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Rhode Island's Health Equity Zones: Addressing Local Problems with Local Solutions

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ABSTRACT

The Rhode Island Department of Health (RIDOH) describes the strategies and infrastructure it has developed to fund its place-based initiatives to address the social determinants of health to eliminate health disparities. Using a data driven and community-led approach, RIDOH funded 10 local collaboratives, each with its own, geographically-defined "Health Equity Zone," or "HEZ," and, to support the collaboratives, created a new "Health Equity Institute," a "HEZ Team" of 9 seasoned project managers, and direct lines of communications between these assets and the Office of the Director of Health.

Keywords: Health Equity, Social Determinants of Health, Placed-Based Initiatives, Collective Impact

INTRODUCTION

The Rhode Island Department of Health ("RIDOH") has funded ten "place-based" public health initiatives in geographically-defined "health equity zones" ("HEZs") ranging in size from neighborhood to county (State of Rhode Island Department of Health, n.d.). Place-based initiatives recognize the diversity of local health disparities, on the one hand, and the importance of local community involvement in addressing them, on the other (Bradford, 2005; Kawachi & Berkman, 2003). It has long been recognized that public health resources are insufficient—anywhere—to achieve optimal outcomes without collaboration from the communities served. Strong government-community collaborations, if carefully developed and maintained, can attract

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community-based finances, in-kind resources (valuable assets or labor contributed free of charge), and social capital (social networks, with their potential for the dissemination of information and for the development of coordinated human effort) in the service of public health goals (Healthy People, n.d.). Of special importance is the alignment of social capital—social networks, with all of their potential for the dissemination of information and for the development of coordinated human effort—with public health goals (Eriksson, 2011). Place-based initiatives are especially effective in harnessing the latter, because they operate at the level of organic social networks—the natural social networks that form in any community and that are essential for the daily functioning of that community (Valente, 2010).

Indeed, place-based initiatives are quite traditional in public health, as embodied in local “boards of health,” drawn from the community served, and providing oversight to local health officers. This model was effective for decades in Rhode Island, as elsewhere, in addressing the unique needs of local communities, and in fact, many public health needs are place-based. For example, environmental risks vary from place to place, as does geographic access to health care services. People of different income levels tend to live in different places, and recent immigrants tend to settle in particular places, based on prior settlement, occupational opportunities, and the availability of social services. Settlement patterns are also based upon housing affordability, economic issues, transportation access, policies that support/hinder racial, ethnic, socioeconomic diversity.

However, as the scope of public health has grown in the United States, so too has the importance of state and especially *national* influence on public health priorities. Over the past 50 years, the funding base for public health has shifted dramatically from local (state and community) funding to federal funding. Most of the latter is categorical (earmarked for specific purposes) and dispersed through “cooperative agreements”—not grants—to state-level health departments. The latter approach promotes uniformity of public health effort and effect across the nation, but at the expense of flexibility in addressing diverse local needs (American Public Health Association, 2014). As funding has become centralized, so too has public health planning and priority-setting. The latter is still done, of course, at the state and local level, but its expression is limited by categorical funding and the restrictions placed in its use in cooperative agreements. The upshot of all this is that local stakeholders may feel rather disenfranchised, and, in turn, may be less likely to invest social capital in projects from which they feel distant.

Public Health Landscape in Rhode Island

Rhode Island can ill afford any loss of social capital in its public health efforts, for several reasons. First, the State's economy has been troubled for decades (following the loss of manufacturing and military support jobs), and remains problematic, struggling with budget deficits, uncompetitive taxes, and burdensome business regulations (New England Economic Partnership, n.d.) Second, Rhode Island, unlike most states, does not have regional (county or municipal) health departments. Third, Rhode Island, long a portal of entry for immigrants to the United States, has welcomed several new and very distinct ethnic communities since 1990, each with a unique set of health risks. Today, around one in eight Rhode Islanders are foreign-born (American Immigration Council, 2015).

Accordingly, RIDOH began planning for enhanced community-level involvement in public health a decade ago, and has slowly built capacity for place-based initiatives. The process began with the elevation of “minority health” from office to division status in 2006, followed by the development of collaborative, in-house “teams” of public health professionals across related

state- and federally-funded programs who until that time had operated separately, according to funding stream. Along the way, and with its new Division of Community Health and Equity (“CHE”) in the lead, RIDOH systematically built a workforce to become more racially and ethnically diverse and more sensitive to racial and ethnic concerns, thereby enhancing liaison with newly-arrived immigrants and other ethnically-diverse communities across the State.

