Health Equity
ADRC and Aging Operations Manual

I. Introduction

According to the Centers for Disease Control and Prevention (CDC), health equity is achieved when every person has the opportunity to attain their full health potential, and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances. Health inequities are reflected in disparate health outcomes, such as differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to high quality treatment.

Aging and disability resource centers (ADRC) and aging programs have a responsibility to ensure equitable access to the programs and services that they provide. Equitable access is central to health equity and means meeting people where they are at and ensuring that programs and services are offered through a variety of access points. People should be able to use programs and services regardless of how their unique circumstances may impact access. ADRC programs and services have a direct impact on many social determinants of health, including access to information, resources, and more. ADRCs and aging programs serve, by virtue of their mission, populations of individuals who experience health disparities at a greater rate. Commitment to advancing health equity is critical to the mission and success of ADRCs and aging programs in Wisconsin.

II. Social Determinants of Health

Social determinants of health (SDoH) are conditions in the places where people live, learn, work, and play. SDoH affect a wide range of health risks and outcomes and have a significant impact on factors that enhance quality of life. SDoH are shaped by the distribution of money, power, and resources at global, national, state, local, and individual levels. Programs and policies can directly impact SDoH and contribute to health inequities.

Resources that enhance quality of life can have a significant influence on health outcomes. ADRCs and aging programs provide information and counseling about many such resources and offer programs that enhance these social determinants. Resources such as safe and affordable housing, access to healthy foods, and local health services are some examples directly related to ADRC and aging services.

The CDC offers a place-based framework that outlines five domains of SDoH. These domains are listed below, along with some examples of ADRCs and aging programs and services that can directly impact them.

1. **Health Care Access and Quality**

    - **Definition**: Health care access and quality is the connection between people's health, their access to and understanding of health services, and the quality of the care that they receive. High quality health care is care that is safe, effective, patient-centered, timely, efficient, and equitable.

    - **Key issues**: Health care access, primary and preventive care access, health insurance coverage, health care workforce shortage, health care costs, and health literacy

    - **Program and service areas**: Disability Benefit Counseling (P-03062-05), Elder Benefit Counseling (P-03062-06), Options Counseling (P-03062-02), and health promotion and wellness programming

2. **Social and Community Context**

    - **Definition**: Social and community context is the connection between people's health and wellbeing and societies and communities in which they live, learn, work, and play.

    - **Key issues**: Community cohesion, civic participation, discrimination, workplace conditions, and incarceration.

    - **Program and service areas**: Dementia Care Specialists (P-03062-07), Caregiver Support Programs (P-03062-39), Disability Benefits Counseling (P-03062-05), Elder Benefit Counseling (P-03062-06),

Information and Assistance (P-03062-01), and Options Counseling (P-03062-02)

The three-year aging plan (P-03062-35) is an important tool for addressing health disparities that are present in this SDoH area. Additionally, ADRCs and aging units provide volunteer opportunities within their organizations, which also support social connection.

3. **Economic Stability**

   - **Definition**: Economic stability is the connection between people's health and their financial circumstances, such as income, cost of living, and socioeconomic status.

   - **Key issues**: Poverty, employment, food security, and housing stability

   - **Program and service areas**: Disability Benefit Counseling (P-03062-05), Elder Benefit Counseling (P-03062-06), Options Counseling (P-03062-02), Nutrition Programs (P-03062-38), Caregiver Programs (P-03062-39), and Information and Assistance (P-03062-01)

4. **Neighborhood and Built Environment**

   - **Definition**: Neighborhood and built environment is the connection between people's health and wellbeing and where they live, including their housing, neighborhoods, and environment.

   - **Key issues**: Housing quality, transportation access, healthy food availability, air and water quality, and neighborhood crime and violence

   - **Program and service areas**: Nutrition Programs (P-03062-38), Options Counseling (P-03062-02), Advocacy (P-03062-18), Emergency Preparedness (P-03062-17), transportation programs, and aging plans (P-03062-35)

5. **Education Access and Quality**

- **Definition**: Education access and quality is the connection between health, wellbeing, and education.

