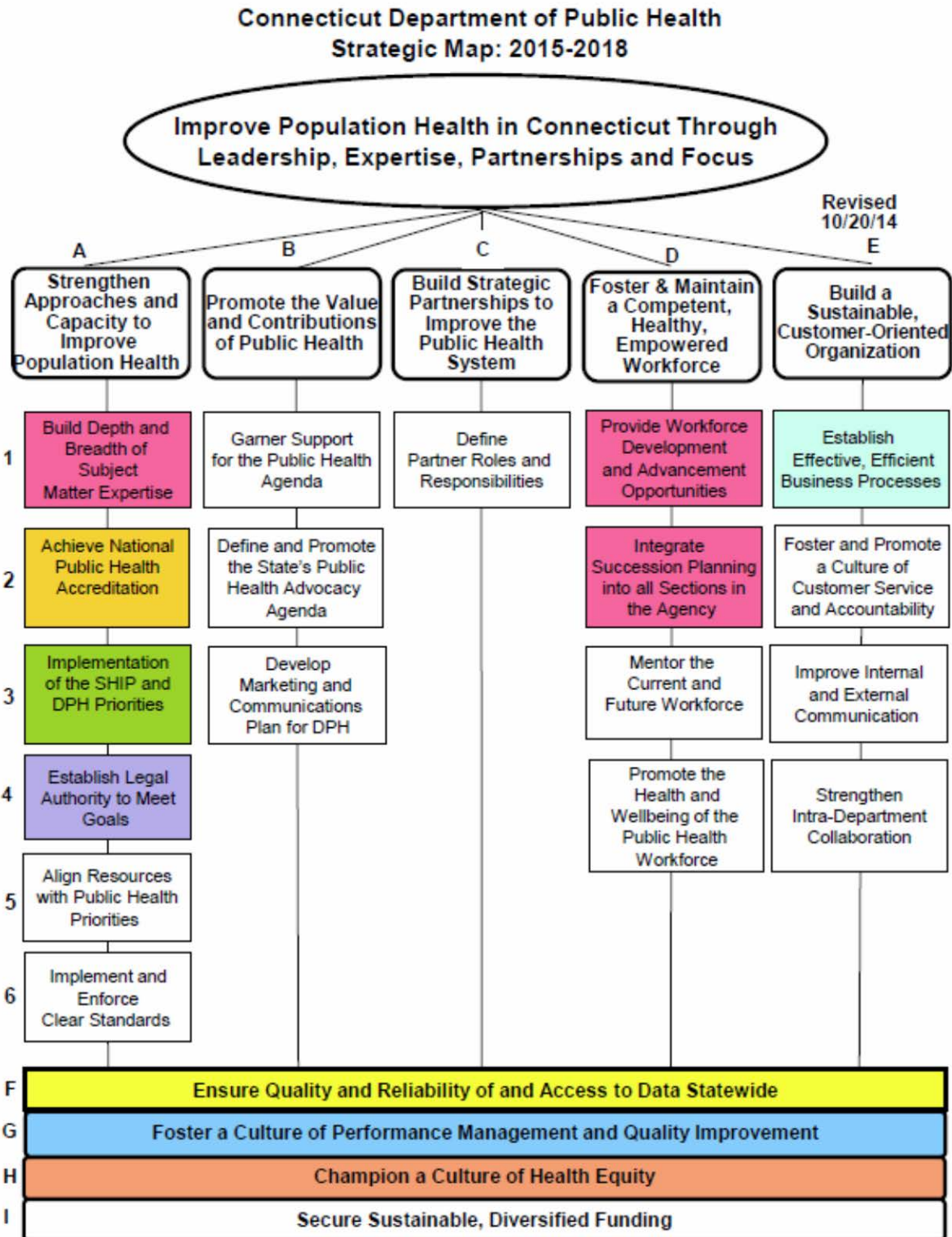


Development of the Office of Health Equity's Strategic Plan

In February 2013, DPH identified “Championing Health Equity” as one of the original priority areas in its five-year strategic plan. In October 2014, we updated the DPH strategic map to reflect the recognition that adopting an equity perspective or “lens” is critical to achieving all of our goals, thereby establishing “Champion a Culture of Health Equity” as a cross-cutting strategic priority. (See [Appendix B](#) for an overview of the Agency’s strategic planning process, and [Figure 2](#) for the updated strategic map.) The newly-created Office of Health Equity was then charged with operationalizing this priority within DPH.

This document outlines our strategic plan to advance this goal over the next three years. In this strategic plan we include an overview of the Office of Health Equity (OHE), describe our internal and external partners, present an analysis of opportunities and challenges for this work, and identify tools we will use to measure progress. We present five strategic goals to advance this cross-cutting priority; each goal is paired with specific objectives that support it. We also discuss ways in which a culture of health equity underlies, supports, and advances the Department’s five priority areas. Finally, we have developed a work plan to guide our activities over the next three years, which will be updated on an annual basis. (Please see [Appendix C](#) for an overview of OHE’s health equity strategic planning activity details.)

FIGURE 2



II. Office of Health Equity (OHE): Structure, Roles, and Responsibilities

The DPH Office of Health Equity (OHE) was created in 2014 through the Connecticut General Assembly's Public Act No. 14-231, replacing the former Office of Multicultural Health. The change in the name and mission statement of the Office followed a two-year re-consideration of DPH priorities vis à vis under-resourced (or socially disadvantaged) populations in the state, and its subsequent decision to integrate principles of health equity into all of its programs, plans, and policies.

OHE is housed within the DPH Community, Family and Health Equity Section. The Office serves to ensure that health equity: 1) is a central component of all agency programs and planning efforts; 2) supports the development of a workforce that applies an equity lens to its daily work; and 3) aligns DPH initiatives so that they serve the public health needs of all Connecticut residents. OHE program activities focus on the underlying social determinants of health and on federally supported initiatives that promote the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. The CLAS Standards are promoted within DPH, as well as among DPH contractors, local health departments, and community-based organizations.

The following vision, mission, and guiding principle will provide direction to OHE regardless of changes in agency goals, strategies, or leadership:

Vision: Healthy people in healthy, equitable Connecticut communities.

Mission: To improve the health of all Connecticut residents by working to eliminate differences in disease, disability and death rates among ethnic, racial and other population groups that are known to have adverse health status or outcomes. Such population groups may be based on race, ethnicity, age, gender, socioeconomic position, immigrant status, sexual minority status, language, disability, homelessness, mental illness or geographic area of residence.¹

Guiding Principle: Equal enjoyment of the highest attainable standard of health is a human right and a priority of the state.²

¹ This mission statement was adopted by the Connecticut General Assembly as Section 5 of Public Act 14-231 "An Act Concerning the Department of Public Health's Recommendations Regarding Various Revisions to the Public Health Statutes," which was signed into law by Governor Malloy on June 13, 2014.

² CGA Public Act No. 08-171.

Responsibilities of the Office of Health Equity are to:

- Provide leadership in the development of a DPH health equity plan and ongoing health equity implementation efforts;
- Provide technical assistance, information, and resources to internal and external partners on relevant issues related to health disparities, health equity, and the social determinants of health;
- Facilitate partnerships to address health disparities, health equity, and the social determinants of health in Connecticut and in local Connecticut communities.
- Provide leadership in the development of CLAS Standards and health equity training materials, and resources for both staff and partners;
- Provide technical assistance to DPH staff, vendors, and local health partners in implementing the CLAS Standards; and
- Coordinate and monitor the implementation of the CLAS Standards within the agency and with its vendors.

The Office is supported by three full-time, state-funded staff. Federal funds¹ have supported a part-time CLAS Standards Coordinator position, which guides the implementation of CLAS Standards within DPH, and with its contractors, local health departments, and other health organizations in Connecticut.

¹ U.S. Department of Health & Human Services OMH State Partnership Grant to Improve Minority Health, 2013 -2015; and the U.S. Preventive Health & Health Services Block Grant, 2013 - 2015.

III. Defining the DPH Culture of Health Equity

Bringing the principles of health equity into our daily work requires that we develop a common language. It is vital to establish a common understanding of core concepts and to use consistent language throughout DPH in order to institutionalize the work. The first step in this process is to define the term and a vision for DPH's "culture of health equity" that complements the Department's vision, mission, and values.

On May 12, 2015, OHE convened staff representing DPH programs, offices, and sections, as well as several key external partners, to draft a definition and vision for the agency's culture of health equity. This session was facilitated by [CommonHealth ACTION](#) consultants. Staff and partners participated in a series of guided discussions in which they:

- defined the DPH Culture of Health Equity;
- established the Culture of Health Equity Vision Statement; and
- revised the DPH Culture of Health Equity Value Statements.

Please see [Appendix D](#) for details about this event and its proceedings.

The following statements define and guide the Office of Health Equity as it leads DPH's efforts to integrate concepts of health equity into our everyday work.

Connecticut Department of Public Health "Culture of Health Equity" Definition and Vision:*

Definition: DPH defines a culture of health equity as *a dynamic process that considers shared values, and diverse beliefs and behaviors, to ensure that all individuals have fair and equitable opportunities to attain their highest potential for social, physical, and mental well-being.*

DPH believes in championing this culture of health equity in Connecticut communities by: 1) respecting the diverse values and beliefs of our state residents; 2) optimizing the equitable use of resources (human, financial, and programmatic); and 3) advocating for socially equitable policies and practices.

Vision: One Connecticut, where all people enjoy shared resources, optimal health and well-being, and a sense of dignity.

* established at the DPH Health Equity Strategic Planning Meeting held on May 12, 2015 in Hartford, CT.

Value Statements: The following value statements complement the Agency’s core values, and serve as guiding principles for DPH as we engage in activities and relationships to champion a culture of health equity within the agency and in communities across the state.

Universal Value Statements:

- Health is a state of complete physical, mental, and social well-being, not merely the absence of disease (World Health Organization, 1948).
- We honor the diversity of the individuals and communities we serve, and value their varying approaches to health and well-being.
- We recognize that the underlying social determinants of health (e.g., systems and institutions related to education, employment, transportation, built environment, health care, and others) are critical to health outcomes, and consider this context when developing programs, policies, practices, and partnerships.
- Timely and appropriate data on health, the social determinants of health, and indicators of disadvantage (e.g., socioeconomic status, race and ethnicity, geographic location, etc.) are critical to advancing health equity.
- Collaborative leadership and effective listening are fundamental to improving the health of our communities.

Internal Value Statements:

- We are responsible stewards of the public’s trust and resources.
- We value and encourage staff diversity. Our staff are selected with care, treated with respect, held accountable for their performance, and encouraged in their personal growth.
- We continuously improve the quality of our work.
- We uphold DPH, state and federal non-discrimination laws and requirements, inclusive of the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS) Standards.

IV. Stakeholders and Partnerships

Engaging diverse stakeholders, and developing and maintaining internal and external partnerships, are critical to implementing the Health Equity Strategic Plan and to achieving the vision of One Connecticut, where all people enjoy shared resources, optimal health and well-being, and a sense of dignity. This vision can only be achieved through the collaboration and input of stakeholders and partners from multiple sectors, both inside and outside of traditional public health practice.

Stakeholders

The Health Equity Strategic Plan affects individuals, organizations, and communities throughout the state of Connecticut, including, but not limited to, all residents across their lifespans, businesses, local health departments, health care providers and hospital systems, transportation agencies, schools, religious institutions, elected officials, social service agencies and community-based organizations. OHE is committed to working with other DPH offices to ensure that all stakeholders are taken into account in DPH policies and programs. All DPH Requests for Proposals (RFPs) and grants include language that specifies a commitment to health equity principles, and all grant applicants and awardees must commit themselves to providing culturally and linguistically appropriate services in a non-discriminatory manner.

Internal Advising Teams, Committees, and Workgroups

Advising teams, committees, and workgroups have helped guide the planning process by supporting efforts to integrate principles of health equity within all DPH offices and programs. Key advising teams, committees, and workgroups have included the following:

- Health Equity Definitions Workgroup (2012 – present)
- Health Equity Data and Surveillance Workgroup (2012 – 2013)
- CLAS Standards Workgroup (2012 – 2013)
- Health Equity Partnerships Workgroup (2012 – 2013)
- Health Equity Staff Training Workgroup (2012 – 2013)
- Public Health Strategic Team (2013 – present)
- Public Health Systems Improvement (PHSI) Unit (2011 – present)

External Partnerships

Developing and maintaining relationships with partners that share similar equity-focused goals, and that have access to different communities and resources, is an essential component of the Health Equity Strategic Plan. By partnering with organizations and agencies that share a common equity-focused perspective, OHE conserves resources while enhancing its ability to have a broad and profound impact within Connecticut's diverse communities. A list of key partners can be found in [Appendix E](#).

V. Strategic Challenges and Opportunities for Health Equity

We, like many public health departments across the country, face challenges with regard to improving the health and quality of life of our residents. Concurrently, DPH and OHE are presented with opportunities that will advance DPH towards championing a culture of health equity.

In August 2014 and again in August 2015, the OHE core team participated in staff retreats in which they identified the internal strengths, weaknesses, opportunities, and threats (SWOT) that would impact the ability of DPH to champion health equity in its everyday work. As a result of the two retreats, the core team generated the following summary of internal challenges and opportunities, which serve as a basis for the strategic objectives outlined in the OHE three-year work plan:

Challenges:

- Funding constraints
- Lack of a common language and coherent messaging regarding health equity
- Disjointed data management, surveillance systems, and technological infrastructure
- Technology that does not always work as needed
- Changes in staffing
- Partners that are resistant to change
- Inadequate internal communications strategy

Opportunities:

- Dedicated and talented core leadership
- Cross-departmental health equity champions
- Supportive DPH Administration
- Technology resources for workforce training that are improving
- Communications resources that are improving
- Strong relationships with equity-focused external networks and partnering organizations
- Partners at regional, state, and federal levels
- Current political climate provides a window of opportunity for health equity

The full SWOT analyses results can be found in [Appendix F](#).

The core team will reconvene and revisit the SWOT analysis exercise at an annual staff retreat, to brainstorm collectively on a broader range of external as well as internal challenges and opportunities. In turn, the work plan may be revisited to reflect these analyses.

VI. Strategic Goals and Objectives to Champion a Culture of Health Equity

The following goals are drawn from the DPH Strategic Plan, recommendations of the Health Equity Strategic Planning Workgroups (see Appendices G, H, I, J, and K for summaries of the Workgroup recommendations), and objectives of the U.S. Department of Health and Human Services Office of Minority Health Strategic Framework for Improving Racial/Ethnic Minority Health and Eliminating Racial/Ethnic Health Disparities.¹

The objectives are aligned with the SWOT analyses conducted by OHE Staff in August 2014 and August 2015, and the DPH Culture of Health Equity definition created by DPH staff and external partners in May 2015. These goals and objectives are part of the one-year work plan, but are subject to change on an annual basis, upon completion of a new SWOT analysis, and/or as DPH policies or practices are updated.

