

Measuring Health Equity

An assessment of equity metrics in performance management and planning



February 2023

Executive Summary

With support from CDC's Center for State, Tribal, Local, and Territorial Support, in 2021, ASTHO initiated a health equity metric assessment to strengthen the evidence base for measuring health equity by identifying and collecting known and emerging metrics that support health equity strategies and monitor advancements toward health equity.

To better understand the state of the field, ASTHO conducted an environmental scan that looked at state and territorial planning documents and national frameworks. As the scan revealed wide variation in how jurisdictions use equity-related terms and limited established metrics, ASTHO convened an advisory group to help identify resources and guide the work's direction.

Participating health agencies told ASTHO about their challenges in developing health equity standards and measures, including obstacles related to the underlying culture and the change management required to evolve toward a more equitable public health system. The agencies described both data limitation challenges and workforce capacity and communication challenges. This ASTHO Report summarizes these challenges, proposes incremental recommendations, and acknowledges the need for states and territories to apply both health equity and performance management strategies to develop health equity standards and measures.

ASTHO recommends:

- **Addressing data limitations** and being transparent about remaining gaps.
- **Building workforce capacity** to recognize and address complex concepts and evolving needs through strategic skills and structural, transitional, and transformational change.
- Employing inclusive planning and performance management promising practices to engage stakeholders to **develop meaningful, community-driven metrics**.
- **Committing to human-centered communication and community engagement** through data visualization, storytelling, and trusted messengers.

While this assessment confirmed that states and territories are interested in a list of nationally vetted common health equity metrics, the findings demonstrate a need for true equity engagement between communities and governmental public health leading to a paradigm shift in how we partner to improve health, prevent disease, and eliminate disparities.

In addition, given that this assessment began before the COVID-19 pandemic, it does not fully account for the ongoing change associated with dedicated COVID disparities funding, investments in data and infrastructure, and the pandemic's complex mental, physical, political, social, and economic impacts. As a result, several jurisdictions may need to adapt strategies already underway that are aligned with ASTHO's recommendations. Health agencies should also consider their level of influence and authority and which partners they would engage to implement these strategies; this may vary by jurisdiction and governance structure. ASTHO will continue to strategize ways to improve and formalize health equity metrics to help public health agencies better serve their communities.

Introduction

The Intersection of Planning and Performance Improvement with Health Equity

Within the broad arena of performance improvement and planning, performance management systems ensure that agencies make progress toward public health goals by systematically collecting and monitoring data to track results and identify opportunities for improvement. Health equity is a top priority for many health agencies and is central to CDC’s [updated 10 Essential Public Health Services](#). In an ideal implementation, public health leaders and the public health workforce can use performance management systems to advance health equity goals and foster transparency by communicating how the health agency will (1) ensure that it meets goals consistently, effectively, and efficiently, and (2) identify opportunities for improvement. These [national accreditation standards](#) and the aligned [foundational public health services](#) emphasize the importance of developing the workforce to collect and center equity data to ensure that planning, prioritization, and systems change address equity.

The evidence base for performance management systems requires standards, measurement, progress reporting, and quality improvement; a functioning performance management system is critical to achieving public health accreditation. Many jurisdictions use established health status indicators to guide health assessment and improvement planning, or as a taxonomy for the performance management system. [Healthy People 2030](#) and [The Community Guide](#) are two common tools health agencies can use to prioritize measures and strategies. Healthy People 2030 includes 355 measurable objectives of health status and health systems, and The Community Guide offers evidence-based strategies on numerous health promotion and disease prevention topics.

Although both resources have traditionally been organized categorically by health topic, each has moved to better identify crosscutting and systems areas that impact multiple health outcomes. This includes social determinants of health, public health infrastructure, and health equity. In the context of the COVID-19 pandemic, the field has further articulated the need for dedicated funding to improve infrastructure, develop the workforce, and modernize data systems.¹



¹ Several recent reports underscore the importance of these evolving frameworks, including:

- Commonwealth Fund, “[Meeting America’s Public Health Challenge: Recommendations for Building a National Public Health System That Addresses Ongoing and Future Health Crises, Advances Equity, and Earns Trust](#)”
- University of Wisconsin Population Health Institute, “[2022 County Health Rankings National Findings Report](#)”

Many government public health agencies and partners are funded primarily through federal grants that include reporting requirements and performance measurement. This is critical to ensuring high quality, transparent, accountable use of federal funds. Grantees must report on metrics that increasingly include measures on health disparities. For example, the national [initiative](#) to address COVID-19 health disparities, released in 2021, requires health agencies to report performance measures by race and ethnicity and measure infrastructure improvements and partnerships to advance these efforts. In 2022, CDC’s [grant funding](#) through the American Rescue Plan Act focused on strengthening U.S. public health infrastructure, workforce, and data systems. As the notice of funding opportunity states:

“The cornerstone of all this work will be demonstrating and improving the health department's ability to advance health equity and address health disparities for populations at higher risk and in medically underserved communities. Across areas, this should be part of a transformation of public health agencies needed to meet the evolving and complex needs of the U.S. population. This transformation will not only involve improvements and changes to public health internal systems and operations; it will also involve repositioning public health entities within the larger health and health care systems in which they operate.”

