

Planning for Community Health Equity

Information, analysis, and strategy

PRESENTER:
john a. powell

DATE:
07 April 2016

Today's Talk

1. Attending to structures and systems
2. Structures and systems in our health
3. Othering & inequality in health
4. Geographies of health
5. Targeted strategies for health
6. Interesting strategies



→ We all live in systems/structures.

→ These structures are not neutral.

→ They enhance or limit life outcomes.

→ We live in Structures and structures live in us.



- Existing health system capacity to address need
- Exists in more than one sub-area of KPNW service area

C. Prioritized description of all the community health needs identified through the CHNA (i.e., issue statements)

Nutrition & physical activity related chronic disease is a health need as evidenced by multiple poor health outcomes, including obesity, diabetes, cancer, cardiovascular disease, and poor mental health.

Economic security is a health need as indicated by poverty, educational attainment, and health insurance coverage, as well as racial and ethnic disparities. Evidence shows that wealth, or a lack thereof, is the strongest determinant of health.

Access to health care, particularly primary care, is a health need with regard to diabetes management, screening for cancers and sexually transmitted disease, and prenatal and dental care.

Maternal and infant health is a health need as indicated by rates of infant mortality, low birth weight, teen births and child poverty as well as racial, ethnic, and geographic disparities.

Mental health is a health need primarily evidenced by suicide, but also by homicide and inadequate social and emotional support, with some geographic and racial disparities.

Cancer, in particular colorectal cancer, but also breast, lung, and prostate cancer, is a health need as evidenced by region-wide higher than benchmark all-cancer mortality rates as well as racial, ethnic, and geographic disparities.

Tobacco use is a health need as a likely risk factor for many poor health outcomes such as breast, lung, and colorectal cancers, and cardiovascular disease, and poor mental health.

Injury is a health need as indicated by both intentional injury (homicide and suicide), unintentional injury (non-transport accidents), as well as racial and gender disparities.

Sexually transmitted disease (chlamydia and HIV) is a health need because it is a general measure of poor health, indicates the prevalence of unsafe sex practices, can be a predictor of cervical cancer (chlamydia), and can be life-threatening (HIV).

Oral health is a health need as indicated by (very) poor dental health, lack of dental care, and in part due to the evidence-based link between oral health and overall health.



Community Health Needs Assessment



D. Community assets and resources available to respond to the identified health needs of the community

1. Existing health care facilities
2. Other existing community resources

Kaiser Permanente has identified and partners with Federally Qualified Health Centers (FQHC), Community Services Clinics (CSC), Tribal Health Centers, and Rural Health Clinics across the *primary* and *secondary* service areas. These health care facilities represent a large set of resources available to respond to the identified community health needs. In addition to providing primary health care services and in some cases specialty care, these health care clinics also serve as resource hubs to connect patients with other essential social

essment, email CHNA-Communications@kp.org.

Opportunity Matters: Space, Place, and Life Outcomes

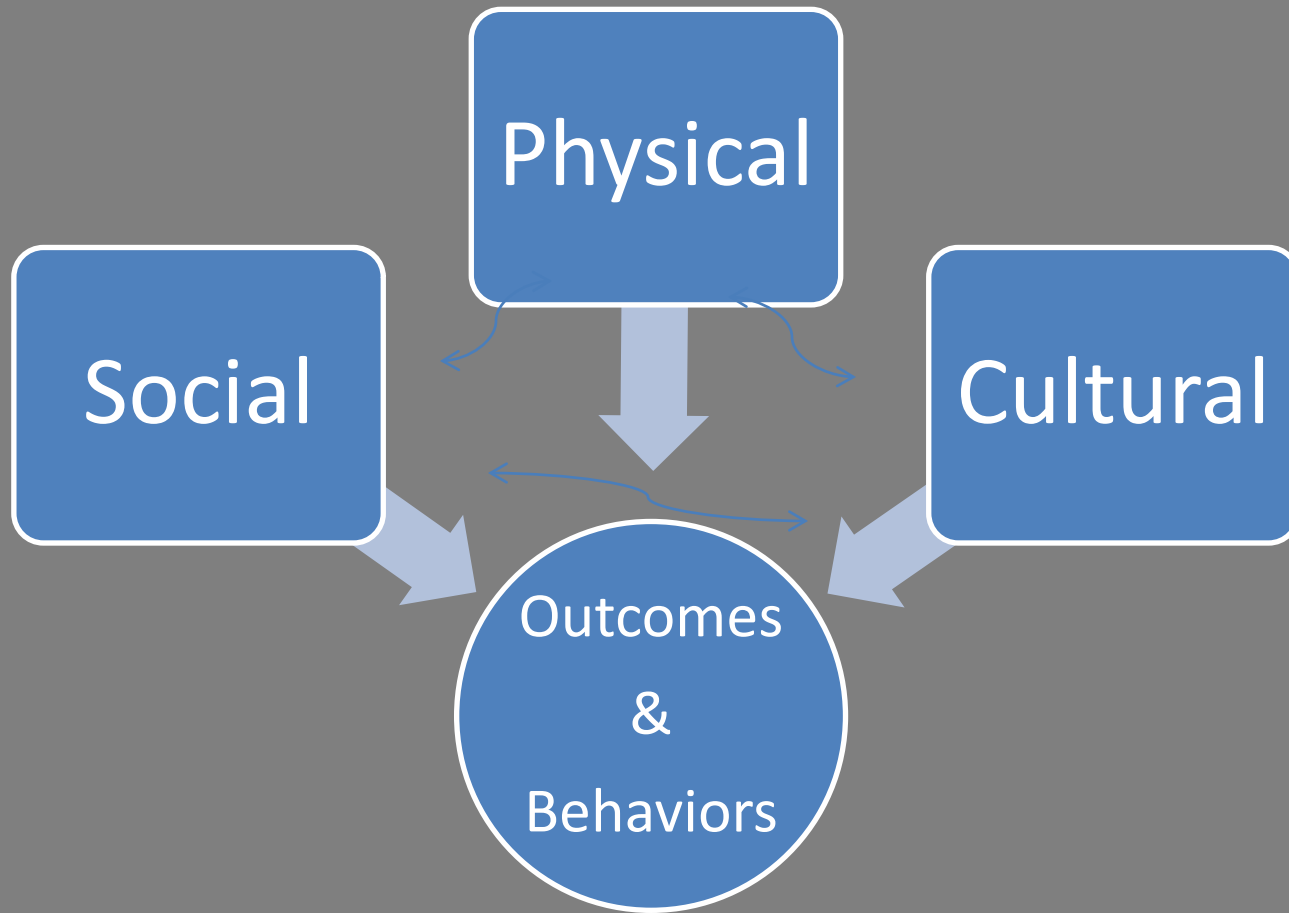
“Opportunity” is a situation or condition that places individuals in a position to be more likely to succeed or excel.

Opportunity structures are critical to opening pathways to success:

- High-quality education
- Healthy and safe environment
- Stable housing
- Sustainable employment
- Political empowerment
- Outlets for wealth-building
- Positive social networks



Systems Thinking: We are all situated within “opportunity structures”



These structures interact in ways that produce racialized outcomes for different groups, but also in ways that influence identity

Structural Racialization & Othering

- How race works today
 - There are still practices, cultural norms and institutional arrangements that help create and maintain (disparate) racialized outcomes
- Othering, structural marginalization addresses inter-institutional arrangements and interactions
 - The ways joint operations of institutions **produce** groups viewed as “other”
 - Creates inequities across those groups
 - Outcomes more relevant than intent

Belonging & Health

- Social belonging is a psychological lever with broad consequences
- African American college freshmen's sense of social belonging led to increased GPA over 3 years, self-reported health and well-being reduced doctor visits, halved the "minority achievement gap"
- Measures of caring and connectedness surpassed demographic variables in protective factors against disturbed and acting out behaviors that together represent the major social morbidities of adolescence
- The effect of teach support in reducing risk-behavior is mediated by social belonging

Achieving Transformative Change

To achieve transformative change, we must create an environment in which everyone *belongs*.

Belonging is the greatest gift society can give us.

Inequality affects our health

othering underwrites inequality

Structural racialization → inequality → different health outcomes

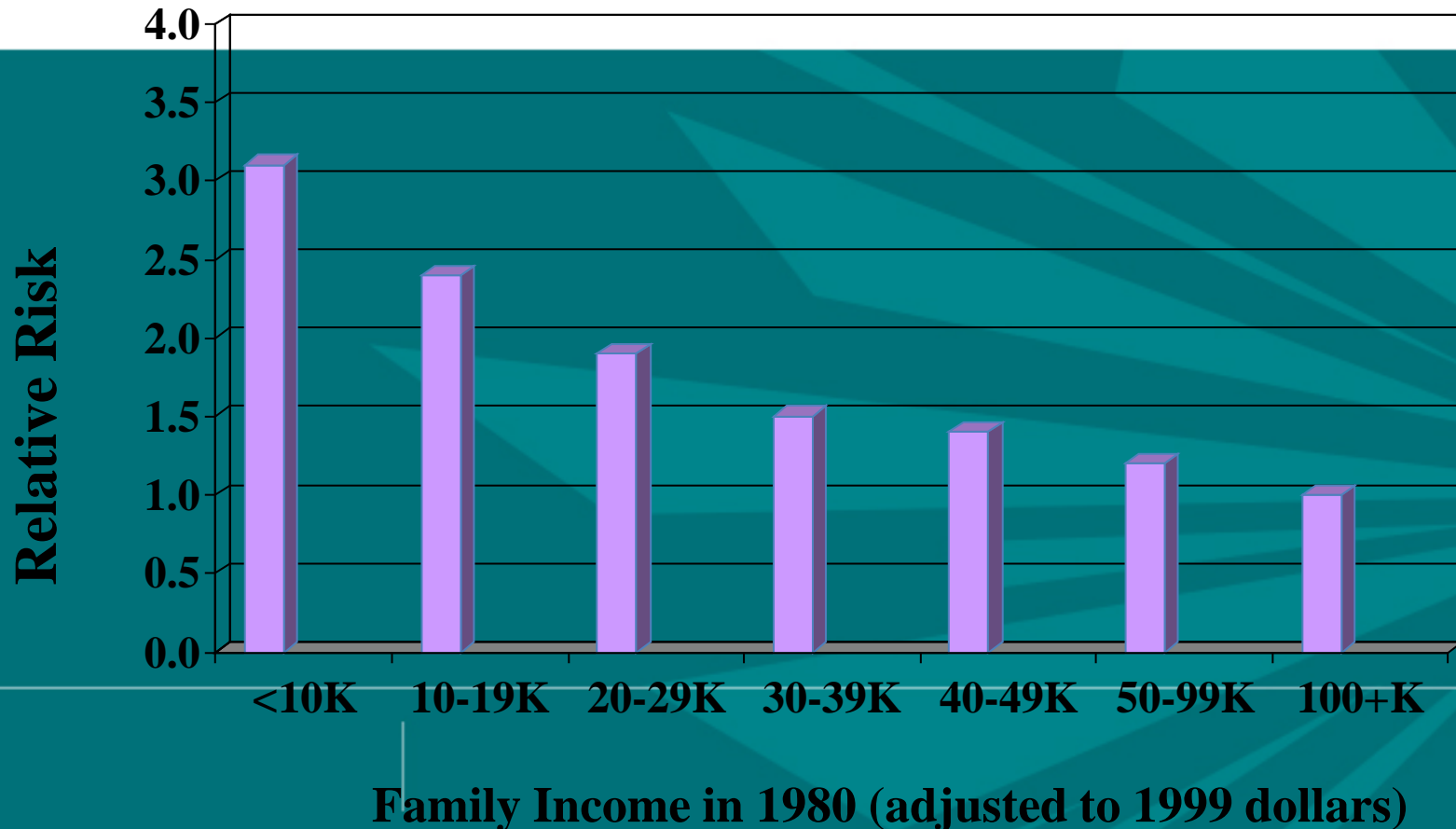
Example :

- College educated Black women more likely to have premature babies than white women without high school diploma
 - Due to stress caused by racialization

