DEPARTMENT OF HEALTH

Advancing practice to address health equity: A learning community approach

IMPLEMENTATION GUIDE

December 2018

Contents

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Introduction

To address the root causes of health inequities, public health organizations must transform the way they do business. Health equity leaders in Minnesota and across the country have identified several areas where they need to change existing practice, including data collection, analysis, and use; community engagement; organizational operations, like policies, budgets, and hiring; and policy work.

In 2017, the Minnesota Department of Health (MDH) Center for Public Health Practice, with support from the Public Health National Center for Innovations (PHNCI), launched a learning community with teams from public health departments in six local jurisdictions, to support locally adopting health equity practices. After an in-depth evaluation, the MDH Center for Public Health Practice modified meeting content and launched a second cohort of seven local teams in October 2018.

This document details the approach and the content of the learning community so that any organization can replicate it with others.

Approach

Public health departments have a long history of working on the consequences of health inequities: that is, providing services to disadvantaged individuals or families or working in low-income communities. This is important work, but we know it will not change the underlying social conditions that create and sustain pervasive health inequities. To address the root causes of inequities, public health needs to "transform toward emerging health equity practices" (NACCHO, p. 5).[1]

Minnesota's approach to changing public health practice has three primary components: (1) shared learning through virtual and in-person meetings, (2) team coaching, and (3) local action steps. This approach is grounded in two fundamental principles: first, that the most effective path to change is learning by doing; and second, an outside perspective (in this case, the coach) is necessary to challenge assumptions and the status quo. The components of our approach are described in greater detail below.

Operationally, the work involved a team of two management-level sponsors and four staff (see Appendix: Roles and responsibilities) and was supported by a steering committee of internal and external partners. MDH selected local teams through an application process. Participating jurisdictions were required to create teams of three to five people and include a member of senior management.

Participating health jurisdictions in the first cohort received grants of $12,000 to support the work. With fewer resources available for replication, participating teams in the second cohort received $4,500. During evaluation, the first cohort suggested that these grants were important to local organizations because it brought visibility to the work and helped justify time spent doing the work. For example, one participant shared that "even though it was a small amount of money, we still had to process it through our system, and that elevates it to the county board… It was very helpful for them to know this work is being done." An evaluation of the second cohort will explore whether the different funding amounts affect learning community outcomes.

[1] National Association of County and City Health Officials (NACCHO). (2014). *Expanding the boundaries: Health equity and public health practice*. Available online at https://nnphi.org/wp-content/uploads/2016/09/Expanding-the-Boundaries-Final_508-091814.pdf.

Meetings

The Health Equity Learning Community meetings provided an opportunity to share foundational concepts that everyone needs to advance equity and structured time for team-based learning. The foundational content included material on health equity practices, implicit bias, structural racism, using an equity lens, and community engagement. MDH facilitated three in-person meetings—one at the start, one at the mid-point, and one at the conclusion of the learning community—and facilitated all other meetings virtually via WebEx webinars. MDH facilitated meetings more frequently at the start of the cohort, and then shifted to bimonthly to provide sufficient time between meetings for teams to work within their local organizations.

MDH structured webinars around brief overview presentations, followed by team-based small group discussion, and a full group debrief. The foundational content allowed individuals and teams with various levels of understanding to learn and grow, and the group discussions provided opportunities for individuals and teams to augment each other's learning. Meetings concluded with an opportunity for participants to share resources with each other, and a brief list of next steps.

Whenever possible, MDH asked teams to participate in webinars together, rather than individually, in order to have a shared learning experience. Teams that were not able to do so connected with each other by phone during the small group discussion portion of the meeting. Teams did not use webinars for local project updates, and webinars were not specific to any particular local project or activity.

The second and third in-person meetings provided opportunities for teams to learn from each other's experiences through a series of structured roundtable conversations.

Though presented below in the order they occurred, each individual meeting is intended to be "portable;" that is, any replication of this approach would not need to follow the same sequence. Additionally, each meeting was implemented in the spirit of continuous improvement. The project team evaluated each learning community meeting with a very brief post-meeting evaluation survey, and MDH will continue to adapt and revise meeting content in current and future cohorts. In addition, as more communities adopt equity practices in Minnesota and across the United States, the resources and materials available for teaching, training, and supporting action will grow and evolve.