Thus, an investment in infrastructure, workforce, and data modernization is intrinsically linked with systems improvement.

As health agencies gather, analyze, and discuss data with stakeholders, they may compare their communities to national benchmarks (as in Healthy People 2030), look for areas of similarities or difference, and complement quantitative data with qualitative context to make meaning and use the data for action. These conversations should adapt and adjust benchmarks, tailor outcomes to meet communities’ needs, and ensure data is relevant and meaningful to the populations it represents. A best practice in health assessment is to also understand and be transparent about known gaps in the data—what cannot be

measured or not measured well? Through these assessment and engagement processes, health agencies can identify opportunities for improvement and prioritize collective action based on data and community input. This can occur at both a process improvement scale or at the level of community and culture change. The quantitative and qualitative data available for these conversations will drive the agenda of this work. If health equity data is absent, public health strategies risk being less effective and less equitable.



What is Health Equity?

To ensure public health data integrate health equity, stakeholders must have a common understanding of terms. **Health equity** occurs when "everyone has a fair and just opportunity to be as healthy as possible in a society that values each member equally through focused and ongoing efforts to address avoidable inequities, historical and contemporary injustices, and the elimination of disparities in health and healthcare." Achieving this requires ongoing societal efforts to:

- Address historical and contemporary injustices.
- Overcome economic, social, and other obstacles to health and healthcare.
- Eliminate preventable health disparities.

Alignment with CDC

In 2016, and alongside other initiatives to advance equity, CDC and ASTHO collaborated to publish a supplement to the *Journal of Public Health Management and Practice* that included articles on **Paving the Road to Health Equity**. This initiative acknowledged programs, measurement, and policies that are important to achieving equity and the infrastructure needed to implement all three. CDC aligns with this internally through its **CORE Commitment to Equity**, which focuses on cultivating comprehensive health equity science, optimizing interventions that address the drivers of disparities, reinforcing and expanding robust partnerships, and enhancing capacity and workplace diversity, inclusion, and engagement.



This ASTHO Report

This ASTHO assessment focused on the measurement component of the road to health equity. It sought to better understand how health agencies are using data to communicate the impact of health equity initiatives and how they gather the health equity measures that contribute to their planning and improvement processes. The extent to which jurisdictions assess and discuss health equity measures alongside health status measures should indicate progress toward advancing health equity or gaps that require additional understanding, resources, or commitment. With practice-based and anecdotal understanding that there was not an equivalent “list” of health equity measures, ASTHO sought to systematically assess the state of health equity data integration into performance management systems and planning processes to inform future technical assistance, tools, resources, and capacity building efforts.

Purpose: This ASTHO Report describes the findings and recommendations from the assessment process to:

- Explore activities to better understand state and territorial health agency use of data to communicate health equity.
- Facilitate meaningful collaboration and intersection between health equity and performance improvement.
- Gather recommendations and guidance on the needs of state and territorial health agencies and the field.
- Inform future technical assistance, support, tools, and resources.

Shorter-term objective: Strengthen the evidence base on health equity measurement by identifying and collecting known and emerging metrics that support health equity strategies and monitoring advancements toward health equity.

Longer-term objective: Align health agency impact on health equity through the lens of measurement and performance improvement.

Findings

Environmental Scan

To prevent redundancies and build on and align with other public health efforts in this arena, ASTHO brainstormed resources to be included in the scan that mentioned health equity or health equity metrics.

- The authors prioritized **state health improvement plans (SHIPs)** for this scan due to their link with public health accreditation and their required stakeholder engagement processes.
- The authors also made **strategic plans (SPs)** a central element of this review, as SPs often emphasize structural and organizational improvement priorities.

