Building Healthy Communities: A Case for Health Reform: In Sickness and In Health
Presentation Goals

- Provide a basic overview of health equity concepts.
- Highlight the extent to which “place” matters with regards to improving health outcomes.
- Highlight the importance of policy to eliminate health disparities.
“Despite the unprecedented explosion in scientific knowledge and the phenomenal capacity of medicine to diagnose, treat and cure disease, Blacks, Hispanics, Native American Indians and those of Asian/Pacific Islander Heritage have not benefited fully or equitably from the fruits of science or from those systems responsible for translating and using health sciences technology.”
Why does Policy Matter?

Health Disparities

Social Determinants of Health

Health Inequity
Congress requested that the IOM:

- Assess the extent of racial and ethnic disparities in healthcare;
- Identify potential sources of these disparities; and
- Suggest intervention strategies.

The study committee was struck by what it found. The research indicated minorities are less likely than whites to receive needed services, including clinically necessary procedures, even after correcting for access-related factors, such as insurance status.
An Overview of Current Disparities

- Ohio’s African-American infant mortality rate is twice that of white infants.

- In 2004-2006 Hispanic males and males of other races: Asian Pacific Islander, American Indian, Alaskan Native had the highest prevalence of heart attack, compared to other racial/sex groups.

- The African American average annual cancer incidence rate was 7% higher than whites for all sites/types combined.

- On average, black males die seven years earlier from heart disease than white males and black females die nine years earlier than white females.

- Hispanic and adults of other races were least likely to recognize the symptoms of a heart attack and appropriate response to call 911 when someone is having a heart attack, compared to white adults.
Figure 1: Layers of Determinants of Health

1. sex, gender, sexual orientation, race/ethnicity
2. social support from community networks
3. health care access, health care quality, housing conditions, job security, working conditions
4. power, wealth, education, discrimination, gender equity, stigma

Adapted from Dahlgren G, Whitehead M.
Understanding Health Inequities

When inequities are high and community assets are low, health outcomes are worst.

Violence
Substance Abuse
Smoking
HIV/AIDS
Infant Mortality
Malnutrition
Stress
Obesity
Depression
Heart Disease

When inequities are low and community assets are high, health outcomes are best.

Venn Diagram: A tree representing health outcomes, with branches indicating conditions such as Heart Disease, Malnutrition, Stress, Depression, Smoking, Substance Abuse, and Violence. The roots of the tree illustrate factors contributing to these conditions, such as Access to Healthcare, Adequate Income, and Quality Housing.
Where We Live Matters for Our Health: Neighborhoods and Health

1. Introduction

Just as conditions within our homes have important implications for our health, conditions in the neighborhoods surrounding our homes also can have major health effects. Social and economic features of neighborhoods have been linked with mortality, general health status, disability, birth outcomes, chronic conditions, health behaviors and other risk factors for chronic disease, as well as with mental health, injuries, violence and other important health indicators.

Physical and social environments in neighborhoods can be overly hazardous—for example, polluted or crime-ridden. They also can severely limit the choices and resources available to individuals. For example, an individual’s social— and neighborhood—environment—such as exercise and food choices and exercise and social conditions—can determine whether his or her health improves or not. Studies have shown that a neighborhood’s socioeconomic conditions can affect whether it promotes health care, and practice self-reproductive behaviors. By the same token, aspects of neighborhood environments—such as the presence of sidewalks and playgrounds, after-school physical activity programs for children and youth, and availability of affordable healthy food—can promote health by encouraging healthy behaviors and making it easier to adopt and maintain them. Similarly, people are more likely to receive recommended medical care when facilities are accessible from where they live, either because they are located nearby or because safe, convenient transportation is available.
Prevalence of Coronary Heart Disease by Race/Ethnicity/Sex

Race/Ethnicity and Sex

The prevalence of CHD varied by race/ethnicity and sex. For the years 2004-2006, Hispanic (7.6 percent) and white males (5.3 percent) reported the highest prevalence of diagnosed disease, while Hispanic females (1.9 percent) and females of other races (Asian, Native Hawaiian, Pacific Islander, American Indian, Alaskan Native or races other than white or black) (3.2 percent) reported the lowest prevalence of diagnosed disease (Figure 1-17).


Data Source: Ohio Hospital Association
PLACE MATTERS


Data Source: Ohio Hospital Association
## PLACE MATTERS! Enhanced Demographic Snapshot

