Transcript

Hi. Thank you for joining us today.

We're going to be talking about partnering to advance health equity, working within and across organizations. Next we would like to thank our funding sponsor, the US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, who supports both the Children's Safety Network and the National Center for Fatality Review and Prevention.

Next our presenters today are myself, I am the director of the Children's Safety Network and Education Development Center. Jenny Stern Carson, the Associate Director of the Children's Safety Network and Education Development Center. Susannah Joy, the project coordinator at National Center for Vitality Review and Prevention And we don't have more on my case here today, but she is one of our partners, and she is the director of research at Safe Kids Worldwide.

Next.

And here are the titles of our respective organizations.

And we all come together under a national alliance called a Children's Safety Net Alliance.

This is an alliance of federal partners, state agencies, hospitals, universities and national organizations, all committed to supporting the health and well-being of children and adolescents ages zero to 19.

We do this through support of Title five agencies or departments of Public Health by developing resources and offering training and technical assistance across a number of child safety topic areas. Next the workshop objectives for today are to define health equity, describe strategies to improve health equity and inclusion both within and across organizations. And to share two resources with you that we will walk through and we will then take your questions about those resources. Next I'm going to talk a bit about health equity and disparities in inequity definitions next. So we often find that people find the umbrella term health equity to be very broad, and they say, where do we start working? We find that it is very important to start by having a common definition both within your own organization, among colleagues, but also across your partner organizations.

You also want to think about who are your partners. How can you leverage those partnerships and do you need to be establishing new partnerships?

Leadership support is critical.

Having leaders who are supporting the initiative, devoting resources to this initiative and really fostering a culture of inclusion both within and across organizations is important.

There are a number of tools and resources that you can draw upon, such as health equity frameworks and guides in New York over some of those today, as well as knowing where to access data.

Where to start to develop plans strategic plans.

Operational plans that can move you toward achieving health equity. You want to ensure that your capacity of the capacity of your staff is up to speed. You want to develop your workforce so that they are all ready to take on this challenge.

And you want to make sure that there's adequate financial support so that your efforts can be sustained. Next, a definition of health equity that we like to use is by Whitehead and Dahlgren.

Health equity is the attainment of the highest level of health for everyone. And no one is disadvantaged from achieving this potential because of any socially defined circumstances. Addressing the role of social determinants of health such as economic and social conditions in the places where people live, learn, work and play can advance health equity and child safety work Next there is a distinction between health inequity and health disparity. When we talk about inequity, we are talking about those avoidable differences in health outcomes.

Those avoidable differences are because something unjust or unfair is taking place.

And the key question that we ask is whether the disparity in the rates are due to differences in social, economic, environmental or health care resources. When we talk about a disparity that is talking about the differences in health outcomes between the groups and the question is, is there a difference in rates between that population, between those two populations. Next. When we talk about injury disparities, especially within the Children's Safety Now Alliance, we are talking about disparities by race and ethnicity, as well as a number of other social determinants of health.

I'm going to give you some details that we have pulled together for you today. Racial and ethnic differences are noticeable across injury and tend to type Unintentional injuries mean accidental injuries from various causes such as motor vehicle traffic poisoning.

Firearm fire and burn drowning. Cutting, piercing suffocation and false homicide refers to increase that are inflicted by another person with the intent to injure or kill. Suicide includes intentionally self-inflicted injuries that result in death injury deaths that have insufficient information to identify, intent, type, or labeled undetermined. The number of legal intervention related injuries are too small to look at separately.

So those have been combined with homicides for this term. Unintentional injury rates and suicide rates are highest among American Indian.

Alaskan Native children and adolescents.

Unintentional injury and suicide rates in American Indian Alaskan Native children and adolescents are approximately twice the rate of their white counterparts. Black children and adolescents have the highest homicide, injury, death rates, homicide, death rates, and black children and adolescents is nearly eight times the rate of white children and adolescents.