Using a layered approach, ASTHO began with keyword searches of "health equity" and "equity" in 93 documents, including SHIPs and SPs. ASTHO gathered plans published on state health agency websites and publicly accessible in 2019. ASTHO did not include plans from island jurisdictions due to lack of publication. Check marks in the table below indicate explicit mentions of health equity (as well as broader terms such as “socially vulnerable” and “underserved populations”) in either a jurisdiction’s SHIP or SP. Only terms included within a goal, objective, target, or metric were counted (i.e., terms that appeared in agency values or background text were omitted).² There are some limitations to the report findings because states varied in the level of detail they provided in their SHIPs and SPs. In addition, key terms change frequently; a jurisdiction may not have included “health equity” in a document when they published it, but this does not necessarily reflect its efforts in this field.³

In general, a higher proportion of SPs (35 of 44) than SHIPs (31 of 49) mentioned these terms. Half of agencies referenced measures to specifically address health equity, while the other half alluded to vulnerable populations or targeting specific populations (e.g., racial disparities in infant mortality). Of the states where ASTHO included both plans in the scan, five had no explicit mention of these terms.



² This list of terms was developed based on available plans and common terms at the time. It does not represent best practice or the field’s evolution away from certain terms. See CDC’s [Health Equity Guiding Principles for Inclusive Communication](#) for current guidance.

³ The scan did not include SHIPs from Nevada or West Virginia (N=49), nor strategic plans from Missouri, Nevada, New Hampshire, New Jersey, Ohio, Tennessee, or Wisconsin (N=44).

Table 1. Use of "health equity" or broader terms in state health improvement plans and strategic plans published in 2019 or earlier.

✓ = terms included ● = terms not included — = plan not included in this analysis

States and Washington, D.C.	SHIP	SP
Alabama	●	●
Alaska	✓	✓
Arizona	●	✓
Arkansas	✓	✓
California	●	✓
Colorado	✓	✓
Connecticut	✓	✓
Delaware	●	✓
District of Columbia	✓	●
Florida	✓	✓
Georgia	✓	✓
Hawaii	●	✓
Idaho	✓	✓
Illinois	✓	✓
Indiana	✓	✓
Iowa	✓	✓
Kansas	●	●
Kentucky	✓	●
Louisiana	✓	✓
Maine	✓	✓
Maryland	✓	✓
Massachusetts	✓	✓
Michigan	●	●
Minnesota	✓	✓
Mississippi	●	●
Missouri	✓	—

States and Washington, D.C.	SHIP	SP
Montana	●	✓
Nebraska	✓	✓
Nevada	—	—
New Hampshire	●	—
New Jersey	✓	—
New Mexico	✓	✓
New York	✓	✓
North Carolina	●	✓
North Dakota	✓	✓
Ohio	✓	—
Oklahoma	●	✓
Oregon	✓	✓
Pennsylvania	●	✓
Rhode Island	✓	●
South Carolina	✓	✓
South Dakota	✓	✓
Tennessee	●	—
Texas	✓	✓
Utah	●	●
Vermont	✓	✓
Virginia	✓	✓
Washington	●	✓
West Virginia	—	●
Wisconsin	●	—
Wyoming	●	✓

Despite the common mentions of equity and vulnerable populations, the initial scan found limited measures of equity. ASTHO moved to a deeper scan using Nvivo qualitative coding software to text mine 49 SHIPs and 44 SPs using 28 additional key terms, including race, racism, inequity, environmental justice, and bias. (See the appendix for the complete list of terms.) SHIPs were more likely than SPs to contain these terms. **Table 2.** Illustrates the most and least common terms.

Table 2. Terms in state health improvement plans and strategic plans.

Most Common		Least Common	
Disparity/Disparities	28 of 50 SHIPs / 16 of 45 SPs	Anti-Racism	0 of 50 SHIPs / 1 of 45 SPs
Health Equity	15 of 50 SHIPs / 25 of 45 SPs	Environmental Justice	3 of 50 SHIPs / 1 of 45 SPs
Diverse/Diversity	22 of 50 SHIPs / 16 of 45 SPs	Injustice	1 of 50 SHIPs / 0 of 45 SPs

This scan revealed that state health agencies use varying terms related to health equity, and that less than half of SHIPs and SPs integrated additional key terms. (See the appendix for a summary of counts by term and plan examples.) When SHIPs and SPs included these terms, they appeared in a mix of quantifiable measures and broader goals/objectives that would more precisely be characterized as strategies or activities using a performance management framework such as Results Based Accountability.⁴ As public documents, some SHIPs and SPs may have intentionally avoided complex terms such as ‘health equity’ that can be misunderstood or assume a higher health literacy of the reader. This is a tension within applied planning and communication to support the public in having equitable access to the information. Together, these variations suggest the formal integration of equity into planning is still in a phase of change and that the paradigm shift for true integration into both planning and broader health agency culture is still in progress.⁵

Performance management and epidemiological principles hold that no single measure can fully inform public health and health equity efforts. A suite of measures can provide context for the status of health and disparities in communities and be used for data-driven decision making. A limitation of this approach is that the suite of measures may vary across communities just as it did in the sources reviewed for the environmental scan. Looking at Tables 1, 2, and Appendix A confirms the absence of a national common language and commonly used set of measures.