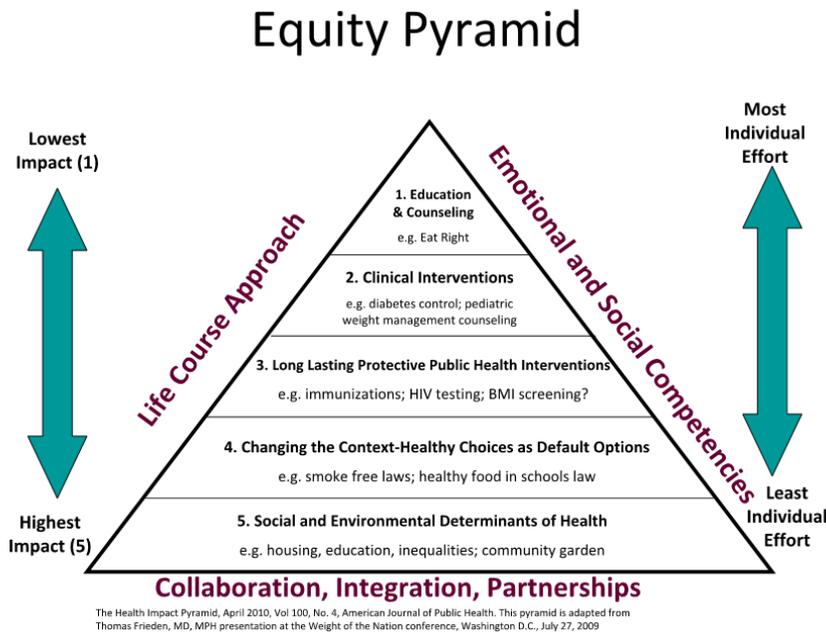
Of note, CHE adopted and adapted the CDC’s “Health Impact Pyramid” (“HIP”) as a framework within which to assess the potential effectiveness of the programs it inherited from the reorganization of other divisions (Frieden, 2010). CHE adapted HIP by adding three fundamental principles to be considered in the development and evaluation of all public health programs:

- To make collaboration with community partners in all sectors and at all “levels” a key process goal in every function of public health (assessment, policy development, and assurance) and, in collaboration, to assure integration of public and private efforts
- To take a “life course” approach in all programs, where applicable and possible, and to envision traditionally age-specific programs as elements in an integrated continuum with transitions to be smoothed and gaps to be filled in the “life course” experience
- To consider always, in every program, the emotional and social needs- “competencies” of the people we serve, as we plan, organize and field public health programs.

The adaptation is graphically represented using the HIP as its core, with the three fundamental principles as a frame in which the HIP is centered. The result was renamed the “Equity Pyramid” and was subsequently adopted by all Divisions of RIDOH as its “Health Equity Framework” (Figure 1). Examples of policies/systems/environmental change or program development representative of this framework include:

METHODS

Figure 1: Health Equity Framework – Equity Pyramid



POLICY/SYSTEMS/ENVIRONMENTAL CHANGE

- Transform land and property to affordable, quality housing,
- Construct and/or maintain parks and other open spaces for recreation,
- Encourage walking, biking, and use of public transportation,
- Increasing access to locally grown, culturally appropriate fresh fruits and vegetables
- Implement replication the Harlem Children's Zone's Asthma Initiative,

PROGRAM DEVELOPMENT

- Implement a chronic disease self-management education program
- To promote health and financial education,
- Develop and support parenting groups,

Building on these assets and on long-standing collaborations with a broad base of community stakeholders, RIDOH was able to fund eight "Centers for Health Equity and Wellness" ("CHEWs") for three consecutive years (2012-2015) (State of Rhode Island Department of Health, n.d.). Much was learned from this initial experience, upon which the HEZs were founded.

