Applying an Equity Lens to a Coalition-Based Prevention Evaluation

Jordan Newburg, PhDC, Konul Karimova, PhDC, Heather Terral, PhD, Gitanjali Shrestha, PhD, Brittany Cooper, PhD[1], and Sarah Mariani[2], CPP

1. Washington State University, 2. Washington State Health Care Authority

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Our Team

Brittany Cooper, PhD
Associate Professor
Dept. of Human Development
Washington State University

Clara Hill, MPH
Research Associate
Dept. of Human Development
Washington State University

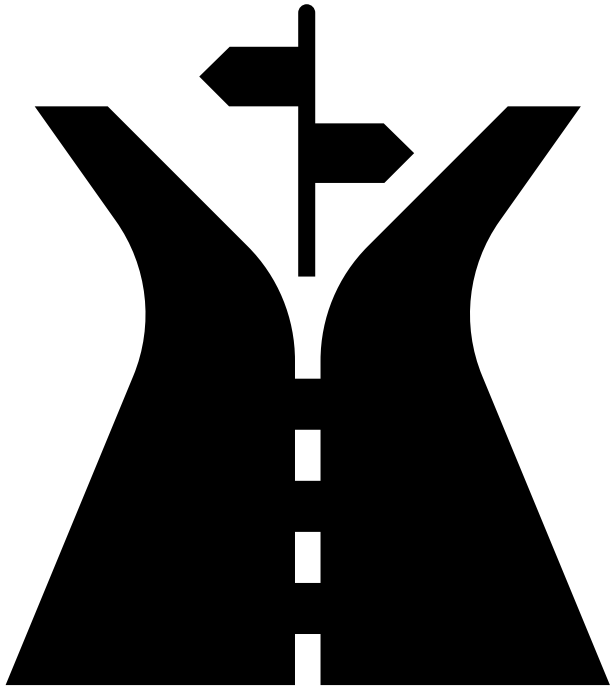
Gitanjali Shrestha, PhD
Associate Professor
Dept. of Human Development
Washington State University

Tyler Watson, PhD, MPH
Former* Prevention Research & Evaluation Manager
Washington State Health Care Authority

Jaymie Vandagriff, MS, PhD
Prevention Research & Evaluation Manager
Washington State Health Care Authority

*Current role: Research Specialist, Washington State Liquor and Cannabis Board

First, a road map…



- Cover Workshop Objectives
- Description of the Community Prevention Wellness Initiative (CPWI)
- Description of the Health Equity Evaluation
- Brief review of results of the Health Equity Evaluation
- Discussion and Q&A

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Workshop Objectives

- Receive an overview of a community coalition model in Washington State
- Discuss the design of a health equity focused evaluation, limitations, and improvements
- Reflect upon results, implications, and presentation of the evaluation
- Discuss how results were used by state-level funders and how similar work might be used

Creating an Action Item

We have influence over about 15% of a project; 85% is controlled by context, organizational structures, etc.

How would you use your 15% to drive health equity work in your corner of the world?

Simmer on this, we'll discuss at the end.

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Warm Up

What does health equity look like in the context of your work?

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Community Prevention and Wellness Initiative

Funded by the Washington State Health Care Authority, Division of Behavioral Health and Recovery (HCA / DBHR)

