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Arizona Department of Health Prevention Services' Work to Advance HealthEquity Starts with an Assessment of Its Own Organizational Culture

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Abstract

Objective: To identify skills, organizational practices, and infrastructure needed to address health equity.

Design, Setting, and Participants: We developed an anonymous online staff survey to assess how to address health equity and policy implications. We distributed invitations to participate to all Arizona Department of Health Services (ADHS) Division of Prevention Services (DPS) state and non-state designated employees February 2021.

Main Outcome Measures: Employee perceptions of how agency, division, and programs address health inequities; information about (1) organizational and individual traits needed to support our ability to implement effective health equity focused work and (2) processes that will enable improved organizational and workforce capacities; implications for strategic planning.

Results: Seventy-eight percent (78.0%, N=123) of eligible staff participated. Overall, we identified 21 of 28 organizational and 17 of 31 workforce capacities needing significant improvement. Organizational capacities needing significant improvement were "Institutional Commitment to Address Health Inequities" (described using 6 elements), "Hiring to Address Health Inequities" (2), "Structure that Supports True Community Partnerships" (3), "Support Staff to Address Health Equities" (4), "Transparent and Inclusive Communication" (4), "Community Accessible Data and Planning" (1), and "Streamlined Administrative Process" (1). Workforce capacities were "Knowledge of Public Health Framework" (4), "Understand the Social, Environmental, and Structural Determinants of Health" (1), "Community Knowledge" (1), "Leadership" (4), "Collaboration Skills" (3), "Community Organizing" (3), and "Problem Solving Ability" (1). Using survey results, staff groups identified change needed, specific actions, and training and communication to increase employee understanding. Proposed activities focused on data/evaluation, program planning/contracts, communications, personnel development, and community engagement.

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Conclusions: This survey allowed ADHS to prioritize increasing staff knowledge of the ADHS organizational commitment to address health inequities; results show us how to strengthen our capacity to achieve better outcomes and improve health outcomes and improve health and wellness for all Arizonans.

Keywords

health equity; staff development; cultural diversity; disparities

Background

Achieving health equity through the elimination of health disparities has been an overarching goal of the Health and Human Services (HHS) Healthy People Initiative the past two decades.[1–5] Healthy People 2030 defines health equity as the "attainment of the highest level of health for all people"[4] and "requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities." A health disparity can be defined as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage" that can adversely affect "groups of people who have systematically experienced greater obstacles to health" based on racial or ethnic group, religion, socioeconomic status, gender, age, mental health, disability, sexual orientation or gender identity, geography-all historically linked to discrimination or exclusion.[4] The goals of Healthy People have incrementally increased from "reduce health disparities among Americans" (2000)[1] to "eliminate [not just reduce] health disparities" (2010)[2] and further to "achieve health equity, eliminate disparities, and improve the health of all groups" (2020).[3] Nationwide, observed decreases in disparity have occurred in only 3.4% to 12.5% of Healthy People objectives by selected population characteristics examined (i.e., sex, race and ethnicity, educational attainment, family income, disability status, geographic location).[5] Healthy People 2030 includes an objective to "eliminate health disparities, achieve health equity, and attain health literacy."[4]

Racism, both interpersonal and structural, can negatively impact health by preventing some people the opportunity to attain the highest level of health. A growing body of evidence links significant differences in health outcomes to race, neighborhood of residency, educational attainment, income, and other social factors. [6–10] Public health practice can result in beneficial changes to social determinants of health as well as to clinical management and prevention or targeted health education. The Arizona Department of Health Services (ADHS), Division of Prevention Services (DPS) therefore is striving to advance health equity by intentionally creating a culture with racial equity as a core value, being united in our shared vision to achieve health equity for all Arizonans, co-creating with the community by honoring voices and ensuring opportunities, having humility to continuously learn and improve, acting with inclusivity and transparency, and holding ourselves accountable to the communities we serve. We are also committed to assessing our work environment to identify where change is needed; implementing systemic changes in our programs, planning processes and business operations, and providing professional development and written and

online materials that make racial equity understandable and appropriately integrated into the work we are doing.