PUBLIC HEALTH LESSONS LEARNED AND APPLIED IN RHODE ISLAND

Centers for Health Equity and Wellness: Lessons Learned

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In 2012, RIDOH established eight CHEWs at a cost of about \$100,000 per year, each. Requests for proposals (RFPs) were issued from community-based organizations serving low-income neighborhoods in Rhode Island. The goal was emphasized as advancing the national strategic direction “to create, sustain and recognize communities that promote health and wellness through prevention” via evidence-based programs designed to address either chronic disease and its risk factors or key priorities for maternal and child health (National Prevention Council, 2011). Funded projects in three low-income “core city” areas, or communities in which more than 25% of children live in poverty, proposed to achieve the following (HEALTH Epidemiologist and Evaluator Group, 2012):

- To reduce diet related health disparities and to improve eating behaviors by increasing access to locally grown, culturally appropriate fresh fruits and vegetables,
- To transform land and property to affordable, quality housing,
- To construct and/or maintain parks and other open spaces for recreation,
- To encourage walking, biking, and use of public transportation,
- To promote health and financial education,
- To implement a chronic disease self-management education program,
- To replicate the Harlem Children’s Zone’s Asthma Initiative,
- To develop and support parenting groups, and
- To increase access to healthy foods by turning unused city property into urban farms.

A comprehensive evaluation report was produced at the conclusion of the three-year program. Highlights include (related to EP levels 1-5):

- The development of several substantial urban agricultural areas to improve the diets of ethnically-diverse population groups (EP Level 5)
- Multiple, significant, and observable improvements to nuisance/blighted properties and to street-level amenities (e.g., walkways and lighting), resulting in increased physical activity and public safety (EP Level 5)
- The enrollment of more than 300 families and family child care providers in the *Incredible Years Parenting Education* curriculum (EP Level 3)
- A model school-based asthma awareness and management program, resulting in the abatement of common asthma triggers in the school (EP Level 3) and the development of asthma action plans for 21 children (EP Level 2)
- Enhanced health and financial education for 1500 enrollees of common community-based educational and vocational programs such as English as a Second Language programs (EP Level 2/3)

Lessons Learned about Community Engagement

Several significant “lessons learned” emerged from the evaluation of the CHEWs’ experience—lessons about the importance of community engagement, lessons about the nature of community partnerships, and lessons about evaluation as a management tool:

- Public health initiatives are most successful when they engage the community served.
- Facilitating community convening and conversing enhances community engagement among stakeholders.

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- New initiatives are most likely to succeed if they align with existing community initiatives.

Lessons Learned about Community Partnerships

- Community partnerships may be fragile. Some cannot be sustained. Have a "Plan B."
- Strong partnerships are built upon knowledge of one another's goals and limitations.
- Strong, culturally diverse partnerships are founded upon cultural competence.
- Clear goals and action steps facilitate partnerships by reducing misunderstandings.
- The strongest partnerships are built upon long-standing relationships.
- Local governments may be very strong partners, especially in place-based initiatives.
- Visible success attracts new partners.

Lessons Learned about Evaluation

- Well-designed evaluation tools aid management.
- Evaluation best serves an initiative if it is place before the initiative begins.

The experiences of the CHEWs, as embodied in their achievements and encapsulated in “lessons learned” was studied and used by RIDOH staff to develop an RFP for the HEZs. There are several differences in the design of the CHEW program and the design of the HEZ initiative, but two of them are key. First, the HEZ initiative is “place-based,” while the CHEW program, although focusing on selected “communities,” was “project-based.” Some CHEW awards were granted on the basis of proposals to field particular evidence-based programs to one or more “communities,” defined in various ways, e.g., a geographic area, a patient population, a student population, etc. In contrast, HEZ awards were granted on the basis of proposals to serve entire populations of defined geographic areas, with *non-specified* evidence-based programs *to be planned* in close collaboration with the populations served.

Second, based on lessons learned from the CHEW program, the HEZ initiative is *founded on* community engagement, while the CHEW program *valued* it. Thus, HEZ awards were granted to community-based organizations in large part on the basis of their ability to convene and engage community partners in area-wide public health surveillance and planning efforts, only later to facilitate the development of evidence-based public health interventions. The HEZ initiative is designed to unfold in stages, with the entire first year of funding to be spent on community engagement by *convening* (diverse stakeholders representing the entire population of the geographic area to be served), *discussing* (known social and environmental causes of poor health in the area), *assessing* (burden of disease, health disparities, and access to public health and healthcare services in the area), and *prioritizing* (those problems or disparities to be addressed first) with the full participation of community stakeholders. Such a design structure was required to assure that subsequent public health *planning* in, by, and for the HEZ reflects the needs and concerns and priorities of the entire population served within that geographic setting.

