

# Strategies and Frameworks for Promoting Health Equity



Oregon  
**Health**  
Authority



Office of  
Equity & Inclusion

## Goals of the presentation

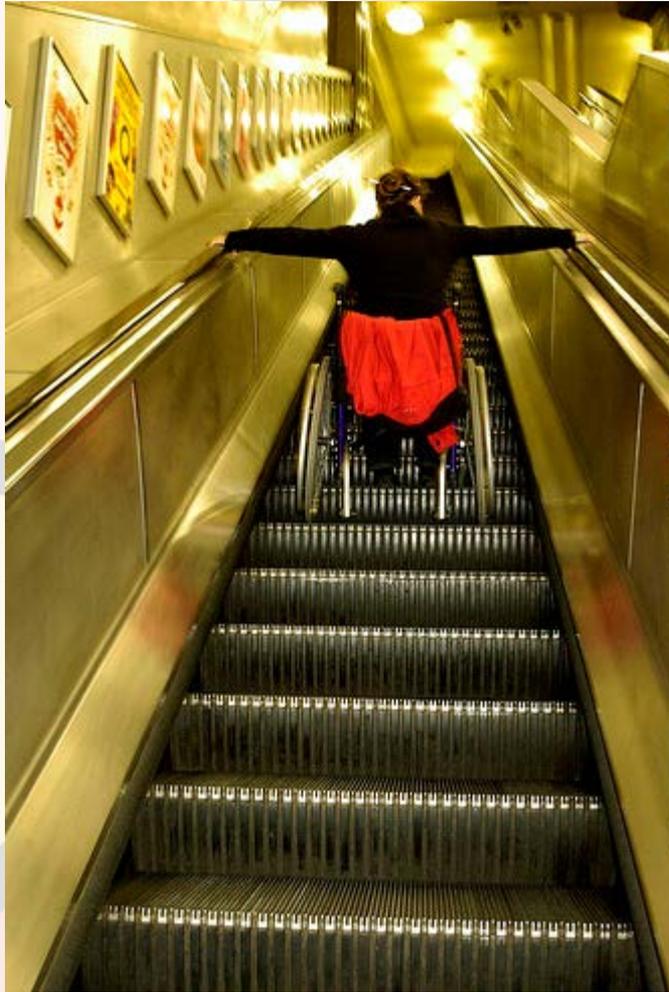
- Increase understanding of the **determinants** of health equity
- Increase awareness of the current **challenges** to health equity
- Increase awareness of the **business case**, and other reasons, for promoting health equity
- **Highlight models** that have been adopted nationally for promoting health care equity





# **What is Health Equity?**



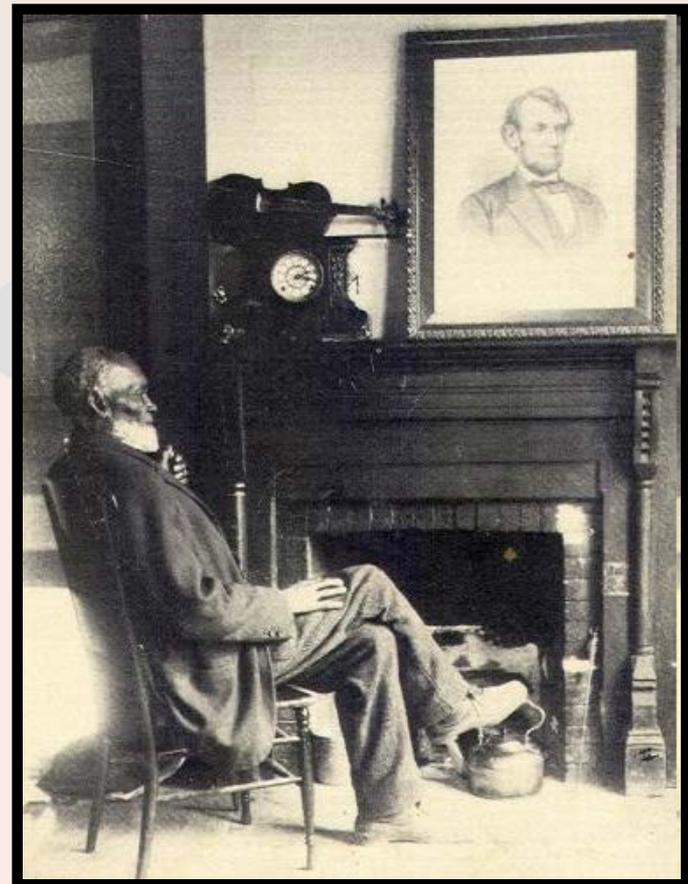


**Health inequities** are systemic, avoidable, unfair and unjust difference in health status and mortality rates and in the distribution of disease and illness across population groups.

They are sustained over time and generations and beyond the control of individuals.

# Social Determinants of Health Equity in Oregon

- **1844-1857** The Black Laws of Oregon
- **1857** The Oregon Constitution



# Social Determinants of Health Equity in Oregon

- **1923 Oregon Alien Land Law**





# Social Determinants of Health Equity in Oregon

- **1965:** Valley Migrant League
- **1986:** Oregon Department of Labor report



# Social Determinants of Health Equity in Oregon



- **2006:** PolyHeme Study
- **2007:** Income inequality increases in Oregon

# Social Determinants of Health Equity in Oregon

- **2008:** Oregon Driver's license law
- **2008:** AMA apologizes for racial discrimination



# The Four Great Race Disparities

- Health
- Wealth
- Education
- Criminal Justice (Incarceration)