Substantial racial disparities remain in Arizona, ultimately shortening the lives and worsening the quality of life for people of color.[11–17] Health equity is therefore the hub of the new essential services of public health for ADHS,[18] and has been selected as 1 of 5 priority areas for the 2021–2025 Arizona Health Improvement Plan.[19] Rates of infant mortality have consistently been highest among Black/African American and American Indian/Alaska Native infants from 2010–2019.[11] In 2019, compared with White persons (3.6 per 1,000 live births), the infant mortality rate for Black/African American persons was nearly 3.5 times higher (12.3 deaths per 1,000 live births) and it was nearly 2.0 times higher for American Indian/Alaska Native persons (6.1 deaths per 1,000 live births).[11] The rate of severe maternal morbidity among American Indian or Alaska Native women (303 per 10,000 delivery hospitalizations) was over 3.5 times higher than the rate for non-Hispanic White women (83.3).[12] Life expectancy among American Indian persons (62.0) and Black/African American persons (66.0) in Arizona is 10 years lower than the state average (76.0 years).[14] The percentage of Arizona adults who reported not having a personal doctor or health care provider in 2020 was highest among American Indian/Alaska Native (40.1%) and Hispanic (40.4%) persons, and lowest among White non-Hispanic persons (22.4%).[15] Black/African American persons in Arizona have consistently had the highest death rates due to cardiovascular disease. In 2019, the rate of death due to cardiovascular disease was 254.7 per 100,000 population among Black/African American persons, compared to the statewide rate of 184.9.[13] Poverty is a significant determinant of health and varies by race and ethnicity.[16,17] In 2020, while 9.6% of non-Hispanic White persons in Arizona lived in poverty, 31.5% of American Indian/Alaska Native persons, 19.7% of Black persons, and 19.2% of Hispanic persons lived in poverty.[17] Homeownership is an important indicator of opportunity for financial stability.[16] In 2018, the rate of home ownership among White persons (71.5%) was twice as high as that of Black/African American persons (35.2%) and a third higher than Latino (53.8%) and Native (55.7%) persons in Arizona.[16]

Organizational cultural competence involves an understanding of the strengths and weaknesses of the health care organization and the unique needs of the people it serves.[20] Cultural competence training can improve services, understanding, and skills; and ultimately ensure staff are prepared to meet the needs of racially and ethnically diverse populations.[21] Self-reflection and awareness of one's professional and personal culture is an important component of cultural competency.[22] Through a survey of staff regarding the overall capacity, we hoped to be equipped to identify strategies and opportunities to address health inequities, and provide professional development and training opportunities to staff so they will understand what ADHS DPS will do to advance health for all persons.

Methods

We developed a staff survey by making minor modifications to the previously validated Bay Area Regional Health Inequities Initiative (BARHII) "Organizational Self-Assessment Toolkit" staff survey,[23] and aligning it with the ADHS DPS principles, actions, and vision (Table 1). The BARHII toolkit provides public health leaders with tools and guidelines

that help identify the skills, organizational practices, and infrastructure needed to address health equity and provide insights into steps local health departments can take to ensure their organizations can have a positive impact on policies. The self-assessment is intended to serve as the baseline measure of capacity, skills, and areas for improvement to support health equity focused activities. For ADHS it will also serve as a tool to assess progress towards identified goals developed through the assessment process.

The survey assessed employee perceptions of ways the agency, division, and specific program areas address health inequities; organizational and individual traits to support our ability to implement effective health equity focused work; information to guide strategic planning; and processes to develop and implement improved organizational and workforce capacities. An independent internal steering committee and the ADHS human resources team assisted in reviewing and modifying the survey and obtained informed consent from all participants. These two bodies also ensured participation was voluntary and anonymous. Both state and non-state designated employees working at ADHS could participate. Prior to survey dissemination, we held a series of informational and listening sessions with staff to provide an overview of the background, intent, and process. We removed 4 questions from the BARHII to ensure staff anonymity: individual length of time at the department (Q4), time in current position (Q5), make up of interview panels (Q123), and equitable promotion (Q125). We modified questions pertaining to the recruitment and retention of culturally diverse staff (Q115–Q120) to more generally assess (a) recruitment of culturally diverse managers, supervisors, senior management level/unit or program lead staff, (b) recruitment of culturally diverse non-management staff, and (c) retention of culturally diverse staff members.

