April 2020

Operationalizing Health Equity

Options for Internal Change Towards Equity

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Acknowledgements

I would like to acknowledge the members of The Health Equity Committee at the Thomas Jefferson Health District for granting me the opportunity to be a part of their meaningful and necessary efforts to advance health equity in a community I care deeply about. Thank you for providing me direction and imparting a deeper understanding of issues related to health and health equity. Your dedication to improve the lives of the disadvantaged through your work will continue to inspire me.

Without the expertise, support, and guidance of the members of the community at the Frank Batten School of Leadership and Public Policy I would not have been able to complete this APP.

Thank you to all of my classmates who have contributed to and accelerated my growth as both a person and a student of public policy. To Sarah Tmimi and Alex Hendel, thank you does not begin to capture the gratitude that I feel towards you both for your capacity to help, uplift, and challenge me in our pursuits towards being better people and making better policy.

To all of my professors at the Frank Batten School of Leadership and Public Policy thank you for equipping me with the knowledge, skills, and care necessary to be a good public servant and lead from anywhere. I am especially appreciative to Professor Lucy Bassett, Associate Professor of Practice of Public Policy, and Professor Leora Friedberg, Associate Professor of Economics and Policy, for their feedback, expertise, and support in serving as my advisors on this APP.

Dedication

This APP is dedicated to my mother, Dana Fields-Johnson. You have spent 30 years of your career fighting against systems that perpetuate inequity and negatively affect our country's most vulnerable and disadvantaged populations. May your unending dedication, grace, and empathy continue to guide me in my career and beyond.

Disclaimer

The author conducted this study as part of the program of professional education at the Frank Batten School of Leadership and Public Policy, University of Virginia. This paper is submitted in partial fulfillment of the course requirements for the Master of Public Policy degree. The judgments and conclusions are solely those of the author, and are not necessarily endorsed by the Batten School, by the University of Virginia, or by any other agency.

Honor Pledge

On my honor as a student, I have neither given nor received aid on this assignment.

Acronyms

MAPP: Mobilizing for Action through Planning and Partnerships

NACCHO: National Association of County and City Officials

TJHD: Thomas Jefferson Health District

UVA: The University of Virginia

VDH: Virginia Department of Health

Executive Summary

Health equity is a public health priority, yet health departments and districts throughout the nation struggle to adequately institutionalize health equity into their policies, procedures and everyday work. Health equity means that everyone has an equal opportunity to live the healthiest life possible – this requires removing obstacles to health. The United States ranks last on nearly all measures of equity, as indicated by its large, disparities in health outcomes (Braveman et al, 2011).

Despite the United States' low rankings, health equity is increasingly integrated into the infrastructure, resourcing, goals, and major activities of state and local health departments (Association of State and Territorial Health Officials, 2020).

The Thomas Jefferson Health District is committed to becoming an equity informed organization and in line with that goal, established the Health Equity Committee to drive organizational change.

This Applied Policy Project assesses three options for the Health Equity Committee to address the internal infrastructure of the Thomas Jefferson Health District, with the ultimate goal of operationalizing health equity into the policies, procedures, and every day work of the organization. The options are as follows:

Option 1: Status Quo

Option 2: Dismantle and Restructure the Health Equity Committee

Option 3: Advocate for TJHD to Hire a Health Equity Coordinator

This analysis evaluates each of the policy options along the following criteria: Effectiveness, Autonomy, Administrative Feasibility, and Sustainability. Based on the assessments of all criteria, this analysis recommends Option 3: Advocate for TJHD to Hire a Health Equity Coordinator. This option will be the most effective and sustainable action to operationalizing health equity at TJHD in order to achieve their goal of being an equity-informed organization.

Important to note is that my work for the Health Equity Committee centers around best practices that will promote health equity *within* their organization. This is distinct from the external work that the Health Equity Committee and TJHD will do to see the fruits of becoming an equity informed health department within the community.

Table of Contents

Problem Definition

Too often, public health organizations struggle to effectively address health disparities in the communities they serve because they do not operationalize health equity into their internal practices, thereby limiting the impact of their initiatives. In their efforts to address health equity, the Thomas Jefferson Health District's Health Equity Committee faces this challenge, and without intervention, will be unable to translate their commitment to health equity into community impact. [1]

Background

The Thomas Jefferson Health District

The Thomas Jefferson Health District (TJHD) is one of the 35 health districts that comprise the Virginia Department of Health (VDH). TJHD provides public health services to the City of Charlottesville, and the counties of Albemarle, Fluvanna, Greene, Louisa, and Nelson (Thomas Jefferson Health District, 2020). TJHD is composed of health departments for each of the aforementioned localities providing services to over 250,000 Virginia residents.

Population Demographics

Population demographics are integral to understanding TJHD and the landscape of health equity in its localities. Serving over 250,000 individuals living in urban, suburban, and rural environments means that there are a variety of different circumstances and identities that inform the work of TJHD. TJHD has done an excellent job collecting data on population demographics and their findings between the years 2013-2017 are summarized below (Thomas Jefferson Health District, 2019).

Overall, an estimated 12.4% of the TJHD population identified as African American although the percentage is higher in some areas (City of Charlottesville) and lower in others (Greene County).

[1] To help address this problem I used many methods to collect, analyze and ultimately recommend a solution. The information specific to TJHD was gathered through interviews with staff who are members of the Equity Committee or through attendance at open dialogue meetings hosted by the committee. While I was not able to speak with every individual stakeholder, through my in-depth research into best practices, expert interviews, and time spent observing the committee and TJHD, I was able to develop a deep understanding of the organization from top to bottom.

27.7% of people identify as Hispanic and this population has the highest percentage of uninsured persons in TJHD. The African American population had the next largest percentage of uninsured persons at 16%.

According to the Census' American Community Survey 2013–2017, in TJHD, Louisa County had the largest percentage of the civilian population with a disability (16.6%), while Albemarle County and the City of Charlottesville (both 8.9%) had the smallest.

Data on the LGBTQ+ community are scarce. Locally, UVA and VDH are collaborating on a survey that explores the health, wellness, and experience of transgender and gender non-conforming Virginians.

