A Qualitative Study of Health in All Policies at the Local Level

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Abstract

Health in All Policies (HiAP) encourage health-conscious policymaking in non-health sectors; however, there are no standardized measures or guides for assessing progress in HiAP implementation. The purpose of this study was to describe how HiAP in local public health agencies (LPHAs) are implemented at the local level in Colorado and identify challenges and opportunities for implementation. We conducted semi-structured interviews with 13 key informants identified through purposive sampling. Interviews were recorded, double-coded, and analyzed using thematic analysis. The themes we identified relating to the implementation of different HiAP approaches were as follows: the importance of building trusting relationships, a need to understand the work of LPHAs and public health, and LPHA structure and role clarity. Tools and tactics that respondents identified in their implementation and practice of HiAP are sharing data and data platforms, community dashboarding, providing services to partners, sharing programs or services, attending meetings regularly, and measurement instruments. This study demonstrates HiAP approach variation and the need for a state-wide standardized framework for initiatives and progress. Future HiAP implementation research should focus on county-level analysis using outcomes that LPHAs are targeting based on their health priorities and should also capture the activities of sectors outside of public health.

What do we already know about this topic?
We know that using the HiAP framework can have a substantial impact on the social determinants of health, depending on how it is practiced and implemented.
How does your research contribute to the field?
This research contributes to the field exploring how HiAP are understood and implemented at the local level in Colorado highlighting the different approaches that may be used in public health systems.
What are your research's implications toward theory, practice, or policy?
This study highlights that in order to successfully implement HiAP at the local level, there may be a need for policies implemented at the state level to support, facilitate, and monitor HiAP progress.

Introduction

Social determinants of health contribute to the intractability of public health challenges. Local public health agencies (LPHAs), hospitals, and community clinics feel ill-equipped to address such systemic factors on their own.[1] The emerging of Health in All Policies (HiAP) has been a topic of interest for tackling the social determinants of health.[2-5] The World Health Organization[6] defines HiAP as, "an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts to improve population health and health equity."

HiAP is a promising approach for health-conscious policymaking and practices within sectors not explicitly related

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to public health, such as transportation, education, and housing. HiAP is practiced at national, state, and local levels,[2] though it is often not called HiAP. HiAP depends on context, and as a result, there are different approaches.[3,7] Given this context dependence, the literature has presented mixed findings on how to best implement HiAP to ensure the healthiest populations possible.[8-10]

Although HiAP is practiced at every level, most of the attention has been at the national and state level and not at the municipal or local level. At the state level, several agencies have created health equity offices where the main purpose is to reinforce attention to creating cross-sectoral efforts to address health disparities.[11] In a recent study, public health officials from 5 states and 14 localities all agreed that HiAP is a means to promote health equity as a policy concern.[11]

HiAP is gaining momentum in big cities around the United States, including Los Angeles, Boston, Seattle, and Nashville to name a few.[12] In Colorado, there is no state mandate to implement and evaluate HiAP initiatives, but several cities as big as Denver and as small as rural Leadville are currently using an HiAP approach. One example of how HiAP has been practiced at the local level in Colorado is an agency that established an intersectoral project focused on youth health, adult health, and health equity. This HiAP effort engaged stakeholders such as school districts, recreation departments, nonprofits, and the community to develop a master plan for policy priorities. Several initiatives that came out of this plan included a family leadership training for schools, support for agencies to increase health equity capacity through coaching, working with health providers to address barriers for underserved communities, and the creation of community leadership groups such as Lideres Latinoamericanos.

There is no consensus on the best way to measure HiAP progress and its impacts on health equity.[11,13] Since HiAP is largely dependent on the context of the needs of the community, the political environment and the availability of resources, it is difficult to evaluate the progress and the impact it has on health outcomes.[14] Some of the practice-grounded tools that are currently used to implement and evaluate HiAP include using logic models and case studies.[14] This study aims to characterize how Colorado LPHAs are using the HiAP approach at the local level, identify tools and tactics they employ to advance the HiAP practice and identify successes and challenges associated with HiAP implementation.