The survey was designed and administered using QualtricsXM.[24] A valid response for each question was required. Participants had an opportunity to pause and return to complete the survey at a later time. The survey was distributed to all employees during February 9–26, 2021. Follow-up reminders to complete the survey were disseminated weekly. Completion time for the survey ranged from 20 to 35 minutes. The overall participation rate, including fully completed surveys only, was 78.0% (ranging from 73.1% to 84.8% across all 3 Bureaus: Chronic Disease and Health Promotion, Nutrition and Physical Activity, and Women’s and Children’s Health). A total of 123 surveys were submitted: 110 (89.4%) fully completed, 11 (9.0%) blank, and 2 (1.6%) partially completed.

Discussion forums, including town halls and work groups, were also conducted to discuss relevant findings and strategize specific actions which could be taken internally. All staff, whether they participated in the survey or not, were invited to participate in these various forums. Participation was voluntary. These discussions were facilitated by an impartial group of staff peers. Together, the survey findings and discussion forum feedback were combined to inform specific focuses.

Analysis

Analyses were completed using SAS v 9.4 (Cary, NC).[25] The frequency and distribution of all items were examined individually and within each BARHII domain, matrix element, and ADHS principle and action. Individual survey question responses were coded from 0

(deficient) to 5 (proficient) to enable creation of summary scores and relevant comparisons across all 17 BARHII domains and 59 matrix elements within the BARHII domains. As an example, for a matrix element identified as “A—Familiarity with major health inequities affecting residents” the response options were: Strongly Disagree/Disagree [0], neutral [3], Agree/Strongly Agree [5]. As another example, for a matrix element identified as “B—Standards and expectations for how to work with the community” the response options were: No [0], Moving in that direction [3], Yes [5]. We coded responses of “I don’t know” as 0.5 because we believe they demonstrated a lack of knowledge of various constructs. Mean scores and 95% confidence intervals (CI) were calculated for each matrix element. The 95% CIs are presented to allow for comparisons relative to the threshold (3.5) established a priori to identify matrix elements requiring significant improvement. Matrix elements were identified as needing significant improvement if the 95% CI upper bound did not exceed the established threshold. All responses were aggregated and stratified by Bureau (Bureau level results were only used internally).

Results

Of 110 participants, nearly two-thirds were in a non-supervisory position (63.6%) and one-third were in a supervisory position (36.4%) (Figure 1). The majority were classified as state employees (90.9%). Participants worked in the following bureaus: Chronic Disease and Health Promotion (25.5%), Nutrition and Physical Activity (40.0%), or Women’s and Children’s Health (34.6%). Participants’ experience working in public health was from 0–5 years (29.1%), 6–10 years (32.7%), or 11+ years (38.2%). Less than half of participants worked directly with the public (41.8%) and less than a third supervised staff who work with the public (30.0%). Participants were diverse with respect to ethnicity and race (Hispanic [19.8%]; non-Hispanic White [52.8%], multiracial [15.4%], African American/Black [7.7%], Asian/Pacific Islander [2.2%], American Indian/Alaska Native [2.2%]).

Applying a threshold of 3.5, we identified 21 of 28 organizational (Figure 2), and 17 of 31 workforce (Figure 3) capacities that needed significant improvement. Of the organizational characteristics examined, at least one matrix element capacity needing significant improvement was identified within the BARHII domains of “I—Institutional Commitment to Address Health Inequities” (6 of 7), “II—Hiring to Address Health Inequities” (2 of 4), “III—Structure that Supports True Community Partnerships” (3 of 4), “IV—Support Staff to Address Health Equities” (4 of 4), “V—Transparent and Inclusive Communication” (4 of 4), “VII—Community Accessible Data and Planning” (1 of 1), and “VIII—Streamlined Administrative Process” (1 of 1). All of the matrix element capacities were satisfactory within the organizational characteristic BARHII domain of “VI—Institutional Support for Innovation”.

Of the workforce characteristics examined, at least one matrix element capacity needing significant improvement was identified within the BARHII domains of “X—Knowledge of Public Health Framework” (4 of 4), “XI—Understand the Social, Environmental, and Structural Determinants of Health” (1 of 2), “XII—Community Knowledge” (1 of 5), “XIII—Leadership” (4 of 4), “XIV—Collaboration Skills” (3 of 4), “XV—Community Organizing” (3 of 4), and “XVI—Problem Solving Ability” (1 of 1). All of the matrix

element capacities were satisfactory within the workforce characteristic BARHII domains of "IX—Personal Attributes" and "XVII—Cultural Competency Humility."

