Roadmaps to equity
Opportunities for closing health gaps in Northeast Ohio

May 24, 2017
Understanding health disparities and inequities
A discussion of the data
Health Policy Institute of Ohio
May 2017
Learning objectives

1. Understanding the concepts: health disparities, health inequities and health equity
2. Discussing Ohio’s greatest health challenges, disparities and inequities
3. Identifying the data challenges

What is health equity?

Address avoidable inequalities
Opportunity to achieve

Socioeconomic Injustices
Valuing everyone equally
Highest level of health
No one at a disadvantage
Resource allocation Discrimination

Copyright © 2017 Health Policy Institute of Ohio. All rights reserved.
Health inequities, disparities and equity

Health inequities → Health disparities

Health equity

“Working definition from the CDC Health Equity Working Group, October 2007

Copyright © 2017 Health Policy Institute of Ohio. All rights reserved.

Health inequities, disparities and equity

Health inequities
Disparities in rates due to differences in the distribution of social, economic, environmental or healthcare resources

Health disparities
Differences in health status among segments of the population such as by race or ethnicity, education, income or disability status

Health equity

“Working definition from the CDC Health Equity Working Group, October 2007

Copyright © 2017 Health Policy Institute of Ohio. All rights reserved.
1. Collect data to assess community health needs – including the needs and strengths of specific population groups
2. Examine root causes of health disparities
3. Advocate for improvement to local and state-level data collection
What is the state health assessment (SHA)?

A comprehensive and actionable picture of health and wellbeing in Ohio

- Informs identification of priorities for the State Health Improvement Plan
- Provides template for state agencies and local partners (uniform set of categories and metrics)
Many opportunities exist to decrease health disparities and inequities by:

- Race and ethnicity
- Income and education-level
- Age and gender
- Disability status
- Geography

Racial and ethnic disparities and inequities
### Racial and ethnic disparities and inequities

**African-American/black Ohioans** were much more likely than any other racial and ethnic group to experience poor health outcomes.

<table>
<thead>
<tr>
<th>Health Assessment Data Profile</th>
<th>Percent of Adults</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population health</td>
<td>100% (9 metrics)</td>
<td></td>
</tr>
<tr>
<td>Healthcare system</td>
<td>14.3% (1 metric)</td>
<td>65.7% (4 metrics)</td>
</tr>
<tr>
<td>Access to healthcare</td>
<td>100% (2 metrics)</td>
<td></td>
</tr>
<tr>
<td>Public health and prevention</td>
<td>100% (1 metric)</td>
<td></td>
</tr>
<tr>
<td>Social and economic environment</td>
<td>100% (3 metrics)</td>
<td></td>
</tr>
</tbody>
</table>

**Disparities by income level**

**Adult diabetes, by income.** Percent of adults who have been told by a health professional that they have diabetes (2014)

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Percent of Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;$15,000</td>
<td>18.9%</td>
</tr>
<tr>
<td>$15,000-$24,999</td>
<td>17.2%</td>
</tr>
<tr>
<td>$25,000-$34,999</td>
<td>13.6%</td>
</tr>
<tr>
<td>$35,000-$49,999</td>
<td>10.4%</td>
</tr>
<tr>
<td>$50,000+</td>
<td>7.7%</td>
</tr>
</tbody>
</table>

**Source:** Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (2014)
Disparities by age

Diabetes and hypertension prevalence increased with age, greatly impacting those ages 65 and older.

Hypertension prevalence, by age. (2013)

Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (2013)

Disparities and inequities by disability status

People with disabilities experienced substantial disparities across metrics related to health outcomes and accessing health care.

Adult depression prevalence, by disability status. (2014)

Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (2014)
Disparities and inequities by geography

Appalachian counties in southern and eastern Ohio generally had poorer health-related outcomes, such as higher rates of child poverty, although there are counties with significant health challenges in all areas of the state.
Pathway to improved health value: 
A conceptual framework

Data in context

<table>
<thead>
<tr>
<th>Example</th>
<th>Rankings</th>
<th>Progress and trends</th>
<th>Highlighting other states</th>
<th>Disparities and inequities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>46</td>
<td>Greatly improved</td>
<td>Most improved state(s)</td>
<td>Little to no disparity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>TN, NV, LA</td>
<td>Medium disparity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Large disparity</td>
</tr>
</tbody>
</table>

World Health Organization definition of health: Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Copyright © 2017 Health Policy Institute of Ohio. All rights reserved.
How does Ohio do?

Where does Ohio rank?

43 Population health + 31 Healthcare spending = 46 Health value in Ohio

Health + Spending = Value

Copyright © 2017 Health Policy Institute of Ohio. All rights reserved.
Why does Ohio rank so poorly?
Ohio performs poorly on many of the factors that impact health value.

