
ASTHO Snapshots: State Activities to Reduce Health Disparities and Promote Health Equity

Although eliminating racial and ethnic health disparities and improving health outcomes for minority¹ populations has been a national and state public health priority over the past three decades, few actual reductions in racial/ethnic health disparities have occurred. One factor that has contributed to this limited progress is that little is known about effective methods that have lasting impacts on reducing racial/ethnic health disparities.

To fill this knowledge gap, in 2007 ASTHO conducted a survey of state and territorial health agencies (STHAs) regarding their approaches to eliminating racial/ethnic health disparities (HD) and improving minority health (MH) outcomes. ASTHO used the data reported in the survey to develop the state/territorial summaries included in this compendium as a way to provide a point-in-time “snapshot” of minority health/health disparity (MH/HD) activities in the states/territories. The data summarized in the snapshots were drawn from information reported both in the 2007 ASTHO survey and during extensive follow-up that was carried out to verify survey information. All included snapshots have been reviewed by both the focal points for MH/HD in the states/territories and the state/territorial health officials (STHO).

Each snapshot is a stand-alone document that can serve as a quick reference regarding state/territorial minority health/health disparity activities. The snapshots include basic descriptive information on the following:

¹ For purposes of this survey, racial and ethnic minorities refer to individuals identified in the United States Census as: Black or African Americans, American Indians and Alaskan Natives, Asians, Native Hawaiians or other Pacific Islanders, people of Hispanic or Latino ethnicity who may also be of any race, Multi-Racial individuals, or individuals of Other Race not identified as White.

- S/T demographics
- STHA health priorities
- Organization/infrastructure
- Financial investments
- Human capital investments
- Strategic planning
- Evaluation/tracking
- History
- Partnerships
- STHA program/activities

Taken together, the snapshots provide a national portrait of state/territorial health agency approaches to addressing minority health/health disparities (MH/HD). In addition, ASTHO hopes that the snapshots will increase awareness of state/territorial approaches to MH/HD, facilitate direct communication related to MH/HD among states, and serve as a launching pad for dialogue regarding the relative effectiveness of health agency approaches to MH/HD.

ASTHO does not, however, advocate the use of these snapshots for critical comparison or ranking of states. Although the survey was launched among states/territories in a standard method, considerable variation emerged with regards to the primary survey respondents, the quality of submitted responses, and the time periods covered by responses. In many cases, considerable follow-up was necessary to ensure completeness and accuracy of the data.

ASTHO Minority Health/Health Disparities Survey (2007)

The 2007 ASTHO Minority Health/Health Disparities Surveys went out to ASTHO's 57 state and territorial health officials including those in: all 50 states, the six territories, and the District of Columbia. Between the period of July and November 2007, ASTHO received a total of 46 responses to the survey.

The surveys were sent to the state and territorial health officials in an effort to capture an agency-wide overview of minority health/health disparities (MH/HD) activities rather than activities specifically administered by designated state/territorial minority health/health disparities offices or programs. In many cases, however, the primary respondent to the survey was indeed the focal point (office, program, staff person) for minority health/health disparities.

The survey was administered on-line and included 22 open and closed- ended questions. Survey questions sought to gather information on the following categories of information:

- State demographics and STHA health priorities;
- Organizational and strategic frameworks for addressing MH/HD;
- Financial and human capital investments in MH/HD;

- Partnerships around MH/HD;
- Specific MH/HD programs and activities: types, target populations, funding sources, partners, evaluation methods, outcomes.

ASTHO plans to administer a similar survey in 2010 to track changes at the state levels in indicators of interest.

