PUBLIC HEALTH BRIEFING
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Introducing Rhode Island's Health Equity Zones

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This article is the first in a series of Public Health Briefings that will explore the efforts of Health Equity Zones (HEZs) to reduce health disparities and improve health outcomes in 10 geographically defined, economically disadvantaged communities with poor health outcomes.

ABSTRACT

Many social and environmental factors contribute to the health – and unhealthiness – of a community, and the mix of these factors varies widely from one community to another. A persistent challenge to public health is just how to address so many variables, in so many combinations, in so many diverse communities. The Rhode Island Department of Health is exploring an innovative approach, its Health Equity Zone Initiative, to meet this challenge.

KEYWORDS: Health Equity Zones, HEZs, healthy communities, health inequities

Over the past several decades, efforts to improve health in the United States have focused primarily on reforming the health care system. Despite substantial investments, however, the United States (US) continues to experience poorer health outcomes than other developed countries, and significant health inequities between populations remain.[1]

There is increasing recognition that social and environmental determinants – economic status, education, the built environment,[2] employment, social networks, and health care – have a considerable impact on health outcomes and play a pivotal role in fostering health inequities.[3] One recent meta-analysis of almost 50 studies demonstrated that these factors accounted for over a third of deaths in the United States in one year.[4]

Lower-income and minority populations are more vulnerable to the impact of social and environmental determinants, since they are less likely to live in areas where these factors make a positive contribution towards promoting healthy lifestyles. Their neighborhoods are more likely to have higher rates of crime, limited access to healthy foods and physical activity options, few employment and job training opportunities, poor quality housing and education, and less access to health care and other services.[5]

Addressing the wide-ranging problems that confront at-risk communities requires an expansive view of what "creates" health. In contrast to traditional public health interventions – which focus on a narrowly defined set of disease causes, e.g., poor nutrition as a singular cause of obesity – public health solutions for at-risk communities must be comprehensive. It is also best for them to be "place-based," to address the unique mixes of challenges and resources presented by individual communities. And, if we are to harness the social capital and local ownership needed to overcome these multifaceted problems, public health solutions must engage community members in all phases of work – assessment, planning, and intervention.

The Rhode Island Department of Health (RIDOH) has a long history of using community-driven approaches to address complex public health problems. Beginning in the 1990s, for example, our Parent Consultant Program engaged families of children with special needs in an effort to improve the public health programs that served them. More recently, RIDOH-sponsored Centers for Health Equity and Wellness pulled together and supported networks of community-based organizations and residents around efforts to prevent chronic disease.

RIDOH has synthesized "lessons learned" from these earlier efforts and has recently embarked on a new approach – the Health Equity Zones (HEZ) Initiative – to support the kind of comprehensive, placed-based, community-driven work that we believe is needed to confront the underlying systemic factors that promote poor health outcomes. We began by issuing a request for proposals (RFP) to solicit interest from communities interested in forming HEZs.

A HEZ is an economically disadvantaged, geographically defined area with documented health risks. A group of volunteer stakeholders, organized as a "HEZ collaborative," works to achieve health equity for the residents of the HEZ by eliminating health disparities, and using place-based (where you live) strategies to promote healthy communities. The HEZ collaborative:

- **Convenes** regularly;
- **Assesses** the health needs of HEZ residents;
- **Plans** to achieve health equity by:
  - Defining goals;
  - Identifying evidence-based strategies;
  - Designing projects;
- **Develops** resources to conduct projects;
- **Implements** projects;
- **Evaluates** the effectiveness of projects.