Meeting materials are available online: MDH: Health Equity - http://www.health.state.mn.us/divs/opi/healthequity/

Meeting sequence	Objectives	Available materials
1. Learning Community kickoff *(webinar, 1.5 hours)*	▪ Create shared expectations for the learning community ▪ Provide grounding in health equity practices ▪ Describe participants' starting places	▪ Presentation: Overview of health equity practices

Meeting sequence	Objectives	Available materials
2a. Introduction to narrative **2b. Using a health equity lens** (part 1 of 2) *(webinar, 1.5 hours)*	▪ Discuss narratives in the field of public health and how they shape our work ▪ Begin to share reflections and questions ▪ Practice using a health equity lens	▪ Presentation: Introduction to narrative ▪ Presentation: Using a health equity lens ▪ Activity and discussion: Scenarios: Using a health equity lens
3. Implicit bias (part 1 of 2) *(in person, 5.5 hours)*	▪ Connect health equity work to public health values ▪ Understand implicit bias and how to address it ▪ Advance plans for initial action steps	*Meeting content provided by contracted consultant and supplemented with facilitated activities* ▪ Exercise: Reviewing organizational mission, vision and values
4. Deepening our understanding of equity *(webinar, 1.5 hours)*	▪ Deepen understanding about equity and social conditions that shape health ▪ Identify opportunities to apply new insights in daily practice	▪ Video: Cliff analogy of health ▪ Video: Allegories on race and racism: The gardener's tale ▪ Video: Allegories on race and racism: Life on a conveyer belt ▪ Discussion guide: Camara Jones videos
5. Strengthening our skills: Applying an equity lens (part 2 of 2) *(webinar, 1.5 hours)*	▪ Recognize the limitations of current practices in public health ▪ Identify concrete ways to do public health work differently ▪ Share helpful resources with each other	▪ Presentation: Seeing things differently: Applying a health equity lens ▪ Scenarios: Applying a health equity lens
6. Community engagement *(webinar, 1.5 hours)*	▪ Increase awareness of the range of community engagement practices ▪ Share an approach to engagement that supports equity ▪ Share helpful resources with each other	▪ Presentation: Community engagement as a health equity practice ▪ Model: Community engagement continuum ▪ Video: Communities driving health equity: PUSH Buffalo ▪ Video: Communities driving health equity: KKV ▪ Handout: Principles of authentic community engagement

Meeting sequence	Objectives	Available materials
7. Implicit bias (part 2 of 2) *(in person, 5 hours)*	▪ Share learnings, ideas, and encouragement ▪ Understand how implicit bias becomes embedded in organizational norms and patterns ▪ Identify strategies for changing organizational patterns	*Meeting content provided by contracted consultant and supplemented with facilitated activities* ▪ Homework: Reflection and learning worksheet ▪ Handout: Ground rules for difficult conversations and talking about race ▪ Article: Elements of white middle-class dominant culture
8. Reviewing organizational policies *(webinar, 1.5 hours)*	▪ Learn how to assess an organizational policy or procedure with a health equity review tool ▪ Gain new insights into how organizational policies and procedures can hinder or advance equity ▪ Share helpful resources with each other	▪ Presentation: Reviewing organizational policies with a health equity lens ▪ Tool: Racial Equity and Social Justice Tool: Fast Track Tool
9. Health in all policies *(webinar, 1.5 hours)*	▪ Connect health issues with relevant polices that affect them ▪ Describe the public health role in influencing policy ▪ Identify the assets and competencies needed to address policies that shape health ▪ Share helpful resources with each other	▪ Presentation slides: Health in all policies as a health equity practice ▪ Worksheets: Health in all policies opportunities ▪ Video: Collaborative health slideshow ▪ Infographic: What is health in all policies?
10. Celebrating and sustaining the work *(in person, 5 hours)*	▪ Connect with others to share ideas and experiences ▪ Reaffirm commitment to advancing health equity ▪ Create a vision for sustaining health equity work into the future	*Meeting content provided by contracted consultant and supplemented with facilitated activities* ▪ Roundtable conversation starters ▪ Envisioning health equity: Individual reflection

Coaching

Individualized support for local health jurisdictions is one of the MDH Center for Public Health Practice's primary responsibilities. For most content areas, this support follows a traditional consultative model: state staff with expertise in a specific content area share tools, resources, and information with local partners and respond to specific questions.