GOAL 1: Develop a common language that all DPH employees and partners can use to communicate about health equity and apply an equity lens in their daily work.

Establishing a common language demonstrates unity for the DPH culture of health equity, and facilitates understanding and cooperation among internal and external partners.

Objective 1.1: Develop an institutional DPH-wide glossary. The glossary will promote a broad understanding of fundamental health equity-related terminology.

DPH Office of Health Equity's Goals to Champion a Culture of Health Equity:

1. Develop a common language that all DPH employees and partners can use to communicate about health equity and apply an equity lens in their daily work.
2. Use data effectively to plan, monitor, and measure the equity impact of DPH policies and programs, with a specific focus on the social determinants of health.
3. Continue implementing the National CLAS Standards to increase awareness and support for health equity.
4. Engage in ongoing health equity training and education to build knowledge and skills among DPH staff and local partners.
5. Develop and maintain internal and external partnerships to build individual and organizational capacity to engage in equity-focused work.

¹ U.S. Department of Health and Human Services Office of Minority Health. 2008. *Strategic Framework for Improving Racial/Ethnic Minority Health and Eliminating Racial/Ethnic Health Disparities*. Accessed 4/21/15: http://www.minorityhealth.hhs.gov/Assets/PDF/Checked/OMH%20Framework%20Final_508Compliant.pdf

- *Objective 1.2: Develop a strategy to communicate the culture of health equity at DPH.* This strategy will serve to identify DPH as a champion of health equity.

GOAL 2: Use data effectively to plan, monitor, and measure the equity impact of DPH policies and programs, with a specific focus on the social determinants of health. By continuously evaluating the effectiveness of DPH equity-focused initiatives, the Agency will ensure that its policies and programs are consistently positioned to promote optimal health in all Connecticut communities.

- *Objective 2.1: Develop best practices in measuring the equity impact of DPH policies and programs.* Collaborate with relevant DPH sections and programs to develop and promote best practices for measuring an equity impact in the areas of data collection, policy, and programming.
- *Objective 2.2: Institute an agency-wide guidance document on measuring the equity impact of DPH policies and programs.* This document will promote institutional knowledge of the value of integrating equity-centered practices into all relevant DPH processes.
- *Objective 2.3: Develop and implement training on DPH's data collection policy.* The web-based training module for the [DPH Policy on Collecting Sociodemographic Data](#) will be updated and promoted among DPH staff.

GOAL 3: Continue implementing the National CLAS Standards to increase awareness and support for health equity. Through implementation of the CLAS Standards, OHE will advance socially equitable policies and practices within DPH and with its partners.

- *Objective 3.1: Develop a strategy with talking points about the connection between CLAS and health equity.* The plan and talking points will introduce stakeholders to the connection between the CLAS Standards and health equity.
- *Objective 3.2: Develop a language access policy.* The policy will identify key principles of language accessibility and provide guidance on the implementation of the CLAS Standards within DPH.
- *Objective 3.3: Develop a language access plan.* The plan will lay out action steps to support the implementation of the CLAS Standards within DPH.

GOAL 4: Engage in ongoing health equity training and education to build knowledge and skills among DPH staff and local partners. Through the cultivation of institutional knowledge, OHE will develop and sustain a workforce that understands its role and responsibility in advancing health equity in Connecticut.

- *Objective 4.1: Work with the DPH Workforce Development Committee and Human Resources (HR) to create an orientation module for new staff.* Introducing the culture of health equity at staff orientation will promote the application of an equity focus from the beginning stages of staff members' careers at DPH.
- *Objective 4.2: Train all DPH staff on the health equity toolkit and develop a plan for continuous learning.* Providing training on the availability and utility of the toolkit materials will help to sustain the DPH culture of health equity as staff transition within or from the Agency.
- *Objective 4.3: Tailor and promote CLAS and health equity toolkits among relevant partners.* Customizing the toolkit to fit the needs of external partners will help to secure support for DPH equity-focused policies and initiatives across the state. (See [Appendix J](#) for a full list of toolkit resources.)

GOAL 5: Develop and maintain internal and external partnerships to build individual and organizational capacity to engage in equity-focused work. Through its relationships with diverse partners, OHE will optimize the use of human, financial, and programmatic resources to advance health equity in Connecticut.

- *Objective 5.1: Create internal DPH recognition awards for staff members who exemplify and champion the culture of health equity.* Champions will be awarded based on their demonstrated commitment to advancing health equity within the DPH work environment and for Connecticut communities.
- *Objective 5.2: Create DPH awards/designations related to health equity for external partners (e.g., Connecticut Health Equity Champion designation).* The award will offer recognition and provide an incentive for external partners that work towards a common equity-focused goal.

VII. Alignment with Other DPH Strategic Priority Areas

Health equity is a cross-cutting priority within the DPH Strategic Plan, and as such, it is fundamental to all other DPH strategic priorities. The OHE Strategic Plan will support the five DPH strategic priority areas in the following ways:

1. Strengthen Approaches and Capacity to Improve Population Health – Applying an equity lens to DPH policies and programs requires a workforce that embraces the responsibility of providing public health services that lead to fair, just, and equitable health outcomes for all Connecticut residents. With support from the Workforce Development Committee, DPH will use the OHE Strategic Plan to develop staff capacity to apply principles of health equity in its everyday work.

2. Promote the Value and Contributions of Public Health – Effective communication is essential to public's understanding of the value of public health services and the vital role DPH plays in improving the health of Connecticut communities. Through the use of a common health equity language, and equity-focused data collection and performance management, DPH will promote public health messages that resonate with stakeholders and speak to the realities of all Connecticut communities.

3. Build Strategic Partnerships to Improve the Public Health System – Diverse partnerships are necessary to expand the reach of DPH services to improve the health of all Connecticut residents. The OHE Strategic Plan will support DPH's efforts to form partnerships that address the needs of the state's most vulnerable populations. Furthermore, the relationships that OHE has developed and strengthened through the implementation of the CLAS Standards can be leveraged for future DPH initiatives.

4. Foster and Maintain a Competent, Healthy, Empowered Workforce – Developing a workforce that understands the vital role DPH plays in addressing the many factors that lead to poor health outcomes is essential for improving the health and well-being of all Connecticut residents. Through implementation of the Health Equity Strategic Plan's training and workforce development activities, DPH will equip its staff with the necessary framework, knowledge, and skills to address the broad public health needs of Connecticut's diverse population.

5. Build a Sustainable, Customer-Oriented Organization – DPH sustainability depends on its having a skilled workforce that understands the complex needs of Connecticut communities and how to effectively plan and communicate strategies to address those needs with stakeholders. Equity-focused workforce development and performance management practices will help to ensure policies and programs that result in equitable outcomes to support diverse partnerships and future strategic planning efforts.

VIII. Monitoring the Progress and Impact of the Health Equity Strategic Plan

OHE staff is responsible for implementing and monitoring the overall Health Equity Strategic Plan, its annual work plan, and all related activities. OHE staff will report on the plan's progress annually via the webpage, www.ct.gov/dph/healthequity. If barriers are encountered in reaching milestones, OHE will seek support and recommendations from its DPH advisory groups identified on page 10.

OHE will work with the Public Health Systems Improvement (PHSI) Unit, and all other DPH sections and offices to develop, document, and distribute data collection and evaluation protocols tailored to measure progress towards integrating an equity focus into agency programs and practices. (See [Appendix L](#) for details regarding the overall roles and responsibilities of PHSI).

In addition, PHSI will support OHE in the implementation of the Turning Point Performance Management Framework. The framework, which was developed by the [Public Health Foundation](#), is organized around the four components of a performance management system, including: 1) Performance Standards, 2) Performance Measurement, 3) Reporting of Progress, and 4) Quality Improvement. The framework will steer OHE towards achieving work plan goals and objectives, and making strategic decisions regarding quality improvement of equity-focused initiatives. (See [Appendix M](#) for more details regarding the framework).

As part of the DPH Strategic Mapping process, the goal "Champion a Culture of Health Equity" currently has six objectives and results that relate to the provision of culturally and linguistically appropriate services. The goal "Ensure Quality and Reliability of Data" currently has four objectives and results related to implementation of the [DPH Policy on Collecting Sociodemographic Data](#). (See [Appendix N](#) for the 2015 annual objectives and results for each of these two goals). These objectives and results are reported to the DPH Strategic Team on a quarterly basis, and they are revised on an annual basis.

As part of the [Healthy Connecticut 2020 Performance Dashboard](#), DPH has added health equity performance measures related to the CLAS Standards training. Other health equity performance measures will be considered and developed over time. The Dashboard displays information and data on a subset of indicators from [Healthy Connecticut 2020](#). Specifically, it displays population indicators, performance measures, and strategies in an accessible, easy-to-understand format, and it describes how the residents of Connecticut are faring in health improvement target areas.

IX. Three-Year Work Plan to Support Health Equity Goals

OHE has mapped out the general activities it will undertake to accomplish the goals and objectives outlined in this strategic plan over the course of three years (2015-2018), which are aligned with DPH’s overall strategic plan timeline.

In recognition that resources are finite and these activities build upon one another, OHE has prioritized specific goals and objectives for Year 1: Goal 1 (both objectives), Goal 3 (all three objectives), Goal 4 (Objective 4.3), and Goal 5 (Objective 5.1).

For greater detail on the Year 1 work plan, please see Section X of this strategic plan.

Office of Health Equity Strategic Plan Three-Year Work Plan			
Goals and Objectives	Major Activities: Year 1 (2015-2016)	Major Activities: Year 2 (2016-2017)	Major Activities: Year 3 (2017-2018)
Goal 1: Develop a common language that all DPH employees and partners can use to communicate about health equity and apply an equity lens in their daily work.			
Objective 1.1: Develop an institutional DPH-wide glossary. Lead 1. M. Mitchell 2. M. Hynes	<ul style="list-style-type: none"> Revise, circulate, and finalize glossary. Promote the glossary. 	<ul style="list-style-type: none"> Promote the glossary & key concepts. 	<ul style="list-style-type: none"> Promote the glossary & key concepts.
Objective 1.2: Develop a strategy to communicate the culture of health equity at DPH. Lead 1. TBD 2. A. Jimenez and M. Hynes	<ul style="list-style-type: none"> Develop and finalize the strategy. Develop and finalize OHE’s “culture of health equity” elevator pitch. Train key staff. 	<ul style="list-style-type: none"> Develop and implement plan to train all staff on this strategy and talking points. 	<ul style="list-style-type: none"> Roll out the plan to train and support all staff.

**Office of Health Equity Strategic Plan
Three-Year Work Plan**

Goals and Objectives	Major Activities: Year 1 (2015-2016)	Major Activities: Year 2 (2016-2017)	Major Activities: Year 3 (2017-2018)
Goal 2: Use data effectively to plan, monitor, and measure the equity impact of DPH policies and programs, with a specific focus on the social determinants of health.			
<p>Objective 2.1: Develop best practices in measuring the equity impact of DPH policies and programs.</p> <p>Leads: 1. M. Hynes 2. K. Sullivan, other key senior staff</p>	<ul style="list-style-type: none"> • Convene key staff. • Develop a work plan. • Collect and develop resource materials. 	<ul style="list-style-type: none"> • Develop, vet, and finalize best practices. • Establish performance measures. • Refine performance measures. 	<ul style="list-style-type: none"> • Release best practices and promote among staff. • Monitor performance measures.
<p>Objective 2.2: Institute an agency-wide guidance document on measuring the equity impact of DPH policies and programs.</p> <p>Leads: 1. M. Hynes 2. K. Sullivan, other key senior staff</p>	<ul style="list-style-type: none"> • Convene key staff. • Develop a work plan. • Collect and develop resource materials. 	<ul style="list-style-type: none"> • Develop, vet, and finalize the guidance. • Develop an internal launch plan. 	<ul style="list-style-type: none"> • Release the guidance and promote it among staff. • Monitor performance measures.
<p>Objective 2.3: Update and implement training on DPH's data collection policy.</p> <p>Leads: 1. M. Hynes 2. Data Collection QI Committee</p>	<ul style="list-style-type: none"> • Convene key staff. • Update and finalize the first training module. • Promote online training. 	<ul style="list-style-type: none"> • Develop a plan to transition from voluntary to mandatory training. • Develop a plan to roll out in phases and support continuous learning. 	<ul style="list-style-type: none"> • Roll out a plan to train all staff and engage in continuous learning.

**Office of Health Equity Strategic Plan
Three-Year Work Plan**

Goals and Objectives	Major Activities: Year 1 (2015-2016)	Major Activities: Year 2 (2016-2017)	Major Activities: Year 3 (2017-2018)
Goal 3: Continue implementing the National CLAS Standards to increase awareness and support for health equity.			
<p>Objective 3.1: Develop a strategy with talking points about the connection between CLAS and health equity.</p> <p>Leads: 1. A. Jimenez 2. A. Stratton, M. Hynes, M. Mitchell</p>	<ul style="list-style-type: none"> • Develop an elevator pitch and key talking points. • Promote the talking points. 	<ul style="list-style-type: none"> • Develop and implement a plan to train all staff. • Develop and implement a plan to train partners. 	<ul style="list-style-type: none"> • Roll out a plan to train and support staff and partners.
<p>Objective 3.2: Develop a language access policy.</p> <p>Leads: 1. M. Hynes 2. A. Stratton</p>	<ul style="list-style-type: none"> • Convene key staff. • Finalize and approve policy. • Promote the policy within DPH and share with external partners. 		
<p>Objective 3.3: Develop a language access plan.</p> <p>Leads: 1. A. Stratton 2. M. Hynes</p>	<ul style="list-style-type: none"> • Convene key staff. • Develop and finalize a plan to implement the new language access policy (completed in Objective 3.2). 	<ul style="list-style-type: none"> • Implement the plan among staff, contractors, partners, and other stakeholders. 	<ul style="list-style-type: none"> • Implement the plan among staff, contractors, partners, and other stakeholders.

