Roadmaps to equity
Opportunities for closing health gaps in Central Ohio

May 9, 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

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

Elimination of disparities
Absence of differences

Health inequities, disparities and equity

Health inequities ➔ Health disparities

Health equity

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

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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

Ohio African-American/black performance compared to U.S. overall rate on metrics included in state health assessment data profile

<table>
<thead>
<tr>
<th>Metric</th>
<th>African-American/black</th>
<th>U.S. Overall Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population health</td>
<td>100% (9 metrics)</td>
<td></td>
</tr>
<tr>
<td>Healthcare system</td>
<td>85.7% (4 metrics)</td>
<td>14.3% (4 metrics)</td>
</tr>
<tr>
<td>Access to healthcare care</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>

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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>Diabetes Rate</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

**Hypertension prevalence, by age. (2013)**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-24</td>
<td>6.6%</td>
</tr>
<tr>
<td>25-34</td>
<td>12.1%</td>
</tr>
<tr>
<td>35-44</td>
<td>20.9%</td>
</tr>
<tr>
<td>45-54</td>
<td>34.9%</td>
</tr>
<tr>
<td>55-64</td>
<td>48.7%</td>
</tr>
<tr>
<td>65+</td>
<td>63.1%</td>
</tr>
</tbody>
</table>

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

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

Disparities and inequities by disability status

**Adult depression prevalence, by disability status. (2014)**

<table>
<thead>
<tr>
<th>Group</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults with disability</td>
<td>51.5%</td>
</tr>
<tr>
<td>Adults without disability</td>
<td>13%</td>
</tr>
</tbody>
</table>

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

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

Child poverty, by county (2014)

Source: 2016 County Health Rankings, based on 2014 data

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Pathway to improved health value:
A conceptual framework

Data in context

<table>
<thead>
<tr>
<th>Rankings</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Progress and trends</td>
<td>Greatly improved</td>
</tr>
<tr>
<td>Highlighting other states</td>
<td>Most improved state(s)</td>
</tr>
<tr>
<td>Disparities and inequities</td>
<td>Little to no disparity</td>
</tr>
<tr>
<td></td>
<td>Medium disparity</td>
</tr>
<tr>
<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.

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How does Ohio do?

Where does Ohio rank?

Population health: 43
Healthcare spending: 31
Health value in Ohio: 46

Health + Spending = Value

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Why does Ohio rank so poorly?
Ohio performs poorly on many of the factors that impact health value.

Data in context

Rankings
Progress and trends
Highlighting other states
Disparities and inequities

Examples

Most improved state(s)
TN, NV, LA

Little to no disparity
Medium disparity
Large disparity
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

- Income: 64.2%
- Race and ethnicity: 53.6%
- Disability status: 26.7%
- Education level: 12.5%
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.

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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

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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

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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

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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 Central Ohio

May 9, 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
- model program
- best practice
- emerging
- effective
- evidence-based
- proven program
- evidence-informed
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*

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**A framework for thinking about evidence**

![Framework Diagram]

- Best available research evidence
- Experiential evidence
- Contextual evidence

Evidence-based decision making
Local community health improvement plan example

Evidence-based decision making

- Best available research evidence
- Experiential evidence
- Contextual evidence
- Expertise and experience of planning team
- Information about community preferences and readiness, available funding, political will and coordination with relevant stakeholders

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

Source: Puddy and Wilkens (2011)

Limitations
policy and systems change
Evidence helps us to steer resources toward what really works.
Where should we look for effective strategies?

HPIO Guide to improving health value

Navigating sources of evidence

A guide to effective prevention strategies

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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)

County Health Rankings & Roadmaps
Building a Culture of Health, County by County

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

Evidence Rating
- Scientifically Supported

Health Factors
- Diet and Exercise
- Decision Makers
- Philanthropy and Investors
- Educators
- Government

Community in Action
- Toledo Launches Universal School Breakfast Program

School breakfast programs offer students a nutritious breakfast, often incorporate healthy and culturally relevant choices. Breakfast can be served in the cafeteria, from grab-and-go carts in hallways, or in classrooms as the school day begins. Schools offer breakfast during a morning break, called second chance breakfast (SNAP-EBP-School Breakfast). Schools that participate in the federal School Breakfast Program receive subsidies for each breakfast served. Students from families with incomes below 185% of the federal poverty level (FPL) are eligible for free breakfast and children from families with incomes between 130 and 185% FPL qualify for reduced-price breakfasts. FPL participation in the federal program varies by state and region (Bartfeld 2010). Participating schools offer free breakfast to all students, others only to qualify (FRAC-Woo 2015).