From 2008–2012, the estimated life expectancy at birth for TJHD was 80.6 years old. Disparities existed by both gender and race. The estimated life expectancy for TJHD's non-Hispanic white population was 81.2 years of age while the estimated life expectancy for TJHD's African American population was 74.7 years of age. By gender, the life expectancy estimate for TJHD's female population was 82.8 years old, while the estimate for TJHD's male population was 78.3 years old. These differences are significant and while race, insurance status, gender, and sexual orientation are not comprehensive determinants of health, they give insight into existing disparities that TJHD seeks to address. The 6.5-year life expectancy difference between White and Black residence in the District, is the most salient and concerning statistic. For this reason, this APP focuses on racial diversity and racial health disparities, conceding that there are other disparities at play in the TJHD community and that those might have their own technical policy options and solutions.

In seeking to address these identity-based inequities, and clear barriers to health improvement and longevity, TJHD began to think about equitable policies and the internal organizational structure to support them that both attenuate and correct health inequities. However, key differences in health by geographic location, gender, race, insurance status, and locality all pose challenges to formulating a cohesive, inclusive, and effective plan to address health equity in the District. Other general factors that have been identified as challenges to TJHD, their health equity mission, and health districts around the nation include: 1) competing priorities (i.e. COVID-19), 2) operationalizing equity internally, 3) managing resistance to internal change, 4) measuring progress and 5) constraints imposed by state level policies and procedures (Schmidt, personal communication, 2020).

Commitment to Prioritizing Health Equity

TJHD used The National Association of County and City Health Officials' (NACCHO) *Mobilizing for Action through Planning and Partnership* (MAPP) as a framework for action to improve health and well-being within its communities. The MAPP framework is a

continuous process of assessment, action planning, implementation, and evaluation (Thomas Jefferson Health District, 2019). The findings from the 2019 MAPP process provided integral data on existing health disparities in TJHD localities and resulted in a district wide commitment to health equity and reducing health disparities.

In July of 2018, TJHD received a competitive Kresge Foundation Emerging Leaders in Public Health Grant to support its commitment to driving health equity. In the grant application TJHD delineated two primary goals: 1) for TJHD to model equity as an organization and 2) for TJHD to accelerate equity in the communities they serve. To lead the organizational change necessary to accomplish the goal of modeling equity as an organization, TJHD convened the Health Equity Committee. The committee's responsibility is to evaluate and provide recommendations on strategies for advancing equity in all practices. Specifically, the committee is tasked to lead discussions with teams, divisions, committees, etc. to deliver and reinforce awareness messages, increase knowledge through training, and communicate reasons for change. There is not currently a system in place to systemically fulfill that task however, it is an individual priority delegated to committee participants.

The Health Equity Committee at TJHD

The Health Equity Committee at TJHD has been instrumental in starting conversation around operationalizing health equity at TJHD. The Committee is a critical part of supporting culture change and reaching across divisions and localities to understand and communicate what health equity is and why it is important. In their monthly meetings, the committee functions as both a workgroup and a learning cohort, bringing in health equity practitioners, members of the community, and other staff to inform their plans for advancing health equity at TJHD. The Committee was designed to include membership representative of all localities and disciplines across the health district. Committee members are responsible for attending at least 75% of meetings, providing feedback and input on programming, proposals and initiatives, and planning an all staff. The most integral responsibility of committee members is to act as equity champions: communicating updates, initiatives, and training opportunities to their respective divisions.

Challenges

Despite a clear to commitment health equity, some defined roles and responsibilities, and diversity of skills, work division representation, race, and occupation, the Committee faces a wealth of challenges in advancing health equity internally. The Committee's challenges somewhat mirror the organizational challenges that TJHD faces. They include: 1) equitable membership and representation, 2) staff time and availability, 3) an unclear ownership of change management, 4) both internal and external resistance and

disagreement on issues related to health equity and governance (Schmidt, personal communication, 2020).

As stated, the purpose of this Applied Policy Project is to bring information to and make recommendations for the Health Equity Committee in order mitigate the aforementioned challenges.

What is Health Equity?

Health equity means that everyone has a fair opportunity to reach their full healthy potential and that a person's identities do not predict how long or how well one will live (Louisville Center for Health Equity, 2017). If it is the case that identities serve as predictive mechanisms for determining health and longevity then health equity does not exist.

Colloquially, people use the words equity and equality interchangeably however, they are not the same. Using equality as a guide for the delivery of health services means that everyone would be treated the same. Contrastingly, using equity as a value for the delivery of health services mandates that existing disparities between demographics would be addressed, and that everyone would get what they need in order to be healthy.