Methods

We used a qualitative approach to explore how LPHAs are implementing HiAP at the local level in Colorado. LPHAs who answered questions that indicated HiAP activity and implementation on the National Association of City and County Health Officials (NACCHO) 2017 report were eligible. We used purposive sampling to identify LPHAs and Colorado-based experts in the field. LPHAs were strategically

Table 1. Population Quartile of LPHAs Interviewed.

Population quartile	Number of LPHAs
Under 10,000	1
10,000-60,000	2
60,000-200,000	3
Over 200,000	2

Note. LPHAs = local public health agencies.

chosen to capture agencies that differ with respect to the size of the population served, agency size, and geographical location. Out of 48 LPHAs in Colorado, we selected 8 agencies to participate in key informant interviews. We conducted 8 interviews with directors and deputy directors of LPHAs. We also interviewed 5 experts with experience in local public health policy that are based outside of LPHAs and who are actively involved in HiAP activities in Colorado.

We conducted interviews between May and August 2017 and analyzed data through March 2018. Interviews were 45 minutes long, recorded and conducted in-person or by video conference. Our interview guide was informed by the peer-reviewed literature and previous interviews with experts. We asked questions based on the five themes of HiAP identified by the NACCHO in their 2017 report: (1) Partnerships and Collaborations, (2) Windows of Opportunity, (3) Building Capacity, (4) Embedding and Sustaining a Framework for Change, and (5) Challenges to Implementation.[15] During the interviews, the term HiAP was used directly, however no set definition was provided. We transcribed interviews and used a thematic approach to evaluate the interview responses with content analysis.

Results

Of the 13 interviews, 8 were with different LPHAs (5 with directors and 3 with deputy directors), and 5 were with experts in the field who work outside of LPHAs. The LPHAs varied in size with the number of people working at each LPHA ranging from 10 to 25 depending on the size of the county and the population served. Two of the LPHAs were from the front range, 2 from the central mountains, 1 from the southeast, 2 from the western slope, and 1 from the Denver metro area. Three of the LPHAs were multi-county agencies that served 2-3 counties. Population quartile in terms of the number of residents and density category in terms of the number of residents per unit area for each LPHA county included in the analysis is demonstrated in Tables 1 and 2. The quartile categories come from the 2017 NACCHO Profile of LPHAs and highlight the different population sizes served by each LPHA that was interviewed.

Following are the 3 main themes related to HiAP implementation, challenges and successes, and tools and tactics used to implement HiAP and to advance equity at the local level in Colorado.

Table 2. Density Categories of LPHAs Interviewed.

Density category	Number of LPHAs
Rural	2
Densely settled rural	2
Semi-urban	2
Urban	2

Note. LPHAs = local public health agencies.

Importance of Building Trusting Relationships

We observed that multiple LPHAs had the same health goal but used different approaches that involved building trusting relationships. One example of this is of 2 agencies that were trying to reduce mental health disparities and rates of suicide in their communities. One agency built a relationship with the faith-based community to promote mental health services, while the other built a relationship with local public officials to issue policies to increase funding for mental health services in the community. Through trusting relationships, LPHAs are able to create opportunities to engage partners in honest and reliable ways that generate alliances. LPHAs engaged a range of partners, including parks and recreation, school districts, police departments, faith-based organizations, healthcare facilities, nonprofit organizations, and the private sector.

A specific approach used to build trusting relationships is one that we will call the Strategic High Touch Approach. The Strategic High Touch Approach is defined as one-on-one relationship building with clarity of purpose and roles. As described by one of the key informants, this approach emphasizes "working with partners using a community centered lens to ensure that you are working on initiatives that people are willing to work on." It also emphasizes the importance of being in touch with people at all times and not only when LPHAs need something. One respondent said, "stay in touch with them in a real manner, in between the times we want to talk about a health issue." Although this approach is a crucial component of the local HiAP implementation, many agencies mentioned it is hard to do because there is little state support or resources to create opportunities to build these types of relationships. Some agencies said they cannot do this because they have to fulfill agency responsibilities and duties first before having downtime to sit and talk with partners.

A second approach is one that we will call the Transactional Approach tempered with an "on the same team" mentality. Interviewees agreed that trust could be built on the successful exchange of resources, repeated demonstrations of value and competence, and the realization of shared circumstances. To illustrate the same team mentality, one respondent said: "[Find out] what they are trying to accomplish and what can we do to help them." By finding out what your partners are trying to accomplish, LPHAs can uniquely position themselves to help their partners achieve their goals while including public health ideas and considerations in the design of the goal and implementation. For example, one LPHA found out the mayor wanted to improve road safety, and the public health agency used this opportunity to include ideas related to health in transportation such as developing bike lanes and sidewalks.