### Education

#### Population Age 25+ by Educational Attainment, Hisp or Lat

<table>
<thead>
<tr>
<th>Description</th>
<th>43204 Columbus [ZIP, 43204]</th>
<th>%</th>
<th>43228 Columbus [ZIP, 43228]</th>
<th>%</th>
<th>43207 Columbus [ZIP, 43207]</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>Less than 9th Grade</td>
<td>1,876</td>
<td>6.58%</td>
<td>2,509</td>
<td>7.59%</td>
<td>1,802</td>
<td>5.87%</td>
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<tr>
<td>Some High School, no diploma</td>
<td>4,297</td>
<td>15.07%</td>
<td>3,317</td>
<td>10.04%</td>
<td>5,339</td>
<td>17.40%</td>
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<tr>
<td>High School Graduate (or GED)</td>
<td>9,588</td>
<td>33.63%</td>
<td>11,208</td>
<td>33.92%</td>
<td>13,872</td>
<td>45.21%</td>
</tr>
<tr>
<td>Some College, no degree</td>
<td>5,119</td>
<td>17.95%</td>
<td>7,139</td>
<td>21.61%</td>
<td>5,446</td>
<td>17.75%</td>
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<tr>
<td>Associate Degree</td>
<td>1,364</td>
<td>4.78%</td>
<td>2,308</td>
<td>6.99%</td>
<td>1,413</td>
<td>4.60%</td>
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<tr>
<td>Bachelor's Degree</td>
<td>4,589</td>
<td>16.09%</td>
<td>4,609</td>
<td>13.95%</td>
<td>2,212</td>
<td>7.21%</td>
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<tr>
<td>Master's Degree</td>
<td>1,086</td>
<td>3.81%</td>
<td>1,457</td>
<td>4.41%</td>
<td>413</td>
<td>1.35%</td>
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<td>362</td>
<td>1.10%</td>
<td>137</td>
<td>0.45%</td>
</tr>
<tr>
<td>Doctorate Degree</td>
<td>195</td>
<td>0.68%</td>
<td>131</td>
<td>0.40%</td>
<td>51</td>
<td>0.17%</td>
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</tbody>
</table>
OHIO’S HEALTH SYSTEM PERFORMANCE

Health Outcomes - 42nd overall
- 42nd in preventing infant mortality (only 8 states have higher mortality)
- 37th in preventing childhood obesity
- 44th in breast cancer deaths and 38th in colorectal cancer deaths

Prevention, Primary Care, and Care Coordination
- 37th in preventing avoidable deaths before age 75
- 44th in avoiding Medicare hospital admissions for preventable conditions
- 40th in avoiding Medicare hospital readmissions

Affordability of Health Services
- 37th most affordable (Ohio spends more per person than all but 13 states)
- 45th most affordable for hospital care and 47th for nursing homes
- 46th most affordable Medicaid for seniors
Patient Protection and Affordable Care Act of 2010
Advancing Health Equity for Racially and Ethnically Diverse Populations
Actions to Improve Access to Health Care

- Support for community health centers - Section 10503
- Nurse-managed health centers – Section 5208
- Community health teams – Section 3502
- Redistribute Graduate Medical Education slots – Section 5503
- Extends authorization of National Health Services Corps – Section 5207
- Teaching community health centers – Section 5508
- Innovative models in Medicare/Medicaid – Section 3021
- School-based health centers – Section 4101
- Pilot projects for emergency & trauma care – Section 3504

http://www.jointcenter.org/hpi/sites/all/files/PatientProtection_PREP_0.pdf
Quality Improvement

- National Strategy for Quality Improvement – Section 3011
- Quality improvement technical assistance – Section 3501
- Interagency Group on Healthcare Quality – Section 3012
- Develop, improve & evaluate quality measures – Section 3013
- Link Medicare payments to quality outcomes – Section 3001
- Pediatric Accountable Care Organizations – Section 2706

http://www.jointcenter.org/hpi/sites/all/files/PatientProtection_PREP_0.pdf
Health Disparities Prevention Initiatives

- National oral health campaign, with emphasis on disparities – Section 4102
- Standardized drug labeling on risks & benefits - Section 3507
- Maternal & child home visiting programs for at-risk communities - Section 2951
  - Culturally appropriate patient-decision aids - Section 3506
- Culturally appropriate personal responsibility education – Section 2953
- Support for preventive programs for AI/ANs – Section 10221

http://www.jointcenter.org/hpi/sites/all/files/PatientProtection_PREP_0.pdf
Social Determinants of Health

• Health Impact Assessments - Section 4003
• Community Preventative Services Task Force review/recommend interventions in social context - Section 4003
• Community Transformation Grants - Section 4201
• Non-profit hospital community needs-assessment - Section 9007
• Primary Care Extension Program - Section 5405

http://www.jointcenter.org/hpi/sites/all/files/PatientProtection_PREP_0.pdf
Workforce Diversity

- Collect and publicly report data on workforce diversity - Section 5001
- Increase diversity among Primary Care Providers - Section 5301
- Increase diversity among long-term care providers - Section 5302
- Increase diversity among mental health providers - Section 5306
- Increase diversity in nursing professions - Section 5309
- Investment in HBCUs and minority-serving institutions - Section 2104
- Grants for Community Health Workers, providing CLAS - Section

http://www.jointcenter.org/hpi/sites/all/files/PatientProtection_PREP_0.pdf
Health Insurance Reforms

- Individual requirement to have coverage - Section 1501
- Expand Medicaid income eligibility to 133% FPL - Section 2001
- Employer requirement to offer coverage - Section 1513
- Increase federal matching rates for Medicaid - Section 2005
- Small business (<25 employees) tax credits - Section 1421
- Multi-state plan option - Section 10104
- Temporary high risk pools - Section 1101
- Consumer Operated and Oriented Plans (CO-OPs) - Section 1322
- State-based American Health Benefit Exchanges - Section 1311

http://www.jointcenter.org/hpi/sites/all/files/PatientProtection_PREP_0.pdf
“Patient-centered medical homes have shown promise in other states in eliminating healthcare disparities within racial and ethnic populations,” said Angela Cornelius Dawson, executive director of the Ohio Commission on Minority Health and a member of the Ohio Patient-Centered Primary Care Collaborative. “We are encouraged by the Kasich administration’s efforts to address healthcare disparities in our minority communities by committing to include socioeconomic factors and racial and minority populations as criteria when selecting the additional PCMH practice sites.”