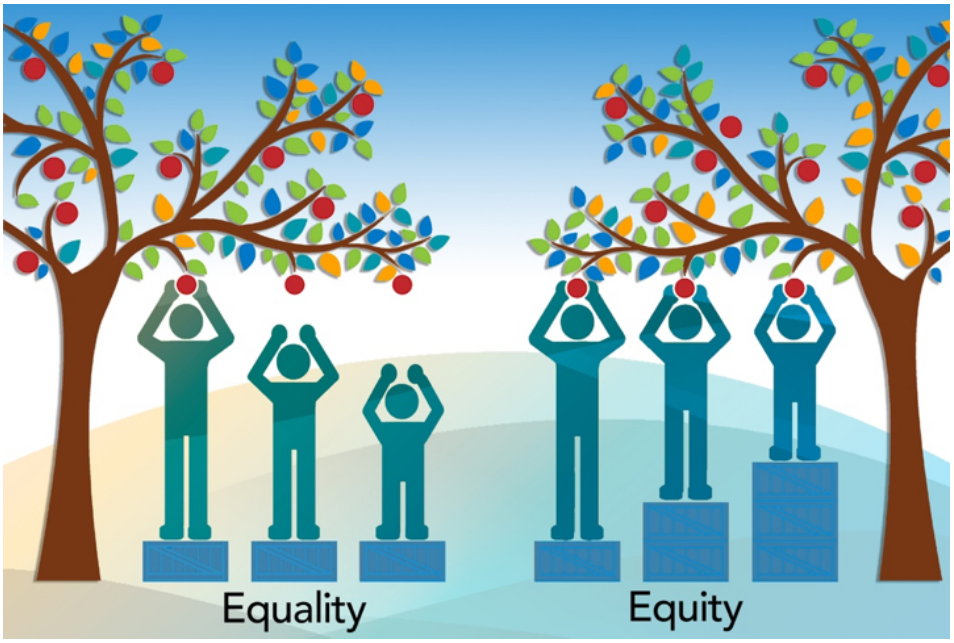

Figure 1: Northwestern Health Unit

This distinction is predicated upon the fact that people face different and compounding barriers to healthy living like environment, disability status, socioeconomic status, discrimination, age, gender, and more. Where people live, play, work, and pray are considered social determinants of health and they have an important impact on health and overall wellbeing (Thomas Jefferson Health District, 2020).

Health inequities are reflected in differences in length and quality of life, rates of disease, disability, severity of disease, and access to treatment (Centers for Disease Control and Prevention, 2020). Health inequity persists nationally, but organizations such as TJHD have set out to address the social determinants of health mentioned above.

The county for Los Angeles Public Health estimates that a population's health is shaped 10% by the physical environment, 20% by clinical health care (access and quality), 30% by health behaviors (largely determined by social and physical environments), and 40% by social and economic factors (Los Angeles County Public Health, 2013). With nearly half of a person's health informed by social and economic factors, health departments around the nation seek to prioritize health equity in order to address these factors.

Internal Organizational Structure: Promoting a Culture of Equity

Local health departments and health districts play a critical role in protecting public health all throughout the country. Research asserts that it is at the health district and department level that a conceptual commitment to achieving health equity must be clearly and sustainably operationalized (Furtado et al, 2018). Changing internal processes and practices can mitigate health inequalities and promote equitable health transformation.

As health departments shift their focus towards health equity, it is important that health equity is not only built into the language of the organization, but also the infrastructure. Absent of internal changes, any efforts to advance health equity will stagnate (Savannah, 2020).

Driving Organizational Change

For over six decades scholars have studied organizations to better understand why most organizational change efforts, despite a vast field of research, still underperform, fail, or make things worse (McFarland, 2020). McKinsey and Company, a renowned management consulting firm, reports that 70% of all organizational transformations fail because of a lack of participation and buy-in, premature communication of change visions, not enough training and resources, and fatigue (Bucy et al, 2016). There is a growing consensus among organizational behavioral experts that cite human resistance to change as the most important issue facing organizations who attempt to change (McFarland, 2020, Gleeson, 2017, Lawrence, 1969).

Resistance to change is inevitable but it can be overcome by understanding why people are resistant to change. Change resistance can be caused by many factors. Commonly identified factors are a confidence crisis, fear that a person will not be able to do what is expected of them, a perception that the physical, emotional, or intellectual costs are too high, change processes that do not include the main people affected, or that the purpose and need for change is unclear (Henry, 1997).

In conceptualizing how, organizations can overcome a culture of change resistance, researchers at Mckinsey and Company identified the axes of change. The three axes make up the transformational triangle" - a balanced, integrated framework for combining the three separate axes into a coherent program that facilitates organizational change (Ditcher et al, 1993). Without integrating all three exes, they assert that sustainable and effective change cannot be achieved.

Figure 2: Three Axes of Organizational Change

Committee Formation and Function: Supporting Organizational Goals

Committees are an efficient way of assembling people to facilitate debate and discuss issues important to an organization and can be effective in driving organizational change and leading decision making. Private sector organizations, non-profits, health departments and so on, have a long history of relying on committees to address key focus areas both internal and external to the organization's mission and purpose.

Bain & Company, one of the largest American consulting firms to private, public, and nonprofit organizations reviewed committees that work and found that they function best when they are given a specified role and delegated a set of critical decisions (Hadley, 2012). When function has been identified, formation follows. Bain research found that six to seven employees is usually the best number for a committee's effectiveness but size is not the only critical variable. The makeup of a committee is integral to its success. Representation from the highest seniority levels and all relevant work divisions as well as membership that reflects the diversity of the community or of the organization are all integral to a committee's ability to drive organizational change (Ditchter et al, 1993). While committee membership's racial diversity is important, experts warn that it can place a disproportionate burden on people of color often causing additional stressors of job compromise and job loss (Savannah, 2020). Additionally, when people of color are the main staff in the organization tasked with leading change initiatives it is easier for others to scapegoat them and write off change efforts as simply something "they" want to do rather than an organizational necessity.

Committees that regularly disseminate information regarding meeting outcomes, monthly goals, and opportunities for broader participation are more effective in garnering buy-in and making progress on decision making (CDC Division of Community Health, 2013). Stagnation is often caused when committees fail to evolve from planning

and participation to decision making and implementation. Committees must evolve into a working group, making decisions at every meeting, establishing weekly, monthly, and annual goals to really be effective at driving change (Savannah, 2020).

Diversity Promoting Organizational Efforts Towards Health Equity

Increasing workforce diversity within health districts is a critical step to achieving health equity (The Colorado Trust, 2013). Greater workforce diversity not only supports organizations in modeling health equity but also, improves population health by increasing access and quality of care for racial and ethnic minority populations. It is widely accepted that diversifying the workforce is a necessary strategy to increase access to quality care, reducing health disparities, and achieving health equity (Williams et al, 2014, Grant, 2010, Ihara, 2004). In their Guidelines for Achieving Health Equity in Public Health Practice the National Association of County and City Health Officials (NACCHO) asserts that local health departments should do all of the following to advance health equity in their communities:

> *1) recruit their workforce from those who have been disproportionately affected by systems of inequity*
>
> *2) hire staff with the skills, knowledge, and abilities to take part in community organizing, negotiation, and power dynamics*
>
> *3) recruit staff with culturally and academically diverse backgrounds, knowledge of the population they serve in relation to racial, ethnic, class, gender characteristics and social and economic conditions in the jurisdiction (NACCHO, 2009).*

Increasing workforce diversity is broken down into three key focus areas: hiring, retention, and promotion.

