

Discussion Paper

Building a Culture of Health Equity at the Federal Level

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DISCLAIMER

This report is a synthesis of information collected via interviews conducted by The Democracy Collaborative of leaders in the federal and non-federal sectors on cross-sector collaboration for health equity. These findings reflect the views of the interviewees and do not necessarily reflect the views of the Office of Minority Health or the U.S. Department of Health and Human Services.

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“Health disparities are the physical embodiment of inequity in opportunities. And these inequities in opportunity have been socially created, which means we are all a part of creating them and that we can now play a role in actually changing them.”

—Jeanne Ayers, Assistant Commissioner,
Minnesota Department of Health¹

The United States spends significantly more resources on health care than any other nation. Despite this fact and the remarkable improvements in the quality of health care over the past century, the nation’s relative standing in health outcomes and life expectancy continues to erode. “Americans die sooner and experience more illness than residents in many other countries,” a 2013 report from the National Research Council and Institute of Medicine bluntly noted (NRC and IOM, 2013).

In the United States, this burden of illness, premature death, and disability disproportionately affects racial and ethnic minority population groups and other underserved populations. These differences in health status, which are also known as “health disparities” or “health inequities,” persist and pose a significant economic burden to both affected individuals and all Americans. A 2009 analysis estimated that the U.S. economy loses \$309 billion annually due to both the direct and indirect costs of disparities (LaVeist et al., 2011). The cost in both dollars and quality of life creates a compelling economic and moral imperative to address the causes of these inequities.

A health disparity is a particular difference in health that is closely linked with social, economic, and environmental disadvantage (HHS Press Office, 2011). Health disparities reflect the strong influence of the conditions in which people are born, grow, live, work, and age—all of which are commonly referred to as the social determinants of health. These disparities are not randomly distributed in the population, are generated and maintained by social processes, and are therefore amenable to change (Dahlgren and Whitehead, 2006).

Addressing health disparities requires the use of the health equity lens. Applying a health equity lens means asking proactively, “What are the systemic factors that lead to poor health outcomes among disadvantaged populations and communities?” rather than focusing attention solely on immediate or downstream causes. This lens is necessary to ensure that the conditions for optimal health will be present in all communities, for all people.

A health equity lens directs attention to addressing the social determinants of health and the upstream causes of poor well-being and health, including stagnant economic mobility and increasing wealth inequality. It also permits an investigation of how these issues intersect with race and ethnicity to shape health (Wilkinson and Pickett, 2011).

Since the Great Recession of 2008, median wealth has plunged 47 percent and, despite job growth, the majority of economic recovery has occurred in low-wage industries, such as food services and retail (National Employment Law Project, 2012; The Stanford Center on Poverty and Inequality, 2014). This is further hollowing out lower skilled, middle-wage jobs, resulting in an acceleration and exacerbation of economic inequality. Pew Research Center has found that for the first time in four decades, the middle class is no longer a majority and is matched in size by those in the economic tiers above and below it. The share of income to middle-income households was 43 percent in 2014, down from 62 percent in 1970 (Pew Research Center, 2015).

¹ Personal communication, Assistant Commissioner Jeanne Ayers, Minnesota Department of Health, telephone interview with David Zuckerman and Violeta Duncan, February 18, 2015.

Political Economist and Democracy Collaborative Co-Founder Gar Alperovitz wrote in *Nonprofit Quarterly* in March 2015 that the income of the top 1 percent has more than doubled in the past two decades, from roughly 10 percent of all income in 1980 to more than 22 percent in 2012. Today, just 400 individuals have more wealth than the bottom 180 million Americans taken together. At the same time, the child poverty rate is comparable to the mid-1960s levels, at nearly 22 percent (The Stanford Center for Poverty and Inequality, 2014).

Many of these figures are even more staggering when parsed by race, ethnicity, gender, and disability. For example, median wealth for a white family with a college education is 10 times greater than for Black families, and about 7 times greater than for Latino families with a college education (Bruenig, 2015). Racial comparisons of median wealth across income levels is similarly skewed (Bruenig, 2013). Current projections of the nation becoming a majority minority nation by 2044 underscore the need to address racial inequities. If the nation continues to ignore racial inequities, it is poised to lose more than \$2.1 trillion in GDP yearly, with concentrated impact occurring on individuals and in communities of color (Treuhaft et al., 2014).