Health Equity Zones: Lessons Applied

The Model. In 2015, as the CHEW program was ending and undergoing a final evaluation, RIDOH issued a new RFP for its Health Equity Zone (HEZ) initiative, “to improve the health of *communities* with high rates of illness, injury, chronic disease or other adverse

health outcomes.” The RFP called for proposals “to engage community organizations and residents to confront the social and environmental (SE) factors that make some Rhode Island communities unhealthy.” Each HEZ is envisioned to be:

- Equity-based (devoted to eliminating health disparities)
- Place-based (defined geographically)
- Population-based (committed to all people within its boundaries)
- Stakeholder-based (designed to engage the community in all phases of work)
- Data-based (pledged to quantitative measurement and evaluation)
- High-impact (aimed at addressing social and environmental determinants of health)
- Evidence-based (required to base all activities upon evidence-based strategies)

The RFP described HEZs as “contiguous geographic areas that are small enough for the program to have a significant impact on improving health outcomes, reducing health disparities and improving the social and environmental (SE) conditions of the neighborhood, yet large enough to impact a significant number of people,” emphasizing that “creating healthier, equitable places, must be done by multiple organizations and community members working together.” The RFP called for work to be performed in five phases over the course of the grant award:

1. Organize: Build, expand, or maintain a HEZ collaborative.

Applicants are required to describe a HEZ Collaborative to achieve project goals, and, if a strong, inclusive, community-based collaborative does not already exist in the geographic area, to plan to dedicate the first six months of Year 1 activities to building one. Applicants are urged to assure that racial and ethnic groups, individuals with disabilities, youth and elderly residents have a meaningful participation in the collaborative.

2. Assess: Conduct a baseline assessment within the HEZ.

Awardees are expected to conduct an assessment of the health status of the residents of the HEZ in Year 1, *after* the successful formation of a HEZ Collaborative, and with the advice and guidance *of* that Collaborative. The purpose of the assessment is to identify and to describe *health inequities* of interest and importance to the community. Awardees are permitted to use *existing* data in their assessments, and are urged to collect *additional* data, if-and-as needed to have sufficient information to develop a plan of action. The use of sample surveys is suggested as a means of collecting additional data.

3. Plan: Develop a plan of action.

The RFP clearly specifies several parameters of planning. Plans *must* be informed by a recent assessment of the health status of the residents of the HEZ. They may address *only* those problematic health outcomes or health risks identified in that assessment. Strategies to address such health outcomes or risks *must* be selected from a list of evidence-based strategies specially developed by RIDOH for the HEZs (based in part on RIDOH's previous experience with the CHEW program), and should address *high impact* targets (targets which are as close as possible to the base of the equity pyramid, e.g., environmental determinants of health). Nevertheless, strategies may *also* address *lower impact* targets (e.g., health screening). In any case, higher and lower impact targets must be aligned in such a way that higher and lower impact strategies support one another.

4. Do: Implement the plan of action.

5. Interventions are expected to adhere to planning, based on careful assessment. Interventions are to rely primarily on evidence-based strategies to address their objectives. The latter must be specified clearly, to facilitate ongoing evaluation of the structure, processes, and outcomes of all interventions fielded by the HEZ.

Additionally, each HEZ is required to track its achievements in organizing, assessing, planning, and implementing its plans, which in essence, embodies a fifth phase of work:

5. Evaluate: Track progress in Phases 1-4.

- a. Document progress in building, convening, and maintaining a HEZ collaborative, including membership, meetings, meeting attendance, issues raised by members of the collaborative, and decisions made.
- b. Document progress in assessing the health status and health inequities of HEZ residents, writing and disseminating an assessment report (and selected findings, as appropriate to address different audiences).
- c. Document the development of a HEZ plan, including planning organization, planning process, planning participants, plan elements, and key objectives.
- d. Document all projects undertaken to achieve the objectives of the HEZ plan, including, for each distinct project, its structure, and processes, and outcomes.
- e. Participate in a collaborative evaluation of HEZs, in which the initiative is evaluated, focusing on those successes and challenges that appear to be common across HEZs.