Discussion

These survey results provide an opportunity to identify specific target areas where ADHS as an organization can focus our attention in relation to personnel workforce and organizational capacity through subsequent discussion forums. We identified several specific opportunities to increase staff's knowledge of the organizational commitment to address health inequities through a shared defined vision, mission, strategic plan, and organizational values and principles. Moving beyond self-assessment is a necessary step towards developing a stronger evidence base for staff cultural competency-related trainings to improve health outcomes in the populations supported.[20] Relevant survey findings and the survey tool were used to guide and inform robust discussions during subsequent town halls (held specifically for this initiative), action planning work group definitions, and facilitated discussions related to organizational racial equity. Participants included ADHS staff who were asked to consider and propose specific change to be accomplished and to take a solution-based approach[26,27] in addressing concerns or issues during these town halls and subsequent work groups. Work groups were inclusive and open to all staff. Work group members identified work environments where change is needed as well as specific actions that could be taken within spheres of influence in the next two years. They also identified professional development opportunities and various means of communication that can make health equity understandable and actionable.

Specific activities proposed for inclusion, based on these survey findings, during town halls and work groups focused on data and evaluation, program planning and contracts, communications, personnel development, and community engagement. Ideas and specific actions proposed, but not fitting within a particular work group, were shared with the steering committee for further consideration. Implementation teams were created to coordinate the work and contribute to completing recommended actions. Data and evaluation actions pertained to data education and training to better describe health events in communities, assessing data collection processes using a health equity lens, improving data sharing and access to increase data understanding, implementing a whole-person health data collection process, increasing use of a variety of data tools and techniques, and addressing funding gaps in needs assessments. Program planning actions pertained to developing enhanced tools and resources to include heath equity language in contracts/agreements and being intentional in funding non-traditional public health groups (e.g., community health workers). Communications actions pertained to expanding the language of health editorial style guides, developing an inclusive communications spectrum, completing a systematic review of the organizational website to address stigmatizing language and improve inclusivity, developing a process for using language from tribal communities, and developing a writing standards toolkit for communication. Personnel development actions pertained to enhancing recruitment and retention of diverse staff, enhancing internships to ensure diversity, establishing

mentorship programs, training on racial inequities and advancing equity, and establishing pathways for upward mobility in the workforce. Community engagement actions pertained to hosting listening sessions to engage communities, establishing affinity groups (e.g., social or structured self-governing groups based on race, ethnicity, sexual orientation, disability status, age, etc.), and expanding use of reflective supervision, which is characterized by active listening and thoughtful questioning to better understand populations served.

There are numerous successful examples of health departments advancing equity both internally and externally by leveraging training and resources for personnel development. The Harris County Public Health Department (Texas) created a department-wide health equity infrastructure, establishing overarching health equity policies, procedures, and staff training to infuse an equity lens into all divisions and programs.[28] The Colorado Department of Public Health and Environment developed a required Health and Environmental Justice 101 training for staff that opened the door for new collaborations across the department, increased awareness of health equity and environmental justice issues, and cultivated new discussions about how to embed equity in public health practice.[29] The New York City Department of Health and Hygiene launched an initiative to reform internal policies, practices, and operations to advance racial equity and social justice across the department by building staff skills to address racism, implementing policies to lessen the impact of structural oppression, and strengthen collaborations with communities across the city.[30] The Maricopa County (Arizona) Department of Public Health increased health equity capacity through an internal assessment, lunch-and-learn series, training and workplan development, and incorporating their work into the department's "cloud" structure to improve communication, leverage resources, build relationships and linkages, reduce duplication of efforts, spark ideas, and increase collaboration.[31] There are specific recommendations health department practitioners can take to improve health equity.[32] For example, health department staff can develop their knowledge and capacity to advance health equity practice with the support of leadership. Health departments could also implement organizational strategies that build theoretical understanding of equity, oppression, and power but also impart skills to apply this understanding across policies, programs, practices, and interventions. Strategies may include agency-wide trainings, workgroups, peer-learning and mentoring, and other opportunities to reflect and discuss equity-related content. Embarking on these strategies requires strong facilitation skills and clear communication to ensure discussions are inclusive and respectful of different staff perspectives and allow staff to share their lived experiences of inequities.