Data in context
Disparity ratio

**Little to no disparity**
Disparity ratio between group with the worst outcomes and group with the best outcomes is less than 1.10

**Medium disparity**
Disparity ratio between group with the worst outcomes and group with the best outcomes is between 1.10 and 2

**Large disparity**
Disparity ratio between group with the worst outcomes and group with the best outcomes is greater than 2
Data availability

Data availability for population groups in the equity profiles

Key findings: disparities and inequities
Ohioans who are black or have a low income are more likely to experience larger disparities and inequities across metrics

Percent of metrics with large disparities by population group

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>64.2%</td>
</tr>
<tr>
<td>Race and ethnicity</td>
<td>53.6%</td>
</tr>
<tr>
<td>Disability status</td>
<td>26.7%</td>
</tr>
<tr>
<td>Education level</td>
<td>12.5%</td>
</tr>
</tbody>
</table>
Key findings: disparities and inequities
Disparities and inequities must be addressed to improve health value

Largest disparities and inequities across equity profiles

<table>
<thead>
<tr>
<th>Metric</th>
<th>Group with worst outcomes</th>
<th>Estimated impact if disparity eliminated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children exposed to second-hand smoke</td>
<td>Low-income</td>
<td>126,776 Ohio children</td>
</tr>
<tr>
<td>Adverse childhood experiences</td>
<td>Low-income</td>
<td>207,722 Ohio children</td>
</tr>
<tr>
<td>Child poverty</td>
<td>Black</td>
<td>134,142 Ohio children</td>
</tr>
<tr>
<td>Adult depression</td>
<td>People with a disability</td>
<td>440,990 Ohio adults</td>
</tr>
</tbody>
</table>

*Estimated impact:* This calculation estimates the impact on Ohioans if the group with the worst outcomes on a metric had the same level of performance as the group with the best outcomes.

Ohio children exposed to secondhand smoke, by family income level

*Estimated Impact of eliminating disparity:* Nearly 127,000 Ohio children would not be exposed to second-hand smoke if the disparity between Ohioans with low incomes and higher incomes was eliminated.

Source: National Survey of Children’s Health and 2017 Health Value Dashboard analysis
Ohio children living in poverty, by race and ethnicity

Estimated impact of eliminating disparity: More than 130,000 black children in Ohio would not be living in poverty if the racial disparity was eliminated.

Source: National Survey of Children’s Health and 2017 Health Value Dashboard analysis

Residential segregation
Black/white dissimilarity index, 2010-2014

*Cincinnati dissimilarity index is calculated from Ohio census tracts only.
Source: American Community Survey, 5-Year Census Tract Estimates. Calculations by the Kirwan Institute for the Study of Race and Ethnicity

Copyright © 2017 Health Policy Institute of Ohio. All rights reserved.
Ohio Commission on Minority Health local conversation reports

Understanding the problems with the data

Data is not consistently collected across population groups

Aggregated data can mask health disparities and inequities within population groups

Need comprehensive data across all factors that impact health
1. Collect data to assess community health needs – including the needs and strengths of specific population groups
2. Examine root causes of health disparities
3. Advocate for improvement to local and state-level data collection

1. Prioritize health issues with large disparities and inequities
2. Identify priority populations or geographic areas that have worse outcomes for priority health issues
3. Set specific and measurable objectives for priority populations
4. Ensure that targets are aggressive to reduce or eliminate existing disparities and inequities
Equal opportunity?

Social, economic and physical environment

Adapted from Saskatoon Health Region's Public Health Observatory

Copyright © 2017 Health Policy Institute of Ohio. All rights reserved.

Equal opportunity

Social, economic and physical environment

Adapted from Saskatoon Health Region's Public Health Observatory

Copyright © 2017 Health Policy Institute of Ohio. All rights reserved.
Universal proportionalism - intensity of investment should increase with need
Ohio’s journey towards health equity

Dashboard material
http://www.hpio.net/2017-health-value-dashboard/

- Full Dashboard with sources
- 2-page executive summary
- 8-page snapshot
- Methodology
- Local-level data crosswalk
- FAQ
- Excel with metric descriptions
Roadmaps to equity
Opportunities for closing health gaps in Northeast Ohio

May 24, 2017

Roadmaps to equity
Opportunities for closing health gaps in Southwest Ohio

May 24, 2017
Evidence-informed strategies to decrease inequities

Health Policy Institute of Ohio
May 2017
Learning objectives

2. Where to find effective strategies to reduce disparities and inequities
3. Upstream partners

Prioritize selection of policies and programs:
• Likely to reduce disparities
• Address underlying causes of health inequities
What are we talking about?