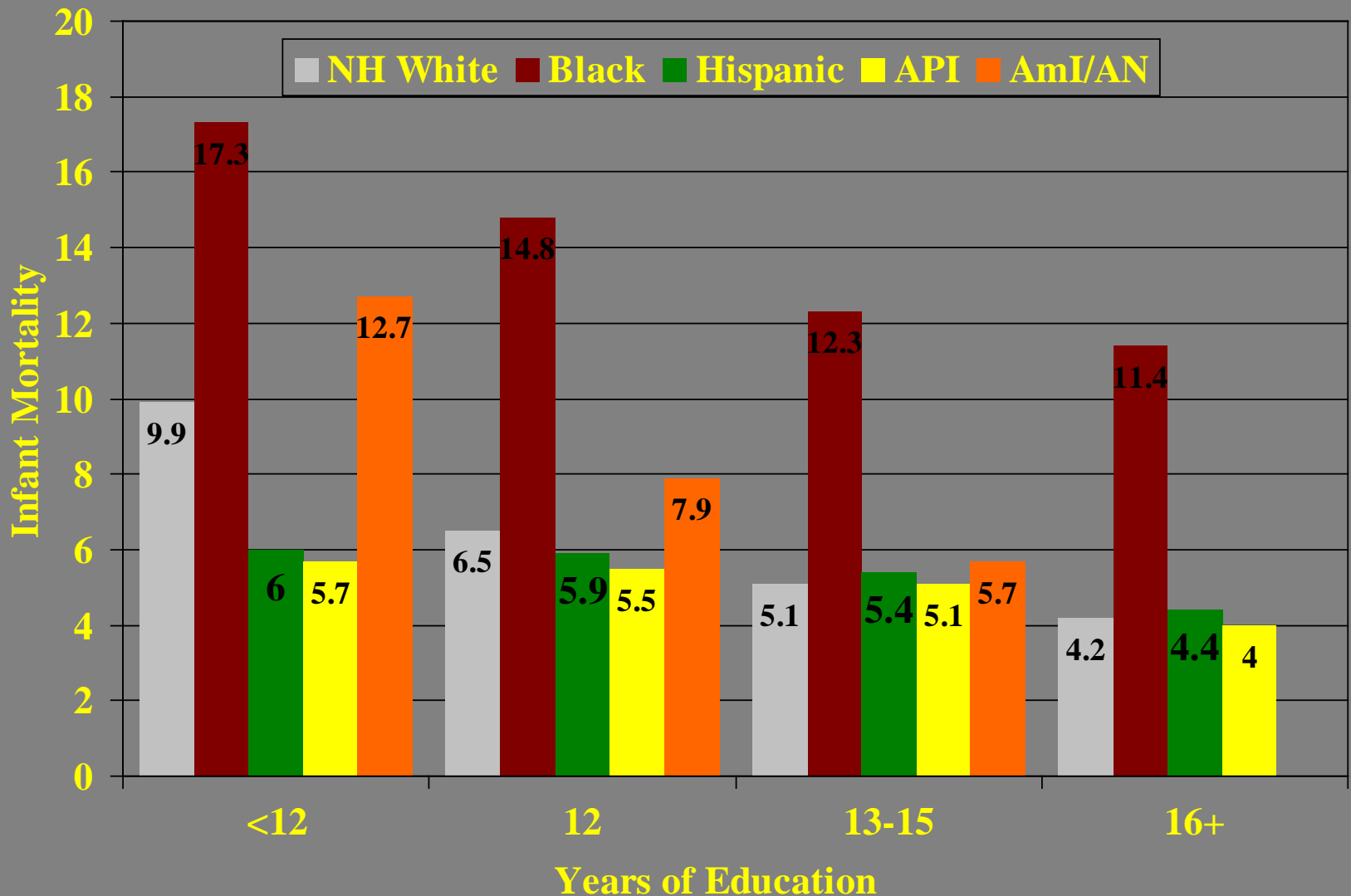
Example:

- Twins who grow up in different environments of opportunities have dramatically different health outcomes
 - Recommended: “Unnatural Causes...Is Inequality Making Us Sick?” on PBS

Relative Risk of Premature Death by Family Income (U.S.)

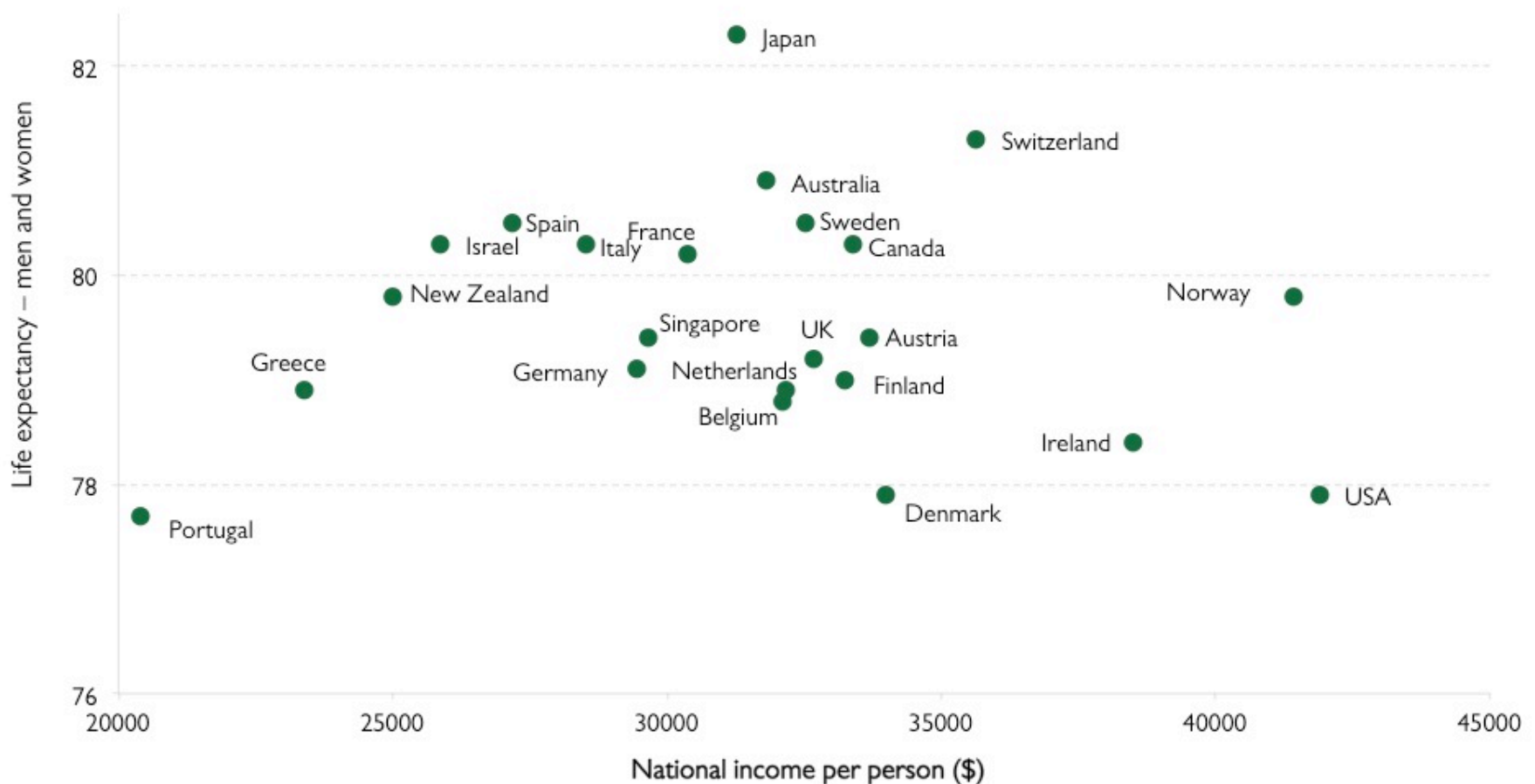


Infant Mortality by Mother's Education, 1995



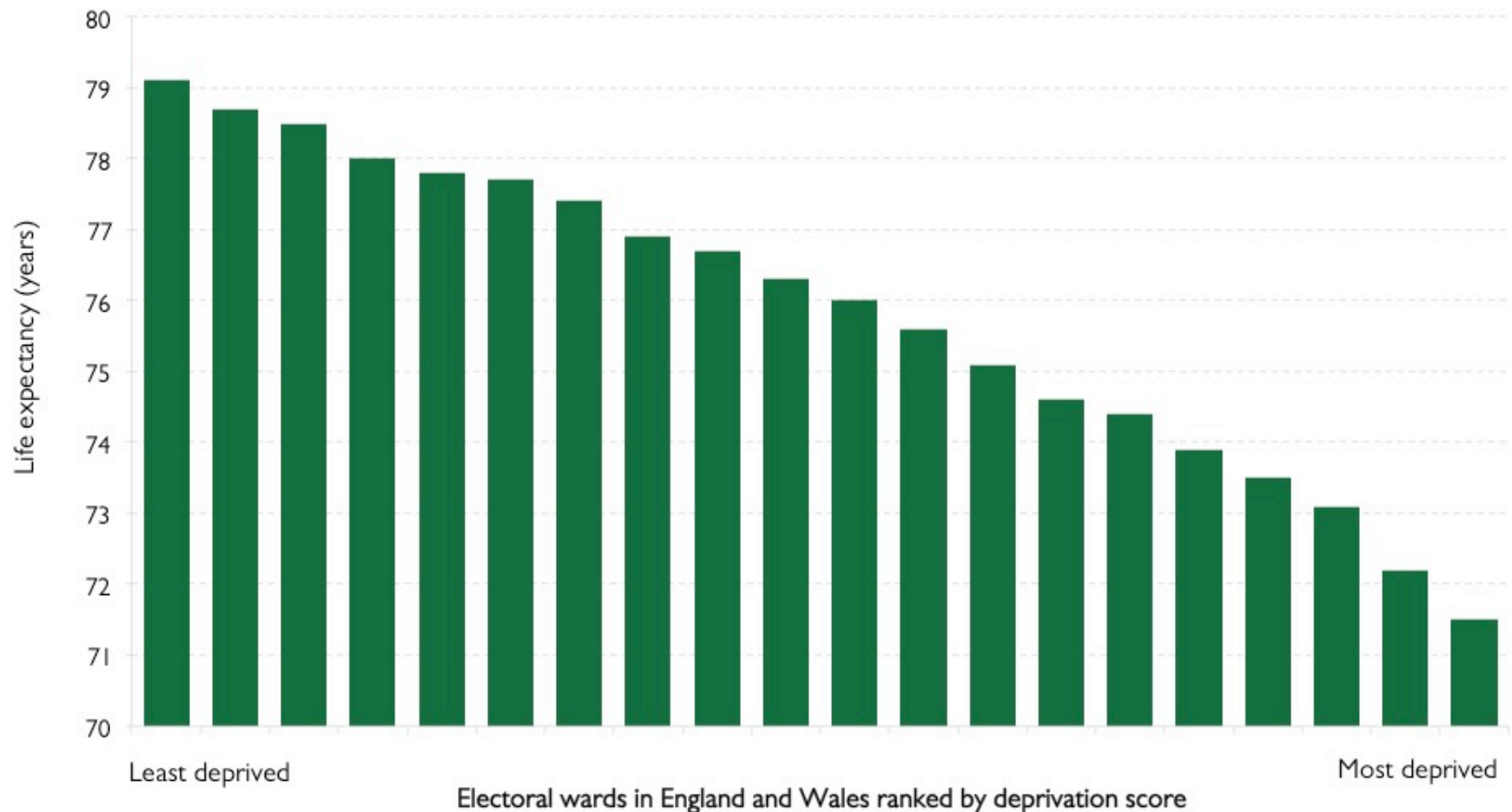
Health is related to income differences *within* rich societies but not to those *between* them

Between (rich) societies

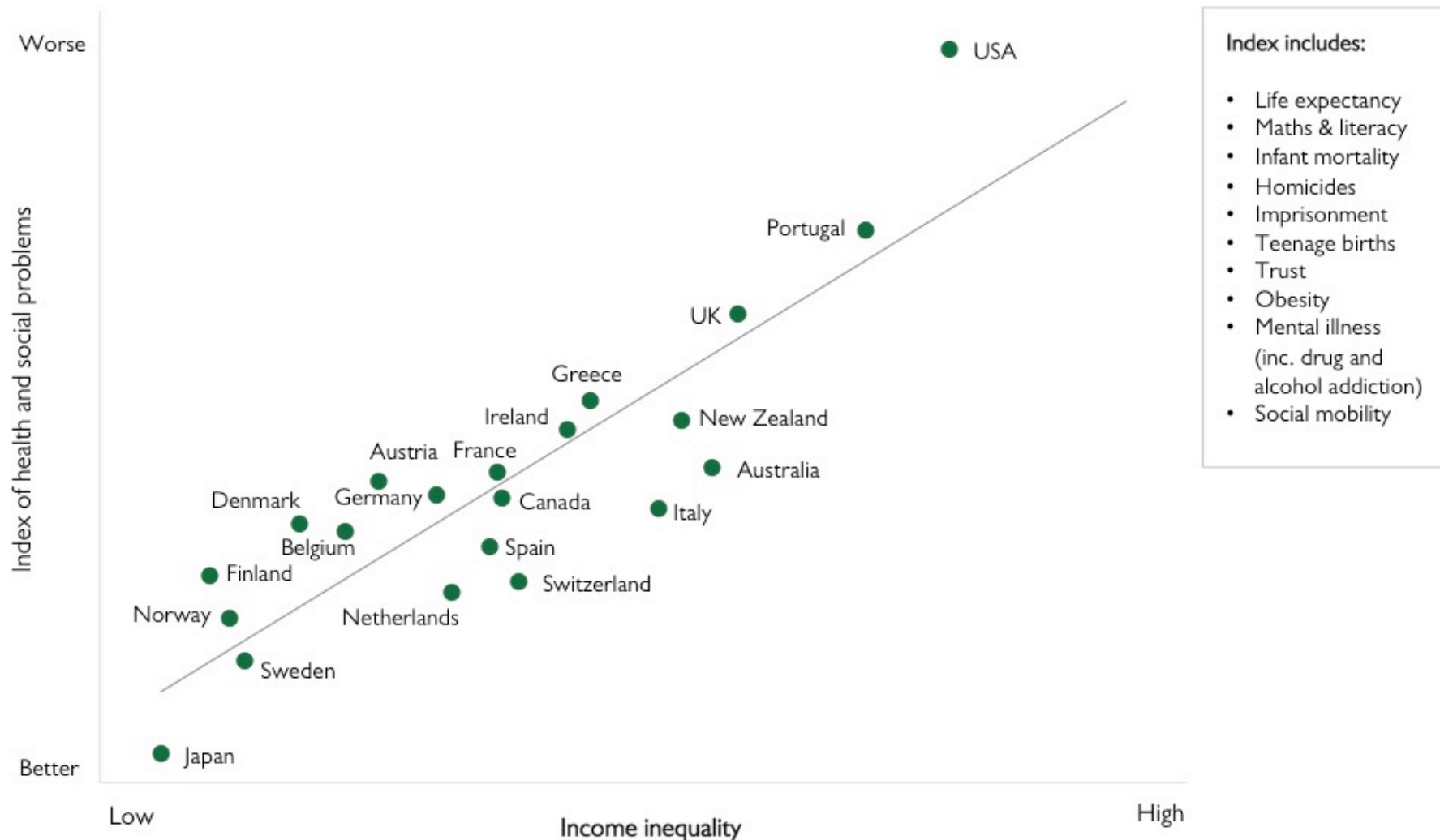


Health is related to income differences *within* rich societies but not to those *between* them