Hiring and Candidate Sourcing

Candidate sourcing is the way in which organizations go about finding and attracting diverse candidates to increase diversity within the workforce. Important tactics to promote diverse candidate sourcing are: (1) equity rhetoric involved in the job posting, (2) encouraging referrals for minority employees, (3) providing metrics for existing diversity and (4) offering workplace flexibility (Kozan, 2019).

Integrating language on health equity principles into position descriptions is important for modeling the organization's commitment to health equity and increasing workforce diversity. 67% of job seekers use diversity as an important factor when considering job offers (Ideal, n.d.). This means, in order for health departments to be effective in hiring more diverse candidates, language surrounding diversity and equity needs to be

included in position descriptions and incorporated into the roles and responsibilities of department positions.

Effective diversity hiring processes often include personality assessments because they have no adverse impact, that is, they do not differ for minority group members (Ideal, n.d). A study of 150 companies conducted by Ideal.com, one of the largest HR software companies, found that those that used a personality assessment in their hiring had more racially diverse workforces.

Hiring managers need to be held accountable for recruiting a diverse pool of applicants to promote representation. The literature shows that when hiring managers lead diversity initiatives they are more effective and sustainable, resulting in greater organizational capacity to address health equity (Health Equity Guide, 2019, Betancourt et al, 2005). Other effective practices for removing bias from the hiring process are asking candidates to solve work related problems or give work samples, standardizing the interview process by asking all candidates the same questions and having a scorecard (Knight, 2017). These strategies help hiring managers calibrate their judgement, critique a candidate's work rather than unconsciously judging them based on appearance, gender, race, or age, and finally, allow hiring managers to focus on factors that have a direct impact on job performance.

The aforementioned diversity recruitment strategies seek to ensure that procedures are free from biases and that the strategies are ultimately effective by increasing underrepresented groups within the workforce.

Retention

When organizations attempt to change, resistance can cause major losses to the workforce posing an organizational threat. If organizations do not change they risk losing internal employees who care about equity, diversity, and inclusion initiatives. In a survey conducted by Deloitte's Leadership Center for Inclusion they reported that of 1,300 full time employees, 23% of respondents indicated that they have already left an organization for a more inclusive one and 72% would consider leaving one organization in favor of a more inclusive one (Deloitte University Press, 2017). Thus, retention is a double-edged sword, if organizations don't change they lose valuable employees who bring diverse interests in equity but if they do change, they risk losing employees who are highly resistant.

Some organizations question if retention is even worth focusing on assuming that the people who are leaving were the individuals responsible for preventing change in the first place. But an organization's failure to retain good employees is costly; evidence from the private sector estimates that the cost of turnover can be 50%-200% of an employee's annual salary (Goodman et al, 2013). Exacerbating the high costs of retention is the institutional knowledge lost when employees leave. Literature argues that public sector

organizations, specifically at local health departments, have more "knowledge-based individuals" compared to the private sector making loss of expertise even more costly (Newman et al, 2014).

Given the costs, local health department executives are often reluctant to support change initiatives that could threaten retention rates. In a survey distributed by the Center for State & Local Government Excellence they found that 70% of top health department executives are concerned about retaining currently funded positions and that 62% are concerned about retaining well-qualified employees (Newman et al, 2014). This valid concern is often enough to prevent top level involvement in change initiatives but their involvement is integral to an initiative's success.

Methods that have been found to support and increase retention during times of change within health departments include using data and evidence to drive change and demonstrate progress, effective onboarding that provides skills and resources to new staff to be successful participants in a change initiative, the use of stories to reinforce the mission, and frequent opportunities to network with change initiative leaders (Center for State and Local Government Excellence, 2019).

Promotion

Given the importance of involvement from high level staff, ensuring that people who are invested in equity and diversity are near or hold those high-level positions is a critical factor to achieving a more diverse workforce. In 2010, the National Association of County and City Officials published data that revealed that 93% of top executives at local health departments were white (Leep, 2010). While the literature offers limited insight into whether the presence of more managers of color, serves to reduce racial and ethnic disparities in health, a common assertion is that having an adequate representation of minorities in *all* levels of the organizations is pivotal to advancing culturally appropriate care and reducing racial disparities in health (Batancourt et al, 2003, Dreachslim et al, 2004).

Common practices that are found to increase the amount of people of color holding high level positions in public health include mentorship programs, unconscious bias training, asking *why* during exit interviews which are a rich source of anecdotal data, investing in anonymous reporting systems so employees feel comfortable speaking up if they are overlooked for a position (Washington and Roberts, 2019). Lastly, employees should not only be evaluated on their skills but on their competencies and potential to do well if given a higher-level position (Washington and Roberts, 2019)

Increasing Institutional Knowledge and Performance: Equity and Diversity Training

In order to address health disparities, health care organizations have enacted cultural competency and diversity and inclusion training to address and reduce health disparities in the communities they serve (Betancourt et al, 2005). Such training is intended to help healthcare professionals shed their biases and help organizations shift towards hiring practices that promote diversity. However, the goals of training should be two-fold: providing the language and understanding of why equity is important and also providing the workforce with skills and work specific strategies for incorporating equity into their daily work. While implicit bias training, is good, it remains at the individual level. In order to really institutionalize the and translate the benefits of training from individual level to organizational level the following recommendations should be considered: 1) training should be made mandatory for all staff, 2) training should be position and division specific if possible, 2) the cadence of trainings should be frequent (1-3 months) and, 4) to start, organizations should receive external training to "train the trainer" and then allow for people from within the organization to lead trainings (Savannah, 2020).

Risks Associated with Diversity Training

The positive effects of diversity training rarely last beyond a day or two and some studies actually suggest that diversity training can activate bias instead of lessen it, when not conducted properly (Dobbin and Kalev, 2016). Effective training that avoids these adverse effects include integration of multiple perspectives on social justice, learning and the business case (for improving equity healthcare provision) and implementing training along with other diversity initiatives (Fujimoto and Härtel, 2017).