MAJOR FINDINGS

Prioritization and Strategic Planning

The minority health/health disparities (MH/HD) survey data revealed that the majority of the states are actively planning around MH/HD work. More than 25 responding states and territories had identified a set of health priorities specifically for racial/ethnic minorities – which they reported, often overlapped with the overall health priorities. These health priorities ranged from broad goals such as improving health access to condition-specific goals such as reducing rates of cardiovascular disease. The most frequently mentioned priorities for racial/ethnic populations included: reducing health disparities, increasing cultural competence, improving cardiovascular health, and reducing infant mortality. Many respondents – representing both states that had racial/ethnic minority-specific priorities and those that had priorities for the population overall only - indicated that many of the overall state health priorities disproportionately affect racial/ethnic minority populations. A small number of states (fewer than 10) included MH/HD as one of overall priorities for the state.

Organizational Approaches to MH/HD

Almost all respondents (more than 40) reported a designated primary contact person within the SHA who tracks, responds to and coordinates issues and activities related to MH/HD and most SHAs reported having an organizational unit with primary responsibility for racial/ethnic health disparities and minority health issues. These reports show that between 1988 and 2007, the number of state offices of minority health increased from fewer than five to almost 35; 2004-2007 represents the period of most dramatic increase in the number of SOMH within state health agencies. Almost 30 of the states reported that state/territorial legislation or mandate dictated the organizational approach pursued by the SHA. States reported numbers of staff dedicated to MH/HD (in part or in full) ranging from 1 to 5; the modal number of reported staff was 1.

Other organizational mechanisms that SHAs have employed to address MH/HD, either in addition to or in place of an office, include: designated MH/HD representatives in program offices throughout the STHA, MH/HD staff and activities at local health departments, MH/HD commissions, and involvement in Government-level or other external coalitions/commissions. Internal and external MH/HD task forces exist, with more external task forces rather than internal reported. Almost 10 states reported a governor's office task force. Other outside

agencies that were frequently mentioned as collaborating partners included: other SHAs, local health departments, and other non-profit organizations. There were robust collaborations with outside agencies as well as reported MH/HD work within the SHA.

Partnerships

Almost all SHAs reported that entities outside of state/territorial health agencies also conducted minority health and health disparities (MH/HD) activities in their jurisdictions that complemented or extended the SHA's activities. Examples of these entities include (by frequency of mention):

- Non-profit organizations
- Other state agency
- Local health department
- Private organization
- Governor's office or task force

Of particular interest, corporations were the least frequently mentioned partner indicating an area of expertise and resources that has gone largely untapped. Within state health agencies, program offices that were most frequently mentioned as collaborators were:

- Chronic disease prevention and health promotion
- Maternal and child health or children with special health needs
- Infectious or communicable disease
- Epidemiology
- Public information and policy

Funding

There was wide variation with regards to the financial investment of states in MH/HD. Of the 30 SHAs who reported having budgets for MH/HD activities, the majority reported receiving either federal or state funding – or a combination thereof. Fewer than 10 reported receiving other funding – such as from local governments, foundations or corporate entities - to support their MH/HD activities in FY 2007.

Of the 20-25 states reporting federal funding, their funding was allocated by the Secretary's Office of Minority Health (OMH) at the U.S. Department of Health and Human Services (USDHHS). The proportion of these units' budgets comprised by OMH funding varied greatly from state to state - from a high 100% of the unit's total budget to a low of 3% of a unit's budget; the average proportion made up of federal support was approximately 33%. State funding – in those states receiving state funding - also varied widely from a high of \$10 million to a low of \$30,000. The majority of states revealed that they could use more funding in the MH/HD arena, reporting a need for additional amounts from \$1 million up to more than \$20 million to adequately address MH/HD.

States reported that decisions regarding budget allocations for MH/HD were made or shared by the following people or entities (in order of frequency of mention):

- State/territorial health official
- State legislature
- Director/coordinator for MH/HD
- Governor
- Other SHA program managers

Future Directions

In addition to re-launching a minority health/health disparities survey in 2010, ASTHO is using the 2007 data to identify promising practices in state-based health equity promotion activities. ASTHO will follow up with identified states in order to carry out in-depth research into promising and innovative practices. Once such practices have been identified, ASTHO will develop resources to support the implementation of promising practices in additional states.

Please contact ASTHO at mmishra@astho.org with any questions or concerns.