Added to these economic challenges is an increasing geographic and racial concentration of poverty and wealth. This underscores the importance of place in the health equity discussion. More than half of America's rural communities have experienced population decline as residents migrate to cities in search of better prospects and higher earnings. Today, the rate of poverty in rural America is 18.2 percent, nearly three percentage points higher than in cities (Bishop, 2012; USDA Economic Research Service, 2014). In urban areas, residential segregation by income has more than doubled, creating more acute disparities in access to resources (Florida, 2014). According to a recent Century Foundation report, the number of Americans living in areas of concentrated poverty has doubled—from 7 million to 14—since the turn of the 20th century (Jargowsky, 2015; Dubb, 2015).

The summary above illustrates how far many of our communities are from having the conditions required for achieving health equity. In addition, many of these trends continue in the wrong direction; the challenges facing the current and future health and well-being of our country are daunting. Achieving health equity in the United States will require an alignment of resources and unparalleled collaboration between two key funding partners—the federal government and philanthropy. To address systemic conditions that exacerbate health disparities and advance a health equity agenda at the federal level, these partners will need to dedicate significant time and resources. This paper discusses opportunities and methods to foster movement building and culture change to support this complex work.

Given the multicausal nature of health disparities and the diffuse spread of resources across several independent federal administrative entities, the elimination and reduction of health disparities is contingent on concerted federal action. The federal government alone spent \$799 billion in FY 2012 on at least 92 programs to meet the needs of lower income Americans in areas such as housing, social services, food aid, health care, veterans, and education and job training (House Budget Committee Majority Staff, 2014). Many of these programs play a critical yet largely unacknowledged role in eliminating health disparities.

Additionally, the requirements of the Patient Protection and Affordable Care Act (ACA) and its broader focus on prevention and moving health care provision from “volume to value” has initiated conversations among an increasingly diverse set of local stakeholders—due to the recognition that health care interventions in isolation only play a relatively small part in creating healthy communities (HHS Press Office, 2015). Despite the widespread recognition that the most significant factors in premature death and poor health are social, environmental, and economic, 95 percent of all U.S. health expenditures are still spent on direct medical services. The availability of funds to address broader population-wide public health improvement is, thus, quite meager for the scale of the challenge (McGinnis et al., 2002; U.S. Census Bureau, 2012).

In addition to the federal sector, non-federal institutions have been investing over many years in programs and activities to promote well-being and improve health in disadvantaged

communities. This change heralds a significant shift. For the first time, large philanthropic organizations are beginning to tackle issues of inequality with a more systemic lens and focus specifically on achieving health equity. For example, in 2007, national funders and health care organizations organized to create the Convergence Partnership. The collaborative fosters healthier and more equitable environments for all children and families. The Ford Foundation—the second largest foundation by assets in the United States—has publicly announced its new commitment to addressing inequality. In December 2015, the foundation’s president, Darren Walker, wrote in a *New York Times* op-ed that “philanthropy can no longer grapple simply with what is happening in the world, but also with how and why... the purpose of our philanthropy must not only be generosity, but justice” (Walker, 2015, p. A39).

How do we start to reverse many of the negative trends highlighted above, and begin to move toward an aligned approach to addressing health equity? This discussion paper presents findings and recommendations for how increased alignment of federal resources to achieve health equity can begin to occur, and ways in which philanthropy can accelerate this shift. It draws from The Democracy Collaborative’s body of research over the past 5 years, including more than 100 in-depth interviews of leaders and practitioners in the federal government, philanthropy, health care, higher education, and community-based organizations, who are invested in building the wealth and improving the health of low- and moderate-income communities across the nation.²

Part of the Collaborative’s research included a rapid review study of the state of cross-sector collaboration to address health equity in the federal, non-federal, and philanthropic sectors, including interviews with nearly 40 practitioners, conducted for the Office of Minority Health in 2015, and the organizing of a meeting of more than 60 stakeholders from across the federal government and philanthropy to discuss and build on the findings of that study (Zuckerman et al., 2015). The discussion below reflects on this study, convening a broader body of research, and outlines enablers for cross-sector collaboration, known and potential challenges to such collaboration, successful mechanisms for overcoming barriers, and recommendations for how to advance this area of practice to achieve health equity.