Analysis and Discussion of Preliminary Scan Findings

From September to December 2021, ASTHO convened an advisory group to continue this assessment process.⁶ The group’s objective was to ensure that state and territorial voices informed both ASTHO’s recommendations and its resources for integrating health equity and planning and performance improvement. By bringing the group’s input together with the scan results, ASTHO intended to engage stakeholders, identify gaps, ensure applicability, and prepare to disseminate findings to the field in an ongoing and iterative fashion.

Through a series of four facilitated meetings, the advisory group reviewed and added to the assessment data. Of note, the group confirmed the scan findings that there is a wide variety of existing health equity measures and that health agencies need more guidance and resources in this area. The group articulated the following four key challenges to more deeply integrating health equity and performance improvement:

- **Data limitations** inhibit health equity measurement. These include missing data from subpopulations (e.g., race, ethnicity, sexual orientation, gender identity, and socioeconomic status data), data suppression and privacy standards, and assumed rather than self-reported identity.
- **Workforce capacity** can be a barrier to measuring health equity because of the complex concepts, evolving needs, and strategic skills needed to advance these efforts.
- **Metric development** has been a challenge because of the need to broadly define equity while being inclusive and ensuring resonance with community members. This leads to lack of a common definition for metrics that do and do not describe the efforts and impact of strategies to advance equity.
- **Communication and community engagement** practices have ongoing needs that must be funded, staffed, and supported to reach different audiences, including funders, legislators, community partners, government staff, and other sectors.

⁴ Friedman M. *Trying Hard is not Good Enough: How to produce measurable improvements for customers and communities*. BookSurge Publishing; 2009.

⁵ Kuhn TS. *The Structure of Scientific Revolutions*. University of Chicago Press; 1962.

⁶ The advisory group included state public health staff from Alabama, Georgia, Kansas, Kentucky, Montana, Nevada, North Carolina, Tennessee, and Wyoming who worked in performance improvement, health equity, and minority health positions.

Given the context of the COVID-19 pandemic, the advisory group noted the unique national dialogue on COVID-19-related disparities. Each state published COVID-19 dashboards, and many included data on cases, deaths, access to testing, and vaccine uptake by populations experiencing inequities. These timely examples of disparity metrics that drove the COVID-19 response and equity conversations informed the advisory group's discussions and recommendations.

Although workforce capacity is noted as an explicit challenge to integrating health equity and performance management, report contributors want to emphasize the human element of this work. While metric definitions of disparity are clear and those for equity are still evolving, strategies to engage in conversation, build consensus, and acknowledge disagreement and differing priorities continue to reflect the cultures in which people live, work, learn, and play. As people use data to inform health equity efforts, they must operate on personal levels, organizational levels, and society levels in iterative ways. This personal and professional (workforce) development impacts how agencies collect, analyze, and report data with an equity lens and builds the capacity, skill, and value for equity.



Recommendations and Resources

Through the iterative group engagement process, the advisory group and ASTHO established participants’ common needs and strategies. An important consideration for health agencies implementing these strategies will be their level of influence and authority and the partners they would choose to implement them. This may vary by jurisdiction and governance structure. Table 3. Organizes high-level, common sense strategies and relevant resources for each of the four key recommendation areas.

Table 3. Recommended strategies, practices, and resources in four focus areas.

	Strategies and Practices to Promote Integration of Health Equity and Data	Resource and Examples
Data Limitations	<ul style="list-style-type: none"> • Commit to increased race and ethnicity completeness and by self-report. • Build informatics capacity. • Advocate for consistent or informed categorization of tribal nations that vary by federal recognition. • Use optional Behavioral Risk Factor Surveillance System (BRFSS) modules such as industry and occupation or sexual orientation and gender identity. • Collect/develop data on places and systems in addition to better data on individuals. • Be transparent about different uses, value, and availability of quantitative and qualitative data on municipal, regional, state, and national levels. 	<ul style="list-style-type: none"> • Healthy People 2030 • Massachusetts Racial Equity Data Road Map and associated journal article • AJPB article • Journal article on surveillance opportunities with industry and occupation BRFSS questions
Workspace Capacity	<ul style="list-style-type: none"> • Conduct an internal assessment on agency staff’s understanding of health equity. • Measure the status and structure of workforce capacity for health equity in each state. • Fund dedicated positions for this time-intensive work. • Ensure leadership support to have “tough” conversations related to causes and impacts of inequities. • Foster collaboration between performance improvement and health equity office/staff. • Establish peer learning opportunities in addition to tailored technical assistance for agencies seeking to improve their efforts. 	<ul style="list-style-type: none"> • Foundational Public Health Services framework • Public Health Workforce Interest and Needs Survey dashboards • 2015 Prevention Institute Health Equity Summary • "Why Am I Always Being Researched" guidebook • COVID-19 health disparities grant funding and program