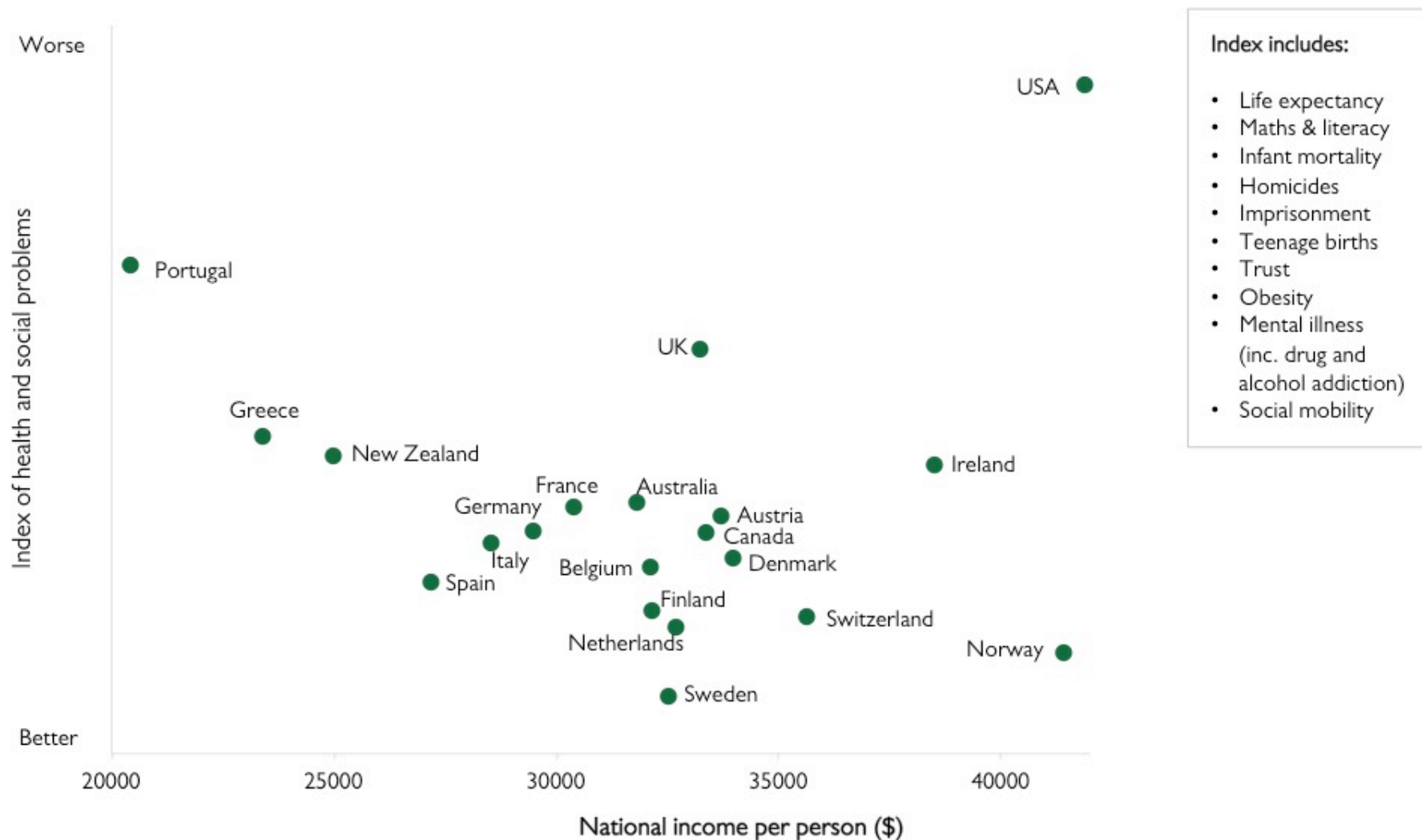
Within societies



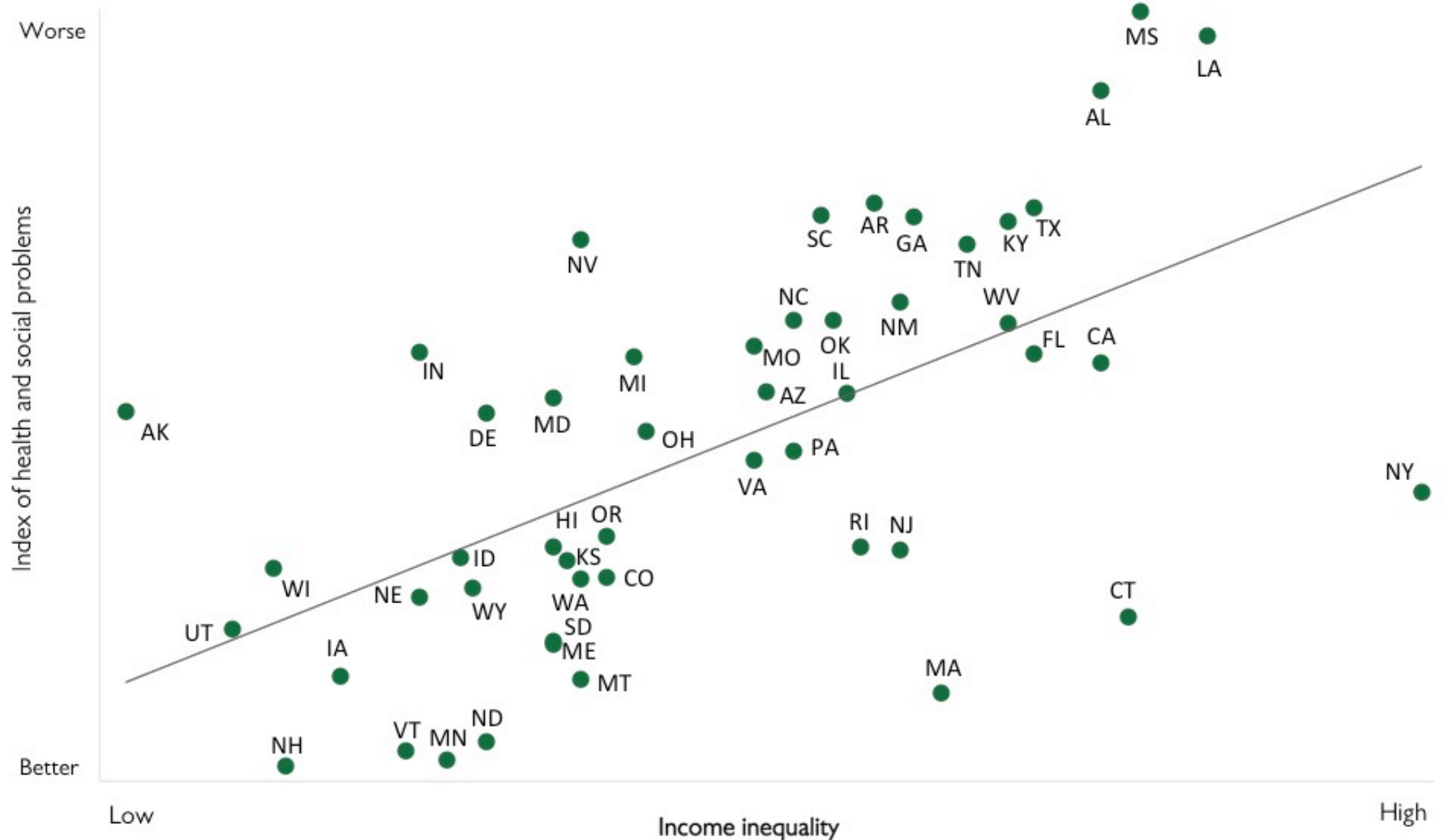
Health and social problems are worse in more unequal countries



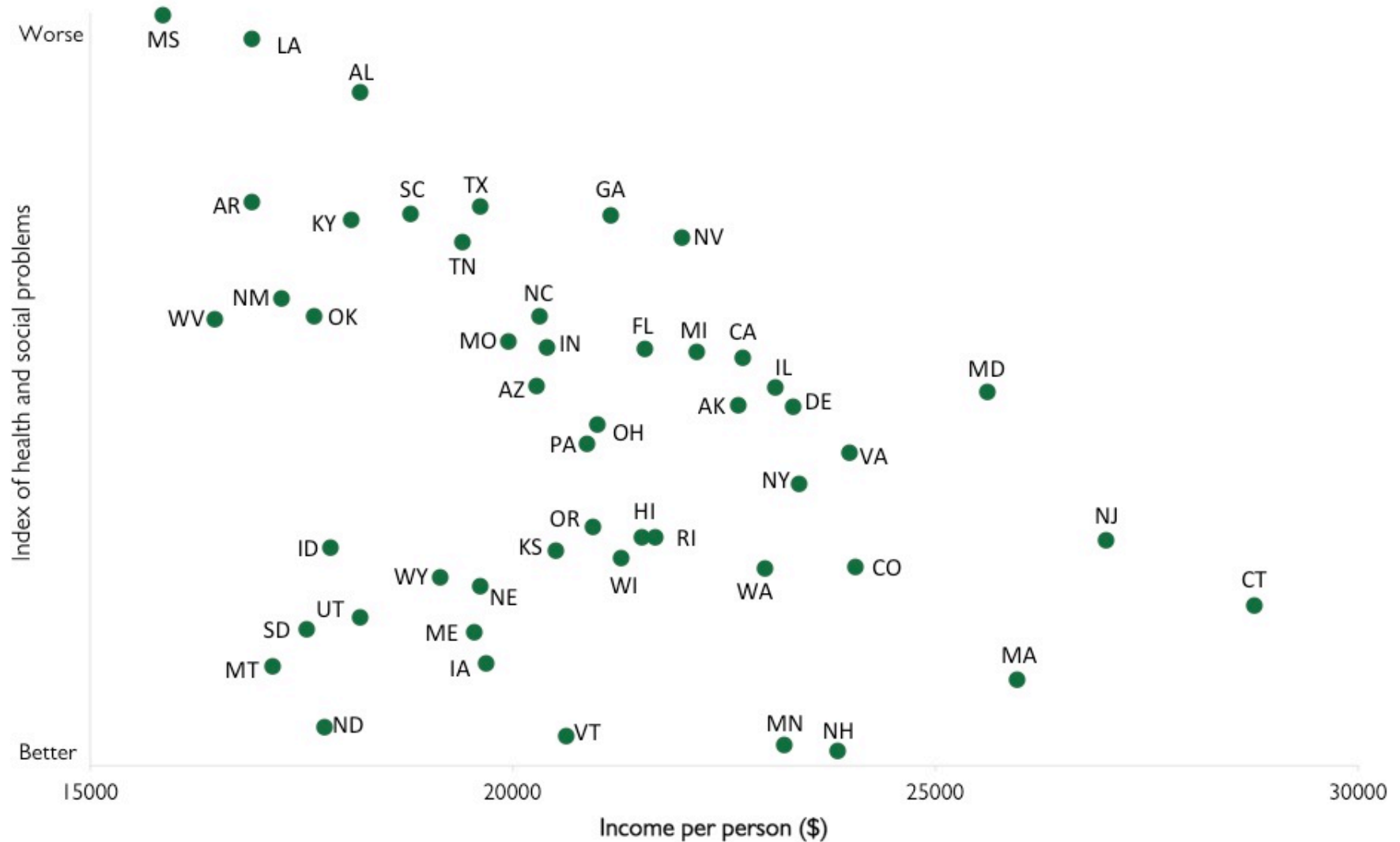
Health and social problems are not related to average income in rich countries



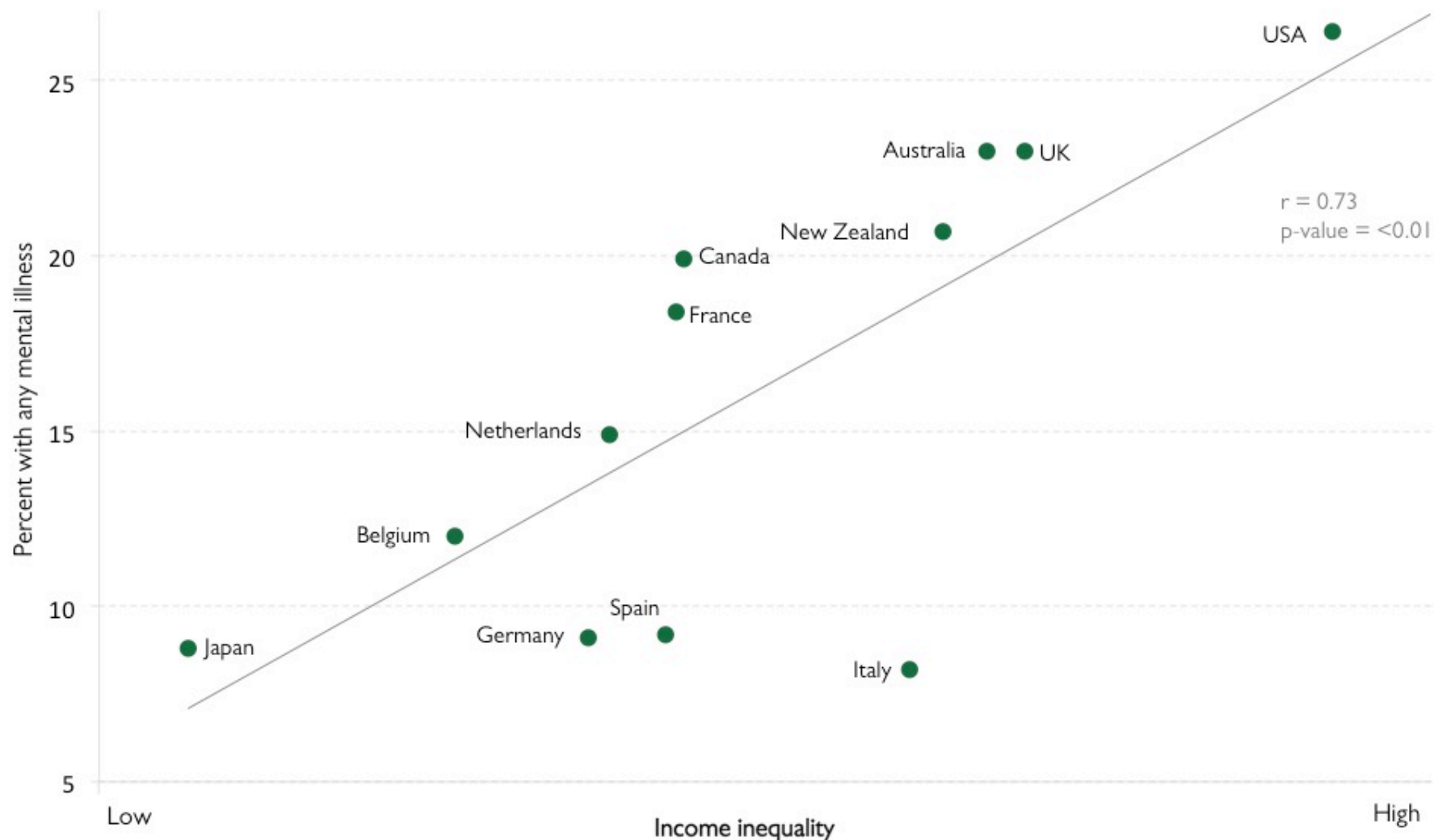
Health and social problems are worse in more unequal US states