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, Adolph 2013). Access to school breakfast programs also increases healthy food consumption and can improve breakfast nutrition (Bhattacharya 2006, Murphy 2011, Ask 2006, ERS-Fox 2004, Frisvold 2015).

School breakfast availability can reduce short-term hunger (Mhurchu 2012), marginal food insecurity, and food-related stressors in low-income households (USDA-Bartfeld 2009, Bartfeld et al. 2010).

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 2013). Low-income children participate in the School Breakfast Program much more than higher-income children, and schools that serve

Implementation Resources
- FRAC-SBP: Food Research and Action Center (FRAC). School breakfast program.
- NH-EBP: School breakfast - MyKidHungry: Center for Best Practices (NBH-EBP). School...
School breakfast programs
Columbus and Newark

Health Equity: School-Based Health Centers

Summary of Task Force Finding
The Community Preventive Services Task Force recommends the implementation and maintenance of school-based health centers (SBHCs) in low-income communities to improve educational and health outcomes.

Educational outcomes include the following:
- School performance
- Grade promotion

If targeted to low-income communities, SBHCs are likely to reduce gaps in education and improve health equity.
School-based health centers
Cincinnati and Cleveland

Figure 3.1: Strategies to address all SHIP priority outcomes
- Likely to reduce disparities
  
Social determinants of health strategies
  
School-based health centers

Early childhood support
- Early childhood education (including center-based early childhood education, preschool education programs, and universal pre-kindergarten)
- Child care subsidies
- Early childhood home visiting programs (including early childhood home visiting to prevent child maltreatment and specific evidence-based home visiting models supported by the Ohio Department of Health)

Affordable, quality housing
- Unit housing subsidy/reducer (operating cost)
- Low-income housing tax credits
- Home improvement loans and grants
- Service-enriched housing

Employment and income
- Earned income tax credits (including outreach to increase uptake, remove cap and/or make credit refundable)
- Unemployment programs such as unemployment benefits for adults and long-term jobs
- Local/regional built environment changes to support active living and social connections
- Community-wide urban design land use policies/streetscape design (Complete Streets)
- Bike and pedestrian master plans
- Green spaces and parks
- Public building safety considerations (such as location of school buildings)

Smoke-free environments
- Smoke-free policies (including maintenance of smoke-free workplace law and increased policy adoption for multi-unit housing, schools and other settings)
- Local smoke-free policies for indoor areas
- Smoke-free policies for outdoor areas
- Smoke-free policies for public settings

Public health system, prevention and health behaviors strategies
- School-based prevention programs and policies
- Universal prevention programs tied to school-based health centers (See Figures 4.1, 4.2, 5.1, 5.2 and 6.1 for topic-specific prevention programs)

Earned income tax credits (including outreach to increase uptake, remove cap and/or make credit refundable)
Social, economic and physical environment

Adapted from Saskatoon Health Region’s Public Health Observatory

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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

Ohio Tobacco QuitLine
Healthy food in convenience stores

Lorain

Columbus- Westside
Cleveland

Fruit and vegetable incentives
Montgomery County

YOU SNAP. WE MATCH. The healthy way to stretch your SNAP.

Shop with SNAP/EBT, get up to $10 in FREE fruits & vegetables!

Market locations:

- Market at Wright Stop Plaza
- Shiloh Farmers Market
- Mission of Mary CSA

Buy 1 Get 2

Shop with SNAP/EBT, get up to $10 in FREE fruits & vegetables!
Earned income tax credit outreach
Columbus, Cleveland and Cincinnati

Service-enriched housing and Rental vouchers
Columbiana County
Early childhood education
Cincinnati and Cleveland

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

Pathway to improved health value

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.
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
- Health leaders
- Leaders from sectors beyond health
- Policymakers
Who are your upstream equity partners?

- People most affected by inequities
- Health leaders
- Leaders from sectors beyond health
- 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
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May 9, 2017

What and who influences policy?

- Constituents
- Personal stories
- Data, research
- Events, crises
- Money
- Professional lobbyists
- Advocacy groups and coalitions
- YOU
Separation of power

legislative

executive

judicial
Who represents you?

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

Policymaking basics

https://osupublichealth.catalog.instructure.com
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