<p>Metric Development</p>	<ul style="list-style-type: none"> • Embed health equity into programs and infrastructure that can further establish metrics and terminology. • Understand the data and information needs of partners, specifically grassroots community organizations and faith-based partners. • Ensure that credibility of metrics from a trusted source are paired with community conversations; work with the community to build the evidence base. • Understand the value of metrics that are comparable across states to support prioritization and improvement strategies. • Use logic models as a tool to develop and communicate meaningful metrics. • Distinguish between population and performance level metrics. 	<ul style="list-style-type: none"> • Results-Based Accountability framework • Socio-Ecological Model • CDC/Agency for Toxic Substances and Disease Registry Social Vulnerability Index • COVID-19 Community Vulnerability Index • Journal article on frameworks, strategies, and measurement for addressing health equity in public health practice
<p>Communication & Community Engagement</p>	<p>Internal to health agencies:</p> <ul style="list-style-type: none"> • Develop formal tools for internal equity communications through accreditation. Include guidance on terminology and formats to showcase equity efforts. • Increase visibility of leadership in this area, e.g., leaders releasing communications related to health equity metrics. • Connect and share where health equity is in quality improvement and strategic plans. <p>In the broader field:</p> <ul style="list-style-type: none"> • Build storytelling capacity in health agencies and partners. • Always invest in relationships, not just during a crisis or for a specific project. • Use trusted messengers specific to the message; local organizations can advise on and tailor messages. • Target language with an understanding of the political nature of health equity. • Leverage broader initiatives, like a governor’s taskforce, to demonstrate data tools and answer questions. 	<ul style="list-style-type: none"> • STRETCH Framework • “Sharing Island Stories on Health Equity” ASTHOBlog • CDC’s Health Equity Guiding Principles for Inclusive Communication • Data Visualization for Performance Improvement ASTHO Learning • Mobilizing for Action through Planning and Partnerships (MAPP) • Human Impact Partners Health Equity Guide • A Research Agenda for Developing and Measuring Community Power for Health Equity • Achieving Optimal Health for All by Eliminating Structural Racism 2021 ASTHO Policy Statement.

Conclusion

This assessment highlights a current gap in the field: systems, data, and tools that support integrating health equity more fully into planning and performance management systems. The national standards and evidence base that emphasize the importance of data and stakeholder engagement to effectively manage governmental public health necessitate that the field continues to advance health equity and align with planning and improvement infrastructure. Acknowledging the state of the field in 2019-2020, this assessment narrowed its recommendations to four key areas of focus:

- **Addressing data limitations** and being transparent about remaining gaps.
- **Building workforce capacity** to recognize and address complex concepts and evolving needs through strategic skills and structural, transitional, and transformational change.
- Employing inclusive planning and performance management promising practices to engage stakeholders to **develop meaningful, community-driven metrics**.
- **Committing to human-centered communication and community engagement** through data visualization, storytelling, and trusted messengers.

All of these efforts are centered within a larger paradigm shift for true equity engagement between communities and governmental public health. Given that the assessment began before the COVID-19 pandemic, it does not fully account for the ongoing change associated with dedicated COVID disparities funding, investments in data and infrastructure, and the pandemic's complex mental, physical, political, social, and economic impacts. Several jurisdictions may have strategies underway that are aligned with these recommendations and may need to adapt.

Limitations

This assessment and report have several limitations given the complex topic and time of transition in the field. One key limitation is lack of SHIP and SP information from territory and freely associated state jurisdictions. Not only are planning and performance resources more limited in these islands, their data is often **excluded from national datasets**, adding an unfair barrier to measuring equity. An additional limitation is that this scan included only published reports that came out before the pandemic.

In addition, the advisory group was not designed to be a representative sample of state health agencies nor surface all possible barriers or recommendations. Finally, planning and performance management are only one lens through which to look at these issues. Like health equity, they illuminate culture and systems issues, but are only part of the evolving approach to governmental public health.