Establishment of Health Equity Zones

RIDOH received a diverse set of proposals in response to its RFP. Several of the Backbone Agencies had led successful efforts in the preceding CHEW program, and used “lessons learned” to develop their HEZ proposals. Other “new” Backbone Agencies had *not* been funded previously—by the CHEW program—but nevertheless benefitted from the *experience* of the CHEWs, which had been analyzed and publicized by RIDOH, and which, of course, had substantially influenced the new (HEZ) RFP.

Three million dollars were awarded to 11 HEZ proposals in 2015. Each of the 11 funded proposals conformed to the seven foundational principles of HEZ initiative as defined in the RFP, i.e. each was deemed to equity-based, place-based, population-based, stakeholder-based, data-based, high impact and evidence-based. Of these, ten remained as the initiative moved into Year 2, in which the Backbone Agencies received funds, hired staff, and otherwise built the organizational structure necessary to organize the stakeholders in each HEZ. Of the ten HEZs, at least one is in each of the state's five counties, three are defined by inner-city neighborhood boundaries, six are city-wide, and one encompasses an entire, county, largely rural in nature. The populations of the HEZs range from about 5,500 (the Olneyville neighborhood) to 178,000 (the City of Providence). Two of the neighborhood HEZs are located within the geographic bounds of another city-wide HEZ (the City of Providence—Rhode Island's largest and arguably most diverse city).

Internal Infrastructure

Throughout this critical start-up period, RIDOH dedicated eight “HEZ Team” members to provide oversight and support of the Backbone Agencies. A ninth HEZ Team Member was given oversight of evaluation planning and implementation. Members of the HEZ Team were carefully chosen for their experience in program development, program management, and

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community organizing. All have substantial experience in public health surveillance and data-based planning and all are firmly dedicated to the ideals embodied in the HEZ initiative. RIDOH staff thus engaged with the new HEZs were encouraged to draw freely upon the resources within the Health Department for additional support as needed. The Director of Health and her leadership team are strong advocates of health equity and worked diligently with staff across RIDOH's Divisions to facilitate support of the HEZ Team. The entire Department has thus been aligned with the HEZ initiative, either directly, e.g. Members of the HEZ Team, or indirectly, assisting the HEZ Team with in-kind support (labor, equipment) for one or more of the HEZs, as specific needs arise. A few examples of indirect support include fiscal guidance, assistance in the establishment of HEZ-level evaluation programs, and the provision of small-area data from RIDOH's many surveillance databases. As available, public health interns were also assigned to support the HEZ Team.

Members of the HEZ Team who have specific responsibility for one or more of the HEZ's were free to garner in-kind RIDOH support, as necessary using formal and informal channels, and were able to benefit from one another's experiences. To assure the full support of the Department in this major initiative, the HEZ Team is convened regularly under the guidance of the 1/The Co-Directors of the RIDOH'S newly-established Health Equity Institute, 2/the Executive Director of Health, and 3/The Associate Director of CHE. (These four "champions" of the HEZ initiative meet regularly with the Director of Health's Office and with program staff across the Department to support the HEZs.) In these regular meetings, HEZ Team members share recent experiences (successes and challenges) and help one another to analyze present and further (anticipated) problems and to think about ways to address these problems, including engagement and application of in-kind resources from RIDOH and other state agencies, ideas which are then explored further at divisional and department levels.

In short, the HEZs benefit from well-organized, in-kind support from seasoned public health professionals, led by three key champions of the initiative, well-positioned to marshal *ad hoc* support—flexibly and quickly—from the Department's substantial assets. All of this *works* because of the considerable groundwork laid by dedicated RIDOH staff, including high-level leadership over the past decade to address health inequities in the state. The elevation of "minority health" from office to division status, the recruitment of a racially and ethnically diverse workforce along with increased awareness within a workforce about the concerns important to racially and ethnically diverse populations, the development of strong community ties, responsiveness to the ever-changing needs of new immigrants and refugees, the adoption of the Health Impact Pyramid and its adaptation as a Health Equity Framework, and more, built slowly but intentionally—all have a role to play in RIDOH's ability to support the HEZs

RESULTS

The First Year: Organizing and Planning

Upon completion of the first year of the HEZ award activities, ten HEZ Collaboratives have been established or strengthened, to assure that the community engagement developed at the beginning of the new initiative is effectively maintained through subsequent components of implementation. Each of the Collaboratives have met regularly to survey the burden of disease and the distribution of health disparities among all residents within the geographic boundaries of its HEZ, facilitated by its Backbone agency. Informative reports, summarizing the first year's

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efforts, have been completed by all of the HEZs. A look at one of the reports from a city-wide HEZ (Woonsocket, RI) is illustrative of the work done thus far.