A HEZ may be as small as several city blocks, or as large as a county. The size and boundaries of a HEZ are defined by stakeholders, as is the way the stakeholders are organized to engage in the activities outlined above. A HEZ collaborative may also vary in its composition, but typically includes scores of stakeholders drawn from local governments, local school districts and schools of higher learning, local businesses, local community service agencies, and local providers of health care.[6] Members of a HEZ collaborative serve as unpaid volunteers. The collaboratives are intended to be inclusive; no one who resides in or serves the residents of a HEZ and who wishes to participate in its collaborative is restricted from doing so. Because the collaboratives thus formed tend to be large, they organize themselves into working groups; each working group focuses on a cluster of planned projects under categories such as "food and nutrition," "physical activity," "substance abuse awareness and prevention," "personal mental health and wellness," etc.

HEZs do not arise de novo, of course. To pull together an effective coalition of HEZ collaborators requires considerable community organizing – and later, management – and this requires resources for personnel and overhead costs such as rent, communication expenses, travel, etc. Even though a fully formed coalition may become self-sustaining by means of member contributions, a forming coalition usually requires several years' "seed" funding to get it to the point where members are willing to invest in the enterprise.

Accordingly, RIDOH began by assembling seed funds "braided" from multiple state and federal funding streams in order to bring "categorical funding" to bear on the unique (and diverse) mix of problems found in real communities. Then RIDOH issued a Request-for-Proposals (RFP) from established community agencies (hospitals, non-profit community service organizations, etc.) who might be willing to serve as the hub or "backbone" of a HEZ, i.e., to function as community organizer, coalition manager, and single-point-of-contact between a HEZ and RIDOH. The RFP permitted considerable latitude in how the boundaries of a HEZ might be defined – by the applicant, not RIDOH – and required the applicant (the community agency proposing to serve as a HEZ backbone) to do considerable organizing of stakeholders (potential members of a HEZ collaborative) before submitting an application, or to have a well-formed plan for developing a robust collaborative in the early stages of their proposed program.

Eleven backbone agencies received HEZ awards in 2015. After a first year dedicated to organizing, assessing, and planning, 10 of 11 HEZs remain, and have begun implementing projects – projects as diverse as the local problems they address, including substance abuse, diabetes, limited access to fresh foods, limited access to primary health care and mental health care, problems with the built environment, and more.[7] As well, evaluation efforts are underway to assess local and statewide impacts of the HEZ initiative. Each HEZ has written a strategy-specific evaluation plan to measure the community-level effect of its equity work (its projects). In addition, a statewide evaluation plan has been written, focusing on the structures, processes, and outputs common to all HEZs, such as partnerships, leveraged resources, the advancement of policy, and barriers and facilitators to the advancement of health equity.

As the 10 HEZs enter the second of four years of seed funding from RIDOH, they are also focusing on the development of sustainable support streams. RIDOH is facilitating this process by suggesting alignments of the work of each HEZ with the work of better-resourced local and state partners, (foundations, hospital systems, etc.). The goal – and main challenge, of course – is to develop sufficient and sustainable investment in each HEZ to assure continuity of the enterprise and to effect lasting change.

References

1. Robert Wood Johnson Foundation, From Vision to Action: A Framework and Measure to Mobilize a Culture of Health, 2015.
2. "The built environment includes all of the physical parts of where we live and work (e.g., homes, buildings, streets, open spaces, and infrastructure)." From: Centers for Disease Control and Intervention. Impact of the Built Environment on Health. National Center for Environmental Health. June, 2011. http://www.cdc.gov/nceh/publications/factsheets/ImpactoftheBuiltEnvironmentonHealth.pdf
3. The Henry Kaiser Family Foundation, Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity Issue Brief, Kaiser Commission on Medicaid and Uninsured, November 2015.
4. Ibid.
5. In Rhode Island, 20% of families with children under 18 years of age live below the poverty level, and 64% of these families live in 4 core cities – Central Falls, Pawtucket, Providence, and Woonsocket. (2016 RI Kids Count Factbook)
6. See http://horsleywitten.com/BristolHEZ/collaborative.html, in which the members of the Bristol, RI HEZ collaborative are listed.
7. See http://www.health.ri.gov/projects/healthequityzones/formore information.

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