We identify six actionable opportunities for stakeholders focused on advancing a health equity agenda at the federal level:

- Develop a “Health Equity Learning Community” of federal mid- and senior-level civil servants in partnership with philanthropy;
- Develop a federal “Healthy Communities” designation, employing Promise Zone³ design principles;
- Collaborate with the National Institute on Minority Health and Health Disparities (NIMHD) to expand research linked to place-based initiatives around how social and economic conditions are linked to health outcomes;
- Facilitate increased coordination at the local level around Community Health Needs Assessments (CHNAs) through federal funder encouragement and information sharing;

² The Democracy Collaborative, founded in 1999, is a national leader in community wealth building—an inclusive, place-based approach to economic development that focuses on leveraging existing assets to expand community ownership for underserved residents. The Collaborative has significant experience convening cross-sector stakeholders, such as non-profits, public sector, financial institutions, health care institutions, and philanthropy, and has published extensive research on the role of many of these sectors in community wealth building.

³ The Housing and Urban Development website, at hud.gov, defines Promise Zones as “high poverty communities where the federal government partners with local leaders to increase economic activity, improve educational opportunities, leverage private investment, reduce violent crime, enhance public health and address other priorities identified by the community.”

- Increase collaboration between the National Prevention Strategy (NPS), the Federal Interagency Health Equity Team (FIHET), and the Convergence Partnership; and
- Embed equity as a value in Executive Core Qualifications for Senior Executive Service.

HOW DOES HEALTH EQUITY ATTAINMENT ALIGN WITH FEDERAL AGENCY PRIORITIES?

A key component of promoting federal action on the topic of health equity is to understand the degree to which health equity is already part of existing federal programs, as well as areas of opportunity to expand this influence. Although adoption of health equity and the social determinants of health language vary dramatically by sector, there is increasing recognition that economic, social, and environmental factors impact health outcomes. Non-health federal agencies more commonly embrace phrases such as promoting well-being, healthy communities, resilience, opportunity, sustainability, or civil rights to describe goals or mission statements related to equity. Often health is not itself presented as a major direct end goal, but rather perceived as a by-product of an agency's core activities and functions.

Many interviewees—regardless of whether they explicitly used a health equity lens—articulated that addressing multiple social, economic, and environmental conditions is inherently cross-sectoral and needed partnership building, especially at the community level. The increasing acceptance that the multiple disadvantages that impact communities are interconnected can help to drive cross-sector collaboration. However, if use of a health equity lens at the federal level is critical to creating the conditions for health and well-being in all communities, our findings indicate a need for education to help organizations and practitioners ascertain if and how their organizational priorities promote health equity.

WHAT IS THE CURRENT STATE OF COLLABORATION?

Cross-sector collaboration is essential to produce better health outcomes in our communities. Our interviews uncovered a number of ways in which individuals categorized their collaborative work that reflect both originating factors/drivers for the collaboration as well as the adopted strategy for the initiative. We capture these perspectives in four non-mutually exclusive categories of collaborative work:

- Place-based initiatives concentrate and coordinate resources around a particular geography, often in areas experiencing multiple disadvantages or underinvestment. Place-based efforts are undertaken primarily by philanthropy or federal agencies with grant-making authority or discretionary funds for technical assistance. Frequently cited examples include Choice Neighborhoods, the Neighborhood Revitalization Initiative (NRI), Promise Neighborhoods, Promise Zones, StrikeForce, and Strong Cities, Strong Communities.
- Issue-based collaboratives channel action and resources around a topic or issue that is not tied to a particular geography. Issue-based efforts are undertaken by funders, both of research and grant programs, and agencies involved in broad education or advocacy efforts. Frequently cited examples include the Financial Literacy and Education Commission; Local Food, Local Places; the National Collaborative on Childhood Obesity Research; and the National Disaster Resilience Competition.
- Outcomes/strategy-based collaboration can be based on either an issue or a place, but puts the focus on aligning strategies rather than overall mission alignment, and also on measurable outcomes. In addition, outcomes-based financing is a growing trend in the field

of philanthropy. A prominent example of a strategy-focused collaborative is the Convergence Partnership.