Unfortunately, disparities persist among U.S. children and adolescents ages zero to 19.

Despite the improvements in injury prevention achieved through identification and implementation of evidence based and evidence informed practices, we see injury differences across race, ethnicity, sex, socioeconomic status, sexual identity and orientation.

Urbanicity, Health, Literacy and Disability.

Next, please So we ask ourselves, how do we identify these disparities?

We start by looking at data.

There is no one data source that can give us a complete picture of health disparities and health equity issues.

This is part of the challenge.

So we rely on multiple data sources.

There are a few data sources listed here for reference.

We look at national and local level data on deaths, hospitalizations, and emergency department visits as they are made available. We also look at surveys that provide information on risk factors and protective factors at the individual level and also at the broader community and societal levels. Use of multiple data sources allows us to understand not just the type of individuals who may be at higher risk for injuries but also the context in which they live, work and play, and how those conditions may be affecting them. Next in order to advance health equity among children and adolescents, we need to eliminate the health inequities.

And this requires a public health approach.

We need public health leaders, practitioners and partners to adopt a systems approach in a health equity lens. As we deliver child safety programs, and services, we have a number of frameworks that are starting to be disseminated widely.

But we have to that we want to talk about today. One is to help equity planner to implement and spread child safety strategies in communities.

And this is for use at a program level or an organizational level.

We also want to talk about the resource that is for use across partner organizations.

And this is the Health Equity, Diversity, Equity and Inclusion Assessment Guide. For Multidisciplinary teams. Next, we're now going to hear from Jenny Stern Gerson on resources for advancing health equity by focusing on your organization and programs work. Thank you, Jennifer.

I'm going to provide a brief overview of the structure of the Children's Safety Network's Health Equity Plan to implement and spread child safety strategies in communities. You can use the scan code you see here on the screen to access this resource and download it from the CSN website.

In this planner, we are trying to offer you a practical approach to health equity and a means to break down this topic into manageable components.

The health equity planner is organized in five sections.

Social determinants of Health.

Scope of Work. Leadership and management.

Child Safety.

Expertise and Systems Improvement.

Throughout our work at CSN supporting Title five agencies, we have found that using a quality improvement approach produces both successful and sustainable results.

You will see that each section has a series of detailed questions

that follow the three phases of quality improvement.

The first is to assess your current situation

The second is to plan your work and test your child safety strategies and programs, making sure that they fit to your local context. And the third phase is monitoring your work and making necessary revisions and adaptations based on data Building up the feedback from our testing experience with several Title five agencies, the health equity planner is designed to be used flexibly as best suits each unique setting.

We know that health equity is a very large topic, and we've heard from many states that the idea of even trying to address it can feel completely overwhelming.

And most often, states say they don't even know how to start or where to begin. So we've tried to design the planner so that you can use it as best suits your situation, as Jennifer noted.

It can be used on either a department or agency or organizational level or it can be used at the program and work unit level. You can choose to fill out the planner as an individual, consulting with others and proceeding on your own or bringing together your team and working on it as a team effort. You could also work through the planner sequentially through all five sections and do each section from start to finish.

Or you could start with any one section that is most important to you and move on to other sections as they are most relative to your work, and use the planner section by section over any period of time.

Similarly, you can breakdown your approach by phases as well.

Really, what we hope more than anything is that this planner will enable you to take that first step towards integrating a health equity focus in your work and in the spirit of quality improvement, just really about getting one foot in front of the other, one step at a time, and being able to adapt, adapt or abandoned processes along the way to help you move forward.

The planner is designed as a fillable PDF, and that's intended to be a living document that you can start working on and return to as often as needed to update and continue. Thus, being able to continue working towards integrating health equity into your work overall the overarching questions in the planner that apply to all five sections are what social determinants of health most affect the communities that you serve. Does your department or program have a shared aim statement for addressing health inequities?