- promising practice
- recommended
- best practice
- effective
- proven program
- emerging
- model program
- evidence-informed
- evidence-based

Evidence-based strategy

Approved
evidence-based strategy
(HPIO definition)

Programs, policies or other strategies that have been evaluated and demonstrated to be effective in improving outcomes based upon the best-available research evidence, rather than upon personal belief or anecdotal evidence.

What criteria would you like a HEALTHCARE PROVIDER to use in deciding how to treat you?

1. Intuition (gut feeling) about what will be effective
2. What they have heard from co-workers is effective
3. Past experience with similar situations
4. Results of controlled experimental studies that show a method is helpful
5. What they know by critically reading the literature in their field

Adapted from: E. Gambrill, Critical Thinking for Helping Professionals
A framework for thinking about evidence

Evidence-based decision making

- Best available research evidence
- Experiential evidence
- Contextual evidence

Local community health improvement plan example

Evidence-based decision making

- Best available research evidence
- Experiential evidence
- Contextual evidence

Recommendations from the 2017-2019 SHIP, What Works for Health and Community Guide

- Information about community preferences and readiness, available funding, political will and coordination with relevant stakeholders

Source: Puddy and Wilkens (2011)
Limitations
policy and systems change

Research evidence
- Overall effectiveness
- Effectiveness for decreasing disparities
- Fidelity to model

Community fit
- Community member needs & interests
- Community norms, readiness & capacity
- Culture & language of priority populations
Evidence helps us to steer resources toward what really works.

Where should we look for effective strategies?
Recommended sources of evidence-based strategies

- Community Guide (CDC)
- What Works for Health (U of WI)
- Hi-5: Health Impact in 5 Years (CDC)
- 6/18: Accelerating Evidence into Action (CDC)
- WA State Institute for Public Policy
- Community Health Advisor (RWJ F)
Recommended sources for what works to decrease disparities

- Community Guide (CDC)
- What Works for Health (U of WI)
- Hi-5: Health Impact in 5 Years (CDC)
- 6/18: Accelerating Evidence into Action (CDC)
- WA State Institute for Public Policy
- Community Health Advisor (RWJF)

Recommended sources for what works to decrease disparities

- What Works for Health
  - disparity ratings
- Community Guide
  - equity systematic reviews

2017-2019 state health improvement plan (SHIP)
WHAT WORKS FOR HEALTH

Find effective programs and policies at
www.countyhealthrankings.org/what-works-for-health

WHAT WORKS FOR HEALTH EVIDENCE RATINGS

› Scientifically Supported
› Some Evidence
› Expert Opinion
› Insufficient Evidence
› Mixed Evidence
› Evidence of Ineffectiveness
WHAT WORKS FOR HEALTH DISPARITY RATINGS

‣ Likely to decrease disparities
‣ No impact on disparities likely
‣ Likely to increase disparities
‣ Disparities by
  – Socio-economic status
  – Race or ethnicity
  – Geographic area

EXAMPLE: SCHOOL BREAKFAST PROGRAMS

School breakfast programs offer students a nutritious breakfast, often incorporating healthy and culturally relevant choices. Breakfast can be served in the cafeteria, at the snack room, in school hallways, or in classrooms, as long as the school day begins after breakfast. The federal School Breakfast Program (SBP) reimburses schools at a rate determined by their Federal Poverty Level (FPL). Lunch programs operate under similar rules.

Expected Beneficial Outcomes (Rated)

‣ Improved cognitive function
‣ Increased academic achievement
‣ Increased healthy food consumption

Other Potential Beneficial Outcomes

‣ Improved nutrition
‣ Increased food security
Evidence of Effectiveness

There is strong evidence that having access to school breakfast programs improves cognition and scholastic achievement, especially among nutritionally deficient or malnourished children (Frisvold 2015, Hoyland 2009, Meyers 1989, Adolphus 2013). Access to school breakfast programs also increases healthy food consumption and can improve breakfast nutrition (Bhattacharya 2006, Murphy 2011, Ask 2006, ERS 2004, Frisvold 2013).


Impact on Disparities

Likely to decrease disparities

Implementation Examples

In the 2013-2014 school year, the federal School Breakfast Program served approximately 11.2 million low income children on a typical day (FRAC-Woo 2015). Low income children participate in the School Breakfast Program much more than higher income children, and schools that serve

Implementation Resources

USDA-SBP - Food and Nutrition Service (FNS), School Breakfast Program (SBP), US Department of Agriculture (USDA).
FRAC-SBP - Food Research and Action Center (FRAC), School breakfast program.
KHIC SBP: School breakfast - No Kid Hungry Center for Best Practice (NKH/CBP). School

School breakfast programs
Columbus and Newark
School-based health centers
Cincinnati and Cleveland
Figure 3.1. Strategies to address all SHIP priorities outcomes

