



**Developing a Principled
 Mechanism for Reducing Health
 Inequities in San Francisco
 Session Two**

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Developing a Principled Mechanism

Session 1: September 28, 2012
 Identifying Priority Groups

Session 2: October 26, 2012
 Making Health Equity Operational and
 Transparent

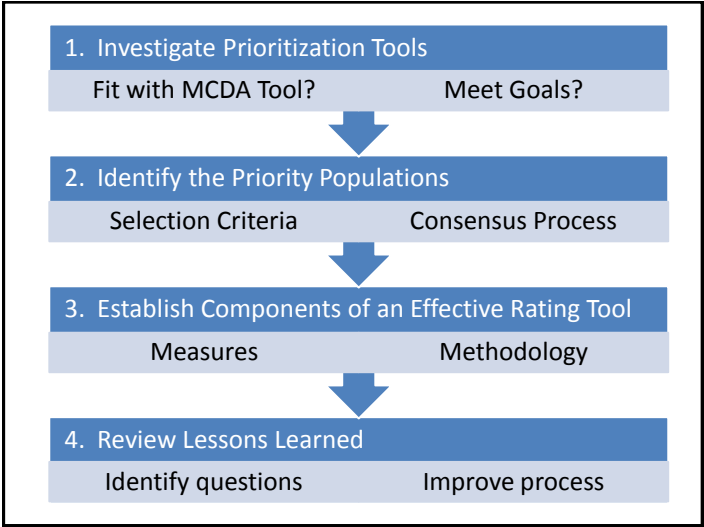
DPH Goals

To engineer Health Equity, a social justice principle, into DPH’s budgetary decision process.

To create a prioritization process that is feasible to administer, transparent, and actionable.

DPH Multi-Criteria Decision Analysis Tool - Budget Prioritization

| Domain | Criteria | Definition | Weight |
|--|---|---|--------|
| Health Impact 41.3 Points | Numbers affected | Number of individuals affected by the proposed change | 5.0 |
| | Equity | Impact on the health status of recognized groups where there is a known health status gap/disparities | 7.7 |
| | Significance of impact | Impact on health outcomes for the patient/client (e.g., risk of adverse events, improved health status) as compared to current practice/service | 6.8 |
| | Effectiveness | 1. Intervention is meeting a demonstrated need; 2. Intervention is known to achieve intended outcomes; 3. Intervention is evidence-based | 8.3 |
| | Health promotion and disease prevention | Impact on illness and/or injury prevention, wellbeing and harm reduction as measured by projected longer term improvements in health | 7.2 |
| | Client experience | Impact on safety, effectiveness, cultural competence, timely access, self-efficacy, and client experience of service(s) provided | 6.3 |
| Strategic Alignment 18.1 Points | Alignment to Health Commission's 5-year budget priorities | | 9.8 |
| | Mandates | | 8.3 |
| Organizational Impact 17.8 Points | Adoption/ implementation | | 5.2 |
| | Workplace environment | | 7.7 |
| | Innovation and knowledge transfer | | 4.9 |
| Financial Impact 22.8 Points | Associated revenue | | 7.6 |
| | Downstream impact on service utilization | | 7.7 |
| | Efficiency and appropriateness | | 7.6 |

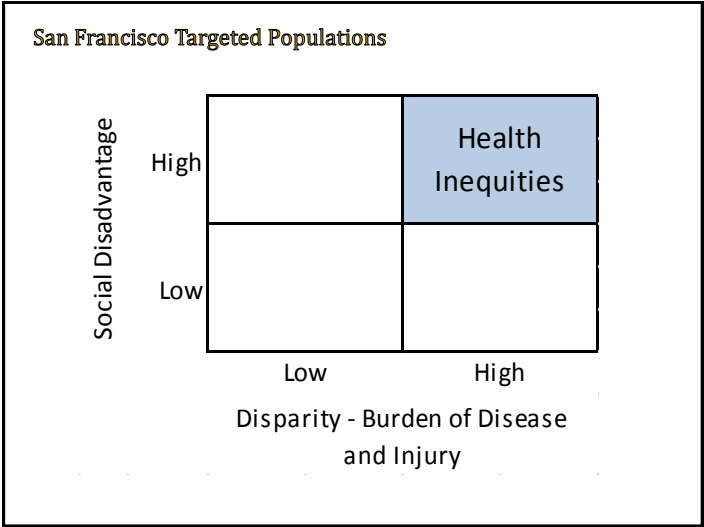


What is Health Equity?