Do your partners share the same statement? Who will champion an institution analyze health equity in your department or program?

And how will you do that?

Are you engaging a diverse community of stakeholders or partners and spreading evidence based in evidence informed, culturally tailored child safety strategies?

And what indicators will you use to assess progress on reducing inequities? Now, I'd like to delve into one of the sections in greater detail to give you a sense of how the plan or works. Each section of the planner follows a similar layout, taking a closer look at the Social Determinants of health section. The planner guides you to start your process by gathering data and clarifying the specific disparities that impact your target population and thus drive the necessity to address health equity.

Understanding of the social determinants of health that affect the communities and populations we are trying to serve is very important because those can point us to where we see issues like housing, quality and access to services, economics, discrimination, and so forth.

Sometimes we have to work with our epidemiologists or data managers who might be on our team to be able to obtain relevant or proxy data in order to understand the role of the social determinants of health and the impact on the population we're focusing on. For example, when trying to ascertain economic stability, this could be based on indicators such as families living in poverty or food insecurity and hunger in the community.

Understanding education, access and quality can be determined by proportion of high school students who graduate in four years or looking at middle school and high school reading skills and math skills in school readiness, health care, access and quality can be based on the proportion of children receiving preventative care or examining access to health insurance. The neighborhood in built environment might be assessed

by looking at toxic pollutants or hazardous sites, or maybe the propensity for alcohol outlets in the community. As practitioners, we all know that the data should be put in context and interpreted to identify health inequities.

The planner design is intended to help you walk through this thought process and then to identify next steps

Next, the planner outlines a series of investigative queries to help you dig deeper into the data and understand how to most effectively leverage the information you have to progress your equity work and engage your partners.

The first is the access phase.

This guides you to do a broad landscape assessment of the data needs and potential next steps.

As I mentioned before, the design of the planner allows for you to complete it as a department or agency or as a program or work unit, and the physical PDF enables you to add as much data to each cell as needed and will begin to scroll to allow for that space. And it's always available for you to go back edit and change and add to as needed as a living document.

The next phase is the plan and test phase.

Here you'll see guiding questions to help you drill down into which data is specifically relevant to your focus, and then again prompting you to think beyond the moment and consider how will you engage your partners to progress your work The final phase is monitor, revise and adapt.

Here we see prompts guiding you to consider how the data is informing your work and where there are potential gaps or missing data that you should consider. Then, as always, the planner prompts you to consider how to progress your work and clarify what next steps are needed I'd like to share with you an example of the health equity planner in action.

The Nebraska Injury Prevention Program has been working to expand their existing motor vehicle safety work and using the planner to better understand the unique culture and factors within targeted communities. Following completion of the pilot effort with two initial communities that they have identified.

The team intends to replicate this process with other high need communities across the state to address unique needs with evidence-based approaches.

The team worked through the assess and plan phases of the Social Determinants of health section of the planner working with an epidemiologist using the Crash Outcome Data Evaluation System or codes.

They began running data in various ways to get a good picture of what is going on around teen drivers in their state.

They looked at the rate of youth related crashes and specific crash characteristics, such as the rate of speed the involvement of alcohol and so forth. They are also using the

social determinants of health, of socioeconomic status, race and ethnicity, geography and age to further refine their data. Additional analysis included examining the data by miles traveled and also by registered team drivers.

Each analysis, using these different layers of data and focus has given them a slightly different picture that they've been able to layer upon layer and really pinpoint their highest priority counties and understand what the priorities are specific and unique to those counties. As a result, they have identified two initial counties to pilot their approach of going deeper into the health inequities and to determine a health equity based strategy and approach to implement evidence based gene driver safety programing and interventions. The reflective process of using the health equity planner has enabled the Nebraska team to really expand how they consider identifying and engaging their community partners.

And this is a new awareness that they've had.