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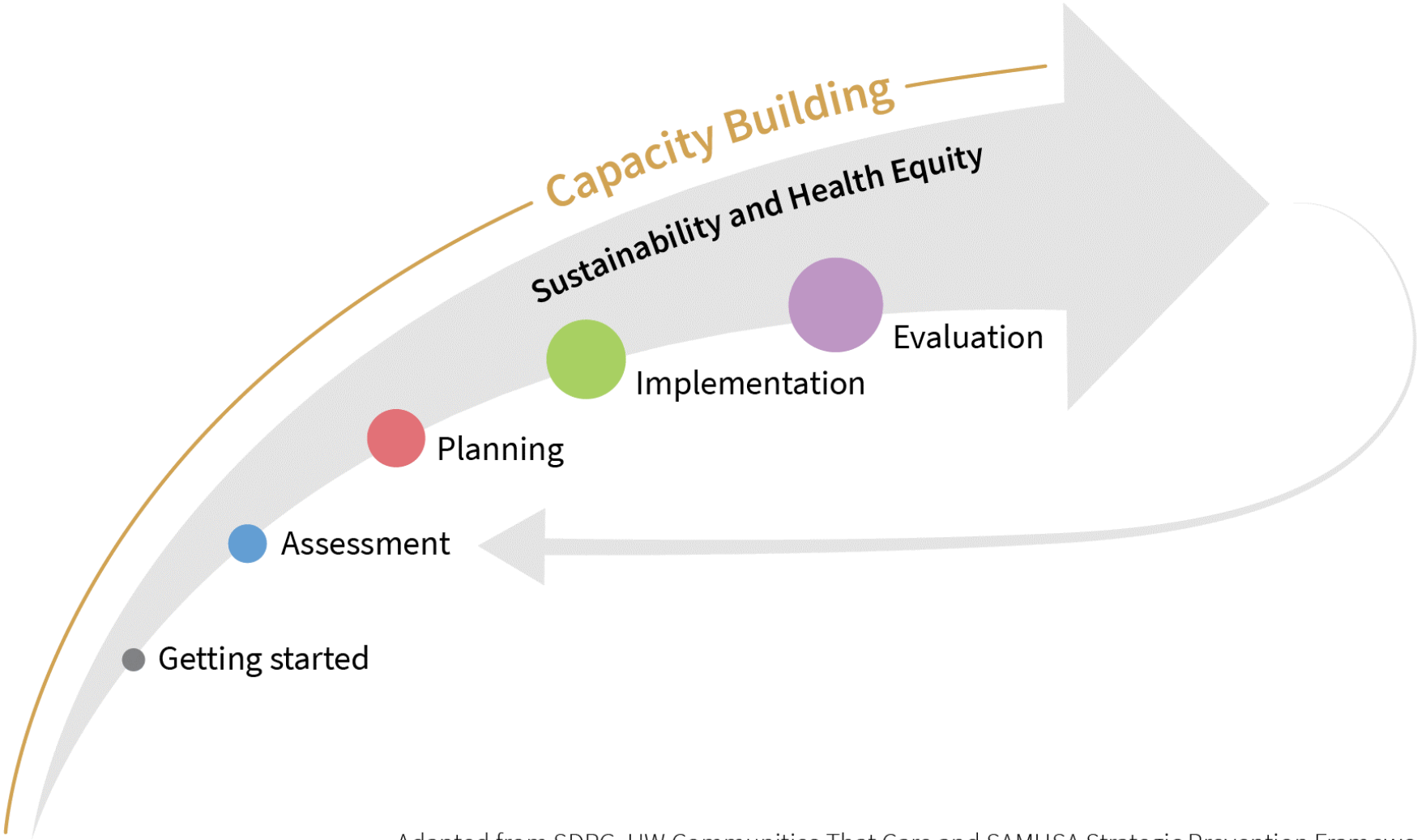
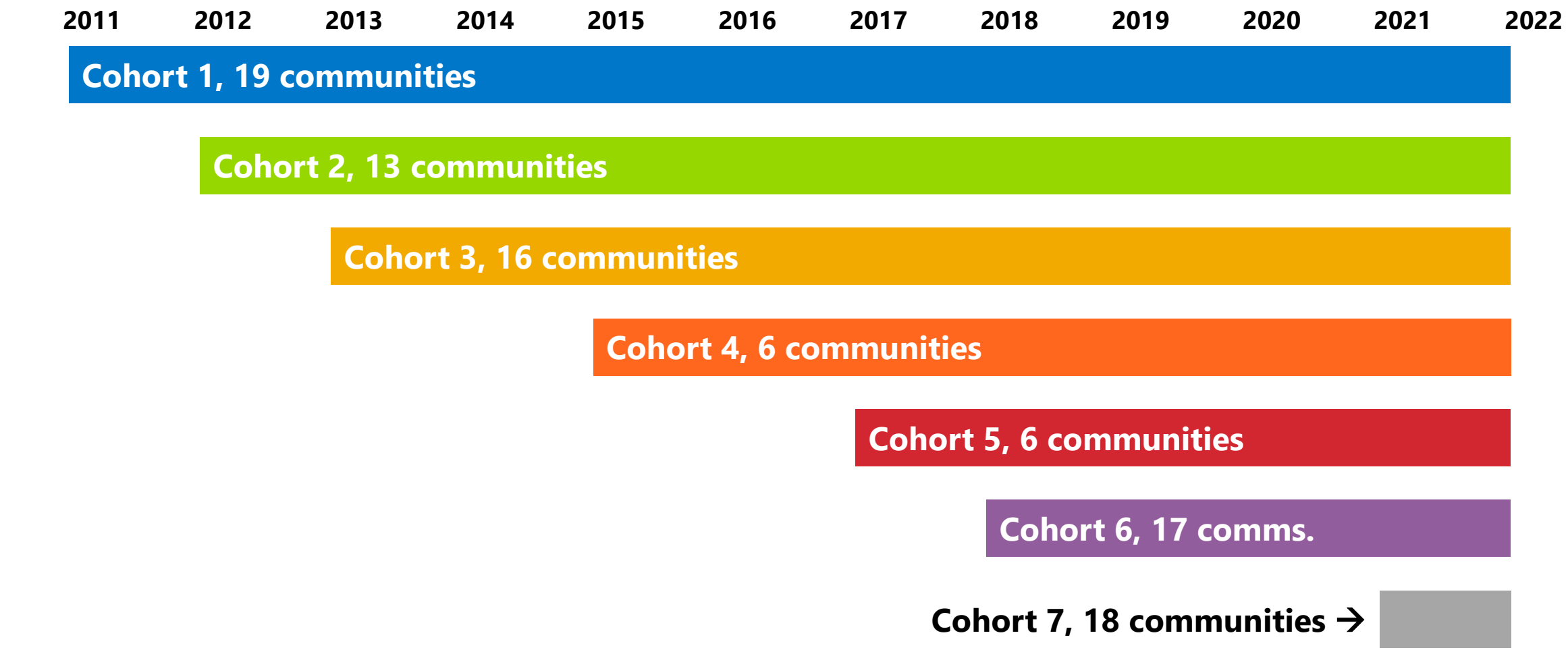
The Washington State CPWI Model

Washington State Prevention Planning Framework



Adapted from SDRG, UW Communities That Care and SAMHSA Strategic Prevention Framework

CPWI Timeline: 95 Communities



CPWI Is Working

CPWI **effectively reduces certain substance use outcomes** and related risk factors.

Evaluation Purpose

We know CPWI is effective, but it was time to examine *how* CPWI is working. Is CPWI working equally well for minoritized groups within communities?

How is CPWI addressing health inequities, and how might evaluations of CPWI assist in advancing equity in prevention?

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Questions so far?