- Departmental initiatives and partnerships within a particular office describe instances in which an agency's mission requires working with partners to maximize effectiveness. These collaborations are often on an agency-to-agency basis, although some have grown into more formalized programs. Departmental initiatives are undertaken by agencies that serve particular constituent populations or agencies whose work inherently involves multiple stakeholders. Notable examples include the Partnership for Sustainable Communities and the Department of Justice's (DOJ's) Access to Justice Initiative.

WHAT ARE CHALLENGES TO CROSS-SECTOR COLLABORATION AND RESOURCE ALIGNMENT?

Despite the increased understanding about the importance of collaboration, significant challenges can impede agencies and philanthropy from forging effective partnerships. None of these challenges are insurmountable; still, acknowledging them is essential to being able to implement possible solutions. We have heard of six key challenges to cross-sector collaboration:

- Barriers to aligning financial resources;
- Limited capacity at the federal and community levels;
- Barriers to sharing data;
- Sustaining initiatives despite staff turnover;
- Overcoming differences in agency and organizational cultures; and
- Identifying and bringing the right people to the table.

Our interview findings are consistent with the Government Accountability Office (GAO) report, *Managing for Results: Key Considerations for Implementing Interagency Collaborative Mechanisms*, which highlights some of the same challenges as important considerations for collaboration, including: securing financial and technical resources to support a collaborative; bridging organizational culture divides; and bringing the right people to the table (GAO, 2012). The GAO report also emphasizes the importance of (1) developing systems to track outcomes and ensure accountability, (2) establishing clear roles, (3) identifying and sustaining leaders, and (4) securing commitment through written agreements. Interview subjects noted several impediments to aligning financial resources:

- Funders have limited knowledge regarding existing complementary resource streams.
- Funders experience legal barriers and other procedural mechanisms that often do not simplify the process for the end user.
- Federal funders are reluctant to concede the ability to designate how their funds specifically are distributed.
- Aligned funds may still require significant time and resources for communities to access.
- Communities are often unaware of complementary resources that may align with their current needs and objectives.

WHAT ARE MECHANISMS TO ESTABLISH PARTNERSHIPS AT THE FEDERAL LEVEL?

Some of the challenges brought up by interviewees can be mitigated at the establishment of the partnership. Although informal relationships are critical, for partnerships to grow and be sustained over time, they must be formalized and embedded within agencies. Interview subjects named four main mechanisms for establishing and maintaining collaborations and partnerships: (1) statutory mandate; (2) presidential mandate or White House initiative; (3) agency-to-agency Memorandums of Understanding; and (4) staff positions or offices dedicated to cultivating partnerships.

Informants noted varying degrees of success with these mechanisms and identified challenges and opportunities for each. The mechanisms exist on a spectrum of formality, from providing explicit authority through a legal mandate to informal agreements among offices. Along the spectrum, interviewees grappled with striking a balance between (1) the empowerment and faster timeframe that comes with an explicit mandate with (2) the political ease, but longer timeframe, that comes with naturally evolved agency-to-agency partnerships.

WHAT ARE STRATEGIES FOR ALIGNING MULTIPLE RESOURCE STREAMS?

Despite the challenge of aligning financial resources, our research identified four strategies that can be used to overcome the barriers: (1) blending; (2) braiding; (3) preferential grant access; and (4) joint grant reviews. These solutions represent a continuum between balancing the importance of meeting the needs of the end user—communities—and the need for agency accountability in tracking and reporting expenditures. None of these strategies are necessarily mutually exclusive, and in certain situations—noted above— some will prove more effective or simply more feasible.

Blending and Braiding

With **blending**, “resources contributed from each individual funding stream lose their original award-specific identity” in order to support a single initiative or strategy. With **braiding**, “resources from several funding streams are coordinated to support a single initiative or strategy, while each individual award maintains its award-specific identity” (AGA Work Group, 2014, p. 6). A single program can have both braided and blended funds.