Having worked with community partners over such a long time that engaging them through a health equity lens will bring a completely new and different effect. Specifically, as a result of using the planner, they are looking more broadly at their scope of work, not just focusing any longer on merely program implementation, but instead now also looking at what community needs are and assessing resources, partners and data that will be most helpful in the situation.

For example, they're looking at what is the access to driver's education like in this specific community, or what sort of knowledge do the parents in this community have about driving restrictions or how do we increase the number of schools that are doing Evidence-Based Driver education programs such as teens in the driver's seat and advocate for improvements to graduate and driver licensing laws based on the needs and the resources in this community. Using this approach has enabled them to expand their partnerships and work effectively with communities to apply quality improvement methods, to test evidence based and evidence informed practices and programs in a unique setting. And the planner has helped them to integrate health equity considerations, collect feedback, and appropriately adapt their work to best serve the targeted population. Overall, the team is reflected that the planner keeps health equity as an important focus of a process that they've been doing for many years and been doing well, but now are seeking to improve and to spread into new areas.

I'd like to now invite my colleague Susanna Joy from the National Center for Fatality Review and Prevention to share the tool that they're leading in their development to work across multiple sectors.

Susanna Joy.

And hello to those of you who joined our presentation today. As Jennifer shared, I am Susanna Joy, and I'm coming to you today from the National Center for Fatality Review and Prevention.

We are the federally funded resource center that supports child death review or CDR and Fetal and infant mortality review or FIMR teams across the country. And I'm joining you today from mid-Michigan, where the National Center sits within the Michigan Public Health Institute.

These teams that I've mentioned, similar to multidisciplinary injury prevention coalitions are made up of professionals from diverse disciplines who provide community services, serve families or provide health care.

A typical CDR team might include representatives from pediatric medicine, maternal child public health and injury prevention program, child welfare and social services, Law Enforcement and often the medical examiner or coroner from a community. Other common partners include schools frequently or community mental health and community advocacy groups. The teams use a variety of records to understand the story and context in which a child in their community lived and died working to identify risk and protective factors, potential points of intervention, and ultimately to make improvements in their communities.

Systems to increase safety and decreased risk. I think to those of us at AMCHP, it may go without saying that this is a profound opportunity to both identify inequities in our communities and work through prevention recommendations to advance equity and improve outcomes. But an issue that CDR teams and other multi-disciplinary teams in this space, like injury prevention coalitions and safe kids coalitions, something they all face is that health equity approaches that we know are key to making a real difference may not be fully understood by the diversity of partners that are represented on these multidisciplinary teams. Next, any of the resources I'm going to share with you today has been developed with these multidisciplinary teams in mind.

What our teams found and what we know is that there are many excellent resources to assess and support individual organizations or teams in their efforts to improve the practices of diversity, equity and inclusion internally, including the release that Jenny just shared with the health equity planner. But these multidisciplinary teams that we think are so vital to improving communities and making them safer are sort of a different animal. And there really weren't resources to support this type of a diverse, multidisciplinary team in their efforts to understand the landscape of these different partners and to ultimately align their understanding and efforts across these varying agencies. Specific contexts and multidisciplinary teams needed a tool that considers the group as a coalition of diverse partners and not just one organization working with one leadership, one funding stream and one set of policies.

They really needed a way to understand the diversity of orientations that team member organizations have.

So to fill this gap, the Safe Kids Worldwide Children's Safety Network and the National Center have come together to develop health, equity, diversity, equity and inclusion assessment guide for multidisciplinary teams. It is a discussion based resource designed to help yield insights into ways partner agencies approach DEI in their home agency.

Context, and guide multidisciplinary team participants to move beyond the internal agency level focus of DEI to the examining of the broader context of the multidisciplinary team. Next one of the foundational concepts we defined and tried to drive home throughout this resource is this difference between the home agency and multidisciplinary team. You can see here that we define

the home agency as the agency or organization that employs staff who serve often as agency level assigned fees on external multidisciplinary teams, coalitions or task forces, and examples of home agencies might be public health agency, a child welfare agency or law enforcement agency. And then the multidisciplinary team is this working group with representatives from multiple home agencies in the community.