Describing the Health Equity Evaluation

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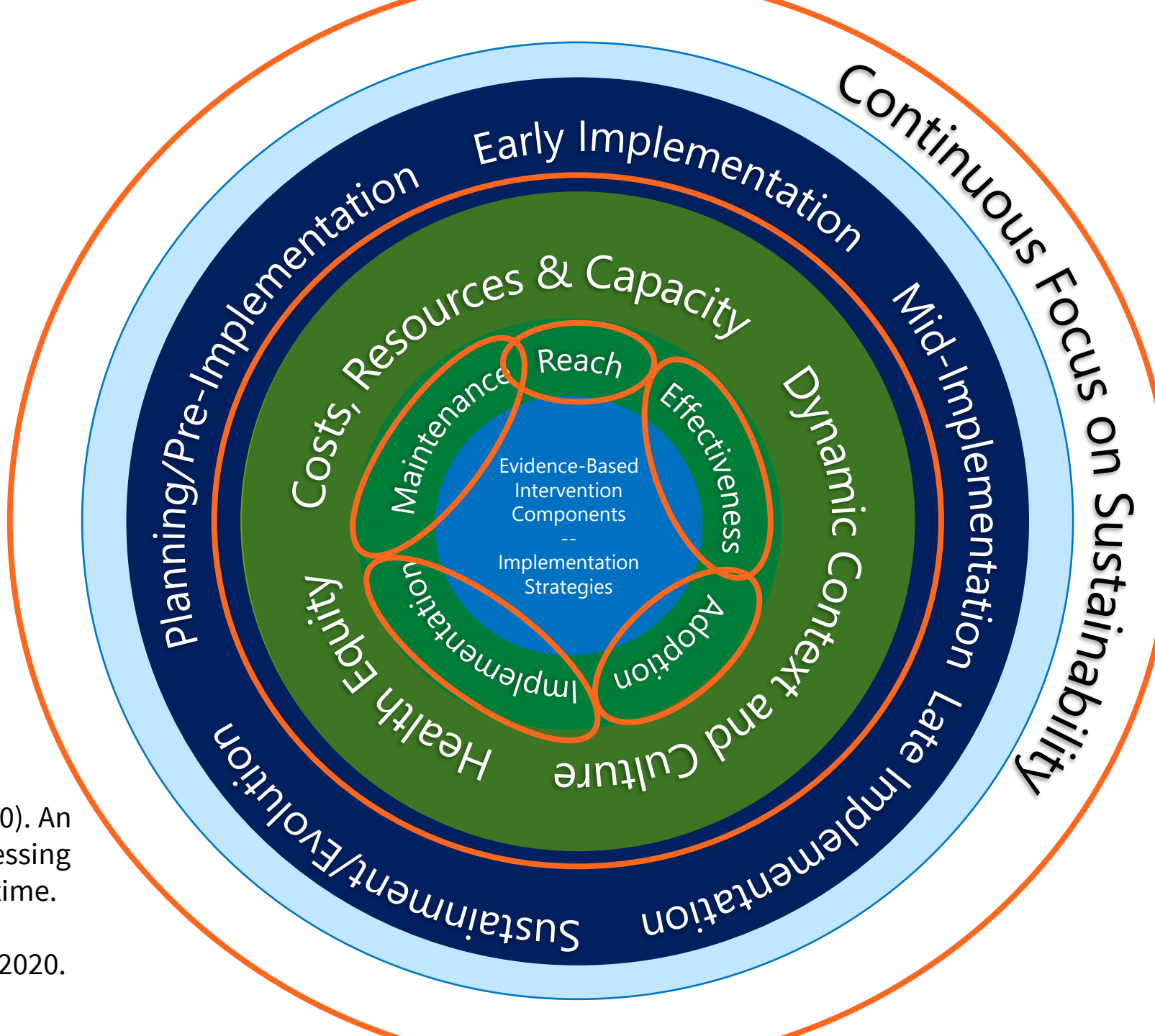
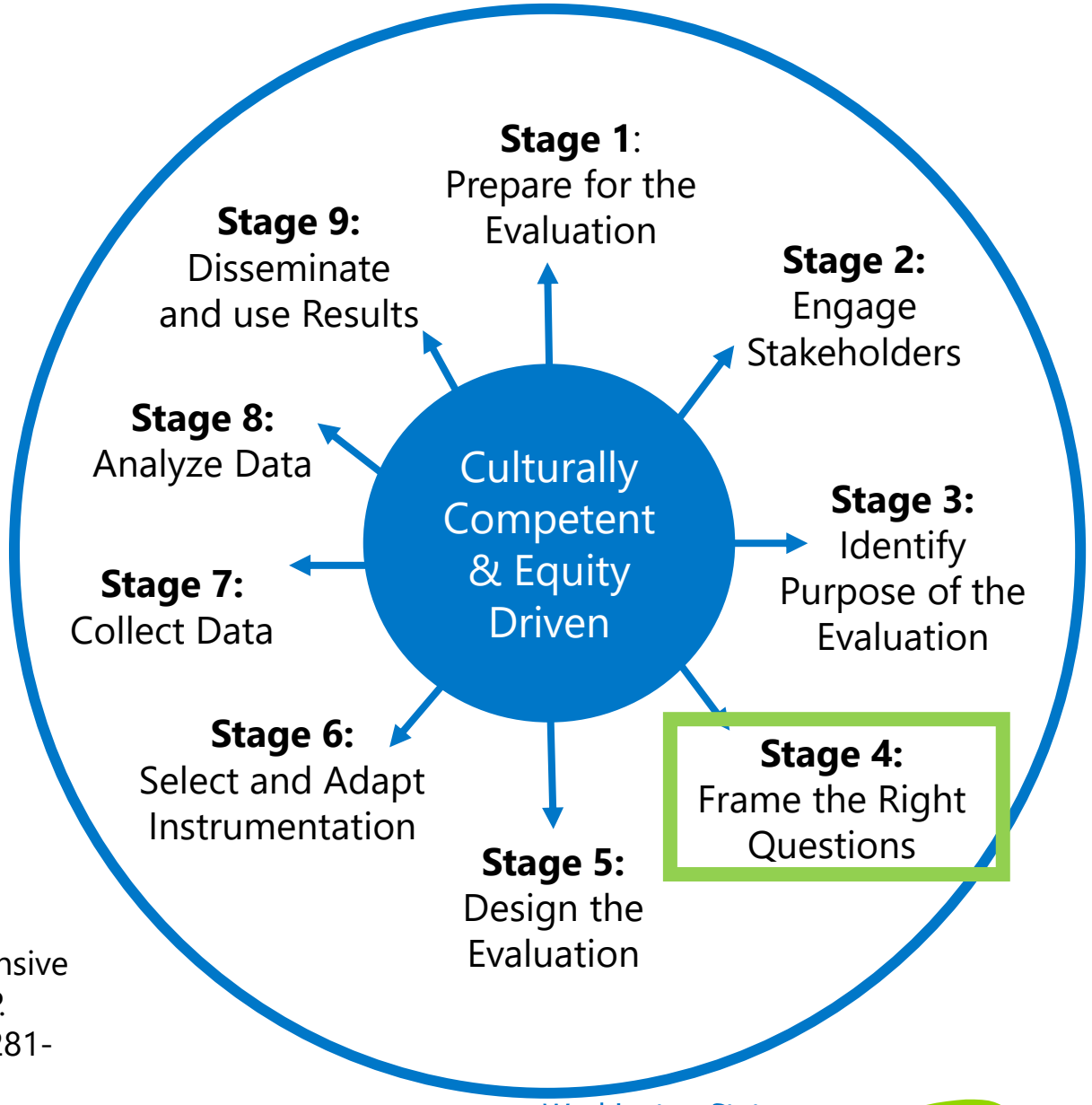
Expansion of the RE-AIM Framework



Recreated from:
Shelton, R. C., Chambers, D. A., & Glasgow, R. E. (2020). An extension of RE-AIM to enhance sustainability: addressing dynamic context and promoting health equity over time. *Frontiers in public health*, *8*, 134. https://www.frontiersin.org/articles/10.3389/fpubh.2020.00134/full

Culturally Responsive Equitable Evaluation



Adapted from: Hood, S. R., Hopson, and K. Kirkham. (2015) Culturally Responsive Evaluation: Theory, Practice, and Future Implications. In K. E. Newcomer, H. P. Hatry, & J. S. Wholey (Eds.) *Handbook of Practical Program Evaluation*. (pp. 281-317). NJ: John Wiley & Sons.

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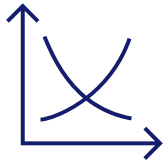
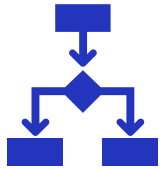
Evaluation Aims

1) What are **positive norms, outcomes, and protective factors** in CPWI communities?

2) What are **differences in teens' substance use** based on marginalized identities / status?



3) Is the effectiveness of CPWI **moderated by marginalized identity / status?**



5) **To describe the health equity promotion efforts** and to gather information relevant for incorporating health equity in the CPWI process.

Think, Pair, Share

- What frameworks do you and / or your organization use?
- What are similarities and differences between those frameworks and what we used?
- What would you say is missed by using these frameworks (RE-AIM and CREE)? What could be enhanced?