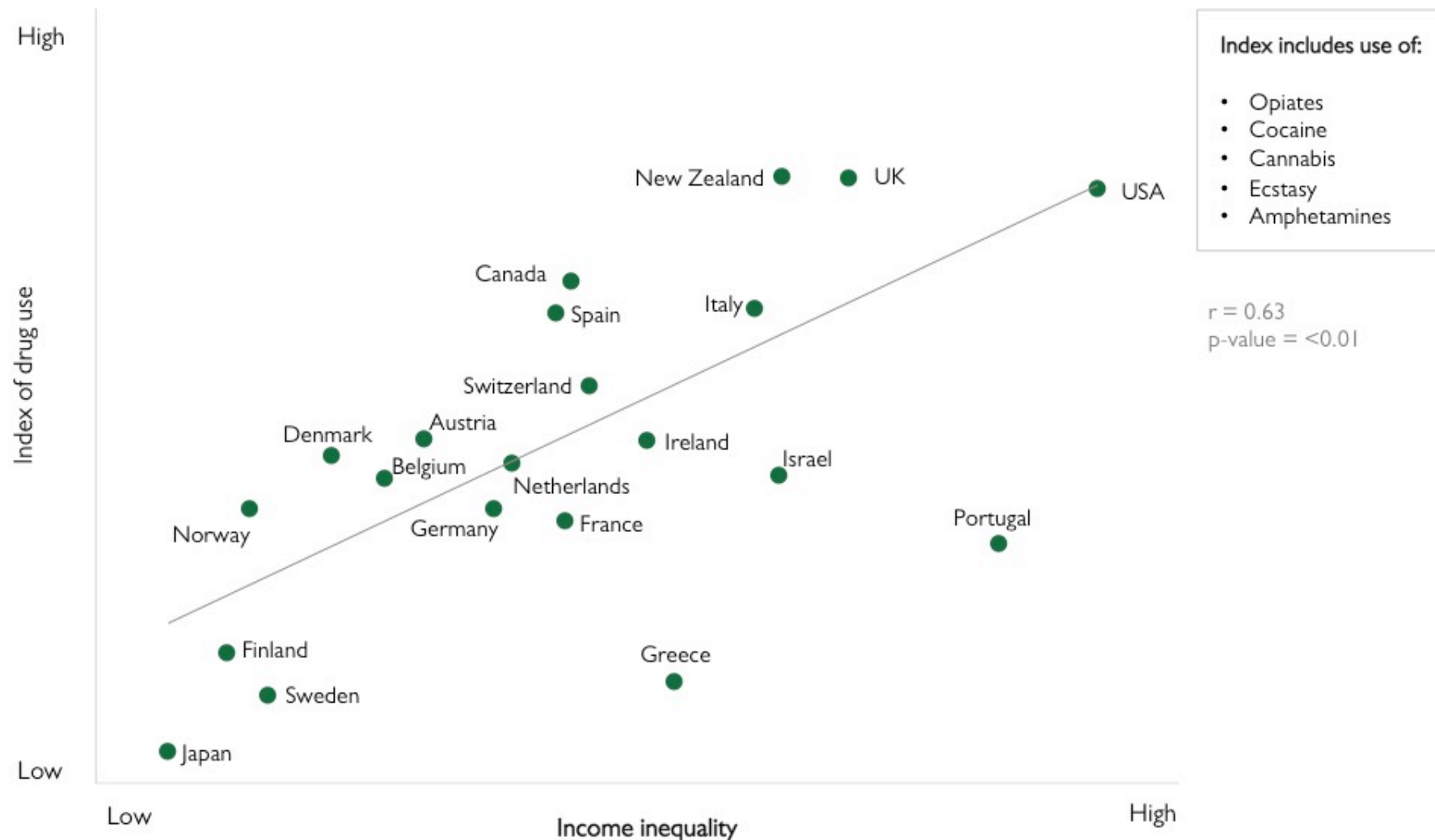
Health and social problems are only weakly related to average income in US states



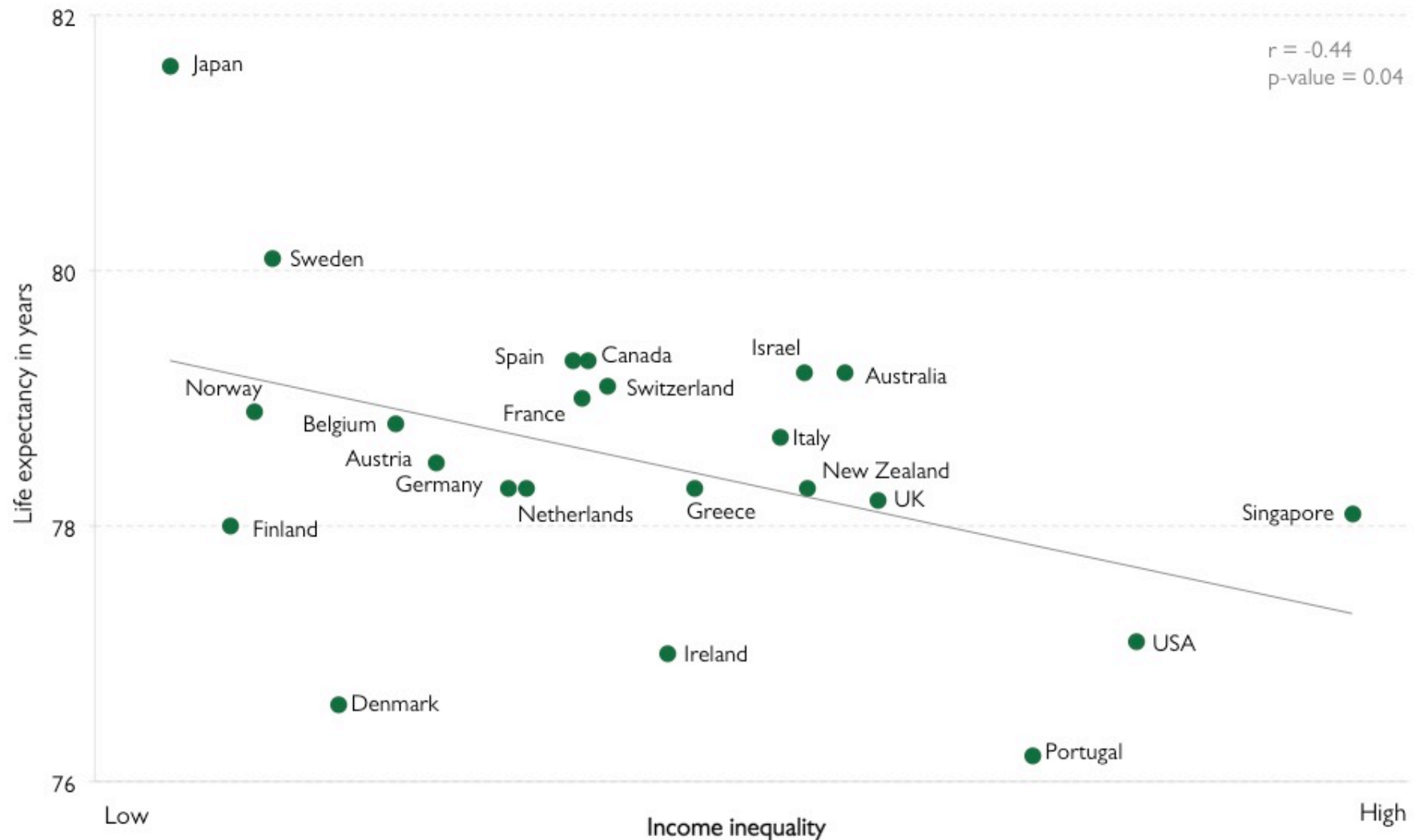
The prevalence of mental illness is higher in more unequal rich countries



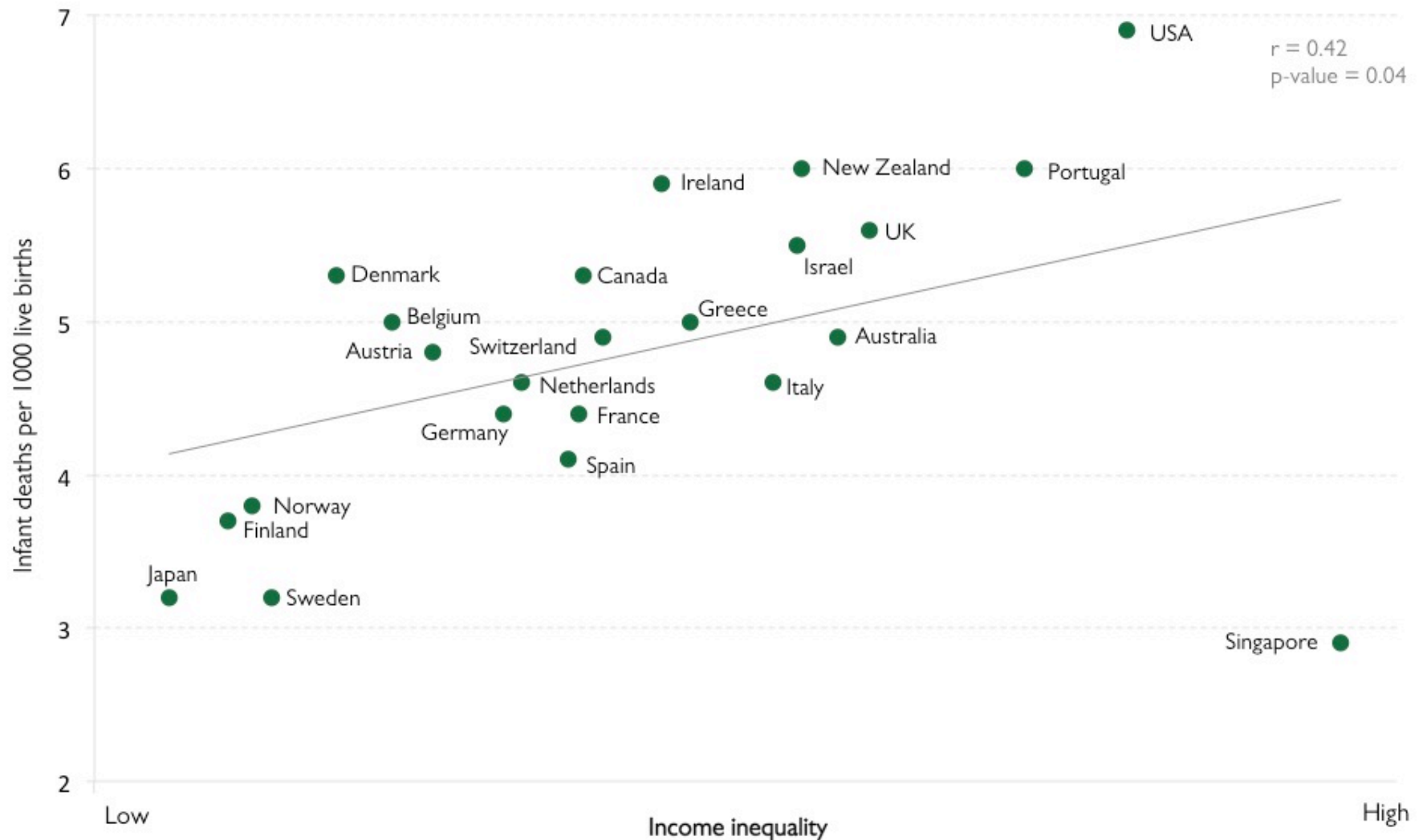
Drug use is more common in more unequal countries