“This announcement is another important step in reforming Ohio’s health-care delivery system and giving Ohioans the quality of care they need to have good health at every stage of life,” Dr. Wymyslo said. “A patient-centered medical home leads to better health and reduces costs for individuals and taxpayers.”

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Ohio Statewide Health Disparities Policy Brief

Ohio Statewide Health Disparities Collaborative

The Ohio Statewide Health Disparities Collaborative (OSHDC) is a collaboration of individuals and organizations working together to achieve health equity and eliminate health disparities in Ohio. The OSHDC is comprised of individuals from non-profit agencies, healthcare organizations, government agencies, academic and private sector organizations who provide statewide leadership for racial and ethnic minorities within the state of Ohio.

Executive Summary

Health disparities are the ongoing insistence in access, quality of healthcare services, and healthcare outcomes which result in higher morbidity and mortality rates for minorities. The current healthcare delivery system does not offer an environment that addresses health disparities for racial and ethnic minorities, the poor, and other at-risk populations.

Language barriers, cultural and linguistic competency in health service delivery and health education, health literacy, diversity in healthcare workforce, and provider lack of cultural sensitivity are all factors that contribute to health disparities in racial and ethnic populations. The empowerment of local communities has been hindered by passive enforcement of policies, leading to inadequate usage of resources and limited inter-organization communication. There is little focus on building the capacity of local and state organizations to address disparities. The lack of building local and state capability to address and solve health disparities on the ground are leading to well established economic burdens. Beyond the heavy burden that health disparities represent for individuals affected, there are additional social and financial barriers borne by the country as a whole. Health Disparities provide both challenges and opportunities for developing new methods for reducing health disparities and the related costs.

Problem

Unaddressed health disparities historically have been a significant driver of healthcare costs. When combined with the current fragmented program silos and funding streams, efforts to impact health disparities are fragmented. Between 2003 and 2006 the combined costs of health inequalities and preventable death in the United States was $1.74 trillion; thirty percent (30%) of direct medical care expenditures for African-Americans, Asian, and Hispanics were expected due to health inequalities. In the same time frame, alleviating health disparities would have reduced direct medical care expenditures by $226.4 billion. As the aggregate of various racial and ethnic minorities moves toward becoming a majority of the country’s populace, addressing health disparities becomes even more critical. If not adequately addressed, inequities suffer through chronic loss of economic capital, loss of human intellectual and leadership capital, and social instability.

Call to Action

The time is now to begin crafting and implementing the policies that will provide health equity for all. Active engagement within the healthcare system is essential. Therefore, it is imperative that aggressive movement in the following areas isInitiated in the State of Ohio in order to eliminate health disparities for racial and ethnic groups:

- A statewide adoption of the national definition of health disparities
- A statewide adoption of the National Standardized Strategies
- The development of policies that address the determinants of health, reduce health disparities, and work to achieve health equity across the lifespan
- Develop statewide plans to diversity Ohio’s healthcare and healthcare related workforce
- Develop a workforce pipeline targeting racial and ethnic minorities
- Create a statewide minority health information exchange
- Ensure that the ORIS eligibility system collects racial, ethnic and linguistic data in meaningful way that complies with the HHS Data Standards
- Ensure that provider EHRs collect racial and ethnic data in meaningful way
- Ensure that Health Plans collect racial and ethnic data in a meaningful way
- Allocate available funding and target future funding initiatives to populations that bear the greatest burden of chronic diseases

The OSHDC has developed the Ohio Plan for Action to End Health Disparities to serve as the initial roadmap for addressing this important issue. To reach the OSHDC, please contact Teri McGover, Executive Director of the Children’s Defense Fund-Ohio at (614) 321-2344 or manager@oshdc.org

Does your Policy Matter?

Does the Strategic Plan for Health Systems in your county align with the National HHS and the OCMH plan to eliminate racial and ethnic health disparities?

What are the health outcomes for chronic diseases for racial and ethnic populations in your county? In Infant Mortality, Cancer, Diabetes? Are they acceptable?

Is your healthcare workforce culturally and linguistic competency?

Do the data collection procedures within your county health systems align with the HHS 2010 requirements?

What is your plan to achieve diversity at all levels within the health care workforce?

How will your expand the leadership at all levels on this issue?
“The success or failure of any government in the final analysis must be measured by the well-being of its citizens.

Nothing can be more important to a state than its public health; the state's paramount concern should be the health of its people”

Franklin Delano Roosevelt