Planning and implementation of cultural competency change should acknowledge the interaction between an intervention and the setting.[20] Prior to this equity initiative implementation ADHS DPS had already begun to have conversations about racial equity, health equity and root causes of health inequities, and incorporated lessons learned into the implementation, communication, and dissemination process. Commitment from leadership and embedded cultural competency within organizational policy documents and strategic plans are more likely to result in sustained change.[20] Strong support was garnered among all senior and mid-level leadership for this process and to ensure staff time could be appropriately allocated and that the findings would be used to influence long term engagement and action. A smaller core team of representatives from each of 3 bureaus

in ADHS DPS ensured relevant concerns were addressed through formal and informal discussions with team and program leaders (who solicited feedback from their staff) and incorporated and encouraged staff to participate by routinely communicating the purpose, intent, and objectives.

Limitations

Our study is subject to at least 4 limitations. First, the modified BARHII instrument used was self-reported and subject to limitations associated with these types of data collection instruments, including a person's recall and perception as well as social desirability bias. However, previous studies have examined issues related to the reliability and validity of BARHII and the instrument's ability to provide valid estimates.[23] Second, the staff survey is just one tool within the BARHII Toolkit to assess capacity and infrastructure of health departments. We did not implement BARHII Toolkit's collaborating partner survey or staff focus groups. We will include the collaborating partner survey in planned future assessments. We conducted staff interviews and an internal document review as suggested in the BARHII Toolkit to inform action planning. Third, current findings and recommendations are based on an initial assessment within only 1 of 4 ADHS operating divisions. Future assessments will include a broader assessment completed across the entire ADHS (i.e., all 3 other divisions) and repeating the assessment (after 12–24 months) within the same division to evaluate the impact of proposed actions. Fourth, we made specific response coding and analysis decisions that may be considered conservative and over-simplified; however, we took this approach to enable direct and concise comparisons across all matrix elements and to gain a realistic perspective for future planning of focus areas.

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Implications for Policy & Practice

- This assessment illuminated important challenges faced internally by our health department. More needs to be done to get at the underlying causes of persistent health disparities. This assessment identified persistent deficits in internal ADHS DPS structures, processes, and systems. It is critical to examine and determine how the structures, processes, and systems in which we work can do a better job of advancing health equity.
- Assessing organizational capacity to do health equity work provides an opportunity to act on specific, effective strategies while building a framework and tools that can be applied groups experiencing disparities and injustices beyond race and ethnicity. We know there are many groups that experience disparities and injustices, including groups based on gender, sexual orientation, age, and ability. This will help us achieve better health outcomes and improved wellness in Arizona for all Arizonans.