Measuring progress toward health equity—both quantitatively and qualitatively—will continue to be essential to ensuring optimal health for all. As public health practitioners design systems change, this report notes four common sense recommendations that health agencies and their health equity partners should discuss. Each jurisdiction will need to acknowledge its own current position and adapt these recommendations based on its own readiness, population needs, and ability to change. Together, health equity and performance management strategies can leverage each other for systems transformation.

Additional State and Territorial Examples

For more information about state and territorial efforts to improve health equity, see the following resources:

- ASTHO's Public Health Review podcast episode, "[Improving Health Equity With Data](#)," which features current and former health agency staff discussing strategies to integrate health equity with planning and performance management.
- [California Healthy Places Index](#)
- Colorado Department of Public Health and Environment's [sweet tools to advance equity, including:](#)
 - » [Racial and Ethnic Data: Considerations for collection and reporting](#)
 - » [Colorado statement on structural inequity](#)
 - » [Measuring performance to advance equity](#)
- [Montana State Health Improvement Plan](#)
- [Rhode Island Health Equity Measures](#)
- Texas Department of State Health Services [Advancing Health Equity](#)
- [U.S. Virgin Islands Community Health Assessment](#)
- [Healthier Washington](#)

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Appendix

Below are the key terms ASTHO used to text mine State Health Improvement Plans (SHIPs) and Strategic Plans (SPs).

- Anti-racism
- Bias
- Cultural competence
- Disability/disabilities
- Discrimination
- Disparity/disparities
- Diverse/diversity
- Environmental justice
- Equity
- Ethnicity/ethnic
- Gender
- Health in all policies/HiAP
- Health equity
- Inclusion
- Inequity/inequities
- Injustice
- LGBTQ
- Linguistic competence
- Minority/minorities
- POC/BIPOC
- Poverty
- Race
- Racism
- Social determinants of health/SDOH
- Social justice
- Structural racism
- Vulnerable populations



Below is a table showing the states and Washington, D.C. (N=50) that mention each of the above keywords in either a state health improvement plan (SHIP) or strategic plan.⁷ Only terms included within a plan’s goal, objective, target, or metric were counted (i.e., terms that appeared in agency values or background text were omitted). Sample text for each term is also provided.

Term	Number of SHIPs	Number of SPs	Example
Anti-Racism	0	1	<p>DC SP Strategic Initiative: Launch Internal DC Health Dialogue on Anti-Racism.</p>
Bias	4	2	<p>New Jersey SHIP Action Plan: 6. NJDOH will design and implement health equity-related training modules on implicit bias, cultural competency, sensitivity and humility and trauma-informed care, starting with its own employees.</p> <p>Arizona SP Annual Initiative: Launch AIM safety bundle; offer training and education on early warning signs information and implicit bias for CHWs, providers and systems of care; promote routine screening for substance use, perinatal mood and anxiety disorders; produce a report on maternal fatalities and morbidity.</p>
Cultural Competence	3	2	<p>Ohio SHIP Strategy: Cultural competence training for health care professionals and implicit bias training.</p> <p>Pennsylvania SP Strategic Initiative: Improve content, work processes, and resources that provide consistent and effective two-way communications with PA residents and visitors, partners and across the department; encourage cultural competence and inclusiveness to attract committed people to the organization; enhance relationships with partners.</p>
Disability/Disabilities	13	7	<p>New Jersey SHIP Action Step: Partner with the Division of Disability Services to increase opportunities for individuals with disabilities to have access to modified physical activity.</p> <p>Maine SP Strategy: Increase public education and awareness of the signs of family violence, including physical and sexual abuse of children and adults with disabilities and the elderly, and how to act to stop it.</p>

⁷ Nevada is excluded from this analysis.

ASTHO gathered plans published on state health agency websites and publicly accessible in 2019.