**Office of Health Equity Strategic Plan
Three-Year Work Plan**

Goals and Objectives	Major Activities: Year 1 (2015-2016)	Major Activities: Year 2 (2016-2017)	Major Activities: Year 3 (2017-2018)
Goal 4: Engage in ongoing health equity training and education to build knowledge and skills among DPH staff and local partners.			
<p>Objective 4.1: Work with the DPH Workforce Development Committee and Human Resources (HR) to develop an orientation module for new staff.</p> <p>Leads: 1. M. Mitchell 2. A. Jimenez</p>	<ul style="list-style-type: none"> • Develop a list of training opportunities. • Convene key staff. • Develop and finalize an orientation training module. 	<ul style="list-style-type: none"> • Implement the module. • Evaluate the module. 	<ul style="list-style-type: none"> • Revise and update the module. • Continue module implementation.
<p>Objective 4.2: Train all DPH staff on the Health Equity Toolkit and develop a plan for continuous learning.</p> <p>Leads: 1. M. Mitchell 2. Workforce Development Committee</p>	<ul style="list-style-type: none"> • Develop a detailed work plan for training and continuous learning. • Meet with key DPH leaders to promote the training plan. 	<ul style="list-style-type: none"> • Roll out the staff pilot training • Finalize a continuous learning plan. 	<ul style="list-style-type: none"> • Roll out the training for all staff. • Roll out the continuous learning pilot. • Revise the work plan for training and continuous learning. • Recruit additional trainers.
<p>Objective 4.3: Tailor and promote the CLAS and Health Equity Toolkits among relevant partners.</p> <p>Leads: 1. A. Stratton 2. A. Jimenez</p>	<ul style="list-style-type: none"> • Update the CLAS Standards Toolkit. • Update the partner list. • Promote the updated toolkit for DPH staff. 	<ul style="list-style-type: none"> • Promote the CLAS Standards Toolkit with partners. • Hold train-the-trainer events. 	<ul style="list-style-type: none"> • Promote the CLAS Toolkit with partners. • Hold train-the-trainer events.

**Office of Health Equity Strategic Plan
Three-Year Work Plan**

Goals and Objectives	Major Activities: Year 1 (2015-2016)	Major Activities: Year 2 (2016-2017)	Major Activities: Year 3 (2017-2018)
Goal 5: Develop and maintain internal and external partnerships to build individual and organizational capacity to engage in equity-focused work.			
<p>Objective 5.1: Create internal DPH recognition awards for staff members who exemplify and champion the culture of health equity.</p> <p>Leads: 1. M. Hynes 2. A. Jimenez, M. Mitchell</p>	<ul style="list-style-type: none"> • Convene key staff. • Complete the draft concept. • Implement a plan to develop the designation. • Award the first designation. 	<ul style="list-style-type: none"> • Promote and continue internal awards. 	<ul style="list-style-type: none"> • Promote and continue internal awards.
<p>Objective 5.2: Create DPH awards/designations related to health equity for external partners (e.g., Connecticut Health Equity Champion designation).</p> <p>Leads: 1. A. Jimenez 2. M. Hynes</p>	<ul style="list-style-type: none"> • Convene key staff. • Complete draft of concept. • Finalize plan. 	<ul style="list-style-type: none"> • Implement a plan to develop the designation. • Promote the designation among partners. • Award first designations. 	<ul style="list-style-type: none"> • Promote the designation among partners. • Award designations. • Leverage designated partners to promote other key activities (trainings, etc.).

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X. Detailed Annual Work Plan to Support Health Equity Goals (Year 1)

The time frame (see column headings) for Year 1 is October 1, 2015–September 30, 2016. (Note: in order to plan a successful launch for this strategic plan, some of these activities were performed prior to October 1, 2015). As noted in our three-year work plan (Section IX), we have prioritized specific goals and objectives for Year 1: Goal 1(both objectives), Goal 3 (all three objectives), Goal 4 (Objective 4.3), and Goal 5 (Objective 5.1).

To move to specific goal activities, click here: [Goal 1](#) | [Goal 2](#) | [Goal 3](#) | [Goal 4](#) | [Goal 5](#)

Office of Health Equity Strategic Plan Year 1 Detailed Work Plan Goal 1			
Goal 1: Develop a common language that all DPH employees and partners can use to communicate about health equity and apply an equity lens in their daily work.			
Objective 1.1: Develop an institutional DPH-wide glossary.			
Measurable Activity	Person(s) Responsible	Time Frame	Resources/Capacity Notes
Revise the glossary of terms.	Lead: M. Mitchell Support: Definitions Committee	December 2015	<ul style="list-style-type: none"> Existing definitions from the Definitions Committee Definitions from the OHE strategic planning process
Circulate draft for DPH agency comment.	Lead: M. Mitchell Support: Definitions Committee	March 2016	<ul style="list-style-type: none"> Email or SurveyMonkey link Feedback at PHST
Finalize the glossary.	Lead: M. Mitchell Support: Definitions Committee	June 2016	<ul style="list-style-type: none"> All DPH comments PHST Feedback
Promote the glossary through activities – town hall forums, meetings with section chiefs, one-on-one meetings, etc.	Lead: M. Mitchell Support: Definitions Committee Consulted: B. Gerrish	July 2016-September 2016	<ul style="list-style-type: none"> Intranet Present at section meetings and town hall forums

**Office of Health Equity Strategic Plan
Year 1 Detailed Work Plan | Goal 1**

Goal 1: Develop a common language that all DPH employees and partners can use to communicate about health equity and apply an equity lens in their daily work.

Objective 1.2: Develop a strategy to communicate the culture of health equity at DPH.

Measurable Activity	Person(s) Responsible	Time Frame	Resources/Capacity Notes
Meet with internal staff to brainstorm the key concepts in communication about health equity.	Lead: M. Hynes Support: OHE staff, DPH Health Equity Team	August 2015	<ul style="list-style-type: none"> DPH Office of Communications brand guidelines
Finalize the communication guidelines.	Lead: TBD Support: OHE staff, DPH Health Equity Team, B. Gerrish	December 2015	<ul style="list-style-type: none"> Staff meetings and meeting minutes
Share the guidelines with DPH staff.	Lead: TBD Support: OHE staff, B. Gerrish	January 2016	<ul style="list-style-type: none"> Staff meetings and meeting minutes
Develop an elevator pitch and top 3-5 messages or talking points about the culture of health equity.	Lead: M. Hynes Support: OHE staff, DPH Health Equity Team, B. Gerrish	December 2015	<ul style="list-style-type: none"> Staff meetings and meeting minutes
Convene and train key DPH and OHE staff to deliver the talking points and messaging.	Lead: M. Hynes Support: A. Jimenez, M. Mitchell Consulted: B. Gerrish	March 2016	<ul style="list-style-type: none"> Staff meetings and meeting minutes

**Office of Health Equity Strategic Plan
Year 1 Detailed Work Plan | Goal 2**

Goal 2: Use data effectively to plan, monitor, and measure the equity impact of DPH policies and programs, with a specific focus on the social determinants of health.

Objective 2.1: Develop best practices in measuring the equity impact of DPH policies and programs.

Measurable Activity	Person(s) Responsible	Time Frame	Resources/Capacity Notes
Convene a meeting of key staff to facilitate buy-in to institutionalize best practices in measuring an equity impact.	Lead: M. Hynes Consulted: K. Sullivan, J. Ascheim, D. Aye, M. Dalal	December 2015	<ul style="list-style-type: none"> • Aligned with Connecticut State Health Improvement Plan (SHIP) • Workgroup expertise • DPH Performance Dashboard
Develop a work plan to institute best practices in measuring an equity impact.	Lead: M. Hynes Support: A. Jimenez, M. Mitchell, Workgroup members Consulted: K. Sullivan, J. Ascheim, D. Aye, M. Dalal	February 2016	<ul style="list-style-type: none"> • Aligned with Connecticut State Health Improvement Plan (SHIP) • Workgroup expertise. • DPH Performance Dashboard
Collect and organize a repository of online resources related to best practices on measuring an equity impact.	Lead: Intern/Fellow Support: M. Hynes, M. Mitchell, Workgroup members	March 2016	<ul style="list-style-type: none"> • Recruit an intern • ASTHO documents • CDC documents • Washington State documents

**Office of Health Equity Strategic Plan
Year 1 Detailed Work Plan | Goal 2**

Goal 2: Use data effectively to plan, monitor, and measure the equity impact of DPH policies and programs, with a specific focus on the social determinants of health.

Objective 2.2: Institute an agency-wide guidance document on measuring the equity impact of DPH policies and programs.

Measurable Activity	Person(s) Responsible	Time Frame	Resources/Capacity Notes
Convene a meeting of key staff to facilitate buy-in to create and institute an agency-wide guidance document.	Lead: M. Hynes Support: A. Jimenez, M. Mitchell Consulted: K. Sullivan, D. Aye, M. Dalal	February 2016	<ul style="list-style-type: none"> • Workgroup meetings
Develop a work plan to create and institute a guidance document.	Lead: TBD Support: A. Jimenez, M. Mitchell Consulted: K. Sullivan, D. Aye, M. Dalal	June 2016	<ul style="list-style-type: none"> • Workgroup meetings

**Office of Health Equity Strategic Plan
Year 1 Detailed Work Plan | Goal 2**

Goal 2: Use data effectively to plan, monitor, and measure the equity impact of DPH policies and programs, with a specific focus on the social determinants of health.

Objective 2.3: Update and implement training on DPH's data collection policy.

Measurable Activity	Person(s) Responsible	Time Frame	Resources/Capacity Notes
Convene key staff and update the data collection policy training modules.	Lead: M. Hynes Support: Data Collection Quality Improvement Committee	January 2016	<ul style="list-style-type: none"> • Data collection policy • Web-based training module
Finalize the updated data collection policy training module.	Lead: TBD; Data Collection Quality Improvement Committee Consulted: Workforce Development Committee; K. Sullivan	August 2016	<ul style="list-style-type: none"> • Data collection policy • Web-based training module
Promote online data collection training.	Lead: TBD Support: Data Collection Quality Improvement Committee	August 2016	<ul style="list-style-type: none"> • Intranet, section meetings town hall forums
Make the updated online data collection policy training available to DPH staff.	Lead: TBD; Data Collection Quality Improvement Committee Consulted: Workforce Development Committee	September 2016	<ul style="list-style-type: none"> • Online training capacity

**Office of Health Equity Strategic Plan
Year 1 Detailed Work Plan | Goal 3**

Goal 3: Continue implementing the National CLAS Standards to increase awareness and support for health equity.

Objective 3.1: Develop a strategy with talking points about the connection between CLAS and health equity.

Measurable Activity	Person(s) Responsible	Time Frame	Resources/Capacity Notes
Develop an elevator pitch and 3-5 key talking points about the role of CLAS in the culture of health equity.	Lead: A. Jimenez Support: A. Stratton, M. Hynes, M. Mitchell Consulted: B. Gerrish, K. Sullivan, J. Ascheim	September 2015	<ul style="list-style-type: none"> • DPH QI Pitch
Promote and circulate the elevator pitch and talking points to key staff.	Lead: A. Jimenez Support: A. Stratton, Hynes, M. Mitchell Consulted: B. Gerrish, K. Sullivan, J. Ascheim	November 2015	<ul style="list-style-type: none"> • DPH QI Pitch • Staff meetings and meeting minutes

**Office of Health Equity Strategic Plan
Year 1 Detailed Work Plan | Goal 3**

Goal 3: Continue implementing the National CLAS Standards to increase awareness and support for health equity.

Objective 3.2: Develop a language access policy.

Measurable Activity	Person(s) Responsible	Time Frame	Resources/Capacity Notes
Convene staff to finalize the language access policy.	Lead: M. Hynes Support: Communications, Administration Consulted: Commissioner's Office	August 2015	<ul style="list-style-type: none"> • Aligned with the SHIP • Public Health Accreditation Board (PHAB) Standard Measure 11.1.4A
Finalize the language access policy with Commissioner's sign-off.	Lead: M. Hynes Support: Communications, Administration Consulted: Commissioner's Office	August 2015	<ul style="list-style-type: none"> • Aligned with the SHIP • PHAB Standard Measure 11.1.4A
Implement the language access policy.	Lead: M. Hynes Support: Language Access Committee Consulted: Commissioner's Office	January 2016	<ul style="list-style-type: none"> • Aligned with the SHIP • PHAB Standard Measure 11.1.4A

**Office of Health Equity Strategic Plan
Year 1 Detailed Work Plan | Goal 3**

Goal 3: Continue implementing the National CLAS Standards to increase awareness and support for health equity.

Objective 3.3: Develop a language access plan.

Measurable Activity	Person(s) Responsible	Time Frame	Resources/Capacity Notes
Convene staff to develop a language access plan to continue implementation of the language access policy.	Lead: A. Stratton Support: A. Jimenez, M. Hynes Language Access Committee	February 2016	<ul style="list-style-type: none"> • Approved language access policy • Public Health Accreditation Standard Measure 11.1.4A
Finalize the language access plan.	Lead: A. Stratton Support: A. Jimenez, Language Access Committee	September 2016	<ul style="list-style-type: none"> • Approved language access policy • Staff meetings and meeting minutes • Public Health Accreditation Standard Measure 11.1.4A

**Office of Health Equity Strategic Plan
Year 1 Detailed Work Plan | Goal 4**

Goal 4: Engage in ongoing health equity training and education to build knowledge and skills among DPH staff and local partners.

Objective 4.1: Work with the DPH Workforce Development Committee and Human Resources (HR) to develop an orientation module for new staff.

Measurable Activity	Person(s) Responsible	Time Frame	Resources/Capacity Notes
Develop a list of potential health equity training opportunities.	Lead: M. Mitchell, A. Jimenez Support: M. Hynes, Workforce Development Committee Consulted: HR Staff	December 2015	<ul style="list-style-type: none"> • Health Equity toolkit • Workgroup recommendations
Meet with the Workforce Development Committee and HR to discuss opportunities to integrate health equity training into the new employee orientation process and present list of potential training modules.	Lead: M. Mitchell, A. Jimenez Support: M. Hynes, Workforce Development Committee Consulted: HR Staff	March 2016	<ul style="list-style-type: none"> • Health Equity toolkit • Workgroup recommendations
Develop and finalize the training module with HR input.	Lead: M. Mitchell, A. Jimenez Support: M. Hynes, Workforce Development Committee Consulted: HR Staff	June 2016	<ul style="list-style-type: none"> • Health Equity toolkit • Workgroup recommendations

**Office of Health Equity Strategic Plan
Year 1 Detailed Work Plan | Goal 4**

Goal 4: Engage in ongoing health equity training and education to build knowledge and skills among DPH staff and local partners.

Objective 4.2: Train all DPH staff on the Health Equity Toolkit and develop a plan for continuous learning.

Measurable Activity	Person(s) Responsible	Time Frame	Resources/Capacity
Develop a detailed training and continuous learning work plan to roll out over 2 years and eventually train all staff.	Lead: M. Mitchell Consulted: M. Hynes, A. Jimenez	June 2016	<ul style="list-style-type: none"> Health Equity Toolkit Workgroup recommendations
Meet with relevant staff leadership to approve and promote the first training cohort.	Lead: M. Mitchell Consulted: M. Hynes, A. Jimenez	August 2016	<ul style="list-style-type: none"> Health Equity Toolkit Workgroup recommendations

Objective 4.3: Tailor and promote the CLAS Standards and Health Equity Toolkits among relevant partners.