# Educational Attainment Inequities

Oregon 2008-09 NCES Statewide High School Graduation Rates & Dropout Rates

Demographic Characteristic	Graduation Rate	Dropout Rate
All students	85.1%	3.4%
Asian/Pacific Islander	89.5%	2.4%
Native American/Alaskan Native	73.9%	<b>6.4%</b>
African American	71.5%	<b>6.1%</b>
Hispanic	75.9%	5.1%
White	87.6%	2.9%
Multi-Ethnic	84.8%	2.8%
Unknown	78.7%	5.7%
Economically Disadvantaged	83.2%	3.1%
Not Economically Disadvantaged	86.1%	3.6%
Limited English Proficient	62.8%	<b>6.2%</b>
Not Limited English Proficient	86.5%	3.2%
Special Education	74.2%	3.7%
Not Special Education	86.1%	3.4%

# Incarceration by Race

<b>Race/ethnicity</b>	<b>General population</b>	<b>Prison Population</b>	<b>Percent Difference</b>
White	70%	35%	-35%
Black	12%	47%	35%
Hispanic	13%	16%	3%
Asian	4%	1%	-3%
Native American	1%	1%	0

Sources: US Dept of Justice

Source: US Department of Justice.

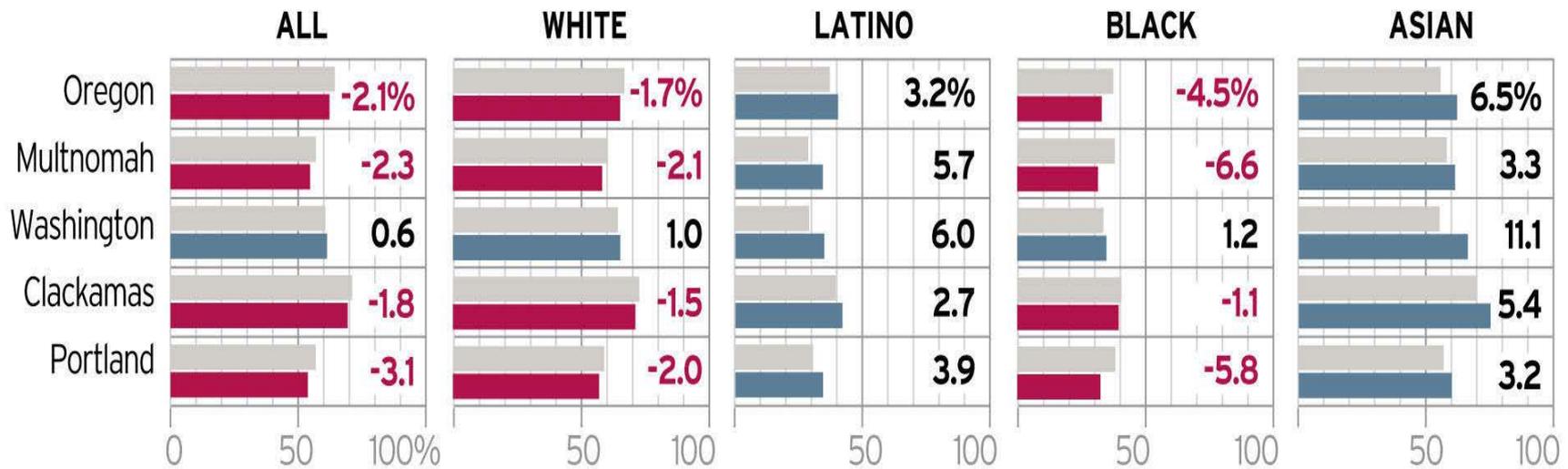
# Home ownership inequities

## Homeownership rates by race

2000

2010 increase

2010 decrease



Source: U.S. Census Bureau

DAVID BADDERS/THE OREGONIAN

**SOURCE: 2010 Census**

# Income Inequities in Oregon

	<b>White</b>	<b>Hispanic</b>	<b>Black</b>	<b>Native American</b>
<b>Poverty Rate</b>	7.4%	23.6%	27.2%	19.3%
<b>Median Household Income</b>	\$51,492	\$37,205	\$29,841	\$38,351