A recent report, *Blended and Braided Funding: A Guide for Policy Makers and Practitioners*, prepared by the Association of Government Accountants, captures the benefits of blending. The authors draw upon lessons learned from the Environmental Protection Agency’s (EPA’s) Performance Partnership Grant (PPG) program. They find that blended resource streams:

- Enable grantees to respond to emergencies more quickly;
- Reduce grantees’ financial and human resource burdens from multiple reporting requirements;
- Facilitate an increased focus on performance and outcomes vs. compliance;
- Efficiently redirect carryover funds to another program;
- Foster greater experimentation at the community level; and
- Provide additional flexibility to grantees to deploy resources to a wide range of related issue areas (AGA Work Group, 2014, p. 8).

Blending funds is uncommon. Two examples are the Performance Partnership Pilots for Disconnected Youth and EPA's PPG program. The former blends discretionary funds from the Departments of Labor (DOL), Education (ED), and Health and Human Services (HHS). The latter permits states and tribes to combine funds from more than one EPA program grant into a single grant with a distinct budget. Ownership concerns as they relate to tracking the unique impact of independent resource streams is an important limiting factor for this approach.

Braiding is a more commonly used strategy than blending. Braiding allows multiple funding streams to be used when there are correlated issues that cannot all be addressed using one particular funding stream. It allows specific outcomes to be linked to specific resource streams. Braiding permits a careful accounting of how each dollar from each funding stream is spent. NRI braids funds from DOJ, HHS, and ED to support the Building Neighborhood Capacity Program, a technical assistance program to help distressed communities. DOJ and HHS have used a joint solicitation to expand substance abuse treatment capacity in adult and family drug courts; the Substance Abuse and Mental Health Services Administration-funded alcohol and drug treatments to offenders and defendants, whereas DOJ provided grants to drug courts to develop strategies for enhancing coordination, services, and treatment capacity.

Preferential Grant Access

Preferential grant access, which is sometimes seen as a type of braiding, provides grantees with an increased likelihood of receiving certain funds if they have been awarded a specific grant by another agency. It requires fewer legal obstacles than blending and allows partners to strategically concentrate and target resources to address multiple disadvantages in communities. An advantage of this strategy is that no additional funding, statute, or mandate is needed.

Promise Zones—the most frequently cited example of this strategy—seeks to increase economic activity, improve educational opportunities, leverage private investment, reduce violent crime, enhance public health, and meet other community priorities through providing preferential grant access in a select number of designated communities.

Joint Grant Review

Through joint grant review, representatives from two or more federal agencies and/or offices collectively provide input on grant applications submitted to one agency or office. Interviewees noted that this approach allows agencies to leverage peer expertise without blending or braiding, in addition to creating an opportunity to meaningfully engage other federal agencies that may not be able to contribute fiscal resources and to impose an interdisciplinary perspective on the grant review process. One example of this process is the checklist developed by the Department of Commerce, DOL, and ED for federal agencies to use in reviewing grants related to training or employment. The U.S. Department of Agriculture incorporated elements of this checklist into the selection criteria for project grants that support employment and training pilots for helping Supplemental Nutrition Assistance Program participants more effectively transition to employment.

In addition to the mechanisms described above, several federal interviewees emphasized the need to facilitate coordinated grant making across agencies, perhaps through a common online platform, as a means to reduce administrative burdens on grant recipients and use resources more effectively.

WHAT ARE WAYS TO STRENGTHEN AND SUSTAIN COLLABORATION AND RESOURCE ALIGNMENT?

Achieving resource alignment is only the first step toward achieving long-lasting impact in communities; strengthening and sustaining cross-sector collaboration over the long term is also critical.