Limitations and Gaps in the Literature

The literature is still divided along 'top-down' and 'bottom-up' approaches to 'who does what' to drive organizational change (Heyden et al, 2016). Some experts support top down approaches to organizational change because without high level executive involvement, equity and diversity initiatives tend to fail. Others argue that because the buy-in of the workforce is so integral to effective change initiatives, organizations need to focus on a bottom-up approach. In any case, these approaches are not mutually exclusive and integrating both strategies are key to successful organizational change (Heyden et al, 2016).

A 2008 profile study of local health departments published by NACCHO showed that in a statistical sample of local health departments throughout the U.S., 16% of employees were African American which is three percentage points higher than the U.S population of African Americans (13% at the time of data collection). While some literature asserts that more diversity is critical to driving health equity, these findings suggest that racial diversity within health departments may not be all that important. While this profile study

found that most local health departments have diversity reflective of the population throughout the U.S., such was not the case in their findings for top level executives (Thomas Jefferson Health District, 2019). This profile study is dated but still well cited in literature related to diversity in health services and health delivery organizations which indicates that more data needs to be collected on workforce demographics at local health departments and health districts.

As stated previously, the literature provides limited insight into whether a greater presence of diversity in leadership positions serves to further organizational goals of reducing health disparities. However, despite limited evidence to this end, many studies have been done making both a moral and business case for more organizational diversity (Brach & Fraser, 2002). Additionally, while there is a wealth of research regarding healthcare organizations and their attempts at advancing health equity, the research about local health departments and the provision of health services is limited. There is a call for greater synergy between the two entities but until the disconnect has been addressed the literature suggests that findings regarding organizational management and diversity and equity initiatives from healthcare organizations *can,* in some cases, be applied to public health and health services organizations because the two are inextricably linked (U.S. Institute of Medicine, 1988, Lurie and Fremont, 2009).

While the literature is broadly applicable to many different health departments and health districts, case studies often serve to offer more organization specific insights and recommendations. Both general applications of the literature and a specific case study are provided in the following sections.

Applying the Literature to TJHD

Change Resistance

- Focus on mitigating resistance by having inclusive meetings, providing support through frequent trainings, hosting open forums and disseminating regular updates to rest the organization.
- Provide data and story telling that drive home the mission of the committee to regularly share with the workforce.

Cohesion in Work and Mission

- Consistently define equity using the same wording in meetings, trainings, and written correspondence in order to build buy-in and understand among staff.

Data Collection

- Prioritize collecting demographic data on the state of diversity among the workforce of TJHD.
- Produce a data packet to disseminate to staff on current and trend data of department and district staff demographics.

Increasing Org. Capacity

- Make basic health equity training a requirement for all staff.
- Offer additional training to individuals who opt-in to being champions of health equity throughout the organization.

Function Follows Form

- Identify which divisions are not represented and then identify an employee within that division to either liaison with the committee or become a member.

- Attempt to add the district director or administrator to the committee.

Workforce Diversity

- Commit to increasing diversity within TJHD and local health departments.
- Make recommendations to hiring managers, disseminating information on the case for more organizational diversity and reviewing HR processes to ensure best practices are supported.

Internal Assessments

- Test for implicit bias within all members of the committee.
- Use the Bay Area Regional Health Inequities Initiative (BRHII) Organizational Self-Assessment toolkit to serve as a baseline measure for capacity, skill, and areas if improvement to support new health equity activities (Health Equity Guide, 2017, Harrison County Health Department, 2020).

Methods for Health Department Transformation Towards a Culture of Health Equity: Case Study

Harris County Health Department, TX

In 2016, NACCHO awarded the Harris County Health Department (HCPH) with the Local Health Department of the Year Award for their impact and focus on closing the gap of health equity in its community (Lopez, 2016). Harrison County has published a wealth of knowledge, advice, and details about their best practices to help other local health departments with advancing equity in their own communities. A synthesis of their best practices and recommendations is provided below based off of The Health Equity Guide's report on HCPH.

Self-Assessments and Executive Training

All top executive-level staff as well as department managers completed NACCHO's Health Equity and Social Justice Self Study Course. This step was essential to build buy-in among leadership.

HCPH then utilized the Bay Area Regional Health Inequities Initiative Organizational Self-Assessment Toolkit to assess staff willingness to embrace health equity priority areas.

Hiring a Health Equity Coordinator Staff Position

This position was locally funded at senior-level management to explicitly focus on health equity. HCPH recommends that the position be locally funded to ensure sustainability of the work. More information about the roles and responsibilities of the Health Equity Coordinator is provided in the Policy Options portion of this APP.

Cultivating Health Equity Through Training

HCPH created a "journey series" which consists of 3 different courses to provide Health Equity training to staff. All department staff are required to complete the first training of the series which was a 50-minute session, done in person or online, providing information about their Health Equity Framework and foundational concepts.

The second training in the series used a cohort model in which 15-25-person cohorts were formed to complete NACCHO's Roots of Health Inequity web-based course. Selection for the cohorts was based off of division directs and self-selection. Following the completion of this course participants published Health Equity stories about how they plan to advance health equity through their work and these stories were distributed to the entire health department to help garner buy-in.

The final course offered is a training on "how to be a health equity champion." Participants in this course worked with the Health Equity Coordinator to develop goals for

their respective divisions and implement the recommendations of the Equity Advisory Committee.

Tracking Progress and Disseminating Information

Integral to HCPH's success in advancing health equity was publishing a monthly memo on the work of the committee, goals for the next month, reminder of annual goals, results and feedback from trainings, and sharing externally related health equity improvements. This is important to diffusing the vision and investment to health equity throughout the entire organization and showing evidence-based effectiveness of trainings, supporting the new role of the Health Equity Coordinator, and spreading the mission and vision of the Health Equity Advisory Committee.

HCPH's Health Equity Coordinator remarks that theory and practice are both critical to agency transformation but they are not mutually exclusive. They need not follow a linear process of creating framework, trainings, and collecting data *and then* attempting programmatic change. Identifying good examples at all levels for how employees build health equity into their work can encourage staff to do more right away prior to programming and data collection by the committee and coordinator (Lofton, 2019).