So if I was a representative from my community's Infant Safe Sleep program, the local health department may be my home agency, while the Safe Kids Coalition that I serve on might be my multidisciplinary team next as we conceptualized the resource and we built it on the framework of the social ecological model, with which I'm sure many of you are familiar due to the nature of the multidisciplinary team's work. The guide really focuses on the organizational community and public policy levels of the social ecological model.

While biased and prejudice show up at the individual level, the model and discrimination can happen between individuals at this interpersonal level. What we find at the organizational community and policy levels is that the environment, cultural values, norms and policies that impact the community can be leveraged to either advance equity or they can reveal institutional and structural oppression for certain populations. Ideally, these organizational community and public policy levels are where these multidisciplinary teams like CDR Injury Prevention Coalitions, are doing their work at the systems level.

So I'm thinking about how this resource could fill the need in communities.

That's where we decided to focus. Next. The guide itself consists of an introduction and an extensive glossary of key concepts and terms that we provided to sort of level set across the membership. Organizational level questions are then included, and they focus on the team members, home agencies,

Then there's a series of community level questions that focus on the home agencies, the multidisciplinary teams, and the broader community and the relationship between those different bodies. And then the public policy related questions are the final section in the guide for discussion and then it wraps up with a place for team members to work through next steps from issues that they may have identified through those discussions. Next. So last year, this work group that I mentioned and provided a draft version of this guide resource to several multi-disciplinary teams across the country and engaging them and their teams in a pilot process to inform the final version of this guide. It was, and the pilot was held for two months and we provided extensive technical assistance to participating sites.

We also engaged Dr. Terry Wright as an equity consultant to support us through the development of the guide We solicited feedback from pilot sites in multiple ways. I'm taking a particularly deep dove into the experience from the perspective of site leaders who facilitated the use of the guide with their teams based on their feedback and the feedback of their team members. We've made some significant improvements to this resource, including the inclusion of a facilitators guide.

And currently we are finalizing the final version Next, I'll briefly go over some of the content of the guide.

I don't know if that slide is progressing. Jimmy or if I'm frozen as I mentioned, after the key concepts and terms glossary, teams will be prompted to focus on the organizational level questions and here's where we're really hoping to get a sense of the DEI context in the home agencies.

Identify what's going well, what opportunities may exist, and then what kind of resources could support home agencies in their DEI practice? The second section is the community focused questions, and it uses discussion to explore the ways the home agencies are connected to and responding to the community, how they're identifying and responding to inequities when they find them, and how health equity is discussed in the community and approached by the home agencies. The section seeks to prioritize the experience of the community as it relates to interacting with partners Next, the third discussion section focuses on the ways in which public policy may impact health equity in the community. One of the things that we heard in our pilot is that this was very important to partners and very interesting and something they wanted to learn from and understand but that many of the teams were not well versed in the relevant public policies. So several of our pilot sites recommended that we guide facilitators to consider engaging with community partners or even internal agency level partners who may have subject matter expertise in relevant state and local policy and their relationship to health outcomes. So that was an important thing we learned through the process of our pilot. Next. Finally, the discussions in the guide will shift to sort of what do we do now? Team members are asked to take the team's key takeaways from the organizational community and policy discussions and consider what the team should do to respond to issues that were raised during those discussions. Next we wanted to share a case study from one of our pilot sites, which was the Fetal Infant Mortality Review Team that serves the metropolitan Nashville Tennessee area, and through the use of the guide. The team identified a need for their multidisciplinary team to become more diverse, and that included racial and gender diversity, as well as including parents who had lived experience with an infant loss. They also identified that just based on the population they were serving, if they were going to have well-rounded membership focusing on community needs that they needed to include an immigrant or refugee advocate as well as representation from their local housing authority. They identified the need to refocus their fatality review discussions on barriers to care as opposed to noncompliance of patients.