Woven into all of the strategies summarized below is the importance of relationship building. Interviewees commonly identified the concept of fostering authentic relationships as a key driver to instigating, refining, and sustaining collaboration. They pointed out that existing relationships could be the source of information about available financial resources and/or potential non-monetary contributions such as expertise, and also increase access to stakeholders, data, and staffing. The interviewees emphasized that in order to assist with authentic relationship building, funders must invest time and resources into building fruitful relationships among themselves and with their grantees. Interviewees identified the following strategies:

- Establish federal-private-sector partnerships: Interviewees noted that non-federal funds can be used for technical assistance, data analysis, and other items that the federal government is challenged to support, such as marketing, launching pilots, or meeting related expenses like travel and facilitation.
- Use a backbone organization or facilitator: Strong backbone structure and facilitation to take control of day-to-day and meeting logistics (e.g., developing meeting agenda, note taking, etc.) were commonly cited elements to facilitate engagement and sustain collaboration.
- Invest resources in mid-level civil servants, with support from senior leadership: Respondents recommended an investment in building the capacity of mid- and senior-level career civil servants to ensure continuity of initiatives, particularly those started by political appointees.
- Demonstrate leadership engagement: Visible engagement from the leadership of an organization was viewed as an important means to communicate institutional investment to collaborators and other stakeholders.
- Co-create cohesive messaging and branding: Co-creation and cohesive branding was recommended on the premise that it spreads ownership roots in a collaborative across individual partners. These roots subsequently provide a strong incentive for continuity when one or more collaborators part ways.
- Develop shared data and metrics: Interview respondents identified shared indicators of success and aligned data collection as a critical component of sustaining collaboration and resource alignment.
- Provide technical assistance to grantees: Technical assistance enhances grantee capacity to effectively apply for resource-aligned funds and manage resource streams allocated to their communities. Interview subjects discussed several benefits, including: (1) better connecting field staff to their communities; (2) providing capacity building and troubleshooting to the grantee for the duration of a project; (3) strengthening resource alignment in federal-philanthropic partnerships; and (4) enabling communities to be better positioned to compete for discretionary funding and use formula-allocated funds more effectively.
- Focus on field building: Respondents described various processes for peer learning and field building, underscored by the understanding that respect for differences was key to achieving lasting collaboration. Field building describes a deliberate effort to educate existing and potential partners about the relationships among their program missions,

priorities, and goals, and the issue for which their participation is needed, such as promoting health equity.

WHAT ARE THE OPPORTUNITIES TO BUILD COLLABORATION AND RESOURCE ALIGNMENT TO ADVANCE HEALTH EQUITY?

Advancing health equity at the federal level will require a coordinated effort between agencies and philanthropy to enact policy and practice changes that will reliably produce the conditions in communities for individuals to achieve their best possible health. Incorporating elements of successful cross-sector collaboration highlighted above, we identify six actionable opportunities to begin to build this culture of health.

(1) Develop a “Health Equity Learning Community” of federal mid- and senior-level civil servants in partnership with philanthropy

A federal learning community of civil servants around health equity would help to expand knowledge of how social, economic, and environmental conditions impact health outcomes within federal agencies and programs. The learning community would also enable relationship building across the government. Relationship building at the federal level in this area has been severely undervalued, and it will be very unlikely to achieve the level of cross-sector partnerships needed to achieve health equity without an investment in this area.

A “Health Equity Learning Community” combines many of the strategies highlighted by those with whom we spoke: focusing on education and field building; investing resources in mid-level civil servants; and establishing federal–philanthropic partnerships. The learning community would address the following challenges: limited capacity for partnership building; limited knowledge of existing complementary resource streams; differences in agency culture; concerns about ownership of funds and initiatives; and bringing the right people to the table.

Building a culture of collaboration allows partners to identify areas of alignment in the first place. Additionally, cross-agency relationships foster more creative thinking on the use of non-monetary resources. A culture of collaboration can help agencies to leverage each other’s expertise, data, and access to stakeholders. Often these non-monetary resources come to light through the process of relationship building and forging partnerships. One particularly strategic area to advance health equity is to develop trust and knowledge among targeted mid-level civil servants, who will be invested in this work for years to come.

Creating a learning community that focuses on how to bring a health equity lens back to the day-to-day work of agencies would help to highlight ways in which all work can contribute to building health and well-being.