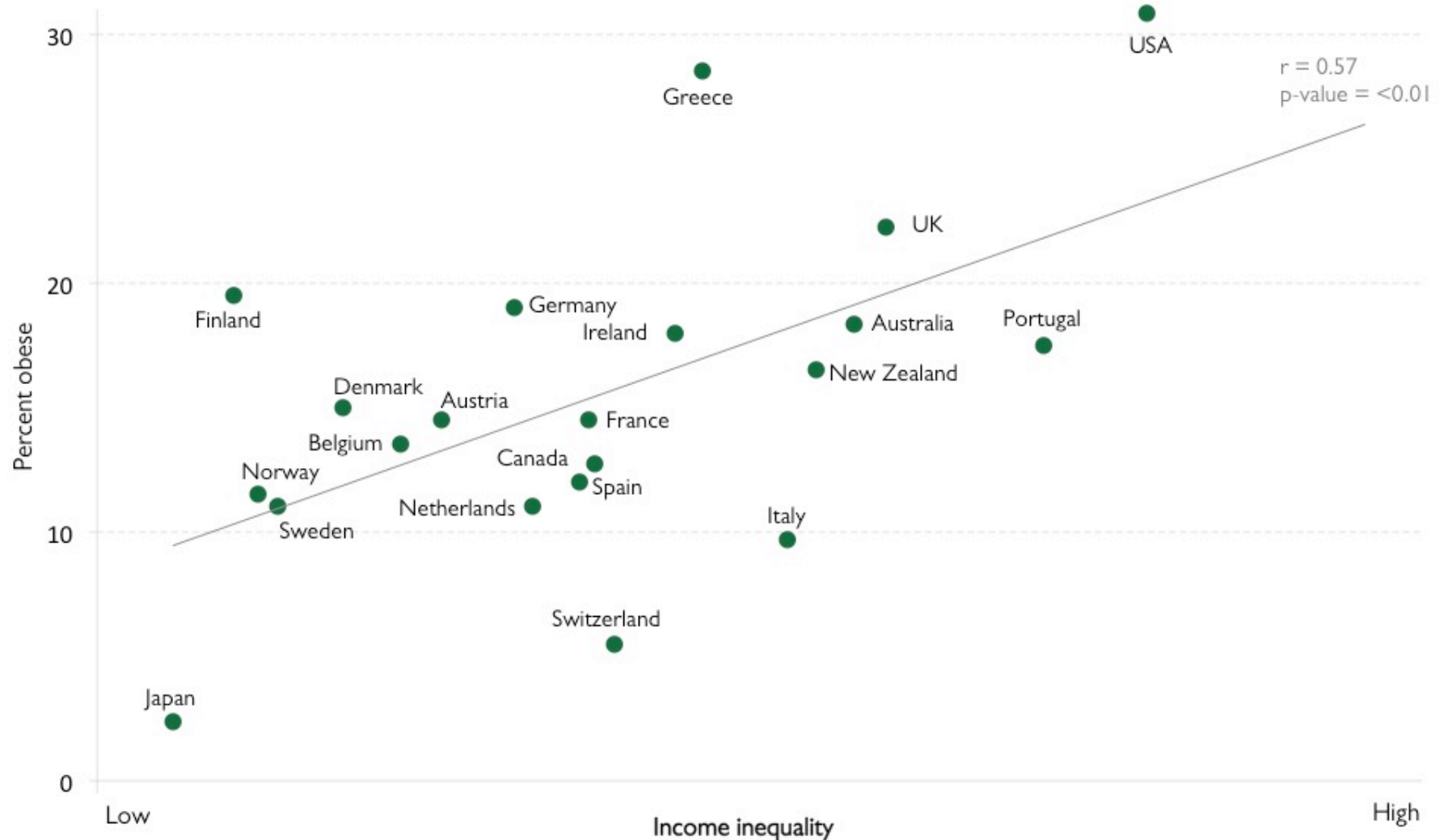
Life expectancy is longer in more equal rich countries



Infant mortality rates are higher in more unequal countries



More adults are obese in more unequal rich countries



Place, Race and Opportunity Structures: Neighborhoods & Access to Opportunity

- Five decades of research indicate that your environment has a profound impact on your access to opportunity and likelihood of success
- High poverty areas with poor employment, underperforming schools, distressed housing and public health/safety risks depress life outcomes
 - A system of disadvantage
 - Many manifestations
 - Urban, rural, suburban
- People of color are far more likely to live in opportunity deprived neighborhoods and communities



How Segregation Can Affect Health

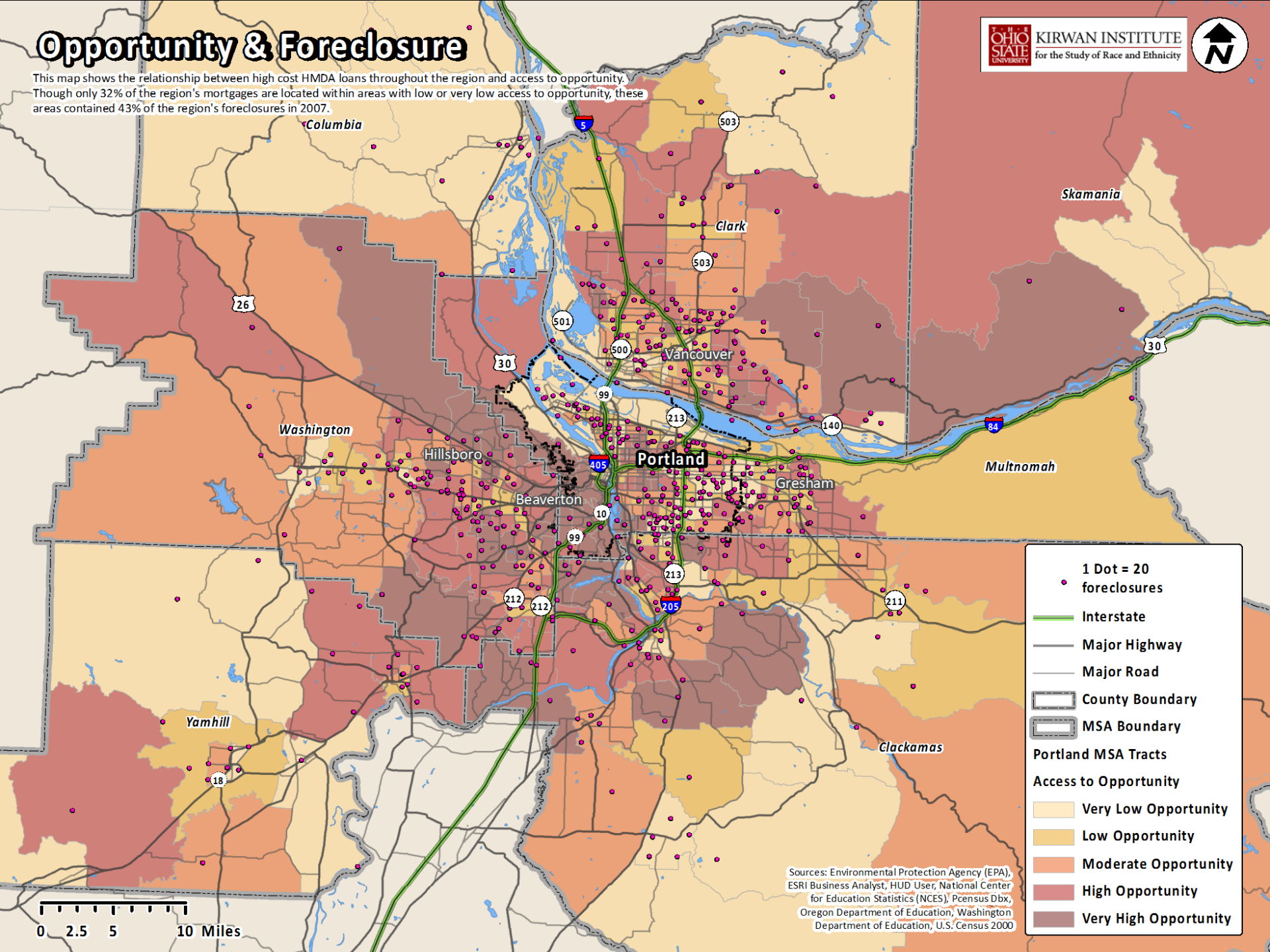
1. Segregation determines SES by affecting quality of education and employment opportunities.
2. Segregation can create pathogenic neighborhood and housing conditions.
3. Conditions linked to segregation can constrain the practice of health behaviors and encourage unhealthy ones.
4. Segregation can adversely affect access to medical care and to high-quality care.

Opportunity & Foreclosure

This map shows the relationship between high cost HMDA loans throughout the region and access to opportunity. Though only 32% of the region's mortgages are located within areas with low or very low access to opportunity, these areas contained 43% of the region's foreclosures in 2007.



KIRWAN INSTITUTE
for the Study of Race and Ethnicity



- 1 Dot = 20 foreclosures
- Interstate
- Major Highway
- Major Road
- County Boundary
- MSA Boundary
- Portland MSA Tracts
- Access to Opportunity
 - Very Low Opportunity
 - Low Opportunity
 - Moderate Opportunity
 - High Opportunity
 - Very High Opportunity

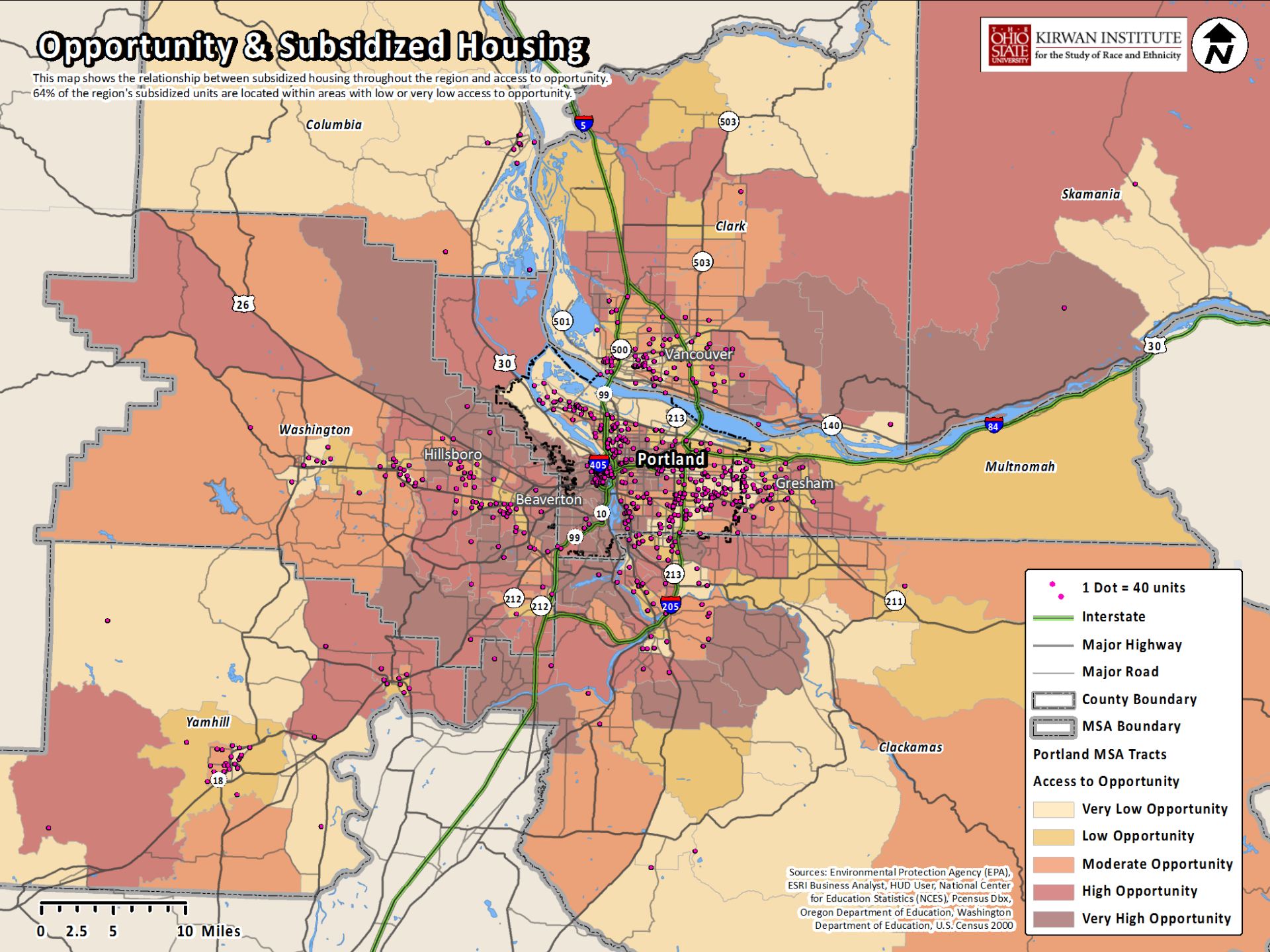
Sources: Environmental Protection Agency (EPA), ESRI Business Analyst, HUD User, National Center for Education Statistics (NCES), Pncensus Dbx, Oregon Department of Education, Washington Department of Education, U.S. Census 2000

Opportunity & Subsidized Housing

This map shows the relationship between subsidized housing throughout the region and access to opportunity.
64% of the region's subsidized units are located within areas with low or very low access to opportunity.