Measurable Activity	Person(s) Responsible	Time Frame	Resources/Capacity
Review and update the CLAS Standards Toolkit.	Lead: A. Stratton, A. Jimenez Support: M. Hynes	December 2015	<ul style="list-style-type: none"> CLAS Standards Toolkit Webinars (existing systems) with local health departments
Update the partner list to include newly formed relationships with providers and local health department staff.	Lead: A. Jimenez Support: A. Stratton, M. Hynes	December 2015	<ul style="list-style-type: none"> Existing partnership list
Promote the Toolkit to partners.	Lead: A. Stratton, A. Jimenez Support: M. Hynes	March 2016	<ul style="list-style-type: none"> Website; partnership list-serve; in-person meetings with partners

**Office of Health Equity Strategic Plan
Year 1 Detailed Work Plan | Goal 5**

Goal 5: Develop and maintain internal and external partnerships to build individual and organizational capacity to engage in equity-focused work.

Objective 5.1: Create internal DPH recognition awards for staff members who exemplify and champion the culture of health equity.

Measurable Activity	Person(s) Responsible	Time Frame	Resources/Capacity
Meet with staff to brainstorm ideas for an internal DPH awards program.	Lead: M. Hynes, A. Jimenez, M. Mitchell	August 2015	<ul style="list-style-type: none"> Health equity meetings and meeting minutes Workgroup minutes and reports
Develop a plan for the yearly awards program.	Lead: M. Hynes, A. Jimenez, M. Mitchell	October 2015	<ul style="list-style-type: none"> Health equity meetings and meeting minutes Workgroup minutes and reports
Launch the first awards program in concert with the strategic plan launch at the DPH Town Hall Meeting.	Lead: M. Hynes, A. Jimenez, M. Mitchell	December 2015	<ul style="list-style-type: none"> Health equity meetings and meeting minutes Workgroup minutes and reports

Objective 5.2: Create DPH awards/designations related to health equity for external partners (e.g., Connecticut Health Equity Champion designation).

Measurable Activity	Person(s) Responsible	Time Frame	Resources/Capacity
Meet with internal staff to brainstorm ideas for an external award or designation program.	Lead: A. Jimenez, M. Hynes	January 2016	<ul style="list-style-type: none"> Internal awards program and plan Partnership list Partnership activities
Complete the first draft of award/designation concept.	Lead: A. Jimenez, M. Hynes Consulted: B. Gerrish, Branch Chiefs	March 2016	<ul style="list-style-type: none"> Internal awards program and plan Partnership list Partner activities
Finalize a plan to promote and implement the award/designation program in Fall 2016.	Lead: A. Jimenez Support: M. Mitchell	June 2016	<ul style="list-style-type: none"> Internal awards program and plan Partnership list Partner activities

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APPENDICES

- Appendix A: DPH's Health Equity History and Process
- Appendix B: DPH's Strategic Planning Process Summary
- Appendix C: Overview of OHE's Health Equity Strategic Planning Activities
- Appendix D: Health Equity Strategic Plan Activities
- Appendix E: Partnership List by Organization Type
- Appendix F: OHE's SWOT Analysis Results
- Appendix G: Workgroup Recommendations—Health Equity Definitions
- Appendix H: Workgroup Recommendations—Health Equity Data and Surveillance
- Appendix I: Workgroup Recommendations—CLAS Standards
- Appendix J: Workgroup Recommendations—Health Equity Workforce Training
- Appendix K: Workgroup Recommendations—Health Equity Partnerships
- Appendix L: Public Health Systems Improvement Unit (PHSI) and the Public Health Strategic Team (PHST): Roles and Responsibilities
- Appendix M: Turning Point Performance Management Framework Details
- Appendix N (1,2): DPH Strategic Map Implementation Planning Worksheets

Appendix A: DPH's Health Equity History and Process

The Department of Public Health is proud of how far we have come on our health equity journey. With the launch of our strategic plan, we look forward to adding new milestones in realizing our vision: *One Connecticut, where all people enjoy shared resources, optimal health and well-being, and a sense of dignity.*

1998

- **July:** Created the Office of Multicultural Health within DPH by state statute CGA 19a-4j.

1999

- **June:** The Office of Multicultural Health published Connecticut's [or, DPH's] first health disparities report, *Multicultural Health: The Health Status of Minority Groups in Connecticut.*

2001

- **October:** DPH's Office of Multicultural Health published *Connecticut Women's Health.*

2002

- **June:** Published *Multicultural Health Resource Directory. Connecticut Department of Public Health, Office of Multicultural Health, 2002.*

2005

- **November:** Published *Mortality and Its Risk Factors in Connecticut, 1989-1998.*

2006

- **June:** Established the Connecticut Health Disparities Project through a grant from the Connecticut Health Foundation. Purpose: To improve the statewide infrastructure for documenting, reporting, and addressing health disparities among racial and ethnic minority residents of our state.

2007

- **August:** Published *Issue Brief: Defining Health Disparities.*

- **October**
 - Published *The Collection of Race, Ethnicity, and Other Sociodemographic Data in Connecticut Department of Public Health Databases*.
 - Published *Issue Brief: Race and Ethnicity Matters: Concepts and Challenges of Racial and Ethnic Classifications in Public Health*.
 - Held the First Statewide Meeting on Health Disparities: *Monitoring Health Disparities: Concepts and Challenges in State Health Data Collection*; CT Legislative Office Building, Hartford, October 19, 2007.

2008

- **July:** Launched the CT Multicultural Health Partnership. Established to draw together expertise, resources, and programming to eliminate health disparities in Connecticut.
- **September**
 - Established the *CT DPH Policy on Collecting Sociodemographic Data*.
 - Published *The Spatial Context of Health Disparities: A Literature Review*.
 - Held the Second Statewide Meeting on Health Disparities: *Monitoring Health Disparities: Creating Data Collection Policies that Work*; CT Legislative Office Building, Hartford, September 19, 2008.
- **December**
 - Held the Third Statewide Meeting on Health Disparities: *The Spatial Context of Health Disparities*; The Lyceum, Hartford, December 10, 2008.
 - Concluded the Connecticut Health Disparities Project.

2009

- **January:** Published *The 2009 Connecticut Health Disparities Report*.
- **June thru December:** Film and Discussion Series: 1) *Unnatural Causes: Is Inequality Making Us Sick*; and 2) *Race: The Power of An Illusion*.

2010

- **March:** Published the *Connecticut Health Database Compendium*.
- **June thru December:** Film and Discussion Series: 1) *Unnatural Causes: Is Inequality Making Us Sick*; and 2) *Race: The Power of An Illusion*.

2011

- **March:** Developed the DPH Health Equity Policy Statement.
- **April:** Finalized the DPH Strategic Map.
- **May:** Commissioner Jewel Mullen, MD, signed the DPH Health Equity Policy Statement.
- **July:** Commissioner Mullen signed the Non-Discrimination in the Provision of the Department of Public Health Programs and Services Policy.
- **August:** Published the *Connecticut Multicultural Health Resource Directory: Available Cultural and Linguistic Services*.
- **September:** Held two-day strategic planning session.

2012

- **March**
 - Established the DPH Data Collection Quality Improvement Initiative through a grant from the National Network of Public Health Institutes. Purpose: Establish a long-range plan to achieve DPH database compliance with the DPH data policy, through a continuous quality improvement process.
 - Published the *Connecticut Health Database Compendium*.
- **May:**
 - Commissioner Mullen signed the DPH Health Policy Statement.
- **June**
 - Established the DPH Health Equity Research, Evaluation & Policy Initiative, to integrate health equity as a cross-cutting principle in all agency programs and planning efforts.
 - DPH mission statement revised to include the principle of health equity.
- **August**
 - Held a one-day strategic plan development session.
 - Updated DPH mission statement to include the principle of health equity.
 - Published the Connecticut Department of Public Health's five-year strategic plan for 2013-2018, identifying "champion of health equity" as one of the agency's cross-cutting goals.

- **September**
 - Formed the DPH Staff Health Equity Workgroups, as part of the DPH Strategic Planning Initiative, in the areas of 1) Definitions, 2) Data and Surveillance, 3) CLAS Standards, 4) Staff Training Needs, and 5) Partnerships.
 - Presented Health Equity Quality Improvement Training, with a focus on health equity, with the Public Health Foundation.
 - Held two-day strategic planning process with TSI, Inc.
- **November:** Concluded the DPH Data Collection Quality Improvement Initiative; issued the final report with recommendations.
- **December**
 - Completed the DPH Health Equity Self-Assessment.
 - Issued the Draft Health Equity Definitions Workgroup Report.
 - Issued the Draft Health Equity Data and Surveillance Workgroup Report.
 - Issued the Draft CLAS Standards Workgroup Report.
 - Issued the Draft Health Equity Staff Training Needs Workgroup Report.
 - Issued the Draft Health Equity Partnerships Workgroup Report.

2013

- **February:** Published the DPH Agency Strategic Plan 2013-2018. Reaffirmed the vision and mission; identified organizational values for the agency; and built consensus around priorities, with an additional focus on worksite wellness and the importance of partnerships
- **September:** DPH was awarded a federal Office of Minority Health State Partnership Grant (SPG) to Improve Minority Health, and to promote and implement the equity-focused National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS).
- **October:** Formed the DPH Data Collection Quality Improvement staff committee, in response to the recommendation of the DPH Data Collection Quality Improvement Initiative. Charge is to ensure adherence to DPH Data Collection Policy and recommend any revisions to the current policy; Standing Committee meets on a quarterly basis.

2014

- **January:** Finalized the Connecticut Department of Public Health Quality Plan.
- **March**
 - Established *Champion Health Equity* as a cross-cutting priority within DPH's Agency Strategic Plan (2013-2018).
 - Published the Connecticut State Health Assessment (SHA) and State Health Improvement (SHIP) Plan, with health equity and the social determinants of health as cross-cutting priorities, including 39 SHIP health equity-focused objectives.
- **June:** Renamed the DPH Office of Multicultural Health the "Office of Health Equity", and revised the mission statement. Name and mission statement were adopted and signed into law by CT Governor Dannel Malloy on June 13, 2014.
- **August:** Held the DPH health equity retreat.
- **September:** Held a one-day DPH health equity planning session.
- **October**
 - Established the DPH Office of Health Equity, October 1, 2014.
 - Published the CLAS Standards Baseline Assessment Report.
 - Updated the DPH Strategic Plan.
 - Selected *Champion a Culture of Health Equity* as the revised cross-cutting priority within DPH's Agency Strategic Plan (2013-2018).

2015

- **May:** DPH staff and partners established DPH's definition and vision of the Culture of Health Equity.
- **June:** Finalized the draft OHE Strategic Plan.
- **July:** Held a 30-day public comment period on the draft OHE Strategic Plan.
- **August:**
 - Commissioner Mullen signed the *CT DPH Policy and Procedures for Communicating with Persons of Limited English Proficiency*.
 - Held the annual DPH health equity retreat.
 - Held a review and comment session on the draft OHE Strategic Plan.
- **October:** Launched the OHE Strategic Plan.

Appendix B: DPH's Strategic Planning Process Summary

A strategic plan serves as a road map for employees and partners to make decisions that further the goals of an organization. To ensure that the plan meets the needs of the people of Connecticut, the Department is engaged in a comprehensive, participatory strategic planning process that includes staff, partners, and the public in identifying needs and setting priorities.

The Connecticut Department of Public Health published its first draft of a five-year Agency Strategic Plan for 2013-2018 in February 2013.

The following six Strategic Priorities were established within the initial version of the Strategic Plan:

1. **Ensuring Programmatic Excellence** by creating a culture of continuous quality improvement that aligns the health needs of the public with the actions of the health department.
2. **Promoting the Value and Contributions of Public Health** by educating the public about the role public health plays in increasing the number of who are healthy at every stage in life.
3. **Building Strategic Partnerships to Improve the Public Health Systems** by seeking input and increasing collaborative efforts.
4. **Fostering and Maintaining a Competent, Healthy, Empowered Workforce** by providing opportunities for continuous skill building in a safe and healthy environment.
5. **Establishing a Sustainable, Customer-Oriented Organization** by increasing access to our services, personnel, and information.
6. **Championing Health Equity** by making a concerted effort to address the many social determinants that impact one's ability to be healthy

In March 2014, health data were analyzed, and community input provided for the *Connecticut State Health Assessment* (SHA) through key informant interviews, advisory groups, Coalition meetings, and public forums. The assessment documented health risks and factors contributing to poor health.

Findings from the health assessment were then used to set priorities for health improvement. The *State Health Improvement Plan* (SHIP) aligned the activities of the health department and its partners with our health improvement goals. DPH asked its partners from the public, private, and nonprofit sectors across Connecticut to identify successful strategies for promoting health. These partners included State, Tribal, and local agencies; hospitals and other providers of medical, dental, and behavioral health care; community and professional organizations and coalitions; businesses; community services providers and representatives of vulnerable populations; academic institutions; and complementary service providers.

The *Connecticut State Health Assessment* (SHA) and the *State Health Improvement Plan* (SHIP) identified the need to update DPH's Strategic Plan, including establishing health equity as an essential component of all programs and policies. In 2015, DPH updated its Agency Strategic Plan to include **Champion a Culture of Health Equity** as one of its four Cross-Cutting Priorities.

Updated DPH Strategic Priorities and Cross-Cutting Priorities (2015-2018):

Strategic Priorities:

1. Strengthen Approaches and Capacity to Improve Population Health
2. Promote the Value and Contributions of Public Health
3. Build Strategic Partnerships to Improve the Public Health System
4. Foster and Maintain a Competent, Healthy, Empowered Workforce
5. Build a Sustainable, Customer-Oriented Organization

Cross-Cutting Priorities:

1. Ensure Quality and Reliability of and Access to Data Statewide
2. Foster a Culture of Performance Management & Quality Improvement
3. Champion a Culture of Health Equity
4. Secure Sustainable, Diversified Funding

Appendix C: Overview of OHE's Health Equity Strategic Planning Activities

Creation of the DPH Health Equity Policy Statement

In the spring of 2011, a DPH Health Equity Policy Statement was developed in consultation with approximately 20 key staff throughout the agency. This statement identifies health disparities priority population groups; a health equity policy based on the ten essential services of public health; and a process to guide the policy. It was signed by DPH Commissioner Jewel Mullen in May 2011, and publicly disseminated.

Health Equity Quality Improvement Workshop

As part of DPH's Quality Improvement (QI) staff training initiative, funded through the National Network of Public Health Institutes, DPH held a one-day workshop in 2012, with Dr. Jack Moran of the Public Health Foundation. Approximately 30 DPH staff participated in this workshop to learn QI tools, through examining two questions: 1) What are the issues of incorporating health equity into our everyday work, and 2) What are the issues faced by DPH in implementing its Health Equity Policy Statement?

Responses generated have provided important information for the development of strategies and activities for a health equity plan.

Strategic Planning Workgroups

As part of the 2012-2013 staff-led DPH Strategic Mapping process, five Health Equity Strategic Mapping Workgroups were formed in the areas of promoting: 1) health equity definitions, 2) health equity data and surveillance, 3) CLAS Standards, 4) health equity staff training, and 5) health equity partnerships. Summary reports and recommendations of these staff workgroups were published in December 2012, and a subset of these recommendations has provided the basis for the Office of Health Equity's work plan from 2013 through the present.