Reducing disparities in health status that are patterned, preventable, and unjust.

It suggests underlying social advantage and disadvantage based on imbalances in political power or privilege.

Whitehead, M. (1992). The Concepts and Principles of Equity and Health. International Journal of Health Services, Vol 22(3) pp 429-445



Did you agree with the top 5 vote getters?

(African Americans, Homeless, & Residents of Public Housing, BVHP, and Tenderloin)

All respondents replied agreement with the five groups as “worthy” priorities, but most qualified their response with concerns about who had been omitted.

Remaining populations that had more than one vote: American Indians (3 votes), Immigrants (3 votes), Latino/a (2 votes), Transgender Male to Female (2 votes).
 Remaining populations with only one vote: Gay, Children Aged 0-5, Visitacion Valley residents, Youth, Immigrants, and Seniors. One vote went to a social disadvantage descriptor (low-income status).

In what ways did you struggle with this prioritization process?

1. Two of the respondents stated they did not struggle as they used their experience to identify priority groups.
2. Most, however, said they had difficulty with the process and their decisions.

If we were to repeat this process, how would you recommend it be changed, if at all?

1. Good start, need more time and more people at table.
2. Is the intersection of health disparities and social disadvantage the right framework for identifying budget priorities?
3. Need to clarify how this process will change what we do now.
4. How far upstream should we think in terms of prioritizing populations?
5. Should more scientific rigor be brought to the methodology?
6. Do numbers matter?

Exercise The Rating Tool

DPH Budget Prioritization: HEALTH IMPACT - Health Equity (Weight 7.67 Points)

Example: African American (100%), Public Housing residents (76%), Homeless (5%), BVHP (15%), Tenderloin (76%)

| Weight | Health Equity Prioritized Populations EXAMPLE 5 CATEGORIES | Example 2 - Keeping each population separate | | | | Points | Weight | Weighted Points (Points x Weight) | Score (Total Weighted Points / 2.8 possible Points) | Health Equity Score (7.67 x Score) |
|--------|---|---|------------|------------|----------|--------------|-------------|--------------------------------------|---|------------------------------------|
| | | Percent of UDC served that fall into the prioritized population category (% = # of prioritized individuals reached / # of total individuals served by the program) | 1 Point | 2 Points | 3 Points | | | | | |
| | Reach | 10% to 25% | 26% to 50% | 51% to 75% | Over 75% | | | | | |
| 20% | African Americans | | | | 4 | 4 | 0.20 | 0.80 | | |
| 20% | Homeless | 1 | | | | 1 | 0.20 | 0.20 | | |
| 20% | Public Housing Residents | | | | 4 | 4 | 0.20 | 0.80 | | |
| 20% | BVHP Residents | 1 | | | | 1 | 0.20 | 0.20 | | |
| 20% | Tenderloin Residents | | | | 4 | 4 | 0.20 | 0.80 | | |
| 100% | | | | | | Total | 2.80 | 1.00 | | 7.67 |

| Weight | Health Equity Prioritized Populations EXAMPLE 3 CATEGORIES | Example 1 - Combining Mutually Exclusive Categories | | | | Points | Weight | Weighted Points (Points x Weight) | Score (Total Weighted Points / 4 Possible Points) | Health Equity Score (7.67 x Score) |
|--------|---|---|------------|------------|----------|--------------|-------------|--------------------------------------|---|------------------------------------|
| | | Percent of UDC served that fall into the prioritized population category (% = # of prioritized individuals reached / # of total individuals served by the program) | 1 Point | 2 Points | 3 Points | | | | | |
| | Reach | 10% to 25% | 26% to 50% | 51% to 75% | Over 75% | | | | | |
| 33% | African Americans | | | | 4 | 4 | 0.33 | 1.33 | | |
| 33% | Homeless &/or Public Housing Residents | | | | 4 | 4 | 0.33 | 1.33 | | |
| 33% | BVHP &/or Tenderloin Residents | | | | 4 | 4 | 0.33 | 1.33 | | |
| 100% | | | | | | Total | 4.00 | 1.00 | | 7.67 |

Instructions:

Take 10 minutes to review the tool with a partner and answer the following questions:

1. ◆ Are the priority populations equal? Should they be ranked? If so, how would you go about it?
2. ● Should we collapse the mutually exclusive categories? What are the pros and cons?
3. ★ Is the % of those served the right %, or is it % of the total population, or...?
4. ▲ Do the ranges weighing the "% distribution of individuals served" make sense?
5. Is this methodology feasible for a manager to complete?