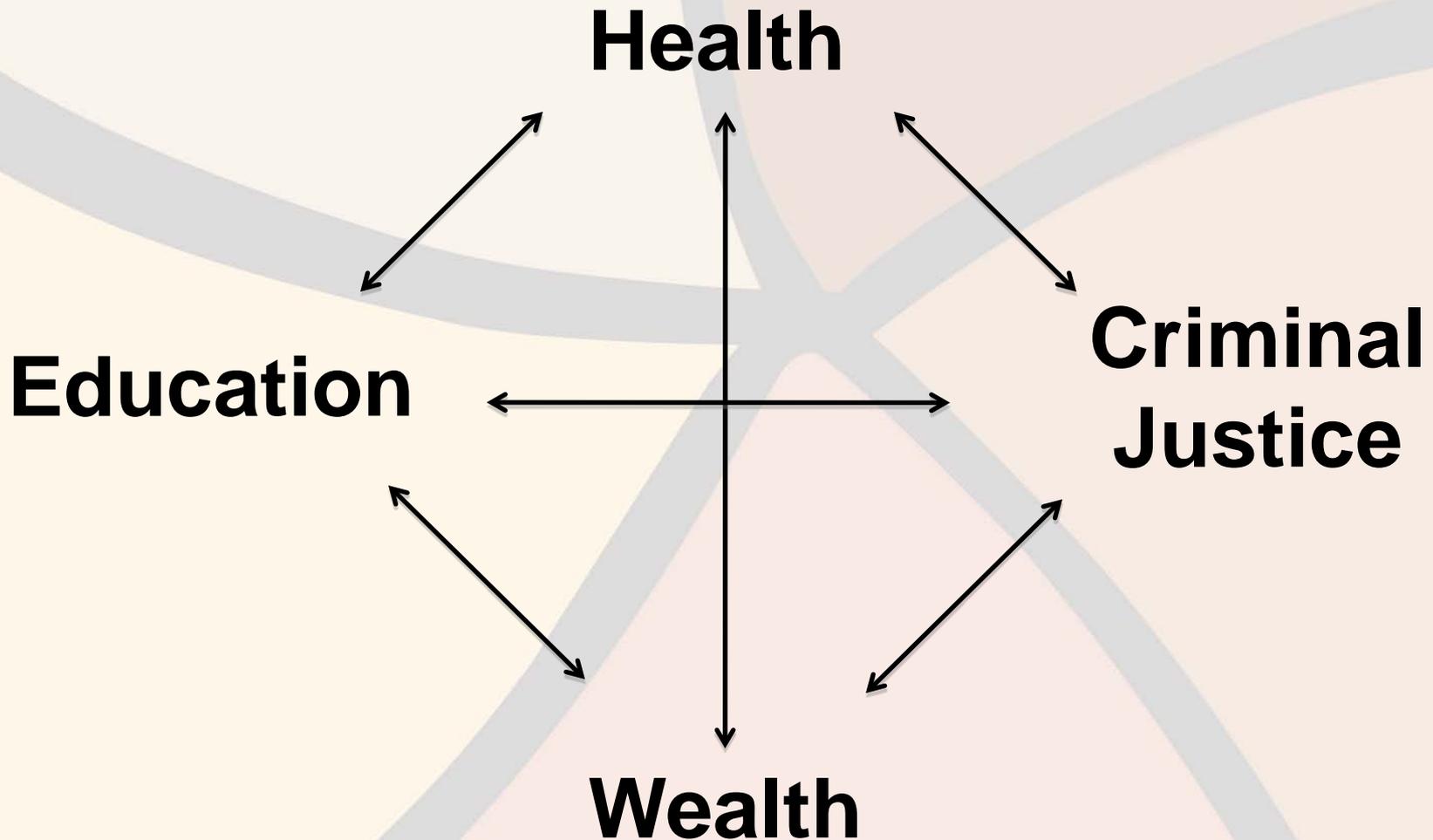
Source: American Community Survey (2006-2008)

# Median Net Worth of Households, 2005 and 2009



Source: Pew  
Research Institute

# The Four Great Race Disparities

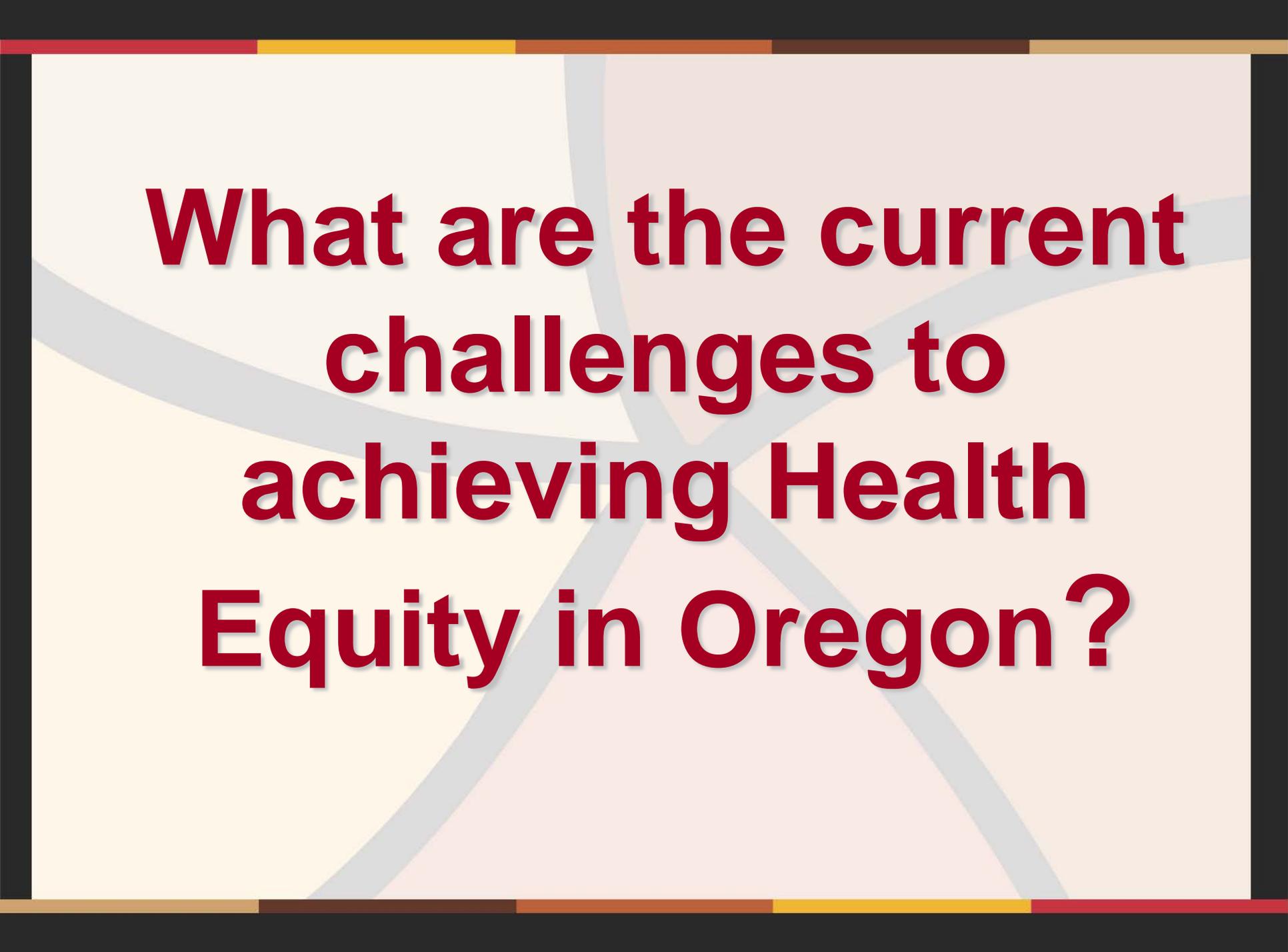


**Health equity** is attainment of the highest level of health for all people.

Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary socially patterned injustices, and the elimination of health disparities.