One of the key characteristics for both of these approaches was Humility and Adaptability. Interviewees valued being nimble and responsive to the direction partners want to go and being able to adjust priorities and goals when possible to demonstrate shared values. One respondent said, "We go in with preconceived notions about what mutual benefit ought to be . . . dialogue helps identify concerns and risks that have not been considered before." By practicing humility and adaptability, many agencies also agreed that they can learn the true needs from the community and work alongside them to develop innovative and culturally relevant programs.

Need to Understand the Work of LPHAs and Public Health

The second main theme was a need for education about public health and the upstream determinants. LPHAs agreed that there is a lack of general knowledge and language among partners and the community about public health concepts and the role of public health in government and the community. "It is important to have a common vocabulary and getting people to speak the same language, this helps get the point across and helps incorporate health into decision making outside of public health." Not being aware of what public health puts LPHAs at a disadvantage when it comes to funding, community engagement, and enacting legitimate change.

There is a misconception of what LPHAs do or what they are supposed to do. Sometimes public health gets confused with healthcare. Public health officials that lacked an understanding about the social and environmental determinants of health mentioned that they looked for opportunities to learn about these determinants. They were able to educate themselves about these determinants through attending conferences and webinars and spending more time in the community. Many LPHAs were also unsure how they can work with the state to get more training and access to resources to learn about these determinants. We also identified that in addition to having public health officials be aware of these determinants, partners also need to be educated about these determinants so they can be more thoughtful about how public health is connected to their area of work. By educating other sectors of the government about the role of public health, it allows LPHAs to establish an HiAP approach. One example of the need for a better understanding of the work of LPHAs was a collaborative effort with the local police department. "The police department wanted us to do this triage center . . . [we are] trying to get them to understand the difference between direct care and population health."

LPHA Structure and Role Clarity

The third theme was centered around LPHA structure and role clarity. LPHA structure influences HiAP capacity and allows the agency to have clear goals and role clarity when resources are limited. As explained by one policy expert for the state: "LPHAs spend time and resources; sending folks to the table who are not systems and policy thinkers limits their ability to see the fuller picture of cause and effect, often leading to unintended consequences." The flexibility of roles was considered important. Many LPHAs are under-staffed, and staff have to play more than one role. Role clarity is important because it allows agencies to know which partners to engage and how to engage them. For many of the LPHAs that are understaffed, they reported that it was hard to implement HiAP because it would just be another thing they have to do. Some agencies do have a specific role for someone to advance HiAP approaches.

By optimizing the structure, agencies are able to utilize resources efficiently and effectively. Respondents expressed that it is better to get good at something and then share that service and skill with partner agencies rather than spread themselves thin. Interviewees indicated that it is essential to reduce competition and "siloing" between agencies and other health service organizations, as explained by one deputy director: "If you want to hold on to agency functions just to define yourself, then that agency will be competing with other local agencies for dollars."

HiAP Successes and Challenges

The LPHAs that are enacting HiAP have seen substantial progress—including the implementation of ordinances, policies, and practices centered around mental health, transportation, food security, and housing security—and have also faced challenges.

A primary success some LPHAs mentioned as important was having direct access to decisionmakers and directly engaging with their local officials to learn about the impacts of policy and the root causes of health inequities. Although having direct support from public officials was important for some, for other agencies it was not as helpful because of the different levels of bureaucracy. One director stated, "Bureaucracy can either help or inhibit HiAP implementation, sometimes it just gets too diffuse and we need to be more united and specific with initiatives."

Another key success was that some LPHAs made HiAP connections at the personal level. This included bringing the people who are impacted by these policies to the table and getting them involved in decision-making and the implementation process. One example was during a walkability assessment; the group made an effort to include a mother with her child and a stroller to make it more personal. Another example was during zoning planning and a food security evaluation, including someone who lives in a food desert. One director explained the benefit of personal stories:

> People in rural areas have an experience we can learn about, and we can use that opportunity to build out some data. We also need to put the data back into those communities just to see if that is what they are really experiencing. It makes the narrative more personal and the data even better for policy change.