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Evaluation Results and Implications

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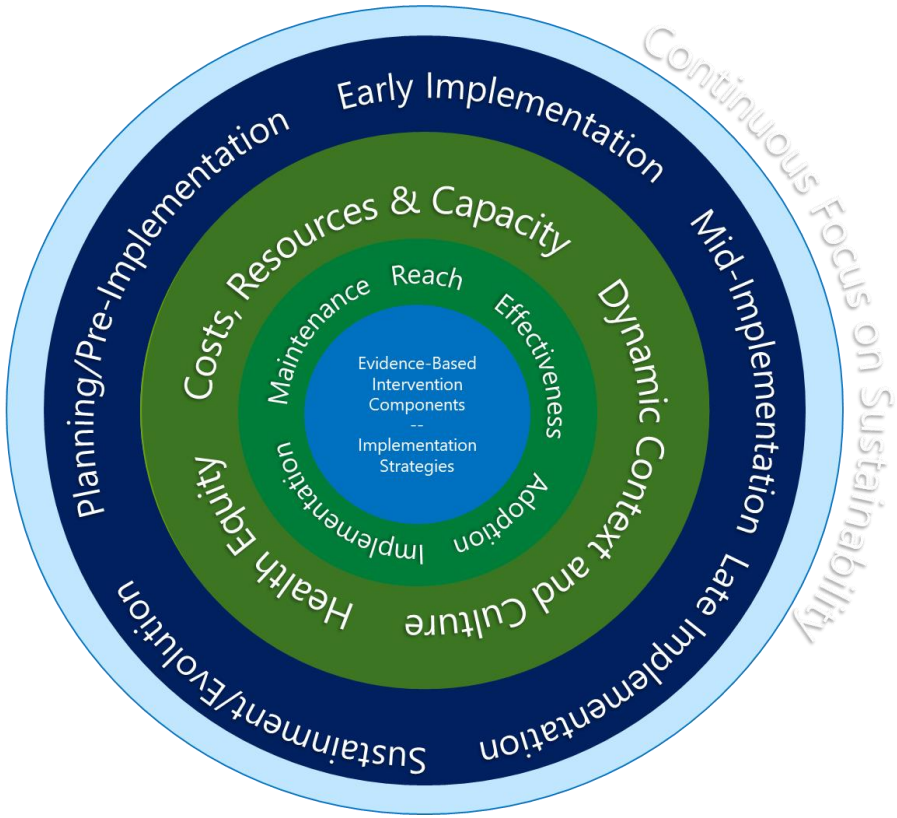
Quantitative Results

Evaluation Aims

1) What are **positive norms, outcomes, and protective factors** in CPWI communities?

2) What are **differences in teens' substance use** based on marginalized identities / status?

3) Is the effectiveness of CPWI is **moderated by marginalized identity / status?**



Prevalence Rates of Protective Factors Across Subgroups in Healthy Youth Survey 2021

Heat Matrix Legend:

A : Race & Ethnicity

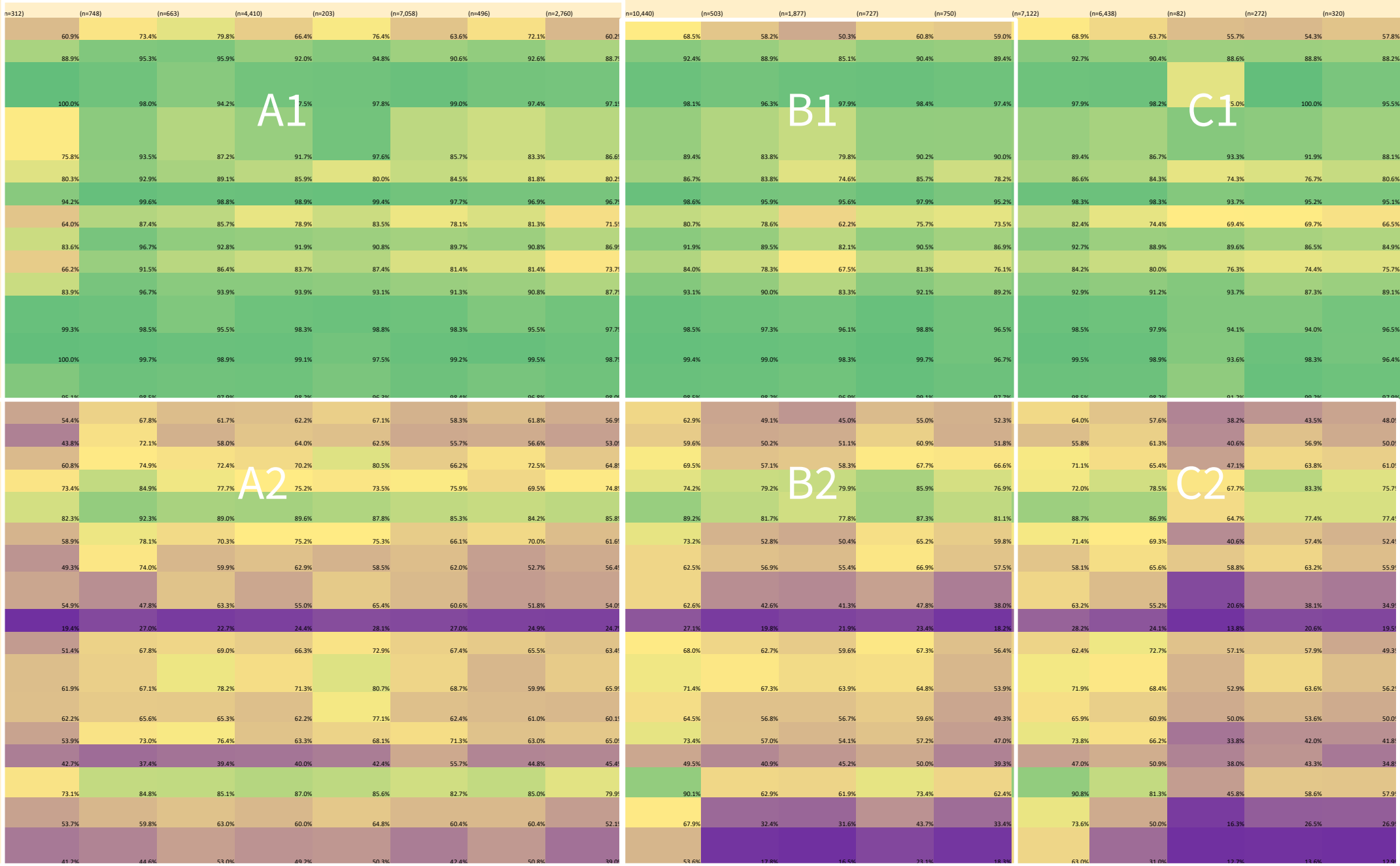
B: Sexual Orientation

C: Gender Identity

1: Substance Use Protective Factors

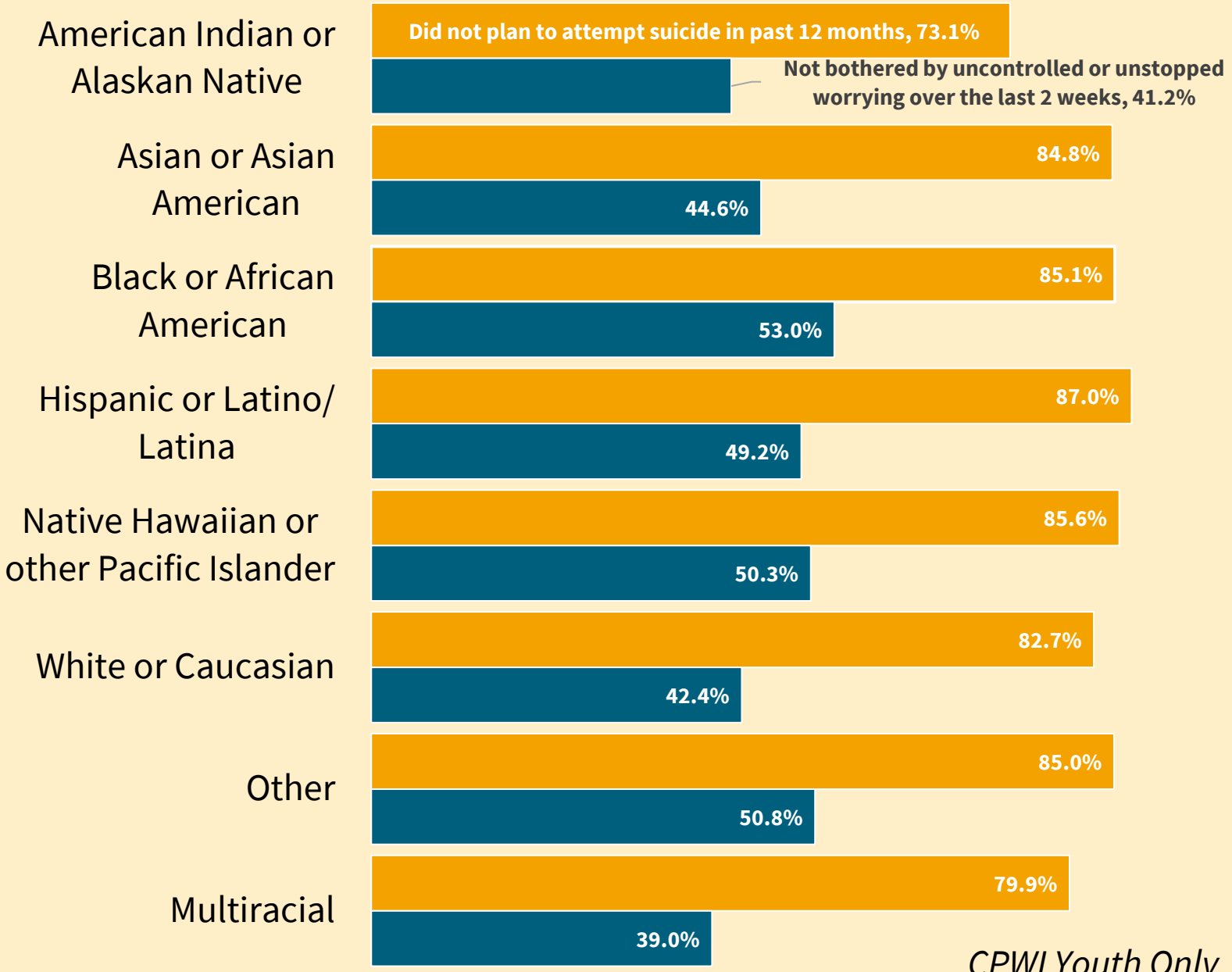
2: Social and Mental Health Protective Factors

Color gradient is purple (low) to green (high)



Insight | Mental Health Protective Factors

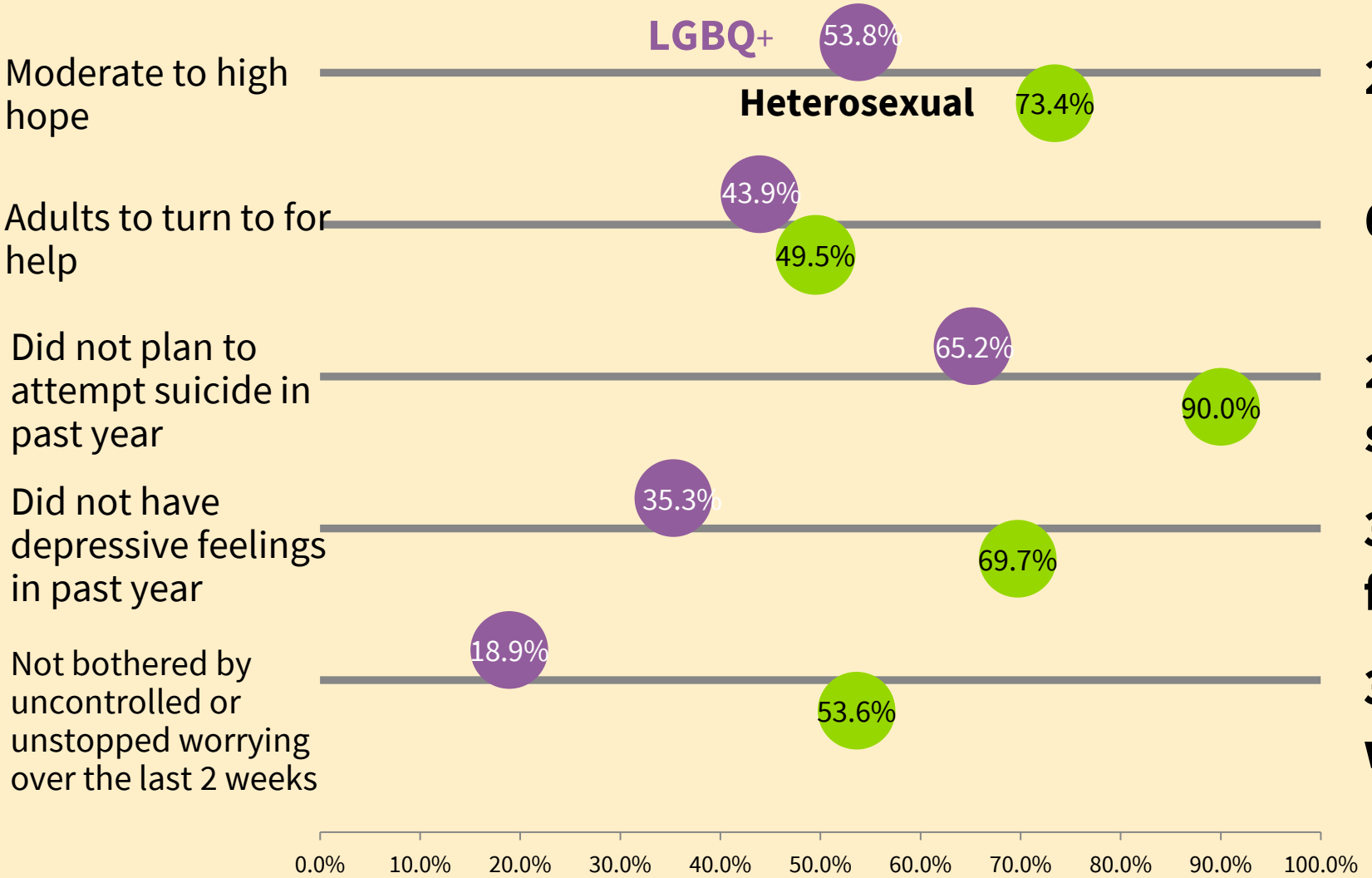
- **Across all racial and ethnic groups**
  - **youth did not report a plan for suicide attempt in the past year**
  - Hispanic or Latino/a/x youth reported at least planning, and American Indian or Alaskan Native youth the most.
- **However**,
  - **bother from uncontrolled worrying in the past two weeks** was more common
  - Black or African American youth reported the least worry, and Multiracial students the most.