The Department of Health and Human Services



**What are the current  
challenges to  
achieving Health  
Equity in Oregon?**

# Current Challenges to Equitable Health Care Access by Women in Oregon

	All Minority		White		Hispanic		Asian		American Indian/ Alaska Native	
	OR	US	OR	US	OR	US	OR	US	OR	US
<b>No health insurance coverage</b>	35.80%	27.9%	17.0%	12.8%	50.4%	37.3%	21.4%	18.2%	No Data	
<b>No personal Doctor/ Health Care Provider</b>	35%	25.7%	17.7%	13.2%	48.0%	36.9%	25.4%	18.9%	29.6%	21.1%
<b>No routine checkup in past 2 years</b>	18.1%	13.6%	21.1%	16.7%	19.3%	18.3%	15%	14.4%	30.0%	19.4%
<b>No Doctor visit in past year due to cost</b>	26.3%	22.8%	18.8%	14.7%	31.3%	27.4%	19%	12.1%	34.5%	25.7%

**Red indicates worst state ranking**

**Source: Kaiser Family Foundation report, *Putting Women's Health Care Disparities on the Map, 2009***

# Current Challenges to Equitable Health Care Access

## Percent of Live Births with Late or No Prenatal Care by Race/Ethnicity

	OR	US
White	15.6%	11.1%
All Minority	27.0%	22.7%
Black	24.4%	23.9%
Hispanic	<b>29.8%</b>	22.9%
Asian and Pacific Islander	18.3%	14.7%
American Indian/Alaska Native	<b>31.1%</b>	30.1%

Source: Kaiser Family Foundation report, *Putting Women's Health Care Disparities on the Map, 2009*

# Current Challenges to Equitable Health Outcomes

## Oregon Life expectancy by race/ethnicity

	1996	2006
Non Hispanic White	77.02	78.96
Hispanic	83.90	87.53
Asian and Pacific Islander	81.52	85.73
Native American	74.31	76.89
African American	71.43	76.80

Life expectancy of migrant/seasonal farm workers: **49 years**

Sources: Oregon Department of Human Services, Office of Health Statistics (2007); Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System; R.D. Grove and A.M. Hetzel, *Vital Statistics Rates in the United States, 1940-1960*; and E. Arias, "United States Life Tables, 2004," *National Vital Statistics Report* (forthcoming).

# Current Challenges to Equitable Health Outcomes

Oregon health rankings:

- **14<sup>th</sup>** in the number of **African American heart disease deaths** per 100,000 population
- **26<sup>th</sup>** in the percentage of **African American and Latino live births by cesarean delivery.**
- **47<sup>th</sup>** in the number of **African American diabetes deaths** per 100,000 population by race/ethnicity
- **47<sup>th</sup>** in the number of **African American number of deaths caused by stroke** and other cerebrovascular diseases.

Source: Kaiser Family Foundation, 2006

# Current Challenges to Mental Health Equity

“Days physical or mental health not good”  
over a 30-day period

	Oregon Disparity Score	Worst State Disparity Score	Best State Disparity Score	All States Disparity Score
Asian/NHPI	7.0	OR 7.0	KS 3.7	5.5
American Indian/Alaska Native	12.9	OR 12.9	NM 7.3	10.5
All Minorities	7.7	KY 9.9	KS 6.2	7.3

Source: Kaiser Family Foundation report, *Putting Women’s Health Care Disparities on the Map, 2009*

# Age at Onset of Chronic Conditions

## COLORECTAL CANCER:

- African Americans were more than **twice as likely** as whites to present with advanced Colorectal Cancer **before age 50**
  - HOWEVER, The American Cancer society suggests that screening begin at age 50.

## BREAST CANCER:

- In the age groups, 30-54 and 55-69 years, African-American women have the **highest death rate from breast cancer**, followed by Hawaiian women, and white non-Hispanic women.
- African American women are more likely to be diagnosed with a later stage of breast cancer than white women.
  - HOWEVER, The American Cancer Society suggests that yearly mammograms do not begin until age 40.

**SOURCE: The American Cancer Society (2010), Jancin, Bruce. "Early colorectal ca screen advised for key groups: African Americans, diabetics, and female smokers are found to be at substantially above-average risk" OB/GYN News. (2005)**

# Current Challenges to Health Equity for LGBT populations

- LGBT persons face documented structural, financial, personal, and cultural barriers when attempting to access health care services
- Multiple studies document provider bias as to LGBT people or patients
- Perhaps in an effort to avoid this bias or because of internalized homophobia, LGBT patients may withhold personal information about their sexual orientation, gender identity, practices, and behavioral risks from their health care providers