Woonsocket's report, entitled *Health Equity Zone, Woonsocket: Report to the Community April 2015 – May 2016*, begins with an encapsulation of the HEZ "philosophy."

"The overall mission of the Woonsocket Health Equity Zone is to utilize collective impact and leverage community resources to address health and wellness disparities in Woonsocket by focusing on the social determinants of health. The Woonsocket Health Equity Zone uses a place-based approach to ensure that the neighborhoods in the community become the kind of places that enable all children and families to succeed and thrive. Disparities are driven by upstream factors including a lack of access to healthy food and recreation, high rates of teen pregnancy, trauma, domestic violence and accidental drug overdoses. The Woonsocket Health Equity Zone decided to focus on these topics after conducting a comprehensive review of available data and talking to community leaders."

Note the references to:

- Equity-based..... ("health and wellness disparities")
- Place-based.....("a place based approach")
- Population-based.....("all children and families")
- Stakeholder-based...("collective impact," "community resources," "community leaders")
- Data-based.....("comprehensive review of available data")
- High-impact.....("social determinants of health," "upstream factors")

Only mention of "evidence-based" is missing, but further on in the document, without using the term, "evidence-based," programs which are indeed evidence-based are listed as possible responses to "lack of access to healthy food and recreation, high rates of teen pregnancy, trauma, domestic violence, and accidental drug overdoses."

The Woonsocket report continues by exhorting collective action ("Organizations work together using collective impact to increase effect") and listing "17 organizations who are partners of the Health Equity Zone," including partners from local government (mayor's office, police department, school department), health care agencies, social service agencies, faith-based organizations, businesses, and even an arts group. Woonsocket goes beyond these organizational partners, however, to improve the "reach" of community engagement, by employing nine part-time "community ambassadors." In the words of the report, "The Ambassadors will act as community catalysts, using a 'bottom-up' approach to raise awareness about health equity and the HEZ."

The Woonsocket HEZ has chosen to address five health inequities: food access, drug overdose, teen health, domestic violence, and barriers to outdoor physical activity. Each problem is stated simply, e.g., "Many people in Woonsocket do not have access to healthy, affordable, fresh food," and then is illustrated with one or more simple statistics, e.g., "Three in ten eligible people are not enrolled in the Women, Infants, and Children (WIC) Program," and "17% of Woonsocket residents eat recommended servings of fruits and vegetables." Several "Health Equity Zone Responses" follow each documented health inequity, based on evidence-based

strategies. Among the responses are calls for additional data, as needed to guide planning, e.g., “Conduct a needs assessment and plan to improve food systems in Woonsocket.”

The reports summarizing the first year's charge for each HEZ, serve as concise “strategic plans” to guide the development of HEZ interventions in years two and three of the program. They are easy to read, using pictograms and simple language, and therefore, they are easily translated into several languages, as appropriate for particular HEZs.

The Second Year: Marshaling Community Resources for Effective Interventions

As the HEZs begin Year 2 (of three to four years of funding), they enter a critical period in which each of the interventions are fleshed out and fielded. Every HEZ Collaborative must effectively leverage local resources to support implementation activities—*fiscal* and *in-kind* donations from community partners, and most importantly, *social capital* from HEZ residents. Every HEZ Collaborative must effectively leverage local resources to support implementation activities: fiscal, in-kind donations from community partners and most importantly, social capital from HEZ residents, a significant community resource frequently underutilized by public health agencies. *This* phase of HEZ work, especially the leveraging of resources, requires a distinct variety of skills (and level of effort), which may or may not have come into play in Year 1. Distinctly, as two different objectives, garnering attendance (a main task in Year 1) and garnering resources (a main task in Year 2 and subsequent years) must be achieved successfully, while also developing meaningful amounts of social capital in order to establish sustained engagements by the community involved.

At least three ingredients are necessary to make a successful transition from Year 1 to Year 2.