Health Equity Assessment

In response to the state Commission on Health Equity's request for an agency self-assessment in relation to health equity, the DPH Health Equity Director met with approximately 32 DPH staff met in small groups to complete this assessment from November through December 2012. The agency self-assessment was completed in December 2012.

Strategic Plan Priorities

The Agency Strategic Plan (2013-2018) updated its cross-cutting priorities to include *Champion a Culture of Health Equity*, which was established in 2014 as a revision to the previous strategic priority, *Champion Health Equity*. Two other quality-related priorities in the Strategic Plan are 1) *Ensure Programmatic Excellence*, and 2) *Build a Sustainable, Customer-Oriented Organization*. Each of these priorities has or is being addressed by a workgroup established through the strategic planning process.

State Health Improvement Plan

A State Health Assessment (SHA) and State Health Improvement Plan (SHIP) were completed in the spring of 2014. Health equity and the social determinants of health were included as cross-cutting priorities in the SHIP. An Advisory Council, comprised of key state partners, oversees the SHIP Implementation Plan, which is organized into seven focus areas. Progress in meeting these objectives is being monitored by the Public Health Strategic Team, using a performance management system.

Health Equity Staff Retreats

On August 20, 2014, OHE held a half-day retreat with five project staff; five other DPH “Health Equity Champions” were invited to participate in a one-hour discussion session. A SWOT (strengths, weaknesses, opportunities, and threats) Analysis was completed to assess project progress.

On August 27, 2015, the second OHE staff retreat was held with four project staff. Last year’s SWOT Analysis was reviewed and a new analysis was completed to identify strengths, weaknesses, opportunities, and threats to project progress in the coming year.

CLAS Standards Baseline Assessment

From September 2013 through September 2014, OHE conducted an assessment of the agency’s promotion and implementation of the CLAS Standards Baseline Assessment, published in October 2014, summarized DPH efforts to date, and laid out a set of eight recommendations for implementation of the Standards. Since October 2014, OHE staff have been engaged in the implementation of these recommendations, in consultation with the Commissioner’s Office and agency partners, especially in the offices of Communications, Equal Employment Opportunity, Strategic Planning, and Administration.

Appendix D: Health Equity Strategic Plan Activities

Culture of Health Equity Working Meeting

On May 12, 2015, the OHE Core Team, DPH staff, and external partners attended a half-day meeting facilitated by CommonHealth ACTION, a national nonprofit, public-health organization that aligns people, strategies, and resources to generate solutions to health and policy challenges. The meeting consisted of three group activities in which participants collectively defined the DPH Culture of Health Equity, established the Culture of Health Equity Vision Statement, and revised the Culture of Health Equity Value Statements. The results of that meeting are published in the Health Equity Strategic Plan narrative.

Later that afternoon, the OHE Core Team met with CommonHealth ACTION staff to discuss strategies to revise the draft Health Equity Plan. CommonHealth ACTION presented and received feedback on a revised Health Equity Strategic Plan outline, and together the two teams established an updated one-year work plan. Based on the compiled results of both the morning and afternoon meetings, CommonHealth ACTION and the OHE Core Team produced the first draft of the Health Equity Strategic Plan.

Health Equity Strategic Plan Communication Strategy Meeting

On June 10, 2015, CommonHealth ACTION and ASTHO facilitated a second meeting with fourteen members of the DPH staff. Participants engaged in two brainstorming activities in which they collectively generated strategies for communicating about their health equity-focused work to internal and external audiences. CommonHealth ACTION used the information produced at the meeting to create the OHE communication plan.

Later that afternoon, CommonHealth ACTION, ASTHO, and OHE reviewed and made revisions to the first draft of the Health Equity Strategic Plan narrative and work plan. CommonHealth ACTION then finalized the full draft of the Office of Health Equity Strategic Plan.

Public Comment and Review of the Draft Strategic Plan

From July 31 through August 29, 2015, DPH held a thirty-day public comment period on the draft Office of Health Equity Strategic Plan. Comments were solicited via the OHE website – www.ct.gov/dph/healthequity as well as through listserv notices. On August 27, 2015, OHE staff also hosted a meeting for 16 invited DPH staff and partners to discuss their comments on the draft strategic plan. Feedback obtained from the public, DPH partners, and staff informed subsequent revisions to the draft strategic plan.

Appendix E: Partnership List by Organization Type

Advocacy Groups	<p> AARP Connecticut Abdul-Majid Karim Hasan Health Awareness Advisory Council American Health, Stroke Association, State Health Alliances African Community Services, Inc (East Hartford) American Cancer Society American Heart Association American Lung Association of (East Hartford) Asian Pacific American Coalition of CT Association of Physicians of Indian Origin (CAPI) Citizens for Quality Sickle Cell Care, Inc. (CQSCC) CT AIDS Resource Coalition (CARC) CT Association for Home Care & Hospice (CAHCH) CT Cancer Partnership CT VNA Hospice Diabetes Support Groups - Connecticut E2 Consulting Services Educational Advocacy Leukemia & Lymphoma Society Lupus Foundation March of Dimes National Association for the Advancement of Colored People (NAACP): -CT State Conference of NAACP Branches - Bridgeport Branch - Hartford Branch - New Haven Branch National Kidney Foundation Sickle Cell Association of America, Southern CT Self-Injury Awareness Network, Inc. (SIAN/CT) c/o APAAC Immunization Plan The Leukemia and Lymphoma Society The Parent Academy Witness Project of CT (Cancer) Women's Center for Breast Health VITAS Innovative Hospice Care Youth Care After Crisis & SBFSP- Negril </p>
Businesses & Consultants	<p> A Different Perspective, Inc. Action for Equity/JZ Consulting Services Blok Group, LLC Diamond Research Consulting, LLC Ficklin Media Group, LLC Fluency, Inc. Greene Law, PC Hartford HealthCare MATRIX Public Health Solutions, Inc. Metaphrasis Language and Cultural Solutions, Inc. Mijoba Communications Muslim Journal Enterprises, Inc. </p>

	<p>MyFitStyle Patient Performance Institute Pediatric Care Center, LLC Performance Edge Qualidigm Rose Ego Center for Health Informatics (ROCHI)</p>
Colleges & Universities	<p>Eastern Connecticut State University (ECSU): - Department of Health & Physical Education Fairfield University: - Department of English - Graduate School of Education & Allied Professions Gettysburg College Northwestern CT Community College Pace University: - Office of the President Saint Joseph College: - School of Pharmacy - School of Nursing Three Rivers College Southern Connecticut State University (SCSU) Tulane University, New Orleans, LA University of Connecticut (UConn): - Connecticut Center for Economic Analysis - UConn Health Center: - Department of Community Medicine: - Community Based Education - General Clinic Research Center - Graduate Programs in Public Health - UConn School of Medicine: - Public Health Program - UConn School of Nursing - UConn School of Pharmacy - UConn School of Social Work - Chair of the Black Studies Project University of Connecticut (UConn)/Stamford Branch: - Sociology & Women's Studies University of Hartford Wesleyan University: - Career Center Yale University: - Internal Medicine, Physician Assistant Program - NIH Center for Eliminating Health Disparities Among Latinos (CEHDL) - Program for Recovery & Community Health - School of Medicine - School of Public Health - FoodNet, Emerging Infections Program</p>
Community Based Organizations	<p>Asian Family Services, Community Renewal Team, Inc. Hispanic Health Council (HHC) Khmer Health Advocates (KHA)</p>

	<p>Lao Association of CT, Inc. Northwest Caring Connection Community Collaborative: - La Vida Latina, Inc.</p>
Developmental Disability Services	<p>Community Enterprises, Inc. HealthMatters</p>
Faith Based Organizations	<p>Conference of Churches Trinity Episcopal Church Episcopal Church in Connecticut: Saint Savior Muhammad Islamic Center Health The Salvation Army</p>
Government – Federal	<p>IRIS - Integrated Refugee & Immigrant Services Social Security Administration US Department of Health and Human Services (DHHS)</p>
Government – Local	<p>City of Hartford: - City Hall - Court of Common Council - Department of Families, Children, Youth and Recreation - Department of Health and Human Services City of New Haven: - Community Services Administration (CSA) Town of Newington: - Board of Education Town of Mansfield: - Mansfield Public Schools Town of Putnam Town of Waterbury -Waterbury School System</p>
Government – State	<p>Children's Trust Fund CT Department of Children & Families (DCF): - Multicultural Affairs CT Department of Developmental Services (DDS): - CT Birth to Three System CT Department of Energy and Environmental Protection (DEEP) CT Department of Mental Health and Addiction Services (DMHAS) CT Department of Public Health (DPH): - Office of Health Equity - Public Health Initiatives Branch - Children with Special Healthcare Needs - Maternal and Child Health - Office of Oral Health - Tumor Registry - Drinking Water Section CT Department of Social Services (DSS) CT General Assembly</p>

	<p>CT General Assembly:</p> <ul style="list-style-type: none"> - Asian American Affairs Commission - Commission on Health Equity - Latino & Puerto Rican Affairs Commission - Legislative Offices <p>CT State Department of Education (SDE):</p> <ul style="list-style-type: none"> - Multicultural Education, Title IX, Sexual Harassment, Civil Rights & Bullying
Health Care Services	<p>Charter Oak Health Care Community Health Center Assoc. of CT Community Health Center (Hartford) Community Health Center, Inc. Community Health Center of Meriden Community HealthCorps, Inc. – (an AmeriCorps program) Community Health Network of CT, Inc. Community Health Services, Inc. (Middletown) Community Resources, LLC Generations Family Health Center, Inc. Latino Community Services, Inc. (HIV/AIDS services) Mashantucket Pequot Tribal Nation Pequot Health Care:</p> <ul style="list-style-type: none"> - Pequot Pharmaceutical Network (PRXN) <p>St. Vincent's Medical Center Stamford Community Health Center (Optimus Health Care) United Community & Family Services</p>
Hospitals	<p>Bridgeport Hospital CT Children's Medical Center (CCMC):</p> <ul style="list-style-type: none"> - Hartford Childhood Wellness Alliance - Special Kids Support, North Central Medical Home Initiative <p>CT Hospital Association:</p> <ul style="list-style-type: none"> - Patient Care Regulations - Health Equity <p>Hartford Hospital Hospital of Central CT Johnson Memorial Hospital Lawrence and Memorial Hospital Middlesex Hospital Saint Francis Hospital & Medical Center:</p> <ul style="list-style-type: none"> - Curtis D. Robinson Center for Health Equity - The Men's Health Institute <p>William W Backus Hospital</p> <ul style="list-style-type: none"> - Nursing and Community Health Education Department <p>Windham Hospital Yale New Haven Hospital</p>
Housing Services & Homelessness	<p>Beulah Heights Social Integration CT Coalition to End Homelessness Willimantic Housing Authority</p>

Insurers	Aetna, Inc. Aetna, Inc.: Children's Center CIGNA
Language Translators and Interpreters	Language Link Interpreters and Translators, Inc. ISI Translation Services Say Hi Translate and Owner Latino Expo Transcreating, LLC
Local Health	CT Association of Directors of Health (CADH) East Shore District Health Department Eastern Highlands Health District Ledge Light Health District New Britain Health Department Town of Somers Health Department Uncas Health District
Mental Health & Addiction Services	Advocacy Unlimited, Inc. Community Mental Health (New Britain) CT Council on Problem Gambling Fellowship Place Hartford Dispensary (Opiate Treatment Programs) National Alliance on Mental Illness (NAMI-CT): - Farmington Valley - Hartford North Central Regional Mental Health Board, Inc. Wellpath
Philanthropic	Aetna Foundation CT Health Foundation Hartford Foundation for Public Giving (HFPG) The Community Foundation for Greater New Haven The William Caspar Graustein Memorial Fund Universal Health Care Foundation
Uncategorized	91 Holiday Hill Enharmonic Solutions Essay Writers Galaxy Insight Unlimited, LLC NYSL RED Evaluation and Training/FLECHAS, Inc. Truven Health Analytics

Appendix F: OHE's SWOT Analysis Results

Connecticut Department of Public Health
Health Equity Staff Retreat
Wednesday, August 20, 2014, 8:30 – 11:30 a.m.

In Attendance: Tiffany Cox, Margaret Hynes, Angela Jimenez, Marijane Mitchell, Alison Stratton

SWOT Analysis (9:30 – 10:30 a.m.)

Question: *In thinking about our group objective “Championing Health Equity in everyday work at DPH,” what would you say are our strengths, weaknesses, opportunities, and threats?*

1. Strengths

- ✓ Dedicated, committed staff with a variety of experiences, skill sets, and talents
- ✓ Expert leadership
- ✓ State-funded positions to support work
- ✓ Partial (0.2 FTE), federally funded position to support work
- ✓ One free DHPE Fellow (~ 0.5 FTE)
- ✓ Knowledge re: how to “work” a state agency, overcome bureaucratic hurdles
- ✓ Agency climate focused on Public Health Accreditation
- ✓ Strong, supportive internal group networks across the agency
- ✓ Individual health equity champions across DPH
- ✓ DPH Administration that is supportive

2. Weaknesses

- ✓ Insufficient funding (and staff) to accomplish large goals
- ✓ Bureaucracy (various systems, e.g., contracts’ process can be an impediment to our work)
- ✓ Internal groups that create obstacles (e.g., in implementing CLAS language access standards)
- ✓ Lack of coordinated agency messaging and communications with the public
- ✓ Data and surveillance of health disparities are fragmented and not integrated throughout the agency
- ✓ Technology does not always work as needed
- ✓ Inadequate communication (e.g., failure to share important information across the agency)
- ✓ Failure to keep up with larger trends in Public Health (e.g., use of social media to communicate message)

3. Opportunities

- ✓ Current political climate (governor, legislature) provides a window of opportunity for health equity
- ✓ Networks and partner organizations, especially the CT Multicultural Health Partnership
- ✓ State partner agencies
- ✓ State commissions
- ✓ Regional partners (e.g., Regional Health Equity Council)

- ✓ Federal partners (technical assistance, resources, and funding through HHS/OMH)

4. Threats

- ✓ Political environment, and consequent agency infrastructure and funding changes
- ✓ Negative public perceptions of state agency workers
- ✓ Federal partners may not always be helpful
- ✓ State agencies that are resistant to CLAS Standards directives and data standardization
- ✓ Lack of data sharing among state agencies
- ✓ Impending staff retirements and no succession plan
- ✓ Inadequate state technology infrastructure to support our work

**Connecticut Department of Public Health
Health Equity Staff Retreat
Thursday, August 27, 2015**

In Attendance: Margaret Hynes, Angela Jimenez, Marijane Mitchell, Alison Stratton

SWOT Analysis (8:30 – 9:45 a.m.)