# Current Challenges to Health Equity for LGBT populations

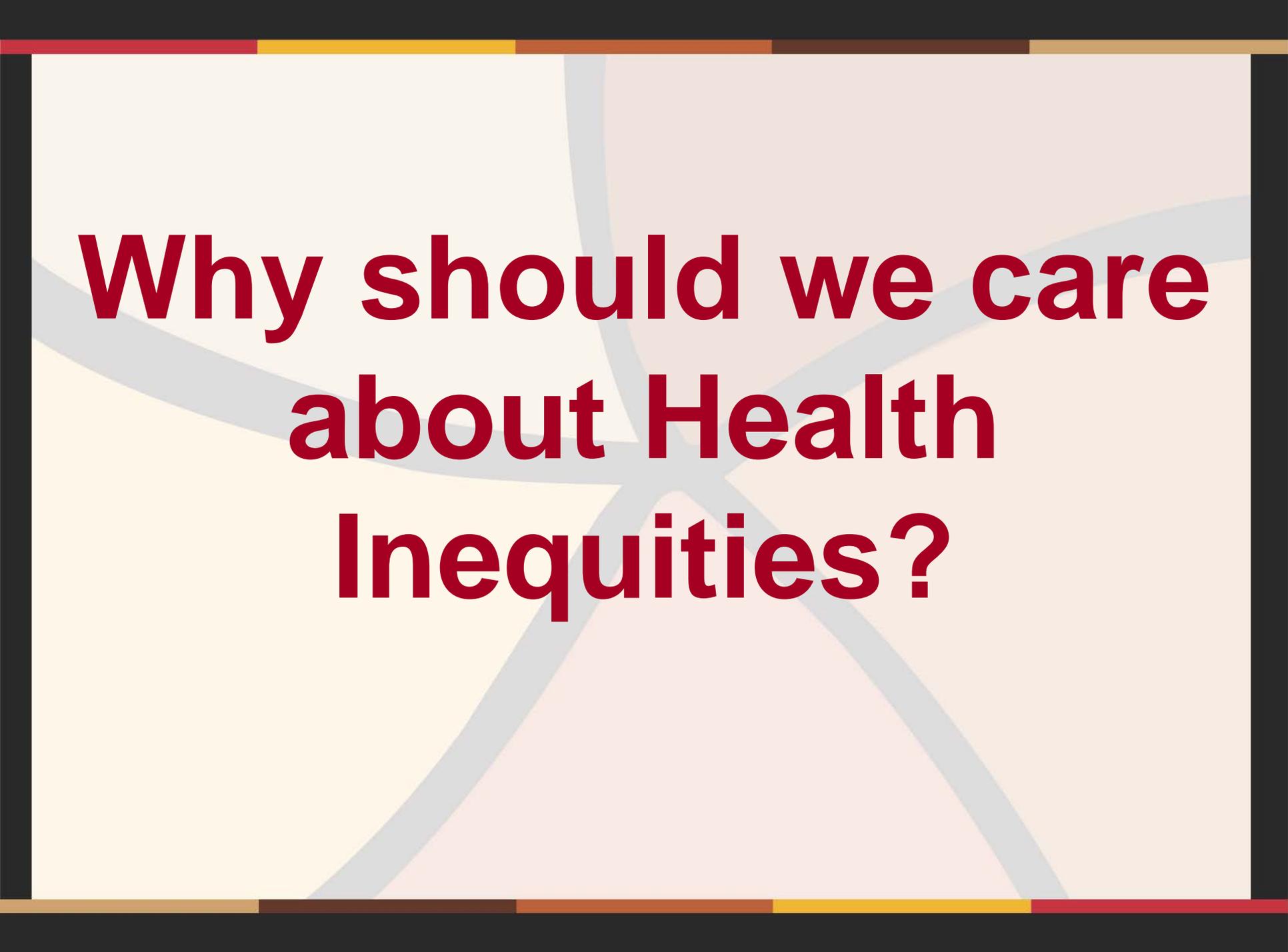
- Barriers could result in LGBT people not seeking needed preventive screening tests and preventive interventions, or delaying seeking treatment for acute health conditions or exacerbation of chronic conditions
- Without legal acknowledgement of the LGBT family unit, LGBT persons whose partners become medically incapacitated can be
  - left out of medical decision making,
  - denied information on their partner's condition
  - barred from seeing their partner

# Current Challenges to Health Equity for LGBT populations

- The National Lesbian Health Care Survey (NLHCS) highlighted groups of lesbians particularly likely to lack insurance: those who were younger, unemployed, in school, poor, and/or African American
- Evidence from limited research that LGBT seniors are more likely to live alone. Senior service programs frequently do not offer any services specifically for LGBT seniors and do not have outreach efforts to lesbian and gay seniors.