Agencies mentioned challenges related to lack of funding, time, direction from the state, and political will. Funding was restricted in the sense that the dollars they get to enact health measures are considered categorical funding. This means that funds must be used only for the designated category in which they are appropriated. For example, if an agency receives state funds for tobacco control, it can only be used for tobacco control activities and nothing else. Categorical funding restricts LPHAs' ability to be innovative and use funds on how the community thinks they should be used. Many LPHAs said that since 2003 there have been funding cuts which have forced them to rely heavily on partners for funding and have limited the time they can spend on HiAP activities. One agency said that they only have half the funding recommended for their size. Other challenges related to limited funds include high staff turnover, insufficient physical space for community engagement, and lack of updated technology and equipment. Some agencies reported that HiAP would be an ideal approach but are not sure how to best implement it because of the lack of guidance from state health authorities.

A formidable challenge for LPHAs is lack of political will. Considering that public health is still an emerging topic that is often politicized, it is sometimes difficult to create buy-in from political stakeholders. One director described this difficulty as "there is still some hesitation on policy development . . . there is recognition of the need, but the want is not there." It was clear that some LPHAs are aware of the health issues that need to be addressed in the community and know how to address them; however, political will is often lacking. Some examples of policy development that lack political will include passing ordinances around afford-able housing, criminal justice reform, workforce and labor, the built environment, transportation, healthy school policy, and healthy food availability. The main challenge around political will was that message framing from the state and public health community is lacking and as a result, political actors do not make these issues part of their agenda.

Tools and Tactics for HiAP Implementation

LPHAs employ different tools and tactics to implement HiAP. A primary tactic is *sharing data and data platforms*. One large LPHA (serving over 100k) said they share a population health data management system with partners in a healthcare coalition. A valuable tool was *community dash-boarding*. Three respondent agencies are investing in the Thriving Colorado community dashboard system, a tool that allows data sharing for statewide collective impact. Another tactic was *providing services to partners*. Four respondents

report helping partners (including other agencies) when grant writing. Two reported operating as a fiscal agent for smaller partners. By serving as a fiscal agent, the LPHA is able to manage funding for the partner and gives LPHAs the flexibility to use these funds how they deem appropriate to meet the goals and objectives of their partners. LPHAs are also able to request grants from state or federal sources when they can demonstrate that they are working with partners. Another tactic was *sharing programs or service delivery*. Two agencies reported sharing public health programs for partner agencies and organizations to run. Another tactic was *being present in the community*. Four respondents discussed regularly attending planning, economic development, transportation, and other meetings even when not presenting something. *Measurement instruments* were also identified as important tools. One respondent agency reported tracking their impact on local policies and resources that went into different initiatives. Agencies are also seeking a way to catalog all LPHA staff interaction with local government.

One specific measurement instrument tool emphasized the important role of Community Health Assessment (CHA) and Improvement plans. A CHA is also known as a community needs assessment, and it is used to identify the current health status, needs, and issues of a community. CHA and improvement plans can position LPHAs as system-level experts who can provide invaluable data, facilitation, and technical and administrative resources. The approach also reveals underlying determinants to partners and becomes a springboard for HiAP. "The CHA process is a great opportunity to bring your stakeholders together . . . to identify what the data says . . . help them make the SDH connections." By using a CHA, this allows LPHAs to work directly with stakeholders and allows partners and the community to better understand what public health is and is a direct way to get them involved to take actions to improve health equity. Rather than telling the community that these health concerns exist, a CHA allows them to identify the health issue and gives them more shared responsibility to address it. While many LPHAs felt that CHAs can be really impactful, they expressed that CHAs require a lot of time and expertise which they may not have in-house.

Discussion

The study demonstrates that Colorado's LPHAs implement HiAP in different ways. Building trusting relationships, educating others about public health and the work of LPHAs, and optimizing LPHA structure and clarifying roles are important for HiAP implementation. LPHAs also reported using different tools and tactics to implement HiAP along with varied success and challenges.