In this case, for FIMR, they would likely be talking about pregnant and birthing people. They identified a need to support cultural humility and awareness in health care and education. And finally, they identified barriers to advancing health equity at the community level, as well as strategies like those I already covered, and to include a community voice in their team's work . Next. These are some of the key takeaways that we have from our pilot sites. And I just want to take this opportunity to thank them for their significant contribution to this effort.

The teams recommended stretching out the use of a guide over time. They said that they had to think through next steps creatively and so we've integrated several of their recommendations into that section of our guide.

They requested additional facilitation support resources. So we have been responding to that and creating a facilitators guide and specifically providing resources related to facilitating challenging conversations in the multidisciplinary team context. In general, they said that the process of using the guide enriched their understanding of equity within their own communities.

Next when we were looking across feedback mechanisms and the various things that we heard from sites the feedback really focused on these themes that you'll see here, that the process enriched understanding that they were able to think through next steps because of the guide that they could use additional resources, which we heard loud and clear and have been providing, and that using the guide created opportunities to learn from their community partners which we thought was such a benefit. One participant shared the guides stimulated meaningful conversations between agencies in regards to varying methods or strategies used that are being employed to assess and engage organizations in DEI efforts. Several of the strategies shared were easily transferable to other organizations that were not as far along in their DEI work and may serve as important first steps to engage others in this work. Next So finally, just here is where we are in the process. The draft guide and facilitate the facilitation manual are being finalized and submitted for graphic design so you can expect to be able to access this resource next month. And while in May of 2022, you can expect it to be disseminated through Safe Kids Worldwide and Children's Safety Network and the National Center, as well as our networks and partners to keep your eyes open.

And please reach out if you have any questions for us about this resource or about this process.

Thank you.

And I will turn it back over to Jennifer Thank you so much, Susanna, for that wonderful overview of the guide.

I'm going to talk a bit about some resources, additional resources that are available by the three partner organizations that have come together today. Next as a reminder, the Children's Safety Network coordinates the Children's Safety

Our Alliance, which these three member organizations, Save Kids, Children's Safety Network and the National Center are a part of. So on the Children's Safety Network website, you will see a number of resources, both from the National Alliance and from Children's Safety Network, some health equity resources are moving towards equity, understanding and addressing child and adolescent injury disparities. There is a lot of research and a lot of data in this resource for you across a number of social determinants of health.

We also have the framework for quality improvement and innovation in child safety, and this framework has health equity embedded in it. We then have the resource we introduced today, the health equity planner, to implement and spread child safety strategies in communities. And then we have improving injury outcomes, understanding health equity from a systems perspective.

So these are all supportive resources for you.

In addition, you can request training and technical assistance from the Children's Safety Network by filling out a TA request form.

And the hyperlink is there for you on the slide. And if you are not part of our mailing list, we encourage you to go ahead and sign up to receive our monthly e-newsletter. Next Safe Kids Worldwide, they have a plethora of resources also available on their website at SafeKids.org. They have a number of publications, infographics, fact sheets, tip sheets, videos and research reports that are available.

You can also connect with the Safe Kids State Office or local coalitions and they also have a newsletter mailing list that we encourage you to go ahead and join if you are not part of that already. Next And the National Center for Fatality Review and Prevention, they can help your state, your jurisdiction.

Their website is NCFRP.org.

They have a number of publications and infographics that are very well done that are available on their website for you. They have a training module series and a number of webinars that have been archived in New Webinars that you can sign up for. And they also have a listserv and a newsletter that we encourage you to go ahead and sign up for.

I want to thank everyone for coming today.

I want to thank Safe Kids and the National Center for coming together with CSN to really advance health equity through the National Alliance. And we hope that this encourages you to leverage your partnerships, join together, collaborate and advance health equity in our nation. Thank you.