# Current Challenges to Mental Health Equity for LGBT populations

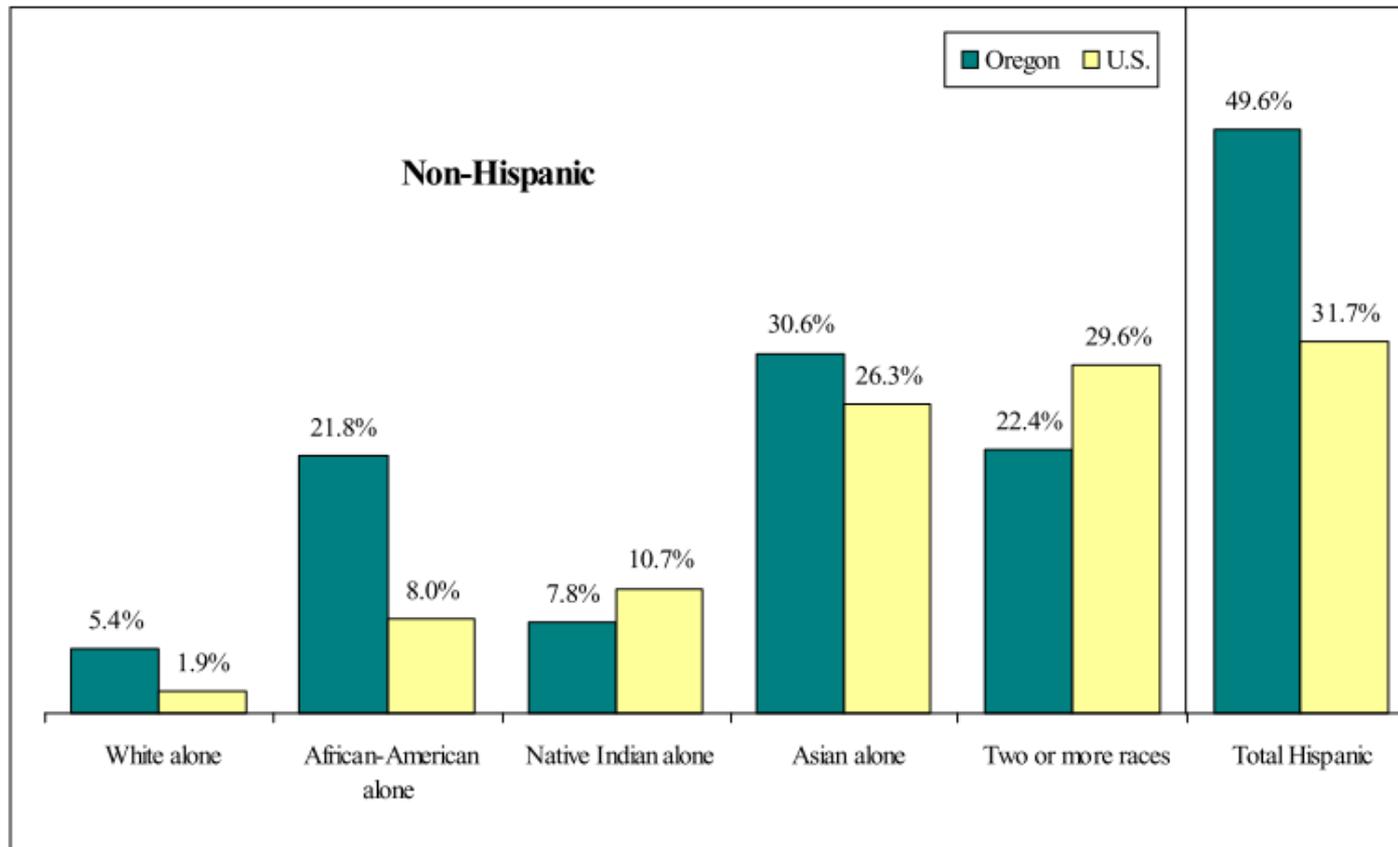
- A report from the DHHS's Task Force on Youth Suicide found
  - gay men are up to six times more likely to attempt suicide than their heterosexual counterparts
  - lesbians are up to twice as likely to attempt suicide than heterosexual women.
- Later research on suicide shows the rates of suicide attempts among LGBT youth are consistently between 20 and 42 percent.



**Why should we care  
about Health  
Inequities?**

# Growth in Diversity in Oregon Outpaces National Trend

## Population Growth by Race and Ethnicity, 2008



**Source:**  
State of Oregon:  
Office of Economic  
Analysis,  
February  
2010

# 40% of Oregon Health Plan Enrollees are People of Color

## DISTRIBUTION OF AGE, RACE/ETHNICITY AND GENDER AMONG CLIENTS ON THE OREGON HEALTH PLAN

1/15/2011 Totals

AGE by RACE/ETHNICITY									AGE by GENDER			
AGE	Black or African-American	American Indian or Alaska Native	Asian, Native Hawaiian or Other	White	Hispanic or Latino	Other/Unknown <sup>1</sup>	TOTAL	% of OHP	Female	% Female	Male	% Male
<1	785	293	726	12,778	7,130	2,934	24,646	4.0%	12,009	48.7%	12,637	51.3%
1-5	4,021	1,540	2,823	54,114	35,163	11,444	109,105	17.9%	53,135	48.7%	55,970	51.3%
6-12	5,043	2,342	3,504	63,605	38,175	9,873	122,542	20.1%	59,770	48.8%	62,772	51.2%
13-18	3,966	1,986	2,714	49,294	22,109	5,910	85,979	14.1%	42,612	49.6%	43,367	50.4%
19-21	994	416	552	13,255	3,447	1,725	20,389	3.3%	13,715	67.3%	6,674	32.7%
22-35	3,515	1,517	2,165	55,388	15,254	7,255	85,094	14.0%	59,352	69.7%	25,742	30.3%
36-50	2,849	1,354	2,192	51,155	8,222	3,220	68,992	11.3%	40,569	58.8%	28,423	41.2%
51-64	2,252	1,161	1,695	43,072	2,565	879	51,624	8.5%	29,491	57.1%	22,133	42.9%
65+	<u>1,022</u>	<u>452</u>	<u>4,285</u>	<u>32,062</u>	<u>3,126</u>	<u>671</u>	<u>41,618</u>	6.8%	<u>28,204</u>	67.8%	<u>13,414</u>	32.2%
TOTAL	24,447	11,061	20,656	374,723	135,191	43,911	609,989		338,857		271,132	
% of OHP	4.0%	1.8%	3.4%	61.4%	22.2%	7.2%			55.6%		44.4%	

GENDER by RACE/ETHNICITY							
Female	13,297	6,214	11,705	210,775	72,328	24,538	338,857
% Female	54.4%	56.2%	56.7%	56.2%	53.5%	55.9%	55.6%
Male	11,150	4,847	8,951	163,948	62,863	19,373	271,132
% Male	45.6%	43.8%	43.3%	43.8%	46.5%	44.1%	44.4%

Includes all Medicaid recipients: OHP Plus, Standard benefits and recipients eligible under the classes: QB, QS, NP, CW, and BC.

