APPENDIX F1: 2023 Health Equity Policy

Health Equity Policy 2023

Philadelphia Department of Public Health, Division of HIV Health

I. Purpose

The purpose of this policy is to provide high level guidance for prioritizing and including health equity as practice in all policies, programs, procedures, services, surveillance, data, interventions, and initiatives in the Division of HIV Health at the Philadelphia Department of Public Health. Following these equity-based guidelines therein, DHH staff and leadership will collaborate internally and with community partners/stakeholders to develop programs, initiatives, services, work plans, and engagement that advance health equity as a primary goal.

This policy, along with a health equity guide and strategic framework will serve as the centralized foundation to operationalize and institutionalize health equity in DHH's services, programs, and initiatives, improving upon the goals and accomplishments in all respective areas.

II. Background

At the time of this policy's original drafting, Philadelphia has a population of over 1.5 million residents[1] making it the 6th largest and the 5th most populous city in the nation[2]. The average household income in Philadelphia is $65,090 with a poverty rate of nearly 25%[3]. 11-14% of Philadelphia's population identify as immigrants/foreign born, one-fifth of whom are recent arrivals since 2000, along with 23% of Philadelphia households speaking another language at home[4] (*Note: It is not to be presumed to exclusion that households that speak another language identify as immigrants.*) 42% of the city is Black, 41% White, 7% Asian, and 9% another or two or more races[5] (*Note: Latinx/Hispanic was divided amidst these racial groups but is approximately 14% of the population.*) 49% of the population has obtained a high school degree or less, and the leading number of bachelor degree or higher holders are White with the lowest acquisition among the Black community[6]. For those most impacted by poverty, Black, Latine/Hispanic, and undisclosed non-White communities are at the highest probability,

[1] *US Census Annual estimate*
[2] *US Census City/Town Population estimates*
[3] *2014-2018 American Community Survey 5 Year Estimates*
[4] *2014-2018 American Community Survey 5 Year Estimates*
[5] *2014-2018 American Community Survey 5 Year Estimates*
[6] *2014-2018 American Community Survey 5 Year Estimates*

Department of Public Health

compounded further by gender, with women and people with disabilities being overrepresented as distinct groups in poverty and being the leading groups experiencing unemployment[7]. in 2018 there were 1100 unintentional drug overdose deaths in Philadelphia which is a doubling of these deaths in the past decade[8].

All of these disparities (along with a variety of others that have not been listed above to maintain brevity in this document) are expected to further expand as we continue to traverse the ever-shifting landscape of the largest global public health crisis in over a hundred years. It is vital that in the wake of being shown nationally how egregiously we have failed to build systems that lift people beyond social determinants, what currently exists is a breeding ground for health inequities that target, make invisible, and harm marginalized and vulnerable groups. This policy serves as a foundational step for the team within DHH and its community partners to begin and continually focus their efforts and intentions beyond the disparities, aiming at where they foment first by addressing the systemically created social determinants of health inequity.

III. Glossary of Terms and Key Concepts

(Note: The following terms and key concepts appear as they are defined by the Michigan Health Equity Roadmap, 2010)

Social determinants – refer to social, economic, and environmental factors that contribute to the overall health of individuals and communities.11 Social factors include, for example, racial and ethnic discrimination; political influence; and social connectedness. Economic factors include income, education, employment, and wealth. Environmental factors include living and working conditions, transportation, and air and water quality. A focus on health equity in Michigan calls for more targeted efforts to address these and other social determinants of health in order to optimize health promotion and disease prevention efforts.

Health disparities - significant differences in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates in a racial or ethnic minority population as compared to the health status of the general population.8 Health disparities refer to measured health differences between two populations, regardless of the underlying reasons for the differences.

Health inequities - differences in health across population groups that are systemic, unnecessary and avoidable, and are therefore considered unfair and unjust. Health inequities have their roots in unequal access or exposure to social determinants of health such as education, healthcare, and healthy living and working conditions. Racial and ethnic minority populations are disproportionately impacted by poor conditions in these areas which, in turn, result in poor health status and health outcomes.

[7] *2014-2018 American Community Survey 5 Year Estimates*
[8] *PDPH Combating the Opioid Epidemic Report*

Health equity - the absence of systematic disparities in health and its determinants between groups of people at different levels of social advantage. To attain heath equity means to close the gap in health between populations that have different levels of wealth, power, and/or social prestige. For example, low-income persons and racial/ethnic minorities generally have poorer health relative to people who have more economic resources or who are members of more powerful and privileged racial groups. Health equity falls under the umbrella of social justice, which refers to equitable allocation of resources in society. Eliminating health disparities and health inequities between racial and ethnic populations moves us toward our goal of health equity and social justice, and a significant focus of this effort is to address social determinants of health that influence our priority public health outcomes.