Community Engagement: Community engagement—a never-ending challenge—must be strengthened. Chances are high that “initial” community engagement, although enthusiastic (over newly-awarded funding, etc.), is narrow, i.e., that it is confined largely to organized groups who derive direct or indirect benefit from participation in HEZ activities, such as funding, support of core organizational mission, substantial “say” in community initiatives, publicity, etc. Using the Woonsocket HEZ as an example, this level of engagement has been displayed by the 17 partner agencies of the Health Equity Zone. It must be broadened significantly, to include many more organizational *and* individual “partners,” as interventions are developed and fielded. Recognizing this fact, the nine “community ambassadors” in the Woonsocket HEZ have been dedicated to this very task. The Community Ambassadors served as the linkage for the community needs and the Woonsocket HEZ. The success or failure of their mission, “to raise [‘bottom-up’] awareness about health equity and the HEZ,” may very well echo what reflects the success or failure of the entire HEZ mission.

Flexible, Expert Support: The intervention phase, even more so than the organizational and planning phase of the HEZ initiative, will require flexible, expert support to each of the ten HEZs—each “backbone agency” (the recipient of funding and facilitator of its HEZ Collaborative), each HEZ Collaborative, and each HEZ intervention, however it may be structured. Given the limited current funding of the HEZs that focuses on the Collaboratives effectuating the interventions, the primary immediate source of such support is RIDOH, and much, if not all of this support will be in-kind from staff members dedicated to other public health projects. Therefore, continued commitment from RIDOH in form of training and technical assistance, enhanced by the judicious alignment of “standard” public health programming with HEZ programming, is critical.

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In the future, however, there is another potential source—a potentially valuable source—of flexible, expert support for the HEZs: *academia*. Rhode Island is rich in schools of higher learning, both publicly and privately funded, including a medical school and a school of public health. Appreciating the many benefits of collaboration with academia, RIDOH has purposefully restructured itself as an “academic health department,” creating an “Academic Center” under its aegis for the purpose of developing specific, formal collaborations with local colleges and universities. RIDOH’s Academic Center has great potential to channel academic expertise to the HEZs, and in return, opportunities for community-level education and research to several academic communities.

Immediate, Specific, and Winnable Objectives: At this critical juncture, careful decisions about objectives for HEZ “interventions” are especially important for sustaining and growing community support. In short, even the “partner agencies” that make up the core of the HEZ Collaboratives have not committed fully to the HEZ concept. HEZs are “something new,” and recognition of the culture change that takes time is a wise approach. Funding is viewed as limited and tenuous, and success is indeed dependent upon a variety of factors. The ability of a few core agencies to attract strapped community-based organizations, and to engage and align social capital in resource-poor (low-income) communities- is critical at this phase of the program. To be most willing to commit scarce resources, potential contributors—partner agencies and HEZ residents alike—must see the HEZs working. They must experience tangible successes, and, in order to maintain morale, they must experience them expediently. “Immediate, specific, and winnable” were Saul Alinsky’s core principles of community organizing, and to this day, community organizers understand that deviation from these principles is at their own peril (Miller, 2014). Thus, among planned “responses” to various health disparities, the HEZs would be well served to know that the best strategy is to start with “low-hanging fruit,” approaches that are *quick to complete* (immediate), *visible* (specific), and *certain to work with available resources* (winnable). Governmental public health resources have always been limited, and, relative to arising challenges, may be diminishing. Therefore, as ever, public health agencies must find and engage resources other than tax dollars – “community” resources, including the monetary and “in-kind” resources of community based organizations, the engagement of local residents, and other resources of social capital-to protect the public’s health and to assure health equity.

Other “Key” Ingredients: In addition to the critical ingredients just described, other ingredients are undoubtedly important to the continued development and success of the multi-sectorial HEZ initiative. For example, the engagement of community leadership (resident leadership) is key to the long-term sustainability of the HEZs, as is the sustainability of financial resources, at least sufficient to support vibrant HEZ Collaboratives and other basic infrastructure over time. Finally, the “political will” of state and local government and the news media, while perhaps not necessary to the success of grassroots efforts, would certainly help to sustain the commitment of persons and organizations to long-term effort.