Question: ***In thinking about our group objective “Championing (a culture of) Health Equity in every day work at DPH,” what would you say are our strengths, weaknesses, opportunities, and threats?*** Our conversation included a look at, and re-evaluation of, our comments from last year.

1. Strengths

- ✓ Dedicated, committed staff with a variety of experiences, skill sets, and talents
- ✓ Expert leadership
- ✓ State- funded positions to support work
- ✓ Partial (0.2 FTE) federally funded position to support work
- ✓ Expert external consultants (e.g., Yale)
- ✓ Knowledge re: how to “work” a state agency, overcome bureaucratic hurdles
- ✓ Agency climate focused on Public Health Accreditation
- ✓ Strong, supportive internal group networks across the agency, which has increased since last year
- ✓ Individual health equity champions across DPH, who have increased since last year
- ✓ DPH Data Collection Quality Improvement Committee
- ✓ DPH Leadership that is supportive
- ✓ Increased avenues for public exchange and sharing of information with the public
- ✓ Improved communication with key partners (e.g., Commission on Health Equity)
- ✓ Greater external exposure, e.g., publicizing CLAS Standards
- ✓ TRAIN-CT postings of courses (e.g., CLAS 101, Data Collection Policy)
- ✓ Improved technology (purchase of Captivate software for course development)

2. Weaknesses

- ✓ Insufficient funding (and staff) to accomplish large goals
- ✓ Bureaucracy (various systems, e.g., contracts process can be an impediment to our work)
- ✓ Internal groups that create obstacles (e.g., in implementing CLAS language access standards)
- ✓ Agency messaging and communication with the public is not always consistent
- ✓ We do not have all the support we need in terms of communicating our message
- ✓ Under-utilization of social media to communicate agency (public health) messages
- ✓ Important information is not always shared across the agency
- ✓ Data and surveillance of health disparities are fragmented, lacking, and not always consistent throughout the agency
- ✓ Technology does not always work as needed

3. Opportunities

- ✓ Current political climate (governor, legislature) provides a window of opportunity for health equity
- ✓ Networks and partner organizations, especially CT Multicultural Health Partnership
- ✓ State partner agencies
- ✓ State commissions
- ✓ Regional partners, e.g., Region I partners
- ✓ Federal partners (funding through OMH and ASTHO)
- ✓ State offices of minority health
- ✓ State offices of refugee health
- ✓ Student internship potential
- ✓ Heightened national awareness of racism, inequality, and health equity

4. Threats

- ✓ Political environment, and consequent agency infrastructure and funding changes
- ✓ Negative public perceptions of state agency workers, but this seems improved in the past year
- ✓ Federal partners may not always be helpful
- ✓ State agencies that are resistant to CLAS Standards directives and data standardization
- ✓ Lack of data sharing among state agencies
- ✓ Impending staff retirements and no succession plan
- ✓ Inadequate state technology infrastructure to support our work

Appendix G: Workgroup Recommendations— Health Equity Definitions (December 2012)

Workgroup Purpose and Members:

The Health Equity Definitions Workgroup was tasked with defining key concepts describing the relationship between public health and the social environment.

The Health Equity Definitions work group was comprised of the following DPH staff: Federico Amadeo, Suzanne Blancaflor, Nordia Grant, Susan Hewes, Margaret Hynes, Marijane Mitchell, and Alison Stratton. Five meetings were held from September to November 2012 at which key concepts were discussed, relevant readings were exchanged, and definitions were reviewed, revised, and or developed. A series of recommendations were also generated.

The workgroup proposed the following definitions:

Health Disparities

“...the differences in disease risk, incidence, prevalence, morbidity, and mortality and other adverse conditions, such as unequal access to quality health care, that exist among specific population groups in Connecticut. Population groups may be based on race, ethnicity, age, gender, socioeconomic position, immigrant status, sexual minority status, language, disability, homelessness, mental illness, and geographical area of residence. Specifically, health disparities refer to those avoidable differences in health that result from cumulative social disadvantage.”¹ (Adapted from Stratton A, Hynes MM, and Nepaul A (2007) *Defining Health Disparities*. Hartford, CT: Connecticut Department of Public Health).

Health Equity

“Equity in health refers to how uniformly services, opportunities and access are distributed across groups and places, according to the population group. Equity in health implies that ideally everyone could attain their full health potential and that no one should be disadvantaged from achieving this potential because of their social position or other socially determined circumstance. Efforts to promote social equity in health are therefore aimed at creating opportunities and removing barriers to achieving the health potential of all people. It involves the fair distribution of resources needed for health, fair access to the opportunities available, and fairness in the support offered to people when ill” (Adapted from the WHO).

¹ Connecticut Department of Public Health (2012) *Health Equity Policy Statement*. Hartford, CT: Connecticut Department of Public Health. Available at: http://www.ct.gov/dph/lib/dph/hisr/pdf/Health_Equity_Policy_Statement.pdf

Social Determinants of Health

“The social determinants of health are the conditions in which people are born, grow, live, work, age and die, including the health system. These circumstances are shaped by the distribution of money, power, and other resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between communities.” (Adapted from the WHO Commission on Social Determinants of Health).²

Health Disparities Populations

Various terms are used in the public health literature to describe populations that experience “health disparities”, such as: “socially disadvantaged,” “vulnerable,” “at risk,” “priority,” and “target.” These terms convey slightly different meanings and one term may be more appropriate than others in any given context. No one term is recommended for use by this work group.

- *Socially disadvantaged* groups are described as those “who have persistently experienced social disadvantage or discrimination...and systematically experience worse health or greater health risks than more advantaged social groups...” while *socially advantaged* refers to a group’s relatively high “...position in a social hierarchy determined by wealth, power, and/or prestige” (Braveman, 2006).

The terms “socially disadvantaged” and “socially advantaged” appear to communicate important, nuanced information vis à vis health and relative position in the social hierarchy. Our group agrees that these are two terms that well describe societal underpinnings/structures leading to unequal health outcomes, and are appropriate for use in surveillance reports and other documents that contextualize health disparities within a given social environment.

- *Vulnerable populations* have been described by the Urban Institute Health Policy Center as those that are “not well integrated into the health care system because of cultural, economic, geographic, or health characteristics.” UIHPC furthermore notes that “This isolation puts members of these groups at risk for not obtaining necessary medical care, and thus constitutes a potential threat to their health. Commonly cited examples of vulnerable populations include racial and ethnic minorities, the rural and urban poor, undocumented immigrants, and people with disabilities or multiple chronic conditions” (Urban Institute Health Policy Center 2010).

² WHO Commission on Social Determinants of Health. Available at: http://www.who.int/social_determinants/en/

Some advocates have suggested that the term “vulnerable” populations, may connote levels of disempowerment, frailty, and/or “not being well,” and as such may not be an appropriate way to characterize all health disparities populations. While this work group recognizes the sensitivity of and nuances surrounding this issue, we agreed that there may be some instances in which “vulnerable population” is an appropriate term – for example, in discussing the frail elderly, youth under 18, rural communities, or undocumented persons without access to care. This is an important consideration when determining the content and the audience for a particular DPH communication and should be used carefully.

The terms “at-risk,” “priority,” and “target” population have been used by federal agencies and funders, and as such, DPH programs may choose to use these terms for purposes of consistency.

- *At risk* is a commonly used term in public health to describe the high probability of an unfavorable health outcome due to an identified exposure. Similarly “risk group” is a term that is used very frequently in the environmental health arena and in epidemiological investigations. It has also been incorporated into the chronic disease literature.
- *Priority* refers to preceding others in terms of rank or need; and this may be an appropriate term for DPH plans (and reports) that set health priorities for the agency (e.g., Healthy Connecticut, which will be the state health improvement plan).
- *Target* population refers to a population of interest, and is commonly used in the field of marketing. The term does not have any other additional “health-related” connotations about the population.

References

Braveman, P. 2006. Health Disparities and Health Equity: Concepts and Measurement. Annual Review of Public Health 27:167-94. Available at:
<http://www.ops.org.bo/textocompleto/riarph270004.pdf>

Urban Institute, Health Policy Center. 2010. Vulnerable Populations. Washington, DC: Urban Institute, Health Policy Center. Available at:
<http://www.urban.org/center/hpc/index.cfm>

Recommendations

Following are recommendations to DPH Leadership from the Health Equity Definitions Workgroup:

1. Include these definitions in all plans and surveillance reports published by DPH.

The DPH definitions of health equity, health disparities, the social determinants of health, and disparities populations should be included in DPH plans and reports in

either the narrative section or else as part of a glossary section. This will promote consistency in usage of important concepts across the agency.

2. Create issue briefs on cross-cutting topics, such as homelessness and health, which emphasize an integrated approach to pressing public health concerns.

The leadership for this activity, initially at least, should come from the Health Equity Research, Evaluation and Policy Initiative, in consultation with other DPH programs as appropriate.

3. Coordinate cross-cutting issues (e.g., housing) that impact health across programs through the DPH webpage/webmaster.

The leadership for this activity, initially at least, should come from the Health Equity Research, Evaluation and Policy Initiative, in consultation with other DPH programs as appropriate.

4. Reconsider the name and mission statement of the DPH Office of Multicultural Health so that it is aligned with current agency strategic planning efforts regarding health equity.

The concept of multiculturalism has been used in both Europe and the United States to describe the increased recognition and appreciation of cultural diversity and ethnic heterogeneity as a societal good. A long-standing criticism of this concept is that it does not recognize or acknowledge the underlying social and economic structures in place that are the basis of widespread inequality, which lead to health disparities. A fuller appreciation of cultural diversity alone will not sufficiently address structures and institutions responsible for social and economic inequality and subsequently health disparities. "Health equity" embodies the principle of health as a human right and social good, and it is consistent with DPH strategic planning efforts as well as other statewide initiatives.

Appendix H: Workgroup Recommendations— Health Equity Data and Surveillance (December 2012)

Workgroup Purpose and Members

The Health Equity Data Surveillance workgroup was responsible for providing recommendations for integrating an equity lens into DPH data collection and surveillance practices. Members included Federico Amadeo, Chris Andresen, Nordia Grant, Susan Hewes, Margaret Hynes, Cathryn Phillips, Robin Tousey-Ayers, and Susan Logan.

Recommendations

- 1. Programs should develop a baseline description with a plan to reach compliance for data not currently in compliance indicating what resources are needed** so that all DPH databases comply with the *Connecticut Department of Public Health Policy on Collecting Sociodemographic Data, September 2008*, as well as federal standards.³
- 2. DPH staff should keep in mind several key factors when reviewing data to collect and consider in planning programs.** These factors include: the social determinants of health and which socio-demographic variables have been reported in the literature as being most closely related to the program involved, training for data collectors, and current system limitations and expense.
- 3. DPH should work towards linking DPH datasets such as birth and death, infectious, chronic diseases and environmental data to enhance understanding of our population and associations between variables.** As a first step the chronic disease epidemiology and surveillance group should explore what data sets are currently linked, where linkage of public health databases would likely benefit public health, and what are the impediments working against such linkages.
- 4. The chronic disease epidemiology and surveillance group should encourage current efforts and consider additional ways to share knowledge within the department** such as a SAS book of common codes for epidemiologists to use, and reworked census data with social determinant focus

³ See DPH *Policy on Collecting Sociodemographic Data* http://www.ct.gov/dph/lib/dph/multicultural_health/collecting_sociodemographic_data.pdf. Federal standards that are applicable may a) vary somewhat between DPH programs, and b) be subject to change over time, so this is not a one-time exercise. Common standards include: *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity* (Office of Management and Budget [OMB] 1997 http://www.whitehouse.gov/omb/fedreg_1997standards/), and Section 4302 of the Affordable Care Act. See the Shared drive under “Health Equity” for more on these and other documents.

which also considers the need for bridged data to reconcile changes in definitions between programs and over time.

5. **Continued iterations of *The Connecticut Health Database Compendium* (2010, 2012) are encouraged.** *The Compendium* provides up-to-date descriptions of DPH databases, associated contacts, related publications and web pages. It has been a valuable reference tool for DPH staff and statewide partners; in fact, the “Improving Data” work groups of the Strategic Mapping Initiative spent considerable time reviewing the Compendium as a key DPH data resource.

Appendix I: Workgroup Recommendations— CLAS Standards (December 2012)

Workgroup Purpose and Members

The “CLAS Standards” workgroup, was responsible for reviewing and compiling information about the *National Standards for Culturally and Linguistically Appropriate Services in Health Care* (CLAS Standards) promulgated by the U.S. Department of Health and Human Services’ (DHHS) Office of Minority Health in March 2001.

Work for the subcommittee took place from September 13, 2012 to December 7, 2012. The members of the subcommittee included: Alison Stratton (Chair), Salina Hargrove, JoAnn Ettienne-Modeste, Robin Tousey-Ayers, Marijane Mitchell, and Angela Jimenez.

This subcommittee agreed to focus work on: 1) Understanding, reviewing and compiling information about CLAS standards 4-7, and 2) internal DPH CLAS initiatives and staff knowledge of CLAS standards, as consistent with DPH Strategic Planning efforts. By integrating CLAS standards into DPH’s own systems, processes, actions, and policies, DPH will set an example of how it expects contractors, local health departments and providers to behave relative to the CLAS standards, and health equity more generally.

Recommendations:

The subcommittee’s recommendations for future DPH action to promote the CLAS standards regarding linguistic access to health services may be grouped thematically. Issues regarding both *interpretation* (spoken or signed communication) and *translation* (written communication) are reflected below.

1. Commissioner Statement Prioritizing CLAS standards/Designation of a DPH CLAS standards/LEP Issues Guru/ Establish LEP Issues Community Advisory Group:

- a. Recommend that the DPH Commissioner issue a statement to all DPH employees emphasizing that awareness of and adherence to the CLAS standards (especially regarding the mandated language access standards) are priorities for the agency.
- b. Designate and fund a CLAS/LEP Issues Guru, located in the DPH Office of Multicultural Health who would spearhead/coordinate DPH internal efforts as well as oversee the public face of DPH regarding linguistic access to DPH services.
- c. Require workforce development and training of all DPH staff about their own responsibilities regarding language access to health services. Send out reminder emails about internal DPH expertise and key people for language access issues.
- d. Create a Community Advisory Group that will assist DPH in its efforts to promote CLAS standards and access for persons with LEP.