IV. Division of HIV Health Equity Values

Note: "Values" as they are defined when applied to an organization or systemic entity are the standards and norms by which they are meant to operate and be held accountable to.

a. Commitment to the ongoing pursuit of narrowing and subsequently eliminating health inequities in HIV prevention, surveillance, and care management as they occur in programming, initiatives, inclusion, and access at DHH and our related provider agencies

b. Equitable access to and provision of HIV related resources that are written at a low literacy level

c. An organized, replicable health equity lens and foundation at all levels of and in all services provided by DHH and its partner provider agencies, with a consistent systemic application of these policies and frameworks

d. Inclusion of and adaptation to new well sourced and researched knowledge, information, and data, with an investment in innovative ways of executing programming and providing services at DHH and our partner organizations/provider agencies

e. A commitment to collaborating and sharing resources across programs, Divisions/Offices, and city departments as it pertains to advancing equity-based goals

f. A commitment to making community engagement program and initiative decisions that are community focused, collaborative, and inclusive with a centering of marginalized/vulnerable populations needs, barriers, opportunities, and input

g. Ongoing, competent, and intersectional diversity and inclusion assessment and training as a key component of workforce development for DHH leadership and staff

h. Addressing internal biases in hiring, promotion, programming, processes, and goals and holding the same accountability and standards with our partner organizations/provider agencies

i. Sound equitable stewardship and distribution of fiscal resources for greatest and most expansive community inclusion and impact

j. Accountability through measurement, ongoing honest assessment, and quality management

k. To set a strong example and be a leading champion of health equity practices in the Philadelphia Department of Public Health

V. Guidelines and Standards for Operation

1. Apply a health equity lens to current and new HIV prevention and care programs, policies, initiatives, data collection processes, services, and interventions to ensure they include public health actions that intentionally disrupt systemic inequities and inaccessibility in the community and centralize inclusivity of marginalized/vulnerable populations.

2. Ensure and fortify current and new programs, policies, initiatives, data collection processes, services, and interventions so they do not further or perpetuate health inequities in HIV prevention and care services.

3. Provide institutional means through grants, resources, and access to support through a health equity team or leader for community-based organizations and individual community members to utilize so they can integrate inclusion and participation in decision-making for programs, policies, budgeting, initiatives, data collection processes, services, interventions, and materials.

4. Include intersectionality driven health equity and social determinants in community needs assessment, improvement planning, surveillance, and other monitoring efforts of community health status.

5. Provide health education/presentations, community engagement events, and other public information opportunities about community health status, our successes and challenges in our goal to end the HIV epidemic and needs in the context of intersectional health equity and HIV prevention and care (e.g., focused on systemic determinants vs. focusing solely on individuals' health behaviors and choices).

6. Utilize opportunities to educate program participants and community members on social determinants of health that relate to HIV (clients, users, customers, etc.) so they can become self-advocating and collaborative in the community health programming they engage and so they can identify moments of bias or inequities and hold service providers accountable.

7. Establish, benchmark, and report on providers and grantees inclusion and expansion of health equity practices and policies as part of a performance and quality improvement system.

8. Maintain an assessment of workforce diversity and apply strategies for active recruiting and hiring a workforce that reflects the demographic, cultural, and linguistic characteristics of the populations we serve within DHH and at our partner organizations/provider agencies.

9. Engage the community, partners, and other interconnected departments at PDPH in strategic, collaborative partnerships to develop health department wide policies for the purposes of addressing and eliminating health inequities.

10. Support an ongoing, intersectional, staff and professional development within DHH, PDPH, partner organizations/provider agencies, and grantees that aspires to the attainment of core competencies in health equity and cultural competency that are rooted in intersectionality.

11. Track and monitor the delivery of services and budgeting internally and with partner organizations/provider agencies to ensure equitable distribution so marginalized/vulnerable populations have equitable access.

12. Each partner organization/provider agency and grantee will collaborate both with DHH to develop written plans that operationalize and advance health equity goals in their respective areas. Every partner organization/provider agency receiving grants and/or funding from DHH will create and adopt a health equity policy and operational framework from which they design out future HIV programs, initiatives, budgeting, and services.

13. Prioritize the utilization and support of partner organizations/provider agencies that meet our standards criteria and are led, run, and centralize marginalized/minoritized populations

14. The following list of systemic, social determinant related issues that are outside the purview of DHH but greatly affect the experience and health trajectory of individuals living with HIV as well as an individual's risk of seroconversion is provided here for DHH staff and leadership to have guidance on advocacy if/when DHH is utilized in an advisory role to other departments, offices, or city leadership on programming, initiatives, and support services.

a) Supporting endeavors and programs that center equitable living conditions and advocate creating affordable, stable, accessible, long-term housing

b) Promoting healthy prevention-based lifestyles, activities, wellness, and self-care that take into consideration and tailor programming to include culture, religion, socioeconomics, housing security, literacy, and accessibility

c) Promoting equitably designed STI prevention and services with the inclusion of harm reduction models when possible

d) Surveillance and assessments that (when possible and safe to those communities to collect with anonymity and the ability to opt out of revealing) include

sexual identity, expansive gender identity options, socioeconomic status, disability status, and immigrant status

e) Promoting internal social and institutional equity as it relates to hiring, pay, promotion, and project team leads both at the city and community partner organizations/provider agencies

f) Promoting equitably designed substance abuse prevention and services with the inclusion of harm reduction models when possible

g) Supporting and encouraging equitable budget development processes, with an end goal of participatory budgeting design implemented in programs

h) Promoting the adoption of equity-based policies, guides, frameworks, and strategic plans that are bespoke to those departments, offices, community partners, and community members

i) Supporting expansive, intersectional, coalition building amongst partner organizations/provider agencies

j) Supporting expansive, intersectional, collaboration and coalition building amongst city departments

k) Supporting and encouraging the utilization of cultural, inherent/marginalized identities, and religion-based organizations, practices, beliefs, and systems to design outreach, engagement, information distribution, and community initiatives

l) Promoting a reading comprehension and multi-language translation standard for distributed materials, information, websites, social media, and all other places written text is utilized that is consumable for those with intellectual disabilities, English as a second language, and low literacy and/or visibility

ADVANCING ORGANIZATIONAL EQUITY TOOLKIT

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