KIRWAN INSTITUTE
for the Study of Race and Ethnicity

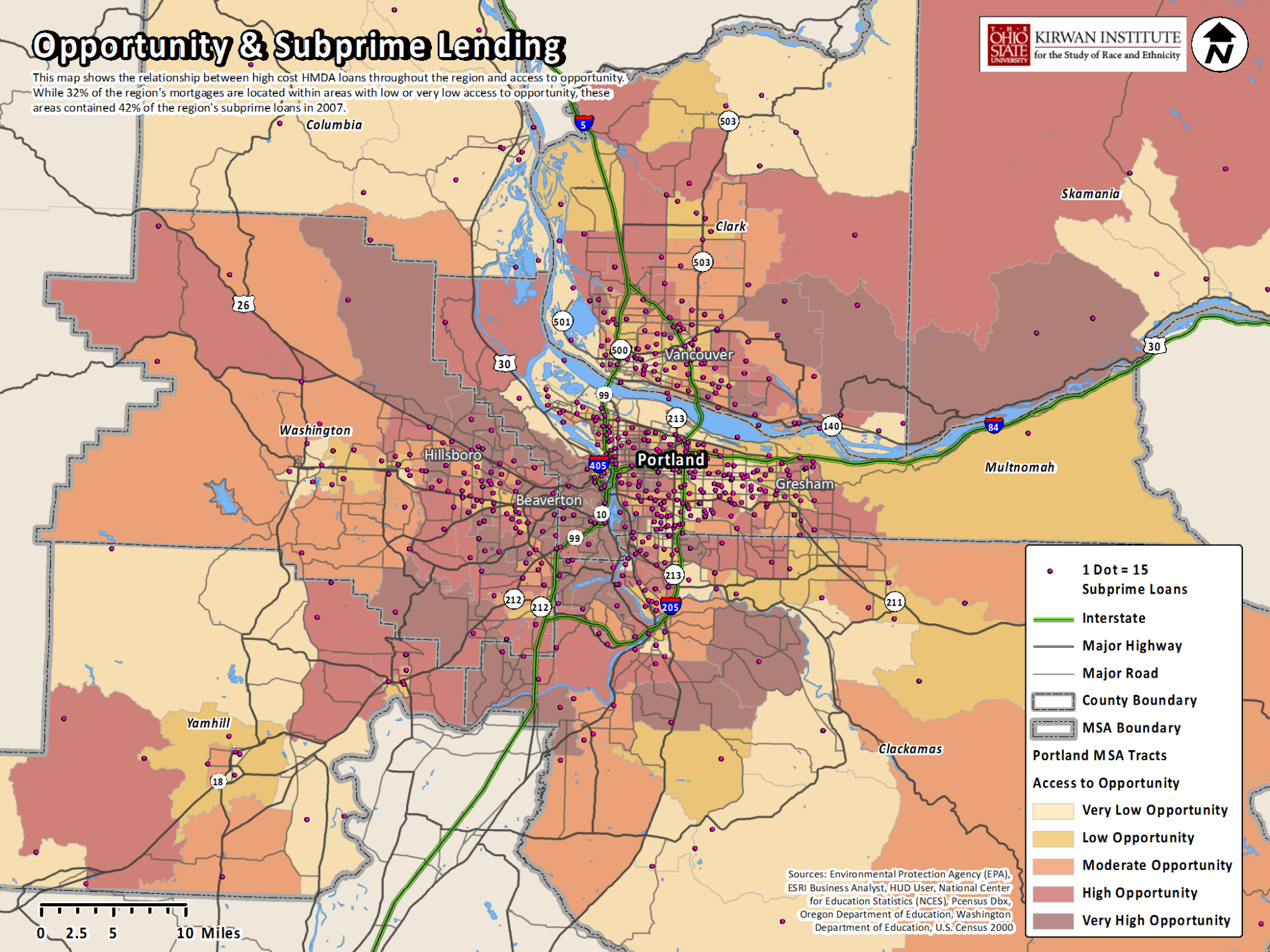


- 1 Dot = 40 units
- Interstate
- Major Highway
- Major Road
- County Boundary
- MSA Boundary
- Portland MSA Tracts
- Access to Opportunity
 - Very Low Opportunity
 - Low Opportunity
 - Moderate Opportunity
 - High Opportunity
 - Very High Opportunity

Sources: Environmental Protection Agency (EPA),
ESRI Business Analyst, HUD User, National Center
for Education Statistics (NCES), Pncensus Dbx,
Oregon Department of Education, Washington
Department of Education, U.S. Census 2000

Opportunity & Subprime Lending

This map shows the relationship between high cost HMDA loans throughout the region and access to opportunity. While 32% of the region's mortgages are located within areas with low or very low access to opportunity, these areas contained 42% of the region's subprime loans in 2007.

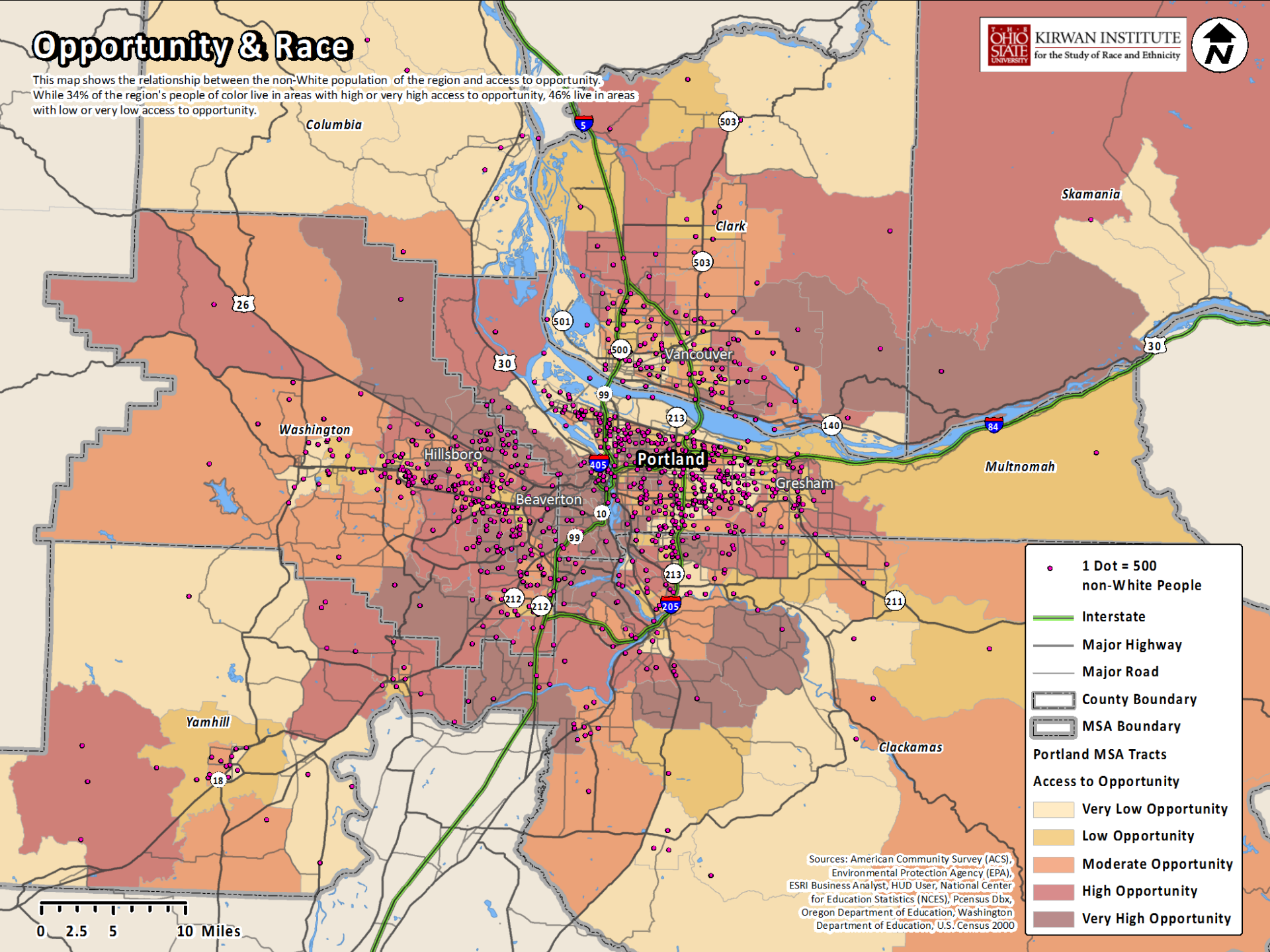


- 1 Dot = 15 Subprime Loans
- Interstate
- Major Highway
- Major Road
- County Boundary
- MSA Boundary
- Portland MSA Tracts
- Access to Opportunity
 - Very Low Opportunity
 - Low Opportunity
 - Moderate Opportunity
 - High Opportunity
 - Very High Opportunity

Sources: Environmental Protection Agency (EPA), ESRI Business Analyst, HUD User, National Center for Education Statistics (NCES), Pcenus Dbx, Oregon Department of Education, Washington Department of Education, U.S. Census 2000

Opportunity & Race

This map shows the relationship between the non-White population of the region and access to opportunity. While 34% of the region's people of color live in areas with high or very high access to opportunity, 46% live in areas with low or very low access to opportunity.