(2) Develop a federal “Healthy Communities” designation, employing Promise Zone design principles

Place-based collaboratives were frequently named as successful models for collaboration and for effectively deploying resources at the community level in many of our interviews. Given that many place-based initiatives already focus on many social determinants of health, using a place-based approach for health equity merits consideration. In our research, the Promise Zones model was frequently cited as a promising model of effective collaboration. This suggests that preferential grant access and coordinated federal staff support within a particular geographic focus would be an important set of strategies to employ.

A “Healthy Communities” designation capitalizes on the strategy of technical assistance to grantees. It also uses cohesive branding and messaging around the social determinants of health. Such a designation would help to address the following challenges: limited knowledge of

resource alignment opportunities within communities; trouble accessing funding streams by communities; limited capacity at the local level; and lack of shared measures of success/data.

Apart from seeking to create a “Healthy Communities” designation, there is a similar opportunity to embed a health equity lens within existing place-based efforts, which currently lack health or well-being as an explicit goal (even if individual communities have included them as priorities). This represents a missed opportunity for two reasons: it means (1) that slight modifications to existing interventions that could improve health and well-being may be overlooked, and (2) that the opportunity to empirically measure how addressing social determinants improves health is lost.

The California Endowment’s \$1 billion Building Healthy Communities initiative provides an example of a resourced place-based initiative with health equity objectives, focused on transforming 14 of California’s poorest communities “most devastated by health inequities.” The goal is to advance statewide policy and transform the narrative so that these communities have access to the resources and opportunities “essential for health,” such as affordable housing, living wage jobs, clean air, and healthy food (Pastor et al., 2014; The California Endowment, 2013). The sites were chosen based on health data, grant history, and stakeholder interviews. Priority was given to communities with poor health outcomes, but with sufficient infrastructure and opportunities to be successful (The California Endowment, 2015).

(3) Collaborate with the National Institute on Minority Health and Health Disparities to expand research linked to place-based initiatives around how social and economic conditions are linked to health outcomes

The notion of health equity has not widely penetrated federal agencies. We interviewed several persons who said their work directly addressed key social determinants of health, but failed to identify their work as promoting health equity, instead using the term exclusively to refer to clinical health initiatives. More integrated research on the social determinants of health would help agencies connect their work to the goals of health equity, and help make the case for prioritizing interagency solutions. This would also help to integrate health equity goals into existing programs and orient existing research resource streams toward health equity. A robust research program that is focused on how the improvements in social and economic conditions can improve health outcomes would address the challenges of data sharing, limited capacity at the federal level, and differences in agency culture.

The creation of NIMHD in 2010 was a significant step in bringing a social determinants and health equity lens to the clinically oriented National Institutes of Health (NIH). NIH is uniquely positioned to build out the social determinants of a health research portfolio because NIH, in its mission and practice, does not create end-use research, which is largely the purview of private-health–sector researchers. Instead, NIH focuses on basic scientific research that is not immediately marketable. NIH, by continuing to broaden its mandate, has a unique chance to assume a leadership role in providing the research basis for more effective alignment between community development and health.

Every 5 years, NIH conducts strategic planning to evaluate the impact of its research, assess progress, and develop new initiatives. NIH’s strategic planning process represents an opportunity to support new research that more effectively advances our understanding of how specific determinants impact health and well-being.

(4) Facilitate increased coordination at the local level around Community Health Needs Assessments through federal funder encouragement and information sharing

ACA has been a driver for innovative work around health equity and the social determinants of health because of the increased focus on prevention. In particular, the ACA requirement for non-profit health systems to complete CHNAs has created unrealized opportunities for broader coordination among federal grantees at the local level. Such an effort would provide technical assistance to grantees, use a place-based frame, and share data and indicators of success. It would also mitigate the challenges of access to data and lack of knowledge in communities about funding opportunities.

Now that the CHNA rules are finalized and because health systems are often the largest organization in a community required to complete a CHNA, the Centers for Medicare & Medicaid Services (CMS) is well positioned to play a leadership role. This role might include the promotion of coordination and relationship building among community actors that receive federal resources and have to complete CHNAs, such as accredited public health departments, United Way affiliates, federally qualified health centers, and Community Action Agencies. Although CMS is best positioned to play this role, other agencies and offices that provide resources for local organizations that conduct CHNAs could include language or preference for this type of alignment.