<sup>1</sup>This count contains a substantial number of clients of Hispanic ethnicity. The database no longer uniquely captures Hispanic ethnicity. #2131; Version 1

State of Oregon, Division of Medical Assistance Programs, 500 Summer Street NE, Salem, OR 97301-1016

Source: DMAP DSSURS data warehouse: DateLoad = 2/9/2011

# Cost Savings

Between 2003-2006:

- **30.6 percent** of medical care expenditures for African-Americans, Asians and Hispanics were excess costs that were the result of inequities in the health of these groups
- **\$1.24 trillion**

**Eliminating health disparities  
for people of color would have  
reduced direct medical care  
expenditures by **\$229.4 billion**  
for the years 2003-2006.**

# Medical Liability

- **Costly legal judgments** against health care entities for failure to provide language access services mandated by Title VI of the Civil Rights Act.
- In a 2003 Oregon case, lack of health care interpreter ended in loss of sight and a **\$350,000 settlement.**

# Market Share in Communities of Color

- In 2010 the combined buying power of African Americans, Asians, and Native Americans will be **\$1.7 trillion**—more than triple its 1990 level
- Health and mental health care organizations that **embrace the values of cultural and linguistic competence**— and incorporate them into their policies, structures, and practices—are **well positioned in the current marketplace** as the diversity of the U.S. population continues to increase

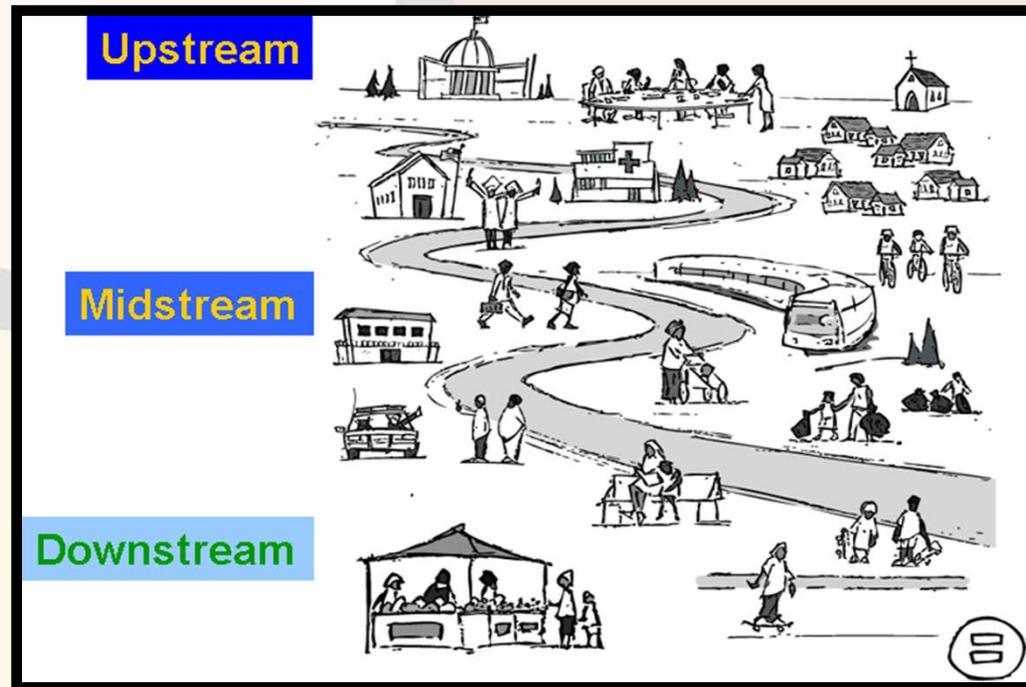
# Staff Turnover

- The average costs to hire varied from \$276 for administrative assistants to \$36,743 for attending physicians.
- The annual cost of turnover (i.e., recruitment, hiring, training, working, and termination) represented 3.4 percent to 5.8 percent of the annual operating budget, or \$17 million to \$29 million on a \$500 million base across the medical center.