CPWI Youth Only

Insight | Mental Health Protective Factors

Compared to **heterosexual** peers, **gay or lesbian, bisexual, questioning, and those who responded "something else fits better"** reported…



20% less hope

6% less adults to turn to

25% more planned to attempt suicide

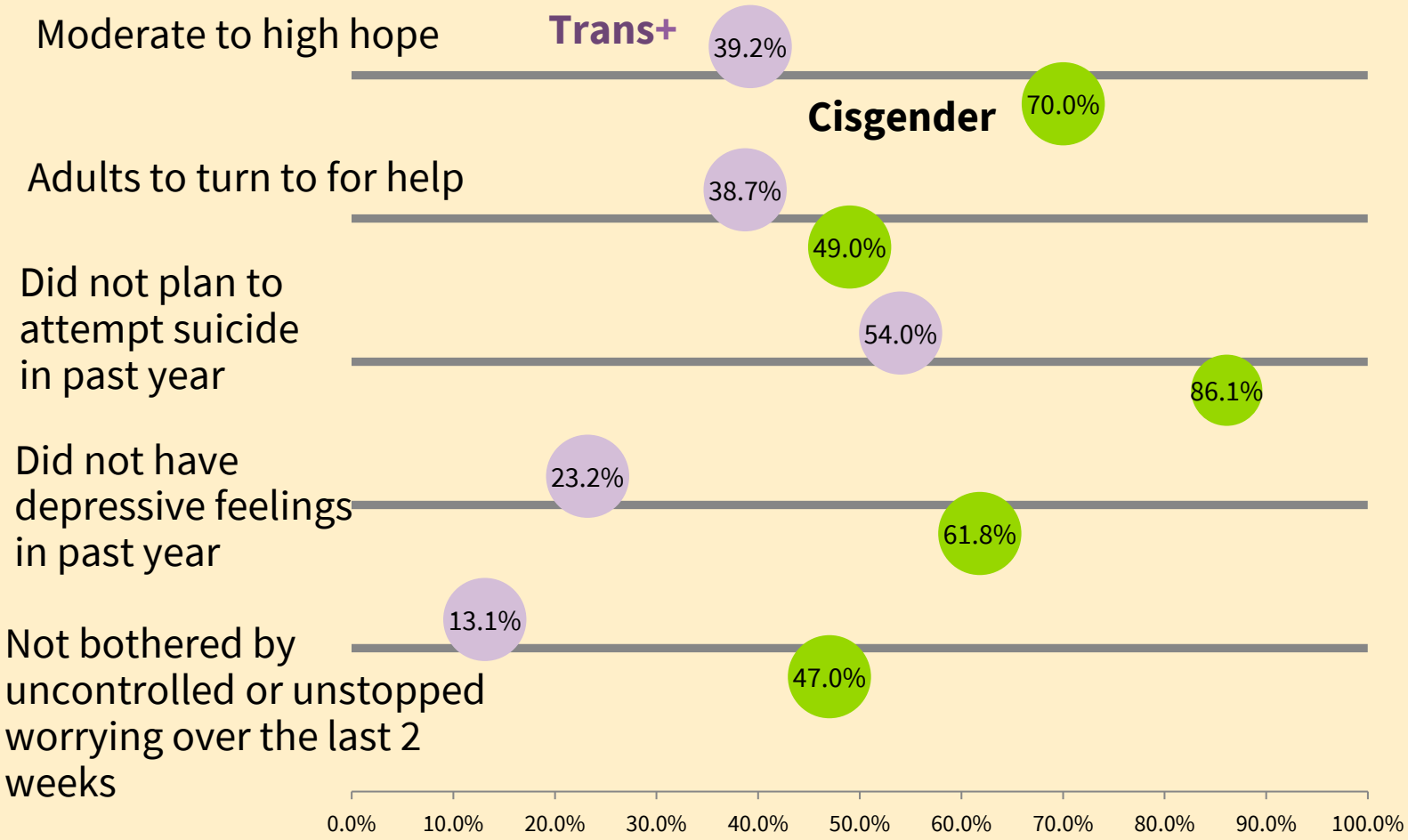
34% more depressive feelings

35% less uncontrolled worrying

CPWI Youth Only

Insight | Mental Health Protective Factors

Compared to **cisgender male and female peers**, **transgender, questioning, those who responded "something else fits better"** reported…