Outcomes and Impacts

92% of the department staff completed the first iteration of their health equity training in 2016 with a pass rate of 80% for their knowledge of health equity. NACCHO recognition, along with their other achievements, has helped position HCPH as a go-to regional organization for health.

Health Equity Guide, 2017.

Evaluative Criteria

The final recommendation of this policy project will seek to advance the internal goals outlined by the Health Equity Committee at TJHD as well as the overarching goal of making the District an equity-informed organization. I will evaluate each of the three policy options according to the following criteria: effectiveness, autonomy, administrative feasibility, and sustainability.

The merits of each policy option according to the above criteria are measured on a qualitative scale of High – Moderate – Low. Given that the following policy options are not mutually exclusive, the purpose of these evaluative criteria is to determine which option(s) the Health Equity Committee should prioritize.

Effectiveness

This criterion assesses how well each policy option creates an organization wide commitment to health equity. A "High" performing policy option creates a cohesive definition of health equity, trains staff to drive organizational change, and represents each locality and division.

Additionally, for this criterion how each option affects diversity within the TJHD workforce is considered. Possible metrics used to measure the outcome of diversity are: 1) better relationships among diverse staff members that could be assessed via survey, 2) number and percent increase in the applications, hiring, retention, and promotion of traditionally discriminated and underrepresented groups, 3) the use of social distancing scales to show decreased social distance and less prejudiced thinking/unconscious bias within the workforce (Brenman, 2013). An "excellent" policy option will increase workforce diversity resulting in any of the three outcomes mentioned above.

Reduction in health disparities measured in TJHD localities is not the goal of this criterion. The organizational change intended to yield better health outcomes for TJHD communities will presumably take a large amount of time and is not easily predictable.

Autonomy

This criterion addresses a major organizational concern that there is an unequal consideration across divisions and localities for the priorities, resources, and representation of identity and locality subgroups. An "excellent" policy option allows each locality and division within the district to have agency over their respective health equity challenges and equitable involvement both within the committee and in the implementation of the recommended policy option(s).

Administrative Feasibility

This criterion measures the likelihood that a given policy option gains the employee buy-in, funding, and general administrative support necessary for implementation. An "excellent" option, (1) requires little administrative approval and involvement from people at the top of the district hierarchy, (2) limits the costs associated with implementation, and (3) supports lateral implementation and top-down implementation. To measure the degree of administrative feasibility of each policy option, I take into consideration the formal positions of current committee members and their ability to implement a given policy option.

Sustainability

This criterion evaluates whether a policy option provides the long-term organizational support and structure necessary for an effective health equity initiative within the Thomas Jefferson Health District. An "excellent" policy option for this criterion changes the organization's procedures and practices, and be independent of the existence of the committee such that if the committee ceases to exist the policy option(s) recommended and implemented would remain in place.

Policy Options to Advance Organizational Change at TJHD

Option 1: Status Quo

In December of 2019, the Health Equity Committee published a committee charter outlining their purpose, internal and external goals, committee membership roles / responsibilities, and defining health equity. This document forms the foundation of the status quo policy option. This option involves monthly meetings with the current committee members, discussing challenges to health equity in their respective work divisions and localities, consulting experts to bring information to the group on driving organizational change and working to establish regular equity training for non-committee staff members. Despite defined roles, increased access to information on health equity, and regular meetings, thus far the status quo has not yielded the results that the committee hoped for. Additionally, the status quo includes limited metrics for assessing success, no long-term timeline for achieving internal organizational change, many unfilled roles, and high levels of turnover within the committee. Lastly, while this policy assumes no changes in the function of the committee, it considers the addition of membership to achieve representation from all localities and disciplines across the health district.

Effectiveness

The outcome of this policy option has been "moderate" concerning the criterion of effectiveness. This option has not resulted in substantive change in the hiring practices at TJHD and has not yielded a clear definition of what health equity informed work will look like at TJHD and struggled to clearly define the goals and tasks of the committee and its members. The committee has made progress on increasing their own knowledge and continues to be committed to their mission of driving organization change. However, absent additional strategic focus it is not likely they will be able to affect TJHD's overall organizational commitment to health equity.

Autonomy

This option performs "low" concerning the criterion of autonomy. As stated, the criterion of autonomy is conceived such that a "high" scoring policy option would allow each locality and division within the district to implement health equity based on their respective interests. Currently within the committee, each locality is represented but there is not representation from all work divisions which poses challenges to garnering

buy-in and understanding how health equity can be institutionalized into each divisions every day work. Ultimately, these offsets the benefit of striving to have equal representation on the committee. The committee intends to produce materials on what health equity looks like in each department for each locality. If this outcome is generated, it will satisfy the autonomy criterion, as well as increase effectiveness.

Administrative Feasibility

This option performs "moderate" concerning the criterion of administrative feasibility. Given that this committee already exists, it requires little administrative oversight, and there are no additional administrative costs such as more time invested or additional money associated with implementation, this option is administratively feasible.

An implementation concern regarding the recommendation of this APP is that, from an administrative perspective, the existence of the committee is enough to represent health equity efforts by the district. External to the committee, it is unclear whether the organization is invested in seeing the efforts of the equity committee come to fruition. One way to measure if this assumption is true or not is by surveying randomly selected district staff members to gain a more concrete view on the overall perception of the committee and assess the external understanding of the work that they do.

Sustainability

This option performs "low" concerning the criterion of sustainability. As stated, the current committee has struggled to clearly defined roles and responsibilities for its members and is still working on a concrete plan of action to lead a lasting health equity initiative. The committee has not sought to change the policies and procedures of TJHD to incorporate health equity meaning that in the absence of the committee, this health equity initiative is not sustainable. Additionally, the committee has seen high amounts of turnover already within its members. Given these two considerations, the status quo is not sustainable.