(5) Increase collaboration among the National Prevention Strategy, Federal Interagency Health Equity Team, and Convergence Partnership

Officially established in 2010 through Executive Order, the National Prevention Council was called for in the *Affordable Care Act* to provide leadership and coordinate federal efforts related to prevention, wellness, and health promotion. The Council is chaired by the U.S. Surgeon General and housed in HHS. ACA mandates the participation of 12 agencies, and since its establishment, 3 more agencies have been appointed by the Surgeon General (Rigby, 2011). The statutory mandate associated with the National Prevention Council as well as the involvement of high-level officials give the NPS a level of visibility and prestige.

The National Partnership for Action to End Health Disparities (NPA) is a national movement created in response to recommendations from community leaders, health equity experts, and other stakeholders for cross-sector, partnership-based, community-driven, and systems-oriented approaches to tackle health disparities (HHS Office of Minority Health, 2011). Under the NPA, a body of federal agencies and programs known as the Federal Interagency Health Equity Team was convened through the Office of Minority Health in 2011 to create a platform for strategic cross-sector collaboration and coordination. Because it is not clear how well connected mid- and senior-level civil servants are to implementing the NPS, FIHET's involvement would help to connect many individuals at that level and would help to address the challenge of sustaining momentum as political appointees change.

Given the scarcity of federal resources, collaboration with Convergence Partnership could help leverage this federal infrastructure with private resources to deepen impact. This collaborative of national funders and health care organizations is working to foster healthier and more equitable environments for all children and families. Nine organizations make up the steering committee: Ascension Health, The California Endowment, Kaiser Permanente, The Kresge Foundation, MacArthur Foundation, Nemours, Robert Wood Johnson Foundation, and W. K. Kellogg Foundation, and the Centers for Disease Control and Prevention, which serves as the Partnership's technical advisor. PolicyLink continues to act as the program director, and the Prevention Institute as strategic advisor. Together, the organizations work to craft strategy, provide leadership, assess progress, and advance the Partnership's vision of Healthy People, Healthy Places (Convergence Partnership).

Deeper relationships among NPS, FIHET, and Convergence Partner would help align federal and philanthropic efforts to increase adoption of a health equity lens and embed it within the federal government.

6) Embed equity as a value in Executive Core Qualifications for Senior Executive Service

Field building and education around the importance of equity can come from outside pressure, but there is also significant opportunity for those within a particular agency to advance a health equity lens. One strategy would be to embed language about equity into Executive Core Qualifications for Senior Executive Service, elevating the importance of equity as a key component of accountability and success. This would not only help incentivize a focus on health equity, but it would also help to address the challenge of ensuring equity remains a priority as leadership changed because future staff would be held to these same standards.⁴

CONCLUSION

“Healthy communities’ is shorthand for collaboration among four sectors—community development, economic development, public health, and health care—to create shared value.”
—Elizabeth Sobel Blum, Senior Community Development Advisor,
Federal Reserve Bank of Dallas⁵

This paper has outlined a number of opportunities on how federal and philanthropic partners can further cross-sector collaboration that will advance health equity. Although there is no doubt regarding the challenges to ensuring the conditions for health and well-being in all of our communities, a genuine excitement, interest, and expertise exists to accomplish these goals. Through examining the existing state of collaboration, this paper brings forward useful mechanisms to establish partnerships, clear strategies for aligning financial resources, and helpful elements to sustain cross-sector collaboration.

We envision the opportunities noted in this paper as first steps toward embedding an equity lens within the federal government, in partnership with philanthropy. As the federal government and philanthropy sharpen their focus on ending health disparities and achieving health equity, they must remain open to new ways of aligning resources. In so doing, we can help move American society from its traditional emphasis of reacting to ailing communities to a proactive culture of health that results in equitable health outcomes and fosters prosperous and thriving communities for all, regardless of an individual’s race, income, or Zip code.

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⁴ Office of Personnel Management (executive core qualifications).

⁵ Personal communication, Senior Community Development Advisor Elizabeth Sobel Blum, Federal Reserve Bank of Dallas, interview with David Zuckerman and Violeta Duncan, March 19, 2015.

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