30% less hope

10% less adults to turn to

32% more planned to attempt suicide

39% more depressive feelings

34% less uncontrolled worrying

CPWI Youth Only

Qualitative Results

Evaluation Aim

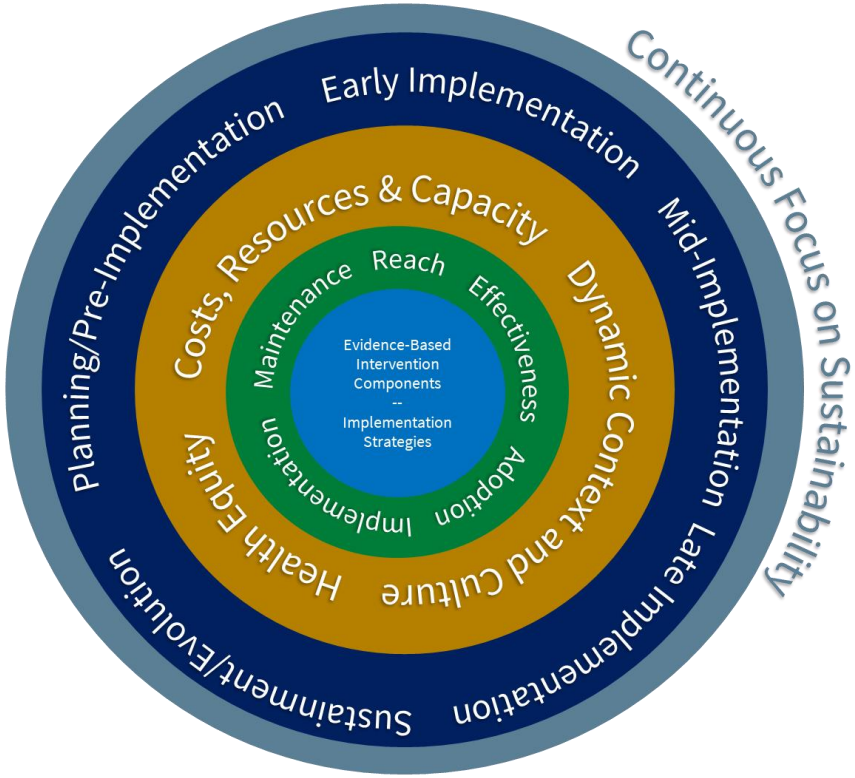
5) To describe the health equity promotion efforts and identify:

- Success stories,
- Facilitators,
- Barriers / challenges, and
- Other information

relevant for incorporating health equity in the CPWI process.

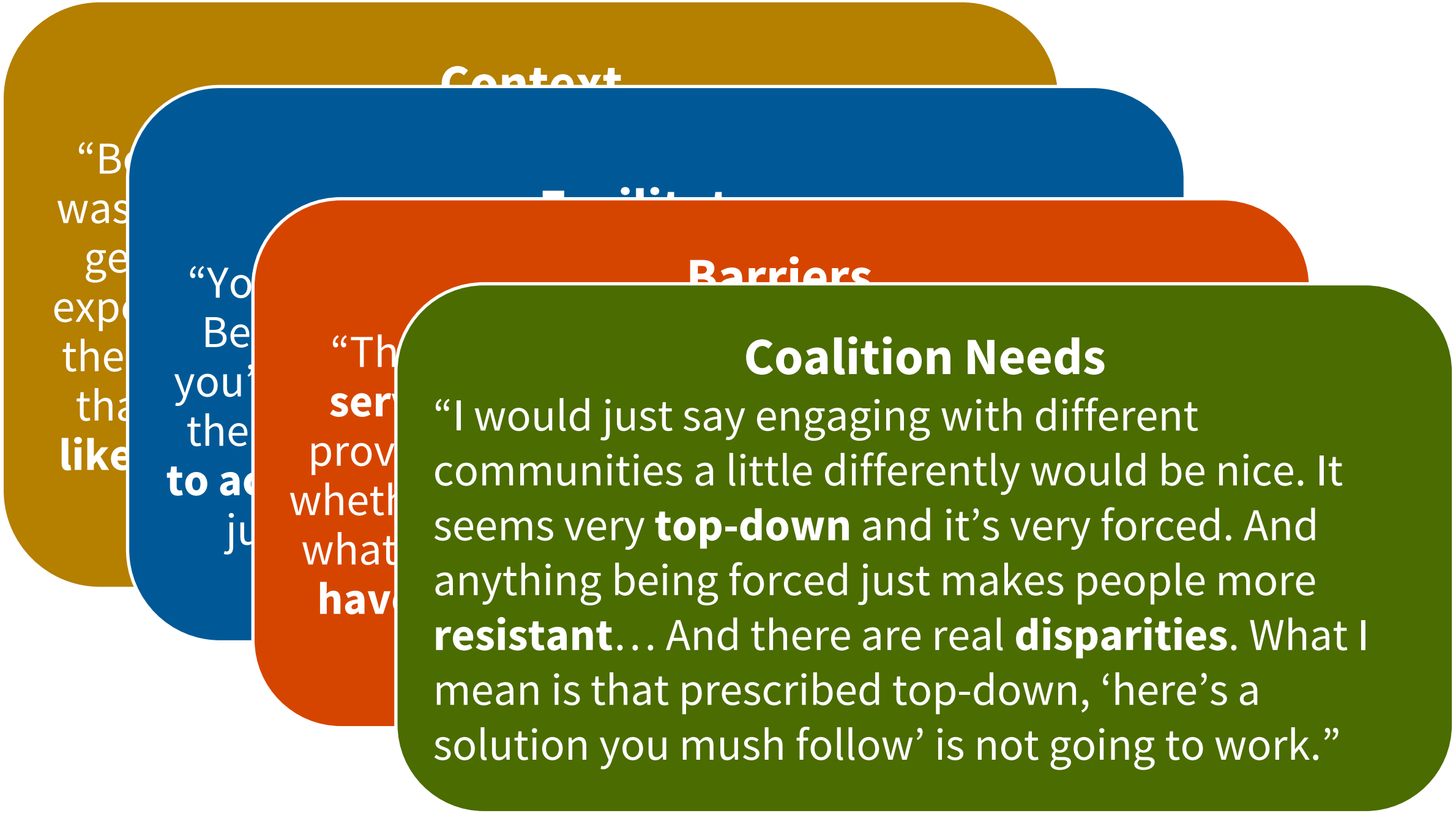
RE-AIM Dimensions

Adoption, Implementation, and Maintenance



Key Themes from Coordinator Interviews

Context	• Coordinators' expertise, lack thereof & positionality • Coalition processes and membership • Local meaning of diversity
Facilitators	• Adaptation of materials, processes etc. • Community buy-in • Health equity conversations
Barriers	• Resource constraints • Lower community capacity and readiness • Language and cultural barriers
Coalition Needs	• Spending flexibility and un-siloed funding (substance use or mental health) • Accessible training and capacity building • Material support


Coalition Needs
“I would just say engaging with different communities a little differently would be nice. It seems very **top-down** and it’s very forced. And anything being forced just makes people more **resistant**… And there are real **disparities**. What I mean is that prescribed top-down, ‘here’s a solution you mush follow’ is not going to work.”