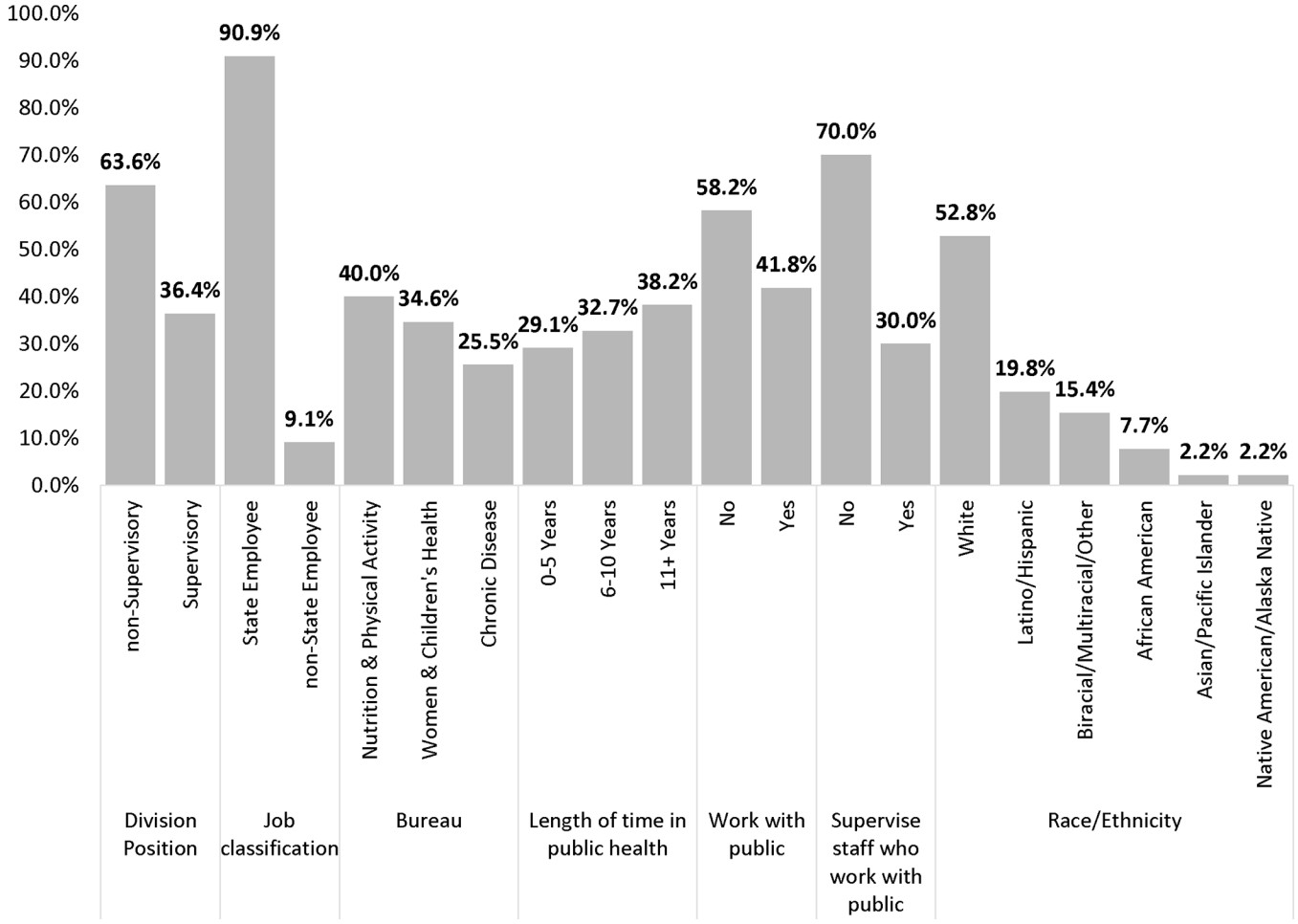

Figure 1.
Staff Survey Participant Characteristics (N=110)