1. Likely to reduce disparities
   - School-based health centers
   - Early childhood supports
     - Early childhood education
     - Preschool education
     - Early childhood home visiting programs
   - Child care subsidies
     - Early childhood home visiting programs
   - Affordable, quality housing
     - Affordable housing subsidies
     - Rent assistance
     - Home improvement loans and grants
     - Affordable housing tax credits
   - Employment and income
     - Earned income tax credits
     - Local/regional built environment changes to support active living and social connectedness
     - Community-accredited design
     - Bike and pedestrian master plans
     - Green spaces and parks
     - Public transit
     - Smoke-free environments
     - Public health systems, prevention, and health behavior strategies
     - School-based prevention programs and policies
   - Support interventions in community settings

Earned income tax credits (including outreach to increase uptake, remove cap and/or make credit refundable)
Equal opportunity

Social, economic and physical environment

Adapted from Saskatoon Health Region’s Public Health Observatory

Copyright © 2017 Health Policy Institute of Ohio. All rights reserved.

Strategies likely to increase opportunity & health equity:
8 examples from the SHIP

- School-based health centers
- Tobacco QuitLine
- Healthy food in convenience stores
- Fruit and vegetable SNAP incentives
- School breakfast
- Earned Income Tax Credit
- Housing assistance
- Early childhood education

Lack of healthcare access
Lack of healthy food access
Low wages, low economic mobility and poverty

Copyright © 2017 Health Policy Institute of Ohio. All rights reserved.
Ohio Tobacco QuitLine

Healthy food in convenience stores

Lorain
Fruit and vegetable incentives
Montgomery, Summit & Stark counties

Produce Prescriptions
East Cleveland (REACH)
Earned income tax credit outreach
Cleveland and Akron

Service-enriched housing and Rental vouchers
Columbiana County
Subsidized housing
Youngstown

YWCA of Youngstown

YWCA Rayen Apartments
Located in the downtown area
Subsidized housing for income eligible individuals

- Newly Renovated Apartments in the historical YWCA building
- Subsidized housing for income eligible individuals
- 25 one-bedroom and 4 efficiency apartments
- Handicap accessible
- On the bus-line located in downtown Youngstown
- Coming soon! Activity Areas, Fitness Room & Computer Lab

Rayen Avenue, Youngstown, OH 44503
Youngstown to view more pictures

Early childhood education
Cincinnati and Cleveland

Voters approve Cincinnati Public Schools tax levy to fund district-wide preschool program

Cleveland Plain Dealer
Pathway to improved health value

Upstream partners to achieve equity

- Who are they?
- What works to engage upstream partners?
Who are your upstream equity partners?

- People most affected by inequities
- Leaders from sectors beyond health

- Health leaders
- Policymakers
## Examples of decision makers in sectors beyond health

- School district superintendent or principal
- Police Chief or County Sheriff
- Convenience store owner
- Transitional housing agency director
- CEO of a large employer
- Farmer

## Examples of policymakers

- State legislator (representative or senator)
- State Board of Education member
- Director of Ohio Department of Job and Family Services
- City Council member
- County Commissioner
- Metropolitan Planning Commission board member
Decision maker analysis

• What do you want?
• Who has the decision-making authority to make it happen?

What works to engage cross-sector partners and policymakers?

1. Find out what’s in it for them
2. Use effective messaging
3. Build relationships
4. Use “collective impact” (or similar framework) to sustain common agenda over time
Prioritize selection of policies and programs:
• Likely to reduce disparities
• Address underlying causes of health inequities

Identify and engage upstream equity partners:
• People most affected by inequities
• Health leaders
• Leaders from sectors beyond health
• Policymakers
Who has the power to make the decision to enact this policy change?

Will you need to reach out to individual policymakers?

What policy change would you like to see?

Advocacy
- Education
- Facts
- Bipartisan
- Balanced
- No call to action (position not taken)
- Activities that defend, support or maintain a cause
- Usually broad issues

Lobbying
- Influencing legislation, regulation, funding
- Actions aimed at influencing public officials to promote or secure passage of specific bill or funding
- A paid representative for a particular organization

What is Advocacy? Fact Sheet
What is Lobbying? Fact Sheet
Ways to influence policy

• Write letters, emails or make phone calls
• Provide district specific data
• Provide analysis of a bill
• Provide testimony at a legislative hearing
• Provide a one-page fact sheet
• Organize community partners to visit key policymakers
• Invite policymakers to visit your organization or speak at a meeting you host
Who represents you?

Policymaking basics

https://capwiz.com/nra/dbq/officials/

https://osupublichealth.catalog.instructure.com
Roadmaps to equity
Opportunities for closing health gaps in Southwest Ohio

May 11, 2017