Term	Number of SHIPs	Number of SPs	Example
Discrimination	4	1	<p>Minnesota SHIP Activity: Using narrative tools and techniques to reduce polarization and fragmentation, specifically naming and revealing racism, sexism, classism, and other forms of discrimination.</p> <p>Louisiana SP Strategy: Conduct an environmental scan and use the data from the Center for Health Informatics and other data sources to identify and address health disparities, especially disparities related to race/ethnicity, age, gender/gender identity, disability, socioeconomic status, religion, geographic location, or other characteristics historically linked to discrimination or exclusion.</p>
Disparity/ Disparities	28	16	<p>Connecticut SHIP Objective: Reduce by 10% the disparity between infant mortality rates for non-Hispanic blacks and non-Hispanic whites.</p> <p>Illinois SP Objective: By December 2024, IDPH programs are data driven and include prioritization of funding and effort focused on public health work that includes strategies on health disparities and systemic inequity. (Note: disparities and inequities are not limited to racial inequities and may also include, among others, populations such as LGBTQ+, non-binary, ethnicity, poverty, senior residents, individuals experiencing homelessness, undocumented immigrants, different abilities, rural communities, etc.)</p>
Diverse/ Diversity	22	16	<p>Rhode Island SHIP Strategy: Healthcare Career Pathways—Skills That Matter for Jobs That Pay. Prepare Rhode Islanders from culturally and linguistically diverse backgrounds for existing and emerging good jobs and careers in healthcare through expanded career awareness, job training and education, and advancement opportunities.</p> <p>Mississippi SP Goal B: Promote healthy lifestyles through population and evidence-based interventions including policy, systems, and environmental changes in worksites, schools, and diverse community settings at the local and statewide level.</p>

Term	Number of SHIPs	Number of SPs	Example
<p>Environmental Justice</p>	<p>3</p>	<p>1</p>	<p>Colorado SHIP <i>Recommendations:</i> Health Equity, Environmental Justice and Social Determinants of Health 1. Continue developing and implementing cross-cutting health equity and environmental justice initiatives and partnerships that integrate public and environmental health across the community spectrum.</p> <p>Massachusetts SP <i>Measure 7.1:</i> Increase blood level screening rates in high-risk communities (as defined by low socioeconomic status, percent of old housing stock, and other factors) by 10% (relative). 7.1.1 Use existing coalitions and collaborations to develop programs to target all children under six years of age. Use blood lead poisoning surveillance data to identify the highest risk populations in urban areas, such as minority populations in larger cities, in schools, and in out-of-school time programs to promote environmental justice.</p>
<p>Equity⁸</p>	<p>7</p>	<p>4</p>	<p>Florida SHIP <i>Strategy:</i> Promote equity in educational access and outcomes.</p> <p>Nebraska SP <i>Priority:</i> The Division of Public Health promotes equity in all activities, programs and services.</p>
<p>Ethnic/ Ethnicity</p>	<p>17</p>	<p>8</p>	<p>Michigan SHIP <i>Strategy:</i> Develop messages appropriate for population at large and culturally sensitive messages related to race and ethnicity.</p> <p>Florida SP <i>Objective:</i> By 6/30/19, establish baseline data that show the diversity of the department’s current workforce to include race, ethnicity and gender.</p>
<p>Gender</p>	<p>8</p>	<p>3</p>	<p>Alaska SHIP <i>Action:</i> Expand statewide current efforts to engage and reach men to promote equitable gender norms and to prevent sexual violence by increasing understanding of consent using sexual violence prevention messaging.</p> <p>Massachusetts SP <i>Standard:</i> Reduce gender based and youth violence.</p>

⁸ Only includes mentions as a standalone term and not “health equity.”

Term	Number of SHIPs	Number of SPs	Example
Health in All Policies	7	3	<p>Oklahoma SHIP <i>Strategy:</i> Develop and maintain a scalable Health in All Policies-based partnership framework to address obesity through the targeting of contributing social determinants of health and reducing disparities throughout the state of Oklahoma.</p> <p>Indiana SP <i>Action:</i> Promote equal opportunities for all people to achieve optimal health through a Health in All Policies approach.</p>
Health Equity	15	25	<p>Connecticut SHIP <i>Strategy:</i> Engage and plan with established community support networks to promote health equity in breastfeeding initiation, exclusivity and duration.</p> <p>North Carolina SP <i>Objective:</i> Work with underserved and underrepresented communities to improve access to quality health care to promote health equity.</p>
Inclusion	4	4	<p>Alaska SHIP <i>Strategy 3:</i> Increase diverse youth inclusion, influence and leadership within state, Tribal, local governments, public agencies (e.g., library, parks, recreation, museums) and youth serving organizations.</p> <p>Utah SP <i>Area of Emphasis:</i> Promote a supportive work environment. Develop strong teams, promote inclusion, and prepare staff for future opportunities.</p>
Inequity/ Inequities	7	7	<p>Virginia SHIP <i>Strategy:</i> Form neighborhood collaboratives co-led by community members in under-resourced communities to identify obstacles and develop plans to address the root causes of health inequities.</p> <p>New York SP <i>Strategy Description:</i> Educate department staff on the causes and impacts of health inequity.</p>
Injustice	1	0	<p>Colorado SHIP <i>Activity:</i> Educate, train and support staff at every level in local and state agencies to address the root causes of health inequity and environmental injustice, and incorporate it into daily work.</p>