- **Key issues**: Early childhood education and development, high school graduation, higher education, educational attainment, language and literacy, health and wellness education, and health literacy

- **Program and service areas**: Options Counseling (P-03062-02), specifically with youth transition services, and Caregiver Programs (P-03062-39), specifically with programs for grandparents raising grandchildren

III. Narratives

Narratives are value-based stories that we use to understand our world. To advance health equity, we must examine our narratives and shift our worldviews. Worldview refers to the rich variety of values, beliefs, and assumptions that we draw upon and inherit from the larger social world in which we live.

Narratives are a way of communicating or reinforcing a worldview. They make people consider their understanding of the world around them.

Frames are like lenses that bring some aspects of a picture, or situation, into focus while distorting others. Part of the power of a frame is that it points the audience toward solutions that are grounded in a particular narrative and worldview.

Messages are how we communicate the story that we want specific audiences to hear. We use verbal and non-verbal messages to communicate frames, narrative, and worldview. Oftentimes we use personal stories, or narratives, to deliver messages.

To advance equity, we must work to transform the narratives that are creating barriers. The goal is to illuminate people's values, beliefs, and assumptions.

The aging and disability network was built upon a common set of values and beliefs that are well-reflected in Wisconsin's transformative narrative for public health policy. The foundation on which the Older Americans Act was created is known as the "The Aging Difference," which at its core is the notion that people for whom programs and services are designed ought to decide what those programs and services are, and should have a real sense of ownership and agency in regard to

them. Similarly, the Disability Rights Movement was anchored in the value statement of "nothing about us without us." ADRCs and aging units have the responsibility to uphold and continually recommit to these values for the success of aging and disability policy.

Transformative narratives for Wisconsin include:

- **All people have inherent dignity and autonomy.**
  Our inherent worth comes from being alive—regardless of our origins or attributes.

- **Across many beliefs, this dignity and autonomy continues in death as well. Everyone deserves a just opportunity to thrive.**
  The social, environmental, and economic policies and systems we make have the greatest influence on our ability to thrive. We are called to transform our social fabric for health equity—so physical, mental, and social health and wellbeing are possible for everyone.

- **In Wisconsin, we take care of each other.**
  Our well-being is bound to each other, and we refuse to leave anyone behind. It is our collective responsibility to cultivate strong, healthy communities.

- **We believe that people deserve meaningful inclusion in decision-making that affects their own lives.**
  Everyone brings knowledge that should guide public decision-making. Authentic inclusion leads to better decisions—and people thrive when we see ourselves as valued members of our communities.

- **We know achieving a better Wisconsin for all is both a process and an outcome.**
  We're committed, hopeful, honest, and brave about the risks, transformation, and time it will require of each of us.

- **We have what it takes to transform Wisconsin so that everyone is better off.**
  We are facing complex issues, and we will need to address them individually, in our communities, and in our institutions. We collectively have the knowledge, resources, and power to change communities and our state so that we can all thrive.

Source: Wisconsin Healthiest State Initiative Narrative Workgroup, convened by the Mobilizing Action Toward Community Health (MATCH) Group of the University of Wisconsin Population Health Institute, 2020.

IV. Agency Responsibilities

A. Agency Requirements

ADRC and aging programs empower customers to make informed choices about options to live with dignity, security, independence, and a high quality of life. To achieve this mission in an equitable way, ADRCs and aging units must identify and consider disparities that affect each unique customer. ADRCs and aging units will actively work to build capacity in the space of equity and inclusion. Health equity is reflected in the mission of the ADRCs and aging units through advocacy and services provided to people who face marginalization due to ageism and ableism. ADRCs and aging units must also consider how age- and ability-related identities intersect with additional marginalized identities, which are inherent in the populations we aim to serve. Additionally, ADRCs and aging units must make sure marginalized communities are represented and valued in their hiring practices and in the recruitment of governing board and commission members.