- 2. Using the “four-factor analysis” tool promulgated by DHHS (Federal Register 2003), all DPH programs should conduct inventories of:**
 - a. All service populations reached by the program.
 - b. All languages spoken by the service population.
 - c. Frequency of interaction with members of the service population, and their preferred languages.
 - d. All materials written and distributed in oral, written, or electronic format, and the languages into which they are/have been translated.
 - e. All DPH materials put into the public domain, with assessment of translation needs.
- 3. Database Update: Federal law and DPH policy present opportunities to collect language data. Some DPH programs have already expanded possibilities of collecting complex language data.**
 - a. At a minimum, all DPH databases should follow the federal OMB categories and the data collection parameters for primary language mentioned in Section 4302 of the Affordable Care Act.
 - b. Further, all DPH databases should try to use the expanded/ideal parameters for language data collection as promulgated and approved in the *DPH Policy on Collecting Sociodemographic Data* (2008).
 - c. All data collection instruments and databases should incorporate the option of “Other language, please specify”.
- 4. Public Face of DPH regarding Access to DPH services for persons with LEP:**
 - a. Designate and fund a DPH Webmaster who would ensure consistency and cross-linkage of CLAS standards efforts and websites, and translated materials nationwide and at DPH.
 - b. DPH 8000 Line: Increase training for all operators or hire bilingual operators [currently contracted with Easter Seals – need more polished/CLAS –competent training].
 - c. Revamp all entrance areas to DPH: include signage in those languages identified as the most-encountered languages at DPH.
 - d. Review effects of the only bilingual signage being a warning about weapons.
 - e. Train security guards as appropriate – Ensure that security personnel receive updated DPH staff directories.
 - f. Ensure the completion of revisions to the DPH Office of Multicultural Health website.
 - g. Investigate the possibility of partnering with the State Department of Higher Education in order to pursue proper educational and administrative

structures by which to ensure professionally-trained and certified/ licensed medical interpreters.

- h. Post the CLAS standards and supporting documents on the main page of the DPH website.
- i. All DPH programs should cross-link to the federal and state CLAS/ LEP web pages.
- j. Encourage a public information campaign about CLAS standards responsibilities and benefits.

5. Translation of written documents:

- a. Encourage a translation contractor to translate all DPH documents. Currently, individual programs at DPH must translate their own documents at their own expense (and often do not, for a variety of reasons). A DPH-wide undertaking would provide consistency and capacity.
- b. DPH programs should create documents in Plain English and/or incorporate picture language as basis for all documents. These can then be translated and back-translated to ensure clarity and consistency of messaging.

6. Coordination of work among various DPH committees/initiatives already working on promoting health equity in everyday work.

- a. Committees or staff involved in: Quality Improvement; Workforce Development; Workforce Training; Emergency Preparedness; Communications.

7. Ensure Language Line (or other telephonic interpretation) contracts:

- a. For all DPH programs that interact with persons with LEP, and train DPH staff how to use telephonic interpretation.

References and selected resources

- Americans with Disabilities Act of 1990 (ADA) (42 USC §§ 12101 et seq.)
<http://www.ada.gov/pubs/ada.htm>
- Commission on Social Determinants of Health. 2008. Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health.
- Geneva, World Health Organization.
http://www.who.int/social_determinants/thecommission/finalreport/en/index.html
- Connecticut Association of Health Directors (CADH). Health Equity Index.
<http://www.cadh.org/health-equity/health-equity-index.html>
- Connecticut Department of Public Health (DPH). 1999. Multicultural Health: the Status of Minority Groups in CT. <http://www.ct.gov/dph/lib/dph/hisr/pdf/multiculturalhealth1999.pdf>
- Connecticut Department of Public Health (DPH). 2001. Connecticut Women's Health.
<http://www.ct.gov/dph/cwp/view.asp?a=3130&q=389688>
- Connecticut Department of Public Health (DPH). 2005. Mortality and its Risk Factors.
http://www.ct.gov/dph/lib/dph/hisr/hcqsar/mortality/riskfactorsreport/mortality_report.pdf

- Connecticut Department of Public Health (DPH). 2008. DPH Policy on Collecting Sociodemographic Data. http://www.ct.gov/dph/lib/dph/hisr/pdf/dph_data_collection_policy_sept2008.pdf
- Connecticut Department of Public Health (DPH). 2009. The Connecticut Health Disparities Report. http://www.ct.gov/dph/lib/dph/hisr/pdf/2009ct_healthdisparitiesreport.pdf
- Connecticut Department of Public Health (DPH). 2011. Affirmative Action Policy.
- Connecticut Department of Public Health (DPH). 2011. Health Equity Policy Statement.
- Connecticut Department of Public Health (DPH). 2012. Mission Statement.
- Connecticut Department of Public Health (DPH). 2011. Contract Language (Section A, Subsection A.1, 8 b-e).
- Connecticut Health Foundation. 2006. *Interpretation: Estimates for the Costs of Interpretation Services for Connecticut Medicaid Recipients*. http://www.hartfordinfo.org/issues/wsd/health/est_cost_interpreter_services.pdf
- Connecticut Multicultural Health Partnership. 2010. Language Needs and Services of Local Health Districts and Community Health Centers. <http://www.ctmhp.org/wp-content/uploads/2010/06/Final-Report-Language-Services-Project.pdf>
- Connecticut General Assembly (CGA). 2008. Public Act No. 08-171: An Act Establishing a Commission on Health Equity.
- Executive Order 13166. 2000. Improving Access to Services for Persons with Limited English Proficiency. 65 FR 50121, August 16, 2000. <http://www.justice.gov/crt/about/cor/Pubs/eolep.pdf>
- Hanlon C, Rosenthal J, and Hinkle L. State Documentation of Racial and Ethnic Health Disparities to Inform Strategic Action. Online March 11, 2011. U.S. Agency for Healthcare Research and Quality. <http://www.hcup-us.ahrq.gov/reports.jsp>
- Institute of Medicine. 2002. Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare. <http://www.nap.edu/openbook.php?isbn=030908265X>
- Institute of Medicine (IOM). 2009. Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement. Washington, DC: The National Academies Press. <http://www.iom.edu/Reports/2009/RaceEthnicityData.aspx>
- *Lau v. Nichols* 1974. 414 U.S. 563. [http://scholar.google.com/scholar_case?case=5046768322576386473&q=Lau+v.+Nichols+\(414+U.S.+563+%5B1974%5D\)&hl=en&as_sdt=2,7&as_vis=1](http://scholar.google.com/scholar_case?case=5046768322576386473&q=Lau+v.+Nichols+(414+U.S.+563+%5B1974%5D)&hl=en&as_sdt=2,7&as_vis=1)
- National Center for Cultural Competency, Georgetown University. <http://nccc.georgetown.edu/about.html>
- Office of Management and Budget. 1997. Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity (62 FR 58782, October 30, 1997). http://www.whitehouse.gov/omb/fedreg_1997standards
- Patient Protection and Affordable Care Act. March 23, 2010. (ACA) (PL 111 – 148). <http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf>
- Race: The power of an Illusion (film)
- Resolution Agreement Between The U.S. Department Of Health And Human Services Office For Civil Rights And Rhode Island Department Of Human Services. January 2011. Transaction Number: 08-76828. <http://www.hhs.gov/ocr/civilrights/activities/agreements/ridhhsagreement.pdf>
- Title IV of the Civil Rights Act of 1964. 42 U.S.C. 200d et seq. <http://www.justice.gov/crt/about/cor/coord/titlevstat.php>
- Unnatural Causes: Is Inequality Making us Sick? (Film)

- U.S. DHHS. 1985. Report of the Secretary's Task Force on Black and Minority Health. <http://minorityhealth.hhs.gov/assets/pdf/checked/1/ANDERSON.pdf>
- U.S. DHHS. Healthy People 2020. <http://www.healthypeople.gov/2020/about/default.aspx>
- U.S. DHHS. 2001. National Standards for Culturally and Linguistically Appropriate Services in Health Care: Executive Summary. March 2001. <http://minorityhealth.hhs.gov/assets/pdf/checked/executive.pdf>
- U.S. DHHS. February 1, 2002. *Office for Civil Rights: Title IV of the Civil Rights Act of 1964; Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons with Limited English Proficiency* (67 FR 4968). <http://www.hhs.gov/ocr/civilrights/resources/laws/revisedlep.html>
- U.S. DHHS. 2003. Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons. Federal Register, Vol. 68, No. 153, August 8, 2003. (68 FR 47311) <http://www.justice.gov/crt/about/cor/lep/hhsrevisedlepguidance.pdf>
- U.S. DHHS. 2011. Final Data Collection Standards for Race, Ethnicity, Primary Language, Sex, and Disability Status Required by Section 4302 of the Affordable Care Act. <http://minorityhealth.hhs.gov/templates/browse.aspx?lvi=2&lvid=208>
- U.S. DHHS. 2011. Implementation Guidance On Data Collection Standards For Race, Ethnicity, Sex, Primary Language, And Disability Status" <http://aspe.hhs.gov/datacncl/standards/ACA/4302/index.shtml#Purpose> or <http://aspe.hhs.gov/datacncl/standards/ACA/4302/index.pdf>
- U.S. National Center on Minority Health and Health Disparities. <http://www.nimhd.nih.gov/>

Appendix J: Workgroup Recommendations— Health Equity Workforce Training (December 2012)

Workgroup Purpose and Members

The Health Equity Workforce Training workgroup was created to develop recommendations for training staff on health equity concepts and their application in DPH policies and programs. The workgroup included: Errol Roberts (convener), Margaret Hynes, Marijane Mitchell, Suzanne Blancaflor, Marc Camardo, Nordia Grant, Kathryn Shuttleworth, Amanda Anduaga-Roberson, Angela Jimenez, and Kristen Day. The subcommittee convened on September 19 and came to a close in December after gathering enough information to be presented as recommendations. Areas of discussion included:

- Identifying staff training opportunities:
 - In house available staff training resources
 - Resources outside of DPH, National and local organizations that advocate cultural competency
 - Other recommended material resources
 - Human resource, certified trainers, a Speakers Bureau
- Training application and sustaining the process:
 - Facilitation, how to create interest amongst staff
 - Curriculum design, content, format
 - Conversation moving/discussions to fill in the gaps
 - Sustaining the training

In addition to the members of the staff training subcommittee contribution we had focused group meetings with the attendees from the film and discussion series on the social determinants of health – *Unnatural Causes: Is Inequality Making Us Sick?* as well as *Race: The Power of an Illusion*. A series of questions were asked about the film series/trainings and the responses were collected and added to the findings from the subcommittee.

Recommended Health Equity Resources

1. In-House Available Staff Training Resources

- [*Race: The Power of an Illusion*](#), a 3-part film series that examines the historical and social construction of race in American society, describes the difference between social and biological views of race, and the origin and basis of the race construct in U.S. society. The film gives examples of how federal housing policies institutionalized segregation and wealth disparities.

- [Unnatural Causes: Is Inequality Making Us Sick](#), a 7-part film and discussion series that address the root causes of socioeconomic and racial inequalities in U.S. health through the following objectives: 1. Increase awareness and understanding of the social and economic influences on health. 2. Promote an understanding of ways that disempowerment and race and class structures can 'get under the skin' and influence health status. 3. Move discussions of public health "upstream" beyond individual factors to underlying social conditions that influence health outcomes. 4. Illustrate and discuss the influence of social policies on public health.
- Multicultural Training curriculum through the Dept. of Mental Health and Addiction Services (DMHAS) cultural competence and training.
- [Stir Fry Films, Lee Mun Wah, Last Chance for Eden](#), a three-part documentary on sexism and racism. *The Color of Fear* is a film about the state of race relations in America as seen through the eyes of eight North American men of Asian, European, Latino and African descent.
- [A Class Divided Film & Study Guide](#), a PBS Video about an innovative teachers' (Jane Elliot) 1970 daring experiment in her elementary school classroom to evaluate how racial stereotypes effect young children. This program presents the long-term effects of racial stereotyping.

2. Resources Outside of the Department, National and Local Organization that Advocates Cultural Competency

- [Peace Skills: Manual for Community Mediators, The National Conference for Community and Justice \(NCCJ\), Healing Racism-Facilitated Dialogue](#). NCCJ is a human relations organization dedicated to fighting bias, bigotry and racism in America. NCCJ promotes understanding and respect among all races, religions and cultures through advocacy, conflict resolution and education.
- [The Connecticut Women's Consortium](#) is an independent nonprofit agency in Hamden with a history of strong collaborations with many of Connecticut's community, academic and health care institutions on issues of women's mental health, substance use disorders, addiction, domestic violence and trauma. The Connecticut Women's Consortium provides trainings, advocacy and policy for caregivers and service providers in the behavioral health field.
- [Fenway Health - The Network for LGBT Health Equity](#) is community-driven network of advocates and professionals looking to enhance LGBT health by eliminating tobacco use, and enhancing diet and exercise. The Network is one of six CDC-funded tobacco disparity networks and a project of The Fenway Institute in Boston. It directly trains state health departments or other policymakers in LGBT cultural competency and forge bridges between them and local LGBT health specialists. It actively monitors national and state health policymakers and

urge community action when there is an opportunity to enhance LGBT wellness.

- [National Latino Tobacco Control Network](#) is an open information and support system for tobacco control and health disparities advocates and experts who want to become more effective in changing policies and social norms around tobacco control through exchange of information and personal and institutional linkages. It is one of six CDC-funded tobacco disparity networks.
- [CommuniCare Community Behavioral Health System](#) (CCI) is a unique collaborative organization formed 15 years ago to promote high quality, cost effective, community based behavioral related services. A 501©(3) non-profit organization and its member agencies are licensed and accredited community based agencies established as Local Mental health Authorities (LMHAs), offering a comprehensive range of psychiatric and substance abuse services. Each agency provides community clinical, rehabilitative and support services for people with serious mental illnesses and substance abuse disorders in the towns they serve.
- [The Multicultural Leadership Institute, Inc. \(MLI Inc.\)](#) is a private, non-profit 501(c) (3) corporation that was established in 1997. Its mission is to provide leadership for positive change through implementing and coordinating multicultural and diversity awareness, education, advocacy and research programs.
- [National African American Tobacco Prevention Network](#) (NAATPN) is one of six CDC funded networks that engages national and statewide partners by providing technical assistance in tobacco control and prevention activities. In its role, NAATPN maintains and strengthens its national network by: educating and sharing information about tobacco's history, facts, and prevalence, assessing the impact of tobacco within disparate populations, and identifying gaps in data, interventions and/or research involving African Americans and tobacco use. NAATPN's National Network is open to any individual or organization that is willing to assist in decreasing the impact of tobacco in Black communities.

3. Other Recommended Material Resources

- [NACCHO Roots of Health Inequity](#), a web-based course for the public health workforce. It also serves as an online learning collaborative to address systemic differences in health and wellness that are, actionable, unfair, and unjust.

4. Human Resources, Certified Trainers and a Speakers Bureau

- [State of Connecticut Train the Trainer Certificate Program](#) provides our workforce with the necessary knowledge and skills to deliver effective training that transfers smoothly to the work environment. Since the start of the Train-the-Trainer

Certificate Program there have been several DPH employees who have gone through the program and can be assets to in-house trainings. By forming a Speakers Bureau, DPH can create a list of speakers we can call on that lists each trainer skill set and availability. **Facilitation, How to Create Interest Amongst Staff**

- A comprehensive agency plan for staff training in public health should be developed, and health equity should be incorporated into this overall plan. For example, DPH should offer courses such as Public Health 101 and Health Equity 101, and where possible offer continuing education credits for completion of these basic courses.
- Health Equity 101 training should be mandatory for the DPH workforce. Health inequity is at the root of many public health problems, and so principles of health equity are essential knowledge for all staff.
- Managers' support for Health Equity staff training is crucial and managers should participate and support their staffs' involvement in training by including staff training as part of their PARS.