Term	Number of SHIPs	Number of SPs	Example
LGBTQ+ ⁹	8	2	<p>Maine SHIP Strategy: Increase cultural competency of health and public health professionals around messaging to the LGBTQ+ community and increase awareness of cancer disparities within the LGBTQ+ community among health care providers and patients.</p> <p>Hawaii SP Milestone: Assure vulnerable populations such as children who are homeless, served by state child welfare and juvenile justice systems, or LGBT receive services.</p>
Linguistic Competence ¹⁰	0	5	<p>Pennsylvania SHIP Activity: Promote cultural humility and linguistic competency across the treatment system.</p> <p>South Carolina SHIP Strategy: Support the health care workforce and related organizations to promote the availability of cultural and linguistic competency training.</p>
Minority/ Minorities	10	6	<p>Hawaii SHIP Strategy: Increase public and professional awareness about cancer-related health inequities. Engage and provide outreach and education to minority populations on cancer risk, community screening services, and other resources to overcome barriers to screening and follow-up.</p> <p>Washington SP Indicator: Increase the percent of total agency spending that is awarded to small, minority-, women-, and veteran-owned businesses.</p>
POC/BIPOC	1	0	<p>Oregon SHIP Strategy: Require state agencies to commit to racial equity for BIPOC-AI/AN in planning, policy, agency performance metrics and investment.</p>

⁹ Includes searches for “LGBT,” “lesbian,” and “gay.”

¹⁰ Some states referenced “linguistic diversity” or “linguistically appropriate services,” but not “linguistic competency” specifically.

Term	Number of SHIPs	Number of SPs	Example
Poverty	16	4	<p>Alaska SHIP <i>Objective #21:</i> Increase the percentage of residents (all ages) living above the federal poverty level (as defined for AK).</p> <p>Mississippi SP <i>Strategy:</i> Serve as a “safety net” provider of prenatal care for pregnant women, particularly those in high-risk categories, by offering maternity services through county health departments, targeting women whose income is at or below 185 percent of the federal poverty level.</p>
Race	11	5	<p>New Jersey SHIP <i>Action Step:</i> NJDOH will develop an Office of Health Equity, building on the expertise of the Office of Minority and Multicultural Health (OMMH). The newly established office will ensure that decision making at NJDOH is shaped by the pursuit of health equity and a commitment to ending disparities in New Jersey based on race, ethnicity, gender identity, income and locality.</p> <p>Minnesota SP <i>Goal:</i> 60 percent of staff agree that colleagues they interact with at MDH are comfortable talking about race and racism by December 31, 2019.</p>
Racism	2	3	<p>Vermont SHIP <i>Strategy:</i> Program, Policy and Budget Development – Apply knowledge about bias, structural racism, and other forms of discrimination when developing programs, policies and budgets.</p> <p>DC SP <i>Strategic Initiative:</i> Launch Internal DC Health Dialogue on Anti-Racism.</p>
Social Determinants of Health/ SDOH	16	11	<p>Colorado SHIP <i>Recommendation:</i> Provide data at the smallest geographic level possible and link clinic and population-based health data with social determinants of health data to inform policy development, resource allocation, and program development.</p> <p>Louisiana SP <i>Action Step:</i> Seek new, flexible funding to address social determinants of health.</p>

Term	Number of SHIPs	Number of SPs	Example
Social Justice	1	1	<p>Alaska SHIP <i>Action:</i> Support youth and/or student groups or clubs that focus on helping others in the community, social justice issues or local concerns.</p> <p>Florida SP <i>Objective:</i> By December 2020, the number of DOH employees who completed all three parts of the FDOH Health Equity and Social Justice 101 training will increase from 1,320 to 14,130.</p>
Structural Racism ¹¹	4	1	<p>Vermont SHIP <i>Strategy:</i> Program, Policy and Budget Development – Apply knowledge about bias, structural racism, and other forms of discrimination when developing programs, policies and budgets.</p> <p>Minnesota SP <i>Strategy:</i> Change systems, structures, and policies that perpetuate inequities and structural racism.</p>
Vulnerable Populations	4	4	<p>Arizona SHIP <i>Tactics:</i> Promote and develop focused interventions for vulnerable populations. Action Items: Identify vulnerable populations for asthma and Chronic Obstructive Pulmonary Disease (COPD).</p> <p>New Mexico SP <i>Measure:</i> Percent of cities and counties with Access and Functional Needs (AFN) plans that help prepare vulnerable populations for a public health emergency.</p>

¹¹ Some states referenced “structural inequities” or “structural barriers” within their objectives/strategies, but not “structural racism” Specifically.