	Effectiveness	**Autonomy**	**Administrative Feasibility**	**Sustainability**
Status Quo	Moderate	Low	Moderate	Low

Option 2: Disassemble and Restructure the Health Equity Committee

Health equity committees function best when they are designed to include various employees within the hierarchy, specific roles are identified and filled by current employees, clear responsibilities are delegated for each role to support the overall goal, and specific requirements for being on the committee are laid out (Health Equity Guide, 2017). Given that this is not the case for the Health Equity Committee at TJHD, this option would dismantle the committee and direct the de-facto "head of the committee" to address these requirements. This option advocates to reassemble the committee based on these and other qualifications stated in the review of the literature. In reassembling the committee, TJHD could ensure that the best practices for committee structure and organization are met, that they produce a concrete timeline and plan of action, and that these pursuits ultimately yield organizational change.

Effectiveness

This option performs "moderate" concerning the criterion of effectiveness. Dismantling and reassembling the committee would involve ensuring that the necessary foundations for committee formation are met resulting in a shift in the hiring practices of TJHD, a cohesive definition of health equity throughout TJHD, and clearly defined roles for the committee and its members. Given the importance of committee formation to the committee's overall function and ability to be effective, this option could be successful. However, considering that the first iteration of this committee has struggled to with producing a timely plan of action for a health equity initiative, undertaking this policy option risks reverting back to the status quo.

Autonomy

This option performs "high" concerning the criterion of autonomy. Given the research of this APP, the trial and error of the committee thus far, and subsequent data collection on the nature of the organizational and leadership failures, dismantling and reassembling the committee would allow for more autonomy. Reassembling the group to have equal representation across work divisions and localities within TJHD will allow representatives to incorporate their distinct health equity challenges within the committee.

Administrative Feasibility

This option performs "low" concerning administrative feasibility. Given the time that the current committee members have already invested in the work of the committee, support to dismantle is not likely to come from administration. This policy option would require more involvement for administrative approval which poses a challenge to implementation. Given that most of the time and resources put into the committee thus far would be lost upon dismantling the committee, the costs associated with this option

are high. However, if restructuring the committee is well defined and guided based on the qualities of effective committees, administrative support could be reached.

Sustainability

This option performs "moderate" concerning sustainability. As stated above, there are risks associated with this option if TJHD does not restructure the committee under new guidelines. This policy option will be sustainable if the restructured committee prioritizes incorporating health equity into the procedures and practices of the organization. With the proper implementation of this if the committee ceases to exist in the long term, TJHD would still be an equity informed health department.

	Effectiveness	**Autonomy**	**Administrative Feasibility**	**Sustainability**
Dismantle and Reassemble	Moderate	High	Low	Moderate

Option 3: Advocate for TJHD to Hire a Health Equity Coordinator

This policy option proposes the creation of a full-time health equity coordinator staff position at TJHD. This option will work in tandem with the current committee. The current committee will remain in place in order to offer guidance and feedback to the new staffer to ensure the preservation of institutional knowledge. The added benefits of a dedicated staff member are expertise, accountability, symbolism of a commitment to health equity, and formal authority to drive organizational change.

The Health Equity Coordinator should be responsible for working with each division to create the workplans that will infuse health equity into the day-to-day practice of each office and program, developing a specific health equity framework for TJHD on how health inequities occur and how to break that cycle, tracking goals and outcomes related to trainings and increased institutional knowledge, and serve as a leader of the Health Equity Committee. The committee will continue to meet monthly and play a key role in guiding the Health Equity Coordinator on priorities, acting as subject matter experts, and advising on staff training (Health Equity Guide, 2017).

Effectiveness

This option performs "high" about effectiveness. Many health departments throughout the United States have introduced this position to lead health equity initiatives. The CDC recommends that health departments align funding streams with a commitment to health equity (CDC Division of Community Health, 2013). This recommendation came to fruition in the Rice County Health Department, the Rhode Island Health Department, and the Harris County Health Department who all reported that they were able to effectively implement their health equity plan because they had a health equity coordinator staffed position (Health Equity Guide, 2017). This criterion results in a cohesive definition of health equity throughout TJHD and would bring a knowledge and expertise of health equity not only to diversify TJHD staff but also would alleviate some of the challenges to the committee allowing them to focus on more specified actions towards organizational change effectively moving from theory to practice.

Autonomy

This option performs "high" with regards to this criterion. This option grants consideration to enacting health equity into all work divisions and allows for broader involvement and representation within the committee.

Administrative Feasibility

Option 3 performs "low" concerning this criterion. While there is some uncertainty surrounding feasibility, the committee suggested that this was an infeasible option given the strain on already scarce monetary resources it would require. However, this assertion was made without consultation from the budget or hiring departments and there may be a chance this recommendation could be implemented.

Sustainability

Option 3 scores an "high" with regards to sustainability. It is recommended that the position be locally funded to better support the ends of this criterion. Since this option works in conjunction with the committee, absent of the committee, the effectiveness of this option would not be inhibited making it even more sustainable.

	Effectiveness	**Autonomy**	**Administrative Feasibility**	**Sustainability**
Advocate for TJHD to Hire a Health Equity Coordinator	High	High	Low	Moderate

Recommendation

I recommend Option 3: advocate for the hiring of a health equity coordinator. This option would continue the work of the Committee and institutionalize TJHD's commitment to health equity. This policy option is the most effective and given that Harris County Health Department, Rice County Health Department, Madison-Dane County Health Department, as well as a myriad of other public sector organizations have added this position to their operational systems, the risks associated with this option are limited. One concern regarding this recommendation is that the committee does not have the authority to create and hire a new staff person. However, by adding a senior management person to the committee who does hold this authority, this recommendation can be achieved. While this option requires heavy administrative support and involvement relative to the other options, that could serve as a benefit to advancing health equity at TJHD because success requires high level leadership's support and involvement. This option promotes the involvement of all work divisions and localities in its implementation making it the best option for the criterion of autonomy. As stated, the Health Equity Coordinator would be responsible for working with each division to create the workplans that will infuse health equity into the day-to-day practice of each office and program which add to its performance with regards to autonomy.