Given the complex and emergent nature of health equity work, MDH opted for a different approach. For health equity, there are no ready solutions, no easy answers, and no straightforward pathways. Instead, support for local health jurisdictions needs to provide space for reflection, learning, and real-time course corrections as public health professionals learn new practices and approaches to their work—needs better met through coaching than consultation.

In essence, coaches ask questions to draw out the knowledge and wisdom that exists in an individual or group and facilitate new learning—coaching releases the potential of an individual or group to find their own solutions and enables learning and change. In other words, it helps "unlock what is already present in people and groups and helps them frame their own solutions" (Emery, Hubbell, and Miles-Polka, p. 9).[2] Coaching provides a forum for asking powerful questions to drive action and facilitate learning. In the context of the learning community, coaching provided accountability for action and helped learning community participants actively engage with equity in a more meaningful way.

Prior to the learning community, the coaches underwent specific training that prepared them for this role. For example, coaches are well versed in the Technology of Practice Focused Conversation Method - https://icausa.memberclicks.net/top-focused-conversation, which shares a similar emphasis on asking questions to facilitate creative thinking and elicit new ideas. In addition, consultants facilitated training in coaching methods for all staff. At the start of the learning community, staff identified as coaches for the project participated in a coaching "refresher" using internal training and development resources. Coaches also borrowed concepts and ideas from World Institute for Action Learning - https://wial.org/action-learning/ and Human Systems Dynamic Institute Adaptive Action - https://www.hsdinstitute.org/resources/adaptive-action.html to guide their approach.

The coaching process had the following characteristics:

- Each coach worked with a team, rather than an individual.
- Coaching meetings were most frequently held by phone, and occasionally facilitated in person. Most meetings lasted an hour in duration, but some were longer depending on local needs.
- Coaches met with local teams once each month, often with additional email communication between meetings.
- Coaches supported each other through regular "coaches' meetings," where they shared ideas and experiences with each other.
- There was no coaching "script."[3] Each coach was equipped with a set of potential questions that could be used in different circumstances, but they were also free to adapt questions and generate

[2] Emery, Mary, Ken Hubbell, and Becky Miles-Polka. (2011). *A field guide to community coaching*. https://cyfar.org/sites/default/files/cyfar_research_docs/A%20Field%20Guide%20to%20Community%20Coaching.pdf

[3] For sample questions, coaches used internally developed resources. Sample coaching questions can be found in the following resources:

their own. Coaches prepared for each meeting by thinking about what questions were pertinent at the time, whether the team was just getting started, in the middle of implementing something, or having just completed an activity.

- Coaches used a separate note-taker for most coaching calls. This allowed the coach to focus on active listening and asking questions.
- Coaches did occasionally move into more of a "consultative" role when necessary, particularly for teams with little previous knowledge of equity concepts. In those instances, coaches had some flexibility to be more directive than is typical in a true coaching relationship.

Coaching proved to be the most valued aspect of the support provided through the learning community. Participants reported that it was helpful to "have somebody just help circle us back around, keep us on track, and walk alongside us." The coaching element provided added accountability for action as well as a more individualized experience.

Steering committee

Advancing health equity requires acknowledging implicit bias at the individual level and the biases that have been embedded in systems and institutions. The MDH Center for Public Health Practice created a steering committee to correct for its "blind spots" and tap into the experience and wisdom of others. The committee consisted of internal and external partners with knowledge and experience in organizational transformation and health equity. Steering committee members advised project leadership on learning community activities, shared expertise and resources, and made connections to other health equity efforts as appropriate.

The committee met quarterly. Steering committee members shared resources that were integrated into learning community meetings, and MDH relied on members' expertise to help think through and interpret its own actions and experiences. The steering committee helped MDH frame learning in a larger context and conveyed the urgency of this work. Its passion and commitment reinforced that of MDH.

Evaluation

MDH evaluated the learning community in order to document lessons learned; identify successes and challenges of adopting new practices; provide rapid feedback about learning community activities; and inform broader transformation of Minnesota local health jurisdictions toward health equity practice.