• 1 Dot = 500
non-White People

— Interstate

— Major Highway

— Major Road

▭ County Boundary

▭ MSA Boundary

Portland MSA Tracts

Access to Opportunity

Very Low Opportunity

Low Opportunity

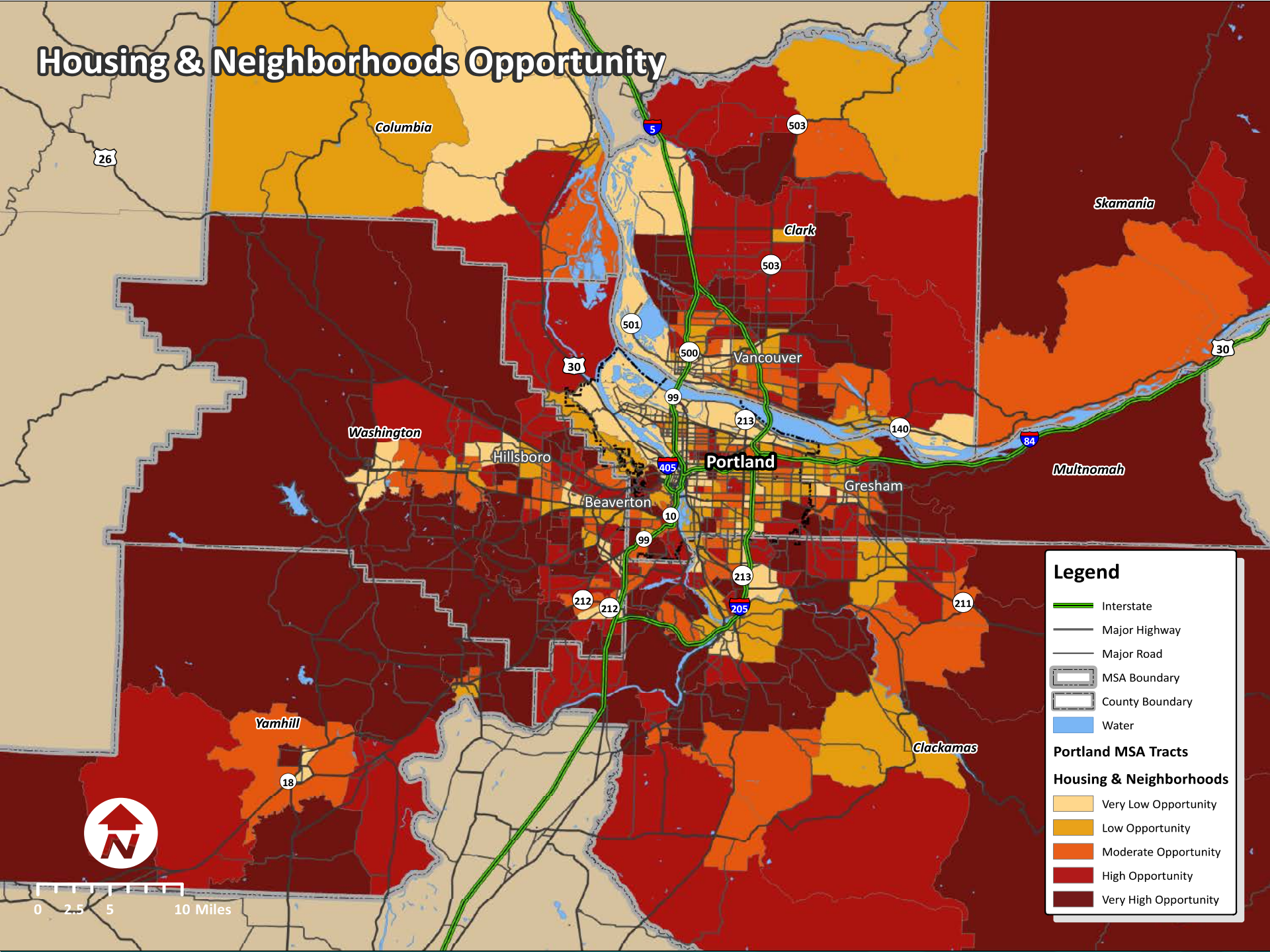
Moderate Opportunity

High Opportunity

Very High Opportunity

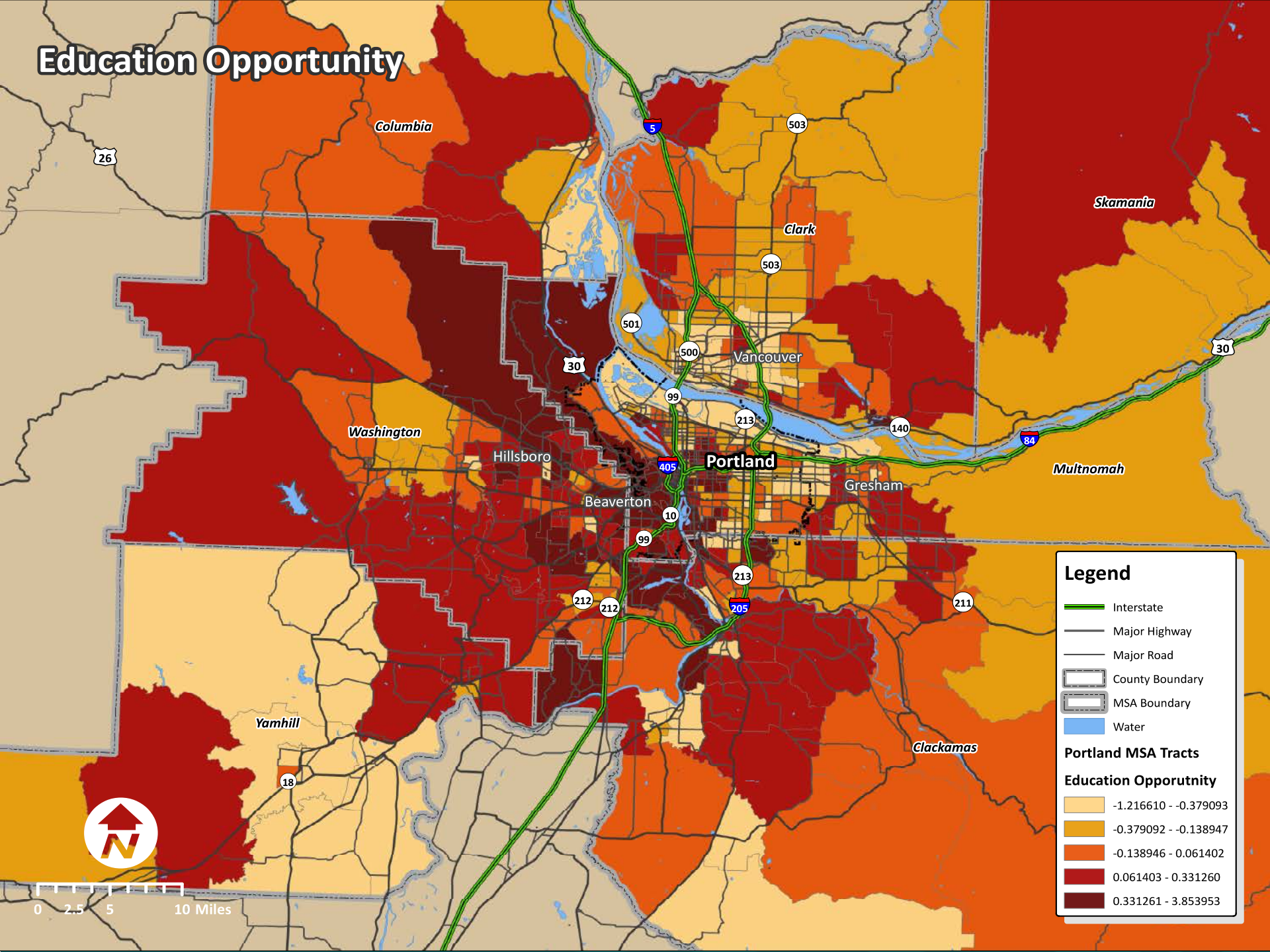
Sources: American Community Survey (ACS),
Environmental Protection Agency (EPA),
ESRI Business Analyst, HUD User, National Center
for Education Statistics (NCES), Pccensus Dbx,
Oregon Department of Education, Washington
Department of Education, U.S. Census 2000

Housing & Neighborhoods Opportunity

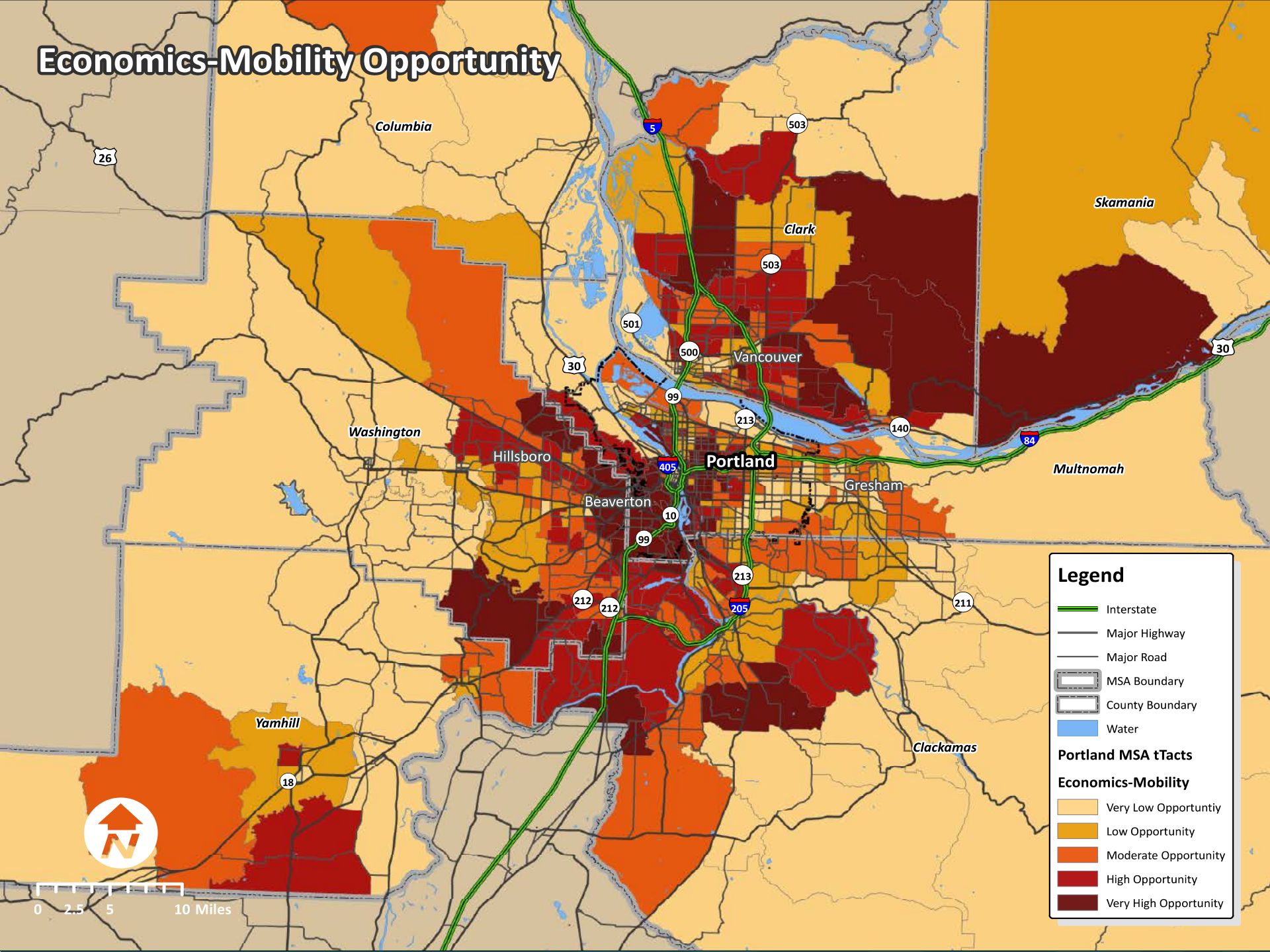


0 2.5 5 10 Miles

Education Opportunity



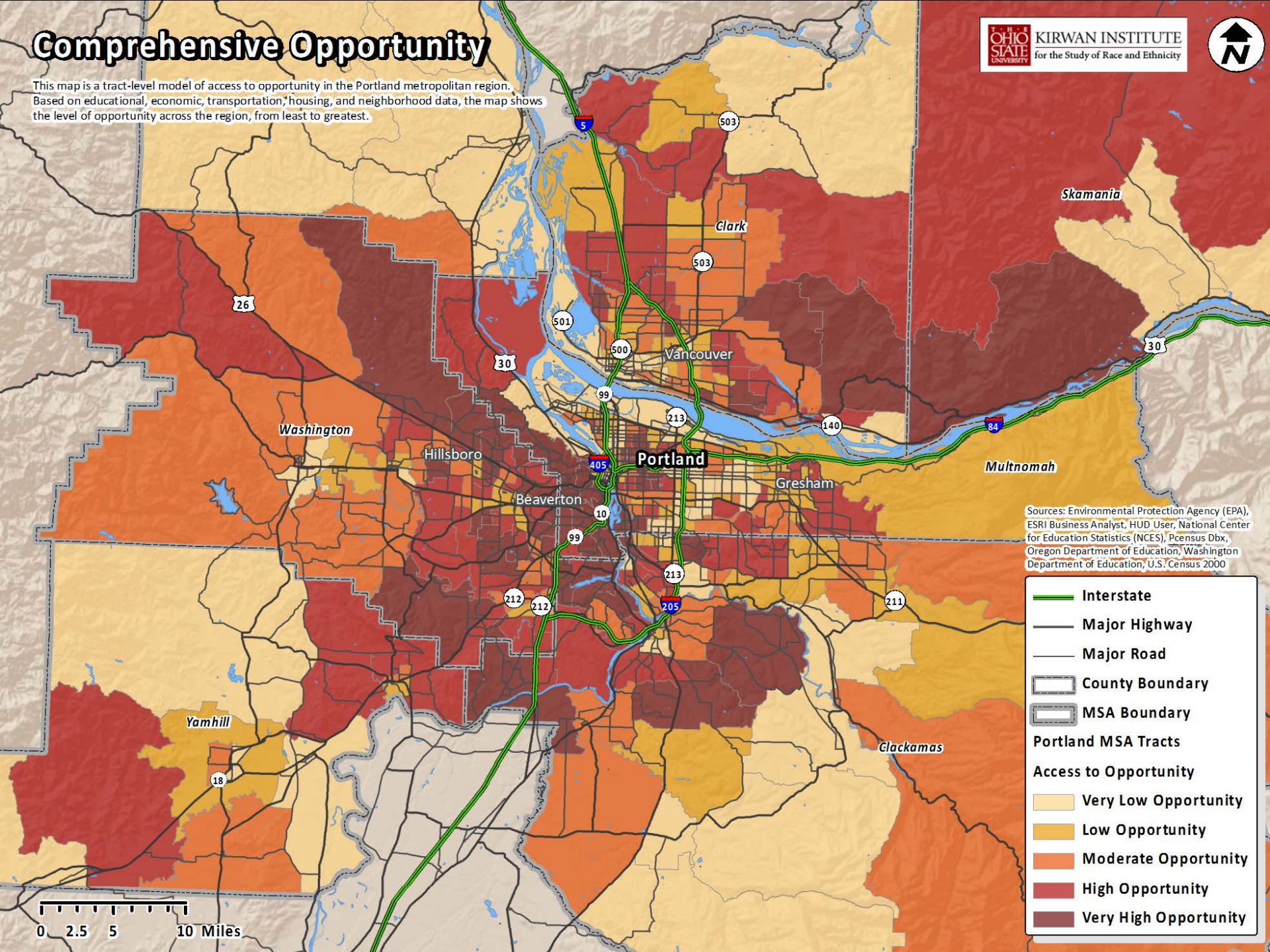
Economics-Mobility Opportunity













0 2.5 5 10 Miles

Comprehensive Opportunity

This map is a tract-level model of access to opportunity in the Portland metropolitan region. Based on educational, economic, transportation, housing, and neighborhood data, the map shows the level of opportunity across the region, from least to greatest.



Sources: Environmental Protection Agency (EPA), ESRI Business Analyst, HUD User, National Center for Education Statistics (NCES), Pcenus Dbx, Oregon Department of Education, Washington Department of Education, U.S. Census 2000

-  Interstate
-  Major Highway
-  Major Road
-  County Boundary
-  MSA Boundary
- Portland MSA Tracts**
- Access to Opportunity**
-  Very Low Opportunity
-  Low Opportunity
-  Moderate Opportunity
-  High Opportunity
-  Very High Opportunity

Place & Neighborhoods: Significant Impact on Child Development and Health - *Neighborhoods as Systems of Disadvantage*





How do we target strategies to further the goal of healthy lives for everyone?

Equity requires a targeted approach.

Racialized...

- In **1960**, African-American families in poverty were **3.8** times more likely to be concentrated in high-poverty neighborhoods than poor whites.
- In **2000**, they were **7.3** times more likely.

Spatialized...

- marginalized people of color and the very poor have been spatially isolated from opportunity via reservations, Jim Crow, Appalachian mountains, ghettos, barrios, and the culture of incarceration.

Globalized...