CONCLUSION

Leading to New Ways Ahead of Addressing Local Problems with Local Solutions: A New Way Ahead for Public Health Departments

The concept that public health resources are limited, even dwindling, in relation to new challenges, is considered a truism. Yet there is vast potential in grass-roots efforts, on the one

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hand, and effective collaboration between grass-roots and governmental efforts on the other. Place-based initiatives seem to have the greatest potential for tapping this vast resource, but developing them within the current structure of public health funding (heavily federal, heavily categorical, and heavily “contractual”) is tricky. Place-based initiatives like the HEZs are “different.” Their reliance on diverse community input seems “messy” in relation to, say, a nice, neat, managed-by-objective screening program. Their person-to-person community organizing seems slow, even never-ending, and their progress can be difficult to quantify. And yet, there is a vast, largely untapped resource, right there at the fingertips of the community, and urgently needing to be aligned with life-saving and life-altering initiatives.

With such great potential, we must do our utmost to test the effectiveness and viability of place-based initiatives, taking the long view (community engagement takes time and effort!), but assuring visible wins of recognized value as we proceed. Alignment of effort: alignment of organizations in the community, and alignment of available resources within the public health system, is the key to success. Rhode Island, as well as other jurisdictions throughout the U.S., have worked steadily to activate such alignment, and having done so are well-positioned to test the potential of place-based initiatives. Hopefully, government at all levels will recognize the potential value in HEZ-like initiatives, and stay the course of support with patience, until they are fully developed and evaluated.

A New Way Ahead for Public Health—Defining Boundaries

Traditionally, “public health” has functioned as an arm of Government, hence “*public* health” as opposed to “private health” or just “health.” It was developed as such because many health issues were best addressed “wholesale,” and government, in most cases, was the most universal “wholesaler” in most jurisdictions. It was also developed as such because addressing certain health problems required the legal, or financial, or even the military power of government to get the job done (Turnock & Atchison, 2002). The positives in all of this are numerous, but two stand out as key: First, for the most part, Government participation in addressing the public’s health works very well. Children are immunized, tobacco use is restricted from most public environments, awareness is raised about preventing transmission of certain diseases, at-risk persons are screened and cannot be denied emergency care, the rescue arrives soon after a 911 call is made, and so on. Second, public health is unquestionably accepted—and expected to be—a primary responsibility of government. Public health budgets may wax and wane, but when a problem arises, the buck stops at the highest levels of government. They *must* respond (Committee on Assuring the Health of the Public in the 21st Century, Board on Health Promotion and Disease Prevention & Institute of Medicine, 2003).

Nevertheless, government “ownership” of public health has had two major drawbacks. First, government ownership makes public health “*their* job” in government, as opposed to “*our* job” together. “*We* pay the bills, and *they* had better do the work!” This attitude is not absolute, of course, but it certainly exists, and to the extent that it does exist, it tends to dampen the investment of social capital in public health efforts. Second, because *efficiency* is a key goal of governmental expenditures—whether or not the goal is achieved (!)—“wholesale” government-sponsored public health programs have traditionally been fielded as “one-size-fits-all.” Only lately (in the past several decades) has this approach been recognized not only as a poor means of eliminating health disparities, but also, in some cases, as a *cause* of health disparities (disparities caused by differential access to beneficial public health programs). Place-based initiatives are envisioned as remedies for both of these “side effects” of governmental ownership

of public health. Because they are *so* local, place-based initiatives are well-structured to avoid the pitfalls of “one-size-fits-all” public health, and they have great potential to harness social capital, and to grow it into the *local* ownership of public health that promotes the most effective sustainability.

Those on the government side of this new model must be cognizant of the inherent tensions – between the government and the people the government serves - as place-based initiatives develop. The power of place-based public health lies in *local ownership*, but of course, initiatives to achieve this goal usually begin as *government* initiatives (stimulated by *government* RFAs, funded with *government* dollars, supported by *government* personnel, and guided by *government* standards). Where does government ownership end, and local ownership begin? Are we, in government, willing to cede control absolutely? If not, do we risk loss of social capital? As local control grows, will the much-vaunted government-private *partnership* model morph into a *competitive* or even an *antagonistic* one? The answer to these questions, of course, will vary from place to place—such is the nature of place-based initiatives—but above these differences, we must envision, discuss, and “work through,” a model of shared control and leadership and accountability, for one simple reason: so much of public health relies on state- or federally-sanctioned *authority* and by law, this authority has been delegated to governmentally-appointed directors of health and further delegated to subordinate state officials and workers. Therefore, as we stimulate and nurture local ownership, we would be well served by engaging in discussions, even at this very early stage, about the characteristics, limitations, and optimal *mixes* of public vs. private ownership in the conduct of public health.

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