The research is consistent with the literature of how HiAP success varies in different contexts.[3,7,16] There are multiple factors and recommendations to take into account to implement HiAP in local and in state agencies. Even though there are no right ways to perform HiAP, there are standard practices and steps that can be completed to gain a necessary groundwork to expand HiAP and build capacity.[13] Building trusting relationships are important for increasing cross-sector collaboration and increasing community engagement.[16] As identified by Johnson, shared principles for HiAP implementation can be summarized by creating collaborations across government agencies, advancing policies while furthering agencies' core missions, and incorporating health conscious decision making in engaged agencies.[17] By utilizing the different approaches as well as the tool and tactics defined by the key informants, LPHAs can enact and implement these shared principles.

It is crucial to understand the factors that need to be emphasized in order to optimize the potential for impact on population health. Two topics identified by participants in this study that warrant special attention are budgeting and state-level prioritization of public health and HiAP. Budgeting is a challenge that some referred to as insufficient funds and time. The use of HiAP budgets can be helpful in promoting collaboration and also increases stakeholder engagement and accountability. Considering that the state does not provide LPHAs direct financial support to complete these tasks, discretionary funds are used instead. However, many LPHAs know that these discretionary and flexible funds are small in amount and they can be leveraged if they partner with other sectors of government and other surrounding LPHAs. The state needs to be more involved in making sure that public health is a top priority, or else it will be hard to enact change. As described by one of the deputy directors, utilizing state police powers is an important avenue to implement HiAP: "We are good at being regulators, states should be focusing working with LPHAs on using the police powers as it relates to all policies that impact health."

There are various strengths and limitations of this study. The primary strength of this study is that it is the first study conducted in Colorado that explores HiAP implementation at the local level. Key informants represented a range of LPHAs from around Colorado and the diverse populations that they serve. Another strength of this study was that it was informed by both LPHAs and policy experts who work outside of LPHAs. This gives the study a broader scope of how HiAP is understood and implemented from the perspective of the agency experts as well as public health policy experts. The main limitation of this study was that there was a lack of consideration about the context of HiAP. HiAP is nonlinear and activities are not always dependent on each other. Historical events such as the passage of the Affordable Care Act in 2008 or the removal of Title Five funding used for tobacco prevention could have had a substantial influence not captured in our analysis. Another limitation was that we did not interview representatives from other sectors (eg, education, police departments, etc.) which would have provided the perspective of agencies that collaborate with LPHAs on HiAP.

Our study identifies implications for policy and research. Although HiAP is gaining traction, this research has highlighted that there are different ways to go about it at the local level. The LPHAs that we interviewed may have different understandings of what a HiAP approach means, although they are currently implementing HiAP. Future outcome measures for HiAP should be selected by matching policy initiatives to community health priorities. It is recommended that LPHAs require support from the state to conduct health policy scans and CHAs to get a better idea of where they can implement HiAP in their respective communities. Additionally, we recommend that the state of Colorado develop a standardized framework that LPHAs can use to track HiAP implementation and progress.

HiAP is key to sustainable change because it helps codify public health into institutional practices. The greatest potential for health improvement in big cities lies largely outside the immediate purview of public health agencies.[12] Many of the elements required to implement HiAP are not directly related to health and are mostly focused around activities that focus on relationship building, education, and leveraging existing support and structures. These findings suggest that it is important to educate stakeholders on the value of public health and the role of the determinants of health, to demonstrate commitment through trusting relationships beyond each individual agency, and to optimize the structure and define role clarity around HiAP activities. Many LPHAs believe that there could be more buy-in from the state and that they can help institutionalize HiAP across all LPHAs in Colorado.

Conclusion

Policymaking in sectors that are not typically aligned with public health goals, such as transportation, education, criminal justice, and the business community, has tremendous potential to impact the health of their communities in direct and indirect ways. The promise of HiAP lies in encouraging these sectors to adopt a "public health" lens through educational and productive partnerships with LPHAs and community members. LPHAs in Colorado implement HiAP through different approaches that employ building trusting relationships including the Strategic High Touch Approach and the Transactional Approach. Tools and tactics range from a community dashboard to simply being present in the community. LPHAs identified specific successes to HiAP implementation at the local level and also highlighted challenges of limited resources, political will, and lack of direction from the state level. More state direction could help institutionalize HiAP implementation across Colorado through a standardized evaluation framework that highlights progress at the local level and captures community-defined health priorities.

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