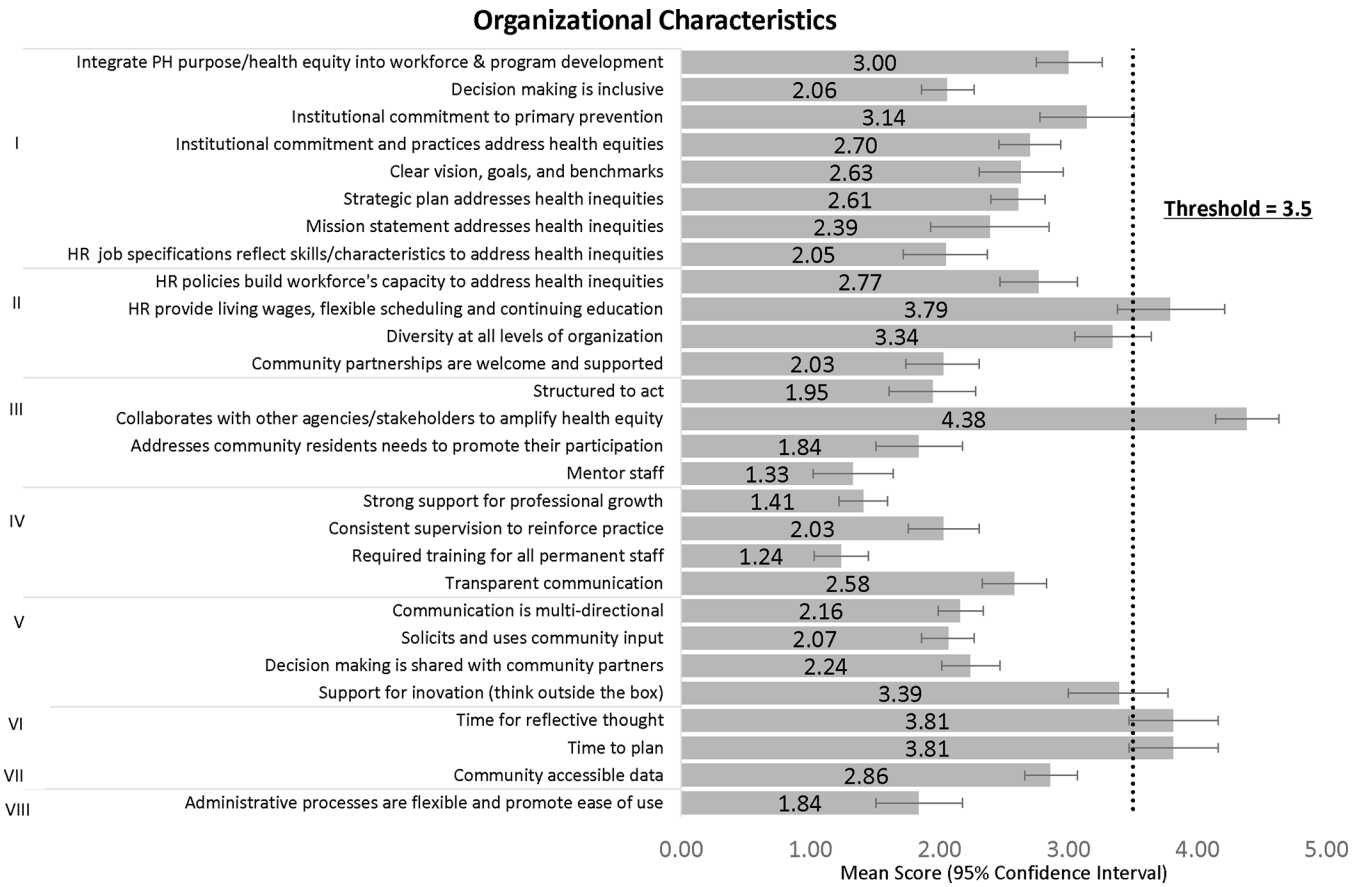

Figure 2.