- Economic globalization
- Climate change
- the Credit and Foreclosure crisis

Universal Goal with Targeted Strategy

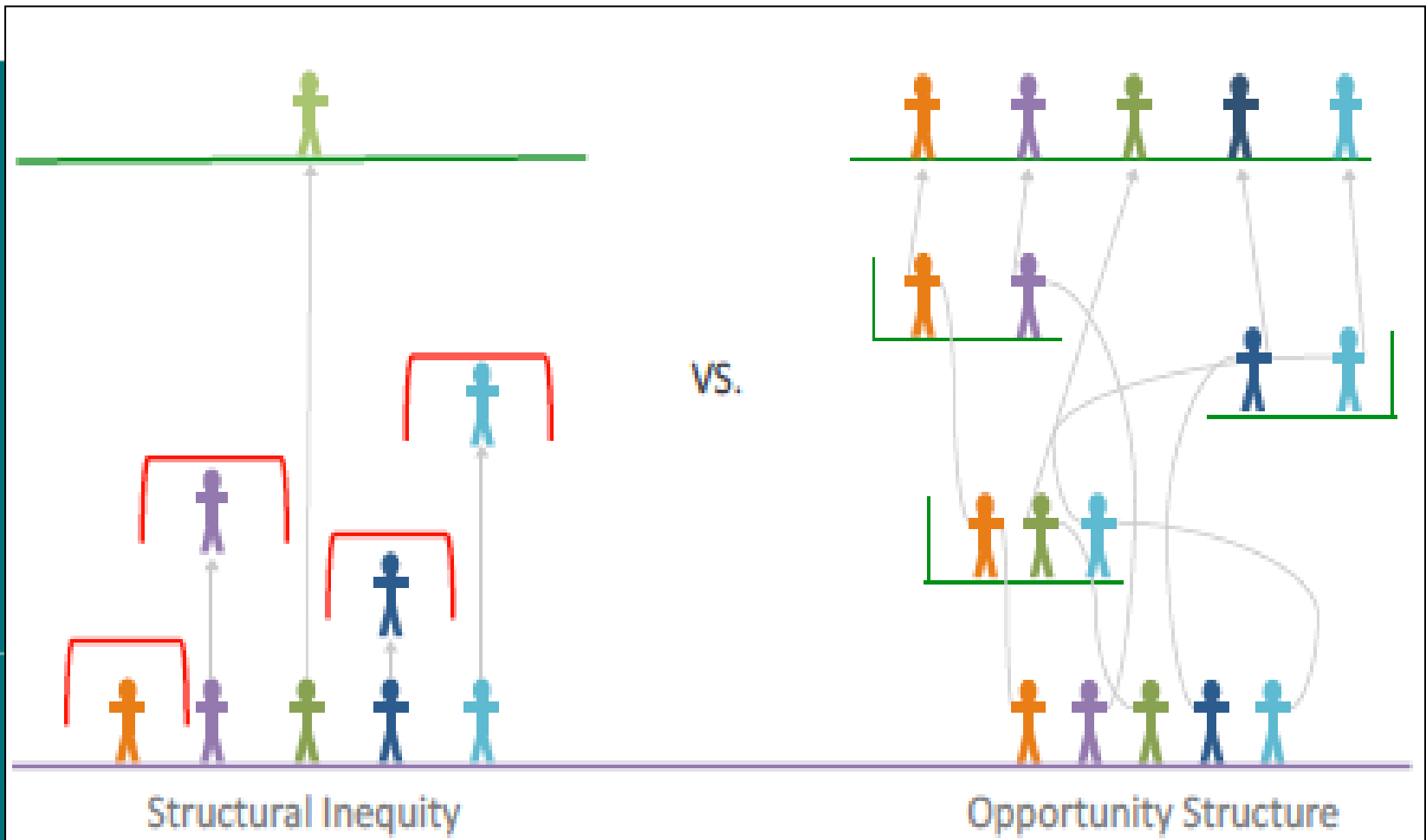
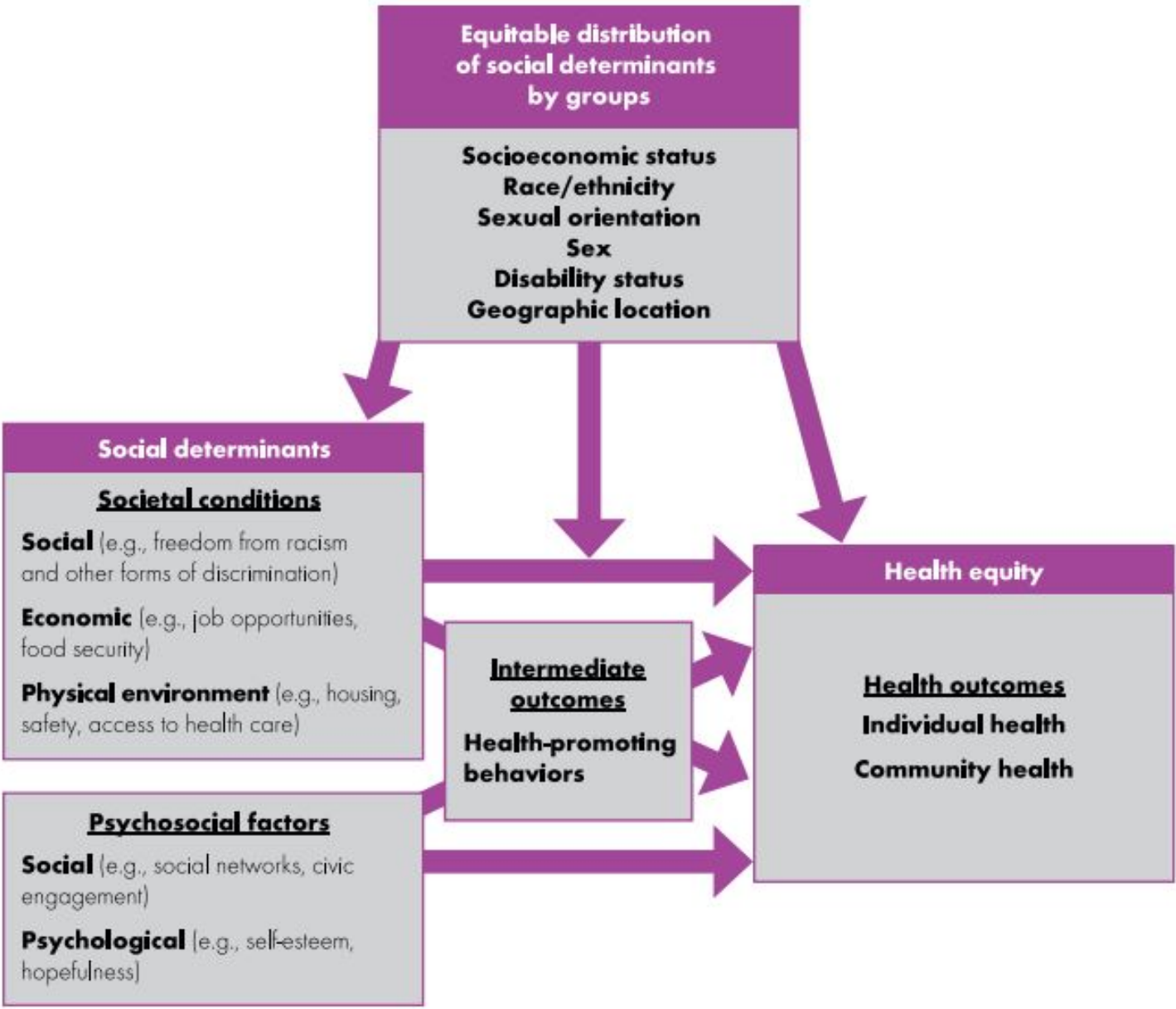


Figure 1.1: Pathways from Social Determinants to Health



Social determinants of health broadly include both societal conditions and psychosocial factors, such as opportunities for employment, access to health care, hopefulness, and freedom from racism.

These determinants can affect individual and community health directly, through an independent influence or an interaction with other determinants, or indirectly, through their influence on health-promoting behaviors by, for example, determining whether a person has access to healthy food or a safe environment in which to exercise.

Figure adapted from Blue Cross and Blue Shield of Minnesota Foundation, http://www.bcbsmnfoundation.org/objects/Tier_4/mbc2_determinants_charts.pdf and Anderson et al, 2003.^{38,39}

Identifying Strategic Issues to Address Health Equity

As you develop strategic issues, remember that questions are never neutral. Rather, people apply frames that influence the questions they ask. They are posed within specific social, political, historical, and cultural contexts. Questions are often driven by institutional agendas, values, and priorities that may or may not address community members' needs and wants.

The following table contrasts conventional and health equity questions that can be used to understand public health problems and identify potential solutions. When analyzing data from the MAPP Assessments to identify strategic issues, use a health equity frame to ask your community these questions.

CONVENTIONAL APPROACH	HEALTH EQUITY APPROACH
Why are people unhealthy in our community?	What social conditions and economic policies make some people more likely to be unhealthy?
Why can't vulnerable populations access services?	What institutional policies and practices prevent people from accessing services?
What types of services and resources do we need to improve health?	What fundamental policy changes do we need?
How do we reduce disparities in health outcomes?	How do we eliminate the social injustices that produce inequities in health outcomes?
What programs and services do we need to address health disparities?	What kind of collective action and structural social changes do we need to tackle health inequities?
What unhealthy behaviors should we discourage among vulnerable populations?	What interests and power structures affect people's health and wellness?
Which government officials, expert researchers, or media personalities best understand the issue?	Which community members and grassroots organizations can best define the issue?
Which public officials and research institutions will decide on appropriate courses of action?	How can we work within our communities to define and prioritize public health concerns?
How can we make people more responsible for their own health?	How can we create social responsibility and public accountability to protect the public good?

Health Equity

PHASE FOUR: Identify Strategic Issues

Equity is not equality

- The MAPP framework and CHIP process looks at inequities, not inequalities
- Equity requires consideration of difference rather than a gap in performance measures

Disparities focus

- Sets better performing group as the achievement goal
 - Middle-aged White Americans have rising death rates driven by suicide, drugs, and alcohol abuse
 - Death rates declining for other races, ethnicities, and other wealthy countries
- Focuses on practices of underperforming groups
- Closing gaps doesn't mean systemic and structural change



Multiple organizations gathering information

- Africa House
- ORCHWA
- APANO
- CIO
- Milagro
- NAYA
- Multnomah County Patient Advisory Council
- Puentes
- Sisters of the Road

Different targeted groups & key areas provide information

- African immigrants and refugees
- Asian American Pacific Islander
- LGBTQI
- Youth
- Latino/a
- Maternal child health
- HIV services
- Latina mothers
- County staff
- Native American youth and parents
- Parents and elders
- Latino/a adults
- Unhoused

- Existing health system capacity to address need
- Exists in more than one sub-area of KPNW service area

C. Prioritized description of all the community health needs identified through the CHNA (i.e., issue statements)

Nutrition & physical activity related chronic disease is a health need as evidenced by multiple poor health outcomes, including obesity, diabetes, cancer, cardiovascular disease, and poor mental health.

Economic security is a health need as indicated by poverty, educational attainment, and health insurance coverage, as well as racial and ethnic disparities. Evidence shows that wealth, or a lack thereof, is the strongest determinant of health.

Access to health care, particularly primary care, is a health need with regard to diabetes management, screening for cancers and sexually transmitted disease, and prenatal and dental care.

Maternal and infant health is a health need as indicated by rates of infant mortality, low birth weight, teen births and child poverty as well as racial, ethnic, and geographic disparities.

Mental health is a health need primarily evidenced by suicide, but also by homicide and inadequate social and emotional support, with some geographic and racial disparities.

Cancer, in particular colorectal cancer, but also breast, lung, and prostate cancer, is a health need as evidenced by region-wide higher than benchmark all-cancer mortality rates as well as racial, ethnic, and geographic disparities.

Tobacco use is a health need as a likely risk factor for many poor health outcomes such as breast, lung, and colorectal cancers, and cardiovascular disease, and poor mental health.

Injury is a health need as indicated by both intentional injury (homicide and suicide), unintentional injury (non-transport accidents), as well as racial and gender disparities.

Sexually transmitted disease (chlamydia and HIV) is a health need because it is a general measure of poor health, indicates the prevalence of unsafe sex practices, can be a predictor of cervical cancer (chlamydia), and can be life-threatening (HIV).

Oral health is a health need as indicated by (very) poor dental health, lack of dental care, and in part due to the evidence-based link between oral health and overall health.



Community Health Needs Assessment



D. Community assets and resources available to respond to the identified health needs of the community

1. Existing health care facilities
2. Other existing community resources

Kaiser Permanente has identified and partners with Federally Qualified Health Centers (FQHC), Community Services Clinics (CSC), Tribal Health Centers, and Rural Health Clinics across the *primary* and *secondary* service areas. These health care facilities represent a large set of resources available to respond to the identified community health needs. In addition to providing primary health care services and in some cases specialty care, these health care clinics also serve as resource hubs to connect patients with other essential social

essment, email CHNA-Communications@kp.org.

Understand the problem before creating strategies.

- Questions to answer:
 - How does quantitative and qualitative data tell the story about health and illness in our community?
 - What information is missing?
 - Who should we be talking with?
- Next Steps
 - Once we have the information and data compiled, how do we turn it into actionable knowledge?
 - Strategies
 - Collaborative social research, interpretive focus groups





Collective work in health must be...

Transformative

- Create System Level Change
- Catalyze change
- Target Leverage Points
- Impact Cross-Domain, Cross-Sector, Cross-Issue

Power-Building

- Support Alliances
- Build Coalitions
- Broaden Stakeholders
- Build Movement

Change the Narrative

- Inspire Action
- Raise Consciousness
- Create Coherence Between Issues
- Resonate Widely

Developing Network Partnerships in Health

Infrastructure and Structured Alliances

- More than a coalition, but less than an organization.
- A shared platform or structure that holds together and has the capacity to support and link critical interdisciplinary and inter-sector relationships, with a particular emphasis on those that bridge across social cleavages.

Achieve Scale to Play Big

- Tackle Big Issues/Game Changers
- Alignment: Bring together Advocates, Researchers, Organizers, and Policymakers

Identify Strategic Partners and Expand Outward

- Identify core groups
- Grow in stages. Legitimate and communicate community ambition.
- Shared Governance: Participants contribute to and define the agenda.

Medicaid Health Homes

- *Overlap between chronically ill patients served by health homes and low-income residents served by affordable housing providers*

Community Health Needs Assessment

- *Highlight the intersection of health and housing, can lead to direct investment in housing by community hospitals (anchor institutions)*
- *St. Joseph Health System has invested in affordable housing construction in Orange County, CA*

Medicaid Rule on Eligible Providers

- *Non-medical and non-licenses practitioners can offer preventative services and receive reimbursement provided services have been recommended by a doctor or licensed practitioner*
- *Restricted services to those directly diagnose, treat, or prevent illness (ex. lead exposure)*

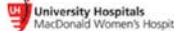
CLINICAL PARTNERS

Clinical Partners

Our Results

Industry Movement

Health Leads works closely with our clinical partners to build a coordinated approach to care that addresses the basic resource needs of patients.



Through CHIP process, Pinellas Cty, FL

- police were included in approach to encounters rooted in mental health and substance abuse
- Mobile command bus offers resources and social resources through collaboration with local agencies

- IRS clarified rule on actions nonprofit hospitals can take to improve local community health beyond charity care. It can include addressing social determinants of health.
- Boston Medical Center physicians write prescriptions for food to be obtained at the food pharmacy
- ACA contains incentive structures moving hospitals to be focused on prevention

RACING TO JUSTICE

*transforming our conceptions of self and other
to build an inclusive society*

john a. powell

For more information, visit:

<http://www.iupress.indiana.edu/catalog/806639>



Like the Haas Institute on Facebook!

www.facebook.com/haasinstitute