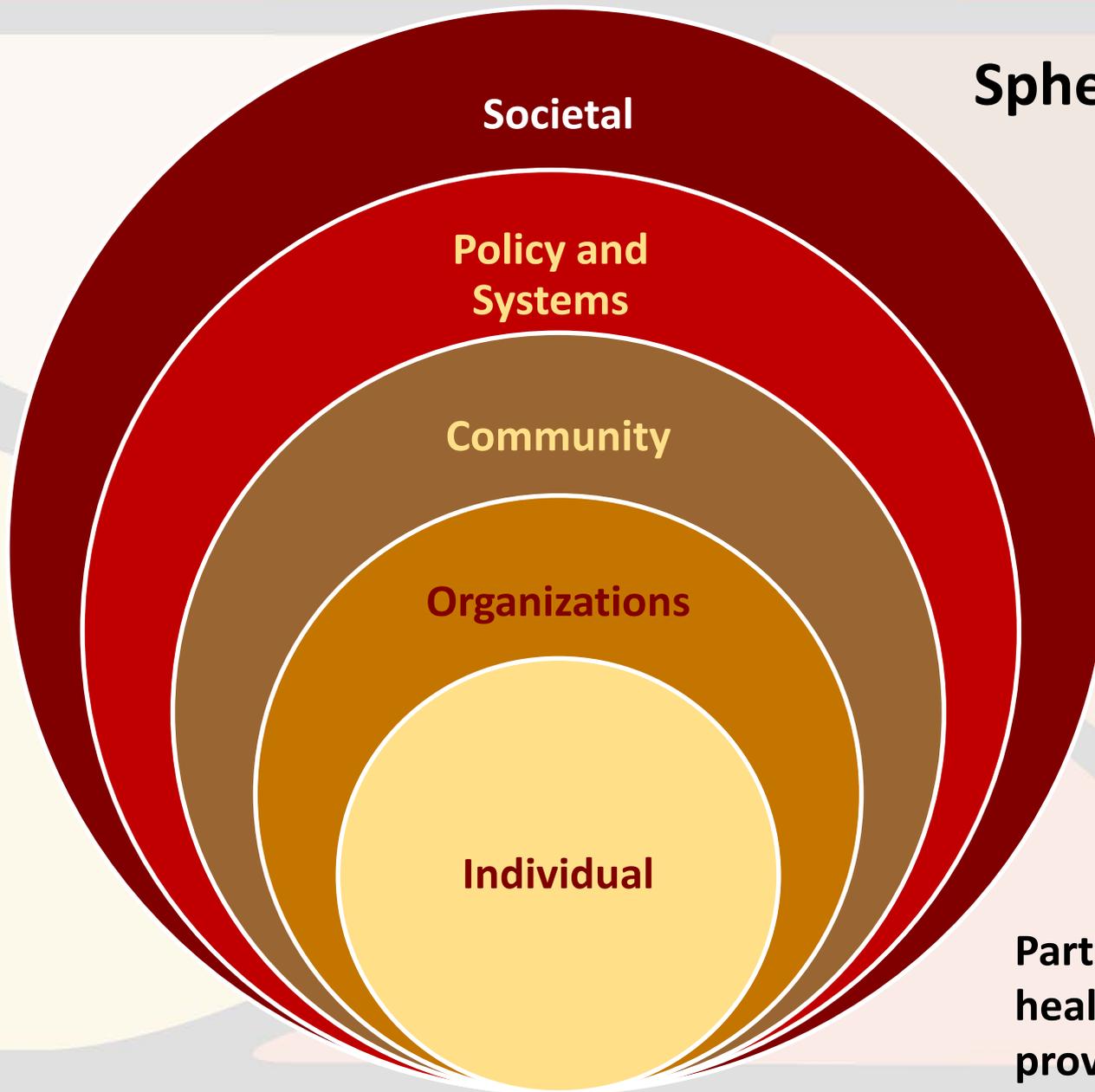
# **Models for Promoting Health Equity**

# Framework for promoting health equity



Adapted from: Multnomah County Health Equity Initiative, February, 2009.

# Spheres of Influence



Shift in health outcomes

Smoke-free Workplace Law

Smoke free events, restaurants, social spaces

School medication safe-carry policy

Partnership with health care provider

# Joint Commission

The Joint Commission views effective communication, cultural competence, and patient- and family-centered care as important components of safe, quality care.

**The Joint Commission, Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals, 2010.**

# Joint Commission

- Care Continuum
  - Admission
  - Assessment
  - Treatment
  - End-of-Life Care
  - Discharge and Transfer
- Organizational Readiness
  - Leadership
  - Data Collection and Use
  - Workforce
  - Provision of Care, Treatment, and Services
  - Patient, Family and Community Engagement

**The Joint Commission, Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals, 2010.**

# AMA Ethical Force – Patient Centered Communication

In the United States today:

- > 22 million people speak English less than “very well”
- > 34 million people were born in another country
- > 95 million people have literacy levels below what they need to understand basic written health information

**AMA Ethical Force Consensus Report;  
Improving Communication – Improving Care, 2006.**

# AMA Ethical Force – Patient Centered Communication

- Organizational Commitment
- Collect information
- Engage communities
- Develop workforce
- Engage individuals
  - Socio-cultural
  - Language
  - Health literacy
- Evaluate performance

**AMA Ethical Force Consensus Report; Improving Communication – Improving Care, 2006.**

# Assuring Healthcare Equity: A Healthcare Equity Blueprint

Quality improvement strategies in 5 categories:

- Create partnerships with the community, patients, and families
- Exercise governance and executive leadership for providing quality and equitable care
- Provide evidence-based care to all patients in a culturally and linguistically appropriate Manner
- Establish measures for equitable care
- Communicate in the patient's language – understand and be responsive to cultural needs/expectations

**National Public Health and Hospital Institute and National Association of Public Hospitals and Health Systems in collaboration with the Institute for Health Care Improvement, 2008.**

# NCQA Distinction in Multicultural Health Care

- Race Ethnicity and Language Data Collection
- Access and Availability of Language Services
- Practitioner Network Cultural Responsiveness
- Culturally and Linguistically Appropriate Services Program
- Reducing Health Care Disparities

National Committee for Quality Assurance, 2008.

# **OEI's POLICY PROCESS: Communities of Color Policy Forums, Health Review Equity Policy Committee**

## **Policy Priorities:**

- Equal access to health care regardless of documentation status or disability
- Culturally sensitive/competent health care systems
- Diverse and culturally competent health care providers
- Reimbursement for Community Health Workers
- Granular Data Collection

# How can all health professionals advocate for health equity?

- Everyone is responsible for assuring that OHPB policies advance health equity, not just committee members who are people of color, people with disabilities, and LGBTQ.
- Meet with community members to understand the issues they are experiencing. Structure meeting time to allow for different modes of participation and communication styles
- Acknowledge the privilege you and others bring to your work by virtue of your race, class, physical ability, organizational position - and the assumptions you might make as a result.
- Learn about health equity through research and reports, and explore diverse perspectives

Excellence is an art won by training and habituation.

We do not act rightly because we have virtue or excellence, but we rather have those because we have acted rightly. We are what we repeatedly do.

Excellence, then, is not an act, but a habit.

*Aristotle*

# Questions?

Tricia Tillman

Carol Cheney

Rachel Gilmer

Office of Equity and Inclusion

800 NE Oregon Street, Suite 550

Portland, OR 97232

Phone: 971-673-1240

<http://www.oregon.gov/OHA/omhs/>