Summary of Results

Quantitative

- Favorable findings regarding substance non-use outcomes and related protective factors
- Concerns regarding mental health factors for all Washington youth
- Social protective factors for gender and sexual minority youth require additional support

Qualitative

- Coordinators' expertise and positionality influence how they support coalitions
- Relationships can make or break health equity and prevention work
- Barriers include how funds and resources are used, community buy-in and readiness, and "selling" prevention (e.g., framing conversations)
- Coalitions can be supported with increased flexibility, access to training/education, and guidance on incorporating health equity more explicitly into work

Summary of Results

Social and mental health outcomes among all Washington youth require additional supports as youth report fewer protective factors in these domains. **Gender and sexual minority youth report even fewer social and mental health protective factors than their peers.**

Given the importance of Coalition Coordinators' expertise and positionality**, leveraging technical assistance to increase their understanding, capacity, and readiness**—to incorporate health equity into their work and to educate and engage coalition and community members—**would help to fill gaps in prevention among gender and sexual minority youth**.

Think, Pair, Share

We are trying to be mindful of how we present results. We want to reduce bias and avoid perpetuating disparities we see.

Ex, how we explain race/ethnicity is not a risk factor itself, it's a proxy.

Do you have any examples of how sharing results was done well? Or not so well? What should we keep in mind?

Open Discussion and Q & A

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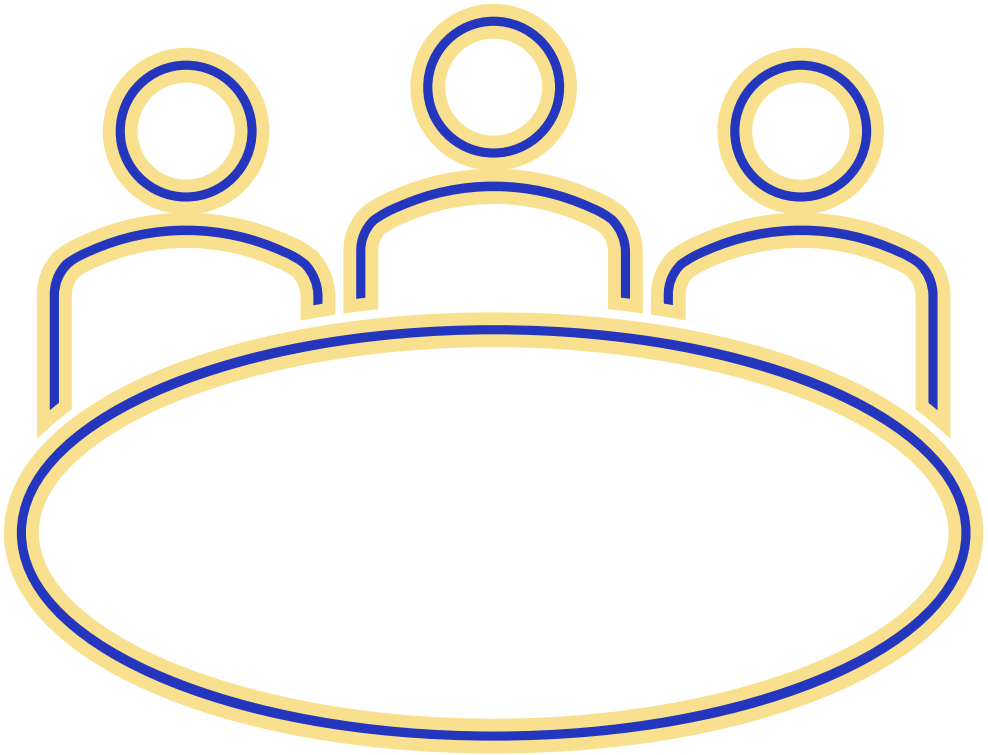


- What was helpful or not helpful about this evaluation?
- How might this evaluation support others' health equity evaluations or promotion?
- How can we avoid inadvertently perpetuating inequities and biases as we present these results and methods?
- How can we improve our presentation to appropriately call out inequities for effective action?

HOW THIS ALIGNS WITH CURRENT GUIDANCE

Additional Resources:

- Boyd, R. C. et al. (2023) Strategic Directions in Preventive Intervention Research to Advance Health Equity. *Prevention Science*.
- Biglan, A., Prinz, R. J., & Fishbein, D. (2023). Prevention Science and Health Equity: A Comprehensive Framework for Preventing Health Inequities and Disparities Associated with Race, Ethnicity, and Social Class. *Prevention Science*.
- https://preventionresearch.org/advocacy/advocacy-for-health-equity-in-prevention-science/

Goal 1: Promote Health Equity in Prevention Science

1. Promote etiological and intervention research addressing health equity.

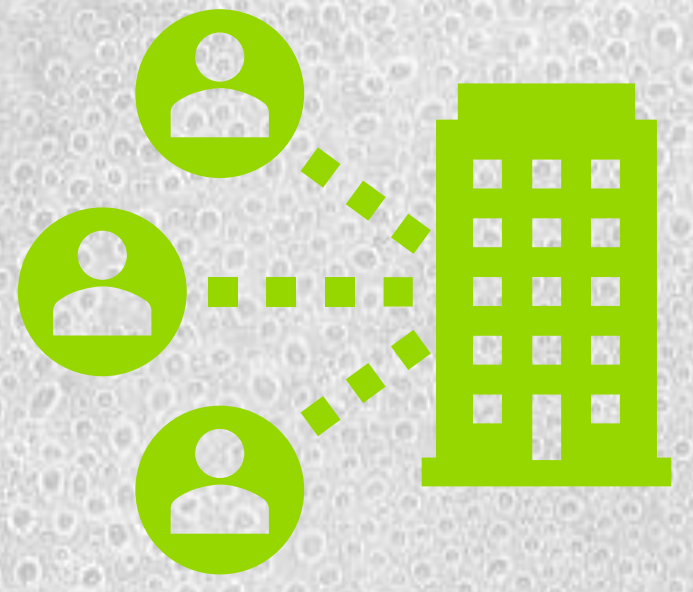
2. Promote the equitable inclusion of diverse groups in etiological and intervention research, in terms of role (funder, researcher, practitioners), race/ethnicity, international work, and methodological expertise (quantitative and qualitative).

3. Promote research to develop multilevel and multi-sectorial interventions that address the micro-, meso-, and macro-level social determinants of disparities and structural oppressions and develop principles for their implementation.

Action Item: What's your 15%?

We have influence over about 15% of a project, 85% is controlled by context, organizational structures, etc.

How would you use your 15% to drive health equity work in your corner of the world?



For more information:

- https://www.liberatingstructures.com/7-15-solutions/
- https://bit.ly/4bXoYbd

Thank you!

Jordan.Newburg@wsu.edu

Konul.Karimova@wsu.edu

Heather.Terral@wsu.edu

GShrestha@wsu.edu