To ensure that equity impacts are systematically and rigorously considered in organizational decision-making, we strongly encourage agencies to thoroughly assess health equity impacts in the following circumstances:

- Planning: Determine what to change and prioritize in programs in an appropriately contextualized manner.
- Budgeting: Consider which items to prioritize, add, or cut and the equity impacts of the decision.
- Personnel: Determine whom to hire, retain, promote, or develop.
- Policy development: Consider what to propose or change and why.
- Practices: Consider routines or protocols to continue, modify, or eliminate.

Questions that agencies need to consider when assessing for health equity impacts include:

- Who will be affected? Who will be burdened or advantaged?

- What are potential unintended consequences? Is there any potential for unintended traumatization or re-traumatization?
- Have stakeholders or community partners, especially those most affected, been informed? Meaningfully involved? Authentically represented in the development or process?
- Who is missing and how can they be engaged?
- What is the plan for sustainable implementation?
- How will accountability occur? How will impacts be documented and evaluated?

The Health Equity Assessment Tool and the Social Determinants of Health Dataset are available on the ADRC and Aging SharePoint site. Additional health equity assessment resources are also linked below in the Resources and Tools section.

B. Supervision

Supervisors and directors will promote an inclusive environment within their staff, agency, and community. This includes engaging the ADRC board and commission on aging in promoting health equity and access to services.

Agencies should monitor the communities from which they are and are not receiving customer contacts and work to engage in a meaningful way with the communities in which they are not. Supervisors and directors are responsible for bringing equity- and access-related concerns to their assigned regional quality specialist, or other BADR staff, when program or policy requirements contribute to the concern. Agencies can submit ideas and comments to BADR regarding health equity via SharePoint. All ideas and comments submitted to BADR will be acknowledged within two business days and routed to the appropriate program and policy staff to determine next steps.

C. Training and Certification Requirements

BADR is available to provide suggestions for trainings about health equity. Currently, there are no training or certification requirements specific to health equity for aging units, AAAs, ADRCs, ADRC staff, or ADRC governing board members.

Recommended training includes the following:

- UW Population Health Institute's Health Equity Training Modules
- Witnessing Whiteness workshop series
- Nehemiah's Justified Anger course
- Cultural Humility presentation
- Health Equity and the Social Determinants of Health presentation
- Viewing Alzheimer's Through a Cultural Lens—panel discussion from the Alzheimer's Association Conference, June 2021
- The ADRC and Aging SharePoint site has recordings of trainings on a variety of topics, including topics related to health equity. Staff are strongly encouraged to visit the training page and view recordings from training opportunities that they may have missed.

V. Resources and Tools

A. Policy Assessment Tools

Health Equity Assessment Tool (created by BADR health equity consultant, Katherine Cullinan)

Analysis Tools, City of Madison Racial Equity & Social Justice Initiative

- Comprehensive Racial Equity Analysis (docx)
- Fast Track Racial Equity Analysis (docx)
- And more

Voices for Racial Justice Tools for Action

Voices for Racial Justice – Racial Equity Impact Assessment Pocket Guide (PDF)

Wisconsin Community Resilience and Response Task Force – Equity Considerations in Rapid Response

Big Cities Health Coalition Equity Lens Tool for Health Departments

Government Alliance on Racial Equity – Racial Equity Toolkit

Race Forward – Racial Equity Impact Assessment Toolkit

B. Data Resources

Aging Program Data Dashboard

Aging Demographics in Wisconsin

Social Determinants of Health Dataset

County Health Rankings and Roadmaps

C. Other Resources

Older Adults Equity Collaborative (OAEC) Resource Library

Not Another Second Project – LGBT+ Seniors Share Their Stories

Glossary for Understanding the Dismantling of Racism/Promoting Racial Equity Analysis, The Aspen Institute Roundtable on Community Change

Sage: Advocacy and Services for LGBTQ+ Elders

We Make the Future – Race Class Narrative