Organizational Domains and Elements

Acronyms: HR, Human Resources

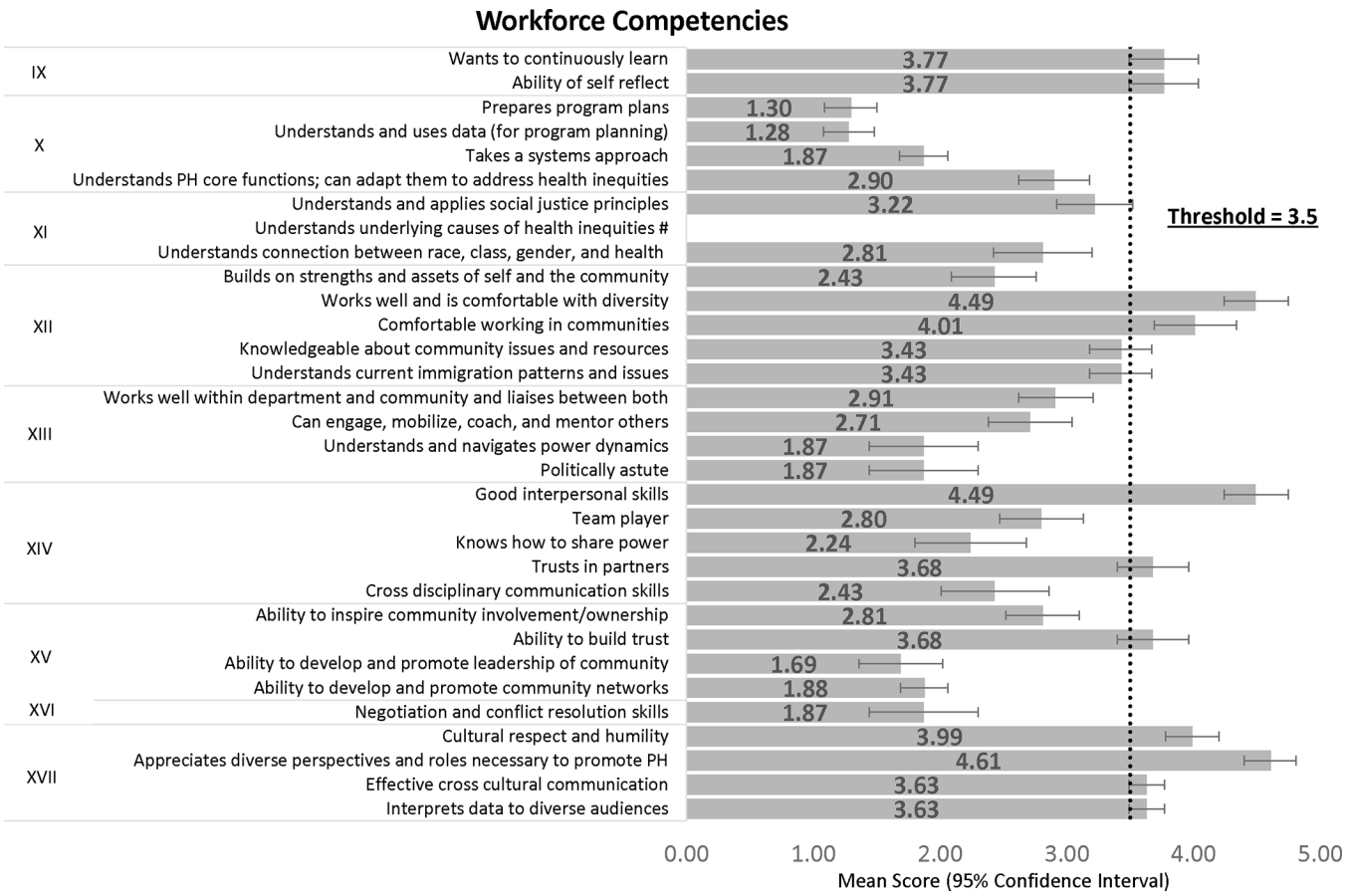

Figure 3.

Workforce Domains and Elements

Acronyms: PH, Public Health; #, Element not assessed through current staff survey

TABLE 1.

Crosswalk Matrix: BARHII Domains and ADHS Division of Prevention Principles and Actions

BARHII DOMAINS	ADHS Prevention Division Principles & Actions							
	Be Intentional About Creating a Culture with Racial Equity as a Core Value	**Be United in our Shared Vision to Achieve Health Equity for all Arizonans**	**Co-create with the Community by Honoring Voices & Ensuring Opportunities**	**Have Humility to Continuously Learn and Improve**	**Act with Inclusivity and Transparency**	**Hold Ourselves Accountable to the Communities We Serve**	**Use our Spheres of Influence to Implement Systemic Changes in our Programs, Planning Processed, and Business Operations**	**Provide Professional Development and Communication that makes Racial Equity Understandable and Actionable**
I Institutional Commitment to Address Health Inequities	X	X			X	X	X	
II Hiring to Address Health Inequities	X						X	
III Structure that Supports True Community Partnerships			X		X	X		
IV Support Staff to Address Health Inequities				X			X	X
V Transparent & Inclusive Communication (Community, Staff, Partners, etc.)		X	X		X	X	X	X
VI Institutional Support for Innovation				X			X	
*Creative Use of Categorical Funds							X	
VII Community Accessible Data & Planning			X				X	
VIII Streamlined Administrative Process							X	
IX Personal Attributes				X				X
X Knowledge of Public Health Framework				X				X
XI Understand the Social,				X			X	X

BARHII DOMAINS	ADHS Prevention Division Principles & Actions							
	Be Intentional About Creating a Culture with Racial Equity as a Core Value	**Be United in our Shared Vision to Achieve Health Equity for all Arizonans**	**Co-create with the Community by Honoring Voices & Ensuring Opportunities**	**Have Humility to Continuously Learn and Improve**	**Act with Inclusivity and Transparency**	**Hold Ourselves Accountable to the Communities We Serve**	**Use our Spheres of Influence to Implement Systemic Changes in our Programs, Planning Processed, and Business Operations**	**Provide Professional Development and Communication that makes Racial Equity Understandable and Actionable**
Environmental, and Structural Determinants of Health								
XII Community Knowledge			X		X	X		
XIII Leadership			X	X	X	X	X	
XIV Collaboration Skills			X	X	X	X	X	
XV Community Organizing			X		X			
XVI Problem Solving Ability				X		X	X	
XVII Cultural Competency Humility	X			X	X			X

Acronyms: Bay Area Regional Health Inequities Initiative (BARHII); Arizona Department of Health Services (ADHS)

*Excluded from staff survey