5. Curriculum Design, Content, Format

- Many DPH employees do not know what health equity is, and may be confused by related concepts and terms such as health disparities. Before each discussion, defining health equity and discussing several different social determinants of health can help prepare the attendees for a clearer and more focused discourse.
- Developing two tracks, Health Equity 102 for those who have strong academic background /experience in public health and Health Equity 101 track for those with little to no public health experience/education, to better engage and challenge the attendees ensuring better participation.
- To help gauge a person's thinking before and after the training, a pre and posttest should be administered for the benefit of the attendee's awareness of their progress.
- Using multiple formats of delivery such as the DAS course offerings, Webinars, Guest lectures, CT-Train and On-line trainings, the scope of health equity trainings can serve employees both inside and outside of DPH. This training can reach our sister organizations, local health departments, hospitals and other health care institutions with an interest in culturally competent care. Building a curriculum to be used outside of DPH should ultimately be the goal.

6. Conversation Moving / Discussions that Fill in the Gaps

- The State of Connecticut Train-the-Trainer Certificate Program provides our workforce the necessary knowledge and skill sets to deliver effective training that transfers smoothly to the work environment. Certified facilitators are able to manage and bring out discussions especially in some of the more sensitive subject matters.
- We recommend a co-facilitator that can offer a different perspective. With that second facilitator attendees may share a perspective that may otherwise be overlooked and / or underrepresented and having this may broaden perspectives which can encourage further participation.
- We have found as with the film series / trainings that having small groups and a nice blend from different programs allows for better interaction between the attendees. Attendees can go back to their programs and share what they have learned to increase the effectiveness of the training.

7. Sustaining the Training

- To embed Health Equity principles in the Department's culture, these trainings should be an on-going year-to-year practice. Annual and follow up trainings assure that the new lessons/skills sets learned are being applied appropriately.
- Using multiple means of sending Health Equity messages to the Department employees will preserve a greater awareness of the new practices learnt. Some creative ways of getting the message across may include: having payroll inserts and display banners for program events and posters for information boards throughout DPH. Using personal stories from staff that show how health equity has benefited them and the need for further trainings can increase fellow employees buy-in.

Appendix K: Workgroup Recommendations— Health Equity Partnerships (December 2012)

Workgroup Purpose and Members

As part of the DPH Strategic Mapping process, the Health Equity Partnerships Workgroup identified potential partners in relation to the DPH priority populations. These priority populations may be based on: race, ethnicity, age, gender, socioeconomic position, immigrant status, sexual minority status, language, disability, homelessness, mental illness, and geographical area of residence.⁴

The Health Equity Partnerships work group was comprised of the following DPH staff: Kim Burkes, Salina Hargrove (convener), Margaret Hynes, and Angela Jimenez. Our work group reached out to other DPH “Partnership” working groups including the SHA/SHIP (Olga Armah and Suzanne Blancaflor), Connecticut Multicultural Health Partners (Angela Jimenez), and Coordinated Chronic Disease (Eileen Boulay) to coordinate our mutual efforts. Three meetings were held from September to November 2012 at which partnership lists, formats for these lists, and recommendations were discussed. A series of recommendations for DPH Leadership were also generated.

Recommendations

1. **The DPH Partnership Master List should be housed and maintained in one central office, possibly the DPH Office of Communications.** We also recommend that the Master List be put into an ACCESS database. An ad hoc DPH Partnership group should be convened to determine the details on maintaining this Master List.
2. **The Health Equity Partnership list should be maintained by the staff in the DPH Health Equity Initiative.** Updates will be sent to the Agency Partnership List as appropriate. The Health Equity Partnership list will be shared with other DPH staff and programs, for use when DPH advisory groups and committees are being formed. Health Equity staff will market the Health Equity Partnership list as a resource for DPH programs seeking diverse consumer representation.
3. **While DPH has active, engaged “Health Equity” partners, new partners representing our priority populations - race, ethnicity, age, gender, socioeconomic position, immigrant status, sexual minority status, language, disability, homelessness, mental illness, and geographic area of residence – should be engaged in the following ways:** a) Identify and develop expert staff within DPH with some knowledge of the community to help engage potential

⁴ Connecticut Department of Public Health (2012) Health Equity Policy Statement. Hartford, CT: Connecticut Department of Public Health.
http://www.ct.gov/dph/lib/dph/hisr/pdf/Health_Equity_Policy_Statement.pdf

partners. A more personal approach can be helpful in engaging potential partners who may not be familiar with DPH mission and work; and b) DPH staff should communicate the benefits of partnership, and how can this help the community.

4. **DPH “Partnership” briefing documents should be developed and distributed in consultation with the Communications Office**, including: a) A Partnership Fact Sheet; b) Agency Guideline for building partnerships; and c) A press release.

Appendix L: Public Health Systems Improvement Unit (PHSI) and the Public Health Strategic Team (PHST)

Roles and Responsibilities

Public Health Systems Improvement (PHSI)

The Public Health Systems Improvement (PHSI) unit is responsible for directing, managing, and coordinating all, strategic planning, public health improvement planning, quality improvement and performance management and public health accreditation efforts for the department. The unit is staffed by a full-time manager, full-time contracts administrator, full-time administrative assistant, full-time senior planning analyst, full-time performance improvement manager, and .75 FTE epidemiologist.

Responsibilities:

- Provide staff support to the Public Health Strategic Team (PHST) and the Quality Improvement (QI) Council.
- Provide technical assistance to QI Teams and DPH staff carrying out quality improvement initiatives.
- Coordinate and/or provide training on quality improvement tools and methods.
- Coordinate and monitor strategic planning and implementation.
- Coordinate and monitor State Health Improvement Planning and implementation.
- Coordinate all accreditation planning and activities.
- Develop and monitor the performance management system.
- Manage a performance management IT application.
- Assist DPH staff and programs in the development and monitoring of performance measures.
- Develop, monitor, implement, and update the agency quality plan.
- Develop and assist in the implementation of a systematic process to assess and improve internal and external customer satisfaction.
- Assist in the development of a workforce development plan.

Public Health Strategic Team (PHST)

The Public Health Strategic Team leads and assures the alignment of all major planning and strategic initiatives including: organizational Strategic Planning, State Health Assessment, State Health Improvement Planning, accreditation, and performance management to maintain and improve the health of the population of Connecticut. The PHST is comprised of senior leadership and strategic thinkers recruited and assigned to the team from across DPH. The inclusion of staff from across DPH promotes buy-in and diffusion of planning efforts throughout the organization. The team shall be comprised of 15-20 members.

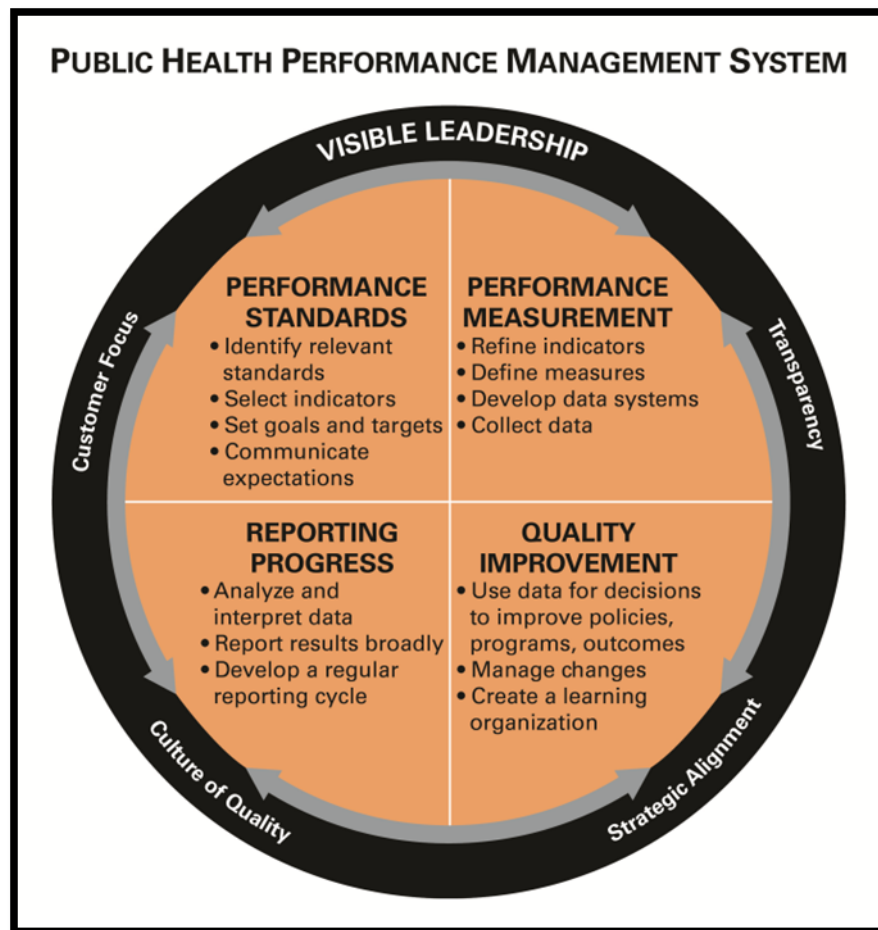
Responsibilities:

- Identify State Health Improvement Plan priorities to be addressed by DPH.
- Support implementation and monitor achievement of DPH priorities determined through the Strategic Plan and State Health Improvement Plan.
- Promote the use of data to drive decision-making and to plan and monitor programs
- Promote the use of evidenced based practices and/or promising practices across the department.
- Initiate and oversee quality improvement projects that address Department level priorities.
- Promote a culture of quality throughout the organization by serving as role models, creating and communicating performance expectations, encouraging training, and empowering staff to make necessary changes to improve quality.
- Consider strategic and health improvement priorities identified through strategic initiatives when making budgetary and policy decisions.
- Provide leadership and support DPH staff to carry out requirements to achieve accreditation.
- Monitor implementation of the Quality Plan and make recommendations for change.
- Advise the development of the Performance Management IT system and promote its use.
- Advise the development of future State Health Assessments and monitor data over time.

Appendix M: Turning Point Performance Management Framework Details

DPH has adopted the Turning Point Performance Management framework as the underpinning for performance improvement work in the department. This framework was developed by the Turning Point Performance Management National Excellence Collaborative in 2004 and has been adopted widely by public health practitioners around the country.⁵ The framework, updated by the Public Health Foundation in 2013, is organized around each of the four components of a performance management system including: 1) Performance Standards, 2) Performance Measurement, 3) Reporting of Progress, and 4) Quality Improvement. See **Figure A**.

Figure A: Turning Point Performance Management System Framework, Updated by the Public Health Foundation, 2013



⁵ From Silos to Systems: *Using Performance Management to Improve the Public's Health*, prepared by the Public Health Foundation for the Turning Point Performance Management Excellence Collaborative, 2003.

This performance management framework also aligns with the Quality Trilogy approach to managing for quality created by JM Juran.⁶ The trilogy consists of three processes: quality planning, quality control and quality improvement and was designed for business and manufacturing.

This trilogy can be easily adapted and applied to public health.

- **Quality planning** includes determining the customer or population's needs, developing programs or services that meet their needs, establishing goals to meet the needs, and using evidenced based or proven processes that can work under the existing conditions.
- **Quality control** essentially combines performance standards and measurement to assure that we are setting standards and measuring and monitoring performance to know when we are not meeting targets.
- **Quality improvement** is acting when we are not meeting targets by looking for causes, using quality improvement methods to make changes and assuring that the changes are making a difference. While this trilogy and the performance management model are consistent with sound public health practice, the field of public health has only recently begun to manage for quality consistently and deliberately.

⁶ Juran, JM, The Quality Trilogy: A Universal Approach to Managing for Quality. Presented at the ASCQC 40th Annual Quality Congress in Anaheim, California, May 20, 1986. Available from: pages.stern.nyu.edu/~djuran/trilogy1.doc



Strategic Map Update 2015 Implementation Planning Worksheet

Central Challenge Improve Population Health in Connecticut Through Leadership, Expertise, Partnerships and Focus

STRATEGIC PRIORITY OR GOAL: [CHAMPION A CULTURE OF HEALTH EQUITY]

TRACK OF WORK/OBJECTIVES: [HEALTH EQUITY]

Result	Deadline	Accountability	Status/Comment
1) Complete revisions to Health Equity Toolkit (on DPH Intranet).	4/30/15	OHE, Communications	Completed
2) Complete Language Access Policy Draft for Internal Review.	3/1/15	OHE	Completed
3) Adopt DPH Language Access Policy.	6/30/15	OHE, Commissioner's Office	Completed
4) Complete Language Access Plan Draft for Internal Review.	5/31/16	OHE	Not started
5) Adopt DPH Language Access Plan.	8/31/16	OHE, Commissioner's Office	Not started
6) Complete "CLAS Standards 101" tutorials for all staff via TRAIN.	8/31/15	OHE	Completed

Track of Work: an objective or set of related objectives on the strategic map

Result: "what"—a specific outcome to be achieved in support of the track of work/objectives

Deadline: "when"—the date by which the result will be achieved

Accountability: "who"—the person or group responsible for achieving the result

Status/Comment : - the status in reaching the result. Note if: on track, off track, completed (with date), comments as needed.



Strategic Map Update 2015 Implementation Planning Worksheet

Central Challenge Improve Population Health in Connecticut Through Leadership, Expertise, Partnerships and Focus

STRATEGIC PRIORITY OR GOAL: [ENSURE QUALITY AND RELIABILITY OF DATA]

TRACK OF WORK/OBJECTIVES: [DATA QUALITY AND RELIABILITY]

Result	Deadline	Accountability	Status/Comment
1) Complete review of and decisions re: new data elements to be included in a revised DPH Policy on Collecting Sociodemographic Data.	2/28/15	Data Collection QI Committee and Subcommittee	In progress
2) Complete revisions, if any, to the 2008 DPH Policy on Collecting Sociodemographic Data.	12/31/15	Data Collection QI Committee	Not started
3) Increase policy compliant DPH databases from 16 to 20.	10/31/15	Data Collection QI Committee	In progress
4) Update Committee Charter.	12/31/15	Data Collection QI Committee	In progress

Track of Work: an objective or set of related objectives on the strategic map

Result: “what”—a specific outcome to be achieved in support of the track of work/objectives

Deadline: “when”—the date by which the result will be achieved

Accountability: “who”—the person or group responsible for achieving the result

Status/Comment : - the status in reaching the result. Note if: on track, off track, completed (with date), comments as needed.