I fully acknowledge that this recommendation may be impossible to implement in the face of a potential economic slowdown due to COVID-19 and due to local health district resources and staff members being diverted for emergency response and crisis management to COVID-19. The opportunity cost of using resources for this position at the expense of addressing the very real health crisis unfolding as a result of COVID-19 are much higher than they once were. However, COVID-19 exacerbates existing inequities and can serve as an opportunity to drive home the importance of health equity work.

In the implementation section to follow, I outline a few concrete steps and focus areas that should be done irrespective or along with the above recommendation.

Implementation

Stakeholders

The Health Equity Committee must consider key stakeholders, including district senior management, current members, and the community, in order to advance the recommendation and advocate for TJHD to hire a Health Equity Coordinator.

Senior Management

Valerie Washington and Melissa Pace, the District Administrator and Business Manager will be integral to opening this position by finding the resource allocation to fund the salary for this position. Additionally, the committee should not limit its efforts to the HR department but should work closely with the District Director, Denise Bonds, to support this new position from the highest district leadership position.

Other Departments

Other departments may see funding this new position as a threat to their budget allocation and may show resistance to this recommendation. This resistance can be mitigated if the Health Equity Committee emphasizes the positive impacts that this position will yield, senior management supports the recommendation, and the departments are made aware that the new position will work closely with them to incorporate their perspectives and interests.

Community Members

Community members may exhibit a combination of both support and resistance. Support will come in seeing the district make a real and substantive change to its organizational foundations to prioritize health equity. Resistance may come if the community feels that TJHD is simply checking a box but not making any substantive change and spending resources that could be directly allocated to community members. Resistance can be mitigated in this scenario by including community members in the process of defining the roles and responsibilities of the new position, or possibly publishing a press release announcing the new position and what this means for the direction TJHD is going in to support health equity.

Worst Case Scenario Analysis

Along with the aforementioned risks, other major risks involving this recommendation are as follows: 1) the District hires someone not well-qualified to fulfill the demands of the position or who does not have the expertise necessary to transcend the work that the committee was already doing, 2) the District is unable to find funding for this new position, 3) due to the formal addition of this position, the committee loses momentum knowing that it is now someone else's formal responsibility.

All of the above "worst-case scenarios" have some likelihood to occur and they would all fail to accomplish this recommendation. However, by focus on the key takeaways from the literature as well as the key aspects identified below these risks can be mitigated.

Future Steps

Working in tandem with the Health Equity Coordinator the Health Equity Committee should focus on the following key aspects to drive organizational change at TJHD.

BUILDING BUY IN

- Add a member of senior level leadership. Consider identifying people on the District Management Team to join the Health Equity Committee to reduce the conflict of "who does what" and increase the authority of the committee.
- Continue effort to add a member from each locality and work division. Assign a subcommittee to begin the work of conceptualizing and sharing specific applications of health equity to their respective work division.
- Allow dissenting voices a seat at the table in the form of a bi-monthly open forum. Until dissenting voices are brought on board to be heard they just become a force for stagnation.

COMMUNICATION

- Publish a monthly equity memo updating the workforce on training opportunities, stories of equity in action, and providing committee outcome updates. Such updates could include the addition of new members, knowledge gained from an expert visit at meetings, or survey results from the staff completion of previous trainings.

- Produce an anonymous feedback system where staff can offer suggestions to the committee and resistant voices can be heard. Designate a role within the committee for monitoring and reporting out this feedback.

- Produce a data packet to disseminate to staff on current and trend data of department and district staff demographics.

DATA COLLECTION

- Prioritize collecting demographic data on the state of diversity among the workforce of TJHD.
- Filter data by locality, position within the District and work divisions to gain more insight into where the committee should on increasing diversity.

WORKFORCE DIVERSITY

- Recommend the use of standardized interview questions, scorecards, integrating language on health equity principles into position descriptions and the use of personality assessments in the hiring process.
- Make bias training mandatory and yearly for all staff members directly involved in hiring processes.

TRAINING

- Make training mandatory for all district staff and map out an annual training plan
- Focus on designing or acquiring training for all levels of the workforce. Training should be frequent.
- It should be the responsibility of the Health Equity Coordinator to design training specific to target groups.
- Training is context specific and will be more beneficial to the workforce if instead of broad staff training, the Coordinator and the Committee design trainings by levels in the organization and work divisions.
- Consider a series of trainings where the members of the staff complete who complete the series go on to become trainers and host their own trainings to reduce the burden on the committee and increase organizational capacity.

Lastly, while this Applied Policy Project speaks to organizational practice change to promote health equity, the next wave of amplification needs to focus on external steps for achieving equity outcomes in the communities TJHD serves.

Resources and Tools

Handbook for Recruiting, Hiring, and Retention: Applying an Equity Lens to Recruiting, Interviewing, Hiring & Retaining Employees

Available at: https://cms.cityoftacoma.org/OEHR/facilitatingchange/COT_Handbook_for_Recruitment_and_Hiring_October_2015.pdf

Sample Charter from Harris County

Available at: https://drive.google.com/file/d/0B-layDEKFCCcUzVWbmJTcTVSeWNndHFQSzR1X0M3TDhyNDNR/view

Sample Surveys: Assessing Trainings, Department Attitudes Towards Health Equity and Frameworks for Change

Available at: https://drive.google.com/file/d/0B-layDEKFCCcRXh3b1dLREJtVWMwNTFHSDNUZEJPOXRFY280/view

Implicit Bias Testing

Available at: https://implicit.harvard.edu/implicit/

Racial Equity Toolkit Assessment

Available at: https://www.racialequityalliance.org/wp-content/uploads/2015/10/GARE-Racial_Equity_Toolkit.pdf

Development, Implementation, and Assessment of Health Equity Action Training: Local Health Departments

Available at: https://digitalscholarship.unlv.edu/cgi/viewcontent.cgi?article=1167&context=jhdrp

Health Equity Dialogue Facilitators Guide

Available at: https://www.preventioninstitute.org/sites/default/files/publications/Louisville%20Department%20of%20Public%20Health%20and%20Wellness%20Center%20for%20Health%20Equity%20-%20Health%20Equity%20Dialogue%20Facilitators%20Guide.pdf

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