- Stanfield, R.B. (ed.). (2000). *The art of focused conversation: 100 ways to access group wisdom in the workplace (ICA series)*. New Society Publishers.
- Zenger, J.H. & Stinnett, K. (2010). *The extraordinary coach: How the best leaders help others grow*. McGraw-Hill Education.
- Hubbell, K. & Emery, M. (2009). *Guiding sustainable community change: An introduction to coaching*. Coaching for Community Change Initiative. Retrieved from: http://www.ncdsv.org/images/CC_GuidingSustainableCommunityChangeAnIntroToCoaching_5-2009.pdf
- Emery, M., Hubbell, K., & Miles-Polka, B. (2011). *A field guide to community coaching*. Retrieved from: https://cyfar.org/sites/default/files/cyfar_research_docs/A%20Field%20Guide%20to%20Community%20Coaching.pdf

Evaluation activities were braided into project activities from the outset. Each learning community meeting was evaluated with a brief survey following the meeting. The feedback from these surveys shaped subsequent meetings and refinements to the overall approach. Other evaluation strategies included:

- Opportunities for reflection built into in-person meetings
- Qualitative interviews with individual teams and a group interview with team leads.
- Notes from facilitated conversations with the MDH Center for Public Health Practice's planning team

Evaluation materials are available upon request, including interview protocols, meeting evaluation surveys, and the broader evaluation plan.

Acknowledgements

This work would not have been possible without the support of the Public Health National Center for Innovations (PHNCI) and the Robert Wood Johnson Foundation. The time, talent, and resources provided by PHNCI gave MDH the necessary infrastructure and support to test its approach and catalyze transformation towards equity practices across Minnesota.

Special thanks also to the learning community steering committee, including Maria Regan Gonzales, Senior Program Manager of Community Initiatives at Blue Cross Blue Shield Minnesota; Kathy Hedin, Healthy Communities Division Manager, St. Paul-Ramsey County Public Health; Bruce Thao, Director of the MDH Center for Health Equity; and Kim Edelman, Research Scientist with the MDH Office of Statewide Health Improvement Initiatives.

Finally, MDH would like to thank Sarah Hernandez, Director of Policy for the Colorado Office of Health Equity; Jacques Colon, the Health Equity Coordinator at Tacoma-Pierce County Public Health Department; and the many others who generously shared their time, tools, and materials they have developed for advancing equity in their departments.

Appendix: Roles and responsibilities

Project director

Supervise the project; participate on the planning team and steering committee; engage partners to support the work plan.

Project manager

Provide leadership for the planning team, coordinate the project steering committee, and support for the coaches; coordinate and manage all aspects of the project to assure goals and objectives are met; represent the project internal and external partners.

Project planning team

Participate in planning and implementing project activities to meet work plan objectives, including:

- Shaping the learning community structure and content
- Leading portions of learning community meetings as needed
- Reflecting on data to inform real-time course corrections
- Synthesizing lessons learned to inform project deliverables
- Participating in evaluation activities or other opportunities to document results, experiences, and lessons learned

Time commitment: Monthly check-ins (1.5 hours) and occasional one-on-one or small group meetings to provide input for specific activities as needed; approximately 1-3 hours/month of desk time for meeting preparation, reviewing materials, or communicating with the team; 1-2 hours/month to participate in virtual learning community meetings; 6-12 hours to participate in face-to-face learning community events (2/year).

Total: 4-7 hours/month (average).

Steering committee

Advise project leadership on learning community activities and strategies. Share expertise related to advancing health equity and supporting change in systems and organizations. Make connections to other health equity efforts as appropriate.

Time commitment: Quarterly in-person meetings (1.5 hours/each); periodic desk work for communications, reading and reviewing materials and email communications; occasional conference calls in between as needed.

Total: 3-5 hours/quarter.

Coaches

Act as primary point of contact for health equity content, tools, and resources. Arrange and facilitate monthly meetings (by phone or in-person) to coach local teams through their efforts to adopt health equity practice(s). Communicate with teams between calls as needed. Provide tools, information, or other resources available through the resource library. Serve as a guide to support LHJs in changing their practice: Encourage and challenge them, provide technical assistance, and go onsite at least once during

the project period. Document coaching activities and LHJ progress, challenges, and successes as needed to contribute to project evaluation and deliverables. Participate in meetings with other coaches to address questions or challenges as they emerge.

Time commitment: At least monthly coaching calls (1 hour/each); monthly coaching team meetings (1-2 hours/each, variable); desk work to communicate with LHJs and other project team members; and identify tools or helpful resources (3-6 hours/month, variable).

Total: 5-8 hours/month (expected to start high and lessen after startup).

Evaluator(s)

Lead evaluation activities for the project. Develop and implement an evaluation plan and coordinate evaluation activities with the project director and other appropriate staff. Gather, analyze, and synthesize data to produce case studies, reports, or other products.

Time commitment: Variable.